The Mandate

A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015

Equality Analysis

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Introduction

Equality human rights and diversity in the new health system

1. Equalities, human rights and diversity are at the heart of the new health system. The Health and Social Care Act 2012 creates a legal duty on the Secretary of State for Health, NHS Commissioning Board (NHS CB) and Clinical Commissioning Groups (CCGs) to have regard to the need to reduce health inequalities; this complements the existing Public Sector Equality Duty (Equality Act 2010) which the NHS CB and CCGs are also subject to.

2. As part of these duties, the NHS CB will set out in its business plan how it intends to exercise its duty to have regard to the need to reduce health inequalities, reporting on how effectively they have done so in their annual report.

3. The Secretary of State is also required to set out in his annual report how effectively he has fulfilled his inequality duty. Furthermore, in line with the Public Sector Equality Duty, the Department of Health has recently published *Better Health, Better Care and Better Value for All* setting out its statutory Equality Objectives up until 2016.[1] Meeting these objectives and reporting yearly on progress will be a powerful force for tackling inequalities and improving the health of the most vulnerable - through the Mandate, the NHS and Public Health Outcomes Frameworks, and commissioning decisions.

4. The Department is subject to the Public Sector Equality Duty, which requires public bodies to have due regard to the need to:
    - Eliminate discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010;
    - Advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
    - Foster good relations between people who share a protected characteristic and people who do not share it.

5. The Department of Health's Corporate Plan for 2012-13 states that:
    - as a system leader of the reformed health, public health and social care system we will ensure equality remains an integral and vital part of transition
    - as a policy maker we are committed to ensuring that equality is central to policy, based on the best available evidence and understanding of the public we serve
    - as an employer we will continue to promote and achieve equality and diversity in the workplace.

    The Corporate Plan is supported by the Department of Health Equality Objectives and its Action Plan on Equality published this year.

6. Our approach to developing the draft Mandate has been consistent with the both the Department's Corporate Plan and the requirements of the Public Sector Equality Duty for the following protected characteristics:
    - Age

[1] http://www.dh.gov.uk/health/files/2012/04/DH-Equality-Objectives-Action-Plan.pdf

- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation.
- Carers 'by association' with some of the protected characteristics e.g. disability and age

The Mandate

7. The new NHS CB will oversee the way that over £95 billion of taxpayers' money is spent to secure NHS services for the people of England. The way in which it operates will need to ensure that working to achieve equitable outcomes is built into all aspects of its functions so that this money is used effectively.

8. Under the Health and Social Care Act 2012, the Government must set objectives for the NHS Commissioning Board in a 'Mandate'. The Mandate is a multi-year document setting rolling objectives, but refreshed annually following consultation.

9. The Mandate provides democratic legitimacy for the work of the Board. It will be updated annually and laid before Parliament. The Government will maintain constancy of purpose, and strive to keep changes between mandates to the minimum necessary. In this way the Mandate will help provide greater stability for the NHS to plan ahead, innovate and thrive.

10. The Mandate, in conjunction the NHS Outcomes Framework, is one of the main formal accountability documents setting objectives for the NHS CB. It is one part of a broader relationship through which the Secretary of State will hold the NHS CB to account for its performance. The NHS CB will also operate to standard Government accountability features such as framework agreements setting out working relationships and a limited number of financial directions. In addition, the Health and Social Care Act 2012 and associated regulations, set out the services that the NHS CB is required to commission itself, and impose requirements on it in relation to its commissioning functions.

11. This Equality Analysis (EA) examines the potential impact that the Mandate may have on people sharing protected characteristics as outlined in the Public Sector Equality Duty. While conducting this analysis, we considered the detailed information available in the Equality Impact Assessments (EIAs) and Equality Analyses (EAs) which underpin the policies from which the Mandate's objectives are drawn. A full list of these EIAs and EAs is available at Annex A.

12. The initial discussion focuses on the changes that have occurred to the Mandate since the publication of the draft consultation, including feedback from stakeholders and the wider public with the full EA at the end of this document looking at the final Mandate.

Consultation process

13. The consultation on the draft Mandate[2] ran between 4th July and 26th September. The Department of Health held a number of meetings and two larger-scale events with key stakeholders[3], as well as encouraging organisations to involve their members.

14. During the consultation, we were able to reach out to a broad audience in a range of ways:
    - We had a series of discussions with stakeholders from the health and care community, ranging from small meetings to larger-scale events;
    - we encouraged organisations to hold discussions with their members to inform their own response;
    - we received 211 number of consultation responses in the form of letters, email responses and feedback via the website;
    - over 24,000 unique page views of the mandate website http://mandate.dh.gov.uk/; and
    - 80 people responded to an online survey which we set up to poll what people thought about the objectives.

15. A breakdown of the organisations that responded can be found at Annex B. Responses were also received from people who use health and care services, carers, NHS staff and the wider health and care workforce. We analysed all the feedback we received: website comments, the feedback forms, letters submitted and summaries of events and formal consultation responses.

16. The consultation process was particularly helpful in assessing any potential impact of the Mandate on people sharing protected characteristics that were not covered by our previous EA and the links between poor health, socio-economic groups and geography.

17. Over a quarter of the responses came from organisations with a keen interest in equality or hard to reach groups. Many highlighted the need to ensure the needs of these groups are considered in producing the final Mandate.

18. A number of the decisions made following the consultation process potentially impact on people sharing protected characteristics and below follows a discussion of the changes that have occurred and how they affect individuals who share protected characteristics.[4]

Changes since the consultation

19. Overall, the consultation responses highlighted that the Mandate should be strengthened by:
    - Setting clear expectations for the NHS, articulating the outcomes it should achieve but without being prescriptive about how it should be done;

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[2] *Our NHS care objectives: A draft mandate to the NHS Commissioning Board* http://www.dh.gov.uk/health/2012/07/draft-mandate-consultation/

[3] See Annex C for full list of attendees. Many of the attendees also responded to the consultation and came from a wide range of representative organisations

[4] Readers interested in seeing the reasons behind the changes and a more detailed analysis of the changes should read the full consultation response published alongside this EA.

- Embedding the principle of local autonomy and innovation, and empowering patients, service users and carers;
- Setting the tone for, and encouraging the right behaviours and culture across the health and care system;
- Setting a longer term agenda and providing stability for the NHS to plan ahead and innovate;
- Focusing and driving forward an outcomes based approach and putting greater emphasis on putting patients, carers and families at the heart of the NHS;
- Transforming the way that NHS priorities are set; and
- Promoting the values and principles of the NHS constitution.

20. Having analysed the consultation responses we decided that the Mandate should:
    - Set a clear vision and long term agenda in transforming the NHS to improve outcomes;
    - Restructure the document around the domains of the NHS Outcomes Framework and embed the objectives under the relevant domain;
    - No longer set levels of ambitions
    - Shorten and simplify the document to make it more accessible.

Clear vision and long term agenda

21. The Mandate needs to hold the NHS CB to account and set out a clear vision for the future of the NHS. In the consultation responses, many organisations found that the draft Mandate did not adequately set out our vision for the NHS.

22. By failing to set a clear vision for the NHS, and one that puts at its heart the need to advance equality and reduce health inequalities, people felt that we had not been challenging enough to the NHS CB. Without this, it could have created an incentive for the NHS CB to focus on easier to reach groups to show that progress was being made for all.

23. In the final version of the Mandate, we believe we have set clear and long term priorities with an appropriate focus on vulnerable and hard to reach groups.

24. The Mandate therefore identifies five priority areas, on which the Government expects to see the greatest rate of progress:
    - improving standards of care and not just treatment, especially for older people and at the end of people's lives;
    - the diagnosis, treatment and care of people with dementia;
    - supporting people with multiple long-term physical and mental health conditions, particularly by embracing opportunities created by technology, and delivering a service that values mental and physical health equally;
    - preventing premature deaths from the biggest killers;
    - furthering economic growth, including supporting people with health conditions to remain in or find work.

25. The long-term goals the NHS CB should be working towards:
    - preventing ill-health, and providing better early diagnosis and treatment of conditions such as cancer and heart disease, so that more of us can enjoy the prospect of a long and healthy old age;

- managing ongoing physical and mental health conditions such as dementia, diabetes and depression – so that we, our families and our carers can experience a better quality of life; and so that care feels much more joined up, right across GP surgeries, district nurses and midwives, care homes and hospitals;
- helping us recover from episodes of ill health such as stroke or following injury;
- making sure we experience better care, not just better treatment, so that we can expect to be treated with compassion, dignity and respect;
- providing safe care – so that we are treated in a clean and safe environment and have a lower risk of the NHS giving us infections, blood clots or bed sores

26. In order to meet these objectives it is vital that the NHS CB pays specific attention to the effect that having a protected characteristic, socio-economic status, geography and other factors can have on a person's ability to access healthcare and achieve successful health outcomes.

27. Furthermore, so as to make sure that this clear vision for the NHS does not adversely affect quality of care for anybody, the Mandate is very clear that all of the objectives should focus on improving outcomes.

Focus on outcomes

28. The consultation responses showed that the link between the Mandate and the NHS Outcomes Framework was not explicit enough. As far as possible, it is our aim to focus upon health outcomes and therefore many of the changes since the publication have been to make the Mandate more outcomes focused.

29. Many of the respondents to the draft Mandate noted that because of this failure to explicitly link the Mandate to the NHS Outcomes Framework we have potentially added an unnecessary layer of complexity; in practice creating a two-tier system of accountability between the NHS CB and Department.

30. As such, the draft Mandate had five objectives based on the NHS Outcomes Framework – which were supposed to underpin the document - and 18 other objectives that highlighted the importance of other areas of work. The final Mandate has five overarching objectives based on the NHS Outcomes Framework and all other objective flow from these.

31. By setting a clear vision that emphasises how the objectives contribute to improving outcomes, we believe that the NHS CB and CCGs will be able to focus their attentions on tackling inequalities and advancing equality.

32. We want to move to a system where the NHS Outcomes Framework is used as the mechanism through which the Secretary for State for Health holds the NHS CB to account. It has been designed to provide an indication of the overall progress of the NHS, wherever possible, in an international context. It will be for the NHS CB to determine how best to deliver improvements by working with CCGs and making use of the various tools and levers it will have at its disposal.

33. The NHS Outcomes Framework has been designed to include a balanced set of outcomes across the breadth of NHS responsibilities, including the needs of different groups. As far as possible, the indictors in the NHS Outcomes Framework have been chosen because the

data can mainly be broken down by equalities characteristics and by geography so that outcomes for disadvantaged groups can be measured.

34. Focusing on outcomes presents a new and radical approach for the NHS but we are only at the start of this journey. Our aim is to improve the framework to ensure that over time it becomes better at monitoring outcomes on vulnerable and hard to reach groups, as currently not all indicators in the framework can be broken down by protected characteristics. Each year we will be refreshing the framework[5] and we are committed to having an independent review in 2015.

35. However, there is always the possibility that, as organisations such as St Mungo's and Turning Point highlighted in their consultation responses, there are many hidden groups who will continue to be difficult to collect data on as they rarely show up in local surveys or national data – homeless people, sex workers and traveller communities for example.

36. If we judge the NHS only on how it improved outcomes at a national level then there may be a risk that some people will suffer consequently. For example, the NHS CB could choose to target its resources on groups of people for which it gets the greatest return in terms of improved outcomes. The groups with the worst outcomes are not necessarily the groups for which the greatest gains can be made at the lowest cost - in particular, they may be hard to reach. In short, national-level improvement goals alone may not prevent discrimination and may not narrow inequalities.

37. In order to tackle this problem, as part of any review of the NHS CB's progress, we will be inviting feedback from CCGs, local authorities, and the public, as well as other organisations. This comprehensive feedback will give us a much deeper understanding of progress made to tackle inequalities compared to previous accountability frameworks that have too often focused on processes rather than people.

38. The consultation responses to the draft Mandate have been very helpful in developing the final Mandate and in us identifying key areas of concern by groups who deal with various hard to reach groups. We fully expect this engagement with key stakeholders to continue and to help us to advance equality in future mandates.

39. Having both the NHS Outcomes Framework and feedback from a broad range of stakeholders – in addition to consultations on future mandates – we should be able to assess progress in advancing equalities and tackling inequalities for all groups, including hidden groups.

- **Removal of levels of ambition**

40. A key change since the consultation has been to remove setting quantified levels of ambition for improvement against the five domains of the NHS Outcomes Framework.

41. Previous iterations of the framework indicated that a range of metrics would be required to measure progress to cover the indicators in the framework. The first NHS Outcomes Framework in 2010 explained that the Government would set 'levels of ambition' against

[5] Each iteration of the NHS Outcomes Framework has a corresponding EA

the Framework. The Government outlined proposals for how these could be set in the draft Mandate consultation.

42. Although the principle of focusing on outcomes received strong support, there was criticism from some that the proposals for setting levels of ambition were too reliant upon precise technical assumptions for which the evidence base is not robust. Additionally, some were concerned that these would be perceived as local 'targets'. Instead, the Mandate requires the NHS CB to make progress on all areas of the NHS Outcomes Framework.

43. As such, setting levels of ambition could have had a significant impact on people sharing protected characteristics. Potentially leading to perverse incentives whereby some groups are disadvantaged. This risk is present in any accountability structure, but the move to focus more on outcomes – described above – should have reduced this risk.

44. Removing levels of ambition has made it very important that the NHS CB take into account their duties under the NHS Act 2006, as amended by the Health and Social Care Act 2012, to have regard to the need to reduce inequalities, and to act with a view to improving the health outcomes for all groups. The yearly review of their progress will be crucial in this regard.

- **Shorter and simpler**

45. The consultation responses were very clear that the Mandate was too long and too inaccessible. Our aim with the NHS reforms has always been to put patients at the centre of their care and build the service around them. If patients and the public do not feel the document relates to them, it fails to empower them.

46. By making the Mandate shorter we have tried to make the document easier to read and much more accessible to a wide range of audiences.

47. In making these changes, attention has been paid to not exclude the concerns of, and issues affecting, people sharing protected characteristics, who may face discrimination or disadvantage.

48. In particular, we have removed the specific objective from the draft Mandate[6] that addressed inequalities. We believe it should increase the focus on inequalities as a whole and, as such, advance equality in the long term.

49. Good practice shows that embedding equality, human rights and diversity into the day-to-day systems and behaviours in an organisation is the most effective way to advance equality, eliminate discrimination and foster good relationship between people with different protected characteristics. Advancing equality and reducing avoidable health inequalities must be at the centre of every objective in the Mandate. Working to a separate single objective may have meant that this important work was seen as other people's business rather than core to the day-to-day work of the NHS CB.

50. Hence why in the Mandate now states:

[6] Objective 7 read: Provide an assessment of progress in narrowing inequalities in life expectancy at birth (as mentioned by the Slope Index of Inequality) through greater improvement in more disadvantaged communities

The NHS is a universal service for the people of England, and the NHS Commissioning Board is under specific legal duties in relation to tackling health inequalities and advancing equality. The Government will hold the Board to account for how well it discharges these duties.

51. We believe this approach will be more effective at improving healthcare for all. It also allows us explicitly hold the NHS CB to account on how they have advanced equality in each objective.

Full equality analysis

52. This is the assessment of the impact we expect the Mandate to have on people who share protected characteristics.

53. All of the objectives set in the Mandate strive to improve outcomes for all. Indeed, they have been chosen so that the NHS CB can seek to reduce health inequalities and increase equality.

54. As part of achieving improvements set out in the Mandate, we would expect the NHS CB to demonstrate how they have met these objectives and how they have taken into account their duties in relation to advancing equality and reducing health inequalities. As such, the EA will not detail all of the objectives specifically.

Title: The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015

The Mandate has been produced as part of fulfilling a number of commitments made in Department of Health Business Plan 2011-2015.

Also, to contribute towards the Department of Health's Corporate Plan for 2012-13 which states that:

- as a system leader of the reformed health, public health and social care system we will ensure equality remains an integral and vital part of transition
- as a policy maker we are committed to ensuring that equality is central to policy, based on the best available evidence and understanding of the public we serve
- as an employer we will continue to promote and achieve equality and diversity in the workplace.

The intended outcomes of this work

The Mandate sets out the Government's priorities for the NHS by setting objectives for the NHS CB. The objectives in the Mandate form a key element of the NHS CB's accountability relationship with the Department, underpinning both the Secretary of State for Health's responsibility for the health service as a whole and the NHS CB's responsibilities for driving improvements in the NHS through the commissioning system.

Who will be affected?

Everyone, be they patient, service user, carer, health and care professional or someone who has never yet accessed the heath and care system should be affected by the aims of this Mandate. Every one in England shares a number of protected characteristics and the Public Sector Equality Duty is there to protect everyone. The Mandate aims to improve outcomes for all, reduce health inequalities everywhere and advance equality for everyone.

Evidence

The evidence considered

As well as building on available evidence referenced in the endnote, we used existing Equality Impact Assessments (EIAs) and Equality Analyses (EAs) highlighted in Annex A. Furthermore, we also reviewed responses to the formal consultation on the Mandate, including from specific engagement with stakeholders who represent a cross section of the protected characteristics identified within the Public Sector Equality Duty.

Disability

People with a disability routinely struggle to access appropriate care and support; because of this, many disabled people experience negative health inequalities.[i] [ii] [iii] [iv] This often puts them at greater risk of certain conditions and major health problems.[v]

These entrenched problems are a matter of significant concern. In the new health and social care system, the Department of Health plays a vital role in tackling these problems and coordinating with key stakeholders to overcome many of the barriers people with a disability face.

One area were there is a particular need for improvement is in supporting children and young people with special educational needs or disabilities (SEND). In the Mandate there is an objective on the NHS CB to ensure that they have access to the services identified in their agreed care plan and that their parents will have the option of a personal budget based on a single assessment across health, social care and education. In addition, focusing on having the lowest mortality rates in Europe and on having the improving support for people with multiple long term physical and mental health conditions can only be achieved by tackling these ingrained health inequalities for people with a disability. Finally, having a strong focus on mental health should have a significant impact on people with a disability who have higher rates of co-occurring mental health conditions than the general population.[vi]

Our intention is to put mental health on a par with physical health. Mental health conditions are the leading cause of disability in the UK and people with mental health conditions have increased health needs. For instance, people with schizophrenia or bipolar disorder have higher rates of heart disease, stroke, high blood pressure and diabetes compared to the rest of the population.[vii] They are also 90% more likely to get bowel cancer and 42% more women are likely to get breast cancer.[viii] As such, in order to achieve our goal to put mental health on a par with physical health it is vital that we improve not just an individual's mental health, but also their physical health at the same time. Taking into account the significant but often avoidable health inequalities people face.

People with a learning disability

As well as people with a disability facing health inequalities, people with a learning disability face significant barriers to accessing healthcare, Mencap described this in their *Death by Indifference* report as 'institutional discrimination' at every level of the health service.[ix]

People with a learning disability are 58 times more likely to die before their 50th birthday than other people.[x] Moreover, the median age at death for people with learning disabilities is about 25

years younger than for those who do not have learning disabilities.[xi]

Making sure the NHS is patient centred means that for people with a learning disability – and particularly for those with a profound and multiple learning disabilities[xii] – the service has to think differently and involve the person and their family as much as possible.[xiii] The NHS reforms have always aimed to embed in the NHS a real sense of 'no decision about me without me' and the Mandate is no different.

The shocking events that occurred in Winterbourne View hospital highlight again that change is required and in the Mandate we have explicitly called on the NHS CB to ensure that vulnerable people – including those with a learning disability and autism – are treated in safe appropriate environments. A key test of this will be a reduction in inpatient admissions, yet this cannot be the only measure. Improving the health outcomes for all requires us to make significant progress in improving poor health outcomes for people with a learning disability.

We hope the Mandate will go some way to tackling these problems, but the yearly reviews of the NHS will be a good opportunity for us to monitor progress being made.

Sex

Men and women share many health risks. Yet there are some marked differences between men and women which impacts morbidity, mortality and health outcomes.

Domain One of the NHS Outcomes Framework concerning life expectancy shows that it has been steadily rising for males and females since 1990 and though female advantage persists, the gap between males and females has narrowed over time.

Many of the indicators in the NHS Outcomes Framework can be broken down by gender and this will allow us to monitor the differences and confront the issues.[xiv] This is particularly important for the five biggest killers – cancer, stroke, heart, liver and respiratory disease.

Further to the above, men tend to access GP services less often than women. They also appear to ignore symptoms of ill-health and delay healthcare seeking more often than women, especially when it comes to seeking medical advice about illnesses deemed embarrassing or related to sexual health. Men may be more likely than women to self-medicate in harmful ways, e.g. through use of alcohol and drugs when experiencing mental distress.[xv]

Setting an objective for the NHS CB to make every contact count should help to reduce inequalities caused by men's reluctance to access GP services and advance equality. In addition, the drive to improve information and advice available to all should help raise awareness and encourage more men to seek advice earlier.

Finally, an area we need to pay special consideration to is the impact of some of the objectives on people who have been in abusive relationships. In particular the proposal to give everyone electronic access to their own health records held by their GP. Privacy is an essential factor to consider in this proposal. It is vital that every effort is made to ensure the records are securely kept so to prevent inappropriate access to health records, which could be a risk for people who have experienced abuse.[xvi]

Race

The relationship between race and health inequalities is complex. Some groups experience significantly higher levels of ill-health and premature death than the rest of the population. However, not every ethnic group experiences worse outcomes compared to those who identify themselves as White British.[xvii]

There are also groups who have low levels of health and wellbeing – notably gypsies and travellers, asylum seekers and refugees – for whom more research is needed to identify action needed to address many of the problems people face.

Communication is often cited as a problem for people, with people not being given the time during consultations or being dismissed out of hand. Poor communication can lead to poor health outcomes. An objective in the Mandate is for the NHS CB to ensure the NHS becomes dramatically better at involving patients and their carers, and empowering them to manage and make decisions about their own care and treatment. It is vital, therefore, that communication issues are taken into account as without good communication you cannot have greater involvement.

People from different ethnic groups or recent migrants/refugees can also be at increased risk of mental health conditions.[xviii] The disruption to people's lives or not being able to communicate can exacerbate the isolation and lead to poorer mental health. As above, therefore, in trying to put mental health on a par with physical health, it is vital that we consider the impact race can have on people's mental health and take steps in planning to counteract this. This will inevitably fall upon the people commissioning and delivering the services i.e. NHS CB, CCGs and providers. Nonetheless, it is an important area to monitor and have regard to in the future, especially for groups who have been consistently let down by the NHS e.g. black Caribbean and black African men who are, for example, disproportionately detained in secure psychiatric institutions.[xix]

Age

Older people are particularly vulnerable because they often have co-morbidities; they are physically frailer; their treatment usually depends on taking medication; and their personal autonomy can be severely reduced in an unfamiliar setting. Loss of confidence and autonomy could mean that older people are less able to identify the things they can do to mitigate harm being caused to them; they may also have difficulty understanding risks when healthcare staff communicate to them. Furthermore, older people have high rates of accident mortality and raising levels of suicide (particularly for men in the oldest age groups).

Children and young people also face considerable health and care problems. The recent report by the *Children and Young People's Health Outcomes Forum* found that, amongst other things, 1 in 5 children are overweight or obese by age 3. Approximately 75% of hospital admissions of children with asthma could have been prevented with better primary care and more than a third of short stay admissions in infants are for minor illnesses that could have been managed in the community.[xx]

The NHS can play a vital role in tackling these poor health outcomes and the Mandate makes it an objective for the NHS CB to look to tackle many of these issues and to improve the standards of care that people receive. Our aim is to put the patient at the centre of their

care and this can only be done by considering everyone's individual needs. Overall, therefore, we expect the Mandate to have a positive impact reducing inequalities across all ages.

Our priority areas all rely on improving services for young and old alike. Many of the problems that lead to premature mortality can be traced to problems from a young age e.g. half of lifetime mental illness starts by the age of 14.[xxi]

An area in the Mandate that we pay specific attention to concerns dementia. There is a risk that having a focus on one condition may lead to health inequalities for others. Although as explained above we do not believe this is the case, we also believe that there is a real need to improve the health outcomes for people with dementia. One in three people over 65 will end their lives with dementia.[xxii] Many of the problems faced by people growing old are natural. Some of the most serious are societal however. Dementia has a huge impact on how an individual engages with people and this inevitably leads to greater health problems. The cumulative affect of age and dementia warrants specific attention, as does the fact that there are 800,000 people with dementia in the UK which is forecast to increase to over a million by 2021.[xxiii]

Gender reassignment (including transgender)

Data on health outcomes for transgender and transsexual people is poor. We know that these groups are particularly vulnerable to discrimination and harassment. The Lesbian & Gay Foundation highlighted that transgender and transsexual people face problems with access to healthcare and there are significant privacy issues.

Judging outcomes using the NHS Outcomes Framework is particularly important in this regard. Although we have to be conscious of problems identifying the transgender community in national data, our focus on outcomes should still have a positive impact on equality. In particular, domain 4 relating to the patient experience and domain 5 concerning safety are relevant.

Furthermore, a key part of the Mandate centres on making the NHS better at involving the patient and guaranteeing shared-decision making. As The Lesbian & Gay Foundation highlighted in their response to our consultation, this is particularly relevant for the transgender community who find it very hard to access their preferred services. As such, building better relationships between patient and services – and between different services – is an important factor in reducing inequality.

A risk we need to consider in relation to the transgender community concerns privacy. To improve the data collection and judge outcomes better we would need to collect more information. This is a sensitive area and there is a risk that any moves to collect more information could be met with resentment or hostility by the individuals themselves. It could also adversely impact on their health if people where worried about private information being misused/abused. This concern also needs to be considered in light of the proposal to give people access to their health records.

Sexual orientation

There is very little data on the link between sexual orientation and life expectancy and in the 2007 Citizenship Survey there was no difference in self reported good health between

heterosexual and gay/lesbian people. Bisexual people and those self-classified as "other" were, however, more likely to report not good health.

In responding to the consultation on the draft Mandate, The Lesbian & Gay Foundation highlighted that LGB&T people are more likely than heterosexual people to smoke, drink alcohol and potentially be overweight, and so are at higher risk of a range of conditions. In addition, mental health surveys have shown that there is a higher prevalence of mental health conditions amongst the lesbian and gay population when compared to heterosexual population.[xxiv] A particularly worrying feature of this concerns suicide rates, of which there is some evidence to suggest that younger LGB&T people have higher than average suicide rates.[xxv] Finally, sexual health issues remain an issue and year on year increases in the diagnosis of HIV and other sexually transmitted infections in gay men is an ongoing health concern.[xxvi]

The NHS CB has an important role of working with partners, including Public Health England, to reduce some of the main detriments to health. The Mandate has a clear focus to tackle many of these problems, and in particular to look at improving public health and disseminating information. We have also set an objective in the Mandate for the NHS to take action to identify those groups known to be at higher risk of suicide than the general population.

Currently, sexual orientation is not routinely monitored in the NHS and, as such, the needs and experiences of LGB&T patients are marginalised in the NHS Outcomes Framework. There are problems associated with recording sexual orientation – confidentiality concerns are a particular issue – but the NHS CB and CCGs will have to consider how to tackle this issue to meet its duty under the NHS Act 2006, as amended by the Health and Social Care Act 2012, to have regard to the need to reduce inequalities.

The Mandate, we believe, sets the foundation for this to happen. By giving local areas more power they can work with communities – including the LGB&T community – to address this issue head on and find a solution that works for them. By focusing on outcomes and the patient, local areas will have to tackle ingrained inequalities and consider the needs to LGB&T communities.

Finally, the Mandate puts significant emphasis ensuring the new commissioning system promotes and supports participation in research by NHS organisations and NHS patients. A key issue that needs to be addressed to improve health outcomes for groups based on sexual orientation is the lack of research and data. In seeking to achieve this objective it is vital the NHS CB consider how best to address this lack of research and data on groups who share characteristics. Improving this knowledge should help to reduce inequalities and advance equality in the future.

Religion or belief

Health inequalities for people of different religions or beliefs are not well understood. Census data from Great Britain has shown that among males, the age-standardized percentage of people reporting not good health was highest among Muslims (12.8%) and those reporting 'Any other religion' (12.2%) and lowest among Jewish males (6.5%). Among females, the highest percentage was again among Muslims (16.1%) with the percentage among Sikhs (13.8%) and 'Any other religion' (13.7%) also being high, and lowest again among the

Jewish group (6.9%).[xxvii]

We know certain groups face considerable access issues which can lead to poorer health outcomes. For instance older Muslim and Sikh women, particularly those with poor English language skills, appear to suffer heavy burdens of ill-health, disability and also caring responsibilities. These women are also often in a weak position to negotiate religiously appropriate support from statutory services.[xxviii]

The Mandate should help reduce these inequalities by setting an objective of extending choice in the NHS, in particular through personal health budgets – subject to the final analysis of the pilots and potential future role out. This should help people choose religiously appropriate services and empower people to commission the services they choose and not those chosen for them.

There is a risk that people who have access issues will not be able to benefit from this extra choice and this is something we have to mitigate by improving information and targeting support to people who historically struggle to access services. Anecdotal evidence from the health budgets pilot areas has highlighted the benefit to people of buying religiously appropriate services and we are awaiting the full evaluation to explore this in more detail. Nonetheless, by setting an objective of increasing choice and improving information we believe the Mandate should advance equality and improve patient experience for people of all faiths.

Pregnancy and maternity

One of the ambitions of the Mandate is to help give children the best start in life, and promote their health and resilience as they grow up. To achieve this ambition we need to tackle inequalities faced during pregnancy and maternity.

In the Mandate, we have asked the NHS CB to better join-up care between the NHS and local authorities to improve the experience of women and families during pregnancy and in early years. We want to give women the greatest possible choice of providers, build better relationships between women and midwives by personalising their care and reduce postnatal depression through earlier diagnosis as well as better support.

A long-standing problem with maternity services has been concerns about coercive and disrespectful behaviour experienced by patients, in particular by ethnic minorities.[xxix] We believe the NHS CB has a pivotal role in changing this. By including in the Mandate the changes we want to see, we expect action to be taken to reduce these inequalities.

Carers

Carers play a vital role in the supporting the NHS. It simply could not do what it does without the vital work that carers do to support their loved ones. Despite this, however, carers have poorer health outcomes and face significant barriers because of their caring roles.

The 2001 Census showed that nearly 21% of carers providing over 50 hours of care say they are in poor health compared to nearly 11% of the non-carer population. It also showed that carers are twice as likely to suffer ill health as the general population. Furthermore, younger adult carers are up to three times more likely to be in poor health compared with

their peers.[xxx]

As rapid demographic change increases demand for care and support, our public services, communities and workplaces must keep pace in terms of the support they provide to families. By 2017 we will reach the tipping point for care when the numbers of older people needing care will outstrip the numbers of working age family members currently available to meet that demand.[xxxi]

It essential that the NHS addresses the needs of the people being cared for and addresses the health needs of carers themselves. The Mandate aims to do this by setting an objective for the NHS CB to give five million carers looking after friends and family members access to information, advice and support – including respite care. We also aim to make the NHS the best in Europe at supporting people with long-term conditions. Giving people more choice and control should also have a positive impact on carers and improve support for carers.

Other identified groups

Socio-economic status and geography

Health outcomes for people living in the most deprived areas are poor compared to other areas. Men and women in these areas face the highest rates of amenable mortality and mortality from all its component causes, and the lowest life expectancy at birth and at 65.[xxxii] Annually, some 7,500 deaths amongst people younger than 65 could be prevented if inequalities in wealth narrowed to their 1983 levels.[xxxiii] In addition, data from the Health Survey for England has shown that respondents in unskilled manual, semi-skilled manual and skilled manual jobs tend to have poorer health states than people in management or professional jobs.

The North of Britain and its worse-off inner city areas experience higher rates of premature death in relative and sometimes absolute terms, while the South East and more affluent rural areas enjoyed lower and lower rates of premature death.[xxxiv] Furthermore, males are affected by this divide more than females, and the variation across age groups is substantial.[xxxv] Finally, from 2000 to 2008 there has been an increase in inequality despite the public policy emphasis in England.[xxxvi]

The Mandate hopes to contribute towards reducing inappropriate variations in health outcomes across the whole of England. The NHS CB should shine a light on variation and unacceptable practice, to inspire and help people to learn from the best. Furthermore, the Government expects the principle of ensuring equal access for equal need to be at the heart of the NHS CB's approach to allocating budgets.

A key part of this work will involve reporting results at the level of local councils, CCGs and, if possible, providers and consultant-led teams. A drive to develop clinical audit and patient-reported outcomes – as part of the work to improve the NHS Outcomes Framework – as well as putting a much greater emphasis on feedback from patients and carers, so that timely, easy-to-review feedback on NHS services becomes the norm. This work should help to drive up standards across the country and the transparency should help areas identify were they need to improve.

In addition, this work should enable local commissioners to empower local areas to tackle

the problems they face. This should contribute to reducing inequalities in health outcomes by giving areas power to address the specific health needs in each area.

Finally, making the Mandate align more closely with the NHS Outcomes Framework should also help contribute to reducing health inequalities as consideration has been given in the framework to the extent to which indicators in can be disaggregated by socio-economic groups and area deprivation. We recognise that data strands for some indicators are more complete than for others; however, work is underway to explore the feasibility of increasing coverage for areas such as socio-economic status.

Marital status

There is evidence to suggest both positive and negative effects on being married on mental and physical health. For instance, there is evidence to suggest that married men have better survival rates for some conditions compared to single men when all other factors are held constant.[xxxvii] Living in a relationship can also help prevent memory loss and other cogitative impairments.[xxxviii] It can also be associated with reduced mortality.[xxxix] Yet, getting married may also relate to increased risk of obesity.[xl] [xli]

Other studies have shown that enduring first partnerships were associated with good mental health. Partnership splits were associated with poorer mental health, although the reformation of partnerships partially reversed this. Cohabiting was more beneficial to men's mental health, whereas marriage was more beneficial to women's mental health. The more recently a partnership split had occurred the greater the negative outcome for mental health. Women seemed more adversely affected by multiple partnership transitions and to take longer to recover from partnership splits than men. Single women had good mental health relative to other women but the same was not true for single men relative to other male partnership groups.[xlii]

We fully expect that the Mandate will help to reduce health inequalities and advance equalities by focusing on improving outcomes for all. Marriage is an important feature of modern society and an enduring tradition. The impact marriage has on individuals needs to be considered and the positive and negatives impact need to be actively considered as the NHS CB carries out its duties.

Engagement and involvement

This work was subject to the requirements of the cross-government Code of Practice on Consultation: http://www.bis.gov.uk/files/file47158.pdf

Gathering and testing the evidence available and testing the policy proposals

The Mandate has been subject to a full formal consultation, which ran from 4th July to 26 September 2012. Prior to this exercise, extensive engagement was carried out with a wide variety of stakeholders. For a full analysis and breakdown of the consultation process, please see the response published alongside this EA.

Summary of Analysis

- Mandate sets the foundation for the NHS CB to meet its duties to advance equality and reduce health inequalities.
- In order for the NHS CB to meet its objectives and improve outcomes for all, it is vital that they consider the health needs of people who share protected characteristics.
- Making health information more accessible to the public could potentially impact on people who have been in abusive relationships or people from the LGB&T community.
- We fully expect the Mandate to help reduce inequalities and improve outcomes for all and this will remain an active consideration in the production of future mandates.

Action planning for improvement

The Department is subject to Public Sector Equality Duty, requires public bodies to have due regard to the need to:

- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010;
- Advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- Foster good relations between people who share a protected characteristic and people who do not share it.

We believe the Mandate is the key driver for reducing inequalities and advancing equality. It has been developed in accordance with the Public Sector Equality Duty and along with the:

1. Greater emphasis placed on the need to reduce inequalities in the NHS Act 2006, as amended by the Health and Social Care Act 2012,
2. Focus on outcomes via the NHS Outcomes Framework; and
3. Framework agreements setting out working relationships between Department of Health and NHS CB

We believe we have a robust mechanism to evaluate progress and hold the NHS CB to account. We also believe that by liberating the NHS we have laid the foundation for them to advance equality and the Mandate is adamant that this has to be worked towards.

The Mandate will be reviewed annually following engagement with key stakeholders and comprehensive feedback on the NHS CB's performance, which will include an examination of the work the NHS CB has done to reduce inequalities and advance equality. From this annual review, we will take steps to improve areas of concern.

Name of person who carried out this assessment:

Anthony Houlden

Name of responsible Director/Director General:

Ian Dodge
Director, NHS Policy & Outcomes Group

Department of Health
Date assessment was signed: 12/11/2012

Annex A

Links to related Equality Impact Assessments or Equality Analyses prepared by the Department of Health, and other sources of evidence from external organisations:

Department of Health publications

Health & Social Care Bill (now Act)
Coordinating document for Impact Assessments and Equality Analysis:
http://www.legislation.gov.uk/ukia/2011/244/pdfs/ukia_20110244.pdf

Equality Analyses:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129978.pdf

NHS Outcomes Framework
Equality Analysis:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131722.pdf

No decision about me, without me: Further consultation on proposals to secure shared decision making

Equality Analysis:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134219.pdf

The Power of Information: Putting us all in control of the health and care information we need

Equality Analysis:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134183.pdf

Recognised, valued and supported: Next steps for the Carer's Strategy
Impact Assessment & Equality Impact Assessment:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_123279.pdf

Piloting Personal Health Budgets
Impact Assessment:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094799.pdf

Publications by other organisations

Department for Education
Support and aspiration: A new approach to special educational needs and disability

Munro Review of Child Protection: A child-centred system
http://www.education.gov.uk/munroreview/downloads/8875_DfE_Munro_Report_TAGGED.pdf

Minister of Defence
The Armed Forces Covenant:
http://www.mod.uk/DefenceInternet/AboutDefence/CorporatePublications/PersonnelPublications/Welfare/ArmedForcesCovenant/TheArmedForcesCovenantDocuments.htm

Ofsted
Ages of concern: learning lessons from serious case reviews
http://www.ofsted.gov.uk/resources/ages-of-concern-learning-lessons-serious-case-reviews

National Audit Office
Oversight of special education for young people aged 16-25
http://www.nao.org.uk/publications/1012/special_education_for_young_pe.aspx

The King's Fund
Patient Choice: How patients choose and how providers respond
http://www.kingsfund.org.uk/publications/patient_choice.html

Clinical and service integration: The route to improved outcomes
http://www.kingsfund.org.uk/publications/clinical_and_service.html

The Evidence Base for Integrated Care slidepack
http://www.kingsfund.org.uk/current_projects/integrated_care/integrated_care_work.html

The Nuffield Trust
Integration in Action: Four international case studies
http://www.nuffieldtrust.org.uk/publications/integration-action-four-international-case-studies

Carers UK
In Poor Health: The impact of caring on health
http://www.carersuk.org/media/k2/attachments/In_Poor_Health__The_impact_of_caring_on_health.pdf
In the know – the importance of information for carers
http://www.carersuk.org/media/k2/attachments/In_the_Know.pdf

Childhood Wellbeing Research Centre
Health Related Work in Family Intervention Projects
http://www.cwrc.ac.uk/documents/Final_FIPs_report(acceptedApril2012).pdf

Annex B:

Respondents to the draft consultation

2020health
Academy of Medical Royal Colleges
Academy of Medical Sciences
ACEVO
Action against Medical Accidents (AvMA)
Action on Hearing loss
Advisory Group for National Specialised Services
Age UK
Alliance Boots
Alzheimer's Society
Arthritis Research UK
Aspire
Association of Medical Research Charities
Association of Surgeons of GB and ireland
Association of the British Pharmaceutical Industry (ABPI)
Asthma UK
Bliss
BMA
BMJ Group
Boehringer Ingelheim
Breast Cancer Campaign
Breast Cancer Care
British Association of Dermatologists
British Dental Association
British In Vitro Diagnostics Association (BIVDA)
Bury Council Adult Care Services
Cancer Research UK
Cardiff Community Safety Partnership and Cardiff University Health Board
Care Quality Commission (CQC)
Carer Support Wiltshire
Carers Trust
Carers UK
Cares UK (Newham) branch
Centre for Public Scrutiny
Chelsea and Westminster Hospital NHS Foundation Trust
Cheshire East Council and Cheshire East Shadow heath and wellbeing board
Chief Nursing Officer Black and Minority Ethnic Advisory Forum
Child Accident Prevention Trust
Children and Young People's Mental Health Coalition
City of York Council
CLIC Sargent
Climate and Health council
Coalition of health and social care voluntary sector organisations
Coalition of Mental Health charities
College of Optometrists and Optical Confederation (joint response)
Coloplast
Concord Medical Centre and University of Bristol
Crossroads Care Bury
Deafblind UK
Dignity in Dying
Disability Rights UK
East of England Regional Academic Public Health Forum
English Community Care Association
Essex County Council
Faculty of Public Health
Forest Heath District Council
Foundation Trust Network
FPA and Brook
Gateshead Local Involvement Network Easton Planning
Genetic Alliance UK
Genzyme Theraputics Ltd
Greater Manchester Police
Greater Manchester Public Health Network
Guild of Healthcare Pharmacists
Hampshire County Council Adult Services
Healthwatch England
Healthwatch-UK
Help the Hospices
Hepatitis C Trust
HM Inspectorate of Prisons
Independent Advisory Panel on Deaths in Custody
Isle of White NHS PCT
Kidney Alliance
Local Government Association and ADASS
Lundbeck Ltd
Luton Borough Council/NHS Luton

Macmillan Cancer Support
Marie Curie Cancer Care
Medtronic
MENCAP
MENCAP and The Challenging Behaviour Foundation
Men's Health Forum
Monitor
Motor Neurone Disease Association
MS Society
NACRO
NAT (National AIDS Trust)
National Children's Bureau
National End of Life Care Programme (NEoLCP)
National Institute for Clinical Excellence (NICE)
National Osteoporosis Society
National Rheumatoid Society
National Voices
NHS Alliance
NHS Alliance PPI Steering Group
NHS Bournemouth & Poole
NHS Bristol
NHS Bristol
NHS Clinical Commissioners
NHS Commissioning Board Authority
NHS Confederation
NHS East Midlands
NHS Kent & Medway
NHS Kirklees
NHS Midlands and East
NHS Partners Network
NHS South of England
NHS South of England
NHS Sustainability Unit
NHS Wiltshire
NIHR Clinical Research Network
North Somerset Council
Nottinghamshire Healthcare NHS Trust
Novo Nordisk Ltd
Oxfordshire Local Involvement Network
Parkinson's UK
Patient Governance
Pfizer
Pharmacy voice
Picker Institute Europe
Probation Chiefs Association
Prostate Cancer UK
PSNC
Revolving Doors Agency
Royal Collage of General Practitioners
Royal Collage of Paediatrics and Child Health
Royal Collage of Speech and Language Therapists
Royal College of Anaesthetists
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians of Edinburgh
Royal College of Surgeons
Royal National Institute of Blind People
Royal Pharmaceutical Society
Royal Town Planning Institute
Salford City Council
Sanofi
Sefton Recovery Group Network
SHA Learning Disabilities leads group
Shire Pharmaceuticals Ltd
SOLACE
Somerset Partnership NHS Foundation Trust
South East Coast Ambulance Service NHS Foundation Trust
Spatial Planning and Health Group
Specialised Healthcare Alliance
Specialised Services Patient and Public Engagement Steering Group
St Mungo's
Staffordshire County Council
Standing Commission on Carers
Stonewall
TB Alert
Teenage Cancer Trust
The Association for Perioperative Practice
The British Geriatrics Society
The Carers Resource
The Faculty of Intensive Care Medicine
The Health Foundation
The King's Fund
The Lesbian and Gay Foundation
The National Autistic Society
The National Council for Palliative Care
The Neurological Alliance
The Nuffield Trust
The Parliamentary & Health Service Ombudsman
The Patients Association
The Royal College of Anaesthetists
The Royal College of Ophthalmologists
The Royal College of Radiologists

The Whittington Hospital NHS Trust
Trade Union Side of the Social Partnership Forum
Tuke Institute
Turning Point
UK Partnership Forum
UNISON
Urology Trade Association
Wellcome Trust
Young Minds

Annex C:

Attendees at consultation events

Academy of Medical Royal Colleges
ACEVO
Age UK
Allied Health Professions Federation
Bliss
BMA
Brook
Compact Voice
CQC
Disability Rights UK
Faculty of Public Health
Leonard Cheshire Disability
Local Government Association
Monitor
National Association of Primary Care
National Council for Palliative Care
National Heart Forum
National Voices
NAVCA
NHS Alliance
NHS Commissioning Board
NHS Confederation
Nuffield Trust
Patients Association
Pharmaceutical Services Negotiating Committee
Picker Institute Europe
Rethink
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Physicians
Royal College of Surgeons
Royal Society of Obstetricians and Gynaecologists
Royal Society of Paediatricians and Child Health
Scope
Society of Local Authority Chief Executives
Specialised Healthcare Alliance
Standing Commission on Carers
The Health Foundation
The King's Fund
Turning Point
Unison

Endnotes

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