

Equity and excellence:

Liberating the  
NHS

Initial Equality Impact Assessment (EqIA)  
July 2010

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# 1. Context

- 1.1. On 13 May 2010, the Conservative-Liberal Democrat Coalition Government was formed following a general election. **The Coalition: Our programme for Government**, which set out the Government's programme for partnership government for the next five years, was published on 20 May 2010. On 25 May the Queen's Speech set the outline legislative programme for the new Parliamentary session. It includes a Health Bill the purpose of which will be to strengthen the voice of patients and the role of doctors in the National Health Service (NHS) to improve public health and to take action to reduce health inequalities.
- 1.2. The programme for the NHS has been developed in more detail in the Department of Health's (DH) overarching White Paper: *Equity and Excellence: Liberating the NHS*<sup>1</sup>. It will be accompanied by five consultation papers, covering the Outcomes Framework, GP commissioning, Local democratic legitimacy, the Arm's Length Body review, and the Economic regulator.
- 1.3. **This is an initial equality impact assessment (EqIA) of the White Paper.** It is based on current available evidence and is informed by listening events with a range of health and public health professionals, representative and advocacy groups, as well as staff groups. Further involvement with stakeholders and partners, including patients, service users, carers, the workforce and the general public will take place over the coming months on the detailed policies in the White Paper. Feedback from this involvement will provide further evidence and will inform a full EqIA, which will be produced in the autumn, alongside the response to the consultation on the White Paper.
- 1.4. The programme set out in the White Paper is rooted in the Government's intention to put patients first, to achieve amongst the best health outcomes in the world, and to empower clinicians to innovate and take decisions based on their clinical judgement. A patient-led NHS is one which involves all patients in the development of services which meet their needs and takes account of their lifestyles, backgrounds and characteristics. Setting out an intent that fairness be a cornerstone of the new direction, the White Paper includes 'equity' as part of its description. In taking account of all patients' needs and aspirations, services will need to change to address current inequalities and insensitivities, some of which are described and evidenced in Chapter 2 and

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<sup>1</sup> Published 12 July 2010

Annex A. This will require an understanding of and genuine dialogue with patients so that their needs are properly understood and addressed . The consultations described in Chapter 5 show how the provisions of the White Paper are designed to address these issues.

## 2. Equality integral to a quality NHS

- 2.1. The NHS is an integral part of our society. Its core principles are that it is free at the point of use and available to everyone on the basis of need, not ability to pay. Despite this, there is evidence of uneven access to and take-up of healthcare, wide variation in needs and inequitable outcomes. The first principle of the NHS Constitution reiterates the significance of rights, responsibilities and fairness in provision of services.
- 2.2. GPs are recognised as having the key role within the health and public health system. The role of the GP consortia [para 4.6] sets out the requirement for GP consortia to have a “duty to promote equalities”. This is in recognition of their responsibility as gateway to the health system, for planned, commissioned, care. As a result, they must be at the forefront of ensuring equality of access in order to address the inequalities in outcomes.
- 2.3. This is a very real need. For instance, black and Asian people are less likely than white people to be satisfied with services from their GP, which may affect whether they go on to access further treatment<sup>2</sup>. Transgendered people are likely to have inadequate or inappropriate access to services<sup>3</sup>. Lesbian women are more likely to self-harm or suffer from eating disorders, and are less likely to take up health screening tests, than heterosexual women<sup>4</sup>. Older people are less likely to receive screening and appropriate treatment for a range of conditions in both primary and secondary care than younger adults<sup>5</sup>. Overall, men have a lower life expectancy than women and, as younger adults, are 50% less likely than women to visit a GP, which often leads to late diagnosis. However women are more affected than men by some issues with a big impact on health, such as domestic and sexual violence<sup>6</sup>. Socio-economic background has been suggested as having the biggest impact of all on people’s long-term health and wellbeing<sup>7</sup>. Addressing these inequalities will lead to greater efficiencies in the health system as well as promoting and supporting a fairer society.

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<sup>2</sup> GP patient survey 2007, 2008

<sup>3</sup> EHRC Trans research review 2009

<sup>4</sup> Stonewall ‘Prescription for Change’ 2008

<sup>5</sup> Centre for Policy on Ageing, Ageism and Age discrimination in primary and secondary health care in the UK, two reviews of the literature, 2009

<sup>6</sup> British Crime Survey, Home Office, 2009.

<sup>7</sup> Fairer Society, Healthier Lives, Marmot, 2010

- 2.4. In order to achieve quality of service provision for all, equality must be at the heart of the NHS. A high quality, safe service is no good to someone who needs it but cannot access it, or who does not want to use it because it is insensitive to their needs. Even if the service is used, its impact on patients may be such that it hinders their progress towards health and wellbeing and deters them from using services in future. For instance, women of some faiths or transgendered people may be so distressed by having to use mixed sex accommodation or services provided by staff of the opposite sex that they may develop mental health problems as a result or refuse care altogether.
- 2.5. There is a particular issue about people in transition from one stage of life or being to another: whereas there are specific services for children and for adults, teenagers often fall between the two and may end up using services which are inappropriate for them. Rigidly applied age limits can mean that appropriate services are denied to those who would benefit from them. It can be difficult, during transition from male to female or female to male, for transgendered people to find appropriate and sensitively delivered services, since they may face exclusion from single sex services that would be appropriate for them (eg gender-related cancer screening).

### 3. The need to assess the impact of the White Paper on Equality

- 3.1. One of the purposes of the proposals described in the White Paper is to refocus the NHS on delivering excellence and promoting equality. This acts as a steer for ending discrimination and tackling inequalities in the outcomes of healthcare. By assessing the potential impact on equality of the policies set out in the White Paper and the policies it sets out we aim to set a baseline against which we can measure progress in reducing inequalities over time, and to identify where most effective action needs to be taken.
- 3.2. There is sufficient evidence at this stage to suggest the policies in the White Paper provide many opportunities to make a positive impact on equality and to tackle current inequalities. The Equality Impact Assessment will inform and help shape the detailed development of policy options and identify and mitigate any risk of policies discriminating against patients and service users. The White Paper includes a specific commitment to end discrimination in the NHS, including introducing a ban on unjustified age discrimination from 2012 in line with the requirements of the Equality Act 2010. We will use the process of engagement on the White Paper to ensure that we have considered this properly and we will report on this and how we will address the issues raised in the full EqIA.
- 3.3. In developing and setting out the policy direction through the White Paper, there are specific duties on the Secretary of State and Department of Health. There are currently three public sector equality duties: the race, the disability and the gender duty. These general duties can be found in section 71 of the Race Relations Act 1976 (inserted by the Race Relations (Amendment) Act 2000), section 49A of the Disability Discrimination Act 1995 (inserted by the Disability Discrimination Act 2005) and section 76A of the Sex Discrimination Act 1975 (inserted by the Equality Act 2006). These provisions are supplemented by detailed requirements set out in the Race Relations Act 1976 (Statutory Duties) Order 2001<sup>8</sup>, the Disability Discrimination Public Authorities (Statutory Duties) Regulations 2005<sup>9</sup> and the Sex Discrimination Act (Public Authorities) (Statutory Duties) Order 2006<sup>10</sup>.

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<sup>8</sup> S.I.2001 No.3458.

<sup>9</sup> S.I. 2005 No.2966 as amended by S.I.2007 No.618 and S.I. 2008 No.641.

<sup>10</sup> S.I.2006 No.2930.

- 3.4. In summary, these specific duties place a requirement for assessing the impact of policies and practices, or the likely impact of policies and practices on equality and the arrangements for gathering information on the effect of the policies and practices. There are additional requirements on the Department to prevent discrimination in provision of goods, facilities and services and in employment. In developing the White Paper, as evidenced through this initial assessment of the impact on equality, we have taken account of these provisions on race, sex, disability, religion or belief, sexual orientation. In addition, we have considered the employment regulations on these characteristics and on age in developing the White Paper.
- 3.5. Early consultation and involvement events on the White Paper will be supplemented by implementation involvement events during the period of official consultation.



## 4. Methodology

- 4.1. The following sources of evidence have informed this initial equality impact assessment:
- The equality aspects of the intended policy direction were considered at consultation events with National Voices and Patients' Association on 8 June 2010; the Department's National Stakeholder Forum, with the Department's Corporate Partners and Strategic Partners on 15 June 2010; and its Strategic Partners on 22 June 2010.
  - Information from EqIAs on related policy areas carried out recently by DH.
  - Research and statistical data held within DH and other Government sources.
  - Research published by equalities organisations.
- 4.2 Information from these sources has been summarised and presented against the relevant policy areas of the White Paper in the following chapter. This is not seen as a full evidence base and will be complemented by consultation and involvement with stakeholders and partners. The full EqIA will also help to identify areas for further research.
- 4.3 Notes of the roundtable discussions on 15 June are available on request. Details of those consulted and involved in the period to publication of the White Paper are available on request. Additional involvement and engagement events will consider implementation in more detail during the period of official consultation.

## 5. The Evidence Base

- 5.1 The evidence base presented here covers the general areas covered by the White Paper, and more details will be covered in the full EqIA to be produced later this year. The main areas where there is a need for more evidence are indicated, and we will specifically seek to fill these gaps during consultation and involvement and as the policy proposals are developed.
- 5.2 At Annex A is a selection of evidence which demonstrates the different needs and issues of different groups in the population, with some of their concerns and problems in accessing or using healthcare. These show that generally there is a need to consider a wide range of communication and adaptations necessary to make sure that healthcare is suitable for all sections of the population.

### Putting patients and the public first

- 5.3 Some patients are more likely, because they are more able, to become involved in their care. There is some evidence about the extent to which patients are involved in decisions about their care<sup>11</sup>. People were asked to rate their experience of their GP involving them in decisions. In England, 42% of people rated their experience as very good, with no significant differences between men and women and between people of different sexual orientations. There was a strong link with age, however, with only 31% of under 25s saying they felt very involved in decisions, compared to 50% of over 65s. There were also significant differences for people of different ethnic backgrounds and religious beliefs and by those with or without a disability.

#### *An NHS information revolution*

- 5.4 Similarly not all people use information to inform their choice of health care to the same extent. In the same survey<sup>12</sup> there was little difference between men and women in the proportion who used information to make choices about the care they receive (33% men used information compared to 30% women)<sup>13</sup>.

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<sup>11</sup> Source: GP Patient Survey, Department of Health, Q1-Q3 2009-10

<sup>12</sup> Source: GP Patient Survey, Department of Health, Q1-Q3 2009-10

<sup>13</sup> Source: primary care survey, Ipsos-MORI, May 2010

- 5.5 A higher proportion of people from black and minority ethnic background are aware that using information to make choices about their care should benefit them compared to white-British people (31% vs. 20%), whereas people with a disability are less likely to use information to make choices about the care they receive compared to those without a disability (21% vs. 31%).
- 5.6 The range of information available to people will be reviewed and expanded to give people access to comprehensive, trustworthy and easy to understand information from a range of sources on conditions, treatments, lifestyle choices and how to look after their own and their family's health allowing them to make informed decisions and exercise choice.
- 5.7 During the consultation on the WP, the Department will seek views regarding people's information needs and publish an information strategy this autumn to seek views on how best to implement these changes. Its equality impact will be assessed.

#### *Increased choice and control*

- 5.8 The White Paper sets out how choice will be increased significantly meaning not just about where you go and when but a fundamental control of the circumstances of the treatment and care that people receive. It is explicit about putting patients and the public first and articulates the need for shared decision-making.
- 5.9 Information is central to increasing choice and control and the White Paper seeks to address the imbalance of 'who knows what' [para 2.6]. Recognising the need for accessibility, there will be a requirement for accessible and easy to use information. Patients and carers will be able to access the information they want through a range of means, to ensure that no individual or section of the community is excluded. In addition to easing the access to information to support patient choice, assistance will be made available for people who do not either access online health advice, or who would particularly benefit from more intensive support. [para 2.15]
- 5.10 Increasing patient and choice will be explored with the professional and patient groups around how rapid progress towards this goal can be made. The Department will consult widely on this and involve a wide range of stakeholders and partners. We will need to tackle a range of issues, including support to patients with different language needs and patients with disabilities to ensure that they can exercise choice.
- 5.11 There are also differing attitudes to choice. Whilst choice is welcomed in theory, many are not familiar with the concept or do not believe that they could be offered choice of hospital at the point of referral. For some, the idea

of exercising choice is not culturally familiar as decisions are often deferred to other family members. Others are sceptical that the concept of choice could work in relation to the NHS.

- 5.12 This seems to indicate that there is a need to build on existing knowledge of awareness and attitudes to patient choice amongst key ethnic minority communities in order to develop targeted communications. GPs can play a vital role in raising awareness of patient choice (if explicitly communicated), explaining what choices patients can make and, where possible, going through the process with the patient.
- 5.13 Work commissioned by the Department of Health from Dr Foster in 2005 to help delivery of the national policy for Choose and Book showed a strong gender and age profile governing the degree to which people want to become involved in their care.

#### *Patient and Public voice*

- 5.14 The voice of patients will be strengthened (building on the role of Local Involvement Networks (LINks)) through provisions in the forthcoming Health Bill to create HealthWatch, a new independent consumer champion. They will support people to access and make choices about services, particularly supporting those people who lack the means or capacity to make choices.
- 5.15 This key role will need to explicitly take account of and represent the views of all patients, groups and communities, particularly where there are concerns about inequalities, discrimination, harassment or unfair treatment. During consultation we will seek information on participation by different protected groups, barriers to participation and how these barriers may impact on the objective of strengthening the patient's voice and how these can be overcome.
- 5.16 There is now a commitment to look at existing mechanisms, including relevant legislation, to ensure that public engagement is fully effective in future, and that services meet the needs of all neighbourhoods.

### **Improving healthcare outcomes**

- 5.17 There is significant variation in health outcomes. In males, life expectancy in urban areas ranged from 72.3 years in the most deprived quintile to 80.3 years in the least deprived, compared with 73.5 years and 79.9 years respectively in rural areas. The variations were much smaller in females, with life expectancy ranging from 78.1 years to 83.6 years in the most deprived to the least deprived urban areas and from 78.4 years to 83.3 years respectively in rural

areas. The figures show that inequalities were widest among men in urban areas (8.0 years)<sup>14</sup>.

- 5.18 We will launch a public consultation on the different approaches that can be taken to developing a set of national outcome goals spanning five domains, including an assessment of the potential impact on equality. The Outcomes Framework will be based on the principles of effectiveness, patient safety, and patient experience.

#### *Developing and implementing quality standards*

- 5.19 Quality standards should be applied to pathways for all patients, some of whom will need additional help with existing conditions to reach the same quality of care. NICE will develop authoritative standards setting out each part of the patient pathway, and indicators for each step – across health and social care (through the Health Bill), which will be used to commission services. NICE recently published its revised Equality Scheme for 2010-13, in which it sets out its approach to developing Quality Standards, including a commitment to undertake EqIAs for the Quality Standards, to publish these and to report on how findings from the EqIAs have affected the development of the standards.

#### *Incentives for quality improvement*

- 5.20 The Department will design and implement a more comprehensive, transparent and sustainable structure of payment for performance. This will include exploring in primary care, and will also accelerate the development of best-practice tariffs, the scope and value of the Commissioning for Quality and Innovation (CQUIN) payment framework, to support local quality improvement goals. The principle will be that funding should follow the registered patient, on a weighted capitation model, adjusted for quality, with ways of improving access to primary care in disadvantaged areas through incentives. We will need to assess impact of payment system and how this will impact on protected groups.
- 5.21 Following consultation, piloting and informed by an equality impact assessment to see who are currently disadvantaged and how to remedy this, a new dentistry contract will be introduced. This will focus on improving quality, achieving good dental health and increasing access to NHS dentistry, with an additional focus on the oral health of schoolchildren. This will build on evidence in the Independent Review of NHS Dental Services in England published in 2009.

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<sup>14</sup> Variations in life expectancy between rural and urban areas of England, 2001–07  
ONS Health Statistics Quarterly Summer 2010 Edition 46

- 5.22 Lack of use of dental services and poorer oral health tend to correlate with lower socio-economic status<sup>15</sup>. Disabled people are more likely to be unemployed and therefore fall into this category. Men visit the dentist less than women, which is in line with their use of other parts of the healthcare system. There are different levels of current utilisation of dental services across different ethnic communities<sup>16</sup>.
- 5.23 The community pharmacy contract, through payment for performance, will incentivise and support high quality and efficient services, including better value in the use of medicines through better informed and more involved patients. This will include assessing who will benefit most, who may be disadvantaged, and how to address this.
- 5.24 The way in which drug companies are paid for NHS medicines will be reformed, moving to a system of value-based pricing, ensuring better access for patients to effective drugs and innovative treatments on the NHS and secure value for money for NHS prescribing of medicines. As an interim measure, a new Cancer Drug Fund will be created to help patients get the cancer drugs their doctors recommend.

## **Autonomy, accountability and democratic legitimacy**

### *GP commissioning consortia*

- 5.25 Power and responsibility for commissioning services will be devolved to GP consortia. The Government will shortly issue a document setting out the proposals in more detail, and providing the basis for fuller engagement with primary care professionals, patients and the public, with legislation in the forthcoming Health Bill. The document will be accompanied by an impact assessment considering the impact of GP commissioning on promoting equality and reducing inequality, relating to both patients and staff.

### *An autonomous NHS Commissioning Board*

- 5.26 A statutory NHS Commissioning Board will be created to support GP consortia in their commissioning decisions, which will be an expert organisation, free from day-to-day political interference, with a business model that draws from best international practice, set out as a formal mandate from the Secretary of State. It will play its full part in promoting equality in line with the Equality Act 2010. As the Board develops the new NHS Outcomes Framework it will ensure the framework reflects the Board's duties

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<sup>15</sup> Health Survey for England 2001

<sup>16</sup> CAB/MORI survey

to promote equality and tackle inequalities, particularly in healthcare outcomes. [paragraph 3.10]

#### *Local democratic legitimacy*

- 5.27 The Government will strengthen the local democratic legitimacy of the NHS. Building on the role of the local authority as the convener of local public services, we will establish a new statutory arrangements within local authorities - "health and wellbeing boards" - to take on the function of joining up the commissioning of local NHS services, social care and health improvement. These health and wellbeing boards - or alternative arrangements - will allow local authorities to take a strategic approach and promote integration across health and adult social care; children's services including safeguarding; and the wider local authority agenda.
- 5.28 We will assess how local authorities and boards will ensure that the health and wellbeing of all groups within the local population are taken into account in carrying out these functions.

#### *Freeing existing NHS providers*

- 5.29 The White Paper signals a range of initiatives to create the largest and most vibrant social enterprise sector in the world, putting foundation trusts outside state control, for example legislating to remove borrowing limits, abolish the cap on the amount of income foundation trusts may earn from other sources to reinvest in their services, and enable foundation trusts to tailor their governance arrangements to their local needs. A consistent approach will apply across all types of NHS funded services, including completing the separation of commissioning from provision and moving to any willing provider. Foundation trusts are currently bound by the requirements of equality legislation, and as we consult on and develop our proposals we will consider their implications for this. We will ensure that as they move to new governance arrangements they build on existing arrangements and good practice in the commercial and social enterprise sector to continue to take account of their corporate social responsibility and embed ethics, equality and rights across their services and functions.

#### *Economic regulation and quality inspection to enable provider freedom*

- 5.30 The Care Quality Commission will act as quality inspectorate across health and social care, and Monitor will be developed into an economic regulator. Providers will have a two-part licence overseen by both Monitor and CQC, to ensure that their services meet necessary standards of safety and quality, and are financially sustainable. Monitor's functions will also be extended into social care. Both organisations are themselves required to pay due regard to

the current equality duties as extended to a single public sector duty in April 2011, in their functions and as employers. We will look at the equality impact of the different aspects of the new licensing system as a basis for future adaptation as necessary.

### *Valuing staff*

- 5.31 The White Paper signals the intention to give employers greater autonomy and accountability for their workforce planning decisions, and education and training. The Department will publish proposals for consultation in due course. We will undertake an equality impact assessment on these proposals, which will consider issues such as underrepresented groups, equality of opportunity to access education, training and ongoing professional development and the impact of good workforce planning on staff health and well-being, as well as changing nature of the workforce.

## **Cutting bureaucracy and improving efficiency**

### *Cutting bureaucracy and administrative costs*

- 5.32 By streamlining and simplifying the infrastructure, administrative costs will be reduced by more than 45% freeing up resources to reinvest in front-line services. In making those decisions, the Department and the wider health system, will take into account and disseminate the detailed guidance from the Government Equalities Office '*Reducing the deficit fairly*' to those policy areas charged with this responsibility. We will evidence our decision making, through an equality impact assessment, which will include involving relevant stakeholders and staff groups to identify risk of negative, adverse or disproportionate impact and take steps to address issues identified.
- 5.33 A review of all the Department's arm's length bodies will be published, with recommendations that, on the principle that they should only perform functions requiring technical expertise, political impartiality, or an independent perspective. The review will be accompanied by a consultation which will explore the potential impacts of any actions on different patient and user groups. Those responsible will take account of the Government Equalities Office guidance on '*Reducing the deficit fairly*'.
- 5.34 The Government will cut the bureaucracy involved in medical research. We have asked the Academy of Medical Sciences to conduct an independent review of the regulation and governance of medical research. In the light of this review we will consider the legislation affecting medical research, and the bureaucracy that flows from it, and bring forward plans for radical



simplification. We will consider ways in which different groups of patient and service users are involved in research and take steps to address or remove any barriers for underrepresented groups.

- 5.35 As a further measure to support front-line services, the Department of Health will apply major cuts to its budgets for centrally managed programmes such as the national programme for IT, consultancy services and advertising spend. NHS services will increasingly be empowered to be the customers of a plural system of IT and other suppliers.

## **Human Rights**

- 5.36 The policies in *Equity and Excellence: Liberating the NHS* aim to support many of the rights enshrined in the European Convention of Human Rights. This is shown through the strengthened involvement of patients in the design of services and decisions about their own care, the requirement for shared decision-making set out in putting patients and the public first, explicitly requiring 'no decision about me without me' and extending patient rights to information, choice and involvement.

## 6. Next Steps

- 6.1 We have highlighted some equality issues in this initial EqIA. In developing the final EqIA for the White Paper we will take the following actions:
- We will hold a number of engagement and involvement events with partners;
  - We will gather and analyse in more detail relevant evidence on the specific areas covered in the White Paper; and
  - We will ensure that we pay due regard to the impact of equality in the further policy developments in public health and social care which we will be bringing forward as part of our overall reforms, of which this White Paper is the first tranche.

### *Proposals for legislation*

- 6.2 Many of the changes in this White Paper require primary legislation. The Queen's Speech included a major Health Bill in the legislative programme for this first Parliamentary session. The Government will introduce this in the autumn.
- 6.3 The Department would particularly welcome comments on these proposals requiring primary legislation, and will publish a response to the views raised, prior to the introduction of the Bill. The Bill will have an appropriate equality impact assessment. Comments should be sent by 5 October 2010 to:

NHSWhitePaper@dh.gsi.gov.uk  
Room 601  
Department of Health  
79 Whitehall  
London SW1A 2NS

### **For the Record**

Name of person completing the EqIA:	Rosalind Mead
Date Initial EqIA completed:	7 July 2010
Name of Director General endorsing the EqIA:	Mark Davies for Una O'Brien
Date EqIA endorsed:	7 July 2010

## Annex A

The specific evidence used is available from documents cited in the list below on request.

Help the Aged, 2007, Large survey

Help the Aged, 2009, Survey

You're Welcome quality criteria: Making health service young people friendly, Department of Health, March 2007

DRC Equal Treatment: Closing the Gap: One Year on, 2007

Empowerment: RADAR's Guide to improving your local services

No patient left behind: how can we ensure world class primary care for black and minority ethnic people? DH, 2008

Creating a Gender Equality Scheme: A Practical Guide for the NHS, Department of Health, 2007

British Crime Survey, Home Office 2009

GIRES A guide to trans' service users' rights: Transgender wellbeing and healthcare

Equality and Human Rights Commission 2009, Trans Research Review

Network of European Foundations, 2009 Religion and Healthcare in the European Union: Policy issues and trends

Stonewall – Serves You Right: Lesbian and Gay People's Expectations of Discrimination

Stonewall - Prescription for Change: Lesbian and Bisexual Women's Health Check 2008, Ruth Hunt and Dr Julie Fish

DH analytical study of socio-economic disadvantage, 2010

## Annex B

### **Feedback from meeting between Secretary of State for Health and representatives of National Voices and Patients' Association: 8 June 2010**

1. The Secretary of State discussed his policy direction as described in **Liberating the NHS** at an event for patients' representatives co-ordinated by National Voices and the Patients' Association at Bromley-by-Bow on 8 June 2010. About 100 people attended, including many from Local Involvement Networks (LINKs). People from a wide range of diverse backgrounds and characteristics were represented. Main points raised were:
  - The need to ensure involvement of patients and the public in shaping services, especially including those who are seldom heard
  - The need to build on what is already happening well to engage and involve patients
  - Concerns about meeting the needs of people with specific conditions
  - Concerns that the needs of the most vulnerable, who are often the least visible, are taken into account as proposals for organisational change are developed.

### **Feedback from meeting of DH's National Stakeholder Forum: 15 June 2010**

2. The full Health Ministerial team met the DH National Stakeholder Forum with the Department's Corporate Partners and Strategic Partners on 15 June to discuss the themes of the White Paper. There were around 70 participants representing DH's main partners: NHS and local authorities; professional bodies; voluntary sector organisations including equalities and carers; statutory bodies involved in health system regulation; Royal Colleges, negotiating bodies, and the Health Service Ombudsman. Preventing discrimination and tackling inequalities was specifically discussed in the roundtable discussions, chaired by Ministers. Main points raised were:
  - The need for an holistic approach to recognise individual people's needs and reflect these in joined up services
  - The need for good information as the basis for patient choice and for service delivery

- The need for better engagement between staff and patients, whose views of good outcomes often differ greatly from those of professionals
- The need for better communication, including improving patients' voice, especially for those who find participation difficult.

**Feedback from meeting of DH's Strategic Partners: 22 June 2010**

3. Officials held a listening event with the DH Strategic Partners, who represent the voluntary sector including many organisations which work on behalf of people from minority groups. They discussed the themes of the White Paper. Main points raised were:

- The need for integrated pathways
- Access to healthcare for all
- Staff to take an holistic view of a person's needs and self-view
- Information sharing to inform better choice, care and outcomes
- Accountability based on patient feedback and a satisfactory complaints process
- Service users to be proactive in shaping services.

***Attendees at 22 June Strategic Partners event***

Age Concern and Help the Aged

Age Concern England

Men's Health Forum

Faith Action Network

National Children's Bureau

National Care Forum

National Council for Palliative Care

National Heart Forum

NAVCA (National Association for Voluntary and Community Action)

NCF/VODG (National Care Forum/Voluntary Organisations Disability Group)

NCIL (National Centre for Independent Living)

RADAR

Race Equality Foundation

Regional Voices

Shaping Our Lives National User network  
Voluntary Organisations Disability Group