Equality Analysis

NHS Standard Contract 2012-13

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NHS Standard Contract 2012-13

Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

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

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help Department of Health staff members to comply with the general duty.

Please complete the template by following the instructions in each box. Should you have any queries or suggestions on this template, please contact the Equality and Inclusion Team on 020 7972 5936 or aie@dh.gsi.gov.uk

Equality analysis

Title: The NHS standard contracts for acute hospital, mental health & learning disabilities, community services and care homes.

Relevant line in DH Business Plan 2011-2015**:**

What are the intended outcomes of this work? *Include outline of objectives and function aims*

Commissioners have a responsibility to commission a range of healthcare and/or social care services to meet the needs of the population for which they are responsible. This responsibility includes the commissioning of acute hospital, mental health and learning disability, community services and care home services for people of all ages and Ambulance Services (including Patient transport Services.

In order to fulfil those responsibilities the commissioners secure the provision of services from the provider and the provider provides the services to the commissioner on the terms of the Contract ('the Agreement'.) The agreement is made by the coordinating commissioner and its associates ('the commissioners') with the provider to secure the provision of services by the provider.

The NHS standard contract covers agreements between PCTs and all providers delivering NHS funded services. The contract applies to agreements with:

- NHS Trusts
- NHS Foundation Trusts
- Independent Sector providers
- Charitable and Voluntary sectors
- Social Enterprises

Use of the NHS standard contract is mandated for all relevant NHS funded services. The contract will be updated each year to reflect the requirements of the NHS Operating Framework.

The new contract has three main sections, i) The Particulars, ii) The Services) and The Standard Terms (including Definitions) and.

Standard variations

Standard variations to all existing contracts that continue to be effective after 1 April 2012 will also be published.

The Contract supports and reflect the NHS Operating Framework for 2012/13 and should be read in conjunction with the Principles and Rules for Co-operation and Competition and the PCT Procurement Guide.

The Operating Framework for the NHS in England 2012/13[1]set out the expectation that 'The 2012/13 NHS Standard Contract will see the implementation of the first phase of the fundamental review of the contracts signalled in the NHS Operating Framework 2011/12.' In addition, it stated that 'The 2012/13 NHS Standard Contract will be a single agreement for use by commissioners when commissioning services from providers seeking to deliver NHS funded secondary and community

[1] Department of Health (2011) The Operating Framework for the NHS in England 2012/13. London: Department of Health
[2] Department of Health (2011) The Operating Framework for the NHS in England 2012/13. London: Department of Health

services. Commissioners must enforce the standard terms, in particular the financial penalties for under performance. [2]

The Contract contains a general requirement for providers to comply with the Law, which is defined to include Guidance. Providers are required to deliver a wide range of policies referenced in the contracts for example:

- Eliminating mixed sex accommodation,
- National and local priorities for Health Care Acquired Infection (eg HCAI reduction plans),
- Payment by results (including introduction of reduction tariff),
- Quality accounts
- CQUIN
- Choice

The Contract require a number of mandated plans to be put in place. These plans are an integrated part of the management of the Contract and allow providers to demonstrate progress against agreed performance milestones. This includes:

- Business Continuity Plans and Essential Services Continuity Plan
- Service Development and Improvement Plan (which includes specific reference to QIPP to allow parties to record the contribution the provider will make to the local or regional QIPP plans)
- Data Quality Improvement Plan

The Contract also contain a requirement to comply with Choice Guidance and changes to clauses about staff to reflect the amendments to the Cabinet Office Code. Furthermore, the equity of access, equality and no discrimination clause of the Contract have been updated to reflect the Equality Act 2010. With a contract term, bringing non-public bodies into scope when delivering NHS funded services.
The Contracts provides a framework to hold providers to account for the delivery of high quality services.

Who will be affected? *e.g. staff, patients, service users etc*
The Contract has been developed to allow it to reflect the new commissioning architecture (Clinical Commissioning Groups (CCGs)) envisaged in *Equity and excellence: Liberating the NHS*[2] and set out in the Operating Framework and the Health and Social Care Bill, which is subject to Parliamentary approval.

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment. For more information, see the current DH Transparency Plan.*

What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.*

Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.*

Although there is a lack of routine data measuring health outcomes for disabled people, research shows that disabled people generally fare less well than non-disabled people do across a wide range of indicators and opportunities. It is estimated that approximately 20% people in the United Kingdom have

[2] Department of Health (2010) Equity and Excellence: Liberating the NHS. London: Department of Health

a disability, with the percentage increasing to 47% when focussing on those over the state pension age.[3]

Learning disabilities- People with learning disabilities experience worse health outcomes than the general population for a variety of diseases and conditions, such as respiratory disease, heart disease, mental ill health, hearing and visual impairments and osteoporosis.[4]

Sex *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).*
There are differences in risk factors and health outcomes between men and women. Some are due to biological and physiological differences, for example, the life expectancy for women continues to be considerably higher for women at 82.02 years compared to men at 77.93 years.[5] However, although women tend to live longer than men, they spend more years in poorer health.

Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*

Race - In 2026, it is estimated that the total BME population will rise to 28.4%. The contributing factors to the predicted BME population increase includes: a younger age profile of BME communities, higher fertility rates among females resident within England and Wales but born outside the UK, and inward migration.[6]

Asylum seekers and refugees – some health studies have shown that refugees and asylum seeks have poorer health outcomes with two thirds having experienced anxiety or depression and one in six refugees having a physical health problem. [7]

Gypsies and travellers - Romany Gypsies and Irish Travellers make up 0.6% of the total UK population. Key health issues for Gypsies and Travellers include mental health problems, diabetes, respiratory problems, maternal & child health and long term illness. The common problems of primary care access for this group includes registering at a GP practice, as staff often insist on being given a permanent address, which can lead to increased reliance on A&E and walk-in centres.[8]

Language barriers - In a report examining equality of access to services[9], the authors highlighted a number of barriers faced by BME communities, including i) language - availability to translation and interpreting services remains a key issue, especially when accessing out of hours services. ii) knowledge - newly arrived communities can experience difficulty in navigating the UK health service. In countries with less developed primary care, health services are often accessed via the nearest hospital. iii) cultural awareness – studies have revealed a lack of knowledge among healthcare professionals about the cultural practices of different ethnic communities.

Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*

Many of the health inequalities faced by children are directly linked to poverty with children and young

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[3] Williams B, Copestake P, Eversley J and Stafford B (2008) Experiences and Expectations of Disabled People. London: Office for Disability Issues
[4] Hollins S, Attard MT, von Fraunhofer N, McGuigan S and Sedgewick P (1998) Mortality in people with learning disability: Risks, causes and death certification findings in London. *Developmental and Child Neurology.* Vol.40, pp127–132.
[5] Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base [online] www.nchod.nhs.uk
[6] Lievesley N (2010) Older BME People and Financial Inclusion Report: The future ageing of the ethnic minority population of England and Wales. London: Runnymede and the Centre for Policy on Ageing
[7] Burnett A and Peel M (2001) Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees. *British Medical Journal.* (2001). Vol.322, pp.544-547
[8] Parry G (2004) The Health Status of Gypsies & Travellers in England. London: University of Sheffield.
[9] Goddard MK (2008) Quality in and Equality Of Access to Healthcare Services in England. University of York Centre for Health Economics

people under 16 comprising of just over 20% of the national population. Infant mortality rates have fallen steadily over the ten years to 2008, and is now at its lowest ever level. However, despite this decrease, rates in England are higher than the EU-15 average. [10]

People over the age of 65 and older account for 16% of the national population[11] and by 2024, this is likely to increase to 40%. Many risk factor for poor health, such as obesity, hypertension, disability and poverty increase with age.

Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*

Data and research on trans health are limited but the evidence base is growing. We know that trans people are particularly vulnerable to discrimination and harassment, and also experience inequalities in access to healthcare and poorer health outcomes.

Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*

The Civil Partnership Act 2004 means that gay men and lesbian women in the UK are now able to register civil partnerships, giving them the same rights as heterosexual married couples in areas like tax, social security, inheritance and workplace benefits. Evidence suggests that there is a strong association between marriage and better health, particularly for men, but it has also been found that troubled marriages have negative health consequences.[12]

From the 2009 Integrated Household Survey, a slightly greater percentage of heterosexual respondents aged 16 and over reported being in perceived good health 78.8% compared to 78.1% of lesbians, gay men and bisexual (LGB) respondents.

'Prescription for Change', a Stonewall 2008 lesbian health survey, found that the perceptions of healthcare professions were having a direct impact on access to preventive services. Half of the respondents also stated that they have not discussed their sexuality with their GP.[13]

Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*

Healthcare services need to be sensitive and responsive to the cultural and religious needs of different communities, particularly attitudes to health and well-being issues such as birth, prognosis, disease, treatment, care giving and death[14]. It should not be assumed that all individuals from a certain religion would adhere to all practises.

The 2001 Census showed that Muslims had the highest rates of self-reported ill health (13% for Muslim males and 16% for Muslim females) once standardised for age. Hindus also reported high rates of ill health. Jewish and Christian communities were least likely to report their health as not good.[15]

Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*

A key area of health and care for women is pregnancy and maternity. In 2010, the Care Quality

[10] Department of Health (2009) Health Profile for England 2009. London: Department of Health

[11] Census, April 2001, Office for National Statistics

[12] Wood R, Goesling B and Avellar S (2007) The Effects of Marriage on Health: A Synthesis of Recent Research Evidence. Washington: Department of Health and Human Services.

[13] Hunt R and Fish J (2008) Prescription for Change: Lesbian and bisexual women's health check 2008. London: Stonewall

[14] Worth A et al (2009) Vulnerability and access to care for South Asian Sikh and Muslim patients with life limiting illness in Scotland: prospective longitudinal qualitative study. *British Medical Journal.* Vol.338 [online] http://www.bmj.com/content/338/bmj.b183.abstract Accessed 8 November 2010

[15] Census, April 2001, Office for National Statistics

Commission) conducted a survey of over 25,000 women who used maternity services and found that during antenatal check-ups women saw a combination of heath professionals with midwives being the most prevalent of the group. [16]

Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*

The health and well-being of carers needs to be a key consideration with over 5.2million carers in England and Wales. There is also a significant number of people caring for people who themselves require support or care – around 273,000 people with long term conditions or disabilities are caring for others, with 105,000 of this number providing 50 or more hours of care.[17]
Carers UK carried out a Carers, Employment and Services (CES) Study in 2006-07, which identified a link between the length of time as a carer and poorer health.[18]

Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*

Socioeconomic status –the socioeconomic status of an individual can have a significant impact on their health and well-being. Communities often experience poorer physical and mental health problems where there are poorer outcomes in key determinants of health, such as education, employment and housing. Although as noted above, the life expectancy is increasing overall, there is still evidence of a gap between socioeconomic groups, with the number of health year's life expectancy being lower amongst the most deprived wards.[19] [20]

Homeless people – 40% of rough sleepers have multiple, concurrent health needs relating to mental and physical health as well as substance misuse, indicating that homeless people have significantly higher level of premature mortality and ill health (mental and physical) than the rest of the general population.[21]

Engagement and involvement

Was this work subject to the requirements of the cross-government Code of Practice on Consultation? (Y/**N**) No

How have you engaged stakeholders in gathering evidence or testing the evidence available?

Yes.

As part of the development of the 2012/13 Contract, a wide range of stakeholder meetings and discussions were held and these ranged from small group sessions to large sessions with over 40 stakeholder representatives. The Contracts Team made presentations at the any qualified provider (AQP) policy Workshops.

How have you engaged stakeholders in testing the policy or programme proposals?

[16] Care Quality Commission (2010) Women's experiences of maternity care in England. London: Care Quality Commission
[17] Census, April 2001, Office for National Statistics
[18] Yeandle S, Bennett C, Buckner L, Fry G and Price C (2007) Diversity in Caring: towards equality for carers. *Carers, Employment and Services Report Series.* No.3. London: Carers UK
[19] Marmot M (2010) Fair Society, Healthy Lives. London: Marmot Review Team
[20] Equality and Human Rights Commission (2010) Health. *How fair is Britain? Equality, Human Rights and Good Relations in 2010. The First Triennial Review.* Part 2, Ch.9 London: Equality and Human Rights Commission
[21] Department of Health (2010) Healthcare for Single Homeless People. London: Department of Health

Yes.

A stakeholder reference group was established to facilitate engagement with users of the Contract, to ensure that the changes to the structure and drafting facilitated ease of use and understanding. As well as adequately meeting, the needs of commissioners and providers of NHS funded services.

Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

The Contract and the supporting guidance highlight equality issues and refer to specific requirements, which will provide assurance that commissioners and providers are taking account of equality. They represent an instrument, which underpins the delivery of key policy requirements by mandating that providers supply monthly monitoring reports to the commissioners. DH monitors compliance with the contract through SHAs and if evidence suggests that any protected group is adversely affected, then PCTs, with support from their SHA are responsible for resolving this.

The contract requires providers to have regard for the NHS Constitution, including two key NHS principles. For example:

You have the right to be treated with dignity and respect, in accordance with your human rights.

The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.[22]

Providers are also contractually required to act at all times in the best interests of patients. They are not able to refuse to provide or discontinue services without appropriate reasons. If they do decide to stop providing a service they are responsible for ensuring the commissioner is aware so that they can make alternative arrangements.

Providers who identify a patient or group of patients other than those to whom they are providing services, may have an unmet health or social care need, are required to notify the commissioner. The commissioner would need to assess what action should be taken to address this unmet need.

From a performance management perspective, the contract can result in remedial action plans being produced or in certain circumstances, withholding of funding by commissioners if concerns (including from an equality perspective) remain unaddressed.

The 2012/13 Contract will bring the four acute, ambulance, community and mental health and learning disabilities into a single contract.

The Contract is flexible to ensure it meets the needs of the NHS service users in an equal and fair manner.

It is creates a framework so encourage equality in providing high quality services for all providers and all service types.

[22] Department of Health (2010) The NHS Constitution for England. London: Department of Health

Common and unambiguous language is used through the Contract so that providers and commissioners have a template to help support a fair 'playing field' for all types of provider.

Patients, carers, service users and protected groups will benefit because the Contract supports the achievement of key national standards and outcomes. Quality improvement is at the heart of the standard contracts. The Contracts is a means by which commissioners encourage and reward the provision of good quality services for the local populations. More specifically, the contract requires the commissioner and provider to seek the views of the patient, service user, carers and staff, as well as to act on and publish the results of national, local and provider initiated experience surveys. The requirement to publish outcomes and actions taken as a result of patient and carer surveys is an additional requirement of transparency. In addition, the contracts oblige providers to involve the patient, service user and carers in the development and progress of their care package.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

General

The Contract pulls together existing policies that will have already undergone equality impact assessment. It may be that some of these policies are more relevant in terms of eliminating discrimination, harassment and victimisation and where this is the case, the issues will be identified and addressed so that the policies do not disproportionately impact on people in terms of their age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation.

The Contract requires providers to comply at all times with the law on anti-discrimination and equal opportunities in relation to their staff, patients, service users and carers. Providers are required to act in accordance with guidance on "Tackling violence and antisocial behaviour in the NHS: Joint Working agreement between the Association of chief Police Officers, the Crown Prosecution Service and NHS Protect [23] ,which addresses the issue of potential harassment and discrimination of staff. The Contract also require providers to ensure their staff are aware of and respect equality and human rights of colleagues, service users, carers and the public.

Age

The Commissioners have a responsibility to commission a range of healthcare and/or social care services to meet the needs of the populations for which they are responsible, and this responsibility includes the commissioning of acute healthcare services for people of all ages. The contracts require providers to comply with commissioner's policies on safeguarding and promoting welfare of children and adults in vulnerable circumstances. This could apply particular to younger children and older people who may be at greater risk. The mental health and learning disability contract covers the full range of mental health and learning disability services. It therefore applies to people of all ages, including children and adolescents, adults of working age and older adults.

The CQC investigation into Kingsmead Lodge Bristol[24] (care home for residents with severe dementia) found that staff did not have an understanding of the complex needs of residents in their care, and that residents' needs were not fully assess on admission and limited information was provided to staff about patients' medication. The Contract commits providers to have in place a 'transfer and discharge plan' to

[23] Tackling Violence and antisocial behaviour in the NHS: Joint Working agreement between the Association of chief Police Officers, the Crown Prosecution Service and NHS Protect (2011)

[24] Care Quality Commission (CQC) (2010) http://caredirectory.cqc.org.uk/_db/_documents/1-102642572_Mimosa_Healthcare_(No_4)_Limited_1-131055248_Kingsmead_Lodge_RoC_December_2010_201012200112.pdf

ensure continuity of a service users' care which is maintained to a high standard at all times. Within the transfer and discharge plan, requirements are placed on the provider to include, amongst other obligations, details of:
i) records of care, treatment and support provided up to the point of transfer and discharge, ii) previous medical history that is relevant to the service users current needs, iii) any medicine a service user is required to take and iv) assessed needs.

We anticipate that effective use of the Contract will result in good quality care for people of all ages.

Disability
The Contract requires providers to comply with commissioner's policies on safeguarding and promoting welfare of children and adults in vulnerable circumstances. This could apply particular to people who may be at greater risk because of mental health problems or learning disabilities.

The Contract require providers to consider the accessibility of service environment and equipment, including the need to make reasonable adjustments where required. The contracts include specific clauses on providers needing to comply with the Disability Discrimination Act 1995 and Disability Discrimination Act 2005.

The Contract also makes provisions to ensure that providers give appropriate assistance for service users who have communication difficulties (including without limitation hearing, oral or learning impairments). In addition, the Contract commits the provider to engage, liaise and communicate with service users, their carers and legal guardians in an open and clear manner in accordance with the Law, good health and social care practice and their human rights.

Investigations following publicised cases (e.g., Winterbourne) highlighted the need to provide support and training for staff in care environments.. The Care Homes Contract places a duty on the providers to have in place systems for seeking and recording specialist professional advice and to ensure that every member of staff involved in the provision of services receives proper and sufficient continuous professional and personal development, training and instruction. As well as a full and detailed appraisal in terms of performance and ongoing education and training - (utilising where appropriate the knowledge and skills framework, or similar equivalent framework) - staff will receive professional leadership commensurate with services.

Gender and gender reassignment

The Contract requires providers to comply with the Sex Discrimination Act 1975 and the Equality Act 2010, to promote equality of opportunity between men and women.

Pregnancy and maternity
Whilst the Contract is not explicit regarding pregnancy and maternity, the Contract requires service specifications for all services commissioned which allows the commissioner to hold the provider to account for the service being provided. This demonstrates consideration and focus towards women, with provisions included to ensure providers make their services accessible to all, appropriate advice is available and users understand the advice on options for continuing or terminating pregnancy. This also includes benefits and risks to enable them to make informed decisions and to ensure that the service does not discriminate.

Race
The Contract requires providers to comply with the Race Relations Act 1976, the Race Relations (Amendment) Act 2000 and the Equalities Act 2010 in respect of service users and carers to eliminate unlawful racial discrimination and promote equality of opportunity and good relations between persons of different racial groups.

The Contract also make provisions to ensure that providers give appropriate assistance for service

users who do not speak, read or write English or who have communication difficulties (including without limitation hearing, oral or learning impairments). They also make clear that providers should comply at all times with anti-discrimination and equal opportunities legislation.

Religion or belief
The Contract requires providers to take account the pastoral, spiritual, religious and cultural care needs of service users through liaison with relevant authorities where necessary.

Sexual orientation
The Contract makes provisions for the provider not to discriminate between service users on the grounds of sexual orientation and to have due regard to need to comply with the Sex Discrimination Act 1975 and the Equality Act 2010 to eliminate unlawful discrimination and harassment.

Advance equality of opportunity *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

General
The Contract pulls together existing policies that will have already undergone equality impact assessment. It may be that some of these policies are more relevant in terms of equality of opportunity and where this is the case, the issues will be identified and addressed so that the policies do not disproportionately impact on people in terms of their age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation.

The Contract require providers not to withhold any service that is in the best interest of any patient or service user. In cases where a provider proposes to withhold or discontinue a service they are required to inform the patient/service user, carer or legal guardian and to inform them of the right to challenge the provider's decision through the complaints procedure.

Age

Elements of the Contract that apply to mental health and learning disability services require providers to ensure that no patient / service user under the age of 18 receives services on an adult psychiatric ward, unless otherwise required by law. This will help to ensure that children with mental health problems are treated in appropriate settings and therefore treated more favourably.

Disability
The specifications that apply to mental health and learning disability services require providers to promote positive attitudes towards disabled people. It also requires providers to give evidence to the commissioner that they have involved service users and carers in the development of services. The provider is also required to engage, liaise and communicate with patients/service users, and carers in an open and clear way which will encourage people with mental health problems to be more involved, and participate in decisions about their care, as well as encourage participation by disabled persons in public life.

Gender
The Contract require the provider to have due regard in its performance of the Contract to the need contemplated by section 76A Sex Discrimination Act 1975 and the Equality Act 2010 as amended to promote equality of opportunity between men and women.

Promote good relations between groups *Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).*

General
The Contract pulls together existing policies that will have already undergone equality impact assessment. It may be that some of these policies are more relevant in terms of promoting good

relations between groups and where this is the case, the issues will be identified and addressed so that the policies do not disproportionately impact on people in terms of their age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation.

Disability
The Contract requires providers to provide evidence to the commissioner that they have involved service users and carers in the development of services. The provider is also required to engage, liaise and communicate with patients/service users, and carers in an open and clear way which will encourage people with mental health problems to be more involved and participate in decisions about their care, as well as encourage participation by disabled persons in public life.

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?*

The Contract reflects existing policy and commitments in the Operating Framework and are the means through which policy is enacted in the NHS. The Contract does not in itself create new policy. They require providers to comply at all times with the Law on anti discrimination and equal opportunities in relation to their staff, service users, patients and carers. Providers are not able to discriminate people on grounds of age, disability, gender (including gender reassignment), pregnancy and maternity, race, religion or belief and sexual orientation.

We anticipate that effective use of the contracts will result in good quality care for all people.

The Contract requires local commissioners and providers to undertake their own AIEs in relation to their use of the Contract.

Addressing the impact on equalities *Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.*

Action planning for improvement *Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.*

The 2012/13 Operating Framework committed the Contracts Team to continue the development of the Contract. It is planned to seek to:
(a) simplify;
(b) reduce volume; and
(c) reflect changes arising from the Health and Social Care Bill

By factoring in the early engagement and involvement of stakeholders into our planning process we have already ensured there is an inclusive approach to the Contract and have now commenced this programme of activities.

Some system changes have yet to be agreed/finalised, which may affect the development of the Contract and its final format for use from April 2013.

Local monitoring and reporting will provide information on a range of issues, including clinical outcomes, patient experience and equality to help inform future improvement of services. Providers are required to implement new datasets adopted across the NHS.

If this is done in line with Good Practice on Equality Monitoring[25], it will provide useful information on different groups and communities allowing the commissioning and provision of appropriate services.

Please give an outline of your next steps based on the challenges and opportunities you have identified. *Include here any or all of the following, based on your assessment*

- *Plans already under way or in development to address the **challenges** and **priorities** identified.*
- *Arrangements for continued engagement of stakeholders.*
- *Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)*
- *Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies*
- *Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results*
- *Arrangements for making information accessible to staff, patients, service users and the public*
- *Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.*

In 2013/14, the focus of contracting will be based on the service requirements and outcomes defined and negotiated locally by CCGs. It is envisaged that the NHS Commissioning Board will issue a 'standard terms' document for use by Commissioners. The intention is for providers to work to core NHS standard terms contained in streamlined legally binding commercial contracts. The emphasis of the future contract will be on local content to meet the locally identified needs and desired outcomes. There will be a much stronger focus on service quality, with more detailed outcome focused specifications for key services.

Links need to be made with teams in DH/NHS CB/Social Care who are currently involved in ensuring equality is established in commissioning to ensure appropriate levers and incentives are used in the system to underpin equality throughout the NHS. The future standard contract will have a significant part to play in this.

For the record

Name of person who carried out this assessment:
Mamta Malhotra-Sharma

Date assessment completed:
XX December 2011

Name of responsible Director/Director General:
Bob Ricketts

Date assessment was signed:
XX December 2011

[25] Department of Health (2007) A practical guide to ethnic monitoring in the NHS and social care. London: Department of Health
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4116927

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation	Stakeholder engagement in developing the drafting for the 2013/14 Contract.	From March 2012	Richard Dodds (CSM-Provider Policy)
Data collection and evidencing	Ernst and Young were externally commissioned to review current PCT contracts, the project is known as Deep Dive. As well as collecting hard data concerning contract numbers and values, the review also includes 'soft' data gathering from contract managers at the test sites covering performance management issues. Ongoing in 2012/13.	Completion of transfer of responsibilities from PCTs to new Commissioning Authorities	Richard Dodds (CSM-Provider Policy)
Analysis of evidence and assessment	We will commit to look at the results and information from the 'Deep Dive' work and consider whether there are any implications to be investigated when undertaking the development of contracts for 2012/13. Update in December 2011 – Action competed via David Flory letter issued on 10 November 2011 to CHA and PCT Cluster chief executives.	Completion of transfer of responsibilities from PCTs to new Commissioning Authorities	Richard Dodds (CSM-Provider Policy)
Monitoring, evaluating and reviewing	The responsibility for the future evaluation and review of the NHS standard contract from 2013/14 onwards will lies with the NHS Commissioning Board. The exact process for monitoring the development is yet to be determined. Stakeholder engagement Bill Team – waiting for royal assent NHS functions and Transition Team	Developed during quarter 3 and quarter 4 2012/13	Richard Dodds (CSM-Provider Policy)
Transparency	PCTs are required to publish redacted copies of new tenders	Ongoing	Commissioners

(including publication)	and contracts over the value of £10,000 in line with the Government's commitment to increase trasparency. Clause 60.7 of the 2012/13 Contract enforces this, establishing a contractual right for the contracts to be publised subject to the provisions of the Freedom of Information Act		
Guidance being published for the 2012/13 NHS standard contract	The 2012/13 Contract wil be supported guidance to assit commissioners with the implementation of the Contract. Supporting templates will acompancy the Contract's guidance as additional support.	End Dec 2012	Richard Dodds (CSM-Provider Policy)