Department
of Health

Coordinating Equality Analysis

Living well for longer: National support for local action to reduce premature avoidable mortality

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Coordinating Equality Analysis

Living well for longer: National support for local action to reduce premature avoidable mortality

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Contents

Contents 4
Introduction 5
Equality and inequality in the health and care system 6
Our approach 8
Appendix A: Links to existing equality impact assessments, analyses and equality commitments 12

Introduction

1. We know that too many people die too early from diseases and illnesses that are largely avoidable either through better prevention, earlier diagnosis of conditions and by having access to the highest quality treatment and care. To address this the Secretary of State for Health first published his 2013 'Call to Action[1]' for the health and care system to join him in ensuring that England should be amongst the best in Europe at reducing levels of premature mortality. This was supported by a coordinating equality analysis[2] which brought together existing equality analyses and stakeholder engagement to give a strategic overview.

2. Delivering this will be a challenge. It requires improvements in outcomes across the health and care system and along the entire care pathway; starting with prevention of illness through public health interventions, earlier diagnosis of conditions through greater symptom awareness amongst professionals and the public, and by having access to the highest quality treatment and care.

3. To help the system to meet this challenge *Living well for longer: National support for local action to reduce premature avoidable mortality*[3] sets out what the different national partners will do to achieve the ambition. It is a resource for readers, bringing together in one place the national policy actions and support that is available for delivering local priorities, as well as examples of good practice and resources that might help local commissioning and service delivery. It is designed to help people navigate and understand how the national system as a whole is supporting local action to help people live well for longer.

4. Similarly, this coordinating equality analysis provides an overview of existing analyses and documentation to give a strategic overview of current and emerging equalities and inequalities evidence relating to the reduction of preventable mortality in England. It builds on, and mirrors, the approach taken in the previous equality analysis, following the structure and approach of the previous document, specifically in that it addresses the same areas for improvement amongst and across specific groups to support national and local partners to meet the challenges ahead to reduce preventable mortality for everyone.

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181103/Living_well_for_longer.pdf

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181104/LW4L_EQIA_Final.pdf

[3] Referred to as *Living well for longer* in this document

Equality and inequality in the health and care system

5. Equalities, human rights and diversity are at the heart of the health and care system. The duties set out in the Health and Social Care Act complement the existing Public Sector Equality Duty (PSED)[4] which the Department of Health, NHS England, Public Health England, local authorities and CCGs are also subject to. These are referred to as 'general duties'. The PSED requires public bodies to have due regard to the need to:

   - eliminate discrimination, harassment, victimisation and any other conduct prohibited by or under the Equality Act 2010;
   - advance equality of opportunity between people who share a protected characteristic (see below) 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.

6. The PSED covers the following protected characteristics:

   - Age
   - Disability
   - Gender reassignment
   - Marriage and civil partnership (only in respect of the requirement to have due regard to the need to eliminate discrimination, harassment etc.)
   - Pregnancy and maternity
   - Race
   - Religion and belief
   - Sex
   - Sexual orientation

   Bodies should also ensure they do not discriminate against carers 'by association' with someone with one or more of the protected characteristics e.g. disability or age.

7. In addition, The Equality Act 2010 also created specific duties that require many public bodies including DH, PHE and NHS England to:

   - publish information which demonstrates compliance with the equality duty at least annually, and
   - set equality objectives, at least every four years.

[4] The Equality Act 2010

8. The Health and Social Care Act (2012) also introduced legal duties on the Secretary of State for Health, NHS England, and clinical commissioning groups (CCGs) to have regard to the need to reduce health inequalities when exercising their functions. PHE has the same duty and also one of its principle aims is to reduce health inequalities. Monitor also has a duty in relation to integration of services where this could reduce health inequalities[5].

9. The legislation requires CCGs (in their annual commissioning plans) and NHS England (in its annual business plan) to set out how they intend to discharge this duty. NHS England's annual performance assessment of each CCG is also required to include an assessment of how well CCGs have discharged this duty. Finally, the Secretary of State, the NHS England and CCGs have to set out in their annual reports how effectively they have discharged their inequalities duties and the SofS must consider NHS England's report and set out in a letter an assessment of how it has discharged its duty.

10. Meeting these objectives and the process of annual reporting provides a strong mechanism to tackle inequalities and improve the health of the most vulnerable - through the Mandate, the NHS, Public Health and Adult Social Care Outcomes Frameworks, and commissioning decisions.

11. The Department of Health set out its statutory equality objectives and action plan up (2012-2016) in *Better Health, Better Care and Better Value for All*[6]. The commitments in the plan are reinforced by the DH Corporate Plan for 2013-14 which states that, as part of its leadership role in the new health and care system DH will ensure it puts 'equality and diversity at the heart of what we do'; ensuring it meets its obligations under the Equality Act, to improve the quality of its policy making, analysis and evidence base. NHS England has identified both equality and health inequalities as a primary business area in their business plan[7] and PHE will also set out in its annual business plans how it will refine its equality objectives[8] and set out the actions it will undertake to meet them.

12. Our approach to developing *Living well for longer* has been consistent with the duties placed on the Secretary of State, the Department's Corporate Plan and the requirements of the Public Sector Equality Duty.

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[5] Sections 1C, 13G, 14T of the NHS Act 2006 and 62(4) of the Health and Social Care Act 2012

[6] https://www.gov.uk/government/publications/department-of-health-equality-objectives-2012-to-2016

[7] Putting patients first: The NHS England Business Plan for 2013/14 – 2015/16 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/276798/Equalities_objectives.pdf

[8] PHE *Our equality objectives from April 2013* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/276798/Equalities_objectives.pdf January 2014

Our approach

13. In order to reflect the national and strategic nature of *Living well for longer* we have continued the approach taken with the previous equality analysis. This includes the framework of issues we believe need particular consideration in developing plans and systems. As the system steward, the Department of Health has a role in ensuring our partner organisations meet their individual responsibilities with regard to the inequality duty and the Public Sector Equality Duty but it is for them to consider the impact of their individual policies.

14. The information contained here is intended for local and national bodies to use to address their obligations with regard to equalities and inequalities issues while developing plans and strategies to reduce preventable mortality. The issues discussed below build on a number of sources:

    - a brief call for evidence from the Department's Voluntary Strategic Partners Programme[9];
    - engagement with other stakeholders including a series of roundtable Ministerial meetings and one to one discussions with the major disease-specific charities and professional groups
    - co-production with a specialist group of stakeholders of a dedicated commissioning framework for managing co-morbidities[10] – with a special focus on populations who disproportionately suffer health inequalities and mental illness;
    - a meeting of Voluntary Sector Strategic Partners Programme, and dedicated policy topic discussion forums.

    These have been combined with the Department's existing equalities analyses (see Appendix A). Specific issues for specific groups are important, and are included in the existing equality analyses referenced in the next section.

15. The main areas for consideration are set out in the paragraphs below.

One size does not fit all

16. Specific messages and interventions are appropriate for specific groups. Professor Sir Michael Marmot's strategic review of health inequalities[11] stated "For specific groups who face particular disadvantage and exclusion, additional efforts and investments and diversified provisions will be needed to reach them and to try to reduce the multiple disadvantages they experience"[12].

[9] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128237
[10] http://livinglonger.dh.gov.uk/conversations/comorbidities-framework/
[11] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
[12] Page 39 as above

17. Action on the four main risk factors for premature mortality (tobacco use, excessive alcohol consumption, poor diet and physical inactivity), should take account of their unequal distribution throughout society. For example, more young women (age 16-19) smoke and so are at risk of lung cancer, compared to young men[13].

Access to services

18. Access to services is an issue for a many people Adults in work and/or with caring responsibilities can struggle to access services that are mainly provided 9-5, Monday to Friday. Other groups who report significant access issues include some black and minority ethnic groups, refugees and asylum seekers[14], the homeless, gypsy and traveller communities, the disabled, trans people, carers and lesbian, gay and bisexual people[15].

19. Access issues can be due to stigma, a “no recourse to public funds” immigration status, or lack of a permanent address — all of which can impede registering with a GP. We have already tried to address these issues through, for example, the Department’s guidance on the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies[16], which will support local authorities in planning and commissioning public health services for all sections of local populations.

Use of data to identify trends

20. National and local bodies should consider improvements to monitoring of all the protected characteristic groups, and use of the data to identify trends and improve services, as currently most of the data in outcomes frameworks are not disaggregated by all protected characteristics[17]. Best practice exists for local NHS organisations, such as this NHS-funded guide to monitoring sexual orientation of staff and service users http://www.lgf.org.uk/policy-research/SOM/.

Patient experience and clinical outcomes

21. Data indicates that there is a correlation between patient experience (including access to services) and clinical outcomes.[18] In particular, evidence and discussion with stakeholders has shown that marginalised groups have a worse experience as a patient.

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[13] ONS (2008) ‘Focus on Gender’ http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-51144

[14] HPA Migrant Health Guidance: http://www.hpa.org.uk/MigrantHealthGuide/GeneralInformation/SpiritualityReligionAndHealthBeliefs/

[15] A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research, p. IV, http://blgbt.org/downloads/LGBT_health_26.03.09_final_version.pdf

[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

[17] https://www.wp.dh.gov.uk/publications/files/2012/11/Improving-outcomes-and-supporting-transparency-part-1B1.pdf (Appendix C)

[18] http://www.kingsfund.org.uk/publications/improving-gp-services-england

22. The GP Patient survey[19] indicates, for example, that lesbian, gay and bisexual patients are more likely to rate their GP or nurse as poor or very poor. Research[20][21] also shows that a third of gay and bisexual men and half of lesbian and bisexual women who accessed healthcare services had a negative experience related to their sexual orientation. This includes concerns about confidentiality and access to advice tailored to their sexuality.

The role of the voluntary and community sector (VCS)

23. The VCS has important roles to play as providers of care, patient advocates and customers of health system information. Some stakeholders have reported that local clinicians' knowledge of their local VCS can be low, which may adversely impact on cross-sector partnerships and service delivery.

Health literacy and numeracy

24. Research[22][23] indicates that there are low overall levels of health literacy and numeracy in England. Health literacy (HL) is defined as "more than just the ability to read, write, and understand numbers in the health setting. Health literacy is the cognitive ability to understand and interpret the meaning of health information in written, spoken or digital form. It impacts on whether people are able to embrace or disregard actions relating to health, and make sound health decisions in the context of everyday life"[24] .

25. Research[25][26] from the USA suggests that low HL is associated with limited participation in screening for diseases, limited understanding of one's illness or treatment plan, difficulties managing a chronic conditions (such as diabetes mellitus, coronary health disease, heart failure, and asthma) higher mortality and higher health care costs. Therefore, health information does have a therapeutic role, and as such should ideally be tested, pre-publication, with its target audience(s).

Focusing around the needs of patients

26. The increasing proportion of people living with multiple long-term conditions means that there is significant and growing value in different parts of the system coming together focused around the needs of patients, working across professional and institutional boundaries.

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[19] http://www.gp-patient.co.uk/
[20] http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/4922.asp
[21] http://www.stonewall.org.uk/what_we_do/research_and_policy/health_and_healthcare/3101.asp
[22] http://www1.lsbu.ac.uk/php5c-cgiwrap/hscweb/cm2/public/news/news.php?newsid=115
[23] Rowlands G, Protheroe J, Winkley J, Richardson M, Rudd R. Defining and describing the mismatch between population health literacy and numeracy and health system complexity, an observational study. Submitted to BMC public health currently out for peer review
[24] https://www.racgp.org.au/afp/200903/200903adams.pdf
[25] Health literacy outcomes: An updated systemic review', Berkman ND, Sheridan SL et al (2011) (http://www.ncbi.nlm.nih.gov/books/NBK82434/)
[26] Impact of Health Literacy on Longitudinal Asthma Outcomes, Mancuso CA, Rincon M J.Gen Intern Med 2006, 21 (8):813-817 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831574/)

27. At a national level, the Department is committed to empowering local areas to innovate and find the best way to deliver integrated care designed to meet local needs, including establishing 14 integrated care pioneers to showcase innovative ways of creating change. The Department has also collaborated with partners including National Voices, NHS England, Monitor, the Local Government Association, and the Association of Directors of Adult Social Services to develop a document which sets out how local areas can use existing structures for integrating care[27].

[27] Integrated care and support: our shared commitment https://www.gov.uk/government/publications/integrated-care

Appendix A: Links to existing equality impact assessments, analyses and equality commitments

Living well for longer: a call to action to reduce avoidable mortality, equality analysis
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181104/LW4L_EQIA_Final.pdf

Equality analysis on call to action on obesity in England
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213721/dh_130511.pdf

Healthy lives, healthy people: a tobacco control plan for England
https://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

Improving outcomes: a strategy for cancer, assessment of the impact on equalities
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213786/dh_123411.pdf

An outcomes strategy for chronic obstructive pulmonary disease (COPD) and asthma in England, assessment of the impact on equalities
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216140/dh_128427.pdf

The Government's alcohol strategy
http://www.homeoffice.gov.uk/publications/alcohol-drugs/alcohol/alcohol-strategy?view=Binary

No health without mental health: analysis of the impact on equality
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123989.pdf

The power of information, equality analysis
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134183.pdf

UK physical activity guidelines
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127931

Public Health Outcomes Framework, equality analysis
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216164/dh_132374.pdf

NHS Outcomes Framework, equality analysis
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256458/NHS_Outcomes_Framework_equalities_analysis.pdf

Mandate to the NHS England, equality analysis
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213134/Full-EA-Mandate-v11.pdf

Healthy Lives, Healthy People, Public Health White Paper
https://www.gov.uk/government/publications/healthy-lives-healthy-people-our-strategy-for-public-health-in-england

Health & Social Care Bill (now 2012 Act), equality analyses
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129978.pdf

DH equality objectives 2012 to 2016
https://www.gov.uk/government/publications/department-of-health-equality-objectives-2012-to-2016-progress-update

PHE equality objectives from April 2013
http://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf

NHS England equalities web page
http://www.england.nhs.uk/about/equality/

Putting patients first: The NHS England Business Plan for 2013/14 – 2015/16
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/276798/Equalities_objectives.pdf