DH Business Plan – the six priorities	Equality Objective	Actions	Delivery Date & Success Measures	Status: March 2013	Additional actions identified: 2013-14
1. Better health: strengthening our public health system, protecting people's health, promoting health and wellbeing to improve health outcomes and tackle health inequalities across all ages.	1.1 To reduce health inequalities and advance equality in the early years of life as part of our drive to improve outcomes in infant, maternal and child health.	1.1a. Low Birth Weight (LBW) – support work to reduce the gap in low birth weight babies at term and the gap in all LBW babies between the most advantaged socio-economic groups and the least advantaged socio-economic groups.	1.1a. The gap has been narrowing over the last 4 to 5 years. However, in 2010 there was a slight rise in the gap from 0.8% to 1.1% due to a fall in the percentage of LBW babies in the more advantaged group. The percentage of LBW babies in the least advantaged group was unchanged. http://www.dpm.cabinetoffice.gov.uk/resource-library/opening-doors-breaking-barriers-strategy-social-mobility-update-progress-april-2011 The proportion of LBW babies at term in 2010 was 7.3%.	1.1a The proportion of babies LBW at term is an indicator in the Public Health Outcomes Framework (PHOF). Although the PHOF indicators normally take account of socio-economic differences, such differences are not available for LBW babies at term. ONS only publishes data with socio-economic differences for all LBW babies. This data (and data on LBW babies at term) are published annually. The continuing development of the Health visitor and Family Nurse Partnership programmes – as well as the Healthy Child Programme – will help address this issue	While data on LBW babies at term by socio-economic groups are not published by ONS, they are collected. We will explore options with them for making this data available in the future.
		1.1b. Infant Mortality – improve the life chances, health and well-being of the health and well-being of both mothers and babies by reducing the gap in infant mortality. Infant mortality rates are higher than average in babies born to mothers from Pakistan, the Caribbean and Africa.	1.b. The gap between socio economic group continues to narrow. The gap is now 9% (2009-11) compared to 18% in 2002-04, as measured by the difference between routine and manual groups and the whole population. Other data is available by age, and ethnicity, with a proxy indicator for ethnicity by mothers place of birth. The infant mortality gap is falling faster in lower socio economic groups than higher groups.	1.1b Infant mortality is in NHS and Public Health Outcomes Framework. The continuing development of the Health visitor and Family Nurse Partnership programmes – as well as the Healthy Child Programme – will help address this issue.	
		1.1c. Under-18 conceptions –- support cross-government work (with the Department for Education) to reduce the rate of under-18 conceptions.	1.1c Conception data is collected by age, gender and area [Public Health Outcomes Framework 2013-16).	1.1c The under-18 conception rate is included in the Public Health Outcomes Framework, monitoring of impact of system-wide changes will continue. The under-18 conception data rate in 2011 was 30.9 conceptions per 1,000 women, the lowest level since 1969. Data published annually (next date: February 2014).	
		1.1d. Programme delivery –- for example, doubling the Family Nurse Partnership programme; and expanding the universal health visitor service by an additional 4.200 health visitors by 2015.	1.1d. Related programmes across the social determinants of health will contribute to this objective's delivery. For example, the child poverty strategy (also including in the PHOF) and housing and early years education (e.g. the recent provision of early years education for the most disadvantaged two year old children), as well as DH programmes on breastfeeding and smoking in pregnancy.	1.1d Social Justice strategy will supply information to update this area. Due in April 2013.	
	1.2 To ensure the Public Health Outcomes Framework published in January 2012 provides the transparent means that local communities, commissioners and Government can use to understand how well public health outcomes are achieved for all people by their equality characteristics, and how health inequalities have been reduced.	1.2a. Lead the development of the Public Health Outcomes Framework (PHOF), including publishing baselines for public health indicators	1.2a. Modelling options for presenting equalities disaggregations and seek input and collaboration with experts on the selection of best options (Dec 2012). *The Public Health outcomes Framework is not a performance management framework with a target driven regime. Instead it reflects a comprehensive range of those evidence based actions that can be taken to improve public health for all. 66 Indicators in the Framework provide the measures that will give us some sense of how likely we are to increasing healthy life expectancy and reduce health inequalities.*	1.2a As part of the technical refresh, we published an updated version of the technical appendix (Appendix C of Part 1A) details which inequalities and equalities breakdowns are feasible for PHOF indicators.	
		1.2b. Public Health England (PHE) will deliver a range of evidence and intelligence products and services that focus on the health needs and outcomes of diversity groups. This will be public information made up largely of previously published material, but collated and analysed to fully understand health impacts. It will be for local councils to demonstrate what an d how commissioning decisions have been made in order to drive improvements in outcomes.	1.2b. Products and services will include publication of national and local progress against the indicators in the Public Health Outcomes Framework including, disaggregation by protected characteristics (where possible) and by promoting data quality improvement. Published on a web-portal, public health data and information would be available to any organisations or individuals who may wish to hold local authorities (at upper tier levels) to account. Baseline data for public health indicators will be published in a series of tranches between Autumn 2012 and Spring 2013. Following this, we expect annual publication of performance data at national and local level during the Autumn of each year, enabling local authorities, the NHS and wider public services to base their business plans on the most up-to-date information.	1.2b On the Equalities tabs of the data tool, we presented data for a number of indicators broken down by some of the equalities characteristics. We will be seeking feedback from users on the best way to present such data, and will seek to improve the presentation and expand the number of indicators, and range of equalities characteristics, for which it is presented in future updates to the web tool. On 20 November 2012 we published the first set of baseline data for 39 of the 66 supporting indicators n the PHOF on an interactive data tool - providing England and local authority level data.	
2. Better care: reforming social care and working with the NHS to improve choices and health outcomes.	2. To place equality at the heart of work to improve quality in health and social care with a focus on improving health outcomes.				

	Specifically to:				
	2.1a ensure that mental health strategy and policy development identifies and addresses the needs of equality groups, focusing on people with protected characteristics where the evidence shows greatest need;	2.1a. Work with partners to develop indicators for commissioners on improving Independent Mental Health Advocacy provision to people in protected characteristic groups.	2.1a. Development of indicators 2013.	2.1a Research completed which indicates areas for improvements	Work is being commissioned to support the implementation of the statutory duty of access to and delivery of high quality IMHA services through the development of good practice locally. Feb – March 2013.
		2.1b. Introduce routine data collection and monitoring across the range of protected characteristic groups for IAPT services.	2.1b. Routine data is currently available for gender and age in IAPT services. • Reports on race, religion, sexual orientation and disability to be available from November 2011 (service use April – September 2012), this will be analysed for data quality/completeness. • March 2013 qualitative analysis will be available. • Aspirations beyond 2013 are to include data collection on transgender, pregnancy/maternity and marriage/civil partnership.	2.1b Race, religion, sexual orientation and disability reports received in Sept. 2012. This is being refined in line with the preliminary data received.	IAPT services qualitative reports to be published in Spring 2013.
		2.1c. Support the British Psychological Society (BPS) to establish a work programme to enable equitable access to older people to IAPT services.	2.1c. As part of work programme: • September 2012: Publish a "working with older people" module for existing IAPT services. Specialist older people module for supervision training. • March 2013: Quality standards and commissioning guidance for commissioning services for older people. Revised outcome measures for older people.	2.1c Older people training module delivered in Sept. 2012. Curriculum development on older people piloted in Oxfordshire and Southampton in Nov and Dec 2012 with positive feedback	Older people's commissioning guidance will be combined with mainstream guidance and published in Spring 2013.
		2.1d. Develop the Mental Health Minimum Dataset (MHMDS) to collect information on all protected characteristics.	2.1d. Subject to consultation and ISB Board approval, the Mental Health Minimum dataset will collect information on all Equality Act protected characteristic groups. • ISB Board considers March 2013 • If approved, collection notice issued April 2013 • If approved, collection starts October 2013	2.1d The MHMDS mandate dates have been delayed for technical reasons and to ensure effective stakeholder engagement. MHMDS V4.5 collection notice to be issued April 2014. MHMDS version 5 planned to be mandated from April 2015.	CAMHS dataset reports available from Oct 2013.
		2.1e. Develop the Child and Adolescent Mental Health Services (CAMHS) dataset to include equality data.	2.1e CAMHS data collection starts April 2013. Reports available October 2013.	2.1e Collection starts in April 2013.	
	2.2.a. provide greater choice and control for people with learning disabilities and people with autism and their families and carers, as part of our drive to improve outcomes for people with learning disabilities and autism;	2.2a DH will work with key national partners to agree the actions that need to be taken to deliver the right models of care for people with learning disabilities and autism. This will include working with partners to agree what information and data needs to be collected to measure progress.	2.2a The NHS Outcomes Framework will include an indicator to capture excess mortality in people with learning disabilities. Subject to consultation and Information Services Board approval, the Mental Health Minimum Dataset will collect information on people with learning disabilities. ASCOF and PHOF provides two indicators focusing on the proportion of adults with learning disabilities who live in their home and the proportion who are in paid employment.	2.2a. The NHS Outcomes Framework and the Adult Social Care Outcomes Framework include placeholder indicators on reducing excess mortality rate in adults with learning disabilities under 60. The Department will also work with the NHS Commissioning Board, the Health and Social Care Information Centre and others to develop the Mental Health Minimum Data Set. There will be some changes to allow collection of data on people with learning disabilities in 2014 with further changes in 2015.	Work to develop these indicators will commence in 2013 in partnership with the NHS Commissioning Board and other stakeholders.
	2.3a. work with stakeholders to promote good practice in dignity in care for all people, particularly older people through the health and social care system.	DH will work with stakeholders to promote good practice in dignity in care for all people, including: 2.3a. Establish and support an independent Nursing & Care Quality Forum (N&CQF)	2.3a. The N&CQF will be supported by DH in a work programme to carry out their aim to improve the quality for nursing care across all care settings.	2.3a.The Nursing and Care Quality Forum was established by the Prime Minister in January 2012 with the aim of helping nursing and care workers to deliver the fundamental elements of good care first time, every time and to everyone. Over the last 12 months, the Forum has helped drive improvements in the standard of nursing and care in this country. This has been through improving the uptake of initiatives like hourly ward rounds, and the use of fully supervisory status for ward sisters and community team leaders. The Forum's work has also focused on the wider context in which nursing and care takes place – leadership, staffing levels, training – given the affect that this has on frontline care.	
		2.3b. Support health and well-being boards to better understand, identify and consider the issue of loneliness in older age in Joint Strategic Needs Assessments (JSNAs) and Joint Health and Well-being Strategies (JHWSs).	2.3b. DH will publish a reducing loneliness and isolation toolkit for health and well-being boards as part of the Campaign to End loneliness (by end 2013).	. 2.3 b/c The DH has funded a "digital toolkit" for local commissioners, which was developed by the Campaign to End Loneliness. It was launched in July 2012. The toolkit has been supporting commissioners in understanding, mapping and commissioning for loneliness and social isolation in their communities. In terms of outcomes, all 154 health and wellbeing boards have heard about the toolkit, and it has been downloaded by over 140 local government and NHS employees. For more information, see:	
		2.3c. Establish dignity as a key priority for the NHS.	2.3c. The NHS Operating Framework for 2012-13 establishes the issue of high quality, dignified and compassionate care as one of four key priorities for the NHS. Data for all the indicators in the NHS Outcomes Framework will be published on the NHS Information Centre's indicator portal (NHS Information Centre Indicator Portal).		
		2.3d Obtain a year-on-year national view of Local Authority performance on the Adult Social Care Outcomes Framework in respect of people having a positive experience of care and support, to inform future policy	2.3d. Social care service users should experience effective, safe and appropriate care, treatment and support that meets their physical, mental and nutritional needs and protects their rights. Prioritised in the Adult Social Care Outcomes Framework 2012-		

		development and implementation.	13.	http://campaigntoendloneliness.org/toolkit/ DH has also facilitated the Campaign to end Loneliness to engage with health and wellbeing boards, through a series of webinars. 2.3d Monitoring of outcomes ongoing.	
3. Better value: providing better quality of care by improving productivity and ensuring value for money for the taxpayer and reducing bureaucracy.	3.1. To ensure, as a system leader allocating and distributing funding, that the drive to increase value, efficiency and productivity across the health and care system considers the needs of all people with protected characteristics.	3.1a. Public Health: new formula and consideration of further developments in the medium term. 3.1b. New funding formulae for adult social care: equality issues will be considered its development and ASCOF will be used to monitor outcomes by protected characteristics where data is available.	3.1a. The public health formula for 2013-14 will be finalised by December 2012. This will draw on available evidence for differences in need for public health services. The final allocation of resources to local authorities will be supported by an Equality Analysis.	3.1a The Advisory Committee for Resource Allocation (ACRA) has developed a formula for the preferred relative distribution of public health resources between local authorities that takes account, for the first time, of within area health inequalities. ACRA's final recommendations build on a major engagement process that tested views of interim proposals; one of the results of this was to strengthen the impact of within area health inequalities on the estimated target formula. While the recommended formula does not explicitly take account of differences in the relative populations of people with protected characteristics (ACRA found no evidence on which to base an explicit correction), they are captured implicitly where they tend to have poorer health status this may be reflected in the health outcome indicator used. ACRA also believes that in the medium-term the preferred relative distribution of public health resources should be driven more explicitly by the underlying drivers of need rather than a health outcome measure. Subject to the available evidence, this could include direct reference to the needs of populations with protected characteristics. The resulting allocation of resources also takes account of the historic or baseline distribution of resources. An equality analysis of the 2013-14 and 2014-15 allocations has been published at www.dh.gov.uk/health/2013/01/ph-grants-las/ 3.1b Consideration of equalities issues has closely informed the development and implementation of new policies over the last year. We recognise that our reforms must be responsive to the specific needs of people who come into contact with care and support, of all ages and with a range of disabilities. In autumn 2011, the Government engaged extensively with a wide range of people and groups during the development of the draft Care and Support White Paper and draft Bill, including people who use care and support services, carers, local councils, care providers and the voluntary sector. The findings of this engagement have directly informed the equality analysis undertaken as part of policy development and published alongside the White Paper. The Health and Social Care Information Centre published provisional Adult Social Care Outcomes Framework (ASCOF) data for 2011/12 on 12 September 2012. The publication included national level disaggregations by certain protected characteristics, where this was supported by the underlying data, enhancing transparency on disparities in the outcomes and experiences of care for people with protected characteristics. An updated ASCOF for 2013/14 was published on 22 November 2012. This was supported by an equality analysis, which set out the ASCOF's role in enhancing transparency and accountability on equality to drive improvement. The analysis also reiterated the Department's commitment to working with local government to support further improvements to the availability of equality disaggregations for outcome measures, where this is proportionate and feasible. The ASCOF for 2013/14 also included a Ministerial commentary on adult social care outcomes for 2011/12, focusing on the disparities in the outcomes and experiences of care experienced by different groups of people who use services, including older people and those with learning disabilities or mental health problems. The research contract for taking forward the review of	Public Health: There will be a consideration by ACRA of further developments in the medium term. Social care: ASCOF will be used to monitor outcomes by protected characteristics where data is available. Equalities issues will be considered in the development and implementation of new policies, drawing on the available evidence including ASCOF, and evidenced through Equality Analyses were appropriate (ongoing through to 2013/14). Equalities issues will be considered in the development of a new funding formulae for adult social care.

		3.1c. The Mandate supports the NHS Commissioning Board's responsibility for embedding equality in its approach to allocating resources to CCGs.		the adult social care relative needs formulae has now been let. Our tender specifically stated that the research would need to take account of the new equality act, and investigate how this will affect the structure of our formulae. 3.1c. NHSCB published 2013-14 allocations to CCGs on 17 December 2012. Full details can be found at www.commissioningboard.nhs.uk/allocations-2013-14/	
	3.2. To establish and support Public Health England (PHE) to be a respected, professionally-led expert body, providing: - information on the best evidenced and best value for money public health interventions; - and leading the way on expanding the evidence and research-base that will support achieving equitable outcomes in health.	3.2a. PHE's work will be lead by health intelligence. The application of knowledge and research will be a critical tool in transforming the approach to improving health and reducing inequalities across the entire health, social care and public health system. 3.2b. PHE will work closely with its partners, data producers and suppliers to ensure that the voice of protected populations are listened to, inform its work and develops a national view of priorities. 3.2c. PHE will ensure that its advice includes dimensions of equity and equality.	3.2a. PHE will deliver a new internationally recognised evidence and intelligence service. Measures of performance will be published across the transition period to ensure a safe transition, and on establishment to monitor improvements. 3.2b. PHE will ensure that information gaps on the health needs and outcomes of diversity groups are addressed – through improved data collection and data linkage to maximise the utility of existing collections. 3.2c. PHE tools and resources will also help commissioners best target interventions, understand and forecast the health status of their populations across protected characteristics, and achieve value for money.	3.2a/b/c Progress to deliver the Chief Knowledge Officer's directorate in PHE continues. The HR process to move knowledge, expertise and capacity that will enable PHE to deliver on these objectives is underway and any gaps in delivering on its ambition will be addressed. This will enable PHE to fulfil its commitments to deliver an internationally recognized evidence and intelligence service. We are considering the public health intelligence workforce development needs including both PHE and LA staff. We will need to work with HEE to address these needs as the two workforces move across to the new system.	
4. Successful change: ensuring an effective transition to the new health and care system by April 2013.	4.1. To assess the equality data that should be collected and maintained at a national level to inform the Department's priorities, including initial dis-aggregation of such data where appropriate and to provide leadership on using relevant data in decision-making.	4.1a. Develop an approach to the availability of equality data to inform DH decision making in its role as the new health and social care system leader. 4.1b. Produce 'Project Scoping Plan' which outlines our approach.	4.1a. Development of a clear plan of action to fill the gaps in data across health and social care (by Sept 2013).	4.1a Audit of NHS, Public Health and Social Care Outcomes Frameworks disaggregation status completed. 4.1b Progress Update agreed by DH Equality and Human Rights Assurance Group in Feb 2013.	Establish best option for data bridging gaps, including advantages, disadvantages, feasibility and timescales: May 2013.
	4.2 To quality assure the overall development of the health and social care system so that equality and diversity is prioritised in the design of the new system. Ensure advancing equality and reducing health inequalities is embedded into the structures and delivery frameworks governing key relationships between the new NHS, public health and social care organisations being established.	4.2a. Embed equality into each of the individual transition programmes. 4.2b. For our People Transition provide a baseline for HR data related to four of the protected characteristics. 4.2c. Establish a reporting system for monitoring the impact of transition, between 'sender' and 'receiver' organisations, on staff with protected characteristics. 4.2d. Embed advancing equality and reducing avoidable inequalities into 'the Mandate' and related government mechanisms between the DH and the NHS Commissioning Board.	4.2a/b/c Integrated Programme Office assures that equalities activities are included in all programmes scopes and plans. People Tracker reviewed quarterly, compared to baseline position at April 1 2012. 4.2d. Publish draft and final Equality Analyses (by Sept 2012).	4.2 a/b/c/d Completed. Closedown report will be submitted to the DH Equality and Human Rights Assurance Group in May 2013. New health and care system operational from 1 April 2013.	Continue to embed advancing equality and reducing inequalities into the Mandate and related government mechanisms between the DH and the NHS Commissioning Board (ongoing commitment between DH and NHS CB)
5. Our partners: developing strong relationships with our external stakeholders, effective ways of working with the new partnership organisations, and OGDs.	5.1. To support and assure the Department in building and developing relationships with stakeholders, including those that represent groups with protected characteristics as appropriate, to improve policy design and delivery.	5.1a. Ensure that equality stakeholders have representation at the regular National Stakeholder Forum which convenes top stakeholders across health and social care. 5.1b. Identify equality stakeholders as part of the revamped DH stakeholder map. 5.1c. Incorporate equality prompts and signposts into the refresh of stakeholder engagement guidance.	5.1a DH Secretariat for three National Stakeholder Forum meetings per annum. 5.1b. Revamped stakeholder map (Dec 2012). 5.1c. Refreshed guidance published (Dec 2012).	5.1a .Three meetings of the National Stakeholder Forum (NSF) held on 21 May, 12 July and 5 December, 2012. 5.1b/c. Action to revamp the DH stakeholder map and refresh guidance will be completed by March 2013.	Publish a strategic vision for working with the DH's external partners and stakeholders (March 2013). Overhaul the NSF and further strengthen equality stakeholder representation (June 2013)
	5.2. To maintain and develop a specialist advice function in DH that will contribute to cross-government opportunities to advance Equality and promote Human Rights.	The DH Equality and Inclusion Team will: 5.2a. Establish a 'policy partner' system mirroring the new structure to support policy leads to embed equality. 5.2b. Lead and coordinate DH contribution to cross-government activity on equality and human rights.	5.2a. New policy partner system in place (March 2013). 5.2b. Review / re-publish Public Sector Equality Duty guidance (March 2013).	5.2a New Assurance system for equality, including role of policy partners, agreed by EHRAG Feb 2013 5.2b Guidance due out in Spring 2013	Continue to support work to embed equality in to new DH and system-wide structures. Cross-government support and health sector co-ordination for the GEO-led review of the Public Sector Equality Duty.

		5.2c. Support DH engagement with equality stakeholders.	5.2c. LGB&T stakeholder engagement, partnership working with EHRC and Third Sector Strategic Partners.	5.2c. Two engagement events held. One with transgender stakeholders on commissioning (May) and one with LGBT stakeholders on public health (October, 2012). Ongoing and regular engagement with the LGBT groups.	
6. Us: improving our capability, developing new ways of working and becoming a better department.	6. To ensure that the Department has a motivated and engaged workforce that represents the community it serves, at all levels in the organisation - through the provision of relevant policies and guidance, learning and development, and targeted initiatives. We will assess progress using internal and external indicators of best practice and achievement.	6.1 Equality analyses completed for all stages of people transition between 'sending' and 'receive' organisations. 6.2 Continue to meet external standards of success. 6.3 Embed accountability at senior management level.	6.1 Publish equality analyses. 6.2.a. Cabinet Office targets – women, disabled and BME staff in SCS. 6.2.b. Stonewall Workplace Equality Index 2013. 6.2.c. Develop diversity strategy and action plan (Dec 2012). 6.2.d. Provide directorate level data on staff diversity 6.3 Embedding accountability at directorate level.	6.1 Ongoing – see http://www.dh.gov.uk/health/2013/01/dh-workforce/ 'People & Posts' – DH's overall diversity analysis and report produced in February 2012. It examined the cumulative and organisation-wide impact by diversity characteristics of this phase of the programme. Report submitted to Departmental Management Committee in April 2012. The high-level findings were published on the DH intranet in June 2012. 6.2.a. Department continues to meet/exceed the current Cabinet Office targets for women, disabled and BME staff in SCS. 6.2.b. For the third year running, the Department improved its ranking in the Stonewall Workplace Equality Index (WEI) 2013, rising to 24th place from 53rd in the 'Top 100 Employers' league table. Work underway to assess Department's position against Opportunity Now benchmarking standard (gender). 6.2.c. Pending. Awaiting launch of refreshed cross-government diversity strategy. Revised delivery date by March 2013. 6.2.d. Revised delivery date 30/4 or when the transition programme is nearing completion and the position re: workforce profiles is stable. 6.3 Pilot underway with the SCLGCP Directorate – have developed Directorate action plan, with success measures. 'Diversity Day' events (March 2013) will promote the behaviours and actions (by all) that make a difference, including re-launching the diversity objectives for the SCS.	