



NHS 111 Public Sector Equality Duty (PSED) Analysis of Impact on Equality (AIE)

October 2012

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For the record

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Executive Summary

This analysis will contribute to the NHS 111 programme's fulfilment of the Public Sector Equality Duty (PSED). This report considers the impact of the transition from NHS Direct's 0845 telephone service to NHS 111, mitigation methods to address any disproportionate impact and opportunities to maximise evidence based 'positive action'¹. The evidence used is both qualitative and quantitative, including research papers, evaluation reports, patient and public surveys, health outcomes data, and stakeholder feedback.

The Department, NHS and NHS Direct have undertaken a number of exercises over the last few years, which, taken together, go a good way to demonstrate the programme's commitment to the PSED. This includes:

- An Equality Impact Assessment Initial Screening on the introduction of a three-digit number (3DN) in 2009
- Consultation activities with patients, representative groups, the NHS, local government and the voluntary sector
- NHS Direct's formal consultation with front line staff in June 2011 and publication of Equality Information on 0845 and 111 in 2012
- The University of Sheffield's NHS 111 Evaluation Report incorporating equity of access and equity of service

It was identified that NHS Direct & NHS 111 services do not currently routinely collect patient information on all of the protected characteristic groups. NHS 111 commissioners and providers will need to balance the impact of collecting this data on service delivery, with an assessment of proportionality and the relevance of the data to ensure it is sensitively executed and legally compliant. Knowing who the population is and understanding the different health needs of groups and localities will improve precision of service delivery, and thus value for money. This will in turn improve health outcomes and patient experience. However, this will not be achieved without collecting the information necessary for commissioners to act. The robust collection and use of disaggregated data will help to ensure the equitable delivery of the service, which is critical to the primary aims of NHS 111.

It was identified that individuals were more likely to have used NHS 111 if they had a disability, limiting long-term illness or from a lower socio-economic status, indicating that NHS 111 is reaching some groups of the population with the greatest needs. However, respondents were less likely to have used NHS 111 if they were older or male. This is broadly in line with NHS Direct's 0845 4647 telephone service and appears to be inherent in telephone based health care. There were also lower levels of awareness and reported usage for people in

¹ The Equality Act allows service providers to take action that may involve treating one group more favourably where this is a proportionate way to help members of that group overcome a disadvantage or participate more fully, or in order to meet needs they have that are different from the population as a whole

black and ethnic minority groups (BME), although its statistical significance is called into question when controlled for confounding factors.

The NHS Commissioning Board will assume national oversight, planning and delivery responsibilities of NHS 111 from 1 November 2012. The promotion of the NHS Constitution, equality, reduction of health inequalities and integration will be embedded in the design of the NHS Commissioning Board's functions. Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board will have clear duties to exercise their functions in ways that are designed to reduce inequalities of access. This could go some way to mitigating concerns raised by the Equality and Human Rights Commission that equality is not consistently considered in NHS commissioning plans and recommendation that this must be addressed both in the design of commissioning structures and local commissioning decisions.

The NHS, CCGs and providers of the NHS 111 service will be required to have due regard to the PSED as an integral part of service development and implementation. This report will be shared to help inform service design and support continued service improvement in accordance with the PSED. As the equality duty is a continuing duty, this report also makes a number of recommendations for the programme going forward.

Public Sector Equality Duty

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.²

The Public Sector Equality Duty (PSED) was created by the Equality Act 2010 and replaces the race, disability and gender equality duties. The duty applies to age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation.

The general equality duty requires public authorities, in the exercise of their, 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

There is evidence across the equality strands that the failure of NHS services to recognise and meet diverse needs undermines health outcomes and contributes to poor service satisfaction.³ There is also evidence that failure to adequately recognise and respond to diversity contributes to poorer healthcare experiences, outcomes and may result in health services mirroring the processes of discrimination and exclusions that operate in wider society.⁴

The PSED requires due regard to be given to equality as an integral part of the policy development and decision-making in order to be made in a fair, transparent and accountable way. This involves giving proper, informed consideration to equality issues at the right time and recording of that consideration to demonstrate compliance with the PSED.

All NHS bodies, commercial and third sector providers supplying public services are required to take account of the NHS Constitution in their decisions and actions. One of the seven principles in the Constitution is that 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 every individual it serves

² Department of Health, NHS Constitution for England (8 March 2012)

³ Equality and Human Rights Commission, LIFE & HEALTH: An evidence review and synthesis for the Equality and Human Rights Commission's Triennial Review (2010)

⁴ Ibid

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.

Overview of NHS 111

The introduction of the NHS 111 service is part of the wider revisions to the urgent care system to deliver a 24/7 urgent care service that ensures people receive the right care, from the right person, in the right place, at the right time.

The NHS 111 service will:

- Be available 24 hours a day, 365 days a year, via the new free to call, easy to remember three-digit number;
- Provide a clinical assessment at the first point of contact, without the need to call patients back; will direct people to the right NHS service, first time, without the need for them to be re-triaged; and will be able to transfer clinical assessment data to other providers and book appointments for patients where appropriate;
- Work alongside the 999 emergency service and will be able to despatch an ambulance without delay and without the need for the patient to repeat any information.

We expect the introduction of the NHS 111 service to:

- Improve public access to urgent healthcare services;
- Increase the efficiency of the NHS by ensuring that people are able to quickly and easily access the healthcare services they need;
- Increase public satisfaction and confidence in the NHS;
- Enable the commissioning of more effective and productive healthcare services that are tuned to meet peoples' needs; and to
- Increase the efficiency of the 999 emergency ambulance service by reducing non-emergency calls to 999.

The development of the NHS 111 service will improve the quality, efficiency and coherence of our urgent care system. To allow the service to operate effectively within the local health environment, it is being managed and partially designed at a local level. However, national standards in the form of the NHS 111 National Service Specification will apply to the service across all areas. This ensures that the public experience the same high quality of service, wherever they are.

NHS 111 is not intended to be the only number for access to NHS healthcare services. The NHS 111 service is intended to help direct member of the public towards the most appropriate local service, in particular where their need is urgent but is not life-threatening. For less urgent health care needs, we expect the public to contact their GP or local pharmacist in the usual way.

The NHS Operating Framework 2012/13⁵ and the Coalition's Programme for Government⁶ set out a commitment to establish NHS 111 across England by April 2013. On 1st October 2011, The Prime Minister and the Secretary of State

⁵ Department of Health, The Operating Framework for NHS in England 2012-13 (2011)

⁶ Cabinet Office, The Coalition: Our Programme for Government (May 2010)

for Health announced that the NHS 111 service would be operating across England by April 2013:

I believe people should get the care they need, when and where they need it. However, too many people are confused about what is available to them or how best to get it, especially at night or if they are away from home.

That's why we are introducing NHS 111. The new service will make sure callers can access the care and advice that is right for them, 24 hours a day, 365 days a year. (David Cameron, Prime Minister, 1 October 2011)

The commissioning of healthcare services can have a direct impact on the health and wellbeing of communities. It is clear that the PSED does not mean treating everyone the same, rather responding in a proportionate way to people's different needs. The NHS 111 service is being locally commissioned and it is the responsibility of the NHS, working with Clinical Commissioning Groups and local clinicians, to manage a multi-provider service. Strategic Health Authorities (SHAs) are responsible for the planning and implementation of NHS 111 and the Department maintains national oversight.

When NHS 111 is rolled out nationally, it will replace the NHS Direct 0845 4647 telephone number. Until then, NHS Direct will continue to provide its current service. While the telephone number will no longer exist in the long term, we expect an ongoing role for NHS Direct, alongside other providers, in delivering the NHS 111 service. We expect 95% of the country to be able to access NHS 111 by April 2013.

We anticipate that this new locally commissioned service will have a positive impact on protected characteristic groups in addressing both individualised local needs and health inequalities. This will enable the commissioning of more effective and productive healthcare services that are tuned to meet the needs of patients and locally sensitive. This includes identifying commissioning gaps, local and characteristic specific health needs, and increasing understanding of the shape of demand for each service. Where it is already live, patients are experiencing high levels of satisfaction, positive outcomes, and more importantly a service that can direct patients straightaway to a local service that is best able to meet their needs.

We are committed to launching an NHS111 on-line service alongside the telephone service. The NHS 111 on-line service will be delivered through the new single portal that will eventually replace the current NHS Choices website.

Background

In 1997, the Calman Review⁷ conducted a consultation with the public who reported confusion about which service to attend when they had an urgent health problem. The Review recommended the introduction of a simple three-digit accessed telephone service to address this issue. NHS Direct was established to meet this need, rolling out a national service by 2000. However, this was a new 0845 service rather than the three-digit number envisaged in conception.

Changes in the way in which services are delivered, in particular the introduction of new services like NHS walk-in centres or Urgent Care Centres has since exacerbated the complexity of decision making for patients requiring urgent care. A poll conducted by Which?⁸ revealed 83% of adults did not know the number to call for NHS Direct.

In 2006, a consultation with the public also identified the same problems of confusion about the most appropriate service to contact.⁹ Recommendations included establishing a seamless telephone service where the public make one call to a number familiar to them, receive a rigorous assessment of the degree of urgency, which is consistent and safe and get them to the right care without having to repeat information.

Following Lord Darzi's Review¹⁰, the Department undertook to consider the costs and benefits of a new national three digit number to access non-emergency healthcare which would promote and drive forward the Government's commitment to integrated urgent health care. Subsequently, the Department conducted research to explore the most suitable three-digit numbers in terms of ease of use, memorability and association with any existing three-digit numbers. In its research, the Department took positive action and paid particular attention to the needs of blind or partially sighted users, and those with restricted mobility, to ensure that there would be no adverse impact in any change but rather an improvement.¹¹

'111' emerged as the overwhelmingly preferred option. We found that the blind and partially sighted, those with movement restrictions, people over the age of seventy-five and those with long-term conditions, separately identified '111' as the best option. Health professionals, wardens and carers further endorsed this view.¹²

⁷ Calman, K., *Developing emergency services in the community*, Department of Health (1997)

⁸ Out-of-Hours Care, Which? Only 17% of 1367 adults interviewed knew the number for NHS Direct (June, 2006)

⁹ Department of Health, *Direction of Travel for Urgent Care: A Discussion Document* (2006)

¹⁰ Professor the Lord Darzi of Denham KBE, *High Quality Care for All: NHS Next Stage Review Final Report* (2008)

¹¹ Cragg Ross Dawson, *Three Digit Number for Urgent Care. Qualitative Research to help identify the most appropriate number* (April, 2009)

¹² Ibid

In 2009, the Department commissioned the Office of Communications (Ofcom) to consult on the eligibility of a new 3 digit number (3DN), the choice of number and tariff for the purpose of accessing urgent healthcare needs. 214 responses were received and indicated overall support of the introduction of a three-digit number for non-emergency healthcare services.¹³

As part of their evaluation, Ofcom also considered whether to undertake a full Equality Impact Assessment for this consultation. Following an Initial Equality Impact Assessment Screening, Ofcom determined that it was not required as the new number should be equally accessible to all. However, for patients with disabilities, General Condition 15 (“GC15”) required that:

The Communications Provider shall ensure that such of its Subscribers who, because of their disabilities, need to make calls in which some or all of the call is made or received in text format, are able to access a Relay Service.¹⁴

The Department conducted its own enhanced Initial Screening Equality Impact Assessment of proposed changes in May 2009. This was updated (appendix A) in December 2009 to inform the development of this policy and nationwide roll-out. The report considered and recommended ways to address equality issues in accordance with the single equality scheme.

We set out our commitment to launch the NHS 111 service nationally as part of an integrated 24/7 urgent care service in the White Paper, *Equity and Excellence: Liberating the NHS*, setting out the long-term vision for the future of the NHS:

[To] develop a coherent 24/7 urgent care service in every area of England that makes sense to patients when they have to make choices about their care. This will incorporate GP out-of-hours services and provide urgent medical care for people registered with a GP elsewhere. We will make care more accessible by introducing, informed by evaluation, a single telephone number for every kind of urgent and social care and by using technology to help people communicate with their clinicians¹⁵

The changes developed since the NHS White Paper are rooted in the Government’s intention to put patients first, to achieve better outcomes, and to empower clinicians to innovate and take decisions based on their clinical judgement. A patient-led NHS is one that involves all patients and their carers in the development of services that meet their needs and take account of their choices, lifestyles, backgrounds and characteristics.

¹³ Ofcom, A Three-digit Number for Non-Emergency Healthcare Services: Proposals for the number and tariff; including notification of a proposed modification to General Condition 17 (July, 2009)

¹⁴ Ibid

¹⁵ Department of Health, *Equity and Excellence: Liberating the NHS* (2010)

The title, *Equity and Excellence*, reflects the importance the Government places on the principle of fairness and its role as a cornerstone of the new direction. In taking account of all patients' needs and aspirations, services will need to change to address current inequalities and insensitivities. This will require an understanding of and genuine dialogue with patients, carers and the public so that their needs are properly understood and addressed.

At the outset of NHS 111 development, plans included an independent evaluation to inform national roll-out. In November 2009, we commissioned the Medical Care Research Unit at the University of Sheffield to conduct an independent evaluation of the NHS 111 service in four pilot sites for the first 12 months of live operation. This evaluation was also commissioned to analyse equity of awareness and equity of use. The statistical data and findings shall be incorporated as part of this equality analysis.

NHS Direct, a provider for NHS 111, collated usage data of protected characteristic groups in Luton, Lincolnshire and Nottingham and compared this against population statistics. This information was also gathered to identify the extent to which groups with protected characteristics access this service. The data gathered from these pilots will also be utilised to assess the impact of this new service.

During the development of this policy, the Department continued to engage with various stakeholders including patient and advocacy groups working with marginalised or seldom heard communities. These engagement exercises helped to address the broader access requirements of individuals. A number of key outputs have been incorporated into this analysis.

As the PSED is an ongoing duty, the NHS and its providers will be required to review the service in full recognition of the diverse needs, circumstances and concerns of the people who will be affected by them. While equality impact assessments are no longer compulsory, they are necessary in order to demonstrate giving proper, informed consideration to equality issues at the right time and keep a record of that consideration to demonstrate paying due regard to the PSED. It is therefore more than good practice, and we recommend this exercise as a good and transparent means to review and develop NHS 111 services and approaches in accordance with the PSED.

The NHS has developed the Equality Delivery System (EDS) to the NHS and providers to meet their obligations under the general duty. In particular, use of the EDS will help NHS organisations to comply not only with the general duty but also the specific duties to publish information to demonstrate compliance and prepare and publish equality objectives. The EDS can be accessed at www.eastmidlands.nhs.uk/eds

If adopted and used effectively, the EDS should help commissioners and providers to start the analysis that is required by section 149 of the Equality Act 2010 (“the public sector Equality Duty”) in a way that promotes localism and also helps to deliver on the NHS Outcomes Framework, and the NHS Constitution. It will also help providers to continue to meet CQC’s “Essential Standards of Quality and Safety”.

Summary of Analysis and Overall Impact

This section considers the likely or proven impact of the NHS 111 programme on patients with protected characteristics, as well as the actions that have been taken to mitigate any negative impact and examples of positive action.

This intelligence was obtained from a range of organisations and sectors and disaggregated data was obtained where possible. In order to identify whether there is disparate impact, the appropriate pool for comparison would be people who are affected by the decisions but do not share the protected characteristic.

The following sources of evidence have informed this equality assessment:

- The equality aspects of the intended policy direction were considered at consultation events
- Information from EqIAs on related policy areas carried out recently by the DH & NHS
- Research and statistical data held within DH and public sources
- Research published by equalities organisations

Information from these sources has been summarised and presented against the relevant strands in the following chapter. The main areas where there is a need for more evidence are indicated, and we will specifically seek to fill these gaps through recommendations to the NHS, local commissioners and providers in order to promote equality in health service delivery.

It is worthy to note that usage data analysis on protected characteristic groups assumes that all groups have equal need and that any differences in use indicate inequitable use. Nevertheless, as the PSED is an evidence-based duty, this analysis contributes to the collection of evidence based as far as is possible on objective data.

It is also important to note that the separate protected characteristic groups set out below are a useful categorisation for legislative purposes; however, it is also important to recognise cross-over themes, for instance communication must be culturally competent, sensory sensitive and appropriate to the needs of all patients but may differ for each group. Likewise, individuals who are members of more than one group may also face multiple barriers.

The Department carried out a series of consultation activities with patients, representative groups, the NHS, local government, and the voluntary sector. Responses to the NHS White Paper consultation highlighted how the proposals set out present significant opportunities to embed equality and human rights in the commissioning and delivery of health services.¹⁶

¹⁶ Department of Health, Health and Social Care Bill 2011: Coordinating document for the Impact Assessments and Equality Impact Assessments (2011)

Some respondents were concerned that CCGs might not have the right skills and expertise for commissioning NHS services, in particular that they might lack knowledge or awareness of specific groups, communities or conditions. However, the Yorkshire and Humber Learning Disability Commissioners recognised associated benefits, including the opportunity to improve understanding of the needs of local population and communities to offer greater personalisation and coordination of the care through skill and knowledge development.¹⁷

The Equalities and Human Rights Commission (EHRC) recognised that a 'bottom-up' approach of commissioning by CCGs could potentially bring many benefits including: identifying and tackling health inequalities at a more local level; ensuring greater emphasis on patient care; and fostering greater opportunity for joint working between public, voluntary and private sector providers.¹⁸

However, the EHRC found that at present equality is not consistently considered in commissioning plans, with particular groups such as transgender people and Gypsy/Traveller communities routinely overlooked. In order to achieve the expected benefits, the ECRC recommended that this must be addressed both in the design of commissioning structures and in local commissioning decisions.¹⁹

We acknowledge that the change from a national service provided by an NHS Trust to a locally commissioned, multi-provider service may have a disproportionate impact on protected characteristic groups. For instance, a range of stakeholders felt that the increased diversity of provision at a local level might risk worsening inequalities within and between existing commissioning areas. This suggests a risk that some inequalities could remain entrenched due to inadequate commissioning.

However, CCGs and the NHS Commissioning Board will have clear duties to exercise their functions in ways that are designed to reduce inequalities of access and outcomes and could go some way to mitigating this potential impact.²⁰ The NHS Commissioning Board will assume national oversight, planning and delivery responsibilities of NHS 111 and support CCGs in their commissioning role from 1 November 2012. Its broad responsibilities will be to provide leadership, guidance and hold CCGs to account for delivering their statutory responsibilities and to commission services. Although a clear aim is to give CCGs greater autonomy, the NHS Commissioning Board is obliged to produce guidance to CCGs on the discharge of their commissioning functions.

¹⁷ Ibid

¹⁸ EHRC, *The Public Sector Equality Duty: A Way Forward For the Health Sector* (July, 2011)

¹⁹ Ibid

²⁰ Department of Health, *Health and Social Care Bill 2011: Coordinating document for the Impact Assessments and Equality Impact Assessments* (2011)

CCGs will also be able to buy in commissioning support to reduce inequalities and improve health outcomes. A combination of local management and national oversight should avoid fragmentation of urgent care, while allowing it to be responsive to variation.

The promotion of the NHS Constitution, equality, reduction of health inequalities and integration will be embedded in the design of the NHS Commissioning Board's functions. This includes unpacking the new health inequalities requirements within the Health and Social Care Act²¹, identifying the processes, arrangements and relationships necessary to enable the commissioning system to meet the duty in full.²² Prof Steve Field is now appointed to the role of Deputy National Medical Director (Health Inequalities) and will be responsible for providing leadership to reduce health inequalities in line with the NHS Constitution.

NHS Direct continues to work closely with Departmental officials to successfully manage the transition from the NHS Direct's 0845 service to NHS 111. The Department is also working with local commissioners to retain the wealth of valuable skills and expertise of NHS Direct staff by ensuring that the majority of NHS Direct frontline staff will be able to move to the appointed local NHS 111 provider.

In June 2011, NHS Direct embarked on formal consultation with front line staff and their representatives about transition changes to the service. This extensive consultation was conducted over a period of 101 days and information collated during this period incorporated impact on protected characteristic groups to inform an equality analysis and final recommendations.²³

NHS Direct has committed to undertaking an updated equality analysis, setting out the likely impact on employees with protected characteristics as part of the transition planning process and where necessary, establish specific support for protected groups. NHS Direct's 2012 Equality Report and Equality Objectives can be accessed via www.nhsdirect.nhs.uk

To better understand the impact of service transition, a service-to-service comparison pilot was undertaken in Luton, comparing calls made to 111 and 0845. This pilot analysed the type of calls received and the demographic of callers by age, gender & ethnicity by monitoring 0845 caller traffic through NHS 111. This approach is intended to inform the potential impact of the transition from NHS Direct's 0845 service to NHS 111 and provide data on the overall

²¹ CCGs have a duty to have regard to the need to reduce inequalities in access to health services and the outcomes achieved for patients. under the Health and Social Care Act 2012

²² [Developing the NHS Commissioning Board](#)

²³ NHS Direct, 'Our Future Workforce' recommendations (Nov, 2011)

http://www.nhsdirect.nhs.uk/about/corporateinformation/minutesofmeetings/boardmeetingpapers2011/~media/files/boardpapers/november2011/item9_ourfutureworkforce-finalrecommendations.ashx

make up of calls to the 111 service e.g. % of Health Information, dental and pharmacy calls. Unfortunately, this data is not yet available to analyse for this report. Similarly, the data is limited to 3 protected characteristic groups as comparable data from NHS Direct was also limited. Nevertheless, it will be available for future analysis as the PSED is an ongoing duty.

Health information and self-management form a core part of the service offered by NHS Direct. Protected characteristic groups may be particularly vulnerable from any changes in service provision. A key part of service development for NHS 111 is to incorporate such services to prevent any adverse impact on equality strands. NHS 111 will enable patients or their carers to take control of their health conditions wherever practical and appropriate. Any clinical assessment system adopted as part of the NHS 111 service will be required to incorporate clinical content with an extensive range of self-care advice, covering a wide range of conditions and symptoms.²⁴ This also incorporates health advice, information and reassurance in order to ensure that patients have access to the information they want, to make choices about their care.

Quality information empowers people to make choices that are right for them. Each patient may have a unique and differing need for information and patients will require varying levels of depth for information provision. We believe it is vital to ensure quality, accessibility and availability of health information is retained within the NHS 111 service for all service users.

The NHS 111 Operations Group recognised a key challenge faced by commissioners as the NHS 111 National Service Specification had not explicitly outlined how the Health Information requirement will be transitioned from NHS Direct and delivered locally. The Department subsequently developed a 'Health Information Requirement', stipulating further guidance to commissioners including assuring themselves that providers are accredited with the Information Standard quality mark²⁵ to produce safe and reliable health and social care information and advice service.

The Department is exploring alternative options for delivering the service. This is part of the wider review of the NHS's central online offer, and we are currently piloting options for delivering an NHS 111 service through digital channels, which includes potential for a multi-channel/web and mobile contribution. The NHS 111 Digital Prototype project has been developed in partnership with the NHS, NHS Direct, NHS Choices, NHS Informatics, the DH Digital team and the NHS 111 programme team.

Currently, users of the current NHS Direct online content may receive an end point offering a call back from a nurse, which requires the ability to use a

²⁴ 'Self Care Within NHS Pathways' factsheet available at:

<http://www.connectingforhealth.nhs.uk/systemsandservices/pathways/comms/selfcareweb.pdf>

²⁵ The Information Standard is a certification scheme for health and social care information producers

telephone. However, if the user does not have the assistive equipment to complete this action, it could delay an urgent referral. The NHS 111 Digital Pilot aims to test the extension of the webchat facility to complete such interactions with a clinician. This would enable some users with hearing impairment to have equity of access to a clinician. The outcomes and considerations of digital channels in relation to the PSED will form part of a separate equality analysis.

Access to data in order to identify areas of inequity is a recurrent theme across the NHS. NHS Direct & NHS 111 services do not currently routinely collect patient information on all of the protected characteristic groups. Although public bodies, including NHS Trusts, are obliged to collect service and workforce data disaggregated by equality groups, the completeness of this data varies considerably.²⁶ Specifically, these services do not currently routinely ask for data on gender reassignment, marriage and civil partnership, pregnancy and maternity, sexual orientation and religion/belief.

The EHRC found that data quantity and quality varies across the strands, but even where it is better for particular strands, there is a lack of routine analysis and interpretation at local level so that the commissioning of services is often not done in a way that is responsive to diverse needs and disadvantaged groups.²⁷

The robust collection and use of disaggregated data will help to improve equitable service delivery and promote the primary aims of NHS 111. This includes improving access to urgent healthcare and driving improvements in the way in which the NHS delivers that care.

We expect that improving monitoring and collection of health information will have a positive impact on protected groups as better understanding of their needs can help to promote efficient management, targeting of services, precision of service delivery, and thus value for money. This in turn may improve equitable health outcomes and patient experience. However, NHS 111 commissioners and providers need to balance the impact of collecting this data on the call length, with an assessment of the proportionality and relevance of the data to ensure it is sensitively executed.

The Department has also been working with the NHS and CCGs to explore opportunities for coordinated care and integrated services within NHS 111 to assist patients with complex health needs. Summary Care Records²⁸ (SCR), currently being rolled out nationally, are a subset of information from a patient's GP record and can be particularly useful when patients need to access

²⁶ Care Quality Commission, NHS Performance Ratings 2008/09. London: Care Quality Commission (2009)

²⁷ Equality and Human Rights Commission, Life & Health: An evidence review and synthesis for the Equality and Human Rights Commission's Triennial Review (2010)

²⁸ SCRs are designed to provide a summary of clinical information which would be deemed useful in the event of urgent or emergency care for a patient, particularly when other sources of information may not be readily available

unscheduled care services. SCRs incorporate essential clinical records required to support safe care in urgent and emergency settings. However, providing enhanced information can allow the delivery of greater personalisation and quality of care by clinicians and health and social professionals. Examples of additional information include long-term condition care plans and chronic disease management.

A number of local health communities have begun to incorporate End of Life Care Plans for patients undergoing palliative care. Coordinate My Care (CMC) is a single electronic register storing clinical information currently being rolled out across London alongside NHS 111. CMC aims to promote patient choice, improved quality of life and allows seamless capture and sharing of information across multiple locations in the acute and community sectors. It is confidential and can only be accessed by health professionals who have a legitimate relationship with the patient. The CMC plan includes the wishes of patients and enables the coordination and delivery of appropriate care at the right time with the right data.

Special Patient Notes (SPNs) are mainly used by GPs to pass information relating to patients with more complex health and social needs to their local deputising GP Out of Hours service (GP OOH). As NHS 111 will increasingly become the single point of access for unscheduled health & social care, and likely front end for access to GP OOH services, it is important to explore how SPNs might be accessed and utilised as part of the patient's journey through 111. As more providers will become involved with both generating and utilising SPNs, it will become increasingly important for NHS 111 to ensure safe usage and maximise its benefits.

SPNs may include:

- **Care Plans / Crisis Plans** – e.g. outlining health and social care professionals (with contact details) involved in patient care and potential steps in managing and meeting the patient's health care needs or crisis presentation – this can include plans relating to the Mental Health Act, Children's Act and corresponding local safeguarding arrangements
- **End of Life Plans / Advance Directives** – agreements/decisions reached about how to manage anticipated problems (e.g. pain, bleeding, cardiac arrest) in patients with palliative care needs
- **Medication / Resources** – medications/resources that may be accessible for the patient (e.g. analgesia/'rescue pack' medication in the home) which could aid decisions on how to manage the patient
- **Access / Next of Kin / Carer information** – e.g. practical information on how to get access to the patient's home (e.g. keysafe codes) if vulnerable/disabled and/or next of kin details
- **Patients with long-term conditions** - such as diabetes/severe mental health illness/COPD/asthma

The content, structure and purpose of the SPNs can vary and while there is significant potential, realising its benefits remains complex. This should be managed and controlled by the local NHS through governance arrangements and made transparent to the local health community. National guidance for the NHS 111 service is currently under development, in addition to establishing local arrangements with security and information governance controls²⁹

However, this creates an opportunity to build on the NHS 111 service, and potentially extending SPNs to a wider group of vulnerable callers including patients with co-morbid physical and mental health problems. We anticipate that SPNs will have a positive impact on protected characteristic groups who may be particularly susceptible to complex health and social care needs. Groups³⁰ representing patients with such needs are becoming increasingly interested in this area and have begun to actively engage their members about the benefits of the SCR, in particular. We recommend that the development of NHS 111 guidance on SPN be established in consultation with protected characteristic groups, carers and their representatives to promote equitable access and advance equality of opportunity.

Analysis and Overall Impact by Age

From 1 October 2012, it will be unlawful to discriminate on the basis of age when delivering a service, unless there is an ‘objective justification’³¹ or practice is covered by an exception from the ban.³² This does not apply with respect to children aged under 18 and service providers can continue to provide specialised or conditioned services for children.

People at different stages in their life may have different healthcare needs. The programme is keen to encourage the public to access healthcare at an earlier stage in their illness. We know in particular that older people can be reluctant to contact health services, including ‘999’ and other emergency services³³.

Usage data indicates high use of the NHS 111 pilots for patients aged 0 to 4, and those over 80 when compared to the average use. There is proportionately lower

²⁹ A number of considerations include compliance with data protection, Caldicott Principles and Information Governance standards

³⁰ Examples include; MENCAP, Asthma UK, Diabetes UK, British Heart Foundation, and Children’s Hospices UK

³¹ A legal formula to justify what would otherwise be unlawful - if you can justify when challenged, that it is a proportionate means of achieving a legitimate aim

³² For guidance and a list of exceptions, see <http://www.homeoffice.gov.uk/publications/equalities/equality-act-publications/equality-act-guidance/>

³³ Jigsaw Research, *3DN Tariff Research* – of 87% of people surveyed who had not access any telephone health services in the last year this percentage rises to 90% for those aged 75+ (May, 2009)

usage for patients aged 30-59. This is broadly in line with NHS Direct's 0845 4647 telephone service.³⁴

Children and Young People

There is no evidence to suggest that introducing the NHS 111 service would create an unequal provision for young people. However, it is important to recognise the needs of children and young in their own right, who may require a distinct and tailored services rather than receiving the same services as offered to adults.

The new service may well improve the provision given two factors. The memorability of the number may be beneficial for those accessing the service while away from home³⁵, perhaps at university and the anonymity of the service may encourage young people to access health information services, especially in reference to discreet conditions.

PCT clusters will need to ensure a sustained focus on robust safeguarding arrangements, including work in partnership through Local Safeguarding Children Boards (LSCBs), and to ensure ongoing access to the expertise of designated professionals in line with local need. They will need to work with CCGs as they develop to ensure they are well prepared for their safeguarding responsibilities and that robust local arrangements, including future input to LSCBs are put in place.³⁶ CCGs will be required to be members of LSCBs. CCGs will also be under a duty to make arrangements to safeguard and promote the welfare of children and to co-operate with the police and local authorities to improve the wellbeing of children.

The statutory duties associated with safeguarding and promoting the welfare of children has been reinforced in the NHS 111 National Service Specification. Robust child protection policies and systems should be implemented by providers, including a system for flagging children for whom there are safeguarding concerns.

Older People

Estimates suggest that by 2020, the percentage of older people in the general population will rise to 26%³⁷ and the Department of Health predicts that there will be an increase in the numbers of people living over the age of 80 years by more than 50% and over 90 years by 100% within the next 20 years.³⁸ As an increasingly ageing population, it will be important to ensure that services are tailored to meet their needs accordingly.

³⁴ NHS Direct, PSED Publication of Information (2012)

³⁵ *3DN Tariff Research, Op Ct*

³⁶ NHS Operating Framework for the NHS in England 2012/13

³⁷ WHO, Better palliative care for older people (2004)

³⁸ Department of Health, National Service Framework for Older People (2004)

Older people are often reluctant to access healthcare advice and assistance at the onset of illness, or after an accident through fear of putting unnecessary burdens on the system. Research suggests, for instance, that despite the high mortality rate due to accidents in older people, this is not reflected in a higher rate of attendance at A&E.³⁹ Older people also appear to be reluctant to use the telephone to access out-of-hours care.⁴⁰

Research suggests that elderly people maintain regular contact with their GP's and this is their preferred route to accessing healthcare.⁴¹ NHS 111 would not change this as the public would still be expected to contact GP services where appropriate. However, at a time when help is urgently needed, older people reported feeling anxious about having to make multiple telephone calls and many expressed concerns about their needs being assessed over the telephone.⁴²

NHS 111 is a memorable route into 24/7 urgent care, and as an alternative to 999, may encourage the elderly to access NHS services without the fear of putting unnecessary burdens on the system.⁴³ Research has also suggested that the actual number '111', as a number that is physically easy to dial, will benefit the elderly as a group with a higher likelihood of restricted mobility and partial sight.⁴⁴ Conversely, we found respondents were still less likely to have used NHS 111 if they were older.⁴⁵ This indicates no change or progress in usage from NHS Direct⁴⁶ and appears to be inherent in telephone-based health care. However, further consideration on how best to maximise uptake should be undertaken including targeted marketing via appropriate routes and promoting alternative access points to unscheduled care.

A recent study highlighted a clear relationship between level of deprivation and older people's use of NHS Direct. Older people from deprived areas made more calls⁴⁷ than people in affluent areas, particularly in Yorkshire and the Humber, the East Midlands and London. The call rate in England increased with increasing deprivation and the highest rate in the most deprived areas. Further, older women used the service more than older men and increasing general use

³⁹ EHRC and Centre for Health Research, Sheffield Hallam University, *Life and Health: An Evidence Review and Synthesis for the EHRC's Triennial review 2010*, (October 2010)

⁴⁰ Foster, J., Dale, J. and Jessopp, L., A qualitative study of older people's views of out-of-hours services. *British Journal of General Practice* (2001)

⁴¹ *Reactions to a new three digit number* "compared to the average, older people are less likely to call NHS Direct in any of these scenarios and more likely to call their GP"

⁴² Foster, J., Dale, J. and Jessopp, L., A qualitative study of older people's views of out-of-hours services. *British Journal of General Practice* (2001)

⁴³ Centre for Policy on Ageing, *Ageism and Age Discrimination in Primary and Community Health Care in the United Kingdom* (2009)

⁴⁴ *Reactions to a new three digit number* (April 2009)

⁴⁵ The University of Sheffield, Evaluation of NHS 111 Pilot Sites: Final Report (July, 2012)

⁴⁶ Knowles et al, Equity of access to health care: Evidence from NHS Direct in the UK. *Journal of Telemedicine and Telecare* (2006)

⁴⁷ This includes calls made on behalf of older people e.g carers

amongst the oldest age group.⁴⁸ This poses a number of questions, including whether this is indicative of inequity of access, awareness or specific health needs among subgroups. An individual's decision to seek medical help and the route chosen can be affected by various factors and this warrants further investigation in order to improve uptake and understand access barriers to NHS 111.

Analysis and Overall Impact by Disability

Disability affects the length and quality of life, and can adversely affect access to services. There is heterogeneity amongst disabled people arising both from variations in impairment and from variations in socio-demographic characteristics. It is estimated that approximately 20% of people within the UK have an impairment and this percentage increases to 47% for those over the state pension age.⁴⁹ According to the 2001 Census, 18% of people reported a long-term illness or impairment that restricted their daily activities. The Department is working towards better understanding existing barriers and have explored a number of ways to increase access as part of service development.

Data from the NHS 111 pilot sites found that individuals were more likely to have used NHS 111 if they had a disability or limiting long-term illness, indicating that NHS 111 is reaching some groups of the population with the greatest needs.⁵⁰ This is in contrast to evidence on NHS Direct, which indicated that those with greater health needs were not accessing the service as frequently as others.⁵¹

Nevertheless, it is clear that further benefits can be achieved by promoting coherent integration. A system that is better coordinated will make it easier for people to access services and maintain their wellbeing. The ageing population and a rise in the prevalence of long-term conditions mean that health and social care needs are converging. We know that many people find care and support difficult to navigate and this can often result in people seeking help too late. Improving the commissioning and delivery of services for all individuals, families, carers and the wider population will have positive equality implications.

People with complex or multiple needs, most frequently older people, are likely to feel the benefits of improved integration.⁵² As part of the Government's White

⁴⁸ Hsu W-C, Bath PA, Large S and Williams S, *The association of geographical location and neighbourhood deprivation with older people's use of NHS Direct – a population-based study*. Age and Ageing (2011)

⁴⁹ Williams B, Copstake P, Eversley J and Stafford B (2008) *Experiences and Expectations of Disabled People*. London: Office for Disability Issues

⁵⁰ The University of Sheffield, *Evaluation of NHS 111 Pilot Sites: Final Report* (July, 2012)

⁵¹ Ring, F. and Jones, M., *NHS Direct usage in a GP population of children under 5 years: is NHS Direct used by people with the greatest health need?* *British Journal of General Practice* (2004)

⁵² Kings Fund /Nuffield Trust: *A report to the Department of Health and the NHS Future Forum: Integrated care for patients and populations: Improving outcomes by working together* (2012)

Paper on reforming Care & Support⁵³, we will explore how NHS 111 can help to signpost callers that may also have social care needs to local services and future developments that can support further integration.⁵⁴ Integration must be locally led, have the support of front-line professionals, based on sound evidence and co-designed to reflect the diversity within local communities. In time, the scope of the service will grow and could become the single telephone access point for all urgent healthcare and social care services.

A modern NHS will use appropriate technological advances to help people stay independent for longer, receive care on-line or in their own homes, avoid unplanned hospital admissions or unnecessary visits to clinics. Offering different ways to communicate with health professionals means a more streamlined efficient NHS. For instance, telemedicine including telehealth and telecare are useful innovations for people with long-term conditions, which may significantly improve an individual's health and quality of life.⁵⁵

We are committed to making NHS 111 an inclusive service, and we are currently exploring the options for delivering an NHS 111 service through alternative channels. A number of provisions have been created to help those with communication difficulties or impaired hearing. These groups are able to use the NHS 111 service via a textphone, by calling 18001 111 as stipulated by Ofcom during its equality analysis.⁵⁶ Calls are connected to the TextDirect system, and the textphone will display messages to tell the user what is happening. A Typetalk Relay Assistant will automatically join the call and they will speak the users typed conversation the NHS 111 adviser and will type back the adviser's conversation so that this can be read on the caller's textphone display or computer.

Stakeholder Engagement

Stakeholders have been engaged throughout the development of the programme. A key example of this is the NHS 111 Stakeholder Reference Group, which has been set up to provide an opportunity for stakeholders to inform policy and to feed their views into the implementation and delivery of the NHS 111 service. Membership of this group includes organisations who work for those with a protected characteristic, including Action on Hearing Loss, MIND, and the RNIB. Expressed concerns for how the service will affect those they represent and how the service will support their inclusion have been actively considered by the Department.

⁵³ Department of Health, *Caring for our future: reforming care and support* (July, 2012)

⁵⁴ The development of the DoS and Special Patient Notes may prove particularly beneficial in promoting integration

⁵⁵ The Department believes that at least three million people with long term conditions and/or social care needs could benefit from the use of telehealth and telecare services. For further info on *3millionlives* see <http://3millionlives.co.uk/about-3ml>

⁵⁶ Ofcom, *A Three-digit Number for Non-Emergency Healthcare Services: Proposals for the number and tariff; including notification of a proposed modification to General Condition 17* (July, 2009)

For instance, a representative from MIND queried if already well-known access routes, such as the MIND telephone information and legal line, could use NHS 111 facilities to ensure those they represented made good use of the service. The Department accepts it is important to consider the role of the third sector in identifying positive opportunities to advance equality and in particular through existing access routes. This may well include the potential interface between NHS111 and existing national advice line services operated by the third sector. This will be explored as part of future developments to support further integration in accordance with proposed care and support reforms. However, local health communities have been working in partnership with the third sector and social care services towards populating their DoS with non-NHS/Local Authority commissioned services in order to improve access for patients with specialised needs.

During service development, Action on Hearing Loss queried the ability of the programme to deal with those who have difficulty with standard phones due to hearing loss, and in particular proposed the development of an SMS service. The Department considered the option of introducing an SMS text service for NHS 111. However, we found that we were not able to take this option forward as an NHS 111 SMS text service would not be clinically safe.

This is due, in large parts to the length and complexity of the clinical assessment algorithms used within NHS 111. Call handlers are comprehensively trained to not just ask the right questions, but also interrogate answers for any additional clues that a caller might give out. Every question within the clinical assessment process must be answered but not necessarily asked – this could happen if a patient gives additional information earlier in the call that answers a later question. With an SMS service, the additional time it takes to write and respond to text messages could leave patients with urgent conditions waiting for a longer time than is clinically safe, and any shortcuts on the algorithms would also present an unacceptable risk to patient safety. However, as aforementioned, the NHS 111 Digital Pilot aims to explore alternative measures. Further, a 999 SMS service⁵⁷ is available for registered users in emergencies.

Learning disability

Learning disability is one of the most common forms of disability and affects up to 1.5 million people in England alone.⁵⁸ However, they are 2.5 times more likely to have health problems and suffer higher levels of unmet need.⁵⁹

⁵⁷ The emergencySMS service lets deaf, hard of hearing and speech-impaired people in the UK send an SMS text message to the UK 999 service where it will be passed to the police, ambulance, fire rescue, or coastguard. SMS text messages will be connected to 999 through the Text Relay 18000 service

⁵⁸ Emerson E, Hatton C (2008) *People with learning disabilities in England* (PDF 571.9KB). Lancaster: Centre for Disability Research (CeDR), Lancaster University

⁵⁹ Disability Rights Commission, *Equal Treatment: Closing the Gap - One Year On*, (2007); Sir Jonathan Michael, *Healthcare for all: Independent Inquiry into Access to Healthcare for People with Learning Disabilities* (2008); Mencap, *Death by Indifference. Following up the Treat me right report* (2007)

Another key example of stakeholder engagement is the NHS 111 Operations Group, a meeting with local commissioners, providing an arena for considering results of stakeholder engagement in local areas. Following a meeting in October 2011, National Learning Disability Leads queried what marketing engagement was available for individuals with learning disabilities. In order to help those with learning disabilities to understand the service, an 'easy reading' version of the NHS 111 leaflet has since been developed.⁶⁰ Its development involved applying good practice and seeking feedback in order to incorporate recommendations from representative groups. This was finalised in March 2012 and will be made available via the NHS 111 web pages and through local NHS services.

Mental Health

Poor mental health is more common in areas of deprivation. It can lead to higher risk health behaviours (e.g. smoking and drug misuse). This, combined with unequal access to quality healthcare, can result in poor health outcomes and shortened life expectancy.⁶¹ The mental health outcomes strategy, *No Health Without Mental Health*⁶² sets out that mental health should have parity of esteem with physical health. At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time.⁶³

Research by The King's Fund⁶⁴ found more than 4 million people in England with a long-term physical health condition also have mental health problems and evidence suggests that many of these people receive poorer quality care than those with a single condition. Those with long-term conditions and co-morbid⁶⁵ mental health problems disproportionately live in deprived areas, significantly contributing to generating and maintaining health inequalities. Developing more coordinated, integrated and collaborative models of care for patients' multiple needs could improve outcomes and play an important role in improving quality and productivity in health care.

For many people, their GP is their first point of contact with medical or support services at the onset of a crisis and can be a valuable source of support. However, further development is required to ensure services are available at the right level of care (e.g. Crisis Resolution and Home Treatment teams, and Community Mental Health Teams). NHS Pathways currently incorporates a full

⁶⁰ This is available at:

<http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Documents/2012/NHS%20111%20Easy%20Read%20leaflet.pdf>

⁶¹ Ibid

⁶² Department of Health, *No health without mental health: a cross-government mental health outcomes strategy for people of all ages* (2011)

⁶³ Mccrone P, dhanasiri s, Patel A et al, *Paying the Price: The cost of mental health care in England*. london: King's Fund (2008)

⁶⁴ King's Fund, *Long-term conditions and mental health: The cost of co-morbidities* (2012)

⁶⁵ Comorbidities are diseases or conditions that coexist with a primary disease but they also stand on their own as specific diseases

suite of pathways for assessing mental health calls including acute mental health crisis or long-term conditions. The endpoints can be mapped to local mental health services with varying degrees of urgency through the DoS, including referral to emergency services or local crisis teams.

Managing mental health patients appropriately and supporting mental health provision within NHS 111 should be a priority in order to develop parity of esteem with physical health. Work is underway locally to develop mental health services for NHS 111. For instance, local areas have been working closely with mental health leads, mental health clinicians or recruited specialist mental health practitioners to inform continuous service improvements. This has involved organising engagement events with frontline mental health professionals and representatives, and working with NHS Pathways to refine mental health pathways.

These exercises have assisted to address a number of issues and highlighted where further work is required. These include improving training and competency of call handlers to manage callers with a mental health need and/or experiencing a mental health crisis effectively, improving the population and management of the DoS, and ensuring reporting functionality allows data to be available for commissioners to monitor mental health access to NHS 111.

We anticipate that through gap analysis, commissioners will better understand local healthcare needs and commission accordingly. Commissioners and providers are encouraged to continue working with patients, their carers, Local Authorities and representative groups to address any further access barriers.

Prevention of long-term conditions

80% of heart disease, stroke, and type 2 diabetes cases and 33% of cancers could be prevented by eliminating tobacco and excessive alcohol, maintaining a healthy diet, physical activity. The World Health Organisation (WHO) declared these as the main shared risk factors in the development of long-term conditions.⁶⁶ NHS 111 may well play an important role in supporting people to improve general health and wellbeing, prevent the development of long-term conditions and reduce social inequalities in health.

The NHS 111 SHA Leads' Group monthly meeting allows the opportunity for representatives from the SHAs to share learning, good practice and innovation. NHS Midlands and East presented at this meeting in May 2012 on Making Every Contact Count (MECC). MECC is about staff using the contact they have with service users and the public to give healthy lifestyle information and signposting to services around stopping smoking, drinking alcohol within recommended limits, having a healthy diet, maintaining a healthy weight and undertaking the recommended levels of physical activity. SHAs agreed to explore future

⁶⁶ WHO, Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases (2008)

opportunities for incorporating MECC into the NHS 111 service, including loading healthy lifestyle choices onto the DoS and delivering this information through digital channels at the end of the call. This will promote an operating environment that supports cultural change towards the prevention of long-term conditions and reduction in health inequalities.⁶⁷

Analysis and Overall Impact by Race

An important influence on both entering into the health care system and maintaining contact is perceptions of cultural sensitivity of services. Help-seeking barriers include lack of awareness regarding values and beliefs, language difficulties and lack of translation facilities.⁶⁸

The Afiya Trust suggests that “many minority ethnic communities have poor access to health and social care services for a variety of reasons including language barriers, lack of awareness/information, social isolation, lack of culturally sensitive services and negative attitudes about communities”.⁶⁹

Some minority ethnic groups experience significantly higher levels of ill-health and premature death than the White British majority. These inequalities are persistent and do not appear to be improving across generations for most groups. Urgent and emergency care is by no means free from these health inequalities. Figures from the Care Quality Commission confirm that people of South Asian and Chinese origin report less positive experiences than the White British majority across a range of care settings, but that differences are particularly noticeable in primary care. Gypsies and Travellers have extremely poor experiences of primary care, and asylum seekers and refugees face access issues. Poor communication is a commonly cited problem, and there are widespread inadequacies in interpretation and translation facilities.⁷⁰ There is clearly potential to eliminate discrimination, advance equality and promote good relations.

One of the key inequalities faced by Black & Ethnic Minority (BME) communities is accessing the right urgent care services, as there are a wide range of different providers and numbers which can be confusing, especially for those with limited knowledge of the British healthcare system. For instance, research commissioned by the Department of Health consistently showed BMEs were more likely to access emergency services than their local GP in an out-of-hours situation⁷¹.

⁶⁷ An Implementation Guide and Toolkit for Making Every Contact Count:
http://learning.nhslocal.nhs.uk/sites/default/files/mecc_booklet.pdf

⁶⁸ Goddard MK, Quality in and Equality Of Access to Healthcare Services in England. University of York Centre for Health Economics (2008)

⁶⁹ The Afiya Trust in ‘Achieving Equality in Health and Social Care’ (2010)

⁷⁰ Ibid

⁷¹ Ibid

There is evidence that groups about whom very little research has been conducted, notably Gypsies and Travellers, asylum seekers and refugees, have particularly low levels of health and wellbeing.⁷² Those without fixed addresses, such as Roma, gypsies and travellers, asylum seekers and refugees, have difficulty in accessing services and their needs are often different and unknown.

Results of a quantitative survey by Sheffield University highlighted that Gypsy Travellers have significantly poorer health status and significantly more self-reported symptoms of ill-health than other UK-resident, English speaking ethnic minorities and economically disadvantaged white UK residents. Gypsy Travellers also have poorer health than that of their age sex matched comparators.⁷³ Objectives to provide equitable services and reduce health inequalities to socially excluded groups are believed to be impeded, in the case of Gypsy Travellers, by conceptual ambiguity (distinction of race/ethnicity/culture) and the absence of accurate health status data.⁷⁴

However, Gypsy Travellers were found to be less likely to visit GPs or to contact NHS Direct for advice, than their counterparts. Conversely, more Travellers had spoken to health visitors or used Accident and Emergency services.⁷⁵ Research in Cumbria suggested that Gypsy travellers have a high attendance at A&E, one respondent said they had been to A&E “lots of times, if I can’t get to the doctor’s I go to the hospital”.⁷⁶ This suggests that Gypsy Travellers may not be accessing the most appropriate service to meet their needs. It is important to understand the barriers preventing this access. This is especially critical in the relation to NHS 111, which aims to make it easier for the public to access urgent healthcare and will drive improvements in the way in which the NHS delivers that care.

There are also problems with access to care, as Gypsy Travellers often have a lower rate of registration with a GP, do not fully understand the system, and have their care interrupted due to their level of mobility.⁷⁷ The NHS 111 service aims to improve access to local health services, via a freephone service and does not require fixed residence in a particular area.

An analysis of access to health services in England highlighted the importance of individuals, particularly those from disadvantaged groups, to be adequately supported to exercise choice, in order to avoid confusion and possible inappropriate use of acute services:

⁷² *Life and Health*, (October 2010)

⁷³ University of Sheffield, *The Health Status of Gypsies & Travellers in England: Report of Department of Health Inequalities in Health Research Initiative Project 121/750* (2004)

⁷⁴ *Ibid*

⁷⁵ *Ibid*

⁷⁶ NHS Cumbria, *Health Needs Assessment: Cumbria Gypsies and Travellers* (2009)

⁷⁷ *Ibid*

Thus services that require a lot of 'work' on the part of the patient to access them are less 'permeable' than others and this might explain the higher use of Accident and Emergency services amongst disadvantaged groups compared with other groups, as this is a permeable service that is relatively straightforward to access.⁷⁸

The Sheffield Report indicated that there were slightly lower levels of awareness for people in black and ethnic minority groups and reported usage was also lower within this group. However, while there were differences in reported awareness and use, there was also uncertainty related to its statistical significance when adjusted according to age, sex and site.⁷⁹ This is in contrast to NHS Direct, which confirmed lower usage amongst minority ethnic groups.⁸⁰

While the new NHS 111 service indicates higher use amongst this group compared to NHS Direct, it warrants further investigation, monitoring and understanding. In particular, collating disaggregated data according to ethnic group, communities and their specific health issues rather than a meta level of BME information in order to better understand its statistical significance and impact on health inequalities.

The NHS 111 service also uses a translation service so that it is accessible to people that do not speak English. Leaflets explaining NHS 111 service are available in a number of different languages via www.nhs.uk/111

Analysis and Overall Impact by Religion and Belief

2001 Census data for Britain as a whole reveal large differences in self-reported 'not good' health between religious groups. Among men, the age-standardised percentage of people reporting 'not good' health was highest among Muslims (13%) and those reporting 'any other religion' (12%) and lowest among Jewish men (7%).

Among women, the highest percentage was again among Muslims (16%) with the percentage among Sikhs (14%) and 'Any other religion' (14%) also being high, and lowest again among the Jewish group (7%) (compared to around 8% for Christian men and women).⁸¹ Older Muslim and Sikh women, particularly those with poor English language skills, appear to suffer heavy burdens of ill-health, disability and also caring responsibilities. These women are also

⁷⁸ Smith J et al, A review of the effectiveness of primary care-led commissioning and its place in the NHS. London: The Health Foundation (2004)

⁷⁹ The University of Sheffield, Evaluation of NHS 111 Pilot Sites: Final Report (July, 2012)

⁸⁰ Ring, F. and Jones, M., NHS Direct usage in a GP population of children under 5 years: is NHS Direct used by people with the greatest health need? *British Journal of General Practice*, 54 (2004); Knowles et al, Equity of access to health care. Evidence from NHS Direct in the UK. *Journal of Telemedicine and Telecare* (2006); Shah, S.M. and Cook, D.G., Socio-economic determinants of casualty and NHS Direct use. *Journal of Public Health* (2008)

⁸¹ Allmark, P et al. Life and Health: An evidence review and synthesis for the Equality and Human Rights Commission's Triennial Review (2010)

particularly vulnerable due to difficulty negotiating religiously-appropriate support from services.

Muslim people continue to report worse health than average. However, it is unclear how far these worse-than-average outcomes are related to Pakistani, Bangladeshi and Muslim people's relatively poor socio-economic position. There is some evidence that people of minority religion, and particularly Muslims, are less likely to report that they feel they are treated with respect in healthcare than Christians. A number of qualitative studies support this picture, with common themes including: feelings of exclusion, dismissiveness and lack of engagement with professionals.⁸²

This area may warrant further investigation, monitoring and understanding by Commissioners. In particular, collating disaggregated data according to religious/faith groups and non-religious/faith groups to better understand the impact of this new service. While a lack of comparable data will make it difficult to assess the full impact, it is important to improve understanding and collection of data.

Analysis and Overall Impact by Gender

Men tend to access GP services less often than women- this may only in part be based on need but on the appropriateness of services and how accessible they are to men. Men also appear to ignore symptoms of ill health and delay seeking healthcare more often than women.⁸³

The Sheffield Evaluation reported that respondents were less likely to access NHS 111 if they were male.⁸⁴ However, men are also less likely to report using NHS Direct.⁸⁵ There is evidence across a range of health services that patterns of access, uptake and treatment diverge between women and men. The patterns are, however, complex so that both men and women appear to be disadvantaged in some arenas of healthcare.⁸⁶

Research suggests that 'patchy attention' to gendered influences on health means that many areas of service provision continue to operate in a 'gender blind' fashion and fail to adapt to the differential needs of men and women.⁸⁷ This may warrant further investigation, monitoring and understanding by NHS 111 commissioners. A more mainstreamed approach has been advocated to ensure

⁸² Ibid

⁸³ Ibid

⁸⁴ The University of Sheffield, Evaluation of NHS 111 Pilot Sites: Final Report (July, 2012)

⁸⁵ Larner, A.J., NHS Direct telephone helpline: frequency of use over time and by age and gender in an outpatient population. *Telemedicine Journal & E-Health* (2009)

⁸⁶ Ibid

⁸⁷ Equality and Human Rights Commission: Evidence analysis for the triennial review (2010)

that gender sensitivity becomes part-and-parcel of health policy, commissioning and service delivery.⁸⁸

Analysis and Overall Impact by Sexual Orientation

The Citizenship Survey 2007 highlighted that perceived health levels for the LGB respondents were largely similar to heterosexual respondents, and similarly that there is no significant difference between levels of long-term illness or disability.⁸⁹

Research also indicates that 60% of LGBT people disclosed their sexual/gender identity to their GP. The majority of LGBT people are happy to give information about their LGBT identities if the information is confidential and anonymous, and the service is considered LGBT friendly. Focus groups indicated that signage could help with perceptions of LGBT friendliness and a willingness to address LGBT issues with GPs. There was also a desire to build community networks to support LGBT people. However, homosexual men are reported to be less likely to disclose their identity, in order to keep this information 'off the record'.⁹⁰

Commissioners may wish to work with providers to undertake further consultation with this group and their representatives, and collate disaggregated usage data, where appropriate, to analyse the actual impact of the new service to inform continuous service improvements in accordance with the PSED.

Analysis and Overall Impact by Gender reassignment (including transgender)

The Act defines gender reassignment as a protected characteristic. People who are proposing to undergo, are undergoing or have undergone a process (or part of a process) to reassign their sex by changing physiological or other attributes of sex have the protected characteristic of gender reassignment. Under the Act 'gender reassignment' is a personal process (that is, moving away from one's birth sex to the preferred gender), rather than a medical process.

The 'Count Me In Too Survey'⁹¹, highlighted that 30% of the local trans⁹² population said that their physical health was 'poor or very poor' compared to 8% non-transgender. Trans people had particular issues with GP provision and the

⁸⁸ Ibid

⁸⁹ Allmark, P et al. Life and Health: An evidence review and synthesis for the Equality and Human Rights Commission's Triennial Review (2010)

⁹⁰ 'Count Me In too', Brighton & Hove Lesbian, Gay, Bisexual & Transgender Community Strategy (2001 – 2006) <http://www.countmeintoo.co.uk/library.php>

⁹¹ Ibid

⁹² For the purpose of clarity, throughout this report the term 'trans' will be used as an umbrella term when referring to people with the widest range of gender identities including transgender, transsexual, transvestite, androgyne/polygender and so on

gender identity clinics that they used. Trans people found that these often act as barriers to their health and wellbeing.

68% of trans people thought that their current GP was good or very good but qualitative data pointed to the need to locate 'safe' GPs and using networks to find 'trans-friendly' GPs. Experiences of transphobic and ill-informed GPs was found to influence the engagement with future services, as well as affecting mental and physical health for trans people.

In order to improve uptake of the NHS 111 service and overcome some of these existing barriers to healthcare, commissioners and providers may wish to consider best practice recommendations. Promoting understanding through awareness training and materials will assist to foster good relations and tackle prejudice.

Whittle *et al* (2007)⁹³ made several such recommendations:

- Training to ensure an awareness that once a person's trans issues have been addressed, they will still have the health problems that other people face
- Training on recognising that trans people, when presenting with non-transrelated health problems, need treating equally alongside other patients.
- Simple education and leaflet guidance for doctors, nurses and other healthcare staff on how to work with trans patients on issues of dignity, particularly the right to be treated as a member of their new gender, and privacy obligations

Commissioners may wish to work with providers to undertake further consultation with this group and their representatives, and collate usage data, where appropriate, to analyse the actual impact of the new service to inform continuous service improvements in accordance with the PSED. In addition to this, through gap analysis, commissioners would be alerted if this group had a specialised urgent health need and take proportionate action. Similarly, development of the DoS could assist to improve the provision of information about specialist transgender or 'transgender friendly' services available.

Analysis and Overall Impact by Pregnancy and Maternity

There is evidence that maternity services frequently fail to provide satisfactory care to women, and particularly to those from minority ethnic backgrounds.⁹⁴ Maternal and infant outcomes remain very poor for women from BME groups,

⁹³ Whittle, S., Turner, L. and Al-Alami, M., *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination*, London: The Equalities Review (2007)

⁹⁴ *Life and Health* (October 2010)

particularly among those women who have recently migrated to the UK.⁹⁵ Research has highlighted some important difference in the way that women from BME backgrounds may access and utilise maternity services compared to their white counterparts. This is identified as a factor contributing to adverse maternal and neonatal outcomes.⁹⁶ Causes of this poor access and utilisation of maternity services include lack of appropriate and accessible information, inadequate interpretation and translation support for non-English speakers.⁹⁷

No Specific work has been done on the impact of the NHS 111 service on pregnancy and maternity. However, by providing a single point of access for unexpected or urgent healthcare needs, the service should provide a number of benefits which help mothers to be, and especially those who are from BME, to get the health care they need. This may improve access for mothers who have a limited understanding of the services provided by the NHS and those who are concerned but are unsure if they need to see a doctor. The aforementioned NHS 111 translation service may also help to remove barriers to access for non-english speakers.

Commissioners may wish to work with providers to undertake further consultation with this group and their representatives, and collate usage data to analyse the actual impact of the new service to inform continuous service improvements in accordance with the PSED.

Analysis and Overall Impact by Carers

Carers provide care and support to ill, frail or disabled friends or family members. Over 3 in 5 people in the UK will become carers at some time in their lives, and may potentially experience a lack of appropriate information, support and isolation.⁹⁸ Those providing high levels of care are twice as likely to have poor health compared with those without caring responsibilities. There is also a clear relationship between poor health and caring that increases with the duration and intensity of the caring role.⁹⁹

Carers consistently rate access to information, provided at the right time, very highly. A lack of information about support provided by health and social services can have a long-term negative impact on patient and carers' health and well-being. Information and focused support at key stages along the care pathway, can improve health outcomes, experience for carers and cost-effectiveness.¹⁰⁰

⁹⁵ Race Equality Foundation, *Addressing Ethnic Inequalities in maternity service experiences and outcomes: responding to women's needs and preferences* (October 2008)

⁹⁶ Ibid

⁹⁷ Ibid

⁹⁸ Carers UK, *'In Poor Health; The Impact of Caring'* (2004).

⁹⁹ Ibid

¹⁰⁰ Ibid

In 2006, the Department of Health held workshops with service users and carers, where carers expressed their support for simplifying access to urgent care through the use of a new three-digit number.¹⁰¹ Along with health professionals, carers overwhelmingly supported the number '111' for the service.¹⁰² In 2008, the Department commissioned qualitative research to explore whether there would be public support for the idea of a new three digit number as a way of accessing healthcare services. This research found that 'Carers saw the introduction of the number as potentially life-changing, because it would give them straightforward access to support, advice and help 24 hours a day, seven days a week, enabling them to share responsibility for difficult medical decisions.'¹⁰³

Commissioners may wish to work with providers to undertake further consultation with carers and their representatives, and collate usage data to analyse the actual impact of the new service to inform continuous service improvements in light of carer's needs.

Analysis and Overall Impact by Other Identified Groups

Vulnerable Adults

The NHS will need to ensure a sustained focus on robust safeguarding arrangements, including working in partnership through Local Safeguarding Adult Boards, and to ensure ongoing access to the expertise of designated professionals in line with local need. CCGs will need to be supported as they develop to ensure they are well prepared for their safeguarding responsibilities and that robust local arrangements, including future input to Local Safeguarding Adult Boards, are put in place.¹⁰⁴

Safeguarding adults involves a range of additional measures taken to protect patients in the most vulnerable circumstances. Patients that are currently defined as 'vulnerable adults'¹⁰⁵ may be due to illness, impaired mental capacity, physical or learning disability or frailty brought about by age or other circumstance.

Safeguarding is central to the quality of care and the NHS outcomes framework.¹⁰⁶ The Care Quality Commission, Essential Standards for Quality and Safety sets specific outcomes for safeguarding and safety as a requirement for registration.¹⁰⁷ All providers of the NHS 111 service must be registered with the

¹⁰¹ *Reactions to a new three digit number*, (April 2009), p.38, section A5.4

¹⁰² Ibid

¹⁰³ Ibid

¹⁰⁴ NHS Operating Framework for the NHS in England 2012/13

¹⁰⁵ Department of Health/Home Office, *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (2000)

¹⁰⁶ Department of Health, *NHS Outcomes Framework* (2010)

¹⁰⁷ Care Quality Commission, *Guidance about compliance, Essential Standards for Quality & Safety* (20110)

Care Quality Commission as stipulated in the NHS 111 National Service Specification.

Resident status (migrants)

According to the Equality and Human Rights Commission¹⁰⁸, new migrant communities have different health needs from established minority communities, and increasing ethnic, linguistic and cultural diversity demands new responses from health services. Effective diagnosis and treatment may be undermined when ethnic minority people do not present with the 'typical' symptoms that have been identified on the basis of research and clinical experience with the majority White British population.

Asylum seekers and refugees may be affected by:

- Difficulties accessing GP treatment and consequent increased reliance on Accident and Emergency services
- Uncertainty and lack of clarity among service providers about asylum seekers' eligibility for healthcare services resulting in care being withheld in some cases
- Inadequate response to communicable diseases, particularly Tuberculosis

Commissioners may wish to work with providers to undertake further consultation with this group and their representatives, and collate disaggregated usage data to analyse the actual impact of the new service to inform continuous service improvements in accordance with the PSED.

Rural areas

There are particular challenges when providing health services to rural communities. Communities in rural areas are more dispersed and so can require more effort and greater resources to deliver an equitable service. Distance, travel times and availability of transport are critical for patients in accessing healthcare in rural areas. The demographic profile of people in rural areas is also different with higher rates of older people who may experience difficulty in accessing services.

A locally commissioned NHS 111 will be required to deliver safe and effective care, taking into account local circumstances, such as the rural nature of an area. A fully populated DoS for all unscheduled care which is integrated with 24/7 urgent care transport services may help to mitigate any disproportionate impact.

¹⁰⁸ EHRC, Life & Health: An evidence review and synthesis for the Equality and Human Rights Commission's Triennial Review (2010)

Socio-economic Groups

In February 2010, the Marmot Review¹⁰⁹, a yearlong independent review into health inequalities in England found:

- There is a social gradient in health – the lower a person’s social position, the worse his or her health. Action should focus on reducing the gradient in health
- Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
- Effective local delivery requires effective participatory decision-making at local level

The Review also noted that social inequalities exist across a wide range of domains including age, gender, race, ethnicity, religion, language, physical and mental health and sexual orientation. These inequalities interact in complex ways with socio-economic position in shaping people’s health status.¹¹⁰

Research by the Nuffield Trust¹¹¹ found that in a typical locality, 90% of social care users over the age of 55 had been in contact with secondary care during a three-year period. The Sheffield Evaluation measured socio-economic status through home ownership and responses to the NHS 111 pilots found that people who did not own their home were more likely to use NHS 111.¹¹² This is contrast to NHS Direct usage, which was lower in groups who did not own their own home¹¹³, or had a low income.¹¹⁴ This indicates that NHS 111 is reaching some groups of the population with the greatest needs.

¹⁰⁹ Marmot, Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010

¹¹⁰ Ibid

¹¹¹ The Nuffield Trust, ‘Predictive Risk: The Way Forward’, Martin Bardsley, Head of Research speaking at the PRIMS+ Annual Conference (September, 2010)

¹¹² The University of Sheffield, Evaluation of NHS 111 Pilot Sites: Final Report (July, 2012)

¹¹³ Knowles et al, Equity of access to health care: Evidence from NHS Direct in the UK. Journal of Telemedicine and Telecare (2006)

¹¹⁴ Shah, S.M. and Cook, D.G., Socio-economic Determinants of Casualty and NHS Direct Use. Journal of Public Health (2008)

Addressing the impact on equalities and Action planning for improvement

We believe that the introduction of NHS 111 has the potential to make a positive impact on equality groups through increasing equity of access by reducing the barriers and inequalities that currently exist. However, there are a number of risks and challenges, which will require mitigation and action.

Challenge

We acknowledge the need to develop knowledge and capability for commissioners and providers to meet the needs of the diverse populations they serve in accordance with the PSED.

Action

Information-led, knowledge-driven equity of service can only be achieved with further development at local level to gather information and intelligence in an proportionate and sensitive manner. Improving data collection and analysis will have a positive impact on equality groups as better understanding of the outcomes of different groups can help to promote more efficient targeting of effective interventions and deliver equity of access.

Mitigating this risk will increase the potential for further benefits and will undoubtedly reinforce the ethos underpinning the introduction of the new NHS 111 service. Commissioners and providers may wish to work collaboratively to develop good practice and support mechanisms to obtain disaggregated data by protected characteristics. This will promote a culture of equality and opportunity across the Health Economy.

The NHS has developed the Equality Delivery System (EDS) to support commissioners and providers to meet their obligations under the general duty. In particular, use of the EDS will help NHS organisations to comply not only with the general duty but also the specific duties to publish information to demonstrate compliance and prepare and publish equality objectives.

If adopted and used effectively, the EDS should help organisations to start the analysis that is required by section 149 of the Equality Act 2010 (“the public sector Equality Duty”) in a way that promotes localism and also helps them deliver on the NHS Outcomes Framework, and the NHS Constitution. It will help providers to continue to meet CQC’s “Essential Standards of Quality and Safety”.

Challenge

We acknowledge that the change from a national service provided by an NHS Trust to a locally commissioned, multi-provider service may have an impact on protected characteristic groups. Increasing plurality and numbers of non-NHS

providers may increase the complexity of contracts, monitoring and assurance for the PSED.

Action

The NHS Commissioning Board, is responsible for establishing, authorising and providing national oversight of CCGs. CCGs are required to be able to demonstrate compliance with the general provisions of the PSED, and have used the EDS, or equivalent, to help attain compliance and ensure good equality performance in order to be granted approval for its establishment. The NHS CB also explicitly promotes the use of EDS to help CCGs to comply with the PSED.

The EHRC reported key lessons drawn from an assessment of SHAs and PCTs on equality performance and highlighted a number of recommended actions for the NHS CB. These will be 'unpacked' to pinpoint any actions that need to be taken at this stage of NHS CB development. The assessment also concluded that attention needs to be paid to all elements of commissioning activities, including planning, contracting, and contract management.¹¹⁵

Commissioners may wish to develop robust contracts that make equality duties and responsibilities explicit. Similarly, commissioners may wish to monitor providers to ensure that they are delivering culturally competent services through robust contract performance management arrangements. Developing a partnership approach will help meet the duty and promote local ownership.

Challenge

Meaningful engagement with advocacy groups and working with marginalised or seldom heard communities to support service development in accordance with the PSED and expand their participation in public life.

Action

The Department will continue to develop meaningful engagement of representative groups until the NHS Commissioning Board (NHS CB) assumes national oversight, planning and delivery responsibilities of NHS 111. The Board will have a statutory duty to involve the public and will engage with patients, carers and the public to ensure it focuses first and foremost on what matters to patients. The NHS, commissioners and providers will be expected to continue to engage with these groups to inform service design and improvements at local level.

¹¹⁵ EHRC Report, The performance of the health sector in meeting the Public Sector Equality Duties: moving towards effective equality outcomes: A Focus Consultancy Report (July, 2011)

Appendix A

Improving Access to Urgent Care Services (3DN)

Equality Impact Assessment (EqIA) –
Initial Screening Assessment

December 2009

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EXECUTIVE SUMMARY

- i. This Initial Screening for a full Equality Impact Assessment (EqIA) examines the impact of the introduction of a three-digit number (3DN) for access to non-emergency healthcare, on different groups in the community, to inform any possible final decision on nationwide roll-out. It anticipates and recommends ways to avoid any negative consequences for particular groups who may be subject to discrimination on the grounds of: race, gender, disability, faith, sexuality or age.
- ii. In summary, the introduction of a new three-digit number for this purpose is likely to benefit all equality areas. Research commissioned to inform policy suggests there would be a high uptake for such a service.
- iii. There is strong evidence based research to suggest that the number '111' could be particularly beneficial due to its memorability and ease of dialing to those with learning difficulties, sensory impairment or hand movement restrictions.
- iv. The evidence also suggest that the hardest to reach group will be older people (+75) where the research suggests a strong connection with their GP and in parallel to this a lack of use of NHS services across the border, early on in the onset of illness. This will therefore be a challenge for communication of the service and will need to be targeted by individual SHAs taking forward piloting.
- v. The more ambiguous research revolves around equality areas such as BME's, young people, LGBTs, faith and gender differences. Some assumptions about the likely benefits are made in this screening assessment and will be monitored carefully in the evaluation period that will inform a full EqIA and any possible decision on nationwide roll-out.
- vi. A full EqIA will be undertaken following the completion of an evaluation project of the pilot sites and SHAs piloting the 3DN will be required to undertake their own EqIA on the service delivery element.

1 BACKGROUND

1.1 The principle aim of the 3DN Programme is to:

“consider options to introduce a new three-digit telephone number to help people find the right local service to meet their urgent, unplanned care needs.”¹¹⁶

1.2 Following Lord Darzi’s Review, ‘High quality care for all: NHS Next Stage Review’¹¹⁷, the Department undertook to consider the costs and benefits of a new national three digit number (3DN) to access non-emergency healthcare which would promote and drive forward the Government’s commitment to integrated urgent health care.

1.3 The screening assessment looks at those benefits and their impact on the principle of equal access to all. Existing research demonstrated that people often find it difficult to know how to access urgent healthcare, who to call, where to go. A poll conducted by Which?¹¹⁸ revealed 83 per cent of adults did not know the number to call for NHS Direct.

1.4 The public know the ‘999’ number is an emergency number. It is important policy reinforces this and enables the public to contact other more appropriate health services, where their health need is not life threatening. By developing a more memorable non-emergency number, we will simplify the distinction. It will give the public, for the first time, a clear, simple choice, namely: “If the situation is an emergency, call 999; for all other urgent health needs, call 3DN and we will work out with you what is the best way of meeting your needs.”

¹¹⁶ ‘High quality care for all: NHS Next Stage Review’ final report, Lord Darzi of Denham KBE, (June 2008)

¹¹⁷ Ibid

¹¹⁸ Out-of-Hours Care, Which?, June 2006. Only 17% of 1367 adults interviewed knew the number for NHS Direct.

1.5 The new 3DN will be able to:

- Identify immediate life threatening emergencies and transfer to 999;
- Respond to requests for health or service information;
- Assess the clinical needs of all other callers and, where necessary, route them to a local service provider who is able to meet their needs for a face-to-face consultation.

1.6 It will provide a quick, convenient and accessible way for people to navigate their way around local urgent care services right across the country, at any time of day whether at home, at work or out of area but critically this would not replace existing local numbers.

1.7 The new number is not designed to replace access to services that are already familiar. For example, it is expected that people will continue to telephone their GP practice for (long-term) appointments in the same way that they do now. However, where they are unsure about what to do, or if they need information about a particular health condition or about a service provided by the NHS, this will be the number to call.

1.8 The new number is part of a wider programme of reform and it is anticipated it will act as a driver to help deliver the wider vision of integrated urgent care services.

1.9 Early in 2009, The Department of Health asked the Office of Communications (Ofcom) to consult on the use of the 3DN '111' for the purpose of accessing urgent healthcare needs. Ofcom published this consultation paper on 9 July 2009¹¹⁹ and ran until 20 August 2009. Over 200 responses were received, both from members of the public and from bodies

¹¹⁹ Ofcom consultation, http://www.ofcom.org.uk/consult/condocs/three_number_non_emergency/main.pdf (July 2009)

with a professional interest. The response was generally very positive, with 83% of respondents stating they were in favour of the concept of a 3DN for this purpose, and 68% of respondents stating they favoured '111' over any other number.

1.10 In undertaking preliminary research into the public, reaction to the use of a 3DN for this purpose over three quarters were positive¹²⁰.

“Public opinion. Spontaneous responses to the 3DN concept were, on the whole, very positive, from both a personal and a societal point of view. Particularly appealing was the ‘999 style’ memorable number, especially in light of the low recall of the current NHS Direct number in this sample and we understand generally. The service was expected to make for easy access to NHS care through a single number and it was anticipated that it would be easier to get through to a ‘real person’ in comparison to calling the GP’s surgery. The ‘call handler’ was expected to possess useful local knowledge and to be able to help clarify situations. Overall, there was a feeling that the 3DN service would be an ‘even better’ NHS Direct. This in itself was expected to have societal benefits, reducing pressure on 999 and, to a lesser extent, GP services. Moreover, there was a feeling it would give permission to use the NHS and reduce any guilt pangs.”¹²¹

¹²⁰ Three Digit Number For Urgent Care Concept Research, Qualitative Research Report, Diagnostics for DH (November 2008)

¹²¹ Ibid.

2. PURPOSE OF EQIA

2.1. The purpose of the Screening Assessment is to examine the impact on different groups within the community of introducing a 3DN to access urgent and unplanned healthcare. It should be used to anticipate and recommend ways to avoid any discriminatory or negative consequences for a particular group, on the grounds of

- race,
- gender,
- disability,
- faith,
- sexuality or
- age

2.2 Equality Impact Assessment is an essential part of meeting the Department of Health's general duties towards equality. It considers what effect the Department's activities have on eliminating unlawful or unjustifiable discrimination, promoting equality of opportunity and meeting other requirements of the equality duties, such as promoting positive attitudes towards disabled people. It also enables us to show how positive effects can be maximised, and negative effects minimised or eliminated, by modifying policies and practices.¹²²

2.3 Ensuring that all Strategic Health Authorities (SHAs) proposing to pilot the 3DN undertake a rigorous EqIA is an important requirement of the programme. As SHAs work with their local Primary Care Trusts to determine the nationwide expansion of this programme, a thorough EqIA of local service will be undertaken.

¹²² Equality Impact Assessment: Guidance for policy makers, DH (2008)

3. METHODOLOGY

3.1 The approach to this screening assessment recognises a number of challenges and constraints in the analysis. For the purpose of this, a baseline of data, based on usage of NHS Direct services and qualitative public research, make up the statistical data.

3.2 The services accessed via the 3DN will be new and different to that currently provided by any healthcare or private sector equivalent providers. Therefore, this means equality data comparisons are constrained to the current nearest service provider.

3.3 The Department of Health and NHS will therefore necessarily be piloting the new 3DN in order to test amongst other things the effect of the new service on hard to reach groups and those with particular and specialised needs.

3.4 Within the evaluation period of the pilot sites there will be the following indicators which will be evaluated for their ability to meet different service users needs:

- What was the public/patient experience of using the service and did it improve quality, safety and health outcomes?
- Did it represent value for money?
- Did it improve access to services?
- What impact did the introduction of the service have on the local health economy?

3.5 During the development of the policy, the Department of Health sought the opinion of various stakeholders including minority groups and clinicians. These were all broadly supportive of the principle of a new 3DN for accessing urgent health care.

3.6 Following this research, two important aspects of the service were unknown: the most significant being the actual number and the cost-to- caller of accessing the service. These are two significant factors for equality and these will be evaluated in the pilot sites for their impact on BME's, older people and the disabled in particular.

3.7 The research concluded:

- Qualitative research – The Number

“On the basis of this research, 111 is by far the most popular of the candidate 3DNs: it was the clear first preference in every sample sector, despite a few individual dissensions. 111 is distinctive, basic and easy to use in its own right, and it benefits from associations with 999 without losing its distinctiveness. As a result, it was almost universally expected to be the most memorable, most reliable to recall in urgent situations, and easiest of use of all the candidate 3DNs. It also has the additional benefit of conferring confidence in the quality of the service offered, and suggesting a vital public service as opposed to a useful private-sector one.”¹²³

- Quantitative Research – The Tariff

There are four tariff options under consideration:

- Free to caller, including payphones and mobiles
- 10 pence per call, regardless of call length
- 3 pence per minute
- Local rate (which would vary in respect of different kinds of telephone provider).

¹²³ Three Digit Number for Urgent Care: Qualitative Research to help identify the most appropriate number, Cragg Ross Dawson for COI Research and DH, March 2009

“None of the tariffs have a major impact on likely usage but there is a significant increase in claimed uptake if the new service is free of charge – especially if alternative tariff is 3p per minute.

At least as many people expect to pay for the new service as expect it to be free. More likely to anticipate a charge if believe current services are charged for – especially in middle class, middle aged life stages.

Most people are at least fairly likely to use the new service regardless of what they might have to pay for it.

Most likely to use the new service if out of hours and/or away from home.¹²⁴”

¹²⁴ Reactions to a new three digit number, Jigsaw Research for COI Research and DH, April 2009

4. EQUALITY AREAS

It is important to note that the separate equality areas set out below are a useful categorisation but are not separate from each other – e.g. an older black person with a disability may face multiple barriers.

Data cited in this report should be read along side the ‘Methodology’ section of this assessment. Any conclusions drawn reflect the possible impact of the programme nationwide. Local impacts will be assessed by SHAs piloting the scheme.

The Department of Health commissioned two major strands of research on the preferred number for the service and the potential tariff options. They both concluded that there was overwhelming support from all areas of society for a new 3DN, with an average uptake of the service likely in all scenarios at 82%¹²⁵.

4.1 Age

4.1.1 People at different stages in their life may have different healthcare needs.

The programme is keen to encourage the public to access healthcare at an earlier stage in their illness. We know that particularly older people can be reluctant to contact health services, including ‘999’ and other emergency services¹²⁶.

4.1.2 The programme recognises the challenges of providing services for different age groups and their particular sensitivities. These will be monitored at a local level in the EqIA’s undertaken by SHAs that will consider local service provision.

¹²⁵ Reactions to a new three digit number, Jigsaw Research for COI Research and DH, April 2009
Three Digit Number for Urgent Care: Qualitative Research to help identify the most appropriate number, Cragg Ross Dawson for COI Research and DH, March 2009

¹²⁶ Reactions to a new three digit number, Jigsaw Research for COI Research and DH, April 2009
– of 87% of people surveyed who had not access any telephone health services in the last year this percentage rises to 90% for those aged 75+

4.2 Young People

4.2.1 There is no evidence to suggest that introducing the 3DN would create an unequal provision for young people. Research commissioned did suggest that they would expect the service to be free as compared to other groups¹²⁷; however, this does not worsen the current situation where a local rate tariff is paid for NHS Direct and most GP services.

4.2.2 The new service may well improve the provision given two factors. The memorability of the number may be beneficial for those accessing the service while away from home¹²⁸, perhaps at university and the anonymity of the service may encourage young people to access health information services.

4.3 Older People

4.3.1 Older people are often reluctant to access healthcare advice and assistance at the onset of illness through fear of putting unnecessary burdens on the system. A new 3DN would be a more memorable route ('111') into services and may 'give permission' to access NHS services.

4.3.2 However, research also suggests that older people maintain regular contact with their GP's and this is the preferred route to accessing healthcare¹²⁹. The new 3DN service would not change this and people would still be able to access their GP where they know the number in the same manner.

¹²⁷ Ibid – of the 14% of respondents who said they were unlikely to use the service just 24% cited the cost as a barrier (36% of this was in the 16-24 bracket)

¹²⁸ Ibid – under each tariff option the uptake for the service increased in the scenario when 'away from home' – 81% average under each tariff, compared to 76% when at home

¹²⁹ Ibid – "compared to the average, older people are less likely to call NHS Direct in any of these scenarios and more likely to call their GP"

4.3.3 The commissioned research suggests: *“particularly older age group tends to be lower than average, whether or not the 3DN is free or charged for. These groups also display a lower propensity to use current services. This suggests that price is less of a barrier than entrenched behaviours e.g. “suffer in silence”.*”¹³⁰ The pilot sites will need to ensure that the service is considered comparable to 999 in quality in order to gain support from these more entrenched behavioural groups. This will be included in the evaluation and success criteria.

4.4 Disability

4.4.1 The focus of this screening assessment as regards to the needs of people with a disability or sensory impairment, has been on the ease of dialling and memorability of the number - a particular issue for those with learning difficulties or hand movement restrictions.

4.4.2 In general, the programme does not worsen the current service provision, provided by a sometimes confusing array of urgent healthcare providers. These will continue to exist and it is likely that the 3DN programme will assist people with a disability, or long-term condition, and those such as the disabled and those with learning difficulties that currently may be unsure how to access those services.

4.4.3 The Department of Health commissioned research to determine the best number taking into account:

- Memorability;
- ergonomic ease;
- navigation for the partially sighted or blind; and

¹³⁰ Reactions to a new three digit number, Jigsaw Research for COI Research and DH, April 2009

- most appropriate and resonance to the service¹³¹.

4.4.4 The research consulted experts in dyslexia, dyscalculia, psychology and other fields. The researchers also interviewed individuals that were over 75, had a long-term condition, partially sighted or blind and those with restricted movement in their hands and their carers, as well as carers.

4.4.5 Across the research groups, '111' consistently emerged as the clear preference for health professionals but also for people with a learning disabilities or movement restriction. This was the number that would best meet the three objectives for the number (see paragraph 1.5).

4.4.5 The Department is currently liaising with the Royal National Institute for Deaf People (RNID) on technical options for deaf or hard of hearing callers. The Ambulance Services is currently piloting a text messaging service that may be a useful comparison for the 3DN programme.

4.4.6 The evaluation of the programme will also seek to address the broader access requirements of individuals with a range of other disabilities. More work will also be needed to consider the needs of people with sensory impairment and those with physical disabilities.

4.5 Race

4.5.1 Britain is a multi-cultural society. Historically, people from black and minority groups have suffered from poorer health, have reduced life expectancy and have greater problems with access to health care than the majority white population¹³².

¹³¹ Three Digit Number for Urgent Care: Qualitative Research to help identify the most appropriate number, Cragg Ross Dawson for COI Research and DH, March 2009

¹³² National Institute for Mental Health in England (NIMHE): Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England, London, DH, 2003

4.5.2 There is now sufficient and increasing amounts of epidemiological data to assist public health agendas and preventative initiatives in tackling health inequalities¹³³. In the case of BME communities rising rates of chronic diseases amongst some BME populations are concerning. We know, for example that:

- death rates from Chronic Heart Disease among the population of England and Wales born in South Asia are 50% higher than the average,
- The death rate for strokes amongst The African Caribbeans is 50% higher than average,
- Women born in India and East Africa have a 40% higher suicide rate than the general population,
- Prenatal mortality amongst Pakistani born women is double the UK national average.¹³⁴
- BME populations are nearly six times more likely than the general population to report having diabetes, with risk ratios amongst Pakistani men and women being high¹³⁵.
- Pakistani/Bangladeshi men and women are three to four times more likely than the general population to describe their health as bad or very bad¹³⁶.

4.5.3 Equality of access, especially for BME communities is most significant in regards to memorability of the number and cost to caller. People from BME communities can experience particular difficulties accessing out of hours services where the wide range of different providers and numbers is sometimes confusing. The barriers range from practicalities such as the

¹³³ Evidence of health Inequalities, Raleigh, S. V., Polato, G, M. 7Health Care Commission.

¹³⁴ Reaching Out to Black and Ethnic Minority Communities: Addressing Their Health Needs, S. Sharma, 2006

¹³⁵ Diabetes U.K. 2006

¹³⁶ Social Focus in Brief: Ethnicity, National Statistics, 2002

range of languages used for health information through to attitudinal challenges and the quality of health professionals understanding of cultural diversity. Currently, NHS Direct provides a translation service in over 100 languages. This will be a minimum requirement for the 3DN pilot sites.

4.5.4 In research commissioned by the Department of Health on the tariff for a new 3DN service consistently showed BMEs were more likely to access emergency services than their local GP¹³⁷ in an out-of-hours situation¹³⁸. A 3DN has the potential to improve awareness of other services and improve integration. A new more memorable number could therefore provide better access.

4.5.5 In regards to price sensitivity, vulnerable groups such as BMEs displayed slightly higher price sensitivity than other groups¹³⁹. However, over the four price ranges (see paragraph 3.7) BME groups on average displayed a high uptake of the potential new service at an average of 80% over the 3 priced tariffs in the out of hours and 77% away from home periods¹⁴⁰.

4.6 Religion and Belief

4.6.1 No specific work has been done to date on the potential impact of the 3DN programme with regard to religion and belief. There is no current data to suggest that the programme would have a negative effect on any particular religious groups.

¹³⁷ Reactions to a new three digit number, Jigsaw Research for COI Research and DH, April 2009 – “compared to the average, BME’s are more likely to dial 999 in any of these scenarios”

¹³⁸ Ibid

¹³⁹ Ibid – of the 14% of total respondents who said they were unlikely to use the service citing the cost as a barrier, 40% were of these were of BME origin.

¹⁴⁰ Ibid

4.6.2 In cases such as the Muslim community where a large proportion may not have English as their first language the service will provide a translation service in the same configuration as NHS Direct. NHS Direct currently provides its telephony service in over 100 languages.

4.6.3 The anonymity of the service may also encourage religious groups that are harder to reach due to cultural differences and embarrassment about certain health issues to access the service.

4.7 Gender

4.7.1 During the evaluation period, information will be gathered to determine whether the services are equally meeting the needs of both men and women. There is evidence that men are less likely to access healthcare early on in the onset of illness and have lower rates of attending their GP.

4.7.2 NHS Direct currently receives 15 percent of calls from men compared to 28 percent from women in the same age bracket¹⁴¹. The memorability of the service and anonymity may increase the likelihood of men accessing health care services earlier.

4.8 Sexual Orientation

4.8.1 No specific work has been done on the effect of the service provision on people from the Lesbian, Gay, Bisexual and Transgender (LGBT) community.

4.8.2 Historically the unequal treatment of LGBT people by healthcare services has meant that they were often discriminated against. Previous research

¹⁴¹ NHS Direct dataset – February 2009 – in the age range 16-44 years old NHS Direct received 15% of calls from men compared to 28% from women in the same age bracket, in February 2009

on the extent to which the LGBT community are confident of the understanding of their local GP services to their specific needs¹⁴² suggests that the anonymity and improved integrated services of the 3DN service may encourage people to access healthcare information early. The NHS will need to engage with representative groups during the evaluation and piloting process to gauge the level of usage by the LGBT community and any specific deficits relating to this group in the service provision.

¹⁴² "Count Me In" - Brighton & Hove Lesbian, Gay, Bisexual & Transgender Community Strategy 2001 - 2006

5. MONITORING AND COLLECTING INFORMATION

- 5.1 Under the Race Relations Act 1976 (Statutory Duties) Order 2001, every public body must *'monitor by reference to those racial groups, the admission and progress of students and the recruitment and career progress of staff.'* In the Commission for Racial Equality's Statutory Code of Practice on the Duty to Promote Race Equality, monitoring is defined as the collection of *'information to measure an institution's performance and effectiveness. The results may suggest how the institution can improve.'*
- 5.2 Equality monitoring is critical for the successful implementation of any policy or programme. Monitoring is a way of checking how well policies, procedures and practices are working; it can then be linked to policy development, implementation and evaluation.
- 5.3 It is an essential component of the 3DN programme that participating organisations:
- Undertake local equality impact assessments
 - Collect a range of input and outcome measures, as stipulated by the programme's data set, in order to evaluate any success criteria.
- 5.4 This information is collected and reported at different levels to satisfy local service improvement, commissioning decision-making, regional, and national strategic planning. The 3DN programme is likely to commission an academic institute to undertake such a study and the conclusions will inform a decision on nationwide roll-out.
- 5.5 The development of the 3DN service will be monitored by the 3DN Programme Board following OGC guidelines. The reporting structure is

detailed at Appendix F. More detailed information regarding equality areas will be collected and monitored locally.

- 5.6 Responding to the national service provision across all equality areas will be important in informing future policy direction. Working closely with the 3DN programme board, a local evaluation of usage of the 3DN service by BME, older people and disabled groups will be undertaken. Understanding and responding to the needs of BME, older people and disabled communities has been identified as a priority with SHAs.
- 5.7 Each of the pilot areas trailing the 3DN programme has been tasked specifically to look at the equality agenda and the outcomes will be fully reflected in a full EqIA scheduled for publication following the completion of the pilot schemes. This will contribute to any final decision on nationwide roll-out and the mode of any potential roll-out.
- 5.8 To support the embedding of equality issues into the pilot phase of the 3DN Programme, we have commissioned the SHAs to produce local EqIAs to inform their local service provision for a 3DN.