



Department
of Health

Equality in DH

How the Department of Health complied with the public sector equality duty in 2014

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How the Department of Health complied with the public sector equality duty in 2014

Prepared by the Equity and Community Development Team

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Introduction

The Department of Health (DH) helps people to live better for longer. We lead, shape and fund health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve.

As stewards of the health and care system, it is our job to ensure that the system as a whole delivers the best possible health and care outcomes for the people of England. We work with our partner organisations to develop policies that ensure services continue to meet the expectations of patients, carers, users and the public on fairness, efficiency and quality.

The public sector equality duty (PSED) in [section 149](#) of the Equality Act 2010 is a key lever for ensuring that public bodies like DH take account of equality when shaping policy and delivering services. Under the PSED, public bodies are required to consider the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations when making policy decisions and delivering services.

Advancing equality of opportunity involves considering how our decisions can:

- remove or minimise disadvantages suffered by people due to their protected characteristics;
- take steps to meet the needs of people who share a particular protected characteristic, where those needs are different from the needs of those who do not share that protected characteristic; and
- encourage people with particular protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

Policy makers, programme managers and decision makers, including Ministers, must have due regard to the three equality aims in the duty when developing or changing any policies or services that impact on people. Documentation detailing how decisions have been reached is

required to demonstrate compliance under PSED, including a record of how a policy was considered under the specific matters set out in section 149 of the Act.

The equality duty aims to embed consideration of equality into the day-to-day business of public authorities. It requires organisations to consider how they could positively contribute to the advancement of equality in the design of policies and the delivery of services. This makes good business sense as organisations that are able to meet the diverse needs of its users and employees are likely to achieve their objectives more efficiently. Decisions taken without considering their impact on different groups are unlikely to have the intended effect and lead to greater inequality and poor outcomes. Proper consideration of equality issues on the other hand, are more likely to result in increased user satisfaction with services that are also more efficient and cost-effective.

[The Equality Act \(Specific Duties\) Regulations 2011](#) imposed further duties on certain public bodies to help them to meet the PSED more effectively. The specific duties in England commenced in September 2011 and require relevant public bodies to publish information to demonstrate their compliance with PSED at least annually from January 2012, and to set and publish equality objectives at least every four years from April 2012.

The 'protected characteristics' covered by the Equality Act are age, disability, gender reassignment, pregnancy and maternity status, race (includes ethnic or national origins, colour or nationality), religion or belief (including lack of belief), sex and sexual orientation. The Act also applies to marriage and civil partnership status, but only in respect of the first aim of the duty (eliminating unlawful discrimination). Further guidance on the public sector equality duty is available from the [Government Equalities Office](#) and the [Equality and Human Rights Commission](#).

Equality duties also apply to the Department's arm's length bodies (ALBs). While those organisations are public authorities subject to equality legislation in their own right, in line with its system stewardship role, the Department takes steps to ensure that each organisation has arrangements in place to discharge their duties effectively. The Department's sponsor teams provide ongoing advice to ALBs and discuss equality duties as part of regular accountability meetings.

This publication provides information on the delivery of [equality objectives](#) published in 2012. The new set of equality objectives that we will work towards in the next four years can be found on page 17. We will ensure that these objectives are re-confirmed with the new government following the general election in May 2015.

This year's report also explains how the Department of Health met PSED in delivering its services and functions in 2014. Equality information about the Department's workforce is published in a separate report which can be found on the [equality and diversity pages](#) of our website.

Equality objectives 2012 – 2014

In order to support the aims of the equality duty, objectives should address the key equality challenges facing a public authority. The Department, therefore, set itself a comprehensive set of objectives in [2012](#) and subsequently updated them in [2013](#). Those objectives were linked to the six priorities of the DH Business Plan and as set out in the following table, significant progress was made towards achieving them which has yielded benefits for people using health and care services in England. It is critical to our success that advancing equality of opportunity and eliminating discrimination are central to the department's work to ensure equitable policy-making and improved health outcomes.

The Department will now work towards a new set of high-level equality objectives which are set out in the next chapter. At the same time, programmes of work that have contributed to progress against current objectives will continue and DH will embed equality considerations in its internal business processes, so that equality is an integral part of everything we do.

Objective 1: To reduce health inequalities and advance equality in the early years of life as part of our drive to improve outcomes in infant, maternal and child health

1.1.a Low Birth Weight (LBW) – support work to reduce the gap in low birth weight babies at term and the gap in all LBW babies between the most advantaged socio-economic groups and the least advantaged socio-economic groups.

The proportion of babies born at low birth weight decreased between 2011 and 2012 in both the 'routine occupations, are unemployed or never worked' socio-economic groups (0.6 percentage points) and the 'higher managerial and professional occupations' groups (0.5 percentage points).

The gap in low birth weight (LBW) between babies born to parents in the 'routine occupations are unemployed or never worked' socio-economic groups and the 'higher managerial and professional occupations' groups narrowed slightly between 2011 and 2012.

In 2011, the proportion of babies born at low birth weight (<2500g) in parents classified as working in "Higher managerial and professional occupations" was 6.4%, compared to 8.3% of babies born to parents who work in routine occupations, are unemployed or never worked, a difference of 2.0 percentage points.

In 2012, the proportion of babies born at low birth weight (<2500g) in parents classified as working in "Higher managerial and professional occupations" was 5.9%, compared to 7.7% of

babies born to parents who work in routine occupations, are unemployed or never worked, a difference of 1.9 percentage points.

1.1.b Infant Mortality – improve the life chances, health and well-being of the health and well-being of both mothers and babies by reducing the gap in infant mortality. Infant mortality rates are higher than average in babies born to mothers from Pakistan, the Caribbean and Africa.

Infant mortality rates are at a record low level at 4.0 infant deaths per 1,000 live births. The gap in infant mortality between socio-economic groups narrowed between 2002-04 and 2009-11 as measured by the difference between the routine and manual group and the whole population. The latest data compiled using a new method shows that the gap between higher managerial and professional groups has also narrowed from 5.8 deaths per 1,000 live births in 2011 to 5.5 deaths in 2012. Caution is needed as this first publication of this data, and small numbers mean that some variation in the figures over time is to be expected.

Differences in infant mortality remain between the national rate and the rate for certain groups but both rates – and the infant mortality gap – between babies born to mothers from Pakistan, the Caribbean and Africa have fallen between 2011 and 2012 – from 7.6 to 6.1 infant deaths per 1,000 live births (Pakistan), from 9.6 to 7.4 per 1,000 live births (Caribbean) and 7.4 to 6.4 (Western Africa).

1.1.c Under-18 conceptions – support cross-government work (with the Department for Education) to reduce the rate of under-18 conceptions

The under-18 conception rate is included in the Public Health Outcomes Framework, monitoring of impact of system-wide changes will continue. The under-18 conception rate for 2012 was 27.9 per 1,000 women 15-17, the lowest level since 1969. Rates have declined sharply since 2010 with a 21.8% reduction between 2010 and 2012 (the latest year for which data is available). Data is published annually (next date: February 2015).

1.1.d Programme delivery –for example, doubling the Family Nurse Partnership programme; and expanding the universal health visitor service by an additional 4,200 health visitors by 2015.

The Health Visiting Programme is on target to deliver an additional 4,200 Health Visitors by 2015.

The Family Nurse Partnership is on target to increase its places to 16,000 by 2015. FNP commissioning will transfer to LAs as part of children's public health in October 2015. It is currently serving 16% of the eligible population.

1.2 To ensure the Public Health Outcomes Framework published in January 2012 provides the transparent means that local communities, commissioners and Government can use to understand how well public health outcomes are achieved for all people by their equality characteristics, and how health inequalities have been reduced.

1.2.a Lead the development of the Public Health Outcomes Framework (PHOF), including publishing baselines for public health indicators

Baseline data published for 62 out of 68 indicators. The remaining six indicators will be published by March 2015. Equalities and inequalities data is available for 12 indicators (<http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/7/par/E12000004/are/E06000015>)

1.2.b Public Health England (PHE) will deliver a range of evidence and intelligence products and services that focus on the health needs and outcomes of diversity groups. This will be public information made up largely of previously published material, but collated and analysed to fully understand health impacts. It will be for local councils to demonstrate what and how commissioning decisions have been made in order to drive improvements in outcomes.

PHE published a wide range of information products, such as the local Health Profiles, Children's and Young People's Benchmarking tool, and many others. These can be found at: <http://datagateway.phe.org.uk/> Additionally, guidance from the Lesbian and Gay Foundation and links to Stonewall reports for each local authority were published on the PHOE website (<http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/7/par/E12000004/are/E06000015>)

Objective 2. To place equality at the heart of work to improve quality in health and social care with a focus on improving health outcomes. Specifically to:

2.1 Ensure that mental health strategy and policy development identifies and addresses the needs of equality groups, focusing on people with protected characteristics where the evidence shows greatest need.

2.1.a Work with partners to develop indicators for commissioners on improving Independent Mental Health Advocacy provision to people in protected characteristic groups.

We have funded the University of Central Lancashire and the Social Care Institute for Excellence to develop quality indicators for commissioners of IMHA services. They are due to report in January 2015.

2.1.b Introduce routine data collection and monitoring across the range of protected characteristic groups for IAPT services.

The new reports which will be published from November 2014 will include data on Age, Gender, Ethnicity & Disability.

2.1.c Support the British Psychological Society (BPS) to establish a work programme to enable equitable access to older people to IAPT services.

A new CPD training module has been developed for existing IAPT practitioners to support their work with Older Adults. The module is included in all PWP (low intensity training) and High Intensity training courses and is offered as CPD to previously trained staff. The IAPT programme is currently reviewing the module with a view to providing an updated curriculum for 2015/16 academic year.

2.1.d Develop the Mental Health Minimum Dataset (MHMDS) to collect information on all protected characteristics.

Requirements sent to the Health and Social Care Information Centre (HSCIC) to review some of the protected characteristics which are currently poorly defined and need improvement. HSCIC to undertake further work to assess the requirements submitted by the Department.

2.1.e Develop the Child and Adolescent Mental Health Services (CAMHS) dataset to include equality data.

Data requirements for the planned Child and Adolescent Mental Health Services (CAMHS) dataset are available on the Health and Social Care Information Centre (HSCIC) website. This dataset will form part of the maternity and children's dataset which will be implemented during 2015/16. NHS England is currently reviewing the implementation timetable for the collecting and reporting of data from CAMHS services.

2.2 Provide greater choice and control for people with learning disabilities and people with autism and their families and carers, as part of our drive to improve outcomes for people with learning disabilities and autism

2.2.a DH will work with key national partners to agree the actions that need to be taken to deliver the right models of care for people with learning disabilities and autism. This will include working with partners to agree what information and data needs to be collected to measure progress.

This includes collecting and publishing 'Assuring Transformation' data every quarter from commissioners on the number of patients with learning disabilities, autism and/or challenging behaviour in in-patient settings. This includes a breakdown of the number of patients according

to age and gender. This information is used by DH to track progress and highlight any intractable issues and challenges that need addressing.

DH will work with the Health and Social Care Information Centre on the publication of the Learning Disability Census 2014 which provides a snapshot of provision of the number of people in hospitals, how long they had been there and how far they were from their homes.

DH will allocate £7m capital funding to selected LAs to show what it is possible to achieve rapidly via adaptations to existing builds to support people with LD, autism and/or challenging behaviour to live in the community where that is the right setting for them.

Action 11 in Think Autism states that the Autism Team will work with staff in DH to have access to training on autism and work with DH's arm's length bodies on including autism in their equality and diversity training.

Action 15 in Think Autism states that DH will seek to build partnerships between equality and autism third sector groups to explore what their networks can do together to support people with autism.

2.3 Work with stakeholders to promote good practice in dignity in care for all people, particularly older people through the health and social care system.

DH will work with stakeholders to promote good practice in dignity in care for all people, including:

2.3.a Establish and support an independent Nursing & Care Quality Forum (N&CQF)

The Nursing & Care Quality Forum was launched by the Prime Minister in January 2012 with Sally Brearley appointed as independent chair. The Forum organised its work and good practice under four themes many of which informed the development of the Nursing Vision: "Compassion in Practice" 6C's for compassion in care. In November 2013, the Forum published over 150 examples of good practice as a searchable resource on NHS England's 6C's Live website.

2.3.b Support health and well-being boards to better understand, identify and consider the issue of loneliness in older age in Joint Strategic Needs Assessments (JSNAs) and Joint Health and Well-being Strategies (JHWSs)

In 2012, the Department of Health funded the Campaign to End Loneliness to develop a digital toolkit for use by Health and Wellbeing Boards and commissioners in identifying and commissioning interventions to tackle loneliness in older age. This can be found at <http://www.campaigntoendloneliness.org/for-local-government-and-healthcare/>

A year after the toolkit's launch (in June 2013) the Campaign to End Loneliness found that 61 of the 128 Joint Health and Wellbeing Strategies published at the time acknowledged that loneliness and isolation were serious issues.

2.3.c Establish dignity as a key priority for the NHS

Jane Cummings, Chief Nursing Officer for England and Viv Bennett, Director of Nursing at DH and Lead Nurse for Public Health England jointly published "Compassion in Care" in December 2012. This is a three year Vision and Strategy for Nursing, Midwifery and care staff in England. The publication introduced the 6Cs of compassionate and dignified care and set out actions to embed and deliver this vision.

In 2012 the national network of Caremakers started with student and newly qualified nurses. Caremakers volunteer to be role models and advocates for the 6Cs. They go over and above their covert roles to be ambassadors and take part in national events to promote the 6Cs and influence policy and strategy. Caremakers started with student and newly qualified nurses. They have expanded to include many professional groups, CEO's, NEDs, Chaplains and patient leaders.

2.3.d Obtain a year-on-year national view of Local Authority performance on the Adult Social Care Outcomes Framework in respect of people having a positive experience of care and support, to inform future policy

Data published annually by the HSCIC on behalf of DH to populate the ASCOF. The final data for the ASCOF for 13-14 will be published in December, meaning that there will be three years of data available allowing for year on year comparison for most measures. The data is disaggregated by age (65+ and working age adults) and gender. Work continues to promote better data on other protected characteristics, which has most recently involved a project to produce a LGBT companion document for the ASCOF with the National LGBT partnership.

3.1 To ensure, as a system leader allocating and distributing funding, that the drive to increase value, efficiency and productivity across the health and care system considers the needs of all people with protected characteristics

3.1.a Public health: new formula and consideration of further development in the medium term

Equality analyses were developed and equality implications were considered.

3.1.b New funding formulae for adult social care: equality issues will be considered in its development and ASCOF will be used to monitor outcomes by protected characteristics where data is available.

Equalities have been considered in the deferred payments and additional assessments formulae (which are currently out to consultation), and are being considered in the new Relative Needs Formula and the cap formula (which are currently under development and will also be

subject to consultation). ASCOF will be used to monitor outcomes by protected characteristics where data is available.

3.1.c The Mandate supports the NHS Commissioning Board's responsibility for embedding equality in its approach to allocating resources to CCGs.

Equality analyses were developed and equality implications were considered.

3.2. To establish and support Public Health England (PHE) to be a respected, professionally-led expert body, providing: -information on the best evidenced and best value for money public health interventions; -and leading the way on expanding the evidence and research-base that will support achieving equitable outcomes in health.

3.2.a PHE's work will be led by health intelligence. The application of knowledge and research will be a critical tool in transforming the approach to improving health and reducing inequalities across the entire health, social care and public health system &

3.2.b PHE will work closely with its partners, data producers and suppliers to ensure that the voice of protected populations are listened to, inform its work and develops a national view of priorities. & 3.2.c PHE will ensure that its advice includes dimensions of equity and equality

PHE embedded equalities into its internal governance processes and is ready to advise other ALBs on this issue.

PHE published a number of data tools and commissioning guidance for local authorities which include dimensions of equity and equality (please see above for detail).

4.1 To assess the equality data that should be collected and maintained at a national level to inform the Department's priorities, including initial dis-aggregation of such data where appropriate and to provide leadership on using relevant data in decision-making.

4.1.a Develop an approach to the availability of equality data to inform DH decision making in its role as the new health and social care system leader.

The equality data project investigated the availability of data and evidence across the three Outcome Frameworks for each protected characteristic. It concluded that there was a range of differing actions for each Framework and that the responsibility for such work was best aligned within the governance structure for each. Each framework is now responsible for enhancing the availability of its own equality data in an appropriate manner.

4.1.b Produce 'Project Scoping Plan' which outlines our approach.

This is currently being developed between the Outcomes Frameworks leads, and an update will be provided to the Outcomes Frameworks Policy Group in December.

4.2 To quality assure the overall development of the health and social care system so that equality and diversity is prioritised in the design of the new system. Ensure advancing equality and reducing health inequalities is embedded into the structures and delivery frameworks governing key relationships between the new NHS, public health and social care organisations being established.

4.2.a Embed equality into each of the individual transition programmes.

Diversity was an element of all the transition work-streams.

4.2.b For our People Transition provide a baseline for HR data related to four of the protected characteristics. & 4.2.c Establish a reporting system for monitoring the impact of transition, between ‘sender’ and ‘receiver’ organisations, on staff with protected characteristics.

For people transition the final HR steering group received a report of the overall diversity position.

4.2.d Embed advancing equality and reducing avoidable inequalities into ‘the Mandate’ and related government mechanisms between the DH and the NHS Commissioning Board.

Advancing equality and reducing inequality are both covered in the mandate for NHS England. Progress on both was covered in NHS England's latest annual report which was published in July 2014.

5.1 To support and assure the department in building and developing relationships with stakeholders, including those with protected characteristics as appropriate, to improve policy design and delivery.

5.1.a Ensure that equality stakeholders have representation at the regular National Stakeholder Forum which convenes top stakeholders across health and social care.

We have refreshed the National Stakeholder Forum (NSF) which, on 30 April 2014 was re-launched as the Health and Care Partnership (HCP). This new Partnership aims to develop a more inclusive relationship with our partners with a more diverse membership that is representative of the full range of equality characteristics.

5.1.b identify equality stakeholders as part of the revamped DH stakeholder map

Equality stakeholders are integral to the approach to stakeholder mapping adopted by DH in December 2012. The mapping approach draws on the HCP members as well as other equality stakeholders relevant to individual policy priorities.

5.1.c Incorporate equality prompts and signposts into the refresh of stakeholder engagement guidance.

A refresh of engagement guidance in December 2012 included equality prompts and signposts. This is now being replaced by more detailed guidance that will be made available to all staff in December 2014.

5.2 To maintain and develop a specialist advice function in DH that will contribute to cross-government opportunities to advance equality and promote human rights.

5.2.a Establish a ‘policy partner’ system mirroring the new structure to support policy leads to embed equality.

Director Level Assurance Leads (DLALs) and Deputies have now been established in each Directorate. DLALs meet the DG Champion for equality and human rights in DH on a quarterly basis to discuss issues of concern. If necessary, these are escalated by the DG Champion at quarterly meetings of the DH Executive Board. Equity & Inclusion Team members provide advice and support to DLALs and their Deputies. Each Directorate now seeks to embed its own equality objectives in local business plans.

5.2.b Lead and co-ordinate DH contribution to cross-government activity of equality and human rights.

This is an ongoing commitment.

6. To ensure that the Department has a motivated and engaged workforce that represents the community it serves, at all levels in the organisation -through the provision of relevant policies and guidance, learning and development, and targeted initiatives. We will assess progress using internal and external indicators of best practice and achievement.

6.1 Equality analyses completed for all stages of people transition between ‘sending’ and ‘receive’ organisations.

Equality analysis completed.

6.2 Continue to meet external standards of success.

DH has focused on Stonewall benchmarking and have achieved a good ranking.

6.3 Embed accountability at senior management level.

We have a director-level assurance lead in each directorate. The Director General for Social Care, Local Government and Care Partnerships ensures executive board engagement

From 2013-14, the Department rolled out the Connecting Programme which is a ‘back-to-the-floor’ scheme to help staff connect to the experiences of patients and people using services. All Senior Civil Servants and staff in policy teams are expected to make connections to people who provide or use health and care services and see DH policies in action. In 2014-15, DH staff have been out connecting in the health and care system nearly every week, sharing their experiences and learning along the way. This is an important mechanism for developing the right behaviours in staff and develop their understanding of the diverse communities they serve.

Equality objectives 2015 – 2019

The Department will work towards achieving the following high-level equality objectives in the next four years:

- DH will ensure that the public sector Equality Duty is embedded in Directorate business plans and reflected in our corporate priorities and is an integral part of any future priority setting for our organisation.
- We will continue build and develop our relationships with stakeholders and the public, including those that represent groups with protected characteristics, to improve our functions and services.
- We will ensure that it is clear, throughout the policy development process, how we have paid due regard to the public sector equality duty.
- As stewards of the health and social care system, we will build on our strengths in knowledge and intelligence by improving the information we hold and collect. We will reflect back this intelligence to our partners, in order to improve the health and well-being of the whole population.
- We will seek to improve accessibility and ease of understanding of any information and policies we produce. We will seek to improve the accessibility of the information that we provide to the public and stakeholders.
- We will improve our internal business processes so that equality and diversity is an integral part of everything we do. Our drive to increase value, efficiency and productivity will always consider the needs of people with protected characteristics, internally in DH and in our externally facing functions.
- We will ensure we have a motivated, diverse and engaged workforce who:
 - live our behaviours of respect for each other;
 - experience equality in the workplace regardless of their position in the organisation.

Published equality analyses

As explained in last year's [report](#), the Department publishes equality analyses for major decisions that will have a significant impact on people sharing the characteristics protected in The Equality Act 2010. The following table provides links to equality analyses that have been published on the Department's website in 2014.

GP contract changes 2014/15	https://www.gov.uk/government/publications/plans-to-improve-primary-care
NHS Mandate 2015 to 2016	https://www.gov.uk/government/publications/nhs-mandate-2015-to-2016
Public Health Grants to Local Authorities 2013-14 and 2014-15	https://www.gov.uk/government/publications/ring-fenced-public-health-grants-to-local-authorities-2013-14-and-2014-15
Smoking in private vehicles carrying children	https://www.gov.uk/government/consultations/proposals-to-make-private-vehicles-smokefree-when-carrying-children
Care Act 2014 (There are 11 impact assessments each incorporating an equality impact assessment)	https://www.gov.uk/government/publications/the-government-published-a-series-of-impact-assessments-alongside-the-care-bill
Standardised Packaging of Tobacco Products	https://www.gov.uk/government/consultations/standardised-packaging-of-tobacco-products-draft-regulations
GP contract changes 2014/15	https://www.gov.uk/government/publications/plans-to-improve-primary-care
Living well for longer: National support for local action to reduce premature avoidable mortality	https://www.gov.uk/government/publications/helping-people-live-well-for-longer
Public Health Outcomes Framework 2013 to 2016	https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency
Age of Sale for Nicotine Inhaling Products	https://www.gov.uk/government/consultations/nicotine-inhaling-products-introducing-a-minimum-age-of-sale
Infant milk legislation including a cost benefit analysis which includes a consideration of the impact to different social groups	https://www.gov.uk/government/consultations/amendment-to-infant-milk-legislation
Consultation on the Medical Innovation Bill (pages 30-32 of Legislation to encourage medical innovation: a consultation and paragraph 73 of The Report on the Consultation on the Medical Innovation Bill)	https://www.gov.uk/government/consultations/medical-innovation-proposals-to-make-clinical-negligence-law-clearer

Previously unpublished information

DH officials are responsible for making Ministers aware of the impact of policies on equality and how this has influenced their recommendations and presentation of the options. Where publishing a full equality analysis is deemed disproportionate for a decision, officials are required to set out equality considerations in ministerial decision making processes and option appraisals.

The following paragraphs summarise how equality information and engagement with stakeholders have been used to inform decisions for a selection of work undertaken in DH in 2014.

Organ Donation

DH continues to support work to further increase donation and transplantation rates, particularly promoting collaborative working amongst organisations and raising awareness of donation in the Black, Asian and Minority Ethnic (BAME) population.

A new seven year UK-wide organ donation and transplantation strategy was published by NHS Blood and Transplant (NHSBT) on 11 July 2013. The strategy is evolutionary and revolutionary, particularly in respect of increasing consent rates, encouraging people to be proud to donate and aiming to make the UK system comparable with the best in the world.

DH has continued to fund the National Black Asian and Minority Ethnic Transplant Alliance (NBTA), supporting its administration with the aim of raising awareness of the need for stem cell and organ donation and increase the number of people from BAME communities who can benefit from either a stem cell or organ transplant.

DH funding has enabled the establishment of a cohesive alliance (that includes NHSBT) that is able to share good practice, methodology and learning between its members and through its website. Specific work has focused on identifying data across faith and cultural communities to direct communication and research (for example DH funding of a peer educator project in 2009.)

Through Kidney Research UK, the learning from the 2009 project has been rolled out to a Birmingham project targeted at Pakistani Muslims (data showed this was one of communities least engaged/supportive of stem cell and organ donation and transplantation) DH funding is training peer educators from the community to raise awareness about donation and explore perceptions and religious beliefs in this community. The project was officially launched in June 2014.

Release of £10 million capital funding to improve NHS maternity care settings

The NHS environments in which women receive maternity care can have a big impact on the overall experience of care for both parents and should provide for the safe care of mothers and babies in a comfortable, relaxing place that facilitates what is a normal physiological process.

Families and maternity staff who have already benefitted from improved birthing environments said it was the small things that made a big difference. Things that make maternity care feel more personalised and less 'Institutional', such as: making the rooms feel like a home away from home, privacy, en suite facilities, birthing pools and large baths, comfortable furniture for themselves and their partners, equipment and facilities that allow fathers to support their partner and be involved in the birth.

In addition to funding the creation and refurbishment of birthing environments, the 2013-14 fund will also provide funding for projects that:

- support services where the birth rate has increased quickly or where the environment needs to adapt to local demographic population changes, or
- can make a difference to women who have mental health or substance misuse problems.

Not all babies are born healthy. In these circumstances parents often require extra care and support, so we are encouraging services to also consider projects to support women and families when things go wrong, for example dedicated accommodation for families who are bereaved or when the newborn baby requires specialist care.

The current guidance on the planning and design of maternity care facilities does not include any special requirements to meet the needs of the protected groups listed within the Equality Act 2010. From the evidence considered as part of this analysis, it is clear that there is little high quality research that considers the spectrum of equality characteristics pertaining to physical care environments.

However, we have made it part of the selection criteria for this capital funding that the bids must demonstrate due regard has been given to the PSED.

Dementia

We have strengthened our governance of the Prime Ministers Challenge to include people with dementia and carers to have specific representation on equalities issues. For example, on our Dementia Programme Board, we have secured representation from a carer of a person with dementia and from the Race Equality Foundation. We are also working with Public Health England to inform the development of an equality toolkit, which will be published in 2015.

Visitor and Migrant NHS Cost Recovery Programme

The Visitor and Migrant NHS Cost Recovery Programme (“the Programme”) is working to improve the systems and processes for identifying and charging overseas visitors and migrants for the use of their NHS healthcare in England. As part of policy development, we have continued to look at the possible impact on people sharing protected characteristics as set out in the Equality Act 2010. The Programme has a dedicated lead for equality and health inequalities to explore and consider any potential impact and appropriate mitigating actions.

During 2014, the Programme team have continued to engage with a number of stakeholders and interested parties to listen to concerns and suggested solutions. This includes regular meetings with Still Human Still Here, Maternity Action, National AIDS Trust and Doctors of the World.

Other stakeholders included the organisations named below and a comprehensive list of engagement events undertaken in 2014 is available on request.

- Christian Kitchen, Walthamstow
- City Reach – The Matrix
- Doctors of the World
- Eaves (Poppy Project)

- Freedom from Torture
- Guys and St Thomas Community Health Services
- Homeless Link
- Kalayaan
- King's Health Partners – Homeless team
- Maternity Action
- Medaille Trust
- Migrant Rights Network
- Migrants Resource Centre
- National AIDS Trust
- Sandwell and West Birmingham Clinical Commissioning Group
- St Mungo's
- Still Human, Still Here
- Tower Hamlets – New Residents and Refugees Forum
- Training and Support for Services and Exiles TS4SE
- University College London Hospital – Homeless Team
- West Midlands Ambulance Service NHS Foundation Trust
- Women's Mental Health – King's College London

The equalities forward plan for this programme includes:

- Ongoing: In 2014, 23 engagements have been carried out with key vulnerable group representatives and stakeholders and there are plans for more. This will include further update meetings with Doctors of the World, Still Human, Still Here, Maternity Action and National AIDS Trust and additional shadowing.
- By February 2015: A supplement to the current Equality Analysis (published December 2013) will be published.
- By March 2015: Guidance will be provided for the NHS on the new registration process and steps to assist individuals such as those for whom English is not their first language or who are vulnerable, to prove their residency status.

New statutory arrangements for children and young people with special educational needs

DH has been working closely with the Department for Education on the development of new statutory arrangements for children and young people with special educational needs. These will greatly improve the responsiveness and effectiveness of how education, health and social care services support young people with learning difficulties and disability. DH has itself issued guidance for Health and Wellbeing Boards on how they assess the needs of children and young people with complex needs, designed to ensure that Joint Strategic Needs Assessments and

Joint Health and Wellbeing Strategies are appropriately considering the needs of this group, and that HWBs are considering how CCG commissioning plans reflect the needs of this group. The resource provides links to a wide range of evidence on prevalence and need. We have also provided grant funding for the development by the Royal College of Paediatrics and Child Health and key partners of online training resources for staff –both clinical and non-clinical – who work with people with a disability ('Disability Matters') which is due to be launched in early 2015. These resources are intended to ensure that services are responsive to the specific needs of people with the protected characteristic of disability.

Genomics

Patient and public involvement is an integral and vital part of the 100,000 Genomes Project. Potential participant views were sought by Genomics England on key ethical policies relating to consent for rare diseases and cancer, using a range of experienced independent specialist market research companies and a national rare disease charity as outlined below. This feedback was then used in a separate project to inform the design and content of literature. This literature was then extensively tested with potential participants before submission to the Research Ethics Committee. Literature supporting consent was also tested with professionals involved in the consent process in order to ensure that there was no divergence in understanding between professionals and patients. Genomics England intends to further evaluate and revise its literature and patient and public materials at the 10,000 participant recruitment point; and will publish its ethical policies and the market research in due course.

- Solutions Research did two pieces of research (Aug - Sep 2014): "Examining the attitudes to and awareness of four different BAME groups to health news in general and to the Project". This was with 4x 6-person focus groups: Bangladeshi females, Pakistani males, African-Caribbean mixed sex, Indian females, aged 25-55. "Understanding attitudes of the general public towards data collection and sharing in conjunction with health and clinical information." 5 x 8-person, mixed sex focus groups, aged 18-55 general public.
- GfK NOP conducted research with cancer patients and carers to examine "Ethical issues relating to involvement of cancer patients in the 100,000 genomes project" with 2x male and 2x female qualitative focus groups each with spread of ages and social grades. (Aug - Sep 2014)

- Genetic Alliance UK did a quantitative online survey with 231 rare disease patients and follow up telephone interviews. “What do patients with rare genetic conditions think about whole genome sequencing in the NHS?” (June – Aug 2014)
- Randall Fox – tested our patient information literature in two stages with potential participants, health care professionals, young people aged 10-18 and parents of children aged 6-15. (Sep – Oct 2014)

NHS Outcomes Framework

Health inequalities were identified as an area for development in the review of the NHS Outcomes Framework undertaken in 2014. We set out the method and criteria by which we proposed to identify indicators in the NHS Outcomes Framework to break down to identify health inequalities. Alongside inequalities dimensions such as deprivation, the possibility of breakdowns by the protected characteristics has been included as part of this work, subject to data constraints: <https://www.gov.uk/government/consultations/nhs-outcomes-framework-review>

The work to finalise the set of indicators to break down in this way is ongoing and the outcome will be published in due course. An equality assessment is expected to be published alongside this work, describing the impact of changes to the NHS Outcomes Framework this year on those who share the protected characteristics.

Reducing inequalities in raising awareness of cancer symptoms

Be Clear on Cancer campaigns have very clear target audiences primarily aimed at those over 50 (with the exception of the breast cancer campaign which was aimed at women over 70) and positive results have been seen in older populations for lung, blood in pee and the oesophago-gastric campaigns.

The clearest peak in increased urgent referrals for suspected lung cancer for April 2014 (during the second lung reminder campaign) was seen for those aged in their 60s and 70s.

Of the cancer diagnoses resulting from an urgent referral for suspected cancer, the number of bladder, kidney and urological cancer diagnoses increased for those aged 50-59 (urological cancers only), 60-69 and 70-79. Those aged 70-79 had the largest increases, ranging from 19% (bladder) to 56% (kidney).

Of those diagnosed cancer cases recorded on the cancer waiting times database, the number of bladder cancers decreased by 11% for those aged 80 and above, and by 11% for females. The number of kidney cancers increased by 24% for those aged 70-79 and by 13% for males. The number of urological cancers increased by 14% and 15% for those aged 60-69 and 70-79, respectively, and by 11% for males.

Larger increases in suspected upper GI cancer referrals were found for those aged in their 50s (85%) and 60s (69%), with a smaller increase for those aged 80 and over (18%).

Less favourable were the results for the ovarian campaign. All age groups in the regional pilot area had statistically significant increases in the number of referrals for suspected gynaecological cancers. The largest increase was for the under 50 age group (35%) and the smallest increase for the 70-79 age group (14%).

There is also some evidence to suggest that the campaigns are successfully targeting harder to reach groups (for instance, more deprived people and men):

- For the national bowel campaign: significantly more men than women said the campaign adverts told them something new (55% vs 48%), felt the adverts were relevant to them (70% vs 64%), and reported booking a GP visit after seeing/hearing the adverts (7% vs 4%). There was also a larger increase in men visiting their GP with key campaign symptoms during the period compared with the previous year than for women (37% for men vs 22% for women).

Public Health England ran a *Be Clear on Cancer* pilot in London to raise awareness of the increased risk of prostate cancer amongst black men aged 45+ in October and November 2014 in six London Boroughs: Hackney, Haringey, and Newham in NE London, and Lambeth, Lewisham and Southwark in SE London. The key message of the campaign was:

'1 in 4 black men will get prostate cancer. Prostate cancer often has no obvious symptoms. If you are a black man over 45 and want to discuss your personal risk of prostate cancer, visit your GP.'

The campaign messaging was developed using focus groups of black men and GPs, advised by research experts Ethnic Dimension and Multicultural Marketing Consultancy. The four-week campaign saw outdoor poster advertising in railway stations and high streets locations, and posters in hair salons and barbershops. The posters featured a black cancer survivor and a black urological consultant. Street ambassadors engaged directly with the target audience in key community outlets and at Black History Month events.

NCIN report, *Cancer and equality groups: key metrics 2014 report*, can be accessed at this link:

http://www.ncin.org.uk/cancer_type_and_topic_specific_work/topic_specific_work/equality

Response to the Independent Review of the Liverpool Care Pathway

In preparing the response, the Leadership Alliance for the Care of Dying People, of which DH and NHS England were members:

- undertook an extensive public engagement process from October 2013 to January 2014 on its proposals for the principles that should underpin care in the last few days and hours of life. The engagement document stated that “The proposals ... are directed at health and social care practitioners, and have been drafted with advice from some professionals, families and carers. We now wish to engage more widely with patients, families and carers, professionals and organisations with an interest in the care of dying people, covering the nine characteristics given protection under the Equality Act 2010;”
- as part of the above engagement, there was specific engagement work with BME groups – NHS England commissioned interviews with 20 black or minority ethnic families and with organisations not directly related to End of Life Care, asking for comments on the care principles and what the impact might be on different groups. The Deputy Director for Equalities at NHS England was involved with this work. The Alliance produced a document extensively summarising the responses and setting out how this work had regard to people from population groups sharing the protected characteristics defined in the Equalities Act and others affected by health equalities. A document summarising the engagement was published alongside the system wide response in June 2014 and is available online here:

<https://www.gov.uk/government/publications/liverpool-care-pathway-review-response-to-recommendations>;

- sought advice from expert advisory groups (Clinical Advisory Group and Guidance Education and Training Advisory Group) in developing the proposals and their deliberations included regard to equality issues;
- sought and received input from Alliance members and the organisations they represent on matters relating to equality. This has included advice on equality issues, such as respecting cultural and religious needs.

As a result of this work, the five priorities for care which are the central plank of the Alliance's approach to care in the last few hours and days of life, have been formulated and worded with specific regard to equality issues. The priorities are set out below. One example of this regard is the wording "the dying person and those identified as important to them", which is carried through to all the documents published and has been selected as the most inclusive phrase – specifically it does not exclude non family members, such as carers or friends that the dying person has said should be involved.

When it is thought that a person may die within the next few days or hours...

- *This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.*
- *Sensitive communication takes place between staff and the dying person, and those identified as important to them.*
- *The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.*
- *The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.*
- *An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.*

A further example of how the regard for equality issues has been reflected in the Priorities for Care is in the expanded explanation for priority five, which reads:

A plan for care and treatment must be developed to meet the dying person's own needs and wishes in relation to how their care should be managed and any treatment preferences they may want to express. This plan must include attention to symptom control (e.g. relief of pain and other discomforts) and the person's physical, emotional, psychological, social, spiritual, cultural and religious needs. The person must be supported to eat and drink as long as they wish to do so, and their comfort and dignity prioritised. There must be prompt referral to, and input from, specialist palliative care for any patient and situation that requires this. The plan of care must be documented so that consistent information about the person's needs and wishes is shared with those involved in the person's care and available at the time this information is needed.

The merger of North West London and Ealing NHS Trusts

This work entailed the dissolution of the two Trusts, the establishment of a new NHS trust, and the transfer of assets and liabilities to the newly formed body, which took effect on 1st October 2014. The following information was part of the ministerial submission:

- The merger itself involves no service change, with the LNWHT taking on the full existing range of service commitments, so there is no direct impact on patients.
- All staff employed by EHT and NWLHT will transfer under TUPE to the LNWHT, under existing terms and conditions, so there is no direct impact on staff.
- Clinical Commissioning Groups retain an on-going responsibility to monitor the impact of SaHF implementation on services and their impact on equalities. Additionally NWLHT has built in local mechanisms to ensure Trust-wide monitoring of the impact of its local Action Plan.
- The new Trust is keen to take forward the aim of increasing diversity and equality. As part of its PMIP it demonstrated commitment to positively encourage equality and diversity e.g:
 - Involving Staff Side in its diversity forum, incorporating an action plan following independent review of its business case as part of its PMIP;
 - Seeking the appointment of a 7th Non-Executive Director to lead this agenda at Board level;
 - Ring-fencing resources to improve a local service for patients with sickle-cell disease.

Health inequalities

- SofS has previously been satisfied with the detailed assessment undertaken in regard to SaHF, not least since it promotes an agenda towards improving out-of-hospital care, the beneficial impact of which will be felt most heavily in poorer sections of the local community.
- Most of these benefits will be available to all patients and staff and better health outcomes, resulting from the transaction, will contribute to reducing local health inequalities across Brent Harrow and Ealing. These benefits have been highlighted in a high level Health Inequalities report received by the respective Trust Boards in August.
- Additionally there will also be wider economic benefits generated by the proposed investment in CMH (subject to business case approval processes described above). The transaction secures funding that has the potential to generate jobs and further work in the construction sector arising from the further development of the current site. These wider economic benefits are only made possible through the transaction, based on securing three years of transitional funding whilst the business case is prepared.
- In conclusion the DH and NHS TDA are assured that the merger should serve to improve equalities through local investment and by enhancing the provision of services throughout the new Trust.

The Acquisition of Barnet and Chase Farm Hospitals NHS Trust (BCF) by the Royal Free London NHS Foundation Trust

The Trust Development Authority (TDA) and DH officials have considered how the transaction would impact on equalities and we are assured that:

- It involves no change to NHS services, with Royal Free taking on the full existing range of BCF's service commitments, so there is no direct impact on patients.
- Virtually all staff employed by BCF will transfer under TUPE to the Royal Free, under existing terms and conditions, so there is no direct impact on staff (with the exception of the redundancy of four executive directors of BCF).

- It has come about as a direct consequence of implementing the earlier BEH strategy, where at the outset in 2007 Enfield PCT undertook a detailed equality impact assessment on the proposed service changes at Chase Farm Hospital. Prior to implementation in December 2013, this assessment was revisited and refreshed by Enfield CCG in August 2013. This set out positive and negative impacts in relation to relevant protected characteristics, plus deprivation, for each of the four areas of service change – (i) emergency care; (ii) maternity/neonatal services; (iii) paediatrics and (iv) planned care, along with an analysis of those characteristics where it was found that there was no differential impact. It concluded that the positive impacts significantly outweigh the negative impacts, and set out an action mitigation plan to address any negative impacts – in particular in relation to improving transport links.
- Clinical Commissioning Groups retain an on-going responsibility to monitor the impact of the BEH strategy implementation on services and the impact on equalities. The TDA have given assurance that this will continue and have confirmed that local CCGs and the Royal Free have undertaken extensive analysis of the proposals on the likely impacts of change on access, across the whole of North Central London (not just Barnet, Enfield and Haringey - but including parts of Hertfordshire and Central London). This approach is core to the proposal whether from the perspective of access to A&E (where the modelling, based on travel times, has proven to be very accurate) or in regard to the underlying epidemiology and the need to shift focus to a more out-of-hospital model of care, supported by changes to infrastructure (e.g. Modifications to local authority funded bus routes to aid access).
- In conclusion, we consider that the transaction should serve to improve equalities through local investment and by enhancing the provision of services, particularly at the Chase Farm Hospital site. In turn, DH has regard to these issues when considering approving the business case for the transaction, noting in particular that there is a local commitment to continue to consider these on an ongoing basis.

Requesting further information

If you would like to find out more about how the Department met its equality duty in respect of a policy or decision, you can make a request under the Freedom of Information Act 2000 by using the on-line form at <http://www.info.doh.gov.uk/contactus.nsf/memo?openform> or by addressing your correspondence to:

Ministerial Correspondence and Public Enquiries Unit
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

Further information on making a Freedom of Information request is available at <https://www.gov.uk/make-a-freedom-of-information-request/the-freedom-of-information-act>