Equality and Human Rights Commission
Policy paper

The Public Sector Equality Duty: A way forward for the health sector

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1. Introduction

Good health matters. It matters because it enables people to work and further their careers, to look after their families, and to pursue social and leisure activities to the full. However, the evidence shows[1] that there are some groups of people who are more likely to experience 'poor' health, and some who find it difficult to access care and support that meets their particular needs.

Men are less likely to use their GP than women, leading to later reporting of health conditions and worse health outcomes. In terms of ethnicity, infant mortality is higher than average among Black Caribbean and Pakistani groups. Among groups defined by religion, Muslim people tend to report worse health than average. The incidence of reported mental health conditions is significantly higher for women and some groups seem to be at greater risk than others – including Pakistani and Bangladeshi groups, lesbians, gay men, bisexual and transgender people, Gypsies and Travellers and asylum seekers. There is evidence to suggest that the health service sometimes deals with some older people in ways that they find humiliating or distressing.

Health bodies in England have been subject to equality duties since 2001, initially in relation to race, then disability from 2006 and gender from 2007. These duties were designed to ensure that health bodies understood and acted on the different needs of their communities, leading to more effective services that meet patient needs and ultimately to improved health outcomes.

In 2010 the Equality and Human Rights Commission (the Commission) undertook an assessment of the performance of a sample of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) in England on how they are meeting the duties.

Since the assessment was undertaken, wholesale changes to the structure of health service delivery have been announced, and, from April 2011, the existing duties were replaced by the new Public Sector Equality Duty .[2] Whilst the legislation has changed and SHAs and PCTs are due to be abolished, the assessment provides both useful and timely lessons for how health services can more successfully meet their new legal obligations, do more to embed equality in commissioning and service delivery, and improve patient outcomes.

2. Key findings

The key findings of the assessment identify the main challenges of meeting the duty and ensuring that the health needs of protected characteristics are considered in the health service, in whatever structure services are commissioned or delivered in the future.

The assessment looked specifically at how SHAs and PCTs had used the duties to improve equality outcomes, rather than focus on whether they had the necessary processes in place. To do this the researchers looked at a wide range of relevant programmes, initiatives, and published materials relating to authorities' and trusts' functions and equality planning and performance.

What they found raised some serious concerns since, although there was always some level of activity, SHAs and PCTs appeared to struggle to clearly identify key equality priorities and translate these into clear aims and objectives for different equality groups. When promising activity appeared to be happening, there was no sense of whether any practical outcomes were being achieved.

In examining why this was the case, the assessment found that:

- There was little evidence of equality having been mainstreamed into strategies, plans and programmes.
- There was a lack of good quality equality data and, critically, it did not feed through into service commissioning, planning and delivery. It was not always clear if this was because it did not exist, or if it did but was not used.
- There was a lack of clearly identified priorities and objectives that sought to achieve tangible and measurable outcomes.
- It was not clear that SHAs and PCTs were effectively holding to account other health providers for whom they were responsible.

Overall performance was slightly better on disability, but our concerns cut across each equality area. Transgender people and Gypsy and Traveller communities were typically overlooked.

3. Implication of findings for compliance with the Public Sector Equality Duty

The findings suggest that health bodies will need to take a fundamentally different approach if they are to successfully meet the new Public Sector Equality Duty. Health bodies will need to understand how different groups are affected by their policies and practices, across eight protected characteristics. There will now be far less prescription in terms of the specific duty steps that health bodies have to take.[3] However, there will be an increased emphasis on the publication of equality information and the setting of measurable objectives – both areas of significantly poor performance to date.

In order to successfully meet the new duty, our research suggests that health bodies will need to:

- Improve the quality of their equality information and ensure it is routinely used in policy development, commissioning and service delivery.

- Make information more accessible, both about what they are doing and what they are achieving.

- Commission services based on needs assessments that cover all protected characteristics.

- Move away from process-based objectives to ones that are outcome-focused and measurable.

4. NHS reform: Lessons for a changing NHS

The Government has set out an ambitious programme of change for the NHS. These include: devolving the responsibility for commissioning services to clinical consortia; enhancing the role of local authorities; and, strengthening the voice of patients through the creation of a National Health Watch and its local equivalents. Commissioners will be held to account by an independent NHS Commissioning Board – a body which will have an explicit duty to promote equality and tackle inequalities.

4.1 Equality at the heart of health

Equality will need to be more effectively integrated into these new service delivery arrangements – from the Department of Health right down to individual service providers – to address the concerns identified by the Commission's assessment. Taking action to do this now will ensure that the NHS that emerges after the Health and Social Care Bill is passed is in the best place possible to comply with the new Public Sector Equality Duty and, as a result, to improve patient experience and health outcomes.

4.2 Commissioning for equality

The proposed 'bottom-up' approach of commissioning by clinical consortia could potentially bring many benefits including: bringing primary care closer to patients; 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.

However, our evidence shows that equality is not consistently considered in commissioning plans, with certain groups[4] being routinely overlooked. If the proposals are to achieve these benefits, this must be addressed both in the design of commissioning structures and in local commissioning decisions.

4.3 Demonstrating performance through evidence and outcomes

Evidence-based decision making and a focus on practical outcomes are common principles of both the Public Sector Equality Duty and NHS reform. The NHS Commissioning Board will be held to account by the newly developed NHS Outcomes Framework, which places a high priority on ensuring equality. This includes a focus on achieving priority outcomes and measuring success through disaggregated data. The equality duty means public bodies (including health bodies) need to be able to demonstrate how they are building consideration of equality into their work.

5. Next steps

The recommendations below take into account the steps that the Commission thinks should be taken to ensure that health bodies can more successfully meet the Public Sector Equality Duty:

Nationally:

- The Department of Health should ensure a strong national evidence base across all the protected characteristics, identifying any key information gaps and taking action to fill them. This will ensure they can take a lead in using a sound evidence-based approach that can be used by all the different components of the sector, both at a national and local level.

- The Department of Health should ensure that the health sector, including new bodies, have timely and appropriate guidance on the Public Sector Equality Duty, focused on the main equality challenges.

- The Pathfinder GP Commissioning sites should be evaluated on the extent to which they are able to successfully commission based on clear and evidence-based needs assessments, across all protected characteristics.

- The NHS Commissioning Board, once established, should ensure that equality considerations are included in commissioning criteria and guidance for local commissioners, and that specialised health needs provided nationally, such as access to gender reassignment services, are fit for purpose. This will be essential to ensuring consistent standards.

- NICE should ensure that the requirements of the Public Sector Equality Duty are adequately reflected in the quality standards they will produce to inform commissioning decisions.

- Monitor will need to ensure the requirements of the duty are effectively integrated into their governance and regulatory role.

- CQC needs to ensure that Health Watches both nationally and locally are fully representative and truly reflect the communities they serve.

Locally:

- Commissioners need to improve their evidence base, across all protected characteristics and ensure they routinely use equality data in order to have due regard in their commissioning decisions and to put equality at the heart of the value for money considerations in these decisions.

- Listed health bodies[5] will need to have a clear evidence base from which they can determine and set clear and measurable equality objectives – the Commission expects the objectives to address the most significant equality issues and health needs of their local population.


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- Local Health Watches will need to truly reflect the communities they serve, taking steps to increase participation of under-represented groups where necessary.
- Local authorities, through Health and Well Being boards will be taking an increasingly important role in issues concerning public health, so early and practical links between authorities and all the new local bodies on equality matters are essential.

6. What the Equality and Human Rights Commission is doing:

- Producing authoritative statutory and non-statutory guidance to enable public bodies, including health bodies, to meet the Public Sector Equality Duty.
- Using our informal agreement with the Department of Health to ensure that the Department is meeting the duty and embedding equality in its roles as employer, policy maker and system leader.
- Carrying out initial monitoring of the data that health bodies are due to publish under current proposals for the specific duties.
- Developing a public sector duty evaluation framework to enable us to benchmark the performance of public bodies and assess the impact of the new duty.
- Reviewing access to NHS Gender Reassignment Services, through the report we will be producing in Summer 2011.
- Continuing our targeted collaborative regulation with CQC through our Memorandum of Understanding, including publishing joint guidance for CQC Inspectors in Summer 2011.
- Seeking to work with other regulators in the sector and with the new parts of the structure to put considerations of equality at the heart of service delivery.

More information on the duty, including access to our guidance can be found at: http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/guidance-on-the-equality-duty/

Endnotes:

1 The Commission's Triennial Review (How Fair is Britain?).
2 The new duty covers the following protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. It also applies to marriage and civil partnership, but only in relation to the elimination of discrimination.
3 Usually referred to as the specific duties.
4 As mentioned before, Transgender people and Gypsy and Traveller communities were typically overlooked.
5 Local authorities, health trusts and regulators and central government departments are covered by the duty. We expect commissioning consortia also to be subject to the duty.

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Published July 2011
ISBN 978 1 84206 393 4