The performance of the health sector in meeting the Public Sector Equality Duties:
moving towards effective equality outcomes

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For information

In 2010 the Commission undertook an assessment of the performance of a sample of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) in England in meeting the race, disability and gender equality duties. This report presents the findings of that assessment. We would like to thank Focus Consultancy for undertaking this work on our behalf. The Commission endorses the findings of this report.

Since the assessment was undertaken, wholesale changes to the structure of health service delivery have been announced, and the previous duties have been replaced by the Public Sector Equality Duty, extending across all protected characteristics in the Equality Act 2010. In this context the findings of this report are even more relevant, providing a strong steer on where improvements will be needed if NHS reforms are to meet the challenges of the new duty.

Acknowledgements

We would like to express our sincere thanks to all those authorities and trusts that took part in the assessment for providing the materials requested. We would also like to thank the individuals with whom we conducted follow up work and interviews.

Executive summary

Background and relevance

This research report examines performance on the Race, Disability and Gender Equality Duties (the equality duties) by Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) in England. Effective implementation of and successful performance on the PSDs can assist healthcare providers in reducing relative inequalities in health, employment, and commissioning outcomes and as such the life chances and wellbeing of millions of people in the UK.[1] But these outcomes can only be achieved through the development of clear outcomes-focused policies and programmes throughout the NHS that encompass concrete plans and actions with observable and measurable results. The practices and lessons identified in this report can help health planners now and in the future to ensure improved equality outcomes across commissioning, service, and employment functions.

Method

In December 2009 the Equality and Human Rights Commission (the Commission) commissioned an assessment of the performance on the equality duties by nine SHAs and 19 PCTs in England.[2] This was achieved through an evaluation of all relevant programmes, initiatives, and published materials relating to authorities' and trusts' functions and equality planning and performance.

The aims of the assessment included following up on performance concerns with various PCTs on the Disability Equality Duty (DED) (please see Scope of the assessment on page 15) and highlighting practices that promoted equality outcomes across functional areas including services, commissioning, leadership, and employment. A detailed report for each authority was produced, on which basis this overarching report was prepared.

Assessment of performance

The assessment raises serious concerns regarding performance on the equality duties. In particular, there was a significant lack of evidence of implementation and impact resulting in a lack of evidence of improved outcomes for equality groups.

A key finding was that most equality planning and data was restricted to equality schemes and did not form significant parts of mainstream materials including commissioning, service, and employment plans. This meant the assessment itself was often restricted to a review of equality schemes, which by themselves provide little or no indication of how the general or specific duties are being achieved in practice. The indication from the evidence was that authorities do not seem to be effective at bringing equality into mainstream plans and reporting. Coupled with a lack of reporting on the implementation of equality scheme commitments, this appears to have led to serious shortcomings in the ability of many authorities to demonstrate how they are meeting their general duties in practice.

Other key findings included:

- On the basis of the evidence made available to the assessment team, no authority or trust included in the sample was likely to be fully performing on all the three duties, and most were likely to have significant failings in performance.
- The assessment suggested that performance against the duties was regarded by the majority of authorities and trusts as a 'box ticking' exercise and only rarely encompassed the achievement of equality outcomes in practice.
- There was very little in the way of joined up planning and delivery between equality plans and schemes and other mainstream strategies, plans, and programmes.
- Much greater attention needs to be paid to leadership, commissioning, and employment than the assessment suggests has been the case up to this point.
- In the majority of cases organisations' mainstream reports and plans lacked significant or relevant equalities data. Most information relating to performance on the equality duties was published in equality schemes. It was therefore often difficult to judge how equality actions were leading to improved outcomes for equality groups.

- Performance on the Disability Equality Duty (DED) was strongest, followed by the Gender Equality Duty (GED) and Race Equality Duty (RED) in equal measure.

- Several common causes were found for potentially inadequate performance. A key problem was the lack of equality planning and reporting in mainstream materials such as strategic, employment, and commissioning plans. It was therefore often unclear how the general duties were being delivered.

- Problems were also often found around the development of clear and measurable priorities and objectives on SMART criteria with specific outcomes in terms of employment, commissioning, and/or service provision. While this was found across REDs, DEDs, and GEDs respectively, there seemed to be a particular issue with regard to gender.

- It was not clear whether priorities, objectives, and actions were based on adequate needs assessment. Typically, transgender, transsexual and Gypsy and Traveller communities were overlooked.

- The quality of actions and reporting on the equality duties in mainstream plans and documents was very poor. This included action resulting from and reporting of achievements in equality schemes.

- A clear and urgent problem was identified with regards to a lack of action-orientated priorities and objectives with real and tangible outcomes. The current state of play suggests that few mechanisms exist by which aims and improvements for equality groups can be defined and achieved.

- There is a need for greater joined up thinking and practice between regional and local health planners and equality teams to ensure that programmes targeting health inequalities benefit from the regulatory framework and underpinning that the equality duties provide.

- Twenty-four of the twenty-eight authorities assessed had failed to: set clear gender objectives; set clear means of effectively promoting equal pay through objectives; and addressing causes of inequality (see Table 3 for more information in Section 2 of the report). Equally, under-representation and gendered occupational segregation in employment was frequently unaddressed, as were health inequalities stemming from gender differences.

- Transgender issues were often not mainstreamed in the planning and commissioning of healthcare services.
- It is clear that SHAs and PCTs are not effectively holding dependent organisations and providers to account for the duties.

Practices promoting equality outcomes

The assessment specifically sought out examples of effective practice. This revealed a range of practices that promote equality outcomes across functional areas and equality groups, and key lessons for leadership and engagement, commissioning, employment, and service delivery activities. While these are detailed in Sections 3 and 4 of the report, key practices and lessons include:

- **Leadership and engagement:** In NHS East Riding of Yorkshire, NHS Plymouth, and NHS North East, senior leadership took an active role, equality leads were executive board members, and programmes and initiatives took place that ensured patient and equality group consultation and engagement in the decision-making process.
- **Commissioning:** In NHS Leicester City and NHS North West, commissioning included initiatives that involved patient commissioning boards made up of diverse stakeholders representing local communities.
- **Services:** In a large number of authorities and trusts, services included those based on rigorous, local evidence, clear priorities and objectives, and clear action and delivery plans.
- **Cross-functional practices:** In NHS North West and NHS Somerset, some practices can promote equality outcomes across several functions simultaneously – including employment, commissioning, and service delivery. These too depend on a careful consideration of the needs of local equality groups and effective consultation, engagement, and monitoring strategies.

The equality duties represent an opportunity for healthcare providers to develop systems and procedures that truly reflect the diversity of modern Britain, protect the rights of disadvantaged groups, and deliver improved health and wellbeing for all. Not only can this lead to improved employment and health outcomes for different groups in society, but also deliver public spending savings and greater economic growth.

Given that the health sector, NHS, and duties themselves are constantly evolving, the approaches developed must similarly change and improve over time. When so doing, there are several fundamental steps that organisations should take into account to ensure that all equality planning, priorities, objectives, and actions stay relevant and effective regardless of the wider changes taking place. By reviewing and adopting the practices and lessons outlined in this report, as well as consulting the Commission's published and forthcoming guidance, healthcare commissioners, employers, and providers can help to ensure the health, economic, and social wellbeing of employers, suppliers, and service users.

1. Introduction

This research report examines performance on the Race, Gender and Disability Equality Duties (the equality duties) by Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) in England. The NHS is England's largest employer, and is responsible for planning and delivering public healthcare for over 1 million patients every 36 hours.[3] However, according to the Healthcare Commission,[4] the NHS still demonstrates horizontal and vertical occupational segregation and under-representation of diverse groups including on the grounds of age, gender, disability, race and ethnicity, religion or belief, and sexual orientation, while according to the Marmot Review inequalities in health exist for many groups.

Health sector organisations are under a legal duty to have due regard to equality (please see page 12 for more details). Effective implementation of and successful performance on this can assist healthcare organisations in reducing relative inequalities in health, employment, and commissioning outcomes and the life chances and wellbeing of millions of people in the UK.[5] This report presents the overarching findings of a project designed to examine the performance on this area by SHAs and PCTs, developing and applying a methodology that attempts to move the focus from the content of schemes to the achievement of equality outcomes as a key measure of performance. The assessment therefore gathered and considered a wide range of evidence detailed on page 15.

This framework enables authorities to work to achieve equality and respond to diversity across healthcare provision. To meet these obligations organisations need to develop clear outcomes-focused policies and programmes throughout the NHS that encompass concrete plans and actions with observable and measurable results.

1.1 The equality duties: general and specific outcomes

Until April 2011, public bodies in England[6] were subject to the Race Equality Duty (RED), Disability Equality Duty (DED), and Gender Equality Duty (GED). These have been replaced by the Public Sector Equality Duty (the equality duty or PSED) which covers eight legally protected characteristics which are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The legislative framework for the previous and existing duties have two main components: the general duty and the specific duties. The general duty sets out the main objectives of each of the duties, while the specific duties are the more detailed steps that support public bodies to meet the general duty. Although the general and specific duties varied for race, disability, and gender, all three duties share a common vision: for public services to mainstream equality to ensure that all individuals are able to benefit equally from public services, eliminating discrimination and where appropriate taking account of their race or gender, or whether they are disabled.

The aim of the equality duties is to mainstream actions on equality and the outcomes that derive from them. An assessment of effective mainstreaming would therefore expect to find evidence of action on equality in, for example, strategic plans, business plans, annual reports, commissioning plans, and so on, as they relate to different organisational functions.

More information regarding the duties can be found on the Commission's website: www.equalityandhumanrights.com/advice-and-guidance/public-sector-equality-duty. Advice designed for health sector organisations can also be downloaded from the site.

1.2 Change in the NHS: The Coalition Government's White Paper

Over the next couple of years significant changes are likely to take place in the way that healthcare services are planned, commissioned, and delivered across the UK.

These will have far-reaching impacts on how health inequalities are identified and addressed, and how the equality duties are performed. In July 2010 the new Coalition Government published *Equity and excellence: Liberating the NHS*,[7] a White Paper setting out the Government's plans for the NHS in the future. The White Paper is based around the strategic goals of:

- Putting patients and public first
- Improving healthcare and outcomes
- Autonomy, accountability, and democratic legitimacy
- Cutting bureaucracy and improving efficiency.

At the core of the White Paper is a proposal to reorganise healthcare planning and delivery, including the abolition of SHAs and PCTs and their replacement with local consortia of GP practices. A fundamental principle of the proposed new arrangements is identified as being that every GP practice will be a member of a consortium, as a corollary of holding a registered list of patients. It is proposed that practices will have flexibility within the new legislative framework to form consortia in ways they think will secure the best healthcare and health outcomes for their patients and locality. GP consortia will therefore have the freedom to decide what activities they undertake for themselves and what activities they choose to buy.

Regardless of how the NHS is organised over the next few years, the obligations will continue to apply. The lessons learnt from the assessment of the present system of SHAs and PCTs around the key issues of health and social care, employment, and commissioning that are presented in this report will be of relevance for health planners and providers as change takes place. This report will assist those involved to build on the work that has taken place on the equality duties (for over a decade in the case of the RED).

1.3 Research methodology

In December 2009 the Equality and Human Rights Commission (the Commission) commissioned an assessment of the performance on the Race, Disability and Gender Equality Duties by SHAs and PCTs in England. This was achieved through an evaluation of all relevant programmes, initiatives, and published materials relating to authorities' and trusts' functions and equality planning and performance. (Please see Focus of the assessment on page 16 for the details of the materials that were requested during the assessment.)

The aims of the assessment included following up on ongoing performance issues with various PCTs on the Disability Equality Duty (DED) (please see Scope of the assessment on page 16) and highlighting practices that promoted equality outcomes across functional areas including services, commissioning, leadership, and employment.

As described above, during the assessment period the general election led to a change in government as well as proposed changes to the NHS and the equality duties. However, the general duties as well as the functional areas of new healthcare providers and commissioners established will remain broadly similar in the new system, if organised and monitored differently. The findings and lessons learnt through the assessment of SHAs and PCTs will therefore be of value to health planners and providers in the future and in the process of transition.

SHAs and PCTs

Since 2002 responsibility for healthcare has been given to regional SHAs and local PCTs, in addition to other bodies. SHAs' and PCTs' functions included commissioning, accountability, governance, employment, and service provision, all of which are examined in this report and all of which will remain integral to any new system. SHAs were created to manage the regional NHS on behalf of the secretary of state. There were originally 28 SHAs, with the number reducing to 10 in 2006. Currently, SHAs remain responsible for:

- Developing plans for improving health services in their local area

- Making sure local health services are of a high quality and are performing well

- Increasing the capacity of local health services so they can provide more services

- Making sure national priorities (for example, programmes for improving cancer services) are integrated into local health service plans.

SHAs also hold responsibility for the PCTs in their area, which in turn commission and manage primary care services at local level (for example NHS GPs, dentists, opticians, pharmacies, walk-in centres, and 'NHS Direct' telephone services). There are currently 151 primary care trusts in England. PCTs work with local authorities and other agencies that provide health and social care locally to make sure that local community needs are being met, including identifying health inequalities and the needs of diverse user groups. In the current system, PCTs reside at the centre of the NHS and control 80% of the NHS budget.[8]

Scope of the assessment

Under the original project brief all 10 SHAs and 31 PCTs in England were to be assessed. These were to include three PCTs in the London SHA region and two PCTs in all other regions. However, due to ongoing Commission engagement on performance issues within one SHA and the region during the assessment period, it was decided to exclude that organisation and associated PCTs from further activity. Nine SHAs and 19 PCTs were therefore selected for assessment (28 authorities in total). These included:

- London SHA, Newham PCT, Harrow PCT, and Richmond PCT
- East of England SHA, Peterborough PCT, and Norfolk PCT
- South Central SHA, Isle of Wight PCT, and Berkshire West PCT
- South West SHA, Somerset PCT, and Plymouth PCT
- Yorkshire & The Humber SHA, Leeds PCT, and East Riding of Yorkshire PCT
- North East SHA, Darlington & County Durham PCT, and Northumberland PCT
- North West SHA, Liverpool PCT, and Trafford PCT
- West Midlands SHA, Coventry PCT, and Herefordshire PCT
- East Midlands SHA, Derbyshire County PCT, and Leicester City PCT

Fifteen of these PCTs had previously been assessed in relation to the DED, and concerns on performance were found.[9] Having received guidance on how to improve performance on the DED they were included in the new sample to measure progress made, given that adequate time had passed to allow implementation.

In order to ensure a representative sample of two PCTs per SHA region, five new PCTs were selected. This was done on the basis of the 'Hampton Principle'[10] that 'no inspection should take place without a reason'. Paragraph 6.2 of BERR's Regulators' Compliance Code: Statutory Code of Practice for Regulators,[11] states that 'regulators should use only a small element of random inspection in their programme to test... the effectiveness of their interventions'. Therefore in SHA areas where only one PCT was drawn from the earlier assessment, an additional PCT was selected on the basis that the locality it administered was demographically and economically distinct from that of the previous PCT. For example, where the PCT in the original sample was responsible for an urban locality, the new PCT was selected because it was responsible for a rural locality. Census data and Index of Multiple Deprivation (IMD) rankings were used to assess PCT localities. This methodology was further justified by the fact that the assessment was not only looking at performance but also seeking out effective practice.

Focus of the assessment

The focus of the assessment was on all relevant programmes, initiatives, and published materials providing evidence on organisational and equality planning and performance. This was in relation to four core functional areas relevant to both SHAs and PCTs, including employment, commissioning, service provision, and leadership and governance. Evidence was therefore sought from mainstream publications as well as equalities publications.

The Chief Executives of the SHAs and sample PCTs were written to by the Commission informing them of the assessment and highlighting its importance. They were asked to provide a list of materials deemed relevant to the assessment. For SHAs this included:

- Most recent Strategic Plan

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- Most recent and last two Annual Reports

- Most recent and last two Annual Reports on the equality duties

- Annual Health Check

- Workforce strategy and data

- Most recent and any previous equality scheme(s) including any separate schemes for disability, gender, and race

- Equality Action Plan(s)

- Equality reviews and/or assessments

- Equality Impact Assessment Schedules and the results of key impact assessments plus additional templates/methodologies

- Any recent research documents relating to equality issues.

The same materials were requested from PCTs, along with any commissioning, workforce, and workforce strategic plans and joint strategic need assessments.

Evaluation framework

An evaluation framework for the assessment of the authorities' and trusts' submissions was designed in close collaboration with the Commission. The framework included three sections relevant to each of the equality duties (RED, DED, and GED) and key functional areas (services, employment, commissioning, and leadership), with space for progress made for any actions on the new equality duty and other functional domains. Each section of the framework was further divided into three parts focusing on 'form and content of assessment materials,' 'priorities and objectives of equality plans, programmes, and initiatives' and their 'implementation and impact'. These parts contained 'prompts' relating back to the general and specific equality duties for each strand. The prompts were developed to inform the assessment. They included checklists on health issues and particular equality groups, consultation and involvement, leadership and governance, monitoring and evaluation, and other areas of SHA and PCT and activity on the equality duties.

Data gaps

While every authority and trust that had been contacted returned materials, the quality varied. As seen in Section 2 of this report, a key problem was that in the majority of cases, organisations' mainstream reports and plans lacked significant or relevant equalities data. Most information relating to performance on the equality duties was published in equality schemes. It was therefore often difficult to judge how equality actions were leading to improved outcomes for equality groups.

In some cases single equality schemes had recently been published and all materials relating to legacy schemes, including impact assessments and progress reports, had been deleted or destroyed. This meant that it was not possible to trace the development of performance on equality duties over time. In other cases recent or on-going restructurings of PCTs affecting their different functions had led to a confused state wherein equality schemes developed for the old organisation were still seen as relevant to the new organisation, even through strategic actions and priorities had changed. Similarly, staff changes, particularly of the equality lead, led to significant delays in the return of materials, or gaps in some of those requested.

Assessment reports

A detailed assessment report was prepared for each authority and trust on the basis of the evidence submitted and additional follow up work conducted. These were submitted to the Commission, and will inform decisions regarding any future follow up work. The individual reports were also reviewed together by the assessment team in order to gather the evidence for this report, including examples of practices that promote equality outcomes set out in Section 3 below. The findings and lessons presented in this report are based on that review, plus additional requests for information from the authorities and trusts when required.

Limitations of the method

The sheer scope of the assessment limited the time that could be spent on any one authority or trust and the depth of the analysis that could be completed. This likewise limited the time that could be spent on the review that underpins this report. As will be seen in the following sections, a significant problem encountered by the assessment team was the authorities' and trusts' understanding of the equality duties

and their relationship to organisational functions and other mainstream documents. This too was compounded by the large number of materials that had to be reviewed, and the fact that very little in the way of joined up planning and delivery between equality plans and schemes and other mainstream strategies, plans, and programmes seemed to exist. The assessment suggested that performance against the duties was regarded by the majority of authorities and trusts as a 'box ticking' exercise that stopped at the creation of an equality scheme, and only rarely encompassed the achievement of equality outcomes in practice.

Equality impact assessments (EIAs) should have provided a better indication of how the duty was being met in practice, but they tended to be limited in number and poor in quality.

Confidentiality and anonymity
In the main, the identity of authorities and trusts will remain confidential throughout this report, as will the identities of interviewees who participated in the assessment process. Where we have identified examples of practices that promote equality outcomes, the authorities and trusts concerned will be named.

2. Assessing the performance of SHAs and PCTs

2.1 Overview of the field: performance on the PSDs

A key finding of the assessment was that most equality planning and data was restricted to equality schemes and did not form significant parts of mainstream materials including commissioning, service, and employment plans. As mentioned in the Focus of the Assessment section on page 16 a number of materials were requested from SHAs and PCTs including key EIAs, the most recent and the last two annual reports on the public sector duties and equality action plans. However, in most circumstances these materials were not available or not sent. When they were sent both the quality and the information contained within them tended to be quite poor. This meant the assessment itself was often restricted to a review of equality schemes, which by themselves provide little or no indication of how the general or specific duties are being achieved in practice. This is of particular concern as it leaves organisations at risk of not being able to demonstrate how they are meeting their general duties in all of their functions.

A review of assessment reports suggested that of the 28 authorities and trusts in the sample, 17 had published a single equality scheme (SES) and nine still had separate race equality schemes, disability equality schemes, and gender equality schemes. One organisation had archived its separate schemes but had yet to publish its SES, meaning that no scheme was formally in operation at the time of the assessment. Another organisation had published a SES for the period 2009-14, but it was still in draft form. It was not clear, therefore, whether the separate schemes or the SES were operational.

Performance

A formal assessment of performance against the equality duties can only be made on the basis of a full and comprehensive legal review, which the assessment team was not qualified to undertake. With this proviso, the tables and discussions below provide a brief assessment of performance against the RED, DED and GED, in relation to the general and specific duties of each, on the basis of the evidence available to the team. The assessment focused on performance of the duties in

practice, looking not only at what authorities said that they would do and the existence of equality documentation but also attempting to move beyond this to look for evidence of outcomes. While the equality duties are duties to have 'due regard', evidence of outcomes are a key indicator of how effectively this has been done in practice. The team examined a wide range of relevant evidence, including mainstream employment, service, and commissioning plans looking to identify how authorities had identified and ultimately achieved improvements as regards race, disability, and gender. Evidence of this has been grouped into three areas: clear evidence of outcomes, limited evidence of outcomes, and insufficient evidence to determine.

Race Equality Duty

The general duties of the RED require that public bodies must have 'due regard' to the need to:

- Eliminate unlawful racial discrimination
- Promote equality of opportunity
- Promote good relations between people of different racial groups.

The specific duties require all listed public bodies to publish a race equality scheme that identifies all functions/policies that are relevant to race equality. The scheme should be a timetabled and realistic plan, setting out the public body's arrangements for meeting the general and specific duties. They must also set out arrangements to:

- Assess and consult on the likely impact proposed policies will have on the promotion of race equality
- Monitor policies for adverse impact
- Publish the results of the impact assessments, consultation, and monitoring
- Make sure the public have access to information and services
- Train staff on both the general and specific duties
- Review the list of functions/policies at least every three years.

The assessment suggested that performance on the RED by authorities and trusts was weak. Just one organisation provided clear evidence of outcomes with regards to the general duties, and a few others provided limited evidence.

Table 1   Performance of SHAs and PCTs on the Race Equality Duty

Duty	Clear evidence (N)	Limited evidence (N)	Insufficient evidence (N)	Total
General duties	1	6	21	28
Specific duties				
• Assess/consult	1	4	23	28
• Monitoring	1	5	22	28
• Publishing	1	1	26	28
• Accessibility	1	2	25	28
• Training	1	1	26	28
• Reviews	1	1	26	28

Disability Equality Duty

The general duties of the DED require that public bodies must have 'due regard' to the need to:

- Promote equality of opportunity between disabled persons and other persons
- Eliminate discrimination that is unlawful under the Act
- Eliminate harassment of disabled persons that is related to their disabilities
- Promote positive attitudes towards disabled persons
- Encourage participation by disabled persons in public life, and
- Take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons (for example, the provision of an accessible parking bay near a building, where parking is not available for other visitors or employees).

The specific duties require all public bodies to publish a disability equality scheme, demonstrating how they intend to fulfil their general and specific duties. Public bodies should involve disabled people in the development of their responses to the DED, implement the action plan set out in the scheme, and review and revise the scheme every three years. The scheme should include:

- Information about how disabled people have been involved in its development
- The authority's methods for undertaking impact assessments
- An action plan setting out the steps it will take to meet the general duty
- Arrangements for gathering information on the effect of the authority's policies and practices on disabled people
- Arrangements for using this information, including reviewing the effectiveness of the action plan and preparing subsequent disability equality schemes, reporting annually on steps taken in the action plan, the results of information gathering and how the information has been used.

Table 2   Performance of SHAs and PCTs on the Disability Equality Duty

Duty	Clear evidence (N)	Limited evidence (N)	Insufficient evidence (N)	Total
General duties	4	10	10	28
Specific duties				
• Involvement of disabled people	2	9	17	28
• EqIA methods	1	6	21	28
• Action plan	0	5	23	28
• Gathering information	1	9	18	28
• Using information	0	6	22	28

The assessment found that most authorities and trusts published and provided insufficient evidence to determine performance on all the elements of the DED. Only four authorities or trusts provided clear evidence of performance on the general

duties, alongside 10 that provided limited evidence and 10 that provided insufficient evidence. Performance on the specific duties appeared equally weak. The majority of authorities and trusts failed to provide sufficient evidence of performance on any of the specific duties, with action plans and the use of information, including reviews, being the weakest areas.

Gender Equality Duty

The general duties of the GED require that public bodies must have 'due regard' to the need to:

- Eliminate unlawful sex discrimination and harassment (including for transsexual people)
- Promote equality of opportunity between men and women.

The specific duties require all listed public bodies to produce a gender equality scheme showing how it intends to fulfil the general and specific duties. It should also set out the gender equality objectives that the authority has identified for meeting the duty. In preparing a scheme, public bodies should:

- Consult employees, service users and others (including trade unions)
- Take into account any information it has gathered on how its policies and practices affect gender equality in employment and the delivery of services
- In formulating its gender equality objectives, consider the need to have objectives to address the causes of any gender pay gap.

In addition, the scheme should:

- Set out how the authority will gather information on gender equality in employment, services and performance of its functions
- Use this information to review the implementation of the scheme's objectives
- Assess the impact of its current and future policies and practices on gender equality
- Consult relevant employees, service users and others (including trade unions)

- Ensure implementation of the scheme's objectives.

Organisations should report progress annually and review and revise the scheme at least every three years.

As with the RED and DED, the assessment found a low level of clear evidence of performance on every element of the GED, alongside high levels of limited and insufficient evidence.

Table 3   Performance of SHAs and PCTs on the Gender Equality Duty

Duty	Clear evidence (N)	Limited evidence (N)	Insufficient evidence (N)	Total
General duties	1	6	21	28
Specific duties				
• Consultation	1	4	23	28
• Using information	1	2	25	28
• Objectives	1	4	24	28
• Gathering information	1	1	26	28
• Implementing objectives	1	1	26	28
• EqIA	1	3	24	28

Summary

Overall, the review of assessment reports suggested that, on the basis of the evidence made available to the team, no authority or trust included in the sample was likely to be fully performing on all the three duties, and most were likely to have significant failings in performance. Within this context, the assessment suggested that performance on the DED was strongest, followed by the GED and RED in equal measure.

Nevertheless, examples of practices leading to equality outcomes across functions were identified from a range of authorities and trusts and can be found in Section 3 of this report.

Common causes of potentially poor performance

The review of the assessment reports suggested several causes for potentially poor performance. A key problem found was the lack of equality planning and reporting in mainstream materials such as strategic, employment, and commissioning plans. It was therefore often unclear how the general duties were being delivered.

Restructurings within all PCTs since 2006 were a common cause, as mainstream plans reviewed in the assessment had apparently failed to consider equality outcomes and equality schemes had struggled to keep up to date with the changes taking place. In a large number of cases, staff changes within equality teams had led to delays and oversights in the publication and/or evaluation of schemes. When asked, some interviewees stressed that changes or reviews were high on the agenda but had yet to take place. In three cases recent organisational changes within PCTs had appeared to result in the absence of schemes relating to the new trusts, or the blanket application of old schemes to new trusts.

Common content problems revolved around the development of clear and measurable priorities and objectives on SMART criteria with specific outcomes in terms of employment, commissioning, and/or service provision. While this was found across REDs, DEDs, and GEDs respectively, there seemed to be a particular issue with regards to gender. Twenty-four of those assessed had failed to set clear gender objectives and set clear means of effectively promoting equal pay through objectives and addressing causes of inequality (see Table 3). Equally, under-representation and gendered occupational segregation in employment was frequently unaddressed, as were health inequalities stemming from gender differences. Despite the fact that the Gender Equality Duty requires specific consideration of transgender equality, this was often not a part of work to meet the GED, either through SES, GES or mainstream plans and strategies.

Summary

The assessment specifically looked beyond equality schemes to try and identify if equality practice was happening within the mainstream of the organisation, in recognition of the fact that performance of the duties is more than considering if equality schemes are in place. A central problem found in every authority was a lack of joined-up policy and practice on equality with other mainstream functions' plans. This meant that as well as being difficult to assess equality outcomes across organisational functions and stakeholders, it is likely that organisations themselves are prevented from understanding fully the outcomes of their own actions. This, combined with the concerns regarding the ability of schemes to enable authorities to meet their general duties outlined above, increases the likelihood that inequalities across commissioning, services, and employment not only remain but also become more pronounced.

2.2 Form and content

The content of organisational materials was assessed according to the criteria identified in the DED, GED, and RED. Although each duty requires slightly different issues to be covered in schemes, they included:

- Due regard to general duties
- Taking action on the specific duties
- Gathering evidence to support the development of organisational strategies and plans, specific duties, and monitoring progress and outcomes
- Ensuring consultation with and involvement of equality groups
- Developing, training on, and publishing the results of EqIAs
- Identifying and addressing employment issues for equality groups
- Providing and monitoring equality and diversity training for all staff
- Publication commitments regarding equality schemes, reviews, and the outcomes of other relevant work as required by the duties
- Ensuring public access to information and services regardless of disability, language, and other possible barriers.

Although the assessment looked at all relevant organisational materials on commissioning, employment, and service provision, evidence of performance on the duties was usually only found in equality schemes.   This can be considered a significant failing as performance of the general duties requires due regard to the equality duties in all an authorities functions and this suggests that this may not be happening, or at the very least that those assessed will have difficulty in demonstrating that it is.

Due regard to the general duties

A fundamental indicator of the successful performance of the equality duties is the identification of clear priorities and objectives in organisational strategies, plans, and equality schemes as they relate to the functions of the organisation. These should be developed on the basis of a clear, empirically-based rationale of relevance and need. However, many of the materials that were reviewed in the assessment did not set out the information or analysis on which priorities were identified, either with regards to the authority's or trust's functions or to the position of equality groups. The only evidence from the published or submitted materials of performance came from equality schemes, although this was limited in the extent to which it related to functional areas (21 with regards to the RED, 10 the DED, and 21 the GED; see Tables 1 to 3). It was impossible, therefore, to adequately assess the priorities and objectives laid out by authorities and trusts to enable them to meet the general duties.

In addition, the assessment suggested that some materials including SESs sometimes referred to the duties in a generic way, rather than to address the DED, GED, and RED individually. Indeed, the tendency for SESs to combine equality group issues, priorities, and objectives without a clear rationale for doing so (and thus possibly failing to respond to specific needs and issues of each) was a considerable failing found in many authorities and trusts.

Finally, the assessment suggested that, while many authorities had voluntarily chosen to extend their commitments to additional equality strands and human rights, there was insufficient evidence that this commitment was carrying through into

equality practice. This includes a lack of priorities and objectives, particularly on human rights. With the new equality duty, such problems need to be urgently addressed as authorities may underestimate the work that is needed to prepare for the extension of the duties.

Taking action on the specific duties

The assessment revealed that problems relating to the general duties tended to follow through to affect authorities' and trusts' responses to specific duties and action plans. Although in some cases accountabilities and specific timelines for priorities and objectives were highlighted (again limited to schemes), the majority lacked details about how actions would be delivered or indeed deliver on the duties through their completion (see Tables 1 to 3). Many SES action plans did not cover the different equality strands as they should, excluded some equality groups, or combined responses to strand issues together without explaining how different groups would benefit. For example, in many cases a SES covered all six strands (although usually excluding or failing to specify gender identity) through cross-strand actions, and it was not possible to judge how the statutory race, disability, and gender duties were being addressed.

A common problem as identified throughout this report was the lack of joined-up thinking between equality schemes and health and social service user outcomes.

Gathering evidence and monitoring progress and outcomes

The equality duties are clear that organisational planning through strategic documents and equality schemes and interventions should be based on clear evidence of need and reviewed regularly (every three years by law for the DES and GES and voluntarily for the RES). However, the assessment suggested that most mainstream plans and equality schemes lacked an empirical base regarding the demographic make-up of local communities, or the disaggregation of health inequalities by equality strands within the local population, instead providing national data on key trends affecting equality groups (see Tables 1 to 3). According to follow up work with organisations, this was due to a lack of such data being available. While this does not mean that programmes aimed at targeting health inequalities were not

developed on the basis of such data, it does indicate that no clear connections were evident between local conditions and the priorities and objectives set out.

Where data was available or published on equality groups, it was often aggregated to a meta level of 'BME', 'physical disability', 'mental impairment', and other broad labels. Very little disaggregated data was published regarding, for example, the presence of newly settled communities in local regions and their specific health issues, or physical or mental disabilities by type.

Likewise, very few of the materials assessed included plans or processes for monitoring equality and diversity issues, either internally or in health and social services (see Tables 1 to 3). In such cases it was difficult to ascertain how authorities or trusts could monitor for improved equality outcomes through the actions undertaken.

Consultation with and involvement of equality groups

While the vast majority of assessment materials provided (mainly equality schemes) provided evidence of consulting with and involving some equality or patients' groups in the development of programmes and initiatives, clear links between those activities and the identification of priorities and outcomes was not provided (see Tables 1 to 3). Nor did many materials provide evidence of how groups would continue to be involved in their development, including schemes, for example at the time of reviews.

Where evidence of consultation and involvement was present, it was often not clear on what grounds stakeholders had been identified. For example, little information was provided that demonstrated specific equality groups in the local population had been consulted on particular employment, health, or commissioning problems facing them. It was therefore not clear whether priorities, objectives, and actions were based on adequate needs assessment. Typically, transgender, economic migrant, and Gypsy and Traveller communities were overlooked.

Assessment of equality impact

With regards to assessments of impact on equality, the evidence suggested that few authorities or trusts provided enough information to make a judgement about their quality, usage, and impact. In some cases assessments were simply not published, in breach of the RED. Where they were published it appeared that guidance on EIA methodology was usually in place, and provided on the authority or trust website. However, in some cases it was possible that the assessments were insufficient to deliver performance on the duties.

Overall, it appears that impact assessment methodologies were often unclear, and that those published tended to be summaries rather than full assessments. The team noted few action plans or evidence of evaluation of outcomes as a result of actions taken, leading to concerns about the ability of assessments to assist authorities in meeting their duties.

Identifying and addressing employment issues

The majority of authorities and trusts failed to demonstrate they had consulted with staff, unions, and employee equality groups when identifying and addressing employment issues (see Tables 1 to 3). For example, several of the schemes assessed did not include staff diversity breakdowns or information about how staff diversity reflected regional or local populations or user groups. Where data was available, disability information was often only volunteered by a small number of staff. However, schemes did not discuss why this was the case and what measures could be developed to encourage self reporting of disability.

In many cases it was unclear how – or indeed if – any workforce monitoring arrangements were being used to inform actions and set targets where necessary (see Tables 1 to 3). As suggested above, objectives and actions to address gender inequality in employment were badly reflected in both GESs and SESs as well as other material reviewed. Little evidence could be found on how many authorities and trusts had developed measures on gendered occupational segregation, the identification of organisational barriers and enablers, and equal pay. Little evidence too could be found on whether actions dealing with these issues were being accomplished. Likewise, evidence of under-representation of disability or ethnic

minority groups at certain levels or in certain occupations was not accompanied with measures to improve the diversity of the workforce.

Overall, it was often unclear how authorities and trusts identified or addressed employment issues facing equality groups. Where employment monitoring data was provided analysis was often lacking to establish trends to inform actions. As a result of this only two practices of promoting equality were identified around employment issues.

Providing and monitoring training

All schemes reviewed suggested that equality and diversity training was or will be delivered to all staff during the scheme's lifetime. However, the majority failed to provide information on the success of completed training programmes, for example through the inclusion of evaluations and outcomes for staff or user groups (see Table 1 with regards to the RED). Moreover, training was often focused on general equality and diversity awareness, and it was unclear the extent to which they engaged with the duties or were targeted for specific staff groups, such as managers.

Publication commitments

Given the recent replacement of many individual schemes by single schemes in the sample it was difficult to assess whether publication commitments, for example of reviews, were on track or had been missed. In many cases three year reviews of individual schemes would have been due by the time the assessment took place, but the recent publication of a SES had lead to the deletion of legacy schemes and failure to conduct reviews.

There was a common lack of data published on workforce monitoring. Similarly, research studies on equality and diversity issues relating to staff and user groups, commissioning, and service delivery, if conducted at all, was not published or made available to the assessment team (see Tables 1 to 3).

Public access to information and services

In most cases authorities' and trusts' websites provided clear links to equality pages, documents, and contact information for equality personnel. However, in some cases

these basic requirements were not met and it is unclear how members of the public could express concerns relevant to equality issues. In other cases some pages were out of date.

On the basis of the available evidence, the assessment team found that measures were in place to promote access to services, for example through translation and addressing barriers to disabled people, across all authorities and trusts assessed. However, as suggested, there was also a lack of data on local equality groups and needs so it was not possible to determine whether full access was being achieved in practice.

Summary

Overall, the assessment revealed that the quality of equality duty actions and reporting in mainstream plans and documents was very poor. The assessment revealed a need for greater joined up thinking and practice between regional and local health planners and equality teams to ensure that programmes targeting health inequalities benefit from the regulatory framework and underpinning that the equality duties provide.

2.3 Priorities and objectives

A common problem with many of the assessment materials submitted by authorities and trusts was a lack of clarity on how priorities, objectives, and actions had been identified and how they would be delivered and evaluated. For example, the assessment revealed that in relation to the GED only one organisation provided clear evidence on performance on this issue and four limited evidence (Table 3). These problems stemmed from the issues raised in the previous section discussing form and content.

On the basis of materials that were provided many authorities included what can best be described as 'process driven' priorities and objectives that were lacking either clear and measurable outcomes or the systems and procedures in place to carry out such assessments. For some authorities priorities and objectives were not developed for each of the duties or equality strands individually, but instead related to all duties

and strands together. While the fact that most actions had only been in progress for a short time limited the degree to which any assessment of relevance or impact could be made, the lack of long term data collection or planning meant that any eventual benefits were also likely to go unrecorded. Finally, and as already suggested, in several cases priorities and objectives identified in individual schemes were not carried over in the SES that replaced them.

Overall, the assessment identified a clear and urgent problem with regards to action-orientated priorities and objectives. The current state of play suggests that few mechanisms exist by which aims and improvements for equality groups can be defined and achieved.

2.4 Implementation and impact

The assessment team was unable to identify many examples of successful implementation and impact. This appears to be due to the lack of clearly identified and measureable priorities and objectives and the preponderance of process-driven actions. This affected priorities and objectives found in commissioning, employment, service, and other functional plans. While various strategies relating to the needs of equality groups were highlighted in equality schemes, there was little clear evidence of how these were put into action or of what effect they had on the achievement of equality outcomes.

In some cases authorities and trusts demonstrated strong partnerships with local equality bodies and groups and understanding of local conditions and needs. Nevertheless, the link between this and the intended outcomes that they had prioritised was often not evident. In some cases service strategies tended to express good intentions to communicate and work with service users and staff taking into account inclusion, equality, and diversity characteristics and needs, but failed to illustrate what that would look like in terms of practicable action and outcomes.

Where clear and measurable priorities and objectives were identified, a lack of monitoring and impact assessment data hindered an assessment of their effectiveness and reach.

With regards to employment, a common problem identified by the assessment team was a lack of evidence on how monitoring data on the diversity characteristics of staff informed action to promote equality (see Tables 1 to 3). Similarly, little evidence was identified by the assessment team that provided information on how outcomes or barriers to equality would be addressed. When evidence of clear priorities and objectives were identified, many authorities and trusts failed to provide information regarding progress or achievements.

Given that a key intention of this assessment was to move the focus from the content of equality schemes to the achievement of equality outcomes as a key measure of performance, the lack of evidence of implementation and impact is of serious concern.

3. Examples of practices that promote equality outcomes

3.1 Assessing equality outcomes

The assessment actively sought out practice examples that demonstrate where outcomes have been achieved. Given the findings above, it was decided to widen the scope to include examples of practices that showed evidence of promoting equality outcomes. A fundamental requirement for practices was for them to at least address the issues of service provision, commissioning, and/or employment, and also, where relevant, to cover race, disability, gender, and the new protected characteristics that are covered now that the new equality duty has come into force (from April 2011). If these criteria were met, candidate programmes and initiatives were assessed on the following grounds:

- Demonstrated need using relevant data relating to employment, commissioning, health and/or other relevant inequalities
- Consultation with and involvement of target groups and other stakeholders
- Clear priorities and objectives relating to equality outcomes.

Identified practices are here presented by the functional areas to which they relate:

- Health services provision
- Commissioning
- Communication, engagement, and leadership
- Cross functional services.

3.2 Outcomes in healthcare provision

The following practices were identified as promoting equality outcomes in healthcare provision:

- Truth about TB Campaign for members of the Pakistani community and health practitioners – NHS Peterborough

- Race for Health initiatives focusing on themes including infant mortality, coronary heart disease and stroke, diabetes, and mental illness – NHS Leeds

- Community Dental Service for people unable to access general dental care – NHS Coventry

- Transition Strategy Group for young people with learning disabilities transiting to adult services – NHS Peterborough

- Supporting people with learning disabilities – NHS Leeds

- Cardiac Rehabilitation Project for people with learning disabilities – NHS Leeds

- Pacesetters initiatives covering Gypsy and Traveller communities, breast screening for female prisoners, and palliative care services for faith communities – NHS East Midlands

- Improving take up of breast screening by ethnic minority women aged 50 to 70 years – NHS Leeds

- Addressing domestic violence – NHS Leeds

- HPV awareness raising amongst African Caribbean and Irish Traveller communities – NHS Leeds

- Recognising the cultural context of health experiences, take up, and delivery – NHS Berkshire West.

Truth about TB Campaign, NHS Peterborough

The Truth about TB Campaign involved interactive training for children and adults from the Pakistani community and health practitioners in the local area. Between January and December 2008 NHS Peterborough developed the pilot scheme 'TB or not TB' to establish training programmes for clinicians working in the community with high risk groups. Following significant increases of TB cases in Peterborough the pilot was developed to investigate levels of awareness within high risk communities. The pilot scheme introduced tailored training programmes to prevent further spread of infection. The multidisciplinary project team membership included Public Health specialists, a TB specialist nurse, the head of the school of nursing and a representative from the Health Protection Agency.

A wide ranging consultation was undertaken to ascertain levels of awareness of TB and how best to communicate key messages about services and support available to the target audience. The consultation targeted a range of people across gender, age, and language groups. A social marketing campaign was implemented to help change behaviours through raising awareness and by maximising engagement with the community and clinicians.

The quality of training has ensured the scheme is effective while the outcomes of the pilot have improved care pathways for TB referrals. The scheme has the aim of benefiting the community by improved knowledge and more people are able to recognise the symptoms of TB.

The evaluation report of the pilot project which ran from January 2008 to March 2009 suggests that 296 people were trained at Level 1, exceeding the target of 200. Ninety-two healthcare professionals were trained at Level 2, against a target of 75. Translated appointment letters improved access and training participants 'overwhelmingly expressed positive feedback'.

Race for Health initiatives, NHS Leeds

NHS Leeds has launched a number of programmes and initiatives that promise to deliver on elements of the RED. A project board chaired by the Executive Director of Workforce and Development, along with commissioning and public health leads, oversees the work. Annual reports on progress are produced for the Board. Progress to date includes:

- **Infant Mortality:** the target is to reduce rates in the 10 per cent super output areas (SOAs) from 8/1000 to 7/1000 by 2013. A review by the National Support Team for Infant Mortality in January 2009 recognised the *'proactive approach to addressing health needs of BME communities'*. A refreshed action plan picked up on the recommendations made by the review. This was launched at three events and presented at the Core Cities Collaborative in Liverpool.
- **Coronary Heart Disease/Stroke:** A Local Enhanced Service (LES) was offered to 43 practices with more than 30 per cent of their population living in

the 10 per cent most deprived SOAs in Leeds. The specification for Cardiovascular disease CVD risk assessments includes an increase risk score for ethnic minority communities, particular of South East Asia origin. Ethnic data will be considered as part of the overall evaluation.

- **Diabetes:** NHS Leeds took part in a diabetes open day in 2009 held at a community centre and a Mosque. The event was held in partnership with Diabetes UK and aimed to get feedback from ethnic minority communities.

- **Mental Health:** Achievements over the last 18 months include – service user led research on the perceived mental health needs of ethnic minority populations in Chapeltown and Harehills; introduction of quarterly performance monitoring reporting from all jointly commissioned third sector mental health providers that includes requirement for high quality ethnicity monitoring; the new mental health provider contract includes stronger metrics for ethnicity monitoring.

Community Dental Service, NHS Coventry

The Community Dental Service is a specialist service that provides dental treatment for children, adults, and older people who, because of a physical or mental impairment, are unable to access general dental care. The dental staff have expertise in the care, management, and understanding of people with special needs. The provision of this dedicated care is often more complex and challenging. The Community Dental Service specialises in the provision of services for people with:

- Learning disabilities
- Mental health conditions
- Physical disabilities
- Severe or complex medical problems
- Social/emotional/behavioural problems
- Phobias that are currently undergoing treatment
- Older people who are housebound, in residential care or receive domiciliary care.

In addition, refugees and asylum seekers who have difficulty in accessing general dental services can be referred to the Service by a health professional.

Transition Strategy Group, NHS Peterborough

A Transition Strategy Group has been established to ensure forward planning for young people with learning disabilities who transit to adult services. Detailed care pathways are developed for children with learning disabilities. In addition, work is carried out to raise expectations regarding employment with young disabled people still at school or college.

The Strategy Group oversees partnerships with local educational providers. The Group has also supported the development of a transitions toolkit outlining individual future employment options for Year 9 pupils with learning disabilities. The toolkits were distributed to 57 children.

Supporting people with learning disabilities, NHS Leeds

Supporting people with learning disabilities is a priority area for NHS Leeds and a number of actions are in place. A joint Learning Disability Strategy for NHS Leeds and Leeds City Council was agreed in May 2009 to take forward the national Valuing People Now strategy. NHS Leeds commissioned a voluntary sector organisation to conduct a Health Needs Assessment for people with learning disabilities to identify views and experiences of accessing health services so that the information could inform future commissioning. Directly Enhanced Services are in place to encourage GPs to identify people for the Learning Disability register and provide them with health checks.

Cardiac Rehabilitation Project for people with learning disabilities, NHS Leeds

NHS Leeds' Pacesetter Cardiac Rehabilitation Project aims to develop accessible information for people with learning disabilities who have experienced a cardiac incident. NHS Leeds is working with People in Action, a voluntary sector organisation working with and for people with learning disabilities. The intention is to develop information in consultation with people with learning disabilities and provide awareness training to healthcare professionals. People in Action facilitated two workshops with people with learning disabilities and carers in the autumn of 2009 to

get views on the current booklets used and experiences of services. An awareness session was also being arranged for the city wide cardiac rehabilitation team. An evaluation report was due in February 2010.

Pacesetters initiatives, NHS East Midlands

'Pacesetters' is a national initiative to test out innovation and new ways of working to address inequalities in health and health services. It is a partnership programme, requiring strong engagement with local communities, patients, service users, carers and staff. The initiative focuses on inequalities that arise from organisational discrimination and exclusion of people on account of their age, disability, gender, gender identity, race or ethnicity, religion or belief, and/or sexual orientation. The discrimination may result in a lack of access to healthcare, inappropriate treatment, and less favourable outcomes.

NHS East Midlands is one of six strategic health authorities who are working with the Department of Health on this project. Within the East Midlands, the Pacesetters programme initially focused on three PCTs, and currently covers nine. The SHA is working on a diverse range of projects with a variety of community groups. Projects include Gypsy and Traveller 'health ambassadors' in Leicestershire, improving access to breast cancer screening for female prisoners in Lincolnshire, and improving palliative care services for faith communities in Nottingham.

An initial focus was placed on securing good project management and developing effective community engagement. As a result the SHA has presented three of its projects at a national conference on patient involvement, had an article published in a national health journal, and have been invited to speak at an international seminar in Hungary.

Improving take up of breast screening by BME women aged 50 to 70 years, NHS Leeds

NHS Leeds has set up a Pacesetter project to improve the uptake of breast screening by ethnic minority women aged 50 to 70 living in the Super Output Areas (SOAs). The project's focus is to improve the systems for collecting ethnicity information through GP referrals and self referrals so that gaps in service take up can

be identified and ethnic minority women targeted where necessary. GP Surgeries that are scheduled for the NHS Breast Screening Programme between October 2010 and November 2011 have been mapped to select possible project sites and a communication strategy and action plan was being drawn up.

Addressing domestic violence, NHS Leeds

NHS Leeds has set up a number of actions addressing domestic violence. Women's Aid has been commissioned to provide drop-in services at A&E and antenatal clinics, e-training for NHS staff on domestic violence has been developed which includes signposting to appropriate services, and the PCT part funds the City Council's Domestic Violence service, while its Health and Domestic Violence co-ordinator leads on the training for NHS staff. A Community Awareness Campaign and a 'prevention and education' programme is also being developed. A resource pack for working with men and young adults is to be piloted in Chapeltown with the aim of rolling out a 'Domestic Violence preventive education programme for working with men and young adults'.

HPV awareness raising amongst African Caribbean and Irish Traveller communities, NHS Leeds

NHS Leeds ran a campaign to raise awareness amongst African Caribbean and Irish Traveller communities of the HPV vaccination programme as a means of preventing cervical cancer. Details of take up were not available for review. NHS Leeds also helps fund ASHA, a community centre for Bangladeshi and Pakistani women. ASHA offers well women and baby clinics, support on domestic violence and help on accessing health services. ASHA is currently working with NHS Leeds and Shatona women's centre on a project to raise awareness of the health risks of chewing *paan*.

Recognising the cultural context of health experiences, take up, and delivery, NHS Berkshire West

NHS Berkshire West's SES indicates that human rights are vital to achieving its aims and objectives. The equality strands are discussed in some detail (race, disability, gender and transgender, older age, younger age, religion or belief, and sexual orientation) and three 'key messages' are identified for each. These include:

- **Race:** access to interpreters and goods communications; finding out about cultures and health beliefs; involving BME communities in service development and developing BME staff.
- **Disability:** staff training to ensure person-centred care; better partnership working and positive action planning; better communications.
- **Gender:** more awareness raising on issues impacting on men, women, and transgender people; better gender balance at senior levels of the workforce.

The 'messages' regarding race are particularly interesting, as they note the impact of culture on understandings, aetiologies, and responses to illness and health.

3.3 Outcomes in commissioning activities

The following practice was identified as promoting equality outcomes in commissioning activities (more are provided in cross-functional examples in Section 3.5. below):

- Patient and public engagement in commissioning – NHS Leicester City.

Patient and public engagement in commissioning, NHS Leicester City

To improve patient and public engagement in commissioning decisions, NHS Leicester City has trained 10 lay patient representatives to sit on commissioning panels to support the PCT with investment and disinvestment decisions. The aims and objectives of the panel are:

- To involve patients and the public in the Commissioning Cycle
- To engage more proactively with patients and the public to make sure the services procured truly match the requirements of the people of Leicester
- To help the PCT to decide the best providers, from a patients perspective
- To have a patient panel representative of the population of Leicester
- To run two patient panels: diabetes services and renewal of 4 GP contracts plus one new GP contract in the City.

Further information can be found at:

3.4 Outcomes through communication, engagement, and leadership

The following practices were identified as promoting equality outcomes through communication, engagement, and leadership:

- Health Equality Stakeholder Engagement (HESE) guide – NHS North West
- Development of health services – NHS East Riding of Yorkshire
- Equality group and user involvement – NHS Plymouth
- Engagement with disability groups – NHS North East

Health Equality Stakeholder Engagement (HESE) guide, NHS North West
NHS North West identified the need to develop formal arrangements for engaging with equality target group stakeholders. The term *engagement model* was coined in order to emphasise that the approach is about more than simply setting up a consultation group. The philosophy extends much further and includes:

- The overall objective of ensuring that the SHA should have easy access to stakeholder-based knowledge and expertise covering health experiences and needs.
- A methodology for transparently selecting the most appropriate stakeholder organisations to approach and work within each equality area.
- A vision for ensuring that relationships formed have long term sustainability and can build the capacity of stakeholders to take an increasingly involved role in strategic planning.

The HESE Guide lists seven steps for successful stakeholder engagement, and addresses issues according to strand-specific barriers and enablers. These include:

- Decide on how you are going to embrace all the diversities
- Decide on the criteria for picking suitable partners
- Decide how much work is involved

- Commit to the philosophy that expertise has value
- Pick your partners using a fair and objective basis
- Put it all into a formal agreement
- Invest in your stakeholder partners' skills and knowledge.

Development of health services, NHS East Riding of Yorkshire

NHS East Riding of Yorkshire's Communication and Engagement Strategy 2008-11 commits to ensuring that everyone has equal access to being fully engaged in the development of health services. A key objective is to '*ensure seldom heard groups are actively engaged*' and three associated actions have been identified. These are to:

- Assess the requirements of disadvantaged groups and provide support to help them get engaged
- Regularly engage with key local groups representing the six strands of equality and diversity
- Introduce community development workers to work with ethnic minorities to help identify unmet mental health needs.

Progress to date on engaging seldom heard groups includes work conducted by the PCT's Joint Equality and Diversity Board to map and establish links for engagement with groups representing all six strands of equality and diversity. The Board also organised two 'Disability Fayres' in 2009 to raise awareness of services for people with disabilities (for example, access to breast feeding services) and to encourage communication between service providers. The events attracted over 300 people.

Equality group and user involvement, NHS Plymouth

NHS Plymouth's Strategic Framework states that user involvement is a core value of the PCT. The PCT is a signatory of the Plymouth Compact which is underpinned by codes of practice which include working with ethnic minority voluntary and community organisations. The PCT Communication and Engagement Strategy was revised in 2009 and the stakeholder analysis includes 'hard to reach,' marginalised, and vulnerable groups, as well as recognition of some of the associated issues.

Patient and public involvement (PPI) is a core area of work which is included in induction and core management training. EqIAs have been integrated into PPI impact assessments and a range of PPI tools, based on the Department of Health Real Involvement Guidance, are in development. A PPI steering group chaired by a Non-Executive Director with members of the community and partner organisations has been established to oversee an action plan. The action plan was not available for this assessment and so it is not known how in practice the equality agenda will feed into the work but there is an acknowledgment that the PPI agenda is closely aligned to and supported by the SES.

A paper to the Board in September 2009 says that the PPI lead has established links with 'quieter voices' in Plymouth and as a result service level agreements (SLAs) are in place with a number of community organisations: for example Plymouth & District Racial Equality Council (PDREC) and Plymouth Pride Forum. These have led to some practical outcomes, for example, working with the PDREC the PCT developed a 'Quick Guide' to engaging with ethnic minority communities which outlines best practice and sources of support and information and run the Chinese Elders project (a series of workshops with the largest ethnic community in the city). PDREC has also provided training to staff on community engagement.

The PCT also sponsors and participates in a range of targeted events.

Engagement with disability groups, NHS North East
When developing the DES, the SHA commissioned an extensive regional six month engagement exercise with disabled people that was described as good practice by the Disability Rights Commission (DRC). A local disabled user led organisation had designed and managed the project and a regional reference group of disabled and Deaf people had been established. The project had involved a range of engagement methods resulting in 47 recommendations from disabled people and staff.

3.5 Outcomes across functions

The following practices were identified as promoting equality outcomes across functions:

- Equality Performance Improvement Toolkit (EPIT) – NHS North West
- Health Equality Library Portal (HELP) – NHS North West
- Equality Impact Assessment guidance – NHS Somerset

Equality Performance Improvement Toolkit (EPIT), NHS North West

EPIT has been designed by NHS North West for use by NHS organisations in the region. The toolkit helps PCTs to self assess and report their progress towards excellence in equality of outcomes for everyone, regardless of age, disability, gender, gender identity, race or ethnicity, religion or belief, sexual orientation, or social background, as well as the progress of their service providers. Assessment is based on work towards or attainment of five goals:

- Goal 1: Increase the diversity, representation and the working lives of our workforce
- Goal 2: Develop data to monitor, information to manage and knowledge to act
- Goal 3: Develop the right services: targeted, useful, usable and used
- Goal 4: Move beyond legal compliance to initiating best practice
- Goal 5: Develop our specialists and leaders

The self assessments are intended to show North West NHS organisations' individual and collective progress on delivering real outcome benefits for all sections of the region's diverse population. The intention is that they will be easily accessible online by all stakeholders, including the Department of Health, NHS North West, PCT boards, partnership boards, the Equality and Human Rights Commission, the Care Quality Commission (CQC), as well as staff and patient groups.

Health Equality Library Portal (HELP), NHS North West

The HELP is NHS North West's central repository for up-to-date equality and diversity information. Its purpose is to:

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- Support the production of effective equality impact assessments of all strategies, policies, plans, or activities

- Support PCTs in achieving World Class Commissioning competency five: manage knowledge and assess needs

- Identify knowledge and evidence gaps

- Share best practice and policy material and prevent unnecessary duplication of effort

- Support equality and diversity leads in their roles.

The tool is for use by all northwest NHS organisations, third sector organisations, local authority organisations, and other stakeholders across the region. The HELP tool provides service planners and commissioners with detailed, relevant information relating to equality groups in the region. This should allow them to design and roll out more effectively programmes aimed at improving employee inclusion and representation and user outcomes.

Equality Impact Assessment guidance, NHS Somerset

New EqIA guidance was issued by NHS Somerset in November 2008, and a quality assurance process introduced in 2009. The process has a number of stages. Firstly, an EqIA will be completed and then accompany a policy through its approval process. A member of the relevant PCT approving committee will complete an EqIA Quality Assurance form which will be signed off by the committee's Chair. The 'Policy for the Development and Management of Procedural Documents' includes details of the PCT committees responsible for completing an EqIA quality assurance document. These committees cover all of the functions of the PCT. The Quality Assurance form and full EqIA documentation will be sent to the Patient Experience Administrator to be logged. The approved policy (with an EqIA summary only) then goes to be ratified. Once the policy is ratified the full EqIA will be published.

4. Conclusions and recommendations: lessons for the future

4.1 General conclusions and recommendations

The assessment of nine SHAs' and 19 PCTs' performance on the Race, Gender and Disability Equality Duties was based on a review of both mainstream and equalities-specific organisational policies, plans, programmes, and initiatives. The aims of the assessment were to find examples of practices that promoted equality outcomes across functional areas including commissioning, service delivery, employment, and leadership, and also provide the Commission with evidence of performance in the sector. Detailed individual reports were prepared for each authority and trust. This report provides an overarching analysis of key findings and practice examples that promote equality outcomes across functional domains.

As discussed in Section 2 of this report, a key finding of the assessment was that the majority of organisations in the sample focused their performance on the equality duties through equality schemes and seemed to adopt a tick box approach to the duties. The research revealed very little equality consideration, planning, and outcomes-reporting in mainstream strategy and policy (for example, commissioning) plans. It was therefore difficult to assess the extent of performance in key areas such as commissioning and employment. The majority of practices discussed in Section 3 addressed relative inequalities amongst race, disability, gender, and other diversity strands.

Overarching lessons drawn from the assessment include:

- Gaps in evidence of performance often came from an overly general approach with a lack of attention paid to the different elements of the general and specific duties for each of the equality groups.
- A lack of attention to equality and the lack of equality related data in mainstream and other plans and initiatives was a significant problem. In most authorities it was not apparent how work on the equality duties related to mainstream programmes and initiatives around, for example, commissioning, service delivery, employment, and leadership.

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- A lack of evidence based priorities meeting SMART criteria was an overarching concern. Many of those assessed lacked clearly identified and articulated priorities and objectives on equality. Where objectives were articulated they often lacked analysis and evidence on how those chosen had or were expected to improve equality outcomes in terms of employment, commissioning and service provision.

- The most significant omissions appeared to be in relation to transgender, transsexual, economic migrant and Gypsy and Traveller communities as well as the gender pay gap under-representation and gendered occupational segregation in employment and health inequalities stemming from gender differences.

- Limited information on progress made across the duties and organisational functions impeded the ability of the assessment to identify outcomes achieved. In some instances promising activity could be identified, but it was not clear if outcomes were being achieved or how successes were informing further work.

- The assessment suggested that many authorities were not joining up thinking and practice between regional and local health planners and equality teams to ensure that health programmes benefit from the regulatory framework and underpinning that the equality duties provide.

- It appeared to the assessment team that many authorities were failing to follow the advice and guidance available, including that from the Equality and Human Rights Commission, and that this had resulted in significant misunderstandings of what the duties required.

4.2 Key lessons for organisations' functions

In health authorities and trusts the duties are delivered across four main organisational functions:

- Leadership and governance
- Commissioning
- Employment
- Service delivery.

The assessment revealed wide ranging variations in performance across functions. It is notable that the majority of practices identified in Section 3 relate to service provision. While this may be expected, given the closeness of service delivery functions to service users, it raises concerns about the extent to which equality is embedded in the functions of the organisation with a concern that examples may operate in isolation and not as part of the core work of authorities.

In the following sections key findings and recommendations are presented that should help future health planners, commissioners, and employers, as well as the existing system of authorities and trusts, to effectively deliver performance on the duties.

4.3 Leadership and governance functions

By 'leadership and governance' we mean:

- Internal responsibilities for performance on the duties, including for the development and delivery of equality schemes and actions by SHAs and PCTs.
- SHA responsibilities for PCTs and other dependent organisations, including suppliers.
- PCT responsibilities for dependent organisations and suppliers.

Internal responsibilities

The most promising and effective schemes and practices were found in organisations where equality and diversity was led clearly, from the top. This included organisations where the equality lead was a board member and had executive functions.

The assessment showed that significant problems arose when authorities and trusts were restructured and/or when equality leads moved posts. This appeared to be the result of an insufficient overarching vision for equality and diversity programmes as well as continuity planning and talent management.

SHA and PCT responsibilities

This worked well when an SHA took a clear lead in holding PCTs to account. The only example in the sample of this being done effectively was the NHS North West EPIT tool (described above).

Overall it appeared that the SHAs and PCTs assessed are not effectively holding dependent organisations and providers to account for the duties. Overall even where contractual obligations were found to be used, they had little or no follow up in place.

Key lessons drawn from the assessment include:

- High level leadership is vital for sustainable progress to be made in performance of the duties.
- Organisations that have a core function of oversight of others (such as SHAs and, through Commissioning and purchasing PCTs) need to do more to ensure that they are meeting their obligations in relation to performance on equality.
- Planning and management on equality needs to be more clearly a key consideration during organisational restructurings, ensuring mainstream plans consider equality outcomes and ensure continuing performance of the duties.

4.4 Commissioning functions

Very little evidence of good performance on commissioning functions was uncovered by the assessment team. The assessment team therefore concluded that attention needs to be paid to all elements of the commissioning activities, including planning, contracting, and contract management.

Practices promoting equality outcomes were identified, including:

- NHS Leicester City's patient and public engagement in commissioning decisions, involving the training of 10 lay patient representatives to sit on commissioning boards.
- NHS North West's HELP tool, a central repository for up to date equality and diversity information to support, amongst other elements, PCTs in achieving high performance commissioning.

Key lessons drawn from the assessment include:

- It is apparent that many authorities have not used available guidance to support their work in this area. Authorities should use this in order to assist them to establish how the duties impact this area and identifying priorities, objectives, and actions.
- Engagement with equality and stakeholder groups was important in those assessed and organisations should seek active participation of equality groups through the creation of, for example, patient and user commissioning boards.
- It wasn't always clear how equality evidence has been used. It will therefore be important that authorities establish systems and processes by which the most relevant and up-to-date local and national evidence is used to develop priorities, objectives, and actions around commissioning.

4.5 Employment functions

The assessment showed that many authorities and trusts have failed to deliver on employment elements of the RED, DED, and GED. As discussed in Section 2, key issues include:

- Failing to collect data on and monitor workforce diversity and its relation to user and community diversity.
- Failing to establish procedures to encourage disclosure of equality characteristics.

- Failing to collect evidence on occupational segregation along gender and other lines, and failing to act if segregation is proven.
- Failing to establish and monitor effective practices for the equalisation of pay between women and men.

The assessment revealed several effective means by which these kinds of problems can be addressed. These included:

- NHS Herefordshire's inclusion of Equal Opportunities Commission guidance in its GES on employment issues including part time work, recruitment, occupational segregation, leave for carers and parents, and equal pay.
- NHS Berkshire West's SES that included key messages on employment issues relating to diverse employees, for example specific measures to develop ethnic minority staff and understanding the causes of gender imbalances at senior levels.
- NHS North West's engagement exercise with disabled staff (and user groups) while developing the DES.

Key lessons drawn from the assessment include:

- There is a need to set out clearer priorities and objectives for meeting the duties in employment policies and practices. To be effective these should be based on research, evidence and consultation with employee and stakeholder groups.
- Impact assessment to support this needs to be able to identify issues for each of the equality groups, avoid an overly generic approach and lead to the setting of actionable timeframes and targets for actions.
- Insufficient attention was paid to pay gaps.
- Reporting gaps need to be addressed so that progress can be monitored and visible, with action taken where insufficient progress is found.

4.6 Service functions

The assessment revealed a number of practices promoting equality outcomes in health for members of different equality strands. However, some failings were also identified. These included:

- Failing to make clear links between evidence and priorities, objectives, and actions – for example using specific evidence of health inequalities amongst different groups rather than generic data.
- Failing to address the health needs of different equality groups in programmes or documents addressing generic equality issues.
- Failing to consult with members of equality groups and stakeholders.
- Failing to draw links between equality schemes and initiatives and 'mainstream' health inequality schemes and initiatives.
- Failing to monitor and report on progress made towards reducing health inequalities as a result of the equality duties.

Practices promoting relative equality outcomes in health included:

- NHS Leeds' actions to support people with learning disabilities and Pacesetter projects on gender and race issues in health.
- NHS Peterborough's work with gypsy and traveller communities.
- NHS Berkshire West's SES that highlights the relationship between cultural beliefs and health.
- NHS North West's consultation exercise with regional disability groups.
- NHS East Riding of Yorkshire's Communication and Engagement Strategy.
- NHS Plymouth's Strategic Framework highlighting communication and engagement with patients and members of the public.
- NHS Coventry's Community Dental Service.
- NHS East Midlands' Pacesetters programmes.
- NHS Peterborough's Transition Strategy Group for children with learning disabilities.
- NHS Peterborough's 'The Truth About TB' campaign.

- NHS Leeds' Race for Health programmes and initiatives.

Key lessons drawn from the assessment include:

- A need to better ensure that health interventions are planned taking into account relevant equality strands and needs.
- Popular datasets such as the Index of Multiple Deprivation may not correlate with the residence patterns of equality groups. There is also a need to ensure use of datasets appropriate to the equality groups, including those that can help to determine the nature and causes of health inequalities across equality groups.
- Clear and ongoing consultation with members of equality groups and stakeholders can benefit initiatives as they are developed and rolled out.
- Monitoring of the impact and effectiveness of health inequality initiatives plus predicted and unpredicted outcomes will be important in ensuring that actions are effective in achieving equality outcomes in practice.

4.7 In conclusion

The new equality duty represents an opportunity for healthcare providers to deliver services in a way that is responsive to the diversity of modern Britain and delivers improved health outcomes and wellbeing. However, this assessment has found that although progress has been made on delivering the previous Race, Disability and Gender Equality Duties, much work across all the duties' elements and organisations' functions is still to be done. Given that the health sector, NHS, and the duties themselves are constantly evolving, the approaches developed must similarly change and improve over time. When so doing, there are several fundamental steps that organisations should take into account to ensure that all equality planning, priorities, objectives, and actions stay relevant and effective regardless of the wider changes taking place.

The lessons learnt from the assessment illustrate that several measures can be implemented to ensure that common failings and mistakes are not made, and progress is achieved. These will remain relevant regardless of the changes that might occur in the NHS and attention to key lessons will be vital over the coming months and years as the current system of SHAs and PCTs is expected to be replaced by new structures and organisations with accountability, commissioning and delivery functions.

Endnotes

[1] *Fair Society, Healthy Lives. The Marmot Review*, Strategic Review of Health Inequalities in England, post-2010. Available at: http://www.marmotreview.org/

[2] This work is undertaken under the Commission's general powers. 'Assessment' in this context does not therefore refer to assessments in the context of s.31 of the Equality Act 2006.

[3] http://www.guardian.co.uk/society/2010/aug/25/nhs-record-complaints

[4] Now the Care Quality Commission.

[5] *Fair Society, Healthy Lives. The Marmot Review*, Strategic Review of Health Inequalities in England, post-2010. Available at: http://www.marmotreview.org/

[6] These duties also extend to Wales and Scotland. However, this report only considers their application by health authorities in England.

[7] See:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

[8] See: http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx

[9] See: http://www.equalityhumanrights.com/advice-and-guidance/public-sector-duties/resources/research-on-the-duties/

[10] See: http://www.bis.gov.uk/policies/better-regulation/improving-regulatory-delivery/assessing-our-regulatory-system

[11] See: http://www.berr.gov.uk/policies/better-regulation/improving-regulatory-delivery/implementing-principles-of-better-regulation/the-regulators-compliance-code

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