

Equality Impact Assessment

World Class Commissioning
Assurance Framework

World Class Commissioning
of Primary Medical Care Guidance

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For Recipient's Use

Summary

Effective commissioning of local health services is one of the most critical functions of the modern NHS. The purpose of the world class commissioning programme is to rapidly improve the commissioning processes and performance of Primary Care Trusts, with the aim of improving health outcomes and reducing health inequalities.

This report assesses the impact of the World Class Commissioning Assurance Framework and the related World Class Commissioning of Primary Medical Care on the six key equality dimensions of race, disability, gender, age, sexual orientation and religion or belief.

In addition to utilising existing intelligence on commissioning, population health and organisational capacity in the context of equality and diversity, we sought views from a diverse group of statutory and non-statutory agencies to inform our appraisal. Feedback from stakeholders highlighted collecting data disaggregated by equality group, widening community involvement, developing organisational capacity to deliver equality and diversity and using health outcome measures to tackle health inequalities as key issues for action. Almost all respondents called for the Department of Health to include more explicit references to equality and diversity across the framework.

Our overall assessment found that an adverse impact was unlikely. However, as local populations, structures and service configurations are so varied, the Department's ability to assess the actual impacts of implementing the initiatives at a local level is extremely limited. Despite this, the assessments produced a number of recommendations for action relevant to primary care trusts, strategic health authorities and the Department of Health itself.

There are a very small number of good practice examples and no specific guidance on assessing the equality impacts of frameworks or functions. This, and the fact that the Department of Health is 'two steps removed' from the implementation of world class commissioning, added an additional element of complexity. Challenges aside, we trust that our equality impact assessment will assist others in carrying out similar work on functions and frameworks in the future.

Author and Contributors

As part of our commitment to the co-production of policy with the NHS, the World Class Commissioning Team secured additional support from Lewisham Primary Care Trust to carry out this Equality Impact Assessment.

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Contents

Summary 2

Author and Contributors 4

Contents 5

Background 7

Introduction 7

Policy Context 7

Scope 8

Methodology 8

World Class Commissioning Assurance Framework 9

Aims and Objectives 9

Relevance to Equality 9

Screening 10

Evidence Base and Stakeholder Consultation 10

Challenges and Opportunities 10

Outcome Measures 10

Competencies 11

Governance 13

Assurance Process 14

Assessment of Impact 14

Recommendations for Action 14

Department of Health 14

Strategic Health Authorities 15

Primary Care Trusts 15

World Class Commissioning of Primary Medical Care 17

Aims and Objectives 17

Relevance to Equality 17

Screening 17

Evidence Base and Stakeholder Consultation 17

Challenges and Opportunities 18

Distinctive Features of Commissioning Primary Medical Care 18

Mapping the Baseline 18

Developing the Vision 19

Making it Happen 20

Assessment of Impact 20

Recommendations for Action 20

Conclusion 22

Appendix A: Evidence Base and Stakeholder Feedback 23

Evidence Base 23

Race 23

Disability 24

Gender 25

Transgender 26

Age 26

Sexual Orientation 27

Religion or Belief 27

Organisational Issues 28

Stakeholder Feedback 29

Data Collection 29

Embedding Equality 29

Outcome Measures 30

Community Involvement 30

Organisational Capacity and Development 31

Organisations consulted as part of this Equality Impact Assessment 32

References 34

Background

Introduction

1. Equality Impact Assessment (EqIA) is a tool aimed at improving the quality of local services, by ensuring public bodies systematically consider the actual or potential impacts of their policies and practices on certain communities or population groups. Organisations are required to take action to mitigate or eliminate the negative impacts and maximise the positive impacts or opportunities for promoting equality.
2. The duty to undertake race, disability and gender impact assessment is enshrined within the Race Relations (Amendment) Act 2000, Disability Discrimination Act 2005 and Equality Act 2006 respectively. This EqIA also considers the possible impacts on age, sexual orientation and religion or belief.
3. The purpose of this EqIA is to inform the future development of two commissioning initiatives so that, as far as possible, their implementation (a) does not generate or exacerbate inequities in access to healthcare or health outcomes, and (b) supports local efforts to reduce health inequalities and promote equality. These initiatives are the **World Class Commissioning Assurance Framework**, and a closely related guidance document, **World Class Commissioning of Primary Medical Care**.

Policy Context

4. Improving commissioning is at the heart of the future strategic direction for delivering healthcare. The interim report from the NHS Next Stage Review signalled where we are going in the journey towards an improved NHS. It talked about an NHS that is fair, personalised, effective and safe, and which is focused relentlessly on improving the quality of care.
5. The World Class Commissioning programme sets out a new approach to commissioning for health and care services - investing NHS funds to secure maximum health gain. The programme will bring about a step change in commissioning, ultimately improving health and well-being outcomes and dramatically reducing health inequalities.
6. The vision and organisational competencies for World Class Commissioning were developed in partnership with the NHS and its partners and published on 3 December 2007. The documents set out what a World Class Commissioning organisation will look like and list the knowledge, skills, behaviours and characteristics Primary Care Trusts (PCTs) will need to demonstrate. This was followed by the launch of the World Class Commissioning Assurance Framework in June 2008, the performance and development system aimed at showing whether PCTs are improving as commissioners of better health outcomes.
7. The Next Stage Review Primary and Community Care Strategy also outlines the vision for developing high quality, integrated primary care services that are responsive to the needs of local communities. To clarify and support the application of the World Class Commissioning programme to primary care, we will be developing a implementation framework, accompanied by a series of practical 'How To' guides and complimentary

master classes. Successful local development of practice-based commissioning (PBC) is a critical element of this strategy. We also plan to reframe and reinvigorate PBC to increase GP practice engagement, placing it at the heart of World Class Commissioning.

8. 'Health Inequalities: Progress and Next Steps' sets out how the World Class Commissioning programme can make a direct and powerful contribution to the reduction of inequalities to 2010 and beyond, for example, through planning based on evidence of need, working with local partners to tackle inequalities and commissioning services responsive to the needs of disadvantaged groups. The impact assessment carried out on that policy will also inform this report¹.

Scope

9. This Equality Impact Assessment (EqIA) will focus on the policy documents or guidance for each initiative, which are listed below:

<i>Initiative</i>	<i>Relevant Document</i>
World Class Commissioning Assurance Framework	Commissioning Assurance Handbook ²
World Class Commissioning of Primary Medical Care	Draft guidance document

Methodology

10. We have used the Department of Health toolkit, developed by the Equality and Human Rights Team, as a guide for completing this EqIA³.
11. The two initiatives are closely related, in terms of their relationship to the World Class Commissioning programme and the evidence that informs each impact assessment. Both the evidence base and the feedback from stakeholders will be summarised within a separate appendix to this report (Appendix A). We have referred to this evidence within each impact assessment as appropriate.
12. The World Class Commissioning Team will review and update this EqIA to reflect any equalities issues arising from the implementation of World Class Commissioning.

¹ The policy and accompanying equality impact assessment can be found at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085307

² The assurance handbook can be found at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085148

³ Department of Health (2008) ***Equality Impact Assessment: Summary, Tool and Guidance for Policy Makers.***

World Class Commissioning Assurance Framework

Aims and Objectives

Aim:

To drive the performance and development of PCTs as they move towards becoming world-class commissioning organisations.

Objectives:

(a) To assess PCTs' performance across four areas:

- The improvement in health outcomes of their local populations;
- The organisation's competency in carrying out commissioning processes;
- The organisation's governance arrangements;
- Their potential for improvement in the above areas.

(b) Through assessment, to help PCTs:

- Identify areas of development;
- Act to fill gaps in their capabilities.

Relevance to Equality

13. At the heart of World Class Commissioning is the belief that the way in which health services are commissioned can have a profound effect on the extent to which health is improved and inequalities are reduced. A number of the assurance competencies for World Class Commissioning explicitly support the aim of reducing health inequalities. Specifically:

- Competency 2 (work with community partners) - PCTs should "work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities";
- Competency 3 (engage with public and patients) – the PCT "proactively challenges and, through active dialogue, raises local health aspirations to address local health inequalities and promote social inclusion";
- Competency 4 (collaborate with clinicians) - the PCT "oversees and supports PBC decisions to ensure effective resource utilisation, reducing health inequalities and transforming service delivery";
- Competency 5 (manage knowledge and assess needs) - the PCT must have a "robust ongoing Joint Strategic Needs Assessment demonstrating a full working understanding of the current and future local population's health and well-being needs, especially relating to relative inequalities in health outcomes and experience";
- Competency 6 (prioritise investment) – the PCT "identifies and tackles inequalities of health status, access and resource allocation".

14. As part of the World Class Commissioning programme, all PCTs will be working towards achieving these competencies. Their performance will be assessed as part of

the World Class Commissioning assurance system, to ensure that all PCTs are improving their commissioning capability. In order to achieve 'world class' status therefore, PCTs will need to have demonstrated that they are undertaking a full assessment of the needs of their population, and prioritising investment in order to reduce health inequalities.

Screening

Could this policy have a significant impact on equality?

15. The positive or negative impacts that the World Class Commissioning Assurance Framework could have on particular groups will be highly significant, in terms of:
 - the number of people who will ultimately be affected by the framework
 - the resources involved
 - the extent of the change
 - its wider public policy implications.
16. However, as we are assessing the impact of a framework that we will not directly implement, our ability to mitigate possible negative impacts is limited by the inevitable local differences there will be in applying the framework, such as:
 - Population – local demographics, rural/urban, levels of deprivation
 - Commissioning arrangements – systems, resources, expertise
 - Service delivery – local service configuration, health professional/patient ratios
17. Having said this, we can use the assurance framework to encourage and support activity that promotes equality and reduces inequality at a local level.

Evidence Base and Stakeholder Consultation

18. As stated within the **Methodology**, the evidence base and stakeholder feedback has been summarised in Appendix A of this report.

Challenges and Opportunities

Outcome Measures

19. Reducing health inequalities is central to the World Class Commissioning programme. The metric given for measuring health inequalities is the average Index of Multiple Deprivation (IMD) score⁴. There are some possible risks associated with this approach:

⁴ The Index of Multiple Deprivation 2007 combines a number of economic, social and housing indicators into a single deprivation score for each area in England. This allows areas to be ranked relative to one another according to their level of deprivation.
(<http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/>)

- IMD is a relative measure of deprivation, which means that a locality can be ranked lower or higher, not due to its own efforts to reduce inequalities but because other areas have improved or worsened.
- IMD scores compare geographical inequalities only. This metric provides no way of measuring reductions in some of the entrenched inequalities experienced by specific communities or groups, for example, minority ethnic communities and mental health, adults with learning disabilities and access to appropriate services.
- The focus on IMD scores to measure health inequalities could lead to a reduced emphasis on inequalities in specific health outcomes. For example, inequalities in cardiovascular disease (CVD) mortality (geographically or for particular population groups) may be overlooked because the metric for CVD focuses on maximising general health improvement rather than the reduction of the gap.

20. To mitigate these possible risks, the Department could encourage PCTs to include a focus on reducing the inequalities gap for each outcome measure selected. Trusts also have the option of selecting up to three locally defined indicators that more closely reflect their health priorities. Where appropriate, these could be used to focus activity on reducing gaps in health outcomes.

Competencies

21. Although health inequalities featured quite strongly across the framework, it is clear from consultation that stakeholders wish to see the promotion of equality and diversity embedded within the competencies. Individuals feared that without having a clear steer from the framework, equality issues might be overlooked, particularly if there is little or no specialist equality and diversity capacity within the PCT.
22. Competency 1 refers to the leadership role of the PCT and its ability to steer the health agenda locally and influence at all levels.
23. Evidence shows that there are significantly different levels of satisfaction with primary care services among minority communities compared to satisfaction levels as a whole. When seeking the views of the local population on improvements to services, disaggregating feedback - by ethnicity, disability and gender at least – would allow PCTs to see whether satisfaction levels are improving across the board or just among certain communities.
24. The inclusion of a strong equalities element within commissioning training programmes would give staff a clearer understanding of the health inequalities within their locality, and how their commissioning plans could contribute to reducing the inequalities gap and promoting equitable access to services. It is important that commissioning staff also have equal access to any training and development opportunities identified through the World Class Commissioning programme.
25. Competency 3 relates to engaging with patients and the public. In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, PCTs will need to engage the public in a variety of ways, openly and honestly. They will need to be proactive in seeking out the views and experiences of

the public, patients, their carers and other stakeholders, especially those least able to act as advocates for themselves.

26. This competency states that PCTs will need proactive listening and communication skills to address the needs of all relevant stakeholders, including using third sector and community partners to seek and engage the voice of those who are seldom heard. PCTs will need to demonstrate evidence of engaging hard-to-reach groups, such as through the Healthcare Commission's 'Data quality on ethnic groups' indicator. They should also use community profiles that proactively identify and seek out communities that experience the worst health outcomes, and through dialogue and engagement raise local health aspirations. By becoming world class in this competency, PCTs will be able to encourage participation of all members of their local community in commissioning decisions, sharing their experiences of health and care services and helping to decide local investment priorities.
27. Core competency 5 for World Class Commissioning relates to managing knowledge and undertaking robust and regular needs assessments in order to establish a full understanding of current and future local health needs and requirements. Commissioning decisions should be based on sound knowledge and evidence. By identifying current needs and anticipating future trends, PCTs will be able to ensure that current and future commissioned services address and respond to the needs of the whole population, especially those whose needs are greatest. The Joint Strategic Needs Assessment (JSNA) will form one part of this assessment, but when operated at world class levels will require more and richer data, knowledge and intelligence than the minimum laid out within the proposed duty of a JSNA.
28. By becoming world class at this competency, this will in particular, help to ensure robust and ongoing Joint Strategic Needs Assessments, demonstrating a full working understanding of the current and future local populations health and well-being needs, especially relating to relative inequalities in health outcomes and experience. It will also enable the mapping and identification of areas of greatest need and relatively poorest health and well-being access and outcomes. PCTs will need to invest in the necessary systems and expertise to effectively segment their population, in order to identify these communities.
29. Competency 6 states that PCTs should prioritise investment according to local needs, service requirements and the values of the NHS. By having a clear understanding of the needs of different sections of the local population, PCTs, with their partners, will set strategic priorities and make investment decisions, focused on the achievement of key clinical and health and community outcomes. This will include investment plans that address the areas of greatest health inequality.
30. The criteria used to prioritise investment, and their application, need to be carefully considered. There is a risk that the considerable health inequalities experienced by particular groups or communities may not score as highly in the prioritisation process due to the size of the population or the lack of quantitative data with which to make a robust commissioning case. Conducting equality impact assessments of investment proposals could assist PCTs in demonstrating how the reduction of health inequalities has informed investment decisions.

31. Competency 7 focuses on the stimulation of the local health economy to meet demand to secure improved health outcomes. Encouraging the third sector to provide health services is an important aspect of this competency. A considerable number of these agencies provide services tailored to specific communities or are managed by people from minority groups – or both. It is important the processes and criteria employed to identify potential delivery partners do not inadvertently screen out these smaller, not-for-profit organisations.
32. Generally, third sector organisations are often well positioned to provide more personalised, cost-effective and culturally appropriate services, based on specialist knowledge, experience and skill. PCTs should be made aware of this strength when developing their strategies to increase the choice of healthcare provision available to patients.
33. Competency 8 requires PCTs to promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration. This will include developing innovative services and care pathways that are able to respond to the needs of different groups and individuals.
34. Competency 9 outlines the requirements for effective procurement. Legislation clearly states that when a public agency contracts out a public service (to which an equality duty applies), the relevant obligations need to be passed on to the contractor, such as the collection to data in order to monitor access and outcomes by ethnicity, disability and gender. These obligations should be clearly stated in the contract conditions. The Office of Government Commerce gives clear and useful guidance on how to effectively incorporate equalities and other social issues into all stages of the procurement process. A key message of the guidance is to consider equality from the outset, not just at the stage when contract conditions are being finalised.
35. Competency 10 focuses on performance and contract management, including the collection and use of data. Collection of data on service use is critical, as this provides quantitative evidence of progress towards improving access and health outcomes and reducing health inequalities. Legislation obliges PCTs to monitor the impact of its services on people from different ethnic backgrounds, people with disabilities, men and women. Performance data should be disaggregated by ethnicity, disability and gender in order to facilitate this.

Governance

36. The governance element of the assurance framework contains three main components: strategy, finance and board. How to guides and checklists are available to PCTs to assist them in developing plans in each of these areas.
37. The reduction of inequalities is an underlying theme that runs throughout the strategic plan checklist. A number of the 'exhibits' (illustrative examples of narratives that could be found within a strategic plan) also support this theme and act as good practice examples of how action to tackle health inequalities can be embedded within commissioning strategies. The document also recommends appropriately disaggregating information on the population, disease incidence and prevalence and access to/use of services by key population segments such as age, gender, socioeconomic status and ethnicity.

38. Section 4 of the checklist refers to the goals and their supporting initiatives, including reviewing their overall impact on health outcomes and inequalities. Carrying out equality impact assessment on each initiative could be a way of identifying the impacts for those groups that often experience worse health outcomes than the general population, such as black and minority ethnic communities, people with disabilities and long-term conditions and older people.
39. Evidence indicates that there is a possible capacity gap in the NHS around equality and diversity, and capability and knowledge gaps around equality impact assessment. These areas could be addressed through the '7S' framework of levers, in particular through skills and staff. In developing the PCT Board Development Framework, we assessed providers on the extent to which they will incorporate equality and diversity into board-level support. We encourage PCTs to use a similar approach at a local level when buying in skills or training.

Assurance Process

40. The panel day is the focus of the assurance process, where PCTs are assessed against their chosen outcome measures, the commissioning competencies and governance components. We have drafted guidance to assist panels in carrying out their role, including a number of sample questions. As tackling health inequalities is one of the principle aims of World Class Commissioning, it would be appropriate for assurance panels to prepare a line of questioning on how the outcome measures of the PCT's strategic plan are related to its health inequalities priorities and equality scheme objectives.

Assessment of Impact

41. An adverse impact is unlikely. On the contrary, there is potential to reduce barriers and inequalities that currently exist. There is insufficient evidence, however, for this assessment to be made with as much confidence as is desirable. The Department's ability to assess the impact of the commissioning assurance framework is limited primarily due to the varied nature of PCT populations, commissioning arrangements and service configurations.

Recommendations for Action

42. Although the World Class Commissioning Assurance Framework is now in place, the following actions could improve its potential to reduce inequality and promote equality and diversity:

Department of Health

43. Future iterations of the assurance framework should contain explicit references to equality and diversity duties within the existing competencies and the governance element. These references should be relevant to each competency or governance area and, where appropriate, highlight existing legislative obligations, policy and best

practice. The Department should also consider adding equality schemes to the document checklist of supporting evidence.

44. Indices of Multiple Deprivation (IMD) measure geographical inequalities, but provide no measure of inequalities experienced by different population groups or communities. The Department of Health should encourage broader and more comprehensive approaches to measuring reductions in health inequalities that go beyond the use of average IMD scores.

Strategic Health Authorities

45. To reflect the framework's emphasis on health inequalities, assurance panels should be encouraged to prepare and ask questions on the relationship between a PCT's chosen outcome measures, its local health inequalities priorities and equality scheme objectives.

Primary Care Trusts

These are the recommendations that we would encourage PCTs to consider when implementing World Class Commissioning at a local level:

46. The robust collection of quantitative and qualitative data is central to PCTs' ability to commission world class health services. PCTs should prepare to invest in the necessary systems and expertise to enable effective identification and segmentation of their local populations by healthcare needs. Performance data should be disaggregated by ethnicity, disability, gender wherever possible, in order for PCTs to monitor the impact of its commissioned services on the corresponding population groups.
47. Through their organisational plans, PCTs should ensure that they have sufficient equality and diversity capacity to support the commissioning function. This should include both training and development for commissioning managers (with particular emphasis on conducting Equality Impact Assessment) and specialist/dedicated support
48. The criteria used by PCTs to prioritise investment should encourage the equitable allocation of resources according to need, and avoid exacerbating existing health inequalities. This is particularly important when considering the healthcare needs of smaller, hard to reach communities or groups, where local data and intelligence may be more difficult to obtain.
49. Promotion of equality and diversity should be considered throughout the procurement process, from the initial stages of identifying service needs through to contract monitoring. The equality duties relevant to the provider need to be explicit and clearly stated within PCT's contract conditions.
50. PCTs should consider the unique strengths of third sector providers when developing strategies to increase choice of healthcare provision. Voluntary sector organisations can often provide cost effective and culturally appropriate services tailored to the needs of specific groups or communities.

51. PCTs are strongly encouraged to assess the impacts of their strategic plans and individual programmes of work ('initiatives') on key equality groups.
52. Promoting equality and tackling health inequalities should be a 'golden thread' running through all World Class Commissioning board support programmes; PCTs should ensure that training and development providers possess the necessary expertise to deliver in this area.

World Class Commissioning of Primary Medical Care

Aims and Objectives

Aim:

To rapidly enhance the skills of PCTs in commissioning primary and community care.

Objective:

- (a) Produce a practical framework document for the world class commissioning of primary medical care

Relevance to Equality

53. Primary care is the collective term used for the community-based health services that are often the first point of contact that patients make with the NHS, such as family doctors (GPs), practice nurses, pharmacists, dentists and midwives.

54. We know that:-

- 99% of the population is registered with a GP
- 90% of all contacts within the NHS take place within primary care
- 80% of people who use NHS services are treated within general practice

55. The commissioning of primary healthcare services clearly has a direct and significant impact on the health and well-being of all communities. However, evidence shows that not all population groups have equal access to primary care services or experience equality in health outcomes. It is therefore important that any guidance on improving primary care commissioning is informed by an assessment of the possible effects on specific groups and communities that have experienced discrimination or disadvantage.

56. This guidance is the first in a series of documents aimed at giving practical advice to PCT Boards and managers on commissioning primary and community care. Although each guide will have a specific focus, it is envisaged that this EqIA will also inform the development of future guidance documents.

Screening

Could this guidance have a significant impact on equality?

57. This guidance has the potential to significantly impact on the health and well-being of specific equality groups. However, World Class Commissioning of Primary Medical Care is a guide rather than an obligatory national framework; the impact will be dependent on how individual PCTs utilise the guidance at a local level. However, we can use this document to encourage and support activity that promotes equality and reduces health inequalities.

Evidence Base and Stakeholder Consultation

58. As stated within the **Methodology**, the evidence base and stakeholder feedback has been summarised in Appendix A of this report.

Challenges and Opportunities

Distinctive Features of Commissioning Primary Medical Care

59. The guidance touches on the 'dual status' of GPs and other primary care providers: on one hand legally independent contractors and on the other, an integral part of the NHS 'family'. This has often led to confusion regarding the responsibilities of providers with respect to equality and diversity. Legally, PCTs are ultimately accountable for the services they commission, however recent developments, such as practice-based commissioning and LIFT⁵, have added another layer of complexity to this relationship.

Mapping the Baseline

60. Assessing health needs of the local population is the first stage in the commissioning cycle and Joint Strategic Needs Assessment is highlighted as the vehicle for identifying these needs. The JSNA can give a high-level picture of need; however further work will be necessary to determine the specific needs of the groups and communities identified through the JSNA. Access to good quality segmented data, and the specialist support to analyse it, is critical to effectively assessing health need.

61. The guidance states that the key datasets necessary for completing the baseline exercise of what services are currently commissioned include:

- Capacity
- Clinical quality
- Access
- Patient choice
- Patient experience
- Value-for-money
- Premises
- Demand
- Enhanced services

62. When considering capacity, e.g. number of GPs per 1000 weighted population, areas with large gypsy, traveller or migrant worker communities may need to factor these communities into their calculations, as they are often poorly represented in official statistics. In addition, these communities tend to have far lower percentages of GP registrations than the general population.

63. Access to primary care is a key issue for most service users. The guidance gives a number of examples of how access can be measured, including opening times, 48 hour access and uptake of extended hours. It may also be useful to examine the percentage of non-attendances, as this may highlight additional access issues. For

⁵ Local Improvement Finance Trust – this is a public private partnership (PPP) arrangement that allows the NHS to develop new primary care facilities in new locations.

example, evidence shows that deaf patients can often miss appointments because they are unable to hear waiting room announcements.

64. Physical access to premises is also important. The Disability Equality Duty states that public organisations must make 'reasonable adjustments' to ensure that their services are equally accessible to disabled people as they are to other members of the public. This may require physical adjustments, such as the installation of ramps or levelling surfaces, widening entrances and exits, rearranging public spaces (e.g., reception areas), or the use of induction loops and other auxiliary aids. Where physical changes to premises are not possible, then adjustments can also be made to the manner in which services are delivered, even if this results in more favourable treatment for disabled people. An example of this could be a practice nurse arranging a home visit for a patient who has a walking difficulty.
65. In addition to locally enhanced services, the Department of Health negotiates a number of national directed enhanced services⁶ (DES) that GP practices can opt to deliver. Guidance has recently been issued on five new clinical DES, including three for:
- collecting data on ethnicity and first language of all practice patients
 - health checks for people with learning disabilities
 - extended practice opening hours
66. These new DES present PCTs with a valuable opportunity to improve the quality and quantity of data collection for two population groups that experience considerable inequalities in access to services and health outcomes. Maximising take up of each DES at a local level would facilitate more robust analyses of primary care service use and assessment of healthcare needs for these communities.
67. Finally, overlaying local needs assessments with current patterns of service provision to identify key health or investment issues must involve the use of segmented data, in order to identify underserved population groups as well as geographical areas with poor access to services.

Developing the Vision

68. The 'patient offer' is expected to set out the provision available to and guarantees for primary care service delivery. This can be used as an opportunity for PCTs to outline the support available to service users accessing primary care, for example, translation services and auxiliary aids. Enhanced, non-core services should also highlight the provision available for specific groups, for example, sexual health clinics for young men, mental health services for Black women, and could be linked to the take up of the new directed enhanced services.
69. It is important that the patient offer is available in a variety of formats and community languages. Local voluntary sector health groups, health trainers and community health activists also need to be fully briefed on its contents, as they regularly act as local 'signposts', directing (often vulnerable) individuals to the most appropriate primary and community care services.

⁶ <http://www.nhsemployers.org/pay-conditions/primary-893.cfm>

Making it Happen

70. The performance management process for primary and community care providers needs to embed equality and diversity objectives in an explicit and measurable way. Compliance with existing legislation and regulators' core standards should be incorporated as a minimum, however, any equality standards agreed with providers should be considered as integral to good performance rather than 'secondary' or aspirational requirements. PCTs could also seek to incentivise particular equality standards in order 'fast track' change or support innovative activity in this area.
71. When developing performance metrics, PCTs may wish to consider the use of relative measures as well as absolute ones. The weakest practices can often be in the poorest areas, where the burden of ill health and levels of deprivation are highest; expecting similar levels of health improvement to their more affluent neighbours may not be feasible. Having said this, challenging development programmes, with the accompanying PCT support, should be put in place for these areas, in order to obtain (and maintain) equitable levels and standards of healthcare.
72. The guide recommends a balanced scorecard approach to assessing performance and suggests that developing a local scorecard is an opportunity to discuss wider performance issues, improvements to process and future priorities. This process could also be extended to representative groups of service users (e.g. local LINKS groups), who may also have strong views on what they consider valuable local measures of performance. The performance management process for primary and community care should also be a developmental process. In addition, the specialist skills on offer from the PCT should also include support to embed the reduction of health inequalities and promotion of equality and diversity.
73. Where possible, the views of local communities must be actively sought and used to inform local commissioning decisions. For example, although some communities might benefit from a less traditional model of care, other may wish to access care through existing services, provided key access issues are resolved.

Assessment of Impact

74. An adverse impact is unlikely. On the contrary, there is potential to reduce barriers and inequalities that currently exist. However, this positive impact is dependent on the extent to which the guidance is implemented at a local level.

Recommendations for Action

We would encourage PCTs to consider these recommendations when commissioning primary medical care at a local level:

75. Joint Strategic Needs Assessments will highlight the high level health and social care needs of the local population. However, PCTs may need to secure additional capacity and expertise to support more detailed needs assessments for specific communities or conditions to inform primary care commissioning.

76. The relationship between PCTs and their primary care providers is a complex one, therefore it is important that both parties understand their respective roles and responsibilities regarding equality and diversity. These should be clearly outlined within the service contract, and any accompanying performance metrics are discussed, agreed and signed off as part of the performance cycle.
77. PCTs should ensure that providers are aware of the legal duty to make 'reasonable adjustments' so that disabled people have equal access to primary medical care. Adjustments may require physical adaptations to premises, use of auxiliary aids or changes to the way services are delivered.
78. PCTs should encourage the local uptake of the directed enhanced services for ethnicity, learning disability and enhanced opening hours access, linking them to the standards and services set out in the 'Patient Offer'.
79. The Patient Offer should be widely publicised, with copies produced in various format and principal community languages. PCTs should also brief community health workers on its contents.
80. PCTs should actively seek the views of local communities at various stages of the commissioning process, e.g. when assessing health needs, developing models of care and agreeing performance metrics.

Conclusion

A number of key issues have emerged from this equality impact assessment of the assurance framework and primary medical care guidance that we believe could be relevant to other World Class Commissioning workstreams.

Firstly, equality and diversity needs to be explicitly incorporated into emerging programmes of work. Not only are implicit messages likely to be overlooked or overshadowed by other priorities, commissioners who wish to be proactive in this area are left without the necessary policy levers required to initiate change.

Secondly, the collection of good quality disaggregated data and community intelligence is central to effective commissioning. The health needs of disadvantaged groups cannot be accurately identified without access to data that is appropriately segmented or meaningful dialogue with the communities themselves.

Thirdly, PCTs require sufficient equality and diversity capacity to support commissioning effectively at a local level, be it learned, shared or bought in. The role of Strategic Health Authority equality and diversity leads also needs to be clarified, so that any local support complements (rather than duplicates) their regional function.

A considerable number of stakeholders were disappointed that a retrospective impact assessment was carried out for an initiative of this significance. Although opportunities remain to influence the implementation of world class commissioning, we acknowledge that equality impacts are best assessed at the policy development stage. Despite this, other stakeholders felt that the actual approach to undertaking the EqIA - a combination of impact assessment training and short-term, intensive support seconded from the NHS - was a good practice model that could be rolled out across other teams.

Finally, although public bodies have a duty to assess the impact of all relevant practices, EqIAs of organisational functions are extremely rare. We encourage NHS Trusts and other healthcare providers to build on our work so that the examples of impact assessments available to the health service can accurately reflect the breadth of its activities.

Appendix A: Evidence Base and Stakeholder Feedback

Evidence Base

There is very little intelligence on the impact of commissioning frameworks on health inequalities or the promotion of equality; most evidence focuses on the effectiveness of commissioning processes or cost and quality of commissioned services.

A study of European health systems conducted by Figueras, Robinson and Jakubowski (2005) found that although there were some advantages to devolving aspects of commissioning, other functions, such as public health and equity, demanded a national approach. A similar study of the health system in New Zealand found that a separation of commissioner and provider roles opened up the system to new providers offering services for specific population groups, for example, the Maori community.

In his overview of health care commissioning systems, Ham (2008) highlighted population profiling according to risk in order to develop relevant prevention and disease management interventions as a key skill required by commissioners. However, this level of profiling requires robust, segmented quantitative and qualitative data on the health of local communities.

Race

The UK is more ethnically diverse now than ever before. Approximately 11% of the population of England and Wales is from a black and minority ethnic (BME) background. The 2001 Census indicated that, owing to their in-migration as young adults from the 1950s and the younger profile of BME communities, there will be a significant increase in the numbers of BME older people in the coming decade, particularly among African Caribbean and South Asian communities. The numbers of BME elders in London is projected to treble between 1991 and 2011.

Risk factors and disease patterns vary between ethnic groups, for example:

- South Asians, particularly Bangladeshis and Pakistanis, have significantly higher CHD prevalence and mortality than the general population.
- Although people of African-Caribbean descent have a low prevalence of CHD compared with the white population, they have much higher prevalence of and mortality from hypertension and stroke.
- South Asians (particularly Pakistanis and Bangladeshis) and African-Caribbeans have a three to six-fold higher prevalence of Type 2 diabetes. The quality of care is reportedly inadequate for Asian and African-Caribbean patients, with poor compliance caused by inadequate information, leading to patients' lack of knowledge about disease management.

The ODPM⁷ Social Exclusion Report 'A Sure Start to Later Life: Ending Inequalities for Older People' highlighted that ethnic minorities - across all ages - are more likely to be in poor general health, particularly those from Pakistani and Bangladeshi communities. The report also stated the Policy Research Institute on Ageing and Ethnicity has commented

⁷ Office of the Deputy Prime Minister (now Communities and Local Government)

that 'Black and minority elders do not enjoy the same quality of life of their peers, continue to have many unmet needs, from care to quality of life issues, which reduce their potential for participation...'.

There is evidence of unequal access to services according to ethnic origin. People from most black and minority ethnic groups are less likely than White-British people to use hospital services, for example compared to 26% of white British people using hospital services in the previous year, 18% of those from an Indian background, 18% from a Bangladeshi background and 23% of those from a Pakistani background did so. However, a higher proportion (31%) of people from a Black Caribbean background used hospital services in the last year. These statistics will partly reflect the age profile of these different groups, the prevalence rates discussed above and perception and cultural attitudes to using health services.

'Count Me In 2007', the third national census of in-patients in mental health and learning disability services found that 22% were from minority ethnic groups – double the percentage within the national population. Black Caribbean patients experience particularly stark inequalities in access to appropriate mental healthcare, and as a result, suffer higher rates of admission, referrals via the criminal justice system and detention under the Mental Health Act than other ethnic groups. Conversely, there is evidence that some BME groups are less likely to be referred to primary and secondary psychological (talking) therapies. The impact of delayed access to timely and appropriate services is that service users are more likely to be at a crisis point when entering services rather than accessing through a managed care pathway.

There are also marked differences in satisfaction with primary care services. People from BME groups report significantly worse access than the White British population. Performance on access is worst for people from Pakistani or Bangladeshi backgrounds: 10-20 percentage points below the access reported by people from White British backgrounds. 'No Patient Left Behind' outlined some of the key issues preventing certain BME groups obtaining equal access to primary care services, including dysfunctional communication between healthcare organisations and patients and poor NHS links with local communities.

Although there are clear differences in health outcomes between different ethnic communities and between BME groups and the general population, closer examination of these inequalities also reveals significant differences *within* ethnic groups. In addition, the third or fourth generation of the more established BME communities are still experiencing the same inequalities as their forbears. This indicates that we cannot cite 'cultural differences' or genetic disposition alone as explanations for these disparities; we must also consider the collective experiences of these communities. For example, people from minority ethnic communities often experience discrimination and socio-economic disadvantage (e.g. lower incomes), both of which can have a substantial impact on health.

Disability

Disability affects the length and quality of life, and can adversely affect access to services. There is heterogeneity amongst disabled people arising both from variations in impairment and from variations in socio-demographic characteristics. Disabled people generally fare less well than non-disabled people do across a wide range of indicators and opportunities.

The lack of inclusion of disability in routine recording makes it difficult to measure equity of access and treatment for disabled people.

- Almost 1 in 5 (18%) people in the 2001 Census reported a long-term illness or disability that restricted their daily activities.
- Many older people with learning disabilities begin the ageing process at an earlier age than the general population. About a third of people with Down's syndrome may be expected to show clinical signs of dementia, which may begin in the early thirties and involve rapid deterioration in health.

People with learning disabilities experience the full range of health problems as experienced by the general population. People with learning disabilities are also more predisposed to mental health problems and some long-term conditions. However, entrenched inequalities exist in access to health services and health outcomes, as highlighted in Mencap's 2007 report, 'Death By Indifference', where a lack of adequate or appropriate access to services resulted in the deaths of six people with learning difficulties.

Although people with sensory impairments experience unique difficulties in accessing services, these can often be easily overcome through relatively small, local adjustments. For example, approximately 24% of people who are deaf or hard of hearing miss GP appointments because they cannot hear their names being announced. Deaf people also experience difficulties when booking appointments due to the increased use of automated telephone booking systems.

Gender

There are particular issues around risk factors and access for both men and women. For example:

- Men live, on average, about five years fewer than women (75.4 and 80.2 years respectively).
- While women can expect to live longer than men, they are also more likely to have more years in poor health. On average, males in England spend 59.1 years in good health and 15.9 years in poor health; for women the corresponding figures are 61.4 years and 18.6 years.
- The gender difference in life expectancy is greatest in deprived areas.

Working age men use hospital services less than women, but men aged over 65 use hospital services relatively more. For those under 65, there are 210 outpatient first attendances for every 1,000 men, compared to 310 for every 1,000 women. However, for those over 65, there are 490 outpatient first attendances for every 1,000 men, compared to 480 for every 1,000 women.

Perceptions of risk factors between men and women are an issue that may affect health outcomes. For example, there is evidence that people perceive vascular disease as a problem for men. In fact, women's levels of risk catch up with men's at the menopause. Women also tend to present later and their symptoms are not always recognised, leading to late diagnosis and poorer outcomes.

There are no significant differences in reported satisfaction with primary care services when analysed by gender. More comprehensive primary care services have generally delivered reduced health inequalities.

Transgender

Although data and research are limited, we know that trans people experience inequalities in access to healthcare and health outcomes, often related to the discrimination they often receive from health professionals and the public.

Two key health issues for trans people are self-harm and suicide. In addition, male to female trans people can be subjected to violent attacks, as they are often 'visibly' trans for a number of years before living full time in their preferred gender role.

Accessing appropriate care can be problematic, in terms of both the services offered and the attitudes that trans people encounter. Trans service users are often excluded from potentially life-saving cancer screening programmes (cervical, breast, prostate) or are not given information about important general health and well-being issues because of the preconceptions of healthcare staff.

Age

Children and young people under 16 years of age comprise just over 20% of the national population.

Many of the health inequalities faced by children are directly linked to poverty. For example, children and young people from poorer backgrounds are more likely to become obese, suffer from tooth decay and develop mental and emotional health difficulties. They are also more likely to grow up in a household exposed to tobacco smoke and to begin smoking at a young age. Young people from deprived backgrounds are also more likely to become teenage parents, and children of these parents tend to have poorer health outcomes.

We know that there are particular groups of children and young people who experience considerable inequalities in outcomes and access to services, such as children in care, children with learning disabilities, young refugees or asylum seekers and children from some minority ethnic communities (e.g. Black Caribbean). An example of this is access to appropriate mental health services; a recent interim report from the national CAMHS⁸ review stated that ensuring vulnerable children have swift and easy access to appropriate services remained a key challenge.

The Healthcare Commission's national health survey of local health services 2008 found that 38% of younger people aged 16-35 years stated that found GP practice opening times inconvenient. Also, when attempting to access their GP surgery by 'phone, 50% reported experiencing difficulties some or all of the time.

People aged 65 years and older account for 16% of the national population (2001 Census). By 2024, this is likely to increase to 40%.

⁸ Children and Adolescent Mental Health Services

Many risk factors for poor health, such as obesity, hypertension, disability and poverty increase with age:

- The prevalence of most acute and chronic diseases increases with age including cancer, cardiovascular disease, diabetes, suicide, and dementia. Older people also often suffer co-morbidities.
- The proportion of people with a long term illness or disability that restricts their daily activities increases with age. About 3.5 million people aged 65+ have a limiting longstanding illness or disability.
- Older people accounted for 47% of the 4,000 accidental deaths at home in 1999, and suffered the largest number of fatal injuries (62%).

These risk factors are reflected in the percentage of 65 year olds using hospital services in the last year (36%) compared to adults aged less than 65 years (23%). Despite this, there were still significantly more people aged under 65 being referred to hospital care (6.7 million people aged 16-64 years) compared to those over 65 years (2.6 million). Also, when older people used care, they did so more intensely – despite people aged over 65 years accounting for 16 per cent of the population, they used 27 per cent of all outpatient first attendances, 36 per cent of all inpatient episodes and 64 per cent of all emergency bed days.

Older people have highlighted the difficulties they face in accessing health and care services. This may be a challenge due to poor transport networks, limited mobility, or in some areas due to lack of local services. Research has highlighted that the number of GP consultations for rural older people is low, but emphasises that it is not clear whether this is due to good health or limited access to primary care facilities.

Sexual Orientation

There is currently limited data available on the health and well-being of lesbian, gay and bisexual people (LGB). Smaller studies have found that rates of smoking and level of substance misuse are higher among LGB people than within the general population, and that access to appropriate sexual and mental health services were a particular concern.

From the General Household Survey, there were 127,000 people living in same sex couples, of whom 27,000 had used hospital services in the past year. This is lower than the proportion of the population as a whole using hospital services, although this is likely to reflect the age profile of those in same sex couples. In primary care, 32% of gay men feel unable to disclose their sexuality to their GP.

'Prescription for Change', Stonewall's 2008 lesbian health survey, found that 15% of lesbian and bisexual women over 25 years have never has a smear test (compared with 7% nationally) and less than half had been screened for sexually transmitted infections. Fifty per cent of women under 20 years had self harmed compared to 1 in 15 women nationally. Half of the respondents also stated that they have not discussed their sexuality with their GP.

Religion or Belief

Healthcare services need to be sensitive and responsive to the cultural and religious needs of different communities, their attitudes and reactions to disease, types and

modality of treatment, prognosis, care-giving and death. Of all faiths, limiting long-term illness or disability rates are highest among Muslims (24% females, 21% for males).

Organisational Issues

Access to high quality data in order to identify areas of inequality is a recurrent theme across the NHS. Although public bodies, including NHS Trusts, are obliged to collect service and workforce data disaggregated by ethnicity, gender and disability, the completeness of this data varies considerably. The 2006/07 Annual Health Check found that among PCTs, completeness of trust coding for ethnicity in patient data sets ranged from 96% to just over 20%.

According to the Healthcare Commission's 2007 audit of equalities publications, a high percentage of NHS Trusts have produced race and disability equality schemes (76.7% and 81.5% respectively). Despite this, standard C7e⁹ had the fifth lowest level of compliance in 2006/07; almost 18% of PCTs either had not met the standard, produced insufficient evidence to ascertain compliance or had their declaration of compliance adjusted. This may have been due in part to the low percentage of Trusts that had published workforce data disaggregated by ethnicity (33.8%) or race equality impact assessments (15.9%), both legal duties under the Race Relations (Amendment) Act 2000.

The 2007 Staff Survey showed inequities in the percentage of staff experiencing discrimination based on their race, gender, disability or age. The number of black and minority ethnic staff experiencing discrimination rose to 9% (8% in 2006). For gender, disability and age, not only were the percentages smaller (between 3% and 1%), they remained the same or were lower than previous years. The Race Equality Service Review conducted across the South East Coast SHA area uncovered the extent of the disadvantages faced by BME staff in a number of areas, including recruitment, grievances, pay and levels of bullying and harassment. Although focussed on one region, it is widely accepted that the findings reflect the national position.

The 2007 survey also asked whether individuals had undertaken any equal opportunities training. The table below shows the total percentage of respondents who had received training for each equality dimension:

Equality Dimension	Percentage of Staff Trained
Race	45
Disability	47
Gender	39
Age	40
Sexual Orientation	38
Religion or Belief	39

The mixed picture on equality and diversity, including compliance with legislation may reflect the differences in capacity at a local level. Often the equality and diversity role is added to the portfolio of an existing employee. However, where Trusts have dedicated

⁹ Standard C7e requires organisations to 'challenge discrimination, promote equality and respect human rights'

staff, their level of seniority can vary considerably, from relatively junior employees to director-level appointments.

Stakeholder Feedback

A range of statutory and voluntary sector organisations were given the opportunity to comment on the possible equalities impacts of World Class Commissioning and the assurance framework. A list of consultees can be found at the end of this appendix. We have also referred to a number of recent consultations, in particular, feedback from an event on the Primary and Community Care Strategy and the engagement analysis of the NHS Next Stage Review consultation.

Data Collection

The systematic collection of data and community intelligence, disaggregated by race, disability and gender as a minimum, was highlighted by most respondents as critical to the ability of the programme to reduce health inequalities. Organisations argued that without this data, PCTs could not adequately identify the healthcare needs of their communities, the first step in the commissioning process. However, a few were concerned about the capacity of PCTs to collect the quality and quantity of data required for world class commissioning.

An equalities lead also pointed out that even with segmented data, there was still the risk that the needs of equality 'sub-groups', e.g. people with learning disabilities, may be overlooked, underlining the need to collect at least the minimum legal dataset. The importance of qualitative data was also highlighted, particularly for groups where official statistics or service data was limited or unavailable at a local level.

Embedding Equality

Many of the responding organisations felt that although a separate competency may not be necessary, the promotion of equality and diversity needed to be far more explicit, not only within the existing competencies and governance element but across the framework as a whole. This omission was identified as one of the key risks to embedding equality and diversity within the commissioning process. A number of respondents also mentioned the use of suitable metrics to measure progress on promoting equality; as one equality lead stated, "what isn't measured won't be dealt with".

Some agencies referred to local strategy plans, recommending that their vision and strategic objectives should also include specific references to promoting equality, and show clear links to the organisational Single Equality Scheme. A few respondents stated that the local SES should be considered a key 'enabler' of the commissioning strategy plan, and PCTs should ensure that both their priorities and activities are aligned.

One organisation suggested that PCTs should be asked to submit their equality schemes as part of the document checklist of evidence, arguing that a world class PCT would have (a) already met the legislative duties and (b) understood the role of commissioning in promoting equality. It was also felt that the Department of Health should link the World

Class Commissioning programme to the objectives of their Single Equality Scheme. This would also serve as an example of how the two strategies are related at a local level.

Responding organisations believed that to embed and to be explicit were not mutually exclusive concepts when referring to equality and diversity; the Department needed to be explicit on **how** PCTs could embed promoting equality and reducing health inequalities within their local commissioning strategies.

Outcome Measures

A recurring theme across the responses was the focus on eight health outcomes. Respondents were concerned that PCT would allocate a disproportionate amount of resource on general health improvement across the selected outcomes, neglecting other important health areas, and become less efficient as a result. Although this may not be the intention of the PCT, this can often be the reality, as explained by one organisation:

“There is evidence of providers who offer multiple services, some of which are more closely measured than others, achieving decreased efficiency overall as they focus their efforts on the measured areas at the expense of the unmeasured ones¹⁰. It is possible that the output of commissioners may suffer the same consequences as a result of their identifying 8 priority outcome indicators under the WCC programme.”

Another expressed concern was the risk of picking the ‘low hanging fruit’ – improving the health of those easiest to reach – and possibly increasing inequalities as a result. It was suggested that all outcome measures should have an inequalities element, where narrowing the gap was as important as improving health overall:

“There needs to be an explicit emphasis in outcome measures on improving equity of provision and patient experience overall in health services, as well as within each of the agreed priority areas, rather than a crude measure of overall performance for each priority area.”

Community Involvement

Consultation responses for the NHS Next Stage Review included a call for “extending consultation to vulnerable and hard to reach groups through greater involvement of the voluntary and community sector who can act as intermediaries and advocates for people in these groups”. This view was echoed by third sector organisations representing specific marginalised groups (e.g. gypsies and travellers, victims of domestic violence and rape), who felt that those already skilled in accessing healthcare would benefit the most from improved commissioning:

“Where improvements in services are monitored and measured, there can be a tendency to improve things for those people who it is most easy to help, putting the very marginalised, chronically excluded, people into the ‘too difficult’ box.”

Attendees at a consultation event on the draft Primary and Community Care Strategy felt that patient involvement and choice were positive and potentially empowering. However, concerns were raised over whether its implementation could be truly equitable; individuals

¹⁰ Propper, C. and Wilson, D. (2003). The use and usefulness of performance measures in the public sector. *Oxford Review of Economic Policy*, 19: 250–67

felt the more articulate and affluent would be the ones who would most likely benefit, and those in more deprived areas were more likely to simply trust their GP rather than engaging in a discussion about their healthcare.

Generally, respondents highlighted service user and public involvement as a key element of the commissioning process, stressing the importance of working with local groups to find out what approaches work best with certain communities. A few organisations suggested that a representative from the local community should be selected to sit on each assurance panel.

Organisational Capacity and Development

With respect to workforce capacity, some respondents highlighted that there could be equality impacts for staff in PCTs moving from being partial service delivery agents to purely commissioning organisations. Equality and diversity leads (and commissioning managers) may need different or additional skills than were required prior to commissioner-provider separation.

The knowledge and capacity of PCT Boards to lead on this area of work was a particular concern; a number equality leads mentioned working to Boards that did not have a full grasp of, or interest in, this agenda. Training and development for Board members and commissioning managers was raised by a range of organisations. Conducting Equality Impact Assessment was specifically mentioned as a training need.

A few organisations were unsure whether assurance panels would be equipped to probe PCTs on their health inequalities priorities or their equality objectives, especially as senior level NHS appointments generally do not reflect the diversity found within the population. An NHS manager questioned whether panel members would be 'thinking equalities', so that they could ask challenging questions and intelligently assess the quality of the answers given.

As the framework focuses quite heavily on the commissioning activities of PCTs, there was some concern that the role and responsibilities of Strategic Health Authorities in relation to reducing health inequalities and promoting equality will be downplayed. SHA equality leads in particular questioned what their role would be with respect to World Class Commissioning, as their responsibilities in this area have not explicitly outlined within the framework or any of the subsequent guidance documents.

Organisations consulted as part of this Equality Impact Assessment

Equality Dimension	Government Departments	External Organisations
Race	Department for Communities and Local Government	<ul style="list-style-type: none"> • Afiya Trust • Black Health Agency • Black Training and Enterprise Group • Council of Ethnic Minority Voluntary Sector Organisations • East Midlands Black & Minority Voluntary Sector Forum • Race 4 Health • Race Equality Foundation • Race Equality West Midlands • Voice 4 Change
Gypsies and Travellers	Department for Communities and Local Government	<ul style="list-style-type: none"> • Friends, Families & Travellers • Gypsy Council • Irish Traveller Movement
Disability	Office for Disability Issues (DWP) Department for Communities and Local Government	<ul style="list-style-type: none"> • Disabled Living Foundation • Mencap • Mental Health Alliance • MIND • National Centre for Independent Living • RADAR • RNIB • RNID • SCOPE • Voice UK
Gender - Men	Gender Equality Advisory Group (DH)	<ul style="list-style-type: none"> • Men's Health Forum
Gender - Women	Government Equalities Office Gender Equality Advisory Group (DH) Women's National Commission	<ul style="list-style-type: none"> • Muslim Women's Resource Centre • Rape Crisis (England & Wales) • Women's Aid • Women's Health Concern • Women's Resource Centre
Gender - Trans	Gender Equality Advisory Group (DH)	<ul style="list-style-type: none"> • Press for Change
Age – Older People		<ul style="list-style-type: none"> • Age Concern • Help the Aged
Age – Children & Young People	Department for Children, Schools and Families	<ul style="list-style-type: none"> • Barnardos • National Children's Bureau • NCH (Action for Children) • The Children's Commissioner • The Children's Society
Sexual Orientation	Sexual Orientation and Gender Identity Advisory Group (DH)	<ul style="list-style-type: none"> • Stonewall

Religion & Belief	Department for Communities and Local Government	<ul style="list-style-type: none"> • College of Healthcare Chaplains • Faith Regen Foundation Ltd • The Interfaith Network for the United Kingdom
General	Equality & Human Rights Group (DH) Single Equality Scheme Learning Sites Group (DH) Government Equalities Office	<ul style="list-style-type: none"> • Equality and Diversity Forum* • Improvement and Development Agency for Local Government • Kings Fund • Local Government Association • National Council for Voluntary Organisations • Strategic Health Authority Equalities Leads • World Class Commissioning PCT & SHA Event Attendees (30 Trusts)
Workforce Issues	Department for Work and Pensions (Health and Work)	<ul style="list-style-type: none"> • ACAS • Association of Directors of Social Services • British Medical Association • Faculty of Public Health • NHS Employers • Royal College of Midwives • Royal College of Nursing • Trades Union Congress

*The core members of the Equality and Diversity Forum also include:

<p>Advice UK Board of Deputies of British Jews British Humanist Association British Institute of Human Rights Children's Rights Alliance for England Citizens Advice Discrimination Law Association End Violence Against Women Campaign Equality Challenge Unit Fawcett Society Forum Against Islamophobia and Racism Institute for Public Policy Research JUSTICE</p>	<p>Law Centres Federation Liberty National AIDS Trust Policy Research Institute on Ageing and Ethnicity Press for Change Race On The Agenda Refugee Council Runnymede Trust The Age and Employment Network UKREN UNISON Unite the Union (Amicus section) Women's Budget Group</p>
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