race for health

NHS

Tackling Health Inequalities in the New NHS

Recommendations for Action

March 2011

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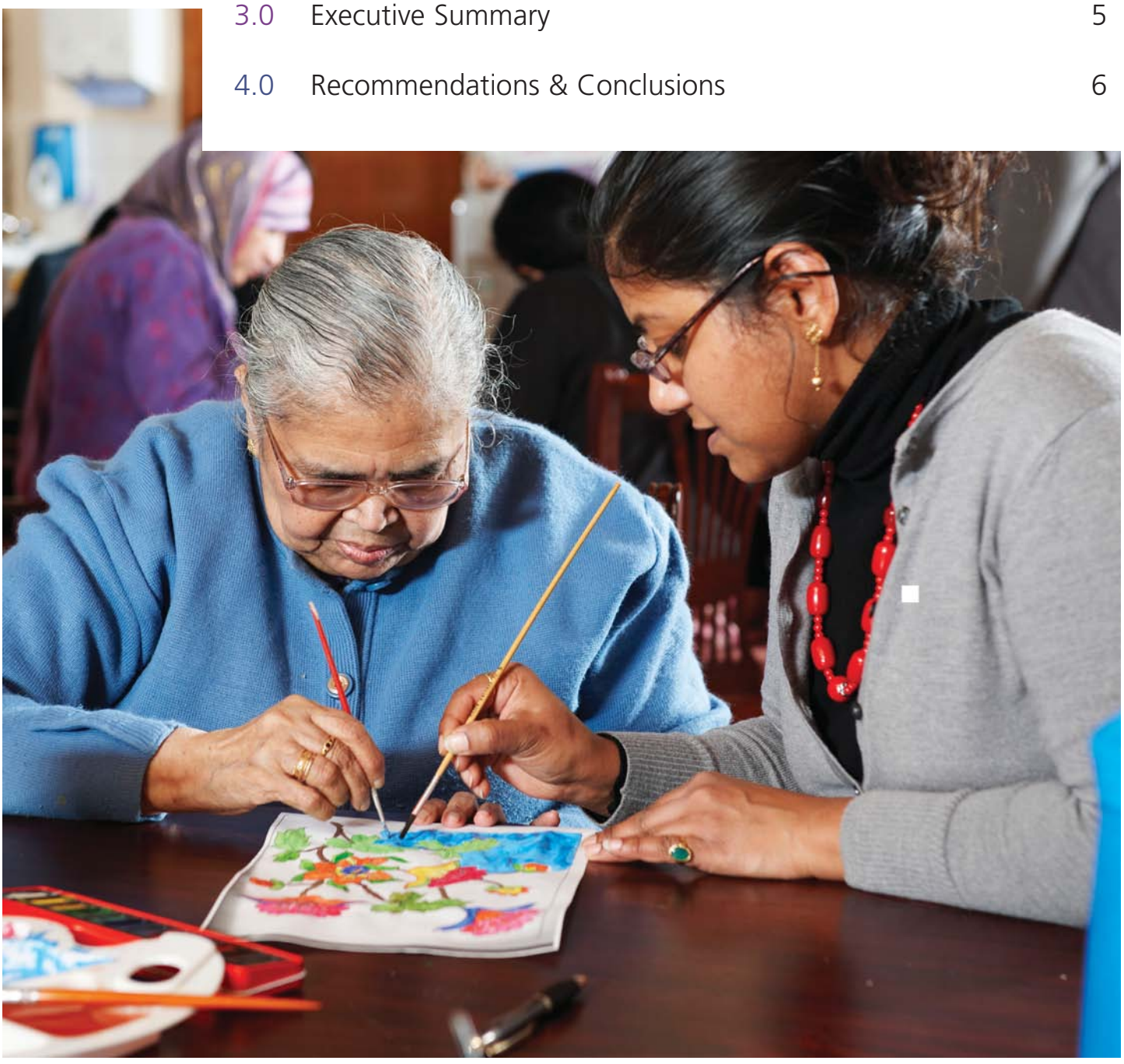
Contents



1.0 Introduction

Gideon Ben Tovim, Chair, Race for Health

We are experiencing considerable organisational turbulence in the NHS. There is, additionally, the very difficult financial situation that is affecting all parts of the public sector. This combination produces a very challenging environment. It is important, therefore, to examine how, in this context, we can maintain the progress that has been developed around tackling health equalities in the NHS. If we don't keep a clear focus on this issue, there is a danger of increasing inequality.

This is why in February 2011, Race for Health called together a Summit, entitled 'The New NHS: Building Equality'. It drew together commissioners and practitioners from the old and the new systems in order to support a smooth transition to the new NHS. This report's conclusions, agreed at the summit of 70 leading figures in the field, will be brought to policy makers and practitioners to ensure that we make the most of the opportunities that the new NHS offers to reduce inequalities.

We have three big issues to tackle. First, to ensure that there is leadership and responsibility for equality and diversity in the new NHS. In recent times, Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) have been system leaders in this field. We must understand who will take over their various roles.

Secondly, we need to understand how equality and diversity will be delivered by way of the Public Sector Equality Duty that comes into place in April under the Equality Act 2010. Who will make sure that progress is maintained? The third issue is where the drivers of equality in the new environment will be and how we can make good use of those drivers. We have, for example, the new Equality Delivery System. We need to understand how that will be embedded and made real. We also have the Outcomes Framework. We need to understand how we can use that effectively to ensure equality.

These are some of the issues that our work at the Summit, in generating these recommendations, was designed to tackle. We must make sure, as the new system takes shape, that we are in a position to maintain the progress already made in tackling health inequality in the NHS.

2.0 Agenda for Action

Professor Helen Hally, National Director, Race for Health

The February Summit was a working conference at which delegates heard presentations from those taking over responsibility for equalities in the new NHS, notably from GPs involved in developing commissioning. It sought to understand their requirements for skills, knowledge and expertise in tackling inequalities.

The Summit also heard from those currently responsible for this work in PCTs and SHAs. Their role was to set out the learning, success and capacity that already exist, in order that it can be harnessed and built into the new systems that are being developed.

Representatives from the Third Sector expressed the needs and expectations of those communities that feel marginalised by inequality and hope that the new NHS will build on current progress.

We were particularly grateful to Barry Mussenden, Deputy Director of the Health Inequalities and Partnerships Directorate at the Department of Health, for setting out how progress on tackling health inequalities will remain the focus of clear policy frameworks, managerial responsibility, legislation and practice.

The Summit conclusions, set out below, demonstrate the case for ensuring that tackling inequalities is a mainstream priority for the NHS, not least because of its capacity to save costs and raise quality. It highlights considerable expertise and learning within the system. But there are clear warnings that key skills and knowledge risk being lost amid cutbacks in the period before new commissioners take over responsibilities. The Summit also heard some confusion as to where responsibilities will actually lie for taking this agenda forward. There was additionally concern among some GPs that they have neither sufficient skills nor the knowledge to take on this agenda without support.

The Summit produced detailed recommendations designed to understand the needs of new commissioners, capture the skills and knowledge of those working in the old system and transfer them effectively to GP commissioners and others who will take up these responsibilities for equality and diversity.

3.0 Executive Summary

1. GP Consortia will save money and achieve higher quality, more cost-effective services if they invest in tackling health inequalities.
2. Commitment to equality is a requirement built into every level of the new NHS.
3. Equalities work must be mainstream in the new NHS.
4. The primary care sector has considerable useful knowledge and skill in tackling health inequalities. However, some of it is at risk of being lost during the transition to the new NHS.
5. The skill of effective community engagement is particularly important and is at risk.
6. Those taking over responsibility for tackling health inequalities in the new NHS are concerned about gaps in their knowledge and expertise. There is some confusion about where responsibilities lie.
7. Urgent action is required to support the transfer of knowledge and skills about equality and diversity to those with responsibility in the new NHS.

4.0 Summit Conclusions & Recommendations

1. GP Consortia will save money and achieve higher quality, more cost-effective services if they invest in tackling health inequalities

- We can reduce spending in the acute sector by improving the early access of marginalised groups to primary care services.
- Registration drives, for example, at primary care level with BME communities often lead to reduced costs down the line. Equalities work can also substantially help to reduce 'do not attend' rates.
- Early intervention and preventive health programmes among marginalised groups demonstrably reduces both the incidence and costs of, for example, heart disease, stroke, cancers and diabetes.
- Equalities spending should face similar levels of VFM testing to other health work. Sometimes, high levels of evidence are required for commissioning services for BME people, while many "mainstream" services are commissioned on the basis of relatively scant evidence.
- Small scale community providers are often highly cost-effective in achieving better outcomes than mainstream providers.

2. Commitment to equality is a requirement built into every level of the new NHS

- As public bodies, GP consortia and the NHS Commissioning Board share the same legal duties as Primary Care Trusts and Strategic Health Authorities to comply with the Equality Act 2010 and allied equalities legislation. They are required to ensure that local processes provide fairness and transparency.
- The Equality and Human Rights Commission will continue to check the compliance of public bodies with Equalities legislation. GP Consortia are open to judicial review as well as reputational risk if they fail to tackle inequalities.
- Processes to facilitate sound equalities work in the NHS are being laid down in the new Equality and Diversity Specialist Competency Framework, the Equality Delivery System (EDS), Health and Well-Being Partnership Boards (HWBPB), and Joint Strategic Needs Assessments (JSNA), the NHS Operating Framework and Performance Monitoring.
- GP Consortia and Foundation Trusts are required to use the EDS as part of their approval process. They may be at financial risk if they fail to fulfil requirements in this field.
- Recent DH Guidance to SHA Chief Executives requires that an equality analysis of staffing should be undertaken before and after 'business critical' roles are determined during any restructuring, taking into account provisions of the Equality Act 2010.
- There may be opportunities to introduce further drivers for tackling inequalities via the General Medical Council (GMC) and the GP Contract.
- Local E & D Leads, advocates and champions can help further to embed the equalities agenda into the work of the new NHS.

"Leadership, nationally and locally, to tackle health inequalities is vital. We have that leadership. We have a legislative framework. Above all, we have to draw on the experience on the ground of programmes such as Race for Health and apply it to the changes that are taking place."

Barry Mussenden, Deputy Director of the Health Inequalities and Partnerships Directorate at the Department of Health

3. Equalities work must be mainstream in the new NHS

- The EDS will be the main tool for delivery of outcomes, provided that there is expertise for work to be done effectively.
- Strong accountability needs to be built into the EDS so that equality and diversity performance is assured. A requirement for rigorous verification of EDS self assessment grades should be built into SHA transitional plans, as is already the case in some SHAs.
- Local SHA transition plans should also ensure that Equalities are fully featured in future JSNAs. This will help Public Health teams to develop an clear base line of the challenges they face and to draw the links between health inequalities derived from poverty, and those linked to ethnicity or any of the other protected characteristics.
- Regulators should focus on equalities and be tougher than in the past. Local groups must have a key role assuring progress in this field. Capacity building support will be needed if these local groups are to hold commissioners effectively to account.
- There are great skills and knowledge in Equality and Diversity within the NHS. These should be fully used and built upon. Otherwise, there is a danger of adding long-term cost and inefficiency to service delivery.
- Urgent action is required to ensure that sufficient expertise and knowledge is available to new commissioning bodies. The requirement for changes in the NHS workforce to undergo Equality Impact Assessments is likely to reinforce concern about the loss of skill and learning in this field. The recent Department of Health Cluster Implementation Guidance (see below) also emphasises the need to pursue Equalities objectives when restructuring PCTs.
- We must keep existing networks alive. We must develop and embed champions at all levels across NHS and partner agencies, continuing to engage stakeholders, patients and partners to ensure joined up thinking and planning across organisational boundaries.
- Clear lines of accountability and responsibility should be embedded in the new structures at every level. Commitment to Equality and Diversity should be expressed explicitly in statements of organisational values at each level of NHS work.

"My key message to you is that, if you have not already activated, in shadow form, your Health and Well-Being Partnership Board, then you should do so as quickly as possible."

Sue Charteris, Co Founder and Advisor, Shared Intelligence.

4.0 Summit Conclusions & Recommendations (continued)

4. The primary care sector has considerable useful knowledge and skill in tackling health inequalities. However, some of it is at risk of being lost during the transition to the new NHS.

- The Public Health Observatories, set up by the Department of Health to provide knowledge, information and surveillance in public health, are an important source of health data. Other sources of knowledge include Public Health teams, community development coordinators and BME coordinators, Patient and Public Involvement Teams, E & D leads, senior champions and networks, the voluntary sector, thinking partner groups as well as performance and information teams. They can share best practice at all levels.
- There is a great deal of knowledge throughout PCTs and SHAs on public and legal duties related to equalities, on conducting Equality Impact Assessments (EIAs), as well as on creating and implementing Single Equality Schemes and use of the Equality Performance Improvement Toolkit (EPIT).
- The wider social determinants of ill health as they relate to equality and diversity are well understood within PCTs and SHAs.

"GPs will need all the support they can get from local inclusion and equality leads not only to meet their duty to advance equality of opportunity and foster good relations between different groups but also, most important of all, in tackling health inequalities. We must do our best to increase the local expertise or at least to maintain it so that effective services can be provided to patients, carers and communities often left out of the decision- making processes and services. We can't afford to start again. We must do everything we can to stop the revolving door."

Maqsood Ahmad, Director of Inclusion, East Midlands SHA

- There is also substantial data in these bodies regarding BME preferences with respect to attending treatment services and screening appointments. Equalities staff often understand where people like to attend, why they attend and why they sometimes fail to attend.
- There are established infrastructures for sharing knowledge about equalities among champions via local networks (such as BME forums) and national support organisations such as Race for Health.
- E & D Leads in PCTs often have more extensive responsibilities and knowledge in this field than is recognised. Most are also commissioners/leads for interpretation and translation services. Many lead their organisations in community engagement, homeless support, the social inclusion agenda, supporting community development workers and bi-lingual health link workers as well as acting as expert advisors on workforce issues. They ensure that equality and diversity is embedded within service specifications.
- The E & D function often supports the PALS or complaints agenda, and recognise key cultural sensitivities. E+ D Leads typically have expert knowledge of local politics and the complex inter-relationships that exist within communities. For example, it is important to understand in groups such as the Somali community, that clan issues may be as influential as broad ethnicity.
- PCTs understand that inequalities continue to exist particularly for BME communities. They recognise that, despite all the resources deployed, they have struggled to convert strategy into grassroots action. However, where investment in E & D has been championed by senior management, improvements have been demonstrable.

"We have a population of about 460,000 people and 60,000 are from ethnic minority communities. If consortia are too big and management systems are slimmed down so that everything is decided from above, there is a real danger that the needs of these people will get lost and they will be further marginalised."

Dr David Soodeen, GP and Clinical Lead for the Bristol Inner City and East Commissioning Locality

5. The skill of effective community engagement is particularly important and is at risk.

- GPs tend to know individuals but many do not understand their communities to the same extent. They may not be local or live in the communities they serve. GPs tend to have less local knowledge that in the past, remaining in post for an average of only seven years.
- New commissioners should be mindful of the influence of macroeconomic policies on communities, particularly migrants and refugees.
- New commissioners should be wary of actions that lead to 'consultation fatigue' – if recommendations from consultation fail to reflect community concern or are not implemented, communities can become distrustful and disillusioned.
- Commissioners need to develop systems to link community engagement to the Joint Strategic Needs Assessment.
- If individuals/communities are not empowered, community engagement will fail. So capacity building is essential. It is important to empower the most marginalised. That means involving communities at the beginning of a process to make it relevant/owned and ensuring that action follows consultation.
- PCTs understand theories and models of engagement/expertise and have built valuable local contacts. It is vital to harness this knowledge and resource.

"The challenge we face is to make services that are wrapped around the individual patients, carers and our diverse communities needs. For example, how do we provide effective health services for the gypsies and travelling community, the elderly and those with learning disabilities as well as for those faced with health inequalities such as those faced by white young men and Asian women? GPs know their patients better than anyone but the challenge they face as commissioners and providers is not just knowing the health needs of their patients. It is knowing the health needs of their communities including those that are most vulnerable within our society."

Maqsood Ahmad, Director of Inclusion, East Midlands SHA

4.0 Summit Conclusions & Recommendations (continued)

6. Those taking over responsibility for tackling health inequalities in the new NHS are concerned about gaps in their knowledge and expertise. There is some confusion about where responsibilities lie.

- Members of GP Consortia say they are overwhelmed by the many issues they face during the transition period and that they lack space at this time to consider the Equalities agenda. As a result, many do not know now what they will need to know in the future. This gap in knowledge needs to be considered as part of the transitional planning arrangements to ensure that learning is still available when it is eventually sought and required.
- GP Consortia will, for example, need help in contract and performance management of NHS providers and non-NHS providers, including with EPIT/EDS submissions. PCTs currently hold this knowledge and expertise.
- There is some confusion among GP Consortia about how much responsibility they actually have for Equality and Diversity, particularly as some public health responsibilities are devolving to local authorities.
- There is a need for capacity building to support the transition to the new NHS. For example, in one PCT in the south of England, the E & D lead has developed a social inclusion strategy to address the membership of Links and Health Watch.

"My worry is that we, as GPs, do not have any clarity about how this good work around inequalities will happen in the future after PCTs are abolished. Most of the focus on GP commissioning is around referrals to hospitals, choosing between providers and managing financially challenged budgets. Tackling inequalities is an area that we don't ourselves do at the moment and I am not sure that GPs necessarily, alone, have the skills and experience to address this. I think there should be changes in legislation so that this area should be protected and not vanish. Local authorities should be the natural home for a lot of commissioning around inequalities, and, with Public Health playing a leading part. GPs should be involved with local authorities but should not take over what they are not equipped or best placed to do."

Dr Chand Nagpaul, GP Committee, British Medical Association

7. Urgent action is required to support the transfer of knowledge and skills about equality and diversity to those with responsibility in the new NHS.

- Consideration should be given to the risk of losing vital knowledge through cuts currently underway in PCTs and local authorities. Suspension of redundancies for E & D leads should be considered. EIAs should be undertaken of processes locally. E & D roles should be considered 'business critical' as set out under the DH's 'business critical guidelines'.

"Whilst GPs are committed to the equality agenda, are they confident to embed culturally competent, equality evidenced-based approaches into commissioning, in line with the new Public Sector Equality duties?"

Michelle Cox, Head of Equality & Diversity, NHS Liverpool

- The Department of Health should encourage PCTs to use the E & D leads as experts to support the transition to GP Consortia commissioning. They will need to transfer learning about community engagement and a host other equalities functions that they offer.
- An on-line equality hub should be established, including resources/signposting that shares best practice and peer learning.
- PCTs and SHAs should work collaboratively with GPs and consortia to develop training via case studies based on value for money and tangible measureable improvements.

- Information about Equalities should be linked to QIPP to ensure that equalities sits within mainstream responsibilities.
- GPs and consortia should be asked to identify a shopping list of help they require to meet the needs of their populations, in terms of knowledge, frameworks, tools and techniques.
- Health and Well-being Partnership Boards should be a focus for the development of Equality and Diversity agenda in the new NHS. JSNAs will also be useful. However, JSNAs typically focus on traditional public health interventions. They will be more effective around equalities if an EIA has been conducted on the JSNA.
- PCTs should note and implement the DH requirement in PCT Cluster Implementation guidance. The relevant section states:

  "All the appointment processes required for these changes should comply with the Equality Act 2010 and the principles of fairness with every effort being made not to lessen the representation of people of protected characteristics such as BME people and women in senior roles. It will be particularly important for the NHS to retain its expertise and intelligence on tackling health inequalities (including those arising from discrimination) during the transition. The SHA, in conjunction with its PCTs, should carry out an Equality Impact Assessment of these proposals."
- PCTs should commission or deliver bespoke training around E & D for the new clusters.
- To ensure best practice, an organisation such as Race for Health should be used to offer bespoke training and cultural training support, in addition to using its expertise in networks, peer reviews, deep dives and expertise of thinking partners.
- Those involved in smoothing the commissioning transition should maintain the following principles:

  Stay motivated – change has been achieved in the past and it has taken a long time.

  Engage with GPs - you may have to introduce yourself to GPs individually, giving them information about their communities and their needs.

  Signpost good practice to commissioning GPs, such as:

  - tying community engagement into the JSNA process
  - have a clear, written community engagement strategy, with sign up from public sector partners; then you can ask Consortia to sign up
  - utilising existing Neighbourhood governance systems,
  - The Department of Health, study of community engagement, "A Dialogue of Equals," by Stafford Scott
  - Working through religious leaders and making links with faith and health care communities

  Strengthen scrutiny of GP Consortia via:

  - GP Champions
  - representation on Consortia Boards (but not via one person)
  - requiring evidence from Consortia that they are tackling Equality and Diversity

  Use all the resources available - communities as well as equality practitioners

  Bridge the divides that may exist between health services and local communities

"GPs have an excellent opportunity through management and allocation of their budgets to work in partnership with carers and voluntary organisations to help them to tackle health inequalities. For example, they can work with the homeless people and gypsies and travellers, African and Caribbean men on prostate cancer, Pakistani women regarding infant mortality. Now is their moment to use their resources to make the difference."

Maqsood Ahmad, Director of Inclusion, East Midlands SHA

Race for Health

Race for Health is an NHS membership organisation sponsored by the Department of Health and hosted by Liverpool PCT. The programme is designed to support and challenge NHS organisations to tackle health inequalities particularly among people from black and minority ethnic communities.

A vibrant and interactive website – www.raceforhealth.org – ensures that knowledge and understanding of equality issues spreads far beyond the programme core membership.

The programme is run by the national director, Professor Helen Hally. Gideon Ben-Tovim (Chair of NHS Liverpool) chairs the programme and Clare Chapman, Director of Workforce for the NHS and social care, is the Department of Health's sponsor.

A Board comprising Chairs, Chief Executives and other board members from the participating NHS organisations, shapes the strategy for the programme and engages with Ministers, the Department of Health and NHS leaders.

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