Single Equality Scheme 2007–2010

Contents

Introduction

The Single Equality Scheme (SES) is a public commitment of how we at the Department of Health plan to meet the duties placed upon us by the equality legislation. The Race Relations (Amendment) Act 2000, Disability Discrimination Act 2005 and the Sex Discrimination Act as amended by the Equality Act 2006 place these upon us. It also includes actions on age, religion and belief, and sexual orientation. The SES is a public document, which means that we are answerable to the public for delivering the commitments it sets out.

Driven by legislation, this should be the minimum standard to which a Department of State aspires. The Department has a central role in leading the field in relation to equality and human rights, and the key to making a positive difference to the quality of people's lives starts with policy making that has equality and human rights at its core. The ambitious programme currently being delivered by the Department aims to put all people at the centre of the health and social care agenda. The ability to design and support the delivery of services that can respond to the differing needs of all our communities is our core business.

The Department is also a major employer, and the human resources aspects of this Scheme are important for every employee. The needs and aspirations of our staff will obviously vary according to individual circumstances, but the Department recognises that preferences and choices relating to employment at the Department must not be affected in a detrimental manner by race, disability, gender, age, sexual orientation or by religion or belief. The diversity of our workforce enriches us all, and allows us to deliver best-in-class policy.

Therefore this Single Equality Scheme is relevant to all of us who work at the Department of Health, both in what we do and as employees. The Scheme will be regularly refreshed to ensure its continued relevance in a rapidly changing world, and I would encourage you to reflect upon it and become involved in it, either through your Directorate or by contacting the Equality and Human Rights Group direct. I endorse this Scheme, and welcome the progress that we have made – and must continue to make – towards equality and human rights at the Department of Health.

Hugh Taylor
Permanent Secretary,
Department of Health

Surinder Sharma
National Director for
Equality and Human Rights

Executive Summary

1. The Single Equality Scheme (SES) is a public commitment of how the Department of Health plans to meet the duties placed upon it by equality legislation.

2. The DH SES is based around six equality strands (race, gender, disability, age, sexual orientation and religion and belief), and is also part of the DH human rights programme. The Scheme covers the period 2007-2010.

3. The SES covers the Department's responsibilities in relation to the health and social care system and as an employer in our own right.

4. The SES recognises that information gathering and monitoring form the foundation of informed, evidence based policy making, and commits the Department of Health to using such tools to develop policy that meets the needs of the whole population.

5. DH acknowledges, through the SES, that striving for equality means recognising and valuing diversity. Equalising inputs does not always lead to equalised outcomes, but evidence and research-based policy may result in differentiated inputs which will lead to appropriate outcomes for different groups in society.

6. The use of Equality Impact Assessments (EqIAs) is fundamental to achieving not only legal compliance, but also to ensuring that an evidence base that is directly related to equality and human rights informs policy development and implementation.

7. The Department of Health as a significant and high profile public employer forms an important part of the SES. The involvement of its employees and trade unions in driving forward equality and human rights is an ongoing commitment.

8. DH recognises the tensions that developing a Single Equality Scheme may create, but believes that the most effective approach to delivering personalised and effective services results from valuing the interdependencies between equality strands, rather than viewing them as competing pressures.

9. Effective governance processes underpin this SES, and the governance arrangements are set out in detail in the document. Each director general will be held personally accountable for equality deliverables, as expressed in their specific business area.

10. The most important element of the SES are the Action Plans, which set out detailed and specific areas in which equality and human rights will be pursued. These Action Plans are the commitments by which DH will be measured.

11. As part of the commitment to transparency and openness, the Department of Health will continue to work with stakeholders who will hold us to account for the statements and commitments made in this Single Equality Scheme.

1 Background and Context

The aim of equality legislation is to ensure that public bodies properly discharge their obligations to all sections of society – to people of different races, disabled people and non-disabled people, men and women, regardless of sexual orientation, gender identity, religion and belief (or absence thereof), and appropriate to all age groups. The Government's Social Exclusion Unit identified six groups in society that face particular disadvantage in accessing mainstream public services, including the NHS and social care. These groups of people are:

- disabled people and those with long-term health conditions;
- people belonging to some minority ethnic groups;
- excluded older people;
- younger people with complex needs;
- people with low levels of literacy; and
- disadvantaged people who move frequently.

In turn, this informs the six strands of equality that provide the overarching framework for the Department of Health:

- race;
- gender (including gender identity);
- disability;
- age;
- sexual orientation; and
- religion or belief.

The Department of Health (DH) embraces the moral, legal and service obligations as an opportunity to demonstrate its commitment to equality and human rights, and to go beyond a 'lowest common denominator' towards exemplar status. It is important to state openly, however, that the process of 'levelling up' on these six strands is ongoing. This is due to a number of factors, including levels of expertise and experience, proportionality and prioritisation, and the need to make the most

cost-effective and biggest impact on the greatest number of people as quickly as possible.

The Department has made a strategic commitment to adopting a Single Equality Scheme (SES) approach. The reasons for this include a recognition that inequalities are rarely experienced in isolation, but are often interdependent; a desire to strive for a holistic approach to service planning and delivery, rather than uncoordinated initiatives; a determination to see patients and service users as real people, rather than as 'cases'; and a commitment to maximising the impact of resources and investment. This SES sets out how DH recognises the differences between people, and how this informs a differential approach to ensure that (as far as is practicable) any gaps between outcomes are identified and mitigated.

Human Rights is an important underpinning factor in the production of this Scheme. An appreciation of how the principles of human rights apply to equality is vital to understanding how traditional NHS values are expressed in a modern NHS and social care system. This SES is therefore also part of the DH human rights programme.

The SES also sets out how the Department is meeting its obligations towards its own staff, both in terms of how they are treated as employees and how they are enabled to contribute towards the Department's equality objectives.

The SES is structured to demonstrate compliance with equality legislation. The Action Plans at the rear of the document set out a practical work programme incorporating all of the functions (Directorates) of the Department of Health. The SES is a fully 'live' document, in that it will be subject to the governance and performance management systems of the Department. Ongoing work is also taking place to explore how best to allow stakeholders to hold the Department to account for the commitments made, and to increase involvement and ownership in this Single Equality Scheme.

2 About the Department of Health

The Department of Health (DH) is a Department of State, with the overarching aim of improving the health and wellbeing of the population of England.

The Department is led by the Permanent Secretary, who leads the department as a whole, the NHS Chief Executive, who provides leadership to the NHS and is the chief adviser to the Secretary of State on NHS matters; and the chief Medical officer, who is the chief professional adviser to Ministers and across Government on public health and medical matters. The DH structure chart can be found at Appendix 1.

Roles

The Department of Health has three key and interdependent roles:

- to act as a Department of State on a broad and complex range of Governmental activity; and
- to act as the effective national headquarters of the NHS;
- to be responsible for setting policy on public health, adult social care and a range of related areas.

Strategic Objectives

The Department of Health has eight Public Service Agreement (PSA) targets, which can be found at Appendix 2. From these, DH has derived seven strategic objectives, as follows:

1. Improve and protect the health of the people of England, with special attention to the needs of disadvantaged groups and areas.
2. Enhance the quality and safety of services for patients and users, giving them faster access to services and more choice and control.
3. Deliver a better experience for patients and users, including those with long-term conditions.
4. Improve the capacity, capability and efficiency of the health and social care systems.

5. Ensure that service reform, service modernisation, IT investment and new staff contracts deliver improved value for money and higher quality.
6. Improve the service provided as a Department of State to and on behalf of ministers and the public, nationally and internationally.
7. Become more capable and efficient in the Department, and cement its reputation as an organisation that is both good to do business with and good to work for.

DH has a national role, and is accountable nationally for the use of NHS resources as a whole. But it is important to distinguish this role from the explicit accountability of individual NHS organisations. DH has responsibility for overall system leadership. But each strategic health authority, primary care trust, and NHS trust is a public body, and is accountable in its own right for its own performance and compliance with the law. In relation to equality and human rights, this means that whilst DH can provide leadership and offer support and guidance, it is for every NHS organisation to ensure that it properly understands and complies with the law.

Service Recipients

The Department of Health recognises that society and lifestyle choices are not static, but continue to evolve. Every member of society is likely, at some point, to be a recipient of health and social care. DH welcomes diversity in society, acknowledging that experiences, aspirations and needs are also diverse – and that this applies equally to minority groups, and to those whose voices are seldom heard by the health and social care system. The Department therefore recognises that the needs of people will be affected by a number of factors (not just those that are health related), and that specific attention should be paid to the needs of:

- black and minority ethnic (BME) people;
- disabled people;
- men and women;
- younger and older people;
- lesbian, gay, bisexual and transgender (LGBT) people;
- people of different religions and beliefs or those who have had no religious belief;
- asylum seekers and refugees; and
- Gypsies and Travellers

Furthermore, it is an obvious but important point to acknowledge that people will often fall into more than one 'neat' category – and that when the Department is formulating policy, this consideration needs to be paramount.

Departmental Values

The following core values of the Department describe the behaviours that DH wishes to promote and exemplify:

- lead and share best practice: a leading Whitehall Department that sets standards of excellence across the wider health and social care system, focused on measurable improvements in health and wellbeing;
- work together in partnership: work collaboratively within and between teams, with other departments and with the wider system to achieve the most productive outcomes;
- learn and continuously improve: bring together collective skills, knowledge and experience to develop new ways of working that improve performance and support wider system reform;
- add best value: make the best use of available resources to deliver solutions valued by stakeholders and end users; and
- respect and support each other: value diversity by respecting and supporting the contribution of others. Challenge unacceptable attitudes and behaviours.

Key Strategic Drivers (Levers)

Crucial to the further development of the Department of Health's strategic policy in equality and human rights are the developments in the way that the NHS operates in order to meet the challenges for the 21st century. In December 2006, the Chief Executive of the NHS, David Nicholson, issued the document *The NHS in England: the operating framework for 2007/08* to the NHS. This set out the parameters within which local organisations will work in 2007/08, and which underpin the expectations for the local delivery plans (LDPs) to be agreed between strategic health authorities (SHAs) and the Department of Health.

The framework proposes 10 principles to help bind together all members of the NHS family in a partnership for patients and the public. One of these principles is that the NHS is committed to equality and non-discrimination. This means being committed to equality for patients and service users no matter what their age, gender, disability, sexual orientation, race, language, religion or national, ethnic or social origin. It also includes providing services that are culturally appropriate to the needs of different communities.

In addition, the framework set out the actions that Primary Care Trusts needed to take forward in order to lay the foundations for future improvements. A key action is to use needs assessment systematically to identify and address the specific needs of different groups in the population. In particular, PCTs should review how commissioning should be tailored to meet the needs of disabled people, people with learning disabilities, people from black and minority ethnic communities, and people from different gender, sexual orientation and age groups.

The development of commissioning for health and well-being across the health and social care system is key to the Department of Health progressing the equality and human rights agenda. In the document, *Commissioning framework for health and well-being* published in March 2007 the Department sets out commissioning as the process of translating the aspirations and needs of local citizens into best value services for users that deliver the best possible health and well being outcomes including promoting equality.

Commissioning for the health and well-being of individuals is about helping all local citizens remain independent, participate fully in their communities and have both choice and easy access to the type of help they need when it is needed.

More broadly, commissioning for the health and well-being of a local population means identifying future need and promoting both health and inclusion whilst supporting independence. It is also, crucially, about identifying groups or areas that are getting a raw deal and providing them with a voice to influence services.

Following an initial assessment of the impact of commissioning upon equality it has been suggested that for commissioning to be successful there needs to be:

- Accurate ethnic monitoring
- Identification and engagement of different groups and individuals
- A focus on tackling access issues
- Tailoring the application of policy to meets the differing needs of different groups and individuals
- More resource focussed on addressing differential need and hard to reach populations and individuals
- Extra training for health and social care staff
- Development of appropriate standards
- Inspection and evaluation

3 Public Sector Equality Duties: the Legislative Context

The legal requirements for public bodies to publish equality schemes is contained in:

- the Race Relations (Amendment) Act 2000;
- the Disability Discrimination Act 2005; and
- the Equality Act 2006.

These pieces of legislation contain specific equality duties, including a requirement for public sector organisations to publish equality schemes. While there are clearly similarities between these three statutory duties, there are also differences. Wherever practical, it is the intention of the Department of Health to use the 'higher' standard, e.g. one requirement of the Disability Discrimination Act 2005 is to 'involve' disabled people in the publication of the Scheme, whereas the Race Relations (Amendment) Act 2000 requires proper 'consultation'. In future, the Department of Health will therefore aspire to involve, as well as consult in the production and subsequent review of all strands of the SES.

The three statutory duties have a common aim – to ensure that the public sector works to promote equality and eliminate discrimination in all of its activities. Each piece of legislation containing the statutory duties focuses on delivering equality in the most appropriate manner for different ethnic groups, disabled people, and for men, women and transgender people, with the underpinning aim of ensuring real, measured and positive outcomes for all sections of the communities served.

The individual requirements of each of the public sector equality duties and wider equality legislation can be found at Appendix 3; and the specific duties relating to employment can be found in section 11.

4 Context of the Equality Strands

The Department of Health has made a strategic commitment to adopting a Single Equality Scheme. The rationale for this is the principle that the 'strands' of equality – race, disability, gender, age, sexual orientation and religion and belief – do not present 'competing' issues, but rather provide opportunities for synergies to be developed and addressed through integrated action. It is often the case that inequality and prejudice are perceived and experienced on multiple levels, and in this respect the separation or isolation of strands can in itself be 'artificial'. In practical terms, this means that DH is producing an integrated equality scheme (this SES), rather than three separate equality schemes. It is important, however, to provide some specific context relating to the separate strands, in order both to provide assurance that DH has an appreciation and understanding of particular issues, and to inform action planning (see section 15).

The following is intended to be indicative and to highlight some key issues relating to each strand. It is not intended as a comprehensive statement of every issue and every action relevant to health and social care. Other key publications are cited in Appendix 8, in order that more detailed matters are properly referenced, and also to avoid duplication of other action plans or programmes in this SES.

Race

Issues

Urban and rural diversity. The challenges facing the NHS and social care vary widely between rural and urban environments. For example, 44 per cent of the ethnic minority population of England and Wales lives in London, while the issues faced by ethnic minorities living in rural areas present very different challenges. This not only makes a 'one size fits all' approach from the Department of Health inappropriate, but also emphasises the importance of local consultation and involvement, and using strategic partnerships on a local level to maximise intelligence and economies of scale.

Infant Mortality. The infant mortality rate for England and Wales in 2003 was 5.2 per 1,000 live births. Babies of mothers born in Pakistan had an infant mortality rate over double this average, at 10.5 per 1,000 live births.

Mental Health. Young black men are six times more likely than their white counterparts to be sectioned under the Mental Health Act for compulsory treatment. This issue needs to be examined to understand this difference, and local mental health providers need to be mindful of their local position in relation to this. In addition Irish men are twice as likely as the general population to be in psychiatric care.

Ethnicity and Gender. Asian women aged 65 or over (likely to be first-generation immigrants to the UK) have the highest rate of limiting, long-term illness, at 64.5 per cent compared to 53.1 per cent for all women aged 65 or over. Caribbean women have a higher prevalence of cardio-vascular disease and they and Pakistani women are also 20 per cent more likely to have high blood pressure and to be obese than women in the general population.

Actions

Health Inequalities. Through Spearhead Groups, the Government has a target to narrow the gap between the population as a whole and the 20 per cent of areas that have the worst health and deprivation indicators. These geographical areas include 44 per cent of the total BME population of England and 53 per cent of the Muslim population.

Smoking Cessation. Some BME groups, particularly men of Bangladeshi and Pakistani origin and Irish men and women, have higher smoking rates than the general population. The Department's new tobacco campaign specifically targets Asian communities through the multilingual Asian tobacco helpline, leaflets and information in community languages and a smoking cessation campaign targeting Muslims during Ramadan.

Campaigns. Organ donation campaigns have been developed to target African, Caribbean, Asian and faith communities. NHS Blood and Transplant is running specific campaigns targeting black and minority ethnic blood and bone marrow donors.

Mental Health. 'Count Me In', a census of the ethnicity, language and religion of mental health inpatients, was first conducted in 2005 and is now an annual programme. Furthermore, the 2007/08 Operating Framework includes recruitment of Community Development Workers for BME mental health as one of two service delivery priorities.

Health Reform. Applicants for Foundation Trust status are required to demonstrate that their governance arrangements have included the whole catchment population, including BME and groups that are seldom listened to.

Nursing Care. The Chief Nursing Officer has recently appointed a National Officer for Diversity to support work ensuring that patients and staff from racially diverse backgrounds receive a fair and culturally sensitive service within the NHS.

Patient Experience. The Healthcare Commission continues to work on analysis and improvements in relation to the participation of black and minority people in national patient surveys.

Disability

DH uses the social model (as opposed to the medical model) of disability: i.e. it is the barriers (physical, attitudinal) that society puts in the path of disabled people that prevents disabled people from living fuller lives, rather than any inherent factor. This concept – which has gained wider credence due, in part, to equality legislation – is fundamental, for it informs subsequent strategy and policy decisions relating to health and social care.

Issues

Disability and Age. There is a clear link between age and disability, with approximately 75 per cent of men and women over the age of 85 reporting a disability.

Policy Development. DH recognises that disability equality needs to be an underlying theme in policy development and the delivery of national priorities, for disabled people make greater use of health services than non-disabled people. It is not therefore possible to elevate standards in the overall health and social care system without paying specific attention to the needs and aspirations of disabled people.

Improving Life Chances. Cross-government action on disability equality was given impetus by the publication by the Prime Minister's Strategy Unit of *Improving the Life Chances of Disabled People*. This states that, by 2025, disabled people should have full opportunities and choices to improve the quality of their life, and to be included and respected as full members of society. Government departments are set challenges around four key areas: independent living, early years and family support, transition to adulthood, and employment.

Actions

Policy making. A guide for policy makers (*Promoting Disability Equality in Policy Making to Support National Priorities for Health & Social Care*) developed jointly with the Disability Rights Commission (DRC) is available to all staff as part of the package of information on equality impact assessment that features on the Department's intranet.

Supporting the NHS and social care organisations. The Department has worked in partnership with the DRC on a range of joint actions to improve the rights, independence, choice and inclusion of disabled people through ongoing development of the health and social care system.

Learning disabilities – Valuing People. Publication of *Valuing People: a New Strategy for Learning Disability for the 21st Century* sets out four key principles for the furtherance of this work: rights, independence, choice and inclusion. At DH, the Valuing People Support Team comprises regional and national advisors working within the Care Services Improvement Partnership (CSIP) to lead implementation of the strategy.

DEEL. DEEL is a national framework for Disability Equality and Etiquette Learning, developed in partnership with a number of organisations, including DH and the DRC.

As the DEEL framework is put into use across health and social care organisations, the greater awareness of staff that will result will help to tackle many of the issues raised at the involvement workshop (see Appendix 5).

Gender

The Department of Health is committed to tackling gender inequalities within the healthcare sector by recognising the specific health needs of men, women and transgender people. There has been increased awareness among healthcare professionals of the correlation between gender and health and its impact on access, quality of healthcare and medical treatment for men and women. The Department's commitment to creating a patient-centred service that extends choice and is responsive to all patients and users, especially with regards to the gender perspective aims to ensure that any gender differences in treatment and access are eliminated.

Issues

Cancer. Men are twice as likely as women to develop and die from the ten most common cancers that affect both sexes.

Primary Care. Men are much less likely to visit their GP than women. Men under the age of 45 visit their GP only half as often as women under the age of 45.

Obesity. Men are almost 10 per cent more likely than women to be overweight or obese, and are therefore much more likely than women to suffer from such consequences of being overweight and obese as cancer and coronary heart disease.

HIV/AIDS. Male to female infection with HIV is more than twice as efficient as female to male infection.

Immunity. Women's immune systems make them more resistant than men to some kinds of infection including tuberculosis.

Domestic Violence. The British Crime Survey of 2005 showed 45 per cent of women in the UK have experienced some form of domestic violence, sexual assault or stalking. This has a clear consequence for health and well being.

Mental Health. A high proportion of Irish women suffer from various mental health problems and Irish women have the highest rates of suicide and self-harm. Admission rates for depression amongst Irish women are 410 per 100,000 compared with a rate of 166 amongst English women.

Transgender people. Many health professionals confuse Transgender issues with sexual orientation; mental health problems are a serious concern, but there is no targeted service provision; social prejudice and discrimination are a common experience; treatment and support services are fragmented; and sexual health needs are ignored.

Actions

Men's health. The Department of Health commissioned the Men's Health Forum to work with five primary care trusts (PCTs) to develop a tool to assist PCTs in providing gender -sensitive services. PCTs will be able to identity where changes can be made and how to approach implementation of the Gender Duty.

Cross-government working. The Department of Health has been working in partnership with the Department of Trade and Industry, the Equal Opportunities Commission, practitioners, service deliverers, NHS equality leads, voluntary organisations and other stakeholders to explore issues surrounding gender-sensitive services and the gender duty, which came into effect in April 2007. This has helped to inform the Gender Duty Code of Practice and the guidance specifically intended for the Health Sector.

Gender Equality Advisory Group. A Gender Equality Advisory Group has been set up to advise the Department on current health and inequality trends, provide a consultative forum on outward-facing policy initiatives that impact on the NHS, and to review and monitor the implementation of policy as a critical friend.

It is also important for this Scheme to make explicit mention of issues of violence against women. DH recognises that health and social care settings are often a key contact point for both the victims and perpetrators of violence against women, and accordingly, issues of 'domestic' violence and abuse may well form part of gender-specific responses and plans by NHS and social care organisations. On a national level, some of the key aspects relating to this issue include:

- The Maternity standard of the Children and Young People's National Service Framework includes a number of recommendations, including some relating to improving maternal health and the needs of pregnant women experiencing domestic violence.
- In 2006, DH published *Responding to Domestic Abuse; A Handbook for Health Professionals*, updating the *Domestic Violence Manual* produced in 2000.
- The Maternity standard of the Children and Young People's National Service Framework and Confidential Inquiries into Maternal Deaths emphasise the importance of providing an enabling environment for pregnant women to disclose abuse or violence, if they so wish.
- In 2005, DH established the Domestic Abuse and Pregnancy Advisory Group; and in 2006, a guide – *Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse* – was published, following joint work by DH, the National Institute for Mental Health in England (NIMHE) and the Victims of Abuse Prevention Programme.
- DH also has links with specialist organisations such as FORWARD, whose aims are concerned with female genital mutilation – DH is funding research into the prevalence of this, and is assisting with the production of a training/awareness video.

Age

Issues

Resources: NHS. The NHS spent around £16.5 billion on people over the age of 65 in 2003/04, accounting for 43 per cent of the total NHS budget for that period.

Resources: Social Care. In 2004/05, people aged over 65 received 71 per cent of social care packages.

Age and Ethnicity. In 1997–99, 7 per cent of the population were aged 65 or over and belonged to an ethnic minority. The largest of these minority groups comprised Black-Caribbean people; the next largest was made up of Indian people.

Demographics. The number of people over pensionable age in the UK is projected to rise from 11.2 million in 2006 to 11.9 million in 2011, and 13.1 million by 2021.

Suicide Prevention Strategy. Young men continue to be the group with the highest risk of suicide, although suicide rates continue to fall among all age groups.

Action

Service Commitment. DH published a National Service Framework (NSF) for Older People in 2001. The first standard in this NSF sets out to ensure that older people never suffer unfair discrimination in relation to accessing the NHS or social care.

Consultation and involvement. In June 2006, the Minister for Care Services launched an online survey to seek the public's experiences of the level of dignity of treatment in NHS and social care.

Combating age discrimination. The second phase of the Older People's NSF, *A New Ambition for Old Age,* encouraged the involvement of older people in service planning and the promotion of healthy ageing. Progress in combating differential treatment on the grounds of age is being made, with discrimination now less likely; for example, heart surgery for the over-75s has risen from 2 per cent to 10 per cent.

Specialist older people's services. In January 2007, the National Director for Older People launched *A Recipe for Care – Not a Single Ingredient*, a report setting out the drive for the reconfiguration of services to ensure that older people receive the best possible care. This included a five-point plan: early intervention, the management of long-term conditions, early supported discharge, acute hospital care when needed, and partnership working between the agencies involved in caring for and supporting older people.

Partnerships for Older People Programme (POPP). Pilot areas in this initiative were specifically directed to address the needs of 'excluded groups' of older

people, including carers. The definition of 'excluded older people' includes older BME people.

Religion and Belief

The Department of Health recognises that the United Kingdom is a multi-cultural, multi-faith society. Accordingly, DH is committed to recognising the needs of patients and staff of diverse religious groups, and of people with no religious belief, and to responding sensitively and appropriately to their needs. The NHS and social care must take account of the personal needs, such as religious, cultural and dietary requirements of the multi-cultural and spiritually diverse population that it serves.

Issues

Diversity of belief. The United Kingdom has a more diverse faith community than any other country in the European Union, with the largest minority beliefs being Islam, followed by Hinduism and Sikhism. An increasing minority of the population also express no religious belief, ranging from atheism to humanism.

Freedom of belief. Article 9 of the Human Rights Act 2000 confers on individuals the right to freedom of thought, conscience and religion. The freedom to manifest religion or belief shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

Faith institutions and health and wellbeing. Many faith institutions and places of worship are involved in a wide range of educational, health and social welfare activities, especially for ethnic minorities. Places of worship offer major opportunities to engage health professionals, and those already involved in work with their own communities and congregations. In this respect, the specifics of the religious affiliation are less relevant than the opportunity for health professionals to engage with minority communities 'on their own terms'.

Actions

Consultation and Involvement. DH and the NHS consulted with faith communities when producing the NSFs for coronary heart disease, diabetes and mental health, and they continue to engage faith communities in public health campaigns (such as tobacco education) where this can further the strategic objectives of improving the health of the nation and reducing health inequalities.

Cross-government working. DH works with other government departments and external agencies, including the Home Office, Cabinet Office, Local Government Association and the Inter Faith Network for the UK, to review the way in which they engage and involve faith communities in policy making and service delivery.

Publication of guidance. DH has published guidance – *Meeting the Religious and Spiritual Needs of Patients and Staff*; it also launched the *NHS Chaplaincy Guide* in 2003. The guidance is aimed at ensuring that NHS chaplaincy services take account of the religious diversity of the communities they serve, and that services are not designed exclusively around majority beliefs (as they may be expressed in the local population). The Department also commissioned the publication of a *Ramadan Health Guide* in order to provide information and advice on maximising health gain during the Muslim fast.

Sexual Orientation and Gender Identity

For the purposes of this Scheme, the scope of issues covered under the sexual orientation strand also includes issues relating to transgender health.

Issues

Health inequalities. Lesbian, Gay and Bisexual (LGB) people have a variety of unique health needs – eating disorders, obesity, self-harm, substance misuse are all issues within these communities.

Suicide. Gay and bisexual men are more than seven times more likely to attempt suicide than the general population.

Sexual health. Gay men remain the group in the UK at highest risk of acquiring HIV, and there is evidence that transmission is continuing at a significant rate. In 2006, there were 2,400 newly diagnosed infections. Lesbian women often have their sexual health needs ignored.

Actions

Strategic direction. The Sexual Orientation and Gender Identity Advisory Group (SOGIAG) is a prime mechanism for addressing LGB and transgender (LGBT) health issues on a strategic scale.

Mental health. The Department has funded a literature review into suicide and self-harm in LGB people that will be published shortly. The launch and dissemination strategy is currently being developed.

Employment – the medical workforce. In 2004, the Department of Health issued a consultation document, *Sharing the Challenge, Sharing the Benefits – Equality and Diversity in the Medical Workforce*. This outlined the key equality and diversity challenges facing the medical workforce over a five-year period, highlighted good practice where it exists, and sought views and comments from stakeholders on how best to tackle the issues. The Department of Health has also been liaising closely with the organisation representing gay and lesbian doctors (GLADD, Gay and Lesbian Association of Doctors and Dentists) in this respect. As a result of the feedback from the consultation, NHS Employers – which is now responsible for equality and diversity issues in the NHS workforce – produced a partnership action plan. The *Equality and Diversity for the Medical and Dental Workforce Partnership Action Plan* was launched in 2005, having been developed in conjunction with key stakeholders in the medical community.

The Department has also commissioned Stonewall to undertake a project to explore why lesbian, gay and bisexual individuals may not report homophobia in the NHS, social care or the Department of Health. The project builds on Stonewall's previous work, *Harassment and Sexual Orientation in the Health Sector*. The Stonewall report is due to be published shortly, along with the Department's response.

Transgender health. The Department has commissioned a project to map existing models for provision of services to people undergoing gender reassignment in England.

Promotion of positive image/good relations. The Department of Health SOGIAG commissioned the taking of LGB and transgender images, which were then put into the NHS photo library for use in NHS and DH publications.

The following leaflets, published on 30 April 2007, form a package of resources to help healthcare organisations improve the quality and uptake of health services for LGB and transgender people:

i. 'An introduction to working with lesbian, gay and bisexual people';

ii. 'An introduction to working with transgender people';

iii. A set of briefing papers to provide easily accessible and understandable guidance for health and social care commissioners, service planners and front-line staff.

In collaboration with PRISM (the Department's LGBT staff group), GLADD and RCN OUT (the Royal College of Nursing's LGBT group), the Department will be

sponsoring a float in the Pride London Parade (30 June, 2007) for LGBT people working in the health and social care sector.

Sexual health. The Department of Health has recently (April 2007) produced a leaflet, *Sexual Health Information for Women Who Have Sex with Women*, which is available from the Sexual Health Information Line. The Department continues to prioritise men who have sex with men for national HIV health promotion, and contracts with the Terrence Higgins Trust to manage and deliver national work. We also fund targeted work with African communities in England and work with the African HIV Policy Network on this. In May 2007, the Department published *Tackling HIV Stigma and Discrimination*, which sets out why action to challenge HIV-related stigma and discrimination is important and describes the new work we are funding to help take this forward. *Tackling HIV Stigma* also sets out how amendments of the Disability Discrimination Act provides protection to people with HIV or AIDS.

5 Involvement and Consultation

The Department of Health is committed to ensuring that all stakeholders are given the opportunity to contribute to and influence policy formulation – within, of course, the context of the DH being a Department of State and thus being subject to executing government policy, subject to the will of Parliament. Stakeholders thus include national interest groups, specialist interest groups, other government departments, and the NHS.

For the Single Equality Scheme to make a genuine impact on reducing inequality and promoting equality, it is vital that the Scheme – in particular the Action Plans – is the result of meaningful consultation and genuine involvement. As stated in the Department of Health Business Plan 2007/08, *'the Department is focused on improving health and well being in the longer term by listening to those who use services and those who provide them. The Department wants to put the user at the heart of what it does'.*

It is also important to explicitly acknowledge that true consultation and involvement cannot be a 'one-off' process or isolated incident, and must be an ongoing process. Methods of consultation and involvement used during the production of this Scheme have concentrated on two broad areas – workforce and service/policy issues.

Workforce Involvement and Consultation

Department of Health staff groups, such as the Ethnic Minority Working Group, EnABLE (the disability staff network), and PRISM were also involved in the production of the SES. Equality and Human Rights Group (EHRG) officials maintain regular contact with these staff groups, and directorate Action Plans will be submitted to them for comment and prioritisation. The Department recognises that these relationships need to be maintained and developed to ensure that staff engagement and involvement is further embedded in core business.

Service/Policy Involvement and Consultation

Following the publication of the initial Department of Health Single Equality Scheme in December 2006, the EHRG invited comments from a number of stakeholders. These bodies are listed in Appendix 4.

The EHRG also invited comments from all recipients/readers of the SES (as set out on page 7 of the December 2006 Scheme), and used a dedicated email address (singleequalityscheme@dh.gsi.gov.uk) to receive comments and views. This email inbox was used by both staff and external commentators.

Views on the content of the Scheme were sought from NHS equality and diversity specialists through DH-run groups, the Strategic Health Authority Equality Leads group and the NHS Single Equality Scheme Learning Sites.

In relation to **race,** an example of involvement and consultation is the Leadership Race Equality Action Plan (LREAP) Independent Panel. The terms of reference for LREAP include:

- providing challenge to NHS leaders on the progress they are making in taking forward the Action Plan;
- assisting in mobilising NHS leaders and leading partners to take action that will have real impact, both in the short and the long term; and
- sponsoring ideas and innovative action for wider take up across the service.

In relation to **disability,** the internal DH staff group EnABLE is active, and the chair of the group is becoming increasingly involved. Furthermore, in October 2006, the DH ran an interactive workshop for disabled people and organisations, facilitated by an independent, external consultant, to assist in the identification and prioritisation of issues. A report on this event can be found as Appendix 5.

There were a number of issues raised at the workshop that were useful to us in reinforcing the need for action, for example:

- information should be available in suitable formats;
- bullying and harassment can occur because of a lack of understanding, training can help tackle this;
- complaints procedures should be simple and quality assured;
- health and social care staff should be aware of how to communicate with people with a learning disability;
- those consulted should be told the outcome of the consultation;
- monitoring information should be collected as part of a single patient record; and
- access should be improved, e.g. for blind people in waiting rooms.

All of these issues are being taken forward by various parts of the Department. A follow-up event is being planned for the autumn, when we shall report back to

participants on what we have done as a result of the first workshop, and seek views on what we should be doing next.

In relation to **gender equality**, the Department has established a Gender Equality Advisory Group (GEAG). The Group comprises a range of key external stakeholders, including Press for Change, the Men's Health Forum, Women's Health Concern, the Equal Opportunities Commission, NHS Employers, the Women and Equality Unit (Department of Communities and Local Government) and key leads from the DH EHRG. GEAG will facilitate wider consultation and the involvement of other stakeholders and policy leads to inform the development of DH policy in its stewardship role of the NHS, linking across all diversity strands when considering gender objectives.

DH has also worked closely with the Men's Health Forum on a number of gender initiatives, including commissioning the Gender Equity Project, which produced a number of recommendations for DH and the NHS that are being incorporated into current action plans. GEAG is also considering further research to analyse gender difference in the way that services are accessed.

In relation to **sexual orientation and gender identity**, the Sexual Orientation and Gender Identity Advisory Group (SOGIAG) was established in 2005. SOGIAG is a group of stakeholder individuals and organisations assisting the Department with the development and delivery of a programme of work to promote equality and eliminate discrimination and prejudice for LGBT people in health and social care, both with respect to service provision and employment. The group has four workstreams: better employment, improving services, reducing health inequalities and transgender health.

On a **national level**, the Secretary of State chairs every two months meetings of a National Stakeholder Forum, and DH will also develop a stakeholder relationships management approach, which will include annual quantitative and qualitative surveys.

New requirements are also being placed on Primary Care Trusts (PCTs) to respond to the views of local people, as expressed through Local Improvement Networks (LINks), and these requirements will need to be delivered in the form of an Annual Report setting out what issues local people raised and what actions the PCT will take in response.

6 Gathering and Analysing Evidence

Gathering and analysing evidence is a central tenet of meaningful equality schemes. The recent Equalities Review, which reported in February 2007, was set up to carry out a fundamental review of the persistent social, economic and cultural causes of discrimination in society today. The main recommendation for a number of government departments including DH was the need to improve the collection and co-ordination of equality data. The Review has been a useful impetus to look at the way DH co-ordinates and can better use equality data. DH is already taking action on this issue.

Equality Monitoring Group

In early 2007, the Department established an Equality Monitoring Group (EMG) chaired by the Permanent Secretary. The EMG will take stock of the equality data currently collected by DH, with a view to refining collection methods and improving the use of data once collected. Some of the specific activities of the EMG include:

- examining existing datasets in relation to equality, and exploring options for data collection to best meet legislative duties and the practicalities of data gathering;
- through the above, identifying obvious gaps and developing improved metrics;
- establishing systems to monitor and evaluate policy and guidance regarding the legal duties to promote equality; and
- exploring the viability of using incentives for the NHS and social care to collect data (i.e. the possible inclusion of data collection in tariff arrangements).

The EMG is looking in particular at data collection broken down by the category of disability, an issue raised at the involvement workshop with disabled people (see Appendix 5).

The EMG will meet every two months during 2007 to assess progress and oversee implementation.

It is important to note, however, that in relation to health and social care, this is most easily achieved by organisations that directly deliver services – as pointed out in section two, the Department of Health does not directly offer or provide services to patients. Accordingly, the most relevant manner in which DH can reconcile its overarching role with the requirement to gather and analyse evidence is through issuing guidance to the NHS, through the consideration and analysis of 'national data' – that is, demographic trends, public health data (through Regional Public Health Groups, for instance) – and through the identification and factoral analysis of groups of people suffering the greatest health inequalities.

A selection of how evidence is used by the Department, and how the Department encourages the NHS to collect and analyse evidence, is set out below:

Race and religion. Patients admitted to hospital are monitored by ethnicity. General practices are required to collect ethnicity data for new patients and this is one of the factors examined during formal visits by the PCTs. DH has produced guidance, *A Practical Guide to Ethnic Monitoring in the NHS and social care* (2005), on monitoring service users by ethnicity. This booklet is aimed at front-line staff, managers, system designers, Boards and committees. The guide also includes advice on monitoring by religion, language and diet. The guidance covers why monitoring is important, the need for this work to be led from the top, which categories to monitor (ethnic codes), the process of monitoring (how to collect the information), and how to analyse and use information collected. It also stresses the need for training staff and informing the public on the importance of ethnic monitoring. In addition, DH is currently looking at how data collection may be improved, for example by ensuring that birth and death registration records ethnicity.

Disability. In October 2006, DH produced guidance for the NHS on measuring impact in terms of disability, *Creating a Disability Equality Scheme: A Practical Guide for the NHS.* This covers involving disabled people, mapping services, assessing policies and action planning. During the workshop involving disabled people (see Appendix 5), categories for the classification of disability were tested. Those present were happy with all recommended categories except 'cognitive impairment' (which covers autistic spectrum disorders). This they felt should be rephrased to be more easily identified by disabled people as representing the category to which they belong. The other categories included 'physical impairment', 'sensory impairment', 'mental health conditions', 'learning difficulty', 'long-standing illness' and 'other' (these are from *Evidence Gathering*, a Disability Rights Commission guide). Those at the workshop stressed the importance of self-definition and the need to have sub-categories and space for those who have multiple disabilities. Information on disability should be collected as part of the

single patient record. DH will take these views into account when drafting guidance on monitoring for disability.

Gender. Monitoring by gender is already widespread, and the challenge for policy makers and the NHS is to use this data (for example, through disaggregation) to inform strategies that are most likely to achieve a particular aim for the targeted gender. DH recognises that under the Gender Equality Duty, being 'gender neutral' is no longer sufficient or adequate – the gathering and analysis of evidence by gender, against the particular service or strategic objective, is now required. The Equality and Human Rights Group issued guidance for the NHS, entitled *Creating a Gender Equality Scheme: a Practical Guide for the NHS*.

Sexual orientation. DH recognises the importance of monitoring by sexual orientation. For example, the national census of patients in mental health wards carried out in March 2006 ('*Count me in*') included monitoring by sexual orientation. In addition, DH commissioned research from Stonewall, *Monitoring Sexual Orientation in the Health Sector*, which gives clear guidance on monitoring of staff but advises that further research is needed to establish how best to support monitoring of patients. DH is also participating in a Cabinet Office pilot to consider the best way to introduce monitoring of sexual orientation in employment practice.

Age. Collating evidence of the uptake and usage of NHS and social care by age is relatively straightforward, as the date of birth is a standard piece of information that is collected by the health and social care system. Some of the challenges include devising the most appropriate age bandings, and reconciling clinical advice in relation to provision and access. On a macro level, based on the 2001 Census, 18.4 per cent of the UK population were over pensionable age; a man over 60 lived on average for another 19.2 years, and a woman of the same age for another 22.8 years

Benchmarking and External Standards

The Department also recognises the value of using external tools and benchmarking standards to assist in the gathering and analysis of evidence – for example, DH is a member of the Stonewall *Diversity Champions* scheme. Since the publication of the December 2006 SES, DH has recognised that further evidence relating to disability would be beneficial in meeting the general and specific duties, and is planning to join the *Disability Standard*. The Disability Standard is a benchmark survey, allowing an organisation to assess its relative position on disability.

The Disability Rights Commission regards the standard as an excellent tool for assisting compliance with the public sector duty, with its emphasis on collecting evidence, setting targets, and taking appropriate action to achieve those targets. As a result of DH participation in this programme, the Department will receive a Disability Benchmark Report, which will form the basis for ongoing action.

7 Identification and Assessment of Key Functions Relevant to the Equality Duties

Given the inherent nature of the core business of DH, the majority of its functions and processes are relevant to the equality duties. It is important, however, to prioritise these in accordance with government policy, and areas of greatest impact and effectiveness. Appendix 7 sets this out, grouping the work into broad policy areas by directorate.

As this Scheme and the DH structure continue to evolve, it is important that the assessment of key functions for their relevance and priority order to the equality duties remain refreshed. It is therefore an early action for the Equality and Human Rights Group to lead this review process, with staff groups taking a prominent role in this work.

8 Equality Impact Assessments

Undertaking Equality Impact Assessments (EqIAs) is a central tenet of compliance with equality legislation. Public bodies are required by law to complete EqIAs relating to race, disability and gender, and as DH is adopting a Single Equality Scheme approach, DH EqIAs will also address age, religion and belief, and sexual orientation.

Impact Assessments provide an effective mechanism for directorates within DH to identify existing or potential unintended differential impacts, which, unless mitigated, would be disadvantageous to certain groups of individuals. The EqIA process focuses on assessing, consulting upon, recording and acting upon the likely equality impact of a DH function or policy. The Department recognises that inequalities in health persist across the equality spectrum (race, disability, gender, age, religion and belief, or sexual orientation), and that these factors often overlap. It is thus vital that DH policy implementation acts to mitigate these inequalities whenever possible, both to meet organisational aims and to act within equality legislation. This does not, however, mean 'treating everybody the same' – as the gender equality duty highlights, for instance, men and women respond to the same initiative or policy in a different way. Rather, the process of undertaking an EqIA reveals where and how differential inputs may be required to drive towards equality of outcome. When an EqIA reveals a potential unfavourable differential impact, DH commits itself to exploring alternative means of achieving the same business objective that cause no (or fewer) adverse impacts.

Undertaking EqIAs

In broad terms, the following process is followed when undertaking an EqIA:

- identification of departmental responsibility or ownership of the policy or function; identification of the intended recipients or beneficiaries; and identification of key stakeholders;
- consideration of the stated aims and objectives of the policy or function; what should be achieved; and what the success criteria or desired outcomes are; and
- consideration and recording of all the relevant evidence for potential discrimination, or promotion of equality and good relations.

A range of evidence may be used, including, for example:

- surveys and questionnaires;
- census and data from National Statistics;
- employment monitoring data and workforce plans;
- service evaluations and audits;
- academic and clinical research;
- the NHS Information Centre; and
- NHS data returns to the Department of Health.

Service or policy-specific evidence is of most relevance, and function specialists within DH are best placed to identify the most appropriate source of data to inform EqIAs.

The Department will provide Equality Impact Assessment Training to all relevant staff across all policy areas. Following successful pilots, this training is currently being rolled out. As this proceeds, it will be continually evaluated to ensure it continues to meet its aims and objectives.

In addition to raising awareness across the Department, the training has been specifically commissioned to add value in terms of increased skill levels among staff.

The aim is for policy colleagues:

- to gain an understanding of equality issues and why they are important to the work of the Department of Health;
- to understand how carrying out equality impact assessments will improve efficiency and effectiveness;
- to be able to relate impact assessments to present and forthcoming legislation;
- to understand equality impact assessment processes including the relevance screening stage;
- to gain the knowledge and skills to carry out an equality impact assessment; and
- to have the opportunity to carry out an equality impact assessment.

With the guidance of external advisors, the Department has developed an integrated EqIA tool for use by policy makers. This tool is designed to lead policy makers through the process outlined above, and to provide a mechanism for recording how policies have been developed and formed by the EqIA process.

Supporting this is a recently revised Cabinet Office framework (Impact Assessment) for undertaking assessments of expected costs, benefits and impact of a policy, for use by all departments. The framework reaffirms the need for due regard to be given to the legal obligation to conduct race, disability and gender impact assessments for all relevant policies. The framework also makes it clear that these assessments should be rigorous and robust examinations of the policy's impact upon each of the equality strands. In addition, the framework invites policy makers to ensure that they have given appropriate consideration to other potential impacts of a policy, e.g. on health, sustainable development or the rural community.

9 Publication of Monitoring, Assessments and Consultations

The Department recognises that, as part of developing and maintaining credibility, confidence building and transparency, the publication of the results of monitoring exercises, assessments, consultation events and involvement initiatives is important.

DH has a number of mechanisms for making such information available to its staff and stakeholders. Equality Impact Assessments are published, either as part of a policy document or separately, on the DH website. The Department also publishes an Annual Departmental Report, which includes a progress report on equality issues.

In addition, the Equality and Human Rights Group will be exploring means of ensuring that DH continues to be held to account on progress relating to the Single Equality Scheme (particularly the directorate action plans), and publishing the results of monitoring, assessments and consultations will assist in making this a meaningful process.

10 Workforce: the Department of Health as an Employer

The Department recognises the importance of having a diverse workforce, with this diversity presenting itself at every level. As the Department of State responsible for health and social care – sectors which themselves have a proud history of diverse employment profiles – DH accepts its responsibilities as an employer in relation to promoting good relations between all people through fair and effective employment practice.

In terms of reinforcing this commitment, the strategy is to ensure that diversity is mainstreamed into all human resources (HR) programmes, so that diversity is not an 'add-on' or an afterthought, but part of the full employment life cycle.

Monitoring

The HR department currently monitors its employment processes by race, disability and gender (in accordance with the statutory duties), age and working pattern, and intends to extend monitoring to sexual orientation later in 2007. Monitoring takes place across the following strands:

- staff in post;
- applicants for employment, training and promotion;
- staff receiving training;
- performance ratings;
- staff involved in grievance and disciplinary procedures;
- analysis of staff by termination; and
- displaced staff and staff applying for voluntary severance.

We also monitor the levels of staff satisfaction and experience of working at the Department of Health. The primary vehicle for this is the staff survey. The survey data is analysed by five equality strands, and actions are planned based on this analysis.

We recognise the need to deliver improvements in our baseline data to ensure we minimise the numbers of 'unknowns' across the data strands and to make data analysis more meaningful. Employment data analysis is presented each quarter to

the HR Programme board to identify trends, and will also be made available on the Department's internal website.

Workforce Demography

The workforce demography of the Department is set out in Table 1 below.

Table 1: DH Workforce (as at 28 February 2007)

Grade	% Female	% BME*	% Disabled*	Total**
AO	68.9	45.8	9.0	122.3
EO	69.6	33.9	6.7	428.2
HEO	51.0	23.6	5.8	241.2
SEO	52.7	15.7	7.0	376.5
Grade 7	50.8	8.1	4.7	413.5
Grade 6	39.8	5.8	2.2	234.0
SCS	40.0	5.8	5.6	227.5
Fast Stream	46.8	3.9	7.3	62.0
Total	53.5	17.8	5.8	2,105.3

Age (% by age group)

<20	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	>=60
–	2.6	10.3	12.6	13.6	17.9	15.6	15.9	9.8	1.6

The Department gathers data on disabled staff using the following categories (number by disability)

Hearing impairment	19
Learning difficulties	***
Mental illness	10
Neurological conditions	13
Other	20
Physical coordination impairment	11
Progressive conditions	20
Reduced physical capacity	21
Severe disfigurement	***
Speech impairment	***
Visual impairment	17
Walking impairment	17

* % of those where information is known
** A full-time equivalent figure that includes permanent DH employees currently engaged on DH work
*** Less than 10

- Across all government departments, DH ranks third in terms of the proportion of BME staff in the Senior Civil Service (SCS): 8.8 per cent (taking SCS staff in our agencies into account. The number of BME staff in the SCS in the core Department is proportionately lower).
- Nearly 18 per cent of all DH staff are from BME groups.

Figure 1. Percentage of staff by grade who are female

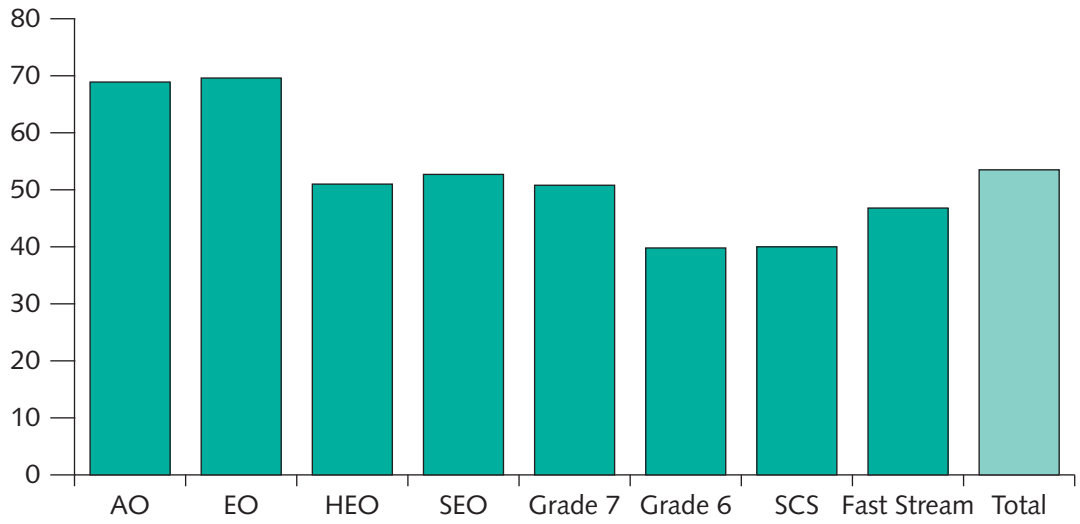


Figure 2. Percentage of staff by grade who are BME

(excludes people where information is unknown)

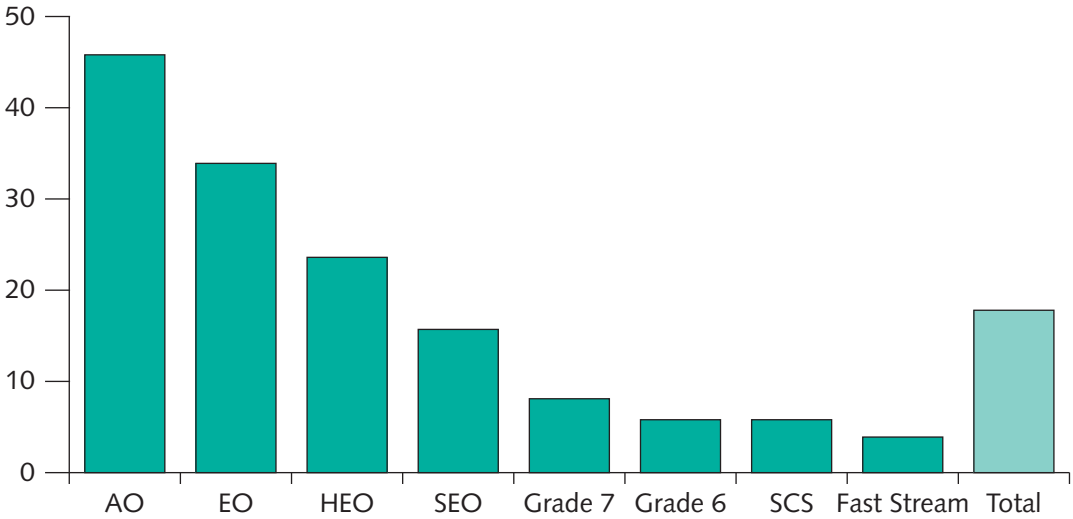


Figure 3. Percentage of staff by grade who are disabled

(excludes people where information is unknown)

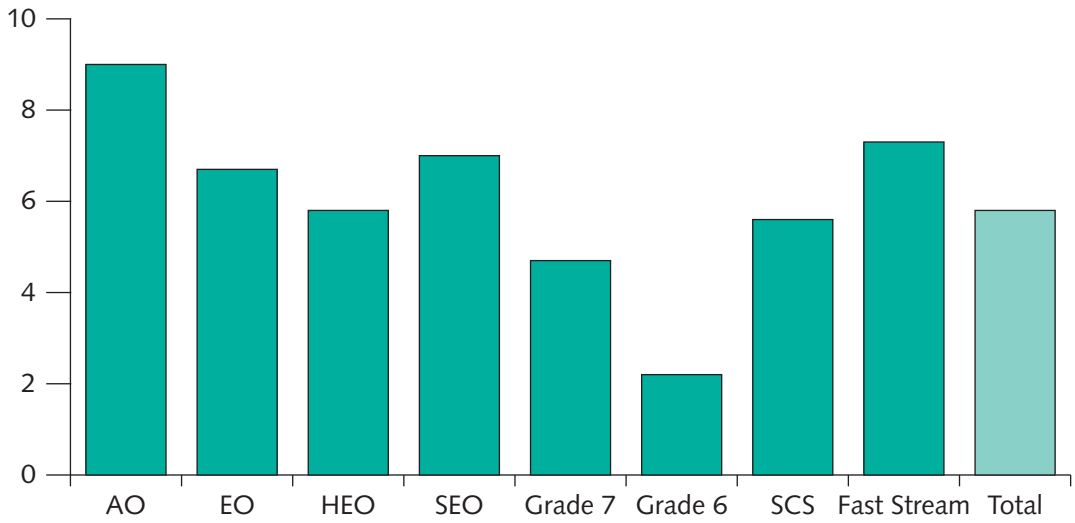
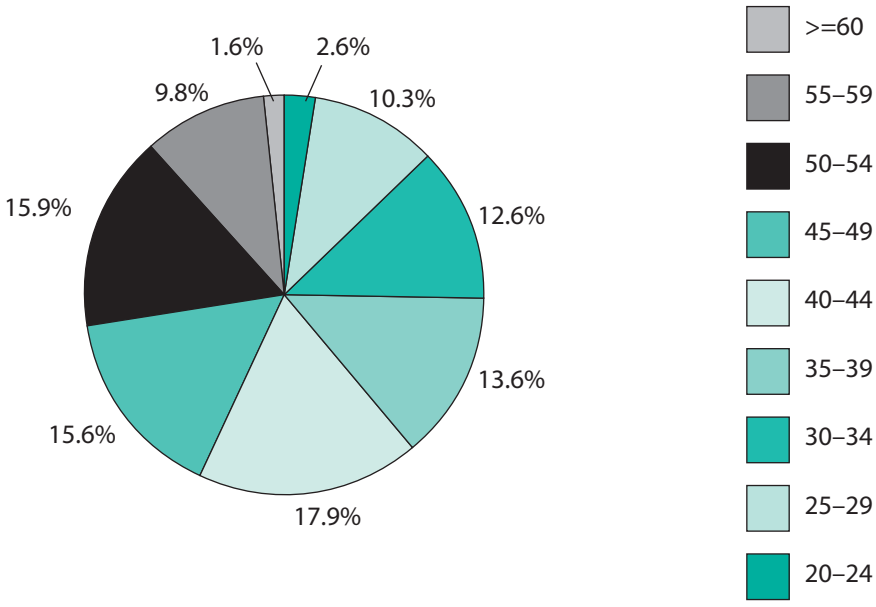


Figure 4. Percentage of staff in each age group



Targets

While overall the diversity profile of the Department has improved significantly, DH recognises that more work needs to be done to ensure much better representation in the senior grades. As part of its commitment to diversity, the Cabinet Office has set out a 10-point plan to improve representation across all government departments and their agencies. The Cabinet Office set targets in 2005 to improve representation for disabled, BME and women in the SCS by 2008. However, in 2005 the Department had already exceeded those targets and so has set 'stretch targets' as an additional challenge to improve from our baseline data.

Local action will continue to be taken to support staff in under-represented groups, and progress will continue to be made towards the DH target for the SCS. The targets by April 2008 for the DH are:

- 43 per cent of the SCS to be female;
- 35 per cent of paybands 2 and 3 to be female;
- 10 per cent of the SCS to be from BME groups; and
- 5 per cent of the SCS to be from disabled people.

The Department ranks second in terms of the proportion of women in the SCS grade, and already exceeds the cross-Civil Service target of 37 per cent. In total, over half of DH staff are female.

The DH targets contrast with other government departments, as illustrated in Table 2.

Table 2: Civil Service Departmental Equality Targets

Department	Women in SCS		Women in TMP		BME in SCS		Disabled in SCS	
	April 2006	2008 Target	April 2006	2008 Target	April 2006	2008 Target	April 2006	2008 Target
Cabinet Office	33.7%	40.0%	21.4%	35.0%	3.4%	6.0%	2.9%	5.0%
Crown Prosecution Service	39.3%	37.0%	16.7%	40.0%	7.7%	15.6%	7.4%	9.5%
Dept for Communities & Local Government	40.3%	42.0% to 46.0%	31.0%	30.0% to 33.0%	2.9%	5.0% to 8.0%	1.5%	3.2% to 4.5%
Dept for Constitutional Affairs	34.8%	45.0%	34.4%	37.0%	5.0%	4.0%	1.9%	3.2%
Dept for Culture Media & Sport	29.4%	37.0%	20.0%	No Target	3.0%	4.0%	0.0%	3.2%
Dept for Education & Skills	38.4%	45.0%	37.1%	40.0%	1.5%	6.0%	3.0%	4.0%
Dept for Environment Food & Rural Affairs	26.4%	37.0%	26.8%	30.0%	2.9%	4.0%	2.2%	3.0%
Dept for International Development	27.7%	37.0%	33.3%	35.0%	10.1%	12.0%	3.6%	4.0%
Dept of Trade & Industry	26.7%	37.0%	22.8%	35.0%	4.3%	8.0%	15.6%	4.7%
Dept for Transport	21.4%	30.0%	22.5%	30.0%	2.4%	4.0%	0.7%	3.2%
Dept for Work & Pensions	35.7%	39.0%	27.3%	30.0%	2.3%	5.0%	3.4%	6.0%
Dept of Health	40.5%	43.0%	30.8%	35.0%	8.8%	10.0%	4.2%	5.0%
Foreign & Commonwealth Office	32.4%	25.0%	37.5%	10.0%	0.0%	4.0%	33.3%	3.2%
GCHQ	11.4%	20.0%	0.0%	No Target	0.0%	No Target	0.0%	No Target
HM Revenue & Customs	25.1%	32.0%	17.5%	25.0%	2.6%	3.3%	4.1%	8.0%
HM Treasury	35.5%	37.0%	25.0%	30.0%	3.1%	4.0%	4.6%	3.2%
Home Office	31.1%	40.0%	32.1%	30.0%	4.8%	8.0%	1.3%	3.2%
Ministry of Defence	8.8%	15.0%	12.9%	15.0%	0.0%	3.2%	2.2%	4.0%
National Assembly for Wales	34.7%	40.0%	16.0%	30.0%	1.7%	2.5%	2.5%	3.2%
Scottish Executive	31.9%	37.0%	26.5%	30.0%	0.4%	2.15%	0.8%	3.9%
Treasury Solicitors	42.9%	50.0%	46.2%	55.0%	10.5%	10.5%	3.4%	5.0%

Source: SCS Database, Personnel Statistics, Cabinet Office
Data is based on departmental returns and, where applicable, reflects numbers 'In Post' as at the date specified, irrespective of funding arrangements.

SCS Database figures exclude some Civil Servants who work at senior level, e.g. senior diplomatic and military personnel.
The Foreign and Commonwealth Office's own departmental diversity data can be found at: www.fco.gov.uk
'No target' denotes department chose not to set target in their Departmental Diversity Delivery plan.
TMP stands for top management posts (payband 2 and above); BME stands for black and minority ethnic.

Equal Pay

For 2007, the Department will conduct a full **equal pay review** for AO–Grade 6 staff. Detailed plans are being developed and have been fully discussed with recognised trades unions. Agreement to the plans is anticipated in summer 2007. The review will look at gender (as an explicit commitment in response to the gender equality duty), ethnicity, disability and age across the full range of reward mechanisms. Findings are expected in summer 2007 and an action plan is scheduled for agreement in summer 2007.

Recruitment

Overall, we recognise the important role that recruitment can play in helping to deliver a more representative profile. Although the Department's workforce has remained static, we are aware that we need to deliver improvements, in particular to our Leeds office, where the profile across all grades is much less representative in terms of BME staff than the local population. We will develop plans [to work] proactively [over the coming year to improve this profile], by developing links with appropriate organisations that can help support action locally. We also need to ensure we monitor by geography and grade the other statutory strands.

We will be developing and rolling out the Professional Skills for Government (PSG) gateways, which will apply to both recruitment and promotion across the Department.

In relation to equality and diversity, the benefits of the PSG Gateway implementation are:

- no identification of the individual at earlier stages (identified by a unique candidate number);
- consistency of standards to PSG (rather than post-specific promotion);
- interviewed by independent people within Department (and possibility some representation across government on recruitment panels to aid consistency and independence); and

- only trained personnel can take part in any stage of the Gateway process.

Organisational change

A key equality issue for human resources professionals is the impact that organisational change can have on the diversity profile of an organisation. DH recognises that the most appropriate method for dealing with such concerns is to take an objective and transparent approach to the issues; to identify any adverse impact; and then plan to take mitigating action.

The Department recently undertook a restructure of its corporate services. An equality impact assessment was undertaken by an independent consultant and revealed some evidence of adverse impact. The report and its recommendations are currently being considered, in order that DH can take the appropriate action.

As a result of the outcome of its business planning processes, the Department will have a number of displaced staff to support. Recruitment controls and a new deployment policy have been introduced alongside a Voluntary Exit Scheme. The implications of these outcomes for staffing will be monitored across diversity strands at each stage of the selection process.

Employee support and involvement

The Department has a number of groups to support staff from under-represented groups. We have a disabled working group, an ethnic minority working group and a group to support gay, bisexual and transgender staff. The Department is reviewing the governance arrangements for these groups, and plans to develop an overarching equality group that will consider issues across all diversity strands. The plan is to ensure that this group feeds into policy review and development in a more systematic way.

In addition, the Department plans, as part of developing work on the SES, to instigate a more systematic process in terms of employee engagement, in particular in relation to people with disabilities, but also to staff from minority ethnic groups and LGB staff. The staff networks will be formally involved in this process, as will the departmental trade unions.

The key steps in this process will be:

- production of a paper on existing activity and priorities, including an analysis of employment monitoring data (by end of August 2007);
- involvement with groups of staff to establish requirements – i.e. what aspects of strategy should be prioritised – and to identify areas that should be included (by end of October 2007); and
- development of an action plan setting out clearly which aspects of requirements will be taken forward and why, response to involvement – including timescales, resource implications (including long-term benefits), and who is accountable for delivery (plan published by 1 December 2007).

Departmental Arm's Length Bodies

There are currently 23 arm's length bodies (ALBs) in the sector, employing over 23,000 staff. Because of the ALB review, there have been a number of change programmes affecting staff. The ALB HR best practice and policy guidance clearly set the expectation that equality impact assessments are a fundamental part of every strategic analysis and decision-making process.

In carrying out the HR programme, individual organisations must demonstrate due regard to the equal opportunities policies in place within their organisations and ensure that all staff are treated fairly. Staff should be given access to appropriate dispute resolution procedures if they feel they have been unfairly treated.

In applying the best practice policy and guidance equality of opportunity should be provided, so that no staff are discriminated against either directly or indirectly in the application of any of the policies and guidance.

Individual ALBs must be able to demonstrate due regard to the equal opportunity policies in place in their organisation, and ensure that all staff are treated fairly, and they should carry out an impact assessment to ensure there is no discrimination resulting from any change activities.

Learning and Development

DH recognises the value and importance of providing fair and equitable development opportunities for all staff, throughout their careers. As stated in the Department's valuing diversity policy *'valuing diversity is core to the Department's delivery of its functions, celebrating the differences between people in ways that promote the values, behaviour and working practices of everyone in the organisation'*. DH is committed to promoting fair and equal opportunity in all Learning and Development activities.

Training, and equality of access to training, has a key role to play in promoting equality of opportunity, and good relations between all staff. In line with the DH equal opportunities policy statement, the Department aims to promote equality of opportunity, so that no employee is discriminated against either directly or indirectly on grounds of race, colour, ethnic or national origin, sex, marital status, responsibility for children or other dependants, disability, age, work pattern, sexual orientation, gender reassignment, trade union membership or activity, or religious or political beliefs.

Talent Management

There is an emerging focus on developing internal talent through effective and systematic talent management and succession planning. During 2007, human resources at DH will be formulating a talent strategy, then mapping out and designing the future talent management programme based on the principles set out in that strategy. A talent management programme will then be rolled out from October 2007 onwards, with evaluation to ensure that it meets expectations and provides equality of access and outcomes to all employees. DH is also currently participating in *Leaders Unlimited*, a cross-government development scheme to support staff from under-represented groups.

Ensuring that learning and development meets the needs of a diverse population

DH recently commissioned an external consultancy to conduct an assessment of learning products, supporting material and facilitators/providers.

The aim of the assessment was to ensure that training and development activities carried out within the Department of Health do not discriminate against any group of people and do promote equality wherever possible. More specifically, the objectives were to:

- help identify areas of potential or actual discrimination (direct or indirect) arising from the leadership development carried out at the Department of Health;

- ensure that there are no unintended or discriminatory constraints on individuals' access to and engagement with programmes;
- ensure that the content and delivery of programmes is both non-discriminatory and contributes to the maintenance of a positive organisational culture; and
- help to mainstream or integrate equality in all the policies and procedures within the Department of Health.

A report, *Equalities Proofing Development Activities*, was produced by the Office for Public Management in March 2007. Two separate audit tools have been created to assess:

1. participation and attendance on the programmes; and
2. wider issues, including marketing and teaching material, facilitator impact, design and evaluation.

DH plans to implement the recommendations in the report, and to use the tools to assess all learning and development provision.

Governance

Responsibility for the employment aspects of diversity for the Department as an employer sits within the HR function. Equality deliverables have been embedded within the various programmes of HR, and individual members of the Senior Leadership Team are responsible for delivery. Furthermore, the HR Programme Board receives regular updates on diversity, including quarterly monitoring on employment data. Regular reports are also provided to the Departmental Management Board.

In addition, involvement with the Departmental Trade Union Side (DTUS) is ongoing in accordance with HR policy framework, DTUS quarterly meetings with Corporate Services Director General's and Senior HR team and working within the Partnership Agreement. HR Policy involves DTUS as key stakeholders in HR projects/deliverables at the development stage through to implementation and review stage as standard practice. Equality and impact are taken into consideration and factored into the final deliverable – with DTUS and HR Policy working together.

11 Ensuring Public Access to Information and Services

The Department of Health is committed to transparency and openness, and recognises that individual members of the public and sections of the community may experience barriers in accessing information and services. DH therefore makes an overarching commitment through this SES to use language appropriate to the intended audience and ensure that information is available in accessible formats.

DH also makes the following commitments with respect to improving and ensuring public access to information and services:

- All information will be written in plain English, and, where illustrations are used, there will be good colour contrast.
- When DVDs or similar types of media are produced, they will be signed or subtitled as a matter of course – an issue raised at the involvement workshop (see Appendix 5).
- All information intended for the public will be in accessible formats.
- Standard information leaflets will make it clear whom to contact to obtain information in alternative formats.
- Information for the public will be drawn up with the help of disabled people.

DH understands that different sections of the community prefer to receive information in different ways; and indeed that different communications styles are more effective with some people than with others. DH will thus seek to be informed by specialist groups about preferred or most effective communication methods, and will try to be a learning organisation when it comes to understanding how barriers to accessing information and services are perceived by the intended recipients of communications.

12 Successes in Promoting Equality

The Department of Health is committed to reducing inequality in health and social care and, as an employer, to demonstrating the highest employment standards relating to equality and diversity. There is a recognition that these tasks are challenging, and that the nature of these challenges will evolve as the expectations of society and of the workforce change over time. However, the Department of Health has some notable successes in promoting equality and demonstrating good practice, and this section highlights some of these.

Race: *Many Rivers to Cross* – Promoting Good Race Relations

On 2 April 2007, the Minister for Health Services hosted a lunch event to celebrate the contribution of all those featured in the book *Many Rivers to Cross – the History of the Caribbean Contribution to the NHS*. The book, published in November 2006, tells the fascinating story of the Caribbean men and women who staffed the NHS in its formative years. It includes personal testimonies from those who made this vital contribution, as well as archive photography. The event commemorated the bicentenary of the abolition of the slave trade and was attended by BME public servants and the Deputy Prime Minister, who recognised the vital part that people from the Caribbean had played – and continue to play – in the evolution of the NHS over the past 60 years (*Many Rivers to Cross* is available from the Stationery Office at www.tsoshop.co.uk).

Learning Disabilities: NHS Connecting for Health – Electronic Prescription Service

As part of NHS Connecting for Health's commitment to ensuring that information about its programmes is accessible to all parts of the community, a leaflet about the Electronic Prescription Service has recently been developed for people with a learning disability.

The leaflet (developed in consultation with Mencap) explains how the new Electronic Prescription Service will be implemented and what changes patients can expect to see in the future. The leaflet is part of a suite of inclusive communication methods aimed at a diverse range of people – it is available in 16 languages other than English, as well as in Braille, large print and audio format.

Older People and Disability: DH Campaigns Team – Dignity in Care

The Dignity in Care campaign encouraged health and social care staff to work in partnership with a range of organisations that represent and work with older people and those who care for them. The campaign received several positive reports in the *Nursing Times* in January 2007 – an article reporting that the number of elder abuse cases coming before the nursing regulator had halved in the previous year wrote: *'nurses attributed the decrease in cases to new elder abuse awareness initiatives such as the Government's Dignity in Care campaign, launched last November'*. During 2007/08, the plan is to extend the focus of the campaign to include disabled groups.

Race/Mental Health/Religion and Belief: DH Communications – *Positive Steps*

Positive Steps is a new resource for health professionals. It is a practical guide to delivering race equality in mental health (part of the Delivering Race Equality programme), and offers advice and support for improved responses to the needs of BME patients. The guide highlights good practice in the mental healthcare system, aiming to disseminate and widen best practice. It incorporates key mental health issues and religious and cultural needs for different ethnic groups. The next stage of the programme is a campaign to increase awareness of mental health services among BME communities.

Sexual Orientation, Gender, Ethnicity, Age: Promotion of Good Sexual Health

Evidence indicates that women, gay men, young people, black African and black Caribbean people are at highest risk of experiencing poor sexual health. Publications from the Health Improvement Directorate target these groups in particular – for example, gay men and black Africans are targeted for HIV testing to help reduce levels of undiagnosed HIV. A 'Civil Partnership' box has also recently been added to forms and documentation.

Learning Disabilities: *Positive Practice, Positive Outcomes* – A Handbook for Professionals in the Criminal Justice System Working with Offenders with Learning Disabilities

This handbook was published by the Care Services Improvement Partnership (CSIP) as part of compliance with the Disability Discrimination Act 2005, in response to the duty to eliminate discrimination and harassment of disabled people and promote greater equality of opportunity for disabled people, including

interactions between people with learning disabilities and the criminal justice system. The aims of the handbook are to help criminal justice professionals to:

- recognise when a person has learning disabilities;
- improve their communication with and support for people with learning disabilities;
- establish and maintain links with local learning disability services and other support services; and
- be aware of the legislation in place to protect people with learning disabilities.

Human Rights: *Human Rights in Healthcare – a Framework for Action*

DH has produced *Human Rights in Healthcare – a Framework for Action*. This is the product of a project jointly run by the British Institute of Human Rights and the Equality and Human Rights Group: they worked with five NHS pilots on developing a framework for NHS organisations to help them use a human rights-based approach to improve service planning and delivery. It is intended to assist NHS organisations that wish to take human rights forward in their own organisations.

All Strands: Guides for the NHS – Equality and Human Rights Group Publications

The Equality and Human Rights Group (EHRG) has published a number of guides for the NHS and social care, to encourage and assist them in achieving compliance with equality legislation and best practice. These guides include *Creating a Gender Equality Scheme: A Practical Guide for the NHS*, *Creating a Disability Equality Scheme: A Practical Guide for the NHS*, and *Equality and Human Rights in the NHS – A Guide for NHS Boards*, which was published alongside the 2007/08 Operating Framework.

Sexual Orientation: *Real Stories, Real Lives* and LGBT History Month

Real Stories, Real Lives, LGBT people and the NHS was a DVD produced by DH and launched in June 2006. The DVD was produced as a training and awareness resource for the NHS, and aimed at supporting healthcare organisations to develop strategies to promote equality and eliminate discrimination for LGBT people in the health and social care system. The stories included in the DVD were real-life experiences of LGBT service users and staff in the NHS and social care. In February 2005, DH and PRISM (the LGBT staff group) held an LGBT History Month. This

had ministerial support, and there were keynote speeches delivered by the NHS Chief Executive and the National Director for Equality and Human Rights.

Disability: *You Can Make a Difference* leaflets

The Department of Health and the Disability Rights Commission jointly produced good practice guidance for both primary and secondary care – *You Can Make a Difference* – that gives practical suggestions for ways in which NHS managers and healthcare staff can make a real difference by meeting the needs of disabled service users. First published in 2004, to date over 150,000 copies have been ordered.

13 Procurement, Partnerships and Governance

Procurement

The potential that major public bodies have to use their purchasing and procurement power as a lever for positive impact on equalities is significant. DH acknowledges this influencing factor, and views procurement as an opportunity to exercise this influence through open and transparent processes and systems.

The duties conferred on public bodies by equality legislation also apply to procurement. Public bodies must take race, disability and gender equality into account when procuring goods, service or works from external providers. Public bodies must build relevant race, disability and gender equality considerations into their procurement processes to ensure that all of their functions meet the requirements of equality legislation, regardless of the actual provider of the goods, services or works.

In relation to disability, if a contractor is carrying out public functions on behalf of a public authority, the disability equality duty (DED) applies to that contractor. If the contractor is simply providing services on behalf of a public authority, then the obligation to comply with the DED remains with the public body that contracted out the work.

In relation to gender, where a contractor is carrying out a public function on behalf of a public body, the legal liability for the gender equality duty (GED) in relation to that function remains with the public body contracting out the function.

At the Department of Health, information about these legal obligations is included in the standard terms and conditions for the contracting of services. Clauses in contractual terms explicitly specify that contractors must comply with equality law, and must monitor equality within contracts awarded. Race equality training is being delivered on an ongoing basis for procurement staff, and monitoring of compliance with procurement guidance has been introduced as part of the audit process.

Procurement guidance within DH is explicit about standards and expectations of equality and diversity from those who provide services to or on behalf of the Department. Procurement guides are under regular review, and this allows

up-to-date advice to be provided by the Equality and Human Rights Group to ensure that legislative requirements are inherent in the process.

The Mosaic Project. The Department of Health recognises the vital importance that procurement has in the NHS, where approximately £15 billion is spent on goods and services. Accordingly, in 2004 DH established the Mosaic Project, which aimed to align race equality and procurement goals. The project itself resulted from the Commission for Racial Equality (CRE) guide for public bodies, *Race Equality and Public Procurement*. The Guide provides help to all public authorities and all NHS bodies to meet their duty under the Race Relations Act (RRA) when procuring goods, works and services from external suppliers. It explains how public authorities should take account of their duty to promote race equality in their general procurement policies and practice and, for individual contracts, at each stage of the procurement process.

Mosaic is organised around three broad goals – developing, through pilot sites, good practice of procurement based on CRE guidelines; promoting and disseminating the learning from the pilots; and supporting the development of procurement professionals and networks.

Its methodology has three aspects: working with NHS organisations and staff; working with NHS prime or first-tier suppliers and getting them to understand the legal responsibility to the RRA; and promoting the use of small and medium-sized enterprises (SMEs), BME suppliers, and supplier diversity. Fundamentally, the Mosaic methodology works with both the supply and the demand sides of the procurement process.

Mosaic is now hosted by Guy's and St Thomas' NHS Foundation Trust and continues to work to integrate race equality into procurement processes, improve the quality of services and meet the needs of different communities. The project is based on improving the overall value for money of goods, services and works purchased, and on an appreciation that good race equality practice relates to good business sense. Thus Mosaic is an expression of the Department's commitment to the promotion of good race relations. Mosaic is now building on its work on race equality by looking at the promotion of wider equality strands within procurement, and it recently produced good practice guidance on integrating equalities into healthcare, entitled 'Beyond Procurement: connecting procurement practice to patients'.

Partnerships

The Department welcomes and encourages partnership working across the range of public, private and voluntary agencies where the strategic interests coincide. In such multi-agency forums, DH will ensure that it leads in advocating a positive endorsement of partnership functions and programmes to promote equality, diversity and human rights. It is important for this SES to make clear that the Department applies the same principles to partnerships as it does to procurement: that is, DH will not knowingly enter into partnerships with organisations or bodies that do not comply with all equality legislation. This does not preclude dialogue with organisations or bodies that hold controversial or challenging views – DH recognises that health and social care have many stakeholders – but formal partnerships with those who actively campaign against equality legislation, or contravene it, will not form official DH policy.

Governance

The organisational effectiveness of equality schemes is determined by the governance structures that underpin workstreams such as this Single Equality Scheme. Commitment from departmental leaders (the Permanent Secretary) is vital, and needs to be reinforced by clear and effective governance structures. The role of the Equality and Human Rights Group and the National Director for Equality and Human Rights is central to this, but ownership of the agenda cannot be left solely to a centralised directorate. Thus effective governance underpins DH commitment to the Single Equality Scheme.

The Department of Health continues to improve on the accountability, responsiveness and openness to equality by ensuring that equality is not a stand-alone function, and that monitoring compliance with legislation, progress to improve upon past performance and reporting on equality are not separated from the general leadership of the organisation, but are fully incorporated across the structure that directs the organisation.

As part of the further embedding of equality and human rights in the DH priorities, monitoring and reporting of progress against this Single Equality Scheme's high-level Action Plan will fall to the Policy Committee. This will improve the ability of the senior leadership team to monitor policy screening and identify any upcoming policy development that requires equality impact screening, as well as to review outlying results of equality impact assessments.

The Departmental Management Board (DMB) of DH has ultimate responsibility for ensuring that the Department fulfils the objectives of this policy and complies with the relevant legislation. Annually, it will review the report of progress against this SES, taking into account any recommendations made by the HR Programme Board and Corporate Management Board and Committee and, if appropriate, make recommendations and amendments. The Departmental Management Board will receive this in the form of an annual assurance to enable it to satisfy itself that due regard is being taken of equality in both policy delivery and people management. The equality content of the Departmental Annual Report (and Autumn Report) will subsequently be agreed by the DMB.

The Policy Committee (of the Departmental Management Board) is responsible for monitoring this SES action plan and the continued application of equality screening and equality impact assessments across the DH policy delivery. This Committee will receive a report at least quarterly on progress against the SES action plan and the programme of policy equality screening. The Policy Committee will contribute to the Annual Report to the Departmental Management Board.

The Corporate Management Board is responsible for oversight and for monitoring performance against the overall Department's corporate plan, covering HR, finance, planning and 'governance' issues. The Corporate Management Board will receive a quarterly report on equality and human rights alongside the balanced scorecard. This forms part of the overall corporate leadership of DH, providing a high-level approach to corporate activity and the performance of DH primarily as an employer.

On an individual basis, the Permanent Secretary in his role as Accountable Officer is accountable for effective implementation of equality. The Permanent Secretary is advised by the Director of Equality and Human Rights.

The Human Resources Directorate is responsible for ensuring that procedures relating to staff recruitment, selection, career development and discipline are carried out in accordance with the policy. Reporting through the Director of Human Resources, the directorate is responsible for reporting through the HR Programme Board to the Corporate Management Committee progress against application of equality and diversity procedures in DH.

The Equality Delivery Assurance Group (EDAG) is at the heart of the governance system relating to equality, and has been established to connect organisational objectives with the internal equality agenda. The EDAG will be the major lever across the equality and human rights work programme, challenging strategy and implementation both within EHRG and the wider Department.

The Equality Delivery Assurance Group is an advisory body, whose responsibility is to coordinate and provide assurance on compliance with equality legislation and delivery against the equality work programme in DH, taking into account the range of NHS-based pilot and programme activities and cross-government activity. The EDAG will be key in delivering assurance that the Department is meeting its responsibilities with regard to equality and human rights both as an employer and, more generally, against policy aspects of the DH work programme to the Policy Committee.

All members of the **Senior Leadership Team** in DH (Senior Civil Service) are responsible for facilitating a culture of diversity and respect in the areas of the Department for which they are responsible. Each member of the Senior Leadership Team has a specific equality and diversity objective that forms part of his or her business objectives. In addition, each member will be individually performance managed on the carrying out of their business and personal objectives with due accordance of equality and to identify and facilitate appropriate development opportunities for all staff and encourage staff to take up those opportunities.

14 Action Plans

The action plans are the foundation of any equality scheme. In putting together these plans, the following points should be noted:

- Plans that cut across strands are listed only once, to avoid duplication.
- The development of action plans is an ongoing, and that some issues are included which may have been published in other forums.
- All areas of DH will integrate equality actions into the mainstream business planning process from 2007–08.

In order to provide an overarching framework for the action plans, actions have been grouped as follows:

(**Note**: Due to departmental organisational changes, responsibility for some of the areas may change.)

Action Plan – Human Resources/Workforce

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Establish further development programmes (for under-represented groups	Three Threshold workshops very successful. Need to run more to help support 10-point plan targets	DMD-HR	December 2007	Improved representation in DH workforce	✓	✓	✓	✓	✓	✓
Ensure talent scheme is inclusive and representative		DMD-HR	October 2007	Improved representation in DH workforce	✓	✓	✓	✓	✓	✓
Incorporate development tools in programmes that help to promote 'valuing difference'	To raise awareness of Diversity issues across DH	DMD-HR	September 2007		✓	✓	✓	✓	✓	✓
Outputs from PSG to be analysed as the basis for further action	Better targeted Learning and Development initiatives	DMD-HR	September 2007		✓	✓	✓	✓	✓	✓
Rollout training on equality to staff	To improve employment practice and raise awareness of equality and diversity	DMD-HR	August 2007	Improved awareness of equality and diversity	✓	✓	✓	✓	✓	✓
Analysis of monitoring data to identify areas of concern; gaps to be identified	To provide systematic diversity analysis and to feed into HR policy development	DMD-HR	Ongoing	Inclusive and compliant HR policy	✓	✓	✓	✓	✓	✓
Evaluate access to corporate and local training schemes	Analyse data from evaluation of Corporate Learning & Development programmes to identify diversity issues in training provision	DMD-HR	Ongoing	Improved learning and development	✓	✓	✓	✓	✓	✓
Establish a single Diversity network	Better integration of equalities issues into DH governance arrangements	DMD-HR	October 2007	Improved governance arrangements	✓	✓	✓	✓	✓	✓
Ensure diversity champions support key initiatives	Visible support for equalities issues	DMD-HR	Ongoing	Improved governance arrangements	✓	✓	✓	✓	✓	✓
Participation in pilot for sexual orientation and faith and belief monitoring	Improved monitoring data across statutory strands to better analyse impact of employment duties	DMD-HR	August 2007	Better quality HR monitoring data					✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Employee and union involvement; Key steps to include: - report on existing position - involvement with staff groups to establish requirements and priorities - production of action plan to set out activity schedule	Better involvement of employees and union in prioritisation of equalities agenda	DMD-HR	December 07	Increase in staff involvement and better focused diversity strategy	✓	✓	✓	✓	✓	✓
Mainstream equality/diversity through business improvement plans	Raise awareness at local level of equalities issues	DMD-HR	July 2007	Improved policy development and delivery	✓	✓	✓	✓	✓	✓
Articulate the business case for Diversity and share examples/ success stories	Embed Diversity into mainstream of DH	DMD-HR	July 2007	Improved policy development and delivery	✓	✓	✓	✓	✓	✓
Strategy to deliver greater diversity in Leeds	Linked with project on improving working livers in Leeds to improve diversity profile in QH	DMD-HR	Dec 2007	Increase in diversity representation		✓	✓	✓		✓
Develop Comms plan to: - raise profile of Equality/Diversity - celebrate success - link to development of single equality schemes		Communications	Dec 2007							
Ensure that recruitment agencies and head-hunters apply diversity proofing to their processes.	Improved recruitment practice to support 10-point plan targets	DMD-HR	July 2007	More representative DH workforce		✓	✓	✓		
Ensure new resourcing strategy/ recruitment policy & practice is inclusive.	Improved recruitment practice to support 10-point plan targets	DMD-HR	July 2007 and ongoing	More representative DH workforce	✓	✓	✓	✓	✓	✓
Undertake Equal Pay Review for grades AO-Grade 6	Analyse reward across race, disability, gender and age, to firstly examine any unexplained differences; then to inform a remedial action plan	DMD-HR	July 2007	Ensure equal pay provision across DH	✓	✓	✓	✓		

Action Plan – Corporate Business

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Equality integrated into research planning	Equality built in at planning of R&D programmes	Lead officer for diversity within RDD	September 2007	National programme directors aware of paragraph 2.2.7 and its implications		✓	✓	✓		
Revisit R&D statement on race equality and mainstreaming. Amend to represent all strands of diversity	Communication to all involved in health and social care R&D	Lead officer for diversity within RDD	October 2007	National programme directors aware of paragraph 2.2.7 and its implications *Initial focus	✓	✓*	✓*	✓*	✓	✓
Communicate with DH and NHS-funded programmes about Single Equality Scheme and implications for DH/NHS R&D	Appropriate plans made according to research programme	Lead officer for diversity within RDD	March 2008	National programmes replied to Director of R&D with their intended approach	✓	✓	✓	✓	✓	✓
ACRA to routinely screen for impact on equalities, in particular using the Equality Impact Assessment Toolkit	Knowledge will allow proactive or reactive steps to be taken where adverse impacts on equality are detected	ACRA	Ongoing	Regular screening surveys conducted	✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Support NHS communicators to communicate with BME audiences and people with disabilities	Greater knowledge of needs of and awareness by BME/disabled audiences	Communications – Marketing	Mar 2008	Involvement methods/ stakeholder relations – working with partners/ voluntary groups/ support groups/ religious groups, etc.		✓	✓			
Maintain web accessibility compliance	Promote accessibility for all web users addressing issues of disability and incapacity. However, following them makes Web content more available to all users.	Communications – Content delivery	March 2008	AA compliance (web accessibility standard)	✓	✓	✓	✓	✓	✓
Delivery of communications around the dignity in care campaign	Health and social care staff and stakeholders to work in partnership with a range of organisations who represent and work with older people and those who care for them.	Communications – Policy	March 2008	Feedback/ decrease in abuse cases	✓	✓	✓	✓	✓	✓
Launch of *Positive Steps* – A practical guide to delivering race equality in mental healthcare	Increase awareness of mental health services among BME communities	Communications – Policy Communications /Marketing	February 2008	Launch of guide/ feedback				✓		

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Use team leader and face-to-face briefing to convey gender equality duty requirements to all directorate	Improved knowledge and awareness of the duty leading to better gender-focused equality impact assessment	EHRG	May 2007	Percentage responses confirming face-to-face briefing completed			✓			
Issue revised and expanded guidance to the NHS and social care regarding equality monitoring, specifically to extend to include disability and sexual orientation	NHS and social Care have access to correct leading practice and legislation, reducing overall resources and providing a baseline to work from	EHRG	Autumn 2007	NHS *Chief Executive Bulletin* entry/ entries *Specific focus		✓	✓			✓
Complete equality reviews of PSA targets	Explicit linkages between core DH business and the mainstreaming of equality and human rights	EHRG	April–September 2007 September 2008–March 2009		✓	✓	✓	✓	✓	✓
Commission gender research and develop guidance to determine how men and women access services		EHRG	2007–08	Robust gender research data and outcome measures available			✓			
Develop an action plan to address discrimination against transgender people	Transgender issues incorporated in policy development, to be addressed in health and social care provision. Future-proofing against new or changed legislation	EHRG	2007–08	Action plan approved and signed off by Equality Delivery Assurance Group			✓			

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Raise awareness of EqIAs as part of mainstream policy development, e.g. through external Gateway training	Policy developed that addresses diverse needs and improved application of EqIAs	EHRG and external Gateway	2007–10	Increased number of EqIAs recorded	✓	✓	✓	✓	✓	✓
DH balanced scorecard incorporates equality screening of policy	Only equality-screened documents issued through the NHS Gateway	EHRG/Human Resources	2007–10	Quarterly balanced scorecard element at 100%/Green	✓	✓	✓	✓	✓	✓
Introduce improved equality assessments to ministerial submissions	Better informed policy initiation	EHRG/ Ministerial Support Unit	2007–10	Increased equality focus in briefing/ private office guide	✓	✓	✓	✓	✓	✓
Develop evidence base on the importance of equality in the health inequality agenda	Reduce duplication of effort by better coordinated working	EHRG	2007–08	Equality & inequality publication(s)	✓	✓	✓	✓	✓	✓
Review EqIA tool following feedback from training sessions	Production of an EqIA tool that is fit for purpose	EHRG	October 2007	Evidence of completion of effective EqIAs	✓	✓	✓	✓	✓	✓
Creation of further governance arrangements for equality and human rights within DH, e.g. Delivery Assurance Group & Stakeholder Sounding Board	Improved arrangements for governance and 'holding to account'	EHRG	September 2007	Annual report to Departmental Management Board *Specific focus on statutory duties	✓	✓*	✓*	✓*	✓	✓
Production of age equality, sexual orientation & religion & belief guides for the NHS	Providing leadership/stewardship for the NHS	EHRG	January 2008	Guides welcomed and used by NHS organisations	✓				✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Develop and improve relationships with specialist staff groups, e.g. EnABLE, PRISM, Ethnic Minority Working Group, GEAG	Improved policy making, involving staff	EHRG	October 2007 and ongoing	Demonstrable increase in staff involvement in priority setting and policy making		✓	✓	✓		✓

Action Plan – Policy

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Undertake equalities impact assessment (EqIA)of all health programmes	Improved access for discriminated groups to more appropriate healthcare and related areas	Director of Programmes	March 2008	100% equality screening	✓	✓	✓	✓	✓	✓
EqIA to be completed and published with policy guidance NHS Choice portal to increase access to information and support	Better and more equitable access to information and support to exercise choice	Policy and Strategy DSR	June 2007	Completed EqIA report Monitor (count) uptake and awareness of choice and NHS Choice portal	✓	✓	✓	✓	✓	✓
EqIA to be completed and published with 'Choice Framework' consultation document. Targeted consultation	Equitable extension of choice through developing, consulting and implementing 'Choice Framework'	Policy and Strategy DSR	Summer 2007	Results of uptake and awareness of choice and NHS Choice portal	✓	✓	✓	✓	✓	✓
Development and introduction of new, person-based approach to PBC budget setting EqIA screening	More equitable PBC budget setting leading to a better match between need and budgets	Policy and Strategy DSR	2009–10 EqIA for 2009–10 interim framework	Completed EqIA screening	✓	✓	✓	✓	✓	✓
Contribute to the development of appropriate commissioner development programmes	Enhanced commissioning of healthcare, health & wellbeing services and increased capacity	Policy and Strategy DSR & Commissioning	During 2007	100% equality screening of programmes	✓	✓	✓	✓	✓	✓
EqIA screening to be undertaken on the results of consultation on the future of PbR	The Tariff and its rules are not discriminatory, directly or indirectly	Policy and Strategy – PbR team	2007–08	One (minimum) Equality screening report	✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Consideration of 'think pieces' on social care, analysis, demand, supply, system management and regulation, and pricing and incentives in the context of equality	Better understanding of impact of reform policies on equality and inequality	Policy and Strategy Policy Support Unit with EHRG	Autumn 2007	Project group review reports	✓	✓	✓	✓	✓	✓
Ensure the Section 64 and OFV funding streams meet the equality duty across all strands. Use EqIA and Strategic Funding Review consultation to identify any issues. Implement monitoring of grant awards	Fair access to all and no discrimination in awarding DH funding to third-sector organisations to support DH goals such as reducing health inequalities	Experience, Involvement & Professional Leadership. Third Sector Partnership Team	2008–09	Monitoring system in place for funding from 2008–09	✓	✓	✓	✓	✓	✓
Review method for measuring the impact of healthcare-acquired infections on different groups of patients (elderly, BME or disabled patients) MRSA Team has conducted full equality impact assessment and identified issues around older men to be acted upon in Year 1	Clearer understanding of high-risk populations and establishing a strategy to deal with the issues raised	MRSA and Health Protection Teams	2007–08	Cross-referencing of HES (Hospital Episode Statistics) and MESS (Mandatory Enhanced Surveillance System) data	✓	✓		✓		
Information review (patient journey and 'mystery shopper' activity) report will highlight gaps in equality aspects of patient information	Better inform the Community Information Bank requirements	Information for Choice Programme Team	2007–08 (January)	Gap analysis completed	✓	✓	✓	✓	✓	✓
Develop accreditation scheme based on agreed standards for information development	Improved access to high-quality information that people can trust.	Information for Choice Programme Team	2008–09	Accreditation standards in place		✓		✓		

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
In line with contractual requirements proactively extending the range of specialist resources to meet the needs of under-represented groups	Independent Complaints Advocacy Service (ICAS) providing: – greater scope for individual voices to be heard – increased access to ICAS and NHS complaints procedure – increased feedback to NHS on experiences of	Responsiveness and Accountability Team	2007–08	Closer alignment between profiles of service users and complainants	✓	✓	✓	✓	✓	✓
Complete EqIA on Complaints Reform Ensure formal consultation process reaches a diverse population. Consultation includes review of data collection methods to ensure SES compatibility	Development of inclusive arrangements for capturing peoples feedback of their experiences of using health and social care services	Responsiveness and Accountability team	2007–08	Completed EqIA report Recommendations for Equality compatible data collection methods	✓	✓	✓	✓	✓	✓
Develop EqIA as part of the Regulatory Impact Assessment. Include provisions regarding diversity in the host's contract specification. Issue explicit guidance to local authorities, hosts and LINks on diversity and equality.	Local Involvement Networks are implemented with appropriate measures to ensure diversity of members and representation allowing greater diversity in involvement	Patient and Public Involvement	2007–08	Equality-based LINks introduced 2008–09 EqIA report	✓	✓	✓	✓	✓	✓
Coordinate strategic approach to Single Equality Scheme action Plan across EI&G Directorate to include transition of CNO BME Advisory Group to multi-professional advisory group	Equality embedded as part of business improvement. Greater access to expertise and knowledge of nursing Allied Health Professionals and HCS from diverse backgrounds contributing to policy development in widest context	Experience Involvement & Professional Leadership SMT	2007–08 (January)	Stakeholder lists and advisory group members representative of equality strands 100% equality screening	✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
To disaggregate national PSA by patient subgroup. To report against the patient-experience PSA target	A qualitative national measure of variations in patient experience by patient subgroups. Results of use to policy areas across the Department in completing their SES/EqIAs	Improving Patient Experience programme	2007–08	National patient survey programme	✓	✓	✓	✓		
As part of the Expert Patient Programme (EPP), continue the work established through DH to provide courses and course materials in a range of languages, including Hindi, Gujarati, Greek, Urdu, Punjabi, Bengali, and Chinese. A multi-language DVD, including sign language also to be completed by the community interest company (CIC) (which will run the EPP independently from DH from 1 April 2007). To meet commitments to deliver the EPP	Equality and human rights embedded in core business in relation to project management disciplines, staff training and development, baseline audits and undertaking of EqIAs	Experience, Involvement & Professional Leadership DH (CIC)	April 2007	Increase number of course places from 12,000 per year to 100,000 Establish CIC to deliver EPP		✓		✓		
Building on NHS Operating Framework 2007–08 develop a maternity framework document to set out a strategy to meet the Government's commitments for improving choice, access and continuity of care in maternity services	Equality is one of the drivers for the document. When published, it will give women national choice guarantees over the place of birth, improved access to maternity services, and will ensure continuity of care so that the specific needs of individuals can be met	Team Leader – Maternity	Spring 2007	100% equality screening Framework document published through NHS Gateway	✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Public health information strategy and policy guidance for development of joint PCT/ LA strategic needs assessment designed to support local analysis of commissioning and service development needs by specific population group	Local data available by population group to support PCTs and LAs plan and commission health and social care services to meet the needs of their populations	Health Improvement Directorate	2007–10 2007–10	EQIA completed on all planned development work National policy guidance supports analysis of local prevalence and service-use data by population group	✓	✓	✓	✓	✓	
Pilot individual budgets Mainstream in control Increase direct payments Pilot Common Assessment Framework Pilot self-assessment Develop Carers Strategy Develop user-led organisations and social enterprise Influence policies and strategies of Other Government Departments and across DH to align development Office of Disability Issues on the Independent Living review	Policies providing individuals with greater control, choice and personalisation of services by improving quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible (PSA 8 target)	Social Care, Local Government & Care Partnerships Directorate	2007–10	100% equality screening Progress against the number of older people helped to live at home (measured in annual statistical returns)	✓	✓				

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Work with Department for Communities & Local Government on the developing housing strategy including Supporting People Complete implementation of the Mental Capacity Act Mainstream NSF for long-term neurological conditions Users experience greater control, choice and better personalisation of services to meet their needs		Social Care, Local Government & Care Partnerships Directorate								
Design new services for older people (including mental health) focusing on early intervention and prevention through: – system reform for older people's services – partnerships for Older People Projects – community equipment review – input to whole-systems demonstrator pilots. Involving older people at every stage of development and activity; monitoring equality impact in the pilot sites	Promote the commissioning, development and provision of services that allow people to live independently in the community of their choice	Social Care, Local Government & Care Partnerships Directorate	2007–10	100% equality screening Increasing uptake of direct payments, national minimum standards and complaints reform	✓	✓	✓	✓		

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Taking forward the actions arising from the DRC's formal investigation, "Equal Treatment: Closing the Gap", and the MENCAP report "Death by Indifference"	To ensure equal treatment in health and social care for adults and children with learning disabilities	Social Care, Local Government & Care Partnerships Directorate	2007–2008	Independent inquiry to report to Secretary of State		✓				
Developing policy on user-led organisations involved in service development throughout England	To meet objectives in "Improving life chances" strategy	Social Care, Local Government & Care Partnerships Directorate	Autumn 2007	To increase involvement of disabled people						
Continuing organisational development Equality screening and EqIA on Directorate Learning and OD Programme	Equality and human rights embedded in core business in relation to project management disciplines, staff training and development, baseline audits and undertaking of equality impact assessments	Social Care, Local Government & Care Partnerships Directorate	2007–2010	Numbers of staff through EqIA training 100% equality screening	✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Revise the Mental Health Act Code of Practice in a way that captures and responds to concerns of BME communities and encompasses values-based practice National projects on: – supervised community treatment – professional roles and workforce – the tribunal system – values-based practice – advocacy Regional implementation projects, led by CSIP, working closely with DRE leads	Revised Code more explicit about the need for equity and fairness and sets out how practitioners should carry out their duties under the Act and treat patients Service users, specifically including BME users, to be involved in drafting the revised Code The specifications for new professional roles will include diversity awareness	Mental health legislation	2007–08 Final draft to be published by autumn 2007 2008–09 Implementation planned for April 2008, but may slip to mid 2008–09 if legislation is delayed	EqIA on Code of Practice 100% screening on related implementation programmes		✓		✓		
Develop work programme to ensure the national mental health programme is compliant including projects like Improving Access to Psychological Therapies Programme	Mainstreaming consideration of race equality into general mental health policy development, demonstrated by effective impact assessments for all significant policy initiatives Governance through Mental Health Programme Delivery Board	Wider BME Mental Health Programme	2007–10	100% Equality screening Documented governance system for Mental Health Programme Delivery Board		✓		✓		
Investment and delivery (over three years) in mental health training for prison staff. The aim is to improve knowledge, competence and cultural awareness among prison healthcare staff and other prison staff	More culturally sensitive and effective mental healthcare in prisons improved understanding of the cultural needs of people with mental health problems from BME groups; more accurate assessments and fair access to more effective treatments	Mental health	2007–08	Count – training records (via funding/ investment agreement)		✓		✓		

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Produce guidance on effective community and court liaison to address gender and ethnicity issues to build on findings of NACRO survey	More responsive approach to community and court liaison	Social Care, Local Government & Care Partnerships Court diversion and criminal justice liaison	2007–08	100% equality screening Guidance published through NHS Gateway	✓	✓	✓	✓	✓	✓
CSIP is undertaking a national survey of community development workers to assess the extent to which they engage with prison	Access to effective services more proportionate to need. Service users assess the service more positively	Social Care, Local Government & Care Partnerships Community Development	2007–09	Survey results completed	✓	✓	✓	✓	✓	✓
The Refugee Council who are providing a one-day assessment service and the Medical Foundation for the Care of Victims of Torture is piloting a new way of linking up PCTs to provide counselling services for torture survivors	Access to effective services more proportionate to need. Service users assess the service more positively	Social Care, Local Government & Care Partnerships Initial Health Assessment	2007–09	Count – local PCT subscribers to pilots		✓		✓		
Develop mental health guidelines on commissioning services for asylum seekers and refugees	The guidelines support the wider Delivering Race Equality in Mental Health Care Action Plan.	Social Care, Local Government & Care Partnerships Directorate	2007–09	100% equality screening Guidelines published through NHS Gateway		✓		✓		

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
PCT and prison partnerships to undertake evidence-based commissioning to reduce the number of unnecessary external treatment episodes. BME health needs evidence to be specifically included BME monitoring explicitly included as part of PCT/prison partnership boards' governance arrangements PCTs will be encouraged to include prison health services in their equality/diversity impact assessments & other monitoring/ consultation mechanisms	More culturally sensitive and effective mental and physical healthcare in prisons; better and more accurate assessments and fair access to more effective treatments	Social Care, Local Government & Care Partnerships Escorts and bedwatches	2007–2008	Monitoring data includes race Equality screening of guidance to PCTs on prison health monitoring		✓		✓		
Development of an offender health strategy for young people which will tie in with a wider offender health strategy and which is underpinned by the children's' NSF	Better consideration of the particular needs of young BME groups. To incorporate this into the work programme that will emanate from the strategy.	Offender Strategy Team	October 2007	100% equality screening Strategy published through NHS Gateway	✓	✓	✓	✓	✓	✓
Production of a Protocol for the Transfer to Hospital of Young People in the Secure Estate with Severe Mental Illness	In its production, the protocol will consider whether they are experiencing particular delays or have particular needs that can be addressed through this piece of work		Late spring/ early summer 2007	Reduce transfer time to seven days Reduce treatment waiting times		✓				

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Development of an evidence-based mental health care pathway for young people, based on the adult version. Incorporate best-practice templates	Improved understanding of the cultural needs of young people with mental health problems from BME groups; leading to more accurate assessments and fair access to more effective treatments	Social Care, Local Government & Care Partnerships Directorate	2007	100% equality screening Guidance published through NHS Gateway	✓	✓		✓		
Produce best-practice guidance on commissioning for the provision of offenders to ensure that the services being commissioned meet the diverse needs of the population	Improved primary care services to offenders. Offenders from BME backgrounds are a specific group within the assessment, which informs the commissioning	Social Care, Local Government & Care Partnerships Directorate	October 2007	100% equality screening Guidance published through NHS Gateway		✓		✓		
Incorporate needs related to ethnicity, disability, consent to treatment, religious requirements, language and dignity into service planning activity. Produce Workforce Strategy to support the implementation of the Integrated Drug Treatment System (IDTS), which highlights the need to ensure that staff recruited come from all backgrounds, represent many different cultures, and mirror the diversity present in society	Equitable and improved access by all prisoners, BME groups to substance misuse services and care. Access to prison drug services by BME prisoners is known often to be limited. Ongoing links with local community organisations that are developed to help make services in prisons and the community more accessible	Social Care, Local Government & Care Partnerships Integrated Drug Treatment System (IDTS)	2007–2008	100% equality screening	✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Ensure that all elements of the team's work take forward equality and human rights in policy development, business planning and continuing organisational development	Team trained on taking forward equality and human rights issues Team to actively engage with stakeholder account directors/ managers/leaders to ensure partners undertake appropriate EqIAs Team to ensure appropriately diverse service-user input to stakeholder groups and forums	Social Care, Local Government & Care Partnerships Directorate	March 2008 March 2008 Ongoing March 2008	100% equality screening applied to projects	✓	✓	✓	✓	✓	✓
Following DMB's approval of the enhanced regional presence proposals for 2007/08: i) deliver project to support implementation of the interim year proposals; and ii) develop DH regional presence policy for 2008/09 and beyond in light of the DH's defined national roles and functions	Purpose of the enhanced regional presence is set out in the roles, functions and outcome framework. The framework reflects the DH priorities in relation to delivering its social care and health and care partnerships policy agenda, and reflects the policy commitment to equality within these programmes	Social Care, Local Government & Care Partnerships DH regional and local partnerships	Autumn 2007		✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Following the commitment in the LGWP, to bring forward legislation that provides for health and wellbeing partnerships under the LSP, the LGPIH Bill was amended to place a duty on LAs and PCTs to undertake a joint strategic needs assessment of the health & wellbeing needs of the local population	The duty to undertake a joint strategic needs assessment is explicitly aligned to the Commissioning Framework for Health and Well-being and supports the overarching aim to improve cross-sector commissioning at the local level. One of the explicit aims of improving commissioning is to enable commissioners to meet the needs of under-represented parts of society. A full equality impact assessment of the Commissioning Framework was undertaken, of which this duty will fall within.	Social Care, Local Government & Care Partnerships DH Regional and Local Partnerships	Commissioning Framework consultation – Mar–May 2007 LSP Place-shaper consultation & guidance – autumn 07-spring 2008 New LG performance framework April 2008		✓	✓	✓	✓	✓	✓
"Delivering Gender Equality for Women's Mental Health" A strategy to mainstream women's mental health in commissioning and delivery of services. Four main themes: – strengthening accountability for gender equality both centrally and within trusts – progressing implementation through regional networks of stakeholders – preparing for implementation of gender equality legislation – developing the workforce to enhance understanding of women's mental health	Key outcomes of a successful strategy: – improvements in the quality and experience of services – more choice & increased access to psychological therapies – improved support for women with perinatal mental health problems – increased attention and understanding of women from BME communities – increased access to support for women who have experienced violence and abuse – improved access to care for women who offend	Social Care, Local Government & Care Partnerships Mental Health	Workplan runs 2006–08		✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
	Evaluation & monitoring based on a number of sources, including mental health minimum dataset and Healthcare Commission surveys. Governance through Mental Health Programme Delivery Board									
78 actions for local or national implementation by 2010, focused on: – more responsive services – better community engagement – better information	If successful: – less fear of services among BME communities – increased satisfaction with services – reduced rate of admission of people from BME communities – reduced rates of compulsory detention of BME service users – fewer violent incidents – reduced use of seclusion in BME groups – prevention of deaths following physical intervention – more BME service users reporting recovery – reduced disparities in prison populations – more balanced range of therapies – more active role for BME communities and service users – an organisation capable of delivering appropriate and responsive services	Social Care, Local Government & Care Partnerships	2007–10		✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
	Evaluation & monitoring based on a number of sources, including annual ethnicity census of patients, mental health minimum dataset and Healthcare Commission surveys. Governance through Mental Health Programme Delivery Board.	Social Care, Local Government & Care Partnerships	2007–10							
Ensure that all emergency preparedness guidance to the NHS is produced following detailed discussion with a broad-based stakeholder and expert group, followed by formal public consultation	This includes a consultative approach based on best-practice principles set out in the Civil Contingencies Act 2004. This approach means that the underlying principle is to put in place plans, processes and arrangements designed to give the best-quality care and treatment to all those affected by any emergency situation	Health Protection, International Health and Scientific Development (HPIHSD) Emergency Preparedness Division	Ongoing	Guidelines published through NHS Gateway	✓	✓	✓	✓	✓	✓
Ensure all emergency preparedness guidance to the NHS takes account of the needs of children	Advice to the NHS is designed to ensure the specific needs of children are addressed (such as availability of paediatric doses), so that they receive care and treatment that is as good as adults receive	HPIHSD Emergency Preparedness Division	Ongoing	Guidelines published through NHS Gateway	✓					
Implement DH's revised performance management systems and processes	Internal management processes in each HPIHSD division are based on the DH principles of equality and equal opportunity	HPIHSD Divisional Heads,	Ongoing	Staff survey Feedback from face-to-face briefings	✓	✓	✓	✓	✓	✓
Develop and implement policies to increase the number and diversity of blood donors	Increased availability of matched blood for ethnic minority groups and therefore better health outcomes	HPIHSD Health Protection Division	Ongoing	NHS Blood and Transplant reports				✓		

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Develop an information resource for South Asian communities as part of the awareness campaign to support the Hepatitis C Action Plan for England	Improved prevention, diagnosis and treatment of hepatitis C in this ethnic minority group	HPIHSD Health Protection Division	2007	Incidence of hepatitis C infections				✓		
Implement a Find and Treat project to tackle TB in London. to Actively identify barriers and overcome them by addressing: – format – provision of information materials in Braille, tap, large print – language – provision of materials translated into a number of languages – place – availability of information resources through stakeholder groups	To actively find TB cases so that there is equality of access to information, treatment and immunisation, all of which will lead to better health outcomes	HPIHSD Health Protection Division	2007–2008	Increase in TB cases receiving treatment Longer-term decrease in the incidence of TB		✓		✓		
Publication of proposals for revised legislation on assisted reproduction. Proposed that, where treatment providers continue to be required to take account of the welfare of the prospective child, the current reference in law to the child's 'need for a father' will be removed	The recognition of legal parenthood following assisted reproduction will be extended to cover civil partnerships and other same sex couples, broadly mirroring existing provisions relating to married and unmarried couples	HPIHSD Scientific Development and Bioethics Division	2007	Legislation presented to Parliament			✓			
Implementation of joint pilot service development programme with Macmillan Cancer Care dealing with families at risk of inherited forms of cancer	Pilot specifically focused on the needs of BME families to develop more culturally sensitive approaches to improving families' awareness of, and access to, these services	HPIHSD Scientific Development and Bioethics Division	2007	Wider implementation of service model following pilot scheme				✓		

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Fund and support research studies into the choices offered to mothers as part of the national sickle cell and thalassaemia antenatal and postnatal screening programmes	Improved access to screening for black and ethnic minority mothers, leading to improved health outcomes	HPIHSD Scientific Development and Bioethics Division	Ongoing	Increase in screening tests				✓		
Implementation of the Mental Capacity Act 2007	Establishes a statutory framework for making treatment decisions on behalf of people who lack capacity, which is based on the person's best interests. Clarifies how people should be supported to make their own decisions whenever possible and confirms that decision makers must not make assumptions about a person's best interests merely on the basis of their age, appearance or condition	HPIHSD Scientific Development and Bioethics Division	2007	To be confirmed (routine monitoring)	✓	✓				
Review policy on consent to treatment – in particular to consider any differences in that experience by age, sex, beliefs, ethnic group or disability, and to revise national policy as appropriate	Improve the focus of local NHS consent procedures on the rights of individual patients and their relatives, to assess patients' experience when they are asked to give their consent to treatment	HPIHSD Scientific Development and Bioethics Division	2007–08	Feedback at local level	✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Public health information strategy and policy guidance for development of joint PCT/ LA strategic needs assessment designed to support local analysis of commissioning and service development needs by specific population group, taking account of age, gender, disability, ethnicity, religion and belief. Priorities include: – prescribing for CVD – use of maternity services – breastfeeding – overweight and obesity in children – use of smoking cessation services – use of contraceptive services – use of sexual health services – use of drug treatment service – alcohol consumption – related hospital admissions	Local data available by population group to support PCTs and LAs plan and commission health and social care services to meet the needs of their populations. The information is also being used to improve services to the local population	Health Improvement Directorate	2007–10 2007–10	EqIA completed on all planned development work National policy guidance supports analysis of local prevalence and service-use data by population group	✓	✓	✓	✓	✓	

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Development of tools and approaches (including monitoring and evaluation) designed to support healthcare practitioners, SHAs, PCTs, and LAs target intervention in specific population groups taking account of socio-economic status, ethnicity, age, gender, disability. Priority areas include: – improving access to early intervention through primary care, particularly in Spearhead Areas – improving provision of services to support smoking cessation, treatment of sexually transmitted diseases, prevention and treatment of drug and alcohol misuse, overweight and obesity	Reduced prevalence of preventable ill-health in sectors of the population with highest risk through access to early treatment and support	Health Inequalities and Health Improvement	2007–10 2007–09	EqIA completed on all planned development work, taking account of evidence from tracking data on prevalence and service use by population group Evaluation of impact of new guidance and tools taking account of evidence from tracking data on prevalence and service use by population group	✓	✓	✓	✓	✓	
Development and roll-out of social marketing campaigns, based on market segmentation and targeted to reach specific population groups. Specific materials and messages tailored according to age, sex, BMEG and other equality issues, as well as socio-economic status	Raised public awareness of health impact of diet (including breastfeeding), physical activity, contraception, sexual health, smoking, drug use	Health Inequalities and Health Improvement Public Health Communication	2007–10	EqIA completed on all planned campaigns Independent evaluation of scope and reach across key population groups	✓	✓	✓	✓	✓	

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Development of strategies to increase awareness of health issues in communities, schools, workplaces. Specific materials and messages tailored according to age, sex, BMEG and other equality issues, as well as socio-economic status	Raised public awareness of health impact of diet (including breastfeeding), physical activity, contraception, sexual health, smoking, drug use	Health Inequalities and Health Improvement Public Health Communication	2007–10	EqIA completed on all planned development work, taking account of evidence from tracking data on prevalence and service use by population group	✓	✓	✓	✓	✓	
Plans for communication and implementation of regulations on smokefree legislation targeted to secure high levels of compliance across all sectors	Raised public awareness of health impact of diet (including breastfeeding), physical activity, contraception, sexual health, smoking, drug use	Health Inequalities and Health Improvement Public Health Communication	2007–10	EqIA completed on all planned development work, taking account of evidence from tracking data on prevalence and service use by population group	✓	✓	✓	✓	✓	
NST visits programme and guidance designed to support PCTs and LAs meet the needs of highest-risk groups within local populations, taking account of age, gender, disability, ethnicity, religion and belief	National Support Teams provide effective support for PCTs with the highest degree of challenge in meeting national targets for health improvement	Health Inequalities and Health Improvement Public Health Communication	2007–10 2007–09	EqIA completed on all planned guidance Independent evaluation of NST process	✓	✓	✓	✓	✓	

Action Plan – Drivers for Local Service Improvement

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Include equality in ROCR justification process	Equality integral at proposal stage for all official collections	Equality Monitoring Group Information Centre/EHRG	2007–2008	Equality factored into all proposals by end July 2007	✓	✓	✓	✓		
Make ethnicity data mandatory in the four commissioning datasets (CDS)	Increased ethnicity monitoring data available – improved locally held datasets	Equality Monitoring Group Information Centre	2008–2009	DSCN issued				✓		
Include equality data requirements in contracts with independent sector providers of NHS commissioned care and in DH model contracts for acute and out-of-hospital services	Improved patient-level datasets	Equality Monitoring Group Information Centre/ Commissioning Directorate/ EHRG	2008–2009	Equality data included in all independent sector contracts	✓	✓	✓	✓		
Extending mental health minimum dataset (MHMDS) to cover the independent sector	Improved patient level datasets	Equality Monitoring Group Information Centre/ Commercial Directorate	2007–2008 2008–2009	Dataset review Contracts revised	✓	✓	✓	✓		
Equality fields made mandatory in the new Electronic Staff Record (ESR)	Improved staff equality monitoring across the NHS	Information Centre	2007–2008 2008–2009	Options reviewed/ implementation Collection started	✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Build ethnicity data into the GP contract	Improve patient level datasets	Equality Monitoring Group Primary Care Contracting Team	2008–2009	Equality monitoring introduced to GP contracts	✓	✓	✓	✓	✓	✓

Action Plan – Executive Agencies

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Review Choose & Book website to ensure it is user-friendly, and review patient information leaflets to determine need for production in community languages	Increased accessibility of patient information	NHS Connecting for Health Patient Access Team and Communications Team	2007–2008	Patient information on Choose & Book service meets the needs of an ethnically diverse population				✓		
Continue the review of existing policies. Equality review all new policies	All policies will be 'equality proofed'	NHS Connecting for Health Information Systems & Corporate Services	2007–2008	NHS CfH Management Board to confirm	✓	✓	✓	✓	✓	✓
Build gender, sexual orientation and belief into all new policy development	Improved impact assessment process	MHRA Policy	July 2007	Published policies do not have adverse impact			✓		✓	✓
Publication of quarterly diversity monitoring (all-strand) reports to Executive Board	Improved quality of dataset, allowing improved analysis and identification of trends	MHRA HR	July 2007	Achievement of targets set by Cabinet Office and DH	✓	✓	✓	✓	✓	✓
Improve diversity information as part of recruitment & selection training	Higher-quality recruitment and selection decisions, fairer employment practices	MHRA Learning & Development Manager	April 2007	Feedback, Staff Survey, HR diversity monitoring *Specific focus	✓	✓*	✓*	✓*	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Design and implement diversity training as part of annual learning calendar	Creating a workplace where all differences are valued	MHRA Learning & Development Manager	June 2007		✓	✓	✓	✓	✓	✓
To incorporate the DH EqIA methodology into NHS PASA's own policy impact assessment (PIA) methodology and PIA tool	All policies to have EqIA before being given approval by NHS PASA's Management Executive Team	Policy and Strategy Directorate	2008	Self-assessment by NHS PASA *Initial focus	✓	✓*	✓*	✓*	✓	✓

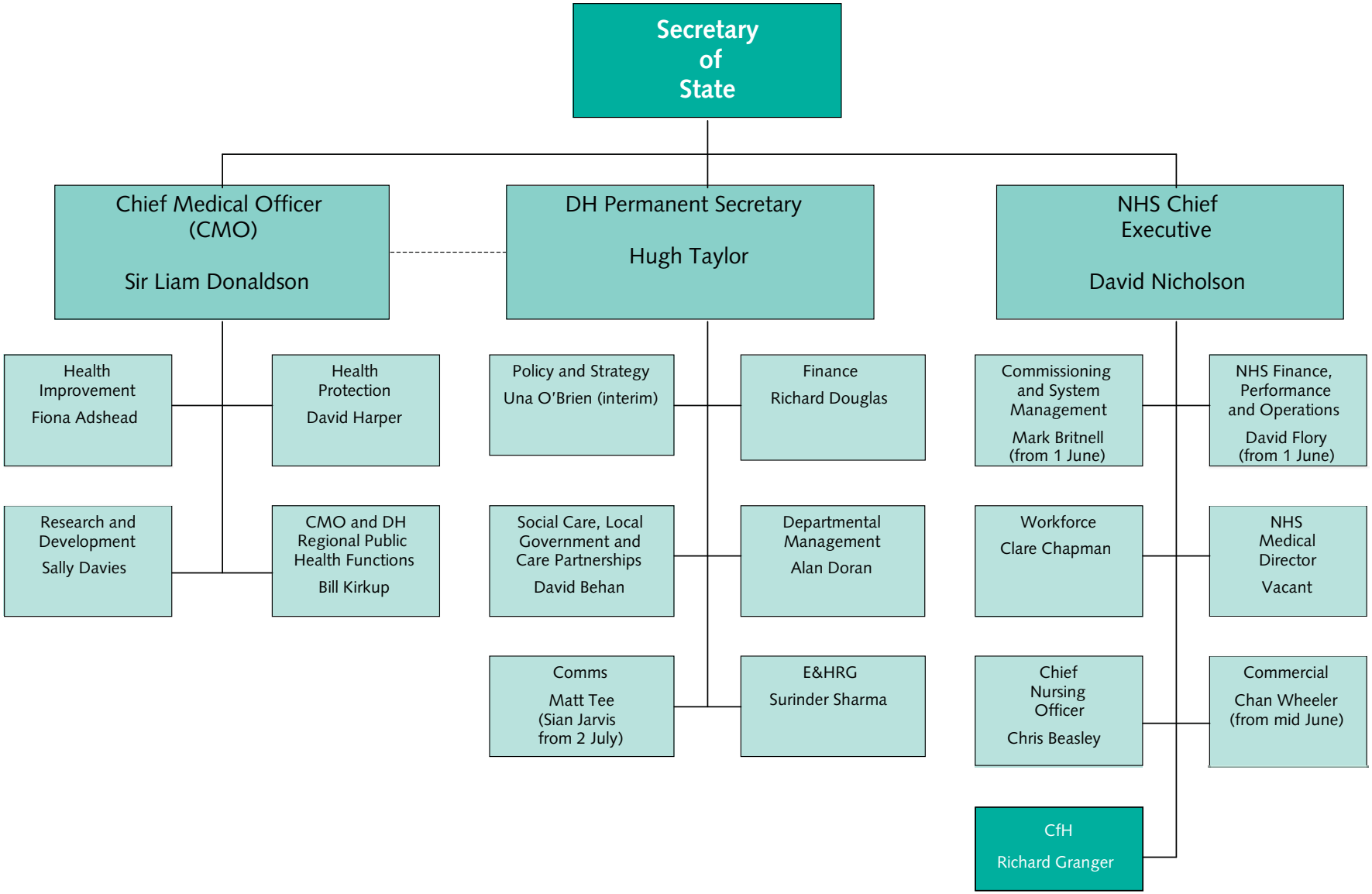
NHS Purchasing and Supply Agency Action Plan

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Ensure that all NHS PASA policies and procurement procedures are reviewed in order to ensure compliance with all relevant equality legislation.	Compliance with equality legislation.	NHS PASA Policy Directorate and Procurement Enablement Directorate	2008-2009	All policies are subject to scrutiny and approval by NHS PASA's Management Executive Team before publication. Updated procedures.	✓	✓	✓	✓	✓	✓
Assess the impacts that proposed policies might have on any of the component equality strands by incorporating the DH EqIA methodology into NHS PASA's own Policy Impact Assessment methodology and PIA tool.	Understanding the impacts that policies may have upon the equality strands.	NHS PASA Policy and Corporate Services Directorates	2008-2009	Self-assessment by NHS PASA Policy Directorate and Human Resources team with review by MET. Self-assessment by NHS PASA Policy Directorate.	✓	✓	✓	✓	✓	✓
Ensure that the HR reporting systems for PASA and any successor body meet the requirements of the SES.	Mitigate against SES actions not being carried out	NHS PASA Corporate Services Directorate	2007-2009	Monitoring arrangements to be confirmed.	✓	✓	✓	✓	✓	✓
To review relevant NHS conditions of contract to include an obligation on contractors to comply with a wide range of equality legislation, including the DDA 1995 (as amended).	All contractors to NHS PASA are compliant with equality legislation.	NHS PASA Policy Directorate	2008	Self-assessment by NHS PASA Policy Directorate.	✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
To ensure PASA communications strategy underpins this goal.	Relevant stakeholders are engaged.	NHS PASA Corporate Services Directorate	2007-2009	In our current business plan we set out how we intend to develop our stakeholder engagement programme and to build in a system of monitoring the effectiveness of these strategies. (e.g. surveys, focus groups, web monitoring Issues around equality, accessibility and relevance of communications to the different audiences are part of our ongoing monitoring programme. We have stated that we will listen to our internal and external stakeholders and adapt our communication efforts as necessary.	✓	✓	✓	✓	✓	✓

Action	Benefits	Lead	Timescale	Metric	Age	Disability	Gender	Race	Religion/ Belief	Sexual Orientation
Undertake equal pay review and address any pay anomalies identified to ensure fair and equitable pay for PASA staff	Remuneration for PASA staff is transparent and fair	NHS PASA Corporate Services Directorate	2007	Evidence from equal pay audit.	✓	✓	✓	✓	✓	✓
Monitor and review PASA workforce performance in relation to SES requirements	Can use evidence-based practice to enhance the delivery of services	NHS PASA Corporate Services Directorate	2007-2009	Quarterly formal reporting on issues relating to organisational staffing to be put into place, including exit data to identify any areas of concerns for ME.	✓	✓	✓	✓	✓	✓
Ensure staff are aware of their obligations in relation to the SES and aware of diversity issues	Ensure that SES actions are delivered and equality is promoted among staff	NHS PASA Corporate Services Directorate	2007	Review the provision of diversity training for the organisation and make sure this is rolled out as necessary. Diversity and SES issues also to be included in any recruitment and selection activities.	✓	✓	✓	✓	✓	✓

Appendix 1: Department of Health Structure



Appendix 2: Department of Health Public Service Agreements (PSAs)

PSA	Target
Reduce mortality from heart disease and cancer	Reduce mortality rates from heart disease, stroke and related diseases by at least 40% in people under 75 by 2010
	Reduce mortality rates from heart disease, stroke and related diseases with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole
	Reduce mortality rates from cancer by at least 20% in people under 75 by 2010
	Reduce mortality rates from cancer with a reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole
	Reduce mortality rates from suicide and undetermined injury by at least 20%
Reduce health inequalities	Reduce health inequalities by 10% by 2010, as measured by infant mortality
	Reduce health inequalities by 10% by 2010, as measured by life expectancy at birth
Tackle the underlying determinants of health and health inequalities	Reduce adult smoking rates to 21% or less by 2010
	Reduce prevalence among routine and manual groups to 26% or less
	Halt the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole
	Reduce the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health

PSA	Target
Long-Term Conditions	Improve health outcomes for people with long-term conditions by offering a personalised care plan for the most at risk vulnerable people; and reduce the emergency bed days by 5% by 2008
18 Weeks (some sub-elements included above)	Ensure by 2008 that no-one waits more than 18 weeks from GP referral to hospital treatment
Drug Treatment	Increase the participation of problem drug users in drug treatment programmes by 100% by 2008
	Increase year on year the proportion of users successfully sustaining or completing treatment programmes
Patient Experience	Secure sustained national improvements in patient experience, as measured by independently validated national surveys
	Ensure that individuals are fully involved in decisions about their healthcare, including choice of provider, as measured by independently validated surveys
Older people	Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by:
	Increasing the proportion of older people being supported to live in their own home by 1% annually in 2007/2008
	Increase by March 2008 the proportion of those supported intensively to live at home to 34% of the total being supported at home or in residential care

Appendix 3: Summary of Equality Legislation

Race Relations (Amendment) Act 2000

The Department has a statutory duty to promote race equality with due regard to the need to:

- eliminate unlawful discrimination;
- promote equality of opportunity; and
- promote good relations between people of different racial groups.

The elements of the duty are complementary, and therefore full compliance depends upon all three aspects of the general duty being addressed.

There is also a specific duty upon public bodies (which includes the Department of Health) to publish a Race Equality Scheme (RES) setting out how the Department intends to meet the general duty and to review this Scheme every three years. Other specific duties include:

- assessing and consulting on the likely impact of proposed policies relating to the promotion of race equality;
- monitoring policies for any adverse impact relating to the promotion of race equality;
- publishing the results of any assessments, consultations and monitoring;
- ensuring public access to information and services provided; and
- training staff on the Race Equality Duty.

Disability Discrimination Act 2005

The Department has a statutory duty to carry out its functions with due regard to the need to:

- promote equality of opportunity between disabled people and other people;
- eliminate discrimination that is unlawful under the Act;
- eliminate harassment of disabled people that is related to their disability;
- promote positive attitudes towards disabled people;

- encourage participation by disabled people in public life; and
- take steps to take account of the disabilities of disabled people, even where that involves treating disabled people more favourably than other people.

This last point is important, as it allows for positive discrimination in favour of disabled people.

There is also a specific duty upon public bodies (which includes the Department of Health) to publish a Disability Equality Scheme (DES) setting out how the Department intends to meet the general duty and to review this Scheme every three years. This Single Equality Scheme includes the needs of the Disability Equality Duty. The Department of Health recognises that disabled people face many barriers to a full participation in public life from attitudinal and environmental factors, which excludes and marginalises disabled people.

The Equality Act 2006 (Gender Equality Duty)

The Equality Act 2006 introduced a duty upon public bodies to promote gender equality. Discrimination on the basis of gender has been prohibited by the Sex Discrimination Act 1975 in relation to employment and the provision of goods, facilities and services. However, under the Gender Equality Duty (GED), public bodies are required to actively promote gender equality through their key functions, and this clearly has major relevance to the Department of Health. The general GED requires public authorities to have due regard to the need to:

- eliminate unlawful discrimination with regard to obligations under the Sex Discrimination Act 1975 and the Equal Pay Act 1970, and to take steps to ensure compliance with these Acts; and
- promote equality of opportunity between men and women, and take active steps to promote gender equality when carrying out functions and activities.

The specific duties include:

- publishing Gender Equality Schemes, including equal pay policies, in consultation with employees and stakeholders;
- monitoring progress and publishing progress reports every three years; and
- conducting and publishing gender impact assessments on major new legislation and policy.

The GED is intended to shift the burden from the individual having to make a complaint about unequal treatment, to the public body having to demonstrate that it is taking active steps to promote equality. The GED is also important as it highlights issues of multiple discrimination: women, men and transgender people may suffer discrimination and unequal treatment not only on the basis of their gender, but also dependent upon their ethnicity, age, disability, sexuality, and religion or belief. Thus DH is committed to developing policy that is sensitive to gender differences, delivering (and encouraging the NHS to deliver) services that are tailored to the specific needs of women and men, using employment practices that challenge workplace discrimination, and using procurement practices that promote equality.

In addition to the statutory equality duties relating to race, disability and gender, the premise of a Single Equality Scheme is to address the six 'strands' of equality, that is including sexual orientation, religion and belief, and age. While there is currently no statutory equality duty relating to these latter three strands, the legislation set out below informs the inclusion of these aspects in this Single Equality Scheme.

Employment Equality (Age) Regulations 2006

From 1 October 2006, the Employment Equality (Age) Regulations made it unlawful to discriminate against workers, employees, job seekers and trainees because of their age. The Regulations cover recruitment, terms and conditions, promotions, transfers, terminations and training.

The Human Resources implications of these Regulations are addressed in section 11.

Equality in Employment Regulations (Sexual Orientation)

These Regulations made it unlawful to discriminate on the grounds of sexuality, directly or indirectly; or to harass or victimise somebody because they have made a complaint or intend to, or if they give or intend to give evidence to a complaint of discrimination. This applies to all aspects of employment (recruitment, terms and conditions, promotions, transfers, terminations and training) and vocational training.

The Human Resources implications of these Regulations are addressed in section 11.

In relation to **services**, the Equality Act 2006 makes it unlawful for a public body involved in providing goods, facilities or services to discriminate on the grounds of sexual orientation through:

- refusing to provide a person with goods, facilities or services if they would normally do so to the public, or to a section of the public to which the person belongs; and
- providing goods, facilities or services of an inferior quality to those that would normally by provided, or in a less favourable manner or on less favourable terms than would normally be the case.

Equality in Employment Regulations (Religion or Belief) 2003

These Regulations made it unlawful to discriminate on the grounds of religion or belief, directly or indirectly; or to harass or victimise somebody because they have made a complaint or intend to, or if they give or intend to give evidence to a complaint of discrimination. This applies to all aspects of employment (recruitment, terms and conditions, promotions, transfers, terminations and training) and vocational training.

In relation to **services**, Part 2 of the Equality Act 2006 (due to come into effect in April 2007, the time of publication of this Scheme) makes it unlawful for a public body involved in providing goods, facilities or services to discriminate on the grounds of religion or belief through:

- refusing to provide a person with goods, facilities or services if they would normally do so to the public, or to a section of the public to which the person belongs; and
- providing goods, facilities or services of an inferior quality to those that would normally by provided, or in a less favourable manner or on less favourable terms than would normally be the case.

Gender Recognition Act 2004

The Gender Recognition Act 2004 provides for legal recognition of a transsexual person in their acquired gender and an opportunity to acquire a new birth certificate in their new gender (a Gender Recognition Certificate or GRC). Of importance to public bodies and officials is the fact that these Regulations make it an offence to disclose information acquired in their official capacity about the gender history of a person holding a GRC. The holder of a GRC is not obliged to inform their employer that they hold a GRC, but if they do so the employer is obliged to hold this as 'protected information'.

The Human Rights Act 1998

Article 14 of the Human Rights Act 1998 refers to the prohibition of discrimination, and states that the enjoyment of the rights and freedoms set out in the European Convention on Human Rights shall be secured without discrimination on the grounds of sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

Appendix 4: Organisations Consulted with in the Development of the Department of Health Single Equality Scheme

Age Concern England

Association of Directors of Social Services

Audit Commission

Black Health Agency

Black Training and Enterprise Group

British Humanist Association

British Medical Association

Commission for Social Care Inspectorate

Commission on Integration and Cohesion

Communities and Local Government

Department for Constitutional Affairs

Department for Culture, Media and Sport

Department for Education and Skills

Department for Transport

Department for Work and Pensions

Department of Trade and Industry

Equal Opportunities Commission

Foreign and Commonwealth Office

Greater London Authority

Healthcare Commission

Health Foundation

Help the Aged

HM Treasury

Home Office

Joseph Rowntree Foundation

King's Fund

Local Government Association

MIND

Monitor

National Council for Voluntary Organisations

NHS Single Equality Scheme Learning Sites

NHS Strategic Health Authority Equality Leads

Race Equality Foundation

RNIB

RNID

Royal College of Nursing

Stonewall

Trades Union Congress

In addition, existing comments from the Commission for Racial Equality and the Disability Rights Commission were taken into account in producing this document.

Appendix 5: Report on the Workshop with Disabled People on 25 October 2006

1. Introduction

The Department of Health ran a workshop for disabled people and organisations supporting disabled people, to help develop the Department's Single Equality Scheme. Twenty people attended the one-day-long workshop.

People came from the following organisations:

- Deafblind UK
- Eastern Mentor
- Equalities National Council
- Foundation for People with Learning Difficulties
- Guide Dogs for the Blind
- Linkage Community Trust
- MIND
- National Association of Deafened People
- National Autistic Society
- National Federation of the Blind of the UK
- RNID
- South Birmingham Primary Care Trust
- The Stroke Association
- United Response
- University of Bristol School of Medicine
- Vitalise

An external consultant facilitated the workshop, and staff from the Department helped lead discussion groups and took notes. Participants had a variety of disabilities, including visual and hearing impairments, mobility impairment and

learning difficulties. There were an equal number of men and women, and participants belonged to different ethnic groups.

Two palentypists and one signer helped throughout the day.

2. Workshop format

The day started with a presentation on what a Single Equality Scheme was and why the Department was running the workshop. Participants were divided into groups seated at round tables. Facilitators at each table made sure that everyone was able to contribute to the discussion. The day was built around a series of sessions looking at different issues. Each session lasted 45 minutes and started with a two-minute presentation followed by round-table discussions. Sessions ended with a ten-minute plenary. We chose as topics for discussion issues we needed to address in the Single Equality Scheme. Topics chosen were: access to information, involvement and consultation, bullying and harassment, and monitoring. We left one discussion slot at the end of the day for people to raise any other issues concerning access to services.

All information gathered was then used in drafting the Scheme. The following is a summary of points raised by participants on the different topics.

3. Access to information

Participants were asked to comment on which means of information-giving they preferred and to give suggestions for improvement.

- There should be a wide variety of formats available.
- Information should be in plain English and 'friendly looking', and it should have pictures and illustrations.
- Most people cannot access non-visual information.
- For many disabled people, and particularly BME disabled people, it is better to impart information face-to-face.
- The most successful information people had received was always face-to-face.
- Use practice nurses to pass on information face-to-face.
- Efforts must be made to get information to homeless people.
- Apart from face-to-face, information is best given through posters and advertisements on TV or radio.

- If different formats are available on request, it needs to be made clear where to get them and not just give a telephone number. There should be a choice of contact methods, for example so that those with a hearing or speech impairment can access the information they need. Contact numbers for requests of different formats should not be written in small print.
- Contact details on leaflets for more information should also offer different routes (telephone, email, text, post, fax, etc).
- If a website address is given for more information, it should be specific and not just a general website that leaves the users to hunt down the information needed.
- Font size 18 should be standard (an example given was that in one PCT area GPs increased the uptake of flu jobs from 30 per cent to 65 per cent just by using font size 18 on the information that was distributed).
- Use colour contrasts.
- Information needs to be multi-layered: directed at disabled people as well as carers.
- Information through DVD is very useful. It should be subtitled or signed (both should be on offer separately, not together on the same DVD).
- Information needs to be timely: given while still in hospital not after having left.
- Information on complaints or Patient Advice and Liaison Services (PALS) should give more than just a telephone number; it must be accessible to British Sign Language users (e.g. a postcard?).
- Health and social care staff need training in how to communicate and where to get advocates to help those who have learning difficulties (important for the choice agenda).
- The Department of Health should set standards (or guidelines) for PCTs and Health Trusts on how to communicate.
- Involve disabled people in drawing up information for the public.

4. Involvement and consultation

People were asked how consultation or involvement should occur in policy or service development or in impact assessments.

- Ensure that involvement is genuine and not tokenistic.

- Be creative about involvement, and do more than involve the usual suspects.
- Involvement should happen at two levels: with organisations and with individual disabled people themselves.
- Don't just consult voluntary organisations, but consult disabled people directly.
- Go to local groups not just national organisations.
- Use GP lists to contact disabled people.
- Don't make involvement complicated or intimidating.
- Use the expertise of disabled people who may be seasoned users of the NHS and social care. Listen to how they have overcome barriers.
- Consultation must be face-to-face for people with learning difficulties.
- You need to hear the overall voice, not just the strongest voice.
- Use different methods for different disabilities (don't use a telephone survey with deaf people!).
- Use existing mechanisms to consult, e.g. RNIB magazine.
- Don't be tokenistic: acknowledge that no-one is representative of a whole group of people.
- There needs to be a mechanism for self-feedback.
- Get frontline staff involved: get them talking to people to collect views.
- Get disabled people to do the consultation on behalf of health and social care providers and pay them!
- Set up forums of service users.
- Just do it! You don't always need to get it right.
- Give feedback to consultees about the outcome of the consultation and decisions taken. Consultation fatigue results from lack of communication after consultation.
- Develop the capacity for participants to be fully involved.
- Don't just consult a self-selected group.

5. Bullying and harassment

This session covered bullying and harassment from staff to users, from users to staff, and from user to user.

- Ensure that there is guidance for the residential sector.
- Harassment and bullying occur largely because there is a lack of understanding around disability – raise awareness on disability through campaigns or training.
- Help staff to identify bullying and harassment.
- More training is needed for staff in raising awareness about bullying and harassment and how to deal with them.
- A confidential reporting system is needed.
- Extend PALS to include reporting bullying and harassment.
- Put systems in place that give security, so that people can be reassured that there will be no victimisation following a complaint.
- Any complaints procedure should be simple and quality-assured.
- Always include a named person to contact.
- Have lots of different routes to use for a complaint.
- Encourage complaints: the climate must be receptive to change.
- Address the culture of the organisation.
- Provide advocacy for people with learning difficulties.
- Harassment at work often happens because there is a lack of knowledge of funding available (Access to Work).
- The Department of Health should identify the extent of the problem (bullying by staff to patients).

6. Monitoring categories

Participants were shown the list of categories recommended by the Disability Rights Commission in its publication *The Disability Equality Duty: Guidance on Gathering and Analysing Evidence to Inform Action.* Participants were asked for their views on the use of suggested categories to collect information for monitoring purposes.

- Always use self-definition where possible.

- Make it clear what the information will be used for.
- Avoid jargon – people will not identify with 'cognitive impairment'.
- Categories should not be too rigid – subcategories are needed.
- How do you capture people who have 'cerebral palsy', which falls into several categories?
- How do you ensure correct categorisation of people with multiple impairments?
- How do you capture those who are disabled but do not consider themselves disabled?
- Link all information collected to gender and ethnicity.
- Monitoring information should be collected as part of a single patient record and should follow the patient through health and social care services.
- Information for assessing an individual's needs is different from information collected for statistical purposes. The first is confidential to that patient and those caring for them, the second is anonymous and not linked to any individual. The first is to find out 'needs' (e.g. communication needs), the second is to prevent discrimination.
- It may be better to categorise people by need rather than by impairment.
- In planning services, information on needs is more useful than on the standard impairment categories.

7. Access to services

People were asked to raise any issue of access to services, or any other issue they felt had not been covered in the other sessions.

- There should be a single point of contact for those with multiple needs, e.g. those with muscular dystrophy and people with learning difficulties.
- Many premises are still not accessible.
- Independent living is an important part of the picture.
- There is a need to look at the cultural views that exist in society of some disabilities.
- There should be more shared learning across the NHS and social care.

- 'The NHS is obsessed with handling things over the phone!' Offer other means of contact.
- Action on sexual health should consider the needs of adults with autism or people with learning disabilities.
- Guidelines should be drawn up on sexual health for people with learning difficulties and should also cover relationships and contraception. An example was given of Lincolnshire NHS Trust who produced a video on sexual health that was made by people with learning difficulties.
- People with learning difficulties need better access to psychiatric services.
- Cervical smears and breast screening: residents in care homes are not being invited to attend.
- Screening: the machinery is not appropriate for many disabilities.
- Transport should be available for people to attend screening.
- Waiting rooms are often not adapted for those who are blind; staff could tell them when it is their turn. They don't, as there is a lack of awareness around the needs of blind people.
- Public health posters should include images of disabled people.

8. Conclusion

At the end of the day, people were asked if they would like to participate in similar workshops, particularly helping the Department in undertaking equality impact assessments. All participants were interested in continuing to help improve services in this way. The Department thanked everyone who attended and made it clear that the developmental version of the Single Equality Scheme, together with the report on the workshop, would be sent to all participants.

Appendix 6: Assessment of Key Department of Health Functions and Policies for Relevance to Equality Duties

Assessment of DH functions and policies (or proposed policies) for their relevance to the promotion of equality

Health Improvement Directorate	
Function	**Assessment[1]**
Lead and drive health improvement policy development, ensuring effective delivery of programmes, objectives and targets to reduce health inequalities and improve population health in general	H
Broad policy areas	
• Reduce health inequalities	H
• Tackle childhood obesity	M
• Reduce teenage pregnancy and improve broader sexual health	M
• Encourage better 'self care' through initiatives such as Lifecheck, Health Trainers and Improving health literacy	H
• Reduce smoking	H
• Strengthen the sources of public health information and the evidence base	M
Equality and Human Rights Group	
Function	**Assessment**
Policy development	H
Broad policy areas	
• Equality is built into modernisation and systems reform, including the work of bodies established/sponsored by the Department	H
• Equality is built into the design and delivery of health and social care programmes, and the impact on different social groups is monitored	H
• The Department promotes systematic integration of equality and human rights within action to improve capacity within health and social care	H
• The Department is capable of meeting its statutory obligations and commitments in relation to equality and human rights, as an employer and in policy making	H
• Equality and Human Rights Group operates effectively as part of the corporate department	L

1 Priority – High, Medium, Low

Social Care Directorate	
Function	**Assessment**
Leadership of social care	H
Broad policy areas	
• Develop a strategy for the future of social care	H
• Actively engage those in government to improve the experience of children, families, adults and communities	H
• Engage people who use services, carers and stakeholders in the development and review of policy, service provision and practice	H
• Support the resourcing and the efficient and equitable delivery of high-quality services	H
Workforce Directorate (outward facing)	
Function	**Assessment**
Human Resources	H
Broad policy areas	
Leadership development	H
Organisational Development and change	M
HR Policy: Review key HR processes to reinforce social and organisational change including reward, recruitment and performance	H
HR Resourcing: Review key HR processes to reinforce social and organisational change including reward, recruitment and performance	H
Reward: Review key HR processes to reinforce social and organisational change including reward, recruitment and performance	H
Workforce planning and information systems	H
Commissioning Directorate	
Function	**Assessment**
Policy development	H
Broad policy areas	
• Lead in planning, performance, capacity and capability in the health and social care system	H
• Set a baseline for commissioning standards in healthcare	H
• Set headline, overarching priorities	H
• Hold SHAs to account in respect of performance	M

Experience, Involvement and Professional Leadership Directorate	
Function	**Priority**
Provide leadership to nurses, healthcare scientists and Allied Health Professionals; and support an improved patient experience, patient surveys and delivery of the MRSA PSA	H
Broad policy areas	
• Contribute to the strategic development of a modern, high-quality service that meets the needs of patients and has the confidence of the public	H
• Develop, promote and mainstream structures and behaviours that enable the views of the patients and the public to inform and influence the modernisation and improvement of health and social care services	H
• Improve the patient experience in terms of emotional factors	H
• Design a strategic framework and overall objectives for self-care, to develop a culture where self -care is accepted as part of the health and social care solution by professionals; and a culture of healthy partnership between professionals and the empowered public	H
• Improve the patient experience; contribute to changing professional attitudes to complaints and concerns so that they are valued for the focus they give to what needs to be improved; and contribute to development	H
• Improved health, especially of the poorest: strengthen the influence that people from disadvantaged groups have over access to health services and decisions about their treatment and care	H
• Improved patient experience: in collaboration with the Healthcare Commission, design a national patient feedback programme and a framework for analysing the responses that generates bottom-up demand for more frequent tracking, which can be rolled up to track national progress	H
• Transforming DH: introduce new ways of working with the NHS, social care and other organisations	H
• Introduce new ways of working that improve support to Ministers and senior officials, strengthen matrix working and our communication capacity and capability, and free up colleagues to do what only they can do	L
• Support the change of the Department to a 'knowledge working' era and maintain the DH position at the forefront of government in the field	H
• Ensurie the Department's resilience against increasing terrorist and cyber threats	L
• Ensure that DH complies with health and safety legislation and requirements	L
• Maintain Information Services Group's reputation for sound finance and programme management	L

Communications Directorate	
Function	**Assessment**
Corporate communications	M
Broad policy areas	
• Public: manage the reputation of the health and social care system, raising awareness of job opportunities in health and social care and maintaining public confidence and building the NHS as a brand for health	M
• Staff and stakeholders: communicate cultural change and promote engagement among staff and stakeholders	M
• Patients: develop ways of providing more information to local patients, users and communities	H
• Work across, contribute to, and support the staff and aims of the Communications Strategy, implement new ways of working, assist support mechanisms and assist colleagues to deliver and meet their own, and the directorate's, objectives	M
Health Protection, International Health and Scientific Development Directorate	
Function	**Assessment**
Health protection	L
Broad policy areas	
International health:	
• Manage European and global business for DH and the Devolved Administrations in a way that delivers UK objectives	L
Emergency preparedness:	
• In the field of emergency preparedness, develop and improve the Department's capacity and capability to fulfil its responsibilities as part of the central government response and to provide effective leadership, guidance and direction to the NHS, to ensure that all parts of society are protected equally	M
• Deliver all essential management tasks and obligations	L
Health protection:	
• Protect the health of the people of England from current and emerging hazards, such as infectious diseases and chemical and radiological contamination	M
• Management contribution	L
• Change programme	L
Scientific development and bioethics:	
• Promote new developments in healthcare science and take-up by NHS, and pursue Government policy on bioethics and human tissue	L

Research and Development Directorate	
Function	**Assessment**
Research	M
Policy and strategy	
• Contribute to health and social science and research policy for the UK	M
• Engage effectively with the UK Clinical Research Collaboration	M
• Manage the implementation of the UK Clinical Research Network	M
• Deal efficiently and effectively with all internal and external communications relating to research	M
Research and development: delivery	
• Implement strategic development of research and research capacity in the NHS	M
• Implement the research strategy, *Best Research for Best Health*, through the National Institute for Health Research	M
• Develop a coherent research programme to inform policy-making in health and social care – ensuring that policy development is informed by the cross-fertilisation of research evidence across health and social care sectors and by expansion of the capacity for whole-systems approaches	M
Coronary Heart Disease (CHD) Programme	
Function	**Assessment**
Health improvement	H
Broad policy areas	
• Improve access to services across the patient pathway and increase patient choice	H
• Increase the proportion of people receiving thrombolysis within 60 minutes	M
• In primary care, update practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with National Service Framework standards; ensure that practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30	H
• Improve the management of patients with heart failure, in line with National Institute for Clinical Excellence clinical guidelines	M
• Ensure cross-cutting support to delivery of CHD objectives	L

Cancer Programme	
Function	**Assessment**
Health improvement	H
Broad policy areas	
• Deliver cancer targets and commitments set out in the NHS Plan, the NHS Cancer Plan, and the Cancer Strategy	H
• Management contribution	L
Health and Care Partnerships	
Function	**Assessment**
Policy development	H
Broad policy areas	
Children and mental health:	
• Deliver improvements to mental health services and legislation, and deliver the NSF for Children, Young People and Maternity Services	H
• Management contribution	L
Health partnerships:	
• Improve health, address health inequalities and reduce crime by maximising the opportunities provided by better integration of health, social care and criminal justice systems	H
Older people and disability:	
• Support delivery of the Government's key targets as set out in the NHS Plan, PSA, PPF, and ministerial commitments, to create a high quality social and healthcare system that is flexible and responsive to the circumstances of people's lives and which puts service users and carers first	H
• Carry out baseline accountability work including correspondence, Parliamentary Questions, parliamentary business, briefing, speeches and invitations	L
• Prison health	H
Regional Public Health Groups (all)	
Broad policy areas	**Assessment**
• Improve health and tackle health inequalities	H
• Protect the health of the population	L
• Build capacity in the Department and across public health	L
• Contribute to the delivery of DH and other Government Departments PSAs	L

Finance Directorate	
Function	**Assessment**
Financial management/flows, procurement	L
Broad policy areas	
• Ensure that financial planning for the periods covered supports delivery of NHS and social care objectives within the financial envelope set by HM Treasury (HMT)	M
• Ensure that the Department has in place the systems, programmes and incentives to deliver the efficiency improvements for the health and social care system and that the efficiency gains can be properly measured and communicated	L
• Develop fit-for-purpose financial management and reporting systems and processes in DH and the NHS that support effective decision-making at all levels throughout DH	L
• Ensure that DH and the NHS meet their statutory, parliamentary and HMT obligations for the proper management and stewardship of public funds, including accounting for the use of resources	L
• Ensure that the Department's systems, programmes and processes support delivery of a fit-for-purpose capital infrastructure that meets the capacity requirements of the NHS	L

Assessment of executive agencies' functions and policies (or proposed policies) fo their relevance to the promotion of race equality

NHS Connecting for Health	
Functions and policies	**Assessment[2]**
Create an NHS Personal Care Record Service to improve the sharing of patients' records across the NHS with their consent	High
Choose and Book: make it easier and faster for GPs and other primary care staff to book hospital appointments for patients	High
Provide an electronic transmission of prescriptions	Medium
Ensure that the IT infrastructure can meet the NHS's needs now and in the future	Medium

NHS Purchasing and Supply Agency	
Functions	**Assessment**
Ensure that purchasing and supply strategies reflect and contribute towards the achievement of DH policies, strategies and priorities for the NHS, and have equality embedded in processes	High
Develop purchasing and supply policy for the NHS	High
Determine and control the appropriate level at which purchasing and supply decisions are made	Low
Deliver a comprehensive, cost-effective supply chain for the NHS	Low
Improve skills, expertise and professionalism of NHS purchasing and supply staff, including that of NHS Boards	Medium
Coordinate national NHS supplier management strategy	Medium
Create and manage a national contract portfolio that is available to the NHS	High
Provide of 'once only' services to the NHS, such as standard terms and conditions of contract, purchasing guides, an operational purchasing procedures manual and the provision of legal advice	High

Medicines and Healthcare products Regulatory Agency	
Functions	**Assessment**
Ensure that medicines for human use, sold or supplied in the UK, are of an acceptable standard of safety, quality and efficacy	Low
Ensure that medical devices meet appropriate standards of safety, quality and performance	Low
Communications: promote safe use of medicines and devices through the provision of authoritative and accessible information	High
Influence international regulation	Low
Monitor and ensure compliance with statutory obligations relating to medicines and devices, through inspection and taking enforcement action where necessary	Low

2 Priority High, Medium, Low

Appendix 7: Useful Publications

To help keep this Scheme as brief as possible, it has not been possible to set out in detail associated publications that relate to equality and human rights from the Department of Health or its key agencies. Some of these documents and are set out below, and they may contain evidence, commitments or Action Plans that relate to equality and human rights and DH functions.

Our health, our care, our say: www.dh.gov.uk/assetRoot/04/14/00/65/04140065.pdf

Delivering race equality in mental health care: www.dh.gov.uk/assetRoot/04/10/07/75/04100775.pdf

Patient and public involvement (*A stronger local voice*): www.dh.gov.uk/assetRoot/04/10/07/75/04100775.pdf

NHS Employers, Equality & Diversity: www.nhsemployers.org/kb/kb-757.cfm

Health reform in England: www.dh.gov.uk/assetRoot/04/13/72/30/04137230.pdf

The NHS Cancer Plan: www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Cancer/fs/en

Independent inquiry into inequalities in health: www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/fs/en

Valuing People – A New Strategy for Learning Disability for the 21st Century: www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/LearningDisabilities/fs/en

Framework for partnership action on disability: www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance%2fPublicationsPolicyAndGuidanceArticle%2ffs%2fen?CONTENT_ID=4083501&chk=iHUANf

Sharing the challenge, sharing the benefits – Equality and Diversity in the Medical Workforce: www.dh.gov.uk/Consultations/ClosedConsultations%2fClosedConsultationsArticle/fs/en?CONTENT_ID=4089415&chk=%2BNet5M

Equality and diversity: www.dh.gov.uk/PolicyAndGuidance%2fEqualityAndDiversity%2ffs/en

Positively Diverse: www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining%2fModelEmployer%2fEqualityAndDiversity%2fPositivelyDiverseIntro%2ffs/en?CONTENT_ID=4052110&chk=OPteqx

Department of Health study of Black, Asian and Ethnic Minority issues: www.dh.gov.uk/PublicationsAndStatistics/Publications%2fPublicationsPolicyAndGuidance%2fPublicationsPolicyAndGuidanceArticle%2ffs/en?CONTENT_ID=4006450&chk=GVe6sx

Improving the life chances of disabled people, Prime Minister's Strategy Unit, 2005

A Recipe for Care – Not a Single Ingredient, Department of Health, 2007

Produced by COI for the Department of Health

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