The Equality Delivery System for the NHS

STATEMENT ON COSTS AND BENEFITS

Regulatory Impact Assessment for the Public Sector Equality Duty

In June 2011, the Government Equalities Office published its Regulatory Impact Assessment (RIA) for the costs and benefits of creating a single set of specific duties to underpin the new Public Sector Equality Duty.

This RIA can be accessed at :
http://sta.geo.useconnect.co.uk/equality_act_2010/public_sector_equality_duty.aspx

Costs

The RIA set out the one-off and recurring costs and associated benefits to public services, including the NHS, of implementing the Public Sector Equality Duty.

The one-off costs mainly comprised the costs of staff familiarising themselves with the Public Sector Equality Duty.

The annual recurring costs of the Public Sector Equality Duty arise from public bodies taking steps to gather and publish data in relation to employment and service delivery and any underlying raw data. Public bodies will also need to be transparent about the impact they are seeking to achieve on equality and will be required to publish information that will inform the public of the equality objectives they are going to focus on to advance equality.

It is anticipated that large NHS bodies would have a person with responsibility for drawing up and publishing the equality objectives with input from statistical/research support and an administrative assistant over a period of around eight days per year. It is estimated that similar tasks will take a small NHS body around 3 days to complete.

To help better comply with the Public Sector Equality Duty, and as a matter of best practice, NHS organisations will also assess the impact on equality of their policies in the design of key policy and service delivery initiatives. Evidence and discussions with health sector bodies suggests health bodies will conduct 15-20 (small bodies five-seven) of these each year, taking an analyst around one day each on average. There is no requirement on NHS bodies to publish this information.

It is also anticipated that some larger NHS bodies, may continue to commission research for the purpose of developing and reviewing their equality objectives at an assumed average cost of £20,000 per body per four-year reporting period.

Benefits

The RIA also calculates the net benefits that accrue to local organisations in having to respond to one piece of equality legislation rather than three separate pieces of equality legislation, as was the case before the Equality Act 2010.

There are wider benefits as well. The previous three duties tied public bodies into seeing people from the prisms of race, gender and disability, and further constrained them to the reporting requirements which may not have achieved an equality outcome or provided a bespoke solution to the needs of patients, service users or customers. The new duties are designed to ensure that public bodies take account of the needs of disadvantaged individuals, both as employers and in the development and delivery of public services. They will help highlight, and make public bodies consider, hidden discrimination, systematic barriers, and shifted them towards considering the available evidence leading them to take action. This will result in improved, more efficient, public services, and reduce social costs of inequality. Though it is not possible to robustly monetise these benefits, these are nonetheless significant.

Net benefits

For the NHS as a whole, the following estimates arise out of these considerations of costs and benefits. Low and high figures are given, enabling allowance to be taken of the size of NHS bodies.

Costs / benefits to the NHS as a whole		
	Low	High
One off costs of familiarisation	£149,977	£199,970
Annually recurring costs of new specific duties	£767,871	£933,952
Annually recurring benefits of removing three separate equality duties	£1,201,369	£1360,373
Net Benefits Year 1 of the new specific duties	£67,448	£442,524
Net Benefits Year 2 onwards of the new specific duties	£267,417	£592,501

Broadly speaking the RIAs reveal a net benefit to NHS organisations in implementing the new Public Sector Equality Duty.

Equality Delivery System

As the Equality Delivery System for the NHS has been designed by the NHS to help its organisations respond more effectively to the Public Sector Equality Duty, the costs and benefits given above may apply to the EDS. What is more the EDS provides a ready-made approach to delivering on the Public Sector

Equality Duty that directly relates to health outcomes for patients and better working environments for staff.

Impact on patients, public and staff

The RIA of the Government Equalities Office focused solely on processes. If the EDS can help NHS organisations to identify poor performance and poor workforce practice and put that right, then the net benefits should increase. For example :

- If public health campaigns can reach out to more people, then changes in lifestyle or health regimes coupled with a greater take-up of screening / vaccination programmes can lead to the reduction of illness and the saving of lives among local communities.
- If more people can access the NHS in timely ways, then earlier interventions could again lead to the reduction of illness and the saving of lives.
- Helping people regain and retain their health also has knock-on effects for the contribution that individuals can make to their families, communities and in employment.
- If NHS organisations invest in the health and well-being of their staff, and outlaw bullying and harassment and promote flexible working options, the impact can be dramatic on staff illness and departures.
- Finally, a confident and competent workforce can deliver better outcomes to patients and the public.

For more details on these matters, please refer to Annex.

Annex

The costs and benefits of equality : a detailed analysis

Introduction

The NHS Constitution is very clear: "everyone counts" be they patients or staff. This means the NHS needs to consider the outcomes that different people experience: taking different or extra steps to improve access and design services so that their health outcomes and experience are equitable. These ideas of fairness and equity are intrinsic to the new NHS, that will emerge as a result of the White Paper "Liberating the NHS", and sets out the aim of patient-centred care, to involve patients, carers, local communities and staff in improving the NHS. For staff, the NHS needs to build working environments where all staff are confident in their skills, thriving in workplaces that are fair and free of discrimination.

Quality and productivity challenge

Not all NHS organisations take a systematic approach to identifying who is using their services and who may need to use their services. This results in services that may appear to be fully utilised, but not by all the patients that might need to use them, which can cause some protected characteristic groups to experience differential health care that may lead to health inequalities. Health inequalities can be addressed by providing quality prevention services and better-targeted public health promotions, such as smoking cessation, screening programmes, cardiac rehabilitation, and self-management of diabetes. Some people with protected characteristics need extra resources to enable them to access or use prevention and other services, so that they do not add to the productivity challenge. Below are some clear examples of exclusions from services:

Patient access to services:

- Last year's National Audit of Cardiac Rehabilitation (NACR) demonstrated that women are under-represented in cardiac rehabilitation. If men and women were taking part in proportion to the case rates for heart attack we would expect there to be 63% men and 37% women. In practice, women made up 32% of referrals but only 26% of participants. It is mainly older women who are under-represented in cardiac rehabilitation; women over the age of 80 are less likely to take part than men of the same age[1].
- Between 25-50% of adult [mental health] disorders are potentially preventable with treatment during childhood or adolescence (Kim-Cohen at al, 2003)[2]. People with mental health problems have much higher rates of physical illness, with a range of factors contributing to greater prevalence of, and premature mortality from: coronary heart disease, stroke, diabetes, infections and respiratory disease (Harris and Barraclough 1998; Wulsin et al 1999; Phelan et al 2001; Osborn et al 2007). [3]
- 42% of gay men, 43% of lesbians and 49% of bisexual men and women have clinically recognised mental health problems compared with rates of 12% and

[1] NACR Annual Report 2010

[2] www.cabinetoffice.gov.uk/media/.../**inclusion-health-evidencepack**.pdf

[3] Friedli Dr. L., *Mental health, resilience and inequalities*, 2009, WHO Europe and Mental Health Foundation

20% for predominantly heterosexual men and women[4] LGB people may, for example, be reluctant to disclose their sexual orientation to their GP, because they anticipate discrimination, and then fail to receive appropriate health care[5].

- Research commissioned by Leeds Partnership NHS Foundation Trust as part of the Pacesetters programme found that one third of LGB people in Leeds encountered mental health challenges, with more than half reporting having had suicidal thoughts at some point in their lives. One third of participants also reported self-harming. Of those who reported self-harming, 24% had not accessed a mental health service. Similarly, 33% of those who reported having suicidal thoughts had not accessed a mental health service[6].
- Just 3% of women aged 18 and over with learning disabilities living within a family, and 17% of those in formal care have had [cervical] screening, compared to 85% for women aged 20-64 nationally[7].
- Some health care professionals think that lesbians do not require cervical smear tests[8], yet 10% of lesbians have abnormal smears – this includes 5% of lesbians who have never had penetrative sex with a man[9]. Lesbian and bisexual women were up to 10 times less likely to have had a test in the past three years but lesbians and bisexual women have often been invisible patients within health services and their needs are poorly understood.[10].
- Type 2 diabetes is 3.5 times more prevalent in South Asians than Europeans.[11] However, a Diabetes UK survey of South Asian members found that only 16% of those responding had attended a course to help manage their diabetes[12]
- Gypsies and Travellers are reported to be more likely to visit A&E than a GP because of a lack of trust of some GP surgeries[13,] for example, "Barriers to health care access were experienced, with several contributory causes, including reluctance of GPs to register Travellers or visit sites, practical problems of access whilst travelling, mismatch of expectations between Travellers and health staff, and attitudinal Barriers"[14]

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[4] Warner J., McKeown E., Griffin M., Johnson K., Ramsey A., Cort C., and King M., *Rates and predictors of mental illness in gay men, lesbians and bisexual men and women*, 2004, British Journal of Psychiatry

[5] Hunt R. and Minsky A., *Reducing health inequalities for Lesbian Gay and Bisexual people: Evidence of health care needs*, 2006, Stonewall and DH.

[6] Richards A., *Closing the Gap – service needs and prohibitions to access: The LGB community, self harm, suicide ideation and suicide,* 2010, Leeds Partnership NHS Foundation Trust

[7] *The NHS – health for all? People with learning disabilities and health care*, Mencap, 1998

[8] Hunt R. and Minsky A., *Reducing health inequalities for Lesbian Gay and Bisexual people: Evidence of health care needs*, 2006, Stonewall and DH.

[9] In the Pink Providing Excellent Care for Lesbian, Gay and Bisexual People: A practical guide for GPS and Other Health Practitioners, 2010 NHS Sheffield citing Stonewall/ Cancerbackup

10 Fish J., Cervical screening in lesbian and bisexual women*: a review of the worldwide literature using systematic methods*, 2009, De Montford University.

[11] *Diabetes in the UK 2010*, Diabetes UK

[12] *Survey of South Asian people with diabetes 2006: Access to healthcare services at a glance*, Diabetes UK

[13] Social Exclusion Task Force research (2009)

[14] Parry G., Van Cleemput C. et al, *The Health Status of Gypsies and Travellers in England*, The University of Sheffield, October 2004.

Patient experience

- GP Patient Survey results 2009/10: Patients very satisfied with the care from their GP or health centre by ethnicity: Irish 60%, British 56%, compared with Chinese 27%, Bangladeshi 28% and Pakistani 29%[15].
- According to the NHS In Patient Survey, Asian/Asian British patients were 20% less likely to give a positive response to the question "*Overall, did you feel you were treated with respect and dignity while you were in the hospital?*" when compared to the White British group.[16]
- Similar patterns emerge from a question regarding Emergency Departments. For example, other than White Irish patients, all ethnic minority patients were less likely to give a positive response to the question *"Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?"*. In particular, the Chinese/other patients were approximately 50% less likely to give a positive response when compared to White British patients. [17]
- From the same In Patient Survey, all ethnic minority patients, in comparison to white British patients, were less likely to give a positive response to the question *"Did the doctor treat you with respect and dignity?"*, with Asian/Asian British patients being 50% less likely and Chinese/other patients being 66% less likely to give a positive response. [18]
- A report by MIND found up to 36% of gay men, 26% of bisexual men, 42% of lesbians and 61% of bisexual women recounted negative or mixed reaction from mental health professionals when being open about their sexual orientation.[19]
- People who are admitted to hospital over the age of 80 are twice as likely to become malnourished than those under the age of 50[20]. Becoming malnourished leads to serious consequences for us, including: the need to stay in hospital for longer, the need to take more medications, an increased risk of suffering from infections and even death.[21]

Staff experience

- Due to staff experiencing discrimination, bullying and harassment from fellow colleagues, patients and their families, the NHS experiences very high staff absences and a high turnover rate, which is costing the NHS approx. £1,682,048,391 and £766,077,482.6 respectively a year[22.]
- The 2009 NHS Staff Survey found that more disabled staff (24% rising to 26% in acute trusts) and non white staff (20% rising to 25% for mixed race staff in acute trusts) experienced harassment, bullying or abuse than non-disabled (15%) and white British staff (15%)[23].

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[15] GP Patients Survey 2009/2010

[16] *Report on the self reported experience of patients from black and minority ethnic groups*, June 2009, DH and National Statistics, citing the National Survey of Adult Inpatients 2008/09

[17] Ibid

[18] Ibid

[19] King M. and McKeown E., *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales*, 2003, MIND.

[20] *Malnutrition within an Ageing Population: A Call for Action*, European Nutrition for Health Alliance, 2005

[21] *Still Hungry to Be Heard, the scandal of people in later life becoming malnourished in hospitals*, Age UK, 2010.

[22] NHS Health and Wellbeing, Benefit Evaluation Model, 2008

[23] *National NHS Staff Survey 2009 Key findings*, prepared by Aston Business School

- The same survey also found that Black/ Black British (16%) staff experienced the most discrimination in the last 12 months, with this figure rising for Other Asian staff (20%) in acute trusts and Black African staff (18%) in acute and mental health / learning disability trusts. What is notable is the sharp increase of discrimination in ambulance trusts of disabled staff (20%), other white staff (23%), Indian staff (25%) and mixed background staff (33%)[24].
- Research in 2010 found that BME staff were almost twice as likely to be disciplined in comparison with white staff – and the problem could be more common, as a web audit found that only 80 NHS trusts published annual data broken down by ethnicity as required by the Race Relations (Amendment) Act 2000. "Trusts need to develop robust systems for data collection and analysis relating to all aspects of employee relations"[25].

The correlation between staff satisfaction and patient experience:

- Aston Business School was commissioned by the Healthcare Commission to explore whether staff satisfaction and patient experience were linked. They used the NHS staff and patients surveys in 2007 to identify possible pairs of variables, and then narrowed down pairs to the relationships that appeared most substantial. It is important to note that no inference about causality can be drawn from the analysis. Findings included:
- Prevalence of discrimination against staff is related to several areas of patient experience, particularly their perceptions of nursing staff, such as: When you had important questions to ask a nurse, did you get answers that you could understand? And, Did you have confidence and trust in the nurses treating you?
- High levels of bullying, harassment and abuse against staff by outsiders relates to many negative patient experiences. As with the discrimination findings, it is obvious that these effects could take on either, or both, causal directions: aggression from patients towards staff could be a result of perceptions of poor quality of care, and/or could result in poorer quality care being delivered. [26]

[24] Ibid

[25] Archibong U. and Darr A., *The Involvement of Black and Minority Ethnic Staff in Disciplinary Proceedings*, March 2010, Centre for Inclusion and Diversity, University of Bradford.

[26] Dawson J., *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys*, July 2009, Institute for Health Services Effectiveness, Aston Business School.