

Health and the Disability Equality Duty

**Guidance for public authorities
working in the health sectors in
England and Wales**



Foreword

We all want to live in communities where we can participate fully and equally. When we need to see a doctor, visit a hospital or access other medical services, we want this to be delivered in ways which help us to be included in society. We know that for many disabled people this hasn't yet happened and there remains considerable work to be done across the health sector before disabled people are treated equally.

The Disability Rights Commission's 'Formal Investigation into Health Inequalities Equal Treatment: Closing the Gap' has provided a stark reminder of the health outcomes disabled people currently encounter using the health services. Disabled people die sooner than non disabled people and become ill more often, yet continue to face barriers in securing healthcare.

The statutory Disability Equality Duty (DED) has been introduced to ensure that the public sector addresses such imbalance and looks at ways of ensuring that disabled people are treated equally. This includes public authorities working in the health sector.

The duty is not about public authorities making adjustments to ensure that they do not unlawfully discriminate against individual disabled people. Other parts of the Disability Discrimination Act already protect disabled people at an individual level. The duty is about weaving equality for disabled people into the culture of public authorities in practical and demonstrated ways. This means including disabled people and disability equality in policy development and actions from the outset, rather than focusing on individualised responses to specific disabled people. It is about planning for equality at the beginning rather than trying to add it at the end.

Effective engagement with the DED will not only improve your performance on disability equality. It will also help you to meet your wider strategic priorities, such as those set out in the Department for Health's white paper 'Our health, our care, our say; or the Welsh Assembly Governments health strategy; Designed for Life.'

Bert Massie, DRC Chairman

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About this Guidance

What does this guidance do?

This guidance explains how the Disability Equality Duty (DED) will apply in practice to the health sectors in England and Wales.

The DED requires all public authorities to have due regard to the need to promote disability equality. Promoting disability equality involves promoting equality of opportunity for disabled people, eliminating unlawful discrimination and harassment, promoting positive attitudes towards disabled people and encouraging participation of disabled people in public life. The duty requires due regard, even where that involves treating disabled people more favourably than other people.

This new duty will have a significant impact on the whole of the healthcare sectors in England and Wales and therefore anybody involved in, or who has an interest in healthcare, needs to both understand and get involved in this process. It is in force from 4 December 2006.

Do you need to read it?

You will need to read this guidance if:

- you are a senior manager working in the health sectors in England and Wales
- you are a manager with responsibility for diversity working in the health sectors
- you are responsible for implementing, delivering or monitoring a Disability Equality Scheme (DES)
- you are responsible for the design or delivery of health services
- you assess, monitor or regulate the delivery of publicly funded healthcare
- you commission or procure within the health sectors
- you employ people or are responsible for human resources within the health sectors

- **you are interested in your rights as a disabled person and particularly if you are a disabled person who is involved in creating a DES for a public authority working in the health sectors**
- **you are disabled person employed within the health sectors.**

This guidance is relevant to people working across healthcare, not just for those working in services specifically targeted at disabled people.

See also the Other Information section of this guidance which directs readers to the statutory guidance on the DED for public authorities available at the Disability Rights Commission's (DRC) website, www.dotheduty.org, along with other guidance on specific aspects of the duty.

Context setting – the Disability Equality Duty and healthcare

The DED will have a particularly marked impact on the health sector. This is because whilst the situation is improving healthcare is an area of public service where the inequalities that disabled people encounter remain stark.

Equal Treatment: A Formal Investigation into healthcare inequalities

The Disability Rights Commission has recently completed a Formal Investigation into healthcare inequalities. The investigation, called ‘Equal Treatment: Closing the Gap’, considered the health inequalities encountered by people with learning disabilities and people with mental health problems.

The Formal Investigation provides an invaluable resource for health organisations working to meet their disability equality duties, as it sets out a clear evidence base for proposed actions to end discrimination for two groups of disabled people particularly affected by health inequalities.¹

The Formal Investigation found that both groups of people were much more likely than other citizens to have significant health risks and major health problems.

The investigation highlighted:

- Amongst other inequalities, people with mental health conditions are less likely than the general population to receive certain standard checks when they are ill. For example, people with mental health problems who have heart disease are less likely to receive cholesterol checks and cholesterol lowering drugs such as ‘statins’ than others with heart disease.

¹ Disability Rights Commission (2006) ‘Equal Treatment: Closing the Gap - a formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems’, www.drc-gb.org

- People with learning disabilities who have diabetes are less likely to have their body mass index measured than others with diabetes. Those who have had a stroke have fewer blood pressure checks than other stroke patients.

The advent of the DED is of course a prime opportunity to address the inequalities identified in the Formal Investigation.

It is likely that the Formal Investigation's findings will be of broader application to a range of impairments and medical conditions. Other research by the DRC has indicated that other groups of disabled people also encounter discrimination. For example, 64 per cent of profoundly deaf people find accident and emergency units either inaccessible or inadequate for their needs (Indeed, 21 per cent of all disabled people expressed similar concerns).²

Wider health inequalities

Many disabled people also encounter 'multiple discrimination' because of gender, sexuality, race and age. For example, people with mental health conditions who are also from Black and Minority Ethnic (BME) communities are significantly more likely to be compulsorily admitted to hospital as a result of their condition and are likely to stay longer.³ They are also more likely than white people to be prescribed drugs or Electroconvulsive Therapy, rather than psychotherapy or counselling.

Healthcare frameworks

It is important when considering the context of the DED and healthcare to recognise that many different organisations will have an impact on the health equality of disabled people.

Providing high quality health services can also play a crucial role in supporting disabled people in other areas of their lives, like helping them to stay in work and participate in family life and other activities. It is

² Disability Rights Commission (2004) 'Discriminating Treatment? Disabled people and the Health Service', www.drc-gb.org

³ Department of Health (2006) *Delivering Race Equality at a Glance*, www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/MentalHealth/BMEMentalHealth/BMEMentalHealthArticle/fs/en?CONTENT_ID=4114938&chk=keKB6t

important to relate to the person in the context of their whole life and to enable them to participate in society, not to focus on treatment alone.

The framework through which healthcare is delivered in the UK is complex. The majority of public healthcare is provided through the National Health Services in England and Wales, which itself is made up of a complex web of organisations. Each will have to consider how the DED affects them.

Healthcare is not limited to medical care. So, in addition to the care provided under the supervision of doctors and nurses, healthcare covers a wide range of services, including public health issues, ambulance services, cancer screening, dentistry and optometry - all of which have an impact on the health outcomes of disabled people.

Although there are very different types and sizes of organisation – from foundation trusts in England to Local Health Boards in Wales - the principles for how they can meet their disability equality duties will remain consistent.

Disabled people will often not differentiate between health and social care, so to achieve equal health outcomes public authorities in both healthcare and social care sectors will have to work closely together. (The DRC has produced information and separate guidance for the social care sectors in England and Wales, which is available to download at www.dotheduty.org.)

A challenging agenda

The changes public authorities working in the health sector will need to make to ensure they meet their Disability Equality Duties are challenging. Such changes should not be seen as an additional burden, but as a way of ensuring health bodies meet wider objectives.

Ending discrimination is not just about making hospital buildings accessible by putting in ramps or producing health information documents in alternative formats. It is about systematically identifying barriers and reducing inequalities. This will take time, understanding and effort, but your disabled staff and service users will help you do this.

Introduction to the Disability Equality Duty

The purpose of the DED

The overall purpose of the DED is to make public authorities working in the health sectors in England and Wales think about the needs of disabled people when planning, delivering or monitoring healthcare services.

The DED covers all disabled people including those with long-term health conditions, covered by the Disability Discrimination Act (DDA) 1995 (as amended by DDA 2005).

In addition each public authority has a legal obligation to involve in the development of its Disability Equality Scheme disabled people who appear to have an interest in the way in which that authority carries out its functions.

A Strategic Health Authority (SHA) in England is developing its Influenza Pandemic Preparedness Plan. The objective of the plan is to reduce the impact of an influenza pandemic on the health of the population covered by the authority.

To meet this objective the authority will have to consider the needs of disabled people and ensure the promotion of disability equality – in other words, that disabled people are able to benefit equally from the intended outcomes of the Plan. The SHA will need to consider the following:

- disabled people are more likely to be affected by an outbreak of flu
- the plan will have significant gaps if it does not meet the needs of disabled people. One in five people in the UK are covered by the provisions of the Disability Discrimination Act 2005
- the SHA, as a public authority, has a statutory Disability Equality Duty to ensure that the needs of disabled people are met.

The SHA should ensure that disabled people have equal access by:

- involving disabled people. For example, co-opting representatives from a local organisation of disabled people and an older people's

organisation - as there is a greater prevalence of disability amongst the elderly - onto its Pandemic Control Planning group.

- ensuring that there are mechanisms for disabled people to get accessible information if their were a pandemic
- specifically considering the needs of disabled people - for example, how disabled people may access places where vaccines are to be distributed

The outcome of effectively considering the needs of disabled people is that the Authority is prepared to meet the needs of the whole population, and in doing so will be meeting its Disability Equality Duty.

Ending institutionalised discrimination

This duty ensures that for the first time ever public authorities take responsibility for tackling institutional disability-related discrimination. This is a dramatic progression from the focus on individual rights of the Disability Discrimination Act 1995.

The Disability Equality Duty does not give individuals more rights, instead it is about improving public authorities' policies and services as a whole, for all disabled people. Its focus is not so much on removing physical barriers (which authorities should have already addressed in compliance with DDA 1995), but more on removing those barriers within policy or the design of services or initiatives that have a negative impact on the lives of disabled people.

A Local Health Board (LHB) in Wales is planning to improve out-of-hours GP services. In carrying out this function, the LHB will need to have due regard to the need to promote disability equality. This will involve:

- gathering and analysing information to determine whether current arrangements unlawfully discriminate against disabled people
- involving local organisations of disabled people in gathering evidence of the barriers to equal access that could prevent someone accessing out of hours GP services. This could also involve working with organisations of older people or people who have long term medical conditions such as cancer

- **identifying whether additional resources are required to ensure that any revised out-of-hours service fully meets the needs of disabled people**
- **ensuring that ongoing service performance and review arrangements include mechanisms to identify whether the new plan meets the needs of disabled people**

Social model

The DED reflects the social model of disability, which takes the approach that what stops or hinders a disabled person doing something - such as achieving access to a health service - are the barriers that society has put in place or failed to remove. It is society that disables a person; not their impairment.

The duty applies the social model to the functions of a public authority. It does this by recognising the negative impact on disabled people of a society designed for non-disabled people. It also recognises that active steps are needed to promote equality for disabled people.

Which disabled people does the duty apply to?

The duty is owed to ‘disabled people’, which is based on the definition of disability used in the DDA 1995 as amended in 2005. This applies to a very wide range of physical and mental impairments, including those with long-term health conditions, such as Alzheimer’s disease, arthritis, HIV, multiple sclerosis, depression, diabetes, cancer and so on. The duty requires authorities to consider the equality of all disabled people who fall within this definition. Public authorities will need therefore to consider the impact of specific impairments, as well as the general issues that may affect all disabled people.

Overview of the Disability Equality Duty

As a consequence of the introduction of a Disability Equality Duty, all public authorities are required to adopt a pro-active approach, mainstreaming disability equality into all its functions. This is known as the general duty and is described in greater detail below.

Some public authorities - will also be subject to the specific duties. These set a framework to assist authorities in planning, delivering and evaluating action to meet the general duty and to report on these activities. At the heart of this framework is the Disability Equality Scheme. The specific duties are described below.

The vast majority of public authorities working in the health sector will be subject to both the general and specific duties. A 'public authority' for the purposes of the DED includes any organisation that exercises some functions of a public nature, so the general duty may extend, for example, to a private company or voluntary organisation carrying out a healthcare function on behalf of a publicly funded body.

Enforcement

The DRC and its successor the Commission for Equality and Human Rights (CEHR) will have the power to take legal action where an authority fails to comply with its specific duties. Any interested party, including the DRC or CEHR, may, depending on the circumstances, be able to bring an action for judicial review where an authority fails to comply with its general duty.

It should be noted that relevant inspection bodies will also be building compliance with the DED into their assessment regimes. This will include, for example, evidence of the involvement of disabled people in developing Disability Equality Schemes.

The general duty

This chapter provides more detail about what is required of an organisation working in the health sector in order to meet the general duty.

The general duty applies to all public authorities, so as a contractual or legal obligation will directly affect the planning, delivery or monitoring of all publicly funded healthcare. This chapter will therefore be of interest to everyone who works in the health sectors in England and Wales.

In many cases public authorities working in the health sector will meet their general duties through the framework of their DES. However, it remains essential that all those individuals who make up a particular public authority have a full understanding of the general duty as it represents the heart of this legislation and DES simply evidences that authority's commitment to the requirements of the general duty.

Requirements of the general duty

The general duty requires public authorities when carrying out their functions to have due regard to the need to:

- promote equality of opportunity between disabled people and other people
- eliminate discrimination that is unlawful under the DDA
- eliminate disability-related harassment
- promote positive attitudes towards disabled people
- encourage participation by disabled people in public life
- take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons.

The next sections of the guidance describe each of these in more detail with reference to the healthcare sector and demonstrate how the various components interact and overlap in the overall promotion of disability equality.

‘Due regard’ means that organisations should give due weight to the need to promote disability equality in proportion to its relevance. The duty applies to all authority functions, including budget and target-setting, strategic planning and commissioning.

‘Equal Treatment’, the DRC’s Formal Investigation into health inequalities, recommends that Primary Care Trusts (PCTs) provide incentives, for instance through a Directed or Enhanced Service (as now applies to Local Health Boards in Wales), to ensure that regular health checks are provided for people with learning disabilities. The investigation also called for national training programmes for health professionals to counteract diagnostic overshadowing and improve attitudes and understanding. In England, this training should be spearheaded by the Department of Health with partners and in Wales by the Welsh Assembly Government with partners, including the ‘Equip’ project led by RCGP Wales. In both countries the GP contract and the GP appraisal system should incentivise training.

These are examples of giving ‘due regard’ to disability equality.

Promoting equality

Equality of opportunity for disabled persons is the overarching goal of the general duty.

All public authorities will need to promote equality of opportunity between disabled and non-disabled people. It will be particularly important for public authorities who have responsibility for planning healthcare to promote equality in health outcomes.

This should be an extension of good practice that already exists in many health bodies, when designing or delivering high quality public services.

Promoting equality in healthcare will often need to be done in relation to clear strategic objectives.

A Local Health Board (LHB) is planning to alter a child immunisation programme. This is being done following a directive from the Welsh Assembly to increase the number of children who are being vaccinated in early childhood. Health visitors have noticed that parents who have a learning disability appear to have been less likely to take up immunisation for their children.

The LHB has a duty to promote equality of opportunity between disabled people and other people. This means that those responsible for delivering the programme will have to ensure that the service is designed to offer the same opportunities to disabled parents as to other parents.

This could be done by several LHBs working together to look at how they can meet the Disability Equality Duty in this area. A key part of this work would involve drawing on advice from people with learning disabilities to advise on how programmes could be made more accessible. An impact assessment will also help to identify what aspects of the proposed programme may disadvantage disabled people and how equality of opportunity may be better achieved.

A Primary Healthcare Trust is setting up an Expert Patients' programme. This offers people with long-term health conditions, such as diabetes or asthma, the opportunity to manage their condition more effectively. Some groups of disabled people, such as people with mental health conditions, are more likely to have other long-term physical conditions such as diabetes. Better self-management not only benefits the individual, but saves the NHS money, as people who manage their conditions well have less interaction with healthcare services.

It is important that the Expert Patients' programme is designed in a way that is accessible. The PCT has a duty to ensure equality of opportunity between disabled people and non-disabled people. This could be done by actively promoting the programme to disabled people, ensuring that the programme is run in an accessible way (see the section 'Accessible Mechanisms' below) and monitoring it to ensure there are no barriers to the participation of disabled people.

Eliminating unlawful discrimination

The general duty requires public authorities to have due regard to the need to eliminate discrimination that is unlawful under the Disability Discrimination Act 1995 (as amended).

This aspect of the general duty reinforces the reasonable adjustment duties of the DDA. It complements and in some cases overlaps with the existing anticipatory duty to make reasonable adjustments, which requires adjustments to be made in advance of individual disabled people attempting to use the service.,

The DDA 1995 continues to protect individual disabled people. As part of their duties under the DDA, All organisations are required to make reasonable adjustments to ensure they do not unlawfully discriminate against an individual.

The duty to make reasonable adjustments in relation to service provision is an anticipatory one – in contrast to the duty in relation to employment, which is a duty triggered by an employer knowing (or being reasonably expect to know) that a disabled individual requires an adjustment. The DED reinforces the anticipatory aspect of the duty, requiring unlawful discrimination to be systemically identified and eliminated across all aspects of an organisation’s functions – including employment.

A pro-active, systematic approach to removing the full range of barriers is essential to opening up services and ending discrimination. This will need to be planned at a strategic level and will be most appropriate where it relates to the functions of an organisation.

It is brought to the attention of a Mental Health Trust that people from the deaf community find it difficult to alter appointments because outpatient receptions do not have a textphone system. It would be a reasonable adjustment for the trust to provide such a system.

Provision of an auxiliary service such as textphone would be a reasonable adjustment under the Disability Discrimination Act 1995. The outcome of purchasing a textphone system and training staff to use it is that more deaf people can now interact with the trust.

Whilst the DED builds on the anticipatory duty of the provisions of the DDA 1995, the mental health trust will only meet its disability equality duties if it takes a **systematic** approach to removing discrimination in the way it develops and delivers policies, practices and services.

This will need to be planned and resourced at senior management level.

The actions resulting from this may include:

- creating an accessible information policy
- consulting with disabled patient groups or representative bodies on how it communicates with people
- gathering and analysing evidence by examining trends of take-up of services to ensure it is not, through institutional practice, failing to include or be accessible to a group of disabled people.

The outcome of applying the Disability Equality Duty in this way is that disabled people will be able to interact with the trust in a more effective way. By doing this the trust is not only meeting its general duty, it is helping ensure its resources are spent wisely.

Public authorities working in the health sector will also need to remove barriers that result in unlawful discrimination against their current workforce or potential employees. This will need to be undertaken systematically and in a way that anticipates, then removes discrimination.

Health authorities working in the health sector will need to look at recruitment, training and retention of staff, including 'fitness standards,' to ensure that these processes have not been designed in a way that unlawfully discriminates or fails to promote disability equality.

Where disabled people are under-represented, for example, in senior management roles or take-up of training strategies will need to be put in place to ensure that disabled people have real equal opportunities and that this is demonstrated by outcomes.

Eliminate disability-related harassment

The general duty requires authorities to have due regard to eliminate harassment of disabled people for reasons related to their impairment or long-term health condition (ie harassment on the grounds of disability).

Harassment is a very broad concept and can take many forms, from direct verbal abuse, to comments that make an individual feel uncomfortable, intimidated or degraded. Disabled people often experience considerable harassment in daily life – including when at work or when receiving services.

In a healthcare setting harassment can often be hidden or under-reported for a number of different reasons. Disabled people are particularly vulnerable to harassment where they live in residential settings or are receiving care in institutionalised settings. For example, people who access inpatients service, use day care or stay at respite care settings.

Harassment may be directed against a person because of their impairment. It may also be due to another factor that relates to healthcare that may not appear to be initially connected to a person's

impairment. For example, a person who is bullied by colleagues because they have to make regular visits to the toilet as a consequence of having had surgery for bowel cancer.

Many healthcare organisations will already have an anti-harassment policy. For those that do not, the DRC recommends that they preferably develop one in agreement with service users and staff, which explicitly refers to the importance of prohibiting harassment of disabled people. The outcomes of this policy need to be assessed regularly to ensure they do this to make sure harassment is not a hidden practice and to specifically ensure they are supporting the inclusion of disabled staff and service users.

Healthcare organisations will often have to ensure that staff are appropriately trained in working professionally with disabled people, including those who are in distress. This will include staff receiving disability equality training to create a baseline for good customer service. It may also be appropriate for staff to receive training on specific issues such as the side effects of medication and understanding the importance of advocacy and communication support for people in vulnerable situations.

As part of meeting the DED an Ambulance Trust ensures that all its frontline staff receives disability equality training. In addition to implementing national guidelines, the trust develops a protocol with local disability organisations for good customer care for serving people in mental distress. As part of this process the trust consults with organisations that represent people with mental health conditions. This includes organisations working with homeless people and bodies working with people who have been through the criminal justice system, amongst whom there may be greater prevalence of mental health conditions.

It is important for healthcare organisations to consider how they can eliminate harassment in relation to the functions of the organisation. For example, a body that commissions nursing care from independent contractors should ensure that any contractors have in place proper procedures to monitor and eliminate harassment. These should be built into the commissioning / procurement process and ultimately, if not addressed, lead to the suspension of a contract.

Public authorities will need to develop strategies to gather evidence on harassment, such as discreet and sensitive methods for reporting

incidents of harassment, with reference to a clear and widely publicised policy, and to identify how best to stop it. In view of the wide definition of harassment, promotion of disability equality in this context also requires public authorities to have due regard to the basic treatment of disabled people and preservation of their dignity.

Promote positive attitudes

The general duty requires public authorities to have due regard to the need to promote positive attitudes towards disabled persons.

Whilst many people have positive attitudes towards disabled people, some express pity, fear, lack of respect, or even contempt. Stereotypes, or simply the absence of any representation in public images, have very negative impact on disabled people's lives. Such attitudes are not only hurtful, but can lead to discrimination and place unnecessary restrictions on disabled people.

This is particularly important when considering the design of health promotion or services such as screening programs. The assumption that should be inherent is that disabled people are part of strategy, not separate to it.

The Department of Health is running a campaign aimed at good maternity health.

The images and case studies selected for the campaign include the representation of disabled people.

Campaign material is made available in a wide variety of formats. This will not only make the information accessible, but will highlight that disabled people are an important integral audience for the campaign.

Healthcare organisations will need to consider what they can do to eliminate ignorance and prejudice in the wider community. An important part of this will be ensuring that all staff training programmes contain disability equality training, based on the social model.

This will help ensure that all staff, including those on the front line, have a better understanding of disability equality and play their part in treating disabled people with respect.

Participation in public life

The general duty requires public authorities to have due regard to the need to encourage participation by disabled people in public life.

Disabled people bring valuable experience and skills to the work of healthcare organisations. Such participation will encourage positive attitudes towards disabled people and may lead to a reduction in harassment and discrimination.

The public are already encouraged to participate in the governance of public authorities working in the health sector.

Examples include

- patients' associations
- market research focus groups
- user groups for a service provided by a health authority
- membership of boards
- government public appointments.

Public authorities will need to ensure that disabled people are well represented on these groups.

Patient and Public Involvement Forums

Patient and Public Involvement (PPI) Forums enable people to have a say in how local health services are provided. It is important that disabled people can have an active voice on PPI Forums – or indeed in any comparable involvement mechanism. It is important that this includes involving those disabled people who are often overlooked in engagement processes, such as

- BSL users
- people with high support needs
- people with learning disabilities

- people with mental health conditions who are regular users of primary healthcare services.

Community Health Councils

Community Health Councils (CHCs) are a key involvement mechanism for people in Wales to influence health services. To do their job effectively CHCs must take into account the views of disabled people during their community consultations. This will necessitate ensuring that disabled people are at the core of involvement strategies and that this involvement is monitored and assessed over time.

Where the CHCs are not able to maintain the participation of a wide range of disabled people they will need to employ separate mechanisms to ensure they represent the views of all disabled people, including people with learning disabilities, people with mental health conditions and disabled children.

Executive boards

Health trusts, boards and authorities should ensure that there is representation of disabled people on the executive boards. Executive boards are meant to be representative of the local community, but now the trust has a statutory duty to encourage the participation of disabled people on them. As theirs will be a representative role, any disabled person appointed to such a board should ideally be capable of representing the interests of disabled people more broadly than their own impairment or condition, and should have a good understanding of the workings of healthcare.

A Council of Governors of a Foundation Hospital decides that it will ensure that adequate representation of disabled people from the local community is guaranteed by reserving an elected position for a disabled person. Nominations are sought for this position through consultation with organisations of disabled people.

More favourable treatment

It is important for health sector organisations to remember the underpinning principle of the general duty: the need to take steps to take account of disabled people's impairments and access needs, even where

that involves treating disabled people more favourably than other persons. This requirement is very different from the approach of the gender and race equality duties, and builds on the recognition through the concept of reasonable adjustments that disability equality cannot be achieved simply by treating disabled and non-disabled people alike.

Public authorities will be required to take steps to meet disabled people's needs, even if this requires treating disabled people more favourably than non-disabled people.

A hospital trust ensures cancer patients who travel regularly to hospital for treatment are exempt from hospital car parking charges. This is because research shows that such patients travel on average 53 times to hospital during the course of their treatment, which is considerably more than other patients. Although this is treating cancer patients more favourably than non-disabled people, it is to ensure they have fair access to services.

Organisations have to use a specific approach to make sure they are including all disabled people. This may, for example, involve providing additional dedicated services to enable disabled people to access healthcare equality. Where a separate service specifically aimed at disabled people is provided alongside a 'mainstream' service, this should be there as a choice, not as an enforced, segregated provision provided because disabled people are unable to access the mainstream service.

A Primary Healthcare Trust has funded two General Practitioner surgeries to receive specialist training on meeting the needs of people who have both visual and hearing impairments. For example, staff are trained in:

- finger-spelling
- working with older people who have acquired visual and hearing impairments
- how to contact patients by accessible means.

The two surgeries become centres of excellence whose role is also to provide other surgeries with advice and support within the trust area.

A number of deafblind people choose to register with the new surgery as they feel it will now offer them a more accessible service.

The Trust encourages all GPs to learn from the Centres of Excellence so that they can give a deafblind person the highest level of care.

Wider functions

The general duty, remember, applies to all functions, not just to employment and service delivery. Disabled people will need to be considered where proportionate and relevant in a wide range of functions.

For example, when drafting clinical guidelines, standards and good practice guides public authorities should take into account how these may be relevant to a wide range of disabled people. These should take into account relevant research and where appropriate public authorities should undertake evidence-gathering processes themselves.

The National Institute for Health and Clinical Excellence (NICE) is producing guidelines on effective approaches to health promotion.

To ensure it meets its Disability Equality Duty, NICE must make sure the guidance is relevant to promoting good health for disabled people.

Where a particular health inequality is well known, NICE may need to produce specific guidance for a group of disabled people. For example, it may produce guidelines on effective health promotion strategies aimed at supporting people with mental health problems to give up smoking or target people with learning disabilities in campaigns aimed to reduce coronary heart disease, diabetes or obesity – and so on.

A Hospital Trust is altering its night-time security arrangements. It originally proposed that night-time entry to the trust buildings for staff would be restricted to a single entry / exit point at the front of the building, except for disabled staff members who would be permitted direct access / egress from the car park at the buildings' rear. Although the operation of a single entry /exit point would reduce costs, it would also mean that staff would have to travel considerably further to and from their vehicles in the car park.

As part of its impact assessment process, the trust consulted with the trade unions' disabled members' groups, who are concerned that the proposal would have a discriminatory effect on disabled staff members, in particular those who do not define themselves as disabled. The trust therefore allows everyone night-time access directly to and from the car park at the rear.

Access is extended to everyone to ensure that all disabled people can benefit from the arrangements. For example, it will benefit disabled people who are not part of the blue badge scheme and to disabled people travelling with colleagues.

Commissioning and Procurement

The general duty also requires due regard to be paid to disability equality when public authorities in the health sectors are commissioning and procuring goods or services. The two terms are used distinctly in the healthcare sectors, but for the purposes of DRC, guidance on procurement is intended to include commissioning activities.

See the final chapter of this guidance on ‘Commissioning and Procurement’ in the health sector for more details.

The DRC has produced information and guidance on procurement which is available at www.dotheduty.org. This should be consulted by people who have responsibility for commissioning or procuring within a healthcare setting.

Specific duties

All public authorities working in the health sector will also be subject to the specific duties.

These ‘specific duties’ form a practical framework for authorities to show how they are meeting the general duty, and they focus on the publication of a Disability Equality Scheme. The initial Scheme had to be in place by 4 December 2006. Subsequent Schemes will need to be developed every three years.

The specific duties are designed to assist authorities in planning, delivering, evaluating and reporting on their activities to ensure compliance with the general duty.

To which organisations do the specific duties apply?

Most large and many smaller health bodies are subject to the specific duties. The following are all subject to the specific duties:

- Strategic Health Authorities
- Specialist Health Trusts
- Acute Trusts
- Foundation Trusts
- Primary Care Trusts
- Local Health Boards.

A full list of those covered by the specific duties is set out in regulations made under the Act and is included in Appendix A of the Codes of Practice to the duty.⁴ (The regulations with the list of bodies to whom the specific duties apply will be periodically supplemented / revised. Healthcare bodies are therefore advised to check for current inclusions.)

Independent contractors such as GPs, pharmacists or dentists; along

⁴ DRC (2005) ‘The Duty to Promote Disability Equality: Statutory Code of Practice (England and Wales)’, www.dotheduty.org

with voluntary and private bodies will not be directly subject to the specific duties and so will not be required to produce a Scheme.

What is required by the specific duties?

The key feature of the specific duties is a requirement for these organisations to produce a DES demonstrating how they intend to fulfil their disability equality duties.

The Disability Equality Scheme must contain an Action Plan and be published. The actions set out in the Action Plan should be clear, specific and measurable and must be carried out, unless it is unreasonable or impracticable to do so. Authorities must report annually on progress towards meeting the actions. It may be particularly useful to involve disabled people in this annual reporting process so that they may ensure that actions are progressing appropriately.

The Disability Equality Scheme

The essential elements which the Disability Equality Scheme must cover are:

- a statement of how disabled people have been involved in developing the Scheme
- the Action Plan
- arrangements for gathering information about performance of the public body on disability equality
- arrangements for assessing the impact of the activities of the authority on disability equality and improving these when necessary
- details of how the authority is going to use the information gathered, in particular in reviewing the effectiveness of its Action Plan and preparing subsequent Schemes.

The following chapter describes each of these elements in more detail and includes some helpful practical examples.

Involvement statement

Public authorities must involve in the development of their Disability Equality Scheme ‘disabled people who appear to that authority to have an interest in the way it carries out its functions.’⁵

The Scheme must include a statement covering how disabled people have been involved its development. This should describe briefly the involvement processes and specify how and when disabled people have been able to directly influence the development of Disability Equality Schemes. It is likely that this will cover the number of meetings, activities or events held with disabled staff and disabled people who use the authority’s services.

Where healthcare organisations group together or work with other public sector organisations it is important to delineate what the involvement process has brought to each individual DES. This is because public sector healthcare organisations often have very different functions that range from planning through to delivery.

A number of Primary Care Trusts, Hospital Trusts including an acute Mental Health Hospital Trust and local authorities are working together to develop their Disability Equality Scheme.

To do this effectively they have been holding joint meetings and seminars. At these, they discuss issues that are general to all the authorities, but have breakout sessions to discuss issues specific to individual authorities’ functions. This will for example include looking at health priorities for disabled people in a given area.

People with mental health conditions are not represented at the meetings, so the mental health hospital trust takes responsibility for holding an additional focus group of people with mental health conditions. It also feeds back to the Primary Healthcare Trusts issues relating to primary healthcare and people with mental health conditions.

It would be beneficial for the statement also to set out lessons learned for future Schemes. As with all new initiatives it is likely that the process of creating a DES will require fine tuning. Disabled people will be in a good position to provide the context for the future development of Disability

⁵ **Disability Discrimination (Public Authorities) (Statutory Duties) Regulations 2005**

Equality Schemes, including how to improve information-gathering processes; how to improve involvement of disabled people; priorities for future action; and so on.

Involvement guidance

The DRC has produced detailed guidance on how public authorities should involve disabled people in creating Disability Equality Schemes. This is available online at the DRC website www.dotheduty.org and should be consulted by those responsible for involving disabled people in creating an authority's Disability Equality Schemes.

Inherent features in the involvement process

In order to be fully effective, the statutory Code of Practice on the duty indicates that the involvement process should have a number of inherent features:

Be focussed

This means that the public authority should put effort into defining the initial parameters for the DES. They should also clearly indicate the budget and resources available. It is likely that before disabled people are involved, an authority will have developed a framework Scheme that clearly outlines the functions that the Scheme will cover.

It is important for disabled people to be made aware of the remit of the Scheme and that this will only cover the functions of that organisation. Within the context of healthcare this will be particularly important as the general public may not easily differentiate the work of different tiers of organisations. It will often not be obvious to people, for example, what a Health Trust has the power to change and what it does not.

At the start of the involvement process a Local Health Board creates a simple document outlining what its main functions are. This clarifies what it has power to change and what it does not.

The document is easily converted into alternative formats, is given to people participating in the involvement process at meetings and is put on-line so people can access the information before they get involved.

Use accessible mechanisms

Public authorities need to take steps to ensure that a wide range of disabled people can contribute to the process of developing a Disability Equality Scheme. This is particularly important in a health setting as everyone potentially has an interest in the way health services are run. Care should be taken to ensure the participation of seldom-heard-from groups, including:

- **people with learning disabilities**
- **older people using care services**
- **people with mental health conditions**
- **disabled children**
- **disabled people from BME communities people in residential and nursing care settings.**

Care should be taken to make sure the mechanisms as well as documents are as inclusive as possible. For example, public authorities should look at the structure of meetings through which the Disability Equality Scheme is developed to ensure that meetings are of appropriate length, at disability-friendly times, with sufficient breaks, with appropriate materials, free of unnecessary jargon and, of course, in accessible venues, with appropriate facilitation and communication support. For more information see DRC ‘Guidance for Public Authorities on Effective Involvement of Disabled People’ which is available at www.dotheduty.org.

All public authorities should ensure that disabled people taking part in developing a Disability Equality Scheme can contribute fully. This will often necessitate:

- **producing documents in alternative formats and publicising their availability**
- **paying for personal assistants or sign language interpreters or other enabling support**
- **ensuring that childcare is provided when appropriate**

- providing transport where public transport is not available or accessible.

Be proportionate

The approach a Primary Care Trust takes will naturally be different to the Department of Health in developing a DES. It is likely that the Department for Health or other large public authority will have a standing committee or group of disabled people who will be involved in their Disability Equality Scheme. A Primary Care Trust may join together with other public authorities to manage the involvement process.

Be influential

The Scheme itself should contain the detail of how disabled people were involved. This will need to highlight explicitly where disabled people have influenced the process.

The involvement process must have the power to influence and change how the organisation acts in relation to disability equality. If the involvement process does not change anything, it is likely not to have been influential enough.

Again it is important within a health setting to clearly identify how the involvement process has been influential in relation to the various functions of an organisation.

Be transparent

You should provide information about who has been involved and who they represent. To maintain ongoing commitment by disabled people they need to know that their involvement has been influential, not tokenistic. If a particular viewpoint has been notably disregarded in a Scheme, it would aid transparency if the reason for that decision were explained.

User protocols

Public authorities should already be aware of the need to develop user involvement protocols for both commissioning and monitoring services, in consultation with disabled people.

For some smaller public authorities, this approach may be disproportionate, and they may make effective use of existing mechanisms of involvement.

Gathering information

The DRC have produced guidance on gathering and analysing evidence to inform action, which is available online at www.drc-gb.org. The following provides the context for gathering evidence to inform disability equality in a health setting.

Public authorities working in the health sector must set out in their Disability Equality Scheme their arrangements for gathering information on the effect of their policies and practices on outcomes for disabled people and in particular on:

- arrangements for gathering information on the effect of its policies and practices on the recruitment, development and retention of its disabled employees;
- arrangements for gathering information on the extent to which the services it provides, and those other functions it performs, take account of the needs of disabled persons.

It is important for public authorities working in the health sector to identify what evidence gathering process will adequately describe the experience of disabled people as the users of health services.

The Equal Treatment Investigation recommended the establishment of arrangements for mapping health inequalities to provide a baseline for measuring progress on closing gaps between disabled people and other sections of the local population.

The involvement of disabled people in the development of improved outcomes, indicators and targets, and in the development and inspection of standards will be crucial to fulfilling the DED in the context of healthcare.

The requirement to analyse and act on evidence

Information gathering is not an end in itself and will need to be actually used to help healthcare organisations make decisions about what actions would best improve disability equality. Information will often show up a particular pattern or experience and this should be a trigger to investigate further and take remedial action.

As part of the evidence gathering process a Hospital Trust decides to survey a sample of patients to identify why readmissions after surgery seem to be higher for some groups of disabled people. Despite anecdotal evidence that older people with neurological conditions are often readmitted, this group is not reflected in survey returns.

The hospital trust decides to carry out more detailed follow-up research aimed at older people. This is undertaken in partnership with a representative group of older people.

The follow up research identifies that although older people are as likely to attend post-operative clinics, they are less likely to find the information given to them accessible. The trust takes steps to ensure that material is provided in large print and medical staff are encouraged to convey information clearly. They also decide to trail longer consultation times for older people with neurological conditions.

Public authorities working in the health sector will also need to gather evidence on what types of healthcare are being accessed by disabled people. If it appears that a group of disabled people is under-represented or over-represented in an area of healthcare delivery, then the public authority will likely need to act to correct this imbalance. There may be a number of reasons for such imbalance.

For example:

- it may not be an appropriate way of delivering healthcare for that particular group
- additional action and / or resources may be required in order to deliver healthcare for this particular group
- the policy that underpins the healthcare delivery may be discriminatory.

It should also be remembered that public authorities working in the health sector already have a significant body of evidence on which they may draw. It should also be noted, however, that gathering evidence in the context of healthcare services may tend to raise issues of disempowerment of disabled people, in that disabled people have traditionally been the focus of research rather than active participants in the research process. It may therefore, for example, be wise to include disabled people in any reference group that an authority may convene to undertake evidence-gathering work.

A Primary Healthcare Trust, as part of its evidence gathering, seeks to identify how accessible its commissioned dentistry services are for people with learning disabilities. Through the partnership board they commission a local self-advocacy group to undertake the research to identify:

- the barriers that they encounter going to the dentist
- the number who do not have a dentist and the reasons why
- which dentists people with learning disabilities feel most comfortable visiting, who may be able to serve as models of good practice

In ‘Equal Treatment: Closing the Gap’, referred to above, the DRC recommends that PCTs in England and Local Health Boards and Local Authorities in Wales analyse the physical health needs, experiences and views of people with learning disabilities and / or mental health problems. This will then form part of the local strategic assessment of need and this data may be directly used to commission services to close gaps in equality.

The Investigation found that some groups of people with learning disabilities and mental health problems faced barriers accessing primary care. It therefore recommended that PCTs and LHBs should also identify people living in institutional or residential settings who may require primary care through in-reach provision, and commission such services accordingly.

Impact assessments

Disability Equality Schemes will be required to include a description of how public authorities will be assessing the impact of their policies and practices or likely impact on both existing and proposed policies and practices on disabled people. These cover all proposed, current and previous activities of an organisation.

The DRC has produced information and guidance on undertaking impact assessments and how to ensure that they lead to improvements in outcomes.

There are already many impact assessment methodologies in wide use across the healthcare sectors in England and Wales. As part of the process of developing the Disability Equality Scheme, disabled people may need to identify a preferred impact assessment tool.

An NHS Trust covering a rural area provides an integrated acute and community healthcare service. The trust is planning to close a community hospital, relocating its services to the main acute hospital.

The impact assessment must be able to identify whether the reorganisation will have a disproportionate effect on disabled people. This may include identifying whether the distances that people will have to travel will prevent or deter disabled people from receiving treatment, visiting relatives or working under the proposed arrangements.

Developing policies and practices that ensure that all individuals are treated equally, is the first step towards delivering health services that are patient-focused and effective.

A hospital trust is introducing a new patient record database.

They ensure that a comprehensive impact assessment is undertaken of the proposal to ensure that the new system will be fully compatible with the range of access technology available for disabled people. They also ensure that the database will be able to produce information in a range of accessible formats, will cover an appropriate range of data sets and will enable medical staff to easily identify and monitor patients' access requirements.

The impact assessment shows that the existing brief for the system does not meet these requirements. The brief is altered to ensure that the system is accessible and the situation monitored to ensure continued suitability.

Authorities will need to prioritise which existing programmes or policies should be impact assessed first. Disabled people should be involved in this decision and this information included in the Scheme's Action Plan.

Impact assessment is just part of the process of promoting disability equality and should be seen as a positive process by which to identify opportunities to improve policies and practice to better promote disability equality. It should not be seen as an end in itself and is simply a tool to identify those changes and then put in place improvements that will lead to positive outcomes for disabled people.

The process of impact assessment should not be arduous, but should be appropriately thorough. It should always be effective and its impact on improving outcomes should be monitored, tracked and even celebrated.

An NHS hospital trust has a very clear policy on visiting times, which do not start until three pm. Disabled people who have been involved in looking at the system for prioritising policies for impact assessments have highlighted this as a particular issue.

When the hospital undertakes an impact assessment of this policy they discover that it has an adverse impact on many disabled people who wish to visit friends or relatives. This is because of the fatigue associated with some impairments, which makes travelling later in the day more difficult. This is compounded by the fact that the local door-to-door accessible transport provider does not provide transport after five pm which further limits the periods in which disabled people may visit.

Whilst there are very good clinical reasons for restricting visitors in the morning, the hospital decides to adjust its policy so that morning visiting is available at weekends. They also have discussions with the door-to-door transport provider about their restricted hours.

Action Plans

The Disability Equality Scheme must include a statement of the steps that a public authority proposes to take to ensure the fulfilment of the general duty within the period of time covered by the Scheme. These steps are referred to as an 'Action Plan'.

There are many action planning processes used within the health sector and these may be incorporated into creating the DES. The action planning process should not be seen as an additional burden, but a tool to enable them to deliver the DED (and other regulatory requirements) more efficiently. Disabled people will, however, need to be involved in the action planning process and especially in prioritising how they are developed.

Remember that the action planning processes must aim to make practical improvements in equality for disabled people.

The Action Plan should reflect a number of things including:

- the priorities of disabled people
- the strategic priorities of the public authority
- the specific outcomes to be achieved
- how the outcomes are to be measured and assessed
- who is responsible for delivering the specified outcomes
- a realistic timetable for delivering each outcome

It is recommended that healthcare organisations set specific targets in key employment or service delivery areas against which it may readily measure its performance. Schemes are unlikely to be able to address all areas of concern to disabled people in the first three years. Priorities will need to be considered, so that efforts are concentrated on those areas that will have the maximum impact on disabled people's lives.

Initial Action Plans within the first round of Disability Equality Schemes are likely to include a certain focus on equipping the authority to engage effectively with its ongoing duty to promote disability equality. So, an

authority may need to improve its processes for gathering information on its disabled staff and service users. It may also need to agree protocols for impact assessment and processes for strategic involvement of disabled people.

Other areas that healthcare organisations may wish to consider in the context of initial Schemes include

- health inequalities
- training needs
- supporting Independent Living
- tackling multiple discrimination
- participation of disabled people in health governance.

These are discussed further below.

Health inequalities

The Action Plan of a public authority working in the health sector is expected to include action to tackle health inequalities experienced by disabled people. The extent to which the plan covers these issues and how they are covered depends on how much work the authority has already done in this area and where gaps currently exist.

For example, some national and local public health bodies lack systems to identify and monitor health inequalities faced by disabled people and so action may include improving data collection and research so that information on patterns of mortality and morbidity for disabled people (by broad impairment group) are available and systems are in place to measure take up of services, health promotion, screening and treatment by disabled people and to measure and compare health outcomes.

The Equal Treatment formal investigation found that in some cases, data was not available because systems were not in place, and in other cases that data was available but wasn't being used effectively by those commissioning services.

A Local Health Board will need to take steps to identify and address inequalities in access to primary healthcare such as GPs' surgeries.

A Strategic Health Authority may look at its screening provision to ensure it meets the needs of the whole population, including people with learning disabilities. Similarly, health promotion activities, such as smoking cessation programmes, should appropriately target people with mental health conditions who tend to smoke more.

A hospital with a postgraduate medical school should ensure that its curriculum addresses health inequalities.

Training needs

A public authority working in the health sector may consider in its Action Plan how it trains staff on disability equality issues. This could involve training in disability equality and the social model for staff who have contact with patients and also for those responsible for planning or the delivery of policies and programmes.

Several Primary Care Trusts, in partnership with a representative group of disabled people, develop a training programme for practice managers and other front-line staff that focuses on meeting the needs of people with learning disabilities or people with mental health conditions.

They also produce an on-line resource for practice managers on disability equality issues. This keeps managers up-to-date with changes to policy and best practice.

Public authorities responsible for commissioning services should ensure that training in disability equality and an understanding of the social model are included in the commissioning contract.

A Local Health Board writes into the conditions of a contract to commission services from nursing homes in its area that managers of those homes receive disability equality training from a local organisation of disabled people.

Supporting Independent Living

A public authority working in the health sector in England or Wales may consider in its Action Plan how it supports independent living, as a goal intrinsic to the well-being of disabled people. This will require authorities to identify key steps that will ensure the promotion of choice, control and the ability for people to live with dignity in the community.

A Primary Healthcare Trust may look at how it commissions services that empower disabled people to take an active part in the community rather than simply as receiver of medical care. For example, they may realign their community nursing services to enable more people to receive nursing care in their own homes, working with local partners to promote independent living.

A foundation hospital discovers that people are unable to leave a rehabilitation support unit to move into the community because of a lack of accessible housing. The foundation hospital works with the local authority and other public authorities to identify how an increase in accessible housing can be developed.

Tackling multiple discrimination

A public authority working in the health sector may consider in its Action Plan what steps it will take to tackle the discrimination disabled people from BME communities, disabled homeless people, people who use care services or disabled people who been through the criminal justice system particularly encounter. Authorities could choose, in partnership with people from these groups, priorities for action.

A regulatory body working in the health sector may develop protocols for monitoring the take up of services for disabled people who also encounter multiple discrimination. This may require health trusts to gather additional evidence.

Participation of disabled people

Whilst a public authority working in the health sector, will of course need to have due regard to each component of the general duty, it may particularly benefit from consideration in its Action Plan of how it will increase the participation of disabled people within its governance structures.

A Strategic Health Authority sets out a process through which more disabled people will feel confident in applying to be non-executive board members.

This involves providing training for future applicants and indicating that non-executive board members will, if they so wish, receive professional mentoring during the first year of appointment.

It may also identify how disabled people can participate more widely in its strategic direction. By doing so it will increase the expertise of disabled people and their organisations to inform future Disability Equality Schemes. One obvious way of doing this would be to fund a representative organisation of disabled people either individually or collectively.

A group of primary healthcare trusts, in conjunction with a local authority, resource a local organisation of disabled people. As part of the contractual relationship, the organisation of disabled people encourages people to take part in participation processes.

The organisation of disabled people will also be in a good position to comment on future Disability Equality Schemes and suggest how involvement, evidence gathering, and action planning processes may be refined.

Commissioning and procurement

This final short chapter deals with commissioning and procurement in the health sector. The DRC has produced separate guidance on **Commissioning and Procurement**. This is available online via the DRC website www.drc-gb.org and should be consulted by people responsible for commissioning or procuring in the health sectors.

Commissioning in the health sector

Commissioning healthcare services is an inherent part of the day-to-day functions of many public authorities working in the health sector. As such, ensuring that the commissioning process meets an authority's Disability Equality Duty will often go a long way to ensuring the whole organisation meets its duties.

When a public authority working in the health sectors in England and Wales commissions another organisation to undertake a function on its behalf, then the commissioned body will attract its own responsibility to meet the general duty in relation to carrying out that public function. This will be the case, even if the commissioned body is not otherwise a public authority, but is, for example, a voluntary organisation or private company.

A Local Health Board and Local Authority have jointly commissioned a local voluntary sector organisation to create an independent advocacy project. This is so they meet their responsibilities under the Mental Health Act.

Both the Local Health Board and the Local Authority will have to ensure that the actual process of commissioning is carried out in a way which meets its own disability equality duties. For example, the terms of the contract specify that the advocacy project will provide an accessible service.

Likewise, the voluntary sector body may be carrying out a function of a public nature, and may also have to ensure that it meets its own acquired general duty in regard to the advocacy project.

Where a commissioned body is not undertaking a function of the public authority, but merely providing a service, the obligation to comply with the duty in relation to the function remains with the public authority that

commissions the function.

A PCT is commissioning NHS-funded Continuing Care beds at a private nursing home. The PCT will need to ensure that the specification for the contract contains relevant requirements under the disability equality duty.

Supporting commissioning and procurement processes

Steps that will assist public authorities in ensuring that they meet their obligations when commissioning or procuring goods or services include:

- reviewing commissioning frameworks or procurement terms and conditions to include information about the Disability Discrimination Act 2005
- including a requirement in every contract that the commissioned body or the goods and services procured must comply with the anti-discrimination provisions of the Act
- clearly identifying where relevant, what evidence the commissioning body or contractor should gather for the authority to demonstrate its compliance with the general or specific duties
- ensuring that disability equality is appropriately reflected, and given due weight, in the specification, selection and award criteria, and the contract conditions. For goods and services this must be done in a way which is consistent with applicable EC and UK procurement rules
- ensuring that contractors fully understand any disability equality requirements of the contract
- monitoring performance of disability equality where relevant to the contract
- providing training for all staff involved in procurement or commissioning so that they fully understand the provisions of the Act and the relevance of the Disability Equality Duty to their area of work.

The DRC's 'Equal Treatment: Closing the Gap', referred to above, recommends that:

- PCTs in England and Local Health Boards in Wales should build robust disability access and quality standards into all contracts with providers, in the public, private and voluntary sectors;**
- The Department of Health should introduce incentives in the new General Medical Services (GP) contract for annual health checks for people with learning disabilities and for people with enduring mental health problems, and for reasonable adjustments to be made in primary care; and require audit of health checks and their outcomes for both groups in terms of quality and subsequent treatment. It is also recommended that the Welsh Assembly Government builds on its progress to date to achieve similar ends.**

National leadership

Certain Secretaries of State and the National Assembly for Wales (through the First Minister) will have to publish a report every three years that gives an overview of the progress made by public authorities in their policy sector in relation to the promotion of disability equality. They must also set out proposals for co-ordination of action by public authorities in that policy sector, or remit area, to bring about further progress on disability equality.

The first set of these reports is due in December 2008; a year in advance of the publication of the second Disability Equality Schemes. This duty allows for a greater degree of strategic co-ordination across government. Healthcare organisations should expect to be asked to provide information to help inform the Secretary of State for Health or the National Assembly for Wales when it comes to reporting. Healthcare organisations might also wish to make use of this imperative as a supportive mechanism to ensure support from Chief Executive level to meet the duty, rather than responsibility for complying with the duty resting solely with equality officers and / or HR departments.

Conclusion

The Disability Equality Duty will have a significant impact on public authorities working in the health sector. It will not only enable them to end the discrimination that disabled people encounter, but also to provide a more efficient and effective service with a user-focused approach.

For the first time ever, public authorities working in the health sector will be formally asking disabled people and their organisations to become involved, to help them in developing their Disability Equality Schemes. This is an exciting opportunity to help get public services right for all disabled people.

It has to be recognised that improving public services for disabled people is likely to be a learning process for everyone and that progress will be realisable over a period of time. It is vital that healthcare organisations liaise with each other where they perform a similar function to share experience along the way.

As with all public authorities, healthcare organisations may not get everything right from the outset, but what is vital is whether actual improved outcomes are achieved for disabled people.

The practical emphasis of Disability Equality Schemes should equip health bodies to deliver substantial tangible improvements in health equality. Disability Equality Schemes need to be more than just a showcase for current good practice and to achieve substantial improvements. Health organisations can use the full three years of the Scheme and beyond to take gradual but meaningful steps in this direction for positive, permanent change.

Other information

The DRC has produced a wide range of guidance documents on important components of the Disability Equality Duty, including on involving disabled people and evidence gathering. All DED guides can be found on the Disability Rights Commission website www.dotheduty.org.

All guidance documents (except guidance for disabled people, overview guidance and guidance on involvement which will be published in a range of formats) are purely online documents and can be downloaded free of charge from the DRC website. You can get a copy of the published guidance by contacting the DRC Helpline, details of which are below.

Copies of the Disability Discrimination Act and regulations made under it can be purchased from The Stationery Office. Separate codes covering other aspects of the Act, and guidance relating to the definition of disability are also available from The Stationery Office. The text of all the DRC's codes can also be downloaded free of charge from www.dotheduty.org.

The DRC, with the Department of Health, has also produced a series of short guides called 'You Can Make A Difference', which illustrate in practical terms what kind of barriers disabled people face. These are available from the DRC website www.drc-gb.org.

The DRC website also contains further information on the Equal Treatment Formal Investigation.

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Disclaimer

The information in this guidance is based on the law but its main purpose is to help authorities to comply with and make the most of the Disability Equality Duty. The Statutory Code of Practice on the Disability Equality Duty provides further detail of the legislation.