

Overview of Primary Care Trust Disability Equality Scheme assessments by the Disability Rights Commission

Introduction

The Disability Rights Commission (DRC) has assessed a sample of 20 Primary Care Trusts' (PCTs) Disability Equality Schemes in England to determine their overall compliance with the Disability Equality Duty (DED) and the extent to which their schemes implement the recommendations of the DRCs Equal Treatment formal investigation into health inequalities experienced by people with learning disabilities and/or mental health problems. This report gives an overview of the assessment results, focussing on key trends, strengths and weaknesses in the schemes.

There are 152 PCTs in England and the sample of 20 was chosen to reflect the national spread of black and minority ethnic communities, population density and rural/urban areas. It includes 2 PCTs from most Strategic Health Authority (SHA) areas and 7 of the 20 PCTs are situated within Department of Health Spearhead local authority areas, which are those specifically charged with addressing health inequalities.

The functions of all PCT's are –

- providing Primary Care Services
- improving the health of the local community and reducing health inequalities
- providing community health services
- consultation and patient and public involvement
- employment
- commissioning services
- integrating health and social care

- promoting training, education and staff development
- infection control
- assessment of local health needs
- securing provision of hospital and acute services
- developing and maintaining robust policies and procedures
- monitoring and reviewing key functions as a service provider and commissioner
- non clinical support services

DED Compliance

All 20 sampled PCTs produced a scheme (although a small minority were draft schemes) which is a better overall performance than the Strategic Health Authority schemes we assessed. These assessments reveal a mixed picture. Only two of the 20 have been assessed as being technically DED compliant, although even these two require some revision to bring them up to the standard DRC looks for. The other 18 vary in standard, some being much nearer the compliance mark than others.

Two schemes that were close to being compliant were strong on involvement, action plans and impact assessments but failed to meet what was required from the DED regarding evidence gathering and information. Across the board, the evidence gathering and information components of the sampled PCT schemes were seriously lacking.

Involvement of disabled people

The Regulations 2(2) and 2(3) (a) provide that the authority must involve disabled people who appear to that authority to have an interest in the way it carries out its functions in the development of the Scheme, and that the scheme must include a statement of the way in which such disabled people have been involved in its development.

“Involvement” requires a more active engagement of disabled stakeholders than “consultation”. The involvement must go further than a paper exercise This allows a variety of perspectives, from

disabled 'experts' across a range of subjects, to employees and end users, reflecting the full range of disabled people. The Code states that "It is important to consider the full diversity of disabled people – in terms of the type of impairment, as well as other dimensions such as ethnicity, age, gender, sexual orientation and religion or belief."

The Code also states that the involvement process should be both influential – people outside the organisation should be able to see how the involvement has affected the public authority's plans; and transparent – to maintain on-going commitment to involvement by disabled people they need to know that it has been influential, not merely tokenistic. This requires reporting on the results of involvement.

The duty to involve disabled people in the preparation of a Disability Equality Scheme is the foundation of a Scheme. The DRC thus regards the failure to comply with this as a fundamental flaw which requires the revision of the Scheme.

The PCT schemes with the strongest and most impressive involvement mechanisms were 2 that come under the auspices of the North East Strategic Health Authority (SHA). The DRCs assessment of all 10 SHAs in England concluded that the North East SHA was, by a long margin, the best and in many respects, particularly in terms of its involvement process, was an exemplar scheme. The North East SHA engaged a wide range of disabled people and disability organisations in producing their scheme and coordinated their approach with constituent PCTs so that each PCT engaged with the involvement process and applied it locally. Therefore this finding is not surprising. What it demonstrates is the far reaching effects for disability equality that a carefully coordinated and integrated approach between SHAs and their PCTs can have.

A separate PCT with robust involvement mechanisms was alone in identifying groups of disabled people they found it hard to engage with (children, young people and bme disabled people) and acknowledged they had more work to do to ensure these groups' involvement in the future. This self awareness is to be welcomed in schemes.

Apart from these 3 schemes the others failed to comply fully with the DED involvement requirements. Common flaws were thinking

that one off consultation events or questionnaire exercises represented true involvement, limiting involvement to engagement with either staff or service users. At their worst, schemes were entirely aspirational as regards involvement, i.e. stating what they plan to do instead of having done it.

Gathering evidence and using information

Regulations 2 (3) (d) (i) and (iii) provide that the scheme must include a statement of the authority's arrangements for gathering information on the effect of its policies and practices on disabled people and in particular its arrangements for gathering information on their effect on the recruitment, development and retention of its disabled employees, and the extent to which the services it provides and those other functions it performs take account of the needs of disabled persons. Regulation 2(3) (e) provides that the Scheme must include a statement of the authority's arrangements for making use of the information it gathers to assist it in the performance of its general duty and, in particular, its arrangements for reviewing on a regular basis the effectiveness of the action plan, and preparing subsequent schemes.

A major problem with implementing the DED is the lack of an evidence base of health needs in the local populations. Statistics on disabled people's access to or use of healthcare have not been and are not adequately collected although DH and DWP statistics (including DLA recipients) can be used to provide regional demographic profiles of different impairment categories.

Perhaps it is therefore not that surprising then that almost all PCT assessed fail to meet what the DED requires of them in terms of gathering evidence. However, some have a much clearer understanding of what they need to do to rectify this failing and set out coherent objectives in their action plans to ensure evidence required will be available in future years.

Action Plan

Regulation 2(3) (c) provides that the scheme must include a statement of the steps which the authority proposes taking over the period of the Scheme towards the fulfilment of its general duty to:

- give due regard to the need to promote equality of opportunity for disabled people
- eliminate discrimination which is unlawful under the Act
- eliminate disability related harassment
- promote positive attitudes
- encourage participation by disabled people in public life.
- take steps to take account of disabled people's disabilities even where that involves treating disabled people more favourably than others.

An authority needs in drawing up its Action Plan to consider the relevance of each of these dimensions of equality in relation to each of its functions. The Statutory Code explains that equality of opportunity for disabled people is the overarching goal, and the requirement to treat disabled people more favourably where appropriate is the underpinning principle.

As with the SHAs assessed, most action plans are inadequate in their failure to address all the functions of the SHA (most cover employment, access to buildings, procurement and contract providing but in very general terms) The listed actions tend to comprise only those which the authority needs to do to start the development of an effective and compliant scheme. They restate their activities required by the different elements of the DED (so for instance the need to do impact assessments, engage disabled people in implementing the scheme, monitor work force, and publish the scheme)

Most action plans appear to have been developed without any involvement of disabled people or disability organisations which is a major omission. Other common omissions were failing to identify whether actions had originated from involvement or evidence gathering; failing to set time deadlines on actions and failing to

attribute the responsibility for actions to individuals. Even more concerning though was that a small minority of PCTs sampled failed to produce an action plan at all.

Impact Assessment

Regulation 2(3) (b) provides that schemes must include the authority's methods for assessing the impact of its policies and practices, or the likely impact of its proposed policies and practices, on equality for disabled people. The Code of Practice states that public authorities need to develop criteria enabling them to determine whether the policy is a major one for the authority or although a minor one, it is likely to have a major impact on disabled people. In all cases the impact assessment is the weakest part of the schemes.

Most PCTs assessed failed to fully comply with this requirement. Some had developed good impact assessment toolkits but failed to set out how and which policies would be prioritised for impact assessment.

Implementation of Equal Treatment investigation recommended actions

8 of the 20 sampled PCT schemes reference the Equal Treatment formal investigation (FI) in some way, 5 of which are PCT's in Spearhead areas. It needs to be noted though that FI references in schemes are not necessarily an indication that the scheme is a good one generally!

It was disappointing and glaringly obvious from the outset that none of the PCT schemes have picked up on all, or any in detail, of the recommended FI Inquiry Panel actions which include –

- actions to tackle health inequalities by using the FI findings in equality impact assessments and monitoring
- actions to ensure that commissioned services are tracked over time to check that the local health economy leads to a reduction in health inequalities experienced by disabled people
- actions to support and empower disability organisations
- actions to measure whether disabled people have more

problems accessing GP's

- actions to ensure PCT's commission services which trigger health checks for disabled people at key significant points e.g. hospital admissions, CPA assessments etc
- actions to ensure disabled people in residential care have easy access to GP's and primary care services which are free of charge
- actions to ensure services are relevant and accessible to disabled people who do not have easy access to GP's e.g. homeless people
- implementing audits of legally required reasonable adjustments by using patient satisfaction surveys with disabled people
- monitoring the use of routine interventions given to disabled people to rectify under use
- actions to ensure healthy living strategies, e.g. encouraging '5 a day', and services are available to disabled people in residential care
- implementing disability equality and awareness training for PCT staff and promoting this through commissioned services

Rather than systematically building these actions into their disability equality schemes the sampled PCT's that reference the FI do so very briefly and in one or more of three ways. Either they use the general FI message that disabled people experience (often preventable) health inequalities as their rationale for promoting disability equality, or they pick up on specific FI findings as evidence that these health inequalities exist or they include in their Action Plan an overarching action to implement the FI's recommendations.

So, for example a PCT scheme which is clearly and well written, albeit not overall compliant, states in a laudable way that their rationale for promoting disability equality is to reduce health inequalities and eliminate barriers for service users and staff. It then goes on immediately to quote from a document on the DRC's 'Disability Debate' website (whose address is given) which picks up on the FI findings:

“Disabled people, who make up around a third of NHS users in Britain, die earlier, often from preventable illnesses, experience unequal access to health services, including cancer screening, immunisation and primary health care generally”(p5).

Whilst it is heartening to see this strong FI message given such prominence in a PCT scheme, it is disappointing that this is the only place the FI, its findings or (most importantly) its recommended actions are mentioned.

Other PCT schemes in the sample go a bit further when setting out the context and rationale for their schemes by referring to the general FI message and then going on to cite some specific findings.

For example, in its section about national context one PCT has a general sentence about the FI shortly followed by a statement that three key areas should be considered when providing and commissioning services which are: the range of physical health problems people with learning disabilities are more likely to be susceptible to; health inequalities caused by poorer access to health service; and that the DED introduces an environment that ensures this evidence must no longer be ignored. The scheme also goes on to highlight the finding that people with mental health problems are less likely than others to receive standard interventions for common diseases, e.g. statins for heart conditions (p14). This scheme also references the FI web link.

It is good to see the FI evidence being applied to this schemes' analysis of the national context but surprising that there is nothing in the action plan to ensure these issues are addressed locally.

Those PCT's sampled that do include references to the FI in their action plans do so in a basic way. One PCT, as part of its objective to ensure disabled people can access services, include an action to 'establish how best to implement recommendations of Equal Treatment: Closing the Gap (DRC formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health needs' (p11). And in a similar fashion another has a task in its action plan to improve outcomes for mental health service users and people with learning disabilities which is to 'develop an action plan based on recommendations in DRC's Equal Treatment: Mind the Gap (sic) report' (p14).

These action plan FI references, although basic, are more encouraging because they signify tangible commitments which according to the DED must be reviewed and monitored. Therefore it is hoped that these general undertakings to implement the FI recommendations act as a springboard for more detailed attention to what is required in the future.

Conclusion

DRCs assessment of the Disability Equality Schemes of 20 sample PCTs reveals a disappointing picture. Only two of the schemes was assessed as being compliant and none had taken up the recommendations of the DRC's Equal Treatment formal investigation in a systematic way. The crucial DED requirement of involving disabled people in developing PCT schemes was only properly fulfilled in 3 schemes. Evidence gathering and impact assessment were consistently weak across most of the schemes.

The DRC has written to these PCTs setting out in detail their assessments and recommending what each PCT needs to do to rectify their schemes. The Commission for Equality and Human Rights will assume responsibility for ongoing monitoring of these and other Disability Equality Schemes.

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