

The Strategic Health Authorities and the Disability Equality Duty

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How have the Strategic Health Authorities responded to the new Disability Equality Duty?

The Disability Equality Duty came into force in December 2006. It requires all public authorities to give due regard to the need to promote disability equality.

It is intended to be transformative; to change the practices of government and public authorities and make equality for disabled people central to policy making and implementation.

The Duty is rooted in the principle of community empowerment. The transformation of public services is to be achieved by engaging disabled people as partners. Disabled people have historically been treated as the passive recipients of charity, and excluded from public life. The Duty sets out to change this.

A key purpose of the Disability Equality Duty is to provide transparency between public authorities and disabled people – so that authorities can inform disabled people about their actions to promote disability equality and that disabled people are thereby able to hold the authority to account in delivery.

This Report is an early assessment of the performance of Strategic Health Authorities (SHAs) on the Disability Equality Duty. All SHAs must produce and put into effect Disability Equality Schemes. These Schemes set out how each Authority measures its performance on disability equality, and how it plans to improve its delivery for disabled people.

The incidence of disability in the population is of key importance to the strategic health authorities who are responsible for the delivery of the NHS objectives in the local region. The reduction of health inequalities is a major national policy of the NHS with PSA targets being set by government. Disabled people are among the most disadvantaged socio economic groups and may, because of their impairment, be most in need of services. However there is evidence that they are inadequately served by the NHS as service users and as members of staff. The Formal Investigation into the Health

Inequalities of People with Learning disabilities and users of mental health services ("Closing the Gap") demonstrated the unequal access of these groups to health services, unequal outcomes and discriminatory practices. The problems of diagnostic overshadowing were highlighted. While the health inequalities of disabled people vary across regions and require responses at a local level there are likely to be common themes across England. There is also evidence of the low level of recruitment of disabled people to work in the NHS.

This Report assesses the Disability Equality Schemes and performance of 8 of the 10 Strategic Health Authorities: North East; East of England; North West; West Midlands; East Midlands; South Central; South East Coast and South West. The London and Yorkshire and Humber SHAs have not yet produced their Schemes.

It is of course too early to assess the implementations of these Schemes, which have only been in force for some months. However, strong Schemes provide the indispensable foundation for strong implementation and outcomes.

Overview

Most Strategic Health Authorities were slow to respond to their duty to produce a disability equality scheme and only 2 authorities, North East and East of England, met the legal deadline for final Schemes of 4 December 2006. Three of the SHAs failed to produce a scheme and another 5 only had a draft scheme by the beginning of May 2007. The problems of regional restructuring have undoubtedly contributed to the slow start. However since May 2007, and in response to letters from the DRC, most have made real efforts to complete their Schemes. Dates for final Schemes have been set or final Schemes have been produced.

This state of affairs nevertheless gives cause for concern. It is an indication of how rushed the effort to comply with their obligations has been for some SHAs. This in turn reflects on the quality of the Schemes since it has not been possible to involve disabled people fully or conduct a full examination of the evidence. We would expect to see this rectified over the life of the Schemes. The haste has also meant that some Schemes omit some key information and may not give a true picture of the work that has been done or is proposed on disability. This, together with the fact that final Schemes are yet to be produced, makes some of our conclusions quite provisional.

Strengths and weaknesses

The picture of the Schemes is a mixed one. They vary considerably in the extent to which they comply with the legal requirements. At their best (for instance the North East SHA) they have grasped the essential nature of the duty, committed themselves to fulfilling it and made a considerable effort to engage disabled people in the production of their scheme.

Both NHS North East and South Central Coast produced Schemes that are commendable for their comprehensiveness and for the degree of involvement by disabled people. The Schemes produced by NHS North West, South West and South East Coast all have some strong features that can be built upon over the remainder of the 3 years, but West Midlands and East of England SHAs have a considerable way to go to show that they will deliver improvements

for disabled people or comply with the duties. West Midlands has produced a single equality scheme that covers a range of activities but makes no reference in its Action Plan to specific actions for disabled people. London SHA which has the largest number of trusts to manage but has yet to produce a scheme, has agreed to produce their DES by December 2007. **Yorkshire and Humber have**, but did not publish a draft scheme and will produce a final scheme on October 2 having had some months of involvement with disabled people on their initial “ Remedial Plan”. We have not assessed this Plan.

With the exceptions of North East and South Central the SHAs have not collected evidence of the health status or needs of disabled people in their region to inform the plan. The impact assessment process, a key tool for producing outcomes, is hard to assess because the Schemes contain only sketchy details of the process and aspirational statements that may have no practical outcome.

In summary, our assessments of the Schemes revealed a number of common weaknesses across all but two SHAs:

- failure adequately to involve external stakeholders;
- failure to clearly and transparently indicate how involvement had influenced the Scheme;
- failure to develop actions across the full range of the SHA functions;
- failure to show how they would use the information that they gathered;
- failure to include a methodology for conducting impact assessments of new and existing policies and practices.

The role of SHAs

The functions of SHAs, as stated on the Department of Health website, are:

- the strategic leadership of the NHS in the region, including developing strategic partnerships and supporting the implementation of national programmes;
- the development of NHS organisations and staff in the NHS. Supporting PCTs to become fit-for-purpose in discharging their functions and promoting best practice and supporting NHS Trusts to become NHS Foundation Trusts;
- ensuring the local NHS operates effectively and delivers improved health and healthcare performance. This includes:
 - driving improvement in quality, responsiveness, efficiency and equity by assessing and performance managing PCTs and NHS Trusts, holding them to account for the effective delivery of their respective functions, intervening, if necessary, to deal with failure.
 - assuring delivery primary through effective PCT commissioning and contracting arrangements.

This overarching role is most relevant to the implementation of the Disability Equality Duty. It is the SHA who should be in a position to gather evidence of the health care profile and needs of the disabled population within their region. They should also be in a position to survey the experiences of disabled people in their access to healthcare at both primary and secondary levels. They could also survey the experience of staff and potential staff of the NHS trusts in their region. While the SHAs do not commission services they are in a position to monitor standards for commissioning and the effectiveness of trusts' initiatives. As part of their performance management, SHAs should ensure that PCTs address specific disability issues (including those identified in the DRC's Health Investigation) in their review of local needs and their health equity audits.

The Schemes from North East, South Central and North West are broad in their coverage and include procurement, partnership working and their strategic role in the region but the others are much narrower. East of England SHA and South East Coast for instance concentrate on the function of the SHA as an employer of disabled staff. Most Schemes lack any attention to the crucial role of the SHA in helping to raise standards of healthcare and improve access for disabled people throughout the NHS in its region.

DRC assessment of compliance with elements of the duty

Involvement

The duty to involve disabled people in the preparation of a Disability Equality Scheme is the foundation of a Scheme. Involvement goes further than consultation. The DRC's Code of Practice on the Disability Equality Duty 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 North East Scheme meets these requirements effectively, demonstrating what can be achieved with the assistance of disabled people. They commissioned a regional engagement project jointly with participating NHS organisations from the region. Over a period of six months a local user led organisation of disabled people carried out the first independent, peer review of legislation, policy and strategy that drives disability equality involvement in the NHS in the NE. It then carried out a questionnaire survey to the public and disabled staff in the NHS and held open and safe space discussion forum meetings with disabled people and NHS employees. Priorities and recommendations from this were included in the DES and reflected directly in the Action Plan. This level of resource commitment to ensure really meaningful involvement is very impressive.

South Central SHA has also involved disabled people directly in the scheme and commissioned a user led organisation to develop priorities. However there is less evidence of the results of their engagement in the Action Plan.

The other SHAs do not come close to this level of engagement. The case of South West SHA is typical of the other Schemes. The draft scheme was produced without the input of disabled people but the Action Plan includes steps to set up a disability reference group and

to consult disabled groups. Their input will shape the priorities for the updated plan. North West SHA similarly has consulted disabled people in preparing the final scheme and records the results but does not directly reflect them in the Action Plan. East Midlands SHA approached a local network of disabled people's organisations to help devise an engagement strategy. This may be an effective approach and yield good results once done but it is impossible to assess at this stage.

South East Coast indicates their intention to involve disabled people. Least satisfactory were the Schemes of East of England and West Midlands whose Schemes demonstrate no involvement of disabled people and lack an understanding of the nature and purpose of involvement.

This lack of meaningful engagement with disabled people is evident in the Schemes which by and large do not show that their priorities are being acted upon through actions in the Action Plan. Overall most Schemes so far fail to measure up to the requirement to show that disabled people's involvement has been influential and transparent. It also results in actions in the Plan that are general and aspirational, with few measurable outcomes

Gathering evidence and using information

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 Department of Health and Department for Work and Pensions statistics (including Disability Living Allowance recipients) can be used to provide regional demographic profiles of different impairment categories. The East Midlands Scheme acknowledges "As a new organisation there is clearly much that we don't know about the experience of disabled people within the NHS regionally. Additionally as we have yet to complete the recruitment and selection process for our new posts we do not have a baseline for the disability profile of our employees". Steps to redress this are briefly mentioned in the Action Plan.

Surveys of the experience of disabled people as users of services and as employees of trusts is mentioned in three of the Schemes.

NHS North East leads the way in having collected enough qualitative and quantitative information to provide a basis for the Action Plan. They did a mapping of the regional and local needs of the population to show disabled people's locality and health status. Surveys of the NHS staff and of service users provide a detailed guide for prioritising actions.

South Central NHS also has a systematic approach. They recognise the need for disaggregating existing mechanisms for collecting information to include the views and satisfaction levels of disabled people. This will include Trusts' indicators for meeting Healthcare Commission standards. PCT progress in disability equality will be tracked by monitoring trends in morbidity, survival rates, diagnosis, condition management and patient experience. In addition, they state that disabled people will undertake independent reviews and evaluations of their services, functions, policies, decisions and employment. However the Plan does not specify the steps to ensure that these objectives are met or that the information is then put to use.

South West SHA sets out its three-stage plan to collect data on promoting disability equality in relation to the "defined priority and human resource work areas". The first phase is to map existing information, work out gaps and how they may be filled. The second phase is to collect information, including a survey of disabled staff. The third phase is to consider how to use the data in conjunction with the equality impact assessments. These phases are incorporated into the Action Plan.

Regrettably there is little awareness among the SHAs of the DRC formal investigation into the Health Inequalities of People with Learning Disabilities and Users of Mental Health Services ("Equal Treatment : Closing the Gap"). Only one scheme, South Central, addresses its findings directly and, with the exception of North East, East Midlands and South West, the other Schemes fail to mention the Report. The opportunity to use the report as part of the evidence base to develop the DES has thus been overlooked. It is disappointing that this important report which is so relevant to the work of the SHAs has not been more widely acknowledged and its

recommendations addressed.

Employment

Some Schemes recognise a need to promote equality in employment but are silent on the percentages of disabled people in their employment. It does not appear from that statistics relevant to disability are already being collected although (as stated above) measures to collect SHA staff statistics on all relevant issues during the course of the next 3 years are covered in most Schemes.

Information needs to be collected on recruitment, development and retention of disabled staff. The compliance with this requirement is variable. Most Schemes demonstrate that data is being collected on at least some of these issues. South East Coast, North East, East of England and West Midlands all collect evidence on disability but it is not clear that this occurs in North West SHA. South Central states that their data collection includes data about disabled candidates, access needs of employees, uptake of work-based placements and training, appraisal outcomes, promotion, benefits, access requirements, retention, harassment complaints, grievance and disciplinary matters, exit interviews and redundancies. Existing good practice in flexible working for disabled employees will be mapped and promoted. All of these will be monitored and evaluated.

The section concerning evidence should also consider where there are gaps in knowledge (i.e. where disability has not been built into the evidence data set) which need to be filled. This needs to be addressed when the Scheme is revised to include evidence in all relevant matters. There is no Scheme that addresses this requirement in a systematic way.

Using evidence

Schemes must also set out how authorities are going to use the information which they gather to help them measure their performance on disability equality.

The purpose of evidence gathering is to inform the development of the Scheme, and in particular to identify the actions for the Action Plan. In some Schemes there were encouraging statements about

using monitoring information to identify and address problems. However, the widespread failure to apply this approach to drawing up the Action Plan causes us to doubt how this will operate in practice. Secondly, evidence gathering allows progress to be measured. In many instances this will be assisted by the adoption of targets. However no scheme mentioned targets in relation to employment. Thirdly, a strong evidence base of quantitative and qualitative information provides the essential underpinning for effective equality impact assessment. The absence of systematic reviews of the evidence of disabled people's experiences will impede Authority's ability to conduct meaningful disability equality impact assessments.

Action Plans

Most action plans are very patchy in their attention to the functions of the SHA and to all elements of the duty. In general they cover employment and access requirements. They make some reference to procurement and contract providing but in very general terms.

Exceptionally, the East of England scheme has some specific action points on procurement. They list actions which the authority needs to do to start the development of an effective and compliant scheme, but restrict other activities affecting services to the removal of barriers to access. These actions have been required under the Disability Discrimination Act prior to the introduction of the Disability Equality Duty.

They should be using the Action Plan to promote equality for disabled people as service users and as staff. Most particularly the duty to promote positive attitudes to disabled people is largely ignored. The only actions which should go some way to addressing this element of the duty are those requiring training of staff but unless this training is delivered or evaluated by disabled people this may not contribute to this goal. Action points - for instance to review and revise their website and their written materials to provide positive images of disabled people - would have been welcome.

There is a real opportunity to use the law to drive forward change which is being missed.

However most Action Plans are still incomplete, covering detailed

actions only for 2007 (or in the case of East Midlands only 3 months) and their revision will give the chance for a more ambitious and forward looking agenda. There are also some examples of good practice that can be built upon and learned from.

The Action Plans of North East and, to a degree, South Central, again stand out as exceptions.

North East SHA has written three action plans - the first is specific to each of the directorates and incorporates the functions and policies that have been assessed for relevance to the promotion of disability equality. The second focuses on how the SHA will meet the specific duties and those actions underpin the directorate specific action plans. The third is dedicated to employment and training activities. All strands of the general duty are addressed,

The actions are excellent in the range of functions they cover. In relation to the National Service Frameworks for chronic heart disease, diabetes, mental health, long term conditions, renal, children and young people, maternity services and older people, the SHA will liaise with NE NHS organisations/network leads/ implementation leads to ensure that disabled peoples' needs are addressed in implementation plans and that patients and staff with the particular condition inform the planning and monitoring process.

South Central SHA's Draft Action Plan is also comprehensive in the range of actions and SHA functions it covers. Actions cover a wide range of issues: providing accessible information and accessible services; monitoring to cover equal access to services; projects; policies; commissioning; public and patient involvement; those in residential care; delivery of maternity services and sexual health; preventative screening and health care for people with learning difficulties and mental health service users and the implementation of the DRC's Formal Investigation recommendations. However the action points are stated as general objectives and lack detailed timeframes, full accountability, milestones and measurable outcomes. This was also a defect of other Action Plans, making it doubtful whether the objectives will be fulfilled.

Employment

All but the East Midlands Action Plan cover the employment of disabled people but vary in the robustness of their action points. The East of England scheme for instance includes some useful and specific actions to redress inequality in employment. They include actions to promote employment of disabled people – consulting with disabled peoples’ groups on barriers to employment, changing recruitment practices, ensuring accessible buildings, office spaces and communication methods. That said, these are matters which should by now have been thoroughly addressed under the Disability Discrimination Act 1995. South Central also addresses the issues of employment comprehensively but fails to set time frames and accountability mechanisms. The DRC’s Code of Practice refers to setting targets for the employment of disabled people but no Action Plan has adopted this approach.

Impact assessment

Regulation 2(3) (b) provides that the scheme 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 DRC’s 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, is likely to have a major impact on disabled people. The methodology needs to include monitoring and evaluation, a clear link to management and organisational decision-making and the prioritisation and timetable of existing policies and practices to impact assess.

Schemes are required to set out the authority’s arrangements for assessing the impact of proposed or current policies and practices on disability equality and they should include a timetable for assessing the impact of their principal activities.

When reviewing the Schemes we also looked to see whether those elements which we consider the indispensable building block for good equality impact assessments were in place. This includes whether assessments are clearly embedded in decision-making processes and whether staff have the necessary skill (and hence are being given training, guidance and evidence to draw on).

In all cases the impact assessment is the weakest part of Schemes, none completing all the requirements. The South West Scheme is one of the better examples where the screening of human resource policies has already occurred. The text acknowledges that both existing and future policies need to be assessed, that missed opportunity as well as adverse impact must be taken into account, the Action Plan provides for training for the assessment and the development of an evidence base. The methodology however is still to be finalised and a timetable set in place. Given that the Authority intends to undertake equality impact assessments, the distinct elements relating to disability, including issues specific to different impairment groups, need to be specified

North East SHA also demonstrates a clear understanding of the assessment for disability equality but the others fail to do so. The Schemes for East of England, South Central and East Midlands content themselves with general statements and action points about their intentions to fulfil the duty. West Midlands, North West and South East Coast provide more detail but lack a detailed methodology and refer to assessing for adverse impact rather than also covering missed opportunities. They refer to the assessment of future policies and fail to provide a timetable for the assessment of the backlog of existing policies.

Leadership

Most Schemes express the commitment of the Chief Executive to the goals of the disability equality duty and have devised a structure of accountability that devolves from Board level to individual directors and is backed up by training for the relevant staff.

While all Schemes recognise the need for annual reporting only a minority have a robust reporting framework to measure progress on the Action Plan on a regular basis. The Action Plans in several Schemes are limited to the first of the three years covered by the DES. This will give the opportunity for them to be revised and updated as the expertise on the duties grows. In any event the extension of the Action Plan is most likely to be necessary to ensure their compliance with the general equality duty.

Next steps

1. We have been monitoring and supporting the revision and development of Departmental Schemes. We will pass information to the Commission for Equality and Human Rights to enable it to follow through on this when it takes over our functions in October 2007.
2. We want to encourage Parliamentarians, and those concerned with equality for disabled people, to refer to these SHA Schemes and our assessments of them which provide important information about Government plans in relation to disabled people.
3. The Discrimination Law Review will consider the future shape of public sector duties. We will feed these early positive indications of the positive impact of these duties, in particular the powerful impact of the involvement requirement, into that review.

Appendix: Background – What is a Disability Equality Scheme?

SHAs (like most public authorities) must produce a Disability Equality Scheme. In essence these Schemes are delivery plans, which must include an Action Plan setting out the steps they will take 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.

They must also set out how the authority will assess the impact of existing or proposed policies and practices on disability equality. Whilst the latter requirement is designed to 'mainstream' disability equality into the work of public authorities, the first requirement is designed to produce some immediate and tangible outcomes.

The Scheme must be evidenced-based, showing what evidence the authority is collecting regarding its performance on disability equality in relation to employment, education (where relevant) and other services and functions. (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 people.)

There is no point in collecting information if it is not used, and

therefore Schemes must also set out how authorities are going to use the information which they gather to help them measure their performance on disability equality. (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 novel, and very important, element of the Disability Equality Duty is its requirement that disabled people should be involved in the development of Schemes. (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.)

These requirements build on lessons from the race duty, being more outcome focused and leaving considerable scope for flexibility with a framework on common standards. They resonate with important themes of public sector renewal – such as community involvement, responsive services, evidenced based policies, and the importance of transparency and accountability.

The objective is that the development and delivery of Schemes will provide a framework for shared ownership and a shared vision of what Departments are trying to achieve.