



Appointments
Commission



Equality and Human Rights in the NHS

A Guide for NHS Boards

Equality and Human Rights in the NHS

A Guide for NHS Boards

DH INFORMATION READER BOX

Policy	Estates
HR/Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working
Document purpose	For Information
Gateway reference	7499
Title	Equality and Human Rights in the NHS – A Guide for NHS Boards
Author	Equality and Human Rights Group, Department of Health
Publication date	11 Dec 2006
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs
Circulation list	
Description	This Guide is designed to help NHS Board members understand and comply with their obligations under equality and human rights legislation. Every NHS organisation, as a public body, needs to assure itself of legal compliance.
Cross reference	Promoting Equality and Human rights in the NHS, A Guide for Non-Executive Directors of NHS Boards
Superseded documents	N/A
Action required	Check compliance with existing equality and human rights legislation
Timing	N/A
Contact details	Steve Gulati Equality and Human Rights Group Department of Health 80 London Road, Skipton House London SE1 6LH (020) 7972 5123
For recipient's use	

Contents

1	Foreword by the NHS Chief Executive	3
2	Executive Summary	4
3	Purpose of This Guide	5
4	How Organisations Can Meet Their Duties	12
5	Board Accountabilities	16
6	Twenty Questions for your Board	19
7	Useful Links & Sources	21
Annex A	Summary of Equality & Human Rights Legislation	23
Annex B	Statistical Information – Health Inequalities	27

Message from the Chair of the NHS Appointments Commission

No longer 'someone else's business'.

There can be nothing more critical to good governance in the NHS than to ensure that your organisation offers a service 'open to all at the point of access'.

The quality, commitment and motivation of the whole Board and staff is expressed through the delivery of services which meet everyone's needs.

So often we hear equality and diversity is 'someone else's business'. Yet if we wish to ensure the provision of services meets high standards of care, it is the responsibility of each of us to play our part and ensure that we are driving change.

As a Board member, you have a unique opportunity to put this into practice. Equality and human rights are not mere 'add ons' or extras to be thought about when you have the time. Fundamental to the work that you do is the need to embrace all groups and individuals regardless of their gender, race, disability, sexual orientation, age, religion or belief.

As the new Chair of the Appointments Commission. I am delighted to have the opportunity to endorse this guide, which will help all involved in governance with our duties.

Your response will show that together we mean business.

Anne Watts CBE

Chair, Appointments Commission

1 Foreword

As a member of an NHS Board, you are in a powerful position to make a lasting difference to the health and wellbeing of the local population that you serve.

We know that health inequalities persist in our society, despite ongoing progress in life expectancy and health outcomes overall. This is not acceptable in 21st century Britain, and is a real and pressing concern for local NHS organisations.

NHS bodies are also very often major local employers, and can use this position to act as good corporate citizens, working for the welfare and cohesion of their workforces and economic regeneration of the communities in which they are based. Again, in spite of progress in employment standards (such as the achievement of standards such as Improving Working Lives Practice Plus), certain groups remain under-represented in NHS workforces and also experience difficulty in gaining promotion and development.

This Guide has been produced to assist members of NHS Boards in clarifying the legislative framework around equality and human rights; reiterating the business case; and aiming to help local Boards in assessing and challenging their own performance relating to equality and human rights.

Equality and human rights is core business for the NHS – and that is why this Guide is accompanying the 2007/08 NHS Operating Framework for Health and Wellbeing. I hope that as a Board member, you will use this Guide to help shape your local approach to equality and human rights, and help to ensure that the NHS organisation that you lead complies with the law.

David Nicholson CBE
NHS Chief Executive

2 Executive Summary

- Equality and human rights legislation places specific obligations upon public bodies, including the NHS.
- Chairs, Chief Executives, Board Directors and Non-Executive Directors all have a responsibility for ensuring that the NHS organisation that they lead is compliant with equality and human rights legislation.
- Equality and human rights is as applicable to service issues as it is to employment, and as such is the responsibility of all parts of the organisation and of all Board members.
- There is a compelling synergy between legal compliance, aspiring to exemplar status, and the business imperative in relation to equality and human rights in NHS organisations.
- Both the core and developmental standards in the Standards for Better Health framework provide NHS organisations with an opportunity to measure their own performance in relation to equality and human rights, identifying areas of both good practice and potential shortcomings.
- Undertaking Equality Impact Assessments (EQIAs) is a specific legal obligation, and conducting EQIAs and using the evidence to create a meaningful dialogue with communities (especially seldom heard from groups) is central to effective commissioning and service provision. This will create an evidence-based approach.
- Governance frameworks for the Board level management of equality and human rights already exist through, for example, Integrated Governance guidelines and Standards for Better Health declarations. The challenge for Boards is to develop local mechanisms that ensure equality and human rights is included in these frameworks.

3 Purpose of this Guide

As a Board member for an NHS organisation, you hold a position of power and influence – and responsibility. As a leader of a public body, you have certain legal obligations relating to equality and human rights. Equality and human rights legislation places specific duties on those who run public bodies, and it is important that you understand both your individual and collective responsibilities.

The purpose of this Guide is to assist Board members of NHS organisations to:

- Understand the statutory Board responsibilities as they relate to matters of equality and human rights;
- Understand your obligations under the law;
- Make the connections and inter-dependencies between equality and human rights and the core business and governance for your NHS organisation; and
- Consider how these obligations may have a different expression, depending upon the type of NHS organisation of which you are a Board member, and depending upon whether you are an Executive or Non-Executive Board member.

Board Responsibilities

This Guide sets out your responsibilities for equality and human rights as a member of an NHS Trust Board. Just as sound financial management and good people management practice is applicable regardless of the type of NHS Trust that you lead (Primary Care Trust, hospital Trust, Ambulance Service or Foundation Trust), so equality and human rights runs through your duties as a Board member. NHS organisations across the country are required to find the synergies between implementing national targets and priorities (as set out in national targets and in the annual Operating Frameworks) and meeting the health and social care needs and aspirations of the local populations that they serve. Board members – Chairs, Accountable Officers, Directors, and Non-Executive Directors – are ultimately accountable for the performance of their organisations. As described in the Integrated Governance Handbook (Department of Health, February 2006).

“The Board of every NHS organisation carries the final overall corporate accountability for its strategies, its policies and its actions as set out in the Codes of Conduct and Accountability issued by the Secretary of State. These Directions clearly specify the duties of the Boards”.

(Source: Integrated Governance Handbook – A Handbook for Executives & Non-Executives in Healthcare Organisations).

Matters of equality and human rights are central to the proper discharge of governance responsibilities for the NHS, founded as it is on the principles of equity of access and treatment according to need, rather than ability to pay. Executive Directors and Non-Executive Directors are expected to bring different qualities to the Boards of NHS organisations; Non Executive Directors might find it helpful to refer to *Governing the NHS, A Guide for NHS Boards (NHS Appointments Commission, June 2003)*, and also *Promoting Equality & Human Rights in the NHS, A Guide for Non-Executive Directors of NHS Boards (Department of Health, NHS Appointments Commission & NHS Confederation, July 2005)*. Concepts of equality and human rights being the exclusive domain of ‘special interests’ in parts of the organisation, or having accountability vested exclusively in certain individuals, is no longer (if it ever was) valid – even where specialist posts exist. Board members in NHS organisations need to be clear about their responsibilities, accountabilities and contribution to equality and human rights, both individually and corporately. This Guide aims to assist NHS Boards to make arrangements most appropriate for local circumstances in meeting their obligations.

Equality and human rights is core business for which Board members are accountable, and that you actively need to manage. The principles by which NHS Boards should conduct their business in described in the Integrated Governance Handbook, which describes ‘inputs’ as:

- National targets
- Compliance with Standards for Better Health
- National Service Frameworks; and
- The NHS Plan and its implementation

(Source: Integrated Governance Handbook – A Handbook for Executives & Non-Executives in Healthcare Organisations).

Equality and human rights runs through all of these inputs, and as a Board member, you need to consider how the legal obligations described next are incorporated into the governance arrangements of your organisation.

Obligations Under the Law

Equality and human rights legislation places some very specific obligations upon public employers, and by extension, upon those who lead them. The principal aim of legislation is to create a ‘minimum threshold standard’, beneath which no public organisation is expected to fall. However, the public sector generally, and NHS organisations in particular, can act as exemplars of best practice in equality and human rights. As a Board member, you can help lead the drive for more robust systems and processes, and aspire to outcomes (for patients and employees) that go well beyond a ‘minimum threshold’.

It is vital that Board members are absolutely clear about their obligations under the law. A summary of equality and anti-discrimination legislation is attached as Annex A, and Board members should ensure that they understand these legal duties and are aware of further developing legislation. Current equality and human rights legislation comprises:

- Employment Equality (Age) Regulations 2006
- Disability Discrimination Act 2005
- The Civil Partnership Act 2004
- The Gender Recognition Act 2004
- Employment Equality (Sexual Orientation) Regulations 2003
- Employment Equality (Religion or Belief) Regulations 2003
- The Human Rights Act 1998
- The Race Relations Act 1976 (as amended by the Race Relations (Amendment) Act 2000)
- The Sex Discrimination Act (as amended) 1975
- The Equal Pay Act (as amended) 1970

Clearly, the span of this legislation covers a very wide variety of areas where discrimination or lack of equal treatment can occur. It is your duty to systematically identify and then eliminate any discriminatory practice (be that in employment or service provision), and positively promote equality of opportunity. As leaders of the organisation, the principle of **vicarious liability** applies to Board members; the employer will be liable for acts and omissions of the employee during the course of their employment. It is therefore vital that you satisfy yourself that adequate **education and training** relating to equality and human rights is delivered in your organisation. Ensuring that the appropriate level of equality competences are incorporated within the **Knowledge and Skills Framework** at the appropriate level for different grades of staff can make considerable progress towards driving the required shift in understanding, attitudes and practices.

As Board members, you are directly accountable for all actions and omissions in relation to equality and human rights legislation, and this accountability cannot be delegated. As equality and human rights legislation has now been in place for a number of years, the legal enforcement authorities (such as the Commission for Racial Equality, Disability Rights Commission, Equal Opportunities Commission and the forthcoming Commission for Equality & Human Rights, for example) have increasingly high expectations of all public bodies. As a service rooted in the principles of equality and service to all, the NHS is likely to be at the forefront of their considerations. If you suspect or identify any shortcomings in relation to legal compliance in your organisation, it will be to the benefit of your patients and your own Trust Board for this to be highlighted, and for individual Directors or Non-Executive Directors to demonstrate leadership in investigating and tackling these issues. It is particularly important that members of PCT Boards recognise that these duties extend to all of the services that the organisation provides through its employed staff and through its independent contractor community (Dentists, pharmacists and optometrists as well as GPs and GP practices) as well as to all of the services that it commissions from other providers – whether these are NHS, third sector or private sector organisations.

Section five deals with Board accountabilities further.

The Business Imperative

Given the compelling moral arguments in favour of equality and human rights in the NHS, Board members – as key leaders entrusted with improving the health of your local populations – you will undoubtedly be aware of importance of this work. However, it is helpful to consider precisely how Boards can link the various workstreams for which they are responsible and discuss these at Board meetings, and by so doing demonstrate to the public that their NHS organisation is meeting the needs of their population.

Services

In relation to services commissioned and provided, the case is clear. If individual patients from particular communities or groups are denied timely access to health and social care, or are otherwise treated unfairly or less favourably because of who they are or what they believe in, then the NHS has failed to respond to their health needs and circumstances in accordance with the founding and enduring principles of the service. Your organisation will have failed to deliver equity of access and of treatment, and will not be delivering the universal service for all people from all communities. This is undoubtedly so, as all NHS localities and catchment areas contain local populations which reflect the richness of diversity of modern Britain.

Examples of how equality and human rights forms part of core NHS business is reflected as follows:

National Standards, Local Action – Planning Framework 2005/06 – 2007/08. Reducing health inequalities is a key priority. It requires an evidence based approach, targeted action and a cycle of evaluation. Evidence can come from Equality Impact Assessments; and under the Race Relations Act (as amended) and the Disability Discrimination Act (as amended), evaluation of EQIA evidence requires the involvement and engagement of communities (especially for qualitative measures). Delivering good quality care will require organisations to demonstrate competence in identifying and taking action on inequality; and also needing to engage with communities that have not found accessing public services as easy as the majority population. The recently published NHS Operating Framework states that trusts should continue to use needs assessment systematically to identify and address the specific needs of different groups in the population.

The Commissioning Framework. Working with Public Health colleagues, NHS commissioners and commissioning organisations have a uniquely powerful position in addressing health inequalities. It is very often the case that the worst levels of health deprivation exist among communities or groups of people who have in some way found access to mainstream services difficult. Annex B provides some illustrative examples of this. The connections between commissioning activity and equality and human rights is implicit, as properly designed and executed commissioning both reduces health inequalities and can act to promote equality of access and health outcomes.

Integrated Governance. The issue of how Board members might want to deal with obligations relating to equality and human rights in respect of integrated governance is briefly discussed above. Specific governance arrangements are for local determination, but it is important that both the Chief Executive and Chairman of the Board can demonstrate (to the satisfaction of the enforcement agencies, if necessary) that equality and human rights is properly accounted for and is embedded into the strategic planning, operational delivery and any evaluation actions of the Board and of the organisation as a whole.

The Health Care Commission: Standards for Better Health. Standards for Better Health set out the high level and overarching expectations for the safety and quality of publicly funded NHS provision (the core standards) and their commitment to continuous service improvement (the developmental standards) – which sit alongside the NSFs. The Health Care Commission assess the NHS against a set of targets through the Annual Health Check. Board members will be familiar with core standard C7e, which stipulates, *“healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably”*. However, equality and human rights also runs through a number of other core standards – consider the following:

- Core standard C6: Healthcare organisations co-operate with each other and social care organisations to ensure that patients' individual needs are properly managed.
- Core standard C13: Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.
- Core standard C16: Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care.
- Core standard C17: The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services
- Core standard C18: Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.
- Core Standard C22: Health care organisations promote, protect and demonstrably improve the health of the community served and narrow health inequalities.

The above are not intended to be exhaustive, but provide a useful indication and possible set of 'prompts' for you as a Board member to identify how equality and human rights is implicit in the business of the NHS; and for your Board to consider the extent to which these standards have been achieved equitably in relation to all of the members of the communities served.

National Service Frameworks. Board members are reminded that National Service Frameworks set national quality requirements and identify key interventions for a defined service or care group and frequently refer to the need to tackle inequalities, combat discrimination and ensure accessibility of services for patients/services users.

- Impact assessment of services will ensure people at particularly high risk are identified and offered appropriate advice and treatment
- The Department of Health website contains much useful information about National Service Frameworks and related tools for benchmarking.

By their nature, these frameworks refer to services that run across organisational boundaries. Particularly in relation to disadvantaged or marginalised individuals or groups, co-ordination between different NHS (and other) organisations that deliver NHS care is important.

Employment

In relation to the NHS as an employer, the legislation places some very specific duties to collect, analyse and publish various employment indices. The business case for demonstrating and exceeding compliance quality requirements range from the most basic – that is, avoidance of the cost and negative publicity of Employment Tribunals (Stonewall, for example, estimate general Tribunal costs at £35000 and employee replacement costs up to £50000) – to more strategic matters, including:

Workforce Resourcing. General national demographics, and the NHS workforce demographic (on a national basis) demonstrate an ageing workforce. The NHS is a labour-intensive sector (employing people across the range of skills), and as such needs to compete in an increasingly sophisticated and competitive labour market. Employment practices that appeal to the whole range of age bands, and workforce strategies that have this type of intelligence as their basis, will have the potential to assist both individual Trusts and local health economies to maintain the supply of a full range of services.

Employer of Choice. Similarly, equality and human rights is at the core of Human Resources business in the NHS. The NHS is competing for talent in an employment market with other public employers, as well as the private and independent sector. Demonstrating best practice standards will enhance the prospect of NHS organisations being able to engage meaningfully with all sections of the community/potential workforce, and equality and human rights ‘quality standards’ such as Improving Working Lives Practice Plus, the Disability Two-Tick symbol, Age Positive status, and the Stonewall Diversity Champions provide a visible commitment to existing and potential employees.

4 How Organisations can meet their duties

NHS bodies have, over the years, developed some innovative methods to assist them in meeting the duties set out in equalities legislation. It is also fair to point out that these developments have not been universal or consistent throughout the NHS, and in section six you will find a series of key questions or ‘prompts’ to help you work towards an assessment of the position of your own organisation. The size, complexity and differing type of NHS organisations makes it impossible to recommend a ‘one size fits all’ or prescriptive approach to meeting the duties. What follows is therefore some practical approaches rather than a set of tick-box ‘requirements’ – as a Board member, you are best placed to assess the needs of your patients, population and employees, and also of what is most likely to have strategic fit in your own local health economy.

Using Evidence

Commissioning or decommissioning services, being responsible for the provision of services, and recruiting, developing and leading workforces can be a complicated and challenging task. For Board members, the task can be made all the more complex by the pace of the NHS, and the ever-evolving needs of our patients. It is therefore all too easy to respond to these issues using stereotypes, or by feeling that a proper grasp on the detail of the issues is impossible. However, as in the development and delivery of clinical treatments, the creation, analysis and intelligent use of evidence is possible, and can potentially make a significant contribution to meeting the duties relating to equality and human rights.

An explicit obligation under various elements of equality legislation is the need for public bodies to conduct **Equality Impact Assessments (EQIAs)**. There exist a number of ways to conduct EQIAs – the choice of the most appropriate methodology is for your organisation to determine. It is sometimes the case that NHS organisations conduct EQIAs, but focus a disproportionate amount of effort on the process of doing so, rather than using the outcomes to further meet their strategic aims and objectives. EQIAs can yield very valuable sets of evidence, from which, for example, commissioning decisions can be made that can have a real impact upon reducing health inequalities. The bedrock of an evidence base is monitoring data, and in July 2005 the Department of Health issued *A Practical Guide to Ethnic Monitoring in the NHS & Social Care*. Some NHS organisations are exploring how to use the additional functionality provided by Connecting for Health to use Information Management & Technology to support the collection and analysis of data. Thus conducting EQIAs – a legal obligation upon your Trust – also contributes to your mainstream business, and as such is a mainstream activity which in itself will be of interest to your Board.

Connecting With Your Community.

There is an underpinning duty placed on NHS organisations to ensure that the experiences of individual patients (as well as larger groups and communities) are positive (the duty of quality), and that the voice of patients has increasing influence in the design and delivery of health and social care services (the duty of patient and public involvement). Indeed, concepts of ‘choice and voice’ are key tenets of the wider healthcare reform agenda. The opportunities and challenges that this presents will have been considered by every health and social care community, and is very likely to have featured in discussions at Trust Board meetings. Engaging and involving your local community, and reaching out to parts of your community that have not traditionally been engaged by the NHS, is core business in effective commissioning. It is therefore in the business interests of NHS organisations to develop mechanisms to connect with all communities, and all parts of these communities – people of different (or no) faiths, people of different races, addressing men’s and women’s health issues equally, engaging appropriately with lesbian, gay, bisexual and transgender people, people of all ages, and disabled people. This can be a particular challenge in rural areas, where minority populations can be very small and widely dispersed, and creative approaches will be needed in these parts of the country. If your Trust ‘gets this right’ – and can demonstrate as much – it will inherently meet a key aspect of its legal duties, such as those to consult people of black and minority ethnic backgrounds in the production of your Trust’s Race Equality Scheme, for example, or the obligation to involve (not just consult) disabled people in the production of your Disability Equality Scheme. So, connecting with your community meets the core business requirements related to equality and human rights through the wider engagement (patient and public involvement) strategy.

Board members might also want to consider how best to use the opportunities in forming strategic partnerships to engage with communities in a more holistic manner. Local Strategic Partnerships (LSPs), Local Area Agreements (LAAs), PCT Local Delivery Plans (LDPs) and the delivery of the transformational ‘Our Health, Our Care, Our Say’ agenda provide both challenges and opportunities in engaging people, and presenting a more integrated public services forum in which to ensure that the health and social care needs of all sections of the community are met. It is important for Board members to guard against the development of policy or the making of decisions based on only partial engagement, or making decisions before engaging, consulting or involving local communities. As well as risking cynicism and disengagement in communities, this type of approach is likely to fail to meet the statutory duty of patient and public involvement as well as that of conducting meaningful EQIAs, and is also likely to incur the criticism of those bodies tasked with enforcing equality and human rights legislation.

The Cycle of Engagement For Service Delivery

NHS bodies need to be able to demonstrate compliance with the need to consult and involve their whole communities (including minority groups) in the design and development of, and changes to, services. It will obviously be preferable for this type of activity to be embedded in the business practises of your organisation, rather than for it to be considered later on in the process. Whilst there is no definitive method to achieve this aim – indeed, the element of a locally designed approach is invaluable – some of the principles could include the following:

- a) A patient and community focussed approach.
- b) Collecting and using relevant data to establish a local evidence base.
- c) Assessing the scope for differential impact of existing and proposed functions, policies and services.
- d) Designing locally specific interventions, possibly with partners (Local Authorities, Practice Based Commissioning hubs), to deal with (c).
- e) Performance management frameworks.

An Integrated Equality Strategy

Existing equalities legislation oblige public bodies to produce/have produced a **Race Equality Scheme** (under the Race Relations (Amendment) Act 2000), and a **Disability Equality Scheme** (under the Disability Discrimination Act 2005). From October 2006, age discrimination as it relates to employment has become unlawful; and in 2007, there will be an additional duty to produce a **Gender Equality Scheme**. Naturally, these obligations overlap, and NHS organisations may want to consider whether they want to develop a Single Equality Scheme to cover the following areas where discrimination is known to occur:

- Race
- Disability
- Gender
- Sexual Orientation
- Age
- Religion & Belief

If Boards adopt this approach, it is of course important that the particular requirements of each strand is dealt with sufficiently robustly to satisfy the requirements of law, but adopting an integrated approach may be suitable for some organisations and may assist in developing a holistic view of equality, diversity and human rights. The Department of Health itself is producing a SES, and details will be available on the Department of Health website in December 2006.

5 Board accountabilities

As mentioned in earlier sections, the Integrated Governance Handbook (*Department of Health, February 2006*), contains much useful information for NHS Boards. It is important that individual Board members and the Board collectively, however, consider how matters of equality and human rights are locally accounted for.

Chief Executive Officers – Accountable Officer Status

Chief Executive Officers (CEOs) are the most prominent of leaders in NHS organisations. Both their words and deeds are open to high levels of scrutiny (and sometimes challenge), and this puts the Chief Executive in a powerful position to lead, and through leading, enact change. Chief Executives also hold ‘accountable officer’ status, a formal designation that cannot be delegated, and puts them into a position of being held to account for the actions and omissions of the organisation.

In relation to equality and human rights, the CEO is personally accountable for:

- Ensuring that all of the policies, functions and services delivered by your organisation do not discriminate against sections of the community covered by equality legislation;
- You are personally accountable for ensuring that the services provided by your organisation are compliant with human rights legislation;
- Ensuring that a Race Equality Scheme and Disability Equality Scheme is produced and reviewed for your organisation (future legislation may also lay down a requirement for formal Schemes for other equality strands);
- Ensuring that sufficient resources are provided to realistically support the Action Plans that underpin these schemes;
- Accounting to the NHS & Social Care regulatory bodies, or the equalities and human rights enforcement agencies, for the equalities and human rights strategies adopted, and the extent to which Action Plans have been designed, enacted and progress assessed.

As CEO, it is important that you feel confident in understanding the specific duties placed upon public bodies in order that you can satisfy yourself that your organisation is operating within the law.

Directors

Board Directors can be either voting or non-voting members. In practical terms, this distinction can sometimes have little importance. It is the contribution of specialist skill and knowledge, allied to corporate and collective responsibility that will determine the effectiveness of Board Directors.

Most NHS organisations do not have a Board Director portfolio which carries a title relating to equality and human rights (although a small minority do). Thus the responsibility for this work rests with a Director who has another professional specialism. Perhaps because of the historical association of ‘equal opportunities’ being an issue relating to employment, equality and human rights has often fallen into the portfolio of the Director of Human Resources, although more latterly portfolios of Public Health, Operations/Clinical Services/Quality, or (in PCTs) Commissioning have taken the brief.

In practice, the positioning of the work is a matter of local ‘fit’, and certainly of less relevance than the extent to which Boards understand that equality and human rights is an overarching subject, and feel comfortable and confident in rigorously debating and scrutinising the work. With respect to this Guide, as a Director, it is important that you understand what the equality and human rights implications are for your specific portfolio, and also contribute to the corporate leadership of this work. Your personal obligations under the law are likely to include the following:

- Being the accountable officer for elements of Action Plans under the statutorily required Equality Schemes;
- You are personally accountable for ensuring that Equality Impact Assessments are undertaken for the areas of the organisation for which you are accountable;
- You are personally (and/or vicariously) accountable for ensuring that all of the policies, functions and services delivered by your area of the organisation do not discriminate against sections of the community covered by equality legislation;
- You are personally accountable for ensuring that the services provided by your part of the organisation are compliant with human rights legislation.

Non-Executive Directors

In leading the Board, the Chair has a specific responsibility to ensure that issues of equality and human rights are appropriately reflected in all aspects of the Boards strategic planning, performance scrutiny and its own agenda and activities. She/he needs to ensure that all members of the Board and all Directors understand their corporate responsibilities in relation to issues of equality and human rights.

Non-Executive Directors (NEDs) have a vital role to play on NHS Boards. According to *Governing the NHS, A Guide for NHS Boards (NHS Appointments Commission, June 2003)*, “legally there is no distinction between the Board duties of executive and non-executive directors, they both share responsibility for the direction and control of the organisation”. NEDs do, however, have the potential to act as ‘critical friends’ of the NHS organisation to which they belong, and this can be a very useful contribution to matters relating to equality and human rights. As pointed out by the NHS Appointments Commission,

Accountability: Non-executive directors are appointed by the NHS Appointments Commission on behalf of the local community. They therefore have a responsibility to ensure the Board acts in the best interests of the public, and is fully accountable to the public for the services provided by the organisation and the public funds it uses.

(Source: Governing the NHS, A Guide for NHS Boards, NHS Appointments Commission, June 2003).

Executive Directors, whilst having a collective corporate responsibility, are appointed with a specific portfolio (eg Human Resources, Finance etc). NEDs, on the other hand, are able to range freely across the spectrum of strategic matters, scrutinising the strategy and performance of the organisation. The Board of an NHS organisation is, as a whole, responsible for reflecting the communities that they serve, and Non-Executive Directors have a key role in applying proper scrutiny to equality and human rights in NHS organisations.

6 Twenty questions for your Board

These questions are not designed as performance management tools, or intended as a definitive list by which to assess your organisation's progress in equality and human rights. However, as a Board member, you might find them useful in helping to promote positive change. As a starting point for further discussions, ask yourself:

- Are we compliant with the law?
- Am I confident that I am discharging my responsibility as a Board member?

1. Has your organisation made an explicit connection between helping all communities and groups and contributing to national NHS targets?
2. Do you understand how your role as a Board member (Chair, CEO, Director or Non-Executive Director) is accountable for equality and human rights in your organisation?
3. Does your organisation routinely make use of Equality Impact Assessment data at every level when making strategic decisions?
4. Does your organisation consider equality and human rights as integral to the Standards for Better Health compliance in the widest sense (i.e. beyond C7e)?
5. How does your organisation monitor compliance with the Human Rights Act 1998?
6. Do you personally, and your Board collectively, know how your Trust's Equality Schemes integrate into organisational and local (eg Directorate, Division, Departmental) objectives, and is there a system for regular, formal review?
7. Does your organisation procure or commission services openly and appropriately, taking into account the needs that services will address and the desired outcomes?
8. Does your organisation understand and act upon the recommendations of 'Delivering Race Equality in Mental Health Care' (as part of the Black and Minority Ethnic Mental Health programme), consulting with and involving BME communities to ensure that services are accessible, appropriate and effective?
9. Is equality and human rights explicitly addressed as part of your organisation's action planning around the National Service Frameworks (NSFs)?

10. Do you understand the benefits of seeking and achieving some of the ‘best practice’ awards around equality and human rights (eg Two-Tick symbol, Stonewall Diversity Champions).
11. Does your organisation have (or know how to access) the necessary expertise to support it in meeting the required duties as they currently stand, and to prepare it for future legislation?
12. What governance arrangements are in place within your assurance framework to ensure appropriate risk-management of compliance/non-compliance with the duties of equality and human rights?
13. Does your organisation have mechanisms to assess whether local people from all groups (not just majority groups) have similar levels of satisfaction with services commissioned/provided?
14. How do local people from all groups (not just majority groups) know about and actively use opportunities to influence the development, delivery and monitoring of health services?
15. Can your organisation demonstrate that evidence based strategies and action plans are used to identify disadvantaged sections of your local community, and that this evidence informs subsequent action plans?
16. How does your organisation work with other public service commissioners and providers to reduce inequalities and challenge discrimination?
17. Can your organisation demonstrate an integrated, strategic approach to using Information Communication Technology and Patient & Public Involvement in addressing inequitable access or take-up of services?
18. Have you personally, and your Board collectively, made explicit links between the management of quality and the patient experience with local strategies to identify and tackle inequalities?
19. Has your organisation been using/continue to use *Race Equality; Demonstrating Progress; a Performance Framework for Race Equality within the NHS*?
20. Are you personally, and your Board collectively, confident that your organisation could respond positively to enquiries about legal compliance from the equality and human rights enforcement authorities?

Having considered these prompts, it is likely that a number of additional questions that are relevant to your local health economy will emerge. Ultimately, it is for you as a Board member to aspire to ambitious outcomes for your whole population, and to ensure that proper governance arrangements are in place to support these.

7 Useful links and sources

What follows is a selection of links that are of relevance to equality and human rights. Some of the data used in the main body of this Guide is drawn from these sources. Although this list is not an exhaustive, you can use these links to obtain more information on specific areas.

Our Health, Our Care, Our Say:

<http://www.dh.gov.uk/assetRoot/04/14/00/65/04140065.pdf>

Commission for Race Equality:

<http://www.cre.gov.uk/>

The Healthcare Commission:

www.healthcarecommission.org.uk

Delivering Race Equality in mental health care:

<http://www.dh.gov.uk/assetRoot/04/10/07/75/04100775.pdf>

Patient & Public Involvement ('A Stronger Local Voice'):

<http://www.dh.gov.uk/assetRoot/04/10/07/75/04100775.pdf>

Disability Rights Commission:

www.drc.org.uk

Commission for Equality & Human Rights:

www.cehr.org.uk

NHS Employers, Equality & Diversity:

<http://www.nhsemployers.org/kb/kb-757.cfm>

NHS Appointments Commission:

www.appointments.org.uk

Lesbian, Gay, & Bisexual:

www.stonewall.org.uk

Leadership – National Audit Office, Delivering Public Services to a Diverse Society:

http://www.nao.org.uk/publications/nao_reports/04-05/040519_i.pdf

Age Concern UK:

www.ageconcern.org.uk

Single Equality Scheme Discussion Paper:

<http://www.dh.gov.uk/assetRoot/04/13/60/13/04136013.pdf>

Race & Health – The Health of Minority Ethnic Groups:

<http://www.archive.official-documents.co.uk/document/doh/survey99/hse99-00.htm>

Health Reform in England:

<http://www.dh.gov.uk/assetRoot/04/13/72/30/04137230.pdf>

South Asian Health Foundation UK:

<http://www.sahf.org.uk/>

Centre for Evidence in Ethnicity, Health & Diversity (University of Warwick):

<http://www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth/>

Ethnicity & Health Specialist Library:

<http://www.library.nhs.uk/ethnicity/Page.aspx?pagename=LINK>

Annex A

A Summary of Equality and Human Rights Legislation

The Equal Pay Act (as amended) 1970

The Equal Pay Act gives an individual a right to the same contractual pay and benefits as a person of the opposite sex in the same employment, where the man and the woman are doing:

- Like work; or
- Work rated as equivalent under an analytical job evaluation study; or
- Work that is proved to be of equal value.

The Sex Discrimination Act (as amended) 1975

The SDA (which applies to women and men of any age, including children) prohibits sex discrimination against individuals in the areas of employment, education, and the provision of goods, facilities and services and in the disposal or management of premises.

The Human Rights Act 1998

The Human Rights Act came fully into force on 2 October 2000. It gives further effect in the UK to rights contained in the European Convention of Human Rights. The Act:

- makes it unlawful for a public authority to breach Convention rights, unless an Act of Parliament meant it could not have acted differently;
- means that cases can be dealt with in a UK court or tribunal; and
- says that all UK legislation must be given a meaning that fits with the Convention rights, if that is possible.

Employment Equality (Religion or Belief) Regulations 2003

These regulations outlaw discrimination (direct discrimination, indirect discrimination, harassment and victimisation) in employment and vocational training on the grounds of religion or belief. The regulations apply to discrimination on grounds of religion, religious belief or similar philosophical belief.

Employment Equality (Sexual Orientation) Regulations 2003

These regulations outlaw discrimination (direct discrimination, indirect discrimination, harassment and victimisation) in employment and vocational training on the grounds of sexual orientation. The regulations apply to discrimination on grounds of orientation towards persons of the same sex (lesbians and gay men) and the same and opposite sex (bisexuals).

The Gender Recognition Act 2004

The purpose of this Act is to provide transsexual people with legal recognition in their acquired gender. Legal recognition will follow from the issue of a full gender recognition certificate by a Gender Recognition Panel. In practical terms, legal recognition will have the effect that, for example, a male-to-female transsexual person will be legally recognised as a woman in English Law. On the issue of a full gender recognition certificate, the person will be entitled to a new birth certificate reflecting the acquired gender and will be able to marry someone of the opposite gender to his or her acquired gender.

The Civil Partnership Act 2004

This Act creates a new legal relationship of civil partnership, which two people of the same-sex can form by signing a registration document. It also provides same-sex couples who form a civil partnership with parity of treatment in a wide range of legal matters with those opposite-sex couples who enter into a civil marriage.

The Disability Discrimination Act 1995

This Act prohibits discrimination against disabled people in the areas of employment, the provision of goods, facilities, services and premises, and education; and provides for regulations to improve access to public transport to be made.

The Race Relations Act 1976 (as amended by the Race Relations (Amendment) Act 2000)

The Race Relations Act (RRA) makes it unlawful to treat a person less favourably than another on racial grounds. These cover grounds of race, colour, nationality (including citizenship), and national or ethnic origin. The Race Relations (Amendment) Act outlawed discrimination (direct and indirect) and victimisation in all public authority functions not previously covered by the RRA, with only limited exceptions. It also placed a general duty on specified public authorities to promote race equality and good race relations. There are also specific duties for listed organisations including the production of Race Equality Schemes.

Disability Discrimination Act 2005

This Act makes substantial amendments to the Disability Discrimination Act 1995 (see above). The 2005 Act places a general duty on public authorities to promote disability equality and to have due regard to eliminate unlawful discrimination. Those listed bodies within the public sector will also be subject to specific duties of the 2005 Act. The specific duties provides a clear framework for meeting the general duty and includes the requirement to produce a **Disability Equality Scheme**. The Disability Equality Duty for the Public Sector comes into force in December 2006.

This will mean that all NHS bodies will have to have in place by December 2006 Disability Equality Schemes demonstrating how they intend to fulfil their general and specific duties under the Act. This will include:

- a public authority should involve disabled people in the development of the scheme
- the scheme should include a statement of:
 - the way in which disabled people have been involved in the development of the scheme
 - the authority’s methods for impact assessment
 - steps which the authority will take towards fulfilling its general duty (the “action plan”)
 - the authority’s arrangements for gathering information in relation to employment, and, where appropriate, its delivery of education and its functions
 - the authority’s arrangements for putting the information gathered to use, in particular in reviewing its action plan and in preparing the next Disability Equality Scheme
- A public authority must, within 3 years of the scheme being published, take the steps set out in its action plan (unless it is unreasonable or impracticable for it to do so) and put into effect the arrangements for gathering and making use of information.
- A public authority must publish a report containing a summary of the steps taken under the action plan, the results of its information gathering and the use to which it has put the information.

The first scheme must be published by 4 December 2006 and will have to cover the following three years and this must be a living document, regularly monitored and reviewed.

Employment Equality (Age) Regulations October 2006

The Age Regulations implement the age strand of the EU Employment Directive 2000, which prohibits discrimination on specified grounds in work and vocational training. The Age Regulations will apply to all workers and to people who apply for work. In addition, they will cover access to vocational training. The Age Regulations will prohibit direct and indirect age discrimination, harassment and victimisation.

The Equality Act 2006

The Equality Act received Royal Assent on 16 February 2006. The Act's main provisions include:

- the creation of the **Commission for Equality and Human Rights (CEHR)** which replaces the existing three equality commissions. The new Commission would give individuals suffering from discrimination easier access to support and provide employers and service providers with improved advice and information in a one-stop-shop. The purpose and functions of the CEHR are outlined in the Act and the new Commission will be operational from October 2007 (with the Commission for Racial Equality joining in 2009)
- **to make unlawful discrimination on the grounds of religion and belief and sexual orientation** in the provision of goods, facilities and services, education, the use and disposal of premises, and the exercise of public functions; and
- to create a **duty on public authorities to promote equality of opportunity between women and men ('the gender duty')**, and prohibit sex discrimination in the exercise of public functions. This will also include a specific duty on public bodies to produce a Gender Equality Scheme. The Gender Duty will come into force in April 2007.

Annex B

Statistical Information

– Health Inequalities

Race & Ethnicity

Heart Disease: South Asian people are 50% more likely to die prematurely from coronary heart disease than the general population.

Dental Health: Around 90% of children in the general population have visited a dentist. This contrasts with approximately 40% of Bangladeshi and 60% of Pakistani children.

Gypsies & Travellers have a significantly poorer health status and more self-reported symptoms of ill health than the general UK population. In spite of this, Gypsies & Travellers are less likely to access health services such as GPs, Practice Nurses, dentists, opticians or services such as NHS Direct than the general population.

Age

The prevalence of longstanding illness, disability or infirmity increases from 15% of those aged under 5 to 72% for those aged 75+.

36% of people aged 75 and over are taking four or more prescribed medicines. The NHS spends around 40% of its budget on this group.

Sexual Orientation

Lesbians report violence and bullying to a greater extent than heterosexual women.

Lesbian and gay young people are up to six times more likely than heterosexual young people to commit suicide.

42% of gay men, 43% of lesbians and 49% of bisexual men and women have clinically recognised mental health problems compared with 12% and 20% for predominantly heterosexual men and women.

Disability

Uptake for breast screening is 76% for all women in the UK, but just 17% (family care) and 52% (formal care) for women with learning disabilities; for cervical screening, the rates are 85 % (all women aged 20-64), but 3% (family care) and 17% (formal care) respectively.

24% of deaf or hearing-impaired people miss appointments, and 19% miss more than five appointments, because of poor communication – such as not being able to hear staff calling out their name.

There are just under 12 million disabled people in the UK (1 in 5 people), and the prevalence of disability increases with age.



© Crown Copyright 2006

278711 2p 2k April 07 (CWP) 280886

Produced by COI for the Department of Health

If you require further copies of this title quote

278711/Equality and Human Rights in the NHS: A guide for NHS Boards
and contact:

DH Publications Orderline

PO Box 777,

London SE1 6XH

Email: dh@prolog.uk.com

Tel: 08701 555 455

Fax: 01623 724 524

Textphone: 08700 102 870 (8am to 6pm Monday to Friday)

278711/Equality and Human Rights in the NHS: A guide for NHS Boards may
also be made available on request in braille, on audio, on disk and in large print.

www.dh.gov.uk/publications