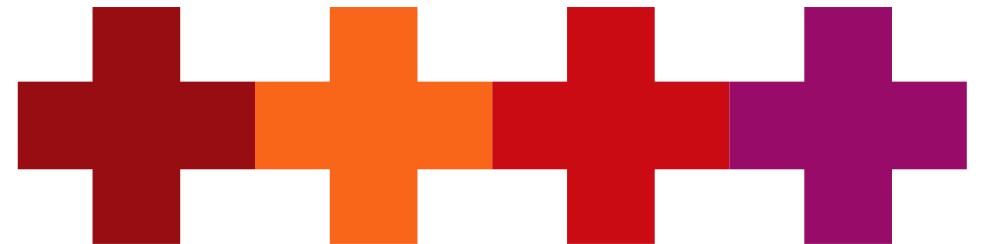


# Towards Race Equality in Health



race for health



A Guide to Policy and Good Practice for  
**COMMISSIONING SERVICES**

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## About Race for Health

The Race for Health programme is led by primary care trusts (PCTs). It aims to create an NHS in which the health needs of black and minority ethnic (BME) people drive the health services they receive. The programme's national director is Professor Helen Hally, and its chair is Evelyn Asante-Mensah, OBE, chair of Central Manchester PCT.

Race for Health, which has been running since 2002, enables PCTs to deliver measurable improvements in the health outcomes of BME people. Prompted by the findings of the Stephen Lawrence Inquiry, Race for Health was originally a Department of Health initiative, spearheaded by the health minister Lord Hunt and Elizabeth Al-Kahalifa, head of equality strategy.

Race for Health supports a network of 13 PCTs across England, in the belief that PCTs are best able to make significant progress in this arena by working with each other in three key areas:

- The workforce
- Commissioning
- Service improvement

### All the trusts involved are committed to working with BME communities to:

- Improve health
- Modernise services
- Increase choice
- Create a more diverse NHS workforce

### The 13 PCTs in the Race for Health programme are:

- Bradford City Teaching PCT
  - Bristol Teaching PCT
  - Central Manchester PCT
  - Ealing PCT
  - Eastern Leicester PCT
  - Haringey Teaching PCT
  - Lambeth PCT
  - Shropshire County PCT
  - Slough PCT
  - South Birmingham PCT
  - Wandsworth Teaching PCT
  - Westminster PCT
  - Wolverhampton City PCT
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The changing nature of the NHS and the increasing diversity of the population make Race for Health ever more relevant. A modern, dynamic NHS should reflect the experiences and aspirations of all its users. Closing the health gap for black and minority ethnic communities will be a real measure of success.

**Further information is available from:**

www.raceforhealth.org

**Contact Race for Health:**

enquiries@raceforhealth.org or 0161 958 4081

## How to use this guide

This guide is designed to provide practical pointers and examples of good practice for everyone involved in commissioning on how to close the health inequalities gap for BME groups. The two other guides in this series are on Workforce Development and Service Improvement.

Based on the experience and knowledge of commissioners in the 13 Race for Health PCTs, this guide aims to share information and encourage innovation in commissioning practice.

**It will help commissioners:**

- Comply with the relevant policy and legal requirements
- Ensure that services meet the health needs of diverse communities
- Understand how to design services for diverse communities
- Identify measurable outcomes for improving health and reducing health inequalities
- Involve diverse communities in service planning and procurement
- Demonstrate value for money
- Assess their organisation's competencies for commissioning for race equality

**For the purposes of this guide the term commissioning is defined as an entire cycle comprising:**

- Needs assessment
- Identifying available resources
- Resource planning
- Arranging for services to be delivered
- Service review
- Reassessment of need

**For ease of reference, the guide is divided into the following sections:**

**1. Introduction – page 04**

Legislation; national policy; role of commissioning

**2. The commissioning cycle – page 06**

What it is; who is responsible; competencies required; how to do it

**3. The commissioning tasks – page 10**

Needs assessment; strategic planning and setting priorities; putting services in place; performance management and quality

**4. The future of commissioning – page 16**

Commissioning a patient led NHS; Practice Based Commissioning; Payment by Results; Patient Choice

**5. Involving communities – page 20**

Legal requirements; understanding how to involve BME communities in shaping services

**6. Commissioning from alternative service providers – page 27**

Decommissioning; capacity building; working with BME voluntary and independent sector organisations

**7. Procurement – page 35**

The procurement cycle; NHS Knowledge and Skills Framework

**8. Contracts – page 39**

Legal requirements; integrating race equality; contract clauses; information and monitoring

**9. Equality Impact Assessments – page 44**

Stages; consultation; monitoring and review

**10. Monitoring and evaluation – page 49**

What's involved; data sources; Health Equity Audit; using information for service redesign

**11. A summary of relevant equality legislation – page 57**

**Where appropriate, each section contains a:**

- Key point summary
- List of relevant legislation/policy documents
- Useful tips
- Checklist questions
- Resources
- Case studies

**Useful questions to bear in mind when using this guide are:**

- How do you best match the theory on commissioning with the day-to-day reality of commissioning health services?
- What levers can you use?
- How realistic is it to de-commission some services in order to integrate different service providers?
- How can you best measure change?

## 1. Introduction

It is 30 years since the Race Relations Act came into force, and six years since it was amended. Yet black and minority ethnic (BME) groups continue to face significant inequalities in educational achievement, employment opportunities, income, health, and quality of life.

### For example:

- ✦ Over two thirds of BME people in England live in the 88 most deprived areas, compared with 40 per cent of the general population.
- ✦ Three out of four Bangladeshi and Pakistani children, and almost two thirds of Black African children, in Britain live in poverty.
- ✦ African-Caribbean men are three times more likely to be diagnosed with prostate cancer than white men.
- ✦ Women born in India and East Africa have a 40 per cent higher suicide rate than those born in England and Wales.
- ✦ Black people are six times more likely than white people to be detained under the Mental Health Act.

In 2002, Home Office figures revealed that one in six BME people said that they had experienced racial discrimination, abuse, or harassment when contacting a public service. And in 2003 the public spending watchdog the Audit Commission stated that the NHS had made slower progress than other public sector organisations in working towards achieving race equality.

Most primary care trusts (PCTs) have found commissioning difficult, largely because of gaps in appropriate skills, staffing, and 'market intelligence', coupled with radical changes in health and social care policy and public expectations.

The health gap for BME communities is therefore still unacceptably wide. But services that are relevant, accessible, and grounded in a thorough understanding of the needs of diverse communities have a key part to play in closing it. That means threading race equality through every single stage of the commissioning process.

Essential first steps to addressing the health inequalities gap include ethnicity monitoring, which takes account of the heterogeneity of ethnic groups. Among the UK's population of 60 million, more than 300 different languages are spoken, and at least 14 different faiths practised.

In 2005, the London Health Observatory noted the importance of understanding differentials in health services and identified some of the key indicators of which commissioners need to be aware.

### These include the need for:

- Information on the ethnic and age/sex profile of local populations served
- Information on the ethnic and age/sex profile of the national population
- Information on health experience or services used, expressed using the same ethnic coding as that of the local/national population.

If services are to respond to need and be truly effective, community involvement is also essential. Trusts have an obligation to consult with all sectors of the community under sections 8 and 11 of the Health and Social Care Act 2001.

Some innovative approaches will be required if engagement is to reach those communities, such as refugees and asylum seekers, who may not have adequate community representation, and if it is to move beyond some of the traditional methods, such as surveys and questionnaires.

Recent policy also emphasises the need to narrow the health inequalities gap. Both *Commissioning a Patient-Led NHS* and *Our Health, Our Care, Our Say* focus on reducing health inequalities and boosting equal access to good quality health and social care.

*Commissioning a Patient-led NHS* places Practice Based Commissioning at the centre of the modernising process within the NHS, and with it the importance of stipulating race equality concerns when contracting with independent and voluntary sector providers, not just other NHS organisations.

These policies herald considerable organisational change. And placing race equality at the centre of the commissioning process is no less a challenge. The key to success is to acknowledge the extent of that challenge, and to set about generating solutions.

Not only are there moral, human rights, and legal imperatives to promote and sustain race equality, but there are also sound economic reasons for doing so. And with the advent of so much change in the way in which services will be commissioned in future, there has never been a better opportunity to shape and improve the health of BME communities.

## 2. The commissioning cycle

This section defines what commissioning is, who is responsible, the competencies required, and what's involved.

### Key points

- ❖ Commissioning has proved challenging for PCTs, largely because of gaps in appropriate skills, staffing, and 'market intelligence', coupled with radical changes in health and social care policy and public expectations.
- ❖ Effective commissioning is nevertheless a key element in addressing health inequalities.
- ❖ Commissioning for race equality should be integral to every stage of the commissioning cycle.
- ❖ The views of the public, patients, and healthcare professionals should inform all commissioning decisions and be mainstreamed.
- ❖ The range of individuals/organisations involved in commissioning will broaden as Practice Based Commissioning becomes a reality.
- ❖ Independent and BME voluntary sector organisations may sometimes be the most appropriate agencies from which to commission services.

### Relevant policy

*Commissioning a Patient-Led NHS*, Department of Health July 2005

*Leadership and Race Equality Action Plan*, Department of Health February 2004

*Our Health, Our Care, Our Say: a New Direction for Community Services*, Department of Health January 2006

### What is commissioning?

**Commissioning is the process of:**

- Assessing need
- Planning services to meet those needs
- Setting priorities and allocating resources
- Developing specifications as to what services are required
- Securing services from the most appropriate providers, including BME voluntary sector organisations and the independent sector
- Monitoring and review to ensure that those services are effective and of high quality

**The process aims to ensure that services:**

- Meet need
- Provide for a culture of continuous improvement
- Represent value for money
- Are effective and improve health outcomes
- Meet performance targets and care standards at national and local levels

### Who is responsible?

Commissioning in the NHS takes place at several different levels, depending on the service to be commissioned and the population to be served.

- Most commissioning is carried out by local PCTs.
- Some specialist services are commissioned by groups of PCTs acting together, and generally linked to Strategic Health Authorities (SHAs).
- Highly specialised services, targeted to small numbers of patients, are commissioned at a national level.
- A good deal of PCT-led commissioning is carried out in partnership with local authorities, particularly when it comes to 'client group' services, such as mental health, learning disabilities, and children's services.

GPs and other primary care health practitioners will increasingly become involved in commissioning as a result of Practice Based Commissioning, due to take effect nationally by the end of 2006.

### What competencies are required?

**These broadly fall into:**

- Communication and interpersonal skills
- Knowledge and understanding
- Leadership
- Partnership working

**Communication and interpersonal skills include:**

- Facilitating meetings and workshops
- Chairing meetings
- Report writing
- Presentations
- Influencing skills

**Knowledge and understanding include:**

- Numeracy and numerical reasoning
- IT literacy, especially spreadsheets
- Note and minute taking
- Project management
- Ability to pull out key messages from reports and documents
- Understanding of health needs assessment
- Ability to use public health data and information appropriately
- Understanding of principles of value for money, effectiveness, and efficiency
- Understanding of health economics
- Policy and strategy implementation
- Understanding of policy context
- Understanding of health service structure
- Understanding of finance, contracting, Payment by Results
- Understanding of clinical governance
- Understanding of modernisation techniques and the ability to apply them
- Critical appraisal skills
- Audit, evaluation, and monitoring skills

**Leadership skills include:**

- Team working/building
- Active listening
- Strategic thinking
- Line management and supervision
- Change management
- Negotiation skills

**Partnership working includes:**

- Ability to work across agencies
- Public and patient involvement
- Ability to work with clinicians and other health and social care professionals

**Fact: Asian women aged 65 and over have the highest rates of long term illness among all women of this age group.**

**What is involved?**

Several different tasks are involved in commissioning at both strategic and operational levels. These are, respectively, described as 'transformational' and 'transactional'.

**The strategic or transformational tasks include**

- Assessment of need
- Strategic planning
- Setting priorities
- Specifying in broad terms what services are required and what outcomes are expected

**The operational or transactional aspects of commissioning include:**

- Procuring the services from appropriate providers
- Agreeing the terms of contracts
- Monitoring activity and spend against those contracts

Commissioning in the NHS has tended to focus on the transactional rather than the transformational elements. This has its roots in the split between 'purchasers' and 'providers', with commissioners often being more concerned about cost and activity than effectiveness, quality, and outcomes.

Commissioning can, and should, be a transformational activity, ensuring that services genuinely meet the needs of people from all communities, including those from BME communities.

**Useful resources**

*Commissioning in Primary Care Trusts*, NHS Confederation, Briefing 125 October 2005  
*The Commissioning Friend*, available through [www.natpact.nhs.uk](http://www.natpact.nhs.uk) and [www.networks.nhs.uk](http://www.networks.nhs.uk)  
*Health Equity Audit: a self-assessment tool*, Department of Health January 2004  
*The NHS Contractors' Companion*, Department of Health October 2003  
*What is out of hospital care?* NHS Confederation Briefing 127 December 2005

### 3. The commissioning tasks

This section tackles needs assessment, strategic planning and priority setting, putting services in place and managing performance and ensuring quality.

#### Key points

- ✦ Ethnicity monitoring is an essential first step for effective commissioning for BME communities.
- ✦ Some services may need to be decommissioned or commissioned from different providers.
- ✦ Some capacity building of BME voluntary sector organisations may be required.

#### Relevant legislation/policy

*Commissioning a Patient-Led NHS*, Department of Health July 2005

*Leadership and Race Equality Action Plan*, Department of Health February 2004

*Our Health, Our Care, Our Say: a New Direction for Community Services*, Department of Health January 2006

#### Assessing need

This involves analysing the need for services by population, patient or care group, or any other appropriate configuration. Use the Health Equity Audit cycle to help you (see section 10).

Information on needs assessment and commissioning for diverse populations is available from a range of sources.

#### These include:

- Demographic information, such as that from the census
- National data on disease prevalence
- Research on best practice
- Health impact assessments
- Clinical data from:
  - ✦ The Quality and Outcomes Framework
  - ✦ Specific clinical professionals
- Feedback from service users/patients and the public, including user surveys
- Information from service use: monitoring data
- Information received from partners, stakeholders, and community groups

**Tip:** Monitor who uses existing services and compare the information with the needs assessment, so that inequities can be tackled (see section 10).

**Tip:** Work with GP practices and commissioning groups in your area to pinpoint health needs among BME communities.

Most people need a very low level of services, and the aim is to maximise the numbers of those who do not need high levels of health care (see figure). Significantly, 80 per cent of contacts in the NHS are in primary care, but 80 per cent of the money spent on the NHS goes into hospital based care.

#### Strategic planning and setting priorities

##### Tasks here include:

- Working with partners, stakeholders, communities, users and carers on the most appropriate responses to identified needs
- Focusing on key issues: these include both the priorities identified from the health needs assessment and those which are likely to be most effective.



### Specific areas with the potential for the greatest impact could include:

- ❖ Diabetes
  - ❖ Cancer
  - ❖ Mental health
  - ❖ Heart disease
  - ❖ High blood pressure
  - ❖ Issues around specific client groups, such as older people or young men
  - ❖ Specific areas, such as sickle cell anaemia or thalassaemia
- Setting priorities and allocating resources, including the management of budgets
  - Pinpointing where culturally specific services may be required and/or provided by specialist providers
  - Developing models and specifications for services in the context of overall patient pathways
  - Dealing with clinical issues and tackling barriers to access
    - ❖ Ensure information on how to access services is itself accessible and culturally appropriate
    - ❖ Work with community groups to encourage access
    - ❖ Provide support and advocacy where required.
    - ❖ Work on maintaining good health and prevention, including lifestyle advice and support, and screening
    - ❖ Ensure need for language support is built into the process
  - Forecasting long term service demand and planning how that can be met
  - Assessing existing and future service staffing and resources
  - Identifying suitable providers and/or developing appropriate existing or new providers
  - Redesigning services where appropriate
  - Identifying any issues in the market that will have an immediate or long term effect: for example, identifying a need for which there are no appropriate providers available
  - Setting out the plans to commission services, while ensuring that resources are used effectively, targets are met, and patient choice and contestability are ensured.
  - Identifying where services may need to be decommissioned, or commissioned in different ways, or from different providers.

**Tip:** Use the former Modernisation Agency's 10 high impact areas and other tested re-design models, such as Local Area Agreements, and the PDSA approach (Plan, Do, Study, Act).

**Fact:** In 2003 babies of mothers born in Pakistan had an infant mortality rate more than double that of the overall rate for England and Wales. The second highest infant mortality rate was among babies of mothers born in the Caribbean.

### Putting services in place

- Specify the services required
  - ❖ Involve service users/communities in drafting these specifications
  - ❖ Ensure they cover quality and equalities requirements (non-discrimination, support for service access)
  - ❖ Specify a requirement for culturally specific services as appropriate
- Determine how the service will be procured
- Ensure that commissioned services comply with a patient's right to choose (Patient Choice), and expectations to commission services from a range of providers
  - ❖ Negotiate with providers
- Agree a contract with the preferred provider(s)

### The contract should incorporate (see section 8):

- The service specification (which itself sets out the purpose of the service) should also be written to incorporate clear statements which promote race equality.
- Quality standards
- Activity levels
- Agreed costs of the service
- Performance requirements
- Monitoring and reporting arrangements
- Arrangements for dealing with variations in performance, disputes, complaints, etc

**Tip:** Don't overlook independent sector and BME voluntary sector providers, as they may offer the most appropriate services.

### Managing performance and ensuring quality

- Put systems in place to receive information from providers about service performance
  - ❖ activity, achievement against targets
  - ❖ financial, quality, and outcomes
  - ❖ monitoring patient/user feedback
- Review effectiveness of the service in meeting needs of patients/users, and of the wider community
- Include a feedback loop to take account of diverse communities' experiences of the service
- Where necessary, change the service or provider to ensure that services continue to be effective

**Tip:** Ensuring quality will include decommissioning existing services where appropriate, and replacing them with new or different ones.

**Tip:** Ensure that independent sector and voluntary sector providers are capable of supplying the information you need on performance management and quality.

### Case study: Wandsworth tPCT Substance Misuse Project

**When commissioning services for substance misusers, commissioners look at:**

- BME referrals
- Assessments
- Completed care plans
- Retention
- Long term outcomes

Attrition rates can then be used to ensure equity of access and appropriateness of treatment for all service users.

Equity Impact Assessments are integral to the monitoring of individual services and the treatment system as a whole. Translation services are also available.

The tPCT funds two community workers at the Wandsworth Drug Project. They undertake outreach work, focusing particularly on minority communities that are under-represented in services.

They run awareness-raising events and train drug and alcohol misusers to act as peer educators. These peer educators then spread accurate information about drugs and drug treatment services within their own communities. The community workers also work with community groups, helping them to come up with proposals for funded activities for which a sum of money is specifically set aside for work in diverse communities across the borough.

A previously inexperienced drug worker was recruited from one of these communities, and now works in the service as a trainee.

### Checklist

- Have you developed a profile of who lives in the area, along with their overall needs? Ethnicity monitoring is an essential component of area profiling.
- Is the information on how to access services user friendly and culturally appropriate?
- Do your service requirements include quality and equalities components (non-discrimination, support for service access)?
- Do your contracts include race equality requirements?
- Have you built in provision for potential language requirements?
- Do you have the right systems in place to receive feedback on service use and performance?
- What will you do when faced with a small BME community with a specialist need?

### Useful resources

*The nuts and bolts of practice based commissioning*, NHS Alliance June 2005.

*A practical guide to ethnic monitoring in the NHS and social care*, Department of Health July 2005.

*Race equality and public procurement: a guide for public authorities and contractors*, Commission for Racial Equality July 2003.

*Local area agreement guidance* Office of the Deputy Prime Minister June 2005

*New business structures in health and social care: a discussion paper about Implications for NHS Commissioning Boards*, The Moore Adamson Craig Partnership LLP (in press)

Website [www.mooreadamsoncraig.co.uk](http://www.mooreadamsoncraig.co.uk)

[www.mosaic.nhs.uk](http://www.mosaic.nhs.uk) – Website on race equality in procurement for the NHS

NHS Institute of Learning, Skills and Innovation [www.institute.nhs.uk](http://www.institute.nhs.uk) (Modernisation Agency's 10 high impact changes)

## 4. The future of commissioning

Several policies will have a major impact on commissioning.

### These include:

- Commissioning a Patient-Led NHS
- Patient Choice
- Payment by Results
- Practice Based Commissioning

### Commissioning a Patient Led NHS

#### This policy specifies:

- Improving the health of the community and reducing health inequalities
- Securing the provision of safe, high quality services
- Contract management
- Engaging with local people and other service providers
- Provision of integrated health and social care services

#### What will it mean?

The policy aims to both improve the commissioning process and save money on management costs. This is likely to be achieved by separating out the transformational and transactional aspects of commissioning (see section 2). Practice based commissioners and PCTs will lead the transformational activity.

The transactional aspects, such as procurement, contract monitoring, and payment arrangements will remain the responsibility of PCTs, but can be achieved through several PCTs working together and sharing administrative and managerial support.

### Patient Choice

Services will be commissioned from a greater range of service providers, including the independent and voluntary sectors.

#### What will it mean?

Nationally, this often means commissioning services from established businesses in the private sector. But for PCTs it may be more appropriate to consider local organisations, such as local or national voluntary organisations, also called third sector organisations, and specialist independent sector providers who might be particularly well equipped to deliver good services to BME communities.

The government has stated its intention to increase the impact of third sector organisations. A new alliance of these organisations called the Voluntary Sector Management of Public Service Delivery Network has been established for this purpose.

This represents an important opportunity for the growth and development of the BME voluntary and community sector.

### Payment by Results

Commissioners are now required to pay service providers, such as acute hospitals, only for the actual activity they undertake. This payment is fixed at a standard national tariff for each procedure.

#### What will it mean?

This means that the commissioning role is now less about negotiating payments with providers, and much more about how demand is managed and capacity planned to ensure that the most appropriate and cost effective services are in place for patients.

### Practice Based Commissioning

This transfers commissioning responsibilities, along with the associated budget, from the PCT to primary care commissioners. Although largely led by GPs, a wider group of primary care clinical and non-clinical staff should also be involved.

General practices will therefore take a much greater role in the commissioning process.

#### This includes:

- Defining services
- Priority setting
- Determining patient pathways
- Monitoring activity and performance
- Managing budgets

PCTs will act as agents, undertaking any required procurements and carrying out the administrative support to underpin these processes. The target for full implementation is December 2006, and a new directed enhanced service will reimburse practices for the time it takes them to switch over.

#### What will it mean?

Practice Based Commissioning offers the potential to divert money from the hospital sector into general practice and community nursing, where most patient care is delivered.

It seems to work best when practices team up in large clusters. In Wandsworth, south west London, for example, clusters vary from a population of 70,000 to 140,000. Larger clusters enable practices to make significant changes to services and to invest the savings made as a result. Practices will need to agree these spending priorities with their patients.

### Case study: Listening to service users in Wandsworth

As a result of feedback, Wandsworth tPCT now offers a male circumcision service for infants under the age of 2 weeks. Wound infections were common when the procedure was carried out locally by non-medically qualified practitioners.

The impact of race, cultural diversity, language and ethnicity will be significant.

#### This will be felt especially in the following areas:

- Health needs assessment
- Service development
- Spending decisions on new services in primary care

The health needs assessment will now be broken down into to much smaller areas and should be much more sensitive to local needs. Practices taking part could have populations as small as 5,000.

The expectation is that these small populations will enable public health specialists, community development workers, GPs and nurses to assess local health needs more effectively, and highlight diversity issues. Strong patient and user input will be critical. Without it, BME community patients could once again be disadvantaged.

For example, patients whose first language is not English can find it difficult to use the recently advocated advance access GP appointment system, which encourages patients to make same day appointments by phone.

Patients not able to use a phone have to book an appointment face to face, returning later in the day, if successful, to see the GP or nurse. Patients not able to access general practice appropriately will simply use emergency care or walk-in centres as their first port of call instead.

Practice based commissioning has the potential to energise the development of primary care services and address health care inequalities among diverse communities. The

challenge will be to make sure that the equalities agenda is fully integrated, and that GPs and other practice based commissioners really do involve patients and listen to communities to drive their commissioning decisions. The responsibility for this lies with the PCT.

All practices involved in practice based commissioning will have to comply with 'Choose and Book'. This offers patients up to five alternatives for secondary care treatment and the ability to book online if they wish. Again, this is much more difficult for people with English as a second language.

**Tip:** Choose and Book won't work properly without good translation and Interpreting services. Large practices should consider having an interpreter based permanently at the practice.

## 5. Involving BME communities

This section covers legal requirements and how to go about effective community engagement.

### Key points

- ❖ Research by the Audit Commission shows that the principles of effective community engagement, includes:
  - Commitment
  - Support
  - Structure
  - Representation
  - Willingness to hand over control
  - Ability to learn from experience
  - Focus on real results
- ❖ The need to involve patients and the public in all aspects of service design and delivery is enshrined in law.
- ❖ Public and patient involvement should occur right at the start of service planning, development, and operation.
- ❖ Local community and voluntary groups are often best placed to understand and reflect the needs of particular target or geographic communities.
- ❖ It may be hard to reach a representative cross section of BME community groups. More innovative approaches, which go beyond surveys and questionnaires will be needed.
- ❖ Consultation alone is not enough.

### Relevant legislation/policy

- Health and Social Care Act 2001
- Race Relations (Amendment) Act 2000
- Local Government Act 2000 (section 21)

### Legal requirements

Section 11 of the Health and Social Care Act 2001, which came into force in January 2003, places a duty on the NHS to consult and involve patients and the public in:

- Planning services
- Developing and considering proposals for changes in service provision
- Decisions affecting how those services operate
- Public and patient involvement should occur right at the start of any of these processes, and should be ongoing. In broad terms, public and patient involvement means discussing:
  - ❖ Their ideas

- ❖ The organisation's plans
- ❖ Their experiences
- ❖ The reasons for change
- ❖ Their requirements
- ❖ How to make the best use of resources

Consultation alone is not enough, and it is important to tailor the method of involvement according to the issue and the target group(s).

Section 7 of the Health and Social Care Act 2001 ensures that strategic health authorities, PCTs, and NHS trusts are answerable to their local authority. And section 8 allows for joint overview and scrutiny committees to be set up, so that decisions affecting more than one local authority can be jointly scrutinised.

### Under the Race Relations (Amendment) Act 2000, public authorities have a duty to ensure that as policy makers and service providers they:

- Consult ethnic minorities
- Take account of the potential impact of policies on ethnic minority groups
- Monitor the actual impact of policies and services
- Take remedial action to address unwarranted or unexpected disparities

Therefore, if NHS organisations have not consulted with ethnic minority communities in their areas, when planning, developing, implementing and operating services, they could be brought to task by the appropriate overview and scrutiny committee.

**Tip:** When inviting feedback, set a time frame for the experiences people have had. This avoids the repetition of complaints going back years.

### How to go about it

Involving local communities in service design and delivery is not easy. It is often difficult to include people who do not have access to community based organisations, and it may be hard to reach a representative cross section of BME community groups.

More innovative approaches, which go beyond surveys and questionnaires are therefore needed.

Bradford City Teaching Primary Care Trust, which covers a growing population of around 153,000, 62 per cent of whom are of South Asian origin, has adopted an innovative approach to public and patient involvement.

Bradford City tPCT has adopted a four tier approach to involving local communities in the commissioning of health services, beyond its ongoing work with strategic partners in the NHS and in local government.

**These four tiers are:**

- 1 Funding community health related projects
- 2 Influencing service modernisation
- 3 Holding community open events
- 4 General feedback

**Tier 1: funding community health related projects**

The trust gives in excess of £400,000 a year to local community health related projects. The maximum funding available for any one project is £15,000 a year for two years.

**Funding criteria include:**

- Showing how a proposal will demonstrably serve to reduce health inequalities
- Evidence of need
- Feedback on client concerns about health services to the trust

Each funding round focuses on a specific area of need, such as advocacy or improving children's health. Such projects include the Asian Disability Network, which supports deaf Asian women, and Sharing Voices, which runs service user events to identify the particular needs of minority ethnic users of mental health services.

The trust recognises that local community and voluntary groups are often best placed to understand and reflect the needs of particular target or geographic communities. And once commissioned, they can take an active role in improving health services. Proposals can also highlight previously unknown gaps in provision, which the trust can then address.

Some projects can be mainstreamed: the Bradford Sickle Cell and Thalassaemia Service are two such examples. The Carer's Support Service, which provides two designated support workers to work, respectively, in South Asian and African and Caribbean communities, and the Maternity Service User Involvement Project, are now in their final year of funding and the trust plans to mainstream both from April 2007.

**Case study: Sharing Voices in Bradford (SVB)**

This nationally recognised project works with BME communities to provide culturally sensitive mental health services. It signposts to existing statutory and voluntary services, provides support to individuals and groups, and encourages the development of other relevant services.

As part of the current Service Level Agreement, the project was asked to develop proposals to ensure that services are redesigned to meet the particular needs of young South Asian adults and young Afro Caribbean men.

Bradford City tPCT's community development workers are now provided by this project as independence from statutory services is thought to be an essential element in successful engagement with BME communities.

**Case study: South Asian Women's Health Awareness Association (SAWHAA)**

The South Asian Women's Health Awareness Association developed out of the Sharing Voices project. It provides a range of information and support services for women with mild to moderate mental health problems.

As a result of having a Service Level Agreement with Bradford City tPCT, SAWHAA had the credibility to contract with Child & Adolescent Mental Health Services to provide an information service to young Asian women in the city's comprehensive schools and further education colleges.

**Tier 2: Influencing service modernisation**

The trust has a major programme of modernising local GP surgeries. As part of this process, all patients registered with a GP surgery scheduled for modernisation are notified in writing and invited to feedback their comments about the proposals to the trust.

Patients are also invited to join the user group set up to inform each development. This gives local patients and other relevant local stakeholders the opportunity to exert direct influence, including the provision of additional health, social, or community services on site.

**Tier 3: Community open events**

The trust holds various open events each year as part of its ongoing strategic and service

development. These events are held in individual services across the city, in specific communities of interest, or in specific neighbourhoods. The views of local people are then used to inform both commissioning and service delivery.

In June 2005 a health priorities planning meeting was held in each of the trust's three localities to give local people the opportunity to comment on the trust's priorities for health and to express their own. Comments are then used to commission additional services and/or improve existing ones.

#### **Tier 4: General feedback**

**The trust routinely collects feedback from patients through:**

- Direct comments from patients and the wider public
- Ongoing work with strategic partners
- The Patient & Public Involvement Forum
- Neighbourhood Forums with which the trust works in partnership with the local authority

This feedback is used to inform ongoing service improvement and pinpoint future commissioning needs. But there are also other ways of generating feedback. When the Patient Advice and Liaison Service (PALS) for the trust was set up, it was given a specific role in supporting the views of people from South Asian communities. The trust advertised for a candidate who could speak two or more South Asian languages.

**Tip:** To avoid breaking the law on discrimination, you can employ a worker from a particular BME community under the aegis of a Genuine Occupation Qualification.

BME Health Forums are another way of generating feedback. Westminster PCT set up such a forum for BME communities with mental health problems in Chelsea, Kensington, and Westminster, looking at access to, and use of, mental health services.

**Tip:** Even when services have been mainstreamed, remain vigilant about race equality issues

#### **Case Study: Oral health – Smiling with the Prophet**

Delivered by Bradford City tPCT Oral Health Promotion Unit, this project uses the teachings of Islam on oral health. It is primarily aimed at South Asian Muslim children. Originally a pilot, this has now been running for five years and has been mainstreamed. Eight mosques take part.

#### **Case study: Local radio**

##### **Ramadan radio campaign**

Bradford has a local radio station to which thousands of Muslims tune in during the month of Ramadan. Supported by Bradford City tPCT the station airs several programmes and adverts about generic healthcare and specific topics of interest to the Muslim community.

During 2005, over 30 shows and various different adverts were broadcast covering a broad range of topics, including flu vaccinations, heart disease, diabetes, emergency care, antibiotics, and dental health. Lots of patients called in with questions or comments, and these have helped the trust to identify service needs.

##### **Bradford Community Broadcasting**

The Health Education Officer at the Equality & Diversity Department of Bradford City tPCT works with South Asian communities to provide a health education information service.

The Officer presents health programmes on Bradford Community Broadcasting (BCB) on 96.7FM and Radio Fast FM. These often involve other health professionals or live discussions. Listeners are given information about other organisations and groups where they can obtain further help and support.

#### **Case study: The Barbershop Project**

The barbershop project aims to raise the profile of men's health. It offers a Health MOT and lifestyle advice on diet, exercise, substance misuse, and smoking cessation to the predominantly South Asian clientele at barber shops in Bradford and Keighley. Many men who do not usually access NHS services have been checked and referred to their GP for follow up.

The project began in February 2003 with the Men's Health Team visiting Asian Barber Shops to screen for blood pressure, blood glucose, cholesterol and check body mass index.

Clients are mostly of Pakistani origin, but also include African-Caribbean, White British, Somali, Kurdish, Iraqi and Iranian people. Around 400 men have been screened since the barbershop project started, thanks to local barbers Mr Shafiq Ahmed (Bradford) and Mr Azhar Mahmood (Keighley).

### Case study: Mental wellbeing in Kensington, Chelsea, and Westminster

The project, which was set up in 2003, aimed to assess whether local mental health services best served the needs of diverse communities.

In Kensington, Chelsea, and Westminster, the population includes migrant African-Caribbean and Moroccan communities as well as refugees and asylum seekers from the Middle East, Africa, and South Asia.

The project was coordinated by the BME Health Forum, commissioned by Chelsea, Kensington, and Westminster PCTs, and the Migrant and Refugee Communities Forum. Representatives from 15 BME communities, voluntary, and statutory agencies were also involved from the start.

The BME representatives were encouraged to attend a two day training course on how to run community consultations. Everyone participated in developing a pro-forma, rather than a questionnaire. This was used to prompt questions about specific health issues. Twenty consultation events were held, in addition to a series of public meetings with speakers on specific mental health issues.

**Fact: Young Asian women are more than twice as likely to commit suicide as young white women.**

### Checklist

- Are there any misconceptions about mainstreaming services provided by BME voluntary groups?
- Have you reached out to grass roots people, not just community leaders and educated, affluent groups?
- Have you included hard to reach groups, such as refugees and asylum seekers?

### Useful resources

*The Journey to Race Equality. Delivering improved services to local communities*, Audit Commission January 2004.

BME Health Forum, Westminster PCT

Website: The Moore Adamson Craig Partnership: [www.publicinvolvement.org.uk](http://www.publicinvolvement.org.uk)

## 6. Commissioning from alternative service providers

This section covers decommissioning, capacity building, and working with BME voluntary and community organisations.

### Key points

- ✦ Decommissioning is perceived to be difficult, because of the nature of NHS contracts, but it will be required in the move to establish a greater mix of private and public sector provision.
- ✦ PCTs have a role as strategic market managers in encouraging high performing or particularly innovative providers into their local market.
- ✦ It will undoubtedly take time to develop this role and require new approaches, using the skills of the independent sector as well as of more established partners to develop new service designs.
- ✦ Capacity building will underpin the move towards commissioning a greater mix of service providers.

### Relevant policy

*The NHS in England: the operating framework for 2006/7*, Department of Health February 2006

### Decommissioning

The perception is that the nature of NHS contractual arrangements makes decommissioning difficult: large block contracts to large acute service providers leave little room for manoeuvre.

But *Commissioning a Patient-led NHS* has signalled the need to overhaul service commissioning and provision. It has highlighted the importance of establishing a greater mix of private and public sector service provision rather than just relying on what can be provided directly from the PCT.

The aim is to bring a degree of contestability to community based services, to provide more varied services that more accurately reflect patient need. Services may therefore need to be decommissioned in order to achieve this.

**The NHS Operating Framework for 2006/7 points out that:**

“...from 2007, each PCT will be expected to review formally and systematically whether local services are delivering high quality, effective and efficient care, and whether they are tackling health inequalities. This applies both to directly provided and contracted services, and will be a central part of each PCT’s role as a commissioner. Good management of community services is essential for good patient and carer experience. There is no requirement for PCTs to divest themselves of provision, and nor will there be in future, but PCTs will also be free to make different arrangements where they believe these will continue to improve services, especially in relation to health inequalities...” (p13)

**The NHS Confederation has noted that the key decisions in future provision will be:**

- How to design models that best meet the needs of patients
- How to ensure that there is a systematic approach to ‘make or buy’ choices between services provided by localities and practices and those purchased from other suppliers
- How to develop a market that will not require unnecessary or major re-configuration
- How to ensure the most appropriate type and level of contestability for each type of service

The NHS Confederation also notes that PCTs have a role as strategic market managers in encouraging high performing or particularly innovative providers into their local market to ensure that local differences can be fully catered for when developing the necessary partnership arrangements.

It will undoubtedly take time to develop this role and require new approaches, using the skills of the independent sector as well as of more established partners to develop new service designs.

In its response to *Commissioning a patient-led NHS*, Race for Health identified the importance of commissioners working more closely with the BME community and voluntary sectors to help them fulfil their potential as providers.

This will require more innovative ways of thinking and the need to work with small, independent service providers, to improve both routes into care for people from BME communities as well as boosting their access to more appropriate services.

Area-based initiatives, such as the Lambeth, Southwark and Lewisham Health Action Zone (LSLHAZ), which focused on commissioning for diversity, were a precursor to these burgeoning new ways of providing services. They offer important pointers to inform future

development of third sector organisations as alternative providers of mainstream services.

The LSLHAZ project identified several key areas in its developmental commissioning process and made several recommendations for change.

**These were:**

- Development of a commissioning brief
- Issuing notices
- Extension of timescales
- Evaluation

**Development of a commissioning brief**

- Consult with relevant service providers before the official tendering process starts
- Include voluntary sector providers in the consultation stage
- Agree the type of service to be commissioned and include explicit race equality targets for the service in the consultation stage
- Discuss the specification with BME organisations with the relevant skills before the tendering process gets under way

**Issuing notices**

- State that the commissioning organisation is prepared to consider choosing more than one provider
- State that consortium tendering is welcomed and that joint and multiple liability will not necessarily be required

**Extending timescales**

- Extend the time for commissioning by giving notice at the start of each financial year of commissioning intentions for that year
- Issue notices in local and national media and extend the timescale for notices, tendering, and shortlisting

**Evaluation**

- Include race equality principles in the evaluation criteria where appropriate
- Give more weight to race equality principles in the evaluation criteria where appropriate
- Include references and site visits as part of the evaluation process where appropriate.

**Fact: By 2026, the older minority ethnic population in the UK will have risen tenfold from 175,000 to over 1.8 million.**

## Outcomes for capacity building

Capacity building will underpin the move towards commissioning a greater mix of service providers.

Broadly, capacity building means strengthening the capacity of communities, families, and individuals in civil society so that they can participate fully in the political and social arena. Specifically, it means building the capacities of voluntary and community organisations so that they can achieve their objectives.

The need for capacity building has been universally accepted in the commissioning cycle, yet there has been no broad agreement on what outcomes are to be achieved.

### Case Study: Latin American Golden Years Club

The Latin American Golden Years Day Centre was set up in 1992 in Lambeth to meet the needs of older members of the Latin American community. The Centre quickly established itself as a place where older people could come to relax, socialise, learn new skills and take part in a range of creative and educational activities.

The management committee is now considering how to expand the organisation. Should the organisation continue to focus on the Latin American community (over 3,500 in Lambeth) or broaden its services to include all communities?

A capacity building programme for the organisation was developed with help from the PCT, local authority Adult and Community Services (formerly Social Services), Age Concern Lambeth, and Health Action Zone funding for an independent consultant. The consultant's remit is to:

- Map similar or complementary services provided to older Latin American people in Lambeth and its neighbouring boroughs, identifying any gaps and highlighting examples of good practice
- Analyse Lambeth's population for future trends in the Latin American community and make recommendations for effectively responding to these
- Undertake detailed and extensive consultation with stakeholders, including the PCT, local authority, voluntary and community organisations and the Latin American community to identify ways of working together, shared resources, funding sources, etc
- The outcome of the exercise will be a business plan and fundraising strategy, based on the needs of the organisation and its target community

### Case study: The African Organisational Development Project

The African Organisational Development Project (AODP) has been going since the 1990s. It works with new and emerging African community-based organisations providing sexual health services.

Funded by PCTs in south-east, south-west, and north central London, it is run by independent consultants. The project aims to enhance the organisational capacity and strengthen the professional base of target organisations.

There are currently 24 organisations registered on the programme. They receive one to one and group support on various matters.

#### This includes:

- Developing financial systems and policies
- Developing organisational policies and governance arrangements
- Quality assurance training
- Training for management committee members
- Developing business plans
- IT support and training

#### An evaluation of the project in 2005 found that:

- Most of the organisations had increased their volunteer numbers
- Retention of volunteers and staff had improved
- Most of the organisations had increased their capacity to fundraise
- Some larger organisations were acting as leads for partnership projects and looked after the funds
- Some organisations had received quality marks, such as Investors in People
- Financial systems and controls had been computerised
- Most organisations viewed partnership working as a major way forward

### Working with BME voluntary and community organisations

To enable BME voluntary and community organisations to respond appropriately, organisational development needs to focus on:

- A mission statement  
Is the organisation clear about what it wants to achieve?
- A management committee  
What are the roles of each member?

- Fitness for purpose  
What needs to happen to achieve this?
- Partnership working
- Business training in policies and procedures, etc.  
How much of this can be undertaken through mentoring or training? PCT human resources and finance staff may have a role.
- Monitoring and evaluation

### Case study: Chinese Health Information Centre (CHIC)

The Chinese Health Information Centre (CHIC) was set up in 1987 to tackle health inequalities among the Chinese communities of Manchester and the north-west, and to improve access to health services.

The Health Education Authority discovered that fewer Chinese people were accessing GP services (18 per cent) compared with the population as a whole (28 per cent). Language difficulties were thought to be the primary barrier. CHIC provides a surgery staffed by volunteer Chinese GPs. Over 5,400 patients are registered.

Rates of diabetes are also higher than average in Chinese people. CHIC runs a diabetic clinic and foot screening service. Other services include health promotion and education, drug awareness, health activities for older people, parenting courses, first aid and interpreting services.

### What commissioners need to do

#### To achieve the following outcomes of:

- Information on inequity and inequalities
- Voluntary and community organisations providing good quality, effective services that are responsive to need
- Patient Choice

#### Commissioners will need to:

- Carry out needs assessments, including health equity audits
- Develop a sound knowledge of BME voluntary and community organisations: where they are, who they are, what they do
- Develop potential providers
- Communicate clearly about what services are to be commissioned, and how
- Build mechanisms for developing and increasing the capacity of the BME voluntary and community sector into Service Level Agreements

### Case study: Delivering race equality in mental health

As part of delivering race equality in mental health, Lambeth PCT is recruiting five BME community development workers in bid to improve the commissioning and provision of mental health services for BME communities.

The steering group includes representatives from the PCT, local authority, mental health trust and the BME voluntary sector.

#### It has identified the following key priorities:

- A whole systems, holistic approach
- BME networks, structures, processes and capacity
- Faith communities
- Refugees and asylum seekers
- Over representation of BME people in prison and criminal justice systems
- Over representation of BME people in institutional mental health care

Joint funding opportunities are being looked at to ensure a systems-wide approach. And where possible, community development workers will be placed in voluntary and community sector organisations, with supervision and peer support negotiated with the mental health trust.

Two local organisations have expressed an interest in coordinating the BME network and capacity building, and a black mental health user/survivor organisation is interested in focusing on inpatient services.

The Drug and Alcohol Action Team has indicated support for joint funding of community development work with younger people with dual diagnosis. Local organisations who may be interested in working with black prisoners are currently being approached, and initial work on training black prisoners to discuss experiences is being taken forward with Brixton and Belmarsh prisons. A dual approach, linking up with the mental health trust's chaplaincy services and faith communities in Lambeth, is also being explored.

This holistic approach is strengthening partnership working across BME mental health voluntary sector organisations, ensuring that capacity building is integral to the process.

**Tip:** Specify capacity building for BME voluntary organisations in the service level agreement.

## Checklist

- Do you know the profiles and characteristics of your client communities?
- Is your organisation meeting ethnic monitoring targets?
- Have you mapped the skills and resources which exist in the BME voluntary and community sector?
- What inherent mechanisms exist for engaging with the BME voluntary and community sector?

## Useful resources

The National Council for Voluntary Organisations [www.ncvo-vol.org.uk](http://www.ncvo-vol.org.uk)

*New Business Structures in Health and Social Care: A discussion paper about Implications for NHS Commissioning Boards* The Moore Adamson Craig Partnership LLP (in press) [www.mooreadamsoncraig.co.uk](http://www.mooreadamsoncraig.co.uk)

*The Future of Provision*. Briefing 126 The NHS Confederation November 2005.

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## 7. Procurement

This section includes the procurement cycle and the NHS Knowledge and Skills Framework

### Key points

- ✦ Historically, procurement and commissioning have tended to be separate activities.
- ✦ But as more services are subject to value for money assessment as part of competitive tendering, procurement expertise is beginning to assume greater importance in commissioning.
- ✦ As a result, more formalised contractual relationships, which are widely used for procurement, are becoming increasingly common in commissioning.
- ✦ An equality impact assessment (EIA) is key to understanding the scope of future need and is part of good procurement practice (see section 9).

### Relevant policy

*One Future- Different Paths. The UK's Shared Framework for sustainable development*, DEFRA 2005.

### The historical difference between commissioning and procurement

Procurement is the acquisition of goods and services from both public and independent sector providers to support those providing direct patient care.

Commissioning focuses on the provision of direct patient care and associated services to support and promote patient choice.

**Tip:** The NHS Purchasing and Supply Agency and the Department of Health have produced a procurement guide for alternative provider medical services. [www.pasa.nhs.uk/procguides](http://www.pasa.nhs.uk/procguides)

### The procurement cycle

The procurement cycle is designed to ensure that the process of acquiring goods and services is open, transparent and complies with good governance, including the new public sector directive, which combines separate directives for goods, services, and works. Sustainability is a prominent feature of this new directive.

#### The cycle means that:

- Contracts can be assessed for their impact on equality at an early stage
- Service providers can work closely together to ensure that their approach is consistent with the values that would be applied if the service were in-house

### Equality Impact Assessments

The use of equality impact assessment (EIA) is key to understanding the scope of future need and is part of good procurement practice. This will require training and should be linked to the six core dimensions of the NHS Knowledge and Skills Framework (KSF).

An EIA, which links into the use of a pre-qualification questionnaire for suppliers, should be used for the initial stages of contract forming or renewal. This will reveal potential suppliers' approach to equality and diversity at an early stage, and it will also help them to understand commissioners' requirements.

#### Case study: Termination of pregnancy service

An existing PCT termination of pregnancy service was provided by a local NHS Trust, but with the opportunity to refer to an independent provider. As the agreement with the local NHS trust was drawing to a close, the PCT undertook a market testing exercise.

Equal access to the service was a primary concern, and to comply with diversity issues, the PCT recognised the need to consider independent sector providers as primary sources.

Most of those requiring a pregnancy termination are likely to be in their teens or younger; termination of pregnancy is part of the sexual health agenda and falls under public health.

A project team was formed with appropriate representation, including a procurement adviser, and a project plan was developed. Diversity and equality were considered at the specification stage and monitored throughout the process. Issues such as transport, especially public transport, and clinic access after school hours and at weekends were included.

These considerations were shared with potential providers at the outset, both to eliminate those unable to meet the specification and to communicate the core values against which the service would be evaluated.

Diversity in this instance had an added dimension in that many clinicians hold personal and professional views on the time limits for termination of a pregnancy. They may not be willing to operate beyond this point, which could affect service provision and equal access.

**Fact: Older ethnic minority people, especially those from Pakistani and Bangladeshi communities, face much greater poverty in retirement.**

### NHS Knowledge and Skills Framework

The Knowledge & Skills Framework (KSF) is a framework and tool to support personal development and career progression in the NHS. The KSF is made up of six core dimensions which will be part of everyone's job.

#### These are:

- Communication
- Personal and people development
- Health, safety and security
- Service development
- Quality
- Equality, diversity and rights

Although equality and diversity is a core dimension of the framework, the specification for procurement posts will probably only describe the lowest level of required competency.

Gateway 3 refers to procurement and commissioning. Level 1 involves monitoring, ordering, and checking supplies of goods and/or services; level 2 involves assisting in commissioning, procuring, and monitoring of goods and/or services. Level 3 involves commissioning and procuring of products, equipment, services, systems, and facilities, while level 4 involves developing, reviewing, and improving commissioning and procurement systems.

**Tip:** Look carefully at your monitoring figures. BME people might be accessing a service more heavily than other groups, but these figures could still be much lower than the population data would suggest.

## The Mosaic Project

To examine how race equality could be promoted in procurement, Equality and Human Rights at the Department of Health commissioned the Mosaic project. Working across several pilot sites, this aims to:

- Develop good practice in procurement based on Commission for Racial Equality guidelines
- Promote and disseminate the learning from the pilots
- Support the development of procurement professionals and networks

The Mosaic project works with both the supply and demand sides of the procurement process, across NHS organisations. This includes prime or first tier suppliers, helping them to understand their statutory duties in respect of the Race Relations (Amendment) Act 2000, and promoting the use of small and medium sized enterprises and BME suppliers.

The range of activities being piloted include

- Working with prime contractors to open up supply chains
- 'Selling to us' workshops for small and medium sized enterprises
- Reviewing standard terms and conditions of contracts, including how equality is monitored
- Identifying and assessing the supplier base to create a baseline
- Developing and delivering procurement training for non-procurement professionals
- Examining the relevance of social enterprises as delivery agents to the NHS
- Exploring the benefits of consortia purchasing and impacts on local business

Several key resources have emerged, such as training materials for suppliers and procurement officers; balance scorecards for strategic health authorities on race equality and procurement; patient questionnaires and equalities surveys; factsheets for suppliers on equalities; guidance notes on the social economy; procurement tips for non-procurement professionals; and best practice case studies.

For further information about the Mosaic project contact either:  
Dr Kemal Ahson, procurement advisor ( 020 7937 0919; kemal@lifeworld.info) or  
Jennifer Jean-Jacques, Acting Head of Communications, South East London Strategic Health Authority (020 7716 7059; Jennifer.Jean-Jacques@selondon.nhs.uk).  
Alternatively, visit the Mosaic project website (www.mosaic.nhs.uk).

## Useful resources

- *Race equality and public procurement: a guide for authorities and contractors*, Commission for Racial Equality 2003.

## 8. Contracts

This section covers contract types, how to integrate race equality into commissioning, contract clauses and information and monitoring.

### Key points

- ❖ A wide range of contracts and service level agreements is in use.
- ❖ Currently, neither the NHS national contract nor Foundation Trust contracts include requirements for race equality objectives.
- ❖ Contract clauses can be rewritten, but they must take into account EU regulations and related case law, which impose a principle of non-discrimination and transparency on all contracting public authorities.
- ❖ Contracts must be regularly reviewed to check compliance with race equality.

### Relevant legislation/policy

The Sex Discrimination Act 1975  
Disability Discrimination Act 1995  
Age Discrimination Act 2006  
Race Relations (Amendment) Act 2000  
Race Directive  
Employment regulations 2003

### Contract types

#### These include:

- Legal contracts for:
  - ❖ NHS Foundation Trusts
  - ❖ Independent sector contractors
  - ❖ Voluntary sector organisations
- NHS service agreements for NHS trusts
- National NHS contracts for primary care providers
- Grants to voluntary bodies
- National Department of Health contracts with independent sector organisations

#### Similarly, there are a range of providers. Currently, these include:

- NHS or Foundation Trusts, including hospital, mental health, and PCTs
- Voluntary sector
- Independent sector
- Primary care contractors, including GPs, pharmacists, optometrists, and dentists

PCTs will need to commission from alternative NHS and independent sector providers in order to support and promote Patient Choice.

### Integrating race equality in commissioning

The Race Relations Amendment Act places a general duty on all public authorities, including the NHS to:

- Eliminate unlawful racial discrimination
- Promote equality of opportunity
- Promote good relations between people of different racial groups

### When applying race equality to the commissioning cycle, there are some useful guiding principles:

- Race equality is relevant to the commissioning of all services
- The more relevant race equality is to a contract, the more it must be considered at every stage of the commissioning cycle
- Commissioning and procurement must be considered within the context of providing value for money and relevant European regulations
- Race equality and service quality goals can be aligned if commissioners apply sound commissioning principles

### These principles take into account other equality legislation including:

- The Sex Discrimination Act 1975
- Disability Discrimination Act 1995
- Employment regulations that cover sexual orientation and religion (2003)
- Age Discrimination Act (2006)

They can also be used to structure a Race Equality Scheme. This specifies how the 'general duty' to tackle race discrimination and promote equality of opportunity and good race relations are met.

### Contract clauses

Contract clauses can be written, which take a more positive approach to the 'general duty' outlined in the Race Relations (Amendment) Act. But they must take into account EU regulations and related case law, which impose a principle of non-discrimination and transparency on all contracting public authorities.

### Important legal considerations, drawn from current best practice include:

- Race equality considerations must be an objective of the procurement process from the outset

- The concept of what is considered to be 'economically advantageous' can encompass social considerations, such as race equality
- Where race equality forms part of what is considered to be the most economically advantageous, it can be used as a deciding factor between two otherwise equal bids
- Race equality cannot be used as a distinct criterion for assessment on its own
- The European Court of Justice has ruled that any requirements of locality are difficult to justify and will generally be deemed as discriminatory

### Standard clauses

The Commission for Racial Equality stipulates that standard clauses, which include race equality responsibilities to the NHS, should require the provider to:

- Not discriminate unlawfully
- Cooperate with any investigation or proceedings concerning alleged contravention of the Race Relations Act in fulfilling the contract
- Identify the responsible authority in the case of any finding under the Act arising out of the provider's acts or omissions
- Impose the same obligations on any subcontractor

Where a provider's staff work on NHS premises or alongside NHS staff, they must comply with existing organisational employment and race equality policies and procedures.

### How to boost race equality in standard clauses

A typical clause used in NHS commissioning contracts covering race equality and discrimination reads as follows:

*Neither party shall discriminate unlawfully within the meaning and scope of any law, enactment, order, regulation or similar instrument relating to discrimination (whether in relation to race, gender, disability, religion or otherwise) in employment or performance of the services, and both parties shall take all reasonable steps to ensure the observance of this clause by all members of the parties' personnel and by all providers and subcontractors of the parties.*

*This standard clause can be improved with additional sub-clauses covering the need to eliminate unlawful race discrimination, the monitoring of staff, and preparation of reporting systems. For example:*

*The provider shall be deemed to include without limitations an obligation to have due regard to the need to eliminate unlawful racial discrimination and to promote equality of opportunity and good relations between persons of different racial groups.*

*The provider shall monitor the representation among its staff of different racial groups, having regard to the NHS procedures for monitoring representation among its own employees.*

*Where a racial group is underrepresented among the provider's staff doing that work compared with their representation on the provider's staff or in the population from which the provider's staff are normally recruited, such actions as are reasonably appropriate to address this imbalance may be undertaken.*

*The provider shall submit a report statement demonstrating compliance with the race equality legislation 12 months from the date of this agreement.*

**Fact: Nearly half of the ethnic minority population in the UK is under 24, compared with a third of the white population.**

### Information and monitoring

The reality is that most baseline contracts from one year are rolled into the next, based on the previous year's performance, taking into account any specific new national or local requirements.

But the monitoring of any contract has a major role in ensuring that race equality is promoted. Effective monitoring involves several key steps.

#### These are:

1. Determine who will be responsible for evaluating and monitoring the race equality elements at different stages of the commissioning cycle.
2. Provide appropriate training for those responsible for monitoring race equality elements, contract monitoring, and contract management.
3. Establish sound procedures for monitoring and managing a contract, including how often it is to be monitored and the type of information the provider needs to submit for review.
4. Build a strong positive rapport between the commissioner and the provider to help promote race equality.
5. Encourage providers to voluntarily put in place additional measures to promote race equality.
6. Take prompt action if the provider fails to comply with the race equality aspects of a contract.
7. Continually monitor and assess contracts in order to create expertise in race equality commissioning and so influence future commissioning decisions.

Regular meetings should be held with the provider for which a monitoring template should be drawn up. This should include all the types of information which need to be reviewed for any particular commission.

#### These could include:

- Minutes of meetings
- Staff monitoring
- Service user interviews

A systematic approach to recording race equality performance data against the requirements of the contract is essential.

All the information must comply with current NHS data standards in respect of how it is collected and provided.

Systems and procedures for recording information in accordance with the NHS Data Dictionary and Manual and the NHS CDS Manual may therefore need to be set up.

### Checklist

- Are you up to date on all equality legislation and does it actively inform how your organisation carries out its core business?
- Have you boosted the equality aspect of your service level agreement?
- Do you ask prospective contractors about their equality and diversity policies and procedures?
- What is their track record?

### Useful resources

*The NHS Contractors' Companion*. Department of Health 2003

*Race Equality Scheme 2005-8*. Department of Health July 2005.

*Public Authorities and Partnerships. A guide to the duty to promote race equality*.

Commission for Racial Equality 2004.

## 9. Equality Impact Assessments

### Key points

- ❖ An Equality Impact Assessment (EIA) is a way of systematically and thoroughly assessing, and consulting on, the effects that a policy, function, or strategy is likely to have on people.
- ❖ The EIA helps to pre-empt the possibility that a policy could disadvantage some groups on the grounds of race, disability, age, gender, sexuality, faith, language.
- ❖ This means involving appropriate groups/users at every stage in the design, review, and development of a policy, standards or service.
- ❖ The publication of the results of the EIA, including consultations and action plans is a statutory duty.

### Relevant legislation/policy

Race Relations (Amendment) Act 2000

### Origins of the assessment

Wandsworth Teaching PCT developed the Equality Impact Assessment (EIA) to help it review existing functions and policies for their impact or relevance to race and equalities in accordance with the statutory duty placed on the NHS under the Race Relations (Amendment) Act 2000.

An EIA is a way of systematically and thoroughly assessing, and consulting on, the effects that a policy, function, or strategy is likely to have on people. The assessment extends to monitoring the actual effects of the policy, once it is put into practice, and may include a test run. The EIA helps to pre-empt the possibility that a policy could disadvantage some groups on the grounds of race, disability, age, gender, sexuality, faith and language.

### EIAs:

- Ensure improvements in employment practice and in clinical activities
- Offer choice and more informed decision making
- Allow for effective targeting of policies and openness about policy and services
- Encourage meaningful dialogue with diverse groups during decision making
- Boost confidence in the PCT and minimise the risk of legal action

### There are two stages to an EIA:

**Stage 1** involves screening policy or legislative proposals to see if they are relevant to race and equalities. All policies, strategies should be screened.

**Stage 2** involves fully assessing policies identified as being relevant to make sure they do not disadvantage any groups.

### Consultations

A major aspect of an EIA is consultation with diverse groups to find out if a proposed or existing policy or service disadvantages them in any way, to what extent, and how that might be redressed. This means involving appropriate groups/users at every stage in the design, review, and development of a policy, standards or service.

Consultations can take the form of surveys, focus groups, questionnaires and interviews. But this approach may not be suitable for smaller vulnerable groups.

### Checklist

- What languages do your target groups speak?
- Is the venue accessible to people with disabilities?
- Will the venue make people feel comfortable?
- Is the group for consultation truly representative?
- Will the timings make it easy for the audience to respond?
- How do you intend to include 'hard to reach' communities?

### Consultations may reveal a:

- **Positive impact:** no action is required
- **Neutral impact:** the component is not likely to disadvantage any group but it does not promote equality of opportunity. It is then to check with directorate, users (where applicable) and partners if equality needs to be promoted within the component.
- **Differential impact:** different groups want different services and therefore the component may have a differential outcome. This is acceptable.
- **Negative impact:** consultations with relevant groups, legal experts, and appropriate partners will provide options for changing or reducing the impact of the policy, function, strategy or service.

### Tips on successful consultation

- Establish a relationship founded on trust
- Actively listen
- Ask people what they think
- Be careful to get the language and tone of consultation right
- Give people something they want
- Take your time, be flexible, and encourage honesty

### Monitoring and review

EIAs are the start of a continuous monitoring and review process. It is therefore important to put in place arrangements for monitoring the component and reviewing how it is/is not working. This will ensure that changes and recommendations arising from the EIA are achieved and that the expected outcomes are delivered.

Publication of the results of the EIA, including consultations and action plans is a statutory duty.

<b>Example: Wandsworth tPCT Template</b>	
<p><b>Type of component (policy, procedure or strategy)</b> Please do a separate one for each document. But if it interlinks with, or has an impact on, another component, do them together</p> <p><b>Version:</b> State if new or is planned</p> <p><b>Author(s):</b> If responsibility is shared with internal/external partners please state</p>	<p><b>Component:</b></p> <p><b>Version</b></p> <p><b>Authors:</b></p> <p><b>Date created:</b></p> <p><b>Next review:</b></p>
<p><b>Summary of aims</b> Consider any proposed changes to be made to an existing component. Ask why it is needed</p> <p><b>Summary of objectives and outcomes</b> Consider what it will achieve, how it will be applied, and by whom, who the beneficiaries are and how will they benefit</p>	<p><b>Aim:</b></p> <p><b>Objectives:</b></p> <p><b>Outcomes:</b></p>
<p><b>PHASE 1</b> <b>Initial screening for relevance</b> Evidence could be ethnic monitoring, public health evidence, complaints, consultations, patient feedback, research, national data, etc</p>	<p><b>Evidence used to establish relevance and a brief summary of what evidence tells us:</b></p>
<p>Confirm if component is relevant or not relevant to race and equalities duties:  ethnicity, disability, religion, age, gender, language, sexuality</p>	<p><b>Tick appropriately</b></p> <p><b>(A) Component has relevance to race and equalities: proceed to phase 2</b></p> <p><b>(B) Component has no relevance to race and equalities (sign off and process ends here)</b></p> <p><b>Director/Assistant Director sign off and date:</b></p>
<p><b>PHASE 2</b> <b>Interrogating evidence</b> Interrogate evidence further. If evidence is not sufficient consider other information: for example, further research or consultations As part of this process determine what the issues are likely to be: Translation services required?</p> <p>Is it to do with how and where services are delivered? Is it to do with who delivers the service or policy, how it is applied and managed? Is it a sensitivity issue and the needs of different cultures? Is it to do with eligibility criteria? Does it break equality legislation?</p>	<p><b>Details:</b></p>

<p><b>Consultations</b> Consult with groups likely to be affected by the outcomes of the policy</p> <p>Note that consultation must not be one off. It must be ongoing, part of your regular decision making process and part of monitoring arrangements (inbuilt process)</p> <p>It must not be tick box, and you must demonstrate to those you consult that you have taken their views on board, and included in action plans</p> <p>If you are not able to meet all needs, tell them</p>	<p><b>Details:</b> Internal/External State which groups, their involvement, and outcome of consultations:</p>
<p><b>The full effects/impact of the component</b> Do the data or consultations indicate that the policy has differential impact on particular groups? Please provide details</p> <p>Does it or could it, or is the perception that it could, exclude, disadvantage, or marginalise anyone?</p>	<p><b>Please summarise:</b></p>
<p><b>How does the component promote/not promote equality of opportunity?</b></p> <p><b>How does it/does not tackle unfair discrimination?</b></p> <p><b>How does it/does not promote good relations between diverse groups?</b></p> <p>Provide detailed information</p> <p>Note: if component does not promote equality of opportunity, if it discriminates and does not promote good relations, abandon it.</p> <p>If component or aspects promotes race equality, diversity, good relations and does not discriminate, please state clearly</p>	<p><b>Equality of opportunity</b></p> <p><b>Tackling unfair discrimination</b></p> <p><b>Promoting good relations</b></p>
<p><b>Consider the following as part of this:</b></p> <p>Could aspects of the policy be changed, take additional measures to reduce or remove impact without changing the policy's overall aims?</p> <p>Explore alternatives?</p> <p>How do we make sure in trying to achieve equality for one group, others are not excluded or disadvantaged? Consult with groups.</p> <p>If you decide to go ahead with component irrespective of EIA, you will need to justify why</p> <p>Note: you can never justify direct discrimination according to the law. Indirect discrimination, however, could be justified</p>	

Continued...

<p><b>Are there any financial implications to this?</b></p>	<p><b>How will you finance and ensure that component promotes equality of opportunity?</b></p>
<p><b>Monitoring arrangements</b> This is not optional. All decisions must include monitoring arrangements to ensure that implemented policy is appropriate.</p> <p>If no monitoring information is available, or is not sufficient, put one in place to determine likely effects. Part of the monitoring may include consultations</p> <p>Monitoring must not just be on the basis of ethnicity alone, but on wider diversity</p> <p>Work with Public Health to collate appropriate evidence. Monitoring is useful in commissioning and distributing services equitably and must be done meaningfully</p> <p>As part of monitoring you may consider a pilot to see how policy works and use this to inform the assessment process or improvements to the policy. Be clear on information to be gathered, from whom, and the timescales</p> <p>Consider how the effects on equality of opportunity and good relations will be monitored</p> <p>Who will be responsible? How often will you visit the evidence to ensure that the policy is non-discriminatory and achieving its desired outcomes?</p>	
<p><b>Important Information</b> Once a component has been assessed for relevance to race and equalities, or has been equality proofed, please state clearly within the actual document that this has happened, the actions taken, and the date</p>	<p>Confirm that the component has been equality proofed and that the following actions taken/will be taken within a given timescale to minimise impact identified</p> <p><b>Director/Assistant Director sign off and date</b></p>

## 10. Monitoring and evaluation

This section covers what's involved, including: monthly activity reports; generic patient surveys and clinical audits; focus groups and population based audits; the Standards for Better Health Declaration; Health Equity Audits; and alternative sources of data

### Key points

- ✦ Sound processes for monitoring and evaluating the clinical and cost effectiveness of commissioned services and for understanding who is actually accessing healthcare are essential.
- ✦ Comprehensive evaluation will identify commissioning decisions that have produced unintentional inequities and pinpoint where and how change needs to be made.
- ✦ Comprehensive evaluation will provide vital information on predicting future need, costs, and where best to target preventive measures.
- ✦ Only systematic monitoring, broken down by ethnicity, disability, age and gender, can really show exactly how health services are being used, and by whom.
- ✦ As an essential first step, health equity audits need to record patients' ethnicity, avoiding over-reliance on the use of 'other', which is the most frequently recorded category currently used.

### Relevant policy

Choose and Book: Patients' choice of hospital appointment and booked appointments – policy framework. Department of Health August 2004.

*Leadership and Race Equality Action Plan* Department of Health February 2004.

### What's involved?

The process of monitoring and evaluation is continuous, but there are specific activities, which need to be carried out. These vary according to the type of service being commissioned. Commissioners should understand the equity issues in relation to all policy initiatives, such as Choose and Book, and all types of services being commissioned.

#### These include:

- Primary care
- Emergency care
- Hospital services, including independent sector providers
- Dental care
- Eye care
- Screening programmes
- Immunisation programmes

Although certain groups may be more prone to particular diseases or conditions, equity of access is not a given. Specifically commissioned services for some groups are essential if health inequalities are to be eliminated. It is important to identify what information needs to be collected and how it will be evaluated.

Universal hospital services, which absorb most commissioning resources, are the most difficult to monitor and evaluate for their differential impact. The new electronic patient record system may help to change this.

### Case study: Evaluating a specifically commissioned service

Bradford City PCT is located in an area of high deprivation, with a large percentage of ethnic minority communities in the population. It is one of nine such PCTs participating in the Diabetes, Heart Disease and Stroke (DHDS) Prevention Project.

#### Each PCT works closely with three general practices focusing on people aged 40 and over to:

- Screen 90 per cent of those considered to be at high risk of developing diabetes, based on either a prior diagnosis of cardiovascular disease, and /or a body mass index (BMI) more than or equal to 25kg/m<sup>2</sup>.
- Enhance the identification, care, and treatment of people with cardiovascular disease and diabetes, as outlined in the National service Frameworks (NSFs).

In Bradford, the aim is to screen all those aged 40 and over, regardless of BMI, on the grounds that a BMI of  $\geq 25\text{kg/m}^2$  misses out many patients of South Asian origin who may be at risk.

Patients are invited to a specific DHDS clinic run by a health care assistant or practice nurse, or they are seen at a chronic disease review for cardiovascular disease. If the finger-prick test shows that their blood glucose is  $\geq 6.0$  mmol, they are referred for an oral glucose tolerance test.

All newly diagnosed diabetic patients are placed on the practice diabetes register so that they can be referred to specialist services, such as podiatry, etc. And they are given lifestyle advice about healthy eating, exercise, and smoking cessation, where applicable.

A template is completed for each patient in the project, so that full evaluation can be carried out when the screening phase of the programme has been completed.

But whatever is being monitored, or how often, the same data analysis cycle applies.

#### This comprises:

- Receipt of raw data
- Assessment of data quality
- Analysis against commissioning objectives
- Evaluation against desired outcomes
- Identification of required changes to service and new specification
- Specification of new data needs

**Tip:** Use direct and client-specific patient surveys to gain recent experiences of acute and other services. The Wandsworth tPCT survey: *How Was it for You (2005)* asked questions of patients who use its secondary care services.

### Monitoring

Information on commissioned services will come from various sources. Its usefulness will depend on how often it is supplied and the specificity of the questions it is designed to answer.

#### To promote race equality you need to ask these questions:

- Are all sectors of the population accessing services appropriately?
- Is the experience of those services different for different groups, and if so, why?
- Are those services equally effective in improving health outcomes?

### Monthly activity reports

Although frequent and reliable, the information in the reports that most commissioners receive is insufficient to assess how BME communities are accessing services.

The information from these reports can generally be broken down into specialty, age, gender and postcode, but the data on ethnicity often contains too many 'uncoded' fields. Commissioners need to encourage their providers to follow the standards set by the Department of Health.

Monthly activity reports on access to services, broken down by ethnicity against sound indicators, may be possible with the roll out of the electronic patient record and local co-operation on data quality and reporting standards. This would mean that unforeseen problems could be detected early and dealt with swiftly.

### Generic patient surveys and clinical audits

Generic patient surveys may contain good information on ethnicity, and offer some general pointers, but may not be fully representative. The questions relating to satisfaction with services are too general to guide commissioners on which services need to be changed, and how.

Similarly, clinical audits can give excellent results on patient outcomes. But they are usually specific to a clinical area and don't often take ethnicity into account. They are rarely conducted on a population basis, but if commissioners and provider organisations were to encourage this, then they could be a rich source of data.

### Focus groups and population based audits

Targeted focus groups provide the most comprehensive information on the acceptability, accessibility, and effectiveness of services. But again, it is important to think about the questions that need to be answered.

Their drawback is that they cannot provide concurrent, comprehensive information, although they are the most effective way of assessing user experience of specific services and how those need to be changed.

### Standards for Better Health Declaration

These set out how the organisation plans to meet the Healthcare Commission's required core and developmental standards. Commissioners need to clarify with providers how they intend to scrutinise these declarations challenge their robustness and implementation. The Healthcare Commission will assess PCTs on ethnicity monitoring for acute care.

### Case study: Ethnic monitoring in Bradford

To improve the standard and quality of the information being collected, Bradford City Teaching PCT has encouraged their 42 general practices to adopt a common patient information system that makes the collection of ethnicity data easier.

A project team drawn from across the PCT identified a common dataset for ethnicity profiling. This is collected in a standardised format using an electronic template on the practice clinical system.

The data will be collected using the central reporting features of SystemOne, the principal system used in Bradford City tPCT. The ethnicity profile will then be used to overlay existing disease registers to provide 'intelligent data' from which, for the first time, 'intelligent information' can be produced.

**Tip:** Profiling data can be used to assess demand for facilities that will help improve access, such as translation and interpreting services and wheelchair access.

### Evaluation

All PCTs have a statutory duty to ensure that services, policies and functions do not discriminate on the grounds of race, creed, or gender. Equality Impact Assessments and Health Equity Audits are useful ways of ensuring that services are being scrutinised appropriately.

Health Equity Audit (HEA) can be used to help service planners narrow the health gap. It does this by examining the current distribution of services or other resources in relation to the health needs of different groups and areas and then planning changes where inequities are found. The overall aim is to distribute resources relative to health need.

#### The stages of the HEA are:

- 1 Agree partners and issues
- 2 Equity profile: identify the gap
- 3 Identify how to narrow the gap
- 4 Agree priorities
- 5 Secure changes in investment and service delivery
- 6 Review progress and assess impact

There may be overlaps between Equality Impact Assessments and Health Equity Audits (See Health Service Improvement Guide).

The information gathered in these audits can then be used to build the evidence needed to inform timely action to improve access to effective and culturally appropriate services for those in most need and so prevent ill health and premature death.

**Fact:** The prevalence of diabetes is significantly higher in Black Caribbean, Indian, Pakistani and Bangladeshi men and women than in the general population.

### Where else to look

Given how little good quality information commissioners receive to help them fully understand the impact of their decisions on health equity, it is worth looking elsewhere for bespoke information.

The Association of Public Health Observatories produces reports which highlight where certain ethnic minority groups have worse health indicators, although not access to services.

The size of ethnic minority populations varies substantially across regions, so commissioners need good quality local information to set indicators.

In spite of the mainstreaming of ethnicity monitoring, very few routine health datasets are coded by ethnicity. And there are virtually no ethnicity data in primary care or in birth and death registers. Furthermore, there are no uniform classifications of ethnicity. This is a national problem, which must be addressed.

Other clues may come from local or national specific audits. The hardest hitting information shows differential outcomes by ethnic grouping for local services.

#### Examples currently proving useful are:

- Cancer survival rates
- Cardiovascular disease survival rates
- Diabetes control – amputation rates
- Severity of condition at presentation to services
- Measures of mental health

#### Case study: Heart failure testing in Lambeth PCT

Lambeth PCT carried out a health equity audit in Lambeth in 2004, highlighting how heart failure remained under-diagnosed in the borough. A review of emergency care visits showed that a large proportion of patients were being diagnosed with heart failure rather than by their own GP. GPs also reported that they found it difficult to diagnose.

To improve the diagnosis of heart failure in primary care, a test was provided (NT pro-BNP) for general practices across the PCT. If the test is negative it is unlikely that the patient has heart failure and that another diagnosis will be needed. If the patient tests positive, the patient should then be referred on for an echocardiogram to get a full diagnosis. Cut off values for a positive or negative test are based on national evidence.

A set of guidelines on when to refer and on issues around breathlessness, as well as a resource pack around the diagnosis of heart failure, have now been developed. These have been sent to local practices in Lambeth and include: An event was held to inform practice staff about how to use the test and its importance in the diagnosis of heart failure.

The new service is now being evaluated to assess its impact.

#### Using this information for service redesign

Evaluation processes aim to highlight where services are failing to meet the needs of all clients.

#### Information from them can be used to:

- Revise planning processes
- Identify demand management requirements
- Adjust service specifications
- Redesign patient pathways
- Decommission services.

In short, the evaluation informs needs assessment, which starts the commissioning cycle.

#### Case study: Improving access to cancer services (CHEC)

The Cancer Help for Ethnic Communities (CHEC) service was set up in June 2002 with joint Lottery and PCT funding to improve access to cancer services for BME communities living in Bristol, North Somerset, and South Gloucestershire.

Based on national data on cancer diagnoses, research on the needs of BME groups with cancer and the barriers to access and support, it became clear BME patients in the locality were not accessing services and were often presenting late. Significant cultural barriers meant BME patients had little support at all stages of their illness.

CHEC services are based on needs identified by patients, carers, voluntary sector and health and social care staff. Focusing on caseload and development work, CHEC works in partnership with existing services and each stream of work informs the other. It provides

- A needs based service including emotional, practical and language support, signposting and advocacy, which is run in partnership with other service providers
- Training for social and healthcare professionals in cancer and diversity
- Outreach to raise awareness of cancer, screening and other services available in the community
- Service users with a voice in the BME Cancer Forum (part of the local cancer network user involvement programme), St Peter's Hospice BME Advisory Panel
- Influence on partnership working to develop equitable access to services

## Checklist

- Think about all your data sources: what information do you receive?
- What inequalities are you aware of now? What haven't you got?
- How are these being managed? What do you do with the information you receive?
- What further information could be generated?
- Does your PCT equality and diversity policy include an equality impact assessment process?
- What health outcome measures would be useful to you?
- How are you going to obtain this information?
- What process do you have for feeding these findings back into service specifications and future monitoring?

## Useful resources

*A practical guide to ethnic monitoring in the NHS and Social Care*. Department of Health July 2005

The Association of Public Health Observatories (*APHO Indications for Public Health in the English regions, issue 4: Ethnicity and Health*), available at: [www.erpho.org.uk](http://www.erpho.org.uk)

Cancer Statistics registrations: *Registrations of cancer diagnosed in 2001, England*.

*Series MB1 no.32. 2004*, Office for National Statistics

Lodge N The identified needs of ethnic minority groups with cancer within the community: a review of the literature. *European Journal of Cancer Care* 2001; 10: 234–44.

Deepak N. *Beyond The Barriers: providing cancer information and support for black and minority ethnic communities: a report*. Cancer BACUP; 2004.

*Ethnicity Monitoring: Benefit*, Office of the Deputy Prime Minister January 2004.

*Ethnic Group Statistics. A guide for the collection and classification of ethnicity data*.

Office for National Statistics 2003

## 11. A summary of relevant equality legislation

The following summary is taken from *Promoting Equality and Human Rights in the NHS: A guide for non-executive directors of NHS boards*, published by the Equality and Human Rights Directive of the Department of Health in July 2005.

### 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.

### 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).

### Sex Discrimination (Gender Reassignment) Regulations 1999

These regulations are a measure to prevent discrimination against transsexual people on the grounds of sex in pay and treatment in employment and vocational training. They effectively insert into the Sex Discrimination Act a provision to extend the Act, insofar as it refers to employment and vocational training, to include discrimination on gender reassignment grounds.

### 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
- Says that all UK legislation must be given a meaning that fits with the Convention rights, if that is possible

### 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.

### The Sex Discrimination Act (as amended) 1975

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

### The Equal Pay Act (as amended) 1970

This 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 related as equivalent under an analytical job evaluation study; or work that is proved to be of equal value.

### 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 a specific duty of the 2005 Act. The specific duty 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 will come into force in December 2006.

### The Equality Act 2006

#### The main provisions include:

- The creation of the Commission for Equality and Human Rights (CEHR) which 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 will be defined in the Bill
- To make unlawful discrimination on the grounds of religion and belief in the provision of goods, facilities and services, education, the use and disposal of premises, and the exercise of public functions
- 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 government has also announced forthcoming legislation to outlaw discrimination on the grounds of age by December 2006.

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