



# Age Equality in Health and Social Care

*A Report on the Consultation*

## Age Equality in Health and Social Care, a Report on the Consultation

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# Age Equality in Health and Social Care

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## 1. SUMMARY

1.1 This is a report on the consultation that the Department of Health (DH) conducted from November 2009 to February 2010 on age equality in health and social care.

### *Background*

1.2 In April 2009, the then Secretary of State for Health asked Sir Ian Carruthers OBE (Chief Executive of NHS South West) and Jan Ormondroyd (Chief Executive of Bristol City Council) to consider what the new measures on age in the Equality Bill would mean for health and social care. The report of their review was published in October 2009<sup>1</sup> and made twenty-eight recommendations. Some of these recommendations were concerned with legislation. The remainder dealt with action that DH, and the National Health Service (NHS) and social care more generally, should take to prepare for the introduction of the new public sector equality duty and of the ban on age discrimination.

1.3 DH published a consultation paper in November which invited views on the review's non-legislative recommendations and DH's proposals for taking them forward. DH also published an Impact Assessment and Equality Impact Assessment, and invited comments on these. Four consultation events were held across England which provided an opportunity to discuss the proposals in the consultation paper.

### *Responses*

1.4 Over two hundred people attended the consultation events, and around ninety written responses were made to the consultation paper. In general, the responses were supportive of the proposals. (Fuller information about the comments made is set out in chapters 4-7 of this report). DH is grateful to all those who helped to develop thinking on how to take the proposals forward.

### *DH position*

1.5 The table at Annex A sets out the position DH has reached on the proposals that called for action by DH. The other proposals called for action by other bodies, and the DH position on them is covered in chapter 7.

### *Scotland and Wales*

1.6 This report is concerned with action in England. The Equality Bill applies throughout Great Britain. The Scottish Executive and the Welsh Assembly Government are considering separately what action to take to prepare the NHS and social care in Scotland and in Wales for implementation of the Equality Bill.

### *Next steps*

1.7 DH plans now to take forward the actions set out in Annex A, in preparation for implementation of the measures on age in the Equality Bill.

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<sup>1</sup> *Achieving age equality in health and social care*, available at [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH\\_107278](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_107278)

## 2. THE WRITTEN CONSULTATION

2.1 The consultation was run in accordance with the Government Code of Practice on consultations.

2.2 The consultation ran for twelve weeks, from 23 November 2009 to 15 February 2010. Around ninety responses were received by 1 March 2010 (two weeks after the formal deadline for responses) and we have taken these into account in preparing the summaries of responses in chapters 4-7. (If any later comments are received, we aim to bear them in mind in taking the work we plan forward).

2.3 The responses came from local government, the NHS, the third sector, regulators such as the Care Quality Commission (CQC) and the Equality and Human Rights Commission (EHRC), health professional bodies and unions, and others, including some individuals. (Annex B lists those who responded, grouped according to the sector we understand they are in). Several responses came from the South West, perhaps reflecting the interest generated by the review, which was based there. We were pleased that responses came from each of the sources that we thought had an interest in the proposals, and we are grateful to all the respondents for helping to develop our thinking.

### *Form of responses*

2.4 Around half the responses used the response form provided on the DH website and around half did not. Some organisations held meetings or events on the consultation and provided us with a summary of comments made. Some provided related articles or publications written by members of their organisation. We took comments into account whatever format was used.

### *Comments on the impact assessment and equality impact assessment*

2.5 No comments were received on the impact assessment published alongside the consultation paper. DH has not identified any reason to change the assumptions, figures or analysis and appraisal of the policy options considered in the impact assessment.

2.6 Some comments were received on the equality impact assessment published alongside the consultation paper. These are summarised in Annex C.

### *Diversity*

2.7 The response form invited those who were responding as individuals to provide some information about themselves, to help DH monitor the diversity of those replying (for example, in terms of age, gender, and ethnicity). However, few responses came from individuals, and few provided this information. We were pleased, however, that responses came from third sector organisations that represented both ends of the age spectrum (on the one hand, Young Equals, and on the other hand, various bodies representing the interests of older people), and also from bodies that represented people from minority ethnic backgrounds.

### *Complaints about the consultation process*

2.8 We received one complaint about the consultation process, which was that Local Involvement Networks (LINKs) were not included in the target audience. However, they were included in the list at Annex B of the consultation paper (which listed the bodies to which the consultation paper was being sent), and we are grateful for the responses we received from LINKs and the contributions they made at the consultation events.

2.9 Some responses included comments on the consultation process:

i) a small number thought the consultation paper too long, and the questions it posed too many or unclear.

The length of the consultation paper, and the questions it posed, were largely determined by the fact that the review's report made twenty-eight recommendations and the purpose of the consultation was to seek views on these. We will continue to keep in mind the importance of making documents accessible to all those likely to have an interest in them. The response form emphasised that there was no need for respondents to respond to all the questions.

ii) one respondent thought the questions in the response form were too directive.

However, the response form stated "you do not need to use this form – if you prefer you can write to us setting out your response in whatever way is easiest for you".

iii) the Local Government Association (LGA) were concerned that they were omitted from the list at Annex B of the consultation paper.

We apologise for this omission, which was not intentional, and are grateful for the response LGA sent jointly with the Association of Directors of Adult Social Services (ADASS).

### 3. CONSULTATION EVENTS

3.1 Four consultation events took place across England during January and February 2010. These were in Birmingham, Bristol, London and Leeds. Those who attended came from the NHS, the third sector, local authorities, regulators and health professional bodies. In total, 255 people attended the events. 103 people gave feedback on the events. Of these 99 rated the events as excellent or good, and 4 as fair.

3.2 Each event introduced the purpose of the review's report and of the resulting consultation. There were presentations on particular topics, and a panel discussion where experts took questions from the floor.

3.3 To generate input into the consultation, two workshops were held during the day, which all those attending were encouraged to attend.

3.4 Workshop one focused on the recommendations of the review's report and provided an opportunity to:

- a) comment on the recommendations, including on the approach to exceptions;
- b) identify which recommendations were of greatest importance;
- c) suggest any amendments; and
- d) highlight any omissions in the recommendations.

3.5 Workshop two focused on local preparation and implementation and the resource pack. It provided opportunities to:

- a) comment on the recommendations in the review's report that related to local implementation;
- b) discuss how localities could prepare for 2012;
- c) comment on the structure and approach being developed in the resource pack recommended by the review (see Proposal 8).

#### *Key points*

3.6 A range of opinions were expressed on which recommendations and proposals were of greatest importance. However, several areas came up consistently. These were:

- leadership and culture (Proposal 15);
- training and support for staff including attitudes as well as knowledge and skills (Proposal 20);
- resource allocation to Primary Care Trusts (PCTs) and local authorities and the resource allocating system for individual social care users (Proposal 7);
- commissioning, specifically about where public authorities could change the actions, behaviour and rewards for service providers and develop a good understanding of local needs (Proposal 11); and

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- the importance of preventative services for people of all ages (Proposal 19).

### 3.7 Other comments made at all the consultation events included:

- support for the age discrimination ban to come into force in health and social care in 2012, at the same time as in other sectors;
- the need for a change in the attitudes of those working in health and social care. This was pivotal in tackling age discrimination but would take time to achieve.

### 3.8 Other comments included:

- there is a need to be evidence-based in developing screening programmes and other interventions;
- older people are often too easily satisfied with services and don't challenge them enough – although there is a generational shift under way;
- local authorities tend to categorise by age and PCTs by condition. Integrating services when there are such differences in basic categories is a real challenge;
- it is important to ensure that staff in the health and social care sector are able to challenge discrimination.

3.9 We have taken the comments made at the consultation events into account in arriving at the DH position on each of the individual proposals set out in chapters 4-7 of this document.

## 4. LEGISLATION

### Proposal 1: Timing of the ban on age discrimination

4.1 The consultation paper noted that the age equality review recommended that the Government should ban age discrimination against adults in health and social care from the same date as in other services and public functions. Subsequently, the Government confirmed (in January 2010) its intention of bringing the ban into force in all sectors, including health and social care, in 2012.<sup>2</sup>

4.2 The consultation paper invited comments on the timing the review had proposed for the ban. It asked, in particular:

- Is there further action, additional to that outlined in the consultation paper, that needs to be taken to prepare health and social care for implementation of the ban on age discrimination?
- Is there any action that needs to be completed by a particular date to ensure that implementation happens smoothly?

*The date for commencement*

#### Responses

4.3 The consultation paper did not ask when the legislation should be commenced, but sixteen responses expressed a view on this. These responses came from:

- the third sector (Young Equals, the National Pensioners Convention (NPC), the Civil Service Pensioners Alliance (CSPA), the Greater London Forum for Older People (GLF), and Equality South West on behalf of the South West Age Equality Network);
- local government (ADASS/LGA in a joint response, and three others);
- the NHS (three PCTs);
- regulators (EHRC and CQC); and
- Unite.

4.4 These all supported implementation of the ban on age discrimination in health and social care in 2012, at the same time as in other services. The arguments put forward in favour of 2012 included the following:

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<sup>2</sup> See chapter 5 of *Equality Bill: Making it work: Ending age discrimination in services and public functions, Policy statement*, published January 2010 and available at: [http://www.equalities.gov.uk/news/age\\_consultation.aspx](http://www.equalities.gov.uk/news/age_consultation.aspx)

- it was important to give people rights at the earliest opportunity (Young Equals, NPC, CSPA);
- 2012 fitted well with other initiatives under way in health and social care (GLF, a local government response);
- the NHS should be leaders in banning age discrimination (a PCT); health and social care were the areas where older people would gain most from implementation of the age measures in the Equality Bill (Saga);
- a unified commencement date across all sectors would help focus stakeholder engagement, avoid potential confusion, and assist those producing statutory and non-statutory guidance on the new law – “including ourselves” (EHRC). It would ensure a joined up approach for people using the services and their carers (CQC).

4.5 No response argued against the date of 2012. However, some of those who supported 2012 noted that it would pose challenges:

- ADASS/LGA argued “Much will depend on agreeing the detail of a fully costed implementation plan for social care and the NHS”;
- CQC said “this process cannot be rushed. Due to the challenges arising from the way health and social care services are structured and commissioned and the need to win hearts and minds, the implementation process will require substantial effort and resources”;
- one local government response said that, although care packages created from 2012 would be equal, it would be harder to achieve equality in care packages created before that date;
- GLF thought that the 2012 Olympics might distract some, particularly the boroughs involved, from a focus on ending age discrimination.

4.6 Saga feared that the Government might have decided to move implementation of the public sector equality duty back from April 2011 to 2012.

### DH position

4.7 DH wants to see age discrimination in health and social care eradicated as soon as possible. It therefore welcomes the support expressed for commencing the ban on age discrimination in health and social care in 2012, at the same time as in other sectors. Ending age discrimination and promoting age equality have been aims of DH policy since publication of the National Service Framework for Older People in 2001, and there is no need to wait until the legislation is commenced before taking further action to achieve them. To help health and social care make further early progress in these areas, *The Operating Framework for the NHS in England in 2010/11*, published in December 2009, highlights the fact that “NHS organisations need

to take account of *Achieving age equality in health and social care*, the report of the review led by Sir Ian Carruthers and Jan Ormondroyd<sup>3</sup>.<sup>3</sup> The resource pack (see Proposal 8) will support NHS bodies and local authorities in making their own plans for implementation, bearing in mind that, as explained in the impact assessment published with the consultation paper, where costs arise, money will need to be reallocated from existing activities. We will keep in mind the other points recorded in paragraph 4.5 above in considering how to support the implementation process. On the point recorded in paragraph 4.6, the Government's intention to implement the public sector equality duty from April 2011 has not changed.

### *Further action to be taken*

#### Responses

4.8 Forty-three responses commented on whether there was further action, additional to that already outlined in the consultation paper, that needed to be taken to prepare health and social care for implementation of the ban on age discrimination.

4.9 Twenty-four said no further action was needed. Of these responses:

- seven came from the third sector (three LINKs, NPC, CSPA, Help the Hospices and NACRO);
- nine from local government and one from a local authority jointly with a PCT;
- three from the NHS (two PCTs and one NHS Trust);
- three from health professional bodies and unions (the British Geriatric Society, the Nursing and Midwifery Council, and the Royal College of Physicians and Surgeons of Glasgow (RCPSG)); and
- one from an individual.

4.10 Six of these responses nevertheless mentioned actions that could be taken. One PCT suggested more consultation – but another said “More can always be done to prepare for implementation but will delay the implementation date”. A LINK emphasised the need to pay attention to child-to-adult transition issues. One local government response called for financial modelling, another for preparation of a short summary of the key issues and of more detailed guidance on the new legislation, and a third for engagement nationally with service users and carers to inform them of the new legislation – although it recognised that this was an issue that went wider than health and social care.

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<sup>3</sup> Paragraph 1.8 of [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_110107](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107)

4.11 Of the nineteen responses that said further action was needed:

- five came from the third sector (a LINK, Breast Cancer Care, Croydon African Caribbean Family Organisation (CACFO), the Council of Ethnic Minority Voluntary Sector Organisations (CEMVO), and Young Equals);
- seven from local government;
- three from the NHS (all PCTs); and
- others from the Royal College of Psychiatrists, CQC and two individuals.

4.12 Of these nineteen, two did not say what further action they thought was needed, while two suggested a review of all screening programmes, and of the breast cancer screening programme in particular.

4.13 Of the others who said further action was needed, four raised cross-cutting issues relevant throughout the health and social care systems:

- there was a need to guard against multiple discrimination, for example because of age and race (CACFO, CEMVO);
- it was important to involve user organisations led by older people (a local government response);
- the Royal College of Psychiatrists were concerned about unintended consequences of the legislation. They said “this is our most important comment to make. Trusts and PCTs should prepare an impact statement for implementing the ban and describe how they will ensure that implementation does not result in inadvertent loss of age-appropriate services. Specific guidance should be issued that specialist services for older people should not be disrupted or disinvested in as a result of the new legislation. [...] The legislation will be counterproductive if it leads to a loss of specialist care for older people: this should be made crystal clear to commissioners”.

4.14 Seven responses focused on action to be taken primarily at national level, calling for:

- a long-term strategy “which is co-produced and provides a joined up approach to targeting leadership, workforce and the supportive mechanisms to drive this important agenda. We suggest a further study into the barriers for health and social care services in implementing the ban and developing a phased plan to target this area” (CQC);
- additional guidance, or guidance in particular forms. In particular, guidance should cover young adults, as well as older people (Young Equals) and identify good practice sites (a local government response);

- a training package that could be used locally (a PCT);
- awareness raising (two responses – one from local government, one from a PCT) and for easy-read material that could be used to alert all stakeholders to the coming changes (a local government response).

4.15 Two local government responses said that authorities would need to review all their policies and procedures, to ensure that they were lawful, and another said there was a need for an implementation plan whose delivery would be monitored.

### DH position

4.16 DH welcomes the thought that respondents have given to whether further action is needed. In particular:

- we agree that it is important for all those involved to tackle the issues of unintended consequences, user involvement, and multiple discrimination identified in paragraph 4.13. We will bear in mind these issues, and the points made about the nature and content of guidance (including guidance on young people and transition issues) and training packages, in the work we undertake to support health and social care (for example, in taking forward Proposal 8);
- the action requested on screening is considered under Proposal 7;
- we agree that there is a need to raise awareness amongst the public generally, and service users and carers in particular, about the new rights the Equality Bill will give them. Part of this task falls to EHRC, but we intend to work with them to ensure that appropriate material is included, for example in NHS publications. The NHS Constitution already refers to the right not to be unlawfully discriminated against, and the Handbook to the NHS Constitution will be updated in due course;
- individual bodies are best placed to act on some of the issues identified, for example, identifying what changes they need to make and undertaking any related financial modelling.

### *Action to be taken by a particular date*

### Responses

4.17 Thirty-eight responses replied to the question whether there was action that needed to be taken by a particular date. Of these responses,

- ten came from the third sector (three LINKs, NPC, CSPA, GLF, Breast Cancer Care, CACFO, CEMVO and NACRO);
- fifteen from local government (one jointly with a PCT);
- six from the NHS (five PCTs and an NHS Trust);

- three from health professional bodies (the British Geriatric Society, the Nursing and Midwifery Council, and RCPSG); and
- one from Saga and three from individuals.

Of these, eighteen said no further action was required, while seventeen said further action was required: several of these added extra comments. Three others commented without ticking either the yes or no box on the response form.

4.18 The comments made often made similar points, regardless of whether their authors had ticked yes or no. The majority emphasised that guidance needed to be made available in good time. This point was made in responses from the third sector (Breast Cancer Care, GLF), local government (three responses), and the NHS (two PCTs). Several argued that guidance, from EHRC and/or DH, needed to be available more than three months before the implementation date, for example, because of the scale of change involved, and to enable it to be taken into account as local authorities implemented the Transformation of Adult Social Care. There were also requests for the resource pack (see Proposal 8) to be made available as soon as possible.

4.19 In addition, there was support for early progress on awareness raising, particularly amongst staff (a LINK, a PCT, and two local government responses, one jointly with a PCT).

4.20 Other areas where early progress was thought important were:

- establishing what specific exceptions, if any, would apply (a PCT);
- joint working between local authorities and the NHS, as proposed in the review's recommendation 19 (a local government response);
- the implications of any framework for the National Care Service (CEMVO).

#### DH position

4.21 DH is grateful for the thought that respondents have given to whether particular action is needed by a particular date. We agree it is helpful if guidance and other supporting material (for example, to help awareness raising) is made available sooner rather than later: we shall draw this to the attention of EHRC, with whom the Government is already working to ensure that guidance is delivered well in advance of the commencement of the provisions in the Equality Bill. We shall also bear it in mind in our own further work on guidance. A final version of the resource pack (see Proposal 8) is expected to be available in the first half of 2010.

4.22 For the position on exceptions and joint working, see the discussion of Proposals 2 and 16 later in this report. DH is taking account of the implications of the age legislation in its work on the National Care Service.

### **Proposal 2: Exceptions**

*The review's recommendation 6*

4.23 The consultation paper recorded DH's agreement with the review's conclusion (its recommendation 6) that areas of health and social care should not be removed wholesale from the scope of the ban on age discrimination.

Responses

4.24 The consultation paper did not pose any specific questions about the review's recommendation 6, but nine responses agreed that no areas of health and social care should be removed wholesale from the scope of the ban on age discrimination. These responses came from:

- CQC, Age Concern/Help the Aged, the Royal College of General Practitioners and Unite;
- local government (ADASS/LGA and two others); and
- the NHS (two PCTs).

No response argued against recommendation 6.

DH position

4.25 DH welcomes the support for the review's recommendation 6. The Government's position has since been confirmed in paragraph 2.24 of the policy statement published by the Government Equalities Office (GEO) in January 2010, which says:

We fully accept that recommendation. We want health and social care to be within the scope of the equality legislation and subject to the disciplines it imposes.

*The review's recommendation 7*

4.26 The consultation paper noted that the review had also recommended that "The Government should consider further whether any more specific exceptions are needed for health and social care" (recommendation 7). The consultation paper explained that the Government's thinking on this would be set out in a policy statement, which subsequently appeared in January 2010.

4.27 Paragraph 2.31 of the January 2010 policy statement explains that:

As recommended by the age equality review, we want to consider further the arguments [for] and against the options of i) relying on objective justification alone or ii) having some specific provisions as well. We want to do this in an open way that allows those outside Government to contribute their views. In considering the options, we have an open mind and are neither advocating nor rejecting the possibility of such provisions.

4.28 The policy statement went on to explain, in particular:

- what any such provisions would be intended to achieve (paragraph 2.32);
- that if they were created, that would happen only where there is a clear need for them to support the appropriate use of age in health and social care, and that it would be essential to ensure that they would not be a licence to discriminate, or perceived as such (paragraph 2.33);
- that consultation on a draft Order later in 2010 would enable all those with an interest to compare the merits of i) relying on objective justification alone and ii) creating particular exceptions to support the delivery of effective and personalised services (paragraph 2.38).

### Responses

4.29 The consultation paper did not pose any questions about the review's recommendation 7, but twenty responses, again from a variety of sources, commented on whether specific exceptions should be created. Several made the point that it is sometimes right to treat people differently because of their age, and that the legislation should not discourage or prevent this. However, there was a range of views on the best way of achieving this:

- seven responses saw no need for exceptions, and in some cases thought that they would undermine the aim of the ban on age discrimination (NPC, CSPA, Regional Action and Involvement South East, and a LINK; two local government responses; and Unite);
- two responses (Help the Aged/Age Concern and EHRC) did not see exceptions as necessary. In addition:
  - Help the Aged/Age Concern said that in principle there were circumstances in which exceptions would be acceptable (firstly, “where a practice is objectively justifiable BUT it is thought desirable to enshrine that in legislation to prevent legal uncertainty and the harmful consequences of risk-averse decision making”; secondly, where “a practice is not objectively justifiable, but still thought to be desirable”);
  - EHRC said that the objective justification test was well established under discrimination law, and guidance, including from EHRC itself, would be available to assist service planners and providers in deciding whether a particular age-based approach was lawful or not. They did not see exceptions adding to legal certainty, or the lack of them having a “chilling effect” (that is, deterring service providers from providing different services for people of different ages where it was appropriate to do so);

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- Equality South West also thought that “if possible, specific exceptions should be avoided”;
- of the other responses, three indicated support for the Government’s plan to do further work on whether exceptions should be created or not (CQC, ADASS/LGA, a PCT);
- others emphasised points to bear in mind in carrying out the further work. In particular, the need for transparency and clarity was stressed (CQC, Equality South West, PohWER, and GLF). Exceptions should be used sparingly (one PCT), should be the subject of consultation (another PCT), should be created only where there was a need for them and should be kept under review (a third PCT).

### DH position

4.30 DH will bear the points made in mind in contributing to the further work outlined in the GEO policy statement. We also encourage all those with an interest to contribute to the Government’s work on whether to create specific exceptions for health and social care. As explained in the GEO policy statement, this can be done by:

- sending comments, by 30 April 2010, to [age@geo.gsi.gov.uk](mailto:age@geo.gsi.gov.uk) on what uses of age should be able to continue, by whom, and the legal way forward;
- taking part in the consultation planned for autumn 2010 on the draft Order.

## 5. MAINSTREAMING THE REQUIREMENTS OF THE EQUALITY BILL INTO THE DEPARTMENT OF HEALTH'S OWN PROCESSES

### Proposal 3: Understanding the requirements of the Equality Bill

5.1 The consultation paper asked:

Do you agree that DH and its executive agencies should write to their advisory non-departmental public bodies to alert them to the requirements of the Equality Bill and to the training and guidance that are available?

#### Responses

5.2 No response dissented from the proposal that DH should write to its advisory non-departmental public bodies (ANDPBs) along the lines suggested. Fifty-seven responses said that they agreed with the proposal. These responses came from:

- the third sector (Young Equals, NPC, CSPA, GLF, Gillingham Seniors Forum (GSF), CEMVO, CACFO, Equality South West, Breast Cancer Care, Help the Hospices, Sense, NACRO, and four LINKs);
- local government (seventeen responses);
- the NHS (six PCTs and one NHS Trust);
- health professional bodies and unions (the British Geriatric Society, British Medical Association, Nursing and Midwifery Council, Royal Pharmaceutical Society of Great Britain, RCPSG, Royal College of Psychiatrists, and Unite);
- regulators (CQC and EHRC); and
- Saga, the Fitness Industry Association, a consultancy and three individuals.

5.3 Some responses added further points to bear in mind about the content and timing of the guidance. In particular:

- the guidance on the public sector equality duty should make clear that the duty (unlike the ban on age discrimination in services and public functions) applies to children (Young Equals);
- DH's internal information and training should cover age equality for people with dual sensory loss (Sense);
- guidance and training should be available before the legislation came into force (the Royal Pharmaceutical Society of Great Britain);

- it was important to clarify the relationship between equality legislation and human rights legislation (the Fitness Industry Association).

5.4 EHRC suggested that in taking forward the proposal, DH and its executive agencies should:

- assess the ongoing impact this approach would have on practice changes;
- promote the listing of the ANDPBs for the general and specific duties;<sup>4</sup>
- consider the impact on equality of any advice that DH and its agencies receive from the ANDPBs and choose to follow;
- take account of EHRC's recent public sector duty assessment of the Department of Work and Pensions through Jobcentre Plus. EHRC said "Of particular note, is the need to take a more strategic and joined up approach to Equality Impact Assessment in order to avoid duplication of effort and to ensure that equality considerations are factored in at the policy development stage. The Commission's new Equality Impact Assessment guidance can assist with this process".

5.5 Unite emphasised that the public sector equality duty should not be approached with a "tick box" mentality and made some comments on the specific duties that might be set to support better performance of the general equality duty.

5.6 Some responses argued that it was important for other bodies and services to tackle age equality too. These included "the transport advisory body" (suggested by a local government response) and housing and learning (suggested by a LINK).

### DH position

5.7 DH welcomes the support expressed for the proposal that it should write to its advisory non-departmental public bodies to alert them to the requirements of the legislation and to the training and guidance that are available. It plans to do this as soon as possible after the legislation receives Royal Assent.

5.8 These letters will be only part of a continuing dialogue between DH and its advisory non-departmental public bodies. In taking forward that dialogue, DH will bear in mind the points mentioned in paragraph 5.3 above.

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<sup>4</sup> This refers to the fact that the public sector equality duty in the Equality Bill applies to bodies listed in Schedule 19 to the Bill in relation to all their functions and that the Bill provides a power to impose specific duties (in secondary legislation) on those bodies. The duty in the Bill also applies to those carrying out public functions, in relation to those functions.

5.9 DH was interested to see the suggestions from EHRC recorded in paragraph 5.4 and will discuss them with the Commission. The Government Equalities Office plan a consultation later this year on which bodies should be listed in Schedule 19 to the Equality Bill for the purposes of the public sector equality duty.

5.10 DH has drawn Unite's comments on the specific duties that might be set under the general equality duty to the attention of the Government Equality Office, and the points about the relevance of housing, transport and education to the attention of the Departments for Communities and Local Government, Transport, and Business, Innovation and Skills.

#### **Proposal 4: Equality Impact Assessment**

5.11 The review recommended that:

DH and the wider system ensure the use of tools such as Equality Impact Assessments to ensure compliance with the age discrimination ban and the public sector equality duty in all new policies (Recommendation 21).

The consultation paper noted that existing requirements on equality impact assessments are linked to the specific duties currently set under the three existing public sector equality duties, and that the Government Equalities Office was expected to publish a policy statement on specific duties to be set under the new public sector equality duty in the Equality Bill. In the meantime, the consultation paper invited comments on the review's recommendation.

#### Responses

5.12 Fifty-three responses commented on this proposal. These came from:

- regulators (CQC and EHRC);
- the third sector (Young Equals, NPC, CSPA, GLF, Equality South West, Help the Hospices, Breast Cancer Care, NACRO, CACFO, and four LINKs);
- local government (nineteen responses);
- the NHS (seven PCTs and one NHS Trust);
- health professional bodies and unions (the British Geriatric Society, British Medical Association, Nursing and Midwifery Council, Royal College of Psychiatrists, RCPSG, Unite); and
- Saga, a consultancy and three individuals.

5.13 Forty-two of these responses confirmed their support for the use of tools such as equality impact assessments by ticking the "yes" box on response form; none ticked the "no" box. Several added some points in further comments.

5.14 Additional points made, specifically on equality impact assessments, were that:

- all new and existing policies and practices should be assessed for their impact on age equality (GLF). Age equality impact assessments should cover the impact on children as well as on adults (Young Equals, a PCT). Consulting trade unions would help to advance age equality in health and social care (Unite);
- the quality of assessments was currently variable: there should be more emphasis on training and supporting those carrying them out, and a greater emphasis on starting equality impact assessment earlier in the process (CQC). Equality South West also supported a focus on training, to ensure assessments did not become a “tick box” exercise because of a lack of awareness of equality and diversity issues;
- processes for carrying out equality impact assessment had become bureaucratic and had lost outcome-focus; a simpler approach was needed to ensure real change and an impact on age equality (a local government response). Screening for equality impact assessment worked well, but more detailed scoping was challenging, particularly in relation to consultation and involvement. There was a case for looking at a set of policies in the round (rather than individually) and for taking better account of related work, for example on health equity audits (a PCT); rigid application of set tools could be counterproductive (an individual);
- the aim should be to make minor changes to existing systems, rather than wholesale changes (a local government response);
- tools for equality impact assessment should be made available to voluntary organisations so that they could check progress on compliance (a LINK, GLF);
- one response described the steps a county council had taken to embed equality impact assessment and make sure it was an effective part of their processes.

5.15 Points made on tools more generally were that:

- equality impact assessments were only one tool; all the specific duties needed to be met to ensure compliance with the general public sector equality duty, and an assurance process, as suggested in Proposal 14, was essential. DH should alert the sector to all the relevant tools in its communications (EHRC);
- there were a number of tools in use at present, which could lead to inconsistency. It would be helpful if the tool kit (which we understand to be a reference to the resource pack considered in Proposal 8) could

be the driver of such assessments. The tool kit also needed to link into organisations' corporate impact assessment and other performance management processes (a local government response).

#### DH position

5.16 DH agrees with the review's recommendation. Implementation of this recommendation needs to take account of, and will be supported by, the new specific duties that the Government plans to create for public bodies bound by the public sector equality duty.

5.17 The Government Equalities Office published a policy statement about those specific duties in January 2010.<sup>5</sup> This includes material relevant to demonstrating how impact on equality has been assessed (reproduced in the box below). DH will take account of the work described in the policy statement in taking forward the recommendation. It will also bear in mind the comments received in the further work it plans to support health and social care in advancing age equality.

#### **Assessing impact on equality**

3.9 We are clear that under our proposals public bodies will continue to need to assess the impact on equality of what they do, and that this now needs to include the impact on all characteristics protected under the Equality Duty.

3.10 While we do not propose to prescribe in legislation how they should do this, the consultation responses made clear that there is an appetite for clear and detailed guidance about ways to assess impact. We will therefore now undertake work in co-operation with the EHRC to ensure that guidance addresses:

- how to assess impact across all protected characteristics
- when to do so i.e. the range of policies, services and decisions like to be affected and at what point in the policy/decision making cycle
- how public bodies should demonstrate that they have taken evidence of the impact on equality into account, and what "key" policy and service delivery initiatives are suitable for such a full assessment
- issues relating to transparency and accountability
- how this links to the evidence gathering requirement under the equality objective setting duty.

3.11 EHRC will explore whether it is feasible to adapt the guidance so that a sector-based approach is taken, to make the guidance applicable to a public body's business and promote good practice within its sector.

#### **Proposal 5: Research**

5.18 The consultation paper invited views on the review's recommendation that:

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<sup>5</sup> Available at [http://www.equalities.gov.uk/equality\\_bill.aspx](http://www.equalities.gov.uk/equality_bill.aspx)

DH through the NHS National Institute for Health Research and its school for social care research should review the relevant guidance to ensure it is compliant with the Equality Bill, and promote further research on ageing (Recommendation 28).

The response form split this into two questions:

Do you agree that guidance on clinical trials needs to reflect the requirements of equality legislation?

Do you agree that further research on ageing can play a useful role in helping DH and other bodies to meet the requirements of the public sector equality duty in relation to age?

### Responses

5.19 No respondent answered “no” to the questions on the response form. Forty-one answered “yes” to the first question, and thirty-eight to the second. Of these responses:

- eleven came from the third sector (four LINKs, NPC, CSPA, GSF, Breast Cancer Care, CACFO, Equality South West, and NACRO);
- fifteen from local government;
- four from the NHS (all PCTs);
- four from health professional bodies and unions (the British Geriatric Society, Nursing and Midwifery Council, Royal College of Psychiatrists, RCPSG); and
- four from others (Saga and three individuals);

plus, in the case of the first question, an NHS Trust, a further PCT, and a consultancy.

5.20 In addition, over twenty responses commented on the proposal. These comments came from:

- the third sector (Age Concern/Help the Aged, Breast Cancer Care, the Children’s Rights Alliance for England, CSPA, CEMVO, Equality South West, GLF, Help the Hospices, and NACRO);
- local government (ADASS/LGA and two other responses);
- the NHS (three PCTs);
- health professional bodies (the British Medical Association, the Royal College of Psychiatrists);

- CQC, the Nuffield Council on Bioethics, Saga, and Roche.

Key points from the comments they made are summarised below.

### *Reviewing the guidance*

5.21 Those commenting agreed that DH and the National Institute for Health Research (NIHR), including its School for Social Care Research, should review its current guidance to ensure compliance. One local government response noted the need to look at current research to see how much of the guidance had been acted on.

5.22 Comments raised the issue of the need to ensure that older people are included in clinical trials – otherwise, “an evidence base is lacking for those that need it most” (Royal College of Psychiatrists; also Breast Cancer Care, GLF, NPC, CPSA, a local government response, a PCT and Roche). In particular, guidance was needed to increase the participation of older women in trials (Breast Cancer Care).

5.23 Comments also mentioned the importance of involving older people and their networks in the research decision-making process (CACFO, a LINK). ADASS/LGA urged that DH work closely with their organisations in commissioning further research, in order to ensure that it is focused on achieving positive outcomes for older people.

### DH position

5.24 DH’s Research Governance Framework for Health and Social Care sets out the general principles that should apply to all research. This was first published in 2001 and revised in 2005. DH has undertaken appropriate development and review of its guidance against the primary legislation, as set out below. We recognise however that further review may be needed when the nature of the secondary legislation (for example, on specific public sector equality duties) becomes clear.

5.25 In respect of age and other equalities, the Research Governance Framework makes clear that:

Research, and those pursuing it, should respect the diversity of human society and conditions and the multi-cultural nature of society. Whenever relevant, it should take account of age, disability, gender, sexual orientation, race, culture and religion in its design, undertaking, and reporting. The body of research evidence available to policy makers should reflect the diversity of the population. (Para 2.2.7)

In this way, DH actively encourages those commissioning or undertaking research – including clinical trials – to consider equality issues as an integral part of planning and delivery of programmes and projects. It collects and monitors equality data where it is reasonable to do, and whilst respecting the right to privacy.

5.26 DH accepts the need to include older people, where relevant, as participants in trials and other studies. There is current good practice in this respect in the National Programmes of NIHR and in the DH Policy Research Programme. NIHR's Health Technology Assessment programme, for example, requires its trials to recruit people representative of all NHS patients, including older people. Upper age limits are not applied unless there is a specific inclusion criterion. DH notes the specific recommendation in the Roche report<sup>6</sup> that "The National Clinical Research Network may wish to consider what further measures can be taken to recruit more older patients to clinical trials".

5.27 The principle of age-inclusiveness however has to be reconciled with the aim of delivering high quality meaningful outputs and maximising value from research funds. Research design will depend on the specific research questions being addressed. It is unethical, as well as poor value for money, to involve participants in research that is unlikely to achieve a reliable and worthwhile result. We encourage funders and researchers to seek expert advice on these issues where available.

5.28 NIHR is developing a more consistent approach to patient and public involvement (PPI) across its National Programmes. This will cover PPI in research commissioning as well as in the conduct of studies and the dissemination of their findings. PPI will be monitored after contracts are let with researchers to ensure that proposals for public and patient/service user/carer involvement in the study are being implemented as planned.

5.29 We note the suggestion that organisations such as ADASS and LGA are involved in setting research agendas for age-related research. This involvement is already routinely sought in much of the DH Policy Research Programme's funded research, typically via participation in advisory groups for large scale research initiatives. Representation from the non-statutory sector is also actively sought, where relevant. The Advisory Board for the NIHR School for Social Care, for example, includes members from ADASS, the Improvement and Development Agency for Local Government (IDeA), Carers UK, and Turning Point among others. The School's User, Carer, and Practitioner Reference Group includes older people themselves and their carers, a number of whom are assisting the School with decision-making and consultations.

### *Further research on ageing*

5.30 Comments welcomed the recommendation for further research on ageing including research to help DH and other bodies to meet the requirements of the age equality duty (Age Concern/Help the Aged and a local government response). One response commented that research on ageing should only be promoted where it can be shown to provide clear benefits for age equality (British Medical Association).

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<sup>6</sup> *Meeting the Needs of older People with Cancer. A Report Assessing what more can be done to tackle Cancer in Older People.* December 2009. This was provided as Roche's response to the consultation.

5.31 Funding for conditions such as dementia which have a disproportionate impact on older people was seen to be relatively low (Nuffield Council on Bioethics, CQC) and robust evidence lacking on the implications of age-based criteria on fair access to care (CQC). Responses called for research on ways to ensure that care decisions are based on individual need, rather than age, and on the risks and benefits when services are provided on an age-differentiated basis (CQC, Help the Hospices and a local government response).

5.32 Many more specific research topics were mentioned in the responses to the consultation, including research on ageing prisoners (NACRO), ageing in the black community (CACFO), discrimination against older people with dual sensory loss (Sense) and age and gender (British Medical Association). Comments also made the point that DH must ensure that it meets its public sector duty in respect of research on children and young people (Young Equals).

5.33 More generally, comments called for funders to take active steps to develop and articulate a reasoned basis for the division of research funds and sustain research communities carrying out high quality research (Nuffield Council on Bioethics; Help the Aged/Age Concern).

### DH position

5.34 We are grateful for the thought that has gone into the comments made on this element of the proposal. We note the suggestion that the DH funds research to help ensure it and other bodies meet the requirements of the age equality duty. Research units funded by DH's Policy Research Programme have a long track record of research on the impact of age inequalities on care services.

5.35 We note the specific areas for future research on ageing highlighted by responses and will take these into account, among other priorities, in developing our research commissioning agendas. A significant volume of funding is available for health-related research. By 2011, for example, NIHR alone will be investing just under £1 billion. This is available for any area of science, including age-related research. However, all research is funded through fair and open competition and success in any area of science will depend on the quality of the proposals made by the relevant scientific community.

5.36 The mission of NIHR is to support outstanding individuals, working in world class facilities on leading edge research focused on the needs of patients and the public. In addition to its research funding programmes NIHR also invests to support and equip the scientific workforce, building its capacity and capability in all areas of health-related research. In 2008/9 some £44m was spent on research training and career development. A further £11m was spent on providing training fellowships for gifted individuals with the potential for scientific leadership.

5.37 The importance of helping to encourage research on dementia has been acknowledged. A Ministerial Summit on Dementia Research was held in the summer of 2009 and followed by the establishment of a new Ministerial Group on Dementia Research in 2010. The Group brings together the main organisations with a stake in dementia research to advise on ways to increase the volume and impact of dementia research.

5.38 DH acknowledges the relevance of the age equality duty for research on and with children and young people. The past decade has seen the development of a significant body of evidence-based policy on child health and continued improvements in children, young people and families' health and health care. In February 2009, DH and the Department for Children, Schools and Families set out a long-term strategy *Healthy Lives, better futures* to improve health outcomes for all children and young people.

5.39 The equality impact assessment considered the possible impact of *Healthy Lives, better futures* according to age, disability, race, religion and beliefs, gender and sexual orientation. The assessment identified potential issues contained in the strategy relating to these groups and to ensure that development of the strategy had taken account of the potential issues and that they inform continuing developments to reduce inequality.

### **Proposal 6: Quality-adjusted Life Years (QALYs)**

5.40 The consultation paper noted that the review had made clear that it supported the continued use of QALYs, but had noted that some have argued that there are inadequacies in the way they are used. In the light of this, the review recommended that:

DH and the NHS review the use they make of quality-adjusted life years (QALYs) and other similar support tools to inform their decision-making prior to the Equality Bill coming into force. (Recommendation 11; discussed at paragraphs 5.9-13 of the review's report).

The consultation paper invited comments on points that DH should take into account in keeping its use of QALYs under review.

### Responses

5.41 The response form asked if those responding agreed with the review's recommendation on QALYs. None of those responding said they did not, and thirty-six said that they did. Of these responses:

- eleven came from the third sector (four LINKs, NPC, CSPA, GSF, CACFO, NACRO, Equality South West, Breast Cancer Care);
- fifteen from local government;
- three from the NHS (all PCTs);

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- three from health professional bodies (the British Geriatric Society, Nursing and Midwifery Council, and RCPSG); and
- four from others (Saga, a consultancy and two individuals).

5.42 In addition, around thirty responses commented on this proposal. The sources from which these comments came were:

- the third sector (Help the Aged/Age Concern, Alzheimer's Society, Anchor, Help the Hospices, CEMVO, CACFO, CPSA, and two LINKs);
- local government (ADASS/LGA and seven others, one jointly with a PCT);
- health interests (four PCTs and the Royal College of Psychiatrists); and
- CQC, Saga and some individuals.

5.43 From each of these sources there were comments that were broadly supportive of the proposed action as a means of ensuring that QALYs are not used in a way which discriminates on grounds of age. Views on the best way of guarding against such effects varied. Some responses argued for a move away from QALYs as a tool to inform decision-making, though other stakeholders acknowledged that at present no better tools for quantifying and comparing health-related utilities exist. Others drew attention to the need for continued improvement in the sophistication and sensitivity of the QALY as a tool, the importance of explaining clearly the role it played in informing specific decisions or recommendations and the merits of keeping its application under periodic review.

5.44 A number of responses raised issues relating not to the use of QALYs (which quantify health-related benefits) as such, but to the scope of the costs and benefits that are considered by NICE and other decision-makers as part of their deliberations.

### DH position

5.45 DH is grateful to those who commented. As explained in the consultation paper, we shall keep the methods in which QALYs are applied under review to ensure that we are aware when the methodology treats an age group less favourably and consider whether there are alternative methods that could be adopted. In doing so, we will bear in mind the comments made.

### **Proposal 7: Reviewing age criteria in national policies/age weighting**

5.46 The consultation paper invited comments on:

- a) the proposal that DH should ensure there are reviews of the age criteria used in its national policies and publish the results;

b) the review's recommendation that DH should review the relative weighting of the two Relative Need Formulae for adult social care before 2012, and that it should ensure that this and future reviews of the formulae ensure compliance with the ban on age discrimination and the public sector equality duty (Recommendation 9);

c) the review's recommendation that DH should ensure that a programme of research is commissioned that enables the Advisory Committee on Breast Screening to advise on the upper limit of the breast cancer screening programme, and regularly updates the evidence (Recommendation 3).

### *Age criteria used in national policies*

#### Responses

5.47 No response disagreed with the first element of this proposal, and forty-two responses confirmed that they agreed. Of these responses:

- eleven came from the third sector (four LINKs, NPC, CSPA, GSF, Breast Cancer Care, CACFO, Equality South West, NACRO);
- seventeen from local government (one responding jointly with a PCT);
- six from the NHS (five PCTs and an NHS Trust);
- four from health professional bodies (the British Geriatric Society, Nursing and Midwifery Council, RCPSG, and the Royal College of Psychiatrists); and
- four from others (Saga, a consultancy and two individuals).

5.48 In addition, there were comments on the proposal from:

- the third sector (Young Equals, NPC, CSPA, GLF, Help the Hospices, Sense);
- local government (five responses, one jointly with a PCT);
- the NHS (one NHS Trust and three PCTs);
- CQC and the British Medical Association.

5.49 Additional points raised in these comments were:

#### Areas to tackle

- the proposal to review the use of age criteria affecting those aged under 18 was particularly welcome (Young Equals);

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- reviewing age equality in palliative and end of life care should be an early priority (Help the Hospices);
- there was a particular need to review the age criteria used in mental health policies (NPC, CSPA);

### Review processes

- the reviews needed to be evidence-based, and their timing should allow the collection of good quality data (a PCT);
- publication of the results was welcomed, as it would help inform those devising and applying policies at local level (a local government response). It would also help the service users and carers affected to see that they were not being discriminated against (British Medical Association).

### DH position

5.50 DH welcomes the support expressed for its proposals on reviewing age criteria and will take these forward, ensuring that there is publication of the results.

5.51 On some of the more detailed points made:

- the End of Life Care Strategy highlighted the importance of providing good quality end of life care for all adults, and recognised that palliative and end of life care are still largely geared towards people with cancer. As a consequence, many people with other conditions and co-morbidities, such as dementia or chronic disease, which disproportionately affect older people, do not get the best care. Ongoing work to implement the Strategy will help address this inequity in care provision;
- in December 2009, we launched *New Horizons: A Shared Vision for Mental Health*, our comprehensive programme for improving the mental health and well-being of the whole population and the services for those with poor mental health. New Horizons supersedes the National Service Framework for Mental Health, which covered working-age adults only. New Horizons takes a lifespan approach, from laying down the foundations of good mental health in childhood, through promoting and protecting continued well-being into adulthood, to supporting and maintaining resilience in older age.

*The relative weighting of the Relative Needs Formulae for adult social care*

### Responses

5.52 Two local government respondents disagreed with this second element of Proposal 7. The reasons they gave were:

- in one case, that the proposed review came too soon after earlier reviews; moreover, there was no link between the grant received by the authority and the service level that an individual enjoyed;
- in the other case, that equal outcomes for all clients were required and the current funding mechanism through the two formulae ensures that this is achieved, by providing more financial support when people aged over 65 need this support.

5.53 Thirty-four responses answered yes to the question that asked about the Relative Needs Formulae. Of these responses:

- eight came from the third sector (three LINKs, NPC, CSPA, GSF, CACFO, Equality South West);
- sixteen from local government (one responding jointly with a PCT);
- three from the NHS (all PCTs);
- three from health professional bodies (the British Geriatric Society, Nursing and Midwifery Council, RCPSG); and
- four from others (Saga, a consultancy and two individuals).

5.54 In addition, there were comments on the proposal from:

- local government (ADASS/LGA and nine others, one jointly with a PCT);
- the third sector (Help the Aged/Age Concern, Anchor, Sense, NPC, CSPA and a LINK); and
- the Royal College of Psychiatrists, the British Medical Association, and a PCT.

5.55 These comments supported the proposal for the review. They also made the points that:

- the review needed to include consultation, in particular with local government and the Department for Communities and Local Government (several local government responses);
- the review needed “to mirror the new landscape promised by age equality rather than simply evolve from historic funding levels”. The Government should issue a clear directive that the review should not interfere with authorities’ own schedules for implementing age equality (Help the Aged/Age Concern).

Responses also mentioned some aspects of the formulae themselves, rather than of their relative weighting, that they thought merited attention: for example, the low income adjustment, the extra-weighting given to those aged over 90, the level of deprivation for a geographical area, and the interaction with the equivalent formulae for children.

### DH position

5.56 DH welcomes the support expressed for the review's recommendation. It recognises that the concept of the Relative Needs Formulae is a relatively complex one. There are two formulae for adult social care (one for adults aged under 65 and the other for adults aged 65 and over). Their relative weighting contributes to determining what share of resources should go to each local authority. Other things being equal, an authority will receive more funding per younger adult if the formula for younger adults is more heavily weighted; and more funding per older adult if the formula for older adults is more heavily weighted. The formulae and their weighting determine the distribution of resources from central to local government; they do not determine what individual authorities spend on the services concerned.

5.57 In the short to medium term DH will undertake a review of the relative weighting of the two Relative Needs Formulae for the two age bands. Ministers will not make a decision on a future review of the formulae themselves until the completion of a feasibility study, but the implications of the new legislation on age for the formulae will be kept under review. In taking both parts of the recommendation forward, DH will take account of the detailed comments made, and will ensure that there is consultation as appropriate with stakeholders.

### *Research on the upper limit for the breast cancer screening programme*

### Responses

5.58 One individual disagreed with this third element of Proposal 7, on the basis that it should not be necessary if guidelines were followed.

5.59 Thirty-eight responses confirmed that they agreed with this element of the proposal. Of these responses:

- ten came from the third sector (Breast Cancer Care, four LINKs, NPC, CSPA, CACFO, Equality South West and NACRO);
- sixteen from local government (one responding jointly with a PCT);
- six from the NHS (one Trust and five PCTs);
- three from health professional bodies (the British Geriatric Society, Nursing and Midwifery Council, RCPSG); and
- three from others (Saga, a consultancy and one individual).

5.60 In addition, there were comments on the proposal from:

- the third sector (Breast Cancer Care, Cancer Research UK, NPC, CSPA, CEMVO, CACFO)
- four PCTs, the British Medical Association, and the Royal College of Psychiatrists;
- CQC; and
- five local government responses.

5.61 Additional points made in these comments included:

- the upper age limit should be removed in advance of further research, on the basis of evidence in other countries (CSPA);
- raising the upper age limit for breast cancer screening might not be the most effective way of promoting earlier diagnosis in older women. Research was also needed on the relative effectiveness of other interventions, for example, encouraging older women to contact health services sooner once they noticed a breast change (Cancer Research UK);
- the entitlement of women to request regular mammograms after screening invitations has stopped should be more heavily promoted (Breast Cancer Care, NPC);
- the lower age limit for breast cancer screening should also be kept under review (Breast Cancer Care, a PCT) and also age limits for other screening programmes (Royal College of Psychiatrists), particularly cervical cancer screening for those under 25 (CQC); “decisions over the future of screening programmes should be made on the basis of the best available clinical evidence” (British Medical Association).

5.62 The proposal was also considered by the Advisory Committee on Breast Cancer Screening (ACBCS) at their meeting in January 2010. ACBCS welcomed the recommendation and noted that, although there is evidence of the diminishing effectiveness of breast screening in women aged over 80, this was not the case for women in their 70s, although there is little evidence of the balance of benefits and harms of screening in this age group.

### DH position

5.63 DH is grateful for the responses to this element of the proposal. It will take the recommendation for more research forward in the following way. The breast screening programme is currently being extended to women aged 47-49 and 71-73. The extension is being randomised by screening batch so that half of eligible women will be invited at age 47-49 and half at age 71-73, creating natural control groups of those women not invited in those particular age ranges. ACBCS recommended that the cohort of women being invited at age 71-73 should be re-invited for a further two screening rounds at ages 74-

76 and 76-79. This would give sufficient numbers in the screened cohort and the control cohort to make decisions based on the benefits and harms of screening in this age range. The 2010-11 NHS Operating Framework stated that PCTs need to work with their cancer network to ensure that all screening services have made plans to start the extension of breast cancer screening offered to women aged 47-49 and 71-73 from April 2010.

## 6. HOW THE DEPARTMENT OF HEALTH CAN SUPPORT HEALTH AND SOCIAL CARE TO MEET THE REQUIREMENTS OF THE BILL

6.1 This chapter considers the proposals that were primarily concerned with ensuring that DH supports health and social care in meeting the requirements of the legislation.

### Proposal 8: Resource Pack

6.2 The review recommended that:

DH should ensure that an up-to-date pack of resources, including good practice material, is available to health and social care organisations to support them to meet the requirements of the Equality Bill relating to age, and consider whether to identify national centres of expertise to co-ordinate work at a regional level to implement the provisions of the Equality Bill (Recommendation 27).

The consultation paper explained that a resource pack was being prepared through a partnership between NHS South West, Government Office South West and ADASS. The resource pack would include an audit tool on age discrimination; good practice guidance for the NHS; and illustrative practice guidance for adult social care departments within local authorities. The consultation paper invited comments, both on the proposed resource pack and on whether other guidance would be useful.

### Responses

6.3 The response form asked “Do you agree that DH should ensure that an up-to-date pack of resources, including good practice material, is available to health and social care organisations to support them to meet the requirements of the Equality Bill relating to age, and consider whether to identify national centres of expertise to co-ordinate work at a regional level to implement the provisions of the Equality Bill?” Two responses (from a third sector organisation and a PCT) answered “no”; thirty-eight responses answered “yes”. Of the responses answering “yes”:

- nine came from the third sector (three LINKs, NPC, CSPA, GSF, Equality South West, CACFO, NACRO);
- sixteen came from local government;
- five came from the NHS (all PCTs);
- three came from health professional bodies (the British Geriatric Society, Nursing and Midwifery Council, and RCSPG); and
- five came from others (Saga, a consultancy and three individuals).

6.4 Two responses (one from local government, one from an individual) answered “no” to the question “Do you agree that other guidance in addition

to the resource pack would be useful?” (The individual said that further guidance should not be necessary, if there was access to web-based material). Seventeen responses answered “yes”. Of these responses:

- ten came from local government;
- five from the third sector (CACFO, Equality South West, a LINK, NACRO, GSF); and
- two from individuals.

6.5 Some of these respondents, and some others, including CQC, EHRC, Age Concern/Help the Aged, Help the Hospices, Young Equals, Sense, CEMVO and GLF, ADASS/LGA, the British Medical Association, the Royal Pharmaceutical Society, Unite, and the Fitness Industry Association) also provided comments setting out their thinking.

### *The resource pack*

6.6 Most comments were about the resource pack. Several, including CQC, EHRC, the British Medical Association and the Royal Pharmaceutical Society of Great Britain, indicated their support for the principle of it. One local government response welcomed the fact that organisations in health and social care that were serving the same population would have the same core materials.

6.7 There were many further comments on the idea of the resource pack. In terms of its aims, EHRC thought that ideally it would help organisations, across the key functions of leadership/policy development, commissioning, service design and delivery, compliance and monitoring, to understand the issue and to focus on age equality outcomes rather than only processes.

6.8 In terms of how it was produced and made available, some responses said their authors looked forward to seeing drafts. Comments from various sources said:

- its production needed to involve the public, service users and their carers;
- it should be produced in good time and should be freely available, including to service providers in the voluntary sector, and there should be arrangements for updating it;
- it should be available in a variety of formats to aid training for a diverse workforce. (The training material for the Mental Capacity Act was cited as a good example).

6.9 In terms of its content:

- it should be consistent with other national initiatives, such as CQC standards and work by EHRC and IDeA;
- the suggestions it made and examples of good practice it put forward should be costed and financially realistic, bearing in mind that the new public sector equality duty would apply to other characteristics as well as age;
- it needed to focus on joint working between health and social care (a local government response) but it also needed to recognise that some local authorities are responsible for functions in addition to social care, many of which can contribute to age equality.
- it should stress the importance of involvement with the public, service users, and unions and staff in making progress on age equality;
- ideally it would provide a suggested implementation timetable, encourage a strategic and joined up approach, and include appropriate links to EHRC material.

### 6.10 Other suggestions were that it should cover:

- children as well as adults, and issues of transition from child to adult services. In particular, it should make clear that the public sector equality duty in relation to age applies to children as well as to adults (Young Equals);
- the needs of people with dual sensory loss (Sense, who provided several detailed suggestions on what should be included on this topic);
- human rights as well as equality (the Fitness Industry Association and a local government response).

### *Further guidance?*

### 6.11 When responses explained why they thought further guidance necessary, the points made were:

- the public and service users needed information in plain English (two LINKs, CSPA, Equality South West and a local government response), for example, so that they could monitor local performance (a LINK). (However, some others thought that the resource pack itself should be prepared with the public and service users in mind);
- service providers needed more support, for example in the form of a training package which could be used locally (a PCT), advisory visits on request (one local government response), or regional work to support the spread of good practice (another local government response). There should be specific organisational support at local or

regional level and training for those tendering for contracts, including voluntary sector service providers (GLF);

- it was important to have guidance available for those working in children's social care services (Young Equals). There also needed to be guidance and support on the needs of older offenders (NACRO) and of young adults making the transition from child to adult services (Help the Hospices, Young Equals).

### DH position

6.12 DH welcomes the comments on the proposal to create a resource pack. The South West will continue to work on the co-production of a pack for the NHS and local authorities to use, aiming to take as many as possible of the comments into account, including the wish many bodies have expressed to have guidance available sooner rather than later. We agree that the involvement of a variety of organisations and individuals is important, so input from national experts and local communities is being fed in to help shape the final products.

6.13 As explained in the consultation pack, the pack will have three component parts: an audit tool, an NHS Guide and a local authority practice guide. The pack will also cross-reference other advice, toolkits and documents that support the NHS and local authorities in ending age discrimination and promoting age equality (including material from IDeA, CQC, EHRC etc). It will be available in the first half of 2010 and although targeted at the statutory sector, it will encourage them to engage with third and independent sector organisations and members of the public as well as with patients, service users and carers. The pack will be freely available, including to the public, via the internet.

6.14 Once the resource pack has been produced through the partnership between NHS South West, Government Office South West and the Association of Directors of Adult Social Services, DH will keep under review the need for updates. We do not envisage that it will be feasible to provide teams to provide advice on request, but advice to Strategic Health Authorities and DH teams in Government Offices will be included with the resource pack.

6.15 DH will bear in mind the other points made about guidance more generally (for example, in taking forward work on Proposal 13), taking account of material that becomes available from other sources, such as EHRC itself.

### **Proposal 9: Age-specific dataset**

6.16 The consultation paper invited comments on the review's recommendation that:

DH should work with the Health and Social Care Information Centre to explore how to construct an age-specific dataset to support the resource pack and help local organisations analyse and monitor

patterns of service provision by age. This must link into wider work on indicators, including the programmes of the Public Health Observatories and the National Indicator Set (Recommendation 24).

### Responses

6.17 In answer to the question “Do you agree that DH should work with the Health and Social Care Information Centre to explore how to construct an age-specific dataset to support the resource pack and help local organisations analyse and monitor patterns of service provision by age?”, forty-one responses said “yes” and one (from local government) said “no”. Of the responses that said “yes”:

- twelve came from the third sector (four LINKs, NPC, CSPA, GSF, Equality South West, CACFO, NACRO, Breast Cancer Care);
- fifteen from local government (one jointly with a PCT);
- five from the NHS (five further PCTs and one NHS Trust);
- four from health professional bodies (the British Geriatric Society, the Nursing and Midwifery Council, RCSPG, and the Royal College of Psychiatrists); and
- five from others (Saga, a consultancy and three individuals).

Some of these added comments, and there were also comments from others, including Anchor, Sense, ADASS/LGA, the British Medical Association, EHRC, and CQC.

6.18 Although the majority of responses supported the proposal, several of the comments also raised concerns that needed to be taken into account in exploring the construction of a data set. In some cases, this led them to question whether a new dataset should be taken forward.

6.19 The two main concerns raised were:

- how the proposed dataset would relate to other information.

Some respondents noted that age-specific information and data were already available. An additional requirement to collect and analyse data was not welcome (ADASS/LGA) and would not be cost-effective. The dataset needed to be considered in line with the proposed Health and Social Care Performance Framework and linked to Local Area Agreement targets where possible (a local government response). Perhaps it might best be developed by the public health observatories (another local government response);

- the proposal risked giving disproportionate focus to age (British Medical Association).

There was a wish for the dataset to cover characteristics in addition to age, including ethnic origin (a local government response) and dual sensory loss (Sense).

6.20 Other points made included:

- it was important for age data to use the narrowest practicable age bands (EHRC);
- there was a need to develop measures for transition points as well as for the younger end of the adult age spectrum (CQC).

### DH position

6.21 Over the period of the consultation, DH has worked closely with the Health and Social Care Information Centre to explore how best to support local organisations analyse and monitor patterns of service provision by age. In common with some of those who commented, we have concluded that, whilst a toolkit to support the resource pack is vital, there is no need to commission an additional dataset. We are currently working with the Public Health Observatories to take this work forward, bearing in mind all the points made. We are sympathetic to the argument that the toolkit should not focus solely on age but should also cover other protected characteristics to enable additional analyses to be carried out at an appropriate level, and we are investigating how to do this in practice.

### **Proposal 10: Performance Measures**

6.22 The consultation paper invited comments on the review's recommendation that:

Future performance measures that are both proportionate and targeted should be developed in accordance with the age discrimination ban and the public sector equality duty (Recommendation 25).

It explained that DH agreed with the review's recommendation. As the review acknowledged, age-related indicators remained appropriate in some circumstances: for example, where screening programmes are directed at particular age cohorts.

### Responses

6.23 All forty who used the yes/no box on the response form indicated that they supported this proposal. Of these responses:

- eleven came from the third sector (four LINKs, NPC, CSPA, GSF, Breast Cancer, CACFO, Equality South West, NACRO);
- five from the NHS (all PCTs);

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- four from health professional bodies and unions (the British Geriatric Society, Nursing and Midwifery Council, Royal College of Psychiatrists, and Royal Pharmaceutical Society of Great Britain);
- sixteen from local government (one jointly with a PCT); and
- four from others (Saga, one consultancy and two individuals).

Some of these made additional comments.

6.24 Comments also came from:

- four others in the third sector (Age Concern/Help the Aged, Anchor, CEMVO, and GLF);
- a further PCT, the British Medical Association and Unite;
- ADASS/LGA and another local government respondent; and
- CQC.

These too supported the recommendation.

6.25 The main additional points made were:

- the objective should be to establish performance measures that reflect age equal services, defined by outcomes (Help the Aged/Age Concern). ADASS/LGA also emphasised the value of measures that focused on outcomes;
- data nevertheless needed to be available by age, to provide objective justification for targeted action to tackle higher needs in particular age groups (Help the Aged/Age Concern, Anchor, Breast Cancer Care, a PCT);
- it was important to guard against the risk that publication of performance data might lead older people to be “deselected” from certain procedures, to improve performance where they were seen to be higher risk (Help the Aged/Age Concern, Equality South West);
- it was also important to keep bureaucratic burdens to a minimum. For that reason, it might not be appropriate to break all data down by age group (ADASS/LGA, three local government and one PCT response, Royal College of Psychiatrists);
- there were currently no baseline data about age discrimination, and no systematic mechanism to assess whether there is a reduction in age discriminatory practice. There was also a strong need to develop

measures for transition points as well as for younger end of the adult age spectrum (CQC).

DH position

6.26 We are grateful for the comments made and will bear them in mind in taking forward work on performance measures.

**Proposal 11: World Class Commissioning**

6.27 The review recommended that

DH should ensure that there are clear and emphatic references to ending discrimination in relation to the eight protected characteristics (including age) and advancing equality in the 2010/11 World Class Commissioning assurance process (Recommendation 12).

The consultation paper said that DH agreed with this proposal and planned to take it forward. It invited views on whether it was right in principle to add references to discrimination and equality to the World Class Commissioning assurance process, and on how this might be done (for example, should attention focus on competencies 2, 3, 5 and 6, as the review suggested?).

Responses

6.28 Thirty-five responses agreed (by ticking the “yes” box on the response form) that it was right in principle to add references to discrimination and equality to the World Class Commissioning assurance process. Of these responses:

- three came from the NHS (all PCTs);
- four from health professional bodies (British Geriatric Society, Nursing and Midwifery Council, Royal College of Psychiatrists, RCPSPG);
- eleven from the third sector (four LINKs, NPC, CSPA, Breast Cancer Care, CACFO, Equality South West, NACRO, GSF);
- thirteen from local government (in one case jointly with a PCT);
- and five from others (SAGA, a consultancy and two individuals).

No respondent ticked the “no” box on the response form, but one individual commented “not necessary”.

6.29 Some of these respondents added comments on the proposal, and comments also came from CQC, a further PCT and an NHS Foundation Trust, Unite, Age Concern/Help the Aged, Anchor, CEMVO and GLF. The majority of comments were positive about the proposal to add references to equality and discrimination to the World Class Commissioning assurance process, although NPC said they had doubts about the whole concept of World Class Commissioning (which they saw as likely to lead to further

privatisation) and another respondent (a consultancy) wondered how much it influenced commissioners.

6.30 On the question of where to add references to equality and discrimination, the comments made said:

- there was support for the review's suggestion of focusing on competencies 2, 3, 5 and 6 (three responses);
- alternatively, there was a case for referring to equality in all the competencies (two responses);
- competency 6 would be particularly relevant. Effective modelling of need would mean, for example, better prevention services for older people (Age Concern/Help the Aged);
- there was a case for adding competency 7 to this list, "as this relates to stimulating the market to meet the needs of the population". The competency refers to longer-term research on future population profiles, and a breakdown of the population by protected characteristic would be relevant here (Equality South West);

6.31 Other points made included:

- guidance and training, supported by good practice examples, were important to deliver the change that was sought in commissioning (Equality South West, an NHS Foundation Trust);
- monitoring was needed to ensure that commissioning produced the outcomes that were intended (an NHS Foundation Trust, CSPA), and should involve service users (GLF). CQC said that they would be conducting periodic reviews of both PCT and local authority commissioning, with a focus on the extent to which the health and well being of the whole population is considered and the extent to which resources are aligned with priorities for tackling inequality and deprivation;
- Unite commented on equality in procurement in health and social care more generally, and particularly in relation to the public sector equality duty.

### DH position

6.32 As made clear in the consultation paper, DH agrees with the recommendation that there should be clear and emphatic references to ending discrimination (in relation to eight protected characteristics, including age) and advancing equality in the 2010/11 World Class Commissioning (WCC) assurance process, and we welcome the support the responses showed for that. DH has already aimed to take account of this in the material developed for the 2009/10 assurance process, launched in September 2009. Specifically, DH strengthened the references to ensuring seldom heard and

equality target groups were taken into account in the planning and delivery of services. This is brought out throughout the framework, with particular emphasis on Competency 3 ('Proactively build continuous and meaningful engagement with the public and patients to shape services and improve health'). Every reference to the PCT's population is described as including equality target groups which explicitly includes older people.<sup>7</sup>

6.33 In the future development of the WCC assurance process, including the supporting information to be made available later in 2010 for use in the 2010/11 assurance process, DH will bear in mind the detailed suggestions made in the responses to the consultation, and will ensure that equality continues to be clearly referenced and that the assurance process continues to highlight areas where equality issues have not been considered as part of the commissioning process. For example, the guide for WCC panels for 2010 provides a series of specific equality related questions to consider when assessing the PCT.

6.34 We have drawn the 3 comments provided by Unite to the attention of the Government Equalities Office.

### **Proposal 12: Improving Quality and Productivity**

6.35 The consultation paper said that DH agreed with the review's recommendation that:

DH and the health and social care system ensure that work to prevent harm and waste and spread innovation within the system should be designed to help promote age equality and that measures to end age discrimination are implemented so that they improve quality and productivity (Recommendation 20)

and proposed to take it forward by ensuring that the Quality, Innovation, Productivity and Prevention (QIPP) agenda included a focus on age equality.

### Responses

6.36 Thirty-nine of those who used the response form ticked the "yes" box to indicate that they supported the proposal. Of these responses:

- six came from the NHS (one NHS Trust and five PCTs);
- four from health professional bodies (the British Geriatric Society, Nursing and Midwifery Council, Royal College of Psychiatrists, RCPSG);

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<sup>7</sup> "Equality Target Groups should be considered when making reference to population, staff and services provided. Includes women, women in maternity, men, black and minority ethnic (BME) people, lesbians, gay men, bisexual people, transgender people, children, young people and older people, disabled people and people from different religious or belief groups.)" – Assurance Handbook, 2009/10-2010/11, available at [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_105117](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105117)

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- ten from the third sector (three LINKs, NPC, CPSA, GSF, Breast Cancer, CACFO, Equality South West, and NACRO);
- thirteen from local government (one jointly with its PCT); and
- six from others (Saga, three individuals and a consultancy).

6.37 There was also support for the proposal in comments from three further respondents (Age Concern/Help the Aged, the British Medical Association and a further PCT). In particular, Age Concern/Help the Aged argued that:

- addressing age discriminatory practices represented a significant opportunity to improve quality and productivity in health and social care services, for example by improving care for conditions particularly associated with later life (such as osteoarthritis, incontinence, and falls);
- as the population aged, it would become increasingly important to equip staff to deal with the needs of older people;
- the NHS could not claim to deliver a high quality service if it was not addressing the needs of older people, who were its highest users.

6.38 More detailed points made in comments were that:

- there were systemic problems that might hamper the sharing of practice on age equality (Unite);
- the waste of medication needed to be looked at (Gloucestershire Health Community & Care Overview and Scrutiny Committee).
- as part of its work on age equality, the QIPP agenda should address services for older people with sensory loss (Sense);
- resources were needed to support quality and productivity (National Pensioners Convention, Civil Service Pensioners Alliance);

6.39 No respondent ticked the “no” box on the response form, but two local government respondents were unsure what QIPP involved.

### DH position

6.40 As made clear in the consultation paper, DH agrees with the review’s recommendation on improving quality and productivity and proposes to take it forward for the NHS by ensuring that the QIPP programme includes a focus on age equality.

6.41 QIPP is a programme for the NHS: it sets out to enable the NHS to make significant improvements in efficiency and productivity over the period 2011-2014 through a focus on quality improvement. It builds on Lord Darzi’s

report *High Quality Care for All* which laid out a commitment to putting quality at the heart of everything the NHS does. The QIPP programme includes work to track the impact that QIPP is having on quality and productivity in the NHS. This work will include looking at age and other equality strands.

6.42 On the specific points made:

- in order to deliver large-scale rapid progress in meeting the QIPP challenge, national workstreams are being established in key areas where high impact changes can be made. The first wave of these workstreams has been set up. All of the workstreams seek to identify and implement those interventions which will make the most significant difference to improving health for all groups and to reducing health care costs. Some of the workstreams will focus particularly on improving the quality of services received by older people, such as the Long Term Conditions workstream and the End Of Life Care workstream. We expect these arrangements to support the spread of good practice;
- we welcome the suggestions about areas that need addressing, and will bear them in mind. We accept that medications could be used more effectively, and the Medicines Use and Procurement workstream is looking at this issue;
- David Nicholson, Chief Executive of the NHS, has made clear that in responding to the downturn in public spending, the focus of the NHS needs to be firmly on improving quality and efficiency simultaneously.

6.43 The review's recommendation concerns social care as well as health services. DH has published several resources to help social care implement best practice, including *Improving care and saving money*<sup>4</sup> and *Making a Strategic Shift to Prevention and Early Intervention – Guide and Key Messages Summary*.<sup>8</sup>

### **Proposal 13: Registration, inspection, regulation and assessment**

6.44 The consultation paper invited comments on the review's recommendation that:

All relevant national regulatory organisations, especially the Equality and Human Rights Commission and the Care Quality Commission, should work together and with DH to ensure that a shared understanding of the implications of the law is the basis for registration, inspection, regulation and assessment of the health and social care system (Recommendation 26).

It explained that DH accepted this recommendation and intended to work closely with EHRC to develop guidance on the requirements of the legislation, in relation not just to age but also to the other protected characteristics, and

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<sup>8</sup> <http://www.dhcarenetworks.org.uk/prevention/>

that CQC were also contributing to that process. This in itself would help to ensure that, when DH, EHRC and CQC come to assess the performance of health and social care bodies against the requirements of the legislation, they would do so with a shared understanding of its implications. DH would also be working with those bodies to keep to a minimum any burdens associated with registration, inspection, regulation, and assessment, for example by ensuring that information that meets the needs of one body will also meet the needs of another.

### Responses

6.45 No response ticked the “no” box on the response form. Forty responses indicated their support for the proposal by ticking the “yes” box. Of these responses:

- ten came from the third sector (three LINKs; Breast Cancer Care, CACFO, NPC, CSPA, GSF, Equality South West and NACRO);
- sixteen from local government (including one jointly with a PCT);
- five from the NHS (five further PCTs);
- three from health professional bodies (the British Geriatric Society, Nursing and Midwifery Council, Royal College of Psychiatrists); and
- five from others (Saga, a consultancy and three individuals).

6.46 Some of those listed above added comments. In addition, there were comments in the responses from:

- CQC and EHRC;
- five others in the third sector (Help the Aged/Age Concern, Alzheimer's Society, GLF, Sense and Young Equals);
- ADASS/LGA and one further local government response;
- one further PCT;
- four other health professional bodies and unions (the British Medical Association, the Health Professions Council, the Royal Pharmaceutical Society of Great Britain, and Unite),

all of whom we understood to support the proposal.

6.47 EHRC said “clearly, we will enforce the law where organisations are in breach of their statutory obligations. But crucially we will also seek to enable and encourage, giving organisations the information and the confidence they need to embed equality and human rights in the way they work.” They set out their plans for producing codes of practice and guidance, including guidance

on the implementation of the new provisions to tackle age discrimination in goods, facilities and services, which would be published three months ahead of commencement. They confirmed that they wanted to work with, and learn from, DH and other health and social care organisations in taking forward their plans.

6.48 CQC emphasised that human rights lay at the heart of their approach, and that this would ensure that people were at the centre of the care process and were treated fairly irrespective of their age. They believed “this process will provide the incentive and drive for the providers and commissioners of health and social care services to function in a way that is fair and nondiscriminatory. Wherever possible we will weave in equalities dimension into our periodic and special reviews.”

6.49 Other comments supported, in particular, having standards common to all organisations concerned, which several responses thought would help partnership working, and avoiding duplication in inspection and assessment.

6.50 Further points made included the following:

- there needed to be a robust framework for involving users, since “There is currently an unacceptable disparity between self-reported success from providers and actual experience from service-users” (Age Concern/Help the Aged; a similar point was also made by GLF);
- the shared understanding as the basis for registration, inspection, regulation and assessment must include the needs of people with dementia (Alzheimer’s Society) and inspection should cover implementation of the Deafblind guidance (Sense);
- the co-operation proposed in relation to the NHS should be extended to include all health and social care that is funded by NHS or other public funding streams (Royal Pharmaceutical Society of Great Britain);
- guidance from EHRC and CQC on the implications of the law for regulation of health care professionals would be welcome (Nursing and Midwifery Council);
- assessments needed to be supported by detailed evidence and data (Unite).

### DH position

6.51 We welcome the support expressed for the recommendation and DH’s proposal for taking it forward, and will bear in mind the points made in tackling this work. We will also keep in mind that there may be other bodies, in addition to EHRC and CQC, with whom a shared understanding of the requirements of the equality legislation would be useful. We recognise the importance of having arrangements for registration, inspection, regulation and assessment that are effective, proportionate and targeted. We recognise too

that sharing of data, rather than proliferation of data collections, will be critical to limiting any bureaucratic burden.

**Proposal 14: A joint social care and health assurance process**

6.52 The consultation paper invited comments on the review's recommendation that:

DH develops a joint assurance process for social care and health to demonstrate progress with implementing the age equality provisions of the Equality Bill. The Equality and Diversity Council should consider how to support this process to ensure it is aligned with other assurance processes covering health and social care (Recommendation 22).

It explained that DH was asking the Equality and Diversity Council to consider both how this recommendation should be taken forward, and whether any of the action covered by the proposals in chapter 7 should be reported through the same assurance process.

Responses

6.53 No respondent ticked "no" in answer to the question on the response form, but two responses which did not use the form indicated concerns about the proposal:

- it was bureaucratic (Royal College of Psychiatrists);
- an additional assurance process was not required (a PCT).

6.54 Thirty-nine respondents ticked "yes" on the response form. Of these:

- nine were from the third sector (three LINKs, NPC, CSPA, GSF, CACFO, Equality South West, NACRO);
- sixteen from local government (one jointly with a PCT);
- five from the NHS (one NHS Trust and four PCTs);
- three from health professional bodies (the British Geriatric Society, Nursing and Midwifery Council, and RCPSG); and
- five from others (a consultancy, Saga, and three individuals).

Several of these also provided comments, and two further responses (one further PCT and one further local authority) made clear in comments that they supported the proposal.

6.55 Those who expressed support for the proposal also made the following points in comments:

- the joint nature of the proposed process was welcome (the Nursing and Midwifery Council, a PCT, a local government response, and an individual);
- there could be a case for extending it to make links as well with education and training (a PCT, CACFO) and family and housing (CACFO);
- all the protected characteristics should be covered (a local authority response);
- it was important to avoid duplication and to ensure alignment with other processes (the Royal Pharmaceutical Society of Great Britain, a local government response);
- establishing a process would not in itself guarantee the achievements intended: such systems could “often seem more like tick box exercises than real tools in bringing about change and improvement” (a PCT).

6.56 One response said the question should be simplified. One was not familiar with the role of the Equality and Diversity Council, and asked if EHRC might be better placed to lead the process.

#### DH position

6.57 In coming to a decision on how to take this proposal forward, DH has considered the comments received, including those which emphasise the need not to duplicate existing arrangements. The Equality and Diversity Council is currently developing its work programme which includes an approach to assurance that covers all the protected characteristics, including age. Although the Council's primary focus is on the NHS, this work includes social care and the third sector. It is crucial that the approach to assurance involves both health and social care at the regional as well as the national tier, so DH expects Strategic Health Authorities (SHAs) and Government Offices (GOs), working co-operatively with ADASS and other key players, to agree with local authorities and other NHS bodies how they will be assured that localities are preparing for the legislation coming into effect. As noted in paragraph 4.7, the NHS Operating Framework for 2010/11 has already highlighted the importance of preparing for the age equality legislation. In taking this forward, DH expects SHAs and GOs to bear in mind the comments made, particularly on the value of a joint system and of ensuring alignment with, and no duplication of, other processes.

6.58 In addition, the authors of the review with ADASS will write to SHAs, GOs and regional ADASS chairs to launch the resource pack, explaining how it will help them be assured that local health and social care communities are preparing for the implementation of the legislation. A model process will be outlined in the resource pack to help identify the key components of an assurance system and the linkages with existing assurance systems.

6.59 On the other points made:

- EHRC clearly has a role in relation to equality in health and social care as well as elsewhere, but those accountable for health and social care also need to address equality issues;
- the Equality and Diversity Council is a sub-committee of the NHS Management Board and chaired by the NHS Chief Executive. Its role is to provide clear leadership and to champion equality in the NHS. It includes members from the highest levels of the NHS and DH, as well as representatives from patient groups, unions and the third sector. It has established working groups to affect change across the NHS with a cross cutting focus on workforce issues;
- the comment about the need for a simpler question is considered in paragraph 2.8 above.

## 7. PROPOSALS RELATING TO ACTION BY OTHER BODIES

### Providers and commissioners of health and social care

7.1 The review made a number of recommendations addressed, not to DH, but to providers and commissioners of health and social care. Some of these were cross-cutting, while others were concerned with specific services. These were set on in Proposals 15-22 in the consultation paper. (The text of these proposals is reproduced in Annex D).

7.2 The consultation paper invited comments on:

- whether the actions called for in these recommendations were appropriate steps to take;
- whether progress on any should be considered for inclusion in the assurance process considered under Proposal 8;
- whether there was action that DH should take to support health and social care in meeting these recommendations, over and above production of the resource pack that was already planned.

### Responses

#### *Are these appropriate steps to take?*

7.3 Around forty respondents, from a variety of sources, indicated by ticking the box on the response form that they thought the actions called for in these recommendations were appropriate steps to take. (The number agreeing with the actions proposed was highest (forty-two) for Proposal 20 and lowest (thirty-seven) for Proposal 18). In addition, Anchor confirmed in comments that it supported all the actions. One (individual) respondent ticked the “no” box, for Proposal 16 (only), adding that the proposal might not be the best way to implement the age provisions in the Equality Bill.

7.4 The main comments about the case for these proposals, and ways in which they could be taken forward, are recorded in Annex D.

#### *Should progress be considered for inclusion in the assurance process considered under Proposal 8?*

7.5 Smaller numbers (ranging from twenty for Proposal 15 to seven for Proposal 22) ticked the box on the response form to show that they thought progress on the proposals concerned should be considered for inclusion in the assurance process considered under Proposal 8. No respondent ticked the “no” box on the form.

7.6 Relatively few comments were made on the question of the assurance process: for individual proposals, these are recorded in Annex D. More generally, there was:

- a request for an assurance process to cover the work of Job Centre Plus and the Learning and Skills Councils successor bodies (a LINK); and
- a request for DH to play “a more robust and visible role in driving the equality duties through the health and social care systems and tackling ageism” (Unite).

*Is there action that DH should take to support health and social care in meeting these recommendations, over and above production of the resource pack that is already planned?*

7.7 Smaller numbers (ranging from fourteen for Proposal 15 to four for each of Proposals 17-19 and 22) indicated by ticking the box on the response form that they thought there was action DH should take, over and above preparation of the resource pack to support health and social care in meeting the recommendations.

7.8 Again, there were relatively few comments on what further support from DH was needed. The main points made are recorded in Annex D.

### DH position

7.9 DH welcomes the support expressed for these proposals. As explained in the consultation paper, they are for providers and commissioners of health and social care services to take forward. A more detailed account of the DH position on the individual proposals is provided in Annex D. The work of Job Centre Plus and the Learning and Skills Councils successor bodies are the responsibility of other Government departments.

### Other recommendations

7.10 The consultation paper invited comments on two other recommendations which were directed at, respectively, professional regulators and providers of education and training.

## **Proposal 23: Professional regulatory bodies**

7.11 The review recommended that:

All professional regulatory organisations will need to review and, if necessary, revise their standards, codes of conduct and education programmes to advance equality and to ensure that age discriminatory behaviour is clearly identified as unacceptable and a failure in professional standards (Recommendation 14).

The consultation paper said that DH agreed with this recommendation. It explained that most of the bodies concerned<sup>9</sup> are fully independent of DH but

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<sup>9</sup> Council for Healthcare Regulatory Excellence; General Chiropractic Council; General Dental Council; General Medical Council; General Optical Council; General Osteopathic Council; General Pharmaceutical Council; General Social Care Council; Health Professions Council; Nursing and Midwifery Council; Office of the Health Professions Adjudicator.

accountable to Parliament. (Only the General Social Care Council has an accountability relationship to DH). However DH had already written to the bodies concerned to alert them to the requirements of the Bill.

### Responses

7.12 Forty responses ticked the “yes” box on the response form to show their support for this proposal, and six others made comments.

7.13 Comments came mainly from the bodies concerned, who described what they had already done or were doing in relation to equality:

- the General Medical Council said: “In 2009 we published new editions of our standards for undergraduate education, *Tomorrow’s Doctors (TD)* and the Foundation Programme, *The New Doctor (TND)*, taking full account of equality and diversity issues”;
- the Health Professions Council said “As part of our commitment to equality and diversity, we have produced a position statement for education and training providers on age discrimination”;
- the Royal Pharmaceutical Society of Great Britain said it “regularly reviews its standards, Code of Ethics, including standards for educational programmes, to ensure that they are up-to-date and fit-for-purpose”;
- the Nursing and Midwifery Council said how the Alzheimer’s Society and Age Concern/Help the Aged had been involved in some of the project groups established to inform the policy development stage of the review of pre-registration nursing education.

7.14 In addition, two local government responses said it was useful to involve LINKs and public networks and CQC. CQC said that regulatory bodies had an important role in ensuring non-discriminatory practice through their own conduct as well as through their education and training programmes.

### DH Position

7.15 DH is pleased to see the activity already taking place and the readiness of the bodies concerned to tackle issues of equality and discrimination.

### **Proposal 24: Education and training in health and social care**

7.16 The consultation paper invited comments on the review’s recommendation that:

All organisations responsible for education and training in health and social care will need to ensure that their curricula and programmes enable staff and trainees to apply the law effectively in time for its commencement. We recommend that the providers of education develop ways of involving older people in the delivery of education

programmes, especially to trainees at an early stage in their learning (Recommendation 15).

### Responses

7.17 Thirty-nine respondents confirmed their support for this proposal by ticking the “yes” box on the response form. One ticked no, but the comment made (“Not all providers adapt this process at an early stage and we should ensure that every provider involves the process of training at the early stage”) suggested it supported the proposal. In addition, seven other respondents made comments.

7.18 The comments made included examples of where older people were already involved in training. An NHS Trust said that “learning from patients has proved to have a powerful and memorable impact on trainees”, and a local government response said involving older people in training had been valuable in highlighting both the skills of older people and the effects of age discrimination where it had been experienced. The Alzheimer’s Society made the point that dementia does not mean a person is unable to share his or her experiences. Others supported the involvement of people of all age groups, including young people (Young Equals and others) and of people with other protected characteristics, such as disability.

### DH position

7.19 DH welcomes the support expressed for the proposal, and encourages organisations responsible for education and training to take it forward, bearing in mind the value of involving people who are able to contribute from a variety of perspectives.

## **Proposal 25: Mainstreaming the Equality Bill in other parts of the health and social care system**

7.20 The consultation paper explained that three of the recommendations considered in chapter 5 in relation to DH’s own processes also applied to other parts of the health and social care system. These were:

Arms-length Bodies, such as Executive Non-departmental Public Bodies, should satisfy themselves that any age-based criteria they apply comply with the new legislation (Recommendation 8);

DH and the NHS review the use they make of quality-adjusted life years (QALYs) and other similar support tools to inform their decision-making prior to the Equality Bill coming into force. (Recommendation 11);

and

DH and the wider system ensure the use of tools such as Equality Impact Assessments to ensure compliance with the age discrimination ban and the public sector equality duty in all new policies (Recommendation 21).

The consultation paper explained that DH planned to alert the executive non-departmental public bodies that it sponsors to the requirements of the Equality Bill, and to update them on thinking about tools such as equality impact assessment, in the same way as it plans to alert its advisory non-departmental public bodies (see Proposal 3). It invited comments on the recommendations and DH's plans for taking them forward.

### Responses

7.21 Respectively forty, thirty-four and thirty-nine responses indicated their support for the three recommendations by ticking the yes box on the response form. Some of these, and a small number of other responses, added comments. The comments made were generally supportive, and/or repeated points made in relation to Proposals 4 and 6.

### DH position

7.22 DH is grateful for the comments made. It plans to write to its arm's length bodies in similar terms as discussed for its advisory non-departmental public bodies under Proposal 3.

**ANNEX A: SUMMARY OF DH POSITION**

<b>Proposal</b>		<b>DH position</b>
1	Timing of the ban on age discrimination	The consultation paper asked if there was action, additional to that outlined in the consultation paper, that needed to be taken to prepare health and social care for implementation of the ban on age discrimination, and if there were actions that needed to be taken by a particular date to ensure that implementation happens smoothly. DH is grateful for the thought respondents gave to answering these questions, and will bear in mind the suggestions made in taking forward the work that is planned. In particular, DH recognises the emphasis that respondents placed on having guidance ready sooner rather than later.
2	Exceptions	The consultation paper did not pose any questions about exceptions, but explained that the Government Equalities Office would be publishing a policy statement on this topic. (This subsequently appeared in January 2010). DH encourages all those with an interest in this issue to contribute to the Government's work on whether to create specific exceptions for health and social care. As explained in the GEO policy statement, this can be done by: <ul style="list-style-type: none"> <li>• sending comments, by 30 April 2010, to <a href="mailto:age@geo.gsi.gov.uk">age@geo.gsi.gov.uk</a> on what uses of age should be able to continue, by whom, and the legal way forward;</li> <li>• taking part in the consultation planned for autumn 2010 on the draft Order.</li> </ul>
3	Advisory non-departmental public bodies	DH will write to its advisory non-departmental public bodies to alert them to the requirements of the legislation and to the training and guidance available. It plans to do this as soon as possible after the legislation receives Royal Assent.
4	Equality impact assessments	DH agrees with the review's recommendation (that it should "ensure the use of tools such as Equality Impact Assessments to ensure compliance with the age discrimination ban and the public sector equality duty in all new policies") and will take it forward, bearing in mind the new specific duties that the Government plans to create for public bodies bound by the public sector equality duty.
5	Research	DH will keep under review its Research Governance Framework for Health and Social Care, to ensure compliance with the equality legislation. A significant volume of funding is available for health-related research. All research is funded through fair and open competition, and success in any area of

		science will depend on the quality of the proposals made by the relevant scientific community.
6	Quality-Adjusted Life Years (QALYs)	DH will keep the methods in which QALYs are applied under review to ensure that it is aware when the methodology treats an age group less favourably and considers whether there are alternative methods that could be adopted.
7a	Age criteria in national policies	DH will take forward its proposal for reviewing age criteria in national policies, ensuring that there is publication of the results.
7b	Local authorities and the Relative Needs Formulae for social care for adults	In the short to medium term DH will undertake a review of the relative weighting of the two Relative Needs Formulae for adults aged under 65 and aged 65 and over. Ministers will not make a decision on a future review of the formulae themselves until the completion of a feasibility study, but the implications for the formulae of the new legislation on age will be kept under review.
7c	The upper limit for the breast cancer screening programme	The breast screening programme is currently being extended to women aged 47-49 and 71-73. The extension is being randomised by screening batch, so that half of eligible women will be invited at age 47-49 and half at age 71-73, creating natural control groups of those women not invited in those particular age ranges. The Advisory Committee on Breast Cancer Screening recommended that the cohort of women being invited at age 71-73 should be re-invited for a further two screening rounds at ages 74-76 and 76-79. This would give sufficient numbers in the screened cohort and the control cohort to make decisions based on the benefits and harms of screening in this age range. The 2010-11 NHS Operating Framework stated that PCTs need to work with their cancer network to ensure that all screening services have made plans to start the extension of breast cancer screening offered to women aged 47-49 and 71-73 from April 2010.
8	Resource pack and guidance	The South West will continue with co-production of the resource pack, aiming to take in account as many as possible of the comments made, including the wish many bodies have expressed to have guidance sooner rather than later. DH will bear in mind the suggestions made about other guidance that would be useful, taking account of material that becomes available from other sources, such as the Equality and Human Rights Commission.
9	Age specific dataset	We have concluded that, whilst a toolkit to support the resource pack is vital, there is no need to commission an additional dataset. We are currently working with the Public Health Observatories to take

		<p>this work forward, bearing in mind all the points made. We are sympathetic to the argument that the toolkit should not focus solely on age but should also cover other protected characteristics to enable additional analyses to be carried out at an appropriate level, and we are investigating how to do this in practice.</p>
10	Performance measures	<p>DH agrees with the review's recommendation that future performance measures that are both proportionate and targeted should be developed in accordance with the age discrimination ban and the public sector equality duty, and will bear in mind the comments made in taking this work forward.</p>
11	World class commissioning	<p>DH agrees with the review's recommendation that there should be clear and emphatic references to ending discrimination (in relation to eight protected characteristics, including age) and advancing equality in the 2010/11 World Class Commissioning (WCC) assurance process. It has already aimed to take account of this in the material developed for the 2009/10 assurance process, and will continue to do so in the future development of the WCC assurance process, including the supporting information to be made available later in 2010 for use in the 2010/11 assurance process, bearing in mind the detailed suggestions made in the responses to the consultation.</p>
12	Improving Quality and Productivity	<p>DH agrees with the review's recommendation (that it should ensure that work to prevent harm and waste and spread innovation should be designed to help promote age equality and that measures to end age discrimination are implemented so that they improve quality and productivity) and is taking this forward by ensuring a focus on age equality in the Quality, Innovation, Productivity and Prevention agenda.</p>
13	Registration, inspection etc	<p>DH agrees with the review's recommendation that it and the relevant national regulatory organisations should work together to ensure that a shared understanding of the implications of the law is the basis for registration, inspection, regulation and assessment of the health and social care system. It is taking the recommendation forward by working closely with the Equality and Human Rights Commission on the development of guidance on the new legislation, and the Care Quality Commission is contributing to that process. DH is also working with the relevant bodies to keep to a minimum any burdens associated with regulation, inspection etc.</p>
14	Assurance process	<p>The Equality and Diversity Council is currently developing its work programme which includes an</p>

		<p>approach to assurance that covers all the protected characteristics, including age. Although the Council's primary focus is on the NHS, this work includes social care and the third sector. It is crucial that the approach to assurance involves both health and social care at the regional as well as the national tier, so DH expects Strategic Health Authorities (SHAs) and Government Offices (GOs), working co-operatively with ADASS and other key players, to agree with local authorities and other NHS bodies how they will be assured that localities are preparing for the legislation coming into effect. The NHS Operating Framework for 2010/11 has already highlighted the importance of preparing for the age equality legislation. In taking this forward, DH expects SHAs and GOs to bear in mind the comments made, particularly on the value of a joint system and of ensuring alignment with, and no duplication of, other processes.</p>
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## ANNEX B: WHO RESPONDED TO THE CONSULTATION?

### Local government

Association of Directors of Adult Social Services/Local Government Association  
Blackburn with Darwen Borough Council  
Bristol City Council  
Cornwall Council Adult Care and Support  
Durham County Council  
Forest Heath District Council  
Gloucestershire Health Community & Care Overview and Scrutiny Committee (two responses)  
Hampshire County Council Adult Social Care Department  
Kent Adult Social Services  
Lambeth Council Adults' and Community Services  
Lancashire County Council  
London Borough of Barking & Dagenham Adult Commissioning  
London Borough of Croydon, following discussion with their Older Peoples' Network  
London Borough of Redbridge Adult Social Services  
London Borough of Richmond  
London Borough of Tower Hamlets Adults Health and Wellbeing Equalities Focus Group  
Newcastle upon Tyne Adult Services  
Sandwell Metropolitan Borough Council Adult Services Health  
Staffordshire County Council Social Care & Health Directorate  
Sunderland City Council  
Surrey County Council  
Wakefield Council Adult Services  
West Sussex County Council  
and one anonymous response

### Joint local government and NHS

Cheshire West and Chester Council and NHS Western Cheshire

### NHS

2gether NHS Foundation Trust (Foundation Trust for Gloucestershire)  
Harrogate and District NHS Trust  
NHS Berkshire East  
NHS Cornwall and Isles of Scilly  
NHS North Somerset  
NHS Nottinghamshire County  
NHS South Gloucestershire  
NHS South of Tyne and Wear  
NHS Telford and Wrekin Joint Commissioning Team

### Third sector

Age Concern/Help the Aged  
Age Concern MK  
Agewell Sandwell

Alzheimer's Society  
Anchor  
Arthritis Care  
Breast Cancer Care/Breast Cancer Campaign  
Cancer Research UK, Kings College London  
Civil Service Pensioners Alliance  
Council of Ethnic Minority Voluntary Sector Organisations  
Croydon African Caribbean Family Organisation  
Equality South West on behalf of the South West Age Equality Network  
Gillingham Seniors Forum (two responses)  
Greater London Forum for Older People  
Help the Hospices  
Kensington & Chelsea LINK/Kensington & Chelsea Forum for Older Residents  
Mind  
NACRO  
National Pensioners Convention  
North Yorkshire LINK  
Nottinghamshire County LINK  
POhWER  
Regional Action and Involvement South East  
Sense  
Shropshire LINK Community Involvement in Care and Health  
Sunderland Voice for Carers  
Young Equals

**Regulators**

Care Quality Commission  
Equality and Human Rights Commission  
Health Professions Council

**Health professional bodies and unions**

British Geriatric Society  
British Medical Association  
General Medical Council  
Nuffield Council on Bioethics  
Nursing and Midwifery Council  
Royal College of General Practitioners  
Royal College of Physicians & Surgeons of Glasgow  
Royal College of Psychiatrists  
Royal Pharmaceutical Society of Great Britain  
Unite

**Others**

Community Care Research & Consultancy  
Fitness Industry Association  
Saga  
Roche  
Five individuals

## ANNEX C: EQUALITY IMPACT ASSESSMENT

C.1 DH published an equality impact assessment alongside the consultation paper and asked six questions about it:

- a) Do you agree with the analysis in this equality impact assessment?
- b) Do you think any of the recommendations are likely to have a negative impact on people with a protected characteristic(s)? What actions could be taken to minimise this?
- c) Do you think any of the recommendations are likely to have a positive impact(s)? What actions could be taken to promote this across all protected characteristics?
- d) Do you have any examples of good practice which highlight the positive impact which the recommendation(s) can have?
- e) Do you agree with the monitoring and evaluation section?
- f) Do you agree with the conclusion?

### Responses

C.2 Comments on the equality impact assessment were provided by Equality South West, CACFO, a LINK, and five local government responses.

C.3 Points made on the specific questions were:

#### On question a)

- i) mention could be made in the race section about specific issues for BME elders with dementia for whom English is not a first language.
- ii) greater equality for older people could have a detrimental impact on people who, at present, benefit from packages of care, which are more generous than the average package for a person over 65.

#### On question b)

- iii) there should be review of anti-racism policies.

#### On question c)

- iv) research into multiple discrimination could be explicitly included in the proposal, perhaps with a particular focus on age and lesbian, gay, bisexual and transgender issues, in recognition that there are considerable information gaps.

- v) care management and assessment guidelines and self directed support already encompass all age groups.

#### On question d)

vi) the involvement of older people, including for example the use of 'community champions' for older people forums, could have a positive impact.

On question e)

vii) the EHRC duty to monitor progress was welcome. Monitoring and evaluation should be used to develop service delivery.

There were no comments on question f).

C.4 More general comments on the equality impact assessment were:

viii) it was important to cover all the protected characteristics, so that none was neglected, and to be alive to the possibility of dual or multiple discrimination.

ix) all documents relating to the Equality Bill and associated policies should be written in clear language, fair, transparent, needs based and accountable.

DH position

C.5 DH agrees that:

- it is important to keep in mind all protected characteristics, and to be aware of the possibility of, and to tackle, dual and multiple discrimination (relevant to points i and viii), and to involve service users and stakeholders of all ages in developing policies and reviewing services (relevant to point vi);
- there need to be appropriate arrangements for keeping policies under review and for monitoring and evaluating services (relevant to points iii and vii).

C.6 On point ii), we believe that everyone benefits from greater fairness, and that this is particularly so for age, which changes over time. We understand point vii) to be making the point that many local authorities already aim to achieve fair allocation of resources to adults of different ages. On point iv), the DH position is as set out under Proposal 5. On point ix), we have aimed to make this document meet these requirements.

C.7 In the light of this, we are adding to the equality impact assessment published alongside the consultation paper the following paragraph:

Update in the light of the consultation

The comments made in responses to the consultation generally confirmed the position taken in this assessment. They also drew attention to the importance of involving service users and carers, of being alive to the possibility of multiple discrimination, and of making appropriate arrangements for review, monitoring and evaluation. DH will bear these points in mind in taking forward the recommendations which are for it to take forward, and encourages those responsible to taking forward the other recommendations to do so too.

## ANNEX D: DETAILED COMMENTS ON THE PROPOSALS COVERED IN CHAPTER 7

<p><b>Proposal 15: Visible leadership</b></p> <p>Leaders of health and social care organisations, including the boards of those organisations and Elected Members, will want to set out a clear commitment to their staff and the wider public to meeting the requirements of the age discrimination ban and the public sector equality duty and demonstrate how the health and social care sector can show leadership in tackling ageism in society.</p>
<p><b>Comments</b></p> <p><i>How to take forward</i></p> <p>Organisations could appoint age equality champions lead (Alzheimer’s Society, Equality South West and ADASS/LGA). Board members would need training (Equality South West, local government response). Groups such as LINKs should be involved to inform local leadership (a LINK, GLF). Stakeholder evaluation should reveal the extent to which leadership has achieved these goals (Nursing and Midwifery Council). Clear performance measures needed (local government response).</p>
<p><i>Include in assurance process?</i></p> <p>Leadership is already part of the assurance process for World Class Commissioning and so assurance should be incorporated into existing processes (two PCTs)</p>
<p><i>Support needed from DH?</i></p> <p>Good practice guidance, particularly regarding the shared responsibility of health and social care organisations (a local government response). Publicity and advertising through DH would help support local initiatives (local government response). DH needs to analyse the results of applying the toolkit, issue deadlines for completion of this exercise, collate the responses and support organisations in completing the toolkit (British Geriatrics Society).</p>
<p><b>DH position</b></p> <p>The suggestions made will be built into the resource pack. These include the suggestion to create Age Equality Champions and board level training on equalities. DH will not require Age Equality Champions but will encourage organisations to follow the advice in <i>Achieving age equality in health and social care</i> ("Organisations may also want to consider the use of board-level champions", page 43).</p>

<p><b>Proposal 16: Joint working</b></p> <p>Local social care and health commissioners and providers will want to work together to implement the age provisions in the Equality Bill. We are producing a resource pack to support local communities and recommend that the local approaches share the following features/outcomes:</p> <ul style="list-style-type: none"> <li>• Led by Primary Care Trusts (PCTs) and Local Authorities (LAs), with joint audit of services, systems and processes across health and social care;</li> </ul>
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<ul style="list-style-type: none"> <li>• Joint action planning across health and social care that sets out how local organisations will meet the public sector equality duty and comply with the age discrimination ban;</li> <li>• Work with NHS, LA, third and independent sector providers and those working in them to embed actions in provider improvement plans;</li> <li>• Assessment and agreement of the local resource consequences of implementation within local funding parameters;</li> <li>• Involvement of members of the public in the work through Local Involvement Networks (LINks), forums and other networks and discussion of the conclusions of the local analysis by NHS Boards and Elected Members in public;</li> <li>• Use the local scrutiny processes and bodies such as Health Overview and Scrutiny Committees to provide transparency and build public confidence;</li> <li>• Build on existing approaches to implementing equalities and quality improvement but recognise that the age provisions in the Bill are a new requirement.</li> </ul>
<p><b>Comments</b></p> <p><i>Whether to take forward</i></p> <p>The personalisation agenda will demand this (a local government response)</p>
<p><i>How to take forward</i></p> <p>Joint working already under way, many existing examples that can be built on (four local government responses, one jointly with a PCT)</p> <p>Requirement for partnership should be set out in service specifications (a PCT)</p> <p>Contractual obligation should support equality (Nursing and Midwifery Council)</p> <p>Involve LINks and Overview and Scrutiny Committees (ADASS and others) and organisations representing older people (Equality South West)</p> <p>Address issues of dual sensory loss (Sense)</p> <p>Hospices tell us that joint working is difficult to achieve for a number of reasons including skills shortage, lack of respite care and attitudinal problems. For it to be effective, PCTs, in their lead role, need to be better informed about local needs and services for end of life care. Joint-action planning should be the strongest element in developing joint-working practices, but should be as independent as possible (Help the Hospices)</p>
<p><i>Include in assurance process?</i></p> <p>The world class commissioning quality assurance framework needs explicitly to look at commissioning services for older people (British Geriatrics Society)</p>
<p><i>Support needed from DH?</i></p> <p>Through proposed centres of expertise (a local government response)</p> <p>Include examples of good practice in national guidance (a local government response)</p> <p>DH will need to work jointly with local authorities to ensure that areas of joint funding (e.g. long-term care) are considered. (Royal College of Physicians)</p>
<p><b>DH position</b></p> <p>DH is actively promoting closer partnership working between public sector bodies locally while recognising that there can be different local models to</p>

create joined up services to the public. The resource pack will help LAs and the NHS identify the opportunities for the health and social care sectors to work together and provide an opportunity for localities build the work on age equality into their existing partnership working arrangements. It will also highlight approaches that bring the third, voluntary and independent sectors into the partnership work. On the comments about the assurance process and centres of expertise, see Proposals 11 and 8 respectively.

**Proposal 17: Local authority assessment procedures**

Local authorities review their assessment procedures and the resulting packages of care and funding arrangements for both service users and carers in preparation for the new legislation focusing on the outcomes that are delivered for service users and their carers.

**Comments**

*Whether to take forward*

Already working with councils to end differential service specifications based on ageist assumptions (LGA and ADASS).

To some extent this is already underway via the Equality Impact Assessment Process (local government response).

*How to take forward*

Local authority assessment processes must identify needs arising from dual sensory loss (Sense).

Local authorities should review arrangements with a view to providing greater lower-level interventions for dementia (Alzheimer's Society).

Changing the assessment process must ensure that other groups with protected characteristics (disability) are not disadvantaged (local authority jointly with a PCT).

Review should be done in the light of personalisation of care agenda and taking account of resource implications (various local authorities).

Need to monitor implementation of the Fair Access to Care Services guidance to ensure needs are adequately met (Alzheimer's Society, CSPA).

*Include in assurance process?*

DH should establish a timetable and framework for the review of local authority assessment procedures (Help the Hospices)

*Support needed from DH?*

Difficult to measure the degree of age discrimination in funding or commissioning local services; will require some thought and a sophisticated methodology (British Geriatrics Society). Guidance would be useful (various) and should be specific on where the outcomes of the review should be reported to (a local government response)

**DH position**

DH recognises that local authority assessments for service users and carers can sometimes be discriminatory against older people. We are pleased that the local authorities who responded to this proposal did so positively and demonstrated equality is already on the agenda for assessments with the use of Equality Impact Assessments.

In the light of the findings of the independent review, undertaken by the

Commission for Social Care Inspection on the application of eligibility criteria,<sup>10</sup> we consulted on, and have now published a final version of, revised Fair Access To Care Services guidance. Its aim is to bring about improvements to the system as it currently stands, making implementation fairer and more consistent for people seeking support and reinforcing the current direction of policy established by *Putting People First*, our policy statement which sets out the direction for adult social care over a ten year period from October 2008. Alongside the new Fair Access to Care Services guidance, the Social Care Institute for Excellence are developing an online training resource for social care staff to ensure that the criteria are applied more consistently across the country.

**Proposal 18: Mental health**

Every provider and commissioner of mental health services will need to consider how to achieve non-discriminatory, age-appropriate services, drawing on insights from reports such as *Equality in Later Life* and other sources of good practice.

**Comments**

*Whether to take forward*

Must abolish funding gap in the mental health services offered to older people compared to younger people (Alzheimer’s Society, NPC, CSPA, local government response)

*How to take forward*

Involve Royal College of Psychiatrists (a PCT)

It should be possible for specialist projects or services to justify their age focus when this is appropriate – a way of closing the gap rather than perpetuating discrimination (Mind, British Geriatric Society).

Need to maintain and develop the skills of specialists in the psychiatry of older people (a local authority jointly with a PCT)

Older people with dual sensory loss are sometimes dismissed as being ‘confused’ or developing dementia – this is an age discrimination issue as such assumptions would less easily be made about a younger person.’

(Sense)

Keep in mind transition issues (child to adult) (Young Equals)

Need to recognise that younger people with dementia have particular support needs related to their age, for example they are more likely to have dependent children at time of diagnosis, may experience greater difficulty rationalising loss of skills at a younger age and may have greater capacity for physical activities (Alzheimer’s Society)

*Include in assurance process?*

Central government reinforcement is needed in addition to guidance (a local government response)

*Support needed from DH?*

Include good practice guidance in resource pack for social care. DH should make sure that it implements the recommendations made to it in the *Equality in Later Life* report. This includes ensuring that the age specific dataset

<sup>10</sup>

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_113154](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113154)

includes data on discrimination by age and mental health (Equality South West)
<p><b>DH position</b></p> <p>DH will provide support to those taking forward this proposal through the workstreams arising from <i>New Horizons: a shared vision for mental health</i> published in December 2009.</p> <p>DH welcomes the work already being done by providers of mental health services in order to address the gaps between younger and older patients. It is important that provision of services meets the population needs and ensures access to appropriate services for all mental health service users, regardless of age.</p> <p><i>New Horizons</i> makes clear that DH will work with the NHS Information Centre for health and social care and regulatory bodies to ensure that regular monitoring of experience of services and access to services is inclusive of the full age range.</p>
<p><b>Proposal 19: Prevention</b></p> <p>Health and social care organisations work in partnership to implement demonstrated best practice in prevention programmes that improve the quality of life of older people.</p>
<p><b>Comments</b></p> <p><i>Whether to take forward</i></p> <p>Integrated prevention services are essential for improving care, promoting cost effectiveness and preventing unnecessary acute hospital admission and premature admission to long-term residential care as well as maximising independent living and quality of life. (Alzheimer’s Society)</p> <p>Prevention features in nearly all consultations but when funding becomes tight it tends not to remain as a focus for service provision (GLF)</p> <p>Links to transformation and personalisation agendas (local government response)</p>
<p><i>How to take forward</i></p> <p>Need to engage with service users across all age groups (a PCT, two local government responses), particularly older people (NPC, CSPA); embed this at all levels, including local area boards and delivery groups (a LINK)</p> <p>Training would be helpful in establishing the joint approach to prevention (CACFO)</p> <p>An award for the most progressive health and social care organisation on achieving Age Equality could be useful (a local government response)</p> <p>Prevention programmes and their evaluation should specifically address the needs of older people with sensory loss. This should include access to timely and appropriate support from both health and social care as well as targeted work in areas such as healthy lifestyles, falls, isolation, mental wellbeing. (Sense)</p> <p>Commissioning and the public mental health framework which is part of <i>New Horizons</i> are significant for this proposal (Mind)</p>
<p><i>Include in assurance process?</i></p> <p>-</p>
<p><i>Support needed from DH?</i></p>

We would welcome plans, beyond the toolkit, on how the DH will encourage providers to work in partnership. (Help the Hospices)  
 Good practice guidance would help (local government response)

**DH position**

DH agrees that partnership working in delivering prevention programmes, particularly across health and social care, is key to improving the quality of life for older people. DH has published several resources to support health and social care organisations in implementing demonstrated best practice:

*Improving care and saving money*, and *Making a Strategic Shift to Prevention and Early Intervention - Guide and Key Messages Summary*, October 2008.

As outlined in *Use of Resources in Adult Social Care*, a focus on prevention is particularly important when pressures on budgets are increasing. The recent *Partnership for Older People Projects (POPP) Evaluation* has shown that an investment in preventive care results in acute care savings; for every £1 spent on POPP services, there is a saving of £1.20 in emergency bed days.

The implementation preparedness toolkit and list of actions recommended in *Achieving age equality in health and social care* look at the provision of non-ageist services across the local health and social care economy. These help ensure that services are matched to the needs of the population and not excessively skewed to one group of service users based on age alone.

The suggestion made about training is sensible and DH agrees and thinks this is vital. 70% of bed days are occupied by people over 65, around 60% of the social care spend is on over 65s and over 65s are 5 times as likely to consult a GP. But the evidence from the national report on age discrimination and the Centre for Policy on Ageing reviews showed that education and training at both undergraduate and postgraduate level often didn't meet the needs of the biggest group of service users. It is now 9 years since the National Service Framework for Older People stipulated that "all professionals working with older people had the right skills and training".

**Proposal 20: Training**

Local statutory organisations should build into their contracts with providers of training programmes (including third sector and private organisations) the need for an explicit focus on age equality that supports staff in providing high quality services to people of all ages.

**Comments**

*Whether to take forward*

Crucial - health and social care professionals often have little specific training around the needs of older frailer people even though these are the core users or services and staff working in those areas are often under-valued, supported, and rewarded (British Geriatrics Society, also support from Unite) There is institutional ageism and it will take longer than 2 years to overcome a culture where older people are seen as the burden on society (GLF)

*How to take forward*

Need to cover the human rights agenda (a PCT, a local government response) and ethnicity, sexual orientation and disability (local government response). Emphasise relevance and proportion so that this does not become "tick box" (local government).

<p>Involve older people (GLF, local government)                  Multi-disciplinary training important (NPC, CPSA, local government)                  More joint commissioning of training programmes will encourage more joint working to promote change (a PCT)                  Make training available to others, not just professionals working for statutory organisations (RAISE, CACFO, two local government responses).                  Provide access to the ongoing education needed to equip staff and carers to respond appropriately to ethical problems, and to forums for sharing and receiving support in making ethical decisions.' (Nuffield Council on Bioethics)</p>
<p><i>Include in assurance process?</i>                  -</p>
<p><i>Support needed from DH?</i>                  Specific guidance for procurement staff and commissioners? (local government response)                  Prioritise work on recommendation 13 of the National Dementia Strategy for England (national leadership to address the dementia skills gap in the workforce is critical for supporting this proposal), include this proposal as a priority for action in the Workforce Action Plan, due March 2010 (Alzheimer's Society)                  Consider tools apart from the resource pack (Help the Hospices)</p>
<p><b>DH position</b>                  DH encourages those commissioning training to bear in mind the points made.                  DH has identified objective 13 of the National Dementia Strategy on delivering "An informed and objective workforce for people with dementia." as one of 7 priorities for implementation and will shortly be receiving the results of a mapping exercise to identify accredited education and training in dementia for all relevant health and social care professionals. Based on this information, DH will identify priorities for improving existing education and training provision, pre and post-qualification.</p>
<p><b>Proposal 21: Complaints</b>                  Local NHS and social care commissioners and providers, and the people that work in them, consider how they can use the new NHS and social care complaints process to achieve rapid resolution of individual instances of potential discrimination.</p>
<p><b>Comments</b>  <i>Whether to take forward</i>                  Yes – older people often find it difficult to make a complaint, for example if they are isolated and do not have the support of families and friends (Age Concern/Help the Aged); the system is too complicated, takes too long (POhWer and others); procedures inhibit many members of the general public. Those receiving social care often find it difficult to complain especially about staff they depend on every day (GLF). Implicit in the revised 2009 complaints procedure (a PCT)</p>
<p><i>How to take forward</i>                  Shorter timescales for responses to complaints (NPC, CSPA)                  Provide information on progress in a child-friendly manner (Young Equals)                  Allow people to report incidents via a local community group (local government response)</p>

<p>Procedures need to be about not just responding or “box ticking” but systematic learning from the experiences of service users and their carers to improve practice (British Geriatrics Society)</p> <p>Bear in mind number of complaints involving both health and social care to be handled (local government response)</p> <p>Some mentioned systems they already have in place: “to ensure a rapid resolution to any complaint that cuts across both Health and Social Care, the agencies involved work to an agreed protocol. Part of this protocol is based on the early resolution of all complaints, or sign posting the complainants to an organisation that can help/assist with any outstanding issues” (a local government response)</p>
<p><i>Include in assurance process?</i></p> <p>-</p>
<p><i>Support needed from DH?</i></p> <p>-</p>
<p><i>DH position</i></p> <p>DH agrees with the review’s recommendation. In April 2009, we reformed the NHS and adult social care complaints arrangements. The new arrangements seek to deliver:</p> <ul style="list-style-type: none"> <li>• more accessible, responsive and simpler to understand complaints arrangements,</li> <li>• better quality feedback from complaints to support organisational learning and commissioning decisions,</li> <li>• greater user satisfaction, better outcomes, and improved service delivery.</li> </ul> <p>The new arrangements allow for complaints to be made to local authorities and NHS bodies about the exercise of their functions. It is right for these organisations to have arrangements in place that allow anyone who feels they may have suffered discrimination to raise their concerns, to have these concerns addressed, and to receive an appropriate response. DH is pleased to see the confidence expressed by some respondents about the complaints procedure already working effectively in their organisations.</p> <p>Nonetheless, we recognise that individual complaints may raise sensitive and/or complex issues. It is right that each complaint is treated on its individual merit, with an appropriate response being sent to the complainant. So, in some instances, it will take longer for the response to a complaint to be sent than in others.</p> <p>Similarly, we realise being able to raise a complaint as an older person may be more difficult than, perhaps, for other service users. The new arrangements allow for complaints to be made orally because not all people will wish to do so in writing. When acknowledging a complaint, the local authority or NHS organisation must offer to discuss the complaint with the complainant.</p> <p>Overall, we believe complaints offer an important source of feedback from users. This feedback assists organisations to improve the delivery of their</p>

services. But it is vital that people who use and rely most on these services are able to make their views known.

**Proposal 22: Joint improvement partnerships**

Local authorities use the Joint Improvement Partnership process to share learning and progress, thus ensuring linkage with the implementation of *Putting People First*

*Whether to take forward*

-

*How to take forward*

Much of this work is already going on at local level (a PCT). This should be written into practice of "Putting People First" (NPC, CSPA)

*Include in assurance process?*

-

*Support needed from DH?*

-

**DH position**

DH recognise that a lot of good work is already happening using the Joint Improvement Partnership. DH published "Use of resources in adult social care: A guide for local authorities" in October 2009 detailing ways in which councils could look to make efficiencies in the way that they provide services.

**ANNEX E: KEY TO ABBREVIATIONS USED IN THIS REPORT**

ACBCS	The Advisory Committee on Breast Cancer Screening
ADASS	The Association of Directors of Adult Social Services
ANDPB	Advisory Non-Departmental Public Body
CACFO	Croydon African Caribbean Family Organisation
CEMVO	The Council of Ethnic Minority Voluntary Sector Organisations
CQC	The Care Quality Commission
CSPA	The Civil Service Pensioners Alliance
DH	The Department of Health
EHRC	The Equality and Human Rights Commission
GEO	The Government Equalities Office
GLF	The Greater London Forum for Older People
GO	Government Office
GSF	Gillingham Seniors Forum
IDeA	The Improvement and Development Agency for Local Government
LGA	The Local Government Association
LINK	Local Involvement Network
NHS	National Health Service
NICE	The National Institute for Health and Clinical Excellence
NIHR	The National Institute for Health Research
NPC	The National Pensioners Convention
PCT	Primary Care Trust
PPI	patient and public involvement
QALY	quality-adjusted life year
RCPSG	The Royal College of Physicians and Surgeons of Glasgow
SHA	Strategic Health Authority