NHS England

NHS Standard Contracts 2017/18 and 2018/19

Equality impact analysis

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Document Status

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NHS Standard Contracts 2017/18 and 2018/19

Equality impact analysis

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This Equality Impact Analysis has been updated (August 2017) to reflect the fact that the name of the Multispecialty Community Provider (MCP) Contract has changed to the Accountable Care Model Contract. This Contract is now usable for accountable care models including MCP and PACS models.

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

Equality and Health Inequalities Analysis

Title: NHS Standard Contracts 2017/18-2018/19

The NHS Standard Contract is mandated by NHS England for use by NHS commissioners to contract for all healthcare services other than primary care. It is published in a full-length and in a shorter-form version.

The Five Year Forward View introduced the concept of a Multispecialty Community Provider (MCP) and the Primary and Acute Care System (PACS). A detailed description of the MCP care model was then set out in the Multispecialty Community Provider Emerging Care Model and Contract Framework, published in July 2016, and a detailed description of the PACS care model was set out in the Integrated Primary and Acute Care System (PACS) – Describing the Care Model and the Business Model framework, published in September 2016.

A separate Equality and Health Inequalities Analysis has been produced for the New Care Models Programme.

In essence, an MCP brings together GPs and other providers of out-of-hospital services to deliver a more integrated model of care. It incorporates a much wider range of services and specialists than traditional models and can encompass mental health services, and social care services where this is agreed by the CCG and local authority. The scope will vary between different MCPs but in some cases could also include the delivery of some elective services previously delivered in hospitals. PACS models of care incorporate a wider scope of acute services. In many cases the model is based on local units of integrated primary care provision, serving natural communities of 30-50,000 population. This integration of services will support the reduction of health inequalities in the population covered. Both the MCP and PACS models are forms of Accountable Care Organisations (ACOs). For 2017-19, a third version of the NHS Standard Contract (the Accountable Care Models Contract) has been published. The Accountable Care Models Contract provides for the delivery of accountable models of care, including the delivery of primary care and other services through a single contractual model.

The term 'NHS Standard Contract' is used below to refer to both the NHS Standard Contract and the Accountable Care Models Contract, except where indicated otherwise. The NHS Standard Contract was published in final form in November 2016, and the Accountable Care Models Contract was published in August 2017, replacing the draft MCP Contract published in December 2016.

What are the intended outcomes of this work?

NHS Standard Contract

The outcome of this work is to update the NHS Standard Contract from the 2016/17 version to the 2017/18-2018/19 version. We undertook stakeholder engagement in July – September 2016, and undertook consultation in September - October 2016, and used the outcomes of this to inform changes to the Contract. The changes keep the Contract up-to-date and relevant, for example: to ensure it correctly relates

to new legislation; to ensure it reflects significant new policies that have already been published over the last year; and to deliver technical improvements.

Accountable Care Models Contract
The outcome of this work is to publish a version of the NHS Standard Contract suitable for use with Accountable Care Organisations including MCPs and PACS. The Accountable Care Models Contract will incorporate the legal requirements covering primary care (APMS contracts) and secondary care (NHS Standard Contract), and will include new requirements specific to the MCP and PACS care models.

Who will be affected by this work?

Parties to the Contracts will be directly affected:

- NHS commissioners
- NHS providers
- Independent sector providers
- Third sector providers
- NHS specialised commissioning

Local populations, service users, and staff will also be affected.

Equality and health inequalities implications

In their roles as commissioners, employers and local and national system leaders, Clinical Commissioning Groups and NHS England have a key part to play in addressing equality and health inequalities.

Commissioners are required to use the NHS Standard Contract. The Contract therefore relates to all groups with 'protected characteristics' under the Equality Act 2010 (age, disability, gender reassignment; marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation). The Contract is aligned to the principles and duties of the Equality Act. Under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012, CCGs and NHS England have duties in relation to health inequalities in the following areas:.

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.13G and s.14T);

- Exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality and reduce inequalities in access to those services or the outcomes achieved (s13N and s.14Z1);

It should be noted that health inequalities can occur across a range of social and demographic indicators, including socio-economic status, occupation, geographical

locations and the nine protected characteristics of the Equality Act 2010.

The NHS Standard Contract prohibits discrimination on the basis of the nine protected characteristics set out in the Equality act 2010, this being a mutual obligation on the commissioner and on the provider. Service Condition 13 of the NHS Standard Contract 2017/18-2018/19 (Service Condition 17 of the Accountable Care Models Contract) relates specifically to 'Equality of Access, Equality and Non-Discrimination' and states:

SC13 Equity of Access, Equality and Non-Discrimination

13.1 The Parties must not discriminate between or against Service Users, Carers or Legal Guardians on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, or any other non-medical characteristics, except as permitted by Law.

13.2 The Provider must provide appropriate assistance and make reasonable adjustments for Service Users, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral or learning impairments). The Provider must carry out an annual audit of its compliance with this obligation and must demonstrate at Review Meetings the extent to which Service improvements have been made as a result.

13.3 In performing its obligations under this Contract the Provider must comply with the obligations contained in section 149 of the Equality Act 2010, the Equality Act 2010 (Specific Duties) Regulations and section 6 of the HRA. If the Provider is not a public authority for the purposes of those sections it must comply with them as if it were.

13.4 In consultation with the Co-ordinating Commissioner, and on reasonable request, the Provider must provide a plan setting out how it will comply with its obligations under SC13.3. If the Provider has already produced such a plan in order to comply with the Law, the Provider may submit that plan to the Co-ordinating Commissioner in order to comply with this SC13.4.

13.5 The Provider must implement EDS2.

13.6 The Provider must implement the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing that standard.

New for 2017/18-2018/19, the NHS Standard Contract includes a requirement on providers to implement and report on the National Workforce Disability Equality Standard:

13.7 The Provider must implement the National Workforce Disability Equality Standard from 1 April 2018 and must submit a report by 31 March 2019 and

then annually to the Co-ordinating Commissioner on its progress in implementing that standard.

The NHS Standard Contract also places a positive obligation on commissioners and on providers to promote the NHS Constitution, and its values and pledges (Service Condition 1.3 / Accountable Care Models Service Condition 1.7). The Contract also places an obligation on providers with regard to safeguarding (Service Condition 32 / Accountable Care Models Service Condition 24) and on ensuring that the providers' staff are aware of and respect equality and human rights of colleagues, Service Users, Carers and of the public (General Condition 5.3.5 / Accountable Care Models Contract Service Condition 5.3.5).

Evidence

The NHS Standard Contract relates to all health care services (other than primary care) for the population of England; it therefore impacts upon all people and groups with 'protected characteristics' under the Equality Act 2010 (s4 (9)).

The main types of data and information that evidence inequalities relate to:

- patient access to services, experience and health outcomes
- workforce experience
- the correlation between staff satisfaction and patient experience

The list of data and research referred below provides some examples of the evidence that relate to inequalities and is not exhaustive.

Patient access to services, experience and outcomes:

- The 2013 National Audit of Cardiac Rehabilitation (NACR) demonstrated that **women** are under-represented in cardiac rehabilitation. It is mainly older women who are under -represented in cardiac rehabilitation; women over the age of 80 are less likely to take part than men of the same age [1].

- Between 25-50% of **adult mental health** disorders are potentially preventable with treatment during childhood or adolescence [2]. People with mental health problems have much higher rates of physical illness, with a range of factors contributing to greater prevalence of, and premature mortality from: coronary heart disease, stroke, diabetes, infections and respiratory disease [3].

- It is estimated that 40% of **lesbian, gay and bisexual** people have a clinically recognised mental health problem, whereas 25% of the general population will experience some kind of mental health problem in the course of a year. Over 1 in 12 lesbian and bisexual women aged between 50 and 79 have been

[1] http://www.cardiacrehabilitation.org.uk/docs/2013.pdf
[2] www.cabinetoffice.gov.uk/media/.../inclusion-health-evidencepack.pdf
[3] Friedli. L., *Mental health, resilience and inequalities*, 2009, WHO Europe and Mental Health Foundation

diagnosed with breast cancer. In 2011, 70% of all sexually transmitted infection (STI) clinic attendees received an HIV test; with the highest coverage among men who have sex with men (83%) [4].

- Findings from the 2013 Confidential Inquiry into premature deaths of people with **learning disabilities** found that men die 13 years sooner than men without a learning disability, and women with learning disabilities tend to die 20 years sooner than those without. They are likely to find it more difficult than others to communicate their symptoms. It has also been found that people with learning disabilities have reduced access to generic preventative screening and health promotion procedures, such as breast or cervical screening [5].

- Some health care professionals think that lesbians do not require cervical smear tests, yet 10% of lesbians have abnormal smears – this includes 5% of lesbians who have never had penetrative sex with a man [6]. **Lesbian and bisexual women** are up to 10 times less likely to have had a test in the past three years but lesbians and bisexual women have often been invisible patients within health services and their needs are poorly understood [7].

- The health care system in England is key to many **transgender** people managing to fulfil their lives. For the majority the interaction with the NHS will be on the receiving end of help, including the care they receive in the process of obtaining gender reassignment surgery, or other relevant services.

- Type 2 diabetes is 3.5 times more prevalent in **South Asians** than European populations [8].

- NHS In Patient Surveys indicate that certain **ethnic minority** patients are less likely to give a positive response to the question, "*Overall, did you feel you were treated with respect and dignity while you were in the hospital?*" when compared to the White British group. Similar patterns emerge from a question regarding Emergency Departments [9].

Gypsies and Travellers are known to have low child immunisation levels, higher prevalence of anxiety and depression, chronic cough or bronchitis (even after smoking is taken into account), asthma, chest pain and diabetes, as compared with the general population [10]. Gypsy women die 12 years earlier than women in the general population [11].

[4] http://www.lgf.org.uk/evidence-exchange
[5] http://www.bristol.ac.uk/cipold/
[6] In the Pink Providing Excellent Care for Lesbian, Gay and Bisexual People: A practical guide for GPs and Other Health Practitioners, 2010 NHS Sheffield citing Stonewall/Cancerbackup
[7] Fish J., Cervical screening in lesbian and bisexual women*: a review of the worldwide literature using systematic methods*, 2009, De Montford University.
[8] *Diabetes in the UK 2010,* Diabetes UK
[9] http://www.nhssurveys.org/
[10] *Department for Communities and Local Government, 2012*
[11] http://www.communities.gov.uk/documents/planningandbuilding/pdf/2124046.pdf

Workforce experience:

- With regard to age distribution by Agenda for Change (AfC) bandings for posts within the NHS, the **age** distribution across the AfC bandings varies. As is seen in most professions, promotions within the NHS appear to be gained, and responsibility increases, with age.

- The 2013 NHS Staff Survey indicates that **Disabled** NHS staff are more likely to report bullying and harassment from members of public. Thirty-four per cent have reported such an incident while the national average is 28%. In addition, 13% of disabled staff have experienced discrimination by managers - while the national average is 7% [12]. An average of 14% of disabled staff report that their NHS employer has not made a reasonable adjustment for their disability in their place of work.

- With regard to **ethnicity**, in the 2013 NHS Staff Survey, 39% of Black staff compared to 63% of White staff felt that their organisation acted fairly with regards to career progression and promotion. The survey findings also showed that 29% of non-White staff and 34% of Black African staff have experienced harassment and bullying from members of public. In 2014, ***'The snowy white peaks of the NHS'*** report found that the BME population is largely excluded from senior positions both as NHS managers and as NHS Trust Board members in London [13].

  The NHS workforce in England comprises 22% black and minority ethnic (BME) staff; however, only 7% of the workforce in senior manager roles is of BME origin. Twenty-four per cent of NHS consultant doctors are of Asian or Asian British origin, yet the proportion of BME Board-level Medical Directors is less than 3%.

- The 2013 NHS Staff Survey shows variation in staff experience by **religion or belief**. 37% per cent of people identifying their religion or belief as 'any other religion' have experienced harassment and bullying or abuse from members of the public in the last 12 months, compared with the overall figure of 28% for all staff [14].

- The composition of the working age population in England, by **sex**, is 51% women and 49% men. According to NHS Digital data, 81% of non-medical and 45% of medical staff are women. However, despite making up the significant majority (81%) of the NHS workforce, women remain under-represented in NHS leadership roles.

- With regard to the 2013 NHS Staff Survey, 36% of **gay** and 34% of **lesbian** staff have experienced harassment or bullying from members of the public compared

[12] http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2013-Results/
[13] http://www.mdx.ac.uk/__data/assets/pdf_file/0012/59799/The-snowy-white-peaks-of-the-NHS.pdf.pdf
[14] http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2013-Results/

to a national average of 28%. Gay men are close to 3 times more likely to experience discrimination from patients, at 15% compared to a national average of 6% [15].

- Data on workforce composition or experience within the work environment by pregnancy and maternity, and by marriage and civil partnership are not readily available.

The correlation between staff satisfaction and patient experience:

- In 2009, the Aston Business School explored whether staff satisfaction and patient experience were linked. They used the NHS staff and patients surveys in 2007 to identify possible pairs of variables, and then narrowed down pairs to the relationships that appeared most substantial. It is important to note that no inference about causality can be drawn from the analysis. Findings included:
  - Prevalence of **discrimination against staff** is related to several areas of patient experience, particularly their perceptions of nursing staff.
  - High levels of **bullying, harassment and abuse against staff** by outsiders relates to many negative patient experiences [16].

Engagement and involvement

The NHS Standard Contract Team has engaged with NHS England's Equality and Health Inequalities Team and the WDES Implementation Team on drafting this Analysis.

NHS Standard Contract
NHS England undertook engagement and consultation on the NHS Standard Contract over July – October 2016, and engaged directly with internal and external stakeholders. The stakeholder engagement has included extensive engagement with a range of commissioners, providers and provider representative organisations – including the voluntary and independent sectors that represent the spread of protected characteristics.

During the engagement and consultation, we engaged with:

Who:
NHS Standard Contract Team, NHS England directorates, Department of Health, CQC, Healthwatch, NHS Improvement, NHS Digital, CSUs, NHS England teams, providers, provider groups.

[15] ibid
[16] Dawson J., *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys*, July 2009, Institute for Health Services Effectiveness, Aston Business School.

How:

- By direct approach by the NHS Standard Contract Team
- Via engagement and consultation undertaken over July – October 2016

When:
July – October 2016

Key outputs:

- NHS Standard Contract 2017/18 – 2018/19 (full-length) (draft for consultation)
- NHS Standard Contract 2017/18-2018/19 (shorter-form) (draft for consultation)

- Draft NHS Standard Contract for 2017/18-2018/19 (full-length and shorter-form): A consultation

- NHS Standard Contract (full-length) 2017/18-2018/19
- NHS Standard Contract 2017/18-2018/19 Technical Guidance

- NHS Standard Contract (shorter-form) 2017/18-2018/19
- NHS Standard Contract (shorter-form) 2017/18-2018/19 User Guide

All of the above outputs are available on the NHS Standard Contract 2017/18 web page.

Accountable Care Models Contract
NHS England has engaged continuously with MCP and PACS vanguard sites on Contract content since their inception in March 2015. The vanguard sites have involved different groups of patients and the public in every element of the work, and there is a core group of patient and public voice representatives volunteering for the NCM programme.

- NHS Standard Contract (Accountable Care Models)

Summary of Analysis

Eliminating discrimination, harassment and victimisation
Advancing equality of opportunity
Promoting good relations between groups

The NHS Standard Contract prohibits discrimination on the basis of the nine characteristics given protection under the Equality Act 2010 s4(9); this is a mutual obligation on both the commissioner and the Provider. The Contract also places a positive requirement on NHS Providers to make reasonable adjustments for Service Users, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral or learning impairments),

and to report on this in the Review Meetings held with commissioners.

The Contract includes an obligation on NHS Trusts and Foundation Trusts to implement the Equality Delivery System (EDS2); this tool is designed to help organisations to improve their equality performance for patients and the NHS workforce across all nine protected characteristics (and other disadvantaged groups), and help the organisation to meet the three elements of the Public Sector Equality Duty: eliminate discrimination, harassment and victimisation; advance equality of opportunity and promote good relations between groups that share and do not share a protected characteristic. Implementing EDS2 can also be used to support organisations to deliver on aspects of their health inequalities work.

Providers are also obliged to implement the Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementation and subsequent reduction in workplace discrimination on the basis of ethnicity. Providers are strongly encouraged to use the EDS2 and WRES reporting templates and to publish these on their websites.

Providers are also required to implement the Workforce Disability Equality Standard from 1 April 2018, and to report on this to their commissioner annually from March 2019.

The Contract also places a requirement on the Provider to provide a plan setting out how it will comply with its obligations contained in section 149 of the Equality Act 2010 and section 6 of the Human Rights Act 1998, and to provide this plan to the commissioner.

It is expected that each NHS organisation will have its own local strategic and operational plans that will demonstrate how the needs of people with characteristics given protection under the Equality Act 2010 will be met, ensuring equitable access to, and experiences of, NHS services.

Evidence Based Decision-Making and Sharing this Analysis

From 2017/18, NHS England will continue to:

- Monitor and develop the NHS Standard Contract, using feedback from internal and external stakeholders, and subject to legal input;
- Undertake stakeholder engagement as required to develop the Contract;
- Engage with NHS England's Equality and Health Inequalities Team to ensure that the relevant contract terms are kept up to date in line with new legislation and best practice.

This Equality and Health Inequalities Analysis will be published alongside the NHS Standard Contract 2017/18-2018/19 on the NHS Standard Contract 2017/18 web page and alongside the Accountable Care Models Contract on the New business models web page.