Equality Impact Assessment

Summary, Tool and Guidance for Policy Makers

DH INFORMATION READER BOX

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Equality Impact Assessment

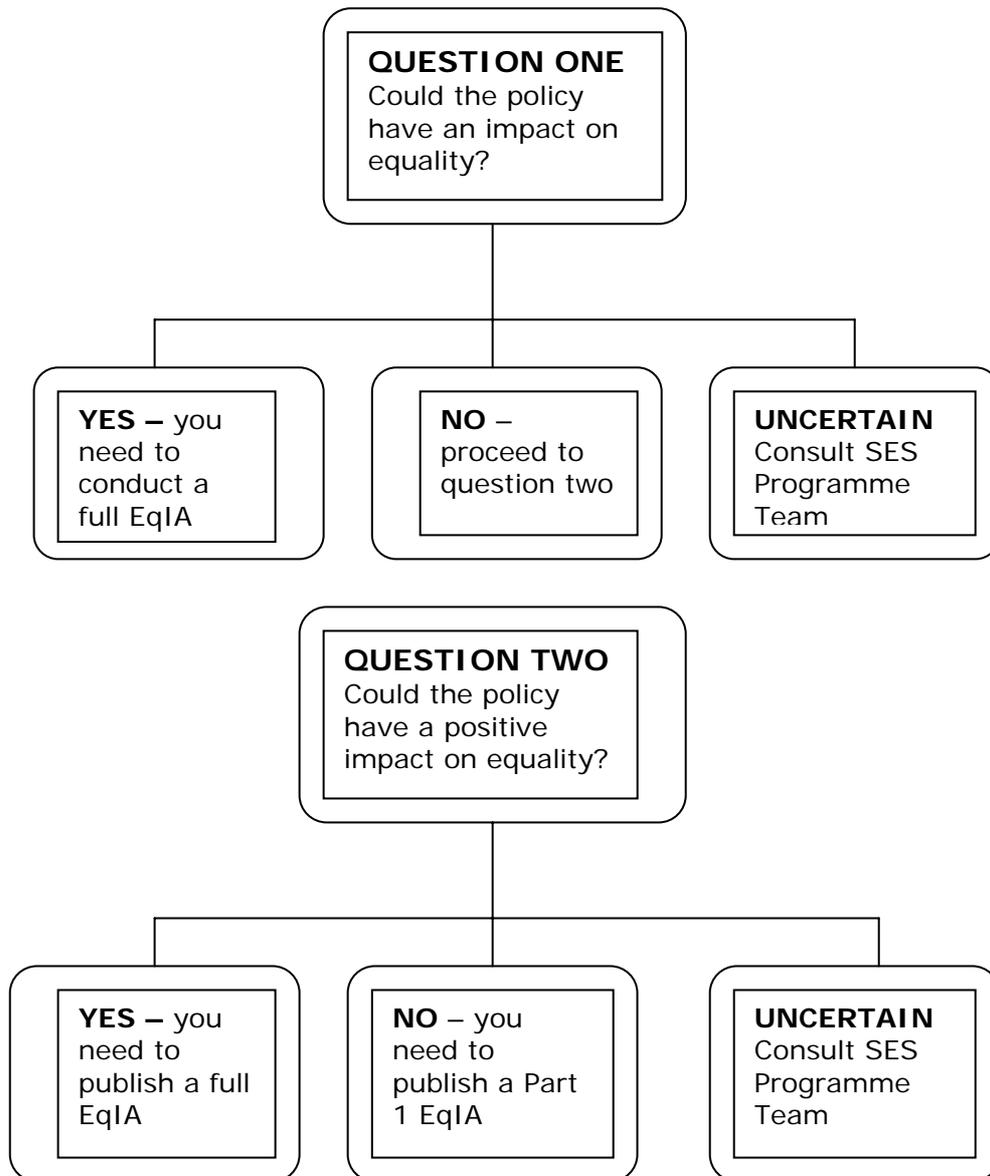*Summary, Tool and Guidance for Policy Makers*

Summary, Tool and Guidance for Policy Makers

QUESTION ONE
Could the policy have an impact on equality?

YES – you need to conduct a full EqIA

NO – proceed to question two

UNCERTAIN Consult SES Programme Team

QUESTION TWO
Could the policy have a positive impact on equality?

YES – you need to publish a full EqIA

NO – you need to publish a Part 1 EqIA

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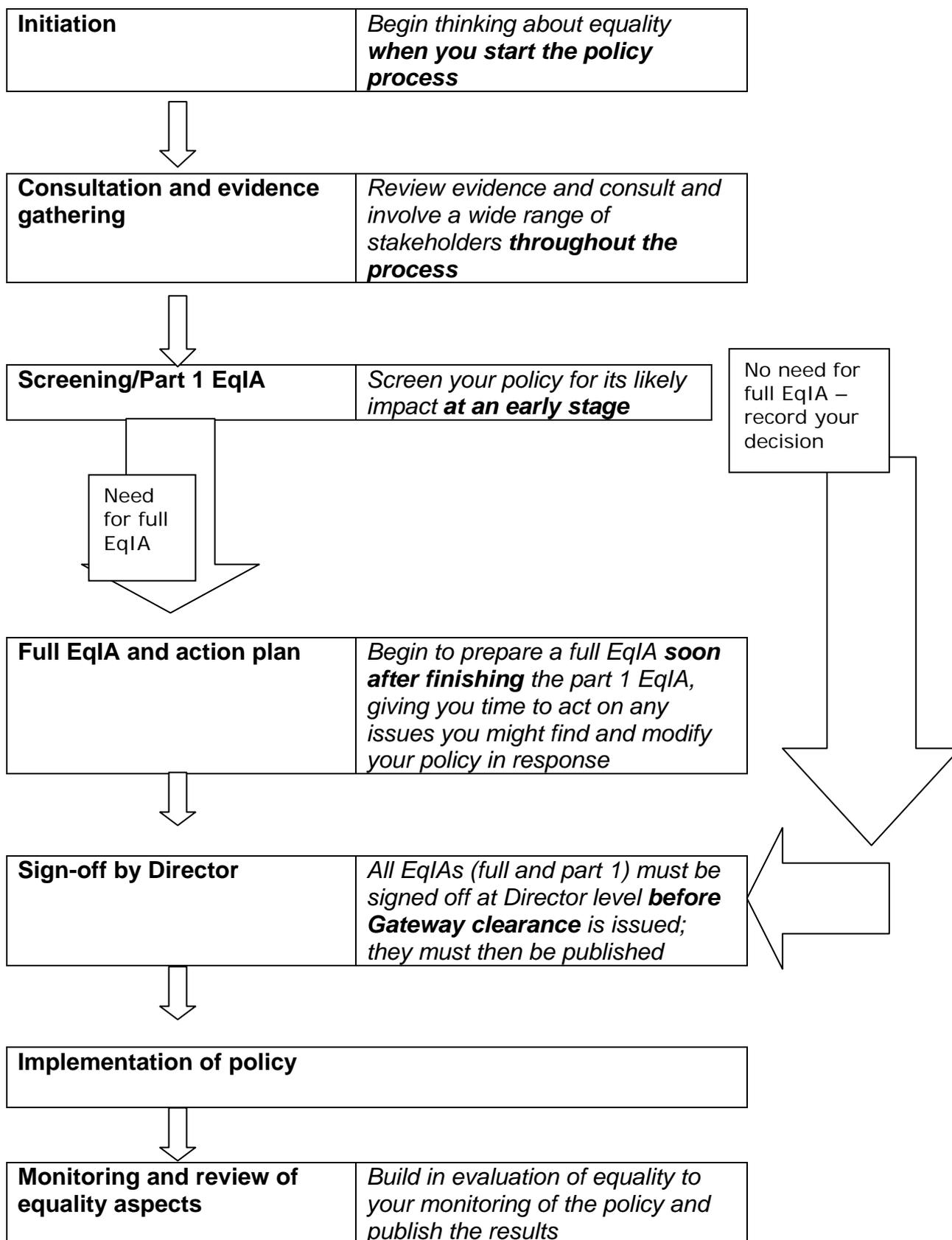
SECTION 1: EXECUTIVE SUMMARY

1. The Department of Health (DH), like all other public bodies, has a **legal duty** to promote equality and eliminate discrimination. It is also legally required to foster positive relationships between different groups of people, eliminate harassment, and involve people in decisions regarding their health and social care and their access to services.

> "The NHS of the 21st Century must be responsive to the needs of different groups and individuals within society and challenge discrimination on the grounds of race, gender, age, ethnicity, religion, disability and sexuality. The NHS will treat patients as individuals, with respect for their dignity. Patients and citizens will have a greater say in the NHS, and the provision of services will be centred on patients' needs". *(NHS Plan, 2000)*

2. Equality impact assessment (EqIA) is the process by which the DH seeks to meet its legal requirements in conjunction with the DH Single Equality Scheme (SES) and to narrow the health inequalities that exist in England between people from different **ethnic** backgrounds, people with **disabilities**, **men and women** (including **transgendered** people), people with different **sexual orientations**, people in different **age** groups, and people with different **religions or beliefs**. Policymakers must screen all new (and eventually, all existing) policies for their impact on people from each of these groups.

3. Decisions about the potential for impact on these various groups must be **evidence based** and **proportionate**. You should begin by screening your policy; if this shows that it has no potential for a significant differential impact on any of the above groups, then you will only need to publish this decision as a part 1 EqIA. If, however, you identify that your policy has the potential to have a significant impact (negative *or* positive), you will need to carry out and publish a full EqIA. An EqIA should help to **inform and strengthen your policy** throughout its development and implementation. It is not an add-on at the end of the process.

4. While the NHS is a universal service, and social care is provided based on need, equity of provision does not ensure equality of access let alone equality of outcome. For example:
   - **Access**: a person whose first language is not English may need information to be provided in a different language to have an equal opportunity of accessing it. Similarly, a person with a visual or hearing impairment may require the information in a different format. Buildings will need to be accessible to all.
   - **Differences in take-up and outcome**: Men between the ages of 16-44 are 50% less likely to visit a GP than women, often leading to late diagnosis. Men are also twice as likely as women to develop and die from the ten most common cancers affecting both sexes. We need to consider how to target services more specifically at men.

5. This document is in three sections. Section 1 has a flow-chart describing the process of conducting EqIA. Section 2 is a tool for policymakers with templates for each stage of the process, and Section 3 contains further guidance on filling out the templates.

Overview of process

Initiation	*Begin thinking about equality **when you start the policy process***

Consultation and evidence gathering	*Review evidence and consult and involve a wide range of stakeholders **throughout the process***

Screening/Part 1 EqIA	*Screen your policy for its likely impact **at an early stage***	No need for full EqIA – record your decision

Need for full EqIA

Full EqIA and action plan	*Begin to prepare a full EqIA **soon after finishing** the part 1 EqIA, giving you time to act on any issues you might find and modify your policy in response*

Sign-off by Director	*All EqIAs (full and part 1) must be signed off at Director level **before Gateway clearance** is issued; they must then be published*

Implementation of policy	

Monitoring and review of equality aspects	*Build in evaluation of equality to your monitoring of the policy and publish the results*

SECTION 2: EqIA TOOL

Introduction

1. The DH exists to improve the health and wellbeing of people in England. The NHS is a universal service, and social care is available to all based on identified need. However, equity of provision does not mean that people are able to access health and social care equally. There are recognised inequalities:
   - between **women and men**,
   - **disabled and non-disabled** people,
   - people from different **ethnic** backgrounds,
   - people with different **sexual orientations**,
   - people of different **ages**, and
   - people with different **religions or beliefs**.

2. To ensure its policies are effective in improving health and social care, the DH needs to understand the effect its policies has on all these groups, and *you will need to assess your policies for impact on each separately.*

What is an EqIA?

3. Like all other public authorities, the DH has a **legal duty** to conduct and publish EqIAs of all its policies and programmes in relation to disability, ethnicity and gender. The DH has also decided, as a matter of policy, to take a similar approach with regard to the other equality 'strands' of age, sexual orientation, and religion or belief.

Equality impact assessment (EqIA) considers:

- what effect the DH's activities have on:

   o eliminating unlawful/unjustifiable discrimination and harassment;
   o promoting equality;
   o fostering positive relationships between different groups of people, thereby improving community cohesion;
   o promoting positive attitudes towards disabled people, and taking account of someone's disabilities even where that involves treating them more favourably than other people; and
   o involving people in decisions regarding their health and social care, and their access to services.

It is an integral and essential part of the policy making and management processes and must inform and influence the decisions and actions that the Department takes. It needs to be based on sound evidence. Lack of evidence is not an excuse for inaction but should prompt you to consider how you can obtain evidence.

There is further information about how an EqIA fits with the policy governance framework and other assessments such as **Impact Assessment** in Annex 3.

4. Please note that you will also need to consider equality issues in any **procurement** process that you undertake, as the legal liability in relation to the equality duties usually remains with the public body that issues the contract (further guidance).

Use in policy making

5. **An EqIA is not simply a one-off document written at the end of the policy process.** Used properly, it will help and strengthen the policy making process throughout. You need to build evidence-gathering, writing and consulting with diverse groups into policymaking from the beginning. This document describes how to ensure a policy is as equitable as possible, and, consequently, how to write a legally compliant EqIA. There is more information on the legal position at Annex 1.

6. If you need help or advice at any point in the process, please contact the SES Programme Team.

Step by step guide to writing an EqIA

Stage 1: Screening

1. The first step is to screen your policy[1] to decide whether you need to do a full EqIA on it. For your convenience, a template is provided for you to fill in. There is also guidance on language and style at Annex 2.

Proportionality

2. You will need to think about the scope and implementation of the policy when deciding whether any negative or positive impact you identify is 'significant'. You may find that the policy has an impact only on a very small, perhaps localised, group of people.

3. Remember that you will almost certainly be working on a piece of *national* policy or guidance. This will mean that it may be more appropriate for EqIAs to be carried out locally during implementation. If this is the case, you will need to ensure that your policy has enough flexibility to allow for different applications at the local policy and clinical level. You should also note how you intend to ensure that the policy is properly analysed for its impact on equality at the point of delivery, for instance by including advice in any guidance you send out that a local EqIA will be needed prior to implementation.

4. If you are in any doubt about proportionality, ask the SES Programme Team for advice.

Part 1 EqIA

5. If you decide that your policy does not need a full EqIA, you will need to record this decision and show all the evidence that you based it on. You will also need to show how you will monitor and review the situation. This document will then be published as a 'part 1 EqIA'.

6. If your screening shows that you need to do a full EqIA, you will move on to Stage 2.

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[1] Please note the the term 'policy' is used here to describe any policy area, strategy, policy strand, programme, project, guidance, function or service with which the assessment is concerned.

Screening template

Note: Please delete guidance notes (in italics) after completing the screening template

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Title and short description

Give the title of the policy, and a short description of the policy (around 300 words).

Negative impact

Could your policy have a significant negative impact on equality in relation to:

- disability
- ethnicity
- gender
- sexual orientation
- age
- religion or belief

You will have to assess each of these six 'strands' separately, along with [human rights](#).

Some things to consider:

- Will the policy present any **problems or barriers** to any community or group? Yes/No

- Will any group of people be **excluded** as a result of your policy? Yes/No

- Does the policy have the potential to **worsen** existing discrimination and inequality? Yes/No

- Will the policy have a negative effect on **community relations**? Yes/No

NB: If the answer to any of these questions is yes, you will have to prepare a full EqIA.

Positive impact

- Could the policy have a significant positive impact on equality by reducing inequalities that already exist? How will it meet our duty to:

1. Promote **equality of opportunity**?

2. Eliminate **discrimination**?

3. Eliminate **harassment**?

4. Promote **good community relations**?

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5. Promote **positive attitudes** towards disabled people?

6. Encourage the **participation** of disabled people?

7. Consider **more favourable treatment** of disabled people?

8. Promote and protect **human rights**?

NB: If the policy has potential to affect any of these, you will have to prepare a full EqIA.

Evidence

- What is the evidence for your answers above?: *(guidance on how to find the evidence base)*

- What does any **available research** say? Please consider quantitative, qualitative, national and international evidence, results of any consultations you might have carried out, etc

- What **additional research or data** is required to fill any gaps in your understanding of the potential or known effects of the policy?

- Have you considered commissioning new data or research?

Screening assessment

In light of the above, do you consider that your policy requires a full impact assessment? (guidance on how to phrase your assessment)

Next steps

If you need to do a full EqIA, the guidance for doing so is below.

*If you decide that you do **not** need to do a full EqIA:*

- Explain what **other measures** might be necessary to ensure that your policy promotes equality and eliminates discrimination, e.g. flagging up the need for those implementing it locally to publish their own EqIAs.

- Note how you will **monitor** the situation as policy development proceeds and the policy is implemented. Identify any **further research** that may be required.

*Get the document **signed off** by a Director, have it published, and keep it on file as your Part 1 EqIA. Copy it to the SES Programme Team.*

Stage 2: Full Equality Impact Assessment

1. If initial screening shows that a policy, programme or practice could have a significant negative impact, or has the potential to have a significant positive impact, or both, it is necessary to conduct a full assessment. A template for this process is provided below. The evidence, challenges and opportunities you identify will eventually form the basis for your action plan.

2. If you have not already done so, you may find it useful to look at the brief unofficial history of EqIAs at Annex 3. You may also like to look at some other recent EqIAs published by the DH [www.dh.gov.uk], and to remind yourself of the **principles,** which underlie our commitment to equality:

   o **eliminating** unlawful/unjustifiable discrimination;
   o **promoting** equality;
   o **fostering** positive relationships between different groups of people, thereby improving community cohesion;
   o **promoting** positive attitudes towards disabled people and taking account of someone's disabilities even where that involves treating them more favourably than other people; and
   o **involving** people in decisions regarding their health and social care, and their access to services.

Template for a full Equality Impact Assessment

Note: Please delete guidance notes (in italics) after you have completed the EqIA

Title and description of the policy

Give the title of the policy[2] with which this assessment is concerned. Write a summary of the policy. This should include a description of the policy's aims and intended outcomes and explain how it fits into the Department's strategic objectives.

The evidence base

List the principal sources of relevant evidence on each equality strand, both quantitative and qualitative. The latter may include statements of concern and opinion from stakeholders as well as academic research. (Guidance on what to include.)

- How is the policy likely to affect the **promotion of equality and elimination of discrimination** in the areas of:

- age

- disability

- gender (including transgender)

- race

- religion or belief

- sexual orientation, and

- human rights

- How will the policy **meet the needs** of different communities and groups?

- Provide details of any **consultation** that has already been undertaken which is relevant to the development of this policy?

- Are there any examples of existing **good practice** in this area, e.g. measures to improve access to the policy among particular groups?

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[2] Please note the term 'policy' is used here to describe any policy area, strategy, policy strand, programme, project, guidance, function or service with which the assessment is concerned.

What the evidence shows – key facts

Provide a selection of key facts relevant to each equality strand. If there is little or no evidence, state what you might do to change this situation. (Some examples of the types of evidence you might find)

- **Age**

- **Disability**

- **Gender (including transgender)**

- **Race**

- **Religion or belief**

- **Sexual orientation**

Challenges and opportunities

*Indicate the policy's potential to reduce and remove **existing inequalities:***

- What measures does, or could, the policy include to address existing patterns of **discrimination, harassment or inequality**?

- What impact will the policy have on **promoting good relations** and wider community cohesion?

- If the policy is likely to have a **negative effect**, what are the reasons for this?

- What practical changes will help **reduce any adverse impact** on particular groups?

- What will be done to **improve access** to, and take-up of, services or understanding of the policy?

- What can be done in terms of **procurement** to promote equality and eliminate discrimination?

Equality impact assessment
Choose, adapt and explain one of the statements in this list of statements.

Next steps
Please outline an action plan, based on the challenges and opportunities you have identified above. This might include:

- Plans that are already under way or under active consideration to address **challenges and priorities** highlighted.

- Arrangements for continued **dialogue and involvement with stakeholders**.

- Arrangements for **monitoring and evaluating** the policy for its impact on different groups throughout the policy making process and as the policy is implemented.

- Arrangements for ensuring that evaluations of any **pilot projects** take account of the concerns and discussions outlined in the assessment, and that they are assessed to check that they are delivering the intended impact.

- Arrangements for discussing with **other agencies, service providers, Non-Departmental Public Bodies (NDPBs) and regulatory bodies** the scope for taking account of the concerns and discussions in the assessment.

- Arrangements for ensuring that the assessment is brought to the attention of all relevant **colleagues**, and in this contributing to reviews of the Department's Single Equality Scheme (SES)

- Arrangements for **disseminating information** about the assessment to all relevant stakeholders who will be implementing the policy

- Arrangements for improving the **evidence base**.

For the record

All EqIAs must be signed off at Director level before publication. Signing off means that the Director will need to satisfy themselves that you have **consulted and involved** *stakeholders from each group, you have gathered all* **relevant evidence**, *and you have an* **action plan**. *For the record, but not for publication, give:*

Name of person completing the EqIA
Date EqIA completed

Name of Director / Director General endorsing EqIA
Date EqIA endorsed

Action plan grid

This is a suggested template for your action plan. You might wish to adapt the suggested categories in column 1 to reflect the types of actions most suited to your policy.

	Actions	**Target date**	**Responsible post holder and Directorate**
Involvement and consultation			
Data collection and evidence			
Assessment and analysis			
Procurement and partnerships			
Monitoring, evaluating and reviewing – including publishing the results of this			

SECTION 3: FURTHER GUIDANCE

The evidence base

1. An EqIA should name, with full bibliographical details as appropriate, the principal sources of relevant evidence which have been consulted.

2. The principal types of relevant evidence are summarised below. Please note that the word 'evidence' is used here in the broad sense that is used in the proceedings of a committee of inquiry, or in those of a court. There are many kinds of evidence, that is to say, ranging from substantial academic research to accounts of personal experience and viewpoint by individuals and groups. There are also many ways of gathering and assessing evidence, ranging from the methods used by social scientist (often resulting in 'soft' or 'grey' literature) to, where appropriate, the results of randomised controlled trials in the medical literature.

3. You will probably need to note and use the familiar distinction between quantitative evidence and qualitative. There are further notes on the distinction below.

Quantitative evidence

4. Quantitative evidence in the health and social care services in relation to equalities is mostly about relative levels of health, health determinants, life expectancy, and take-up and effectiveness of services on offer. Some examples are summarised below.

5. Several further sources of quantitative evidence for inequalities are given in the bibliography.

6. Quantitative evidence in the health and social system is derived in part from administrative data collected by the DH, the Information Centre (IC) for health and social care and other arm's length bodies, the Office for National Statistics (ONS) and other Government departments and agencies. The information is collected principally from commissioners and providers of health and social care (e.g. Primary Care Trusts (PCTs), Local Authorities (LAs), NHS Trusts, Foundation Trusts (FTs), Independent Sector Treatment Centres (ISTCs), Ambulance Trusts, GPs, Dentists, Pharmacists, the Third Sector) via either dedicated returns or systems such as the Secondary Uses Service (SUS), Electronic Staff Record, Quality Management Analysis System and Prescription Cost Analysis system. Many of these organisations also undertake or commission regular or one-off surveys based on representative samples such as the Health Survey for England (HSE), the General Household Survey (GHS) and the English Longitudinal Study of Ageing (ELSA), the GP Patient Survey and the Healthcare Commission's Patient Survey Programme. The secondary analysis of these administrative and survey data yield additional sources of quantitative evidence such as forecasts of, for example, population numbers, obesity and smoking prevalence.

7. In addition to quantitative evidence about participation and outcomes, it may be relevant to cite also the results of opinion surveys of various kinds. For example, the 2007 report of the British Social Attitudes survey contained an article on attitudes towards disabled people and an article on attitudes to work-life balance. The Cabinet Office Equalities Review commissioned research on prejudices and negative attitudes towards various groups and communities, based on a conceptual scheme developed at the Centre for the Study of Group Processes, University of Kent.

Qualitative evidence

8. The principal **types** of qualitative evidence include:

    - case studies and project evaluations;
    - literature reviews;
    - interviews and focus groups;
    - inspection reports;
    - views, proposals, recommendations and good practice guides;
    - responses to Green Papers and White Papers;
    - responses to draft equality impact assessments; and,
    - international comparisons.

9. The principal **authors** of qualitative evidence include:

    - research centres and units based in universities;
    - specialist consultancy organisations;
    - the three equality commissions (CRE, DRC and EOC) and, more recently, the Equality and Human Rights Commission (EHRC);
    - other government departments;
    - the DH itself; and,
    - interest and advocacy groups, including trade unions and professional associations, specialist organisations, and associations and alliances representing concerns around various equality strands.

Sources of evidence

1. *Literature review*

   The systematic review of relevant literatures which can be carried out in three stages: a literature search and selection of articles; quality assessment of papers identified; and data extraction and synthesis.

2. *Medline searches*

   Articles may be limited to English language publications. Looking at 'access' and 'ethnicity' using the MeSH terms available and a combination of other key words. This may be supplemented by 'hand-searching' of recent issues of selected journals.

3. *Search of other databases*

   Searches can be performed on other databases, including the Department of Health, King's Fund and Nuffield Institute for Health in Leeds (HMIC); the Cochrane library; the Warwick Centre for Research in Ethnic Relations (CRER) database; the CINAHL (Nursing and related studies) bibliographic database; the National Institute for Clinical Excellence (NICE) database; and others.

If you are having any difficulty accessing any of this information, contact the Library for assistance.

4. *Identification of grey literature*

   Some previous studies have demonstrated the significance of grey literature to studies of minority ethnic groups. In order to gather relevant grey literature, letters can be sent to all or selected health authorities, trusts and local authority social service departments requesting copies of any relevant reports or grey literature. Similar letters can be sent to agencies identified from previous work or in a 'web search' as being actively developing ethnic health research.

Examples of the types of evidence you might use

1. Listed below are examples of the health inequalities faced by various groups. These illustrate the types of key facts you should search for to complete your evidence base.

Access to health and social care

- uptake for cervical screening amongst women aged 18 and over with learning disabilities is 3% (living within a family) to 17% (in formal care) compared to 85% for women aged 20-64 nationally[3].

- 40% of visually impaired people believe that their GPs are not fully aware of their needs[4].

- 50% of people with mental health conditions report feeling unfairly treated by general health care services[5].

- of patients who use outpatients services those from minority ethnic groups were more than twice as likely as white patients to report that they were not as involved as they would like to be in decisions involving their care and treatment[6].

- 24% of deaf or hearing-impaired people miss appointments and 19% miss more than five appointments because of poor communication. Disabled people are also four times more likely than the general population to find their dentist's surgery inaccessible.

- Inequality was also revealed in a survey of community hospitals.[7] Although 315 (91%) of hospitals were visited routinely and regularly by Christian ministers, only two were visited by ministers of other faiths.

- people from some Black and Minority Ethnic (BME) groups are less likely to be offered psychological therapy, less likely to access mental health care through GPs and community services and more likely to access them through social services or the criminal justice system[8].

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[3] *The NHS – health for all? People with learning disabilities and health care,* MENCAP, 1998

[4] Nzegwu F. *The experience of visually impaired users of the NHS : a survey*, The Guide Dogs for the Blind Association, 2004

[5] Read J. and Baker S. *Not just sticks and stones : a survey of the stigma, taboos and discrimination experienced by people with mental health problems*, MIND, 1996

[6] *Improving Opportunity, Strengthening Society: Two years on - A progress report on the Government's strategy for race equality and community cohesion (Annex)*, Department for Communities and Local Government, August 2007

[7] Payne S. (2004) *Community hospitals: an under-recognised resource for palliative care.* Journal of The Royal Society of Medicine

[8] *Count me in 2007: Results of the 2007 national census of inpatients in mental health and learning disability services in England and Wales*, Healthcare Commission, 2007

Some outcomes

- 4,000 people still commit suicide each year and suicide is the most common cause of death in men under 35[9].

Risk factors for **cardiovascular disease** - data from the Health Survey for England 2004 show that compared to women in the general population:

- Bangladeshi and Pakistani women were about four times more likely to report bad or very bad health.

- Pakistani and Black African/Caribbean women were more likely to be obese.

- Irish and Black Caribbean women were much more likely to have high blood pressure.

- Pakistani and Bangladeshi women were half as likely or less to meet current recommendations on physical activity levels.

- Indian, Bangladeshi, Pakistani, and Black Caribbean women were between two and five times more likely to report doctor-diagnosed diabetes.

- A clear divide remains in smoking between manual and non-manual groups and there are also significant differences between different ethnicities and genders. Over 40% of Bangladeshi men smoke compared to around 5% of Bangladeshi women and more than one in four Irish women.

- Although Muslims are represented amongst a wide range of ethnic groups, including many of African origin, the majority are of Pakistani and Bangladeshi origin where there is clear evidence of health inequality including higher smoking rates amongst men and higher rates of coronary heart disease and diabetes.

Mental Health

- People with severe mental illness are 1.5 times more likely to die prematurely than others, often from preventable causes and they are also less likely to access routine health checks.

- Studies of psychiatric patients in hospitals also show that up to 70% smoke.

- Gay and bisexual men are over four times as likely to have attempted suicide in their lifetime as heterosexual men.

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[9] *Mortality Statistics*, Office for National Statistics, 2007

- Lesbian, gay and bisexual people have at least one and a half times the risk of depression or anxiety disorders as heterosexual people.

- The 2007 national 'Count Me In' census of mental health in-patients showed that Black people and Mixed White/Black people have significantly higher than average admission rates and are more likely to be compulsorily admitted under the Mental Health Act 1983. Admission rates were also higher for White Irish people and lower than average among the White British, Indian and Chinese groups.

- The 2008 'Count Me In' census showed that thirty per cent of patients had been in hospital for one year or more. In the Black Caribbean group, 40 per cent of patients had been in hospital for over a year.

How to summarise evidence of impact

1. In the light of principles and criteria for assessment you have used, and of the evidence you have reviewed, make an assessment.

2. We suggest you copy and paste one of the following statements into your document, and then expand and explain it as appropriate.

    A.   A positive impact is explicitly intended and very likely.

    B.   An adverse impact is unlikely, and on the contrary the policy has the clear potential to have a positive impact by reducing and removing barriers and inequalities that currently exist.

    C.   An adverse impact is unlikely. On the contrary there is potential to reduce barriers and inequalities that currently exist. There is insufficient evidence, however, for this assessment to be made with as much confidence as is desirable.

    D.   Adverse impact is unlikely, but positive impact is also unlikely.

    E.   Adverse impact is probable or certain, since certain groups will be disadvantaged, either proportionately or absolutely, or both. Remedial action is therefore necessary.

    F.   Adverse impact is probable or certain for certain groups but the policy as a whole can nevertheless be justified.

    PLEASE NOTE

    If you select option F it will be necessary to obtain legal advice.

ANNEXES

Annex 1: The legal background

1.1 The general public sector equality duties

1. Public bodies, including the Department of Health, are bound by three statutory equality duties, relating to race, disability and gender. Common to all three duties is the requirement that:

    In carrying out its functions, a public body must have due regard to the need:
    - to eliminate unlawful discrimination; and
    - to promote equality of opportunity.

2. In addition:

    - the race equality duty includes a requirement to have due regard to the need to promote good relations between persons of different racial groups;

    - the gender equality duty includes a requirement to have due regard to the need to eliminate harassment;

    - the disability equality duty includes requirements to have due regard to the needs:
        - to eliminate harassment of disabled persons that is related to their disabilities;
        - to take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons;
        - to promote positive attitudes towards disabled persons; and
        - to encourage participation by disabled persons in public life.

3. The relevant provisions in primary legislation are:

    Section 71(1) of the Race Relations Act 1976, which came into force on 2 April 2001;

    Section 49A of the Disability Discrimination Act 1995, which came into force on 4 December 2006;

    Section 76A of the Sex Discrimination Act 1975, which came into force for these purposes on 6 April 2007.

4. A point worth highlighting, as it may not be generally recognised, is that unlawful discrimination and harassment on gender grounds include discrimination and harassment on the grounds that a person intends to undergo, is undergoing, or has undergone, gender reassignment.

Why the race, disability and gender equality duties were introduced

5. The race equality duty was introduced in 2002 following the Macpherson Report on the murder of Stephen Lawrence. It reflected concern that more effective tools were needed to tackle the institutional racism that the report identified. The way in which the duty calls for public bodies not only to prevent unlawful discrimination but also to promote equal opportunities recognises the fact that "not all inequality stems from discrimination, and therefore not all inequality can be addressed by legal remedy".

6. The disability and gender equality duties were designed to take account of experience with the race equality duty.

Possible changes in future

7. *Framework for Fairness*, a Government consultation paper published in June 2007,[10] proposed that the race, disability and gender public sector equality duties should be replaced by a new single public sector equality duty. The new single duty would cover race, disability and gender, and might also extend to cover age, religion or belief, and sexual orientation. The Government is currently considering the responses to the consultation.

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[10] http://www.communities.gov.uk/documents/corporate/pdf/325332

1.2: Content of equality schemes

Race

1. Article 2(2) of the Race Relations Act 1976 (Statutory Duties) Order 2001 ("the 2001 Order") provides that:

   A Race Equality Scheme shall state, in particular-

   (a) those of its functions and policies, or proposed policies, which that person has assessed as relevant to its performance of the duty imposed by section 71(1) of the Race Relations Act; and

   (b) that person's arrangements for:

       (i) assessing and consulting on the likely impact of its proposed policies on the promotion of race equality;

       (ii) monitoring its policies for any adverse impact on the promotion of race equality;

       (iii) publishing the results of such assessments and consultation as are mentioned in sub-paragraph (i) and of such monitoring as is mentioned in sub-paragraph (ii);

       (iv) ensuring public access to information and services which it provides; and,

       (v) training staff in connection with the duties imposed by section 71(1) of the Race Relations Act and this Order.

Disability

2. Regulation 2(3) of the Disability Discrimination (Public Authorities) (Statutory Duties) Regulations 2005 ("the 2005 Regulations"), provides that:

   A Scheme shall include a statement of:

   (a) the ways in which … disabled people have been involved in its development;

   (b) that authority's methods for assessing the impact of its policies and practices, or the likely impact of its proposed policies and practices, on equality for disabled persons;

   (c) the steps which that authority proposes to take towards the fulfilment of its section 49A(1) duty;

(d) that authority's arrangements for gathering information on the effect of its policies and practices on disabled persons and in particular its arrangements for gathering information on:

(i) their effect on the recruitment, development and retention of its disabled employees,

…

(iii) the extent to which, in the case of an authority specified in Part I or V of Schedule 1, the services it provides and those other functions it performs take account of the needs of disabled persons; and

(e) that authority's arrangements for making use of such information to assist it in the performance of its section 49A(1) duty and, in particular, its arrangements for:

(i) reviewing on a regular basis the effectiveness of the steps referred to in sub-paragraph (c), and

(ii) preparing subsequent Schemes.

<u>Gender</u>

3. Article 2 of the Sex Discrimination Act 1975 (Public Authorities) (Statutory Duties) Order 2006 ("the 2006 Order") includes the following material on the content of a Gender Equality Scheme:

(4) A listed authority shall ensure that its Scheme sets out the overall objectives which it has identified as being necessary for it to perform its section 76A(1) duty and its duties under this Order.

(5) A listed authority shall, when formulating its objectives for the purposes of paragraph (4), consider the need to have objectives that address the causes of any differences between the pay of men and women that are related to their sex.

(6) A listed authority shall ensure that its Scheme sets out the actions which it has taken or intends to take to:

(a) gather information on the effect of its policies and practices on men and women and in particular –

(i) the extent to which they promote equality between its male and female staff, and

(ii) the extent to which the services it provides and the functions it performs take account of the needs of men and women;

(b) make use of such information and any other information the authority considers to be relevant, to assist it in the performance of its section 76A(1) duty, its duties under this Order, and in particular its regular review of –

(i) the effectiveness of the actions identified for the purposes of sub-paragraph (e), and

(ii) its arrangements for the preparation of subsequent Schemes;

(c) assess the impact of its policies and practices, or the likely impact of its proposed policies and practices, on equality between women and men;

(d) consult relevant employees, service users and others (including trade unions); and

(e) achieve the fulfilment of the objectives set out for the purposes of paragraph (4).

1.3. Human Rights

1. The Human Rights Act, which came into force in October 2000, incorporates into domestic law the European Convention on Human Rights to which the UK has been committed since 1951. Section 6 of the Human Rights Act makes it unlawful for a public authority to act in a way that is incompatible with a Convention right. The underlying intention of the Act is to create a Human Rights culture in public services.

2. If you think that your policy may have Human Rights implications, you may wish to consider the following questions:

   - Will it affect a person's right to life?

   - Will someone be deprived of their liberty or have their security threatened?

   - Could this result in a person being treated in a degrading or inhuman manner?

   - Is there a possibility that a person will be prevented from exercising their beliefs?

   - Will anyone's private and family life be interfered with?

If the answer is 'yes' to any of these questions, can the policy be amended to avoid impacting upon Human Rights? If not, seek legal advice before proceeding.

1.4. EqIA caselaw

1. *(On the application of C) v SECRETARY OF STATE FOR JUSTICE (2008)*. Court of Appeal case on equality impact assessments. The Home Office had failed to carry out a race equality impact assessment on some affirmative resolution regulations. The Court of Appeal held that the correct relief in such a case was that the regulations should be quashed.

   This moves the case law on from BAIPO where the High Court had been content merely to make a declaration.

   The failure to produce a race equality impact assessment prior to laying the Secure Training Centre (Amendment) Rules 2007 before Parliament was a defect in the procedure that was of substantial, and not merely technical, importance and the rule of law and the proper administration of race relations law required the Rules to be quashed. Judgment was given on 28 July 2008.

2. In *BAPIO v Home Secretary and SofS for Health - R (on the application of Bapio Action Ltd and another) v Secretary of State for the Home Department [2007] EWHC 199 (QB), [2007] All ER (D) 127 (Feb)* the Home Office was found to be in breach of section 71(1) for failing to carry out a race equality impact assessment in relation to a change in the Immigration Rules. The judge held –

   "If there had been a significant examination of the race relations issues involved in the change to the Immigration Rules, there would have been a written record of it. In my judgment, the evidence before me does not establish that the duty imposed by section 71 was complied with.

   In any event, there was a subsequent REIA the sufficiency of which has not been challenged. In these circumstances, there will be a declaration that the SofS for the Home Dept failed to comply with his duty under section 71 of the RRA."

   This case demonstrates that a failure to perform a specific duty could lead to breach of the general duty.

3. In *R (on the application of Eisai Ltd) v National Institute for Clinical Excellence [2007] EWHC 1941 (Admin) [2007] All ER (D) 67* it was held that in issuing guidance the National Institute for Clinical Excellence (NICE) had not given proper consideration to its duties under section 71 of the Race Relations Act 1976 to promote equal opportunities and to have due regard to the need to eliminate discrimination. It was held unreasonable and unlawful to overlook that responsibility. There was no evidence that before issuing the guidance any thought was given to obligations under anti-discrimination law and the guidance would have to be amended.

4. In *R on the application of Priti Hansraj Chavda and others v London Borough of Harrow [2007] EWHC 3064 (Admin),* a judicial review was brought against the local authority's decision to restrict care services to people with critical needs only. One of the grounds of challenge was that the decision-making process did not comply with the authority's general disability duty under section 49A of the Disability Discrimination Act (DDA) 1995. The claimant succeeded on this ground. Paragraph 2.34 of the former Disability Rights Commission's statutory code of practice (which must be taken into account by public authorities) states that "due regard" in section 49A of the DDA comprises two linked elements – relevance and proportionality and requires public authorities to do more than simply give consideration to disability equality. The local authority had carried out an equality impact assessment that the decision-makers had seen and the summary referred to "potential conflict with the DDA" but the Court held that the oblique reference was not sufficient to give a busy councillor any idea of the serious duties imposed by the DDA. He also stressed that in the absence of a proper record of such consideration it was

legitimate to conclude that no proper consideration had been given (the court relied on the *BAPIO* case in relation to this point). The decision was therefore unlawful.

5. In *Baker & Ors, R (on the application of) v Secretary of State for Communities and Local Government & Ors [2008] EWCA Civ 141* the Court of Appeal held that the race equality duty under section 71 of the Race Relations Act was not a duty to eliminate unlawful racial discrimination or promote equality of opportunity and good relations between persons of different racial groups. Rather, it was a duty to have due regard to the need to achieve those goals. The failure to make explicit reference in a decision was not determinative of whether section 71 had been complied with. It was good practice nonetheless to make reference to the duty in all cases where the duty is in play since it is more likely to ensure that relevant factors are taken into account. The case also gives further guidance as to what due regard means. The regard that is due is that which is appropriate in all the circumstances, in this case, the importance of the decision to the areas of life of the members of the disadvantaged group and the extent of the inequality on the one hand and the countervailing factors that are relevant to the function which the decision making is performing (in this case the need to protect the green belt and apply planning guidance PPG2

Annex 2: Style Guide

1. Over time languages and words change in their meanings and implications, and mean different things to different people. Changes of language occur partly because the outer world changes; partly because understanding of the world changes; and partly because various groups and communities gain greater power and influence than hitherto and in consequence can make their voices and viewpoints better known (for example: see 'African-Caribbean' below).

2. Words are often used in different contexts. With regard to race equality, for example, there tend to be differences between:

   - legal, administrative and official usage
   - usage in most ordinary conversation amongst the general public, reflected and reinforced by usage in the media
   - usage reflecting the self-understanding of individuals and communities from minority ethnic, religious and cultural backgrounds
   - usage in academia.

3. 'Race' as a term (as in 'race relations' and 'race equality') and 'racial' ('racial group') frequently occurs in official documents referring to legislation. Also, they frequently occur in everyday conversations and in the media. They virtually never nowadays, however, occur in academia, unless with inverted commas to signal they are problematic. The preferred term in academia is ethnicity.

4. It will be a long time before there is a shared vocabulary for talking and writing about race and ethnicity across all contexts even in the UK, let alone in the rest of the English-speaking world, or in international forums. We cannot stipulate how words should always be used. We can, however, be consistent in our own use of language. Also, we can and should explain how and why we use contested terms ourselves.

5. When writing an EqIA, we recommend that you adopt the conventions as set out below. However, there are departures here from the terminology used by, for example, the Office for National Statistics (ONS). The main differences between terminology you may see are as follows:

   - African can be used rather than Black African.
   - African-Caribbean can be used instead of Black Caribbean.
   - South Asian can be used rather than Asian to refer to people of Bangladeshi, Indian or Pakistani heritage. Occasionally this involves including a small and statistically not significant number of 'other Asian' people.
   - Words such as heritage, background and community can be used in preference to group.
   - Ethnicity can be used rather than race, even in references to legislation.

- The term BME can be used, or the phrase (black and minority ethnic) for which it is an abbreviation.

Myth busting.

Race/ethnicity

The terms 'race' and 'ethnicity'

- *Race* appears in legislation, as for example in the terms *race equality*, *race relations* and *racial group*. There is no scientific basis for dividing the human species into races, however. The term *ethnicity*, which implies cultural, linguistic and religious aspects of identity as well as (sometimes but not always) visible differences, more accurately reflects the intentions in race relations legislation.

The term 'BME'

- The term BME (short for 'black and minority ethnic') can be useful for providing a broad-brush overview in order to refer to all people not categorised as 'white British'. It is seldom if ever helpful, however, for clarifying the practical measures which need to be introduced to make improvements in provision. improvements in provision. It can infer homogeneity when in fact there are significant differences within and between minority ethnic communities who, for example, are not a homogenous group for health status, disease patterns or health behaviours and will have different needs and preferences.

- There term BME is sometimes expressed as BAME (short for 'black, asian and minority ethnic') and again the same issues apply as above.

The term 'Asian'

- Publications sometimes use the term *Asian* as a blanket reference to Bangladeshi, Indian and Pakistani communities. However, these communities vary considerably in terms of social class and migration history; recent economic trends; the geographical area within Britain where they are mainly settled; religious tradition, culture and language; and the nature of the prejudice, hostility and discrimination they may encounter. There are few if any practical policies and measures that are relevant to all 'Asian' communities without exception.

The term 'Black'

- In an analogous way, publications sometimes use the blanket term *black*, without distinguishing between African and African-Caribbean communities. Occasionally, further, reports use the term *black* to refer to all people who may experience racism based on their physical appearance. Whilst the term *black* can be a useful shorthand within publicity material, policy should generally refer to specific communities such as African and African-Caribbean, or use the generic term BME.

The term 'white'

- Similarly the word *white* is used in different ways in different studies. Sometimes it refers to all people who describe themselves as white in the categories of the 2001 census. At other times, however, it refers only to those who *in addition* describe themselves as British. Since terms such as 'ethnic minority' and 'BME' are usually defined as 'not white', it follows that they too vary in their meaning according to who is and is not classified as white.

The term 'African'

- Communities of African backgrounds in Britain are different from each other in terms of in terms of social class and educational levels in the countries from which they came; the length of time they have been in Britain; the mix of push and pull factors affecting their decision to move to Britain; religious tradition, culture and language. Because of these differences, there are few if any practical policies and measures that are relevant to all 'African' communities without exception.

The term 'African-Caribbean'

- You may see an abbreviated form of this title as 'Afro- Caribbean' in many documents. In this context, the word 'Afro' means of African origin. Opinion regarding this term has changed and may now be found to be offensive to many, as the word 'Afro' most commonly relates to a hairstyle rather than ancestry.

Disability

The term 'disabled'

- 'Disabled' is the accepted term for describing people who have a wide range of impairments, including physical impairments (such as cerebral palsy or cystic fibrosis), sensory impairments (such as problems with sight or hearing), cognitive impairments (such as learning difficulties), or mental health problems (such as schizophrenia, depression or bipolar disorder). However, its use to describe an individual can be more problematic. Many people feel that the term 'disabled' puts the focus too much on the individual rather than on the social structures which do not allow them to reach their potential (for example, inaccessible buildings or literature in inaccessible formats). 'Disabled' is therefore useful as a general term but should be used more cautiously to describe an individual.

The term 'impairment'

- For the reasons described above, many people prefer to use the term 'impairment' over 'disability' when describing an individual's situation. An example would be the term 'hearing impairment'. More information on the

social model of disability and how it differs from the medical model is available here.

The term 'victim'

- You might have seen the term 'victim', as in 'AIDS victim' or 'cancer victim' used in the media. This usage is not advisable, because it is disempowering. It is better to use the terminology 'person living with HIV/AIDS', 'person with schizophrenia', etc.

Sexual orientation

- Preferred terms are heterosexual, gay, lesbian, gay woman, and bisexual.

- Some women object to the term 'lesbian', preferring 'gay woman'. It is therefore best when monitoring to have the option 'gay/lesbian' as one box and disaggregate later based on gender, if required.

- The term 'heterosexual' is frequently misunderstood, so it is best to use heterosexual (straight) where possible.

- Transgender is not a sexual orientation but a gender identity. If you need to address trans issues you should keep the issue separate from sexual orientation (of course, trans people will themselves have a sexual orientation just like everyone else).

Further reading

Equalities Review Panel (2007) *Fairness and Freedom: the final report of the Equalities Review,* Cabinet Office
http://archive.cabinetoffice.gov.uk/equalitiesreview/

Platt, Lucinda (2007) *Poverty and Ethnicity in the UK*, The Policy Press for the Joseph Rowntree Foundation
http://www.jrf.org.uk/KNOWLEDGE/findings/socialpolicy/pdf/2059.pdf

Red Cross briefing note on the social model of disability:
http://www.redcross.org.uk/standard.asp?id=58926

Annex 3: Rationale and FAQs

Q1. Why equality?

A few reasons (not a comprehensive list):

- *the Department's own [Strategic Objectives](#) on better health, better care and better value **for all**; and*

- *The goal for the NHS that the [Prime Minister](#) set out on 7 January 2008, with his emphasis on making the NHS "personal to each of us"; and*

- *Delivering [Public Service Agreement 15](#), to "address the disadvantage that individuals experience because of their gender, race, disability, age, sexual orientation, religion or belief"; and*

- *"The NHS of the 21st Century must be responsive to the needs of different groups and individuals within society and challenge discrimination on the grounds of race, gender, age, ethnicity, religion, disability and sexuality. The NHS will treat patients as individuals, with respect for their dignity. Patients and citizens will have a greater say in the NHS, and the provision of services will be centred on patients' needs" ([NHS Plan](#));*

- *the Department's commitment to [reducing health inequalities](#).*

Q2. **What are we trying to achieve?**

Our vision is that the Department of Health is committed to equality and will be an effective government champion for health and wellbeing for all, by:

- setting national direction and priorities, and supporting delivery of health and social care, in ways that promote equality and tackle health inequalities that result from disadvantage and damaging discrimination;

- taking action to support people to maximise their potential by maintaining and promoting their health, wellbeing, independence, choice and control; and,

- supporting all the people who work for the Department to deliver these goals, recognising the value of their differences in the contribution they make.

Q3. Do I really, really need to do an EqIA?

You must consider doing an EqIA whenever new policies are proposed and developed, and whenever existing policies are reviewed. They are particularly important in the case of high-profile policies, for example when a Green Paper or White Paper is being written, or when there is a Ministerial announcement, or when there is substantial media and political interest.

Q4. But my policy is aimed at everyone equally…

All policy sets out to achieve a benefit. However, there is always a risk that the policy will not reach all those it is intended to help, or that it will have unintended negative consequences. Usually it is the most disadvantaged in society that are more at risk as they are often hard to reach and vulnerable. It is therefore vital to consider these consequences as soon as possible in the policy development process as it is easier and usually cheaper to address them earlier rather later. No matter how sound the aims of policy, if it fails to reach large sections of the population then it cannot fully achieve its aims.

The public sector equality duties do not take the form of saying "treat everyone equally". Instead, they are about **eliminating** unjustifiable discrimination and **promoting** equality.

Sometimes it is necessary to treat people differently in order to give them equality of opportunity. For example, a person whose first language is not English may need information to be provided in a different language to have an equal opportunity of accessing it. We know that certain groups of people frequently experience difficulty accessing health and social care services. For instance, women with learning disabilities have a very low take-up rate for cervical screening services, and that almost a quarter of deaf or hearing-impaired people miss appointments due to poor communications.

Additionally, it is important to bear in mind that the **disability equality duty** requires public bodies to have due regard to the need "to take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons".

Q5. My policy is going to be implemented by NHS bodies/local authorities/Arms Length Bodies (ALBs), so I can leave equality impact assessment to them?

No. It is necessary for both DH and other public bodies to take account of equality issues.

Policies are often decided at national level and then implemented at local level in ways that take account of local circumstances. It is rare for the Department to prescribe exactly what must happen at local level, leaving no scope for decision-taking at local level.

In setting priorities for health and social care the Department needs to take account of equality issues at national level. It is helpful to the NHS and local authorities if the work the Department does sets out the equality issues. This avoids the need for bodies at local level to reinvent the wheel: they can take account of the information the Department has already identified, and make use of it in considering the equality issues that arise in their own circumstances. A national EqIA should also help ensure that there is enough flexibility for the policy to be adapted to suit local circumstances, including local equality issues.

Q6. And procurement …?

Where a contractor is carrying out a public function on behalf of a public authority, the legal liability in relation to that function remains with the public body that contracts out that function. However, "a contract to provide services to the public, or a section of the public may involve the contractor in activities that constitute functions of a public nature; this would make the contractor a public authority in relation to such functions, for the duration of the contract, with its own liability under equality legislation".

Whilst as a general rule, laws relating to social, environmental and environmental issues should not be highlighted in the contract conditions, OGC guidance on Social Issues in Contracting (2006) suggest that as 'there has been political agreement that the laws covering equality should be mentioned as standard'.

Pre-qualification questionnaires (PQQ)may be used to determine a supplier's compliance with equalities legislation in terms of employment and goods and service provision. Consideration should be given to Small and Medium Size Enterprises, BME businesses, women and disabled-owned businesses and the voluntary and community sector which can help enhance choice, personalisation and provide and important source of innovation.

For further advice on procurement, contact the Commercial Directorate.

Q7. Who can help?

The SES Programme Team can advise you on carrying out an EqIA. At least one person from each policy team should be trained. And, if your team is involved in developing a big policy initiative - for example in the run up to new legislation or a departmental policy paper - it is often helpful for the whole team to attend together. You can use issues you are working on as case examples to work through with the trainers.

It is a good idea to contact the SES Programme Team early in the policy process. The first points of contact are Zawar Patel and Ricky Lawrence. There is also training available in how to do an EqIA, plus a series of masterclasses, which include equality issues as an integral part – look out for announcements on Delphi or contact Clive Pritchard or Guy Cross.

Q8. What about Impact Assessment, Health Impact Assessment, Rural Proofing, etc, etc …?

Impact Assessments (IAs) are an integral part of the policy making process. The purpose of an IA is to focus the policy maker's attention on scrutiny of the policy, why intervention is necessary and what impact the policy change is likely to have, highlighting costs, benefits and risks. An IA is needed for regulations and all policies, which have an impact on either business, or the public sector, including those that require Cabinet Committee clearance.

An impact of:

- More than £20m on the NHS
- More than £5m on all other front line services.
- Or novel or contentious, that is, likely to attract high levels of political or media interest.

There is more guidance on IAs here, or contact Marie-Elaine Frith or Julie O'Connell.

You will probably need to do an IA as well as an EqIA on your policy and may well have to do other assessments too. **However, even if you do not need to do an IA you will still need to screen your policy to decide whether to do an EqIA on it**. Many policies that do not require an IA will require an EqIA.

The focus of the different assessments is on different things, and the circumstances in which they need to be carried out differ. But you may well find that some of the material you use for one assessment is also relevant to another.

A good reason to start an EqIA early in the policy process is that as part of your IA you will need to consider resource implications of any action that's needed to address potential negative impacts of the policy on particular groups.

Q9. How do I balance the requirement for monitoring information against the need to reduce the 'burden of bureaucracy'?

Consult your analyst/statistician and think creatively about what is already out there. The DH's SES sets out what is being done to improve the availability of equality data at national level.

Q10. The policy I am working on is specifically designed to focus on one sector of the population. Does that make it incompatible with the equality duties?

Not necessarily. Sometimes it is necessary to treat people differently in order to promote equality of opportunity.

Sometimes it may be helpful to set the policy you are working on in a wider context in order to assess the equality impact. For example, it would not be possible to defend a decision arbitrarily to target a service (for example, screening for a particular disease) on one particular group of people. But a decision to target that group of people could be exactly what is needed to promote equality of opportunity if there is sound evidence to show that that group of people are at higher risk than others of developing the disease.

Bear in mind the requirements in the race and disability duties to promote good relations between people of different races/positive attitudes to disabled people. An arbitrary decision to favour one group of people over others is unlikely to achieve that, but a reasoned one may well do so.

Q11. Where does Human Rights fit in?

Every person is of equal value. We all have basic human rights which must be upheld. Human rights are about ensuring **F**airness, **R**espect, **Equality**, **D**ignity and **A**utonomy (FREDA) for everyone.

Everyone has the right to enjoy their basic human rights such as right to life and not be treated in an inhuman or degrading manner, protected by the Human Rights Act 1998. For example, there could be human rights implications if policies have a negative impact upon or neglect certain groups regarding issues such as life expectancy and liberty.

We assess our policies for their impact on various groups because we want to uphold human rights for all. More detailed information on the Human Rights Act 1998 is available at Annex 1.3, and more information about human rights is available from Mark Joannides.

Annex 4: The story so far – a brief unofficial history

Where do they come from?

Q1. I hope this isn't a silly question. It seems to me that equality impact assessments have arrived suddenly out of nowhere. What's the background? Where and when were they dreamed up, and why?

It's not a silly question at all! You're right that EqIAs are new, though they're not quite as new as you may think. It's definitely useful to recall how, where, when and why they started, and to see that thinking about them has developed over the years, and is developing still.

The history of the legal phrase *impact assessment* goes back at least to the 1960s and was developed in the first instance with regard to the environment. It was given a boost internationally by the United Nations Environment Conference, *Only One Earth*, that took place at Stockholm in 1972. The key underlying concern was to identify possible harmful effects for the physical environment of new industrial developments, projects and processes, *before* these were introduced. The first EU directive on this subject was issued in 1985. A standard international definition, published in 1999, is: 'the process of identifying, predicting, evaluating and mitigating the biophysical, social and other relevant effects of development proposals *prior to* major decisions being taken and commitments made.'

Q2. What are the key ideas?

An essential idea in environmental impact assessments is the concept of *unintended consequences* – bad things can happen without anyone deliberately intending them. Soil can be polluted, pesticides can cause declines in bird populations ('the silent spring'), the consumption of fossil fuels can damage the ozone layer, and so on.

Other key ideas include:

- the need to avoid harmful consequences if at all possible, combined with the need to mitigate those which cannot be avoided

- the need to consult not only with experts and specialists in environmental sciences but also with individuals and communities likely to be directly affected

- the need to publish assessments so that all interested parties can study and, if they wish, critique them

- the need for ongoing monitoring and review.

These essential ideas are relevant also in other areas of policy, for it can happen that the unintended consequences of a new policy or programme can

involve injustice and disadvantage to certain groups and individuals. During the 1990s it was increasingly realised that unfairness affecting women, for example, or certain communities, can occur without this being consciously intended. So the concept of equality impact assessments was developed, based on the same principles and underlying ideas as environmental impact assessments. The concept of unintended consequences in environmental matters was and is similar to that of indirect discrimination in legislation regarding gender and ethnicity.

The first EqIAs internationally?

Q3. When were EqIAs, as distinct from environmental ones, developed?

The concept of gender impact assessments received international prominence through the World Conference on Women at Beijing, which in 1995 called on governments to 'mainstream a gender perspective into all policies and programmes so that, **before decisions are taken** an analysis is made of the effects on women and men respectively.' This requirement was then built into the Treaty of Amsterdam, Articles 2 and 3, 1997.

The first EqIAs in Britain?

Q4. When were equality impact assessments introduced into UK law?

They were introduced first in Northern Ireland through the Northern Ireland Act 1998, Section 75. This built on Northern Ireland's Fair Employment and Treatment Act (FETO), which had made it unlawful to discriminate on the grounds of religious belief or political opinion.

The Northern Ireland Act extended the number of groups and communities that are protected against unfair discrimination. It was concerned not only with religious and political affiliation, that is to say, but also with disability, ethnicity and gender. It has been amended from time to time over the years and there are now nine categories of persons who are protected. (In the rest of the UK, incidentally, there are at present six, to do with age, disability, ethnicity, gender, religion or belief and sexual identity.)

One of the requirements of the Northern Ireland Act was that all public authorities should draw up an equality scheme and that this should include arrangements for compiling and publishing impact assessments. The key idea in such assessments, as in those concerned with environmental matters (see above), was '*adverse impact*'. As mentioned and emphasised below, however, thinking and legislation have moved on since this initial concern. More recently, particularly due to thinking in relation to disability and gender, there has been growing emphasis on maximising potential positive impacts, as distinct from minimising possible negative ones.

The rest of the UK?

Q5. When were equality impact assessments introduced into the rest of the UK?

The first key legislative development in England, Scotland and Wales came with the Race Relations Amendment Act 2000. This introduced the requirement, similar to the one in Northern Ireland, that all public authorities should prepare and publish an equality scheme setting out how they intended to fulfil their duties to promote ethnicity equality and good relations between different communities.

Such schemes must include arrangements for assessing and consulting on the likely impact of proposed policies on the promotion of ethnicity equality; monitoring of policies for any adverse impact on the promotion of ethnicity equality; and publishing the results of such assessments, and consultations on which they are based. The first ethnicity equality schemes had to be published by 31 May 2002 and to be reviewed by 31 May 2005[11].

Detailed guidance on the conduct of race equality impact assessments was published by the Commission for Racial Equality (CRE) (now the Equality and Human Rights Commission) in 2002, and re-issued in 2005. The guidance did not and does not have legal force, and as yet there is no case law to clarify exactly what compliance with the legal duty to conduct impact assessments involves. The guidance is substantial, however, and in the light of it government departments have been under increasing pressure from the CRE to observe it. Pressure has also come from campaigners, activists and other interests, both directly and indirectly.

The requirement extended

Q6. When was the requirement to conduct equality impact assessments extended to issues of disability and gender?

It was not until December 2006 that all public authorities were required to publish disability equality schemes, the legal basis for this being the Disability Discrimination Act 2005, amending the Disability Discrimination Act 1995.

It as not until April 2007 that gender equality schemes were required, in accordance with the Equality Act 2006, which in turn amended the Sex Discrimination Act 1975.

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[11] A semantic note: the term in legislation is 'race equality' not 'ethnicity equality'. The latter term is preferred in this workbook, however, as a more accurate reflection of the concerns which race relations legislation addresses. There is discussion of this topic in the style guide.

Single equality schemes

Q7. What are 'Single Equality Schemes', and what is the legal basis for them?

It is legally permissible for an organisation to continue to publish separate schemes for disability, ethnicity and gender. But increasingly public authorities are choosing to combine their three separate schemes into a single scheme. At the same time they are choosing to conduct impact assessments which similarly deal with all three dimensions.

The DH published its first Single Equality Scheme on 6 July 2007.

Changes over the years

Q8. Thank you for this history lesson! How has thinking about impact assessments changed or developed over the years?

An extremely important question. The most significant single development has been away from simply thinking about *adverse impacts* (the key concern in environmental matters) and towards thinking about *actively promoting greater equality*.

The key question, it follows, is not only: 'Might this policy have a negative or adverse impact?' Also, it is: 'Does this policy have the potential to have a positive impact?' If the answer to the latter question is yes, then the immediate follow-up question is 'How can we ensure, then, that there really is a positive impact?'

The importance of this change in thinking cannot be over-emphasised. All EqIAs of DH policies, programmes and practices must bear it in mind.

Annex 5: The equality duties and bodies of interest to DH

The general equality duties

1. The general equality duties for gender and disability apply to any "public authority", which is defined for these purposes broadly as any person who has public functions (with certain exceptions, which are unlikely to be relevant for DH purposes). So the gender and disability general equality duties generally apply to the public bodies with which the Department of Health works (including NHS bodies, local authorities and non-departmental public bodies).

2. The general race equality duty applies to bodies listed in Schedule 1A of the Race Relations Act 1976. Listed bodies that are most likely to be of interest to the Department of Health are shown in the table below.[12]

3. The potential that major public bodies have to use their purchasing and procurement power as a lever for positive impact on equalities is significant. The Department acknowledges this influencing factor and views procurement as an opportunity to exercise this influence through open and transparent processes.

4. The duties conferred on public bodies by equality legislation equally apply in the procurement process. Public bodies like the Department must take race, disability and gender equality into account when procuring goods, services or works from external providers. We must build relevant race, disability and gender equality provisions into procurement processes to ensure that the requirements of the equality legislation are met.

The specific equality duties

5. The table below also shows which bodies most likely to be of interest to DH are currently (March 2008) required to produce equality schemes. From time to time, bodies are added to the list of those to whom the duties apply; so those listed were not necessarily bound by the duties from the date the duties first came into force generally.

	Race general duty*	Specific (scheme) duty		
		Race	Disability	Gender
NHS bodies				
Special and strategic health authorities	Yes	Yes	Yes	-
NHS trusts, PCTs	Yes	Yes	Yes	Yes

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[12] In some areas (for example medical examinations under the Immigration Act 1971), DH works closely with the Home Office and immigration authorities. Section 71A of the Race Relations Act 1976 provides that "in relation to the carrying out of immigration and nationality functions", the duty to have due regard to the need to promote "equality of opportunity" does not apply.

NHS Foundation trusts	Yes	-	Yes	Yes
Local authorities				
Within England, a county council, London borough council, or district council; Greater London Authority; Common Council of the City of London in its capacity as a local authority or port health authority; Sub-Treasurer of the Inner Temple or the Under-Treasurer of the Middle Temple, in his capacity as a local authority; Council of the Isles of Scilly	Yes	Yes	Yes	Yes
A port health authority constituted by an order under section 2 of the Public Health (Control of Disease) Act 1984	Yes	-	-	-
Other bodies				
Administration of Radioactive Substances Advisory Committee	Yes	-	-	-
Audit Commission for local authorities and the NHS in England and Wales	Yes	Yes	Yes	Yes
Commission for Healthcare Audit and Inspection	Yes[13]	-	Yes	Yes
Commission for Patient and Public Involvement in Health	Yes	-	Yes	-
Commission for Social Care Inspection	Yes[14]	-	Yes	Yes
Council for Healthcare Regulatory Excellence	-[15]	-	Yes	Yes
Council for the Regulation of Health Care Professionals	Yes[16]	-	-	-
General Chiropractic Council	Yes	-	Yes	Yes
General Dental Council	Yes	-	Yes	Yes
General Medical Council	Yes	-	Yes	Yes
General Optical Council	Yes	-	Yes	Yes
General Osteopathic Council	Yes	-	-	Yes
General Social Care Council	Yes	-	Yes	Yes
Health Professions Council	Yes	-	-	-
Health Protection Agency	Yes	-	Yes	Yes
Human Fertilisation and Embryology Authority	Yes	-	Yes	Yes
Independent Regulator of NHS Foundation Trusts	Yes	-	Yes	-
Joint Committee on Vaccination and	Yes	-	-	-

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[13] The Health and Social Care Bill amends the Race Relations Act to replace this with a reference to the Care Quality Commission.

[14] The Health and Social Care Bill amends the Race Relations Act to remove this reference.

[15] But see footnote to next entry.

[16] The Health and Social Care Bill amends the Race Relations Act to replace this with a reference to the Council for Healthcare Regulatory Excellence.

Immunisation				
National Biological Standards Board	Yes[17]	-	-	-
Nursing and Midwifery Council	Yes	-	Yes	Yes
Postgraduate Medical Education and Training Board	Yes	-	Yes	Yes
Royal College of Anaesthetists	Yes**	-	-	-
Royal College of General Practitioners	Yes**	-	-	-
Royal College of Midwives	Yes**	-	-	-
Royal College of Nursing	Yes**	-	-	-
Royal College of Obstetricians and Gynaecologists	Yes**	-	-	-
Royal College of Ophthalmologists	Yes**	-	-	-
Royal College of Paediatrics and Child Health	Yes**	-	-	-
Royal College of Pathologists	Yes**	-	-	-
Royal College of Physicians	Yes**	-	-	-
Royal College of Psychiatrists	Yes**	-	-	-
Royal College of Radiologists	Yes**	-	-	-
Royal College of Speech and Language Therapists	Yes**	-	-	-
Royal College of Surgeons of England	Yes**	-	-	-
Royal Pharmaceutical Society of Great Britain	Yes**	-	-	-
Standing Dental Advisory Committee	Yes	-	-	-
Standing Medical Advisory Committee	Yes	-	-	-
Standing Nursing and Midwifery Advisory Committee	Yes	-	-	-
Standing Pharmaceutical Advisory Committee	Yes	-	-	-
Unrelated Live Transplant Regulatory Authority	Yes	-	-	-

*Bodies bound by the general race equality duty are also bound by the duty in Article 5 of the Race Relations Act 1976 (Statutory Duties) Order 2001 to monitor staff etc by racial group and to publish the results annually, except that the duty in Article 5 does not apply to the Standing Dental Advisory Committee, Standing Medical Advisory Committee, Standing Nursing and Midwifery Advisory Committee or the Standing Pharmaceutical Advisory Committee, or, except in respect of their Scottish functions, the Administration of Radioactive Substances Advisory Committee and the Unrelated Live Transplant Regulatory Authority.
** in respect of its public functions (and in the case of the Royal Pharmaceutical Society in respect of its statutory functions and the regulation of the pharmacy profession).

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[17] The Health and Social Care Bill amends the Race Relations Act to remove this reference.