

Summary: Intervention & Options

Department /Agency: Department of Health	Title: Impact Assessment of the NHS Constitution	
Stage: Final proposal	Version: 2.0	Date: 17 December 2008
Related Publications: Handbook to the NHS Constitution, Statement of Accountability		

Available to view or download at:

<http://www.nhs.uk/constitution/pages/nhsconstitution.aspx>

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What is the problem under consideration? Why is government intervention necessary?

The foundations of the NHS could be more strongly secured - the principles and values have never been set out in one over-arching document. This would guard against future changes, which could undermine the efficiency and equity of the English healthcare system.

Many patients do not know what they are entitled to, and do not always receive what they should. There could be greater clarity around how decisions are made in the NHS and who is accountable. Only government has the incentive and authority to address these issues.

What are the policy objectives and the intended effects?

1. Safeguarding the NHS as an efficient and equitable health system
2. Empowering patients, the public and staff within the NHS - which will increase equity

What policy options have been considered? Please justify any preferred option.

Two options have been considered:

- 1) Not having a Constitution; and
- 2) Having a Constitution and providing a framework in primary legislation.

The second option is the preferred one. We have considered a variety of elements for inclusion: principles, values, rights, pledges and responsibilities. By bringing all these together in a Constitution, patients, the public and staff will be more informed and empowered; this will be reinforced through primary legislation.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? There will be a duty on the Secretary of State to report on the effect of the Constitution on NHS patients, NHS staff and members of the public. The report will be every 3 years, starting 5 July 2012.

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:

..... Date:

Summary: Analysis & Evidence

Policy Option: 2

Description: NHS Constitution and providing a framework in primary legislation

COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups' <u>Transitional costs include central administrative costs and communications nationally.</u> The costs represent an <u>indicative assessment of the impact readily quantifiable costs</u> of the NHS Constitution to the NHS are estimated at £20m p.a. <u>These costs primarily arise upon from improving</u> the timeliness of NICE's guidance and increased uptake of NICE approved drugs.
	One-off (Transition)	Yrs	
	£ n/a <u>approx £0.5m</u>	—	
	Average Annual Cost (excluding one-off)		
	£ <u>approx £20m</u>		Total Cost (PV) £ <u>approx £1905m</u>
Other key non-monetised costs by 'main affected groups' Non-monetised costs could include increased costs from dealing with complaints and from redress, <u>to the extent that these are not pre-empted by improved service standards in anticipation.</u> The risks that greater empowerment of patients could place significant additional demands on staff. There may be associated costs from			

BENEFITS	ANNUAL BENEFITS		Description and scale of key monetised benefits by 'main affected groups' The main affected group is patients. The main benefits for them which can be monetised arise from additional spending (as set out above) on cost-effective NICE approved drugs.
	One-off	Yrs	
	£ <u>n/a</u>		
	Average Annual Benefit (excluding one-off)		
	£ <u>approx £45m</u>		Total Benefit (PV) £ <u>approx £420m</u>
Other key non-monetised benefits by 'main affected groups' The <u>constitution should mitigate the risk of erosion of core values, and increase equity of access to care</u> benefits from this option are more likely to be delivered & in a more enduring way as the Constitution will be reinforced through specific clauses in legislation. <u>The clauses will reduce the risk that the impact of the</u>			

Key Assumptions/Sensitivities/Risks. The average cost per QALY of new drugs is currently £22k and the value of a QALY is taken to be £50k. Following DH convention, net benefits are estimated on the assumption that the marginal opportunity cost of £1 of government expenditure is £2 of benefit; thus Net Benefit = Benefits less twice costs.

Price Base Year 2008	Time Period Years	Net Benefit Range (NPV) £ <u>n/a</u>	NET BENEFIT (NPV Best estimate) £ <u>approx £25m</u>
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What is the geographic coverage of the policy/option?		England	
On what date will the policy be implemented?		if/when, 2009	
Which organisation(s) will enforce the policy?		DH and NHS bodies	
What is the total annual cost of enforcement for these organisations?		£ N/A	
Does enforcement comply with Hampton principles?		Yes	
Will implementation go beyond minimum EU requirements?		No	
What is the value of the proposed offsetting measure per year?		£ N/A	
What is the value of changes in greenhouse gas emissions?		£ N/A	
Will the proposal have a significant impact on competition?		No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium Large
Are any of these organisations exempt?	No	No	N/A N/A

Impact on Admin Burdens Baseline (2005 Prices)		(Increase - Decrease)	
Increase of £ xxx	Decrease of £ xxx	Net Impact	£ xxx

Key:

Annual costs and benefits: Constant Prices

(Net) Present Value

Evidence Base (for summary sheets)

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

The evidence base is structured as follows:

- 1. Introduction and background**
- 2. Objectives**
- 3. Rationale for Government intervention**
- 4. Options**
- 5. Costs and benefits**
- 6. Evaluation plans**
- 7. Conclusion**

Annex A: Equality Impact Assessment

Introduction and background

In the Next Stage Review Interim Report, published in October 2007, Lord Darzi set three main challenges for work on an NHS Constitution:

- to help secure the enduring principles and fundamental values of the NHS, based on evidence of what matters to patients, the public and staff;
- to embed a stronger focus on rights and responsibilities; and
- to establish a stronger framework for responsibility, accountability and legitimacy for decision making within the service.

The duty of the Secretary of State to promote a comprehensive health service (the NHS), aimed at securing improvement in the physical and mental health of the people of England, is set out in legislation (currently the NHS Act 2006). The Act also sets out the basis on which any charges can be levied. But the law does not define in any more detail the purpose of the NHS, nor the principles and values on which it is based. From time to time in various publications, the Department of Health has defined some of these – most significantly in the NHS Plan, which set out the NHS's principles. But there is no clearly accessible, single and authoritative statement.

The rights and responsibilities of the public, patients and staff in relation to the NHS are scattered in various pieces of legislation. For example, employment laws and contracts cover the rights of staff, and various Acts, regulations and directions cover the rights of patients. Most are not framed as individual rights but as duties on NHS bodies and as such are obscure even to health professionals. Policy also creates expectations about how the NHS will treat patients and the public – for example, in relation to waiting times. And the NHS has expectations of patients – for example that they participate in vaccination programmes, and that they comply with their treatment regime. But, again, it is not clear to everyone what these expectations are. The public would benefit from a greater understanding of what they are entitled to and can expect from the NHS.

Objectives

The NHS Constitution must address two objectives. These are explained in detail below:

1. Safeguarding the NHS as an efficient and equitable health system
2. Empowering patients, the public and staff within the NHS.

Rationale for Government intervention

1. Safeguarding the NHS as an efficient and equitable health system

The foundations of the NHS, as a comprehensive, tax-payer funded service for all, based on clinical need and regardless of the patient's ability to pay, have the strong support of the public. 80 per cent of people think that the NHS is critical to British society and must be maintained.

These foundations are the basis of the efficiency and equity of the NHS and the wider healthcare system in England. The Wanless Review's analysis of the evidence about different funding models concluded that "private health spending has no advantages over public health spending. The most obvious consequence of shifting from public to private spending is to shift the burden from the relatively rich to the relatively poor." The Review also concluded that the UK system of financing is relatively efficient and equitable. "It delivers strong cost control and prioritisation and minimises economic distortions and disincentives. A further key advantage of the UK's funding system is its fairness, providing maximum separation between an individual's financial contribution and their use of health care."

However, although some of the principles are incorporated in legislation in the NHS Act 2006, such as the principle that the NHS provides a comprehensive service available to all, many of them are not explicit or secured.

Furthermore, the NHS needs to act to meet rising public expectations; despite the investment in the NHS and substantial improvements in performance, more needs to be done to meet external challenges.

Finally, as more third sector and independent organisations begin to provide NHS care, it becomes necessary to safeguard and promote the ethos and foundations of the NHS, with the result that everyone understands and abides by the same ethos and values.

Only the Government has the incentive to act to address these issues.

2. Empowering patients, the public and staff within the NHS

All patients and members of the public should feel able to challenge if they do not get the services they should. However, some groups of patients appear to be less empowered than others: for example, there is a social gradient in referral for outpatients and elective surgery (Morris 2002, Centre for Health Economics, York Technical Paper 27). GPs' referral decisions vary even for patients with similar age, sex and morbidity group.

This is in part because patients are not aware of, and do not understand, their rights in relation to the NHS and what they can expect from the NHS. Nowhere are the rights of patients and the public clearly set out in one accessible place.

There is a strong case to seek ways to empower patients, the public and staff to know their rights and to change their behaviour and help the NHS to work effectively and to ensure resources are used responsibly, through the development of an NHS Constitution.

Options

There are two options:

- 1) **Do-nothing option** is the continuation of the status quo – i.e. no NHS Constitution.
- 2) **Produce an NHS Constitution and provide a framework in primary legislation.**

1) Do-nothing option

This is the continuation of the status quo – i.e. no NHS Constitution. Patients' rights would continue to be scattered across various documents, and staff rights would continue to be present only in their contracts. There would be no clear list of responsibilities, or pledges that the NHS commits to do above and beyond its legal requirements.

2) Produce an NHS Constitution and provide a framework in primary legislation

Although there is a multitude of options for intervention which could help achieve some of the objectives above, a Constitution is the only option which addresses them all in a coherent way. We have therefore considered a single alternative option: producing a **NHS Constitution** and providing an underpinning framework in primary legislation.

The NHS Constitution

The NHS Constitution is a document containing:

- A declaration of the purpose of the NHS
- A declaration of essential NHS principles
- A declaration of the NHS values that bind it together
- A declaration of legal rights for both patients and staff
- A declaration of responsibilities of the public, patients and staff: what the NHS expects from them
- A statement of pledges from the NHS to patients, the public and staff
- A commitment to a statement about the accountability arrangements in the NHS.

The Constitution provides details of each of these; the content is the result of consideration of a range of options and formulations.

Providing a framework in primary legislation

The preferred option is to support the NHS Constitution by having specific clauses in legislation. Legal powers will reinforce the value of the Constitution and act as an important symbol, particularly to organisations providing NHS care. However, the Constitution itself will remain a "declaratory document", which brings together existing rights and policies in one place, but does not replace them.

It is intended that **primary legislation** will be introduced to:

- Place a duty on the Secretary of State to adopt a Constitution and to renew it every ten years, following full engagement with patients, the public and staff;
- Place a duty on the Secretary of State to review the Handbook to the NHS Constitution at least every three years.
- Place a duty on NHS bodies, primary care contractors and all third sector and independent providers of NHS care to have regard to the NHS Constitution. The duty will also extend to Monitor (the independent regulator of NHS foundation trusts) and the Care Quality Commission;

- Place a duty on the Secretary of State to report on the effect of the NHS Constitution on NHS staff, NHS patients and members of the public, at least every three years.

The proposed duty to have regard to the NHS Constitution will apply when organisations are performing their health service functions (commissioning or providing health services, or in the case of Monitor and CQC, in relation to their regulatory functions). This would act as an important symbol. All bodies providing NHS services should have regard to the NHS Constitution as it underpins their shared purpose, values and principles, and secures the NHS for the future.

The proposed duties place an obligation on Secretary of State to review and hold a consultation on any changes to the relevant part of the Constitution at least every 10 years. These duties will ensure that the Constitution and its Handbook can evolve to reflect changes in the relevant laws and/or policies, whilst safeguarding core principles. There is also a proposed duty on the Secretary of State to measure and report on the effect of the NHS Constitution on NHS staff, NHS patients and members of the public, at least every three years.

Costs and benefits

Benefits

The benefits of producing a Constitution are two-fold:

A) Ensuring the NHS is an efficient and equitable health system in the future

The NHS faces a number of challenges, for example from improved technology, shifts in the way services are delivered, continuously improving medical practice and rising public expectations. The Constitution aims to equip the service with the capability it needs to work with all these changes and preserve its unique nature, safeguarding efficiency and equity. The Constitution aims to secure the foundations of the NHS and to ensure that the enduring principles and values of the NHS will not be undermined, preventing the threats of an inequitable health system within the NHS materialising. Furthermore, by articulating these principles and values, it becomes easier for third sector and independent organisations providing NHS care to know what behaviour is expected of them: it binds all organisations providing NHS care into common behaviours and values.

By clarifying the fundamentals that will not change – through establishing a consensus and articulating in an enduring way the NHS's purpose, principles and values – progress in meeting 21st century challenges will be easier.

B) Greater Empowerment of patients, the public and staff

The NHS Constitution sets out the legal rights of both patients and staff, and articulates everyone's responsibilities. Greater patient, public and staff understanding of what they can expect would be a step towards greater empowerment; it could provoke challenge and mutual respect for NHS services, and force up standards.

The Constitution gives people more information about what they can expect from the NHS. Derek Wanless pointed to the need for patients to be supported to make better decisions about their own health and welfare, citing one of the current barriers to decision-making as a lack of information (Wanless D, 2007, Ch 7 Securing Good Health for the Whole Population).

Currently, few patients know their rights and how they should complain or seek redress if their rights are infringed or the pledges are not honoured. National surveys have found 60 per cent of service users do not know where to seek help about making complaints (Which? *The state of*

the NHS, April 2006) and only 18 per cent of users were given information about how they could complain (Picker Institute, *Is the NHS becoming more patient-centred? Trends from the national surveys of NHS patients in England 2002-07*, September 2007).

By bringing together all the rights and pledges in one place, more people will understand what to expect from the NHS, and will be provided with a firmer basis to challenge when the NHS deals with them in ways, which are not in accordance with their rights and the NHS pledges made to them. Furthermore, patients empowered with rights and pledges that apply uniformly across the country may create pressure on Primary Care Trusts to reduce unjustified variation.

The Constitution is accompanied by a Handbook to the NHS Constitution. This sets out the legal basis of the rights, and the specifics of the the pledges – e.g what access means in terms of waiting times, the mechanisms by which they will be delivered (e.g. through the Care Quality Commission, through performance management, through World Class Commissioning and/or through contracts with PCTs). The Handbook also explains how the NHS will ensure that the pledges are delivered, and how redress can be sought if the NHS fails to deliver on either the pledges or rights. Through publishing the Constitution and its accompanying Handbook, there will be a greater number of patients and staff who know their rights, pledges and responsibilities and what these mean in practice.

Setting out responsibilities in the Constitution, to explain how patients and the public can play their part in looking after their own and their families' health, and to encourage people to see the NHS as a partner, may provide a foundation for further communications to help change behaviours. The Constitution in this case will be an important platform to effect a change in behaviour; it will help provoke challenge and encourage mutual responsibility. Patients will become more responsible in their use of services if they adhere to their responsibilities. Staff may be constructively challenged if they are not living their responsibilities. Mutual responsibilities will ensure patients and staff enter a mutual partnership of respect for NHS services.

Ensuring that NHS staff are engaged by their employer and empowered to develop better services for patients underpins Lord Darzi's *High Quality Care for All*, and will be critical to achieving the vision. Fully engaged staff are likely to be more committed to their work and their employer, to 'go the extra mile' and to get involved in improving services for patients (West, M et al, 2002, 'The link between the management of employees and patient mortality in acute hospitals', in [The International Journal of Human Resource Management](#), Volume 13, Issue 8, pp 1299 – 1310.) Setting out clearly what is expected of staff, and what staff can expect from the NHS as an employer, will empower them and support fuller engagement.

Costs

Promotion of patient rights and pledges through the Constitution may cause more patients to view the NHS as an entitlement. Patients may demand more from health service staff, particularly when they perceive that they are not getting what they should or are entitled to – using the rights and pledges in the Constitution as a basis for their demands.

A phased communications approach is being developed to engage NHS staff in the first instance in both their own rights and pledges and those of patients. Their positive engagement will be key as they are the public's most trusted source of health information, and so will help achieve positive patient and public engagement with the content of the Constitution.

Communications will initially seek to build awareness and understanding of the Constitution before delivering more detailed messages about individual rights and pledges. Activity will be delivered at both a national and local level. The locally delivered activity will be key to ensure that all demographics and hard to reach groups are communicated with. It is estimated that the costs for such an approach will be approximately £500,000 between now and 2010. There will be further communication costs in the future, but it is difficult to predict what these will be with

any certainty as we will evaluate and refine our communications over the coming months and years. Where there are local communications, we expect it to be built into existing communication plans, rather than separate initiatives and therefore we do not expect additional costs to be material.

Complaints could decrease over the medium term as NHS organisations become more responsive as a result of the Constitution setting out what everyone is entitled to; but it is also likely that they will increase initially – through either increased patient awareness of their rights, or because there is increased awareness of the complaints and redress system. The administration and legal costs of dealing with complaints may increase, as well as the costs of putting things right. Overall, complaints are an important source of information on how to improve performance, and provide an incentive to improve the quality of services. The complaints system is being reformed in April 2009; a separate impact assessment will be carried out on this policy.

The right to drugs and other treatments recommended by NICE technology appraisals, where it is clinically appropriate.

Rather than being a new right, this is a declaration of the existing duty on PCTs to make funding available for drugs and treatments following recommendation by NICE Technology Appraisals. This right sits alongside other measures being taken outside the Constitution aimed at improving take-up of NICE approved drugs and treatments.

Making patients aware of this right will empower them in their dealing with clinicians, so that they get drugs that they can benefit from and which are cost effective. It could encourage PCTs to more actively promote access to NICE approved drugs, rather than making funding available passively. This will help ensure that the uptake of cost-effective NICE drugs and treatments is maximised. It will also reduce variation between PCTs in the speed at which drugs and treatments recommended by NICE technology appraisals are taken up – thus increasing equity.

Effects could arise from:

- increasing the final uptake of the NICE approved drug or treatment; or from
- shortening the period between the production of NICE guidance and full uptake of the drug or treatment. This period varies substantially between drugs. For Herceptin, full take-up was achieved within one year; for statins, full take-up has taken place over a five year period.

We consider that the predominant effect of this right will be to shorten the period between NICE appraisal and full take-up of a drug. Indicatively, if this period were shortened by 3 months, the additional annual costs of spending on NICE approved drugs and treatments would average around £20m per annum. This assumes that the average full year cost of drugs and treatments approved by NICE over the course of a year is £150m. Additional spending on cost-effective NICE drugs will, produce commensurate benefits. The estimate of £20m p.a. is viewed as being at the upper end of the likely range.

The monetised benefits are estimated to be approximately £45million per annum. This is based on an estimate that the average health gain arising from recently approved new drugs is a Quality Adjusted Life Year (QALY) for £22k. So an additional £20m of spending on such drugs should yield 909 QALYs. QALYs are estimated to be valued by the public at £50k (internal DH guidance), so 909 QALYs is worth £45.45m. The opportunity cost of the £20m on the other hand is estimated at 800 QALYs (because at the margin DH buys QALYs at some £25k).

Additional rights – where rights have been strengthened or have been developed (e.g. you have a right to make choices about your NHS care. The options available to you will develop

over time and depend on your individual needs), as and when additional measures are put in place, this will be assessed in a separate impact assessment.

Pledges - The pledges are supported by policies outlined in the Handbook. They are existing policies and as such have already had assessments carried out to ensure that the benefits exceed the costs. When additional measures are put in place for new policies, these will be assessed in a separate impact assessment.

Specifically for staff, the pledges outline things that good employers will already be committed to, such as providing staff with clear roles and responsibilities and rewarding jobs. The amount that employers will spend on meeting these pledges will depend on how far they are currently from meeting them, and the extent to which greater awareness of their expectations increases the pressure that staff put on their employers. There are offsetting savings from greater investment in staff, for example lower rates of sickness absence and turnover. Development and training of staff enable them to provide better services, improving outcomes for patients.

Proposed legal duties:

On NHS bodies, Monitor (the independent regulator of NHS foundation trusts), the Care Quality Commission, primary care contractors and independent and third sector providers of NHS care to have regard to the Constitution.

Consideration of the Constitution by bodies providing NHS care may involve changes in planning and commissioning and an increased emphasis by bodies providing NHS care for patients, public and staff to know their rights, pledges and responsibilities and appropriate redress. These may have both costs and benefits; there is currently insufficient data to make a realistic estimate.

Availability, review and revision of NHS Constitution

The costs of this clause is estimated to be £400,000 per review – therefore every ten years (this includes publishing and administrative costs). There may be additional costs; however, at this stage these costs have not been estimated, as we do not have any basis for making plausible assumptions. There are benefits to ensuring the Constitution is up to date and reflects the current direction of the healthcare system.

Availability, review and revision of the Handbook to the NHS Constitution

The costs of this clauses is estimated to be £250,000 for at least three reviews over a ten-year period. There are benefits to ensuring the Handbook, which explains what underpins the rights, pledges and responsibilities, is revised in a timely manner – for example, what we are currently doing to honour our pledges changes as policy changes. This will allow the policies that support the pledges to be reviewed and assess whether the benefits still exceed the costs.

Report on effect of NHS Constitution

Further detail on this will be published at a later date.

Evaluation plans

There will be a duty on the Secretary of State to report on the effect of the NHS Constitution on NHS staff, NHS patients and members of the public, at least every three years.

It is important to restate that the NHS Constitution is a summary of existing rights and responsibilities, not a framework for assessing performance. Its purpose, and usefulness, will be when it is used in conjunction with other policies.

As mentioned above, a communications plan is under development, which will look at the next three years. The Constitution needs to be rooted in everyone's minds – DH employees when formulating policy, NHS staff when carrying out their duties, and patients and the public when using NHS services – if it is to be effective in fulfilling its objectives.

Conclusion

The NHS Constitution will be a powerful aid in supporting patient, public and NHS staff empowerment and ensuring the principles of the NHS endure. This would help ensure the NHS is well-equipped to deal with external 21st century challenges and embrace future change.

The Constitution will be reinforced through primary legislation, and requiring NHS bodies, primary care contractors and all third sector and independent providers of NHS care to have regard to it, as well as Monitor (the independent regulator of NHS foundation trusts) and the Care Quality Commission.

By imposing duties on various organisations to have regard to it, and on the Secretary of State to review it at least every 10 years by consulting NHS staff, NHS patients and members of the public, it will be in the forefront of people's minds.

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	No	No
Small Firms Impact Test	No	No
Legal Aid	No	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	No	No
Race Equality	Yes	Yes
Disability Equality	Yes	Yes
Gender Equality	Yes	Yes
Human Rights	Yes	Yes
Rural Proofing	No	No

Annex: Equality Impact Assessment

The policy objective is to safeguard the NHS as an efficient and equitable health system, and to empower patients, the public and staff within the NHS. We have considered two options: (1) do nothing; and (2) publish an NHS Constitution and put a framework in primary legislation. Option (2) is the preferred option.

There is a very strong opportunity for the Constitution to promote equality of opportunity, for patients, public and staff. The latter is particularly important, as the NHS is the single largest employer of BME staff in the UK.¹ Through articulating the enduring principles of the NHS, rights, NHS pledges and responsibilities, the NHS Constitution renews our national commitment to a comprehensive health service that provides world-class care.

The Constitution restates the enduring principles of the NHS. The first principle states: 'The NHS provides a comprehensive service to all irrespective of gender, race, disability, age, religion or belief or sexual orientation...it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.' From the outset, the Constitution presents the enduring idea that no group should be discriminated against. This is reinforced through the proposed duty on NHS bodies, Monitor (the independent regulator of NHS foundation trusts), the Care Quality Commission, primary care contractors and third sector and independent providers of NHS care to have regard to the Constitution, to be included in the forthcoming NHS Health Bill.

Specifically, equity will be improved by making more individuals aware of their entitlements to specific treatments. The Constitution restates existing law, including 'You have the right not to be unlawfully discriminated against in the provision of NHS services including on the grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness.)' Restating this particular legal right and essential principle meets our duties to promote equality of opportunity, eliminate discrimination, eliminate harassment, encourage the participation of disabled people, and promote and protect human rights. It sets out what the law is, and how people can seek redress if they do not get it. Promoting equity applies to members of staff as well as patients and the public: the right of staff to be 'treated fairly, equally and free from discrimination' is signalled in the staff section of the Constitution.

Previously, rights were spread over different documents; for the first time it is all in one place, which will empower all patients, public and members of staff. The Constitution is clear about exactly what these groups have a right to expect from the NHS, and what they can do if they do not get it. It will also make it clearer what patients' responsibilities are, which will help to reduce inequalities of knowledge between groups. The Black Disabled People's Association responded positively to the consultation on the draft NHS Constitution, agreeing that it was helpful for their members to have rights and pledges set out for them, and agreeing that the redress mechanisms were clear to them. Similarly, Scope commended the Constitution for bringing together the key patient rights and pledges.

Setting out patient, public and staff rights, pledges and responsibilities in a Constitution means that everyone has the same information about what they can expect from the NHS, rather than an educated few. This is particularly important for equality, as research has shown that there is a range of variations between black and minority ethnic (BME) groups and their white British counterparts. Where differences do exist, most are negative, indicating that BME groups are less likely to report a positive experience. For example, Asian/Asian British groups are often less likely to report positive experiences relative to White British respondents on a range of

¹ www.networks.nhs.uk

surveys and questions. A particular area that elicits less positive responses from patients from BME groups is involvement in decisions about their care and treatment, and the quality of information given to them in the better information, more choice domain. This is mirrored in responses to the inpatient, outpatient and A&E surveys, where patients from BME groups are more likely than those from the White British group in the building closer relationships domain to say that staff talked in front of them as if they were not there.²

To ensure rights are known as widely as possible, there will be a comprehensive communications strategy to reach patients, public and staff. This is listed in more detail in the main Impact Assessment. This information is accessible in different formats and in different languages; the Constitution is available in braille; Arabic; Bengali; French; Gujarati; Polish; Portuguese; Punjabi; Somali; Turkish; and Urdu. This will ensure that those people whose first language is not English, and those with a visual impairment, will be able to access the information. This will further assist in giving everyone an equal opportunity in accessing the NHS Constitution, and in knowing their rights and responsibilities. Various consultation responses have addressed this: Guide Dogs for the Blind, for example, has stressed the importance of considering the needs of people with sensory impairments as well as those from different ethnic communities.

The impact along each dimension of equality is summarised in table A1.

Table A1
Summary of Impact on Equality by Dimension

Race	<p>Positive impact on equality of opportunity on BME groups, due to higher likelihood of universal understanding of what patients and the public are entitled to and what their responsibilities are. The draft Constitution is available in Arabic, Bengali, French, Gujarati, Polish, Portuguese, Punjabi, Somali, Turkish, Urdu, and the revised Constitution will be printed in the same languages. This will further promote wide access for peoples of different races.</p> <p>The Constitution will increase knowledge of what people are entitled to, in staff and professionals as well as patients and the public, particularly as people from minority races are reporting less involvement in decisions about their care.</p>
Gender	<p>Positive impact on gender due to higher likelihood of universal understanding of what patients and the public are entitled to and what their responsibilities are.</p>
Disabled people	<p>Positive impact expected due to higher likelihood of universal understanding of what patients and the public are entitled to and what their responsibilities are. Draft Constitutions are available in braille and easy read guides, and final Constitutions will be produced in these formats, which will further promote access to the Constitution for some disabled people.</p>
Age	<p>Positive impact expected due to higher likelihood of understanding of what patients and the public are entitled to and what their responsibilities are.</p> <p>The Constitution brings together rights and principles that cover older people, and there are plans to update the Constitution and Handbook to take account of forthcoming Age Discrimination legislation, when it comes into force.</p> <p>The Handbook makes specific references to what certain pledges mean for children.</p> <p>We are looking into producing a separate leaflet aimed at families and young</p>

² Healthcare commission and Department of Health, *Report on self-reported experience of patients from black and minority ethnic groups*, May 2008.

people, to be read alongside the Constitution and explain what it means for this age group specifically.

Religion

Potential positive impact expected due to higher likelihood of understanding of what patients and the public are entitled to and what their responsibilities are, to the extent that certain religions are more common among BME groups.

The Constitution will increase knowledge of what people are entitled to, staff and professionals as well as patients and the public, particularly as people from minority religions are reporting less involvement in decisions about their care.

Sexual Orientation

Potential positive impact expected due to higher likelihood of understanding of what patients and the public are entitled to and what their responsibilities are, and clear mechanisms for seeking redress, for example if people are being discriminated against.

Further Evidence

Deprived and minority groups are likely to be amongst those whose rights are currently ignored. Of patients who use outpatient 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. In mental health, research has shown a widespread reluctance by BME parents to use mental health services and their perceptions of cultural insensitivity, exclusion, patronising behaviours and a general lack of understanding of the needs of BME mental health clients. For instance, African–Caribbean people are twice as likely as white people to be diagnosed with a mental health problem, but they are less likely to access treatment and care. Although a lack of awareness and information about mental health problems within some BME communities, such as black African and African–Caribbean groups, may be a factor, it is evident that many BME service users and their carers are dissatisfied with mainstream services, which they often perceive as misunderstanding and/or misrepresenting their situation.³

Disabled people often face unacceptable difficulties when they try to use NHS services, or to work in the NHS. These difficulties can be caused by a variety of factors, including the lack of understanding of disability by some staff. A good practice guide recommends that if the NHS is to provide a fair service for disabled people, it has to be taken seriously by senior managers in health authorities, primary care groups and NHS Trusts. Managers and service providers must listen and respond appropriately; disabled people are the experts in their needs.⁴

The Constitution would assist in addressing these problems of lack of knowledge, of patients, public and staff, as it brings together for the first time, all the rights to which patients are legally entitled. The Constitution will list the existing legal right to be involved in discussions about their care, and this will be published in 10 different languages as well as braille, meaning that those unable to read English will not be penalised. As a result of this, awareness of the constitution amongst ‘hard to reach’ groups will increase, and the consequence will be an increase in equity due to more frequent assertion of rights.

Monitoring impact on equity

The impact of the Constitution on equity will be monitored and policy adjusted to make sure that it is achieved.

³ Ruby green et al, SCIE Research briefing 29: Black and minority ethnic parents with mental health problems and their children, September 2008.

⁴ Doubly Disabled: Equality for disabled people in the new NHS, NHS Executive, January 1999.

We are proposing to put a statutory duty on the Secretary of State to update the Constitution at least every 10 years, and to consult NHS patients, NHS staff and members of the public in doing so. We are also proposing a duty on the Secretary of State to report on how the NHS Constitution has affected NHS patients, NHS staff and members of the public. These duties will be included as part of the Health Bill.

As mentioned above, we are in the process of formulating a three year communications strategy to support and embed the Constitution. This will begin by focussing on staff awareness, and roll out to patients and public once staff have been fully briefed on what the Constitution is and what it means for everyone.

It is important that patients and the public have a clear understanding of what they can do if they have concerns about the care they receive from the NHS. The Constitution itself has a key role in setting out what patients can expect and how they can raise concerns or seek legal redress in defined circumstances. The rights to complaint and redress are supported by pledges covering the effective handling of patient complaints.

Conclusion

The NHS Constitution has the potential to have a positive impact on equality in relation to disability, ethnicity, gender, sexual orientation, age, or religion or belief. No group of people will be excluded as a result of the Constitution, and existing discrimination and inequality will not worsen. Indeed, the purpose of the Constitution is to set out, in clear and simple terms, what people's rights are, what their responsibilities are, and what the enduring principles of the NHS were, and still are.

The Constitution has the potential to have a greater impact on particular groups or communities, such as minority ethnic groups, older people and disabled people who are currently far less likely to be involved in their care than the overall population.

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