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# Briefing note for Integrated Care Boards on legal duties in respect of reducing inequalities

Commissioned by the Strategy Unit to provide a legal perspective on their report 'Strategies to reduce inequalities in access to planned hospital procedures' (May 2022, for the Midlands Decision Support Network)

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# Foreword

In May 2022, the **Strategy Unit** published a report on strategies to reduce inequalities in access to planned hospital procedures.

https://www.midlandsdecisionsupport.nhs.uk/knowledge-library/strategies-to-reduce-inequalities-in-access-to-planned-hospital-procedures/

The report was commissioned by the 11 ICSs that make up the **Midlands Decision Support Network** (MDSN - for which the Strategy Unit acts as the development centre). The report was a follow-up to our 2021 publication which presented analyses of the current position, of trends and of stages in the patient journey at which socioeconomic inequities (ie. in relation to estimated levels of need) were most pronounced.

These reports showed a position of considerable inequity, and one that has worsened over the last decade. They also demonstrated that the lockdown period of the COVID-19 pandemic has been particularly damaging in terms of elective equity across the NHS in England. To help Integrated Care Boards (**ICBs**) in thinking through how they might address this issue, the May 2022 report sets out a series of potential strategies that might be adopted and recommends a systematic process that systems/boards might go through in order to tailor such for their local situation and then measure the effect.

Responding to this is a considerable decision-making challenge for ICBs, coinciding as it does with the demands of 'elective recovery' (post lockdown) and their newness as statutory organisations. Deciding to do more for certain groups (and therefore, when resources are finite, almost certainly less for others) in the interests of equity is not a technocratic exercise – it involves value judgements and fundamental questions of decision-making legitimacy. It also involves a full appreciation of legal duties.

To try to help ICBs and others in taking the insights from these Strategy Unit reports into action, we have commissioned some further perspectives on the possible strategies we have described to reduce inequalities in access to planned hospital care. The first of these - this publication from colleagues at Hill Dickinson - starts with an up-to-date overview of the legal duties placed upon ICB decision makers in relation to reducing inequalities and then considers the range of possible strategies proposed in our report from that legal perspective. Given that since publication of our reports we have already experienced instances where ICS/ICB Board members have been unsure of whether the law allows them to adopt some of the strategies outlined, I hope that this timely paper from Hill Dickinson helps build decision-maker confidence around the legal context in which they must act.

This paper will be followed later in the year by one that addresses the ethical dimensions of developing strategies to address socioeconomic inequalities in planned care. That too will be published on the Strategy Unit website.

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# Briefing note for Integrated Care Boards

## Legal duties in respect of reducing inequalities

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## Executive summary

This briefing note has been commissioned by the **Strategy Unit** to provide a legal perspective on reducing health inequalities in access to planned hospital care. It was commissioned for the attention of Integrated Care Boards (**ICBs**) in response to the report produced by the **Strategy Unit** for the **Midlands Decision Support Network** and published in May 2022 'Strategies to reduce inequalities in access to planned hospital procedures'.

https://www.midlandsdecisionsupport.nhs.uk/knowledge-library/strategies-to-reduce-inequalities-in-access-to-planned-hospital-procedures/

This note aims to summarise the legal duties on ICBs with regards to reducing inequalities and considers, from a legal perspective, the discharge of these duties in the context of implementing the strategies set out in the May 2022 report to reduce inequalities in access to planned hospital procedures.

There are various statutory duties on ICBs under the NHS Act 2006 (as amended by the Health and Care Act 2022) that relate to health inequalities. The main and general duty with regards to reducing inequalities is set out at section 14Z35 of the 2006 Act, which requires an ICB, in the exercise of its functions generally, to have regard to the need to reduce inequalities with respect to peoples' ability to access health services and reduce inequalities with respect to the outcomes achieved for those individuals by the provision of health services.

The public sector equality duty under section 149 of the Equality Act 2010 obliges an ICB to have due regard to the need to *advance equality of opportunity between people who share a protected characteristic and those who do not*. This duty is based on protected characteristics, as listed in the Equality Act, but we state in this note that the general duty on ICBs to have regard to the need to reduce inequalities, and the duties we refer to in this note which sit alongside or supplement the general duty, will both allow and arguably require ICBs to consider socio-economic factors when determining the health inequalities that exist in any given area and in adopting strategies to try and tackle/reduce those inequalities.

The main and general duty is to 'have regard to' the need to reduce inequalities, which will involve being able to demonstrate how the adoption of a policy or strategy or the making of a decision has taken into account the need to reduce inequalities and how the policy, strategy or decision has furthered that objective, or it if hasn't, the reason for that. The duty does not oblige an ICB to evidence that it has in fact reduced inequalities.

The May 2022 report introduces a number of strategies that may serve to demonstrate discharge of the inequality duties and compliance with the principles and values enshrined within the NHS Constitution in the commissioning of planned hospital care. The legal framework does not impede the adoption of any of the strategies described in the report. Adopting such strategies may mean that ICBs avoid any allegations or challenges that they are not complying with their statutory duties with regards to inequalities.

However, it is important to note that implementing those strategies alone will not discharge the duties fully, as the duties are continuous in the exercise of the ICB's functions and apply to the exercise of all functions, not only the function of commissioning planned hospital care.

The legal framework does not dictate how an ICB must exercise its commissioning functions to 'meet the reasonable requirements of the people for whom it has responsibility', nor does it dictate the strategies that an ICB must adopt or the decisions it must make to discharge its inequality duties – strategies will need to reflect and be tailored to the population health needs and inequalities that exist within any given system. In adopting an approach/strategy, however, this note explains that an ICB must be cognisant of its obligations with regards to non-discrimination based on protected characteristics, its obligation to involve patients and others when planning changes to commissioning arrangements and its obligations to abide by public law principles.

## 1. Introduction

This briefing note has been prepared for ICBs in response to, and to be read in conjunction with, the report produced by the **Strategy Unit** for the **Midlands Decision Support Network** and published in May 2022 on 'Strategies to reduce inequalities in access to planned hospital procedures' (**the Report**).

https://www.midlandsdecisionsupport.nhs.uk/knowledge-library/strategies-to-reduce-inequalities-in-access-to-planned-hospital-procedures/

The Report notes that *'"reducing health inequality" must be one of this country's most stable policy aims. With peaks and dips in emphasis, it has been featured consistently in policy statements since at least the late 1990s. Yet outcomes have got worse. Gaps between rich and poor have widened. Defying a trend that began in late Victorian times, gains in life expectancy have stalled for poorer groups - and have even fallen for women from the poorest backgrounds. Variation in the experiences and outcomes of different communities during the COVID-19 pandemic served to bring this issue back into focus'*.

The NHS 2022/23 priorities and operational planning guidance sets out that ICSs will have four strategic purposes, one of those being to tackle inequalities in outcomes, experience and access. With the passing of the Health and Care Act 2022 (**the 2022 Act**), ICBs are given responsibility for a broad range of commissioning functions. The NHS policy objective of tackling inequalities in access to healthcare is enshrined in the 2022 Act, which imposes statutory duties on ICBs with regards to reducing inequalities in the exercise of their functions.

This note aims to summarise the legal duties on ICBs with regards to reducing inequalities and considers, from a legal perspective, the discharge of these duties in the context of implementing the strategies set out in the Report to reduce inequalities in access to planned hospital procedures.

## 2. What are health inequalities?

According to NHS England, health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies.

The Report references that an equitable distribution of services is one where rates across population subgroups follow the distribution of need, such that a patient with a given level of need in one subgroup has the same chance of accessing a service as their counterparts with a similar level of need in other subgroups, and that this is the standard that the NHS seeks to achieve. As the Report sets out strategies to help ICBs achieve equity in access to planned hospital care, this note is therefore to be read in that context.

## 3. Legal context - obligations on ICBs in relation to reducing inequalities

There are well established legal obligations on NHS bodies, now also imposed on ICBs, not to discriminate, directly or indirectly, on the basis of protected characteristics in the exercise of public functions. There are certain exceptions and there can be 'objective justification' for a difference in treatment.

The protected characteristics are:

- age
- disability
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- race (including colour, nationality, ethnic or national origin)
- religion or belief
- sex
- sexual orientation.

These obligations are set out within the Equality Act 2010 and are unchanged by the passing of the 2022 Act.

As this note explores the legal duties imposed on ICBs in the context of implementing the strategies set out in the Report to reduce inequalities in access to planned hospital procedures, it does not explore the non-discrimination laws imposed by the Equality Act. Instead, it focusses on the statutory duties on ICBs with regards to reducing health inequalities.

The statutory obligations imposed on ICBs in respect of reducing inequalities in access to healthcare are contained primarily within the 2022 Act, which in the main came into force on 1 July 2022. However, the public sector equality duty (**PSED**) set out in the Equality Act 2010 also imposes obligations in respect of health inequalities.

## 3.1 Statutory obligation on ICBs under the Equality Act 2010 – the public sector equality duty

Section 149 of the Equality Act 2010 introduces a legal duty known as the public sector equality duty (**PSED**). This duty is applicable to public bodies, including ICBs. In summary, this duty imposes legal obligations on ICBs to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The element of the PSED which involves having due regard to the need to advance equality of opportunity is based on protected characteristics (as listed above) ie. having due regard to the need to advance equality of opportunity between those individuals who share a protected characteristic and those who do not.

Having "due regard" involves considering the aims of the duty in a way that is proportionate to the issue at hand. This will involve being able to demonstrate the impact or potential impact policies or decisions may have on those sharing protected characteristics in comparison with those who do not share the protected characteristic, and the ways in which the impact has been mitigated. In other words, 'having due regard' will involve being able to demonstrate how the adoption of a policy or the making of a decision has taken into account the duty and how the duty has been applied. The PSED does not oblige an ICB to evidence equality of opportunity – it simply obliges them to have due regard to the need to advance equality of opportunity when exercising functions. In developing policies, in exercising their functions and in making decisions, ICBs must therefore consider the impact upon groups of individuals who share protected characteristics and take into account the duty to advance equality of opportunity between those groups and groups of individuals who do not share that protected characteristic. Such considerations are often carried out by way of equality impact assessments, which serve to demonstrate how the duty has been taken into account.

Although social deprivation is not a protected characteristic under the legislation outlined above and is not therefore a factor which ICBs are obliged to have due regard to under the PSED ie. the PSED is not a duty to have regard to advancing equality of opportunity between those who are living in certain social, environmental and economic conditions and those who are not, the legal duties outlined below will in our view allow and require ICBs to consider socio-economic factors when determining the health inequalities that exist in any given area and in adopting strategies to try and tackle/reduce those inequalities.

## 3.2 Statutory obligations on ICBs under the NHS Act 2006 (as amended by the Health and Care Act 2022)

The obligations imposed on ICBs by the 2022 Act form part of the NHS Act 2006 (**the 2006 Act**) (the 2022 Act has essentially amended the NHS Act 2006).

### 3.2.1 Commissioning

The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act). An ICB is required to exercise its commissioning functions "to such extent as it considers necessary to meet the reasonable requirements of the people for whom it has responsibility".

This duty in itself could be said to impose a requirement to consider how services could be commissioned and functions exercised with a view to reducing inequalities in access to healthcare, as services must be commissioned to meet the reasonable requirements of the people ie. all people for whom the ICB is responsible.

### 3.2.2 General duty to have regard to the need to reduce inequalities

Section 14Z35 of the 2006 Act (as added by section 25(2) of the 2022 Act) imposes the general inequality duty on an ICB that it:

"must, in the exercise of its functions, have regard to the need to—

(a) reduce inequalities between persons with respect to their ability to access health services, and

(b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 14Z34(3)".

This general provision is broadly the same as that imposed upon CCGs by virtue of section 14T of the 2006 Act. The difference is that in (a) "patients" has been changed to "persons", possibly to reflect the more integrated nature and operation of an ICB within a system of various health and care commissioners and providers.

The reference to outcomes described in section 14Z34(3) is new and this refers to the relevant outcomes achieved including, in particular, outcomes which show: the effectiveness of the service; the safety of the service; and the quality of the experience undergone by patients. These are all now factors that need to be considered in any inequality assessment.

As in the case of the PSED, to 'have regard to' 'is broadly the same as to have 'due regard' to. It will involve being able to demonstrate how the adoption of a policy or strategy or the making of a decision has taken into account the need to reduce inequalities and how the policy, strategy or decision has furthered that objective or, if it hasn't, the reason for that. The duty does not oblige an ICB to evidence that it has in fact reduced inequalities – it simply obliges an ICB to have regard to the need to do so and to demonstrate how it is exercising its functions, adopting policies, implementing strategies and taking decisions to further a reduction in inequalities.

We refer above to social deprivation/conditions not being a protected characteristic for the purposes of complying with the PSED. This general duty on ICBs under section 14Z35 of the 2006 Act to have regard to the need to reduce inequalities is not based on inequalities due to protected characteristics – it is much wider than that, which is why we are of the view that in complying with this duty, ICBs could and should take into account socio-economic factors where necessary to do so to aim to reduce inequalities in access to health services and in the outcomes achieved for patients.

ICBs as entities are of course in their nascent stages. The statutory obligation on ICBs referenced above came into force only on 1 July 2022. However, the statutory obligation on ICBs and the equivalent obligation applicable to CCGs in the 2006 Act are largely the same. Therefore, previous legal cases will continue to provide some guidance on the discharge of the duty.

In *R (on the application of A and others) v South Kent Coastal CCG and others*, the court considered the duty on CCGs under section 14T of the 2006 Act to have regard, in the exercise of their functions, to the need to reduce inequalities between patients with respect to their ability to access health services. This was a judicial review of the decision to de-commission stroke services at one of the four local hospitals in favour of approving the establishment of hyper-acute stroke units (HASUs) at the three others. The claimants lived in an area recognised as socially deprived (Thanet) in the vicinity of the closed stroke unit.

The defendants in this case were the CCGs responsible for commissioning healthcare services in Kent. In 2017, they formed a joint committee to consider how best to commission stroke services in order to meet the needs of the people in their area. The defendants worked together to develop Integrated Impact Assessments, incorporating a health impact assessment, a travel and access impact assessment, and an equality impact assessment. The defendants were found to have acted appropriately and to have complied with their duty under section 14T.

Various considerations were taken into account in the judgement.

**Competing statutory duties** – it was noted that the 2006 Act imposed a number of different duties on CCGs relating to a wide range of factors, reflecting the complexity of decision-making in an advanced healthcare system such as the NHS. The duties engaged socio-economic interests, and in balancing the competing factors the 2006 Act involved the exercise of substantial discretion, judgment or assessment.

**Health inequality duty** – the duty under section 14T was considered – it was noted that Parliament intended CCGs to enjoy a broad discretion when making decisions and, in the absence of a public law error, there was no reason for the court to interfere. In the instant case, it was held that the defendants had considered the health inequalities arising from social deprivation but did not rate them as a key evaluative criterion in determining the location of HASUs. Furthermore, it was held reasonable for the defendants to take the view that improved stroke services would benefit those from deprived communities in Thanet and elsewhere in Kent to a greater degree than others and so would play a part in reducing health inequalities. Other groups would benefit too, such as older people and frail people who might suffer strokes but who might not suffer social deprivation. However, nothing about section 14T mandated the defendants to locate stroke services in areas of high deprivation; the terms of section 14T did not mandate a particular outcome.

**Public sector equality duty** - the defendants had carried out two full integrated impact assessments which dealt expressly with the impact of the recommended options upon those with protected characteristics. They addressed the key questions required by section 149 of the Equality Act 2010 and the public sector equality duty was not breached.

This case is an example of how general the duty actually is and how it might be applied in practice.

### 3.2.3 Duty to promote the NHS Constitution

Section 14Z32 requires that ICBs must, in the exercise of their functions, act with a view to securing that health services are provided in a way which promotes the NHS Constitution.

From an equality perspective, this includes the principles: that the NHS provides a comprehensive service, available to all; that access to services is based on clinical need, not an ability to pay; and that the NHS is committed to providing the most effective, fair and sustainable use of finite resources. NHS Values are also outlined including that the NHS "value every person… and seek to understand their priorities, needs, abilities, and limits". The NHS also looks to "maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind".

The duty to ensure the promotion of the NHS Constitution also encompasses, therefore, an obligation on ICBs to consider inequalities and arguably to reduce them.

### 3.2.4 Duty to promote involvement of each patient

Section 14Z36 requires ICBs to promote the involvement of patients, and their carers and representatives (if any), in any decision which relates to the prevention or diagnosis of illness in the patients, or their care or treatment.

This duty is not a duty aimed specifically at reducing inequalities, but it dovetails with the general duty set out in 3.2.2 above and in fact shared decision making in primary care is noted in the Report as a potential strategy to reduce inequalities. The way in which the involvement of patients in their care and treatment is promoted must take into account the duty to reduce inequalities in access to services and outcomes, as it is often the engagement with and involvement of patients which is a key challenge in seeking to reduce inequalities in access and outcomes.

### 3.2.5 Duty to obtain appropriate advice

Section 14Z38 of the 2006 Act requires ICBs to obtain appropriate advice for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in the prevention, diagnosis or treatment of illness and the protection or improvement of public health.

Individuals from different backgrounds face different challenges with their own health, whether that is for example susceptibility to catching an illness or ability to effectively fight an illness. As we have seen throughout the Covid-19 pandemic, the effect has been far greater on some demographics.

ICBs will have varying demographic ranges within their system, and it will be important for ICBs to comply with this duty and seek appropriate advice to ensure that all such demographics are taken into account in determining the extent of health inequalities in their area and in seeking to reduce those inequalities.

### 3.2.6 Duty to promote integration

Section 14Z42(1) of the 2006 Act places a duty on ICBs to secure that health services are provided in an integrated way where it considers that this would improve the quality of those services (including the outcomes achieved) and reduce inequalities between persons with respect to their ability to access those services and with respect to the outcomes achieved.

Section 14Z42(2) extends this duty on ICBs to secure that the provision of health services is integrated with the provision of health-related services or social care services where it is considered that this would improve the quality of those health services and/or reduce inequalities between persons with respect to their ability to access those services or with respect to the outcomes achieved.

"health-related services" means services that may have an effect on the health of individuals but are not health services or social care services. The provision of housing/ accommodation is a health-related service.

"social care services" means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970 or for the purposes of the Social Services and Well-being (Wales) Act 2014).

This is integral to the integrated care model ensuring that health services not only operate together with other health services but also in joined up models with providers across the health and care network where that would be likely to reduce inequalities.

### 3.2.7 The wider effect of decisions

The 2022 Act introduces a new duty requiring ICBs to have regard to the wider effect of their decisions about the exercise of their functions. Under Section 14Z43 ICBs must have regard to all likely effects of their decisions in relation to:

- the health and well-being of the people of England (including the effects in relation to inequalities between people with respect to their health and well-being);
- the quality of health services provided to individuals (including the effects in relation to inequalities between individuals with respect to the benefits they can obtain from those services); and
- efficiency and sustainability in relation to the use of resources,

– the so called "triple aim" duty.

This duty to have regard to the wider effects of decisions will require ICBs to consider how each decision they make will or may affect inequalities, essentially supplementing the general duty referred to in 3.2.2 above.

## 3.3 Public involvement and consultation by ICBs

Section 14Z45 of the 2006 Act states that the ICB must make arrangements to secure that individuals to whom services are being or may be provided, and their carers and representatives (if any), are involved (whether by being consulted or provided with information or in other ways) in the planning of the commissioning arrangements by the ICB, in the development and consideration of proposals by the ICB for changes in the commissioning arrangements, and in decisions of the ICB affecting the operation of the commissioning arrangements. This duty reflects the involvement and consultation duties currently on NHS commissioners and providers.

In order to comply with inequality duties, an ICB will need firstly to understand the inequalities that exist across its population and the reasons for those inequalities before action can be taken to address and reduce inequalities. It will of course be vital for an ICB to engage with and take into account the views of recipients or potential recipients of health services within its area in deciding upon and adopting strategies to discharge its inequality duties and reduce inequalities. ICBs must consider their public involvement duties in this context.

## 3.4 What is meant by "have regard to" in the duties?

This is also referenced in sections 3.1 and 3.2.2 above.

To "have regard to" means health inequalities must be properly and seriously considered and taken into account when making decisions or exercising functions, including balancing inequality factors against any other countervailing factors.

It will involve being able to demonstrate how the adoption of a policy or strategy or the making of a decision has taken into account the need to reduce inequalities and how the policy, strategy or decision has furthered that objective or, if it hasn't, the reason for that. The duty does not oblige an ICB to evidence that it has in fact reduced inequalities – it simply obliges an ICB to have regard to the need to do so and to demonstrate how it is exercising its functions, adopting policies, implementing strategies and taking decisions to further a reduction in inequalities.

The inequality duties must be exercised with an open mind on an objective basis and must be at the forefront of decision making. ICBs will need to be able to demonstrate a full awareness of the duties, and how they have been considered from the start and throughout any decision-making process.

## 3.5 Guidance for NHS commissioners on equality and health inequalities legal duties

Guidance for NHS commissioners on equality and health inequalities legal duties (**the Legal Duties Guidance**) was published in 2015 with CCGs, Commissioning Support Units and NHS England as the target audience. It is not known at the time of writing whether this guidance will be updated for the purposes of ICBs, but as the legal duties on ICBs with regards to inequalities broadly mirror those currently imposed on NHS England and CCGs, a lot of the guidance remains applicable in any event. This note captures salient points from this guidance with regards to the duties to reduce inequalities.

## 3.6 Equality related statutory obligations on NHS England under the NHS Act 2006 (as amended by the Health and Care Act 2022)

### 3.6.1 Statement on the powers available to relevant NHS bodies

A requirement arising from section 11 of the 2022 Act (introducing section 13SA into the NHS Act 2006) is that NHS England must publish a statement setting out a description of the powers available to *relevant NHS bodies* (including ICBs) to collect, analyse and publish information relating to inequalities between persons with respect to their ability to access health services and with respect to the outcomes achieved for them by the provision of health services. NHS England must also publish its views about how those powers should be exercised in connection with such information.

This guidance will presumably be useful to ICBs in formulating their strategies as to how they discharge their inequality duties.

### 3.6.2 Performance assessments

Section 14Z59 of the 2006 Act imposes a requirement on NHS England to conduct a performance assessment of each ICB in respect of each financial year. The assessment must review how well the ICB has discharged its duties in respect of (amongst other things) reducing inequalities.

ICBs will be accountable to NHS England for the discharge of their duties, including their duties to reduce inequalities.

It is not known how NHS England will seek to assess ICBs in accordance with this provision. Pending any confirmation of this from NHS England, ICBs should seek

to ensure that their policies, procedures and decision-making processes incorporate an element of giving due consideration to the inequality duties with evidence to demonstrate how those duties have been taken into account and discharged. It may be that one way this is done is by way of a completed equality impact assessment which considers not only inequalities on the basis of protected characteristics (which is what most equality impact assessments currently consider), but health inequalities generally. The impact assessment could describe the impact of the policy/strategy/decision on the need to reduce inequalities in access to healthcare and outcomes and thus demonstrate how the duties have been discharged.

## 4. Adopting the strategies set out in the Report against this legal context

### 4.1 General points

Having knowledge of the statutory duties imposed upon ICBs is one thing. It is another thing to apply the duties when exercising functions and commissioning planned hospital care. Whilst the duties themselves do not require an ICB to evidence a reduction in inequalities, merely to have regard to the need to reduce inequalities, ICBs will have to be able to evidence how a policy, strategy or decision either will, may or seeks to reduce inequalities, or be able to provide a clear rationale as to why a policy, strategy or decision may not have this effect, in order to be able to demonstrate that it is having due regard to the objective.

As noted above, to "have regard to" means health inequalities must be properly and seriously considered and taken into account when making decisions or exercising functions, including balancing inequality factors against any other countervailing factors. Sometimes, inequality factors may not tip the balance, meaning that a decision might be taken not to implement or continue a particular strategy. This does not mean that an ICB is not complying with its inequality duties – as long as it can demonstrate that it had regard to the need to reduce inequalities, and has a clear and reasonable rationale for taking its decision, it cannot be said that it is not complying with its duties.

The adoption of one or more of the strategies set out in the Report will assist an ICB to demonstrate that, in commissioning planned hospital care, it is discharging its duty to have regard to the need to reduce inequalities. Adoption of the strategies will also demonstrate that an ICB is having regard to the likely effects of its decisions in relation to inequalities.

However, it is important to note that implementing those strategies alone will not discharge the duties fully, as the duties are continuous throughout the exercise of the ICB's functions and apply to the exercise of all functions, not only the function of commissioning planned hospital care.

If an ICB does decide to implement one or more of the proposed strategies, to comply with the inequality duties, an ICB must continuously monitor the implementation of a strategy so as to assess the impact of that strategy on reducing inequalities, and must be prepared to change a strategy if it is not having the desired outcome. Such monitoring is necessary to ensure continuous compliance with the duty to have regard to the need to reduce inequalities regarding access to services but also with respect to the outcomes achieved. The monitoring of strategies is covered in Chapter 5 of the Report.

As ICBs are new statutory bodies, it is not yet known how each ICB will seek to discharge the duties imposed on them by the statutory provisions outlined above. It is also likely to be the case that each ICB will encounter different forms and a different scale of health inequalities within its area such that a number of different strategies may have to be adopted in an effort to seek to reduce those inequalities.

The duty to have regard to the wider effects of its decisions is a new and currently untested duty, although arguably it is no wider than the general duty in section 14Z35 of the 2006 Act to have regard to the need to reduce inequalities, as this duty is applicable in the ICB's exercise of its functions generally – when adopting policies, deciding on strategies, implementing strategies and making decisions. Section 14Z43(3) of the 2006 Act states that in discharging this duty, ICBs must have regard to guidance published by NHS England. No such guidance has been published at the time of writing.

### 4.2 Implementing the strategies

In developing its strategy, an ICB must give detailed consideration to the inequality duties referenced above and how the ICB can both adopt and implement strategies that aim to discharge those duties.

In order to comply with inequality duties, an ICB will need firstly to understand the inequalities that exist across its population and the reasons for those inequalities before it can properly have regard to the need to reduce those inequalities and before action can be taken to seek to reduce them. As referenced in the Report, assessing supply-to-need is not an easy task. An ICB will then need to adopt and implement strategies that seek to reduce inequalities in order to be able to demonstrate that in exercising its functions it is having regard to the need to reduce inequalities.

Public engagement and consultation is at the heart of effective decision-making around the adoption of strategies which serve to reduce inequalities in access to services and outcomes. Understanding the existence of inequalities in each area of a system and the factors that lead to these inequalities is crucial in seeking to address them.

Even where ICBs do not feel that the statutory duty to involve the public is engaged, public involvement and engagement may be one way in which an ICB is able to clearly demonstrate the discharge of its inequality duties by giving due consideration to people's circumstances and views regarding health services and how they may be commissioned to reduce inequality in access and outcomes.

The Report introduces a number of strategies that may serve to demonstrate discharge of the inequality duties and compliance with the principles and values enshrined within the NHS Constitution. The legal framework does not impede the adoption of any of the strategies described in the Report. In fact, the strategies serve to enable ICBs to demonstrate compliance with the inequality duties when it comes to the commissioning of planned hospital care.

The three routes to equity referenced in the Report – levelling-up, levelling-down and zero-sum redistribution – are all legally permissible routes to seeking to achieve equity. As referenced above, an ICB is required under statute to exercise its commissioning functions "to such extent as it considers necessary to meet the reasonable requirements of the people for whom it has responsibility". Therefore, the concept of supply-to-need, as explored in the Report, is underpinned by this general legal obligation. An ICB must act with a view to ensuring supply meets the "reasonable requirements" of its population. The legal framework does not dictate how that is done. It is a matter for an ICB to determine how it makes best use of the resources and capacity it has to meet the reasonable requirements of all.

The legal framework likewise does not dictate the strategies that an ICB must adopt or the decisions it must make to discharge its inequality duties – strategies will need to reflect and be tailored to the population health needs and inequalities that exist within any given system.

One "Place" within an ICB boundary may have very different expectations and needs from the next, and the commissioning of services by an ICB will need to take this into account and be tailored to address the inequalities that exist in any given "Place" or "Neighbourhood". The ICB will be expected to discharge its inequality duties across the system, but taking into account the differences in inequalities and strategies to tackle inequalities that may need to be adopted in each locality within the system. To this end, it is likely that different approaches/strategies may need to be adopted by an ICB across its footprint to effectively discharge its duty to have regard to the need to reduce inequalities. What this also means is that an ICB will undoubtedly be taking a different approach to seeking to reduce inequalities to a neighbouring ICB.

In adopting an approach/strategy, however, an ICB must of course be cognisant of its obligations with regards to non-discrimination based on protected characteristics, its obligation to involve patients and others when planning changes to commissioning arrangements and its obligations to abide by public law principles (see further on this below).

## 4.3 Public law principles

Any decisions taken by public bodies such as an ICB, such as decisions to implement certain strategies, need to be taken in accordance with public law principles if legal challenges are to be reduced or avoided.

### 4.3.1 Lawful

Decisions must be taken in accordance with relevant laws and in accordance with statutory duties and powers. ICBs must always act in accordance with their equality duties under the Equality Act 2010 and NHS Act 2006 (as amended by the Health and Care Act 2022).

### 4.3.2 Reasonable

Decisions taken must be reasonable ie. within the range of decisions that a reasonable ICB would/could take. They must not be irrational. ICBs can demonstrate reasonableness by always ensuring that there is a clear and documented rationale for decisions and that they are evidence based.

An irrational or unreasonable decision is one that was not reasonably open to the decision-making body. A determination of this sort is known as *Wednesbury unreasonable*.

Taking a decision to adopt one or more of the strategies set out in the Report, for example, could be regarded as a 'reasonable' step to take, as the Report and the strategies outlined within it are evidence-based and are underpinned by a clear rationale.

#### 4.3.3 Proportionate

Decision-making by ICBs needs to be proportionate, considering the entire population of the system and how commissioning functions are exercised to best meet the needs of the population, whilst also having regard to the need to reduce inequalities. Strategies adopted and decisions taken must be proportionate to the outcomes they are expected to achieve and must not have a disproportionate impact on certain parts of the population such as to increase inequalities.

In Chapter 4 of the Report, it explores how an ICB might develop its strategy for reducing inequalities in access to planned hospital procedures. As is set out in that chapter, the strategy must be developed taking into account the relevant investment required and available to the ICB and resultant potential savings/outcomes. The chapter also highlights the other considerations/factors that an ICB will need to consider. The Report proposes a structured and measured way of progressing the adoption and development of a strategy, and makes specific reference to multi-criteria decision analysis (MCDA) as being one process which may support decision-makers to demonstrate that a diligent and rational process has been followed. Progressing the development of a strategy in this way is therefore one way in which ICBs can demonstrate that a reasonable and proportionate process has been followed and that the end decision is in itself reasonable and proportionate.

#### 4.3.4 Fair

Decisions made by ICBs need to be in keeping with the public law duty of fairness.

Fairness dictates that the decision maker takes into account all relevant facts and evidence and, where relevant, the opinions of those who may be adversely affected by the decision. Ensuring that ICBs undertake appropriate assessments to understand the inequalities which exist in their area and the reasons for these inequalities is crucial in then determining which strategies it may be helpful to adopt to seek to reduce these inequalities and ensure fairness across the system. This therefore has important implications for how ICBs establish and operate their intelligence functions to enable both the qualitative and quantitative analysis of data to support these assessments.

### 4.4 Further considerations in adopting the strategies

Other issues that an ICB will need to consider in respect of adopting and implementing the strategies include:

- Being able to demonstrate the assessment of inequalities that has taken place at system, Place or Neighbourhood level (as referred to above) to guide discussions and decisions as to the strategies that might best reduce inequalities and help the ICB discharge its inequality duties.
- Taking action to ensure those taking decisions or involved in implementing the strategies are aware of the inequality duties and how the strategies being considered or adopted serve to ensure compliance with those duties.
- Ensuring there is clear accountability at a sufficiently senior level for the strategies adopted and the role they play in the ICB ensuring compliance with the duties.
- Ensuring all strategies and decisions aimed at reducing inequalities are evidence-based (insofar as evidence is available to underpin those strategies and decisions) or, where there is no such evidence base, that the strategies and decisions take into account and are based on whatever information there might be available to inform the adoption of the strategy/decision ie. that there is a clear and reasoned rationale for the adoption of the strategy/decision.
- Ensuring that the strategies adopted and decisions taken with a view to reducing inequalities in access and outcomes are routinely monitored to ensure that they continue to be the right strategies and decisions and are producing the desired outcomes. This is particularly important where the strategies adopted may be new and have no or little evidence base/previous evaluation. Analytical support (including expert review and evaluation as necessary) is crucial to enable the appropriate monitoring of those strategies adopted and to support any decision to change course where the adopted strategy is not working as hoped or intended.
- Ensuring records and evidence of all the above are securely retained.

### 4.5 Failure to meet the legal duties

In addition to ICBs being subject to performance assessments by NHS England with regards to their discharge of the inequality duties, ICBs could be challenged by individuals or patient groups on their compliance with the duties – the most obvious challenge being by way of judicial review, which explores the decision-making processes adopted by a public body and whether relevant statutory duties have been complied with, as well as whether the decision-making process in itself followed the general public law principles of fairness, reasonableness and proportionality described above.

A judicial review process will scrutinise whether a decision was lawful and give a judgement on whether relevant duties have been complied with. If not, public bodies can be ordered by the court to start afresh with their decision-making process, making sure that all relevant duties are taken into account and discharged.

ICBs can mitigate the risk of challenge by ensuring that they have given due regard to their health inequalities duties throughout all decision-making processes, that they have robust processes in place, and that they have comprehensive documentation in place to demonstrate compliance with the duties.

As referred to previously in this note, ICBs are not under a duty to demonstrate an actual reduction in inequalities – although evidence of a reduction may in itself demonstrate compliance with the inequality duties. ICBs must simply ensure that they have regard to the need to reduce inequalities in all that they do and can demonstrate that they have 'had regard', and that they take decisions which will, may or seek to lead to a reduction in inequalities where possible to do so. The adoption of one or more of the strategies outlined in the Report will therefore enable an ICB to demonstrate this. To emphasise the importance of such strategies, it is probably true to say that it would be difficult for an ICB to demonstrate its compliance with inequality duties if it has not adopted any strategies which would serve to reduce inequalities.

As referred to above, it is important to acknowledge that the duties impose an on-going duty on ICBs to have regard to inequalities and the need to reduce them – even after a decision has been made to adopt a particular strategy, ICBs must continue to monitor the implementation of that strategy and the outcomes achieved to ensure that they are continually complying with their duties. This would extend to taking the decision to change a strategy or stop a particular strategy if it was proving not to have the desired effect.

## 5. The strategies referred to in the Report – legal considerations

As referred to above, the legal framework does not impede the adoption of any of the strategies described in the Report. In fact, the strategies serve to enable ICBs to demonstrate compliance with the inequality duties when it comes to the commissioning of planned hospital care. However, we set out below a number of legal considerations in respect of each strategy. As the proposed strategies are generic in nature (a detailed review of how the strategies may be implemented in practice is beyond the scope of the Report), the below legal considerations are equally broad, and a detailed review of all the legal considerations that may need to be taken into account in developing a particular strategy are likewise beyond the scope of this note. Some of the strategies do not necessarily invoke any legal considerations, whereas others may. Legal advice should be sought where deemed necessary in relation to the proposed adoption of any particular strategies so as to ensure that the strategy adopted is supported by the legal framework and will not become subject to successful legal challenge.

### 5.1 Identification and referral to secondary care

#### 5.1.2 Targeted case-finding and screening strategies

Targeted case-finding places the responsibility for initiating the care pathway with the health service. It involves selectively inviting patients with specific characteristics to be seen by a health service professional for initial assessment. The term screening is used to describe case-finding when applied to asymptomatic patients.

The patient characteristics that determine invitation might include age, sex, ethnicity, family history, health conditions and prior health service use, where these are thought to be associated with an increased risk of a health condition or poor health outcome.

As the Report points out, targeted case-finding and screening strategies have been previously developed for many conditions including several forms of cancer, cardiovascular disease, diabetes, chronic obstructive pulmonary disease and dementia.

While targeted case-finding and screening on the basis of a protected characteristic (or other factor) may appear to place one group at an advantage over others, this form of "positive action" has a clear rationale and justification and can therefore legitimately be used as a tool to increase health equality, as long as the action is a proportionate means to achieve the aim. Such an approach aligns with the general duty on ICBs to have regard to the need to reduce inequalities.

#### 5.1.2 Public campaigns

The use of public campaigns to increase public awareness of health issues and encourage patients to visit their GP does not raise any issues from a legal perspective, other than the need to ensure that campaigns take into account their method and format of delivery so that they are accessible to all and that the information/advice contained within the campaign material is accurate and up to date.

#### 5.1.3 Shared decision making in primary care

The Report notes that evidence suggests that shared decision making leads to improved outcomes and that greater patient involvement in their care should reduce unwarranted variation in preference sensitive care choices.

As set out in 3.2.4 above, section 14Z36 of the 2006 Act requires ICBs to promote the involvement of patients, and their carers and representatives (if any), in any decision which relates to the prevention or diagnosis of illness in the patients, or their care or treatment. Therefore, adopting the strategy of promoting shared decision making enables ICBs to comply with this statutory duty.

#### 5.1.4 Decision aids and decision coaches

Both of these techniques aid a patient's understanding of their health and needs and thus encourage and promote a patient's involvement in their care.

Section 14Z37 of the 2006 Act states that ICBs must, in the exercise of their functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them.

Again, therefore, adopting this type of strategy will enable ICBs to comply with their statutory duty to promote the involvement of patients in their care and treatment and also comply with their duty to enable patients to make choices.

In addition, section 14Z39 of the 2006 Act states that each ICB must, in the exercise of its functions, promote innovation in the provision of health services (including innovation in the arrangements made for their provision). Innovation may be key in helping ICBs to address inequality through for example the adoption of various initiatives, policies, use of data or equipment. The use of decision aids and coaches could therefore be said to be an innovative way of providing services such that in adopting such techniques, ICBs are also complying with their duty to promote innovation.

There does however need to be consideration in respect of how user friendly any such strategies may be to ensure that they are accessible to all.

#### 5.1.5 Referral thresholds and eligibility criteria

Adjusting referral thresholds downwards or loosening eligibility criteria (only those criteria that are used to ration treatments rather than those relating to indications or risk) are more direct, short-term strategies noted in the Report.

As noted above, an ICB must act with a view to ensuring supply meets the "reasonable requirements" of its population and it is a matter for an ICB to determine how it makes best use of the resources and capacity it has to meet the reasonable requirements of all. Therefore, adjusting referral/eligibility criteria is a matter for an ICB, but in doing so it must be cognisant of its obligations with regards to non-discrimination based on protected characteristics, its obligation to involve patients and others when planning changes to commissioning arrangements and its obligations to abide by public law principles.

### 5.2 Pre-admission assessment and management

#### 5.2.1 Outpatient appointment reminder systems

The Report notes that studies have shown that reminder interventions reduce DNA rates. An approach that is suggested is potentially adopting more costly, personalised reminder systems for deprived populations. This could to some extent be regarded as akin to where reasonable adjustments are made for those with a disability. Essentially an ICB would be making an adjustment to favour those living in deprived areas. Assuming the ICB would not be discriminating against particular patient groups based on protected characteristics, there is nothing from a legal point of view to prevent an ICB from taking this approach if it is felt to seek to reduce inequalities in accessing care, and it could certainly be seen as one way in which an ICB is seeking to comply with its duty to have regard to the need to reduce inequalities in access.

#### 5.2.2 Telephone and video appointments

The legal framework does not impede the adoption of a strategy of offering telephone or video appointments to seek to reduce inequalities in access to care. However, face to face appointments must also be offered where possible if patients are unable to access telephone or video technology. As pointed out in the Report, the technological nature of the delivery mechanism may in fact increase inequalities meaning that the adoption of such techniques may in fact lead to a suggestion or challenge that an ICB is not complying with its inequality duties.

#### 5.2.3 Transport systems and costs

Adopting schemes to provide free transport or assist with transport/parking costs for those on low incomes (means tested) can be one way of seeking to reduce inequalities in access to planned care. As eligibility would be means tested, it would be based on objective criteria other than protected characteristics and such schemes are therefore legally permissible.

#### 5.2.4 Out of hours appointments

Offering out of hours appointments could be one method by which to seek to reduce inequalities and for an ICB to comply with its general duty to commission services to meet the reasonable requirements of the population for which it is responsible.

#### 5.2.5 Active waiting

Adopting this sort of strategy is similar to the adoption of decision aids and coaches in that it could serve to promote the involvement of patients in their care.

### 5.3 Decision to treat

#### 5.3.1 Shared decision making and decision aids in secondary care

The same issues apply here as set out in 5.1.3 and 5.1.4 with regards to primary care.

#### 5.3.2 Differential provider payments

Such payments have traditionally been hampered to some extent by the rigidity of the NHS Tariff, but following the introduction of the 2022 Act, there is expected to be more flexibility in how providers are commissioned and paid. Differential provider payments can be justified based on patient cohort and needs and the actual cost of providing the service ie. an objective and commercial justification.

#### 5.3.3 Carer support and patient payments

Such support and payments to cover out of pocket expenses associated with undergoing a hospital procedure may lawfully form part of a strategy to seek to reduce inequalities in accessing planned care – in the same way as the provision of transport costs. However, again such payments would have to be based on objective criteria (such as means tested) or available to all so as not to lead to an increase in inequalities and challenges based on discrimination.

### 5.4 Waiting list prioritisation

The Report explores the possibilities of prioritising based on clinical outcomes and also based on the likely impact of treatment on a patient's social, familial, educational and occupational context. Adopting strategies of prioritisation based on such factors will be challenging, particularly with regards to developing the criteria that are used to determine priority. ICBs must take into account their duties to avoid discrimination in doing so.

However, it must also be borne in mind that the general duty on ICBs to have regard to the need to reduce inequalities has as its second limb the duty to have regard to the need to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. Therefore, the outcomes likely to be achieved by the planned procedures (whether clinical or non-clinical) can arguably be taken into account at the waiting list stage as part of discharging this duty.

### 5.5 Treatment accessibility

#### 5.5.1 Treatment reminder systems and transport systems and support

The issues considered in 5.2.1 and 5.2.3 above apply equally in the context of accessibility at the point of accessing the treatment itself.

#### 5.5.2 Minor surgery in primary care

The legal framework already enables minor surgery services to be commissioned from primary care providers. Increasing the availability of minor surgery in primary care as a strategy to seek to reduce inequalities in access and outcomes is a viable and permissive approach, although consideration would need to be given to the type of surgery to be commissioned, and the criteria that would apply to enable patients to access services in this way.

#### 5.5.3 Out of hours treatments

See 5.2.4 above.

## Conclusion

There are various statutory duties on ICBs under the NHS Act 2006 (as amended by the Health and Care Act 2022) that relate to health inequalities. The main and general duty with regards to reducing inequalities is set out at section 14Z35 of the 2006 Act, which requires an ICB, in the exercise of its functions generally, to have regard to the need to reduce inequalities with respect to peoples' ability to access health services and reduce inequalities with respect to the outcomes achieved for those individuals by the provision of health services.

The PSED under section 149 of the Equality Act 2010 obliges an ICB to have due regard to the need to *advance equality of opportunity between people who share a protected characteristic and those who do not*. This duty is based on protected characteristics, as listed in the Equality Act, but we state in this note that the general duty on ICBs to have regard to the need to reduce inequalities, and the duties we refer to in this note which sit alongside or supplement the general duty, will both allow and arguably require ICBs to consider socio-economic factors when determining the health inequalities that exist in any given area and in adopting strategies to try and tackle/reduce those inequalities.

The main and general duty is to 'have regard to' the need to reduce inequalities, which will involve being able to demonstrate how the adoption of a policy or strategy or the making of a decision has taken into account the need to reduce inequalities and how the policy, strategy or decision has furthered that objective, or it if hasn't, the reason for that. The duty does not oblige an ICB to evidence that it has in fact reduced inequalities.

The Report introduces a number of strategies that may serve to demonstrate discharge of the inequality duties and compliance with the principles and values enshrined within the NHS Constitution in the commissioning of planned hospital care. The legal framework does not impede the adoption of any of the strategies described in the Report. Adopting such strategies may mean that ICBs avoid any allegations or challenges that they are not complying with their statutory duties with regards to inequalities.

However, it is important to note that implementing those strategies alone will not discharge the duties fully, as the duties are continuous in the exercise of the ICB's functions and apply to the exercise of all functions, not only the function of commissioning planned hospital care.

The legal framework does not dictate how an ICB must exercise its commissioning functions to 'meet the reasonable requirements of the people for whom it has responsibility'. The legal framework likewise does not dictate the strategies that an ICB must adopt or the decisions it must make to discharge its inequality duties – strategies will need to reflect and be tailored to the population health needs and inequalities that exist within any given system. In adopting an approach/strategy, however, an ICB must of course be cognisant of its obligations with regards to non-discrimination based on protected characteristics, its obligation to involve patients and others when planning changes to commissioning arrangements and its obligations to abide by public law principles.

It is hoped that, by setting out the legal framework and duties on ICBs to have regard to the need to reduce inequalities and the legal considerations associated with the proposed strategies in the Report, this note will encourage ICBs to give careful consideration to those strategies so as to take action to seek to reduce inequalities in access to planned hospital care.

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