HOUSE OF LORDS

Revised transcript of evidence taken before

The Select Committee on the Equality Act 2010 and Disability

Inquiry on

EQUALITY ACT 2010 AND DISABILITY

Evidence Session No. 14 *Heard in Public* *Questions 123 - 130*

TUESDAY 17 NOVEMBER 2015

4.35 pm

Witnesses: Flora Goldhill, John Holden and Sally Warren

Members present

Baroness Deech (Chairman)
Baroness Brinton
Baroness Campbell of Surbiton
Lord Faulkner of Worcester
Lord Harrison
Baroness Jenkin of Kennington
Lord Northbrook
Baroness Pitkeathley

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Examination of Witnesses

Flora Goldhill, Director for Children, Families and Communities, Department of Health, **John Holden**, Director of Policy, Partnerships and Innovation, NHS England, and **Sally Warren**, Deputy Chief Inspector of Adult Social Care, Care Quality Commission

Q123 The Chairman: Good afternoon, everybody. Thank you very much for coming. We welcome this afternoon Flora Goldhill, Director for Children, Families and Maternity and Health Inequalities at the Department of Health. I should say right away that Flora and I worked together very closely for a number of years when we were both at the Human Fertilisation and Embryology Authority. We welcome John Holden, who is Director of Policy, Partnerships and Innovation at NHS England, and we welcome Sally Warren, Deputy Chief Inspector of Adult Social Care at the CQC. Thank you all very much for coming.

The session is open to the public and a webcast of the session goes out live and is subsequently accessible via the parliamentary website. One of our members is in hospital now and is able to watch on the website as we work. A verbatim transcript of the evidence will be taken and will be put on the parliamentary website. A few days after this session, you will be sent a copy of the transcript to check for accuracy. It would be helpful if you could advise us of any corrections as soon as possible. If, after this evidence session, you wish to clarify or amplify any points made during your evidence or you have any additional points to make, you are welcome to submit supplementary evidence to us. I say that because, as you know, we are rather pressed for time and you have to be rather concise. When you leave, I am sure you will think, "I wish I had submitted this or that other piece of evidence", in which case, please do write in and send it to us and we will read it and take it on board.

Each of the questioners here will, before they question you, declare any interests they have that are relevant to this inquiry. To save time, I shall list the many interests of Baroness Campbell. She is a patron of Just Fair, a patron of the National Disability Arts Collection and Archive, founder and member of Not Dead Yet UK, and recipient of a social care personal budget, disability living allowance and access to work. She was a disability rights commissioner throughout the life of the Disability Rights Commission and was a commissioner at the Equality and Human Rights Commission for three years. The first question comes from Lord Harrison.

Q124 Lord Harrison: The draft EHRC strategic plan cites evidence that disabled people, particularly those with a learning disability or mental health condition, are more likely to have significant health risks, major health problems and shortened life expectancy. They are also less likely to receive health checks, screening tests and treatment, and services can fail to investigate or treat physical ill health because it is viewed as part of a mental health

condition or learning disability. How are government policy and the health and social care systems responding to such evidence of inequality?

John Holden: I do not think there is one magic bullet or one easy solution to the problem you describe. We accept that it is a recognised problem. There is good evidence, not just from the EHRC report but more generally, that patients presenting with a learning disability can be disadvantaged.

The way the health system works at the moment is that we rely on clinical commissioning groups, local doctors and clinicians working with partners locally to commission care on behalf of the populations they serve. One of the important aspects of this is an increased amount of personalisation of care. Working with partners in local government and elsewhere, they try to focus on the individual patient, which is difficult at a population level but not impossible. You can start to look at the different characteristics of different parts of the population. There are some very good examples where local clinical commissioning groups have identified precisely the problem you allude to: that patients with learning disabilities are not able to take advantage of the services on offer and that have been paid for by the taxpayer.

Screening is a very good example. One situation I am aware of is the Hardwick Clinical Commissioning Group in Derbyshire, which looked at the evidence and realised that patients with learning disabilities were probably about a third less likely to get the cancer screening they needed for bowel or cervical cancers and about a quarter less likely to get the screening they needed for breast cancers. It did this by examining the evidence and interpreting it. It then came in with a set of propositions for what to do about that and, to be honest with you, it sounds like common sense written down. It is taking some very practical steps to address the problem: making sure that communications are straightforward and intelligible, making appointments last a little longer to give more time for a reasoned discussion, and so on. It has implemented that, and that is one of the instances where lessons learnt from this can be replicated elsewhere. We know that screening levels across the country are not good enough. There is a practical example of one clinical commissioning group doing something about it.

Lord Harrison: Flora Goldhill, can you offer a similar practical example of a response to a problem identified? Sally Warren, I would be grateful if you could reflect on that, too.

Flora Goldhill: The example I would like to give to you is the establishment of the National Learning Disability Board, which is chaired by Jon Rouse, who is our director-general responsible for this area in the Department of Health, and Karen Flood, who is a person with learning disabilities. This is a cross-cutting group whose ambition is to create a plan that deals with the response to the issues of greatest concern to people with learning disabilities and their families. The aim is to identify the actions and the metrics that will show progress. It is a high-level group, with access to Ministers, feeding back information about the issues that really matter.

Lord Harrison: It came into creation. Give us a practical example of where it has then operated successfully.

Flora Goldhill: One of the areas it will look at is the annual checks. John has described one example. What the National Learning Disabilities Board would want to see is how that kind of good practice is being promulgated across the whole country: what steps are being taken, how we know it is happening, how quickly we can support it in happening, and so on. There will be challenge about the pace at which progress is made in order to make it go as fast as possible. That would be one example. Flu vaccines would be another example.

Lord Harrison: Very good. Sally Warren, could you give me a similar example to John and Flora?

Sally Warren: Yes. Before I go into the specific example, I will just give a little context about how we address these issues in our inspections so you understand how we go about finding this evidence. In our inspections of GP practices, we look at different population groups. "Mental health" is a population group we look at specifically and rate separately. "People in vulnerable circumstances" includes people with learning disabilities. There are separate ratings for those population groups so that we can see how well GPs support them. In hospitals, we already include specific key lines of inquiry and questions around how well hospitals can identify patients with learning disabilities and how they are making reasonable adjustments for those patients. From next year, we will start to include commentary in all our acute hospital reports on learning disabilities. We are looking at these population groups and recognising the challenges you set out.

In terms of a specific example, this is an example of an outstanding GP practice that has really gone above and beyond to try to meet the needs of its population. This is a practice in the north-east, in a deprived area with over 7,000 registered patients. It had twice as many patients with learning disabilities as its neighbouring practices, and it recognised this. To address the needs of those patients, it undertook staff training for all of their staff and invited in a local voluntary group that uses experts by experience to audit the practice for how well it was meeting the needs of people with learning disabilities. The audit was very positive and it identified further areas for improvement. The practice is implementing those areas. It did a very practical thing with health checks for this population group. It not only sent letters to patients to remind them of being invited but followed those up with a phone call to make sure the person with learning disabilities understood what they were being invited to and could try to facilitate that take-up. From my point of view, that really reflects a GP practice thinking very hard about the different needs of the population it is serving and how it can make very small changes, such as adding a phone call into the process, that mean it is more likely to get better take-up from people with learning disabilities and is then able to support them to manage their health better.

Lord Harrison: I have one last question, if I may: how do you replicate that shining example?

Sally Warren: From the Care Quality Commission's point of view, we are really keen that to support improvement we need to share best practice. In primary medical services, earlier this year we published an "outstanding" toolkit. For all our five key questions and our key lines of inquiry, it uses real examples of practices we have inspected and rated "outstanding" to demonstrate really good and practical examples of what real GP practices are doing to improve outcomes and experience and to demonstrate outstanding practice to the CQC. That has been available and it is one of the most popular web pages on the CQC website, I believe. I do not have the exact figures of how often it is used, but it is used a lot. We are looking to replicate that in adult social care early next year as well so that we can do much more in terms of sharing practice. Earlier this year, we published a document highlighting some of the outstanding practice we were seeing across all of our sectors in order to start to be able to show other services how they can make that improvement journey from "inadequate" to "requires improvement" and from "good" to "outstanding".

Q125 Baroness Brinton: This question is for Flora Goldhill and John Holden, for reasons that will become obvious. How is the Equality Act applied to the commissioning of NHS and social care services? How is compliance by clinical commissioning groups and local authority social care commissioners with their obligations under the Equality Act monitored?

John Holden: NHS England is responsible for the support and assurance of clinical commissioning groups. The way that works in practice is that we have—forgive the jargon—an assurance framework with five different components. I probably will not remember all five now, but they include, "Is the organisation well led?", "How is it doing on its finances?", "Does it have a plan for a sustainable future?", and, "How does it deal with its delegated responsibilities?".

Under the "well led" domain, there are specific questions, one of which reminds clinical commissioning groups about their responsibility to fulfil their legal duties in respect of the Equality Act, but also the Health and Social Care Act, which makes specific reference to health inequalities. Over and above that, there is specific reference to the need to have regard to equality and health inequalities and, indeed, to other particular focus areas such as learning disability. In the assurance framework, which clinical commissioning groups know is the conversation that NHS England will be having with them, it is very explicit that there are these legal duties and areas of particular focus.

I do not want to give the impression to the Committee that this is all about some kind of top-down, very heavy-handed performance management. As I am sure your Lordships are aware, NHS England has a statutory duty of autonomy with respect to the clinical commissioning groups. We cannot direct them to do all sorts of things we just think would be a good idea. The whole object of the 2012 Act was to take that kind of micromanagement out of the day-to-day operation of the NHS. Clinical commissioning groups are clinically led and operationally independent. That was seen by Parliament, in enacting the Health and Social Care Act, as an important thing.

We have to strike a balance. That is the important point I want to make. We have to assure ourselves that the clinical commissioning groups are fulfilling those legal responsibilities, are providing continuing improvement and are seeking quality in the care of patients in the services they commission. At the same time, we have to recognise that they need the headroom to do that. If we try to micromanage them, it is self-fulfilling: it will never happen.

Typically, what will happen is that through the course of the year there is a continual assessment conversation. To some extent, it is risk-adjusted. Those CCGs who have shown—perhaps as a legacy of the situation they inherited or perhaps because of their own situation—they are doing very well will have a more light-touch regime. Those CCGs who are struggling are more likely to have greater attention from NHS England. The regional teams of NHS England will have a dialogue with the clinical commissioning group about some of those individual areas, which, in the "well led" domain, include, "How are you doing on equalities and your health inequalities? What is the evidence to show that you are taking account of diversity? What is the evidence to show that you are assuring yourself that the services you commission from hospitals are meeting the requirement of the public sector equality duty and they are making reasonable adjustments?". I can say more, but I am conscious of time. That is the kind of approach we take.

The Chairman: I am just a bit worried about the term "micromanagement".

Baroness Brinton: I was going to come back on that, but I want to hear from Flora first. I have a specific example I want to use to draw that out.

Flora Goldhill: There are similarities between local authorities, but the relationship between DH and local authorities is an even further step back. We work through partnerships and relationships with the Local Government Association, which has created tools for local authorities to self-assess their performance. This recognises that local authorities are democratically elected bodies that make decisions for local areas. We work with local

government, the Local Government Association and DCLG, in the same way as John has described, to get information that is as transparent, open and accessible as possible, to offer opportunities for benchmarking, to identify where things are happening well and to help local authorities that are doing less well with where they can get support to raise quality.

We also have outcomes frameworks, particularly the adult social care outcomes framework, but these are quite slow-moving things. They are about delivering outcomes to populations. The steps that you need to take to deliver change deliver that change over such a long timescale that the changes are hard to see year on year, but, over time, we will have a very good set of outcome frameworks that show local population measures in terms of achieving for people with protected characteristics. We also work through Public Health England, which helps local authorities with good evidence on what works and provides data about how different areas are performing to enable benchmarking.

Baroness Brinton: That is very helpful. If I could go back to John Holden's comment about not micromanaging, I think most people recognise that services for transition from young people to adult services, whether it is mental health or learning disabilities, can be very patchy. What would you do to ensure that there is a consistent service while not micromanaging? How far do you go in to a CCG to say, "Your figures show that most of the families are very unhappy with the service here" and what would you then do about it?

John Holden: It is interesting. I am not sure, with respect, if you were leading me there, but you said "most of the families". That is precisely the kind of approach we would take. We do not just take one point of evidence or one data point. As far as possible, we try to get lots of different data sources and lots of different evidence. Some of that will be through a friends-and-family test or perhaps a focus group. NHS England would use its local offices to bring together local service users and ask them precisely that sort of question.

Baroness Brinton: How do you then use that to make the relevant CCG change what it is doing?

John Holden: I use the words "dialogue" and "conversation". I am trying not to be mealy-mouthed, but this is very much about the way NHS England seeks assurance and says to the CCG, "It looks like there is a bit of an issue here. What is your plan for resolving it?". It may be that the clinical commissioning group has inherited a long-standing problem and is some way along the trajectory to trying to solve it. It could be—this is hypothetical; I do not know—it is oblivious to the problem, in which case NHS England's response would be, "That is not good enough". In our assurance, we have a range of judgments that broadly mirror the CQC assessment of providers, and we would be very concerned that you are failing in one of the areas and we would not be able to say we were assured about you being well led if you did not have a grip on the problem.

In the case of transition, frankly, it is not just about mental health and learning disability, is it? This is right across the health service. Transition is a cliff edge. A lot of children are terrified of it. What do we do about it? This is precisely the kind of conversation my colleagues who are responsible for this work in local teams are having with clinical commissioning groups, who are themselves, on the whole, not unaware. Many of them are practising clinicians and get patients and their families in the GP surgery every single day.

The sort of conversation NHS England would have is, "What is your plan for improvement? What is the timescale? What is the evidence you are using? Does that accord with what we are hearing from service users? Does it accord with the evidence we see objectively and the numbers? If it is about providers, what does the CQC scrutiny show?". We would triangulate the evidence. We would have the conversation. If necessary, we would ratchet it up. As you

would expect, there are degrees of escalation. There is a nuclear option for an organisation that is manifestly failing in its legal responsibilities. We can go there; we have not gone there yet. Then there are stages along the way. There are powers of direction for a CCG that is failing. There are special measures we can take, and so on. In practice, if we are doing our job right, we should not be getting there very often, because this is not a once-a-year pass-or-fail test; this is a continual dialogue about constant improvement. That is how it works.

Q126 Baroness Pitkeathley: I have one interest to declare, which is that I am a vice-president of Carers UK. This is a question for you, Sally, at the CQC. How is the Equality Act applied to your regulation and inspection function? What sanctions are available for failure to meet the requirements of the Equality Act? What is the appropriate role of the CQC with regard to individual complainants?

Sally Warren: In the CQC, we were quite fortunate with the new regulations that were brought in this April, which gave us an opportunity to embed Equality Act considerations in our regulations. We have been able to reflect those requirements in our regulations. I will not read them out word for word, but the main ones were that we have applied Equality Act considerations are regulation 13(4)(b) around safeguarding, regulation 9(3)(h) on person-centred care, and regulation 10(2)(c), which is around dignity and respect. I can send these to the Committee afterwards if you would prefer. That allows us to be sure that, in our regulations, we are properly considering the Equality Act. It is really important that the Equality Act is embedded in our regulations, because we cannot take action under the Equality Act; we can take action only under the Health and Social Care Act 2008. The regulations are the basis on which we can do that.

For the most part, the sanctions available are civil sanctions, examples of which include being able to suspend or cancel somebody's registration. For the regulation relating to safeguarding, in some very specific, defined circumstances we can take criminal proceedings as well. Those are the sanctions available and how we have embedded the Equality Act in our regulations.

It is also worth saying that, as we have implemented our new approach to inspection across all three sectors, we have done an impact assessment on the new methodology so we can be confident that we are applying the regulations and applying our approach in a way that best supports CQC and the organisations we inspect to be able to meet the Equality Act. We have also been working on a programme to support the knowledge of our inspectors and our workforce as well, which we might come back to on one of the later questions.

As for the appropriate role for the CQC in regard to individual complainants under the Equality Act, we do not act on behalf of individual complainants. We are very keen to have information about people's individual experiences. That allows us to assess whether there has been a breach of regulations, which allows us then to take action. Our memorandum of understanding with the EHRC allows us to share information, where the EHRC may have information that we should consider as part of our regulatory function. We also encourage the public and people who work in the services to contact us directly with any concerns they may have. That allows us to build up a picture about a particular service and decide the right regulatory response.

I should also just add that, in terms of evaluating our approach, we are in the middle of procuring an evaluation of how our regulatory approach is supporting the equality and human rights of people who use services. That can help inform the future direction of our regulatory model.

Baroness Pitkeathley: When individuals contact you and you refer them on, do you find they are disappointed that you are unable to take up an individual complaint? How do you deal with that?

Sally Warren: Over the last few months, we have been doing quite a lot of work in CQC on this issue. It would be perfectly fair to say that the expectations of the CQC are not quite understood. People expect us to take on individual cases and resolve those for people. There is a key challenge in how we communicate more clearly what information we want from the public and why, and how we are going to use that information. It is extraordinarily valuable information for us to understand people's experiences and it makes us a much more effective regulator, but we need to be much clearer upfront about why we want that information, how we are going to use it and what feedback individuals can expect. That is not just about Equality Act complaints; that is about complaints about providers generally. What you should see starting early in the new year is much clearer communication from the CQC about the "why" and "what" of sharing information with us.

Q127 Baroness Campbell of Surbiton: My question is mostly for Flora Goldhill. What is your relationship with the Government Equalities Office and the Office for Disability Issues? Do you feel that you receive sufficient support from them in identifying and acting on the issues faced by disabled people? Historically, we all know that between the two departments there has been a little bit of standoff at times, shall we say. How is it going? What is it like now?

Flora Goldhill: I would say that relationships are positive. We have good links with the Government Equalities Office. It helps us to understand the nuances of the Equality Act. It has a much broader range of input and evidence than we do and it can often help us solve some difficult and particularly novel issues that come up. We know it is there to support us and advise us with that breadth. The most recent thing it helped us with was a Westminster Hall debate and the transgender equality inquiry, which is being conducted by the Women and Equalities Committee. Transgender issues are quite new for us and it has been very helpful to us in working our way through that. It has also helped us with gay-conversion therapy, which has been an issue recently; there has been debate about whether gay-conversion therapy ought to be legally banned. These are the sorts of questions. It has a very helpful perspective for us on that. It has also talked to us because they want to know how our arm's-length bodies do. It keeps close to us on that as well. Generally, we have a strong relationship through the Equality and Diversity Council, which is led by NHS England. We have a good understanding of where our arm's-length bodies are. We have less contact with the Office for Disability Issues, but it keeps tabs on what progress we are making.

Baroness Campbell of Surbiton: How does it do that?

Flora Goldhill: It invites us to contribute to their updates and progress reports. It has been interested to know exactly where we are going, for example, on the information standard we are introducing. It also likes to know how we are reporting on the Health and Social Care Act 2012 health inequalities duty in respect of people with disabilities. It asks us for reports so that it knows what progress we are making.

Baroness Campbell of Surbiton: I am thinking more in terms of collaboration, not just you chucking all the reports at them, them reading the reports and then putting them on the shelf. Let us talk about collaboration. Are you working together? Let us take the transfer of the Independent Living Fund from the DWP to the DoH. Some would say that was not a very good collaboration, and a lot more could have been done to ensure that disabled people

were not failed during that process in terms of their equality and their human rights. Let us talk about collaboration and not reports.

Flora Goldhill: I mentioned the National Learning Disability Board. The Office for Disability Issues is represented on that board. That board will identify the issues that are most important to people with learning disabilities. That is a starting point for us to collaborate on the issues that matter most to people with learning disabilities. I am sorry to hear about the transfer of the Independent Living Fund. I am not aware of the history on that, and I apologise for that. I am very sure we have learned lessons from that.

Baroness Campbell of Surbiton: It would be really nice to hear more about that, if you would not mind writing to us. That has become one of the most significant issues for disabled people. It is strange that you have not heard about it, given that it has been going on for two years and the relationship issue was brought up on countless occasions. More could have been done to have a smooth transition.

Flora Goldhill: I will undertake to write to you and give you more information about the lessons that we have learnt from that.

Baroness Campbell of Surbiton: You sit on a board together. What else do you do? What projects are you embarking on together?

Flora Goldhill: At the moment, we are not embarking on any, but I imagine that the starting point for new collaboration will come from the National Learning Disability Board. That would be a starting point.

Baroness Campbell of Surbiton: And on other equality and human rights issues?

Flora Goldhill: At the moment, there is no direct collaboration. I would be very happy if you were able to suggest areas where you think we ought to be collaborating and I will certainly make sure that is taken back to the department now.

The Chairman: In this age of austerity, when your department, the Department for Education and the DWP are all supposed to be cutting, how can you all reconcile that with your different responsibilities to the welfare of disabled people?

Flora Goldhill: I apologise for not being well briefed in this area. There are colleagues in the department who I am sure would be able to explain this to you very well if they were sitting here. The whole focus at the moment, certainly about how, in a time of austerity, we are looking at services, is very much based on outcomes rather than inputs. What are the outcomes that people are looking for from services? What are their needs? What are their aspirations? Rather than simply describing inputs—"We will give you this and we will give you that"—it is thinking about, "How do we shape the market differently so that we create new models that provide the kinds of services that people actually want?". That is the methodology that permeates the thinking. There are challenges when benefits are involved, but that is at the heart of how we are trying to reconcile some of these challenges, so that we bring together the thinking in terms of working around the needs and aspirations of people with disabilities.

Q128 Lord Faulkner of Worcester: Mine is quite a simple question and it is also about relationships—with the Equality and Human Rights Commission. How does each of you view that relationship? May I particularly ask Sally whether you are members of the Regulators, Inspectorates and Ombudsmen Forum?

Sally Warren: We think we have a very good relationship with the EHRC. We have a memorandum of understanding with it that sets out the key areas of joint working. On the back of that MOU, we have been able to secure funding for our programme of learning on equality and human rights. That is the biggest programme of learning we are doing for all

staff in CQC this year. It has been fantastic to roll that out to make sure all of our staff are aware of these issues.

We are indeed a member of the Regulators, Inspectorates and Ombudsmen Forum. We find it a very useful forum for discussing issues with other regulators and keeping up to date. Our human rights approach to regulation was cited as an example of good practice by that forum in terms of how far we have embedded that approach, which is really helpful. To give you some examples of how the MOU works in practice, where we have needed to get a particular opinion on particular equalities issues in our regulatory activity, EHRC have provided that to support our work in taking forward action with providers.

Lord Faulkner of Worcester: Would you say the balance is right between enforcement and collaboration?

Sally Warren: Like all regulators, the EHRC needs to think about what the balance is between the soft and the hard in terms of trying to achieve its objectives. They have a very significant objective in a big societal shift and a big shift in public services. They do need to make sure they have that balance right between where they collaborate, encourage and cajole and where, as regulators, they hit people over the head. It is a difficult balance.

Flora Goldhill: The Department of Health has a long relationship with the EHRC. Our most recent engagement with it was when it came to address our senior leadership group, which is led by the Permanent Secretary, the CMO and the most senior leaders in the department, to talk us through *Is Britain Fairer?*, the report it was working on and just about to publish at that time. It clearly engaged with colleagues in the department in thinking through the issues that ought to be reflected in that report. In my team, we have quarterly meetings with the EHRC when we each have the opportunity to keep each other informed and raise issues, and then we have a day-to-day relationship on issues that are topical and where we would welcome its advice.

Baroness Campbell of Surbiton: Have you met with the EHRC Disability Committee and the Disability Commissioner on issues they see as a priority to address within the next few years within the Department of Health?

Flora Goldhill: Certainly, that is something we should put on our agenda. Thank you.

John Holden: NHS England has a set of formal arrangements for managing its relationships with external partners. As you can imagine, they are legion; there are lots of them. In respect of EHRC, I am the nominated account director. I have regular appointed meetings with the EHRC. The person I usually meet is Tim Gunning, who is the policy director who looks after health. So much for the committees and the process—we do that. That is to make sure we understand not only the content but also the health of the relationship: "Is this working? Do we have this right? Is there something missing in this?".

On a more practical level, we have worked with the EHRC. For example, in 2014 and 2015, we co-designed and co-delivered a series of workshops for NHS England and CCGs around the country—about eight of them—talking about the public sector equality duty and the EHRC's expectations. We were very practically asking them, "What does 'good' look like? What can we do? How do we measure up?". We are having a discussion with them now about, potentially, how we continue that process and run some more workshops, with a possible change of emphasis, but that is to play for.

My final observation is that, as Flora has already alluded to, NHS England and my boss, Simon Stevens, chairs the Equality and Diversity Council. That is a body made up of a number of national partners, including the department and the CQC. We have arranged for EHRC to attend the next meeting, which is in January, to talk to all the national leaders around the

table about *Is Britain Fairer?* and the implications of that report for our collective and separate endeavours. We have a pretty good relationship, collectively and individually.

Q129 The Chairman: Are there any last questions from around the table? I still have something of a worry that there is no championing of the disabled across the departments, as is required by the Equality Act. It is not micromanagement; it should be filtering through everything that one does. I fear that the interests of disabled persons are being lost in the cracks somehow.

Flora Goldhill: We had an internal audit of our approach to these issues and a complete overhaul of how we responded. What we now have in the department is an assurance system that is led by the director-general, Jon Rouse. Each Directorate is represented at my level, with another senior civil servant as a back-up. They have quarterly meetings to give assurance that equality issues across the piece are being addressed in policy. We have taken the EHRC's guidance and tried to embed it in the department so that senior leaders across the department are taking responsibility and are fully accountable for the equality issues in their areas. I happen to have oversight of the Equality Act. It is not down to my team to make sure it happens; it is down to all the senior leaders in the department to make sure it is happening. We also have a division that deals specifically with disability. The reason the person who leads that is not here today is that, when we saw the title of the Committee, we thought it was about the Equality Act specifically. You have gone much wider, and it would have been helpful to have had my colleague here today to answer some of the questions that the noble Baroness has raised. I will get her to respond, too. I am sure she is on top of them in a way that I am not, but that is because she is the accountable person for those issues. Then we publish our report on how the Department has complied with the public sector equality duty. Clearly, we need to raise the profile of that with the Committee.

Q130 Baroness Brinton: We have heard a lot about the various groups that are talking to each other. It is great that there are disability champions, certainly in both your organisations. Is there a golden thread? If I asked my local CCG, "Is one of the directors on the CCG also a disability champion who will be looking at everything in that CCG?", what response would I get? It is great that it happens at a strategic level, but it is no use if it is not happening on the front line.

Flora Goldhill: The point you are making is a good one. How do we have that golden thread? It is something that, with the help of the Equality and Diversity Council, we ought to be looking at. It is not just a matter for the Department of Health or NHS England or one CCG; it is a matter for the whole system to be thinking about how we are doing that across the system.

John Holden: If I may, having champions is necessary but it is not sufficient. Just as important, if not more important, is changing the way that people are able to take responsibility for their own care. A lot of the work we are doing at the moment, collectively across all of our organisation and described in the five-year forward view, is about more self-care, more personal health budgets, allowing people more directly to control the care they receive and empowering them. We have not talked today—there probably is not time—about the accessible information standard we have introduced, which allows people to play a greater part in understanding their care, controlling the care they receive, taking part in screenings and assessments and so on, and staying well. It is all of these things.

I am slightly nervous about the language of "champions". I understood the point, and it is good and important, but it is not a panacea. We also need to work from the bottom up and make sure that individual patients feel sufficiently confident and informed to take

responsibility, with their carers and the local professionals, for their care as well. It is "both/and", rather than just having a champion who oversees.

Baroness Brinton: It is not just about care; it is about the entire structure. Forgive a personal anecdote, but, turning up at out-patients the other day, I discovered that the maintenance department had allowed asbestos-removal people to block the only dropped kerb that a wheelchair could use to access that particular road into out-patients. I could not have done anything about that with my care providers. It is about making sure that everybody in the organisation thinks through those issues. Quite often, you need somebody in the organisation who has the responsibility—somebody I could complain to. It is no good saying, "Write to PALS". That is no good—I could not get into flipping out-patients. It is a very practical example. I am sure Lady Campbell would have many other ones about care and things like that. I am concerned, because I am hearing a lot of talking going on at the top level but my experience on the ground level is different.

Baroness Campbell of Surbiton: Actually, you do need champions when you are empowering people to take care of their own services. Having been a champion of direct payments, you needed the champion to get the people to do the strategic work, for that to feed down to a local level, and then to empower the people at the bottom to take that up. They feel so much more positive about taking care of their own circumstances when they know they have a champion on their side. I disagree that champions are not that necessary; they are vital to the empowerment process.

John Holden: I agree: it is "both/and", not "either/or".

The Chairman: We understand what a difficult job the Department of Health and the CQC have, not just for disabled people but nationally. Thank you very much for your time. Thank you for answering our questions so frankly. If there is anything else you would like to send us, as I said, please do. Thank you very much for confronting all the difficulties we have put before you and for helping us think about what the solutions might be, if solutions are needed. I am very grateful.