Summary: Intervention & Options

Department /Agency:	Title:	
DCSF	Impact Assessment of revised statutory guidance on promoting the health of looked after children	
Stage: Consultation	**Version:** 1	**Date:** 24 April 2009
Related Publications: White Paper: 'Care Matters: Time for Change' and Children and Young Persons Act 2008 (section 20)		

Available to view or download at:

http://www.dcsf.gov.uk/publications/timeforchange/

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

There are 60,000 looked after children (LAC) at any one time. Evidence shows LAC have poorer access to advice and enter care with worse levels of health than peers. 2003 ONS survey est that 45% of LAC had a diagnosable mental health problem compared to 10% of all children. Inconsistent healthcare practice found (2008 CI report). Government intervention is necessary to address equity concerns by ensuring LAC have comparable health outcomes to their peers, to resolve the inefficiency of imperfect information for LAC and realise the positive externalities associated with improved health.

What are the policy objectives and the intended effects?

The overarching aim is to improve the healthcare experiences and health outcomes of looked after children (LAC). Revising the guidance is intended to reinforce key messages in the 2002 guidance so that everyone involved in promoting the health of LAC has a shared understanding of what needs to be done. The intended effect is that LAC experience a more co-ordinated, cohesive and consistent approach to their healthcare. Making the revised guidance statutory on health as well as on local authorities reflects health bodies' key role in this process and the reality of the 2004 duty to cooperate.

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

Three policy options were considered:

1) Not revising the guidance

2) Updating the guidance but keeping it on a statutory footing only for local authorities

3) Updating the guidance and putting it on a statutory footing for health bodies as well as for LAs

The third option was selected as 2002 guidance does not reflect the current context in either policy or practice and putting the guidance on a statutory footing for health bodies ensures consistency across different bodies

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? The revised guidance is a commitment from 'Care Matters: Time for Change', which will be monitored via a published annual stocktake. OfSTED and the Care Quality Commission will inspect as well.

Ministerial Sign-off For SELECT STAGE Impact Assessments:

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:

8 May 2009 Date:

Summary: Analysis & Evidence

Policy Option: 2	Description: Revise the guidance but let it remain statutory only for local authorities

COSTS

ANNUAL COSTS	Description and scale of **key monetised costs** by 'main affected groups'
One-off (Transition) **Yrs**	Cost of civil servants' time in revising the guidance
£ **7830**	
Average Annual Cost (excluding one-off)	
£	**Total Cost** (PV) £ **7830**

Other **key non-monetised costs** by 'main affected groups'
Staff time to read and understand the guidance

BENEFITS

ANNUAL BENEFITS	Description and scale of **key monetised benefits** by 'main affected groups'
One-off **Yrs**	
£	
Average Annual Benefit (excluding one-off)	
£	**Total Benefit** (PV) £

Other **key non-monetised benefits** by 'main affected groups' Up-to-date guidance more likely to inform commissioning and practice. However, benefits would be limited as this option would mean the guidance would not have statutory force in relation to the main commissioners and providers of healthcare services.

Key Assumptions/Sensitivities/Risks

Price Base Year	Time Period Years	**Net Benefit Range** (NPV) £	**NET BENEFIT** (NPV Best estimate) £

What is the geographic coverage of the policy/option?				
On what date will the policy be implemented?				
Which organisation(s) will enforce the policy?				
What is the total annual cost of enforcement for these organisations?			£	
Does enforcement comply with Hampton principles?			Yes/No	
Will implementation go beyond minimum EU requirements?			Yes/No	
What is the value of the proposed offsetting measure per year?			£	
What is the value of changes in greenhouse gas emissions?			£	
Will the proposal have a significant impact on competition?			Yes/No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	Yes/No	Yes/No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of £ Decrease of £ **Net Impact** £

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Summary: Analysis & Evidence

Policy Option: 3	Description: Revising the guidance and making it stautory on PCTs and SHAs as well as on local authorities.

COSTS

ANNUAL COSTS	
One-off (Transition) **Yrs**	Description and scale of **key monetised costs** by 'main affected groups' One-off cost of staff time. No additional costs to local authorities as there are no new requirements of LAs in the revised guidance. Health bodies have already, by and large, been acting in accordance with the 2002 guidance and additional costs of £6.2 to 9.3 million p.a. represent cost of consistent practice nationwide
£ 7830	
Average Annual Cost (excluding one-off)	**Total Cost** (PV) **£ 66.4 m (10 yrs)**
£ Approx. £7.76m	

Other **key non-monetised costs** by 'main affected groups' Staff time to read and understand the requirements of the guidance

BENEFITS

ANNUAL BENEFITS	
One-off **Yrs**	Description and scale of **key monetised benefits** by 'main affected groups' The proposals will give an extra 6545 LAC access to a designated nurse and an extra 14280 LAC access to a designated doctor.
£	
Average Annual Benefit (excluding one-off)	**Total Benefit** (PV) **£**
£	

Other **key non-monetised benefits** by 'main affected groups' The meeting of mental and physical health needs should mean more stable placements. Healthier and happier children tend to achieve better at school and have better long-term outcomes. There are therefore short and long-term benefits not only for the child but also for those who support them as well as for society.

Key Assumptions/Sensitivities/Risks The key assumption is that local authorities and health bodies are mostly acting in accordance with the guidance already. This is evidenced by independent research and the results of OfSTED inspections.

Price Base Year 2009	Time Period Years 10	**Net Benefit Range** (NPV) £	**NET BENEFIT** (NPV Best estimate) £

What is the geographic coverage of the policy/option?				England
On what date will the policy be implemented?				September 2009
Which organisation(s) will enforce the policy?				N/A
What is the total annual cost of enforcement for these organisations?				£ N/A
Does enforcement comply with Hampton principles?				Yes/No
Will implementation go beyond minimum EU requirements?				Yes/No
What is the value of the proposed offsetting measure per year?				£ 0
What is the value of changes in greenhouse gas emissions?				£ 0
Will the proposal have a significant impact on competition?				No
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	Yes/No	Yes/No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of £ Decrease of £ **Net Impact** £

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Evidence Base (for summary sheets)

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

Summary

Existing guidance, "Promoting the health of looked after children" was published by the Department of Health in 2002 and is statutory on local authorities. A commitment was made in the "Care Matters" White Paper (2007) to revise the guidance and make it statutory on health bodies as well as on local authorities. Before starting to revise the guidance, the Government commissioned Thomas Coram Research Unit (TCRU) to conduct fieldwork amongst a range of health and children's services professionals to assess how well the existing guidance was being implemented and what was required of the revised guidance.

Since the publication of the 2002 guidance, there is evidence (TCRU research) that practice in relation to assessing and meeting the health needs of looked after children have improved. For example:

- The percentage of looked after children receiving an annual health assessment and dental check rose from just under a third of eligible children in 2001/02 to almost 89% in 2006/07
- Improvements in immunisation rates ((Ofsted, (2008) Safeguarding children: The third joint Chief Inspectors' report on arrangements to safeguard children. www.safeguardingchildren.org.uk quoted in TCRU fieldwork p.14)
- 89% of PCTs have a dedicated nurse and over and over ¾ have a designated doctor for looked after children (National Child Health, CAMHS and Maternity mapping exercise cited in TCRU report, p.27)
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However, there was also evidence of inconsistency of healthcare practice. A joint Chief Inspectors' report in 2008 confirmed improvements in health monitoring for looked after children and care leavers since 2005. However, the quality of individual health plans was still judged to be variable, and the role of corporate parent was not fully understood by all council members and officers. Overall, particular weaknesses in promoting the health of looked after children identified in inspection reports included:

- safe administration of medicines in residential settings
- arrangements for securing health services for children placed out of authority, and
- waiting times for assessment and treatment for children with behavioural difficulties and lower levels of mental health needs. Fast-tracking arrangements for access to specialist CAMHS and therapeutic services for children with high levels of need, such as self-harming behaviour, were judged to be effective in most areas.

(Ofsted, (2008) Safeguarding children: The third joint Chief Inspectors' report on arrangements to safeguard children. www.safeguardingchildren.org.uk quoted in TCRU fieldwork p.20)

The TCRU fieldwork carried out to inform the revision of the existing guidance found evidence of inconsistency particularly relating to the quality of health assessments and how effective they were in leading to health needs being met.

Given the worse health outcomes and overall outcomes (including educational attainment and being in education, employment or training and 19) of looked after children, there is a strong case for issuing statutory guidance relating to the health of this specific group in order to give them a better chance of achieving the same positive outcomes as their peers.

Three policy options in the context of revising the existing statutory guidance were considered:

1) Not revising the guidance

2) Updating the guidance but keeping it on a statutory footing only for local authorities

3) Updating the guidance and putting it on a statutory footing for health bodies as well as for LAs

Option 1 was ruled out because revising the guidance was assessed as being a crucial step as the 2002 guidance was out-of-date. In particular, it did not reflect the requirements of the 2004 Children's Act and the significant changes in integrated working and commissioning that have taken place since that Act. These include the "duty to co-operate".

Option 1 - Advantages	Option 1 - Disadvantages
Allows civil servants to focus on other priority areas of work as revising guidance is time-consuming	2002 guidance is out-of-date and does not reflect current policy or practice
	2002 guidance will lose credibility if perceived by practitioners as being out-of-date
	Some key aspects of 2002 guidance are not being implemented so doing nothing is not an option
	All guidance should be regularly revisited and revised if out-of-date so presentational challenges to having out-of-date guidance in force

Option 2 was ruled out because not making the revised guidance statutory on health bodies would appear "out of step" in light of the duty to co-operate and the increasing advent of joint guidance and joint duties. In relation to looked after children, local authorities are the corporate parent and as such have overall responsibility for their wellbeing and their outcomes. Health bodies are, however, the key provider of healthcare services for looked after children and their co-operation is crucial to ensuring good outcomes for looked after children. For these reasons, making the guidance statutory solely on local authorities would not meet the necessary policy objectives and would have caused confusion in the front line because there would have remained a fundamental inconsistency with the duty on health bodies to cooperate. An evidence sheet for Option 2 is included in this Impact Assessment even though Option 2 has been ruled out.

Option 2 - Advantages	Option 2 - Disadvantages
Would ensure that guidance was up-to-date and reflected current policy and practice	Statutory status only in relation to local authorities would not reflect the duty to co-operate introduced by the 2004 Children Act
Some evidence that PCTs and SHAs are already implementing the 2002 guidance without it having statutory force	PCTs are the key providers of healthcare services to looked after children. Therefore, putting health guidance on a statutory footing for local authorities and yet not for health bodies, would be inconsistent with the reality of commissioning and provision
	Statutory status raises the profile of guidance within organisations, particularly with senior management and commissioners and makes it more likely it will be adhered to when policy is developed and services are commissioned and delivered

Option 3 was selected because this was judged to be the best way of achieving the policy objective, as well as being consistent with other Government policy and bringing the guidance into line with the requirements of Section 10 of the Children Act 2004, which require PCTs and SHAs to cooperate with local authorities.

Option 3- Advantages	Option 3- Disadvantages
Local authorities are the corporate parents of looked after children and health bodies provide the healthcare so putting the guidance on a statutory footing for all key partners reflects the reality of delivery	Putting the guidance on statutory footing for PCTs and SHAs makes it particularly important that the statutory requirements reflect the reality of practice and secure the support of health stakeholders.
This option reflects the legal requirements of Section 10 of the Children Act 2004	
Statutory status ensures that the guidance is considered by senior management and commissioners when developing policy and commissioning services	

Rationale

The rationale for having this guidance is that looked after children have traditionally had far worse health outcomes than their peers. They move more frequently than their peers and around 30% are placed outside of their home local authority, which can lead to difficulties in ensuring continuity of high quality healthcare.

As a group, looked after children experience particular health difficulties:

- 45% of looked after children have mental health problems (Melzer et. al. 2003)
- The majority of looked after children come in to care as a result of abuse or neglect
- Looked after children are more likely to experience a range of health problems including problems with speech and language, eye and sight, bedwetting and co-ordination difficulties (Melzer et.al. 2003)
- Looked after children are less likely than children living at home to have a good immunisation status (TCRU 2008)

Government intervention to revise the guidance and make it statutory on the key partners with responsibility for looked after children's healthcare is necessary to further improve health outcomes for looked after children and to:

- Address the need for co-ordination within healthcare bodies to meet the needs of children in care
- Strengthen protocols and agreements with NHS bodies
- Update guidance to reflect new statutory requirements.

The overarching objective is to improve the healthcare experiences and health outcomes of looked after children (LAC). Underpinning this overarching objective are aims including:

- The reinforcement and clarification of key messages in the 2002 guidance
- Ensuring that everyone involved in promoting the health of LAC has a shared understanding of what needs to be done
- That LAC experience a more co-ordinated, cohesive and consistent approach to their healthcare.

Making the revised guidance statutory on health as well as on local authorities reflects health bodies' key role in this process and the reality of the 2004 duty to cooperate.

Costs and Benefits

Costs

As a one-off cost, the cost of revising the guidance is calculated based on the cost of civil servant time spent on the revision:

125 hours - time from DCSF policy lead

80 hours – time from DH policy leads

25 hours – time from Children in Care Division's policy adviser

20 hours – time from other members of the Children in Care policy team

20 hours – other policy leads who have contributed to the content of the guidance

20 hours – Equality policy people, analysts, DD time

A reasonable average cost per hour, given the Grades of most of these people, would be about £27 per hour. The total cost is then 290 hours multiplied by £27 which comes to £7830.

In terms of policy implementation, there are no additional costs to local authorities. The only requirements of local authorities that are in this guidance but were not in the 2002 guidance are ones that have been introduced by subsequent legislation (most notably the Children Act 2004) and statutory guidance; including statutory guidance on children's trusts. It is important that this guidance reflects all the relevant existing requirements on local authorities. However, it does not create any new duties.

Health bodies have already, by and large, been acting in accordance with the 2002 guidance to a similar extent to local authorities. This is supported by the evidence provided via the TCRU fieldwork carried out to inform the revision of the guidance which. While this research found significant challenges in quality and consistency of healthcare services for looked after children, it did show that health bodies were very much taking responsibility for the provision of health services to looked after children including the carrying out of health assessments by appropriately qualified professionals and were increasingly implementing non-statutory parts of the guidance including designated doctors and designated nurses.

Additional costs represent the cost of ensuring consistency nationwide in implementing the guidance which largely amount to the introduction of a lead professional and of designated doctors and designated nurses in every PCT. These costs will mostly be associated with the role of the designated doctor and nurse and the lead health professional, and the estimated costs in this Impact Assessment are for staff in these roles. The only source of data on numbers of staff already doing this work comes from the children's health services mapping data collection - this has data on staff time for designated doctors and nurses, but not for lead health professionals. Mapping data is available at http://www.childrensmapping.org.uk/index.php

The cost of a statutory role of a lead health professional has been calculated as somewhere between £6.2 m and 9.3m. This calculation was done based on 2008 salaries, and based this on three scenarios, to reflect the current uncertainty around the costs for lead health professionals. The scenarios are based on three different sets of assumptions about the number of days of staff time required per annum for each child and the proportion of children who have more complex needs. These assume that 85% / 80% / 75% of looked after children need 1.5 / 2 / 2.5 days of band 6 nurse time per annum and 15% / 20% / 25% need 4 / 5 / 6 days of band 7 nurse time per annum (the children with more complex needs).

The mapping data was used in order to estimate the extent to which the work involved in the roles is already being funded by PCTs. Data on PCTs reporting designated doctors and nurses in post, and the named nurse data was used as an indicator of the likely extent to which the lead health professional role is already being funded. The resulting estimates are £6.2m, £7.7m and £9.3m depending on which assumptions are used for the lead health professional role. The table below shows how these totals were calculated:

Estimated costs

1. Costs for designated doctors		
PCTs **not** reporting a designated doctor in post, 2008 (a)	32	
Average wte per PCT for PCTs reporting designated doctor in post, 2008 (a)	0.40	
Annual salary for consultant paediatrician incl oncosts (£) (b)	147,136	
Total costs for PCTs **not** reporting a designated doctor in post (£m)	1.90	
2. Costs for designated nurses		
PCTs **not** reporting a designated nurse in post, 2007 (c)	16	(17 in 2008 draft data)
Average wte per PCT for PCTs reporting designated nurses in post, 2007 (c)	1.02	(0.96 in 2008 draft data)
Proportion of PCTs reporting nurse for CLA is a senior nurse, 2007 (c)	0.86	(0.74 in 2008 draft data)
Annual salary for band 6 nurse incl oncosts (£) (d)	34,579	
Annual salary for band 7 nurse incl oncosts (£) (e)	41,292	
Total costs for PCTs **not** reporting a designated nurse in post, (£m)	0.66	
3. Costs for lead health professionals (LHP)		
Number of children looked after (f)	59,500	
Number of CLA in PCTs with no named nurse for CLA (c) and (f)	11,020	
Estimated daily staff cost for CLA with most complex needs (b) and (e)	200	(Band 7 nurse)
Estimated daily staff cost for CLA with less complex needs (b) and (d)	167	(Band 6 nurse)

	Scenario A	Scenario B	Scenario C
Number of days of staff time required per year per child for CLA with more complex needs	4	5	6
Number of days of staff time required per year per child for CLA with less complex needs	1.5	2	2.5
Proportion of CLA with more complex needs	15%	20%	25%
Estimated costs for LHP not currently being met (£m)	3.7	5.2	6.8
Estimated total cost for PCTs reporting no designated staff and no lead prof. (£m)	6.2	7.7	9.3

Notes
Sources:
(a) 2008 Mapping draft data
(b) PSSRU Unit Costs 2008 - hospital based doctors, consultant incl. oncosts
(c) 2007 Mapping data
(d) Median of Band 6 pay range 2009 + 20% oncosts
(e) Median of Band 7 pay range 2009 + 20% oncosts
(f) DCSF Children Looked After at 31 March 2008 (LA data mapped to PCTs)

Benefits

The benefits of implementing the new statutory guidance are:

1. consistency across and within LAs on the availability and quality of services provided to LACs
2. improved health outcomes for looked after children leading to better life outcomes for them in the short and long term
3. cost savings over time to the healthcare system from prevention and early intervention for LACs with mental and/or physical health problems

While the benefits coming from clarity of expectation and consistency of quality of provision cannot be quantified at this stage, steps are being taken to obtain further quantitative evidence through the consultations process. It is a key assumption underpinning Government health policy for all groups that meeting health needs will have short, medium and long-term benefits and this is just as likely to apply to looked after children as to other people. Indeed, as the starting point for looked after children's health is so much lower than for other children it is likely that the gains from providing them with consistent and high quality health care will be of greater value and realised more quickly than for other groups. In addition, looked after children are part of the young population so there is potential for cost savings over a long period of time by taking a preventative rather than curative approach to their healthcare. Meeting the health needs of looked after children is likely to improve the likelihood of more stable placements and

increase their chances of achieving at school and going on to higher education, employment or training. For these reasons, despite the lack of quantitative data at this stage, we are confident that the long-term benefits of meeting health needs and taking a holistic approach to the health and wellbeing of this vulnerable group will outweigh the costs outlined above.

The revised guidance on promoting the health of looked after children will be statutory on Primary Care Trusts and Strategic Health Authorities in addition to local authorities. This ensures that health service providers at local level are engaged with looked after children and make special provisions for them, such as providing each looked after child with a lead health professional. This is expected to have a positive impact on both the mental and physical health of looked after children. The impact on mental health, especially, can be expected to be substantial because prevalence of mental health problems is much higher in looked after children than others. An ONS survey finds that 44.8% of looked after children have some sort of mental disorder as compared with 9.6% of all children .

Given that 89% of PCTs have a designated nurse for looked after children, it is reasonable to assume that around 89% of the approximately 60,000 looked after children at any one time have access to a designated nurse. Therefore, implementation of this revised guidance would give an extra 6545 looked after children at any one time access to a designated nurse.

Given that 76% of PCTs have a designated doctor for looked after children, it is reasonable to assume that around 76% of the approximately 60,000 looked after children at any one time have access to a designated doctor. Therefore, implementation of this revised guidance would give an extra 14280 looked after children at any one time access to a designated doctor.

Savings on costs to health services are difficult to quantify, however the example below shows the cost savings from the prevention of conduct disorder:

- From NICE Guidance 2008 "Systematic review of the effectiveness of interventions to promote mental wellbeing in primary schools", cost to public purse of conduct disorders per child per year = £1435
- From DCSF Statistical Release "Children Looked After in England in the year ending 31st March 2008", the number of looked after children = 59,500
- Looked after children who are affected by the requirement for a designated nurse in new statutory guidance = 11% of 59,500 = 6545
- From the ONS 2003 survey, the percentage of looked after children with a conduct disorder = 37%

Therefore the number of looked after children affected by the new guidance with a conduct disorder is

$(37/100)*6545 \approx 2422$

To give us a relatively conservative estimate, we assume that imposing the new statutory requirements on health bodies prevents 5% of these children from developing a disorder. The savings in one year from implementing the new guidance are then:

$(5/100)* 2422 \approx 122$

$122*1435 = £175,070$

This savings figure is from the effect of the guidance on one aspect of mental health in one year.

The above estimate is only for conduct disorders. Looked after children experience a range of other health problems and some of the other benefits resulting from the implementation of the guidance could be:

- Preventing young people from developing drug or alcohol problems.

- Preventing young people from developing other mental disorders and the physical health problems correlated with them (e.g. allergies, bedwetting, speech and language problems, etc.)

- Increasing stability of placement for children in care: if carers receive more support from health services and the children's health problems are resolved more effectively it could result in less changes of placement per child.

The cost savings from these effects of the implementation of the statutory guidance are unknown but they can be expected to be substantial.

There will also be savings in the long run as a result of meeting health needs. For example, the cost of lost employment as a result of mental disorders is currently estimated to be £26.1 billion which is currently more than the direct NHS and social care services costs of supporting people with mental disorders. The cost of lost earnings is projected to rise to £41 billion by 2026. (Ref. Paying the Price: The Cost of Mental Health Care in England to 2026 by Paul McCrone, Sujith Dhanasiri, Anita Patel, Martin Knapp and Simon Lawton-Smith, 2008, Kings Fund)

In addition, research specifically on looked after children, found that "For some children postponing service provision only reduced short term costs; in the long term more costly services and placements were required increasing the overall cost of the care episode." (Ref. Looked After Children: Counting the Costs Report on the Costs and Consequences of Different Types of Child Care Provision study, Holmes, Lisa 2003)

Risks

The key assumption is that local authorities and health bodies are mostly acting in accordance with the existing guidance already. This is evidenced by independent research and the results of OfSTED inspections but there is the risk that the existing guidance is only being followed to a limited extent. In this case, the cost estimates would have to be revised upwards.

Evaluation

The revised guidance is a commitment from the White Paper, 'Care Matters: Time for Change'. All Care Matters commitments are monitored via an annual Ministerial stocktake. In addition, both OfSTED and the Care Quality Commission inspect on how services meet the health needs of looked after children . The extent to which local authorities and health bodies successfully meet health needs of looked after children in line with this statutory guidance, and any difficulties they encounter in achieving the desired effects, will be monitored by both these bodies.

Specific Impact Tests: Checklist

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

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

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

Annexes

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