PSED Review Consultation

NHS Employers

Equality and Diversity Partners 2012/13

Held on 25th February 2013

Report

Contents

Executive Summary

This executive summary is based upon the deliberations of the Round Table Discussion held on the 25th February 2013 with NHS Employers Equality and Diversity Partners. They are outlined more fully in the conclusions.

Key areas from the conversations and debates identified the following:

- The guidance to help public sector bodies understand the Public Sector Equality Duty was seen as open to interpretation. There were mixed feelings within the discussion group regarding how helpful this was. Publishing information emerged as an area of concern.
- Inconsistencies in levels of understanding about the Public Sector Equality Duty exist. With senior leadership and equality leads having a firmer grasp of the language of the requirements. The interpretation for staff was clearly articulated as staff having a good understanding of the behaviours required to eliminate discrimination.
- Bringing together the protected characteristics was generally viewed by participants in a positive light as was the move towards setting objectives and an outcome focus. This was generally considered by participants to be a more realistic approach. However, it was suggested that this was the Single Equality Scheme in another form.
- Working with the voluntary sector, community sector and public sector partners was reported as having increased through the Public Sector Equality Duty, as was engagement with groups with protected characteristics. However, the real change was considered to be in the monitoring and reporting on these activities.
- The Equality Delivery System was seen by the participants to be a key driver for engagement, although this was not without difficulties as the public engagement tool was in the developmental stage.
- There were reported instances of integration within high-level overarching structures and processes, for example, Care Quality Commission standards and Clinical Commissioning Group authorisation processes. Integration of equality within the data collection systems was reported as not yet robust.
- There was little evidence in the discussions of an increase in requests for equality information.
- Monitoring of engagement activities demonstrated a developmental enhancement of previous activities with reference to reporting and recording information. Publishing equality information appeared to emerge as a critical area of increased workloads.
- There was little reported evidence of changes to how NHS organisations mitigate or reduce the risk of legal challenge.
- The round table discussions highlighted the different journeys undertaken by NHS organisations. There was a sense of moving forward with the embedding processes required to integrate equality into the new emerging NHS structures. This was not always seen as attributable to the Public Sector Equality Duty.
- The embedding of equality was partly observed as a feature of the overarching governance directives from the Department of Health and the NHS Commissioning Board.
- A considerable commitment to leading equality was reported at Board level.

- Equality Delivery System surfaced as a direction-setting tool and the main driver for equality, conveying guidance for providers and commissioners alike.
- The Equality Delivery System was reported as developed to support the delivery of the Public Sector Equality Duty.
- It was evident that equality leads in NHS organisations provided an interpretation of the Public Sector Equality Duty for board executives and managers alike.

1. Introduction

The Government Equalities Office (GEO) is undertaking a review of the Public Sector Equality Duty (Public Sector Equality Duty), part of the Equality Act 2010, to establish whether the Duty is operating as intended.
The NHS has lots of evidence and experience to contribute to the review (for example, the Equality Delivery System implementation and the NHS Constitution).

The Department of Health (DH) has agreed to work directly with the GEO to collect this evidence and to influence future Public Sector Duty policy and legislation. This work will be of national significance. In light of its specific expertise and knowledge in equalities, the equality legislation, gathering, evaluating and presenting evidence and information and access to organisations across the NHS, NHS Employers is ideally placed to capture the NHS learning and experience and will be project managing the work on behalf of the DH.

NHS Employersô comprehensive networks are to be utilised to liaise with the range of different NHS organisations in order to facilitate the collection of information and evidence.

2. Main aim and objectives of the overall NHS Contribution to the Public Sector Equality Duty project

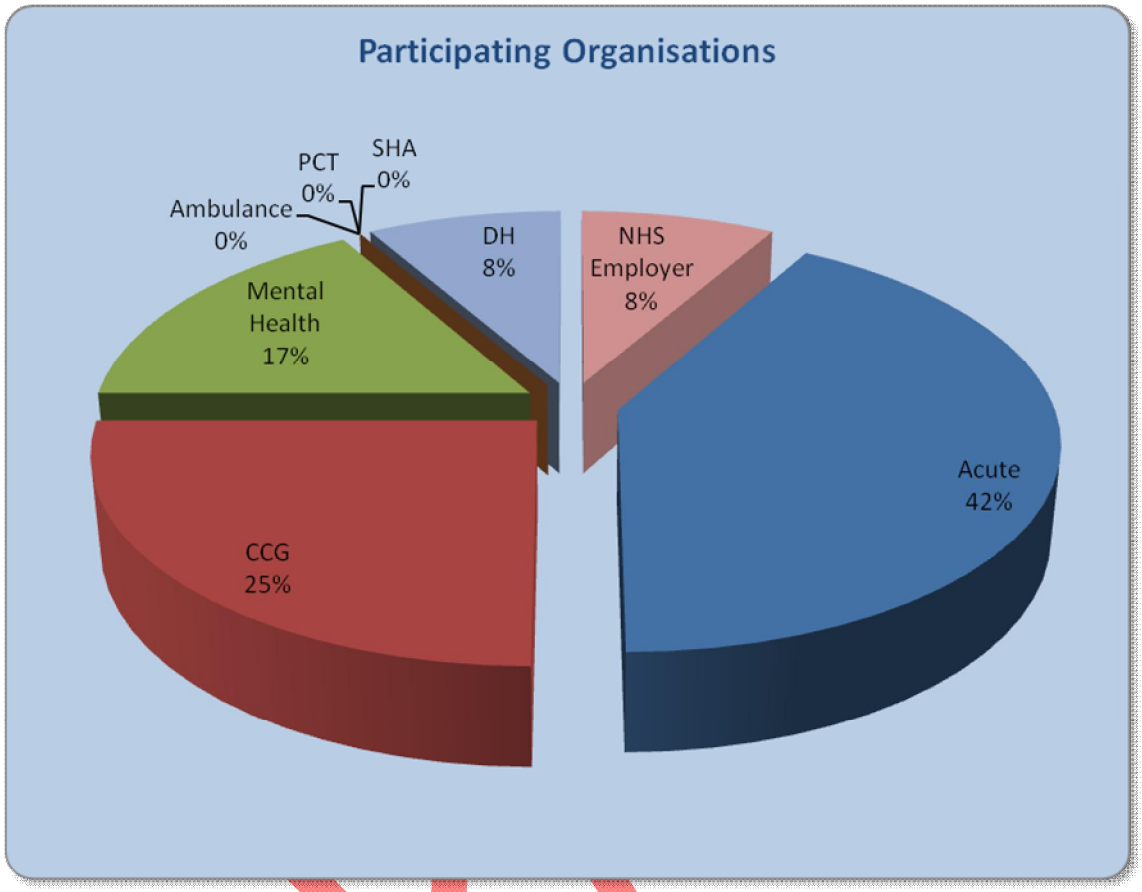
The main aim of the project is to utilise existing NHS Employersô networks to collect the evidence and experiences of the NHS in regard of the operation of the Public Sector Equality Duty in a wide range of NHS organisations.
The objectives are to examine:

- how both the General and Specific Duties are working;
- how effectively the Duty supports delivery of the UK Governmentôs Equality Strategy; and
- options and recommendations for changes or improvements in the way the Duty operates

3. Project Audience

The overall audience for the project is seen as senior managers including board members, personnel/ HR Managers, policy makers and advisors (including E&D specialists) and front-line staff.
With this in mind on the 25th February a round table discussion was held with NHS Employers Equality and Diversity Partners. The session was one hour long and comprised of the following participants:

4 Participating Organisations



The session was introduced and chaired by Carol Baxter Head of Equality and Diversity NHS Employers and supported by Mohamed Jogi.
The facilitator for the session was Maroline Lasebikan Reddenhill Consulting Ltd.

Participants:

1. Sally Pike, Inclusion and Equality Manager at Salford Royal NHS Foundation Trust
2. Diane Brown, Independent Director, at Salford Royal NHS Foundation Trust which provides acute care and community services, an Integrated Care Provider
3. Habib Naqvi, Equality Manager, at the Department of Health
4. Max Liverson, Pay and Contracts Team, at NHS Employers
5. Kate Wilson, Head of Engagement and Inclusion for NHS Kernow covering Cornwall and the Isles of Scilly Clinical Commissioning Group.
6. Barbara Pendleton, Main member with NHS Kernow
7. Cheryl Farmer, Equality and Human Rights Manager, for Liverpool Womenûs Hospital which is a Specialist Acute Trust for Gynaecology and Obstetrics
8. V Smith, Equality and Diversity Manager, for the Royal Liverpool and Broadgreen University Hospitals NHS Trust
9. Charlotte Johnson, Whittington Health Integrated Care Trust
10. Nicola Ryan, NHS Bassetlaw Clinical Commissioning Group
11. Sandy Zavery, Lincolnshire Partnership Foundation (Mental Health) Trust.
12. Stef Abrar, Equality Co-ordinator, for Berkshire Health Care which is a Mental Health Learning Disability and Community Health Integrated Trust

5. How the session was run

Introductions were made with each participant stating their role, organisation's name and type of organisation to which s/he belonged.
Each participant was given a statement sheet (with a Public Sector Equality Duty Aide Memoire on the reverse side) and a red and green card.
The statement sheets and red and green cards were explained to participants as enabling the display of an instant reaction conveying disagreement or agreement with each statement from which discussion could emerge and provide a tool for collecting quantitative data.
Participants were asked to enter the type of organisation that they worked in at the top of a statement sheet. Participants were informed that they would be guided as to when to complete each statement.
Participants were asked to maintain confidentiality to within the group.
A very short brief was provided.

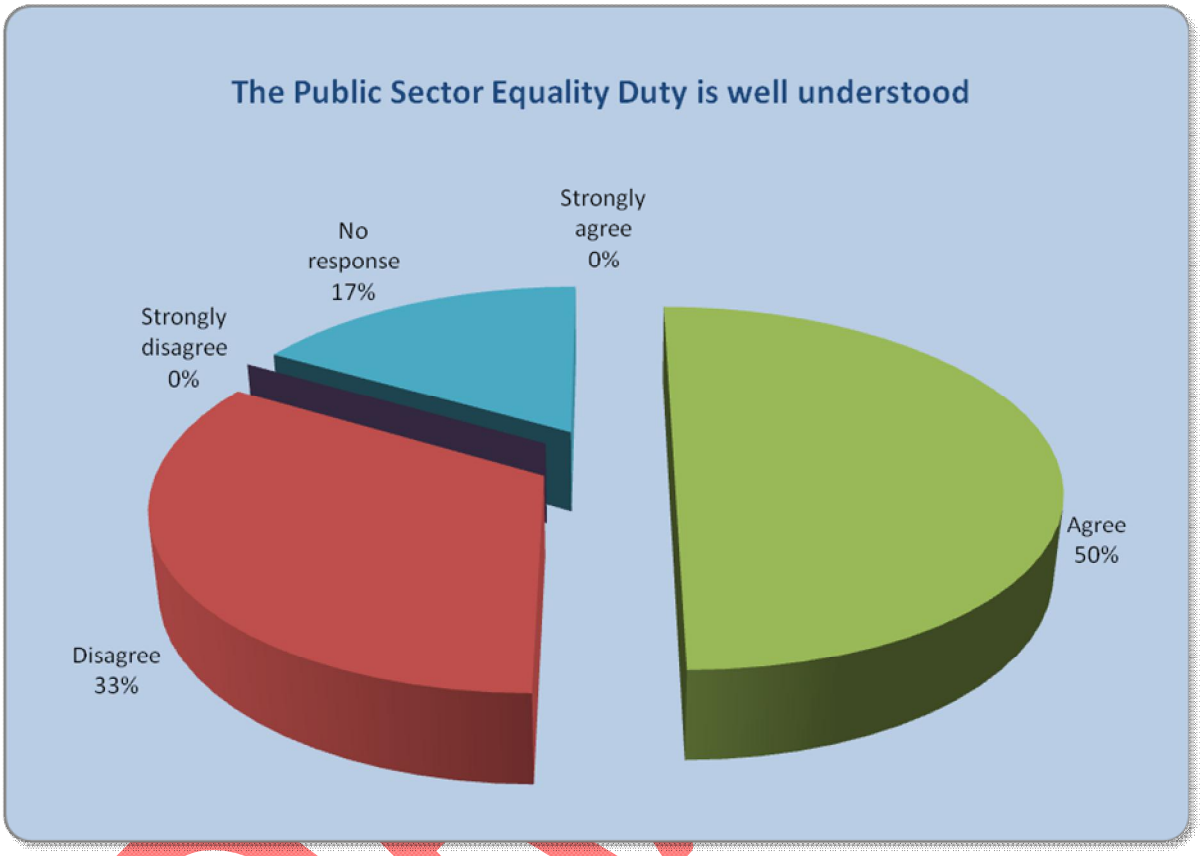
The session was delivered using round table general guidelines. All participants contributed greatly. Ground rules for the conversation were set, participants were informed that they were free to contribute, ask questions whenever they wished and that everyone was responsible for the success of the meeting. They were asked to be courteous to each other even if they disagreed.

6. Findings

The findings are presented here for each statement.

6.1 Statement 1: **The Public Sector Equality Duty is well understood in my organisation**.

Findings



6.1.1 Within Clinical Commissioning Groups it was suggested that a lot of the foundation work included equality and diversity which was undertaken during the authorisation processes.

6.1.2 Lay members may not always have had the exposure to the subject so equality may not have been addressed fully.

6.1.3 Governing bodies, through the authorisation process, have taken equality on board.

6.1.4 Cascading commitment to equality and diversity throughout the organisation is less robust.

6.1.5 At a senior level people know and understand their responsibilities for equality and diversity.

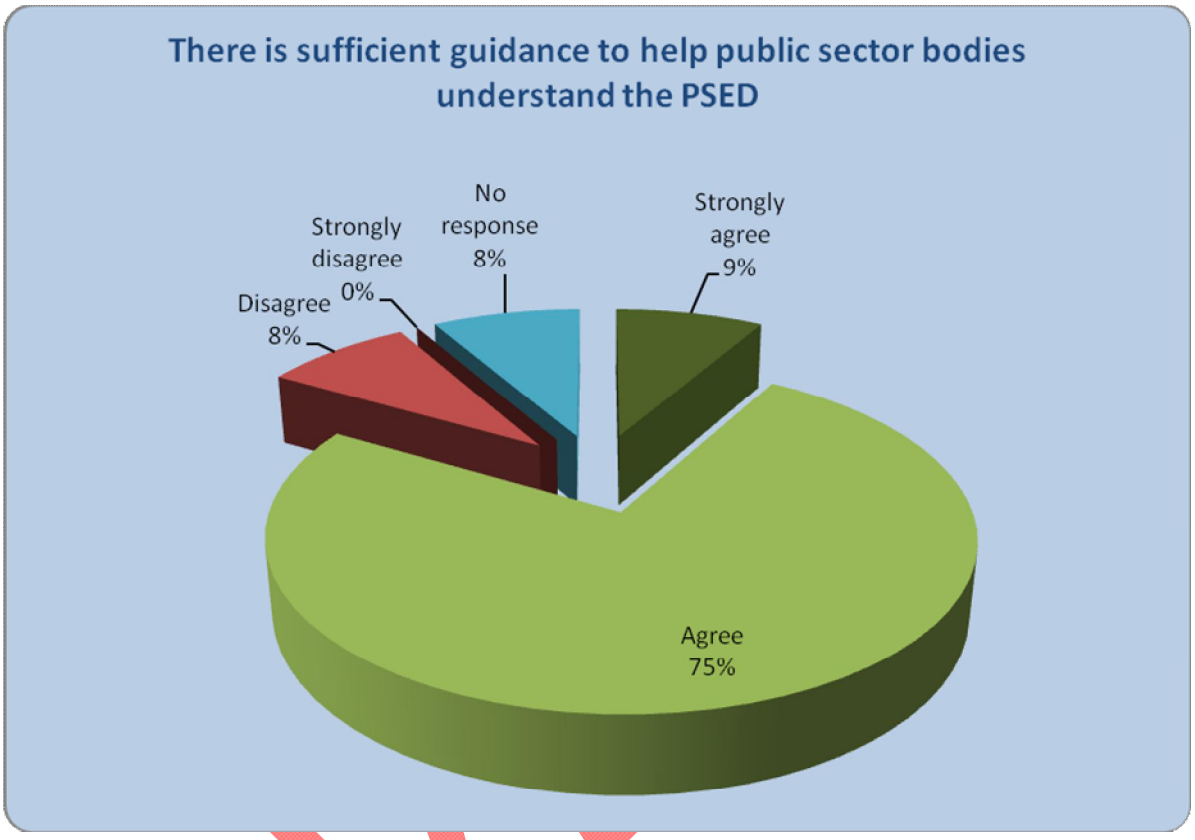
6.1.6 A high level of general awareness has been achieved in hospital settings though training.

6.1.7 Staff understand discrimination but may not relate this to the technical language of the Public Sector Equality Duty.

6.1.8 Some NHS organisations no longer publish information on disciplinaries and grievances. The Public Sector Equality Duty does not give examples of what can be published.

6.2 Statement 2: There is sufficient guidance to help public sector bodies understand the Public Sector Equality Duty

Findings



6.2.1 It was generally thought that there is sufficient guidance. However, it was suggested that the guidance tends to support a mechanistic approach.

6.2.2 It was suggested that what does not tend to come across in the guidance is the focus on people, the need to regularise and understand the different needs of individuals and how to reflect this in advancing equality in organisations.

6.2.3 It was felt that the guidance is open to interpretation (related to the publishing information).

6.2.4 It was recognised that there is a need for the guidance to be flexible as it is used by all public sector organisations. This was thought to be a good thing because different organisations do things in different ways.

6.2.5 It was said that the vagueness of direction in relation to publishing information can create nervousness as organisations want to get it right in terms of what they publish.

6.2.6 It was suggested that there is enough information for equality managers but not necessarily for service managers.

6.2.7 It was stated that the guidance is quite clear, but there is work to be done to cascade the understanding throughout organisation.

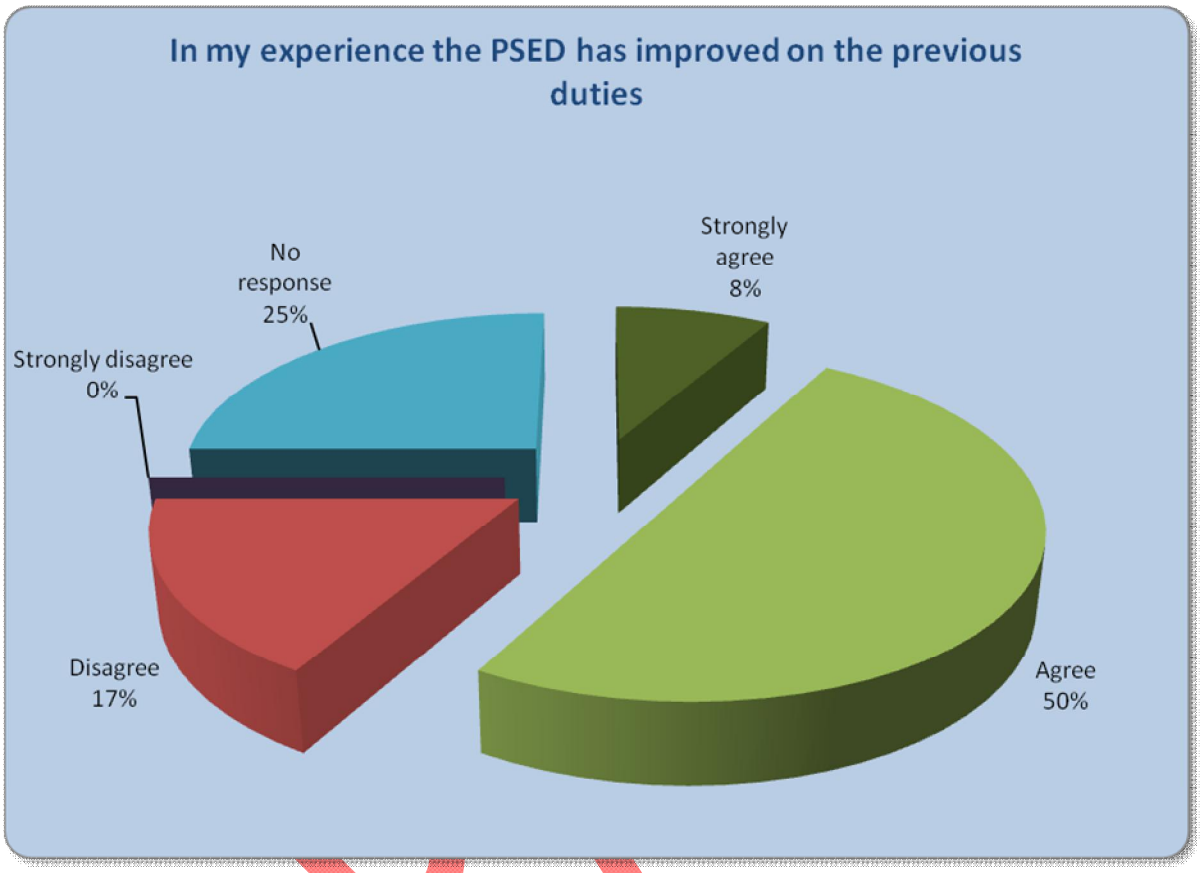
6.2.8 It was stated that some people will want a prescriptive system whereas others want a bottom-up approach.

6.2.9 The following agencies were given as first ports of call for equality information and guidance Equality and Human Rights Commission, the Advisory, Conciliation and Arbitration Service, equality dot gov, NHS Employers, Department of Health are the websites most used to get information.

6.2.10 There was some confusion as to whether or not the equality objectives should determine the reporting of information.

6.3 Statement 3: In my experience the Public Sector Equality Duty has improved on the previous duties

Findings



6.3.1 *It was stated that bringing the protected characteristics together rather than three duties is an improvement.*

6.3.2 *It was stated that equality analysis was thought to be an improvement to equality impact assessment.*

6.3.3 *It was also stated that it was thought that there continues to be a tick box mentality rather than an embedding process.*

6.3.4 *It was suggested that the new approach to objectives was more realistic and focused on actions and outcomes.*

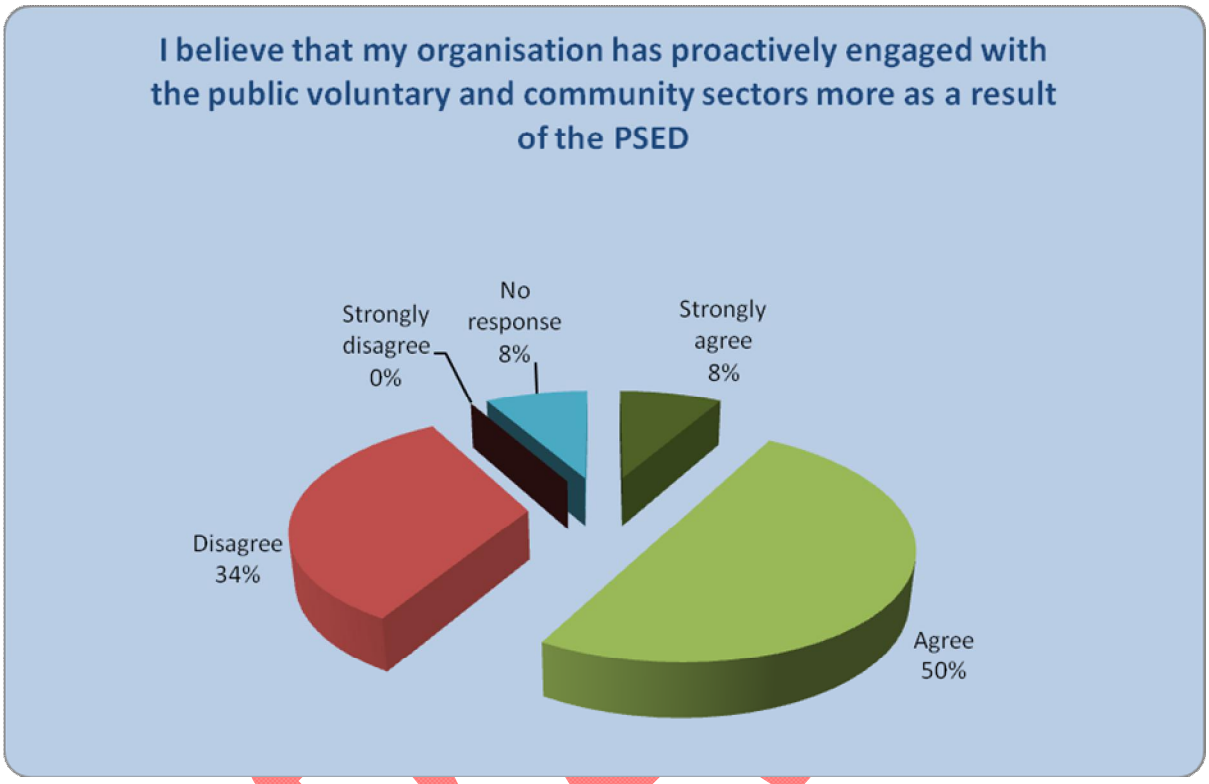
6.3.5 *It was also suggested that this was another form of the single equality scheme.*

6.3.6 *It was thought that a combination of the Public Sector Equality Duty, Equality Delivery System and the links with the Care Quality Commission standards has resulted in triggering improvements.*

6.3.7 *An issue was raised regarding the struggle faced through the change in culture from being told what to do to and making own decisions regarding equality, particularly with regard to the publishing of information and data.*

6.4 Statement 4: I believe that my organisation has proactively engaged with the Public, Voluntary and Community Sectors more as a result of the Public Sector Equality Duty

Findings



6.4.1 It was reported that as a direct result of the Public Sector Equality Duty, Clinical Commissioning Groups working with public sector partners has increased as has working with voluntary and community sectors.

6.4.2 It was suggested that this work was going on anyway through drivers such as commissioning and Equality Delivery System. The Public Sector Equality Duty may have been the trigger.

6.4.3 The transparency element of publishing was seen as a driver.

6.4.4 Engaging with groups with protected characteristics was seen as already going on. What appears to have changed was reported by participants as the monitoring of these activities.

6.4.5 The Equality Delivery System was seen as a driver which had engaged organisations' Boards. It was also reported as having a positive effect on engagement activities.

6.4.6 It was reported that some parts of the community found it difficult to engage with the scoring system of the Equality Delivery System, particularly as the Equality Delivery System did not have a tool for use with the public.

6.5 Statement 5: In my experience the Public Sector Equality Duty has resulted in organisations adopting a more integrated approach to equality

Findings

6.5.1 *The response to whether the Public Sector Equality Duty has resulted in a more integrated approach to equality was mixed. In terms of monitoring patient satisfaction by protected characteristics there was a positive response.*

6.5.2 *Equality was seen as integrated into the authorisation processes of Clinical Commissioning Groups.*

6.5.3 *It was reported that all NHS organisations reported red on health community training which is now on the agenda.*

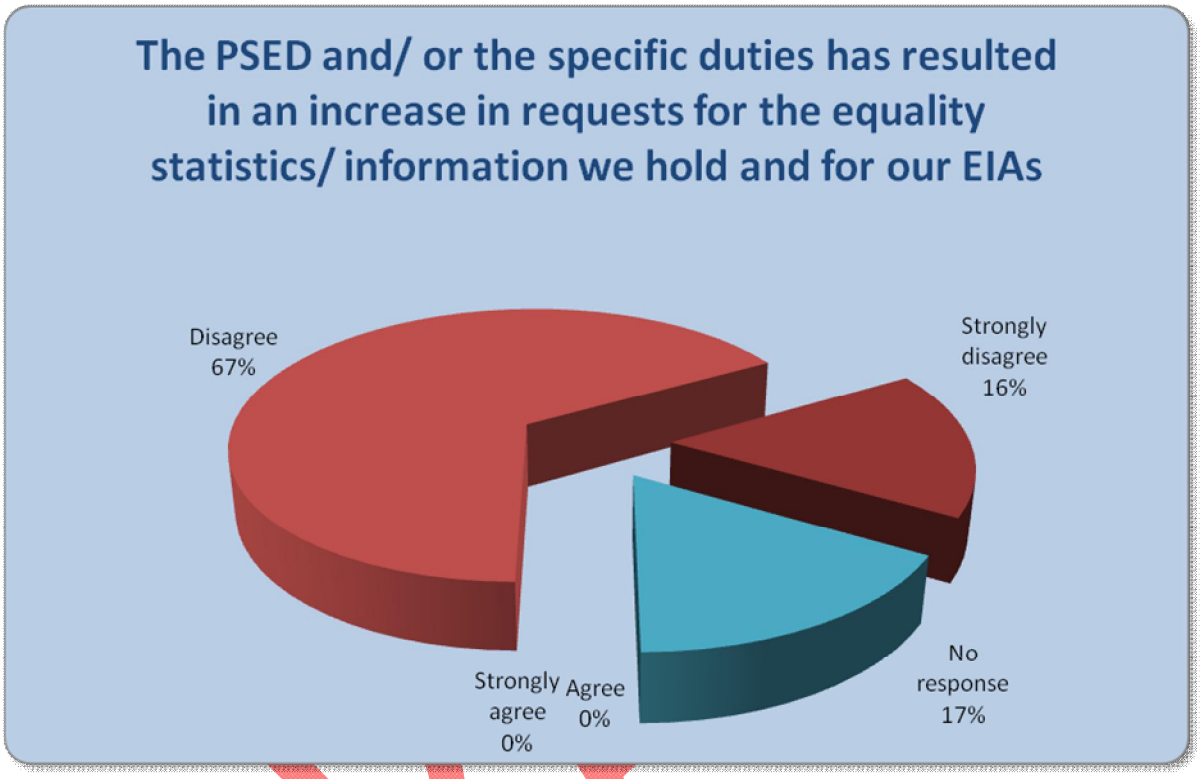
6.5.4 *It was reported that equality was being integrated with Care Quality Commission standards and evidence.*

6.5.5 *It was reported that data collection systems were insufficiently robust to collect data by protected characteristics.*

6.5.6 *It was suggested that the recording of data by protected characteristics would only take place if there was a directive from the Department of Health.*

6.6 Statement 6: The Public Sector Equality Duty and/ or the specific duties has resulted in an increase in requests for the equality statistics/ information we hold and for our EIAs

Findings



6.6.1 No increase in requests for equality statistics were reported.

6.6.2 One request for equality impact assessment information was reported.

6.6.3 The group reported an internal increase of the provision of information and statistics to support service managers.

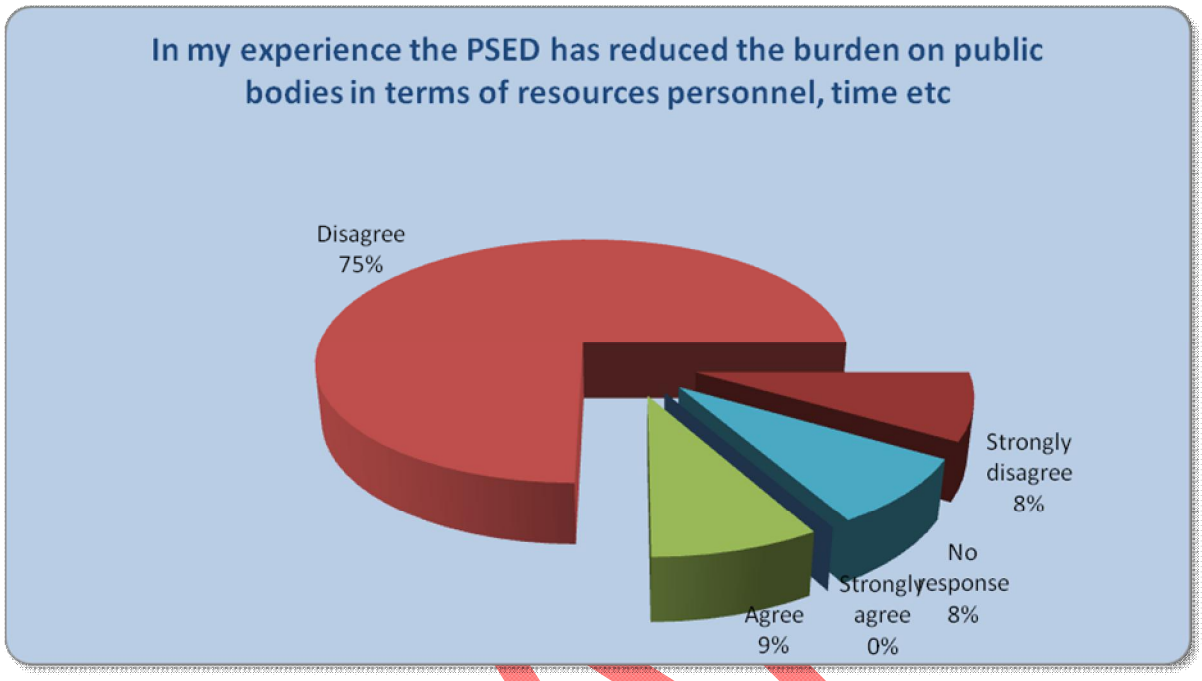
6.6.4 Engagement with public and partners involves sharing statistics and information.

6.6.5 Data in terms of national statistics was reported as hard to find and inconsistent.

6.6.6 It was reported that in the health sector access to services was collected by prevalence so if equality is not in the prevalence requirements then it will not be collected.

6.7 Statement 7: In my experience, the Public Sector Equality Duty has reduced the burden on public bodies in terms of resources, personnel, time etc

Findings



6.7.1 *It was suggested that the workload had increased and that this could probably be attributed to an improved understanding of the Public Sector Equality Duty created by the Equality Delivery System. It was perceived by some as a 'good thing' for equality.*

6.7.2 *It was suggested that the pressure around deadlines and timescales has created increased workloads as the deadlines approached.*

6.7.3 *It was recognised that changes in the NHS had also contributed to the increase in equality workloads.*

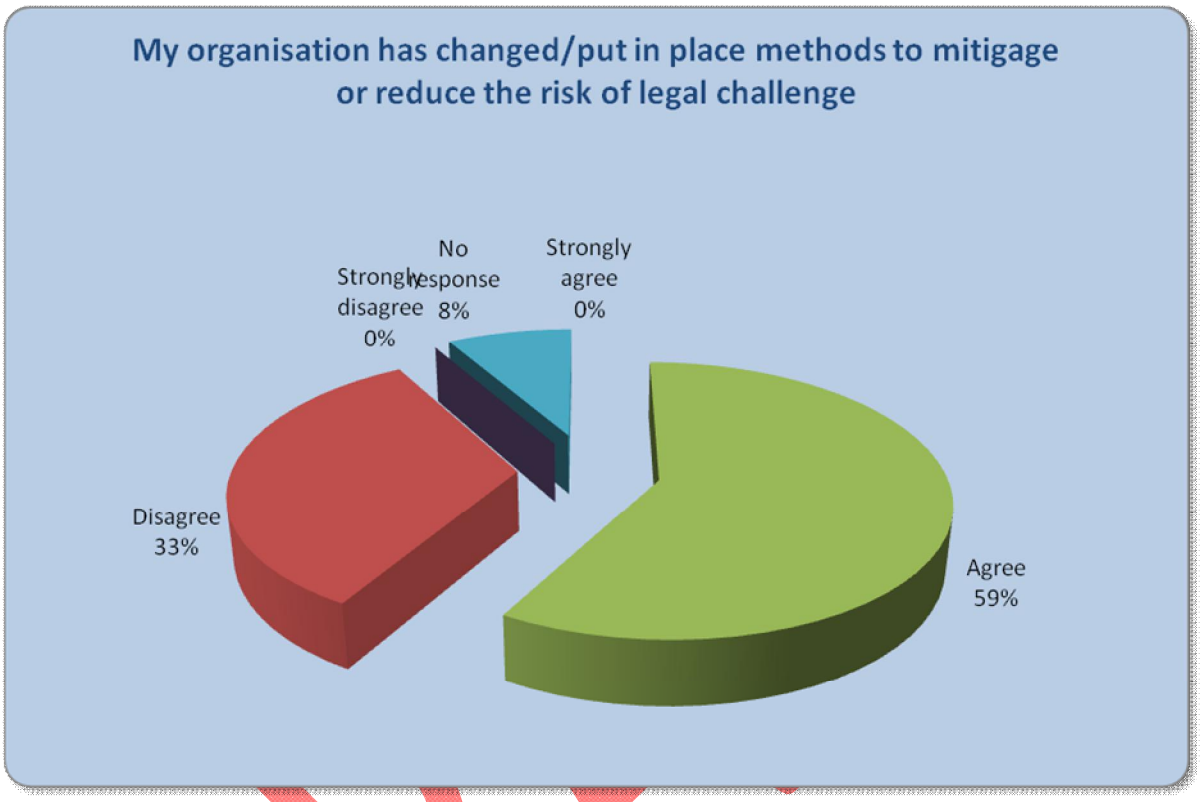
6.7.4 *It was suggested that the perceived deadlines for Public Sector Equality Duty (publishing information) did not fit with NHS reporting structures and therefore created an artificial, stressful and undue pressured environment.*

6.7.5 *It was suggested that it was the Equality Delivery System rather than the Public Sector Equality Duty that had resulted in the increased workloads.*

6.7.6 *It was suggested that this first year, the transition phase, would be the most difficult after which the reporting cycle was expected to settle.*

6.8 Statement 8: My organisation has changed/ put in place methods to mitigate or reduce the risk of legal challenge

Findings



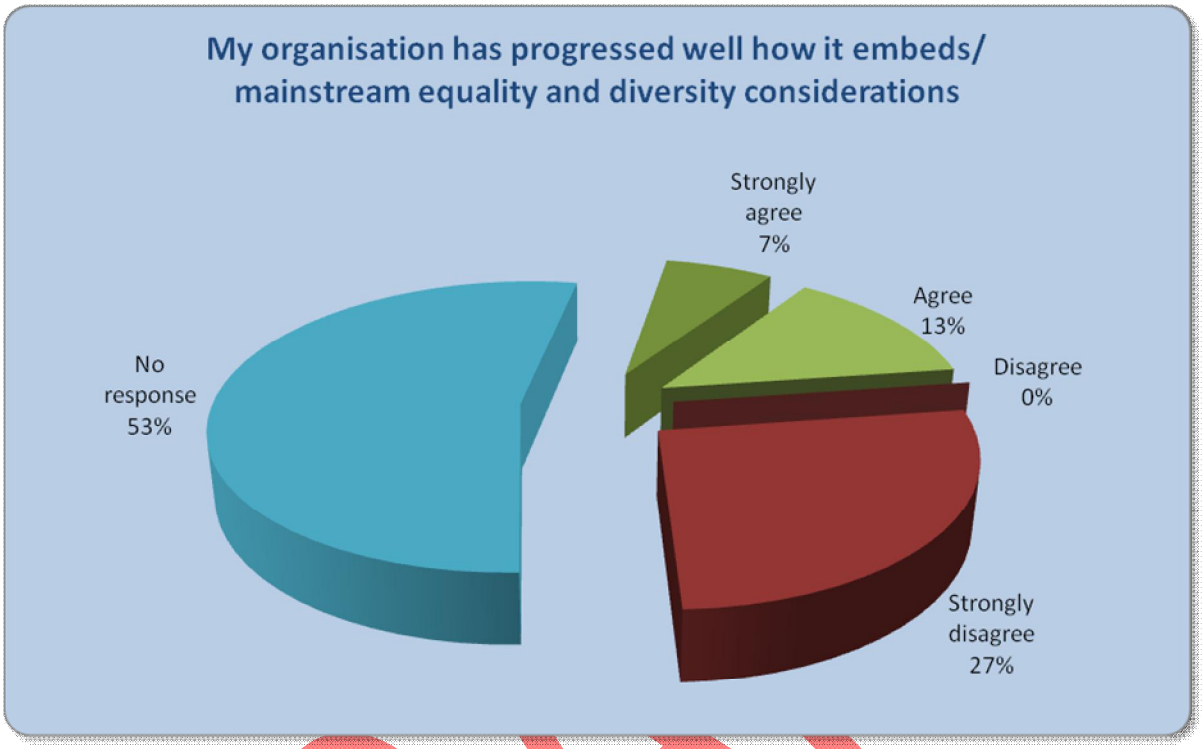
6.8.1 *It was suggested that publishing equality information was helpful as was the equality impact assessment processes.*

6.8.2 *The transition to equality analysis was reported as at different stages within different organisations.*

6.8.3 *Equality impact assessment/ equality analysis were seen as ways of evidencing compliance with the Public Sector Equality Duty.*

6.9 Statement 9: My organisation has progressed well how it embeds/ mainstreams equality and diversity considerations

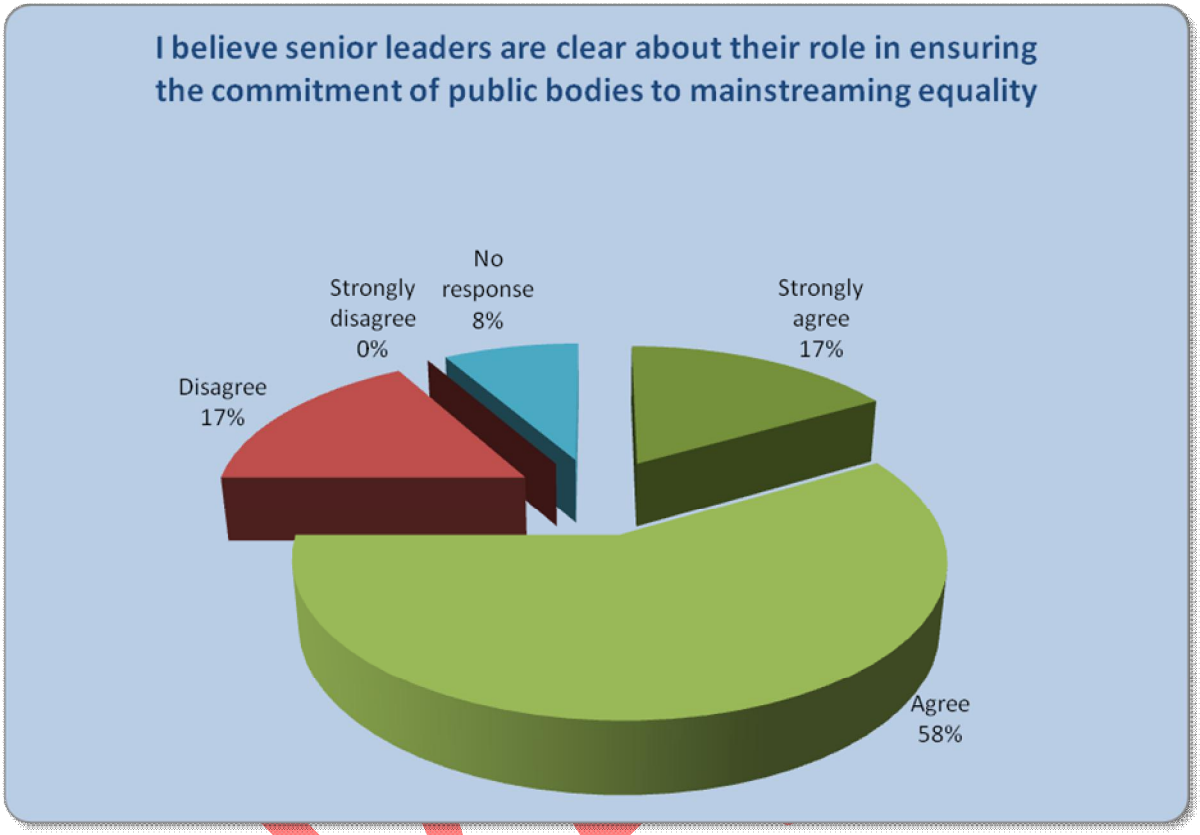
Findings



6.9.1 The group felt that they had already addressed this statement in statement 5.

6.10 Statement 10: I believe senior leaders are clear about their role in ensuring the commitment of public bodies to mainstreaming equality

Findings



6.10.1 It was generally agreed that senior leaders are aware of their role and know what is required of them.

6.10.2 The group suggested that most of this role is delegated and that organisations have a strong reliance on equality leads.

6.10.3 The group stated that there are some clear leaders for equality at board level, who understand the agenda. However, this is not always reflected throughout management.

6.10.4 It was reported by participants from commissioning organisations that equality and a patient focus have now been included in a number of tender documents. Participants from provider organisations had noticed that they were responding to equality questions within tender documents.

7 Conclusions

Statement 1: The Public Sector Equality Duty is well understood in my organisation

7.1 Different levels of understanding about the Public Sector Equality Duty were evidenced, with senior leadership and equality leads having a firmer grasp of the language of the requirements. The interpretation for staff was clearly articulated as staff having a good understanding of the behaviours required to eliminate discrimination.

Statement 2: There is sufficient guidance to help public sector bodies understand the Public Sector Equality Duty

7.2 The guidance was evidenced as open to interpretation. There were mixed feelings regarding how helpful this was.

7.3 The guidance on publishing information emerged as an area of concern.

Statement 3: In my experience the Public Sector Equality Duty has improved on the previous duties

7.4 Bringing together the protected characteristics was generally viewed by participants in a positive light.

7.5 The move towards objectives and an outcome focus was generally considered by participants to be a more realistic approach. However, it was suggested that this was the Single Equality Scheme in another form.

Statement 4: I believe that my organisation has proactively engaged with the Public, Voluntary and Community Sectors more as a result of the Public Sector Equality Duty

7.6 Working with the voluntary sector, community sector and public sector partners was reported as increased through the Public Sector Equality Duty, as was engagement with groups with protected characteristics. However, the real change was considered to be in the monitoring and reporting on these activities.

7.7 The Equality Delivery System was considered by the participants to be a key driver for engagement, although this was not without difficulties as the public engagement tool was in the developmental stage.

Statement 5: In my experience the Public Sector Equality Duty has resulted in organisations adopting a more integrated approach to equality

7.8 There were reported instances of integration with high-level overarching structures and processes, for example, Care Quality Commission standards and the Clinical Commissioning Group authorisation processes.

7.9 Integration of equality within the data collection systems was reported as not yet robust.

Statement 6: The Public Sector Equality Duty and/ or the specific duties has resulted in an increase in requests for the equality statistics/ information we hold and for our EIAs

7.10 There was little evidence in the discussion of an increase in requests for equality information.

7.11 Equality impact assessment was evidenced as continuing with some progress into equality analysis.

Statement 7: In my experience, the Public Sector Equality Duty has reduced the burden on public bodies in terms of resources, personnel, time etc

7.12 Monitoring of engagement activities demonstrated a developmental enhancement of previous activities around reporting and recording information.

7.13 Publishing equality information appeared to emerge as a critical area of increased workloads.

Statement 8: My organisation has changed/ put in place methods to mitigate or reduce the risk of legal challenge

7.14 There was little reported evidence of changes to how NHS organisations mitigate or reduce the risk of legal challenge.

Statement 9: My organisation has progressed well how it embeds / mainstreams equality and diversity considerations

7.15 The round table discussions highlighted the different journeys of NHS organisations. There was a sense of moving forward with the embedding processes required to integrate equality into the new emerging NHS structures. This was not always seen as attributable to the Public Sector Equality Duty.

7.16 The embedding of equality was partly observed as a feature of the overarching governance directives from the Department of Health and the NHS Commissioning Board.

Statement 10: I believe senior leaders are clear about their role in ensuring the commitment of public bodies to mainstreaming equality

7.17 A considerable commitment to leading equality was reported at Board level.

7.18 The Equality Delivery System surfaced as a direction-setting tool and the main driver for equality providing guidance for providers and commissioners alike. The Equality Delivery System was reported as developed to support the delivery of the Public Sector Equality Duty; this could then be viewed as demonstrating a relationship to delivery of the Public Sector Equality Duty.

7.19 It was evident that equality leads in NHS organisations provided an interpretation of the Public Sector Equality Duty for board executives and managers alike.

Attachment 1

Transcript of the Round Table Discussion Held on 25th February 2013 with NHS Employers Equality and Diversity Partners

Statement 1: **The Public Sector Equality Duty is well understood in my organisation.**

The statement was read out by the facilitator and participants were asked to reflect on it and then turn their card to red or green accordingly. A discussion amongst participants was then facilitated.

Within the Clinical Commissioning Group setting being a lay member a lot of the foundation work has been undertaking during the authorisation processes before the Board was assembled so lay members may not always have the knowledge of the preceding period, and this subject may not have been addressed fully yet.

I think as a new Clinical Commissioning Group we were wave one this is part of the authorisation process so I think for emerging new organisations this is very much on their governing bodies mind, it has had to be, so for us as an organisation this has been an advantage, we have got something that normally Trust Boards - they like a paper on it and then move onto something else etc. so for me I can agree with the statement at the moment because the authorisation process has made it so.

I think that it is understood because we have also been through the authorisation processes it is understood at a senior level. I think the cascading down through the organisation is less robust and probably less understood the further down the organisation you go; certainly we have an equality strategy because we needed this as part of the authorisation processes, and the equality strategy refers to the Public Sector Equality Duty. But if I was to say to one of the project officers within our programme management team ó*Do you know what the Equality Duty is?*ô they would look at me as if I was talking double Dutch. We are working on improving that.

I agree with that because, I think, at a very senior level they know they have to understand the responsibility they have. At a lower level the understanding of the duty it and what it means may be limited. It is doubtful if they would know about the general and specific duties.

I think in our Trust (hospital) that there is a general awareness and understanding of the equality duties. Our managers are trained in equality and diversity as part of our training programme and we have about 90% completion of all staff attending the training.

I agree with all the comments made that at a senior level - I have seen the work that they have been doing with the Trust Board - that there is an understanding again as you cascade down. I think staff understand discrimination, not to discriminate, and general issues around equality and diversity but not specifically relating this to the Public Sector Equality Duty. They may not know about things like publishing objectives and information and supporting and engaging protected groups. That depth of knowledge may not be understood, but the Equality Act generally maybe.

People understand the first branch of the three duties. The second and third - around advancing equality - I don't think managers really understand what that means. ó*Fostering*

*good relations*ô we do struggle to define what that actually means. I think with the specific duty it is actually not that specific you can interpret it in terms of what should be published. We have just published our data on the 31st January. I think this was my specification as to what we published. It was up to me to determine what I thought we could publish.

The previous legislation specified, to some extent, what you should publish; for example, information around grievances and disciplinaries, whereas the current legislation doesnôt. Neither has it given me the guidance through examples of what you can publish. So we havenôt and actually this is one of the key areas where we may want to get NHS organisations to look at, we no longer publish this information (disciplinary/grievances).

Statement 2: There is sufficient guidance to help public sector bodies understand the PSED

The statement was read out by the facilitator, participants were asked to reflect on it and then display the card (either red or green) that corresponded with their disagreement or agreement with the statement. A discussion amongst participants was then facilitated.

I think there is sufficient guidance; I think what tends to happen is that the guidance is read in terms of a set of actions that organisations have to take which, in a sense, tends to be mechanistic in going through the motions. What tends not to come across in the guidance is the focus on people and the need to regularise and understand the different needs of individual people and reflect that in advancing equality in organisations.

I think the guidance is there but if you try to look at it individually you interpret it in terms of what you read. So I found that ï like the publication of the data by the 31st of January, I published a whole raft of data staff data and various patient data etc. When I asked my colleagues in the region what they were publishing they had published less than what I was publishing. This led to me thinking ôDo I publish?ô, ôNot publish?ô, ôWhat do I do?ôI have collected this data and done a report. So the guidance is there but interpreting it is very much up to the individual. So will do over and above, some the bare minimum. I think there is no clarity in this.

I agree. There is nothing really prescriptive.

Is that a good thing or a bad thing?

I think that because it applies to all sectors it does need to have that flexibility. It needs to be flexible because different sectors will need different things.

Would anyone like to expand on that?

I think it is a good thing because different organisations have to do things in different ways. I have published equality information for the PCT. I havenôt published it for the Clinical Commissioning Group because we donôt have a lot of that data at the moment - for example, we donôt have disaggregated workforce data from the PCT. So we canôt publish data until we have gone through the ESR system and taken out all the staff that have transferred to the Clinical Commissioning Group and set up a new ESR system for the Clinical Commissioning

Group. We don't have that level of workforce data: we will have it in April and then we will be publishing a very similar type of information for the Clinical Commissioning Group. What I have done with the information for the PCT is taken responses to the Equality Delivery System and I have said that we will ensure that our successor organisations will publish this data. There is something to cling on to for the Clinical Commissioning Group and I will publish something that looks similar in April without having to put maximum effort into doing so.

I think there is a nervousness by being so vague. I think organisations want to be absolutely certain that they are publishing the right things and that they have the right things on their websites. Then, whoever scrutinises it knows what the benchmark is. I think that, at the moment, there is lots of guidance but it's difficult to say, people are publishing all sorts of things, it can be an advantage but it can also be a disadvantage because Chief Operating Officers are thinking *'I might not have done the right thing'* and wondering if they are going to get caught out and *'Will this reach the press?'*

On reflection on my Trust experience, if the question is about *'Is there enough guidance to help public sector bodies as organisations?'* then the answer is *'Probably No!'* because I went to somebody on the board to ask what information to publish. I think there is enough information for me as the equality manager to know what to publish but actually in terms of the service delivery side I find that, as an individual and equality manager that it is down to me to make sure that the information is together and published. So I suppose it's about *'Does the guidance tell Trust Boards what they need to publish and whether they have that knowledge and skill?'* We work in a geographical forum and the same thing that gets repeated back is that the guidance tells the equality manager what to publish and we spend our time putting together the workforce and service data. Whereas if I went to a service manager and said we need to publish equality information to ensure compliance with the public sector equality duty I would get some blank expressions. So it's about how I (equality manager) support the organisation and how the organisation supports me. I think this is the big gap in learning - in cascading the requirements.

Can I clarify that please? As an equality manager you are interpreting the guidance for your organisation and the managers?

Yes, it's very much down to me, as the equality manager, to say I need to pull this information together. So the guidance guides me but I'm not sure how effective it is in guiding the whole organisation. If I was to give the guidance to managers they would struggle.

Exactly the same its all down to me I have to rush round trying to pull reports of the ESR making sure that the data collected recently is updated for me to work with.

I agree with that but I think what I have experienced is that the guidance is quite clear, it's not difficult to understand, but I think we are moving on to how do we get the engagement for those who are in those roles to take on that responsibility. Which I think is a slightly different thing.

The guidance itself I found it sufficient and easy to understand. It's getting the engagement from colleagues across the organisation to take on that responsibility that can be an issue.

Building on what people are saying, the timeframe for meeting the specific duties for Clinical Commissioning Groups are, I think, different and, so, the information does not have to be published to the same time as PCTs so I think its setting equality objectives by October and publishing information next January. When we were designing the Equality Delivery System it was quite interesting the feedback we got from people. Some people wanted a prescriptive system whereas others wanted a more bottom-up approach. The evaluation of the Equality Delivery System was interesting as well in terms of how organisations are tailoring the system to meet their own needs. That was exactly how it was designed. It was about having a conversation between local interests and the organisation. The Equality and Human Rights Commission have said that if you carry out that engagement process and publish engagement outcomes that goes a long way to meeting your specific duty of publishing information. And, obviously, you then have your outcomes and you select priorities.

Did you all know that?

No we didn't.

It's quite clear in the Equality Delivery System to consult. The timings don't quite match, that is the problem. So if you did your Equality Delivery System after the 31st January then a whole year might not have passed before you put your evidence together again.

I think it will take a couple of years before people grasp that.

Where would you go for guidance?

Equality and Human Rights Commission website is my first port of call.

Equality dot gov would be mine. They have good summaries of the guidance.

I have also gone to ACAS. They have good information.

And NHS Employers. It's cascaded down in a weekly bulletin. And chief operating officers' bulletins.

Anything DH related

I got the distinct impression that not everyone published this year, I got that impression. It doesn't say you have to publish by 31st January it says you have to publish annually. You can publish within your annual report so I am not necessarily going to publish by 31st January. I just think there is a bit of confusion and that not everyone is aware of when exactly they should publish.

There is also some confusion about whether your objectives should determine what you should report on or whether you should report on what the guidance suggests you should report on which is different. The guidance says the kind of things you can report on are, for example, how accessible your services are, patient satisfaction, complaints, and workforce profile. But your objectives might be something completely different they might be about reducing health inequalities, inclusive leadership, and cultural competence in our managers. So they don't necessarily match the guidance we will report on those and link them.

The guidance says that we want you to determine things locally and then gives you a deadline to publish it by. With, for example, our staff survey the results can't be published until next month so all the stuff that I have published is from last year's survey, it's all out of date and that is what artificial deadlines create. It puts a false reporting structure on an organisation if you want to be fluid reporting should fit in with our reporting structures.

Statement 3: In my experience the PSED has improved on the previous duties

The statement was read out by the facilitator, participants were asked to reflect on it and then display the card (either red or green) that corresponded with their disagreement or agreement with the statement. A discussion amongst participants was then facilitated.

I think in the way it has brought all the protected characteristics together rather than having three duties is an improvement.

Bringing them together in one place is an improvement.

I think changing the requirement for completing equality impact assessments to equality analysis is an improvement as its more outcome focused.

I think, as I understand it, the changes are trying to make the point that organisations need to act on the analysis, these are all to the good.

I was just going to say that I think it's improved because it's not just about documentation now. It is about making a difference at the front line. I think that is the improvement in it. It's in how that gets delivered that there is a struggle in terms of what difference does it really make.

I don't necessarily think it has. I think we are still at the 'tick box' mentality because, again, all we are worrying about is publishing stuff by a certain date and actually it's about embedding this into the agenda and working with it. Whereas again all the focus on dates and deadlines for me that's not what it should be about. It should be about embedding and using the good practice that we had before and further developing it. Whereas I think this is just a 'tick box' in a different direction.

For me, I personally I think it's a good move because we are moving away from the single equality schemes where the action plans had hundreds of actions that were almost tokenistic and because of that the majority of those actions were meaningless. So focusing down on maybe four or five actions or outcomes; specific ones that are smart objectives, I think, focuses the organisation on making sure that they do make a difference.

I would agree with that. It makes it more realistic and achievable when you focus on four key equality objectives.

But we could have done that with the single equality schemes, we chose not to. That's my point - you didn't need thousands of objectives you could have had a very smart focus if you'd done the single equality scheme properly. And actually we might have four objectives but how many organisations will achieve them over this year?

The objectives are for a four-year period.

Yes but how are organisations working towards those objectives? Is it just another version of the single equality scheme in a different format?

Can anybody give me an example of the Public Sector Equality Duty in action? Something it has helped with or something it has hindered in your organisation?

I think with the alignment of the Equality Delivery System which we rolled out last year, just the way it raised the profile within the organisation. Because we have integrated with community services all of our engagement has obviously been through trust membership manager and with the Equality Delivery System coming along for our engagement process it has triggered a massive development programme for governors around a theme this year of getting the views of protected groups in the area. We have also been put onto the quality improvement collaborative which is the first time the QI Team were aware that an equality team has led on a quality improvement collaborative. I think that the Equality Act Public Sector Equality Duty has created momentum coupled with the Equality Delivery System. The profile of equality, diversity and inclusion across the organisation has kind of exploded.

I think it is a combination of the Act, the information and the Equality Delivery System and the E&D partners has triggered something.

I would like to say that having the Equality Delivery System and the links with Care Quality Commission standards and implementing it and now front line with a portfolio of evidence to actually demonstrate where we are meeting the Equality Delivery System has all helped and that shows an improvement. I don't know whether this is consistent.

People are not quite used to working so flexibly and are holding on to deadlines and exactly what they should for example publish. The Equality and Human Rights Commission guidance has only recommended stuff, you can see a struggle in the NHS with coming to terms with not being told what to do and when to do it by. That is the challenge for us.

Our job is to support the NHS. How do we support you through this culture change as opposed to a top-down approach?

Statement 4: I believe that my organisation has proactively engaged with the Public, Voluntary and Community Sectors more as a result of the PSED

The statement was read out by the facilitator, participants were asked to reflect on it and then display the card (either red or green) that corresponded with their disagreement or agreement with the statement. A discussion amongst participants was then facilitated.

I think that within (our organisation) we have worked with our public sector partners, particularly the council, very closely and that was as a direct result of the Public Sector Equality Duty and the need to set equality objectives. So, as well as organisational specific equality objectives which we have actually set for the Clinical Commissioning Group as well - because they signed up jointly to the PCT ones last year - we have equality objectives for (the organisation) and they have been approved by our Public Sector Group (PSG) which is all health, council, police, job centre etc, where all the very senior officers of those organisations attend. They approved those last year at the April meeting and I co-chair the

multi-agency group that delivers those objectives for (our organisation) and I am reporting back to them on progress this year. They have been set with the voluntary and community sectors - there was a big consultation and we, also as part of that, have voluntary and community sector equality and diversity group which leads a lot of that work. So I think that's a direct result of the Public Sector Equality Duty.

I was just going to say that I don't think it's made us go out to the voluntary sector and community sector more, we were actually doing the work anyway. So it's not changed anything for us. Actually, it's other drivers that have progressed us more to work with the community.

Could you explain the other drivers that you mention?

Collaborative commissioning, the Clinical Commissioning Groups are different types of organisations, we are doing a lot of other work, local partnerships are another example.

The Equality Delivery System has been the main driver for us. It has really driven most of the change that has happened; it's not been the Public Sector Equality Duty, apart from having four objectives.

The Public Sector Equality Duty, I think, triggered the Equality Delivery System. My understanding was that the Equality Delivery System was developed because of the Public Sector Equality Duty.

With my Chief Executive it's definitely the transparency element of having to publish those grades that has had an effect and drives the work to engage, and improve performance.

There is something about engagement as a whole, but also about engaging with those nine protected groups. I think a sub-question could be about '*How well the Public Sector Equality Duty and the Equality Delivery System has helped organisations to engage with the different protected groups?*'

The specific duty is about fostering good relations between the groups with protected characteristics and those who do not have protected characteristics. So how well has the Public Sector Equality Duty helped organisations to engage with protected groups?

We were doing it anyway; the only thing now is we have added the monitoring of it so we know which groups we have a proportion of and where we need to more engagement and encouragement to engage.

We have just had the first evaluation of the Equality Delivery System and the evaluation told us - and there were a large number of Trusts that took part - they have told us that the Equality Delivery System helped them to improve their engagement with the community. This was the strongest outcome from the evaluation of the Equality Delivery System. Not so much that the outcomes for patients have changed but the engagement has.

Given that the Equality Delivery System was developed as a system to help NHS organisations deliver the Public Sector Equality Duty can we explore how it has helped or not helped?

I think it has helped, particularly for us as a Trust. It's put it on the agenda, and it was approved by the Board so it got integrated into portfolios.

How has the Equality Delivery System been of benefit in your organisation?

I think it's about Chief Executives not wanting 'reds' on their dashboards. That's really cynical but that's what makes them focus when they see a possible red. It makes action happen. It gives that power to actually get something done.

Have you got any tangible examples of what the Public Sector Equality Duty has helped to improve apart from monitoring?

It would be the monitoring because it's something that we didn't do/ didn't do very well prior to Public Sector Equality Duty and Equality Delivery System. It's something now that Clinical Governance look at and all our assurance committees are all on board with ensuring that we are doing the monitoring and that we are able to collect the data; putting the funding in so that someone can input the data to make sure that we can use it. It's also an assurance scheme the Care Quality Commission, etc all sit up and listen to.

I think that the integration of community services very much did engagement; it's quite a new role for me to be doing that. I think what it did is the staff - when we did the engagement - and the community groups felt that they could score the organisation. It really empowered people, it really felt like they were having a say. The first time I did engagement it felt like there was an outcome that you could show people. The fact that we had something to work with, that they were empowered to score us was a really powerful tool.
At the end of it I had a lady who said she had been doing engagement work previously and had been on citizens' panels and she said that it was the first time she had understood why we do what we are doing and how its moving the organisation forward. She was 80 + and she said '*Thank you so much for this*' It was the whole Equality Delivery System tool that helped this to happen.

We have actually found the opposite; we have found that people are really reluctant to score us because they don't feel they have a high enough knowledge base to do that. I fed that back, we found that over two successive years. I fed that back for the Equality Delivery System review.
The VCS groups do have a higher knowledge base and are able to do that. Our public sector partners, HealthWatch are able to do that, but when we say '*How do you think we are doing?*' they say '*Look, I'm sorry I just don't feel that I know enough about the organisation all be it that you have presented this evidence to me*' The engagement itself was really good and we had a lot of really positive feedback and a lot of negative feedback and things we can work on, but we just couldn't ask people to score us. It didn't work at all.

The actual Equality Delivery System tool didn't have anything for the public to use. There wasn't a toolkit for the public, patients and public. When we were going out to groups to engage with them, we spent quite a lot of time telling them what it was we were trying to get them to understand, trying to get them to understand the Equality Delivery System.

The Equality Delivery System has one piece of support material on engagement, there is another tool to support Equality Delivery System which NHS Employers is proposing to the commissioning board going forward because of the feedback that we have had. One of

the things that the DH did when Equality Delivery System was designed was ï it needed an instrument to support staff, patients and the public in holding the NHS to account in terms of equality duties. This is a piece of work that we think is going to go forward. A tool is on its way, in actual fact, a lot of work has been done on the tool and then the transition held it up.

Statement 5: In my experience the PSED has resulted in organisations adopting a more integrated approach to equality

The statement was read out by the facilitator, participants were asked to reflect on it and then display the card (either red or green) that corresponded with their disagreement or agreement with the statement. A discussion amongst participants was then facilitated.

I think itôs been mixed. I think that in terms of monitoring we have looked at patient satisfaction, so all our patient satisfaction scoring is done with the 7 protected characteristics so that we can tell how satisfied people are across this spectrum. Itôs been amazing, there is nothing like patient satisfaction by protected characteristics to make services actually sit up and say ï well, actually, our LGBT customers donôt appear very satisfied. There must be something we can do here. So itôs been really good from that perspective, but when it comes to doing focussed work, I think we still had a very separate approach so working with the LGBT community is very different to working, say, with women. I think we have still maintained a separation at some level.

I think there has been very much, at the outset of the formation of the Clinical Commissioning Group a desire to make sure that we get this right and what I am hearing from, not necessarily because of the Public Sector Equality Duty, they are not looking at it from a legal perspective, more from a moral perspective, which is a better way forward; we are not doing it because the law says we have to, we are doing it because we want to. Certainly with the executive directors there is very much ï one of our objectives ï we scored red on managers supporting staff to work in culturally competent ways ï we are running health community training courses which will start very shortly because all organisations in the NHS scored red on those ï to move us on to developing and I have had no directors coming back to me and saying no Iôm not going to send my staff on it. I have had one director, in particular, saying ô*I want as many people as possible to do it and I am going to do it myself*ô So I think there is an appetite to do it, but itôs not necessarily because the law says they have to itôs because they want to.

I just want to say we have integrated it with the Care Quality Commission standards and evidence. I think the difficult part has been about data. We know our data systems donôt collect by the nine protected characteristics and continually ï I worked with the region on pulling together guidance to then take forward and agree, because until that comes from the national office the Department of Health to say you need to collect the patient data by protected characteristics our patient data is not going to do that. Therefore, that is not flowing right through to teams to support them to collect the data. So there is some kind of support and help and some not, I think itôs very mixed as to integration.

Even within organisations this is mixed.

I agree because some of positive people said we have not got any directive from the Department of Health to say we have to record this equality monitoring data. Yet the Public

Sector Equality Duty says we have to do it so there is massive conflict there. We are not going to change this until we get a directive from the Department of Health. I have experienced that.

It's the same with GPs as well.

I think it is in development at the moment.

Statement 6: **The PSED and/ or the specific duties has resulted in an increase in requests for the equality statistics/ information we hold and for our EIAs**

The statement was read out by the facilitator, participants were asked to reflect on it and then display the card (either red or green) that corresponded with their disagreement or agreement with the statement. A discussion amongst participants was then facilitated.

I have never had a request before apart from equality impact assessment.

Have you had a request now?

No

Likewise we had minimal requests before - the only F.O.I. request had links to equality.

I think we had one request for an EIA and then there was a lot of scurrying around to make sure it was done. But no, certainly since the Public Sector Equality Duty has come along I have seen no requests at all.

We do know that there was an audit on checking equality information last year, they did a web audit.

Who did this?

I think it was the Equality and Human Rights Commission

So, do I take it that no one has had an increase in requests either for any of the equality statistics or for EIAs?

What about internally when someone is designing or redesigning a service or making changes etc?

No. I have to give information and stats to them - they don't ask me for them.

The only way we have had an increase is because we have a document control procedure now where you have to complete an equality screening and equality outcome assessment at the end of it. No document can be approved without it.

Even to the point where I am now integrating the process into our project management so any projects that come on board ï but even then it's not every piece of work is going to go through that process, so there are still gaps.

We gave our panels quite a lot of statistics last year - a pack of what we had published and they had so much trouble with it, it was really difficult for members of the public even people in the voluntary sector to interpret a load of tables.

Did you do the analysis with them?

I do now, I do it visually and I have done the demographics but even then it's such a high level for people it really doesn't relate to your own personal experience of services.

Can I also say that data collection is hard enough but data in terms of national statistics are hard to get, let alone local data. There is an inconsistency which makes it difficult

In the health sector if you look at equality statistics in terms of access to services they are collected by prevalence so you can't tell whether the service is being equally used if you don't have it in your prevalence statistics. They have to be drilled down to quite a low (local) level. That is quite a complex analysis. There is no guidance on how to do that.

I think there is some work coming up on the data warehouse to make it a repository of information we need.

Statement 7: In my experience, the PSED has reduced the burden on public bodies in terms of resources, personnel, time etc

The statement was read out by the facilitator, participants were asked to reflect on it and then display the card (either red or green) that corresponded with their disagreement or agreement with the statement. A discussion amongst participants was then facilitated.

I think the workload has actually increased but that maybe as a result of the Equality Delivery System being developed to help compliance with the Public Sector Equality Duty.

I think the Public Sector Equality Duty and Equality Delivery System understanding has increased the workload. But it is work that we should be doing, but because it has put it higher up the agenda and its being performance managed.

It's a good thing for the equality agenda because things are moving.

I would say that the increase is probably around timescales and deadline. Any that is probably where people felt that the activity was. The 31st March and the Equality Delivery

System deadlines so you probably would have seen quite a marked increase in workload at that time as opposed to generally over /every year. Because all the stuff that is in there is stuff that we would be doing anyway.

I would agree that the timescales, because equality schemes had a three year lifespan and for good or ill you only had to review them every three years. And you didn't have to publish equality information annually which is fine, and I have to say that our equality scheme was a huge unwieldy document with hundreds of actions. Equality information is a lot shorted but took a lot of activity to get it and publish it to the deadline. I am also finding that in my role as performance monitoring providers I have had to recognise that there has been an awful lot of change with their equality staff and I am having to spoon feed them to make sure they are compliant and I feel as if I'm making sure that all the organisations even the those who I don't work for are relying on me to make sure it is done. I think it's the performance management thing for example in provider organisations some of which are very up to speed and some who need an awful lot of pushing. This has increased my workload.

I agree, I think the setting up of artificial deadline has increased the workload. I know that we in the (55.50) we have our commissioners who we have to report to and we have been asked to agree a date for when we can meet with commissioners to publish equality information. What we are trying to do is integrate all of it into a fluid report that we can use. Because we have the Equality Delivery System, we are saying to commissioners if we use Equality Delivery System and sign that off with them, do our Equality Delivery System scores and the 31st January deadline which kind of tweaks all your then the report twice a year so again it just feels that you are setting these deadlines to create a very artificial, stressful and undue pressured environment.

It doesn't even fit with the contracting round or anything.

Is the 'burden' because of the Public Sector Equality Duty, changes that are happening in the NHS is it because of a new system of monitoring, how would you attribute the 'burden'?

I don't think it is because of the Public Sector Equality Duty I think it's because of the Equality Delivery System. I have noticed my workload increase because of the Equality Delivery System and its reporting requirements and the Public Sector Equality Duty , if you read it, it's not onerous there is little in it you don't have to publish anything really. I don't really see, I don't think it says that you have to publish on the 31st January either it just says you have to publish once a year.

The first deadline date was the 31st January, last year and then annually thereafter so you can then choose.

I'm going to choose to publish with my annual report so I am going to publish twice this year once on the 31st January and once with the annual report then next year I will just have to do it with the annual report cycle. I think it's just this first year; the transition phase.

Statement 8: My organisation has changed/ put in place methods to mitigate or reduce the risk of legal challenge

The statement was read out by the facilitator, participants were asked to reflect on it and then display the card (to red or green accordingly) that corresponds with their disagreement or agreement with the statement. A discussion with participants was then facilitated.

It has made me publish equality information annually which helps us.

Iôm not sure we have changed anything else because we already had an equality impact assessment procedure. I know that the Public Sector Equality Duty talks about equality analysis, I had enough trouble getting people to do EIAs so if I had said you have now got to do equality analysis, they would have said so I have to do that as well so I havenôt changed the name I have just made the point that we will use EIA to do our equality analysis. So no it hasnôt.

I agree, one thing we did change was the equality Impact assessment to equality analysis so as to make it more streamline and understandable and less bureaucratic.

I have added the other protected groups to the process.

But the law does not say that you have to do equality analysis does it. The fact is we have chosen in the NHS to do equality analysis so as to be able to prove that we have complied with the duties.

I think then the other question is how you then say that you have not disadvantaged a protected group. So it is a way of proving that we donôt disadvantage a protected group.

Statement 9: My organisation has progressed well how it embeds / mainstreams equality and diversity considerations

The statement was read out by the facilitator, participants were asked to reflect on it and then display the card (either red or green) that corresponded with their disagreement or agreement with the statement. A discussion amongst participants was then facilitated.

The group felt that they had already addressed this statement in statement 5.

Statement 10: I believe senior leaders are clear about their role in ensuring the commitment of public bodies to mainstreaming equality

The statement was read out by the facilitator, participants were asked to reflect on it and then display the card (either red or green) that corresponded with their disagreement or agreement with the statement. A discussion amongst participants was then facilitated.

Yes, senior leaders are aware of their duty, they know what is required of them and they know what to do. On the flip side I am doing the role for them. They have a strong reliance on equality leaders.

I agree.

I think having come today has increased my awareness materially. Today was useful. Similarly we have been summoned by the safeguarding adults people as well. It focuses them on the things they have to attend to.

I feel that, in our organisation, we have some real clear leaders at board level who understand where this is going whereas some other managers want to know how this comes under QI and reducing cost. We have some real champions,I have noticed over the last six months, who completely see where we are going with this and understand the whole business case. I think there are other people at board level who if I went to them and asked them to explain that statement would look at me blankly.

Has equality and diversity influenced how you commission services or have you examples of commissioning and delivery where its made a difference?

We have included equality and patient focus in a number of tender documents where I have actually been involved in pulling the questions together and evaluating the responses. For example, our Out of Hours, a primary care service we are just commissioning and that has invoved training patient groups around the equality duty and having patient representatives to come and evaluate them with myself and a colleague.

We also have noticed that - as a provider - when we are filling out tenders we see those questions and have to demonstrate how we are meeting the requirements. Commissioners in terms of equality and diversity are stronger.

We have run out of time, thank you all for participating.