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Rob Hayward
Chair, PSED Review Steering Group
Government Equalities Office
2 Marsham Street
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31st May 2013

Dear Rob

Re: Submission of evidence from the health sector for the Ministerial Review of the Public Sector Equality Duty

Healthcare in England is, in the main, provided by England's public health service, the National Health Service, that provides healthcare to all permanent residents of the United Kingdom that is free at the point of use.

The workforce within the health sector is at the heart of decision making about health care services and their delivery, as well as being service users themselves and therefore has extensive experience of the implementation of the Public Sector Equality Duty.

I am delighted in my role of representing the health sector, to present with this letter, evidence towards the Ministerial Review of the Public Sector Equality Duty. This evidence consists of (i) a report on the deliberations from round table discussions focussing upon the effectiveness of the PSED and (ii) a summary of evidence of the extent to which the Equality Delivery System supports NHS organisations to meet the Public Sector Equality Duty.

The Equality Duty is an effective way of operating that has allowed health care organisations to recognise people's different needs and to achieve better outcomes for all service users. During a time when organisational transparency and quality of care are more important than ever, the Equality Duty is viewed by the health sector as an essential practical tool.

Inequalities of access, care and outcomes still exist, and there are instances when people are not treated with the dignity and respect that they deserve. By recognising that every person has different circumstances, we can better meet

High quality care for all, now and for future generations

needs and improve outcomes for all. Evidence indicates that the Equality Duty goes a long way in helping us to achieve this. In addition, for NHS organisations, the Equality Delivery System appears to be an invaluable tool that helps to meet the Equality Duty.

On behalf of the health sector, I would urge for the accompanying evidence to be given full consideration during the Review of the Public Sector Equality Duty.

Yours sincerely

A handwritten signature in cursive script, appearing to read 'Paula Vasco-Knight'.

Paula Vasco-Knight
Chief Executive, South Devon Health Care Foundation Trust
National Lead for Equality, NHS England

Research on Implementing the Public Sector Equality Duty

**Contribution towards the Health Sector's evidence
for the Ministerial Review of the Public Sector
Equality Duty**

May 2013

Initial draft prepared on behalf of the Health Sector by NHS Employers and Reddenhill Consulting Limited

Contents

	Executive summary	3
1	Introduction	4
2	Aim and objectives	4
3	Participants	4
4	How the sessions were run	5
5	Findings	6
6	Conclusions	19

Executive Summary

On behalf of the health sector, the Department of Health (since April 2013, this work has been led by NHS England on behalf of the health sector) commissioned NHS Employers to conduct exploratory research that would contribute towards the Ministerial Review of the Public Sector Equality Duty (PSED).

This report presents deliberations from six round table discussions involving a total 106 participants, held by NHS Employers between February and April 2013. Participants represented a range of health care organisations from across the country.

Participants communicated a diverse range of views drawn from their functional perspectives of operating at a variety of service levels across an array of healthcare and partner organisations. Despite this, care needs to be taken when ascribing the views of this relatively small sample of participants, to the health sector as a whole.

Participants indicated sufficient guidance to help public sector bodies understand the Public Sector Equality Duty. There was a general feeling that the Equality Act 2010 and, in particular, the PSED was a general improvement upon previous equality legislation – with a more clear approach towards outcomes for patients, communities and staff.

Improving meaningful engagement with the wider community was viewed as a positive feature of the PSED, with data and evidence resulting in a better understanding of the populations that health care organisations served. Indeed, the Equality Delivery System for the NHS (EDS) was seen as an effective tool to help support (NHS) organisations to meet the PSED.

However, as the PSED only came into force in April 2011, participants, in general, felt that it may be too early to measure its impact and that further time was necessary for it to be embedded within organisational processes.

1. Introduction

The Government Equalities Office (GEO) is undertaking a Ministerial Review of the Public Sector Equality Duty (part of The Equality Act 2010), to establish whether the Duty is operating as intended.

On behalf of the health sector, the Department of Health (since April 2013, this work has been led by NHS England on behalf of the health sector) commissioned NHS Employers to conduct exploratory research that would contribute towards the Review.

The findings of this research exercise are presented below.

2. Aim and objectives of the research

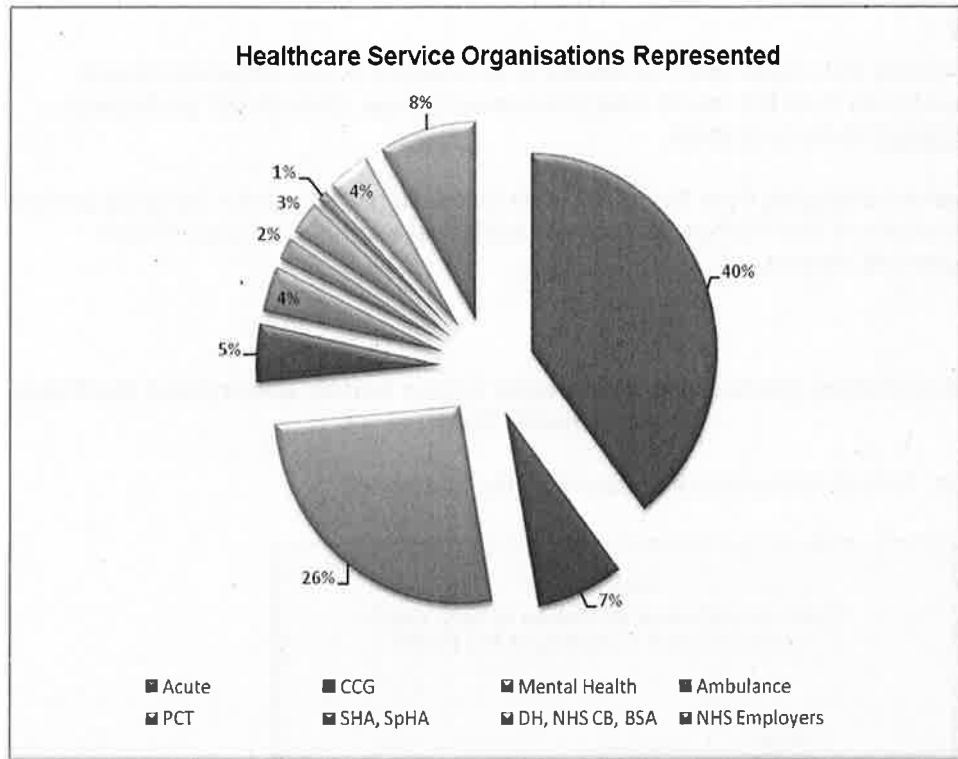
The main aim of the research was to collect the representations of the health sector in regard to the operation of the Public Sector Equality Duty.

The objectives were to examine:

- how both the general and specific duties are working;
- how effectively the Duty supports delivery of the UK Government's Equality Strategy;
- options and recommendations for changes or improvements in the way the Duty operates

3. Participants

A total of 106 individuals participated in the research, including executives, policy makers, advisors and front-line staff. Contributions were noted, for example, from senior managers, corporate executive directors, non-executive directors, inclusion managers, heads of engagement, development advisors, equality and diversity managers and strategic leads, community development workers, project workers and training and development advisors.



4. How the sessions were run

For each individual round table session introductions were facilitated with each participant stating their role, organisation's name and type of organisation which s/he represented. Each participant was provided with a statement sheet, and a Public Sector Equality Duty Aide Memoire on the reverse side.

The statement sheets were explained to participants as enabling participant recordings of an 'on the spot' reaction conveying disagreement or agreement with each statement from which discussion could emerge and providing a tool for collecting quantitative data.

Participants were asked to record the type of organisation that they worked in on each statement sheet. Participants were informed that they would be guided as to when to complete each statement. All participants were asked to maintain confidentiality to within the group.

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.

Sessions were brief and lasted no longer than one and a half hours in duration.

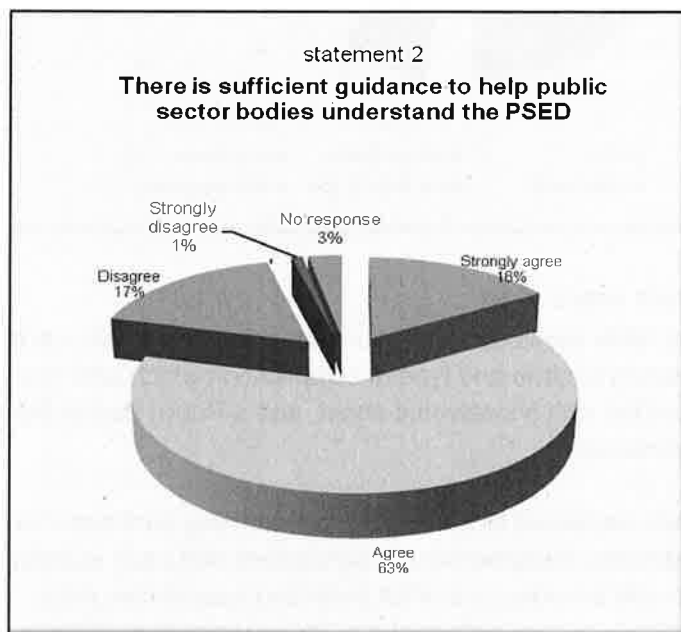
5. Findings

This section provides the reader with the results of an analysis of the statement sheets together with examples from the round table discussion groups. Overall 106 participants returned a completed statement sheet.

The general themes emerging from the round table discussions have been captured and are laid out in the analysis of the findings below, with additional examples of quotes from participants to provide context.

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

Overall Findings: 79% of respondents agreed with the statement



Key analysis from round table discussions

Analysis of the findings provides evidence suggesting that:

- sufficient guidance is available.
- what does not tend to come across in the guidance is a focus on people, the need to regularise and understand the different needs of individuals and how to reflect this in advancing equality in organisations.
- there is a recognised 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.

- there is enough information for equality managers but not necessarily in language appropriate for service managers and staff.
- the guidance is quite clear, but there is work to be done to cascade the understanding throughout organisations.
- some people will want a prescriptive system whereas others want a bottom-up approach.
- the following agencies are 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.

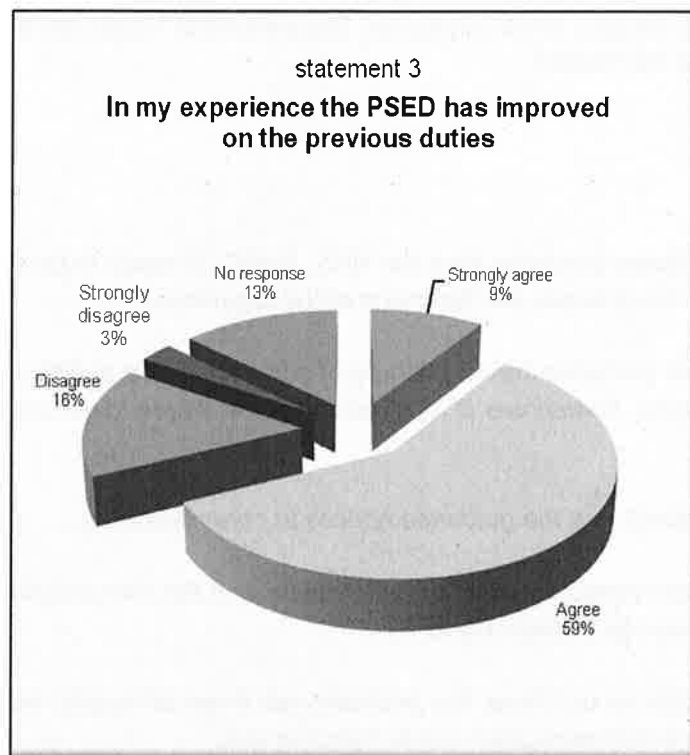
Narrative quotes

- *Yes, there is sufficient guidance from the NHS, EHRC. It needs to be more concise and appropriate for all levels and functions of the organisation.*
- *There is sufficient guidance from a plethora of sources, aimed at different levels within organisations. Sometimes (it is) difficult to know where to go and which is reliable.*
- *Clarity needed about how the guidance applies to commissioners.*
- *There is more than enough guidance; the problem is in the interpretation of the guidance which can be a major issue.*
- *Mountains of guidance out there. For professionals it can be helpful; sometimes how the messages are communicated needs improvement.*
- *Guidance is not purely for equality professionals; it has to be for a number of interested parties including trade unions, Boards, staff and patients.*
- *It is the role of equality professionals to translate guidance for the organisation providing context for different services/ roles.*
- *The joint health and social care agenda is taking us in a different direction so EDS and PSED need to be amended to fit the new approach to providing services.*
- *The cornerstone of PSED is your data that you publish. PSED only works if you can demonstrate that you have data that illustrates that you are meeting your compliance duties.*
- *EDS provides us with a policing system, for example, when we invite member of the public to assess our organisations.*

- *Good governance produces good results for PSED.*
- *Examples of good practice within guidance would be useful.*

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

Overall Findings: 68% of respondents agreed with the statement



Key analysis from round table discussions

Analysis of the findings provides evidence suggesting that:

- generally, bringing the protected characteristics together rather than three duties represents an improvement.
- equality analysis was generally thought to be an improvement to equality impact assessment.
- there continues to be a 'tick box' mentality rather than an embedding process.
- the new approach to objectives was more realistic and focused on actions and outcomes.

- a combination of the Public Sector Equality Duty, the Equality Delivery System and the links with the Care Quality Commission standards has resulted in triggering improvements.
- 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.

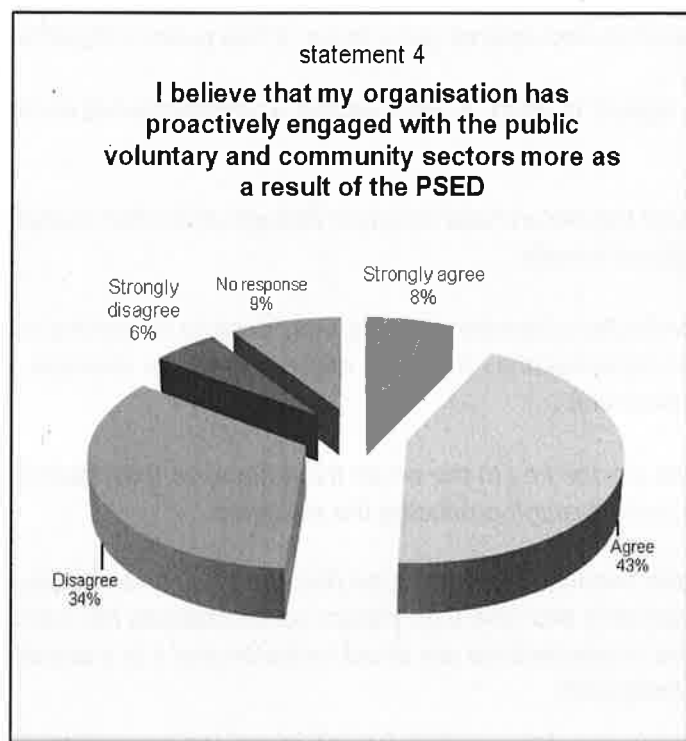
Narrative quotes

- *It maybe the culture of the organisation - not the legislation - that determines compliance with the PSED.*
- *Yes, there has been an improvement. What has happened is that the people who they felt were discriminated against get a focus. It has pulled it together quite nicely.*
- *The duty of 'due regard' is good. It helps people understand what is meant by 'due regard'.*
- *The law has moved the hierarchical structure through protected characteristics to which weighting them equally.*
- *Out of the nine protected characteristics the easy ones to fix are the ones that seem more attractive to organisations. The more difficult areas, for example, around race then take a backward step.*
- *The specific duties are the key to the whole thing because they identify what an organisation has to do through producing the evidence.*
- *I think it has helped because the landscape has changed. The interplay between protected characteristics and how they impact on life chances has come to the fore. The nine protected characteristics are about inclusion and it is a positive thing that we look at them holistically.*
- *Good improvement because it is more evidence-based.*
- *Improvements in data collection leading to setting the road map for improvements. It has been used to set some positive action programmes.*
- *From where we were – originally, race, gender and disability – yes, it has been a massive step forward.*
- *Not including socio-economic requirements within the duties was a bad thing; it was key to moving health inequalities forward.*
- *It was helpful to move away from the bureaucratic approach.*

- *It (PSED) has, through EDS, raised the profile of equality within the Trust.*
- *The PSED has simplified and clarified a lot of issues around different equality groups.*
- *It is brilliant that we have all nine protected characteristics as genuine areas for discussion. It also means that you can always refer to situations that people understand.*

Statement: 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

Overall Findings: 51% of respondents agreed with the statement



Key analysis from round table discussions

Analysis of the findings provides evidence suggesting that:

- as a direct result of the Public Sector Equality Duty, working with public sector partners, voluntary and community sectors has increased for Clinical Commissioning Groups and NHS Trust.
- engagement work was ongoing through drivers such as commissioning and the Equality Delivery System. The Public Sector Equality Duty may have been the trigger.

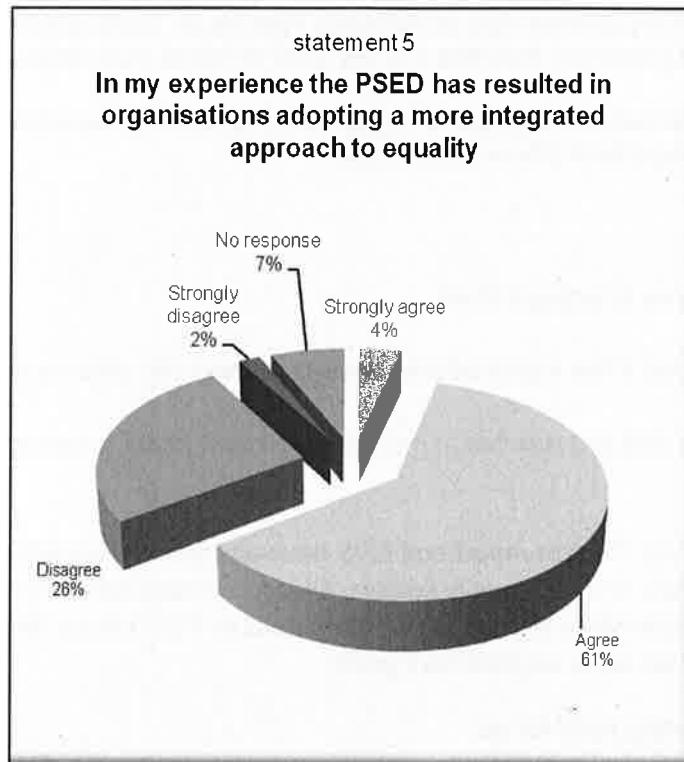
- the transparency element of publishing was seen as a driver for change.
- engaging with groups with protected characteristics was seen as ongoing. What appears to have changed is how these activities are monitored and reported upon.
- the Equality Delivery System was consistently seen as an under-pinning tool to drive investment in engagement activities and the level of Board commitment.
- some of the organisations that did not agree to the statement, were those that already had engagement processes in place.

Narrative quotes

- *EDS has helped us to engage more.*
- *Strongly agree that it has improved how we engage with the patients and the public.*
- *It has been EDS that has resulted in more engagement which is based on delivering the PSED.*
- *Patient Family Test, Francis report and EDS have all impacted on engagement with the public voluntary and community sectors. Disaggregating these from the PSED is difficult. The debate about whether it has been EDS or PSED is not relevant as they go hand in hand as far as engagement goes.*
- *PSED was a starting point for us.*
- *We have service engagement groups that are well representative of protected characteristics. As well as consulting wider. The positive outcome is the change in relationships between staff and service engagement representatives.*
- *Usually representatives from different groups are united when they are helping us*
- *We have a project around breast feeding where the local clinicians are working with community groups and community shops to make sure there are safe areas for breast feeding which is work that was on-going anyway but we would link it to the PSED.*

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

Overall Findings: 65% of respondents agreed or strongly agreed with the statement



Key analysis from round table discussions

Analysis of the findings provides evidence suggesting that:

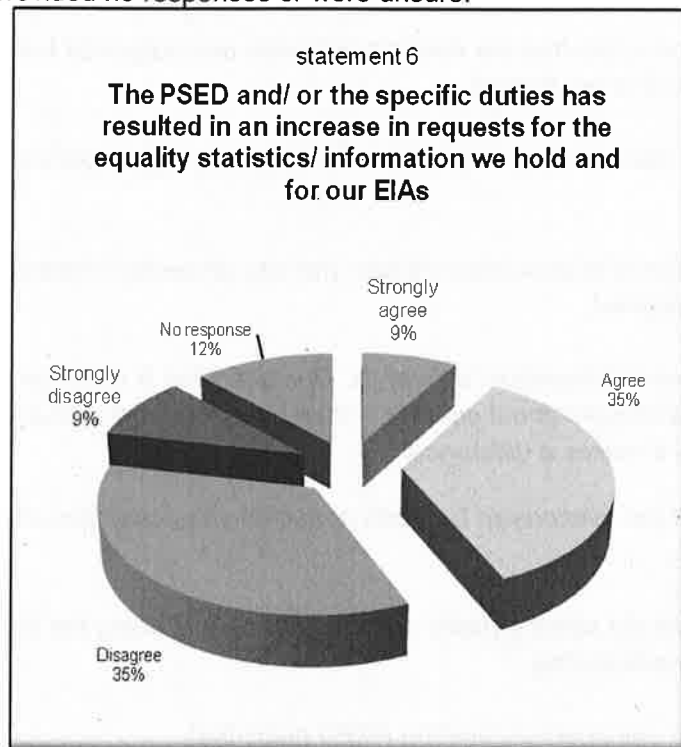
- equality was seen as integrated into the authorisation processes of Clinical Commissioning Groups.
- a high reporting of 'red' on health community training indicated considerable distance of travel in adopting a more integrated approach in relevant services.
- the embedding processes are beginning to demonstrate alignment with meeting key governance and assurance systems; for example, equality is being integrated with Care Quality Commission standards and evidence.
- some data collection systems were insufficiently robust to collect data by protected characteristics.
- the recording of data by protected characteristics would only take place if there were to be a directive from the Department of Health [this is currently being produced by NHS England].

Narrative quotes

- *It has been a challenge for us as an Acute Trust; it may be about size. PSED has helped. It may not be consistent across the organisation.*
- *What I have found is bits that are easier to integrate are integrated but difficult areas of equality continue to lag behind.*
- *It has to be 'yes' because now it includes nine strands whereas before there were three.*
- *It is now more aligned to population needs - the way protected characteristics are delivered and designed.*
- *People use the word 'integration' differently. One definition is when service managers have a conscious thought about equality in their everyday work and are able to demonstrate that it makes a difference.*
- *It has highlighted the relationship between protected characteristics and health inequalities.*
- *I think that it's now not about equality and diversity people doing the work, but more about everyone participating.*
- *It's about change management and the PSED helps that.*
- *I don't think it has really had time to show benefits yet. Change doesn't come overnight.*
- *EDS - although not perfect, there appears to be flaws in the grading system - has acted as a lever for the PSED.*
- *It has helped us to be a little more transparent.*

Statement: 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

Overall Findings: 44% of respondents agreed with the statement and 44% disagreed. 12% of respondents provided no responses or were unsure.



Key analysis from round table discussions

Analysis of the findings provides evidence suggesting that:

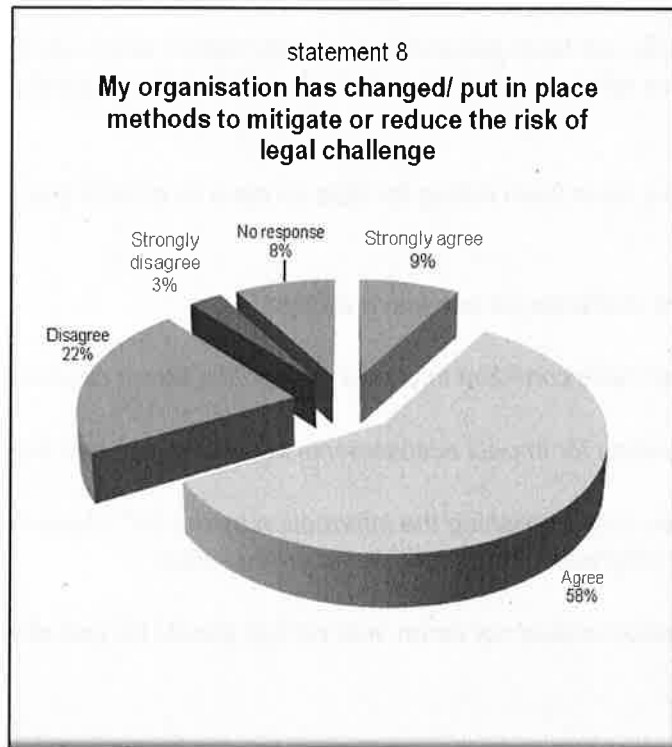
- there has been no significant increase in requests for equality statistics.
- very few requests were made for equality impact assessment information as a result of PSED.
- increased levels of engagement with public and partners involved sharing statistics and information.
- data in terms of national statistics continues to be hard to find and inconsistent.
- in the health sector if equality is not in the prevalence requirements then it will not be collected and that can create a barrier to accessing information to guide service design, development and improvement.

Narrative quotes

- *There has been an increase but not a significant increase as a result of the PSED. Public (are) more aware as are senior people in the organisation.*
- *Not for us. Internally, we have generated more information which we have been able to utilise to improve efficiency and commissioning. This is the biggest area for improvement.*
- *Local organisations have been asking for data as have local MPs and interest groups.*
- *Seen slightly more challenge on service re-design.*
- *People need to get more confident in challenging public sector organisations*
- *The only people asking for impact assessments in our organisation are the Trade Unions.*
- *All of us have been busy publishing the information by the 31st I haven't had one single request for information from outside the organisation.*
- *Publishing information should not be an 'add on' but should be part of our annual reporting system.*

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

Overall Findings: 67% of respondents agreed with the statement and 25% disagreed.



Key analysis from round table discussions

Analysis of the findings provides evidence suggesting that:

- publishing equality information was helpful as were the equality impact assessment processes.
- the transition to equality analysis was at varying stages within different organisations.
- equality impact assessment/equality analysis were seen as ways of evidencing compliance with the Public Sector Equality Duty.
- generally, systems were in place to mitigate legal challenges.

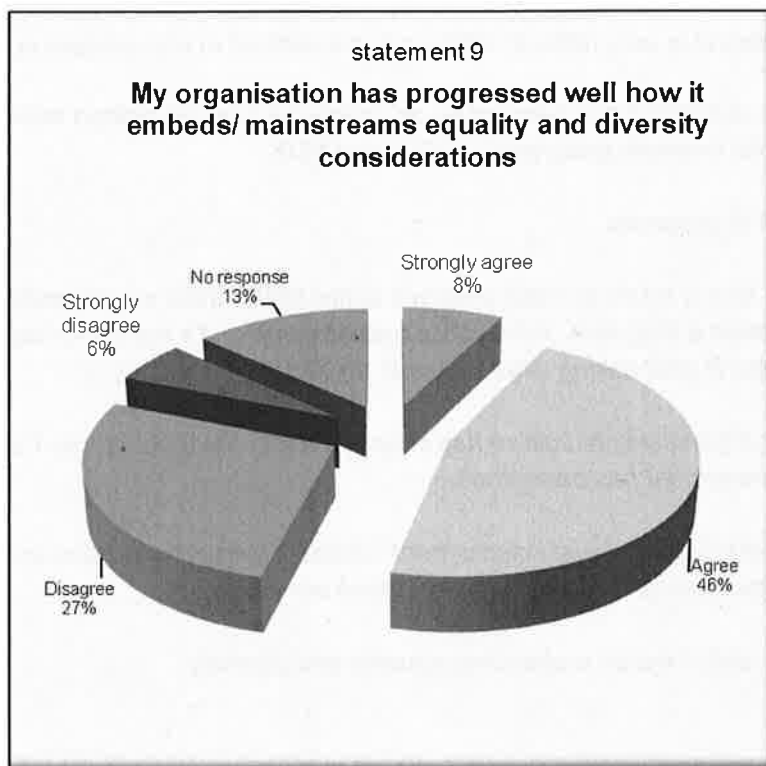
Narrative quotes

- *Some boards have a legalistic approach to equality and diversity.*
- *HR consistently requires advice to avoid legal challenge.*
- *Already got strong governance. Well embedded in governance.*

- *We have included equality and diversity on our risk register which has worked well.*
- *Where an organisation has already had a legal challenge they are more likely to put things in place.*
- *My organisation hasn't changed anything. But this does not mean that we don't need the PSED. If we took the PSED away it could be dangerous.*

Statement: My organisation has progressed well in embedding and mainstreaming equality and diversity considerations

Overall Findings: 54% of respondents agreed with the statement



Key analysis from round table discussions

Analysis of the findings provides evidence suggesting that:

- progress on embedding equalities was varied. Of particular concern was the synchronisation with reporting mechanisms.
- engaging middle managers with the equalities agenda was a difficult area.

- embedding/ mainstreaming was described as part of change management and a long-term plan, therefore, this stage of implementing PSED was considered too early to determine effectiveness.

Narrative quotes

- *The link between clinical effectiveness and patient safety and patient experience needs to be clearly made. These are vital to the NHS going forward.*
- *Yes, with the use of EDS, Francis report, and other national reports.*
- *We have improved data collection but this does not always translate into mainstreaming equality and diversity.*
- *Getting public health disaggregated information – needs assessment (by protected characteristics) is very difficult. Without it, it is difficult to mainstream equality.*
- *A number of issues have focused us on improving how we embed equality and diversity, for example geography, PSED and EDS.*
- *It's a work in progress.*
- *Given the time it takes to make changes in the NHS I think we are doing quite well. Change takes a long time. If it's about mainstreaming, it's not really happening. The organisation is now asking what they can do better.*
- *I think our organisational culture has changed a lot; now people ask if an equality impact assessment has been done.*
- *PLACE visits (Patient Lead Assessment Clinical Environment) have an equality and diversity question so that any equality issues are picked up.*
- *There is a shift towards embedding equality and diversity.*

6. Conclusions

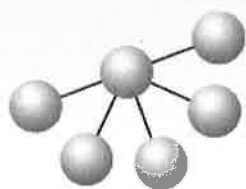
This report presented deliberations from six round table discussions involving a total 106 participants, held between February and April 2013. Participants represented a range of health care organisations from across the country.

Though the timing of the Ministerial Review of the PSED may be too soon, in general, findings from this research exercise indicated a positive reflection upon the PSED. The PSED is viewed as an improvement to previous equality legislation, providing a holistic approach to equality.

The move towards objectives and a focus towards outcomes were generally considered by participants to result in realistic and positive differences. In addition, working with the voluntary sector, community sector and public sector partners was reported as increased through the Public Sector Equality Duty and the Equality Delivery System (EDS), as was engagement with groups with protected characteristics.

REVIEW OF EVIDENCE

Review of evidence of the extent to which the Equality Delivery System (EDS) supports NHS organisations to meet the Public Sector Equality Duty (PSED)



SHARED INTELLIGENCE

Contents

Executive Summary	3
1 Introduction	7
Methods used for this evidence review	7
Structure of this report	9
2 To what extent does the EDS support NHS organisations to meet the general principles of the PSED?	10
Supporting NHS organisations with legal compliance	10
Strengthening organisational leadership for equality	11
Embedding equality/making it core business	14
Supporting NHS organisations to become more outcomes-focussed	18
3 To what extent does the EDS support NHS organisations to meet the PSED General Duty?	19
Eliminate discrimination and advance equality of opportunity among ‘new’ and ‘old’ protected characteristics	19
Foster good relations between people who share a Protected Characteristic	21
4 To what extent does the EDS help NHS organisations to meet the PSED Specific Duties?	25
Specific duty to publish relevant, proportionate information/data showing compliance with the Equality Duty	25
Specific duty to set equality objectives	28
5 Conclusion	32

Executive Summary

Introduction

This report presents the evidence in support of the role of the NHS Equality Delivery System (EDS) in helping NHS organisations to become compliant with the Public Sector Equality Duty (PSED) as required under the Equality Act 2010. The report examines three principal questions:

1. To what extent does the EDS support NHS organisations to meet the general principles of the PSED, defined as
 - Supporting legal compliance with the Equality Duty 2010
 - Strengthening organisational leadership for equality
 - Embedding equality/making it 'core business'
 - Outcomes focussed.
2. To what extent does the EDS support NHS organisations to meet the PSED General Duty, which requires public authorities to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations across all of the characteristics protected by the Equality Act 2010, including 'new' as well as 'old' characteristics.
3. To what extent does the EDS help NHS organisations to meet the PSED Specific Duties, under which all public bodies are required annually to
 - publish information to demonstrate how they have complied with the general duty
 - set themselves one or more equality objectives in order to fulfil one or more of the aims of the duty.

To what extent does the EDS support NHS organisations to meet the general principles of the PSED?

Legal compliance

Compliance with equality legislation was the main motivation for EDS implementation for NHS organisations taking part in the research (with the exception of Mental Health trusts who were more motivated by improving outcomes). Compliance was a particularly strong driver for Acute trusts (across organisation type) and NHS organisations in London (across the broad regions).

Organisational leadership for equality

Raising the profile of equality among senior management and leaders has been the biggest impact of the EDS for NHS organisations surveyed (although London reported a lower impact than other regions). Senior managers outnumber equality and diversity officers as the organisational leads for EDS outcomes. It was found to be more of a challenge to engage

senior managers than the Board in the EDS, although both were less challenging to engage than middle managers.

The Board is engaged in EDS governance in two-thirds of NHS organisations (Mental Health trusts reporting the most engaged Boards and senior managers across organisational types). Boards and senior managers in the North and in Foundation Trusts were less involved and influential in the selection of organisations' equality objectives than those in other regions and in non-Foundation trusts. London Boards and senior managers were reported to be the most involved and influential in the selection of equality objectives; with London organisations also the most likely to have shared their equality objectives with Boards and senior managers.

Embedding equality/making it 'core business'

Embedding equality across the organisation was a strong driver (third highest scoring) for EDS implementation among NHS organisations surveyed. This is less of a driver for NHS organisations in London than other regions, and London organisations also reported a lower impact than other regions on organisational commitment to equality.

However, NHS organisations based in London and the Midlands are more motivated than other regions by the EDS helping them deliver key 'core business' NHS frameworks and standards; and both regions are also more likely to have shared their equality objectives with the whole organisation.

Three-quarters of NHS organisations reported positive impacts of EDS on increased commitment to, and staff awareness of, equality. Commissioners and Mental Health trusts reported a higher impact on commitment to equality than other organisational types; and Mental Health trusts were more likely than others to have shared their equality objectives with the whole organisation. The research found specific examples, mainly among commissioners, of NHS organisations using the EDS to integrate equality into organisational 'core business' such as contracts, planning and service design.

Outcome focussed

Achieving improved outcomes for patients, carers, communities and staff was the second strongest driver for EDS implementation for NHS organisations (with the exception of Mental Health trusts for whom it was the strongest driver). It was a particularly strong driver for non-Foundation Trusts and for NHS organisations in the Midlands and the North.

Patient/community facing outcomes are more attractive to NHS organisations than process-based outcomes, but they do not expect that these will be achieved in the short-term, however do expect them to lead on to outcomes for patients, staff and communities in the longer-term.

To what extent does the EDS support NHS organisations to meet the PSSED General Duty?

Engaging protected characteristics

Some of the 'new' protected characteristics were the least engaged in the EDS process. However the research found specific examples of Trusts identifying gaps in engagement with such groups and taking initial steps to remedy them.

The research also uncovered examples, mainly among commissioners, of work being undertaken as a result of the EDS impacting on protected groups' engagement with, access to and experience of healthcare.

Fostering good relations

The flexibility of the EDS process is evidenced by the various examples found in the research of the approach taken by different organisations to local engagement and involvement, with trusts in many areas coming together to pool resources and ensure a co-ordinated approach to local engagement.

Three-quarters of organisations reported an impact of EDS on their engagement and involvement of local interests (with commissioners reporting a higher impact than other NHS organisations). London reported a lower impact than other regions. Commissioners, and organisations in the Midlands and North, reported the most involvement and influence in the selection of equality objectives of the voluntary and community sector (VCS), and of communities.

Overall patients were less involved and influential than the VCS and communities in the process of selecting equality objectives, particularly in organisations in the South. Mental Health trusts, Foundation Trusts and organisations in the Midlands were the most likely to have shared their equality objectives with patients, carers, the VCS and communities.

To what extent does the EDS help NHS organisations to meet the PSED Specific Duties?

Publishing equality information

The research found specific examples of improvements being made to data collection and analysis achieved through the EDS process, and of comprehensive, accessible evidence being used to implement EDS effectively.

EDS implementation assisted the majority of NHS organisations in meeting the specific duty on information (NHS organisations in the Midlands finding it most helpful and London organisations least helpful). Respondents had high hopes for the EDS in improving the collection, analysis, sharing and use of evidence. However they found the assembling of evidence for EDS, and sharing it with local interests, to be challenging. This was commonly because of the lack of data in relation to all nine protected characteristics, and the difficulty in making the evidence understandable and accessible to local people.

Identifying gaps in equality data was the biggest impact of the EDS in terms of strengthening organisational processes (although London organisations reported a lower impact). Nearly half of NHS organisations reported an impact of EDS on co-operation between organisations in relation to data collection and sharing (the highest impact being reported in the Midlands).

Setting equality objectives

The setting of equality objectives encompassed a range of approaches and investment levels demonstrating the local flexibility of the EDS, with the research including specific examples of this and the range of objectives chosen.

Four-fifths of NHS organisations surveyed had prepared equality objectives, with most reporting that the EDS had been to some extent helpful in this task. Providers, Acute trusts, non-Foundation Trusts and NHS organisations in the Midlands were most likely to have found the EDS helpful in this regard. Mental Health trusts reported the highest impact of EDS on their organisation's prioritisation of equality work. Regionally, NHS organisations in the London region reported the lowest impact.

Variations

The research found a number of organisational and regional variations within the overall findings (although these should be treated with caution given the small numbers answering some of the questions). The Conclusion section of this report includes a table which summarises the main regional variations detailed within the document. This shows that NHS organisations in the Midlands have reported a higher impact of the EDS than other regions, perhaps reflecting the fact that EDS implementation was led from this region. Midlands organisations reported a particularly strong impact in comparison with other regions in relation to work relevant to the good relations limb of the general duty. London organisations reported a comparatively high impact and Northern organisations a comparatively low impact in relation to the PSED general principle of organisational leadership for equality.

1 Introduction

- 1.1 NHS England commissioned Shared Intelligence to produce this evidence review in order to support the Ministerial Review of the Public Sector Equality Duty (PSED). It presents the evidence in support of the role of the NHS Equality Delivery System (EDS) in helping NHS organisations to become compliant with the Public Sector Equality Duty as required under the Equality Act.
- 1.2 This document presents data gathered from the first stage of the independent evaluation of the EDS. Whilst this evaluation has taken a wide view of the experience of NHS organisations in implementing the EDS, the focus of reporting has not been explicitly on examining how the EDS has supported compliance with the PSED. Therefore Shared Intelligence was asked to conduct additional analyses of the data in order to understand to what extent and how the EDS has supported NHS organisations to become compliant with the PSED.

Methods used for this evidence review

- 1.3 This document presents findings from additional analyses conducted on the data gathered as part of the EDS evaluation. To do this we conducted a more detailed analysis of the data, and then analysed this thematically using the PSED as a framework.

Detailed analysis by group

- 1.4 We conducted further analysis on our quantitative and qualitative data using cross tabulation to explore how different groups of NHS organisations had responded in both the qualitative and quantitative elements of the evaluation. We broke responses down into the following groupings.

Variable	Groupings
Type of Organisation	Provider/Commissioner
Type of Provider organisation	Acute/Mental Health/Other Foundation/Non-Foundation
Region	London/South/Midlands/North

Thematic analysis on PSED

- 1.5 In order to analyse the data gathered in terms of its contribution towards the PSED, the PSED was broken down into its general principles, its general and its specific duties. Using these elements as a framework, we mapped our existing qualitative and quantitative evaluation data against it to give a picture of how the data related to the PSED specifically.

Limitations

- 1.6 In reading the analysis of the quantitative data by group, it's important to note that some questions had a high non-response rate. All data tables indicate the size of the response, and where small numbers of responses were received these findings should be treated cautiously. This is also relevant to findings around the differences between types of provider, which is a sub-set of the survey responses and therefore based on smaller numbers.
- 1.7 In the main, it is self-evident and the data we had contained clear links across to these elements of the PSED. One decision should be noted as containing a less clear link when

mapped across to PSED: data pertaining to engagement work with the voluntary and community sector, patients and communities has been grouped under the general duty of 'fostering good relations between people'. In our view there is a case for this activity being considered as making a contribution towards this part of the PSED albeit indirectly.

Source of this evidence: the evaluation methodology

1.8 The evaluation used mixed methods to gather both qualitative and quantitative evidence. This enabled the evaluation to look both at the scale of take-up of the EDS, and to understand in-depth the experiences of staff implementing the system. The first phase of research was carried out between January and August 2012 and provided a 'snapshot' of EDS implementation at that time. The methods used in this study are outlined below:

- A **desk review of literature and monitoring data** was used to identify key contextual factors and inform the development of the online survey questions.
- A **baseline survey** was designed and administered through April-May 2012 to establish a picture of EDS take-up and the experiences of different organisations across the country. The survey received 203 responses from staff leading on the EDS in a range of NHS organisations, as outlined in Figure 1 below.
- Twelve **follow-up interviews** were conducted with equality leads in NHS provider and commissioner organisations between May-June 2012 to explore their experience of using EDS in more depth to build on the findings from the survey.
- Seven **in-depth interviews** were conducted with national stakeholders to outline and contextualise the aims and objectives of the EDS and explore hopes, ambitions and any concerns. Interviewees included the staff in the stakeholders from external organisations with an interest in equality and/or patient care; and members of the EDC, EDS programme office and Department of Health Equality team.
- Six **case studies** were conducted in July and August 2012 to capture a range of experiences of EDS implementation from different types of NHS organisations, their partners and local interest groups.

Figure 1: Baseline survey respondents by type of NHS organisation (nb. Respondents were able to select multiple-responses)

Type of NHS organisation	%	Number
Acute - Foundation Trust	22.4%	46
Primary Care Trust Cluster	20%	41
Acute - non Foundation Trust	15.1%	31
Mental Health - Foundation Trust	8.8%	18
Community Health Service	7.3%	15
(emerging) Clinical Commissioning Group	3.9%	8
Ambulance Trust	3.4%	7
Strategic Health Authority Cluster	2.9%	6
Mental Health - non Foundation Trust	2.4%	5
Business Support Unit (or equivalent)	0.5%	1
Other	13.2%	27
TOTAL		205

Limitations

1.9 A limitation of this methodology for readers to note is that research participants from NHS organisations have largely been self-selecting in that they were drawn from respondents who chose to complete the survey, and therefore the results will have a self-selection bias.

Structure of this report

- 1.10 This report presents both the qualitative and quantitative evidence we gathered in to the following against the following headings:
- 1.11 The General Principles of the PSED
 - Legal compliance
 - Outcome focus
 - Embedding equality / making it core business
 - Leadership from the top
- 1.12 General Duties of the PSED
 - To eliminate discrimination;
 - To advance equality of opportunity; and
 - To foster good relations - between people who share a protected characteristic and those who don't
- 1.13 Specific Duties of the PSED
 - To publish relevant, proportionate information/data showing compliance with the Equality Duty
 - To set equality objectives.

2 To what extent does the EDS support NHS organisations to meet the general principles of the PSED?

2.1 In this section, we present the evidence to explore the extent to which the Equality Delivery System (EDS) is supporting NHS organisations to adhere to the general principles of the Public Sector Equality Duty, which we define as:

- Supporting legal compliance with the Equality Duty 2010;
- Strengthening organisational leadership for equality;
- Embedding equality/making it 'core business'; and
- Outcomes focussed.

2.2 We present the evidence below to show the extent to which the EDS is helping NHS organisations to progress and strengthen the underlying principles of the PSED/Equality Duty, including where variations exist.

Supporting NHS organisations with legal compliance

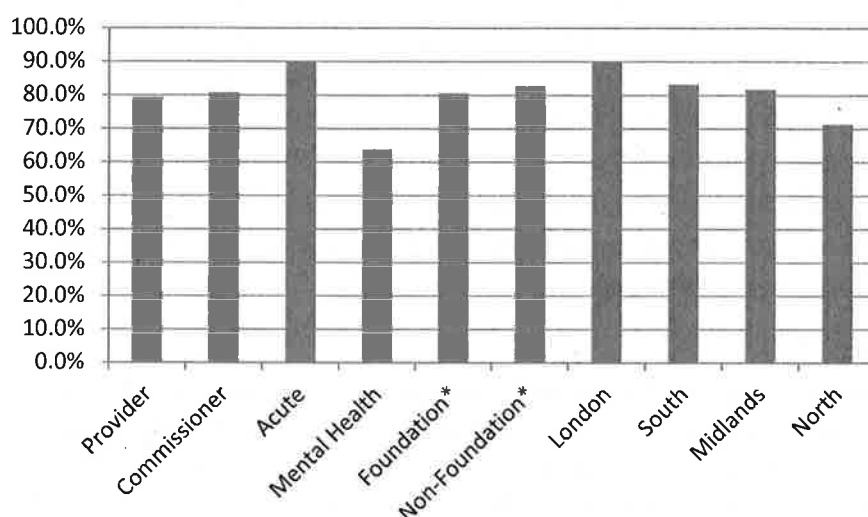
Compliance with equality legislation was the main motivation for EDS implementation for NHS organisations taking part in the research, with the exception of Mental Health trusts who were more motivated by improving outcomes. Compliance was a particularly strong driver for Acute trusts across the country and, exploring regional differences, for organisations in London.

General findings

2.3 81%¹ of NHS commissioner and provider organisations identified compliance with equality legislation as a motivation for implementing EDS, with this being the highest scoring motivation. There was a regional variation within this: 90% of London organisations identifying compliance as a motivation compared to 71% in the North (and 82% in the Midlands and 83% in the South).

¹ % of 203 equality leads responding to SI survey completed in April-May 2012. These respondents self-selected to respond to the survey, making it a snapshot of over 200 NHS organisations across England rather than a representative sample.

Figure 2: The extent to which compliance with equality legislation is a key motivating factor the NHS organisations in implementing the EDS (source: national EDS survey)
[*Mental health and Acute organisations only]



- 2.4 87% of NHS organisations who responded to the survey understand that the EDS helps with PSED compliance.

Specific sectors/organisations

- 2.5 Compliance was identified as a motivation by 90% of **Acute Trusts** and 81% of **NHS commissioner organisations** who responded to the EDS survey.

"With my organisation it had to be 'you'll be served with a notice of compliance, David Nicholson and the Equality and Diversity Council leading it, you'll be in a national league table compared to other organisations ... I had to use it as a stick to get any buy in from my organisation."

"Highlighted the needs of CCGs to ensure they meet the public sector duty."

"Seen as the 'must have' tool to help with compliance and reminded organisations of their PSED."

- 2.6 Compliance was a less significant driver for **Mental Health trusts**, with compliance being the second highest scoring motivation, identified by only 64% - compared to 76% identifying improved patient/staff outcomes as a motivation. However Mental Health trust leads were more likely than other organisational leads to believe that implementing the EDS made their organisation fully compliant with equality legislation.

Strengthening organisational leadership for equality

Raising the profile of equality among senior management and leaders has been the biggest impact of the EDS for NHS organisations surveyed, although London reported a lower impact than other regions. Senior managers outnumber equality and diversity officers as the organisational leads for EDS outcomes.

It was found to be more of a challenge to engage senior managers than the Board in the EDS, although both were less challenging to engage than middle managers. The Board is engaged in EDS governance in two-thirds of organisations, with Mental Health trusts reporting the most engaged Boards and senior managers. Boards and senior managers in the North and in Foundation Trusts were less involved and influential in the selection of organisations' equality objectives than those in other regions and in non-Foundation Trusts. London Boards and senior managers were reported to be the most involved and influential in the selection of equality objectives, with London organisations also the most likely to have shared their equality objectives with Boards and senior managers.

General findings

- 2.7 The biggest impact of the EDS for NHS organisations surveyed has been to raise the profile of equality among senior management and leaders. Buy-in from local board members rated very low as a concern among survey respondents, resonating with findings from qualitative research that board and senior support was achieved during the EDS process, with the most difficult group to engage being middle management.
- 2.8 82% of respondents reported that the EDS has had an impact on raising the profile of equality work amongst senior management and the Board within their organisation. Over half reported a 'medium' or 'large' impact in this way. There were however regional differences with the South (61% 'medium' or 'large' impact) and the Midlands (60%) reporting a higher impact in this area than the North (53%) and London (44%).
- 2.9 65% of respondents explicitly stated that their Trust Board is involved in the governance of the EDS – slightly more of Mental Health Trusts reporting this (76%) than PCT Clusters (62%) and Acute Trusts (59%). More Mental Health Trusts reported a more engaged Board and senior management team compared with Acute Trusts and PCT Clusters.
- 2.10 In general organisations found it more difficult to engage senior managers in the EDS than Board members or colleagues. 64% found it 'straightforward' to engage their Board in EDS implementation, although a further 30% found it 'challenging'. 46% reported that it had been challenging to engage senior management, while 40% found engaging colleagues/peers a challenge.
- 2.11 52% of NHS organisations reported that a Board chair or member had been 'very' or 'quite' involved in selecting the organisation's equality objectives. There is a differential between FTs and non-FTs: 24% of FTs reported a Board member/chair to be 'very' involved in this, compared to 47% of non-FTs. There is also a regional difference – just above or below one-third of London, South and the Midlands organisations reporting the Board to be 'very involved', compared to 11% of the North.
- 2.12 65% of NHS organisations reported the CEO/senior management team to have been 'quite' or 'very' involved in this process. Again there is a difference between FTs and non-FTs – 31% reported CEO/senior managers to be 'very' involved compared to 52% of non-FTs. There is also a regional difference – over half of London organisations reported CEO/senior managers as 'very' involved, and around two-fifths of the South and Midlands organisations, compared to 10% in the North.

- 2.13 58% of NHS organisations reported a Board chair/member to have been 'influential' or 'very influential' on the equality objectives selected by the organisation. 72% reported the CEO/senior management team to have been 'influential' or 'very influential' on the equality objectives selected.
- 2.14 Non-FTs (47% 'very' influential) reported stronger Board influence on objectives than FTs (23%), and stronger CEO/senior management influence (half of non-FTs reporting these as 'very' influential on objectives compared to 18% of FTs.) There were also regional differences with slightly below or above one-third of London, South and the Midlands organisations reporting the Board as 'very' influential compared to 14% in the North. 40% of London organisations reported the CEO/senior management team as 'very' influential on objectives, and around one-third of the South and Midlands, compared to only 7% of the North.
- 2.15 68% of respondents had shared their equality objectives with their Board, and 71% with their senior management team (this percentage being slightly higher among Mental Health Trusts and Acute Foundation Trusts compared to PCT Clusters and Acute Non Foundation Trusts). There were regional differences with London organisations most likely to have shared their objectives with the Board (86%, compared to 73% in the Midlands, 66% in the South and 58% in the North). The Midlands organisations were most likely to have shared the equality objectives with their senior management team (86%, compared to 71% in London, 61% in the North and 59% in the South).
- 2.16 There are slightly more senior management leads (39%) for EDS outcomes than E and D team members (27%).

Selected examples and quotes

- 2.17 A PCT Cluster's Executive Lead for Equalities gave presentation and development sessions on the EDS to the Boards of the PCT Cluster and all six CCGs in the area. These helped the Boards review the governance of equality under the new CCGs and area offices, and also helped the organisations in setting their equality objectives. The EDS was also presented to staff at sessions such as Executive team meetings, using scenarios to bring the EDS to life and facilitate engagement.

"Has enabled other senior managers and leaders in the organisation who do not normally attend our diversity matters steering group to become involved and input into E&D."

"The Board is actively interested in promoting Diversity events and the general profile of equality and diversity."

"The board have embraced EDS. Our Non-Executives and Directors have championed equality and dignity. Chairman is an excellent role model to promote equality, engagement and dignity agenda."

"EDS Goal Leads who are senior managers are responsible for their relevant area. This means holding individuals to account for timescales and progress."

Embedding equality/making it core business

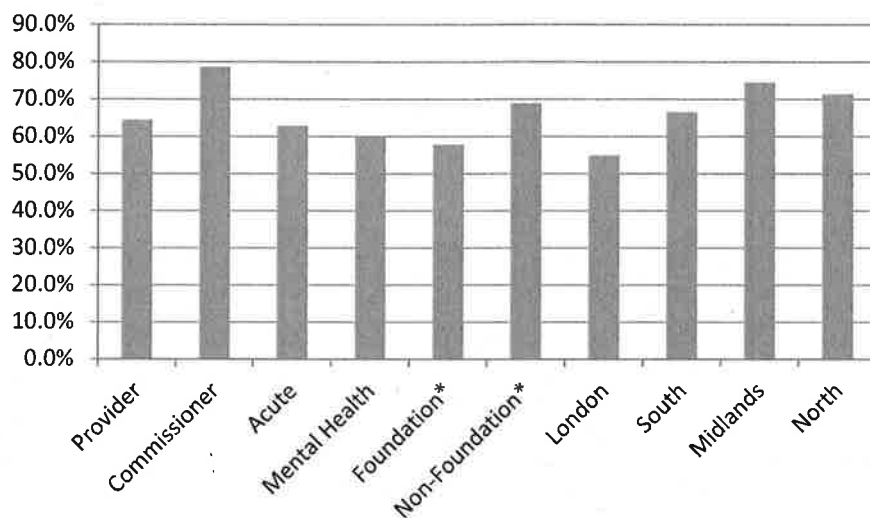
Embedding equality across the organisation is also a strong driver (third highest scoring) for EDS implementation among NHS organisations surveyed. This is a lower driver for London than other regions, and London organisations also reported a lower impact than other regions on organisational commitment to equality. However London and the Midlands organisations are more motivated than other regions by the EDS helping them deliver key 'core business' NHS frameworks and standards, and both regions are also more likely to have shared their equality objectives with the whole organisation.

Three-quarters of organisations reported positive impacts of EDS on increased commitment to, and staff awareness of, equality. Commissioners and Mental Health trusts reported a higher impact on commitment to equality than other organisational types, and Mental Health trusts were more likely than other organisational types to have shared their equality objectives with the whole organisation.

The research found specific examples, mainly among commissioners, of organisations using the EDS to integrate equality into organisational 'core business' such as contracts, planning and service design.

- 2.18 69% of organisations identified embedding equality and diversity across the organisation as a motivation for implementing EDS, with this being the third highest scoring motivation after legal compliance and delivering improved outcomes. There was regional variation with embedding equality being identified as a motivation by 75% in the Midlands and 71% in the North, compared to 67% in the South and 55% in London. London and the Midlands organisations were more motivated than North and South organisations by the EDS helping them deliver the NHS 'core business' of the Care Quality Commission (CQC) standards and the NHS outcomes framework.

Figure 3: The extent to which embedding equality and diversity is a key motivating factor the NHS organisations in implementing the EDS (source: national EDS survey) [*Mental health and Acute organisations only]



- 2.19 71% of NHS organisations reported that the EDS has led to **improved awareness of equality** in the workforce. 43% reported that the EDS has started to **change attitudes and behaviours** around equality among staff and their responsibility around equality.
- 2.20 Three-quarters of NHS organisations reported that the EDS has had a positive impact around **increased commitment to equality** across the organisation, e.g. helping staff to understand how 'equality' fits into their role and the work they do and why that is important. There are regional differences with London organisations reporting a lower impact than other regions on commitment to equality (30% 'medium' or 'large' impact compared to 46% in the North, 58% in the South and 59% in the Midlands).
- 2.21 Embedding equality was a higher motivation for NHS commissioner organisations (79%) than provider organisations (65%). Commissioners reported a higher impact of the EDS (48% 'medium' or 'large' impact) than providers (34%) in terms of increased commitment to equality across the organisation, and Mental Health trusts (48% 'medium' or 'large' impact)

Figure 4: The extent to which the EDS has led to increased commitment to equality across NHS organisations (source: national EDS survey, 2012) [*Mental health and Acute organisations only]

Increased commitment to equality across the organisation								
Responses (% of crosstab total)								
	We're not at this stage yet	We expect some impact within next 6 months	No impact	Small impact	Medium impact	Large impact	Not sure / Don't know	Non respondents
Provider	1.90%	17.10%	4.80%	39.00%	24.80%	9.50%	2.90%	23
Commissioner	6.50%	4.30%	6.50%	32.60%	39.10%	8.70%	2.20%	7
Acute	3.40%	22.00%	1.70%	45.80%	23.70%	3.40%	0.00%	17
Mental Health	0.00%	12.00%	12.00%	24.00%	32.00%	16.00%	4.00%	3
Other	0.00%	10.00%	5.00%	35.00%	20.00%	20.00%	10.00%	3
Foundation*	1.90%	18.50%	9.30%	35.20%	25.90%	7.40%	1.90%	10
Non-Foundation	3.40%	17.20%	0.00%	44.80%	24.10%	10.30%	0.00%	10
London	0.00%	28.60%	9.50%	38.10%	19.00%	0.00%	4.80%	5
South	2.90%	11.40%	2.90%	37.10%	34.30%	8.60%	2.90%	7
Midlands	5.50%	9.10%	3.60%	38.20%	30.90%	10.90%	1.80%	11
North	2.50%	12.50%	7.50%	35.00%	27.50%	12.50%	2.50%	6

2.22 Examples of how organisations were **embedding equality** included:

2.23 A PCT Cluster required the **PCT Directors to do the EDS self-assessment grading** feeling this to be important for mainstreaming – “otherwise it just lands at the equality person’s desk”. The E and D team provided support and kept the Executive and staff regularly briefed about EDS helping overcome resistance. The VCS EDS grading group, which consisted of senior VCS people e.g. Chief Executives, made it clear to the PCT Chief Executive that it wanted to hear from PCT Directors rather than junior staff, and accordingly PCT Directors attended the grading meetings to present information and answer questions. The grading group changed down some of the PCT’s initial self-assessment grades.

Selected examples and quotes

- 2.24 A CCG has **linked the EDS to the Quality agenda**, and has put in its Quality Improvement Framework a requirement that providers are making significant progress against the EDS. It considers the EDS to be a useful performance management tool for CCGs in managing providers: it is less nebulous than broad statements on equality as in previous contracts; has specific domains; requires evidence to validate and confirmation from the local community; gives a baseline and provides a mechanism for seeing year on year improvement.
- 2.25 A PCT has made it a **contract requirement** for their providers to implement EDS. The PCT sent all EDS scores to CEOs, Directors of Nursing and Directors of HR, to ensure these were owned by the organisation and not just equality leads.
- 2.26 A CCG felt going through the EDS process has **changed the way the CCG thinks about service redesign** – “it made us realise we’re not paying enough attention to the needs of protected groups” – and its approach to EIAs will change as a result. The EDS has added to the CCG’s knowledge of the local area. The lead feels the EDS is far more practical than previous equality frameworks and impact assessment which “were just seen as bureaucratic exercises”. The CCG made the organisation’s seven strategic objectives the basis of its EDS

equality objectives. The lead felt it was more meaningful to link the strategic objectives to the EDS objectives rather than have an action for each equality objective. The action plan is monitored on a quarterly basis by the stakeholder reference group, with exception reporting up to the governing body. In year two of the EDS the CCG will include the EDS element in its mainstream business plan and will not have a separate EDS plan. The CCG plans to undertake engagement on its strategic objectives, including EDS areas, rather than undertaking a standalone EDS engagement exercise.

- 2.27 In a PCT Cluster EDS implementation was overseen by a pre-existing E and D Committee, a sub-committee of a Board Committee and chaired by a senior leader, and including representation of functional Directorates such as HR, Nursing and Quality. This was seen as important as meaning that EDS implementation was overseen by functions with direct influence on commissioning activity.

"Commissioners and providers [involved in the EDS] ... left with a greater understanding that equality was part of their job and there was a lot they could do differently."

"Our organisation has changed as a result of EDS – we are more proactive towards the E and D agenda."

"[The EDS has] influenced higher level that this is core business e.g. commissioning for local population must include protected groups – this message has got through – [and now has] direct commitment from CEO."

"As a PCT Cluster we have taken on board the EDS and used it as an internal business tool to develop our evidence and equality objectives"

"It seems in our organisation everybody seems to be interested and listening about equality, when before it felt like it was an uphill struggle that never got any easier."

"The impact EDS has made is that it's moved the role and responsibilities from the E and D leads to senior frontline staff who are delivering services to members of the public."

"The Trust's E and D work (EPIT, and SES, more lately EDS) and not specifically EDS has had a great impact generally as the organisation does no longer see E and D as a 'topic' but more as part of the foundations of the Trust's work and embedded in the 'Values'. EDS will continue to support embedding E and D across a large and growing organisation."

"The report and grading process has allowed the Board and managers to understand how Equality issues are mainstream and linked to everyday work."

"The EDS has been integrated into the CQC framework when collecting evidence to demonstrate how changes have been made to improve patient access."

"All contracts have EDS and Equality Objectives embedded within them. Quality Accounts will be the method used to chart progress."

"We have integrated it with our CQC work streams and assurance processes."

Supporting NHS organisations to become more outcomes-focussed

Achieving improved outcomes for patients, carers, communities and staff was the second strongest driver for EDS implementation for NHS organisations, with the exception of Mental Health trusts for whom it was the strongest driver. It was a particularly strong driver for non-Foundation Trusts and for organisations in the Midlands and the North. Patient/community facing outcomes are more attractive to organisations than process-based/backroom outcomes, but it is not expected that these will be achieved in the short-term.

- 2.28 76% of organisations identified achieving better outcomes for patients, carers, communities and staff as a motivation for implementing EDS, with this being the second highest motivation after legal compliance. As noted above, achieving better outcomes for patients/staff communities was the highest scoring motivation for implementing EDS for Mental Health Trusts. Outcomes were a stronger motivation in the Midlands (80%) and the North (81%) than in the South (69%) and London (60%). There was also a difference between Foundation and non-Foundation Trusts, with outcomes identified as a motivation by 90% of non-Foundation Trusts compared to 65% of Foundation Trusts.
- 2.29 Respondents favoured patient and staff facing outcomes when asked to identify their hopes for the EDS. For example improved health outcomes, engagement and patient experience rated highly, whereas backroom outcomes such as benchmarking, systematic recording of equality work and better use of resources were less prominent. This is in line with the general principles of the PSED to move away from the previously process-focused approach to equality to work towards achieving an impact on service users and communities. One-fifth of survey respondents expected the EDS to have some impact within the next 6 months on patient experience, access to services and health outcomes. However most people interviewed for the evaluation believe it will take at least a year for the EDS to translate into actual impact for patients, communities and staff.

"It gives a clear framework and keeps the discussions very outcome focused."

3 To what extent does the EDS support NHS organisations to meet the PSED General Duty?

- 3.1 In this section, we present the evidence to explore the extent to which the Equality Delivery System (EDS) is supporting NHS organisations to meet the PSED General Duty. The general duty requires public authorities to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations across all of the characteristics protected by the Equality Act 2010. These include the existing characteristics of race, disability and gender as well as some new characteristics, including age, sexual orientation, and religion or belief.
- 3.2 We present the evidence below to show the extent to which the EDS is supporting NHS organisations in this way, including where variations exist.

Eliminate discrimination and advance equality of opportunity among 'new' and 'old' protected characteristics

Phase 1 of the EDS evaluation unearthed specific examples of Trusts identifying gaps in engagement with groups who share some of the 'new' protected characteristics and taking initial steps to address these gaps. It also uncovered examples, mainly among NHS commissioner organisations, of work being undertaken as a result of the EDS starting to impact on protected groups' engagement with, access to and experience of healthcare.

- 3.3 The evaluation revealed varying levels of engagement in the EDS across the protected characteristics. The characteristics who have been longest protected under equality legislation, race and disability, have been the most engaged groups to date; with 'new' characteristics including Marriage and Civil Partnership, pregnancy and maternity, and gender reassignment the least engaged. There are however examples of NHS organisations identifying and beginning to address these gaps, which are set out below.
- Selected examples and quotes***
- 3.4 A **PCT Cluster** developed a local survey to supplement the national Patient Survey, to ensure that it was gathering views of patients from across all nine protected characteristics, which were not well represented in the national survey results. It specifically targeted all protected groups to ensure a sufficient response from them.
- 3.5 A **CCG** focused its engagement on high density protected characteristics in its local area, rather than consulting all protected characteristics. It takes a mixed approach to engagement of local interests with different protected characteristics. Where it makes

sense so to do, the CCG is working in partnership e.g. to engage transgender people who tend to congregate in the city. A different approach is used for other groups, e.g. engaging a local Asian elders group who live locally and get together over lunch. The CCG tailored its engagement with people with learning disabilities e.g. using pictures and colour coding. Engagement with this group has continued on an on-going basis about the wider healthcare agenda. The EDS has enabled the CCG to identify the issues faced by refugees and asylum seekers and people with learning disabilities.

- 3.6 A **PCT Cluster's** EDS work led to the publication of an 'In the Pink' guide for the LGB community; funding the translation of a welcome pack for refugees and asylum seekers; the commissioning of the Gypsy Life group to undertake health ambassador work; and commissioning with the SHA a race equality engagement review around how race equality can be improved in the new commissioning world.
- 3.7 An **Acute Foundation Trust's** engagement on the EDS led to it linking with a local community group to develop a toolkit for the Chinese community giving health information, which it is hoped will help community/hospital engagement and save on interpretation and translation costs. The Trust is now doing similar toolkits in Arabic, Polish and Nepalese.
- 3.8 An **Ambulance Foundation Trust** has entered into formal partnership arrangements with organisations that represent Gypsies and Travellers, people with learning disabilities and general disabilities to ensure they are properly considering their needs. They plan to enter into similar arrangements with a transgender organisation as they have identified a gap in engagement with this group and their membership figures are low in this area.

"[Our EDS work has had a] very big impact for the Deaf ... and hard of hearing – we received a big thank you from this community for the engagement we have done with them and they are now working with the two PCTs and local Acute provider to identify issues and solutions for improving the patient journey".

"[EDS implementation has] Made the CCG more aware of the problems faced for individuals claiming Asylum and their problems seeking primary care support, this has resulted in a project being taken forward to improve awareness within primary care that will allow for better access for these individuals".

"The [EDS] has helped the engagement people think about different groups e.g. emerging communities, Gypsies and Travellers, socio-economically deprived."

"Transgender group said we were the first from NHS to ever go to speak to them."

"More targeted work with protected and disadvantaged groups."

"EDS has widened the equality strands for example sexual orientation and transgender are higher on the agenda when compared with previous work."

"Improved access for Deaf Blind clients. Improved access to education for HIV + service users. Provided placements for Autistic young people to gain work experience."

Foster good relations between people who share a Protected Characteristic

Three-quarters of NHS organisations reported an impact of EDS on their engagement and involvement of local interests, with commissioners reporting a higher impact than other organisations, and London reporting a lower impact than other regions. Commissioners and organisations in the Midlands and the North reported the most involvement and influence of voluntary and community organisations and of communities in their selection of equality objectives. Overall patients were less involved and influential than the VCS and communities in this process, particularly in organisations in the South. Mental Health trusts, Foundation Trusts and organisations in the Midlands were the most likely to have shared their equality objectives with patients, carers, the VCS and communities.

The flexibility of the EDS process is evidenced by the various examples found in the research of the approach taken by different organisations to local engagement and involvement, with trusts in many areas coming together to pool resources and ensures a co-ordinated approach to local engagement.

- 3.9 There are many examples of the local health economy coming together to engage local interests, to pool resources and minimise duplication and 'engagement fatigue' among local interests. Some organisations have used existing groups to engage with patients and communities, while others have put relatively large amounts of resource into engagement activity, reflecting the local flexibility built into the EDS.
- 3.10 77% of organisations reported that the EDS has impacted on the way they engaged and **involved local interests** – half saying the EDS has had a 'medium' or 'large' impact in this way. NHS commissioner organisations were most likely to report that EDS has had a 'medium' or 'large' impact on their engagement and involvement of local interests. There are regional differences with London NHS organisations (30% 'medium' or 'large' impact) reporting a lower impact than those within other regions (46% of North, 58% of South and 59% of Midlands).
- 3.11 50% of organisations said EDS engagement with local interests is leading to improved trust and confidence among local interests, most suggesting that it has had a 'small' or 'medium'

level impact in this way. 68% reported that VCS organisations had been 'relatively' or 'very' involved in the EDS process. VCS organisations have mostly been involved in agreeing EDS grades (68%) and identifying local interests (58%).

- 3.12 60% of NHS organisations reported that voluntary and community organisations had been 'quite' or 'very' involved in selecting their equality objectives. Commissioners (74 % 'quite' or 'very' involved) reported a higher involvement of voluntary and community organisations in the selection of equality objectives than providers (52%); Acute (56 %) than Mental Health trusts (45 %); and non-FTs (65%) than FTs (49 %). Again there were regional differences, with the VCS more closely involved in the selection of equality objectives in the Midlands and the North (70% and 65% 'quite' or 'very' involved) than in London (50%) and the South (42%).

Figure 5: The extent to which voluntary and community organisations have been involved in selecting equality objectives (source: national EDS survey, 2012) [*Mental health and Acute organisations only]

<i>Voluntary and community organisations</i>										
	Response (Count)					Response (% of crosstab total)				
	Not involved	A little involved	Not sure / don't know	Quite involved	Very involved	Not involved	A little involved	Not sure / don't know	Quite involved	Very involved
Provider	10	22	2	17	20	14.1%	31.0%	2.8%	23.9%	28.2%
Commissioner	4	4	2	14	14	10.5%	10.5%	5.3%	36.8%	36.8%
Acute	6	10	1	11	11	15.4%	25.6%	2.6%	28.2%	28.2%
Mental Health	2	7	1	3	5	11.1%	38.9%	5.6%	16.7%	27.8%
Other	2	4	0	3	4	15.4%	30.8%	0.0%	23.1%	30.8%
Foundation*	5	14	0	10	8	13.5%	37.8%	0.0%	27.0%	21.6%
Non-Foundation*	3	3	1	5	8	15.0%	15.0%	5.0%	25.0%	40.0%
London	1	4	1	3	3	8.3%	33.3%	8.3%	25.0%	25.0%
South	7	7	1	7	4	26.9%	26.9%	3.8%	26.9%	15.4%
Midlands	4	7	1	10	18	10.0%	17.5%	2.5%	25.0%	45.0%
North	2	8	1	11	9	6.5%	25.8%	3.2%	35.5%	29.0%

- 3.13 62% reported that communities had been 'quite' or 'very' involved in the selection of equality objectives. Commissioners (73% 'quite' or 'very' involved) reported higher involvement than providers (55%), and non-FTs (66%) than FTs (53%). There were regional differences with organisations in Midlands and the North reporting higher communities' involvement in selection of equality objectives (70% and 66% 'quite' or 'very' involved) than in London and the South (both 50%).
- 3.14 53% of organisations reported that patients had been 'quite' or 'very' involved in the selection of equality objectives. Commissioners (66% 'quite' or 'very' involved) reported higher involvement than providers (46%), and non-FTs (58%) than FTs (41%). There were regional differences with patients less involved in the South (42% 'quite' or 'very' involved) than in other regions (Midlands 59%, London 54% and the North 53%).
- 3.15 39% of organisations had shared their equality objectives with patients, carers and communities and 50% with voluntary and community organisations. Mental Health trusts were most likely to have shared their objectives with patients, carers, communities and voluntary and community organisations - half having shared them with patients and carers, and nearly two-thirds with communities and with voluntary and community organisations. Foundation Trusts were more likely than non-FTs to have shared their objectives with

patients, carers and voluntary and community organisations. The Midlands were more likely than other regions to have shared their objectives with patients, carers, communities and voluntary and community organisations.

Selected examples of where the EDS was supporting NHS organisations to foster good relations

- 3.16 **A PCT Cluster** used its co-ordinating role to ensure a consistent approach to EDS grading across provider trusts in the area. This was achieved by developing the capacity of five local LINK organisations to become a locality-wide EDS grading panel. The support offered to them included Equality Act 2010 training for around 40 LINK volunteers and EDS training for LINK support workers. LINKs recognised EDS as an important piece of work and feel that their work and involvement is being positively recognised, feel proud that they have worked together to deliver something as a region, and that they have been able to influence change in an area of work that is important to the people in their communities. The PCT mediated the relationship between NHS providers and LINKs throughout the process, meaning that face-to-face conversations about feedback and evidence did not take place. The PCT is keen to address ensuring a more open dialogue and information exchange between LINKs and NHS providers in year two of the EDS.
- 3.17 **A VCS group** took the lead in developing an EDS grading group which constitutes Chairs and Chief Executives of key local VCS organisations including LINK, Young Health Ambassadors, Age Concern and mental health charity reps. The group has its own terms of reference and will continue to meet and hold the local NHS to account.
- 3.18 **A CCG** undertook the grading with local interests by going out to small community groups targeting the high density protected groups in the catchment area, given that as a new organisation there was not capacity to engage with all protected groups. As the City PCT was engaging with city wide groups the CCG lead decided to go to smaller groups such as tea, lunch and carers' groups. She adapted terminology to make the EDS outcomes more relevant to Asian and Asian elders' groups and developed specific material to work with the learning disabilities group, feeding back on the issues raised by community groups at weekly staff meetings. The governing body accepted the community grades including some 'reds'.
- 3.19 **A PCT Cluster** has developed an accredited element, through the local college, of involvement of community members in E and D work including the EDS, in response to community members at EDS engagement sessions who said they would like something to help with careers/CVs. This accreditation element was at the time of research a pathfinder project, and it will be up to the CCG whether to carry it on.
- 3.20 **A PCT Cluster** received money from the SHA which it pooled with local NHS organisations for joint EDS engagement events, using the money to commission a local VCS organisation to help them organise the events. The events represented all protected characteristics, bringing them all together in one room. Participants, generally VCS representatives, were "assertive" and said "loud and clear" that in some cases the NHS organisations had over-graded themselves and subsequently downgraded them. The workshops drew on a model from Kettering Hospital which bolted the EDS outcomes onto a patient pathway model, enabling discussions about GPs, community services, the hospital and mental health services from the patient perspective. To supplement the events an Everyone Counts survey was undertaken to gather the views of patients and service users, with focused efforts made to

target people from protected groups, using community networks and a mix of online and paper copies. Through these means it was ensured that potentially marginalised groups such as people with learning disabilities and the local Nepalese community responded to the survey. However VCS participants in the process expressed scepticism as to whether the EDS would lead to tangible change for patients and service users with criticism expressed of some of the NHS organisations involved not having kept in touch subsequently. However the Cluster lead felt that the fact that the local interests had in some areas downgraded the NHS organisations was “powerful”; and that the EDS provides more focused and structured engagement with local interests, compared to consultation on equality schemes under previous equality legislation.

“In developing equality impact analysis of changes in services there has been greater local interest engagement.”(Acute Trust)

- 3.21 **An Acute Foundation Trust** had already started to have conversations with local VCS organisations as part of its equality work, who had helped the Trust to identify issues for the patients and communities from whom they advocate and work. The Trust wanted to build further on this existing work, and used the EDS as a framework to do this, linking their work to EDS goals and outcomes. The Trust tapped into meetings that were already happening, e.g. the Trust’s Patient Care Council, but broadened them to bring in others and focus on the EDS requirements. The Trust looked at what it could offer VCS organisations in return for their expertise in a mutually beneficial way. For example, it offered to provide the VCS with free training space, and use of its Learning Hub which works with long term unemployed people to get them back into employment.

“The engagement and grading events have had a real impact of local interest groups feeling more involved and included”.

- 3.22 **A Mental health and learning disabilities Trust** is delivering training to community members to enable them to participate in the next round of EDS grading making that a more stringent process than was possible in the first year. The Trust has found it difficult to bring a grading group together and get it going as the county lacks established community groups on E and D, and the Trust has had to build up local understanding of the NHS.

“The voluntary and community sector are now aware of what is expected and how they can help influence real and meaningful change across all NHS organisations.”

4 To what extent does the EDS help NHS organisations to meet the PSED Specific Duties?

- 4.1 In this section, we present the evidence to explore the extent to which the Equality Delivery System (EDS) is supporting NHS organisations to meet the PSED Specific Duties. Under the specific duties, all public bodies are required to publish information by 31 January each year to demonstrate how they have complied with the general duty. They must also set themselves one or more equality objectives in order to fulfil one or more of the aims of the duty. At least one objective was to be published by 6 April 2012 and new objectives are required at intervals of no greater than four years.
- 4.2 We present the evidence below to show the extent to which the EDS is supporting NHS organisations in this way, including where variations exist.

Specific duty to publish relevant, proportionate information/data showing compliance with the Equality Duty

EDS implementation assisted the majority of NHS organisations in meeting the public sector equality duty of publishing equality data, with Midlands organisations finding it most helpful in this regard and London organisations least helpful. Respondents had high hopes for the EDS in improving the collection, analysis, sharing and use of evidence but found the assembling of evidence for EDS and sharing it with local interests to be challenging, commonly because of the lack of data in relation to all nine protected characteristics and the difficulty in making the evidence understandable and accessible to local people. Identifying gaps in equality data was the biggest impact of the EDS in terms of strengthening organisational processes, although London organisations reported a lower impact in this regard. Nearly half of organisations reported an impact of EDS on co-operation between organisations in relation to data collection and sharing, with the highest impact being reported in the Midlands.

The research found specific examples of improvements being made to data collection and analysis achieved through the EDS process and of comprehensive, accessible evidence being used to implement EDS effectively.

- 4.3 70% of organisations found the EDS ‘extremely’, ‘very’ or ‘quite’ helpful in helping the organisation meet the public sector equality duty of publishing equality data. Non-Foundation Trusts were more likely to report it helpful in this regard than FTs, and Acute

Trusts found it more helpful than Mental Health Trusts. There were also regional differences – 51% in the Midlands scored the EDS ‘extremely’ or ‘very’ helpful in this regard, compared to 36% in the South, 26% in the North and 14% in London.

Figure 6: The extent to which NHS organisations felt the EDS was helping them to meet the public sector equality duty of publishing equality data (source: national EDS survey, 2012) [*Mental health and Acute organisations only]

Responses (% of crosstab total)	<i>Extremely helpful</i>	<i>Very helpful</i>	<i>Quite helpful</i>	<i>A little helpful</i>	<i>Not at all helpful</i>	<i>Other (please specify)</i>
Provider	12.8%	23.1%	33.3%	19.2%	6.4%	5.1%
Commissioner	17.5%	20.0%	40.0%	17.5%	0.0%	5.0%
Acute	15.6%	20.0%	35.6%	15.6%	6.7%	6.7%
Mental Health	11.1%	16.7%	33.3%	33.3%	5.6%	0.0%
Other	7.1%	35.7%	28.6%	14.3%	7.1%	7.1%
Foundation*	9.8%	19.5%	34.1%	22.0%	7.3%	7.3%
Non-Foundation*	26.1%	17.4%	34.8%	17.4%	4.3%	0.0%
London	7.1%	7.1%	42.9%	21.4%	21.4%	0.0%
South	7.1%	28.6%	42.9%	14.3%	0.0%	7.1%
Midlands	24.4%	26.7%	28.9%	15.6%	0.0%	4.4%
North	9.7%	16.1%	35.5%	25.8%	6.5%	6.5%

- 4.4 Leading to more robust collection, analysis, sharing and using of evidence was survey respondents’ second most common hope for the EDS. Over 80% of respondents had completed the EDS stage of assembling evidence. 94% used their workforce reports, and 93% used patient and staff surveys, to inform EDS implementation.
- 4.5 The biggest impact that EDS implementation has had in strengthening organisational processes has been **to identify the gaps in equality data** that NHS organisations currently collect - 76% stating that the EDS had had an impact in this way. There were regional differences with London organisations reporting the lowest impact in this area.
- 4.6 48% stated that the EDS has increased co-operation between organisations around data collection and sharing. There were regional differences with the Midlands reporting highest impact in this area and the North lowest.
- 4.7 64% of organisations reported finding assembling evidence to be challenging, this was highlighted as one of the biggest challenges that organisations faced in implementing the EDS, commonly for the lack of data to evidence all outcomes for all protected characteristics. Sharing the evidence with local interests was also highlighted as a particular challenge, particularly in a way that is accessible and meaningful to local people, who perhaps have not previously had much experience/skills around interpreting data. A key risk highlighted throughout the evaluation was for organisations to strike the right balance between providing enough data/analysis for those involved in the grading to make informed decisions for accountability, and providing the data in an easy to understand, accessible way.

Selected examples and quotes

- 4.8 A **PCT Cluster** supported the six emerging CCGs by providing them with detailed equality demographic data on their catchment area, broken down by the nine protected characteristics, giving them a basis on which to focus their EDS work. For example this

enabled one of the CCGs to identify that it had a high population of people with learning disabilities enabling it to prioritise engagement with this group.

- 4.9 A **PCT Cluster** found it useful to use an online portal for exchanging EDS evidence, as it made the process manageable and brought all evidence together for stakeholders to access at any time. It found that triangulating evidence and data with systems developed for CQC etc prevented duplication of efforts. The EDS implementation has also led to the development of a regional Equality Dataset.

"Workforce data has highlighted key areas of undisclosed information which has prompted a need for a data cleansing exercise that will benefit the organisation and all staff members."

"[The EDS] highlighted the need to cover all nine [protected characteristics] in surveys of staff and patients."

"More awareness within the organisation of lack of current data and the need to collect and analyse more robustly."

- 4.10 An **Acute Foundation Trust** developed a data collection sheet covering all 9 protected characteristics which is now being used regionally.

- 4.11 An **Acute Foundation Trust** found producing its evidence against each EDS outcome to be the biggest challenge, feeling that these requirements are disproportionate to the requirements of the PSED. The Trust believes that the next round of work will be more light touch in terms of updating the evidence base and collecting supplementary evidence. The EDS provided impetus for the Trust in strengthening its data collection and analysis processes. Its major audit tool for nursing quality now looks at organisational development/staffing issues alongside quality of patient experience, providing a quarterly temperature check at a ward/department level. The EDS drove comprehensive coverage of the protected groups, e.g. expanding the local audit tool looking at the quality of care to include transgender and religion or belief.

"One of the main problems of implementation is the fact that the EDS and legislation asks for equality monitoring data for all of the protected characteristics. This is impossible to gather as the DH have not mandated this as part of their IT programme, it would be up to individual Trusts and organisations to fund changes to their IT systems, which, in this economic climate is not practical."

- 4.12 An **Acute Foundation Trust** interrogated its complaints data early in the EDS process, feeling this was the best place to start in getting to know the issues for the Trust. Through analysing its existing data and consulting with VCS partners the Trust was able to build a picture of the most pertinent issues, with a focus on highlighting the 'more difficult' issues among the lesser understood protected characteristic groups.

"We are now reviewing patient and staff survey results by protected characteristic and are starting to look at equality performance for patients."

Workforce data by protected groups has been analysed and gaps in data are being addressed."

"Changes made to nursing assessment documentation to reflect the needs of the nine protected characteristic patient groups."

"[A] key challenge has been how to present quite complex evidence in an accessible way which enables external groups to understand and grade, particularly given the complexity of the grading system." (Ambulance Trust)

Specific duty to set equality objectives

Four-fifths of NHS organisations surveyed had prepared equality objectives, with most reporting that the EDS had been to some extent helpful in this task. Providers, Acute trusts, non-Foundation Trusts and organisations in the Midlands were most likely to have found the EDS helpful in this regard.

Mental Health trusts reported the highest impact of EDS on their organisation's prioritisation of equality work. Regionally, organisations in the London region reported the lowest impact.

The setting of equality objectives encompassed a range of approaches and investment levels demonstrating the local flexibility of the EDS, with the research including specific examples of this and the range of objectives chosen.

- 4.13 69% of NHS organisations found the EDS 'extremely', 'very' or 'quite' helpful in setting equality objectives. Acute trusts (one-half 'extremely' or 'very' helpful) reported the EDS to be more helpful in this regard than Mental Health trusts (35%); providers (44%) than Commissioners (19%); and non-FTs (64%) than FTs (38%). There were regional differences with Midlands reporting greater helpfulness (nearly half 'extremely' or 'very' helpful) than other regions (London 40%, South 37%, North 28%).

Figure 7: The extent to which NHS organisations felt the EDS was helping them to meet the public sector equality duty of setting equality objectives (source: national EDS survey, 2012) [*Mental health and Acute organisations only]

Responses (% of crosstab total)	<i>Extremely helpful</i>	<i>Very helpful</i>	<i>Quite helpful</i>	<i>A little helpful</i>	<i>Not at all helpful</i>	<i>Other (please specify)</i>
Provider	13.3%	30.7%	24.0%	25.3%	1.3%	5.3%
Commissioner	12.2%	17.1%	36.6%	26.8%	0.0%	7.3%
Acute	20.5%	29.5%	25.0%	20.5%	2.3%	2.3%
Mental Health	5.9%	29.4%	29.4%	23.5%	0.0%	11.8%
Other	0.0%	38.5%	7.7%	46.2%	0.0%	7.7%
Foundation*	12.8%	25.6%	25.6%	30.8%	2.6%	2.6%
Non-Foundation*	22.7%	40.9%	18.2%	9.1%	0.0%	9.1%
London	13.3%	26.7%	20.0%	26.7%	0.0%	13.3%
South	10.3%	24.1%	41.4%	13.8%	3.4%	6.9%
Midlands	18.6%	30.2%	23.3%	23.3%	0.0%	4.7%
North	6.9%	20.7%	27.6%	41.4%	0.0%	3.4%

- 4.14 The research found that EDS was found to be most useful in setting equality objectives to organisations where equality work was previously least developed. Those who found it useful explained that the EDS provided them with a focus and a framework, including a timeline and structures to help set meaningful objectives, particularly during a time of change within the NHS. A number of survey respondents said the EDS helped them comprehensively to undertake gap analysis, helping them to identify priority areas for objective setting. While some respondents explained that the EDS told them nothing new, others found the process helpful because it reinforced what they knew and helped them to be more certain of where to focus resources and attention.
- 4.15 42% of NHS organisations saw the EDS as a tool to help the organisation prioritise its equality work. Mental Health trusts reported the highest impact of EDS on prioritisation of equality issues. London organisations reported a lower impact than other regions in this regard.
- 4.16 Different approaches and levels of investment were involved in the setting of equality objectives, again highlighting the local flexibility of the EDS.

Selected examples and quotes

- 4.17 **A PCT Cluster** piggybacked on local authority events for the majority of its EDS consultation, consulting 4,000 citizens to identify its equality objectives, e.g. going out to all local community festivals. EDS questions were put into an existing council survey to help identify equality priorities. The 18 EDS outcomes were paraphrased to make them simpler and make sense to the community. Views on local priorities were sought which were put into themes, with events hosted for prioritisation by the community. A coloured star chart was developed to enable the Cluster to get a view from local patients and users on EDS outcome priorities for Goals 1 and 2. Young people really liked the star chart. Another star chart for Goals 3 and 4 was developed for use with staff. The issues which were identified by communities as the biggest issues were looked at in more detail by the Cluster. A consultation tool has now been developed which provides quick time analysis, using iPads and BlackBerrys, with Quick Response codes developed so that young people and others

could pull them up on their phone and data quickly and come back to us providing immediate analysis. This enabled the Cluster to analyse the results of consulting 4,000 people on equality priorities in weeks rather than months.

4.18 **A PCT Cluster** put together a list of equality objectives based on its evidence gathering and initial self-grading process, but these were essentially process-based (e.g. training). Going to the grading workshops of VCS representatives and undertaking a survey of service users from protected groups led them to 'ditch' these objectives, with a new shortlist compiled corresponding directly to the issues raised at workshops and in the service user survey. Six were chosen as being measurable and constituting PCT core business, as well as having a clear need as identified by local VCS/the service user survey. These six were then prioritised with two chosen for Year One:

- Increasing access to the IAPT service for people from BME groups and LGBT people (both highlighted by local interests) and for veterans, males, people with LTCs and older people (these groups having been highlighted by internal data analysis). The IAPT lead is baselining access to the service of protected groups and will then roll out an awareness raising campaign with protected groups, subsequently measuring its impact on access leading to new robust measures
- An objective to increase take up and awareness of the Say it Once campaign and the Personal Profile, where answers to questions asked by NHS professionals are written on a form/profile which the patient takes with them around the healthcare system. The Cluster is working with the VCS to raise awareness among protected groups, is uploading it to the county Health Record and is raising awareness of it among clinicians.

"The EDS helped us to identify priority objectives that as an organisation we can focus on and make real improvements. The previous action plan had 36 actions in and there were no real improvements to show year on year, it is hoped with fewer actions more real improvements around equality will be made."

"We have focused on a few outcomes as defined by our CCG ... from this the equality objectives have been identified."

"We would have set equality objectives anyway but it [EDS] forced leadership, including CCGs and CSS to come up with objectives."

"The EDS helped us to prioritise equality objectives which were linked to Local Authority objectives so that there was more impact across the population."

"Through the engagement and grading events it has identified the gaps where without EDS these wouldn't necessarily have been recognised."

"Understanding of the link between the Public Sector Equality Duty and EDS framework to look at the evidence was useful in identifying equality objectives."

“Using the information that was already being captured and showing how it could be used to justify improvements to service provision rather than individuals making decisions with no real justification.”

- 4.19 An **Acute Foundation Trust** took the decision early on in the EDS process to focus resources and effort on identifying and addressing four key objectives that would make the biggest difference to their organisation and ultimately their staff and patients. It was recognised early on that the biggest problems it faced were a disproportionately high number of complaints from disabled people and especially those with learning disabilities. These issues became key priorities for the Trust. The four equality objectives agreed focused on strengthening its data collection processes to include all protected characteristics for both patients and staff, as well as strengthening the Trust’s already established Dignity in Care initiatives.
- 4.20 An **Acute Foundation Trust** decided to focus its equality objectives around addressing the needs of older patients and staff with disabilities so that they can deal with a range of issues that sit underneath these broader objectives.
- 4.21 An **Ambulance Trust** felt that the following objectives emerged clearly from the grading process:
- Patients report a positive experience where their needs are understood, respected and adjustments are made to ensure there are no barriers to services and they receive the right care
 - The Trust will promote an inclusive working culture that works to eradicate harassment, bullying and violence and improve working lives, and staff wellbeing
 - The Trust will improve engagement levels by demonstrating fair and inclusive employment opportunities and career progression.
- 4.22 These objectives were then allocated to relevant business units with action groups responsible for progression, which report to the E and D group which in turn reports to the Trust Board. A campaign was launched to explain the equality objective and how they will be approached, and commencing work on objective 2.

Conclusion

- 5.1 This report has examined the impact of EDS implementation on NHS organisations' implementation of the PSED, the main findings being as follows:

General principles: Legal compliance

- 5.2 Compliance with equality legislation was the main motivation for EDS implementation for NHS organisations taking part in the research.

General principles: Organisational leadership

- 5.3 Raising the profile of equality among senior management and leaders has been the biggest impact of the EDS for NHS organisations surveyed. It was found to be more of a challenge to engage senior managers than the Board in the EDS, although both were less challenging to engage than middle managers. The Board is engaged in EDS governance in two-thirds of organisations.

General principles: Embedding equality/making it 'core business'

- 5.4 Embedding equality across the organisation was a strong driver (third highest scoring) for EDS implementation among NHS organisations surveyed. Three-quarters of organisations reported positive impacts of EDS on increased commitment to, and staff awareness of, equality. The research found specific examples, mainly among commissioners, of organisations using the EDS to integrate equality into organisational 'core business'.

General principles: Outcome focussed

- 5.5 Achieving improved outcomes for patients, carers, communities and staff was the second strongest driver for EDS implementation for NHS organisations. Patient/community facing outcomes are more attractive to organisations than process-based/backroom outcomes, but they do not expect that these will be achieved in the short-term.

General duty: Engaging protected characteristics

- 5.6 Some of the 'new' protected characteristics were the least engaged in the EDS process. However the research found specific examples of Trusts identifying gaps in engagement with such groups and taking initial steps to remedy them. It also uncovered examples, mainly among commissioners, of work being undertaken as a result of the EDS impacting on protected groups' engagement with, access to and experience of healthcare.

General duty: Fostering good relations

- 5.7 The flexibility of the EDS process is evidenced by the various examples found in the research of the approach taken by different organisations to local engagement and involvement, with trusts in many areas coming together to pool resources and ensure a co-ordinated approach to local engagement. Three-quarters of organisations reported an impact of EDS on their engagement and involvement of local interests. Overall patients were less involved and influential than the VCS and communities in the process of selecting equality objectives.

Specific duties: Publishing equality information

- 5.8 The research found specific examples of improvements being made to data collection and analysis achieved through the EDS process, and of comprehensive, accessible evidence being used to implement EDS effectively. EDS implementation assisted the majority of NHS

organisations in meeting the specific duty on equality information. Respondents had high hopes for the EDS in improving the collection, analysis, sharing and use of evidence. However they found the assembling of evidence for EDS, and sharing it with local interests, to be challenging. Identifying gaps in equality data was the biggest impact of the EDS in terms of strengthening organisational processes. Nearly half of organisations reported an impact of EDS on co-operation between organisations in relation to data collection and sharing.

Specific duties: Setting equality objectives

- 5.9 The setting of equality objectives encompassed a range of approaches and investment levels demonstrating the local flexibility of the EDS, with the research including specific examples of this and the range of objectives chosen. Four-fifths of NHS organisations surveyed had prepared equality objectives, with most reporting that the EDS had been to some extent helpful in this task.

Variations

- 5.10 The research found a number of organisational and regional variations within the findings (although these should be treated with caution given the small numbers answering some of the questions). The table below summarises the main regional variations detailed within this document. As the table shows, organisations in the Midlands have reported a higher impact of the EDS than other regions, perhaps reflecting the fact that EDS implementation was led from this region.
- 5.11 The Midlands organisations reported a particularly strong impact in comparison with other regions in relations to the indicators linked to the good relations limb of the general duty. London organisations reported a particularly strong impact in comparison with other regions, and Northern organisations a comparatively low impact, in relation to the indicators linked to the PSED principle of organisational leadership on equality.

Figure 8: Summary of regional differences outlined in this report

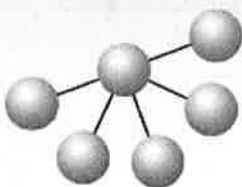
REGION	Organisations in this region most likely to report:	Organisations in this region least likely to report:
LONDON	<p>Compliance: Compliance as a motivation for EDS implementation</p> <p>Organisational leadership CEO/senior managers very involved in selecting the organisation's equality objectives</p> <p>CEO/senior management team very influential on equality objectives</p> <p>Equality objectives shared with the Board</p>	<p>Organisational leadership EDS impact on raising the profile of equality work amongst senior management and the Board</p> <p>Embedding equality Embedding equality as a motivation for EDS implementation</p> <p>Impact of EDS on organisational commitment to equality</p> <p>Outcome focussed Achieving better outcomes for patients/staff communities as a motivation for EDS implementation</p> <p>Good relations</p>

		<p>Impact of EDS on engagement and involvement of local interests</p> <p>Communities' involvement in selection of equality objectives</p> <p>Information duty EDS helpful in meeting equality data specific duty</p> <p>EDS impact on identifying gaps in equality data</p> <p>Objectives duty EDS impact on helping organisation prioritise its equality work</p>
MIDLANDS	<p>Organisational leadership EDS impact on raising the profile of equality work amongst senior management and the Board</p> <p>Equality objectives shared with senior management team</p> <p>Embedding equality Embedding equality as a motivation for EDS implementation</p> <p>Impact of EDS on organisational commitment to equality</p> <p>Outcome focussed Achieving better outcomes for patients/staff communities as a motivation for EDS implementation</p> <p>Good relations Impact of EDS on engagement and involvement of local interests</p> <p>VCS involvement in selection of equality objectives</p> <p>Communities' involvement in selection of equality objectives</p> <p>Patient involvement in selection of equality objectives</p> <p>Sharing equality objectives with patients, carers, communities and VCS</p> <p>Information duty</p>	

	<p>EDS helpful in meeting equality data specific duty</p> <p>EDS increased co-operation between organisations around data collection and sharing</p> <p>Objectives duty EDS helpful in setting equality objectives</p>	
NORTH	<p>Outcomes focussed Achieving better outcomes for patients/staff communities as a motivation for EDS implementation</p>	<p>Compliance Compliance as a motivation for EDS implementation</p> <p>Organisational leadership Board chair or member very involved in selecting the organisation's equality objectives</p> <p>CEO/senior managers very involved in selecting the organisation's equality objectives</p> <p>Board very influential on equality objectives</p> <p>CEO/senior management team very influential on equality objectives</p> <p>Equality objectives shared with the Board</p> <p>Information duty EDS increased co-operation between organisations around data collection and sharing</p> <p>Objectives duty EDS helpful in setting equality objectives</p>
SOUTH	<p>Organisational leadership EDS impact on raising the profile of equality work amongst senior management and the Board</p> <p>Embedding equality Impact of EDS on organisational commitment to equality</p> <p>Good relations Impact of EDS on engagement and involvement of local interests</p>	<p>Good relations VCS involvement in selection of equality objectives</p> <p>Communities' involvement in selection of equality objectives</p> <p>Patient involvement in selection of equality objectives</p> <p>Organisational leadership Equality objectives shared with senior management team</p>

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