

# EVALUATION OF THE EQUALITY DELIVERY SYSTEM (EDS) FOR THE NHS

## PHASE ONE: CASE STUDY COMPENDIUM



November 2012

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# 1. SUMMARY

## About the case studies

- 1.1. In November 2011, NHS Midlands and East and the Department of Health (DH) commissioned Shared Intelligence to conduct an evaluation of implementation of the EDS across the NHS.
- 1.2. As part of this evaluation, six in-depth case studies were developed to explore in more detail the dynamics and mechanisms behind adoption of the EDS amongst NHS organisation in practice.
- 1.3. This case study report complements the phase one EDS Evaluation report published in November 2012<sup>1</sup>, and includes the following six case studies:
  - Royal Devon and Exeter NHS Foundation Trust
  - North East Ambulance Service Foundation Trust
  - NHS Merseyside
  - Nottinghamshire PCT Cluster and Clinical Commissioning Groups
  - Southampton City, Hampshire, Isle of Wight and Portsmouth (SHIP) PCT Cluster
  - University Hospitals Birmingham NHS Foundation Trust
- 1.4. The case studies allowed us to capture a wider range of experiences behind the adoption of EDS, incorporating feedback from interviews conducted with the following groups:
  - Patients and patient groups
  - Community groups and the wider public
  - Staff networks and staff-side organisations
  - Local voluntary organisations and groups, such as
  - LINKs and HealthWatch

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<sup>1</sup><http://www.sharedintelligence.net/downloads/Evaluation%20of%20the%20Equality%20Delivery%20System%20for%20the%20NHS%20-%20Final%20Report.pdf>

- Health and Wellbeing Boards
- Other parts of the local authority and other local statutory agencies

1.5. To facilitate sharing the lessons learned from these case studies to other NHS organisations around the country, we have highlighted the key messages under four themes:

- Consultation and engagement
- Organisational structures
- Resource-effectiveness
- Building an evidence base

## **Key lessons**

### ***Consultation and engagement***

- The EDS is being used as an opportunity to strengthen and improve existing engagement mechanisms. For example, providing LINKs with training and guidance.
- Different groups of people prefer to engage in different ways. This can be achieved by offering different ways of being involved – from light-touch through to in-depth - and topic areas that match peoples' interests.
- Cost-benefit analysis of implementing the EDS can be a useful tool to engage an organisation at board level.
- To maintain a positive perception of the value of consultation and engagement, it is important to provide timely and visible feedback on actions and outcomes, and follow up on any promises made.

### ***Organisational structures***

It is important to ensure that EDS is positioned to influence across an organisation or a group of organisations:

- EDS can be used as a framework for developing an approach appropriate for different organisations.
- To ensure that EDS is not seen as an 'annual tick-in-the-box', it must be a constant process which evolves continually.

- It is important to ensure buy-in from all those who will play a part in the EDS and equality initiatives, and spread workload to those who can handle it appropriately. This can be achieved by embedding EDS processes across the organisational structure at an early stage.
- EDS can be used by PCTs and SHAs to leave a lasting equality and EDS legacy.

### ***Resource-effectiveness***

There are often many opportunities to prevent duplication and capitalise on the potential of existing networks:

- Duplication of effort can be avoided by collaborating with the voluntary and community sector and other parts of the NHS, and triangulating data with other sources (e.g. CQC data).
- When commissioning voluntary organisations, recognise that there are many demands on their time, and consider what they may gain in return from their involvement.
- There may already be enthusiasm for the equality agenda amongst partners and workforce, which needs to be sought out and capitalised upon.
- Tackling existing, critical complaints data can be a useful starting point for identifying potential improvements.
- Some NHS commissioning organisations are making use of EDS a contractual requirement.

### ***Building an evidence base***

- Avoid focusing on the specifics of EDS process where this distracts from the intended outcomes. Focus of the EDS should be upon organisations having a conversation on their local interests.
- Data should be gathered in a way that enables it to be easily drawn upon for evidence as and when necessary.
- The data gathering process can be used to identify wider data gaps within the organisation.
- If resources are limited, prioritise a number of datasets and sources of evidence when first doing the EDS grading. Use these to produce a manageable set of initial actions to build upon in the future.

- Providing grading, and outcomes of grading online improves the efficiency of its exchange and ensures that all stakeholders, including external organisations, have access at any time.
- EDS can help NHS organisations meet the requirements of the Public Sector Equality Duty.

## 2. ROYAL DEVON AND EXETER NHS FOUNDATION TRUST

### ***What they did***

The Royal Devon and Exeter NHS Foundation Trust (RD&E) was one of the first Foundation Trusts to be created in the country. The Trust provides specialist and emergency hospital services to approximately 350,000 residents and visitors primarily within Exeter and East and mid Devon. RD&E took an approach to the EDS which made the most sense to their organisation – drawing on and enhancing its existing mechanisms and processes and using the tool as a driver to further embed equality into the way the organisation operates. In this way, the Trust feel the EDS has ‘complemented and enhanced’ their equality work.

### ***How they did it***

- 2.1. The Royal Devon and Exeter NHS Foundation Trust (RD&E) took the decision to take the underlying principles of the EDS prior to its launch as ‘guiding principles’ to make sure that key organisational processes were fit for purpose – namely its data collection and analysis processes and staff and patient engagement mechanisms.
- 2.2. RD&E felt as though much of the groundwork for the EDS was already in place. The Trust had done much work over the last few years on integrating its patient and staff side agendas – linking quality staff and quality care as well as embedding inclusive engagement of patients and staff within that agenda.
- 2.3. This is driven by integrated data systems: for example, the Trust’s major audit tool for nursing quality now looks at organisational development/staffing issues alongside quality of patient experience and can show, therefore, the impact of staffing issues on patient experience. Information from this audit has also proved beneficial for Trust in pulling together its evidence for the EDS.
- 2.4. RD&E’s governance systems tie together its staff and patient agendas. The Trust has a parallel governance structure that runs up and down the organisation for both patient care and staff experience – with many links across the two agendas at each level of the organisation to ensure that staff and patient data feeds into decision-making at each level of the organisation.

*"Workforce and patient care is very much linked up. In terms of our Workforce and Diversity committee and Engagement and Experience*

*committee – the vice-chair on the former (an Executive Board member) also sits on the other.” (Head of Organisational Development)*

2.5. The Trust decided to start work on the EDS prior to its launch, because it was clear to the Trust that the EDS was to focus on engagement of patients, carers, communities and staff as well as rigorous collection and use of data and evidence. In light of this, the Trust started by reviewing its current engagement processes and data collection systems, asking the question ‘how well are we involving and capturing data across all Protected Characteristics’.

2.6. At the same time, the Trust worked to **strengthen its engagement mechanisms** to ensure they were fit for purpose for the EDS. This was something that was in the pipeline but the EDS provided the impetus. The biggest improvement they made was with the Trust’s Patient Experience Group. The Trust wanted to strengthen its accountability mechanisms and its representation. This Group is led by a senior nurse and has reporting links to the Engagement and Experience committee a sub group of the Board. This helped with broadening membership as the Trust was able to use the seniority of the lead as a selling point:

*“We could then say - come and join in, get heard in a group led by a very senior nurse and feeding into high level group with senior people, so your voice is heard at the highest levels.” (Equality Manager)*

2.7. The membership of the Patient Experience Group has developed and now has representatives on there who can articulate views and experiences right across the different protected characteristics. The data collection systems had gaps in patient outcome data, and so were strengthened to include two new outcome measures which capture the essence of what hospital care intends to deliver .

2.8. Over the summer of 2011, the Equality Manager collected evidence which involved drawing on the Trust’s data available from its staff and patients surveys, from its data collection systems and from previous consultations. This resulted in approximately 60 pages of evidence that the Equality Manager then worked to distil down to ensure people could engage meaningfully.

2.9. The Trust took the decision to undertake **three levels of engagement** throughout autumn 2011 to enable patients, staff and the public to engage on a level that best suited them. Level one was a quick fire survey for patients and staff on the equality issues. Level two engaged staff and patients through existing structures (diversity leads group, joint staff forum, patient experience group) where the data was simply presented and people were asked if they agreed with the grading and made the same material available to all, online. This was slightly more intensive for the diversity leads who scrutinised all the available data. And at level three –the full evidence document was provided via the Trust website and intranet and people were asked to respond. On the back of responses, the Trust downgraded/upgraded itself for each outcome, accordingly.



- 2.10. By January 2012, the Trust had its agreed grading for all EDS outcomes with the judgements based on well argued evidence. The Trust took the decision to focus its equality objectives around addressing the needs of older patients and staff with disabilities so they can deal with a range of issues that sit underneath these broader objectives.

### **Challenges**

- 2.11. The biggest challenge that the Trust faced was **producing its evidence** against each EDS outcome. This took the Trust a significant amount of time and effort and it was felt at times that the requirements as set out in the EDS are somewhat disproportionate to the requirements of the Public Sector Equality Duty. The Trust found that **some of the EDS outcomes were extremely hard to achieve**. In particular, outcome 4.3 (which states "The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes") - is felt to be extremely difficult to implement. The Trust has 200+ staff at Band 7 and if taken literally, it would mean that its equality and diversity requirements would need to be built into all job descriptions to be reviewed through staff appraisals - which would be a huge task. This doesn't however mean that the Trust isn't dedicated to embedding equality within its performance management process, and has plans to do this through embedding its recently launched values in its recruitment, selection and appraisal process.

### **What it achieved**

- 2.12. The Trust feels that the best thing about the EDS is that it gives a **transparent nationally measured assurance to Directors** to say that the Trust is doing well on equality. Now they have an externally recognised standard to say that the Trust is excelling /achieving on 16/18 equality outcomes. It is also a useful tool to **show the areas that need attention**, at a time when the Board and Executive have other priorities. In this way, the EDS makes sure equality stays on agenda at the highest level.

*"It provides tool and standards to measure your services by – gives something to aim for" (Lead nurse, Paediatrics)*

*"It gives us a way of showing the board and executive with a 3 second glance that we're doing well, and shows the two areas we haven't fixed yet. If it's still not fixed it's a constant reminder to us all that something still needs addressing (Equality Manager)*

*"[The EDS] drives people to do something" (Member of Diversity Leads Forum)*

- 2.13. The EDS provided a structured approach which has provided both **impetus and focus** to the Trust's equality work. The Trust believe it has helped them in collating together relevant information for CQC and has brought together

the work they are doing on equality in a structured way. – helping to **raise the profile** of equality within the organisation.

*"It's helped us focus our work more effectively rather than a scattergun approach" (Director of HR, executive lead for equality)*

*"Get the feeling management are more aware now of what the [equality] requirements are. ...It feels in the last 12 months there's a better understanding and willingness [to address equality issues]" (Unison representative)*

- 2.14. The EDS provided impetus for the Trust in **strengthening its data collection and analysis** processes and its engagement mechanisms. The Trust's major audit tool for nursing quality now looks at organisational development/staffing issues alongside quality of patient experience and can show, therefore, the impact of staffing issues on patient experience, providing a quarterly temperature check at a ward /department level. The EDS acted as a driver to ensure comprehensive coverage of the protected characteristics through consultation and data collection, including, for example, expanding the local audit tool looking at the quality of care to include transgender and religion or belief.
- 2.15. Although the EDS didn't surface any new intelligence for the Trust, it did **reinforce what it already knew**, in terms of setting its equality objectives and areas of weakness. One of which is the need to embed impact assessment at the strategic level. But this has now given directors a clear, informed sign of what needs to be addressed. Another was embedding equality through the competency framework. RD&E now plan to pursue a values-based approach, rolling out the Trust's values (Equality is one of those) and has hopes to embed those values in all recruitment, selection and performance management processes.
- 2.16. The EDS gave **staff another opportunity to have their say** in many different areas in some detail - another chance for them to register any concerns and then have that reflected in the EDS evidence and grading.

*"It's one thing having nice discussion with me, but quite another when they see 18 boxes and think 'that grade has changed because of what I said' - it's empowering" (Equality Manager)*

### **Next steps**

- 2.17. The Trust believes that after quite intensive work on collecting evidence for the EDS in 2011, the work in 2012 will be much more light touch in terms of updating that evidence base and collecting supplementary evidence to enhance it. This will then provide evidence of how things have changed. The engagement also intends to focus on the change data and asking people how things have changed for them from their perspective through their various committees including the Patient Experience Group, Diversity Leads Forum and the Joint Staff Forum, the main consultative group with staff.

- 2.18. The Trust also has a very clear focus for its equality agenda on disability for staff and care of older patients and is actively planning further innovation in both areas.

### **Lessons**

- **Good quality data is key to the EDS:** It will give you hard evidence to fall back on and then you're not exposed to extremist views. Make sure you have structured evidence to start with before consultation so you can use it to negotiate your grades.
- Take a **multi-level approach to engagement** so people can engage at whatever level suits them – either lighter touch or more in-depth.
- **Use mechanisms that you already have in place to engage.** Use your mainstream vehicles for consulting so don't need separate resourcing that you can't repeat year on year. Use it as an opportunity to strengthen existing mechanisms.
- **Don't try to cover everything with everyone:** guide staff and patients to those areas of the EDS that they will have an interest in, so they can clearly comment and don't switch off. It's a better, more focussed use of people's time.
- **Be prepared to do your own thing:** Get models of engagement and evidencing that suit your organisation and have the courage of your convictions to stick with them.

### 3. NORTH EAST AMBULANCE SERVICE FOUNDATION TRUST

#### ***What they did***

The North East Ambulance Service (NEAS) took a pragmatic approach to EDS in their first year and is already starting to improve EDS for continual use, in particular, developing the evidence base for the EDS. In 2012, the EDS helped the Equality and Diversity team highlight important equality issues within the trust. Firstly, it identified objectives relating to workforce equality because this was a clear priority within the trust, and secondly, the EDS provided impetus to engage specifically with people with a learning disability.

#### ***How they did it***

- 3.1. NEAS covers the areas of 12 unitary authorities from the Scottish border down to the top of North Yorkshire. The Equality and Diversity (E&D) team are based at the service's headquarters in Newcastle.
- 3.2. The Equality and Diversity lead at NEAS came into post with the EDS as one of her first tasks, and facing a tight timeline. Their EDS process began with an **internal communication campaign** to tell staff about the EDS and invite their involvement in it. To do this, they used existing internal communication channels such as staff newsletters and e-resources but also out-reach, for example attaching information to payslips going out to every staff member across the service. Feedback was then gathered through an online and paper survey, 'drop ins' at stations and open-door feedback sessions.
- 3.3. In tandem, the team planned and conducted consultation with local interest and community groups. Given the short time scale and limited resources, the team looked for opportunities to **'piggy-back' onto existing consultation work** taking place with other organisations, and in particular found it valuable to connect with other trusts through the NHS North East Equality and Diversity network. In this stage they met face-to-face with a number of local groups, and surveyed members of various networks – from groups such as LINKs to social networks like Twitter and Facebook to reach the public.
- 3.4. The Equality and Diversity group at NEAS used the evidence gathered through consultation, in addition to their own knowledge, to complete the EDS self-assessment. This raised important issues for the group, as one member said it asked "*questions we hadn't thought of, and didn't have the evidence for. We were bang to rights*". (E&D Group member)
- 3.5. Two grading events followed the self-assessment. The first was held with staff, staff group representatives, patient representatives and members of

the community. A very clear message which came back from staff was how their work lives were affected by equality and diversity in the organisation. Although none of the issues were new, and some of the staff there “almost expected them”, the seriousness of the issues was made clear in these sessions and surprised some of the HR, staff representatives and E&D staff taking part.

*“A bit surprised that people didn’t always feel 100% supported” (HR Advisor)*

- 3.6. A second grading event was devised and held specifically for people with a learning disability – a group which the consultation had highlighted had problems accessing services through the established pathways. The trust had an existing link, via a governor, and joined a South of Tyne consultation event involving people with learning disabilities; following the issues raised the NEAS E&D team felt it necessary to hold a regional session at NEAS headquarters to identify whether the issues raised were reflective across the region and had any key issues been missed. The E&D team worked in collaboration with the governor to produce a reasonably adjusted version of the grading guidance which could be more easily understood. Taking part in this grading was also **an “eye-opener”** for staff.

*“It was a really good way to engage...frontline contact is rare, so I was grateful to get that opportunity” (Contact Centre manager)*

*“Understanding how what we do related to patients...and pulling it all together. We tend to focus on the HR stuff” (HR Advisor)*

- 3.7. Many involved in the sessions reported back on their **atmosphere and environment**, which was described variously as “open”, “honest” and “informal”. Some of the people involved thought that conducting the session in small groups encouraged discussion and participation, as did the relatively hands-off facilitation used by the E&D team- for example a presentation was made to put the session in context, but it was kept very short with discussion taking centre stage.
- 3.8. The E&D lead at NEAS felt that objectives were very clear from the grading process and the following were selected:
- 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.
- 3.9. These objectives were then allocated to relevant business units and we set up action groups responsible for progression. These groups report to the E&D group, which itself reports up to the board.

## Challenges

- 3.10. The E&D team and the Trust chair identified **specific challenges to delivering EDS within an ambulance trust**. In particular, the two areas of service provided by the trust – A&E and patient transport – have very different levels of user engagement. Reaching a ‘community’ around A&E is difficult as emergency situations can be inappropriate and untenable situations in which to seek views and feedback, especially on sensitive issues. Therefore: *"[in emergency service] trying to find and create the opportunities to get good quality feedback is challenging"* (Chairman)
- 3.11. The **resources and time** available to the trust made collaboration on consultation essential. In the future, the E&D team would like to collaborate with other trusts in other parts of EDS. In part, this has the potential to make best use of resources, but it is also one way of using EDS to mirror the way that patients experience services: as a single NHS.
- 3.12. In particular, the ambulance service links into a range of other health services, and is often a point of transition between services. A **joint approach to EDS** would be to recognise these ‘seams’ and challenge them to improve the overall experience that people have of healthcare and systematic consultation and stakeholder mapping across Trusts could help to organise this. This could then be augmented with equality champions who hold each bit of the health service accountable for its share of progress towards the overall improvement.

## What is achieved?

- 3.13. A campaign, ‘Treat Us Right’ was launched in summer 2012 and this explains the equality objectives, and how they will be approached. This campaign also begins the work on objective two – which includes establishing an employee forum, a place where issues around bullying and harassment can be informally discussed, and support given; providing more information on what investigations involve – an issue identified as important in the grading. Work on objective three will begin later in the year.
- 3.14. The E&D team have been careful to ensure that **EDS objectives are aligned with the business goals of the Trust**. As a result, EDS is one of the Trust’s corporate objectives, progress on objectives is reported to the board and EDS indicators are reflected in many other corporate plans.
- 3.15. More widely amongst staff, the E&D team perceive **greater awareness of equality** and feel that equality has moved from being viewed as an ‘add on’ to a mainstream objective. However, for some other staff it felt that this change was limited to certain groups, especially those within the services headquarters. A remaining challenge is to reach clinical and operational staff spread out across the region:

*"I'm sure the average clinician on the road will say I'm sorry but my job is dealing with people who are critically ill...operational focus, no time to worry about 'soft stuff'."* (Chairman)

### Next steps

3.16. Ultimately, the aim in NEAS is to improve and promote *equality* not to promote the EDS. Therefore the next steps are about developing systems within the “EDS framework”, which help them provide equity for all staff and patients. In particular they will be **developing their evidence base**. The EDS lead and the chair were both clear that EDS was only as effective as the evidence gathered and *“it’s the task of assembling evidence that’s necessary to be quite sure that grading is accurate”* (E&D Manager)

3.17. The previous experience of EDS, combined with some stakeholder mapping has highlighted a number of areas where evidence was not as substantial or robust as it could be. In order to improve this, the team have made links with a refugee group and are now attending their meetings with a view to working with them on EDS. The team will now gather data all year round and **treat EDS as an on-going commitment** rather than doing consultation in a single block. For example over the coming weeks the E&D team will be attending events such as Northern Pride and different Melas:

*“making sure we get involved in events where our future workforce or patients might be”* (E&D Manager)

3.18. A final evidence challenge NEAS faces where data is unclear or controversial. One example given their E&D Advisor, was:

*“a dignity at work report says bullying and harassment is down, but our staff tell us something else. That’s why we’ve developed action groups to drill down and find out what is actually happening”*

3.19. A continuing challenge is also how to **measure change**, and the trust understands that it takes years to develop a solid baseline against which change can be measured.

### Lessons

3.20. A **positive attitude and a pragmatic approach** have helped NEAS deliver an EDS which they see as an honest attempt to get an accurate grading of their services. They had treated EDS as a framework to “bend and shape” to meet the needs of the trust itself.

3.21. This experience has highlighted the key areas where EDS needs to be changed in order to deliver meaningful improvements in equality.

- **Plan resources** and be realistic about what can be achieved in a short time period, collaborate with other parts of the NHS when it comes to consultation.
- **Continually improve the evidence you use** - it’s the back bone of your EDS.

- **Use EDS as a framework for activity**, and as something which can bring coherence and drive to your existing equality work.
- **Use cost-benefits analysis** to identify the business benefits to equality, this encouraged boards to give equality the priority it merits.



## 4. NHS MERSEYSIDE

### ***What they did***

NHS Merseyside commissions health services across the Merseyside area. The Equality and Diversity (E&D) team used their co-ordinating role to ensure a consistent approach to EDS grading across NHS provider trusts in the Merseyside. They achieved this by developing the capacity of five local LINK organisations to become one, locality-wide EDS grading panel.

This new approach pooled the resources of all local LINKs and organised the requirements of providers to encourage the best use of LINK time and resources, whilst also providing robust and consistent assessment of each providers' evidence

### ***How they did it***

- 4.1. When EDS was introduced, NHS Merseyside recognised that it was a significant piece of work that required extensive resources and project management expertise. Moving from Equality Performance Improvement Toolkit (EPIT) to the EDS framework represented **significant change**. In particular, EDS required providers to formally engage with communities, and local interest groups who then play a significant role in the grading.
- 4.2. Ensuring that equality is firmly embedded into commissioning processes and contracts was something that NHS Merseyside felt was integral to good commissioning practice, and moreover there was recognition at senior level that commissioning organisations played a crucial role in promoting the use of EDS and observing the evidence. In recognition of this role, NHS Merseyside made it a **contract requirement for their providers to implement EDS**.  
  
*"EDS should be led by system leaders...and that's especially important in a time of flux" (Chairman)*
- 4.3. The E&D team's own aspirations for EDS were that it be robust and **sustainable** beyond the lifespan of Primary Care Trusts (PCTs). They wanted a **consistent approach** to grading that ensured the system was fair and equitable, and importantly they wanted to be able to drive-up performance across the Merseyside area. It was important that organisations could share **best practice and benchmark** their performance.
- 4.4. To ensure these aspirations were at the heart of EDS in Merseyside, the E&D team approached local LINK organisations as potential partners in the grading process.

- 4.5. LINKs were not only “**experts by experience**”, but organisations that already had experience of working with NHS trusts. A Merseyside-wide grading panel was developed because the skills and expertise within each organisation would complement a wider group. Moreover, NHS Merseyside recognised an opportunity to engage LINKs in the EDS in 2011 to build-up their experience and expertise for the future, and thereby support future Health Watch organisations.
- 4.6. LINKs displayed a real enthusiasm to work on the equality agenda – described as their “bread and butter” - with a more focused approach than had been done previously. However they also knew that participating in a grading panel for the whole of Merseyside would be **a huge commitment and challenge**. They benefited from the support of NHS Merseyside in “unpacking the EDS process” and explaining the system in stages. The support offered to them included:
- Equality Act 2010 training for around 40 LINK volunteers;
  - EDS training for LINK support workers, including a simplified set of guidance, and a template which “broke grading up into stages...more manageable”;
  - A shadow-grading process which was an opportunity to “put what we had learnt into practice”; and,
  - A “Meet the NHS Providers” event for LINKs and NHS Providers to meet and gain an understanding of each other, and the process ahead.
- 4.7. With the grading panel established, NHS Merseyside had to consider the logistics of the grading process. They approach NHS North West, who provided financial support and web design expertise, to develop a custom-built web portal. This ensured evidence was collated, exchanged and made accessible in a consistent way.
- 4.8. The volunteers within LINKs worked in groups and shared their expertise of the evidence being presented. One LINK mentioned the benefit of reading the evidence aloud within groups to give a basis for shared understanding. LINKs generally reported a consensus view. If a consensus was not reached this was noted in the grading, and further discussions were held with commissioners at NHS Merseyside to triangulate other evidence such a contract/performance management reports.
- 4.9. NHS Merseyside aims to **raise the equality agenda across all Trusts**, and to that end all EDS scores were sent to Chief Executive Officers, Directors of Nursing and Directors of Human Resources. The intention was to ensure these were owned by the organisation not just equality leads.

### **MERSEYSIDE LINKs' TIPS FOR CLEAR EDS EVIDENCE**

- Be concise
- Clear and free from jargon
- Qualify claims with specific examples
- Say how a claim has been measured
- Treat it like a job application - make a point and give evidence to back it up

## **Challenges and Learning**

- 4.10. NHS Merseyside's programme was an innovative and bold way of approaching EDS. There were challenges along the way.
- 4.11. NHS Merseyside **mediated the relationship between NHS providers and LINKs** throughout the process because *"there were anxieties. LINKs and providers each had concerns...additionally we didn't want LINKs to be overburdened"* and they were also aware of the *"potential for feedback overload - 12 Providers x 4 Goals, x 18 Outcomes x 9 Equality Strands"*
- 4.12. As a consequence of the above, face-to-face conversations about feedback and evidence did not take place. NHS Merseyside recognised this had caused a level of frustration for a small number of Trusts.
- "When we got the validation back, we'd been reduced down to 'developing'. We don't know what they [LINKs] thought we missed. It would have helped if we could have a more open dialogue" (Provider Trust)*
- 4.13. This 'open dialogue' is something that NHS Merseyside is keen to address in year two of the EDS.
- 4.14. LINKs recognise that the challenges from year one will inform the learning in year two. There was an appreciation from the beginning that agreed **time frames** must be adhered to, and this was a challenge. A crucial resource in helping LINKs to meet their deadline was the administrative help from supporting officers which **enabled the best use of volunteer time**, concentrating on grading activity rather than report writing.
- 4.15. Some NHS provider trusts have more than one NHS commissioner, and this can become complex as the provider may need to respond differently to different commissioners. This is also a challenge to LINK organisations that are outside of **a Trust's geographical boundary**, but may have a key interest in its performance. Some NHS providers wanted the support and capacity extended to LINKs organisations outside of NHS Merseyside, however this would require additional resources, and at a time of transition

and reconfiguration of NHS organisations it was not deemed viable. However, this is not ruled out for future development.

### **What is achieved?**

- 4.16. LINKs recognised EDS as an important piece of work, they feel now that their work and involvement is **being positively recognised**. They also feel that they have been able to **influence change** in an area of work that is important to the people in their communities, and they feel proud that they have worked together to deliver something as a region. The E&D team echoed this sentiment, saying that a very positive aspect of their approach was that by working together LINKs were able to **pool their skills and knowledge of equality** to deliver something which would be very challenging for a single LINK organisation to do alone.

*"I'm proud of how Merseyside worked together on this. It's a sign of commitment" (LINK representative)*

*"They all came together, a range of experiences and a range of knowledge. There may have been some weaknesses in knowledge of some communities but together they shared skills amongst them" (E&D Manager)*

- 4.17. Some providers felt a conflict, in that they were engaging with other local third sector organisations that were pleased with their performance but were not part of the LINK network. Because of this, these providers felt their scores did not fully reflect their communities. However for many it was a useful guarantee that they could complete their EDS grading in a resource-effective and consistent fashion.
- 4.18. Equality leads appreciated the potential for local interests to raise equality on their trusts' agenda, and to this end a next step requested by some was that *"there should be more capacity-building"* for local interest groups (Provider Trust).
- 4.19. NHS Merseyside now has a robust and consistent benchmark for EDS in their trusts. They've avoided consultation-fatigue in the local voluntary sector and built up capacity of the LINKs to continue their work independently in the future. They have also ensured that grading is guarded against favouritism and bias.

### **Next steps**

- 4.20. There is a new arrangement in place from 2013 which aims to **mainstream the relationship between the LINKs and providers**. The two groups will meet to discuss progress towards EDS' objectives and there will be on-going dialogue and information exchange, culminating with agreed grades that formalise the years' development.
- 4.21. This arrangement will exist at arms-length from NHS Merseyside- which will be abolished in 2013 when Clinical Commissioning Groups (CCGs) will become responsible for health care commissioning and contract

management. It's therefore intended that this system will form part of the **PCT legacy** to the new CCGs.

- 4.22. This model is intended to be sustained. It is equipped to ensure that challenges are made by local interest groups, LINKs, Health Watch, to monitor the equality performance of NHS provider trusts. This has eased the concerns of the Chair of NHS Merseyside who perceived accountability structures in place in EDS to be quite 'loose'; this model solidifies that accountability.
- 4.23. Ultimately, everyone involved in this programme is aiming towards service improvement, better patient outcomes, a reduction in health inequalities and improvement in grades.

### **Lessons**

- **Use an online portal** or other similar system for exchanging evidence. This makes the process manageable and brings all evidence together for stakeholders to access at any time.
- **Invest in local structures** that can take EDS forward in the future. This is especially important in a time of transition.
- Consistency of approach can be achieved and has benefits such as benchmarking and resource-effectiveness; however **there is a balance to be achieved** with keeping the EDS locally relevant and flexible.
- **Open communication, dialogue and involvement** are likely to engage the majority.
- Ensure EDS is a **continual, evolving process**, rather than an annual report.
- EDS can be resource intensive so **capture the enthusiasm**. There is a lot of great work and commitment to the Equality agenda out there.
- EDS needs to be **embedded within the organisational structures**, not singularly the response of an E&D manager.
- **Prevent duplication** of efforts by triangulating evidence and data with systems developed for CQC, etc.

## 5. NOTTINGHAMSHIRE PCT CLUSTER AND CLINICAL COMMISSIONING GROUPS

### *What they did*

Nottinghamshire PCT Cluster was an 'early adopter' of the EDS. The Cluster Executive Lead for Equalities involved the six emerging Clinical Commissioning Groups in EDS implementation, as part of their development. The CCGs were supported by the PCT providing them with detailed equality demographic data on their catchment area giving them a basis on which to focus their EDS work.

### *How they did it*

- 5.1. The Cluster Executive Lead for Equalities started by developing a Single Equality and Diversity Strategy (SEDS) incorporating the EDS, a policy/strategy document which was adopted by the PCTs and the emerging CCGs. In developing the SEDS the lead asked all emerging GP consortia (as then called) to set their three key equality objectives to go into the SEDS, which she feels "**really got them thinking very quickly**". The objectives have since been reviewed by the CCGs. The SEDS included a local demographic breakdown, so that each different CCG had their own geographical area broken down by the nine protected characteristics. "*The work was done for them by the PCTs then we told them to get on with it to develop their own EDS.*" The CCGs subsequently developed their own EDS, with 5 out of 6 now having done their own grading and engagement (the sixth changed Board and lay members delaying EDS implementation) which fed into the Cluster PCTs' overall EDS reporting. "*There wasn't a need for us to do it, we wanted to do it, get a heads up for next year.*" (CCG Equalities lead)
- 5.2. The Cluster Executive Lead for Equalities gave presentations and development sessions on the EDS to the Boards of all the CCGs and of the PCT Cluster. These sessions 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. A Cluster senior leader interviewed noted the effectiveness of the Director in being a "*strong ambassador*" for the EDS. The EDS was also presented to staff at sessions such as Development Days and Executive Team meetings, using scenarios and examples to facilitate staff involvement and engagement and bring the EDS to life.
- 5.3. Nottingham North and East CCG's equalities lead, the Head of Primary Care Operations, found the **detailed demographic information** provided by the Cluster invaluable in enabling her to implement the EDS. "*I did my targeting from these demographics. E.g. We've got high learning disabilities in our area so I thought that was a key group to contact straightaway.*" The CCG lead

spoke to partners and the local authority and undertook the grading self-assessment with clinicians on the CCG Board. She used a survey monkey questionnaire to gain staff input into the grading of Goal 3.

- 5.4. She undertook the grading with local interests by **going out to small community groups**. She prioritised by targeting the high density protected groups in the CCG catchment area (Asian people, people with learning disabilities, mental health users and carers), given that as a small new organisation she did not have the capacity to engage with all protected groups. The first stage in the process was to identify the community groups, as this was the first time the CCG had gone out to small local groups. As the City PCT was engaging with city wide groups on EDS the CCG lead decided to go to smaller groups such as tea groups, lunch groups and carers' groups – *"I prefer that approach to a one event approach – meeting them on their territory where they are comfortable"*. She gave some basic information to the groups as a basis for their grading of the eighteen outcomes and used colour cards for all groups. She **adapted her terminology to make the outcomes more relevant** to the Asian and Asian elders groups, and developed specific tailored material to work with the learning disabilities group, using pictures and simple language. She fed back on the issues being raised by the community groups at weekly staff meetings. The governing body accepted the community grades including some reds.
- 5.5. The Newark and Sherwood CCG equalities lead, the Head of Service Improvement and Engagement, presented the EDS to the CCG stakeholder reference group followed by a community engagement workshop with the VCS which undertook initial grading. She supplemented this with a staff survey. The results of these were sense checked against the reference group and taken back to the CCG governing body. An action plan was then developed, linked to the CCG's seven strategic objectives, which formed the basis of its EDS equality objectives. She felt that it was more meaningful to the organisation to **link the strategic objectives to the EDS objectives** rather than have an action for each equality objective. The action plan is now monitored on a quarterly basis by the stakeholder reference group, with exception reporting up to the governing body.
- 5.6. The Cluster PCTs in Nottingham City and County also undertook their own separate grading and engagement work with staff and the public.

### **Challenges**

- 5.7. Challenges identified by interviewees included:
- need to strengthen links with LINK/Healthwatch
  - who will provide support to CCGs on EDS once the PCTs are abolished
  - more guidance needed on how to embed EDS in day to day work rather than as a stand alone exercise



- more guidance needed on what to do once you've got your grading eg how to improve grades
- the demands of the timetable
- the potential for the EDS to heighten expectations among the community members involved and for concerns raised during engagement to go unaddressed
- the limited nature of data on the protected groups available within the NHS and the need for a central drive to improve this .

5.8. Three VCS representatives were interviewed who had been involved in two EDS events, one contributing to another county CCG's grading and the other a regional grading event. It is noteworthy that some community members were not aware that it was a grading session, which raises questions about their **effectiveness as accountability exercises**. The two who had been invited to the regional event, who represented an organisation working with asylum seekers and refugees, were concerned that they had not been involved in the EDS on a more local level, feeling that the regional level was "**not that relevant to us**".

### **What is achieved?**

- 5.9. The Cluster lead feels that the EDS as an NHS developed tool led from the top "*has been a good tool to promote/sell the equality agenda at a time of transition and change*". It got a lot of staff 'on board' and **put equality and diversity "at the centre of the Board agenda"**. A member of staff noted that the EDS work had enabled Cluster staff **to think differently** about issues such as patient choice and GP patient delisting – "*they are now thinking through the implications for patient and service provision more than before*". A senior leader noted how much more straightforward the EDS was compared to previous equality processes such as equality impact assessments which were "*seen as a bit of a pain*". He also noted that it had been "*good to get [EDS] in CCGs when forming rather than later*".
- 5.10. The Nottingham North and East CCG lead feels that the EDS has **opened up communication between the CCG and protected groups in the community** - in particular leading to an on-going partnership with the learning disabilities group - and has improved the general knowledge and awareness of healthcare service among the protected groups. The EDS has enabled the CCG to identify the issues faced by refugees and asylum seekers and people with learning disabilities, and highlighted problems in primary care.
- 5.11. The Newark and Sherwood CCG lead feels that gave the CCG **an opportunity to talk to people** and "*say we need to understand where the health system is not working for you*". 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 equality impact assessments will change as a result. The EDS has added to its knowledge of the local area. She feels the EDS is far **more practical** than previous equality frameworks and impact assessments which *"were just seen as bureaucratic exercises"* and that it has raised the profile of equality and diversity/addressing health inequalities with the governing body and stakeholder groups.

- 5.12. Two VCS representatives were interviewed who took part in the County PCT EDS grading group , which took place over two meetings and included staff members , VCS representatives and service users (including some with literacy problems and learning difficulties). They felt extremely positive about their involvement, one noting that he had felt initial scepticism about the EDS but that his *"concerns were allayed by the **passion and degree of involvement we had**"* and that it had been *"beautiful to see our service users come along and feel thoroughly involved"*.
- 5.13. The PCT Cluster has developed **an accredited element**, through the local college, of involvement of community members in equality and diversity work including the EDS. This was in response to community members at EDS engagement sessions who said they would like something that would help them with careers/CVs. This accreditation element is currently a pathfinder project and it will be up to the CCGs to see if it will carry on.
- 5.14. The EDS grading and engagement work highlighted a number of areas where **potential improvements were identified and work subsequently commissioned** by the Cluster including: the publication of an 'In the Pink' Guide for the LGB community, which is now in its second print run; a guide in everyday language entitled 'What Does Equality Mean for Me?'; funding the translation of a welcome pack for refugees and asylum seekers; and the commissioning of a group called Gypsy Life to undertake health ambassador work - *"the EDS grading reignited the voice of Gypsies and Travellers"*. The Cluster's consideration of the impact of the EDS on commissioning led to the commissioning, with the SHA, of a race equality engagement review, with a number of community groups engaged around how race equality can be improved in new commissioning world. This ties in to the Cluster's work on refugee and asylum seekers and on Gypsies and Travellers.
- 5.15. The EDS led to the **establishment locally of a county wide Equality Trust group** involving various Trusts and independent providers, working together on the rollout of the EDS to avoid duplication and to be as efficient as possible. This group is chaired and co-ordinated by the Cluster lead and it is currently unclear whether it will continue once the PCTs are abolished.
- 5.16. EDS implementation has also led to the development of a regional Equality Dataset.

### **Next steps**

- 5.17. The Nottingham North and East CCG lead feels that the next step is to learn from different groups what the organisation needs to do to improve its EDS grades. She will continue on an on-going basis the engagement with the

small local groups she worked with on EDS grading. *"You can't just leave it there and go there next year – you have to go back to them and say what you're doing, keep the interaction going."* In the next EDS 'round' she would like to do more joint working with partners e.g. the local authority and other CCGs, but not at the expense of a local focus – *"that's the whole point of CCGs"*.

- 5.18. Next year the Newark and Sherwood 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 stand alone EDS engagement exercise. The CCG lead plans to work with county wide partners to avoid different organisations talking to the same groups. She feels the CCG needs to achieve more detailed rather than high level knowledge of its communities with better engagement needed with clinicians who know their patch.
- 5.19. The Cluster is about to do another EDS grading round in preparation for its abolition. It is unclear whether or not the PCT will be implementing the EDS once it becomes a Local Area Team (LAT) of the National Commissioning Board (NCB). A senior leader interviewed hoped that this would be the case noting that it would be *"crucial"* in relation to particular LAT responsibilities such as offender health but another staff member interviewed stated that the LAT would be monitoring the EDS but not implementing it.

### **Plans for the future**

- 5.20. Issues for the future raised by interviewees include:
- the EDS needs review to ensure that it reflects the various bodies involved in new commissioning arrangements. Further Goals 3 and 4 are written for large organisations and lack relevance to CCGs who have a small workforce
  - EDS needs to be revised to make it less onerous and bureaucratic - the process described in the grading manual being *"not achievable"*, not only because eighteen outcomes are too many to get through, but also because the evidence needed to support the outcomes does not currently exist.
  - the performance management and monitoring of the EDS on a regional and national level needs clarification and strengthening. *"There's been no holding to account from the centre/SHA – the 'so what' factor."*

### **Lessons**

- 5.21. The Nottingham North and East CCG lead's biggest learning was around patient involvement and the importance **of follow up/feed back to groups**. *"I hate to think other organisations go in for [EDS] grading and say see you next year"*, feeling this would take away from the positive benefits of

the EDS. In her EDS engagement work she found that some groups had had such bad experiences in the past - *"I've managed to turn them round by promising to go back, and then going back."* She emphasises that the EDS is not an annual tick box but a constant review. Her advice to others implementing the EDS would be not to *"get too hung up around how you do EDS"* but to go out and talk to protected groups, **"have a chat and see how it leads you"**.

5.22. The Newark and Sherwood CCG lead recommends:

- linking the EDS to the organisation's business rather having a stand alone action plan on the EDS objectives
- starting early
- working collaboratively with other organisations on your patch around engagement

5.23. The Cluster lead advises:

- getting and sustaining a core group of community members, to act as a catalyst for EDS engagement and grading
- working across NHS local organisations – *"the public don't care what NHS organisation is talking to them"*
- going around Boards systematically, developing their understanding and confidence on the EDS.

## 6. SOUTHAMPTON CITY, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH PCT CLUSTER

### *What they did*

Southampton City, Hampshire, Isle of Wight and Portsmouth PCT Cluster (SHIP PCT) worked in partnership with NHS providers across the local health economy to implement the EDS. As part of its EDS evidence gathering it developed a local survey to supplement the national Patient Survey given that the response to this locally was considered insufficiently diverse and to ensure that it considered the views of patients and service users from protected groups directly as well as through their VCS representatives at engagement events. The EDS equality objectives it adopted reflected issues which had been identified by local interests and service users.

### *How they did it*

- 6.1. Implementation of the EDS was overseen within the Cluster by the pre-existing Equality and Diversity Committee, a sub-committee of a Board Committee and chaired by a senior leader, which included 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. The Committee met quarterly and received reports on EDS implementation from the equality and diversity leads of the four PCTs within the Cluster.
- 6.2. The Cluster Equalities lead had first heard about the EDS at the South Central Equalities Network meeting, out of which grew the idea of local NHS organisations undertaking the EDS in partnership in response to concerns raised by patients and service users that otherwise they would be over-consulted. The organisations received money from the SHA which it pooled for **joint EDS engagement events**, using the money to **commission a VCS organisation to help** them organise the events. The SHIP Board signed up to the EDS in January 2011, followed by awareness raising events with local interests during the spring and summer of 2011. This included presentations on the EDS being given at the Hampshire Independent Equality Forum which brings together protected groups, and to the Health and Wellbeing Board and the local LINK.
- 6.3. Data gathering commenced in Summer 2011 with a template developed by the partner organisations to gather data across the organisations. Initially it was planned to hold grading events in Autumn 2011 but it was not possible to do this as some organisations had not yet gathered their data. SHIP

carried out a self-assessment in December 2011 and arranged an event where all partner organisations came together to look at the data that they had and consider what grades they were likely to be. At this point it was realised that the various organisations were all at different stages and the process ended up being one of separate self-assessment by each organisation with different organisations undertaking different approaches. As the SHIP Cluster brought together four PCTs four different sets of data and grades had to be produced, as each had a statutory duty under the Equality Act.

- 6.4. These interim grades were presented to the Board in January 2011 and published at the end of the month as part of the equalities information collated to meet the specific public sector equality duty. The interim grades were then taken to 'Everyone Counts' events with local interests, with four taking place between the end of January and March (a different approach was taken on the Isle of Wight which used existing forums to gather views rather than holding specific engagement events ).
- 6.5. The events represented all protected characteristics, bringing them all together in one room. Participants were "assertive" and said "loud and clear" that in some cases the PCTs and provider trusts had over-graded themselves and subsequently downgraded them.
- 6.6. In initial awareness raising work service users had said that they did not understand the EDS and that some of it had gone over their head. They said that careful thought needed to be given to **making the EDS more accessible**. The workshops were therefore designed carefully taking this into account, drawing on a model from Kettering Hospital publicised at a national EDS Conference which bolted the EDS outcomes onto a patient pathway model. This enabled discussions to be held about GPs, community services, the hospital and mental health services from the patient perspective.
- 6.7. Only the outcomes in Goals 1 and 2, the patient-focused outcomes, were included. Rather than going through each of the nine outcomes, some of the outcomes were used as a prompt for conversation, with some lending themselves better than others to this – it was not found possible to cover all the nine outcomes directly in the workshops. It was considered that going through each outcomes one by one would be too "dry and boring" and that a 'steered conversation about the NHS' was preferable. While the evidence gathered for the EDS was physically taken into the room, it was considered that it was not possible to "trawl through" it all in one day with participants, with the organisations instead describing why they thought they were a certain grade. (However in one of the four events the process was spread over two days, with the first being introductory, talking about EDS and the evidence, and the second day spent doing the grading.)
- 6.8. Particular themes clearly came through the discussions. Both of the VCS participants in the grading group interviewed commented that they had appreciated the **diverse range of the community** which the grading group participants represented, finding it valuable to include a cross-section of

protected and age groups and of both the voluntary and independent sector (e.g. nursing homes). They felt that a good job had been done in making the material accessible and in checking out people's understanding throughout.

- 6.9. The organisers recognised that they could only include a limited number of people, generally VCS representatives, in the grading workshops. They focused on people used to engaging with the public sector in response to the feedback that service users found the EDS really difficult to understand. However to supplement these events an Everyone Counts survey was undertaken to gather the views of service users, targeted at protected groups – “a way of giving ordinary service users their voice” rather than only going through their representatives. The survey asked about people's experience using different parts of NHS services, with questions modelled on national Patient Surveys so that direct comparison could be made between local scores and national findings.
- 6.10. However it was felt that protected groups in the SHIP catchment area had not been well represented in the national surveys and so focused efforts were made **to target service users from protected groups** to respond to the survey, using community networks and a mix of online and paper copies of the survey. For example, 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. The results of the local survey highlighted similar issues to those which had been raised in the grading workshops.
- 6.11. The Cluster had already put together a list of equality objectives based on its evidence gathering and initial grading process, but these were essentially process-based e.g. training. “Going to the workshops brought it down to earth... we ditched all our original equality objectives”. A new list of equality objectives were shortlisted corresponding directly to the issues raised at workshops and in the service user survey.

*“Otherwise we would have just had a list of corporate actions that didn't correspond as well to what service users and communities told us.” (EDS lead)*

- 6.12. They were chosen as being objectives which were measurable – it was possible to gather and analyse data on them – and constituting PCT core business, as well as having a clear need as identified by local interests/the survey. These six objectives were then prioritised with two chosen for Year One:

- Increasing access to the Improving Access to Psychological Therapies (IAPT) service for people from BME groups and LGBT people (both highlighted by local interests) and for veterans, males, people with long-term conditions and older people (these groups having been highlighted by internal IAPT 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.
- One of the issues raised by local interests was that 'professionals ask us the same questions again and again as we move through the system', seen as particularly difficult for those with language/communication difficulties. The local interests highlighted the Say It Once campaign where answers are written on a form/profile which the patient takes with them around the healthcare system. The Cluster has adopted an objective to increase take up and awareness of Say It Once and the Personal Profile. It is working with the voluntary sector to raise awareness among protected groups, is uploading it to the Hampshire Health Record, and is raising awareness of it among clinicians.

### Challenges

- 6.13. The decision to implement the EDS in partnership across the local health economy meant that a key challenge was **how to co-ordinate the approach across so many organisations**, each of which were at a different stage of implementation. E.g. this led to the grading events being delayed from the original timetable. "It would have been a lot easier to just do it for the PCTs, but it would have meant local interests were over-consulted."
- 6.14. **Gathering evidence** was also found to be challenging, particularly against a background of organisational change in which colleagues did not have the capacity to fully contribute to the evidence gathering process and which generated an atmosphere of uncertainty. To make the process manageable it was decided to prioritise certain datasets. Halfway through the process it was realised that while data in relation to four or five of the protected characteristics was relatively straightforward, data for all nine was not available – a national rather than local problem requiring qualitative engagement to fill the gaps.
- 6.15. As a result of the above process significant amounts of data were gathered for each goal making it a key challenge to **make the process of engaging local interests interesting and accessible**. As set out above it was decided to develop further the Kettering Hospital model of bolting EDS outcomes onto the patient pathway to meet this challenge.
- 6.16. The Cluster EDS lead felt that **more support** in delivering the EDS would have been welcome – "implementing the EDS took most of my time for 12



months". He had hoped that working in partnership across organisations would have lessened the work but in reality this was not the case. He would also have welcomed colleagues having more capacity to contribute to the evidence gathering process. The timing of the final version of the national guidance was also criticised as having come out too late in the process.

- 6.17. Two VCS participants in the grading workshops were interviewed. Both were critical of the **lack of follow up** by the NHS organisations involved subsequent to the grading workshops – “no follow up, only an incomprehensible website” - feeling that they should have had direct feedback on the rest of the EDS process e.g. an email setting out the equality objectives and action plans subsequently adopted by the organisations. Further down the line it was felt that the NHS organisations should report back to the group in accessible terms on progress and tell them whether and how they had changed as a result of the process. One expressed disappointment that she had met some local NHS organisations for the first time at the grading group and they had promised that they would be in touch with her but had not kept this promise, making her feel that the EDS was “an exercise in word only ... we were hoping for more engagement and on-going liaising and communication but it didn’t materialise”. Both participants interviewed were willing to be involved again but had no idea what the future process would be and whether/how they would be asked.
- 6.18. The VCS participants expressed scepticism as to **whether the EDS would lead to any tangible change** for patients and service users. One because of the lack of feedback given about actions being taken - “I don’t expect it to make a difference – I don’t know what programmes are in place to address the ‘reds’” and because of the view that the EDS is an internally focussed management tool - “very much an internal measure not an external measure – means nothing to the end user in direct terms”. The other participant felt the EDS needed strengthening to “have some teeth” in relation to GPs who it was felt were answerable to nobody.

### ***What is achieved?***

- 6.19. The fact that local interests in some areas downgraded the NHS organisations is seen in itself as “powerful” by the Cluster EDS lead who feels that the EDS provides **more structured and focused engagement** with local interests compared to consultation on equality schemes.
- 6.20. The use of the Everyone Counts local survey and the process of identifying which protected groups had not filled it in and working with community networks to target service users from these groups is seen as a valuable means of **ensuring the voice of service users were heard directly**, in addition to the engagement events which brought together VCS organisational representatives. The data gathered for EDS has “dramatically improved” the quality of equality analysis undertaken by the Cluster.
- 6.21. The EDS is considered by the EDS lead to have **increased awareness and buy in** of equality and diversity at Cluster Board level and among commissioners both of whom “now get it more as a result of EDS”. The



senior leader who oversaw EDS implementation feels it gave the four commissioning organisations coming together as a Cluster a common approach to service improvement and facilitated a dialogue about the best way to effect change, without insisting that 'one size fits all'. Its evidence based approach enabled the changes which needed to be made to address organisational weaknesses (e.g. staff awareness/training) to be robustly argued for and the necessary time and resources secured. Such evidence is particularly "vital" at a time when resources are tight, and enabled equality and diversity to be re-prioritised higher up the commissioning agenda than previously.

- 6.22. The two equality objectives are still in early stages of implementation. However, the IAPT Commissioning Manager has produced baseline data, feels that she is now "**paying more attention to equality in contract monitoring**", and has secured funding for awareness raising work among target groups. The local authority and VCS officials interviewed who work on the Say It Once project feel more confident of its sustainability as a result of its adoption as an EDS equality objective.

### **Next steps**

- 6.23. The senior leader overseeing EDS implementation is confident the Cluster can enable EDS to be a legacy to be taken up by successor organisations (NCB and CCGs – ideally through a CSS rather than at individual CCG level) should they wish to do so. This is important given the role of EDS in the CCG authorisation process.

*"People are fearful the CCGs will start from the beginning, rather than build on work that has already happened."* Local authority official involved in the Say It Once equality objective work.

- 6.24. The senior leader feels that the EDS has a reliance on improvements which only larger employers i.e. providers can manage – whereas there will not be many staff deployed in commissioning in the future. He also queried whether the new NHS would be able to invest sufficiently to make the EDS productive, and how governance and leadership of equality and diversity issues will work in the new environment.

### **Lessons**

- 6.25. The Cluster EDS lead's key learning was around the better use of data for equality and diversity. The EDS process has provided a range of data which the organisation had not had previously and a more detailed knowledge of data gaps. Data improvement is now being taken forward in a focused way through implementation of the equality objectives rather than across the board as this is considered to be unmanageable.
- 6.26. The EDS lead's tips to others implementing the EDS include:

- **bring together a project team** – including e.g. an information analyst, key commissioning managers -to implement EDS rather than just giving responsibility to the equality and diversity lead, as this would achieve staff buy in from the start and make the workload more manageable.
- **undertake engagement in partnership** with other NHS organisations and the local authority, working in partnership with VCS eg commission them to organise EDS events. Use existing networks and resources to full potential.
- look at **what data is already available** and prioritise a limited number of key datasets rather than try and do everything – this was echoed by the senior leader who warned against being “blinded by the data and trying to do too much”, advocating setting aside time to really look at the data and intelligence and produce practical and limited actions. He emphasised that the Cluster had chosen only two out of the six equality objectives for Year One implementation because “you need to focus your resources adequately to deliver change – you need to focus in”.

## 7. UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

### *What they did*

University Hospitals Birmingham Foundation Trust (UHBFT) is the leading university teaching hospital in the West Midlands. The Trust runs two hospitals – the Queen Elizabeth Hospital and Selly Oak Hospital which provide adult services to more than half a million patients every year. UHBFT are led by their values which are focused on Respect, Responsibility, Honesty and Innovation all of which they see as being intrinsic to delivering on the equality agenda. UHBFT took an approach to EDS implementation that was meaningful to them by using it as a catalyst to push forward on their equality and engagement work currently underway, particularly to provide impetus in developing meaningful relationships with its voluntary sector partners.

### *How they did it*

- 7.1. University Hospitals Birmingham Foundation Trust (UHBFT) took the decision early on to use the EDS in a way that was most useful to the organisation in terms of progressing its equality work. The Trust wanted to use the EDS as a **catalyst** to push forward with embedding its values and specifically, to continue to mainstream equality so that it becomes everybody's responsibility and to drive meaningful change – that makes a difference for its patients and staff.
- 7.2. UHBFT's Senior HR Manager in Governance, recently took over the role of equality lead and found the EDS to be a useful structure to **help bring together the good work within the Trust**, take stock and push forward with the equality work he had already started.
- 7.3. The Trust found that the underlying principles of the EDS dovetail with its overall approach to equality particularly in terms of building meaningful relationships with communities. In this way, the Trust used the EDS as a framework **to focus their efforts and build momentum**. The Trust's approach to equality is building from the 'bottom up', which for them means working with local voluntary groups who advocate on behalf of specific groups of people to identify and address issues - particularly for those groups who are more vulnerable and 'harder to reach'.
- 7.4. The Trust is in the early stages of its equality work. To kick start the EDS work, an equalities steering group was established at executive level, led by the Director of Partnerships – the executive director for equality. The Trust were keen not to reinvent the wheel – they knew that a lot of good things

were being done within the Trust on equality, it being an integral part of the Trust's values but that weren't necessarily badged as 'equality and diversity' work. So one of the first things that the Trust did was to bring together all interested parties - identifying work streams and talking to people about what they were doing with the aim of taking stock.

- 7.5. Early on in the process, the Trust interrogated its complaints data. The Trust wanted to spend some **time getting to know the issues** for the Trust and felt this was the best place to start. Through analysing its existing data and through consulting with its voluntary sector partners – the Trust was able to build a picture of those issues most pertinent for the Trust – with a focus on highlighting the 'more difficult' issues among the lesser understood protected characteristic groups.
- 7.6. UHBFT took the decision early on to focus their 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. The Trust consciously didn't want to reinforce the 'equality and diversity silo' with their approach to the EDS but wanted to use it to build on the work they were already doing and the progress they were already making in terms of equality. 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.
- 7.7. UHBFT had already started to **have conversations with local third sector organisations** as part of its equality work, so they looked to push this further using the EDS as a catalyst. The Trust had carried out some consultation prior to the EDS and from that had begun to build relationships with local voluntary sector organisations – Sense, Restore (working with refugees), BID (Birmingham Institute for the deaf), Autism West Midlands, Birmingham LBGT, Action for Blindness and Guide Dogs, who had helped the Trust to identify issues for the patients and communities they advocate for and work with. Because this is the type of work the EDS advocates, the Trust wanted to build on this existing and on-going work further, using the EDS as a framework to do that, linking their work up to EDS goals and outcomes.
- 7.8. The relationships that the Trust is building with voluntary organisations are **mutually beneficial and collaborative**. Termed '3<sup>rd</sup> sector collaborative working', the Trust looked at what they could offer voluntary organisations in return for their expertise in a mutually beneficial way. The Trust has a large education centre and so offered to provide voluntary organisations with free training space in return for filling in deficits or bringing their more relevant knowledge and experience in the Trust's knowledge around specific client groups, providing expert teaching and education and 'critical friend' support with policies and procedures which is invaluable in terms of fulfilling the trusts equality duty. The trust also has a unique facility called the Learning Hub which works with long term unemployed people to get back into employment. The Trust recognised that this facility could be of use to the 3<sup>rd</sup> sector groups clients in helping them with literacy, numeracy and to become

'job ready' better focussing 3<sup>rd</sup> sector monies away from services that could be delivered by UHB to other priority areas.

- 7.9. For example, working collaboratively with Sense has helped the Trust to recognise the deficits in patient experience and care for deaf blind patients. Sense identified issues in residential homes for its clients and as a result, clinical nurse specialists up-skilled staff in residential homes for improved care for service users. It was also recognised that some deaf blind clients were not seen as promptly in the Trust's emergency department, so a unique passport system, complimented with departmental teaching delivered by Sense was developed whereby every deaf blind client is issued with a **personalised passport** which assists in the early identification and treatment of a group with specific needs, where delay might hamper diagnosis and treatment.. So this way of working has created a 'free flow' of information back and forth – a continuous dialogue and the responsiveness of UHBFT has helped to develop a trusting and meaningful relationship with voluntary sector organisations. Although this was already in place, the nature of these relationships has proved beneficial for the EDS requirements.

*"We've formed a good relationship [with the HR manager]. We've done training for A&E staff on mental health and same sex domestic violence. And we have been able to hold an exhibition of transgendered portraiture here in reception [at UHB] and we got a fantastic response". (Director of Birmingham LGBT)*

- 7.10. A series of consultation workshops were held with the Trust's Patient Carer Council (PCC) representatives, relevant Trust staff and voluntary sector partners. The PCC members have all have been patients and advocate on behalf of wards. They regularly meet to share good practice or issues on wards and so this was recognised as a useful forum to support the EDS. So the Trust tapped into meetings that were already happening, but broadened them out to bring in others (voluntary sector partners and other staff, e.g. Anglican Chaplain) and focus on the requirements of EDS - reviewing the evidence, grading and objective setting.
- 7.11. This resulted in four equality objectives being agreed for the Trust with a focus on **strengthening its data collection** processes to include all protected characteristics for both patients and staff as well as **strengthening the trusts already established Dignity in Care** initiatives.

### **Challenges**

- 7.12. A specific challenge identified in terms of delivering the EDS within a Foundation Trust setting was that **some of the requirements of the EDS were not relevant**, particularly some of the specific outcomes, for example, Public Health vaccinations. However, the Trust worked with the EDS in the best way they could that worked for them.
- 7.13. The Trust felt that more coordination within the region would have been helpful particularly to coordinate engagement with voluntary sector organisations in Birmingham to minimise 'consultation fatigue' among the

voluntary sector. The Trust felt that this was a missed opportunity for the region to ensure a coherent, cohesive consultation process that built meaningful relationships with voluntary sector and communities and for NHS organisations to build specific areas of expertise around certain protected characteristics and in effect to become 'beacons sites' where good practice could be shared regionally and nationally..

- 7.14. A challenge faced by members of the PCC in engaging in the EDS process was in fully understand the process and in particular, the terminology used which was particularly difficult in terms of the RAG rating process: "*[The EDS] is full of NHS speak, jargon, abbreviations – it was a concern, we thought 'how are we going to do this?'*" (Member of UHBFT Patient Carer Council).

### **What is achieved?**

- 7.15. The Trust agreed that the EDS has given more **weight to the equality agenda**, giving the equality lead 'more power to my elbow'. This has meant that the EDS has been used as a lever to ensure people are 'paying attention' and respond to requests for information, for example. Its links to the CQC and its national profile has helped with this.

*"The EDS is an enabler. With the links to the CQC it helps re-prioritise when there's a lot going on"* (Executive Lead for Equality, UHBFT)"

- 7.16. UHBFT's equality leads were keen to identify and prioritise issues for harder to reach groups, and found that the EDS **legitimises the work that was already being done** for harder to reach groups, groups they feel can easily be forgotten. The EDS gives all nine Protected Characteristics equal importance – something that's really important for the Trust.

*"It's useful for focussing – so we're not missing groups out"* (member of UHBFT Patient Carer Council)

- 7.17. The EDS **has provided a useful structure** to equality within the Trust, particularly helpful with the equality lead being new to the role. This has helped the Trust to align its work with the EDS goals and outcomes but also has helped to **integrate equality work strands** within the Trust. For example, the work that the Anglican Chaplain is doing in terms of building links with local faith organisations is now being integrated into mainstream equality work – prompted by the EDS. The Chaplain will test out the Trust's equality objectives with faith groups across the city through consultation events.

*"It's enabled us to be more coherent – pulling disparate groups doing good stuff for less duplication and more sharing and celebrating good practice"* (Equality lead and Senior HR Manager – Governance)

*"It feels like (the EDS) is a natural progression of what we're doing anyway. It helps to reinvigorate and is an opportunity to develop our work and make it more integrated"* (Anglican Chaplain, UHBFT Multifaith Team)

- 7.18. The EDS has **provided impetus** for third sector collaborative working – helping the Trust to **build on its relationships with voluntary sector organisations**. Voluntary sector partners were invited to the Trust’s EDS consultation workshops and were involved in reviewing equality data and the RAG ratings. The Trust believe that through this process, its voluntary sector partners have developed a better understanding of how the organisation works and identify more opportunities and ‘ways in’ to work with the Trust and influence services and activities.

*"It has brought a different pace to it (equality work)" (UHBFT Director of Partnerships)*

- 7.19. Highlighted need to **improve equality monitoring**, so anticipated that it will lead to improvements in that respect, which will help the Trust to systematically highlight inequalities that exist in terms of access, experience and outcomes for its patients and staff.

*"The impetus (for strengthening equality data) came through the EDS" (Lead Nurse for Care of Older People)*

### **Next steps**

- 7.20. The Trust aims to continue to build enduring relationships with voluntary sector organisations and work towards its equality objectives identified.
- 7.21. The Equality lead is looking to work closer with voluntary sector orgs around the EDS to empower them to be more proactive with other NHS organisations both locally and nationally, so that voluntary organisations can use the EDS as ‘a way in’ in terms of more pro-active engagement and involvement.
- 7.22. The Trust is looking to provide people with particular needs the opportunity to undertake work experience in the hospital and to take positive action as an employer. So that it becomes truly about working collaboratively with voluntary sector for improved outcomes for patients and the community alike
- 7.23. And in light of its equality objectives, the Trust will work to strengthen its data collection processes to include all protected characteristics for both patient and staff.

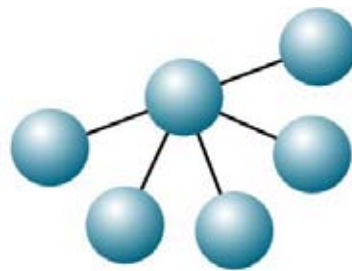
### **Lessons**

- 7.24. Critical **complaints data** is a good place to start. You will gain more respect from communities and voluntary sector partners if you put your hand up as an organisation and say this is where we’re going wrong, but this is how we’re going to put that right together.
- 7.25. UHBFT are **setting their own pace** and allowing the work to ‘feed’ the EDS agenda at the same time. They’re keen to build meaningful relationships with voluntary sector organisations, and they recognise that that can take time. But demonstrating that you’re responsive to issues for certain groups can go

a long way to earning respect and developing mutually beneficial and long lasting relationships.

- 7.26. Don't expect voluntary organisations to do something for nothing. They are professional organisations with many demands on their time. Think about **what you as an organisation can offer them in return for their expertise**. This could be training for their staff or providing meeting/training space.





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