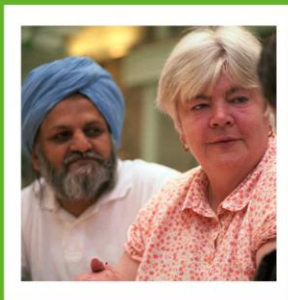


# The Equality Delivery System for the NHS



Making Sure Everyone Counts



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## Abbreviations

CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DH	Department of Health
EDC	NHS Equality and Diversity Council
EDS	Equality Delivery System for the NHS
GEO	Government Equalities Office
JSNA	Joint Strategic Needs Assessment
LINKs	Local Involvement Networks
NHS	National Health Service
PALS	Patient Advice and Liaison Services
PPEE	Public and Patient Engagement and Experience
PCT	Primary Care Trust
QIPP	Quality, Innovation, Prevention, Productivity
SHA	Strategic Health Authority

# The Equality Delivery System for the NHS

## Making Sure Everyone Counts



### Foreword

As we create the new health and care system with many brand new organisations, we have a major opportunity to re-embed the NHS Constitution throughout the NHS and make sure everyone counts.

Equality lies at the heart of what we believe about the NHS – its values, processes and behaviours. Therefore, as we build a service that is personal, fair and diverse at its core, we must look

first to patients and their aspirations and remove the barriers that stop nurses and doctors working to their full potential. We must ensure workplaces treat staff, as well as patients, fairly and treat them well.

The NHS should take great pride in its achievements to date on equality. Since 2009 the NHS Equality and Diversity Council has been leading the way, embedding this vision of a better, personal and fair NHS and working to deliver its aim of making sure everyone counts. We have come a long way, but of course there is always more to be done. That is why one of the very first things the Council initiated was the Equality Delivery System.

The Equality Delivery System we have today is the cumulation of 18 months' hard work. There has been huge involvement from patients, carers, volunteers and those who work in the NHS in creating the Equality Delivery System, and I firmly believe it is richer for this expertise and scrutiny.

Inequalities of access, care and outcome still exist, and there are instances when people are not being treated with the dignity and respect that they deserve. By recognising that every patient has different needs and circumstances, we can best meet those needs and improve outcomes by delivering a personal form of care, using and supporting the diverse talents and experiences of our workforce.

The Equality Delivery System is a toolkit to help all staff and NHS organisations understand how equality can drive improvements, strengthen the accountability of services to those using them, and bring about workplaces free from discrimination.

The changes we make now will shape the way we work for years to come, making the NHS more efficient, more productive and more responsive to the needs of patients and staff alike. The Equality Delivery System will be a central part of achieving this goal. I believe that the work we do on equality will have a defining effect on how the NHS of the future is experienced and perceived. I am certain that with work such as the Equality Delivery System it will be described as being a service that is personal, fair and diverse, and where everyone counts.

**Sir David Nicholson KCB CBE**  
**NHS Chief Executive and**  
**Chair of the NHS Equality & Diversity Council**  
10 November 2011

## Background: Design and Acknowledgements

The Equality Delivery System (EDS) has been built by the NHS for the NHS. Commissioned and steered by the Equality and Diversity Council (EDC), its original development owes a great deal to NHS North West and national implementation is led by NHS Midlands and the East.

The EDC, established in 2009, provides strategic leadership in supporting the NHS to deliver better outcomes for patients, comply with the Equality Act 2010 (particularly the public sector Equality Duty), ensuring services and work places are personal, fair and diverse. The EDC is chaired by the NHS Chief Executive, Sir David Nicholson, and includes representatives from the NHS, Department of Health (DH), trade unions, patient groups, regulators and the voluntary sector. For more information visit: <http://www.dh.gov.uk/en/Managingyourorganisation/Workforce/Equalityanddiversity/index.htm>

For the EDC, work was taken forward by a DH team led by Clare Chapman and a NHS team led by Tim Rideout. At the time, Clare Chapman was Director General of Workforce at DH. Tim Rideout is Chief Executive of NHS Leicester City and currently assigned to work at DH on the design of the NHS Commissioning Board.

At the outset, the content of the EDS was informed by the “Equality Performance Improvement Toolkit” developed and used by NHS North West, in order to arrive at an evidence-based and outcome-focused system to drive forward positive change in the region. Other good practice in the NHS and beyond was also taken into account.

It was subsequently developed through the NHS leadership and resources of, first, NHS East Midlands and, then, NHS Midlands and the East, and published by that Strategic Health Authority (SHA) Cluster on behalf of the NHS.

A Technical Working Group advised on detailed proposals, with SHA Equality and Inclusion Leads playing a major role. Other members represented Primary Care Trusts (PCTs), NHS foundation trusts, NHS Employers and the Care Quality Commission (CQC).

Once the first phase of EDS design work was completed, proposals were extensively shared through over 50 national and regional engagement events from July 2010 to May 2011. The events were chaired by the NHS leaders on the EDC, and were attended by over 3,000 people drawn from patients, community members, voluntary organisations, staff from NHS commissioners and NHS providers, and staff-side organisations. Their views contributed greatly to the final EDS design.

Work on descriptions of the EDS grades took place in a workshop facilitated by Stonewall. NHS Employers and their Diversity Partners, the Inclusion Workstream of the National Leadership Council as was, the EDC Trust Reference Group and the Social Partnership Forum further helped to develop the grade descriptions.

The EDS was made available to the NHS on 29 July 2011. An updated version was made available for the formal launch of the EDS on 10 November 2011, to reflect the enactment of the Specific Duties of the public sector Equality Duty and emerging implementation themes. This current version of the EDS main text, and the accompanying Grades Manual, are revised with respect to references to EDS Outcome 3.2.

# The Equality Delivery System for the NHS

## Making Sure Everyone Counts

### What is the Equality Delivery System?

The EDS is designed to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS is all about making positive differences to healthy living and working lives so that everyone counts.

It is made available to the NHS as an optional tool.

If adopted and used effectively, the EDS should help organisations to start the analysis that is required by section 149 of the Equality Act 2010 (“the public sector Equality Duty”) in a way that promotes localism and also helps them deliver on the NHS Outcomes Framework, the NHS Constitution and the Human Resources Transition Framework. It will help providers to continue to meet CQC’s “Essential Standards of Quality and Safety”.

The EDS is a tool for both current and emerging NHS organisations – in partnership with patients, the public, staff and staff-side organisations – to use to review their equality performance and to identify equality objectives and actions. It offers local and national reporting and accountability mechanisms.

While the EDS can help inform the decision-making process, it is important to ensure that it is used as a tool to assist with evidence gathering and evaluation as part of the decision-making process. Of itself it does not satisfy the public sector Equality Duty. In every case, organisations need to ensure that the decisions they make are in accordance with the requirements of public law. It should be implemented within a culture that already recognises the equality challenges it faces, is ready to engage with patients, communities and staff, and has the resolve to move forward positively.

At the heart of the EDS is a set of 18 outcomes grouped into four goals. These outcomes focus on the issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined.

The four EDS goals are:



1. Better health outcomes for all

2. Improved patient access and experience

3. Empowered, engaged and included staff

4. Inclusive leadership at all levels



The grades are as follows:

- ▲ Excelling – Purple
- ▲ Achieving – Green
- ▲ Developing – Amber
- ▲ Undeveloped – Red



See the following annexes:

Annex A – for the EDS outcomes

Annex B – for how the EDS outcomes align with the first principle, and the rights and pledges, of the NHS Constitution

Annex C – for how the EDS outcomes support the FREDA principles of Fairness, Equality, Dignity and Autonomy (which underpin a human rights-based approach)

Annex D – for how the EDS outcomes align with CQC's "Essential Standards of Quality and Safety", March 2010

Annex E – for the EDS Grades and also the separate "EDS Grades Manual"

## Is it about people or processes?

The EDS focuses on people. It helps to ensure that everyone counts. It provides a tool to help organisations be the best they can be for their patients and staff. It can be used to support commissioners to identify local needs and priorities, particularly unmet needs of seldom-heard populations, and allow them to shape services around people's specific circumstances, and so help to deliver better outcomes.





NHS Midlands and the East is pleased to lead on the EDS on behalf of the NHS across the country. The EDS is about our staff, patients, carers and communities – that is, everyone who relies on and works in the NHS. By getting it right for them, they will become champions for equality. We look forward to supporting our NHS colleagues throughout the region to implement a people-focused EDS. We should all be grateful to Kevin Orford, Chief Executive of NHS East Midlands, for his strong leadership on equality and the EDS and for putting us in such a good position to make progress.

*Sir Neil McKay CB, Chief Executive, NHS Midlands and the East*

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We cannot take the NHS forward unless we integrate care around the needs of all our patients. Successful collaboration between health care providers will move the NHS forward and transform the outcomes that matter most to patients. The EDS will support the NHS to individualise care and meet the needs of our diverse communities.

*Professor Steve Field, Chair, NHS Future Forum*

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The purpose is to provide a tool that can be used to help make evidence-based decisions, taking into account all relevant facts and matters.

Where the EDS is used, resulting equality objectives and associated actions should feed into mainstream patient and workforce initiatives, and be reported and acted on through mainstream business planning. In this way, the documentation in its own right should be kept to a minimum. For example:

- Key headlines and action points arising from EDS-focused discussions with patients, community members and staff should be kept so that all parties can readily see what is being agreed and which party is responsible for what action.
- Grades, equality objectives and associated actions should be communicated simply and briefly to local interests and partners such as local authorities.

No attempt should be made to recreate the processes and paperwork of Single Equality Schemes and Action Plans of the previous equality legislation, despite the quality and usefulness of some of them.

Above all, the EDS is about effecting real change. It is not about using the EDS in order to tick “the equality box”. It is about helping and supporting staff to understand the importance of personalisation, fairness and diversity as they plan and deliver services, and as they work together as colleagues. It is about providing an environment where staff can thrive and, hence, deliver better outcomes for patients. Organisations should consider how they are going to effect the necessary changes in staff knowledge, commitment and confidence on delivering equality.

## **Why is the EDS needed?**

The EDC has prioritised the EDS as the best means of helping the NHS as a whole to improve its equality performance. Despite much good practice, there is considerable evidence that some patients and communities may feel they are not as well served by the NHS as they should be. For example, information that organisations make available to patients and communities may not be accessible to everyone. Access to NHS services or buildings can be difficult for some patients and members of the public. Once people are receiving services, service delivery may not be appropriate to people’s needs and circumstances.

Similarly, some staff may experience difficulties in developing their careers in the NHS. Some staff may feel excluded from some occupations or grades. Bullying and harassment in the workplace can have a greater adverse impact upon some types of staff than others. Staff disciplinary processes can focus on particular types of staff.

The Equality Analysis for the EDS provides this evidence. It also signals the importance and use that Equality Analyses should continue to play in the development of NHS services, functions and policies.

## **How do we get commitment and consensus?**

At the outset, before organisations attempt to use the EDS with their local interests, their leaders should confirm their own commitment to, and vision for, services and workplaces that are personal, fair and diverse. They should attempt to seek local consensus among these local interests including statutory partners. They should consider the evidence (including gaps) of the extent of health inequalities and equality issues in their own areas, and stress that tackling inequalities and promoting equality is everyone’s business, and that no one organisation or stakeholder can work in isolation from others in making progress. They should emphasise that the work of the NHS must, above all, focus on getting it right for people – be they patients, other members of the public and staff – and processes should only be put in place to help get things right. Materials to support organisations communicate a consistent and clear message about equality are set out in the EDC Communications Strategy, available from the EDC at <http://www.dh.gov.uk/en/Managingyourorganisation/Workforce/Equalityanddiversity/index.htm>



The NLC is committed to promoting equality in the NHS through inclusive leadership. It expects all current and emerging NHS leaders to set an example by committing themselves and their organisations to achieving equality through the successful adoption of the EDS.

*NHS Leadership Council*

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## Who does the EDS cover?

The EDS covers all those people with characteristics protected by the Equality Act 2010. There are nine characteristics in total:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race including nationality and ethnicity
- Religion or belief
- Sex
- Sexual orientation

As shorthand, the term “**protected groups**” is used in this document to refer to people with these characteristics. See Annex F for a fuller description of the protected characteristics.



Race for Health warmly welcomes the EDS. It fully supports the aspiration to embed the principles of equality into the cultures and behaviours of the NHS, and is fully committed to offer all necessary assistance to turn this aspiration into reality.

*Helen Hally, National Director, Race for Health*

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The NHS has contributed to progressing equality for patients, staff and the public. However, there is still much to do. Voluntary and community organisations from across England welcome the EDS and we are looking forward to playing an active part towards making equality a reality for patients, staff and the public, in all NHS organisations.

*Age UK*

*Carers UK, Princess Royal Trust for Carers and Crossroads*

*FaithAction*

*LGB&T Partnership*

*Men's Health Forum*

*Mental Health Providers Forum*

*NACRO/Action for Prisoners' Families*

*National Association for Voluntary and Community Action*

*National Care Forum and Voluntary Organisations Disability Group*

*National Children's Bureau*

*National Council for Palliative Care*

*National Heart Forum*

*Race Equality Foundation*

*RADAR, National Centre for Independent Living and Shaping*

*Our Lives National User Network*

*Regional Voices*

*Royal British Legion/Combat Stress*

*National Voices*

*Women's Health and Equality Consortium*

*(Department of Health Strategic Partners)*

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The EDS has been designed for use by NHS commissioners – both in the current NHS and the new NHS as set out in the Health and Social Care Bill 2011 – should they wish to adopt it. This means that the EDS applies to PCTs until they are abolished, and to Clinical Commissioning Groups (CCGs) once established to take over the commissioning work of PCTs.

Currently PCT Clusters have been formed so the NHS reforms set out in the Health and Social Care Bill, currently before Parliament, can be made smoothly with respect to commissioning responsibilities and leadership. In many cases, executive and management functions of individual PCTs have been delegated to other PCTs in the Cluster. The public sector Equality Duty cannot be delegated – the PCT cannot delegate it as such. However, where functions are transferred to another PCT, the duty will apply, in relation to those functions, to the body which exercises those functions. PCTs should take independent legal advice in individual cases where they are unsure as to where the public sector Equality Duty lies.

NHS providers, including NHS foundation trusts, have also been involved in designing the EDS. As with NHS commissioners, they will choose to adopt the EDS or not. Where provider organisations are large, with multiple sites and/or a range of services, the temptation to run separate EDS processes for each site or department should be resisted. Instead, a Board should ensure that within the application of a single EDS for its organisation, it takes account of potential different levels of performance across sites and services. Exactly how large organisations go about applying the EDS in these situations will be up to local determination.

In this document the term “NHS organisation” is used to refer to both NHS commissioners and NHS providers. They have a responsibility not only for the welfare of their patients but also for the welfare of their staff.

NHS commissioners may also require private healthcare providers that are not a part of the NHS, but which may work to contracts issued by NHS commissioners, to implement the EDS via a term in their service contracts.

## What will the EDS deliver?

If organisations choose to implement the EDS, it provides a tool that can be used to:

- Help deliver on the Government’s commitment to localism and local decision-making (DH, White Paper, “Equity and excellence: liberating the NHS”, 2010).
- Help deliver on the Government’s commitment to fairness and personalisation, including the equality-focused rights and pledges of the NHS Constitution (DH, 2010).
- Help deliver improved and more consistent performance on equality for patients, carers, communities and staff. In particular, deliver better outcomes for patients, carers and communities with regard to the NHS Outcomes Framework (DH, 2010).
- Help deliver on the principles, objectives, requirements of the Human Resources Transition Framework (DH, 2011).
- Help comply with the public sector Equality Duty.
- Respond better to CQC Essential Standards, if they are registered providers.
- Ensure that their staff can deliver services that are personal, fair and diverse, and are supported to do so.

By providing a national equalities tool for local use, the EDS will lead to greater consistency, transparency and greater sharing of good practice across the NHS.

*See Annex F for a summary of the Equality Act 2010, the public sector Equality Duty and the associated Specific Duties*



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The Equality and Diversity Council, which has sponsored the Equality Delivery System, and all those in the NHS who have developed it, are to be congratulated.

The EDS will greatly help the NHS meet the requirements of the public sector Equality Duty. This is a good example of how different parts of the public sector can implement the Equality Duty in a way that fits with their own circumstances, and their wider public service objectives.

*Government Equalities Office*



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Delivering the public sector Equality Duty will help health organisations to develop effective services that meet patients' needs, improve the health of the population and tackle health inequalities. It will also help them develop a more representative and inclusive workforce.

However, a recent Commission study found that many health organisations see equality as a box ticking exercise, and few were able to show they have used the equality duties to make a real difference to the health outcomes of certain protected groups. The Commission welcomes the launch of the Equality Delivery System and encourages health organisations to use it to work with their service users, staff and stakeholders to gather and analyse information on equalities; set equalities objectives and make the changes required to become better employers and improve the way frontline health services deliver good health outcomes for the protected groups who experience the greatest inequalities.

*Equality and Human Rights Commission*

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## How does the EDS work?

The steps to implement and use the EDS effectively are listed on the following pages in chronological order. (For a diagrammatic and easy-read version of these steps, see the separate document “Equality Delivery System – Easy read: stages of implementation”.)



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The EDS is paramount in ensuring that equality and diversity is embedded into the main business processes of the NHS. The EDS is a welcomed development to ensure that the NHS continues to improve its performance, in relation to equality, diversity and inclusion, for the benefit of our patients, communities and staff.

*Mary Clarke CBE, Associate Chief Nurse and Lead for Equalities (NHS London), Member of the Chief Nursing Officers Black and Minority Ethnic Advisory Group*

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Effective EDS implementation is based on the following foundations:

- The confirmation of governance arrangements and partnership working (Step 1)
- Engagement with local interests including patients, communities, staff, staff-side organisations and local voluntary organisations (Step 2)
- The use of best available evidence (Step 3)
- Partnership working with local authorities (Step 4)

Step 1 must be taken first. Steps 2 to 4 can be worked on simultaneously.

It is envisaged that participating organisations will have agreed their equality objectives and associated actions with local interests, in good time to be ready to work on them, as part of mainstream business, by 6 April 2012.



## Steps for implementation

### The Equality Delivery System for the NHS

#### Making Sure Everyone Counts

#### Steps for implementation

<b>Step 1</b>	<b>Governance and partnership working</b> <p>NHS organisations should set up or confirm their governance arrangements and partnership working for compliance with the Equality Act including ensuring compliance with the public sector Equality Duty. Once this is done, they set up or confirm their governance arrangements and partnership working for implementing and using the EDS. The best governance arrangements and partnership working will be characterised by the inclusion of patients, governors and members where relevant, communities, staff networks, staff-side organisations and local authority partners in open, on-going and transparent engagement.</p>
<b>Step 2</b>	<b>Identify local interests</b> <p>NHS organisations identify those local interests that will need to be involved in EDS implementation. For the EDS to be effective, these local interests include patients, communities, staff, staff-side organisations, and voluntary organisations and encompass all protected groups. For NHS foundation trusts, the local interests include their governors, representative memberships and staff. <i>See Annex G for details.</i></p>
<b>Step 3</b>	<b>Assemble evidence</b> <p>NHS organisations assemble evidence for analysing their equality performance and setting priorities. Assembling this evidence should include active consideration of any gaps in evidence and how such gaps can be filled. The evidence should draw on JSNAs, public health intelligence, CQC registration evidence, NHS Outcomes Framework data, surveys of patient and staff experience, workforce reports, and complaints and PALS data. As long as it is reliable and valid, the evidence can be quantitative or qualitative. <i>See Annex H for details.</i></p>
<b>Step 4</b>	<b>Agree roles with the local authority</b> <p>NHS organisations agree the part that LINKs / HealthWatch, health &amp; wellbeing boards and public health and other parts of the local authority will play in EDS implementation. <i>See Annex I for details.</i></p>
<b>Step 5</b>	<b>Analyse performance</b> <p>With local interests, organisations analyse their performance on each EDS outcome, taking account of each relevant protected group. Organisations share the evidence they have assembled (at Step 3) with their local interests in accessible formats, so that local interests can play their part in the analysis of performance and setting of equality objectives.</p>



## Step 6

### Agree grades

As a result of these analyses, organisations and local interests should seek to agree an overall grade for each outcome, taking into account any variations between protected groups and any variations in performance across their sites and services. For each outcome, one of four grades is possible: excelling, achieving, developing and undeveloped. If there is a disagreement about the most appropriate grade for a particular outcome, that cannot be resolved, the views of the local interests should generally be given weight. However, decision makers will need to consider each case on its facts; for example, there may be competing interests that need to be considered. *See Annex E for details of grades.* The results of these analyses can form a significant part of the information that organisations will be required to publish, by 31 January 2012 in the first instance, to comply with the public sector Equality Duty (Specific Duties) of the Equality Act. *See Annex F for details.*

## Step 7

### Prepare equality objectives

Using the grades across all 18 outcomes as a starting point, organisations with local interests select no more than four or five equality objectives for the coming business planning period. It is advised that the equality objectives are prepared well before the end of 2011/12, so that they may be incorporated into mainstream business plans. It is further advised that at least one equality objective per EDS goal is chosen. But this is not a hard and fast rule. No doubt these equality objectives will focus on the most urgent challenges. *See Annex J for details.* In reaching its decisions, each public authority will need to ensure that, if challenged, it can justify its decision, and demonstrate that its decision making complies with public law requirements in general and the Equality Act in particular. (The public sector Equality Duty requires that equality objectives are published by 6 April 2012 in the first instance. But waiting that long, will mean equality objectives are not included in 2012/13 business plans.)

## Step 8

### Integrate equality objectives into mainstream business planning

Actions arising from these equality objectives are integrated within organisations' mainstream business planning processes for 2012/13 in the first instance and annually thereafter. It would be helpful to cover how health inequalities are to be addressed, such as inequalities in access to, or the outcomes from, healthcare, or better integration of services to support those with multiple needs. In particular, organisations can report and work on these actions within their NHS Integrated Plans, saying how they will respond to the QIPP challenge. *See Annex K for details.*

## Step 9

### Publish grades and equality objectives

Grades and equality objectives can be published locally in Annual Reports, and in other accessible ways. They should be shared with health & wellbeing boards for comment and possible action. With agreement from all parties, grades and equality objectives may also be shared by NHS commissioners and their local interests with PCT Clusters, for comment and possible action. Providers may report their grades and equality objectives with commissioners as part of agreed contract monitoring processes. Where particularly serious and/or persistent concerns about providers relate to the Essential Standards, CQC should be notified for possible inclusion on organisations' Quality & Risk Profiles, and potential action. (Once established, the NHS Commissioning Board and NHS Trust Development Authority will announce how they are to be assured of the performance of commissioners and providers yet to achieve NHS foundation trust status.) *See Annex J for details.*

## What has the EDS got to do with quality?

Promoting equality is closely related to the pursuit of quality and actions to address and reduce gaps in health inequalities. A quality service is one that recognises the needs and circumstances of each patient, carer, community and staff member, and ensures that services are accessible, appropriate, safe and effective for all, and that workplaces are free from discrimination where staff can thrive and deliver. A service cannot be described as a quality service if only some patients achieve good outcomes while others do not.



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The EDS will help registered providers to ensure that people from protected groups, in their care, receive a quality and safe service, where continuous improvement is the goal.

*Care Quality Commission*

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The needs and circumstances for patients, carers, communities and staff from protected and other disadvantaged groups can be distinct and specific. In providing quality services and workforce environments that are appropriate and effective for all, organisations should prioritise and promote equality. This makes sense on many levels as the majority of patients, carers and staff will have one or more characteristic protected by the Equality Act. The EDS Equality Analysis that accompanies this document, includes evidence and case studies showing how promoting equality can lead to better and more cost-effective outcomes for patients. In whatever way organisations promote and report on quality in the future, they should firmly embed equality in their thinking and actions.



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NHS organisations in the South of England are embracing the EDS to continue to improve the quality of care for all communities we serve.

*Sir Ian Carruthers OBE, Chief Executive, NHS South of England*

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Currently NHS organisations are asked to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements. This “challenge” results in QIPP proposals forming a key part of NHS Integrated Plans. In meeting the challenge, organisations are reminded that “it is crucial that we do not lose momentum in improving the standard of care we deliver. We need to protect and promote quality while releasing savings everywhere. In doing so we will continue to ensure that NHS values are at the heart of what we do and we remain committed to tackling inequalities and promoting equality”. (DH, 2010) These processes and the NHS Integrated Plans should, where appropriate, take account of results and actions arising from the EDS. Organisations should also refer to their use of the EDS in the Equality Analyses of their integrated plans. It should be noted that NHS foundation trusts choose whether or not they participate in NHS Integrated Plans.

It needs to be stressed, however, that some actions arising from equality objectives, that are agreed, because of the EDS, can be costless, low cost or extremely cost-effective. For example:

- As reported by the Royal National Institute for the Deaf, people who are deaf and hard of hearing can miss important hospital appointments because they do not hear their names called out as they wait in hospital waiting rooms. A phone call or electronic alert from the referrer to the hospital would mean appointments are kept, at very little extra cost. (“A simple cure”, RNID, 2004)
- Simple adjustments to the way in which breast screening is offered and carried out for learning disabled women can lead to better use of resources and save lives. (National Cancer Reform Strategy, Equality Impact Assessment, 2007)
- For commissioners and providers of mental health services, there is clear evidence that an approach of working in partnership with Black and Minority Ethnic communities and voluntary sector organisations leads to earlier and more effective interventions, and enables activity to support good mental health to be more effectively targeted at the most vulnerable groups. (“Delivering race equality in mental health care: a review”, DH and partners, 2009)



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The EDS provides guidance to the NHS on how to achieve better equality outcomes. Macmillan will seek to work in partnership with NHS trusts to embed the EDS in cancer services.

*Macmillan Cancer Support*



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The EDS is an important process for NHS organisations to deliver on the public sector duty as part of the Equality Act 2010. The EDS should engage local stakeholders in ensuring that equalities has a strong focus on patient and communities perspectives around service delivery, commissioning and workforce development.

*The Afiya Trust*

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Providers are also required to compile, and deliver on, annual Quality Accounts. In doing so, it is recommended that they should refer to their EDS analyses, grades and equality objectives and related actions.

## How does the EDS tie in with health inequalities?

Socio-economic group, poverty and deprivation are often closely related to the incidence of ill-health, the take-up of treatment and the outcomes from healthcare. In addition, many people from protected groups are challenged by these factors, and as a result experience difficulties in accessing, using and working in the NHS. For this reason, work in support of protected groups is best aligned not only with work on quality but also with work to address health inequalities in general, with a focus on improving performance across the board and, at the same time reducing inequitable health gaps between groups and communities.

This approach has two implications for organisations when using the EDS:

- When analysing the EDS outcomes, organisations and local interests should consider extending the analysis and engagement beyond the protected groups to other groups and communities who face stigma and challenges in accessing, using or working in the NHS. Decision makers should bear in mind the general public law requirement for fairness, and it should be up to them, in discussion with local interests, on whether or not to take this approach; and if they do, which groups and communities to consider depending on local needs and circumstances. Work on “Inclusion health” (DH, 2010) points to people who are homeless, sex workers and people who use drugs as a potential focus for action.

Note: the requirement of the specific duty of the public sector Equality Duty for organisations to identify a limited number of equality objectives would not apply to issues identified for non-protected groups. For work on health inequalities, organisations use the EDS to identify priorities only.

- When working on equality objectives and associated actions, organisations should align work on both protected groups and other groups facing stigma, with their mainstream work on tackling health inequalities with regard to health conditions, health promotion, general issues of patient access, safety and experience, or workforce development. Both the EDS and work on broader health inequalities should always seek to prioritise improved outcomes for patients and communities.

In this document, these other groups and people, facing stigma and discrimination, are referred to as “**disadvantaged groups**”. In other documents and places, they are often referred to as “marginalised”, “hard-to-reach” and “seldom-heard” groups.

The inclusion of disadvantage within the EDS is not an attempt to cast “socio-economic status” as an additional protected group; rather it is a recognition of, first, the connection between disadvantage and the characteristics protected by the Equality Act; and second, the similarity between the experiences of patients and staff from disadvantaged and protected groups. If organisations choose not to extend the EDS to disadvantaged groups, they are free to do so, but it could make the awarding of an “achieving” or “excelling” grade difficult.

## NHS staff and the EDS

In adopting and implementing the EDS, NHS organisations should engage with staff, staff networks and local staff-side organisations. This engagement will provide NHS managers with the opportunity to ensure that staff feel valued and respected for the outstanding contribution they often make.

NHS staff are the most important resource of the NHS. They plan and deliver services. The EDS includes a set of outcomes designed to help organisations ensure that their workplaces are inclusive, supportive and free of discrimination, enabling staff to work well together and

deliver services that are personal, fair and diverse. There is strong evidence to suggest that a confident and well-supported workforce can deliver better outcomes to all communities.

If staff see the merit in their organisations using the EDS, they should make their views known to the Board and senior managers and argue for its adoption. Once adopted, staff supported by their leaders will make the EDS work in the best way.

In taking forward work on equality, and in adopting and implementing the EDS, organisations should consider what support, development opportunities and training should be made available to their staff – at all levels. NHS Employers is the voice of employers in the NHS helping them to put patients first. It provides a range of support to the NHS on a wide range of issues, including equality, and organisations should explore what use they can make of this resource at [www.nhsemployers.org](http://www.nhsemployers.org).

In addressing issues for their staff, and ensuring workplaces are free from discrimination, NHS organisations should refer to the NHS Constitution and the Human Resources Transition Framework.



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We all know it makes sense to have a commitment to equality and diversity. It makes sense intuitively because it speaks to the principles we hold true in the NHS Constitution. But it also makes good business sense. We know if we get equality and diversity right, we get the environment right for our staff and high quality services for our patients. The Equality and Diversity Council have shown clear and essential leadership in developing the Equality Delivery System for the changing NHS landscape.

*Dean Royles, Director, NHS Employers*

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One of the most important resources available to NHS organisations is the staff they employ to drive forward equality for patients and in the workplace. One particular EDS outcome (4.3) asks organisations to use the “Competency Framework for Equality and Diversity Leadership”, developed by the NHS for the NHS, to provide:

- Senior management teams with a tool to help them to ensure that they have the right skills and expertise to excel in leading their organisations to successful equality and diversity outcomes.
- Individual managers, charged with equality and diversity leadership, with a clear picture of their role and the expectations that attach to it, so that they can plan their own career development.

- A tool for evolving a consistent national approach to developing the skills and expertise needed to deliver health care in a way that takes proper account of equality, diversity and inclusion.

For more details on the Competency Framework please access [www.help.northwest.nhs.uk](http://www.help.northwest.nhs.uk)

## NHS commissioners and the EDS



The EDS will support Clinical Commissioning Groups to provide fair, accessible and appropriate services to meet the health needs of all patients – while helping to ensure equity in quality – and reduce health inequalities.

*Dr Amrik Gill, General Practitioner, Currently Chair, Walsall GP Clinical Commissioning Group*

When commissioners are analysing their performance against the EDS outcomes, they should of course focus on their strategic, commissioning and procurement roles. They must carry out these roles in ways that are fair and transparent, in accordance with public law and, in particular, must comply with the public sector Equality Duty. Commissioners must bear in mind that the courts have made it clear that the duty cannot be delegated and must be exercised in substance and with rigour, and must be fulfilled before and at the time that particular decisions are being considered. They must also have clear regard for what is being commissioned and procured from whom, for whom, and with what intended consequences; meaning that commissioners can only really analyse their performance alongside the performance of the organisations they are procuring services from. No matter how fair, transparent and excellent a commissioner's processes are of themselves, if its providers cannot demonstrate excellent results, then the commissioner should be prepared to downgrade its assessment of its own performance.



The EDS will demonstrate that the work of our Integrated Equality Service achieves real benefits, as defined and recognised by our local communities and staff.

*Integrated Equality and Human Rights Service, Leicestershire Partnership NHS Trust and the Leicester, Leicestershire and Rutland PCT Cluster*

NHS providers are required by law to meet the public sector Equality Duty. The provision of commissioned services is a “public function” for the purposes of the Human Rights Act 1998, and a private provider of such services is therefore a hybrid public authority for those purposes. The same analysis applies to the public sector Equality Duty under section 149 of the Equality Act 2010.



Commissioners, in discussion with providers, should play a part in promoting equality throughout the local health system. Through their contracts, they should confirm providers are aware of their duty under the Equality Act, and they can encourage them to adopt the EDS if they have not already done so. Commissioners' service specifications should clearly set out requirements for protected groups where there is a need to do so. Again in discussion, contracts and service specifications may also encourage providers to recruit, retain and develop a workforce with the appropriate skills and competencies to deliver what is required, in support of CQC's Essential Standards. Through their contract monitoring, commissioners can ensure that providers are working towards better health outcomes for all, and improved patient access and experience. The EDS can provide a tool to flag issues of concern that can be dealt with through the contract monitoring process.



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Merseyside PCT Cluster believes the EDS will support NHS organisations to harness best practice and transfer a legacy from PCTs into the new organisational structures, and is delighted that we have a national framework to measure health outcomes consistently across health services.

*Gideon Ben-Tovim, Chair, Merseyside PCT Cluster*

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The “Shared Operating Model for PCT Clusters” (DH, 2011) requires PCT Clusters to support commissioners to pay due regard to the public sector Equality Duty, and to use the EDS.

## NHS providers and the EDS

When evidencing their performance for EDS purposes, against the EDS outcomes, NHS providers can take account of the evidence they have provided to CQC to demonstrate compliance with registration requirements. Specifically, they can refer to the outcomes for service users set out in “Essential Standards for Quality and Safety” (March 2010). (This CQC guidance tells providers how they can achieve compliance with the Section 20 regulations of the Health and Social Care Act 2008.)

For example, when considering EDS outcome 1.4 “The safety of patients is prioritised and assured”, and agreeing a grade, providers can first look at the evidence they provided for those Essential Standards that relate to patient safety, for each protected group. In some instances, providers may have to improve their evidence with regard to particular protected groups.

The link between the Essential Standards and the EDS outcomes is given in Annex D. When there is no match for an EDS outcome among the Essential Standards, providers should use the EDS outcome directly.

## NHS foundation trusts and the EDS

The EDS is made available to the NHS as an optional tool to help NHS organisations review and improve their equality performance in engagement with local interests, and to help them meet the requirements of the public sector Equality Duty. NHS foundation trusts have considerable freedom to manage their own affairs. Just like every other NHS organisation, they can choose whether or not to adopt the EDS. If they decide to adopt the EDS, they can involve their governors and members in EDS implementation, and set publication arrangements for the analyses, grades and objectives, including the use of NHS Integrated Plans.



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The EDS will help all NHS providers, including Foundation Trusts, to embed the equality and diversity agenda into mainstream business planning. It will help the NHS to remove barriers faced by people from different groups, so that they can achieve equal outcomes. Above all, the EDS is about our staff, patients, carers and communities. It is about the people that rely on and work in the NHS.

*Tom Cahill, Chief Executive, Hertfordshire Partnership NHS Foundation Trust*

*Fiona Edwards, Chief Executive, Surrey & Borders Partnership NHS Foundation Trust*

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It should be stressed, as with all other registered providers, serious concerns arising from the use of the EDS may only be referred to the CQC, where they directly relate to the achievement of CQC's Essential Standards.

If NHS foundation trusts decide not to adopt the EDS, they will still need to respond effectively to the public sector Equality Duty and continue to assure themselves that their patients and staff are treated fairly.

## Strategic Health Authorities (SHAs) and the EDS

Currently four SHA Clusters have been formed so the NHS reforms set out in the Health and Social Care Bill, currently before Parliament, can be made smoothly with respect to accountability arrangements and strategic leadership. In many cases, executive and management functions of individual SHAs have been delegated to other SHAs in the Cluster. The public sector Equality Duty is not delegable – a SHA cannot delegate it as such. However, where functions are transferred to another SHA, the duty will apply, in relation to those functions, to the body which exercises those functions. SHAs should take independent legal advice in individual cases where they are unsure as to where the Equality Duty lies. That said, SHAs will need to respond to the public sector Equality Duty until they are abolished. While the EDS has been designed for NHS commissioners and providers, SHAs might turn to the EDS to help them respond to their own statutory equality requirements.

The Equality Delivery System for the NHS



The equality objectives they, or SHA Clusters set, even if for a short while, can greatly help inspire and inform – but not dictate or constrain – the objective setting of the NHS organisations in their regions. Above all, SHAs individually or in Clusters, should continue to work within their regions to impress upon all NHS organisations their responsibilities under the public sector Equality Duty, and how the EDS can provide a most useful way of responding.

## Implementation – overview

Current NHS organisations, with the support of SHAs and the NHS leaders on the EDC, have been preparing for EDS implementation since December 2010. Advice on NHS implementation has been provided by the EDS Support Team which, in turn through routine monitoring, gives the EDC assurance on progress. The Director of the NHS EDS Support Team is Maqsood Ahmad, Director for Equalities, NHS Midlands and the East.

By 29 July 2011, when the EDS was first made available, many NHS organisations had laid solid foundations for local implementation, while others had put in place prototype versions of the EDS or particular aspects of it, such as the outcomes.

Since 29 July 2011, many NHS organisations have continued with their planning for the EDS as part of their own organisational development, and the development of their relationships with local partners including local authorities.

In collaboration with SHAs and SHA Clusters, the EDS Support Team has been very active in helping NHS organisations to implement the EDS. Over 30 EDS Trainer / Champions have been recruited to help explain the technicalities of the EDS and cascade learning in their locations. More EDS Trainer / Champions will be recruited, some with a focus on health conditions, starting with mental health.

With the support of SHAs, and the deployment of the EDS Trainer / Champions, the EDS Support Team led 10 regional Masterclasses from September to November 2011, to further prepare the NHS, their statutory partners and local interests for EDS implementation. The change from previous engagement events was marked. There was a shift from asking questions about the need for the EDS to questions of how organisations and their local interests can make it work best for themselves. There is clear evidence that there is widespread buy-in and take-up of the EDS throughout the country. It clearly is a system by the NHS for the NHS.

Regional and local organisations currently complete an implementation monitoring template for their own use and for feeding back progress to the EDC, via the EDS Support Team. Irrespective of the requirements of the EDC, NHS organisations are encouraged to continue using this template as they implement and review the EDS, and as they prepare to meet the Specific Duties of the public sector Equality Duty using the EDS. Copies of the monitoring template can be accessed at [www.eastmidlands.nhs.uk/eds](http://www.eastmidlands.nhs.uk/eds)

## Implementation – examples

The following examples, supported by the case studies shown in Annexes L and M, give a snapshot of EDS implementation. They do not justice to all the hard work that NHS leaders, staff, patients and communities have put into making the EDS work.

## Examples of EDS implementation

### Midlands and the East

<b>East Midlands</b>	The main focus in NHS East Midlands has been to engage and embed EDS within each health community / PCT Cluster boundary, supported by five nominated inclusion and equality leads, working in a collaboration with the SHA. This approach will support local engagement, shared learning and roll-out of EDS within the emerging system.
<b>East of England</b>	Examples of good practice include the development of a region wide brand for EDS implementation developed by Hertfordshire, bringing together multiple commissioning Clusters for improved EDS governance across Essex, and the development of community partnerships in NHS Luton. <i>(See Annex L for fuller details on NHS Luton.)</i>
<b>West Midlands</b>	Mechanisms of ongoing EDS implementation support for NHS equality and diversity leads and local interests are established across the region. Bi-monthly peer support sessions for equality and diversity staff are designed to share knowledge and good practice with regard to EDS implementation. A specific EDS implementation programme to train and support local interests on EDS implementation has also been developed for roll out in the near future.

### London

<b>London</b>	Led by the SHA Equality Lead, work has been undertaken to influence the Development Programmes for the GP Pathfinders and emerging CCGs to ensure that equality, diversity and the EDS are firmly embedded within the new NHS architecture.
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### North

<b>North East</b>	Effort has been made to ensure a wide range of involvement in EDS implementation in the North East. For example, one trust has gained agreement in principal from their LINKs to assist with grading the evidence against the EDS. In addition, they have also agreed both timescales and format of this scrutiny. It is intended that this model is showcased at a regional event where the involvement of the LINKs in the scrutiny of the EDS will be suggested as good practice.
<b>North West</b>	Commissioners and provider trusts in the North West are building on the strong foundations created from two years of operating the SHA's pioneering EPIT performance framework. Teams are collaborating at PCT Cluster level to translate their achievements and existing stretch plans into EDS terms and build on the best practice already evidenced. Organisations are also benefitting from the equality stakeholder engagement principles established by the SHA.
<b>Yorkshire &amp; the Humber</b>	With support from the SHA, PCT Clusters are taking the lead on developing local engagement arrangements. This will involve developing capacity and capability to ensure effective implementation of the EDS.

## Examples of EDS implementation

### South

#### South Central

Groups of trusts in the region have organised representative stakeholder Equality Panels which will help to analyse performance, agree grades and set local objectives.

#### South East Coast

NHS South East Coast is working closely with PCT Cluster Leads, NHS Human Resources Directors and NHS Equality Leads to lay the foundations for successful EDS implementation across the region in a number of ways. The South East Coast Ambulance Trust is leading work on a good practice model that embeds equality in the mainstream business of South East Coast NHS organisations. EDS focused consultation work and training is being provided to NHS Equality Leads and community interest groups empowering and skilling patients and staff to manage information and monitor progress. An online toolkit for CCGs to ensure that equality is embedded in commissioning plans, is being developed. Briefings (through bulletins and newsletters) for CCGs have been provided to ensure CCGs are aware of their statutory responsibilities.

#### South West

Led by the SHA, EDS Clusters have been set-up mirroring the areas covered by the PCT Clusters to facilitate and localise implementation. A case study from the Royal Devon and Exeter NHS Foundation Trust is included in Annex M.

As NHS organisations work with the EDS, further good practice will emerge. There will also be lessons that point to different ways of doing things. As a small number of good practice examples have been shared in this text, it will be important for good practice and lessons to be widely shared. The EDS Support Team (see below) will play a leading role in this dissemination, putting organisations in touch with each other as required.



NHS North of England is committed to the values of the NHS, including embracing the diversity of people from all groups. The implementation of the EDS will support our desire to provide the best possible experiences for NHS staff and communities across the north.

*Ian Dalton, Chief Executive, NHS North*

## Timeline

The Equality Delivery System for the NHS Timeline	
Date	Action
29 July 2011	The EDS was made available to the NHS on the website of NHS East Midlands.
From August 2011	Current NHS organisations worked to lay the foundations for implementation. A programme to engage with pathfinders and emerging CCGs was commenced.
10 November 2011	A national launch event was held to report on progress and confirm the NHS's commitment to fairness, personalisation and diversity. This, updated, version of the EDS is made available for the launch, and placed on the website of NHS East Midlands.
December 2011	A year-long evaluation of the EDS is commissioned, with fieldwork scheduled to begin in January 2012. It will comprise before-and-after surveys of all organisations, and a deeper-dive of 20 or so.
January 2012	By 31 January 2012, NHS organisations are required by law to publish information to demonstrate their compliance with the public sector Equality Duty. (See <i>Annex F for details</i> .) NHS organisations should be helped by their EDS analysis of their performance, using the EDS outcomes and grades.
From January 2012 to 6 April 2012	NHS organisations are required by law to publish one or more equality objectives (see <i>Annex F for details</i> ). These equality objectives will arise from a consideration of their EDS analyses of their performance. The equality objectives and associated actions for 2012/13 should be ready in good time to be incorporated into mainstream business plans for 2012/13. (The public sector Equality Duty requires that equality objectives are prepared and published by 6 April 2012 in the first instance. But if organisations wait that long, their equality objectives will not be part of mainstream business plans for 2012/13.)
During 2012/13	The take-up of the EDS and early outcomes are reviewed by the NHS Commissioning Board and partner organisations including the NHS Trust Development Authority and Monitor. Early results of the evaluation will be taken into account. If take-up is not extensive, the Board and partner organisations will need to assure themselves how NHS organisations are responding to the public sector Equality Duty. They will also need to review the usefulness of the EDS and its continued use throughout the service.
By 31 January 2013	Helped by the EDS, NHS organisations will again have to publish information to demonstrate their compliance with the public sector Equality Duty (see above).
From January 2013 to 6 April 2016, and beyond	Using the EDS, NHS organisations have reviewed their equality objectives each year, and in good time considered how best to mainstream associated actions into their annual business plans. By 6 April 2016, organisations have formally reviewed and published equality objectives for 2016/17 and beyond, as required by the public sector Equality Duty.

## Support and queries

For further information and queries about the EDS, please contact the EDS Support Team at [edssupport@nhs.net](mailto:edssupport@nhs.net)

A range of guidance, the sharing of good practice and lessons learnt, and other resources in support of EDS implementation will be available in due course at [www.eastmidlands.nhs.uk/eds](http://www.eastmidlands.nhs.uk/eds). Such information and a range of other equality resources and information will also be available on the EDC Hub in due course.



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NHS London welcomes the EDS which will support our commitment to ensuring that our services and employment practices are fair, accessible and appropriate for the diverse London communities we serve and the workforce we employ. NHS London aims to deliver excellence in all we do and recognises that the EDS will play an essential part in helping to embed fairness into the health services provided and to promoting greater diversity and inclusion in everything we do.

*Dame Ruth Carnall CBE, Chief Executive, NHS London*

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## Annex A Equality Delivery System – Goals and Outcomes

Goal	Narrative	Outcome
1. Better health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities
		1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways
		1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly
		1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all
		1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds
		2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment
		2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised
		2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently

Goal	Narrative	Outcome
3. Empowered, engaged and well-supported staff	The NHS should increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades
		3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
		3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately
		3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all
		3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.)
		3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond
		4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination
		4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes



## Annex B Alignment of EDS Outcomes with the NHS Constitution

“The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population”

*First principle of the NHS Constitution (DH, 2010)*

EDS Outcome	The NHS Constitution: your rights and NHS pledges
1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities	<p><b>You have the right</b> to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs considered necessary (p.5)</p> <p><b>You have the right</b> to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide (p.6)</p>
1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways	<p><b>You have the right</b> not to be discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age (and other protected characteristics) (p.5).</p>
1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly	<p><b>The NHS also commits</b> to make the transition as smooth as possible when you are referred between services, and to include you in relevant discussions (pledges) (p.6)</p>
1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all	<p><b>You have the right</b> to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality (p.6)</p> <p><b>The NHS also commits</b> to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice (pledge) (p.6)</p>
1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups	<p><b>The NHS also commits</b> to provide screening programmes as recommended by the UK National Screening Committee (pledge) (p.6)</p>



EDS Outcome	The NHS Constitution: your rights and NHS pledges
<p>2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds</p>	<p><b>You have the right</b> to access NHS services. You will not be refused access on unreasonable grounds (p.5)</p> <p><b>You have the right</b> to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible (p.5)</p>
<p>2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment</p>	<p><b>The NHS also commits</b> to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered (pledge) (p.6)</p> <p><b>You have the right</b> to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests (p.7)</p> <p><b>You have the right</b> to be given information about your proposed treatment in advance, including any significant risks and any alternative treatments which may be available, and the risks involved in doing nothing (p.7)</p> <p><b>You have the right</b> of access to your own health records. These will always be used to manage your treatment in your best interests (p.7)</p> <p><b>You have the right</b> to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons (p.7)</p> <p><b>You have the right</b> to express a preference for using a particular doctor within your GP practice, and for that practice to try to comply (p.7)</p> <p><b>You have the right</b> to make choices about your NHS care and to information to support these choices. The options available to you will develop over time and depend on your individual needs (p.7)</p> <p><b>The NHS also commits</b> to inform you about the healthcare services available to you, locally and nationally (pledge) (p.7)</p> <p><b>The NHS also commits</b> to offer you easily accessible, reliable and relevant information to enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available (pledge) (p.7)</p> <p><b>You have the right</b> to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this (p.7)</p>
<p>2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised</p>	<p><b>You have the right</b> to be treated with dignity and respect, in accordance with your human rights (p.6)</p> <p><b>You have the right</b> to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure (p.7)</p>

EDS Outcome	The NHS Constitution: your rights and NHS pledges
<p>2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently</p>	<p><b>You have the right</b> to have any complaint you make about NHS services dealt with efficiently and to have it properly investigated (p.8)</p> <p><b>You have the right</b> to know the outcome of any investigation into your complaint (p.8)</p> <p><b>You have the right</b> to take your complaint to the independent Health Service Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS (p.8)</p> <p><b>You have the right</b> to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body (p.8)</p> <p><b>The NHS also commits</b> to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and the fact that you have complained will not adversely affect your future treatment (pledge) (p.8)</p> <p><b>The NHS also commits</b> when mistakes happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively (pledge) (p.8)</p> <p><b>The NHS also commits</b> to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services (pledge) (p.8)</p>
<p>3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades</p>	<p><b>The NHS commits</b> to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities (pledge) (p.10)</p>
<p>3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations</p>	<p><b>The rights are there to help ensure that staff</b> have a fair pay and contract framework (p.10)</p>
<p>3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately</p>	<p><b>The NHS commits</b> to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed (pledge) (p.10)</p>
<p>3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all</p>	<p><b>The rights are there to help ensure that staff</b> have healthy and safe working conditions and an environment free from harassment, bullying or violence (p.10)</p> <p><b>The rights are there to help ensure that staff</b> can raise an internal grievance and if necessary seek redress, where it is felt that a right has not been upheld (p.10)</p>

EDS Outcome	The NHS Constitution: your rights and NHS pledges
3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.)	<b>The rights are there to help ensure that staff</b> have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives ( <i>p. 10</i> )
3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population	<b>The NHS commits</b> to provide support and opportunities for staff to maintain their health, well-being and safety (pledge) ( <i>p. 10</i> )
4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond	<b>The NHS aspires to the highest standards of excellence and professionalism</b> ... in the leadership and management of its organisations ... ( <i>p.3</i> )
4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination	<b>The rights are there to help ensure that staff</b> are treated fairly, equally and free from discrimination ( <i>p. 10</i> )
4.3 The organisation uses the “Competency Framework for Equality and Diversity Leadership” to recruit, develop and support strategic leaders to advance equality outcomes	No equivalent NHS Constitution right or pledge, but supports the NHS Constitution and the EDS in general if the <b>NHS is helped to provide a comprehensive service, available to all</b> ( <i>p.3</i> )

Note: except where stated, the EDS Outcomes are aligned to the NHS Constitution’s rights and pledges.

A number of rights and pledges within the NHS Constitution cover all EDS outcomes and relate to the fundamental principals of the EDS. These rights and pledges have not been cited above.

The NHS Constitution can be accessed at [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_113645.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113645.pdf).

## Annex C FREDa principles and the EDS

Human rights and principles of equality should never be a secondary consideration in the provision of NHS services or in the development of the workforce. The five FREDa principles – Fairness, Respect, Equality, Dignity and Autonomy – have been developed to provide general principles that the NHS should aspire to. The FREDa principles readily relate to the EDS outcomes as the following box demonstrates.

FREDa principle	How reflected in the EDS for protected groups?
Fairness	The EDS is designed to assist organisations to promote fairness for patients, communities and staff. In particular, greater fairness will be achieved if health inequalities are reduced (Outcome 1.1); public health programmes reach and benefit all communities (Outcome 1.5); patients, carers and communities can readily access services (Outcome 2.1); staff recruitment and selection processes are inclusive and transparent (Outcome 3.1); levels of pay are fairly determined and applied (Outcome 3.2); and flexible working options are made available to all staff in consistent ways (Outcome 3.5).
Respect	The EDS is a tool to support the NHS Constitution to help the NHS respect both patients and staff from protected groups and beyond. For patients, EDS Outcome 1.2 asks that patients' needs are assessed and services provided in appropriate and effective ways. EDS Outcome 2.3 asks that patients are listened to and respected. EDS Outcome 2.4 asks that patients' complaints are handled respectfully and efficiently. For staff, EDS Outcome 3.6 asks organisations to promote the well-being of their staff; a sure sign that staff are being respected.
Equality	The EDS is designed to improve the equality performance of the NHS. EDS Outcomes 4.1 to 4.3 emphasise that strong and committed leadership and line management, where equality in general, and equality champions in particular, are supported, is essential to the achievement of a fairer and more personalised NHS, staffed by a diverse, confident and competent workforce.
Dignity	For patients, EDS Outcome 1.3 asks that service transitions are discussed with patients, pay due regard to the requirements of the Equality Act, and are made smoothly; and EDS Outcome 1.4 asks the NHS to prioritise the safety of patients. EDS Outcome 2.3 directly secures the privacy and dignity of patients. EDS Outcome 3.4 asks that working environments are free from abuse, harassment, bullying and violence. Achievement of these outcomes will ensure that the dignity of both patients and staff, from protected groups and beyond, will be upheld.
Autonomy	For patients, EDS Outcome 2.2 asks that people from protected groups and beyond are given sufficient information about the NHS and their diagnoses and treatments so that they can make informed choices for themselves. Through support, training, personal development and performance appraisal, EDS Outcome 3.3 seeks a workforce that is confident and competent.

Note: the FREDa principles provide a useful overview of the general principles underpinning a human rights-based approach. Compliance with the FREDa principles will not ensure that an NHS organisation is acting in accordance with the Human Rights Act. Organisations must seek their own legal advice on this point. The Human Rights Act can be accessed at [www.legislation.gov.uk/ukpga/1998/42/contents](http://www.legislation.gov.uk/ukpga/1998/42/contents). More information on human rights and the NHS can be found in reports of joint work between DH, the NHS and the British Institute for Human Rights. (DH / BIHR, 2010)

## Annex D Alignment of EDS Outcomes with CQC Essential Standards

Note: except where stated, all references to regulations in this Annex refer to regulations made under the Health & Social Care Act 2008

EDS Outcome	CQC Essential Standard: outcome as experienced by service user
1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities	<p>1.1a People who use services experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights (<i>Regulation 9, Outcome 4</i>)</p> <p>1.1b People who use services are supported to have adequate nutrition and hydration (<i>Regulation 14, Outcome 5</i>)</p> <p>1.1c People who use services and people who work in or visit the premises benefit from equipment that is comfortable and meets their needs (<i>Regulation 16, Outcome 11</i>)</p> <p>1.1d People who use services can be confident that their personal records are accurate, fit for purpose, held securely and remain confidential (<i>Regulation 20, Outcome 21</i>)</p>
1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways	1.2 People who use services understand the care, treatment and support choices available to them; can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support; and have their views and experiences taken into account in the way the service is provided and delivered ( <i>Regulation 17, Outcome 1</i> )
1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly	1.3 People who use services receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services ( <i>Regulation 24, Outcome 6</i> )
1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all	<p>1.4a Service users are protected against identifiable risks of acquiring such an infection (<i>Regulation 12, Outcome 8</i>)</p> <p>1.4b People who use services are protected from abuse, or the risk of abuse, and their human rights are respected and upheld (<i>Regulation 11, Outcome 7</i>)</p> <p>1.4c People who use services will have their medicines at the time they need them, and in a safe way (<i>Regulation 13, Outcome 9</i>)</p> <p>1.4d People who use services and people who work in or visit the premises are in safe, accessible surroundings that promote their wellbeing (<i>Regulation 15, Outcome 10</i>)</p> <p>1.4e People who use services and people who work in or visit the premises are not at risk of harm from unsafe or unstable equipment (medical and non-medical equipment, furnishings or fittings) (<i>Regulation 16, Outcome 11</i>)</p> <p>1.4f People who use services can be confident that records required to be kept to protect their safety and wellbeing are maintained and held securely where required (<i>Regulation 20, Outcome 21</i>)</p>
1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups	No equivalent CQC Essential Standard.

EDS Outcome	CQC Essential Standard: outcome as experienced by service user
2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds	No equivalent CQC Essential Standard.
2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment	<p>2.2a People who use services understand the care, treatment and support choices available to them (<i>Regulation 17, Outcome 1</i>)</p> <p>2.2b People who use services where they are able give valid consent to the examination, care, treatment and support they receive; and understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed (<i>Regulation 18, Outcome 2</i>)</p> <p>2.2c People who use services, or others acting on their behalf, who pay the provider for the services they receive: know how much they are expected to pay, when and how; know what the service will provide for the fee paid; and understand their obligations and responsibilities (<i>Regulation 19, Outcome 3</i>) (<i>This regulation was made under the Care Quality Commission (Registration) Regulations, 2009</i>)</p> <p>2.2d People who use services wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf (<i>Regulation 13, Outcome 9</i>)</p>
2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised	<p>2.3a People who use services can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support; have their privacy, dignity and independence respected; have their views and experiences taken into account in the way the service is provided and delivered (<i>Regulation 17, Outcome 1</i>)</p> <p>2.3b People who use services can be confident that their human rights are respected and taken into account (<i>Regulation 18, Outcome 2</i>)</p> <p>2.3c People who use services or others acting on their behalf: are sure that their comments and complaints are listened to and acted on effectively; know that they will not be discriminated against for making a complaint (<i>Regulation 19, Outcome 17</i>)</p>
2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently	2.4 People who use services or others acting on their behalf are sure that their comments and complaints are listened to and acted on effectively; and know that they will not be discriminated against for making a complaint ( <i>Regulation 19, Outcome 17</i> )
3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades	No equivalent CQC Essential Standard.



EDS Outcome	CQC Essential Standard: outcome as experienced by service user
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	No equivalent CQC Essential Standard.
3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately	<p>3.3a People who use services are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job (<i>Regulation 21, Outcome 12</i>)</p> <p>3.3b People who use services are safe and their health and welfare needs are met by sufficient numbers of appropriate staff (<i>Regulation 22, Outcome 13</i>)</p> <p>3.3c People who use services are safe and their health and welfare needs are met by competent staff (<i>Regulation 23, Outcome 14</i>)</p> <p>3.3d People who use services have their needs met by the service because it is provided by an appropriate person (<i>Regulation 4, Outcome 22</i>)</p>
3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all	No equivalent CQC Essential Standard.
3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.)	No equivalent CQC Essential Standard.
3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population	No equivalent CQC Essential Standard.
4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond	<p>4.1a The registered person recognises the diversity, values and human rights of people who use services (<i>Regulation 17, Outcome 1</i>)</p> <p>4.1b People who use services benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety (<i>Regulation 10, Outcome 16</i>)</p>

EDS Outcome	CQC Essential Standard: outcome as experienced by service user
4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination	No equivalent CQC Essential Standard.
4.3 The organisation uses the “Competency Framework for Equality and Diversity Leadership” to recruit, develop and support strategic leaders to advance equality outcomes	No equivalent CQC Essential Standard.

Notes:

- Overall, registered persons must take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have (Regulation 17, Health & Social Care Act 2008 (Regulated Activities) Regulations 2010).
- Serious concerns arising from the use of the EDS may only be referred to the CQC, where they directly relate to the achievement of CQC’s Essential Standards.

CQC Essential Standards can be accessed at

[www.cqc.org.uk/\\_db/\\_documents/Essential\\_standards\\_of\\_quality\\_and\\_safety\\_FINAL\\_081209.pdf](http://www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_FINAL_081209.pdf).



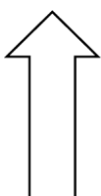
## Annex E Grades

The primary purpose of the EDS is to create a conversation between organisations and their local interests. NHS foundation trusts will prioritise conversations with their governors and members. These conversations should commence with an assessment of the organisation's performance against each of the 18 outcomes; it should conclude with agreement about progress and challenges, and what equality objectives should be worked on and associated actions. The conversations should be systematic and transparent, so that all parties can be confident over what was discussed and agreed. However, compliance with the public sector Equality Duty is the responsibility of the public body and cannot be delegated. This means that following these conversations, the public authority is responsible for its decisions on the equality objectives and related actions, ensuring that the decisions comply with public law requirements in general and the public sector Equality Duty in particular.

To support and facilitate these conversations, the EDS comes complete with a set of grades so that organisations and local interests can award a grade for each of the 18 outcomes. The grades have been tested for their reliability and validity so that different individuals acting independently may arrive at the same grade when faced with the same situation; and over time, the same individual would award the same grade when faced with the same situation.

There are four grades, and a related RAG <sup>"plus"</sup> rating, to choose from:

- ▲ Excelling – Purple
- ▲ Achieving – Green
- ▲ Developing – Amber
- ▲ Undeveloped – Red



Each grade for each outcome is described in detail, in the accompanying “EDS Grades Manual” so that different organisations, with their local interests, can apply them consistently at any one time and over time.

Most of the grades have been designed to reflect and promote:

- The delivery of positive outcomes for protected groups, and to encourage continuous improvement.
- The recognition of inequalities between protected groups and patients or staff as a whole, and how gaps can be reduced while maintaining or improving overall outcomes.
- Good engagement with patients, carers, communities and staff from protected groups.
- The use of best available evidence and good practice examples to inform service and workforce developments.
- Tackling health inequalities for disadvantaged groups at the same time as inequalities for protected groups are addressed.
- Dealing with, and reporting on, equality as part of mainstream business, and in particular relating work designed to promote equality to work focused on the imperatives of QIPP as reported in NHS Integrated Plans. NHS foundation trusts should report within the annual reporting requirements set out by Monitor, and as they see fit with regard to NHS Integrated Plans.

Before embarking on the assessments and using the grades, NHS organisations should be certain that local interests, especially patient and community groups have been supported to understand the grades and how the process will work.

The grades are intended to help organisations clearly identify equality progress and challenges. While both good and poor performance should come to light, the purpose of the EDS and its grades should, primarily, be about helping good organisations maintain and further improve their performance, and helping poor organisations to address and overcome their difficulties and so embed equality into mainstream business. Having said that, if undeveloped and developing grades are agreed for any particular outcome, organisations should be concerned as the welfare of patients, communities and staff may be being compromised, and organisations may be in breach of the public sector Equality Duty.

Where there is a disagreement about the most appropriate grade for a particular outcome, which cannot be resolved, the views of local interests should generally be given weight over those of the NHS organisation. Such occurrences should not be seen in a poor light; but can be seen as a product of localism, and of organisations being prepared to listen to their patients and staff and openly and honestly discuss their performance. Provided it does not add significantly to the bureaucracy of the process, provider organisations and local interests could agree to refer disputes about grades to their local commissioner or a neighbouring provider for arbitration; and local commissioners and local interests could refer their disputes to a neighbouring commissioner, or in exceptional circumstances, the relevant PCT Cluster. However, it is important that both the organisation and local interests taking part understand that at the conclusion of the process, the public sector Equality Duty cannot be delegated, and ultimately the public authority is responsible for decisions and demonstrating compliance with public law requirements.

Over time, all organisations, supported by local interests, should plan to attain and/or maintain the “excelling” grade on all outcomes. The wording for the grades will not only help organisations to gauge their current position; it will highlight how progress might be made and encourage continuous improvement.

The EDS is designed as a tool to assist in complying with the public sector Equality Duty. If during the course of the exercise and evidence gathering, the public authority becomes aware of matters that could potentially amount to prohibited conduct either by way of direct or indirect discrimination contrary to the Equality Act, it should seek legal advice based on the particular facts, and where necessary take immediate steps to rectify this matter.

Detailed descriptions of the grades for each outcome are provided in the accompanying EDS Grades Manual.

## Annex F The Equality Act 2010

The Equality Act received Royal Assent in 2010. It unifies and extends previous disparate equality legislation. Nine characteristics are protected by the Act:

- Age including specific ages and age groups
- Disability including cancer, HIV, multiple sclerosis, and physical or mental impairment where the impairment has a substantial and long-term adverse effect on the ability to carry out day-to-day activities
- Gender re-assignment where people are proposing to undergo, are undergoing or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex
- Marriage and civil partnership
- Pregnancy and maternity
- Race including colour, nationality and ethnic or national origins
- Religion or belief, including a lack of religion or belief, and where belief includes any religious or philosophical belief
- Sex
- Sexual orientation, meaning a person's sexual orientation towards persons of the same sex, persons of the opposite sex and persons of either sex

The Equality Act outlaws direct and indirect discrimination, harassment and victimisation of people with relevant protected characteristics in relevant circumstances. It requires that reasonable adjustments be made for disabled people. The Act applies to providers of services and employers, including NHS bodies and other health providers.

A public sector Equality Duty, section 149(1) of the Act, applies to most public authorities (and bodies exercising public functions) requiring them in the exercise of their functions to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act.
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

For the purpose of the public sector Equality Duty, the protected characteristics are those listed above with the exception of "marriage and civil partnership"; but NHS bodies must be mindful of the other provisions of the Equality Act that prohibit discrimination on the grounds of marriage or civil partnership.

Public authorities for the purpose of the public sector Equality Duty are listed in Schedule 19 to the Act. PCTs, SHAs, most Special Health Authorities, NHS trusts and NHS foundation trusts are listed as public authorities. The NHS Commissioning Board and all CCGs are expected to be added to the list once they are established in law. In addition, bodies that exercise public functions are subject to the public sector Equality Duty in the exercise of those functions (see section 149(2) of the Act). The provision of commissioned NHS services is a "public function" for the purpose of the Human Rights Act 1998, and a private provider of such services is therefore a hybrid public authority for those purposes. The same analysis

applies to the public sector Equality Duty under section 149 of the Equality Act 2010. Thus DH considers that the provision of commissioned NHS services would in all cases amount to the performance of functions of a public nature.

Regulations to ensure better performance of the public sector Equality Duty came into force in September 2011. The Equality Act 2010 (Specific Duties) Regulations 2011 require relevant bodies, including NHS organisations, to:

- Publish information to demonstrate its compliance with the public sector Equality Duty at least annually, starting by 31 January 2012.
- Prepare and publish equality objectives at least every four years starting by 6 April 2012. All such objectives must be specific and measurable.

The information must be published in a manner that is accessible to the public, either in a separate document or within another published document.

For further information on the Equality Act, refer to:

[www.equalities.gov.uk/equality\\_act\\_2010.aspx](http://www.equalities.gov.uk/equality_act_2010.aspx)

[www.equalityhumanrights.com/legal-and-policy/equality-act/](http://www.equalityhumanrights.com/legal-and-policy/equality-act/)

<http://www.home.office.gov.uk/publications/equalities/equality-act-publications/equality-act-guidance/equality-duty>

[http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/guidance-on-the-equality-duty/#Guidance\\_for\\_England\\_and\\_non-devolved-bodies\\_in\\_Scotland\\_and\\_Wales](http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/guidance-on-the-equality-duty/#Guidance_for_England_and_non-devolved-bodies_in_Scotland_and_Wales)

The processes and content of the EDS align with the public sector Equality Duty. Hence, in responding positively to the EDS, organisations should be able to respond more effectively to the requirements of the duty. **However, use of the EDS does not automatically lead to or ensure compliance.**

The public sector Equality Duty came into force from April 2011. NHS organisations should have been responding to, and ensuring compliance with, the public sector Equality Duty from that date. Some organisations might wish to use their Single Equality Schemes under previous equality legislation to help them meet the requirements of the public sector Equality Duty. This approach may be a useful starting point, but organisations should consider how such schemes can be extended to cover the additional protected characteristics covered by the Equality Duty, emphasising outcomes rather than bureaucracy.

Engagement and evidence used to support the development of current schemes can, if fit for purpose, continue to be used to support the new process. EDS guidance on these matters can help organisations to improve the transparency and evidence base of their planning.

The public sector Equality Duty and the EDS are being introduced at a time of transition in the NHS. Until they are formally abolished both SHAs and PCTs must keep within the law.

Currently four SHA Clusters have been formed so the NHS reforms set out in the Health and Social Care Bill, currently before Parliament, can be made smoothly with respect to accountability arrangements and strategic leadership. In many cases, executive and management functions of individual SHAs have been delegated to other SHAs in the Cluster. The public sector Equality Duty is not delegable – a SHA cannot delegate it as such. However, where functions are transferred to another SHA, the duty will apply, in relation to those functions, to the body which exercises those functions. SHAs should take independent legal advice in individual cases where they are unsure as to where the Equality Duty lies.

That said, SHAs will need to respond to the public sector Equality Duty until they are abolished. While the EDS has been designed for NHS commissioners and providers, SHAs might turn to the EDS to help them respond to their own statutory equality requirements. The equality objectives they, or SHA Clusters set, even if for a short while, can greatly help inspire and inform – but not dictate or constrain – the objective setting of the NHS organisations in their regions.

Above all, SHAs individually or in Clusters, should continue to work within their regions to impress upon all NHS organisations their responsibilities under the public sector Equality Duty, and how the EDS can provide a most useful way of responding.

Similarly, PCT Clusters have been formed so the NHS reforms set out in the Health and Social Care Bill, currently before Parliament, can be made smoothly with respect to commissioning responsibilities and leadership. In many cases, executive and management functions of individual PCTs have been delegated to other PCTs in the Cluster. The public sector Equality Duty cannot be delegated – the PCT cannot delegate it as such. However, where functions are transferred to another PCT, the duty will apply, in relation to those functions, to the body which exercises those functions. PCTs should take independent legal advice in individual cases where they are unsure as to where the public sector Equality Duty lies.

New NHS organisations, including CCGs, will be bound by the general provisions of the Equality Act and the public sector Equality Duty. As such, they must fulfil the duty as soon as they are formed.

All organisations must assure their position through independent legal advice.

## Annex G Engagement

### Background

Genuine engagement with local interests and the effective use of evidence lie at the heart of both the public sector Equality Duty and the NHS reforms. Without them, NHS organisations will not be able to focus on those matters that are most important to patients, communities and their staff in an informed, consistent and robust way.

Engagement refers to the process of getting people – patients, community members and staff – involved in decisions about them in a sustained way. This includes planning, developing and managing services, as well as activities that aim to improve health or reduce health inequalities. For staff, engagement also means helping to plan, develop and manage working environments, and activities that aim to improve working lives.

### Local interests

For the purposes of the EDS, local interests comprise but are not restricted to:

- Patients and those local groups that represent them
- Communities and the public in general
- Governors and members of NHS foundation trusts
- NHS staff, staff networks, and staff-side organisations (that is, unions such as Unison)
- Voluntary and community organisations

### Genuine and empowered engagement

When engaging with these local interests, the engagement must be sustained, informed and meaningful. It must go beyond consultation, which can often comprise occasional and one-off explorations of patient, community and staff views on a particular topic. The engagement must span all protected groups and other disadvantaged groups. Contacting, hearing and working with some of these groups will challenge some parts of the NHS, which can sometimes make itself hard-to-reach.

Care should be taken to ensure that seldom-heard interests are as engaged as much as other interests, and are supported to participate. Care should also be taken to include not only those spokespeople who already give so generously of their time to engage with NHS organisations, but also those individuals who have important things to say but whose views are rarely sought or heard.

Participating in public life can be expensive or difficult for local patients, communities and staff groups. It can be expensive in terms of time and possibly money. It can be difficult in terms of the practicalities of participating in meetings or discussions, especially for seldom-heard groups. It can also be difficult for those patients and members of the public who may not be used to talking to NHS administrators and clinicians on equal terms about matters of healthcare strategy or planning. So that these local interests can be enabled and empowered, support and/or financial assistance will need to be considered by NHS organisations.

### Good practice

Within the NHS there is a great deal of good practice about engagement; but this practice can be patchy and inconsistent across time, locations and protected groups.

How to develop and maintain effective engagement in the NHS has been addressed in recent DH publications including “Inclusion health” (DH, 2010) and “A dialogue of equals” (DH, 2009). It has also been the subject of DH’s PPEE initiative – Public and Patient Experience and Engagement.

## **Different approaches**

NHS organisations and their local interests may wish to explore a number of approaches to engagement, before deciding on the model that best suits local circumstances. For example, organisations might empower and enable patient, community and staff groups to attempt the first analysis and grading of NHS performance. This work can then inform a discussion with the NHS, leading to agreement of the grades and which actions should be prioritised.

Alternatively, organisations may plan for all local interests to meet with managers to analyse and grade performance. Whatever model is chosen, the important point is that local interests must be fully engaged and informed.

NHS foundation trusts are well placed to engage with local interests because they are accountable to members drawn from local and wider communities. The best NHS foundation trusts have broad-based memberships that reflect the diversity of the populations they serve. Governors are drawn from this membership, and work with Boards to set and review direction and performance. NHS foundation trusts should include their governors and members in all aspects of EDS implementation. If membership is diverse and representative, it provides NHS foundation trusts with a ready means of securing patient, public and staff views – across the protected groups – and responding to challenges.

Given that some NHS organisations will be serving similar populations, they might like to join together when engaging with local interests – provided that local interests agree to this approach. In this way, the organisations can share the responsibilities, methods and costs; while patients and communities will be asked to take part in far fewer engagement events, lessening the burden on them. Provided that individual organisations hear the specific messages for them, this joined-up approach has much to recommend it. It can be extended to partnership working with local authorities as well.

## **LINKs / HealthWatch**

Local Involvement Networks (LINKs), and their successors the new local Health Watch, have an important role to play in supporting local statutory agencies to engage with and hear the views of local people. They set their own priorities. It is hoped that they will prioritise the EDS. Their role will be to:

- Identify the local patient and community groups that should be engaged in the EDS, ensuring that disadvantaged groups – including marginalised and seldom-heard groups – are not overlooked.
- Support these groups during the actual engagement process, ensuring that they are empowered and informed.
- Add their views to those of other local interests on the performance of the NHS.
- Relay the grades and objectives of individual organisations to health & wellbeing boards.

If the EDS is not prioritised at all or in part, by LINKs and HealthWatch, SHA and PCT Clusters should seek alternatives. For example, NHS Champions and Patient Champions may have a role to play in EDS implementation and operation, as could voluntary sector groups or umbrella organisations such as Regional Voices and Councils of Voluntary Services.



## **Dealing with disagreements**

Most NHS organisations already work well with local interests. For this reason, disputes about assessments against outcomes, and associated grades, and the selection of equality objectives should be rare. Where disputes arise, every attempt should be made to resolve them locally. Where disagreements persist, they should be openly acknowledged, with the views of local interests taking precedence when it comes to the grades. However, provided the process can be kept manageable and reasonable, providers and local interests may agree to ask the local commissioners or neighbouring providers to arbitrate in their disagreements; and commissioners and local interests may agree to approach other local commissioners or, in exceptional circumstances, PCT Clusters over their disagreements.

## **Specific guidance**

Specific guidance on patient, community and staff engagement, to support EDS implementation, is being prepared by Shared Intelligence / Race for Health. Results, together with a range of information on engagement, can be accessed at [www.eastmidlands.nhs.uk/eds](http://www.eastmidlands.nhs.uk/eds) and on the EDC Hub.

## Annex H Evidence

### Using local and national sources

When analysing their equality performance using the EDS, organisations are advised to begin with the evidence contained within local Joint Strategic Needs Assessments (JSNAs), but also make full use of other evidence at their disposal, including soft and hard data. Providers, of course, will refer to the evidence they supplied to CQC for registration purposes. In summary local sources of evidence can include:

- JSNAs
- Public health intelligence, including evidence from the Health Protection Agency
- Evidence from public health campaigns such as Smoking Cessation
- Providers' registration evidence
- NHS Outcomes Framework indicators
- Quality Accounts
- CQC's patient surveys
- GP patient surveys
- CQC NHS staff surveys
- Workforce reports including employment policy (people management)
- Local Public and Patient Engagement and Experience (PPEE) surveys
- Comments and complaints data held by NHS organisations
- Evidence and insights held by Patient Advice and Liaison Services (PALS)

Not all evidence needs to be quantitative. It can be qualitative and, if needs be, derived from focus groups. However, all evidence needs to be either robust or the best that is currently available. In working effectively with a mix of evidence, covering a variety of sources and including hard and softer facets, organisations may wish to refer to public health experts.

Those organisations that make full use of the Electronic Staff Record and have agreed with local staff-side organisations and their staff that all equality codes are used, will be well placed to monitor the composition of their staff and to keep track of important employment processes.

Wherever possible, the evidence – be it hard or soft – should be broken down by protected group. In the longer-term, organisations should have strategies in place to enable them to secure the evidence they need across the protected groups. In any case, where disclosure of evidence that includes personal data is under consideration, organisations will need to take account of the requirements of the Data Protection Act.

### DH guidance

In collecting and analysing data on protected groups, organisations will be supported by guidance on equality monitoring that DH and partner organisations will be publishing later this year. It is titled "Categories and codes for equality data collections: a practical guide for the NHS and social care". This guide updates the "Practical guide on ethnic monitoring in the NHS and social care" (DH and partners, 2005) and takes account of the requirements of the public sector Equality Duty and the new equality codes introduced by the 2011 ONS Census for England.

### **Specific Duty to prepare and publish information**

The very act of using the EDS as a framework to help analyse performance will produce fresh evidence and insights. These insights, together with all the local evidence that has been used in local EDS discussions, will stand organisations in good stead as they respond to the Specific Duty of the public sector Equality Duty to prepare and publish information to demonstrate compliance, by 31 January 2012 and annually thereafter. *See Annex F for further details.*

### **Making evidence accessible**

Guidance on how to make NHS evidence available and accessible to patients, communities and staff is being prepared as part of the Shared Intelligence / Race for Health guidance on engagement. Results can be accessed at [www.eastmidlands.nhs.uk/eds](http://www.eastmidlands.nhs.uk/eds). Information on evidence sources and evidence itself can also be accessed on the EDC Hub.

## **Annex I Working with local authorities**

### **Reason for close working**

It is recommended that NHS organisations work with local authorities in reviewing and improving their equality performance, because the clientele will often be shared, services will complement each other particularly along care pathways, and the equality issues will be similar. Some local authorities will have considerable experience in tackling disadvantage and promoting equality that NHS organisations, particularly new ones, will find invaluable.

### **Equality Framework for Local Government**

Those local authority organisations that use the “Equality Framework for Local Government” will be good comparators and sources of inspiration, as the EDS was designed with this Framework in mind, particularly the grading system.

### **Engagement**

With regard to patients, service users, members, governors and the public, NHS organisations might wish to carry out joint engagement events with local authority partners, particularly where the populations being served are similar and where there are overlaps in the provision and use of health, social care and other services. Some joint engagement events for staff might also be considered.

### **Evidence**

Evidence that reflects the equality performance of NHS organisations is central to the EDS. Organisations will be required to gather, analyse and make appropriate use of both quantitative and qualitative evidence when implementing the EDS. Above all NHS organisations should begin reviews of their performance with JSNAs, which comprise evidence across health, social care and other local authority functions. They can be rich sources of data on inequalities and disadvantage across and within communities. Education data can also be extremely useful on children and young people from challenging backgrounds. In dealing with personal data, organisations need to ensure that they are familiar with, and act, in accordance with the Data Protection Act.

### **Public health and care pathways**

With regards to collecting and using evidence, public health skills and expertise will be an invaluable resource for NHS organisations. With the transition of public health into local authority control, NHS organisations will need to guard against losing public health skills and expertise going forward.

NHS organisations will also wish to work closely with local authorities on EDS outcomes focused on health improvement and public health, where joint action is often required for best results.

The same close working with local authorities, with regard to the collection and use of evidence, will be required on many other health matters, including the journeys that patients and service users make along care pathways, where a range of services is involved. Admission and discharge from hospital will be a particularly important event where evidence can greatly help organisations to review and improve performance.

### **LINKs and HealthWatch**

As set out in Annexes G and I, LINKs and their successor bodies, HealthWatch, can play an important role in EDS implementation. Every effort should be made to secure this role, bearing in mind that LINKs / HealthWatch determine their own priorities. It is encouraging to note that many LINKs have already agreed to support NHS organisations to deliver on the EDS.

**Health & wellbeing boards**

The co-operation of health & wellbeing boards should be enlisted so that they are informed about the EDS, and will agree to receive and comment on summaries of local organisations' grades, equality objectives and associated actions. The critical and independent support of these boards can go a long way in helping the EDS to run successfully.

**Local approaches**

In the spirit of localisation, this EDS guidance is not prescriptive of how NHS organisations work with local authorities on the above matters. Rather, SHA and PCT Clusters should support organisations to find their own local solutions, taking the advice of local interests. Providers should ensure that they have equal access to local authority resources as do NHS commissioners.

## **Annex J Setting local objectives and priorities**

### **Agreeing equality objectives**

Engaging with the EDS process will help NHS organisations, working with local interests, to prepare their own equality objectives. The requirements of the Equality Act 2010 (Specific Duties) Regulations 2011 require listed bodies to prepare and publish one or more equality objectives not later than 6 April 2012, and then subsequently at intervals not greater than four years. NHS organisations are responsible for ensuring that the decisions they make can be justified and satisfy public law requirements, and must comply with the public sector Equality Duty.

As a minimum, the equality objectives should be **Specific** and **Measurable** so that, for one thing, progress and achievements can be gauged. They should also be **Achievable**, **Relevant** and **Timely**. In short, they should be **SMART**.

### **How many equality objectives?**

It is recommended that organisations choose no more than four or five equality objectives, at least one per EDS goal. Working on many objectives could result in efforts being spread thinly, where lasting outcomes are jeopardised. Many Single Equality Schemes suffered as a result of being far too wide-ranging and inclusive.

### **EDS outcomes and protected groups**

The more that equality objectives, and associated actions, are strategic and seek to make improvement across different EDS outcomes and make links between different protected groups the better. Many people will see fairness in such an approach.

But deliberately choosing equality objectives so that all protected groups are covered at any one time, irrespective of need and urgency, can lead to tokenistic unrealistic plans. Backed by evidence, and working with local interests, the EDS analysis should reveal the most pressing needs and help Boards to undertake a rational and carefully documented process of prioritisation, which takes account of all relevant facts and matters and, which if challenged, can be justified.

Of course, the most pressing needs should be prioritised. However, over a three to five year period, it would be unusual for all protected groups not to feature among the chosen equality objectives and associated actions, especially if organisations are choosing areas of need that affect more than one protected group at a time.

### **Unlawful discrimination**

In prioritising some equality objectives over others, NHS organisations must remain mindful of the substantive provisions of the Equality Act, and must not take any action that would allow unlawful discrimination, harassment or victimisation to occur or continue. NHS organisations will wish to seek legal advice based on particular facts. In considering their equality objectives and associated actions, NHS organisations will need to consider whether an Equality Analysis (formerly known as equality impact assessment) should be undertaken to identify actual and potential adverse effects, and what steps could be taken to mitigate those adverse effects.

### **What about issues not prioritised for immediate action?**

It is likely that the first analyses of NHS performance using the EDS will highlight a great many challenges for all organisations. The EDS is meant to highlight the critical challenges and lead to plans / actions to address them. However, when focusing on these challenges, routine and other important work on addressing inequalities should not grind to a halt. As said above, organisations must continue to remain legal and to deliver fair and personalised services to patients and communities at all times. Where some important challenges are not

being immediately addressed, organisations should explain why not, and give a clear idea of when work on them will commence.

### **Mainstream business**

The chosen equality objectives and associated actions should be strategic and cover the most urgent concerns and be firmly based in evidence. Work on the equality objectives should support mainstream business and, in particular, how organisations respond to the QIPP challenge, as part of their NHS Integrated Plans, and reduce health inequalities. (NHS foundation trusts should report as they see fit with regard to NHS Integrated Plans.) In particular, preventive action is not ruled out, if it can result in significant benefits for particular communities and the NHS down the line. However, some equality objectives could represent “quick wins”, which if achieved can pave the way for further success and cost-effectiveness.

The mainstream process will differ depending on what types of improvements are being made, and whether or not the improvements focus on patients, carers, communities or staff. Current mainstream processes that organisations should have in mind as they use the EDS are as follows:

- On-going dialogue and relationship management between commissioners and providers
- Contract setting and contract monitoring
- Procurements
- Responding to the QIPP challenge through NHS Integrated Plans, which for NHS foundation trusts are optional
- Delivering on the NHS Outcomes Framework
- Delivering on the NHS Constitution
- Quality Accounts
- NICE (National Institute for Health and Clinical Excellence) standards and other guidance, and associated implementation plans
- Core Human Resource policies and procedures, including delivering on the Human Resources Transition Framework

### **Missing evidence**

An organisation’s grades could be relatively poor – red or amber – if there is a dearth of evidence across the board or for most protected groups. In these circumstances, organisations will have difficulty in selecting their equality objectives. In this situation, organisations should put long-term plans in place to collect the missing evidence; but at the same time, they should make plans to collect immediate insights into their performance against the EDS outcomes. These immediate plans could involve focus groups, structured discussions, discovery interviews and other qualitative techniques. It is advised that the capturing of immediate evidence be completed in a short space of time, so that any previously masked issues of substance for patients, communities and staff might be addressed sooner rather than later.

### **Focus on the reds?**

It could be tempting for organisations and their local interests to be instantly drawn only to those outcomes where the agreed grade is undeveloped (red). A focus on the red grades could be entirely appropriate; but it could miss particular issues. Consider a situation where, for example, services for lesbian, gay and bi-sexual patients are generally poor, and working environments for staff from this protected group are also difficult; whereas for patients and



staff from other protected groups, there is achieving or excelling practice. A glance at the grades across all outcomes, could give a misleading picture, being populated by mostly greens and purples. Looking behind the apparently good grades should expose the issues for lesbian, gay and bisexual people using and working in the organisation; and equality objectives could well focus on putting things right for them – as well objectives directly related to red grades.

### **Action on single or multiple outcomes?**

An organisation's analysis of performance could indicate significant concerns for particular outcomes. There are some individual outcomes – such as EDS Outcome 1.4 on patient safety or EDS Outcome 3.4 on staff abuse – which if threatened would usually call for urgent and immediate focused action. There will be many other circumstances when several poorly graded outcomes could be usefully reviewed together and, if needs be, an equality objective drawn up that involves action to improve performance across the outcomes in question. For example, it could come to light that general employment processes are unwittingly adversely affecting staff from particular protected groups with regard to EDS Outcomes 3.1, 3.2, 3.3 and 3.5 – from recruitment and pay levels to the availability of development and flexible working opportunities. An equality objective that focuses on the general problems across the outcomes rather than a narrow focus on individual outcomes will probably be more effective.

### **Services and working environments**

The achievement of good results for some outcomes might be dependant on the achievement of good results from other outcomes. Take for example, the connection between strong equality leadership and a competent and motivated workforce on one hand, with the achievement of positive outcomes and improved experience for patients on the other. If an organisation's grades for its leadership and working environment are generally poor or middling, it may count itself lucky if it has reasonable grades for its patient-focused outcomes. In order to sustain good service delivery, the leadership of the organisation may well decide to focus on strengthening and demonstrating its commitment to equality, and to making necessary improvements to the working environment.

### **Timing**

The Specific Duties of the public sector Equality Duty require the first set of equality objectives to be prepared and published by 6 April 2012. So that NHS organisations can work on their equality objectives and related actions as part of mainstream business in 2012/13, they will need to think of agreeing these objectives in time for inclusion in business planning processes for 2012/13. For this reason, many organisations will think through the timing that best suits the mainstream processes that they routinely follow to satisfy both internal and external purposes. For most organisations, setting equality objectives in December 2011 or early January 2012 will help to ensure that they can be built into mainstream business timelines.

### **Making progress on the equality objectives, and keeping track**

In the context of broader strategic plans including NHS Integrated Plans (and responses to QIPP) where these are completed, it is recommended that organisations should describe:

- How progress on equality objectives is to be phased, with related milestones, within the context of continuous improvement.
- How these equality objectives feed into, and support, corporate strategic objectives, plans for tackling health inequalities – improving performance and reducing gaps – and related business plans.
- The grades that they hope to achieve over the business cycle for each outcome, indicating the progress to be achieved in each year.

While the organisation may wish to provide a summary of the actual analysis against outcomes, it is recommended that the agreed grade for each outcome should be given a prominent place in Annual Plans or annual reporting, Quality Accounts or related publications and publicity.

While the equality objectives will become integrated into various other processes, it would make sense for organisations to keep a brief central log that documents which equality objectives are part of what mainstream process, and for progress, challenges and risks to be collated centrally and added to the log. In this way, work on the equality objectives is given coherence, and progress can be reported readily to patients, communities and staff.

### **Review**

The duties under the Equality Act are continuous duties. Although equality objectives should be reviewed at least every four years (as required by Equality Act regulations), organisations should look to their own or NHS business planning cycles. For example, currently, organisations will work to annual business planning processes; and there is a three to five year cycle for Commissioning Strategic Plans.

### **Guidance**

In developing and working on their equality objectives and associated actions, organisations should not only refer to EDS guidance but also to guidance about the Equality Duty from the Government Equalities Office (GEO), the Equality and Human Rights Commission (EHRC), the CQC and other organisations. Some guidance on equality including that issued by NHS Employers in 2008, although pre-dating the Equality Act, is still relevant and useful. DH and NHS Employers will issue fresh guidance on a number of matters up to March 2012.

## **Annex K Reporting processes and consequences**

### **Local reporting**

Organisations' own Boards or corporate leadership play a full part in agreeing equality objectives and associated actions. They should be clearly seen to own this work and how progress is to be made and monitored.

Organisations' grades, draft equality objectives and associated actions can, in the first instance, be reported to local interests including:

- Governance arrangements established for the purposes of the EDS
- LINKs / local HealthWatch
- Governors and members of NHS foundation trusts
- Other established patient and community forums
- Local equality groups including Race Equality Councils or Equality Councils
- Local unions and other organised staff groups such as organisations' staff networks

These interests can be invited to comment, and their views should be taken into account. This engagement should take place in good time in early 2012 so that equality objectives and associated actions can be built into mainstream business plans for 2012/13, and then subsequently published by April 2012.

Once finalised, equality objectives and associated actions can be confirmed to the above interests and, ideally, formally reported to the health & wellbeing board. LINKs and HealthWatch can facilitate this process. Organisations should discuss the involvement of health & wellbeing boards with their local authority counterparts, and how critical comments should be delivered and worked on. Providers should ensure that they can access the support that health & wellbeing boards will contribute to local EDS processes.

Grades, equality objectives and associated actions may also be reported in:

- Annual Plans
- Quality Accounts
- Responses to the QIPP challenge, within NHS Integrated Plans where appropriate
- Any other local, regional or national reporting that is part of NHS or Monitor requirements

All reporting should be made in accessible ways and formats so that patients, communities and staff can readily appreciate the main points. For example, where appropriate and/or requested, written reports should be made available in large print, braille, easy read, different languages, and so on. But reporting in video or aural formats should also be considered if needed.

Where there is agreement from all parties, grades and equality objectives may also be shared by NHS commissioners and their local interests with PCT Clusters, for comment and possible action. Providers should use the contracting process as a means of reporting their grades and equality objectives to their commissioners or in other agreed ways.

## **Wider reporting**

For wider performance assessment / management purposes, from April 2012:

- Serious concerns for any provider, highlighted by the analysis of its performance and which relate directly to CQC's Essential Standards, may be reported to CQC for potential inclusion in its Quality and Risk Profile. At the start of EDS implementation, organisations and local interests should agree who should report to CQC in these circumstances. Where there are concerns, the CQC will consider the most appropriate action, as it would do when in receipt of any potentially negative piece of information about any provider.
- The NHS Commissioning Board, once established will determine how it will be alerted to serious concerns for any NHS commissioner, and the potential action it will take.
- Likewise, the NHS Trust Development Authority, once it commences to monitor and assure itself of NHS trusts' performance following the abolition of SHAs, will determine how it will be alerted and respond to serious concerns for any trust yet to achieve NHS foundation trust status.
- Monitor requires all NHS foundation trusts to be compliant with relevant legislation, including the provisions of the Equality Act 2010.

The full role of CQC is as follows:

- CQC can be notified of significant concerns about providers that are highlighted by the EDS, and which directly relate to the Essential Standards. These concerns will be placed on individual providers' Quality & Risks Profiles. It will then be for CQC to decide what action, if any, it will take. The notification will be on an exception-reporting basis, and will be made by local interests, possibly HealthWatch, that support organisations to use the EDS. There will be no blanket or automatic reporting. (Please note that, at the local level, LINKs and HealthWatch must agree their role in the EDS.)
- CQC will advise its inspectors about the EDS and will be prompted to ask providers whether or not they are using it. Where providers are using the EDS, inspectors can ask to see the results, which they may take into account in their assessments.
- Providers will be informed by CQC that they may use the EDS to review the evidence that they have supplied for registration purposes and, if needs be, effect necessary improvements. To facilitate this type of review, and in response to concerns from providers about having to respond to two systems – the Essential Standards and the EDS – with the support of CQC the EDS outcomes are mapped against the Essential Standards.

## **EDS Support Team**

An EDS Support Team was established in December 2010 to help the NHS think through its approach to EDS implementation, and to provide assurance to the EDC that suitable progress was being made. The EDS Support Team continues to work closely with SHA Clusters, SHAs, PCT Clusters, the NHS foundation trust network, pathfinders and emerging CCGs to support or advise on local, regional and NHS foundation trust governance arrangements so that EDS implementation will be a success.

The EDS Support Team will continue to support and monitor EDS implementation. With the co-operation of SHA Clusters, SHAs and PCT Clusters, it will bring together the grades, equality objectives and associated actions that arise from the local use of the EDS by NHS commissioners and NHS providers yet to achieve NHS foundation trust status, up to 6 April 2012 and beyond. It will, in the first instance, advise the EDC of progress and challenges of

the take-up of the EDS, and signal the progress and challenges for the NHS in addressing inequalities and promoting equality. Once established, the NHS Commissioning Board and the NHS Trust Development Authority will also be informed of these matters, and will determine how to make the grades for all organisations widely available for public comment.

The support of Monitor and the NHS foundation trust network will be sought in thinking through how the position across NHS foundation trusts may be established, and the grades of all NHS foundation trusts taking part in the EDS made widely available.

## Annex L A case study from NHS Luton and partner organisations

For further information on the work described below please contact:

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NHS Luton has established a Luton-wide EDS Implementation Group (EDS-IG) chaired by NHS Luton with relevant staff from partner organisations: Luton and Dunstable Hospital; East of England (EoE) Ambulance Service; Cambridge Community Services; Luton GP Consortia and Luton Borough Council. Members of this group are working collaboratively to ensure implementation of the EDS across Luton.

The aim is twofold: that firstly, the 'wheel is not re-invented' and that resources are effectively utilised and secondly, to ensure this activity both builds upon the ongoing focus of QIPP and the existing community engagement infrastructure in Luton; for example, using a partnership approach to community consultation and involvement.

The EDS has begun to be integrated into the relevant business areas and discussions commenced with relevant Directors and colleagues across NHS organisations (commissioner and providers) on how this may operate on a practical level. For example, meetings have been held with the Director of Public Health to initiate discussions on how the EDS may be embedded within the work of the new health & wellbeing board and work has also commenced on fully embedding the EDS within the Joint Strategic Needs Assessment (JSNA).



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NHS Luton has adopted the EDS to ensure services provided to our communities are based on the principles of quality, innovation, productivity and prevention.

*Dr Steve Feast, Deputy Chief Executive / Director of Transformation, NHS Luton*

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Luton is fortunate in having a well-established system, which can be exploited to facilitate an ongoing dialogue between diverse communities and local service providers. There is a partnership-wide approach to consultation and engagement across the town and the Community Involvement Strategy is underpinned by initiatives such as the Neighbourhood Governance (NG) mechanism. This will allow NHS partners to identify how strategic priorities can be delivered appropriately in local contexts (e.g. by Boundary Wards) and at the same time, on how they (the priorities) can be informed, shaped and progressed by local people's involvement.

This programme is designed to enable citizens and communities to get involved at the level they themselves choose. For example at community festivals, neighbourhood mapping, face-to-face surveys, community planning, participatory budgeting and learning for active citizenship.

In delivering the EDS priority outcomes, work has begun using the NG model to establish what these may be. Initial EDS influenced questions have also been incorporated into a *100 citizen survey*, conducted by the Local Authority. Discussions with GP practices on how we may use their Patient Reference Groups to get as wide a view as possible, have also commenced.

In terms of engaging with local interests groups (including those reflecting protected characteristics) discussions have commenced and have resulted in established and new organisations that would typically not automatically be approached, now being included, such as Voluntary Action Luton, Nyabingi Trust, Changing Lives (refugee and asylum), Impact (mental health) as well as LINKs to name a few. The implementation group is also, based on feedback, looking to develop with the support of others, a programme to support the development of the capacity and capability amongst the members of these groups, to help facilitate more effective and meaningful understanding and engagement with regard to healthcare, and thus enable a more effective approach to implementing the EDS in Luton.

It is also envisaged that the representatives from these organisations will also work with the EDS-IG to agree the initial priority outcomes, critically challenge evidence and help to co-rate each of the organisations.

The initial signs of this approach are encouraging. The 'open' and 'collaborative' approach has ensured that the EDS has been enthusiastically received by all sectors. It is being widely viewed as a unique opportunity, to bring together the 'inclusion' agenda, under one framework, that supports the alignment of Luton's population health needs, with that of the commissioning and service provider objectives.



## Annex M A case study from Royal Devon and Exeter NHS Foundation Trust

For further information on the work described below please contact:

Tony Williams (Equality and Diversity Manager, Royal Devon and Exeter NHS Foundation Trust)

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I am really pleased with what we have achieved through the EDS, so far. We appear to be achieving across 17 of the 18 outcomes with one assessed as developing. It is giving us reassurance about good practice we already achieved, as well as highlighting a few areas where we need to improve. The hard work has been worth it.

*Lynne Lane, Director of Human Resources, Royal Devon and Exeter NHS Foundation Trust*

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The EDS is still very much “work in progress” at the Trust. The Trust presents this case study to show learning to date and is very much aware that its EDS journey is by no means complete.

### “Don’t panic”

With 18 outcomes, each with multiple factors, the EDS initially felt intimidating. That said, the Trust had been doing its best to keep up with the evolving public sector Equality Duty, so once we got to grips with the process, it soon became reassuringly helpful, rather than daunting.

The public sector Equality Duty information and guidance is by definition generic, yet here, in the EDS, we have something tailor-made for the NHS. As the Trust has worked its way through the EDS, it has clearly focused thinking on what it is already doing – and still needs to do – to meet the public sector Equality Duty, not to mention CQC and Human Rights obligations.

There has been plenty of cross-fertilisation with CQC evidence. For example, existing CQC evidence covering initial assessment of patients has been really valuable in evidencing the EDS. In turn, EDS standards have given us a few prompts about how we can improve the CQC material and become even sharper at “getting things right” for our patients, right from the very first contact. Now that our EDS evidence is all but complete, we have plenty of valuable material to link back into our CQC processes, too.

We also found evidence we generated for one EDS outcome could be “re-used” for others. For example, our engagement processes and the way we mainstream equality is broadly the same across all of our patient work – having evidenced it once, we could then re-use the material across multiple outcomes. Evidencing EDS has become progressively easier, the longer we have worked with it.

### **“It’s surprising what we already have”**

Once we got “into the groove” of the language of the EDS outcomes, it was surprising how much evidence was already out there, just waiting to be tapped.

The EDS outcomes have to be worded fairly generally – consider, for one moment, the immense range of NHS services and organisations whose activities all need to fit within the outcomes! The language has to be general; otherwise, the EDS would never achieve the breadth of coverage it needs to.

That inevitably means it cannot spell out exactly what is appropriate, or expected, in our setting, or anyone else’s. Consequently, we learnt fairly quickly to think creatively about “what fits”. It is easy, at first, to feel challenged by the EDS outcomes – but if you think creatively enough (and ask the right people to help you) it is surprising what you can find to fit. Having taken the first jump of creative thinking, in “fitting things in” to the EDS that we would not instantly have thought of, it has been pleasantly surprising to take a step back from our work and see just what a good fit has been achieved.

The Foundation Trust has been working hard, over almost 3 years, to build its evidence-base of equality data. The Trust already knew, before EDS was published, that we needed to do something as regards an equality breakdown of key patient outcome data, alongside the survey information by equality category. The advent of EDS gave us the push we needed, to complete our work in that respect.

The Foundation Trust found two outcomes to analyse, covering the core business of any hospital – looking after patients while they are with us and ensuring the best patient outcomes. The data we needed, looking at patient-related incident reporting and emergency readmissions, was already there – all we had to do was to ask the data experts to “match in” the patient equality data from our central system and it was done! The equality information on emergency readmissions, will have future financial consequences, so has already started to raise wider interest in improving outcomes for key groups.

### **“Don’t build a new cottage industry”**

The EDS very rightly has a strong emphasis on consultation and engagement. A knee-jerk reaction could be to go into overdrive and set up a series of new activities, talking with anyone and everyone about equality. The Trust didn’t need to do this. As a large acute Foundation Trust, the main business is about understanding our patients, and, so we can enable our staff to give a quality service, we need to understand our staff, too.

The key learning for the EDS engagement was not to “build a new cottage industry”. As a Foundation Trust, our engagement needs to centre on those people who matter most to us – our patients and our staff, our members and governors – and we already have plenty of ways in which we talk to and engage with them. Consequently, rather than generating new activity, our EDS engagement work has focused on sharpening what we already do. The Trust is now using existing patient and staff consultative mechanisms (with a little sharpening) to get staff, patients, governors and members talking to us about our provisional EDS grades.

For example, the Trust has reviewed its main consultative groups to make sure they cover all of the protected characteristics, through either the personal identities or personal / professional interests of the members. As a result, the Trust has boosted the membership of some groups, so it hears an even richer diversity of voices around the table, as it works out the final EDS grades.







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