A REFRESHED EQUALITY DELIVERY SYSTEM FOR THE NHS – *EDS2*: QUESTIONS AND ANSWERS

Q. Why is EDS needed?
A key principle of the NHS is that everyone counts – this is at the heart of the NHS Constitution and should be a principle that applies to everyone in the NHS. So over 18 months of hard work led to the design of a tool kit for anyone involved with the NHS – patients, carers, voluntary organisations and the people who work in the service. With this toolkit you can work out how NHS organisations are performing with regard to their equality performance, how they can make it better and how they can get to where they want to be.

We didn't dream this up. When designing the original EDS, we spent 18 months listening to over 3,000 people and positively responding to what they had to say. We have ensured sustained consultation and evaluation since.

Moreover, the EDS provides a ready-made way for the NHS to respond to the public sector Equality Duty. Without the EDS, each NHS organisation would have to work out its own response – at considerable cost. At one level it's a simple framework which organisations can use to analyse their own priorities. By focussing efforts and making better informed commissioning or making changes to service delivery, we can improve both cost effectiveness and quality.

Q. How does EDS work?
In its simplest form, the EDS gives you the tools for you and your organisation to work out your equality performance in relation to:

- How good you are now
- How good you can be
- How you can get there

And as you do this you will be listening to patients, to carers, to people who work in the NHS and to the community and voluntary sector.

At the heart of the EDS are 18 outcomes grouped into four goals. The outcomes cover the things that patients and staff tell us matter the most to them. Working with patients, staff and local voluntary organisations, NHS organisations analyse their performance against the 18 outcomes and use the results to identify equality objectives for the next business planning round.

The outcomes are aligned with key mainstream levers for the NHS – including the NHS Outcomes Framework, the NHS Constitution and the Care Quality Commission's key inspection questions. By delivering on the EDS, organisations can also deliver, to an extent, on mainstream business.

Q. What is the current position with the EDS?
The EDS was made available to the NHS in July 2011 and was officially launched in November 2011. The first year, since the roll-out of the EDS, focused upon supporting NHS organisations to implement and use the toolkit. During 2012, many NHS organisations used the EDS to help them meet the public sector Equality Duty of the Equality Act 2010.

An independent evaluation on the implementation of the EDS during that first year has been carried out by Shared Intelligence. The findings of the independent evaluation were shared with the NHS. As a result of this good practice, insight and engagement, the EDS has been refined and refreshed, so that it is more simple and flexible to implement.

Q. What does the evaluation of the EDS and the consultation exercises tell us?
The independent evaluation was undertaken by Shared Intelligence between January and October 2012, and involved over 200 organisations. Overall, the 2012 evaluation, and the 2013 consultation carried out by NHS England revealed that NHS organisations and local partners welcomed the EDS. In particular, it was emphasised that the original EDS maintained a focus on equality at a time of great NHS change. It also prompted stronger and more inclusive engagement with the public and other stakeholders.

A number of challenges of using the EDS, and related development issues were identified, including:

- Governance
    - Placing the EDS and the management of equality business into a mainstream governance structure is a pre-requisite for success.
- Engagement
    - Most organisations prefer to self-assess themselves before inviting stakeholders to comment, which is fine as long as stakeholders have a genuine chance to express views and these views are taken into account.
    - The EDS promotes engagement with stakeholders but engagement overkill should be avoided.
    - Pre-engagement events can acquaint stakeholders, especially the public, with the EDS and support them to make a more effective input.
- Local adaptation
    - Organisations should make the EDS work for them rather than the other way around. There are good examples of organisations tailoring the EDS to meet their specific needs. Some organisations persevered with the EDS as it was written without adapting it, and struggled as a result.
    - The language of some of the original EDS outcomes is difficult and some organisations used their own wording. In this regard, a preference for plain English and Easy Read versions was stressed during the consultation.
- Evidence
    - Getting hold of robust evidence across <u>all</u> the protected groups remains a challenge for some NHS organisations.
    - Evidence and insight can be developed on the basis of focus groups and other qualitative means. Good practice needs to be shared widely.
- Grading
    - Some organisations usefully use independent third parties – including neighbouring NHS trusts - to take part in EDS gradings of performance.
    - Many organisations found the grading system of the original EDS to be complicated, and in practice used simpler ways to grade performance.
    - But simpler grading systems might mask or downplay the essential purpose of the grades, which is to say how well people with protected characteristic fare compared with people overall.

Q. Why has the EDS been refreshed?
The refreshed EDS – *EDS2* – has arisen out of NHS England's commitment to an inclusive NHS that is fair and accessible to all. Like the original EDS, *EDS2* has been designed in collaboration with the NHS and in light of evidence of how the EDS was implemented and with what result.

It has also arisen from the findings from the evaluation and from consultation feedback. The use of the EDS has resulted in significant improvements in the way services are planned and delivered, and workplaces are organised. The EDS has worked best when organisations made it work for them, and implemented it flexibly to suit local needs and circumstances.

Building on this success and this insight, a refreshed and streamlined EDS – called *EDS2* – has been developed. *EDS2* is a means of making sure the 'process' doesn't get in the way of the 'personal'.

Q. What changes have been included in the refreshed EDS2?
EDS2 is more streamlined and simpler to use compared with the original EDS. There is much in common but some important changes between the two.

As with the original EDS, there are still 18 outcomes in *EDS2,* with enough in common between the original EDS and *EDS2* for meaningful comparisons to be made over time between results.

Two of the original EDS outcomes have been dropped:

- Original Outcome 3.6 focused on a healthy workforce and what organisations could do to address health and lifestyle issues for their staff. It has been removed from the EDS as it has not the same significance for staff with protected characteristics as other workforce outcomes.
- Original outcome 4.3, asked organisations to use the "Competency Framework for Equality and Diversity Leadership". It has been dropped as it was felt that embedding the Framework within the EDS led to duplication.

Two new outcomes have been added:

- *EDS2* Outcome 3.6 focuses on how staff experience their membership of the NHS workforce. It mirrors the 2013/14 business objectives of NHS England.
- *EDS2* Core Outcome 4.2 looks at papers that come before the Board and other major Committees, and the extent to which they identify equality-related impacts including risks, and say how these risks are to be managed. This outcome provides an easy-to-measure check on senior leaders' routine grasp of, and commitment, to equality.

The wording of each *EDS2* Outcome is simplified and NHS organisations are encouraged to express these outcomes in their own words and communicate them effectively to all local audiences, as they see fit.

An Easy Read version of the EDS will be produced and made available to the NHS. Local wordings of *EDS2* outcomes, using plain English and aimed at the general public, will be shared.

The assessment and grading component of *EDS2* has been simplified:

- There is now just one factor for NHS organisations to focus on within the grading process. For most outcomes the key question is: how well do people from protected groups fare compared with people overall?
- There are four grades, as before - underdeveloped, developing, achieving and excelling.
- Rather than having factors about the quality and scope of engagement and evidence incorporated within the assessment and grading of each individual outcome, as was the case with the original EDS, it is recommended that when using *EDS2* organisations take stock of their engagement activities and use of evidence once all outcomes are graded.
- To help with the grading, national and local sources of evidence are given for each outcome.

All other aspects of the processes for using the EDS remain as set out in the original EDS guidance of 2011.

Q. The processes of the refreshed EDS are more streamlined, with a greater emphasis on local adaptation, than the original EDS. Does this mean that the original EDS was flawed, rigid and unwieldy?

The original EDS was successful. It promoted equality at a time of great NHS change and encouraged patient, community and staff engagement in NHS business. It helped many organisations to identify issues and challenges, and to address them. But the grading process turned out to be overly complicated, and attempts at local adaptation could be limited. Because the original EDS was a new national tool, it would have been irresponsible had implementation not been monitored evaluated and results not taken into account. The evaluation, and subsequent consultation by NHS England has pointed to ways in which the EDS can be made more effective and manageable. It would have been equally irresponsible, had not NHS England not changed the original EDS as a result. Despite the changes, *EDS2* has much in common with the original EDS, which will ensure ease of use coupled with consistency and continuity.

Q. How does the grading for *EDS2* outcome 3.1 work? Is it true that, for some protected characteristics, what might be good for some people may not be good for others?

EDS2 outcome 3.1 reads “Fair NHS recruitment and selection processes lead to a more representative workforce at all levels”, and the grading hinges on how well staff members from protected groups fare compared with their numbers in the local population and/or the overall workforce. To see how the grading works, take a typical situation and specific example. Among the population of working age in the area of a CCG, 51% of people are women and 49% are men. In the overall CCG workforce (incorporating CSU staff who work within the CCG), 70% are women and 30% are men. Within the senior management team (SMT) of the CCG, 40% are women and 60% are men; while among administrative and clerical grades 80% are women and 20% are men. In this situation, women fare well in terms of their representation in the overall workforce compared with the local population, and men fare poorly. The CCG might reflect on the reasons for these levels of representation, but analysis and action at the level of the overall workforce may not be so helpful. *EDS2* prompts NHS organisations to look at specific roles and pay bands. In this example, the CCG should be concerned about the low proportion of women, and the high proportion of men, in the SMT compared with the proportions of women and men in both the local population and the workforce. And the CCG should be equally concerned, about the

high proportion of women and the low proportion of men in administrative and clerical grades compared with the proportions of women and men in both the local population and the workforce. As a result, the CCG should assure itself that its job recruitment, selection and promotion processes are fair. In addressing the disproportionate numbers of women and men in various NHS roles and pay bands, there could be winners and losers over time, but the key point is that recruitment, selection and promotion processes are fair so that people's knowledge, skills and experiences are matched to jobs, and talented people can thrive.

Q. Why has the original EDS Outcome 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") been dropped?
The health and well-being of NHS staff is of paramount importance. Many NHS organisations run schemes, and have plans in place, to promote the health of their staff and help them address related lifestyle issues. These schemes and plans are relevant to all staff from whatever background and in whatever role. However, for many staff whose characteristics protected by the Equality Act 2010, and who struggle to thrive in the NHS and fulfil their potential, their health in the workplace is probably best served if they have the same chance to succeed as everyone else, free from discrimination, harassment and abuse. For this reason, organisations are urged to deliver on *EDS2* Outcomes 3.1 to 3.6. By doing so not only will such staff thrive but also their health is likely to improve. For example, there is considerable evidence that discriminated-against, harassed and abused staff experience more sickness, and take more time off work than staff in general. For the moment, as part of the drive to make the EDS slimmer and more focused on issues of greatest relevance to staff with protected characteristics, the original EDS Outcome 3.6 is dropped. Of course, NHS organisations should continue to pursue their general plans that promote the health of their staff, ensuring that these plans are relevant to all staff.

Q. Why has the original EDS Outcome 4.3 ("The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes") been dropped?
Ensuring that the NHS workforce is representative of the communities it serves and that its leaders promote and advance equality outcomes is of central importance. It lies at the heart of the EDS with regard to workforce development. Within *EDS2*, delivery on *EDS2* Outcomes 3.1 to 4.3, and in particular *EDS2* Outcomes 3.1, 3.2, 4.1 and 4.3, will support this ambition. For this reason, and in support of a slimmer *EDS2* with minimum duplication, original EDS Outcome 4.3 is dropped.

Organisations that are already using the "Competency Framework" should continue to do so where benefits are being delivered through its use. Organisations currently not using the "Competency Framework" should look at the benefits of using it, taking into account their use of *EDS2*. NHS England were pleased that the "Competency Framework" was promoted in the original EDS, but it is an independent tool which NHS organisations should use where local benefits are likely to arise.

Q. What is the role of NHS England with EDS2?
The development of the EDS was commissioned by the NHS Equality and Diversity Council. NHS England leads on EDS work on behalf of the NHS – it does so in partnership with the NHS.

NHS England has set itself an equality objective to support CCGs in implementing the EDS.

Q. Will NHS organisations continue to be supported in implementing EDS2?
During the first 12 months after its roll-out to the NHS, support was provided to help organisations implement the EDS. This support will continue to be provided via the Equality and Health Inequalities Team at NHS England.

Q. Is the EDS about political correctness?
No. It's about ensuring the services we deliver meet the needs of everyone. It's about 'making sure everyone counts'. In fact, you cannot have anything more fundamental to the way the NHS goes about its day-to-day business.

Q. Why should staff engage?
This is what our workforce want because we've listened to them. They too should be treated with dignity and respect and empowered to make decisions and to use their skills in a workplace free from discrimination. The way we treat our staff reflects on how they treat others and has a direct impact on service quality.

The evidence is telling us loud and clear that if your workforce feels better engaged then you increase the chances of your organisation's clinical and financial performance improving. The emerging research is showing links between good staff engagement and better outcomes for patients.

Q. Other equality systems haven't worked in the past, why should it work now?
This is different. We're taking a bottom-up and not top-down approach. This isn't rocket science, the goal is clear and simple – it is about how we make sure everyone counts. This is about people coming together, demanding a service that they can access and benefit from. It's about listening to what people want and liberating our workforce to collectively make small changes that can make a big difference to patients and people who work in the NHS.

Q. Is this yet another initiative?
This is all about what the NHS should be doing anyway. It's about the principles and values of the NHS Constitution. It's about what our patients, carers and staff want. It's about putting patients, carers and those that work in the NHS at the heart of everything we do and the decisions that we make. *EDS2* is one way of making sure the 'process' doesn't get in the way of the 'personal'.

Rather than another initiative we see this as a simple to use toolkit which makes life easier. Easier to ensure legal compliance but just as importantly an easier way to ensure services a re designed to make sure everyone counts.

Q. Is this just a tick box exercise?
I would argue that this is the opposite – ticking boxes does not tailor care to the needs of individuals. This is a way of engaging and listening to staff, public and patients as we design good quality services and target our resources more effectively – that is not ticking boxes.

This is not about categories - this is about a very personal service and supportive working environments. It's about treating our elderly people with dignity and respect, not neglecting them or leaving them thirsty and hungry. It's about providing better

primary care experiences for people from a range of black and minority ethnic backgrounds. It's about ensuring that, when it matters and to support better diagnosis and treatment, lesbians and gay men can talk confidently and in confidence to clinicians about their identity. It's about increasingly making reasonable and sensible adjustments in the workplace for staff that need support in caring for younger and older dependents.

Q. The timing is wrong – when the NHS has just gone through major changes?
The NHS is emerging from a time of major change. It is essential that fairness lies at the heart of the decision making of the new system. The implications for staff and patients of poorly considered change could be substantial. NHS organisations should ensure that all decisions should be taken with due regard to the public sector Equality Duty to ensure that decisions are fair, transparent, accountable, evidence-based and consider the needs and rights of the workforce and different members of the community. Fairness will lie at the heart of our work, this will aid, not hinder, building a leaner NHS fit for the future.

Q. Why isn't EDS2 mandatory for NHS organisations?
There is no need as most organisations are using it anyway. In any case, I would turn that question around and ask why would any NHS organisation not want to use the *EDS2*? There has been huge involvement from staff, patients and communities in creating the *EDS2* and I believe this expertise and scrutiny make it stronger. We have done the work nationally to produce this toolkit that can help everyone. It's free, it works and it's simple – why not use it?

Q. What real difference will this make in the NHS?
EDS2 is a framework. It's just a tool. In the wrong hands, or if used to tick the equality box, it will make no difference at all to anything. In the right hands, *EDS2* can be a real force for good by showing organisations where to put their effort and resources in order to make a real difference to real people.

EDS2 is based on involvement of staff, patients and diverse communities and we know often it is the lack of engagement with different groups that can lead to misunderstanding and complaints. Used effectively, *EDS2* will help to bring issues and concerns expressed by staff to the fore. In addition annual reporting as part of EDS2 commitment to transparency regarding complaints and reduction in complaints from staff will also assist in ensuring the NHS progresses on tackling racism and discrimination.

Q. Who's responsible? What happens if there is local disagreement?
The leadership of the NHS organisation adopting *EDS2* is responsible for implementing it. Even if EDS did not exist, chief executives will have to ensure that their organisations are complying with their legal duties under the Equality Act 2010.

What *EDS2* does though is support NHS organisations to work with a range of local interests when using it to evaluate their performance and set equality objectives. It will not work otherwise. Local interests will comprise patients, carers, communities, staff and staff-side organisations.

Q. How much of CCG's performance on the EDS is based on Provider examples? Should CCG's be getting providers' performance – e.g. provider Patient Surveys/GP Patient Surveys, are these relevant to CCG assessment?
A CCG's performance on the EDS outcomes of goals 1 and 2 will greatly depend on its providers' performance but also to some extent on the quality of the CCG's commissioning intentions, contracts and contract monitoring. There could be instances where - despite good commissioning and contract processes - a provider may not deliver, and vice-versa.

A CCG's performance on the above outcomes can rely to a great extent on the grades that a provider is assessed as attaining. It should be assumed that the provider has been assessed and graded on the kind of evidence cited in the question. A CCG might want to satisfy itself that the provider's grades are fair and accurate. But a CCG should also look at the quality of its commissioning and contract processes.

Q. Are CCGs expected to collate evidence for the workforce of the Providers they commission?
With regard to the EDS, a CCG should focus on its own workforce – and those CSU staff who work on behalf of the CCG – and not the workforces of its providers.

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