

The Equality Delivery System for the NHS

29 July 2011



Equality and Diversity Council

Personal, Fair and Diverse



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Abbreviations

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

Foreword

Creating a new health and care system with many brand new organisations gives us a major opportunity to ensure we have a NHS where the needs and aspirations of every individual are fully recognised. Equality must lie at the heart of the NHS - its values, processes and behaviours - if we are to create a service that is personal, fair and diverse, that meets the needs of every patient and all staff.

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 work to embed equality across the service. We have come a long way, but of course there is always more to be done.

Inequalities of access, care and outcome still exist and we still hear about instances when people are not being treated with the dignity and respect they deserve. By recognising that every patient has different needs and circumstances we can best meet those needs and improve outcomes for our patients, by delivering personalised care that is more effective.

The Equality Delivery System is designed as a tool to be used to help all staff and NHS organisations understand how equality can drive improvements and strengthen the accountability of services to patients and the public. It will help ensure that everyone - patients, public and staff - have a voice in how organisations are performing and where they should improve.

There has been huge involvement from NHS staff, patients and communities in creating the Equality Delivery System and I firmly believe it is richer for this expertise and scrutiny.

We now have a major opportunity to embed the essential principles of equality into the cultures and behaviours of our organisations. 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.

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 and 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.

Sir David Nicholson KCB CBE
NHS Chief Executive and
Chair of NHS Equality & Diversity Council

29 July 2011

Background : Design and Acknowledgements

The EDS is a NHS product, initially based on pioneering work by NHS North West. It has been developed through the leadership and resources of NHS East Midlands, and published by them on behalf of the NHS.

Work on the EDS was originated and steered by the EDC. The EDC, established in 2009, has a strategic role to support 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 with equality of opportunity and treatment for all.

The EDC is chaired by the NHS Chief Executive, Sir David Nicholson and its membership includes representatives from the NHS, Department of Health, trade unions, patient groups, regulators and the voluntary sector who are all committed to eliminating discrimination and can reach out to NHS staff, health and care organisations and communities through their own networks. For more information about the EDC visit :

<http://www.dh.gov.uk/en/Managingyourorganisation/Workforce/Equalityanddiversity/index.htm>

Work on the EDS is led by Tim Rideout on behalf of the EDC. Tim Rideout is Chief Executive of NHS Leicester City and is currently assigned to the Commissioning Development Team at DH where he works on the design of the NHS Commissioning Board. An EDS Technical Working Group, reporting to Tim Rideout, has advised on the detailed proposals for the EDS. Although membership of the Technical Working Group changed over time, a constant element was the contribution of SHA Equality and Inclusion Leads. Other members of the Technical Working Group represented primary care trusts, NHS foundation trusts, NHS Employers and the Care Quality Commission. On workforce aspects of the EDS, the contribution of NHS Employers has been invaluable.

At the outset, the design of the EDS was informed by the “Equality Performance Improvement Toolkit” developed and implemented 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 was also taken into account.

Once the first phase of EDS design work was completed, proposals were extensively shared through a series of national and regional engagement events from July 2010 to May 2011. The events were often chaired by the NHS leaders on the EDC, and were attended by a wide range of interests including patients, community members, voluntary organisations, and managers and staff from NHS commissioners and NHS providers. In total over 3,000 people attended these events, and their views and wishes positively contributed to the design of the EDS.

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

The Equality Delivery System for the NHS

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.

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 future priorities and actions. It offers local and national reporting and accountability mechanisms.

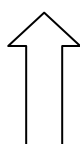
While the EDS can help inform the decision-making process, it is important to ensure that it is used as a tool to assist with evidence gathering and evaluation as part of the decision-making process. Nor of itself does it satisfy the public sector Equality Duty. In every case, organisations need to ensure 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 :

1. Excelling – **Purple**
2. Achieving - **Green**
3. Developing – **Amber**
4. Undeveloped – **Red**



See Annex A for the EDS outcomes.

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

See Annex C for how the EDS outcomes support the Human Rights Act 1998.

See Annex D for how the EDS outcomes align with CQC's "Essential standards of quality and safety", March 2010

See Annex E for the EDS Grades.

See the separate "EDS Grades Manual".

Is it about people or processes?

The EDS focuses on people. It provides a tool to help organisations can be the best they can be for their patients and staff. It can be used to support commissioners 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.

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.

NHS East Midlands is pleased to lead on the EDS on behalf of the NHS across the country. For us the EDS is all about our staff, patients, carers and communities. It is about the people who rely on and work in the NHS. If we get it right for them, then they will become champions for equality. We look forward to working with, and supporting, our NHS colleagues in the region to implement a people-focused EDS.

Kevin Orford
Chief Executive
NHS East Midlands

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 feel that they have 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 affect some types of staff far harder than it affects others. Staff disciplinary processes can focus on particular types of staff.

The accompanying Equality Analysis for the EDS provides this evidence. The production and sharing of this Equality Analysis 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?

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

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>

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

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)

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 Primary Care Trusts (PCTs) until they are abolished, and to Clinical Commissioning Groups 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 departments, 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 departments. 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 and the public sector Equality Duty. As of 29 July 2011, the Equality Act 2010 (Specific Duties) Regulations 2011 have yet to be approved by Parliament. (Approval is expected in early September 2011)

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

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 : 9 Easy Steps".

Following 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), and partnership working with local authorities (Step 4) lay the foundations for effective EDS implementation. 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, and be ready to work on them, by 6 April 2012.

The Equality Delivery System for the NHS Steps for implementation	
Step 1	<p>Governance and partnership working</p> <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. With the support of the EDS Support Team, many organisations have already made progress on these matters. 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>
Step 2	<p>Identify local interests</p> <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, members and staff. <i>See Annex G for details.</i></p>
Step 3	<p>Assemble evidence</p> <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>
Step 4	<p>Agree roles with the local authority</p> <p>NHS organisations agree the part that LINKs / HealthWatch, health & 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>
Step 5	<p>Analyse performance</p> <p>With local interests, organisations analyse their performance on each EDS outcomes, 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>

<p>Step 6</p>	<p>Agree grades</p> <p>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 departments and sites. 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. <i>See Annex E for details of grades.</i> 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. <i>See Annex F for details.</i></p>
<p>Step 7</p>	<p>Prepare equality objectives</p> <p>By 6 April 2012 in the first instance, 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 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. <i>See Annex J for details.</i> 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.</p>
<p>Step 8</p>	<p>Integrate equality objectives into mainstream business planning</p> <p>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. <i>See Annex K for details.</i></p>
<p>Step 9</p>	<p>Publish grades and equality objectives</p> <p>Grades and equality objectives, and associated actions, can be published locally in Annual Reports, and in other ways accessible to local interests. The grades and equality objectives should be shared with health & wellbeing boards for comment and possible action. Where there is agreement from all parties, grades and priority may also be shared by NHS Commissioners and their local interests with PCT Clusters, for comment and possible action. Where particular concerns about providers relate to the Essential Standards, CQC should be notified for possible inclusion on organisations' Quality & Risk Profiles, and potential action. (Once they are established, the NHS Commissioning Board and NHS Trust Development Authority will determine and announce how they are to be assured of the performance of commissioners and providers that have yet to achieve NHS foundation trust status.) <i>See Annex J for details.</i></p>

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

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.

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.

All NHS South West organisations have embraced the Equality Delivery System to continue to improve the quality of care for all communities we serve.

Sir Ian Carruthers OBE
Chief Executive
NHS South West

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)

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

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

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 broad health inequalities work, 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.

Implementing this Equality Delivery System will help the NHS to ensure that reducing inequality in outcomes, access and delivery, becomes a core task for us all.

Sir Neil McKay CB
Chief Executive
NHS East of England

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 opportunity to ensure that staff feel valued and respected for the outstanding contribution they often make.

NHS staff are the most important resource at the disposal 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

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.

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 BME Advisory Group

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 on developing the Equality Delivery System for the changing NHS landscape.

Dean Royles
Director
NHS Employers

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 organisation 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

NHS commissioners and the EDS

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 can play a part in promoting equality throughout the local health system. Through their contracts, they should ensure providers are aware of their duty under the Equality Act, and they can require them to adopt the EDS. Commissioners’ service specifications should clearly set out requirements for protected groups where there is a need to do so. Contracts and service specifications can also require 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.

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.

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

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 priorities, including NHS Integrated Plans.

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

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 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

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.

Already many organisations have laid solid foundations for local implementation, while others have put in place prototype versions of the EDS or particular aspects of it, such as the outcomes.

It will be critical for NHS organisations to continue 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.

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. Copies of the monitoring template can be accessed at www.eastmidlands.nhs.uk/eds

The Equality Delivery System for the NHS	
Examples of implementation	
Region	Example
East Midlands	Supported by NHS East Midlands, Kettering General Hospital NHS FT and their Northamptonshire partners have put EDS governance arrangements in place; and the hospital is testing different approach to engagement over particular EDS outcomes.
East of England	NHS Luton has put strong governance arrangements in place in partnership with neighbouring NHS trusts, the local authority and third sector organisations. See Annex L for fuller details.
London	Led by the SHA, trust Equality Leads have been influencing the Clinical Commissioning Group Development Programme to ensure that the EDS is firmly embedded within the new NHS structures
North East	Efforts have prioritised the involvement of the voluntary sector in EDS implementation.
North West	Organisations in the North West are preparing to migrate from EPIT to the EDS; they will be able to make good progress given the solid foundations laid by the SHA.
South Central	A regional EDS conference was held in June 2011 for all stakeholders and it included a workshop to test the application of the EDS grading system process.
South East Coast	The SHA organised events for current and emerging NHS organisations, as well as GPs, to raise awareness of the Equality Act and the EDS.
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.
West Midlands	A “Masterclass” on the EDS for trust chairs and non-executive directors was held in May 2011.
Yorkshire & the Humber	All organisations are developing communication plans so that the EDS may be explained to patients, communities and other local interests.

As NHS organisations work with the EDS, a good deal of 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.

Timeline

The Equality Delivery System for the NHS Timeline	
Date	Action
By 29 July 2011	The EDS is published for the NHS in July 2011, Supporting guidance is also made available from this date. The EDS Support Team will closely monitor the use of this and related EDS guidance to ensure that it is as helpful and clear as possible.
From August 2011	Organisations work to ensure that : <ul style="list-style-type: none"> • local interests are empowered and supported to play a full part in the local implementation of EDS • evidence, including data and softer material, are assembled, developed and fully utilised • the local authority will play an effective part in EDS implementation
October 2011	A national launch event is held to report on progress and confirm the NHS's commitment to fairness, personalisation and diversity. Based on feedback from the EDS Support Team, changes may be made to the EDS guidance in time for the launch.
November 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.
By 31 January 2012	NHS organisations are required by law to publish information to demonstrate their compliance with the public sector Equality Duty. (See Annex F for details) NHS organisations should be helped by their EDS analysis of their performance, using the EDS outcomes and grades.
By 6 April 2012	NHS organisations are required by law to publish one or more equality objectives (see Annex F for details). 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 incorporated into mainstream business plans for 2012/13 in the first instance.
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).
By 6 April 2016	Using the EDS, NHS organisations have reviewed and published equality objectives for 2016/17 and beyond.

Support and queries

For further information and queries about the EDS, please contact the EDS Support Team at 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 Such information and a range of other equality resources and information will also be available on the EDC Hub in due course.

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 Carnell CBE
Chief Executive
NHS London

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
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 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay
		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>You have a right 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>You have a right 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	No equivalent NHS Constitution right or pledge
1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly	The NHS commits to make the transition as smooth as possible when you are referred between services, and to include you in relevant discussions (pledges) (p.6)
1.4 The safety of patients is prioritised and assured	<p>You have the right 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>The NHS commits 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	The NHS commits to provide screening programmes as recommended by the UK National Screening Committee (pledge) (p.6)
2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds	You have the right to access NHS services. You will not be refused access on unreasonable grounds (p.5)
2.2 Patients are informed and supported so that they can understand their diagnoses, consent to their treatments, and choose their places of treatment	<p>The NHS commits 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>You have the right 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>You have the right 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>

EDS Outcome	The NHS Constitution : your rights and NHS pledges
	<p>You have the right of access to your own health records. These will always be used to manage your treatment in your best interests (p.7)</p> <p>You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply (p.7)</p> <p>You have the right 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>The NHS commits 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>You have the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this (p.7)</p>
2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected and their privacy and dignity is prioritised	<p>You have the right to be treated with dignity and respect, in accordance with your human rights (p.6)</p> <p>You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure (p.7)</p>
2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently	<p>You have the right to have any complaint you make about NHS services dealt with efficiently and to have it properly investigated (p.8)</p> <p>You have the right to know the outcome of any investigation into your complaint (p.8)</p> <p>You have the right 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>You have the right 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>The NHS commits 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>The NHS commits when mistakes happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively (pledge) (p.8)</p> <p>The NHS commits to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services (pledge) (p.8)</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>The NHS commits 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>
3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal	<p>The rights are there to help ensure that staff have a fair pay and contract framework (p.10)</p>

EDS Outcome	The NHS Constitution : your rights and NHS pledges
work and work rated as of equal value being entitled to equal pay	
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>The NHS commits 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>The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed (pledge) (p.10)</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>The rights are there to help ensure that staff have healthy and safe working conditions and an environment free from harassment, bullying or violence (p.10)</p> <p>The rights are there to help ensure that staff can raise an internal grievance and if necessary seek redress, where it is felt that a right has not been upheld (p.10)</p>
3.5 Flexible working options are made available to all staff, consistent with the needs of patients, and the way that people lead their lives	<p>The rights are there to help ensure that staff have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives (p.10)</p>
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	<p>The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety (pledge) (p.10)</p>
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	No equivalent NHS Constitution right or pledge
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 NHS Constitution right or pledge
4.3 The organisation uses the NHS Equality & Diversity Competency Framework to recruit, develop and support strategic leaders to advance equality outcomes	No equivalent NHS Constitution right or pledge

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

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 follow box demonstrates.

<i>FREDA principle</i>	<i>How reflected in the EDS for protected groups?</i>
Fairness	The EDS as a whole is designed as a tool 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, the EDS Outcome 3.6 asks organisations to promote the well-being of their staff; a sure sign that staff are being respected.
Equality	The whole of 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 to do its work.

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

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
<p>1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities</p>	<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>
<p>1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways</p>	<p>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>)</p>
<p>1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly</p>	<p>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>)</p>
<p>1.4 The safety of patients is prioritised and assured</p>	<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>
<p>1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups</p>	<p>No equivalent CQC Essential Standard.</p>

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 so that they can understand their diagnoses, consent to their treatments, and choose their 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 the NHS, where they are listened to and respected and 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.
3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay	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	<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</p>

EDS Outcome	CQC Essential Standard : outcome as experienced by service user
appropriately	<p>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 patients, and the way that people lead their lives	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>
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

Annex E

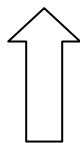
Grades

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^{plus} rating, to choose from :

1. Excelling – **Purple**
2. Achieving - **Green**
3. Developing – **Amber**
4. 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 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 the organisation 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 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 attribute 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".

Public authorities for the purpose of the public sector Equality Duty are listed in Schedule 19 to the Act. Primary Care Trusts, Strategic Health Authorities, most Special Health Authorities, NHS trusts and NHS foundation trusts are listed as public authorities. The NHS Commissioning Board and all Clinical Commissioning Groups 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 were laid before Parliament in June 2011. At the time this guidance was made available to the NHS, the Equality Act 2010 (Specific duties) Regulations 2011 were expected to be made and come into force in September 2011. (Warning : NHS bodies should take legal advice to confirm the up-to-date law.) The regulations would require relevant bodies 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.

Note : as of 29 July 2011, the Equality Act 2010 (Specific duties) Regulations 2011 have yet to be approved by Parliament. Approval is expected in early December.

For further information on the Equality Act, refer to :

www.equalities.gov.uk/equality_act_2010.aspx

www.equalityhumanrights.com/legal-and-policy/equality-act/

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

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. Although the specific duties regulations are not yet in force, 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 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. When it comes to the public sector Equality Duty, and therefore the EDS, individual PCTs not PCT Clusters are listed as responsible bodies in Schedule 19 of that Act. PCTs bear the legal responsibility for compliance, even though PCT Clusters may take an overview and provide leadership on equality across a number of PCTs.

New NHS organisations, including Clinical Commissioning Groups, 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 and 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 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** provided 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 priorities and grades of individual organisations to Local Authority Overview and Scrutiny Committee, health & wellbeing boards.

If the EDS is not prioritised at all or in part, by LINKs and HealthWatch, SHAs 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 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. Initial results, together with a range of information on engagement, can be accessed at 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/ 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.

Where possible, the evidence should be broken down by protected group. Where it is not possible in the short-term to do so, organisations should perhaps turn to more qualitative evidence. 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. 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 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 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 is 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 overlap 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 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 needs to ensure that they are familiar with, and act, in accordance with the Data Protection Act.

Public health

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.

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 through regional engagement events, 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 organisation's 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, SHAs 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

As a result of the analysis of EDS outcomes, it is recommended that NHS organisations and their local interests agree on a small set of equality objectives and associated actions for the coming business planning period. The NHS organisation is responsible for ensuring that the decisions they make can be justified and satisfied public law requirements and must comply with the public sector Equality Duty.

The more that equality objectives and associated actions can seek to make improvement across different EDS outcomes and make links between different protected groups the better. A single strand approach to equality is becoming increasingly irrelevant in today's world, where individuals are a mix of "protected" characteristics.

At any one time, it is recommended that an organisation's chosen equality objectives and associated actions span all four EDS goals. It is recommended that organisations choose no more than four or five equality objectives, at least one per EDS goal. Working on scores of priorities could result in efforts being spread too thinly, where lasting outcomes are jeopardised. Many Single Equality Schemes were often undermined by being too wide-ranging and too comprehensive, as if every part of an organisation had to offer up an action or two, spread out across each protected group.

However, 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 the actual and potential adverse effects, and what steps could be taken to mitigate those adverse effects.

The chosen equality objectives and associated actions should cover the most immediate and urgent concerns and be firmly based in evidence. Work on the equality objectives should support 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.

Choosing equality objectives so that all protected groups are covered at any one time, irrespective of need and urgency, can lead to tokenistic not realistic 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 a complete range of 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.

The equality objectives should be both specific and measurable so that, for one thing, progress and achievements can be gauged.

Link to the Specific duties

Engaging with the EDS process will help NHS organisations 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 specific and measurable equality objectives not later than 6 April 2012, and then subsequently at intervals not greater than four years. The design of the EDS is based on extensive engagement with NHS leaders, staff and patients.

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.

Making progress on the equality objectives

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.

Guidance

In developing and working on their prioritised 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.

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. Of course, 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.

Review and mainstream business

Setting equality objectives and acting on them should be part of the business cycle of the organisation and broad approaches to address inequalities and reduce gaps, deliver on QIPP through NHS Integrated Plans and/or through other appropriate mainstream processes.

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 guidance implementation plans
- Core Human Resource policies and procedures, including delivering on the Human Resources Transition Framework

The duties under the Equality Act are continuous duties. Although equality objectives should be reviewed at least every four years (as required by Equality Duty 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.

Work on the equality objectives may be reviewed annually, to link to the NHS Operating Framework and various other annual planning mechanisms. Again timing will be important for the reasons given above (see “Timing”). This review should include a re-assessment of the EDS outcomes to ensure that equality objectives, if not completed, remain a priority and to check the situation on other challenges. Going forward, it should be made clear how achieving on equality objectives helps an organisation to deliver on its mainstream goals, including its wider systematic work on tackling health inequalities at a population level, and reducing gaps and promoting quality.

Annex K

Reporting process 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 Health Watch
- 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. With regard to the grades, equality objectives and associated actions for 2012/13, this engagement should take place before April 2012 so that the plans can be agreed and 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. 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.

Grades and equality objectives can be published locally in Annual Reports, and in other ways accessible to local interests. The grades and equality objectives should be shared with health & wellbeing boards for comment and possible action.

Where there is agreement from all parties, grades and priority may also be shared by NHS Commissioners and their local interests with PCT Clusters, for comment and possible action.

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 will 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 and the NHS foundation trust network to support or advise on local, regional and NHS foundation trust governance arrangements so that EDS implementation will be a success.

From July 2011 and into 2012/13, 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.

Based on the first three months of EDS implementation, the EDS Support may make recommendations to the EDC about adjusting and improving this guidance. Any updated guidance will be issued to the NHS in time for the proposed launch in October 2011.

Annex L

EDS implementation – 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 & Well being Board and work has also commenced on fully embedding the EDS within the Joint Strategic Needs Analysis (JSNA).

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**

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 and 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 approached, are 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 and 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.