NHS
East Midlands

The
Equality Delivery System
for the NHS

Equality Analysis

Abbreviations

BME	Black and Minority Ethnic
CQC	Care Quality Commission
DH	Department of Health
EDC	NHS Equality and Diversity Council
EDS	Equality Delivery System for the NHS
NHS	National Health Service
ONS	Office for National Statistics
PCT	Primary Care Trust
SHA	Strategic Health Authority

NHS

EQUALITY ANALYSIS
Date of analysis: 29 July 2011

Name of item being assessed:

The Equality Delivery System for the NHS

Brief details:

The NHS Equality & Diversity Council (EDC) has prioritised the Equality Delivery System (EDS) as the best means of helping the NHS improve its equality performance for patients, communities and staff, whatever their background.

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. If used effectively, it should help organisations to achieve compliance with the public sector Equality Duty in a way that 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 Care Quality Commission's (CQC) Essential Standards of Quality and Safety.

The EDS will lead to greater consistency and greater sharing of good practice and lessons, while at the same time leaving it up to NHS organisations to identify their own priorities through engagement with local interests. Because the EDS has been designed to help organisations meet their public sector Equality Duty, it will help to ensure a coherent approach across the NHS, with less likelihood of damaging and expensive consequences arising from Equality and Human Rights Council (EHRC) formal action.

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 help prepare equality objectives as required by the public sector Equality Duty. It includes local and national reporting and accountability mechanisms. At the heart of the EDS is a set of 18 outcomes grouped into four goals. These outcomes focus on the equality issues of most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and equality objectives set.

1. When was the EDS created?

The Equality & Diversity Council (EDC) was established in 2009. The Council initiated work of the Equality Delivery System (EDS) and steered its development. Much of the work to develop the EDS was carried out by NHS staff. The EDS is scheduled to be rolled-out to the NHS on 29 July 2011.

2. Who is intended to benefit from the EDS?

The focus of the EDS is on patients, communities and staff with the nine characteristics protected by the Equality Act 2010. The nine characteristics being:

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

People who are protected from discrimination on the basis of any of these characteristics are described in this document as belonging to one or other “protected group”. In addition, the EDS can be applied to groups of people not afforded protection by the Equality Act, but who often face disadvantage and stigma in life in general and when trying to access statutory services. Such groups include homeless people, sex workers, people who misuse drugs and other groups who experience socio-economic disadvantage.

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 Bill – 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 that emerge to take over the commissioning work of PCTs. (The establishment of Clinical Commissioning Groups is subject to Parliamentary approval.)

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 PCT Clusters. When it comes to the Equality Act, 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. When it comes to EDS implementation and "sign off" of Equality Objectives, as required by the Equality Act, and related priority actions, PCT Clusters and individual PCTs should discuss how best to discharge this responsibility given what the law requires. If in doubt, they should take their own legal advice.

NHS providers, including NHS foundation trusts, as with NHS commissioners, 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.

The EDS may also be applied to all those healthcare providers that are not a part of the NHS, but which may work to contracts issued by NHS commissioners.

The above is a summary. The main text of the EDS should be referred to for fuller and definitive descriptions of PCT responsibilities and how the public sector Equality Duty, and hence the EDS, applies to private and other non-NHS providers, who work under contract to NHS commissioners.

NHS

3. Have up-to-date data and intelligence on the protected groups been used in the development of the EDS?

Up-to-date data and intelligence on the nine protected groups, as listed above, have been used in developing the EDS. The main types of data and information are those that evidence discriminatory outcomes with regard to:

- patient access to services
- patient and staff experience
- the correlation between staff satisfaction and patient experience

The data and research referred below gives a snapshot of the many pieces of evidence considered in the development of the EDS:

Patient access to services:

- The 2010 National Audit of Cardiac Rehabilitation (NACR) demonstrated that **women** are under-represented in cardiac rehabilitation. If men and women were taking part in proportion to the case rates for heart attack, we would expect there to be 63% men and 37% women. In practice, women made up 32% of referrals but only 26% of participants. It is mainly older women who are under-represented in cardiac rehabilitation; women over the age of 80 are less likely to take part than men of the same age.[1]
- Between 25-50% of **adult [mental health]** disorders are potentially preventable with treatment during childhood or adolescence.[2] People with mental health problems have much higher rates of physical illness, with a range of factors contributing to greater prevalence of, and premature mortality from: coronary heart disease, stroke, diabetes, infections and respiratory disease.[3]

- 42% of **gay men**, 43% of **lesbians** and 49% of **bisexual men and women** have clinically recognised mental health problems compared with rates of 12% and 20% for predominantly heterosexual men and women [4] lesbian, gay and

[1] NACR Annual Report 2010
[2] www.cabinetoffice.gov.uk/media/.../inclusion-health-evidencepack.pdf
[3] Friedli Dr. L., *Mental health, resilience and inequalities*, 2009, WHO Europe and Mental Health Foundation
[4] Warner J., McKeown E., Griffin M., Johnson K., Ramsey A., Cort C., and King M., *Rates and predictors of mental illness in gay men, lesbians and bisexual men and women*, 2004, British Journal of Psychiatry

bisexual people may, for example, be reluctant to disclose their sexual orientation to their GP, because they anticipate discrimination, and then fail to receive appropriate health care.[5]

- Research commissioned by Leeds Partnership NHS Foundation Trust as part of the Pacesetters programme found that one third of **lesbian, gay and bisexual people** in Leeds encountered mental health challenges, with more than half reporting having had suicidal thoughts at some point in their lives. One third of participants also reported self-harming. Of those who reported self-harming, 24% had not accessed a mental health service. Similarly, 33% of those who reported having suicidal thoughts had not accessed a mental health service.[6]
- Just 3% of **women aged 18 and over with learning disabilities/difficulties** living within a family, and 17% of those in formal care have had [cervical] screening, compared to 85% for women aged 20-64 nationally.[7]
- Some health care professionals think that lesbians do not require cervical smear tests,[8] yet 10% of lesbians have abnormal smears – this includes 5% of lesbians who have never had penetrative sex with a man.[9] **Lesbian and bisexual women** were up to 10 times less likely to have had a test in the past three years but lesbians and bisexual women have often been invisible patients within health services and their needs are poorly understood.[10]
- Type 2 diabetes is 3.5 times more prevalent in **South Asians** than Europeans.[11] However, a Diabetes UK survey of South Asian members found that only 16% of those responding had attended a course to help manage their diabetes[12]
- **Gypsies and Travellers** are reported to be more likely to visit accident and emergency departments than a GP because of a lack of trust of some GP surgeries.[13] Barriers to health care access were experienced, with several contributory causes, including reluctance of GPs to register Travellers or visit sites, practical problems of access whilst travelling, mismatch of expectations between Travellers and health staff, and attitudinal Barriers.[14]

---

[5] Hunt R. and Minsky A., *Reducing health inequalities for Lesbian Gay and Bisexual people: Evidence of health care needs*, 2006, Stonewall and DH.
[6] Richards A., *Closing the Gap – service needs and prohibitions to access: The LGB community, self harm, suicide ideation and suicide*, 2010, Leeds Partnership NHS Foundation Trust
[7] *The NHS – health for all? People with learning disabilities and health care*, Mencap, 1998
[8] Hunt R. and Minsky A., *Reducing health inequalities for Lesbian Gay and Bisexual people: Evidence of health care needs*, 2006, Stonewall and DH.
[9] In the Pink Providing Excellent Care for Lesbian, Gay and Bisexual People: A practical guide for GPS and Other Health Practitioners, 2010 NHS Sheffield citing Stonewall/ Cancerbackup
[10] Fish J., Cervical screening in lesbian and bisexual women*: a review of the worldwide literature using systematic methods*, 2009, De Montford University.
[11] *Diabetes in the UK 2010*, Diabetes UK
[12] *Survey of South Asian people with diabetes 2006: Access to healthcare services at a glance*, Diabetes UK
[13] Social Exclusion Task Force research (2009)
[14] Parry G., Van Cleemput C. et al, *The Health Status of Gypsies and Travellers in England*, The University of Sheffield, October 2004.

Patient experience

- GP Patient Survey results 2009/10: Patients very satisfied with the care from their GP or health centre by **ethnicity**: Irish 60%, British 56%, compared with Chinese 27%, Bangladeshi 28% and Pakistani 29%[15].
- According to the NHS In Patient Survey, **Asian/Asian British** patients were 20% less likely to give a positive response to the question "*Overall, did you feel you were treated with respect and dignity while you were in the hospital?*" when compared to the White British group.[16]
- Similar patterns emerge from a question regarding Emergency Departments. For example, other than White Irish patients, all **ethnic minority patients** were less likely to give a positive response to the question *"Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?"*. In particular, the Chinese/other patients were approximately 50% less likely to give a positive response when compared to White British patients.[17]
- From the same In Patient Survey, all **ethnic minority patients**, in comparison to white British patients, were less likely to give a positive response to the question *"Did the doctor treat you with respect and dignity?"*, with Asian/Asian British patients being 50% less likely and Chinese/other patients being 66% less likely to give a positive response. [18]
- A report by MIND found up to 36% of gay men, 26% of bisexual men, 42% of lesbians and 61% of bisexual women recounted negative or mixed reaction from mental health professionals when being open about their **sexual orientation**.[19]
- People who are admitted to hospital **over the age of 80** are twice as likely to become malnourished than those under the age of 50.[20] Becoming malnourished leads to serious consequences for us, including: the need to stay in hospital for longer, the need to take more medications, an increased risk of suffering from infections and even death.[21]

Staff experience

- Due to staff experiencing **discrimination, bullying and harassment** from fellow colleagues, patients and their families, the NHS experiences very high staff absences and a high turnover rate, which is costing the NHS approximately. £1,682,048,391 and £766,077,482.6 respectively a year[22.]

---

[15] GP Patients Survey 2009/2010

[16] *Report on the self reported experience of patients from black and minority ethnic groups*, June 2009, DH and National Statistics, citing the National Survey of Adult Inpatients 2008/09

[17] Ibid

[18] Ibid

[19] King M. and McKeown E., *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales*, 2003, MIND.

[20] *Malnutrition within an Ageing Population: A Call for Action*, European Nutrition for Health Alliance, 2005

[21] *Still Hungry to Be Heard, the scandal of people in later life becoming malnourished in hospitals*, Age UK, 2010.

- The 2009 NHS Staff Survey found that more **disabled staff** (24% rising to 26% in acute trusts) and non-white staff (20% rising to 25% for mixed race staff in acute trusts) experienced harassment, bullying or abuse than non-disabled (15%) and white British staff (15%).[23]
- The same survey also found that **Black/ Black British** (16%) staff experienced the most discrimination in the last 12 months, with this figure rising for **Other Asian** staff (20%) in acute trusts and **Black African** staff (18%) in acute and mental health / learning disability trusts. What is notable is the sharp increase of discrimination in ambulance trusts of **disabled staff** (20%), **other white** staff (23%), **Indian** staff (25%) and **mixed background** staff (33%).[24]
- Research in 2010 found that **BME staff** were almost twice as likely to be disciplined in comparison with white staff – and the problem could be more common, as a web audit found that only 80 NHS trusts published annual data broken down by ethnicity as required by the Race Relations (Amendment) Act 2000. "Trusts need to develop robust systems for data collection and analysis relating to all aspects of employee relations".[25]

The correlation between staff satisfaction and patient experience:

- Aston Business School was commissioned by the Healthcare Commission to explore whether staff satisfaction and patient experience were linked. They used the NHS staff and patients surveys in 2007 to identify possible pairs of variables, and then narrowed down pairs to the relationships that appeared most substantial. It is important to note that no inference about causality can be drawn from the analysis. Findings included:
  - Prevalence of **discrimination against staff** is related to several areas of patient experience, particularly their perceptions of nursing staff, such as: When you had important questions to ask a nurse, did you get answers that you could understand? In addition, did you have confidence and trust in the nurses treating you?
  - High levels of **bullying, harassment and abuse against staff** by outsiders relates to many negative patient experiences. As with the discrimination findings, it is obvious that these effects could take on either, or both, causal

[22] NHS Health and Wellbeing, Benefit Evaluation Model, 2008
[23] *National NHS Staff Survey 2009 Key findings*, prepared by Aston Business School
[24] Ibid
[25] Archibong U. and Darr A., *The Involvement of Black and Minority Ethnic Staff in Disciplinary Proceedings*, March 2010, Centre for Inclusion and Diversity, University of Bradford.

directions: aggression from patients towards staff could be a result of perceptions of poor quality of care, and/or could result in poorer quality care being delivered. [26]

4. Was the EDS put together on the basis of the data and intelligence mentioned above?

The EDS is designed to help NHS organisations to comply with the Equality Act 2010 and its associated public sector Equality Duty and Specific Duties (still to be confirmed by Parliament). In the NHS, complying with the Act means tackling health inequalities, avoiding discrimination and meeting the three "aims" of the public sector Equality Duty, namely to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not

The EDS is specifically designed to tackle the types of challenges highlighted in section 3 above. See the ,main EDS text for a fuller and definitive account of how the EDS supports organisations to deliver on the public sector Equality Duty.

5. Describe the equalities profile of the population that is intended to benefit from the EDS?

The EDS is being introduced in England at a time of significant changes to the demographic profiles of England and the UK. The sources of information and statistics given below, unless as otherwise stated, have been taken from the Office for National Statistics (ONS).[27]

- Age – the population of the UK is aging, and it is anticipated that 41% of people will be over 60 by 2033. There were 13.3 million dependent children living in families in the UK in 2010, the same number as in 2001.
- Disability – This broad category includes people with physical and sensory impairments, mental health problems and long-term conditions. Department of Health figures suggest that about 1.5 million people (around 2.5 per cent of the UK

[26] Dawson J., *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys*, July 2009, Institute for Health Services Effectiveness, Aston Business School.
[27] http://www.statistics.gov.uk/default.asp

population) has a learning disability.[28] The prevalence of learning disability is expected to grow by over ten per cent by 2020.

- Gender re-assignment – there is no clear consensus on how to define and enumerate the Trans population. However, it is likely that transsexual people represent only a small proportion of those who might be considered trans, estimates for the UK ranging between 1,550 and 5,000.[29] There is increasing recognition of the rights of transsexual and transgender service users and employees, with the Gender Recognition Act granting legal recognition of a changed gender for transsexual people.
- Marriage and civil partnership – the number of married couple families decreased by 100,000 between 2001 and 2010 to 12.2 million in 2010. (This is consistent with both the increase in opposite sex cohabiting couple families over the same period from 2.1 million to 2.8 million, and the general decrease in the number of marriages since the early 1970s). The proportion of the adult population of England & Wales who are married is projected to decrease over the 25-year period from 2008 to 2033, falling from 49 per cent to 42 per cent. Over the same period, the proportion of adults who have never married is projected to increase, rising from 35 per cent to 43 per cent
- The Civil Partnership Act has granted legal recognition of same-sex couples and the number of civil partnerships rose by 1.7% to 6,385 in the year to 2010.
- Pregnancy and maternity - in 2009 there were an estimated 896,300 conceptions in England and Wales, compared with 888,600 in 2008, an increase of 0.9 per cent. The under-18 conception rate for 2009 (38.3 conceptions per thousand women aged 15–17) is estimated to be the lowest rate since the early 1980s. This represents a fall of 5.9 per cent compared with 40.7 conceptions per thousand women aged 15–17 in 2008.
- Race, including national identity and ethnicity - the population is becoming increasingly ethnically diverse. It is estimated that, across England and Wales, the majority White British group has stayed static in size between 2001 and 2009 with the population in non-'White British' groups growing by an average of 4.1 per cent per year. 72 per cent of the estimated net growth of the non-'White British' groups was directly attributable to net international migration.
- Religion or belief – fifteen per cent of people in Great Britain (8.6 million people) said they had no religion, according to the 2001 Census. Seventy-two per cent of people (41 million) identified themselves as Christian, making it the largest religious group. Muslims were the second largest religious group (1.6 million) and the information provided by them shows a young, tightly clustered, and often disadvantaged, community.

[28] Michael J., Healthcare for All: *Report of the Independent inquiry into access to healthcare for people with learning disabilities*, July 2008, Department of Health.
[29] http://www.equalityhumanrights.com/uploaded_files/research/trans_research_review_rep27.doc

- Sex – the population of England is approximately 50 percent male and 50 percent female and no change is anticipated by 2033.
- Sexual orientation – There is an absence of reliable, statistical data on sexual orientation (Mitchell et al., 2009). However, there is an increasing recognition of the rights of lesbian, gay and bisexual people, the discrimination and harassment they face and the negative impact that these can have on health and wellbeing.

Within these national trends, there are regional and local variations. The EDS guidance document refers to the need for equality work to influence, and be influenced by, local Joint Strategic Needs Assessments (JSNAs). These are a way of local health and social care commissioners understanding and planning for local changes to their populations and the health and wellbeing needs, which arise from these changes.

6. How does the EDS support organisational compliance with equality legislation?

The Equality Act 2010 outlaws direct and indirect discrimination, including less favourable treatment, harassment and victimisation of people based upon their protected characteristics. The Act applies to all individuals, providers of services and employers. In addition, the public sector Equality Duty, arising from Section 149(1) of the Act, applies to public authorities (see section 4 above).

The processes and content of the EDS align with, and support delivery on, this public sector Equality Duty. Hence, in responding positively to the EDS, organisations should be able to respond more effectively to the requirements of this duty. However, use of the EDS does not automatically lead to or ensure compliance. To ensure compliance, the EDS will need to be implemented with due regard to all facets of the Equality Act and within an organisational 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.

As well as the public sector Equality Duty, some Specific Duties arise from the Act 2010, including a duty to prepare and publish equality objectives. The EDS has articulated four goals that encompass a range of matters important to the NHS. organisations should be working towards:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership at all levels

In developing equality objectives, using the EDS, the guidance issued recommends that at least one equality objective per EDS goal should be chosen. (The guidance also points out that this is advice not a hard and fast rule.) The EDS goals and outcomes provide a good focus for the setting of equality objectives as they are based on principles and values around equality and human rights, which are reflected in a range of key strategic documents, such as the NHS Constitution and the NHS Operating Framework.

The Equality and Human Rights Commission (EHRC) support the EDS:

"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

In addition, the Government Equalities Office (GEO) has stated that the EDS will greatly help the NHS meet the requirements of the public sector Equality Duty. GEO views the EDS as a good example of how different parts of the public sector can implement the Equality Duty in a way that fits with organisational circumstances, and wider public service objectives.

There are risks associated with the implementation of the EDS, which could detract from its effectiveness in helping the NHS to comply with equality legislation and improve its performance for patients, carers and staff. These risks have been identified though the consultation and engagement activities that have contributed to the development of the system (see sections 12 and 17). In dealing with these risks, it should be stressed that the EDS is a tool to help organisations. Ultimately, the way in which organisations respond to the public sector Equality Duty and other equality challenges will depend on committed leadership and a workforce that is supported to be competent and confident when dealing with equality matters.

7. Who is responsible for implementing, monitoring and/or developing the EDS?

Individual NHS organisations are responsible for implementing the EDS. An evaluation of the implementation and progress of the EDS is planned to start in late 2011 or early 2012, to develop the baseline of equality performance across the NHS, identify good practice and demonstrate achievable outcomes to late adopters.

One of the key objectives is to provide evidence to the NHS Commissioning Board, once it is established, that improving equality performance using the EDS is an effective way for NHS commissioning organisations to deliver the objectives in The White Paper Equity and Excellence: Liberating the NHS and the Equality Act 2010. Another is to identify good practice ….and share it across the NHS. Anecdotally NHS equality performance has been poor, therefore one of the objectives of the evaluation is to develop the baseline. NHS Commissioners at a local level will put in place contacting monitoring with its providers that should encompass all contracted aspects of performance including equality.

There will be two parts to the evaluation: a national snapshot of equality performance will be taken, to establish a baseline and progress a year on against it; an in-depth evaluation to show progress of up to 20 NHS organisations and identify good practice to write up as case studies.

There will be routine reports arising from the EDS. The EDS grades will be Published and shared with Health & Well-Being Boards. CQC will be alerted to any serious concerns.

8. How does it help to deliver the organisation's wider business objectives?

If organisations choose to implement the EDS, it will help them to:

- Deliver on the Government's commitment to localism and local decision making
- Deliver on the Government's commitment to fairness and personalisation, including the equality-focused rights and pledges of the NHS Constitution
- 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
- Deliver on the principles, objectives, requirements of the Human Resources Transition Framework
- Respond more readily to the Public Sector duty of the Equality Act
- 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. But again, it should be emphasised that the EDS is a tool; simply using it will not deliver on any of the above objectives if it used poorly or used in a tokenistic manner.

9. How does it support compliance with the three aims of the public sector Equality Duty

The public sector Equality Duty is set out in the Equality Act 2010. Whilst the EDS will not automatically lead to or ensure compliance, in responding positively to the EDS, organisations should be able to respond more effectively to the requirements to all three aims of the duty (see section 4 above).

A number of the EDS outcomes relate to eliminating unlawful discrimination, harassment and victimisation. These include (but not limited to) the following EDS outcomes:

- tackling abuse, harassment, bullying and violence towards patients and staff is prioritised (EDS outcome 1.4)
- services are commissioned, designed and procured to meet the health needs of local communities, promote well-being and reduce health inequalities (EDS outcome 1.1)
- complaints about services are handled respectfully and efficiently (EDS outcome 2.4)
- staff receive equal pay for work of equal value (EDS outcome 3.2)

Particular EDS outcomes relate to advancing equality of opportunity. These include (but not limited to) the following EDS outcomes:

- public health, vaccination and screening programmes reach all communities and groups (EDS outcome 1.5)
- patients are informed and supported to be involved in decisions about their care (EDS outcome 2.2)
- recruitment and selection process are fair, inclusive and transparent (EDS outcome 3.1)

Particular EDS outcomes relate to fostering good relations. These include (but not limited to) the following EDS outcomes:

- service changes are informed by engagement of patients and local communities (EDS outcome 1.3)
- working practices are culturally competent and working environments are free from discrimination (EDS outcome 3.3)
- business is planned so that equality is advanced and good relations fostered, within and beyond the organisation (EDS outcome 4.1)

10. Please set out details of any evidence of unequal (disproportionate) take-up or participation by any particular group/s of people if the EDS is currently in use.

Whilst it has not yet been implemented, the EDS is a means to support compliance with the public sector Equality Duty, leading to effective action to address disproportionate access to health services and participation in the NHS workforce and leadership. Evidence of such disproportionate access and participation is outlined in section 3 above. It should be noted that the EDS is only a tool, we need a culture change in the domain of equality, which the EDS can help to promote.

Furthermore, evidence of patchy compliance with previous equality legislation by individual NHS organisations gives some cause for concern that these problems may not be tackled consistently through the EDS. Equality legislation, in force before the Equality Act 2010, gave particular emphasis to race, disability and sex discrimination, including imposing specific, statutory duties on public bodies.

A review conducted by the Equality and Human Rights Commission in 2010 found that many organisations in the health sector were not taking sufficient action to address the diverse needs of people in Britain and to protect the rights of disadvantaged groups.[30] One key finding was about the inadequacy of needs assessments in informing priorities, objectives and actions, with transgender, transsexual and Gypsy and Traveller communities being typically overlooked.

In 2009, a Healthcare Commission audit found that only 88% of PCTs in England self-assessed that they were legally compliant with a regulatory requirement around challenging discrimination, promoting equality and respect for human rights. As recently as December 2009, the Equality and Human Rights Commission served three NHS Trusts with race equality compliance notices. Responding to compliance notices cost one region £495,000 during 2009/10.

Prior to this, the Healthcare Commission carried out web audits in 2006 and 2007 and found that, in 2007, only 9% of NHS Trusts (35 out of 394) were meeting their legal duties under the Race Relations (Amendment) Act 2000 and the Disability Discrimination Act 2005. This showed an increase from seven trusts in 2006, when only race equality duties applied at the time of the audit. In detail, 77% (302 Trusts) had published a race equality scheme, 34% (133 Trusts) had published workforce

[30] http://www.equalityhumanrights.com/

monitoring data, 16% (63 Trusts) had published outcomes of race equality impact assessments, and 82% (322 Trusts) had published a disability equality scheme.[31]

11. **Please set out details of evidence of any group/individuals not having full access to service(s) as an outcome of the EDS, deriving from their needs being outside what is currently offered.**

    N/A – the needs of all people with protected characteristics fall within the scope of the EDS.

12. **Does the data show that the experiences of users of the service to which the EDS relates are, or could be, variable according to their equalities profile?**

    The EDS relates to all services and functions, which could have a bearing on each NHS organisation's duty to promote equality. The data sources referred to in section 3 above show clearly that, at local and national population levels, discrimination, health inequalities and inequality of opportunity are resulting in variable service user experiences between different protected groups. There is also evidence that the needs of some protected groups are typically overlooked (e.g. Trans and some BME groups).

    The EDS is an attempt to address such variations through both targeted action and mainstream NHS business processes. However, evidence of patchy compliance with previous equality legislation, outlined above, gives some cause for concern that these problems will not be tackled effectively and that the EDS will not be applied consistently.

    Furthermore, concerns have been raised, through the EDS consultation and engagement process, that the system might not be implemented robustly across all protected groups. The reasons given relate mainly to the capacity and capability of the key stakeholders who need to be involved in implementation, namely: NHS Trusts, community and voluntary sector organisations and HealthWatch, especially during this time of organisational change and significant funding pressures. Such an outcome would reduce an organisation's ability to eliminate the variable experiences of service users through effective action to tackle discrimination, advance equality of opportunity and foster good relations. A related risk of a backlash from interest groups whose needs are not prioritised is also identified.

13. **Could these differences amount to adverse impact or detriment for any of the groups?**

[31] http://www.cqc.org.uk/_db/_documents/Equalities_publications_audit_briefing.pdf

The EDS provides an opportunity to proactively and systematically tackle those variations in access to services, participation in the workforce, leadership, and service user experiences, which are based on the protected characteristics. There is no evidence that effective implementation of the EDS will amount to adverse impact or detriment for any of the protected groups. The main risk identified is that ineffective, or no, implementation of the EDS may result in the persistence of discriminatory behaviour and outcomes.

Another risk is that some NHS trusts may focus on costs, rather than benefits, leading to ill thought through plans of action to the detriment of some protected groups. The carrying out of balanced Equality Analyses can help mitigate such action and its consequences.

These risks could apply to any of the protected groups in any locality, in terms of commissioning and delivering services and in employment practice.

14. What evidence is there that the EDS could be assessed as directly or indirectly discriminatory?

From an equality perspective, the EDS cannot be assessed as directly or indirectly discriminatory. Similarly, there is no evidence that effective implementation of the EDS will result in discriminatory outcomes for service users or employees.

From a health impact perspective, making the transition from existing performance management systems (such as single equality schemes) to the requirement of the public sector Equality Duty, using the EDS, is likely to generate some of additional work over the first year of implementation at least. However, the Government Equalities Office have not only estimated costs but have also identified overall net benefits from moving from the former equality legislation to the new legislation. Please see the EDS Statement on Costs and Benefits.

15. If there is evidence of indirect discrimination, could it still be justifiable under the Act?

N/A – no evidence of indirect discrimination.

16. Please set out details of alternative ways of achieving the outcome(s) of the EDS, which either exclude or amend the conditions giving rise to adverse impact.

There is no evidence that effective implementation of the EDS will amount to adverse impact or detriment for any of the protected groups. Ineffective, or no, implementation of the EDS, however, is likely to result in a failure to maximise opportunities to tackle discrimination, advance equality of opportunity and foster good relations within the NHS and beyond. Indeed, if NHS organisations do not implement the EDS, then they must devise another system to help them meet the public sector Equality Duty, at a greater cost to themselves compared with adopting the EDS.

17. Details of consultation and engagement

- **Consultation and engagement that has taken place in relation to the development of the EDS, including the type of activities used to seek feedback**

  The development of the EDS was supported by extensive engagement with a range of stakeholders. 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 in the development of the EDS.

  An EDS Technical Working Group 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 or Inclusion Leads. Others members of the Technical Working Group represented Primary Care Trusts, Foundation Trusts, NHS Employers and the Care Quality Commission.

  Once the first phase of EDS design work was completed, proposals were extensively shared through national and regional engagement events, over fifty in total, 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.

General feedback from the engagement events has been very positive, with NHS organisations, patients, communities and other key stakeholders and partner organisations showing support for the EDS. Current NHS organisations, with the support of SHAs, have been preparing for EDS implementation since December 2010. Advice on NHS implementation has been provided by the EDS Support Team, which, through routine monitoring, gives the EDC assurance on progress.

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.

- **Key points of any outcomes/feedback from engagement activities**

Key emergent themes from this analysis of the engagement activities so far focus upon the following areas: the timing of the EDS launch; the capacity and capability of NHS organisations and local interests; and the detailed implementation of the system.

Timing
Different views were expressed about the timing of the EDS launch. On the one hand, it was felt to be ideal, because it coincides with the development of new organisations, such as Foundation Trusts and Clinical Commissioning Groups, who have an opportunity to embed equality and diversity into their plans from inception. On the other hand, some would prefer to see the new structures established before rolling out this new system.

Capacity and capability of NHS organisations
Concerns were raised about the resources and support required to successfully implement the EDS at organisational level. The key resource challenges centred on:

- the ability to manage the scope and complexity of engagement suggested by the EDS, especially for Ambulance Trusts. Ambulance services are structured on a regional scale requiring additional skills, resources and support in implementing the EDS
- the need for capacity building around filling the considerable data and evidential gaps in NHS organisations and around analysing and using the data and intelligence that are currently collected

Several recommendations were made around good practice in inclusive engagement with local interests and about using existing structures, such as Foundation Trust memberships, to make it more manageable. Sharing learning and good practice were seen as important to ensure effective implementation. Ideas for achieving this included: learning from equality and diversity toolkits that were previously effective; publishing the EDS as an online tool; case studies; peer reviews and benchmarking between organisations.

Capacity and capability of local interests
Comments focussed upon equity and inclusiveness in the engagement of local interests around performance assessment and other aspects of the EDS, for example:

- the capacity of voluntary sector organisations to participate in the current climate of funding cuts, including organisations which represent lesbian, gay, bisexual and transgender perspectives
- the reliance of community and voluntary sector organisations on funding from NHS organisations which might compromise their autonomy in terms of holding their funders to account through the performance assessment procedure
- the risk of diluting race equality due to the wide focus of the EDS
- the risk of continuing to exclude particular BME communities during engagement and service delivery (Chinese, Polish, Gypsies, Travellers, African Caribbean men)

HealthWatch organisations were seen by some as having the potential to improve involvement and engagement with local interests, patients, carers and families. However, additional concerns were raised about the capacity and capability of HealthWatch, including:

- a potential conflict between their policing and consultation support roles

- their capacity to be involved in performance assessments for the increasing number of organisations arising from the growing fragmentation of the NHS
- concern about how well they will be expected to, and be able to, represent the interests of all local communities and "protected groups"

Details of implementation
Several issues were raised about how the EDS should be interpreted and implemented, such as:

- how well the goals and outcomes link with legal compliance and reductions in health inequality and long term health costs
- the need to work towards consistency in performance across all "protected groups"
- the need for consistency in different organisations' approaches to grading
- issues of transparency in reporting gradings and issues of recognition and reward for excellent performance
- the need to embed the EDS into the registration requirements and performance management regimes of the Care Quality Commission and Monitor
- how will the EDS link to existing NHS performance management systems, standards and the local health and wellbeing architecture
- the need to improve the integration of equality and diversity requirements into procurement processes and contracts

- **How the feedback has been taken into account in the final drafting of the EDS**

  The views and wishes of all of these stakeholders positively contributed to the design and content of the EDS guidance document and grading manual, which are targeted at the professionals who will be implementing the system within their own organisations.

The final design of the EDS reflects both generally and specifically the points made during the EDS engagement processes. The views of patient groups including people with diabetes, people with learning disability and people with hearing problems was particularly valuable in shaping the EDS.

As a direct result of the engagement events, NHS East Midlands on behalf of the NHS and EDC has commissioned guidance on genuine community engagement and the sharing of evidence with local interests.

Regions received resources from the Department of Health to help them engage local interests and think through the implementation of the EDS.

An EDS Support Team was set up to provide advice, information and direct help to organisations in understanding and implementing the EDS.

18. Recommendations

- The take-up of the EDS and early outcomes should be reviewed by the NHS Commissioning Board and partner organisations including the NHS Trust Development Authority and Monitor. If take-up is not extensive, the Board and partner organisations should seek to assure themselves how NHS organisations are responding to the Public Sector Equality Duty.
- Early results of the EDS evaluation process should be taken into account. The usefulness of the EDS and its continued use throughout the service should be reviewed.
- Adequate support should be provided to NHS organisations to help them implement the EDS.
- The Care Quality Commission should consider NHS organisational performance on relevant EDS outcomes when carrying out their assessments.

These recommendations will be shared with the EDC and actions will be monitored by the EDS Support Team.