

SHARED INTELLIGENCE

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

PHASE ONE: FINAL REPORT



November 2012

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I EXECUTIVE SUMMARY

Introduction

1. The report presents the findings of phase one of the independent evaluation of the implementation of the NHS Equality Delivery System (EDS).
2. The EDS was commissioned by the NHS Equality and Diversity Council. It was rolled-out in July 2011 and officially launched by Sir David Nicholson, NHS Chief Executive on 10 November 2011. The EDS is a tool designed to embed equality within the current and future NHS with the intention to support NHS organisations deliver better outcomes for their patients, carers, communities and staff.
3. In November 2011, NHS Midlands and East and the Department of Health (DH) commissioned Shared Intelligence to conduct an independent evaluation of the implementation of the EDS.
4. The purpose of phase one of the evaluation is to provide an independent assessment of how the EDS is being implemented, how it is benefiting organisations in terms of meeting their public sector Equality Duty (PSED) and how improvements can be made and support provided to ensure the tool is able to effect change within the current and new NHS.
5. The evaluation was undertaken between January and August 2012 and involved over 200 organisations.

Implementation

6. Phase one of the evaluation shows that there are a number of **expectations and hopes** for the EDS that are shared across a range of stakeholders – implementers, national stakeholders and EDS Senior Reporting Officer and policy leads. They included supporting compliance with the PSED, lead to improved outcomes for patients, carers, communities, and staff and increase the profile of equality within NHS organisations.
7. **Concerns** were diverse and included how the EDS would be interpreted in different contexts, how sustainable it would be in the current policy environment, and the fact that the tool is currently not mandatory. A shared concern was the balance of focus between process and outcomes.
8. As intended, the EDS is being **implemented in different ways** with NHS organisations using differing amounts of resource to implement and in particular, the breadth of engagement with local interests and the grading process vary considerably from one organisation to the next.
9. Those few organisations who responded to the survey who were **not yet implementing EDS** were planning to in the future. In the meantime, most had been able to publish data and objectives and believed that they complied with the PSED.

Impact of implementation

10. The biggest impact of EDS implementation to date has been **strengthening equality processes** such as improving engagement mechanisms, prioritisation of equality issues, identifying gaps in equality data and better partnership working around equality and engagement. The EDS has provided NHS organisations with the impetus in which to do this in a structured way.
11. There is also evidence of impact around **changes in perceptions and behaviour** within NHS organisations, the most notable being raising the priority of equality work with senior leaders. There's also evidence that the EDS has led to **increased awareness and commitment** of equality across organisations, including equality in the workforce and evidence of the EDS helping to **change attitudes and behaviours** of wider staff around equality.
12. The majority of survey respondents have **high aspirations** for the EDS and hope it would lead to improved health outcomes for patients, carers, communities and staff in the future. For most this meant seeing changes within 1-3 years.

Experience of implementation

13. Overall, there are reasonably strong **governance structures** in place for the EDS. Organisations are using their existing structures where these have been deemed appropriate, or are strengthening these.
14. A significant proportion of NHS organisations are **working together** within their localities on key aspects of the EDS, most notably, on engaging local interests and grading.
15. Overall, NHS organisations have been relatively successful in **engaging internal staff** at different levels of the organisation with the EDS implementation, most notably, at Board level.
16. As was intended, NHS organisations have approached engagement and **involvement of local interests** very differently both in terms of the extent and depth of engagement and the amount of resource put into engagement activity, according to local structures, circumstances and resources.
17. Organisations have in the main found **collecting and sharing evidence** for protected characteristics against each outcome to be challenging.
18. There was a split amongst EDS leads in terms of how useful they found the EDS in helping their organisation to **set its equality objectives**. There was no distinct patterns across type of organisation in relation to this, rather, the EDS was found to be most useful to those organisations where equality work was least developed previously.

19. Most NHS organisations found the EDS **goals, outcomes and grades** to be fit for purpose. However some reflected that the grading process was long, given the number of outcomes and protected groups considered.
20. The majority of EDS leads found the **support available** helpful, in particular, the main EDS documents (guidance and grading manual), support from SHA and peers, and the EDS training and learning events organised by the EDS Programme Office.

Challenges

21. The biggest challenge that NHS organisations have faced in implementing the EDS to date has been **staffing and resourcing** for implementation and the associated timescales, which is all underpinned by the current NHS operating environment of change and transition.
22. **Limited resources and competing priorities** in particular have had an impact on how easy organisations have found the EDS to implement. Where organisations do not currently have or have limited senior leader buy-in around equality, this has also made implementation more difficult.
23. Overall, most respondents to the survey are very positive about the EDS and its principles, with most finding it **resource intensive but worthwhile**. Many however would like to see it improved – and in particular the process simplified.

Implications

24. The evaluation has raised a **number of implications** for the EDS going forward, in terms of how best to:
 - Ensure the good work done to date by PCTs and SHAs isn't lost;
 - Ensure that there continues to be support mechanisms in place for new NHS organisations particularly CCGs around equality and the EDS going forward;
 - 'Future-proof' the EDS for new NHS organisations (e.g. Health and Wellbeing Boards and CCGs) and for ensuring it's fit for purpose for all types of NHS organisation (including simplification of the process/rationalisation of outcomes);
 - Clearly communicate the parameters around local adaptation;
 - Ensure that where NHS organisations are working on the EDS across local health economies that there still remains accountability for individual organisations;
 - Encourage and coordinate on-going peer support and sharing practice around implementation of the EDS;
 - Consider how intelligence from the EDS could be best used at a national level to identify national implications and feed into policy and developments.

1. INTRODUCTION

The Equality Delivery System

- 1.1. The Equality Delivery System (EDS) was rolled-out in July 2011 and officially launched on the 10th November 2011.
- 1.2. The EDS was commissioned by the NHS Equality and Diversity Council (EDC) as a tool whose purpose is to embed equality within the current and future NHS – both commissioner and provider organisations.
- 1.3. The EDS is intended to play a number of roles within an NHS organisation. Ultimately, it is intended to help NHS organisations deliver better outcomes for their patients and communities, as well as improving the working environment for staff.
- 1.4. A number of the EDS outcomes are designed to CQC essential standards, the EDS has been incorporated into the CCG authorisation process and the EDS is referenced in the NHS Operating Framework for 2012/13. These are strong levers for implementing the tool for both NHS commissioner and provider organisations.
- 1.5. It is also a tool to help the current and future NHS to comply with the Public Sector Equality Duty (PSED) under the Equality Act 2010, and to address relevant parts of the NHS Outcomes Framework, the NHS Constitution and the Human Resources Transition Framework.
- 1.6. The EDS was shaped through engagement events across the country – with almost 3,000 patients, carers, communities, NHS staff and staff-side organisations contributing to the final design of the EDS. The EDS is not mandatory but is supported and championed by the Chief Executive of the NHS and other senior NHS professionals.
- 1.7. The EDS has four goals:
 - Better health outcomes for all
 - Improved patient access and experience
 - Empowered, engaged and included staff
 - Inclusive leadership.
- 1.8. These four goals encapsulate a set of 18 outcomes that lie at the heart of the EDS. These outcomes focus on the issues that are the most pertinent to patients, carers, communities, NHS staff and Boards. Performance is analysed and graded against these outcomes, the results of which are fed into action plans.
- 1.9. Patients and communities have an important role to play in grading performance against those outcomes. As a key part of the EDS process, NHS

organisations need to effectively engage with local interests that span all protected characteristics.

1.10. The nine steps of the EDS are:

Step 1: Governance and partnership working

Step 2: Identify local interests

Step 3: Assemble evidence

Step 4: Agree roles with the local authority

Step 5: Analyse performance

Step 6: Agree grades

Step 7: Prepare equality objectives

Step 8: Integrate equality objectives into mainstream business planning

Step 9: Publish grades and equality objectives

1.11. The goals and outcomes of the EDS are presented in full on page 4.

1.12. In November 2011, NHS Midlands and East and the Department of Health (DH) commissioned Shared Intelligence to conduct an evaluation of implementation of the EDS. This report presents the findings of phase one of the evaluation which specifically explores the implementation of the EDS in the first year.

EDS Goals and Objectives

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

2. THE EVALUATION

Purpose

- 2.1. The purpose of phase one of this independent evaluation is to:
- Explore hopes, ambitions and concerns for the EDS among national stakeholders;
 - Review the take-up of the EDS including insights into what motivates or discourages organisations to implement the tool;
 - Identify the benefits of the EDS implementation;
 - Identify the different experiences of EDS implementation including effective ways of implementation, challenges and lessons learnt;
 - Explore ways in which the EDS can be improved to ensure its content and processes are as relevant and effective as possible to support better equality performance within the NHS.
- 2.2. The evaluation aims to give an independent indication of how the tool is being implemented and the different experiences of implementation including benefits and challenges.
- 2.3. Therefore the evaluation methodology was geared towards an honest exploration of the challenges and opportunities that the EDS presents to organisations implementing it to ensure that learning from the evaluation can feed into improvements of the tool.

Methodology

- 2.4. The evaluation uses mixed methods to gather both qualitative and quantitative evidence. This enables the evaluation to look both at the scale of take-up of the EDS, and to understand in-depth the experiences of staff implementing the system.
- 2.5. This study is being carried out in two phases, and the first phase was carried out between January and August 2012. This phased approach allows the evaluation to look at change over time and across different types of organisations. The methods used for the first phase of the evaluation are outlined below.
- 2.6. A **desk review of literature and monitoring data** was used to identify key contextual factors and inform the development of the online survey questions. This included guidance documents and materials, feedback forms from two national learning events delivered by the EDS Programme Office, the EDS implementation dashboard and collated case study material.
- 2.7. A **baseline survey** was designed and administered through April-May 2012 to establish a picture of EDS take-up and the experiences of different

organisations across the country. The survey received 203 responses from staff leading on the EDS in a range of NHS organisations, as outlined in Figure 1 below.

Figure 1: Baseline survey respondents by type of NHS organisation (nb. Respondents were able to select multiple-responses)

Type of NHS organisation	%	number
Acute - Foundation Trust	22.4%	46
Primary Care Trust Cluster	20%	41
Acute - non Foundation Trust	15.1%	31
Mental Health - Foundation Trust	8.8%	18
Community Health Service	7.3%	15
(emerging) Clinical Commissioning Group	3.9%	8
Ambulance Trust	3.4%	7
Strategic Health Authority Cluster	2.9%	6
Mental Health - non Foundation Trust	2.4%	5
Business Support Unit (or equivalent)	0.5%	1
Other	13.2%	27
TOTAL		205

- 2.8. Twelve **follow-up interviews** were conducted with equality leads in NHS provider and commissioner organisations between May-June 2012 to explore their experience of using EDS in more depth to build on the findings from the survey.
- 2.9. Seven **in-depth interviews** were conducted with national stakeholders to outline and contextualise the aims and objectives of the EDS and explore hopes, ambitions and any concerns. Interviewees included the staff in the stakeholders from external organisations with an interest in equality and/or patient care; and members of the EDC, EDS programme office and Department of Health Equality team.
- 2.10. The findings from the stakeholder interviews were used to set the context for the key findings only and were not used to assess experience of implementation or impact of implementation.
- 2.11. Six **case studies** were conducted in July and August 2012 to capture a range of experiences of EDS implementation from different types of NHS organisations. Case study research involved site visits and interviews with some or all of the following groups:
- patients and patient groups
 - community groups and the wider public
 - staff networks and staff-side organisations
 - local voluntary organisations and groups
 - LINKs and HealthWatch

- Health and Wellbeing Boards
 - Other parts of the local authority and/or local statutory agencies.
- 2.12. The case studies and the lessons from those have been compiled into the supplementary document titled 'Evaluation of the Equality Delivery System for the NHS: Case Studies - Experiences of EDS implementation (volume 2)'.
- 2.13. A limitation of this methodology for readers to note is that research participants from NHS organisations have largely been self-selecting in that they were drawn from respondents who chose to complete the survey, and therefore the results will have a self-selection bias.
- 2.14. To balance this, we propose that in the second phase, part of the methodology will focus on research with organisations that have chosen not to implement the EDS to explore the reasons why and the alternative systems they have in place.

This report

- 2.15. This report presents the findings of the evaluation, based on the first phase of work.
- Section three, *Implementation of the EDS*, presents findings on expectations of, hopes for and concerns about the EDS. It also looks at who is and isn't implementing the EDS and the reasons why.
 - Section four, *Early Impact of Implementation*, outlines the types of process outcomes that have come about from EDS implementation to date.
 - Section five, *Experience of EDS Implementation*, looks at key areas of activity in terms of EDS implementation and uses our understanding of organisations' experiences of these to discuss the challenges and opportunities associated with those.
 - Section six, *Implications*, brings together some key considerations and implications of our research so far.
- 2.16. This report should be read with the limitations described in paragraph 2.13 in mind. The NHS organisation participants in this research have been self-selecting, and therefore it is likely that these results may not be as reflective of the national picture as a random sample would be. However, the findings do provide a useful snapshot of 200 organisations across the country at a particular point in time.
- 2.17. Similarly, the first-hand experiences of EDS which inform this report come from those who have been leading the implementation so far and who may have a different relationship to EDS than other participants and stakeholders.
- 2.18. These other groups, including board members and senior directors, clinicians, staff and local interest groups, will be engaged in phase 2 of the evaluation.

3. IMPLEMENTATION OF THE EDS

Perceptions of the EDS

This section draws on evidence gathered through the online baseline survey of NHS organisations, follow up interviews with a number of organisations implementing EDS, national stakeholders, EDS implementation and policy teams, and members of the Equality and Diversity Council. The findings outlined in this section set the context for the evaluation.

There are a number of expectations and hopes for EDS that are shared across national stakeholders. Those commonly stated are that EDS will support compliance with the Public Sector Equality Duty (PSED), will lead to improved outcomes for patients, carers, communities and staff, and will increase profile/consideration being given to equality within NHS organisational and governance processes.

Concerns were more diverse, with some specific concerns expressed by each group. However, a shared concern was the balance of focus between process and outcomes in the EDS.

Hopes, expectations and motivations

- 3.1. Interviews with national stakeholders revealed a number of ambitions for the EDS which influenced its development.
- 3.2. The main aim of the system was to lead to a practical improvement in health outcomes for communities and working conditions for staff. This outcome-focus is clear in the minds of implementation and policy team members; however they also hoped the EDS would facilitate the putting in place of processes necessary to lead to these outcomes.
- 3.3. The system was intended to help NHS organisations align their equality work and wider service delivery with the aims and requirements of other standards and strategies, including the NHS Constitution, Outcomes Framework, the CQC 'Essential standards of Quality and Safety' and the Human Resources Transition Framework.
- 3.4. The EDS is intended to make meeting these aims and requirements easier, through a single system. Moreover, by linking the EDS into these core strategies equality work was more likely to be mainstreamed into existing processes and strategies – and this was an important role for EDS.

- 3.5. These links to other 'levers' were not only intended to be beneficial for NHS organisations, but were also seen as a way of building "closer relationships" between the NHS and national stakeholders such as the Equality and Human Rights Commission (EHRC) and the Care Quality Commission (CQC). It was envisaged that EDS could do this by providing useful evidence to assist their assessments of whether organisations are under performing, and the actions taken subsequently.
- 3.6. National stakeholders appear to share some of the hopes and expectations expressed by the implementation and policy team members. The comments highlighted below suggest that the EDS is viewed as a helpful tool that provides practical support to NHS organisations in delivering better equality work (for example, through greater transparency) and in meeting the PSED.
- 3.7. From the point of view of national stakeholders the EDS is an important move in the right direction, as they thought it could consistently support the NHS to improve in what was seen by national stakeholders as an area of generally poor performance.
- 3.8. National stakeholders also recognised that the EDS potentially held value for them as a system which was aligned with their strategic goals and had practical applications for them. For example, one organisation identified use of the EDS as something that could contribute to their own monitoring, and another felt that more widely the EDS promoted the same aims and methods as their own organisation.
- 3.9. The responses of EDS leads from NHS organisations who responded to the online survey reflected a broadly positive view of the EDS. For example, when asked to select a statement which best described their view of the EDS it was most commonly seen as a tool to help the organisation prioritise its equality work (42%, 68), and a tool to help embed equality across the organisation (26%, 40).
- 3.10. It appears that more critical views of the system can co-exist with a positive view or belief of the underlying purpose of the EDS. For example, a significant number of respondents described challenges they faced with the system, at the same time, the majority bought in to the ethos behind the EDS.
- 3.11. Interviews with equality leads in particular have revealed a perception that EDS is an opportunity to push the equality agenda forward, in an environment where this has been challenging previously.

"Organisation verbally behind equality and diversity agenda but in practice it's not – lip service. So when I heard of EDS I thought "brilliant – thank goodness we've got something at last". (Equality and Diversity Lead, PCT Cluster)

- 3.12. However, it was clear that in some instances the EDS has had to make a strong case for implementation. As one lead described it – it was a "stick" to

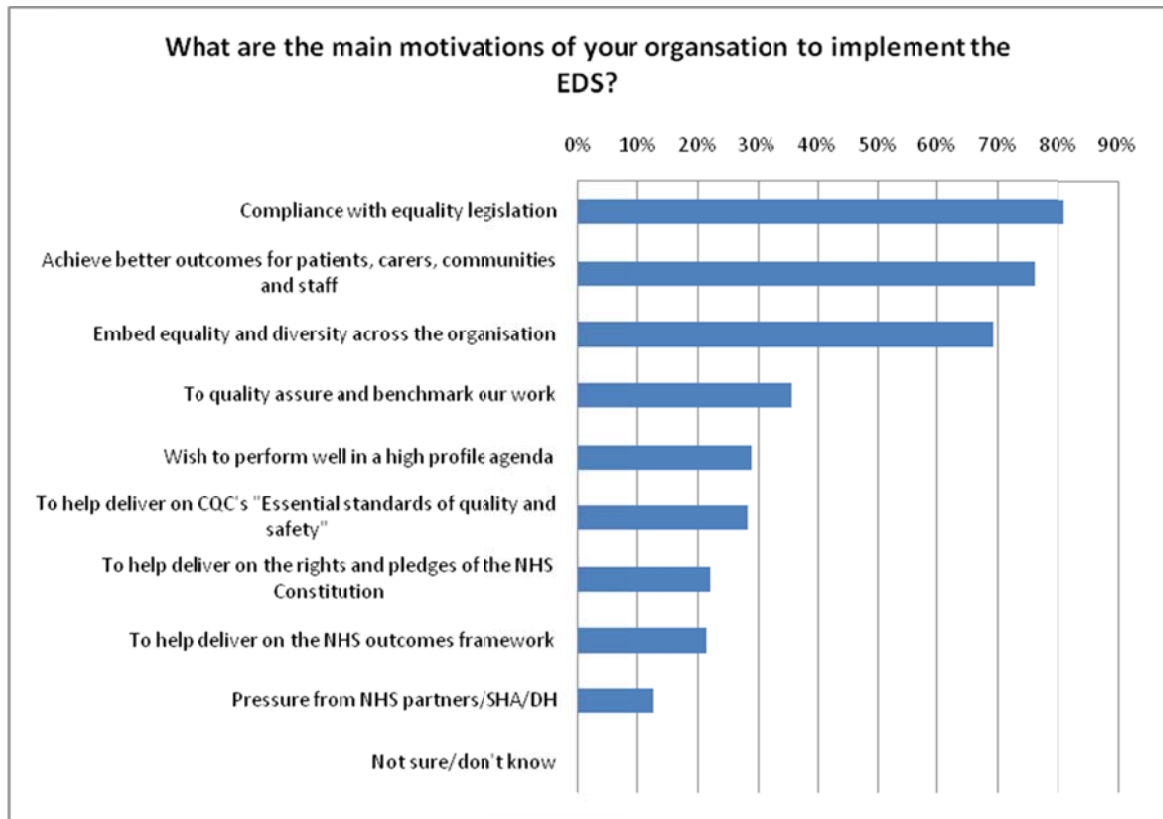
use to persuade their Board and colleagues that they needed to implement EDS.

"[I saw] EDS as a helpful tool – we didn't have anything similar...so advocated for EDS implementation – the Board agreed. Arguments that swayed them were we aren't making as much progress as we should, areas this could help such as HR and engagement, help us focus our work and look at groups, use it to design equality objectives." (Equality and Diversity Lead, PCT Cluster)

"hit all the right notes because it's based on evidence, you can't deny the evidence – people have been ignoring it." (Equality and Diversity Lead, Acute Foundation Trust)

- 3.13. Responses to the survey show a distinct 'top three' motivations for implementing EDS. These are:
- Compliance with equality legislation (81%);
 - Achieve better outcomes for patients, carers, communities and staff (76%); and
 - Embed equality and diversity across the organisation (69%).
- 3.14. These motivations reflect the different purposes of the EDS expressed by EDS programme team/DH equality team members.
- 3.15. The data also suggests that among the less common motivations, organisation-level applications of EDS, such as quality assurance and high-profile performance appear to be more compelling motivations for use of the EDS than alignment with external documents and strategies such as the NHS Outcomes framework and CQC Essential Standards of quality and safety. (See figure 2).

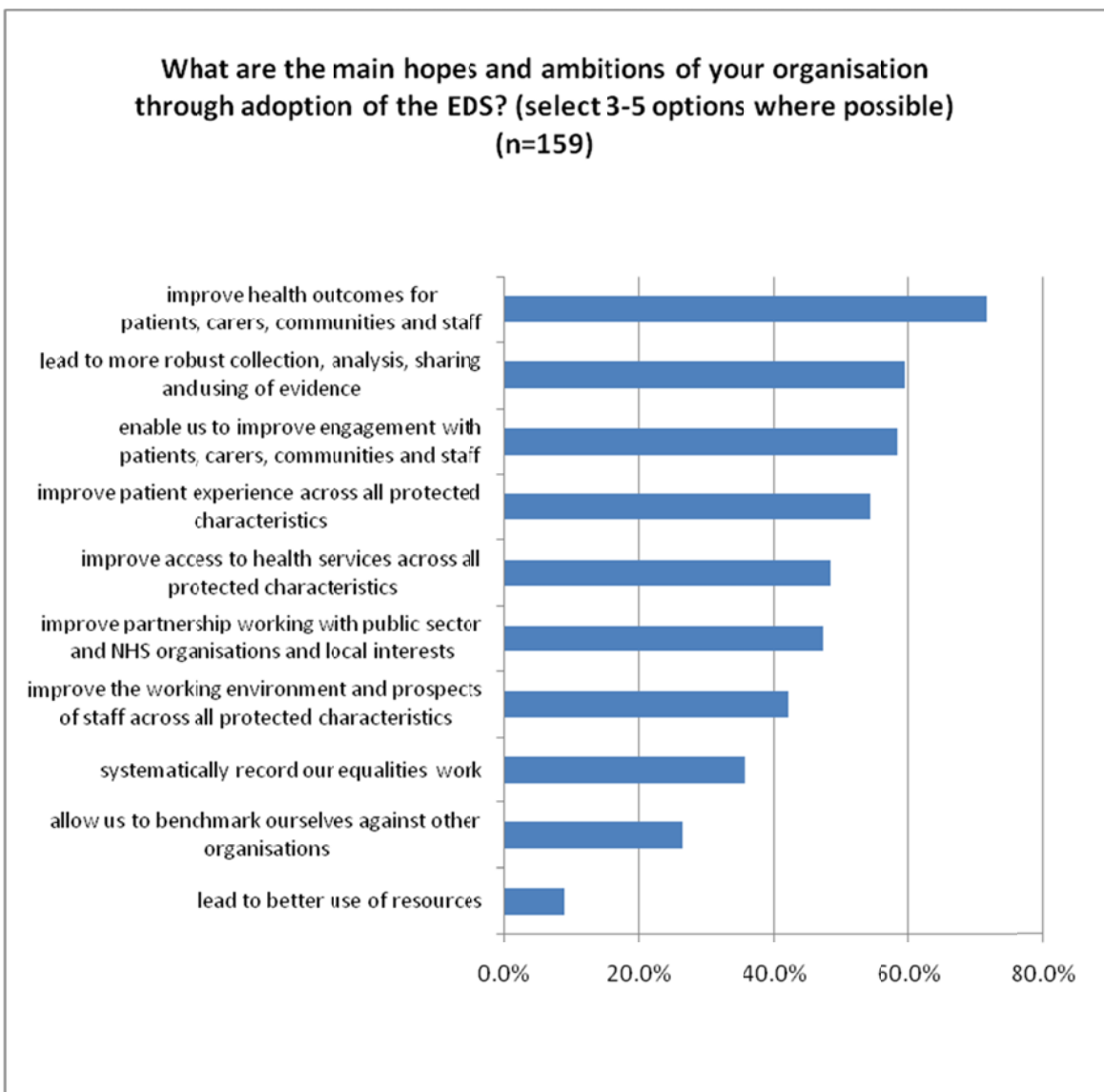
Figure 2: What are the main motivations of your organisation to implement the EDS?



3.16. Given the prominence that compliance with PSED has within these motivations, it's important to note that almost all organisations who responded to our survey (87%, 132) understood that the EDS helps organisations with PSED compliance, rather than making them compliant. The remaining 13% (21) were unsure or had misunderstood this relationship.

- 3.17. When asked about what were the organisations' hopes for the EDS, patient and staff facing outcomes are favoured. For example improved health outcomes, engagement and patient experience all rate highly, whereas 'backroom' outcomes such as benchmarking, systematic recording of equality work and better use of resources are less prominent.
- 3.18. Given this, a notable anomaly is the desire for better use of data and evidence, which is the second most common hope. (See figure 3)

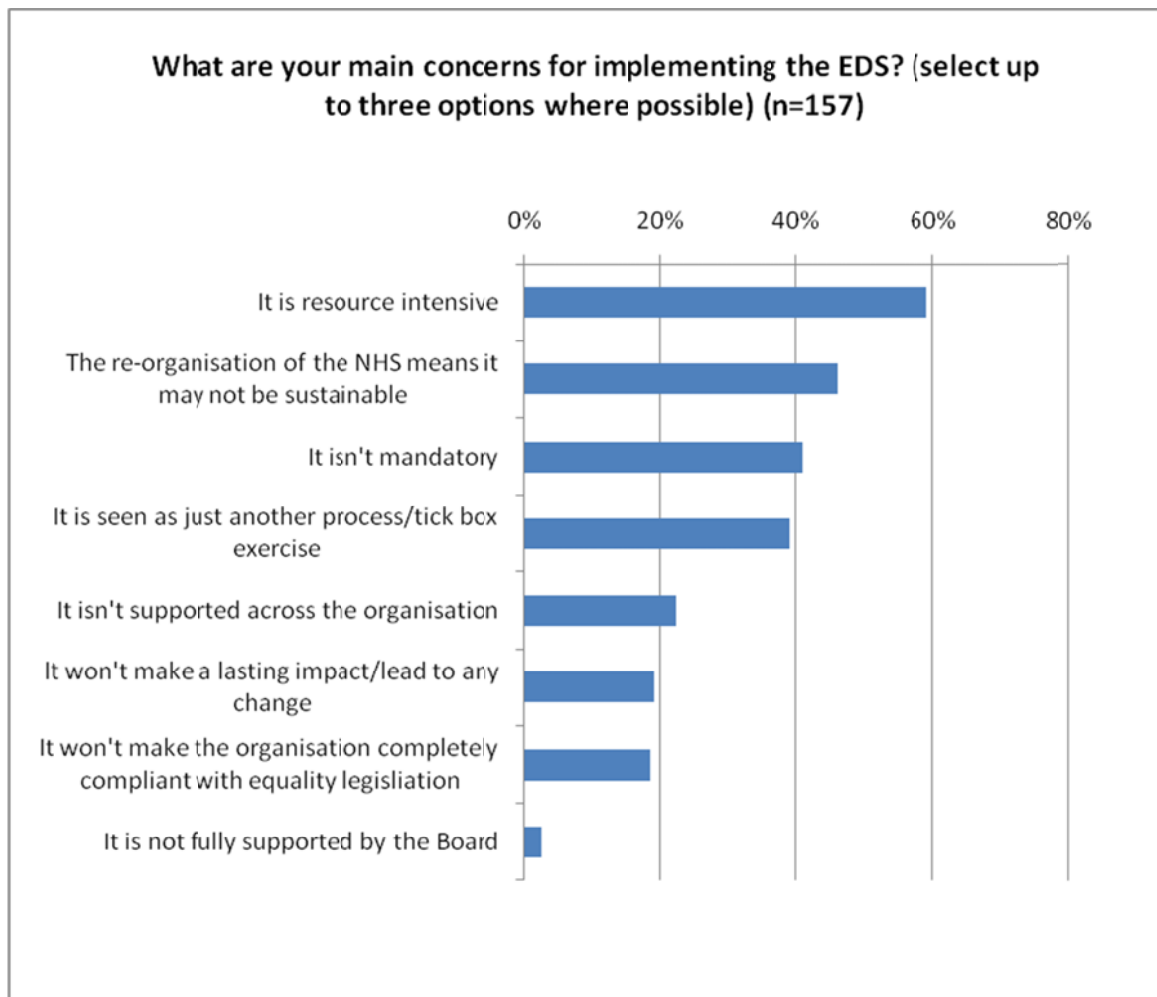
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Concerns

- 3.19. The concerns about the EDS held by national stakeholders focused on how the tool would be used in context: both the policy context and the context in which the system would be implemented.
- 3.20. Some national stakeholders raised the concern about how the EDS will be implemented in NHS organisations. Although local adaptation on engagement of local interests is encouraged, there were some concerns that more of the tool will be adapted and changed – for example, the 18 outcomes. This would have implications for how the tool links with other systems, such as CQC essential standards.
- 3.21. Another concern raised was how staff with expertise in equality will be retained at all levels of the NHS, and what the implications are for EDS in this context.
- 3.22. Some national stakeholders recognised that there were synergies between their work and EDS, the limitation of this synergy was noted. One such organisation felt the EDS was not reliable as a process for self-regulation, and therefore its own independent checks would have to continue in full. Although they would use EDS data, it was not going to be in the way intended by the programme teams.
- 3.23. At the local level, the most common concern for NHS organisations as highlighted in the survey was about how resource intensive the EDS process was (59%, 93). This was followed by concerns over how the re-organisation of the NHS will impact upon sustainability of implementing the EDS, and this was more of a concern for commissioning organisations than providers.
- 3.24. There were some concerns raised through in-depth interviews with equality leads about the tool not being mandatory, most notably, concerns around it not being taken seriously within their organisations and that equality will continue to be perceived as a separate issue to core business.
- 3.25. There is also a very strong sense of it being unfair that organisations feel no repercussions for not undertaking EDS, and that the tool was thereby weakened as a means of holding the NHS to account.
- 3.26. Buy-in from local board members rated very low as a concern. This resonates with findings from some Equality and Diversity leads who found that board and senior support was achieved during the EDS process, and in fact the most difficult group to engage was middle-management.

Figure 4: What are your main concerns for implementing the EDS?



3.27. One concern expressed by all interviewees was that as the EDS system involves significant process, there was a danger that when it was implemented emphasis would be placed on process rather than demonstrable change to outcomes. The concern was that it would be possible to be compliant with EDS, without having made real progress towards improving outcomes.

*“Grades shouldn't be the driver of the EDS – it should be the outcomes.”
(National stakeholder)*

3.28. This balance of process and focus on outcomes was also picked up by NHS organisations, although it isn't one of their key concerns.

“[The EDS is] a good tool [but] it's as good as the people who use it. You can come up with fantastic reports but if you're not making any difference on the ground what's the purpose?” (Equality and Diversity Lead, PCT Cluster)

3.29. One national stakeholder also felt that the EDS was so process orientated, it couldn't satisfy the current and previous governments' aspiration for equality to be less bureaucratic.

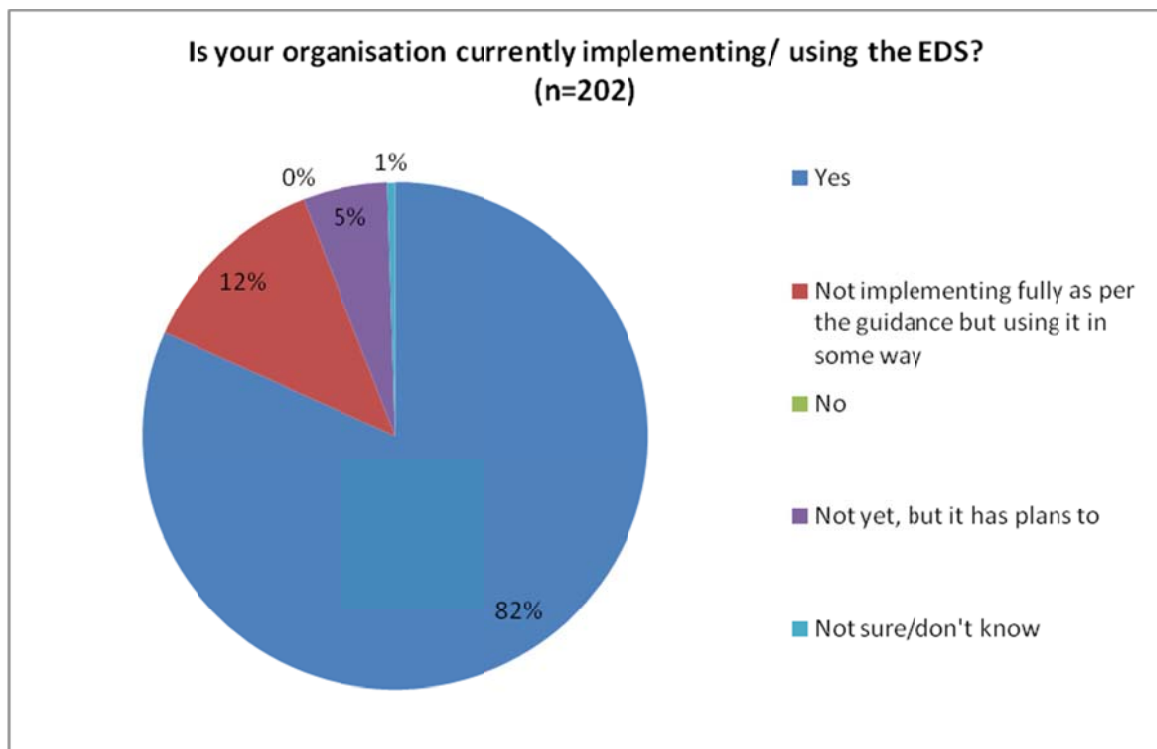
“If not done well, could be bureaucratic – both last and this Government keen to make equality less bureaucratic.” (National stakeholder)

How the EDS is being implemented

As anticipated, the EDS is being implemented in different ways from one NHS organisation to the next. NHS organisations are using different amounts of resource - either its own and/or from local interests and partner organisations to implement the EDS. In particular, the breadth of engagement with local interests and the grading process vary considerably from one organisation to the next taking into account the local circumstances, infrastructure and available resource.

- 3.30. The majority of respondents are implementing the EDS either fully as per the guidance, or using the guidance in some way (together this is 94%, 190), and those who aren't implementing yet are planning to. No respondents said they were not using EDS at all, nor had plans to do so (see figure 5).

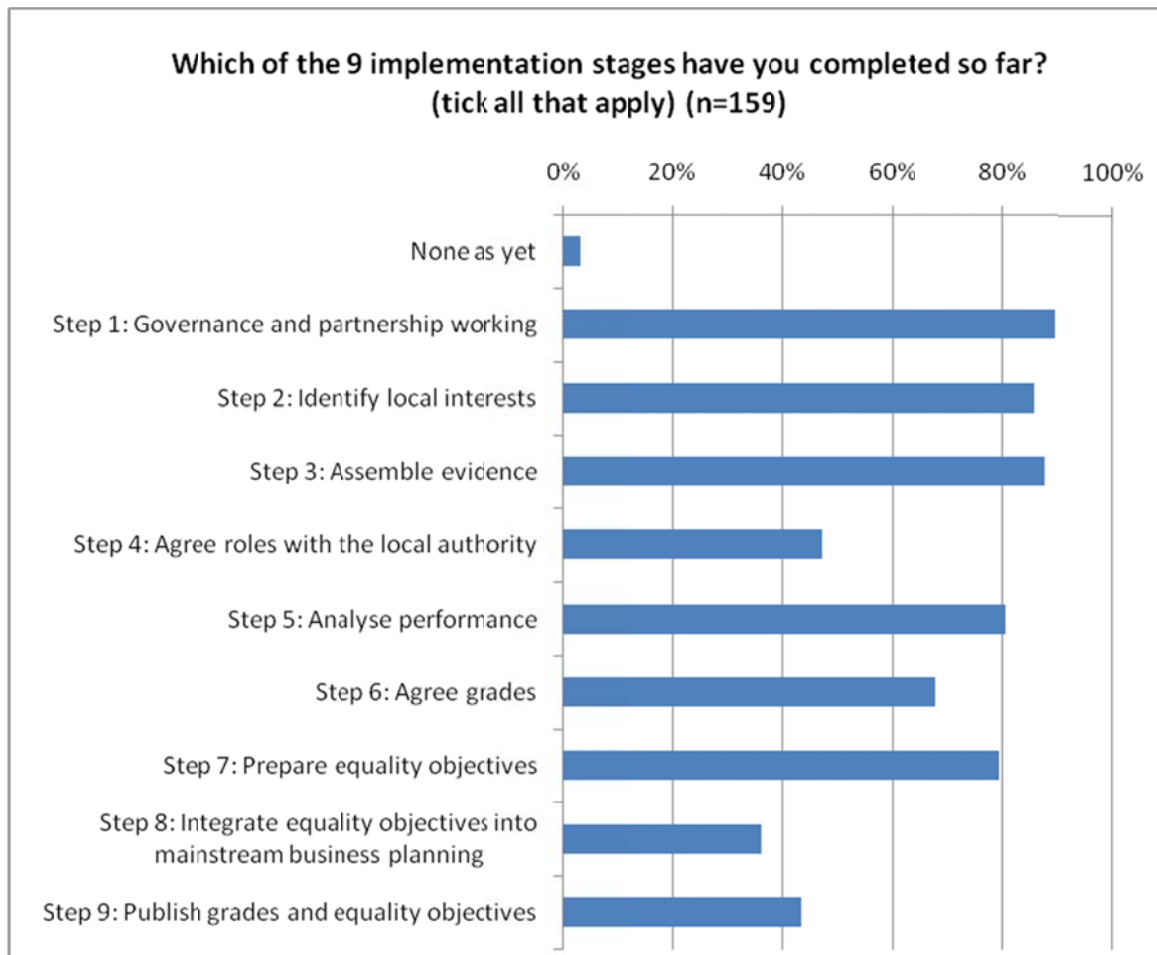
Figure 5: Is your organisation currently implementing / using EDS?



- 3.31. Results show that progress through the nine implementation stages of the EDS (as laid out in the guidance document) is not clearly linear (see figure 6). In particular stage 4, agreeing roles with the local authority, appears not to be being completed by a number of organisations. It's not clear from comments why this has been difficult to establish, and this will be explored in

the next phase of research. Comments in this survey suggest that grading, and publishing grades has been done after objectives have been set, although in guidance these occur before objective setting.

Figure 6: Which of the 9 implementation stages have you completed so far?



3.32. The survey results suggests that implementation of EDS is most commonly being led by an Equality and Diversity team, manager or officer (72%, 108), the second most common lead was Senior Management (15%, 22). Other options, such as the board, external consultant and cross departmental group only received 1-2 responses each and so do not appear to be common leads for the EDS.

How has the system been adapted or changed?

3.33. When asked how they had changed or adapted the EDS process, NHS organisations described both conscious diversions from the EDS as well as tasks that had just ‘panned out’ differently. Both are discussed below.

3.34. Some organisations have chosen to narrow the scope of the EDS - focus on a smaller number of objectives, outcomes or areas of work in their EDS and have chosen to do this because of the wide scope of the EDS and the resources needed to implement it fully.

"We have focused on a few outcomes as defined by our CCG rather than go through the 18 outcomes as suggested in the EDS guidance and from this, the equality objectives have been identified." (Survey respondent)

- 3.35. NHS Commissioner organisations have often taken a leading role in co-ordinating EDS in their area and therefore, some PCTs and CCGs have used different mechanisms to the nine steps to embody the aims of the EDS.

"As a PCT Cluster we have taken on board the EDS and use it as an internal Business tool to develop our evidence and Equality objectives." (Survey respondent)

- 3.36. Organisations are using the EDS as a framework, or as individual parts. They talked about picking and choosing parts of the process that they needed to complete their equality work in a way which felt locally appropriate. For example, some used the process as a guide without using some of the detailed materials.

- 3.37. One common adaptation was making the grading materials simpler and easier to understand, and in one organisation the team had given consideration to additional disadvantaged groups.

- 3.38. From the follow-up interviews conducted with Equality and Diversity leads the variation in how grading in particular has been done is very broad. Although local adaptation is encouraged, it also raises a question in terms of how accountability can be traced through the grading process.

"We adapted the process - discussion with external interests has been more general than speaking about outcomes and grades as this confused, bored and annoyed them" (Survey respondent)

- 3.39. Progressing through the stages differed between NHS organisations as a consequence of the timescale in which they were working to. For example to meet the PSED deadlines in Spring 2012, some objectives were published before gradings were finalised.

- 3.40. Another challenge has been to integrate objectives into mainstream business planning within the timescale, and so in some organisations this isn't yet happening.

"Due to timing issues, we have not as yet been able to integrate equality objectives in to mainstream business planning." (Survey respondent)

- 3.41. A small number of organisations have not involved patients or communities at all in the first round of the EDS – though most have plans to. This was partly due to difficulties in making contacts with local interests because of timescales.

- 3.42. More had not involved their local authority/authorities, again because this was a challenging partnership which could not be developed within the timescale.

“This trust has had some difficulties developing partnership working with LINKs and health & wellbeing board.” (Survey respondent)

“We used assembled evidence to self-rate. Community engagement and final ratings will inform a review of EDS [in the future]. But in the meantime internal intelligence has helped to establish a baseline.” (Survey respondent)

Who isn't implementing and why?

The organisations in our survey who were not yet implementing EDS were planning to in the future. In the meantime, most had been able to publish data and objectives to comply with PSED.

3.43. The organisations who were not implementing EDS at the time of filling out the survey were a mixture of providers and commissioners. Sample numbers are small and so it is not possible to test whether any one type of organisation is over-represented here.

3.44. The small number of organisations who currently are not implementing EDS said they had plans to. Reasons for this were varied: some explained that re-organisation and lack of available resources were the key reasons why they weren't implementing the EDS this time around. Others referenced the fact that EDS isn't mandatory. Qualitative comments suggest that these reasons are often inter-related.

“The organisation has no dedicated E & D resource and is behind with statutory required [sic] which it needs to satisfy before dealing with the EDS.” (Survey respondent)

“The EDS system is a priority and has been incorporated into the development processes of the CCGs” (Survey respondent)

3.45. These organisations had found alternative ways of meeting the legislative requirements of the PSED – to publish equality data in January 2012, and to publish equality objectives in April 2012.

3.46. In response to the need to publish data in January 2012, most trusts had drawn on existing data resources or sub-groups to access 'workforce and service data. They had used this to produce a report, agreed this where necessary with local partners before publishing it. A small number had brought in additional resources such as extra data collection or consultancy support to do this.

“[The organisation] has used the mechanism and process in place to collate equality data that was endorsed by the 3 CCG boards prior to publishing on the [cluster] website.” (Survey respondent)

3.47. However, publishing equality objectives by April 2012 had been more challenging. Three of the seven non-implementing organisations hadn't yet published their equality objectives. Those that had had identified objectives

using equality reports and monitoring data, PALS information, Equality Impact Assessment, existing SES objectives to define objectives. Some organisations had consulted on them, similar to the EDS process, whilst others had immediately published them.

- 3.48. Three of the respondents said that they are going to implement EDS in the near future, and so objectives are short term and for some include implementing EDS.

4. EARLY IMPACT OF IMPLEMENTATION

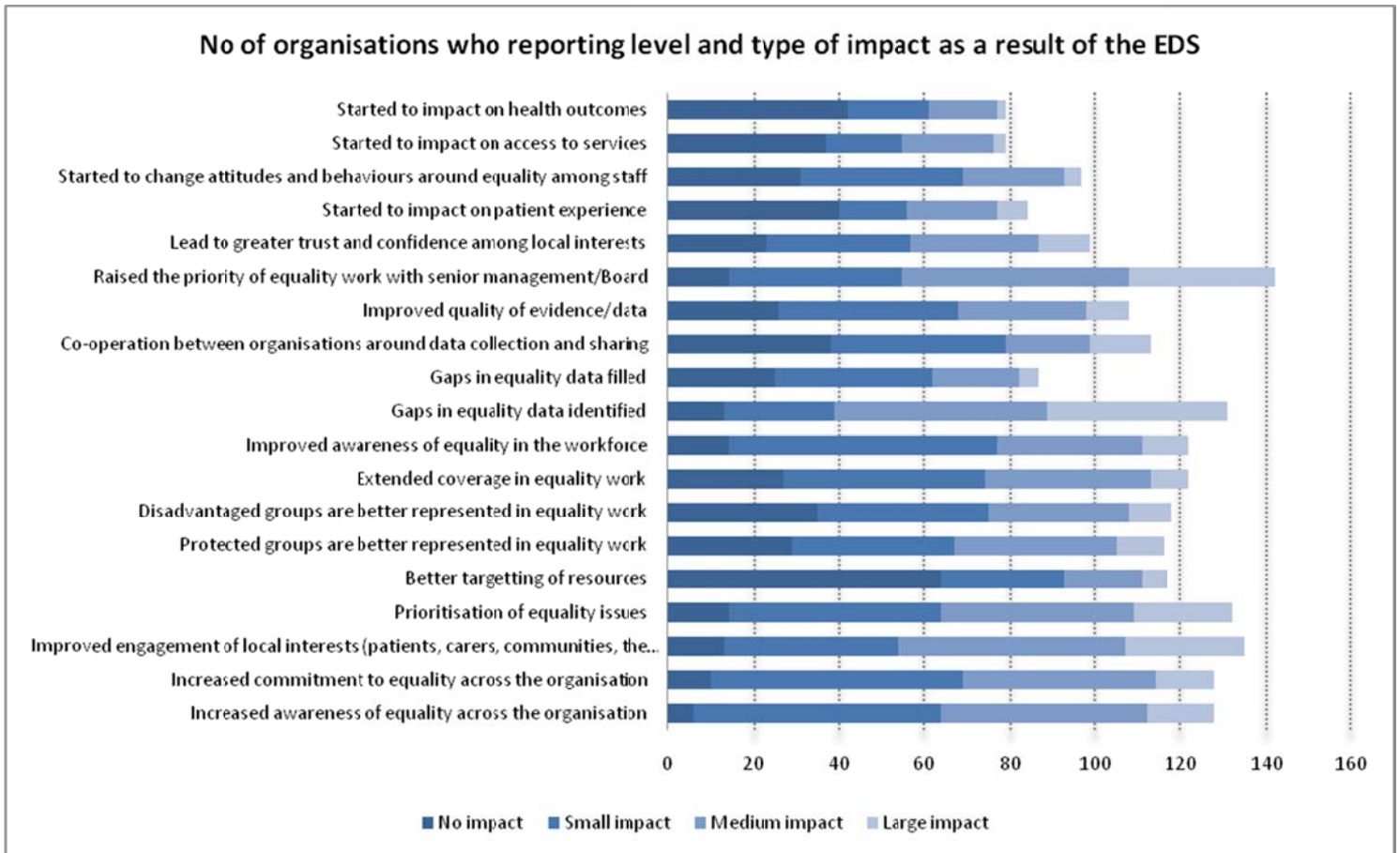
- 4.1. This section of the report draws on the findings from the survey, in-depth interviews with EDS leads within NHS organisations and case studies to explore the early impact that has come about through EDS implementation.
- 4.2. It presents the views of those organisations who self-selected to be involved in the research and therefore findings should be interpreted as a snapshot of 200 NHS organisations across the country rather than a representative sample.
- 4.3. This chapter presents the baseline position of organisations as of May 2012 in terms of the impact they have reported for their organisation to date. This data provides the basis for which to measure change against during the second phase of the evaluation and beyond.

Types of outcomes

As would be expected at this early stage, the types of outcomes being reported in our research are process outcomes that EDS implementation has had at this stage in the evaluation.

- 4.4. The biggest impact that EDS implementation has had to date has been to **strengthen equality processes** such as improving engagement mechanisms, prioritisation of equality issues, identifying gaps in equality data and better partnership working around equality and engagement. The EDS has provided NHS organisations with a framework in which to do this in a robust and meaningful way.
- 4.5. There is also evidence of impact around **changes in perceptions and behaviour** within NHS organisations, the most notable being raising the priority of equality work with senior leaders. There's also evidence that the EDS has led to **increased awareness and commitment** of equality across organisations, including equality in the workforce and evidence of the EDS helping to **change attitudes and behaviours** of staff around equality.
- 4.6. Some organisations anticipate change for patients, carers, communities and staff because of the processes and activity that will come about through the EDS. But at the present time, it is **too early to evidence** any real change in access, experience or health outcomes for local interests.

Figure 7: The number of NHS organisations who responded to the EDS survey reporting on EDS impact to date (as of May 2012)



For patients, communities and staff

At the moment, it is too early to evidence actual impact for patients, communities and staff, in terms of improved access and health outcomes. However there is early evidence of process outcomes that give an indication of 'direction of travel'.

- 4.7. The biggest impact for patients, communities and staff to date, as reported by EDS leads through the survey, has been **improved engagement**. Over two-thirds (77%) of NHS organisations who responded to the survey reported that the EDS has impacted on the way they engage and involved local interests with half of all organisations saying the EDS has had a 'medium' or 'large' impact in this way.
- 4.8. The EDS has prompted organisations to **strengthen their engagement mechanisms** either through making existing mechanisms more robust (e.g. ensuring all protected characteristics are represented through patient and staff groups) or **strengthening the level of involvement**, for example, the way in which organisations have involved local interests in the EDS grading

process. There are examples of how this has **built the capacity** of existing networks and voluntary groups.

***NHS Merseyside** used their co-ordinating role to ensure a consistent approach to EDS grading across provider trusts in the area. This was achieved by developing the capacity of five local LINK organisations to become a locality-wide EDS grading panel. For more information, see full case study in supplementary report.*

4.9. Other organisations have developed **new engagement mechanisms** with local Voluntary and Community organisations, patient groups, communities and staff. And there is evidence where this has been developed in a sustainable way, for example, developing inclusion strategies.

4.10. There is evidence to suggest that the way in which local interests have been engaged through the EDS process is leading to **improved trust and confidence among local interests**. 50% of organisations who responded to the survey said that the EDS has had an impact in this way, with most suggesting it has had a small or medium level impact in this way to date.

“The engagement & grading events have had a real impact of local interest groups feeling more involved and included” (Acute non-Foundation Trust, South West)

“Very big impact for the Deaf... and Hard of hearing - we received a big thank you from this community for the engagement we have done with them and they are now working with the 2 PCTs and local Acute provider to identify issues and solutions for improving the patient journey” (PCT Cluster, North West)

4.11. Reasonably small numbers of organisations that responded to the survey suggested that the EDS has started to have a small impact on **patients and communities** – mostly in the way that gaps have been identified and specific, targeted activities have been put in place as a result of the EDS, which is believed will have an impact on outcomes for patients and communities in the future.

4.12. At this moment in time, it is too early to evidence any actual change for local interests as a result of the EDS.

“It [The EDS] has helped us focus on determining equality objectives which for us includes implementing a protocol for providing services to Trans patients (this is an area where evidence suggests we are particularly weak).” (Acute Foundation Trust, Yorkshire and Humber)

“Made the CCG more aware of the problems faced for individuals claiming Asylum and their problems seeking primary care support, this has resulted in a project being taken forward to improve awareness within primary care that will allow for better access for these individuals.” (Emerging CCG, East Midlands)

“It has highlighted an issue within the local community around access to services for people with neurological conditions. We are now working with them and our own organisation to improve the pathway” (PCT Cluster, East Midlands)

- 4.13. Most people interviewed through the evaluation believe that it will take at least a year for the EDS to translate into actual impact for patients, communities and staff, and one in five who responded to the survey **expect the EDS to have some impact within the next 6 months** on patient experience, access to services and health outcomes.

For staff and staff-side organisations

There is evidence that the EDS has led to increased knowledge and awareness of staff at all levels around equality. 71% of organisations that responded to the survey state that the EDS has led to improved awareness of equality in the workforce.

- 4.14. This has been achieved through engagement of staff through the process and through support mechanisms such as local events and regional training led by the national EDS programme office.
- 4.15. 43% of organisations who responded to the survey stated that the EDS has started to **change attitudes and behaviours around equality** among staff and their responsibility around equality.

“It seems in our organisation everybody seems to be interested and listening about equality [now], when before it felt like it was an uphill struggle that never got any easier!” (PCT Cluster, South West)

The impact EDS has made is that it's moved the role and responsibilities from the E & D leads to Senior frontline staff who are delivering service to members of the public (Community Health Service, East Midlands)

- 4.16. There is evidence that the EDS has prompted NHS organisations to scrutinise staff data better and is leading to **improved workforce data**. 94% of organisations who responded to the survey used their workforce reports and 93% used patient and staff surveys to inform the EDS implementation.

“In developing Equality impact analysis of changes in services there has been greater local interest engagement. Workforce data has highlighted key areas of undisclosed information which has prompted a need for a data cleansing exercise that will benefit the organisation and all staff members.” (PCT Cluster, Community Health Service and Mental Health Foundation Trust, South West)

“We are now reviewing patient and staff survey results by protected characteristic and are starting to look at equality performance for patients” (Acute non-Foundation Trust, North West)

“Workforce data by protected groups has been analysed and gaps in data are being addressed” (Acute Foundation Trust East Midlands)

- 4.17. There is some evidence that those organisations who are effectively engaging staff in the EDS grading process is leading to **better engagement of staff** and increased feelings of empowerment among staff – as perceived amongst Equality leads.

*As a direct result of the EDS, the **North East Ambulance Service** is establishing an employee forum, a place where issues around bullying and harassment can be informally discussed, and support given; providing more information on what investigations involve – an issue identified as important in the grading. For more information, see full case study in supplementary report.*

For NHS Trusts

The single biggest impact the EDS has had for NHS Trusts – from the perspective of E&D leads who responded to the survey - has been to raise the profile of equality amongst NHS senior management and leaders.

- 4.18. Over 140 EDS leads who responded to the survey (82%) said that the EDS has had an impact on raising the priority of equality work amongst senior management and the Board within their organisation, with over half reporting a ‘medium’ or ‘large’ impact in this way.

“It’s certainly raised the profile – has made us reflect as an organisation about what we have achieved and how we have made progress which is important. Raised the profile of E&D in a sensible, structured way” (Acute – non- Foundation Trust, London)

- 4.19. For some organisations, they were seeing a small to medium impact around **increased commitment to equality** across the organisation. 75% of all organisations – over two-thirds, who responded to the survey, said that the EDS has had a positive impact in this way, for example, helping staff to understand how ‘equality’ fits into their role and the work they do and why that is important.

“Commissioners and Providers [involved in the EDS] reported the process as providing a valuable opportunity to assess the gaps in evidence and to consider how they could address these gaps as part of their mainstream work processes - they left with a greater understanding that addressing equality was part of their job and there was a lot they could do differently.” (PCT Cluster, West Midlands)

- 4.20. There is a significant amount of evidence that the EDS has **strengthened existing processes to embed equality** within and across organisations, for example, data collection, the JSNA, staff and patient surveys, provider

contracts and monitoring systems, and the development of strategies and governance structures.

*The **South East Coast Ambulance Trust** has been prompted by the EDS to develop a new Inclusion Strategy – which brings together their current patient and public involvement strategy, membership strategy and equality and diversity elements, and which will outline the importance of involving diverse people in all aspects of work from the very beginning.*

- 4.21. Undoubtedly, the biggest impact that EDS implementation has had in this way has been to **identify the gaps in equality data** that NHS organisations currently collect. 76% of organisations who responded to the survey stated the EDS has had an impact in this way, and there are many examples of how organisations have begun to fill these gaps.

“[The EDS] highlighted the need to cover all 9 [Protected Characteristics] in surveys of staff and patients” (Community Health Service, London)

“Changes made to nursing assessment documentation to reflect the needs of the 9 protected characteristic patient groups” (Acute non-Foundation Trust, West Midlands)

*The EDS acted as a driver for the **Royal Devon and Exeter NHS Foundation Trust** to ensure comprehensive coverage of the protected characteristics through consultation and data collection, including, for example, expanding the local audit tool looking at the quality of care to include transgender and religion and belief. For more information, see full case study in supplementary report.*

- 4.22. The EDS has led to **increased partnership working** across the country, with organisations who responded to the survey recognising the value of that in terms of sharing equality data, for a shared understanding across a particular locality/region and integrating systems where it makes sense to, such as engagement of voluntary and community organisations and CCGs.

- 4.23. 48% of organisations who responded to the survey stated that the EDS has increased cooperation between organisations around data collection and sharing.

“It has been embedded into the terms of reference of the workforce development board. It has allowed us to be far more strategic and develop robust partnership working with other public sector agencies.” (Acute Foundation Trust, West Midlands)

***Nottinghamshire PCT Cluster** involved the six emerging Clinical Commissioning Groups in EDS implementation, as part of their development. The CCGs were supported by the PCT providing them with detailed equality demographic data on their catchment area giving them a basis on which to focus their EDS work. For more information, see full case study in supplementary report.*

For the future

The majority of respondents had high aspirations for the EDS, with 72% hoping it would lead to improved health outcomes for patients, carers, communities and staff.

- 4.24. Approximately one in five organisations who responded to the survey expect the EDS to start having an impact on patient experience, access to services and health outcomes in the next six months (as reported in May 2012), whereas others felt it will take at least 1-3 years to actually make a difference in this way.

The EDS has made a difference to the majority of organisations who have been involved in the evaluation, albeit small at this moment in time, mostly around changes in processes (engagement and data collection and use) and behaviours and attitudes of staff at different levels of NHS organisations.

5. EXPERIENCES OF EDS IMPLEMENTATION

- 5.1. This section of the report draws on findings from the EDS survey to equality leads, twelve follow-up interviews with equality leads from a range of organisations across the country and eight scoping interviews as part of the case study research. It therefore presents the views of the equality leads of those organisations who self-selected to be involved in the research.
- 5.2. As such, the findings should not be used as a true reflection of the national picture, but rather, as providing a snapshot of 200 NHS organisations across the country from the point of view of their equality leads.
- 5.3. This section presents organisations' experience of the EDS – broken down into the key aspects, and presents different approaches, methods, challenges and notable practice that have emerged through the research to date.
- 5.4. Importantly, the findings in this chapter presents the baseline position of organisations as of May 2012. This data provides the basis against which to measure change during the second phase of the evaluation and beyond.

Leadership and governance

Overall, there seems to be reasonably strong governance structures in place for the EDS. Organisations have both used their existing structures, or chosen to strengthen these through identifying champions, more regular meetings or developing new sub-groups. The slight majority of organisations who responded to the survey have Board involvement in EDS governance, with most others having senior involvement through sub-groups of the Board.

- 5.5. The EDS guidance states the importance of Board-level buy-in, indeed, *governance* is part of the first formal implementation stage of the EDS.
- 5.6. Almost 90% of organisations who responded to the survey state that they have completed this step, however, there seems to be some variability in how organisations define good governance and therefore there are differences in governance mechanisms in place for the EDS.
- 5.7. 65% of survey respondents explicitly stated that their Trust Board is involved in the governance of the EDS. This differed to some extent across type of organisation, with slightly more Mental Health Trusts reporting to the Board on the EDS (76%) than PCT Clusters (62%) and Acute Trusts (59%).
- 5.8. Those organisations who do report to the Board on the EDS generally use existing structures, commonly via a sub-group of the Board such as an Equality and Diversity Steering Group.

- 5.9. There is some evidence of where the EDS has **strengthened existing mechanisms** for reporting on equality, such as organisations identifying champions at Board level, more regular reporting to the Board and development of new sub-groups specifically for the EDS.

“We now have a non-exec Director to Champion equality and diversity at board level. We have worked really well with the HR team and they are on board with the EDS” (PCT Cluster)

- 5.10. There are examples of where the EDS has been integrated within current frameworks in organisations and in this way, has been built into existing reporting and accountability mechanisms, such as existing equality governance arrangements, the Quality Framework and CQC workstreams and assurance processes.

- 5.11. In some instances, the EDS is as a result helping to **broaden responsibility and accountability for equality** across organisations and there are examples of where organisations are using the EDS in contract monitoring, embedding it into quality assurance, business planning and governance.

“The EDS has slotted into the Quality framework which means it is considered regularly and monitored through quality assurance” (Mental Health Foundation Trust)

“The approach to the EDS has started to make accountabilities outside of HR clear to the organisation. The link into directorate business plans... should improve understanding within directorates of the agenda” (Ambulance Service NHS Trust)

- 5.12. Where EDS progress is not reported to the Board within organisations, lines of accountability often involve one or more sub-committees, often with a Director-level or CEO lead.

- 5.13. A small number of organisations - mostly acute or mental health non-foundation trusts - who responded to the survey did not have any accountability mechanisms in place at the time of response (as of May 2012), with a number explaining that they are currently working through establishing appropriate lines of accountability.

- 5.14. What is apparent from the evaluation results to date is how important Board and/or senior leadership buy-in is to successfully implementing and embedding the EDS and making sure it becomes everyone’s business.

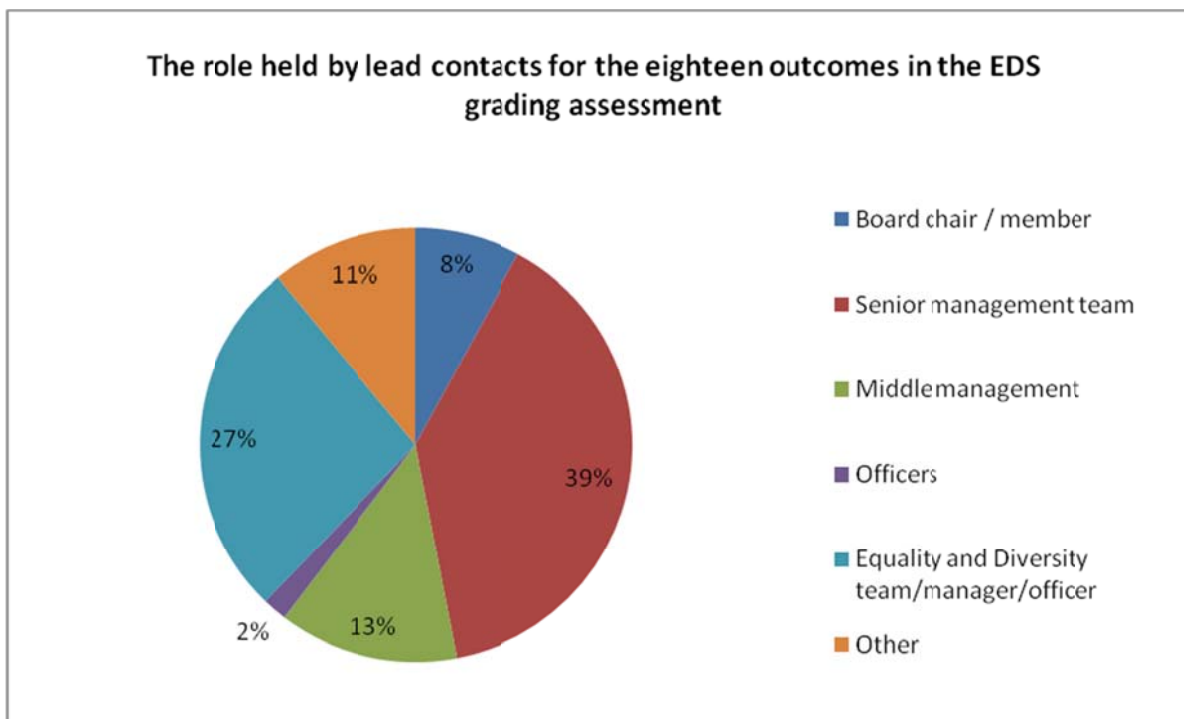
“An executive director is on board who has made it clear that it is everybody’s business. [It has] given clear responsibility. The Board demands quarterly progress report in this arena and officers are questioned to ensure that we are on target to deliver” (Mental Health Foundation Trust)

- 5.15. Although the majority (72%) of operational leaders for the EDS is currently a member of the Equality and Diversity team (manager or officer), there are slightly more senior management leads (39%) for EDS outcomes than

Equality and Diversity team members (27%), which is an indicator for the way in which the EDS is supporting organisations to embed equality throughout organisations, so that it becomes everyone’s business.

- 5.16. There was an expectation laid out in the EDS guidance that the lead contacts for EDS outcomes should be from amongst mainstream senior roles and it should be noted that there remains a sizeable proportion (27%) of organisations who haven’t managed to do that (see figure 8).
- 5.17. This is reflected in the fact that quite a significant proportion of organisations found it difficult to engage senior management in the EDS process (39%).

Figure 8: The role held by lead contacts for EDS outcomes (EDS survey, May 2012)



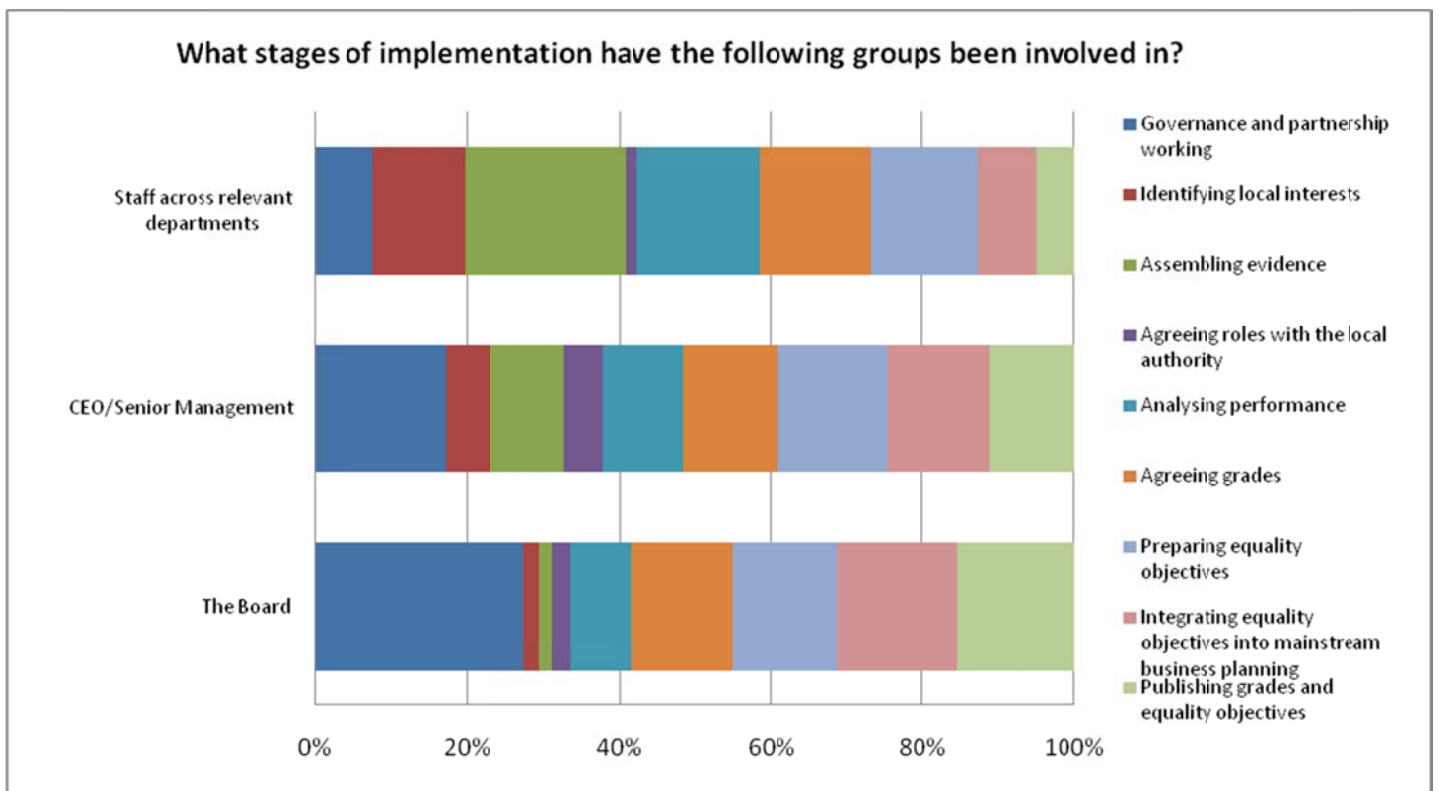
Engagement and involvement – internal

Overall, NHS organisations have been relatively successful in engaging internal staff at different levels of the organisation with the EDS implementation, most notably, at Board level.

- 5.18. The majority of EDS operational leads who responded to the survey have successfully been able to engage Board members in the EDS. 64% found it ‘straightforward’ to engage their Board although a further 30% found it ‘challenging’.
- 5.19. In general, organisations found it more difficult to engage senior managers in the EDS than Board members or colleagues. 46% stated that they found engaging senior managers a challenge and 40% found engaging colleagues/peers a challenge.

- 5.20. The biggest associated challenge was found to be staffing and resourcing for the EDS, where the majority (72%) found this to be a challenge.
- 5.21. The survey results reveal that there is an even split between the extent to which Boards and senior management and other staff/colleagues have been involved in EDS implementation in general, ranging from 'a little involved' to 'very involved'.
- 5.22. There is some difference across organisation type, with more Mental Health Trusts reporting a more engaged Board and senior management team compared with Acute Trust and PCT Cluster.

Figure 9: The stages of EDS implementation that internal groups/levels have been involved in (EDS survey, May 2012)



- 5.23. The evaluation to date provides more examples of engagement of external local interests than perhaps for staff and staff side organisations, which poses a question as to whether organisations have in general been putting more resources into engagement of patients and communities, particularly in grading, whereas staff have been more involved in supporting the 'practicalities' of the EDS.
- 5.24. For example, the survey results reveal that in general, staff have been engaged slightly more in assembling evidence and analysing performance than agreeing grades.
- 5.25. There are some examples where organisations have taken the decision to split the EDS into two groups and have engaged local interests to grade goals

1 and 2 and engaged staff to grade goals 3 and 4, and it is unclear as to whether this is what was originally intended in terms of local accountability.

- 5.26. Engaging staff in the EDS is something the evaluation will be focussing on further in the next phase, through in-depth case studies and focus group discussions.

Engagement and involvement – external

The evaluation has evidenced that engagement and involvement of local interests has varied considerably across NHS organisations, both in terms of the extent and depth of engagement and the amount of resource put into engagement activity.

- 5.27. The evaluation findings to date reveal that organisations have had mixed experiences in how they have found engaging external partners. In general, local voluntary and community organisations have had the biggest levels of involvement in EDS implementation – with 68% of organisations noting that VCS organisations have been ‘relatively’ or ‘very’ involved.
- 5.28. Local Authorities have had comparatively small levels of involvement in the EDS implementation to date.
- 5.29. There are many examples of where the ‘local health economy’ across an area have come together to pool resources around EDS implementation, particularly around engaging local interests to pool resources and minimise duplication and ‘engagement fatigue’ amongst local interests.

Southampton, Hampshire, Isle of Wight and Portsmouth PCT Cluster worked in partnership across the local health economy to implement the EDS. As part of its EDS evidence gathering, the cluster developed a local survey to supplement the national Patient Survey to ensure that it was gathering views of patients from across all protected characteristics. For more information, see full case study in supplementary report.

- 5.30. Although there are many advantages to working in this way, there is a risk around this that engagement becomes too broad and specific questions and therefore accountability for an individual trust becomes lost.
- 5.31. However, there are good examples of where this type of working has helped to build relationships between health organisations in areas and the opportunities this brings, such as strengthening patient pathways and pooled resources, particularly in a time of transition and change.

Nottingham North and East CCG is taking a mixed approach to engagement of local interests with different protected characteristics. Where it makes sense to do so, the CCG is working in partnership to engage specific groups, for example, transgender people who tend to congregate in the city. But for other groups a different approach is used – so for example the CCG is

engaging a local Asian elders group who live locally and get together over lunch.

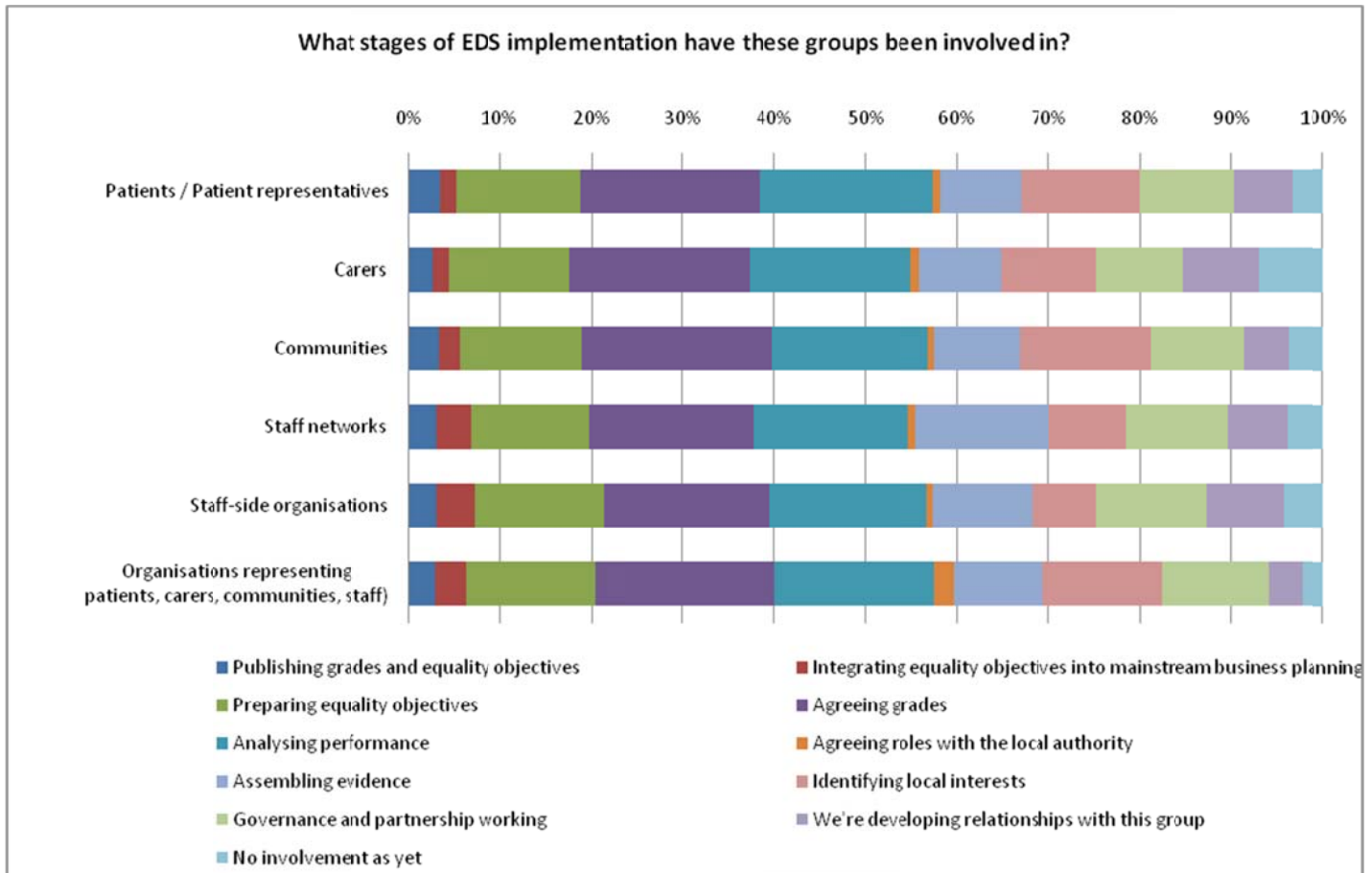
- 5.32. The survey results show that local VCS organisations have mostly been involved in the EDS in agreeing grades (68% of organisations who responded), analysing performance (60%) and identifying local interests (58%).
- 5.33. There are good examples of where through the EDS; NHS organisations are **strengthening partnerships** with local VCS organisations.

Voluntary Action Luton took the lead in developing an EDS grading group which constitutes Chairs and Chief Executives of key local VCS organisations including LINK, Young Health Ambassadors, Age Concern and mental health charity representatives. The group has its own terms of reference and will continue to meet and hold the local NHS to account.

Local interests

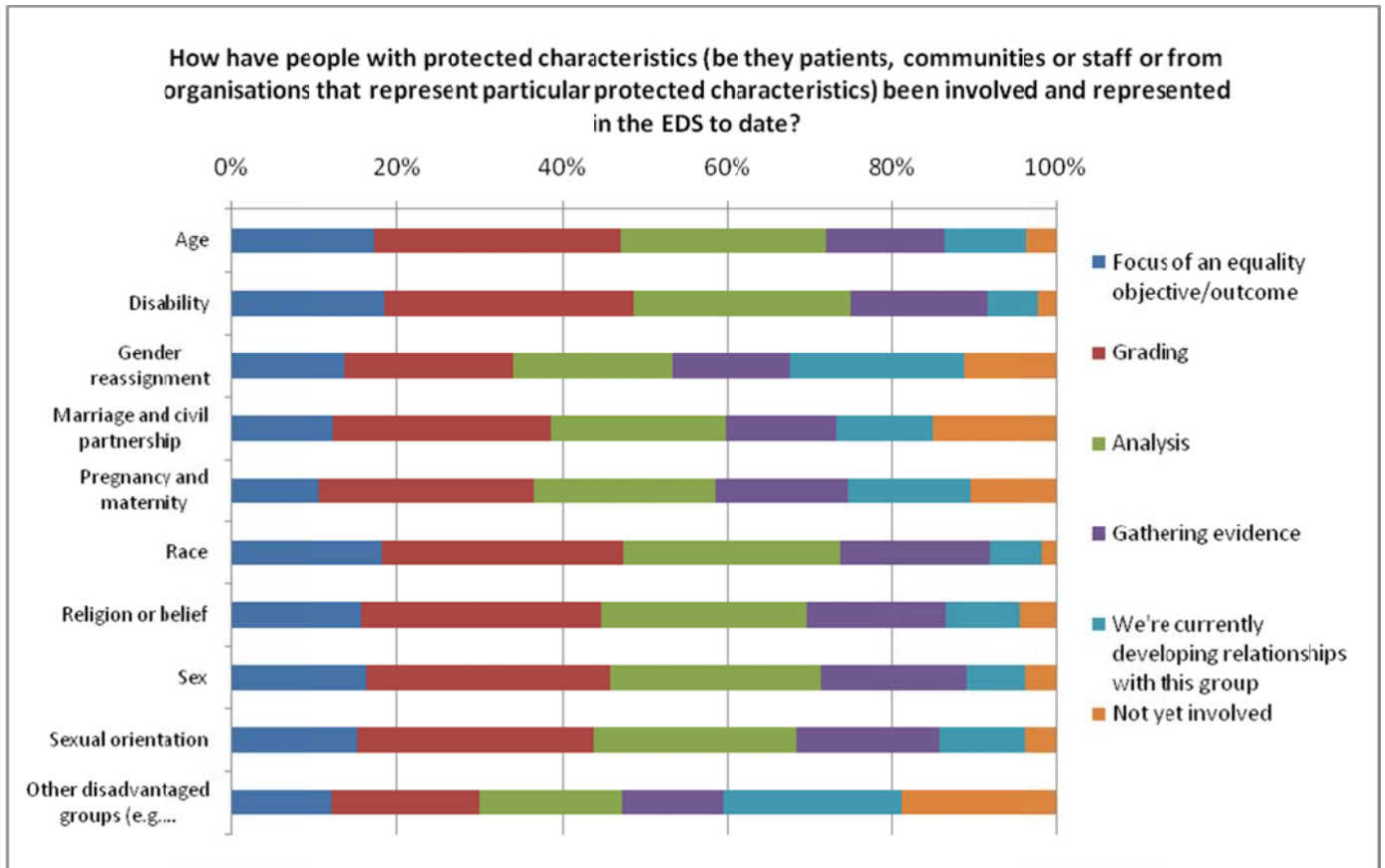
- 5.34. As figure 10 shows below, in the main, NHS organisations have effectively engaged local interests in the EDS implementation, particularly in analysing performance and agreeing grades.
- 5.35. More NHS organisations have involved organisations representing local interests in agreeing grades, more so than other groups, particularly carers, which are the most under-engaged group at this stage.
- 5.36. However, one in five (20%) organisations are developing relationships with carers, and so we would expect this to change over the next twelve months.

Figure 10: The stages of EDS implementation that local interests have been involved in (EDS survey, May 2012)



- 5.37. The evaluation has evidenced a significant amount of variation across organisations in terms of the depth of engagement with local interests that has taken place as part of the EDS. For example, where some organisations have used existing groups to engage with patients and communities, others have put relatively large amounts of resource into engagement activity. This reflects the flexibility built into the EDS in terms of adapting the type of engagement to local circumstances and needs.
- 5.38. The evaluation to date reveals varying levels of engagement of staff, patients and communities across the protected characteristics across NHS organisations who responded to the survey.
- 5.39. Race and disability have been the most engaged groups to date, with Marriage and Civil Partnership, 'other' disadvantaged groups (such as homeless people, sex workers), pregnancy and maternity and gender reassignment representing those groups who have been the least engaged overall.

Figure 11: The proportion of NHS organisations who have involved people with protected characteristics in the different stages of EDS implementation (EDS survey, May 2012)



5.40. The data also reveals the levels to which NHS organisations are working to develop relationships with people representing those ‘harder to engage’ groups, and there are many examples of how organisations have built relationships or are starting to build relationships with staff, patients and communities representing all of the nine protected characteristics and beyond.

University Hospitals Birmingham NHS Foundation Trust took an approach to EDS implementation that was meaningful to them by using it as a catalyst to push forward on their equality and engagement work currently underway, particularly to provide impetus in developing meaningful relationships with its voluntary sector partners. For more information, see full case study in supplementary report.

South East Coast Ambulance Service NHS Foundation Trust has entered into formal partnership arrangements with organisations that represent Gypsies and Travellers, people with learning disabilities and general disabilities to ensure they are properly considering the needs of those groups. They plan to enter into similar arrangement with a transgender

organisation as they have identified that there is a gap in engagement with transgender people and their membership figures are low in this area.

Collecting and sharing evidence

Organisations have in the main found collecting and sharing evidence to be challenging.

- 5.41. The survey results show that 'assembling evidence' was found to be challenging for 64% of organisations who responded to the survey and was highlighted as one as the biggest challenges that organisations faced in implementing the EDS, commonly for the reason of lack of data to evidence all outcomes for all protected characteristics.
- 5.42. Sharing the evidence with local interests was also highlighted as a particular challenge, particularly in a way that is accessible and meaningful to local people, who perhaps haven't had much experience or skills around interpreting data previously.
- 5.43. Collecting evidence was found to be particularly difficult during the period of transition, with organisations merging and their boundaries changing and with organisations working to bring together data from across different systems.

"[A] key challenge has been how to present quite complex evidence in an accessible way which enables external groups to understand and grade, particularly given the complexity of the grading system." (Ambulance Service NHS Trust)

- 5.44. A key risk relating to this and highlighted through the evaluation, was for organisations to strike the **right balance** between providing enough data/analysis for those involved in the grading to make informed decisions for accountability, and providing the data in an easy to understand, accessible way for the grading panel.

Identifying equality objectives

There was a distinct split amongst EDS leads who responded to the survey in terms of how useful they found the EDS in helping their organisation to set its equality objectives. There was found to be no distinct patterns across type of organisation in relation to this, rather, the EDS was found to be most useful to those organisations where equality work was least developed previously.

- 5.45. Those organisations who did find the EDS helpful in setting its equality objectives explained that it **provided them with a focus and a framework**, including a timeline and structures to help set meaningful

objectives, particularly during a time of change within the NHS. A number of survey respondents said it helped them comprehensively to undertake 'gap analysis', helping them to identify priority areas for objective setting.

"The EDS helped us to identify priority objectives that as an organisation we can focus on and make real improvements. The previous action plan had 36 actions in and there were no real improvements to show year on year, it is hoped with fewer actions more real improvements around equality will be made." (Primary Care Trust Cluster)

- 5.46. In other cases, where structures were in place, it **helped to strengthen existing processes** for setting equality objectives, such as getting more people at different levels of the organisation involved in setting the equality objectives, such as senior leaders.

"We would have set equality objectives anyway but it forced leadership, including CCGs and CSS to come up with objectives." (Primary Care Trust Cluster)

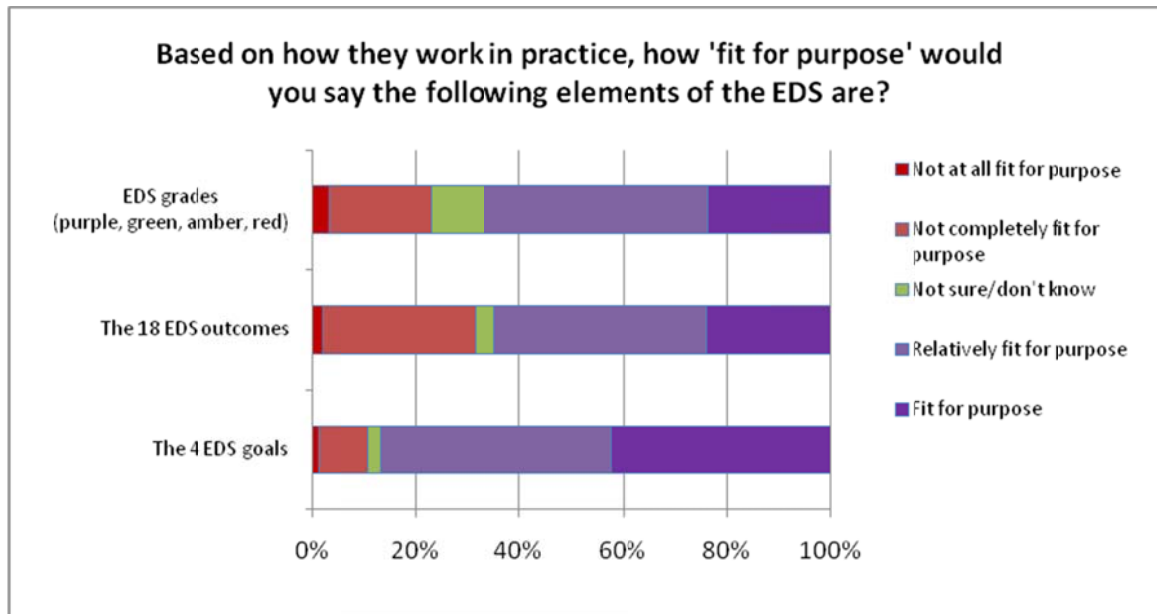
- 5.47. Those organisations who didn't find it as useful had their own systems in place which they felt were robust and comprehensive enough to identify equality objectives in a meaningful way for their organisation. In this way, where some organisations explained that the EDS told them 'nothing new', others in a similar position found the process helpful because it **reinforced what they knew** and helped them to be **more certain of where to focus their resources** and attention.
- 5.48. The majority of survey respondents have **shared their equality objectives** with their Board (68%) and the senior management team (71%). This percentage was slightly higher amongst mental health trusts and acute foundation trusts compared to acute non foundation trusts and PCT Clusters.
- 5.49. The second most popular groups with whom organisations had shared equality objectives were staff (52%) and voluntary and community organisations (50%) and NHS partners (48%).
- 5.50. Smaller numbers had shared its equality objectives with patients, carers, communities (38-39%) and with their whole organisation (38%) and the local authority (34%). However some hadn't got round to doing this yet (at the time of responding to the survey) and spoke of how they planned to do this in the future, for example by going back to the communities that were engaged in the process.
- 5.51. Common methods of communicating equality objectives included publishing them on their websites and through newsletters and staff bulletins, local events and internal accountability structures and emails to partners.

Grading and reporting

Most NHS organisations who responded to the survey found the EDS goals, outcomes and grades to be fit for purpose, with more finding

the goals fit for purpose than the outcomes and the grades. A slightly higher proportion of acute trusts found the grading, outcomes and goals to be 'fit for purpose' compared to PCT Clusters.

Figure 12: The extent to which NHS organisations believe the EDS goals, outcomes and grades to be 'fit for purpose' (EDS survey, May 2012)



5.52. The grading overall was found to be a challenge for 67% of organisations who responded to the survey. A common challenge identified was that the EDS as it stands is not flexible enough to take into account the differences between commissioner and provider organisations, with commissioner organisations saying that it's more geared towards providers and vice-versa.

Others said some outcomes are not relevant to them e.g. mental health trusts, and would appreciate more flexibility. A common outcome highlighted as particularly challenging was 4.3 using the competency framework to embed equality within the workforce. Respondents thought that some outcomes, for example 4.3 could be less prescriptive, simplified or more flexible.

"4.3 should be removed or changed to reflect that many organisations do not intend to implement the framework described there. Alternative frameworks are being put in place but this will always grade red as it is currently written"

"A lot of the goals and outcomes were very focused on patients and as a commissioner organisation we were not always in a position to provide appropriate evidence for each goal/outcome"

"I think that some of the goals were not applicable to our Trust such as the one that focused on public health screenings and vaccinations."

(Survey respondents)

- 5.53. Further, it was felt by many who responded to the survey that the EDS wasn't as clear as it could be – in particular, when trying to use it to engage local interests. The phrasing of the outcomes and goals was felt to be complex and as a consequence, many organisations found it difficult to engage patients and community members. It was also commonly felt that because of the number of outcomes, there was repetition in terms of the type of evidence that was requested.

"I think the outcomes should be simplified and described in ways which patients and staff can relate to. I think it is difficult to use the grading across all outcomes in a systematic manner, averaging is not easy and it can be confusing." (PCT Cluster)

- 5.54. In response to these common challenges, NHS organisations have adapted some of the materials provided and in some cases chosen to focus on specific characteristics or goals. In doing this, organisations can potentially meet the needs of their local groups and/or circumstances, however it raises questions about how far organisations are diverting away from the wording of EDS outcomes.

Support

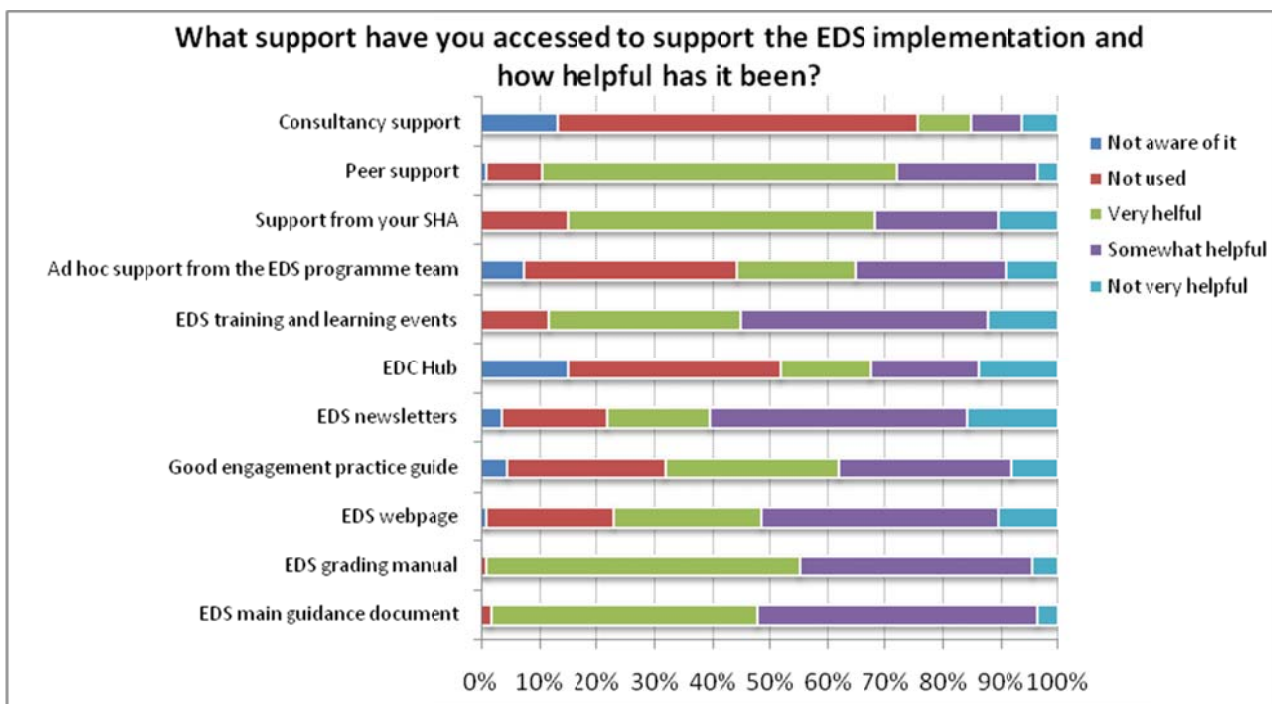
The majority of EDS leads who responded to the survey found the support available helpful, in particular, the main EDS documents (guidance and grading manual), support from SHA and peers and the EDS training and learning events organised by the Programme Office (see figure 13).

- 5.55. The support offered to EDS implementers included ad hoc support from both their SHA and access to the EDS Programme Office to ask questions. A more formal offer of support was put together by the Programme Office and included:
- National launch events and regional learning workshops for NHS staff and local interests, and a series of 'train the trainer' style workshops;
 - Written guidance on implementing EDS including a grading manual, overall guidance, and best practice guidance for good engagement with people with protected characteristics.
 - E-resources including the EDS newsletter distributed via regional EDS leads and EDS webpage.
- 5.56. The responses to the national launch events led by the programme office (through evaluation forms) were overwhelmingly positive. In particular the learning and networking was found to be helpful, providing participants with the chance to obtain practical advice and learn from good practice elsewhere.

“I found the group discussions and exchange of information [helpful]. [It provided] space to think about what this means for local organisations” (delegate, EDS event, February 2012)

- 5.57. The evaluation feedback forms from the events and feedback from the evaluation to date clearly shows an **appetite for further opportunities to share good practice** and practical examples of how other organisations across the country are approaching and experiencing the EDS. Some of this was happening through cluster leads and SHA leads, but this wasn't consistent across the country.

Figure 13: Responses to the support on offer to NHS organisations for EDS implementation



“Cluster lead has been really helpful in providing examples of what other organisations are doing and generally being responsive to any queries.” (PCT Cluster)

- 5.58. There are examples of where people are forming their own networks to share good practice, as they find the peer to peer support, sharing good practice, approaches very helpful.

“We created a sub group of our regional EDS Implementation group of just commissioners... The group has proved invaluable for support and help and we have all shared ideas” (PCT Cluster, South West)

- 5.59. In terms of gaps in the support provided, accessible format of grading tools and more support around grading was a common support need identified by

all types of organisations, but particularly amongst NHS provider organisations.

“Training on actual grading process and how you assign a grading against the protected characteristics, even within regional meeting each Trust interpreted differently” (Acute Foundation Trust)

- 5.60. The evaluation reveals some inconsistency around the levels of regional support for NHS organisations across the country. There seems to be lots of demand for support from the programme office and from regional leads, much of which has been met however some participants had not been able to get the support they expected.
- 5.61. The majority of PCT Clusters who responded to the survey highlighted the need for support for emerging CCGs, including sharing of good practice, securing their commitment to use EDS once they become legal entities and specific training, support and guidance for CCGs.
- 5.62. A common support need identified through the evaluation was more information, support, sharing of good practice around evidence for each outcome and grading. As well as more opportunities for sharing good practice and peer support, for example one suggestion was the development of an informal network of acute trusts for peer support particularly for when the PCT Clusters are no longer operational.

“More guidance and realistic case studies about how equality works at various levels of an organisation and by teams. So how does it actually work in mental health?” (Mental Health Foundation Trust)

Key challenges

Overall, most people are very positive about the EDS and its principles, and in the main it has been well-received. People have found the process to be a lot of work but most have found it worthwhile. They would however like to see it improved – and in particular the process made simpler.

Many who have been involved in the evaluation have said that the EDS has been a time-consuming process, particularly at a time of change and transition within the NHS, with limited resources and competing priorities. Where organisations have not currently got senior leader buy-in around equality, these factors have made it more difficult.

- 5.63. By far, the biggest challenge that NHS organisations have faced in implementing the EDS to date has been staffing and resourcing for implementation and the associated timescales, which is all underpinned by the current NHS operating environment of change and transition (see figure 14).

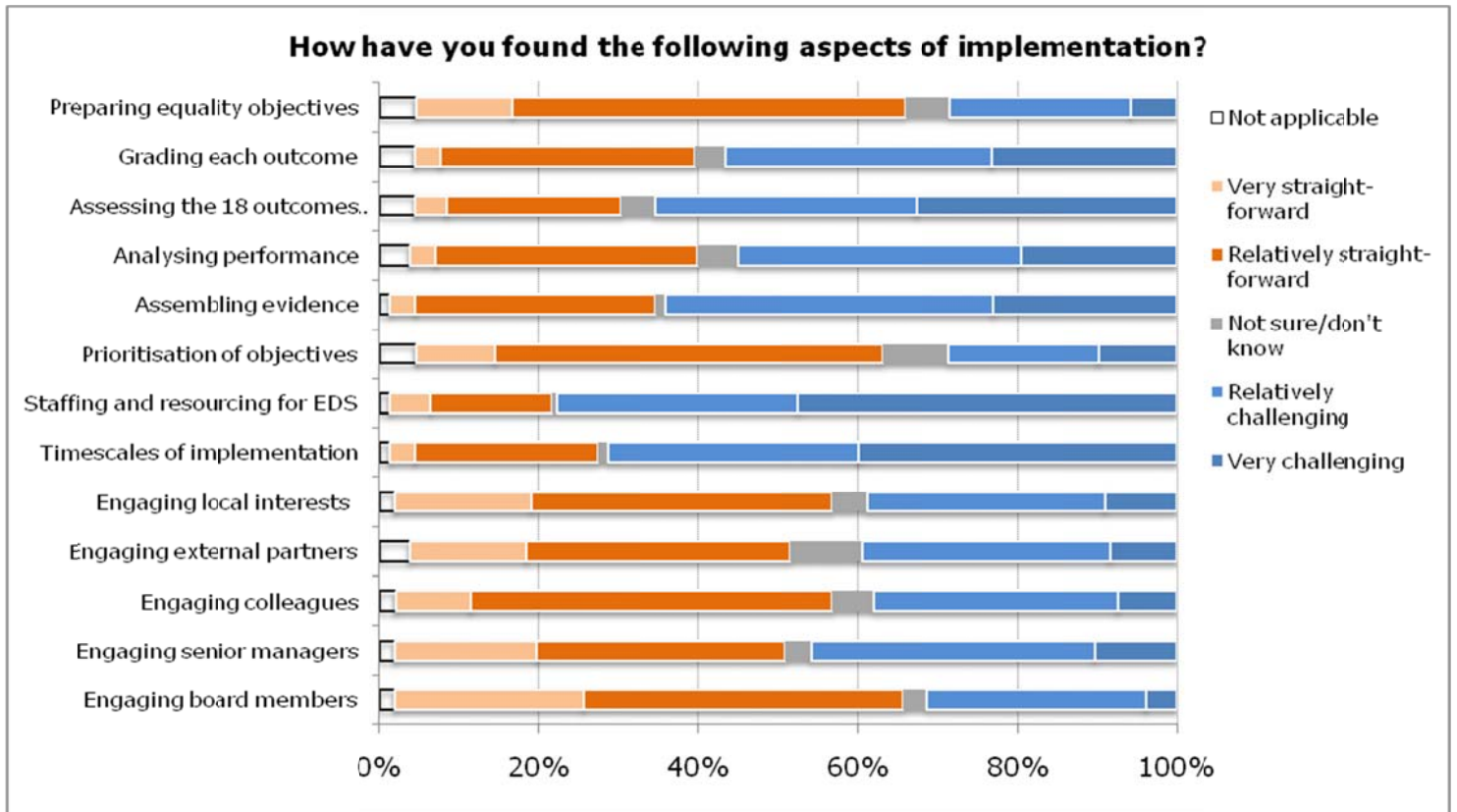
- 5.64. Although over half of organisations who responded to the survey found many aspects of the EDS challenging – in particular, this was due to the timescale associated with implementation coupled with the available resources at a time of unprecedented change and transition within the NHS.
- 5.65. Most people are of the feeling that the principles of the EDS are sound, but it is fair to say that a significant proportion of organisations have found the timescales, the required resources for implementation and the perceived demands of assembling evidence, assessing performance and grading very demanding and challenging, particularly during this time of change. In particular, it seems, for organisations who are further behind in equality work than others and who are starting from a lower base.

“Poor awareness amongst external communities of NHS work/structures and limited previous involvement across ALL protected groups results in limited capacity/knowledge for informed grading. Timescales tight to nurture and develop rapport/trust.” (Ambulance Service NHS Trust)

- 5.66. Where organisations haven't got the support senior leader buy-in, it has been more difficult but there is evidence of the EDS helping to secure senior leader and senior manager buy-in or, at a minimum, attention to the equality agenda.
- 5.67. The context of change and transition in the NHS is also evident here in the practicalities of delivering EDS in a changing work place. For example, EDS has been disrupted by changes in sizes of Trusts, systems being used or diversification of services and roles.

“Collecting evidence made very difficult with the merger of Mental Health and community health services during this period. We doubled our size during this period, [so] difficult to get a handle on performance across the patch.” (Mental and Community Health Foundation Trust, South East)

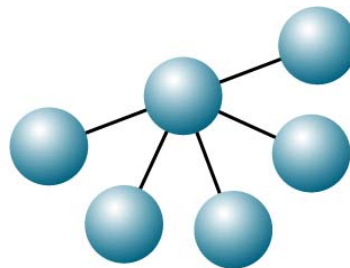
Figure 14: The biggest challenges facing NHS organisations in terms of EDS implementation.



6. IMPLICATIONS

- 6.1. This section of the report draws on the key findings of the first phase of the independent evaluation. We outline below implications for the EDS to be considered going forward.
- 6.2. The evaluation raised concerns amongst commissioning organisations in terms of ensuring the good work done by PCT Clusters to date on the EDS isn't lost and that there continues to be support mechanisms in place for new NHS organisations around implementation of the EDS going forward.
- 6.3. It is suggested that consideration is given to ensure that there is a **legacy from PCT Clusters and SHAs** and that the good work done on the EDS is shared and used to ensure that there continues to be support mechanisms in place for new NHS organisations particularly CCGs around equality and the EDS going forward.
- 6.4. The result of the evaluation to date has revealed that Local Authorities' levels of engagement have been relatively minimal to date. This is highlighted as a risk because of the commissioning responsibilities of the emerging Health and Wellbeing Boards (HWBBs) and their relationship with CCGs, and it is suggested that thought is given in terms of addressing this **limited engagement of HWBBs** to date.
- 6.5. The evaluation has evidenced significant variation in terms of the grading process and levels of engagement with local interests, including the adaption of the grading process itself as well as the materials used in it. Although local adaptation is encouraged, the extent to which the tool can be adapted isn't clear. In light of this, it is suggested that there is **clear communication of the parameters for local adaptation**.
- 6.6. The evaluation has revealed that a significant proportion of NHS organisations are working together within specific localities on key aspects of the EDS, most notably, on engaging local interests and grading. Although this has been found to work well in terms of pooling resources and minimising 'engagement fatigue' among local interests, there is an associated risk in terms of accountability for individual trusts. It is suggested that consideration is given around how to ensure that where NHS organisations are working on the EDS across local health economies that there still **remains accountability** for individual organisations.
- 6.7. Although the EDS has been well-received by those organisations involved in the evaluation, the majority found the EDS to be overly complex and inflexible, in terms of the length and complexity of providing evidence for protected characteristics across 18 outcomes and grading those, as well as their relevance to all types of NHS Trusts. The common feeling is that the process **simplified and tailored** to different types of trusts (including mental health trusts and CCGs) and in that way it would improve the quality of implementation.

- 6.8. It is suggested that consideration is given in how best to **'future-proof' the EDS** for new NHS organisations (e.g. Health and Wellbeing Boards and CCGs) and for ensuring its fit for purpose for all types of NHS organisation (including simplification of the process/rationalisation of outcomes);
- 6.9. The evaluation has highlighted a significant demand for sharing EDS practice across organisations. Peer to peer learning at local, national and regional level has been very well received to date and trusts have stated that they would continue to benefit from more of this. It is suggested that consideration is given in term of how best to encourage and coordinate on-going **peer support and sharing practice** around implementation of the EDS.
- 6.10. A final consideration is how the results of the EDS can be most **effectively used at a national level** to feed into national policy and developments. For example, a number of organisations have struggled with evidencing some outcomes – how can this type of information be used and feed into developments of data collection at the highest levels and fed back to organisations.



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