



“EVERYONE COUNTS”

AN EQUALITY DELIVERY SYSTEM FOR THE NHS

A summary for regional consultation purposes

February & March 2011

ABBREVIATIONS

CQC	Care Quality Commission
DH	Department of Health
EDC	NHS Equality and Diversity Council
EDS	Equality Delivery System for the NHS
EPIT	Equality Performance Improvement Toolkit
GEO	Government Equalities Office
GP	General Practice
LINKs	Local Involvement Networks
NHS	National Health Service
PCT	Primary Care Trust
QIPP	Quality, Innovation, Prevention, Productivity
SHA	Strategic Health Authority

ACKNOWLEDGEMENTS

The EDS is one of the first products of the EDC, formed in 2009, as a sub-committee of the NHS Management Board and chaired by Sir David Nicholson, the Chief Executive of the NHS. The EDC aims to provide visible leadership on equality issues across the NHS. It influences, encourages and empowers people throughout the NHS, Government and communities to drive real improvements in health and care outcomes.

Work on the EDS is led by Tim Rideout on behalf of the NHS Equality and Diversity Council. Tim Rideout is Chief Executive of NHS Leicester City on secondment to Sir David Nicholson's office, to work on commissioning development. A technical working group, reporting to Tim Rideout, has advised on the detailed proposals.

The design of the Equality Delivery System owes a great deal to work in the North West to put in place an evidenced system, the Equality Performance Improvement Toolkit, to help local NHS organisations evaluate and improve their equality performance.

AN EQUALITY DELIVERY SYSTEM FOR THE NHS

What the Equality Delivery System delivers

The EDC has prioritised the EDS as the best means of helping the NHS improve its performance for equality groups, as opposed to individual organisations finding their own solutions. 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. Because the EDS has been designed to help organisations meet their duties under the Equality Act, it will help to ensure a coherent approach across the NHS with less likelihood of damaging and expensive consequences arising from EHRC formal action.

Once implemented the EDS will :

- ❑ Help the NHS deliver on the Government's commitment to fairness and personalisation, including the equality pledges of the NHS Constitution.
- ❑ Deliver improved and more consistent performance on equality
- ❑ Help organisations to respond more readily to the Equality Act duty – something they will need to do in any event.
- ❑ Support commissioners to develop commissioning plans that meet the needs of their communities, and will help providers to respond better to CQC registration requirements.
- ❑ Improve efficiency and bring economies of scale by providing a national equalities framework for local adaptation.
- ❑ Retain a focus on fairness, personalisation and equality during transition

Who is the EDS designed for

The Equality Act is protects people from unfavourable treatment because of the following characteristics, some of which apply to everyone while others apply to groups of people :

- ❑ Age
- ❑ Disability
- ❑ Gender re-assignment
- ❑ Marriage and civil partnership
- ❑ Race including national identity and ethnicity
- ❑ Religion or belief
- ❑ Sex (that is, is someone female or male)
- ❑ Sexual orientation

(For parts of the Equality Act, pregnancy and maternity is also a protected characteristic.)

The EDS helps NHS organisations to comply with the Equality Act, and hence it covers the above groups. As a shorthand, the terms “**protected groups**” and “**protected people**” are used in this document to refer to people protected by the Equality Act. In the past, such groups and people have been called “equality groups” or “equality target groups” or something similar.

In addition, the EDS can be applied to groups of people not afforded protection by the Equality Act, but who often face stigma in life in general and when trying to access statutory services. Such groups include homeless people, sex workers, and people who use drugs and other groups who experience socio-economic disadvantage.

Design

The EDS has been designed for the NHS by the patients and staff of NHS, and other interests, at over a range of national and regional engagement events. When the EDS regional consultation events are concluded in 2011, it is estimated that over 2,000 people will have contributed to the EDS design.

The design of the EDS also draws on good practice in the NHS and beyond. Extensive work in the North West has resulted in a working and practical system to help NHS organisations in the region review and improve their equality performance. At the centre of this system is the “Equality Performance Improvement Toolkit” (EPIT). NHS North West tested and evaluated EPIT, and related processes, with over 60 NHS organisations, in order to arrive at an evidence-based and outcome-focused system to drive forward positive change in the region.

Scope

The EDS applies to both NHS Commissioners and NHS providers – both in the current NHS and the new NHS as set out in the White Paper and Health Bill. This means that the EDS applies to Primary Care Trusts (PCTs), until they are abolished, and to GP Consortia that emerge to take over the commissioning work of PCTs.

The EDS applies to NHS providers including Foundation Trusts, all of whom are registered to provide services by the CQC.

It may also be applied to all those healthcare organisations that are not a part of the NHS, but which may work to contracts issued by NHS commissioners. (This aspect will be confirmed in due course.)

Where provider organisations are large, with multiple sites and/or departments, they should ensure that the analysis of performance and resulting grades, takes account of different levels of performance across sites and departments. Such an approach can help to justify the awarding of a good EDS grade.

System alignment

NHS Operating Framework 2011/12

The NHS Operating Framework for 2011/12 advises the NHS as follows : “NHS organisations will need to comply with the public sector duty of the Equality Act 2010, due to come into force in April 2011. The NHS Equality and Diversity Council is developing an Equality Delivery System to advise boards on how to maintain progress and demonstrate compliance with the Act”.

NHS Outcomes Framework

The five domains of the Outcomes Framework are built into the EDS outcomes, and organisations should use the Outcomes Framework indicators, disaggregated by equality group wherever possible, as evidence of their performance. The five domains are as follows :

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

In the guidance issued to the NHS about the Outcomes Framework, the Department of Health advises that “In selecting outcomes and determining how they should be measured, active consideration has been given to how the indicators can be analysed by equalities and inequalities dimensions to support NHS action on reducing health inequalities. In addition to the legally protected characteristics, particular consideration has been given to socio-economic groups and area deprivation as these are key drivers of poor health outcomes.” (DH, December 2010)

Quality, Innovation, Productivity and Prevention (QIPP)

NHS organisations are asked to improve the quality of care they deliver while making efficiency savings that can be reinvested in the service to deliver year on year quality improvements. This “challenge” results in QIPP plans for all organisations. In meeting the challenge, organisations are reminded that “it is crucial that we do not lose momentum in improving the standard of care we deliver. We need to protect and promote quality while releasing savings everywhere. In doing so we will continue to ensure that NHS values are at the heart of what we do and we remain committed to tackling inequalities and promoting equality” (DH, 2010)

When analysing their performance using the EDS, organisations are specifically asked to review the four elements of QIPP through an equality lens, if they have not already done so. Good EDS grades are achieved only if organisations are delivering high quality outcomes, in cost-effective and innovative ways, with a premium on prevention. As an extra safeguard, organisations should refer to their use of the EDS in the Equality Impact Assessments of their QIPP plans.

CQC Essential Standards

When evidencing their performance for EDS purposes, NHS providers should take account of the evidence they have provided to CQC to demonstrate compliance with registration requirements. Specifically, they should refer to the outcomes for service users set out in “Essential standards for quality and safety” (March 2010). (This CQC guidance tells providers how they can achieve compliance with the Section 20 regulations of the Health and Social Care Act 2008.) In some instances, providers may have to improve their evidence with regard to particular equality groups.

Authorisation processes for GP Consortia and Foundation Trusts

It intended that the requirement for all NHS organisations to use the EDS will be included in the authorisation processes for both GP Consortia and Foundation Trusts. The EDS will also be added into other parts of the system architecture of the NHS, including model contracts and accountable officers' responsibilities. (These points will be confirmed by the NHS Commissioning Board in due course.)

Transition - workforce

To support transition to the new NHS, organisations should refer to the "NHS HR Framework" (to be published shortly). Implementation guidance to PCT Clusters asks them to be mindful of the Equality Act, promote the EDS, and safeguard against adverse impact on the workforce (DH, 2011). Specifically, paragraph 38 asks that "all the appointment processes required for these changes should comply with the Equality Act 2010 and the principles of fairness with every effort being made not to lessen the representation of people of protected characteristics such as BME people and women in senior roles. It will be particularly important for the NHS to retain its expertise and intelligence on tackling health inequalities (including those arising from discrimination) during the transition. The SHA, in conjunction with its PCTs, should carry out an Equality Impact Assessment of these proposals."

Timeline

- Following the successful engagement events of 2010, from February to May 2011, regions led by SHAs continue to consult and engage with local interests on the development and implementation of the EDS.
- The final version of the EDS is trailed in May 2011, and launched in June 2011, when the shadow arrangements for NHS Commissioning Board are in place. An evaluation process will be commenced.
- During the remainder of 2011/12, organisations prepare their Equality Objectives.
- At the same time, organisations work to ensure that local interests are empowered/supported to play a full part in the local implementation of EDS, and that evidence, including data and softer material, are developed and fully utilised.
- By 6 April 2012, organisations will be expected to have prepared and published Equality Objectives, to include their priority actions for 2012/13.
- The take-up of the EDS and early outcomes will be reviewed in 2012 by the NHS Commissioning Board. Early results of the evaluation will be taken into account. If take-up is not extensive, the Board will consider action to ensure that the EDS is used throughout the service.

How it works

Analysis of performance

At the heart of the EDS is a set of nationally agreed Objectives and Outcomes. The Objectives are common for both NHS commissioners and NHS providers. They are :

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive Leadership at all levels

Within each Objective are a set of outcomes. There are 12 outcomes in total across the four Objectives. The outcomes are given below.

NHS organisations, with local interests, should analyse their performance against the outcomes for each group afforded protected status directly or by association by the Equality Act. (For example, a family carer of an individual afforded protected status by the Equality Act is also afforded protection because of her/his “association” with the individual.) The analysis must be evidenced-based and transparent.

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

- Patients and those local groups that represent them
- Communities and the public in general
- NHS staff and Staff-Side (that is, unions such as Unison)
- Voluntary and community organisations

Organisations and local interests may work in a variety of ways when analysing and grading NHS performance. Whatever way is chosen, it must be a partnership of equals.

CQC Essential Standards

When making their analyses, providers should take account of the relevant outcomes cited in CQC’s “Essential standards of quality and safety”, and the evidence that they have provided to CQC to demonstrate their compliance with registration regulations. As they do so, they should use, review or improve this evidence particularly where it falls short for some equality groups.

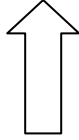
Similarly, commissioners should refer to the outcomes of the “Essential standards”, when they and local interests review their performance against the EDS outcomes. Many of the providers that commissioners procure services from will be registered providers; so it is only appropriate for commissioners to take account of providers’ achievements against the CQC outcomes when assessing their own performance. (The link between the EDS Objectives and Outcomes is given in the Annex.)

Grades

As a result of the analysis, the organisations and its local interests will award a grade for each outcome.

There are four grades, and a related RAG rating, to choose from :

- ❑ Excelling – **Gold Star**
- ❑ Achieving - **Green**
- ❑ Developing – **Amber**
- ❑ Undeveloped - **Red**



Each grade for each outcome will be described in sufficient detail so that different organisations, with their local interests, can apply them consistently at any one time and over time. (Note : the grading will be developed at a series of EDC workshops.)

First and foremost the grades will be designed to reflect the delivery of outcomes, with particular regard to the QIPP challenge, for protected groups and meeting the Equality Act duty. This approach means that :

- ❑ The better the delivery of outcomes, supported by evidence, the better the grade.
- ❑ The more that quality, innovation and prevention and cost-effectiveness can be proven in the delivery of these outcomes, the better the grade.
- ❑ The more, for example, the NHS fosters good relations between groups and communities, and can produce supporting evidence, the better the grade.

While the grades emphasise outcomes as experienced by patients, communities and staff, two processes are also reflected in the grades. The better the use of evidence from JSNAs and other sources, the better the grade. Likewise, the better the engagement of local interests, the better the grade. Lastly, the completeness and take up of issues raised by Equality Impact Assessments will also be a key factor in the award of grades.

In summary, local grades must reflect the extent to which, for protected groups :

- ❑ Good outcomes are delivered
- ❑ The QIPP challenge is met
- ❑ The Equality Act duty is met, including the fostering of good relations
- ❑ The NHS Constitution is delivered
- ❑ Effective use is made of JSNAs and other evidence
- ❑ Local interests are empowered, supported and actually take part.

The grades will also reflect to extent to which organisations use the social model of disability, which focuses on how a person's environment can limit their activities of daily living.

The design of the grades also takes account of NHS good practice, including EPIT, and the Equality Framework for Local Government,

The grading system of the EDS will be critical in supporting organisations to gauge their current position and the continuous progress they need to make in order to embed equality into mainstream business.

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

The grades are intended to help organisations clearly identify equality progress and challenges. While both good and poor performance should come to light, the purpose of the EDS and its grades should, in the first instance, be about helping good organisations maintain and further improve their performance, and helping poor organisations address and overcome their difficulties and so embed equality into mainstream business.

Evidence

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

- JSNAs
- Providers' registration evidence
- NHS Outcomes Framework indicators
- Quality Accounts
- CQC's patient surveys
- GP patient surveys
- CQC NHS staff surveys
- Public and Patient Engagement and Empowerment (PPEE) surveys

Where organisations are not able to assess their performance on an outcome because they do not have sufficient evidence, or have not made the best use of evidence, they should grade themselves as “Undeveloped”.

Over time, all organisations should plan to achieve and maintain the “Excelling” grade on all outcomes, bearing in mind that excellence implies a strong emphasis on partnership working with local authorities and innovation. Foundation Trusts should ensure that on each outcome, the agreed grade is “Achieving “ or “Excelling”. The wording for the grades will not only help organisations to gauge their current position; it will highlight how progress might be made and encourage continuous improvement

EQUALITY DELIVERY SYSTEM - OBJECTIVES AND OUTCOMES

Objectives Menu	Narrative : the NHS is asked to ...	Outcomes
1. Better health outcomes for all	Achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services and care pathways are commissioned or decommissioned, designed or re-designed, procured, provided and contractually monitored so that they meet the needs of patients, carers and local communities
		1.2 Public health outcomes are measurable, substantive and are developed through evidence-based strategies, developed with the involvement of patients, carers and local communities
		1.3 Patient safety outcomes are demonstrating measurable increases across all equality target groups, with the active participation of staff and managers engaging with patient groups and involving local communities
2. Improved patient access and experience	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 are effectively accessing services, taking into account barriers that historically hinder equality of access
		2.2 Patients, carers and communities are provided with appropriate communications support and information about services, so that they can make informed choices and be assured of diagnoses and treatments tailored to their needs
		2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected, and the services they receive are safe, effective and personalised to their specific needs
3. Empowered, engaged and well-supported staff	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 A workforce that is diverse within all occupations and grade levels through fair and flexible recruitment, development, and retention practices
		3.2 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
		3.3 The workforce is confident, competent and feels empowered to deliver appropriate and, accessible services, and improved patient experience for all communities
		3.4 The workplace is free from actual and potential discrimination -from recruitment to retirement - and all staff are able to fully realise their potential
4. Inclusive leadership at all levels	Ensure that throughout the organisation, 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 Corporate leadership demonstrates the commitment and knowledge to assure equality outcomes within the organisation and the local health economy
		4.2 The organisation develops and supports equality leaders and champions within the workforce to the standards of capability defined by the NHS Competency Framework for Equality and Diversity Leadership

Human Rights and the EDS

Human rights legislation in the UK is founded on five key FREDA principles. Human rights should never be a secondary consideration in the provision of NHS services or in the development of the workforce. They should underpin all NHS activity and indeed are at the heart of the NHS Constitution. They are also at the heart of the EDS, as the follow box describes :

<i>Human rights principle</i>	<i>How reflected in the EDS for protected groups?</i>
Fairness	As and when organisations deliver on EDS Outcome 1.1 to meet the needs of all individuals and communities, tailored to their specific circumstance, and provide working environments where all staff are given equal chance to thrive (EDS Outcome 3.1), then the NHS will demonstrate its commitment to fairness to protected groups and beyond.
Respect	The EDS supports the NHS Constitution to help the NHS respect both patients and staff from protected groups and beyond. For patients, EDS Outcomes 2.3 focus on the promotion of safety and access. For staff, the EDS Outcome of 3.2 asks organisations to promote the well-being of their staff. Achievement of these outcomes will be a clear demonstration that individuals' rights to be respected are a priority for the NHS.
Equality	The whole of the EDS is designed to improve the equality performance of the NHS. EDS Outcomes 4.1 and 4.2 emphasise that strong and committed leadership, where equality in general, and equality champions in particular, are supported, is essential to the achievement of a fairer and more personalised NHS, staffed by a diverse, confident and competent workforce.
Dignity	For patients, EDS Outcome 1.3 asks the NHS to prioritise the safety of patients, and EDS Outcome 3.4 asks that working environments are free from discrimination. Achievement of these outcomes will ensure that the dignity of both patients and staff, from protected groups and beyond, will be upheld.
Autonomy	For patients, EDS Outcome 2.2 asks that people from protected groups and beyond are given sufficient information about the NHS and their diagnoses and treatments so that they can make informed choices for themselves. For staff from protected groups and beyond, EDS Outcome 3.3 seeks a workforce that is confident, competent and empowered to make decisions – with patients and within management / professional guidelines – on the most appropriate treatments or courses of actions

(More information on human rights and the NHS can be found in reports of joint work between DH, the NHS and the British Institute for Human Rights. (DH / BIHR 2010))

Health inequalities

Social class, poverty and deprivation are often closely related to the incidence of ill-health and the take-up of treatment. In addition, many people from protected groups are challenged by these factors, and as result experience difficulties in accessing, using and working in the NHS. For this reason, work in support of protected groups is best located in work to address health inequalities in general with a focus on improving performance across the board and reducing gaps between groups and communities.

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

- When analysing the EDS outcomes, organisations and local interests should consider extending the analysis beyond the protected groups to other groups and communities who face stigma, and difficulties in accessing and using the NHS. It should be up to local organisations and interests to decide whether or not to take this approach; and if they do, which groups and communities to consider depending local needs and circumstances. Work on “Inclusion health” (DH, 2010) points to people who are homeless, sex workers and people who use drugs as potential targets.
- When working on Equality Objectives and priority actions, organisations should locate all work on in support of both protected groups and other groups facing stigma within their mainstream work on tackling health inequalities with regard to health conditions, health promotion, general issues of patient access, safety and experience, or workforce development.

Setting local objectives and priorities

As a result of the analysis of EDS Outcomes, NHS organisations and their local interests should agree on a small set of Equality Objectives for the coming business planning period.

Equality Objectives should result in a discrete number of prioritised actions for one or more equality groups. The more that both Equality Objectives and prioritised actions can make links between the different equality target groups the better. A single strand approach equality is becoming increasingly irrelevant in today’s world, where individuals are a mix of “protected” characteristics.

At any one time, it is recommended that an organisation focuses on all four of the EDS Objectives, but only addresses a handful of priorities. Tackling more objectives and scores of priorities could result in efforts being spread too thinly, where lasting outcomes are jeopardised. Many Single Equality Schemes were often undermined by being too wide-ranging and too comprehensive, as if every part of an organisation had to offer up an action or two, spread out across each equality group.

The chosen priorities should cover the most immediate and urgent concerns and be firmly based in evidence. Preventive action is not ruled out, if it can result in significant benefits for particular communities and the NHS down the line. However, some priorities could represent “quick wins”, which if achieved can pave the way for further success.

Choosing priority actions so that all equality groups are covered at any one time, can lead to tokenistic not realistic plans. Backed by evidence, and working with local interests, the EDS analysis should reveal the most pressing needs. It is these needs that should be prioritised. Over a three to five year period, it would be unusual for a complete range of equality groups not to feature among the chosen prioritised actions, especially if organisations are choosing areas of need that affect more than one equality strand at a time.

In the context of broader strategic plans, organisations should describe :

- How progress on prioritised action phased and related milestones, within the context of continuous improvement.
- How these priorities feed into, and support, corporate strategic goals, plans for tackling health inequalities – improving performance and reducing gaps - and related business plans.
- The grades that they hope to achieve over the business cycle for each outcome, indicating the progress to be achieved in each year.
- The local interests that it has engaged with in compiling the Equality Objectives and in verifying the assessment against the outcomes. Any disagreements or concerns should be recorded.
- The sources of evidence the organisation used in analysing its performance and identifying priorities, and its long-term plans to improve its collection and use of evidence, with explicit reference to the requirements of the Equality Act.

While the organisation may wish to provide a summary of the actual analysis against outcomes, the agreed grade for each outcome should be given a prominent place in the annual plans or related publications and publicity.

In developing and working on their Equality Objectives and prioritised actions, organisations should not only refer to EDS guidance but also to guidance about the Equality Act 2010, and how to respond to it, from the Equality and Human Rights Commission (EHRC), the CQC and other organisations. Some guidance on equality including that issued by NHS Employers in 2008, although pre-dating the Equality Act, is still relevant and useful.

Immediate priority actions and longer-term plans

Through the EDS, organisations identify and address critical issues for patients, communities and staff in a focused and planned way, as part of broader work on tackling health inequalities and as part of mainstream business. It is likely that the first analyses of NHS performance using the EDS will highlight a great many challenges for all organisations.

The EDS is meant to highlight the critical challenges and lead to plans / actions to address them. However, when focusing on these challenges, routine and other important work on addressing inequalities should not grind to a halt. Of course, organisations must continue to remain legal and to deliver fair and personalised services to patients and communities at all times.

Process of working with local interests

Genuine engagement lies at the heart of this Government's approach to public services. It is an imperative of the Equality Act. It is the focus of the DH / NHS PPEE initiative. How to do it properly has been addressed in recent DH publications including "Inclusion health" (DH, 2010) and "A dialogue of equals" (DH, 2009).

Within the NHS there is a great deal of good practice; but this practice can be patchy and inconsistent across time, locations and protected groups. As part of EDS support to the NHS, the SHAs are commissioning a comprehensive piece of work to identify good engagement practice with regard to patients, communities and staff, including how evidence may be shared in accessible ways with local interests.

There are a number of engagement approaches that NHS organisations and their local interests will wish to explore, before deciding on the model that best suits local circumstances. For example, organisations might empower and enable patient, community and staff groups to attempt the first analysis and grading of NHS performance. This work can then inform a discussion with the NHS, leading to agreement of the grades and which actions should be prioritised. Alternatively, organisations may plan for all local interests to meet with managers to analyse and grade performance. There will be a range of models to choose from. The important point is that local interests must be fully engaged and informed.

Foundation Trusts (FTs) are already an important part of the NHS, and the Government plans for all NHS providers to achieve FT status in due course. FTs operate with a degree of independence from central direction. They are all accountable to members drawn from local and wider communities. The best FTs have broad-based memberships that reflect the diversity of the populations they serve. Governors are drawn from this membership, that work with Boards to set and review direction and performance. FTs should include their local members and Governors in all aspects of EDS implementation. If membership is diverse and representative, it provides FTs with a ready means of securing patient, public and staff views and responding to challenges.

Engaging and supporting local interests

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

Any organisation that fails to engage with local interests in the analysis of its performance, subsequent grading and the setting of priorities, would automatically be graded as "Undeveloped" on each outcome.

Participating in public life can be expensive or difficult for local patients, communities and staff groups. Expensive in terms of time and possibly money. Difficult in terms of the practicalities of participating in meetings or discussions, especially for seldom-

heard groups; and difficult for those patients and members of the public who may not be used to talking to NHS administrators and clinicians on equal terms about matters of healthcare strategy or planning. So that these local interests can be enabled and empowered, support and/or financial assistance will need to be provided.

Local co-ordinating role

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

- Identify the local patient and community groups that should be engaged in the EDS, ensuring that marginalised and seldom-heard groups are not overlooked..
- Support these groups during the actual engagement process, ensuring that they are empowered and informed.
- Add their views to those of other local interests on the performance of the NHS.
- Relay the priorities and grades of individual organisations to Local Authority Overview and Scrutiny Committee, Health and Well Being Boards

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

Mainstream business

Equality Objectives and prioritised actions should be part of the business cycle of the organisation. Equality Objectives may be best set for a three to five year period, to match the cycle of Commissioning Strategic Plans. Prioritised actions may be reviewed annually, to link to the NHS Operating Framework and various other annual planning mechanisms. This review should include a re-assessment of the EDS outcomes.

While Equality Objectives and prioritised actions may be seen as discrete, organisations should resist publishing them as separate documents; rather they should be integrated into mainstream reports and publications. It should be made clear how achieving on Equality Objectives helps an organisation to deliver on its mainstream goals, including tackling health inequalities and reducing gaps..

NHS Commissioning Board

The NHS Commissioning Board, when it is established will be classified as a public body for Equality Act purposes. It may wish to set the national direction, tone and example for the EDS, by publishing its own Equality Objectives and prioritised actions.

From Equality Schemes to Equality Objectives

The process and content of the EDS map directly onto the general and public sector duties of the Equality Act. Hence, in responding positively to the EDS, organisations should respond more effectively to the requirements of the Equality Act.

During 2011/12, organisations should decide how best to migrate from equality schemes under previous equality legislation to the Equality Objectives of the Equality Act and the EDS. By April 2012, the migration should be completed. A good approach would be to review the action plans of current schemes using the EDS Objectives Menu and Outcomes, and narrow down the existing actions into a smaller set of critical priorities. In this way, organisations will remain compliant while moving from the old to the new equality duties.

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

A “route map” for migration is provided at Annex B. It has been developed by NHS South West.

Local disputes

Most NHS organisations already work well with local interests. For this reason, disputes about assessments against outcomes, and associated grades, and the selection of priority actions should be rare. Where disputes arise, every attempt should be made to resolve them locally. In this regard, organisations will remember that the NHS is all about patients and communities, and their experience of the NHS; it is not about how NHS leaders would like themselves and their services to be perceived. Where disagreements persist, they should be openly acknowledged, with the views of local interests taking precedence when it comes to the grades.

Working with local authorities

As set out in the White Paper, NHS organisations should work with local authorities in reviewing and improving their equality performance. Those local authority organisations that use the Improvement and Development Agency’s “Equality Framework for Local Government” will be good comparators and sources of inspiration, as the EDS (and EPIT) are designed with this Framework in mind, particularly the grading system. The Joint Strategic Needs Assessments, conducted across local authorities and the NHS, and related structures of engagement and evidence gathering will all help the EDS to be implemented, and function more effectively, than would otherwise be the case. NHS organisations will also wish to work closely with local authorities on EDS outcomes focused on health improvement and public health. This latter point is particularly important given the Government’s aim to migrate public health functions to local authorities as part of current NHS reforms.

An organisation would only be able to grade itself “Excelling” on any outcome, if it collaborated in peer reviews with another NHS organisation, and involved a local authority in thinking through its Equality Objectives and priority actions.

In the spirit of localisation, this EDS guidance is not prescriptive of how NHS organisations work with local authorities in ensuring the best use of JSNAs, the involvement of local authorities in helping NHS organisations to analyse and grade their performance, and the extent to which public health is included in the EDS. Rather, SHAs and PCT clusters should support organisations to find their own local solutions, taking the advice of local interests.

Local reporting process and consequences

Organisations’ own Boards or corporate leadership should play a full part in the drafting and finalising of Equality Objectives and priority actions. They should be clearly seen to own these documents and their content.

Organisations’ draft Equality Objectives and priority actions should, in the first instance, be reported to local interests including :

- LINKs / local Health Watch
- Members and Governors of Foundation Trusts
- Other established patient and community forums
- Local equality groups including Race Equality Councils or Equality Councils
- Local unions and other organised staff groups such as organisations’ staff networks.

These interests should be invited to comment, and their views should be taken into account. With regard to the Equality Objectives and priority actions for 2012/13, this engagement should take place before April 2012 so that the plans can be agreed and published by April 2012.

Once finalised, Equality Objectives and priority actions should be confirmed to the above interests, and formally reported to the Local Authority Overview and Scrutiny Committee and the Health and Well Being Board. LINKs and HealthWatch can facilitate this process.

National reporting

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

- The agreed Equality Objectives of providers’ will be reported to Health Watch England at CQC. Health Watch England will advise CQC of concerns so that these concerns can be taken into account in the Quality Risk Profiles for each organisation. Where there are concerns, the CQC will consider the most appropriate action, as it would do when in receipt of any potentially negative piece of information about a provider. The ultimate sanction for continued poor performance could be loss of registration. Concerns could centre on organisations with any “Undeveloped” grades and/or organisations that, over

DRAFT V2

The contents of this draft are liable to change

time, fail to achieve any “Achieving” or “Excelling” grades. [Drafting note : to be confirmed with CQC]

- In line with the role for the NHS Commissioning Board, the agreed Equality Objectives for commissioners will be reported to the NHS Commissioning Board for evaluation and management action.

Published results

All Equality Objectives, priority actions and grades should be published as stand-alone documents. As well as featuring prominently in these plans, each organisation should publish its grades in summary format against each EDS outcome at the same time.

The RAG ratings for all organisations should be published on the websites of the NHS Commissioning Board. Individual organisations should publish their results on their websites and in other accessible ways, and as part of routine reporting processes including Annual Reports for their local communities. They should do so in such a way that local interests can readily access the results and comment on them.

DRAFT

ANNEX A**EDS OUTCOMES AND CQC OUTCOMES FOR SERVICE USERS**

<i>EDS Outcomes</i>	<i>Outcomes for service users, from “Essential standards of quality and safety”</i>
1.1 Services and care pathways are commissioned or decommissioned, designed or re-designed, procured, provided and contractually monitored so that they meet the needs of patients, carers and local communities	1.1a People who use services experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights (<i>Regulation 4, Outcome 4</i>)
	1.1b People who use services are supported to have adequate nutrition and hydration (<i>Regulation 14, Outcome 5</i>)
	1.1c People who use services receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services (<i>Regulation 24, Outcome 6</i>)
	1.1d People who use services and people who work in or visit the premises benefit from equipment that is comfortable and meets their needs (<i>Regulation 16, Outcome 11</i>)
	1.1e People who use services can be confident that their personal records are accurate, fit for purpose, held securely and remain confidential (<i>Regulation 20, Outcome 11</i>)
1.3 Patient safety outcomes are demonstrating measurable increases across all equality target groups, with the active participation of staff and managers engaging with patient groups and involving local communities	1.3a Service users are protected against identifiable risks of acquiring such an infection (<i>Regulation 12, Outcome 8</i>)
	1.3b People who use services are protected from abuse, or the risk of abuse, and their human rights are respected and upheld (<i>Regulation 11, Outcome 7</i>)
	1.3c People who use services will have their medicines at the time they need them, and in a safe way (<i>Regulation 13, Outcome 9</i>)
	1.3d People who use services and people who work in or visit the premises are in safe, accessible surroundings that promote their wellbeing (<i>Regulation 15, Outcome 10</i>)
	1.3e People who use services and people who work in or visit the premises are not at risk of harm from unsafe or unstable equipment (medical and non-medical equipment, furnishings or fittings) (<i>Regulation 16, Outcome 11</i>)
	1.3f People who use services can be confident that records required to be kept to protect their safety and wellbeing are maintained and held securely where required (<i>Regulation 20, Outcome 21</i>)
2.2 Patients, carers and communities are provided with appropriate communications support and information about services, so that	2.2a People who use services understand the care, treatment and support choices available to them (<i>Regulation 17, Outcome 1</i>)
	2.2b People who use services where they are able give valid consent to the examination, care, treatment and support they receive; and understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed (<i>Regulation 18, Outcome 2</i>)
	2.2c People who use services, or others acting on their behalf, who pay the provider for the services they receive: know how much they

DRAFT V2

The contents of this draft are liable to change

EDS Outcomes	Outcomes for service users, from “Essential standards of quality and safety”
they can make informed choices and be assured of diagnoses and treatments tailored to their needs	are expected to pay, when and how; know what the service will provide for the fee paid; and understand their obligations and responsibilities (<i>Regulation 19, Outcome 3</i>) 2.2d People who use services wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf (<i>Regulation 13, Outcome 9</i>)
2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected, and the services they receive are safe, effective and personalised to their specific needs	2.3a People who use services can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support; have their privacy, dignity and independence respected; have their views and experiences taken into account in the way the service is provided and delivered (<i>Regulation 17, Outcome 1</i>) 2.3b People who use services can be confident that their human rights are respected and taken into account (<i>Regulation 18, Outcome 2</i>) 2.3c People who use services or others acting on their behalf: are sure that their comments and complaints are listened to and acted on effectively; know that they will not be discriminated against for making a complaint (<i>Regulation 19, Outcome 17</i>)
3.3 The workforce is confident, competent and feels empowered to deliver appropriate and accessible services, and improved patient experience for all communities	3.3a People who use services are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job (<i>Regulation 21, Outcome 12</i>) 3.3b People who use services are safe and their health and welfare needs are met by sufficient numbers of appropriate staff (<i>Regulation 22, Outcome 13</i>) 3.3c People who use services are safe and their health and welfare needs are met by competent staff (<i>Regulation 23, Outcome 14</i>) 3.3d People who use services have their needs met by the service because it is provided by an appropriate person (<i>Regulation 4, Outcome 22</i>)
4.1 Corporate leadership demonstrates the commitment and knowledge to assure equality outcomes within the organisation and the local health economy	4.1a The registered person recognises the diversity, values and human rights of people who use services (<i>Regulation 17, Outcome 1</i>) 4.1b People who use services benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety (<i>Regulation 10, Outcome 16</i>)
Note : there are no direct CQC outcomes for the following EDS outcomes : 1.2 “public health”; 2.1 “access”; 3.1 diverse workforce; 3.2 “healthy workforce”; 4.2 “supported equality champions”.	

Annex B : Equality Migration Roadmap for NHS Organisations

