Equality and Diversity Council: A review of its function, form and remit

Paper for the 30th January 2015 meeting of the EDC

Purpose

1. This paper summarises the findings of a review into the function, form, remit and membership of the Equality and Diversity Council (EDC). It outlines evidence collected from the review and offers suggestions on how the EDC can change to meet some of the challenges identified.

Executive Summary

2. There is a consensus that the purpose and work programme of EDC should be explicitly focused on promoting equality and diversity in the NHS. There should be recognition of shared interests with social care, but EDC is rightly concerned with the NHS and is not the place to attempt to "cover all bases". Likewise, EDC will deal with issues which can help address health inequalities, but this is not its core purpose. Membership is unwieldy - it could be reduced, for example by removing some of the NHS England members. Members with a nil or very low attendance could be replaced by others more able to attend. It is also suggested that the purpose for each person's membership should be clarified so it is clear in what capacity they attend and this be clearly stated in the Terms of Reference. The policy on substitutes attending, and their status, needs to be clear. The work of the Council must be informed by lived experience. There is a powerful case for involving patients or people with lived experiences as part of the work of the Council, through business planning and more directly through membership of the five subgroups, with attendance at the main EDC according to the issues under consideration.

3. EDC needs to develop a strategic overview across its remit so there is clarity about the key areas of focus and their relative priority. Using this overview, EDC should decide which issues would benefit from being driven nationally by the system leadership and which would benefit from a more localised approach with facilitative support from EDC. From this, an annual work plan should be produced setting out what the EDC plans to tackle in the year and what it plans to support local areas to do. It could consider planning its work in an annual business planning event that involves a much wider group of people, including those with lived experience. In line with other national bodies the EDC could also consider producing an annual report summarising what it has achieved. This would help communicate the Council's work out to the system, reinforce to the EDC its own purpose and added value, and help maintain the credibility and momentum of the Council.

4. Consideration should be given to sharing the secretariat role across the EDC partners, and the ToR amended to ensure NHS England is neither required to carry the burden nor left to dominate. Adoption of a co-Chair could help to demonstrate EDC's independence and collective leadership, and the agenda setting shared and papers co-produced by members of the council. The sub-groups' terms of reference should be revisited and if necessary refreshed by EDC, and their objectives set by EDC as an integral part of the annual business planning process. Membership of the sub-groups should be refreshed to ensure all EDC members can nominate attendees; they should

each devise a work plan to achieve the objectives set, enabling participants to join in (virtually if necessary) and all should have their progress discussed at EDC meetings in a way that is more meaningful than at present.

Background

5. The review was commissioned following a discussion at the EDC meeting on 30th October 2014. At that point, the refreshed council had been operating for a year and it was considered an opportune time to take stock of the work it was doing and how it was operating. All EDC members were approached to share their views and documents such as the Terms of Reference (ToR) and meeting papers were examined.

Why does the EDC exist?

6. The EDC was formed by DH in 2009 in response to the challenge that there was no senior system-wide forum to promote equality across the NHS. At that time, the EDC was a sub-committee of the NHS Management Board. In 2013 it was temporarily disbanded due to the health and social care reforms and refreshed in its current form, in November 2013 by NHS England, who sought a new membership and refreshed the Terms of Reference to extend the remit of the Council to include health inequalities, human rights and social care.

7. From discussions with EDC members, there is consensus that the EDC is important and should continue to exist, but there are conflicting views on what its specific role should be. Several members are unclear about the purpose, remit and added value of the Council and welcome this being restated within clearer and realistic ToR.

What is the EDC's remit?

8. The ToR state the EDC's purpose is to help "shape the future of health and social care from an equality, health inequalities and human rights perspective". Each of these components can be examined in turn, to see how well this remit is embedded into the work of the EDC:

9. **Equality:** The EDC has met five times so far and papers from the meeting show that three items have dominated the agenda: the development of the Workforce Race Equality Standard (WRES) borne out of a discussion in the May 2014 meeting on the 'Snowy White Peaks' report; the Statement of Declaration and the Equality Diversity System (EDS2). These all relate to equality and diversity and the WRES relates specifically to race, just one of the nine protected characteristics. A number of members voiced their frustration at the emphasis on race to the detriment of other elements and wanted a balanced perspective on all equality and diversity issues.

10. **Health Inequalities:** From the focus of the meetings and subgroups it is clear that health inequalities are not given the same level of attention as equality. This is backed up by discussions with members, some of whom were unaware that the EDC even had health inequalities or human rights within its remit. Some members felt any references to health inequalities were merely rhetoric and that often the words 'and health inequalities' were tagged to the end of a sentence as an afterthought. Naturally there are differences of opinion as to whether the EDC should genuinely expand its focus onto health

inequalities. A number of people were opposed to its inclusion as equality and diversity is a big enough agenda and they are concerned about losing focus. However, most people felt that it should be part of the Council's remit as there are strong links between the two agendas, but exercised caution that if the EDC was truly going to tackle health inequalities, there should be a realistic work plan.

11. **Social Care:** Although the wording in the ToR states the purpose of the EDC is to focus on health "and social care", there is a bias within the ToR towards the NHS with an emphasis on NHS organisations, the NHS Constitution and on what the healthcare system can do. The outputs of the subgroups and the EDC meetings show little relevance to social care and members advise there are limited references in the main EDC meeting discussions. NHS representatives dominate the membership of the Council with only one representative from ADASS and one from LGA as opposed to 32 from NHS organisations. Whether or not the EDC could meaningfully expand its focus on to social care was met with scepticism by some who felt this would dilute the purpose of the EDC and make it an unmanageable 'talking shop', that creating change within the NHS was already a big enough scope. Others referred to mechanisms that exist within the Local Government Association (LGA) and throughout social care to promote equality and diversity and that it is unclear what added value being part of the EDC can practically offer the sector.

12. Some also argue that the successes of the EDC such as the WRES and EDS2 were due to its ability to focus in a deliverable area: a chain of command to commissioners and providers exists within the NHS through national controls and system levers such as the Standard Contract and the Assurance Framework. The same leverage doesn't exist for social care and so a national group like the EDC can't practically influence and use leverage over social care in the same way it can over NHS. However, others disagreed with this assessment and feel the EDC could influence social care, if it rebalances the membership and changes the way it operates by focussing on what local areas can do, on facilitating and empowering local leaders, local councils, Health & Wellbeing Boards and supporting local commissioning plans and their Joint Strategic Needs Assessments. And of course, the current landscape advocates greater integration of care and working across organisational boundaries, so excluding social care from the EDC would signal a move against the current direction of travel.

Recommendations

A. EDC should agree whether its remit is just the NHS or whether it extends to be as equally relevant to social care. It is recommended that EDC retains a core focus just on the NHS but has a read-across to social care and engages with social care in relevant areas of work. Facilitating change within the NHS alone is a big challenge and social care already has existing mechanisms in place to help deliver improved equality. There will be areas where collaborative work makes sense and having social care representation on the EDC gives a sense check and read-across without conflating the agenda.

B. EDC should agree whether its remit is just equality and diversity or whether it should extend its remit to be equally as focussed on health inequalities. It is recommended that EDC has a primary focus on equality and diversity but retains an interest in

health inequalities as a secondary concern, consciously dedicating a smaller proportion of its time to this. Equality and diversity alone is a large agenda and has not yet received comprehensive coverage at the EDC, so it would be ambitious of the EDC to broaden its scope to health inequalities and realistically do justice to both.

C. Depending on whether the EDC decides to truly broaden its scope to social care and / or health inequalities, it should then consider changing the name of the council beyond that of equality and diversity to reflect its actual remit.

Membership

13. There are currently 44 members of the EDC. Key issues need to be addressed regarding the membership including the size, organisational balance, staff, lived experience and patient balance, the use of substitutes and the diversity of Council members.

14. Feedback from members is that the EDC meetings feel too big and that it is unclear what everyone's roles and responsibilities are, in what capacity people are attending and for what purpose. Whilst the ToR outline what is expected of members, they do not outline whether each EDC member is representing an organisation, a particular interest group, or because they have a particular skill set.

15. Currently 12 members (28% of the full EDC membership) are from NHS England. The ToR fail to explain the unique role of each individual member – they cannot all be there to represent the view of one organisation or communicate emerging themes back into one organisation. Many EDC members find the large contingent that attend perplexing, particularly the NHS England Regional Directors as no equivalents from other organisations are invited.

16. Whilst 32 EDC members are from health organisations, the representation from social care is very small – one Director of Adult Social Services (ADASS) and one LGA representative on the whole council, with a further 4 organisations having an interest in both. This imbalance both reflects and is a cause of the bias towards focussing on NHS matters above social care.

17. It is not known how diverse EDC membership is in terms of all nine protected characteristics and some members feel it should be a more representative group. However, most members accept that the reality is that the senior management of the NHS has limited diversity and that one of the roles of the EDC is to change this through initiatives such as WRES and that the group should retain a membership fit to deliver its function rather than recruiting people to fit an equality profile.

18. Several members feel the voice of the patient is not heard at EDC meetings. There are representatives from Healthwatch and the Patients Association who represent the interests of patients but even so, the EDC is regarded by many as too far removed from grass roots lived experience and the issues that it is trying to solve. Several members are keen to see one or more people with lived experience as EDC members as they think that it will get people engaged in the strategic work of the EDC and generate ideas from a patient perspective without regard to preconceived constraints. The NHS Values Summits were described as rich sources of individuals with lived experience who could be invited to join the EDC on either a permanent or rotational basis.

19. However, although most agreed on the importance of hearing the voice of the patient at meetings, there were consistent concerns raised such as whether it would be tokenistic. Questions repeatedly raised included: which people would be chosen, from which group? How would they contribute in a meaningful way? Would their experience be regarded as representative of a whole group? A small number of members were also anxious about whether their presence could inhibit debate and would lead to needing a second EDC to have the honest debate - but most people didn't recognise this as an issue. The main concern voiced was the lack of clarity on the role that a person with lived experience would play and that it could easily be regarded as tokenistic.

20. Similarly to patient representation, concerns have been raised about staff representation and whether this is adequate. At the moment, there are representatives from NHS Employers, the Leadership Academy and NHS Staff Council but no staff representation from social care or other Trade Unions.

21. Some concerns were also raised about attendance from core members and the number of deputies sent along to meetings. It is inevitable that on occasions, deputies will need to be sent due to diary commitments. However it can become a problem if deputies are unclear of their role as every meeting could result in a discussion about the remit and purpose of the EDC. Looking at attendance data most people have attended around 3 of the 5 meetings held to date, however 4 members have never attended a meeting.

Recommendations

D. The capacity in which members are part of the EDC and their unique purpose for being a member should be clearly outlined within the ToR.

E. Consider reducing the NHS England membership to bring more balance to the EDC.

F. If the remit of the EDC is to be extended to equally consider social care, the membership should be meaningfully rebalanced to reflect this.

G. The EDC should consider how best to ensure its work is informed by lived experience. For example, the Council could invite a person with lived experience to become a member of the Council, providing clarity of their role is clearly defined within the ToR, or adopt a more common approach such as starting each Council meeting with a patient story.

H. Staff representation should be reviewed, in particular whether other Trade Unions should be invited to attend to ensure that all relevant staff groups are represented.

I. When core members cannot attend, deputies should be briefed before attending in their place.

J. If members haven't attended any meetings then consideration should be given to whether the EDC would still benefit from their membership, whether they should be asked to nominate an alternative person or another person contacted directly to fill their space.

How does it function?

22. There is a tension amongst members with two opposing views of the EDC and how it should function.

23. The first view advocates a strategic Council that is a demonstration of national commitment, bringing together a powerful membership of system leaders from key organisations that can effect change. The group can use their collective power to bring about change, use system levers and controls to set standards and expectations. Its power lies in its membership and ability to make things happen.

24. The second view advocates a Council that operates as a facilitator and sharer for best practice. It doesn't focus on national transformational policy, use of centralised controls, system levers or ensuring compliance but instead empowers local areas to achieve the culture change needed. It recognises that Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards know what their problems are and supports them to achieve this through their own local joint commissioning.

25. All members recognise the work on WRES, Statement of Declaration and EDS2 are positive and that these were achieved by the Council operating as per the first view of the Council as a strategic group using their collective power to change things. However, whilst they are generally considered to be successes that the Council can build on, a number of members questioned whether these achievements have actually made a difference to patients, service users and staff. For example, can staff within each organisation that signed up to the Statement of Declaration see any change following its publication? There is a will amongst many members to refocus the meetings away from the available levers and processes and instead look at real issues, making meetings topic or thematic based. There are concerns that the EDC looks towards processes, such as EDS2 to resolve problems and fails to have a reality check as to if these processes are actually having an impact.

26. A number of members cited the meeting in May 2014 where the 'Snowy White Peaks' report was discussed, as the best meeting so far because a problem was presented, leading to a focussed discussion and practical, agreed outputs (even though many still regard the outputs as too centralised).

27. It is not clear how things are added on to the agenda and there isn't a work plan for the EDC. Overall, the EDC meetings can lack focus and the outputs aren't always clear. Minutes and actions from the most recent two meetings appear to show the same issues being discussed (WRES), all previously agreed actions are 'ongoing' and there is little sense of the most recent meeting yielding any outputs other than agreement to review the remit and purpose EDC. Frustration is evident amongst members where meetings seemingly lack outputs and things could have been done via email; several people felt the meetings are often more akin to a 'talking shop' and that there is a lack of positive action. The overall feel of the EDC has been described as a bringing together of lots of vested interests and people sitting around the table, talking about their particular interest and contributing their own little bits rather than a cohesive, corporate style council that is ready to co-produce.

<u>Recommendations</u>

K. It would be beneficial for EDC to develop a system-wide overview across its remit, understand what the key focus areas are and create a hierarchy in terms of need. For example, across health inequalities, is the biggest concern Black and Ethnic

Minority patients and mental health, or is it clinical diagnosis amongst people with learning disabilities? It should be able to map which issues are being addressed through existing initiatives and programmes (for example the Winterbourne View Concordat) and identify gaps that need action.

L. Using this overview, EDC could decide which issues would benefit from being driven nationally and which would suit a more localised approach with facilitative support. This combined approach realises the benefit of the EDC as system leaders who can make things happen at a national level whilst also acknowledging that some things should be resolved locally.

M. Using this analysis, the EDC needs to develop a strategic overview across its remit so there is clarity about the key areas of focus and their relative priority. EDC should produce an annual work plan setting out what it plans to tackle in the year and what it plans to support local areas to do. For example, with equality and diversity, evidence might show that it is not necessary for all nine of the protected characteristics to form part of a workplan this year. The EDC needs to formally acknowledge which areas it is going to focus on, which it is not and have a clear rationale for this.

N. The EDC could devise its workplan at an annual business planning event, involving a much wider group, including people with lived experience - perhaps as a peoples' council. This would help to ground the work of the EDC in reality, communicate the Council's work and generate a richness of ideas from patient, staff and service user perspectives.

O. In line with other national bodies the EDC could also consider producing an annual report summarising what it has achieved. This would help communicate the Council's work out to the system, reinforce to the EDC its own purpose and added value and help the momentum of the Council and its work.

Subgroups

28. There are five subgroups covering the same workstreams as the previous EDC did. Overall, although members feel the subgroups are focussing on the right areas, there is a lot of criticism about them and there appears to be some disconnect between the EDC meetings which are very senior and strategic and the subgroups which are more inclusive in membership and more granular in focus.

29. Some members feel there is overlap between subgroups (such as the system alignment subgroup and the EDS2 subgroup); the terms of reference are unclear; it is not known whether they are task and finish groups or ongoing, what their work programmes are and how these are decided; that they appear to lack momentum; whether they overlap with existing groups across the system; how attendance is decided as it can feel exclusive; that they are dominated by a cohort of enthusiastic people with a particular sphere of interest and that they are difficult to attend because they are most often physically located in London.

30. Some of this criticism is perhaps inevitable given the work of the subgroups is not discussed in depth at the EDC meetings, despite them being the five areas of work that are apparently important for the Council to focus on to deliver change. Although a summary of their work is shared as part of the papers circulated in advance of the

meeting, some members feel unable to ask about the subgroups and their perceived lack of progress as they are dealt with 'for information' only and given scant attention.

Recommendations

P. Each subgroup should have clear terms of reference that are agreed by the EDC, making it clear whether they are each 'task and finish' groups or ongoing.

Q. Each subgroup should be given clear objectives by the EDC that link to the overall objectives and work plan of the EDC. They should use these to develop their own work plans, which will be signed off by EDC. This will ensure the subgroups are focussed, are supporting the overall work of the EDC and duplication of effort between subgroups is prevented.

R. Membership of each subgroup should be reviewed and agreed by the EDC to ensure all EDC members are able to nominate people to join. This will remove the feeling of exclusivity that some members have towards the subgroups and the perception that they are being driven by a narrow cohort of people.

S. Subgroups should all enable people to join in with the meetings virtually, to increase attendance.

T. Progress against each subgroup's objectives should be discussed at the main EDC meetings so the full EDC can give them direction, note progress and help tackle problems. This should both help to maintain the momentum of the subgroups and give the EDC an overview and level of ownership of their work.

Governance

31. The governance of the Council is outlined in the ToR as a Partnership Forum that doesn't report into another structure or organisation but instead, works through its own organisations. However, the ToR are dominated by NHS England – currently it is the only named organisation and appears six times, which has led some members to conclude that the Council is not an independent, equal partnership.

32. The original intention, agreed at its meeting on 20th November 2013 was to have a shared secretariat across the EDC membership but this has not happened and NHS England fulfils this role alone - both for the quarterly meetings and all the subgroups which is a significant administrative burden. For the full EDC meetings NHS England sets the agendas, supplies the papers and Chairs the meetings. Whilst many people are pleased NHS England does this and thinks the involvement of the Chair in particular sets a strong signal of intent, many members feel that NHS England is too dominant. It is felt that consultation on agenda setting does not routinely take place and NHS England appear to provide papers for comment at meetings rather than allowing the council to demonstrate genuine co-production.

33. The EDC relies on its membership to individually use their influence to communicate out to the rest of the system the work of the EDC and bring views of their organisations and networks back into the EDC. From discussions with members, it is unclear whether all members share the same view on this responsibility. At a previous EDC the possibility of webstreaming was raised as a solution for engaging with the public and demonstrating the EDCs independence but it is unclear who the audience would be for this; it is also

not a substitute for members communicating across their own organisations and networks and is not an effective mechanism for publicising the work of the Council. An annual workplan, a workplanning event, an annual report and more clarity over the role of individuals at the EDC as already outlined in previous recommendations should help to address these concerns.

34. Questions were also raised by individuals about a public consultation on any changes to the Council's form, function and remit. As the work of the Council is not communicated out to the system and public as well as it could be, the audience for this consultation is unclear, similar to the webstreaming suggestion. And at the moment, there is also a lack of tangible components that the Council could consult on: for it to be meaningful, the EDC membership would probably need to define its purpose and propose workplan options so it has something to seek an opinion on.

Recommendations

U. The ToR should be amended to minimise the references to NHS England, to reinforce the independence of the Council.

V. The EDC should consider appointing a co-chair to the EDC, to help demonstrate independence and collective leadership, whilst also retaining what they feel is a powerful chair in the Chief Executive of NHS England.

W. The EDC should consider resourcing a shared secretariat to ensure NHS England is neither required to carry the burden nor left to dominate.

X. Although the co-produced work plan should set the bulk of the agenda, the secretariat should canvas for agenda items in advance of each meeting and the Chair(s) agree the final agenda to ensure it is manageable and consistent.