EDC1 10/14

Equality and Diversity Council Meeting Paper

30th October 2014

Discussion: whether to mandate a Workforce Race Equality Standard and EDS2 in 2015/16 national Standard Contract

Introduction

1. At its 29 July meeting, EDC requested further work to consider the proposal to mandate a Workforce Race Equality Standard (WRES) and EDS2 in the Standard Contract for 2015/16 (see Annex 1 for agreed actions from that meeting). This paper sets out the findings from a series of engagement events, surveys and data analysis. Based on these findings, the paper outlines pros and cons of mandating WRES and/or EDS2, and proposes a way forward, including risks and mitigations, as well as suggested handling/project management.

Recommendations

2. There is widespread support for the introduction of a WRES and for promoting consistent implementation of EDS2, through inclusion of both in the Standard Contract. However the issues raised are different. Therefore:

   - ***EDC should agree*** *the proposal to introduce a Workforce Race Equality Standard across the NHS with effect from April 2015.*

     - An Advisory Group should be established to support and guide the WRES work and ensure regular reports are provided to the EDC.

     - Support to the WRES project would include strategic input from the Workforce & Leadership sub-group ensuring alignment with the EDC's wider workforce and leadership work programme.

     - Core resourcing of the WRES project is to be supplemented with additional staffing and financial resources from partner bodies.

     - Similar expectations (for a transparent standard) could in due course be placed on commissioners (CCGs and NHS England) and other relevant national bodies.

   - ***EDC could agree*** *the proposal to require the implementation of EDS2 across the NHS with effect from April 2015.*

     - This would require further work to be commissioned with immediate effect by the EDS2 sub-group of the EDC to develop and provide assurance on a consistent methodology for benchmarking, grading and EDS2 assurance.

- Given the variability in current utilization of EDS2, it may be prudent to require implementation from April 2016.

Background

3. At the 29 July meeting, Council members discussed the recommendations of a working group which had examined the issues in a dedicated session in June. EDC agreed the proposal to develop and implement a WRES across the NHS, committing to develop the proposal and consult on inserting a relevant clause in the 2015/16 Standard Contract.

4. There was general agreement that:

   - the focus of this Standard on race did not preclude a focus on other groups in due course and preliminary discussions on scoping this have begun;
   - robust project management was needed for this work;
   - Board and senior level representation needs a strong focus; and
   - there should also be engagement on mandating EDS2 within the 2015/16 NHS Standard Contract.

5. The proposal included an outline work plan, which set out the initial steps required to develop the Standard. This included system-wide consultation and engagement on the Standard, its performance indicators and the proposed improvement process, including regulation and other levers.

6. EDC agreed that an Equality Analysis of the proposed Standard should be circulated to EDC members for their input and consideration by 5 September. The draft Equality Analysis was circulated to EDC members in August and will continue to be iterated in the light of further comments as the approach develops.

Consultation on the NHS Standard Contract 2015/16

7. A discussion document, outlining proposed changes to the 2015/16 standard contract, was shared for engagement from early August until mid-September. Question 14 of the discussion document asked whether a WRES and EDS2 should be embedded within the NHS Standard Contract. A total of 184 organisations submitted responses to question 14 (Summary to be found in Annex 2).

8. A clear majority[1] of respondents favoured mandating the WRES as well as requiring the implementation of EDS2. A minority of respondents expressed the view that the WRES should be incorporated within EDS2 and a minority favoured mandating either the WRES or EDS2 in isolation, however the overall preference was that the WRES and EDS2 should retain their distinct identity but be linked and complementary to each other.

9. A range of additional comments were made which underlined these different views and put forward further supporting rationale. Some respondents highlighted areas where more information would be helpful regarding certain elements of the proposal, including applicability, exemption and scope. These comments have been addressed via the development of an August FAQ document[2]. In response to suggestions and comments regarding the specifics of the proposed seven indicators, further refinement work has been undertaken and a working group established to finalise the indicators in early November. This will be essential if the WRES is to be mandated – it would not be credible to publish the clause in the final contract (probably early December) if the standard itself is not sufficiently developed.

Staff Survey on the proposed Workforce Race Equality Standard

10. The NHS Black and Minority Ethnic (BME) Network published its response to the proposed WRES in September 2014 and submitted its organisational response to the Consultation on the NHS Standard Contract 2015/16.

11. 238 members responded to the survey, with 216 members completing comprehensive questionnaires on the proposed Standard. The members' responses to the Network's survey are outlined in its published report[3] and summarised in Annex 2.

12. The network chair, Dr Vivienne Lyfar-Cisse, summarised members' responses to the proposed Workforce Race Equality Standard in her foreword to the report, concluding;

    "It is evident from the responses that members believe that NHS Trusts should be required to collect substantive race equality data and demonstrate by evidence that they have a process in place to address any deficiencies identified in order to comply with the standard. The vast majority of members also believe that the race equality standard should be separate from the Equality Delivery System 2".

13. The network also called for NHS Trusts that consistently fail to deliver on this important agenda to be subjected to harsh penalties, including financial sanctions.

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[1] Excluding nil responses

[2] http://www.leadershipacademy.nhs.uk/about/our-work-and-its-impact-on-the-nhs/the-nhs-workforce-race-equality-standard-faqs

[3] http://www.nhsbmenetwork.org.uk/wpcontent/uploads/NHSBMENetworkSurveyReportSept2014-Race-Equality-Standard.pdf

Engagement events

14. Four regional engagement events and a national webinar have taken place during October. The purpose of the events was to seek views on the details of the proposal from Equality and Diversity leads, HR colleagues and system leaders.

15. The events responded to feedback from the contract discussion document, and focused on the WRES, its performance indicators and the proposed improvement process, including regulation and other levers. The events provided an opportunity for participants to explore what the relationship between the WRES and EDS2 might be, and for detailed discussion about how the proposal to mandate EDS2 would be implemented. A range of additional engagement activity, meetings and discussions has taken place through existing networks. Presentations have also been made on the proposed WRES and EDS2 to system leaders and key stakeholders.

16. A very large majority of attendees at the events supported the proposed NHS Standard Contract requirement to adopt the WRES and to require implementation of EDS2. Prominent themes which emerged are listed in Annex 3 and a summary of feedback will be made available on the EDC website[4]. Some had concerns about the timing of implementation, in particular because of the variability in uptake and consistency of approach to EDS2 at present.

Options appraisal

17. The table below sets out the primary options available with regard to mandating the WRES and/or EDS2 and doing so either with immediate effect or deferring mandation until 2016/17. Considerations regarding the potential pros and cons of each option are also outlined.

Option	Pros	Cons
1. *Mandate WRES with immediate effect via 2015/16 NHS Standard Contract*	▪ Maintains and accelerates momentum behind introduction and development of Standard Contract. ▪ Facilitates start of dialogue with BME staff, wider workforce and managers to build evidence-based programme of action.	▪ Risk of slow start up as Standard Contract does not yet have system-wide traction. ▪ May not provide time to build social movement from outset. ▪ May limit time to refine narrative building case for WRES and tailor messages for specific audiences.

[4] http://www.england.nhs.uk/ourwork/gov/edc/

	▪ Allows organisations to assemble relevant data in 2015/16 for reporting to Boards and regulators at year end. ▪ Consistent with Kline Report research re necessity for immediate action to effect change for BME NHS staff.	▪ Potential for reduced time for preparation of implementation across key organisations.
2. *Defer mandating WRES until 2016/17*	▪ Allows time for additional research to refine programme of action and narrative building case for WRES. ▪ Provides time to build social movement and mobilise more support amongst key players across the system, ensuring centrality of BME staff. ▪ Enables organisations to use 2015/16 as a shadow year to prepare for implementation.	▪ Year one is already framed as a development year with incorporation into "well led" domain by regulators not until 2016. ▪ Risks very significant loss of momentum behind introduction and development of Standard. ▪ Delay may mean existing gap in BME staff experience, treatment and promotion widens before implementation. ▪ Likely to foster significant disaffection amongst BME staff around perceived lack of priority and what this symbolises. ▪ Failure to fully communicate wider plan may cause BME staff to become demoralized that their feedback was not heard.
3. *Mandate EDS2 implementation with immediate effect via NHS Standard Contract*	▪ Ensures implementation is not significantly after mandating complementary WRES programme of action. ▪ May help to prove that focus is distributed evenly across all equality strands.	▪ Likely lack of consistency in reporting across organisations (given significant current variance in implementation and grading of EDS2) – this may in turn invite suggestions of EDS2 giving false assurance.

	▪ Guarantees that traction and coverage for EDS2 not lost through being overshadowed by WRES agenda.	
4. *Defer mandating EDS2 implementation until 2016/17*	▪ Provides time to ensure consistency in implementation and grading of EDS2 across organisations. ▪ Enables organisations to use 2015/16 as a year to prepare for comprehensive implementation.	▪ Potential for organisations to deprioritise EDS2 as a tool to promote equality across all protected groups due to implementation delay. ▪ May risk the perception of focus emerging disproportionately on one equality strand. ▪ If WRES mandated before EDS2, risk that energy diverted from the wider equality agenda, with EDS2 losing traction and coverage across the system.

Risks

18. In our various discussions and analysis we identified various risks, two of which were reported to be quite probable and could have significant impact. These two are set out below alongside the principal mitigations:

    a) *Risk that, with WRES, we are introducing a single focus standard which could be to the detriment of other protected groups and could also be challenged under the Equality Act.*

        - We have obtained legal advice which reassures us that the proposed WRES is an appropriate and proportionate way in which to address clearly evidenced issues relating to NHS BME staff outcomes, and is generally compliant with the Equality Act 2010.

        - The legal advice also recommend that the WRES is introduced as the first step in a larger equalities programme, over time, and that this would mitigate concerns by other groups with protected characteristics (particularly disabilities, sexual orientation and gender) that the focus on race will not side-line their needs. Our accompanying narrative would need to explain this.

- The legal advice highlighted that the proposed metric which deals with shortlisting as potentially be thought prejudicial – we may need to reconsider whether this component of the standard is essential if it is confirmed that this would be susceptible to legal challenge.

b) *Risk that, in EDS, we are mandating something that has significant variability in implementation and is currently not nationally benchmarked for grades or outcomes.*

- The EDC noted at its last meeting that the revised EDS is still bedding in and will evolve over time, although it appears that it is being implemented by a majority of organisations across the country.

- We commissioned a rapid analytical review of the correlation between organisations' self-assessments under EDS and their objective performance using other publicly available measures. The analytical review does not offer a categorical judgment for or against the implementation of EDS but notes that the lack of consistent use of EDS by most organisations could make it vulnerable on assurance. We are also concerned about false comfort drawn from apparently "green rated" EDS returns. (Annex 4).

- The most obvious mitigation would be to delay the mandation of EDS by a year until April 2016 to allow more time for organisations to improve their understanding and address variability in reporting. However there is a widely held counter-view that implementation of EDS must be mandated alongside WRES to help address the misperception in risk a) above, i.e. that our approach is overly focused on race to the detriment of other protected characteristics. In this context, it would be preferable to mandate EDS and then address variation through implementation, rather than try to make it perfect first.

Project plan and handling

19. Key actions and milestones have been identified in order to ensure an immediate and swift start to the implementation. This builds on preparatory work already undertaken. (Annex 5).

Next steps

20. In order to reserve EDC's position, the draft standard contract currently includes clauses mandating both WRES and EDS2. These clauses could be withdrawn before the contract is finalised. The current timetable assumes a short (e.g. 2-3 week) consultation on the standard contract during November and publication of the final contract potentially in early December.

21. EDC is invited to advise on its preferred approach in the light of this paper.

Annex 1

Progress on actions required by the EDC at 29 July meeting

Action	Progress	Status
1. Consultation and engagement on the Standard and mandating EDS 2	Four Regional events and one national webinar held. Presentations given and meetings held with various stakeholder organisations and partnerships including community and voluntary sector, unions and professional bodies. Presentation on the Standard at the Social Partnership Forum scheduled in November. 'Social Movement' approach to commence immediately after the October EDC meeting with credible Ambassadors engaging with organisations and staff, ensuring BME staff leadership of the agenda.	Ongoing
2. Include a relevant clause in the 2015/16 standard contract.	Draft final contract includes clauses mandating both WRES and EDS2. Agreement with NHS England Contract team that these clauses could be withdrawn or amended if required before the contract is finalized.	Ongoing.
3. Collate and circulate Equality Analysis of the proposed Standard	Circulated in August to EDC members for input and comment. Will continue to update as the project develops.	Ongoing
4. Communications: Development of a 'call to action' , a core narrative for the Standard, and collection of best practice exemplars and other materials	Press release on Standard issued after EDC meeting in July. Handling plan agreed for communicating decision of EDC immediately after the October meeting. Senior system leaders have publically pledged support for the Standard, including Simon Stevens, Jane Cummings, David Behan. Presentational material developed and utilised to profile the proposed WRES and the mandation of EDS2 at conferences, with stakeholder organisations and networks. WRES webpage design and content agreed.	Ongoing

	Discussions held with main employer organisations (Confed, NHS Employers) the Leadership Academy, RCN and MiP, especially on best practice approaches. Case studies for the Standard (BME diversity, intersectionality and potential benefits for other protected characteristics) and the EDS2 requested. Going live on EDC webpage at the end of October.	
5. Develop plan to resource the WRES project	Discussions held with partners and a number of 'in principle' agreements to secondments, financial input and staff resources secured.	Ongoing
6. NHS regulators to include compliance with the standard as part of their consideration of whether an organisation is "well led".	Care Quality Commission (CQC), Monitor, Trust Development Authority (TDA) are already discussing a consistent agreed approach to "well led" and this proposal has been fed into these discussions and well received. Meetings held with regulators to discuss improvement process, regulation and other levers. Follow on meeting planned for early November. Discussions held with CCG and Commissioning Support Unit stakeholders and meetings planned in early November to discuss and refine role of commissioners including NHS England.	Ongoing
7. Refinement of the Standard and its indicators	Expert reference group to meet early November to refine indicators in light of technical and consultation feedback.	Ongoing
8. Additional research	Literature review commissioned from Kings Fund/ Michael West on 'Making Diversity at Work Work' and research to identify the characteristics of organisations that have better performance with relation to BME treatment and senior representation and have a robust and systematic approach to managing and improving staff diversity and inclusion. EDC experts identified to support additional research and work on race, sexual orientation, disability and gender. Agreed data transfer and potential to repeat Clinical Commissioning Group (CCG) national survey on BME/gender representation in leadership.	Ongoing

Annex 2

What the consultation responses told us

A majority[5] of respondents to the consultation responded positively to the proposed inclusion of the WRES in the NHS Standard Contract for 2015/16.		
58	**(46%) positive responses**	for the inclusion of a WRES in the 2015/16 Contract (responses were from: providers= 34, commissioners= 21, 'other'= 4)
26	**(21%) negative responses**	for a WRES not to be included in the 2015/16 Contract (responses were from: providers= 12, commissioners= 10, 'other'= 4). 33% provided no response either way.
207	**(95.8%) positive responses from the NHS BME staff network**	for the WRES to be analysed as part of organisation's statement of internal control and to be included in the 'Well Led Domain' section of the CQC inspection regime; (the network submitted a collated response to the consultation drawn from questionnaire returns from 216 members).
A majority of respondents to the consultation responded positively to the proposed inclusion of EDS2 in the NHS Standard Contract for 2015/16.		
77	**(61%) positive responses**	For the inclusion of EDS2 in the 2015/16 standard contract (responses were from: providers= 44, commissioners= 24, 'other'= 10).
7	**(5%) negative responses**	For the inclusion of EDS2 in the 2015/16 standard contract (responses were from: providers= 4, commissioners= 2, 'other'= 1) 34% provided no response to this question.
A majority of respondents to the consultation thought that the WRES and EDS2 should be linked and complementary to each other.		
14	**(6.4%) responses**	for the WRES to be 'included within' EDS2.
57	**(26.4%) responses**	**from the NHS BME staff network** for the WRES to be 'included within' EDS2.
42	**(65.7%) responses**	**from the NHS BME staff network** responses for the WRES to be separate from EDS2.

[5] Excluding nil responses

Six responses wanted a more inclusive approach to workforce equality. Five responses indicated that further detail was needed in order to make an informed decision on the WRES. Fifty four responses included 'no comment', 'nil' or 'n/a'. One response was jointly submitted by a provider and its three commissioners.

General Comments

Overall there is a positive response for mandating both the WRES and EDS2. Below are a selection of insights taken from additional comments made by respondents to question 14.

- The need for more information upon the proposals for a WRES and for details of the Equality Delivery System to be made available.
- The need for clarity to be established on the relationship between the WRES and EDS2.
- The need for robust narrative around the WRES to underline that it is not to the detriment of other equality groups and that the learning from the WRES can be systematically applied across the protected characteristics.
    - Concerns over duplication and confusion with the Public Sector Equality Duties (PSED).
    - The metrics should be transferable for use in the PSED and across protected groups.
    - A need to focus on data collection – what are we collecting? Will there be consistency across the system?
    - Which categories will be used and how do we capture what's not there. The data needs to have robust methodology behind it. Health and Social Care Information Centre (HSCIC) have offered support and would be key advisors.
    - The data for medical staff should be separated.
- Clear guidance on implementation is required which a takes into account the size of the CCG/ provider, its population, geography – i.e. proportionality.
    - What will the monitoring, follow-up, action plans and reporting look like?
    - Alternative ways of reporting – an annual equality report
- Need to share the consultation process and who consulted with regulators – transparency. Include the official full consultation response
    - Incentives and enablers are required for providers – CQUINS.
    - Promotion of the Standard requires sensitive handling.

- CCGs and providers should do it.
- A long phase-in is required.

- VCF already collect data and are heavily monitored by funding streams – proportionality and assurance

- Consider benchmarking and the flexibility of EDS. There is a tension between keeping EDS flexible and requiring metrics to ensure standardisation, governance and therefore assurance.

- Guidance needed to create consistency in EDS implementation. Methodology and benchmarking required.
    - Differences of opinion on the Standard being part of EDS or not.
    - Standard takes attention from other groups so EDS mitigates risk.
    - Not applicable to Pharmacy and independent sector – due to small businesses and alternative measures in place.
    - Learn lessons from the WRES.
    - We needed more time to consult.

Annex 3

Selected themes from engagement events

Event	WRES	EDS2	Prominent feedback themes
London, 14/10/14	✔	✔	1. Support for WRES and EDS mandation but need to ensure singular focus on race does not detract from issues faced by other protected groups in the workplace. 2. Necessity for further clarity on who WRES and EDS2 should apply to (e.g. primary care, non-NHS providers) and for clarity on monitoring and assurance responsibilities for CCGS and Area Teams. CSUs can be working with 12 CCGs, each with a very different approach to EDS2 implementation. How can EDS2 implementation be benchmarked. 3. Scale and size of EDS is a challenge, with lack of budget to pay volunteers involved in grading process and who require education about its rationale to ensure objective participation. 4. There is a need for Boards to fully understand the data and the metrics by talking to BME staff about their experiences as there can frequently be incidents of under-reporting of treatment issues. Consider how best to engage with BME staff to ensure the initiative is a success and remember that people often have more the one protected characteristic. Multiple facets of discrimination and compounded discrimination must not be overlooked. 5. CCGs must also apply the Standard and win hearts and minds, looking at what is behind the metrics and ensuring there are clear consequences if the metrics gap isn't narrowed and there isn't an concerted effort to change organisational culture. 6. Education and development initiatives helps but need to mandate WRES to force change and consider what can be learned from other successful initiatives e.g. women on

			boards, looking at both public and private sector successes and promote the WRES from a values base. Need status and prestige to accrue when an organisation makes progress with the WRES.
Birmingham, 15/10/14	✔	✔	1. The WRES is needed to help organisations focus specifically upon workforce race equality, going beyond data collection. It's needs to be outcomes focused with clarity upon what differences we are looking for from the application of the WRES. It would be useful if we were able to benchmark race equality progress between organisations and area and close alignment with EDS2 is also positive. 2. Both WRES and EDS should be embedded across the organization, with clear mandate on enforcement for action on implementation; ensure evidence base for action and progress in tackling race equality to go beyond information gathering exercise 3. WRES must assess full recruitment pathway, from advertisement to appointment, including where and how jobs are advertised? Where are the “drop-offs” all the way through? Need to draw upon good practice; for example the NHS graduates scheme does excellent analysis on diversity. 4. Whilst there is variation in EDS implementation because of differences between organisations, this is similar to the equality framework for local government; need to strengthen emphasis of use of EDS2 as an organisational journey. 5. EDS needs to have stronger benchmarking in place to ensure that the outcomes can be benchmarked on progress. 6. Request for practical implementation e.g. leadership development and positive action programmes and the ability to use the law to lever change. This good practice will be added to the Guidance as we go along (leadership development, and positive actions). The guidance will add lessons as

			go along and needs to be clear.
Exeter, 20/10/14	✔	✔	1. Can the WRES be part of a wider ‘Equality Standard’, so that we start with race in the first instance, and demonstrate commitment to other protected characteristics? 2. It was felt that mandating EDS in the contract would be a very positive move as it would help ensure leadership focus of the work. 3. The Electronic Staff Record (ESR) system needs to be fit for purpose to support the WRES. 4. Potential for implementation to the detriment of other protected groups needs to be noted– work needed to improve disclosure rates and experience of e.g. disability and protected sexual orientation staff groups. 5. Low percentage of BME population in SW region makes it important to also have a differentiated approach to reflect and proportionately respond to local demographics (inc. high proportion of Cornish ethnicity). 6. EDS2 has good traction across NHS and at Board level in organisation but requires ownership from the whole organization and more guidance on evidence for, and prescription of, outcomes.
National Webinar, 21/10/14	✔	✔	1. Should the WRES be made mandatory in the 2015/16 Contract? 62% said yes. 2. Are these the right metrics? 57% said yes. 3. Should EDS2 be made mandatory in the 2015/16 contract? 67% said yes. 4. The term ‘BME’ needs to be defined – does it for example include gypsies and travellers and Eastern Europeans, or is it only visible BME groups? 5. How will variations in local population be

			incorporated into the standard – for example in Kent gypsies and travellers are the largest minority group. 6. Good data systems need to be put in place to support Trusts with implementation of the standard and refinements made to ESR.

Annex 4

Analytical review of EDS grades – report

Equality Grading System Summary Analysis

A. Task Overview

Analysts to provide an independent view of whether EDS self-assessment scores are supported by published evidence.

- Specifically to provide a rapid assessment by focusing on a couple of specific areas of the self-assessment
  - By reviewing the evidence provided in the self-assessment on protected characteristics
  - Making comparisons to national data sources where these provide additional evidence (triangulation).

A.1. Specific Ask

To select a sample of NHS provider organisations that are using the EDS from internet search and obtain their EDS grades. To cover a range of organisations across regions.

To compare grades for EDS Outcomes against indicators that would shed some light on the validity of those grades. EDS Outcomes such as:

1. EDS Outcome 2.3: People report positive experiences of the NHS
2. EDS Outcome 3.4: Staff are free from abuse, bullying and harassment from any source

This may be from results of related questions from National Surveys for the organisation in question, and/or the evidence that the organisation cites on their website as having used to derive the grade.

A.2. Feasibility

A.2.a) Patient Experience and Staff Surveys

There is no readily accessible central information at an individual organisation (provider or commissioner) level, from either patient or staff surveys, disaggregated by protected characteristics, for the specific questions on the patient and staff experience surveys

- Individual organisations commission the surveys and own the underlying data – they are able to analyse the survey responses by protected characteristics.
- At a National level survey results are disaggregated by protected characteristics

It has not therefore been possible to systematically compare the local survey results with local self –assessment.

A.3. Context

EDS scores are self-assessed and a range of evidence is included in the grading process. This rapid review does not seek to review all the evidence, but focuses on evidence:

1. published by organisations and compared to national survey results on specific EDS questions

2. of whether organisations demonstrate an understanding of how to assess whether groups with protected characteristics report different experiences to the general population

These factors are components of those that contribute towards the final grades.

A.4. Methodology

Methodology for this study is presented in the more detailed report.

From EDS, two out of the eighteen outcomes were selected based on the possible indicators that are available to the Analytical Service team, namely:

- EDS Outcome 2.3: People report positive experiences of the NHS
- EDS Outcome 3.4: Staff is free from abuse, bullying and harassment from any source

One approach was used to make comparisons to the self-assessed score for outcome 2.3, two approaches were used for outcome 3.4

A.4.a) Approach 1 for both outcomes 2.3 and 3.4

A review of organisations self-assessment was made using the following

a) Is there evidence that organisations have analysed survey data by protected characteristic groups?
b) How outcomes for protected characteristic groups were when comparing to whole survey population
c) Is there a plan of action for protected characteristic groups with inequalities?

A.4.b) Approach 2 for question 3.4

From NHS staff national survey, data was collated for each one of the 15 organisations (excluding CCGs, where no data is available) on two questions directly related to outcome 3.4 and a comparison made with the national average for the same questions. For six protected characteristics, variations of more than 10% from the national average were highlighted. These were cross checked against protected characteristics mentioned by the organisations on their self-assessment.

B. Results

B.1. Organisations Reviewed for EDS grading

The sample (n=19 organisations) reviewed, included one organisation per type healthcare service[6] and per region, where EDS assessments were available publicly.

B.2. Headline Results – Approach 1

Based on the limited sample of 19 organisations, there were significant differences between organisations self-assessments scores and the independent assessment made, by NHS England analysts. (Note: these assessments were based purely on specific aspects of the evidence provided by organisations in their self-assessments and do not take into account the wider factors that it is intended that organisations use to make their self-assessments.)

Where there were differences in an organisation's self-assessment and assessments made by the analysts in all cases except one, the self-assessment score was higher than the analytical assessment.

Assessment of each organisation's results were based on a judgement of the evidence presented on the following questions:

a. Is there evidence that organisations have analysed survey data by protected characteristic groups?
b. How outcomes for protected characteristic groups were when comparing to whole survey population.
c. Is there a plan of action for to address inequalities in protected characteristic groups?

Self-assessment results for the sample of 19 organisations were in the middle range i.e. mostly developing or achieving, rather than under-developed or excelling. Despite this, the analytical assessment based on the evidence provided by the organisations against the three question scoring system set out above, developed for this piece of research, suggested that there is a tendency for Trusts to over grade themselves.

Of the 19 organisations in the sample across the two outcome areas (2.3 and 3.4):

There was complete agreement between organisations' self-grading and the suggested grade for 3 organisations (16%).
There was agreement between organisations' self-score and the suggested score in one of the two outcomes for 6 organisations (32%).
There was no agreement at all between organisations self-grading and the suggested grade for 10 organisations (53%).

For question 2.3: People report positive experiences of the NHS

- Eight organisations did not provide evidence for any of the three questions listed above

[6] The types of health service reviewed were: acute (Ac), ambulance (Am), CCG (CCG), community (Com) and mental health (MH)

For question 3.4: Staff is free from abuse, bullying and harassment from any source

- Seven organisations did not provide evidence for any of the three questions listed above

EDS2 grading was only available at 3 organisations. The EDS grading found is [almost] evenly split between the three annual periods (2011-12, 2012-13, 2013-14).

Organisation	EDS/EDS2	year	Organisation self-grading Outcome 2.3	self-grading Outcome 3.4	Analyst suggested grade Outcome 2.3	Analyst suggested grade Outcome 3.4	Agreement between self- and suggested grades
Provider 1 (Ac)	EDS	2011-12	(Ach)	(Dev)	(Ach)	(Dev)	2 (2.3, 3.4)
Provider 2 (Ac)	EDS	2013-14	(Dev)	(Ach)	(Und)	(Dev)	0 (,)
Provider 3 (Ac)	EDS	2012-13	(Ach)	(Dev)	(Und)	(Und)	0 (,)
Provider 4 (Ac)	EDS	2011-12	(Dev)	(Dev)	(Und)	(Dev)	1 (, 3.4)
Provider 5 (Am)	EDS	2012-13	(Ach)	(Dev)	(Dev)	(Dev)	1 (, 3.4)
Provider 6 (Am)	EDS	2012-13	(Dev)	(Dev)	(Dev)	(Ach)	1 (2.3,)
Provider 7 (Am)	EDS	2012-13	(Dev)	(Dev)	(Dev)	(Und)	1 (2.3,)
Provider 8 (CCG)	EDS	2013-14	(Dev)	(Ach)	(Und)	(Und)	0 (,)
Provider 9 (CCG)	EDS	2012-13	(Exc)	(Ach)	(Und)	(Und)	0 (,)
Provider 10 (CCG)	EDS2	2013-14	(Dev)	(Dev)	(Und)	(Und)	0 (,)
Provider 11 (CCG)	EDS	2011-12	(Dev)	(Ach)	(Und)	(Nna)	0 (,)
Provider 12 (Com)	EDS	2011-12	(Dev)	(Dev)	(Dev)	(Dev)	2 (2.3, 3.4)
Provider 13 (Com)	EDS2	2013-14	(Dev)	(Ach)	(Und)	(Dev)	0 (,)
Provider 14 (Com)	EDS	2013-14	(Ach)	(Ach)	(Dev)	(Und)	0 (,)
Provider 15 (Com)	EDS	2012-13	(Dev)	(Dev)	(Und)	(Dev)	1 (, 3.4)
Provider 16 (MH)	EDS	2011-12	(Dev)	(Dev)	(Und)	(Dev)	1 (, 3.4)
Provider 17 (MH)	EDS2	2013-14	(Ach)	(Ach)	(Und)	(Und)	0 (,)
Provider 18 (MH)	EDS	2013-14	(Dev)	(Dev)	(Und)	(Und)	0 (,)
Provider 19 (MH)	EDS	2011-12	(Und)	(Und)	(Und)	(Und)	2 (2.3, 3.4)

Key:	No narrative available (Nna)	Undeveloped (Und)	Developing (Dev)	Achieving (Ach)	Excelling (Exc)

B.3. Headline Results – Approach 2

Based on the limited sample of 15 organisations (data are not available for CCGs in the sample viewed in approach 1).

Using this approach there were also significant differences between organisations prioritisation of protected characteristics which contributed to the self-assessment scores and the independent assessment made, by NHS England analysts. (Note: again these assessments were based purely on specific aspects of the evidence provided by organisations in their self-assessments and do not take into account the wider factors that it is intended that organisations use to make their self-assessments.)

Trusts, demographic and discrimination data was analysed and broken down by PCs, when possible. Trusts with variations of 10% higher or 10% lower the national average.

	EDS Outcome 3.4										
Protected Characteristic	Age	Disability	Gender reassignment	Marriage and civil partnership	Pregnancy and maternity	Race	Religion or belief	Gender	Sexual orientation		
Provider 1 (Ac)	B	B				B	S	E	E	**EDS**	**2011-12**
Provider 2 (Ac)	B	E				B	B	B	E	**EDS**	**2013-14**
Provider 3 (Ac)	S	N				N	N	S	S	**EDS**	**2012-13**
Provider 4 (Ac)	N	N				B	S	E	S	**EDS**	**2011-12**
Provider 5 (Am)	S	S				S	N	S	S	**EDS**	**2012-13**
Provider 6 (Am)	B	B				B	B	B	E	**EDS**	**2012-13**
Provider 7 (Am)	S	S				S	S	S	S	**EDS**	**2012-13**
Provider 12 (Com)	S	S				S	S	S	S	**EDS**	**2011-12**
Provider 13 (Com)	S	N				S	S	S	S	**EDS2**	**2013-14**
Provider 14 (Com)	N	S				S	N	S	S	EDS	2013-14
Provider 15 (Com)	B	B				B	S	E	S	EDS	2012-13
Provider 16 (MH)	S	S				N	N	S	S	EDS	2011-12
Provider 17 (MH)	S	N				S	N	N	S	EDS2	2013-14
Provider 18 (MH)	S	S				S	S	S	S	EDS	2013-14
Provider 19 (MH)	S	S				S	S	S	S	EDS	2011-12

Key:	Where is PC referred
S	NHS Staff Survey
E	Trust EDS grading
B	Both
N	Nowhere

C. Conclusion

This piece of research:

- raises questions about the quality of organisations self-assessment scores
- implies that, based on the evidence analysed for the sample of organisations, there is a tendency to over inflate self-assessment scores, where appropriate evidence has not been provided
- suggests that there is a lack of understanding of some fundamental issues around inequalities, particularly around incorrectly assuming that positive overall survey results automatically imply that groups with protected characteristics within those organisations do as well as the average.
- shows missed opportunities to look at specific groups using the protected characteristics as the main focus in Trusts is on overall outcomes at an aggregate level.
- suggests that organisations are using the EDS guidance in different ways, some more actively than others. Those organisations that use it more actively tend to demonstrate a greater understanding and better presentation of robust evidence and a more accurate self-assessment than those organisations that appear to use EDS less actively.

Possible further work:

- Develop additional guidance/ training/ good practice examples for organisations to increase their understanding of how to assess patient and staff experience
- Commission additional research to assess whether the findings from this short piece of research on a small sample of organisations for two of the outcomes is more widespread
- Consideration of whether a more detailed analysis is required to test self-assessments against a wider selection of questions
- Consideration of whether a more detailed study could be followed with a ‘deep dive’ into individual organisations giving them an opportunity to present their evidence
- Clarify how organisations should be using EDS. Currently EDS is a voluntary tool, trusts use it in the way they find it more suitable for their own needs and duties.
- Provide guidance to Trusts around publishing more detailed evidence to justify the self-assessment scores in order to increase accountability

Annex 5

DRAFT Project Plan: November – March 2015 Key Milestones

Task	Considerations	Timescale	Resources	Lead
1. Confirm the Project EDC Advisory Group and draft TOR	Invite key stakeholders	Nov 2014	E&HI	Ruth Passman / John Holden
2. Produce a programme mandate for internal use & Director approval	• Cover, scope and organisational context. What are the high-level objectives of the programme? • Alignment across the system. • Dependencies. • Measurable and defined objectives in terms of the programme's major deliverables, effort, cost, tolerance, reporting and expected business benefits.	Nov 2014	E&HI Team to support	Ruth Passman / John Holden
3. Identify and agree additional resources required	Consult with key partners who have offered support, agree costing and timescales.	Nov 2014	E&HI & HR Team	Stephen Moir / John Holden
4. Produce a 'micro site/Hub home' for the project with updated FAQs and detailed equality analysis	Ensure survey and workshop feedback is available.	Nov 2014	E&HI	Ruth Passman / Head of Communications
5. Establish a working group to refine and further develop the metrics and methodologies as required with Kings Fund, Michael West, Roger Kline, NHS	Collate existing/recent evidence to inform approach. Ensure the methodologies consider application across the protected characteristics – capture learning for further development. Invite key organisations representing protected	Nov 2014	E&HI	Ruth Passman

Employers and leading academics and HSCIC.	groups to contribute and inform future work. Establish priorities for start date for implementation			
6. Identify project consultants and project management staff	Consider & secure immediate “in kind” support available from partners and existing knowledge, relationship base, expertise, and economies of scale to obtain immediate start.	Nov 2014	E&HI team & HR	Ruth Passman/ NHS Leadership Academy & NHS Employers and stakeholders
7. Communications plan in place	Must include scoping of current Equality and Diversity and HR activities and re-iterate PSED duties & EDS remain in place for all NHS orgs. Mitigate against risk.	Dec 2014	Project team/ Comms Team	Ruth Passman / Head of Comms
8. Establish process for handling queries and publicise	Note to take advice from the NHS contract management team on process and referrals.	Jan 2015		Ruth Passman /Contract Management team / Head of Comms
9. Produce and agree a full detailed WRES implementation plan	Take into account feedback on implementation from CCGs & Trusts. Consider staged roll-out and use SWOT approach. Internal buy-in required – CCG assurance team.	Feb 2015	Project Team/ key stakeholders	Project lead consultants/ Ruth Passman / John Holden
10. Publish Guidance for implementation	Internal consultation required.	Mar 2015	Consultants & Project managers & Equality Leads	Project Team / Ruth Passman / John Holden/ Stephen Moir