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# Translating theory into practise

Follow up from Levers and Incentives workstream

# Background

- In October 2017 EDC first committed to looking at how we can "embed levers and accountability" to enable a reduction in inequalities in access, experience and outcomes for people based on their equality characteristics
- A working group, chaired by Dominic Dodd and Adam Sewell-Jones did thinking around this, including looking at evidence of inequality in cancer and mental health care, current levers and considering potential models of influencing improvement
- This work helped contribute to content in the NHS Long Term Plan and fed into to the national cancer screening strategy call for evidence.
- Agreed at last EDC meeting that we needed to look at next steps following publication of the LT Plan. This included the support the EDC could give to local systems as well as looking at national arrangements. Rob Webster volunteered West Yorkshire and Harrogate ICS as a pilot.

# Summary

**The Ask**

- Building on previous EDC papers about using data and levers, undertake engagement at a national, regional and local level to develop options for practical next steps for EDC
- Think about setting expectations, monitoring delivery, support and consequences

**Activity**

- c.20 telephone meetings (local, regional, national)
- Iterative development of proposals with Kevin Holton, Dominic, Lucy and Rob

**Today**

- 5 proposals for discussion, depending on resources and prioritisation

*What the data tells us:*

*Those with Protected characteristics (PCs) largely receive poorer access, experience or outcomes when using NHS services*

# What we know about data

The data shows that having one or more protected characteristic (PC) is correlated with less good access, experience and outcomes in health and care

- Cancer has good data (especially on BAME, gender, age) on access, experience and outcomes. But data is not available for all PCs and is being reviewed. Cancer Alliance supports analysis.
- Mental health data is more patchy. This is being addressed (as outlined in the NHS Implementation Framework) and team hope to set outcome targets in 2021 (working with PHE on headline indicators).

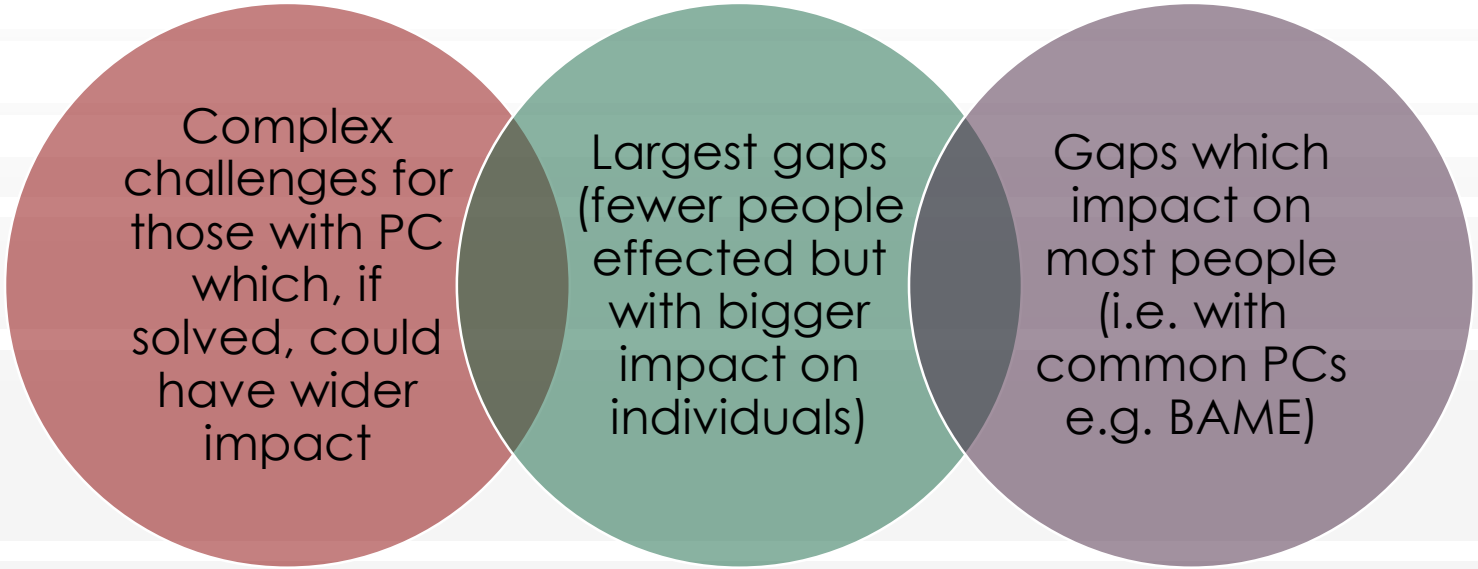
We know setting targets risks unintended consequences so it's important not to set them without full consideration (and not just choosing a metric because it is measured)

We also know publishing metrics will lead to comparisons between providers/areas which may lead to competition/a desire not to underperform. Benchmarking can be helpful IF data is credible

# Context – an Health and Care Partnership learning to work together

- West Yorkshire and Harrogate (WY&H) are committed to working as a Health and Care Partnership / Integrated Care System (ICS), and are currently building networks – consequence is pockets of work not necessarily joined-up (yet) or located within an overarching EDI strategy
- Culture change is considered vital for success, starting with investment in BAME staff networks, with emphasis on inclusivity – progress has been made but more work to do
- No appetite for additional targets (although some openness to targets changing to reflect equalities priorities) but also no mention of conflicting asks relating to EDI
- Limited evidence that data packs / dashboard data go beyond the original recipient(s) and feedback these are not necessarily in a format that 'inspires curiosity' – look at local data and intelligence first (typically focussed on local areas within the ICS), especially as believe local nuance isn't reflected in national data-sets
- Frustration that evidence base for improving EDI appears to be focussed on short-term projects, rather than long-term changes to services which show sustained improvements, this should be addressed in part by implementation of LT Plan
- More emphasis on Health Inequalities over Equalities – more focus on deprivation, and work in LA more than NHS

# Where to start?




- Possible to justify each of these starting points
- Expectation is that each will have transferable learning and knock-on benefits for person-centred care
- Nonetheless, potentially helpful to decide which is the priority then consistently advocate for chosen approach

- Also, provide clarity on whether process or outcome indicators are the priority (is this related to the strength of the evidence base for desired change?)

# A range of opportunities

Higher potential Impact (and commitment)

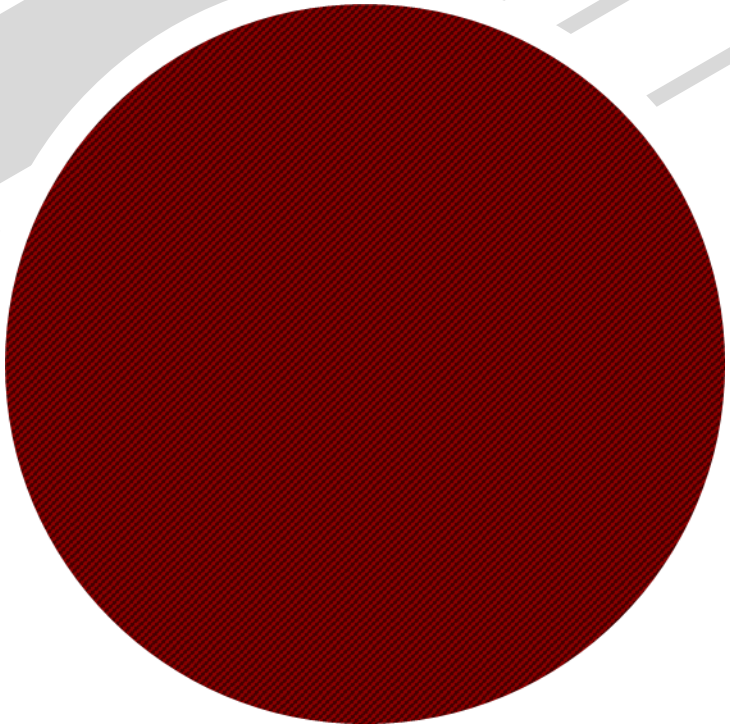
| | |
|---|---|
| Strengthen central leadership | Communicate clear, consistent messages about EDI, integrated in wider messaging (not separate / an add-on) |
| Active listening | Use local expertise to identify barriers and act nationally to remove them |
| Improve data | Help build better data sets by improving data collection |
| Develop EDI expertise | Empower local experts to influence service design through EIAs |
| Test intervention | Experiment with ways to shift EDI metrics (e.g. improve BAME access to cancer screening) |

Could be used to test Theory of Change approach (or similar) to design and accountability

Higher resource investment

# Five big questions

1. What does EDC believe the early priorities should be?
   - Greatest numbers, greatest impact and/or greatest complexity
2. Do we know 'what works' or is it appropriate to 'let 1000 flowers bloom'?
   - Is EDC's priority to inspire (by providing best practice) or assure (through measurement)?
3. For greatest impact, EDI progress should be reviewed at multiple levels (provider, CCG, ICS, regional, national) – is this feasible?
   - How to ensure consistent messaging across ALBs and workstreams/pathways from top down?
4. Is there an opportunity for a 'grand gesture' to put EDI in the limelight?
   - Might this include turning the spotlight on national bodies and their EDI commitments?
5. Do the benefits of transparency outweigh the risks? How do you fix a problem we are reluctant to talk openly about?



# Ideas in depth

# 1: Communicate clear, consistent EDI messages

## Outcome: Greater clarity that EDI is integral to delivering high quality care

| Context | Activities | Advantages | Challenges | Resource |
|---|---|---|---|---|
| • LTP clear that localities should set aspirations – but is this message consistent and heard locally?<br>• Not about new voices but embedding messages into existing voices | • Increased emphasis on importance of reducing variation in all communications<br>• Link up national workstreams to ensure clear EDI strategy<br>• Provide examples of transferable best practice | • Will ensure greater clarity<br>• Help people to understand *everyone* can (and must) get better at inclusion | • Difficult to get the messaging exactly right<br>• To indicate strong commitment would require significant change of narrative<br>• Need to clarify relationship between HI and EDI | • No additional resource required for messaging<br>• One part-time role to monitor and influence work across ALBs and workstreams |

# 2: Build active-listening networks

Case study: Accessible information standard was introduced nationally BUT to implement would ideally require changes to IT systems which are not easily adapted at a local level. Support from the centre to ensure systems could capture relevant info would be more efficient and support delivery of the standard

## Outcome: Network of 'ears on the ground' for EDC to surface emerging opportunities/challenges

| Context | Activities | Advantages | Challenges | Resource |
|---|---|---|---|---|
| • Within the ICS there are enthusiastic staff in existing networks looking to build inclusive services<br>• Sometimes their impact is reduced by factors outside their control | • Schedule meetings with EDI leads and/or BAME staff networks to listen to their views<br>• Where appropriate, bring issues to relevant national bodies to resolve once for all localities | • Ensure that work to improve equality is not unnecessarily held back<br>• Do the work once, rather than in every area<br>• Show national commitment to making it easy to do the right thing | • Some barriers will be harder to address than others<br>• Difficult to plan for as do not know what issues will arise (IT systems, workforce, best practice, analysis, data gaps etc) | • 3 days to design / set up and gain buy-in<br>• c. ½ day per month listening<br>• Unknown resource (across ALBs) needed to remove / address barriers |

Note: high risk as unclear where emerging work will sit, but important to bring about change

# 3: Support better data collection in MH

Case study: One MH Trust tried changing their computer systems to improve the collection of EDI data. Patient ethnicity was asked before a patient could be admitted and 'not asked' option was removed. Result was high % 'refused' - attributed to staff reluctance / inability to explain importance, plus inappropriate timing of question.

## Outcome: Better PC data in ICS and training to support WY&H and other areas, to improve data collection going forward

| Context | Activities | Advantages | Challenges | Resource |
|---|---|---|---|---|
| • Despite efforts to make capture of ethnicity mandatory, high levels of "undisclosed" remain<br>• Anecdotal evidence this is because staff don't understand value of data to communicate this to patients | • Admin support for clinical audit of recent cases<br>• Analysis of cases to see if issues evident<br>• Develop training in collecting PC data<br>• Deliver training | • Develop evidence that issues are local<br>• Bring about culture change so data more systematically captured<br>• Healthwatch identify access to MH services as a key concern in the ICS | • Trust already required to collect this data<br>• If focus on detentions of BAME this is entrenched problem<br>• Issues with GDPR / ethics? | • Student/admin for audit of cases (2-3 weeks or on-site) & analysis (1 week)<br>• Development of staff training with EDI experts (2 weeks)<br>• Deliver training (1 week plus local staff time)<br>• Evaluate training |

Note: potential link to work on sexual orientation monitoring standard?

# 4: Support local EDI managers to develop their roles

## Outcome: Empowered EDI champions with close links to EDC

| Context | Activities | Advantages | Challenges | Resource |
|---|---|---|---|---|
| • EDI managers across the CCGs are starting to work more closely together<br>• Time feels focussed on EIAs and reporting, rather than thinking more proactively about designing inclusive services | • Firstly need to map skills and understand appetite for more proactive E&D work<br>• Provide training / support / examples to encourage and inspire<br>• (Could also involve HR directors and others)<br>• Evaluate impact | • Energise local EDI advocates / experts, supporting them to take a more pro-active role<br>• Build network for EDC to draw on for 'on the ground' insight | • Not all people will be suited to changed role<br>• Risk that approach perpetuates EDI being the job of 'other people'<br>• May not have capacity<br>• How to ensure this supports work at ICS level | • Design/deliver workshop to understand appetite, barriers and enablers (3 days)<br>• OD expertise to design/deliver training (TBC)<br>• Evaluation (c.12 days over course of year) |

Note: explore ways to make EIA more impactful (e.g. GM example) and share these

# 5: Task and finish exercise on BAME cancer screening

Case study: With strong senior support, WY&H has active BAME staff networks seeking to a) support development of BAME staff into leadership roles, b) support wider staff to understand and be confident about inclusion (at all levels) and c) undertaking outreach into local communities with important messages

## Outcome: Better understanding of whether/how an intervention to improve BAME access works

| Context | Activities | Advantages | Challenges | Resource |
|---|---|---|---|---|
| • BAME network in WY&H are planning outreach work to encourage BAME communities to undertake screening | • Provide experienced project manager to support and co-ordinate work<br>• Would need local buy-in and support | • Some work is already underway so this would be supporting existing work (and links to commitment in WY&H LTP)<br>• Achievable in 6-12 months and proof of concept to show metrics can be moved | • Risk that pilot doesn't work / doesn't move metrics<br>• Less clear link to whether / which levers lead to action – more about whether targets are fair/reasonable /useful | • Part-time project manager over 6-12 months<br>• c.15 days design, 10 days monitor/support and 5 days evaluate<br>• Ideally revisit at 1 year and 2 year point to see if any impact sustained |

Note: potentially could sit better within cancer team (Sir Mike interested in this and due to report by end of year)

# 6: Reduce unwarranted variation in hip replacements

## Outcome: Evaluation of whether shared-decision making approaches reduce unwarranted variation

| Context | Activities | Advantages | Challenges | Resource |
|---|---|---|---|---|
| • The CCGs have done work looking at unwarranted variation (by deprivation) of hip replacement across the ICS<br>• Insufficient data to look at PC drivers directly, but anticipate this is a cause | • ICS has asked each of the 6 areas to develop local plan to reduce variation<br>• CCGs interested in training GPs in shared decision-making which has been demonstrated to reduce variation (but need financial support) | • Training in areas with lowest / highest hip replacements could demonstrate impact on over/under treatment<br>• Approach designed to be inclusive so should work across different PCs and evaluation can capture this | • Not clear if GPs bought into need for training – might be challenging to engage?<br>• Can EDC help find funding for training, and is investment in one ICS a good use of funds? | • Engage local GPs, identify and deliver appropriate training course (cost TBC)<br>• Evaluate training delivery and impact on patients with different PCs (£5-10k qual plus analysis of data) |

Note: potential to build on co-creation work already undertaken?