EDS2 grading 10.11.2016 Report

1. Background

In December 2016, NHS Salford CCG held a public grading of its equality performance using the NHS Equality Delivery System (EDS) 2. EDS2 aims to drive up equality performance and embed equality into all NHS business. It was designed to help NHS organisations meet:

- The requirements of the public sector Equality Duty
- Equality aspects of the NHS Constitution
- Equality aspects of the NHS Outcomes Framework
- Equality aspects of CQC's Essential Standards
- The requirements of the Workforce Race Equality Standard
- The requirements of the Accessible Communication Standard

EDS2 is one of the tools we use to help ensure we meet the health needs of all our communities and ensure that our workforce is inclusive and supported. It looks at how we consider the needs of specific groups of people who share a particular "protected characteristic", both when we design/plan healthcare services and as an employer.

> The nine protected characteristics are laid down by law in the Equality Act (2010); they include
> - Age,
> - Sex,
> - Gender Reassignment,
> - Religion,
> - Race,
> - Sexual Orientation,
> - Marriage/Civil Partnership, Pregnancy/maternity
> - Disability.
>
> We also consider the needs of carers and other groups when planning and commissioning services.

EDS2 is split into 4 goals,
1. Better health outcomes for all
2. Improved patient access and experience,
3. A representative and supported workforce
4. Inclusive leadership;

It is used by all NHS organisations to show how Equality, Diversity and Human Rights are part of everything we do.

The 4 goals are split into different specific outcomes, which look at a different aspect of the whole. EDS2 looks specifically at protected characteristic groups and the way we consider their needs. It asks the question "How do protected groups fare when compared to the general population?"

It is flexible enough so we can look in detail at particular groups of people or areas of work, examining any barriers to access particular groups of people encounter, and to look for possible solutions.

EDS2 gives representatives and individuals from local protected characteristic groups the opportunity to review our equality work and tell us how well they think we

are doing. We learn from their experience to discover what are getting right and where we can improve – we aim to use the findings of the panel to build on what we do to be even more inclusive as a commissioner and an employer.

2. Our goals and outcomes

Our Engagement and Experience Management Group (EEMG) agreed that the 2016 grading would focus on Goal 2 "Improved patient access and experience" to see how the way we commission services improves access and experience for vulnerable groups. We also agreed to revisit Goal 4 "Inclusive leadership" to show how we have progressed since our last grading.

At our previous EDS2 grading in 2014, participants requested that the evidence be sent out in advance. We sent the information to representatives and groups of the nine protected characteristics in time to read by the date of the grading; the engagement team agreed to undertake pre-work with people with particular communication needs from 14.11.16 onwards. The information consisted of brief evidence for each of the outcomes for Goal 2 and a reappraisal of progress against Goal 4. The evidence is available at Appendix 1 and 2.

3. Methods

Participants were seated in small groups, with a facilitator from the CCG and/or the relevant engagement officer. We split the outcomes into approachable questions (see figure 1 below) and asked participants for comments and possible actions, which were captured by facilitators, or written by participants on post-it notes, then put on flip charts under the appropriate question. There was plenty of opportunity to ask staff for clarification, or comment.

Members of CCG staff were available to answer questions at the event.

We then used the Turning Point electronic voting system to grade each question. Participants then graded us according to the evidence using the scale:-

- Extremely well (equivalent to EDS2 grade **Excelling**)
- Quite well (equivalent to EDS2 grade **Achieving**)
- OK (equivalent to EDS2 grade **Developing**)
- Not well (equivalent to EDS2 grade **Undeveloped**)

The process was simplified so that answer button 1 always indicated the best position, and answer button 4 always the worst.

The EDS2 grades have been shown in Figure 1and Figure 2 below.

Recommendations for action will be determined by participants' responses. We made it clear that we may not be able to act on all the suggestions, but we will act on the areas that they identify as needing work. We will send participants a copy of the report when it is written, in alternative formats as appropriate.

Participants consisted of thirteen members of the public and four members of staff from external local stakeholder organisations. Nine non-participating members of CCG staff also attended. The disabilities disclosed included learning disability, physical and sensory disabilities.

Participants' ages ranged from 14-77. Only one participant disclosed a BME ethnicity, and there was no Trans representation. A small number of participants disclosed LGB sexual orientation, though most disclosed heterosexual orientation or disclosed no sexual orientation.

Religions disclosed included Christian, atheist, no religion and Bahai.

This gave representation over eight characteristics. However, we recognise that certain groups (people from BME communities, carers and people with mental health issues) were not well-represented. Attendance at any "snapshot" event is self-selecting, so representation from any one group is not guaranteed; however, measures to increase the breadth of representation will be tried for the next event.

The EDS2 grades have been shown in Figure 1and 2 below.

We asked participants for comments and possible actions. These have been ordered by theme, and we will use them to develop actions.

Figure 1

Goal 4 Inclusive leadership	Questions	Old grade	New grade
4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Our staff have done more work to show their commitment to equality How do you think we are doing now?	🟧	🟩
4.2 Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	We have developed our systems to improve the way we find and reduce adverse equality impacts. How do you think we are doing now?	🟧	🟩
4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	We have worked to improve the way we understand and work with people from different protected characteristics in the workplace. How do you think we are doing now?	🟩	🟩

Figure 2

Goal 2 – Improved access and experience		Single grade	Overall grade
2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Do you think we understand the health needs of Salford's diverse communities and the barriers they face?	Green	Green
	Do you think we are taking steps to reduce these barriers?	Amber	
	Do you think our plans show that we want to reduce health inequalities in Salford?	Green	
2.2 People are informed and supported to be as involved as they wish to be in decisions about their care	Do you think that the new ways of working with the Council will join services up to make it easier for patients?	Amber	Amber
	Do you think we are trying to make patient information accessible?	Amber	
2.3 People report positive experiences of the NHS	Do you think we are listening to what vulnerable groups are telling us?	Green	Green
	Do you think we are using this information when we plan services?	Green	
2.4 People's complaints about services are handled respectfully and efficiently	Do you think that all our communities understand how to complain about NHS services?	Amber	Amber
	Do you think patients know how to find the help and support they need to feed back about their experience of NHS care?	Amber	

4. Themes

4.1 Engagement

Participants felt that, in general, the CCG engaged well with local communities and that the appointment of dedicated engagement officers for specific communities was a positive development. However, they felt that more engagement was needed with young people, people with a disability (including Mental Health), BME communities (including refugees and asylum seekers) and the LGBT community. In some cases, extra individual support would be needed to engage with people from these communities. There were questions about the ways in which the CCG uses engagement information from other organisations such as GMMH.

There were some specific suggestions for new initiatives:-

- Using colleges to survey and collect young people's views
- Engaging the homeless community, and

"The CCG is doing some things but could do more around race and LGBT."

"You need to empower communities to speak to each other and promote partnership working"

having a Homelessness Charter (possibly working with the Coffee4Craig charity).
- Board members and commissioners need to engage with communities directly
- Engaging with the following groups separately, as they are not the same thing
  - ➢ Refugees
  - ➢ Asylum seekers
  - ➢ Migrants
  - ➢ BME

4.2 Understanding and reducing barriers

In general, participants felt that the NHS had a reasonably diverse workforce which encouraged awareness of individuals' cultural needs, and that the CCG commissioned reasonably inclusive services. There was a general agreement that more awareness of the barriers experienced by particular communities (e.g. LGBT, some BME communities) and that cultural competency training for staff would be a positive development and build on the CCG's good work.

There were a number of specific actions and questions which can be seen below:-

> "Deaf people always have to wait, for appointments, for information and for an interpreter."

- Make it clearer to GPs what services are available for transgender needs (i.e. care pathways)
- What plans are being put in place to address national policy for paying of services for vulnerable R and AS (?)
- Dementia is still not being notified on all medical records.
- The CCG should look at health inequalities and barriers in other groups beyond protected characteristics – e.g. homeless, veterans, and socio-economic groups.
- Professionals often talk to the carer (of a person with LD or dementia) not the person themselves.

- We need to include equality in everything we do and take more positive action. Inclusion requires a differentiated service.
- The CCG should see Equality Analysis as an opportunity as opposed to a mitigation

4.3 Reducing health inequalities

Participants felt that the CCG was reducing health inequalities and that engagement went some way (though by no means all the way) to understanding inequalities, but that it did not fill all the gaps in the CCGs knowledge. They felt that the information in (e.g.) the JSNA needed to be kept up to date and

> "We need to ensure we have the background data to know where different communities live and it is up to date".

that it should be a part of a process to form actions across the whole health economy and hold organisations to account. It was suggested that there should be a lead in each organisation responsible for implementing the actions specified in the JSNA. The BME needs assessment was seen as a step forward.
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4.4 Accessible Information

There was general agreement that information should be made available in different formats as appropriate to the different needs of individuals. However there were particular concerns as to what records will be shared by different professionals and how this will be done safely.

> "On my own I don't get all the information to make decisions".

Participants felt that the Browsealoud software on the CCG website would increase accessibility to information, and that it would allow for some information to be translated. However, there were concerns that not everyone has access to, or can use, computers so it is not a full solution. It was felt that this cohort of people would also need extra support to engage with the CCG.

There were some concerns about the training given to interpreters (there is no specialist medical training) and the ways in which Deaf people can make GP appointments. There were also concerns about young people being denied access to their medical records by GPs, but there were no specific examples given.
There were some specific comments:-
- The CCG needs to communicate more about Salford Together
- Each GP has an accessible information pack but it hardly ever gets used because
- In other areas interpreters are booked by the GP when a Deaf person books an appointment, and the interpreter is waiting for them at the appointment. This is not the case in Salford. This is requested.

4.5 Integrating services

Participants felt that the plans for Salford Together should promote better health outcomes for vulnerable groups and should make it easier for individuals to get the health care they need. However, they also felt that it would need time to embed joint systems, so it was not possible to

> "Salford together – the plan is fairer and easier! Hope it works."

say categorically that this was the right way to go from the point of view of specific disadvantaged groups. They felt that working together should lessen the communication barrier, as long as it was recognised that it's important the people know where to access the information so one single communication hub could be established. It was agreed that more publicity is needed to tell people about the changes.

There were concerns around sharing the evidence about individuals as this could lead to professionals discussing individual patients, but this same sharing of information was also seen as a positive. This suggests that more work needs to be done to inform patients how their information will be shared and how it will be kept safe. Specific queries and comments included the need to work with care homes to reduce the barriers for BME groups and LGBT groups to access these, and to improve personal care for these groups.

4.6 Closing the loop

Participants felt that the CCG needed to be clearer about how the experiences and opinions gained from engagement with people from protected characteristic groups actually influenced decision making. They wanted more explicit "You said we did" information. They felt that using the Insight system as a resource for commissioning staff was a positive development, but that staff need to be well-trained in when and how use it.

> "What evidence have we got that the Governing Body are listening?"

4.7 Patient experience/complaints

In general, participants agreed that complaints were dealt with efficiently and correctly, though it is a lengthy process. However, there are some areas that need work.

1. There is still an expectation that if someone complains they will receive a poorer service, which suggests that we need to work on educating patients about their right to complain about health services and that it will not have an adverse effect on their care. Information should be available in different formats and languages. We need to be sensitive to communities which have cultural barriers to complaining.

> "People don't always feel confident enough to complain."

2. The information about PALS/complaints is published on our website, and not everyone uses a computer. This suggests we need to promote people's right to complain about health services among certain communities, especially those who do not engage well with health services.

> "People feel that they have to be aggressive or assertive to get anyone to listen or take notice. They don't like to feel they are mithering."

We will use the information above to formulate actions to address the areas of work shown and incorporate them into the business planning and objective setting process for 2017/18.