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NHS Equality Delivery System 2022

EDS Technical Guidance

For service users, patients, staff, stakeholders, leaders, and EDI leads in the NHS

Version 1, 15 August 2022

Contents

Glossary

AIS	Accessible Information Standard
BME	Black, Asian, and Minority Ethnic communities [we only use acronyms and collective terminology where we absolutely must.]
CQC	The Care Quality Commission
EDC	(NHS) Equality and Diversity Council
EDS	Equality Delivery System
ESR	Electronic Staff Record
FFT	Friends and Family Test
ICS	Integrated Care System
ICB	Integrated Care Board
JSNA	Joint Strategic Needs Assessment
NHS	National Health Service
PCN	Primary Care Network
Partners/ Partner organisations	NHS organisations within the same integrated footprint. Partner organisations can also be local authority organisations who are commissioned to provide healthcare
PSED	The Public Sector Equality Duty
Service users	Patients and members of the public that use services – can be referred to as clients and are referred to as patients within the EDS
Staff network	This can be a formal network, steering group, or forum for staff with protected characteristics
Stakeholders	Organisations and groups within an integrated footprint. When working with non-NHS organisations, these can include representatives from social care services and VCSE organisations
SOM	(NHS) Sexual Orientation Monitoring (Information Standard)
SUS	NHS Secondary Uses Service
VCSE	Voluntary and Community and Social Enterprise
VSM	Very Senior Managers:
WDES	(NHS) Workforce Disability Equality Standard
WRES	(NHS) Workforce Race Equality Standard

Introduction

This document is written for those with responsibilities for implementing the Equality Delivery System (EDS) within NHS organisations, and for those in local authorities and in other organisations that work in partnership with the NHS to deliver the EDS. This document provides technical guidance so that those mentioned in NHS and other organisations can understand exactly what they need to do throughout the process.

NHS organisations or local NHS partnerships may wish to produce their own version of this guidance, to support understanding for patients and service users, community groups and others who may take part in the scoring and rating process. Further support for scoring and rating can be found in the EDS Ratings and Score Card supporting guidance.

An overview of the EDS

The EDS is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations in England - in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services, workforces, and leadership. It is driven by evidence and insight.

The third version of the EDS was commissioned by NHS England and NHS Improvement with, and on behalf of, the NHS, supported by the NHS Equality and Diversity Council (EDC). It is a simplified and easier-to-use version of EDS2.

To take account of the significant impact of COVID-19 on Black, Asian, and Minority Ethnic community groups, and those with underlying and long-term conditions such as diabetes, the EDS now supports the outcomes of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) by encouraging organisations to understand the connection between those outcomes and the health and wellbeing of staff members. The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users.

The EDS comprises eleven outcomes spread across three Domains, which are:

1) Commissioned or provided services
2) Workforce health and well-being
3) Inclusive leadership.

The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement.

The EDS is designed to encourage the collection and use of better evidence and insight across the range of people with protected characteristics described in the Equality Act 2010, and so to help NHS organisations meet the public sector equality duty (PSED) and to set their equality objectives.

All NHS providers are required to implement the EDS, having been part of the NHS Standard Contract from since April 2015 (SC13.5 Equity of Access, Equality and Non-Discrimination). In addition, NHS Commissioning systems are required to demonstrate ‘robust implementation’ of the EDS as set out in the Oversight Framework.

The completion of the EDS, and the creation of interventions and actions plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the CORE20PLUS5 approach, the five Health Inequalities Priorities, and addressing inequalities in elective recovery highlighted in the 22/23 Guidance and set out below:

- Priority 1: Restore NHS services inclusively
- Priority 2: Mitigate against digital exclusion
- Priority 3: Ensure datasets are complete and timely
- Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
- Priority 5: Strengthen leadership and accountability

How to apply the EDS

The EDS can be best applied in partnership through a number of ways:

- By NHS providers working together in a regional or Integrated Care System (ICS) footprint, or in some other sub-regional boundary
- By NHS commissioners and NHS providers working together either at a local borough or place level, or at a regional level through ICSs
- By local place-based NHS and local authority commissioners working with providers and other local stakeholders
- By single Integrated Care Boards (ICBs) working on issues where care pathway and service challenges are best addressed at a regional or ICS level

Prior engagement with service users, patients, the public, staff, staff networks, Chaplaincy, and trade unions, will help NHS organisations in a region or ICS to decide which option to take.

It is recommended (but not compulsory) that from April 2022 the use of the EDS by single organisations should cease as soon as practicably possible (in some cases it may be appropriate to take a phased approach from EDS2 to this version).

Primary Care Networks (PCNs) are a key part of the NHS Long Term Plan, with all general practices being required to be in a network by June 2019, and NHS commissioners being required to commit recurrent funding to develop and maintain them. At regional or ICS level, consideration should be given on how to involve PCNs in the EDS.

Those responsible for the review process should be staff with responsibilities for equality, diversity, inclusion, and health inequalities, working alongside staff who are independent of the services being reviewed.

Engagement with the workforce should be led by Staff networks (in the form of forums or steering groups for smaller organisations, where relevant), union representatives and Chaplaincy staff wherever possible. Organisations should consult with staff with responsibilities for selected services being reviewed.

Once reviews and improvement plans are completed and signed off by Governing Bodies, Committees or Boards, improvement plans should be put in place and implemented.

Responsibilities for delivery

Overall responsibility for the EDS lies with the Executive Board within each organisation. This responsibility may be discharged to the/an EDI Team/senior responsible officer within the organisation, but Board members should retain overall responsibility.

The collation of evidence for Domain 1 is the responsibility of the EDI Lead/Team or equivalent but this must be assisted by managers who sit within relevant service areas. Responsibility for collating the evidence for Domains 2 and 3, sits with the EDI Lead/Team or equivalent but this must be assisted by Boards, Secretariats, Senior Leadership teams, Human Resources and Organisation Development teams.

Once improvement plans have been developed, the implementation of actions identified is the responsibility of the leadership and management of those services that Domain 1 was applied to. Implementation of improvement actions identified for Domains 2 and 3 is the responsibility of the Senior Leadership teams within organisations, supported by Human Resources, Organisational Development colleagues.

Those individuals who carried out the review process should not be responsible for implementation of improvement actions. However, they may have responsibilities surrounding monitoring and reporting for performance management purposes. Individuals’ and teams’ responsibilities for equality, diversity, inclusion, and health inequalities may need to support organisations with specific equality-related advice, guidance, and support.

The results of EDS reviews, and any action planned and/or taken as a result, should feed into organisation’s service-based plans and corporate and strategic objectives. They should also contribute to organisations’ longer-term equality objectives.

Organisations should use the EDS as the core of their equality work and a contributary to strategies to address health inequalities. Additional information on how to apply each Domain can be found further on in this document.

The Equality Framework for Local Government

Local government organisations including councils with social care services responsibilities have reviewed their equality performance through the use of *The Equality Framework for Local Government* (EFLG).[1]

This comprises five areas:

- knowing your communities
- leadership. partnership and organisational commitment
- involving your communities
- responsive services and customer care
- a skilled and committed workforce.

Performance is rated as 'Developing'; 'Achieving' or 'Excellent'.

The EFLG has similarities with the EDS with respect of purpose and content.

Wherever possible. and within the context of place-based partnerships and ICSs, NHS organisations and councils with social care services responsibilities are encouraged to work together in improving equality performance, and in aligning their approaches to the EDS and The Equality Framework.

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[1] https://www.local.gov.uk/our-support/guidance-and-resources/equality-frameworks/equality-framework-local-government

The EDS cycle

There is a difference between carrying out EDS reviews, creating improvement plans and acting on completed EDS reviews and their action plans.

EDS reviews should be carried out annually with the result of the review published on organisation websites by 28th February (or the following working day). Most reviews can be completed in-year; although it is recognised that flexibility may be required. Any justification for late publication must be provided and signed off at Board level.

Within the annual cycle of EDS evidence and insight-based reviews it is recommended that:

- Reviews on Domain 1 (Commissioned or provided services) should take place during the summer months (quarter 2 of the financial year).
- Reviews of Domain 2 (Workforce health and well-being) should take place during the spring and/or summer months (quarters 1 and 2 of the financial year).
- Reviews of Domain 3 (Inclusive leadership) should take place during the Autumn months (quarter 3 of the financial year).

Within each organisation, the planning and conduct of EDS reviews should be identified and handled as a ‘project’ that requires dedicated resources at the appropriate level.

EDS activity should be included in the reporting of the specific duties of the PSED in January of each year. This should include:

- The carrying out of the EDS reviews,
- recommendations, improvement plans and early impacts of the implementation of those plans
- results and progress from previous years’ plans.

The EDS Domains and outcomes

At the heart of the EDS are eleven outcomes, against which NHS organisations measure their successes and challenges with protected characteristic and vulnerable community groups using evidence and insight. The outcomes, grouped into three Domains, are as follows:

Domain 1: Commissioned or provided services

1A: Patients (service users) have required levels of access to the service
(simpler version of EDS2 2.1)

1B: Individual patients (service user's) health needs are met
(simpler version of EDS2 1.2)

1C: When patients (service users) use the service, they are free from harm
(like EDS2 1.4)

1D: Patients (service users) report positive experiences of the service
(same as EDS2 2.3)

Domain 2: Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions (response to COVID-19)

2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source *(like EDS2 3.4)*

2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment, and physical violence from any source (response to Covid-19)

2D: Staff recommend the organisation as a place to work and receive treatment
(like EDS2 3.6)

Domain 3: Inclusive leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities (like *EDS* 4.1)

3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed (like *EDS2* 4.2)

3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients (response to Covid-19)

Protected Characteristics

When rating the Domain 1 and Domain 2 outcomes, NHS organisations and their stakeholders should refer to each of the nine characteristics[2] given protection under the Equality Act 2010.

The nine ‘protected characteristics’ are as follows:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity (*and paternity)*
- Race
- Religion or belief
- Sex
- Sexual orientation

The protected characteristic of ‘Marriage and civil partnership’ was intended by the Equality Act 2010 to apply to employment only. NHS organisations are asked to include this protected characteristic in their review and rating of the outcomes of Domain 1. By doing so, it will help to check any assumptions being made by NHS staff about patients in married or civil partnerships and other relationships.

NHS organisations should include paternity[3] within the ‘Pregnancy and maternity’ protected characteristic when they the review and rate the EDS outcomes.

NHS organisations and their stakeholders are required to engage with inclusion groups when implementing the EDS. By including people who are ‘carers’ or ‘socially excluded’ as specific groups to engage with, related health inequalities can be addressed.

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[2] https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

[3] https://www.gov.uk/employers-paternity-pay-leave

Inclusion Health Groups

Within this version of the EDS, inclusion groups are defined as those who suffer health inequalities. In other words, different population groups who are negatively impacted by differences in health status or in the distribution of health determinants. NHS England has identified the following inclusion health groups:

- Asylum seekers (pre decision and “refused” applicants) and refugees (“granted” status applicants)
- Carers
- Ex-offenders
- Gypsy, Roma, and Traveller communities
- Homeless people
- Those experiencing deprivation and poverty
- Sex workers
- Veterans
- Vulnerable groups (such as those with low literacy skills)

Different protected characteristic groups also suffer from health inequalities. The EDS encourages organisations to take health inequalities into account, recognising that many of our own workforce fall into these community groups, as well as our patients.

Data - local evidence and insight

NHS organisations - in conversations with the communities they serve and the workforces they employ - should make every effort to understand, and go on to address, local inequalities for patients and staff.

Local Joint Strategic Needs Assessments (JSNAs), compiled by local Directors of Public Health and their teams, can assist stakeholders to understand issues within services. Every local authority area will have a JSNA, which provides valuable information on inequalities. Another source is the reports of the local Healthwatch, which is a statutory mechanism to give users of health and social care services and members of the public a collective voice, both nationally and locally. Most Healthwatch organisations conduct surveys in which equalities are examined.

The results from the WRES are provided for all NHS trusts, key national healthcare bodies and, from 2019, for all commissioners; in addition, results from the WDES are provided for each NHS provider. These returns provide a good overview of staffing issues within particular organisations. The results of Equal Pay Audits and Gender Pay Gap reporting inform organisations of pay inequalities.

NHS organisations are required to complete impact analyses of their policies and service changes. Many provide good insight into the impact of services and workforce practices on patients and staff, respectively.

There is a clear case that poor staff health and wellbeing has a significant impact on the performance of NHS organisations. NHS organisations are now encouraged to collate data on the health of their workforce if they do not already do so. Organisations are advised to engage with staff and staff networks to understand and implement support for staff who manage the following long term conditions, in line with the NHS Long Term Plan: Obesity, Diabetes, Asthma, COPD and mental health conditions.

The NHS Health and Wellbeing Framework[4] sets out the standards for what NHS organisations need to do to support all staff to feel well, healthy, and happy at work. The framework helps organisations to plan and implement approaches for improving staff health and wellbeing. We encourage organisations to implement this framework.

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[4] https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/nhs-health-and-wellbeing-framework/

Collaborative engagement with service users, patients and staff

Local insight and qualitative information are required and are complementary to harder quantitative evidence. NHS organisations should actively engage with service users, patients, community and faith groups and with other stakeholders who support or represent the views of patients, to gain feedback on current service provisions and how they can be improved to meet the needs of groups of patients[5].

Equally, NHS commissioners and providers should actively engage with their staff, staff networks, chaplaincy, and trade unions to understand workforce challenges as experienced by the workforce, and what improvements are most necessary so that NHS organisations can better recruit and retain staff and support them to have happier and healthier lives.

Lived experience

The outcomes that comprise Domains 1 and 2 involve the collection and analysis of evidence and insight. Evidence and insight, however, are not an end in themselves, but reflect key aspects of the lived experience of patients and staff. In this context, the evidence and insight should be used as a source of intelligence for organisations in collaborative partnerships with patients, the public, local community and VCSE organisations, staff, staff networks, trade unions, and other stakeholders to explore and implement initiatives to deliver real improvement and positive change in the lived experiences of patients and staff.

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[5] https://www.england.nhs.uk/get-involved/involvementguidance/

Partners and Stakeholders

Partners for the EDS are organisations that work together to complete and EDS cycle. Partners are generally other NHS organisations, Local Authorities and those who deliver commissioned NHS services, where possible. Partner NHS organisations and Local Authorities must belong to the same ICS footprint. Other possible partners will be dictated by the services Domain 1 is applied to.

Stakeholders for the EDS are those groups, organisations and individuals who are involved in the completion of an EDS cycle. Inevitably this will be a much bigger list with more flexibility.

Below is a list of required stakeholders who must be engaged in the EDS process:

- Patients and Service Users *(can be done via representation group)*
- Carers *(can be done via representation group)*
- Community Groups and local members of the public
- Local VCSE organisations
- Staff members
- Staff networks
- Trade Union representatives
- Lay members
- Freedom to Speak Up Guardians
- Chaplaincy *(this can include Faith Networks)*

Leaders and Board members within organisations should be engaged and involved with all Domains. Leaders can include senior management, executive teams, and Medical Examiners. Lay members can also be included. It is important that Leaders and Board members understand the process of Domains 1 and 2, so that they can understand how to take the learning from the process and embed it into the business as usual. It is also important they understand the process to ensure that the correct level of resource is allocated.

Staff networks also have a crucial role to play in the delivery of an EDS cycle. The EDS requires for staff engagement to be led by staff networks (or their equivalent) where possible, to provide staff with safe environments where they can be open and honest. This can also be delivered by Freedom to Speak Up Guardians, Chaplaincy staff (or equivalent) or a combination of the three.

It is important that Trade Unions are also involved and have a specific role to play (particularly in Domain 3) alongside staff networks, providing independent assessments of leadership commitment and engagement.

Domain 1: Commissioned or provided services

NHS organisations, with other health and care partners where appropriate, should choose three services that they commission and/or provide for patients for assessment in Domain 1.

Service number 1 should be a service where data indicates it is doing well; service number 2 where data indicates a service is not doing so well; and service number 3 should be a service where its performance is unknown. Data to be considered should be both internal and external. Local JSNAs and other external sources should be used to identify priorities within a local footprint for addressing health inequalities, as appropriate. The selected services should be agreed by patients and the public and the VCSE sector. Provide justification for selecting services when engaging.

For example, a commissioner and an NHS Trust may wish to look at their Patient Transport Service, their Ante-natal service, and their Bereavement Service in collaboration, based on service user feedback about the services, data regarding who is accessing the services and the level of staff sickness absence across the services. It is strongly recommended that the services chosen for Domain 1 should also differ in size and complexity.

For each service, the following four outcomes should be tested with reference to local evidence and insight in discussion with service users, patients, the public, community groups and VCSE organisations:

Domain 1: Commissioned or provided services

1A: Service users have required levels of access to the service

1B: Individual service user’s health needs are met

1C: When service users use the service, they are free from harm

1D: Service users report positive experiences of the service

Domain 1 data sources

Valuable sources of evidence for Domain 1 include the following:

- The NHS Secondary Uses Service (SUS)
- The General Practice Patient Survey
- National Cancer Patient Experience Survey
- CQC National Patient Surveys
- The Friends and Family Test (FFT)
- Serious incidents, never events and complaints as reported by NHS providers
- The Accessible Information Standard (AIS)
- Reasonable adjustments as made by NHS organisations
- The Health Inequalities Improvement Dashboard

(More details about each source are provided in Annex A)

Organisations should make every effort to gain insight and qualitative data on the services selected for EDS evaluation and rating. Local surveys and research, and local intelligence reports, for example those compiled by the local Healthwatch, can add enormous value to EDS discussions, evaluations, and ratings.

Ahead of discussions with patients, the public and local VCSE organisations, NHS organisations should gather together and provide the available and current evidence and insight and provide easy-to-read analyses and conclusions.

When discussions and focus groups are held, it is important for NHS organisations to assemble individuals or groups that are representative of the service users, patients and public within the local population. Organisations should engage with grassroots patient and community groups comprising of or representing the interests of older, BAME, Disabled, LGBT, homeless, deprived, and other community groups where relevant.

A summary list of local and national sources of evidence that local NHS organisations, patients, the public and local VCSE organisations might draw on to complete the rating of, or provide a context for, the Domain 1 outcomes is set out in Annex E.

Domain 1 data breakdowns

NHS Digital routinely collects information on patients covering the four protected characteristics of age, gender (sex), ethnicity and Disability. For EDS purposes, the following breakdowns should be used during an initial testing of the outcomes:

- Age: under 10 years, 11 to 16 years, 16 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 to 74 years, 75 to 84 years, 85 years and over
- Gender (sex): female and male
- Ethnicity: White and BAME
- Disability: Disabled and not disabled

Finer breakdowns may be attempted. Through evidence, insight and engagement, an understanding can be built up of differences in experiences/outcomes, for example, for different ethnicities, disabilities, and sexual orientations, which may call for further testing via the EDS.

Other breakdowns for other protected characteristics will depend on overall numbers, and the need for anonymity where numbers get small.

At times, some NHS organisations have struggled to explain to patients and the public the need for, and importance of, sexual orientation monitoring. Since 2017, a Sexual Orientation Monitoring Information Standard[6] has been published by NHS England and NHS Improvement. This has been developed in collaboration with NHS Digital and the LGBT Foundation. Reference to this standard will help NHS organisations to improve their collection and reporting of sexual orientation monitoring, based on consent and understanding.

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[6] https://www.england.nhs.uk/about/equality/equality-hub/sexual-orientation-monitoring-information-standard/

Domain 1 rating

Using the above breakdowns, each outcome is then scored and rated by patients, the public, the VCSE sector and NHS organisations as follows:

Undeveloped activity – **organisations score 0** for each outcome	Those who score **under 8,** adding all outcome scores in all Domains, are rated **Undeveloped**
Developing activity – **organisations score 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all Domains, are rated **Developing**
Achieving activity – **organisations score 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all Domains, are rated **Achieving**
Excelling activity – **organisations score 3** for each outcome	Those who score **33,** adding all outcome scores in all Domains, are rated **Excelling**

Scores are then added together to provide organisations with an overall score, or an EDS Organisation Rating

Information on how to score and rate outcomes across the Domains can be found in the EDS Ratings and Score Card supporting guidance document. Please refer to this guidance document before you start to score. This guidance has a full explanation of the rating procedure and can assist you and those you are engaging with to ensure rating is done correctly.

Working with patients, the public, and the local VCSE sector

NHS England has published a range of documents on patient and public engagement to support the NHS. These documents, and NHS England's 'Patient and Public Participation Guidance', published on 7 April 2017, can be accessed at: https://www.england.nhs.uk/participation/resources/docs/

The 'Ladder of Engagement' sets out the different ways in which engagement can be operated, including engagement that is truly collaborative, with final conclusions devolved to patients and the public. Details on the 'Ladder of Engagement' can be accessed at: https://www.england.nhs.uk/participation/resources/ladder-of-engagement-2/

In November 2015, the Race Equality Foundation – in collaboration with the LGBT Foundation, Disability Rights UK, and the Men's Health Forum – published 'The Equality Delivery System for the NHS *EDS2*: Guide to Engagement with the Local Voluntary Sector'. This is full of good advice and practical case studies, all of which remain important. This can be found on the Race Equality Foundation website at

https://raceequalityfoundation.org.uk/health-care/the-equality-delivery-system-for-the-nhs-eds2-guide-to-engagement-with-the-local-voluntary-sector/

Sustaining improvement

In each EDS cycle three new and separate services should be chosen for EDS evaluation and rating. At any one time, or over time, the exploration of care pathways for particular services should be prioritised in line with data available. Where a service is not chosen for EDS evaluation and rating, the good practice and lessons learnt from the chosen services could apply to them.

If a service has received a rating of 'Undeveloped', it is advised that is should be revisited for review and rating after a two-year period, to enable any impact from improvement plans to be monitored and measured.

Domain 2: Workforce health and well-being

The health of our NHS workforce is critical, and NHS organisations are best placed to support healthy living and lifestyles. The EDS recognises that our NHS staff are also our patients, who belong to various community groups; the very same community groups that we serve as the NHS. NHS organisations are now encouraged to monitor the health of their workforce, support self-care and build health literacy among their staff.

Domain 2 should be actively tested through structured engagement with staff, staff networks, Chaplaincy staff and trade unions with reference to evidence and insight. These groups should work together to lead and conduct engagement sessions with staff wherever possible.

Domain 2: Workforce health and well-being

2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions

2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source

2C: Staff have access to support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source

2D: Staff recommend the organisation as a place to work and receive treatment

Domain 2 data sources

The Domain 2 outcomes are designed to promote understanding of the workforce also being patients. **Your workforce includes those who are on contracts and those who are classed as "Bank Staff"**.

As of March 2022, the NHS employs more than 1.2 million full time equivalent staff members in hospitals and community care settings alone. These people belong to community groups, have protected characteristics, and could be at risk of suffering from inequality of access, experience and outcome when using NHS services.

The impact of COVID-19 has highlighted the crucial importance of the health and wellbeing of the NHS workforce, and the EDS recognises that.

Through assessment of how organisations support our NHS workforce to manage their long term conditions; to reduce stress (and the causes of stress) within the working environment; and to support them to have healthier lifestyles, outcomes 2A and 2C have been designed to complement both the WRES and WDES.

This provides NHS organisations with an opportunity to understand the link between the impact of discrimination on staff and the consequent impact on patient care. Domain 2 also provides an opportunity for organisations to improve access to, experience of and outcomes of services, particularly those provided for those community groups at risk of suffering inequalities in healthcare - groups which staff members and their families may well belong to.

For outcome 2A, organisations should collate data on the health of their workforce. Due to the impact of COVID-19, and in line with the NHS Long Term Plan, the EDS encourages NHS organisations to use the collated data to create support for their staff to manage the following conditions:

- Obesity
- Diabetes
- Asthma
- COPD
- Mental Health conditions

Outcome 2B

EDS Domain 2 Outcome 2B directly corresponds to WRES Indicators 5&6 and are based on the same underlying information (Outcomes and Key Finding indicators from the NHS Staff Survey [22, 23, 25 and 26]). Therefore, organisations should use their latest WRES data rather than collecting fresh information for Domain 2.

More information on the WRES, including links to the latest data reports, can be accessed at: https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/

Similarly, EDS Domain 2 outcome 2B corresponds to WDES Metric 4A. Therefore, when gathering workforce information on Disability, organisations should simply use their latest WDES data rather than collecting fresh information. More information on the WDES can be accessed at: https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/wdes/

Special mention needs to be made of the handling of Outcome 2B: ‘When at work, staff are free from abuse, harassment, bullying and physical violence from any source’. This outcome refers to incidents in the past 12 months in line with the NHS Staff Survey, the WRES and WDES.

Organisations will look at abuse, harassment, bullying and physical violence from any source, as set out in in Outcome 2B. In addition, they should identify the various sources of such behaviour, as solutions and actions will vary according to source.

Outcome 2D

For outcome 2D, local surveys and focus groups are encouraged to understand staff experiences as staff members and, where appropriate and relevant, as service users/patients that may potentially use or have used the services from Domain 1.

Sickness and absence data can be used to understand where there may be an opportunity to support staff who suffer with long term conditions.

Organisations should use local data surrounding complaints, disciplinaries, recruitment/appointments and staff retention, alongside information from exit interviews and broken down into protected characteristics, to understand the experience of their workforce. Further focus groups are encouraged to investigate commonalities and themes. Findings from indicator KF1 in the NHS Staff Survey can help inform the rating for this outcome.

Domain 2 data groupings

For the four protected characteristics considered by the NHS Staff Survey as a matter of routine, the following groupings should be used during an initial testing:

- Age: 16 to 30 years, 31 to 40 years, 41 to 50 years, 51 to 60 years, and 61 years and over
- Gender (sex): female, male and prefer to self-describe
- Ethnicity: White and BAME
- Disability: Disabled and not disabled.

A finer breakdown of data should be used where possible. For breakdowns of sexual orientation, organisations should refer to the Sexual Orientation Monitoring Information Standard. Other breakdowns for other protected characteristics will depend on overall numbers, and there is a need for anonymity where numbers are small.

Domain 2 rating

Once as much evidence and insight as possible has been assembled and analysed, using the above clusters and breakdowns, each outcome is then tested and rated by staff, staff networks, trade unions and organisations from Undeveloped to Excelling as follows:

Undeveloped activity – **organisations score 0** for each outcome	Those who score **under 8,** adding all outcome scores in all Domains, are rated **Undeveloped**
Developing activity – **organisations score 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all Domains, are rated **Developing**
Achieving activity – **organisations score 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all Domains, are rated **Achieving**
Excelling activity – **organisations score 3** for each outcome	Those who score **33,** adding all outcome scores in all Domains, are rated **Excelling**

Scores are then added together to provide organisations with an overall score to form the EDS Organisation Rating.

Information on how to score and rate outcomes across the Domains can be found in the EDS Ratings and Score Card supporting guidance document. Please refer to this guidance document before you start to score. This guidance has a full explanation of the rating procedure and can assist you and those you are engaging with to ensure rating is done correctly.

Domain 3: Inclusive leadership

Where NHS organisations are using the EDS in partnership with other organisations to review services for patients, they should take the same partnership approach when it comes to reviewing their leadership with respect to equality and health inequalities. In this context, these partnerships could comprise: Governing Bodies and senior managers of single region-based CCGs; the Boards and senior managers of providers; the Boards and senior managers working at a local or place-based level; and the Boards and senior managers of ICS, once formed.

Within NHS organisations, it is the senior leadership that usually sets the culture and tone and determines quite how inclusive the organisation is. Domain 3 comprises three outcomes that are a real test of commitment and 'inclusive leadership'. All scoring in Domain 3 should be independently tested, that is, by a third party with no direct involvement in managing or working for the organisation(s), alongside trade union staff.

Domain 3: Inclusive leadership

3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities

3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed

3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

Please note that throughout this guidance, for convenience, the terms Board and Board members are taken to include Governing Body and Governing Body members, respectively.

Domain 3 evidence and ratings

Outcome 3A is tested and rated according to the average number of instances that Board members and other senior leaders could demonstrate to the independent evaluator where they actively promoted equality in the last year as part of their Board or executive role.

For evidence, they may point to: papers and reports they have authored; attendance to cultural or religious celebrations that is not connected to their own heritage or culture; speeches or talks they have given at local events; interviews to the media; and so on.

These leaders should also be prompted for their active involvement in the promotion and use of the EDS, the WRES and WDES, and how they have helped to ensure that results have improved their organisations' equality performance.

Outcome 3B is tested and rated by reference to a random sample of substantive Board or prime Committee papers from the last year and the percentage of papers that identified equality-related impacts, through analyses or other assessments which must be defined, and how negative impacts were mitigated, monitored, and managed.

The involvement of trade unions is required in producing the overall rating for Domain 3, particularly for outcomes 3A and 3C. Organisations must include evidence of this involvement.

Equal Pay Audits and Gender Pay Gap reporting

The NHS Staff Council, trade unions and NHS Employers have published information and support material on equal pay.

In 2018, the government made Gender Pay Gap reporting mandatory by amending the Equalities Act 2010 (Specific Duties and Public Authorities) Regulations 2017 so that all public sector employers with more than 250 employees are required annually to measure and publish their Gender Pay Gap prominently on the government website and their own. NHS can use their ESR reports in order to analyse this information.

NHS Employers' information and advice on Gender Pay Gap reporting can be found at: https://www.nhsemployers.org/articles/gender-pay-gap-reporting

Independent Evaluators and Peer Reviewers

Suitable independent or third parties for the evaluation of Domain 3 could include a local Healthwatch, a grassroots VCSE organisation, a place-based umbrella group for voluntary organisations, or a neighbouring NHS organisation.

Where organisations are working in partnership and using the EDS to look at both the partnership overall and the individual organisations within the partnership, the requirement for independent evaluation is increased. Two or more NHS organisations working on the EDS together can agree to peer review each other’s Inclusive Leadership (and other) outcomes and ratings.

In partnership situations, results from Domain 3 will be of interest to both individual organisations and to partnership arrangements. For Domains 2 and 3, comparisons on which part of a system is doing well, and which part not so well, could be instructive and help to boost equality performance and reduce inequalities both in particular parts of the system and in the round.

Approval of EDS ratings and next steps

Once the EDS report has been compiled, it should be sent to Boards and appropriate Committees for comment and final agreement. Some Boards and Committees may wish to provide constructive challenge where they consider there may be insufficient or inconsistent evidence for the ratings reached, or if any part of the process was flawed.

EDS results should feed into the setting of strategic, corporate and equality objectives and the annual reporting of progress on the Public Sector Equality Duty (PSED). Providers trusts should use the results in their Quality Accounts.

Based on the EDS results, improvement plans should be developed by organisations for the chosen services, and for workforce and leadership development. Best practice dictates that learning should be extended to other services for improvement purposes.

The completed and approved EDS report should be published on NHS organisation websites and made available to the public in accessible ways. Organisations are advised to publish as much information as possible from the EDS review. Where organisations have departed from the grading processes described in this document, they should explain, on their websites, precisely how they have rated their EDS outcomes across affected Domains, and with or by whom.

Organisations should explain on their websites how they drew together qualitative data for EDS purposes to complement quantitative data, or to explain a lack of quantitative data. This information must be kept up to date.

Within a partnership of organisations, comparisons and shared learning between the various individual organisations in the partnership is highly encouraged and identified as good practice.

Care Quality Commission (CQC) Well-Led

While the EDS is designed for local use, the CQC takes an active interest in EDS implementation. To facilitate this interest, many of the EDS outcomes can be related to the five key questions that the CQC asks during registration and inspection activities. For further information, please see The EDS Supporting Information guide.

The Public Sector Equality Duty (PSED)

Using the EDS will help NHS organisations to meet the requirements of the PSED of the Equality Act 2010, including setting their equality objectives and, under the specific Duties, publishing information and evidence showing they have addressed the General Duty of the Act; namely, eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010; advancing equality of opportunity between people who share a protected characteristic and those who do not; and fostering good relations between people who share a protected characteristic and those who do not.

The better the coverage of the EDS, and the better documented it is, the more able will NHS organisations be able to fulfil their statutory duties under the Equality Act.

Details on the Public Sector Equality Duty can be accessed at: https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty-guidance

Governance and Accountability; Support for Equality and Diversity Managers

Within both single NHS organisations and NHS partnerships, there must be adequate and effective arrangements for the governance of, and support to, those leading the day-to-day work on the EDS.

The overall responsibility for the EDS lies with the Executive Board within each organisation. This responsibility may be discharged to the/an EDI team/Senior Responsible Officer within the organisation, but board members retain overall responsibility.

Responsibilities for collating evidence for, and engagement delivery for Domain 1 sits with the EDI lead/team or equivalent **but must be assisted by managers who sit within relevant service areas**. Engagement can be delivered by and should include Lay Members, Voluntary Sector and/or Social Enterprise organisations. Responsibilities for the implementation of improvement actions for Domain 1 **sits with the leadership/management of each service to which the Domain 1 was applied**.

Responsibilities for collating the evidence for, and the delivery of Domains 2 and 3, sits with the EDI Lead/Team or equivalent **but must be assisted by boards, secretariats, senior leadership teams, human resources and organisation development teams**. For Domain 2 engagement can be delivered by - and should include - staff networks, chaplaincy and/or trade union colleagues.

For Domain 3 analysis of evidence and any engagement can be delivered by - and should include - trade union colleagues. Responsibilities for the implementation of improvement actions for Domains 2 and 3 **sits with the human resources, organisational development, and senior leadership teams within organisations**.

EDI leads who carried out the review process/deliver the EDS **should not** be responsible for implementation of improvement actions but can have responsibilities surrounding monitoring and reporting for performance management purposes.

The EDS is mandated in the NHS Standard Contract. Board members and other system and senior leaders in the NHS are required to play their part and accept accountability for equality performance and improvement in their organisations.

Board champions

Good practise dictates that a Board, Governing Body member, senior or system leader for each organisation or partnership of organisations should be identified as the EDS Champion who will act as the senior responsible officer and will be accountable for oversight and strategic leadership of the process. Local alternatives may be assessed if separate champions for the different schemes is preferred.

This Champion should keep in routine contact with their local/regional Equality and Diversity teams to make sure that issues and concerns are heard and shared at Board and Committee levels.

In particular, EDS Outcome 3A checks on the input and support that Board members have given to the EDS in the year under consideration. At both Annual General Meetings and Board meetings in public they can give their support to the EDS and summarise results and actions.

Boards should assume responsibility for ensuring that EDS and related equality websites – or parts of website – for their organisations are kept up to date.

Organisational culture

As the NHS shapes its policies and structures to meet the challenges it faces now, and in the future, a focus on culture is as important as ever. The culture of an organisation or system shapes the behaviour of everyone working within it; it affects the quality of care it provides; and it impacts on its overall performance.

It is more often than not, the Board members and other senior leaders of the NHS who set the culture within their organisations. The NHS Interim People Plan states *‘Our leaders play a key role in shaping the culture of NHS organisations. All NHS leaders, in both providers and commissioners, need to focus on developing a positive, inclusive and people-centred culture that engages and inspires all our people and with a clear focus on improvement and advancing equality of opportunity*’.

It follows that Board members and other senior leaders who are committed to equality and who openly support their staff with equality, diversity and inclusion responsibilities can make all the difference. By establishing, maintaining, and personally demonstrating inclusive and compassionate leadership cultures, where equality matters, Board members and other senior leaders can help make inroads into the most persistent and damaging effects of witting or unwitting discrimination.

Acknowledgements

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Annex A - Data sources for Domain 1

There are a range of local and national sources that local NHS organisations and their stakeholders can draw on to inform the discussions that they will have with service users, patients, the public and local VCSE organisations.

General Practice Patient Survey

If a service selected for EDS evaluation and rating is primary care, then data broken down by six protected characteristics may be drawn from the General Practice Patient Survey results, which are now published annually. Various questions asked for this survey have a direct bearing on three of the EDS Domain 1 outcomes. These questions are as follows:

EDS Domain 1 Outcomes and Questions from the GP Patient Survey, 2018

Outcome 1A: Access

- Q1. Generally, how easy is it to get through to someone at your GP practice on the phone?
- Q6. How easy is it to use your GP practice's website to look for information or access services?
- Q8. How satisfied are you with the GP appointment times that are available to you?

Outcome 1B: Needs met

- Q30. Thinking about the reason for your last GP appointment, were your needs met?

Outcome 1C: Free from harm

- See other sources below

Outcome 1D: Positive experience

- Q31. Overall, how would you describe your experience of your GP practice?

The GP Patient Survey ask patients for information on their sex (Q54), age group (Q55), ethnic group (Q56), sexual orientation (Q62) and religion

(Q63). In addition, the GP Patient Survey collects information on long-term physical or mental health conditions, disabilities, or illnesses (Q34), long-term conditions (Q35), activities of daily living (Q36), and hearing (Q60), from which disabilities can be identified.

Please note that it may only be possible to analyse GP Patient Survey results on a borough or even regional basis because numbers of responding patients can be small. Also note that GP Patient Survey questions may change over time.

National Patient Cancer Experience Survey

The National Cancer Patient Experience Survey 2019 is the ninth iteration of the survey first undertaken in 2010. It has been designed to monitor national progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients.

The survey was overseen by a national Cancer Patient Experience Advisory Group. This Advisory Group set the principles and objectives of the survey programme and guided questionnaire development.

The survey was commissioned and managed by NHS England with survey provider Quality Health responsible for designing, implementing, and analysing the survey. Reports are produced at national level, for CCGs, for trusts, and for Cancer Alliances.

National reports present data on key questions such as ‘Were you involved as much as you wanted to be in decisions about your care and treatment?’ to ‘Overall, how would you rate your care?’, disaggregated by age, gender (sex), sexual orientation, ethnicity, and deprivation. With regard to these factors, data reports at sub-national levels are be limited by small numbers. Hence only standalone data on the age and gender of patients who took part is usually given.

CQC National Patient Surveys

The CQC's NHS Patient Surveys[7] programme was established to support patients and public to have a real say about the quality of NHS services. It includes annual surveys of adult inpatients and community mental health services. Additional acute surveys covering maternity services, urgent and emergency care services and children's inpatient and day-case services are also undertaken at least once every two years.

Each person who is asked to complete a survey is asked about their age, sex, religion, sexual orientation, ethnicity, and long-term condition. As well as a national overview, results are published for individual providers.

The 2017 Adult Inpatient survey (published 2018) asked a range of questions that have potential relevance to the EDS, where the answers can be broken down by protected characteristic for several or more protected characteristics. Because numbers can become small – about 1,250 patients per provider are approached and response rates vary between 30-50% - results by protected characteristics may not be available, or may be very limited, for some providers. However, it is worthwhile to see what is available from this source of data when EDS activity is being scoped and planned.

Friends and Family Test

The NHS Friends and Family Test (FFT)[8] asks people who have completed their treatment or are discharged from a service the question: '*How likely are you to recommend our service to friends and family if they needed similar care or treatment?*' Answers are ranked from 'extremely likely' to 'extremely unlikely'. Following this question, people are given the chance to add free text comments.

The FFT is used across most NHS services including community care, hospitals, mental health services, maternity services, GP and dental practices, emergency care, patient transport, and more.

In FFT Guidance, it is strongly recommended that people are asked demographic questions and due consideration is given to the nine protected characteristics. Where a provider has implemented this particular part of the FFT guidance, the

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[7] https://www.cqc.org.uk/publications/surveys/surveys
[8] https://www.england.nhs.uk/fft/

answer to the FFT question analysed by the protected characteristics can be used in the evaluation and rating of EDS outcome 1D for a particular service.

The Secondary Uses Service (SUS)

SUS[9] is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. This source of data can also be explored for EDS purposes.

A simple but effective way of using SUS, would be to ask a trust to provide data on who accessed the service that is being evaluated and rated with the EDS, broken down by the three protected characteristics that they routinely collect information on: age, sex, and ethnicity.

Results for each protected characteristic can then be compared to see if the expected rates of access for each protected characteristic match to the actual rate. If, for example, one of the services selected for EDS review is the Accident and Emergency Department of a local hospital, and within the last year there was a significantly higher proportion of men accessing the emergency department, while a significantly higher proportion of women accessed the urgent care centre, a basis has been laid for asking pertinent questions about this result.

Answers can feed into the evaluation and rating of EDS Outcome 1A.

Serious incidents, never events and complaints

NHS providers are required to keep records of the occurrence of serious incidents and “never events”. They are essential in the review of actual and potential harm that patients might experience. Safer staffing levels in hospital wards and other facilities can also feed into overall assessments of harm. Such data, if broken down by the protected characteristics of patients – or at least by age, sex, and ethnicity – can inform the EDS evaluation and rating of Outcome 1C.

Data from Complaints registers held by NHS organisations can be most useful in monitoring potential harm and patient experience (EDS Outcomes 1C and 1D). Of particular concern will be the nature of complaints and the timeliness in dealing with them. It should be entirely possible for hospitals to match complainants with their

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[9] Secondary Uses Service (SUS) - NHS Digital

records of the age, sex, and ethnicity of patients, and so provide detailed breakdowns of complaints by way of these three protected characteristics.

Accessible Information Standard

For outcome 1A, a good source of information can be the requests made to organisations, and their responses, under the Accessible Information Standard[10]. This Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need, from health and care services. It requires organisations to do five things:

1) Ask people if they have any information or communication needs and find out how to meet their needs.
2) Record those needs clearly and in a set way.
3) Highlight or flag the person's file or notes so it is clear that they have information or communication needs and how to meet those needs.
4) Share information about people's information and communication needs with other providers of NHS and adult social care when they have consent or permission to do so.
5) Take steps to ensure that the individual receives information in an accessible and understandable format and receive any communication support which they need.

Reasonable adjustments

For outcome 1B, relatively direct answers may be sought and found, such as answers to Q30 from the GP Patient Survey [11](see above). However, another way of finding evidence for this answer is to look for reasonable adjustments made by NHS organisations without which patients' needs could not have been met.

Reasonable adjustments could include the provision of an interpreter or signer; both visual and aural means to inform patients in waiting rooms that it is their turn; longer GP appointment times for certain people where not much would be achieved in, say, 10 minutes; ramps to enable those with limited mobility to get in and out of NHS buildings. The list is almost endless. But instances where reasonable

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[10] www.england.nhs.uk/accessibleinfo

[11] https://www.england.nhs.uk/statistics/2021/07/08/gp-patient-survey-2021/

adjustments were made, and where they were not made, can sit alongside other evidence, and be acknowledged within EDS ratings.

The WDES includes ‘reasonable adjustments’ from the perspective of staff. Metric 8 looks at the ‘Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work’. NHS organisations are asked to reflect on this metric through the WDES rather than the EDS, but to mention achievements and challenges in any EDS report to Governing Bodies, Boards, and prime Committees.

The Health Inequalities Improvement Dashboard

The Health Inequalities Improvement Dashboard builds on learning from the COVID-19 pandemic around the importance of good quality data to provide insights to drive improvements in tackling health inequalities. The Dashboard provides key strategic indicators relating to health inequalities, aggregated by ethnicity and deprivation all in one place. It measures, monitors, and informs actionable insight to make improvements on CORE20PLUS5 approach and the five strategic health inequalities priorities as outlined in the 21/22 and 22/23 NHS Planning Guidance to ensure we are restoring services inclusively and narrow health inequalities. The Dashboard can be used to help those delivering the EDS to identify and target those communities and population groups who are seldom heard.

Annex B - Data sources for Domain 2

Outcome 2A can be supported by the implementation of the NHS Workforce Health and Wellbeing Plan[12], created by NHS Employers and designed to offer guidance on how to improve overall staff health and wellbeing. The document offers guidance on all elements of developing a health and wellbeing improvement strategy, and also offers examples of good practice.

Organisations are now encouraged to monitor and influence the health of their workforce. The impact of COVID-19 has shown that staff can be vulnerable, and those from Black, Asian, and Minority Ethnic community backgrounds, those with long term conditions and those with underlying conditions must be protected. The elderly has also been adversely impacted by COVID-19, and so the EDS now provides support for organisations to make considerations and plan for the protection of our workforce.

The outcomes of the EDS are aligned to the WRES and WDES through the NHS Staff Survey that all three systems draw on, particularly outcomes 2B and 2D.

EDS Domain 2 Outcomes and the NHS Staff Survey 2018

Outcome 2B: Free from abuse, harassment, bullying and physical violence

- KF22. % experiencing physical violence from patients, relatives, or the public in last 12 months.
- KF23. % experiencing physical violence from staff in last 12 months
- KF25. % experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months
- KF26. % experiencing harassment, bullying or abuse from staff in last 12 months

Outcome 2D: Recommend the organisation

- KF1. Staff recommendation of the organisation as a place to work or receive treatment

Please note that NHS Staff Survey[13] questions and the numbering of Key Finding indicators may change over time.

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[12] https://improvement.nhs.uk/resources/workforce-health-and-wellbeing-framework/

[13] https://www.nhsstaffsurveys.com/results/

Outcome 2C requires evidence of actions taken to support outcome 2B. In doing this, NHS organisations are now required to show that they are not only working towards providing a safe environment for their workforce, but that effective measures are in place to support those who have suffered from abuse, harassment, bullying and physical violence from any source.

Domain 2 has been altered to support and promote the increase of support required for staff members who are from Black, Asian, and Minority Ethnic communities, LGBT+ and those with physical disabilities and mental health conditions.

Annex C - Summary of sources of evidence and insight

NHS organisations and their stakeholders should explore these national sources[14], for evidence and insight and/or useful context on themselves and peers. Where sources give breakdowns of data by protected characteristics, the specific protected characteristics are described.

- Primary Care – GP Patient Surveys: age, sex, ethnicity, long-term physical or mental health conditions, disabilities or illnesses, long-term health conditions (including some disabilities)
- CQC's National Patient Survey Programme: age, sex, religion, sexual orientation, ethnicity, and long-term conditions
- National Cancer Patient Experience Survey[15]
- NHS England's Overall Patient Experience Scores
- Friends and Family Test (FFT): NHS organisations are encouraged to collect equality and diversity data, including the protected characteristics, as part of the FFT for patients and staff
- Office of National Statistics' National Survey of Bereaved People
- NHS Staff Survey: age, gender (sex), disability, ethnicity and, where requested, religion and sexual orientation
- Other local surveys[16] delivered by smaller organisations within the wider system collating information on staff, patients, and service users
- Model Health System[17] – a digital information hub designed to help NHS providers improve their productivity and efficiency (going forward, Workforce Race Equality Standard data will also be hosted on this hub):

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[14] https://www.england.nhs.uk/statistics/statistical-work-areas/patient-surveys/
[15] https://www.ncpes.co.uk/current-results/
[16] https://www.hqip.org.uk/national-programmes/quality-accounts/ and https://www.hqip.org.uk/national-programmes/quality-accounts/
[17] https://www.england.nhs.uk/applications/model-hospital/

- Patient Reported Outcome Measures (PROMS)[18] for hip replacements, knee replacements, groin hernia, varicose veins
- The National Clinical Audit and Patient Outcomes Programme (NCAPOP)[19]
- NHS Oversight and Assessment Framework[20]

Performance data related to the pledges (standards) to patients within the NHS Constitution, reported at ICS, trust, regional and national levels can play into local EDS discussions, particularly when care pathways are being reviewed.

If data on protected characteristics is limited, due to small numbers, or lack of data on particular protected characteristics, key local findings, or reflections on, for example, cancer care waiting times (for treatment) and referral to treatment waiting times can feed into local focus groups and other patient-led discussions. Information about the pledges – often referred to as the NHS standards – can be accessed on pages 33 and 34 of the Handbook for the NHS Constitution, 2019[21].

In addition, local NHS organisations and their stakeholders should explore the following local sources:

- NHS Provider data can be requested from, and supplied by SUS (Secondary Uses Service, NHS Digital) / CSU Business Intelligence. Usually, these results give data on age, gender (sex), and ethnicity
- Joint Strategic Needs Assessment (JSNAs), which can be relied on to include demographic and other population-based data that refers to the protected characteristics
- Local Healthwatch reports, which will often refer to equality and inclusion
- CCG Governing Body, NHS Provider Board, and prime Committee papers – including information on: NHS performance, patient experience, comments and complaints, NHS staff survey results, Equal Pay Audits and

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[18] https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms

[19] https://www.england.nhs.uk/clinaudit/

[20] https://www.england.nhs.uk/commissioning/regulation/ccg-assess/

[21] https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england

the Gender Pay Gap for staff; and local implementation and results from the EDS, WRES and WDES, and equality analyses

The more diverse the attendance at EDS rating events, and the better the record of who said what, the better the overall usefulness of the aggregated evidence and insights will be.

Annex D - Care Quality Commission (CQC)

The CQC checks that NHS organisations are using the EDS. The EDS outcomes relate well to the five key questions in the CQC's registration and inspection regime: whether services are safe; effective; caring, responsive to people's needs; and well-led. The links between eight of the eleven outcomes and the key questions is described in the table below.

EDS Outcomes	***CQC's Key Questions***
1A: Service users have required levels of access to the service	Are they responsive?
1B: Individual service user's health needs are met	Are they effective?
1C: When service users use the service, they are free from harm	Are they safe?
1D: Service users report positive experiences of the service	Are they caring?
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD, and mental health conditions	N/A
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Are they well-led?
2C: Staff have access to support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	N/A
2D: Staff recommend the organisation as a place to work and receive treatment	All key questions
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Are they well led?
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Are they well led?
3C: Board members, system, and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	N/A

The way that the EDS is implemented is considered when the CQC is applying the 'well-led' key question. Action to address specific EDS outcomes may also have a positive impact on ratings for the other four key questions, as shown in the above table.

For more information on CQC's key questions and how they are used, please access: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/five-key-questions-we-ask

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