Embedding EDI into Reconfiguration through the IDMF

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Paper D

Purpose of report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	X
Noting	For noting without the need for discussion	

Previous consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
Reconfiguration Programme Cmte	22/01/2021	Discussion and assurance
Executive Board - ESB	02/02/2021	Discussion and assurance
Trust Board Committee		
Trust Board		

Executive Summary

Context

The Inclusive Decision-Making Framework (IDMF) aims to enhance our decision-making processes and ensure they are not influenced by biases, and thoroughly consider the diverse needs of our patients, our workforce and the wider community.

Inclusive decision-making involves thorough consideration of equality, diversity, and inclusion when we are developing and implementing strategy, plans, programmes, projects or commissioning, and procuring services.

We have created the framework to support the embedding of equality, diversity and inclusion into our culture, so that it can enable transformation and innovation across the LLR System.

This means promoting inclusive and compassionate leadership so that we can create a diverse workforce which is able to deliver 21st century care to all of the communities in Leicester, Leicestershire and Rutland. The successful application of this framework ensures that we can

integrate equality analyses into our decision-making to reduce health inequalities and attract, retain and develop diverse talent.

The Framework takes in to account our role as an anchor institution whose long-term sustainability is tied to the health and wellbeing of the local community we serve.

Questions

1. How have we practically applied the IDMF six steps and principles to the Reconfiguration Programme?
2. How do we share and build upon the learning from the first 6 months of integration?
3. How do we make the application of the six steps of the IDMF to the Reconfiguration Programme sustainable?

Conclusion

1. We have practically applied the six steps of the IDMF and its principles to key stages of the project management lifecycle through collaborative working, knowledge exchange and drawing on our collective intelligence. We will further embed this work into subsequent stages of the lifecycle to achieve full integration.
2. Extension of the Action Learning Set (ALS) approach to other teams/services area. It is suggested that the creation of a best practice repository of case studies which illustrate practice application of the IDMF will also foster a culture of learning across the LLR system.
3. Alignment to the work currently underway to reduce health inequalities and develop new models of care with the outputs of the integration of the IDMF to the Reconfiguration Programme.

Input Sought

We would welcome the Trust Board's input regarding:

- Further embedding this work into subsequent stages of the lifecycle to achieve full integration
- Extension of the Action Learning Set (ALS) approach to other teams/services area.
- Alignment to the work currently underway to reduce health inequalities and develop new models of care with the outputs of the integration of the IDMF to the Reconfiguration Programme.

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	[Yes]
Improved Cancer pathways	[Yes]
Streamlined emergency care	[Yes]
Better care pathways	[Yes]
Ward accreditation	[Yes]

2. Supporting priorities:

People strategy implementation	[Yes]
Investment in sustainable Estate and reconfiguration	[Yes]
e-Hospital	[Yes]
Embedded research, training and education	[Yes]
Embed innovation in recovery and renewal	[Yes]
Sustainable finances	[Yes]

3. Assessment and Patient and Public Involvement considerations:

- What was the outcome of your Equality Impact Assessment (EIA)? N/A

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required - PPI will be assessed as part of the individual projects

- How did the outcome of the EIA influence your Patient and Public Involvement? N/A

- If an EIA was not carried out, what was the rationale for this decision? N/A

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	**Select (X)**	**Risk Description:**
Strategic: Does this link to a ***Principal Risk*** on the BAF?	x	PR 7 – Reconfiguration of estate
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: [TBC]
6. Executive Summaries should not exceed **5 sides** [My paper does comply]

Embedding EDI into the Reconfiguration Programme through Inclusive Decision-Making

1. Introduction

1.1. In July 2020 a number of LLR System Equality, Diversity and Inclusion (EDI) priorities were identified by the EDI Taskforce; this included the creation and implementation of an Inclusive Decision-Making Framework (Appendix 1). The Inclusive Decision-Making Framework (IDMF) aims to enhance our decision-making processes and ensure they are not influenced by biases, and thoroughly consider the diverse needs of our patients, our workforce and the wider community.

1.2. Inclusive decision-making involves thorough consideration of equality, diversity, and inclusion when we are developing and implementing strategy, plans, programmes, projects or commissioning, and procuring services.

1.3. We have created the framework to support the embedding of equality, diversity and inclusion into our culture, so that it can enable transformation and innovation across the LLR System.

1.4. This means promoting inclusive and compassionate leadership so that we can create a diverse workforce which is able to deliver 21st century care to all of the communities in Leicester, Leicestershire and Rutland. The successful application of this framework ensures that we can integrate equality analyses into our decision-making to reduce health inequalities and attract, retain and develop diverse talent.

1.5. The Framework takes in to account our role as an anchor institution whose long-term sustainability is tied to the health and wellbeing of the local community we serve.

1.6. To facilitate effective implementation three key areas have been identified to test the application of the framework to different contexts. These were:

- The Reconfiguration Programme
- LLR Health Inequalities Framework
- LLR Clinical Design Group Planning

2. Application of the Inclusive Decision-Making Framework to the Reconfiguration Programme

2.1. Putting patients at the heart of what we do, and acknowledging that the environment and spaces in which people are treated is as important as the quality of clinical care delivered, is central to the integration of the IDMF into the Reconfiguration Programme. Throughout the pilot process there has been a clear focus on the patient journey and enabling service

enhancements and improved health outcomes for all patients regardless of their social background.

2.2. EDI considerations have been incorporated at the programme and project level over a 6 month period from July-December 2020. Below is a summary of how this activity maps on to the relevant steps of the framework, reflecting the iterative nature of the embedding process.

3. Setting out the purpose of integrating the six steps of the IDMF into the Reconfiguration Programme

3.1. In the summer of 2020 an initial meeting took place between the Head of EDI and the Reconfiguration Programme Director to discuss the integration of the IDMF into the Reconfiguration Programme. It was agreed that there was a need for a whole team workshop to present the framework and discuss its application to the different work streams within the programme. It was agreed that the pilot would initially focus on Programme Management Office PMO processes and that monthly meeting would take place between the Head of EDI, Head of the Reconfiguration PMO and the Reconfiguration Site Manager to monitor progress and agreed key actions.

4. Developing an evidence-base

4.1. During the aforementioned monthly meetings specific projects were identified which would allow for the testing of the six steps of the IDMF at the design and the implementation stages. It was agreed that it would be advisable to create a 'blueprint' of what works for each of the key stages of the project management lifecycle which would include:

- PCBC (Pre-Consultation Business Case)
- Consultation stage
- DMBC (Decision Making Business Case)
- PID (Project Initiation Document)
- Design Brief
- COP (Clinical Operational Policies)
- SOP (Standard Operating Procedure)
- Implementation stage
- Evaluation

4.2. Work to date has been completed with respect to four out of the 10 stages of the lifecycle at the programme and project level.

- **Project Initiation Document** for the Children's Hospital project
- **Clinical Operational Policy** for Generic Adult Inpatient Ward project
- **Design Brief** for the Reconfiguration Programme
- **Consultation Stage** for the Reconfiguration Programme

Case Study Example: Generic Adult Inpatient Ward Clinical Operational Policy

The Head of EDI and the Project Manager worked together on reviewing the COP to ensure that EDI considerations were included within the policy. This involved identifying the relevance of each policy option and detailing the positive effects on diverse groups of patients and staff. The key outputs from this work included:

- Promoting accountability by including EDI as a criteria for sign-off of the policy
- Inclusion of a revised EDI statement which included the strategic and operational imperatives as well as the legal considerations under the EA 2010
- Health Care Records (E-Records and Written Hard Copies) to embed the key principles of the Accessible Information Standard with respect to recording, flagging, and sharing information, to meet the needs of patients with sensory impairments, learning difficulties and disabilities.
- Privacy and dignity of patients section of the policy to include a statement relating to inpatient wards to be not only welcoming but also inclusive and free from harassment and discrimination.
- Principles of inclusive decision-making being incorporated into ongoing service development beyond the policy
- Accessibility needs of those with disabilities to inform wayfinding approach and transport plans
- Same Sex Accommodation to protect the privacy and dignity of patients of all genders
- Identification of the need to include respect, civility and dignity considerations as they relate to our patients who identify as Trans or Non-Binary
- Patient Areas and Day Rooms and Staff Room/Kitchen Facilities to be fully accessible to those with disabilities and specific religious and cultural needs
- Staff gender neutral toilets to include sanitary facilities

These additions to the COP are intended to be operationalised as part of the progression of the project through subsequent stages of the project management lifecycle.

4.3. The EDI considerations and learning incorporated into the four areas referenced above will be shared with the wider Reconfiguration Team in February 2021 for the benefit of other projects.

5. Engagement

5.1. A key aspect of the engagement stage consisted of incorporating the feedback, views and suggestions of people from diverse backgrounds. Within the context of the Reconfiguration Programme this involved working with local partners and members of LLR communities to foster learning, share ideas and model civil responsibility. The IDMF places an emphasis on the quality of these engagements to ensure that they are culturally intelligent, inclusive of different frames of reference and reflect the lived experiences of diverse groups and individuals.

Case Study: Engagement with the Somali Community in Leicester City during the formal consultation process

As part of the wider Consultation and Engagement to inform the development of the Reconfiguration Programme the Head of the Reconfiguration PMO and Clinical Commissioning Group (CCG) colleagues worked with Eva Radio as a way of getting information in to the heart of communities. Eva Radio is a community radio initiative which follows the key issue which affect diverse ethnic groups within Leicester.

Reconfiguration Team and CCG colleagues reflected on their experience of engaging with the Somali Community working with a local community leader. The team observed that members of the Somali Community had low rates of completion for the consultation survey that they had been circulated which focused on the Building Better Hospitals Programme. During an interview on Eva Radio with the team and a local Somali community leader, it became clear that perceptions of authority within the Somali community differed from that within other communities. The Somali Community viewed clinicians as authority figures whose views and opinions were to be respected, not questioned. Hospitals were the physical embodiment of this authority. When presented with the survey and asked for their views on how the proposals for the Programme would meet their needs, members of the community did not think it appropriate to feedback their views as this would challenge the voice of authority figures.

The Team experienced a 'light bulb moment' and were able to adjust their messaging to take the perceptions of the Somali community into account. Through working closely with the local community leader they met at Eva Radio, the consultation team took a collaborative working approach which opened up new channels of communication e.g. Engagement with the Somali Community via Facebook Live Streams which reached 500+ people.

Through this touch point in the engagement programme colleagues developed new learning and improved their level of cultural intelligence and competence to produce better engagement outcomes. This in turn helped to build trust and positive relationships with community members and leaders which will inform future engagement.

6. Identification of positive and negative effects of the Reconfiguration Programme decision-making process on diverse groups of patients

6.1. An initial analysis of the positive and any potential adverse effects of the programme on people with respect to their Age, Disability, Gender Identity, Pregnancy or Maternity, Race, Religion or Belief, Sex, Sexual Orientation has been considered using information gathered at stages 1-4 of the project management lifecycle. Evidence of this analysis with respect to consideration of EDI is detailed with in the PID, Operational Policy Document, Design Brief and Consultation reports which reduces the need for a specific form.

7. Creating a climate of learning

7.1. Throughout the process colleagues from the EDI and Reconfiguration Teams have engaged in a parallel learning journey which involved working collaboratively and the sharing of knowledge from the respective disciplines.

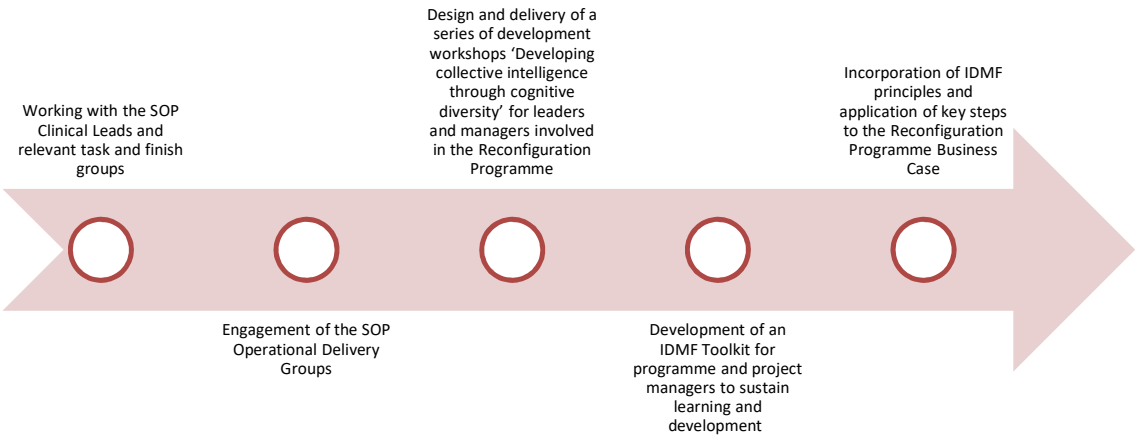
7.2. The Head of EDI used a combination of appreciative enquiry, and coaching techniques to foster a supportive learning environment in engaging with programme and project managers. An emphasis was placed on creating an environment where the collective intelligence of the team could lead to enhanced analysis and problem-solving.

7.3. Project managers were empowered to take forward the learning and put it into practice in their day-to-day work. The learning process is illustrated in Figure 1 below:

Figure 1: NHS England Action Learning Process based on the ABC of Action Learning by Reg Revans

8. Phase 2 of the embedding process

8.1. In terms of next steps it is suggested that the following key actions be taken forward over the next six months:



9. Conclusion

9.1. The work which has been undertaken to integrate the six steps of the Inclusive Decision-Making Framework is at an early stage and will develop as the Reconfiguration Programme progresses through the different stages of the lifecycle. Over the past 6 months, however, we have been able to illustrate that there is evidence of EDI considerations being integrated into the Reconfiguration Programme. Further work will be taken forward over the next 6 months which will build on our progress and extend learning across the remainder of the project management lifecycle.

Appendix 1

INCLUSIVE DECISION-MAKING FRAMEWORK

Produced by Aloma Onyemah
Head of Equality Diversity and Inclusion
JUNE 2020

CONTENTS

FRAMEWORK OVERVIEW

The Inclusive Decision-Making Framework aims to enhance our decision-making processes and ensure they are not influenced by biases, and thoroughly consider the diverse needs of our workforce, our patients and the wider community.
Inclusive decision-making involves thorough consideration of equality, diversity, and inclusion (EDI) when we are developing and implementing strategy, plans, programmes, projects and commissioning and procuring services.

Legal context

The Equality Act (2010) s.149 places a legal duty on all public bodies including Health and Social Care bodies to have thorough consideration of the three aims of the equality duty when exercising their functions as employers, and service providers. The legal duty is a 'due regard' duty and is referred to as the Equality Duty and incorporates three aims set out below:

- Elimination of unlawful discrimination, harassment and victimisation
- Advancing equality of opportunity
- Fostering Good relations between those who share a protected characteristic and those who do not.

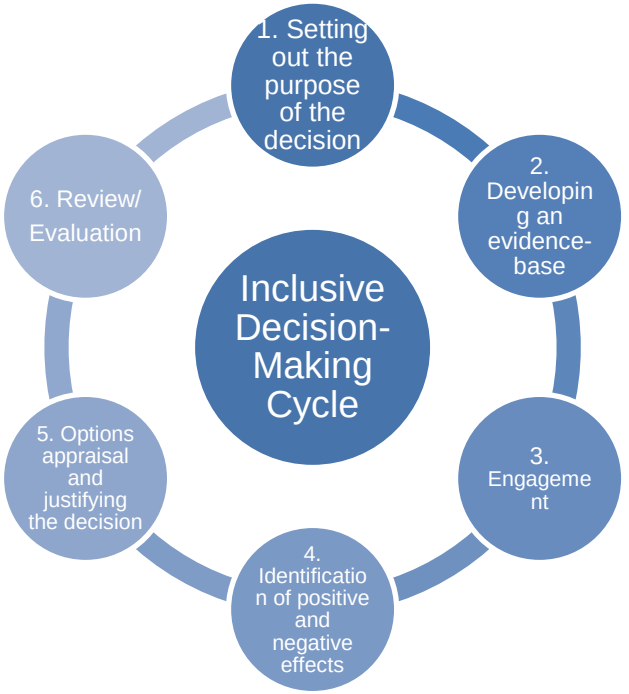
The new Equality Duty is designed to reduce bureaucracy while ensuring public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all. The Equality Duty differs from previous legal duties under equalities legislation in place before 2010 which aimed to assess the impact of policies on equality groups (EIAs).

Why have we created the framework?

We have created the framework to support the embedding of equality, diversity and inclusion in to our culture so that it can enable transformation and innovation across the LLR System. This means promoting inclusive and compassionate leadership so that we can create a diverse workforce which is able to deliver 21st century care to all of the communities in the Leicester, Leicestershire and Rutland. The successful application of this framework ensures that we can integrate equality analyses into our decision-making to reduce health inequalities and attract, retain and develop diverse talent.

Who is this framework for?

This framework is for all staff to apply in their day to day work. This is in recognition that we are all leaders in our own right and have a part to play in embedding EDI across the system. This document provides some guidance on how best to apply the framework and signposts to resources available through the toolkit.



FOSTERING A CULTURE OF INCLUSIVE DECISION MAKING

Mitigating the impact of bias

One of the key barriers to inclusive decision-making is bias. Bias is not just a cognitive process which impacts on the way we think, it is also affective and behavioural. This means that it produces an emotional response which impacts not only the way we think but also our behaviours. Bias prevents us from making rational decisions because our brains make mental shortcuts which impacts on the quality of our choices. Biases can be social, financial or promote short-termism and hinder our ability to make accurate projections about the future.

Social biases have a significant impacts on relationships affect team and organisational cultures. An example of social bias would be Bandwagon Effect when people do something because others are doing it. Affinity Bias is another example of social bias and usually involves selecting and developing talent in your own image.

Financial biases are described as imprecise mental shortcuts we make with numbers. An example of this would be the Ostrich Effect, sticking your head in the sand, pretending that negative financial information simply does not exist.

Short-termism refers to decisions that can be rationalised in the moment, but do not add any long-term value. An example would be Status Quo bias 'This is how we do things here'

Team and organisational decisions are often about projections about the future, but cognitive bias can challenge the accuracy of those estimates. This is known as **Failure to Estimate Bias**.

Bias is not the same as prejudice or discriminatory behaviour, but bias can lead to stereotyping of groups of people and the fostering of negative beliefs about those groups of people. If those beliefs develop into prejudices then this in turn can lead to discriminatory behaviours and practices.

Benefits of cognitive diversity

Inclusive decision-making is not a deficit concept to mitigate bias and prevent discrimination from occurring, it can create opportunities and enable innovation through promoting cognitive diversity.

Cognitive diversity or diversity of thought enables us to make smarter decisions and minimise blind spots. Cognitive Diversity is defined as 'The inclusion of people who have different ways of thinking, different viewpoints and different skills sets' (Schindler 2018)

The evidence-base underpinning the benefits of cognitive diversity shows a correlation between socially and cognitively diverse teams; and enhanced performance. McKinsey (2017) suggest that both financial performance and service quality are positively impacted by having gender and racially diverse senior leadership teams.

IMPLEMENTING THE EQUALITY DUTY TO FACILITATE INCLUSIVE DECISION-MAKING

As public bodies we need to consciously think about the three aims of the Equality Duty as part of the process of decision-making. The Equality Duty will be one of a number of factors that need to be considered. The weight given to the Equality Duty, compared to the other factors, will depend on how much that function affects discrimination, equality of opportunity and good relations; and the extent of any disadvantage that needs to be addressed.

The following principles, drawn from case law, explain what is essential in order for the Equality Duty to be fulfilled. We need to ensure:

Knowledge	• Those who exercise the public body's functions need to be aware of the requirements of the Equality Duty. Compliance with the Equality Duty involves a conscious approach and state of mind.
Timeliness	• The Equality Duty must be complied with before and at the time that a particular function is under consideration or decision is taken – that is, in the development of options, and in making a final decision. A public body cannot satisfy the Equality Duty by justifying a decision after it has been taken.
Real consideration	• Consideration of the three aims of the Equality Duty must form an integral part of the decision-making process. The Equality Duty is not a matter of box-ticking; it must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision
Sufficient information	• The decision maker must consider what information they have and what further information may be needed in order to give proper consideration to the Equality Duty.
No delegation	• Public bodies are responsible for ensuring that any third parties which exercise functions on their behalf are capable of complying with the Equality Duty, are required to comply with it, and that they do so in practice. It is a duty that cannot be delegated.
Review	• Public bodies must have regard to the aims of the Equality Duty not only when a proposal is developed and decided upon, but also when it is implemented and reviewed. The Equality Duty is a continuing duty.

IMPLEMENTING THE EQUALITY DUTY TO FACILITATE INCLUSIVE DECISION MAKING

It is important that people throughout the LLR System are aware of the Equality Duty and their role in the inclusive decision-making process. These include:

Board members – in how they set strategic direction, review performance and ensure good governance of the organisation.

Senior managers – in how they oversee the design, delivery, quality and effectiveness of the organisation's functions.

Equality, Diversity and Inclusion Teams– in how they raise awareness and build capacity about the Equality Duty within the organisation and how they support staff to deliver on their responsibilities.

Human Resources Teams – in how they build equality considerations in employment policies and procedures.

Policy makers – in how they build equality considerations in all stages of the policy making process including review and evaluation

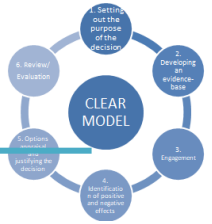
Communications Teams – in how they ensure equality information is available and accessible.

Analysts – in how they support the organisation to understand the effect of its policies and practices on equality.

Front line staff – in how they use equality considerations in the delivery of services to the public.

Procurement and commissioning staff – in how they build equality considerations in the organisation's relationships with suppliers/providers.

THE INCLUSIVE DECISION-MAKING FRAMEWORK



1. Setting out the purpose of the decision

A robust assessment will set out the reasons for the change; how this change can impact on protected groups, as well as whom it is intended to benefit; and the intended outcome. You should also think about how individual proposals might relate to one another. This is because a series of changes to different services could have a severe impact on particular protected characteristics.

Joint working with partners will also help us to consider thoroughly the impact of joint decisions on the people we collectively serve.

2. Developing an evidence base

It is important to consider the information and research already available locally and nationally. The assessment of effect on equality should be underpinned by up-to-date and reliable information about the different protected groups that the proposal is likely to have an impact on. For example, workforce dashboard data and Public Health England dashboards reporting on health inequalities. A lack of information is not a sufficient reason to conclude that there is no impact.

3. Engagement

Engagement is crucial to assessing the effect on equality. There is no explicit requirement to engage people under the equality duty, but it will help you to improve the equality information that you use to understand the possible effect of a proposal on different protected characteristics. No-one can give better insight into how proposed changes will have an impact on, for example, disabled people, than disabled people themselves.

4. Identification of positive and negative effects

It is not enough to state simply that a policy will impact on everyone equally; there should be a more in-depth consideration of available evidence to see if particular protected characteristics are more likely to be affected than others. Equal treatment does not always produce equal outcomes; sometimes authorities will have to take particular steps for certain groups to address an existing disadvantage or to meet differing needs.

5. Options appraisal and justifying your decision

The assessment should clearly identify the option(s) chosen, and their potential implications, and document the reasons for this decision.

6. Review/Evaluation

Although assessments of the effect on equality will help to anticipate a proposal's likely effect on different communities and groups, in reality the full impact of a decision will only be known once it is introduced. It is therefore important to set out arrangements for reviewing the actual impact of the proposals once they have been implemented.

Scenario 1: Executive Board Meet-Implementation of a social distancing approach to support the response to COVID-19.

Setting out the purpose of the decision: Senior Manager (SMEF) from Estates and Facilities sets out the approach and the purpose of the proposal , which is infection prevention and mitigating health and safety risks/hazards related to the pandemic. The approach would be communicated and apply to staff, patients and visitors.

Developing an evidence-base: During the meeting the SMEF set out the evidence base informing the social distancing approach which included information from NHSE&I , PHE, the HSE and patient and workforce demographic data disaggregated by equality area. The SMEF detailed how they had undertaken an analysis of the effectiveness of the proposed approach by triangulating all of the data to ensure that the core aims of the approach could be fulfilled in a way which met the needs of a diverse range of staff, patients and visitors.

Engagement: The SMEF provided detailed information in the proposal on how they worked closely with the PPI/EDI/and staff diversity networks. The SMEF explained that they initiated this activity to understand how the signage process could be inclusive of the needs of those staff, patients and visitors with sight impairments, physical mobility impairments and those whose first language was not English could be met. After attending the Disabled Staff Network and BAME network meetings the SMEF ensured that the information contained within the proposed signage would be translated in to the top 3 languages spoken in the local area, and that information would be provided in braille and audio versions. These changes would support the core aim of the proposal in terms of prevention protection and health and safety, particularly the 2m rule and meet the needs of all staff, patients, and visitors.
In addition the SMEF also worked with his equivalent in HR to endure that some of the feedback received from the Disabled Staff Network about negative behaviours directed at those who have sight impairments could inform guidance to be communicated to staff about inclusive and professional behaviours to support social distancing.

Positive and negative effects of the proposal: The SMEF set out in the proposal how the proposal would advance equality by protecting vulnerable and at risk groups by e.g. BAME Communities, Pregnant women, and people with long-term conditions, men and people over the age of 70. They specifically highlighted the new risk assessment process and associated support package.
The SMEF also set out some of the potential negative effects and how these were mitigated e.g. those with sight impairments, those with impairments related to mobility or those whose first language is not English. THE SMEF set out how there was a potential risk of indirect discrimination relating to disability and race, and provided information on how these potential risks were mitigated.

Options appraisal and justification: Following the presentation of the proposal which included the potential positive and negative effects on certain groups the Board engaged in a discussion of the Social Distancing proposal. The Chair of the Board then summarised the merits of the proposal before the Board decision to approve the approach on the condition that risks and potential negative impacts be reviewed periodically to ensure that no actual negative impacts arose during implementation. The decision was approved and justified based on the work undertaken to mitigate negative effects and the realisation of the positive effects highlighted by the SMEF.

Scenario 2: Programme Team designing implementing a large scale transformation which involves building a new Maternity Unit.

Setting out the purpose of the decision:
A is the project lead and is working with her team to develop the Projective Initiation Document (PID). (A) sets out the rationale and purpose of the transformation, including key objectives, constraints, benefits and budget. (A) sets out how the transformation will benefits all patients staff and meet the needs of the local community. A includes information gained from previous consultations to identify how the transformation project will advance equality and address health inequalities.

Developing an evidence-base:
(A) and their team develops a **Pre- Outline Business Case** detailing the clinical operational policy including the patient pathway. Demographic data disaggregated by relevant equality area is used to assess potential patient needs as well as information relating to health in equalities e.g. disproportionate number of BAME women who die in child birth
It is recognised at this point that the proposed patient pathway should consider the needs a diverse range of potential patients.

Engagement:
The design brief is developed with involvement from a diverse group of people of different abilities, genders, sexual orientations, ages and ethnicities. A decision is made to engage with staff diversity groups and work with the PPI Team. The commissioned lead architect works directly with the chairs of the relevant staff diversity network and Head of PPI to consider the views of staff, patients and of the wider public. Some information that was collected from previous PPI and staff engagement activity is used to examine issues raised by some groups, as well as additional engagement activity with particular groups. (A) also ensures that the patient reps on the project board is representative of diverse communities

Positive and negative effects of the proposal:
(A) and their team develop an Outline Business Case. When drafting the section which sets out how they intend to implement the **DH Public Sector Checklist** they include information in the Strategic Context section about how the project will support the NHS Long-Term Plan, particularly the reduction of health in equalities and the delivery of 21st Century Care through a diverse and talented clinical workforce.
In the **Full Business Case:** (A) and their team include ad expand upon the information included in the **PID, and Outline Business** Case inclusive of the outcome of review information used to inform the evidence-base and relevant engagement activity. A and her team set out the positive and negative effects within the Options appraisal section of the Full-Business Case to influence the final approach.

Options appraisal and justification: (A) and her team set out the positive and negative effects of the transformation project on equality and documented these in the options appraisal section of the **Outline Business Case** and this is also included in the **Full Business Case**

Scenario 3: Commissioning a service to address high rates of diabetes in the local community

Setting out the purpose of the decision:
(C) takes a proposal to a CCG Board meeting setting out the need to implement intervention initiatives to reduce the rates of diabetes in the local area and articulate the benefits for overall population health

Developing an evidence-base:
(C) has undertaken extensive research into the local population and local needs, commissioning and leads the preparation of a **joint strategic needs assessment (JSNA)** and additional supporting data and evidence, such as local health profiles and qualitative sources. (C) identified and articulated local health inequalities and the need to commission for all of the population in the area, not just relying on General Practice registrations.
(C) also cited evidence of what has previously worked in reducing inequalities with respect to diabetes, and evaluated good practice, whilst also considering the 'clustering' of risk factors for some groups e.g. BAME groups. C amplified the need for services to reduce inequalities by being progressively aimed at those who need them the most.

Engagement:
(C) recommended that local engagement activity be taken forward to understand the needs of relevant diverse groups of patients who were identified as being at a high risk.

Positive and negative effects of the proposal:
(C) evaluated the potential positive and negative effects on equality of the proposed intervention. C set out how the intervention could support the reduction of longstanding health inequalities with respect to disability, race, gender and age, supported by the evidence-base. C also highlighted the potential for negative effects on equality specifically the risk of a one size fits all approach which does not include culturally competent interventions, compounding risks with respect to some BAME communities.

Options appraisal and justification:
Having highlighted the evidence-base for implementing the intervention C was able to illustrate how negative effects had been considered and mitigated in the proposed design of the intervention and the considerable benefits to be gained in terms of the clinical case and the opportunity to reduce health inequalities.

FREQUENTLY ASKED QUESTIONS

1. Does the Equality Duty impose a legal duty to conduct an Equality Impact Assessment?

The Equality Duty does not impose a legal requirement to conduct an Equality Impact Assessment . Nor is there is any practical need to conduct one. Compliance with the Equality Duty involves consciously thinking about the three aims of the Equality Duty as part of the process of decision-making.

That will entail understanding the potential effects of the organisation's activities on different people, but there is no prescribed process for doing this. Keeping a simple record of how decisions were reached will help public bodies show how they considered the Equality Duty. Producing an Equality Impact Assessment after a decision has been reached will not achieve compliance with the Equality Duty.

2. Does compliance with the Equality Duty mean we have to examine equality issues in everything I do?

The Equality Duty does not mean examining equality issues where they are not relevant to the matter in hand. Where it is clear from initial consideration that a decision will not have any effect on equality for any of the protected characteristics, no further analysis or action is necessary. For example, if conducting a review in relation to an issue which has no implications for equality – such as temperature testing fridges – undertaking a formal consultation or analysis addressing equality issues where it is evident that the Equality Duty is not relevant would be pointless and is not required.

3. Does the Equality Duty require me to abandon my original approach?

The Equality Duty does not require public bodies to take disproportionate action on equality. A proportionate approach should be taken when complying with the Equality Duty – in practice, this means giving greater consideration to the Equality Duty where a function or decision has the potential to have a substantial effect on discrimination or equality of opportunity for the public or our workforce, and less consideration where the potential effect on equality is slight. For example, we may decide to translate a leaflet about a key clinical service into a few commonly spoken minority languages, in order to ensure people from particular ethnic minority communities have access to the service.

A TOOLKIT TO FOSTER INCLUSIVE THINKING

Self-Discovery: Coaching & Mentoring, 360 Degree Feedback, Emotional Intelligence, Insights, Appraisal, Harvard IAT Test

Leadership: Managing Change and Continuous Improvement, Values-Based Recruitment, Mid-Leadership Programme, Beyond Difference SMT Programme

Self-Directed Learning: Compassionate and Inclusive Leadership, Culturally Sensitive Conversations, Cognitive Diversity, Building Trust, Bias in Organisations

If you require further support and advice, please contact the Equality, Diversity and Inclusion Team

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