Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

EQUALITY DELIVERY SYSTEM (EDS2)

Overview and Comparison Report

April 2019

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Recipient: Workforce Sub-Committee
CCG

Date: May 2019

EDS2 Annual Evaluation Event 2019

On Friday 22nd March 2019 the Equality Delivery System (EDS2) Annual Review took place at Highbury Hall.

The session had the following aims

- To give an overview of EDS2
- To list current evidence in BSMHFT
- To discuss how we are supporting people with protected characteristics
- To suggest possible grades for the self-evaluation

The invitation was open to stakeholders, service users and staff representing all areas, a total of 35 people attended the event. During the event, participants were placed into 5 groups to discuss the evidence presented relating to the four grading outcomes. The event was facilitated by Bina Saini, Senior EDI Lead.

Who Attended the Event?

BSMHFT Staff Including:

Senior Programme Manager	Recruitment Manager	Associate Director of Operations	Service user engagement worker	occupational therapy technical instructor
Chair - DND Staff Network	Clinical Psychologist	Ward manager	Communications Assistant	occupational therapist
Service Users Governor	BHM Service Manager	Lead for service user, carer and public engagement	Associate Director Performance and Information	PA to Deputy Director of Nursing
Training manager	Programme Administrator/ Inclusion Advisor	Admin assistant	AOT team manager	ANP for Risk and Security
IDTS Service manager	Community Psychiatric Nurse	HCA	Community Engagement Team	

Non-BSMHFT Staff Included:

Victim support	Every Step Of The Way	Action for Children	BSOL CCG	Home Group, Birmingham UPS	Service users
John Taylors Hospice	Uffculme Centre	AGEM CSU	Catalyst4Change	Public	Carers

EDS2 Outcomes and Grading Systems:

The EDS2 grading are focused on and assessed against the following four outcomes:
1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and well-supported staff
4. Inclusive leadership at all levels

The Trust is required to grade their performance by using a grading system as follows:

Red – Undeveloped	People from all protected groups fare poorly compared with the demography of the borough OR evidence is not available, or if evidence shows that the majority of people in only two or less protected groups fare well
Amber – Developing	People from only some protected groups fare as well as the people of the borough.

Green – Achieving	People from most protected groups fare as well as the people of the borough.
Purple – Excelling	People from all protected groups fare as well as people overall.

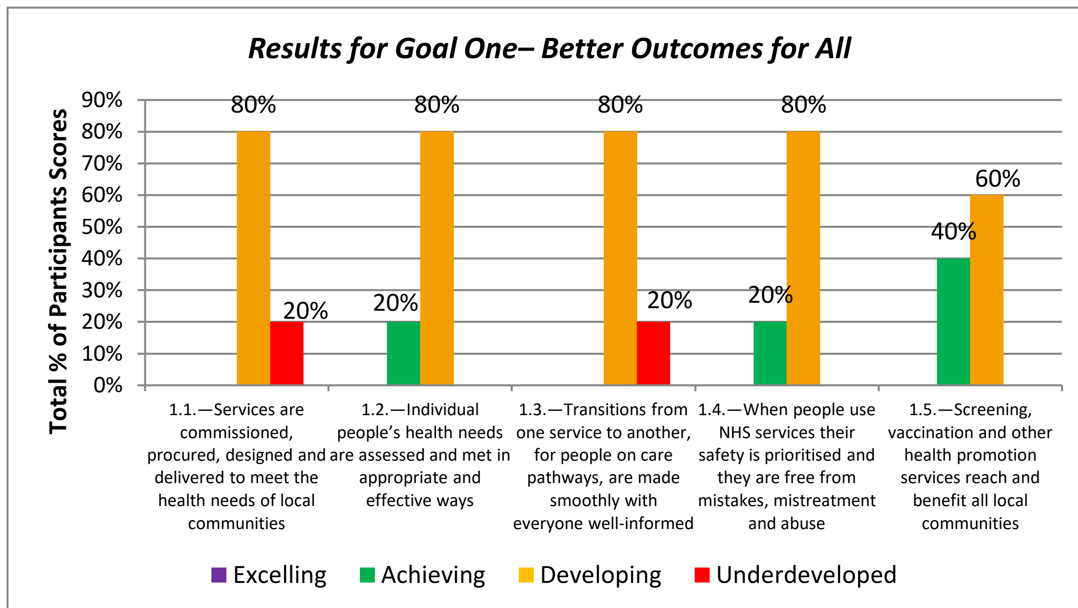
*Last year BSMHFT was graded as **developing** for the period of 2016-2017*

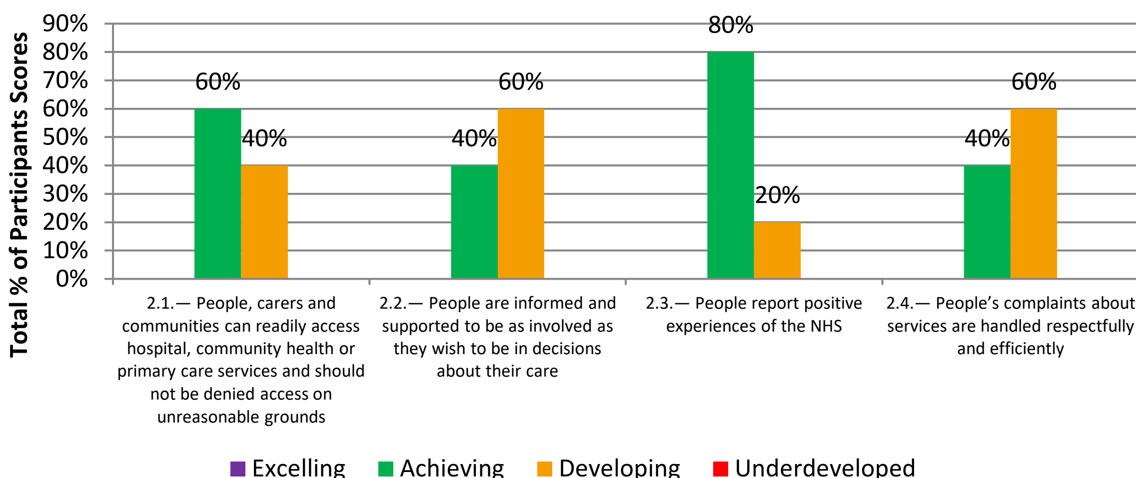
Following the event on the 22nd March 2019 BSMHFT graded as follows:

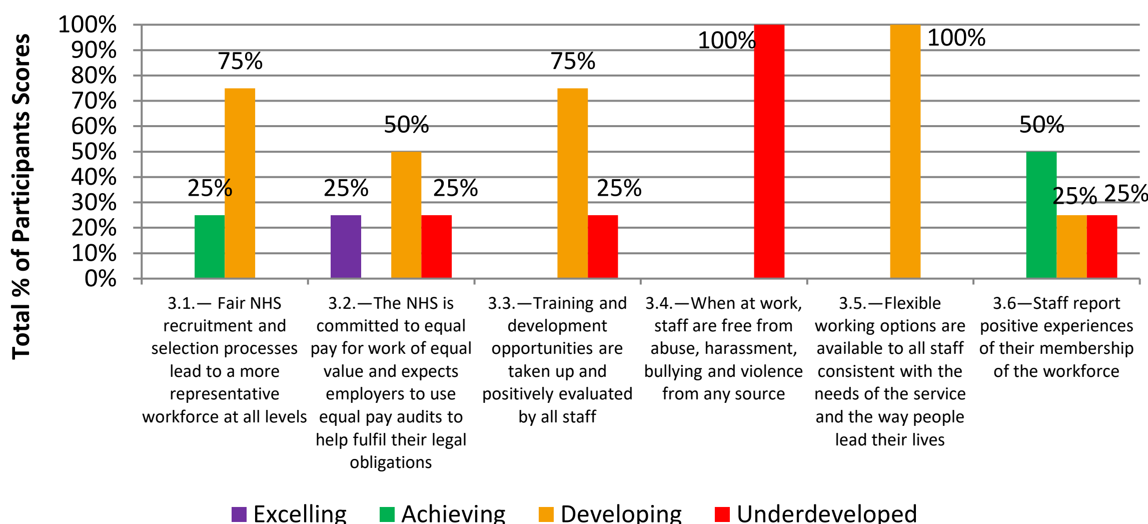
Overall the majority of areas were assessed as **"Developing" for the period of 2017-2018**

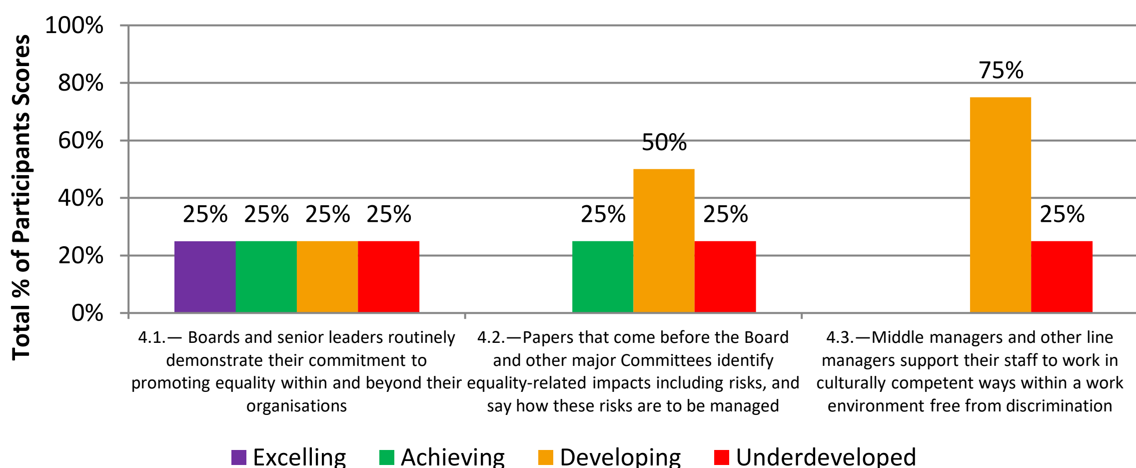
1. Better Health Outcomes – **Developing**
2. Improved Patient Access and Experience – **Achieving**
3. Empowered, engaged and well-supported staff – **Developing**
4. Inclusive Leadership – **Developing**

The following charts provide an overview of the outcome scores for each of the four grading areas assessed by the participants based on the evidence presented:




Results for Goal Two - Improved Patient Access and Experience
Total % of Participants Scores
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
60%
40%
40%
60%
80%
20%
40%
60%
2.1.— People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
2.2.— People are informed and supported to be as involved as they wish to be in decisions about their care
2.3.— People report positive experiences of the NHS
2.4.— People's complaints about services are handled respectfully and efficiently
Excelling
Achieving
Developing
Underdeveloped


Results for Goal Three - Empowered, Engaged and Well-supported staff
Total % of Participants Scores
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
25%
75%
25%
50%
25%
75%
25%
100%
100%
50%
25%
25%
3.1.— Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
3.2.—The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
3.3.—Training and development opportunities are taken up and positively evaluated by all staff
3.4.—When at work, staff are free from abuse, harassment, bullying and violence from any source
3.5.—Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
3.6—Staff report positive experiences of their membership of the workforce
Excelling
Achieving
Developing
Underdeveloped


Results for Goal Four - Inclusive Leadership
Total % of Participants Scores
100%
80%
60%
40%
20%
0%
25%
25%
25%
25%
25%
50%
25%
75%
25%
4.1.— Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
4.2.—Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
4.3.—Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination
Excelling
Achieving
Developing
Underdeveloped

Overall Event Feedback:

Evaluation forms were also used during the conclusion of the event to evaluate participant's feedback on the overall event. From the evaluation forms the following feedback was captured:

1) How satisfied are you in the event overall?

   57% of attendees rated the Overall event as Satisfactory
   43% rated the overall event as Very Satisfactory

2) How satisfied are you with the Speakers/ Presentation?

   48% of attendees rated the speakers/presentations as Satisfactory
   52% rated the speakers/presentations as Very Satisfactory

3) I have learnt something new from attending the event.

   70% of attendees felt they "strongly agreed" with the statement
   20% of attendees felt they "agreed" with the statement
   10% of attendees felt they "neither agreed nor disagreed" with the statement

4) The information provided was useful and relevant?

   48% of attendees felt they "strongly agreed" with the statement
   48% of attendees felt they "agreed" with the statement
   4% of attendees felt they "neither agreed nor disagreed" with the statement

5) I will be able to apply what I have learnt in my working practice?

   30% of attendees felt they "strongly agreed" with the statement
   50% of attendees felt they "agreed" with the statement
   20% of attendees felt they "neither agreed nor disagreed" with the statement

6) Overall how would you rate the discussion that took place on your table?

   43% of attendees rated the Overall table discussion as Very Good
   57% rated the overall event as Good

7) Do you think the event served the purpose of EDS2?

   100% of participants felt that the event served the purpose of EDS2

BSMHFT Grading Comparison 2017- 2019

1. Better Health Outcomes

	1.1.—Services are commissioned, procured, designed and delivered to meet the health needs of local communities	1.2.—Individual people's health needs are assessed and met in appropriate and effective ways	1.3.—Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	1.4.—When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	1.5.—Screening, vaccination and other health promotion services reach and benefit all local communities
EDS2 Review 2016/2017	**Developing**	**Developing**	**Achieving**	**Achieving**	**Developing**
EDS2 Review 22 March 2019	**Developing**	**Developing**	**Developing**	**Developing**	**Developing**

2. Improved Patient Access and Experience

	2.1.— People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	2.2.— People are informed and supported to be as involved as they wish to be in decisions about their care	2.3.— People report positive experiences of the NHS	2.4.— People's complaints about services are handled respectfully and efficiently
EDS2 Review 2016/2017	**Achieving**	**Developing**	**Achieving**	**Achieving**
EDS2 Review 22nd March 2019	**Achieving**	**Developing**	**Achieving**	**Developing**

3. Empowered, engaged and well-supported staff

	3.1.— Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	3.2.—The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	3.3.—Training & development opportunities are taken up and positively evaluated by all staff	3.4.—When at work, staff are free from abuse, harassment, bullying and violence from any source	3.5.—Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	3.6—Staff report positive experiences of their membership of the workforce
EDS2 Review 2016/2017	**Achieving**	**Developing**	**Developing**	**Developing**	**Developing**	**Developing**
EDS2 Review 22 March 2019	**Developing**	**Developing**	**Developing**	**Under developed**	**Developing**	**Achieving**

4. Inclusive Leadership

	4.1.— Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	4.2.—Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	4.3.—Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination
EDS2 Review 2016/2017	**Developing**	**Developing**	**Under developing**
EDS2 Review 22nd March 2019	**Developing**	**Developing**	**Developing**

Unfortunately BSMHFT EDS2 results shows little or no progress being made, with 5 goals worsening than the previous year.

Appendix 1

Detailed Feedback from Participants on 22nd March 2019:

<table>
<tr><td colspan="2">Participants Feedback on Goal One</td></tr>
<tr><td>1.1.—Services are commissioned, procured, designed and delivered to meet the health needs of local communities</td><td>
There is lots going on but were not sure how this is linked to design and commissioning of services.
If we're not already interested, how would you know? How embedded are the initiatives in overall culture and responsibility taken in services? Managers across departments need to encourage teams to understand EDI and attend events
We need to share good practice; examples could be about good attempts with communities around MH/reducing stigma - working with us. How does this show improved changed services: focused on difficult communities.
Where is the wider population about everyone: suicide work for example? Mainstream services where we need to meet the gap about public health not just BSMHFT.
No- Overall - we are secondary services.
EIA are done through the PMO team plus elsewhere. Do we have reports on health needs locally? Data available E.g. Zinnia - designed around demographics local community.
GP Outreach
Small organisations in the community are not linked in with the Trust. The challenge for the trust staff is to find these small organisations to signpost SU's to.
Seminars need to be more available/accessible to staff.
More community engagement events.
More peer support workers
Trust is trying. Really good work but staff development and support needs work
</td></tr>
<tr><td>1.2.—Individual people's health needs are assessed and met in appropriate and effective ways</td><td>
SU only felt listened to when referred to his title as professor. Liaison and Diversion Team a good example. Communities and service user experience and knowledge still under-used
In secondary services (BSMHFT) at the point of service delivery
Some services do struggle, they are bound by what we have available I,e. providing for specialist/cultural diets. Relaxation of SU environmental health for takeaway. IAPT self-referral, instant walk-in (Kully Ingram), Amman Service -using language skills of practitioners, there is limited evidence of this happening. Writing time is very long- more peer support workers.
Referral to other agencies while people are waiting for an appointment. Lack of financial investment
Train staff in care and compassion.
This depends on the individual and the team providing the care. A mix of capacity and lack of appreciation for information required. Demographics such as faith, ethnic background are often missed from forms.
Trust need to help encourage staff to ask these questions in a way that encourages participation
</td></tr>
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1.3.—Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	• Positive experience from a service user present of being supported. • Another SU shared negative experience of leaving inpatient services - not felt supported (felt dumped, half hour notice and on 3 occasions was left without medication when Trust Site pharmacy was closed for bank holiday) varied experience- not consistent. • No, the evidence is that we find transitions difficult. We have people on wards with the same story - that is across the board including in primary care/local authorities/ housing/ social care. Communities within ourselves, service user. • Anawrim, Women's Aid, Pathways into services. Options Available • Separate services. Fear of breaching confidentiality. Waiting List. Volunteers to support people to transition (with lived experience) • A lot of services don't speak to each other or the patient. Also an arrogance to think that your service knows best. Whilst we are individual teams and services, people need to realise that we need to work together. • Service Users trapped in revolving door, highlights that info isn't shred between teams
1.4.—When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	• If not crisis, not a priority • We do try hard to ensure this but we are only human. Some systems in place - when things go bad the staff safety: - often comes with the job, Protocol is there (Links with Section 3, may not feel protected *aimed at patients), Policies and procedures we do not use connect. • Safety is prioritised. • Training Resistant - prone-occurring. PPCEP Project, Carer Involvement. This is hard in secure settings. Mistakes happen given the nature of what we do, but learning from mistakes, recommendations. Accept CQC ratings on them, but recommendations are made and the reality is difficult
1.5.—Screening, vaccination and other health promotion services reach and benefit all local communities	• Community Engagement Team visible and excellent. Good engagement and innovative initiatives. Need to carry on and build on these • What are the Trusts responsibilities? What is another team (outside of Trusts responsibility - That is different, partnership working)? The Trust does this quite a lot. With the trust we are achieving. The trust does ECG, Men's Health, promotion etc.) • Some local communities. MHFA, Young Lives Matter. Unity FM, LGBT+ Older People, Perinatal Mental Health workshops, Transgender - health screening needs. Male Gender Strategy • Physical health workers, Some areas are good and others need a lot of work • CT1 initiative. Developing some good initiatives for health promotion and raising awareness, more work required to benefit all communities

Participants Feedback on Goal Two	
2.1.— People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	• Access patchy. Zinnia- access for people, family (acknowledge reasons - safety). Endeavour house not easy for family to access- disconnect. Oleaster good, facilities for family room, need to focus on transition from hospital to community. Good experience more by good luck rather than good management • All people should be able to access devices, without exceptions (as a Trust we need to have a full zero tolerance against everything that impacts in a negative way. We provide services in prison/police stations. GP Access to the Trust. All our premises are accessible. Any issue we find solutions. Liaison and Diversion. Age UK, SPOA, National Services, Veterans, Young people access other than IAPT, in Birmingham, FCAMS- family/carer days. Self-Referral to IAPT. Memory assessment. Interface acute mental healthcare. Bed shortages. MDT with GP's • Making some progress in this area. Street Triage. Still more work to be done • No one is challenged by demographic in terms of access. Trustwide smoking ban has implications for those on escorted leave. Can people articulate in the "right" way when they need help/access? E.g. Someone with autism - can they feel we adapt our ways of working to accommodate them? Do we interpret their behaviour appropriately/accurately? Hidden disabilities acknowledged?
2.2.— People are informed and supported to be as involved as they wish to be in decisions about their care	• Too much jargon (some clients can be patronised, nor recovery focused (adds to stress/pressure). Feeling of not seeing the person behind the illness. • We do have a patient involvement group, family and friends test, patient councils. This does not always work: Involvement of family and service user in their own care. Works to make sure that there is an updated list of members of a SU family who can be involved in that SU's care. • Improvement does need to be made. • As a Trust we try hard to facilitate this. Where specialist services are requested these are facilitated when available. MDT with GP's - CMHT/IAPT/Third sector/GP, Service Users co-produce information, FFT Test, See Me Team, Advocacy Process in place, Advisory Recovery Strategy. • Some consultants do not always listen to patients about their care and treatment. • Positive feedback from neuro-services and memory assessment • Patients survey data says we are not going this well. Pockets of good/exemplary practice but this is in the minority. Why has PALS been "rebranded"- "PALS" is patient empowering
2.3.— People report positive experiences of the NHS	• Mixed experiences, on balance, some may have positive experience. • Pleasant, seen quickly, supported in and out quickly, follow up (Barberry). Difficulties seen as unintentional experiences where procedures (cigarette breaks) see as control (question if this is helping), Feeling criticised for things out of patients control. • This varies dependant on the patient experience and perception. - Difficult to answer without the date for its pilot.

	• Specialist service - able to follow up with SU from inpatient to discharge. Positive experiences expressed to staff member. Patients who may have problems always a way of letting it be known about the experience, There is always something to offer (staff going the extra mile), help given to SU • Sky1 and access to cultural radio/TV, opportunities for sport/gym, recovery college, board reports, live stream AGM, Data Collected, Carers Pathway • Friends and family test very good feedback. Some area of positive experience, some negative • Family and friends test show good results; lots of people recommend our services despite criticism/suggestions for improvement. • Are there other ways to capture this? There are concerns that some peoples experiences are not being captured by existing feedback systems
2.4.— People's complaints about services are handled respectfully and efficiently	• Respectfully - yes, efficiently - no. No action plan, no learning from complaints. Needs to be shared, transparent • This also goes back to the question of the data: - The number of complaints rose. We can only work on things when they are raised formally: - Raise awareness when things go wrong. Positive experience rose. Staff will have been given the chance to learn from any experience. How are staff treated? Two way road. • Something that went to public media. Can we learn from past experiences? We have Swartz rounds for staff: we need to include staff in the overall patient experience, by organisation and we all need to be considered. Process and procedures in place • Complaints low in proportion. PALS handled respectfully • Through health watch, PALS are handled respectfully. Trust responds positively to complaints • Complaint responses seem to be too "Corporate" or not adequately responded to, E.g. people use other means e.g. conversations with members of community engagement to air complaints about complaints procedures. • Too defensive/reactive. Complaints department are trying to improve ways of working (anecdotally). If people can't articulate their complaint "Well" are they taken seriously?

Participants Feedback on Goal Three	
3.1.— Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	• Recruitment procedures well thought out. Applications judged on merit. Still question of prejudice at interview. Issue of interview panels not being diverse enough. Worry that applicants don't disclose mental health disorders (still stigma within the Trust) • Last year as a Trust we were graded as "Achieving". We use "NAS"- National Apprentices Service –for all apprenticeship posts, as well as NHS Jobs. • How do we support our SU to apply for positions? • Anyone who lives in the area. A lot of positive action. Meeting to take place soon regarding looking at different forms of ways of getting people interested • Promotion above 8A Banding poor • Organisation realises it has a problem and is in the process of working on it but we are yet to see results. • We are in transitions and hopefully we will see results going forward
3.2.—The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	• Need to be more transparent about instances of inequality, still issue of gender pay gap, inequality and opportunity advancement. Within the NHS we have the Agenda for Change system but still inequalities exist. • Clinical excellence awards are another example where inequalities are prevalent. • We as a trust do equal pay audits. Public Sector - gender pay across the organisations - annual. Women - less than men. • Agenda for change ensures pay increases, but we think differently, opportunities are provided to different people whilst in role i.e. with fixed term contracts/secondment opportunities.
3.3.—Training and development opportunities are taken up and positively evaluated by all staff	• Lots of opportunities, opportunity not necessarily for all - being released from role to attend training and development can be a barrier. • Issue of commitment/wishing to develop • Not all training is done by the L&D team. • Training is positively taken up and feedback is good. When we work with colleges/universities in hand in hand. We were well supported. Staff member with visual impairment- has difficulties in the e-learning , other disability dept. have the same difficulties • Releasing Staff from clinical areas should be mandatory • Allow staff time to develop skills and learning externally and with partner organisations • We don't think they are being offered or authorised for all staff. How do you train people in teams - night working staff/domestic staff, which are the most vulnerable and not supported to deal with it? Our WRES Data indicates this.

3.4.—When at work, staff are free from abuse, harassment, bullying and violence from any source	• Not likely to be true. Has been witnessed close ranks, need action, not words, be transparent • The staff survey says that high levels of bullying and harassment. Recent There is willingness to move this from this state. Invite to staff networks to be connected • Staff Survey (poor) • Patients need to feel safe too • Results from WRES Data, Staff Survey/ From Service Users speak for themselves.
3.5.—Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	• Procedures need to be communicated more, within some corporate services we are actioning. Within remote work- a lot of failing. Differences within different roles/services. Very managerial dependant - what can we facilitate with. • If a staff member does not have a voice - it's faded and the actions may not have the right outcome • Bank is good, Rosters – poor • Varies locally. Different representation in different environments. At managers discretion.
3.6—Staff report positive experiences of their membership of the workforce	• Mixed views. Would be nice to have a "Wellbeing supervision" • A member on the table said that he does report positive experiences, within supervision, but between some members within the team. • Bullying and Harassment figures are still high. Despite most members on the table report positive experiences • Improving position. Majority decision not agreed • Sickness policy is punitive, WRES Data, Staff Survey

Participants Feedback on Goal Four	
4.1.— Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	• Need to keep connected to unheard voices - some we don't know yet. They have a good intention, need to practice/do- becomes stronger. Turning a corner, acknowledge difficulty and it takes time. Question of whether it is a tick box exercise. Question of SU on interviews panel (is it really valued?) • From Disability Staff Network (DSN) perspective without the Executive Director who has picked this up - then we would not be anywhere. He is focused on sponsoring and supporting the network at corporate level. We champion the networks. Sue Hartley is executive director of the LGBT Network but is willing to consult with issues caused for the DSN group. Still To lots to do with Board Diversity and engaging with external agencies • Different teams and services seek out these opportunities, but we don't feel the senior leaders and board lead on these matters and are selective on what equality campaign/events and networks they support. Excluding Sue Hartley, she's seen everywhere regularly and really shows a love and care for equality consistently.

4.2.—Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	• Papers do get presented to the Board- on agenda. That input is generating change (even if it may be perceived as tick box exercise) • EIA have to be done for policies. This was raised at a meeting recently as some are not completed fully. When we lose people who work on specific pieces of work, this is a big loss to the Trust. The members on the table were unable to confirm if this was correct - it was agreed by a member of the board that these EIA do go to the board. These are being followed up- all risks are picked up and followed up • Papers have EIA. Process good. Question remains of "So What?" • To most of the workforce this is a mystery and there needs to be transparency on what the board do. • Separate issue but it has also been mentioned that the occurrences and questions asked in board meetings do not appear in board paper minutes
4.3.—Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	• Will be mixed depends on management competence/skills/awareness. Can always do better. Managers to attend days like this? • This is dependent on the manager- some managers need a lot of work and support in order to be able to do this. Depends on the support and training that they have had. You may get manager who is good at one point of the characteristics but may not be good at others. • EIA Training for middle management. Direct Discrimination still happens. Some managers are less effective than others • At managers discretion. Varies dependant on the manager and localities. What is the Trust's understanding/expectation of working in a "culturally competent way"?