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NHS England

# NHS Equality Delivery System 2022

# EDS Reporting Template

Version 1, 15 August 2022

# Contents

# Equality Delivery System for the NHS

***The EDS Reporting Template***

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

# NHS Equality Delivery System (EDS)

| | | |
|---|---|---|
| **Name of Organisation** | **Northern Lincolnshire and Goole NHS Foundation Trust** | **Organisation Board Sponsor/Lead** |
| | | Simon Nearney/ Ivan McConnell |
| **Name of Integrated Care System** | | |

| | | | | |
|---|---|---|---|---|
| **EDS Lead** | Jackie Railton/Karl Portz | | **At what level has this been completed?** | |
| | | | | ***List organisations** |
| **EDS engagement date(s)** | February / March 2025 | | **Individual organisation** | |
| | | | **Partnership* (two or more organisations)** | Northern Lincolnshire and Goole NHS Foundation Trust;<br>Hull University Teaching Hospitals NHS Trust |
| | | | **Integrated Care System-wide*** | |

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|---|---|---|---|
| **Date completed** | 20/03/2022 | **Month and year published** | March 2025 |
| **Date authorised** | | **Revision date** | |

| Completed actions from previous year | | |
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| **Action/activity** | | **Related equality objectives** |
| Tobacco Cessation Service | Annual review of anonymised data by protected characteristic.<br>**Data from September 2024 to January 2025 shows that 455 patients have been assessed by the Tobacco Cessation Service, made up of 327 female and 128 male patients. It is suggested that this difference between genders is due to the Smoking In Pregnancy Pathway (SIPP) being an opt out referral pathway.**<br>**Historically, the initial assessment on this pathway would be carried out remotely, and included a question on ethnicity, resulting in approximately 30% of patients recorded as 'unknown'. This has been the focus of a service improvement effort, which has subsequently seen the level of patients with unknown ethnicity decrease to approximately 12% (based on September 2024 to January 2025 data). It is anticipated that the utilisation of Badgernet will also contribute towards improvements in data quality.**<br>**Data from September 2024 to January 2025 shows that the majority of referrals came from patients in the 30% most deprived deciles (Indices of Multiple Deprivation).** | Patients (service users) have required levels of access to the service. |
| Antenatal Services | Extend the publicising of antenatal events to enable people to attend and self-refer in person.<br>**Antenatal events are publicised via the hospital website, social media and Mumbler (website), which includes the** | Patients (service users) have required levels of access to the service. |

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| | **dates of each event for the year, and can be accessed via QR code attached to all publicity.**<br>**Banners and other publicity for the events are displayed in the hospital, as well as family hubs and midwifery clinics.**<br>**The parent education midwife has visited local midwifery bases and community team meetings to explain the antenatal offer to midwives directly.**<br>**Publicity documents are now displayed in a number of different languages, to improve accessibility.**<br>**Push notifications about these events are also sent via Badger Notes.** | |
| | Consider utilisation of paper-based referrals where online is not an option.<br>**Patients are now able to self-refer to the service via email or telephone, as well as via the online form.** | Patients (service users) have required levels of access to the service. |
| | Undertake a data review of antenatal unplanned attendances and the date/ time of attendance.<br>**A review has been undertaken and has identified that 24/7 telephone triage and triage assessment is required. A staffing review has been undertaken to identify requirements, and the necessary increased staffing has been funded.** | When patients (service users) use the service, they are free from harm |
| | Maternity service, Healthwatch, and Maternity Voice Partnership to collaborate in engagement activities.<br>**Maternity and Neonatal Voice Partnership (MNVP) has been involved in the development of services and guidelines, Quality improvement, and attending Trust meetings.**<br>**Learning from PALS and Complaints - utilized in development of teaching programmes and feedback to Maternity Services.** | Patients (service users) report positive experiences of the service |

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| | Review staff face to face and virtual interactions with service users, including information leaflets/ online information to ensure awareness of choice.<br>**Antenatal sessions include an explanation of birthing facilities available, and the relevant criteria and information that may influence patient's decisions on where to give birth. A video including this information has also been created. Videos of four different birthing rooms have been created by the Parent Education Midwife, and are widely circulated to give patients and their families an insight into the available environments. It has also been requested that these are added to the Trust's external website, to supplement an existing video from the Local Maternity and Neonatal System (LMNS).** | Patients (service users) report positive experiences of the service |
| AAA (Abdominal Aortic Aneurysm) Screening Service | Recruitment to vacant posts and completion of training to enable increase in screening capacity.<br>**Approval to recruit to these posts was delayed, but interviews are scheduled to be held week commencing 20th January.** | Patients (service users) have required levels of access to the service |
| | Re-establish contacts with the traveller community to ensure that potential patients are aware of the service.<br>**Screening processes have continued to be in place for eligible patients within the traveller community, but meetings have been held with a number of staff across Primary Care and the ICB that are working on health inclusion/ improving access to health services for vulnerable groups.** | Patients (service users) have required levels of access to the service |
| | Participate in Public Health AAA Screening Survey 2024 and utilise survey results to inform service improvement. | Patients (service users) report positive experiences of the service |

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| | **Data collection for the survey was carried out 1st – 31st August 2024, and the report was finalised in November 2024. The results of the survey showed that the vast majority of patients (97-100%) were very satisfied with the service, including:**<br>• **Screening time**<br>• **Screening day**<br>• **Screening venue**<br>• **Explanation of test**<br>• **Explanation of result**<br>• **Overall screening experience**<br><br>**A 10-point action plan has been developed for completion ahead of the next survey, which is scheduled for September 2025.** | |

# EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below

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| **Undeveloped activity** – **organisations score out of 0** for each outcome | Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** |
| **Developing activity** – **organisations score out of 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 out of 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 out of 3** for each outcome | Those who score **33,** adding all outcome scores in all domains, are rated **Excelling** |

## Domain 1: Commissioned or provided services
## Chemotherapy Delivery

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***Domain 1: Commissioned or provided services*** | 1A: Patients (service users) have required levels of access to the service | • Hours of operation at NLaG currently differ between the two sites, due to a difference in activity levels:<br>  ○ Grimsby Diana Princess of Wales (DPoW) currently operates Monday-Friday<br>  ○ Scunthorpe General Hospital (SGH) currently operates Tuesday – Friday<br>• Both services operate during standard office hours, and are closed on evenings, weekends and bank holidays<br>• No issues with appointment times, or demand for out-of-hours care have been noted via patient feedback received.<br>• This service is provided by HUTH clinicians providing outreach via a Hub and Spoke model, enabling patients to receive treatment closer to home.<br>• Lloyds Pharmacy Clinical Homecare also provide a Chemotherapy Treatment service 2 days per week, enabling some patients to access this care via an alternative off site clinic location in Scunthorpe | 2 | Vicky Kenney; Karen Smith |

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| | | • The service utilises information provided by Macmillan Cancer Support ( https://www.macmillan.org.uk/cancer-information-and-support) for patient information, which can also be accessed in a range of alternative languages and formats ( https://www.macmillan.org.uk/cancer-information-and-support/get-help/translations-and-other-formats)<br>  ○ It is noted that it is difficult to get specific drug information in alternative formats<br>• Interpretation services are available for patients within the service, provided by Language Line. MacMillan Cancer Support is also able to provide translations and interpretation services, where required. | | |
| | 1B: Individual patients (service users) health needs are met | • Information was shared on the adjustments made to enable pregnant patients to receive their required treatment, in line with their specific health needs and circumstances.<br>• Information was also shared in relation to a patient with Learning Disabilities that is currently receiving treatment, along with the adjustments required in | 2 | Vicky Kenney; Karen Smith |

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| | | order to enable this patient to receive treatment.<br>• Information was shared on the adjustments required for a patient with a mental health diagnosis and collaborative working between the psychiatrist, mental health nurses and the oncology team to enable the patient to be treated safely in line with their specific health needs and circumstances. | | |
| | 1C: When patients (service users) use the service, they are free from harm | • Patient incident data for the previous 12 months in Oncology shows that a total of 13 patient incidents have been reported for Clinical Oncology.<br>• Of the 13 incidents reported, 12 were recorded as having resulted in no harm.<br>• The 1 incident with a reported level of patient harm was reported as 'low harm', and was an extravasation incident.<br>• It was noted that there is no difference in patient safety incident occurrence between those with or without protected characteristics. | 2 | Vicky Kenney; Karen Smith |
| | 1D: Patients (service users) report positive experiences of the service | • Information from the Cancer Patient Experience Survey (CPES) was shared, with Q41.2 and Q42.2 being particularly relevant to Chemotherapy. | 2 | Vicky Kenney; Karen Smith |

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| | | • Results for these questions showed an improvement from 2023 to 2024 | | |
| **Domain 1: Commissioned or provided services overall rating** | | | 8 | |

# Domain 1: Commissioned or provided services

## Targeted Lung Health Check (TLHC)

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***Domain 1: Commissioned or provided services*** | 1A: Patients (service users) have required levels of access to the service | • Invitations to the TLHC are based on lists of eligible patients, as identified by GPs<br>• Eligible patients are those aged 55-74 that are current or previous smokers<br>• A Local leaflet is available, which is sent via post to every invited patient<br>• The leaflet is readily available in Easy Read format, with other formats being available on request from the HNY Cancer Alliance<br>• Easy Read letters are currently going through the approval process<br>• Patients invited to TLHC receive multiple letters, as well as telephone contact if the patient does not respond<br>• Patient's communication support needs can be accommodated at initial contact, provided this information is received from GP records<br>• Further work is being carried out at a senior level within the organisation to identify, record, and make reasonable | 1 | Debra Dyble/ Paul Gledhill |

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| | | adjustments for patients with Learning Disabilities<br>• Initial assessments are typically held via telephone, but can be held in-person, as required.<br>• Assessments can be supported by interpretation, and patients can bring family members/ carers if required. Further adjustments (e.g. longer appointment times) can also be made by the service, as requested.<br>• Scans are provided at a number of community locations across the area, facilitating equity and ease of access.<br>• Work has been carried out with the Forge project (www.theforgeproject.co.uk/) to engage with and provide the service to homeless patients. Further work will be carried to cater to this cohort of patients in 2025<br>• No issues have been identified in terms of patient access to the scanning facilities<br>• Roll out of the LHC programme is still in its early stages on the South Bank, with further expansion needed in North East Lincolnshire (pockets of LHC activity currently). | | |

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| | 1B: Individual patients (service users) health needs are met | • Appointments are offered during weekdays, evenings and weekends, to improve accessibility for patients<br>• Patients' health needs are identified via the TLHC assessment, and those that require a low-dose CT scan are subsequently provided with one<br>• Data from the LHC service across the Humber showed that 4.1% of patients identified for a low dose CT scan (156 of 3805) were ultimately found to have Lung Cancer<br>• Data also showed that 73% of those receiving a low dose CT scan had at least one incidental finding, such as Coronary Calcification, Emphysema, or other suspected cancers. As such, patients were being alerted to health needs that they were unaware of, enabling further diagnostics and treatment to be provided at an early stage | 3 | Debra Dyble/ Paul Gledhill |
| | 1C: When patients (service users) use the service, they are free from harm | • The TLHC service involves a patient assessment, followed by a Low-dose CT scan for applicable patients. The purpose of this is to identify potential health issues (including, but not limited to, cancer) at an early stage, to facilitate further investigation and treatment. | 2 | Debra Dyble/ Paul Gledhill |

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| | | • The nature of this service means that patient harm is incredibly unlikely.<br>• Established governance processes are followed in the event of any incident, and regular meetings are held with the CT equipment provider | | |
| | 1D: Patients (service users) report positive experiences of the service | • A video has been produced with local patients sharing their experience of the service<br>• A feedback process is in place within the TLHC, which can be accessed via both a printed form or QR code | 1 | Debra Dyble/ Paul Gledhill |
| **Domain 1: Commissioned or provided services overall rating** | | | 7 | |

## Domain 1: Commissioned or provided services
## Virtual Ward: North and North East Lincolnshire

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***Domain 1: Commissioned or provided services*** | 1A: Patients (service users) have required levels of access to the service | • The service is provided to adult patients only (ie over 18 years) including the elderly and frail patients.<br>• The Standard Operating Procedure (SOP) for the Virtual Ward was shared, which set out the following information:<br>  ○ Patient eligibility criteria<br>  ○ The services provided<br>• The SOP has not yet been formally approved, but is due for discussion imminently.<br>• All patients are now onboarded for digital elements of the service<br>• Staff are able to provide 1-to-1 training in the use of the relevant equipment where necessary<br>• Patients are asked to submit observations during a 2 hour window, and will be contacted wherever these are not received.<br>• Patients receive a reminder, and are able to submit data via email, text message or telephone call | 2 | Ros Dougan/ Tracy Means/ Garry Cowling |

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| | | • Where patients are unable to take their own observations, or are unable to submit data, this can be done by community staff visiting on a daily basis<br>• Interpretation services are available via language line, if required.<br>• The service noted that they had had no previous experience with a requirement for British Sign Language, but suggested that communication would be possible via face-to-face contacts<br>• Patient Information Leaflets are available in standard formats, and alternative formats can be provided on request<br>• It was noted that different elements of the service require varying levels of care to be provided to patients. As such, the capacity is often flexed to accommodate as many patients as possible.<br>• Where changes are made to a patient's medication, mechanisms are in place to ensure that this can be dispensed by a local pharmacy, for collection by the patient or their relative/ carer.<br>Where this is not possible, medication can be delivered via taxi.<br>• Patients are able to access support and assistance 24/7 via either the | | |

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| | | Community Urgent Response Team (CURT) or Clinical Assessment Service (CAS), as required. | | |
| | 1B: Individual patients (service users) health needs are met | • The service noted that improvements have been made over the last 6 months to better accommodate patient need.<br>• This has included work with diagnostic services, which has resulted in patients on the Virtual Ward now being able to access diagnostic tests within 24 hours, whereas these were previously being provided in similar timescales to other outpatients (i.e. 6 weeks)<br>• Access to out of hours staffing and advice was also noted as a key element of ensuring that patient needs are met | 2 | Ros Dougan/ Tracy Means/ Garry Cowling |
| | 1C: When patients (service users) use the service, they are free from harm | • No active risks are currently recorded on the service risk register<br>• A total of 7 incidents have been reported so far during 2024<br>• However, all of these are reported as causing 'no harm' to patients<br>• Discussion was held on whether the Virtual Ward Service would be aware if patients were struggling with mobility, etc. whilst submitting observations and data. | 3 | Ros Dougan/ Tracy Means/ Garry Cowling |

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| | | • It was noted that mobility issues would be flagged at the initial onboarding of the patient to the virtual ward service, which could then be managed accordingly:<br>○ Requirements to access short term care; unscheduled care therapists; equipment loans; etc. are all documented in the patient record, and are facilitated via the shared management structure responsible for these areas | | |
| | 1D: Patients (service users) report positive experiences of the service | • Data on Patient Complaints was shared, which showed just 1 complaint since May 2022.<br>• Data gathered from the Friends and Family Test carried out in October 2024 was presented:<br>○ This data showed a response rate of 18.7% for the month<br>○ All respondents (17) rated the Virtual Ward service as 'Very Good' | 2 | Ros Dougan/ Tracy Means/ Garry Cowling |
| **Domain 1: Commissioned or provided services overall rating** | | | 9 | |

## Domain 2: Workforce health and well-being (NLaG)

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***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 | • We have offerings in relation to general health for staff including: Health and Wellbeing Ambassadors, wellbeing programme/conversations, coaches, mentors and cultural ambassadors in some areas.<br>• Occupational Health can refer for counselling and staff can self-refer via Employee Assistance and CIC.<br>• We have a menopause peer to peer support group.<br>• We have an Equality, Diversity and Inclusion Steering Group.<br>• Stress risk assessments are available for staff if required.<br>• Mental Health First Aiders in some areas<br>• During the year we promote a number Health Awareness Campaigns to support a variety of health conditions.<br>• We have adopted Trauma, Risk Incident Management (TRiM) | 2 | Karl Portz Equality, Diversity and Inclusion Lead |

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|---|---|---|---|---|
| | 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source | •We have recently signed up to a sexual harassment charter.<br>•We promote a just and learning culture.<br>•We challenge poor behaviour and to give staff the support to achieve this we provide Unconscious Bias training.<br>•Introduced Zero Tolerance to Racism and Zero Tolerance to LGBTQIA+ Discrimination frameworks and Zero Tolerance to Ableism but these still need embedding. | 1 | Karl Portz Equality, Diversity and Inclusion Lead |
| | 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source | •The Freedom to Speak up Guardian has frequent contact with staff and has established a network of Champions in some areas and attends numerous committee meetings.<br>•All Staff Networks are set up but still need to be more accessible to staff and grow in their membership.<br>•Trade unions are also influential in providing impartial support to staff and a Trade Union Partnership is in place.<br>•Also, support is available from Occupational Health and through CIC.<br>•An HR helpline is in place and staff can access HR team support.<br>•Established pastoral support nursing team within the Nursing Directorate. | 2 | Karl Portz Equality, Diversity and Inclusion Lead |

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| | 2D: Staff recommend the organisation as a place to work and receive treatment | Taken from the most recent staff survey, 52.9% of staff recommend the Trust as a place to work. This as increased from 44.8% the previous year. 52% are happy with the care provided for a friend or relative which as increased from 45% the previous year. | 1 | Karl Portz Equality, Diversity and Inclusion Lead |
| **Domain 2: Workforce health and well-being overall rating** | | | 5 | |

## Domain 3: Inclusive leadership

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lead) |
|---|---|---|---|---|
| ***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 | •The Trust Board have received a development session on Equality, Diversity and Inclusion which included the subject of Health Inequalities<br>•An independent Equality Diversity and Inclusion Steering Group has recently been formed.<br>The EDI Steering Group is jointly chaired by the Group Chief Nurse and Director of Strategy<br>•We have the Tailored Adjustment Form to support staff with long term conditions and disabilities and also a disability policy is in place.<br>•We have a number of staff equality networks and recently each network as been appointed an executive lead/sponsor. | 2 | Lucy Vere<br>Director of Learning & Organisational Development |

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| | 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed | Equality, Diversity and Inclusion Steering Group is now established in the Board governance process.<br><br>Workforce Education & Culture Committee (WECC) consider all EDI related papers.<br><br>The Trust has an Equality Impact Assessment policy and framework to ensure Policies, Procedures and Functions identify and address equality and health inequalities. | 1 | Lucy Vere<br>Director of Learning & Organisational Development |
| | 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients | Gender Pay Gap, Workforce Race Equality Standard, Workforce Disability Equality Standard, Accessible information Standards & EDS 2022 all not only go to EDI Steering Group & WECC but are also reviewed and approved at Trust Board | 2 | Lucy Vere<br>Director of Learning & Organisational Development |
| **Domain 3: Inclusive leadership overall rating** | | | 5 | |

| **Third-party involvement in Domain 3 rating and review** | |
|---|---|
| **Trade Union Rep(s):** | **Independent Evaluator(s)/Peer Reviewer(s):** |

## Domain 2: Workforce health and well-being (HUTH)

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lea |
|---|---|---|---|---|
| ***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 | • We have mature offerings in relation to General Health for staff, Coaches, Mentors, Mediators.<br>• Dedicated psychologists for Staff Support in ED, ICU<br>• OH can refer for counselling and Staff can self-refer<br>• EDI can refer directly for counselling for people with protected characteristics when required<br>• Staff can also directly receive support by accessing the groupwide Confidentail Care Employee Assistance Programme<br>• We have embedded Trauma Risk Incident Management<br>• Staff have access to the Tobacco Dependence Treatment Team<br>• We have an Equality, Diversity and Inclusion Steering Group.<br>• During the year we promote a number Health Awareness Campaigns to support a variety of health conditions. | 2 | Lucy Vere<br>Director of Learnir<br>Organisational Development |
| | 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source | • We have the Staff Conflict Resolution & Professionalism Policy and the Zero Tolerance to Racism Framework & Reporting tool to Support staff and tackle issues with colleagues and patients, The fact that the Staff Survey scores for BAME staff haven't deteriorated at the same rate as other scores suggests that it has had some impact.<br>• The Trust launched a Period Dignity with discreet support, for topics such as menopause, domestic violence & women's health.<br>• Established in 2024 Domestic Abuse Champions.<br>• We have launched Zero Tolerance to Ableism framework and have also launched Zero Tolerance to LGBTQ+ Discrimination February 2024 | 2 | Mano Jamieson<br>Equality, Diversity Inclusion Manage |

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|---|---|---|---|---|
| | 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source | • The Freedom to Speak up Guardian has more frequent contact with staff and has established a network of Champions and attends numerous committee meetings and is also now Full Time dedicated to the role. The Freedom to Speak Up Guardian now has access to a Communications Officer, to assist in raising awareness across the Trust of the role, across a number of communication channels. The number of concerns being raised to the Freedom to Speak Up Guardian has risen year on year, indicating that staff are increasingly aware of the role and comfortable with raising their concerns. The Trust operates a Speak Up Champion Network, with local volunteers promoting speaking up and signposting their colleagues to the Guardian role.<br>• All Staff Networks are active and provide support with all network chairs actively involved in representing individuals and promoting their wellbeing<br>• Staffside are also influential in providing impartial support to staff<br>• Also support is available from Occupational Health, Psychological Counselling services, Coaching networks and Mentoring networks<br>• We have independent support groups led by some ethnic minority staff<br>• The nursing directorate has an established pastoral support team | 3 | Mano Jamieson Equality, Diversity Inclusion Manager |
| | 2D: Staff recommend the organisation as a place to work and receive treatment | • Taken from the most recent staff survey, 48% of staff recommend the Trust as a place to work and 52% are happy with the care provided for a friend or relative. | 1 | Myles Howell Director of Communications |
| **Domain 2: Workforce health and well-being overall rating** | | | 8 | |

## Domain 3: Inclusive leadership (HUTH)

| Domain | Outcome | Evidence | Rating | Owner (Dept/Lea |
|---|---|---|---|---|
| ***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 | • A Board Development session was held on the subject of Inclusivity<br>• EDI Steering Group now a Group Wide board and chaired by Group CNO And Director of Strategy<br>• Trust has a policy of being Anti-Racist.<br>• Staff Networks now have dedicated Exec and Non Exec sponsors who attend network meetings<br>• The Chair, Chief Executive Officer and other Group Execs and Non Execs regularly attend the Group Staff Network Conferences and engage with the agenda holding follow up meetings where appropriate | 2 | Lucy Vere<br>Director of Learnir<br>Organisational<br>Development |
| | 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed | The Group Wide EDI Steering Group has been established in the Board governance process.<br><br>Workforce Education & Culture Committee (WECC) consider all EDI related papers | 1 | Jackie Railton<br>Deputy Director,<br>Strategy & Plannir<br><br>Lucy Vere Directo<br>Learning &<br>Organisational<br>Development |

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|---|---|---|---|---|
| | 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients | Gender Pay Gap, WRES, WDES, Accessible information Standards & EDS 2022 all not only go to EDI Steering Group & WECC but are also reviewed and approved at Trust Board. | 2 | Mano Jamieson Equality, Diversity Inclusion Manager |
| **Domain 3: Inclusive leadership overall rating** | | | 5 | |

| EDS Organisation Rating (overall rating): 18 (NLaG) – Developing<br>21 (HUTH) – Developing |
|---|
| Organisation name(s): Northern Lincolnshire & Goole NHS Foundation Trust<br>Hull University NHS Teaching Trust |
| Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**<br><br>Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**<br><br>Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**<br><br>Those who score **33,** adding all outcome scores in all domains, are rated **Excelling** |

| EDS Action Plan | |
|---|---|
| **EDS Lead** | **Year(s) active** |
| | |
| **EDS Sponsor** | **Authorisation date** |
| | |

| Domain | Outcome | Objective | Action | Completion date |
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| **Domain 1: Commissioned or provided services** | 1A: Patients (service users) have required levels of access to the service | Targeted Lung Health Check:<br>• Continue/ extend work to capture eligible patients with the homeless and prison populations<br><br>• To begin work to capture local Traveller populations, in collaboration with the Cancer Alliance<br>• To gather more data on the delivery of the TLHC in the North and North East Lincolnshire areas<br><br>Virtual Ward:<br>• To provide increased service coverage | Targeted Lung Health Check:<br>• To work with the Forge Project to carry out another cycle of work targeting homeless patients<br>• To continue working with local prison services, to ensure that eligible patients within the prison population are able to access TLHC.<br>• To discuss further with the local Cancer Alliance and begin planning to capture local Traveller populations in 2025.<br>• To continue the deployment of the TLHC in these areas, collecting further data and evidence on how the service is provided<br><br>Virtual Ward:<br>• To continue working with system partners to extend step-up care from GPs to a 7-day service in the future. | December 2025<br><br>December 2025<br><br>December 2025<br><br>December 2025<br><br>December 2025 |

| Domain | Outcome | Objective | Action | Completion date |
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| | 1B: Individual patients (service users) health needs are met | Targeted Lung Health Check:<br>• To ensure that patient's specific needs are documented within the EPR, to ensure that these can be acted upon on first contact.<br>• To gather examples of good practice, for use as a training aid and evidence bank for future reviews.<br><br>Chemotherapy Delivery:<br>• To gather examples of good practice, for use as a training aid and evidence bank for future reviews.<br><br>Virtual Ward:<br>• To further develop the service to provide care in line with patient's individual needs | Targeted Lung Health Check:<br>• To review the availability of flagging for LD patients within the EPR.<br><br>• To ensure that examples of excellent patient care/ where staff make adjustments for individual patient needs are recorded.<br><br>Chemotherapy Delivery:<br>• To discuss with unit managers how best to ensure that appropriate examples are captured and recorded for future reference.<br><br>Virtual Ward:<br>• To continue work with the Transitional Lead Nurse in relation to care plans for patients with Learning Disabilities, and providing education on the care plans | March 2025<br><br>December 2025<br><br>December 2025<br><br>July 2025 |

| Domain | Outcome | Objective | Action | Completion date |
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| | 1C: When patients (service users) use the service, they are free from harm | | | |

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| | 1D: Patients (service users) report positive experiences of the service | Targeted Lung Health Check:<br>• To collect and respond to patient feedback in a more structured manner<br>• To ensure that evidence is retained, to show that patient feedback is utilised for the improvement of services<br>• To provide further opportunities for patient experience to be provided<br><br>Chemotherapy Delivery:<br>• To gather increased levels of Friends and Family Test data.<br>• To gather more detailed patient feedback<br>• To use the results of the recent Humber Coast and Vale audit on SACT to inform future service developments | Targeted Lung Health Check:<br>• To develop and implement a process to ensure the regular collection and review of patient feedback<br>• To ensure that patient feedback is retained and reported on<br>• To explore the potential for collecting patient experience data via the TLHC website. This would include an explanation of the purpose behind the data collection, to encourage more patients to participate.<br><br>Chemotherapy Delivery:<br>• To work with Patient Experience to ensure that accurate Friends and Family Test data can be captured and reported.<br>• To arrange and carry out a more focused patient survey, to ensure that appropriate data is gathered.<br>• To obtain and review the results of the most recent HCV audit, when available | December 2025<br><br>December 2025<br><br>July 2025<br><br>April 2025<br><br>December 2025<br><br>April 2025 |

| Domain | Outcome | Objective | Action | Completion date |
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| | | Virtual Ward:<br>• To gather more patient feedback, in order to influence future service developments<br><br>• To review existing patient experience data, for any potential learning opportunities | Virtual Ward:<br>• To discuss with patient experience/ incident reporting to see if it would be possible to introduce a system for reporting positive feedback/ examples of good practice ('Greatix')<br>• To review physical copies of previously received feedback, as there were noted issues with FFT reporting due to data collection being within the short stay ward | December 2025<br><br>April 2025 |

| Domain | Outcome | Objective | Action | Completion date |
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| **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 | To identify what support is needed for each condition and scope out what capacity is needed to offer the level of support required. | To complete capacity and demand exercise for each condition<br>To prioritise interventions using the Health and Wellbeing MDT to identify and allocate resources<br>Roll out or promote interventions identified<br>To roll out the Health and Wellbeing framework – including to training staff in health coaching | March 2026 |

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| | 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source | To reduce number of staff reporting experiences of abuse, harassment, bullying & physical violence in the staff survey | To introduce and embed a number of Zero Tolerance to discrimination frameworks and reporting tools focussing on Race, Disability and LGBTQ+,<br><br>To create clear roles and responsibilities for line managers in protecting their staff form harm including supporting them to upskill and increase their confidence in dealing with challenging situations<br><br>To roll out the Inclusivity Academy including our in house more in depth EDI mandatory training model for the whole group. | Aril 2025<br><br>May 2025<br><br>June 2025 |

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| | 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source | To ensure that a full range of support is available that enables staff to speak up, get support and get their issue resolved without having a permanent impact on their work life and health. | To fully review current routes of advice and ensure that they are fully accessible.<br><br>To fully maximise the Freedom to Speak Up Guardian Services including the network of FTSU Champions with a focus on EDI related complaints.<br><br>To further embed and support our Network Chairs and Vice Chairs to offer support and advice including creating a regular supervision and support sessions for them led by the FTSUG and the Director of Learning and OD.<br><br>To encourage our staff from protected characteristics to join a union to allow them access to external and impartial support. | June 2025<br><br>June 2025<br><br>April 2025<br><br>April 2025 |

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| | 2D: Staff recommend the organisation as a place to work and receive treatment | Develop a values led culture that ensures all staff feel valued, welcome and creates a safe working environment, which ultimately translates into better and safer patient care. | Create a strong leadership development and people management approach that is compassionate and inclusive through a wide range of interventions:<br>• Development programmes<br>• Bespoke work with teams<br>• Coaching and mentoring<br>• Clear metrics and feedback to managers on their progress<br>Create and rollout a group wide Professionalism and Civility Programme (PACT) to ensure all staff understand what is expected of them in creating a healthy work culture. | December 2025 |

| Domain | Outcome | Objective | Action | Completion date |
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| **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 | To embed Equality, Diversity and Inclusion, and Health Inequalities into the personal performance objectives for our Band 9 and VSM leaders | Include Care Group measures on EDI, staff survey scores in accountability to Trust Board along with Action Plans for improvement<br><br>All relevant managers have EDI and Health Inequality objectives built into their appraisals.<br><br>Care Group and Director Level WRES/WDES/LGBTQ objectives and progress tracking built into reporting and governance structures for the Group | June 2025<br><br>December 2025<br><br>December 2025 |
| | 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed | Introduce accountability for Equality, Diversity and Inclusion activity and Health Inequalities at Board Committee level | Ensure Equality and Health Inequality impact assessments are reviewed at relevant Board Committee when service changes are introduced<br><br>Training and Coaching for NED's to ensure that they are able to critically challenge the Exec team when impact assessments are being discussed and agreed at committees and Trust Board. | July 2025<br><br>July 2025 |

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| | 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients | To demonstrate that we have clear metrics and governance in place that allow both executives and non-executives to identify and track improvements for both staff and patients. | To ensure that the new Group Structure governance arrangements are able to identify improvements, hold our Care Groups and Corporate Directorates to account for both remedial and proactive actions required.<br><br>To work with executive and site teams to ensure that they are pursuing performance for these objectives as part of their routine performance meetings and structures. | April 2025<br><br>September 2025 |

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