NHS Equality Delivery System (EDS)

Name of Organisation	Mersey & West Lancashire Teaching Hospital NHS Trust (MWL)
Name of Integrated Care System	Cheshire and Merseyside ICB
Organisation Board Sponsor / Lead	• **Anne-Marie Stretch** Deputy Chief Executive & Director of HR • **Sue Redfern** Director of Nursing, Midwifery & Governance
EDS Lead	• **Cheryl Farmer** Head of Patient Inclusion and Experience • **Darren Mooney** Head of Equality, Diversity & Inclusion (Workforce)
At what level has this been completed?	NHS Trust / Organisation Level
EDS engagement date(s)	30/1/2024
Individual organisation:	• N/A
Partnership* (two or more organisations):	• Healthwatch (Sefton, St Helens, Knowsley, Halton, West Lancs)
Integrated Care System-wide:	Cheshire and Merseyside ICB
Date completed	16/2/2024
Date authorised	29/2/2024
Revision date	02/2025
Month and year published	02/2024

Contents

Note: For the 2023 assessment, MWL used the EDS2/3 template which did not include an action planning section, therefore this section is blank.

Completed actions from previous year	
Action/activity	**Related equality objectives**
N/A	**N/A**

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

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

1. Sexual Health Services

Outcome	Evidence	Rating	Owner (Dept/Lead)
1A: Patients (service users) have required levels of access to the service	**Summary of what the service includes**: • Examination, diagnosis and treatment of STIs • Testing for sexually transmitted infections (STIs • Condom distribution • Pregnancy tests • Assessment for and access to contraception • Emergency contraception • Sexual health advice, education and support (including erectile dysfunction) • Post exposure prophylaxis (PeP) • Pre- Exposure Prophylaxis (PrEP) • Outpatient HIV care • Vaccinations • Young person service • Sexual health outreach and education The service records certain demographic information of the service users who attend (gender, age, ethnicity and sexual orientation). Although the electronic patient record system used in Sexual Health (Lille™) does not have the facility to collect demographic data on disability, this is still assessed for each attendance on the patient pro forma completed by clinicians.	3	Sexual Health Services

Outcome	Evidence	Rating	Owner (Dept/Lead)
	From the information gathered about service users and through the services themselves, teenage pregnancies, asylum seekers/refugees, homeless/rough sleepers and sex workers have been identified as the high-risk groups of service users. The service (which is free to all service users) is delivered via a hybrid model which encompasses online/home testing, telephone appointments and booked/walk in face-to-face clinic appointments. Services are delivered in community settings: • Asymptomatic STI screening and pregnancy testing in settings young people attend • Clinical outreach team can visit vulnerable patients for screenings, vaccinations and contraceptive services • Health improvement team run the condom distribution scheme, via venues used by the community Health improvement team offer outreach testing to people experiencing homelessness (Teardrops, The Hope Centre, Salvation Army and YMCA).		
1B: Individual patients (service users) health needs are met	• Services are provided in ways that meet the service users needs such as interpreters, BSL interpreters, spoken information, CD or braille, large print documents and easy read. • Patients who are identified as vulnerable (list provided on previous slide) are prioritised for appointment offers. • Website development, led by the health improvement team, has resulted in a number of features being included (“recite me” to increase font size, colour scheme adjustments, different languages	3	Sexual Health Services PEI team

Outcome	Evidence	Rating	Owner (Dept/Lead)
	available, read aloud and “hide site” button for quick and discrete exiting of the site). • Info for professionals and patients, as well as helpful tools and advice to support patients available via the site as well. • Facilities are mixed gender and suitable for disabled access (waiting rooms and toilets). • LGBTQIA young people are offered to join Over the Rainbow local support group (LCR Pride 2023 award winner & runner up in St Helens Pride awards 2023), which supports young people parents/guardians. • Psychosexual therapist service offered to patients via hybrid approach (face-to-face and video) • Assessment completed for each visit to identify any additional support needs for vulnerable adults and under 18s. If necessary, can signpost and make referrals to other services • Patients who attend walk-in appointments complete a triage form, which is reviewed by reception staff and discussed with coordinator if necessary.		
1C: When patients (service users) use the service, they are free from harm	• All patients are initially seen alone, to support the assessment of whether a patient is a victim of abuse or being coerced/controlled. • Clinical pro forma for all patients includes routine questions about FGM as well as domestic and sexual violence within current or precious relationships • Every patient is risk assessed for alcohol and substance misuse and can be referred to local drug and alcohol support if they consent to this. • Patients who are identified as having a vulnerability, have a risk assessment completed. If a significant issue is found, staff complete a		Sexual Health Services

Outcome	Evidence	Rating	Owner (Dept/Lead)
	DASH assessment and escalate any safety concerns via the Trust safeguarding team. Clinic also has a named safeguarding nurse. • Dynamics form has been introduced which is gender and sexuality sensitive to ensure the clinician only sees and asks questions relevant to their gender and sexuality. Information from previous consultations is also pulled through to avoid re-asking and re-traumatising about difficult and sensitive information. • Patient safety incidents are reported to the Trust safeguarding team. Clinical governance is also part of the monthly protected teaching agenda. Safeguarding provision is also provided by the Trust safeguarding team. • The Matron will work with colleagues to develop a system, to provide patients with a safe word who feel they are at risk of harm but cannot verbalise it • PACE young persons service offers tailored consultations for young people aged 19 and under ensuring that the clinician they see is trained to deal with additional requirements they may have	2	
1D: Patients (service users) report positive experiences of the service	• Dedicated Cancer Patient Experience and Quality Assurance Group which meets quarterly to highlight patient feedback and learning throughout the department and actions to improve patient experience • National Cancer Patient Experience Survey (NCPES) results, published in July 2023. Both STHK and Southport & Ormskirk scored higher than the national average across all domains. All respondents were of White British ethnicity and over the age of 45 years old • Positive feedback from patients following the implementation of the Self Supported Follow Up Programme, enabling patients to have access to their diagnostic results and reducing the need for patients to attend a face-to-face follow up appointment	2	Sexual Health Services PEI team

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Positive feedback received following the re-launch of the Living With and Beyond Event for patients who have completed definitive cancer treatment, a patient focus group was held to plan and design the event • Positive feedback received as part of the Family and Friends Test • Macmillan Quality Environment Mark awarded to The Lilac Centre, which celebrates achievement of the environment meeting the standards for cancer patients • 36 compliments received from patients for Cancer Services in the 2022/23 year • NHS Staff Survey responses, Cancer Services scored 9.10 for Diversity and Equality surpassing the Trust average of 8.55		
Domain 1: Commissioned or provided services overall rating – Sexual Health Services		2	

2. Cancer services: Faster diagnosis pathway

Outcome	Evidence	Rating	Owner (Dept/Lead)
1A: Patients (service users) have required levels of access to the service	Changes were made to the service following the “faster diagnosis standard”, which is mandated to be in place for all cancer pathways by March 2024. Therefore in 2023, changes were made to the following pathways: • Skin cancer • Lower gastrointestinal	2	Cancer Services PEI team

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Breast The standard indicates that patients who are referred on an urgent cancer pathway should be advised if they have cancer, or cancer has been ruled out, within 28 days of referral from their primary care practitioner. • St Helens Community Diagnostic Centre (SHCDC) offers appointments closer to home, with some diagnostic tests carried out on evenings or weekends to support people working full time or caring responsibilities. • Specialist advice can be accessed from a cancer nurse specialist by telephoning the Cancer Symptoms Advice line for symptoms they may be concerned about • Services are co-designed with patients (SHCDC, d/Deaf patients and local LGBT groups) so patients can say what works for them and what doesn't, as well as help develop new services • Anyone affected by cancer can access info and support from Macmillan Information & Support Centre, via drop-in or referral. The triage process identifies the person's needs and tailors information to support to their needs • Recent cancer performance data (28-day faster diagnosis target) shows 82% of patients are meeting the target, which is the best performance in the region • All patient related policies, SOPs and service changes are Equality Impact Assessed, to ensure patients (protected characteristics) and inclusion health groups are not disadvantaged by changes • Patients have the opportunity to have a chaperone, same sex if requested, for any appointment • The service follows the Trust's Patient Access policy, ensuring timely access to cancer service irrespective of protected characteristic		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Service improvements are developed with patients – urology introduced a pre-appointment call, where patients can talk through any concerns and fears before the appointment, DNA rates reduced.		
1B: Individual patients (service users) health needs are met	• Services are provided in a way that meets the service users needs such as interpreters, BSL interpreters, documents in braille, large print and different languages, easy read, sonic hearing aids and hearing loops are available, early morning appoints at the breast clinic for trans and other patients who wish to be seen at a quieter time or longer appointments for patients due to a learning difficulty, dementia or autism • Patients on a cancer pathway can access holistic forms of support via Macmillan (complementary therapies, counselling and benefits advice) • Good relationships with the Macmillan Centre and local organisations e.g. three times a year, the Trust in conjunction with Macmillan holds health and well-being events • Patients with a confirmed cancer diagnosis are offered a holistic needs assessment which is a discussion with the patient to meet their individual physical, emotional practical and financial needs • Patients/family members who have been diagnosed or treated in the Trust within the last 12 months, can access various therapies tailored to meet their individual needs (counselling, hypnotherapy, group relaxation classes, reiki, aromatherapy, reflexology and Indian head massages) • The service supports some of the most vulnerable and marginalised communities who face barriers when accessing healthcare e.g. Traveller communities and refugees • A Macmillan funded project is underway (Treatable But Not Curable Project), aiming to improve the quality of care and support provided	2	Cancer services PEI team

Outcome	Evidence	Rating	Owner (Dept/Lead)
	to patients living with metastatic disease. It involves patients, experts by experience, members of the patient experience team and clinician across the region		
1C: When patients (service users) use the service, they are free from harm	• Incidents and learning are discussed at the monthly Cancer Services Performance & Governance Assurance meeting • The department has a qualified mental health workplace first aider and onsite mental health services provided by Mersey Care • Relevant policies are in place (Managing Risk Policy, Safeguarding Adults Policy as well as Safeguarding Children and Young People Policy) which are supported by the safeguarding team • Safe Administration of Systemic Anti-Cancer Therapy (SACT) Policy is followed when administering SACT • Cancer MDT Operational Policy and Cancer Services Operational Policy outlines the roles and responsibilities of staff involved in patient care and outlines the governance assurance process • Mandatory and role specific training in place (safeguarding level 2 and 3 for all staff, the Oliver McGowan training for Learning Disability and Autism for all staff, health and safety and resus training) • Lilac Centre nurses all complete the required chemotherapy training and keep competencies up to date to ensure the safe administration of chemotherapy • There are several Freedom to Spek Up Guardians across the Trust, posters of the guardians and how to raise a concern/whistleblowing are advertised via Cancer Services newsletters and departmental posters • No serious incidents or never events have been reported for 2023/24	2	Cancer services

Outcome	Evidence	Rating	Owner (Dept/Lead)
1D: Patients (service users) report positive experiences of the service	• Dedicated Cancer Patient Experience and Quality Assurance Group which meets quarterly to highlight patient feedback and learning throughout the department and actions to improve patient experience • National Cancer Patient Experience Survey (NCPES) results, published in July 2023. Both STHK and Southport & Ormskirk scored higher than the national average across all domains. All respondents were of White British ethnicity and over the age of 45 years old • Positive feedback from patients following the implementation of the Self Supported Follow Up Programme, enabling patients to have access to their diagnostic results and reducing the need for patients to attend a face-to-face follow up appointment • Positive feedback received following the re-launch of the Living With and Beyond Event for patients who have completed definitive cancer treatment, a patient focus group was held to plan and design the event • Positive feedback received as part of the Family and Friends Test • Macmillan Quality Environment Mark awarded to The Lilac Centre, which celebrates achievement of the environment meeting the standards for cancer patients • 36 compliments received from patients for Cancer Services in the 2022/23 year • NHS Staff Survey responses, Cancer Services scored 9.10 for Diversity and Equality surpassing the Trust average of 8.55	2	Cancer services

Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services overall rating		2	

3. End of Life Care

Outcome	Evidence	Rating	Owner (Dept/Lead)
1A: Patients (service users) have required levels of access to the service	Palliative care and care at the end of life is provided by the multi-professional teams providing day to day care across the hospital. If it is thought specialist input might be helpful, usually because someone's needs have become more complex, the clinical team can contact the Hospital Adult Specialist Palliative Care Team (HSPCT) for support. This might be advice or it might involve the palliative care team meeting a patient and the people close to them. The ward teams will ask a patient for permission before asking the HSPCT to meet with them. • The HSPCT works with the person referred, the people important to them and clinical teams, offering assessment and advice on the management of complex physical symptoms alongside psychological, social and spiritual issues. We support people through decisions about the place of care for future treatment and can refer to other professionals who will continue care in hospital, home, care home or a hospice if required. • The service records certain demographic information (gender, age and ethnicity) • The service (which includes face to face, telephone, website and documents) is delivered in a way that meets the service users needs (interpreters, BSL interpreters, hearing loops, documents in audible recording, easy read, different languages and braille, hi-contrast)	1	EOL and Palliative Care PEI team

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• Our facilities also meet the needs of the service user (disabled parking, mobility aids and toilet facilities) • The service can be accessed 7 days a week 9am – 5pm. 80% of the team are non-medical prescribers, allowing patients to have timely access to medication and manage symptoms		
1B: Individual patients (service users) health needs are met	• Holistic assessments help to ensure physical; emotional; psychological; social; spiritual and faith needs are met. A member of the spiritual care team attends HSPCT handover once a week. • As a patient approaches the last days of their life the Individual Care and Communication Record (ICCR) helps to avoid unnecessary interventions and meet the individual needs and wishes of the dying patient as far as possible. • There is also 24 hour advice line and on call service to be able to provide rapid response to the changing needs of patients. Providing access to medicines, equipment e.g., syringe drivers and specialist palliative care support 24 hours a day.	2	EOL and Palliative Care PEI team
1C: When patients (service users) use the service, they are free from harm	• Patients referred are usually seen alone. If a patient has relatives with them consent is gained from the patient to allow them to stay • A multi-disciplinary approach to all End-of-Life Care decisions and treatment plans are communicated effectively and safely between the multi-disciplinary team. • We monitor and act on feedback received from End-of-Life Care incidents, complaints, real time feedback and lessons learned to improve practice and support the delivery of targeted training in response to areas of concern identified • Safety incidents are reported to the safeguarding team. Clinical Governance is included as part of the agenda for our monthly protected teaching	1	EOL and Palliative Care

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• All staff are fully compliant with all aspects of safeguarding training. This is recorded on ESR		
1D: Patients (service users) report positive experiences of the service	• Envoy trust report monthly, 100% of patients were happy with the service • The team record positive feedback received within our Glimpses of Brilliance file • Friends and Family Test response cards have been introduced across the team • National Audit of Care at the End of Life (NACEL) questionnaires are sent out to relatives who have been bereaved. **Case study:** Ongoing work to ensure timely verification and certification of death for patients who desire burial within 24 hours of death due for reasons of faith. • Following any death, verification of death is required by an appropriately trained clinician. In hospital this is currently usually a doctor. • A doctor who has seen the patient is then required to complete a Medical Certificate of Cause of Death (MCCD). • The MCCD is required to register the death, and enable the Certificate of Death and the “permission to dispose of the body” slip to be issued from the registry office. The Registry Office is open 9-5, 5 days a week. • Burial or cremation can only be arranged following the above steps.	2	EOL and Palliative Care PEI team

Outcome	Evidence	Rating	Owner (Dept/Lead)
	• All bereaved families are contacted after death to inform them of the death and support them through this process. The new approach adapts the process for anticipated faith deaths to meet their needs. The recent introduction of the Medical Examiners Office has added an additional step prior to the completion of MCCD. The Medical Examiners Office reviews the case notes of all those who have died and contacts the family to identify any concerns they may have had prior to completion of the Medical Certificate of Cause of Death. This is potentially problematic in a faith death, where burial is required within a short time period. A new approach aims to identify potential faith deaths early, to enable the ME office to review the case and support completion of the MCCD in a timely manner. **Engagement:** September 2023. Aim to identify potential faith deaths prior to death and highlight these patients and families to ward teams, and to proactively inform the Medical Examiners (ME) office. • The need to pro-actively liaise with ME office prior to anticipated faith death is included in all care of the dying training across the trust. • Ongoing work to change process of notification of the development of an “individual plan for care of those thought likely		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	to be dying" from email to Specialist Palliative Care Services (SPCS), to careflow notification to both SPCS and to ME office. • ME Office to review case notes prior to anticipated death, and ensure plan in place to support ME office review, completion of MCCD and registration of death over weekends and bank holidays. ME office previously not made aware of faith deaths until after death. • Medical Examiner: Dr Chris Goddard • Specialist Palliative Care Services: Dr Clare Finnegan (hospital specialist palliative care team • Spiritual Care Team: Rev Martin Abrahams • Patients family with lived experience: via Queenscourt Hospice • Supported by Mortality Operational Group No barriers as universal support to improve the processes to support these patients. Work in progress with SPCS and with careflow team to change notification process of development of an "individual plan for care of those thought likely to be dying". New change affecting small numbers of patients, therefore too early to report on outcomes at this time.		
Domain 1: Commissioned or provided services overall rating – end of life care		2	

Independent Evaluator(s)/Peer Reviewer(s):

- Andy Woods (C&M ICB)
- Anne Rosbotham-Williams (Deputy Director of Governance)
- Dave Wilson (Halton Healthwatch)
- Jayne Parkinson-Loftus (St Helens Healthwatch)
- Emmy Walmsley (Healthwatch Lancashire)
- Elizabeth Okecha (consultant sexual health service)
- Jeanette Reddin (sexual health service)
- Jean O'Keefe (ED)
- Jo Simpson (Assistant Director, Clinical Quality)
- Deborah Beck (Palliative Care and end of life service)
- Jan Lawson (Cancer Services S&O)

Domain 1: Commissioned or provided services overall rating	2	Achieving activity

Domain 2: Workforce health and well-being

Outcome	Evidence	Rating	Owner (Dept/Lead)
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	1. **Health Monitoring**: The Trust maintains a dedicated Health Work and Wellbeing (HWWB) team that monitors the overall population health of the workforce and implements targeted strategies to support staff and improve sickness absence metrics. Employees have access to various interventions, including programs for stress, depression, weight management, physiotherapy, exercise, and bereavement support. 2. **Sickness Absence**: Weekly comprehensive sickness and absence reports are generated and reviewed by the HR Senior Leadership Team, with more detailed reports provided at the department level to enable managers to make informed decisions aligned with the Attendance Management Policy. The Trust's Absence Support Team collaborates closely with the HWWB team, ensuring managers are well-equipped with the necessary training and knowledge for managing absences. Additionally, the Equality, Diversity, and Inclusion (EDI) team works alongside the HWWB team to assist disabled staff and those with long-term conditions by facilitating reasonable adjustments and promoting the use of the disability passport. 3. **Health literacy:** To enhance the workforce's health literacy, the HWWB team, supported by over 150 wellbeing champions and mental health first aiders, maintains informational boards, and organises regular departmental drop-in sessions/events, including an annual event to foster health awareness. The Trust has also introduced innovative initiatives like the 'Find Your Fit' 12-week programme, chair yoga sessions, and the menopause café, which have been widely embraced by the staff. 4. **Communication:** The HWWB team has developed a comprehensive intranet site that directs staff to various national and voluntary support networks. These resources are actively promoted by Wellbeing	2	Health, Work & Wellbeing

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Champions and through Team Briefs, ensuring widespread accessibility and support for the Trust's workforce.		
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	1. **Zero Tolerance Commitment**: The Trust is dedicated to maintaining a safe and respectful work environment, upheld by its suite of policies targeting unacceptable behaviour, domestic abuse, and safeguarding. These include specific approaches to manage incidents, complaints, and support for lone workers. Key information and strategies like the Violence Reduction Strategy and use of bodycams are disseminated through the Trust's intranet, with additional security measures enforced through collaboration with local police and designated safety roles. 2. **Anti-Bullying Policies**: The Trust has the following policies which collectively manage bullying and harassment situations; Respect & Dignity at Work Policy (Anti-Bullying Policy), Equality & Human Rights Policy, Staff Grievance Policy, Staff Disciplinary Policy, Lone Working Policy, Domestic Abuse Policy, Adult Safeguarding Policy, Child Safeguarding Policy, Violence Reduction Strategy, Policy on the use of body cameras. 3. **Bullying is Misconduct/Gross Misconduct**: The Disciplinary Policy and Respect and Dignity at Work Policy strictly prohibit bullying, harassment, and violence, detailing consequences for such misconduct. These aim to establish a clear understanding among staff of acceptable behaviour and provide a structured approach to handle complaints. 4. **Advice and Guidance**: Staff who experience bullying and harassment can seek advice and support from their Line Manager, Trade Union, HRBP's, EDI, and Freedom to Speak Up Guardians. 5. **Bullying by Patients et al**: Staff are supported in reporting and managing abusive incidents from patients, defined under the policy addressing unacceptable behaviour. This includes a range of actions deemed harmful or disruptive, particularly towards staff with protected characteristics. The Trust's response includes clear procedures for	2	Human Resources, Security, Safeguarding

Outcome	Evidence	Rating	Owner (Dept/Lead)
	dealing with such behaviour, emphasising a secure working environment, with the ultimate sanction of removal from the hospital. 6. **Staff Survey Results**: From 2021 to 2022 the reported levels of Physical Violence increased at Legacy STHK from service users (13a), managers (13.b), colleagues (13c); incidents of Harassment increased for service users (14a), and decreased from Managers (14b), and Colleagues (14c). When comparing Legacy STHK 2022 results with MWL 2023 results, there was a decrease in reported incidents for all of these indicators. For all 2022 and 2023 results, Legacy STHK and MWL have reported rates of physical violence and harassment lower than the national/comparator average. 7. **Harassment From Service Users**: In 2022, 6 EDI categories where higher that STHK average, of which 3 had decreased, and 3 increased since 2021. Compared to MWL 2023 all indicators had decreased. Compared to national/comparator average, 2 EDI categories in 2022 were higher: 21-30 (decreased since 2021) and Disabled (increased since 2021). 8. **Harassment from Managers**: In 2022, 7 EDI categories where higher than STHK average, of which all 7 decreased from 2021. Compared to national/comparator average, only 1 EDI category in 2022 was higher: Disabled. 9. **Harassment from Colleagues**: In 2022, 5 EDI categories where higher than the STHK average, of which 4 decreased from 2021. Compared to national/comparator average, 2 EDI categories in 2022 were higher: Disabled (decreased since 2021) and BME (increased since 2021). 10. **Staff Survey Response**: The staff survey results are used by all departments to identify key areas of improvement and take steps to address them. L&OD manage the dissemination of the results and coordinate the collation of a Trust action plan, which includes responses to the B&H questions. Examples of actions taken directly from the staff survey include the introduction of body cameras, a violence reduction strategy, EDI training on Unconscious Bias, Discrimination and		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Harassment for Managers; a follow up Ward Engagement project whereby all wards/clinical areas in the Trust will have been visited by EDI Team by Summer 2024.		
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	1. **Trade Unions:** The Trust recognises and provides 'facilities time' to the following unions, Unison, RCN, RCM, British Dietetic Association (BDA), British Association of Occupational Therapists, CSP, BIOS, BMA, Society of Radiographers, Unite the Union. Unions representatives carry out their duties during work time, and are members of numerous Trust committees including the People Performance Council, Valuing our People Council, JNCC, and Policy Sub Group. MWL does facilitate the pooling of union representatives where there is a need / benefit to do so for example with the RCN reps who will support nurses across the region- in other Trusts. 2. **Freedom to Speak Up:** The Trust has 4 Freedom to Speak up Guardians offering staff a confidential way to raise concerns about any aspect of their work or environment, including abuse or harassment. Speak Up Guardians include the Chief Executive, Director of Medicine, Ass Director of Patient Safety and the Chair of Board. In addition, a network of Freedom to Speak Up Champions at lower bands/roles exist at S&O and are being expanded to STHK. 3. **Staff Networks**: The Trust supports six staff-led networks, each focusing on different aspects of staff identity and experience. These networks provide peer support for those experiencing stress, abuse, bullying harassment, and physical violence and advocate for specific needs related to staff from the following communities LGBTQIA+, Armed Forces, BME, Disability, Carers and women experiencing the menopause. Staff Networks are supported by the EDI Team (HR) who provide advice, admin/events/media support, funding, and consultation/engagement activities, including Equality Impact Assessments. 4. **Staff Network Voice**: Network chairs are members of the Equality Steering Group, the principle committee responsible for the	2	Human Resources

Outcome	Evidence	Rating	Owner (Dept/Lead)
	development and oversight of the Trust EDI Strategies, Policies, Action Plans and Prioritise. In addition Network Chairs have regularly meetings with the EDI Team through which they can raise any ideas/concerns for improvements. Relevant networks are engaged on policy, action plan, charter mark, and accreditation processes. Networks are free to engage in any and all Trust consultations that take place. Examples have included consultation by the recruitment team, the Big Conversation, the approval of the Trust EDI Strategy, and Adjustment Passport. 5. **Independent Support**: Staff can access information, advice and support from Human Resources (HRBP's)(Policies, Grievance etc), EDI Team (Reasonable Adjustments, Bullying and Discrimination), Health Work & Wellbeing (Wellbeing Hub, Psychological Services, Occupational Health, Employee Assistance Programme, Wellbeing Champions, Mental Health First Aiders), Freedom to Speak Up Guardian and Champions, Trade Unions, Security and Police (Assault, Hate Crimes), and Staff Networks (Peer Support/Sign Posting). 6. **Using Data:** The Trust reviews, analysis and acts upon the annual results of the staff survey, grievance/disciplinary data, and incident data collected by the Staff Survey, HR, and EDI (Workforce). A comprehensive staff survey review and action planning process takes place each year, where departments are required to review and act on their results. A central action plan is collated by L&OD which is monitored by the Staff Survey Project Group. EDI Staff Survey results are reviewed by the EDI Team as well as the WRES/WDES process. Actions are incorporated into the EDI Team, Security, L&OD, HR, and department action plans were relevant. 7. **Taking Action:** The People Performance/Valuing Our People/Strategic People Councils receive regular reports on HR and People processes including Grievances and Disciplinaries, HWWB User Statistics, Staff Survey Results, EDI Population Trends, WRES/WDES/EDS assessments, Freedom to Speak Up, Security/Incidents, Safeguarding, and Staff Stories. This intelligence is used to inform and agree action to		

Outcome	Evidence	Rating	Owner (Dept/Lead)
	address negative trends and concerns, and to monitor the implementation. Where relevant Risks are inputted into the Risk Register (in DATIX) and monitored by the risk management process until satisfactory steps have been taken to reduce or remove said risk.		
2D: Staff recommend the organisation as a place to work and receive treatment	1. **Staff would use Trust Services:** Staff at STHK are more likely than the NHS/Comparator average to agree that in the organisation 1) patients are our top priority, 2) its acts on patient concerns, and 3) would recommend the Trust to friends/relatives for care. 2. **Staff recommend Trust as a place to work:** 70% of staff state they would recommend it as a place to work compared to 57% of the NHS/Comparators. 3. **Staff would recommend the Trust to Friends and Family:** 78% of staff state that they would recommend the trust to friends/family for care, compared to 63% of the NHS/Comparators. 4. **Sickness Absence Data:** The Trust employs a strategic approach to staff retention by using sickness and absence data, offering employment breaks for long-term health or personal issues, and closely monitoring absence trends to develop supportive plans with line managers. The HWWB resources assist staff with health issues, facilitating an earlier return to work. This comprehensive approach, which includes a Recruitment and Retention Plan, underscores the Trust's commitment to employee well-being and workforce stability. 5. **Exit Interviews:** The Trust is enhancing its data collection methods for exit interviews, shifting from retrospective gathering after an employee's departure to a new system that collects information before their final day. This change aims to increase response rates and improve the quality of the data obtained. 6. **Equality Data Analysis:** the Staff Survey results are extensively analysed across data sets by Age, Disability, Ethnicity (2 Ways, 5 Ways, 18 Ways), Sex, Sexual Orientation, Religion; and where relevant cross references by Staff Group, Department and Intersectional Data by	2	Human Resources

Outcome	Evidence	Rating	Owner (Dept/Lead)
	the EDI Team. Actions are identified from the data are incorporated into the EDI Action Plans and/or Staff Survey Action Plans. 7. **Partner Working**: The organisation works with a number of partner organisations to improve the experience of all staff in line with the broader NHS People Plan. The organisations include 3rd party companies, membership organisations, charities and VSCE's. Examples include: Business Disability Forum, Employee Assistance Programme, Rugby League Cares, Access to Work, Veterans Covenant Healthcare Alliance, Disability Confident, via Job Centre Plus, NHS Employers, Local Authorities. The Trust works with regional and national NHS networks including the ICB and NHS NW and NHE England.		
Domain 2: Workforce health and well-being overall rating		2	

Domain 3: Inclusive leadership

Outcome	Evidence	Rating	Owner (Dept/Lead)
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	1. **Governance Structure**: The Trust has a developed management and governance committee structures, with a dedicated Patient Experience Council, and a dedicated People Performance Council; both of which report into the Board. EDI and Health Inequality agenda items are regularly discussed and are standing items in the Trust annual committee business. Key agenda items include the Gender Pay Gap, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), EDI Operational Plan Update, Annual reports on EDI, Freedom to Speak Up, Safeguarding, service updates on Maternity. Children, Young People, Women's & Childrens Health, Primary Care, Learning Disability & Mental Health, Chaplaincy etc. 2. **Staff Networks**: Staff EDI Networks are provided strategic support by a dedicated EDI Team in Human Resources. Networks chairs meet formally with the Network Coordinator who escalates agenda items through the EDI Team to HR management were relevant. Network chairs are members of the Trust EDI Steering Group having direct access to EDI decision makers including Senior HR leaders, Patient Governance and Trust Executive members. The Trust has an EDI Senior Champion on the Trust Executive who meets with chairs periodically, and attends network meetings on request. 3. **Cultural Events:** Trust Executive members engaged in a series of EDI related activities each year, sponsoring cultural, religion and EDI events, campaigns and celebrations. Activities include demonstrating the Trusts commitment to EDI via News Articles, Trust Brief Live, attendance and speaking at events (Eid, Diwali, International Nurses Day etc), participating in EDI allyship (signing Anti-Racism Statement) etc. 4. **Underserved Voices:** Senior Leaders enable "underserved voices" to be heard through a number of forums. Staff Stories and Patient Stories	2	Human Resources Patient Inclusion & Experience Governance Team Board/Trust Exec

Outcome	Evidence	Rating	Owner (Dept/Lead)
	are regular features at senior governance committees, example include talks by disabled and BME staff; patient chaplaincy etc. Furthermore, EDI regularly "takes over" the Trust Brief Live, sharing information about events, campaigns, training and updates, led by diverse staff. The Trust further support Staff Networks: BME, Disabled, Carers, LGBTQIA+, Menopause, and Veterans who work to raise the voices of their members. 5. **EDI Scrutiny:** The Board receive and scrutinise all the EDI reports, as well as performance reports relating to workforce and operations; quality reports from the governance committees, and key annual reports including Trusts Strategies updates, annual reports (Safeguarding, Health Work & Wellbeing, EDI etc) 6. **Leadership Framework for Health Inequalities Improvement**: The Trust has not as of yet implemented this framework, but has ongoing activity related to health inequalities. 7. **Board Commitment to EDI:** Each member of the Trust Executive Team has engaged with the EDI/Health Inequalities agenda. This has included reviewing the Trusts WRES, WDES, Gender Pay Gap, and Staff Survey results; approving the Trusts EDI Ops Plan and Action Plan, membership of the Dying to Work Charter and Sexual Safety Charter; participating in EDI Learning & Development; attendance at cultural events including Eid and Diwali; and championing EDI within their areas of responsibility. 8. **Board Communication on EDI:** The Trust Executive Team communicated extensively on EDI/Health Inequalities through the Team Brief Live, Staff News articles, MWL News (Email), and attendance at EDI events. This has included Team Takeovers, signing the Anti-Racism Pledge, launching the EDI Festival 2023, and speaking on key initiatives in staff news.		

Outcome	Evidence	Rating	Owner (Dept/Lead)
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	1. **EDI/HE Committee Agenda Items**: The Trust has a developed management and governance committee structures, with a dedicated Patient Experience Council, and a dedicated People Performance Council; both of which report into the Board. EDI and Health Inequality agenda items are regularly discussed and are standing items in the Trust annual committee business. Key agenda items include the Gender Pay Gap, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), EDI Operational Plan Update, Annual reports on EDI, Freedom to Speak Up, Safeguarding, service updates on Maternity. Children, Young People, Women's & Childrens Health, Primary Care, Learning Disability & Mental Health, Chaplaincy etc 2. **Equality Impact Assessments**: The Trust EIA process states that a EIA screening or full assessment must be completed for all policies et al and strategic change projects. The screening form is embedded in the policy template and committee cover sheets as part of the approval/assurance process. EAI Training sessions for decision makers has been delivered throughout the year to increase competence. A new EIA Form and Process has recently been developed which more clearly focuses on the positive as well as negative impacts of EDI, Health Inequalities and Human Rights. Weaknesses however remain in the quality of the assessment completed. 3. **Staff Risk Assessment:** The Trust has a robust and development Health, Work and Wellbeing department providing Occupational Health, Health Surveillance, Infection Prevention and Control, Non-Clinical Risk, and Wellbeing services to all members of staff. These services include all forma of health based risk assessments and relevant support plans to address risk or support staff in the workplace. Where relevant topic specific risk assessment are completed by department / security etc such as Personal Emergency	2	Human Resources Patient Inclusion & Experience Governance Team Board/Trust Exec

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Evacuation Plans, Pregnancy & Maternity Risk Assessments, Lone Working Assessments etc. 4. **Action Planning and Monitoring**: The Trust has a EDI Action Plan covering 2022-2025, approved in 2022/23. This is regularly reviewed and progress reported to committee. In additional new actions are developed as part of the 1 Year Implementation Plan, and in response to the WRES, WDES, Gender Pay Gap, and Staff Survey Assessments. Action plans are developed and signed off at the relevant level. 5. **EDI/HE Embedded in Business Plan**: The Trust overarching aim is to provide "5 Star Patient Care" which underpins all of our activity. The key organisational strategies to address EDI and HE are the Patient Experience and Inclusion Strategy, and the Equality, Diversity & Inclusion Operational Plan. However, EDI/HE/Widening Participation are key components on the HR Workforce, Recruitment, and Health & Wellbeing Operational Plans.		
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	1. **Monitoring of Tools**: The Board received regular reports on the WRES, WDES, Gender Pay Gap, EDI Action Plan assurance, EDS2022. 2. **Interventions for unmet goals**: The Trust has both EDI action plans for workforce, and for patients, as well as implementation plans. The WRES, WDES and Gender Pay Gap have additional actions. Additional workstreams also exist to implement charter marks such as the Rainbow Charter, Disability Confident etc. 3. **Menopause Support**: The Trust has a Menopause Policy, a Menopause Network with over 350+ members; runs events for World Menopause Day and a ongoing programme of events organised by the network; advice and support provided by Health Work and Wellbeing; 4. **System Partner Working**: The Trust with numerous system partners, especially EDI partners, and local / regional trust, ICB, NHS NW, and	2	Human Resources Patient Inclusion & Experience Governance Team

Outcome	Evidence	Rating	Owner (Dept/Lead)
	national WRES/WDES teams. Health Watch are involved in multiple committees to ensure the patient voice is heard. Similarly trade union colleagues are members of numerous committees to ensure the staff voice is heard. 5. **Band 7+ AfC Population Benchmarking**: The Band 7+ Agenda for Change workforce has a larger proportion of Black, Asian and Minority Ethnic staff, and staff who identify as being religious compared to the local population. The Trust has a lower proportion of Men and Disabled staff when compared to the local population, with men being an reflection that the NHS workforce is 80% female. Finally, the Trust has a larger proportion of LGBO staff than the local population, with the exception when comparing to Liverpool and the Liverpool City Region. On the Age profile, the Band 7+ workforce is obviously different to the local population when consider that to become Band 7+ requires a number of years in the workforce. 6. **Year on Year Improvements in WDES/WRES/GPG**: a. WRES: 7/13 indicates have 1 year improvement, with 5/13 with 3 year improvements. 9 Indicators had seen improvements in 2 of the 3 years. b. WDES: 13/15 indicates have 1 year improvement, with 4/15 with 3 year improvements. c. GPG: 2 year reduction in Mean, 3 year reduction in Median, 1 year reduction in Bonus Mean, 3 year 0% Bonus Median; 2 year increase in %Men in Q1, Q2, Q3. Only negative trends is %F in bonus pay population, which is limited to clinical excellence awards. 7. **Monitoring of Actions:** The Trust has a developed committee system and reporting structure. Senior leaders receive regular reports on all EDI and Health Inequalities activities, including WRES, WDES, EDS2022, Gender Pay, a suite of patient/service reports, reports in		Board/Trust Exec

Outcome	Evidence	Rating	Owner (Dept/Lead)
	Safeguarding, HWWB, complaints, HR metrics, risks etc. EDI Action Plans are regularly monitored by key committees.		
Domain 3: Inclusive leadership overall rating		2	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): • Anthony Lockhart • Yetunde Ekwuruke	**Independent Evaluator(s)/Peer Reviewer(s):** • Adam Harrison-Moran (Warrington & Halton Teaching Hospitals NHS Foundation Trust) • Thomasina Afful (C&M ICB) • Simon Cousins (St Helens Council) • Andy Woods (C&M ICB) • Health Watch

EDS Action Plan

EDS Lead	Year(s) active
• Darren Mooney - Head of Equality, Diversity & Inclusion • Cheryl Farmer - Head of Patient Inclusion and Experience	2024-2025
EDS Sponsor	**Authorisation date**
• Anne-Marie Stretch - Deputy Chief Executive & Director of HR • Sue Redfern - Director of Nursing, Midwifery & Governance	29/2/24

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	To strengthen accessibility of the service further, by implementing additional measures that will increase the reach to underrepresented communities	• Identify underrepresented service user groups from the demographic information. • Identify new ways of promoting/raising awareness of the service, to the underrepresented service user groups. • Conduct engagement with the health inclusion groups and other underrepresented service user groups, to determine any barriers to accessing the service.	Feb 2025
	1B: Individual patients (service users) health needs are met	N/A	N/A	

	1C: When patients (service users) use the service, they are free from harm	N/A	N/A	
	1D: Patients (service users) report positive experiences of the service	To increase the volume of feedback that the service receives and to act on it, by actioning any learning and promoting/recognising best practice.	• Identify and implement ways to encourage/capture feedback from service users within the health inclusion groups. • Review all feedback received and where any learning or negative themes/trends are identified, develop an action plan to address the associated theme/trend. • Review all feedback received on a regular basis and compare to previous feedback reviews, to identify any best practice.	Feb 2025

Domain	Outcome	Objective	Action	Completion date
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	Improve the equality data capture for HWWB activities and events.	• Gap analysis completed • Report metrics agreed • Collaborate with ESR team to develop equality reporting. • Analysis of reports to highlight any actions • Create targeted HWWB initiatives for the above mentioned health conditions.	Nov 2024
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Reduce the occurrence of verbal and physical violence for staff.	• Implement Datix reporting project. • Deliver training to managers on implementing the “Management of Incidents of Unacceptable Behaviour by Patients, Visitors and Members of the Public Policy” • Improve signage in patient and visitor areas • Implementation of the Sexual Safety Charter	Nov 2024

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Train staff network chairs in supporting and guiding staff who have suffered abuse, harassment, bullying and physical violence from any source.	• Create training plan • Organise dates	Dec 2024
	2D: Staff recommend the organisation as a place to work and receive treatment	Survey local workforce on their likelihood to use services, recommend as a place to work and to F&F.	• Develop survey and delivery method	Oct 2024

Domain	Outcome	Objective	Action	Completion date
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	Board members implement the Leadership Framework for Health Inequalities Improvement.	To review and implement framework	Feb 2025
		Board members and senior leaders meet frequently with staff networks.	To arrange regular meetings of staff network chairs with the Senior EDI Champion	Ongoing
		Board members and senior leaders demonstrate commitment to health inequalities, equality, diversity and/or inclusion	Senior Leaders to set EDI SMART objectives	May 2024
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Equality and health inequalities impact assessments are completed	To implement the updated EIA Templates, deliver a EIA training programme, develop new guidance and tools.	Feb 2025
		Equality and health inequalities are reflected in the organisational business plans to help shape work to address needs	To ensure that EDI, and Health Inequalities are explicit in all Trust organisational business plans	Feb 2025

	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	Organisations work with system partners to refocus work, to meet unmet need and demonstrates change Organisations are able to show year on year improvement using Gender Pay Gap reporting, WRES and WDES.	To improve collaboration with workforce EDI partners within ICB to join up key projects. To implement the GPG, WRES, WDES Action Plans	June 2024 Dec 2024