NHS Equality Delivery System (EDS)
Baseline organisational assessment for Leeds Teaching Hospitals Trust – February 2012

Grading: Excelling Achieving Developing Undeveloped

Goal	Outcome	Evidence	Grade	Actions
1. Better health outcomes for all	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities	Lead responsibility for commissioning clinical services in Leeds currently sits with NHS Leeds. The Trust works with NHS Leeds to ensure that the people of Leeds have access to the health services they need. The Haamla service was established in response to research carried out in 1992 which showed that minority ethnic women in Leeds were not always able to access health care that supported their personal needs. The service, based in the obstetric department of St. James's hospital, is a unique service that provides maternity support to women from black and minority ethnic communities, including refugees and asylum seekers. Interpreters accompany the midwives at every appointment where English is not spoken. The maternity needs of women Travellers is currently being assessed in partnership with voluntary organisations in Leeds. Gypsy, Roma and Traveller families are being involved in identifying their specific individualised requirements during their maternity care. This work will inform staff	Developing	Ensure patient menus are accessible to visually impaired patients Review equality monitoring data for patient catering and address any gaps Develop equality and diversity guidance for suppliers to prepare them for supplier review meetings Deliver bespoke equality and diversity training to supplies staff

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		training and could result in a Care Pathway for this client group. Maternity services have developed a robust and sensitive pathway for women with HIV in pregnancy. Because of the complex medical and social needs of women with HIV, networks have also been established with local agencies like Sahara – an organisation which offers safe supported accommodation, Women's Health Matters – an independent voluntary organisation run by women for women, and Skyline - a charity that works predominantly with African communities to increase knowledge and awareness of HIV and provides information to groups. The Trust provides prayer and worship facilities at all of its sites. The chaplaincy team provides a comprehensive service of religious, spiritual and pastoral care to patients and staff. The Trust employs Christian, Jewish and Muslim chaplains and has contacts and honorary appointments for a range of additional faiths including Sikhism, Buddhism and Hinduism. The shape of religious and spiritual care within the Trust is informed by inpatient and local population data, including the Picker inpatient survey. A multicultural menu is available to patients to		

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		meet a range of different cultural and religious needs. We currently offer a kosher menu, a multicultural menu and an African Caribbean menu. The multicultural menu is available in Urdu, Punjabi, Bengali & Arabic. The Trust's pre qualification questionnaire has been updated to include all the relevant legislative changes brought in by the Equality Act 2010. A new guide for suppliers on equality and diversity is currently being developed.		
	1.2 Individual patients' health needs are assessed, and resulting services provided, in appropriate and effective ways	See above evidence (1.1) for maternity services care pathways for specific protected groups. A hospital passport has been developed and is being used at the Trust to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital. The next step is a z card for acute admissions. A 'flag' is available on our Patient Administrative System for patients with a learning disability to enable reasonable adjustments to be made and track care pathways. Bedside symbols depicting an 'ear' and an 'eye'	Developing	See 1.1 above

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		have been implemented by the Trust for patients who are deaf or hearing impaired and/or blind or visually impaired.		
	1.3 Changes across services for individual patients are discussed with them, and transitions are made smoothly	The Trust continues to work and engage with four Advisory Groups - Blind & Partially Sighted, Deaf & Hard of Hearing, Carers and Learning Disabilities Groups. The Groups meet on a quarterly basis with members of the Patient Experience Team and respective service representatives in attendance. In addition to our groups who work corporately across the Trust, we have a number of Patient Panels who work with particular specialities and services for example Kidney Patients Association, Dermatology Patient Panel and Maternity Liaison Committee. As part of our drive to improve privacy and dignity for our patients, we engaged with various patients regarding the style of the hospital gowns we use. We took various samples of gowns to respective groups including Black and Minority Ethnic groups, asylum seekers, pregnant women and the LINk to seek their views and opinions. The new gowns are being piloted across four wards. Equality Analysis is a tool to help the Trust think about the effects of it's decisions on	Developing	Review and relaunch equality analysis template and guidance 4-year rolling programme of equality analysis to be established and implemented Ensure equality analysis is embedded in service change infrastructure Strengthen governance and quality assurance arrangements for equality analysis Complete the mapping of equality groups and update the involvement database identifying any relevant gaps across all protected characteristics

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		different groups of people. To ensure that service changes are discussed with patients and the public, equality analysis is currently being embedded in the service change infrastructure. Whilst we recognise that we have some way to go to ensure that a robust equality analysis is carried out for each service change, we have made some progress in this area. As part of our Equality Analysis for the relocation of the eye clinics, we arranged for senior managers from the Trust to meet with members of our Blind and Partially Sighted Advisory Group. The group met with representatives from the Trust at the new site to do a 'walk about' and help us plan the works required to make the eye clinics fully accessible to blind and visually impaired people. Most of the access improvements suggested by the group have now been implemented.		Ensure the involvement of all protected groups in service changes
	1.4 The safety of patients is prioritised and assured. In particular, patients are free from abuse, harassment, bullying, violence from other patients and staff, with redress being open and fair to all	The Risk Management team is currently working on the DatixWeb project to introduce an online incident reporting system for patient safety and risk management. The new software will allow to the Trust to ensure that the collection and reporting on incidentsof abuse, harassment, bullying and violence will take account of the incidents for the following	Developing	Review equality monitoring data for patient safety and address any gaps Disaggregate and analyse patient safety data by protected characteristic

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		protected groups: race, gender, disability, sexual orientation, gender reassignment, age and religion and belief. The new system will be introdued to pilot areas in early May 2012. The Trust is a partner in the Leeds Safeguarding Adults partnership and there is a multi-agency policy and associated procedures for all participating agencies. A copy of the policy and procedures can be found at: http://www.leedssafeguardingadults.org.uk/professionals.html The safeguarding team at the Trust currently collects data on gender and age for all reported cases and disability for some. We collect information relating to patients with a learning disability where there is a safeguarding concern raised (usually an incident of abuse of neglect that has occurred in the community) as part of the safeguarding policies and procedures. In addition, our patient safety programme is targeted at reducing harm to patients through a number of work streams. Three of these are particularly aimed at older people; these are falls prevention, pressure ulcer prevention and improving nutrition. Additionally, we have a work stream that is improving the management and care of patients with diabetes, a condition		

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		that carries a number of potential risks to older patients.		
	1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups	Awaiting information		
2. Improved patient access and experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds	The Trust currently routinely collects, and can therefore report patient activity data on four of the protected characteristics on the main patient administration systems. These are gender, age, religion and belief and ethnicity. The patient activity data across these protected groups indicates that people can readily access our services. The data suggests that older people and people from BME populations have higher activity rates relative to the local population. For a fuller explanation, please see section 3 of our public sector equality duty report. http://www.leedsth.nhs.uk/public-sector-equality-duty-compliance-report.php	Developing	Improve data quality and completeness for gender, age, religion and ethnicity Explore options for extending data collection across the full range of protected characteristics Increase the range of performance indicators disaggregated by protected group and report at speciality level on a quarterly basis Investigate the key issues arising from the analysis of patient information (section 3.3 PSED report) Analyse access to complaints by protected characteristic and improve access for any

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				underrepresented groups
	2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care, and to exercise choice about treatments and places of treatment	Leeds Language Link (LLL) is the Trust's interpreting service, which provides face-to-face interpreting services for all non- English speaking patients and their families. LLL has around 180 experienced interpreters on hand to provide interpretation in over 70 languages. The Trust can also provide BSL interpreters and deaf blind communicator guides. The Trust is currently looking at ways to improve the accessibility of key health information including the provision of appointment letters, particularly for patients who are blind or visually impaired. We are also exploring the possibility of providing key documents and leaflets in an easy read format. A new Patient Information policy has just been implemented, which sets out how information must comply with a range of standards, especially in relation to patient focus, diversity, equality, and accessibility. Specifically, it must be clear that information can be made available in alternative formats, in particular for people with visual impairment, and people with learning disabilities The Trust carried out an initial analysis of the	Developing	Review interpreting service to determine the best service model in line with the requirements of the four Trusts Improve accessibility of key health information including appointment letters Include a standard strapline on all Trust documents providing details of how to obtain information in different formats Explore the possibility of providing key documents and leaflets in an easy read format Increase representation of protected groups for national patient surveys Integrate local surveys and include a new equality monitory tool

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		results of the national patient surveys for 2011 across four of the protected characteristics; age, gender, disability and ethnicity. The numbers are very small for some of the categories (particularly BME groups and some impairment types) so caution must be exercised when interpreting the data. The samples were not representative of the local inpatient or outpatient population for ethnicity or age. The national outpatient survey 2011 indicated that people with a disability were less likely to receive written or printed information than people without a disability and proportionally more disabled people would like more information. The survey also indicated that older people need more information about who to contact if they are worried about their condition or treatment after leaving hospital. People with a hearing or visual impairment also expressed concerns about who to contact and a higher proportion of BME patients said they were not told who to contact. The national inpatient survey for 2011 requested information about sexual orientation and religion and belief for the first time but responses were too small to be analysed.		Disaggregate and analyse national and local survey data by protected characteristic and explore any reported differences in outcomes

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		The local in-house surveys collect some data for the protected groups but historically the results have not been analysed by protected characteristic. This will be addressed this year as part of the review and management of our local surveys.		
	2.3 Patients and carers report positive experiences of their treatment and care outcomes and of being listened to and respected and of how their privacy and dignity is prioritised	As in 2.2 above, the data from the national patient surveys and our local surveys provides feedback on the experiences of our patients and carers. Again, results broken down by protected group is limited to gender, age, disability and ethnicity although our contract provider (Picker) is now asking patients for information on sexual orientation and religion. The inpatient survey for 2011 indicated that proportionally more men than women felt that they were treated with dignity and respect. And whilst proportionally more people from BME groups felt that they were **always** treated with dignity and respect compared to White patients, the incidence of a negative experience was also higher for the BME population. Again, caution must be exercised when interpreting the results, as respondents for BME groups was very low. Ongoing engagement with our advisory groups also provides us with real time feedback on	Developing	Disaggregate national and local survey data by protected group and explore any reported differences in outcomes

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		both the positive and negative experiences of patients and carers and provides a forum for constructive dialogue between the Trust and the public.		
	2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently	It is not currently possible to analyse the complaints and PALS data by protected characteristic. We do not routinely monitor complaints or PALS by protected group. A new equality monitory system will be implemented for complaints in April 2012 to address this issue. Where one of the primary subjects of a complaint specifically relates to discrimination, we are able to provide a breakdown and summary of the complaints by the following discrimination types: lifestyle, age, disability, racial, sexual and religious discrimination. Analysis of access to our complaints process by protected characteristic also needs carrying out to identify if there are any access issues for particular groups, e.g. young people, disabled people and people from BME groups.	Undeveloped	Implement a new equality monitoring system for complaints Implement a complaints customer satisfaction survey Review approaches to equalities data collection for both PALS and patient postings via NHS Choices and Patient Opinion
3. Empowered, engaged and well-supported staff	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades	The Trust's recruitment policy and guidance, and recruitment training, refer to the need to comply with the Equality Act throughout. Selection data is disaggregated by age, gender, religion, sexual orientation, disability	Achieving	Improve data quality in relation to disability, sexual orientation and religion to better monitor promotions and seniority of disabled

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	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades (continued)	and ethnic group and is monitored at the application, interview and appointment stages of the process. Outcomes from this monitoring demonstrate considerable diversity in the range of applicants, with applications from BME candidates, religious minority groups and all age groups being well-represented when compared with the local population. The figures indicate an under-representation of disabled applicants when measured against Leeds ONS estimates (2006). In order to develop this area of practice, and in line with our commitment to be "Positive about Disabled People", the Trust operates a guaranteed interview scheme for disabled candidates that meet the essential requirements of the advertised role. Conversion rates from application to interview for disabled staff show that this scheme is operating well. The Trust also runs an employability programme in partnership with Leeds City Council. The programme targets local people who are long-term unemployed or on disability allowances, and provides pre-employment training for them within a healthcare setting. It works with disability employment advisors from Jobcentre Plus, Remploy, the Shaw Trust to identify suitable candidates, as well as holding open days. 44 people were employed by the Trust last year through this method. Statistics on staff in post by pay grade and		staff (Action point: Workforce 1) Actively seek to address BME under-representation at senior levels through the Leeds-wide Innov8 charter (Action point: Workforce 2)

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		promotions are also disaggregated to the same extent. Outcomes data suggests BME staff are under-represented within senior grades. Women are under-represented within senior medical grades. Staff survey results indicate that women overall believe career progression processes to be fair. BME staff had lower satisfaction rates with this question than their white counterparts. The reasons for this outcome are currently being investigated in readiness for the publication of the Trust's equality objectives for the forthcoming four years.		
	3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work and work rated as of equal value being entitled to equal pay	All Trust staff except directors, doctors and a very small number of senior managers, are paid according to a national set of pay or conditions for the NHS – Agenda for Change. Within this system, each role is assessed against 16 key criteria, eg communications, patient care, finance etc, by a panel of managers and staff side representatives. In this way, equal pay for equal work is assured across very different role designs. Actual pay rates are disaggregated by age, gender and ethnicity for all staff, including medical staff. NHS Employers guidance states that Trusts should act if pay rates for different groups are wider than 3%. The Trust's pay gap is within these parameters, so no action is currently planned. Work is being undertaken to improve data quality in relation to disability, sexual	Achieving	Improve data quality in relation to disability, sexual orientation and religion to better monitor pay (Action point: Workforce 1)

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		orientation and religion in order to monitor pay rates for these protected groups in future years and this forms part of the Trust's outline equality objectives.		
	3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately	The Trust's staff development policy entitles all staff to training and development to ensure that they are competent and competent to do their work. Staff are appraised annually and individual development plans are agreed as part of that process. Training and appraisal rates are disaggregated by ethnicity, age, religion, sexual orientation, gender and disability. Satisfaction with appraisals, training and development planning are also measured as part of the staff survey. These results are currently reported by age, gender, ethnicity and disability. The next staff survey results (to be published April 2012) will also be disaggregated by sexual orientation and religion for the first time. Staff survey and actual staff records relating to training and appraisal conflict eg training records for disabled staff appear proportionate to the staff in post percentages, but disabled staff are less satisfied with their access to training than those staff who are not disabled. Feedback from the staff engagement event indicated inconsistency of access to training. Further investigation is being undertaken to understand these results before developing equality objectives.	Developing	Review appraisal and development processes to ensure equitable outcomes (Action point: Workforce 3) Disaggregate data for sexual orientation and religion in staff survey results to better monitor perceptions of these protected groups (Action point: Workforce 4)

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	3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all 3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all (continued)	The Trust has established policies, processes and training in place to safeguard its staff. This training is mandatory for all staff. Codes of conduct for staff and patients, and systems of redress for staff subjected to offensive or discriminatory behaviour are clearly outlined within these policies. In addition to support from line managers, HR colleagues and staff side representatives, staff have access to dignity of work advisors who advise on processes and signpost additional sources of support such as counselling. Breaches of the Dignity at Work policy by colleagues are reported through the grievance procedure. Where allegations are made against specific individuals, their conduct is investigated through the disciplinary process. Outcomes data suggests that a disproportionately high percentage of BME staff raised grievances last year. Further investigation is being undertaken to determine whether these cases were related to dignity at work. Additional work is also being carried out to better understand the staff survey results that indicated that women, BME and disabled staff had suffered higher levels of bullying and harassment than their colleagues, in readiness for publication of equality objectives. Feedback from the staff engagement event suggested staff from protected groups sometimes felt	Developing	Increase uptake of mandatory E&D training (Action point: Workforce 5) Additional communication of the new Dignity at Work Policy (Action point: Workforce 6) Establish equality support network(s) for affected groups (Action point: Workforce 7) Additional guidance relating to the disciplinary procedure to be issued to HR service and managers (Action point: Workforce 8)

Goal	Outcome	Evidence	Grade	Actions
		isolated.		
	3.5 Flexible working options are made available to all staff, consistent with the needs of the service, and the way that people lead their lives. (Flexible working may be a reasonable adjustment for disabled members of staff or carers.)	The Trust's flexible working policies allows all staff to request flexible working options which are then evaluated against the needs of the service and accommodated where possible. Whilst open to everyone, the policy states specific circumstances in which there is a legal duty to consider flexible working ie for reasons of maternity, disability, caring responsibilities. It is also offered as an option for staff approaching retirement. The absence management policy refers to changes in working patterns as an example of a reasonable adjustment for disabled staff. Where flexible working options are not agreed, staff have redress through the grievance process. No grievances of this kind were raised last year. Consideration is being given to methods of capturing disaggregated data on flexible working requests within the equality objectives.	Developing	Investigate methods of capturing data on protected characteristics within the flexible working applications process (Action point: Workforce 9)
	3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population	The trust has a Health and Well-Being Committee which leads and monitors work relating to health promotion (eg staff gym, weight loss programmes, advice on diet, alcohol and smoking), health hazards (including health and safety risks and stress reduction) and occupational health services (eg individual consultations and referrals and	Developing	Monitor health improvements by protected characteristic through sick absence statistics over time (Action point: Workforce 10)

Goal	Outcome	Evidence	Grade	Actions
		workplace assessments for adjustments). All of these services are available for all staff. No disaggregated data is available.		
4. Inclusive leadership at all levels	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond	The senior management team have established an E&D group, chaired by the Chief Nurse and Director of HR. The SMT and Board have a development session planned for March 8th. The trust has an established equality analysis process in place for policy development. This process documentation is also available for service change proposals. A rolling programme of equality analyses of individual services has been commissioned and will be monitored through the Trust's workforce committee and Patient Experience sub-committee. Outcomes from these analyses will be published to inform future service change requirements.	Developing	E&D training for the senior team and board (Action point: Workforce 11)
	4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination	Equality and diversity training is mandatory for all staff and covers both employment and service delivery considerations. Every job description explicitly states the requirement to take the individual needs of patients and staff into account and conform to equalities legislation and policy. E&D training is available in a variety of forms –e-learning, face-to-face presentations and individual coaching. The trust has recently put mechanisms into place to monitor the uptake of mandatory training.	Developing	Increase uptake of mandatory E&D training (Action point: Workforce 5) Review content of E&D training for managers (Action point: Workforce 12)

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		Current rates for mandatory E&D training are approximately 38%, having risen from 25% at the end of September. Continued emphasis is being placed on achievement of 95% compliance rates with mandatory training elements. Completion of other E&D courses is not currently monitored.		
	4.3 The organisation uses the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes	The framework has been issued to managers who line manage E&D specialists and work is under way to pilot the framework in these specific roles. The framework will then be applied over the course of the four-year objectives.	Undeveloped	Pilot framework for E&D specialist roles (Action point: Workforce 13) Framework to be incorporated into leadership development work (Action point: Workforce 14)

Key

Excelling	There is evidence for all of the protected groups (all 9 protected groups)
Achieving	There is evidence for most of the protected groups (6 - 8 protected groups)
Developing	There is evidence for some of the protected groups (3 -5 protected groups)
Undeveloped	There is evidence for few or none of the protected groups (0 - 2 protected groups)

The nine protected characteristics/groups are gender, gender reassignment, race, disability, age, faith, sexual orientation, pregnancy and maternity, marriage and civil partnership