Classification: Official

Publication approval reference: PAR1262

NHS Equality Delivery System 2022

North Staffordshire Combined Health Trust

EDS Reporting 2026
(1st April 2024 – 31st March 2025)

Contents

The Equality Delivery System (EDS)

This report presents the Trust's annual self-assessment against the NHS Equality Delivery System 2022 framework, covering commissioned services, workforce health and wellbeing, and inclusive leadership. Evidence draws on service activity, workforce metrics, staff voice and governance assurance. Overall, performance is **Achieving**, reflecting strong operational foundations and positive intent, with further work required to strengthen data quality, consistency and demonstrable outcomes for protected and minoritised groups.

Domain 1 - Overall rating, Achieving (8 out of 12)

Services assessed demonstrate good access, timeliness and safeguarding maturity. Patient experience data and equality analysis require strengthening to evidence impact consistently.

1. **The Children and Young People Intensive Support Hub (CYP ISH)** demonstrate good accessibility and responsiveness, receiving 191 referrals and delivering 1,785 contacts, with an average referral to first contact time of 2.9 days and only five cases exceeding seven days. Safety systems are embedded, with 29 safeguarding or incident reports actively monitored. Experience measures are strong, with 86.2% rating 8 out of 10 or higher and 96% positive Friends and Family Test responses, and service changes directly informed by feedback.

2. **Adult Mental Health Services** maintained strong access and safety performance, receiving 1,953 referrals and delivering 19,225 direct contacts, with 90% of patients seen within four weeks. Daily triage, weekly MDT review and routine supervision support timely, coordinated and personalised care. Safety governance is robust, with 91 safeguarding or incident reports reviewed and structured learning embedded. Patient feedback is positive, but response volumes remain low, limiting the strength of experience data.

3. **Chaplaincy** provides inclusive spiritual and pastoral support across faiths and beliefs. As a small, non-clinical service with limited hours, standalone quantitative data collection is not undertaken. As a result, limited metrics are available and scoring reflects a conservative assessment despite evidence of accessible and inclusive practice.

Domain 2 - Workforce health and wellbeing: Overall rating, Achieving (10 out of 12)

Comprehensive support is available through Occupational Health (OH), counselling, the Psychological Wellbeing Hub and a 24/7 Employee Assistance Programme (EAP). Safeguarding and prevention systems are embedded, with training compliance between 90% and 95% and structured oversight of violence, harassment and incidents. Independent advice is available through partnership with Uniting Staffordshire Against Hate (USAH).

Staff advocacy exceeds national benchmarks, with 74.6% recommending the Trust as a place to work and 81.2% recommending it for care. Workforce data highlights disparities for some groups and informs targeted action.

Provision is broad and proactive, with strong governance. The next step is clearer demonstration of measurable improvement in inequality outcomes.

Domain 3 - Inclusive leadership: Overall rating, Achieving (7 out of 9)

Leadership accountability is embedded through appraisal, EDI training, development programmes and named executive ownership of equality priorities, including delivery of the Patient Carer Race Equality Framework. Governance is transparent, with livestreamed Board meetings, published papers and structured scrutiny. Leaders use workforce and staff voice data, including Dear Buki submissions and Freedom to Speak Up (FTSU) concerns, to identify risks and inform action.

Systems and oversight are established and consistent. Greater evidence of outcome change linked to leadership action is required to progress excelling.

Areas of good practice

Strong service access and timely contact across the assessed Domain 1 services. Robust safeguarding and incident learning culture. Comprehensive staff wellbeing and independent support offer. Workforce advocacy above national benchmarks. Transparent governance and clear executive accountability for equality. Positive CYP experience outcomes with demonstrable service improvements informed by feedback.

Areas for development

Increase patient and carer feedback volumes to strengthen representativeness. Improve equality data completeness and routine analysis across services. Demonstrate clearer measurable outcomes from inequality interventions. Strengthen evidence of impact from leadership actions. Develop proportionate qualitative measures for smaller services such as Chaplaincy.

Next steps

Overall, the Trust demonstrates a solid foundation for equality, access and inclusion across services, workforce wellbeing and leadership. Activity levels are high, access is timely, safeguarding systems are embedded, and staff have comprehensive support and independent routes to raise concerns. Governance arrangements are transparent, with clear executive accountability and routine use of performance and staff voice data to inform decision making.

Across Domains 1 to 3, most outcomes are rated Achieving, indicating that systems and processes are established and consistently applied. Strengths are evident in-service responsiveness, workforce advocacy above national benchmarks, proactive safeguarding, and structured leadership oversight. The Children and Young People Intensive Support Hub provide strong examples of using feedback to shape delivery, while smaller services such as Chaplaincy demonstrate inclusive practice through proportionate approaches.

To progress from Achieving to Excelling, the Trust will focus on strengthening the quality and completeness of equality data, increasing patient and carer feedback volumes, and evidencing clearer, measurable outcomes from targeted inequality interventions. Embedding routine use of equality intelligence within appraisal, supervision and Board reporting will further strengthen accountability and impact.

In summary, the Trust is well placed to build on established systems and move from consistent compliance to demonstrable improvement in outcomes for all communities.

Note: The 2024 Staff Survey dataset was published in 2025, and the 2025 dataset will be published in March 2026 in line with the NHS England annual reporting cycle.

NHS Equality Delivery System (EDS)

Name of Organisation	**NORTH STAFFORDSHIRE COMBINED HEALTHCARE TRUST**	**Organisation Board Sponsor/Lead**	Frieza Mahmood, Chief People Officer
Name of Integrated Care System	Staffordshire and Stoke on Trent ICS		
EDS Lead	Janice Ogonji, Inclusion & Belonging Lead	**At what level has this been completed?** Trust	
			***List organisations**
EDS engagement date(s)	• Senior Leadership Team (SLT) • Joint Negotiating & Consultation Committee (JNCC) • People & Culture Development Committee (PCDC) • Staff Side - Trade Union Rep • Domain delivery leads and teams (Dec 2025 – Jan 2026) • Staff Networks - Combined Ability Network (CAN), Equality Network for Race Inclusion and Cultural Heritage (ENRICH), Lesbian, Gay, Bi and Trans Network (LGBT+) • Associate Director of Organisational Development for the Integrated Care System • University Hospitals of North Midlands NHS Trust (UHNM) • Midlands Partnership University NHS Foundation Trust (MPFT) • Integrated Care Board (ICB)	**Individual organisation**	Yes

			Partnership* (two or more organisations)	• University Hospitals of North Midlands NHS Trust (UHNM) • Midlands Partnership University NHS Foundation Trust (MPFT) • Integrated Care Board (ICB)
			Integrated Care System-wide*	Shared with System Inclusion and Belonging Senior Programme Manager

Date completed	February 2026 (covering period 1st April 2024 – 31st March 2025)	**Month and year published**	March 2026
Date authorised	Approved through JNCC (26th March)	**Revision date**	

Completed actions from previous year	
Action/activity	**Related equality objectives**
Domain 1: Specialist Perinatal Mental Health (PMH)	
• Delivered perinatal and maternal mental health awareness through podcasts and the development of promotional and educational materials. This increased visibility of the service and supported awareness raising across local communities, contributing to increased enquiries and engagement. • Piloted assessments within local family hubs to provide face to face appointments closer to home. This improved accessibility, reduced non-attendance, and led to the pilot being extended based on improved attendance. A seven-day service was maintained with flexible face to face, virtual, and telephone appointments. • Introduced Saturday partner and fathers' coffee mornings alongside couples care planning and therapy appointments. Partner feedback was gathered through questionnaires, with increased engagement from fathers and partners. A dedicated partners pathway has been developed for implementation. • Explored service improvements for neurodiverse service users and delivered staff training on neurodiversity in the perinatal period. Training was made available to the whole staff team through in person sessions and recorded access. Individual environmental adjustments were implemented based on service user preferences, with reported improvements in accessibility. • Updated all service language and materials to use inclusive terminology, including birthing person, and embedded inclusive communication practices across the unit. Staff were briefed on the changes and no formal complaints were received in relation to language or communication. • Produced materials in multiple languages, provided interpreter support for appointments, and worked closely with local asylum and community charities to support families to access care. This strengthened access for underserved communities and increased engagement with the service. • Secured second wave NHS England funding to expand psychological therapies. Additional staff were recruited, increasing the psychological offer across the service and improving access to therapy and support. • Enabled staff to access internal and external perinatal mental health training as part of ongoing professional development. Training sessions were delivered across the service, supporting workforce capability and confidence. • Completed a second Royal College of Psychiatrists Perinatal Quality Network peer review in December 2025. Improvement actions were implemented and progress toward accreditation continues. • Strengthened safety through incident reporting, learning reviews, debriefs, regular team discussions, and routine health and safety checks. This supported a culture of learning and continuous improvement.	• 1A: Improve equitable access to services • 1B: Ensure individual health needs are met equitably • 1D: Ensure patients report positive and inclusive experiences

• Collected service user feedback at multiple points across the care pathway. Feedback was positive overall and informed a range of service improvements based on key themes identified by service users.	
Domain 1: Health and Justice Service (H&JS)	
• Strengthened liaison with referring officers through 1 away day, 6 supervision sessions, and 4 education sessions, engaging officers and contributing to improved referral pathways. • Improved recording of protected characteristics by delivering targeted staff training and supervision, increasing completeness of demographic data from to 100% to support better monitoring of equity and access. • Completed a quality improvement project in 2025 to increase referrals, resulting in referrals rising from 15% to 20%, by Jan 2026. • Produced monthly case studies, totalling a minimum of 12 over the year, to review service use and identify patterns of inequity, leading to service changes or targeted actions as they are identified. • Collected service user feedback through surveys, including peer support involvement, gathering 110 responses and informing improvements including clearer information to service users. • Identified additional approaches to gather feedback from individuals who decline the service, with implementation planned for the next reporting period.	• 1A: Improve equitable access to services • 1B: Ensure individual health needs are met equitably • 1D: Ensure patients report positive and inclusive experiences
Domain 1: Communications Team Service	
• Delivered accessible information across the organisation by enabling website and service content to be translated into over 130 languages, and by coordinating provision of documents in alternative formats including Easy Read and different languages, supporting equitable access for diverse communities • Led Trust wide stakeholder and service user engagement activity through the annual Engagement@Combined programme and a dedicated engagement event attended by service users, carers and over 30 partner organisations, with draft materials shared in advance to support meaningful co production and feedback • Supported large scale service user voice and experience gathering by promoting participation in the national Community Mental Health Survey, with 1,250 people invited to take part, increasing opportunities for diverse service users to influence service improvement • Promoted inclusive and psychologically safe staff voice mechanisms by raising awareness of the Trust's anonymous and confidential reporting routes, contributing to 81 Dear Buki submissions, of which 56 were anonymous, and 86 Freedom to Speak Up concerns raised during the reporting year • Supported digital communication approaches that improve access to care, including appointment reminder text messaging systems associated with a 37% reduction in Did Not Attends, helping reduce barriers to attendance for service users • Completed a review of our website to confirm compliance with the latest Accessible Information Standard.	• 1A: Improve equitable access to services • 1B: Accessible information and access • 1C: People report positive experiences of accessing and using services. • 1D: People feel safe and confident to speak up and provide feedback and organisations act on this.

Domain 2: Workforce health and well-being	
• Provided structured workforce health and wellbeing support through a learning management system comprising 12 chapters and over 300 courses, including dedicated Health and Wellbeing and Staff Counselling and Support content, alongside access to Staff Counselling services and the North Staffordshire Wellbeing College, delivered in partnership and co-produced with stakeholders • Acted on staff feedback to improve inclusion and workplace culture by strengthening anti-discrimination activity, launching a civility and respect campaign and toolkit, and reviewing leadership, organisational development and career development offers, demonstrating responsive action to workforce experience data • Promoted psychologically safe speaking up routes to support workforce wellbeing, with 81 Dear Buki submissions received during 2024/25, of which 56 were anonymous, and 86 Freedom to Speak Up concerns raised, enabling staff to raise issues related to behaviour, safety and wellbeing • Maintained workforce capability and safe practice through high levels of mandatory safeguarding training compliance, achieving 90% for Safeguarding Children Level 1 and 2, 86% for Level 3, 95% for Safeguarding Adults Level 3, and 95% for Prevent training, supporting staff confidence and preparedness in their roles • Continued to develop additional tailored wellbeing and inclusion offers for staff, with further enhancements planned for the next reporting period.	• 2B: Staff feel safe and confident to speak up about concerns and are supported when they do • 2C: Staff are valued, respected and treated fairly • 2D: Monitoring and reducing inequalities
Domain 3: Inclusive leadership	
• Maintained a structured programme of Board development to strengthen inclusive leadership, with all Board members participating in individual appraisal, personal development, statutory and mandatory training and additional learning, including Equality, Diversity and Inclusion training, to ensure leadership capability and awareness of equality and health inequalities • Refreshed Board membership during the year with six senior appointments, including one Chief Strategy Officer, three Non-Executive Directors, one Associate Non-Executive Director and one Interim Chief People Officer, enhancing leadership capacity and governance oversight • Demonstrated visible senior leadership commitment to inclusion, with the Chair explicitly stating strong Board level commitment to diversity and inclusion within formal Board reporting • Progressed implementation of the Patient Carer Race Equality Framework (PCREF) to address racial disparities in care, supported by a steering group led by the Chief Nursing Officer, with a structured self-assessment and improvement programme in place • Embedded governance transparency by livestreaming Open Trust Board meetings, publishing full Board papers and recordings, and circulating Board briefing summaries to staff and stakeholders, enabling clear oversight of decisions and risks • Strengthened performance oversight through regular reporting to the Board and its committees, including the Integrated Quality and Performance Report, review of safer staffing and quality indicators, and monitoring of training compliance and workforce metrics	• 3A: Leadership commitment • 3B: Governance and papers • 3C: Monitoring performance

• Supported inclusive leadership and workforce culture through the PCREF workforce commitments, which promote cultural competence, anti-racist practice, shared learning and progress tracking, creating a safer and more equitable environment for staff and service users	

- **Self-Assessment – 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: Children and Young People Intensive Support Hub (CYP ISH)

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Children and Young People Intensive Support Hub (CYP ISH)	1A: Patients (service users) have required levels of access to the service	• Received 191 referrals between April 2024 and March 2025 and delivered 1,785 contacts, including face to face, telephone, consultation and multi-agency meetings, demonstrating sustained service reach and intensity. • Majority of referrals originated from community CAMHS, evidencing strong integration with local care pathways. • Provides short term, trauma informed intensive support (up to 12 weeks) focused on risk stabilisation and admission avoidance. • Supports young people aged 12 to 18 years, with 15 years the most common age group. • Demographic monitoring in place, with gender recorded (78% female, 22% male) and ethnicity completeness high (3.7% unknown), with open access across all communities and faiths. • All referrals triaged promptly, with first contact based on urgency from within 24 hours to a maximum of 7 days. • Average time from referral to first contact was 2.9 days, with only five cases exceeding 7 days, due to individual circumstances or young person preference. • Expanded family and community access through weekly parent sessions, Non-Violent Resistance groups, and community based therapeutic options, including an allotment project to increase alternative engagement opportunities.	3	Clinical Team Lead (Charlotte Underhill)
	1B: Individual patients (service users) health needs are met	• All referrals reviewed through weekly multidisciplinary team meetings, with urgent cases reviewed within 48 hours, ensuring timely clinical oversight. • 100% of cases reviewed within target timescales, with weekly care plan reviews to monitor risk, progress and outcomes. • Multidisciplinary support includes clinical and youth work input, providing holistic, personalised care.	3	Clinical Team Lead (Charlotte Underhill)

		• Staff receive regular clinical, caseload, peer and safeguarding supervision, supporting quality and consistency. • Outcomes are routinely measured, with all young people completing a recognised outcome measure or goal attainment tool, including CORE 10 and Outcome Star. • Youth voice and co production embedded through the Elevate Youth Council, which meets regularly to inform service design and improvement.		
	1C: When patients (service users) use the service, they are free from harm	• Clear safety policies and procedures embedded, supported by a proactive culture of incident reporting and safety improvement sessions. • All incidents recorded on Ulysses and reviewed within required timeframes, ensuring transparency and learning. • 29 safeguarding or incident reports logged between March 2024 and April 2025, demonstrating active monitoring and appropriate escalation. • Staff receive monthly safeguarding supervision and have immediate access to Trust safeguarding leads for advice and escalation. • Risk assessments and safety plans updated following any new risk or incident, reviewed weekly and monitored through the Community Support Matrix audit tool. • Learning from incidents shared in team meetings and monthly patient safety learning sessions to inform practice improvements.	3	Clinical Team Lead (Charlotte Underhill)
	1D: Patients (service users) report positive experiences of the service	• Routine feedback collected at discharge from young people and families, with 86.2% rating the service 8 out of 10 or higher and 96% positive responses on the Friends and Family Test. • Based on 53 responses, almost all young people and families reported feeling respected, listened to and supported, and valued having a consistent clinician through the core worker model. • Qualitative feedback captured through cards, emails and verbal comments, with themes shared through communications and newsletters to inform improvement. • Service changes are directly informed by feedback, for example increasing allotment sessions and reducing community outings in response to young people's preferences	3	Clinical Team Lead (Charlotte Underhill)
Domain 1: Children and Young People Intensive Support Hub (CYP ISH):			**12 (Excelling)**	

The CYP Intensive Support Hub provides a consistent and well embedded service that is accessible, safe, and responsive to the needs of children, young people, and their families. Referral and activity data demonstrate sustained demand and reach, with delivery through flexible and community-based approaches that reduce barriers to engagement. Multidisciplinary triage, weekly care plan reviews, and regular supervision support personalised, high-quality care and effective risk management. Safety and governance processes are established, with routine incident reporting, safeguarding oversight, and shared learning. Patient and parent experience is systematically captured through structured feedback, with high satisfaction rates and demonstrable service improvements informed by this feedback. *Overall, the service shows routine monitoring, clear processes, and consistent delivery across all outcomes. Further work to strengthen waiting time reporting, protected characteristic analysis, and standardised outcomes measurement will enhance assurance.*		

- **Domain 1: Adult Mental Health Services**

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Adult Mental Health Services	1A: Patients (service users) have required levels of access to the service	• Received 1,953 referrals between April 2024 and March 2025 and delivered 19,225 direct contacts, including face to face, telephone and video consultations, demonstrating high service reach and capacity. • Majority of referrals originate from GPs, evidencing strong integration with primary care pathways. • Provides structured, evidence-based support for people with significant mental illness, focused on risk stabilisation, treatment and recovery across multiple clinical pathways. • Supports a wide age range, from 17.5 years (CAMHS transitions) to 75 plus years, with an average referral age of 37.6 years, demonstrating accessibility across life stages. • Demographic monitoring in place, with gender recorded for 99.8% of patients (51% female, 48.7% male, 0.2% unspecified) and ethnicity recorded for 84%, supporting equity monitoring. • 90% of patients receive first contact within 4 weeks, demonstrating timely access to care.	2	GFC Team Lead (Clare Thomas)
	1B: Individual patients (service users) health needs are met	• All referrals triaged daily through multidisciplinary review, ensuring timely clinical prioritisation. • All patients discussed at weekly MDT meetings at key transition points to review risk, progress and care planning. • Care delivered through a multidisciplinary model, providing coordinated and holistic support. • Staff receive regular clinical, caseload, peer and safeguarding supervision, supporting safe and consistent practice. • Co production approaches used to inform service design and development.	2	GFC Team Lead (Clare Thomas)

	1C: When patients (service users) use the service, they are free from harm	• Clear safety policies embedded with a proactive incident reporting culture supported by regular safety improvement sessions. • All incidents recorded on Ulysses and reviewed within required timeframes, ensuring transparency and governance. • 91 safeguarding or incident reports logged between March 2024 and April 2025, demonstrating active monitoring and escalation. • Staff receive monthly safeguarding supervision and have immediate access to Trust safeguarding leads for advice and escalation. • Learning from incidents embedded through regular reflection and team learning sessions, with improvements implemented. • Proactive, MDT led processes in place for child safeguarding requests from local authorities.	3	GFC Team Lead (Clare Thomas)
	1D: Patients (service users) report positive experiences of the service	• Routine feedback collected at pathway transitions, group interventions and discharge, supporting continuous experience monitoring. • Friends and Family Test responses (n=7) rated the service very good. • Qualitative feedback captured through cards, emails and verbal comments, with themes reviewed in team meetings and shared with the patient experience team. • A co production group is being developed to strengthen patient voice in service improvement.	1	GFC Team Lead (Clare Thomas)
Domain 1: *Adult Mental Health Services* overall rating *Adult Mental Health Services demonstrate strong access, structured multidisciplinary care and robust safeguarding systems, with high activity levels and consistent timeliness of contact. Governance and incident learning arrangements are mature and embedded. Patient experience feedback mechanisms are established but require broader participation to strengthen evidence of impact. Overall performance meets the Achieving standard.*			**8 (Achieving)**	

○ Domain 1: Chaplaincy

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Chaplaincy	1A: Patients (service users) have required levels of access to the service	• Spiritual care available in person and online • Delivered through group and one to one sessions • Oasis multi faith room open to all patients and staff • Information packs on all wards and at reception explaining how to access the service • Referrals accepted from patients, families, and staff • Reasonable adjustments for dementia or cognitive impairment, including familiar music and visual prompts • Language support provided, for example translation app and Polish speaking staff support • Inclusive approach for all faiths and none, with multi faith and civic observances recognised	2	Patient Experience Team (Veronica Emlyn)
	1B: Individual patients (service users) health needs are met	• One to one and group support tailored to individual beliefs and preferences • Patient centred approach aligned to SPAR values • Care planned in collaboration with clinical teams • Inclusive of all genders, sexual orientations, and faith backgrounds	1	Patient Experience Team (Veronica Emlyn)
	1C: When patients (service users) use the service, they are free from harm	• Non proselytising, wellbeing focused practice • Clear professional boundaries and liaison with clinical teams • Compliance with safeguarding and DBS requirements • Staff confident referring patients from diverse backgrounds	2	Patient Experience Team (Veronica Emlyn)
	1D: Patients (service users) report positive experiences of the service	• Informal feedback from patients and staff is positive • Suggestions used to inform improvements • Service delivered under SLA with (10.5 hours per week)	1	Patient Experience Team (Veronica Emlyn)
Domain 1: Chaplaincy overall rating *The Trust provides an inclusive Chaplaincy service offering spiritual, pastoral, and emotional support to patients, carers, and staff of all faiths and none. Support is delivered through ward visits, one to one and group*			**6 (Developing)**	

conversations, and access to a multi faith space. The service promotes equitable access and offers reasonable adjustments to meet individual needs. *The service operates under a Service Level Agreement between the Diocese of Lichfield and NSCHT and is delivered by one Chaplain working 10.5 hours per week. The Chaplain is not directly employed by the Trust. Given the limited hours and the priority placed on patient facing time, the service is designed to remain simple and proportionate, with minimal administrative burden.* *Historically, quantitative activity data has not been routinely collected and there is no dedicated reporting or assurance framework in place. Oversight is therefore provided through existing Trust governance arrangements, including safeguarding, DBS, and supervision requirements, and through collaboration with ward teams, Patient Experience, and governance functions as required.* *Formal feedback routes reflect established Trust wide processes. Ward teams gather routine feedback as part of care delivery, but this is not service specific. The Friends and Family Test is nationally mandated and cannot include Chaplaincy specific questions. The Patient Experience team does not collect direct, service specific feedback outside of Friends and Family Test, PALS, complaints, and compliments, and Chaplaincy related feedback is only captured where patients or carers choose to reference the service. This approach supports inclusive access to spiritual care while maintaining focus on direct patient support and ensuring appropriate safeguarding and governance oversight within existing Trust systems.* *Due to chaplaincy operating as a small, non-clinical service with limited hours, additional standalone equality data collection has not been undertaken, and as a result the availability of quantitative evidence is limited. This has constrained the Domain 1 scoring despite inclusive practice being in place.*		

- **Domain 2: Workforce health and well-being**

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	• Multiple routes to health and wellbeing support are available, including Occupational Health self or manager referral, Staff Support and Counselling Service, Psychological Wellbeing Hub self-referral, VIVUP 24/7 Employee Assistance Programme, and immediate “In the Moment” counselling for emotional support. • Staff have access to online wellbeing resources, including blogs, podcasts and workbooks, alongside regular health promotion communications. • Peer and preventative support includes informal weight management and healthy lifestyle groups, menopause support groups, and wellbeing ambassadors promoting healthy choices at staff events. • Managers support staff with long term conditions and reasonable adjustments, including time off for medical appointments, diabetes monitoring and clinical reviews, with referral to Occupational Health for respiratory conditions such as COPD. • Preventative programmes include Trust wide vaccination delivery, including flu vaccination, in partnership with Nursing and Infection Prevention and Control teams. • Workforce wellbeing and culture indicators remain strong. The 2024 NHS Staff Survey achieved a 64% response rate, with sustained positive scores for “compassionate and inclusive” (7.7/10), staff engagement (7.3) and “voice that counts” (7.1), with results reviewed through Board governance to inform wellbeing and inclusion priorities.	2	Staff Support and Counselling Service (Dawn Ainsworth) Staff Engagement Lead and FTSU Guardian and Being Open Lead (Marie Barley)

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Clear governance and oversight are provided through HR, Freedom to Speak Up, Staff Side, Health and Safety, a multidisciplinary Anti-Harassment and Bullying Working Group, and the Patient and Organisational Safety Team, ensuring coordinated prevention and response. • A dedicated Safeguarding Team delivers Trust wide advice, training, supervision and incident learning, with quarterly safeguarding assurance reports shared across the organisation. • Staff in higher risk clinical settings receive Safety Intervention Training, and all staff can access Staff Support and Counselling, the Psychological Wellbeing Hub, and Critical Incident Stress Management debriefs following incidents. • Additional targeted support includes a Domestic Abuse Champions network, professional supervision and implementation of the Domestic Abuse and Sexual Violence Charter, reinforcing a zero-tolerance approach. • Systems for monitoring and prevention have been strengthened through improvements to the Electronic Patient Record, enabling better tracking of safeguarding concerns and trends. • High safeguarding training compliance is maintained at Safeguarding Children Level 1 and 2 90%, Level 3 86%, Safeguarding Adults Level 3 95%, and Prevent 95%. • Workforce data highlights ongoing risks for some groups. 27 to 33% of disabled, Black and LGBTQ+ staff report harassment, and 28 to 31% report violence, compared with national averages of 27.5% harassment and 14.4% violence. Overall wellbeing confidence is 54.6%, falling to around 49% for disabled staff, with findings reviewed through HR, Safeguarding and Health and Safety governance routes to inform targeted prevention and support actions. • Incident data on violence, aggression, hate crime and discriminatory abuse is reviewed through the Violence and Aggression Steering Group, with a just and restorative approach and follow up support including management review, psychological support and guidance on reporting.	3	Head of Patient & Organisational Safety (Craig Stone) Staff Engagement Lead and FTSU Guardian and Being Open Lead (Marie Barley) Staff Support and Counselling Service (Dawn Ainsworth)

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• Staff have access to multiple independent and confidential support routes, including Occupational Health, Staff Support and Counselling, Psychological Wellbeing Hub, VIVUP 24/7 Employee Assistance Programme, Critical Incident Stress Management, and Freedom to Speak Up, providing advice and support for stress, trauma, harassment and abuse. • Specialist and peer support is available through Domestic Abuse Champions and dedicated safeguarding forums, ensuring tailored support for vulnerable staff groups. • The Patient and Organisational Safety Team has partnered with Uniting Staffordshire Against Hate to provide staff with independent specialist advice and advocacy for hate crime, discrimination and harassment, alongside Trust based wellbeing and management support. • Targeted training has been delivered to leaders to strengthen confidence in recognising concerns and signposting staff to appropriate support. • Staff voice and utilisation of support services are monitored through governance routes, with the 2024 NHS Staff Survey response rate of 64% demonstrating sustained staff engagement and confidence in speaking up.	3	Craig Stone (Head of Patient & Organisational Safety) Marie Barley (Staff Engagement Lead and FTSU Guardian and Being Open Lead) Dawn Ainsworth (Staff Support and Counselling Service)
	2D: Staff recommend the organisation as a place to work and receive treatment	• Staff advocacy remains strong and above national benchmarks. In the 2024 NHS Staff Survey, 74.6% of staff would recommend the Trust as a place to work and 81.2% would recommend it as a place to receive care, both higher than national averages of 69.5% and 78.1%, with results consistent with 2023, indicating sustained confidence in leadership, culture and quality of care. • Advocacy is particularly positive among younger staff and ethnically diverse groups, with staff with declared religious beliefs also reporting high recommendation rates, suggesting inclusive experiences and a culture of belonging. Staff who feel confident disclosing personal characteristics demonstrate higher engagement and morale, indicating psychological safety across teams. • Targeted monitoring highlights disparities for some groups, with disabled staff reporting lower morale (63.4%) and resilience (49.6%), staff not disclosing religion reporting lower morale (55.3%), and LGBTQ+ staff reporting lower morale (65.4%) and flexibility (65.9%). These gaps are tracked through People metrics and inform targeted wellbeing, accessibility and inclusion actions.	2	Marie Barley (Staff Engagement Lead and FTSU Guardian and Being Open Lead)

Domain 2: Workforce health and well-being overall rating *Workforce wellbeing and safety arrangements are embedded and systematic, with multiple access routes to health and psychological support, high safeguarding training compliance, structured prevention of harassment and violence, and independent specialist advice available to staff. Performance and inequality metrics are routinely monitored through governance processes, with targeted actions informed by staff voice and survey data. The breadth and maturity of provision across prevention, support and monitoring demonstrate excelling performance overall.*	**10 (Excelling)**	

○ 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	• All Board members completed individual appraisal, statutory and mandatory training and additional Equality, Diversity and Inclusion training, embedding inclusive leadership capability at senior level. • Governance and leadership capacity were strengthened through six senior Board appointments, including one Chief Strategy Officer, three Non-Executive Directors (NED), one Associate NED and one Interim Chief People Officer. • An Inclusion and Belonging Strategic Plan was launched in 2024, supported by an annual Inclusion and Belonging report to the Board, with a named Trust Executive accountable for delivery of inclusion objectives across clinical and non-clinical services. • Equality leadership is embedded within governance through an Inclusion Council and senior decision-making structures, ensuring escalation of issues and alignment with workforce equality priorities. • Delivery of the Patient Carer Race Equality Framework (PCREF) is overseen by a steering group led by the Chief Nursing Officer, with published intentions and a completed self-assessment to address racial disparities. • Leadership development and capability building are supported through a learning management system offering over 300 learning and development courses across 12 chapters, including Talent and Leadership, Organisation and Personal Development and Quality Improvement, alongside a Leadership Academy programme for Band 7 and above leaders. • Senior leaders engage directly with staff networks, under heard groups, service users and local communities, and work with ICS partners, with themed reviews undertaken to address systemic issues including race equality.	2	Associate Director of Organisational Development (Pauline Grant)

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• Increased transparency and accountability by livestreaming all Open Trust Board meetings, publishing full Board papers and recordings, and issuing post meeting briefing summaries, enabling open scrutiny of decisions and risks. • Operated a formal governance structure comprising one Trust Board and six Board committees, with the Quality Committee and sub committees including PCDC overseeing clinical quality, safety, governance, risk, complaints, regulatory compliance and equality considerations. • Embedded operational scrutiny through the Quality Assurance Group, chaired by the Chief Nursing Officer, with senior leaders routinely reviewing performance data, audit findings, risks, action plans, engagement feedback and workforce development needs, ensuring escalation and follow up. • Equality Impact Assessments and Health Inequality Impact Assessments are incorporated within Board and committee papers, with equality and health inequality considerations discussed, recorded in minutes, and tracked through action logs. • Health inequality risks are recorded within the Board Assurance Framework, with mitigation plans and executive oversight, and corporate and strategic papers link explicitly to equality impacts and risk management. • Patient and staff stories and lived experience insights are regularly presented to inform governance discussions and decision making. • Partnership working with service users, carers and local communities, including annual events attended by over 30 partner organisations, informs risk mitigation and service design.	3	Associate Director of Organisational Development (Pauline Grant) Deputy Director of Governance (Nicola Griffiths)

	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	• Monitored organisational and workforce performance through regular reporting to the Board and committees, including Trust level performance meetings chaired by the Chief Executive, with escalation to the Quality Committee and formal governance routes. • Reviewed performance indicators, audit findings, quality improvement actions, equality metrics and risk management through structured reporting routes, executive dashboards and committee oversight, enabling routine monitoring of inclusion and workforce performance across all directorates. • Progressed delivery of the Patient Carer Race Equality Framework, with formal self-assessment and tracked implementation to address racial inequalities. • Monitored statutory and workforce equality indicators including EDS22, PSED, NHS Staff Survey, AIS, Gender Pay Gap, WRES and WDES metrics, with results reported through governance structures and aligned to the People Plan and workforce oversight arrangements. • Strengthened leadership insight through staff voice and safety data (via Dear Buki submissions and FTSU) thereby, informing improvement and risk management actions. • Incorporated structured feedback from staff networks, service users and partners • Improved reporting systems and monitoring processes, including enhanced recording and tracking of discrimination and workforce issues, supporting earlier identification and action • Used 2024 NHS Staff Survey results, including 7.7 out of 10 for “compassionate and inclusive”, 7.3 staff engagement, 7.1 voice that counts, and a 64 percent response rate, to inform leadership priorities and targeted improvement actions.	2	Associate Director of Organisational Development (Pauline Grant) Deputy Director of Governance (Nicola Griffiths)
Domain 3: Inclusive leadership overall rating *Leadership commitment to equality and health inequalities is embedded across strategy, governance and performance management. Senior leaders receive structured EDI development, equality risks and impacts are routinely considered within Board and Committee processes, and performance is monitored through formal metrics, staff voice data and system wide engagement. Accountability is supported through named executive leads, published reporting and transparent governance arrangements.* *To strengthen further, the Trust will increase the use of defined equality KPIs, trend data, and documented examples of Board challenge and measurable outcomes to demonstrate the direct impact of leadership actions.*			**7 (Achieving)**	
Third-party involvement in Domain 3 rating and review				

Trade Union Rep(s): Jenny Harvey (Staff Side)	**Independent Evaluator(s)/Peer Reviewer(s):** • Balwinder Kaur (MPFT Associate Director of Equity, Diversity, Inclusion and Belonging) • Charlotte Lees (UHNM EDI Lead) • Granville Thelwell (SSOT ICB)

• EDS Action Plan	
EDS Lead	**Year(s) active**
Janice Ogonji, Inclusion & Belonging Lead	10 months
EDS Sponsor	**Authorisation date**
Frieza Mahmood, Chief People Officer	31 March 2026

Domain	Outcome	Objective	Action	Completion date
Domain 1: Children and Young People Intensive Support Hub (CYP ISH)	1A: Patients (service users) have required levels of access to the service	• Ensure equitable access for all protected characteristic groups • Identify and address underrepresentation • Improve referral quality and inclusivity	• Record all protected characteristics for 100 % percent of referrals at assessment and report quarterly • Produce quarterly access report reviewing referrals and contacts by gender, ethnicity, age, and other characteristics, identify gaps and implement actions • Work with CAMHS referrers to reinforce the importance of capturing diversity data and referring underrepresented groups, provide guidance and audit all referrals per quarter	Dec 2026
	1B: Individual patients (service users) health needs are met	• Improve collection and use of equality data in care planning • Use data to review equity of outcomes • Ensure personalised, needs led support	• Capture protected characteristic information at initial assessment for 100% of young people • Analyse outcomes and engagement by protected characteristic and report findings to MDT and governance forums • Evidence care plans and reviews for 100% of cases, demonstrate adjustments made to meet individual needs (CSM completed monthly to support this).	Dec 2026

	1C: When patients (service users) use the service, they are free from harm	• Maintain a strong safety culture • Strengthen safeguarding oversight • Use learning to reduce risk	• Encourage and monitor incident reporting through Ulysses, review 100% of incidents monthly and share learning at team meetings • Continue monthly safeguarding supervision and annual training compliance, target 100% completion • Document 100% of service improvements or practice changes quarterly resulting from incident reviews	Implemented, ongoing
	1D: Patients (service users) report positive experiences of the service	• Increase structured feedback collection • Improve equity insight from feedback • Use feedback to drive improvement	• Implement QR code and online feedback tool at discharge and during episodes of care • Add questions relating to protected characteristics and inclusion experience • Review results quarterly, target 100% responses per quarter, implement and record 100% service improvements per year	Dec 2026
Domain 1: Adult Mental Health Services	**Outcome**	**Objective**	**Action**	**Completion date**
	1A: Patients (service users) have required levels of access to the service	• Ensure equitable access and reduce underrepresentation across protected groups	• Analyse referral and access data by protected characteristic quarterly, identify at least two underrepresented groups, and implement targeted engagement or pathway changes. • Complete the British Muslim access review and implement agreed recommendations. Increase portal awareness through Trust communications and partners to achieve a 20% increase in referrals or enquiries.	Dec 2026
	1B: Individual patients (service users) health needs are met	• Improve equality data capture and ensure personalised, needs led care planning	• Achieve 95% completeness of equality and reasonable adjustment data at assessment. Audit quarterly to ensure 100% of care plans include personalised goals and adjustments. • Introduce a 6 month complex case review panel with MDT oversight for 100% of high complexity cases.	Dec 2026

	1C: When patients (service users) use the service, they are free from harm	• Maintain strong safety culture and strengthen safeguarding oversight	• Record and review 100% of incidents on Ulysses with monthly review and action tracking. Deliver monthly safeguarding supervision and maintain 100% annual safeguarding training compliance. • Evidence at least one service improvement action per year arising from incident learning.	Ongoing
	1D: Patients (service users) report positive experiences of the service	• Increase structured feedback and use patient voice to drive improvement	• Achieve a minimum 25% feedback response rate at discharge and transitions using QR and digital tools. Establish a co production group meeting quarterly. • Review every 6 months and implement at least two service improvements per year linked directly to feedback.	Dec 2026
Domain 1: Chaplaincy	**Outcome**	**Objective**	**Action**	**Completion date**
	1A: Patients (service users) have required levels of access to the service	• Maintain equitable and visible access to spiritual care across all wards	• Continue blended in person and online provision, maintain weekly ward presence, ensure information packs available on 100% of wards and reception.	Annual, ongoing
	1B: Individual patients (service users) health needs are met	• Deliver personalised, patient centred spiritual support aligned to individual needs	• Provide one to one and group support tailored to belief, culture, and preference, liaise with MDTs for care planning, record activity and case examples demonstrating adjustments or inclusive practice	Ongoing
	1C: When patients (service users) use the service, they are free from harm	• Maintain safe, professional, and inclusive practice	• Continue safeguarding and DBS compliance at 100%, maintain supervision and liaison with clinical teams, reinforce non proselytising boundaries, review any concerns or incidents through Trust governance processes	Ongoing

	1D: Patients (service users) report positive experiences of the service	• Use existing Trust feedback routes and ward intelligence to inform improvement	• Monitor relevant themes from FFT, PALS, complaints, compliments, and ward or staff feedback where chaplaincy is referenced, review annually with Patient Experience Team and implement service improvements where themes identified, document examples of changes made	Annual review
Domain 2: Workforce health and well-being	**Outcome**	**Objective**	**Action**	**Completion date**
	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Improve equitable access and measurable uptake of health and wellbeing support for staff with long term conditions	• Monitor utilisation of health and wellbeing services annually with demographic breakdown, achieve 70% awareness of support services (staff survey) and 10% year on year increase in uptake deliver at least 3 targeted wellbeing initiatives per year, reduce wellbeing or safety gaps for protected groups by 5%	Ongoing
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Reduce incidents of bullying, harassment and violence and strengthen prevention and reporting culture	• Monitor incident and staff survey data quarterly, • Deliver Safety Intervention and safeguarding training to 75% of high-risk staff • Promote FTSU and reporting routes, target 5% reduction in incidents year on year	Dec 2026
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• Increase awareness, access and timely use of independent and confidential support services	• Deliver 6-month communications campaigns to increase utilisation of OH, counselling and EAP services • Set 2-day FTSU, of OH, counselling and EAP services response standard. • Collect feedback and report satisfaction annually	Dec 2026
	2D: Staff recommend the organisation as a place to work and receive treatment	• Improve staff advocacy and reduce morale gaps across protected groups	• Maintain recommendation rates above national benchmarks analyse survey results by demographic group, implement targeted improvement plans for lower scoring groups, aim for improvement in morale and advocacy scores	Dec 2026

	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	• Increase representation of ethnically diverse leaders at senior levels • Strengthen leadership accountability for inclusion • Improve leadership capability and understanding of health inequalities	• Implement refreshed talent management and succession planning framework, set baseline and target for ethnically diverse representation To be monitored and reported annually • Introduce inclusion objectives within senior leader appraisals and performance reviews, 90% completion and reporting through Board assurance to Board • Deliver targeted EDI and health inequalities development sessions for Board and senior leaders, 75% attendance and pre and post evaluation of confidence or knowledge	• Dec 2026
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• Standardise equality consideration in decision making • Improve quality of assessments and mitigation planning • Strengthen monitoring of equality risks	• Implement mandatory EIA and HIA checklist within all Board and Committee templates, with completion for 80% of papers. • Provide training and guidance for report authors and leads, audit 5 assessments per year for quality and feedback improvements • Record identified risks on risk register with named owners and mitigation actions, review risks monthly and report progress to Committee	Sept 2026 Ongoing
	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	• Embed inclusion, equality and wellbeing within appraisal and clinical supervision processes to strengthen leadership accountability • Strengthen Board oversight of inequality through routine use of integrated workforce and patient experience data	• Review and update appraisal and supervision templates to include discussion of inclusion and health inequalities, achieve 100% compliance and report through Board assurance • Deliver targeted inequalities training and guidance for managers, 75% completion and evaluation of confidence and behaviour change	July 2026

			• Require Board and senior leaders to review the existing equality dashboard quarterly, with equality metrics included as a standing agenda item and discussion recorded in minutes • Each directorate to document how dashboard insights inform local actions and improvement plans, report 2 examples of actions or changes per year • Provide guidance and training on using dashboard data to identify gaps and monitor progress, 75% completion and evaluation of confidence or use in practice	Oct 2026

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