

## Appendix 2

# Feedback on draft EDS2022 assessment

Collated feedback from the Humber and North Yorkshire Inclusion Assembly (collated by Rach McCafferty).

Feedback has been shared for the approach to EDS2022 overall, rather than specific domains, hence the slightly different template that follows (using the same four key questions as the original).

## Format of this feedback document

This document is split into the following sections:

- [General comments](#)

## General comments – across all 3 domains

Question	Feedback
1) Are you happy with the approach we've taken?	<ul style="list-style-type: none"> <li>• Would prefer engagement before scoring and then scores rationalised</li> <li>• Would prefer engagement events / longer time window for involvement</li> <li>• Summaries of information as well as full documents would be useful to use during engagement</li> <li>• Wider engagement needed, for example, tobacco dependency should focus on tobacco use more broadly, rather than just in in-patient services (ICB to engage wider to include community groups, patients etc)</li> <li>• National data IS available re smoking prevalence among minority groups – would suggest use this until local picture ascertained</li> </ul>
2) Do you agree with the scores based on the evidence provided?	<ul style="list-style-type: none"> <li>• Disagree with achieving and excelling scores (these cannot be achieved without the opinions of others eg service users)</li> <li>• ICB should be firmly in 0 or 1 (developing)</li> <li>• Agree with overall score of 1 - developing</li> <li>• Health inequalities data as part of CORE20PLUS5 doesn't align with current scoring</li> <li>• See earlier note re arriving at provisional scores pre-engagement</li> </ul>
3) Are there any other things we could be doing?	<ul style="list-style-type: none"> <li>• More detail in terms of specific groups at a disadvantage (CORE20PLUS 5 etc)</li> <li>• See above comments re engagement and order of process steps</li> <li>• Align more closely as a system for broader public engagement</li> </ul>
4) Any other comments or feedback?	<ul style="list-style-type: none"> <li>• Would be interested to work on a system approach to this process for future iterations</li> <li>• I wonder if you could feedback to the author(s) of the briefing document that since 2021, we no longer use the term "BAME" when writing about ethnicity as it excludes a number of other minority groups - I have copied the Gov link below for reference: <a href="https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity/">https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity/</a></li> </ul>

RMc (Thursday 29 February 2024)

# Feedback on draft EDS2022 assessment

Collated from the ICB Inclusion Network meeting on Thursday 22 February 2024 and including additional comments shared by email.

## Format of this feedback document

This document is split into the following sections:

- GENERAL FEEDBACK (newly added to the template as applies throughout)
- Domain 1 – commissioned or provided services
  - Access to primary care (GP services)
  - Maternity services
  - Tobacco dependency services
- Domain 2 – workforce health and wellbeing (relates to ICB colleagues only)
- Domain 3 – inclusive leadership
- Any other comments?

## General feedback

### **Regarding the scoring**

We noted that each item of evidence had been scored on the assessment documents, but since then, it has been agreed to only include an overall score for each domain.

This feels simpler.

Prior to this decision, we felt that a score of 'achieving' could only be evidenced if a service or initiative provided as evidence was available across the whole ICB, as the assessment relates to our full area.

The network agreed with an overall score of '1 – developing' but that this is a positive as it gives us a pragmatic baseline to work from.

### **Regarding engagement and the process**

The network acknowledged the tight timeframes this year and that this is the ICB's first EDS2022 assessment.

We did have some discussion around the value of engagement taking place more widely before scoring to ensure a diverse representation of views was heard and included. This is something we hope can be considered for next time when time and capacity permits.

It was noted that we cannot rely solely on engagement with staff regarding public services as there are large groups who face barriers to the workplace... we know we have a lack of diversity in our own workforce. There has been some tendency towards this in some individual work areas, with the argument that staff are patients, so more a general note to flag this belief as it is unhelpful re our EDI duties.

### **A note on what could be considered evidence**

The network acknowledged the huge amount of work that has gone into collating evidence for the assessment and thanks the ICB team for pulling everything together.

Members would challenge whether what we've included in our first EDS2022 assessment is evidence in terms of improved outcomes and access. We have included details of many pieces of great work underway throughout all three domains, however, there is a lack of focus around measurable outcomes, driven by demographic data.

Of all the plans we have included – how are these measured? How do we know they're working? How can we highlight areas of focus without this? If we're focused on continuous improvement, should there be any plans included as evidence that do not have an action against them regarding ongoing measurement and review?

On the policies we've included – have we engaged during the development of these including their EqIAs and if not, why not? How can we be assured that these are equitable for all colleagues or patients with protected characteristics if those voices have not been included in the creation of these?

### **A note on actions**

The network acknowledged that the action plans that sit with these assessments will follow. In the interim, we'd encourage the inclusion of SMART objectives within these to address the lack of measurable information linked to protected characteristics mentioned earlier.

The group will await the final action plan, but in the meantime, suggested these general actions on the back of the assessment:

- 1) To strengthen data gathering and analysis across protected characteristics across all three domains to ensure improvements and areas of focus can be identified and amplified or mitigated against, respectively.
- 2) To broaden the scope of our engagement and involvement work ahead of our next assessment to incorporate a more diverse range of stakeholders, with the process being equality impact assessed for assurance.
- 3) To incorporate any actions on the EDS2022 action plan into wider business, with reporting back to Board on progress.

### **Accessibility throughout**

See the ['any other comments'](#) section for feedback around this point, but it relates to a lack of parity in terms of digital translation tools being available on ICB-commissioned websites including microsites.

There could be a wider action re improving the accessibility of our communications more generally (could fit well with PSED too?)

## Feedback on domain 1 – commissioned or provided services

### Domain 1 – Access to primary care (GP services)

Question	Feedback
5) Are you happy with the approach we've taken?	
6) Do you agree with the scores based on the evidence provided?	<p>The network landed on an overall score of developing as it was felt the evidence was not there to provide assurance that we are meeting the scoring criteria for a '2-achieving'.</p> <p>An example cited was the lack of an EqIA for the access recovery plan (which would technically put us at '0-undeveloped activity').</p> <p>More focus on engagement to reduce barriers for seldom heard groups is needed – we discussed how we still have some GP practices who have completed no annual health checks for people with learning disabilities despite this being part of the national GP contract. We also discussed the experiences shared in the Pride in Our Health report.</p>
7) Are there any other things we could be doing?	<p>A real focus on data is required – we cannot be assured we have reduced barriers to access without understanding what these are / how they affect local communities and then addressing these barriers with measurable mitigating actions.</p> <p>A similar discussion was also had around engagement. The network applauds the involvement of Healthwatch in the review of the assessment process, however, it was acknowledged that there are many minoritised groups in our local communities who cannot engage in this way.</p>
8) Any other comments or feedback?	<p>Taking the annual health checks for people with learning disabilities as an example – this would be useful evidence if we could show an improvement in uptake / these being offered, year-on-year. Currently, around 25% of people with a learning disability do not receive their annual health check.</p> <p>The Pride in Our Health report is a great piece of work – but what have we done as a result of it?</p>

Question	Feedback
	The assessment report feels like a good starting point for our first year but there is room to clarify what we define to be appropriate evidence – perhaps measuring the actions from this year into next could help with this?

**Figure 2: Domain 1 – Maternity services**

Question	Feedback
1) Are you happy with the approach we've taken?	
2) Do you agree with the scores based on the evidence provided?	The network landed on an overall score of 1-developing. Although some really great pieces of work are included in the evidence, we felt we're missing the follow-through – are these initiatives working? How do we measure success?  Given that a pregnant person from an ethnically diverse background continues to be at higher risk when accessing maternity services, it didn't feel appropriate to score '2-achieving'.
3) Are there any other things we could be doing?	Regarding the earlier comment re follow through – we have evidence on the assessment that has 'no further action'. For example, the LMNS EEDI Plan – this is a detailed, evidenced and well thought out plan. But if this is a live plan, then it should require ongoing action to ensure it's operating as hoped and outcomes are measured and evidenced. We're sure this is happening, we just perhaps need to make that clear.
4) Any other comments or feedback?	We noted the language throughout the evidence focused on “mothers” and “women” in a few (not all) places. We perhaps need another quick check just to ensure additive language is used throughout.

**Figure 3: Domain 1 – Tobacco dependency**

Question	Feedback
1) Are you happy with the approach we've taken?	
2) Do you agree with the scores based on the evidence provided?	<p>The network agreed a score of '1-developing'.</p> <p>There is evidence of some great work and it's appreciated that this is in its early stages. However, we must focus on either finding a way to access data by protected characteristic and/or draw on national data to understand the minority groups within our communities who may face barriers to accessing services so that these can be mitigated.</p> <p>EDS2022 specifically focuses on the nine protected characteristics of the Equality Act (2010) so although this work falls into reducing health inequalities more broadly, there is currently a gap in knowledge and therefore mitigating action in terms of reducing the barriers to the service for minority groups within our local communities.</p> <p>Specific examples include local LGBT+ communities, people with serious mental illness (SMI) etc.</p>
3) Are there any other things we could be doing?	See above.
4) Any other comments or feedback?	Yes – the group flagged the work that has happened in York place around smoking cessation during Ramadan and felt this could be a good piece of evidence for this section, that focuses on a specific minoritised group.



## Feedback on domain 2 – workforce health and wellbeing (ICB colleagues only)

**Figure 4: Domain 2 – workforce health and wellbeing (ICB)**

Question	Feedback
1) Are you happy with the approach we've taken?	
2) Do you agree with the scores based on the evidence provided?	<p>The network feels a score of '1-developing' is appropriate.</p> <p>Concerns were shared around the lack of trust in the organisation between senior leaders and staff. Specifically, the new Freedom to Speak Up policy was felt to be more of a roadblock than a genuine attempt to encourage continuous development and learning.</p> <p>There are number of hurdles a person must jump before being able to approach the FTSU Guardian for the ICB and there are questions around how equipped that individual might be to discuss and tackle, for example, incidents of racism, of biphobia etc.</p> <p>Putting a multi-level procedure in place for raising a concern means a person must discuss something with more than one individual before reaching the FTSU Guardian. If this is a situation where discrimination is being raised, that potentially puts a person in a position of being repeatedly retraumatised as they work their way through the policy. Policies around speaking up should be trauma-informed.</p> <p>It was very much felt that the organisation would benefit from a FTSU representative who is not on the Board and is not a clinician – approaching a clinician who is also a Board member is an additional barrier due to the perceived power imbalance.</p> <p>The network noted this policy was not shared with the group as part of its development, when nuances of the experiences of minoritised colleagues could have been discussed and mitigated.</p>

Question	Feedback
	<p>Regarding bullying and harassment – there is a view that this continues to be a concern for colleagues, but that there is a lack of transparency around how the ICB is hoping to tackle this. The follow-up B&amp;H survey done on the back of the staff survey showed higher instances of B&amp;H for colleagues from minoritised groups, yet this wasn't shared with the network, the wider organisation, or a measurable action plan put in place to the network's knowledge.</p> <p>Specifically – it wasn't clear there was any evidence of independent support for colleagues experiencing B&amp;H as detailed in outcome 2C.</p> <p>The creation of the network is welcome and hopefully seeing this being embedded formally across our internal functions eg for policy development / review, in organisational change planning / delivery and by regular dialogue between the network and exec group will see improvement.</p> <p>Regarding the diverse recruitment panels mentioned under 2D and the appetite to do this – the network is keen to support more widely.</p> <p>The network did discuss how we are underdeveloped in terms of addressing health inequalities within our own workforce (2A) and the general point from earlier regarding data is of real importance here.</p> <p>There was an appetite to connect our HR team with our BI team for support in analysing staff data to enable this in future, but also an acknowledgement that the team are doing great work with limited capacity.</p> <p>The theme of trust also surfaced again here as the network acknowledges that a culture of psychological safety is essential if staff are to feel safe enough to share their demographic data on ESR. We don't feel we have this at the ICB yet. This is an area the network could support with for future work.</p>

Question	Feedback
3) Are there any other things we could be doing?	It would be useful to perhaps include working in partnership with the network throughout the actions identified, where appropriate.
4) Any other comments or feedback?	

## Feedback on domain 3 – inclusive leadership

**Figure 5: Domain 3 – inclusive leadership**

Question	Feedback
1) Are you happy with the approach we've taken?	
2) Do you agree with the scores based on the evidence provided?	<p>The scores throughout felt safer as 1-developing.</p> <p>It feels like there is an understanding of health inequalities generally, however, a lack of knowledge around the nuances of the impact of barriers on different minoritised groups in society was identified.</p> <p>For example, it is rare to hear senior leaders talk about racial inequality, there has been no formal action taken after the Pride in Our Health report... confidence around discussing poverty and deprivation is evident, but with the lack of demographic data that has been identified throughout the assessment, it isn't evident that there is a deeper understanding of the realities of the experiences of different groups. We'd need the data to help with this journey.</p> <p>It was identified that the appetite appears to be there, but that further development is needed in terms of how this is communicated by senior leaders. For example, we mention that the Quality Committee ensures EqlAs are in place, but where is the assurance sought around the completion of the mitigating actions these assessments identify?</p>
3) Are there any other things we could be doing?	<p>The network very much looks forward to attending a future exec group and to working in partnership with our senior leaders; informed by lived experience, compassionate curiosity and committing to embracing discomfort as growth.</p>
4) Any other comments or feedback?	<p>Just regarding point 7 – Board Assurance Framework – it's important that this work is informed by not only knowledge and expertise but by lived experience also. The network is happy to support.</p>

## Any other comments?

The following comments were shared outside the network meeting via email:

### **Digital accessibility tools**

The maternity submission makes mention of digital translation services, and this is something I've been dealing with a lot, and Sarah from ICB comms is leading on. It's probably worth the network being aware for more than just this – there are a lot of on page translation services (other ICBs have bought a system called ReciteMe for their sites, but there's multiple options), which allow a multitude of access requirements to be fulfilled, such as read aloud, translation to a very large range of languages, etc.

We know from feedback these are not only important for patients, but they can facilitate communication in medical settings, particularly in unplanned medical settings (so a medical professional could get it to read aloud from the website in an ED setting, rather than waiting for a translator, or just clarify things if the patient/parent/carers English is passable and they haven't requested a translator, but their English is not comprehensive). However, it is moderately expensive!

So at present the ICB is entirely focusing on translating select leaflets for physical display. Obviously digital translation creates its own barriers and exclusions, but this current solution does mean that pretty much none of the ICB's websites are as accessible as they could be.

Frustratingly, the government's recent audit that failed the ICB's main site on accessibility standards focused instead on more basic features, which are now fixed, but didn't mention translation and read aloud. So there seems to be little push from the board to spend money there as a result. But it is a major problem, partially to disability access, but more so to access to people for whom English is not their first language.

Smoking cessation mentions this briefly too – Badgernet will bring in some access to pregnant individuals who speak the top five languages – but this is very narrow, and risks leaving communities of small numbers of speakers behind.

Part of the problem across the ICB is that we have small, concentrated and isolated pockets of foreign language speakers, and without a system that brings together a directory of hundreds of languages, we're going to miss something. So really the digital offer is the only way to reach those kinds of communities.

We've recently had some particular healthcare inequalities due to information not being available to Romanian communities south of the Humber, and the solution offered to that so far is leaflets – I'm just not sure that's going to give the level of information and improve access to health information in a universal and ongoing way.

Updated Wednesday 28 February 2024 (RMc) - FINAL

# Feedback on draft EDS2022 assessment

Organisation: Healthwatch - Hull/York/East Riding/ North East Lincolnshire

Date of assessment: 29<sup>th</sup> February 2024

## Feedback on domain 1 – commissioned or provided services

Question	Feedback on access to primary care (GP services)
1) Are you happy with the approach we've taken?	Evidence could be wider. Online triage not working well this is not reflected in this evidence. Digital exclusion is not acknowledged. PCNs can cause confusion, different rules / procedures. Not always accessible information provided through letters. PPGs how are they working for equality and diversity outcomes? Are they consistent with flagging needs and accessibility – eg. visual impairment, is this kept up to date.
2) Do you agree with the scores based on the evidence provided?	Fair scoring based on available evidence. More evidence required, collected better. More evidence surrounding reoccurring themes.
3) Are there any other things we could be doing?	Health check data should be considered as part of evidence. Shared information amongst, ie integrated neighbourhood teams. Neurodiverse young people consideration - out of hours spaces and barriers for neurodiverse young people.
4) Any other comments or feedback?	Expand evidence bank to reflect reoccurring themes. Resources to reflect local communities. Welcome consistent mechanism throughout patch to link Healthwatch with PCNs. Travelling communities/rough sleeping consideration in key actions to reflect areas.

Question	Feedback on Maternity Services
1) Are you happy with the approach we've taken?	Some evidence not correlating with public voice. Wider sample of information needed. Know more information is out there.
2) Do you agree with the scores based on the evidence provided?	Score is fair for evidence presented but we know there is more evidence.
3) Are there any other things we could be doing?	Raising awareness about barriers under focus on specific barriers in specific areas. Mental health - perinatal mental health. Very few mother and baby units in UK - not one in HNYICB at all. Transport links are poor - many services are out of area – Sheffield/Leeds/Hull/further afield. Assumption people can drive everywhere. NICU is often out of area. Failure to communicate properly to birthing people and families.
4) Any other comments or feedback?	BadgerNet implementation not supportive of some excluded populations. Eastern European communications needs improving - standard practice differences. Poor maternity across the board. Poor bereavement support in maternity. Poor breastfeeding support - people are judged - rudely commented on - public comments. People wanting to be out of area - poor service. People being sent to Grimsby / York etc. from Hull - 30 to 40 miles - unsafe, unmonitored. Consistency across the board in terms of advice given by health visitors/ midwives / anti natal classes / family hubs.

Question	Feedback on Tobacco dependency
1) Are you happy with the approach we've taken?	We know there is more evidence, this needs to be collated better. Need information from wider services from BCSC, social prescribing. Need more links with wider services. People often have comorbidities - are these considered? Homeless population treated poorly by services, unaware of services, low on the radar. Ethnic minorities- many other countries- smoking very cheap and cultural.

Question	Feedback on Tobacco dependency
2) Do you agree with the scores based on the evidence provided?	Scores are fine - feel if further evidence was sourced this could boost score - however developing activity is accurate and should continue to develop.
3) Are there any other things we could be doing?	Health check evidence- should be considered as evidence. Long term health conditions may have data to say people have quit - because of illness may not care (to stop). Needs more transgender / transitioning data. Socioeconomic as well as protected characteristics, should be looked at - health inequalities can come in many forms not just protected characteristics.
4) Any other comments or feedback?	To make stop smoking case studies more accessible - GP surgeries, homeless shelters, through stop smoking campaigns, community centres, social media (not digitally inclusive). ICS equality plan however feels very health focused - how is this being framed through local authority and widen the focus? Should involve all parties- Healthwatch, LA, VCSE, social prescribers, system partners.

## Additional comments

The briefing note circulated prior to the scoring event was helpful.

General comment on the lack of breadth of evidence presented, good in some areas, bare bones in others. Needs systems in place to gather evidence across the ICS. Better cross referencing across services were there is an overlap ie. tobacco dependency and maternity.

Would like to have earlier involvement in the planning and determining of services to be reviewed. ICB can make better use of Healthwatch reports and need a consistent approach to presenting these.

Healthwatch organisations welcome the opportunity to be involved in the longer terms development and delivery against equality actions and objectives.

SL: Thursday 29<sup>th</sup> February 2024



# Feedback on draft EDS2022 assessment

Name: Social Partnership Forum  
 Organisation: Humber and North Yorkshire ICB  
 Date of assessment: 29<sup>th</sup> February 2024

## Feedback on domain 3 – inclusive leadership

Question	Feedback to 3a
1) Are you happy with the approach we've taken?	Overall approach (across 3) feels like it has been carried out involving a minority of people. If SPF reps had had earlier involvement, some of their comments could have been addressed and resolved. It is unclear that all staff are aware that this was taking place. Has there been a staff brief/ comms on it?
2) Do you agree with the scores based on the evidence provided?	3 a – score 1. Developing more appropriate than achieving, as per feedback there is no evidence that the board champions Bushra and Mark are meeting the inclusion network and health and wellbeing (engagement group). 3b – score 1 – agree 3c – score 1 – agree (to note that can't comment on those areas that the ICB is not required to do – as listed in the marking criteria – PCREF Mental Health for example)
3) Are there any other things we could be doing?	SPF – Feel that there needs to be a staff side representative at Board. There used to be in the past (felt used to have in PCT days)  Key action would be to raise awareness of who the EDI leads are and for them to engage with staff. Better comms around this in future, including from the EDI and health and wellbeing leads and more engagement with staff.  The intranet – could be used for links to groups such as HNY Inc and the Inclusion Assembly.

Question	Feedback to 3a
<p>4) Any other comments or feedback?</p>	<p>Did not know that Bushra Ali is the Board EDI champion and Mark Chamberlain is the Board Health and Wellbeing Champion. It is unclear what their roles are in this capacity and what they do. The impression is that they have not introduced themselves to staff nor engaged with them, so how can they champion them at Board? Suggest that to be a champion they should also make themselves more accessible to staff.</p> <p>Not previously aware that Anja Hazebroek is SRO for EDI. If TU reps are not aware, how would staff know? There is a lack of transparency. It hasn't been mentioned in the inclusion network.</p> <p>It is difficult to comment on what is discussed at board as there is insufficient information.</p> <p>How can it be said that you say there is appropriate challenge if EDI Board leads are not attending staff forums. No engagement with staff how is that ok?</p> <p>Note that inclusion assembly will be attending board for the first time soon.</p> <p>Queried whether there is an OD plan.</p>

Question	Feedback to 3b
<p>1) Are you happy with the approach we've taken?</p>	
<p>2) Do you agree with the scores based on the evidence provided?</p>	
<p>3) Are there any other things we could be doing?</p>	

Question	Feedback to 3b
4) Any other comments or feedback?	<p>Overriding concern across leadership – is that it is coming out as undeveloped. It is the most important part of the organisation.</p> <p>Will key actions translate into what we should be doing? At the moment it looks quite mundane and is at risk of being 'tick-boxy'.</p> <p>Should there be training for staff on EDI and how this should be embedded in individual job roles? Not clear that this happens.</p>

Question	Feedback to 3c
1) Are you happy with the approach we've taken?	Feel that it should be made clearer that 3 c 3 ' HNY Health and Wellbeing Committee' is part of a system approach. It sounds like it is something that just the ICB is doing and taking credit for.
2) Do you agree with the scores based on the evidence provided?	
3) Are there any other things we could be doing?	
4) Any other comments or feedback?	<p>Actions – on removing barriers and creating enablers for staff sharing EDI data on ESR – It needs to be a lot clearer to staff why their data is being gathered, what it will be used for and the benefit of them sharing their personal information. And that it is not just a tick box exercise.</p> <p>Feel like the HNY Inc and other inclusion groups (BAME) are not promoted well enough.</p>