Oxford University Hospitals
NHS Foundation Trust

Workforce Race Equality Standard Report 2017

Executive Summary

1. The purpose of this report is:

   - To demonstrate compliance with the Workforce Race Equality Standard (WRES).
   - Detail the Trust's data with regard to the nine WRES metrics.
   - The demonstrate actions that will be taken to mitigate any disparities found in the metrics.

2. Analysis of the metrics produced the following key findings.

   - Distribution of BME staff across the Trust is uneven both horizontally and vertically. The lack of BME representation in senior levels of the Trust is especially noticeable.
   - There is potential for unconscious bias to have a large impact through the recruitment process.
   - There is a lack of Trust from BME staff when it comes to career development and promotion.
   - External career development opportunities are not effectively communicated or monitored.

3. Recommendations were produced as a result to mitigate these findings. The recommendations took into consideration the current financial situation of the Trust and have been thought out in terms of cost implications and feasibility of implementation has been discussed with relevant stakeholders.

4. This report has also highlighted many areas for further investigation and research, which have not been able to be undertaken under the time constraints for this report. This research will enable better understanding of root causes to some issues, or may uncover issues that are currently unknown. These areas of research will be included within the Action Plan for the coming year and will form part of the 2018 WRES Report.

5. An action plan has been produced as a result of the analysis and recommendations.

Workforce Race Equality Standard 2017 Report

1. Purpose

1.1. This report has been created in-line with the Workforce Race Equality Standard (WRES) in order to demonstrate compliance and advance the inclusion of Black & Minority Ethnic (BME) Staff within the Trust.

1.2. This report aims to:
- 1.2.1. Detail the Trust's data with regard to the nine WRES metrics.
- 1.2.2. Discuss and analyse reasons for any disparities within the workforce.
- 1.2.3. Provide recommendations and an action plan to address any disparities.

1.3. The Trust Board is asked to accept and note this report, and the report will then be published on the Trust's external site.

2. Background

2.1. The WRES was introduced as part of the NHS Standard Contract in April 2015 to ensure that employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

2.2. WRES consists of nine metrics which may highlight areas in which BME staff are unfairly treated. Trusts must report on the metrics annually and produce, and implement, an action plan to address any disparities in the metrics.

2.3. The Trust successfully implemented the WRES in 2015 and has been reporting on the WRES metrics annually since then. Previous WRES submissions can be found on the Trust's external website.

3. Research

3.1. Data to report on the nine WRES metrics was received from NHS England and verified using the Trusts:
- 3.1.1. Electronic staff record (ESR) (metrics 1,2 & 9);
- 3.1.2. Electronic learning management system (eLMS) (metric 4);
- 3.1.3. Employee relations case tracker (metric 3) and;
- 3.1.4. NHS Staff Survey results 2016 (metrics 5, 6, 7 & 8).

3.2. Whilst data provided for the metrics is generally deemed to be accurate, it should be noted that 7% of the workforce have chosen not to declare their ethnicity, or there is no recorded information for them. This could mean that some of the metrics are not wholly representative of the treatment of BME Staff, however with 93% declaring, it is likely to be a strong indicator of what is happening. The Equality, Diversity and Inclusion (EDI) Action Plan 2017/18 includes a campaign to increase self-reporting across all protected characteristics, so this should enable our metrics to be more accurate in the future.

3.3. Further analysis was undertaken on the metrics to better understand root causes of issues and this involved use of Trust data available from ESR as well as information from scientific literature and case studies from other organisations.

3.4. In order to better understand BME staff perceptions around career development and promotion, a Listening into Action event (LiA) was held on June 15th. Key themes that arose from this event were:
- 3.4.1. a lack of transparency around promotion and development decisions;
- 3.4.2. a lack of awareness of what opportunities might be available;
- 3.4.3. lack of confidence or trust in applying for opportunities due to previous poor experiences;
- 3.4.4. poor accountability.

3.5. Recommended actions were consulted upon with key stakeholders to ensure they were appropriate and that implementation would be realistic. This included:
- 3.5.1. trade union representatives;
- 3.5.2. the recruitment team;
- 3.5.3. the Leadership Development manager;
- 3.5.4. the Race Equality Action Group, and;
- 3.5.5. the Divisional Leads for Practice Development and Education.

4. WRES Metrics 2017

Below is the Trust's data for each of the nine metrics, with comparisons to the 2016 WRES submission.

Metric 1. Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 or Medical and Dental Subgroups and Very Senior Management (VSM) compared with the percentage of staff in the overall workforce

AfC Pay Band	BME % 2016	BME % 2017	Difference
Under Band 1	26.7%	33.3%	6.7%
Band 1	11.8%	13.8%	2.0%
Band 2	24.5%	25.4%	0.9%
Band 3	13.0%	14.7%	1.7%
Band 4	13.5%	15.7%	2.2%
Band 5	23.4%	22.8%	-0.6%
Band 6	17.9%	19.1%	1.3%
Band 7	11.4%	11.1%	-0.3%
Band 8a	7.9%	8.8%	0.9%
Band 8b	5.0%	4.9%	-0.1%
Band 8c	5.6%	5.0%	-0.6%
Band 8d	4.0%	6.9%	2.9%
Band 9	0.0%	0.0%	0.0%
VSM	11.5%	9.1%	-2.4%

AfC Pay Band		BME % 2016	BME % 2017	Difference
MEDICAL & DENTAL	Consultant	22.1%	21.5%	-0.6%
	Non-consultant career grade	30.5%	26.9%	-3.7%
	Trainee Grades	29.1%	26.6%	-2.5%
Trust Average		**19.4%**	**19.5%**	**0.1%**

Table 1: Percentage of staff in each of the AfC Bands for 2016 and 2017. Difference between the two is shown with green indicating a positive difference from 2016 to 2017 and red indicating a negative difference.

4.1. Overall, 19.5% of the Trust's staff define as BME, similar to last years' overall figure of 19.4%.

4.2. Generally, representation across the Trust has remained relatively consistent. The greatest positive difference was seen at Under Band 1 with a 6.7% rise; however with only a small number of people within this band this is statistically insignificant. The largest negative differences can be seen within the Medical and Dental Bandings as well as in VSM.

Metric 2. Relative Likelihood of staff being appointed from shortlisting across all posts

4.3. The metrics show that white applicants are 1.70 times more likely to be appointed from shortlisting than BME applicants. This is slightly down from the 1.73 times likelihood reported last year, however this difference is insignificant and it is unlikely this demonstrates any improvement in real-terms.

Metric 3. Relative Likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

4.4. This year's metrics demonstrate that BME staff are 1.19 times more likely to enter a formal disciplinary process than white staff. This is an increase from the likelihood reported last year where BME staff were less likely than white staff to enter the process (0.89 times).

Metric 4. Relative likelihood of staff accessing non-mandatory training and CPD

4.5. White staff are slightly more likely (1.04 times) to access non-mandatory CPD and training than BME staff. However, the difference has reduced from last year where white staff were 1.16 times more likely.

Metric 5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

2016		2017	
White	**BME**	**White**	**BME**
23.83%	24%	21.97%	23.38%

Table 2: Percentage of white and BME staff experiencing harassment, bullying or abuse from patients, relatives or the public; Staff Survey 2015 & 2016.

4.6. BME staff report slightly higher levels of bullying and harassment from patients, relatives or the public than white staff; 23.38% compared to 21.97%. For BME staff this is a slight reduction from 24% last year, however the reduction is greater for white staff who previously reported at 23.83%/

Metric 6. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

2016		2017	
White	**BME**	**White**	**BME**
23.20%	20.00%	21.07%	25.97%

Table 3: Percentage of white and BME staff experiencing harassment, bullying or abuse from staff; Staff Survey 2015 & 2016.

4.7. There has been a sharp increase in the bullying and harassment from staff reported by BME staff, with 25.97% reporting they experience this (compared with 20% for 2016). White staff report lower levels of bullying from staff at 21.07% but, unlike for BME staff, this is lower than it was previously at 23.20% in 2016.

Metric 7. Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion

2016		2017	
White	**BME**	**White**	**BME**
91.67%	76.47%	87.50%	69.81%

Table 4: Percentage of white and BME staff believing that the Trust provides equal opportunities for career progression or promotion; Staff Survey 2015 & 2016.

4.8. 69.81% of BME staff believe that the Trust provides equality opportunities for career progression. This is much lower than the perception of white staff, where 87.50% believe this to be the case. For both staff groups, there is a decrease on last year in staff believing the Trust provides equal opportunities for career progression and promotion, this decrease is greater in the BME staff group (a drop by 6.66% for BME staff and 4.17% for white staff).

Metric 8. Percentage of staff personally experienced discrimination at work from a manager, team leader or other colleague in the last 12 months

2016		2017	
White	**BME**	**White**	**BME**
6.63%	13.04%	6.25%	10.26%

Table 5: Percentage of white and BME staff experiencing discrimination at work from a manager, team leader or other colleague; Staff Survey 2015 & 2016.

4.9. The level of BME staff experience discrimination at work from their colleagues has decreased from last year by 2.78% to 10.26%. This is still higher than the levels reported by white staff at 6.25%.

Metric 9. Percentage difference between the organisations' Board voting membership and its overall workforce.

4.10. Similarly to last year, none of the Trust Board members are BME, therefore the percentage difference is 19.5%. In order for the Trust Board to be aligned to the overall workforce, there would be a requirement for 3 of its 16 members to be BME.

5. Analysis

5.1. From the metrics, it can be seen that there are areas that require improvement. Some of these were expected; for example increases in bullying and harassment as this has been noted across the Trust, not just in BME staff.

5.2. One area that was unexpected in terms of the change was Metric 3; relative likelihood of entering the formal disciplinary process. The change to BME staff being more likely to enter the formal process requires further investigation as at this point the cause is not fully understood, so it is difficult to take suitable action. One possible explanation could be the introduction of the new case tracker has enabled us to better capture and record those in formal proceedings, therefore enabling more accurate figures and highlighting an already existing, but previously unknown, problem. Action will be taken to further investigate this to understand root causes over 2017/18.

5.3. Whilst there are some clear areas for improvement with regard to bullying and harassment, this is an area for improvement for the Trust as a whole. There are currently a number of initiatives in place in an effort to reduce overall levels of bullying and harassment. This includes:

- 5.3.1. a refresh of the bullying and harassment procedure;
- 5.3.2. a refresh of the bullying and harassment support colleague scheme;
- 5.3.3. introduction of the Freedom to Speak Up Guardian role who will support the Bullying and Harassment agenda;
- 5.3.4. a Values into Action Conference to engage senior staff with the topic;
- 5.3.5. a Trust-wide audit into current practice with regard to bullying and harassment.

5.4. Work is already taking place with regard to bullying and harassment, therefore specific work as a result of this report will not be considered for the upcoming year to allow us to see the impact of the planned interventions. Equality and Diversity has been considered as part of these interventions however, and it is anticipated that this will have a positive impact on WRES metrics in the future.

5.5. Considering the above, this report, and accompanying action plan, will primarily focus on recruitment and career development and promotion of BME staff; relating to metrics 1, 2, 4 and 7. By narrowing the Trust's focus onto these areas it will enable the Trust to better allocate resource into addressing the root causes on inequalities in these areas thereby allowing any action taken to have a stronger impact. This approach to WRES is recommended by Roger Kline (NHS England, WRES Implementation Team). Of course, action taken to address this area will likely have an impact on other areas of inequality through increased awareness and increased engagement of BME staff.

Recruitment

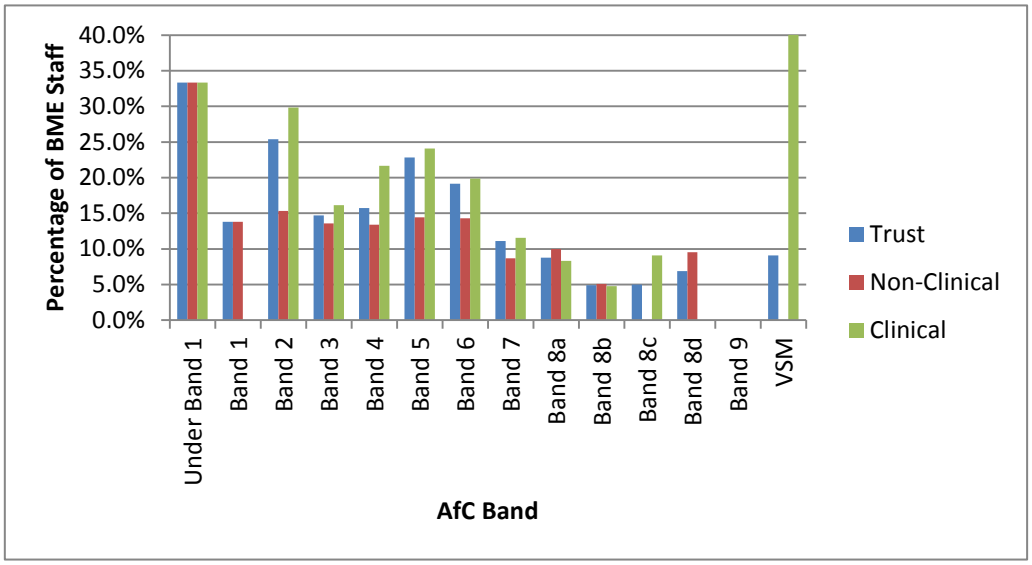

Figure 1. Percentage of BME Staff at each of the Agenda for Change Pay Bands – including comparison between clinical and non-clinical roles.[1]

5.6. First of all, analysis was undertaken to understand the distribution or BME staff across the organisation (Metric 1). Looking at Figure 1, it can clearly be seen that generally there is a great proportion of BME staff within the lower bands, with the percentage of BME staff decreasing at Band 7 and above. A lack of representation at senior levels within organisations is a well-documented phenomenon.[2] This is likely due to issues surrounding recruitment and career development which are further discussed later in the report.

5.7. There is quite a large difference between percentages of BME staff in clinical and non-clinical positions. BME staff are much better represented within clinical roles, which is not unexpected, with the Trust increasingly looking to countries such as the Philippines to fill nursing and medical roles. However, even with better overall representation the trend of representation decreasing as the AfC band increases is still present (although the percentage of BME Staff in clinical VSM roles is 100%, it should be noted this is only 2 people and statistically insignificant).

5.8. Further exploration of the peaks at Bands 2 and 5 shows that these are attributed to BME Staff in clinical roles; Healthcare Assistants at Band 2 and the aforementioned Nurses at Band 5. In general, clinical roles have a higher proportion of BME staff than non-clinical roles. These peaks are seen across the NHS as a whole as seen in the 2016 National Data Analysis Report for WRES, and this is not an issue only experienced by OUH.

[1] The percentage for VSM (Clinical) is 100%; however this is not fully shown to allow the rest of the data to be easily seen.

[2] Kline, Roger. (2014) *The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England.*

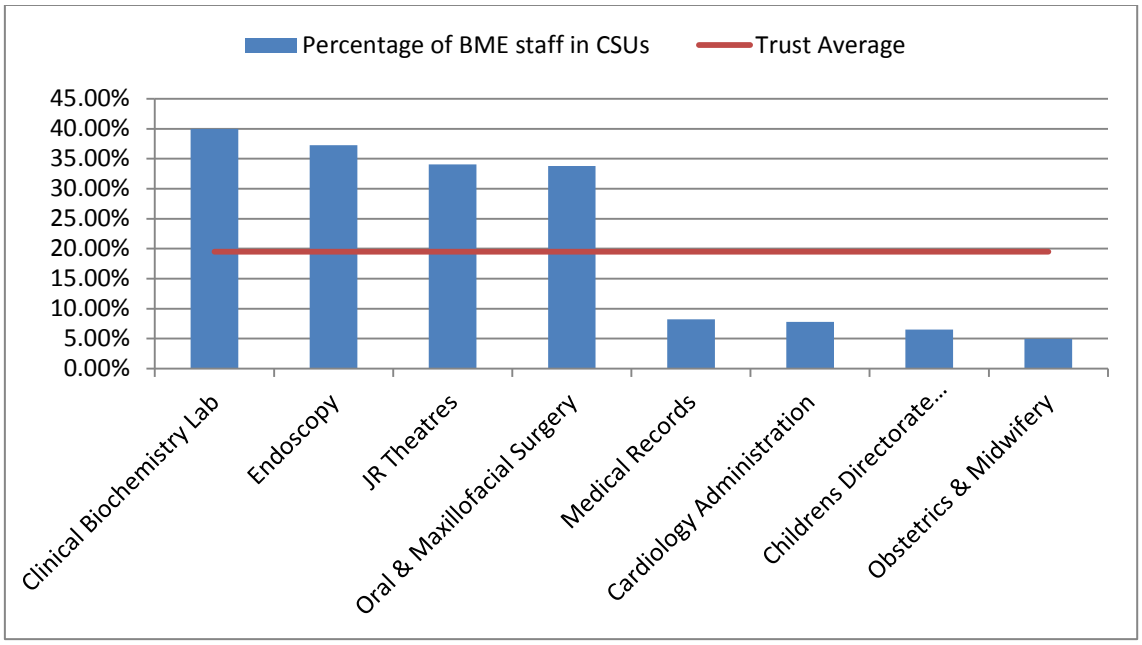

Figure 2. Percentage of BME Staff in CSUs (with minimum 50 staff) with highest and lowest proportions of BME staff. Trust average is 19.5%.

5.9. Distribution across the Trust was also explored in terms of areas of work. When looking at CSUs there is quite a large range of BME staff with areas being made up from 4.9% to 40%.[3] With a range this large, it suggests there is an inconsistency across CSUs in terms of recruitment of BME staff which should be investigated. Exploration of CSUs with both proportionally higher and lower BME representation should be undertaken in order to understand why some areas have lower representation than others and what can be done to remedy this. It will also allow understanding of why areas have stronger representation with possibility of sharing best practice across the Trust.

5.10. Currently the Trust reports on the distribution of BME Staff across the Trust on an annual basis. Whilst this helps to provide an idea of what is happening within the Trust, the long period between reporting means that there is a delay in taking action where there are issues, which may allow some problems to become further embedded into the Trust. It is suggested that reporting on recruitment and distribution of BME staff is done quarterly at the Trusts EDI Steering Group. This reporting should be broken down by pay band and CSU to better allow for trends to be identified and also better enable a continuous process of accountability which will be necessary to fully embed the outcomes of WRES 2017.

5.11. When looking at Metric 2, there is a clear level of inequality for BME staff. When exploring reasons for this disparity, research would suggest unconscious bias is a factor. Unconscious Bias is naturally occurring bias, created on the basis of experiences that can potentially lead to people treat some groups or individuals more favourably than others based on characteristics that they hold. Unconscious bias can be much stronger in situations such as interviews where little might be known about the candidate so people rely on bias to fill in the gaps[4]. With people tending to favour

[3] Range was calculated using CSUs with a minimum of 50 staff to limit statistical anomalies.
[4] CIPD (2015) *A Head for Hiring: The behavioural science of recruitment and selection*

those who are similar to themselves, and the Trust having a predominately white workforce, unconscious bias could be preventing BME people from being successful in the recruitment process.

5.12. There is currently no recruitment training for recruiting managers. This means that recruitment practice is likely to be inconsistent across the Trust and this is another way in which unconscious bias can creep into decision making. In order to mitigate this, the Trust needs to develop training for recruiting managers that sets out clear expectations of these managers. The training should cover from when a position becomes available to induction of the new member of staff, covering equality and diversity considerations and highlighting the behaviours the Trust's wishes its recruiting managers to exhibit.

5.13. A recommendation in the long term should be to introduce this training as a mandatory requirement for all recruiting managers; in so far as interview panels will have to consist of at least one trained person. This will allow for greater consistency across the Trust.

5.14. Furthermore, another way to reduce bias is to encourage recruiting managers to ensure decisions are based on facts and not on 'gut instinct'. Research shows that when having to justify decisions on appointments to a senior manager or higher authority they are more likely to undertake a thorough and complex thought process, thereby helping to reduce bias.[5] It is suggested that the Trust adopts this in requiring managers to give written justification for why they have decided to appoint an individual which will have to be seen by their senior and then sent to the central recruitment team for monitoring and auditing purposes. This recommendation could potentially be considered quite onerous, so could initially be trialled in more senior pay bands before potentially being rolled out across the Trust.

5.15. Another possible intervention that has worked in other Trusts is the inclusion of an independent member to the interview panel as an observer to encourage accountability.[6] Research suggests that their presence affects the expectations of others and it is likely to reduce people's tendency to rely on stereotypes as cognitive shortcuts.[7] As with the previous recommendation, it might be difficult to implement, especially as it would require an extra person to be present at all interviews; therefore this should be done for Band 8a posts and above where representation of BME staff is at its poorest.

5.16. Both research and consultation with BME staff has highlighted the diversity of interview panels as a potential barrier. Evidence from the LiA suggested that increasing diversity on interview panels could potentially put BME candidates at ease allowing them to perform better. In addition having a diverse range of viewpoints on the panel will help to mitigate any unconscious bias. Whilst it would be impossible for the Trust to set strict rules for the make-up of interview panels, guidance can be

[5] Devine, P. et all (2002) *The regulation of implicit and explicit race bias: The role of motivations to respond without prejudice*. Journal of Personality and Social Psychology, 82, 835-848

[6] WRES Implementation Team (2017) *NHS Workforce Race Equality Standard: 2016 Data Analysis Report for NHS Trusts*. NHS Equality and Diversity Council

[7] Philis, K. & Lloyd, D. (2006) *When surface and deep-level diversity collide: The effect of dissenting group members.* Organisational Behaviour and Human Decision Process, 99, 143-160

created and given to recruiting managers on best-practice where it is encouraged that panels are made up of multiple people from differing areas to offer differing perspectives.

5.17. An initial way in which diversity on panels can be introduced easily is through the interviewers for the Values Based Interviews (VBIs); as this pool is centralised it would be much easier to increase diversity in this way. Currently information regarding the diversity of those who are trained to carry out a VBI is not collected, so it is recommended that this is done to enable the Trust to actively increase the diversity of the interviewer pool which would then lead to increased diversity on interview panels.

5.18. In addition to likelihood of appointment from shortlisting, relative likelihood of being shortlisted was also investigated as a potential barrier to entry. This shows that white applicants are overall 1.37 times more likely to be shortlisted than BME staff. As with the disparities at appointment, unconscious bias could also be a factor here, as some applications may have information that implies that they hold certain protected characteristics. Whilst the Trust removes names from applications, information such as names of Universities or school attended, and membership of certain organisations can potentially create biases towards or against candidates.[8] It should be investigated as to whether these can be removed.

5.19. It is also recommended that further research is done on applications to the Trust, examining a sample of them to determine other potential reasons that this disparity might exist and whether it requires further changes to the Trust's shortlisting procedures. If it is identified that there are issues concerning the quality of applications from BME applicants, the Trust could potentially consider positive actions through a series of recruitment workshops open to the local community discussing effective application writing.

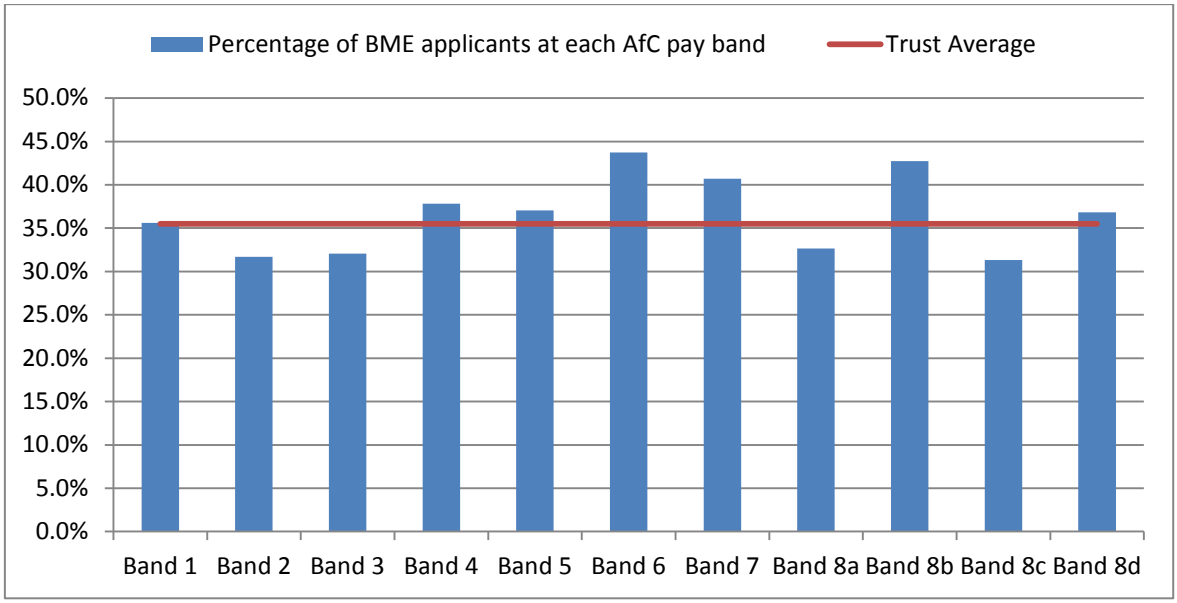

Figure 3. Percentage of BME applicants applying to roles at the Trust within each AfC Pay Band. Trust average is 35.5%.

[8] CIPD (2015) *A Head for Hiring: The behavioural science of recruitment and selection*

5.20. The number of applications made to the Trust was also analysed; Figure 3. It showed that 35.5% of all applications to the Trust were made by BME applicants; this figure is proportionately higher than the Oxford and Oxfordshire BME population figures (22% and 9.15% respectively[9]). Breaking this down further into applications by pay band shows that the proportion of BME applicants to all bands remains high with the lowest percentage seen at Band 3 (31.7%) and the highest at Band 6 (43.7%). The higher proportion of applications at Band 6 could be linked to an issue highlighted in last years' WRES submission: difficulty of Band 5 nurses progressing to Band 6. A high number, combined with lower likelihood could indicate that this remains an issue.

5.21. From this, it can be determined that the Trust is relatively effective in advertising positions and reaching a diverse applicant pool and therefore for the time being, no action needs to be taken against this. Having said this, it should be noted that some people may have applied to the Trust multiple times and may be counted more than once in these figures. It should also be noted that these figures do not cover very senior management roles so there could potentially be issues here which would have to be investigated further.

5.22. When breaking down the data for shortlisting and appointment likelihood by pay band, it can be seen that the poorest performing bands are Band 5 and Band 6. This is surprising given that Band 5 has the highest proportion of BME Staff within the Trust. At this stage, little explanation can be given for this phenomenon, and further exploration will have to be done here. It is suggested that this be broken down by internal and external applicants and by clinical and non-clinical roles to determine whether there is any difference here. It might also be worth breaking this down into divisions and departments to see whether there are any areas of the Trust that require improvement.

5.23. The Trust should be continuously looking to improve its recruitment practice. The CIPD Head for Hiring Report[10] recommends that organisations request feedback from candidates about their experience of the recruitment process on an ongoing basis. The Trust could develop an online questionnaire in order to do this and also capture protected characteristics of applicants to ensure fair and equal experience for different groups.

Career Development and Promotion

5.24. When trying to determine the reasoning for the disparity in Metric 7, consultation with the Race Equality Action Group and the Listening into Action Event brought forward potential explanations through the experiences of BME staff. BME staff spoke about perceptions of favouritism when development opportunities arise; one example was given where a manager would frequently favour a white member of staff when development opportunities arose, such as acting up. So when a position became available to progress within the Trust that person had an advantage. Another example given was where managers would often tell members of staff about opportunities before they were actually advertised, thereby giving certain candidates

[9] Figures from the 2011 National Census
[10] CIPD (2015) *A Head for Hiring: The behavioural science of recruitment and selection*

an advantage. BME staff say instances like this make them less inclined to go for opportunities as they do not want to waste energy on going for positions where a decision appears to have already been made.

5.25. Whilst issues of favouritism are difficult to evidence, let alone tackle, there are some ways in which greater fairness and transparency can be introduced. With the aforementioned recruitment training covering from when a position opens, issues around letting staff know positions are opening before formal advertisement can potentially be addressed.

5.26. Furthermore, by encouraging managers to give justifications as to who takes on acting up responsibilities it can help ensure that these decisions are not made on a biased basis and opportunities are distributed fairly. Amending the Trust's Secondment Procedure to include Acting up will help improve equal access to this. The amendments should include mechanisms for monitoring because, as highlighted in the 2016 National WRES Report, "is it essential access is monitored to avoid discriminatory practice". The Equality Impact Assessment for this procedure must also be updated following the changes to ensure no unfair treatment. The Trust could also introduce formal arrangements around shadowing as this is another development opportunity that could be access disproportionally by different groups and is not currently monitored.

5.27. As well as ensuring that processes are fair, the Trust should also take steps to build trust with BME staff, demonstrating the extent to which it values its BME staff and hopes to see them succeed. Discussions with Divisional Practice Development and Education Leads have highlighted some areas of good practice across the Trust where BME staff have been helped by the Trust to develop their skills and advance through the organisation. The Trust should highlight this good practice and use these case studies to show this is how the Trust expects BME (and all) staff to be treated and demonstrate to BME staff that the Trust has a keen interest in their development and progression.

5.28. Despite metric 4 showing BME staff are just as likely to access non-mandatory training than white staff, there is a potential issue with accuracy. The data for this metric is pulled from the Trust's electronic learning management system (eLMS), and some non-mandatory training is arranged at a local level by managers such as: external courses, conferences, study leave and mentoring, and is often not recorded. Therefore, it is difficult to say whether BME staff do have equal access to non-mandatory CPD. It would be helpful for these figures to be included to ensure accuracy of reporting and it is therefore recommended that monitoring mechanisms are created for this across the Trust; this will enable the Trust to ensure this is accessed fairly by all staff.

5.29. Following on from the monitoring of staff members utilising external training; feedback from the LiA suggests that many staff do not know about these opportunities and that people don't access them due to this lack of awareness. Whilst training opportunities do get circulated, this is often done inconsistently and could mean many people are unaware of them. Establishing a method for circulating this information effectively would help to alleviate this issue. Consultation should take place with relevant stakeholders to enable this to happen.

5.30. eLMS was also given as a potential barrier to accessing training as many feel it is not user-friendly; however this is an issue already recognised within the Trust and steps are being taken to address outside the context of this paper

5.31. Whilst the data above currently shows little difference in access to non-mandatory training, feedback from BME staff and the Race Equality Action Group suggest that there may be some disparity. For example; a series of interview skills workshops, run primarily to address issues identified last year around progression of Band 5 BME nurses, was poorly attended by BME staff and ended up disproportionately being attend by white staff. In addition, the Trust's Leadership and Management Course, introduced this year, has had poor attendance from BME staff. This could be down to previously discussed issues around lack of awareness however more needs to be done to fully understand why this might be happening. Further consultation with BME staff, especially by going into areas where BME staff work to enable better engagement, should be carried out.

5.32. The Trust might also wish to consider positive action. [11] Taking this approach will allow the Trust to demonstrate its commitment to the development of BME staff. A possible approach could be to have protected spaces on the Leadership and Management Training that will be held for BME staff, to ensure fair representation on that course.

5.33. Another positive action approach that would directly enable development of BME staff would be a mentoring programme. This would involve BME staff mentoring other BME staff of lower bands. This approach would allow for the career development of BME staff across the Trust, whilst also highlighting BME role models within the Trust; highlighting diverse role models has been shown to improve outcomes for staff that share a protected characteristic.[12]

Communication

5.34. In addition to introducing work to mitigate the impact of recognised disparities, consideration will also need to be given to how this work is communicated.

5.35. Communications need to be well-considered. It is vital that they aid understanding of White Staff as to why measures are being introduced and how it will benefit them. Also, ensuring that the Trust properly communicates with BME staff and demonstrates how it is holding ourselves as an organisation accountable in order to build trust with them and enable them to feel comfortable applying for development opportunities and promotion. Communications need to demonstrate the Trust takes this issue seriously and senior staff have a key role to play in ensuring this.

5.36. Work that is currently planned as part of the Trust's Equality, Diversity and Inclusion Action Plan 2017/18 will provide useful mechanisms for the communication of WRES and outcomes from it. The creation of a brand in line with NHS Employers Personal, Fair and Diverse campaign will allow for messages to be easily circulated throughout

[11] Positive action is defined in the Equality Act 2010 as actions that can be lawfully taken to enable disadvantaged groups access work or training.
[12] Stonewall (2012) *Role Models, Being Yourself: Sexual Orientation and the Workplace*

the Trust. In addition, by designating a Board Member as a Race Equality Champion for the Trust this will help to demonstrate commitment at a senior level and improve Board level engagement.

Analysis summary

5.37. Analysis of the WRES metrics has brought up a number of findings which can be summarised as follows:

- 5.37.1. Distribution of BME staff across the Trust is uneven both horizontally and vertically. The lack of BME representation in senior levels of the Trust is especially noticeable.
- 5.37.2. There is potential for unconscious bias to have a large impact through the recruitment process.
- 5.37.3. There is a lack of trust from BME staff when it comes to career development and promotion.
- 5.37.4. External career development opportunities are not effectively communicated or monitored.

5.38. Recommendations have been suggested to mitigate the findings of the analysis and these have been translated into an action plan: Appendix 1.

5.39. Considering the current financial situation, recommendations given have been thought out in terms of cost implications and feasibility of implementation.

5.40. This report has also highlighted areas for further investigation and research, which have not been able to be undertaken under the time constraints for this report. This research will enable better understanding of root causes to some issues, or may uncover issues that are currently unknown. These areas of research will be included within the Action Plan for the coming year and will form part of the 2018 WRES Report.

6. Workforce Race Equality Action Plan September 2017 – August 2018

6.1. Following analysis of the Trust's data and potential solutions that have been highlighted through discussions with relevant stakeholders, a high-level action plan has been created for the period, September 2017 – August 2018. This action plan can be found in **Appendix 1**.

6.2. This action plan details the key actions and campaigns that will be undertaken in order to improve Workforce Race Equality for the forthcoming year. Some actions within the plan will potentially highlight further actions that can be taken. As such, it should be recognised that the action plan is a live document that will be updated as new information comes to light or in line with best practice.

6.3. The Trust Board is ultimately responsible in ensuring that this action plan is completed and progress towards it will be reported at 6 month intervals within the Trust's EDI Progress Report (January 2018) and EDI Annual Report (July 2018). Progress against the Action Plan will also be reported to the Trust's Equality, Diversity and Inclusion Steering Group every two months.

7. Recommendation

7.1. The Trust Board is asked to note and accept this report and the accompanying action plan.

7.2. The Trust Board is asked to publish this report and accompanying action plan in the public domain via the Trust's external website.

Lead Author

Susan Young, Interim Director of Workforce

Main Contributors

Tommy Snipe, Workforce Equality, Diversity and Inclusion Lead

Board Lead

John Drew, Director of Improvement and Culture

September 2017

Appendix 1: Workforce Race Equality Action Plan September 2017 to August 2018

The following is a high-level action plan detailing key actions, campaigns and work that will be undertaken across the Trust over 2017/18. These actions will be incorporated into the Trust's EDI Action Plan.

Action	Relationship to Metric	Lead	Due	Success Measure
Investigate disciplinary findings to understand root causes.	WRES 3	Workforce EDI Lead	June 2018	Analysis has been undertaken and actions identified to mitigate root causes.
Analyse the impact of currently planned interventions around bullying and harassment on levels of bullying experience by BME staff.	WRES 5, 6 & 8	Workforce EDI Lead	June 2018	Analysis has been undertaken and
Explore CSUs with the highest and lowest proportions of BME staff to understand what issues there might be and potentially identify and share good practice.	WRES 1	Workforce EDI Lead	January 2018	CSUs have been explored and findings reported to EDI Steering Group.
Report distribution of BME staff across the Trust by pay band, CSU and job role on a quarterly basis to enable accountability and trend identification.	WRES 1	Workforce EDI Lead & Workforce Information Team	October 2017, January 2018, April 2018, July 2018	Reports have been created and analysed. Any areas for improvement have been identified and actions created to support this.
Reintroduce training for recruiting managers – this will cover from when a position opens to induction and will cover aspects of equality and unconscious bias throughout.	WRES 1 & 2	Workforce EDI Lead & Recruitment Manager	January 2018	Training has been created. Minimum of 100 managers to have been trained by July 2018.
Consider requirement for recruiting managers to give written justification for hiring decision.	WRES 1 & 2	Recruitment Manager	December 2017	Possibility has been investigated and decision as to whether it can be implemented made.

Introduce an independent observer at interviews for posts Band 8a and above to encourage accountability.	WRES 1 & 2	Deputy Director of Workforce	February 2018	Pool of potential observers identified and given appropriate training. All Band 8a and above interviews containing an observer.
Produce guidance for recruiting managers on the make-up of interview panels.	WRES 1 & 2	Recruitment Manager	February 2018	Guidance created and circulated.
Monitor the diversity of the pool of Values Based Interviewers with a view to increase diversity if gaps are identified.	WRES 1 & 2	Organisational Development Team	November 2017	Diversity of the pool is representative of the rest of the Trust.
Investigate the possibility of removing information from applications that might create biases towards or against candidates.	WRES 1 & 2	Recruitment Manager	January 2018	Possibility investigated and if possible actions taken to implement.
Investigate a sample of applications to the Trust to determine other potential reasons disparities in shortlisting might exist.	WRES 1 & 2	Workforce EDI Lead & Recruitment Manager	March 2018	Analysis has been undertaken with findings presented to EDI Steering Group. Actions produced as a result.
Further research into shortlisting and appointment statistics, including a breakdown by internal and external applications.	WRES 1 & 2	Workforce EDI Lead & Workforce Information Team	April 2018	Analysis has been undertaken with findings presented to EDI Steering Group. Actions produced as a result.
Produce a feedback questionnaire for applicants to the Trust to fill out to enable the Trust to continuously improve recruitment practice.	WRES 1 & 2	Recruitment Manager	January 2018	Feedback questionnaire produced and sent to all applicants. Results analysed on a quarterly basis with actions taken depending on feedback.
Update the Trust's Secondment Procedure to include Acting up and mechanisms for monitoring access to this.	WRES 7	Workforce EDI Lead	November 2017	Procedure updated and ratified. Monitoring is analysed quarterly to ensure fair treatment.

Introduce a formal shadowing scheme.	WRES 7	Head of Corporate Services	May 2018	Scheme created. Monitoring is analysed quarterly to ensure fair treatment.
Develop case studies highlighting BME staff who have had positive experiences of career progression within the Trust.	WRES 7	Workforce EDI Lead	December 2017	Minimum of three case studies identified by end of 2017. Plans for further case studies to be produced and circulated in the future.
Develop mechanisms for monitoring access to, and promoting, external development opportunities.	WRES 4 & 7	Leadership and Development Manager	June 2018	Effective mechanisms in place and communicated to relevant stakeholders.
Further consult with BME staff across the Trust to understand fully why they might be accessing non-mandatory CPD and what training opportunities they would want to access.	WRES 4 & 7	Workforce EDI Lead & Leadership and Development Manager	February 2018	Consultation carried out with at least 100 BME staff. Actions created as a result of consultation.
Create protected spaces for BME staff on the Trust's Leadership and Management Training to ensure fair representation on the course.	WRES 4 & 7	Leadership and Development Manager	October 2017	Protected spaces created and effectively communicated. Spaces are filled on future cohorts of Leadership and Management Training.
Develop a BME mentoring programme.	WRES 4 & 7	Workforce EDI Lead & Leadership and Development Manager	May 2018	Scheme launched with minimum of 5 mentors having 2 mentees each with a view to expand the scheme in the long term.