Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Combined Equality Standards Report 2020**

Status:	**For Information**
History:	**Equality, Diversity, and Inclusion Steering Group August 2020**
	Trust Management Executive August 2020

Board Lead:	**Chief People Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The purpose of this report is to:
    - Report on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) metrics as required by the NHS Standard Contract;
    - Report on the Trust's gender pay gap as required by Gender Pay Gap (GPG) Reporting Legislation;
    - Summarise action taken since the publication of the last WRES, WDES, and GPG Reports in September 2019;
    - Provide analysis on the WRES, WDES, and GPG metrics, including potential reasons for any disparities;
    - Provide recommendations for further action.
2. The report summarises some of the action undertaken to progress on WRES, WDES and GPG. These include:
    - Supporting the development of Staff Networks and identifying Executive Sponsors for each of those Networks;
    - Identifying a new Non-Executive Director to support a refreshed Equality, Diversity, and Inclusion (EDI) Steering Group
    - Positioning the EDI Function within the Culture and Leadership service, supporting the Trust's strategic objective of developing a compassionate and inclusive culture.
    - Engaging with external organisations to support work on EDI, such as involvement in a national study on the GPG within Clinical Excellence Awards (CEAs) and a national easy-read job application pilot.
3. Key findings from the report include:
    - The Trust has made improvements on a number of WRES and WDES metrics, which is partially attributable to a greater organisational awareness of EDI;
    - Covid-19 has disproportionately impacted a number of different communities, and whilst there has been a focus on supporting BAME staff, attention also needs to be paid to disabled staff;
    - Covid-19 has also generated some opportunities for advancing EDI. This includes opportunities around increased resource on health and wellbeing and increased infrastructure to enable people to work flexibly.
4. This report has made a number of recommendations to support the Trust in the short-term, these are summarised in Appendix 4. These high-level actions were seen at a meeting of the Trust Management Executive on 27th August 2020 and

were agreed in principle. Following this, further work to develop and deliver on these high-level actions will be undertaken.

5. Findings from this report will also be used to support upcoming work on refreshing the Trust's EDI Objectives and Delivery Plan; this will incorporate a 4 year approach to addressing WRES, WDES and GPG.

Recommendations

6. The Trust Board is asked to:

   - Note the metrics for WRES, WDES, and GPG;
   - Note the recommended actions in **Appendix 4**;
   - Identify any areas of further investigation that should be considered in the delivery of the planned EDI Objective Refresh.

Contents

Combined Equality Standards Report 2020

1. Purpose

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1.1.1. Report on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) metrics as required by the NHS Standard Contract;

1.1.2. Report on the Trust's gender pay gap as required by Gender Pay Gap (GPG) Reporting Legislation;

1.1.3. Summarise action taken since the publication of the last WRES, WDES, and GPG Reports in September 2019;

1.1.4. Provide analysis on the WRES, WDES, and GPG metrics, including potential reasons for any disparities;

1.1.5. Provide recommendations for further action.

2. Background

2.1. The Trust has a number of statutory and mandatory reporting requirements relating to equality, diversity and inclusion. These include:

2.1.1. the Workforce Race Equality Standard (WRES);

2.1.2. the Workforce Disability Equality Standard (WDES); and

2.1.3. the Gender Pay Gap (GPG) Reporting.

2.2. For each of these, the Trust is required to publish against a set of metrics. WRES and WDES metrics are required to be submitted to NHS England and Improvement by 31st August 2020, and GPG metrics are required to be submitted to the Government Equalities Office by 31st March 2021.

2.3. For WRES and WDES, Trusts are then required to analyse these metrics and undertaken consultation with affected staff in order to develop actions plans to address any disparities noted in these metrics. For 2020, the publication date for WRES and WDES action plans is 31st October 2020. There is no statutory requirement for a GPG action plan, however the Trust chooses to identify actions as part of its commitment to reducing the gap.

2.4. This report details the data the Trust is required to report for each of the metrics, and provides analysis and recommendations for action.

2.5. A summary of all metrics, definitions of those metrics and the data sources used are given in the following Appendices:

2.5.1. WRES – **Appendix 1**;

2.5.2. WDES – **Appendix 2**;

2.5.3. GPG – **Appendix 3**.

2.6. Data for these metrics is accurate as of 31st March 2020 as required by the national guidance.

3. Action Taken Since 2019

3.1. This section summarises action that has been undertaken since the publication of the last WRES, WDES, and GPG reports in September 2019. The planned actions can be seen in Appendix 1 of the 2019 Equality, Diversity, and Inclusion (EDI) Annual Report.[1]

3.2. It should be noted that the advent of Covid-19 caused many of the Trust's priorities to change, including those relating to EDI. This is reflected in the actions that have been undertaken, with some planned actions having been paused or delayed due to Covid-19.

External Audits on WRES and WDES

3.3. External audits on the Trust's approach to WRES and WDES were commissioned from KPMG. The aim of these audits was to identify any concerns in relation to compliance with the Standards, and also identify potential areas that the Trust could build upon to make further progress.

3.4. Both audits found 'significant assurance with minor improvements'. The improvements identified concerned increasing the resource available to support the delivery against the Trust's EDI delivery plan.

EDI Function Move

3.5. The EDI Function was moved from the Resourcing Team to the newly-created Culture and Leadership Service. This move better enables EDI to be embedded within the Trust's cultural change initiatives, reflecting the Trust's strategic objective to create a compassionate and inclusive culture.

Staff Networks

3.6. Work has been undertaken to develop the Staff Networks and support their activities. The Black Asian and Minority Ethnic (BAME) Network in particular has seen a large amount of growth with over 150 members.

[1] OUH 2019 EDI Annual Report https://www.ouh.nhs.uk/about/trust-board/2019/november/documents/TB2019.103-equality-diversity-report.PDF

3.7. To support development, each Network now has an identified Executive Sponsor who the Networks can engage with and escalate issues to. The Executive Sponsors are as follows:

3.7.1. BAME Network – Sam Foster, Chief Nursing Officer

3.7.2. Disabled Staff Network – Eileen Walsh, Chief Assurance Officer

3.7.3. LGBT+ Network – Jason Dorsett, Chief Finance Officer

3.7.4. Women's Network – Meghana Pandit, Chief Medical Officer

3.7.5. Young Apprentices Network – Sara Randall, Chief Operating Officer

3.8. Further support is still required for the Disabled Staff Network and Women's Network to help them grow, with plans to use the success of the BAME Network as a framework to support them.

Non-Executive Director Sponsor for EDI

3.9. In addition to the Executive Sponsors for the Staff Networks, a Non-Executive Director was identified to sponsor the Trust's EDI Steering Group. Katie Kapernaros will be a core member of the EDI Steering Group and will help to ensure that EDI is championed at Board-level.

International Women's Day Event

3.10. An event was held to promote International Women's Day in March 2020. The event was sponsored by Unison and featured a talk on supporting menopause in the workplace, as well as a panel discussion with some of the Trust's female Board members who shared their career journeys.

Cultural Ambassadors

3.11. The Trust has 10 members of staff who are undergoing development to act as Cultural Ambassadors. In this role, they will provide support to disciplinary processes involving BAME staff to ensure that processes are carried out fairly.

3.12. They are not yet carrying out the role as implementation was paused during Covid-19, however it is expected that they will become active in role by the end of 2020. This is going to be relaunched as part of the Trust's Just Culture approach to employee relations cases.

Easy Read Job Applications Pilot

3.13. The Trust took part in a pilot of easy read job applications that was being run by NHS England and Improvement in Quarter 4 2019/20.

3.14. Whilst no applicants came forward to use the easy read application tool during the pilot, the Trust was able to identify a number of other barriers

for those with learning disabilities in the recruitment process which were fed back to NHS England. This included a need for further easy read resources during pre-employment checks.

3.15. The Trust still has the easy read job application available should future applicants require use of it.

Supported Traineeships

3.16. The Trust has started work with Mencap to host supported traineeships. These would be a 10-week work experience opportunity for those with learning disabilities, with an aim to support those trainees into paid employment.

3.17. Unfortunately, due to Covid-19, delivery on this work has been delayed however traineeship opportunities are now in the process of being re-identified.

Gender Pay Gaps in Clinical Excellence Awards Study

3.18. The Trust took part in a study being conducted with the Behavioural Insights Team of the Government Equality Office on the gender pay gap within Clinical Excellence Awards (CEAs). This was in response to previous Trust GPG reports identifying a large bonus pay gap, which CEAs were a contributing factor for.

3.19. The study collated CEA data from a number of Trusts over a period of five years (2014-2018) and analysed that data to understand if there were differences in application and success rates between men and women.

3.20. The study concluded that overall there wasn't any gender disparity in application and success rates for local CEAs and that difference in current awards amounts are likely down to historical differences in application rates between men and women. This means that the current gap in CEAs should work itself out over time.

3.21. The outcomes of the study were published in March 2020, just prior to Covid-19, so no current action has been planned as a result of this. It should be noted, however, that due to Covid-19 the planned 2020 CEA awards will not take place as usual with NHS Employers proposing that Trusts distribute funding equally amongst those eligible.[2] However, in recognition of the impact this will have on the bonus pay gap, due to the larger proportion of men within the eligible cohort, the Trust is currently examining if there are other options that will appropriately address the gap.

[2] https://www.nhsemployers.org/news/2020/04/local-clinical-excellence-awards-halted-in-light-of-covid19

Support During Covid-19

3.22. As it came to light in April 2020 that BAME staff were being disproportionately impacted by Covid-19, the Trust engaged with BAME staff and other stakeholders to understand some of the reasons behind the disparities and put in place measures to mitigate them.

3.23. Feedback from BAME staff was collated from various sources including the: BAME staff network, Trade Unions, Chaplaincy, local community groups and Occupational Health. Feedback was also received from specific engagement and listening events, such as those by the Freedom to Speak Up Guardians. This feedback was collated and analysed alongside other available data sources, such as Covid-related absence data from First Care.

3.24. Key themes that were identified through the collation and analysis of this feedback included:

3.24.1. Trust data on the impact of Covid-19 mirrored what was being seen nationally with an increased proportion of BAME staff taking sickness absence due to Covid-19, as compared with white staff. In addition, our four colleagues who passed away due to Covid-19 were all BAME staff. These deaths, as well as the increasing awareness of the disproportionate impact Covid-19 was having, also acted to increase anxiety amongst BAME staff.

3.24.2. Manager support for BAME staff was inconsistent, with some BAME staff feeling like they were being treated fairly and their concerns were being taken into consideration, and others feeling like managers did not have the necessary understanding to provide appropriate support. BAME staff gave examples of the disproportionate risk to themselves not being taken into account by managers to then be able to implement effective measures to support them . Cultural factors also had an impact here with some staff identifying that, within some cultures, staff may not question managerial decisions and therefore might not get the appropriate support.

3.24.3. There were cultural differences when it came to the adherence to safety measures. There were examples where overseas staff had received differing safety advice from friends and family members in their country of origin, resulting in confusion for those staff members. There were also examples where language around safety measures created confusion; an example being around ‘staying within households’ where it was observed that some overseas staff in Trust accommodation misunderstood this and therefore interacted with others within the accommodation.

3.24.4. Feedback also reflected an indirect impact of Covid-19 where measures to reduce social contact left people feeling isolated; thereby impacting their wellbeing. This was particularly true for overseas staff as well as staff belonging to cultures where social gathering is a fundamental aspect of their life.

3.24.5. BAME staff experienced barriers in accessing health and wellbeing support. This was largely influenced by cultural factors, with mental health being heavily stigmatised in some cultures, resulting in a reluctance to access support. Accessibility of support was another factor, with some staff expressing that the information was not readily available to them and that also language was a potential barrier. It was also observed that the wellbeing support put in place was not always suitable for all staff; for example food packages distributed to staff would not have been suitable for those observing Ramadan.

3.25. In order to address the above impact, the Trust undertook a number of actions which included the following:

3.25.1. Inclusion of BAME background as a potential risk factor within the Covid-19 risk assessment process to ensure that the needs of BAME staff were adequately considered. Guidance was produced by Occupational Health to support managers with undertaking the assessment. Support was also provided to managers by HR teams to embed these effectively;

3.25.2. Consistent communications across the Trust about the disproportionate impact on BAME staff to raise organisational awareness of the issue and the support that was available. The Executive Team was frequently visible on this area of work to highlight the importance of it to staff. Some recent examples include a message to celebrate Eid from the Chief People Officer and a message from the Chief Executive Officer and Chief People Officer to all staff in response to the global conversations on structural inequality;

3.25.3. Providing support to those impacted by the deaths within the Trust, for example, a Compassionate Conversation was facilitated for one of the affected teams;

3.25.4. Holding workshops with Wellbeing Leads to help them understand the potential barriers for BAME staff in accessing wellbeing support and how they could better support our diverse workforce during Covid-19;

3.25.5. Identifying BAME staff to take on the Wellbeing Lead role so that they could use their lived experience to increase access to wellbeing support for BAME colleagues;

3.25.6. Evolving the Trust's health and wellbeing offer to meet the needs of the Trust's diverse staff. An example of this was specific support to staff observing Ramadan, with juice and dates provided to staff to break their fasts, supported by Oxford Hospitals Charity;

3.25.7. Curating and producing wellbeing resources in a number of languages to increase accessibility of those resources. These resources were included in a comprehensive 'online guide to health and wellness' which brought together a number of resources into one directory enabling greater accessibility. This guide is kept up to date regularly with relevant resources, for example, it now includes a mental health and wellbeing app designed specifically for BAME communities, called 'Liberate';

3.25.8. Initiating a quality improvement project within the Trust's 'Here for Health' promotion service to improve awareness, access, and engagement for BAME staff and their families.

3.25.9. Working with external partners to identify and develop best practice to support BAME staff in the NHS. The Trust's Chief People Officer was involved as part of a regional working group to address the disparities experienced by BAME staff in the NHS.

3.26. In addition to the above action undertaken to support BAME staff during Covid-19, the Trust has been working with Oxford Hospitals Charity to put in an application to the Charities Together fund; a fund for projects looking to support groups disproportionately impacted by Covid-19.

3.27. This application was successful and the Trust is now using the funding to appoint a BAME Health and Wellbeing Lead. This role will build upon the work undertaken so far with a focus on ensuring effective Covid-19 risk assessments are taking place, and supporting the Trust to develop a culturally sensitive health and wellbeing offer.

4. Key Findings for 2020

4.1. Paragraph text. This section discusses some of the key findings in relation to the 2020 WRES, WDES and GPG metrics and the experiences of BAME staff, disabled staff, and women in the Trust.

4.2. These key findings were derived from exploration of the data, and also qualitative feedback received from the above staff groups and others that are providing support to staff, such as Wellbeing Leads and Union Representatives.

4.3. The majority of this feedback and engagement focussed on how groups were being disproportionately impacted by Covid-19, however feedback was also received on other areas which is discussed in this report.

Organisational Awareness of EDI

4.4. It can be seen that the Trust has made progress on a number of the WRES and WDES metrics, with increases in diversity across the Trust, and increases in positive scores on the Staff Survey from both BAME and Disabled staff. Whilst these gains are not consistent across the whole of the Trust, for example there is a greater proportion of BAME staff in senior clinical roles as compared with senior non-clinical roles, this trend is positive.

4.5. These improvements cannot be aligned to specific interventions undertaken, however, feedback from staff suggests that this progress is partly down to an increased organisational awareness of EDI with a number of interventions undertaken increasing the visibility and understanding of EDI-related issues within the Trust. Staff have noted increased communications relating to EDI and also increased visibility of senior staff championing it. It is felt that this has had a positive impact on organisational culture.

4.6. In addition, there has been a large amount of positive feedback on communications relating to EDI from senior staff as stated in section 3.25.2 above. The Trust should continue with this and further its visibility and engagement on a range of topics relating to EDI.

Progress against Model Employer Aspirational Goals

4.7. As part of the WRES, NHS England and Improvement set out aspirational goals for NHS Trusts to increase the representation of BAME staff within leadership positions. These goals set an ambition for BAME staff to be equally represented across all levels within the NHS by 2028. Table 1 below shows the Trust's progress against the ambition for 2020, as well as the number of BAME staff that the Trust would have to recruit to achieve equal representation by 2028.

Table 1: Oxford University Hospitals NHS Foundation Trust progress against WRES Model Employer Aspirational Goals

	2020 Ambition	2020 Actual	2020 Gap	Total BAME Staff in AfC band by 2028 to reach equity[3]	Additional BAME recruitment to 2028 to reach equity[3]
Band 8a	33	46	13	64	18
Band 8b	11	11	0	27	16
Band 8c	4	5	1	14	9
Band 8d	2	1	-1	4	3
Band 9	0	2	2	2	0
VSM	2	5	3	7	2

4.8. Table 1 shows that the Trust has made significant progress against these goals, exceeding the 2020 interim goals in most cases. It is only at Band 8d where these have not been met with a gap of 1. Particular note should be made of Band 9 and VSM where significant progress has been made, proportionate to the group size, with Band 9 already reaching the 2028 aspirational goal from NHS England and Improvement.

4.9. Through exceeding the planned trajectory, it shows that steps taken to enable greater diversity within senior positions is having a positive impact. The Trust should continue to monitor progress against these targets to ensure that BAME representation remains on course with the trajectory set out by NHS England and Improvement.

Bullying and Abuse from Patients and the Public

4.10. One area where there has been little movement in the metrics is in relation to bullying and abuse experienced from patients and the public (WRES 5 and WDES 4). For BAME staff there was no change, and there was a 2.1% increase in disabled staff experiencing it. This is the opposite of what is observed with bullying and harassment from other sources, such as colleagues and managers, where there has been a positive decrease in staff experiencing this.

4.11. In discussion with staff it was felt that, whilst it is difficult to prevent this abuse from happening in the first place, there is no clear approach to

[3] Note: By 2028 this figure may have changed

address issues of bullying or abuse; this is particularly true when abuse is discriminatory in nature.

4.12. The Trust does have a Conflict Management Policy which covers issues such as this, however awareness of this policy is not consistent across the Trust. In addition, staff feedback suggests that managers require further support in how they can adequately support staff in these circumstances. Promotion of the Conflict Management Policy and associated support should be considered by the Trust; whilst this will not necessarily reduce the level of abuse from patients and the public, it will aid in improving outcomes for staff that experience it.

Disproportionate Impact of Covid-19

4.13. The work that has been undertaken so far on supporting disproportionately impacted groups through Covid-19 has primarily been focussed on BAME staff, and whilst there is a clear plan of action to further support the health and wellbeing of BAME staff, there has not been the same focus on other disproportionately impacted groups such as disabled staff. There has been a large amount of helpful feedback from disabled staff on the ways that Covid-19 has impacted them.

4.14. One issue concerned changes made to processes and ways of working that had disproportionately impacted disabled staff. An example was the change to only phone appointments to access the Centre of Occupational Health and Wellbeing (COHWB). Whilst this has now been resolved, in the period that this change was active, staff with an impairment limiting their ability to use a phone had difficulty accessing support from COHWB.

4.15. Another issue was raised by staff who were shielding. There is a much higher proportion of disabled staff amongst those who were shielding and whilst HR teams conducted check-ins with staff who were shielding, there was a feeling of being disconnected from the team. This is becoming a lesser issue as restrictions ease, however consideration should be given in preparations for potential future waves.

4.16. To mitigate against this, the Wellbeing Leads, that have been set up in response to Covid-19, provide an excellent opportunity to keep people connected to teams they are part of as they are part of the teams themselves.

4.17. These issues also highlight a potential need to ensure that equality-related considerations are taken with any changes to processes or services. The Trust has an Equality Impact Assessment Procedure which states that they should be completed for any new, or change to an existing, policy, service, or function. It is understandable that in the immediate aftermath of Covid-19 that this might not necessarily have been done, but the Trust

should consider how this can be embedded in emergency planning processes to ensure that groups who might be disproportionately impacted by necessary changes to services can have support put in place to mitigate or limit the impact.

Opportunities from Covid-19

4.18. Covid-19 has also resulted in a number of beneficial changes for particular staff groups.

4.19. One opportunity is in relation to flexible working. Due to the social distancing measures, there has been a large increase in the number of staff working from home or working flexibly. This has a positive impact for many staff groups including women, who are more likely to have caring responsibilities outside of the workplace, and disabled staff, where flexible working may be part of reasonable adjustments required for them to excel in the workplace.

4.20. In addition, it should be noted that the NHS People Plan 2020/21 has recognised that being able to work flexibly is crucial for retaining all talent, with a commitment for all job roles across NHS England and Improvement to be advertised as being available for flexible working patterns.[4]

4.21. The Trust should consider how it can build upon what has been put in place as a result of Covid-19 to enable greater flexible working opportunities for both new and existing staff.

4.22. The increased focus on staff wellbeing has positively supported the EDI agenda on which the trust can build. Some work to leverage this is already underway and is discussed under action taken (see paragraph 3.22).

4.23. The Trust's new approach to 'Leading with Care' will embed wellbeing as a core leadership behaviour. Leaders will be the principle wellbeing lead for their team, retaining accountability for and role-modelling of 'leading with care' with delegation opportunities to identify additional Wellbeing Leads within a team depending on the team's composition e.g. size, geography. Leaders will be supported with development in this role which will embed inclusion-focussed interventions for wellbeing.

4.24. One example of inclusion-focussed interventions this is the Disability Passport Procedure. This procedure was created in response to previous WDES reports and provides a framework for managers and disabled staff to discuss support needs in the workplace, facilitating a consistent approach across the Trust. Whilst there has been positive feedback from those who have used this procedure, awareness of the procedure and how

[4] NHS People Plan 2020/21: https://www.england.nhs.uk/ournhspeople/online-version/looking-after-our-people/support-during-covid/

to use it is still relatively narrow – the wellbeing leads will provide a more effective way to disseminate this, as well as other tools to support staff wellbeing.

Analysis within Umbrella Groups

4.25. Discussion with the BAME Staff Network has highlighted the importance of not only analysing the race disparities between BAME and White groups, but to also look at the groups within them. BAME is a helpful umbrella term that groups together non-white ethnic groups as there will be some similarities in their experience. However when the focus is on analysing their experience as a homogenous group the Trust runs the risk of not identifying issues and experiences that are specific to groups within that.

4.26. When looking at the 2019 Staff Survey results, the importance of looking at the experience of different groups within the BAME umbrella can be clearly seen. For example, when looking at WRES Metric 5, experienced bullying or abuse from patients and/or members of the public, there are vast differences with 20% of Indian staff saying they experienced it compared to 35% of staff identifying with 'any other Asian background'.

4.27. This is not only restricted to groups within the BAME umbrella, for example it can also be seen when disaggregating the 'White' group with groups such as 'White Other' who report experiencing bullying and abuse from patients and/or members of the public at a higher rate (32%) than 'White British' staff (25%).

4.28. As there are such large differences within these groups, by designing interventions that only consider umbrella groups, the Trust risks not designing interventions that are effective for everybody within the umbrella group; this may limit progress.

4.29. Disability is another area where this is likely to apply and it should be considered here also. However, disclosure on disability is still an area of improvement for the Trust with the Electronic Staff Record (ESR) only currently having capability to capture broad disability categories such as physical impairment or learning disability. There is further activity required to improve data quality before disaggregating the data in this way will be meaningful.

4.30. The Trust should also consider its use of umbrella terms and reporting by umbrella groups; for example, by breaking down BAME into different ethnic groups for reporting. This will provide a clearer idea of staff experience to enable more relevant and targeted action. This approach will be used to inform the refresh of the EDI Objectives and Delivery Plan in 2020/21.

5. Conclusion and Next Steps

5.1. The Trust has made a number of improvements across the WRES and WDES metrics as compared with last year. Although these cannot be directly attributed to specific interventions, it is apparent that there is an increased understanding and awareness of EDI within the Trust which is likely to be having a positive impact.

5.2. A number of recommendations have been made focussing on addressing the disproportionate impact Covid-19 is having on different communities; particularly on disabled and BAME staff. This includes positioning the Trust to mitigate further impact on these communities should there be a second wave.

5.3. These recommendations also ask the Trust to consider how it can build upon the positive outcomes from Covid-19 in order to further advance equality for staff. For example, through building upon the changes made to the Trust's digital infrastructure to enable further flexibility for staff working arrangements.

5.4. A summary of the recommended high-level actions is included in **Appendix 4**. These high-level actions were seen at a meeting of the Trust Management Executive on 27th August 2020 and were agreed in principle. Following this, further work to develop and deliver on these high-level actions will be undertaken.

5.5. In the long-term, further improvement on WRES, WDES and the GPG will be considered as part of the upcoming refresh of the Trust's EDI Objectives and Delivery Plan. This work will consider how the Trust can facilitate divisions and directorates to take further local action on EDI, enabling accelerated improvements. Originally this work was intended to be delivered by November 2020. However it has been paused during Covid-19 and now requires a revised timeline to be agreed by the Trust.

6. Recommendations

6.1. The Trust Board is asked to:

6.1.1. Note the metrics for WRES, WDES, and GPG;

6.1.2. Note the recommended actions in Appendix 4;

6.1.3. Identify any areas of further investigation that should be considered in the delivery of the planned EDI Objective Refresh.

7. Appendix 1: Workforce Race Equality Standard Metrics

Definitions and Data Sources for WRES Metrics

	Metric	Data Source
1	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-Clinical staff • Clinical staff - of which - Non-Medical staff - Medical and Dental staff *Note*: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.	ESR
2	Relative likelihood of staff being appointed from shortlisting across all posts *Note*: This refers to both external and internal posts	TRAC
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation *Note*: This indicator will be based on data from a two year rolling average of the current year and the previous year	ER Case Tracker
4	Relative likelihood of staff accessing non-mandatory training and CPD	ELMS
5	Percentage of BAME staff compared to white staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	NHS Staff Survey Q13
6	Percentage of BAME staff compared to white staff experiencing harassment, bullying or abuse from staff in last 12 months	NHS Staff Survey Q13
7	Percentage BAME staff compared to white staff believing that trust provides equal opportunities for career progression or promotion	NHS Staff Survey Q14
8	Percentage of BAME staff compared to white staff who have personally experienced discrimination at work from a manager/team leader or other colleague in the last 12 months	NHS Staff Survey Q15
9	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board *Note*: this is an amended version of the previous definition of Indicator 9	ESR

Metric 1. Percentage of BAME 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

	2019	2020	Difference	2020 BAME Headcount

Non-Clinical	**14.92%**	**16.18%**	**1.26%**	521
Under Band 1	9.52%	21.74%	12.22%	5
Band 1	0.00%	10.00%	10.00%	<5
Band 2	17.72%	17.97%	0.25%	76
Band 3	15.06%	17.21%	2.15%	117
Band 4	14.98%	17.13%	2.15%	136
Band 5	16.97%	18.03%	1.06%	77
Band 6	16.85%	15.08%	-1.77%	49
Band 7	10.81%	13.62%	2.81%	32
Band 8a	11.61%	11.38%	-0.23%	14
Band 8b	11.29%	8.70%	-2.59%	6
Band 8c	5.26%	5.00%	-0.26%	<5
Band 8d	5.00%	4.76%	-0.24%	<5
Band 9	0.00%	8.33%	8.33%	<5
VSM	11.11%	11.54%	0.43%	<5
Clinical	**20.86%**	**23.48%**	**2.62%**	1909
Under Band 1	0.00%	12.50%	12.50%	<5
Band 1	25.00%	0.00%	-25.00%	0
Band 2	29.08%	28.97%	-0.11%	261
Band 3	19.37%	22.71%	3.34%	211
Band 4	20.68%	22.19%	1.51%	85
Band 5	24.77%	32.38%	7.61%	647
Band 6	21.25%	22.95%	1.70%	509
Band 7	11.71%	12.61%	0.90%	153
Band 8a	9.23%	10.74%	1.51%	32
Band 8b	5.00%	4.50%	-0.50%	5
Band 8c	2.44%	5.77%	3.33%	<5
Band 8d	11.11%	0.00%	-11.11%	0
Band 9	0.00%	0.00%	0.00%	0
VSM	11.11%	66.67%	55.56%	<5
Medical and Dental	**28.12%**	**28.86%**	**0.74%**	622
Consultants	22.69%	23.31%	0.62%	221
Non-Consultant Career Grade	28.43%	30.77%	2.34%	24
Trainee Grade	32.54%	33.39%	0.85%	377
Trust Total	**20.69%**	**22.60%**	**1.91%**	3052

7.1. Overall there has been a 1.91% increase in the proportion of BAME staff within the Trust. In terms of headcount, there are 421 more BAME staff working in the Trust when compared to the previous year.

7.2. Whilst there has been an increase in proportion of BAME staff within each of the staff role types, the greatest increase is amongst Clinical staff.

7.3. When comparing the proportion of BAME staff within each Band against the Trust average, it can be seen that for both Clinical and Non-Clinical roles the proportion of BAME staff generally deviates further from the Trust average as seniority increases. This is a potential indicator that there are barriers for BAME staff progressing within the organisation.

7.4. In Medical and Dental roles, there has been an increased proportion of BAME staff, particularly in non-consultant career grade roles.

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

	2019	2020	Difference
Relative Likelihood	1.66	1.55	-0.11

7.5. White applicants are 1.55 times more likely to be appointed from shortlisting when compared to BAME applicants; this is a slight positive decrease from last year.

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

	2019	2019	Difference
Relative Likelihood	1.37	1.23	-0.14

7.6. BAME staff are 1.23 times more likely to enter a disciplinary process; this is a positive decrease from last year.

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

	2020
Relative Likelihood	1.03

7.7. This metric shows BAME staff are slightly less likely to access non-mandatory training than White staff.

7.8. A comparison has not been given to the previous year has not been given for this metric due to a change in how it has been calculated. For this year, this metric has been calculated using only classroom sessions listed on the electronic learning management system (ELMS), and excluding e-learning packages. It was felt that this would enable the Trust to bring greater focus on some of the barriers BAME staff may have in accessing taught training during work time - less likely to exist with e-learning.

7.9. It should be noted however, even with these changes, there are still issues in the accuracy of this metric as ELMS does not currently capture all learning and training opportunities that staff may access (for example courses provided by the local Leadership Academy).

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

	2019	2020	Difference
White	26.60%	25.80%	-0.80%
BAME	26.40%	26.40%	0.00%

7.10. There has been no change in BAME staff experiencing bullying and harassment from patients, relatives or the public, although there has been a slight decrease for White staff. This decrease brings the proportion of White staff experiencing this below that of BAME staff.

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

	2019	2020	Difference
White	27.90%	26.80%	-1.10%
BAME	31.90%	28.80%	-3.10%

7.11. This metric shows a reduction in staff experiencing bullying, harassment, or abuse from other staff for both White and BAME staff. This reduction is greater for BAME staff, however BAME staff still experience it to a greater extent than White staff.

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

	2019	2020	Difference
White	83.80%	88.30%	4.50%
BAME	71.70%	75.90%	4.20%

7.12. The percentage of both BAME and White staff believing that the Trust provides equal opportunities for career progression or promotion has

increased. BAME staff are less likely than White staff to believe this though.

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

	2019	2020	Difference
White	8.20%	6.80%	-1.40%
BAME	17.00%	15.10%	-1.90%

7.13. There has been a slight decrease in both BAME and White staff reporting they have personally experienced discrimination at work. BAME report experiencing discrimination at work at a significantly higher rate than White staff.

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

7.14. 12.50% of the Board's voting members are BAME; there is a 22.60% difference between this and the overall workforce where 20.69% of staff are BAME. This is a positive improvement on last year where the Trust reported 8.33% of the Board's voting membership as BAME.

8. Appendix 2: Workforce Disability Equality Standard Metrics

Definitions and Data Sources for WDES Metrics

	Metric	Data Source
1	Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. Cluster 1: AfC Band 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, Non-consultant career grade Cluster 7: Medical and Dental staff, Medical and dental trainee grades *Note*: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes	ESR
2	Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts. *Note*: This refers to both external and internal posts.	TRAC
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. *Note*: This Metric will be based on data from a two-year rolling average of the current year and the previous year.	ER Case Tracker
4	a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	NHS Staff Survey Q13
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	NHS Staff Survey Q14
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	NHS Staff Survey Q11
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	NHS Staff Survey Q5
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	NHS Staff Survey Q28b
9	a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. b) Has your Trust taken action to facilitate the voices of Disabled staff in	NHS Staff Survey

	your organisation to be heard? (Yes) or (No)	
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.	ESR

Metric 1. Percentage of Disabled staff in each AfC Band cluster 1-4, 5-7, 8a-8b and 8c-VSM (including executive Board members) and Medical and Dental subgroups compared with the percentage of staff in the overall workforce.

	2019	2020	Difference	2020 Disabled Staff Headcount
Non-Clinical	**3.16%**	**3.82%**	**0.66%**	122
AfC 1-4	3.57%	4.25%	0.68%	81
AfC 5-7	2.87%	3.55%	0.68%	35
AfC 8a & 8b	1.15%	1.56%	0.41%	<5
AfC 8c - VSM	2.25%	2.70%	0.45%	<5
Clinical	**2.48%**	**3.26%**	**0.78%**	265
AfC 1-4	3.18%	3.25%	0.07%	72
AfC 5-7	2.79%	3.37%	0.58%	183
AfC 8a & 8b	1.08%	2.20%	1.12%	9
AfC 8c - VSM	1.54%	1.43%	-0.11%	<5
Medical and Dental	**1.25%**	**0.50%**	**-0.75%**	11
Consultants	0.82%	0.84%	0.02%	8
Non-Consultant Career Grade	0.00%	0.00%	0.00%	0
Trainee Grade	1.72%	0.26%	-1.46%	<5
Trust Total	**2.64%**	**2.95%**	**0.31%**	398

8.1. Across the Trust it can be seen there has been a slight increase in the proportion of disabled staff of 0.31%. This increase can be seen in all the Non-Clinical and Clinical band groupings but one – AfC 8c - VSM.

8.2. There is a higher reported proportion of disabled staff in AfC Bands 7 and below, with a lower proportion in more senior bands.

8.3. The proportion of disabled staff in Medical and Dental roles is much lower than the Trust average, with a significant reduction in those at Trainee Grade. This could be partially due to non-disclosure of disability amongst new staff at this grade.

8.4. It should be noted that disclosure of disability will have a large impact on the robustness of this metric. Disclosure of disability has decreased since

2019 with 18.50% of staff having not disclosed at all compared to 17.44% in 2019. Disclosure rates on the staff survey is much higher, with approximately 15% of those completing it identifying as disabled, so there are clear gaps in the data available on ESR. Disclosure rates likely have a high impact on the changes seen in the proportions of disabled staff across the Trust and so it would be difficult to draw conclusions around the progression or recruitment of disabled staff from this data.

8.5. It should be noted that this low disclosure rate on ESR will also have an impact on the robustness of WDES metrics 2, 3 and 10.

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

	2019	2020	Difference
Relative Likelihood	1.19	1.13	-0.06

8.6. Non-disabled applicants are 1.13 times more likely to be appointed from shortlisting than disabled applicants. This is a positive decrease on 2019.

Metric 3. Relative likelihood of entering the formal capability procedure

	2019	2020
Relative Likelihood	0	2.80

8.7. Disabled staff are 2.80 times more likely to enter into a formal capability process than non-disabled staff in the reporting period. This is significant. However it should be noted that there were only a small number of cases overall (<25) and small changes can create large variations in this figure.

8.8. In 2019 there were no reported capability cases against a member of staff with a disclosed disability therefore relative likelihood could not be calculated.

Metric 4. Percentage of staff experiencing harassment, bullying or abuse from patients and the public, managers, and other colleagues in the last 12 months, and percentage of staff who reported this.

	2019		2020		Difference (Non-Disabled)	Difference (Disabled)
	Non-Disabled	Disabled	Non-Disabled	Disabled		
a) i. Patients	25.80%	31.10%	24.40%	33.20%	-1.40%	2.10%
a) ii. Managers	11.60%	20.10%	11.00%	18.00%	-0.60%	-2.10%
a) iii. Colleagues	22.00%	32.70%	21.10%	30.90%	-0.90%	-1.80%
b) Reported	37.90%	40.60%	45.20%	46.80%	7.30%	6.20%

8.9. Disabled staff reported a slight increase in bulling and harassment over the past year from patients. However there have been positive decreases in experiencing it from managers and colleagues. There was also an increase in the number of disabled staff reporting incidents.

8.10. Non-disabled staff reported decreases in bullying and harassment experienced from all three sources. There was also an increase in non-disabled staff reporting incidents.

8.11. Disabled staff report experiencing bullying and harassment from all sources at a significantly higher rate than non-disabled staff and are more likely to report those experiences.

Metric 5. Percentage of staff believing that Trust provides equal opportunities for career progression or promotion.

	2019	2020	Difference
Non-Disabled	83.30%	87.10%	3.80%
Disabled	75.30%	77.70%	2.40%

8.12. There was an increase for all staff in believing that the Trust provides equal opportunities for career progression or promotion. This increase was greater for non-disabled staff Overall, disabled staff are significantly less likely than non-disabled staff to believe this.

Metric 6. Percentage of staff who say they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

	2018	2019	Difference
Non-Disabled	19.20%	17.50%	-1.70%
Disabled	30.70%	29.00%	-1.70%

8.13. Disabled staff report feeling pressure to come into work from their manager, despite not feeling well enough to perform their duties, at a much higher rate than non-disabled staff. For all staff there was a positive decrease in this, however this decrease was proportionally greater for non-disabled staff.

Metric 7. Percentage of staff satisfied with the extent to which the organisation values their work.

	2019	2020	Difference
Non-Disabled	43.70%	50.00%	6.30%
Disabled	34.60%	37.20%	2.60%

8.14. A greater proportion of non-disabled staff feel satisfied with the extent to which the organisation values their work than disabled staff. There has been a positive increase from last year for all staff, however it is greater for non-disabled staff.

Metric 8. Percentage of disabled staff that feels their employer made adequate adjustments to enable them to carry out their work.

	2019	2020	Difference
Response	74.60%	74.30%	-0.30%

8.15. 74.30% of disabled staff feel that the Trust has made adequate adjustments to enable them to carry out their work. This is 0.30% lower than last year.

Metric 9. Staff Engagement Scores for Disabled and Non-Disabled Staff compared to the organisations' Average.

	2019	2020	Difference
Non-Disabled	7.0	7.2	0.2
Disabled	6.5	6.7	0.2

8.16. Overall the engagement score for disabled staff is lower than the score for non-disabled staff. However, scores for both groups increased from last year, with this increase being proportionally larger for disabled staff.

Metric 10. Percentage difference between the organisations' and Board voting membership and its overall workforce.

8.17. 0% of voting Board members have a disclosed disability; this is the same as the previous year. Compared with the overall workforce this is a difference of 2.95%.

9. Appendix 3: Gender Pay Gap Metrics

Definitions and Data Sources for GPG Metrics

9.1. Under the Gender Pay Gap Reporting Legislation, organisations are required to publish the following figures:

9.1.1. Gender Pay Gap (mean and median averages);

9.1.2. Gender Bonus Gap (mean and median averages);

9.1.3. Proportion of men and women receiving bonuses;

9.1.4. Proportion of men and women in each quartile of the organisation's pay structure.

9.2. These figures have been compiled using a report created by IBM that utilises data kept on ESR.

9.2.1. Bonus pay includes:

9.2.2. Clinical Excellence Awards;

9.2.3. Discretionary Points for non-training grade doctors e.g. staff grades and associate specialists;

9.2.4. Payments made under Trust incentive schemes (including the Winter Incentive Scheme);

9.2.5. Bonus payments;

9.2.6. Distinction awards.

9.3. Pay gaps are reported as the relative percentage difference between men's and women's earnings. A positive percentage difference indicates men are paid higher and a negative percentage difference indicates women are paid higher. All percentages are given to 1 decimal place, as required upon submission to the Government Equalities Office.

Metric 1. Mean and median gender pay gap for ordinary pay.

	Mean Hourly Rate			Median Hourly Rate		
	2019	2020	Difference	2019	2020	Difference
Men	£23.55	£23.65	£0.10	£17.60	£18.65	£1.05
Women	£17.24	£17.70	£0.46	£15.28	£15.55	£0.27
Difference	£6.31	£5.95	-£0.36	£2.32	£3.10	£0.78
Pay Gap %	**26.78%**	**25.15%**	**-1.63%**	**13.16%**	**16.60%**	**3.44%**

9.4. There has been a positive decrease in the mean pay gap of 1.63% and an increase in the median pay gap of 3.44%. The change in median pay gap

indicates a decreased proportion of women within higher paid roles within the Trust.

Metric 2. Mean and median gender pay gap for bonus pay

	Mean Bonus Pay			Median Bonus Pay		
	2019	2020	Difference	2019	2020	Difference
Men	£8,455.35	£8,310.94	-£144.41	£3,015.96	£3,092.00	£76.04
Women	£2,112.73	£3,010.94	£898.21	£660.00	£660.00	£0.00
Difference	£6,342.62	£5,300.00	-£1,042.62	£2,355.96	£2,432.00	£76.04
Pay Gap %	**75.01%**	**63.77%**	**-11.24%**	**78.12%**	**78.65%**	**0.53%**

9.5. There has been a significant decrease in the mean bonus pay gap, with the primary factor being an increase in the mean bonus pay for women. This could be indicative of more women receiving Clinical Excellence Awards (CEAs), or some women receiving larger CEAs. When viewed with Metric 3, where there has been a decrease in the proportion of women receiving bonus payments, it is likely that this decrease has contributed to the decreased mean bonus pay gap. The 2019 winter incentive scheme focused on supporting the flexible staffing pool, whereas in previous years it was open to a larger proportion of staff; this means that in 2019 a lower number of women were accessing these lower bonus payments leading to a lower proportion of women receiving bonuses but an increased mean bonus pay for women.

9.6. The median bonus pay gap has increased slightly for women due to there being no difference in the median bonus pay for women despite but a slight increase for men.

Metric 3. Proportion of men and women receiving bonuses

	2019	2020	Difference	Magnitude of Difference
Men	12.26%	12.55%	0.29%	2.37%
Women	9.26%	7.91%	-1.35%	-14.58%

9.7. There has been a slight increase in men receiving bonuses with a decrease in women receiving bonuses compared to last year.

Metric 4: Proportion of men and women in each quartile of the Trust's pay structure (Q1=low, Q4=high). Headcounts given in italics.

Quartile	2019		2020		Difference in proportion of women
	Women	Men	Women	Men	
1	78.76% *2324*	21.33% *630*	77.26% *2415*	22.74% *711*	-1.50% *91*
2	79.75% *2355*	20.25% *598*	80.47% *2518*	19.53% *611*	0.72% *163*
3	80.91% *2391*	19.09% *564*	80.86% *2530*	19.14% *599*	-0.05% *139*
4	61.68% *1822*	38.32% *1132*	61.54% *1925*	38.46% *1203*	-0.14% *103*

9.8. The proportion of women has slightly decreased within the upper two quartiles of the Trust's pay structure. This might account for the increase in the median pay gap, however the data would need to be examined at greater granularity to understand the distribution of women within each of these quartiles to be able to determine the real impacts.

9.9. Men remain disproportionately represented within the highest quartile of the Trust's pay structure.

10. Appendix 4: Recommended Actions Summary

10.1. The below table summarises the high-level actions that this report recommends the Trust takes in response to the analysis and key findings. These actions were agreed in principle at a meeting of the Trust Management Executive on 27th August 2020. Following this, further work to develop and deliver on these actions will be undertaken.

Action	Lead	Suggested Timeline
Explore implications of the pay gaps in CEA study on the delivery of CEAs within the Trust	Head of Resourcing	End April 2021
Identify future opportunities for senior staff to champion and be visible on EDI	EDI Steering Group	Ongoing
Recruit to the BAME Health and Wellbeing Lead position	Director of Culture and Leadership	End October 2020
Promote the Conflict Management Procedure and identify support for managers and patients where abuse is of a discriminatory nature	Head of Security	End September 2020
Embed equality impact assessments as part of emergency planning processes	Emergency Planning Officer	End October 2020
Consider the opportunities to build upon the changes made to the Trust's digital infrastructure during Covid-19 to enable greater flexible working	Director of Workforce and Interim Director of Digital Services	TBC
Integrate inclusion-focussed interventions for wellbeing as part of the overarching 'Leading with Care' implementation	Director of Culture and Leadership	End October 2020
Ensure that reports on workforce equality data include both umbrella group data and disaggregated data (for example data on ethnicity provides both a BAME/White split as well as data on individual ethnic groups).	Head of Workforce Information	Ongoing
Improve ESR data quality on disability	Head of Workforce Information	End March 2021
Use the findings of this report to inform the delivery of the EDI Objective and Delivery Plan Refresh, ensuring progress against WRES, WDES, and GPG is considered within it	EDI Manager	End March 2021
Utilise the Wellbeing Leads to provide support for shielding staff in future potential waves of Covid-19	Psychological Medicine	N/A