REPORT TO: **Trust Board**

FROM : **Bina Kotecha, Deputy Director of Learning and Organisational Development and Louise Tibbert, Director of Workforce and Organisational Development**

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DATE: **August 3rd 2017**

SUBJECT: **Bi-Annual Equality & Diversity Update Report – August 2017**

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1. Introduction

University Hospitals of Leicester uses the Equality Delivery System (EDS) as its equality delivery framework. The four domains are :

- Better Health Outcomes
- Improved Patient Access and Experience
- A representative and Supportive Workforce
- Inclusive Leadership

We have drafted the first iteration of Equality Action Plan which incorporates all elements of the EDS (patient and workforce activity) and the Workforce Race Equality Standard (WRES) as shown in **Appendix1.** We have appointed a new Equality and Diversity Lead (to commence early September 207) and the finalised version of this action plan will be presented during October 2017 following consultation with and approval by the Trust's Workforce and OD Board.

2. The Purpose of this Report

This report is the first of two annual update reports to The Executive Workforce Board and Trust Board. In addition this report provides evidence of compliance for the Clinical Commissioning Group (CCG) of our performance against the equality requirements of the 2016-2017 Quality Schedule and WRES.

The previous annual Equality Workforce Report was presented to Trust Board in January 2017.

3. Workforce Equality Update

Broadly the areas of focus for Equality and Diversity continue to be:

- Strengthen local accountability by developing CMG diversity metrics.
- Better alignment of diversity with the Trust's 5 year plan.

- To implement Positive Action Interventions (as part of the Trust's Recruitment and Retention Strategy).
- Strengthen partnership working across the system around the Diversity Agenda
- Develop some targeted talent management strategies for under - represented groups.

3.1 Key highlights

3.2 Strengthen Accountability

In April last year the first BME leadership data was reported by Clinical Management Group (CMG) – and is defined as band 8a and above excluding Medical Consultants. From the data, key thresholds were developed and in 2016 all CMG's were RAG rated as red in terms of BME representation within the leadership strata. The threshold is set at 28% which equates to BME representation in the general workforce and reflective of the local community as measured in 2016.

BME Leadership Representation	**2016**	**2017**
Trust as a whole	11.7%	12.2% 
Highest BME representation level within the CMG's	15%	14% 
Lowest BME representation level within the CMG's	6%	8% 

The leadership figures as from April 2017 form part of the Chief Executive performance indicators for the Clinical Management Groups and are reported quarterly. As you can see from the table above there has been little in the way of significant change in the levels of BME representation. It is acknowledged that a shift in performance can take a number of years.

3.3 Quality Improvement Methodology in RRCV

One of the biggest challenges for NHS Trusts and indeed most private sector companies is deciding which interventions could be implemented that would have the biggest impact on shifting the position. The Clinical Director in RRCV has agreed to pilot some targeted interventions, as set out below, to see whether they have a positive impact on their levels of BME leadership representation which currently stands at 9.5%.

- Identifying talented individuals within the CMG and creating a strong medium term talent pipeline
- Introduce Reverse mentoring
- Staff engagement focussing on the 2 WRES indicators - which include the experience of discrimination and access to training opportunities.
- Unconscious Bias Awareness Sessions for recruiting managers.

The base line data set is as follows:

- BME / White break down band 8 and above and band 7 and above
- Friends and Family Test (FFT)
- Staff turnover
- Internal promotions
- Training data for RRCV
- Staff Survey

The aim is to collate the data, agree the timeline and sequence of the interventions and implement once the staff survey has been completed (September 2017 The target of 28% is ambitious and will take a number of years to achieve and needs to form part of a five year equality strategy).

3.4 Reverse Mentoring Scheme

The reverse mentoring scheme commenced in February this year with four of our Executive Leads agreeing to act as "mentees" for our 4 BME mentors. These are; Andrew Furlong Medical Director, Julie Smith Chief Nurse and Louise Tibbert Director of Workforce and Organisational Development and Suzanne Khalid CMG Clinical Director. The principle aim of the scheme is to provide the Directors with the personal experiences of their UHL career journeys. The findings so far have been:

- Despite challenging diaries all the four pairs of Mentors and Mentees have managed to meet at least once which is very encouraging and demonstrates the enthusiasm and commitment from both the Mentors and the Mentees to this innovative pilot project.
- The topics chosen seem to have been useful as a catalyst for the one to one discussions between Mentors and Mentees
- Many useful insights have already been highlighted via this project process which can be used to review, continue and improve processes currently in place in the Trust
- It is positive to note that the project is also highlighting areas of good practice in the Trust that we need to be proud of and continue to build on and/or role out elsewhere.
- The small group of Mentors are all committed to continue with the process and also develop into a steering group at the end of the process to support the Equality and OD teams in publicity, recruitment and support for this type of programme in the future.
- Mentors and mentees have engaged in discussions in differences in experiences and expectations particularly as a result of the generational gap.

The project is due to complete in August 2017 and we will provide subsequent updates.

3.5 Leadership Development East Midlands Leadership Academy (EMLA) attendance data.

The Trust is a member of the East Midlands Leadership Academy and attendance on programmes by underrepresented groups is reported and monitored at quarterly intervals. The 2016-17 Utilisation Report received from EMLA highlights BME representation on leadership programmes The overall BME participation rate for 2016 - 2017 has improved and is currently at 18%, we note that this is 10% less than the overall workforce representation level. White 71% and unspecified 11% suggesting further improvement is required to ensure BME staff participate in external development programmes in the same proportionate numbers as White staff.

To respond to this we have created a greater awareness around national BME specific career and leadership development opportunities and as a result have secured a number of places on specific programmes such as 'Stepping Up' (as reported to the Executive Workforce Board in April 17) targeting bands 5-7.

We have encouraged our staff to contribute to the EMLA Visible Leaders Network which is network for BME leaders (Bands 6-8a) and offers career management development as well as support with transforming equality and diversity at an organisational level.

A new initiative from EMLA is that we now have some insight into staff that are registering interest for EMLA programmes and a suggested action from this is to monitor applications in order to better target greater representation from protected characteristic groups.

3.6 Unconscious Bias Training

Unconscious Bias training is now a supplementary module for the UHL Way Leadership Programme. Adhoc sessions are also available on request. The CMG HR Business Partners have all been trained and are available to deliver sessions as required within their CMG's/Corporate Areas.

3.7 Recruitment

The Learning and Development Team are working with Leicestershire Education Business Company (LEBC), Sector Work Based Academies, Leicester Apprenticeship Hub, and Leicester Enterprise Partnership, to promote NHS, through schools and colleges, community settings, direct mailing to year 12s and 13s across the city and county to promote health based careers within BME communities.

We are also working closely with the Trust's Patient and Public Involvement Lead in drafting a programme of Community Engagement.

3.8 LLR System-wide Interventions

As part of the Leicester Leicestershire and Rutland Sustainability and Transformation Partnership (STP), work is underway in addressing the gaps identified and set out within

the triple aims of the STP. During 2017-18 partners across health and social care will explore collaboration opportunities working towards developing a joint LLR wide Equality Action Plan.

In July 2017 we appointed a LLR Clinical Fellow to support with pulling together the joint action plan. Over the next 12 months our fellow will finalise the joint plan with the LLR Clinical Leadership Group and will commence with implementing interventions supported by the LLR Organisational Development and Change Group and Equality and Diversity Subject Matter Experts employed within partner organisations.

3.9 The Workforce Disability Equality Standard (WDES)

In the last 12 months NHS England and NHS Employers have been developing a Workforce Disability Equality Standard (WDES), which will be implemented formally from April 2018. The finalised standard and technical guidance is expected in September this year. There has been an extension to the timeframe which was originally April 2017.

This standard –will be similar in structure and format to the WRES , however the indicators will be slightly different. The standard offers the same opportunity as the WRES for NHS organisations to quantify the different workplace experiences and outcomes of disabled and non-disabled staff. The data will be collected nationally in April 2018 and potentially reported on later that year.

3.10 Workforce Race Equality Standard (WRES) 2016-2017 National analysis

The WRES aims to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Since July 2015, NHS trusts submitted their WRES data against nine indicators of staff experience and opportunities.

To date, NHS England has published WRES data analyses for 2015 and 2016. The 2015 report highlighted gaps in workplace experience between BME and White staff in access to career opportunities and fair treatment in the world workplace. The 2016 report shows that whilst there is still a long way to go, there are early green shoots of hope with regard to some indicators.

3.11 WRES Revision for 2017

Based on feedback from the WRES baseline data returns and from engagement with the NHS, the wording for Indicators 1 and 9 has been revised in relatively minor ways. The revisions seek to add clarity on progress against these two WRES indicator:

- WRES Indicator 1 now has a clearer definition of “senior medical manager” and “very senior manager”.

- WRES Indicator 9 now requires submission of data that disaggregates: (i) the voting and non-voting members of boards, and (ii) the Executive and Non- Executive members of boards.

- With regard to WRES Indicator 2, organisation's annual data returns are expected to include the shortlisting to appointment data for both internal and external recruitment activity. This will be a challenge for many Trusts as the data isn't currently collected and not easily retrievable using ESR. UHL will need a system, the Recruitment Lead is working on a solution.

3. Key National Findings for 2016

- A higher percentages of BME staff report the experience of harassment, bullying or abuse from staff, than White staff, regardless of trust type or geographical region. Community Provider and Ambulance Trusts are more likely to report this pattern.

- BME staff are generally less likely than White staff to report the belief that the Trust provides equal opportunities for career progression or promotion. This pattern is strikingly widespread regardless of type of Trust or geographical location.

- BME staff are more likely to report they are experiencing discrimination at work from a manager, team leader or other colleague compared to White staff, regardless of Trust type or geographical location.

- NHS Staff Survey responses from BME staff were, in a significant number of cases, too small to report. In some cases, given the demographics of the Trust or the locality served, this was surprising. NHS trusts are strongly recommended to carry out the survey using full rather than small staff samples.

- Community Provider Trusts and Mental Health and Learning Disability Trusts generally report a higher percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public when compared to White staff.

In terms of analysing UHL's position the results have not been 'league tabled ' making it difficult to determine at a glance our overall position. UHL is achieving an average score for indicators 5-8 with only marginal differences between White and BME Staff. The most marked difference for UHL is staff's satisfaction with access to career opportunities with White staff declaring a 20% greater satisfaction rate than BME staff.

4. 2016-2017 WRES Data Submission

By August 1st 2017 all Trusts need to have submitted their 2016-2017 WRES data which will be the second year allowing us to compare and track our performance. Our proposed data for submission for this year is detailed on **Appendix 2.**

4.1 WRES COMPARISON ANALYSIS

4.11 Indicator 1. Clinical and Non - Clinical workforce representation

	Non Clinical		Clinical	
	Ethnicity		Ethnicity	
	BME	White	BME	White
Under Band 1	190	187	5	2
Band 1	398	572	1	2
Band 2	395	899	486	1139
Band 3	137	355	140	468
Band 4	131	444	67	172
Band 5	48	194	860	1684
Band 6	45	127	388	1446
Band 7	24	148	141	778
Band 8A	12	100	31	212
Band 8B	8	62	6	622
Band 8C	1	25	2	25
Band 8d	1	21	1	5
Band 9	1	6	1	5
Very Senior Management (VSM)	0	8	0	1

Total Staff numbers – 14,891

The declaration rate for Ethnicity is 98%

The general Workforce data for this year has seen a rise for BME staff in both clinical and non - clinical roles (28% - 30%). A further rise has occurred in BME Medical representation which now stands at 51%.

4.12 Indicator 2 - Recruitment Data

Historically for most organisations there has been a marked difference in terms of recruitment outcome for White and BME staff. Whilst UHL has successfully recruited BME staff in representative numbers (currently 30%), the conversion rate from shortlisting to appointment has favoured White applicants. The shortlisting to appointment data for BME staff is showing an improved position. Going forward there is a requirement to monitor internal promotions as well as external recruitment activity. We are unable to accurately track internal promotions by ethnicity via ESR or TRAC at present

No head count figure is available for 2015-2016 as the recruitment management system changed in March of this year. The information will be available for the next workforce annual report in December 2017.

4.13 Indicator 3 – Disciplinary Cases

Nationally BME staff are generally over represented in formal disciplinary cases. However our figure for this year shows proportionate numbers for BME and White staff entering the disciplinary process. .

A recent report produced by the National Nursing and Midwifery Council showed that a disproportionate number of Fitness to Practice referrals were made for BME staff although White staff faired less well in terms of the numbers upheld. This may suggest that the formal process is triggered more quickly / frequently/ inconsistently than it is for White staff. The reasons for this warrants further investigation. It would be helpful to look at UHL's data and include it as part of our equality data set going forward.

4.14 Indicator 4 - Access to Non - Mandatory Training

Non mandatory training includes the following types of Professional Development. We would expect that BME and White staff would access training opportunities in proportionate numbers.

- Leadership
- Qualifications and Credit Framework (QCF)
- Day courses
- Apprentices

Attendance for **all** training by BME staff is under-representative at **19%.** However, attendance at Leadership courses for BME staff is **32%** which demonstrates an improving position.

The undisclosed rate for UHL based training is 21% which is very high making accurate trend analysis difficult. We therefore need to ensure course participants complete their equality monitoring forms before enrolment is confirmed**.**

4.15 Indicator 5- Experience of harassment from patients

2017 data shows a reduction for both White and BME staff. The trend however, shows that White staff report a marginally higher rate (1% more) of harassment from patients than BME staffs

4.16 Indicator 6 - Experience of harassment from staff

2017 shows a 5% reduction from the previous year, however, the trend remains the same in that BME staff experience slightly more harassment than White staff from other staff. Bullying and harassment information is collected and there is no evidence to suggest that BME staff are overrepresented in the Trust figures.

4.17 Indicator 7- Career Progression

A higher percentage of White staff believe that they have equal opportunity for career progression at UHL than BME staff. The data for 2017 is showing deterioration in the level of satisfaction for BME staff and therefore warrants a bespoke piece of work looking at

barriers to career progression. A survey has been developed and is being piloted in Renal, Respiratory, Cardiac and Vascular (RRCV). Results will be available in September /October 2017 and will be used to steer the work stream.

4.18 Experience of Discrimination form Managers/Colleagues

Although showing a downward trend BME staff are still twice as likely to experience discrimination than White staff. A discrimination question has been included in the staff questionnaire currently being piloted.

4.19 Summary Position

Generally the WRES data is showing an improved position for 7 of the indicators with a deterioration in the two listed below. More detail can be found at **Appendix 2**

- BME staffs experience of career progression
- BME staff accessing Non - Mandatory training

5.0 Patient Access and Health Outcome Activity

5.1 Interpreter Service

In March 2017 the incumbent interpreting provider, Pearl Linguistics liquidated and ceased trading leaving UHL and many other Trusts without any interpreting service. Within 24 hours Language Line a telephone interpreting company were able to supply a service to us. At this point we were unable to provide a face to face service, whilst this wasn't ideal from a patient and user perspective, it is a clinically safe option. Using the telephone is not popular with some Clinicians and whilst it is fair to say that there are some circumstances whereby telephone interpreting is inappropriate such as breaking bad news, the main barrier to using it effectively is having access to the right equipment in the right place i.e. a cordless speaker phone.

The Trust spent nearly £450k on Interpreting Services in 2015-16 with a year on year increase in usage of which 90% is provided face to face. There is an opportunity for savings if some of the Interpreting activity transfers to telephone. Particularly in relation to those sessions that are less than 30 minutes long (this occurs commonly in Outpatients). To successfully transfer even 20% of activity via the telephone it will be dependent on Clinicians having the right technology at their fingertips to enable easy and quick access to the service. UHL has asked as part of the tender process for the new contract how the suppliers will support the Trust in shifting some of the activity from face to face to telephone. It is hoped that because we have been heavily reliant on the telephone service since March 2017 that some of the resistance may have diminished and staff will be more amenable to conducting consultations where clinically appropriate via the telephone. A fully worked up model will be drawn up as part of the mobilisation process.

5.1.1 Access to British Sign language for Deaf Patients

In terms of interpreting services for deaf patients we approached our two local British Sign Language interpreting providers and agreed that they will provide our BSL service for one year in the first instance. We know from previous engagement with the Deaf Community that access to BSL across the health sector remains inconsistent and that Deaf people by large would prefer a locally based BSL service. The Equality Lead is working with Procurement and our local BSL suppliers to build a more timely and responsive system. Feedback from the community to date suggests that the new system is working very well for them. Previous concerns regarding the capacity of the local providers have not been realised during the initial period (March 2017 – to date), with 98% bookings made filled.

The tendering process is underway with six Interpreting and Translation companies submitted tenders followed up with a presentation to the Equality Team, Procurement and representatives from the CMG's. We are in the process of evaluation to identify our preferred bidder. We are planning to award and mobilise the contract by the end of August 2017.

5.2 The Accessible Information Standard

NHS England has introduced the Accessible Information Standard (AIS) in all organisations that provide NHS or Adult Social Care. Work is progressing and an IT solution is now available in Outpatients that will enable staff to record patient's information requirements. The IT system is also ready to go in inpatients services, however, we need to identify and communicate to staff how the data will be collected and inputted, following the appropriate upgrading of Nerve Centre. There is still some work to do in terms of the system being able to automatically generate information in the patients required format. This appears to be the position that most Trusts are in currently. IM&T have set up a facility on HISS to record patients' communications needs.

- Information in Braille
- Information in large print
- British Sign Language Interpreter
- Correspondence via text
- Correspondence via telephone
- Correspondence via email
- Information in Easy Read
- Foreign language interpreter
- Speech to text reporter
- Other Lip speaker
- Note taker

Further work is required to ensure full compliance is to:

- Develop some staff guidance
- Develop the facility within Nerve Centre for inpatients
- Develop a communication plan for staff and patients.

5.3 Disability Patient Data Collection

Since May 2016 the Trust has collected disability status from patients. In May the data recording rate was 4.4%. This has risen to 15.6% as of November 2016. There is clearly some way to go but the data is showing a month by month increase. The purpose of doing this is to quantify any differences in the levels of access to our services. We plan to report in January 2018 our Do Not Attend (DNA) rate and referral to treatment rates by Gender, Disability and Ethnicity.

6.0 Conclusion

UHL continues to declare legal compliance with the Public Sector Equality Duty as demonstrated in this report and has a range of activities and processes to evidence our position. A stronger emphasis is required to ensure that full compliance with the AIS is achieved now that the Electronic Patient Record is no longer an option.

Recommendation

The Trust Board is asked to comment on progress made and continue to support the Equality Programme.

The Trust is asked to agree the WRES Data for 2017.