**Trust Board Paper Y**

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| **To:** | **Trust Board** |
| **From:** | **Kate Bradley – Director of Human Resources** |
| **Date:** | **20 December 2013** |
| **CQC regulation:** | **Respecting and involving people who use services** |

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| **Title:** | **Equality Agenda Progress Report** |

**Author/Responsible Director:**
Deb Baker, Equality Manager and Kate Bradley, Director of Human Resources

**Purpose of the Report:**

To provide an update for the Trust Board on the equality work programme for 2013/14, changes to the internal assurance process related to the equalities agenda and recent changes to the national Equality Delivery System (EDS).

**The Report is provided to the Board for:**

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| Decision√ | | Discussion√ | |
| Assurance√ | | Endorsement√ | |

**Summary / Key Points:**
This is the second of the bi-annual equality update to the Trust Board which details progress in relation to improving access to hospital care and receipt of fair treatment in all our services. In addition the report addresses our responsibilities in relation to the Public Sector Equality Duty (PSED). The paper includes an update on:

- Equality governance arrangements nationally, regionally and locally
- Progress with the 2013/14 equality work plan
- Audit of practice within our Clinical Management Groups (CMG)
- A summary of the key points of this years workforce monitoring report
- Suggested areas of focus for the April 2014/15 equality work programme

**Equality Delivery System**
The Equality Delivery System (EDS) has been revised and simplified by NHS England and is now referred to as EDS 2 (**Appendix 1**).The content remains largely the same and going forward the Clinical Commissioning Groups (CCG's) and the Clinical Support Unit (CSU) will be responsible for equality monitoring via the Quality Schedule.

**Equality Action Plan 2013/14**

The equality action plan (**Appendix 2**) is progressing well in all areas and is on track for completion by the end of March 2014. Key highlights include:

- The positive evaluation of attendees at the lesbian, gay, bisexual and transgender (LGB&T) conference held in the summer
- Successful engagement with the LGB&T community at the Leicester Pride event where we had an equality stand with Leicestershire Partnership Trust
- A new internal assurance group for Equality, Patient Experience and Engagement

- The development and dissemination of the Reasonable Adjustment Guidance for Managers and staff
- Increased referrals to the Acute Liaison Nurse service

The Equality Advisory Group (EAG) has supported and validated our self-assessed position of green and we are working with CCG equality leads across LLR to align our emerging priorities with theirs.

**Audit of Equality Practice**

Phase one of the qualitative audit of practice which was delayed because of the CMG restructure has been concluded. There is some evidence that services respond positively when a need for 'reasonable adjustment' is identified. For example extending a consultation slot to accommodate the needs of a deaf patient. However, this often occurs once the patient has arrived rather than as part of the appointment planning process. The review has demonstrated a need to have a more proactive and consistent approach to managing patients who present with additional needs. The nomination of a designated CMG equality and engagement lead, the revised terms of reference and renewed membership of the Equality, Engagement and Patient Experience Assurance Committee (**Appendix 3**) and the focus on patient care pathways should enhance services where improvements need to be made and ensure best practice is shared and implemented consistently.

**Workforce Equality Review**

The 2012/2013 workforce report has been completed with no significant variation from last year's report (**Appendix 4**). Broadly, Black Minority Ethnic (BME) and female representation remains static with a small increase in the number of female Consultants and BME representation at senior levels remains unchanged. In order to improve the validity of the data we are undertaking a revalidation exercise across the Trust that will include members of the Board. The levels of 'undeclared status' particularly for disability and sexual orientation have slightly improved but still remain low. The deep dive activity undertaken in respect of career progression for Band 6 BME members of staff does not suggest that there are any discriminatory practices at play but identified some valuable points for further consideration. The deep dive for this year will look at band 7 appointments.

**Emerging Priorities 2014/15**

The focus for 2014/15 will centre on the patient's journey using the care pathway review and due regard process as the means by which this achieved. To further embed equality the CMG Leads will provide assurance reports to their senior teams at least quarterly which in turn will form the basis of the quarterly Executive Assurance Committee report.

**Recommendations:**
To accept and agree the content of the report.

**Previously considered at another corporate UHL Committee?**
No, however, in future it has been agreed that the report will go to the Executive Assurance Committee.

| **Board Assurance Framework:** | **Performance KPIs year to date:** |
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| **Risk 3** | There is an equality indicator as part of the Quality Schedule requiring biannual reports. |

**Assurance Implications:**
The equality programme is assessed for compliance with the Public Sector Duty annually via our web site.

**Patient and Public Involvement (PPI) Implications:**
The UHL Equality Advisory Panel provides external advice and support to the Equality Team. They attend not as individuals but as representatives from a wide range of local communities and are responsible for raising any community concerns with us. These concerns will be included in the 2013 equality annual report due to be published in April 2014. The terms of reference have been updated to include additional scrutiny for the end of year grading process for the Equality Delivery System 2 (EDS 2). A Patient Advisor and a member of the Advisory Group will sit on the newly developed Experience Equality and Engagement Assurance Committee. All equality related documents and action plans are published on the UHL web site. The equality lead is also involved with patients/ carers who raise equality related concerns often advising clinical staff on alternative methods of care delivery. A summary of the learning from the complaints received from patients and carers with a learning disability will be presented in the end of year annual report. Recommendations will be fed back to the Equality CMG leads.

**Stakeholder Engagement Implications:**
It is anticipated that the CCG's and CSU may require additional equality monitoring data in 2014. Further discussions are scheduled.

**Equality Impact:**
The overall intent of the equality work programme is to ensure equal access and fair treatment in all of our services. The emphasis for this year will be around the accessibility of patient care pathways, increased usage of the due regard process and enhanced internal monitoring via the newly developed Experience, Engagement and Equality Assurance Committee.

**Information exempt from Disclosure:**
**None**

**Requirement for further review?**
July 2014

**UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

**REPORT TO:** **TRUST BOARD**
**DATE:** **20 DECEMBER 2013**
**REPORT BY:** **DEB BAKER, SERVICE EQUALITY MANAGER**
**KATE BRADLEY, DIRECTOR OF HUMAN RESOURCES**
**SUBJECT:** **EQUALITY AGENDA PROGRESS REPORT**

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## 1. INTRODUCTION

This is the second of the 2013/14 biannual equality updates to Trust Board to report on our progress with meeting the Public Sector Equality Duty (PSED) where we are required to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups which are:

*Race/ethnicity, Sex, Religion or belief, Gender Reassignment, Sexual orientation including lesbian, gay and transsexual people, Age, Marriage and Civil Partnership, Disability - learning disabilities, physical disability, sensory impairment and mental health problems*

Following agreement from the Trust Board, UHL will publish by the 31st January the annual workforce monitoring report which is a statutory requirement.

## 2. THE PURPOSE OF THE PAPER

The Trust Board report includes an update on:

- The equality governance arrangements nationally, regionally and locally
- The 2013/14 equality work plan progress report
- An update of the Clinical Management Group (CMG) audit of practice
- A summary of the key points of this years workforce monitoring report
- Suggested areas of focus for the 2014/15 equality work programme

## 3. EQUALITY - NATIONALLY, REGIONALLY AND LOCALLY

NHS England has drafted its equality strategy the aims of which are to support the NHS in embedding equality of opportunity and reducing health inequalities with an emphasis upon co-production rather than performance monitoring. Early indications are that NHS England are not intending to dictate 'equality policy' but rather that the strategic direction for equality be determined, agreed and monitored on the basis of local health need and Trust priorities. The strategy indicates that Clinical Commissioning Groups (CCG's) and Clinical Support Units (CSU's) will have a more 'hands on' role in the equality monitoring of provider organisations than has previously been the case.

The early focus of NHS England has been to review and refresh the Equality Delivery System (EDS) which has now been officially launched and re branded EDS 2 (**Appendix 1**).

Whilst EDS 2 has not significantly changed from the original in terms of content, it has been simplified and remains a helpful tool to deliver our ethical and legal equality responsibilities. The four EDS 2 domains are:

**Service Provision**

- Better Health outcomes for all
- Improved Patient access and Experience

**Workforce**

- A representative and supported Workforce
- Inclusive Leadership

Our 2014 Equality work programme will be aligned to the EDS 2 domains as in previous years.

## 3.1 External Governance

The current Quality Schedule equality standard asks for a bi-annual equality progress report against our action plan, which in effect are the Trust Board updates. Early indications from the discussions held to date with the CCG suggest that we may be required to provide additional monitoring data. This could include patient experience feedback, patient safety, complaints and patient access i.e. emergency care, and cancer wait times broken down by protected characteristic. This has yet to be fully discussed but may form part of the forthcoming contract negotiations for 2014/15 that the Equality Manager will be involved in.

The requirement for the annual grading process for EDS 2 remains and requires an independent review of our self assessed grading to validate or refute it. Where there are differences the grading assigned by the external assessors needs to be adopted. Our equality work programme log (**Appendix 2**) was recently assessed by the Equality Advisory Group and the position being reported via this paper has been validated as green, achieved. A full end of year assessment as of 31st March will be reported in the equality annual report published on the external web site.

No formal reporting is required by NHS England other than our legal compliance information that is published on our web site annually on the 31st January.

## 3.2 UHL Governance

The equality work programme is monitored by the Human Resources Equality Group and Equality Advisory Group six weekly. In addition to this we have reviewed the patient experience, engagement and equality group and devised new terms of reference, membership and reporting requirements to enhance assurance and access for patients. The drafts of these are attached at **Appendix 3.** A quarterly equality report will be submitted to the Executive Quality Assurance Committee.

## 4. WORK PLAN PROGRESS LOG

Work is progressing well in all areas and is on track for completion by the end of March 2014. Notable highlights are:

- The positive evaluation of attendees at the lesbian, gay, bisexual and transgender conference held in the summer

- Successful engagement with the LGB&T community at the Leicester Pride event where we had an equality stand with the Leicestershire Partnership Trust. We had a mixture of experiences reported by patients at this event. The overriding theme was the that the attitude of some health professionals was not always positive
- A new assurance group for Equality, Patient experience and Engagement
- The completion of the first phase of the CMG equality review
- The launch of the Reasonable Adjustment guidance for staff and Managers
- A telephone interpreting pilot in the antenatal clinics
- Continued employment outcomes for the Leicester Works students
- The development and implementation of a new e learning training programme
- An increase in the numbers of people undertaking equality training from 37%- 59%

## 5. EMBEDDING EQUALITY – THE CMG REVIEW

Mainstreaming equality has been one of our main challenges for this year. Corporately we have processes in place and a varied programme of work. Within the EDS model each CMG should have responsibility for providing fair, accessible and individualised care to all of their patients.

As a starting point the Equality Manager has conducted a qualitative review of equality work and met with all of the CMG Managers to see how embedded equality principles was in everyday practice, with a view to a more systematic review being conducted in 2014 once the broad themes had been identified.

There were three lines of enquiry that the interviews were based around which were to:

- Understand how CMG services operate for all of our patients.
- Demonstrate how the CMG's 'reasonably adjust' their services to accommodate the needs of everyone.
- Explain how equality and inclusion issues are addressed within the CMG's.

### 5.1 Emerging Themes

#### 5.1.1 Understand how their service operates for all of our patients

Across all CMG's there was genuine commitment to the principles of fairness, equality of access for patients, carers and visitors and equal opportunity for staff. Understanding what this looked like in terms of patient and staff outcomes was less well understood. An example being that patient feedback is generally assessed across the whole patient population. Rarely is there information that looks at satisfaction between groups, making targeted improvement difficult. This is an area requiring further work.

#### 5.1.2 Demonstrate how they 'reasonably adjust' their service to accommodate the needs of everyone

The audit indicates that on a case by case basis this is done well. There is good evidence that the Learning Disability Service is well utilised across the Trust. We have many examples of good practice where a patient with complex care needs has been able to access a service as a result of reasonable adjustment. For example:

*A patient with severe autism needed an ECG. Several attempts had been made by the GP unsuccessfully. The patient is unable to interact and becomes extremely agitated because of unfamiliarity with the environment, people etc. This generally results in destructive behaviour. Our specialist nurse worked with the ECG team and residential care staff and reduced as much external distraction as possible. A side room was allocated with only the ECG machine and a chair. Car parking was arranged as near to the room as possible and the patient was collected in a wheelchair by the care staff and the learning disability specialist nurse. The ECG staff were thoroughly briefed and interaction was kept to a minimum. The ECG was performed successfully and the patient left.*

Without this intervention it is unlikely that the patient would have been able to comply and therefore would most likely not have had the diagnostic test. The aim of reasonable adjustment is to ensure that every effort is made to accommodate the most complex patients in order that they can get access to the health care they require.

For other protected groups it is often less well organised. Impact assessments or due regard tend only to be used when larger scale change or improvements are designed and implemented rather than as a routine element of care pathway design. This can result in some patients needs being overlooked. The test of any care pathway is ‘’if we get it right for the most vulnerable of our patient groups we are likely to get it right for everyone’’.

### 5.1.3 How are equality and Inclusion issues addressed within the CMG?

Again there is clearly an ambition to ‘get things right for patients’ however equality issues tended to be addressed when they arose. Equality tends not to feature regularly on CMG board meeting agendas, when it does the trigger is often a patient complaint or concern. That said there were some examples where services had adapted their provision to take account of a particular patient group. For instance Musculo-skeletal had developed ‘learning cards’ for the patients who had fractured their hips and had dementia or had English as their second language. This enabled the patients to participate in the rehabilitation element of their treatment plan. Maternity run a specialised clinic for pregnant women who have undergone genital mutilation.

### 5.1.4 Summary

Whilst there is both commitment and sign up to the principles of equality and inclusion some gaps remain in terms of how we evidence that access to and delivery of care is in fact equitable for all. The good news is that there is no evidence at present to suggest that access is directly denied on unreasonable grounds for any protected group. That said we do have some issues of consistency in relation to how far a service may or may not go to make the patient journey smoother for our more vulnerable/complex patients. Bed pressures, staffing levels and attitude are clearly major factors in determining how well or not services are flexed to accommodate patients with differing and or additional needs. A more systematic review of current pathways should deliver a better understanding of what is required to ensure that all of our patients achieve the best possible health outcome that they can.

### 5.1.5 Recommendation

To support phase two of the review, which, is to assess with the Equality CMG Lead the most commonly used care pathways and ensure reasonable adjustments are integrated where required.

## 6. Workforce Monitoring Report

We are required as part of the Public Sector Equality Duty to annually collect, analyse and publish our workforce data by:

- Our overall workforce profile
- Pay differences
- Recruitment
- Number of staff leaving Staff leaving
- Number of Disciplinary and Grievance cases
- Access to training

This is shown at **Appendix 4**. The data is analysed by gender, age, ethnicity, religion and belief, sexual orientation and disability.

### 6.1 Key Workforce Priorities Identified for 2013

- There was a higher than average number of males and individuals from a BME background employed on fixed term contracts
- Representation for women and BME staff at a senior level remains our biggest challenge (8a and above)
- Benchmarking some of our workforce data with other similar Trusts
- To develop guidance for staff on ‘’reasonable adjustment’’
- To audit band 6 staff to identify any perceived/real blocks to career progression for BME staff

### 6.2 2012- 2013 Workforce Report Findings

Broadly, representation has remained the same and again there have been some interesting anomalies identified that warrant further investigation.

We identified 5 areas of focused work as a result of last year’s data analysis. In terms of the benchmarking we have started to do our representation for all protected groups is favourable. The other Trusts also face similar challenges in terms of BME representation at senior levels. We need to continue our investigations into short term contracts and the prevalence of BME Staff within the figures.

On the positive side we have seen an increase in the number of female Consultants, a reduction in the number of ‘unknowns’ for disability. In addition the Reasonable Adjustment guidance has been disseminated which will hopefully ease some of the anxiety staff feel as a result of experiencing health problems that have ongoing implications.

In terms of the deep dive activity conducted last year, whilst not all was conclusive and further work needs to be done. The results did provide some assurance that our Human Resources processes do not discriminate against our staff from protected groups. The band six career progression work survey report confirmed this.

As with previous reports the numbers of undeclared or undefined status remains significant this includes Trust Board member’s data. Accurate assessment of representation is therefore difficult in some areas. To this end we are conducting a revalidation exercise and would like to include the Trust Board in order that we can

comply with the Department of Health's memorandum on Governance procedures. It recommends regular reviews of the composition of the Board to ensure that its appropriately diverse in terms of all of the protected characteristics which are gender, age, ethnicity, disability, religion and belief and sexual orientation. Because of the gaps in data it is difficult to accurately report our position.

Finally limitations remain in terms of the data that is recorded and collected. However having completed a second years report using this format we are in a stronger position to identify where the gaps are and what action needs to be taken to address them. This will be included in the 2014/15 equality work plan.

### 6.3 2014 Workforce Key Priorities

- Workforce data revalidation/exercise to be completed
- To conduct some further analysis for those BME staff appointed into band 7 positions
- To identify our Human Resources data recording activity to identify where we are unable to generate accurate equality reports
- Adopt best practice data collection and analysis through benchmarking with East Midlands colleagues
- Conduct a deep dive into the number of LGBT staff represented in disciplinaries

## 7. AREAS OF FOCUS FOR 2014 - 2015

Following the first phase of the CMG review there is clear commitment and sign up to the principles of equality and inclusion, however some gaps remain in terms of how we evidence that access to and delivery of care is equitable for all.

The focus for 2014 will therefore centre on the patient's journey using the care pathway review and due regard process as the means by which this achieved. To further embed equality the CMG leads will provide assurance reports to their senior teams at least quarterly.

## 8. SUMMARY

UHL continues to declare legal compliance with the Public Sector Equality Duty and has a range of activities and processes to evidence our position. In addition we are meeting all of our external requirements via the Quality Schedule and the Learning Disability Self Assessment Framework.

There is no doubt that the principles of equality are well understood by most staff in the Trust. What is more difficult to evidence is the extent to which the principles of equality are fully embedded into everyday thinking and practice at all levels. This will be the main focus of this years work plan.

## 9. RECOMMENDATION

The Trust Board is asked to note and agree the content of the report.

Appendix 1

# A refreshed Equality Delivery System for the NHS: EDS2

Making sure that everyone counts
November 2013

At the heart of EDS2 are 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four goals, as shown in the table on the following page. These outcomes relate to issues that matter to people who use, and work in, the NHS. Among other things they support the themes of, and deliver on, the NHS Outcomes Framework, the NHS Constitution, and the Care Quality Commission's key inspection questions set out in "Raising standards, putting people first - Our strategy for 2013 to 2016". The "Outcomes and gradings" tables shown on pages 18 to 35 identify which national policy initiatives each outcome relates to and helps to deliver.

NHS organisations are advised to assess and grade their performance across all EDS2's outcomes, except for when there is a compelling reason for being selective. Each year, starting in 2014, NHS England will identify one EDS2 outcome where it believes concerted national effort is required in order for the NHS to improve its equality performance. Guidance and support will be provided for delivery on this outcome, and good practice will be shared. On rare occasions organisations may wish to focus on a subset of the 18 outcomes where there is local support for doing so, and local evidence that indicates that a focus on particular outcomes will be beneficial.

NHS organisations are encouraged to express EDS2's outcomes in their own words and communicate them effectively to all local audiences, as they see fit. NHS England will share local adaptations of these outcomes with NHS organisations. An Easy Read version of the EDS will be produced and made available to the NHS.

These outcomes relate to issues that matter to people who use, and work in, the NHS.

# The goals and outcomes of EDS2

| Goal | Number | Description of outcome |
|---|---|---|
| Better health outcomes | 1.1 | Services are commissioned, procured, designed and delivered to meet the health needs of local communities |
| | 1.2 | Individual people's health needs are assessed and met in appropriate and effective ways |
| | 1.3 | Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed |
| | 1.4 | When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse |
| | 1.5 | Screening, vaccination and other health promotion services reach and benefit all local communities |
| Improved patient access and experience | 2.1 | People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds |
| | 2.2 | People are informed and supported to be as involved as they wish to be in decisions about their care |
| | 2.3 | People report positive experiences of the NHS |
| | 2.4 | People's complaints about services are handled respectfully and efficiently |
| A representative and supported workforce | 3.1 | Fair NHS recruitment and selection processes lead to a more representative workforce at all levels |
| | 3.2 | The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations |
| | 3.3 | Training and development opportunities are taken up and positively evaluated by all staff |
| | 3.4 | When at work, staff are free from abuse, harassment, bullying and violence from any source |
| | 3.5 | Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives |
| | 3.6 | Staff report positive experiences of their membership of the workforce |

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| Inclusive leadership | 4.1 | Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations |
| | 4.2 | Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed |
| | 4.3 | Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination |

**Appendix 2**

**University Hospitals of Leicester NHS Trust**

**Progress of Equality Delivery System actions arising from the UHL equality plan December 2013**

| **1. Better Outcomes For All.** | | | | |
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| **Action** | **Lead** | **By When** | **Progress Update December 2013** | **RAG Status*** |
| Ensure that the Due Regard analysis is undertaken on all improvement schemes. If an adverse impact is anticipated /identified this needs to be noted and reported to the Service Improvement Board. Further advice may be required before progressing the scheme | Service Improvement Innovation Project Leads | April 2014 | The monitoring process is in place. Project leads have been trained and the diabetes project, moving some patients from hospital to GP practices has a completed the due regard analysis as does the Ambulatory care project. No adverse impacts have been identified some recommendations have been provided.<br><br>The numbers of assessments received have been disappointing. This suggests that the due regard process isn't as well embedded as it could be. Appointments have been made with the CMG managers to undertake a baseline audit of equality activity. Due Regard assessment will be included in the discussion.<br><br>All CMG interviews with the Managers have taken place and the themes identified. | 4 |
| Produce a UHL Equality Strategy once the national strategy and Equality Delivery System 2 is | Equality Lead | February 2014 | The national strategy is due in October 2013. The national and regional equality structures have now | 4 |

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| launched | | December 2013 | been identified. Equality team to meet with the regional lead for the national update in October 2013.<br><br>The regional lead attended the equality leads meeting and reported that the ED strategy had been delayed. The Regional leads agreed to undertake some benchmarking in the following areas:<br>1. Learning and development data and or access to training,<br>2. Capability and grievances<br>3. Staff survey outcomes<br>4. Exit numbers<br><br>The Regional Strategy has been drafted. | |
| Undertake an audit to assess how embedded equality is into everyday practice<br><br>Develop required actions to inform next years equalit work programme and address any identified gaps | Clinical Management Group Leads<br><br>Equality Team | ~~August 2013~~ November 2013<br><br>April 2014 | The audit template has been developed.<br>Due to the reconfiguration of the Divisions the audit date has been reset for November 2013.<br><br>CMG interviews due to commence and be completed in November. Findings to be reported in the Trust Board report December 2013.<br>CMG qualitative review concluded. | 5 |
| **2. Improved Access and experience** | | | | |
| Implement a training awareness programme for staff on hate crime to better support patients accessing emergency care | LPT, EMAS, the Equality Lead UHL | April 2014 | Some sessions held for staff within ED, delivered by the local Police lead for hate crime. Training not completed.<br><br>The script for the e learning package has been drafted and reviewed.<br>Awaiting draft 2 of the programme. | 4 |

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| | | | No further progress. | |
| Develop clinical guidance for the care of a bariatric patient. This is as a result of several complaints having been received | Bariatric Care Steering Group | ~~December 2013~~ January 2014 | The steering group has been established and all current issues identified. A briefing paper describing the issues and required actions to resolve them to be presented to the Nursing Executive Committee in ~~November 2013.~~ January 2014.<br><br>A solution has been identified and actioned for the provision of a specialised trolley to transport deceased patients to the mortuary. | 3 |
| Work in partnership with other agencies to identify the local mental health priorities for Leicestershire and Rutland | Equality Lead | ~~October 2013~~ The date for publication has been altered by the Public health Lead December 2013 | Data required from UHL has been provided to the Public Health Lead.A Draft report has been completed. | 3 (changed from green to yellow from previous update) |
| **3. Empowered, engaged and well supported staff** | | | | |
| Produce an annual workforce and patient metrics report as part of our compliance with the Public Sector Equality Duty | Equality Team | December 2013 | Format agreed. The report is to be agreed by the Trust Board in December before the publication on the web site in January 2014.<br><br>Agreement secured at the November regional equality leads meeting that local Trusts will benchmark some of their workforce and patient data with one another. The next meeting is December 4th 2013.<br><br>Initial benchmarking undertaken. | 5 |

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| Increase the number of people receiving ED training which is mandatory | Equality Team | December 2014 | Data is monitored annually and reported in the annual equality workforce monitoring report. Latest figures suggest we are at the same point as last year in terms of numbers of people accessing training which on average is250 per month. Overall compliance is however 45% compared to Safeguarding which is 70%. The increased emphasis upon completion of mandatory training and the launch of the new ED online programme should help to increase the level of compliance.<br><br>Numbers of people who have completed their Equality training has increased from 37% to over 59%. | 4 |
| Develop a bespoke ED e-learning package to be managed internally. | Equality Team, e-UHL Team, OBC media | November 2014 | Initial package developed, next stage editing in progress<br><br>Product launched in October 2013. | 5 |
| Develop 'top tips' for the faith and non faith provision of care for patients to increase staff awareness. These will be made available on the equality resource page on Insite | Equality Team | January 2014 | The working group is convened. Members of the public will be invited to contribute at the Annual Public Meeting on the 19th September 2013.<br><br>Feedback received from event. | 4 |
| To improve the food provision for Muslim staff in the restaurants as currently vegetarian food is the only option for Muslim members of staff<br>As per discussion | Interserve and Horizons | ~~September~~ December 2013 | A staff engagement group has been established and we have agreed that we will identify a sandwich provider with the appropriate certification but that we will be unable to provide a hot halal option for staff.<br><br>The preferred supplier originally identified no longer provides non stunned meat. An alternative has to be identified. Interserve are doing a site visit of a potential alternative supplier and will report back at the November meeting. | 4 |

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| | | | No suitable provider has been identified to date. | |
| Develop clear guidance in respect of learning support for staff with Dyslexia and Dyscalculia | Nurse Education, Equality and Training lead | February 2014 | A task and finish group has been established to review the current arrangements. Clearer advice for Education Leads, Managers and staff is required and will be developed by the group<br><br>A paper to be presented to the Nursing Executive shortly by the Education Team.<br><br>No progress. | 4 |
| Undertake a revalidation of staff's personal details. | Workforce Lead | TBC | Equality Lead has met with the workforce Lead. Funding of 5K needs to be identified. Equality Lead to confirm the costing with the Workforce Lead before agreeing the commencement date. Agreement secured. To include revalidation of the Trust Board due to new appointments.<br><br>Work will be completed by March 31st 2014. | 4 |
| **3. Inclusive leadership** | | | | |
| **Actions** | **Lead** | **By when** | **Progress Update** | **RAG** |

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| Act on the findings of the 2012 workforce report. The 2012 workforce monitoring report and Band 6 leadership questionnaire identified the following areas warranting further work and are:<br><br>-Over the age of 40 you fair well from application to short listing, this position is reversed at appointment<br><br>-There is a higher than average number of males and individuals from a BME background are employed on fixed term contracts<br><br>- Look at a selection of applications, short listing and appointments for band 7 recruitment | Recruitment Lead | December 2013 | Deep dive work scheduled to review the age profile of a sample of applications through the application process for a range of different graded posts.<br><br>Deep dive work scheduled to review the BME backgrounds of applicants applying for and subsequently being successful in fixed term posts. Then compare this data to a sample of permanent roles.<br><br>Review a sample of band 7 recruitment activity across the equality groups to identify if any area appears to be disproportional.<br><br>Results included in the annual 2013 workforce monitoring report. | 5 |
| Maintain the Leicester Works programme and secure permanent positions for as many students as possible | Equality Team | September 2014 | | 4 |

*Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

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| ***RAG Status Key:*** | ***5*** | ***Complete*** | ***4*** | ***On Track*** | ***3*** | ***Some Delay – expected to be completed as planned*** | ***2*** | ***Significant Delay – unlikely to be completed as planned*** | ***1*** | ***Not yet commenced*** |

**Appendix 3**

## UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

### Patient Experience, Equality and Engagement Assurance Committee Terms of Reference

1. To develop, review and endorse key performance patient experience, equality and engagement indicators for University Hospitals of Leicester NHS Trust and performance manage their implementation.

2. To review and endorse the Trust Annual report and Annual Quality schedule and any associated work.

3. The purpose of the Patient Experience, Equality and Engagement Group (is to provide an assurance framework to support and monitor) activity across the Trust.

4 To act as a monitoring hub for reports and feedback from CMG's relating to Equality, Engagement and Patient Experience.

5. To monitor and support the Trust's compliance with the relevant legislation national policy, guidelines, Clinical Management Group action plans and progress reports relating to Patient Experience, Equality and Engagement

6. To provide advice to the Trust Board on issues relating to Equality Experience and Engagement. In particular, to highlight the existence of any current or potential risks.

7. To provide a forum to review the effectiveness of collaboration and communication across all Clinical Management Groups to ensure robust practice. Including the dissemination of lessons from patient experience and equality complaints.

8. To review and endorse any policies, guidelines and procedures relating to Engagement, Experience and Equality activity.

9. To receive and approve monthly CMG assurance reports feedback.

10. To disseminate national, regional and local policy and guidelines on issues relevant to equality, engagement and experience.

**Appendix 3a**

## Trust Patient Experience, Equality and Engagement Assurance Committee Membership

**Chair** Director of Nursing
**Vice Chair** Deputy Medical Director
Senior Nurse for Patient Experience
Equality Manager
Patient and Public Involvement and Membership Manager
Patient Adviser
One member of the Equality Advisory Group
Patient Safety representative (complaints )
Allied Health Professional

| | |
|---|---|
| **Frequency of meetings:** | Monthly |
| **Reporting mechanisms:** | EEEAC will report to the Trust Board |
| Other internal reporting mechanisms | Human Resources Senior Equality meeting - Equality Manager<br>Biannual reports to the Trust Board<br>The Nursing Executive Team Head of Nursing Patient Experience |
| **Circulation of minutes:** | Membership<br>To be confirmed |

**Appendix 3b**

# University Hospitals of Leicester
# Clinical Management Group Report for experience, equality and engagement

Clinical Management Group……..

Clinical Management Group PPI / Equality/ Patient Experience Leads ……

Month and Year ……..

## Legal and External Reporting Requirements

**Engagement**
Section 242(1B) of the National Health Service Act 2006 states that [NHS Trusts] must make arrangements as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved in:

(a) The planning of the provision of services
(b) The development and consideration of proposals for changes in the way services are provided
(c) Decisions to be made by that body affecting the operation of those services

**Equality**
To meet the requirements of the Equality Public Sector Duty the Trust needs to:

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups

**Patient Experience Feedback**
Application of the Friends and Family Test score across specifically defined areas and gathered from a minimum of 20% discharge footfall. Improvements as laid out in the Quality Commitment which is the trust's response to patient feedback.

## Supporting evidence / data

| Evidence required | R | A | G | Reporting Timeframe | Comments |
|---|---|---|---|---|---|
| **Standard : The patient's view is reflected in the planning and provision of services** | | | | | |
| Evidence of patient representation in CMG Board / committees | | | | | |
| PPI priorities identified (service developments / key projects / annual planning priorities / complaints data / survey data) and informing annual PPI / Equality plan. | | | | | |
| Actions identified in the annual plan are on track | | | | | |
| Opportunities for involvement communicated and advertised | | | | | |
| PPI leads have attended training / development in PPI | | | | | |
| Number of staff who have completed equality training | | | | | |
| Patient representative progress assessment completed | | | | | |
| Evidence of the outcomes/ impact of PPI activity | | | | | |
| Evidence of completed / ongoing involvement | | | | | |
| Due regard proformas completed for all Service developments /changes for workforce and service developments | | | | | |
| **Standard: Individuals peoples health needs are assessed and met in appropriate ways** | | | | | |
| Use of interpreting | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Documented record of any reasonable adjustments made to a patients care i.e. referral to learning disability specialist nurse | | | | | |
| Complaints analysis discussed at the CMG Board | | | | | |
| Patient experience feedback analysed by gender, age and ethnicity | | | | | |
| Quality account reports | | | | | |
| **People, carers and communities can readily access hospital community health or primary care services and should not be denied access on unreasonable grounds** | | | | | |
| Patient metrics reports | | | | | |
| Patient Experience Surveys completed by carers and relatives | | | | | |
| Flexible visiting for carers and relatives | | | | | |
| **When people use NHS services their safety is prioritised and they are free from mistakes , mistreatment and abuse** | | | | | |
| Evidence that patients detained under the mental health act (where applicable) are provided with information regarding their rights | | | | | |
| Numbers of people trained on hate crime | | | | | |
| **People report positive experiences of the NHS** | | | | | |
| LD annual complaints analysis included in the LD annual report | | | | | |
| **All wards need to achieve 20% return rate for their surveys** | | | | | |
| Identify wards not achieving target number of surveys (20%) | | | | | |
| Identify all wards with a Friends and Family Test score below 50 and identify agreed actions | | | | | |
| Identify 3 improvements within CMG that have resulted from patient feedback each month | | | | | |
| Progress against the quality commitment is monitored and actions agreed | | | | | |

| PES Question | Jan 14 | Feb 14 | March 14 | April 14 | May 14 | June 14 | July 14 | August 14 | Sept 14 | Oct 14 | Nov 14 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Assistance to toilet | | | | | | | | | | | |
| Call button | | | | | | | | | | | |
| Involved in Care | | | | | | | | | | | |
| Medication Side Effects | | | | | | | | | | | |
| Problem / danger | | | | | | | | | | | |
| Who to contact | | | | | | | | | | | |

Report completed by

Please submit monthly returns by xxxxx to

# Workforce Equality and Diversity

# Monitoring Report

2012-2013

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

a

**Contents**

# Executive Summary Equality Workforce Monitoring Report 2012-2013

The Workforce monitoring report has been presented to the Trust Board as to comply with our Legal Duty we need to publish the data against the nine protected characteristics that are:

- Disability
- Sex
- Race
- Age
- Sexual Orientation
- Religion or Belief
- Marriage and Civil Partnerships
- Pregnancy and Maternity
- Gender Reassignment

Currently we only routinely collect staff data on disability, age, race, religion and belief, sex, and sexual orientation. We are awaiting Government confirmation as to whether we will be expected to extend our data collection to all of the nine characteristics in the future.

In line with our requirements under the Public Sector Equality Duty we have collected, analysed and published our workforce data by:

- Overall workforce profile
- Pay
- Recruitment
- Staff leaving
- Disciplinary and Grievance
- Training

## Key Headlines

The total head count of staff remains comparatively stable. We have however seen some changes within our staff groups with a significant number of staff from Estates and Ancillary having transferred to Interserve. There has been a small increase in staff in additional clinical services and medical and dental. Reassuringly our overall profile remains unchanged.

The more detailed data indicates:

- A higher than expected representation of staff involved in the disciplinary process who either have declared a disability, identify as LGB or are aged 41-50 yrs.
- A reduction in the ‘unknown’ status in areas of disability, sexual orientation and religion and belief although not sufficient to draw firm conclusions from data.
- The continued challenge of representation at senior level.

## Limitations of the Data

Whilst we have staff data available in some areas there remain some limitations.

- We continue to be unable to fully report on training as current recording of e-UHL training data does not allow for protected characteristic breakdown. We are therefore unable to draw any concrete conclusions around training.

- Due to limitations of the current reporting processes for recruitment the data does not enable a direct comparison of data sets but gives an indication of trends. This is due to data for applicants applying and shortlisted has been extracted from NHS Jobs, and appointed data is extracted from the Electronic Staff Record. This leads to some discrepancies due to time delays from shortlisting to successful applicants starting and a discrepancy in reports if appointed applicant is an internal candidate.
- The period reported for recruitment is October 2012-September 2012 (due to limitations in reporting on NHS jobs) and excludes junior doctors.

## Top Priorities identified in 2011-2012

In last year's Workforce Report we identified five top priorities as part of our ongoing action plan. Below is an update of how we have progressed:

- **To establish benchmarks with similar acute Trusts so we can consider our performance in line with others and where possible work jointly to resolve issues**.

The regional Equality leads continue with this piece of work to establish a systematically agreed data set across region, with the aim of establishing three top priorities. In order to reassure ourselves that our overall representation is consistent with other Acute Trust's an initial benchmarking of workforce data was carried out. The results indicate (see Appendix A) that our declaration rates are greater than neighbouring Trusts and our overall representation is favourable.

- **To understand why a higher proportion of males and individuals from a BME background are employed on fixed term contracts.**

Our leaver's data indicated that individuals from a BME background employed on fixed term contracts were over represented. Initial deep dive work into this on a sample of posts both fixed term and permanent has indicated that although a higher percentage of individuals from a BME background apply for fixed term posts (51% vs 67%) at the point of shortlisting there is no difference (46% vs 47%).

In order to reassure ourselves that our complete recruitment process is fair we need to complete further analysis on those appointed into positions. This is not recorded on NHS jobs so there is no automatic flow of reporting currently to achieve this. We will look at a sample of posts to verify the reason for the fixed term contract.

- **To develop guidance for staff on ''reasonable adjustment''.**

This piece of work was undertaken to continue to enhance support for staff with a disability or long term health condition. The guidance was developed through the Disability Advisory steering group alongside colleagues from Human Resources. The guidance has been circulated to staff and managers and is available on our internal website for all to access. It is hoped it will support a pro-active attitude to making reasonable adjustments for staff where needed and ensure a standardised approach throughout the Trust.

- **To audit band 6 staff to identify any perceived /real blocks to career progression for BME staff.**

This piece of work was undertaken due to the decreased representation of female and BME staff in senior positions in the Trust as evidenced in our previous annual workforce report. The aim was to investigate career aspirations of band 6 staff and if there were any perceived barriers unique to particular groups that were preventing career progression.

The findings suggest that there is no indication of direct discrimination evident between men and women, ethnic groups or differing age groups which are acting as barriers to career progression.

Common themes were identified across all groups as to the perceived barriers to progression including availability of suitable positions, access to development opportunities and access to additional training.

It is recommended that in order to further validate the findings of this report appointment's to band 7 and above and exit data of staff leaving for promotion should also be reviewed and analysed.

- **To ensure equality data is consistently embedded in all data recording across the Trust, with clear explanation and reassurance given on how the data will be utilised.**

The data in this years report demonstrates improvements in some reporting areas.

In order to provide clarity and ensure all data is captured correctly reporting of disciplinary and grievance data has been reviewed and changed slightly to last year making any comparisons difficult. It has however resulted in the ability to report across protected characteristics in detail for the first time.

For next year we wish to identify our Human Resources data recording activity to identify where we are unable to generate accurate equality reports. Actions will then need to be agreed as to the way forward.

## Section 1 – Disability

We know from the Office of National Statistics that 19% of people of working age have a disability but only about half of these are in work (approx 8.5%).

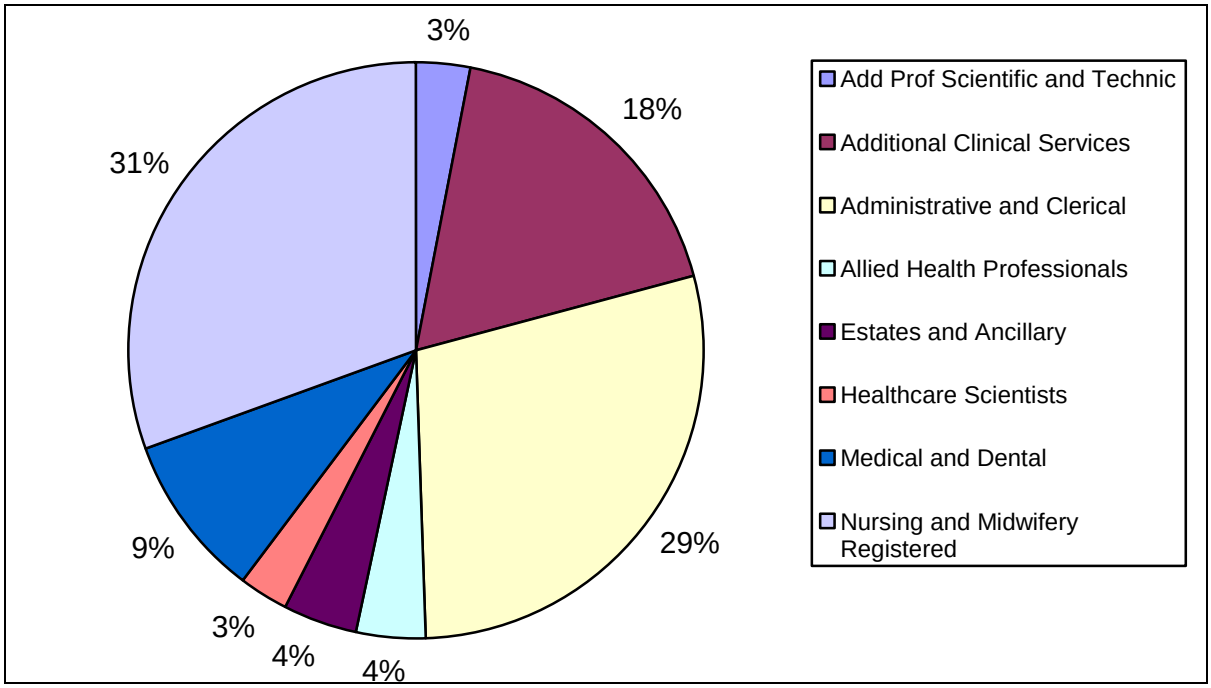
### 1.1 Disability profile of staff in post.

| Year ending | 2013 | 2012 | % of change |
|---|---|---|---|
| No | 56.8% | 51.6% | +5.2% |
| Yes | 1.4%** | 1.1% | +0.3% |
| Choose not to declare | 5.8% | 0.7% | +5.1% |
| Unknown | 36% | 47% | -11% |

** 1.4% represents **159 staff**

The data demonstrates that we have reduced the percentage of staff whose disability status was unknown by 11%. This reduction is reflected in the increase in all other categories including those declaring a disability. This pattern is not seen in other local Trusts, with their percentage of unknown disability status ranging from 67% – 84%. Despite this the % staff that have declared themselves as having a disability in these Trusts varies from 0.9% to 1.8% and therefore remains consistent with UHL's data.

**Comparison of the Percentage of disabled staff in each staff group.**

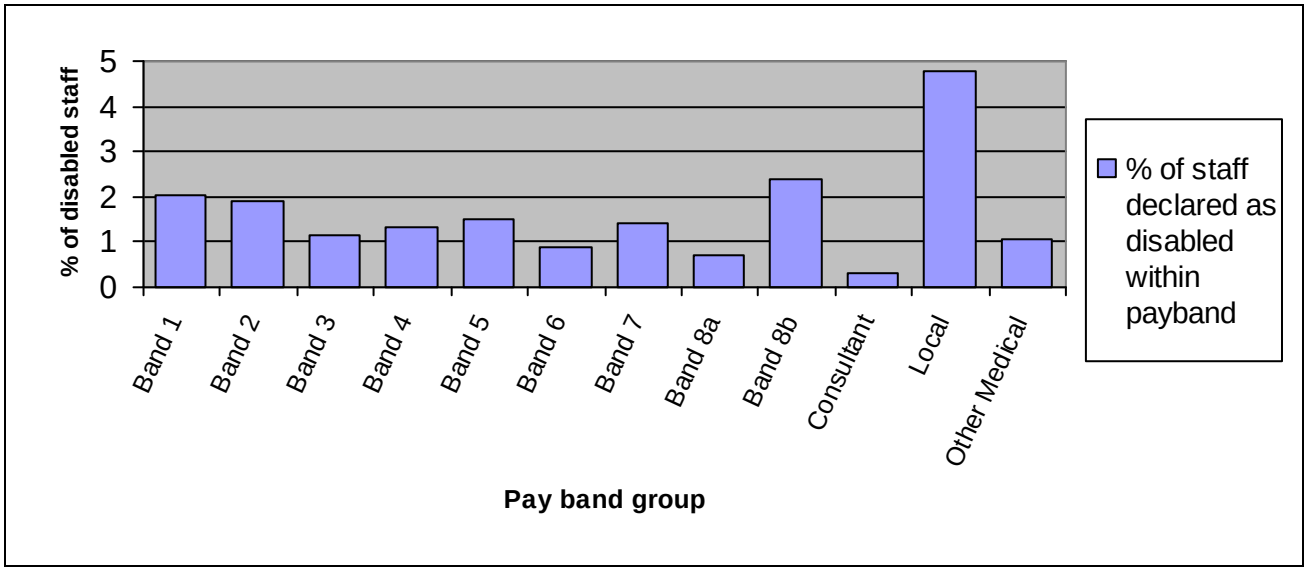



When compared to our previous year's data we can see some changes in the representation of disabled staff within some staff groups:

- Increase of 7% in Medical and Dental – this group has reduced their undeclared status but remain under represented in relation to their workforce numbers.
- Decrease of 7% in Administrative and clerical – in terms of head count there is no change and are over represented in relation to their workforce numbers.

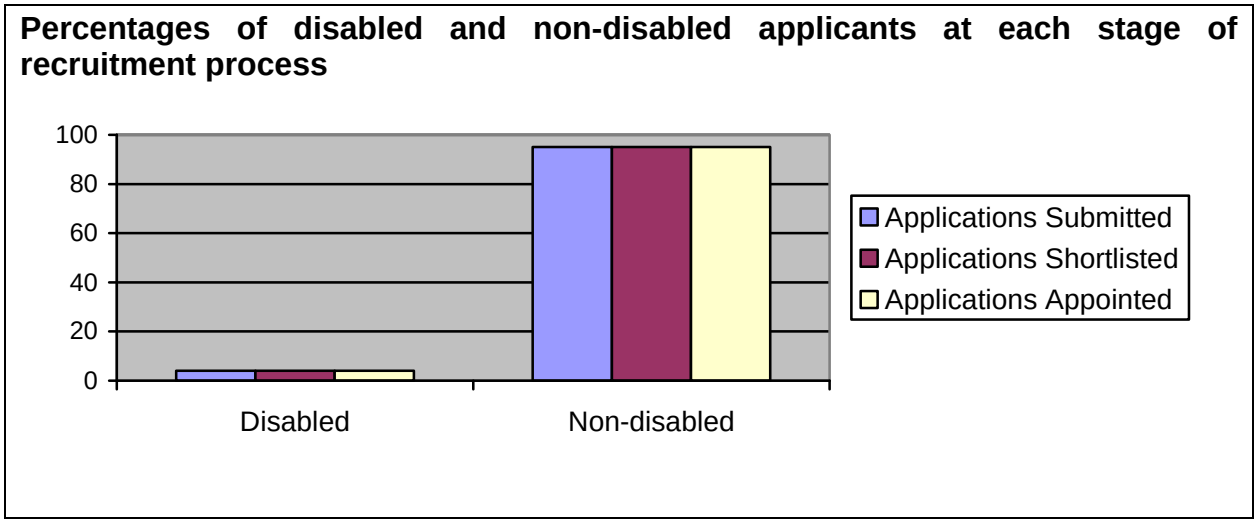
- Decrease of 5% in Estates and Ancillary staff – this group have seen an overall reduction in headcount due to employee transfers.

### 1.2 Disability and Pay




The data shows the percentage of disabled staff within band 5, band 8b, other medical and those on a local pay band have increased. All other bands remain broadly consistent with last year's data.

### 1.3 Disability Profile at Recruitment




The trend in the data shows that there is no discrimination shown to applicants that declare a disability throughout the recruitment process.

### 1.4 Disability of Staff Leaving

31 staff who left the Trust declared themselves as disabled, this equates to 1.7% of the total staff turnover. This is an increase on last year; however 0.5% of these staff were involved in the employee transfer. Taking this into account the data suggest that disabled staff are not over represented in staff leaving the Trust.

### 1.5 Disciplinary and Grievance

2.8% of staff who have been involved in a disciplinary investigation declared a disability. This suggests a higher number of individuals who declare a disability have been involved in a disciplinary process in relation to workforce representation.

The number of grievances brought this year has reduced to 12; we are unable to meaningfully report this data for disability.

### 1.6 Disability and Access to Training

| Courses | Disability | | | | | |
|---|---|---|---|---|---|---|
| | Yes | | No | | Undefined / Undisclosed | |
| Leadership (EMLA) | 0 | - | 107 | 100% | 0 | - |
| Leadership (UHL) | 0 | - | 82 | | 73 | |
| Short Courses | 7 | 1.3% | 300 | 57% | 215 | 41% |
| QCF's | 2 | 3% | 63 | 97% | 0 | - |
| Apprentices | 0 | - | 39 * | 100% | 0 | - |

* 4 Apprentices did register as having learning difficulties.

## Summary

Within the organisation we have continued to see an increase in staff declaring whether they have a disability. The number of staff is comparable to other acute Trusts. There remains however approximately one third of the workforce who's status is unknown and therefore remain unable to draw any firm conclusions from the data.

The data we have demonstrates:

- We have staff declaring a disability in all staff groups and across most pay bands with the exception senior staff of band 8c-9.
- There is no discrimination within the recruitment process with 4% of new starters declaring a disability.
- There was a slight increase in staff with a disability leaving the Trust but this appears to be accounted for by staff within an employee transfer process.
- There is an over representation of disabled staff who have been involved in a disciplinary procedure.
- No staff declaring a disability has undertaken a leadership course although UHL data in this area is incomplete.

## Key actions

- To deep dive into the disciplinary data to establish why we maybe seeing increased representation in staff declaring a disability.
- To continue to encourage staff to declare their disability status through the forthcoming ESR refresh.
- To deep dive into the staff groups recording a low percentage of staff with a disability to ensure there is no indirect discrimination.
- To continue to develop support for staff with disabilities to become an employer of choice.

## Section 2 – Sex (formally referred to as gender)

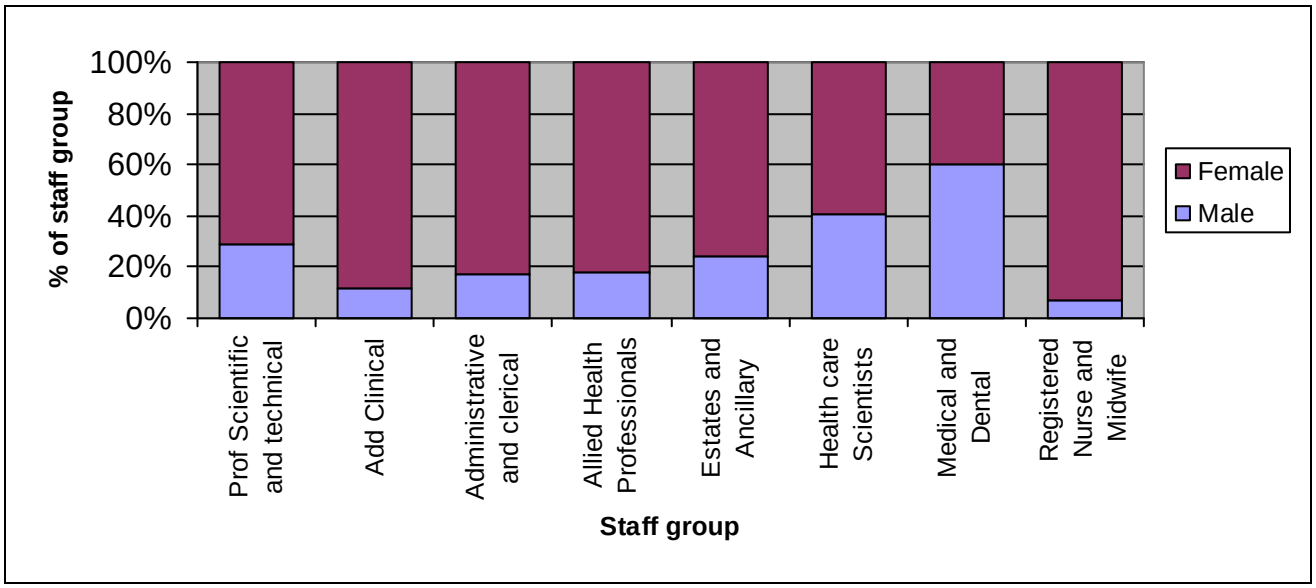
Under the Equality Act (2010) the term ''sex'' has replaced gender.

### 2.1 Sex profile of staff in post.

| | 2013 | 2012 | % of change |
|---|---|---|---|
| Female | 79.2% | 78.5% | +0.7% |
| Male | 20.8% | 21.5% | -0.7% |

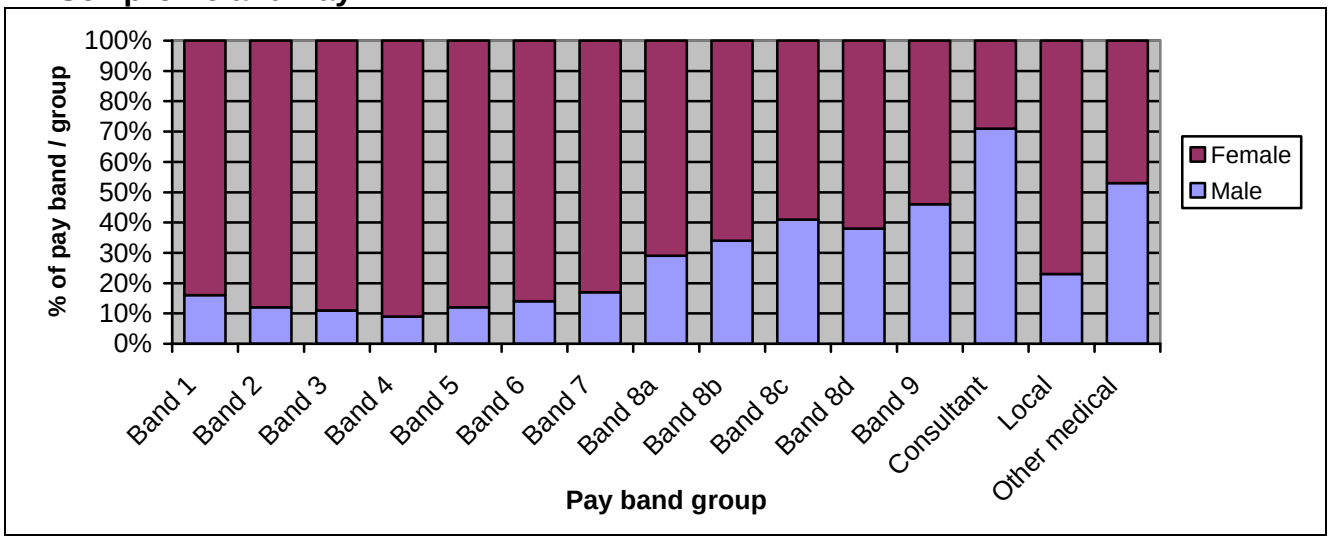
The data shows a small percentage rise in female staff compared to last years data. The broad workforce split of 80% female and 20% male is seen in the data of all but one of the other Acute Trusts used for comparison.

### Sex as a proportion of staff group




There has been a 15% decrease in male staff and corresponding increase in female staff in the Estates and Ancillary following a significant employee transfer from this group of staff. The data demonstrates consistency in all other staff groups with last years data.

### 2.2 Sex profile and Pay



The data continues to demonstrate the overall trend of decreasing female representation and increasing male representation as a proportion as the pay band increases.

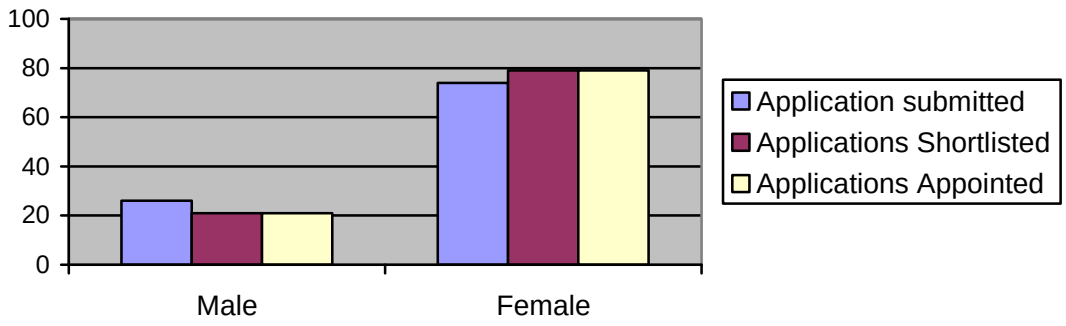
When compared to last years data there is:

- A decrease in the percentage of male representation in bands 1-4.
- An increase in male representation at band 8D and local pay band.
- Stability in all other pay bands.
- A 2% increase in female consultant appointments

"Local" pay bands include staff on the previous Trust payscales, apprentices and senior management.

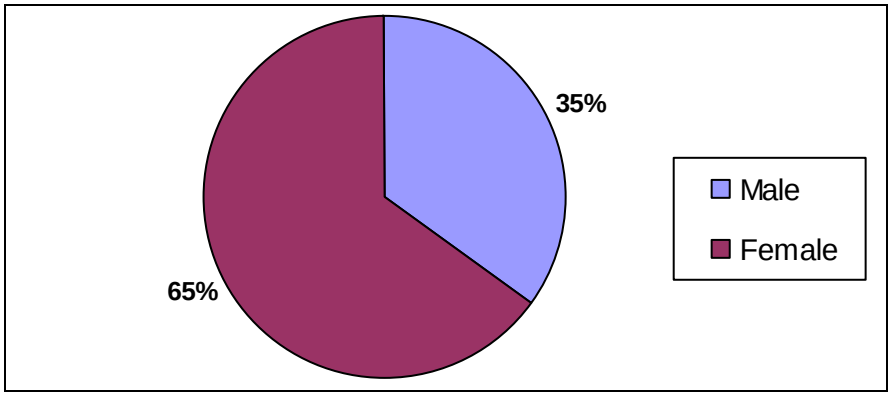
### 2.3 Sex Profile at Recruitment

**Percentages of the sex of applicants at each stage of recruitment process**




The trend in data indicates that less male applicants are shortlisted from applications submitted. The appointment from shortlist however is consistent for both sexes indicating no discrimination.

### 2.4 Sex of Staff Leaving

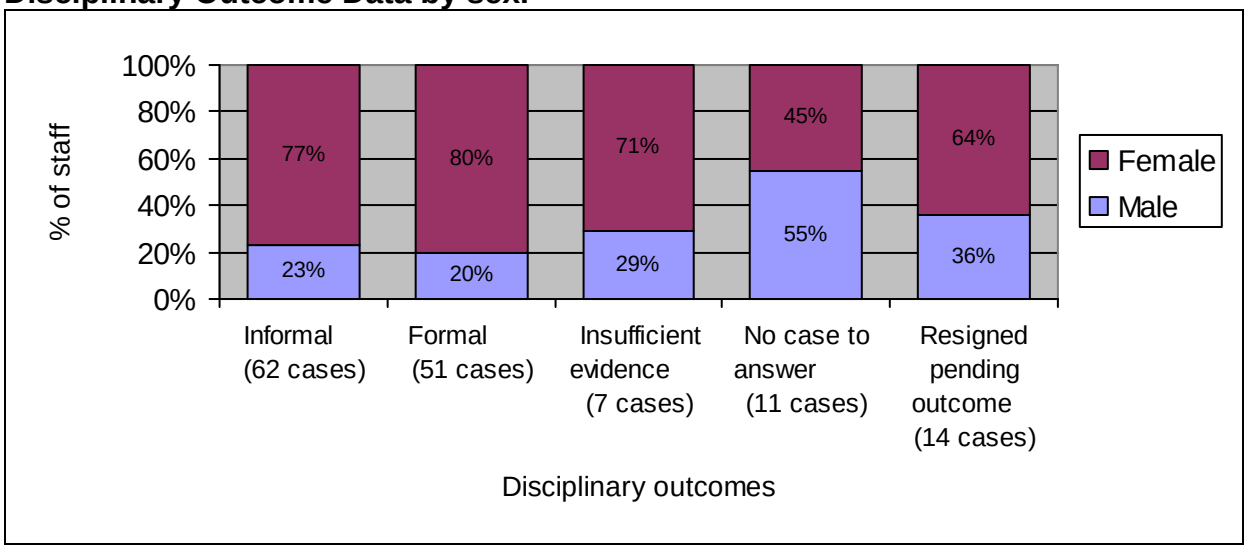



There is no change this year in the percentage of each gender leaving the Trust. This indicates that more male staff than expected based on representation have left the Trust. Further analysis of the data indicates that we continue to see over representation of male staff in ‘end of contracts’ and this year within the employee transfer process.

## 2.5 Sex Profile and Disciplinary and Grievance

A total number of 145 disciplinary cases and 12 grievance cases were concluded during 2012-2013.

**Disciplinary Outcome Data by sex.**




The data suggests that the sex representation in both informal and formally concluded cases was consistent with total workforce representation. There is an increased representation of male staff where it was deemed there was no case to answer or staff choosing to resign before a conclusion was reached. It should be noted however that the number of cases in these areas are small.

**Grievance Outcome Data by sex**

| | Total cases | Female | | Male | |
|---|---|---|---|---|---|
| Upheld | 4 | 4 | 100% | 0 | - |
| Not upheld | 8 | 7 | 87.5% | 1 | 12.5% |

The data demonstrates over representation of female staff bringing a grievance however the total numbers are so small no meaningful conclusions can be drawn from this.

**2.6 Sex Profile and Access to Training**

| Courses | Sex | | | |
|---|---|---|---|---|
| | Male | | Female | |
| Leadership (EMLA) | 50 | 46% | 57 | 53% |
| Leadership (UHL) | 24 | 16% | 131 | 84% |
| Day Courses | 77 | 15% | 445 | 87% |
| QCF's | 12 | 18% | 53 | 81% |
| Apprentices | 11 | 28% | 28 | 71% |

The data demonstrates that more female staff are attending leadership courses at UHL compared with those attending the East Midlands Leadership Academy (EMLA) programmes. The difference in representation on the courses maybe due to only senior staff accessing leadership courses at EMLA, whereas internal leadership courses are accessible to staff across the banding structure. An under representation

of males is also seen in our attended day courses and those undertaking a qualification credit framework (QCF).

## Summary

The sex makeup of or total workforce has remained consistent with previous data, and comparable with other acute Trusts.

The detailed data demonstrates:

- A continued stability in sex representation in all staff groups, with the exception of Estates and Ancillary where there is a reduction in male representation following an employee transfer from this group.
- An overall trend of decreasing female representation and increasing male representation, as a proportion, as the pay band increases.
- During recruitment more female staff are shortlisted from application, but from shortlist to appointment there is no difference between the sexes.
- There is an over representation of male staff leaving the Trust.
- The percentages of sexes involved in informal and formally concluded disciplinary cases is consistent with total workforce representation.
- An under representation of male staff undertaking internally attended training.

## Key Actions

- To further investigate the nature of the fixed term contracts which see a higher proportion of male staff leaving the Trust.
- Investigate how widely flexible working options are accessed at consultant level.

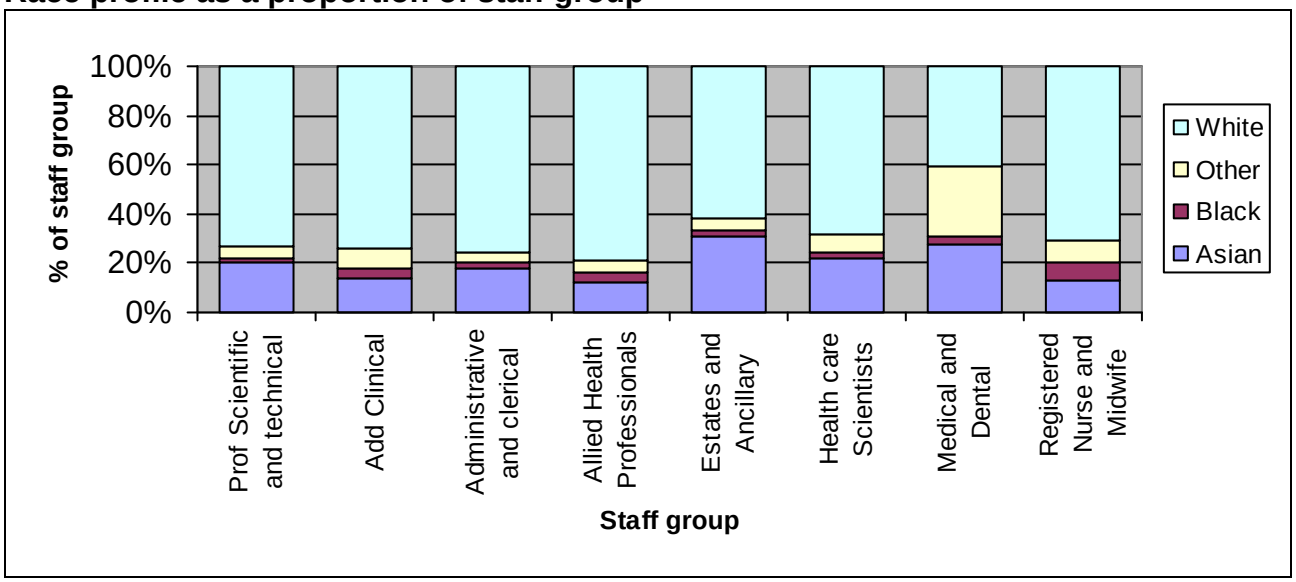
## Section 3 – Race

### 3.1 Race Profile of Staff in Post.

| | 2013 | 2012 | Percentage of change |
|---|---|---|---|
| Asian | 17% | 19% | -2% |
| Black | 4% | 4% | - |
| Other | 11% | 6% | +5% |
| White | 68% | 71% | -3% |

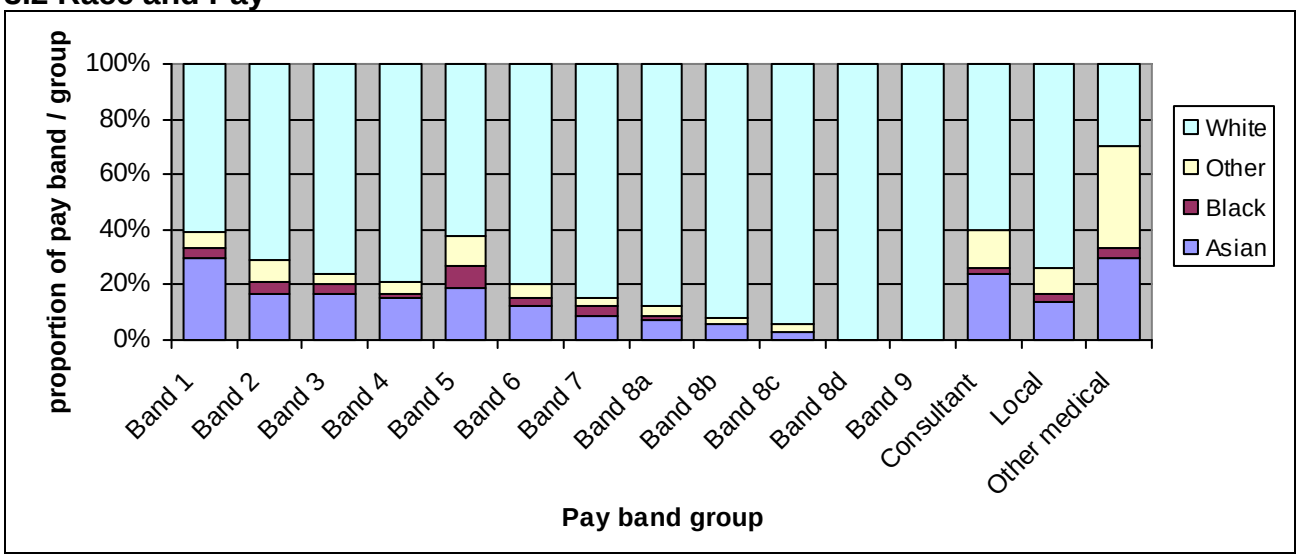
The data indicates an increase in our BME representation from 29% last year to 32% this year. This percentage is higher than any of the other Trusts used for comparison with other Trusts ranging from 12 -28%.

**Race profile as a proportion of staff group**




The data indicates a significant change in the racial makeup of medical and dental staff, with the percentage of staff that falls within the 'Other' category increasing by 18% while representation of staff from a White, Asian or Black racial profile all fell.

### 3.2 Race and Pay

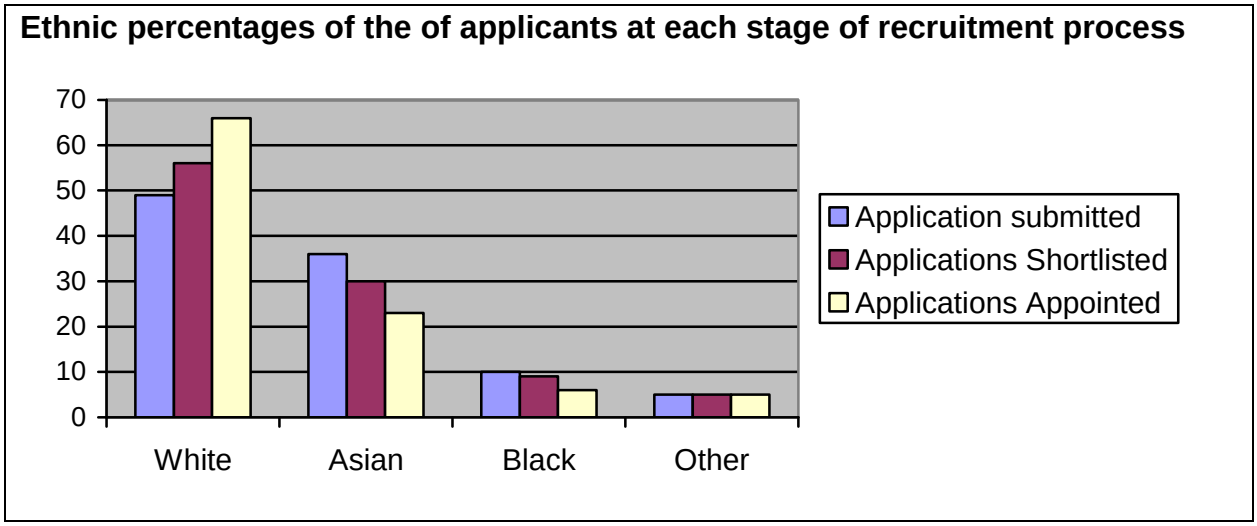


The data demonstrates two significant changes when compared to last years data:

- In 'Band 1' there is a percentage decrease of staff from an Asian and Black background.
- In 'other medical' there is a percentage decrease in staff from an Asian background and an increase in staff from within the 'other' category.

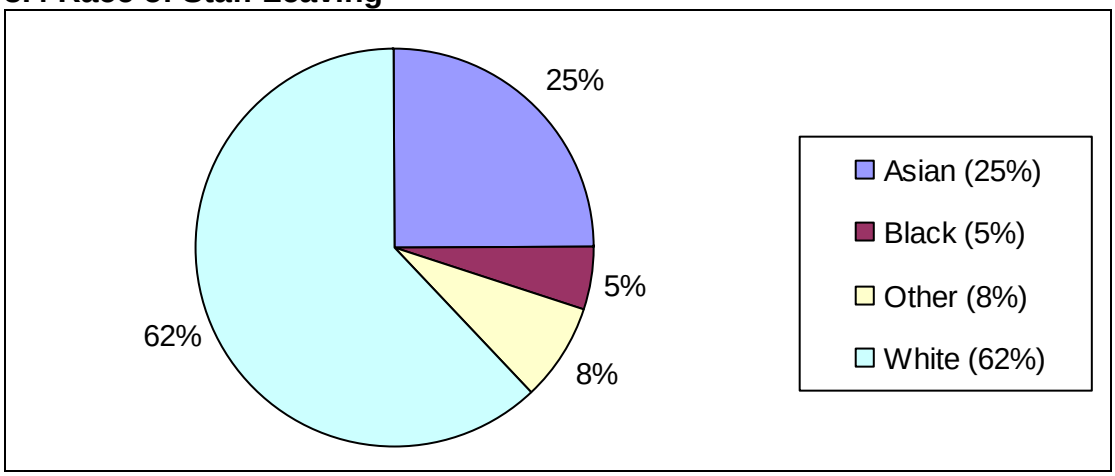
### 3.3 Race Profile at Recruitment

**Ethnic percentages of the of applicants at each stage of recruitment process**




As was evident last year the data trends continue to suggest that applicants from a White background are more successful through the application process, with a higher percentage appointed in relation to initial applications. The reverse is true for applicants from an Asian or Black background.

### 3.4 Race of Staff Leaving

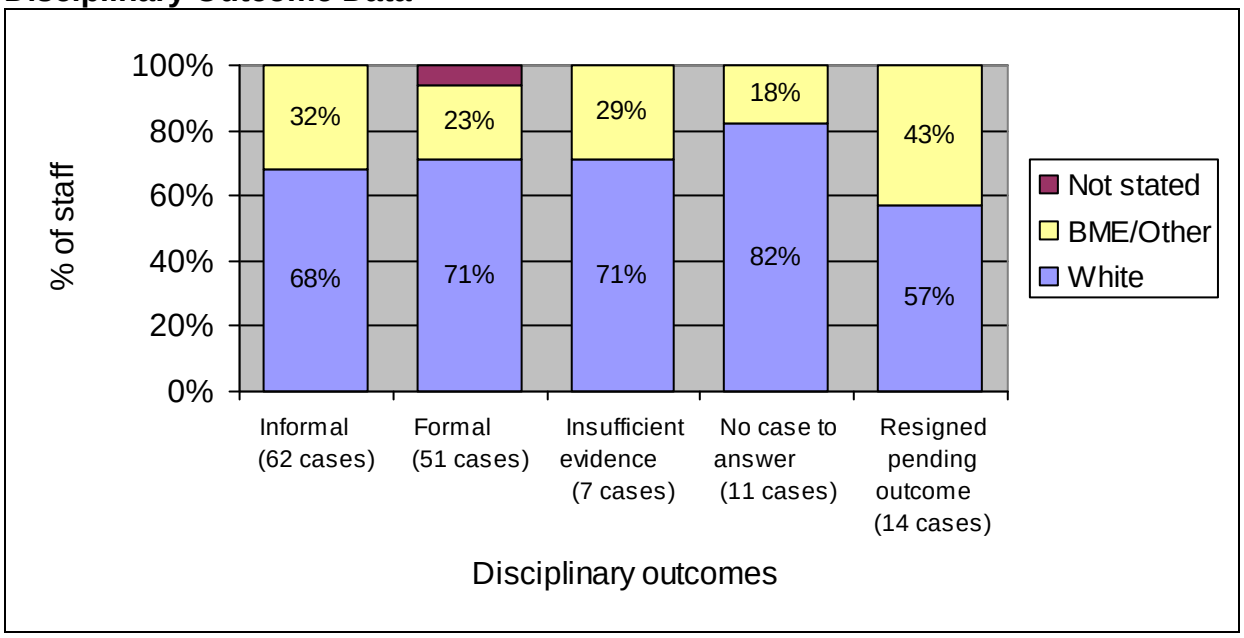



The data indicates that there is an over representation of Asian staff leaving the Trust. Initial investigations show this is particularly evident amongst staff whose employment was transferred, who were working on a fixed term contracts and those whose role involves external rotation (usually medical staff in training).

### 3.5 Disciplinary and Grievance by Race

A total number of 145 disciplinary cases were concluded during 2012-2013.

**Disciplinary Outcome Data**




The data indicates that BME staff are not over represented in any group of disciplinary outcomes except those who choose to resign before the case was concluded. The small numbers in this group however do not allow any meaningful conclusions to be drawn from this.

**Grievance Outcome Data**

| | **Total cases** | **White** | | **BME/Other** | |
|---|---|---|---|---|---|
| Upheld | 4 | 1 | 25% | 3 | 75% |
| Not upheld | 8 | 7 | 87.5% | 1 | 12.5% |

As the total numbers of grievances is small we cannot draw any meaningful conclusions at this time. The data does however demonstrate that a higher percentage of grievance cases brought by non-white staff were upheld.

### 3.6 Ethnicity and Access to Training

| **Courses** | **Ethnicity** | | | | | |
|---|---|---|---|---|---|---|
| | White | | BME /Other | | Undefined/ Undisclosed | |
| Leadership (EMLA) | 60 | 56% | 18 | 17% | 29 | 27% |
| Leadership (UHL) | 120 | 77% | 32 | 21% | 3 | 2% |
| Short Courses | 429 | 82% | 76 | 15% | 17 | 3% |
| QCF | 53 | 82% | 12 | 18% | 0 | - |
| Apprentices | 26 | 67% | 13 | 33% | 0 | - |

Our broad race profile for staff is reflected in those who undertook an apprenticeship. In all other areas of training recorded there is a under representation of non-white staff accessing training.

## Summary

The data indicates a rise in our BME representation within the workforce as a whole.

The detailed data demonstrates:

- A continued stability in BME representation in all staff groups, with the exception of Medical and dental which indicates the percentage of staff that falls within the 'Other' category increasing by 18%.
- An overall trend of decreasing representation of staff from a BME background (with the exception of band 5) as the pay band increases.
- Within medical staff we see an over representation of staff from a BME background in relation to total workforce figures.
- During the recruitment process staff from a white background are more successful than individuals from an Asian or Black background.
- There is an over representation of BME staff leaving the Trust this is particular evident amongst staff from an Asian background. Some of this is due to rotation of medical staff and this year's employee transfer process.
- The racial background of staff involved in the disciplinary process is what we would expect from our workforce population.
- An under representation of staff from a BME background attending training.

## Key Actions

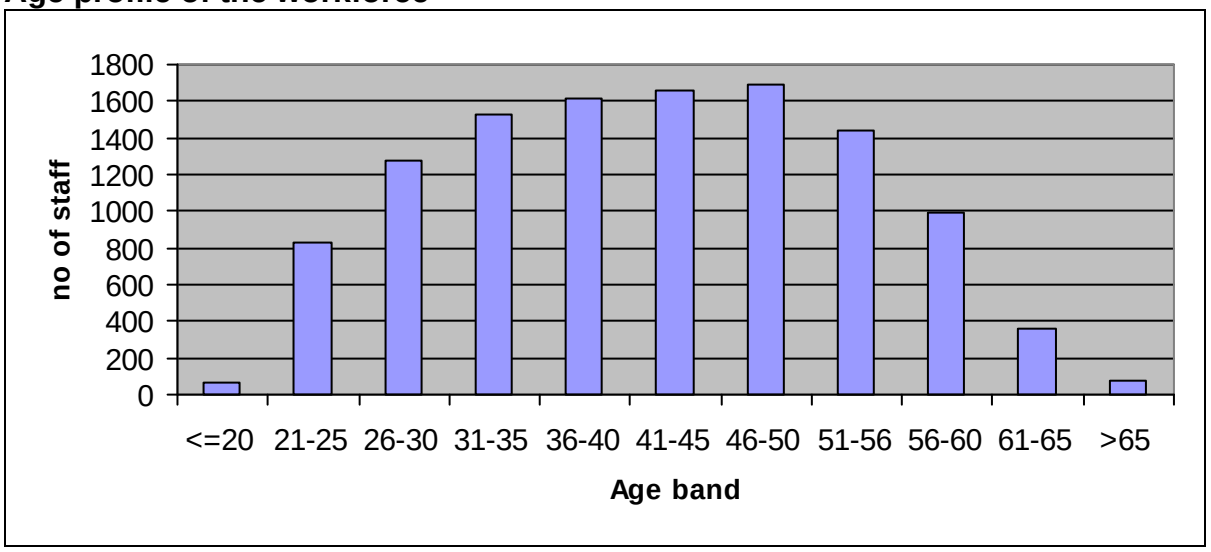
- To investigate why some staff groups have poor BME representation.
- To examine why white staff appear to be more successful at interview.
- To further investigate the nature of fixed term contracts which see a higher proportion of BME staff leaving the Trust.
- To understand why and consider actions to address low representation of BME staff at senior levels.

## Section 4 – Age

### 4.1 Age profile of staff in post.

| | 2013 | 2012 | % of change |
|---|---|---|---|
| <20 yrs | 0.6% | 0.4% | +0.2% |
| 21-25yrs | 7% | 7% | - |
| 26-30yrs | 11% | 11% | - |
| 31-35yrs | 13% | 13% | - |
| 36-40yrs | 14% | 14% | - |
| 41-45yrs | 14% | 15% | -1% |
| 46-50yrs | 15% | 15% | - |
| 51-55yrs | 13% | 13% | - |
| 56-60yrs | 9% | 9% | - |
| 61-65yrs | 3% | 3% | - |
| >65yrs | 0.6% | 0.6% | - |

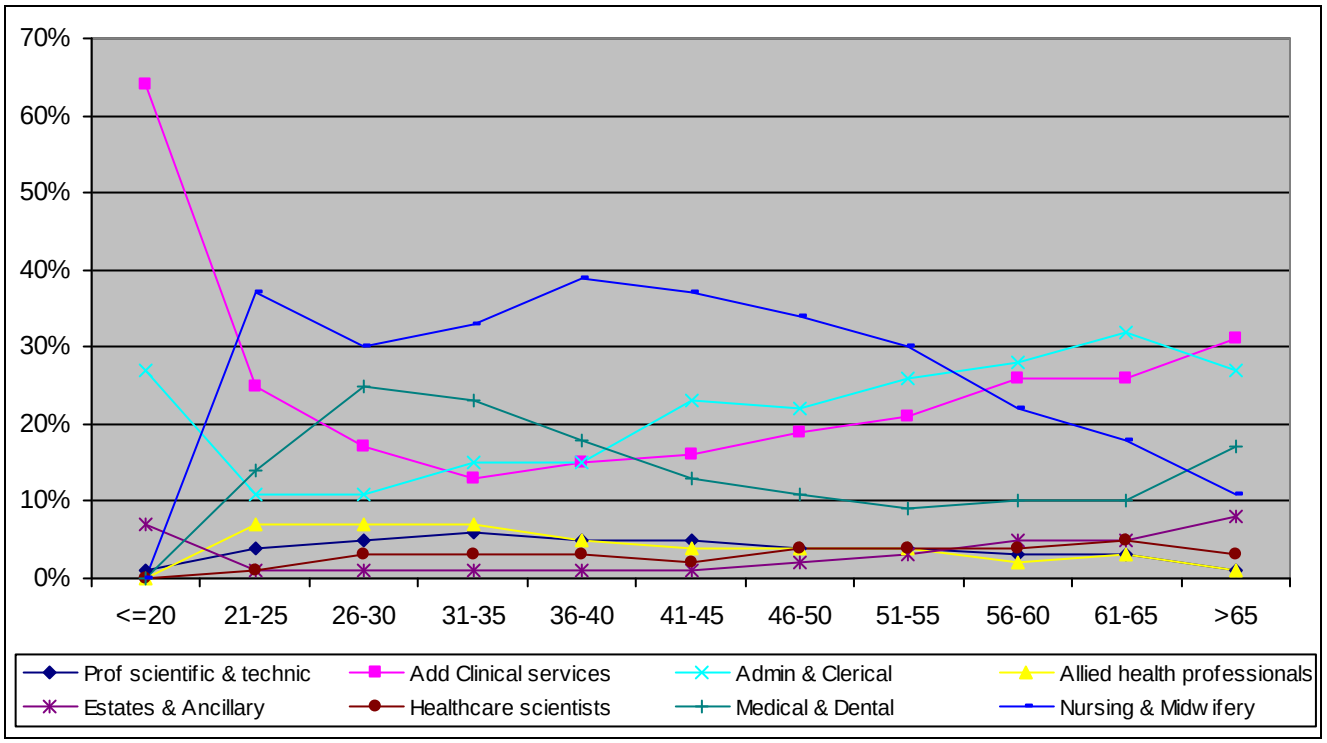
**Age profile of the workforce**




The age profile of staff has remained stable over the last twelve months with data demonstrating a normal distribution across age groups with the majority of staff falling between 36 -50yrs.

UHL's age profile is consistent with other acute Trusts, with the exception of an acute Trust in the north of the country who's profile indicates lower trends of staff <40yrs and higher of staff with aged >41yrs.

**Age profile of staff groups.**

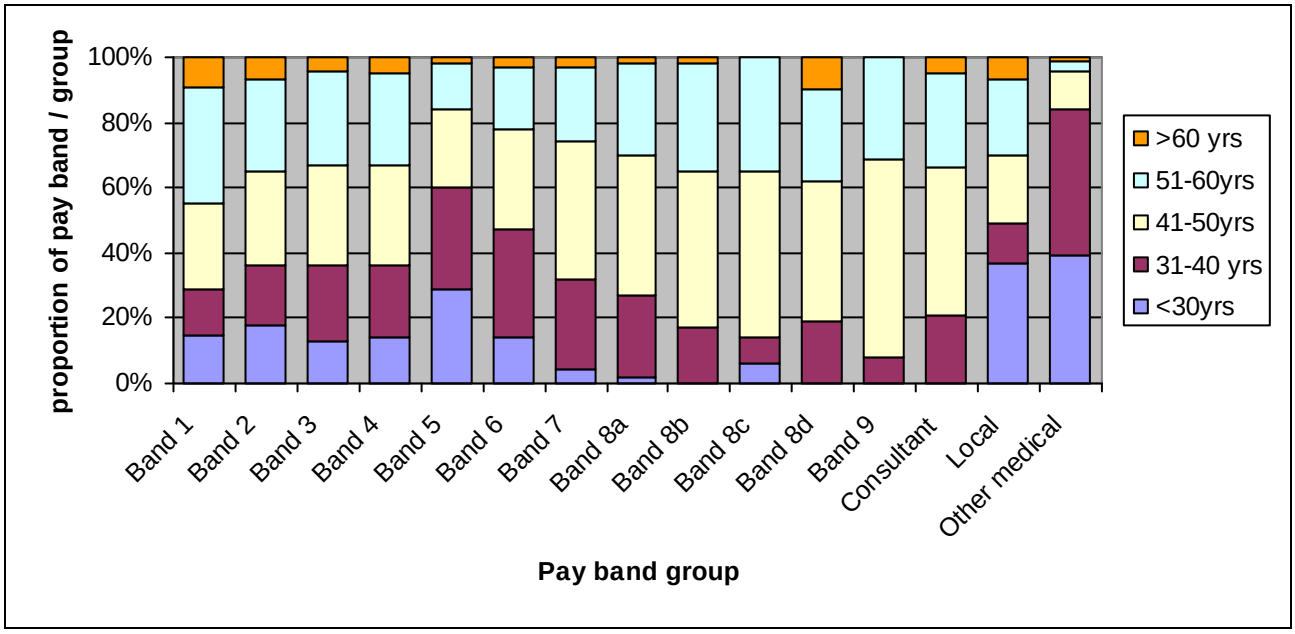



In this years report we have reported staff groups different and therefore we are unable to make direct comparisons with last years data.
The data shows:

- A large percentage of staff that provides additional clinical services is under the age of 25yrs.

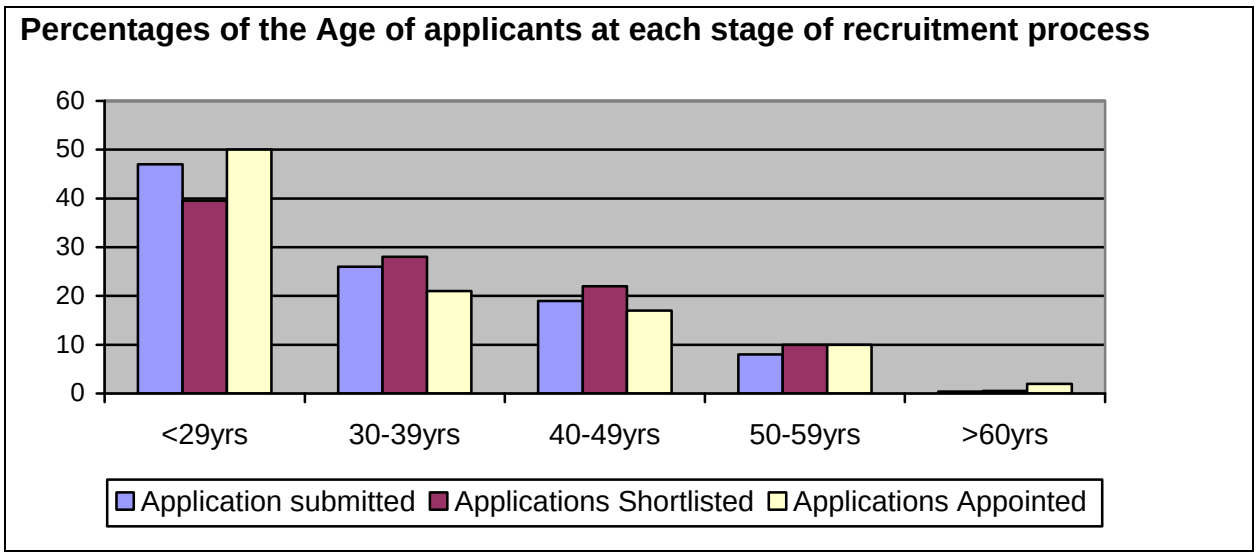
- The majority of our nursing and midwifery staff is between the ages of 25-50 yrs.
- Medical and dental staff peak between 26 -35yrs consistent with numbers of junior staff.
- The percentage of admin and clerical staff increases through each age bracket from 30yrs with a similar pattern seen in staff that provide additional clinical services.
- All other staff groups are reasonably equally represented from the age of 21-65yrs.

### 4.2 Age and Pay




The data continues to show good age representation across all bands, with the expected fewer younger staff (aged< 30yrs) in senior positions.

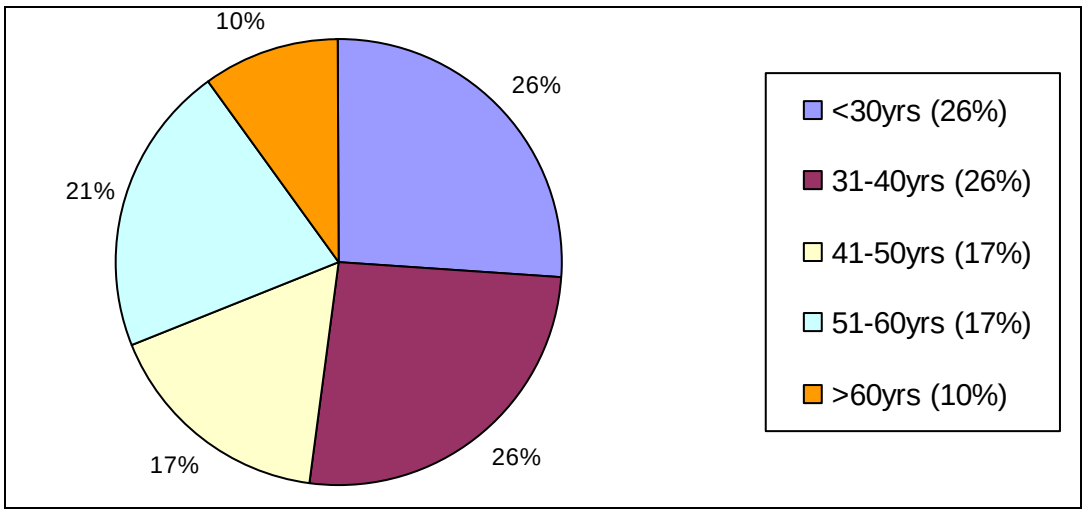
### 4.3 Age Profile at Recruitment




The majority of applicants come from staff aged less than 29yrs, with high percentages of those shortlisted being appointed. The number of applicants decreases with age. The data trends suggest that a higher number of those aged

between 30-59yrs are shortlisted from application but only those between 50-59yrs see the same percentage appointed.

### 4.4 Age of staff leaving

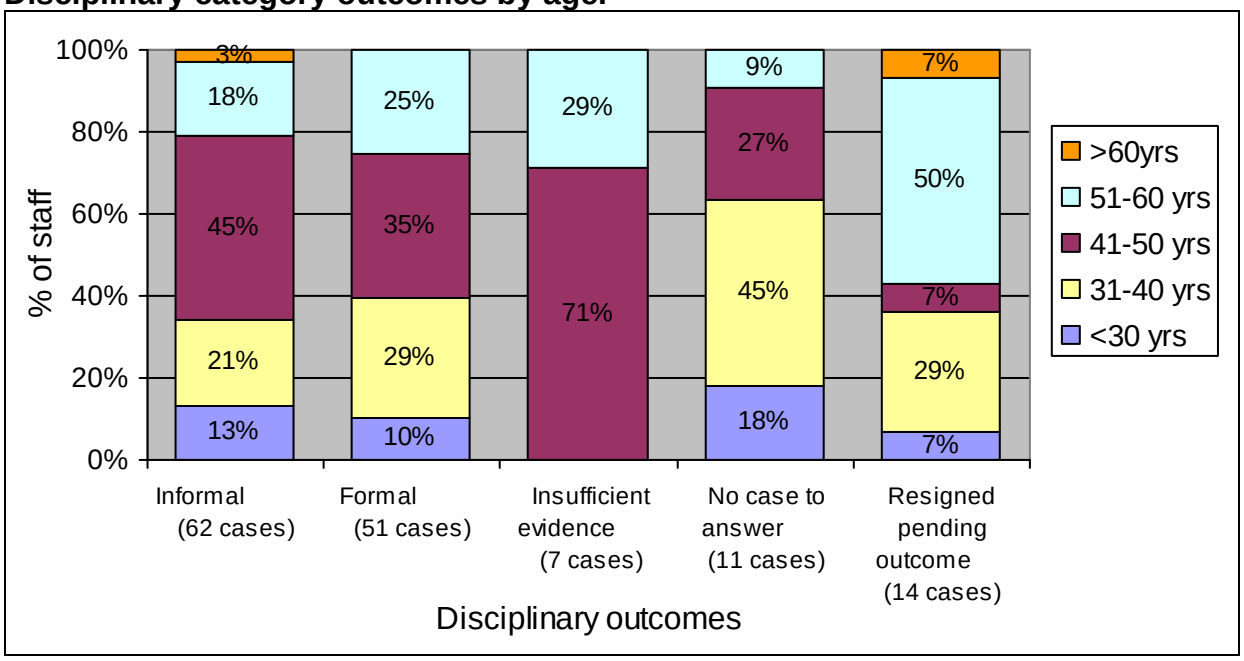



This year's data shows an increase of staff between the ages of 41-60yrs leaving the Trust. Further investigation shows that 68% of staff involved in the employee transfer fell within these age groups.

### 4.5 Disciplinary and Grievance

A total number of 145 disciplinary cases were concluded during 2012-2013.

**Disciplinary category outcomes by age.**




The data shows that:

- There is a higher than expected representation of staff aged 41-50yr involved in disciplinary cases.
- There is a higher than expected representation of staff aged 31-40yr involved in disciplinary cases where it is found that there is no case to answer**.

- There is a higher than expected representation of staff above the age of 51yrs that choose to resign before an outcome in determined**.

**NB numbers in these categories are small.

**Grievances**

| | **Total cases** | **31-40yrs** | | **41-50yrs** | | **51-60yrs** | | **>60yrs** | |
|---|---|---|---|---|---|---|---|---|---|
| Upheld | 4 | 1 | 25% | 2 | 50% | 1 | 25% | 0 | - |
| Not upheld | 8 | 1 | 12.5% | 0 | - | 6 | 75% | 1 | - |

As the total numbers of grievances overall is small we cannot draw any meaningful conclusions at this time. The data does however demonstrate that 58% of grievances were brought by staff aged between 51-60yrs with the majority of them not being upheld.

**4.6 Age and access to Training**

| | <20yrs | 20-30yrs | 30-40yrs | 40-50 yrs | 50-60yrs | >60yrs |
|---|---|---|---|---|---|---|
| QCF learners | 0 | 19 | 17 | 21 | 8 | 0 |
| Apprentices | 9 | 24 | 5 | 1 | 0 | 0 |

*Age is not recorded for Leadership or UHL day courses.

## Summary

The data indicates stability in our age profile across the workforce with the peek of staff between 36 -50 yrs of age.

The detailed data demonstrates:

- A representation of all age bands across staff groups with a particularly high percentage of staff under 25yrs employed in additional clinical services.
- Within the recruitment process staff under the age of 29yrs are most prominent with a high percentage of applicants being appointed, this trend is not seen in any other age group.
- Expected patterns in the age profile of staff leaving the Trust with an over representation in staff aged <30yrs as many are in training posts or >60 yrs as individuals retire.
- There is over representation of staff aged between 41-50 yrs within our disciplinary processes.

## Key Actions – Points to consider

- To deep dive into why and increased number of staff aged 41-50yrs are involved in disciplinary processes.

## Section 5 – Sexual Orientation

In a 2010 survey by the Office of National Statistics 95% of those questioned identified themselves as heterosexual, 1% identified as Gay or Lesbian, 0.5% as Bisexual and the remaining 3.5% as other or do not know. This would suggest that individuals who identify as LGB total 1.5%.

### 5.1 Sexual Orientation Profile of Staff in Post.

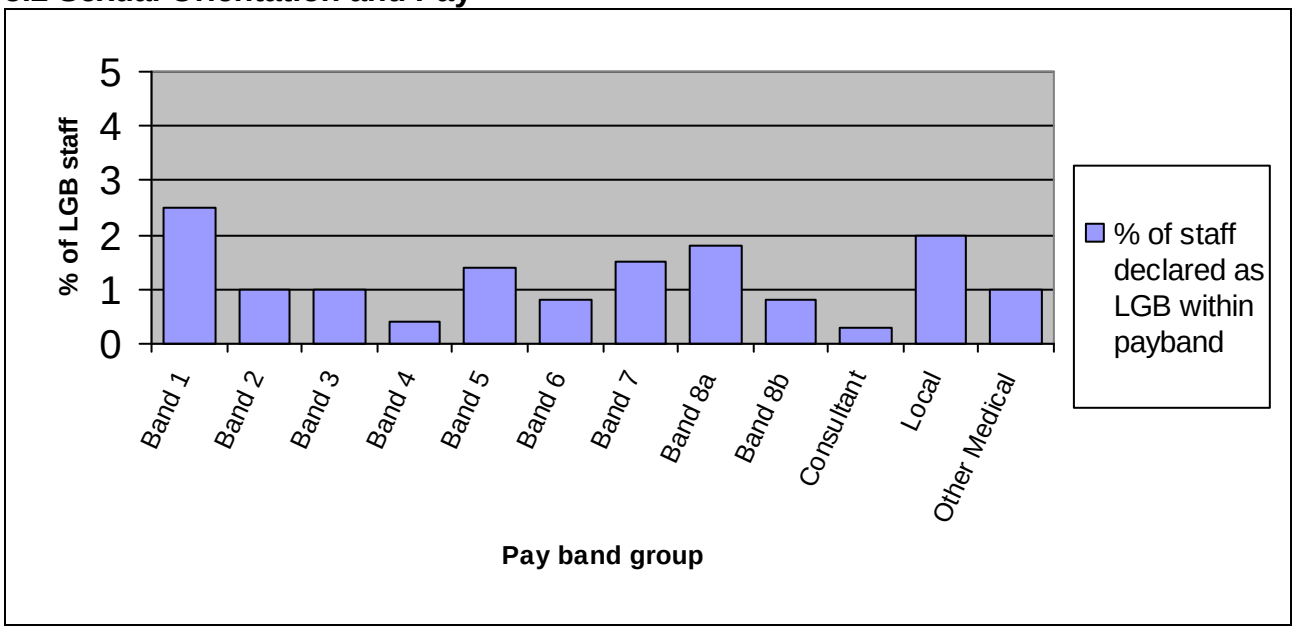
| | 2013 | 2012 | % of change |
|---|---|---|---|
| Bisexual | 0.49% | 0.47% | +0.02% |
| Gay | 0.37% | 0.34% | +0.03% |
| Heterosexual | 53.19% | 44.3% | +8.9% |
| Lesbian | 0.23% | 0.24% | +0.01% |
| Do not wish to declare | 13.2% | 7.8% | +5.4% |
| Unknown | 32.6% | 46.9% | -14.3% |

* 127 staff declared as LGB = 1.1% staff population this is significantly higher than neighbouring Trusts.

The data shows that this year we have seen a decrease in staff with an undefined sexual orientation status. This is mainly reflected in an increase in 'heterosexual' and those who 'do not wish to disclose' their sexual orientation, the number of staff who identify themselves as lesbian, Gay or bisexual (LGB) remains stable.

There are staff that have identified themselves as LGB in all staff groups. The percentages within each staff group ranging between 0.7%-2.2%.

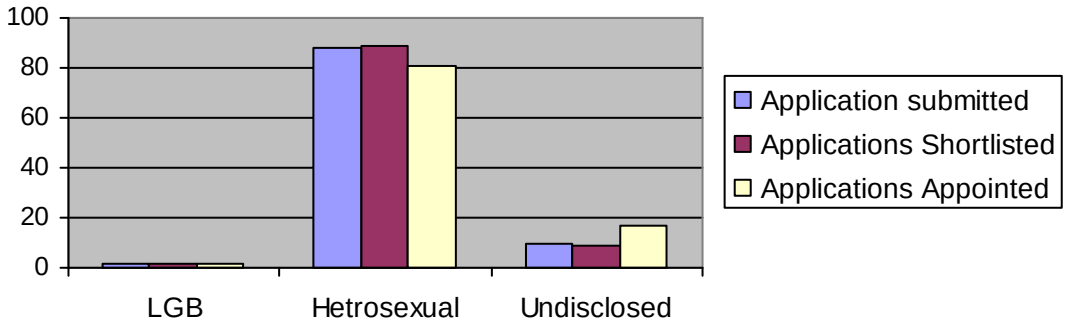
### 5.2 Sexual Orientation and Pay




There is a broadly equal spread of staff that identifies themselves as LGB in all pay bands, except for senior bands of 8C, 8D and 9 where no staff identify as LGB.

### 5.3 Sexual Orientation Profile at Recruitment

**Percentages of the sexual orientation of applicants at each stage of recruitment process**




The data shows that a number of applicants did not disclose their sexual orientation; therefore it is difficult to draw any firm conclusions. From the data available the trends suggest that applicants who declare the sexual orientation as LGB are equally successful through each stage of the recruitment process. Where as those who declare their sexual orientation as heterosexual faired worse at application.

### 5.4 Sexual Orientation of staff leaving

Of staff that left the Trust 1.1% (21) declared their sexual orientation as LGB. Of these 43% left due to employee transfer.

### 5.5 Disciplinary and Grievance

4% of staff involved in a disciplinary process declared their sexual orientation as LBG this is above the average total staff population. As the total number of grievances are so small (12), no trends are able to be identified.

### 5.6 Sexual Orientation and Access to Training

| Courses | Sexual Orientation | | | | | |
|---|---|---|---|---|---|---|
| | LGB | | Heterosexual | | Undefined/ Undisclosed | |
| Leadership (EMLA) | 2 | 2% | 12 | 11% | 93 | 87% |
| Leadership (UHL) | 1 | 1% | 82 | 53% | 72 | 46% |
| Day Courses | 13 | 2% | 294 | 56% | 215 | 41% |
| QCF's | Not currently recorded | | | | | |
| Apprentices | Not currently recorded | | | | | |

A representative number of LGB staff are attending training.

## Summary

The data indicates a representation within the workforce as a whole.

The detailed data demonstrates:

- We have staff identifying as LGB in all staff groups and across most pay bands with the exception senior staff of band 8c-9.

- There is no discrimination within the recruitment process with 2% of new starters identifying as LGB.
- There is an over representation of staff identifying as LGB who have been involved in a disciplinary procedure.

## Key Actions – Points to consider

- To deep dive into the disciplinary data to establish why we maybe seeing increased representation of staff that identify as LGB.
- To continue to encourage staff to declare their sexual orientation through the ESR refresh.

## Section 6 – Religion or Belief

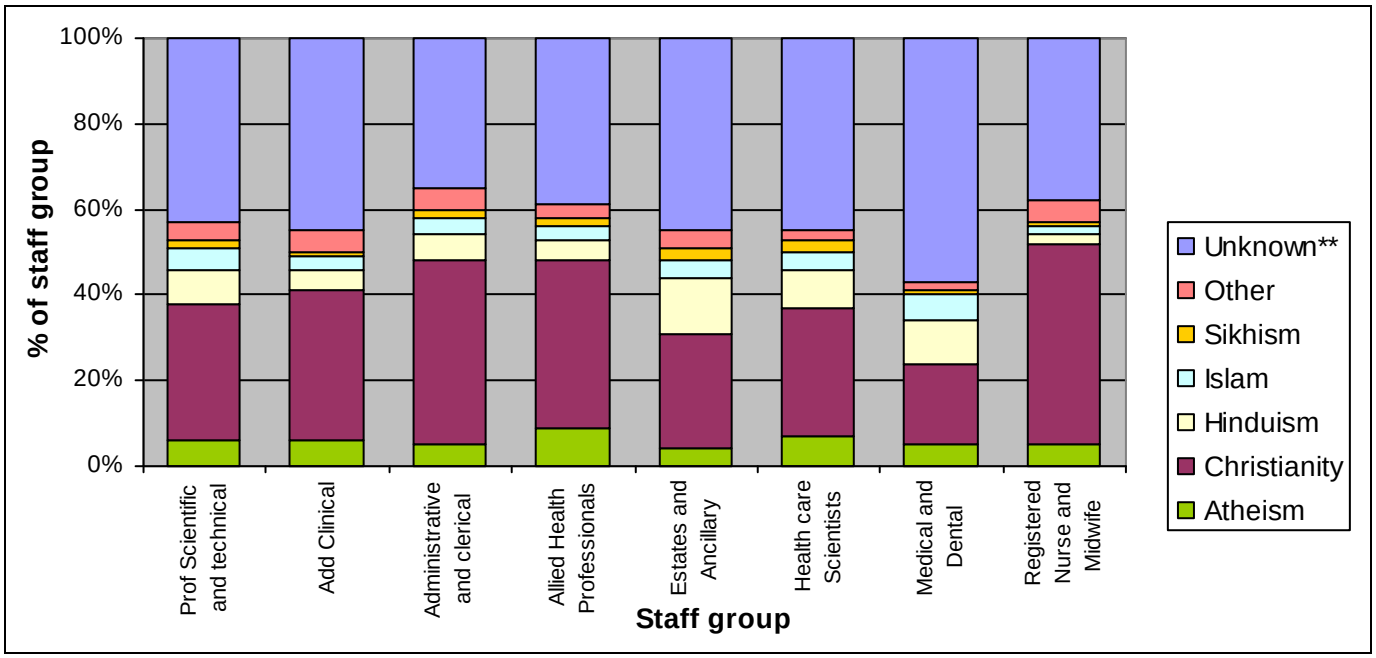
The Equality Act defines ‘’religion’ as ‘’any religion’’, and ‘’belief’’ as ‘any religion or religious or philosophical belief’. This includes all major religions, as well as less widely practised ones. The terms ‘’religion’ and ‘belief’’ in the context of the act also apply if you do not follow any religion or belief.

### 6.1 Religion or Belief Profile of Staff in Post.

| | March 2013 | March 2012 |
|---|---|---|
| Atheism | 5.4% | 3.8% |
| Buddhism | 0.3% | 0.1% |
| Christianity | 38% | 33% |
| Hinduism | 5.4% | 4.6% |
| Islam | 3.3% | 2.4% |
| Jainism | 0.1% | 0.1% |
| Judaism | 0.1% | 0.06% |
| Sikhism | 1.3% | 1.1% |
| Other | 4% | 2.5% |
| Undefined | 31% | 46% |
| Not wish to disclose | 12% | 6% |

**data obtained from the 2011 census.

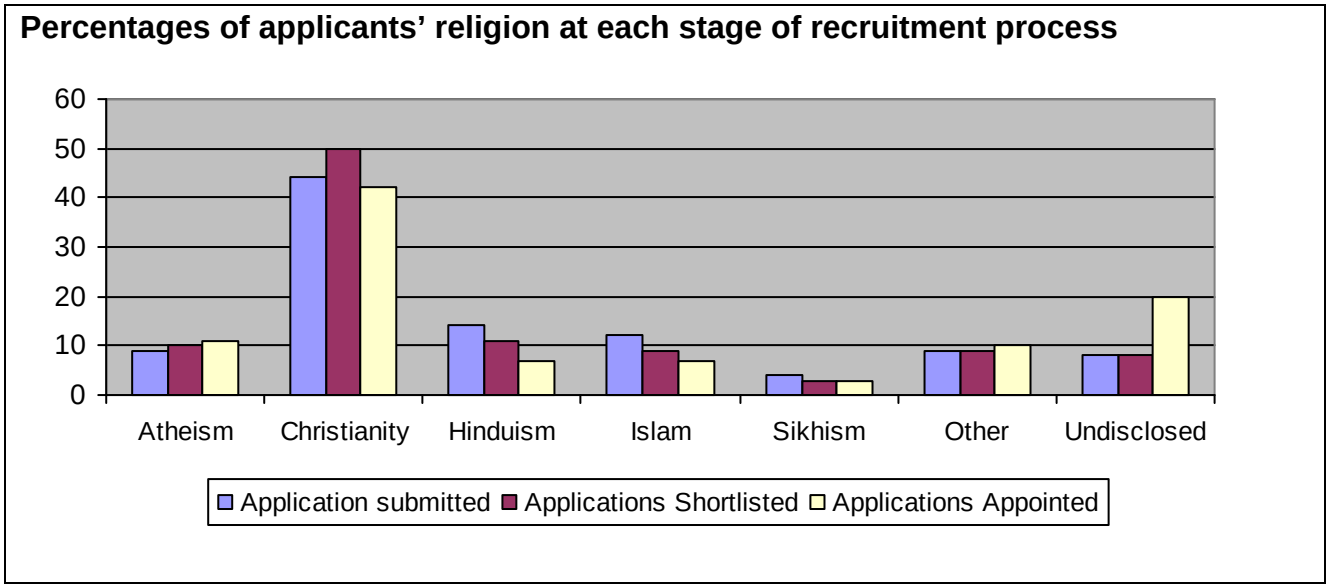
There is a broad range of beliefs amongst staff. The data shows that we have reduced the number of staff who’s religious or belief profiles were undefined by 15%, with most groups demonstrating a percentage increase this year. The representation at UHL favourably compares to neighbouring Trusts.




****** Unknown included both staff who does not wish to declare their religion/belief and those who have an undefined status.

The data demonstrates that staff with a broad range of beliefs is found within each staff group. In most groups however over 40% of individuals beliefs are unknown making comparisons with the local population more difficult.

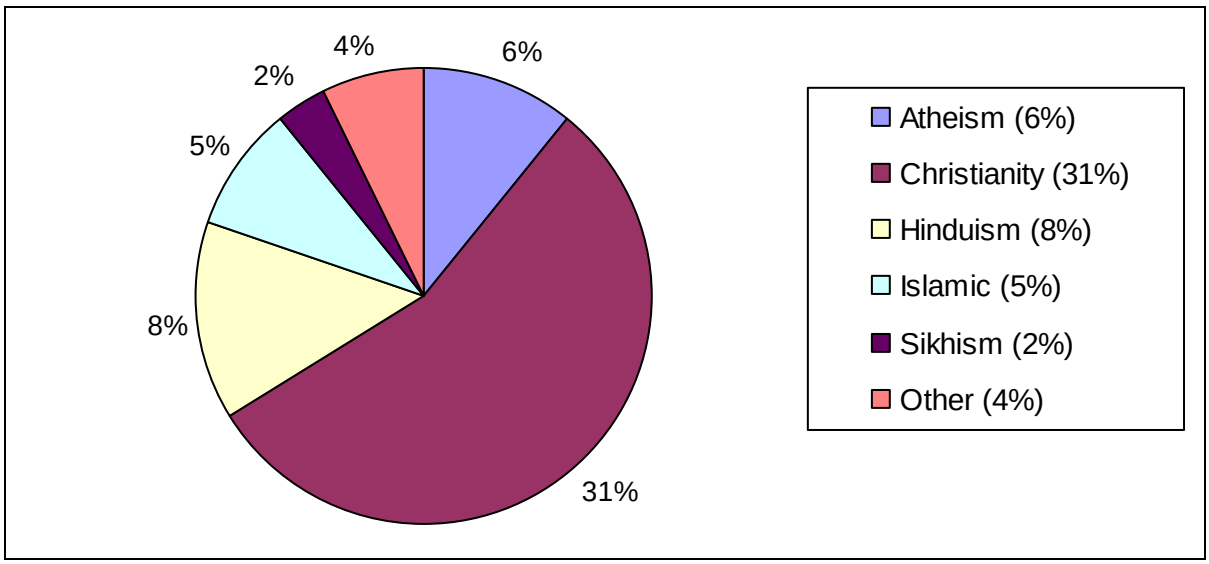
### 6.2 Religion or Belief Profile at Recruitment




The data shows that a number of applicants did not disclose their beliefs especially at appointment; therefore it is difficult to draw any firm conclusions. The data trends suggest that a lower percentage of applicants are shortlisted who have a Hindu, Islamic or Sikh faith.

This pattern is not unique to UHL with similar recruitment trends seen in the other NHS Acute Trusts used for comparison.

### 6.3 Religion or belief of staff leaving




We have seen a percentage increase in all belief groups leaving the Trust, this maybe the result of increased declaration of belief. Those with a Hindu or Islamic belief are higher than would be expected if compared with the staff population figures. Further investigation indicates that staff from these two groups alongside those from a Sikh faith were greater represented amongst the staff involved in the employment transfer when compared to the staff population.

### 6.4 Disciplinary and Grievance

From the total data reported on Disciplinary actions no religious/ belief group appears to be disproportionately represented.

As the total number of grievances are so small (12), no trends are able to be identified.

### 6.5 Religion or Belief and Access to Training

| | Leadership | | Day Courses | |
|---|---|---|---|---|
| Atheism | 15 | 6% | 30 | 6% |
| Christianity | 66 | 25% | 238 | 46% |
| Hinduism | 3 | 1% | 13 | 2% |
| Islam | 5 | 2% | 7 | 1% |
| Sikhism | 6 | 2% | 6 | 1% |
| Other | 4 | 1% | 18 | 3% |
| Unknown ** | 163 | 62% | 210 | 40% |

***This data is not currently collected for apprentices or staff undertaking QFC's.

**** Unknown included both staff who does not wish to declare their religion/belief and those who have an undefined status.

## Summary

The data indicates a rise in our representation across all religion and beliefs within the workforce as a whole.

The detailed data demonstrates:

- There is representation of all religions and beliefs across all staff groups in half of the groups however there remains a unknown status of at least 40%

- Through the recruitment process staff from who follow the Hindu or Islamic religion appear to fair less well with decreasing percentages seen at each stage.
- There is an over representation of staff from who follow the Hindu or Islamic religion leaving the Trust. Some of this maybe explained due to rotation of medical staff and this year's employee transfer process.

## Key Actions – Points to consider

- To encourage staff to declare their religion / belief
- To continue to encourage staff to declare their religion or belief status through ESR refresh.
- To investigate why individuals with an Islamic or Hindu belief fair less well at the shortlisting stage of recruitment.
- To improve our data collection around religious belief at the appointment stage of recruitment.

The following three sections are additions under the Equality act (2010) and minimal data is currently collected. A decision needs to be made as to what data we need to collect in the future.

## Section 7 – Marriage and Civil Partnership

### 7.1 Marital status of staff in post.

| | March 2013 | March 2012 |
|---|---|---|
| Civil Partnership | 0.3% | 0.3% |
| Divorced | 5.5% | 6% |
| Legally Separated | 1.3% | 1% |
| Married | 58% | 59% |
| Single | 30% | 28% |
| Widowed | 0.7% | 1% |
| Unknown | 4.3% | 5% |

## Section 8 – Pregnancy & Maternity

### 8.1 Maternity Leave of Staff in Post.

| | Number of staff | Days taken |
|---|---|---|
| Female | 681 | 110,591 |

## Section 9 – Gender Reassignment.

Data is recorded in this area but not reported due to low numbers with the possibility of breach of confidentiality.

## Summary

Little data is currently collected on these three elements

## Key Actions

- To decide what information around these three areas needs to be reported.
- To establish appropriate data sets and methods for collection.

## Report Summary

Broadly representation has remained the same and again there have been some interesting anomalies identified that warrant further investigation.

We identified 5 areas of focused work as a result of last year's data analysis. In terms of the benchmarking we have started to do our representation for all protected groups is favourable. The other Trusts also face similar challenges in terms of BME representation at senior levels. We need to continue into our investigations into short term contracts and the prevalence of BME Staff.

On the positive side we have seen an increase in the number of female consultants, a reduction in the number of 'unknowns' for disability. In addition the Reasonable Adjustment guidance has been disseminated which will hopefully ease some of the anxiety staff feel as a result of experiencing health problems that have ongoing implications.

In terms of the deep dive activity conducted last year, whilst not all was conclusive and further work needs to be done. The results did provide some assurance that our Human Resources processes do not discriminate against our staff from protected groups. The band six career progression work survey report confirmed this.

Finally we do still have limitations in terms of the data that is recorded and collected. However having completed a second years report using this format it feels as though we are in a much better position to identify where the gaps are and what we need to do to address them. This is going to form part of the work plan for 2014 and phase one will be reported in the July 2014 update.

## Top Priorities

- To conduct some further analysis for those BME staff appointed into band 7 positions.

- To identify our Human Resources data recording activity to identify where we are unable to generate accurate equality reports.

- Adopt best practice data collection and analysis through benchmarking with East Midlands colleagues.

- Conduct a deep dive into the number of disabled and LGB staff represented in disciplinaries.

**Appendix A**

## Workforce Benchmarking Data 2012-2013

| Disability % of Trust Staff | | | | | |
|---|---|---|---|---|---|
| | **UHL** | **NUH** | **Derby** | **UHB** | **PAT** |
| **Yes** | 1.4 | 1.83 | 0.89 | 1.94 | 1.32 |
| **No** | 56.8 | 15.8 | 15.8 | 59.7 | 22.2 |
| **Not declared** | 5.8 | 2.5 | - | 38.4 | 72.3 |
| **Undefined** | 36 | 67 | 53.9 | - | 4.10 |

| Sex % of Trust Staff | | | | | |
|---|---|---|---|---|---|
| | **UHL** | **NUH** | **Derby** | **UHB** | **PAT** |
| **Female** | 79 | 78 | 82 | 72 | 79 |
| **Male** | 20 | 22 | 18 | 28 | 21 |

| Race % of Trust Staff | | | | | |
|---|---|---|---|---|---|
| | **UHL** | **NUH** | **Derby** | **UHB** | **PAT** |
| **Asian** | 17 | 6 | 9 | 13 | 8 |
| **Black** | 4 | 3 | 3 | 8 | 2 |
| **Chinese** | | 0.5 | 0.4 | 1 | 0.4 |
| **Mixed** | | 1 | 1 | 2 | 1 |
| **White** | 68 | 74 | 78 | 71 | 87 |
| **Other** | 11 | 1 | 1 | 4 | 1 |
| **Not declared** | | 14 | 3 | 1 | 0.2 |
| **Undefined** | | | 4 | - | - |
| **BME Total** | 32 | 12 | 15 | 28 | 13 |

| Age % of Trust Staff | | | | | |
|---|---|---|---|---|---|
| | **UHL** | **NUH *** | **Derby** | **UHB** | **PAT** |
| **<30 yrs** | 19 | - | 20 | 20 | 15 |
| **31-40 yrs** | 27 | - | 26 | 27 | 22 |
| **41-50 yrs** | 29 | - | 30 | 28 | 32 |
| **51-60 yrs** | 21 | - | 20 | 20 | 26 |
| **>60 yrs** | 4 | - | 4 | 5 | 5 |

*Use different age brackets therefore unable to use as comparison.

| Sexual Orientation % of Trust Staff | | | | | |
|---|---|---|---|---|---|
| | **UHL** | **NUH** | **Derby** | **UHB** | **PAT** |
| **Bisexual** | 0.49 | 0.19 | 0.1 | 0.5 | 0.13 |
| **Gay** | 0.37 | 0.33 | 0.26 | 0.61 | 0.37 |
| **Heterosexual** | 53.2 | 31.5 | 32.1 | 59 | 34.3 |
| **Lesbian** | 0.23 | 0.23 | 0.12 | 0.31 | 0.23 |
| **Undefined** | 32.6 | 59.1 | 63.9 | - | 2.7 |
| **Do not wish to disclosed** | 13.2 | 8.5 | - | 39.4 | 62.2 |
| **LGB** | 1.09 | 0.75 | 0.48 | 1.42 | 0.73 |

| Religion / belief % of Trust Staff | | | | | |
|---|---|---|---|---|---|
| | **UHL** | **NUH** | **Derby** | **UHB** | **PAT** |
| **Atheism** | 5.4 | 4.8 | 3.5 | 5.7 | 3.5 |
| **Buddhism** | 0.3 | 0.2 | 0.1 | 0.4 | 0.1 |
| **Christianity** | 38 | 21 | 22 | 41 | 22.5 |
| **Hinduism** | 5.4 | 0.7 | 0.4 | 2.6 | 0.4 |
| **Islam** | 3.3 | 0.7 | 0.8 | 3.7 | 0.8 |
| **Jainism** | 0.1 | - | - | 0.04 | - |
| **Judaism** | 0.1 | 0.07 | - | 0.1 | - |
| **Sikhism** | 1.3 | 0.3 | 0.8 | 2 | 0.8 |
| **Other** | 4 | 2.9 | 3.4 | 5 | 3.4 |
| **Undefined** | 31 | 60 | 68 | - | 68 |
| **Not wish to disclose** | 12 | 10 | | 39 | |

UHL = University Hospitals of Leicester NHS Trust.
NUH = Nottingham University Hospitals NHS Trust.
Derby = Derby Hospitals NHS Foundation Trust.
UHB = University Hospitals Birmingham NHS Foundation Trust.
PAT= The Pennine Acute Hospitals NHS Trust.