Northern Lincolnshire and Goole NHS Foundation Trust

Workforce Race Equality Standard Report for Workforce Committee / Trust Board

July 2020

1.0	**PURPOSE OF THE REPORT**
1.1	To update the Workforce Committee **/** Trust Board on progress against the Workforce Race Equality Standard Indicators. (See Appendix 1)
1.2	To update Workforce Committee / Trust Board on our submission and the revised data and information as per our contractual requirements.
1.3	To highlight key priorities and actions required to make improves against the Workforce Race Equality Standard.
2.0	**BACKGROUND/CONTEXT**
2.1	The Workforce Race Equality Standard (WRES) was introduced from 1st April 2015 the NHS Equality and Diversity Council (EDC).
2.2	The link provided will take the reader to a short four minute video clip describing the Workforce Race Equality Standard. https://www.youtube.com/watch?v=G44C9yn-oo0
2.3	Research and evidence suggest less favourable treatment of Black and Minority Ethnic (BME) staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by all patients.
2.4	The WRES seeks to prompt inquiry to better understand why BME staff often receives much poorer treatment than White staff in the workplace and to facilitate the closing of those gaps.
2.5	In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White and BME staff in the NHS. The key focus is that it helps organisations to focus on where they are right now on this agenda, where they need to be, and how they can get there.
2.6	The WRES requires NHS organisations to demonstrate progress against specific workforce metrics including a metric on Board representation.
3.0	**IMPLICATIONS FOR THE ORGANISATION**
3.1	As of the 1st April 2015, the WRES forms part of the standard NHS contract. From April 2016 it has also formed part of the CQC inspections under the 'well led' domain.

3.2 A key component to making progress against this standard is staff engagement and involvement.

4.0 DATA ANALYSIS – METRICS

4.1

	Indicator	31st March 2019		31st March 2020	
WRES 1	Percentage of BME staff in Bands 8-9, Very Senior Managers compared with the percentage of BME staff in the overall workforce *Note: VSM includes Executive Board Members and there were Senior Medical Staff but excludes Medical and Dental Grades eg. Medical Consultants. Data Collection Source Electronic Staff Records (Figures exclude staff who haven't disclose their ethnicity)	**Descriptor**	**Indicator**	**Descriptor**	**Indicator**
		Number of BME Staff in Bands 8-9 and VSM	17	Number of BME Staff in Bands 8-9 and VSM	15
		Total Number of Staff in Bands 8-9 and VSM	247	Total Number of Staff in Bands 8-9 and VSM	230
		Percentage of BME Staff in Bands 8-9	**6.88%**	**Percentage of BME Staff in Bands 8-9**	**6.52%**
		Number of BME Staff in overall workforce	646	Number of BME Staff in overall workforce	703
		Number of Staff in overall workforce (including all staff groups and not disclosed staff)	6679	Number of Staff in overall workforce (including all staff groups and not disclosed staff)	6772
		Percentage of BME Staff in overall workforce	**9.67%**	**Percentage of BME Staff in overall workforce**	**10.38%**

The table above shows that in 2020 BME staff represents 10.38% of all staff in AfC bands 1-9 and VSM's. This represents an increase on last year where it was at 9.67%. The percentage of BME staff in a Band 8 position or above (including VSM) has also slightly decreased from 6.88 last year to 6.52% this year. It also shows that there is a lower percentage of BME staff in bands 8-9 and VSM compared to their representation in the overall workforce.

As recommended by NHS England Medical and Dental Grades are excluded in the 8-9 and VSM figures as these groups generally have a much higher proportion of BME staff. This group includes Consultants and in 2019 there were 406 BME staff and 169 white staff, and in 2020 there were 428 BME staff and 123 white staff.

Please note that the BME workforce should reflect the local population which across England is very diverse. The table below gives rounded figures from 2011 Census to show white and BME populations within the different regions.

Area	White Population	BME Population
England	87%	13%
Yorkshire and Humber	87%	13%
Inner London	55%	45%
North East Lincolnshire	94%	6%
Northern Lincolnshire	93%	7%
East Riding	93%	7%

4.2

	Indicator	2019			2020		
WRES 2	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.	**Descriptor**	**White**	**BME**	**Descriptor**	**White**	**BME**
		Number of shortlisted applicants	4675	698	Number of shortlisted applicants	2718	279
		Number appointed from shortlisting	1120	111	Number appointed from shortlisting	493	63
		Ratio shortlisted / appointed Likelihood candidates are appointed from shortlisting	1120/ 4675 **0.239**	111/ 698 **0.159**	**Ratio shortlisted / appointed** Likelihood candidates are appointed from shortlisting	493/2718 **0.181**	63/279 **0.226**
		The relative likelihood of White staff being appointed compared to BME staff is 0.239/0.159 = **1.5 greater**			The relative likelihood of White staff being appointed compared to BME staff is 0.181/0.226 **= 0.8 greater**		

The table above shows the numbers and percentages of white and BME staff from shortlisting to appointment for positions between 1st April 2018 and 31st March 2019 and, 1st of April 2019 and 31st March 2020. The 2018/19 data show white staff have a likelihood which is 1.5 times greater than BME staff to be appointed from shortlisting. In 2019/20 this likelihood has improved to a ratio of white staff having a 0.8 greater chance of being appointed from shortlisting opposed to BME applicants. Therefore, the likelihood of BME staff being appointed is greater than white staff. However, we should note this is only on small numbers.

4.3

	Indicator	2019			2020		
WRES 3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year.	**Descriptor**	**White**	**BME**	**Descriptor**	**White**	**BME**
		Number of staff in workforce	5787	646	Number of staff in workforce	5823	703
		Number of staff entering formal disciplinary process	38	4	Number of staff entering formal disciplinary process	77	6
		Likelihood of entering a formal disciplinary process	38/5787 **0.007**	4/646 **0.006**	Likelihood of entering a formal disciplinary process	77/5823 **0.013**	6/703 **0.008**
		The relative likelihood of BME staff entering a formal disciplinary process compared to White staff is therefore 0.006/0.007 = **0.86 less likely to enter a formal disciplinary**			The relative likelihood of BME staff entering a formal disciplinary process compared to White staff is therefore 0.008/0.013 = **0.615 times less likely to enter a formal disciplinary**		

The table above shows the relative likelihood of BME staff entering a formal disciplinary process compared to white staff. The figures are very low but the percentages show that BME staff are still less likely to enter a formal disciplinary compared to white staff.

As these numbers are very low for BME staff (only 6 staff) and due to the possibility of the data being personally identifiable, these figures have not been broken-down further.

The 2019 WRES data shows reverse of our picture in that Nationally BME staff are 1.22 times more likely to enter a formal disciplinary process than white staff.

4.4

	Indicator	2019	2020
WRES 4	Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff	See table below	See table below

Descriptor	White	BME
Number of staff in workforce	5787	646
Number of staff accessing mandatory training	4722	566
Likelihood of accessing mandatory training	4722/5787 **0.82**	566/646 **0.88**

The relative likelihood of BME staff accessing non-mandatory training compared to White staff is therefore 0.88/0.82 **= 1.1 times greater**

Descriptor	**White**	**BME**
Number of staff in workforce	5823	703
Number of staff accessing mandatory training	5695	694
Likelihood of accessing mandatory training	5695/5823 **0.98**	694/703 **0.99**

The relative likelihood of BME staff accessing non-mandatory training compared to White staff is therefore 0.99/0.98 **=1.01 times greater**

The table above shows the relative likelihood of BME staff accessing non mandatory training compared to white staff. In 2019 it shows a positive result of 1.1 times greater. The 2020 figures still shows a small positive result of 1.01 times greater. Therefore, BME staff still very slightly more likely to access non-mandatory training and CPD than white staff.

4.5 **NHS Staff Survey 2018**

The WRES indicators 5, 6, 7 and 8 below represent unweighted question level responses to key finding in the NHS staff survey for the Northern Lincolnshire and Goole NHS FT staff. It also includes the average scores for acute Trusts as a comparator.

<table>
<tr><th>.</th><th>Indicator</th><th>2018 Staff Survey Result</th><th>2019 Staff Survey Result</th></tr>
<tr><td>WRES 5</td><td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td><td><table><tr><th>Ethnicity</th><th>%</th></tr><tr><td>White</td><td>26</td></tr><tr><td>BME</td><td>28</td></tr></table>Average Acute Trust score
White 28%
BME 30%</td><td><table><tr><th>Ethnicity</th><th>%</th></tr><tr><td>White</td><td>22.9</td></tr><tr><td>BME</td><td>30.9</td></tr></table>Average Acute Trust score
White 28.2%
BME 29.9%</td></tr>
<tr><td>WRES 6</td><td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td><td><table><tr><th>Ethnicity</th><th>%</th></tr><tr><td>White</td><td>30</td></tr><tr><td>BME</td><td>40</td></tr></table>Average Acute Trust score
White 26%
BME 29%</td><td><table><tr><th>Ethnicity</th><th>%</th></tr><tr><td>White</td><td>29.5</td></tr><tr><td>BME</td><td>37.5</td></tr></table>Average Acute Trust score
White 25.8%
BME 28.8%</td></tr>
<tr><td>WRES 7</td><td>Percentage believing that trust provides equal opportunities for career progression or promotion</td><td><table><tr><th>Ethnicity</th><th>%</th></tr><tr><td>White</td><td>80</td></tr><tr><td>BME</td><td>62</td></tr></table>Average Acute Trust score
White 87%
BME 72%</td><td><table><tr><th>Ethnicity</th><th>%</th></tr><tr><td>White</td><td>81.4</td></tr><tr><td>BME</td><td>70.4</td></tr></table>Average Acute Trust score
White 867%
BME 74.4%</td></tr>
<tr><td>WRES 8</td><td>In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues</td><td><table><tr><th>Ethnicity</th><th>%</th></tr><tr><td>White</td><td>8</td></tr><tr><td>BME</td><td>21</td></tr></table>Average Acute Trust score
White 7%
BME 15%</td><td><table><tr><th>Ethnicity</th><th>%</th></tr><tr><td>White</td><td>7.6</td></tr><tr><td>BME</td><td>14</td></tr></table>Average Acute Trust score
White 6%
BME 13.8%</td></tr>
</table>

4.6 2019 NHS Staff Survey Results:

- Indicator 5 - BME staff at NLaG feel that harassment, bullying or abuse from patients, relatives or the public in the last 12 months has improved for white staff but increased by over 2% for BME widening the gap.

- Indicator 6 – There has been a very slight improvement for BME staff but experiencing harassment, bullying or abuse from colleagues for staff remains significantly worse for our BME staff with an 8% between white and BME staff.

- Indicator 7 - In 2018 BME staff felt 18% less likely to receive equal career development/promotional opportunities compared to white staff. However, this gap has improved but we still have an 11% gap in 2019.

- Indicator 8 – In 2018 BME staff felt 13% more likely to have personally experienced discrimination at work from their manager/team leader or other colleagues compared to white staff. However, this percentage gap has started to improve but we still have a gap of 6.4%

4.7 The table below shows the Trust Board representation between white and BME staff. The change in percentage between 2019 and 2020 relates to an increase in the overall group size, the number of which are shown in brackets.

<table>
<tr>
<td>WRES 9</td>
<td>Boards are expected to be broadly representative of the population they serve</td>
<td>Data at 31/03/19
<table>
<tr><th>Ethnicity</th><th>%</th></tr>
<tr><td>White</td><td>92.86 (13)</td></tr>
<tr><td>BME</td><td>7.14 (1)</td></tr>
</table>
</td>
<td>Data at 31/03/20
<table>
<tr><th>Ethnicity</th><th>%</th></tr>
<tr><td>White</td><td>93.33 (14)</td></tr>
<tr><td>BME</td><td>6.66 (1)</td></tr>
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5.0	**FURTHER ACTIONS REQUIRED**
5.1	In general the WRES data can be very fragile and it would be inappropriate to lose focus on any areas such as recruitment and Trust Board representation. However, by far the most significant area which we must focus on relates to the NHS Staff Survey findings. The experiences of our BME staff in terms of: BME staff experiencing bullying, harassment or abuse from staff, Equal Opportunities for BME staff and Discrimination at work experienced by BME staff.
5.2	More specific actions are to: Ensure all BME staff have the ability to comment on equality data, and from this the Trust must understand any underlying concerns BME staff have. The 2020/21 equality plan must be created and agreed through partnership working, utilising reinvigorated staff networks. Staff networks have previously required face to face attendance for which many staff have struggled to be released. Utilising the increase of GoTo meetings, WhatsApp groups and other technologies now embraced as a result of the COVID-19 pandemic we will encourage far greater BME staff participation in these discussions remotely. To restructure the staff networks so, rather than the ED Lead chairing the meetings, that BME staff members chair the running of these and oversee supported delivery of the action plans. The Chairs of the networks to attend TMB with the ED Lead to present WRES action plan updates. Discussions are to be held with the Acting Director of POE regarding how the BME, staff network links to and helps shape the work and objectives, of the Workforce Committee. As a result of the BAME risk assessment (which also includes all staff categorised by the government as vulnerable) the Trust is analysing the data to identify individual services that could be affected due to the need to redeploy a significant number of staff. Membership of the divisional leadership teams is governed by role. Therefore BME staff attendance at these requires a long-term intervention and features within the WRES action plans to increase equal representation at all levels and roles within the organisation. In the meantime consideration must be given to BME staff attendance, regardless of hierarchical role, as staff representatives. The COVID-19 pandemic has presented the Trust with a range of innovative technological leaps forward in connecting people and in working in different ways. These are to be embraced. The running and governance of the staff networks is to be reviewed with Staff Network Chairs to be established and for how these Chairs and networks report into the organisation. It is hoped that the networks will provide a three way focus: • To support the organisation conducts its business and service developments through gaining BME staff input and influence into decision making • To provide a platform for staff to connect within their own communities, including the social aspect of work and community • To connect with other Trust, regional and national NHS (and non-NHS) staff networks to learn from each other and gain a greater sense of community. The lessons learnt regarding the running of services and supporting BME staff to be brought back into the Trust.

6.0	**The report to be received.**
6.1	To note the contents of this report against the NHS Workforce Race Equality Standard.
6.2	Approve the data content which we are required to share with NHS England and our commissioners by 31st August 2020.
6.3	To agree the priorities, key areas of focus and WRES actions, and offer any support as identified.

Appendix 1.

The Workforce Race Equality Standard indicators	
Workforce indicators For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.	
1.	Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce
2.	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.
3.	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note. This indicator will be based on data from a two year rolling average of the current year and the previous year.
4.	Relative likelihood of BME staff accessing non mandatory training and CPD as compared to White staff
National NHS Staff Survey findings For each of these four staff survey indicators, the Standard compares the metrics for the responses for White and BME staff for each survey question	
5.	KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Q23. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
Boards. **Does the Board meet the requirement on Board membership in 9**	
9.	Boards are expected to be broadly representative of the population they serve.