Workforce Race Equality Standard

REPORTING TEMPLATE

Name of organisation	Date of report: month/year	
Leicestershire Partnership NHS Trust	May	2018

Name and title of Board lead for the Workforce Race Equality Standard

Sarah Willis

Name and contact details of lead manager compiling this report

Kathryn Burt, Deputy Director of HR and OD

Names of commissioners this report has been sent to (complete as applicable)

East Leicestershire CCG

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

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Unique URL link on which this Report and associated Action Plan will be found

http://www.leicspart.nhs.uk/_Aboutus-EqualityandHumanRights-Workforceraceequalitystandard.aspx

This report has been signed off by on behalf of the Board on (insert name and date)

Dr Peter Miller (Chief Executive) and Mrs Cathy Ellis (Chair) – 26th July 2018

1. Background narrative

a. Any issues of completeness of data

At March 2018, ethnicity was known for 97.5% of the substantive workforce (headcount = 5259, excluding non-executive board members).

b. Any matters relating to reliability of comparisons with previous years

None.

2. Total numbers of staff

a. Employed within this organisation at the date of the report

5259 substantive staff (including executive board members, but excluding non-executive board members of which there were 7).

b. Proportion of BME staff employed within this organisation at the date of the report

21.8% (using the total number of staff of known ethnicity as the base, n = 5127).

3. Self reporting

a. The proportion of total staff who have self–reported their ethnicity

97.5%

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

Annually in February / March, a Trust-Wide request is made to employees to ask them to update their equality monitoring information on the Electronic Staff Record. The request is accompanied by promotion (through the staff newsletter and Team Brief), including information giving assurances on confidentiality, the purposes for which the information will be used, and promoting the benefits to the Trust and to the individual of having complete information for the purposes of equality monitoring.

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

Annual request to staff to update their equality monitoring information on the electronic staff record, supported by assurances on confidentiality, the purposes for which the information will be used, and offering examples of positive outcomes for staff related to the use of the information.

4. Workforce data

a. What period does the organisation's workforce data refer to?

Staff in post at the end of March 2018; Recruitment in the 17/18 financial year; Disciplinary cases opened in the 16/17 and 17/18 financial years; Non-mandatory training undertaken in the 17/18 financial year; 2017 NHS Staff Survey undertaken in October – December 2017.

5. Workforce Race Equality Indicators

A key to the colour-coding used in the tables of analysis is given at the end of this report. R: REDACTED due to small numbers.

For each of these four workforce indicators, compare the data for White and BME staff

1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

17/18

	Pay band	Total n*	% BME
Non-clinical	Under Band 1	11	R%
	Band 1	R	R%
	Band 2	263	34.6%
	Band 3	276	32.6%
	Band 4	194	22.7%
	Band 5	132	29.5%
	Band 6	98	28.6%
	Band 7	104	26.0%
	Band 8A	50	24.0%
	Band 8B	38	R%
	Band 8C	18	R%
	Band 8D	R	R%
	Band 9	R	R%
	VSM	R	R%
Clinical	Under Band 1	R	R%
	Band 1	0	-
	Band 2	483	31.3%
	Band 3	472	13.3%
	Band 4	209	11.5%
	Band 5	826	22.8%
	Band 6	1097	13.1%
	Band 7	409	10.8%
	Band 8A	147	10.9%
	Band 8B	60	16.7%
	Band 8C	14	R%
	Band 8D	R	R%
	Band 9	0	-
	VSM	0	-
Medical	Consultant (not senior medical manager)	109	65.1%
	Senior medical manager (consultant)	R	R%
	Non-consultant career grade	32	50.0%
	Trainee grade	17	76.5%
	Other	39	64.1%
	Overall	***5127***	***21.8%***

* total of known ethnicity

16/17

	Pay band	Total n*	% BME
Non-clinical	Under Band 1	R	R%
	Band 1	R	R%
	Band 2	263	29.7%
	Band 3	301	30.6%
	Band 4	196	24.0%
	Band 5	126	27.8%
	Band 6	105	30.5%
	Band 7	104	23.1%
	Band 8A	62	16.1%
	Band 8B	35	R%
	Band 8C	27	R%
	Band 8D	11	R%
	Band 9	R	R%
	VSM	R	R%
Clinical	Under Band 1	R	R%
	Band 1	R	R%
	Band 2	510	29.6%
	Band 3	482	11.8%
	Band 4	202	11.4%
	Band 5	906	20.5%
	Band 6	1128	13.7%
	Band 7	430	9.8%
	Band 8A	135	11.9%
	Band 8B	63	R%
	Band 8C	15	R%
	Band 8D	R	R%
	Band 9	0	-
	VSM	0	-
Medical	Consultant (not senior medical manager)	114	57.0%
	Senior medical manager (consultant)	R	R%
	Non-consultant career grade	28	57.1%
	Trainee grade	60	75.0%
	Other	13	R%
	Overall	***5350***	***20.7%***

* total of known ethnicity

Narrative

At March 2018:

Non-clinical:

- BME people were overrepresented at lower pay bands (2 and 3). This largely reflected an overrepresentation of Asian British people in lower-level Administrative roles.

Clinical:

- Unqualified roles (Bands 2 to 4; essentially Additional Clinical Services): BME people were overrepresented at the lowest pay band (2) and underrepresented at higher bands (3 and 4). This reflected the distributions of Asian British and Black British staff.
- Qualified roles (Band 5 and above): BME people were underrepresented at middle to higher pay bands (6 and 7). This largely reflected the distribution

Action

1. Celebrating the success and role modelling of BME staff in senior roles.
2. Positive action initiatives as appropriate.
3. Promotion of mentoring, coaching and development programmes targeted at under represented groups and specific pay bands (Non-clinical Bands 2 to 4, and Clinical Bands 2 and 5)
4. Development and articulation of career pathways for admin and clerical staff
5. Sharing the work of the BME Focus Group and promoting Staff Support Groups with Board level support.
6. Ensure regular analysis of protected characteristics on Leading Together and WeNurture programmes.
7. National WRES team to work with Trust to identify additional actions.
8. Roll out of Reverse Mentoring (Learning from Diversity) Programme

		of Black British staff. • Medical: BME people, specifically Asian British people, were overrepresented in Medical roles. This reflected occupational segregation, with Asian British people underrepresented in registered Nursing roles. The distributions of BME staff within the workforce at March 2018 and at March 2017 were similar.	

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

Relative likelihood = 1.33

White people were 1.33 times more likely than BME people to be appointed if shortlisted†.

Ethnicity	n shortlisted*	% appointed
White	3253	10.5%
BME	2018	7.9%
Overall	***5271***	***9.5%***

* total of known ethnicity

White > BME†

Relative likelihood = 1.45

White people were 1.45 times more likely than BME people to be appointed if shortlisted†.

Ethnicity	n shortlisted*	% appointed
White	3440	19.2%
BME	2283	13.2%
Overall	***5723***	***16.8%***

* total of known ethnicity

White > BME†

White people were more likely than BME people to be appointed if shortlisted.

More detailed analyses were undertaken, compartmentalised by job role and pay band:

- In Non-clinical roles BME people and White people were similarly likely to be appointed at Band 2, but there was a trend for BME people (especially Asian British people) to be less likely to be appointed at Bands 3 to 4, and at Bands 5 and above;
- in Clinical roles outside of Medicine (primarily Additional Clinical Services at Bands 2 to 4 and Nursing at Band 5 and above), Black British people in particular were less likely to be appointed.

1. Celebrating role models
2. Offering targeted support in making strong applications
3. Ensuring recruitment panels are representative
4. Progressing unconscious bias training for all staff

3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.

Relative likelihood = 1.92

BME staff were 1.92 times more likely than White staff to enter a formal disciplinary process. (Cases opened in 16/17 and 17/18.)

Ethnicity	workforce overall*	% formal disciplinary
White	4011	0.7%
BME	1116	1.4%
Overall	***5127***	***0.9%***

* total of known ethnicity

BME > White†

Relative likelihood = 1.17

BME staff were 1.17 times as likely as (i.e., equally likely as) White staff to enter a formal disciplinary process. (Cases opened in 15/16 and 16/17.)

Ethnicity	workforce overall*	% formal disciplinary
White	4241	0.8%
BME	1109	1.0%
Overall	***5350***	***0.9%***

* total of known ethnicity

White ≈ BME

BME staff were more likely than White staff to enter a formal disciplinary process.

This represents a difference to the position seen for the 15/16-16/17 and the 14/15-15/16 two-year windows when the relative likelihoods were close to 1 (1.17 and 1.19 respectively).

Further analyses indicated that Black British staff were most likely to enter a formal disciplinary process (relative likelihood = 3.53 vs White staff). In terms of workforce context, this issue affected primarily Band 2 Additional Clinical Services staff, but also Band 5 Nursing staff and lower level Administrative staff.

1. Unconscious bias training
2. Ensuring representative panels
3. Use of Cultural Ambassadors (2 trained in June 2018)

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

Relative likelihood = 1.05

White staff were 1.05 times as likely as (i.e., equally likely as) BME staff to access non-mandatory training.

Ethnicity	workforce overall*	% non-mandatory training
White	4011	62.3%
BME	1116	59.1%
Overall	***5127***	***61.6%***

* total of known ethnicity

White ≈ BME

Relative likelihood = 1.13

White staff were 1.13 times more likely than BME staff† to access non-mandatory training‡.

Ethnicity	workforce overall*	% non-mandatory training
White	4241	51.6%
BME	1109	45.6%
Overall	***5350***	***50.4%***

* total of known ethnicity

White > BME†

‡ The relative likelihood appears close to 1; however, the odds ratio was 1.3 – the odds of White staff accessing non-mandatory training was about a third greater than the odds of BME staff accessing non-mandatory training. Odds ratios give a clearer indication of significant differences when the outcome for both groups is relatively common.

White staff and BME staff were equally likely to access non-mandatory training.

This represents a difference to the position seen 16/17 and 15/16 when the relative likelihoods were greater than 1, indicating that in those years White staff had been more likely to access non-mandatory training (1.13 and 1.17 respectively).

Nonetheless, as in previous years, more detailed analyses indicated that White staff were more likely than Asian British staff in particular to access non-mandatory training (relative likelihood = 1.15). This reflected occupational segregation: Asian British staff were overrepresented in Administrative roles, which undertook less non-mandatory training; whilst Asian British staff were underrepresented in Nursing roles, which undertook more non-mandatory training.

1. Career pathway for Administrative and Clerical staff is being developed.
2. All staff to be encouraged to complete study leave forms for all non-mandatory training to ensure it is recorded on uLearn.

National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff.

17/18	16/17	Narrative	Action
5. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.			
Ethnicity / **respondents overall*** / **% experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months** White 1780 24.7% BME 379 23.0% ***Overall*** ***2159*** ***24.4%*** * total of known ethnicity White ≈ BME	**Ethnicity** / **respondents overall*** / **% experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months** White 1804 26.1% BME 376 25.3% ***Overall*** ***2180*** ***25.9%*** * total of known ethnicity White ≈ BME	BME and White people were equally likely to experience harassment, bullying or abuse from patients, relatives or the public. In previous years, further analysis has indicated a specific problem for Black British staff in this area. In 2016, 47.2% of 72 Black British respondents experienced harassment, bullying or abuse from patients, relatives or the public, and in 2015, 47.0% of 83 Black British respondents experienced harassment, bullying or abuse from patients, relatives or the public. However, in 2017, the level of harassment, bullying or abuse from patients, relatives or the public experienced by Black British staff was lower than in previous years: 35.5% of 62 Black British respondents.	MAPA courses (Management of Actual or Potential Aggression) are mandatory for all frontline clinical staff. There is a channel for staff to report abuse from patients, which is recorded and acted upon. The Trust also has a "Freedom to Speak Up" guardian who can act as a channel for all concerns raised within the Trust.

6. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

Ethnicity	respondents overall*	% experiencing harassment, bullying or abuse from staff in last 12 months
White	1784	19.7%
BME	378	18.5%
Overall	***2162***	***19.5%***

* total of known ethnicity

White ≈ BME

Ethnicity	respondents overall*	% experiencing harassment, bullying or abuse from staff in last 12 months
White	1805	19.9%
BME	374	21.1%
Overall	***2179***	***20.1%***

* total of known ethnicity

White ≈ BME

BME and White people were equally likely to experience harassment, bullying or abuse from staff.

However, further analysis indicated that Black British staff in particular were more likely to experience harassment, bullying or abuse from colleagues other than managers (37.8% of 61 Black British respondents compared to 13.6% of 1771 White respondents).

This pattern has varied year-on-year, also being apparent in 2015, but not in 2016 (2016: 16.9% of 71 Black British respondents compared to 14.0% of 1796 White respondents; 2015: 26.8% of 82 Black British respondents compared to 14.7% of 1724 White respondents).

1. The Trust has an anti-bullying and harassment policy and procedure in place to ensure that staff are aware of sources of support available to them and the process to follow if they believe they are being bullied or harassed.
2. The Trust also operates an Anti-Bullying and Harassment Advice Service for staff.
3. A group meets on a bi-monthly basis to consider ways to further encourage reporting of incidents and more effectively manage them. The group has membership from HR/staff side/equalities/freedom to speak up.
4. BME staff have access to support from the BME Staff Support Group.

7. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.

Ethnicity	respondents overall*	% believing that the Trust provides equal opportunities for career progression or promotion
White	1293	90.6%
BME	256	72.7%
Overall	***1549***	***87.7%***

* total of known ethnicity

White > BME†

Ethnicity	respondents overall*	% believing that the Trust provides equal opportunities for career progression or promotion
White	1352	93.0%
BME	261	75.5%
Overall	***1613***	***90.2%***

* total of known ethnicity

White > BME†

BME people were less likely to believe that the Trust provides equal opportunities for career progression or promotion – a trend also observed in the 2016 and 2015 Staff Surveys.

This trend was especially marked for Black British staff (57.5% of 40 Black British respondents believed that the Trust provides equal opportunities for career progression or promotion); similar patterns were evident in 2016 and 2015.

This finding may be linked to the finding that BME people were overrepresented at lower pay bands (Indicator 1) and may point to a specific issue around career development. This finding may also be linked to greater levels of discrimination experienced by BME staff (Indicator 8).

Measures to aid career progression for BME staff are outlined against Indicator 1.

8. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues

Ethnicity	respondents overall*	% experienced discrimination at work from Manager/team leader or other colleague
White	1777	5.7%
BME	378	10.3%
Overall	***2178***	***6.5%***

* total of known ethnicity

White < BME†

Ethnicity	respondents overall*	% experienced discrimination at work from Manager/team leader or other colleague
White	1805	5.9%
BME	373	11.3%
Overall	***2178***	***6.8%***

* total of known ethnicity

White < BME†

BME people were more likely to have experienced discrimination at work from a manager, team leader or other colleague. This pattern was also evident in 2016 and 2015.

Further analysis indicated a specific problem for Black British staff (16.7% of 60 Black British respondents experienced discrimination at work from a Manager/team leader or other colleague); similar patterns were evident in 2016 and 2015.

Again, this finding may be linked to the finding that BME people were overrepresented at lower pay bands (Indicator 1) and may point to discrimination experienced in terms of career development. This finding may also be linked to a lesser level of belief amongst BME staff that the Trust provides equal opportunities for career progression or promotion (Indicator 7).

A more in depth survey carried out in November / December 2015 indicated that discrimination related largely to career progression. Measures to aid career progression for BME staff are outlined against Indicator 1.

Board representation indicator. For this indicator, compare the difference for White and BME staff			
17/18	**16/17**	**Narrative**	**Action**
9. Ethnicity profile of the Board's Executive, Non-executive, Voting, and Non-voting membership. Percentage difference between the organisations' Board membership and its overall workforce.			
Percentage differences: **%BME total board - %BME workforce = -12.7%** **%BME voting board - %BME workforce = -10.7%** **%BME executive board - %BME workforce = -1.8%**	**Percentage differences:** **%BME total board - %BME workforce = -13.1%** **%BME voting board - %BME workforce = -11.6%** **%BME executive board - %BME workforce = -6.4%**	BME people were proportionately represented amongst executive board members compared to their level of representation in the workforce overall. BME people were underrepresented amongst voting board members and amongst all board members considered together compared to their level of representation in the workforce overall. Ethnicity was not known for 15% of Board members.	Please see details in indicator 1. 1. Consider positive action as and when vacancies occur

† Statistically significant (α = .05)

6. Are there any other factors or data which should be taken into consideration in assessing progress?

Leicestershire Partnership NHS Trust produces a comprehensive Annual Workforce Equality Report which, in addition to race, considers the wider equality agenda, other protected characteristics and employment domains, in detail.

http://www.leicspart.nhs.uk/_Aboutus-EqualityandHumanRights-PublicationofEqualityInformation.aspx

These analyses, alongside the WRES, are reported to senior management, at Trust Board and through the Strategic Workforce Group, to inform strategy and decision making.

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

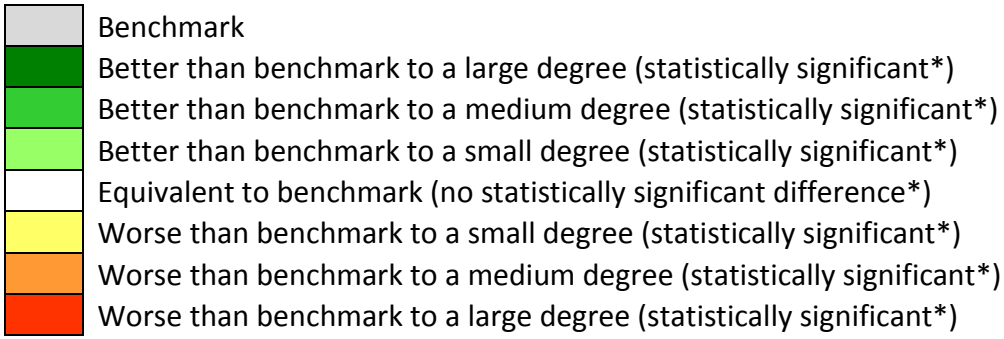
Action plans relating to the WRES and wider equality agenda went before the Trust's board of directors on 26 July 2018

LPT Diversity and Inclusion Approach 2017 – 2021
http://www.leicspart.nhs.uk/_Aboutus-EqualityandHumanRights.aspx

Annual workforce equality monitoring report
http://www.leicspart.nhs.uk/_Aboutus-EqualityandHumanRights-PublicationofEqualityInformation.aspx

WRES and consolidated equality action plan
http://www.leicspart.nhs.uk/_Aboutus-EqualityandHumanRights-Workforceraceequalitystandard.aspx

Key to colour-coding in tables of analysis:



* based on odds ratios (Bonferroni correction applied); the degrees of underrepresentation or overrepresentation (small, medium, large) follow the standards for effect sizes applied in the social sciences

Please note: for some questions (e.g., the percentage agreeing that LPT acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age) “better than the benchmark” was indicated by a higher score and “worse than the benchmark” was indicated by a lower score; whilst for other questions (e.g., the percentage experiencing one or more incident of bullying and harassment from other colleagues in the past 12 months) “better than the benchmark” was indicated by a lower score and “worse than the benchmark” was indicated by a higher score.