NHS
University Hospitals Birmingham
NHS Foundation Trust

Workforce Race Equality Standard Report 2021

Building healthier lives

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Executive Summary

This report marks out the outcomes for University Hospitals Birmingham NHS Foundation Trust's Workforce Race Equality Standard for 2021. It demonstrates a changing position from the Trust on diversity, inclusion, with new insights on equity, disparity and anti-racist practice and work for BME Staff. This year, in a continued approach for change and action the report deliver a pragmatic future plan that will provide divisional data and targets, to provide accountability for inclusion actions and leadership across the organisation.

This report will look at the evidence-based approach we have developed through the WRES and Staff Survey. As we continue to implement it, we believe we can facilitate continuous improvement on the workforce race equality agenda, and in doing so, improve the experience of our colleagues as well as the care of our patients and service users.

We know from this work, and by looking at our workforce race equality data that we can also make further improvements to the experience of our BME colleagues. For example we are particularly keen to see a difference in the make-up of our leadership community and indeed Board membership where currently we do not reflect the diversity of the communities we serve. The start of this work is apparent and can be seen in bands 8b to VSM.

We are well aware that many have been affected by Coronavirus (COVID-19) and subsequent impacts of civil justice issues for BME communities. It has caused untold disruption and worry and our response to these unparalleled situations has meant that we've all had to work and live differently. We need to take time to reflect on the impact of the pandemic and heightened awareness and experiences of discrimination and racism, on our ambitions, performance, our patients and staff and when framing our remedies and interventions as one of the largest trust, employing thousands of staff and treating tens of thousands of patients from a diverse community.

To deliver on the WRES for 2021-2022 and beyond, we have developed this pragmatic 12-24 month action plan. Our action plan will give us flexibility and agility to adapt our approach if required to meet our longer-term strategic Inclusion and Equality Objectives. This will ensure that initiatives are fully and effectively embedded, our people are engaged and the impact is clearly measured.

Time to Act

Key Improvements

This report welcomes the continued record growth and improvement in representation across clinical roles. BME doctors are well represented across all categories of consultants, NCCG and trainees, reporting more than 56% of Trust totals, significantly higher than the BME workforce Trust total of 33.52%. Work is needed to amplify the positive contribution our BME doctors make to the Trust and what they can offer as role models and advocates to their colleagues.

This is mirrored nationally with the first report of its kind looking into race equality among England's doctors. It found that the number of doctors from black and ethnic minority backgrounds working for the NHS is the highest on record.

New data published as part of the inaugural Medical Workforce Race Equality Standard (MWRES) commissioned by the then NHS Chief Executive, Simon Stevens shows that last year more than 53,000 doctors working in the NHS were from a black and minority ethnic (BME) background, up by more than 9,000, a rise of around one-fifth, since 2017.

Over the last year, we have continued to reduce the amount of BME staff entering the disciplinary process. This reduction has slowed to 5.19% from 21.7% last year; however it still illustrates continued levels of change. This equates overall to 15 fewer disciplinaries, 4 of those BME staff. These reflect the cases recorded in ESR from the HGS sites and those at QE.

We have continued to see more BME staff accessing non-mandatory training and CPD than their white colleagues and which indicates a developmental and career-minded workforce. The difference has reduced further this year, with the impact the pandemic affecting training provision and a rise in BME staff numbers. We have seen nearing equal amounts of white and BME staff accessing non-mandatory training, equating to 21.01% and 29.92.

The establishment of the Fairness Taskforce (FTF) last year to tackle systemic and institutional discrimination, unfairness and health inequality practice in UHB, continues to make meaningful strides to enact sustained change.

In the last year the Taskforce has;

- Established three cohorts of Reciprocal Mentoring – development opportunities for staff with protected characteristics. 204 staff members have taken part to date and a current fourth cohort is out to recruitment. This will allow another 50 colleagues plus take part. This has allowed us to exceed the original target of 150 colleagues taking part, and a significant number of those who have already taken part are BAME staff.
- Fairness Route Cause Analysis (FRCA) – adding accountability to discriminatory or racist practice. One session of the FRCA has taken place so far and this was to look into a case of alleged racism at ward level?
- Inclusive Communications Guide has been developed to help understand the language we use
- The FTF continues to meet on a monthly basis – These have lighted new areas of work - including support of the intersectionality of race and neurodiverse staff.

Further work is in the planning as follows;

- Recruitment retention and progression
    - Data dashboards
    - Move away from "first past the post" recruitment
    - Scheduled open sessions for job overviews
    - Fair recruitment experts
    - Accountable decision records

- Talent management and retention
- Recruit for personal qualities and values
- Redesign job specs
- Referral routes from organisations with links to underrepresented staff groups

These initiatives are at work to change the way we think and behave as individuals but fundamentally how we work in our structures and processes with accountability and inclusive leadership.

Key Findings

The longer term figures (2018-2021) show an accelerated rise for BME staff across lower bands 2 to 5 (20.3% to 32.6%) and band 4 clinical and slower increases for bands 6 and 7. Both band 4 and 5 demonstration representation percentages equivalent of the Trust, however in some cases illustrates possible overrepresentation, which acts as bottle necks for promotion to senior posts.

Trust's representation and the demographic of the city are 33.52% and 42.07% respectively; show little movement and the imminent publication of the 2021 census will no doubt see increases in the BME population. BME citizens apply for job at UHB at a higher rate than white applicants. The application figures show in the last 12 months 65% and 34% were female and male applicants, with 59% and 37% were BME and White applicants. This is good news in terms of perception to be 'a good place to work', however that figure plummeted to 42.58% at appointed for BME applicants and rises to 54.79% for white applicants. The redesign of recruitment and retention processes being planned will work to bring further equity.

This report shows a Trust that isn't one of the worst performers in the bottom centile of trusts nationally, but neither does it illuminate as one of the best in the country. It shows a Trust's performance on inclusion, equity and diversity for BME staff that is average. This cast a shadow in the way it treats its BME staff and the subsequent impact on patients, over the exceptional performance and world leading clinical work it does in this health care space. There has been a doubling up of effort through the Inclusion and Fairness agendas to galvanize change at scale and pace. With the immediacy of the new clinical commissioning boards and system thinking and working, the opportunities for far greater success in mastering change and benefiting from a vast array of skills, talent and insight in a diverse workforce will propel the changes necessary for sustained growth in our trust and the community it serves.

Summary

33.5%

As at 31 March 2021, **33.5% (7353)** of staff working in UHB NHS trust is from a black and minority ethnic (BME) background. This is an increase of **18.14%** from 2018. There are **1353** more BME staff and **62** more white staff in 2021 compared to **2018** and a Trust percentage increase from 29.48% in 2018 to 33.52%.

68.9%

The WRES indicator 7 relates to perceptions of beliefs regarding equal opportunities in the workplace show that 68.9% for BME staff and 85.3% for white staff. This has not improved significantly over time for both BME and white staff.

x1.31

White applicants were **1.31 times** more likely to be appointed from shortlisting compared to BME applicants; this was in 2020 (1.66), which showed some improvement on the previous year. There has been year on year fluctuation but no real overall improvement over the past four years (0.37). It was 1.681 in 2018.

x1.18

BME staff were **1.18 times** more likely to enter the formal disciplinary process compared to white staff. This is an improvement on 2019 **(1.28)** however a significant decrease from 2018 when it was **1.06.**

24.3%

24.3% of BME staff, and **23.3%** of white staff, reported experiencing harassment, bullying or abuse from patients, relatives or the public. This is a reduction for both groups. In 2018 it was **24.7%** for BME staff and **25.4%** for white staff.

16.4%

16.4% of BME staff, compared to 6.6% of white staff, reported experiencing discrimination at work from their Manager, team leader or other colleagues, which as increased **2.6%** from 13.8% for BME staff.

Risks of Non-Compliance

The risks of non-compliance with WRES requirements are:

- Breach of the NHS standard contract
- Poor scores in the CQC well-led domain
- Poor staff engagement in BME groups

Recommendations

The UHB WRES Report analysis produced four high-level recommendations:

- Continue to embed structural and organisational change to mitigate the disparities across the banding. Review and develop inclusive and anti-discriminatory recruitment, promotion and development practice system-wide
- Provide skills development, and knowledge-building provisions on cultural intelligence, anti-racist practice and work, and inclusive leadership
- Improve departmental engagement and collaboration and facilitate concerns to be raised and voices to be heard
- Compile divisional data, targets and accountability reports that feed into divisional performance reviews, that support the cultural shift needed to improve equity for BME staff.

Definitions

The definition of ethnicity for this report is provided in the WRES Technical guidance as outlined below:

Definitions of ethnicity: people covered by the WRES

The definitions of "black and minority ethnic" and "white" used in the WRES have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and are as used in NHS Digital data. At the time of publication of this guidance, these definitions were based upon the 2001 ONS Census categories for ethnicity.

"White" staff includes white British, Irish, Eastern European and any "other white".

This is to say that the term BME for this report refers to staff that are from a black or ethnic minority background which is not white.

Definition of non-mandatory training for WRES

The WRES Technical Guidance defines Non-mandatory training as:
'*Any learning, education, training or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g. fire safety training) or mandated by the organisation (e.g. clinical records system training). Non-mandatory and CPD recording practice may differ between organisations.*

Accessing non-mandatory training and CPD – in this context refers to courses and developmental opportunities for which places were offered and accepted

Note

For Metrics 2, 3 & 4 the closer to 1 the score the more even the experience of BAME and white staff. Scores above 1 indicate an 'advantage' to white staff so conversely, scores below 1 indicate an advantage to BAME staff

Workforce Race Equality Standard 2021 Report

1. Purpose

1.1. This report has been created in-line with the Workforce Race Equality Standard (WRES) to demonstrate compliance and advance the inclusion of Black & Minority Ethnic (BME) Staff within the Trust.

1.2. This report aims to:

1.2.1. Detail the Trust's data in relation to the nine WRES indicators.

1.2.2. Discuss, analyse and interrogate reasons for any inequalities within the workforce.

1.2.3. Provide recommendations and an action plan to address any disproportionate impacts.

1.3. The Trust Board is asked to accept and note this report, and the report will then be published on the Trust's external site.

2. Background

2.1. The WRES was introduced as part of the NHS Standard Contract in April 2015, as a response to the Roger Kline's "Snowy White Peaks" paper and subsequent "Beyond Snowy White Peak" health brief, whose research found systemic evidence of discrimination in governance and leadership and the potential impact on patient care in London and England.

2.2. The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

2.3. WRES consists of nine indicators which may highlight areas in which BME staff are unfairly treated. The Trust is required in the NHS Contract to report on the indicators annually and produce, and implement, an action plan to address any inequalities in the indicators.

2.4. The Trust implemented the WRES in 2015 and has been reporting on the WRES indicators annually since. WRES submissions for previous years can be found on the Trust's external website. https://www.uhb.nhs.uk/workforce-race-equality-standard.htm

3. Research

University Hospitals Birmingham NHS Foundation Trust has robust systems in place to ensure that data is captured and the quality is continually improved. The main system for recording information is ESR. However, other systems such as NHS Jobs or internal Microsoft databases or spreadsheets are used. The following table shows the data sources used for each WRES indicator and a broad description of how the sources are derived:

Data to report on the nine WRES indicators was received from the following Trust's or NHS systems.

WRES Indicator Data Source Notes	WRES indicator Data Source Notes	WRES indicator Data Source Notes
AFC band / VSM **Indicators 1,3,9**	ESR	ESR pay scale to produce a WRES banding group.
Recruitment	NHS Jobs	Uses standard pre-set reports from

Indicator 2		NHS Jobs. Directorates must be used effectively.
Disciplinary **Indicator 3**	Microsoft Spreadsheet	Uses internal databases to record casework information (includes equality and diversity data).
Training **Indicator 4**	EasyLearning	Uses a combination of ESR and internal databases. Developments are underway to ensure we are capturing more training data
Culture and experience **Indicators 5, 6 7,8**	NHS Staff survey	Uses data from the full staff survey results.
Board BME representation **Indicator 9**	ESR	Ensures staff are coded correctly on ESR.

Table 1

3.1 To better understand BME staff perceptions around the current disparities, a key stakeholders workshop was held with 40 members of staff from across the workforce to discussion the new data from the WRES and gain interpretation of it from different perspective, which cultivated the following opinions, comments and ideas for possible actions from the group.

3.1.1. A lack of clarity and equity on recruitment, promotion and development decisions. suggestion: - to offer generic / assessment centre based recruitment to mitigate any subconscious/implicit bias decision making

3.1.2. Quantitative data categories that demonstrate who were successful during the recruitment stages and which department were impacted need to be reviewed and analysis for patterns and trends.

3.1.3. Explicit use of language, and terminology should be considered in the recruitment process that is accessible to everyone.

3.1.4. Training and development programmes for all recruitment managers on implicit / subconscious and cultural competence should be implemented.

3.1.5. Disparity of formal disciplinary processes – lack of confident and experienced managers.

3.1.6. Develop specific programmes for managers and leaders to support staff and understand the nuances of discriminatory and racist behaviour. Create guidance and signposting for HR employee relations teams to ensure consistent resolution, processes.

3.1.7. There is insufficient understanding and knowledge of BME workforce; National Staff Survey provides limited intelligence of their experiences. Need to improve staff engagement with BME staff network and wider BME workforce to improve understanding and gain qualitative information based on the WRES outcomes data. Consider implementing BME staff survey, focus groups and increase visibility of the processes and action taken, to increase trust in the process.

3.2 The key stakeholder group included:

- Facilities Director
- Deputy Director of OD
- Education and Quality
- HR Recruitment
- HR Employee Relations
- Head of School of Nursing
- Head of Communications
- Clinical Director Therapies
- Director of Corporate Affairs
- Employee Engagement and Leadership
- Chaplaincy
- Counselling
- Legal
- Inclusion and Wellbeing Leads
- Network Chairs

4. WRES Indicators 2021

Below is the Trust's data for each of the nine indicators. Each of the first four workforce indicators is comparison data for White and BME staff and is compared against the last three to four years of WRES submission, as applicable.

	Workforce Indicators
1.	Percentage of staff in each of the AfC bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-Clinical staff • Clinical staff - of which • Non-Medical staff Note: Definitions are based on Electronic Staff Record occupation codes.
2.	Relative likelihood of staff being appointed from shortlisting across all posts Note: This refers to both external and internal posts.
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. Note: This indicator will be based on data from a two year rolling average of the current year and the previous year.
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) **For each of the four staff survey indicators, the data compare the outcomes of the responses for White and BME staff. This data is draw from the 2020 Survey, published in March 2021. For this data, response rates will be given for context.**
5. **(Q13a)**	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. **Q13c**	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. **Q14**	Percentage believing that Trust provides equal opportunities for career progression or promotion
8. **(Q15b)**	In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for White and BME staff
9.	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: By voting membership of the Board By membership of the Board (including NEDs) By executive membership of the Board Note: This is an amended version of the previous definition of Indicator 9

Table 2

Indicator 1. Percentage of BME staff in each of the Agenda for Change (AfC) bands 1-9 clinical (non-medical) and non-clinical and Very Senior Management (VSM) compared with the percentage of staff in the overall workforce

Non - Clinical				
AfC Pay Band	BME % 2019	BME % 2020	BME % 2021	Difference 2020vs2021
Band 1	28.35%	30.74%	30.63%	-0.11%
Band 2	23.93%	27.01%	28.68%	1.68%
Band 3	24.63%	25.99%	27.38%	1.39%
Band 4	20.97%	21.91%	22.47%	0.56%
Band 5	21.95%	23.21%	23.72%	0.51%
Band 6	20.82%	21.94%	22.85%	0.91%
Band 7	21.35%	22.30%	24.69%	2.39%
Band 8a	20.34%	23.77%	23.30%	-0.46%
Band 8b	10.42%	11.88%	15.15%	3.27%
Band 8c	11.63%	9.38%	15.38%	6.01%
Band 8d	4.55%	9.68%	9.090%	-0.59%
Band 9	0.00%	0.00%	0%	0.00%
VSM	7.27%	9.09%	12.28%	3.19

Table 3

Clinical				
AfC Pay Band	BME % 2019	BME % 2020	BME % 2021	Difference 2020vs2021
Band 1	14.29%	14.29%	14.28%	0.00%
Band 2	33.18%	34.70%	34.97%	0.27%
Band 3	25.03%	27.14%	29.62%	2.48%
Band 4	22.62%	27.35%	32.65%	5.31%
Band 5	40.98%	43.00%	44.88%	1.88%
Band 6	26.46%	27.32%	29.09%	1.78%
Band 7	16.85%	17.51%	18.10%	0.60%
Band 8a	16.89%	17.93%	17.52%	-0.41%
Band 8b	11.11%	13.16%	13.27%	0.12%
Band 8c	8.33%	6.25%	10.25%	4.01%
Band 8d	5.26%	7.41%	8%	0.59%
Band 9	0.00%	0.00%	0%	0.00%
VSM	16.67%	6.25%	20%	13.75%
Consultant	45.50%	48.19%	48.72%	0.53%
of which senior Medical Manager	42.86%	52.78%	45.83%	-6.94%
Non-consultant career grade	63.33%	62.58%	64.04%	1.46%
Trainee Grades	53.75%	53.02%	56.36%	3.35%
Other	55.39%	0%	0%	0.00%

Table 4

4.1 Overall, 33.52% of the Trust's staff identify as BME, slightly higher than last years' overall figure of 32.5%. The median average percentage of BME staff per band is notably below the Trust representation and demographic of the city (24.55% - 2021 clinical) compared to 33.5% and 42.07% respectively. This helps to illustrate the disparity across the banding as they rise, which is particularly visible in nursing and clinical posts.

4.2 Generally, representation across the Trust remains consistent. **Chart 1 (p28)** non-clinical, shows the broadest spread of BME staff in the middle bands and reflects the median average percentage rate across the bands at 22.85% for 2021. The greatest positive difference was seen at band 4 and band 8c clinical, with a 5.31% and 4.01% rise and bands 8b, 8c and VSM non-clinical. However, with only a small number of BME staff within these higher bands, this is statistically insignificant and is also positioned a distance away from the NHS Model Employers targets. The Model Employers targets mentioned in the People Plan 2020 identifies the drastic deficiencies in band 6 and above.

We continue to see overrepresentation of clinical band 5 BME staff at (44.88%) **Chart 2 (p28),** 11.36% above the Trust BME staff workforce figure. This compares to only 51.12% for white staff reflected against the workforce figure of 62.6%. A decline of BME staff from band 6 through to VSM is evident in the figures thereafter. In comparison we identify a steep rise in percentage of white staff in senior bands above the Trust representation, rising from 16.18% above trust rate of 62.2 to 37% when it reaches Band 9.

4.3 Local and national demographics context

The 2011 census shows that 57.9% of Birmingham's population is White British, lower than the England average (80%) and most other core cities. In this sense, Birmingham's population is more like that of Manchester (where 59% of residents are White British). Birmingham's population is not as ethnically diverse as London's, where 45% of resident population is White British. Nationally 13% of the population identify themselves as ethnic minority, with the NHS staff population at 21% (273,359).

4.4 Consideration is now taken for the demographic of the Birmingham and Solihull region as the ICS comes into force in March 2022.

4.5 Total BSol population headcount is 1,358,012, 50.5% are Women, 37.1%, BME, 62.9% White, 18.4% Disability. The regional workforce is made up of 44,829, 72.88% being women, 33.7% BME, 57.7% white, 3.4%disabled.

Birmingham

40% of Birmingham's population lives in the most deprived decile areas in England (IMD2015). 22.5% of Birmingham's Lower Super Output Areas (LSOAs) are in the 5 per cent most deprived areas in England. Birmingham is the most deprived authority in the West Midlands metropolitan area and is ranked the third most deprived Core City after Liverpool and Manchester. Life expectancy in Birmingham is lower than the national average. For males, life expectancy at birth is 77.2 years and females 81.9 years.

Solihull

4.6 With an estimated population of 210,445 Solihull is a broadly affluent borough in both the regional and national context. 11% of Solihull' s population live in the most deprived areas in England and 6% of population in most deprived 5 per cent areas in England. The wards of Chelmsley Wood, Kingshurst & Fordbridge and Smith's Wood are most notably impacted by deprivation. Deprivation issues include fuel poverty and access to transport.

There is a life expectancy gap of eleven years between the most and least affluent. Male life expectancy is 80.4 years (national average 79.5) and female life expectancy is 84.2 years (national average 81.9 years).

4.7 The proportion of the BME population in Birmingham rose by 12.42% to 42.07%, between 2001 and 2011. This represented a 3.4% increase in residents from Asian/Asian British (Indian, Pakistani, Bangladeshi, Chinese and Asian other) backgrounds, which equates to 26.62%. There was a 2.9% increase in Black or Black British (African, Caribbean or other) residents at 8.98%, mixed heritage at 4.44% and 'other' at 2.03%. After White British, the next biggest ethnic group in Birmingham is Pakistani, which makes up 13.48% of the resident population. Over the same time period, White British residents in Birmingham decreased by over 13 percentage points.

4.8 Christianity remains the city's most prominent religion. In the last (2011) census 46.1% of Birmingham residents identified as Christian, this is a decrease of 13 percentage points from 2001. Other major religions were Islam, an increase of 7% to (21.8%), Sikh (3.5%), and Hindu (2.8%). 12.4% of the surveyed population reported having no religion, and 8.4% did not answer the question. Birmingham has a relatively young population compared to comparator areas. Of our patients the highest portion are of a Christian and Islamic faith. Findings show of our staff, 33.6 are Christian and 22.86% are Islamic; 25.18% have not disclosed.

4.9 Birmingham is a "super-diverse" city, nearly half of the population being from an ethnic minority background, reflecting the city's rich and varied cultural heritage. Academic research suggests that there are people from nearly 200 countries who have made Birmingham their home, and was predicted to be a 'minority–majority' city by 2021 as sited in the Birmingham City Council Community Cohesion report 2018.

4.10 What this background tells us is that the growing diversity of both city and Trust are exponential, in comparison to the representation and identity of BME staff across our NHS community and Trust. It also spells out the interplay and impact of race and class; equality and inequality and the disparity towards disadvantages groups across the city. We must use this census data as part of the catalyst that drives the decision making to ensure we are prepared and equipped to support staff and deliver care to what will continue to be a broad and diverse workforce and community.

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

Categories	2019		2020		2021	
	BME	WHITE	BME	WHITE	BME	WHITE
Shortlisted Applicant %	48.9%	48.64%	50.9%	45.89%	48.88%	48.30%
Appointed from Shortlisting %	37.0%	60.75%	39.2%	58.57	42.28	54.69%
likelihood of appointed from shortlisting %	10.86%	17.95%	8.96%	14.83%	6.23%	14.74%
Likelihood appointed from shortlisting White compared to BME Staff		1.652		1.66		1.31

Table 5

4.11 The data in table 5 above shows that white applicants are 1.31 times more likely to be appointed from shortlisting than BME applicants. This has improved from the 1.656 times likelihood reported last year, a 0.34% decrease. The four year period shows movement of a 0.5% increase. This small positive difference is statically immaterial but the perceptual impact of a slow but improving picture for BME staff could demonstrate some of the recent changes and improvement in this and other areas, affecting BME staffs' experiences in the Trust.

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

Categories	2019	2020	2021
Percentage of BME Staff in Workforce	31.54%	32.49%	33.52%
Percentage of BME Staff in formal process	36.22%	36.84%	37.82%
Likelihood of BME Staff disciplinary	24.52%	37.56%	32.30%
Likelihood of White Staff disciplinary	23.06%	30.38%	25.71%
Likelihood White compare to BME staff	1.24	1.26	1.18

Table 6

4.12 This year's indicator demonstrates that BME staff are 1.18 times more likely to enter a formal disciplinary process than white staff, see table 6. This is a slight improvement from the likelihood reported last year, where BME staff were 1.26 times more likely to enter the process.

4.13 The possible reason could the percentage increase in BME staff population, at a higher rate than other ethnic groups. In addition the reduction has slowed from last year for BME staff entering the process, from 19 to 4 less BME staff this year. Resolving a number of cases informally, adopting elements of the NHS 'Just Culture Guide' need to continue to be applied to further reduce the overall number of people entering formal disciplinary. A detail review of themes and processes will be undertaken to gather determinations on any presence of disadvantage or bias in the system.

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

Categories	2019	2020	2021
No of BME staff in workforce %	31.54	32.17	33.52
No of Staff BME accessing NMT and CPD %	32.86	32.93	42.29
Likelihood of BME staff accessing	58.19	48.07	29.92
Likelihood of White staff accessing	53.90	45.03	21.01
Likelihood accessing White / BME staff.	0.92	0.95	0.70

Table 7

4.14 BME staff continue to access NMT and CPD more often that White staff, increasing this year (0.70 times more likely) or 29.92% of all BME staff compared to 21.01% of white staff. This has fluctuated over last the three years of reporting but consistently been higher in comparison to White staff.

4.15 The next four indicators are based on data from the national NHS Staff Survey 2018-2020 and compare the outcomes of the responses for White and BME staff. The NHS Staff Survey is reviewed annually to ensure that organisations' local staff surveys are aligned to the four WRES indicators based upon the NHS Staff Survey questions. Response rate are added for context. The scored are benched marked against other Acute and Acute & Community Trusts and rated best to worst in the NSS. This is noted as Acute Trust in the tables.

4.16 Benchmarking group details:

- Number of organisation in group 128
- Median response rate 45%
- No of questions answered 402,201

Indicator 5 (Q13a). Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

Categories	2018	2019	2020
BAME staff (UHB)	24.7%	26.7%	24.3%
BAME Staff - Acute Trusts	29.8%	29.9%	28.0%
White Staff (UHB)	25.4%	25.4%	23.3%
White Staff (Acute Trusts)	28.4%	28.2%	25.4%
Response rates for BME/White			1,741/ 4,964

Table 8

4.17 BME staff registered a 2.4% decrease in the levels of bullying and harassment from patients, relatives or the public, with a similar decline for White staff; 24.3% compared to 23.3%. Improvements have been made for BME and white staff experiencing harassment from patients and the public.

Indicator 6 (Q13c). Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

Categories	2018	2019	2020
BAME staff (UHB)	28.0%	27.5%	27.2%
BAME Staff - Acute Trusts	28.7%	28.6%	29.1%
White Staff (UHB)	25.1%	24.5%	24.0%
White Staff (Acute Trusts)	24.9%	24.5%	24.4%
Response rates for BME/White			1,738/ 4,956

Table 9

4.18 There has been a minimal decrease in bullying and harassment reported by BME staff, with 27.2% of BME staff who participated in the staff survey (1738) said they experienced this (compared with 24.0% for 2018. White staff reported marginally lower levels of bullying at 24%. The comparison between the staff groups has been static at approximately 3% for the last three years.

Indicator 7 (Q14). Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion

Categories	2018	2019	2020
BAME staff (UHB)	69.2%	69.9%	68.9%
BAME Staff – Acute Trust	73.1%	74.1%	72.50%
White Staff (UHB)	85.6%	84.9%	85.30%
White Staff Acute Trust	86.8%	87.2%	87.70%
Response rates for BME/White			1,125/3,401

Table 10

4.19 68.9% of BME staff believe that the Trust provide equal opportunities for career progression. This would suggest that a significant number of BAME staff are not putting themselves forward for career progression or promotion because they do not believe the Trust acts fairly. This is much lower than the perception of white staff, where 85.39% believe this to be the case. For BME staff, there was a very slight decrease on last year, wiping out previous

gains. Positive gains for White staff were had at (0.4%).

4.20 However, it is noted that the disparity between staff groups has creped up from 15% to 16.4%. This is lower than the benchmark for BME staff.

Indicator 8 (Q15b). Percentage of staff personally experienced discrimination at work from a manager, team leader or other colleague in the last 12 months

Categories	2018	2019	2020
BAME staff (UHB)	14.6%	13.8%	16.40%
BAME Staff – Acute Trust	14.6%	14.2%	16.80%
White Staff (UHB)	7.4%	6.3%	6.60%
White Staff Acute Trust	6.3%	5.8%	6.10%
Response rates for BME/White			1,805/5,099

Table 11

4.21 The level of BME staff that experience discrimination at work from their colleagues has increased abruptly by 2.6% from 13.8% to 16.4%. This is marginally better than the benchmark.

4.22 This is still significantly higher than the levels reported by white staff at 6.60%. The analysis section will question the data and establish possible actions required.

Indicator 9. Percentage difference between the organisations' Board memberships and its overall workforce.

Categories	2019	2020	2021
BME workforce %	30.9%	32.25%	33.5%
White workforce %	64.60%	64.01%	62.56%
Board voting members BME %	0.00%	11%	11.11%
Board voting members White %	100.00%	89.50%	88.9%
Percentage difference voting board / BME workforce	**-30.90%**	**-21.70%**	**-22.41**
Executive Board members BME %	0.00%	0.00%	0.00%
Executive Board members White %	100%	100%	100%
Percentage difference Exec board / BME workforce	**-30.90%**	**-32.5%**	**-33.52%**
Board members BME%	9.10%	8.30%	8.33%
Board members White%	90.90%	91.70%	91.67%
Percentage difference full board Vs White workforce	**26.30%**	**27.69%**	**29.11%**
Percentage difference full board Vs BME workforce	**-21.80%**	**-23.90%**	**-25.19%**

Table 12:

4.23 There was some improvement in 2020 (see table 12), as two of the Trust Board NEDs that gained voting rights are BME. This year, at the point in time 31 March 2021, we see a

percentage difference decrease of 0.71% for voting board members. For full board representation, we have also seen a slight decrease of 1.29%. This gives a continued concerning percentage difference for board representation -25.19%. For the Trust Board to be aligned to the overall workforce 6 of its 19 voting members and 7.5 of its 23 overall executive team should be from a BME background. (As at March 31 2021).

4.23 This widening gap between boards and BME workforces is echoed across NHS organisations. The NHS People Plan 2020 reported that 'every NHS trust, foundation trust and CCG must publish progress against the Model Employer goals to ensure that every level of the workforce is representative of the overall BAME workforce. From September 2020, NHS England and NHS Improvement will refresh the evidence base for action to ensure the senior leadership (very senior managers and board members) represents the diversity of the NHS, spanning all protected characteristics.'

5. Analysis

5.1 This report is useful because it highlights where BME percentages fall below a set target, we can then see at a glance where there are differences. This is already set by using national benchmarking for indicators 5-8. Indicator 1-4 and 9 can be set by the trust representative figure of 33.52%. This kind of report could prompt further investigation in order to explain those differences. Some people find it more useful to have detail in a graphical format, so these are provided in the appendices using horizontal bar charts to show for example the percentage of BME staff in each pay banding, for clinical and non-clinical.

One area that is improving but need further work is Indicator 3 - relative likelihood of entering the formal disciplinary process. There has been a significant reduction in the number of disciplinary cases in the last 24 months, HR has focused on resolving a number of cases informally which has helped reduce the total number of staff entering the formal disciplinary process by 16 staff. However we still had 73 BME staff in the last 12 month that did enter the process. That is 37.82%, above trust representative of 33.52%. White colleagues represented 59.8% through disciplinaries less than the 62.5% they representation of the workforce. **Chart 5, (p30)**

The 'Just Culture' model should continue to be implemented with the HR and inclusion teams developing managers to emphasise the new way of managing staff in difficulty. This would mean that in practice, many more cases which may have previously resulted in a formal disciplinary process could be resolved informally. The focus on learning from errors or incidents, and taking a positive rather than punitive approach where this doesn't feel proportionate or justified, has been effective.

The role of the First Contact team has been central to this, reflected in the overall figures for the year, however more targeted approach to early intervention alongside management training in cultural competency and antiracist practice to support the disciplinary process. Consideration should also be given to adopting the Royal College of Nursing (RCN), Cultural Ambassadors Programme that provides trained independent to support Trust on disciplinaries matters for BME staff.

Further work should identify what the disciplinaries are related to, for both BME and White staff to highlight patterns or differences across ethnicities. Whether further analysis is needed to understand the purpose of the disciplinary at each stage of the process e.g. was the original reason addressed or were there additional explanations why a disciplinary has been escalated. Had BME staff fared worse, not given the benefit or allowed another chance before formal process was started.

This report, and accompanying action plan, will primarily focus on two main areas of analysis and development. It will interrogate indicators 1, 2, 7 and how it impacts recruitment retention and, promotion for BME staff. This is not a move away from last year's focus as we continue to see disparity in recruitment and promotion.

It also picks up on the national theme of action on improving perception of promotion, where we see 29% (Nationally) and 31% (UHB) of staff don't believe there is equality in promotion opportunities. Indicators 5, 6, and 8 show us the experiences of racist and discriminatory behaviour, bullying and harassment data, where the report indicates a static position of reporting over the last three years.

6. Representation, Recruitment and Promotions

6.1 Indicator 1 - **chart 1 (p28),** clearly illustrates that a significant proportion of BME staff sit within the lower bands, with the percentage of BME staff significantly decreasing from band 8b non-clinical and band 6 clinical. A lack of representation at senior levels within organisations is a well-documented disparity[1].

6.2 This is a complex and dynamic moving system, which encompasses a variety of intersectionalities, not just race. Important skills for clinical and managerial leaders are essential, and include self-awareness, shared authority, conflict resolution, and non-punitive critique. Resistance to change is described as a reaction to loss, which needs to be addressed through continuous leadership activity and engagement.

6.3 In order to sustain change, innovation and collective intelligence, through diverse workforces, it is argued within research that leadership must be less accidental, less technical and more adaptive and behaviourial. Cultural development programme that consider behaviours and values are as important as those that explain the processes.

6.4 There is a large difference between percentages of BME staff in clinical, **chart 3 (p29)** and non-clinical positions. BME staff are much better represented within clinical roles, which is not unexpected, with the Trust having increasingly looked to east and south Asian countries to fill nursing and clinical roles and historically these type of roles have been promoted and role modeled in these communities.

6.5 However, even with overall representation, and improvement across the band, more measurable in bands 8b and 8c, non-clinically and 8c and VSM clinically, the trend of decreasing BME staff as the AfC band increases is still stark. Although the percentage of BME Staff in non-clinical VSM roles has increased, 3.2% in the last year, this is only two staff and a total of 7 compared to the 47 white staff, which equates for 87%, 25% above the representative level.

6.6 Further exploration of the peaks at bands 2 and 5 (chart 2, (p29); show that these are dominated by BME Staff in clinical roles; Healthcare Assistants at band 2 and nurses at band 5. In general, clinical roles have a higher proportion of BME staff than non-clinical roles.

[1] BAME representation and experience in the NHS 2019 – NHS Employers

These peaks are seen across the NHS as documented in the 2019 Data Analysis Report for NHS Trust.[2] There are clear barriers in the movement of BME staff bands 2-3, where we see a reduction. The transition seems more possible at band 3-4 and 4-5, where we find the highest level of BME staff, 12.35 over BME staff representation. In comparison the movement of white staff across the same banding seems more fluid, with the representation only dipping at band 5.

6.7 What is concerning in **chart 2 (p28)**, is the year-on-year growth in these bands and the limited movement to bands 7 and above. The WRES centre has developed further the analysis tool, which we will use for divisional reports providing disparity index on the likelihood of movement across bandings for BME compared to white staff. This added data will pinpoint where possible system errors are occurring and change is needed. It will also support progress to meet the 2028 target for equity across band 8a upwards, for BME staff.

6.8 Currently the Trust reports on the distribution of BME Staff across the Trust on an annual basis. Whilst this helps to provide an idea of what is happening within the Trust, the long period between reporting means that there is a delay in taking action where there are issues, which may allow some problems to become further embedded into the Trust. It is suggested that reporting on recruitment and distribution of BME staff is done quarterly. This report should reflect pay bands, divisions and specialty to gain better insights on trends, patterns and to hold to account those responsible to support the necessary embedding of the WRES 2021 Action Plan.

6.9 Indicator 2 - displays a distinct level of inequality for BME staff, **chart 4, and (p30)**. The figure in 2020 show a startling decline of BME staff from 58% of applicants to 39.2% appointed, with a likelihood of appointed of 1.66. This year gives a likelihood of 1.31 more likely that a white staff member would get appointed than a BME staff member. The Trust has been exploring reasons for this disparity since the first WRES report in 2016. Then the comparison was 1.90 more likely for white staff member to get appointed. Accounting for the last 18 months and the raised urgency and awareness of disparity for BME staff, there is some movement of change to understand the important truths about equality and fairness, which continues to impact BME staff at UHB.

6.10 The ethnicity chart shows the percentage of BAME applicant applying for posts within the trust as almost 60%, however this drops to 48.88% being shortlisted, and proving that they had the essential criteria to be interviewed however at interview 42.28% were recruited compared to 54.69% white applicants.

6.11 As with the Religious Belief Chart, the “picture” being presented looks the same, however, the percentages have changed, at the point of the process when shortlisting takes place, there is, this year, only a difference of 0.58% between the White and BAME populations, (last year, that difference was 5.19%). However the change is within the recruited picture, last year 39.55% of new recruits were from a BAME background, and this year that percentage has increased to 42.28%.

6.12 This change is encouraging for it continues a trend, in the year 2016 / 17 the percentage of BAME staff being recruited was 35.22% so progress in narrowing the White / BAME recruitment rate is progressing. However we need to consider the context of 2020 and the impact of the pandemic. We had 3,000 less shortlisted applicants and 1400 less appointed applicants over the same period.

6.13 The development work of HR will support the alignment of these areas, which includes the introduction of fair recruitment experts, trained experts who either identify with an underrepresented staff group or protected characteristic, or they will have demonstrated that they are committed and visible allies. They will become independent, equal third panelist who

[2] NHS Workforce Race Equality Standard. (2020) 2019 Data Analysis Report for NHS Trusts

will be there as part of the process from shortlisting right through to the selection stage at interview. Also being scoped is an accountable decision record. This is going to capture the reasons for appointing one candidate over another. And it will also specifically explain the outcomes for the candidates who we don't offer the role to, and that decision record will be returned to recruitment in the same way as offer forms are returned. Also a part of this doubling up affect to change culture and practice a data dashboards will be established, which will give departments a greater degree of visibility on how their workforce profile compares to the whole Trust.

6.14 Anecdotal evidence, previous reports and research suggest implicit bias is a major factor in the alarming discrepancies. Inclusion, unconscious bias, recruitment and selection training, and improved panel representation have been implemented across the Trust to mitigate these implicit behaviours over this period. In four years we have inched 2.44% towards an equaling of the position, to which we have fairer recruitment at senior levels.

6.15 In addition to likelihood of appointment from shortlisting, relative likelihood of being shortlisted was also investigated as a potential barrier to entry. This shows that white applicants are overall 1.48 times more likely to be shortlisted than BME staff. As with the disparities at appointment, implicit bias is most likely part of the combinations of factors here, as even though personal data is removed from applications, there is still sufficient information that may imply they hold certain protected characteristics and shortlist done outside of panel and sometime just by the panel chair.

6.16 Recruitment and selection training has been mandatory for recruiting managers for many years, as stated above, with 'unconscious' bias added as an element in the last four to five years since the inception of the WRES. In addition to this, the introduction of independent panel members, the Aspire staff interview coaching programme in the last two years has had little impact.

6.17 **Indicator 7 –** The position on perception of equality have worsened slightly. Against the benchmark we are **3.6%** adrift, that's 31.3% of the BME staff that undertook the survey felt the trust was not fair when it came to progression or promotion. Some of the reasons for the disparity and direct discrimination see **chart 9 (p32),** were highlighted through the experiences of BME staff. BME staff spoke about perceptions of favouritism when development opportunities arise. Many gave examples of 'hidden culture', where white staff are coached and prepared for development opportunities or where managers would often tell members of staff about opportunities before they were advertised, thereby giving specific candidates an advantage. BME staff continue to feedback instances like this made them less inclined to go for opportunities as they do not want to waste energy on going for positions where a decision appears to have already been made.

6.18 Whilst issues of favouritism and more nuances of discrimination are difficult to evidence, let alone tackle, there are approaches to improve fairness, transparency the Trust can be doing and has started on that work as this report is being written. With development starting at vacancy development, advertisement to robust system changes for all internal, external and acting-up positions, administered through HR, in-roads can start to be made.

6.19 There are is still further amendments to be made on the Trust's Recruitment and Selection Procedure on Acting-up and fixed-term development roles, to improve equal access. The amendments must include mechanisms for monitoring as highlighted in the 2016 National WRES Report and mentioned in last year's UHB WRES report. The Trust should also introduce formal arrangements around shadowing as it is doing for mentoring, as this is another development opportunity that is most likely being accessed disproportionally by different groups and is not currently monitored.

7 Bullying, Harassment and Discrimination

7.1 BME staff registered a 2.4% decrease in the levels of bullying and harassment from patients, relatives or the public, with a similar decline for White staff; 24.3% compared to 23.3%, **chart 7 (p31)**. Pitched against acute trusts we fair better, with very marginal difference between BME and White staff. This change impact is possibly shared with the campaign 'No excuse for abuse' and possibly the reduction of patient and visitors in the last 18 months due to the Covid pandemic. We are in a better position comparatively than other acute Trusts, however there is more work to be done, as anecdotal recording testify to possible lower levels of official reporting.

7.2 Similar reduction is seen in bullying and harassment reported by BME staff, with 27.2% of BME staff who participated in the staff survey (1738) said they experienced this (compared with 24.0% for 2018. White staff reported marginally lower levels of bullying at 24%. **Chart 8 (p31)** The comparison between the staff groups has been static at approximately 3% for the last three years. Further interrogation of the data is needed to substantiate these disparities as at a macro level this would represent just 6.2% of the total BME workforce and qualifies the need for a more detailed BME staff survey and engagement piece. Based on the staff survey we rated just below the baseline average of acute trusts but further work is needed to improve that score.

7.3 The level of BME staff that experience discrimination at work from their colleagues has increase sharply by 2.6% from 13.8% to 16.4. This is a little better than the benchmark at 16.80. This is still significantly higher than the levels reported by white staff at 6.60%.

8. Analysis summary

8.1 Analysis of the WRES indicators has brought up a number of findings which can be summarised as follows:

8.2 Distribution of BME staff across the Trust is uneven both horizontally and vertically. The lack of BME representation in senior levels of the Trust is distinctively apparent from Band 8a, consistently across the trust apart of medical.

8.3 The evidence of systemic barriers across the recruitment, promotion and development processes continue to prevail, born out in inconsistent processes, hierarchical tendency and hidden cultures at play.

8.4 There is a lack of trust and access for BME staff when it comes to career development and promotion opportunities. The possible argument of meritocracy doesn't bear truth through the numbers of staff accessing non-mandatory training, which should progress to more senior roles.

8.4 Senior external and career development opportunities are not equally communicated, access or monitored for BME staff. There are significant levels of BME staff experiencing discrimination when it comes to accessing senior development programmes and a higher perception of under-reporting.

8.4 Following analysis of the Trust's data and potential solutions that have been highlighted through discussions with relevant stakeholders, a high-level action plan has been created for the period, October 2021 – September 2022. However it should be noted the reality of mitigating these embedded biases will need a much longer term plan of change. One where the interactions and relationships of different components; intersectionality, class and socioeconomic, simultaneously affect and are shaped by the system. This action plan can be found in appendix 3.

8.5 This action plan details the key actions steps for the next 12 months that work towards

improvements on Race Equality for this and forthcoming years. These actions need to be seen in the wider picture of years and not months, as mentioned above. The plan will potentially highlight further steps that can be taken. As such, it should be recognised that the action plan is a live document that will be updated as new information comes to light or in line with best practice.

9. NHS Model Employer

9.1 The Model Employer explains that workforce race equality requires organisations to go beyond operational change as a result of compliance and regulation against metrics and targets. It needs cultural and transformational change on this agenda, across the entire workforce, which should be approached with an honest heart and an open mind.

9.2 The Model Employer approach looks to see what impact the development opportunities have had on shifting parity across the bands. With division data and performance target set for 2021/22 we will in future report on this data's progress to meet the projected NHSEI targets.

10 Communications and Engagement

10.1 Communications need to be well-considered. It is vital that they aid the understanding of all staff as to why measures are being introduced and how it benefits the wider Trust. Furthermore ensuring that the Trust properly communicates with BME staff and demonstrates how it is holding itself to account. It should work to build trust with BME and other staff with protected characteristics that enable them to feel comfortable and competent to apply for development opportunities and promotion. The Inclusion team will work with Communications to support these programmes of work on the following aspirational actions.

10.2 **Raise awareness** - of the WRES, why the organisation wants to make positive change and the benefits of change for staff, patients and our local communities. Give advice knowledge and guidance - to provide the organisation with relevant guidance, information, tools and advice on the WRES and its implementation – tailored to the needs of departments and specialties.

10.3 **Engage** - Actively engage with senior leaders, the workforce and stakeholders. A tailored engagement approach can be in the form of; team or divisional meetings, seminars, workshops case studies of colleague experiences or successes, social media messaging supported by open and frank staff forums where views can be shared.

10.4 **Promote senior leadership on the issue** - Empower, encourage and enable senior leaders in the organisation to be confident about discussing race equality.

10.5 **Build partnerships** - cohesive working and exchange of ideas across teams, departments and business units.

10.6 **Celebrate pacesetters** and those leading by example, making progress, developing and sharing best practice. Work with external organisations and partners to train colleagues and learn from each other.

10.7 **Help spark cultural and behaviourial change on this agenda** - The vision for University Hospitals Birmingham NHS Foundation Trust is for equality not to be an objective to be achieved, ticked, but hardwired as business, engrained in our values, culture and behaviours.

"*Since then, I've focused on solutions; words only work as the groundwork for actions. I've continued to ask others that same simple question: what do we hope to achieve?"*

Sir Lenny Henry 2014

11 Recommendation

11.1 The Trust Board is asked to note and accept this report and the accompanying action plan.

11.2 The Trust Board is asked to publish this report and accompanying action plan in the public domain via the Trust's external website.

Contributors

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October 2021

Appendix 1

Chart descriptions

	Workforce Indicators chart Descriptions
Indicator	Table 1: Data source details
	Table 1: Indicators - Technical Guidance for the NHS Workforce Race Equality Standard (WRES) 2019
1.	Table 2: Percentage of staff in each of the AfC Bands for 2019 to 2021. Difference between the two is shown with green indicating a positive difference from 2019 to 2021 and red indicating mostly a negative difference.
1.	Table 3: Percentage of staff in each of the AfC Bands for 2019 to 2021. Difference between the two is shown with green indicating a positive difference from 2019 to 2021 and red indicating mostly a negative difference.
2.	Table 3: Percentage of BME staff shortlisted and appointed for 2019-2021. Comparison of White/BME staff likelihood of appointment from shortlisted.
3.	Table 4: Percentage of BME staff in formal disciplinary process for 2019 to 2021. Comparison of White/BME staff likelihood of entering disciplinary process. Percentages based on the total number of disciplinaries, 265, 209, 195.
4.	Table 5: Percentage of BME accessing NMT and CPD for 2019 to 2021 Vs. number of BME workforce Comparison of White/BME staff accessing NMT and CPD.
5. **(Q13a)**	Table 6: Percentage of white and BME staff experiencing harassment, bullying or abuse from patients, relatives or the public; Staff Survey 2018 and 2019.
6. **Q13c**	Table 7: Percentage of White and BME staff experiencing harassment, bullying or abuse from staff; NHS Staff Survey 2018 to 2020.
7. **Q14**	Table 8: Percentage of white and BME staff believing that the Trust provides equal opportunities for career progression or promotion; Staff Survey 2018 to 2020
8. **(Q15b)**	Table 9: Percentage of white and BME staff experiencing discrimination at work from a manager, team leader or other colleague; Staff Survey 2018 to 2020
9.	Table 10: Percentage difference of voting and full board representation and BME and white workforce 2019 to 2021

Appendix 2 – Charts

Key

2019 2019
2020 2020
2021 2021

- Blue bars represents – BME Staff / Orange bars represents – White Staff
- Data labels have been added to latest results
- The red horizontal line displays the Trust BME representation of (33.52) used as benchmark for each band for indicator 1-4 and 9 or the National Staff Survey benchmark from acute trust for indicators 5-9.

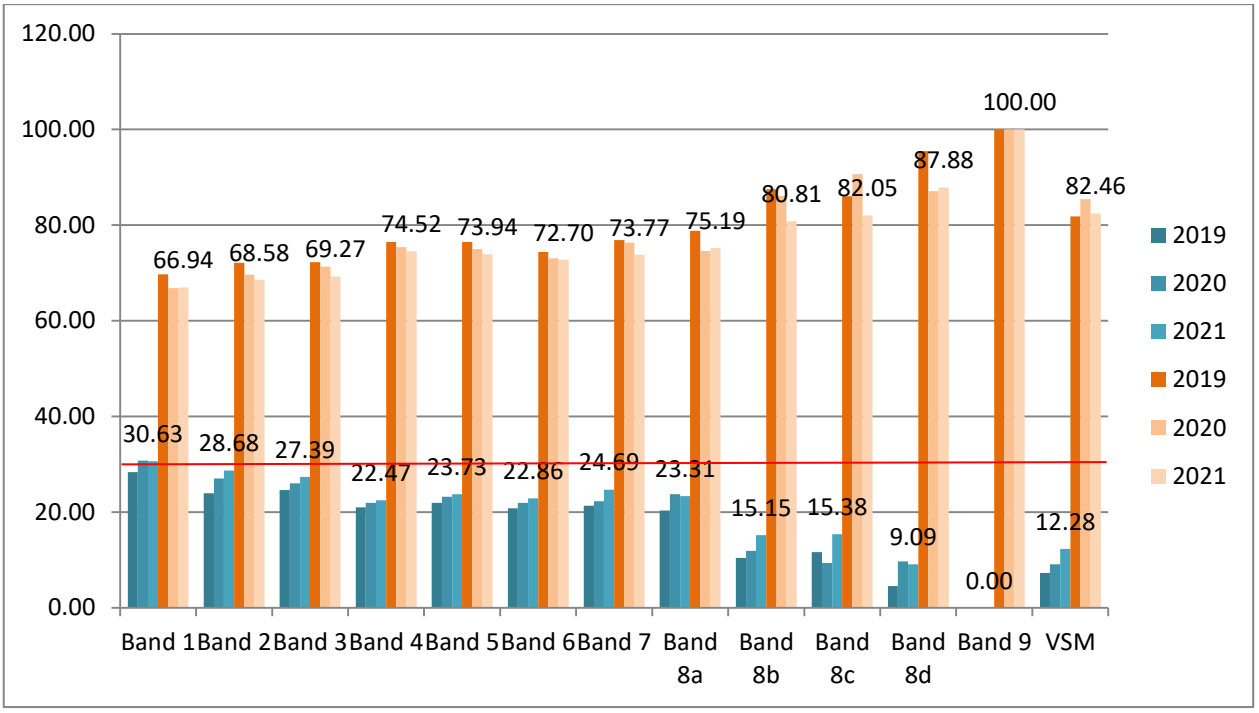

Chart 1. Non-Clinical. Percentage of BME Staff compared to White staff at each of the Agenda for Change Pay band.

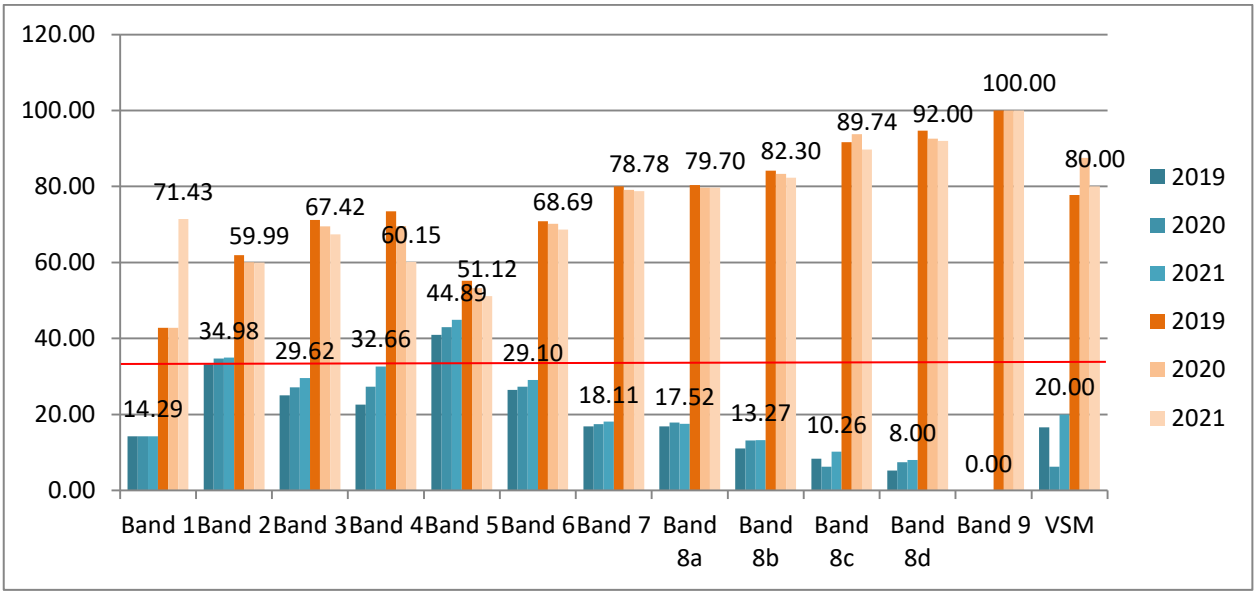

Chart 2. Clinical. Percentage of BME Staff and White Staff at each of the Agenda for Change Pay Banding for 2019-21.

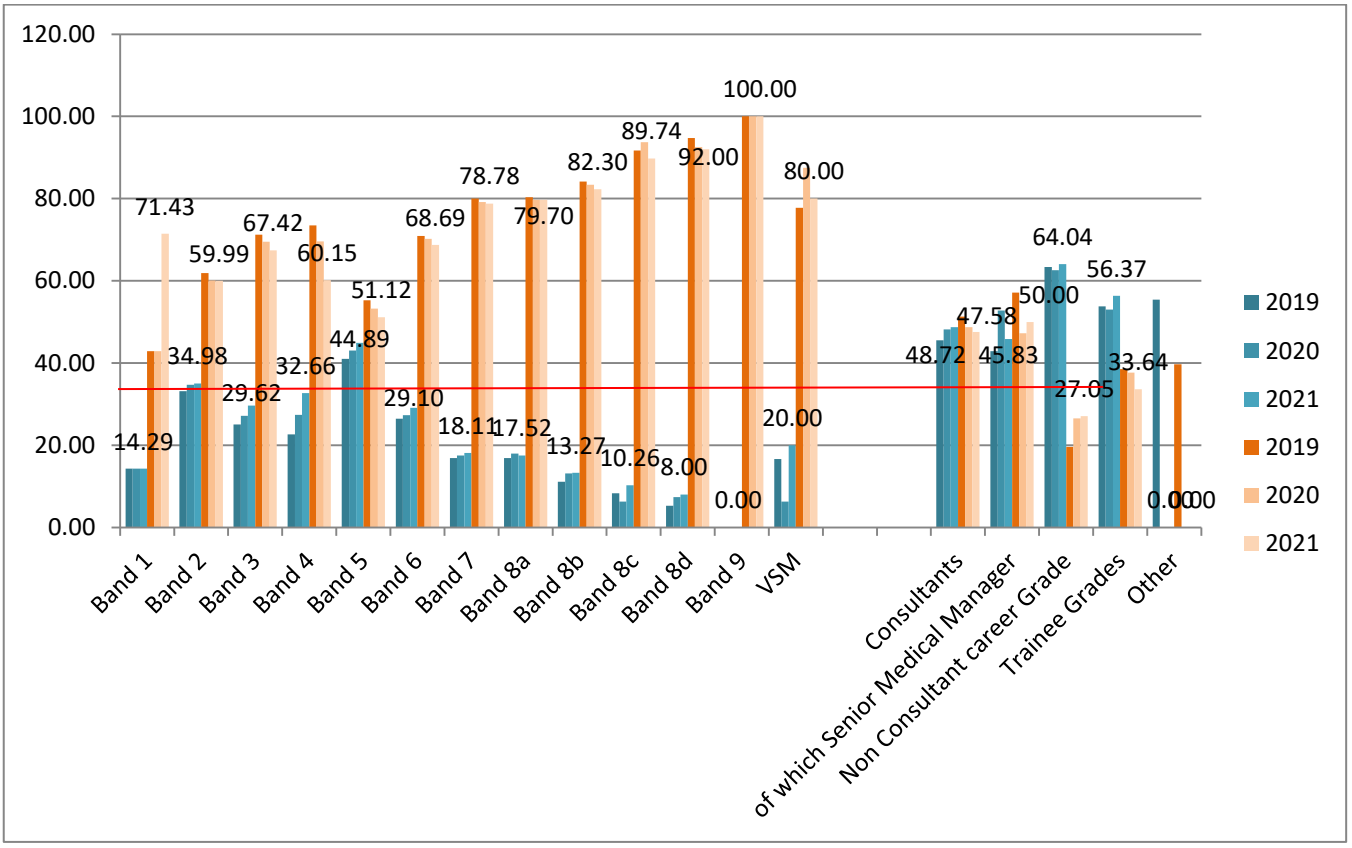

Chart 3. Clinical. Percentage of BME Staff and White staff at each of the Agenda for Change Pay Banding for 2019-21, including doctors.

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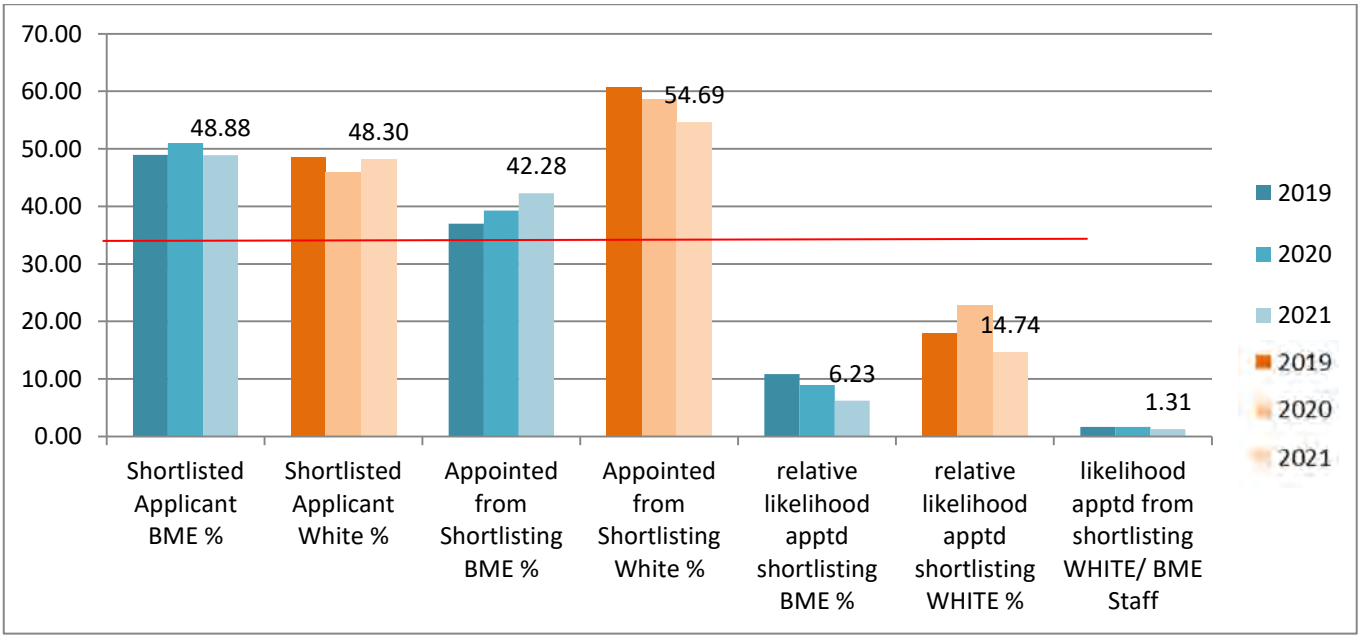

Chart 4. Percentage of BME Staff at each stage of recruitment process from shortlisted to appointment for 2019-21. The overall Trust percentage of BME staff in the Trust (33.52%), and Birmingham Demographics (42.07%).

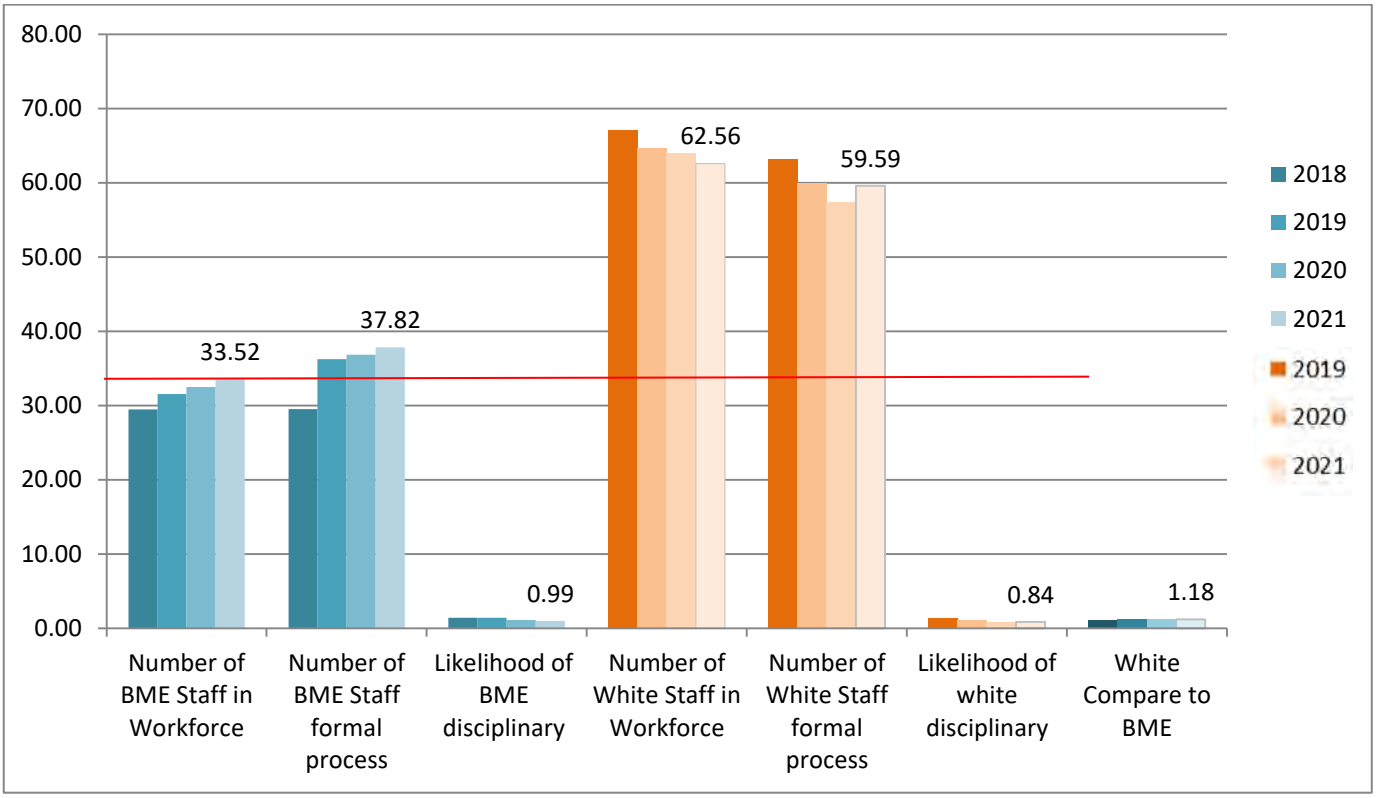

Chart 5. Percentage and likelihood of BME staff in disciplinary process.

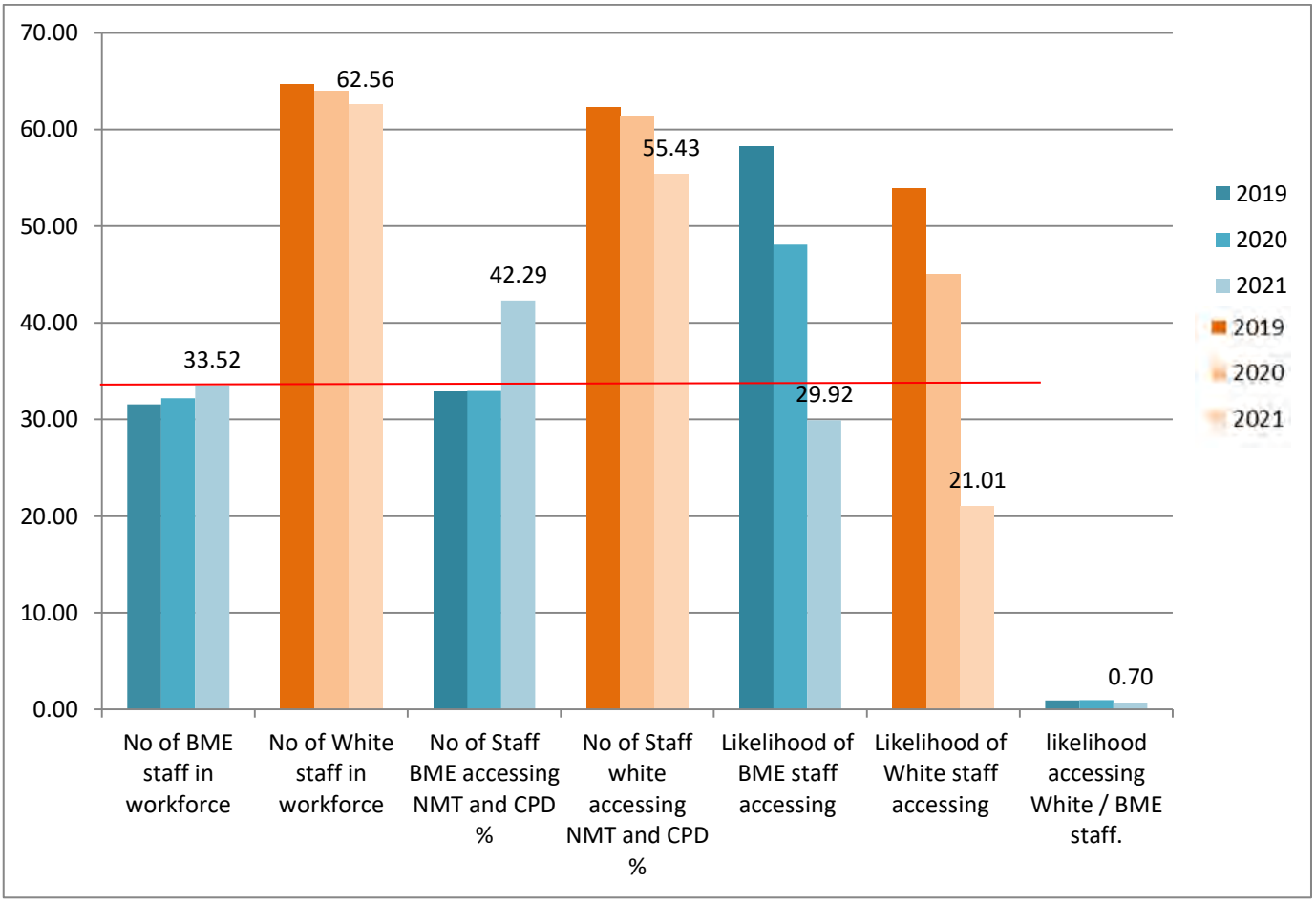

Chart 6. Percentage of BME staff accessing NMT and CPD, 2019-21.

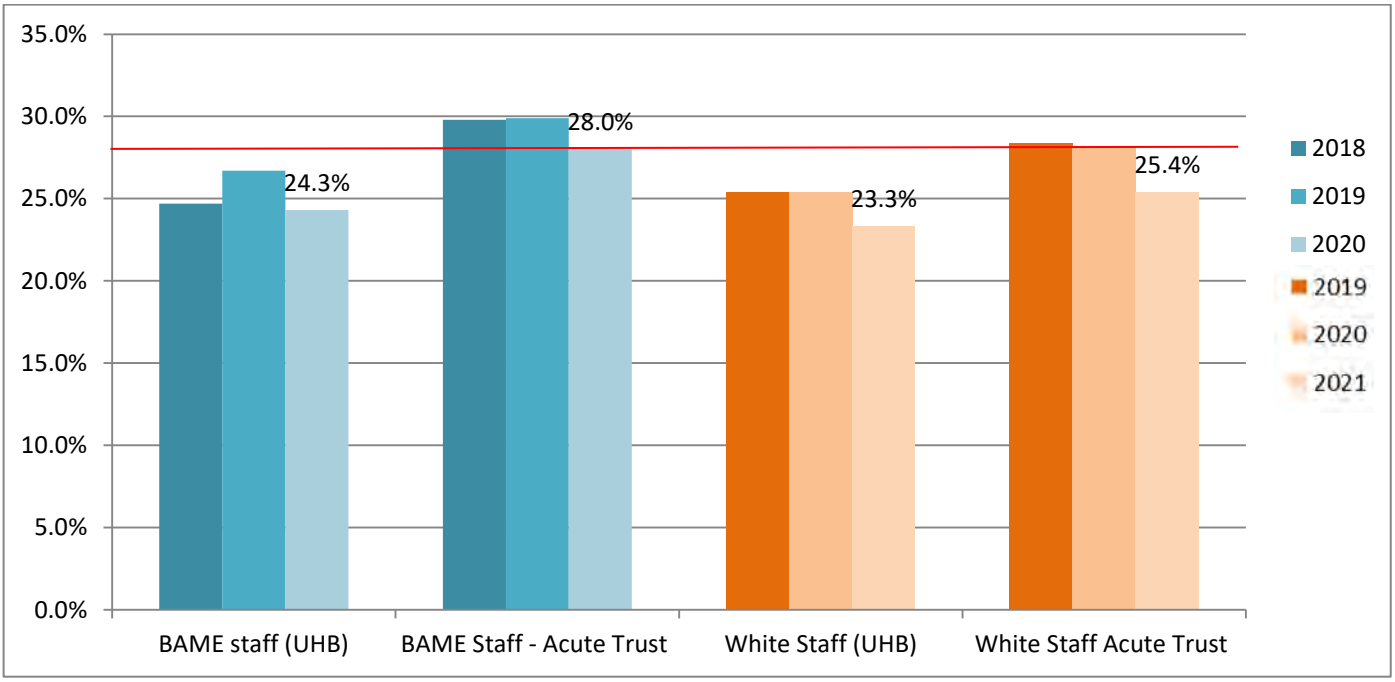

Chart 7. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public, 2018-2020.

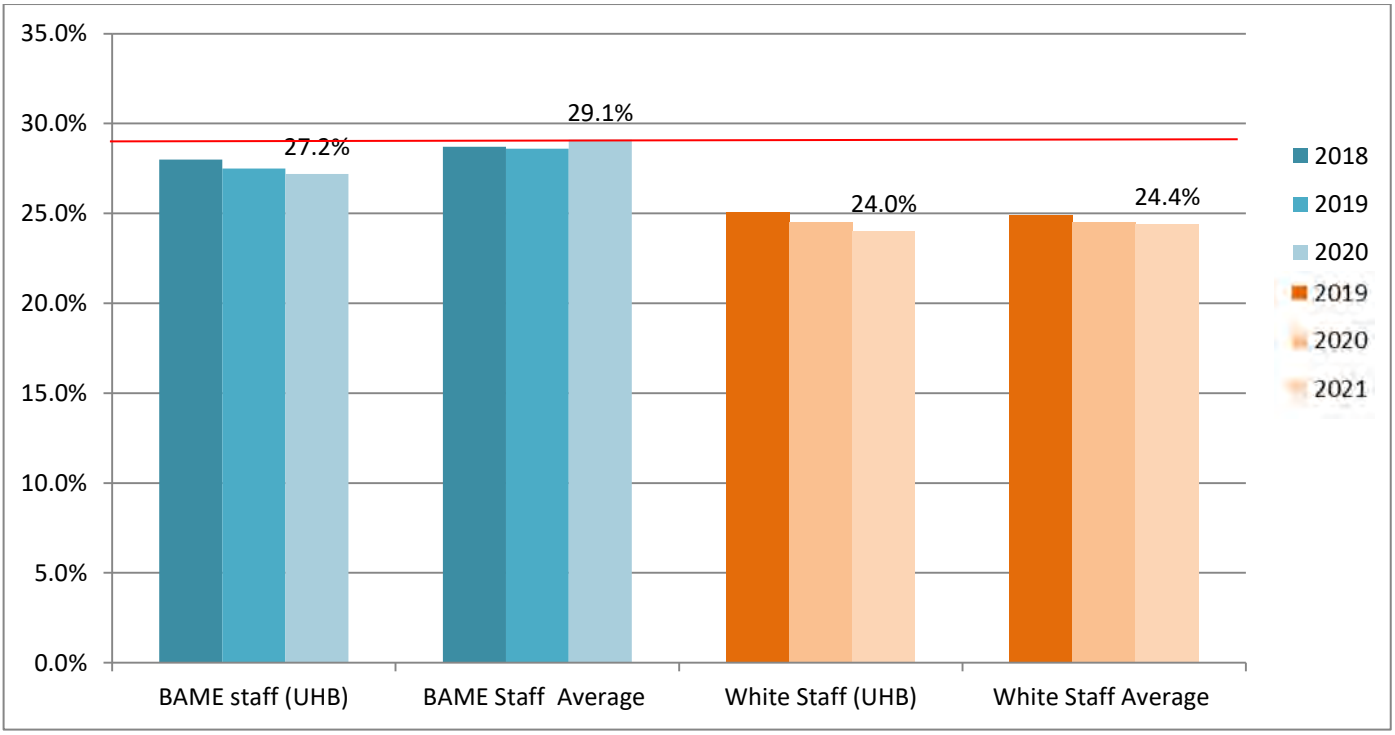

Chart 8. Percentage of staff experiencing harassment, bullying or abuse from staff, 2018-2020.

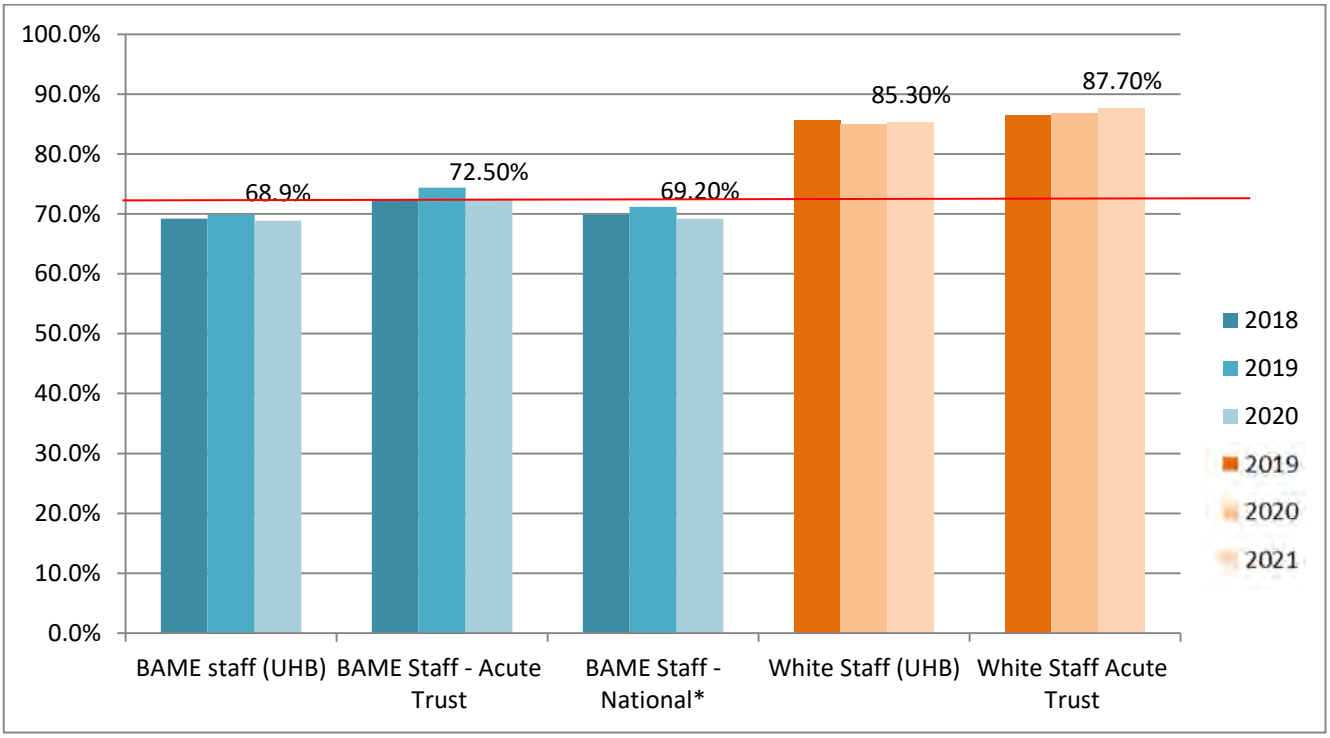

Chart 9. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion, 2018-2020. *Includes CCG and Ambulances services

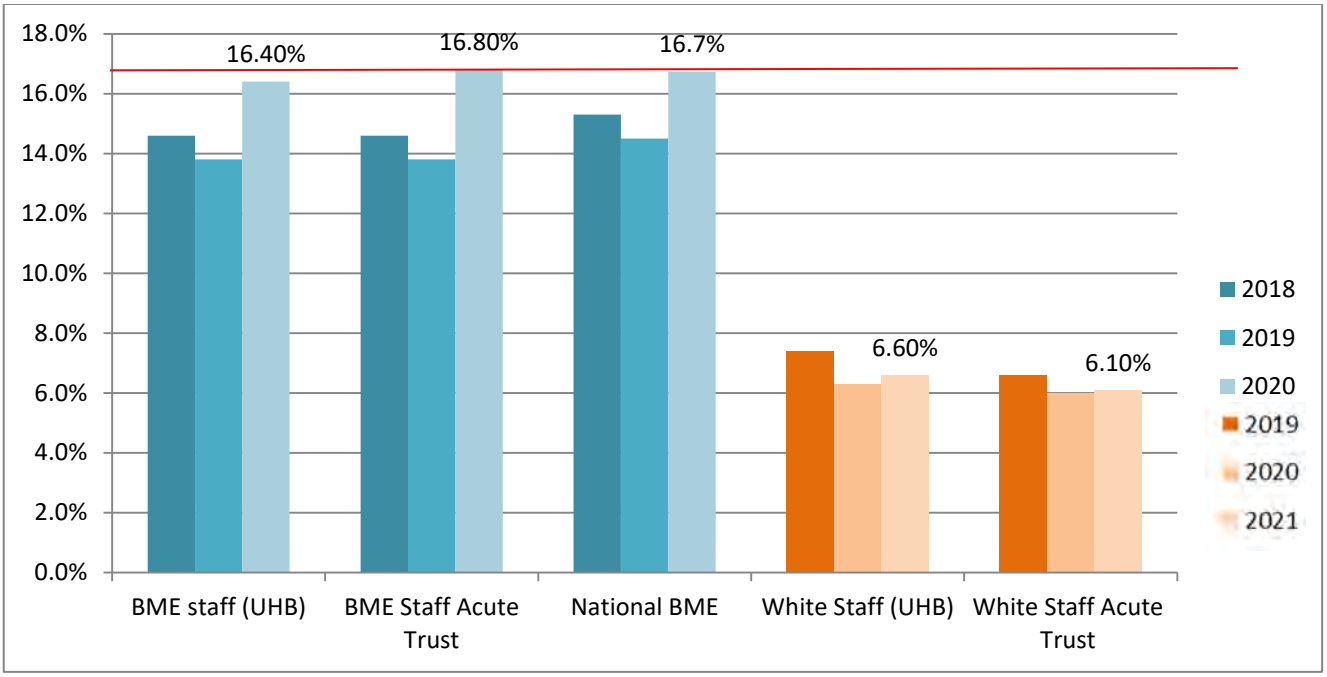

Chart 10. Percentage of staff experienced discrimination at work from manager, team leader or other colleagues, 2018-20

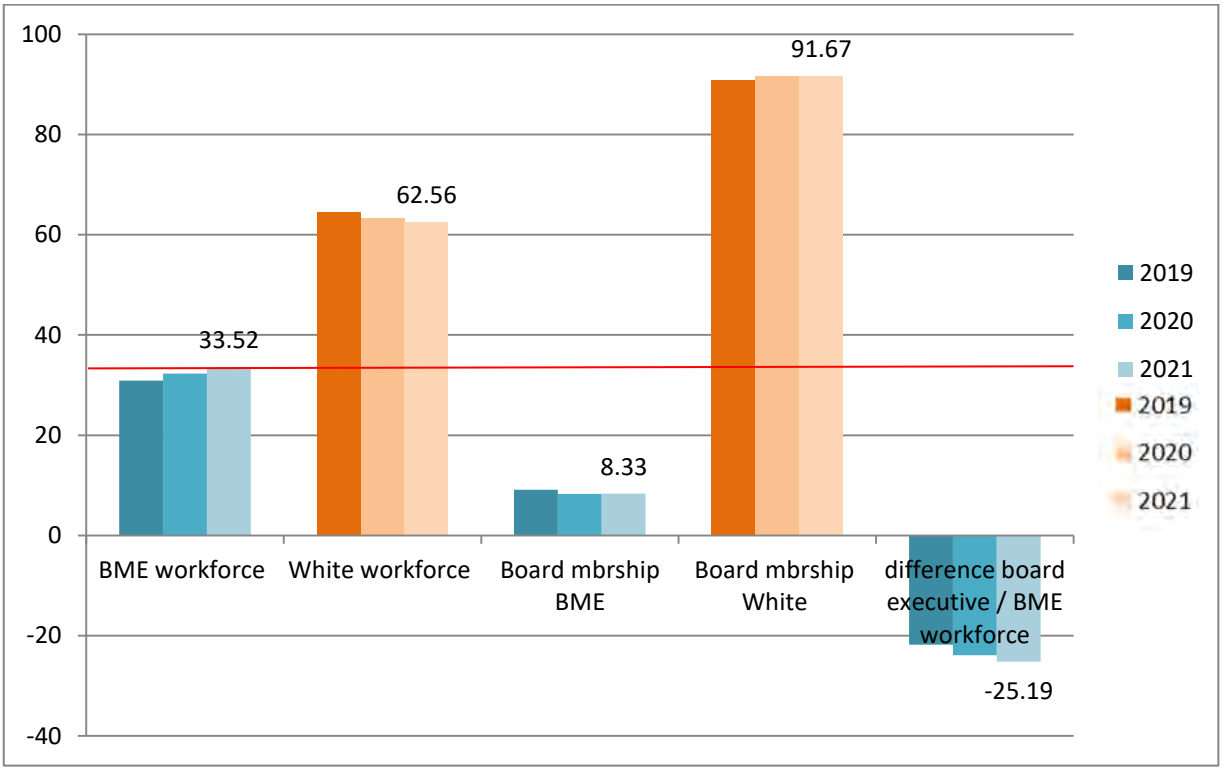

Chart 11. Percentage difference of BME Workforce and Board representation 2019/2020.

Appendix

WRES Action Plan 2020/21

1. Increase development and progression opportunities for BME staff

No	Indicator	Action	Lead	By When	Milestone	Progress	RAG
1	7	Reciprocal Mentoring Programme to be continued – cohort 4 to be started	Fairness Taskforce Lead	Q3	• Cohort 4 out to recruitment		A

2. Develop accountability of systemic and institutional racism and discrimination across Trust

Priority	Indicator	Action	Lead	By When	Milestone	Progress	RAG
2	2,3,6,7,8	Fairness Root Cause Analysis (RCA) programme. To continue to develop accountability across the Trust to systematically challenge discrimination towards BME staff. FRCA will look at individual and organisational issues periodically. FRAC to be schedule bi-monthly Recruitment , Promotion and retention	Fairness Taskforce lead / Mark Garrick HRD/ Fairness Taskforce/ Hd of Inclusion Improvement	Q4/2021 TBC Q4/2021	• Feedback progress on process and outcomes • FRAC session in the planning • Introduction of fair recruitment experts		A

				TBC TBC	• Appointment accountable decision record implemented • Establishing data dashboards to give greater visibility on workforce		

Table Key: Blue: not started | Red : concerns / not on track | Amber : action is on track | Green: action is complete.

3. Create resource to improve culture communication and behaviourial framework

Priority	Indicator	Action	Lead	By When	Milestone	Progress	RAG
3	1, 2, 7 & 8	Inclusive communications Working with Bsol ICS EDI leads and people board create a programme of education and development materials to support inclusive communications Develop supportive materials to embed an inclusive communicative culture to include: • Master classes • Webinars	FTF/ Head of Inclusion-Improvement	Q4/2021Q1/ 2022	• Draft copy of inclusive communication guide • Develop programme of supporting materials • Support roll out of system wide development programme in UHB		

		• Website resources • Online development workshops					

4. Develop skills and knowledge to confidently support those with protected characteristics

Priority	Indicator	Action	Lead	By When	Milestone	Progress	RAG
4	1, 2, 7 & 8	Allyship Working across the Bsol ICS, create a programme of education and development materials to support inclusive relationships Develop supportive materials/programmes to embed an inclusive communicative culture to include: • Master classes • Webinars • Website resources • Online development workshops • Regional Allyship network	Heads of Inclusion/ Bsol BAME EDI leads/BAME chairs	Q3/2021Q1/ 2022 Q4/2021 Q1/2022 Q4/2021	• Develop briefing paper for BSol People Board on aims, objectives and requires, • • BSol system review of available resources • Develop suppository of resources and material accessible across the system • Survey region for current needs and wish on Allyship development		

5. Create a culturally inclusive organisation for all

Priority	Indicator	Action	Lead	By When	Milestone	Progress	RAG
6	1, 2, 7 & 8	• Develop a timetable of Listening and engagement events on critical themes and	Heads of Inclusion	qQ3/2021 Q4/2022	• Develop themes and topic areas • Develop timetable and		

		topics to support culture development in consultation with BAME staff			schedule		
7	5,6,7,8	• Develop a programme of implementation of the Conversation on Race NHS Programme • Develop bespoke cultural competence programme to support team development and dynamic	Heads of Inclusion/ Inclusion training and Development manager/ Director of Education	TBC Q 3 / 4 2021	• working with NHSEI / WRES Team – when launched Initial pilot development with Estates, Diabetes and Imaging		
8		• First Line Leaders programme • Mentoring Programme	Associate Director of Engagement/ Head of Inclusion-Improvement	TBC TBC	• Increase the development opportunity of lower band staff, which would give more accessibility for more BME staff • Develop and promote current mentoring programme to increase BME staff to be mentors and mentees		

6. Divisional Reporting -

	1,2	• Developing a reporting process for the WRES indicators for the divisions to support and to meet set targets	Heads of Inclusion/ Divisional lead on WRES, MDs	Q 3 / 4 2021	• Briefing paper on requirement and expectation on WRES accountability for division • Create Divisional Data		

		• Implement high level Cultural Advocates, situation at SMT level to facility and advocate the inclusion equality needs of staff and patients. • Provide information and development from the inclusion team and intelligence on performance and progression • Provide development and for cultural champions		Q3 2021 Q4/2021 Q4 2021 Q4/2021	set and yearly targets • Schedule programme of implementation • Identification of divisional champions • Development programme		