University Hospitals Birmingham
NHS Foundation Trust

Workforce Race Equality Standard Report 2020

Building healthier lives

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Executive Summary

This report sets out the outcomes for University Hospital Birmingham NHS Foundation Trust's Workforce Race Equality Standard for 2020. It explains our current position on diversity and inclusion for BME Staff as of March 2020, against nine key indicators. It makes a clear and robust plan of action to mitigate against these inequalities in everything that we do, to deliver the best possible outcomes for both our patients and staff.

This report has identified a number of changes that can be made to improve diversity and anti-racist practice within the Trust. Some are easier, some more long term and fundamental, but these changes will help us to recruit a more diverse workforce, take full advantage of the existing talent, and provide health equality to our patients more effectively by having a more representative workforce. If implemented, these should result in a fairer, more inclusive workplace, happier staff and ultimately improved patient care.

The case for action

The headline improvements show that:

Over the last year, we have seen substantial development in the positive decrease in the amount of BME staff entering the disciplinary process. This reduction of 21.87% demonstrates a Trust-wide shift for 2020. This equates to 54 fewer disciplinaries staff, 19 of those BME staff. These reflect the cases recorded in ESR from the HGS sites and those at QE. Resolving a number of instances informally; by adopting elements of the NHS 'Just Culture Guide' has helped reduce the overall number of people entering the formal disciplinary process.

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 from last year, where 58% of BME staff accessed training. Over the last three years of reporting this has fluctuated but has consistently been higher in comparison to white staff.

We also recorded growth and improvement in representation across clinical roles. BME doctors are well represented across all categories of consultants, NCCG and trainees, reporting more than 50% of Trust totals, significantly higher than the BME Trust average of 32.5%. 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.

A world pandemic, and national and international world events, has had enormously significant impact and loss of life on ethnic minoritised communities and specifically our NHS staff. We have worked hard to build trust, develop meaningful relationships and provide much-needed support for all our staff, particularly those been most in need. Listening events, information webinars, resource apps, and staff network meetings have galvanized energy and purpose for change with membership and engagement at an all-time high. Sessions with the CEO have reached well over 1000 staff. These recent events have highlighted long-established inequality and unfair practices across our Trust, our community and broader society.

Reflecting on these challenges, Dr Dave Rosser, Chief Executive of University Hospitals Birmingham is leading on making fundamental changes, and is determined to focus efforts at all levels of the organisation. The establishment of the Fairness Taskforce by Dr Dave Rosser to tackle the well-known issues of race inequality, discrimination and unfairness practice in UHB, will start to set the scene of the Trust's intention of rapid and sustained change.

This Taskforce will initially focus on Black, Asian and Minority Ethnic staff, considering areas of anti-racism and fairness and then consider all the other protected characteristics, as defined by the Equality Act 2010.

With tangible energy and momentum of change in place, work has already started on four key areas;

- Reciprocal Mentoring – development opportunities for staff with protected characteristics
- Fairness Route Cause Analysis (FRCA) – adding accountability to discriminatory or racist practice
- Inclusive Communications Guide - development resources to help to understanding the language we use and which to use
- Allyship – create support initiatives that practice social justice, inclusion and human rights, to advance the interests of groups with protected characteristics

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

The headline findings show that:

There is a significant amount of work to be done at pace and scales, to cultivate a fairer, just and more inclusive Trust. There are consistent themes in this report which point to the disproportional experience of BME staff in most of the processes that support development, promotion and recruitment. This is often exacerbated by discriminatory behaviours of managers and staff and the lower perception of equality of BME staff.

The figures speak clearly; the average percentage of BME staff per band is far below the Trust's representation and the demographic of the city, 32.5 and 42.07% respectively. We see positive gains in that BME applicants want to work for the Trust, and our application figures show we are rated highly as an organisation to work for, with consistently more BME applicants than white applicants. This is good news and one where attention is needed to support more successful applications.

The rise in band 8a non-clinical of 3.1% and bands 3 and 4 clinical with a 2.5% and 3.57% rise is also progressive. The targets of the NHS Model Employers paper now need to be applied, to pull staff across the bands into those higher roles, to improve representation and cultural cognition in strategic decision making.

Outside of clinical roles, we continue to see a recurring theme in appointments. It is 1.656 more likely for a white applicant to be successful at interview. The lack of role models and people that look like those who apply for these posts has diswayed potential applicants from applying and is reflected in the 30%[1] of BME who do not think the Trust is equitable in career development and promotions.

The above experiences are probably culminations of discrimination and implicit bias at a system and structural level, as we see 13.8% of BME colleagues experience discrimination.

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

[1] Note: Data from NHS Staff survey 2019. 30% of the approximate 1650 BME staff that took the survey.

Recommendations

The WRES Report analysis produced four high-level recommendations:

- 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 support, skills development, and knowledge-building provisions on cultural intelligence and inclusive leadership
- Improve departmental engagement and collaboration and facilitate concerns to be raised and voices to be heard

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 2020 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 Cline'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.

3. Research

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

3.1.1. Electronic staff record (ESR) (indicators 1, 3 & 9);

3.1.2. NHS Jobs (indicator 2);

3.1.3. easyLearning (indicator 4);

3.1.4. Excel Spreadsheet case tracker (QE) (indicator 3) and;

3.1.5. NHS Staff Survey results 2019 (indicators 5, 6, 7 & 8).

3.2. Whilst data provided for the indicators is generally deemed to be accurate, it should be noted that on average for the last three years 3.6% of the workforce have chosen not to declare their ethnicity, or there is no recorded information for them. This could mean that some of the indicators are not wholly representative of the treatment of BME Staff. However with 96% declaring, it is likely to be a strong indicator of what is happening. The WRES Action Plan 2020/21 may need to consider a campaign to increase self-reporting across all protected characteristics, particularly where these intersections with other protected groups, such as disability and sexual orientation.

3.3. To better understand BME staff perceptions around the current disparities, a series of listening events took place; BAME Staff Network Webinars, "Let's Talk with…" CEO Dr Rosser, "Your Views – WRES consultation. Key themes and suggestions that arose from these events were:

3.3.1. a lack of clarity and equity on recruitment, promotion and development decisions. suggestion: - to offer generic / assessment centre based recruitment to mitigate any unconscious/conscious bias decision making

3.3.2. lack of confidence or trust in applying for opportunities due to previous poor experiences

3.3.3. a lack of awareness of promotional and development opportunities available;

3.3.4. disparity of formal disciplinary processes – lack of confident and experienced managers

3.3.5. no acknowledgement and revealing of hidden or shadow cultures, how things really happen in the trust - the informal meetings and conversations that grant bias opportunities

3.3.6. Increased rate of bullying, harassment and discrimination in outpatients. Low reporting and escalating because of perceived negative repercussions. General consensus of inadequate accountability and responsibility for escalating and managing bullying, harassment and discrimination concerns from patients and staff. Suggestion: develop a Trust-wide zero-tolerance campaign should be instigated linked to the behaviourial framework

3.5 Recommended actions were consulted upon with key stakeholders to ensure they were appropriate and that implementation would be realistic. These included:

- trade union representatives;
- the Deputy COO
- the Director of HR
- the Inclusion and Wellbeing Leads
- the BAME Action Steering Group
- the Director of Education, and
- Executive Directors

4. WRES Indicators 2020

Below is the Trust's data for each of the nine indicators. Each of the first four workforce indicators is the data for white and BME staff and is compared against the 2019 WRES submission.

	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
5.	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	Percentage believing that Trust provides equal opportunities for career progression or promotion
8.	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 1: Indicators - Technical Guidance for the NHS Workforce Race Equality Standard (WRES) 2019

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**	**Difference**
Band 1	28.35%	30.09%	1.74%
Band 2	23.93%	27.03%	3.10%
Band 3	24.63%	26.17%	1.55%
Band 4	20.97%	21.76%	0.79%
Band 5	21.95%	23.04%	1.09%
Band 6	20.82%	21.45%	0.63%
Band 7	21.35%	22.45%	1.10%
Band 8a	20.34%	23.97%	3.63%
Band 8b	10.42%	10.89%	0.47%
Band 8c	11.63%	9.09%	-2.54%
Band 8d	4.55%	10.00%	5.45%
Band 9	0.00%	0.00%	0.00%
VSM	7.27%	11.27%	3.99%

Clinical			
AfC Pay Band	**BME % 2019**	**BME % 2020**	**Difference**
Band 1	14.29%	15.38%	1.10%
Band 2	33.18%	34.71%	1.53%
Band 3	25.03%	27.53%	2.51%
Band 4	22.62%	26.59%	3.97%
Band 5	40.98%	42.84%	1.85%
Band 6	26.46%	27.43%	0.96%
Band 7	16.85%	17.48%	0.63%
Band 8a	16.89%	17.88%	0.99%
Band 8b	11.11%	13.39%	2.28%
Band 8c	8.33%	6.06%	-2.27%
Band 8d	5.26%	7.69%	2.43%
Band 9	0.00%	0.00%	0.00%
VSM	16.67%	7.69%	-8.97%
Consultant	45.50%	47.82%	2.31%
of which Senior Medical Manager	42.86%	52.78%	9.92%
Non-consultant career grade	63.33%	62.54%	-0.79%
Trainee Grades	53.75%	53.58%	-0.17%
Other	55.39%	53.50%	-1.89%
Trust Band Average	**22.33%**	**23.5%**	**1.17%**

Table 2: Percentage of staff in each of the AfC Bands for 2019 and 2020. Difference between the two is shown with green indicating a positive difference from 2019 to 2020 and red indicating mostly a negative difference.

4.1. Overall, 32.5% of the Trust's staff identify as BME, slightly higher than last years' overall figure of 31.5%. The average percentage of BME staff per band is notably below the Trust representation and demographic of the city, 32.5% and 42.07% respectively. This helps to illustrate the disparity across the banding as they rise, which is particularly visible in clinical posts.

4.2. Generally, representation across the Trust has remained relatively consistent. Chart 1 non-clinical, shows the broadest spread of staff in the middle bands and reflects the average percentage rate across the bands at 23.5% for 2020. The greatest positive difference was seen under band 2 and band 8a non-clinical, with a 3.1% and 3.6 rise and bands 3 and 4 clinical, and with a 2.5% and 3.57% rise. However, with only a small number of people within band 8a, this is statistically insignificant and is 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, as illustrated in chart 8 in the analysis section.

4.3. The largest negative differences can be seen within banding 8c non-clinical and VSM clinical. It should also be noted the year-on-year zero representation of BME staff in and 9, and further interrogation of this should be considered, taking into account the numbers are lower than ten and with no recruitment in the last two years. Also noted in clinical bands in table 1 and charts 1 and 2, page 18; is the bottleneck of BME staff from band 5 through to band 7, with further reduction through to band 9 and VSMs. It also highlights that the higher bands sit considerably below the average representation and Trust overall figures.

4.4. The -0.79% decrease seen in table 1 for NCCG doctors (SAS), is a small but positive improvement. NCCG doctors are appointed by Trusts and often fill gaps in services when doctors in training are not available. There are limited safeguards for such doctors' appointment, with little or no formal educational opportunities, and little possibility of career progression. NCCG posts are often filled by overseas doctors who come to the UK for training but failed to find training posts, or did not pass their corresponding Royal College examination. They can often find themselves locked in this category.

4.5. Local and national demographics comparison

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.

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.

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.

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 it is predicted to be a ‘minority–majority’ city by 2021 as sited in the Birmingham City Council Community Cohesion report 2018

This census data must be 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	2018	2019	2020
Shortlisted Applicant BME %	43.5%	48.9%	50.9%
Appointed from Shortlisting BME %	33.5%	37.0%	39.2%
likelihood of appointed from shortlisting BME %	33.1%	25.6%	28.2%
likelihood appointed from shortlisting White %	55.7%	42.4%	46.7%
Likelihood appointed from shortlisting White/ BME Staff	1.681	1.652	1.656

Table 3: Percentage of BME staff shortlisted and appointed for 2018 to 2020. Comparison of White/BME staff likelihood of appointment from shortlisted.

4.6. The data in table 3 show that white applicants are 1.656 times more likely to be appointed from shortlisting than BME applicants. This has slightly worsened from the 1.653 times likelihood reported last year, a 0.2% increase. This small negative difference may seem immaterial but the perceptual impact of a worsening picture for BME staff could demonstrate the lack of 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	2018	2019	2020
Percentage of BME Staff in Workforce	29.48%	31.54%	32.49%
Percentage of BME Staff in formal process	29.51%	36.22%	36.84%
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	1.06	1.24	1.26

Table 4: Percentage of BME staff in formal disciplinary process for 2018 to 2020. Comparison of White/BME staff likelihood of entering disciplinary process.

4.7. This year’s indicator demonstrates that BME staff are 1.26 times more likely to enter a formal disciplinary process than white staff, see table 4. This is a small increase from the likelihood reported last year where BME staff were 1.24 times more likely to enter the process.

4.8. The reason behind this is possibly associated with a percentage increase in BME staff population, at a higher rate than other ethnic groups.

What this does not acknowledge is a positive -21.87% decrease in the amount of BME entering the process. This demonstrates a Trust-wide reduction for 2019 from 288 to 265, and a further decline to 209 for 2020, which equates to 19 less BME staff entering the process. These reflect the cases recorded in ESR from the HGS sites and those recorded in other ways within QE. Resolving a number of cases informally, adopting elements of the NHS 'Just Culture Guide' has helped reduce the overall number of people entering formal disciplinary.

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

Categories	2018	2019	2020
No of BME staff in workforce %	29.48%	31.54%	32.49%
No of Staff BME accessing NMT and CPD %	45.56%	58.19%	47.01%
Likelihood of BME staff accessing	32.78%	32.01%	29.47%
Likelihood of White staff accessing	31.23%	29.65%	28.05%
Likelihood accessing White / BME staff.	0.95	0.92	0.95

Table 5: Percentage of BME accessing NMT and CPD for 2018 to 2020. Comparison of White/BME staff accessing NMT and CPD.

4.9. BME staff are marginally more likely (0.95 times) or 47% of all BME staff compared to 44.8% of white staff, to access non-mandatory training and CPD. However, the difference has reduced from last year where 58% of BME staff were accessing training. This has fluctuated over last the three years of reporting but consistently been higher in comparison to White staff.

The next four indicators are based on data from the national NHS Staff Survey 2019 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.

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

Categories	2018	2019
BAME staff (UHB)	24.7%	26.7%
BAME Staff - Acute Trusts	29.8%	29.9%
White Staff (UHB)	25.4%	25.4%
White Staff (Acute Trusts)	28.4%	28.2%

Table 6: Percentage of white and BME staff experiencing harassment, bullying or abuse from patients, relatives or the public; Staff Survey 2018 and 2019 .

4.10. BME staff report higher levels of bullying and harassment from patients, relatives or the public than white staff; 26.7% compared to 25.4%. For BME staff this sees another increase this year, from 24.7% in 2018, which showed white staff experiencing more harassment from patients and the public. This year has seen that figure remain constant for white staff, which reported at 25.4%. We are in a better position comparatively than other acute Trusts, yet much more needs to be done.

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

2019		2020	
White	BME	White	BME
25.1%	28.0%	24.5%	27.5%

Table 7: Percentage of White and BME staff experiencing harassment, bullying or abuse from staff; NHS Staff Survey 2018 & 2019.

4.11. There has been a minimal decrease in bullying and harassment reported by BME staff, with 27.5% of BME staff who participated in the staff survey said they experienced this (compared with 28.0% for 2018. White staff reported lower levels of bullying at 24.5%, this also shows a reduction. 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 6.2% of all BME staff.

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

2018		2019	
White	BME	White	BME
85.6%	69.2%	84.9%	69.9%

Table 8: Percentage of white and BME staff believing that the Trust provides equal opportunities for career progression or promotion; Staff Survey 2018 and 2019

4.12. 69.9% of BME staff believe that the Trust provide equal opportunities for career progression. This is much lower than the perception of white staff, where 84.9% believe this to be the case. For BME staff, there was a very small increase on last year, with a similar percentage decrease for white staff at (0.7%). However, it is noted that the disparity between staff groups is a concerning 15%.

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

2018		2019	
White	BME	White	BME
7.4 %	14.6%	6.3%	13.8%

Table 9: Percentage of white and BME staff experiencing discrimination at work from a manager, team leader or other colleague; Staff Survey 2018 & 2019.

4.13. The level of BME staff who experience discrimination at work from their colleagues has decreased from last year by 0.8% to 13.8%.

4.14. This is still significantly higher than the levels reported by white staff at 6.25%, a 120.8% higher. The analysis section will comprehensively question the data and establish the actions required.

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

Categories	2019	2020
BME workforce %	30.9%	32.5%
Board voting members BME %	0.00%	11%
Board voting members White %	100.00%	89.50%
Percentage difference voting board / BME workforce	**-30.90%**	**-21.70%**
Executive Board members BME %	0.00%	0.00%
Executive Board members White %	100%	100%
Percentage difference Exec board / BME workforce	**-30.90%**	**-32.5%**
Board members BME%	9.10%	8.30%
Board members White%	90.90%	91.70%
Percentage difference full board / BME workforce	**-21.80%**	**-23.90%**

Table 10: Percentage difference of voting and full board representation and BME workforce 2019 and 2020

4.15. There has been some improvement in the last year (see table 10), as three of the Trust Board NEDs with voting rights are BME, and therefore we see a percentage increase of 11%. For board representation, we have seen a slight decrease to 8.30%. This gives a concerning percentage difference for voting at -21.70% and board representation -23.90%. 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 2020).

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.'

Analysis

5. From the indicators, it is clear that there are areas that require improvement. Some of these were expected; for example increases in bullying and harassment as this is a Trust-wide concern.

One area that was unexpected in terms of the change was Indicator 3 - relative likelihood of entering the formal disciplinary process. There has been a significant reduction in the number of disciplinary cases within the Trust. In the last 12 months, HR has focused on resolving a number of cases informally which has helped reduce the overall number of staff entering the formal disciplinary process.

The role of the First Contact team has been central to this, reflected in the overall figures for the year. The First Contact structure over the last 12 months has had more of a targeted approach to early intervention and has appointed a dedicated HR Advisory service to deal with these issues.

The 'Just Culture' model is now included in the training for managers, to emphasise the new way of managing staff in difficulty. This now means that in practice, many cases which may previously have resulted in a formal disciplinary process are now being resolved more 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 likelihood of BME staff entering the formal process still requires further investigation as at this point, the causes and nuances are not fully understood, so it is difficult to take additional action.

Further work should identify what the disciplinary is 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. the original reason was addressed or whether there are additional reasons why a disciplinary has been escalated.

5.1. Whilst there are some clear areas for improvement concerning bullying and harassment, this is an area for improvement for the Trust as a whole. The figures when scrutinized show that only 23.4% of the BME workforce participate in the NHS staff Survey, and of that 27.5% state that they experience bullying, harassment or abuse. At a macro level, this equates to 6.25% of the BME workforce. Broader and deeper BME staff surveying is essential to ascertain an accurate picture of these experiences. Both anecdotal and research evidence suggest that many BME staff do not feel comfortable to share their experiences because of possible detriment and recriminations and that these figures are widely underrepresented.

5.2. There are currently a number of initiatives in place in an effort to reduce overall levels of bullying and harassment. These include:

5.2.1. the Dignity at Work Procedure – prevention of bullying and harassment
5.2.2. Fairness Taskforce – Cultural RCA
5.2.3. the increased profile of Freedom to Speak Up Guardian and Confidential Contacts;
5.2.4. the award-winning communications campaign on bullying and harassment

5.3. At a local level, concerns and issues are being dealt with more consistently with the support of, HR, the Fairness Taskforce, BME Action Steering Group and BME staff network, along with management training and development.

5.4. Considering the above, this report, and accompanying action plan, will primarily focus on recruitment and career development, promotion of BME staff and experiences of discrimination; relating to indicators 1, 2, 7 and 8. The considered indicators link with the initial actions of addressing, representation, disparity in promotions and behaviours, of the newly formed Fairness Taskforce, led by CEO, Dave Rosser.

5.5. By narrowing the Trust's focus on these areas it will enable the Trust to better allocate resources into addressing the root causes on inequalities in these areas, thereby allowing any action taken to have a stronger impact.

5.6. This approach to WRES is recommended by Roger Kline (NHS England, WRES Implementation Team). Of course, action taken to address this area will likely have an impact on other areas of inequality through increased awareness and better engagement of BME staff, more importantly through improved skills and knowledge base.

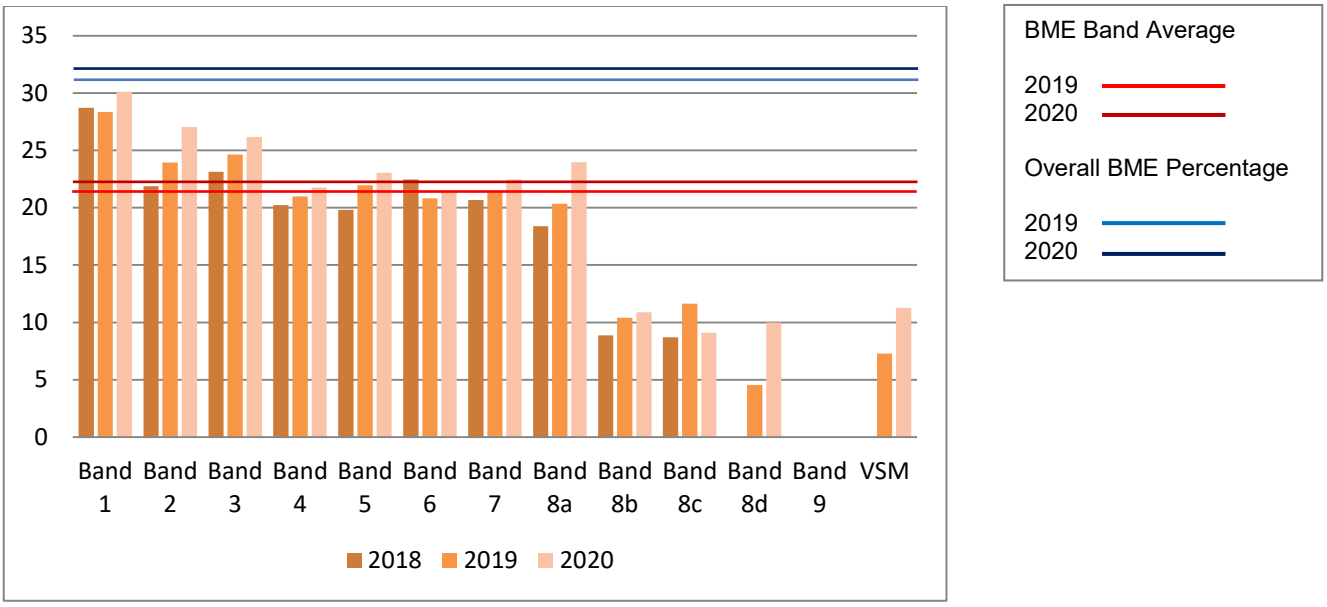

Chart 1. Non-Clinical. Percentage of BME Staff at each of the Agenda for Change Pay. The red horizontal lines display the Trust average banding for 2019/20 (22.33%/23.5%). The upper blue lines represent the overall Trust percentage of BME staff in the Trust (31.5%/32.5%).

Recruitment and Representation

6. **Indicator 1** - chart 1 clearly illustrates that a significant proportion of BME staff sit within the lower bands, with the percentage of BME staff significantly decreasing at band 8b and above. A lack of representation at senior levels within organisations is a well-documented phenomenon.[1] This is likely due to issues surrounding recruitment and career development which is discussed further, later in the report.

6.1. There is a large difference between percentages of BME staff in clinical 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.

6.2. However, even with overall representation, and improvement in bands 8a and 8b, the trend of decreasing BME staff as the AfC band increases is still present.[1] [2] Although the percentage of BME Staff in clinical VSM roles has increased, 4% in the last year, this is only four staff compared to the 17 white staff. Simon Stevens CEO, NHS England, quoted in his June letter; "…the number of very senior managers of BAME background has increased by 30 per cent. But no one thinks this is yet good enough, or fast enough."

6.3. Further exploration of the peaks at bands 2 and 5 (chart 2); 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. These peaks are seen across the NHS as documented in the 2019 Data Analysis Report for NHS Trust [3].

[1] Kline, Roger. (2014) *The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England*.
[2] McGregor-Smith, Ruby, *(2017) The McGregor-Smith Review - Race in the workplace*
[3] NHS Workforce Race Equality Standard. (2020) *2019 Data Analysis Report for NHS Trusts*

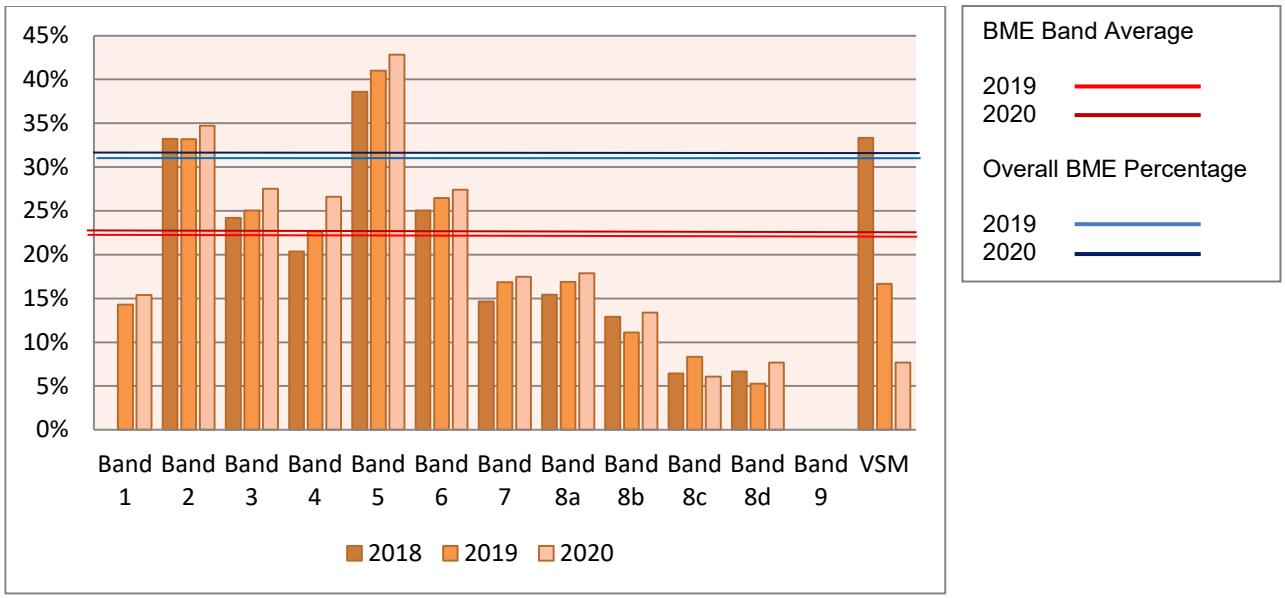

Chart 2. Clinical. Percentage of BME Staff at each of the Agenda for Change Pay Banding for 2018-20. The red lines display the Trust average banding for 2019/20 (22.33%/23.5%). The blue lines represent the overall Trust percentage of BME staff in the Trust (31.5%/32.5%).

6.4. Nationally there are 24.5% BME staff in band 5 clinically. BME staff in the same band at UHB represent 42.8%, an over-representation of nearly 11%, with band 6 similarly highly represented above the Trust average. What is concerning in chart 2, is the year-on-year growth in these bands and the limited movement to bands 7 and above.

6.5. 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 through the Fairness Taskforce, aligned to other survey metrics. 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 2020 Action Plan.

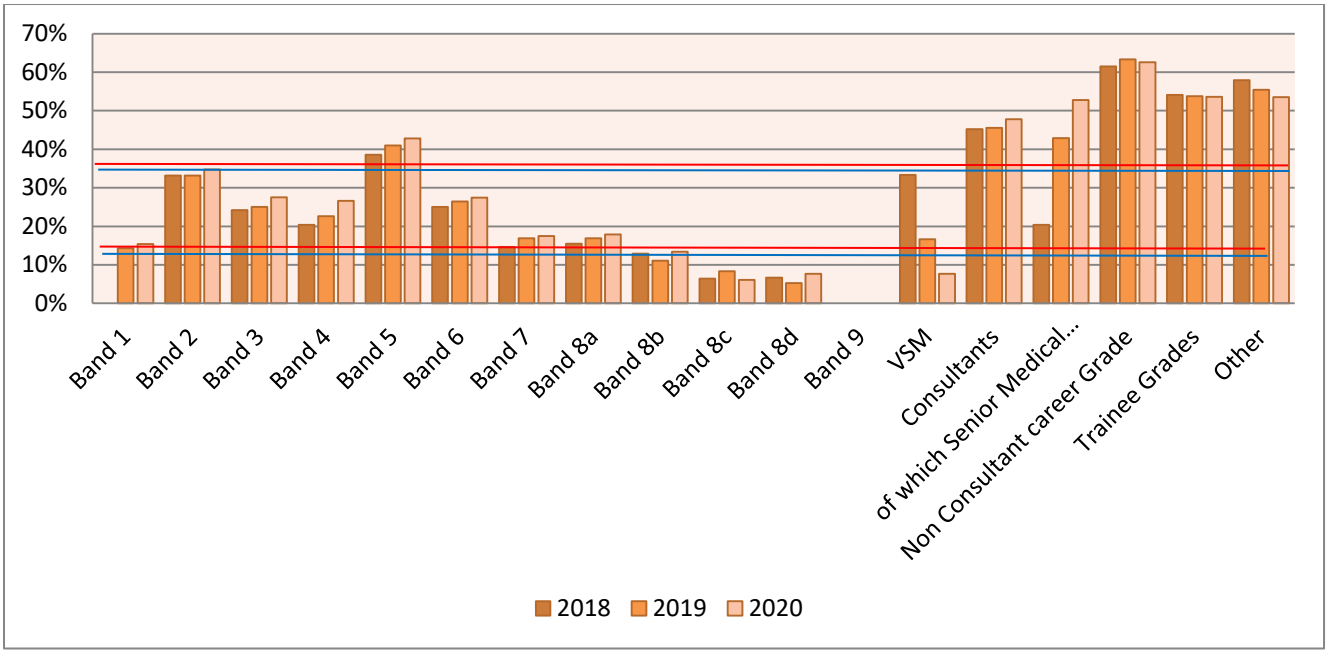

Chart 3. Clinical. Percentage of BME Staff at each of the Agenda for Change Pay Banding for 2018-20, including doctors. The red lines display the Trust average banding for 2019/20 (22.33%/23.5%). The blue lines represent the overall Trust percentage of BME staff in the Trust (31.5%/32.5%).

6.6. The chart above shows a positive and unsurprising picture of representation in clinical non-medical roles. Consultants and senior medical roles have seen positive growth in the last three years. This is an area we need to focus on and engage with our senior managers to call out, support and champion our fairness and equality agenda. Even though some senior clinicians and managers may experience less discrimination, there is still work to be done here. Systemically we see higher and stable proportions of doctors in the NCCG roles as mentioned earlier.

6.7. In addition, the Royal College of Physicians' (RCP) study published in 2018, found that although white British doctors apply for fewer posts when seeking to become consultants, they were both more likely to be shortlisted than BME colleagues and also more likely to be offered a job. White British doctors applied for an average of 1.29 consultant posts before being hired; for BAME doctors, the average was 1.66 applications.

7. **Indicator 2** - displays a distinct level of inequality for BME staff, (chart 4, page 20). The figures show a startling decline of BME staff from 58% of applicants to 39.2% appointed, which gives a likelihood of 1.656 more likely that a white staff member would get appointed than a BME staff member. Or 46.7% of white applicants compared to 28.2% of BME applicants. 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. Taking into account the merger, and the introduction of WRES reporting, it still does not qualify the lack of urgency, misunderstand and obscuring of important truths about fairness and equality, which continues to impact BME staff at UHB.

7.1. 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 tackle the structural racism which exists within the NHS and UHB, changes must be actioned at a strategic and systemic level in the years to come.

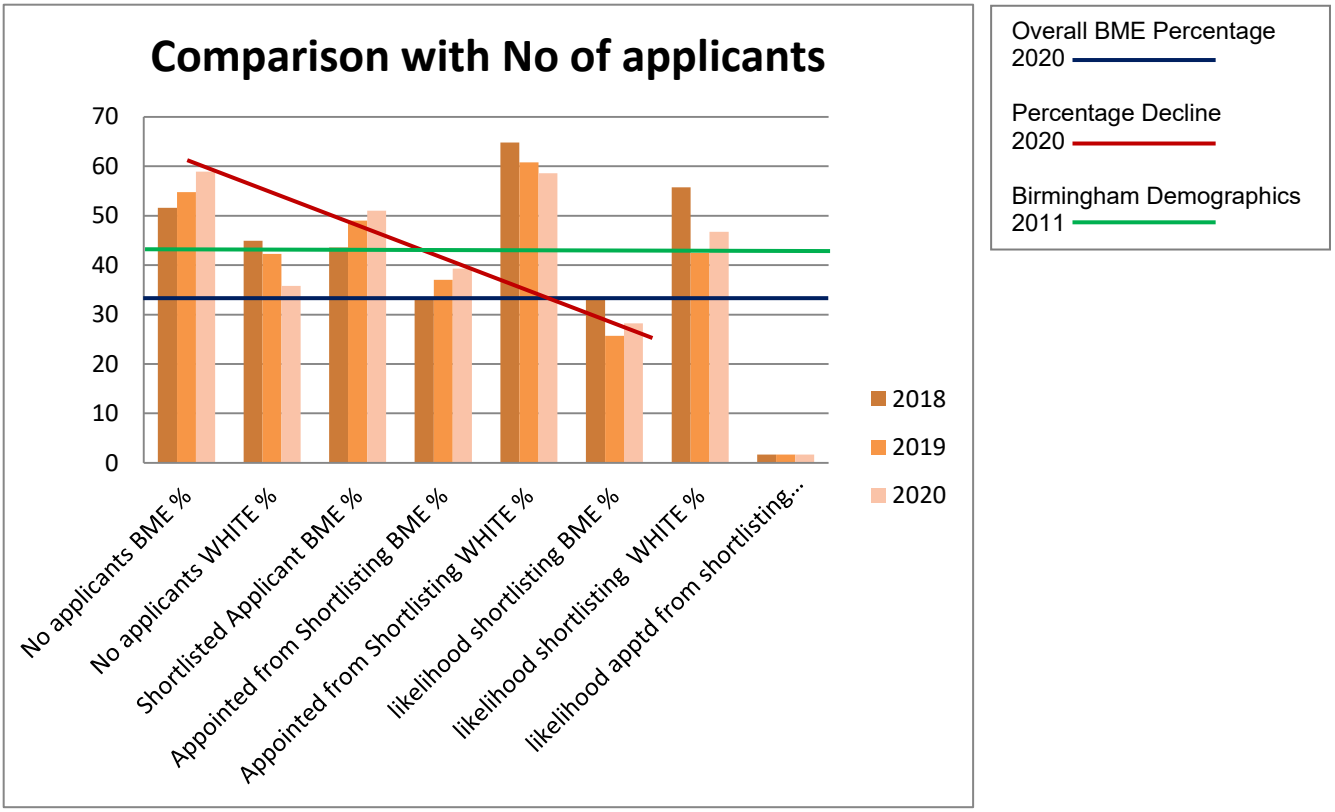

Chart 4. Clinical. Percentage of BME Staff at each stage of recruitment process from application to appointment for 2018-20. Displays the declining representation of BME staff through the recruitment process. The overall Trust percentage of BME staff in the Trust (32.5%), and Birmingham Demographics (42.07%).

7.2. 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 three to four years since the inception of the WRES. In addition to this, the introduction of independent panel members, the Aspire staff interview coaching programme, a Recruitment and Selection Policy update and monthly audits have occurred according to previous reports.

7.3. However, no data of compliance on panel composition, independence and diversity have been collected since reporting started. No aligning of systems since the merger, which has meant QE managers arrange their own interviews, therefore recruitment have no sight of the panel data. Evidence has shown that compliance is not happening at an acceptable level, with concerns and complaints about interview equality being raised frequently. Internal vacancies and acting up posts are formally mentioned in the Recruitment and Selection policy but again there is no evidence to qualify due process is working in practice.

7.4. 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 also a factor here, as even though personal data is removed from applications, there is still sufficient information that may imply they hold certain protected characteristics.

7.5. Urgent further research is needed on applications to the Trust, to determine other potential reasons why this disparity might exist. (charts 3 and 4). Whether it requires further changes to the Trust's shortlisting procedures, also requires further research.

7.6. If it is identified that there are issues concerning the quality of applications from BME applicants, the Trust should consider positive action through a series of interventions to improve effective applications.

Career Development and Promotion

8. **Indicator 7 and 8** - Some of the reasons for the disparity and direct discrimination (see chart 5), 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 stated 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.

8.1. Whilst issues of favouritism are difficult to evidence, let alone tackle, there are approaches to improve fairness, transparency and trust. With recruitment development starting from when a position opens, to robust system changes for all internal and acting-up positions, administered through HR, in-roads can start to be made.

8.2. Further amendments to the Trust's Recruitment and Selection Procedure on Acting-up and fixed-term development roles are necessary 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.

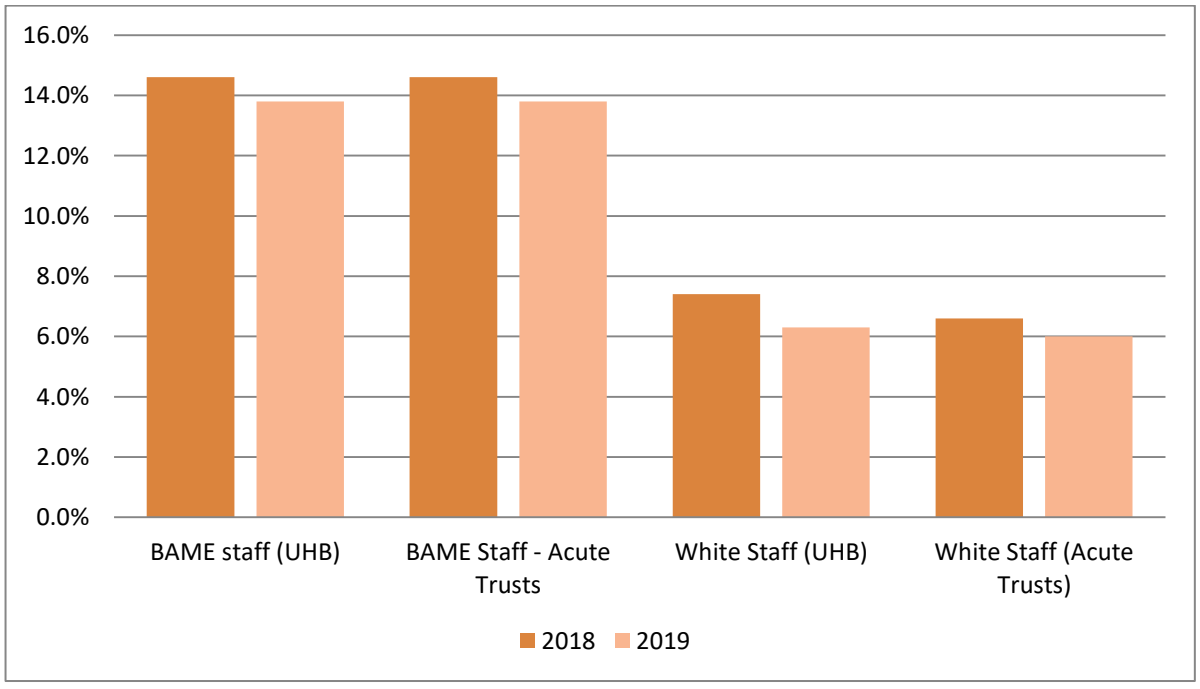

Chart 5. Percentage of BME Staff who have experienced discrimination compared to white staff for UHB and other acute Trust, 2018/2019.

Board Membership Representation

Since its introduction in 2015, the WRES indicators have related to BME representation at senior and board level. Overall, the proportion of board members in NHS trusts is comprised of 88% white, 7% BME, and 5% unknown. This is not reflective of the NHS workforce as a whole or UHB, where 19% and 32.5% of staff are identify as BME.

The figures in charts 6 and 7 below show the UHB current position. Although BME leadership representation both national and locally shows signs of improvement, there is a tremendous amount of work to be done.

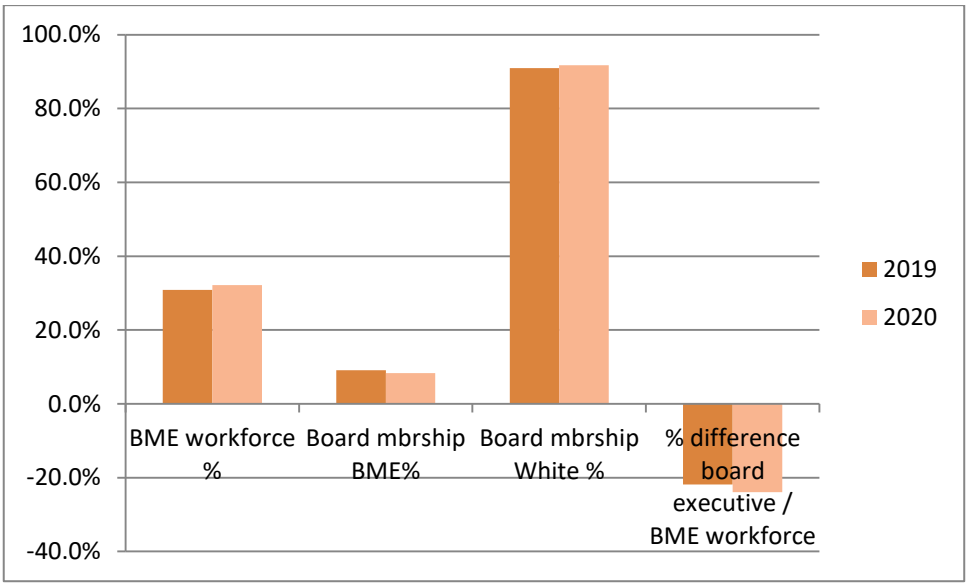

Chart 6. Percentage difference of BME Workforce and Board representation 2019/2020.

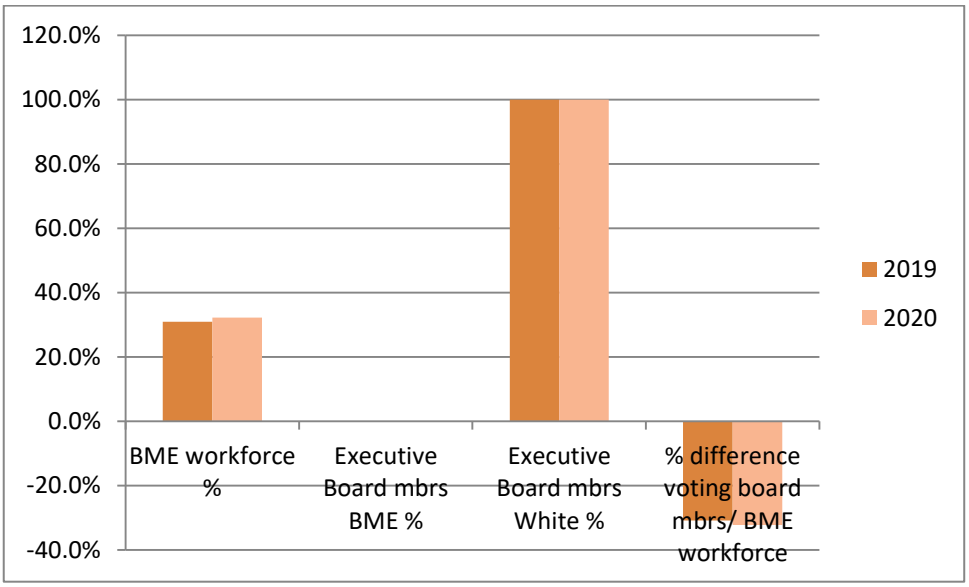

Chart 7. Percentage difference of BME Workforce and voting board members 2019/2020.

Analysis summary

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

9.1.1. 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 especially noticeable.
9.1.2. There is potential for implicit bias to have a large impact across the recruitment, promotion and development processes
9.1.3. There is a lack of trust and access for BME staff when it comes to career development and promotion
9.1.4. External and career development opportunities are not effective and equally communicated or monitored
9.1.5. There are significant levels of BME staff experiencing discrimination

9.2. This report has also highlighted areas for further investigation and research, which have not been able to be undertaken under the time constraints for this report. This research will enable better understanding of root causes to some issues, or may uncover issues that are currently unknown. These areas of research will be included within the Action Plan for the coming year and will form part of the 2021 WRES Report.

9.3. 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, September 2020 – August 2021. This action plan can be found in **Appendix 1**.

9.4. This action plan reviews last year's actions and details the key actions and campaigns that will be undertaken in order to improve Workforce Race Equality for the forthcoming year. Some actions within 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.

Other Considerations

10. Fairness Taskforce

10.1. The Chief Executive of University Hospitals Birmingham (UHB) is determined to focus efforts at all levels of the organisation to tackle the well-known issues surrounding the fairness agenda, across the NHS. With recognition that culture is set and established at the very top of an organisation, the Chief Executive has established a dedicated Taskforce that he will lead. The WRES supports this agenda and will work in tandem to drive forward with pace and scale the necessary change to determine equality and fairness in the Trust.

11. NHS People Plan 2020

11.1. The recent NHS People Plan affirms the actions in this report in the wake of Covid-19, national events and years of exclusion and oppression of ethnic minorities. The plan will need to adopt those additional actions mentioned. The report states, the NHS must welcome all, with a culture of belonging and Trust. We must understand, encourage and celebrate inclusion and diversity in all its forms. Discrimination, violence and bullying have no place. The report also mentions that Workforce Racial Equality Standard (WRES) has led to progress across a number of areas; for example, increases in the proportion of BAME very senior managers.

11.2. We will work closely with the National WRES Team to build up our portfolio of knowledge and skills, to adopt the changing landscape of race and health equalities and increase our

WRES Experts, thereby ensuring the sustainable embedding of cultural change.

12. NHS Model Employer

12.1. Every NHS Trust, Foundation Trust and CCG must publish progress against the Model Employer (see chart 8) goals to ensure that at every level, the workforce is representative of the overall BME workforce.

12.2. The Trust has researched its target based on the Model Employer work using the same premise, ahead of the September 2020 date from NHS England and NHS Improvement. This will ensure us a head-start in working to have a diverse senior leadership (very senior managers and board members) spanning all protected characteristics.

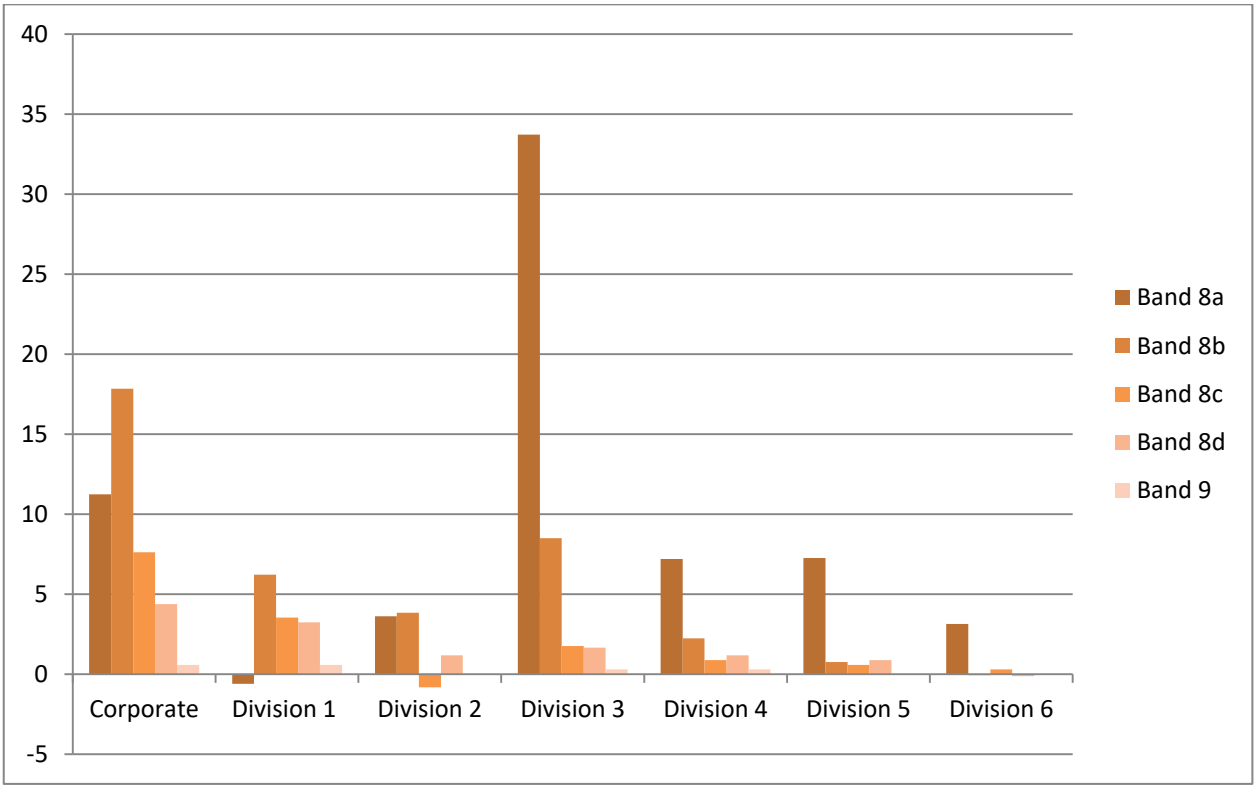

Chart 8. Number of BME staff band 8a and above per division needed to meet the NHS Model Employer targets for 2028

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.

Some of this work has already started via the Fairness Taskforce requiring VSMs and board members to offer reciprocal mentoring and sponsorship to talented ethnic minority and other staff with protected characteristics at AfC band 8d or below.

12.3 The BME staff population of 32.5% was applied against the employees within band 8a and above, within each Division 1 to 6 plus Corporate. This results in 133 more BME employees who need to be recruited within these higher banded posts by 2028, the target date used within the Model Employer paper.

12.4 The Trust Board is ultimately responsible for ensuring that this action plan is completed and

progress towards it will be reported at 6-month intervals through either the Fairness Taskforce or Inclusion Stakeholder Steering Group (March 2021). Progress against the Action Plan will also be reported to the EDI executive lead every quarter.

13. Communications and Engagement

13.1 In addition to introducing work to mitigate the impact of recognised disparities, and promote the practice of anti-racism, consideration must be given to how this work is communicated.

13.2 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. Communications need to demonstrate the Trust takes this issue seriously and senior leadership has a vital role to play in ensuring this.

13.3 Work that is currently planned as part of the Trust's Strategic Inclusion Action Plan 2020/21 will provide useful mechanisms for the communication of WRES and outcomes from it. The creation of the Fairness Taskforce will support consistent and high level messaging of these critical initiatives in the Trust.

14. Recommendation

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

14.2. 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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Board Lead

Lisa Stalley-Green, Executive Chief Nurse

October 2020

High- Level Achievements and Action for 2019

Indicators	Headline Achievements	Context	RAG
3.	**Changing the way we make decisions on application of the disciplinary process.**	The 'Just Culture' model is now included in the training for managers, to emphasis the new way of managing staff in difficulty. The First Contact has used a more targeted approach to early intervention and also appointed a dedicated HR Advisory service within First Contact to deal with these issues.	
		This demonstrates a Trust wide reduction for 2019 from 288 to 265, and a further decline to 209 for 2020, which equates to 19 less BME staff. Further research work to undertaken on comparison of pattern, themes and possible triggers	
2, 7	**Changing the way we conduct recruitment and selection processes.**	Assessment centre have been development for nursing vacancies	
		Internal acting and promotional for band 6 and 7 have been stop. All such role will be arranged under a talented management process.	
2,3,6,7,8	**Increase knowledge, skills and confidence for senior and middle management.**	Implemented Heart and Mind – cultural competence skills developmental sessions for Trust senior midwife, matrons and delivery suite. To be extended to operational managers	
		Developed and extend the Skills Booster online provisions – increase race and inclusion training workshops. Increased the number of course completions	
		Developing a BSol STP system-wide cultural intelligent leadership development programmes, to increase the number of BME staff into higher bands that reflect a more equitable representation and improve culture cognition and racial parity.	

2, 3, 8	**Extend and develop the Trust's staff networks including the BAME staff network**	Extended and develop the staff networks as a source of advice and support for staff as well as a forum to consult, influence, inform and celebrate change.	
		Developing online networking and the use of social media apps to stay connected	
		Increase network membership to 400. Working across speciality to provide support and to extend chairs to Good hope and Solihull sites.	
		During April to July to support the impact of Covid-19 and the national and international world events facilitated six webinars - host by the BAME network. Audience attendance of over 700 staff.	
2,3,6,7,8	**Delivery of a senior leadership development course designed to reflect the Trust's new vision and values, the management of change and resilience, and behaviours needed to create a positive and inclusive culture**	For 2019 the Leadership Development Programme ran four cohorts with 14 attendees per cohort, plus we an extra 6 attendees. In total 62 people went through the programme. 45 places available for the 2020 Leadership Development Programme,	
2,3,6,7,8	**The Trust offers a series of monthly short leadership masterclasses / workshops across a range of leadership developmental activities topics designed to bring managers / leaders together in a discursive way.**	Nine leadership lectures planned, four when ahead pre-Covid with a further number late in the year Attendance so far has been over 1000 staff. A further number are planned with three of those specific to supporting leader on anti-racism and inclusion.	

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	Develop reciprocal mentoring programme – target protected groups to be paired up with a senior leader Programme to be launched with minimum of 15 senior and junior staff, with a view to expand the scheme in the long term to involve 65 – 70 senior staff comprised of members from the Executive Team, Non-Executive Directors, the Divisions and Corporate CEAG .	FT/Inclusion	October 2020	• First cohort start September 2020 • Ensure directorates have a ready pool of additional staff.	• RM paper presented FT Group • Senior and Junior staff of first cohort identified • Training booked for September	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	Develop a Fairness Root Cause Analysis (RCA) programme. To develop accountability across the trust on the disparity of experience of BME staff FRCA will look at individual and organisational issues periodically	FT – Mark Garrick	October 2020	• First FRCA October	FRCA paper to next FT Group in October	A

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 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 • Website resources • Online development workshops	FT/ Head of Inclusion-Improvement	October 2020 March 2021	• Draft copy of inclusive communication guide October FT meeting • Develop programme of supporting materials	• Draft overview created • Present draft guide at next FT • Develop programme outline to present at next FT meeting	A

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 Create a programme of education and development materials to support inclusive relationships Develop supportive materials to embed an inclusive communicative culture to include:	FT/ Heads of Inclusion	October 2020 March 2021	• Draft copy of inclusive communication guide October FT meeting • Develop programme of supporting materials	• Draft overview created • Present draft guide at next FT • Develop programme outline to present at next FT meeting	A

		• Master classes • Webinars • Website resources • Online development workshops					

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 events with specific themes and topics in consultation with BAME staff that they would like to discuss with the CEO and Executive Team	Heads of Inclusion	October 2020 March 2021	• Discuss topic areas at BAME CASG (June 2020) • Develop timetable and schedule in meetings in line with CEO and Executive Team availability	• 2 Trust-wide Let's Talk listening events have taken place. One more planned for December and the New Year. • 4 BAME Staff Network webinars happened. Further sessions to be planned • Staff have requested more, with localised sessions at Directorate level which are being looked at.	A
7	5,6,7,8	• Promote the Race and Cultural Intelligence Skill Booster /Moodle development packages to managers and staff.	Heads of Inclusion/ Inclusion training and Developme nt manager/ Director of Education	December 2020 Jan 2020 March 2021	• Develop communication and engagement approach across trust teams (July 2020) • Commence comms campaign • Increase participation by 1000 users • Curate addition workshops on anti-racism, Allyship, belonging in partnership skills booster	• Schedule of promotional activity commenced across internal channels	

8	1, 2, 7	• Develop a BSol STP system-wide development programme, to increase the career promotion and development opportunities for BME staff in team leaders and middle manager positions. • To provide progressive development opportunities and initiative to support continuous learning and effective culture change	Director of Education / Head of Inclusion-Improvement	July 2020 September 2020 December 2020	• Set up core Working group • System wide Task and Finish Group • First Cohort	• Developed briefing paper • Presented at People Board • Established regional partners • Develop Outline content	
9	7, 8, 9	• Facilitate cultural intelligence /Competency Master classes run by with Above Difference / People Opportunities for board/ UHB education. For executive level, VSM leaders and senior managers	Executive Chief Nurse / Head of Inclusion Improvement Lead	December 2020	• Develop delivery model • Write Briefing paper • Initial discussion with delivery partners	• Broad discussion had with partners • Initial intervention model developed	
10	1, 2, 7, 8	• Initiate a series of research papers into alternative processes to mitigate bias in recruitment, selection and promotion. Considers the following; ○ Panel accountability process ○ Assessment Centre ○ Independent panel members for 8a and above interviews	Director of HR/ Head of Inclusion improvement/ Deputy COO	January 2021	• Identify alternative models • Write Briefing /Option paper •		
11	1, 2, 7 & 8	Support the delivery of WRES Culture Change Programme	Heads of Inclusion	October 2020	• Meeting with NHS WRES team to explore areas for progression (October		

				March 2021	2020) • Establishment of action plan (December 2020) • Delivery of programme (December 2020 – June 2021)		