Board of Directors: 13.07.2017
Agenda Item: Bo.7.17.21

Workforce Race Equality Standard and Equality and Diversity Update June 2017

Presented by:	Pat Campbell, Director of Human Resources	**Author:**	Lorraine Cameron, Head of Equality & Diversity
Previously considered by:	N/A		

Key points	**Purpose:**
1. The Workforce Race Equality Standard (WRES) data will be submitted to NHS Bradford District CCG; NHSE North, Yorkshire & Humber Commissioning Hub and published on our website by 1 August 2017 along with the actions we intend to take to address disparity.	To discuss and note
2. This report includes our performance between April 2016 and March 2017 against targets for achieving a workforce that reflects the local population.	To discuss and note
3. The outcome of the survey and workshops we held with BME staff between October 2016 and January 2017 is complete and the proposed actions are summarised here.	To discuss and note
4. The whole Nurse and Midwifery Survey has been completed and proposed action is outlined here.	To discuss and note
5. NHS England proposals for a Workforce Disability Equality Standard (WDES) from April 2018, which will form the priority work area for equality and diversity for 2017-2018.	To discuss and note

Executive Summary:

The purpose of this paper is to advise the Board of Directors of our draft third submission under the WRES. The report also includes areas where Black and Minority Ethnic (BME) people are either under-represented or report poorer staff experience.

The report includes the annual update on our equality targets, for achieving a workforce more reflective of the local BME population. It shows encouraging progress in our overall BME workforce and areas where we need to concentrate on making improvement such as chance of promotion and turnover.

The paper also highlights the action we propose to take following consultation with BME staff through the online survey and workshops.

The Nurse and Midwifery survey data analysis has been completed. The analysis will be shared with the Diversity Workstream, Executive Management Team and senior nurse leaders. Work will then begin to take action on the issues identified.

It outlines the draft proposals for the WDES, which is similar to the WRES data. Disabled staff report the worst experience of all protected groups across the largest number of questions in the 2016 Staff Survey. We will therefore be focusing attention on addressing the poorer experience

of disabled people during the remainder of 2017 and 2018.

Financial implications:
No

Regulatory relevance:

Monitor:	Quality Governance Framework

Equality Impact / Implications:	Improving access for disabled people
	Improve the access and experience of BME patients and service users
	Improve access to services for people from Gypsy and Traveller Communities
	Reduce inequalities experienced by BME staff and job applicants
	Reduce inequalities experienced by staff
	Increase the diversity of boards and their understanding of equality issues
	Is there likely to be any impact on any of the protected characteristics? (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights) Yes ☒ No ☐ If yes, what is the mitigation against this? Positive impact in relation to having a workforce that reflects the local population and ongoing equality activity around the equality objectives.

Other:	CQC Registration: Outcomes 1, 2, 4, 6, 12,14, 16, 17,

Corporate Objective: *Reference to Corporate Objective(s) this paper relates to*	Our Patients: Patients choose their care with us and recommend us to family and friends
	Our Staff: Staff excel at putting patients first, wherever they work in the FT
	Our Services: We provide a range of services that support the current and future needs of our patients
	Our Organisation: We are a well-managed organisation that meets our obligations to patients

Equality and Diversity Update July 2017

1. BACKGROUND AND PURPOSE

1.1 As previously reported, the Equality Act 2010 requires that we undertake outcome focused activity in addressing equality and diversity issues as a service provider and employer, across nine protected characteristics. We have a general duty to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not share it. As a public sector organisation, we also have specific duty to prepare and publish specific and measurable equality objectives every four years (which we did in April 2012 and 2016) and publish details of engagement on setting our objectives.

1.2 The 2017/18 Standard Contract places a Service Condition (13.) - Equity of Access, Equality and Non-Discrimination - requires that we show evidence of how we:

13.1 must not discriminate between or against Service Users, Carers or Legal Guardians on the grounds of age, disability, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, gender reassignment, or any other non-medical characteristics, except as permitted by the Law.

13.2 provide appropriate assistance and make reasonable adjustments for Service Users, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral or learning impairments). The Provider must carry out an annual audit of its compliance with this obligation and must demonstrate at Review Meetings the extent to which Service improvements have been made as a result.

13.3 comply with the public sector equality duties and section 6 of the Human Rights Act 1998.

13.4 In consultation with the Co-ordinating Commissioner, and on reasonable request, provide a plan or plans setting out how we will comply with our obligations. If the Provider has already produced such a plan in order to comply with the Law, the Provider may submit that plan to the Co-ordinating Commissioner in order to comply with this SC13.4.

13.5 must:

13.5.1 implement EDS2; and

13.5.2 implement the national Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing that standard.

1.3 The WRES seeks to tackle one particular aspect of equality – the consistently less favourable treatment of the BME workforce - in respect of their treatment and experience. It draws on new research about both the scale and persistence of such disadvantage and the evidence of the close links between discrimination against staff and patient care.

1.4 The Equality Delivery System (EDS2) is designed to help us, in discussion with local stakeholders, review and improve our performance for patients, communities and staff in respect to all characteristics protected by the Equality Act 2010. The Board of Directors receive regular updates on our progress against EDS2. There are eighteen goals attached to EDS2. Instead of trying to focus on all goals, in 2015, in consultation with local communities, the health economy across Bradford and Airedale agreed to focus on the following eight outcomes from EDS2:

Goal 2:

- People, carers and communities can readily access hospital, community health or primary care services and should not be denied access
- People are informed and supported to be as involved as they wish to be in decisions about their care

Goal 3:

- Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
- Training and development opportunities are taken up and positively evaluated by all staff
- When at work staff are free from abuse, harassment, bullying and violence from any source
- Staff report positive experiences of their membership of the workforce

Goal 4:

- Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
- Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination.

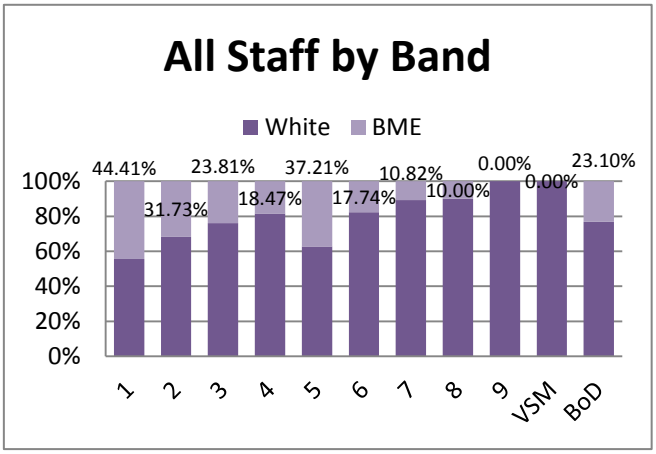
1.5 The WRES and EDS2 are complementary but distinct. The indicators used in the WRES, and the progress made in closing the gap, will assist us in implementing the EDS2. We will continually check how the data published for the WRES can assist and align with EDS2, and in particular with the outcomes under Goals 3 and 4.

1.6 This paper advises the Board of Directors of the draft data we are reporting on our third yearly assessment against the WRES.

2. WORKFORCE RACE EQUALITY STANDARD (WRES)

2.1 The WRES return is due by 1 August 2017. Some of the Indicators have slightly changed from last year so direct comparison is not always possible. The WRES is to be uploaded via the UNIFY2 system, so that progress can be measured at national level. In addition to the data being uploaded via UNIFY2 system, we will publish our report on our website by the 1 August 2017 deadline.

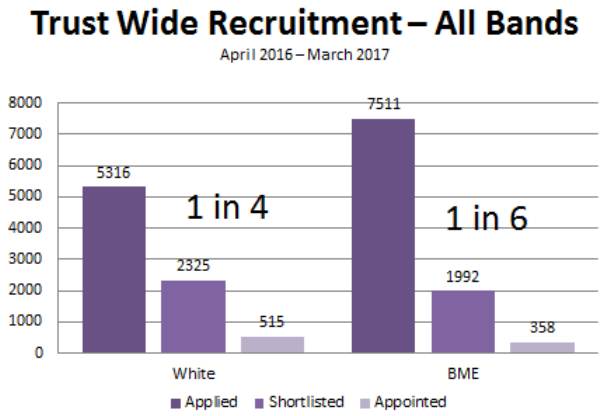
2.2 ***Indicator 1: Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.***



Narrative: Our overall percentage of BME staff is 28.05%. This is an increase of 1.29% since our last WRES report was produced, which encouragingly puts us ahead of our trajectory for overall staff numbers reflecting the ethnic diversity of our local population. The graph above shows the percentage of staff at each of the pay bands.

Action: We agreed to set a 35% employment target for employing BME people by 2025. We will be working with Divisions were there are large numbers of BME who are "stuck" on Bands 5 and 6. We are also focusing on nursing bands, aiming to increase the opportunities for BME nurses to gain experience and progress from Band 5 to 6, 6 to 7 and 7 to 8+. The Chief Nurse has instigated mentoring opportunities and project work with individual BME nurses and midwives who are ready for promotion, which has already seen some success. We are also participating in the Moving Forward programme for the second year, which aims to provide BME staff at Bands 5&6 with the tools and confidence to move on to more senior roles. We are also encouraging more senior BME staff who are considering Director roles, to apply for the Health Education England Nye Bevan programme.

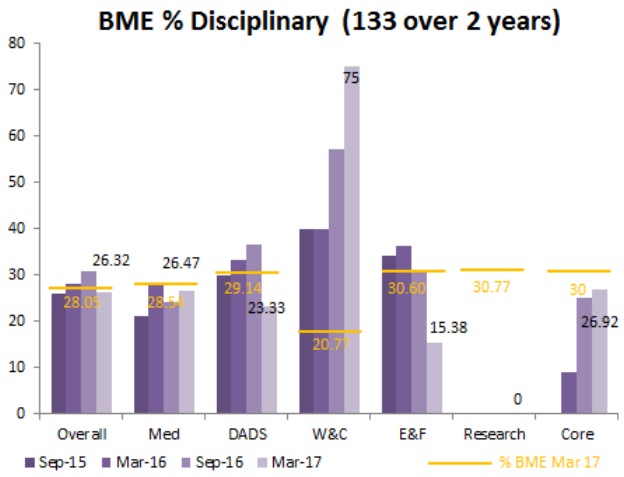
2.3 ***Indicator 2: Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts***



Narrative: White people have a 1 in 4 chance whereas BME people have a 1 in 6 chance. This has worsened from last year when we reported that 1 in 5 BME people were appointed.

Action: We have a breakdown of the chances of appointment by Division and Department. The Director of HR and the Head of Equality and Diversity, will discuss the disparity with Divisions through performance meetings. If the widening trend continues, we will need to consider what further action is required to reduce the disparity.

2.4 ***Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (two year rolling average)***



Narrative: A total of 135 staff entered the disciplinary process between April 2015 and March 2017, of whom we know the ethnicity of 133. 98 white and 35 BME staff entered the process in the past two years. 26.3% were from BME backgrounds, which indicate that BME staff are less likely (0.92) to be disciplined than white staff. This is an improved position on last year.

Action: Human Resource Department to review the process for initiating formal disciplinary investigations in Women and Children's Division.

2.5 ***Indicator 4: Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff***

Narrative: There were 2,531 non-mandatory training sessions between April 2016 and March 2017. Of those for whom we know the ethnicity, 72.38% of sessions were undertaken by white staff and

27.62% by BME staff. This means that white staff are very slightly more likely to access non-mandatory training and CPD than BME staff at 1.02.

Action: If this trend continues, Divisions to review their CPD processes where there is an under-representation of BME staff

2.6 Staff Experience Indicators 5-8: The WRES data compares BME and white staff experience across four indicators. The table below compares perception of BME and white staff to the four indicators. The experience of BME staff has significantly improved since the last staff survey results but in three out of four of the indicators, remains worse for BME.

Staff survey Indicator	White	BME	White	BME	White	BME
	2016		2015		2014	
KF25: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	34%	29%	32%	48%	21%	14%
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	24%	28%	26%	34%	23%	27%
KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	88%	80%	94%	78%	87%	75%
Q27. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	6%	17%	8%	36%	8.18%	17.07%

Narrative: Following last years' staff survey data and reporting for the WRES, a whole BME staff electronic staff survey was undertaken. This was followed up by a series of workshops facilitated by the BME staff network. We have devised an action plan to take forward the recommendations from the survey and workshops. We have an action plan that specifically focuses and responds to issues raised through the staff survey, which is described in 3. below.

Action: Implement the action plan detailed in section 3.

2.7 ***Indicator 9: Percentage difference between the Trusts' Board i. voting membership and its overall workforce and ii. Executive membership and its overall workforce.***
Narrative: As at March 2017, there were 16 members on the Board of Directors.

	Total Board Membership	i.Voting membership	ii.Executive membership
Total	**16**	**13**	**8**
White	81.3% (13)	76.9% (10)	100% (8)
BME	18.8% (3)	23.1% (3)	0% (0)
Workforce	28%		
% BME +/-	-9.3%		

Action: To review every appointment as it arises and seek to ensure that we continue to strive to have a Board of Directors that reflects the diversity of the local population.

3. BME SURVEY AND ACTION PLAN

3.1 At the Board of Directors in June 2016, the WRES data was considered. The data raised concern in a number of areas, but in particular, the Board were concerned about the Staff Experience indicators (Indicators 5-8), as shown in 2.6 above.

3.2 As a result the Board wanted to see action to address the disparity in experience between white and BME staff. A whole BME electronic survey was undertaken and workshops with BME staff were facilitated by members of the BME staff network.

3.3 We carried out a survey in October 2016 which sought views of BME staff about the four areas above. We also used eight questions from the "Culture of Care Barometer" to get a sense of culture that BME staff are working in. 310 BME staff responded to the survey (over 30% of total BME staff who could respond).

3.4 We also asked staff to tell about other action that the Trust should take. 31 BME staff participated in the workshops which were facilitated by members of the BME staff network during December 2016 and January 2017. The main findings from the survey and workshops were:

a. Regarding experiencing harassment, bullying or abuse from patients and the public, there is low reporting due to the perception that nothing happens if it is reported and that the Trust does not take the issues seriously.
b. Regarding experiencing harassment, bullying or abuse from managers or other staff. There was a lack of knowledge and awareness of the help and support available to staff[1]. When staff do contact the service, few want to formalise their concerns. BME staff raised concern that if they did make a complaint, they felt it would be career limiting or they would be accused of "playing the race card". A strong theme in both the survey and the workshop was that BME staff said they want options to report anonymously.

[1] We currently provide all staff with the opportunity to raise concerns about harassment and bullying (H&B) through the Staff Engagement and Equality Manager. We currently have 14 advisors who are assigned to support the complainant when a concern is raised. However, less than 1% of staff seek any kind of support from through this service. This compares with the 28% of BME staff who (25% all staff) said they had experienced H&B through our 2016 staff survey.

c. Many of those who responded to the survey and attended the workshop had the perception that recruitment practices are not open and transparent, jobs are not fairly advertised, not merit based and that people are recruited on the following basis:
    - friends or family
    - it's not what you know
    - if your face fits
    - managers recruit and encourage "people like me"

d. BME staff need more support when they encounter barriers to development and career progression, and avenues to raise concerns.

e. In relation to the Culture of Care Barometer, BME staff had least confidence "that inappropriate behaviour is consistently challenged by managers"

f. In relation to other suggestions that would improve BME staff experience, it was suggested that the Trust should do more to show its diverse workforce that they are valued and need to support a positive work culture where difference and diversity is recognised.

3.5 As outlined in 2.6 above, there has been improvement in the experience of BME staff since 2015 survey results with three of the four results for 2016 showing significant improvement. Although the gap in experience is narrowing, in three of the four indicators the experience of BME staff is still worse than that of white staff. The Head of Equality and Diversity has been working with the BME Staff Network and Staff Engagement Manager and developed an action plan to address the outcome of the online survey and the workshops. The following actions are proposed.

3.6 **Hate Crime reporting**: Addressing the perception that staff do not report harassment, bullying or abuse because they believe nothing ever changes. Our existing reporting systems do not enable us to identify whether we have a significant issue around hate crime. We can improve reporting and increase the confidence that action is being taken by introducing **Hate Crime and Hate Incident reporting**[i]. This will demonstrate to our staff that we are taking their concerns seriously. We will involve the police and Criminal Prosecution Service when we think incidents warrant it. The Head of Equality and Diversity and the Security Management Specialist will develop protocols and processes to support this. In this way we will be able to determine the level of incidence, raise awareness and increase confidence among staff that the Trust is taking action as appropriate on the reporting of hate incidents and hate crime.

3.7 **Divisional/Department Advocates**: With regard to the concerns about staff harassment and bullying, career progression and workplace culture. The harassment and bullying policy is being reviewed. We have looked at improvements in this area in other Trusts. Hull & East Yorkshire Hospitals NHS Trust had a widespread bullying culture. In the 2014 National Survey, the trust's score was in the worst 20 per cent of acute trust's nationally for staff engagement. Following their improvement work the overall score moved to the national average. The problems of bullying were tackled by a number of measures including:

- staff led improvement and decision making devolved to the lowest level where possible
- Reporting of bullying was make easier for staff
- Supporting and promoting staff-led improvement.

3.8 We are developing Divisional/Departmental "staff advocates". These advocates will be members of staff who can be approached by those who have concerns which might include:

- Discrimination
- Harassment and bullying
- Barriers to career development
- Recruitment practices
- Unhealthy work culture
- Anything else that makes working life difficult.

The aim is give our staff confidence that there is an advocate they can go to, in order to seek help or support for their concerns. Advocates will report to a lead staff advocate for each division who, along with the Staff Engagement Manager, will raise any concerns with the Divisional triumvirate (or senior leaders in departments). The advocates can raise concerns on behalf of staff.

3.9 **Career Progression**: See actions in 2.2. We hope, through the development of the advocate role to identify were particular barriers to career progression exists for staff. If barriers continue and progress is not made, we will look at reviewing the composition of interview panels.

3.10 **Targeted intervention with "hotspot" areas:** The advocate link between managers and staff, along with other intelligence, will raise "hotspot" areas, enabling targeted action to be undertaken. The Head of Equality and Diversity will provide tools to address unhealthy work culture, ensuring managers are aware of the particular difficulties in their own work areas and their responsibilities to challenge inappropriate behaviour and practice. This would overhaul the current "broad brush" approach where there is difficulty in identifying tangible action and areas where there are particular difficulties.

3.11 **Contribution made by diverse staff:** There is fear among some BME staff that as a result of Brexit, a political shift to the political right both in the UK and US and the rise of race base hatred, that the Trust needs to ensure that all staff are supported and valued by the Trust. It is proposed that the leadership team will continue to send messages that we support all our staff.

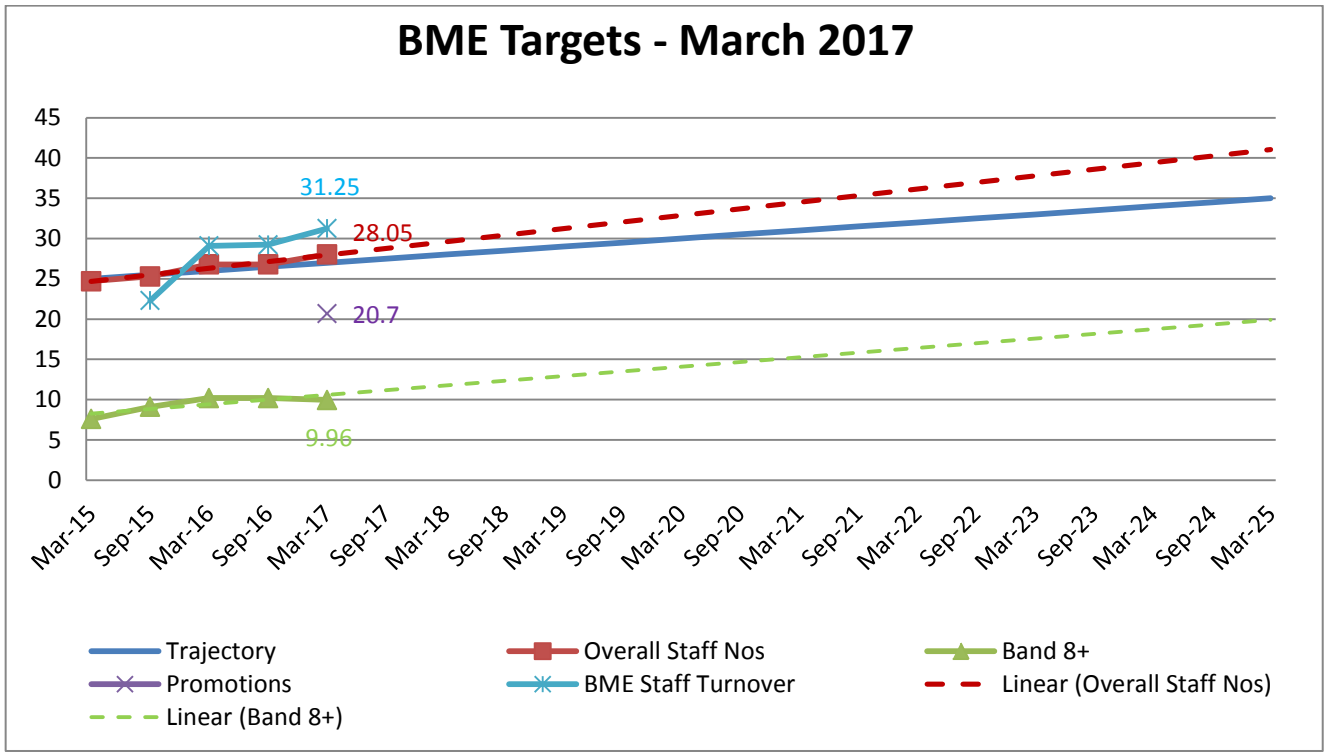
4. BME RECRUITMENT AND EXPERIENCE TARGETS (ANNUAL TARGET PROGRESS REPORT)

4.1 In February 2015, the Board of Directors decided to set a target of 35% staff from BME groups to reflect the local population (mirroring the target set by Bradford District Care Foundation Trust). BTHFT gave itself 10 years to achieve the target. The Board agreed to monitor progress every six months. Below is the data regarding overall numbers and recruitment targets for March 2017. The staff experience targets from the Staff Survey are included.

4.2 The Board agreed that when looking at BME recruitment and retention data, the following indicators are included:

- Overall % of staff
- Overall Band 8+ Senior Managers
- % recruited
- % recruited at Band 8+
- % promoted
- % all staff turnover

4.3 The graph below show the current status of all the above indicators:



4.4 **Overall Workforce:** Overall numbers of all staff in the Trust. There has been a significant overall increase of 1.24% in the proportion of staff who are BME in the last 12 months. This is encouraging and puts us ahead of trajectory for overall staffing numbers. If the current rate trajectory continues, we will exceed our overall BME workforce target by around 6%.

	March 2017		March 2016	
	No	%	No	%
White	4115	71.95	4100	73.19
BME	1612	28.05	1502	26.81

4.5 **Overall Band 8+ Senior Managers:** Overall numbers of Senior Managers in the Trust. There has been a decrease of 0.22% in the overall percentage of BME staff in these posts compared to the same time last year. The overall number of white and BME staff at these levels has fallen by 3 and 1 respectively. Based on this percentage decrease, and assuming a similar % increase each six months, we would fall short by around 15% on our target to have a senior management workforce of 35% by 2025.

	March 2017		March 2016	
	No	%	No	%
White	244	90.04	247	89.82
BME	27	9.96	28	10.18

4.6 Staff Promotions: Between October 2016 and March 2017, 113 staff were promoted. For those that we know the ethnicity, 20.72% are from BME backgrounds (23 out of 111). It should be expected that around 28.15% of those promoted would be from BME backgrounds (in line with the BME workforce). Previous data on promotions has been unreliable and did not reflect the likely number of staff being promoted. The issues with reporting through the electronic staff record have been rectified which means going forward, we should have more reliable data to compare. Therefore the figure below will be used as a baseline against which we can monitor Trust wide, Divisional and Departmental progress going forward.

	March 2017	
	No	%
White	85	79.28
BME	23	20.72

4.7 Staff Turnover: 432 staff left the Trust between October 2016 and March 2017. 135 of those who left were from BME backgrounds which represents 31.25% of the total, again it would be expected that around 28.15 of those leaving would be from BME backgrounds. This is concerning because should this trend continue, we could have a "revolving door" when it comes to BME recruitment and retention targets.

4.8 BME staff experience: It was agreed in February 2015 that we would analyse annually other workforce data to review BME staff experience rates. The WRES data compares BME and white staff experience across four indicators and is shown in 2.6 above.

4.9 Divisional monitoring: The following Divisions/Departments have monthly performance meetings and will receive their individual performance data in July/August 2017:

- Division of Anaesthetics, Diagnostics and Surgery
- Medicine and Integrated Care
- Women and Children's
- Estates and Facilities.

4.10 Conclusion: The April 2016 to March 2017 data has been positive in relation to the overall BME staff rates and the percentages of BME staff recruited. However, should the trend shown in the data continue, we will fail our ten year target in relation to BME staff:

- Band 8+ Senior Mangers
- Turnover

The staff survey results show a narrowing of the gap between white BME staff experience between 2015 and 2016, however there is still disparity between the experience of BME and white staff. The action plan agreed with the BME staff network (outlined in section 3) should further reduce the gap in experience between BME and white staff.

5. NURSE AND MIDWIFERY SURVEY

5.1 In early 2016, it was decided to carry out a whole nurse and midwifery (N&M) staff survey. We commissioned the Bradford Institute for Health Research in conjunction with the University of Leeds and Yorkshire Quality and Safety Research Group to undertake the survey. We wanted to determine whether there any differences for staff by protected characteristics. We have secured sponsorship from the WRES Team at NHS who will be funding the printing and prize costs for the survey. This survey will have national significance as it tests anecdotal experience of difference between white and BME staff and will hopefully give empirical evidence for the need for change.

5.2 The paper based survey was undertaken between February and March 2017. A total of 1704 nurses and midwives received surveys, with reminder surveys sent to non-responders. In total 538 surveys were returned, a response rate of 31.6%. 85% of responses were completed by nurses and 15% by midwives. Although we asked for the sexual orientation of respondents, we are unable to show any comparative analysis for lesbian, gay and bisexual nurses and midwives as we had insufficient responses.

5.3 The detailed analysis will be shared with the Diversity Workstream, Executive Management Team and senior nurse leaders. Work will then begin to take action on the issues identified and an update will be provided in the next Equality Update.

6. WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

6.1 NHS England's Equality and Diversity Council (EDC) has taken another step to advance equality within the NHS. The Council has recommended that a WDES should be mandated via the NHS Standard Contract in England from April 2018, with a preparatory year from 2017-18.

6.2 The WDES is similar to the WRES in that a number of metrics are used to measure Trust performance across the NHS. Again, it is anticipated that the WDES data will be used by CQC under its assessment framework under the "well led domain".

6.3 Disabled staff report the worst experience of all protected groups across the largest number of questions in the 2016 Staff Survey. We will therefore be focusing attention on addressing the poorer experience of disabled people during the remainder of 2017 and 2018.

6.4 The metrics are yet to be finalised but the most up to date ones version is listed below. They must be treated with caution as they are likely to change. We have shown the five metrics relating to performance against the NHS Staff Survey 2016 results (Metrics 4-8):

WDES Metrics (version 9) as at May 2017	
1	Percentage of staff in each of the AfC Band clusters 1-4, 5-7, 8-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce.
2	Relative likelihood of staff being appointed from shortlisting across all posts.
3	Relative likelihood of staff entering the formal capability procedure or formal sickness absence procedure (escalating to stages 2 and 3).

4	KF 26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. **Disabled: 35%, Non-disabled 22%**
5	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion. **Disabled: 78%, Non-disabled 88%**
6	Q9e In the last 3 months have you felt pressure from your manager to come to work despite not feeling well enough to perform your duties? **Disabled: 31%, Non-disabled 20%**
7	Q20b Did your appraisal help you to improve how you did your job? The proportion of respondents who stated they had received an appraisal and said 'Yes, definitely' to the statement: **Disabled: 22%, non-disabled: 25%.** *Q5f How satisfied are you with the extent to which my organisation values my work?* The % of staff who said they were either satisfied or very satisfied: **disabled: 39%, non-disabled 44%.**
8	Q27b Has your employer made adequate adjustments to enable you to carry out your work? **74% (19% of staff in the survey told us they are a disabled person)**
9	Does your trust have a disabled staff network and, if yes, what stage has it reached to contribute to executive decision-making? • Does the Network meet regularly, at least every three months • Does the Network have an elected Chair • Does the Network have representation at key Governance meetings • Is a Board member also a member of the Network
10	Percentage difference between the organisations' Board voting membership and its overall workforce.

7. RECOMMENDATIONS

7.1 The Board of Directors is asked to note:

- The draft WRES data submission and the action we intend to take to address the findings.
- Our performance between April 2016 and March 2017 against targets for achieving a workforce that reflects the local population.
- The recommendations for addressing the issues raised by BME staff through the online survey and workshops
- The action proposed to address the findings from the nurse and midwifery survey
- The draft WDES data and the proposal to concentrate equality activity on addressing the issues raised.

Lorraine Cameron
Head of Equality and Diversity
July 2017

[i] The police and the CPS have an agreed definition of hate crime as: "any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice based on a person's actual or perceived:

- race
- religion
- sexual orientation
- disability
- transgender”