

‘Smart metrics’ and equality and diversity monitoring

Report to NHS Greater Glasgow and Clyde

October 2014

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Executive Summary

1. NHS Greater Glasgow and Clyde's (NHS GGC) equality and diversity data monitoring and management (EDDMM) is designed to meet legislative requirements and NHS Standards.
2. HR management in NHS GGC are interested in whether data collection, analysis and dissemination on equality and diversity issues are optimised, and whether these processes support appropriate follow up action. This report was commissioned to evaluate the efficacy of EDDMM and how these relate to key equality and diversity objectives. Practice in NHS GGC was also compared with practice in a comparator organisation (CO).
3. The data from which this report is drawn comprises secondary statistical equalities data from the Board and primary qualitative data generated through stakeholder interviews with representatives from HR, the Board (non-Executive management), recognised unions, Corporate Policy and Planning and an Employee Partner. In CO, data collection comprised collection and analysis of workforce equalities statistics and interviews with HR staff.
4. This report outlines the regulatory framework, equality and diversity (E&D) data content, organisational responsibilities for collecting and analysing data, data findings and actions arising from the data.
5. In assessing EDDMM this report draws on the concept of 'smart metrics' – that is, the intelligent use of HR metrics supported by a line of reasoning (logic) to inform effective decision making, thus linking EDDMM to key organisational objectives. 'Smart metrics' optimise the use of data and link data to vital issues, thus engaging stakeholders, supporting priority setting and facilitating real impact.

EDDMM Objectives

6. Current approaches to data content and analysis strongly suggest that legal requirements are an important driver of EDDMM within NHS GGC. All stakeholders agreed that E&D data collection and quality in NHS GGC has improved significantly in recent years, is better than in other health boards and responds effectively to regulatory requirements.
7. Beyond responding to regulatory requirements, there was no consistent stakeholder narrative on the role of EDDMM in supporting strategic and operational objectives.
8. The relationship between inequalities in the provision of health services and workforce equalities issues was not widely articulated and understood.
9. Having delivered regulatory compliance, some stakeholders advocated NHS GGC becoming more proactive in EDDMM to support other organisational objectives. Some stakeholders believed that the culture of fairness and inclusivity in the NHS could support an ambitious set of objectives in this area.

10. A key question that needs to be answered is, therefore, what is the purpose of EDDMM, and what data collection and metrics will support delivery of the outcomes sought.

[Recommendations on EDDMM Objectives](#)

NHS GGC needs to clarify its objectives for workforce EDDMM beyond meeting regulatory requirements.

- There is a need for a clear and consistent narrative connecting service EDDMM and workforce EDDMM.
- There is a need for a clearly defined business/operational case for EDDMM that specifies relevant organisational risk and opportunities.
- In setting objectives, NHS GGC should define its ambitions in EDDMM. Stakeholders need to decide whether the organisation wishes to be compliant, developing or path-breaking in EDDMM and what each of the latter two would mean in practice.

These objectives need to be 'owned' more widely than by the HR or Inequalities team:

- Operational management involvement is crucial to defining the business drivers of EDDMM.
- Establishing a clearer link between strategic, operational and EDDMM objectives should be used to strengthen ownership of E&D data across HR and corporate teams.
- Existing high levels of trust and commitment to fairness and inclusion provides a basis for a genuinely collaborative approach across a wider group of stakeholders to defining EDDMM objectives.

[Data collection](#)

11. Most EDDMM data is currently collected through HR systems and EO monitoring forms, particularly during recruitment. There are also specific surveys to look at particular E&D issues. There are inconsistent findings between anonymised against non-anonymised data.
12. Operational management do not appear to be a source of E&D data, and most operational management seem largely disconnected from workforce EDDMM.
13. While unions generate data relevant to EDDMM, this is not a data source for NHS GGC and beyond oversight of the data reports, unions within NHS GGC also acknowledge low levels of engagement with EDDMM.
14. Most strikingly, no data appears to be generated from equality representatives and the latter do not appear to engage with E&D data dissemination and findings.

15. Although equalities data collection has improved in recent years there were some concerns over the level of disclosure of some data (notably religion/belief and sexual orientation) and the reliability of information disclosed (disability data).
16. Beyond planned changes and a small number of areas where additional data collection was considered useful, stakeholders were not in favour of collecting additional quantitative data without a strong rationale for it.
17. There is a lack of any systematic collection and analysis of qualitative data. Some stakeholders were convinced that qualitative data was a necessary complement to quantitative data in understanding E&D.

[Recommendations on data collection](#)

NHS GGC might benefit from greater reliance on a wider range and type of data sources to interrogate the quality of workforce data.

- Data from operational management, equality representatives and unions could enhance the range of quality of data.
- Most importantly, specific qualitative data is required to supplement quantitative data.

Data Analysis and Findings

18. There is evidence that the analysis of E&D data is becoming more sophisticated. To illustrate, more nuanced analysis of equal pay and the relationship to occupational segregation and protected characteristics beyond gender is to be undertaken. Analysis in this area may benefit from more hypothesis-driven analytical approaches.
19. In order to consider how 'smart' the E&D metrics are in NHS GGC, it is useful to distinguish between the different objectives of E&D monitoring. The analysis that is currently undertaken is clearly appropriate for the purposes of meeting regulatory requirements and for reporting to Scottish Government (SG).
20. For the most part, however, data analysis is not explicitly hypothesis driven – for some stakeholders, this leads to too much focus on the 'data' and too little on the 'analysis'. Stakeholders want less of a focus on 'numbers' and more of a focus on the issues underlying the 'numbers'.
21. Data is benchmarked to census data. There are some concerns that the case for a simple benchmarking with census data is weak with regard to some of the protected categories.

22. Stakeholders were interested in different ways of framing analysis of the data by protected characteristic, such as, by grade, occupation or unit.
23. From the stakeholders and data, the key concerns and possible action areas are around the representation of people with disabilities and from BME communities, and gender representation.
24. Three key issues were raised by stakeholders in relation to gender inequality: horizontal occupational segregation; vertical occupational segregation and challenges facing women in relation to caring responsibilities. Few concerns were raised about gender pay inequality.
25. Most NHS GGC staff disclose their disability status, but there are concerns that staff with a disability are choosing to report that they do not have a disability. This is a major concern to the organisation. While staff may not see that having a disability is relevant to their jobs, there are concerns that staff may have anxieties about the consequences of disclosing a disability.
26. The organisation's disability awareness campaign identified the challenges of separating out discussions of disability with discussions of sickness absence.
27. Unions' disabilities agenda relates to the interaction of disability status and absence management and access to reasonable adjustments.
28. NHS GGC face two key challenges in relation to issues of age: the low proportion of young employees and the challenges of an aging workforce, particularly in jobs with a significant physical component.
29. In some jobs/occupations, BME workers are significantly under-represented.
30. No significant issues around faith were raised across the stakeholder group.
31. Concerns were voiced that some parts of the organisation are not as gay friendly as others. However, as data on LGBT status is not analysed by work location, this is not currently substantiated by quantitative data.
32. Trends are looked at year on year, and there appears to be no longitudinal analysis of E&D data.
33. There appears to be no obvious forum for analysis of, and learning from, specific cases or instances.

Recommendations on Data Analysis and Findings

- A more focussed approach to EDDMM should include hypothesis definition for testing. Hypothesis should be constructed using existing knowledge and focus on priority areas.
- Key stakeholders need to consider the use of logic driven approaches to identifying E&D challenges, solutions and outcomes. Within this, there is a need to use tacit and explicit organisational knowledge to develop hypothesis for testing.
- Stakeholders are keen to see more and better qualitative data – the ‘stories behind the numbers’, particularly in three areas: requests for reasonable adjustments, requests for flexible working and, crucially, on the reasons for non-disclosure of E&D data.
- More exploratory analysis of data by alternative units of analysis (eg grade, service, location) should be considered and results compared.
- The choice of benchmarks for comparison should also be logic driven - some existing benchmarks may be inappropriate and risk building failure into the EDDMM system.
- Data analysis should explore the experiences and outcomes of staff who fall into multiple protected categories – e.g. black women or male manual workers with disabilities.
- Chances of success measures may be more helpful in focussing attention on behaviours in the process rather than outcomes of the process.
- Logic driven approaches and hypothesis testing must take into account the interaction of other organisational systems on EDDMM – such as absence monitoring, promotion procedures and resource allocation.

Data Dissemination

34. Reports on E&D data is a standing item at SGC meetings and at Area Partnership Forums.
35. At Board/SGC level, stakeholders reported that interest in E&D data varies. For some, E&D data is seen as the province of E&D or HR specialists who have a specific accountability for it, and not requiring of action by others in the organisation.
36. Engagement with E&D data appears stronger in relation to service equalities issues rather than workforce equalities issues.
37. Union stakeholders found the data presented useful and noted that management are amenable to their requests for further and better information.
38. Unions reported little engagement with E&D data by their members, signalling that engagement required moving beyond presentation of the data to action.

39. Data can be disaggregated to operational units so that data is available for Directorates and CHPs. This data is disseminated to the relevant management teams. It is less clear what operational management do with it.
40. It is not clear that workforce E&D data is disseminated to or accessed by non-management staff.
41. Reporting now places greater emphasis on action from the findings rather than presentation of the findings.
42. There have been recent attempts to improve dissemination through the use of illustrative case studies of responses to E&D data or roadshows to highlight key issues, particularly in relation to disability.

Recommendations on Data Dissemination

- Not all data needs to be reported at all opportunities. Foregrounding key issues while backgrounding others where there are fewer concerns will help to focus attention on issues requiring greater engagement and attention.
- It may be worth reporting summary trends over a defined period (for example, a rolling 5 year period) using summary indicators – for example, ‘↑’, ‘↓’ or ‘-’ (as in Scottish Government’s Scotland’ Performs reporting).

Action and Impact

43. There are concerns within NHS GGC that data dissemination is not leading to sufficient engagement with EDDMM. E&D data monitoring only becomes significant when it is a spur to action which leads to impact. Data dissemination without action and impact are unlikely to engage stakeholders further.
44. A number of initiatives and campaigns have followed on from EDDMM, and in some campaigns, Board members/NEDs, unions and staff have combined as champions for equality.
45. E&D data clearly has an impact in terms of how it is used thereafter by key players, notably HR and CIT. The most obvious action is the reporting of data internally and externally and the most obvious impact is the development of policy and initiatives to address any unequal practices and to mainstream equalities into wider organisational activities.
46. E&D was not considered an operational issue according to stakeholders.

47. Encouraging operational managers to engage more with workforce E&D data has two key challenges: first, reluctance at corporate level to directly intervene in operational entities and issues, and second, no real understanding as to how, in a practical sense, operational managers might be encouraged to engage more with this agenda.

Recommendations on Action and Impact

- Acknowledging that there have been recent moves towards action oriented rather than descriptive reporting, continuing the shift to explicitly action oriented reporting should be encouraged.
- Examples need to be developed that show the relationship between EDDMM, action, impact and outcomes – successful outcomes can then be used to illustrate the importance of EDDMM across the organisation.
- Ensuring impact requires identification of structural barriers (e.g. budgetary arrangements, conflict with other policy areas such as absence management) and structural facilitators (e.g. partnership, high levels of trust, performance management systems).
- Performance management systems, particularly for managers, should be considered to improve engagement and impact.

Capacity issues

48. There are capacity issues in EDDMM across the stakeholder groups – the amount of time/resource available to EDDMM amongst HR, corporate, operational and staff categories is finite.
49. Unions also noted that their low level of engagement with E&D data – which generated frustration among other stakeholders – was a reflection of time and capacity constraints rather than priorities.

Recommendations on Capacity issues

- Benefits might be achieved by using internal capacity more effectively. Unions and union equalities representatives are a potentially useful source of information and capacity for impact although are significantly underutilised at present. Consideration should be given as to how management and unions in partnership can involve equalities reps more effectively.
- 'Free' external capacity opportunities might allow for greater activity in data analysis and reporting, or to generate new qualitative data – for example, ESRC Phd Intern students or through giving access to supervised Masters/MBA student dissertation projects. The authors are happy to engage in further discussions on this recommendation.

1. Introduction and Background

- 1.1 A range of employee data is currently collected in NHS Greater Glasgow and Clyde (NHS GGC). Much of this data is necessary to the EDDMM issues within NHS GGC and in particular to meeting the legislative requirements faced by public sector organisations in general (arising from the Equality Act 2010) and specifically by the NHS in Scotland (arising from the NHS Reform (Scotland) Act 2004). The latter Act outlines the NHS Staff Governance Standard which requires that NHS Boards ensure that all staff are treated fairly and consistently with dignity and respect, in an environment where diversity is valued.
- 1.2 Within NHS GGC, a Staff Governance Committee (SGC) exists to provide assurance to the Board that NHS GGC meets its various legal and organisational obligations. This Committee acts as a subcommittee of the Quality and Performance Committee of the Board.
- 1.3 Employee data relevant to equalities issues is currently collected in a variety of ways, analysed and then reported to SGC, Area Partnership Forum (APF) and, through the HR Matrix, to the Corporate Management Team.
- 1.4 While key stakeholders acknowledge that workforce data had improved in recent years, HR management in NHS GGC were interested in whether data collection, analysis and dissemination are optimised, and whether these processes support appropriate follow up action. To this end, a review of equality and diversity monitoring by an independent party (SCER) was agreed. This report was commissioned by NHS GGC to evaluate the efficacy of data collection, analysis and dissemination and to consider whether the current approach delivers on key objectives in the management of equality and diversity.
- 1.5 The report is presented as follows:

In Section 2, we outline the legislative framework and good practice guidelines governing the collection of E&D data.

In Section 3, we consider debates on smart metrics and the relationship between data collection, analysis and use and the achievement of organisational objectives.

In Section 4, we outline data collection in NHS GGC: what data is collected, how data is collected, what drives data collection, the quality of data collected and stakeholder perceptions of the data collection process and outcomes. In this section, we also consider what data is not collected and its implications for EDDMM.

In Section 5, we consider how data is analysed in NHS GGC.

In Section 6, we reflect on the substantive issues raised by NHS GGC E&D data monitoring.

In Section 7, we outline the processes of data dissemination and how data is used thereafter to impact on E&D policy and practice.

In Section 8, we briefly review EDDMM in a comparator organisation (CO), a public sector organisation also required to meet the requirements of the Public Equality Duty. The data from CO is used to highlight any differences in approach and practice between the two organisations.

In Section 9, we offer a brief summary and identify key issues for further consideration by NHS GGC.

2. Background to Equality and Diversity Monitoring in NHS GGC

- 2.1 As a public employer, NHS GGC is subject to employment regulation as it applies to all employers and to public sector employers specifically. Moreover, NHS GGC describes itself as an equal opportunities employer striving to ensure that its workforce is as representative of the general population as possible. Both of these factors influence the organisation's equality data monitoring and equality practice.
- 2.2 All public sector organisations including Health Boards are required to comply with the Equality Act 2010. Integrated into the Act is the Public Sector Equality Duty which came into force in April 2011 (Government Equalities Office, 2011). This Equality Duty requires public sector bodies to have due regard to the need to:
- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under the Act.
 - Advance equality of opportunity between persons who share a relevant (protected) characteristic and persons who do not. Protected characteristics are sex, race, age, disability, religion and belief and sexual orientation.
 - Foster good relations between people who share protected characteristics and those who do not.
- 2.3 Secondary legislation (the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012) has been implemented to help organisations achieve the General Equality Duty. These regulations require public bodies to:
- Report progress on mainstreaming the equality duty
 - Publish equality outcomes and report progress
 - Assess and review policies and practices
 - Gather and use employee information
 - Publish gender pay gap information
 - Publish statements on equal pay
 - Consider award criteria and conditions in relation to public procurement
 - Publish in a manner that is accessible
- 2.4 Mainstreaming the equality duty requires that equality should be integrated into the core business of an authority. Hence, good equality practice should be incorporated into organisational structures, behaviours and cultures and in all of the ways that an organisation functions (EHRC, 2012). A range of data and evidence (on matters such as recruitment, promotion, training, pay, grievances and disciplinary action) on people with (and without) protected characteristics is crucial to meeting the General Equality Duty, most specifically in relation to undertaking impact assessment and reporting on progress towards the achievement of equality objectives (EHRC, 2011). It is also crucial to eliminating discrimination and harassment at work, improving employment outcomes and promoting a sense of fairness at work (TUC, 2013).

2.5 For NHS GGC, addressing inequality requires action in relation to the delivery of health services to patients and in employment/workforce issues. Organisationally, primary responsibility for the former lies with the Corporate Inequalities Team (CIT), accountable to the Director of Policy and Planning who is the lead director for inequalities. Primary responsibility for workforce EDDMM lies with the HR team. In both cases, however, addressing inequalities relies on the actions and behaviours of all management and staff. In addition, there are areas of common interest and effective joint working across CIT and HR.

3. Smart Equality and Diversity Metrics

- 3.1 The use of metrics is increasing across a range of HR activities. In part, this is driven by the quest within organisations to find common ways of comparing very different activities. It is also driven by a growing emphasis on displaying the value of HR activity in quantitative terms. Undoubtedly, HR metrics use have been facilitated by developments in IT and data collection that make the gathering and manipulation of 'big data' more manageable.
- 3.2 HR metrics allow organisations to effectively measure, assess and evaluate past and present performance (CIPD, 2012) as well as support the business in its strategic decision making (Harrison, 2013). Used appropriately and effectively, reliable evidence and corresponding metrics are crucial to making informed HR decisions. However, as Boudreau and Jesuthasan have noted, "Problems can occur though in how data is used and interpreting figures in a 'measure and response mode' which is the way data are too often used in HR organisations today" (2011).
- 3.3 While it has previously been acknowledged that a lack of metrics hindered the HR profession's ability to demonstrate its value, influence key decision makers, and draw out insights into the effects of human capital on strategic success, information overload is now far more prevalent than the lack of data (Boudreau and Jesuthasan, 2011). Information and metrics do not, however, equate necessarily with effective HR intelligence.
- 3.4 Boudreau and Jesuthasan argue for 'logic driven analytics' or 'smart' metrics that "... elevate the data and their analysis to a new level producing insights and solutions that are far more nuanced and optimised to the organisation's context and systems, and thus more likely to create change that is more richly impactful and sustainable" (2011). There needs to be a line of reasoning that guides the monitoring and analysis of the data collected.
- 3.5 Hypothesis driven inquiry underpins logic driven analytics and smart metrics. Hypothesis driven inquiry is rooted in the organisational knowledge and avoids data collection and analysis for its own sake; rather, focussing on key objectives and challenges and connecting these to human capital strategies can engage key decision makers and improve decisions.
- 3.6 There are a number of clearly established and commonly used E&D metrics, for example, specific approaches to measuring a gender pay gap or to evaluating chances of success in a recruitment and selection process. However, many of the metrics used to report on E&D performance are simple descriptive statistics benchmarked against population measures. These have the attraction of simplicity and comparability but may not be sufficiently insightful to support organisational decision making and action.
- 3.7 Adapting the work of Boudreau and Jesuthasan (2011) to looking at E&D measures, E&D data can be used more or less effectively:

Less effective use of E&D data:

- Data reflect IT system priorities
- Information overload, lots of numbers with no story
- Reflects compliance
- Risk receives little attention, risk reduction is ill-defined, risk analysis is ad hoc
- Analysis fails to engage constituents
- Data and analysis do not engage action
- Constituents do not routinely use evidence in change efforts
- Individual processes operate in silos
- Priorities established separately in different organisational units
- Fairness constituted as standardised/same treatment

More effective use of E&D data:

- Information optimisation
- Data and analysis focused on vital issues
- Data reflects needs for decision making
- Data and analysis motivate strategically vital actions
- Constituents routinely demand and use evidence to direct strategic change
- Organisation naturally treats different segments differently where it makes sense
- Risk is routinely analysed and considered; risk elements are well understood and follows common logical rules
- Processes operate as interconnected systems
- Priorities established jointly across multiple organisational units
- Systems focus on trade-offs that optimise performance across organisational units
- Fairness is understood to mean, where necessary, strategically differentiated treatment

3.8 Taking all of the above together, EDDMM requires attention to the objectives underpinning data monitoring, the information made available through data monitoring, the engagement of stakeholders with data monitoring, actions arising from data monitoring and the outcomes produced by these actions. The remainder of this report will focus on these issues in relation to EDDMM in NHS GGC.

4. Data collection in NHS GGC

4.1 As NHS GGC was created in 2006 from a merger of Greater Glasgow Health Board and Argyll & Clyde Health Board, the establishment of a single workforce information dataset was required to replace five previously existing workforce information systems. By 2009-10 the Board was consistently reporting workforce information as a single unified Health Board.

4.2 NHS GGC collects data on all protected characteristics specified in the Equality Act 2010 and the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 - gender, age, beliefs/religion, disability, ethnicity/race and sexual orientation. This data is collected for members of the permanent workforce. Moreover, data collection is also responsive over time to the findings from previous data collection exercises – for example, Gender Pay Audit activities.

4.3 The content of the data collection and its analysis in relation to legally enshrined protected characteristics strongly suggests that legal requirements are an important driver of data collection within NHS GGC, as is the ability of the Board to report to SG on their equalities related performance and outcomes. This is reinforced by the comments of a range of stakeholders:

“... without the legislation I don’t think it would be as prominent for the organisation.”

“There is quite rightly an anxiety about making sure they comply with legislation and an anxiety around a lot of people who do not understand equalities ... it’s a reputational risk and people are anxious about it. They understand a lot of the risks that they face as an organisation but equalities is not one that is necessarily well understood because it is a relatively recent risk ... it’s relatively new regulation for the NHS.”

4.4. The relatively recent nature of some E&D regulation has undoubtedly concentrated attention on the compliance aspects of EDDMM. It may be useful, however, to consider this a necessary first step in using E&D data effectively, from which other steps can thereafter be taken. One stakeholder captured this idea of stages of development of EDDMM well:

“I think it probably started off as managing risk but they have probably moved away from that. They now feel that their dataset is sufficiently robust that they have dealt with the risk. They are now at the stage of the dataset is almost as good as they are going to get ... they think they have probably managed the risk so it’s about how they now use the data to inform practice.”

4.5 Stakeholders were asked to consider what factors beyond regulation/legislation drive the collection of equalities data and a number of distinct factors were identified. Some stakeholders focused on the equalities agenda as part of the necessary steps to being a good employer and ‘doing the right thing’. Others pointed to the role of equalities ‘champions’ – individuals with a particular enthusiasm for pursuing this agenda – in driving an E&D agenda

and in so doing becoming ‘the conscience of the organisation’ and experts in understanding the data:

“The law is driving it, as it is ... a legal responsibility of the board but it is fair to say that Andy Carter’s commitment to it has been really crucial as well, so they have a champion who is very keen on the data, very good at manipulating the data and understanding it and relating it to things like the national staff survey and so on... and how it can be used.”

- 4.6 What was striking, however, was how few references there were across stakeholders and across secondary documentation to operational drivers for EDDMM. One stakeholder did suggest a strategic driver for EDDMM similar to that for any other kind of data – to provide the evidence and intelligence to manage the business and plan for the future, thus arguing a strategic driver to equalities data monitoring. Another argued that data should be collected to make NHS GGC a more effective employer: “they would want to know if there are any glass ceilings because at the end of the day it’s not in an employer’s interest not to maximise the potential of its staff across the range of people it employs.” Beyond these comments, while there was a clear understanding across the stakeholders interviewed that workforce equalities issues were, in some unspecified way, connected to addressing inequalities in the delivery of health services, the nature and implications of this connection were not clearly articulated save by one respondent:

“The reporting stuff now is helpful in driving the operational agenda in that through the reporting they are beginning to – because they have better reporting – beginning to see the gaps and therefore filling those gaps will help with that broader agenda ... see it as a health improving type issue and therefore if they can increase people who come from more socially excluded groups then that will help in terms of the overall population impact in the west of Scotland.”

Notably, there were no strategic perspectives offered on any relationship between workforce E&D issues, wider workforce issues such as retention, engagement or commitment, for example, and service delivery matters.

- 4.7 Turning from the drivers of data collection to data content, the Workforce Information data and some analyses is provided quarterly for use by the Head of Staff Governance who largely drives the data content. NHS GGC collects workforce statistics on the characteristics of the current workforce and presents the information in a report under the following headings:

- Headcount and whole time equivalent (WTE)
- Staff turnover – the number of leavers over the previous 12 months expressed as a percentage of the current workforce
- Starters and leavers
- Bank, overtime and excess WTE
- Sickness absence (% of workforce)
- Vacancies (all and authorised each month)

- HR activity statistics by area (current information held by local HR teams). This is analysed by directorate/partnership and includes information on training interventions, discipline (misconduct and attendance), capability, grievance, bullying/harassment, suspension.

Focussing specifically on equalities issues, data on the NHS GGC current workforce is presented under the following headings:

Primary variable:	Broken down by:
Total Headcount	Gender Job Family Job family and pay band descriptor Job family and age profile
Job family	Gender Leavers/turnover Workforce change – staff in post by job family movement
Gender of the permanent workforce	Staff count and % breakdown
Age of the permanent workforce	Staff count and % breakdown of age categories
Beliefs/religion of permanent workforce	Staff count and % breakdown
Disability of permanent workforce	Staff count and % breakdown of disclosed disability, disclosed no disability, opted not to answer
Ethnicity/race of permanent workforce	Staff count and % breakdown of 14 ethnicity categories. Ethnicity analysis by extracting 'white' categories.
Sexual orientation of permanent workforce	Staff count and % breakdown

4.8 The Board currently holds no data on transgender status, civil partnership or marital status and maternity or pregnancy status.

4.9 Information on job applicants is captured via Equal Opportunities Monitoring Forms. This information is then used to identify progress through the stages of recruitment. I.e. application – short-listed to interview – offered a job. Data, analysis and commentary is presented in the follow areas:

- Recruitment by age – total applicants, total interviewed, total appointment, success rate (%)
- Recruitment by beliefs – total applicants, total interviewed, total appointment, success rate (%)
- Recruitment by disability – total applicants, total interviewed, total appointment, success rate (%)

- Recruitment by ethnicity/race – total applicants, total interviewed, total appointment, success rate (%)
 - Recruitment by gender – total applicants, total interviewed, total appointment, success rate (%)
 - Recruitment by sexual orientation – total applicants, total interviewed, total appointment, success rate (%)
- 4.10 At the time of interviewing, plans were in place to extend data collection and analysis to consider information on training provision by protected characteristics, a breakdown of leavers by protected characteristics and HR activity in terms of breakdown by policy area relating to the protected characteristics.
- 4.11 The Head of Staff Governance has recently agreed with the Workforce Information Department that statistics on staff in post and recruitment data will be collected every 6 months. The Equality Act 2010 requires this information to be collected annually.
- 4.12 As indicated at 4.8 (above) NHS GGC have acknowledged in their own documentation that there are data gaps in a number of areas such as pregnancy or maternity leave status, marital and civil partnership status and gender reassignment. It is hoped that the roll out of a new Electronic Employee Support System (eEss) will be used to address these gaps.
- 4.13 Stakeholders identified a number of issues not covered or covered fully by EDDMM at present:
- Some stakeholders felt it would be useful to look at occupational segregation more systematically across the organisation, and also to look at the way in which having children alters career paths for women.
 - Others felt that it would be interesting to mine data from exit interviews more in order to find another potential source of E&D data.
 - Mixed views were expressed in relation to the need for further data on Religion and Belief – some stakeholders felt this was an area that required more data and investigation; others felt there was sufficient information available that suggested that faith or otherwise was not a key area of concern within NHS GGC.
 - A number of stakeholders were interested in data on socio-economic status, which is not currently collected.

A number of stakeholders focused less on issues that were not addressed and more on the absence of types of data that would inform understanding of E&D issues, specifically the lack of any systematic collection and analysis of qualitative data. For these stakeholders, qualitative data was a necessary complement to quantitative data in understanding E&D. To illustrate, one stakeholder noted that the organisation does not know in a systematic way what sort of adjustments are being made by managers in relation to disability. This may be a useful source of information given that offering equality of opportunity to people with a disability means not only recruiting more, but also retaining such staff in the workforce, which is likely to require better support for them. Stakeholders suggested that there could be considerable informal adjustments going on that were not known about above an

operational level, and that this information might be useful in showing where reasonable adjustments were possible and hence supporting good practice.

- 4.14 Turning to data sources, the Workforce Information Department in NHS GGC collects a range of data on its workforce in relation to the protected characteristics. This data is sourced from an HR system known as Empower. Empower gathers information from a combination of recruitment paperwork such as Equal Opportunities Forms, application forms in the recruitment process and payroll start (engagement) forms. This HR system is outgoing and the new system eEss aims to introduce a single national HR system for all Boards in NHS Scotland. The system will be introduced in the financial year 2015/16 and will hold and manage employment information for all staff employed by NHS Scotland's 22 Health/Special Health Boards.
- 4.15 In addition to HR data (including E&D monitoring forms), separate data is collected through the NHS national staff survey which feeds into Staff Governance Improvement Plans. These surveys are conducted at regular intervals across NHS Scotland. They are voluntary and are completed by approximately a quarter of the workforce hence yielding statistically valid results. In addition, specific surveys are conducted in this area – notably the CIT baseline survey that preceded the report A Fairer NHS.
- 4.16 There appear to be no other data sources used systematically in EDDMM at NHS GGC. For example, no reference was made to the use of data at an organisational or operational level generated by operational management.
- 4.17 Unions are a potential source of useful data in this area. Union stakeholders made reference to their own surveys and data (for example, on the equality dimensions of poverty). However, this does not appear to feed into organisational processes within NHS GGC. No reference was made to information/data coming from trade union officers or lay representatives/personal case workers. While NHS GGC must rely on their direct data sources for the purposes of regulatory compliance and reporting to SG, multiple data sources are useful in assessing the reliability of organisational data, aiding understanding and formulating action plans. This appears to be at least partly recognised in relation to quantitative data on workforce disability. Surprisingly, no data appears to be generated from equality representatives. Equalities representatives have a specialist role in taking forward E&D issues within unions and in workplaces: as one stakeholder suggested “their role is to be champions for equality in the workplace and pushing the employers’ agenda, working with the CIT to deal with any equalities issues relating to the workforce”. Unions, however, acknowledge that the level of engagement of equality reps is uneven and that the complexity of some E&D issues means that responsibility often lies with union officers. Similarly, management stakeholders noted that “there is no systematic way of gathering information from equalities reps”.
- 4.18 There is little evidence of any attempts at integration across different data sources. Insofar as data other than workforce information/HR data is considered for the purposes of equality monitoring, it is presented discretely. Where multiple E&D data sources are considered (for example, HR data and staff surveys), this has highlighted conflicting data findings between anonymised and non-anonymised data. While this is a challenge to report and to base

action plans on, conflicts of data can be constructive in identifying underlying issues impacting on accuracy of disclosure.

4.19 There was a strong view across all stakeholders that data collection has improved in a variety of ways in recent years. In addition, all stakeholders felt that NHS GGC, perhaps related to its size and resources, are able to produce better information than other Health Boards.

4.20 Turning to the quality of E&D data, two key concerns were raised in documentary sources and by stakeholders: the level of disclosure of some data and the reliability of information disclosed. NHS GGC records that the whole workforce discloses gender, age and disability data. However, at 2012, only 73.2% of the workforce discloses their ethnicity, 59% disclose their belief and 51.4% disclose their sexual orientation. While disclosure levels have increased for all protected categories, these levels do raise concerns among stakeholders:

“Disclosure levels from the workforce of data on protected characteristics are a concern. There are even lower levels of disclosure from patients and clients of this type of data as people do not necessarily want to disclose this information. Employers are an emanation of the state and people are anxious about what info the state has on them.”

4.21 As much of the data is sourced through HR information gathered during recruitment, gaps exist in relation to existing staff, although efforts have been made to address these gaps. HR staff estimate that they have data coverage for around 70% of staff.

“There are a lot of people with long service and back in the past there was not the drive to collect equality data in those days and despite attempts to backtrack and ask staff to complete these things, because it is voluntary a lot of staff chose not to tell them.”

4.22 According to the Head of Staff Governance, the most useful means of collecting equalities data is through the Equal Opportunities forms as people are more receptive to requests for information during the job application process.

4.23 There have been a few initiatives aimed at improving disclosure levels and Staff Governance indicated that they are now ‘smarter behind the scenes’ in terms of collecting data. However, there is still a need to press the workforce to disclose more information about protected characteristics. This is only likely to be successful, however, if the benefits of disclosure to staff as a whole are made clear.

4.24 It is hoped that the implementation of the new HR system will be an opportunity to improve disclosure levels around belief, ethnicity and sexual orientation. It was not clear, however, how proactive an approach would be taken to flag up data gaps to staff once they have access to self service employee records. This issue needs to be reviewed: should staff be prompted with requests for information – and if so how frequently – until it is provided?

4.25 Stakeholders were largely united in the view that first, workforce data is more robust than previously and that it continues to improve; second, that there is strong management commitment and union support for further improvements, but third, that it is impossible

and unacceptable to compel people to provide further E&D information. One step that may assist in improving disclosure levels would be to convey to the workforce why disclosure matters with reference to actions arising from EDDMM.

- 4.26 The second concern over E&D data quality relates to data reliability in some E&D areas. This is acknowledged to be most striking in relation to disability disclosure. HR data suggests that less than 1% of NHS GGC employees have a disability. This is unlikely (although not impossible) given the number of people in the population in the relevant geographical area who report a disability in the Census (although as this report notes later, this may not be the relevant benchmark). It is also inconsistent with responses by NHS GGC staff to confidential surveys:

“Confidential surveys carried out by GGC and confidential staffing surveys that are carried out nationally as well indicate substantially higher numbers of people identifying themselves as having a disability than the formal not anonymous reporting.”

“There are issues of people not declaring some of the protected characteristics but that is a wider societal issue. It would be interesting to see if there was analysis done on whether older generations are less likely to provide information as people are much more open now about religion for example. Those with a disability do not want to be characterised by their disability or see their health issue as a disability even if it might be covered under the Act. This can be problematic when asking for reasonable adjustments.”

- 4.27 This inconsistency has consequences both for the level of understanding around E&D issues and for confidence in the workforce data, which in turn constrains the potential for impact and action:

“ ... data is incomplete and therefore deemed to be a bit unreliable – it doesn’t have the impact it would if they knew it was really good data and consistently collected.”

- 4.28 This issue was the most significant concern raised across the stakeholder group. It may be worth considering more narrowly focussed independent research around the issue of disability disclosure.

5. Data analysis in NHS GGC

5.1 The Workforce Information team provides raw data to the Head of Staff Governance who then produces a Workforce Statistics paper. This paper includes the data referred to in Section 4. The relevant data is presented broken down by known protected characteristics. The data is presented mainly in table and graph format (pie or bar chart) and the figures are presented as headcount and percentage breakdown. There is also some commentary text around these tables and graphs. Some year on year comparison work is carried out to track trends and changes but there is little presentation of longitudinal data and analysis. From 2013, changes have been made to data presentation to include more commentary on the data and statistics provided.

5.2 None of the stakeholders interviewed believed that too much data was collected – although some believed that the reports presented to them could be shorter:

“I’m always wary of getting 25 paged reports because it’s easy to bury something in the bottom half of page 17 so I wouldn’t necessarily say more is better.”

“The information they do get is adequate and allows for the opportunity to read the document and then interpret it. There are other people at the Area Partnership Forum meetings that think 10-12 pages is too much.”

5.3 Union stakeholders felt that the amount of data is sufficient at present. They noted, however, that if they were to engage more with the data collectively then this might drive a need for more information. A number of stakeholders reported that the data revealed interesting things. Many emphasised the importance of striking a balance between “swamping people with data” and focussing on areas that required more in-depth analysis.

5.4 In order to consider how ‘smart’ the E&D metrics are in NHS GGC, it is useful to distinguish between the different objectives of EDDMM. The analysis that is currently undertaken is clearly appropriate for the purposes of meeting regulatory requirements and for reporting to SG.

“There is recognition that the data is adequate because it allows you to do the basic workforce statistical analysis. It would be interesting to produce further analysis for example grievance by gender or another equality category but there is a time and resource issue.”

5.5 It is not clear, however, whether the approach to analysis is driven by any other objectives. Stakeholders were unaware of an overarching narrative that underpinned data analysis and that linked a service focus on diversity with a workforce focus, and there was no clear indication that analysis was hypothesis driven. There is a need, therefore, whether establishing key hypotheses could and should drive data analysis differently.

5.6 A number of stakeholders voiced concerns over the benchmarks for NHS GGC data and targets. The Workforce Statistics data is benchmarked against Scotland’s Census 2011. For

some stakeholders, population statistics provided an ambitious target in relation to some of the protected characteristics; given both the qualification levels demanded in NHS GGC jobs and other job related demands:

“Because so much of the workforce is professional ... they are not representative of a cross section of Glasgow in education and qualification terms so therefore it is quite actually hard to be representative in other ways of the population they serve. That academic qualification thing is a huge differentiator of them (the workforce) from their population. Approximately 70 per cent of their workforce has got a higher education qualification and less than 5 per cent of their workforce are unqualified so that immediately totally differentiates them.”

“There have been some attempts to benchmark against the population, but is the population the right comparison?”

“And that is a problem with disability as well - they have a workforce that is very biased towards people who physically need to be operating at a certain level because a lot of their work is physical professional work so it is kind of a bit of niche ... a lot of other organisations are very different from that.”

“What are they going to do with data? You could say have a target, but what is the basis for that? ... Currently they do not have any analytical evidence that would support that other than that they do believe they have to increase it.”

“Issues of benchmarking against the general population when many disabled people do not work as it sets a very high target.... It may be that the target and benchmark is wrong.”

“Having more meaningful benchmarks would help. Knowing what they should look like is really helpful and maybe a more sophisticated framing of what are reasonable targets would help them.”

“Unrealistic targets annoy people and they say they are never going to be able to do that and you therefore build in failure which is not ideal.”

5.7 There is clearly some merit in constructing more appropriate benchmarks in some circumstances. For example, rather than benchmarking workforce data to the proportion of people in the population with a disability, it may be useful to consider the proportion of people with disabilities in the population who are in employment, or the proportion of people with disabilities by levels of qualification, although care would need to be taken not to blindly reproduce bias in the labour market for the purpose of constructing an alternative benchmark in this particular instance.

5.8 In addition, some stakeholders were concerned about overstating the arguments above and in so doing, closing off more innovative discussions of how opportunity could be extended for people with disabilities:

“One of the risk things about the workforce equalities issue is that people just say they can never be like the population ... and the business they run is not like the people they serve and that is one of the issues about incentivising people to think differently ... for example, they have got a campaign on about disability in the workforce that is partly driven by the fact that a lot of their people say they can't have disabled people because they have got all this

physical work to do and they require people to be operating at a certain level - which is not true across the board and it is not just about physical disability, it is mental disability and other things - so that campaign is directed at trying to get people to think more about concealed disability.”

- 5.9 Looking more specifically at the approach to data analysis, one stakeholder was critical of “still analysing in silos”, that is, distinguishing only between the three main staff groups as this reduced attention to particular job characteristics and work environments. Others were interested in different ways of framing analysis of the data by protected characteristic:

“There is something missing in how it is disaggregated. There might be some other things it would be useful to have. Grade, which part of the organisation you are in, where people work, type of job – having data that you can cut different ways.”

“There are different ways of cutting data ... they have not sliced things by professional/occupational group, which would be another way.”

“The data doesn’t draw attention to within occupation segregation – i.e. women are cleaners and men are porters – but you can see that.”

- 5.10 When looking for nuanced data that requires further drilling down, there is a need to ask the right questions as otherwise the generation of more data is not necessarily useful. There was also an indication of “wanting to get more in amongst the data in a qualitative sense”. For example, a deeper understanding of nuances in the data around recruitment and selection was considered by some to be potentially useful. The importance of a narrative when looking at the data was highlighted as one stakeholder explained, “There is currently no qualitative data collected on any of these issues, so there is no narrative. If they had more of that they would probably get more interest from people in the narrative than just in the data.”

- 5.11 Union stakeholders found the data presented at Area Partnership Forum useful per se and in creating a dialogue between them and management around equalities issues. They noted that management are amenable to their requests for further and better information, even in circumstances where union interest is not related to a personal case issue but rather a more general concern, with examples given of requests for information as to how best to access and attract into employment people with disabilities or people from particular BME backgrounds.

“So the Board do listen when people raise issues about how we are getting hold of these people to tell them there is an opportunity to come and work for GGC.”

- 5.12 A number of stakeholders noted that while aggregate data and statistics were useful, there was no forum for analysis and learning from specific cases or instances.

Section 6: Data findings in NHS GGC

- 6.1 This section will look first at the key findings from the quantitative data collected by NHS GGC and briefly at the most recent NHS wide staff survey. Thereafter the section will focus on stakeholder views around equalities issues for people with particular protected characteristics.
- 6.2 Data from the organisations 'A Fairer NHS 2013-16' report highlights that the workforce is predominantly female (78.7%), there is an under representation of BME for some job families as compared with the general population (except for medicine, dentistry and for health science services); there is an under representation of young people, a significant under representation of disabled people (although there is concern over the reliability of the data on this protected characteristic) and there is evidence of some pay gaps in both directions. Positively, all disclosure levels are increasing and, as one stakeholder noted, while the organisation "have not got an equalities sensitive workforce across the piece ... they have a much more equalities sensitive workforce than they had 10 years ago".
- 6.3 Data from the 2013 NHS-wide staff survey for NHS GGC found that less than half of all survey respondents (41%) agreed that their Board 'acts fairly and offers equality of opportunity with regard to career progression/promotion'. For the minority of staff who said that they had experienced unfair discrimination in the last 12 months (8% reported discrimination from their manager and 9% from other colleagues), just one in three (34%) had gone on to report it and just over a quarter (26%) of these were satisfied with the response received. Staff who did not report unfair discrimination were asked to provide the reason(s) for non-reporting: 90% felt nothing would happen; 81% feared what would happen after reporting; 79% were concerned about confidentiality; 57% thought it would take too long for anything to be done; 33% thought it would take too much time to report it; and 25% were unaware of how to report discrimination.

Gender

- 6.4 Women are over-represented in NHS GGC's workforce. Three key issues were raised by stakeholders in relation to gender inequality: horizontal occupational segregation; vertical occupational segregation and challenges facing women in relation to caring responsibilities.
- 6.5 There is strong horizontal segregation in NHS GGC with women concentrated within particular occupations. As noted at 5.9, some stakeholders felt that the way in which E&D data was grouped for analysis helped to conceal some glaring issues of occupational segregation:

"In the NHS there's an inherent issue around gender inequality with some of that coming from the fact that big tranches of the workforce are women with the two big groups of staff being nurses and administrators. Despite this deep seated occupational segregation, there

are no big discussions or initiatives around gender equality, apart from within union activities.”

- 6.6 Turning to vertical occupational segregation, the management category was highlighted as a concern over gender inequality. As one stakeholder reported:

“... the ratio of women as senior managers is actually very high in Glasgow, but the middle managers ... there is still the dominance of men in promoted posts versus a large number of women in the workforce”.

- 6.7 Stakeholders raised concerns in relation to how requests for flexible working and time off are received.

“There are still issues around some of the arguably softer but equally important issues relating to family and caring responsibilities and the request for time off. This is particularly an issue for single mothers and there are a few cases within the Board relating to this due to the organisation’s 12 hour shift patterns in nursing.”

“There is the view that young new mothers get a tougher time generally speaking in the Board. Despite company policies that try and facilitate, there is a sense of grudging around the time off coupled with the pressure to return to work. This is problematic at a time when the Board is running with quite significant vacancies as a body out of the ward system can be seen as negative, with some areas handling it less appropriately.”

- 6.8 One stakeholder noted that part-time workers have their own equalities issues because they are part-time women workers, citing concerns over part time workers on 10 to 15 hours a week core hours but working an extra 10 to 15 excess hours every week.

“The organisation has recognised this and there is now a process in place across some of the ancillary areas, domestics and catering workers in particular to address this. This is an example of where the workforce statistics have highlighted this issue and [the union] has picked up on this and it has resulted in positive action around an equalities issue.”

- 6.9 Outside of the pay implications of gendered occupational segregation, most stakeholders were unconcerned about gender pay inequality, agreeing that Agenda for Change had explicitly addressed gender pay and removed some historical gender pay inequalities.

Disability

- 6.10 Turning to stakeholder views of the issue of disability, two distinct and related concerns are apparent: first, that EDDMM reveals a significant under-representation of people with disabilities relative to the wider population and second, that the data does not reflect the

actual number of disabled people in the NHS GGC workforce. Most NHS GGC staff disclose their disability status, but there are concerns that staff with a disability are choosing to report that they do not have a disability. Clearly, the extent of the latter concern could in part ameliorate the former concern.

- 6.11 This significant under-representation of disability or of reported disability is a major concern to the organisation. Stakeholders felt that this was a challenge facing other health boards and reflects a number of different concerns: that the organisation may not be offering equality of opportunity to people with disabilities, that staff do not see that having a disability is relevant to their jobs or that they have concerns over the implications for them of disclosing a disability. As one stakeholder noted:

“The disability statistics are quite staggering in an organisation this size, and one that would understand health impact and disability so would expect to be doing better on that front.”

- 6.12 The organisation committed itself to a disability awareness campaign to “increase the proportion of recruits who are disabled and to promote disability as a positive workforce issue”. Part of the campaign work is on positive attitudes to disability. In promoting such positive attitudes, however, stakeholders recognised the challenges of separating out discussions of disability with discussions of sickness absence in order to avoid unconscious unequal treatment of disabled staff.

- 6.13 A number of stakeholders suggested that the appropriate benchmark for representation of staff with disabilities in the NHS GGC workforce should be around the percentage of disabled people in the wider population. However there was no real discussion of why this is the right benchmark. Evidence suggests that disability impacts on education, therefore perhaps the issue is more complex given the qualifications profile of NHS occupations.

- 6.14 Union stakeholders voiced significant concerns around disability, particularly as the disabilities agenda relates to absence management, reasonable adjustments and employability issues (rather than employing issues). They reported on enquiries from individuals who are disabled or have disability related health issues who are being disciplined for non-attendance at work, and that obtaining reasonable adjustments can be problematic, citing a resistance, a lack of knowledge and sympathy around providing reasonable adjustments in some cases.

- 6.15 A number of stakeholders identified structural barriers that may impact differentially on staff with a disability: how reasonable adjustments are funded; absence management policies and pressure on workloads/services. These concerns are outlined clearly in the quotes below:

“We are looking at getting managers to be more open to the realities and contribution of people with a disability in the workplace and not seeing it as perhaps pressures on their budget to make special adjustments.”

“One of the other areas they need to look at is adjustments budget being discrete so that you can draw on that rather than your managerial budgets. You ring fence it – it’s a central budget – whereas in health you would need to find a resource within departmental budgets.”

“Managers may see that someone [a non-disabled person] who is going to be a bit less hassle then they are more likely to go with that individual because of the pressure that they have got in terms of just delivering the service.”

“It might be worth considering taking people with a disability out of the absence standard.”

Age

- 6.16 Stakeholders identified two key challenges in relation to issues of age. The first relates to the low proportion of young people employed by NHS GGC. With 60 per cent of the workforce being professionally qualified, underrepresented of young people in these jobs is inevitable. Better benchmarks for young workers in particular jobs and parts of the organisation – allied to future career pathways – are likely to be a better guide to any future action to address the proportion of young people in the workforce.
- 6.17 The second relates to the challenges of an aging workforce, particularly in jobs such as nursing with a significant physical component, and in the context of the removal of the retirement age and the likelihood that more of the workforce will want to work longer.

Ethnicity/Race

- 6.18 As indicated previously, the health service has a more diverse workplace in relation to race than other public sector organisations, largely due to the proportion of BME doctors, dentists and nurses. Stakeholders did raise concerns, however, that in some jobs/occupations, BME workers were significantly under-represented. However, there was little discussion as to what action could/should arise from this.
- 6.19 One stakeholder suggested that more work might need to be done with the Eastern European workforce to see whether they are as comfortable declaring protected characteristics as other groups.

Faith

- 6.20 No significant issues around faith were raised across the stakeholder group.

LGBT

- 6.21 Stakeholders noted from personal knowledge that some parts of the organisation are not as gay friendly as others. This data is not, however, drawn from workforce statistics, and suggestions were made that data on the presence of LGBT staff be analysed by work location (both service unit and geographical).

Section 7: Data dissemination and Impact in NHS GGC

- 7.1 Since 2009-10, the SGC has met every four months and at each meeting a Workforce Statistics paper, presented by the Head of Staff Governance, has been a standing item. From the SGC the data is also presented at the Area Partnership Forums on a monthly basis. One third of APF meetings focus on a strategic level issue, with the other two focussing on workforce issues.
- 7.2 Improvements have been made to the presentation of E&D data in recent times following insight into commended practice elsewhere. The Workforce Statistics report now places greater emphasis on action from the findings rather than presentation of the findings.
- 7.3 Some stakeholders on SGC suggested that there was little engagement by members with the E&D data. Others noted that engagement was a function of moving beyond the data to action.

“They are doing it because they are required to do it but that cannot just be it as that would be terrible. It needs to be leading to some action and change.”

“You need to show it’s not just a tick box thing, it is actually trying to make change.”

- 7.4 Efforts are being made to encourage more engagement with and reflection on E&D data, for example, by the use of illustrative case studies of responses to EDDMM or roadshows to focus attention, particularly on disability.
- 7.5 Data can be disaggregated to operational units so that data is available for Directorates and CHPs. This data is disseminated to the relevant management teams. However, it was less clear to stakeholders what arises from this dissemination – that is, what operational management do with it. Some stakeholders felt that EDDMM was seen as an organisation-wide issue and therefore not really owned by operational units or properly interpreted for their own units. Others felt that E&D would be more mainstreamed if all HR staff took greater ownership of it. There have been efforts to encourage operational managers to make presentations on E&D data at their level although detail on this was sparse.
- 7.6 Some E&D data is also published online. No reference was made to monitoring of data traffic to identify how widely it is accessed.
- 7.7 NHS GGC also respond to request for E&D data dissemination from Scottish Government and to Freedom of information requests.
- 7.8 Turning from dissemination to impact, the EDDMM clearly has an impact in terms of how it is used thereafter by key players, notably HR and CIT. The most obvious impact is in how the

data meets regulatory requirements directly (via the required reporting mechanisms) and indirectly in terms of the development of policy and initiatives to address any unequal practices and to mainstream equalities into wider organisational activities. In addition, the data can have more diffuse impacts on other stakeholders. These are considered in turn below.

- 7.9 NHS GGC meet all of its statutory requirements in terms of collecting, analysing and reporting E&D data. This data is then used to construct policy for the future – notably, A Fairer NHS Greater Glasgow & Clyde 2013-16. This document outlines the Board’s commitment to ‘an Inequalities Sensitive Health Service in which the workforce represents a diverse population’. Key goals include:
- Enhance disclosure and improve the availability of disaggregated staff information.
 - Address remaining barriers to recruitment and retention, with a particular focus on disability, BME status and gender.
 - Enhance the ability of staff policies to meet the needs of equality groups, specifically addressing pay gaps and assessing parental leave.
 - Enable staff from equality groups to feed back their views to the organisation, notably through the establishment of a network of staff equality forums.
 - Create a non-discriminatory working environment and a workforce which has the skills to tackle inequality.
- 7.10 Plans are in place to further embed the tackling of discrimination and inequality into all organisational activities and to reinforce this via Development Plans and Performance Management Systems.
- 7.11 Plans are also in place to extend equal pay monitoring from considering gender alone to include the protected characteristics of race and disability, and to identify whether there is any clustering effect of employees sharing a particular protected characteristic in specific jobs or grades. More nuanced analysis of equal pay and the relationship to occupational segregation and protected characteristics is to be welcomed and may benefit from more hypothesis-driven analytical approaches.
- 7.12 A number of initiatives have followed from EDDMM, including an anti-homophobia initiative, entry into the 2012 Stonewall Workplace Equality index, a campaign to publicise the rights of disabled workers and encourage disclosure of disability to the employer and a baseline survey on inequality. In some campaigns, Board members/NEDs, unions and staff has combined as champions for equality on specific issues and initiatives.
- 7.13 Turning beyond impact on reporting on policy, the impact on key stakeholder groups will now be looked at in turn to assess the level of interest in and action arising from E&D data reporting.
- 7.14 At Board/SGC level, stakeholders reported that interest in E&D data varies. Some stakeholders noted that the board itself is not particularly diverse, although it has a number

of members who champion activity around particular protected characteristics. A significant concern with equal pay issues was noted by some stakeholders, motivated in their view by concerns over exposure to risk. In addition, the agenda around disability was reported to have become a more important focus of the Board/SGC in recent times.

- 7.15 A few stakeholders raised a concern which is not unique to NHS GGC – that EDDMM is seen as the province of E&D or HR specialists, and not requiring of action by others in the organisation:

“... equalities colleagues become the conscience of the organisations so other people can just think ‘business as usual’.”

“People like Andy become the receptacle for all things related to those workforce statistics so it becomes somebody’s individual world rather than being permeated through the organisation.”

“One of the issues about the whole data collection and its challenges is that people do not see the connection between that and the equalities agenda even if they believe in the equalities agenda.”

- 7.16 The latter quote also signals another concern by Board/SGC members – that EDDMM monitoring only becomes significant when it is a spur to action. As one noted:

“... it tends to be largely descriptive rather than action orientated. It describes where they are, rather than actually saying they are fundamentally going to do something different.”

- 7.17 Looking at the wider management group, there is some evidence that an equalities agenda has become an increasing focus for this group, in formal terms at least, particularly through equality impact assessments for new policies.

“Everybody on their senior management team will have a set of objectives about reducing inequalities, regardless of what job they do. That is always the message right from the top of the corporate plan down. It would be a feature of what managers are asked to do, an expectation that it is an explicit part of their performance management which will all have an objective about equalities. A systemic thing is that it’s supposed to then cascade down to the people who work for them.”

- 7.18 It appears, however, that this is stronger in relation to service equalities issues rather than workforce equalities issues, and stakeholders showed limited awareness of meaningful engagement with workforce EDDMM beyond stakeholders with a specific accountability for it.

“As an organisation we have been good at that formal stuff but it remains a hearts and minds battle how that is then applied by people in practice.”

- 7.19 Stakeholders were concerned that while workforce EDDMM was a significant focus of attention at a strategic level, and despite data being disaggregated and disseminated to operational level, EDDMM was not considered an operational issue by many managers.

“There will be in some strategic and higher level performance desire to see how things are moving, but not impacting on operations as much.”

“There is no doubt it could make a greater impact at department and operational level. It tends to be seen as a more strategic issue.”

“Managers across the service do not see this as an operational issue at this stage. One of the things that they want to get out of this project is how do they operationalise this agenda because if you are a manager responsible for delivery you are more interested than just making sure that you have adequate staff there in order to fulfil the shifts and meet the demand, how that workforce is made up then probably they are bit less focused on.”

“It isn’t clear that it (workforce E&D data) is currently owned by section heads.”

- 7.20 Encouraging operational managers to engage more with workforce EDDMM has two key challenges: first, reluctance at corporate level to directly intervene in operational entities and issues, and second, no real understanding as to how, in a practical sense, operational managers might be encouraged to engage more with this agenda. As one stakeholder noted, “People are well motivated but not sure what to do in terms of the specific action.”

- 7.21 Turning to the interest in, and impact on, unions, all union stakeholders reported that E&D data had improved, that requests for data were met positively and that there was widespread commitment across stakeholders to an E&D agenda in principle. They acknowledged, however, that their engagement with EDDMM was limited and that this generated some frustration among other stakeholders. However, union stakeholders raised concerns about the time they had available to engage further with the data and on the lack of action arising from the data.

- 7.22 Some union stakeholders reported relatively little active engagement with EDDMM largely due to capacity and time constraints. A number of related comments from union stakeholders are outlined below:

“Yes, we get the workforce stats out and we can ask questions about that but I’ve tended to dip into it. I wouldn’t say it’s something that I put first on my agenda and I’m being honest with you there.”

“If I’m absolutely honest I give the demographic kind of breakdown stuff a cursory glance.”

“I would say that for one reason or another it’s not an area that we push well enough...in terms of our involvement, it tends to be hard end of trade unionism. We don’t get involved in the sort of helicopter stuff sort of looking down on the stats.”

“I struggle with NHS Greater Glasgow and Clyde to do the pay and ration stuff, the basics is a challenge at times.”

- 7.23 Management stakeholders also pointed out that unions and employee partners were more focused on industrial relations concerns and were unaware either of a clear union-side equalities strategy or of independent E&D data.
- 7.24 Some concerns were raised about the level of engagement of the professional unions represented on the APF with EDDMM beyond those that directly impacted their professional area. As one noted, “they represent their silos, not themes”. This, it was argued, left more of the work of engaging with EDDMM to the general unions.
- 7.25 Unions reported involvement around issues of equal pay and Agenda for change, but mainly at the end of these processes. No significant equal pay issues were raised by union stakeholders.
- 7.26 In terms of disseminating E&D data, outside of those who receive information as members of the APF, information is also made available to other stewards/representatives. “The reps are made aware of it, but what they do with that or not is another matter.”
- 7.27 Union stakeholders noted that the key to engagement with EDDMM was in its link to actions and outcomes.

“There is also the question of the value of the data - for example bringing forward the disability leave policy request that was rejected ... if you are going try and drive the equalities agenda then you need something to work with.”

“For me analysing the statistics is not where it’s at, it’s the practical fall out from that and my feeling would be that while there are people who are enormously committed to that agenda within the organisation, organisationally NHS GGC are not able, willing or fit enough to take it to the next kind of stage you know they don’t want to be ground-breaking because that’s hard.”

- 7.28 E&D data should be disseminated to staff partnership forums within Directorates. Stakeholders talked of ‘hoping’ that these forums dealt with this data - “ ... you would hope that appropriate data would get to a level where you could make it fit for purpose” – but it was unclear from stakeholders whether this actually happened.
- 7.29 It is not clear that workforce E&D data is disseminated to or accessed by non-management staff.

Section 8: Equality and Diversity monitoring in CO

- 8.1 NHS GGC have access to data and statistics through the Information Services Division at SG to facilitate comparison of equality outcomes across health boards. For the purposes of this review, a comparator outside of the health arena was chosen in order to access new data and to consider approaches from another type of service delivery.
- 8.2 There are very few appropriate comparators to NHS GGC in terms of workforce; for the purposes of this evaluation, a number of comparators were considered. While a private sector comparator might have been illuminating in some ways, the lack of GED requirements on private employers limits such a comparison. A public sector comparator organisation was selected, hereafter referred to as CO, on the basis of a number of criteria but notably on the basis of workforce size. Documentary sources were consulted, including publically available documents and privately provided documents. A list of the same questions asked to the NHS GGC stakeholders was addressed to two key informants in CO. It should be noted that, due to the limited scale of this evaluation project, the evaluation of CO was not of the scale of the evaluation of NHS GGC and there was no triangulation of data sources at CO as there was in NHS GGC. The remainder of this section outlines CO's data and how CO key informants answered the relevant questions, along with any implications for NHS GGC.
- 8.3 The collection of data by CO has been an evolving process in terms of the type of information gathered and how data is captured. Over the last 12 years they have started to capture increasing amounts of workforce data and continually monitor and review that data. In the past they mainly collected basic workforce information in relation to full time employees, gender and ethnicity breakdown. This was also collected at the service level using a template format that would be sent from service level management to corporate HR where they would manually collate this information. In 2002, CO moved to a single database for employee data and services.
- 8.4 CO identified two primary drivers for EDDMM: business requirements and statutory duties. Data is only collected where there is a specific need for it. Beyond meeting their legal requirements, CO collects data for the following reasons:
- To measure the effectiveness of HR strategy and HR Equality and Diversity Action Plans.
 - To engage in best practice to allow benchmarking with comparator organisations.
 - To allow analysis of the workforce across all areas to identify areas of potential discrimination and advance equality of opportunity across the organisation and within individual services; to identify action points and make action plan recommendations for senior management.
 - To compare workforce profile information with population data.
 - To assist in developing evidence-based policy and associated cost savings (for example, costs savings associated with different work-life balance options).

At CO, business drivers were more prominent in the reasons given for E&D data monitoring than in NHS GGC.

- 8.5 The decisions on what data to collect and analyse are taken by the Head of HR or the Corporate Management Team on the advice of the Head of HR. Corporate HR identifies information requirements and works closely with Customer and Business Services (CBS) - who are responsible for maintaining and developing the payroll and HR system – to identify areas of development for recording data. The HR team also works with CBS to explain the rationale for data collection and to identify reporting requirements should this information not be available from existing data systems. Service HR and Strategic Policy and Planning are also involved in the data collection process. In organisational terms, there is little difference in who is responsible for EDDMM in CO and NHS GGC, although CO does not have an equivalent to NHS GGC's CIT. In CO, HR has primary responsibility for all equality statistics.
- 8.6 As in NHS GGC, data is collected from application forms, equal opportunity monitoring forms and payroll data. Data subjects do not include casual or sessional workers and those on zero hours contracts unless they have been paid in the relevant pay period. Depending on the type of information that is being analysed, some reports are either produced from payroll/HR system for each service together with corporate information. Where information is not on the HR system, each service provides information in a template format which is then submitted to HR and integrated into the corporate information. Corporate HR co-ordinate the collation of E&D information for CO. Depending on the type of information some reports are either produced from the payroll/HR system for each service together with corporate information.
- 8.7 As in NHS GGC, no other data sources were prominent, either from line management, unions or equality representatives.
- 8.8 Corporate HR collates a range of information on behalf of CO regarding its workforce and potential workforce. This includes:
- Profile of its workforce by specific age bandings, gender, ethnicity, disability, disability type, sexual orientation and religion or belief.
 - Number of applications received, interviews carried out and appointments made, including whether applicants are currently employed by CO.
 - Number of leavers including their length of service and reason for leaving.
 - Number of grievances received.
 - Number of disciplinary actions taken including the reasons for the action and the action taken.
 - Number of bullying and harassment complaints received and outcome of these.
 - Number of training and development activities carried out including applied and approved (if appropriate).
 - Number of employees who have started and returned from maternity/adoption leave; number of employees who do not return and the reasons for this.

- Number of flexible working requests received and whether they are approved or declined.
 - Gender Pay Gap and Occupational Segregation information for the whole workforce and for distinct services.
 - Top 2% and 5% of earners in CO who are female.
- 8.9 All of the above reports (with exception of the top 2% and 5% of earners) include a breakdown of specific protected characteristics (gender, ethnicity, disability, disability type, sexual orientation and religion and belief) for all employees/potential employees. In addition, CO collect data on the number of employees who have applied for work life balance options (e.g. buying additional annual leave, career breaks and 9 day working fortnight) and associated cost savings. Overall, CO collects a slightly wider range of E&D data than NHS GGC.
- 8.10 Separately, CO conducts an organisation wide staff survey every three years. Responses are analysed by age, disability, gender, race, religion or belief and sexual orientation where respondents disclose that information. Key findings from the most recent survey suggest that around one fifth of staff with a disability felt disadvantaged on account of their disability, and that staff with a disability were significantly more likely to report being dissatisfied in their job than other staff. A higher proportion of staff felt disadvantaged because of their age than because of a disability, particularly at the start and end of their working life. One in eight respondents feel disadvantaged because of their gender but this is just as likely from both men and women. It was not clear from the data provided what actions, if any, had followed this survey. It appeared to be the case, however, that this data sat quite separately from HR/payroll data used for reporting purposes.
- 8.11 No additional data collection needs were identified by CO informants. New data needs are assessed in the process of policy development or amendment and additional information needs are then highlighted. In addition, there is an annual review of information collection to identify any changes in the form of collecting additional data or ceasing to collect data.
- 8.12 CO informants noted that data quality is dependent on the quality of the information on the payroll/finance system. From a validity of data aspect when Corporate HR have collated all information, services are sent courtesy copies of those reports produced by Payroll/HR system. They review this information to make sure that it is accurate. Any issues are addressed and updated at that point. No major concerns were raised as to the quality of this data beyond some transitional issues during the shift to a new Payroll/HR system.
- 8.13 CO currently has high rates of non-disclosure for disability due to a transfer in the past to a new payroll system where data transfer was not compatible. There are also high rates of non-disclosure for religion or belief and sexual orientation due to them being new reporting areas where they have not asked the workforce employed pre 2011 to provide this information. However not all employees have been asked to update this information. Those employees that are PC facing can update their personal information. New employees are asked to provide data as they come into the organisation and can update it thereafter.

- 8.14 CO have an action within their E&D plan to rollout an awareness raising activity informing employees why information is gathered, and what is done with it, before asking them to update their information.
- 8.15 Turning to data analysis, all of the data reports include a breakdown of specific protected characteristics for all employees/potential employees. Data is also broken down by service unit. All data analysed is benchmarked against census data for the relevant geographical area and this is regularly updated in line with changes in the relevant geographical profile. A detailed list of analysis variables is included in Appendix B.
- 8.16 Data is analysed on a quarterly basis by both Corporate HR and each service identifying any reasons for change during the period together with notes of the key points and any activities which may have impacted on the changes in data. Currently this analysis is completed by a person reviewing the data rather than software analysing the data. There is, therefore, some service level engagement with the data, although this remains an HR function.
- 8.17 On a quarterly basis, equalities information is presented in excel spreadsheets. Actual numbers are presented rather than percentages, although percentages are used for key measures. It is not, in the view of the authors of this evaluation, particularly useful to have data in raw numbers rather than percentages, although the small percentages involved present challenges in terms of the most appropriate form of presentation.
- 8.18 Data analysis at CO appears to be more significantly disaggregated than in NHS GGC and also controlled across protected characteristics. To illustrate, the workforce profile by disability looks at:
- % white disabled (male, female, total)
 - % black and ethnic minority disabled (male, female, total)
 - % total disabled
 - % total non-disclosed
- This is then repeated for non-disabled workers. All of this data is then broken down by:
- Overall by grade, FT and PT
 - Overall by service, FT and PT
 - Discrete service units overall by grade, FT and PT
- 8.19 A similar approach is taken to analysing the workforce profile by ethnicity and gender. There is extensive analysis of age not just by disability/non-disability/non-disclosed but also by type of disability (deafness or partial hearing loss, blindness or partial sight loss, physical disability, learning disability, learning difficulty, mental health condition, long-term illness, developmental disorder, other condition, not disclosed). Age is also extensively analysed by sexual orientation, ethnicity, religion and belief and gender.

- 8.20 A detailed analysis of disciplinary action, reasons and outcomes is carried out broken down by disability, disability type, ethnicity, religion and belief, sexual orientation and gender. The same approach is taken to grievances and to complaints of bullying and harassment.
- 8.21 Detailed statistical analysis is undertaken of leavers and exit categories are broken down across the protected categories.
- 8.22 Analysis of applications/recruitment is broken down by all protected categories and by maternity/adoption leave, which is also broken down by protected category. Metrics are calculated reflecting the percentage chance of being successful at each stage of the recruitment and selection process for applicants across the protected categories. CO key informants believe these are helpful in focussing attention on the different chances of success rather than the differing proportions of any particular protected group in the workforce. Most recent reports show an increase in the chances of being invited to interview for all equality categories.
- 8.23 A similar approach is taken to requests for flexible working and outcomes, contractual types, applications for 9 day working, applications to buy annual leave and career breaks. The percentage chance of having an application for flexible working approved is the same across all equality categories (overall, 93% of requests are successful and most are made by women).
- 8.24 In terms of E&D data findings, and using Census 2011 in relation to the relevant geographical area as a benchmark, CO is able to identify that their workforce is predominantly female (70%), that the majority of part time workers are female, and that their workforce has under representation of both black and ethnic minorities (who apply for jobs at CO in small numbers) and disabled people. BME staff comprises 1.8% of CO's workforce while disabled employees make up 2.5%.
- 8.25 In terms of data quality, CO has high levels of non-disclosure in each of the protected characteristics other than gender: 25.5% of employees have not disclosed their race; 92.3% have not disclosed their disability status.
- 8.26 In terms of equal pay, CO has a small pay gap in favour of women (-0.54%), although this includes a small pay gap in favour of men (2.75%) in one distinct occupational group.
- 8.27 There is evidence of vertical occupational segregation at CO's grade 8 and above, and of horizontal segregation " ... that match what is described as societal norms".
- 8.28 To meet statutory duties, E&D data is reported to CO's policy development and scrutiny committee and is made public online. Prior to this, E&D data was reported to CO's Corporate Management Team. A yearly analysis of all management information, including E&D action plans, is prepared and a report of this is shared with the corporate HR senior team. As yet, this is not shared at service level although plans are in place for this to happen in future.
- 8.29 Key informants at CO indicated that their HR strategy and Equality and Diversity HR action plan has actions identified to make sure that the equalities monitoring currently undertaken is robust and employees are actively encouraged to update their personal information.

They note that while there is 'buy in from management on the importance of E&D issues, a dedicated action plan was required (and is now in place) to show explicitly the link between the data collected and reported and the outcomes achieved. In future, each service will be required, as part of their Annual Service Plan and Improvement Report, to identify relevant activities and outputs that support equality outcomes.

- 8.30 CO has constructed an outcomes logic model for equalities in both services and workforce matters that links challenges, activities and outcomes. Challenges were outlined via an evidence review that presented a baseline of key facts and figures. Activities identified the relevant development, management and operational activity. Outcomes were identified, mapped to each area of concern in the evidence review, as the changes or effects that could result from an action the Council has taken aimed at eliminating discrimination, advancing equality of opportunity or fostering good relations. Each outcome has an indicator against which future progress is to be reported. While much of this model focuses on services rather than workforce, the model itself has some merit in focussing attention on what activities are likely to result in improvements in specified outcomes measures.
- 8.31 CO does not have employee partnership structures, although it recognises a number of trade unions for bargaining purposes. CO key informants reported no dissemination strategies in relation to E&D data that involved union representatives, shop stewards or equalities representatives.
- 8.32 The key differences between CO and NHS GGC are as follows:
- A wider range of data is reported on in CO.
 - There is more detailed analysis of breakdowns by protected characteristics in CO – notably, there is more detailed analysis by grade rather than very broad job families as in NHS GGC.
 - CO appear less concerned about levels of disclosure of equalities data, despite the levels being considerably lower than at NHS GGC.
 - Unions appear to play no role in E&D data monitoring in CO.
 - It was not clear, in the view of the authors of this evaluation, how E&D data monitoring related to business/service issues, although this was reported as an objective of E&D workforce data monitoring.
 - CO outcomes logic model could be adapted in relation to workforce E&D data in NHS GGC.

Section 9: Summary and recommendations

- 9.1 All stakeholders agreed that E&D data collection and quality in NHS GGC had improved significantly in recent years. In addition, a number of stakeholders noted that NHS GGC EDDMM is better than in other health boards. There was widespread acknowledgement that the organisation needed to respond to regulatory requirements and that an effective response has been delivered.
- 9.2 Beyond responding to regulatory requirements, there was no clear narrative across the stakeholders interviewed as to any other driver of E&D data monitoring. The role of data in supporting operational and strategic objectives was not well rehearsed or understood: for example, what was the role of E&D data monitoring in improving service delivery or bringing about organisational change. If data monitoring has no role beyond meeting regulatory requirements, this presents no problem. If it has such a role, and some stakeholders alluded to what that role might be, this needs to be more clearly conveyed to a broader group of stakeholders. This is essential to enhancing stakeholder engagement with the data. A clearer statement of what E&D data monitoring is for is therefore required. Recent years have required focus on regulatory compliance; some stakeholders felt that the time was now ripe to move beyond compliance to being more proactive in using data monitoring to support other objectives. A key question that needs to be answered is, what is the data for, and what metrics will deliver the outcomes sought?
- 9.3 NHS GGC might benefit from greater reliance on a wider range of data sources to interrogate the quality of workforce data. Staff survey data is already presented and has focussed attention on the differing findings of anonymised against non-anonymised data. Similarly, data from other sources such as relevant union surveys should be compared with workforce data in order to ask more nuanced questions of workforce data. Alternative data sources allow for a more searching interrogation of E&D data, as the quote below illustrates:
- “It seemed an obvious question to ask why there is such a discrepancy between the anonymous declaration and the non-anonymous declaration and that seemed to suggest that perhaps people could be fearful or concerned about declaring a disability at work which is not unique to this organisation.”*
- If there are serious concerns over reasons for non-disclosure, this may be an area amenable to future independent research.
- 9.4 There is no data emanating from operational management relevant to E&D. This data could provide a better narrative around E&D data informed by how equalities issues are experienced in operational settings. Operational management should be considered as a source of both quantitative data (for example, information on informal flexible working adjustments or informal disability adjustments) and qualitative issues (for example, on how significant E&D issues are in their teams/units).

- 9.5 No stakeholders argued in favour of collecting additional quantitative data without a strong rationale for it. Some gaps in the data collected were acknowledged (e.g. maternity data at recruitment) and plans to address this with the new eEss system. Many stakeholders, however, wanted more qualitative data that would allow consideration of the issues around the data. Better understanding of the issues through better qualitative data could in turn inform the development of quantitative data collection. To illustrate, generating qualitative data around absence management and disability issues might inform discussions of possible under-reporting of disability. Stakeholders wanted less of a focus on 'numbers' and more of a focus on the issues underlying the 'numbers'.
- 9.6 There were, however, some areas where additional data would be of interest to stakeholders – for example, on requests for reasonable adjustments and requests for flexible working.
- 9.7 Data analysis is largely undertaken by one individual. This raises an issue of risk in terms of tacit organisational knowledge available to the Board and the Corporate Team.
- 9.8 Data analysis is not explicitly hypothesis driven. For example, is disaggregating data by job family the best way to cut the data? Stakeholder knowledge of where E&D issues are likely to be concentrated should drive hypotheses for testing through data analysis. Might different results be achieved if data was analysed by grade or unit? Similarly, what is the argument for benchmarking results against census data for protected categories? Should the benchmark for the representation of people with disabilities be the percentage of people with disabilities in Scotland/West of Scotland, or the percentage of people with disabilities who are employed, or the percentage of people with disabilities who have different levels of qualification, with the latter matched to NHS occupations by required qualification?
- 9.9 Data is presented in terms of year on year change. While this is useful, a more longitudinal approach might help both to show progress and to highlight intractable issues.
- 9.10 Data dissemination without action and impact are unlikely to engage stakeholders further. Greater engagement with the data might be achieved by foregrounding action plans and backgrounding descriptive data, for example, by having detailed data reports available on-line and focussing on action plans around a smaller number of key areas. Reporting previous actions based on data might also focus attention on the potential of data as a stimulus to action.
- 9.11 From the stakeholders and data, the key concerns and possible action areas are around the representation of people with disabilities and from BME communities, and gendered occupational segregation. As a precursor to further action in these areas, a stronger evidence based and hypothesis based narrative around under-representation might encourage greater engagement with the data and consequent action.
- 9.12 According to stakeholders, the key to increasing levels and accuracy of disclosure is clear evidence of the impact of data monitoring. Ensuring impact requires identification of structural barriers and structural facilitators. Looking specifically at disability, stakeholders

identified two areas of concern in terms of structural barriers: the impact of absence management policy on the likelihood of disclosing a disability, and the impact of budgetary arrangements on the likelihood that staff will request reasonable adjustments (which requires the disclosure of a disability) and on how such requests might be responded to.

- 9.13 In terms of structural facilitators that could improve interest in and engagement with E&D data, some thought needs to be given to how performance management, particularly for managers, might be used. As one stakeholder noted:

“The first tack is with the managers and the second phase will be with the staff of the organisation with a hopefully greater confidence that their managers will respond positively to it.”

“If there was some performance management rigour in that then it might have more traction at a more local level.”

Performance management for senior staff currently has an equalities dimension although this tends to be more service related rather than workforce related.

- 9.14 A very positive element of the evaluation was the level of trust between stakeholders, who attributed to each other considerable support for an equalities agenda and who were overwhelmingly willing to applaud good practice. The backdrop of partnership appears to contribute to this climate of trust.
- 9.15 There was recognition that some equalities data and issues are not analysed further because of the volume of work and understanding and concern about the costs of this. Investigation of additional capacity without costs (for example, an ESRC PhD intern or the use of Masters student projects) may be worth considering.
- 9.16 One underused source of capacity in the E&D area is equalities representatives and these representatives seem to be marginal to any discussion of equalities. This is unusual given the explicit expectation that through the appointment of equalities representatives, equality duty activity and union activity would “come together to inform data collection, analysis, dissemination and outcomes” (TUC). Consideration should be given as to how to best utilise the access and expertise of equalities representatives within NHS GGC.
- 9.17 In comparing NHS GGC with CO, it was clear that much of the activity carried out by both organisations is similar, which is to be expected given the key role of regulatory compliance in driving recent approaches to EDDMM. In terms of engagement and dissemination to staff, NHS GGC’s practice was more impressive. The data on CO offers helpful insights into the level of data analysis that is possible and the importance of logic driven approaches to identifying challenges, solutions and outcomes.
- 9.18 As part of the process of generating a narrative around EDDMM that goes beyond regulatory compliance, NHS GGC should clarify its ambition in this area - does it wish to be, and can it be, groundbreaking? In addressing this question, it is worth acknowledging, as one stakeholder did, the “in built emotional tie to the whole agenda – the public sector value

and ethos that most staff have is about being fair and reasonable and inclusive.” This represents an important strategic facilitator of improved E&D practice.

Key recommendations:

1. NHS GGC needs to clarify its objectives for workforce EDDMM beyond meeting regulatory requirements. NHS GGC at present, and taking into account planned changes, appears compliant with relevant regulatory requirements. Asking the simple question “what is EDDMM for, beyond meeting legal requirements?” is a necessary first step in producing a line of reasoning that guides EDDMM, supports strategically important action and engages all relevant stakeholders.
 - There is a need for a clear and consistent narrative connecting service EDDMM and workforce EDDMM. The case for service EDDMM is clearly specified in NHS GGC; the case for workforce EDDMM appears as a second order consideration from service equalities issues.
 - There is a significant emphasis in service EDDMM on the impact of socio-economic status that does not appear in workforce EDDMM that might usefully address reflections on what are the non-regulatory objectives of EDDMM.
 - There is a need for a clearly defined business/operational case for EDDMM that specifies relevant organisational risks and opportunities. At present, there is no narrative that connects EDDMM to operational issues such as employee retention, satisfaction, engagement and commitment.
 - In defining objectives for EDDMM, stakeholders need to decide whether the organisation wishes to be compliant, developing or path-breaking and what each of the latter would mean in practice.
2. These objectives need to be ‘owned’ more widely than by the HR or Inequalities team:
 - While corporate personnel have a key role in stimulating action around defining objectives and proposed actions around workforce EDDMM, operational management involvement is crucial to defining the business drivers of EDDMM.
 - Establishing a clearer link between strategic, operational and EDDMM objectives should be used to strengthen ownership of E&D data across HR and corporate teams.
 - Existing high levels of trust in relation to, and positive commitment to, E&D provides a strong basis for a genuinely collaborative approach across a wider group of stakeholders to defining EDDMM objectives.

3. Additional data collection from operational managers, equality representatives and unions may complement existing NHS GGC data and support better interrogation of existing quantitative data.
4. On key priorities, consideration should be given to collecting better qualitative data – what stakeholders refer to as the ‘stories behind the numbers’. Qualitative data alongside existing organisational knowledge is key to generating hypotheses to guide quantitative data collection and analysis.
5. Qualitative data is required in three key areas: requests for reasonable adjustments, requests for flexible working and, crucially, on the reasons for non-disclosure of E&D data. This data could be collected through existing data collection mechanisms or bespoke data collection mechanisms. Exit interviews might be used more systematically to identify E&D issues.
6. A more focussed approach to EDDMM should include hypothesis definition for testing. Hypothesis should be constructed using existing knowledge. To illustrate, if there is a view that parts of the organisation are less LGBT friendly than others, analysis of data by work unit rather than job family may be more fruitful. It would be useful to begin with a limited number of key hypotheses for testing, focussing on E&D issues that pose greatest risk (legal or reputational liability) and those that are most important to helping the organisation perform.
7. Key stakeholders need to consider the use of logic driven approaches to identifying E&D challenges, solutions and outcomes. Within this, there is a need to use tacit and explicit organisational knowledge to develop hypothesis for testing. To illustrate, if employees fear disclosure of a disability may lead to negative consequences for them, this provides a hypothesis in which the experiences of staff with disabilities who have or have not disclosed a disability may be compared. In developing hypotheses, it is important to use conflicting data constructively to interrogate and improve formal data collection.
9. Consideration must be given to the limitations (and strengths) of analysis by job family category alone. More exploratory analysis of data by alternative units of analysis (e.g. grade, service, location) should be considered and results compared.
10. The choice of benchmarks for comparison should also be logic driven – benchmarks need to be appropriate and defensible in context. Some existing benchmarks may be inappropriate and risk building failure into the EDDMM system.
11. Data analysis should explore the experiences and outcomes of staff who fall into multiple protected categories – e.g. black women or male manual workers with disabilities.
12. Chances of success measures may be more helpful than proportion comparisons in analysing data on recruitment and selection and on promotions processes. These are much more likely to focus attention on behaviours in the process rather than outcomes of the process.

13. Logic driven approaches and hypothesis testing must take into account the interaction of other organisational systems on EDDMM – such as absence monitoring, promotion procedures and resource allocation.

Reporting/Dissemination

14. All data does not need to be reported at all opportunities. Foregrounding key issues while backgrounding issues where there are few concerns will help to focus attention on issues requiring greater engagement and attention.
15. To support (14), it may be worth reporting summary trends over a defined period (for example, a rolling 5 year period) using summary indicators – for example, ‘↑’, ‘↓’ or ‘-’ (as in Scottish Government’s Scotland’ Performs reporting).

Action and Impact

16. Acknowledging that there have been recent moves towards action oriented rather than descriptive reporting, an explicit adoption of action oriented reporting should be encouraged.
17. Examples need to be developed that show the relationship between EDDMM, action, impact and outcomes – successful outcomes can then be used to illustrate the importance of EDDMM across the organisation.
18. Ensuring impact requires identification of structural barriers (e.g. budgetary arrangements, conflict with other policy areas such as absence management) and structural facilitators (e.g. partnership structures, high levels of trust, performance management systems). Performance management systems for managers should be considered to improve engagement and impact.

Capacity

19. Benefits might be achieved by using internal capacity more effectively. Unions and union equalities representatives are a potentially useful source of information and capacity for impact although are significantly underutilised at present. Consideration should be given as to how management and unions in partnership can involve equalities reps more effectively.
20. ‘Free’ external capacity opportunities might allow for greater activity in data analysis and reporting, or to generate new qualitative data – for example, ESRC Phd Intern students or through giving access to supervised Masters/MBA student dissertation projects. The authors are happy to engage in further discussions on this recommendation.

Appendix A

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Appendix B

Analysis by CO

Workforce profile by disability

Disability breakdown – white disabled (male, female, total), black and ethnic minority disabled (male, female, total), total disabled, total disabled %, total non-disclosed, total non-disclosed %. This is repeated for non-disabled. Total workforce (total male, total female). This information is presented for:

- Overall by grade, FT and PT
- Overall by service, FT and PT
- CEO & CS overall by grade, FT and PT
- Service A overall by grade, FT and PT
- Service B overall by grade, FT and PT

Workforce profile by ethnicity

Ethnicity – total white (white Scottish, other British, Irish, gypsy/traveller, polish, other white ethnic), mixed or multiple ethnic groups, Arab and Arab Scottish or British, total other ethnic background, Asian (Pakistani, Indian, Bangladeshi, Chinese, Other Asian background, Black (African, other African background, Caribbean, Black, Other Caribbean/Black background), total BME, total non-disclosed, total % (total white employees %, total BME %, total non-disclosed). This information is presented for:

- Overall by grade, FT and PT
- Overall by service, FT and PT
- CEO & CS overall by grade, FT and PT
- Service A overall by grade, FT and PT
- Service B overall by grade, FT and PT

Workforce profile by gender

Male and female – total white, total mixed, total other ethnic background, total Asian, total black, total black and ethnic minority, total non-disclosed, total white %, total BME %, total non-disclosed %, total male, total female, total workforce, total workforce FTE.

- Overall by grade, FT and PT
- Overall by service, FT and PT
- CEO & CS overall by grade, FT and PT
- Service A overall by grade, FT and PT
- Service B overall by grade, FT and PT

Workforce profile by age

Age – under 25, 25-30, 31-40, 41-49, 50-60, 61-64, 65+

Age by disability (disabled, non-disabled, non-disclosed) by grade and by total

Age by disability type (deafness or partial hearing loss, blindness or partial sight loss, physical disability, learning disability, learning difficulty, mental health condition, long-term illness, developmental disorder, other condition, not disclosed) by grade and by total

Age by ethnicity (see earlier categories) by grade and by total

Age by religion and belief (Buddhist, church of Scotland, Hindu, Jewish, Muslim, Other Christian, Roman Catholic, Sikh, Another Religion, None, not disclosed) by grade and by total

Age by sexual orientation (bi-sexual, heterosexual, lesbian/gay, transgender, other, not disclosed) by grade and by total

Age by gender (male, female) by grade and by total

Workforce profile by disciplinary action

Disciplinary – verbal warnings, formal warnings, final warnings, ex final warnings, punitive action warning/unpaid suspension, punitive action warning/demotion, punitive action withdraw OSP, punitive action other, dismissal summary, dismissal with notice, totals.

Disciplinary action by disabled and by disability type

Disciplinary action by ethnicity

Disciplinary action by religion and belief

Disciplinary action by sexual orientation (including gender identity)

Disciplinary action by gender

Disciplinary reasons – timekeeping, unauthorised absence, unacceptable levels of absence, negligence, unsatisfactory work performance, failure to follow procedures, failure to implement health and safety regulations, misappropriation/theft, misuse of resources, fraud/falsification, incapacity alcohol/drugs, other, capability, totals

Disciplinary reasons by disabled and by disability type

Disciplinary reasons by ethnicity

Disciplinary reasons by religion and belief

Disciplinary reasons by sexual orientation (including gender identity)

Disciplinary reasons by gender

Bullying and harassment

Complaints received – bullying/victimisation, racial, sexual, sexual orientation, disability, religion, age, gender, other, total. This is broken down by disabled, ethnicity, gender.

Complaints rejected after assessment – bullying/victimisation, racial, sexual, sexual orientation, disability, religion, age, gender, other, total. This is broken down by disabled, ethnicity, gender.

Complaints in progress – bullying/victimisation, racial, sexual, sexual orientation, disability, religion, age, gender, other, total. This is broken down by disabled, ethnicity, gender.

Complaints completed – bullying/victimisation, racial, sexual, sexual orientation, disability, religion, age, gender, other, total. This is broken down by disabled, ethnicity, gender.

Outcome of complaints completed (upheld, rejected, total) total working days, average. this is broken down by disabled, ethnicity, gender.

Overall harassment contacts return – nature of harassment and number of contacts.

Grievances

Raised an individual stage 1 grievance – religion and belief, sexual orientation (including gender identity), gender, disabled, disability type, ethnicity. Number and %.

Grievance return – informal stage, stage 1, nature of grievance, stage 2, status quo by type of grievance. This is broken down by BEM, Other and total (individual, collective, overall)

Workforce profile by exit monitoring return

Exit reasons – death in service, dismissal – capability (attendance/absence), dismissal – capability (performance), dismissal – conduct, end of temp contract, unsatisfactory probation, redundancy – compulsory, redundancy – voluntary, retirement – normal retirement age, retirement – voluntary, retirement – efficiency, retirement – ill health, transfer to LLP, data migration, totals – non resignation leavers.

Exit reasons by disabled and by disability type

Exit reasons by ethnicity

Exit reasons by religion and belief

Exit reasons by sexual orientation (including gender identity)

Exit reasons by gender

Workforce profile by leavers

Leavers by grade – breakdown by disability, disability type, ethnicity, religion and belief, sexual orientation (including gender identity), gender.

Workforce profile by recruitment

External applications – applications, interviews, appointments, (number, %, male, %, female, %). This is broken down by disability, disability type, ethnicity, religion and belief, sexual orientation (including gender identity), gender.

Internal applications – applications, interviews, appointments, (number, %, male, %, female, %) and complaints (number, %). This is broken down by disability, disability type, ethnicity, religion and belief, sexual orientation (including gender identity), gender.

Combined (external and internal) – applications, interviews, appointments (number, %, male, %, female, %). This is broken down by disability, disability type, ethnicity, religion and belief, sexual orientation (including gender identity), gender.

Workforce profile by maternity/adoption leave

Commencing leave, still on leave, return from leave, non-returners, category for non-returning by grade. This is broken down by disability, disability type, ethnicity, religion and belief, sexual orientation (including gender identity), gender.

Workforce profile by flexible working return

Total requests received, % of requests received, parental responsibility, caring responsibility, WLB by grade. This is broken down by disability, disability type, ethnicity, religion and belief, sexual orientation (including gender identity), gender. This is repeated for requests approved, requests declined, requests outstanding.

Joint staffing watch return – all organisation

Actuals – headcount. Grades by permanent, temporary, sessional/casual.

Actuals – FTE. Grades by permanent, temporary, sessional/casual.

Joint staffing watch – number of employees, by gender, by temporary and permanent. Repeated for full time equivalent.

Corporate Analysis

Workforce by type (contracts) - Grade by contracts – permanent contracts (permanent, right to revert, temporarily assigned, total) temporary contracts (fixed term, temporary, modern apprentice, student placement, total) casual workers

9 day working fortnight return – requests received, approved requests, declined requests -Grade by disability, disability type, ethnicity, religion and belief, sexual orientation (including gender identity), gender.

Buying annual leave return – requests received, approved requests, declined requests -Grade by disability, disability type, ethnicity, religion and belief, sexual orientation (including gender identity), gender.

Career breaks return – requests received, approved requests, declined requests -Grade by disability, disability type, ethnicity, religion and belief, sexual orientation (including gender identity), gender.