NHS
Equality and
Diversity Council

NHS WORKFORCE RACE EQUALITY STANDARD

2017 DATA ANALYSIS REPORT FOR NHS TRUSTS

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NHS Workforce Race Equality Standard
2017 Data Analysis Report for NHS Trusts

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Contents

01 Foreword

We know that one in five NHS colleagues is from a black and minority ethnic (BME) background. The Workforce Race Equality Standard (WRES) data reports published to date, confirm that, in general, the treatment and experiences in the workplace of BME staff often fall short of the values and principles upon which our NHS proudly stands.

To meet these issues head-on, the WRES has been made mandatory across the NHS since April 2015, and built into assurance and regulatory processes – including the Care Quality Commission (CQC) inspections of hospitals. The WRES requires healthcare providers of NHS services to self-assess their workforce data, to understand the specific challenges they face, and to ensure all staff are treated with equity as a result of action planning for continuous improvements.

This report is the third publication of the annual WRES data analysis for NHS trusts, and the second fully comprehensive report that focuses on all nine WRES indicators. It provides an opportunity to examine the level of progress made by NHS trusts and other parts of the NHS over time, and where further concerted support and action is required.

For a second year in succession, we have seen evidence that some organisations are embracing this agenda well and are continuing to develop plans to strive for improvements in the their WRES data. The WRES Implementation team has increasingly focused on supporting organisations in this endeavour. Going forward, the team will further support demonstrable leadership, the embedding of accountability and sustainability on this agenda – building cultures of continuous improvement in all NHS-funded services.

Professor Jane Cummings
Chief Nursing Officer for England and Regional Director of London. National Director, Equality & Diversity / WRES, NHS England

02 Preface

In 2015, when the Workforce Race Equality Standard (WRES) was introduced as part of the NHS standard contract, it was the first time that workforce race equality had been made mandatory in the NHS. It was the result of many people's hard work and perseverance that race inequality in the workplace needed to be tackled.'

The WRES was introduced to enable employees from black and minority ethnic (BME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace. This is vital as the evidence shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisations.

The first WRES data return in 2016 showed contrasting experiences between BME staff and their white counterparts, highlighting the challenges of race equality at organisation, sector and regional levels.

Two years on, we have seen a steady improvement in engaging with provider trusts, data submission against the nine indicators again this year has been a 100% and we have successfully published a third WRES data analysis report. This 2017 report will show that the low baseline we started off from in 2015 has improved, albeit with room to improve further.

The change we to continue to seek in workforce race equality is not change for political correctness; there is a moral, legal, financial and, most importantly, a quality of patient care case for change.

Marie Gabriel
Chair, WRES Strategic Advisory Group, and Member of the NHS Equality & Diversity Council

Yvonne Coghill OBE
Director, WRES Implementation Team NHS England

03 Key findings

White shortlisted job applicants are 1.60 times more likely to be appointed from shortlisting than BME shortlisted applicants, who continue to remain absent from senior grades within Agenda for Change (AfC) pay bands.

An increase in numbers of BME nurses and midwives at AfC Bands 6 to 9 is observed once again in 2017; this pattern has persisted since 2014.

The number of very senior managers (VSMs) from BME backgrounds increased by 18% from 2016 to 2017 – from 212 to 250 in England. This is 7% of all VSMs, which remains significantly lower than BME representation in the overall NHS workforce (18%) and in the local communities served (12%).

BME staff are 1.37 times more likely to enter the formal disciplinary process in comparison to white staff. This is an improvement on the 2016 figure of 1.56.

BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers compared to white staff, at 14% and 6% respectively.

Similar proportions of white (28%) and BME (29%) staff are likely to experience harassment, bullying or abuse from patients, relatives and members of the public in the last 12 months.

The overall percentage of BME staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months dropped from 27% to 26%. BME staff remain more likely than white staff to experience harassment, bullying or abuse from other colleagues in the last 12 months.

There is a steady increase in the number of NHS trusts that have more than one BME board member. There are now a total of 25 NHS trusts with three or more BME members of the board; an increase of 9 trusts since 2016.

04 Introduction

The NHS Workforce Race Equality Standard (WRES) was introduced in 2015 to focus national and local effort in ensuring staff from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Until recently, many organisations did not know how they were performing on the issue of workforce race equality. Unless we know how we are performing now, it is impossible to define and deliver real progress and continuous improvement.

The WRES prompts inquiry and assists healthcare organisations to develop and implement evidence-based responses to the challenges their data reveal. It assists organisations to meet the aims of the **NHS Five Year Forward View** and complements other NHS policy frameworks such as **'Developing People – Improving Care'** A national framework for action on improvement and leadership development in NHS-funded services, as well as the principles and values set out in the **NHS Constitution.**

This is the third annual WRES data analysis report for NHS trusts. The 2015 report presented data on the four WRES indicators drawn from the NHS Staff Survey questions, and on the composition of NHS boards. The report for 2016 presented data for all nine WRES indicators for the first time. In this report, the 2016 WRES data for NHS trusts is compared with the latest data for 2017.

Whilst this report focuses entirely on the WRES data returns from NHS trusts, work to support WRES implementation across other parts of the NHS, including commissioning organisations, independent healthcare providers, and the national healthcare Arm's Length Bodies is also underway. Whilst Arm's Length Bodies are not required to undertake the WRES, they choose to do so as demonstration of their leadership commitment to workforce race equality across healthcare.

The importance of data and intelligence

Without data, carefully analysed, it is difficult for organisations to understand the level of challenges they face on workforce race equality, and on equality in general, and where those challenges are most severe. Organisations need to know where they are now, where they need to be and, with robust action planning, how they will get there. They need to do this with an open mind and an honest heart – in the spirit of continuous improvement.

This is important as differences in workforce race equality have significant adverse impacts on the effective and efficient running of the NHS, including on the quality of care received by all patients. The link between the adverse treatment of staff and poor patient care is particularly well-evidenced in the NHS[1]. Yet it is strikingly clear that whilst

1. Dawson, J. (2009) Does the experience of staff working in the. NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys. Institute for Health Services Effectiveness. Aston Business School.

some organisations and parts of the NHS are embracing the agenda, many still have a lot of work to do to genuinely act on the available insight.

The WRES is encouraging NHS organisations to scrutinise their workforce and staff survey data, to start engaging with their BME staff in meaningful and sustained ways, and to start exploring why there are such differences between the treatment and experiences of white and BME staff – and importantly, how the existing gaps can be closed. In the spirit of continuous learning and transparency, organisations across the country are creating WRES action plans and publishing these on their respective websites alongside their WRES data.

NHS trusts should adopt a 'learning organisation' approach to this report. Understanding the data and producing action plans to build cultures of continuous improvement in these areas will be essential steps in helping to bring about workplaces that are free from discrimination. WRES data continues to create opportunities for peer-to-peer support that focus upon common local challenges, sharing of replicable good practice, and using opportunities for transformational change.

A national strategy for local implementation

The WRES programme has focussed on establishing the architecture for organisations to submit data against the nine WRES indicators and to create meaningful plans of action. The WRES has been successfully embedded into key policy levers including: the NHS Standard Contract, the CQC inspection programme for NHS trusts and independent healthcare organisations in England, and in the CCG Improvement and Assessment Framework. To this end, the process of system alignment with regard to the WRES has been effectively undertaken.

The next phase of the WRES programme builds on the system alignment described above. Focussing on how data and evidence can be used, it will help cultural and transformational change on workforce race equality across NHS organisations, and other parts of the healthcare system. The sharing of good practice and the sustainability of interventions will be key elements of success. The national focus on the nine WRES indicators provides an opportunity for local organisations to work together on specific interventions and to share replicable good practice.

The NHS England WRES team is supporting local organisations and other parts of the healthcare system on this critical agenda. The strategic approach focuses on collective action, which is proportionate and at scale, to reduce the steepness of the 'disparity gradient' for white and BME staff experiences and opportunities. For example, the 2016 WRES data report for NHS trusts showed the London region and the ambulance sector, in particular, as needing focused support. The WRES team has been working closely with both – providing concerted strategic and operational support. The goal is not just to level

the 'disparity gradient', but also to raise the bar for all organisations at the same time.

Gaps in the experiences and opportunities between white and BME staff are not just restricted to the NHS. The ongoing partnership work to dissolve barriers between health and social care, and to bring about integrated care, presents an opportunity to ensure that workforce race equality is built into the new and emerging healthcare architecture. The WRES team is working closely with the Greater Manchester Health and Social Care Partnership to focus upon the prospect of stretching out and embedding the WRES across both health and social care.

An evidence-based model that works

There is now a growing body of international evidence in this area, the outcome of which states that in order for organisational culture to improve on workforce race equality, attention needs to be focussed at the same time on a number of key characteristics:

- Demonstrable leadership
- Robust accountability
- Data and evidence
- Meaningful communications
- Resources and support

Putting this strategic approach into place across an organisation can take some time; however, once it is in place, it can help organisations to continuously improve workforce race equality which as a direct result, improves experience for all staff and patients.

The shared characteristics of effective interventions on workforce race equality were presented within the **2016 WRES data report** for NHS trusts, and included a detailed overview of the above areas.

Organisations that are showing signs of continuous improvement are more likely to be those that have boards and leaders that understand and act on the powerful case for addressing workforce race inequality and the powerful case for addressing it. Many are beginning to apply the evidence-based model for change, whilst some are already beginning to see early signs of improvement.

05 Methodology

5.1. The WRES indicators

The WRES requires NHS trusts to self-assess against nine indicators. Four of the indicators relate specifically to workforce data; four are based on data from the national NHS Staff Survey questions, and one considers BME representation on boards. This report presents data for all of the nine WRES indicators, and where possible compares to the 2016 data.

There were two changes made to the WRES indicators (1 and 9) for the data returns in 2017 as shown in the table below.

Table 1: The changes made to WRES indicators for the 2017 WRES data returns

	Narrative for 2016 data return	Narrative for 2017 data return
WRES indicator 1 (change in definitions)	Very Senior Managers (VSMs) can be defined using the following methods: Occupation code Z2E = Chair and non-executive directors (Except if identified using Job roles as below.) Job roles: Chair, Chief Executive; Finance Director; Other Executive Director; Board Level Director; Non-Executive Director	Very Senior Managers (VSM)" are defined differently in 2017 as exclusively including: • Chief executives • Executive directors, with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and the requirements of the post • Other senior managers with board level responsibility who report directly to the chief executive.
WRES indicator 9 (change in criteria)	Percentage difference between the organisations' board voting membership and its overall workforce.	Compare the difference for white and BME staff: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce.

The WRES indicators were developed in partnership with the wider NHS, and were based on existing data collection and analysis requirements, which a performing number of NHS organisations are already undertaking. The nine WRES indicators are presented in the Annex of this report. The detailed definition for each indicator can be found in the WRES Technical Guidance.[2] The WRES Technical Guidance also includes the definitions of "white" and "black and minority ethnic", as used throughout this report and within the narrative for the WRES indicators.

5.2. Data sources

The WRES data returns in 2017 were collected through individual trust submissions via the UNIFY2[3] system. A return rate of 100% was achieved across all NHS trusts in England.

As was the case in 2016, centrally held data sources were used to prepopulate workforce data and NHS staff survey data in the WRES UNIFY2 submission templates. NHS trusts were given the opportunity to confirm or amend their data before submission.

5.3. Data reporting dates

NHS trusts were asked to provide data on the nine WRES indicators as at March 2017. The submission of data took place from 1 July to 1 August 2017.

Although there is a nine month time lag in the data presented in this report, trusts are able to view and update their own data internally at regular intervals. The Electronic Staff Record (ESR) team has produced a WRES business intelligence report for trusts to access and use to view their data. This ESR report is primarily suited to view workforce data, but it can also prove useful if a trust is using the central ESR system to record recruitment (WRES indicator 2), disciplinary action (WRES indicator 3) and training (WRES indicator 4).

5.4. Data analyses

For the purposes of analysis, organisations have been grouped by geographical regions in England: London, Midlands and East, North and South. Additionally, organisations have also been grouped by NHS trust type in the following ways: acute trust, ambulance trust, community provider trust, and mental health and learning disability trust.

The results presented for WRES indicators 5 to 8 (from the NHS Staff Survey) show percentage responses by BME staff for 2016 in comparison to 2015.

To supplement the analyses presented in the findings section of this report, supporting data for individual NHS trusts are published **online**.

2. NHS England, 'Technical Guidance for the NHS Workforce Race Equality Standard", March 2017
3. UNIFY2 is a secure online collection system used for collating, sharing and reporting NHS and social care data

5.5. Data issues and caveats

1. Four of the WRES indicators are drawn from the national NHS staff survey. Their reliability is dependent on the size of samples surveyed, the response rates, and whether the numbers of BME staff are so small that they may undermine the confidence in the data. The 2016 survey data are more reliable due to larger sample sizes and increased response rates.

2. The 'conditions' against which WRES performance is measured may impact the data. For example, if a trust is undergoing a merger, a major restructure or is under exceptional financial pressures that may impact on WRES indicators 6 and 7. Not one of these pressures means WRES is any less important. In fact, it is even more important in those circumstances in ensuring equality remains central to strategy.

3. Caution should be exercised in assuming that trusts whose data are better are engaged in better practice than those who are not. Indeed, some of the best practice is being undertaken by trusts where relatively poor data have spurred the board and others into taking determined action to redress unfair outcomes.

4. In order to improve confidence levels when using staff survey data to compare trusts whose data suggests better practice may be taking place, a filter was added that excluded trusts with less than 50 BME responses to staff survey questions. The number of trusts affected by this is likely to reduce next year as staff survey sample sizes increase.

5. All averages presented in this report are unweighted and do not take into account the size or type of trust. If sample sizes are small, this has been highlighted in the commentaries within the detailed findings section.

6. In 2017, data was collected for the white, BME and 'unknown/null' ethnicity categories. In the previous years' collection, the unknown null category was not collected and therefore Indicator 1 and Indicator 9 are not directly comparable to 2016. The addition of the third category has meant that the data this year are more accurate than in previous years.

7. Where appropriate, graphs have been rounded to the nearest whole numbers, and for this reason, aggregate percentages may not add to 100.

8. Some NHS trusts may have revised their WRES data returns since their submission via UNIFY2. The results in this report are based on the latest figures returned to NHS England via UNIFY2 and will not necessarily incorporate any updates a trust has made to WRES related publications on organisations' websites.

9. 100% response rate was achieved for the 2017 WRES data returns. However, the quality and accuracy of data submitted varies by trust. Full details on sample sizes for each indicator are available **online**.

10. In some sections of indicator 1 and indicator 9, supplementary data has been sourced from NHS Digital. This is marked clearly in the commentary, e.g. for Indicator 9, NHS Digital data have been used to show historical trends of Very Senior Manager (VSM) staff by ethnicity from 2010 to 2017.

06 Detailed findings: 2017 data

6.1. WRES indicator 1 Percentage of staff in each of the AfC Bands 1 - 9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce

6.1.1. Data source and reliability

The data for WRES indicator 1 are pre-populated from the NHS Electronic Staff Record (ESR) for 2016, for both clinical and non-clinical staff on Agenda for Change (AfC) scales, as well as for medical staff.

There was a good degree of confidence in the quality of AfC data, but perhaps less confidence in the data for "senior medical managers", which historically, in a large number of trusts was merged incorrectly with that of consultants. However, the definition of very senior managers (VSMs) was revised and strengthened for the 2017 WRES data collection, thus enabling the analyses of the medical workforce data going forward.

6.1.2. Overall results

- For NHS trusts nationally, across the non-medical workforce (clinical and non-clinical), the proportion of BME staff in Bands 8a - 9 and VSM was 10.4% compared with 16.3% in the workforce as a whole.
- Nationally, for clinical non-medical staff, the proportion of BME staff in Bands 8 - 9 and VSM was 10.8% compared with 17.6% in the workforce as a whole.
- Nationally, for non-clinical staff, the proportion of BME staff in Bands 8 - 9 and VSM was 9.7% compared with 13.2% in the workforce as a whole.

Table 2. Percentage of senior (Bands 8a-9) and VSM staff by ethnicity, and the overall BME workforce: 2017

	White	BME	Unknown/Null	% of BME staff overall
All non-medical staff (clinical and non-clinical)	86.3%	10.4%	3.4%	16.3%
All clinical staff	86.3%	10.8%	2.9%	17.6%
All non-clinical staff	86.1%	9.7%	4.2%	13.2%

Table 3. Ethnic distribution of the workforce by trust type and region: 2017

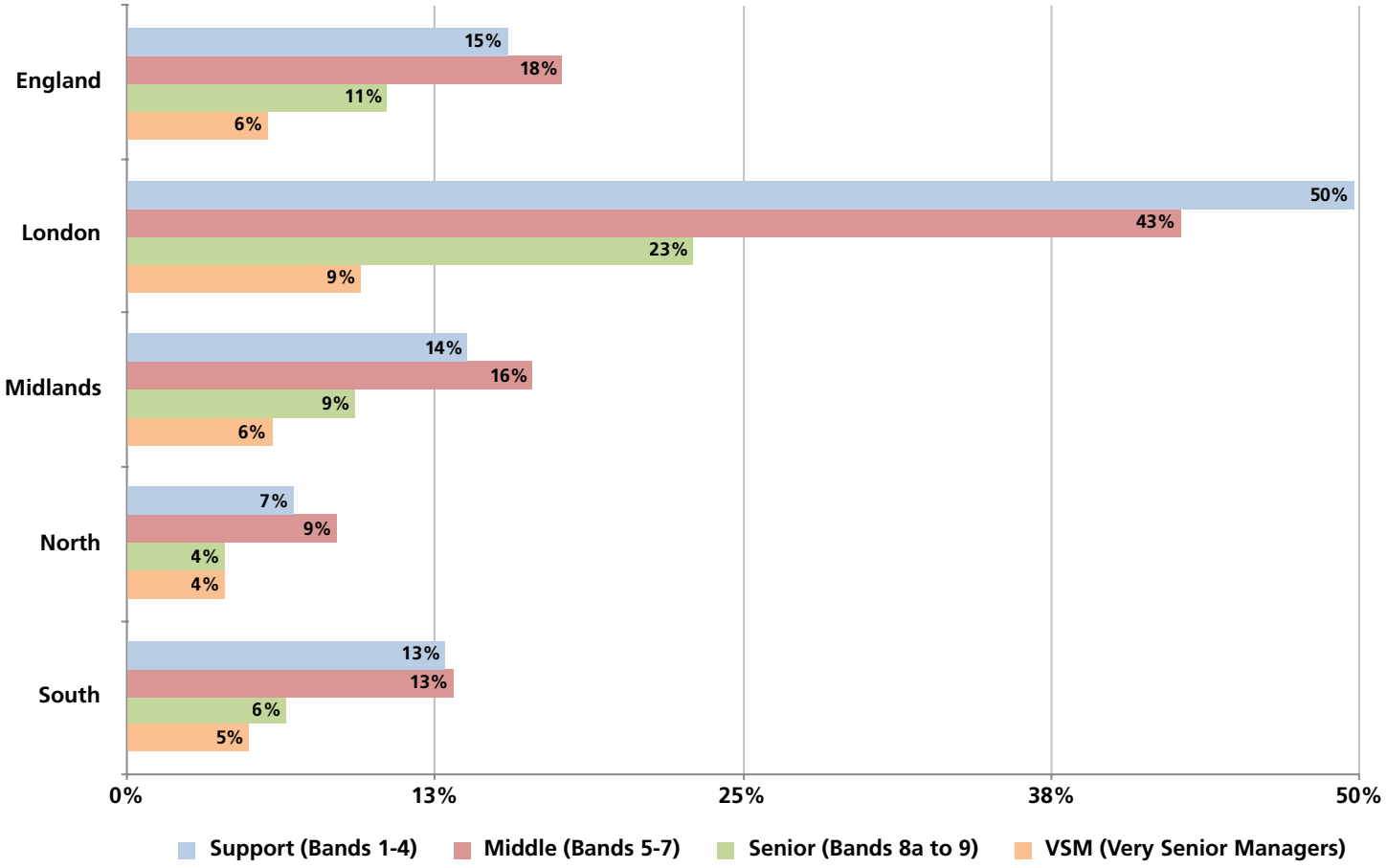
	White	BME	Unknown/Null
Acute	78.6%	17.6%	3.8%
Mental Health	81.0%	15.9%	3.0%
Community Provider Trust	84.6%	9.7%	5.7%
Ambulance	91.5%	4.4%	4.2%
London	51.8%	43.2%	5.0%
Midlands & East	80.8%	14.9%	4.2%
North	89.5%	7.5%	3.0%
South	83.8%	12.7%	3.5%
England	**79.9%**	**16.3%**	**3.8%**

Data source: Aggregates of 2017 WRES UNIFY2 submissions

A greater proportion of BME staff are located in the acute (17.6%) and mental health (15.9%) trust types. In relation to geographical spread, the London region had by far the largest BME workforce (43.2%). See table 3.

6.1.3. By region

Figure 1. Percentage of BME staff by AfC band and region: 2017



Note: Percentages in each category will not add to 100%. Each AfC band is comprised of the white, BME and Null proportions of the workforce. Values for the white and Null workforce are not shown.

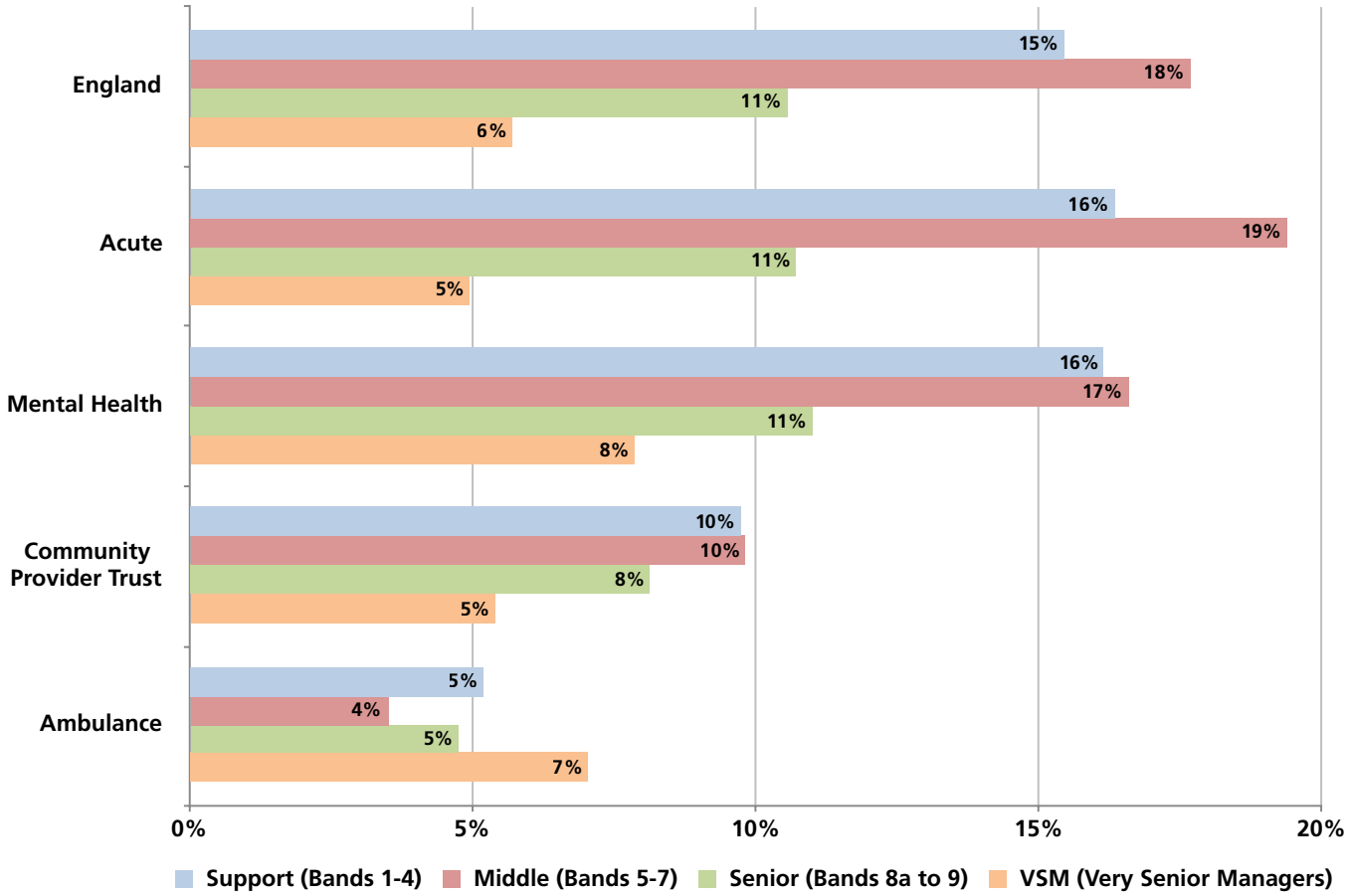
As figure 1 shows, across all regions, BME staff are underrepresented in senior (Bands 8a to 9) and VSM posts. Despite the London region having the largest BME workforce (43%), it has a disproportionate number of staff working at senior level (23%). In comparison, whilst the white workforce in London overall is 51.8%, 73.2% of senior staff across the region are white.

Similarly, the Midlands & East region and the South region have a BME workforce of 15% and 13% (table 3), yet BME representation at senior levels is just 9% and 6%, respectively (figure 1). In comparison, the workforce in these regions is 81% and 84% white, and the proportion of white senior staff is 87% and 90%, respectively.

In the North region, 8% of the workforce is BME, yet only 4% of senior staff are BME. In comparison, the white workforce in North (90%) is sufficiently represented within senior staff (91%).

6.1.4. By trust type

Figure 2. Percentage of BME staff by AfC band and trust type: 2017



Note: Percentages in each category will not add to 100%. Each AfC band is comprised of the white, BME and Null proportions of the workforce. Values for the white and Null workforce are not shown.

As shown in figure 2, there were smaller differences for ethnicity by pay band between the types of trust. These differences may be due to contributing factors such as the size of the trust, the service mix and the proportion of the workforce from BME backgrounds.

With the exception of the ambulance trusts, in all other trust types BME staff were underrepresented in senior levels (Bands 8a-9) in comparison to the overall sector BME workforce population.

Within the acute and the mental health sector, only 11% of the BME workforce were working at senior levels, yet BME staff comprised 18% and 16% of the overall workforce for those sectors, respectively.

6.1.5. Very Senior Managers (VSMs)

The AfC band representation presented above highlight the importance of considering the existing workforce pipeline to executive board director posts and other director posts.

Across England, there is an average of 10 white VSM staff per trust and just one BME member of staff per trust is at VSM grade. In many trusts there are no BME staff on VSM grades, despite the diverse local workforce and population demographic. The lack of BME representation has implications for succession planning and the future likelihood of executive board members being from BME backgrounds.

The talent management plan set out in the National Improvement and Leadership Development Board document: "Developing People – Improving Care" remains a helpful resource that aims to guide team leaders at every level of the NHS to develop a critical set of improvement and leadership capabilities among their staff and themselves. If the number of BME staff at senior levels is to approach the proportion of BME staff in the NHS workforce as a whole, boards will need to give serious attention to the lessons on good practice set out in that resource.

The talent management plan set out in the National Improvement and Leadership Development Board document: "Developing People – Improving Care"[4] remains a helpful resource that aims to guide team leaders at every level of the NHS to develop a critical set of improvement and leadership capabilities among their staff and themselves. If the number of BME staff at senior levels is to approach the proportion of BME staff in the NHS workforce as a whole, boards will need to give serious attention to the lessons on good practice set out in that resource.

Data in table 4 are sourced from the 2017 WRES submissions by NHS trusts through the UNIFY2 system. The data are not directly comparable with 2016 data due to the change in the definition for VSMs, and the additional collection of workforce data for the 'Unknown' and 'Null' categories for the 2017 WRES data collections.

4. National Improvement and Leadership Development Board, 'Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services', February 2016

Table 4 – VSM staff by ethnicity: 2017

	White	BME	Unknown/Null	BME VSMs as a % of all VSMs
Non-clinical	1864	101	148	4.8%
Clinical	540	56	42	8.8%
Combined	2404	157	190	5.7%

Figures 3 to 5 compare the AfC band representation of the BME workforce in 2016 and 2017. In order to provide an accurate comparison against historical trends, data are sourced from NHS Digital.

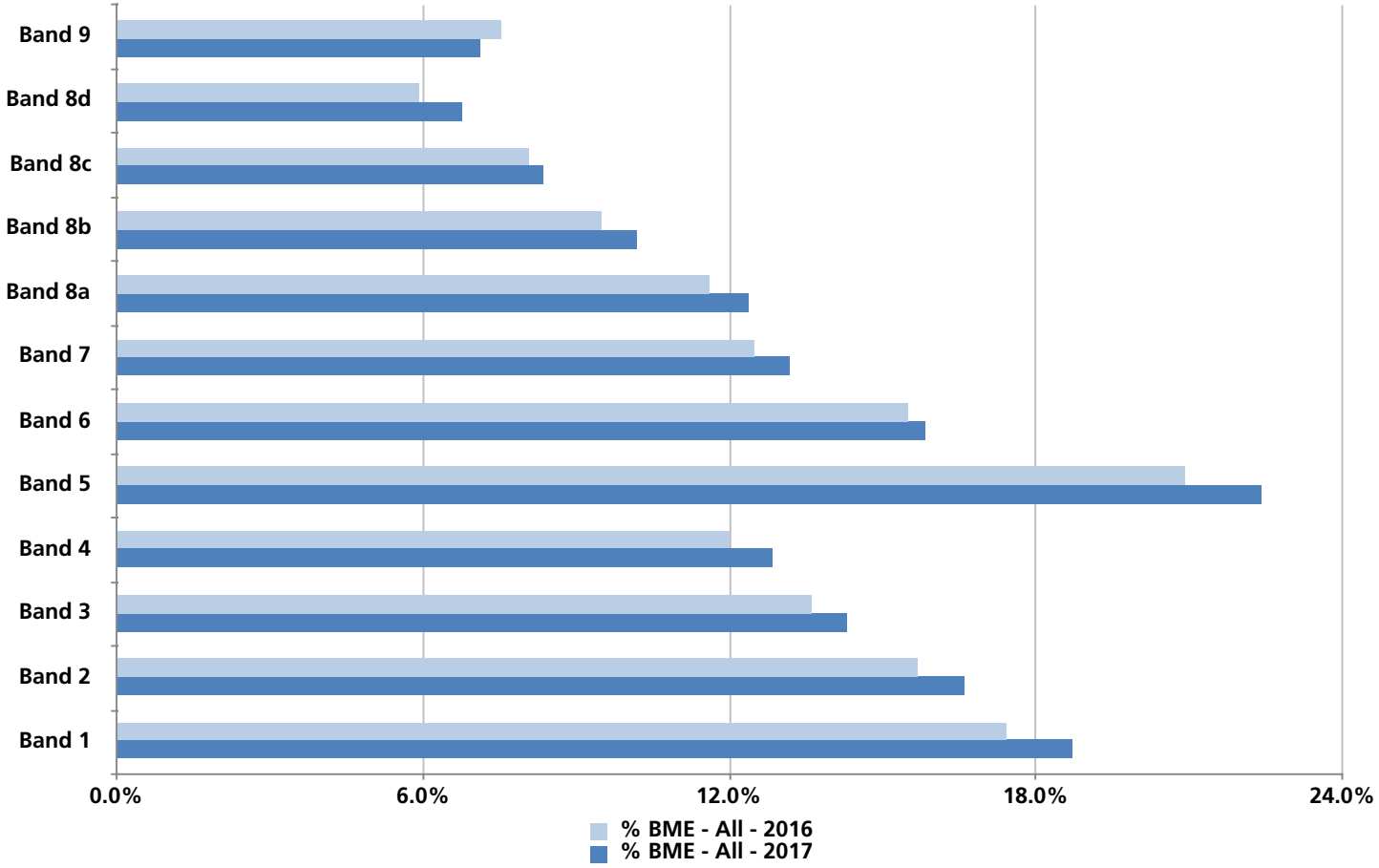
With the exception of AfC Band 9, the proportion of BME staff increased from 2016 to 2017 across all other AfC bands. This finding has strong implications for the progression of BME staff onto VSM and board level positions.

The largest proportional increase was in AfC Band 5, up by 1.5 percentage points to 22.4% in 2017. In AfC Band 9, the proportion of BME staff fell by -0.4 percentage points, to 7.1% in 2017. This equates to a reduction of two headcounts from 2016 to 2017.

Data for AfC Bands 1-4 show a 'bottleneck' in the flow of BME staff in support posts (Bands 1-4). The same pattern is evident within middle (Bands 5-7) and senior posts (Bands 8a-9) where BME representation decreased in line with levels of seniority.

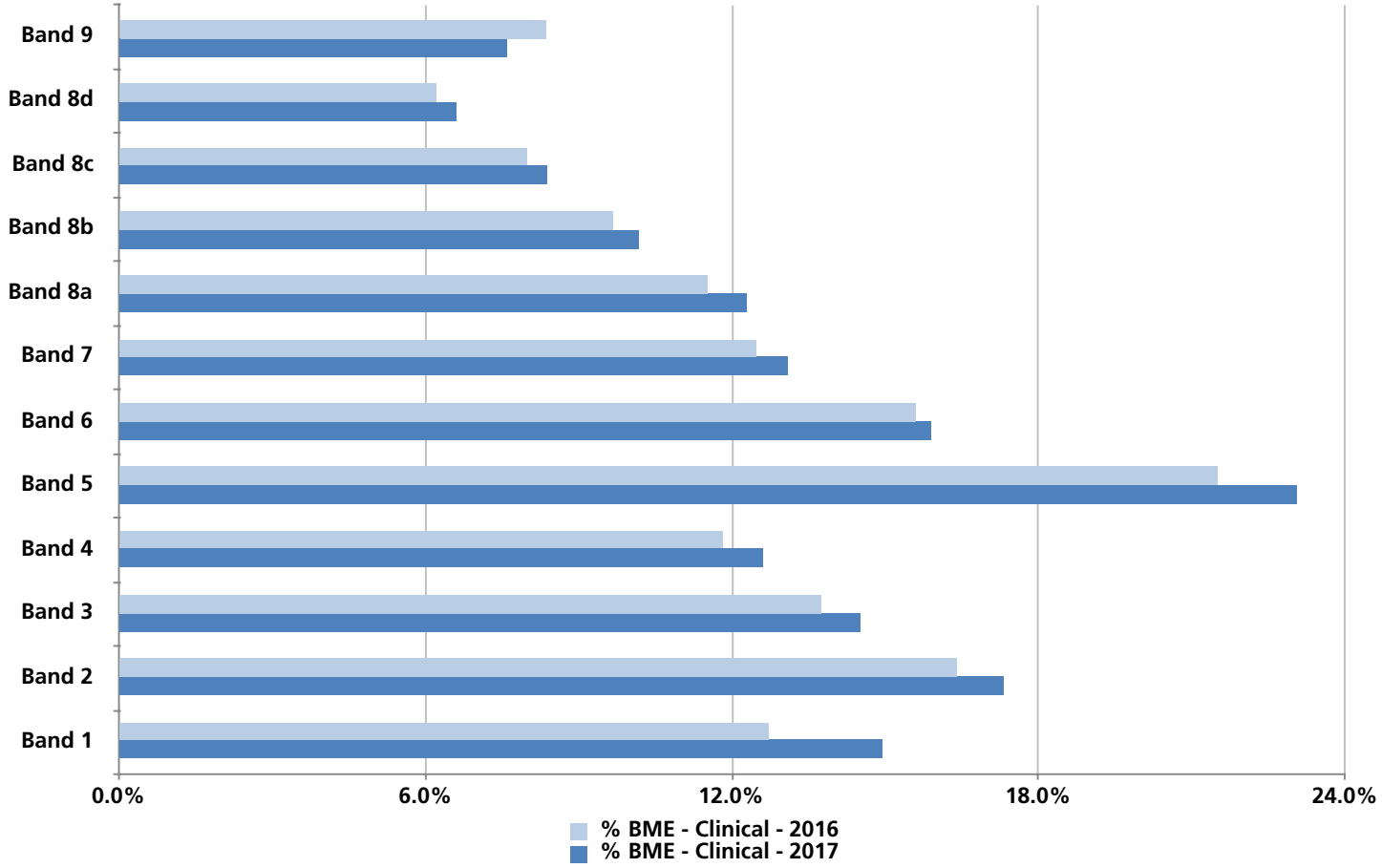
6.1.6. AfC staff overall

Figure 3. BME non-medical staff: 2016 and 2017



6.1.7. AfC clinical staff

Figure 4. BME clinical staff: 2016 and 2017



As figure 4 shows, for clinical staff on AfC bands (non-medical), the proportion of BME clinical staff at Band 5 increased from 21.5% in 2016 to 23.1 % in 2017. The proportion of BME staff in Bands 7 (13.1%), 8a (12.3%), 8b (10.2%) and Band 8c (8.4%) remained low in 2017.

At AfC Band 9, the proportion of BME staff dropped from 8.4% in 2016 to 7.6% in 2017. This equates to a headcount of one member of staff.

6.1.8. AfC non-clinical staff

Figure 5. BME non-clinical staff: 2016 and 2017

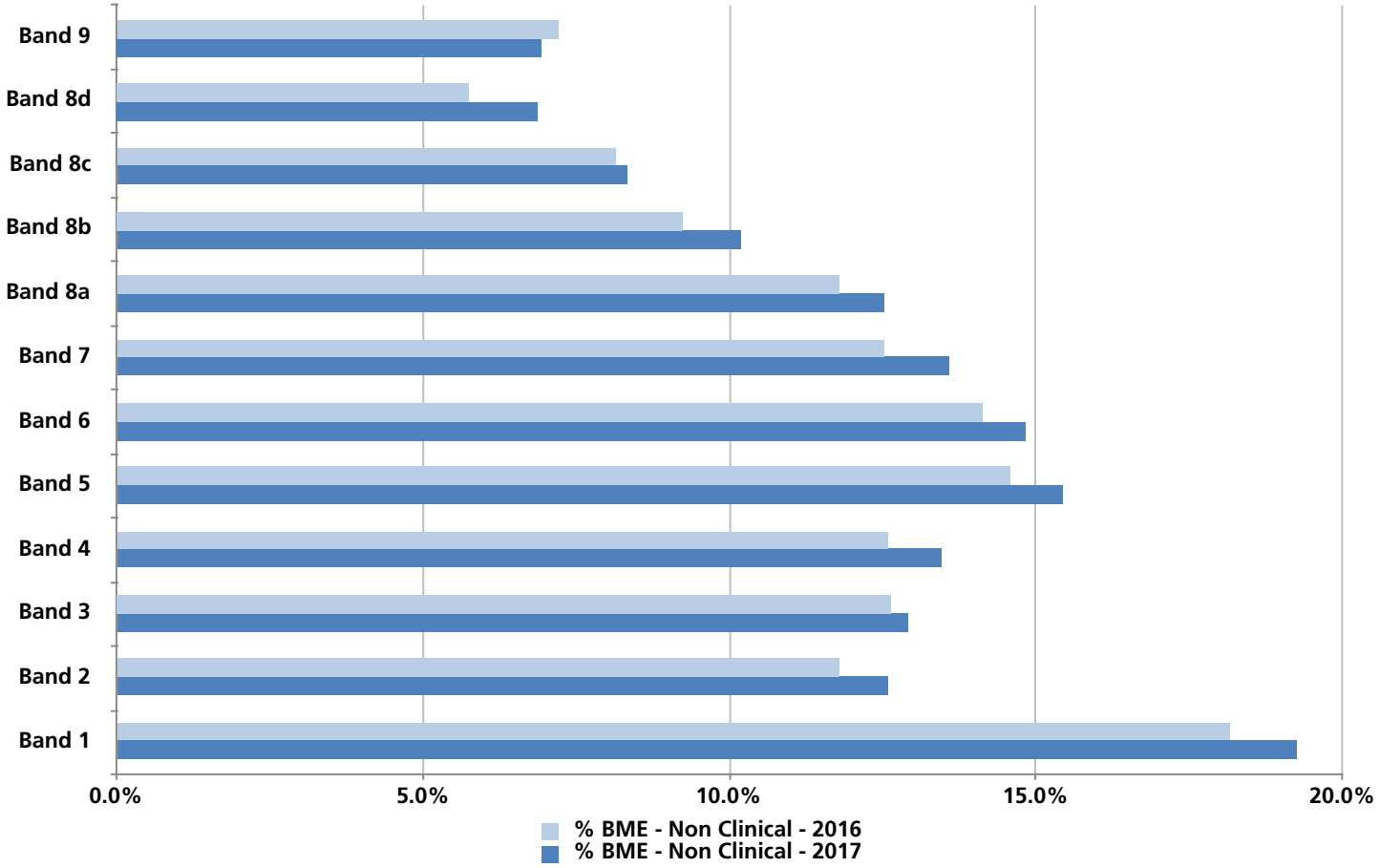


Figure 5 shows that the proportion of BME non-clinical staff increased in all AfC bands in 2017, with the exception of Band 9. The proportion of Band 5 BME staff increased from 14.6% in 2016 to 15.4% in 2017. Similarly, the proportion of BME staff increased in Band 6 (14.8%), Band 8a (11.8%) Band 8b (9.3%) and Band 8c (8.1%).

6.1.9. Nursing and midwifery staff

Nursing and midwifery staff form the largest professional grouping within the NHS. At least one in every five nurses and midwives come from a BME background, and yet data have shown that BME nurses and midwives are, in general, poorly represented in the higher AfC pay bands. Though this has been the case for many years, the 2016 WRES data for NHS trusts indicated some early signs of progress in closing this ethnic disparity.

Within the nursing, health visitor and midwifery profession, a quarter of all BME staff in 2017 were at AfC Band 5. Although BME nurses and midwives remain seriously under represented at Bands 6 and above, the data in figure 6 suggests a pattern of continuous progress. In particular, increases were found in the following AfC bands between 2016 and 2017:

- 6.8% increase at Band 6 (increase of 1347)
- 6.4% increase at Band 7 (increase of 439)
- 9.1% increase at Band 8a (increase of 96)
- 2.4% increase at Band 8b (increase of 5)
- 29.1% increase at Band 8c (increase of 16)
- 63.6% increase at Band 8d (increase of 7)

Figure 6. BME qualified nurses, health visitors and midwives: 2016 and 2017

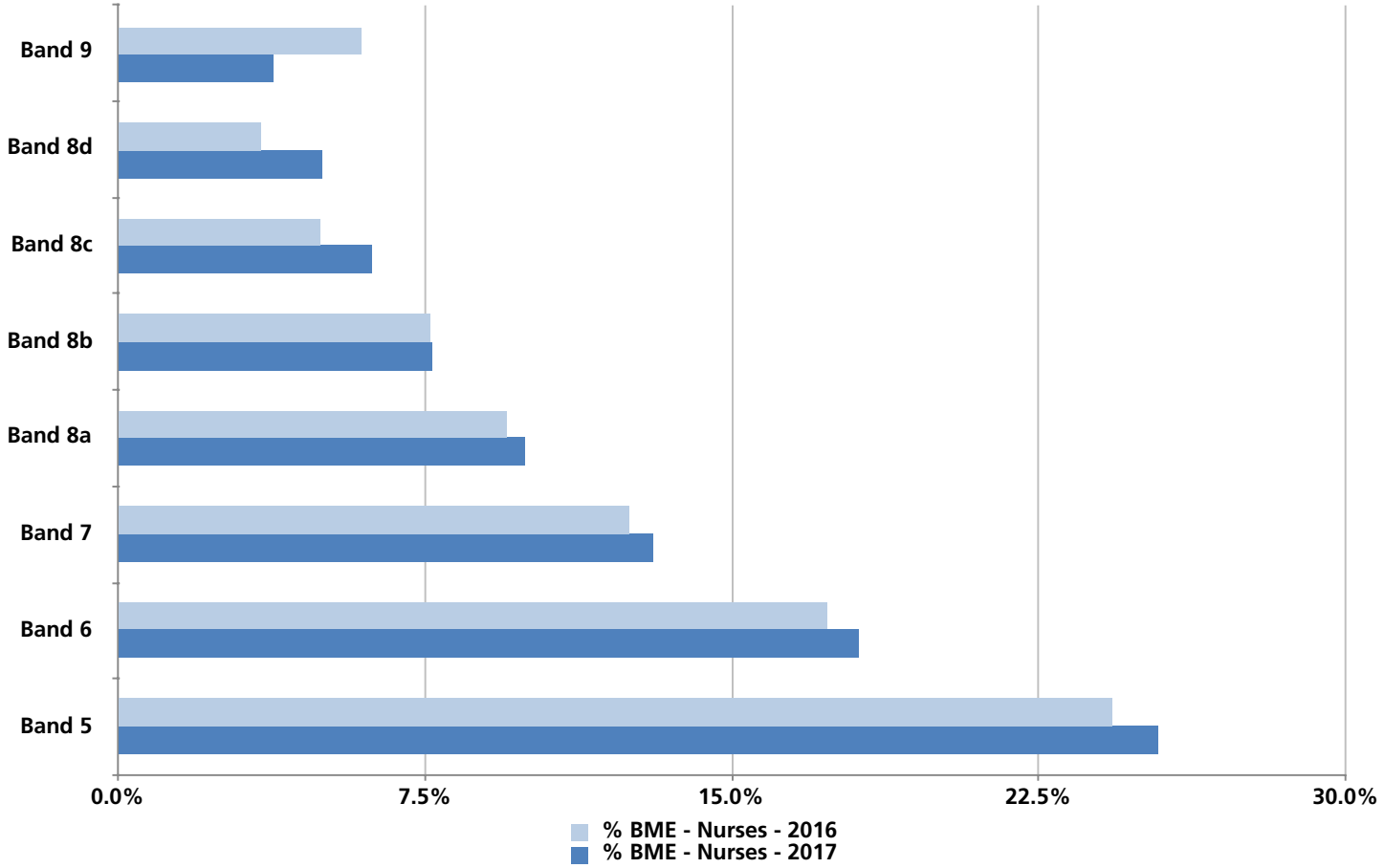


Table 5. BME staff percentage change (% change) by AfC bands within nursing, health visiting and midwifery: 2013-2017

Time period	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
2013 to 2017	-1185 (-3.0%)	4065 (23.7%)	1608 (28.1%)	319 (38.6%)	64 (43.0%)	27 (61.4%)	11 (157.1%)	2 (66.7%)

Source: NHS Digital

Table 6. BME staff headcount change (change in headcount from previous year) by AfC band within nursing, health visiting and midwifery: 2013-2017

Time period	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
2013	39532	17174	5727	827	149	44	7	3
2014	39143 (-389)	17656 (482)	5980 (253)	858 (31)	160 (11)	51 (7)	7 (0)	3 (0)
2015	38328 (-815)	18719 (1063)	6444 (464)	929 (71)	185 (25)	55 (4)	7 (0)	3 (0)
2016	38370 (42)	19892 (1173)	6896 (452)	1050 (121)	208 (23)	55 (0)	11 (4)	6 (3)
2017	38347 (-23)	21239 (1347)	7335 (439)	1146 (96)	213 (5)	71 (16)	18 (7)	5 (-1)

Source: NHS Digital

Tables 5 and 6 show the headcount changes for BME qualified nurses, health visitors and midwives from 2013 to 2017. Although overall representation at senior bands remains low, data show a continued increase in the headcount of BME nurses over time, particularly within Bands 8a to 9.

Table 6 details the actual headcount increase within each AfC band in 2017. There were a total of 124 more BME nursing and midwifery staff in Bands 8a to 8d in 2017 compared to the previous year. The largest percentage increases were within Bands 8a (9.1%), 8c (29.1%) and 8d (63.6%).

These increases, which have been evident since 2015, are welcome and have emerged during a period when concerns about the serious under-representation of BME nurses and midwives above Band 5 has become a real policy priority across the NHS.

Whilst it is not possible to ascertain the exact reasoning behind the observed increases in the number of BME nurses and midwives above Band 5, the introduction of the WRES in April 2015, as well as natural career progression, would certainly be contributing factors. However, there is still much more progress to make for this critical part of the NHS workforce.

The work of the WRES team, as well as that of the NHS Chief Nursing Officer for England's (CNO) BME Strategic Advisory Group, will help to ensure that a particular focus is kept on this area. For example, as a result of the 2016 WRES data, the CNO called for an appreciative enquiry report to help identify and capture the good practice learning from the best performing NHS trusts in this area. The report entitled **"Enabling BME Nurse and Midwife Progression into Senior Leadership Positions"** is scheduled to be published in December 2017. Amongst other key findings, the report demonstrates that improvements in the career progression for BME nurses and midwives across the NHS are entirely possible.

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

6.2.1. Data source and reliability

Before 2016, trust data returns against this indicator were significantly incomplete and inaccurate. This was an indication of the system-wide failures that existed in the recent past to collect such data with any degree of reliability.

Below is a comparison of the 2016 and 2017 data overall, as well as by region and type of trust. Of the 235 NHS trusts, three did not provide or confirm all or part of their data, so percentages used in this section are based upon 232 (98%) trust responses.

6.2.2. Overall results

- The relative likelihood of white staff being appointed from shortlisting compared to BME staff, across all posts, was 1.60 times greater than for BME staff. This is a slight increase to the 1.57 likelihood observed in 2016.
- In 23 trusts (9.9%) there was a greater likelihood of BME staff being appointed from shortlisting compared to white staff. This is an increase compared to 15 (6.9%) trusts in 2016.
- In the remaining 209 trusts (90.1%) there was greater likelihood of white staff being appointed from shortlisting compared to BME staff.
- In 27 trusts (11.6%) it was more than twice as likely that white staff would be appointed from shortlisting compared to BME staff. This is a slight decrease from the 38 (17%) trusts in 2016.
- Across 232 of 235 NHS trusts in England, 19% (142,068) of white shortlisted job applicants and 12% (40,476) of BME shortlisted job applicants were successfully appointed.

6.2.3. By region

Figure 7. Relative likelihood of white staff being appointed from shortlisting compared to BME staff: 2016 and 2017

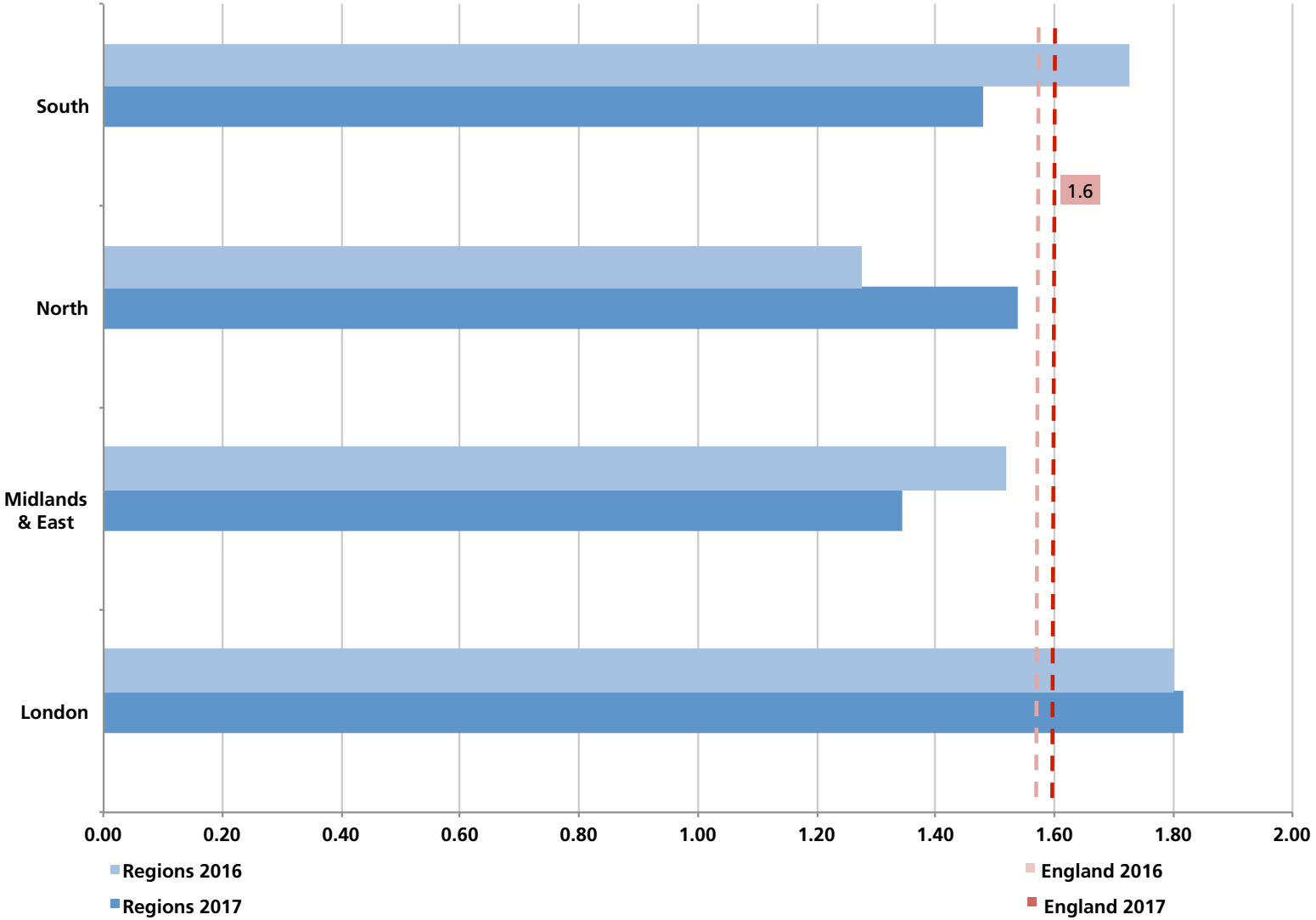


Table 7. Relative likelihood of white staff being appointed from shortlisting compared to BME staff: 2016 and 2017

	2016	2017
England	**1.57**	**1.60**
Region		
London	1.80	1.81
Midlands & East	1.52	1.34
North	1.28	1.54
South	1.73	1.48

As shown in figure 7, the relative likelihood of white staff being appointed from shortlisting compared to BME staff varied between regions. In every region across England, white staff are more likely to be appointed from shortlisting than BME staff.

When comparing the last two years' data on this indicator for the North region, we observe that the likelihood of white staff being appointed from shortlisting compared to BME staff increased from 1.28 in 2016, to 1.54 in 2017.

The London region remains an outlier with white staff being 1.8 times more likely to be appointed from shortlisting in comparison to BME staff. The proportion of BME staff in senior positions, (AfC bands 8 and VSM) as a proportion of the workforce, is also the lowest in London. Since London is the region with the highest proportion of BME staff in the workforce and the highest proportion of BME people within its population, this presents a particular challenge.

The greatest improvement in the data from 2016 is evident within the South region, where the likelihood of white staff being appointed from shortlisting compared to BME staff dropped from 1.73 in 2016, to 1.48 in 2017. Similarly, in the Midlands and East region, the likelihood of white staff being appointed from shortlisting compared to BME staff dropped from 1.52 in 2016, to 1.34 in 2017.

6.2.4. By trust type

Figure 8. Relative likelihood of white staff being appointed from shortlisting compared to BME staff: 2016 and 2017

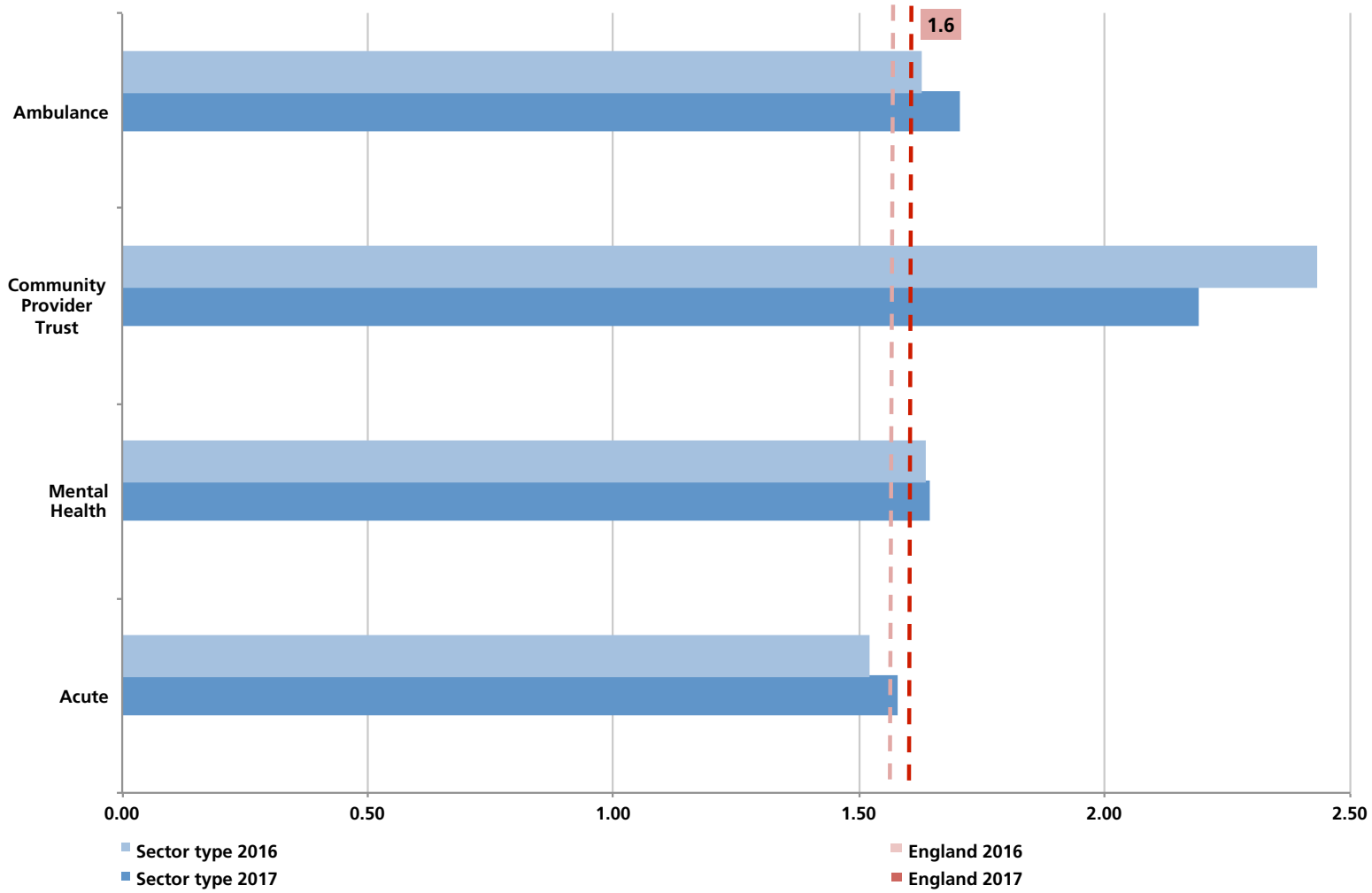


Table 8. Relative likelihood of white staff being appointed from shortlisting compared to BME staff: 2016 and 2017

	2016	2017
England	**1.57**	**1.60**

Sector type		
Acute	1.52	1.58
Mental Health	1.63	1.64
Community Provider Trust	2.43	2.19
Ambulance	1.63	1.71

Figure 8 shows the differences in the relative likelihood of white staff being appointed from shortlisting compared to BME staff within each type of NHS trust.

With the exception of community provider trusts, all other types of trusts align close to the overall England likelihood of white staff being 1.60 times more likely to be appointed from shortlisting.

White staff in community provider trusts are 2.19 times more likely to be appointed from shortlisting than BME staff. Although this is an improvement on the 2.43 reported in 2016 for this sector, it remains significantly higher than the overall England likelihood for 2017.

As shown in table 8, in the acute and ambulance trusts, the likelihood of white staff being appointed from shortlisting compared to BME staff has increased slightly this year from 1.52 to 1.58, and from 1.63 to 1.71, respectively.

All comparative trust data relating to WRES indicator 2 can be found **online**.

6.2.5. Trusts where data suggest practice may be better

It is of particular interest to learn from organisations whose data on this indicator show some marked improvement from 2016 to 2017.

Organisations were not included in table 9 unless all of the following conditions applied:

- Results for Indicator 2 improved from 2016 to 2017 by at least 0.5
- 2017 results are below the sector average
- 2017 results are not below 0.9 (a figure below 1 would indicate that BME staff are more likely than white staff to be appointed from shortlisting)
- The number of BME appointments is at least 10 headcount

Table 9. Trusts where data suggest practice may be better for WRES indicator 2

Berkshire Healthcare NHS Foundation Trust
Bolton NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
City Hospitals Sunderland NHS Foundation Trust
Cornwall Partnership NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
Derbyshire Community Health Services NHS Trust
East And North Hertfordshire NHS Trust
East Sussex Healthcare NHS Trust
James Paget University Hospitals NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Liverpool Community Health NHS Trust
Luton and Dunstable Hospital NHS Foundation Trust
Medway NHS Foundation Trust
North Cumbria University Hospitals NHS Trust
North East Ambulance Service NHS Foundation Trust
North East London NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
Poole Hospital NHS Foundation Trust
Queen Victoria Hospital NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
South East Coast Ambulance Service NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Staffordshire And Stoke On Trent Partnership NHS Trust
The Royal Orthopaedic Hospital NHS Foundation Trust
University Hospital Of North Staffordshire NHS Trust

Caution should be exercised in assuming that trusts whose data is better are all necessarily engaged in better practice than those who are not. Engagement with trusts across the NHS indicates that some of the best practice on this indicator is often undertaken by organisations where relatively poor data has encouraged the board and others into taking determined action to redress disparities.

It should be noted that not being on this list does not necessarily mean good practice is not underway, any more than being on this list means that there is good practice being undertaken.

6.3. WRES indicator 3 Relative likelihood of BME staff entering the formal disciplinary process compared to white staff

6.3.1. Data source and reliability

2016 was the first year in which it was possible to report on data for this indicator with any degree of confidence. Data returns in 2015 were not of a high enough quality to enable analyses and the formulation of robust conclusions.

Of 235 trusts, 232 provided data for this indicator, representing a sample of 99%. Data for three trusts were excluded from the sample due to nil returns.

6.3.2. Overall results

- Nationally, BME staff are 1.37 times more likely to enter the formal disciplinary process in comparison to white staff. This is an improvement on the figure of 1.56 for 2016.

- Although the London region is the biggest outlier from the national average for this indicator, some improvement since 2016 has been made by trusts across the London region. In 2016, BME staff in London were 2.0 times more likely to enter the formal disciplinary process than their white counterparts; this has now decreased to 1.80.

- In 79 (34.1%) trusts the likelihood of white and BME staff entering the disciplinary process was either equal, or white staff are more likely to enter the disciplinary process.

- The number of trusts where the likelihood of BME staff entering the disciplinary process is more than white staff is 153 (65.9%). In as many as 55 (23.7%) trusts, the likelihood of BME entering the disciplinary process is more than twice as likely as for white staff.

- Across 232 of 235 NHS trusts in England, 1.3% (11,857) of white staff and 1.7% (3,854) of BME staff entered the formal disciplinary process.

6.3.3. By region

Figure 9. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff: 2016 and 2017

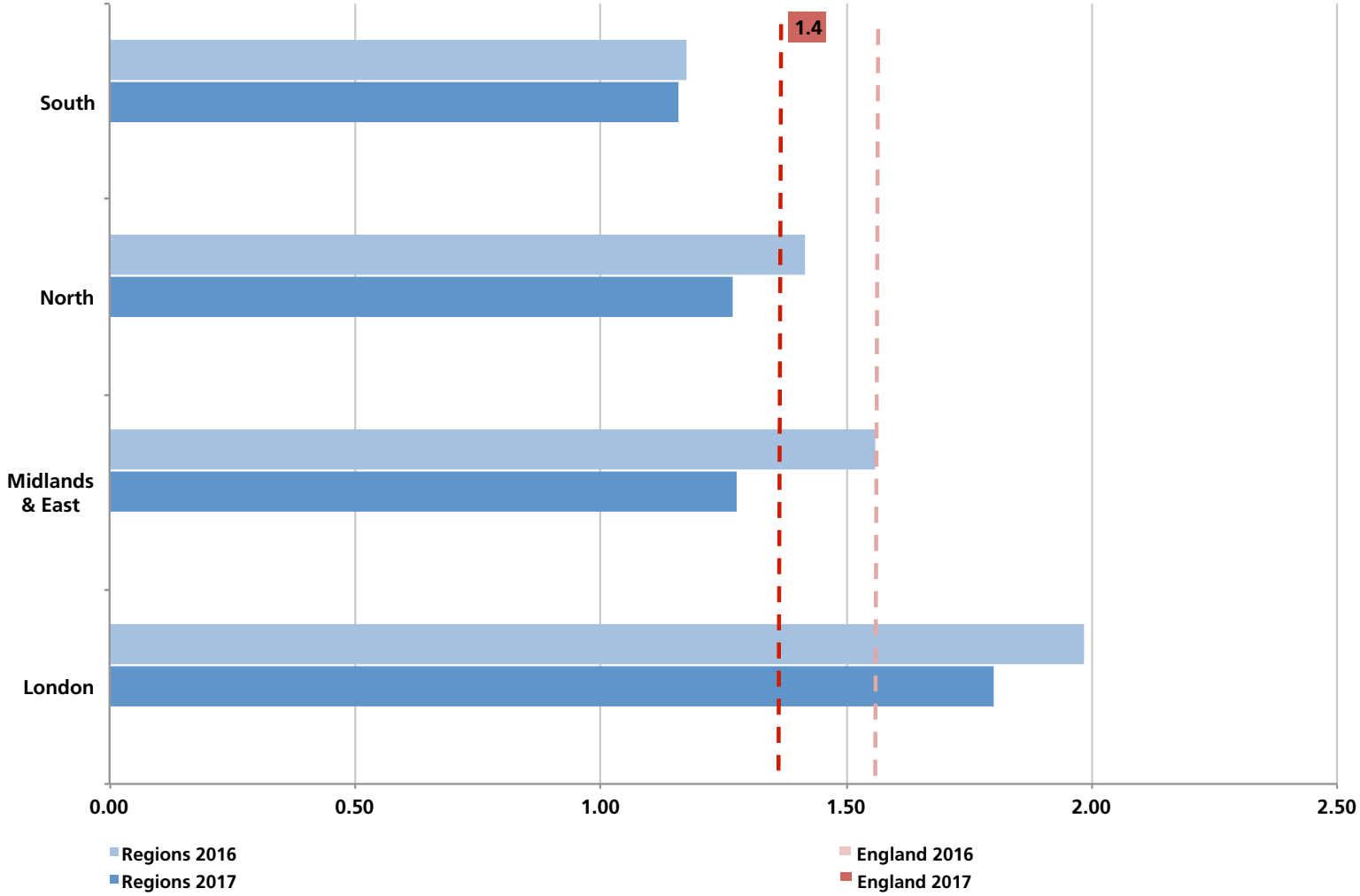


Table 10. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff: 2016 and 2017

	2016	2017
England	**1.56**	**1.37**
Sector type		
London	1.99	1.80
Midlands & East	1.56	1.28
North	1.42	1.27
South	1.17	1.16

All regions across England have shown a continuous improvement on this indicator since 2016; see figure 9 and table 10. In particular, the greatest improvement has been in the Midlands & East region where BME staff are 1.28 times more likely to enter the formal disciplinary process in comparison to white staff. In 2016, this figure was 1.56.

In the North region, BME staff are 1.27 times more likely to enter the formal disciplinary process in comparison to white staff; this is lower than the 2016 figure of 1.42.

With the exception of London, all other regions report the relative likelihood of BME staff entering the formal disciplinary process in comparison to white staff as being lower than the national average of 1.37.

Whilst the likelihood of BME staff entering the formal disciplinary process in comparison to white staff in London, has improved from 1.99 to 1.80 in 2017, it is still significantly higher than the national likelihood of 1.37. The WRES team is undertaking focused work with the NHS trusts in the London region to tackle workforce race inequalities, including this particular WRES indicator.

6.3.4. By trust type

Figure 10. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff: 2016 and 2017

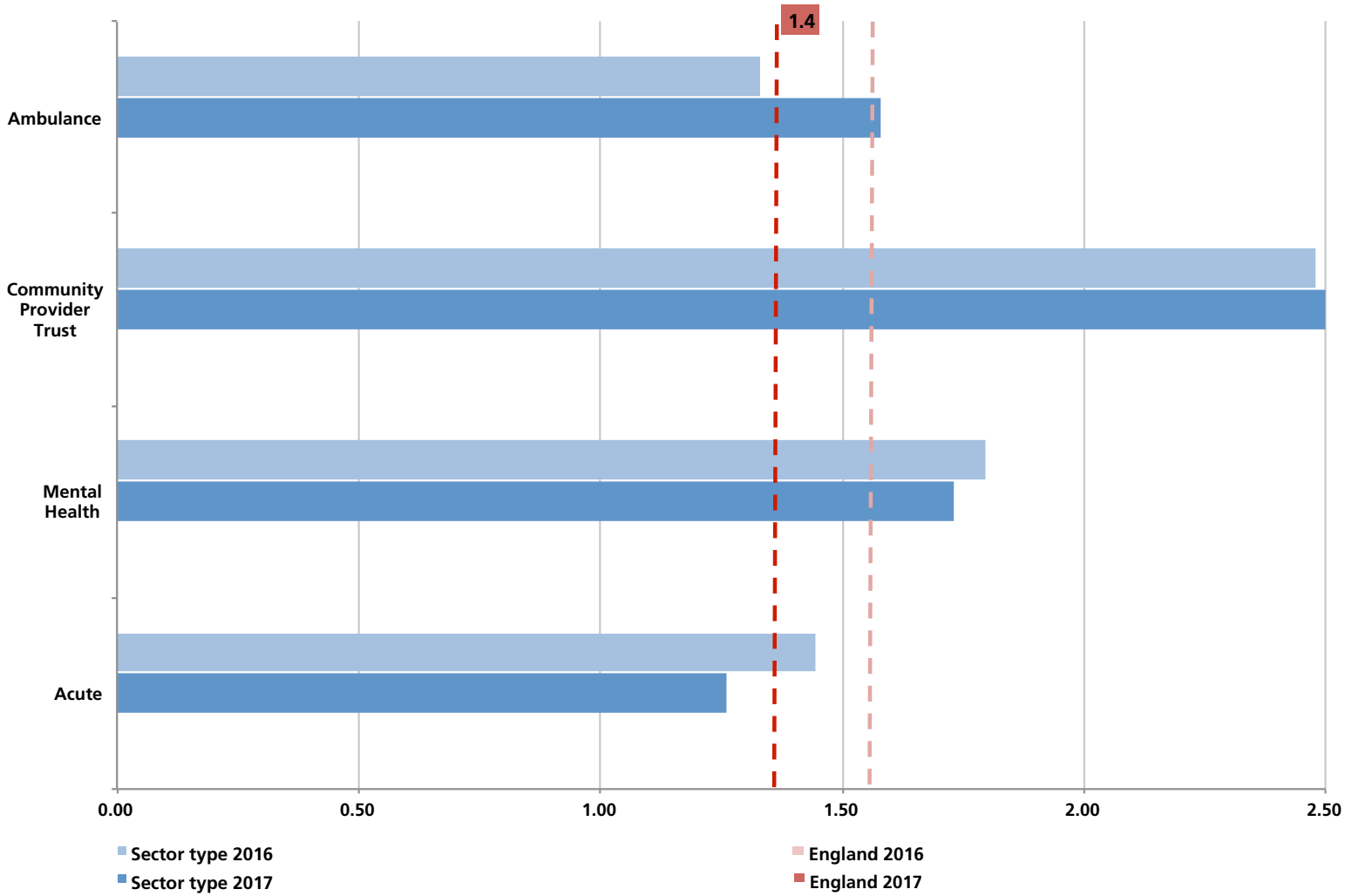


Table 11. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff: 2016 and 2017

	2016	2017
England	**1.56**	**1.37**

Sector type		
Acute	1.45	1.26
Mental Health	1.80	1.73
Community Provider Trust	2.48	3.35
Ambulance	1.33	1.58

Figure 10 and table 11 show the differences in the relative likelihood of BME staff entering the formal disciplinary process compared to white staff within each type of NHS trust.

With the exception of the acute sector, all sectors report the likelihood of BME staff entering the formal disciplinary process compared to white staff to be higher than the England figure of 1.37

The community provider sector is an outlier, with BME staff 3.35 times more likely to enter the formal disciplinary process compared to white staff – higher than the 2.48 likelihood reported by this sector in 2016.

When comparing 2016 and 2017 data, the position for the ambulance sector has become an increasing concern, with the likelihood of BME staff entering the formal disciplinary process compared to white staff increasing from 1.33 to 1.58.

The greatest improvement is within the acute sector, where the likelihood of BME staff entering the formal disciplinary process compared to white staff has decreased from 1.45 in 2016, to 1.26 in 2017.

All the comparative trust data relating to WRES indicator 3 can be found **online**.

6.3.5.Trusts where data suggest practice may be better

It is of particular interest to learn from those organisations where the likelihood of BME staff entering the disciplinary process has improved and is lower than the sector average.

Organisations were not included in the table unless all of the following conditions applied:

- Results for indicator 3 improved from 2016 to 2017 by at least 0.1
- Results for Indicator 3 in 2017 are below the sector average
- Results for Indicator 3 in 2017 are not below 0.9 (a figure below 1 would indicate that White staff are more likely than BME staff)
- The 2016 BME staff results for Indicator 8 are better than the sector average for BME staff
- The 2016 BME sample size for Indicator 8 is more than 50 headcount

Table 12. Trusts where data suggest practice may be better for WRES indicator 3

Avon And Wiltshire Mental Health Partnership NHS Trust
Black Country Partnership NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
Frimley Park Hospital NHS Foundation Trust
Maidstone And Tunbridge Wells NHS Trust
Royal Berkshire NHS Foundation Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Royal National Orthopaedic Hospital NHS Trust
Sheffield Health and Social Care NHS Foundation Trust
Southend University Hospital NHS Foundation Trust
Surrey And Sussex Healthcare NHS Trust
The Hillingdon Hospitals NHS Foundation Trust
The Royal Orthopaedic Hospital NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

Caution should be exercised in assuming that trusts whose data is better are necessarily engaged in better practice than those who are not. It is evident, from ongoing engagement with the system, that some of the best practice on this indicator is often undertaken by trusts where relatively poor data has sparked the board, and others, into taking concerted action to redress disparities in this area. Being included in this list does not necessarily mean good practice is underway, any more than not being in this list means that there is no good practice underway.

6.4. WRES indicator 4 – Relative likelihood of staff accessing non – mandatory training and career progression development (CPD)

6.4.1. Data source and reliability

A total of 205 (87%) trusts provided data of a quality which enabled it to be analysed. Data quality for this indicator has improved this year, with only 23 NHS trusts failing to provide any data, compared to 48 trusts last year. A further seven trusts provided data of a quality that had low confidence levels, compared to 26 in the 2016 collection.

The practice of recording non mandatory and CPD training differs between organisations. The current definition does not explicitly include access to acting up, shadowing, leading projects, secondments, coaching etc. which may be the most important aspects of staff development and which employers may consider including. For these reasons, it is difficult to compare accurately across organisations for this indicator.

6.4.2. Overall results

- Across England, white staff were 1.22 times more likely to access non-mandatory training and career progression development (CPD) than BME staff. This is higher than in 2016, when white staff were 1.11 times more likely to access non-mandatory training and CPD than BME staff.
- The data quality for this indicator improved significantly in 2017. The sample size for this indicator is based on 205 trusts, much higher than the 162 figure for 2016.
- In 75 of the 205 trusts that provided reliable data, it was more likely that white staff accessed non-mandatory training and CPD than BME staff. In 53 trusts it was the same likelihood, and in 77 trusts it was more likely that BME staff accessed non-mandatory training and CPD.

6.4.3. By region

Figure 11. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff: 2016 and 2017

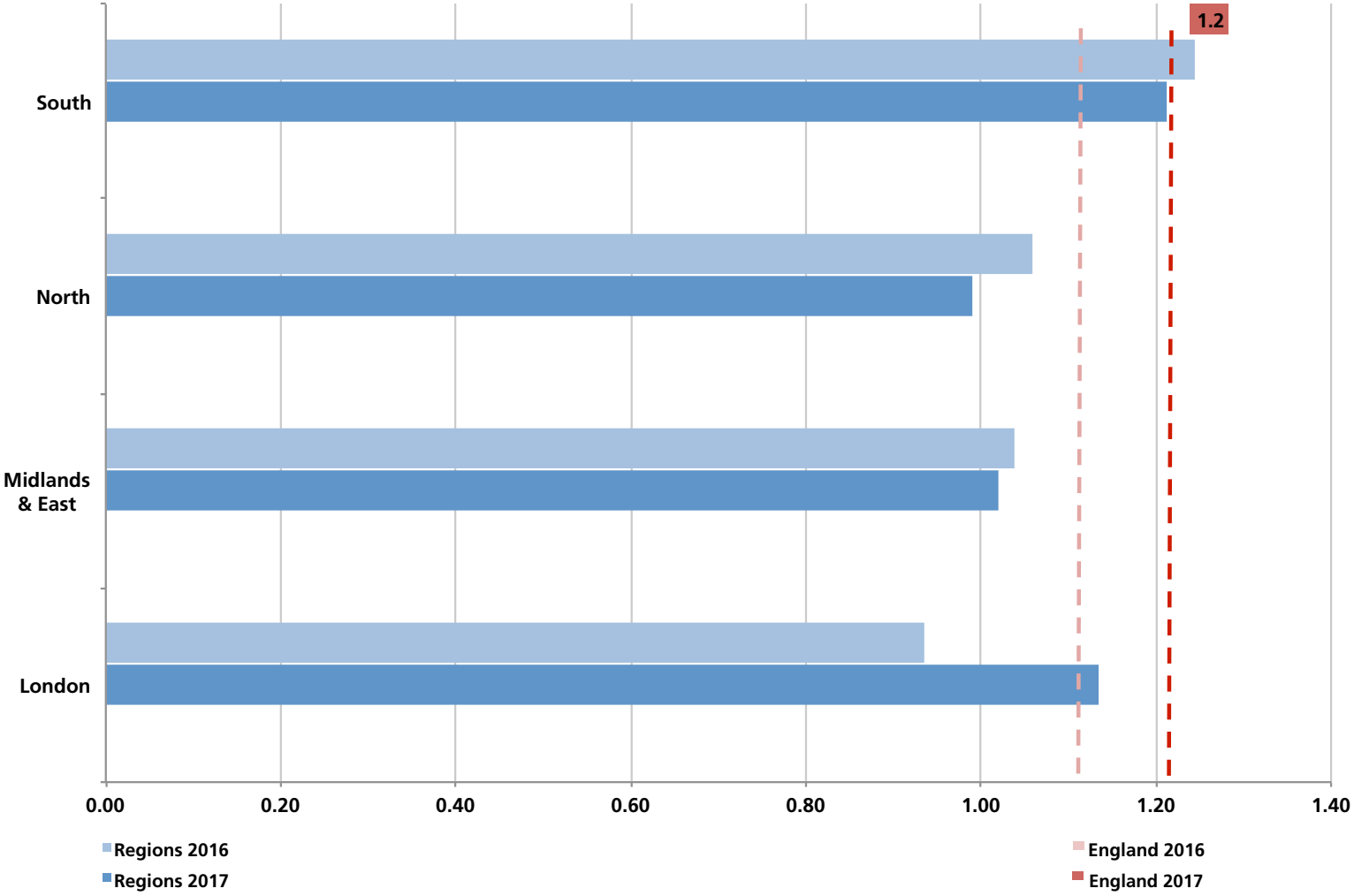


Table 13. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff

	2016	2017
England	**1.11**	**1.22**

Region		
London	0.93	1.13
Midlands & East	1.04	1.01
North	1.06	0.99
South	1.24	1.21

In all regions across England, the likelihood of white staff accessing non-mandatory training and CPD than BME staff is lower than the England average of 1.22; see figure 11 and table 13.

The South region (1.21) has the highest likelihood of white staff accessing non-mandatory training and CPD than BME staff.

The data for the Midlands & East and South regions should be interpreted with caution as the sample sizes for these regions is representative of 85% (61 trusts) and 82% (45 trusts) of organisations in these regions.

6.4.4. By sector type

Figure 12. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff: 2016 and 2017

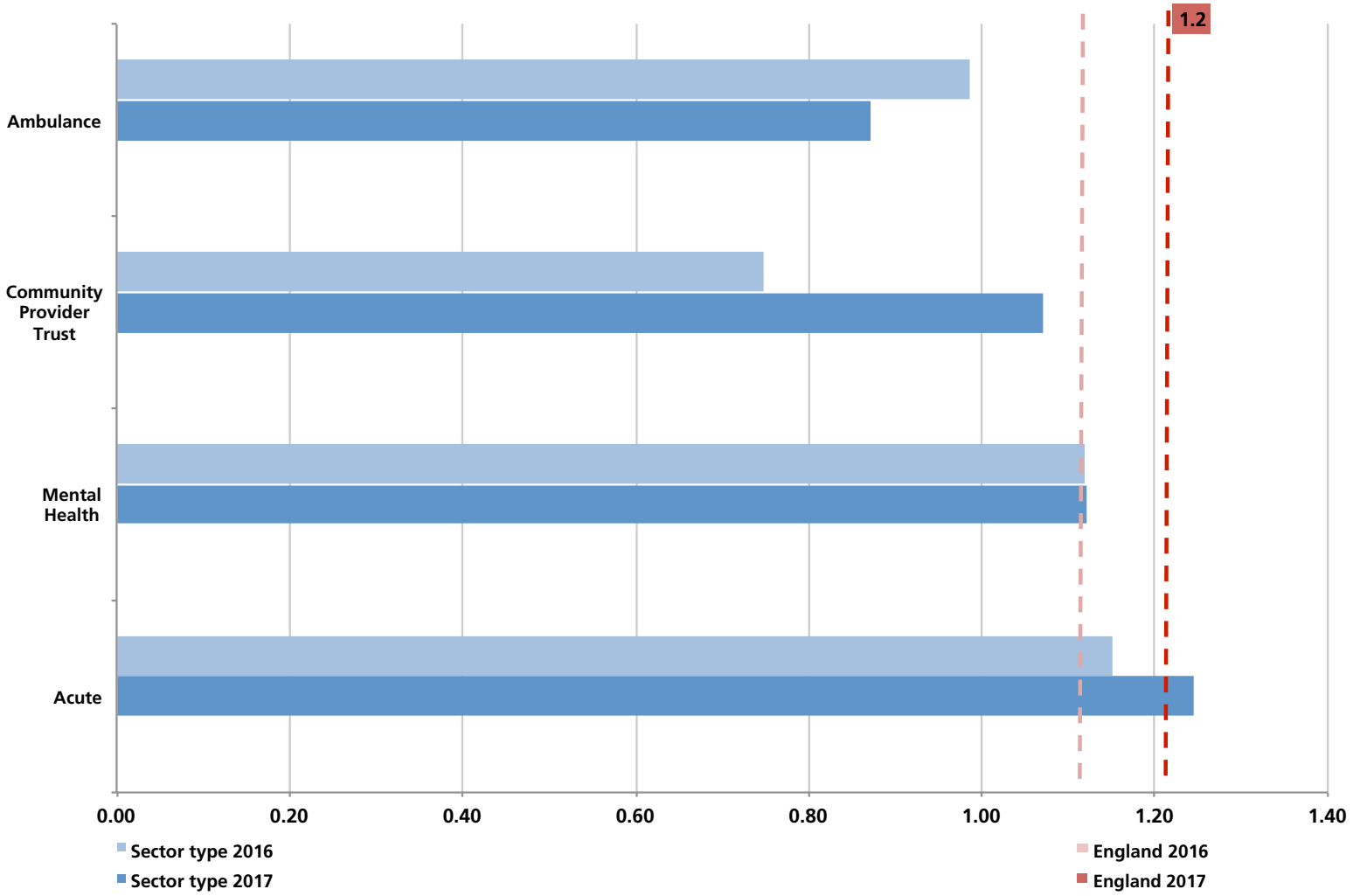


Table 14. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff

	2016	2017
England	**1.11**	**1.22**

Sector type		
Acute	1.15	1.25
Mental Health	1.12	1.12
Community Provider Trust	0.75	1.07
Ambulance	0.99	0.83

With the exception of acute trusts, in all sectors across England, the likelihood of White staff accessing non-mandatory training and CPD than BME staff is lower than the England average of 1.22; see figure 12 and table 14.

The acute sector (1.25) has the highest likelihood of white staff accessing non-mandatory training and CPD than BME staff.

The data for the ambulance and the community provider sector should be interpreted with caution as the sample sizes for these sectors is representative of 80% (eight trusts) and 79% (15 trusts) of organisations in these sectors.

6.5. WRES indicator 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (Key Finding 25)

6.5.1. Data source and reliability

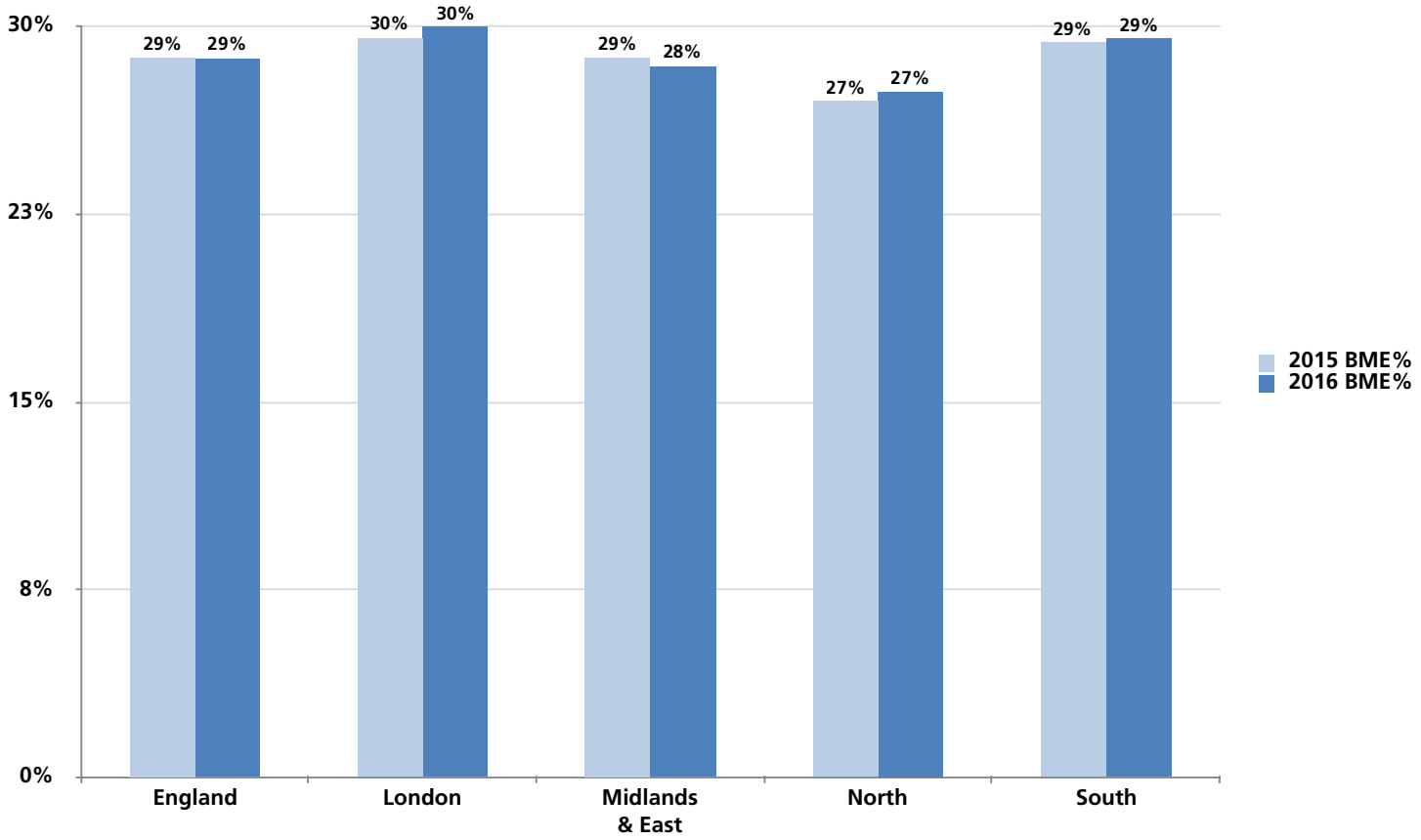
Aggregated trust responses to the indicators drawn from the NHS staff survey questions exclude a number of trusts where the BME responses were so small that they were not published; this helps to comply with the Data Protection Act 2003. Where data are published and presented, trusts that have BME responses from less than 50 staff should be treated with caution.

6.5.2 Overall results

- The overall percentage of all staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months in all NHS trusts dropped from 29% in 2015 to 28% in 2016.
- The percentage of white staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months remained at 28% in 2015 and 2016.
- For BME staff, the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months also remained consistent, at 29% in both 2015 and 2016.
- The difference between the percentage of white and BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months changed marginally, from -0.7 percentage points in 2015 to -0.8 percentage points in 2016.
- The last eight years have seen a very small difference in the experience of white and BME staff across the NHS on this indicator. This remains in contrast to the data that show bullying by colleagues or managers, where the experience of BME staff is, on average, consistently worse than that of white staff across the NHS.

6.5.3. By region

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



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

	2015	2016
England	**28.8%**	**28.7%**

Sector type		
London	29.6%	30.0%
Midlands & East	28.8%	28.4%
North	27.0%	27.4%
South	29.4%	29.5%

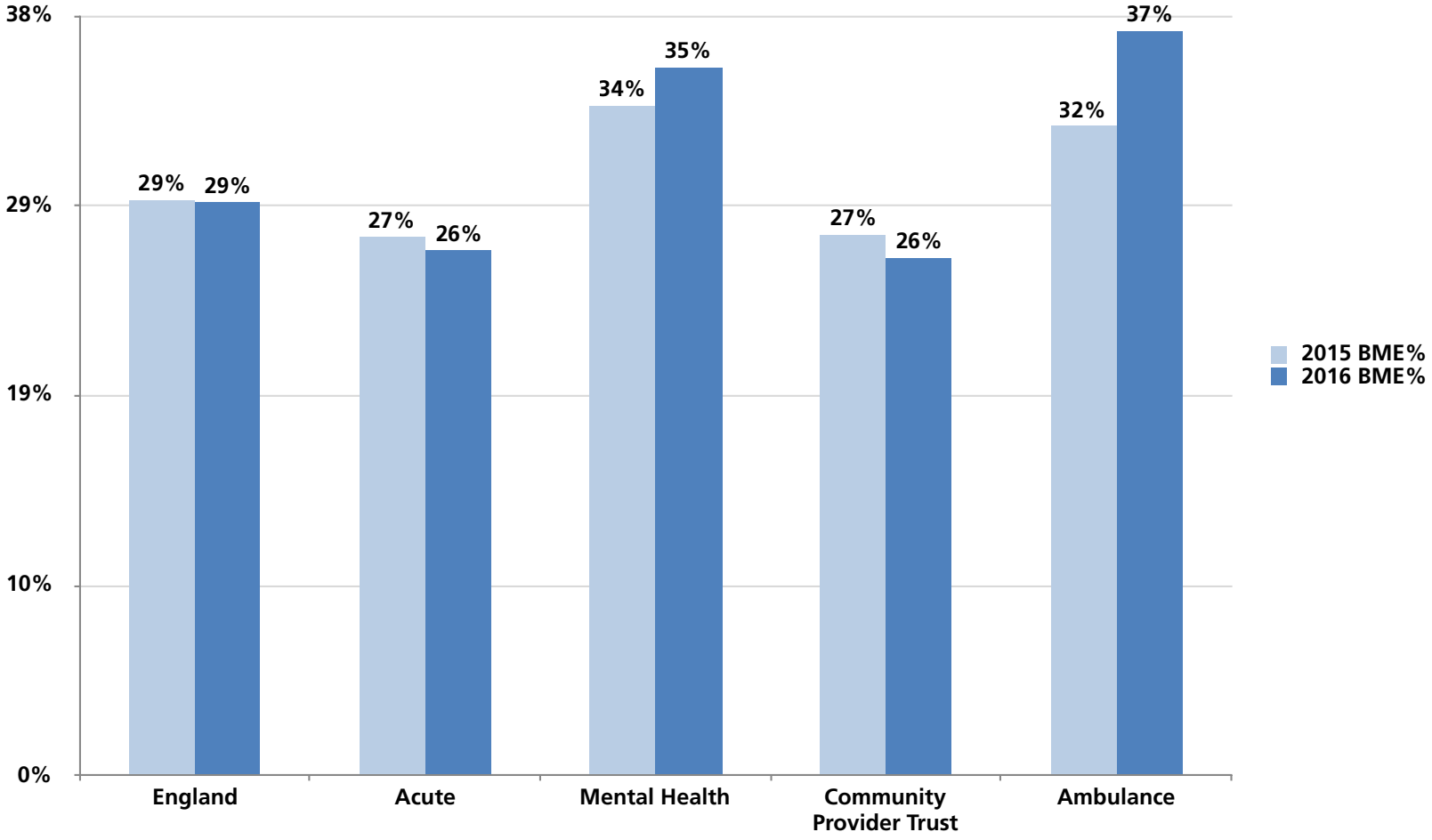
** Data based on greater than 50 responses from BME staff*

As figure 13 and table 15 show, the proportion of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months changed very little in all regions with the exception of Midlands and East, where this statistic fell by 0.4 percentage points.

Both the London and the North regions each showed a 0.4 percentage point increase in BME staff reporting harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

6.5.4. By type of trust

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



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

	2015	2016
England	**28.8%**	**28.7%**

Sector type		
Acute	26.9	26.3%
Mental Health	33.5%	35.4%
Community Provider Trust	27.0%	25.9%
Ambulance	32.5%	37.3%

** Data based on greater than 50 responses from BME staff*

As figure 14 shows, the greatest improvement in the data for this indicator was observed within the community provider trust sector, where the proportion of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months fell by 1.2 percentage points between 2015 and 2016. It should be noted that these results are based on the 63% (12) of community provider trusts that had 50 or more responses from BME staff. See also table 16.

The ambulance sector had the poorest returns, for staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. The data showed an increase of 4.8 percentage points between 2015 and 2016.

These figures need to be read with much caution. In 2015, just one of the ten ambulance trusts collected data for this indicator using a BME sample size of 50 or more staff. In 2016, this increased to 5 out of 10 ambulance trusts. The latest data for the ambulance sector are likely to be the most robust and accurate to date, largely due to a welcomed shift in trusts carrying out full census of the NHS Staff Survey as opposed to sample surveys of their staff.

6.5.5. Trusts where data suggest practice may be better

The table below identifies trusts where data suggest the experience of BME staff in experiencing harassment, bullying or abuse from patients, relatives or the public appears to be better than average and continues to improve.

The following criteria were used to identify trusts that are doing better than average and showing signs of continuous improvement on this WRES indicator:

- BME response rate is 50 headcount or more in each year
- The indicator % is lower (better) by at least 1.0 percentage points in comparison to the previous year
- Results have consistently improved from 2014 to 2016
- The 2016 score is equal to or lower than the sector average for all BME staff

Table 17. Trusts where data suggest practice may be better on WRES indicator 5

Bradford District Care NHS Trust
Coventry And Warwickshire Partnership NHS Trust
Dudley And Walsall Mental Health Partnership NHS Trust
George Eliot Hospital NHS Trust
Guy's and St Thomas' NHS Foundation Trust
Heart of England NHS Foundation Trust
Hertfordshire Community NHS Trust
Liverpool Women's NHS Foundation Trust
Papworth Hospital NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
South London and Maudsley NHS Foundation Trust
South West London And St George's Mental Health NHS Trust
The Royal Wolverhampton Hospitals NHS Trust

It is acknowledged that certain types of trusts and certain parts of some trusts are likely to have higher levels of harassment, bullying or abuse from patients, relatives or the public – notably ambulance trusts, mental health trusts and where staff are working in accident and emergency departments, for example.

Being on this list does not necessarily mean good practice is underway, any more than not being on this list means there is no good practice underway.

6.6. WRES indicator 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (Key Finding 26)

6.6.1 Data source and reliability

Aggregated trust responses on NHS Staff Survey indicators exclude a number of trusts where there BME responses were so small they were not published to comply with the Data Protection Act 2003. Data for trusts with responses of less than 50 staff should be treated with caution. It should be noted that the term "staff", in the wording of this indicator, refers to the entire workforce.

6.6.2. Overall results

- The overall percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months, remained constant at 24% for both 2015 and 2016.
- The overall percentage of white staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months dropped from 24% in 2015 to 23% in 2016.
- The overall percentage of BME staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months dropped from 27% in 2015 to 26% in 2016.
- The gap between the percentage of white and BME staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months increased from -2.2 percentage points in 2015 to -3.1 percentage points in 2016.
- Whilst the difference between the percentage of white and BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months has remained small over the previous eight years across the NHS, there is a significant difference between the percentage of white and BME staff being bullied by colleagues or managers. The experience of BME staff has, on average, been consistently worse with regard to the latter.
- In 2016, the NHS Staff Survey sample sizes increased significantly, as did BME response rates to the survey. Consequently, the latest results are more representative of the wider workforce.

6.6.3. By region

Figure 15. Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months: 2015 and 2016

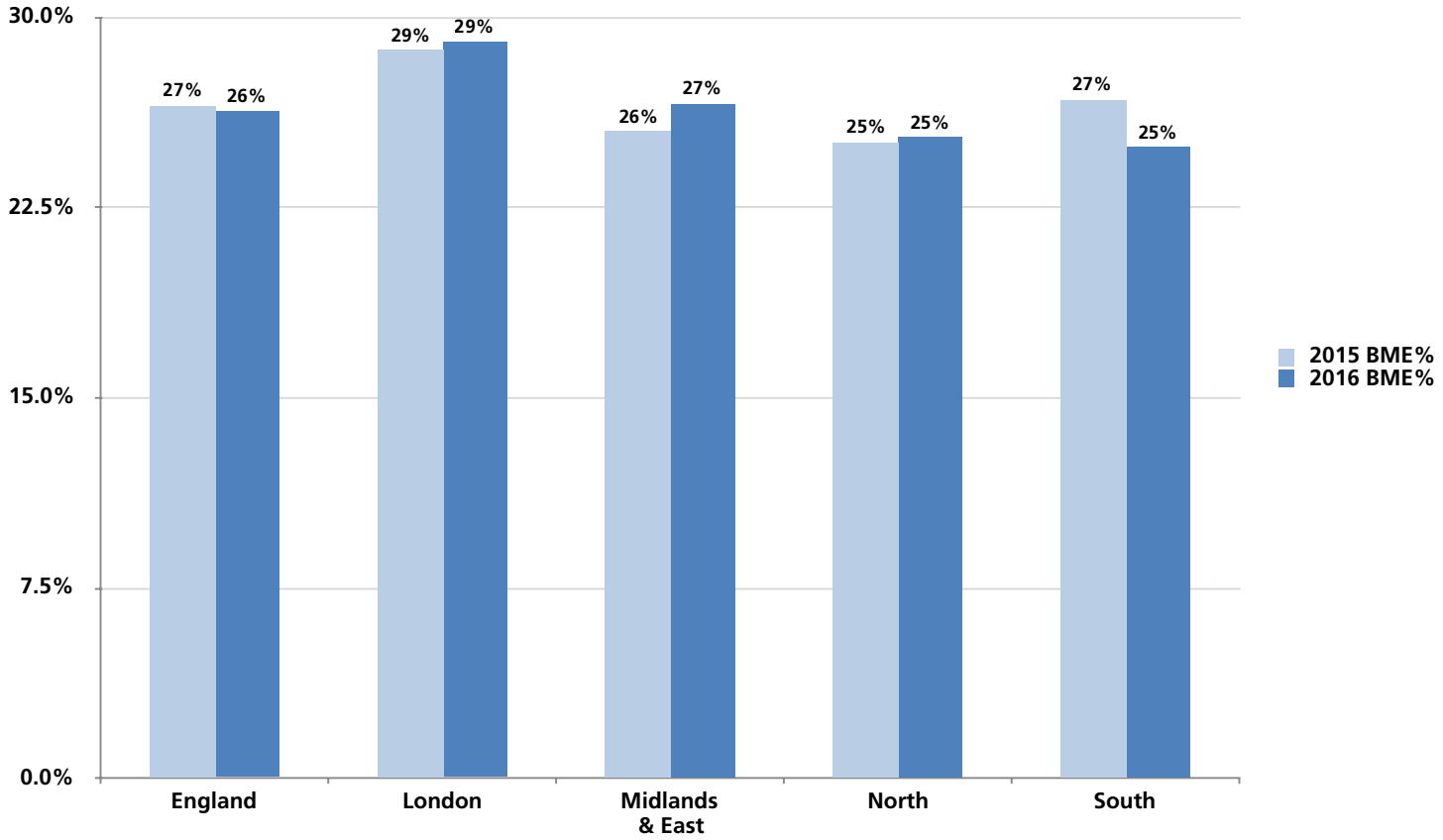


Table 18. Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months: 2015 and 2016

	2015	2016
England	**26.5%**	**26.3%**

Sector type		
London	28.7%	29.0%
Midlands & East	25.5%	26.6%
North	25.1%	25.3%
South	26.8%	24.9%

** Data based on greater than 50 responses from BME staff*

As figure 15 and table 18 show, 29% of BME staff in the London region experienced harassment, bullying or abuse, similar to the previous year; this is the largest proportion across each of the four geographical regions of England.

With the exception of the South, the percentage of BME staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months increased slightly from 2015 to 2016 in all regions across England.

In the South region, the percentage of BME staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months decreased by 1.9 percentage points, from 27% in 2015 to 25% in 2016.

6.6.4. By type of trust

Figure 16. Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months: 2015 and 2016

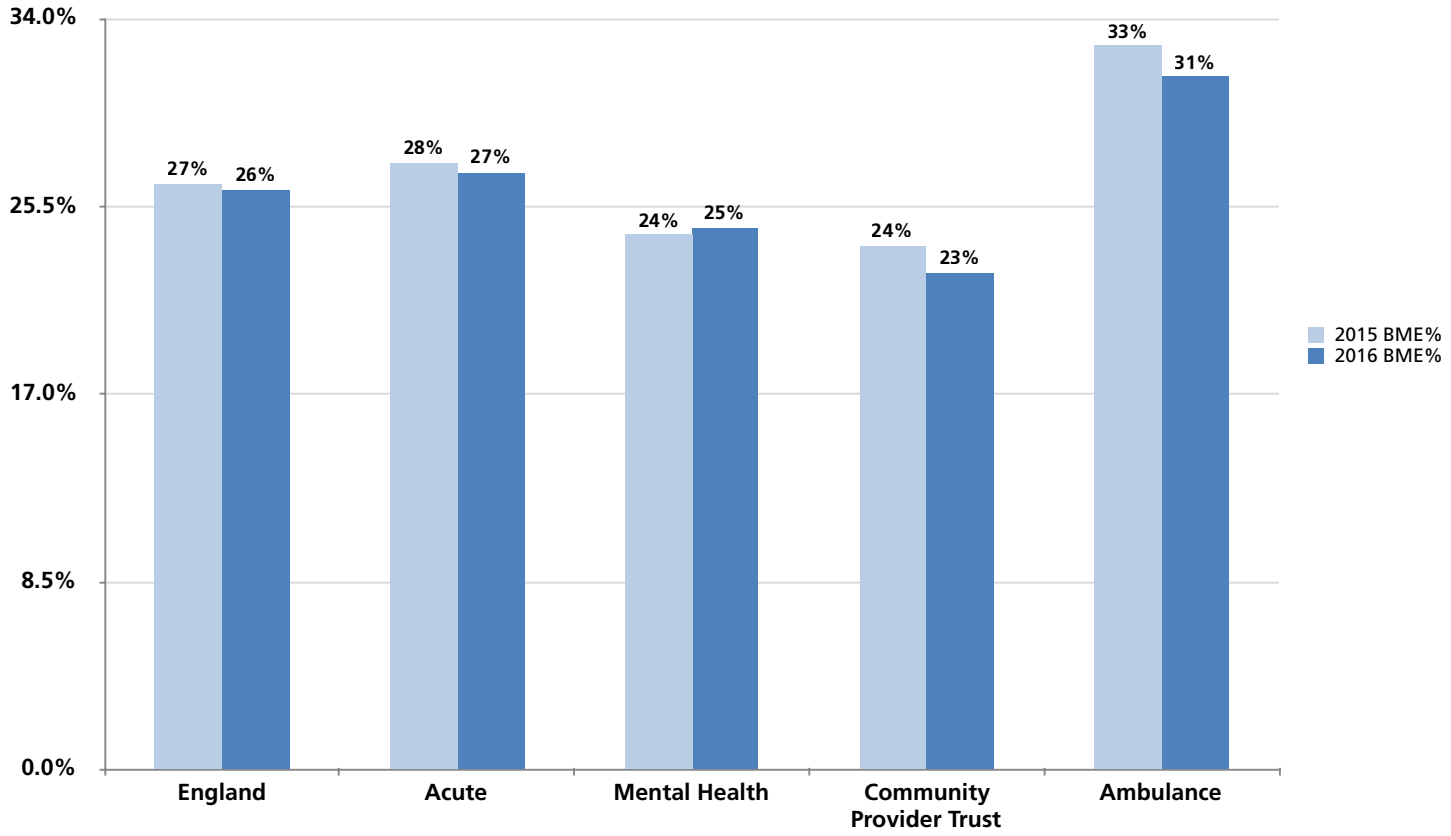


Table 19. Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months: 2015 and 2016

	2015	2016
England	**26.5%**	**26.3%**

Sector type		
Acute	27.5%	27.1%
Mental Health	24.2%	24.5%
Community Provider Trust	23.7%	22.5%
Ambulance	32.8%	31.4%

** Data based on greater than 50 responses from BME staff*

Data in figure 16 and table 19 are based on results from NHS trusts with more than 50 BME respondents to the NHS Staff Survey question upon which this WRES indicator is based. Sample sizes for the ambulance sector (five trusts) and community provider sector (12 trusts) are not fully representative of respective workforces, and therefore should be interpreted with caution.

In the acute sector, the percentage of BME staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months decreased from 28% in 2015 to 27% in 2016.

The percentage of BME staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months in the mental health sector increased slightly from 24% in 2015 to 25% in 2016.

All comparative trust data can be found **online**.

6.6.5. Trusts where data suggest practice may be better

The table below identifies trusts where data suggest the experience of BME staff in experiencing harassment, bullying or abuse from other colleagues appears to be better than average and continuously improving.

Four criteria were used to identify trusts that data suggest are doing better than average:

- BME response rate is 50 headcount or more in each year
- The indicator % is lower (better) by at least 1.0 percentage points in comparison to previous year
- Results have consistently improved from 2014 to 2016
- The 2016 score is equal to or lower than the sector average for all BME staff

Table 20. Trusts where data suggest practice may be better on WRES indicator 6

Birmingham Community Healthcare NHS Trust
Dorset Healthcare University NHS Foundation Trust
East Lancashire Hospitals NHS Trust
Hertfordshire Community NHS Trust
Leeds Community Healthcare NHS Trust
Leicestershire Partnership NHS Trust
Liverpool Women's NHS Foundation Trust
Northampton General Hospital NHS Trust
Pennine Care NHS Foundation Trust
Shrewsbury And Telford Hospital NHS Trust
Yeovil District Hospital NHS Foundation Trust

Caution should be exercised in assuming that trusts whose data is better are all engaged in better practice. Being on this list does not necessarily mean good practice is underway any more than not being on this list means there is no good practice underway at all.

6.7. WRES indicator 7 Percentage of staff believing that their trust provides equal opportunities for career progression or promotion (Key Finding 21)

6.7.1. Data source and reliability

This indicator is drawn from a question in the national NHS Staff Survey. Its reliability is dependent on the size of samples surveyed, the response rates, and hence whether the numbers of BME staff are so small that they may undermine the confidence in the data.

Confidence in the survey data submitted as part of the WRES report increases each year. Trusts are increasingly carrying out census surveys across the entirety of the workforce and response rates are increasing. In 2016, 68% of NHS trusts had BME response from 50 staff or more, in comparison to 52% in 2015.

6.7.2. Overall results

- The overall percentage of staff believing that their trust provides equal opportunities for career progression or promotion dropped slightly from 86% in 2015 to 85% in 2016.
- For white staff, the percentage of staff believing that their trust provides equal opportunities for career progression or promotion dropped from 89% to 88% in 2016.
- For BME staff, the percentage of staff believing that their trust provides equal opportunities for career progression or promotion increased from 74% to 76% in 2016.
- The overall difference between the percentage of white staff and BME staff for this indicator fell from 14.2 percentage points to 12.0 percentage points in 2016.
- The proportion of trusts where there was an improvement in the percentage of BME staff reporting that their trust provides equal opportunities for career progression or promotion was 88 (55%).
- The proportion of trusts where there was a decline in the percentage of BME staff reporting that their trust provides equal opportunities for career progression or promotion was 73 (45%).
- For this WRES indicator, 161 NHS Trusts across England had a BME response size of 50 or more headcounts. From this sample, in 15 (9%) trusts more than 85% of BME staff reported that their trust provides equal opportunities for career progression or promotion. In comparison, in 128 (80%) trusts more than 85% of white staff reported that their trust provides equal opportunities for career progression or promotion.
- In 2016, in 39 trusts, 30% or more of BME staff did not believe their trust provides equal opportunities for career progression or promotion. This figure compares to 35 trusts in 2015. (Data excludes BME sample sizes below 50 staff).

6.7.3. By region

Figure 17. Percentage of BME staff believing that trust provides equal opportunities for career progression or promotion: 2015 and 2016

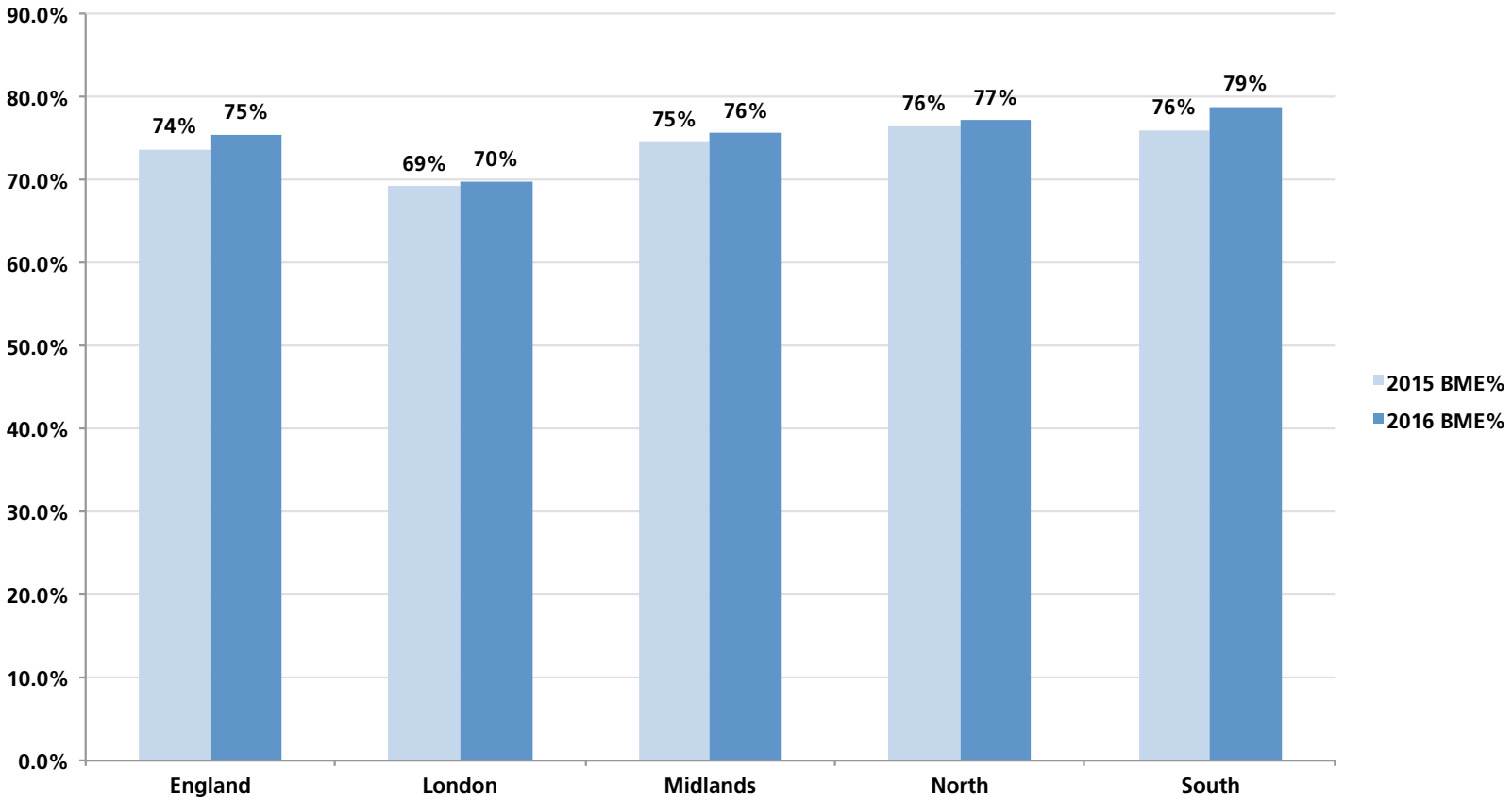


Table 21. Percentage of BME staff believing that trust provides equal opportunities for career progression or promotion

	2015	2016
England	**73.8%**	**75.5%**

Sector type		
London	69.2%	69.7%
Midlands & East	74.5%	75.6%
North	76.5%	77.1%
South	76.0%	78.8%

** Data based on greater than 50 responses from BME staff*

Nationally, the percentage of BME staff believing that their trust provides equal opportunities for career progression or promotion increased from 74% to 76%. As figure 17 and table 21 show, this trend is observed across all regions.

The greatest improvement is evident in the South region where the percentage of BME staff believing that their trust provides equal opportunities for career progression or promotion increased from 76% in 2015 to 79% in 2016.

Although a small increase of 0.6 percentage points was observed for this indicator in the London region, it still remains the region with the lowest proportion of BME staff (70%) believing that their trust provides equal opportunities for career progression or promotion. In every trust in the London region, 1 in 5 BME staff does not believe that their trust provides equal opportunities for career progression or promotion.

6.7.4. By type of trust

Figure 18. Percentage of BME staff believing that trust provides equal opportunities for career progression or promotion: 2015 and 2016

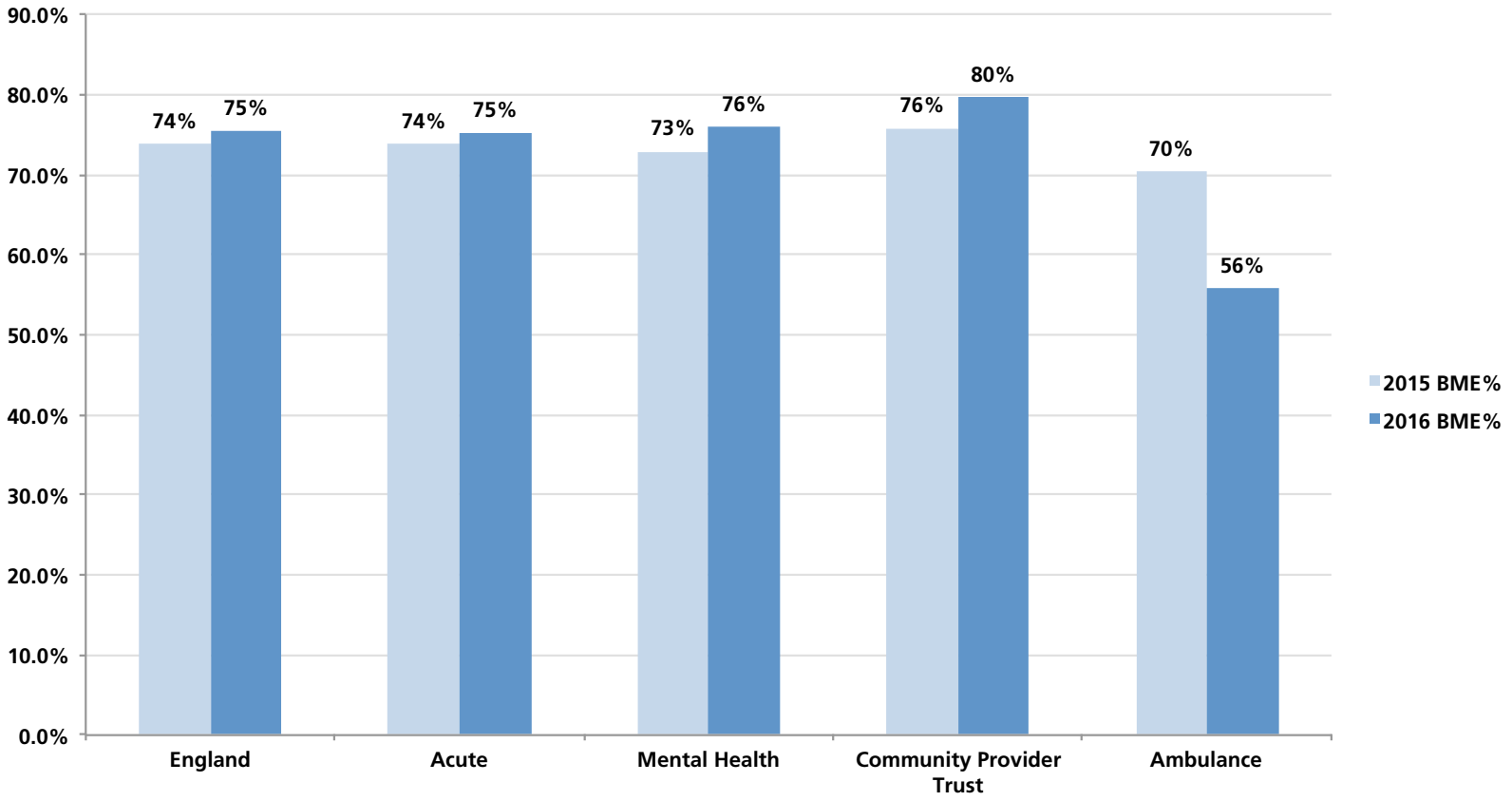


Table 22. Percentage of BME staff believing that trust provides equal opportunities for career progression or promotion: 2015 and 2016

	2015	2016
England	**73.8%**	**75.5%**

Sector type		
Acute	73.8%	75.2%
Mental Health	72.9%	75.9%
Community Provider Trust	75.8%	79.6%
Ambulance	70.4%	55.8%

** Data based on greater than 50 responses from BME staff*

There are differences by type of trust between the proportion of BME and white staff reporting that their trust provides equal opportunities for career progression or promotion; see figure 18 and table 22.

The data presented in figure 18 are based on a total of 161 NHS trusts with a BME response rate of more than 50. The sample sizes vary between sector types. For example, in 2014 and 2015, only one of the 10 ambulance trusts collected data for this indicator using a BME sample size of 50 or more staff. In 2016, only two of the 10 ambulance trusts collected data that could be published. The data for the ambulance sector should therefore be interpreted with caution.

The mental health sector showed the greatest improvement on this indicator, increasing by three percentage points to an average of 73% in 2015 to 76% in 2016.

Comparative trust data can be found **online**.

6.7.5. Trusts where data suggest practice may be better

Table 23 identifies trusts where data suggest the proportion of BME staff reporting for staff reporting that their trust provides equal opportunities for career progression or promotion is better than average and continuously improving.

Table 23. Trusts where data suggest practice may be better on WRES indicator 7

Ashford and St Peter's Hospitals NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Hertfordshire Community NHS Trust
Kent Community Health NHS Trust
Kettering General Hospital NHS Foundation Trust
Pennine Care NHS Foundation Trust
Portsmouth Hospitals NHS Trust
South Essex Partnership University NHS Foundation Trust
Surrey And Sussex Healthcare NHS Trust
The Hillingdon Hospitals NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust

Four criteria were used to identify trusts that are doing better than average:

- BME response rate is 50 headcount or more in each year
- The indicator % is higher (better) by at least 1.0 percentage points in comparison to previous year
- Results have consistently improved from 2014 to 2016
- The 2016 score is equal to or higher than the sector average for all BME staff

It should be noted that being on this list does not necessarily mean good practice is underway any more than not being on this list means there is no good practice underway.

6.8. WRES indicator 8
In the last 12 months have you personally experienced discrimination at work from any of the following - Manager / team leader or other colleagues? (Question 17b)

6.8.1. Data, source and reliability

This indicator is drawn from the national NHS Staff Survey. Aggregated trust responses on staff survey indicators exclude a number of trusts where the BME responses were so small that they were not published to comply with the Data Protection Act 2003.

6.8.2. Overall results

- The overall percentage of staff reporting that they have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months, increased from 11% in 2015 to 13% in 2016.
- The percentage of white staff reporting that they have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months, remained at 6% for 2015 and 2016.
- The percentage of BME staff reporting that they have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months, remained at 14% for 2015 and 2016.
- The overall difference between the percentage of white staff and BME staff reporting that in the last 12 months they have personally experienced discrimination at work from a manager/team leader or other colleagues remained similar, shifting from -7.5 percentage points in 2015 to -7.6 percentage points in 2016.

6.8.3. By region

Figure 19. Percentage of BME staff personally experienced discrimination at work in the last 12 months: 2015 and 2016

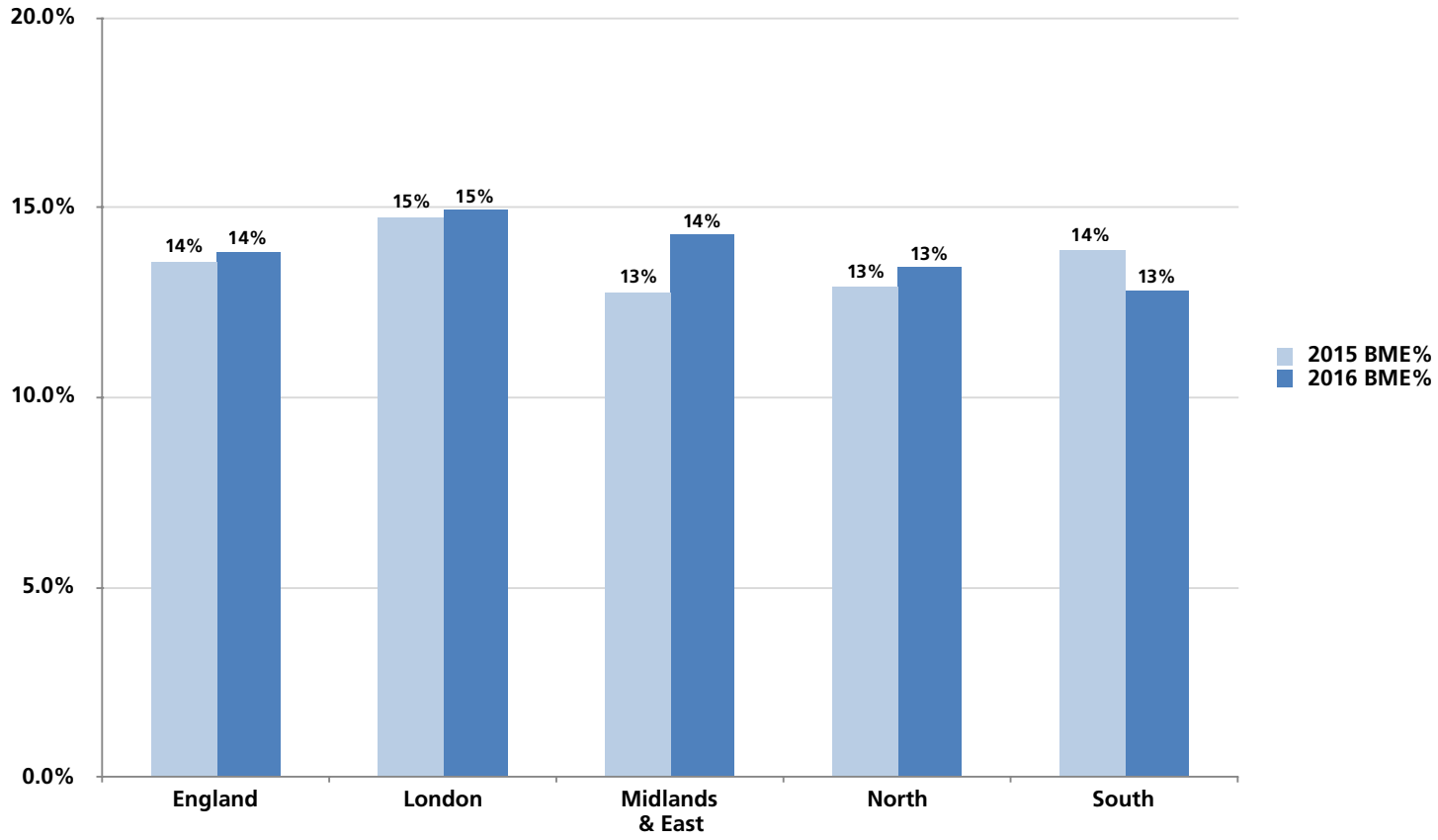


Table 24. Percentage of BME staff personally experienced discrimination at work in the last 12 months: 2015 and 2016

	2015	2016
England	**13.6%**	**13.8%**

Sector type		
London	14.8%	14.9%
Midlands & East	12.8%	14.3%
North	12.9%	13.4%
South	13.9%	12.8%

** Data based on greater than 50 responses from BME staff*

The data presented in figure 19 are based on 194 NHS trusts, where the BME sample size is more than 50 headcount. In 35 trusts, there was difference of more than 10 percentage points between whether BME staff and white staff on this WRES indicator. In 20 trusts, there was a difference of less than five percentage points between the proportion of BME and white staff on this WRES indicator.

Nationally, the percentage of white staff and BME staff reporting that they have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months, remained at 14%. Similarly, in the London and North region, the figures remained at 15% and 13%, respectively; see figure 19 and table 24.

The greatest improvement is evident in the South region where the percentage of white staff and BME staff reporting that they have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months, reduced by 1.5 percentage points to 13% in 2016.

London remains the region with the highest proportion of BME staff (15%) reporting that they have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months.

6.8.4. By type of trust

Figure 20. Percentage of BME staff personally experienced discrimination at work in the last 12 months: 2015 and 2016

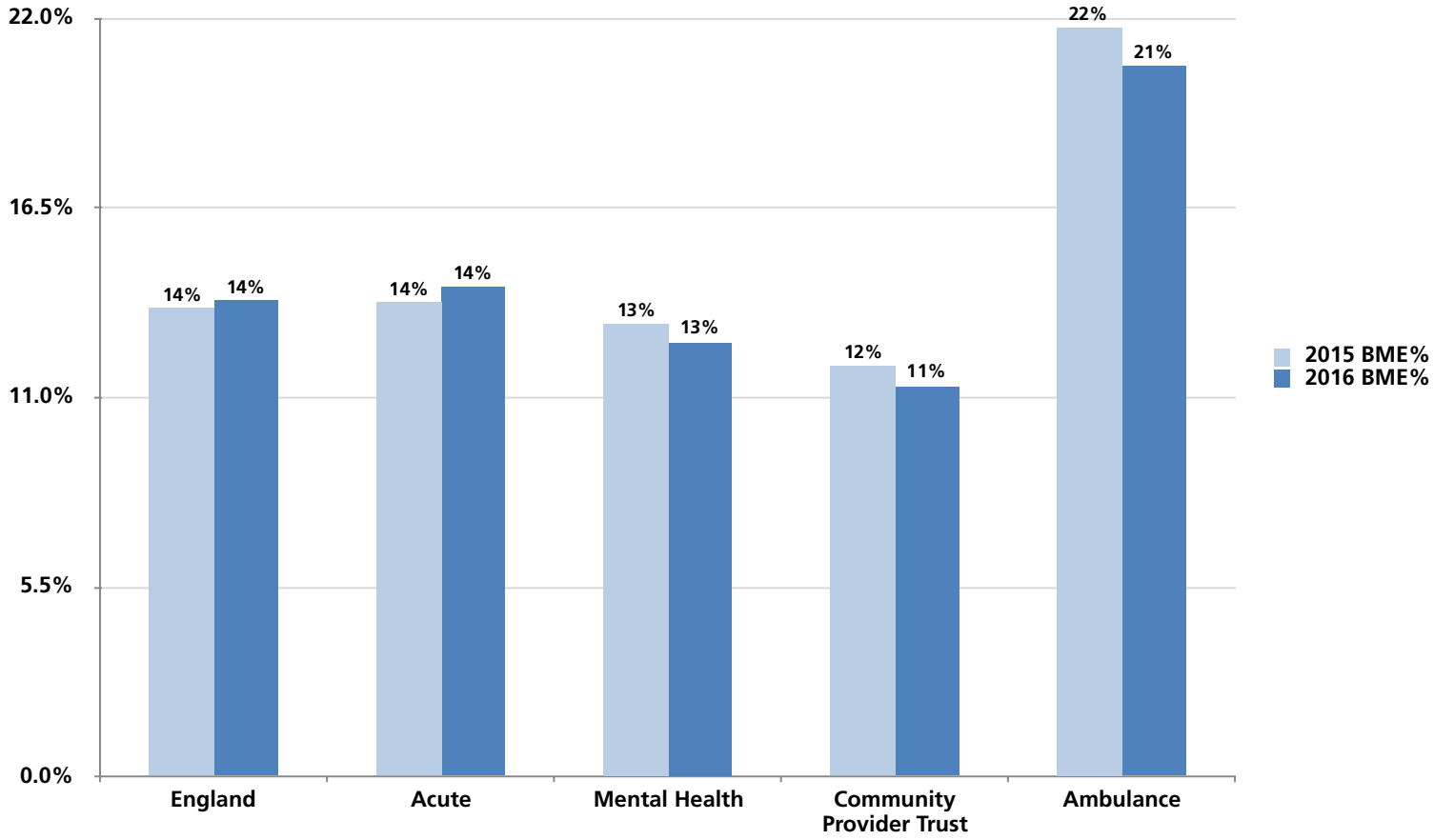


Table 25. Percentage of BME staff personally experienced discrimination at work in the last 12 months: 2015 and 2016

	2015	2016
England	**13.6%**	**13.8%**

Sector type		
Acute	13.7%	14.2%
Mental Health	13.1%	12.6%
Community Provider Trust	11.9%	11.3%
Ambulance	21.7%	20.6%

** Data based on greater than 50 responses from BME staff*

The data presented in figure 20 and table 25 are based on a total of 194 NHS trusts with a BME response rate of more than 50 headcounts. The sample sizes vary between the types of sector. In particular, as in 2015, only two of the 10 ambulance trusts collected data for this indicator using a BME sample size of 50 or more staff. For community provider trusts, data eligible for publication was from 12 out of the 19 trusts. The results for these sectors should therefore be interpreted with an element of caution.

The percentage of white staff and BME staff reporting that they have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months, remained at 14%.

Similarly, there were little differences in the responses from BME staff on this indicator over time, within each of the trust types; for example, there were very slight decreases in mental health (by 0.5 percentage points), community provider (0.6 percentage points) and the ambulance (1.1 percentage points) sectors. There was a slight increase, by 0.2 percentage points, of BME staff reporting that they have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months.

All comparative data for trusts can be found **online**.

6.8.5 Trusts where data suggest practice may be better

The table below identifies trusts (see table 26) where data suggest the proportion of BME staff reporting that they have personally experienced discrimination at work from a manager/team leader or other colleagues in the last 12 months is better than average and continuously improving.

Four criteria were used to identify trusts that are doing better than average:

- BME response rate is 50 headcount or more in each year
- The indicator % is lower (better) by at least 1.0 percentage points in comparison to previous year
- Results have consistently improved from 2014 to 2016
- The 2016 score is equal to or lower than the sector average for all BME staff

Table 26. Trusts where data suggest practice may be better on WRES indicator 8

Buckinghamshire Healthcare NHS Trust
Coventry And Warwickshire Partnership NHS Trust
Dorset County Hospital NHS Foundation Trust
Dorset Healthcare University NHS Foundation Trust
Homerton University Hospital NHS Foundation Trust
Leeds Community Healthcare NHS Trust
Leicestershire Partnership NHS Trust
Lewisham and Greenwich NHS Trust
Liverpool Women's NHS Foundation Trust
Northampton General Hospital NHS Trust
Royal Berkshire NHS Foundation Trust
Royal National Orthopaedic Hospital NHS Trust
Solent NHS Trust
The Royal Marsden NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
Western Sussex Hospitals NHS Trust

Caution should be exercised in assuming that trusts whose data are better are all necessarily engaged in better practice than those who are not. It is evident from field work and engagement with trusts, that some of the best replicable practice on this indicator is being undertaken by trusts where relatively poor data has prompted the board, and others, into taking determined action to redress the disparities.

6.9. WRES indicator 9 Percentage difference between the organisations' board voting membership and its overall workforce

6.9.1. Data source and reliability

It can be argued that BME board representation, and any increase to it, may in general be due to non-executive and non-voting positions as opposed to executive and voting positions. Consequently, for the first time in 2017, trusts were asked for data so that executive and non-executive board members, and voting and non-voting board members, could be distinguished by ethnicity.

Additionally, data for board members who chose to not disclose their ethnicity was not collected for the 2016 WRES data report; however this was collected as part of the 2017 data return and is part of the data analysis reported below.

The data presented is based on the returns for 224 NHS trusts. The results for a small number of trusts have been left out due to nil returns, or low confidence levels in the data returned. Due to the change in the definition of this indicator, caution should be taken when directly comparing the 2016 and 2017 WRES data presented in the tables and figures that follow.

6.9.2. Overall results

Overall, the proportion of board members in NHS trusts is comprised of 88% white, 7% BME, and 5% Null/ Unknown. This is not reflective of the workforce as a whole where 17.7% of staff is from a BME background. The 2011 census identifies 11.9% of the population in England and Wales as BME.

Table 27. BME board membership, percentage and headcount: 2016 and 2017

	2016[1]	2017[2]
0 BME board members	43.5% (84)	43.8% (98)
1 BME board member	37.3% (72)	31.3% (70)
2 BME board members	10.9% (21)	13.8% (31)
3 BME board members	4.7% (9)	7.6% (17)
4 BME board members	2.6% (5)	3.1% (7)
5 BME board members	1.0% (2)	0.0% (0)
6 BME board members	0.0% (0)	0.4% (1)

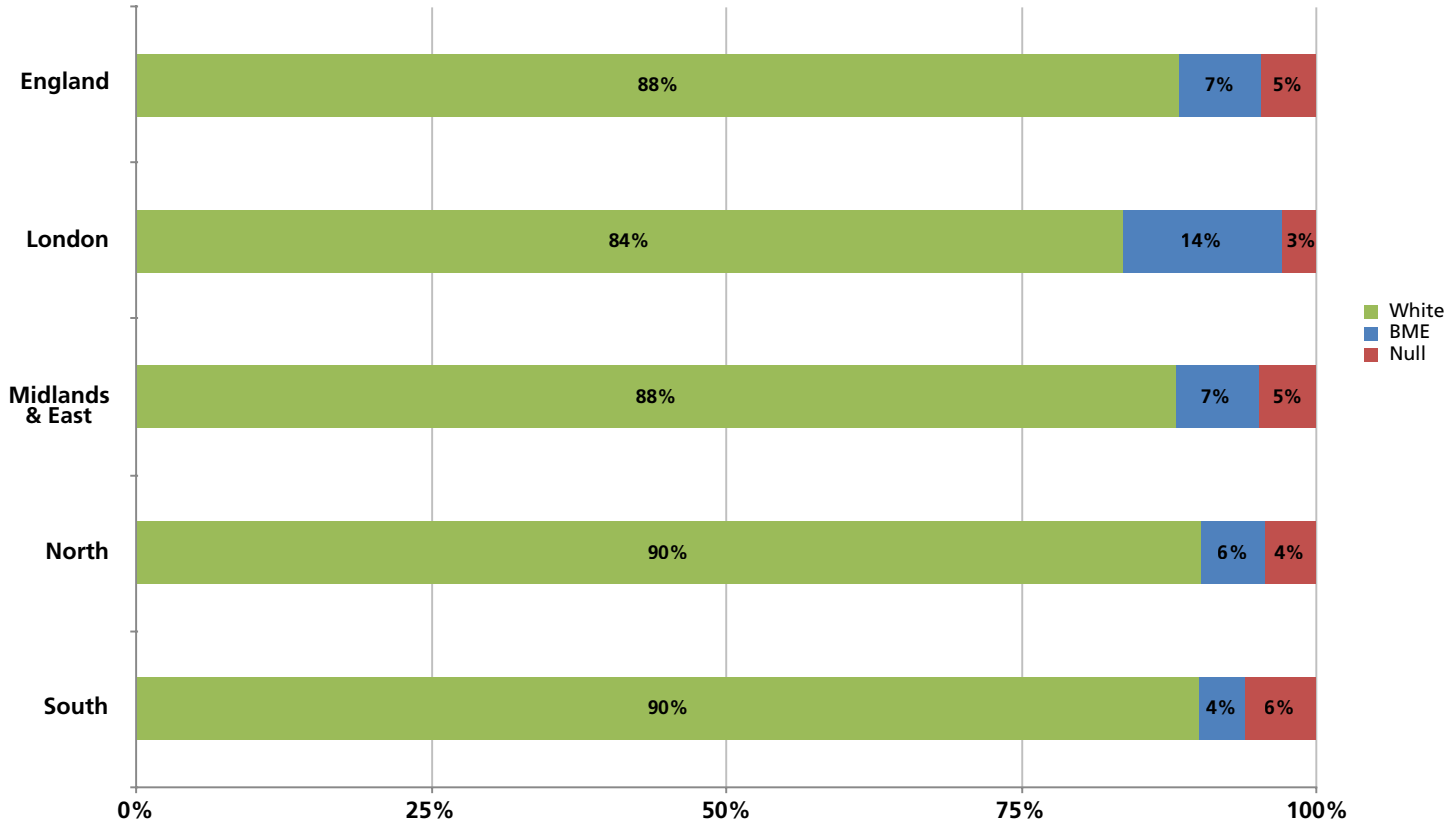
[1] 2016 data based on sample size of 193 NHS trusts.
[2] 2017 data based on sample size of 224 NHS trusts

Table 27 presents all BME board membership regardless of executive/non-executive or voting/non-voting position. It shows little change in the proportion of NHS trust boards with zero or one BME board members between 2016 and 2017. However, there is a steady increase in the number of trusts that have more than one BME board member. There are now a total of 25 NHS trusts with three or more BME members of the board, compared to the 16 trusts reported in 2016.

This welcomed increase between 2016 and 2017 has come during a period of intense WRES implementation support given to the boards of NHS trusts across the country. Further WRES support is planned during 2018 which will engage senior leaders, at local and national level, with the goal of positively influencing organisational succession planning so that boards are truly reflective of the workforce and population that they serve.

6.9.3. By region

Figure 21. Board membership by ethnicity: 2017



The proportion of BME members of NHS trust boards varies by geographical region. In London, 14% of NHS trust board members are from a BME background. Although this is a comparatively larger proportion when compared to all other regions, there is still a significant disparity between BME board representation and the BME workforce population in London trusts, which is 43%.

In the South region, BME board members comprise only 4% of the total board membership, falling below the national average of 7%. This can be compared to the overall BME workforce population in the South of 13%.

Data collected for the null category suggests instances where ethnicity is reported as 'Unknown' or 'Not Stated'. Nationally, the ethnicity of 5% of all board members is not known; this varies between 3% and 6% across all four regions.

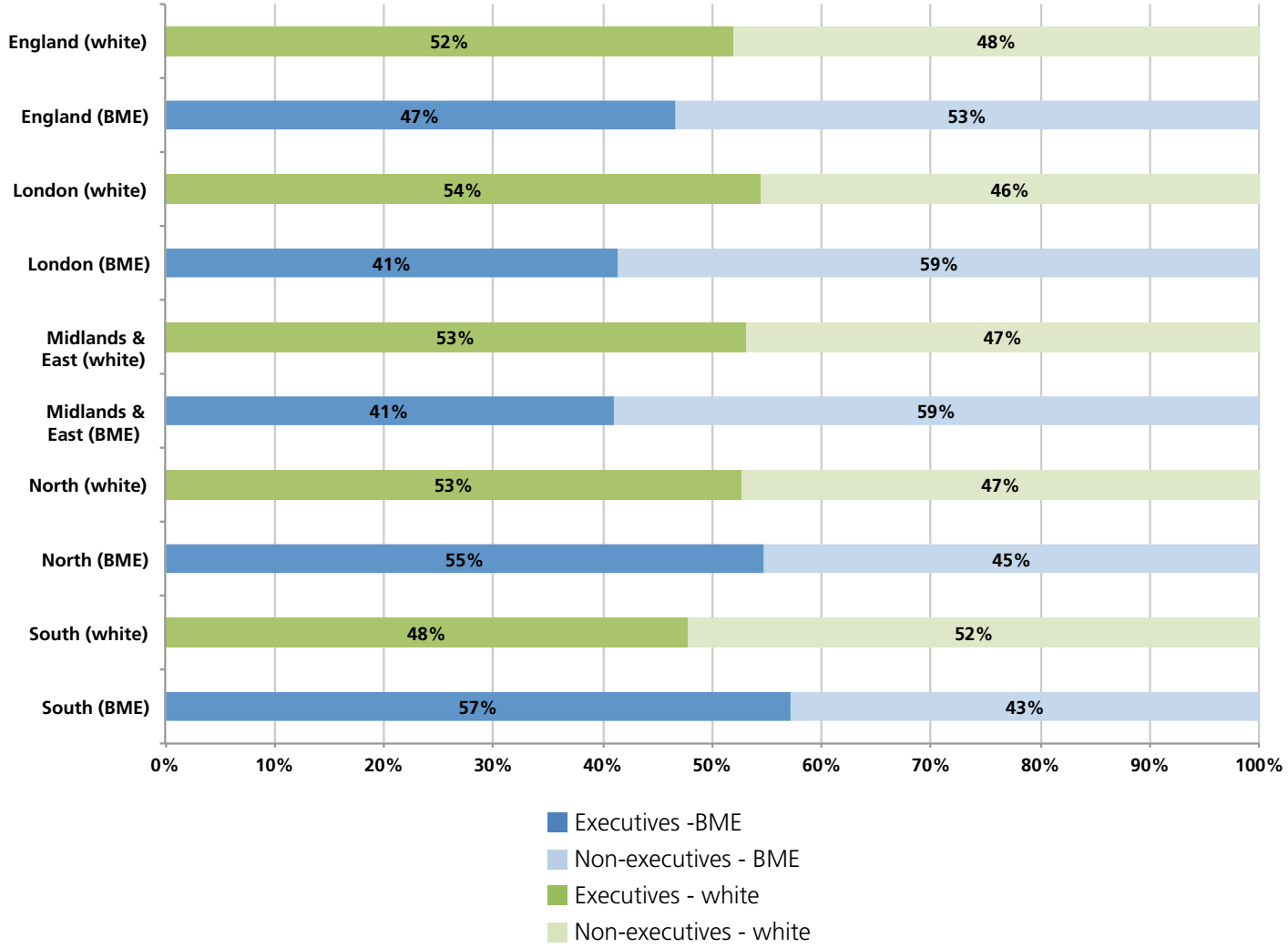
For the 2017 WRES data returns, NHS trusts were asked to report on the number of executive and non-executive board members by ethnicity. Nationally, the proportion of BME executive directors is 47%, and BME non-executive directors are 53%.

The data suggest that although 70 (14%) of all board members in London are from a BME background, a slightly larger proportion of these (57%) are appointed as non-executive directors. The smallest proportion of BME executive appointments lay within the Midlands & East region at 41%, 6 percentage points lower than the 47% across all of England; see figure 22.

In the South region, only 28 (4%) board members are from a BME background but larger proportions (57%) of these appointments are for executive directors. This is 10 percentage points higher than the national average of 47% BME executive board members. The split of BME executive/non-executive roles is the most evenly spread in the North region with 55% of all BME board members taking up executive roles and 45% as non-executives.

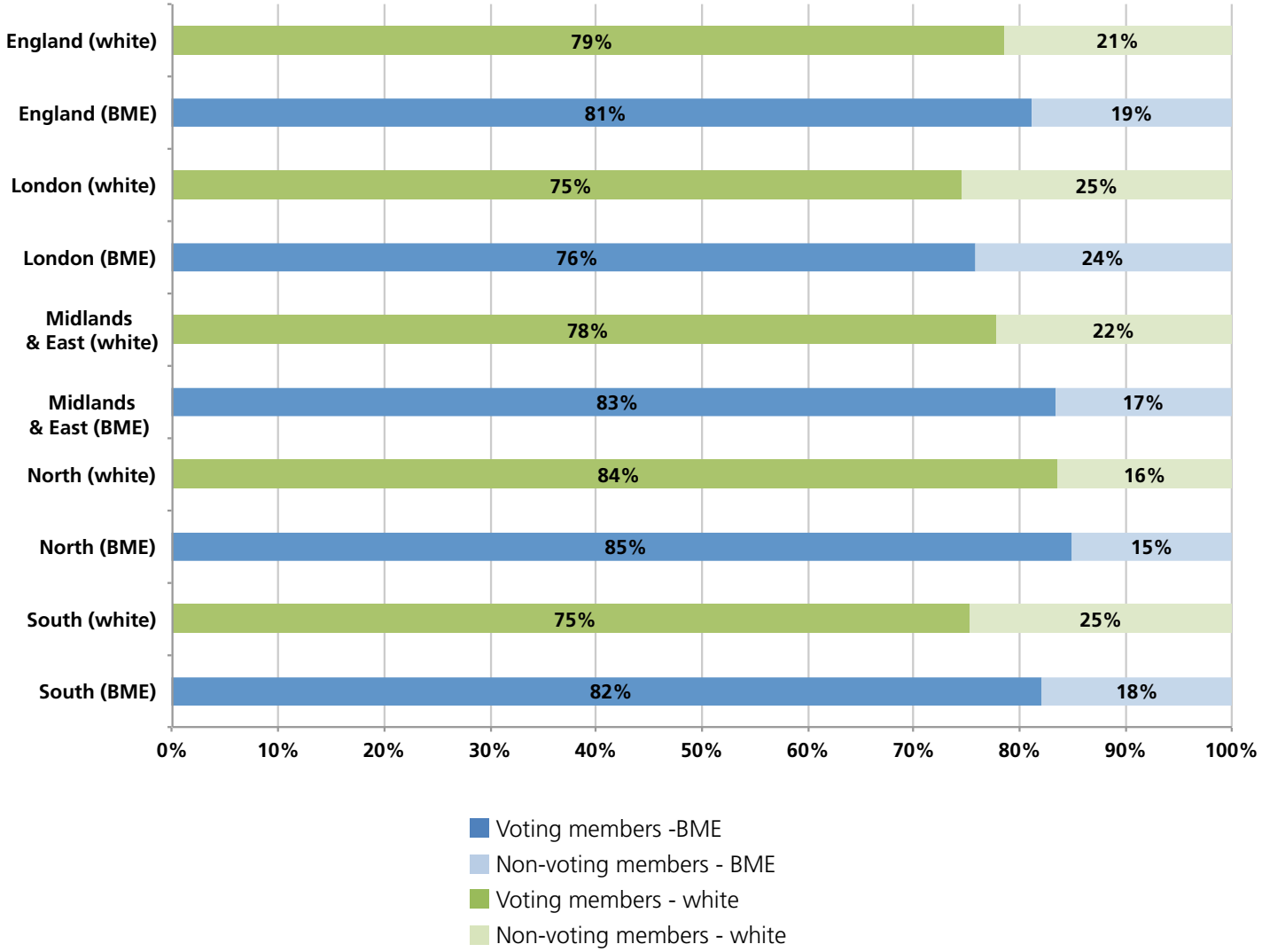
6.9.3.1. By region: executive and non-executive

Figure 22. BME board membership – executive and non-executive breakdown: 2017



6.9.3.2. By region: voting/non-voting

Figure 23. BME board membership – voting and non-voting breakdown: 2017



The 2017 WRES data return also asked NHS trusts to report on the number of voting and non-voting board members by ethnicity. Nationally, the proportion of BME voting members is 81% and BME non-voting members are 19%.

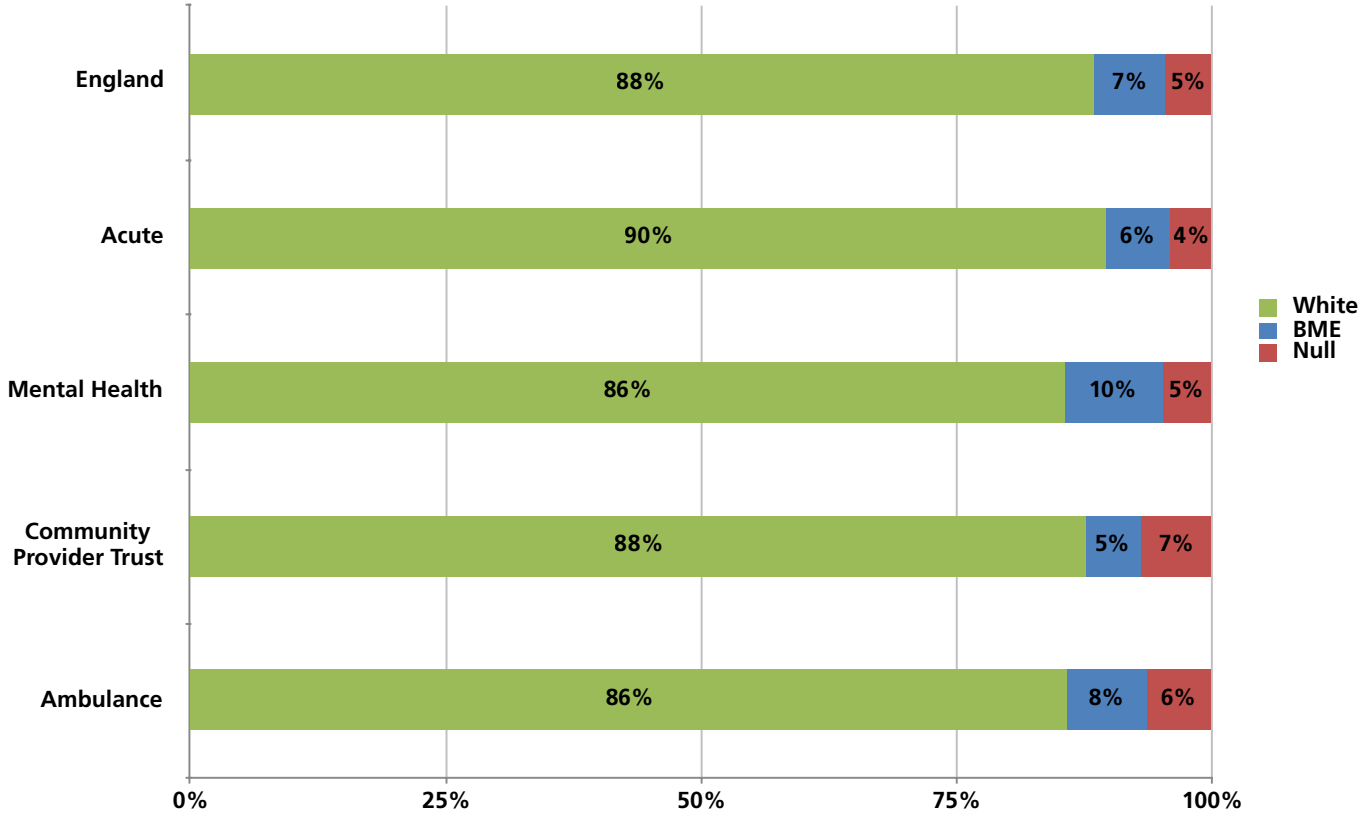
As figure 23 shows, 70 (14%) board members in London are from a BME background. The proportion of these appointed as voting members (76%) is lower than the national proportion of BME voting members (81%).

In the North region, 6% of all board members are from a BME background. The proportion of these appointed as voting members (85%) is higher than the national proportion of BME voting members (81%).

Data for the Midlands & East region and for the South region aligns closely to the national average of 81% BME voting board members and 19% non-voting board members.

6.9.4. By trust type

Figure 24. Board membership by ethnicity: 2017



As figure 24 shows, the proportion of BME board members varies by the type of trust. Across mental health trusts, 10% of board members are from a BME background – the largest representation across all types of trusts in the NHS.

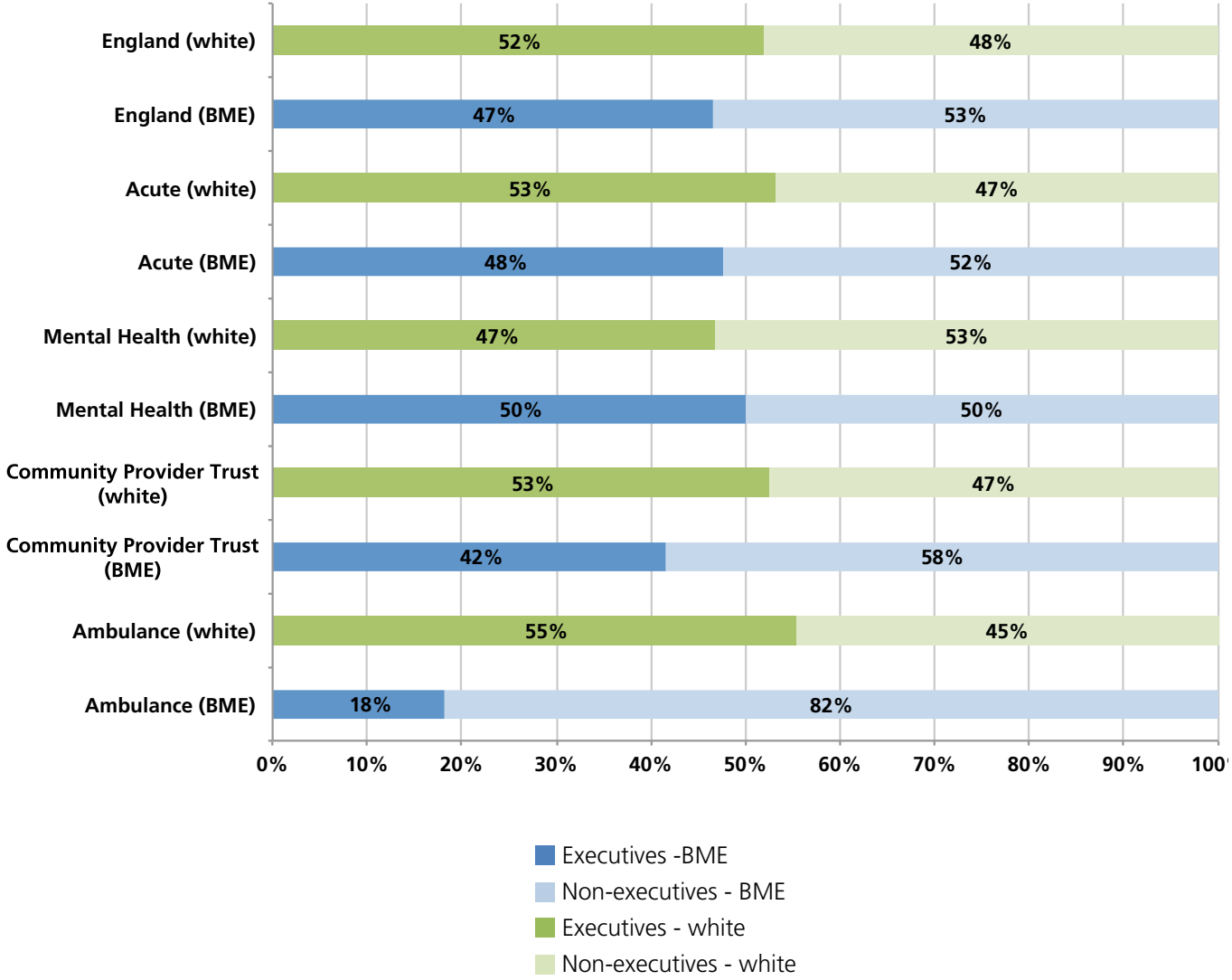
In community provider trusts, BME board members comprise only 5% of the total board membership, falling below the (already low) national average of 7%. The overall BME workforce population in this sector is 10%.

Across ambulance trusts, the BME workforce population is only 4%. Despite this, there is an 8% BME representation at board level. Overall, the proportion of board membership by ethnicity across the ambulance sector aligns closely to the national NHS board representation figures for white (88%), BME (7%) and Null (5%).

Data collected for in the null category denotes instances where ethnicity is reported as 'Unknown' or 'Not Stated'. Nationally, the ethnicity of 5% of all board members is not known but this varies between 4% and 7% across the types of NHS trusts.

6.9.4.1. By trust type: executive/non-executive

Figure 25. BME board membership – executive and non-executive breakdown: 2017



For the 2017 WRES data returns, NHS trusts were asked to report on the number of executive and non-executive board members by ethnicity. Nationally, the proportion of BME executive directors is 47%, and the proportion of BME non-executive directors is 53%; see figure 25.

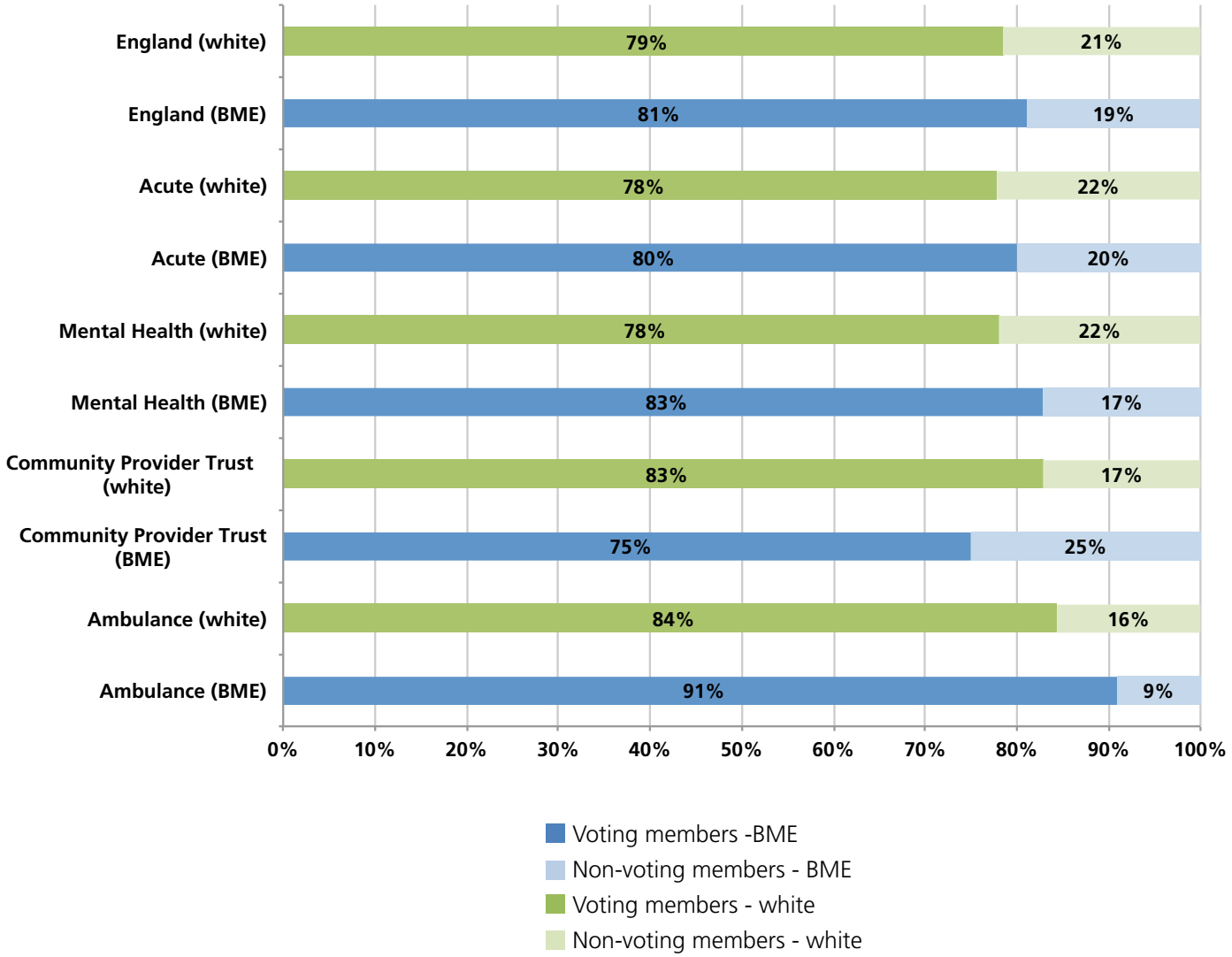
The data suggests that 8% of all board members in the ambulance sector are from a BME background. The proportion of these appointed as executive directors is just 18%, which is significantly lower than the national figure of the proportion of BME executive directors (47%).

In community provider trusts, only 5% of all board members are from a BME background. The proportion appointed as BME executive directors is 42%, which is lower than the national figure of the proportion of BME executive directors (47%).

The split of BME executive/non-executive roles is most evenly spread across the mental health trusts with 50% of all BME board members taking up executive roles and 50% non-executives roles.

6.9.4.2. By trust type: voting/non-voting

Figure 26. BME board membership – voting and non-voting breakdown: 2017



Nationally, the proportion of BME voting members on trust boards is 81% and BME non-voting members on trust boards make-up the other 19%.

In the ambulance sector, 8% of all board members are from a BME background. 91% of BME board members across ambulance trusts are appointed as voting members, this is higher than the national proportion of BME board members with voting rights (81%). Non-voting board members make up 9% of all BME board members for this type of trust – 10 percentage points lower than the 19% across all of England.

Across community provider trusts, 5% of all board members are from a BME background. 75% of BME board members across this sector are appointed as voting members; this is lower than the national proportion of BME board members with voting rights (81%). Non-Voting board members make up 25% of all BME board members for this type of trust.

Data for the acute trusts and for mental health trusts aligns closely to the national average of 81% BME voting board members and 19% non-voting board members.

9.6.5. Comparison over time

As figure 27 shows, between 2010 and 2017, the proportion of VSM staff from a BME background have increased by 2.2%; this equates to an additional 82 headcount. The increase in the proportion of VSMs from BME backgrounds from 2015 to 2017 was 1.2%, an additional 47 headcounts. In comparison, the overall increase in VSM staff (regardless of ethnicity) in the same period was 3.3%, an additional 107 headcount.

Figure 27. BME very senior managers (VSM) as a proportion of all VSM: 2010-2017

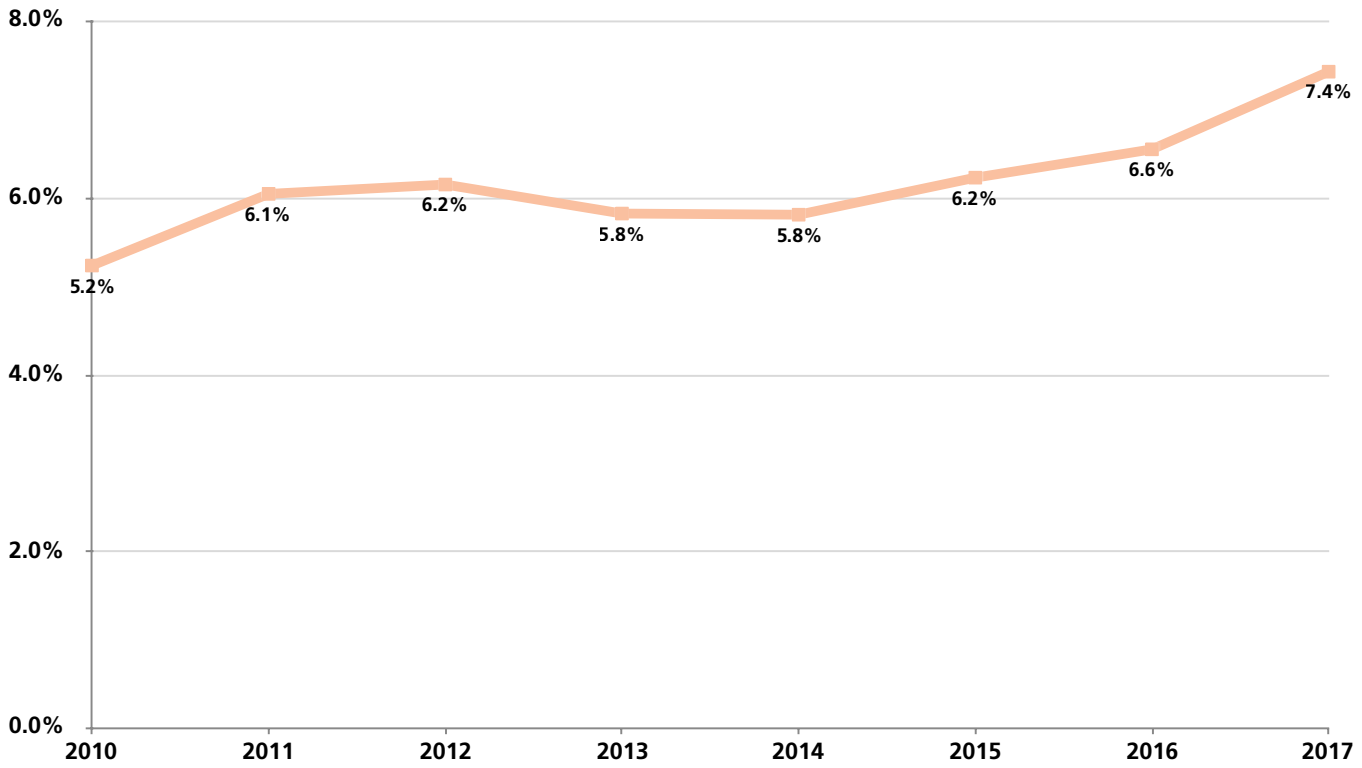
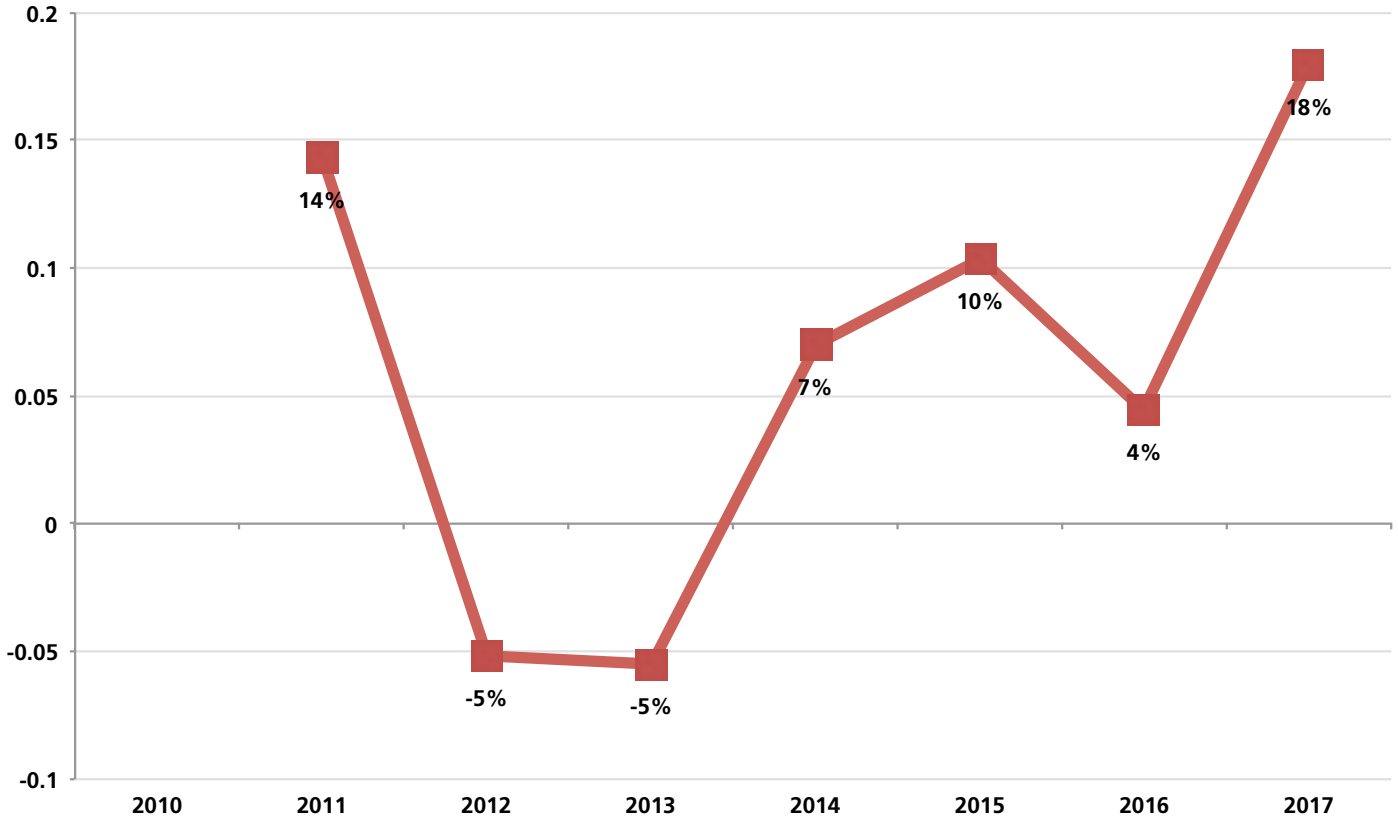


Figure 28: BME very senior managers (VSM) percentage headcount change: 2010-2017



From 2016 to 2017, the numbers of VSM staff from a BME background have increased by 17.9% - this equates to an additional 38 headcount. In comparison, VSM staff (regardless of ethnicity) increased by 4.0%, 129 headcount. The numbers remain disproportionately small but there is some clear sign of progress; see figure 28.

6.9.6. Trusts where data suggest practice may be better

As this is the first year that BME board membership is reported by executive position and voting rights, the following table presents trusts reporting two or more executive BME board members in March 2017. Going forward, future WRES data reports will be able to present patterns of representation over time.

Table 28. Trusts with more than two board members of BME origin

	Of which 100% of BME Board members are:	
	Executive members	Voting members
Barking, Havering and Redbridge University Hospitals NHS Trust		✓
Barts Health NHS Trust		✓
Birmingham and Solihull Mental Health NHS Foundation Trust		✓
Black Country Partnership NHS Foundation Trust		
Bradford Teaching Hospitals NHS Foundation Trust		
Central Manchester University Hospitals NHS Foundation Trust		✓
Coventry and Warwickshire Partnership Trust	✓	✓
Croydon Health Services Trust		
Dudley and Walsall Mental Health Partnership NHS Trust		✓
East Kent Hospitals University NHS Foundation Trust		✓
East London NHS Foundation Trust		
Guy's and St Thomas' NHS Foundation Trust		✓
Hertfordshire Partnership University NHS Foundation Trust		✓
Houndslow and Richmond Community Healthcare NHS Trust		
Mid Essex Hospital Services NHS Trust		✓
North East London NHS Foundation Trust		✓
North Middlesex University Hospital NHS Trust		✓
Oxleas NHS Foundation Trust		
Royal National Orthopaedic Hospital NHS Trust	✓	
Sandwell and West Birmingham Hospitals NHS Trust		
Southport and Ormskirk Hospital NHS Trust		
Surrey and Borders Partnership NHS Foundation Trust		
The Hillington Hospitals NHS Foundation Trust		✓
The Rotherham NHS Foundation Trust	✓	
Walsall Healthcare NHS Trust		

Table 28 lists the trusts that reported two or more BME board members; it also details where the BME board members are in executive posts and/or have voting membership rights on the board.

Caution should be exercised when drawing conclusions with regard to this data. Some trusts on this list will have high proportions of BME staff and local BME populations so that even with more than two BME members of the board they may not be representative of either their workforce nor of their local population. On the other hand there may be some trusts, not listed in the table, which may be representative of their local workforce and population even with having just one BME board member.

07 Conclusion and next steps

Change is challenging and, with all the good intention and will, is never easy. The change that we are working towards on workforce race equality is not a change for the sake of change; rather, there are clear moral, legal, financial and quality of patient care cases for change. A growing number of NHS trusts and senior leaders are beginning to understand and act on this important and powerful narrative, using the WRES as a catalyst for change.

The WRES is designed to help initiate continuous improvement in the treatment of, and opportunities for, BME staff within the NHS. Holding up a mirror to organisations with regard to their own data is an essential first step to realising that goal. The data is also enabling NHS trusts to compare themselves with similar organisations across the country and within their healthcare footprints. Data also enables learning from other organisations, and parts of the NHS, which are beginning to show some success in meeting the challenges.

The data presented in this report are encouraging and show continued improvement in a number of areas including: a decrease in the likelihood of BME staff entering the formal disciplinary process since 2016; a decrease in the overall percentage of BME staff experiencing harassment, bullying or abuse from other colleagues; an increase in numbers of BME nurses and midwives in senior posts, and the steady rise in the number of NHS trusts that have more than one BME board member.

At the same time, whilst there is reduction in the ethnicity gaps in some of the WRES indicators, those gaps still exist. Though some organisations are making progress, many still have much to do on this agenda. As noted in Section 4 of this report, data and evidence are just one of the pieces needed to complete the jigsaw of conditions that require simultaneous attention to shift the dial on workforce race equality. As such, organisations should not be under the illusion that submission of their annual WRES data is the end stage – rather, it is just the beginning.

The design and effective system alignment of the WRES, coupled with the implementation support provided by the national WRES Implementation team, will help to focus organisational attention towards the bigger goal of system-wide cultural change. Its success to spark system-wide cultural change on this agenda depends on mobilising demonstrable leadership, embedding robust accountability, as well as ensuring sustainability and evidencing outcomes over time. These are the key elements that strengthen phase two of the national WRES programme.

5. NHS, 'The Next Steps on the NHS Five Year Forward View', October 2014

We know that changing deep-rooted workplace cultures can take time and is often challenging. However we also know that tackling workforce race equality is not an optional extra. Returns on investment in the WRES, and equality in general, are cumulative and measurable in terms of better outcomes for patients, greater staff engagement and satisfaction and more productive use of resources. Themed analyses are planned to look at these relationships in the coming months.

In the ever evolving healthcare landscape, this year's WRES data report is a constant reminder to organisations of the challenge we face on workforce race equality in the NHS. The Next Steps on the NHS Five Year Forward View commits to a direction of travel for the NHS which depends on ensuring innovation, engages with and respects staff, and draws upon the immense talent of the workforce. The system-wide change that the WRES aims to achieve is identified as a key element in enabling the realisation of that commitment.

Annex: The WRES indicators (2017)

	Workforce indicators For each of these four workforce indicators, compare the data for white and BME staff
1	Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce disaggregated by: Non-clinical staff, Clinical staff, of which - Non-medical staff - Medical and dental staff Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.
2	Relative likelihood of staff being appointed from shortlisting across all posts. Note: This refers to both external and internal posts.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year.
4	Relative likelihood of staff accessing non-mandatory training and CPD.
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.
	Board representation indicator For this indicator, compare the difference for white and BME staff
9	Percentage difference between the organisations' board membership and its overall workforce disaggregated: • By voting membership of the board • By executive membership of the board