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NHS Equality and Diversity Council

Providing national leadership to shape and improve healthcare for all

The NHS Workforce Race Equality Standard (WRES):

Position paper for the NHS Equality and Diversity Council

10th May 2016

Purpose

1. This paper outlines the current position of the WRES programme and highlights key areas for concerted national effort to support WRES implementation across the NHS. The paper makes recommendations on how the NHS Equality and Diversity Council (EDC) can support and provide influence to meet the challenges identified.

Background

1. In 2014, NHS England and the EDC agreed that a Workforce Race Equality Standard should be made available to the NHS, to help improve the experiences of BME staff and their representation at senior levels across the NHS. The WRES programme has been outlined for an initial two-year period (2015/16-2016/17). Much of the first year focused upon setting-up the WRES programme, including the national Implementation Team and supporting local NHS organisations with initial implementation. Though this was a necessary undertaking, it has meant that the programme lost both time and resources.

2. During 2015/16, implementation support to local NHS organisations continued to be provided in line with the agreed WRES Implementation Strategy. The WRES was embedded within key policy levers covering both NHS providers and commissioning organisations; these included the NHS standard contract, the CCG Assurance Framework and the Care Quality Commission inspection programme. NHS trusts submitted their baseline WRES data on 1st July 2015, and will do so annually thereafter. The baseline data have been analysed and a separate report on the analysis is presented to this EDC meeting.

Key observations from year one

3. Four of the nine WRES indicators are based upon questions taken from the national NHS Staff Survey. We know that many NHS organisations do not undertake the annual NHS Staff Survey across the whole of their workforce. Many use small samples which do not lend themselves to statistical analyses when examining particular subsets of the workforce, e.g. BME staff. This particular challenge has been encountered whilst analysing the WRES baseline data for 2015.

4. We also know that leadership and role models are essential for the any kind of transformational change to happen and be sustained. It is a fact that NHS boards across the country are not reflective of the populations or workforces that they serve. If we are to make meaningful and credible difference on this agenda, then we must start at the top. We must also create a social movement on this agenda by training and developing WRES "champions" or experts.
5. A key element that will help assure the capability of the WRES in making continuous improvements will be the sharing of replicable good practices and processes across the country. We realise from year one of the WRES programme that there is a clear need to draw together good local practice threads into national patterns to exploit common opportunities for radical change in workforce race equality across the NHS.

6. It is widely acknowledged that to achieve meaningful and sustained transformational change in any area, a number of criteria and conditions need to be met over a substantial period of time. These include the following: leadership commitment; data and measurement; accountability and regulation; effective communications and sufficient resource.

7. There is a need to stick with constancy of purpose; in particular to ensure strong continuity with set priorities, as improvements in workforce race equality are associated with big fundamental challenges that require action over years not months. This includes coherent support from the national healthcare bodies to deliver the support needed for transformational change and continuous improvement on this agenda.

Recommendations

8. Alongside continued WRES implementation support during 2016/17, we recommend three key areas where we believe concerted national effort is required in order for local NHS organisations to be further supported on both using the WRES and improving race equality in general. These being:
   I. A step change in use of NHS Staff Survey including move away from sample surveys and better engagement of BME staff.
   II. A focussed drive on increasing BME representation on NHS boards, beginning with non-executive directors and associate directors on the boards of the national arm's length bodies.
   III. The systematic sharing of replicable good practice and processes on workforce race equality and the evidence-base underpinning efficacy.

Action on the above will require effective support and sufficient resources from all national healthcare organisations, as such:

IV. National healthcare organisations should support the WRES strategy and the operational expression of the strategic approach, including the ongoing sustainability of the WRES programme.

V. WRES baseline report to be published by the EDC

9. The EDC is asked to approve and support the above recommendations.

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