NHS
Equality and
Diversity Council

NHS WORKFORCE RACE EQUALITY STANDARD

2016 DATA ANALYSIS REPORT FOR NHS TRUSTS

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NHS Workforce Race Equality Standard
2016 Data Analysis Report for NHS Trusts

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01 FOREWORD

Almost one in five of the staff working in the NHS is from a black and minority ethnic (BME) background, yet we now know that the treatment and opportunities that they get in the workplace often do not correspond with the values that the NHS represents. We also know that this has significant adverse impacts on the effective and efficient running of the NHS, including on the quality of care received by all patients.

It was in response to this evidence that the Workforce Race Equality Standard (WRES) was mandated across the NHS in April 2015. Since its introduction, the WRES has required healthcare providers to self-assess on this agenda and to understand the specific challenges they face in ensuring all staff are treated equally and are supported to fulfil their full potential.

This is the second WRES annual data report and the most comprehensive one so far. It will be invaluable to all NHS provider organisations – provider trusts, commissioning organisations, Arm's Length Bodies, as well as to the new models of care – the Vanguards and Sustainable and Transformational Plans (STPs) – in understanding the challenges we face on workforce race equality.

The WRES continues to prompt inquiry and assist 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, as well as the principles and values set out in The NHS Constitution.

IMPROVING HEALTH OUTCOMES

An increasing number of NHS organisations are embracing this agenda by developing systematic and innovative responses to improve the treatment and experience of their BME staff. The work of the WRES Implementation Team is increasingly focused upon supporting organisations to do that, as well as challenging us all to continuously improve on workforce race equality.

We know from research that organisations that treat their staff fairly, listen to them and develop their talent to the full, are ones that provide better care for all patients. This report, for the first time in the history of the NHS, gives us a comprehensive picture of how BME staff are treated and draws on the evidence to suggest ways in which their treatment and experience can, and must, be improved.

Professor Jane Cummings
Chief Nursing Officer for England
National Director, Equality & Diversity / WRES NHS England

Ruth May
Executive Director of Nursing, NHS Improvement,
National Director for Infection Prevention and Control and Deputy Chief Nursing Officer for England

02 PREFACE

The NHS Equality and Diversity Council brings together national system wide organisations across the NHS to provide visible leadership on equality and inclusion. The issue of race and our workforce is critically important, particularly during periods of change. The opportunity to harness the diverse skills we depend upon to deliver care to all communities and people across health and social care is even more important.

People still fall through care gaps such as carers of older people and those with mental health difficulties. Therefore a strengthening of our leadership actions to make a real impact on people's lives is the purpose of the Workforce Race Equality Standard (WRES).

This second annual WRES data report seeks to provide that leadership by holding a mirror to the NHS on how the black and minority ethnic (BME) staff, who are a crucial part of our workforce, are treated. In doing so, we expect all parts of the NHS to work in ensuring BME staff are treated fairly, as the evidence suggests that this is not yet the case.

This report highlights the challenge and starts to point to some of the steps NHS organisations, and system partners, need to take to ensure all staff are treated with the respect that they deserve, and that the less favourable treatment such staff receive is removed.

Research evidence shows that how NHS staff are treated has a substantial impact on how patients are cared for. This report is intended to prompt organisations to examine the data, undertake analysis to understand the causes of the less favourable treatment of BME staff in their own organisations, and thereby contribute to improved care and safety for patients as well as the health, and well-being of those staff.

Additionally, we know that robust data must be acted on to make a difference. The steps needed to tackle this challenge are ones that will benefit all staff and patients, and will help us all to meet the standards set by the NHS Constitution.

Joan Saddler
Co-chair
NHS Equality and Diversity Council

I urge you to read this report, reflect on its implications and your practice, and take the appropriate steps in your own organisation. We owe our staff and people using our services nothing less.

03 KEY FINDINGS

White shortlisted job applicants are 1.57 times more likely to be appointed from shortlisting than BME shortlisted applicants, who remain noticeably 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 for the period between 2014 and 2016.

BME staff in the NHS are significantly more likely to be disciplined than white staff members.

The proportion of very senior managers (VSMs) from BME backgrounds increased by 4.4% from 2015 to 2016 – an additional 9 headcounts. However, BME representation at board and VSM level remains significantly lower than BME representation in the overall NHS workforce and in the local communities served.

BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers, although the percentage of BME staff reporting that in the last 12 months they have personally experienced discrimination at work from staff fell slightly.

White and BME staff are equally likely to experience harassment, bullying or abuse from patients, relatives and members of the public in the last 12 months.

BME staff remain more likely than white staff to experience harassment, bullying or abuse from other staff though this fell very slightly last year.

BME staff remain less likely than white staff to believe that their trust provides equal opportunities for career progression. However, the gap between white and BME staff on this indicator fell from 14.5 percentage points in 2014 to 12.6 percentage point in 2015.

04 INTRODUCTION

In 2014, NHS England and the NHS Equality and Diversity Council agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. It was agreed that a Workforce Race Equality Standard (WRES) should be developed. The WRES was introduced and its implementation made mandatory for NHS trusts in April 2015. The first WRES annual data report, published in May 2016, presented baseline data for the four WRES indicators covering staff experience, by NHS trust and region.[1]

This second report presents data for all nine WRES indicators for the first time, including data on the four WRES workforce metrics, and on the composition of NHS boards. It should be noted that whilst this report focuses wholly upon WRES data returns from NHS trusts, work to support WRES use across commissioning organisations and independent healthcare providers is also underway. Future reports focusing upon WRES implementation progress by these types of organisations will also be produced.

4.1. The purpose of the report

The purpose of the report is three fold:

- To enable NHS trusts to compare their performance with others in their region or providing similar services with the aim of prompting improvement by learning and sharing emerging practice.
- To provide a national picture of the implementation of the WRES and enable national policymakers, networks (including BME networks), commissioners, social partners and regulators to gain a picture of developments.
- To start sharing emerging good practice related to the WRES indicators, from across the NHS.

1. NHS Equality and Diversity Council, 'NHS Workforce Race Equality Standard: 2015 Data Analysis Report for NHS Trusts', May 2016.

This report summarises early lessons on the characteristics of organisations and interventions that appear to be successful in starting continuous improvement in these areas. These 'improvement characteristics' have been presented in this report and have been drawn from research and engagement with organisations in the private sector, across the public sector, and from within the NHS itself.

Further WRES materials will be published to present good practice examples and case studies in more detail. These will be a series of short guides, due later this year, focussed on specific aspects of improvement in relation to each of the WRES indicators, and more generally on the workforce race equality agenda. The first two guides, on lessons from the private sector and on making boards more inclusive are published this spring.

4.2. Who does the WRES apply to?

The WRES applies to all types of providers of non-primary healthcare services operating under the full length version of the NHS Standard Contract; alongside NHS providers. The WRES also applies to independent sector and voluntary sector providers. The date, the foundations for WRES implementation (e.g. workforce ethnicity monitoring, common staff survey metrics) have been fragmented and inconsistent across the independent healthcare sector, which has made WRES reporting across this sector difficult. However, with the provision of additional support, progress on WRES implementation by this sector is expected and a supplementary report on WRES implementation by non-NHS providers will also be made available from 2018.

From April 2016, the Care Quality Commission (CQC) has included the WRES as part of its inspection regime for hospitals. The hospital's WRES data, and other evidence, are considered as one part of the assessment of the degree to which the organisation is "well-led". Other key policy levers include the NHS Standard Contract 2017/18 and 2018/19[2] and the CCG Improvement and Assessment Framework[3] which require CCGs to give assurance to NHS England that their providers are implementing the WRES.

Although there is no contractual obligation for clinical commissioning groups (CCGs) and national healthcare Arm's Length Bodies (ALBs) to implement the WRES, a substantial number of these organisations have applied the WRES to their own organisations and have published their WRES findings. This report does not present WRES data for these organisations.

The report presents data for each of the WRES indicators, summarised by type of trust and by region. A list of trusts is also presented where data suggests some level of continuous improvement for each of the WRES indicators. However, caution needs to

2. NHS England, 'NHS Standard Contract 2017/18 to 2018/19: Service Conditions (Full Length)', November 2016.
3. NHS England, 'CCG Improvement and Assessment Framework 2016/17', March 2016.

be applied when reading the list for a number of reasons. Firstly, improvement in data, or better than average data, does not necessarily mean that the trust is engaging in good practice – indeed some of the better examples of good practice are undertaken by those trusts where relatively poor data has spurred the board to take action to redress unfair outcomes. Secondly, it is not the case that trusts showing improved, or better than average, data for any one indicator are performing well on all aspects of workforce race equality.

4.3. Using the WRES

The best boards and system leaders already understand and act on the evidence of workforce race inequality and the powerful case for addressing it. The WRES seeks to ensure all NHS organisations do so. Each of the nine WRES indicators seek to prompt inquiry to better understand why BME staff often receive much poorer treatment or opportunities than white staff, and to take concerted action so that the gaps in treatment and experience can be closed.

Gathering the data is an important step as "you can't change what you don't know." However it is only the first step. Understanding the data and the root causes behind inequalities is intended to prompt NHS organisations to seek examples where good practice has tackled such gaps successfully. Widespread anecdotal evidence suggests the WRES is already prompting NHS organisations to scrutinise their workforce and staff survey data, to start to listen to their BME staff, to ask why there are such sharp differences between the treatment and experience of white and BME staff and above all, ask how they can reduce the gaps. An increasing number of credible trust WRES action plans are being published and and these will be analysed during 2017.

By using the WRES, we expect that **all** NHS organisations will seek to improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators. Embedding and sustaining continuous improvements will take time and effort, but some trusts are already demonstrating how to act effectively on this agenda.

The national focus on these nine indicators of workforce race equality provides an opportunity for NHS organisations to work together on specific interventions and to share good replicable practice. It also provides an opportunity for new models of care as Vanguards, or through the Sustainability and Transformation Plans (STPs) to ensure that workforce race equality is built into their emerging work.

The WRES is designed to require no additional data capture or analysis beyond that which NHS organisations should already be undertaking as part of meeting the public sector equality duty and using the Equality Delivery System for the NHS (EDS2).[4] The benefits of implementing the WRES can be considerable for all staff, for organisational finances and productivity, and above all, for all patients and service users.

4. NHS England, 'A refreshed Equality Delivery System for the NHS: EDS2', November 2013.

4.4. The NHS workforce

All NHS staff have the right to be treated fairly, equally and to work in an environment that is free from discrimination. This is enshrined in the NHS Constitution[5] which has a contractual status. Similarly, the wider contractual duties of all staff require them not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

Nearly one in every five of the 1.19 million people working in the NHS are from black and minority ethnic (BME) backgrounds, and in some staff groups the proportion is higher (e.g. in nursing, midwifery and medical).

5. Department of Health, 'NHS Constitution for England', October 2015.

Yet research strongly suggests that less favourable treatment of BME staff in the NHS, through poorer treatment or opportunities, has a significant impact on the efficient and effective running of the NHS, on the health and wellbeing of all staff, and on the care and safety of all patients. Research relating to this was summarised in a short publication in 2015 entitled: "WRES NHS Boards Bulletin."[6]

4.5. WRES as a proxy for wider culture change

The less favourable treatment of BME staff in the NHS takes place in a wider societal context. BME people suffer less favourable treatment from birth, through school, into college and employment. At every stage of their lives, BME people face discrimination in accessing employment, their progression through employment, their treatment within employment and when accessing or receiving services. These experiences and their impact were summarised in "Fairness and Freedom: The Final Report of the Equalities Review" (2007)[7], and more recently within the Equality and Human Rights Commission report: "WRES NHS Boards Bulletin."[8]

NHS staff survey and patient survey results suggest that the experience of BME NHS staff is a good barometer of the climate of respect and care for all within the NHS. It is argued that if BME staff feel engaged, motivated and part of a team, patients are more likely to be satisfied with the service they receive. It is also shown that the greater the proportion of staff from a BME background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction[9].

Moreover, evidence suggests that the steps needed to improve workforce race equality are ones that will also benefit the wider culture of each organisation. The case for organisations tackling workforce race discrimination is therefore not just about the treatment of BME staff but is crucially also about the care of all patients irrespective of ethnicity.

The NHS Five Year Forward View[10] commits to the delivery of high quality, safe, patient focused care is dependent on professional commitment, strong leadership and a caring culture and it regards workforce equality as an essential element of achieving that. The WRES is identified as a key element towards enabling the realisation of that commitment.

6. NHS England, 'WRES NHS Board Bulletin', October 2015.
7. The Equalities Review, 'Fairness and Freedom: The Final Report of the Equalities Review', February 2007.
8. Equality and Human Rights Commission, 'Healing a divided Britain: the need for a comprehensive race equality strategy', August 2016.
9. Dawson, J. 'Does the experience of staff working in the NHS link to the patient experience of care?' Aston Business School, July 2009
10. NHS, 'Five Year Forward View', October 2014

05 DATA AND 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. The baseline WRES data report, published in May 2016, presented the findings for the four WRES indicators based upon data from the NHS Staff Survey. This report presents data for all of the nine WRES indicators.

There were two changes made to the WRES indicators for the 2016 data returns as shown in the table below. The WRES aims to highlight differences between the experience and treatment of white staff and BME staff in the NHS, with a view to closing the experience gap in those metrics. The WRES indicators were co-developed in partnership with the NHS, and were based on existing data collection and analysis requirements, which all good performing NHS organisations are already undertaking. The nine WRES indicators are presented in the annex of this report. We have not reproduced the detailed definition for each indicator in this report but they can be found within the WRES Technical Guidance.[11] The Technical Guidance also includes the definitions of "white" and "black and minority ethnic minority", as used throughout this report and within the narrative for the WRES indicators.

Table 1: The changes made to WRES indicators for the 2016 WRES data returns

	Narrative for 2015 data return	Narrative for 2016 data return
WRES indicator 1	Percentage of BME staff in Bands 8-9, VSM (including executive board members and senior medical staff) compared with the percentage of BME staff in the overall workforce	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
WRES indicator 9	Boards are expected to be broadly representative of the population they serve	Percentage difference between the organisations' board voting membership and its overall workforce

11. NHS England, 'Technical Guidance for the NHS Workforce Race Equality Standard', March 2017

5.2. Data reporting dates

NHS trusts were asked to provide data on the nine WRES indicators as at March 2016 and March 2015. The submission of data took place from 1 July to the 1 August 2016.

Although there is a 12-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), training (WRES indicator 3) and grievances (WRES indicator 4).

5.3. 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 – 8, also show percentage responses by BME staff for 2015 in comparison to 2014. This differs from the WRES data analyses presented last year, where the gap between BME and white staff results was given. The methodology employed this year makes comparison of results easier and helps focus on the key areas of improvements for trusts, by region and sector.

To supplement the analyses presented in the findings section of this report, supporting data for individual NHS trusts are published online. NHS organisations are encouraged to use the online data to prompt discussion and enable continuous improvements.

5.4. 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 survey data which will be used in the next WRES report should avoid some of these problems, as sample sizes will be larger or 100% and response rates are likely to be slightly higher.

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. None of those pressures mean 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 good, engage in better practice. Indeed, some of the best practice on this indicator 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. The staff survey England national averages are taken from the NHS Staff Survey publications which include CCGs, and will also include all staff survey responses that have withheld ethnicity details. The national white and BME averages also include the CCG results to make them as comparable to England as possible. Throughout the findings section, the graphs refer to average results by region and by type of trust. These results do not include CCGs; hence there may be a small difference attributable to results from CCG organisations and those respondents who have not disclosed ethnicity.

6. All averages presented in this report are unweighted and do not take into account the size or type of trust. Figures for the ambulance trusts should be treated with extra caution as the averages are based on only one or two organisations that achieved a BME sample size of 50 or more staff. This is highlighted in more detail in the findings sections.

7. Throughout WRES data collections, data are not compiled for the 'unknown/null' ethnicity category. Although the rates of ethnicity self-reporting are very high, this gap may be amplified in categories where smaller numbers are collected. For example, in indicator 9, data were not collected for the 'unknown/null' ethnicity category which may skew calculated percentage figures. It is unclear why any data for boards should not be readily available rather than as 'unknown/null'. In future WRES submissions, a category will be incorporated to include 'unknown/null'. This will help more accurate results and derivatives to be calculated as well as highlight areas in which trusts may need to improve on ethnicity reporting.

8. Where appropriate, figures have been rounded to 0 decimal places, and for this reason, aggregate percentages may not add to 100.

9. Some NHS trusts may have revised their WRES data returns since their submission via UNIFY 2. The results in this report are based on the latest figures returned to NHS England via UNIFY 2 and will not necessarily incorporate any updates a trust has made to WRES related publications on organisations' websites.

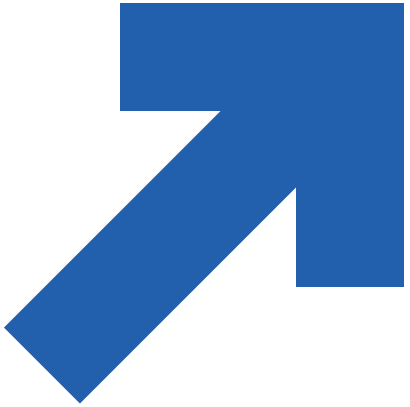
10. Due to the introduction of the UNIFY 2 collection system, 100% response rate was achieved for the 2016 WRES data returns. However, the quality and accuracy of data submitted varies in each trust. NHS England has therefore refined some of the definitions to improve data accuracy for the 2017/18 process.

11. Although an attempt was made to collect data covering a two-year period in WRES submissions, data quality for 2015 data was particularly poor. This can be attributed to the change in process and a change in data definitions which could have led to additional burden

for trusts to potentially source all the 2015 again. For this reason, for WRES indicators 1- 4 and 9, a direct comparison has not been made to 2015 data. This will be possible next year due to less significant changes in the definitions of each indicator and also a more streamlined submission process.

12. In order to provide some historical context, indicator 1 shows a comparison of skill mix for white and BME staff in 2016 and 2015. This data has been extracted from the ESR system and aggregated to a national level.

13. Due to a lack in confidence on the data collected for WRES indicator 9, we are unable to show a historical trend of board members by ethnicity using data collected from the WRES process. However, NHS Digital data have been used to show historical trends of VSM staff by ethnicity from 2010 to 2016. This section is useful in providing some insight into the direction of travel for BME representation in the most senior levels of NHS organisations.



06 DETAILED FINDINGS: 2016 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

Data source and reliability

The data is pre-populated from the NHS Electronic Electronic Staff Record (ESR), for 2015 and 2016, for both clinical and non-clinical staff on Agenda for Change (AfC) scales and for medical and dental staff. This is the first time that collection of this data by pay band and for medics (by broad definition of role) has been undertaken.

There is confidence in the AfC data, but less confidence in the data for "senior medical managers", which in a large number of trusts was merged, incorrectly, with that of consultants. The definition for senior medical managers has been made more precise for the 2017 data collection, thus enabling the analyses of the medical workforce going forward.

Overall results

- For NHS trusts nationally, the proportion of BME staff in Bands 8 - 9 and VSM was substantially lower than it was in the workforce as a whole (NHS Digital, September 2016).
- Nationally, for non-clinical staff the proportion of BME staff in Bands 8a - 9 and VSM was 10.9% compared with 17.7% in the workforce as a whole.
- Nationally, for clinical non-medical staff, the proportion of BME staff in Bands 8 - 9 and VSM was 11.3% compared with 17.7% in the workforce as a whole.
- Nationally, for all non-medical staff (clinical and non-clinical) as a whole, the proportion of BME staff in Bands 8a - 9 and VSM was 11.1% compared with 17.7% in the workforce as a whole; a substantial difference between the two figures.
- Table 2 compares the percentage of BME staff in Band 5 and in Band 8c. White clinical staff are 2.87 times more likely to be in Band 8C than in Band 5 compared to BME staff; for non-clinical staff, white staff are 2.25 times more likely than BME staff.

Table 2. Comparison: White and BME data at AfC Bands 5 and 8C

	White	BME	Total	BME %
Band 5 non-clinical	25917	5532	31449	18%
Band 5 clinical	149197	44667	193864	23%
Band 8C non-clinical	2947	268	3215	8%
Band 8C clinical	2958	261	3219	8%

All the comparative trust data relating to WRES indicator 1 can be found online.

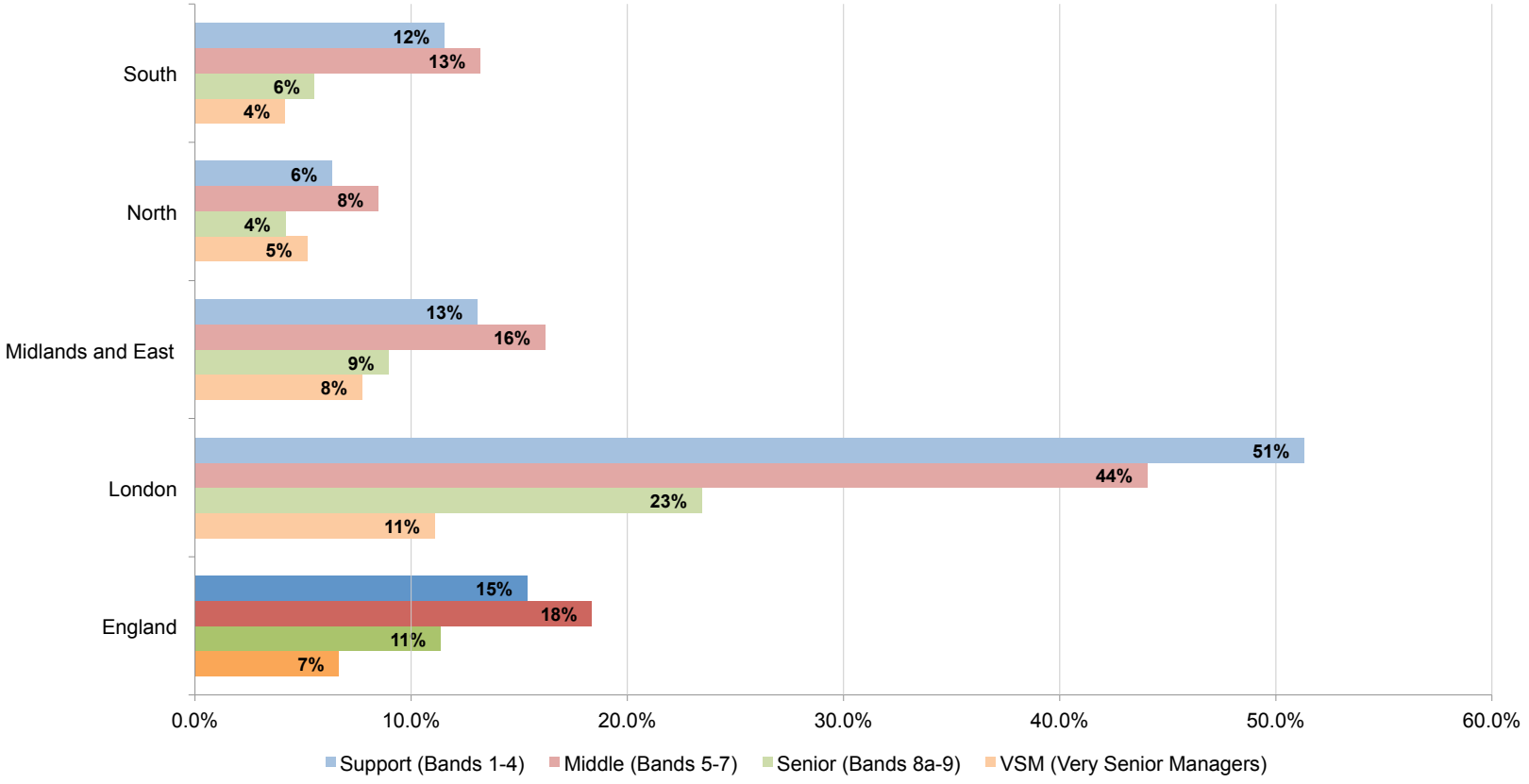
By region

There were significant differences between the different regions as Fig 1.1 shows. London (with the largest BME workforce and highest proportion of BME staff) has the largest difference between the proportion of BME staff in Bands 8 - 9 and VSM compared to the workforce as a whole. This year, an analysis was not carried out on whether there is a significant difference on WRES metrics between trusts on the basis of the proportion of their workforce who are from BME backgrounds. However, that level of analysis will be considered going forward.

The WRES provides guidance to the NHS on how to achieve better race equality in the workforce. NHS Improvement will seek to work in partnership with NHS trusts to help embed the WRES and to seek continuous improvement on this important agenda. Workforce race equality will help make the NHS more efficient, more productive and more responsive to the needs of patients and staff alike.

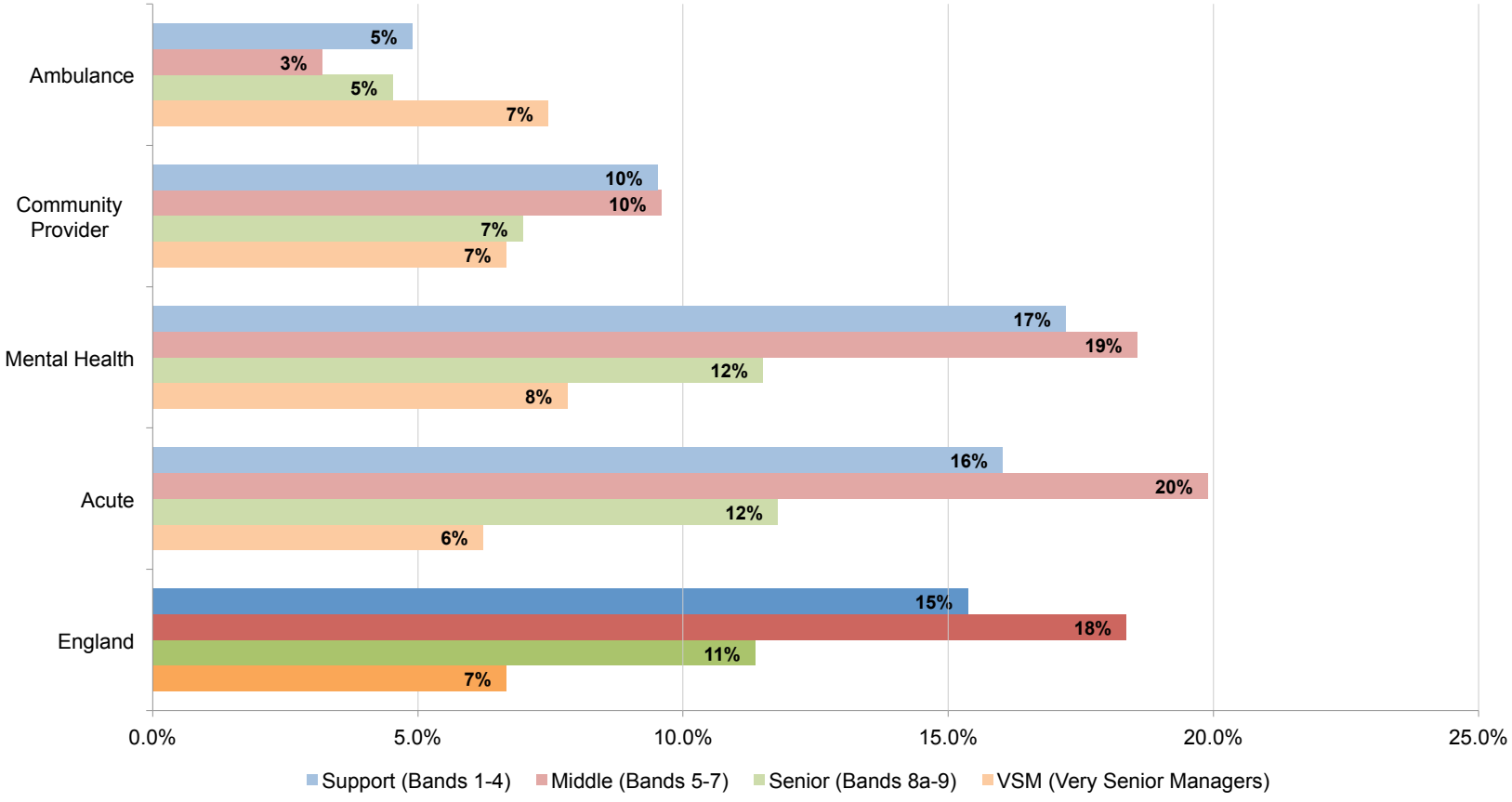
Ed Smith
Chair
NHS Improvement

Figure 1.1: BME Workforce skill mix: by region



Note: Percentages will not add to 1. Each percentage is comprised of the White and BME proportions of the skill mix bands. Values for the White workforce are not shown

Figure 1.2: BME Workforce skill mix: by trust type



Note: Percentages will not add to 1. Each percentage is comprised of the White and BME proportions of the skill mix bands. Values for the White workforce are not shown

By type of trust

As shown in Figure 1.2, there were smaller differences for ethnicity by pay band between the type of trust which may be due to other factors such as size of the trust, the service mix and the proportion of the workforce from BME backgrounds.

Very senior managers (VSM)

The data for WRES indicator 1 enables consideration of the existing pipeline to executive board director posts and other director posts. 17.7% of the NHS workforce are from BME backgrounds.

Whilst there are nearly 14 white staff per trust on a VSM grade, on average just over one BME member of staff per trust is on VSM grade and in many trusts there are none. That inevitably 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"[12] is very helpful and long overdue. If the number of BME staff at senior level is to approach the proportion of BME staff in the NHS workforce as a whole, boards will need to give serious and sustained attention to the lessons on good practice set out in the above document.

Table 3. VSM staff by ethnicity

	White	BME	BME VSMs %
Non-clinical	2058	134	6.1%
Clinical	896	77	7.9%
Combined	2949	211	6.7%

The overall national data are summarised in Figures 1.3 and 1.4

12. 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

Figure 1.3: Non-clinical staff by ethnicity: March 2016

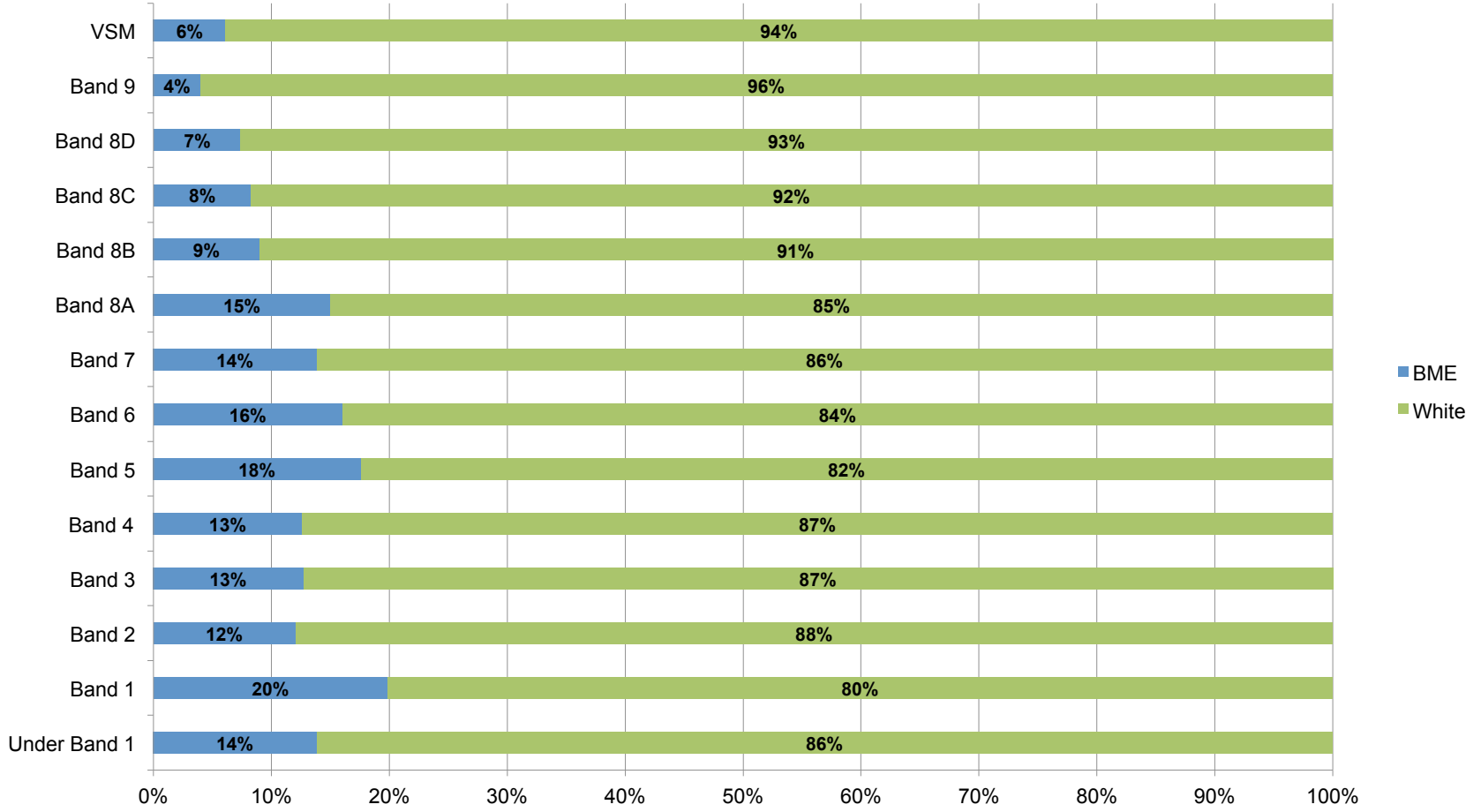
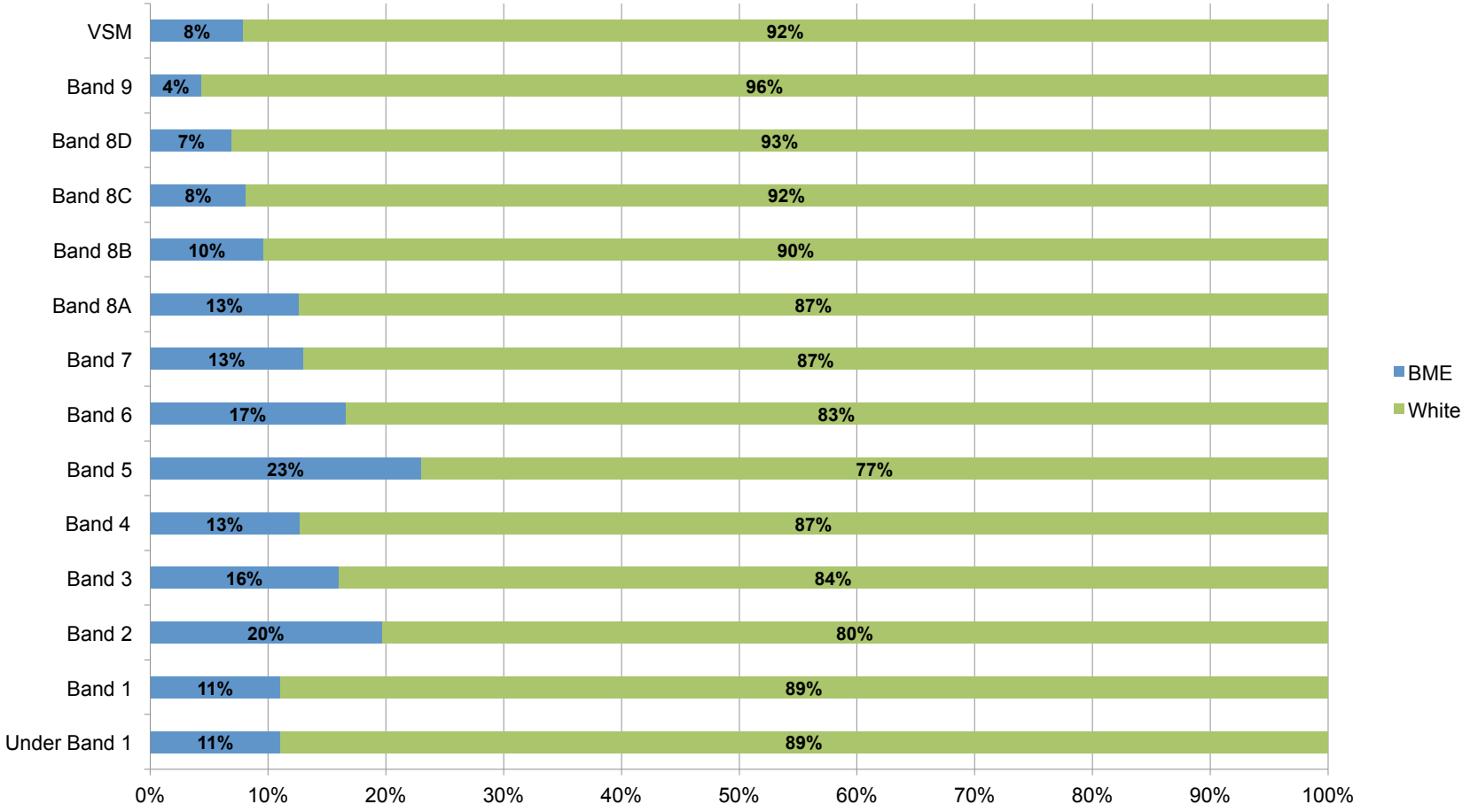


Figure 1.4: Clinical staff by ethnicity: March 2016



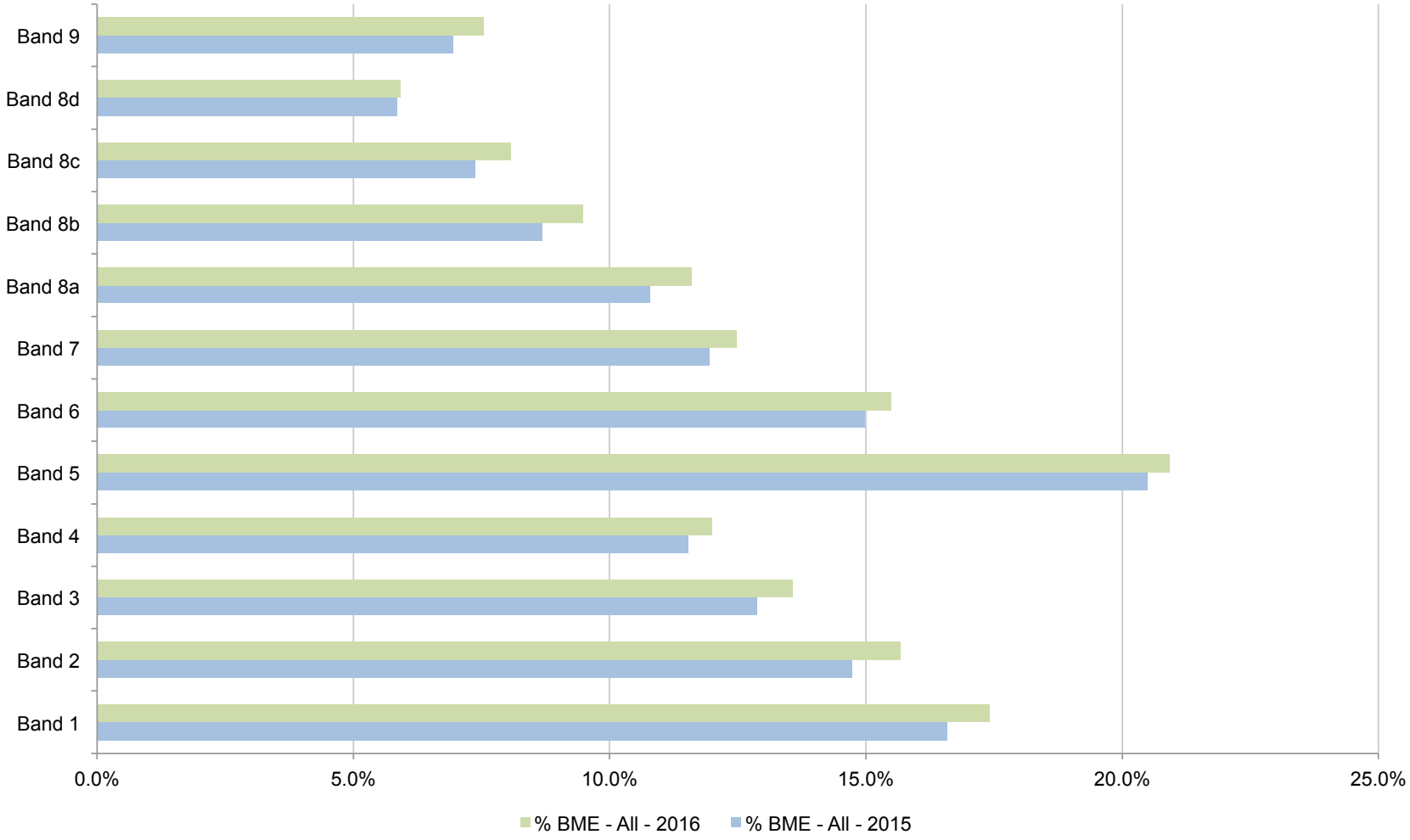
Is there any improvement?

Figures 1.5 to 1.8 below compare the skill mix profile of the BME workforce. In order to provide an accurate comparison against historical trends, data has been sourced from NHS Digital. There is some small evidence of improvement, though we should be cautious about attributing it entirely to WRES implementation. However, the fact that all of these figures (1.5 to 1.8) indicate increases in BME staff percentages across all pay bands since 2015 highlights the importance of WRES implementation going forward.

We know from the CQC that the strongest determinant of a successful organisation is staff engagement. This translates into better outcomes for patients. The WRES data can help focus action on those with the worst experience and accelerate our progress towards consistently high levels of engagement and the best outcomes for patients.

Dame Gill Morgan
Chair
NHS Providers

Figure 1.5: BME non-medical staff: September 2015 and 2016



Across the AfC bands overall, the proportion of BME staff increased from 2015 to 2016. The largest proportional increase was in Band 2, up by 0.9 percentage points to 15.7% in 2016.

AfC staff overall

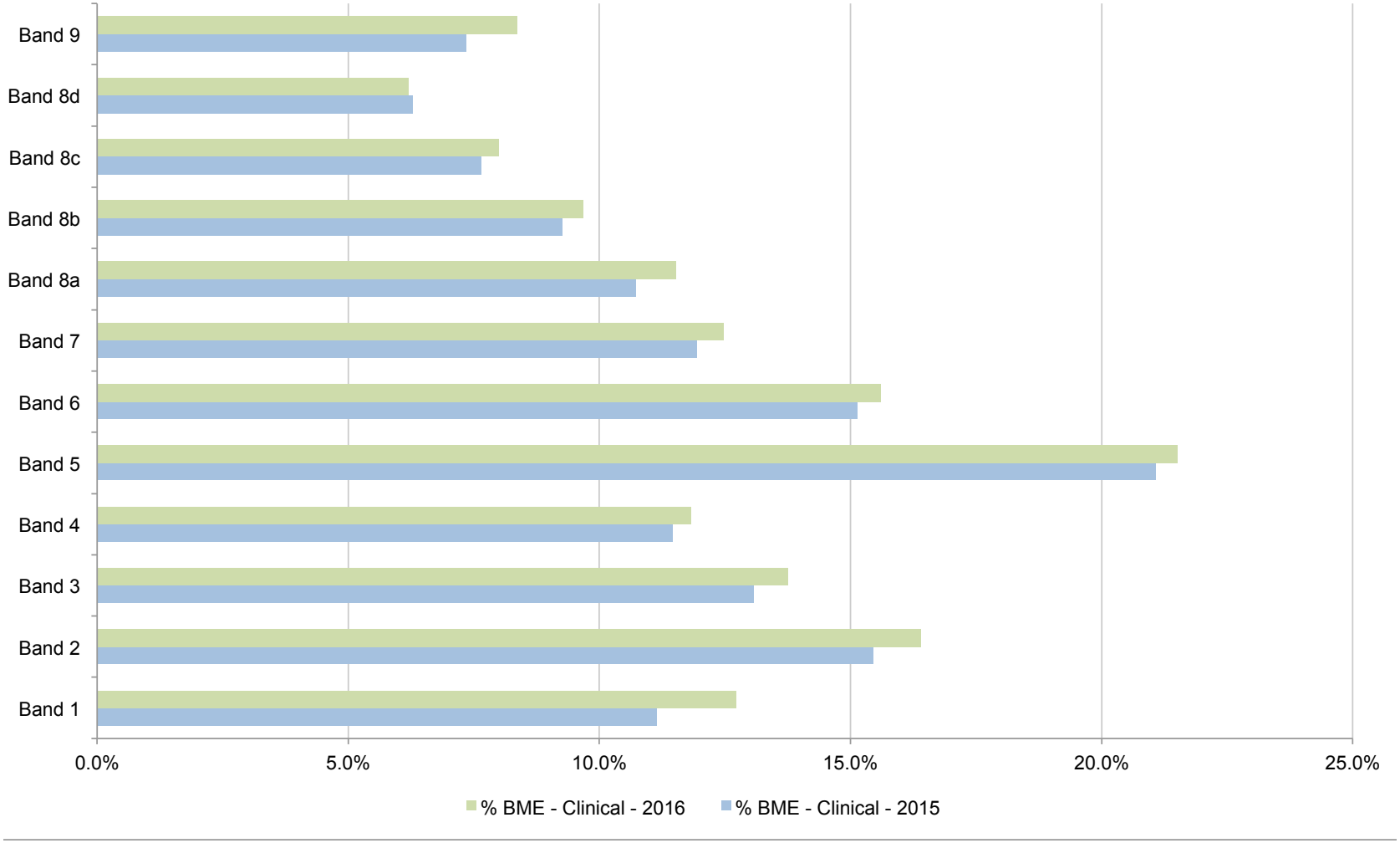
The rate of increase in the proportion of BME staff is the same in more senior bands above Band 5 as it is for the lower bands, with the exception of Band 8D. We are also aware of the so-called 'bottleneck' flow of staff (both clinical and non-clinical) within Bands 1-4; this will be an area that is scrutinised further in future reports.

AfC clinical staff

As Figure 1.6 shows, for clinical staff on AfC bands, the proportion of BME clinical staff at Band 5 increased slightly from 21.1% to 21.5% in 2016. The proportion of BME staff increased more significantly in Bands 7 (12.5%), 8a (11.5%), 8b (9.7%) and Band 8c (8.0%) but still remains low. The proportion of BME staff at Band 9 also increased but this equates to a headcount of just four people.

In general, there is scope to further tighten-up role definitions within the medical workforce (e.g. "senior medical manager"). The definitions of roles underpinning WRES indicator 1 will be refreshed for the WRES data returns in 2017; this will provide further confidence in data for this area of the workforce.

Figure 1.6: BME clinical staff: September 2015 and 2016



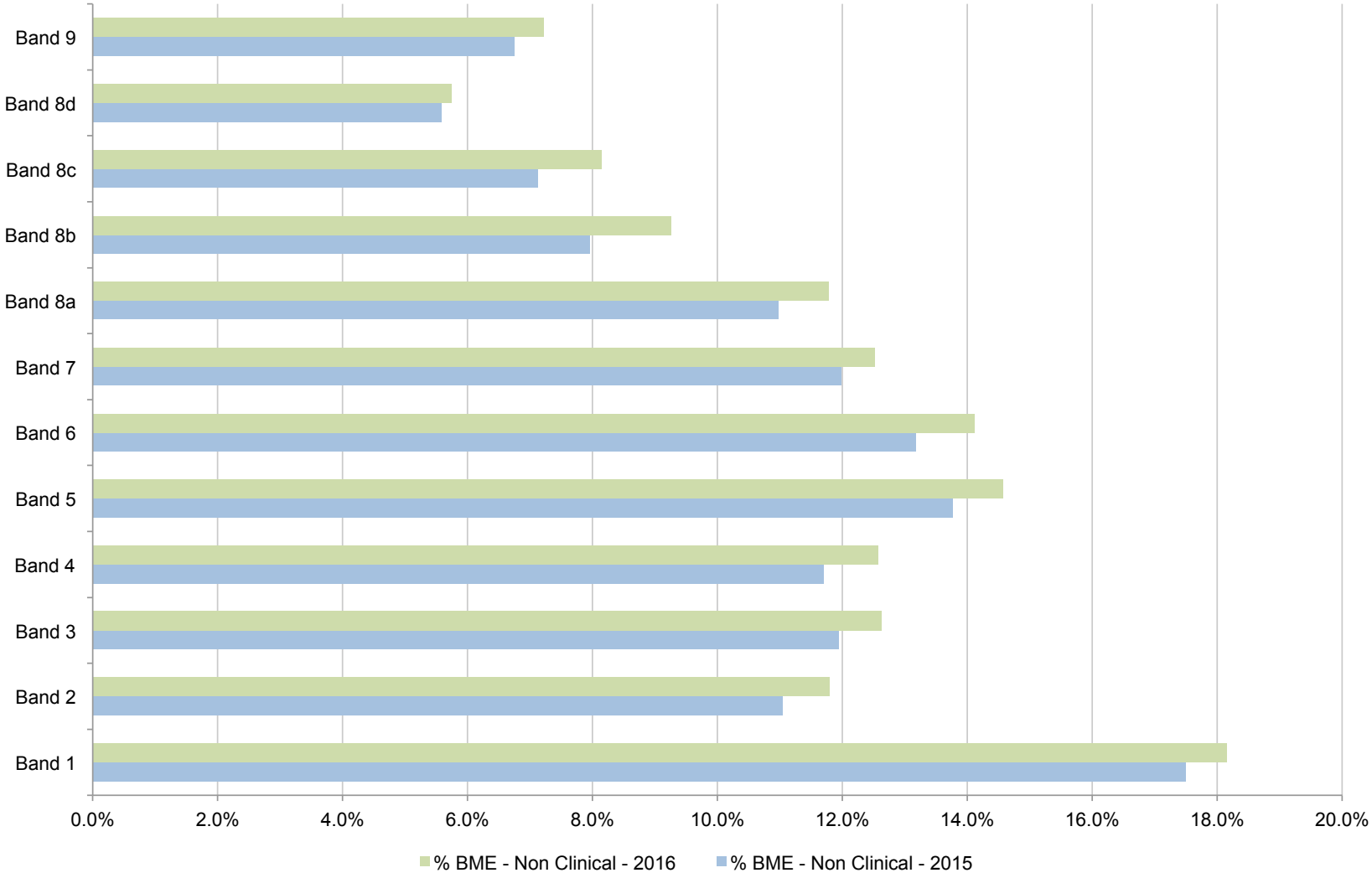
Delivering real transformational change in the NHS where it matters most.

High quality care for all, now and for future generations.

AfC non-clinical staff

Figure 1.7 shows that the proportion of BME non-clinical staff increased throughout all AfC bands. The proportion of Band 5 BME staff increased from 13.8% to 14.6% in 2016. Similarly, the proportion of BME staff increased in Band 6 (14.1%), Band 8a (11.8%) Band 8b (9.3%) and Band 8c (8.1%). The smallest proportional change is evident at AfC Band 8d in which the proportion of BME staff rose from 5.6% to 5.7% in 2016. Similarly, in Band 9, the proportion of BME staff rose nominally from 6.8% to 7.2% in 2016. This equates to a headcount of 11 people.

Figure 1.7: BME non-clinical staff: September 2015 and 2016



Whilst BME nurses and midwives remain seriously under-represented at Bands 6 and above, the data here suggest that some progress, though limited, is underway.

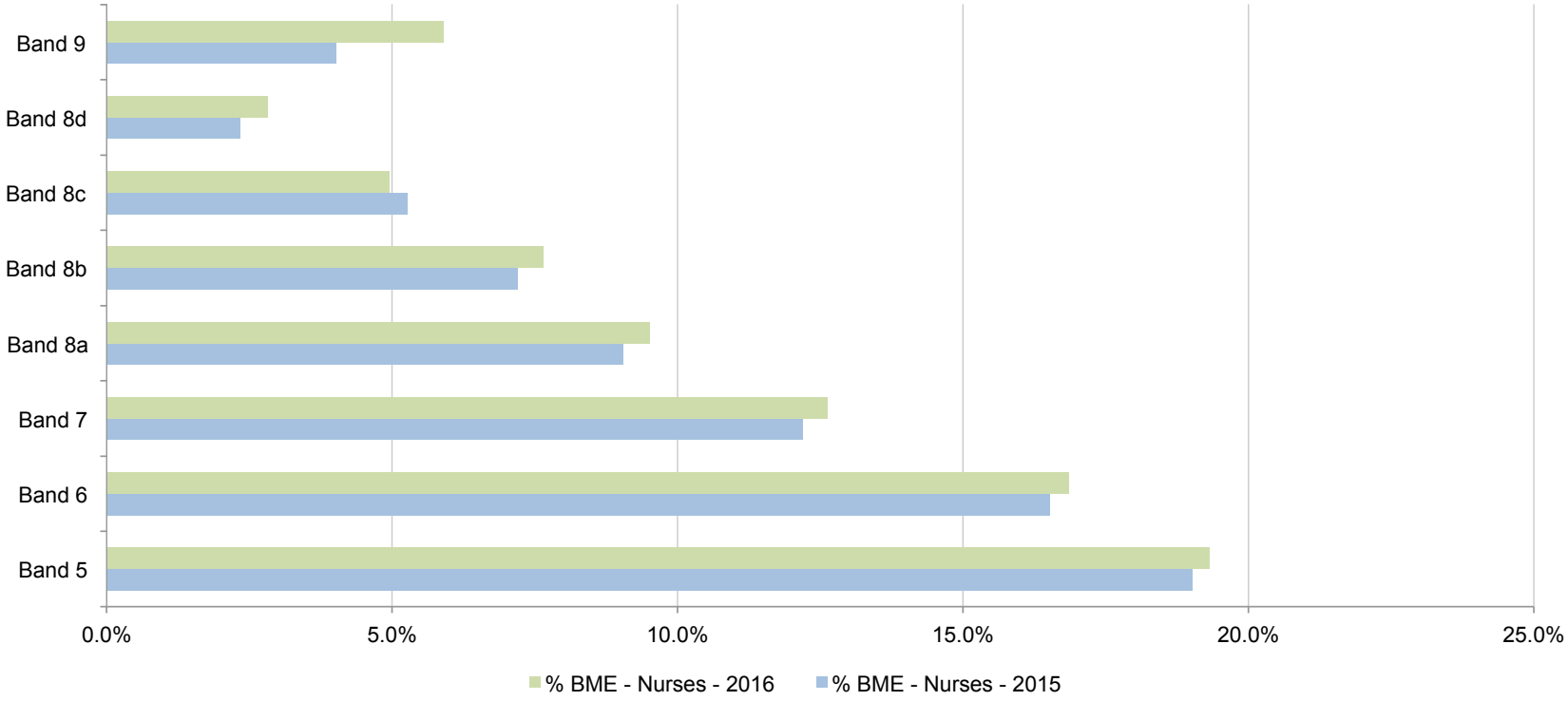
Nursing and midwifery staff

For nursing and midwifery staff overall, the proportion of BME staff at Band 5 remained at 24%, but there were small, yet potentially encouraging, increases in the proportion of BME staff at Bands 6 and above as Figure 1.8 and Tables 4 and 5 show.

Increases in the proportion of BME staff in AfC Bands above 5 are significant. In particular, increases were found in the following AfC Bands:

- 6.3% increase at Band 6 (increase of 1173)
- 7.0% increase at Band 7 (increase of 452)
- 13.0% increase at Band 8a (increase of 121)
- 12.4% increase at Band 8b (increase of 23)

Figure 1.8: BME qualified nurses, health visitors and midwives: September 2015 and 2016



This progress can be seen even more clearly if we look at staff headcount change between 2013 and 2016. As Table 4 shows, from 2014, there was a very modest increase in the numbers of BME nurses and midwives within AfC Bands above 5; Band 5 being the entry grade for qualified nurses.

However, from 2015 this increase became significantly larger at Bands 6, 7, 8a and 8b. Furthermore, in 2015/16 this increase continued across these Bands and was slightly larger still.

Table 4: BME staff headcount (change in headcount from previous year) by AfC band within nursing and midwifery: 2013 – 2016

Headcount change	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
Sept 2013	39532	17174	5727	827	149	44	7	3
Sept 2014	39143 (-389)	17656 (482)	5980 (253)	858 (31)	160 (11)	51 (7)	7 (0)	3 (0)
Sept 2015	38328 (-815)	18719 (1063)	6444 (464)	929 (71)	185 (25)	55 (4)	7 (0)	3 (0)
Sept 2016	38370 (42)	19892 (1173)	6896 (452)	1050 (121)	208 (23)	55 (0)	11 (4)	6 (3)

Source: NHS Digital.

Table 5: BME staff change (% change) by AfC band within nursing and midwifery: 2013- 2016

	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9
2013 to 2016	-1162 (-2.9%)	2718 (15.8%)	1169 (20.4%)	223 (26.9%)	59 (39.5%)	11 (25.0%)	4 (57.1%)	3 (100.0%)

Source: NHS Digital.

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The increases between 2014 and 2016 came during a period when concerns about the serious under-representation of BME nurses and midwives above Band 5, and concerns about race equality more generally, became a policy priority across the NHS. Another milestone to note was the agreement to develop the WRES in 2014, which was rolled out across the NHS in April 2015.

It is not possible to ascertain the exact cause(s) of observed increases in BME nurses and midwives in AfC Bands above Band 5. However what we do know from workforce data is that there was an impact that had a positive influence on representation for these staff groups. Certainly the cumulatively increased number of BME nurses and midwives at Bands 6 to 9 is significant, and 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

Data source and reliability

Although data collection against this indicator was undertaken in 2015, the data returns from trusts were significantly incomplete and inaccurate; an indication of previous system wide failures to reliably collect such data. Hence it was not possible to report against that data with any confidence last year.

Therefore, for this indicator, we have not undertaken a comparison of this years' data against data for the previous year. However, this will be possible in the report for the 2017 WRES data.

Of the 238 respondent trusts (100%), 19 did not provide or confirm all or part of their data, so percentages used in this section are based upon 218 trust responses.

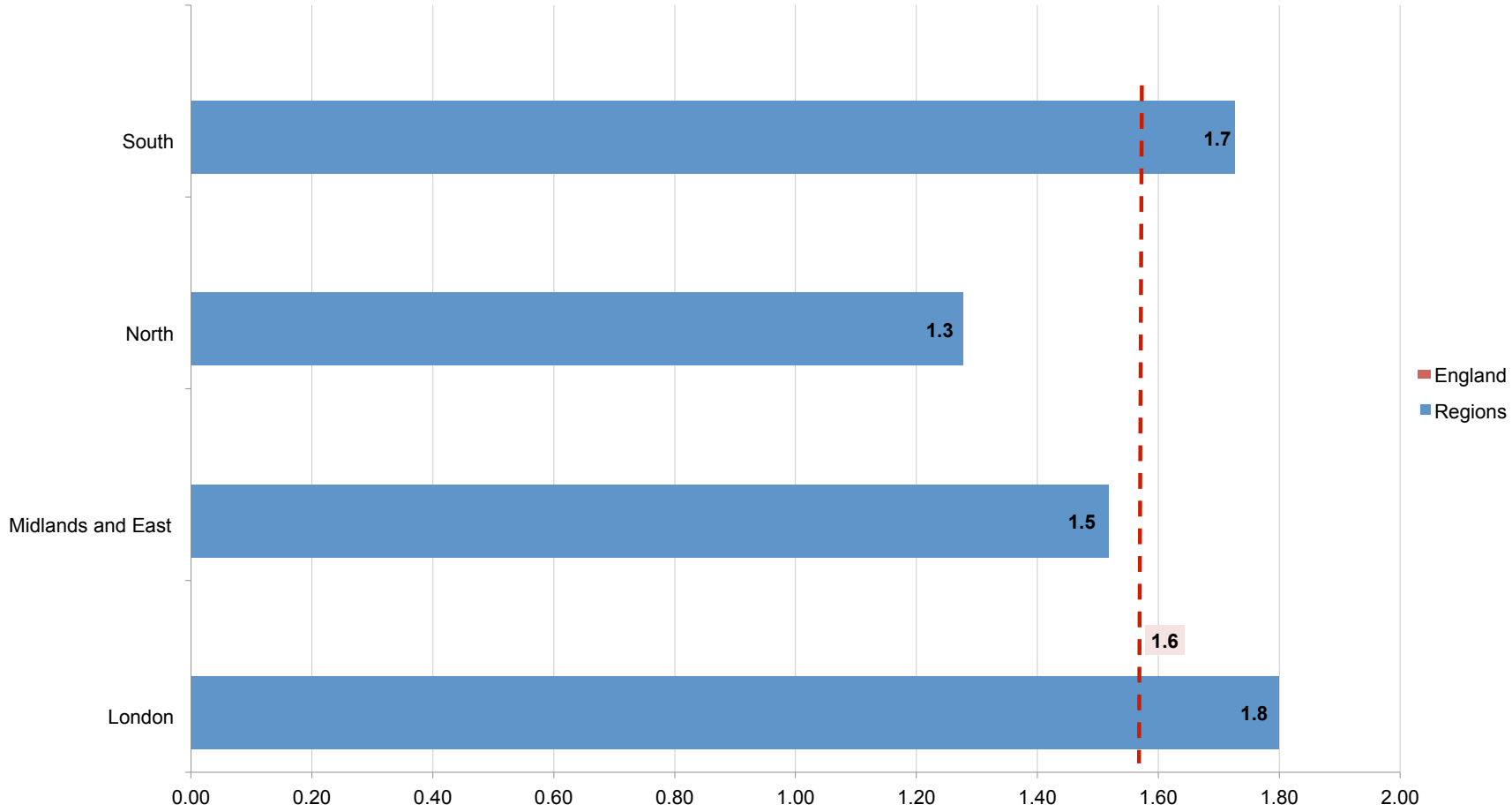
Overall results

- The relative likelihood of white staff being appointed from shortlisting compared to BME staff, across all posts, was 1.57 times greater than for BME staff.
- In just 15 trusts (6.9%) there was a greater likelihood of BME staff being appointed from shortlisting compared to white staff. In the remaining 201 trusts (93.1%), there was greater likelihood of white staff being appointed from shortlisting compared to BME staff.
- In 38 trusts (17%), it was more than twice as likely that white staff would be appointed from shortlisting compared to BME staff.

By region

The relative likelihood of white staff being appointed from shortlisting compared to BME staff varied between regions, as Figure 2.1 shows. In every region, it was more likely that white staff would be appointed from shortlisting than BME staff.

Figure 2.1: Relative likelihood of white staff being appointed from shortlisting compared to BME staff: by region



The London region has the greatest likelihood of white staff being appointed from shortlisting, and also has the highest proportion of trusts where BME staff report they do not believe their trust provides equal opportunities for career progression or promotion.

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 highest proportion of BME people within its population, this presents a particular challenge.

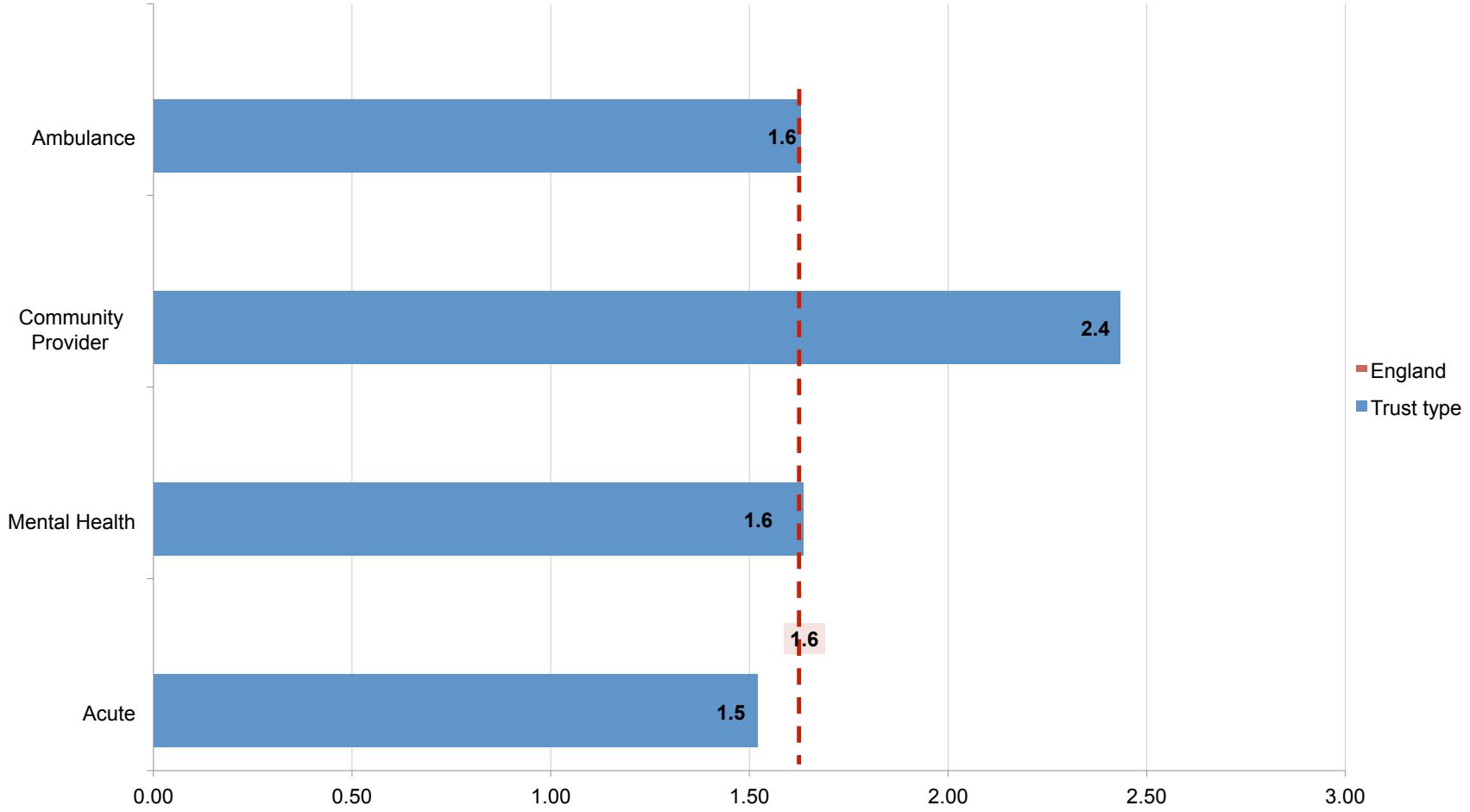
By type of trust

Figure 2.2 shows the differences in the relative likelihood of white staff being appointed from shortlisting compared to BME staff within each type of NHS trust.

In its simplest form, the WRES offers local NHS organisations the tools to understand their workforce race equality performance, including the degree of BME representation at senior management and board level. The WRES highlights differences between the experience and treatment of White staff and BME staff in the NHS. It helps organisations to focus on where they are right now on this agenda, where they need to be, and how they can get there. I welcome the support the WRES has received to date and look forward to seeing the changes it seeks to achieve.

Sir Keith Pearson
Chair, Health Education England and
Chair, *WRES Strategic Advisory Group*

Figure 2.2: Relative likelihood of white staff being appointed from shortlisting compared to BME staff: by trust type



With the exception of community provider trusts, all sectors align to the overall England likelihood of white staff being 1.57 times more likely to be appointed from shortlisting.

White staff in community provider trusts are 2.43 times more likely to be appointed from shortlisting – significantly higher than the England likelihood of 1.57 times. There were very significant differences within each type of trust category.

All comparative trust data related to indicator 2 can be found online.

Trusts where data suggest practice may be better

It was of particular interest to learn from those organisations which in respect of reported data on the relative likelihood of white and BME staff being appointed from shortlisting:

- sustained an above average performance within their type of trust for 2015 and 2016, or
- showed significant improvement to better than average in 2016 of staff reporting that in the last 12 months; and
- observed BME staff reporting significantly above average response in indicator 7, i.e. whether BME staff believe their trust provides equal opportunities for career progression and promotion.

Trusts where the number of appointments of BME staff in 2015-16 was less than ten, have not been included in this list, as the use of such small numbers may undermine confidence levels for the data. That condition may be revisited next year. For this year, trusts with less than 50 BME responses to this staff survey question have been excluded. However, this may be reconsidered next year, when there will be access to two consecutive years of reliable data.

Caution should be exercised in assuming that trusts whose data is good are engaged in better practice than those for whom data show no improvement. Field work and engagement indicate that some of the best practice on this indicator is being undertaken by trusts where relatively poor data has spurred the board and others into taking determined action to redress unfair outcomes. 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 necessarily good practice underway.

Please note that data used to compile the list of trusts below is for the reporting period of this publication i.e. 2015/16. It may be the case that data for these trusts for the following year show fluctuation – the 2017 WRES Data Analysis Report publication will cover any such trends.

Table 6. Trusts where data suggest practice may be better for WRES indicator 2

Basildon and Thurrock University Hospitals NHS Foundation Trust
Bedford Hospital NHS Trust
Black Country Partnership NHS Foundation Trust
Central and North West London NHS Foundation Trust
Dorset County Hospitals NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Mid Yorkshire Hospitals NHS Trust
Milton Keynes University Hospital NHS Foundation Trust
North Essex Partnership University NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Portsmouth Hospitals NHS Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Southern Health NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Western Sussex Hospitals NHS Foundation Trust

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

- Likelihood of white staff being appointed from shortlisting compared to BME staff was below 1.30
- Indicator 7 BME responses were 83% or above
- NHS staff survey response linked to indicator 7 was from a sample that was 50 BME staff or more

The WRES provides guidance to the NHS on how to achieve better equality outcomes for our BME staff. Understanding the data and its implications for our BME staff is a great first step in making the difference that all our staff, patients and communities need and deserve.

John Brouder
Chief Executive
North East London NHS Foundation Trust

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

Data source and reliability

Of the total 238 responding NHS trusts, 14 provided data that were either incomplete or null. Two trusts provided data that were such significant outliers that it was not possible to use it with any confidence. That data significantly impacted on the average likelihood of BME staff entering the formal disciplinary process compared to white staff within the South region.

Overall results

- For the 224 trusts analysed, the (unweighted) relative likelihood of BME staff entering the formal disciplinary process nationally was 1.56 in 2016, with significant variations between regions and type of trust and within regions and types of trust.
- In London, BME staff are 2.0 times more likely to enter the formal disciplinary process than their white counterparts.
- The proportion of trusts where the likelihood of white and BME staff entering the disciplinary process was equal or where white staff were more likely to enter the disciplinary process is 58 (26%) trusts.
- The proportion of trusts where the likelihood of BME staff entering the disciplinary process was more than for white staff was 74% (164). In 65 (29%) trusts, the likelihood of BME entering the disciplinary process was more than twice as likely as for white staff.

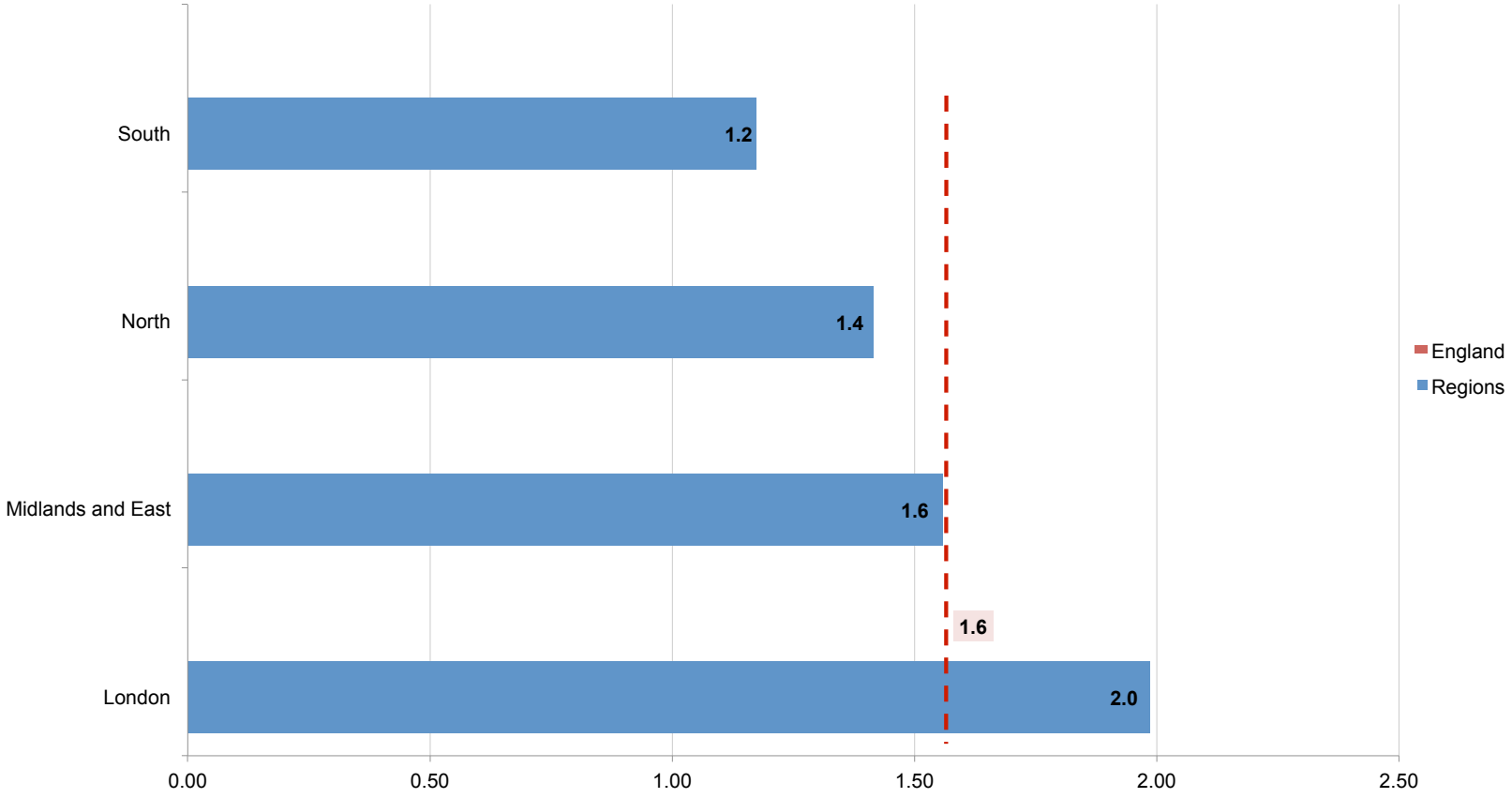
Further analyses of the data may indicate correlations with the proportions of BME staff in the workforce in respect of each region, but not necessarily in relation to the proportion of BME staff in different types of trust. The type of trust may not be so significant other than in specialist acute trusts (better) and ambulance trusts (worse). There may also be correlations between the density of BME staff in some grades (e.g. within lower grades in some trusts) and higher disciplinary rates.

There are significant differences between trusts with regard to the proportion of staff overall (of any ethnicity) entering the disciplinary process; this in itself may well be an interesting issue to consider for the wider NHS.

By region

Figure 3.1 shows that although in all regions, BME staff are more likely to enter the formal disciplinary process, there are regional variations.

Figure 3.1: The likelihood of BME staff entering the formal disciplinary process compared to white staff: by region



In London, BME staff are 2.0 times more likely to enter the formal disciplinary process than their white counterparts.

By type of trust

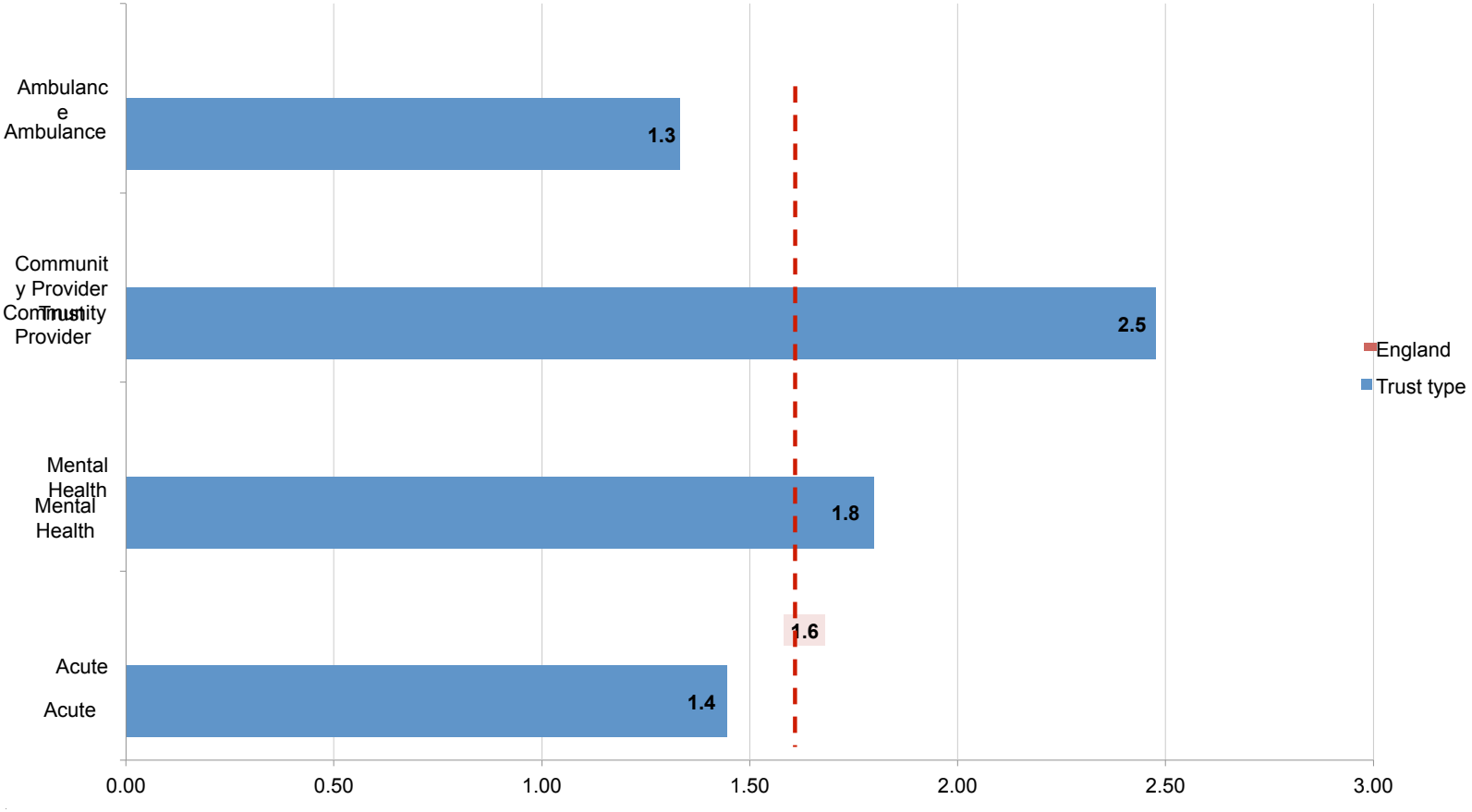
There were significant differences between and within types of NHS trusts. Community provider trusts performed worse, with BME staff 2.5 times more likely to enter the formal disciplinary process.

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

The WRES is designed to analyse whether there is a difference between BME and White staff. From April 2016 onwards, progress on the WRES will be considered as part of the "well led" domain in CQC's inspection programme for all NHS trusts and independent healthcare providers contractual obliged to carry out the WRES.

Sir David Behan
Chief Executive
Care Quality Commission

Figure 3.2: The likelihood of BME staff entering the formal disciplinary process compared to white staff: by trust type



Trusts where data suggest practice may be better

It was of particular interest to learn from those organisations where the likelihood of BME staff entering the disciplinary process was either less than that for white staff or where it was no more than 1.30 times more likely.

Trusts with less than 200 BME staff have not been included on the grounds that whilst their data may well represent good practice, the numbers being disciplined are too small to give confidence in the data. Next year, however, any trust with better than average data for two years running will be identified irrespective of the numbers of BME staff employed.

Only trusts where the BME responses to WRES indicator 8 are also above average have been included. This is an arbitrary filter but is intended to help provide some assurance as to whether the data for WRES indicator 3 corresponds with the wider BME staff view about discrimination within the trust.

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

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. The 2017 data will give some assurance since it will then be possible to confirm developing patterns of continuous improvement in these areas.

Please note that data used to compile the list of trusts below is for the reporting period of this publication i.e. 2015/16. It may be the case that data for these trusts for the following year show fluctuation – the 2017 WRES Data Analysis Report publication will cover any such trends.

Table 7. Trusts where data suggest practice may be better for WRES indicator 3

Airedale NHS Foundation Trust
Ashford and St. Peter's Hospitals NHS Foundation Trust
Bedford Hospital NHS Trust
Birmingham Children's Hospital NHS Foundation Trust
Black Country Partnership NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
Dartford and Gravesham NHS Trust
Dorset Healthcare University NHS Foundation Trust
East Sussex Healthcare NHS Trust
Hillingdon Hospitals NHS Foundation Trust
Hinchingbrooke Health Care NHS Trust
Leeds Community Healthcare NHS Trust
Leeds Teaching Hospitals NHS Trust
Leicestershire Partnership NHS Trust

Table 7. Trusts where data suggest practice may be better for WRES indicator 3 - continued

Luton and Dunstable University Hospital NHS Foundation Trust
Mersey Care NHS Trust
Milton Keynes University Hospital NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Pennine Care NHS Foundation Trust
Plymouth Hospitals NHS Trust
Poole Hospital NHS Foundation Trust
Portsmouth Hospitals NHS Trust
Rotherham NHS Foundation Trust
Royal Brompton and Harefield NHS Foundation Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Royal Wolverhampton NHS Trust
Solent NHS Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Table 7. Trusts where data suggest practice may be better for WRES indicator 3 - continued

Southend University Hospital NHS Foundation Trust
Surrey and Sussex Healthcare NHS Trust
Sussex Partnership NHS Foundation Trust
University Hospitals Coventry and Warwickshire NHS Trust

Organisations were not included on the list unless all of the following conditions applied:

1. More than 200 BME staff employed by the trust
2. Relative likelihood of BME staff entering the disciplinary process compared to white staff is less than 1.30
3. Less than 12% of BME staff reported they were discriminated against in the last 12 months

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

Data source and reliability

Non-mandatory training and CPD recording practice differs between organisations. However, all trusts are expected to maintain internal consistency of approach from year to year, so that changes in uptake trends can be compared over time. Accessing non-mandatory training and CPD in this context refers to courses and developmental opportunities for which places are offered and accepted.

Indicator 4 was included within the WRES because it was apparent that many organisations were not monitoring BME staff access to developmental opportunities despite the fact that national NHS staff survey data (WRES indicator 7) suggested serious concerns over career progression and promotion. Furthermore, data prior to the introduction of the WRES suggested a serious imbalance in BME staff access to external development courses and programmes such as those provided by the NHS Leadership Academy.

Defining this WRES indicator was problematic. The 2014 data returns for this indicator were of poor quality, with a very large number of trusts unable to provide any data at all on the grounds they were not collecting it. Nevertheless, it was felt essential to have the collection of data against this indicator, and in the 2017 WRES Technical Guidance, further advice on better ways of collecting this data have been outlined.

A total of 162 trusts provided data of a quality which enabled it to be analysed. 48 trusts failed to provide any data and 26 provided data of a quality that had low confidence levels. A significant number of trusts provided assurance that they were implementing systems to be able to provide data for 2017.

There is evidence that access to developmental courses and programmes, such as those provided by the NHS Leadership Academy, has improved but the historical failure to monitor CPD and non-mandatory training appears to have been a by-product of the informal allocation of, or access to, courses and development opportunities. This inevitably raises the risk of discriminatory practices.

Overall results

In 84 of the 162 trusts that provided reliable data, it was more likely that white staff will access non-mandatory training and CPD than BME staff. In three trusts it was the same likelihood, and in 76 trusts it was more likely that BME staff will access non-mandatory training and CPD.

This suggests that broadly access to non-mandatory training and CPD is slightly better for white staff but not dramatically so.

Comparative data for individual trusts can be found online.

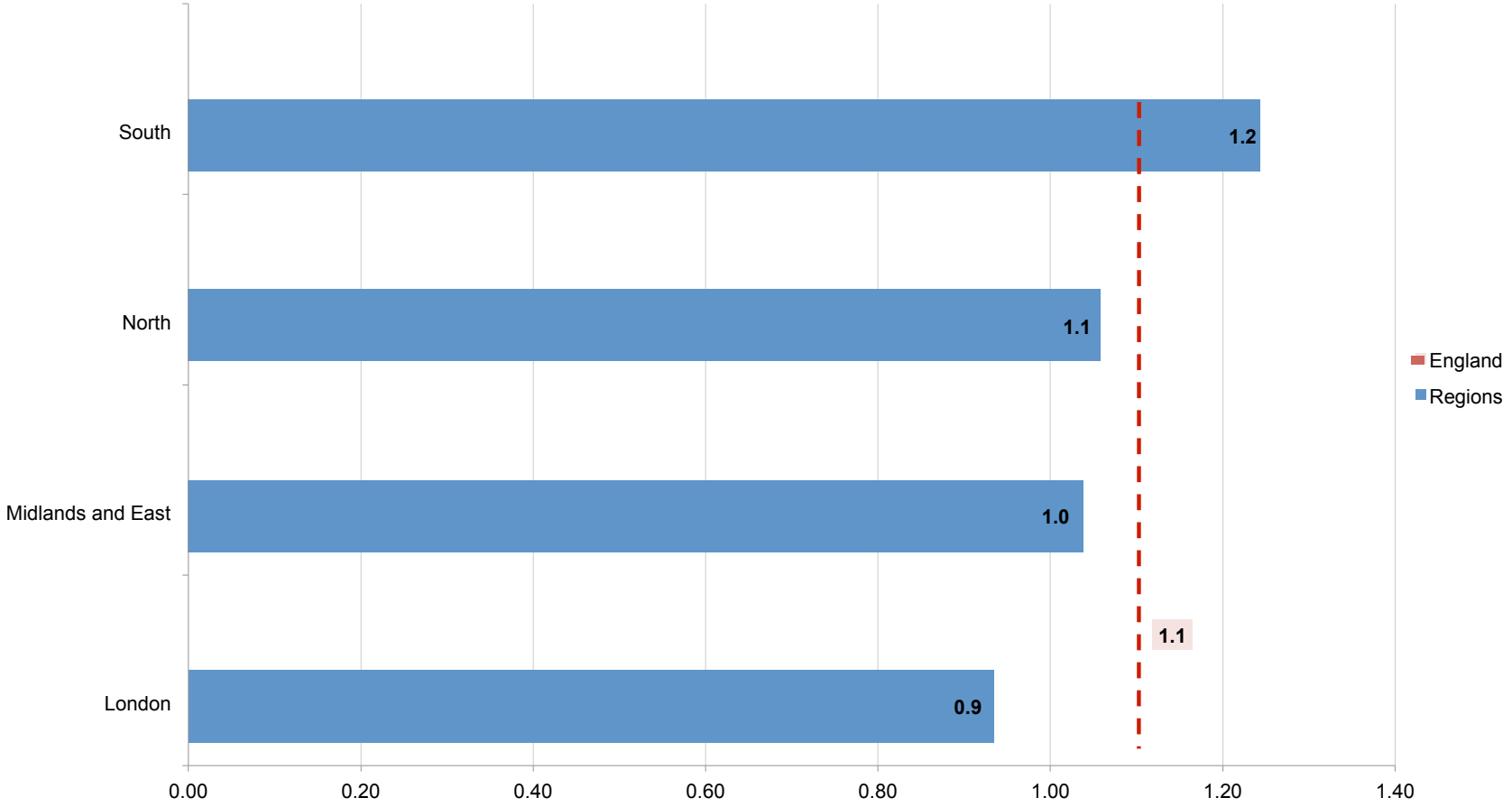
By region

There were differences between the regions on this indicator, as Figure 4.1 shows. The south was the only region which showed a higher than average outcome on this indicator.

The Royal Free Hospital welcomes the WRES and its implementation which will support our commitment to ensuring that our employment practices are fair, accessible and appropriate for the diverse communities we serve and the workforce we employ.

Sir David Sloman
Chief Executive
Royal Free London NHS Foundation Trust

Figure 4.1: Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff: by region



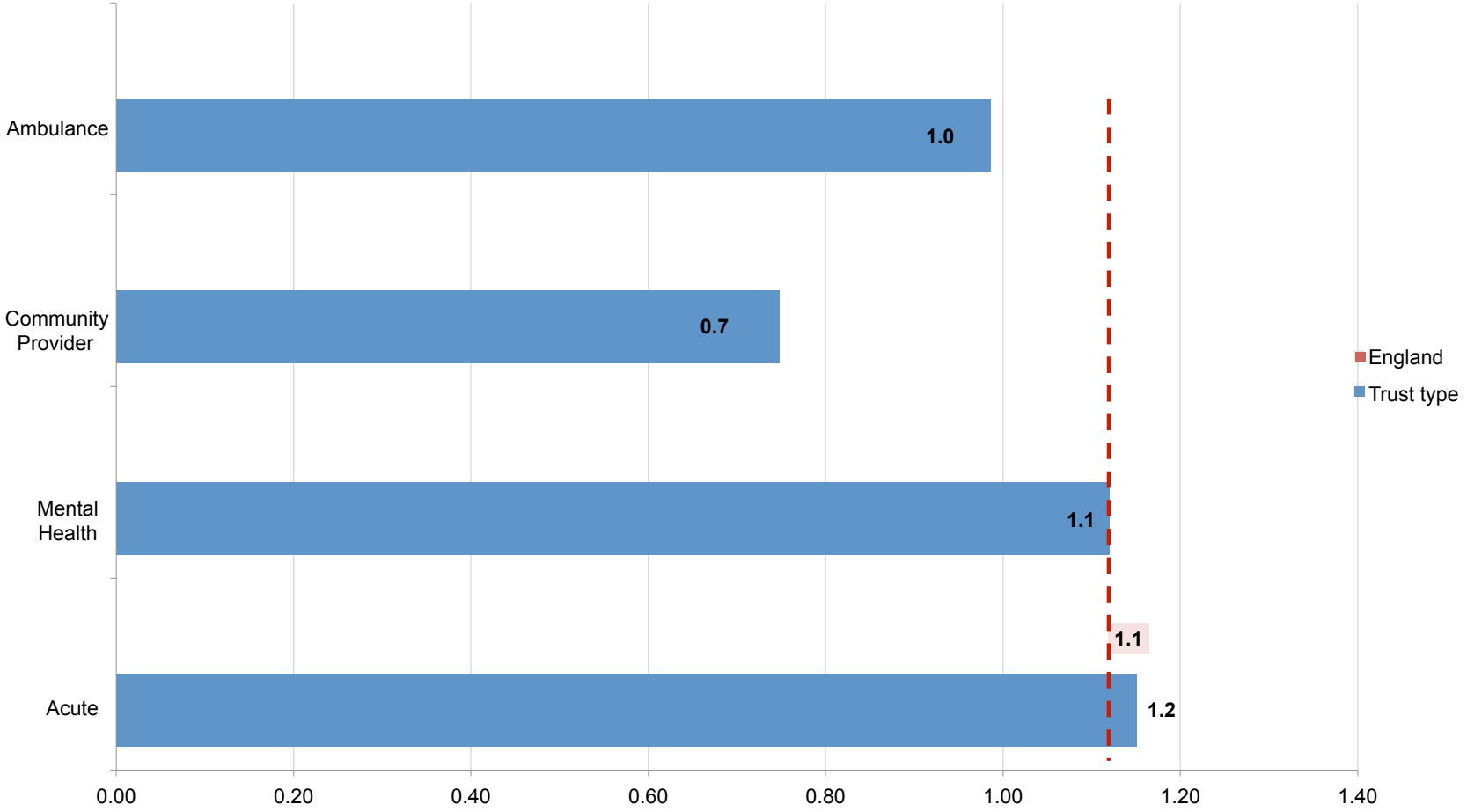
The WRES holds a mirror to us, and enables employers to confront the very different experience of our BME colleagues. The challenge remains though in the response to what we see in this mirror. We must not be defensive or complacent, but must change our cultures, biases, attitudes and behaviours as well as improve our processes and policies. We are committed to ensuring that the talent of all our colleagues is fully realised, to the benefit of the communities and patients we all serve.

Danny Mortimer
Chief Executive
NHS Employers

By type of trust

The differences between types of NHS trust were small with the exception of acute trusts, where white staff were 1.2 times more likely to access non-mandatory training and CPD when compared to BME staff.

Figure 4.2: Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff: by trust type



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)

Data source and reliability

Aggregated trust responses on NHS 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. Where data are published and presented, trusts that have BME responses from less than 50 staff should be treated within caution.

Overall results

The overall percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months remained at 25% in 2014 and in 2015. For white staff the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months remained 28% in 2014 and in 2015. For BME staff the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months decreased slightly from 30% in 2014 to 29% in 2015.

The difference between the percentage of white staff and BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months decreased from -2.2 percentage points in 2014 to -0.7 percentage points in 2015.

The difference between the experience of white and BME staff on this indicator has remained very small over the seven previous years across the NHS as a whole. This is in contrast to the data on whether staff report being bullied by colleagues or managers where the experience of BME staff has, on average, been consistently worse. This is discussed further below.

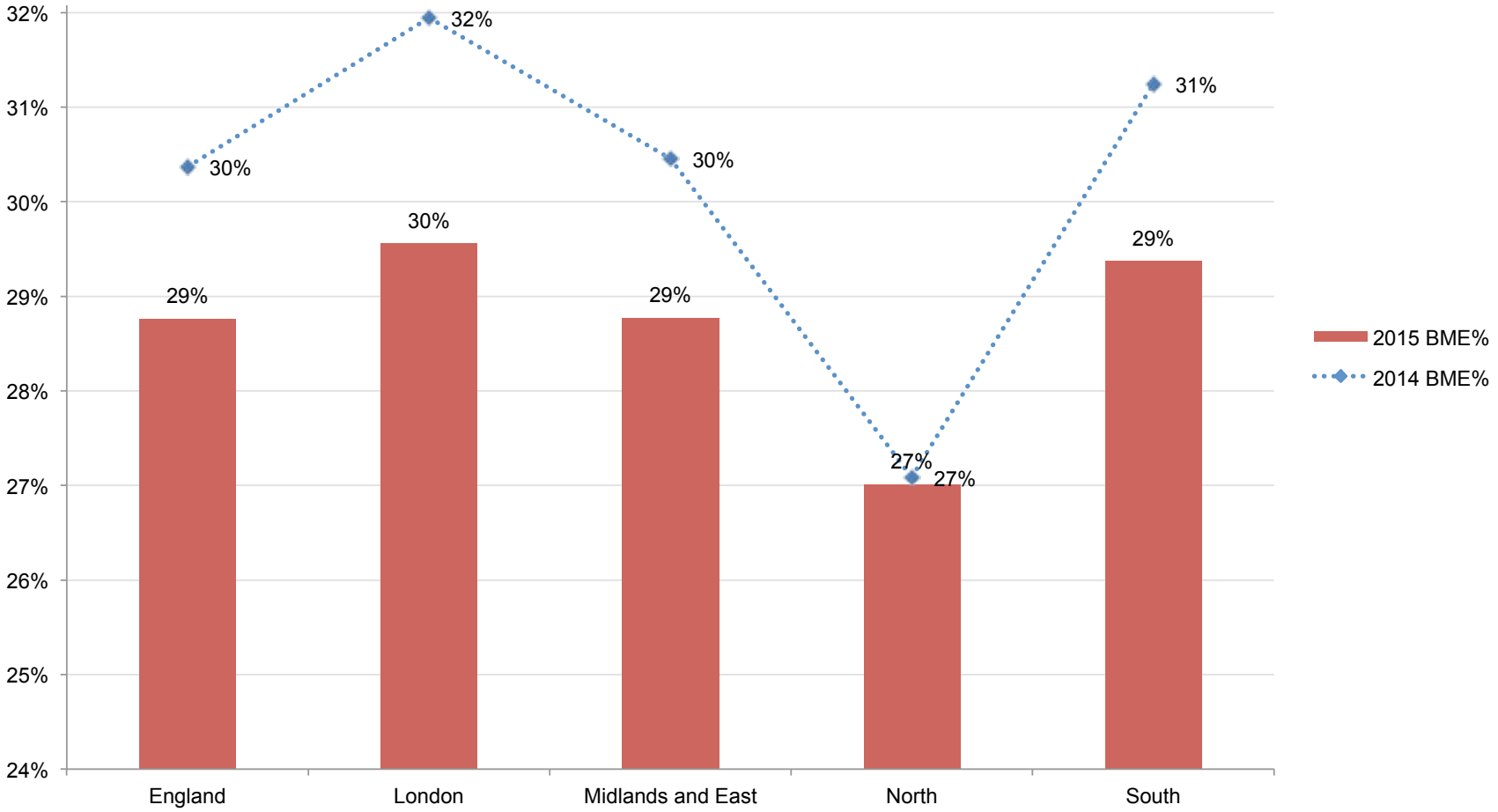
By region

As Figure 5.1 shows,London and South showed the greatest improvement, whilst the North saw little change, in the proportion of BME staff reporting harassment, bullying or abuse from patients, relatives or the public in last 12 months. The London region has now a 0.7 percentage point difference between the treatment of white and BME staff in the results for WRES indicator 5.

The leadership of Mersey Care NHS Trust is committed to workforce race equality. Research and evidence suggest that diverse workforce representation improves teamwork, innovation and productivity. The WRES supports our organisation on this important agenda. It helps us to evaluate performance against indicators of workforce race equality and to produce robust action plans for continuous improvement over time.

Beatrice Fraenkel
Chair
Mersey Care NHS Trust

Figure 5.1: Percentage of BME staff experiencing harassment, bullying and abuse from patients, relatives and the public in last 12 months: by region



By type of trust

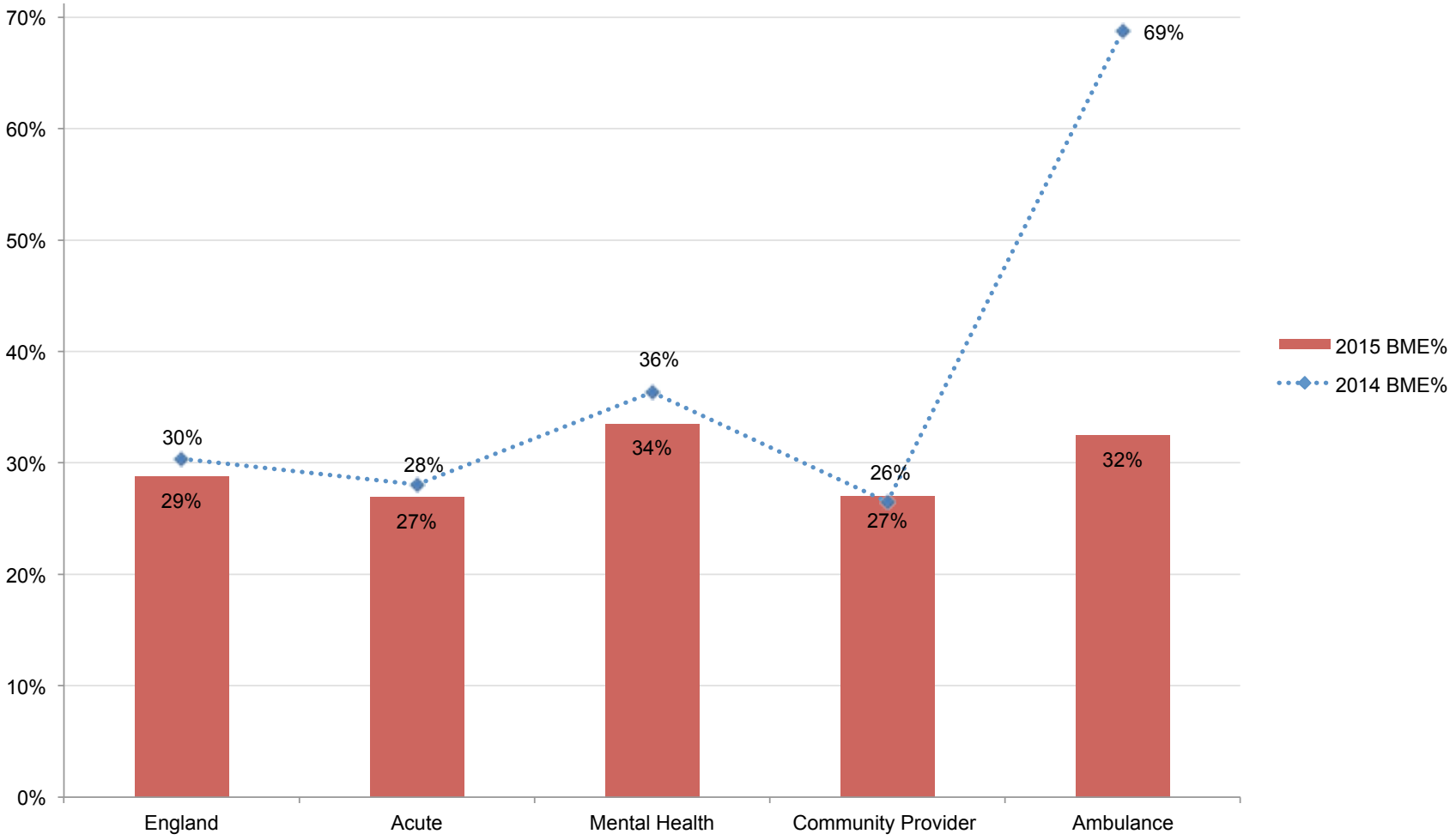
In 2014 and 2015, just one of the ten ambulance trusts collected data for this indicator using a BME sample size of 50 or more. Thus, the ambulance data in figure 5.2 should be interpreted with caution.

With the above in mind, the mental health sector saw the greatest improvement in results whereas the proportion of BME staff reporting percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 month within community trusts deteriorated.

Within each type of trust and within each region, there were considerable differences both in 2015 and in 2016.

All the comparative trust data can be found online.

Figure 5.2: Percentage of BME staff experiencing harassment, bullying and abuse from patients, relatives and the public in last 12 months: by trust type



Trusts where data suggest practice may be better

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

- where the BME staff responses, and the overall level for all staff, of harassment, bullying or abuse from patients, relatives or the public, are above average for their type of trust on both counts for two years running; or

- where the BME staff responses in 2016 are significantly better than in 2015 and above average for their type of trust.

Using these criteria it has been possible to identify the following trusts where data suggest the experience of BME staff (and often of white staff) in experiencing harassment, bullying or abuse from patients, relatives or the public appears to be better than average and/or continuously improving.

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 staff working in accident and emergency departments for example. Please note that in the trusts listed below there may be a question of confidence levels where the numbers of BME staff in total are less than 50. That does not mean the data are not meaningful at all, but it does mean a degree of caution when interpreting the data may be necessary.

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. It is evident, from field work and engagement, that some of the best practice on this indicator is being undertaken by trusts where relatively poor data has spurred the board and others into taking determined action to redress unfair outcomes.

Please note that data used to compile the list of trusts below is for the reporting period of this publication i.e. 2015/16. It may be the case that data for these trusts for the following year show fluctuation – the 2017 WRES Data Analysis Report publication will cover any such trends.

Table 8: Trusts where data suggest practice may be better on WRES indicator 5

Airedale NHS Foundation Trust
Ashford and St Peter's Hospitals NHS Foundation Trust
Birmingham Children's Hospital NHS Foundation Trust
Birmingham Community Healthcare NHS Trust
Birmingham Women's NHS Foundation Trust
Central London Community Healthcare NHS Trust
Cheshire and Wirral Partnership NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
East Lancashire Hospitals NHS Trust
Gateshead Health NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Hounslow And Richmond Community Healthcare NHS Trust

Table 8: Trusts where data suggest practice may be better on WRES indicator 5 - continued

Leeds Teaching Hospitals NHS Trust
Liverpool Heart and Chest NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
North West London Healthcare
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Papworth Hospital NHS Foundation Trust
Pennine Care NHS Foundation Trust
Rotherham, Doncaster and South Humber NHS Foundation Trust
Royal Brompton and Harefield NHS Foundation Trust
Salford Royal NHS Foundation Trust
Sandwell And West Birmingham Hospitals NHS Trust
Sheffield Children's NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
South Tyneside NHS Foundation Trust
Staffordshire And Stoke On Trent Partnership NHS Trust

Table 8: Trusts where data suggest practice may be better on WRES indicator 5 - continued

Stockport NHS Foundation Trust
The Christie NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Royal Orthopaedic Hospital NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust

Organisations were not included in this table unless the trust had 50 or more BME respondents to the staff survey.

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

Data source and reliability

Please note that "staff" in this indicator refers to the entire workforce. Aggregated trust responses on NHS staff survey indicators exclude a number of trusts where the 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 within caution.

Overall results

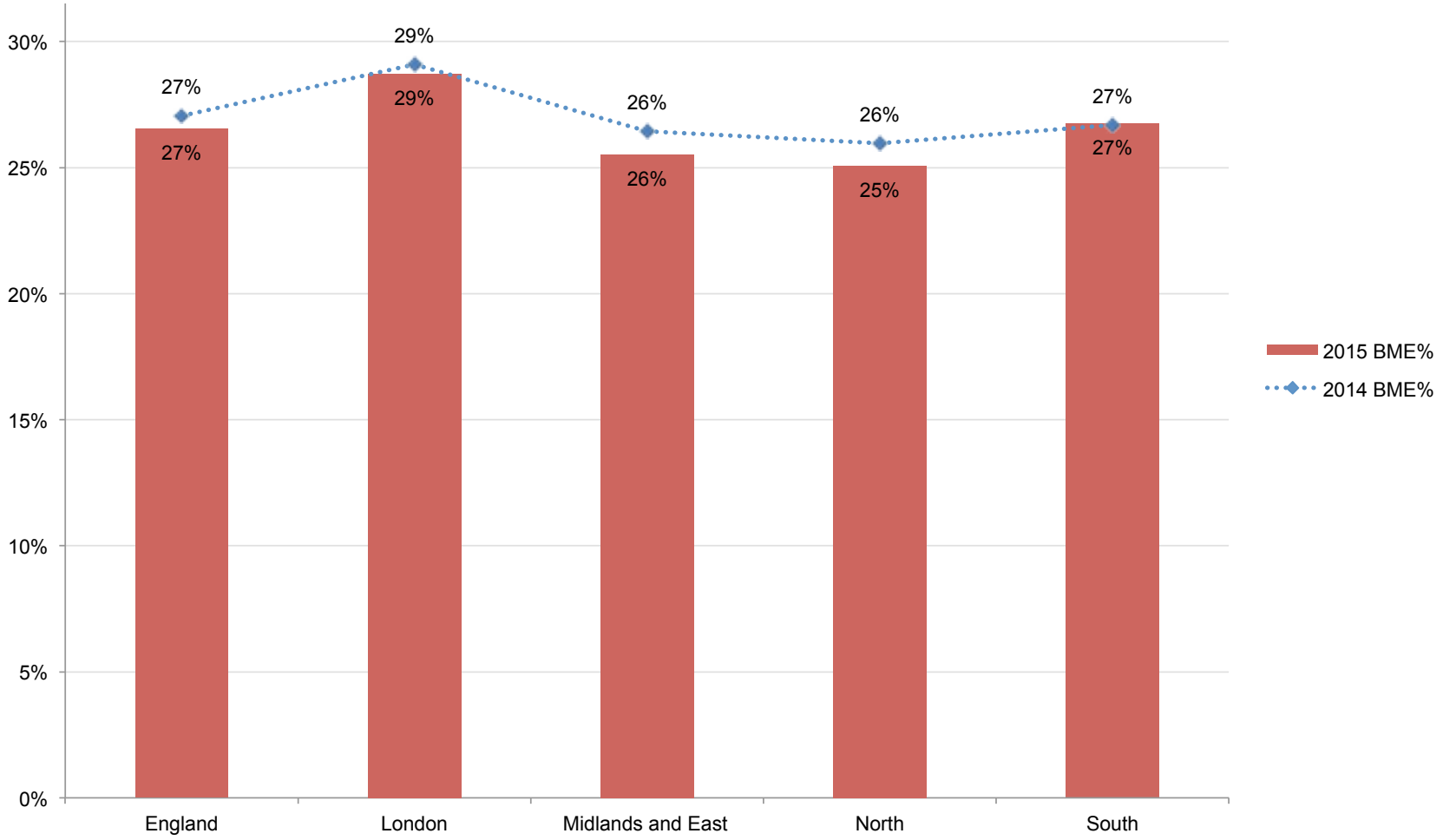
- The overall percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months increased from 22% in 2014, to 23% in 2015.
- For white staff, the percentage experiencing harassment, bullying or abuse from colleagues in the last 12 months increased from 23% in 2014, to 24% in 2015.
- For BME staff the percentage experiencing harassment, bullying or abuse from colleagues in the last 12 months remained at 27% in 2014 and in 2015.
- The difference between the percentage of white staff and BME staff experiencing harassment, bullying or abuse from colleagues in last 12 months decreased from -4.1 percentage points in 2014 to -2.2 percentage points in 2015.
- The difference between the percentage of white and BME staff experiencing harassment, bullying or abuse from patients, relatives and the public in last 12 months has remained small over the seven previous years across the NHS.
- However, the experience of BME staff has, on average, been consistently worse on this indicator. That difference has varied between 14% and 20%.
- The significant and sustained differences between BME responses on WRES indicators 5 and 6 reflects real and lived experience.

By region

Although the overall percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months remained 27% in 2014 and 2015, the figures varied slightly across the four regions.

As Figure 6.1 shows, London still has the highest proportion of BME staff experiencing bullying and harassment. In each of the four regions, there was very little change between 2014 and 2015 results in the percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months.

Figure 6.1: Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months: by region



By type of trust

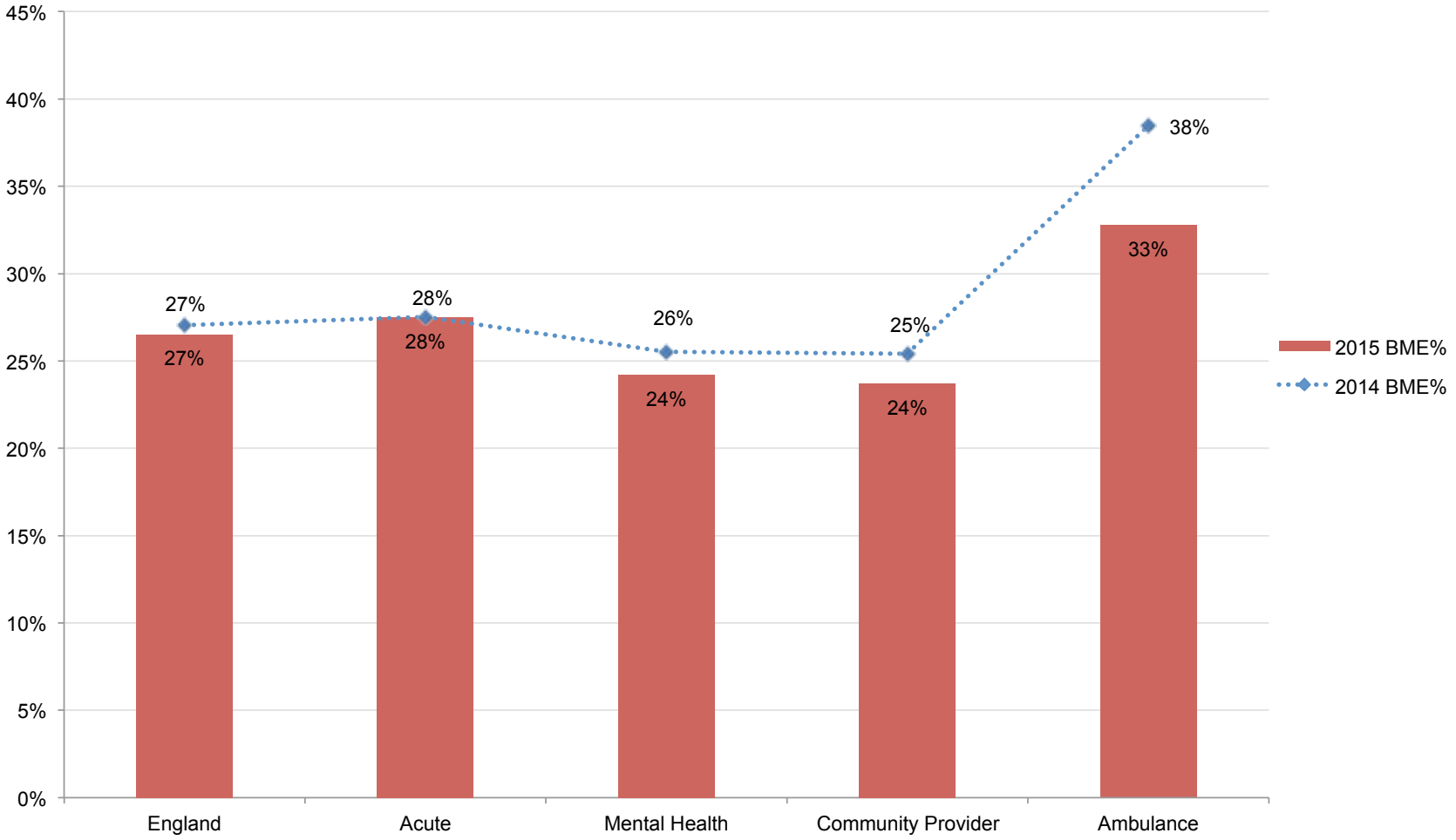
As Figure 6.2 shows, community provider trusts showed the greatest improvement (-1.7 percentage points) from 2014 to 2015. All trust types have slightly lower levels of BME staff reporting harassment, bullying or abuse from staff in the last 12 months.

In 2015, only 2 of 10 ambulance trusts collected data for this indicator using a BME sample size of 50 or more. Consequently, data for ambulance trusts should be interpreted with caution.

Within each type of trust there were differences both in 2015 and in 2016 with regard to WRES indicators 5 and 6.

All comparative trust data can be found online.

Figure 6.2: Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months: by trust type



Trusts where data suggest practice may be better

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

- where the BME staff responses, and the overall level for all staff, of harassment, bullying or abuse from patients, relatives or the public, above average for their type of trust on both counts for two years running

- where the BME staff responses in 2016 significantly better than in 2015 and above average for their type of trust.

The trusts listed in table 9 were identified using these criteria, where the experience of BME staff (and often of white staff) of harassment, bullying or abuse from staff appeared to be significantly better than average and/or improving.

Indeed, some of the best practice emerges when poor practice has been identified either by an external regulatory body, for example the Care Quality Commission (CQC), or internally by the board, the workforce or commissioners.

As a result, the impact of better practice may be reflected in continuous improvements within the data in the coming years.

Caution should be exercised in assuming that trusts whose data is better are all necessarily engaged in better practice than those who are not. It is evident that some of the best practice on this indicator is being undertaken by trusts where relatively poor data has spurred the board and others into taking determined action to redress unfair outcomes. Being listed on this table 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.

Please note that data used to compile the list of trusts below is for the reporting period of this publication i.e. 2015/16. It may be the case that data for these trusts for the following year may show fluctuation – the 2017 WRES Data Analysis Report publication will cover any such trends.

Table 9. Trusts where the data suggest practice may be better on WRES indicator 6

Camden and Islington NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
Derbyshire Healthcare NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Mersey Care NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Oxford University Hospitals NHS Trust
Oxleas NHS Foundation Trust
Pennine Care NHS Foundation Trust
Royal Surrey County Hospital NHS Foundation Trust
South Essex Partnership University NHS Foundation Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Table 9. Trusts where the data suggest practice may be better on WRES indicator 6 - continued

South Tees Hospitals NHS Foundation Trust
Southern Health NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
University Hospitals Coventry And Warwickshire NHS Trust

Organisations were not included on the list unless the trust had 50 or more BME respondents to the staff survey.

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

Data source and reliability

This indicator is drawn from 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.

The survey data which will be used in the next WRES report should avoid some of these problems as sample sizes will be larger, or full, and response rates are likely to be slightly higher.

It is worth noting that in 2015, the number of trusts with BME response rates of 10 or below fell from 32 to 18, suggesting either the use of larger samples or better engagement with the BME workforce.

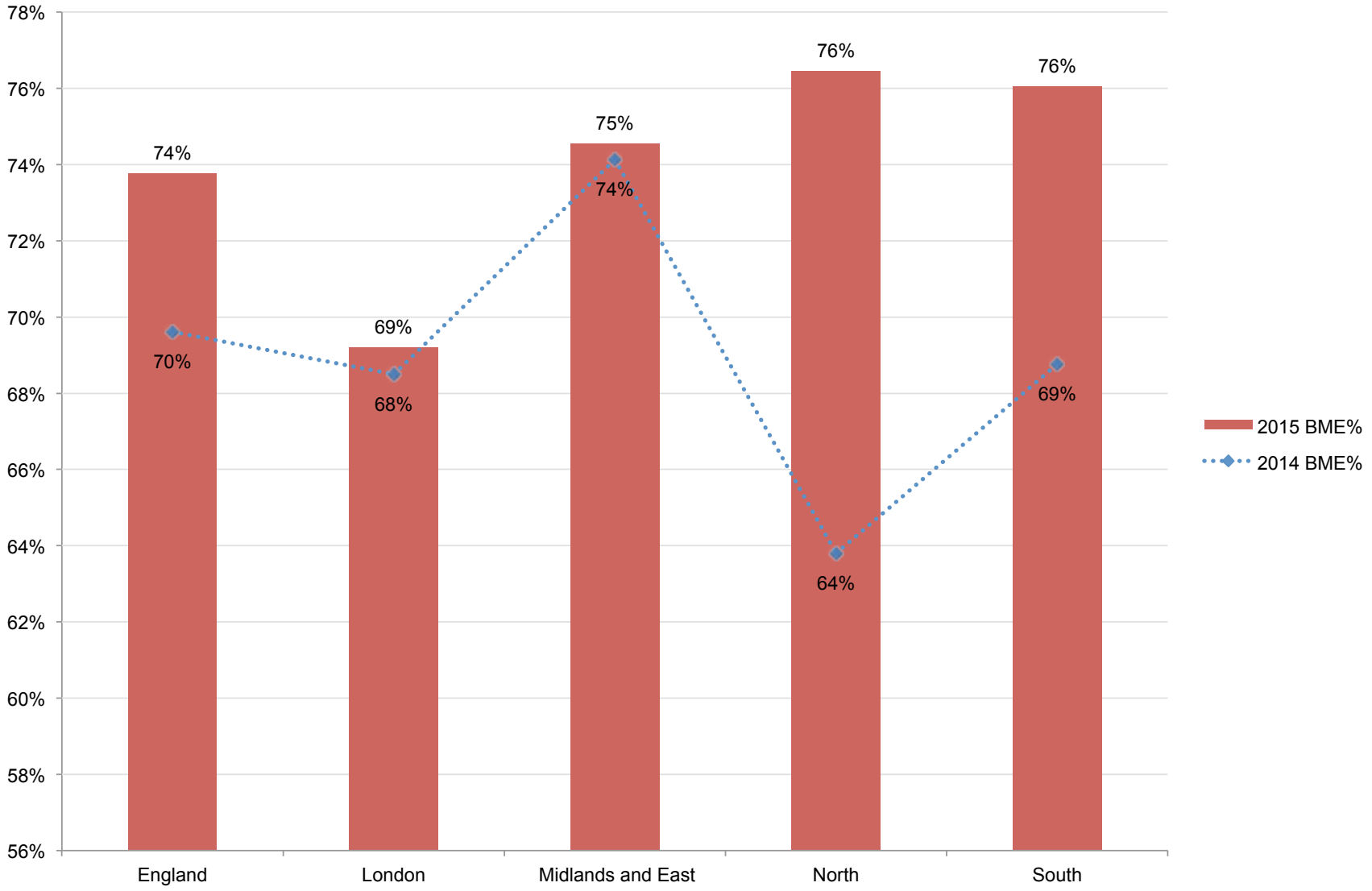
Overall results

- The overall percentage of staff believing that their trust provides equal opportunities for career progression or promotion remained static at 87% in both 2014 and 2015.
- For white staff, the percentage of staff reporting that that their trust provides equal opportunities for career progression or promotion remained 89% in both 2014 and 2015.
- For BME staff, the percentage of staff reporting that that their trust provides equal opportunities for career progression or promotion increased slightly from 70% in 2014 to 74% in 2015.
- The overall difference between the percentage of white staff and BME staff for this indicator fell from 19.0 percentage points in 2014 to 14.2 percentage points in 2015.
- 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 66 (54%).
- The number of trusts where there was an decline in the percentage of BME staff reporting that their trust provides equal opportunities for career progression or promotion was 57 (46%).
- In nine trusts (7%) more than 85% of BME staff reported that their trust provides equal opportunities for career progression or promotion in 2015.
- In 102 trusts (83%) more than 85% of white staff report that that their trust provides equal opportunities for career progression or promotion.
- In 2015, in 35 (28%) of trusts, 30% or more of BME staff did not believe their trust provides equal opportunities for career progression or promotion in 2015. That figure compares to 41 trusts (38%) in 2014. (Data excludes BME sample sizes below 50).
- Overall the proportion of white staff believing their trust provided equal opportunities for career progression or promotion in 2015 was 88% compared to 74% of BME staff. In other words, it was 2.2 times more likely on average that BME staff did not believe their trust provides equal opportunities for career progression or promotion in 2015.

By region

As Figure 7.1 shows, the North region showed the greatest improvement with 76% of BME staff now believing their trust provides equal opportunities for career progression or promotion, in comparison to the 2014 average of just 64%.

Figure 7.1: Percentage of BME staff believing there were equal opportunities for career progression and promotion: by region



London had the lowest proportion of BME staff believe that their trust provides equal opportunities for career progression or promotion (69%). Both the London and the Midlands and East regions made little progress in increasing the percentage of BME staff reporting that their trust provides equal opportunities for career progression or promotion in 2015. In contrast, significant improvement is evident in both the North and South regions.

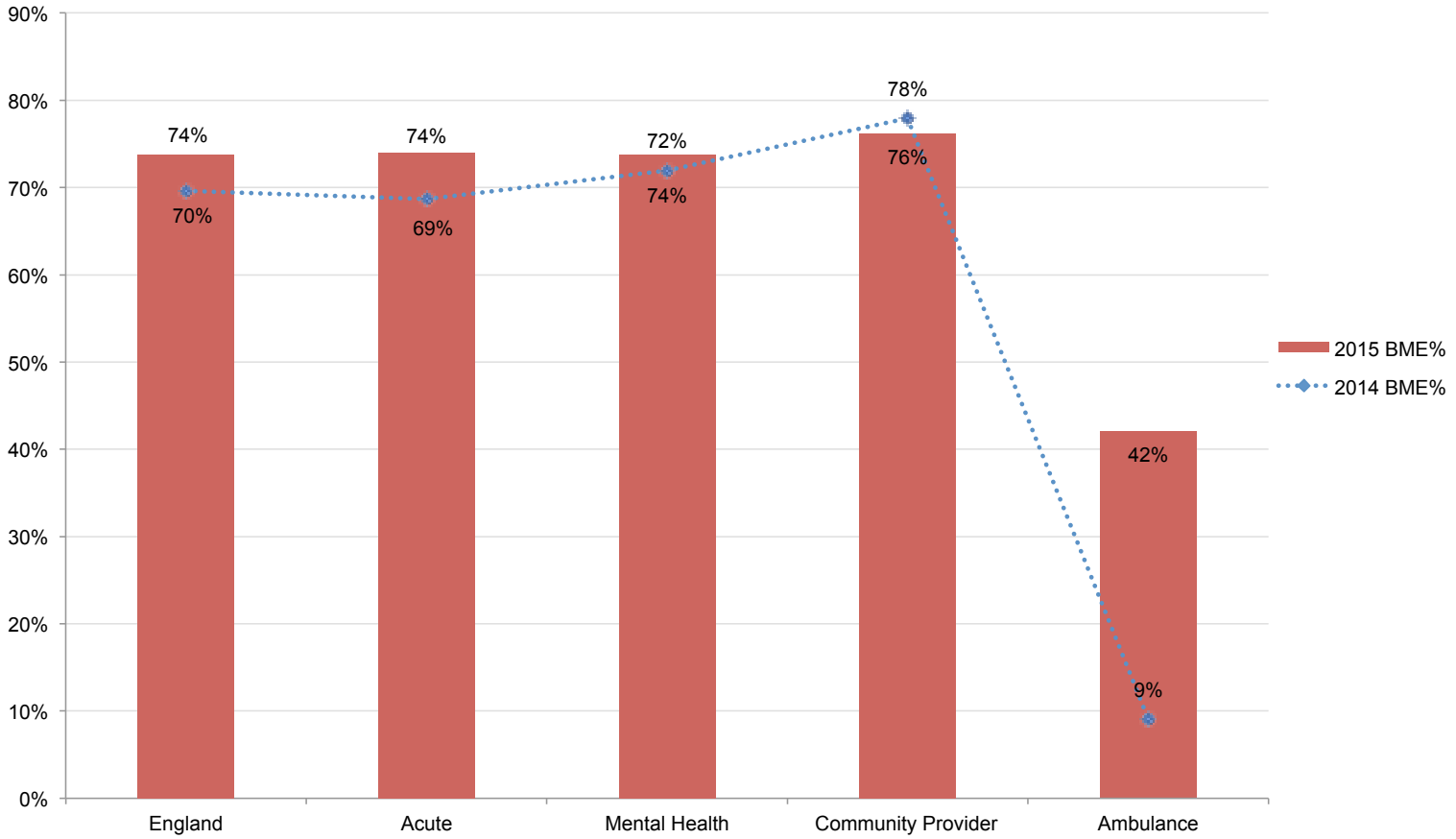
There are very significant differences in the data for this indicator, within each region, between trusts, for the experience of both white and BME staff.

As Figure 7.1 shows, the percentage of staff reporting they do not believe their trust provides equal opportunities for career progression or promotion was much lower in 2015 in London than in other regions. In only two London trusts did more than 80% of their BME staff report their trust provides equal opportunities for career progression or promotion. In other words, in every other trust in London at least one in five of BME staff did not believe their trust provides equal opportunities for career progression or promotion.

By type of trust

There are significant 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.

Figure 7.2 Percentage of BME staff believing there were equal opportunities for career progression and promotion: by trust type



In 2014 and 2015, only 1 of 10 ambulance trusts collected data for this indicator using a BME sample size of 50 or more so the ambulance data in Figure 7.2 should be interpreted with caution.

With the above in mind, the acute sector showed the greatest improvement, increasing to an average of 74% from 69% in 2014.

On average, 76% of BME staff in community health trusts reported that their trust provides equal opportunities for career progression or promotion. This is a notable reduction from 78% in 2014.

All the comparative trust data can be found online.

Trusts where data suggest practice may be better

It was of particular interest to learn from those organisations which either:

- sustained an above average performance within their type of trust for 2015 and 2016 for staff reporting that their trust provides equal opportunities for career progression or promotion; or

- showed significant improvement to better than average in 2016 for staff reporting that their trust provides equal opportunities for career progression or promotion.

Using the criteria set out above, trusts have been identified in table 10, where the proportion of BME staffreporting on this indicator issignificantly better than average.

All such data should be treated with caution where the number of respondents is small. A minimum of 50 BME respondents has therefore been set as a size that gives some confidence that the data can be relied upon, though even at that size, some caution should be exercised. Again, not being in this table does not necessarily mean good practice is not underway any more than being in this table means there is good practice underway.

Please note that data used to compile the table of trusts below is for the reporting period of this publication i.e. 2015/16. It may be the case that data for these trusts for the following year show fluctuation – the 2017 WRES Data Analysis Report publication will cover any such trends.

Table 10. Trusts with better than average responses from BME staff on WRES indicator 7

Countess of Chester Hospital NHS Foundation Trust
Dartford and Gravesham NHS Trust
Dorset County Hospital NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Oxleas NHS Foundation Trust
Papworth Hospital NHS Foundation Trust
Royal Surrey County Hospital NHS Foundation Trust
Sheffield Children's NHS Foundation Trust
Shrewsbury And Telford Hospital NHS Trust
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Staffordshire And Stoke On Trent Partnership NHS Trust

Table 10. Trusts with better than average responses from BME staff on WRES indicator 7 - continued

Surrey and Borders Partnership NHS Foundation Trust
University Hospitals of Leicester NHS Trust
Western Sussex Hospitals NHS Trust

Organisations were not included on the list unless both of these conditions applied:

1. A minimum of 83% of BME staff believing their trust provides equal opportunities for career progression or promotion

2. The trust had 50 or more BME respondents to the staff survey

The challenge for the NHS

There are significant differences in a large majority of trusts between white and BME responses to this indicator. Those responses largely correlate with the data from WRES indicators 1 and 2 which highlight:

- a rapid decline in the proportions of BME staff found in the AfC grades as seniority rises

- a significant difference nationally, and in the majority of NHS trusts, between the likelihood that white and BME staff will be appointed from shortlisting

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)

Data, source and reliability

This indicator is drawn from NHS national staff survey. Aggregated trust responses on staff survey indicators exclude a number of trusts where the BME responses were so small they were not published to comply with the Data Protection Act 2003. Trusts with responses of less than 50 staff should be treated within caution within individual trusts.

Overall results

- The overall percentage of staff reporting that in the last 12 months they have personally experienced discrimination at work from manager / team leader or other colleagues decreased from 11% in 2014 to 10% in 2015.

- For white staff, the percentage of staff reporting that in the last 12 months they have personally experienced discrimination at work from manager / team leader or other colleagues, decreased from 7% in 2014 to 6% in 2015.

- For BME staff, the percentage of staff reporting that in the last 12 months they have personally experienced discrimination at work from manager / team leader or other colleagues, fell slightly from 15% in 2014 to 14% in 2015

- The overall difference between the percentage of white staff and BME staff experiencing harassment, bullying or abuse from staff in last 12 months fell slightly from -8.0 percentage points in 2014 to -7.5 percentage points in 2015.

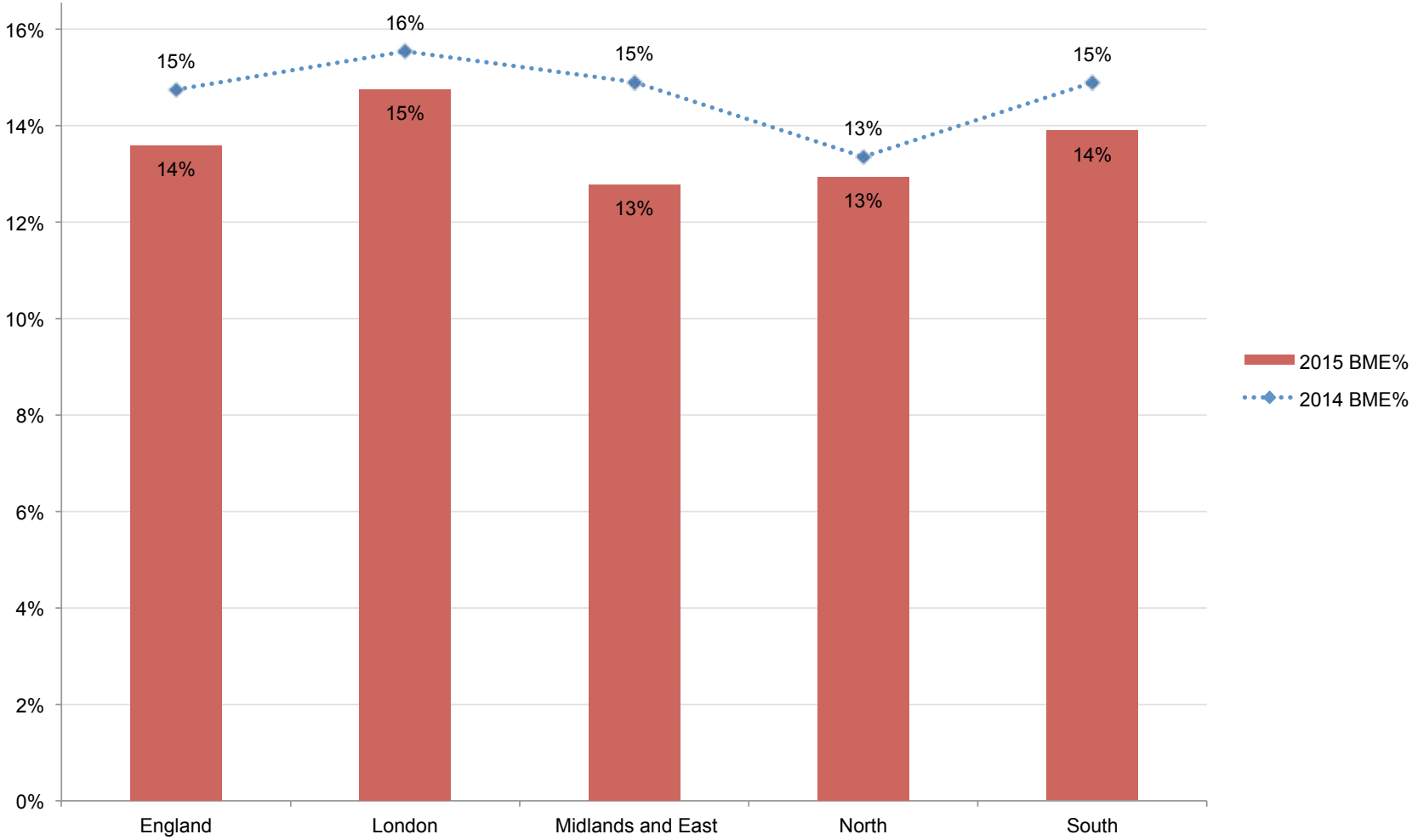
This indicator is a new key finding within the national NHS staff survey, hence historical comparisons cannot be made beyond last year.

By region

Across England, the percentage of BME staff reporting that in the last 12 months they have personally experienced discrimination at work fell from 15% in 2014, to 14% in 2015.

The average results for BME staff experiencing discrimination are lower in 2015 for every region. As Figure 8.1 shows, the Midlands and East region showed the greatest improvement with levels of discrimination for BME staff falling from 15% in 2014 to 13% in 2015. There are very significant differences on this indicator, within each region, between trusts, for the experience of both white and BME staff.

Figure 8.1: Percentage of BME staff experiencing discrimination at work in the last 12 months: by region



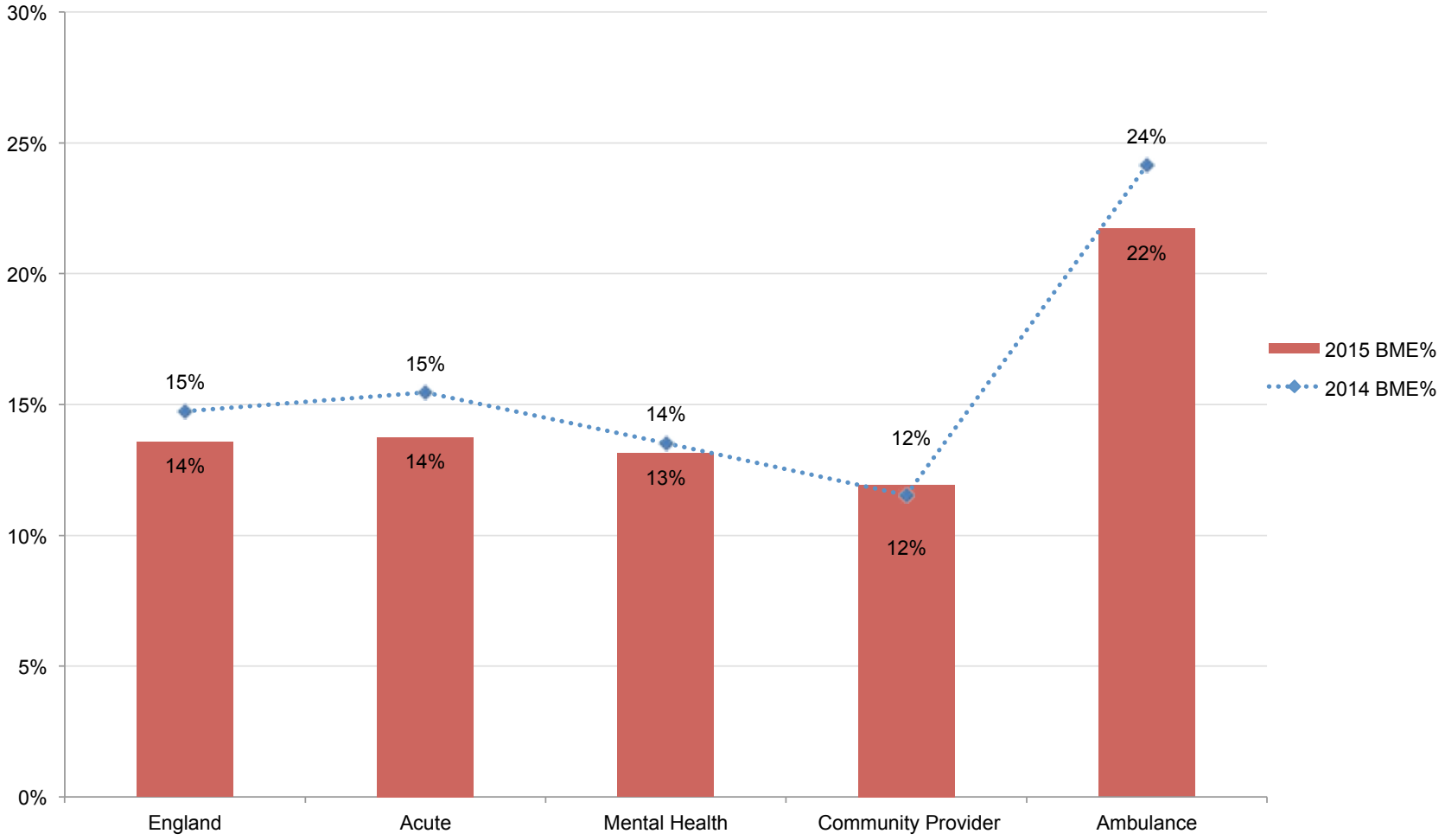
The unweighted average results are based on 144 trusts where the BME sample is at least 50 headcount. In 29 trusts there was a difference of more than 10% between whether BME staff and white staff reported that in the last 12 months they have personally experienced discrimination at work from a manager, a team leader or other colleagues.

In 23 trusts, there was a difference of less than 5% between whether BME staff and white staff reported that in the last 12 months they have personally experienced discrimination at work from a manager, a team leader or other colleagues.

By type of trust

There are differences by type of trust between the proportion of BME and white staff reporting that in the last 12 months they have personally experienced discrimination at work from a manager, a team leader or other colleagues.

Figure 8.2: Percentage of BME staff experiencing discrimination at work in the last 12 months: by trust type



The average results for BME staff experiencing discrimination are lower in 2015 for the acute and mental health sectors. The average for community health trusts increased slightly from 11.5% in 2014, to 11.9% in 2015.

In 2015, only 2 of 10 ambulance trusts collected data for this indicator using a BME sample size of 50 or more. Thus, the ambulance data in Figure 8.2 should be interpreted with caution.

With the above in mind, the acute sector showed the greatest improvement with levels of discrimination for BME staff falling from 15% to 14% in 2015 – a difference of 1.7 percentage points.

All the comparative trust data can be found online.

Trusts where data suggest practice may be better

It is of particular of interest to learn from those organisations which either:

- sustained an above average performance within their type of trust for 2015 and 2016, or
- showed significant improvement to better than average in 2016 of staff reporting that in the last 12 months they have personally experienced discrimination at work from any of the following? - Manager / team leader or other colleagues.

Using these criteria, trusts have been identified where the data suggest they have either been consistently (over two years) better than average or have significantly improved to be above average in the last 12 months, see table 11.

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 that some of the best practice on this indicator is being undertaken by trusts where relatively poor data has spurred the board and others into taking determined action to redress unfair outcomes.

Not being in this table does not necessarily mean good practice is not underway any more than being in this table means there is good practice underway.

Please note that data used to compile the list of trusts below is for the reporting period of this publication i.e. 2015/16. It may be the case that data for these trusts for the following year show fluctuation – the 2017 WRES Data Analysis Report publication will cover any such trends.

Table 11: Trusts where the data suggest practice may be better on WRES indicator 8

Aintree University Hospital NHS Foundation Trust
Airedale NHS Foundation Trust
Bedford Hospital NHS Trust
Countess of Chester Hospital NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Luton and Dunstable Hospital NHS Foundation Trust
Manchester Mental Health and Social Care Trust
Mersey Care NHS Trust
Papworth Hospital NHS Foundation Trust
Sheffield Children's NHS Foundation Trust
South Essex Partnership University NHS Foundation Trust

Table 11: Trusts where the data suggest practice may be better on WRES indicator 8 - continued

Southern Health NHS Foundation Trust
Staffordshire And Stoke On Trent Partnership NHS Trust
Sussex Partnership NHS Foundation Trust
The Rotherham NHS Foundation Trust
The Royal Wolverhampton Hospitals NHS Trust
University Hospitals Coventry And Warwickshire NHS Trust
Yeovil District Hospital NHS Foundation Trust

Organisations were included on the list if:

1. the trust had 50 or more BME respondents to the staff survey

2. less than 10% BME staff reported discrimination from colleagues in last 12 months in both 20915 and 2016 and includes trusts where the proportion of BME staff reporting such discrimination in 2014 was above 10% if significant improvement to below 10% took place in 2015.

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

Data source and reliability

Trusts were not asked for data so that executive and non-executive board members could be distinguished. However this level of analysis will be carried out from 2017, as there is a concern that much of the increase in BME board membership may be amongst non-executive members not executive members.

Overall results

Nine trusts were unable to provide data on their board membership. One trust provided data in which there was a low level of confidence in it accuracy. 34 trusts appear to have misunderstood the definition within indicator 9 and provided details of non-executive directors only despite the fact that the definition explicitly asks for "all voting members of the board irrespective of whether they are executive or non - executive members".

The data for these trusts was not included in the analyses because including non-executive directors only is likely to give a higher percentage of board members as being from BME backgrounds. Furthermore, data on board members who chose to not disclose their ethnicity was not collected in 2016/17 and this may also skew the figures slightly.

Data based upon the WRES returns for 193 NHS trusts, it was found that nationally:

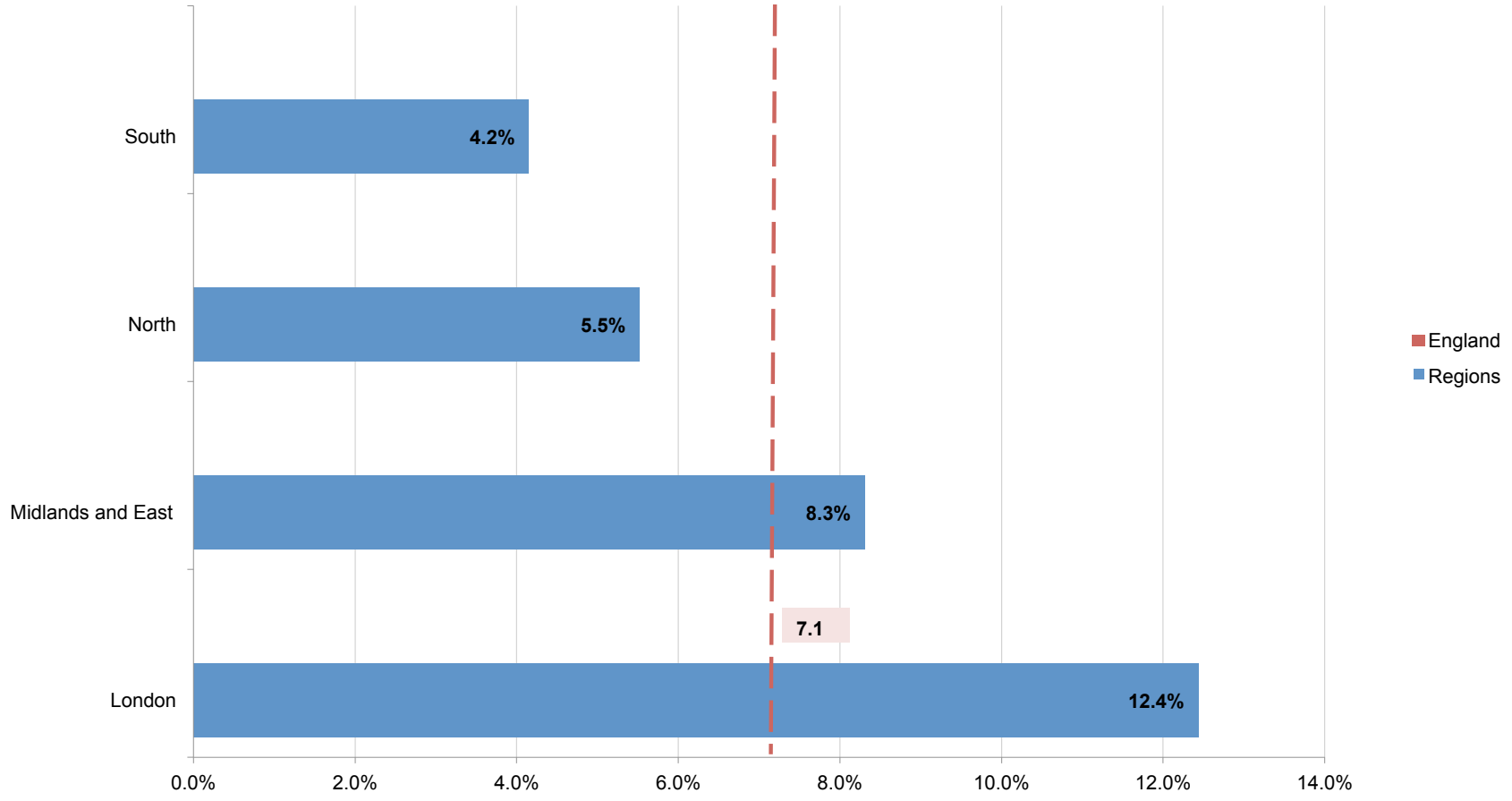
- 43.5% (84) of trusts reported having no BME board members
- 37.3% (72) of trusts reported having one BME board member
- 10.9% (21) of trusts reported having two BME board members
- 4.7% (9) of trusts reported having three BME board members
- 2.6% (5) of trusts reported having four BME board members
- 1.0% (2) of trusts reported having five BME board members

Nearly a fifth of the NHS workforce is of BME origin. If table 3 is analysed again, it would be noted that nationally, for every 11.6 white staff on a VSM grade, there is just one BME member of staff on the same grade. In many organisations there are none at all. This inevitably has implications for organisational succession planning and upon the likelihood of executive board members being from BME backgrounds.

By region

There are significant differences between, and within, regions. The London region and the Midlands and East region have the highest proportion BME staff and of BME populations.

Figure 9.1: Percentage BME board representation by region: 2016



The current proportion of BME board members is neither reflective of the workforce nor of the population served in England as a whole. 81.5% of the England NHS workforce employed in trusts are white and 18.5% are from BME backgrounds (September 2016, NHS Digital). In London the proportion of the NHS trust workforce from BME backgrounds is 44%. In London the 2011 census identified 40.5% of the population as from BME backgrounds. The proportion of the population from BME backgrounds may well have risen since the 2011 census. Whilst there has been an increase in BME representation on London boards, there are still nine trusts in London with no BME board members.

By trust type

There are significant differences by type of trust as Figure 9.2 shows. Mental health trusts are by far the best performers with BME board representation at 9.2% which is above the average for England (7.1%).

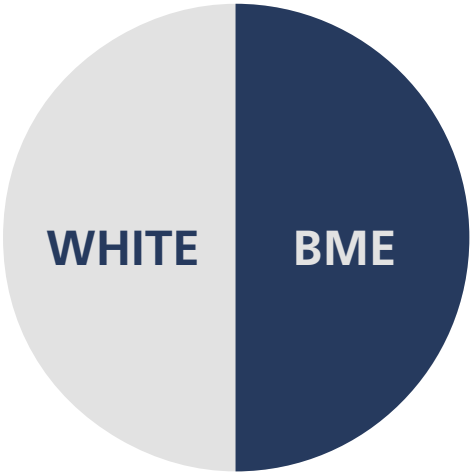
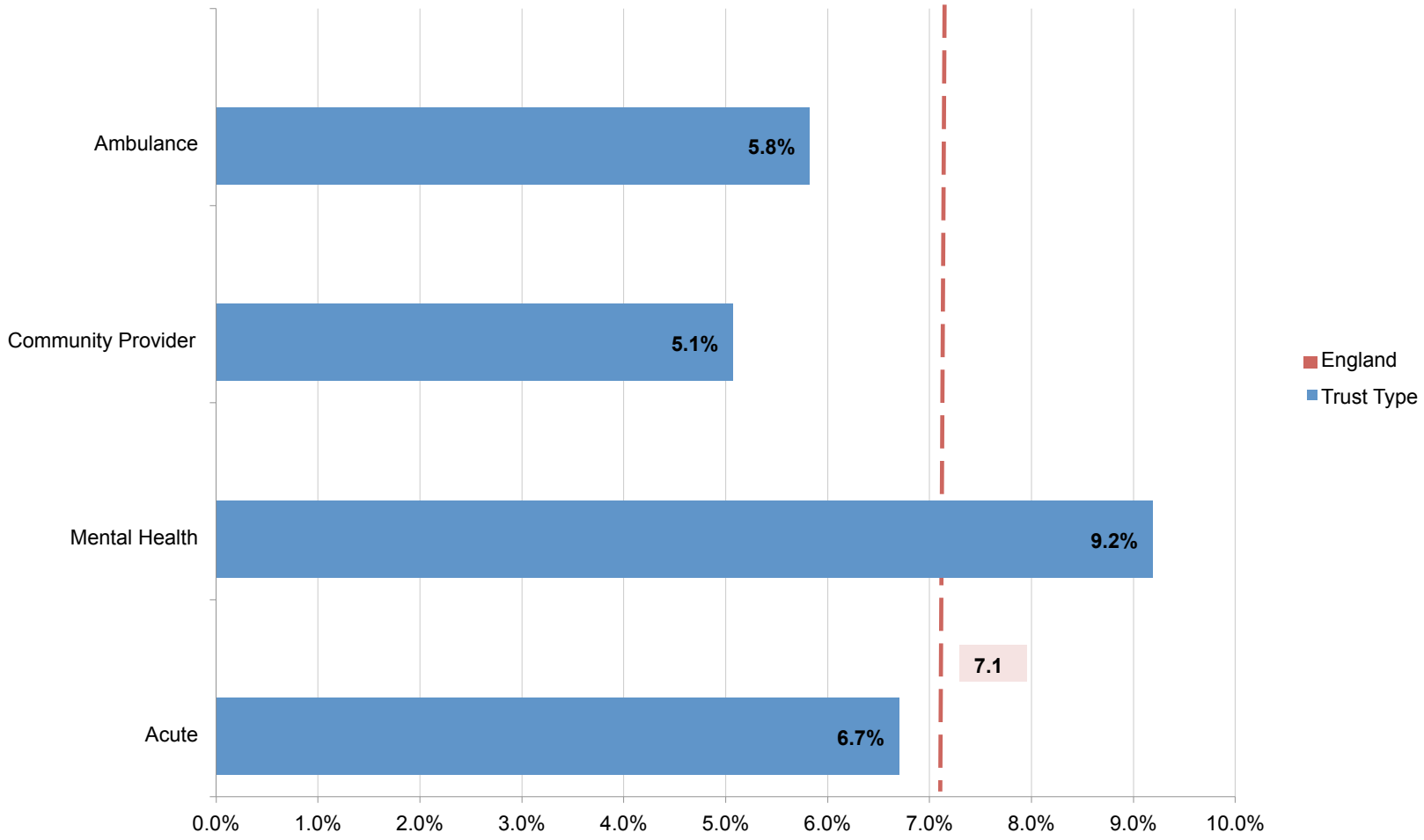


Figure 9.2: Percentage BME board representation by trust type: 2016



Comparison with 2015

Due to data quality issues, it is not possible to make a direct comparison with the 2015 WRES data. However, data from NHS Digital have been used to compare historical changes from 2010 to 2016. Whilst this data source is not comparable with WRES data, it can be used to give an indication of trends over a time period.

With the above caveat in mind, from 2010 to 2016, the numbers of VSM staff from a BME background have increased by 26.2% - this equates to an additional 44 headcount. The increase in the proportion of VSMs from BME backgrounds from 2014 was 13.7%. In comparison, the overall increase in VSM staff (regardless of ethnicity) in the same period was 0.9%, an additional 28 headcount. The numbers remain disproportionately small but there is some limited sign of progress.

From 2015 to 2016, the numbers of VSM staff from a BME background have increased by 4.4% - this equates to an additional 9 headcount. In comparison, VSM staff (regardless of ethnicity) reduced by 0.7%, a reduction of 22 headcount. See figures 9.3 and 9.4.

Figure 9.3: BME very senior managers (VSM) as a proportion of all VSM: 2010-2016

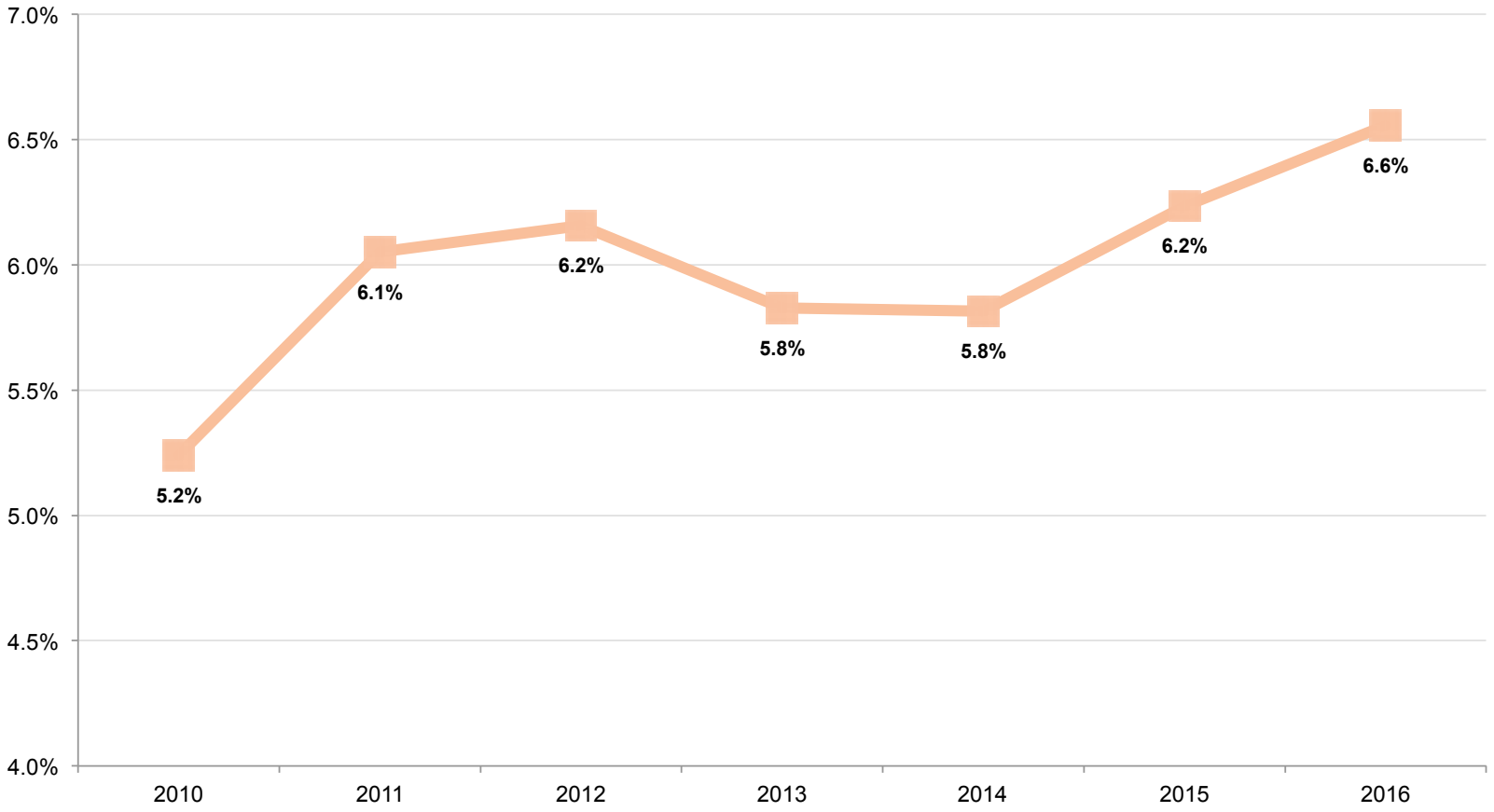
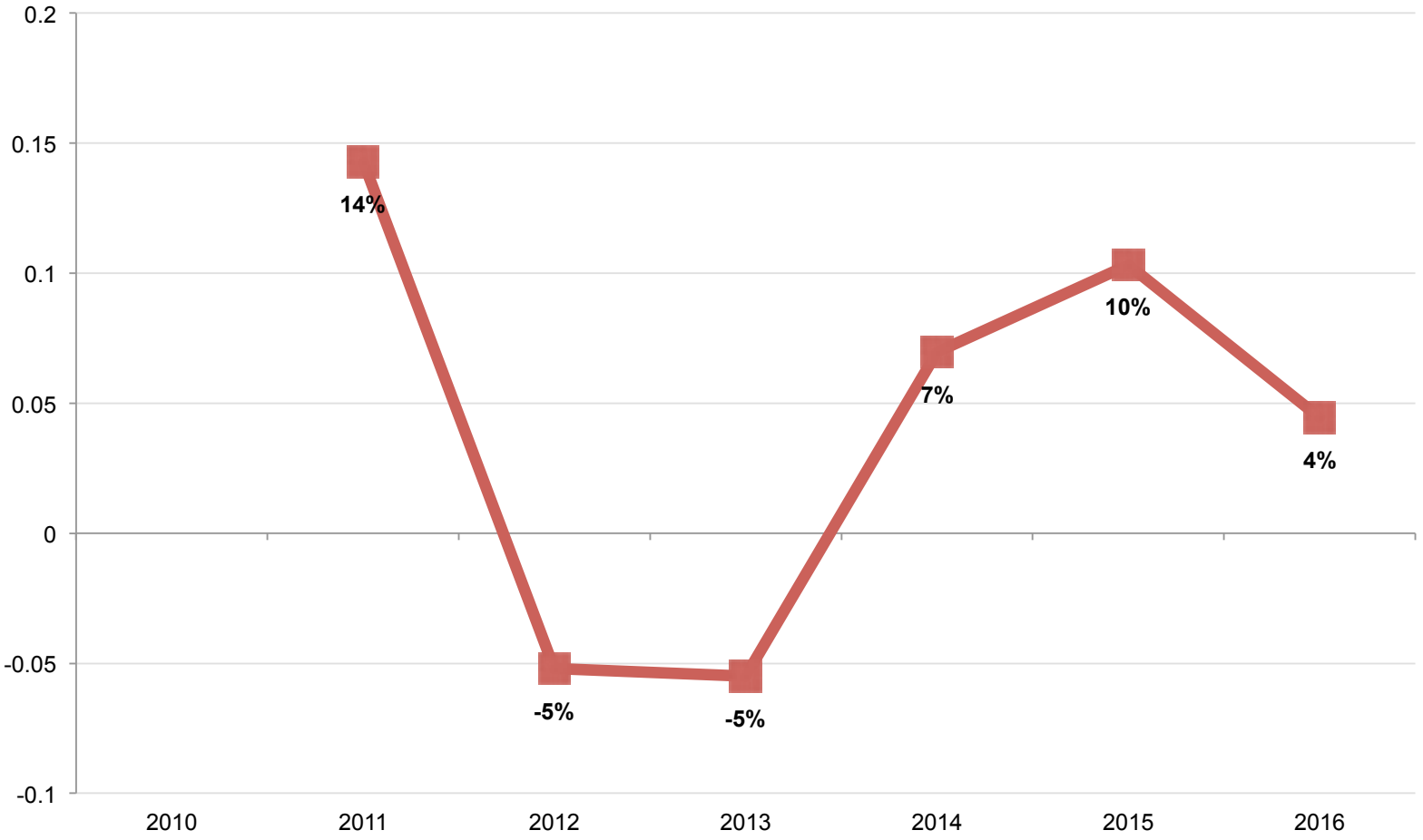


Figure 9.4: BME very senior managers (VSM) percentage headcount change: 2010-2016



All the comparative trust data can be found online.

Trusts where data suggest practice may be better

It is of particular interest to learn from those organisations which either:

- Sustained an above average (of all trusts i.e. two) proportion of their board being from BME backgrounds for 2015 and 2016; or
- showed significant improvement in the proportion of BME executive members who are from BME backgrounds.

Table 12 lists trusts that reported two or more BME board members in March 2016.

Caution should be exercised in drawing conclusions about the implications of being in the table.

Some trusts in this table will have high proportions of BME staff and local BME populations so that even with two BME members of the board, they may not be representative of either their workforce or local population. On the other hand there may be some trusts with one BME board member who may be representative of their local workforce and population.

Please note that data used to compile the list of trusts below is for the reporting period of this publication i.e. 2015/16. It may be the case that data for these trusts for the following year show fluctuation – the 2017 WRES Data Analysis Report publication will cover any such trends.

Table 12. Trusts with more than two board members of BME origin

Ashford and St Peter's Hospitals NHS Foundation Trust
Barking, Havering And Redbridge University Hospitals NHS Trust
Barts Health NHS Trust
Birmingham Community Healthcare NHS Trust
Black Country Partnership NHS Foundation Trust
Bradford District Care Trust
Bradford Teaching Hospitals NHS Foundation Trust
Brighton And Sussex University Hospitals NHS Trust
Buckinghamshire Healthcare NHS Trust
Central and North West London NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
Coventry And Warwickshire Partnership NHS Trust
Dorset Healthcare University NHS Foundation Trust

Table 12. Trusts with more than two board members of BME origin - continued

Dudley And Walsall Mental Health Partnership NHS Trust
East Kent Hospitals University NHS Foundation Trust
East London NHS Foundation Trust
Epsom And St Helier University Hospitals NHS Trust
George Eliot Hospital NHS Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Hertfordshire Partnership NHS Foundation Trust
Hounslow And Richmond Community Healthcare NHS Trust
Mid Essex Hospital Services NHS Trust
Moorfields Eye Hospital NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust
Oxleas NHS Foundation Trust

Table 12. Trusts with more than two board members of BME origin - continued

Rotherham, Doncaster and South Humber NHS Foundation Trust
Sandwell And West Birmingham Hospitals NHS Trust
South Essex Partnership University NHS Foundation Trust
Southend University Hospital NHS Foundation Trust
St Helens and Knowsley Hospitals NHS Trust
The Hillingdon Hospitals NHS Foundation Trust
The Royal Wolverhampton Hospitals NHS Trust
The Whittington Hospital NHS Trust
University Hospitals Of Leicester NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
West London Mental Health NHS Trust

07 WHAT WORKS: EFFECTIVE INTERVENTIONS BY WRES INDICATOR THEMES

7.1. Recruitment, promotion, career progression and staff development (WRES indicators 1, 2, 4 and 7)

Data source and reliability

This section considers the four WRES indicators that impact upon recruitment, promotion, career progression and staff development. The results for WRES indicators 1, 2, 4 and 7 should be read alongside each other. Triangulating the data for these indicators helps to provide a better understanding of the relative treatment of white and BME staff in the workplace.

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

In recruitment and promotion, bias impacts on every stage of the process from how the job description and person specification are written, through how jobs are advertised, how acting up opportunities are filled, how tests and interviews are designed and conducted, and how selection is undertaken. The CIPD Guide called: "A Head for Hiring"[13] summarises some of the research in this field – above all the tendency to "appoint people like us".

13. CIPD, 'A Head for Hiring: The behavioural science of recruitment and selection', 2015

We know from research that there are a number of ways in which accountability can be reinforced. When individuals know they will need to justify their decisions on appointments to a more senior manager, they are likely to undertake more complex thought processes before doing so, and doing so may undermine bias when making decisions.[14] [15] When members of appointment panels know they will have to justify their decisions to a higher authority, they tend to engage in more complex decision-making processes.[16] Holding individuals accountable for their personnel decisions is one way to reduce bias in recruiting and promotion.[17]

The research is clear in that unconscious bias training may help prompt discussion of difficult issues, but it is holding decision-makers to account that is the best means of preventing bias in decision-making. The WRES Implementation Team's forthcoming briefing on unconscious bias training summarises the research in this area.

Good practice will be built on the following principles, which a growing number of trusts are adopting:

- A clear business case explaining why more diverse appointments (including in senior positions) are important.
- An expectation that the likelihood of BME and white staff (and men and women) being appointed from shortlisting is, on average, over time, the same.
- Levelling the pre-interview playing field by ensuring (as per 70/20/10 model – see below) that access to staff development and support is fairly shared - especially acting up, secondments, shadowing, and taking part in projects.
- Monitoring and challenge linked to aspirational targets to which the board holds itself and its managers accountable.

How these principles are applied will vary. Specific case studies are discussed in the WRES Implementation Team's forthcoming publications on good practice on appointments and on staff development.

Analyses of data from a number of trusts show that some boards have:

- Identified specific areas where there is clearly a failure to recruit BME staff – often at more senior grades.
- Set their own goals for recruitment, with clear milestones.

14. Devine, P. et al (2002) 'The regulation of implicit and explicit race bias: The role of motivations to respond without prejudice'. Journal of Personality and Social Psychology 82: 835-848
15. McCracken, D. (2000) 'Winning the talent war for women: Sometimes it takes a revolution'. Harvard Business Review, November-December 159-167
16. Foschi, M. (1996) 'Double standards in the evaluation of men and women'. Social Psychology Quarterly, 59 (3), 237-254
17. Valian, V. (1999) 'Why so slow: The advancement of women'. MIT Press

- Expected regular (not annual) reports on progress, analysed by department, service, or occupation, on whether the ethnicity gap relating to WRES.

- Added an independent member to the interview panel (from HR, or a BME member of staff) to encourage accountability. Their role is not dissimilar to the role of a patient representative on some interviews. Research suggests that the positive impact of diversity on group performance (including on an interview panel) has less to do with what these additional panel members say, but rather that their presence affects expectations of others. In the case of an interview panel that is likely to reduce the tendency to rely on stereotypes as cognitive shortcuts.[18]

- Encouraged the notion that interview panels are not told who to appoint but are reminded of the clear expectation that over time the likelihood of BME staff being appointed should be similar to that of white staff.

- Expected to hold the relevant department or profession to account for interview outcomes whilst considering what continuous improvement methods might assist in improving changing patterns of appointment and promotion.

A number of other interventions are being considered across UK employments that draw upon evidence that they are likely to work:

- "Batch recruitment"– recruitment to two or three posts together is likely to increase the likelihood of a better mix of appointees and mitigate the impact of unconscious bias.[19]

- Asking shortlisting panels to be cautious when using "previous experience" as a criteria – in other words to recognise that BME staff will tend to have gained more qualifications to compensate for the likelihood of having had less opportunity to gain experience at a higher level e.g. through acting up.

The "Developing People – Improving Care" national framework for action sets the agenda on leadership development for the NHS.[20]

18. Phillips, K. & Lloyd, D. (2006) 'When surface and deep-level diversity collide: The effect of dissenting group members'. Organizational Behavior and Human Decision Processes, 99, 143-160
19. Policy Exchange, 'Bittersweet Success? Glass ceilings for Britain's ethnic minorities at the top of business and the professions', November 2016
20. 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

This 70:20:10 model of staff development[21] has significant implications for the opportunities for BME staff. Alongside setting goals or targets for appointment, many trusts have sought to level the playing field with more support and encouragement to BME staff in ways that fit that model. These measures, which are forms of positive action, may include:

- Formalising access to "acting up" opportunities to prevent discrimination is a key opportunity for career progression. Prior experience of acting into a post is widely seen as a means of ensuring those individuals have an inbuilt advantage when a substantive post is filled. Trusts may insist on a rota (or pool) of those capable and willing to "act up". Posts should certainly never be filled without a formal advertisement process. Access to "acting up" should be especially encouraged amongst under-represented staff, and should be monitored in the same was as other development opportunities should.
- Opportunities to join projects, pilot initiatives, shadow more senior staff, be seconded for fixed period, or access mentoring all risk discriminatory practices unless access to them is formalised and monitored.
- Creating "half-way house" grades which staff can have access to in order to stretch themselves and demonstrate they are ready to develop their career.
- Using "internal transfer windows" where staff may request to have a one day a week transfer for a set period to another job at the same grade to develop new skills and confidence ready for the next step in their career progression.

Measures to encourage and support BME staff to gain the skills and opportunities they have missed out on for many years can be important. These are not a substitute for the organisational measures to prevent discrimination but can compensate for the large scale exclusion of BME staff from certain crucial opportunities. Examples include:

- Access to mentoring (including reverse mentoring), shadowing, coaching and encouragement to join NHS Leadership Academy and other courses. It is essential such access is monitored to avoid discriminatory practices. Indicator 4 of the WRES should capture that but how well it does so varies considerably at present between trusts. Indeed, some trusts are still not monitoring such opportunities.
- Consider adopting practices of the best private sector organisations which might include removing from shortlisting information the name of the university, class of degree and name of school, all of which significantly influence shortlisting decisions.
- Act upon the advice contained in the National Improvement and Leadership Development Board national framework for action on improvement and leadership development: "Developing People – Improving Care".

21. Lombardo, M. & Eichinger, R. (2006) 'The Career Architect Development Planner'. Lominger Ltd.

Organisations should avoid a reliance on sending staff away on courses as the sole or primary means of encouraging more BME staff development. Such courses can be invaluable but there is growing evidence that the key to staff development is whether such courses are complemented by opportunities for "stretch assignments" such as acting up, secondment, involvement in project teams or developing pilots. The 70/20/10 Model for Learning and Development,[22] for example, assumes that:

"Development generally begins with a realization of current or future need and the motivation to do something about it. This might come from feedback, a mistake, watching other people's reactions, failing or not being up to a task – in other words, from experience. The odds are that development will be about 70% from on-the-job experiences - working on tasks and problems; about 20% from feedback and working around good and bad examples of the need; and 10% from courses and reading."

22. Ibid

Employers should beware of a reliance on a "deficit" model for aspirant BME staff which assumes the prime issue is giving support for BME staff. That is certainly part of the problem. However for many of those whose careers have stalled or slowed, more development and confidence is only part of the answer. Crucial is confidence that the organisation is serious about valuing their talent and has taken steps to end unfair practices throughout career progression. Years of perceived, and real, unfair practice will make many staff cautious about going for jobs and then being told "you were very good but on the day someone else was better".

Employers should avoid an excessive reliance on "executive search agencies", especially ones unable to demonstrate a track record on diversity, including on race equality. See our forthcoming advice on this for board level appointments.

There are a range of **positive action measures** (some of them are mentioned above) which help to level the playing field. The Equality Act 2010[23] (sections 158 and 159) provides general and specific duties for authorities and bodies carrying out public functions, and positive action initiatives are permitted when their use can be demonstrated to assist, for example, in improving staff numbers or progression from under-represented groups. Positive action does not mean people will be employed or promoted simply because they share a protected characteristic. Its aim is to encourage and assist people from disproportionately under-represented groups to help them overcome disadvantages associated with the protected characteristic when competing with other applicants, or to enable them to participate in the activity.

Positive action in recruitment or promotion could include encouraging particular groups to apply, or helping people who share particular protected characteristics to perform to the best of their ability (for example, by giving training or support not available to other applicants before the actual official application or recruitment phase). Positive action can help create a level playing field to enable people to compete on equal terms and promote equality of opportunity. We will be publishing a short guide to positive action NHS bodies can take around workforce race equality later this year.

Once staff are appointed or promoted, good trusts make a real effort to be proactive and take responsibility for staff development, not leaving it to individual staff to seek them out. Some trusts have adopted an "on boarding" appraoch, common in parts of the private sector, in which career goals are identified at induction, developed and monitored through Personal Development Reviews (PDR), with the employer charged with ensuring staff do get the encouragement and opportunities for development they need.

Much can also be learned from those private sector organisations with good reputations regarding equality, in particular, focussing upon their evidence-based approaches and interventions. The WRES Implementation Team's forthcoming report on this concludes:

23. Equality Act 2010: https://www.gov.uk/guidance/equality-act-2010-guidance

There were a number of common themes that emerged across the interviews. Although the specifics of individual initiatives to promote equality, diversity and inclusion (D&I) varied between organisations, there was some consensus as to the elements that continue to help ensure their success. Interviewees articulated that: clarity around the case for change; accountability; leadership; and good quality data have been fundamental enablers, from their perspective. They also recognised the importance of clear and consistent communications in supporting their various programmes, and wider D&I strategies.

The literature suggests that success in improving diversity can only be achieved when multi-level strategies are implemented over a sustained period of time.[24] Interviewees strongly supported this view. They reflected that there has been no single initiative or approach that can be credited with improving the diversity of their organisations – rather it has been a case of concerted and sustained effort at various levels, to encourage progress.

The WRES Implementation Team's forthcoming publication on good practice in appointments and career progression will provide further evidence on this issue.

7.2. Disciplinary action (WRES indicator 3)

There is extensive evidence that across employment, BME staff risk being treated less favourably within disciplinary processes than other staff.[25] Yet, the most comprehensive analysis of disciplinary processes within the NHS and the treatment of BME staff, was conducted in a review carried out by the University of Bradford on behalf of NHS Employers, and the Institute for Innovation and Improvement.[26] The report found the following:

24. Priest, N. et al. (2015) 'Promoting Equality for ethnic minority NHS staff – what works?' BMJ, 351: h3297
25. Luksyte, A. et al. (2013) 'Held to a different standard: Racial differences in the impact of lateness on advancement opportunity.' of Occupational and Organisational Psychology, 86 (2), 142-165
26. University of Bradford, 'The Involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings', March 2010

- The informal stage of the disciplinary process was critical in sorting out minor issues and that some managers were hindered in this process by a lack of confidence in applying informal strategies with BME staff.

- Managers were more likely to discipline BME staff over insignificant matters.

- Performance issues were not addressed in a timely fashion, often with a lack of effective feedback, performance appraisal, support and monitoring of progress with regard to BME staff.

- There was a sense that line managers were incorrectly using a disciplinary policy to address performance issues.

- The report stated that: Strategies that have been put in place to address this issue (of bias) include the introduction of reverse mentoring, access to mediation, clearer performance appraisal systems, simplification of the disciplinary policy and improved training around equality and diversity issues and they recommended the establishment of personalised induction programmes in the first six months of employment.[27]

Crucially, the authors highlighted the disproportionately unnecessary or inappropriate entry into the disciplinary processes as a key factor, often arising from the difficulty some managers had in conducting with BME staff the informal conversations about conduct or practice they would expect to have with white staff. Some individual trusts, in response to the publications of the WRES data on disciplinary action, have carried out similar, local, root cause analyses of their own disciplinary cases. Having analysed their data those trusts were able to identify specific hot spots (department, shift, profession), discuss the issue with staff and managers, and develop approaches which specifically tackle that issue. NHS trusts have done this primarily by introducing forms of accountability which require local managers to demonstrate that commencing a disciplinary investigation was the appropriate step to take (for all cases not just those of BME staff).

27. Ibid

The methods vary:

- HR staff may be required to check whether on the basis of the case file an investigation should commence at all – or whether the concern should be dealt with informally or be subjected to a learning/improvement approach.

- Managers considering commencing a disciplinary investigation may have to justify to their head of profession why the proposed investigation is necessary and appropriate.

- Some trusts have developed a checklist which draws on some of the principles of the Incident Decision Tree[28] to determine whether managers should proceed with an investigation – an approach which is likely to produce less focus on blame and arguably less likelihood of bias.

- In one organisation there is a joint staff/HR team whose authorisation is needed prior to an investigation starting.

- In addition to these steps some organisations also require HR sign off on any disciplinary action involving serious misconduct.

Other initiatives have focussed on the disciplinary process itself but the evidence underpinning this is less clear. One area identified by the research is the role of effective induction and support for new staff, particularly staff whose previous clinical practice was overseas. If a pattern of less favourable entry into, or outcomes from, the disciplinary process becomes apparent, managers should expect to be asked to reflect on why, and, where appropriate be held to account for bias (unintended or otherwise). Once a disciplinary investigation commences, it is very distressing for the member of staff concerned even if they are cleared of any allegation; very time consuming for managers; can be demoralising for colleagues if they think the processes are unfair; and can run the risk of reinforcing blame, not a learning culture.

Clearly, there will be some occasions when disciplinary action is necessary and appropriate but the different volumes of disciplinary action between similar trusts are striking. Those trusts with low levels of disciplinary action against all staff, and similar levels of disciplinary action against white and BME may well be more likely to have a learning culture than a blame one.

28. The National Patient Safety Agency, 'Incident Decision Tree', February 2004

7.3. Bullying and discrimination (WRES indicators 5, 6 and 8)

There is universal recognition that the levels of bullying of NHS staff, by colleagues and managers, is far too high since there are adverse consequences for staff, for organisational effectiveness, and upon patient care and safety.

For staff, bullying impacts adversely on both physical and mental health, is a cause of turnover and absenteeism and lowers morale. For organisations there is a cost in absenteeism, turnover and a heightened risk due to the impact on patient care and safety. Researchers have found:

- A strong negative correlation between whether, in the NHS staff survey, staff reported harassment, bullying or abuse from other staff and whether patients reported being treated with dignity and respect.

- Higher levels of bullying of staff lead to poorer patient care, more clinical errors, adverse events and compromised safety.[29]

Levels of reported bullying by staff and managers in the NHS staff survey have consistently been, on average, higher for BME staff. Interestingly the levels of reported bullying for BME staff by patients, relatives and the public have consistently been similar. The *Freedom to Speak up Review*[30] noted the impact of the disproportionate bullying of BME staff that had raised concerns.

The literature on what strategies work in tackling workplace bullying emphasises "organisational climate". Evesson et al found that bullying is most common in organisations with poor workplace climates.[31] It is best prevented by strategies that focus proactively and preventatively on ensuring worker wellbeing and fostering good relations, giving employees and managers the confidence to engage in early and informal resolution. Evesson and colleagues were critical of an over-reliance, in isolation, on policies, procedures and training and concluded that:

29. Dixon-Woods, M. et al. (2014) 'Culture and behaviour in the English National Health Service: overview of lessons from a large multi-method study'. BMJ Quality Safety, 23: 106-115
30. 'Sir Robert Francis' Freedom to Speak Up Review', February 2015
31. ACAS and Employment Research Australia, 'Seeking better solutions: tackling bullying and ill-treatment in Britain's workplaces', November 2015

In sum, while policies and training are doubtless essential components of effective strategies for addressing bullying in the workplace, there are significant obstacles to resolution at every stage of the process that such policies typically provide. It is perhaps not surprising, then, that research has generated no evidence that, in isolation, this approach can work to reduce the overall incidence of bullying in Britain's workplaces.

Trusts that have sought to address bullying with some success are those that have agreed at board level that:

- The levels of bullying are such that they constitute a significant risk and must be tackled.
- Bullying of staff is linked to the wider narrative regarding the impact on organisational effectiveness.
- There are links between the bullying of staff, and the care and safety of all patients.
- Sustained and meaningful staff engagement is important.
- Board members should model the behaviours they expect of others and hold themselves to account.
- There should not be reliance upon individual members of staff raising concerns, but instead, there should be an endeavour to improve the organisational climate.

That approach is reflected in the most recent NHS Social Partnership "call to action" on bullying.[32]

In addition, the better trusts have then linked staff and manager training (starting at board level) to an approach that seeks to be proactive analysing staff survey data alongside other data (such as turnover, exit interviews and informal intelligence) to identify areas of good and bad practice. They have found that "early intervention" is crucial to act quickly. It should be noted that such interventions have found BME staff may be particularly cautious about raising concerns openly because of the fear of consequences.

32. http://www.socialpartnershipforum.org/priority-areas/tackling-bullying-in-the-nhs-a-collective-call-to-action/

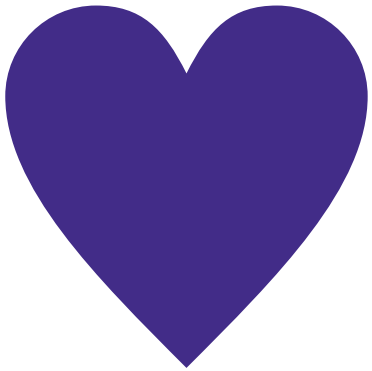
7.4. Board culture and representation (WRES indicator 9)

The most effective boards are both diverse in their demographics and inclusive in their behaviours. Diversity improves boards not only around issues of equality, but in reaching decisions and in their governance around the entire range of decisions that boards have to make. To be effective, demographic change on boards needs to be accompanied by boards becoming more inclusive in their cultures, behaviours and values.

Initiatives around race equality will not succeed unless leaders throughout the organisation, starting with the board but extending to all managers:

Create and disseminate a narrative explaining why diversity is important for healthcare delivery in each trust.

- Respond directly to criticism or avoidance, giving a safe space for discussion whilst emphasising the importance of the issue.
- Model the behaviours and actions they expect of others.
- Ensure accountability through transparency and appropriate metrics, to hold their managers and themselves to account.



Increasingly, good boards strive towards the following:

- Ensure that data are openly shared and honestly analysed with an expectation that an action plan is approved at board level with ongoing scrutiny of specific targets, goals and actions.
- Discuss with trust-wide or departmental meetings of managers within specific occupations or services what their data shows and how to the challenges it raises.
- Ensure the voice of BME staff is heard at the most senior levels by inviting BME network members to address boards and trust leadership fora, and hear within other safe environments the lived experience of BME staff.
- Demonstrate their commitment to race equality through their own mentoring and through support for staff networks.
- Discuss the WRES and action plan at the local Social Partnership Forum.
- Ensure that at conferences, seminars, awards ceremonies, and trust communications, BME staff are not "airbrushed" out of existence.

There are a small but growing number of NHS trusts, for example East London NHS Foundation Trust,[33] that are using a combination of such measures across all or some metrics to drive improvement. In some cases, trusts are trying to adapt quality improvement cycles to improving race equality alongside using such an approach more widely.

The WRES Implementation Team will be publishing two reports in spring 2017, which will focus on: improving board demographics, and on board inclusion. Both reports will draw upon replicable good practices across the NHS, and upon current research evidence in this field.

33. https://improvement.nhs.uk/resources/east-london-nhs-foundation-trust-one-trusts-experience-culture-programme/

08 WHAT WORKS: CHARACTERISTICS OF EFFECTIVE INTERVENTIONS

This section summarises key themes from research literature and from field work in the private sector, the public sector and within the NHS. Identifying, validating, understanding and disseminating evidence-based replicable good practice related to the WRES indicators will become a key priority going forward.

8.1. The ideal approach to the agenda

Typically, when NHS organisations identify factors that impact adversely on patient care and safety, or on organisational effectiveness, we know what to do:

- Acknowledge the problem.
- Collect and analyse relevant data and then "drill" down to understand where there may be particular challenges; compare organisational data with equivalent national data (or sometimes international data).
- Find the relevant literature to understand the appropriate research on the issue.
- Listen to patients, relatives and staff, to learn from their insights and experience.
- Find good effective practice on a particular risk, either within the organisation or elsewhere in the NHS. Communicate with colleagues directly involved making sure we understand not just what they are doing, but why they believe it works, and not just tackling the factor in isolation but understanding the context.
- Take action to adapt or adopt the appropriate intervention, and then monitor and learn, quite possibly using continuous improvement methods.
- Ensure transparency and accountability against measurable outcomes.

The above has not happened systematically with regards to NHS staff from BME backgrounds, despite the fact that we now have ample evidence of the adverse impact of workplace inequalities on staff, on organisations, and upon patient care and safety.

8.2. Learning from what has not worked

Denial and avoidance

On workforce race equality, as on some other issues, the NHS has had a tendency to avoid, deny or gloss over matters that might cause embarrassment, censure or just seem too difficult. In launching the 2013 public inquiry report on Mid Staffordshire NHS Foundation Trust, Sir Robert Francis QC argued:

"There lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism." And that there exists across the NHS, "an institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern."[34]

34. House of Commons, 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry', February 2013

Although workforce and national NHS staff survey data showing disproportionately poor treatment and experience of BME staff have been known to NHS organisations for years, most NHS boards did not receive reports explaining what their own trust data meant. When individual BME staff have raised concerns they have often met a defensive response rather than one of listening and inquiry.

Difficult discussions

As with many other institutions, the NHS has struggled to grapple with workforce race equality and the difficult conversations it may involve. Moreover, BME staff may be reluctant to share concerns about their treatment, because they have learnt over the years that it may be unsafe to raise concerns about racism as they may trigger a defensive, or even hostile, response.

Even when staff have raised concerns and succeeded in internal grievances or even employment tribunals, they have often met a refusal to accept a decision or a failure to go beyond the individual case and consider whether there is a wider organisational challenge. BME staff are often aware of the low likelihood of successfully challenging unfair interview panel outcomes, for example, and know that even if they were successful that they would risk being "non-appointable" in future. BME staff believe they risk being accused of "playing the race card" or being seen as troublemakers, which may deter staff from openly raising their concerns, whilst others feel compelled to leave the organisation.

NHS organisations have often been reluctant to explore these issues or their own bias. For white managers and leaders there is often a reluctance or nervousness about discussing issues of race. This may be due to a lack of understanding of the real experience of BME staff, or a lack of knowledge and confidence about how to have frank discussions with BME staff about practice or conduct. There are directly practical implications of the reluctance to have difficult discussions. For example, the single most important reason that disproportionate numbers of BME staff enter the formal disciplinary process is because some managers are reluctant to have the same informal discussions about apparent "poor" behaviour, conduct or practice that they would normally have with white colleagues.

This may be a particular issue for middle managers within organisations who feel under workload pressure and who may not have been involved in discussions at board or senior manager level about why treating BME staff fairly is so important for organisational effectiveness and the care and safety of patients.

These parallel discourses can be difficult to bridge. But it is essential that leaders and managers listen to BME staff and find effective ways of doing so. When senior white leaders have sat down with BME staff and listened to their experience at work, they have often been shocked at how upset and angry staff may be, and are often then determined to address the issue.

Flawed approaches to tackling race inequality

Many organisations, not just the NHS, have adopted approaches to tackling the poor treatment of BME staff which were simply not evidenced. Two approaches in particular have been dominant:

Excessive reliance on training

The NHS has invested heavily in a range of equality training. Most staff undergo some form of online training around induction. Members of interview panels and disciplinary panels are likely to be expected to undergo further training. More recently, training in "unconscious bias" has become popular and in some organisations, has been heavily invested in.

Evidence for the direct impact of conventional diversity training on attitudes and behaviours is limited. Any positive impact is primarily on those who are already striving to be egalitarian.[35] It is doubtful that any type of training programme would be able to overcome bias among those who are not motivated to be fair or who are explicitly opposed to hiring women and minorities.[36]

A comprehensive analysis of the impact of the corporate diversity policies of 708 US private sector organisations over three decades from 1971 to 2002, found that:

"attempts to reduce managerial bias through diversity training and diversity evaluations were the least effective methods of increasing the proportion of women in management… programmes which targeted managerial stereotyping through education and feedback (i.e., diversity training and diversity evaluations) were not followed by increases in diversity."[37]

35. King, E. et al. (2009) 'The divide between diversity training and diversity education: integrating best practices'. Journal of Management Education, 34 (6), 891-906
36. Correll, S. & Benard, S. (2006). 'Gender and Racial Bias in Hiring', Memorandum report for University of Pennsylvania
37. Dobbin, F. & Kalev, A. (2016) 'Why Diversity Programs Fail', Harvard Business Review, July-August 2016

Kalev and Dobbin suggest that whether bias training has an impact may also be affected by whether or not it is mandatory or voluntary. They found that mandatory diversity training was associated with a 6 to 9 per cent fall in the share of ethnic minority managers in a company over 5 years whilst voluntary training was associated with a 9 to 13 per cent increase. They conclude that what matters is whether white people are buying into the process.

When those involved in selecting, developing, promoting or retaining staff act on their unconscious biases, they take a "cognitive shortcut". Instead of drawing on the information made available to them, they fall back on stereotypes without realising so, even when these may be contrary to their own beliefs. We now know that certain types of organisational intervention can minimise the impact of such biases when judging applicants. Crucially, holding to account those responsible for making decisions has significant benefits, especially when such interventions are undertaken in a matrix of evidenced actions.

A reliance on individual members of staff raising concerns rather than the employer being proactive

Most NHS organisations have, until recently, primarily sought to tackle discrimination, bullying and harassment by:

- Having good practices and procedures in place.
- Training managers to implement them fairly.
- Encouraging (or relying) on individual staff members to use them to raise concerns.

However, research shows that whilst good policies, procedures and training are essential, individuals may well be reluctant to raise concerns formally using such procedures because the consequences may be worse than doing nothing. That is the single most important explanation as to why an organisation may have few if any complaints of bullying, harassment, or discrimination.

By contrast, when staff are able to raise concerns anonymously (as in the national staff survey) significant levels of those concerns may be raised. The conclusions of a recent authoritative review of the international evidence on how best to tackle bullying, for example, concluded that whilst policies and training are essential components of effective strategies there is no evidence they can work in isolation.[38]

There is now a widespread acceptance across the NHS that organisations need to be more proactive and preventative in tackling workforce race equality, so that employers intervene and take prime responsibility rather than relying on the courage of individual staff members to raise concerns.

38. ACAS and Employment Research Australia, 'Seeking better solutions: tackling bullying and ill-treatment in Britain's workplaces', November 2015

An excessive focus on legal compliance, policy and process – often delegated to junior staff

The Equality Act 2010 requires public services to identify where inequality exists, address it in a systematic and coherent way and act on their positive duty to promote equality. Ensuring that NHS organisations understand the legal framework, especially their public sector Equality Duty, is essential. It can be a way of holding organisations to account. Unfortunately, many NHS organisations have consistently failed to meet those statutory duties.[39]

Too many organisations have regarded equality duties as more of a matter of legal compliance rather than being a driver for staff rights and well-being, organisational effectiveness and improved patient care and safety. In the past too many organisations have regarded equality impact assessments as a tick box rather than being a trigger for board level scrutiny, reflection and remedial action focussed on prevention. However, that approach appears to be changing, as NHS Providers note:

Our key message is that real and sustained change will only be made by determined board leadership and commitment. It requires a shift beyond an over-reliance on diversity managers and HR directors to drive change. In short, it means the whole board leading by example and championing race equality not to comply with a newly imposed standard, but as a strategic opportunity to demonstrate their commitment to diversity and to leverage its potential to improve patient care. [40]

39. Equality and Human Rights Commission, 'Publishing equality information: commitment, engagement and transparency', February 2013
40. NHS Providers, 'Leading by Example: The Race Equality Opportunity for NHS Boards', December 2014

8.3. So what does work?

There is a consensus within the literature that organisations require a range of measures and characteristics that reinforce each other. Organisations which achieve that can expect some relatively quick successes, but will still require sustained effort over a number of years to maintain continuous progress.[41]

There are five key building blocks of shared characteristics related to effective workforce race equality interventions, all of which are inter-related.

41. Priest, N. et al. (2015) 'Promoting Equality for Ethnic Minority NHS staff – What Works?' BMJ, 351: h3297

Shared characteristics of effective interventions on workforce race equality

Metrics

Without appropriate data, carefully analysed, it is impossible for organisations to understand what challenges on race equality they face and where those challenges are most severe (and where progress may be taking place). Without appropriate reliable metrics and data, it will not be possible to determine if any progress is being made.

The WRES indicators are designed to enable and oblige organisations to focus on the relative treatment and experience of white and BME staff. Some organisations use additional metrics, such as turnover analysed by department or occupation, to help understand concerns.

Data need to be critically understood if it is to have meaning. For example, prior to the WRES, almost no trust carried out simple calculations like the one below and reported the implications to their board. Table 13 presents some example data. Although the transition from shortlisting to appointment might like quite small for white staff (from 80% to 90%), the relative likelihood of white staff being appointed from shortlisting (112.5/50.0 = 225%) which is actually more than twice that of BME staff who have been shortlisted.

Table 13. Likelihood of white and BME staff being appointed from shortlisting

	% shortlisted	% appointed	Likelihood of being appointed
White staff	80%	90%	112.5%
BME staff	20%	10%	-50%

Data do not explain why there is a problem, but can certainly highlight that a problem exists, and needs attention. In the case of the above data, alarm bells should start ringing.

Workforce data can be analysed by occupation or service or department. Data can be compared year on year. The Electronic Staff Records (ESR) data that underpin WRES indicators 1, 2 and 3, is now available to trusts on an ongoing basis. Staff survey data can be analysed by occupation, service or department and compared year on year. Trusts have been required to stop using small sample surveys from 2016 onwards, so bigger samples should make "drilling down" more reliable.

Sometimes workforce data and staff survey data will say different things. For example, there are trusts where there are almost no formal complaints about bullying but where the staff survey data (indicator 6) says it is a big problem. Trusts increasingly analyse such data to identify good and bad practice within their organisation, as well as to look for examples of good practice outside of their organisation.

Similarly, trusts are increasingly comparing workforce on appointments and support for staff development (WRES indicators 1, 2 and 4) with WRES indicator 7, which reports whether there are significant differences between white and BME staff views on whether there are equal opportunities for career progression and promotion.

The role of BME staff and social partners is crucial in understanding what the data mean and suggesting what sorts of issues need to be addressed. BME staff will be able to highlight, for example, if they believe that the way "acting up" or access to shadowing, mentoring, and access to development courses is allocated, are a key cause for concern.

Some trusts also carefully monitor turnover against the WRES metrics. Data suggesting higher levels of turnover for BME staff in a particular department, occupation or service may well be linked to staff experience reflected in other WRES indicators.

We know that what gets measured tends to get done. That is why there was an initial focus within WRES on collecting, analysing, understanding and acting to change a small number of metrics, the collection of which involves almost no work for individual employers. There is no reason why this approach cannot be extended to look in detail at other specific issues. Some trusts for example, are applying a similar approach to the treatment of EU staff within the NHS.

A convincing narrative or business case, effectively communicated

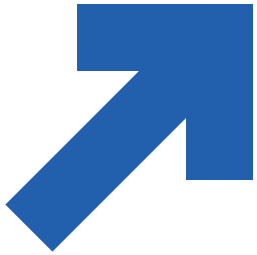
The 2004 NHS Race Equality Action Plan primarily focussed on the damage that discrimination did to the health and wellbeing of BME staff, the waste of BME talent, and the moral unfairness of discriminatory treatment. Those principles are crucial. The WRES not only highlights the damage to the physical and mental wellbeing of BME staff, but is also underpinned by evidence on the adverse impact on organisational effectiveness, patient care and safety, making it both powerful and easy to spread.

This narrative is supported by senior leaders across the NHS, and by being made mandatory through the NHS standard contract and through CQC inspections.

In the NHS, whilst many boards have been persuaded of the need to act, more remains to be done to share that narrative with middle managers whose role will be decisive. The Audit Commission[42] listed four factors which helped to create a more open and honest learning culture:

- Being clear about why race equality matters and how it benefits the wider community.
- Creating an open environment by providing opportunities for 'safe' discussions and being clear about (and enforcing) appropriate behaviours and competencies.
- Drawing on black and minority ethnic staff as a valuable source of information and knowledge.
- Recognising and rewarding improved performance in race equality.

42. The Audit Commission, 'The Journey to Race Equality: Delivering Improved Services to Local Communities', 2004



Proactive leadership that models behaviours and values

The Audit Commission emphasised the importance of leadership at all levels of the organisation, including members and non-executive directors, in prioritising race equality, setting the culture, raising expectations, increasing accountability and following through with action.[43]

The work of Michael West and colleagues has become increasingly influential in shaping the NHS understanding of what good leadership looks like and this is reflected both in the work of the NHS Leadership Academy, and in the recent guidance from the National Improvement and Leadership Development Board on culture, leadership and talent management which makes it clear that:

> Research shows the most powerful factor influencing culture is leadership. Leaders who model compassion, inclusion and dedication to improvement in all their interactions are the key to creating cultures of continuous improvement in health and care… Compassionate and inclusive leadership creates an environment where there is no bullying, and where learning and quality improvement become the norm.
>
> Planning needs to include creating the conditions in which equality, diversity and inclusion thrive in all teams and organisations across health and care services to speed progress towards a truly inclusive health and care leadership.[44]

43. Ibid
44. 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

The Audit Commission identified a five stage journey relevant to WRES implementation.

Table 14. Stages of confidence and progress on race equality

Stage	Level of confidence and progress
Resisting	No understanding of the importance of race equality – focus of work on producing a scheme and/or policy.
Intending	Say race equality is important but still have a poor understanding of the depth of change required.
Starting	Better understanding of local issues, expressed within a high level vision.
Developing	Understand the issues and where they are trying to get to. Still need to prioritise activity.
Achieving	Have a clear vision for where they are trying to get to and have set out and prioritised improvements to specific local outcomes. Achievement is recognised by peers and information and advice is regularly sought.

The Audit Commission proposes: "Those at the resisting and intending stage of the journey must focus on developing a robust rationale, describing why race equality matters locally and how it benefits everyone. Those that are starting must create a vision for where they want to be that is shared with black and minority ethnic groups and the wider community. Those who are developing must concentrate on increasing their capacity and working with partners. Those who are achieving must ensure that they keep on track by managing their performance. This needs to be underpinned by visible and committed leadership from officers, members and non-executive directors at all stages of the journey."

Accountability and transparency

Research highlights accountability as the most crucial ingredient in successful strategies. Accountability may take different forms depending on the context and the challenge being tackled.

The inclusion of the WRES within the NHS standard contract, within the CCG Improvement and Assessment Framework, the publication of all key data that is collected, and the inclusion of WRES within CQC inspections are all forms of accountability. Unless initiatives on equality are mandated and supported by leaders at every level they are unlikely to succeed. With such national accountability in place, emphasis is needed on the range of local accountability with good leaders will seek to exercise through effective use of appropriate metrics and action plans, ensuring middle managers in particular are fully engaged.

Section 7 of this report considered how these principles might be applied to address the specific issues the WRES indicators highlight and thus help tackle the systemic underlying patterns of less favourable treatment that BME staff face in the NHS.

BME staff are part of the solution

BME staff are part of the solution to tackling race discrimination. BME staff have first-hand experience of discrimination. They can identify the specific challenges, and help organisations understand why previous interventions may have failed. They will know some of the practical steps that need to be taken.

BME staff need an effective voice and in good organisations that means direct access to a board member. It means an effective means of making their views heard in a coherent way. Our forthcoming survey of existing practice suggests a number of different ways in which that might be done.

In good organisations, BME staff are intimately involved in identifying problems and developing solutions including the WRES Action Plan, always recognising that it is the role of the existing formal structures of the organisation to articulate those as specific interventions and policies.

Sustainability

A 2016 survey commissioned by the WRES Implementation Team (to be published shortly) of some of the more effective private sector equality practice concluded that:

Progress can be slow. Several interviewees discussed the importance of acknowledging that engrained behaviours and attitudes will take time to change – one individual remarked that for their organisation, improving race equality is like "trying to turn an oil tanker." They stressed that senior leaders must recognise this, and advocate and support a long-term approach to tackling inequality. However, stakeholders also reflected on the importance of finding opportunities to expedite progress within a long-term plan.

Leaders who wish to bring about diversity need to acknowledge and understand their local data on the treatment and experience of staff (recruitment, promotion, discipline, bullying and turnover). Visible support for positive diversity and inclusion policies and practices is essential from leaders and senior managers.[45]

BME staff facing the effects of workplace discrimination need support from leaders who create workplaces that are psychologically safe and encourage open communication between employees without fear of negative consequences and reduce isolation and exclusion.[46] Furthermore, organisations should train staff in strategies to reduce bias and discriminatory behaviour.[47]

In the report "Making a Difference", commissioned by WRES Implementation Team, Michael West and King's Fund colleagues summarise some strategies for individuals, teams and organisations which appear to be more successful.[48]

Alongside the work of NHS organisations such as the NHS Leadership Academy, their recommendations can form an important part of making sustainable the changes that the WRES is helping to park and initiate. Other initiatives such as Developing People – Improving Care National framework for action on improvement and leadership development in NHS-funded services should go a long way in helping to assist the sustainability of this endeavour going forward.

45. Bilimoria, D, et al. (2008) 'Breaking barriers and creating inclusiveness: lessons of organizational transformation to advance women faculty in academic science and engineering'. Human Resource Management, 47, 423–41
46. Singh B, et al. (2013) 'Managing diversity at work: Does psychological safety hold the key to racial differences in employee performance?' Journal of Occupational and Organisational Psychology, 86, 242-263
47. Devine P. et al. (2012) 'Long-term reduction in implicit race bias: a prejudice habit-breaking intervention'. Journal of Experimental Social Psychology, 48, 1267-1278
48. King's Fund, 'Making the Difference: Diversity and Inclusion in the NHS', November 2015

09 CONCLUSION AND NEXT STEPS

The WRES was established to help create a radical improvement in the treatment of, and opportunities for, BME staff within the NHS. Crucial to starting that process was that NHS organisations held a mirror to themselves to discover what their own data told them about the treatment and opportunities experienced by their BME staff. It also enabled organisations to compare themselves with similar organisations, and to identify and learn from other organisations (or parts of their own organisation) which may have had some success in meeting those challenges.

The design and architecture of the WRES, together with effective system alignment, have facilitated its inclusion in the NHS standard contract and within the well-led domain of CQC inspections. Its success as a social movement depends on mobilising people of goodwill to address, with an open mind and an honest heart, the less favourable treatment and opportunities for BME staff which adversely impact on their own health and well-being, on organisational effectiveness, and on the care and safety of all patients and service users.

We know that for the first time in many trusts, boards are considering what the data mean and how to respond effectively with evidenced-based interventions. In some trusts, BME staff voices are being heard in a meaningful way, though not always loudly enough. We also know that a growing number of trusts are developing good replicable practice, though the NHS as a whole has a very long way to go.

Over the next year, the national WRES Implementation Team will seek to build on the initial work of developing and sharing the narrative on this agenda, and on putting the architecture for change in place. It is anticipated that next year's annual WRES report will have a full set of data for two years; this will enable the establishment of trend analyses, indicating the levels of continuous improvement over time.

We also know that changing deep-rooted workplace cultures and discrimination can take time. National healthcare bodies will need the support of local organisations, as much as local organisations will need the support and guidance from the national bodies. In challenging times, tackling workforce race equality is not an optional extra, but one of the ways in which the NHS can develop and value the talent of its entire staff, for the benefit of all patients.

10 ANNEX

Annex: The WRES indicators (2016)

	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, medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce Note: Organisations should undertake this calculation separately for non-clinical and for clinical staff
2	Relative likelihood of staff being appointed from shortlisting across all 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) 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 voting membership and its overall workforce Note: Only voting members of the board should be included when considering this indicator