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Technical Guidance for the NHS Workforce Race Equality Standard (WRES)

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Contents

1 Foreword 4
2 Introduction 5
3 The NHS Constitution and the WRES 5
4 Background and design 6
5 A tool for healthcare providers, commissioners and national bodies 7
5.1 Providers of NHS services 7
5.2 Clinical commissioning groups 9
5.3 Commissioning support units 12
5.4 National bodies 14
6 The WRES indicators 15
Table 1 The Workforce Race Equality Standard indicators 17
7 Definitions of ethnicity: people covered by the WRES 18
8 The links between the WRES and the Equality Delivery System (EDS2) 19
9 Key considerations when implementing the WRES 20
9.1 Leadership and governance 20
9.2 Engagement 21
9.3 Data and action plans 22
9.4 Transparency 24
9.5 Reporting and benchmarking 24
10 WRES and Care Quality Commission inspections 25
11 Milestones for WRES implementation 27
12 Applying the WRES indicators 28
13 Annex A: Independent sector healthcare providers and the implementation of the WRES - additional requirements and advice 36
14 Annex B – The Brown Principles as applied to CCGs use of the WRES 37
15 Annex C – Office of National Statistics 2001 Ethnic Categories 38
16. Annex D – References and sources 39
17. Support and queries 40

1 Foreword

The Five Year Forward View sets out a direction of travel for the NHS which depends on ensuring the NHS is innovative, engages and respects staff, and draws on the immense talent in our workforce.

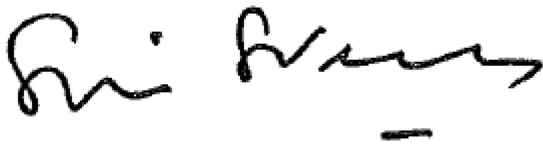
The evidence of the link between the treatment of staff and patient care is particularly well evidenced for BME staff in the NHS, so this is an issue for patient care, not just for staff. Yet it is strikingly clear that the NHS still has an immense amount to do to genuinely act on this insight. The lessons of previous efforts to tackle this challenge show that a focussed natural and local effort will be essential if we are to make the progress we need.

That is why, although we hope and expect NHS organisations will make the changes that research evidence and best practice suggest are needed, the Equality and Diversity Council - representing the major national organisations in the NHS - proposed the Workforce Race Equality Standard, which supports and requires organisations to make these changes.

The “business case” for race equality in the NHS, and for the Workforce Race Equality Standard, is now a powerful one. NHS England, with its partners, is committed to tackling race discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients.

We cannot afford the cost to staff and patient care that comes from unfairness in the appointment, treatment and development of a large section of the NHS workforce. We also know that research shows that diverse teams and leaderships are better for innovation and increase the organisational effectiveness the NHS needs. We know that we do best when healthcare organisations’ leadership broadly reflect the communities we serve.

I welcome the support the Workforce Race Equality Standard has received and look forward to seeing the changes it seeks to achieve.



Simon Stevens
CEO NHS England

2 Introduction

The NHS Workforce Race Equality Standard (WRES) was made available to the NHS from April 2015, following sustained engagement and consultation with key stakeholders including a widespread of NHS organisations across England. The WRES is included in the NHS standard contract, and since July 2015, NHS trusts have been producing and publishing their WRES data on an annual basis.

The main purpose of the WRES is:

a. to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
b. to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
a. to improve BME representation at the Board level of the organisation.

This document updates both the May 2018 version of the *Technical Guidance for the NHS Workforce Race Equality Standard,* and the July 2015 *Supplementary Technical Guidance: Clinical Commissioning Groups and the Workforce Race Equality Standard*. This document is part of package of resources to support NHS organisations to make measurable and continuous improvements in workforce race equality.

3 The NHS Constitution and the WRES

The NHS is founded on a core set of principles and values that bind together the diverse communities and people it serves – the patients and public – as well as the staff who work in it. The NHS Constitution establishes those principles and values of the NHS across England. It sets out the rights, to which all patients, communities and staff are entitled to, and the pledges and responsibilities which the NHS is committed to achieve in ensuring that the NHS operates fairly and effectively. Working towards race equality is rooted in the fundamental values, pledges and responsibilities of the NHS Constitution.

4 Background and design

Commissioned by the NHS Equality and Diversity Council (EDC) and NHS England, the design and development of the WRES is underpinned by engagement with, and contributions from, the NHS and national healthcare organisations, including the WRES Strategic Advisory Group.

The WRES is being implemented as the best means of helping the NHS as a whole to improve its performance on workforce race equality. There is considerable evidence that the less favourable treatment of BME staff in the NHS, through poor treatment and opportunities, has a significant impact on staff well-being, patient outcomes and on the efficient and effective running of the NHS and that the measures needed to address such discrimination will benefit patient care and organisational effectiveness.

Research and evidence show, for example, that that white shortlisted applicants are on average much more likely to be appointed than are BME shortlisted applicants. BME staff are more likely than white staff to experience harassment, bullying or abuse from other staff; are more likely to experience discrimination at work from colleagues and their managers, and are much less likely to believe that their organisation provides equal opportunities for career progression. In general, the proportion of NHS board members and senior managers who are of BME origin is significantly smaller than the proportion within the total NHS workforce and the local communities served.

The WRES provides real impetus, not just on workforce race equality, but on equality generally, for all those who experience unfairness and discrimination within the NHS. For sustained improvement in this area, the focus will not be upon compliance with implementing the WRES, but on using it as an opportunity to help improve the wider culture of NHS organisations for the benefit of all staff and patients.

The WRES has been welcomed as a positive step forward to help support and deliver the NHS' responsibilities under the wider equality and inclusion agenda and forms the first stage in a programme of work to address NHS workforce equality issues. The WRES was subject to an Equality Analysis, which can be found on the NHS England website.

5 A tool for healthcare providers, commissioners and national bodies

The WRES is a tool designed for both providers of NHS services (this includes NHS providers, independent sector, and voluntary sector providers of NHS services) and NHS commissioners. It can also be applied to national healthcare bodies; indeed, many national healthcare bodies are also implementing and using the WRES.

5.1 Providers of NHS services

The WRES applies to all types of providers of non-primary healthcare services operating under the full-length version of the NHS Standard Contract, and so is applicable to NHS providers, independent sector providers, and voluntary sector providers.

Since April 2015, the WRES has been included in the full-length NHS Standard Contract, which is mandated for use by NHS commissioners when commissioning non-primary health services. The Contract requires all providers of NHS services (other than primary care) to address the issue of workforce race inequality by implementing and using the WRES. Service Condition 13.6 of the NHS Standard Contract 2019/20 states the following in relation to the WRES:

> *The Provider must implement the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing that standard.*

Schedule 6A of the NHS Standard Contract requires that providers report annually on their compliance with the WRES.

These provisions do not apply to the shorter-form version of the NHS Standard Contract, which is typically used for commissioning lower value services with smaller providers.

5.1..1 NHS Providers

NHS providers comprise organisations providing community health services, ambulance services, and secondary and tertiary health services. Some organisations focus upon particular health conditions, such as mental health or learning disability or provide particular services – e.g. ambulance services.

Given the range of NHS provider organisations, any centralised benchmarking of WRES data will not only be carried out at individual organisation level, but also by type of organisation and by geographical region.

5.1..2 Independent sector and voluntary sector providers

In addition to NHS providers, there are also independent sector organisations and voluntary sector organisations which provide non-primary NHS services; these organisations are also subject to the NHS Standard Contract. Implementation of the WRES therefore also applies to independent sector and voluntary sector healthcare provider organisations, and the WRES requirements in the Contract quoted above also apply to these organisations.

Many of the independent sector and voluntary sector healthcare provider organisations have a national footprint, and some provide specialist services; however, the issues covered by the WRES, relating to the experiences of the workplace and representation at senior management and Board level for BME staff are as pertinent to non-NHS organisations as they are to NHS bodies.

Independent sector and voluntary healthcare provider organisations do not have a similar level of uniformity in the structure of staff bandings and electronic staff records as is the case within NHS organisations. Furthermore, independent sector and voluntary sector healthcare providers will not be undertaking the NHS staff survey.

In implementing the WRES, independent sector and voluntary sector healthcare providers should focus upon their equivalent staff bandings, HR systems and electronic records, and relevant questions from surveys of their workforce that provide

evidence in line with the NHS staff survey questions which inform the WRES indicators.

To that end, a more tailored approach is needed to support WRES implementation and use within the independent healthcare sector. Additional advice and guidance regarding this is set out in Section 13 (Annex A).

From April 2016 onwards, progress on the WRES is considered as part of the “well led” domain in CQC’s inspection programme. This will cover all NHS trusts and independent healthcare providers that are contractually obliged to carry out the WRES. Further details regarding this are given in Section 10.

5.2 Clinical commissioning groups

Clinical commissioning groups (CCGs) have two roles in relation to the WRES – as commissioners of NHS services and as employers. In both roles their work is shaped by key statutory requirements and policy drivers including those arising from:

- The NHS Constitution;
- The Equality Act 2010 and the public sector Equality Duty;
- The NHS standard contract and associated documents;
- The CCG Improvement and Assessment Framework.

In addition to the NHS standard contract, the CCG Improvement and Assessment Framework also requires CCGs to give assurance to NHS England that their providers are implementing and using the WRES. Implementing the WRES and working on its results and subsequent action plans should be a part of contract monitoring and negotiation between CCGs and their respective providers. If there is something amiss with the providers’ implementation or use of the WRES, and/or what the results of WRES actually show, CCGs should have meaningful dialogue with those providers. However, the credibility of the CCGs relationship with its providers can only be meaningful if the CCG itself is taking serious action to improve its own performance against the WRES indicators.

CCGs should commit to the principles of the WRES and apply as much of it as possible to their own workforce. In this way, CCGs can demonstrate good leadership, identify concerns within their workforces, and set an example for their providers. Formally, of course, CCGs are not required by the NHS standard contract to fully apply the WRES to themselves as some CCG workforces may be too small for the WRES indicators to either work properly or to comply with the Data Protection Act 2018. However, neighbouring or similar (comparator) CCGs may wish to submit a jointly co-ordinated WRES report and action plan; this can counter any potential risk of small workforce numbers. Further information regarding such approaches is provided further below.

At a minimum level however, all commissioners of NHS services, including CCGs, are expected to have "due regard" to using the WRES in helping to improve workplace experiences and representation at all levels for their own BME staff. The key case law principles related to the term "due regard" are commonly referred to as the Brown Principles and are often used to determine whether a public body has shown "due regard" to the Equality Duty. These principles have been drawn upon to underpin the approach commissioners of NHS services, including CCGs, should take to the application of the WRES to their own organisations. Annex B presents alignment between the Brown Principles and implications of "due regard" for WRES use by CCGs.

"Due regard" in this context refers to the CCG giving proportionality, relevance and sufficient attention to implementing the WRES. The CCG is recommended to implement as many of the WRES indicators as appropriate, whilst giving fair consideration to the principles of the WRES within their day-to-day activities. For example, the monitoring of information such as non-mandatory training is good practice, as it can help the organisation identify potential anomalies in the level and type of support offered to different groups within its workforce. Indeed, publication of workforce data in such ways can help the organisation demonstrate compliance with the general duty of the public-sector Equality Duty.

In practice, to aid due regard to the implementation of WRES, CCGs should:

- **Collect data on their workforce** - data should be collected by ethnicity (see Section 7 on ethnicity monitoring) as well as by other characteristics given protection under the Equality Act 2010. This should include both workforce data and staff survey data. Some CCGs already take part in the national NHS Staff Survey. Others may conduct their own equivalent survey. They should analyse that data for each of the relevant WRES metrics.
- **Carry out data analyses** - in many CCGs the numbers of staff employed are small. Hence very small changes in numbers on workforce and survey metrics can result in substantial changes in percentage terms. Such changes should be treated with caution but should not be ignored since, especially where they signify a trend or indicate a concern, they may be extremely useful. It is also possible to aggregate data for some WRES indicators to such an extent that individuals cannot be readily identified. Additionally, similar or neighbouring CCGs may wish to bring together and present their data analyses jointly. In South East London, for example, a number of CCGs work together on many major initiatives.
- **Produce an annual report and action plan** – the report should show the results of their staff survey and workforce data for internal analyses. The report should indicate the steps CCGs are taking to improve their performance against the WRES indicators. The WRES Reporting template has been made available for this purpose; it should be accompanied by the organisation's WRES action plan. Again, similar or neighbouring CCGs may wish to bring together their WRES data and report jointly as a whole.
- **Publish the annual report and action plan** - CCGs will need to give consideration to how such data are published and what conclusions are drawn. Where publication by individual CCGs might lead to the identification of individuals due to small numbers, caution may need to be taken and wider publication may not be appropriate. However, similar or neighbouring CCGs may wish to develop a joint action plan based upon their amalgamated WRES report. In such a situation, the responsibility of making improvements against the WRES indicators should not be delegated to other CCGs; each individual CCG has a responsibility to have due regard to implementing the WRES and to improving the experiences of its own workforce.

A WRES action plan, produced in accordance with principles highlighted above, will enable CCGs to understand workforce matters and the steps needed to help improve BME staff experience and representation at all levels of the organisation. The WRES Reporting Template is available for CCGs to use in this regard. From **2019** onwards, CCGs are expected to submit their annual WRES data to NHS England for analyses and publication.

The CCG Improvement and Assessment Framework requires all CCGs, in their role as commissioners of NHS services, to provide data from their providers in relation to reported harassment, discrimination and lack of equal opportunities between white and BME groups in the workforce. The data are based upon responses to the NHS staff survey (KF25, KF26, KF21, Q17b) as reflected in WRES indicators 5-8. Some CCGs already participate in the national NHS staff survey; those CCGs that do not currently participate, are encouraged to do so, or should undertake a similar workforce survey as noted above.

5.3 Commissioning support units

5.3..1 Supporting CCGs

Commissioning support units (CSUs) provide a range of support services to CCGs and can play an important role in ensuring that CCGs successfully carry out their obligations with regards to the WRES. Where a group of local CCGs are working together on implementing the WRES, the CSU can have a pivotal role to play in helping to bring together and support such a collaborative approach. Below are three examples of the type of approaches being developed by CSUs in implementing the WRES across their respective geographies.

a. Regional workforce race equality trends across CCGs

Aggregating the data for all CCGs in the region for which the CSU has responsibility. The intention is that by aggregating individual CCG workforce race equality data, as part of their support for and assurance role with CCGs, CSUs will be able to identify regional workforce race equality trends within a cluster of CCGs that might not be apparent (or possibly to identify) by scrutiny of individual small CCGs. As highlighted above, this approach will be valuable where reporting by individual CCGs proves to be problematic.

b. Checklist for CCGs

CSUs may develop a checklist for use with CCGs, to include a number of key checks relating to the WRES indicator, subject to Data Protection Act considerations. The use of the Equality Delivery System (EDS2), in particular EDS2 Goals 3 and 4, will be useful here, see Section 7. The checklist may include:

- Equality analysis of the workforce profile and organisational leadership compared with relevant population;
- Equality analysis of recruitment and other employment matters;
- Workforce diversity targets e.g. relating to senior leadership and Board membership;
- Equality breakdown of key staff survey questions, such as experience of violence, harassment, bullying and discrimination (including relevant indicators from the WRES);
- Details of policies and programmes in place to address equality concerns in the workforce.

c. Views of staff from across CCGs

For many CCGs, the numbers of BME (and white) staff may be too small to register on the NHS staff survey, for data protection and person-identifiable data reasons. In such circumstances, CSUs may consider gathering the essential views (using qualitative and quantitative methods) of staff from across a number of CCGs to help identify potential trends and to inform action. It is essential that any such engagement with staff is both meaningful and sustained.

5.3..2 CSUs implementation of the WRES

CSUs carry out public functions using public funding, and as such the general duty of the public sector Equality Duty applies to them. Whilst the specific duties of the Equality Duty (publishing equality information; setting and publishing equality objectives) do not apply to CSUs, carrying out exercises such as analysing, publishing and acting upon workforce data (as appropriate) are viewed as good practice.

Indeed, such exercises may also help the CSU demonstrate compliance with the general duty of the Equality Duty.

There are good practice reasons for CSUs to implement and apply the WRES to their own workforces. We know, as highlighted above, that CCG workforces are 'small'; this is often the case because some functions, such as Human Resources, Finance Support and Equality and Diversity are rationalised and centralised within CSUs. For example, a group of neighbouring CCGs may not have Human Resources staff as they are located within a CSU where they serve the group of CCGs. The same may apply to staff carrying out other organisational functions. Alongside CCGs, insight into the BME composition of CSU staff, and data related to the WRES indicator, will be important in order for the total 'commissioning workforce' to be properly analysed and issues identified. Simply focussing upon the workforces of CCGs alone will only present a partial picture of workforce race equality across commissioning organisations.

5.4 National bodies

National healthcare bodies, including the Care Quality Commission, Health Education England, NHS Digital, the NHS Confederation (that includes NHS Employers), NHS England, NHS Improvement, NHS Providers, and Public Health England, are members of the Equality and Diversity Council, and are committed to supporting the work on the WRES. Alongside local NHS organisations, national bodies are also implementing the WRES as appropriate, including publishing data and action plans, though they are not bound by the NHS contract or subject to regulatory inspection.

Although there is no formal requirement for national healthcare bodies to implement the WRES and report data against its indicators, in the spirit of transparency and continuous improvement, a number of the national healthcare bodies are implementing the WRES and submitting data on an annual basis. These data are published on the NHS England website.

Workforce race equality, and equality in general, is a challenge that requires organisations to go beyond behavioural change as a result of compliance and regulation. Board level commitment and leadership within NHS organisations are critical in transforming the culture of organisations in relation to this agenda. National healthcare bodies have an important role to play in setting the standard of practice for other, local, organisations to follow.

6 The WRES indicators

There are nine WRES indicator. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon BME representation on boards. The WRES highlights any differences between the experience and treatment of white staff and BME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

Based on feedback from the WRES baseline data returns and from engagement with the NHS, the wording for Indicators 1 and 9 have been revised in relatively minor ways. The revisions seek to add clarity on progress against these two WRES indicator:

- WRES Indicator 1 now has a clearer definition of “senior medical manager” and “very senior manager”.
- WRES Indicator 9 now requires submission of data that disaggregate: (i) the voting and non-voting members of boards, and (ii) the executive and non-executive members of boards. **Trusts are encouraged to try and ensure that there are no board members with an unknown ethnicity**.

With regard to WRES Indicator 2, organisation’s annual data returns are expected to include the shortlisting for both internal and external recruitment activity.

As highlighted above, a number of the WRES indicator (5-8) have been taken directly from the NHS Staff Survey questions. The NHS Staff Survey is reviewed annually; to ensure that organisations’ local staff surveys are aligned to the four WRES indicator based upon the NHS Staff Survey questions, organisations not partaking in the NHS Staff Survey should check the current survey questionnaire.

The use of the national NHS Staff Survey data should become even more useful from 2017 onwards as a result of important improvements in increasing survey response rates. The push towards eliminating the use of small staff survey samples should help increase BME staff responses to the survey and make the analyses of data locally more meaningful.

As a whole, the WRES indicator have been chosen to be as simple and straightforward as possible and are almost entirely based on existing data sources (Electronic Staff Records; NHS Staff Survey or local equivalent) and analysis requirements which good performing NHS organisations are already undertaking. The development of the nine WRES indicator owes a great deal to consultation with, and contributions from, the NHS and key stakeholders.

Table 1 The Workforce Race Equality Standard indicators

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

7 Definitions of ethnicity: people covered by the WRES

The definitions of "black and minority ethnic" and "white" used in the WRES have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and are as used in NHS Digital data. At the time of publication of this guidance, these definitions were based upon the 2001 ONS Census categories for ethnicity. These are presented in Annex C.

"White" staff include white British, Irish, Eastern European and any "other white" i.e. categories A–C in the table in Annex C. The "black and minority ethnic" staff category includes all others except "unknown" and "not stated." To aggregate data for BME staff, organisations should include categories D-S from current values and exclude category Z – "not stated" and any "NULL" values, as cited in the table in Annex C. (With regard to the 'old' codes, white staff are represented by category 0; BME staff are represented by categories 1-8, not given is represented by 9. As at December 2015, there were approximately 430 'old' codes allocated to current staff in the NHS.) In some organisations there may be differences between the likelihood of different staff groups self-reporting their ethnicity, with some organisations having low rates of self-reporting. This risk is greatly reduced where organisations are making concerted efforts to increase the overall self-reporting levels. If the proportion of 'not stated' is significant, this should be addressed as it may affect the reliability of WRES data – small numbers may make a significant difference to the published outcomes.

The treatment of staff from ethnic categories [B – white Irish] or [C – Any other white background] i.e. Gypsies and Travellers, or Eastern European who may, in some organisations, be a significant minority group and experience discrimination, is considered in the WRES FAQs document. Where this is the case, organisations should also explore tackling such discrimination using workforce and staff survey data, using the principles of the WRES and taking appropriate action.

8 The links between the WRES and the Equality Delivery System (EDS2)

The Equality Delivery System (EDS2) is designed to help local NHS organisations, in discussion with local stakeholders, review and improve their performance for patients, communities and staff in respect to all characteristics protected by the Equality Act 2010.

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

The WRES and EDS2 are complementary but distinct. Therefore, there should not be any unnecessary duplication in the collection of data for the two initiatives. The data and analyses for the WRES indicators will assist organisations when implementing EDS2, in particular, with the outcomes under EDS2 Goals 3 and 4, as shown below.

Goal 3: A representative and supported workforce – notably EDS2 outcomes:

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

Goal 4: Inclusive leadership – notably EDS2 outcomes:

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

Both the WRES and EDS2 also assist organisations in meeting their public sector Equality Duty requirements. NHS organisations should refer to the Equality Act 2010 and related guidance for a full understanding of the public sector Equality Duty.

9 Key considerations when implementing the WRES

9.1 Leadership and governance

Work on WRES, and other equality initiatives such as EDS2, will only make an impact when it is located within mainstream business and governance structures, and when NHS boards and senior leaders lead the way through not only what they say but also what they do, within and outside of their organisations. Boards are encouraged to avail themselves to developmental initiatives and leadership programmes where the emphasis is on inclusive workforces and healthcare services.

Successful equality, diversity and inclusion work, including work to implement the WRES, requires specialist advice and support. It is increasingly recognised that without good leadership, work on these agendas is very often short-lived, or at best, has little organisation-wide impact.
Leadership must come from Board level, as highlighted by NHS Providers in '*Leading by example: the race equality opportunity for NHS provider boards*':

> *'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'.*

At the outset, the organisation's Board and senior leaders should confirm their own commitment to workplaces that are free from discrimination – where all staff are able to thrive and flourish based on their diverse talent. This is particularly important as the WRES may well challenge the leadership of the organisation to positively demonstrate their own commitment to equality and inclusion, and in particular, to race equality.

Indeed, some organisations are increasingly identifying a Board member to lead or promote this and other equality initiatives, such as EDS2.

One of the most important resources available to NHS organisations is the staff they employ to drive forward equality for patients and in the workplace. Due to recent organisational restructures and financial pressures, the numbers of specialist staff with expertise in equality and diversity may have reduced in some organisations; smaller organisations may only have limited specialist equality expertise or resource.

In taking forward work on the WRES, and on equality in general, organisations should consider what support, development opportunities and training should be made available to their staff – at all levels. Board and senior management level support with regard to this will be critical.

Board-level sponsorship and support of this work, allied with shared ownership across the organisation, is essential if organisations are to meet their contractual and legal equality requirements, the expectation of regulators, the aspirations of staff and the best interests of their patients.

9.2 Engagement

In adopting and implementing the WRES, NHS organisations should engage with staff, staff networks and local staff-side organisations. This engagement will provide the organisation with the opportunity to ensure that staff feel valued and respected for the outstanding contribution they often make, and that their BME staff in particular, are fully involved in the organisation's work on implementing the WRES. Staff who are supported by their leaders will make the WRES work in the best way.

Organisations will be more successful in their implementation of the WRES, and other equality initiatives such as EDS2, when engagement with staff, staff networks, with trades unions and other staff organisations is both meaningful and sustained. In a number of organisations, Board members have met with their BME workforce to hear, at first hand, their experiences of the workplace.

In implementing the WRES, it is essential that the voice of BME staff is heard loud and clear during the processes of identifying the challenges in making continuous improvements against the WRES indicators. Organisations are strongly encouraged to help establish and support BME staff networks – alongside networks for the other protected characteristics – as an important source of knowledge, support and experience. Guidance on BME staff networks in the NHS is available on the WRES webpage.

As part of this, it will be critical for organisations to provide a safe place for BME staff to share their concerns and be listened to in a meaningful and sustained way. Such an approach has been seen to contribute significantly towards the overall success of the organisation's work on equality, diversity and inclusion. Staff side organisations can play an important role in providing intelligence within local organisations and helping to create robust local action plans.

9.3 Data and action plans

Accessing robust data and evidence by ethnicity for each of the 9 WRES indicator should not be a challenge for NHS organisations. Typically, data required for WRES indicator 1-4 and 9 can be sourced from the Electronic Staff Record, whilst the NHS Staff Survey (or local equivalent) presents the data for WRES indicators 5-8. Organisations should ensure that similar questions from the NHS Staff Survey used in Indicators 5-8 are factored into any equivalent local staff survey. The latest NHS staff survey results can be found on the NHS staff survey website.

The national WRES Implementation team will prepare submission templates and make these available online for organisations to download and populate. The WRES Business Intelligence Dashboard suite on ESR will be updated and organisations can use this to download data for indicator one and populate the ESR figures column. Organisations can then use their local knowledge and data to check and amend this data and complete the verified data column. A small amount of manual calculation will be necessary on calculating the numbers of Very Senior Managers, Senior Medical Managers (Indicator 1), and the disaggregation of Board membership data (Indicator 9).

Guidance on the 2016 national NHS Staff Survey made clear the expectation that small staff survey samples were no longer acceptable and that organisations should move towards full staff surveys. This both helps organisations make better use of staff survey data generally and will considerably reduce concerns about the confidence level for BME staff survey data where BME workforces are relatively small. As the annual data also indicate BME staff are often less likely to take part in staff surveys, organisations are strongly encouraged to increase response rates amongst all staff, and to have a concerted focus upon BME staff groups.

WRES data will point organisations towards the direction of focus and attention required to make continuous progress on workforce race equality. As such, of equal importance to an organisation's WRES outcomes against the 9 Indicators will be the action plans that will sit alongside the data.

The WRES is intended to provide a blueprint of what "good" looks like, and through the sharing of replicable good practice on how "good" may be achieved and sustained. It does this by providing the necessary platform and direction that encourages and enables NHS organisations to:

- compare not only their progress in reducing the gaps in treatment and experience over time, but to make comparisons with similar types of organisations on the overall level of such progress;
- undertake meaningful and sustained engagement with staff, staff networks, staff-side organisations and other stakeholders with regard to progress on this agenda;
- produce organisational-level improvement plans to take necessary remedial action following further considerations on the causes of the disparities in the indicator outcomes;
- reduce the differences in the workplace treatment and experience between white and BME staff on each of the WRES indicators.

To assist the development of good practice the WRES Implementation Team has undertaken a significant amount of work (field work and literature search) to identify the

shared characteristics of effective interventions against each of the WRES indicator and across organisations as a whole – looking at good practice in the private sector, other parts of the public sector, and within the NHS itself. The results of this work will be shared from spring 2017 and should further assist organisations' WRES action plans, which in turn will be evidence-based.

9.4 Transparency

Organisations should apply the WRES with an open mind and an honest heart. This means:

- Being open about the nature and scale of the challenge each organisation faces – sharing data however uncomfortable it may initially be.
- Sharing with all staff and trade unions the approaches proposed and inviting real engagement about those processes will help foster good relations between staff that do not share similar characteristics.
- Sharing with all staff, the data from workforce analysis and staff surveys which indicates the challenges around race equality.
- Sharing progress and achievements within and beyond the organisation, and applying that learning to other staff groups where applicable.

9.5 Reporting and benchmarking

9.5..1 Local reporting

Organisation's own boards or corporate leadership play a full part in signing-off the WRES data and agreeing the associated WRES action plans. They should be clearly seen to own this work and how progress is to be made and monitored. Organisations' WRES data and draft action plans can, in the first instance, be discussed with local interests including:

- Organisational governance arrangements established for the purpose of WRES implementation;
- Governors and members of NHS foundation trusts;
- Staff, BME staff networks, local unions and other organised staff groups;
- Local equality groups including Race Equality Councils or Equality Councils.

Organisations can use the WRES Reporting Template to publish their annual WRES data on their websites, alongside their WRES action plans by Friday 27 September 2019. The WRES Reporting Template, which has been amended to make it more user-friendly and printable, can be found on the WRES webpage. This template is not mandatory and organisations are encouraged to use templates that comply with their local board reporting standards.

9.5..2 Wider reporting

From July 2016, NHS provider organisations have been provided with a simple process for uploading their WRES indicator data via the SDCS system, so that progress can be more easily measured, national/regional aggregates can be formulated and good practice shared. Organisations will be given pre-populated WRES Excel templates to complete, verify and check. They are then required to upload their raw data for the WRES indicators into the SDCS system – the necessary calculations will be carried out automatically by the system. A short instructions guide relating to the reporting process will be made available on the WRES resources page.

Each NHS provider organisation's data against the nine WRES indicator will also be published annually. Alongside the guidance on Good Practice being published in spring 2017, this approach will assist the identification and sharing of replicable good practice and learning on improving workforce race equality across the country. It will also help similar types of NHS organisations to benchmark their performance against each other and seek peer support where appropriate.

Key milestones and issues relating to the reporting of WRES data and action plans by CCGs and CSUs are presented in Sections 5.2 and 5.3 respectively.

10 WRES and Care Quality Commission inspections

The WRES is designed to prompt, and where necessary require, inquiry and root cause analyses of the differences in the WRES indicator data for BME and white staff. The WRES indicators are designed to be difficult to 'game' and the cultural challenges that the WRES unearths (bullying culture, blame culture, 'club' culture) are ones that all

organisations will want to tackle in the interests of patient outcomes and organisational performance. Inclusion of the WRES in Care Quality Commission (CQC) inspections is therefore appropriate and necessary.

From April 2016 onwards, progress on the WRES is considered as part of the “well led” domain in CQC’s inspection programme for NHS trusts and independent healthcare providers contractually obliged to carry out the WRES. The organisation’s completed WRES Reporting Template and accompanying action plan are analysed as part of the evidence used in the inspections. Providers inspected are asked how they are addressing any issues arising from their respective WRES data. In addition, a variety of methods are used to engage with BME staff – so that data are also ‘triangulated’ with qualitative findings from the workforce.

The following initiatives have been taken to support the CQC’s use of the WRES as part of the inspection process:

- Recruitment of Equality and Diversity ‘specialist advisors’ who can assist with the assessment of the WRES and other equality and diversity issues for patients or staff, as part of the CQC inspection team during inspection visits.
- Production of short pre-inspection WRES briefings based upon the WRES data, and other relevant workforce race equality evidence, for the trusts being inspected. The briefings will aid CQC inspectors and be a useful source of reference during their inspection visits.
- Ongoing training and development for CQC inspectors and the recruited Equality and Diversity ‘specialist advisors’ – providing the necessary guidance, skills and knowledge required to undertake the WRES related element of the ‘well-led’ domain assessment.
- The WRES Implementation Team is working with CQC to develop a WRES composite score.

11 Milestones for WRES implementation

Milestone	Activity
Data to be submitted by 30 August 2019 and annually thereafter	Publication of 31 March 2019 workforce data and Autumn 2018 staff survey data against all nine indicators. In addition, actions required to make continuous progress (the WRES action plan) should be set out, including where appropriate, analyses of the impact of the previous WRES action plan. The WRES data report and the action plan should be: • shared with the Board, staff and other local interests • submitted centrally via SDCS (applies to NHS providers and CCG's only, and with regard to the WRES data report only) • presented to the lead commissioner (for NHS providers) • published on organisations' websites *CCGs should give consideration to the issue of publishing small numbers as highlighted in section 5.2.
April 2019 – March 2028	Work towards the ambitious challenge of ensuring black and minority ethnic (BME) representation at all levels of the workforce. This includes leadership being representative of the overall BME workforce by 2028.

All organisations are expected to be able to demonstrate that they are starting to close the differences between the treatment and experience of white and BME staff that the 9 WRES indicator highlight. This may involve:

a. Considering the WRES indicator to "drill down" by department or profession, and consider further disaggregation by individual BME groups.
b. For Indicator 1, publication of the organisations' workforce ethnicity data by each pay band – separate for clinical and non-clinical staff will assist in identifying specific areas of concern and barriers to career progression.
c. For Indicator 2, organisations will have considered analysing data on appointment from shortlisting for specific departments, occupations, or pay bands. Organisations may also wish to look at the 'application to shortlisting' stage in a similar way. The data reported for this indicator should also include outputs from internal recruitment campaigns.

d. For Indicators 3 and 4, organisations will have ensured they have in place an organisation-wide monitoring process for discipline and non-mandatory training/CPD analysed by ethnicity and started to consider if there are specific issues relating to particular professional groups, departments or shifts. They will want to consider carefully how they treat career development opportunities such as acting up, secondment, stretch assignments, being mentored and coached, and shadowing, as these are crucial to effective career progression.

e. Using the opportunity highlighted in the national initiative to improve NHS Staff Survey sample sizes, and in particular, increase BME staff sample sizes, as this will aid a better understanding of the specific challenges facing BME staff.

f. Reviewing recruitment processes for posts at all levels of the organisation – including senior management and Board-level appointments.

Discussing with local staff organisations, and with BME staff networks, their understanding of the drivers behind each of the WRES indicator – and developing robust action plans that strive towards continuous improvement. If such networks do not currently exist, then Board level consideration should be given to how they may be established and supported.

g. Considering the establishment of a three-year retrospective comparison, as some trusts already do, to scrutinise trends over time.

h. Considering the requirement for more regular reports to boards on key goals within the organisation arising from WRES implementation (this will be aided by the availability of WRES data throughout the year via the WRES report within the Business Intelligence ESR Dashboard for each trust, as described above).

12 Applying the WRES indicators

Matrices for the nine WRES indicators, plus definitions of terms, and advice on which evidence sources and insight to consider are given in the following set of tables.

WRES Indicator 1 - compare the data for white and BME staff: Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
Definitions: **"Bands 1-9"** – staff paid using the national Agenda for Change (AfC) pay scales for these grades. Where local pay scales are in use, then for non-medical staff, the equivalent basic salary level may be used **Medical and Dental subgroups** – staff paid using the Medical and Dental pay scales. Subgroups are identified by using the grade codes as recorded in the Electronic Staff Record Warehouse. ***"Very Senior Managers (VSM)"*** *are defined as exclusively including:* • *Chief executives* • *Executive directors, with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and the requirements of the post* • *Other senior managers with board level responsibility who report directly to the chief executive.* **"The overall workforce"** refers to: *all directly employed staff*. Organisations should either include all bank and locum staff, students on placement and staff employed by contractors or not include them altogether – as long as the approach is consistent over time. **"Senior medical manager"** *is are defined as: a medical consultant who is either a Medical Director, a Deputy Medical Director or who reports directly to a Medical Director or Deputy Medical Director."* This category cannot be currently pre-populated from ESR so it will need to be manually counted.
The organisation's approach: • The SDCS system should be used to submit the organisation's data for this Indicator • Organisations should submit data for this calculation separately for non-clinical and for clinical staff and further disaggregated for non-medical and medical and dental staff. • Compare the proportions of white and BME staff in the overall workforce with those in each of the AfC Bands, medical and dental subgroups and VSM. • Scrutiny by each AfC Band, and for clinical staff, by ethnicity will help to identify where barriers to staff progression may be occurring, and to consider the action to address these barriers

- Some trusts already also disaggregate and publish AfC Band data by ethnicity and consider what may be happening in shortlisting and appointment processes for each Band boundary. Such scrutiny is likely to involve examination of the data underlying WRES indicator 2 and 4

Sources of evidence and insight will include: Electronic Staff Record (ESR); local NHS workforce data and insight

Calculating the Indicator outcome:

Please note that the SDCS template will calculate WRES Indicator outcomes automatically, following input of data by the organisation. The worked example given below is for AfC Band 6:

Number of BME staff in AfC Band 6 = 50. Total number of staff in AfC Band 6 = 500. Percentage of BME staff in AfC Band 6 = (50/500) 10%
Number of BME staff in overall workforce = 1000. Total number of staff in overall workforce = 4000. Percentage of BME staff in overall workforce = (1000/4000) 25%

WRES Indicator 2 - compare the data for white and BME staff: Relative likelihood of staff being appointed from shortlisting across all posts

Definitions:

- *Relative likelihood* – compares the likelihood of white staff being appointed with the likelihood of BME staff being appointed (ratio)
- *Appointed* – is used rather than "recruited". The two may well be the same, but it is "appointed" staff numbers which should be used, unless not available
- *All posts* – means all directly employed posts. Organisations should take a consistent approach by either including all bank and locum staff, students on placement and staff employed by contractors or not including them altogether – as long as the approach is consistent over time

The organisation's approach:

- The SDCS template should be used to calculate and submit the organisation's data for this Indicator
- Consider if there are significant differences between professions or departments
- Ensure staff who shortlist and interview are appropriately trained, including in the impact of "unconscious bias"
- Review the role of "executive search" agencies
- Carefully consider all the informal advantages some staff may have accrued over others through non-mandatory training and opportunities for acting up, leading projects, mentoring and shadowing
- Organisations may also want to look at relative likelihood of white and BME staff being **shortlisted from application, for both internal and external recruitment campaigns**

Sources of evidence and insight will include: Electronic Staff Record (ESR); local NHS workforce data and insight

Calculating the Indicator outcome:

Please note that the SDCS template will calculate WRES Indicator outcomes automatically, following input of data by the organisation

Number of shortlisted applicants: white = 780; BME = 210
Number appointed from shortlisting: white = 170; BME = 30
Relative likelihood of shortlisting/appointed: white = 0.22; BME = 0.14
Relative likelihood of white staff being appointed from shortlisting compared to BME staff (0.22/0.14) is therefore 1.57 times greater.

A figure below "1" would indicate that white candidates are less likely than BME candidates to be appointed from shortlisting.

WRES Indicator 3 - compare the data for white and BME staff: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (This indicator will be based on data from the most recent two-year rolling average)

Definitions:

- *Entering the formal disciplinary process as measured by entry into a formal disciplinary investigation* – refers to staff who have entered a formal investigation as prescribed by the local disciplinary process. Any occasional cases where disciplinary action is not preceded by an investigation should also be included in this definition. Staff who have been subject to an investigation, but for whom no further action was taken should be counted. Cases where mediation has taken place rather than any kind of formal investigation or disciplinary action should not be counted. Organisations should only count new entries into a formal process in each year's WRES annual report.
- *Data from a two-year rolling average of the current year and the previous year* – means data from whichever two previous 12 month periods (i.e. 2 years) have been used as the basis of the reported data.

The organisation's approach:

- The SDCS template should be used to calculate and submit the organisation's data for this Indicator
- Organisations may wish to consider the findings of the 2017 update of the 2010 NHS Employers commissioned, Bradford University report on ethnicity and discipline
- Organisations may wish to consider whether (and if so, why) there are significant differences between the ethnicity of staff entering the disciplinary process and those receiving sanctions
- Organisations may wish to consider differential outcomes of disproportionate disciplinary action against BME staff.
- Organisations may also wish to consider any impact of disproportionate disciplinary action on referrals to professional conduct bodies

Sources of evidence and insight will include: Electronic Staff Record (ESR); local NHS workforce data and insight

Calculating the Indicator outcome:

Please note that the SDCS template will calculate WRES Indicator outcomes automatically, following input of data by the organisation

Number of staff in workforce: white = 800; BME = 200
Number of staff entering the formal disciplinary process: white = 30; BME = 20
Likelihood of white staff entering the formal disciplinary process (30/800) = 0.0375
Likelihood of BME staff entering the formal disciplinary process (20/200) = 0.1000
Relative likelihood of BME staff entering the formal disciplinary process compared to white staff is therefore 0.100/0.0375 = 2.66 times greater.

A figure below "1" would indicate that BME staff members are less likely than white staff to enter the formal disciplinary process.

WRES Indicator 4 - compare the data for white and BME staff: Relative likelihood of staff accessing non-mandatory training and CPD

Definitions:
Non-mandatory training – refers to any learning, education, training or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g. fire safety training) or mandated by the organisation (e.g. clinical records system training). Non-mandatory and CPD recording practice may differ between organisations. However, all are expected to maintain internal consistency of approach from year to year, so that changes in uptake trends can be compared over time. Trusts are required to keep a record of all included and excluded training.

- *Accessing non-mandatory training and CPD* – in this context refers to courses and developmental opportunities for which places were offered and accepted.

The organisation's approach:

- The SDCS template should be used to calculate and submit the organisation's data for this Indicator
- Organisations will want to ensure that there is a robust organisation-wide system for collecting and analysing consistent non-mandatory training and CPD data for all staff.
- Good practice will include investigating potential differences in non-mandatory training and CPD access, by ethnicity, between professions and departments
- Organisations will want to learn from, and share best practice with, other organisations
- It is acknowledged that organisations may vary in what they include as "non-mandatory training and CPD". The current definition does not explicitly include access to acting up, shadowing, leading projects, secondments, coaching etc. which may be the most important aspects of staff development and which employers may consider including. However all Trusts must keep a record of what they included as non-mandatory training.

- **Sources of evidence and insight will include:**
  Local NHS workforce data and insight; staff professional development reviews Some trusts are using additional means to access or obtain this information e.g. use of a survey monkey, or use of the OLM programme linked to ESR to try to track data more effectively. Some providers also triangulate their data with staff survey data.

Calculating the Indicator outcome:
Please note the SDCS template will calculate WRES Indicator outcomes automatically, following input of data by the organisation
Number of staff in workforce: white = 600; BME = 400
Number of staff accessing non-mandatory training and CPD: white = 300; BME = 150
Likelihood of white staff accessing non-mandatory training and CPD is 300/600 = 0.50
Likelihood of BME staff accessing non-mandatory training and CPD is 150/400 = 0.375
Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff = (0.50/0.375) 1.33 times greater.

A figure below "1" would indicate that white staff members are less likely to access non-mandatory training and CPD than BME staff.

WRES indicator 5-8 - compare the outcomes of the responses for white and BME staff:

- KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
- 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

Definitions:

- The wording of these four indicators is taken directly from the national NHS Staff Survey questions: KF25; KF26; KF21 and Q17.
- With regard to Indicator 7, the word “trust” is taken verbatim from the national NHS Staff Survey (KF 21); in this context it refers to any organisation that is subject to implementing and using the WRES

The organisation’s approach:

- The SDCS template should be used to input and submit the organisation’s data for these Indicators
- Organisations will want to compare their NHS Staff Survey responses against appropriate workforce data (e.g. recorded harassment, bullying or abuse from patients, relatives or the public in the last 12 months) and understanding any discrepancies
- Organisations should look to listen to their BME staff in order to better understand the data
- Organisations will want to compare their data with peer organisations, or similar types of organisations, with the aim of sharing best practice
- Good practice will include drilling down to analyse the data by departments and professions as far as possible
- Organisations will want to increase both their NHS Staff Survey sample size and response rate, particularly from their BME workforce

Sources of evidence and insight will include: Organisation’s most recent responses to the national NHS Staff Survey or local equivalent survey questions

Calculating the Indicator outcome:

Please note that the SDCS template displays the organisation’s most recent responses to NHS Staff Survey questions KF25; KF26; KF21 and Q17b. These results are taken the WRES publications available on the NHS Staff Survey website.

WRES Indicator 9 - compare the difference for white and BME staff: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce

Definitions:

- *Board* – membership in this context includes all members of the Board irrespective of whether they are executive or non-executive members and whether they are voting or non-voting members of the Board who may have been co-opted.
- *Voting membership* – Voting members of the board are usually the executive board members – employed by the organisation. Generally, non-executive members are generally not voting members of the board.
- *Executive membership* – An executive board member is an employee of the organisation and sits on an organisation's board of directors and advises current organisational management on specific operations, e.g. Medical Director or Finance Director, as opposed to a non-Executive board member who is a member of the board of directors of the organisation who does not form part of the executive management team. They are not employees of the organisation or affiliated with it in any other way.

The definition was amended in 2017 to enable disaggregation by executive / non-executive members and by voting / non-voting members

The organisation's approach:

- The SDCS template should be used to input and submit the organisation's data. It may be necessary to manually check Indicator 9
- The Electronic Staff Record enables reporting on Board members (Executive and Non-Executive) if the appropriate Job Roles have been applied. This will enable comparison to be made against the organisation's workforce and the population being served. Job Roles: Chair, Chief Executive, Finance Director, Other Executive Directors, Board Level Directors, Non-Executive Directors, Medical Director, Nursing Director
- Foundation trusts will want to consider whether the ethnicity of trust governors is also broadly representative of the local population
- Organisations should ensure that their executive search agencies are committed to diversity in their policies and processes
- Organisations should plan for and develop an equal playing field for future applicants for all Board positions from diverse backgrounds
- For 2018, Indicator 9 is a priority and organisations are encouraged to work with the board and report the ethnicity of all board members.

Sources of evidence and insight will include: Electronic Staff Record (ESR); local demographic data of the working age population

Calculating the Indicator outcome:

Please note that the SDCS template calculates WRES Indicator outcomes automatically, following input of data by the organisation

The trust has 40% BME workforce and 1 of its 8, i.e. 12.5%, voting members on the Board is of BME origin. On Indicator 9, the percentage difference between the organisations' Board voting membership and its overall workforce will be -27.5%

The trust has 15% BME workforce and 2 of its 8, i.e. 25%, executive members on the Board are of BME origin. On Indicator 9, the percentage difference between the organisation's Board executive membership and its overall workforce will be +10.0%

13 Annex A: Independent sector healthcare providers and the implementation of the WRES - additional requirements and advice

WRES Indicator 1
Many independent healthcare provider organisations operate different salary frameworks unrelated to the NHS Agenda for Change (AfC) salary pay bands. In such cases, organisations are requested to insert workforce headcount data into four pay groups of: support, middle, senior and VSM.

WRES Indicator 2
Independent healthcare provider organisations are required to submit full data against this Indicator. The expectation is that such organisations should have appropriate recruitment processes and systems in place so that they are able to report against this Indicator in a reliable manner.

WRES Indicator 3
Independent healthcare provider organisations are expected to report against this Indicator utilising data from their existing HR recording systems.

WRES Indicator 4
Independent healthcare provider organisations are required to provide full data against this Indicator. The expectation is that such organisations should have appropriate recruitment processes and systems in place so that they are able to report against this Indicator in a reliable manner.

WRES indicator 5 – 8 (NHS Staff Survey)
It is acknowledged that many independent healthcare organisations undertake their own staff/engagement surveys. It is a requirement of the full-length NHS standard contract that provider organisations of healthcare services covered by the contract submit responses to WRES indicator 5 – 8, which are based on annual surveying of the workforce. However, organisations with less than 100 BME staff can choose not to submit data for these WRES indicators. Some independent healthcare providers currently undertake a bi-annual survey. It is expected they will move towards undertaking an annual survey in response of the WRES indicator, but may well do so over a phased period.
Independent healthcare provider organisations are able to change the specific language of each staff survey question so that if fits the corporate or cultural style of their in-house survey. Where necessary, independent healthcare provider organisations are required to insert questions into their annual staff surveys that will enable them to confidently report on WRES indicator 5 – 8.

Independent healthcare provider organisations are reminded of the importance of being able to disaggregate responses by ethnicity for WRES data reporting purposes.

WRES Indicator 9
Independent healthcare provider organisations are expected to report against WRES Indicator 9. It is acknowledged that the Board and governance arrangements for these organisations may differ from organisation to organisation, for example, multi-nationals or national companies, CiCs, or as national or local charities. It is also acknowledged that senior managers within these types of organisations may have differing levels of influence on the Board demographic make-up.

14 Annex B – The Brown Principles as applied to CCGs use of the WRES

Brown Principle	Requirement in respect of the equality duty	Implications of "due regard" for the WRES for CCGs
Knowledge	The decision makers must be aware of their duty to have 'due regard' to the three aims of the duty.	CCGs must be aware of the WRES, its aims and metrics.
Sufficient information	The decision maker must consider what information he or she has and what further information may be needed in order to give proper consideration to the Duty.	CCGs must consider what data they currently have about their own workforce, analysed by ethnicity, and what further information may be needed in order to give proper consideration to the WRES.
Timeliness	The Duty must be complied with before and at the time that a particular policy is under consideration or decision is taken – that is, in the development of policy options, and in making a final decision. A public body cannot satisfy the Duty by justifying a decision after it has been taken.	CCGs are expected to collect and analyse their workforce data using the WRES metrics and to use that data to consider the extent to which gaps exist between the experience and treatment of white and BME staff using both workforce and staff survey data. Where CCGs do not currently participate in the National Staff Survey they should consider what means they might use that are appropriate to determine staff views.
Real consideration (Decision making)	Consideration of the three aims of the Equality Duty must form an integral part of the decision-making process. The Equality Duty is not a matter of box-ticking; it must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.	Consideration of the WRES must form an integral part of the decision-making process. The WRES is not a matter of box-ticking; it must be exercised in substance, with rigour and with an open mind in such a way that it influences decisions on workforce treatment and experience.
Accountability (No delegation)	Public bodies are responsible for ensuring that any third parties which exercise functions on their behalf are capable of complying with the Equality Duty, are required to comply with it, and that they do so in practice. It is a duty that cannot be delegate.	Having due regard to the WRES is not to be delegated to another body.
Monitoring and review	Public bodies must have regard to the aims of the Equality Duty not only when a policy is developed and decided upon, but also when it is implemented and reviewed. The Equality Duty is a continuing duty.	CCGs must have regard to the aims of the WRES not only when a workforce policy is developed and decided upon, but also when it is implemented and reviewed.

15 Annex C – Office of National Statistics 2001 Ethnic Categories

Ethnic Categories 2001
A – White –British
B – White –Irish
C – Any other white background
D – Mixed white and black Caribbean
E – Mixed white and black African
F – Mixed white and Asian
G – Any other mixed background
H – Asian or Asian British –Indian
J – Asian or Asian British –Pakistani
K – Asian or Asian British – Bangladeshi
L – Any other Asian background
M – Black or black British –Caribbean
N – Black or black British –African
P – Any other black background
R – Chinese
S – Any other ethnic group
Z – not stated
Note: a more detailed classification for local use if required is contained in Annex 2 of DSCN 02/2001.
Old Ethnic Codes - staff employed after 1 April 2001 must have their ethnic group assessed and recorded using the new categories and codes as detailed above. The "old" codes shown below are for reference only.
0 – White
1 – Black – Caribbean
2 – Black – African
3 – Black – Other
4 – Indian
5 – Pakistani
6 – Bangladeshi
7 – Chinese
8– Any other ethnic group
9 – Not given

16. Annex D – References and sources

To access more documents, resources and publications on WRES, please visit the NHS England website.

Archibong, U. & Darr, A. (2010) *The Involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings*. University of Bradford.

Care Quality Commission (CQC) inspection information can be found on the CQC website

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

Department of Health (2013) *The NHS Constitution for England*.

Equality Act 2010 and the public sector Equality Duty information can be found on the Equality and Human Rights Commission website

Francis, R. (2015) *Report on the Freedom to Speak Up review*. Department of Health

Kline, R. (2013) *Discrimination by Appointment*. Public World.

Kline, R. (2014) *The Snowy white Peaks of the NHS*. Middlesex University

NHS Employers (2014) *The business case for diversity.*

NHS Employers (2014) *Leading by example: the race equality opportunity for NHS provider boards:*

NHS England (2013) *A refreshed Equality Delivery System for the NHS – EDS2*.

NHS England (2015) *Equality Analysis on NHS Workforce Race Equality Standard (WRES).*

NHS Equality and Diversity Council (EDC) information can be found on the NHS England website

NHS Providers (2014) Leading by example: *race equality opportunity for NHS provider boards.*

NHS Staff Survey Results

NHS standard contract and the CCG Improvement and Assessment Framework can be found on the NHS England website

Stevenson, J. & Rao, M. (2014) *Explaining levels off wellbeing in BME populations in England.* NHS Leadership Academy.

T Foresight Partnership (2013) *The Healthy NHS Board. Principles for Good Governance*. NHS Leadership Academy.

West, M; Dawson, J; Topakas, A. (2011) *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data*. Aston Business School.

West, M. & Dawson, J. (2011) *NHS Staff Management and Health Service Quality*, Aston Business School.

17.Support and queries

For resources, information and queries relating to the WRES, please contact the NHS England national WRES Implementation Team:

Email england.wres@nhs.net

Webpage www.england.nhs.uk/wres/