NHS
Equality and
Diversity Council

NHS WORKFORCE RACE EQUALITY STANDARD

2017 DATA ANALYSIS REPORT FOR NATIONAL HEALTHCARE ORGANISATIONS

Publication Gateway Reference Number: 07850

NHS Workforce Race Equality Standard
2017 Data Analysis Report for National Healthcare Organisations

Version number: 1

First published: March 2018

Prepared by: Dr Habib Naqvi, Owen Chinembiri and Yvonne Coghill

On behalf of the WRES Implementation team

Classification: OFFICIAL

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact: england.wres@nhs.net

Contents

01 Preface

Evidence shows that the treatment and opportunities received by black and minority ethnic (BME) staff in the NHS often do not correspond to the values and principles that the NHS represents. It was in direct response to this that the NHS Workforce Race Equality Standard (WRES) was developed and made mandatory for NHS trusts in April 2015.

Although national healthcare bodies are not required to implement the WRES and report data against its indicators; in the spirit of transparency and continuous improvement, six national healthcare bodies agreed to do so – and are to be commended for their openness.

This is the first WRES annual data report for the national bodies. It presents baseline data and will therefore be invaluable to those organisations in understanding the challenges they face on workforce race equality. It will help prompt inquiry and assist the organisations in developing and implementing evidence-based responses to the questions their data pose.

If we are to see system-wide improvements on workforce race equality across the NHS then it is incumbent upon the national healthcare organisations to lead the way on this agenda. This is the opportunity to ensure that we can be at the forefront of achieving the aspiration of making the NHS a better and more inclusive employer at all levels.

If this opportunity is to be realised, three things will be essential: greater clarity on the case for change; a renewed focus on leadership from boards; and continuation of effective national support being provided by the national WRES Implementation team, to facilitate the sharing of good practice across the sector.

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

02 Executive summary

- The implementation of the WRES is not an obligatory requirement for national healthcare organisations. Despite this, six national healthcare bodies agreed to implement the WRES, as employers in their own right.
- The six organisations that submitted their WRES data were: Care Quality Commission; Health Education England; NHS Digital; NHS England; NHS Improvement, and Public Health England.
- Data were collected for 2016 and 2017, where available, and analysed by comparing the experiences and opportunities between black and minority ethnic (BME) and white staff. Findings are presented by organisation, and where appropriate, national NHS trust averages are presented as comparison.
- Key findings across the six national healthcare organisations show:
  - White shortlisted job applicants are relatively more likely to be appointed from shortlisting than BME shortlisted applicants for all organisations. The relative likelihood ranges from 1.05 to 3.03 times.
  - BME staff are over-represented in low grades and under represented at senior levels across the organisations.
  - BME staff in four of the six organisations were relatively more likely to enter the formal disciplinary process compared to white staff. In one of these organisations, the relative likelihood is 2.63 times more likely.
  - Only two organisations were able to provide data on access to non-mandatory training and career progression development. For these two organisations, BME staff are equally, or slightly more, likely than white staff, to access such opportunities.
  - BME staff are more likely to report harassment, bullying or abuse from colleagues compared to white staff in four of the five organisations that provided data for this indicator.
  - BME staff are less likely than white staff to report that their organisation provides equal opportunities for career progression or promotion.
  - BME staff are more likely to report having personally experienced discrimination at work from a manager, team leader or colleague, compared to their white counterparts.

- For all organisations, the respective percentage of BME staff on the board is lower than the overall BME workforce percentage.
- One organisation has two BME members out of the 16 directors on its Management Committee. For all other organisations, there is no BME executive board member.

- The data for the six organisations suggest that much work is needed to improve workforce race inequality across the national healthcare bodies. As such, this report is an important reminder, to the boards of national healthcare bodies, of the workforce race equality challenge faced.
- Organisations can take learning from a growing number of NHS trusts that are beginning to embrace this agenda, as well as tapping into the support and resources provided by the national WRES Implementation team.

03 Introduction

In 2014, the NHS Equality and Diversity Council agreed action to close the gap in workplace experiences and opportunities between black and ethnic minority (BME) and white employees across the NHS. To help achieve this ambition, 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 2015. Alongside NHS trusts, the WRES is being implemented by independent healthcare providers and clinical commissioning groups. Since 2016, annual WRES data reports for NHS trusts have been published – holding up a mirror to organisational performance on this agenda.

Whilst the implementation of the WRES is not an obligatory requirement for national healthcare organisations, as members of the NHS Equality and Diversity Council, and consequently system leaders for this programme of work, six of the national healthcare bodies agreed to implement the WRES as employers in their own right. The six organisations are: Care Quality Commission (CQC), Health Education England (HEE), NHS Digital, NHS England, NHS Improvement, and Public Health England (PHE). For the first time, this report presents data for these national bodies against each of the nine WRES indicators of staff experience and opportunities.

The national approach to closing workforce race inequality gaps in the NHS has, in recent years, led to these (and other) national bodies working together in concert to advocate clear system leadership on the WRES. However, these organisations also have distinctive national duties laid down upon them by statute, as well as other key responsibilities and obligations as employers.

Implementing the WRES helps healthcare organisations – whether local, regional or national – to meet a number of critical cases, including those related to:

- Patient experience, outcomes and safety
- Organisational innovation and efficiency
- Public Sector Equality Duty
- Morality and social justice

In contrast to local provider and commissioning organisations, national healthcare bodies' implementation of, and performance against, the WRES is not scrutinised by regulation, contract or assurance. Instead, these organisations hold themselves and each other to account, including via the NHS Equality and Diversity Council. By undertaking the WRES with an open mind and an honest heart, such an approach can work successfully – and indeed the openness with which data for these organisations are reported within this publication, is a testament to that endeavour.

Without data, carefully analysed, it is difficult for organisations to understand the level of challenge they face on workforce race equality, and on equality in general, and where that challenge is most critical. Through the collection and publication of their WRES data, national organisations will know where they are now on this agenda, where they need to be and, with robust action planning, how they will get there. We know from the work being undertaken with NHS trusts, organisations that are showing signs of continuous improvement are more likely to be those that have boards and leaders that understand and act upon the many powerful cases for workforce race equality.

Gathering data in response to the nine WRES indicators is important, however, it is only the first step towards moving the 'dial' of workforce inequality that exists across the NHS. We know, from the annual WRES data analysis reports for NHS trusts, of the degree and level of workforce race inequality that exists across the different parts of the NHS. Whilst an increasing number of local NHS organisations are developing systematic and innovative responses to improve the treatment and experience of their BME staff, many others still have much progress to make. It is anticipated that the WRES data for the national bodies, and the response to the data, will be no different.

By implementing the WRES, and adhering to the principles that underpin it, we expect all NHS organisations to seek continuous improvement on workforce race equality – and that those improvements are measured and demonstrated through the annual publication of WRES data and effective action planning. This is the first report publication that brings together the WRES data for the national healthcare bodies. This approach towards openness and transparency will continue going forward and will be further supported by the national WRES Implementation team. This is important as it helps ensure the development of the new and emerging healthcare architecture is led and supported by organisations that are inclusive and make full use of the immense talent within their workforce.

The Next Steps on the NHS Five Year Forward View[1] commits to the delivery of high quality, safe, patient-focused care that is dependent upon professional commitment, strong system leadership and a caring and compassionate workplace culture. It regards the WRES and work on inclusion as a critical element towards enabling the realisation of that commitment. It is therefore necessary that national healthcare bodies, which are at the heart of driving forward that national health agenda, are also seen to be leading the way on improvements in workforce race equality within their own respective organisations.

The emerging healthcare architecture is striving to build local health and care systems that focus upon the shared aim of improving care for individuals, improving population health and well-being, and improving value for money. These complex tasks place new demands not only on those at local level who carry out NHS-funded work, but also upon the leadership, skills and morale of decision-makers in national organisations. Such pressures can leave little time for staff to reflect on their managerial and leadership styles and how best to lead and/or operationalise change. It is partly for these reasons that implementation of tools such as the WRES are critical – helping to build cultures of continuous improvement towards compassionate and inclusive system leadership.

1. https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

04 Methodology

4.1 The WRES indicators

The WRES requires local NHS organisations to self-assess against nine indicators of staff experience and opportunities in the workplace. Four of the WRES indicators relate specifically to workforce data; four are based on data from the national NHS Staff Survey questions (or equivalent staff survey questions), and one considers BME representation on boards. Although national healthcare organisations (often referred to as 'Arm's Length Bodies' or 'ALBs') are not required to report on the WRES, many do and have been implementing the WRES since its inception. For the first time this year, six national healthcare organisations agreed to collectively report against the indicators. This report presents data for six national healthcare bodies, against all of the nine WRES indicators as at March 2017 and where available compares it to their respective data for 2016.

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

4.2 Data sources and reporting dates

On request, individual organisations submitted their WRES data directly to the WRES Implementation team. To help facilitate accuracy and consistency of data collection, a central data collection template was provided to each organisation. Once returned, the data were reviewed further and checked for accuracy. Any anomalies in the data were raised with the respective organisation.

The Electronic Staff Record (ESR) system can prove useful in capturing data, particularly with regard to staff grades (WRES indicator 1), recruitment (WRES indicator 2), training (WRES indicator 3) and grievances (WRES indicator 4). Those national healthcare organisations that were using the ESR system, accessed their relevant WRES data from those systems, those organisations not using ESR had alternative data capture systems. Not all organisations use the Agenda for Change pay scales; in such cases, organisations reported data in relation to salary range.

With regard to WRES indicators 5 to 8, which are based on staff survey responses, organisations submitted data from their most recent staff survey findings – in most cases these were data from their 2016 staff surveys, which were made available in

2. https://www.england.nhs.uk/wp-content/uploads/2017/03/wres-technical-guidance-2017.pdf

2017. It should be noted that NHS Improvement started as an organisation on 1 April 2016, therefore there are no data for this organisation prior to that date.

The submission of WRES data took place between November 2017 and February 2018.

4.3 Data analyses

Data from the six national healthcare organisations are presented against each of the nine WRES indicators. Where appropriate and possible, data are compared over time and the national average for NHS trusts is provided. Where available, the data presented for WRES indicators 5 to 8 show percentage responses by BME staff for 2016 in comparison to 2015.

For some of the indicators, the data were analysed to show 'likelihood' and 'relative likelihood' of an outcome. It is helpful to outline the differences between these two concepts. 'Likelihood' is the probability or chance or something occurring. This is calculated as a percentage. For example, if 12 out of a total of 200 members of staff at trust X entered the disciplinary process, then the likelihood that a member of staff at trust X entered the disciplinary process is 6%. In other words 6 out of every 100 members of staff at trust X will have entered the disciplinary process.

'Relative likelihood' compares the likelihood of something occurring in one sample/population of people compared to a different sample/population. For example, if in trust Y, the likelihood that a member of staff entered the disciplinary process is 12%, then the relative likelihood that a member of staff at trust Y entered the disciplinary process compared to a member of staff trust X is 2.0. In other words, a member of staff at trust Y is twice as likely to have entered the disciplinary process compared to a member of staff at trust X.

4.4 Data issues and caveats

1. Four of the WRES indicators are drawn from organisational staff surveys. The reliability of the data is dependent on the size of samples surveyed and response rates – small samples and response rates may undermine confidence in the data and in the subsequent conclusions drawn.

2. Organisations submitting data do not use the same staff grading frameworks and not all have an Executive Board. In addition, not all of the national healthcare organisations undertook a staff survey; this limited the level of analyses that could be carried out with regard to WRES indicators 5 to 8.

3. The 'conditions' against which WRES performance is measured may impact the data. For example, if an organisation is undergoing (or had recently undergone) a merger, a major restructure or is under exceptional financial pressures, that may impact on WRES indicator data. However, not one of these pressures means workforce race equality is not a priority. In fact, in such circumstances of change and transformation, it is even more important to ensure equality, inclusion and compassionate leadership remain central to both strategy and itsoperational expression.

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

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

6. The data collected are for 'white', 'BME' and 'unknown/null' ethnicity categories. However, for WRES indicator 1 and indicator 9, some organisations reported a significant number of 'unknown/null' classifications. This limits the analysis and conclusions that can be drawn from the data, especially when dealing with small numbers. The issue of data quality is looked at in more depth within the 'Next steps and conclusion' section of this report.

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

8. Whilst precautions and checks have been undertaken to ensure data are accurate, it should be noted that the quality and accuracy of data submitted does vary by organisation.

05 Detailed findings: 2017 data

5.1 WRES indicator 1: Percentage of staff in each band and VSM compared with the percentage of staff in the overall workforce

5.1.1 Data sources and reliability

The data for WRES indicator 1 were submitted using the template provided by the WRES team. All six national healthcare organisations submitted data for this indicator.

Public Health England workforces are made up of both Civil Service and Agenda for Change (AfC) bands, and the Care Quality Commission has its own pay and grading framework. In addition, NHS Improvement also has two sets of pay scales: Monitor and AfC. For the purpose of WRES data collection and analyses, the Civil Service and Monitor pay bands were converted to salary pay scales. However, these pay scales are not always directly comparable to the AfC bands; as such, for some of these organisations, additional data analyses have been carried out.

5.1.2 Overall results

- Four of the six organisations have BME staff representation that is lower than the national average for NHS trusts in England. It should be noted that each of these organisations have offices in London where 40% of the population is of BME origin and 43% of NHS staff across the region as a whole are from a BME background. Though the number of staff within respective London offices, overall, will vary between the national organisations.

- Since 2016, three organisations have seen an increase in the overall percentage of BME staff; one organisation has seen no change, and one has seen a decrease. BME staff are over-represented in 'support' (1-4) and 'middle' (5-7) AfC bands, and are under-represented in 'senior' (8a-9) and in the very senior management (VSM) bands across all organisations.

- All organisations reported more than double the percentage of unknown ethnicity compared to the average reported by NHS trusts across the country.

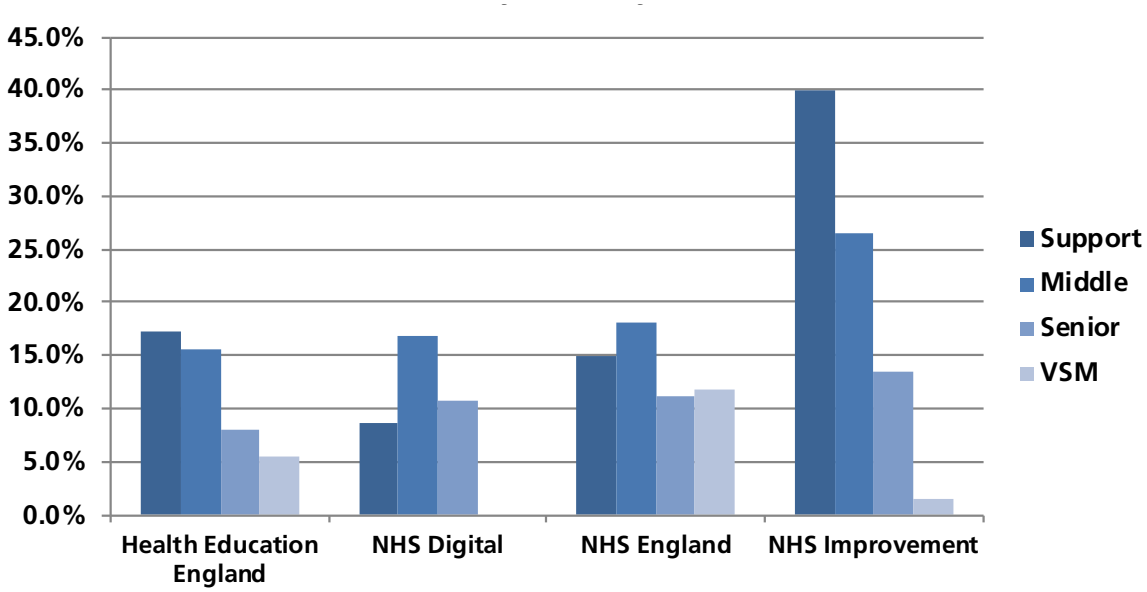
Having accurate information about the ethnic make-up of the workforce is key to the WRES; not just for reporting per se, but also for identifying areas where an organisation can improve, and where there are areas of good practice. Improving the quality of ethnicity recording should be a priority for all organisations going forward.

Table 1. Workforce by ethnicity: 2017

Organisation	White	BME	Unknown
Care Quality Commission	78.3%	12.7%	9.1%
Health Education England	77.0%	13.5%	9.5%
NHS Digital	78.2%	13.1%	8.9%
NHS England	73.7%	14.0%	12.3%
NHS Improvement	67.0%	16.4%	16.6%
Public Health England	65.9%	17.7%	16.3%
NHS trust average	**79.9%**	**16.3%**	**3.8%**

- The percentage of BME staff by organisation ranged from 12.7% at the Care Quality Commission, to 17.7% at Public Health England. The national average of BME staff across NHS trusts is 16.3%. See table 1.
- Four of the six organisations have BME staff representation that is lower than the national average for NHS trusts. NHS Improvement and Public Health England have a percentage of BME staff that is higher than the NHS trust average.
- All organisations reported more than double the percentage of 'unknown' staff ethnicity compared to the NHS trust average of 3.8%.

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



- Figure 1 presents the percentage of BME staff by AfC bands in 2017. For all organisations BME staff were over-represented in the support and 'middle' staff bandings (AfC bands 5-7) and under-represented in the 'senior' (AfC bands 8a-9) and VSM bands.

- At NHS Improvement, BME staff constitute 16.4% of the total workforce, but comprise 40% of 'support' (AfC bands 1-4 or equivalent) roles, 26% of 'middle' bands, and only 1.4% of VSM bands.

Table 2. Percentage of BME staff at VSM pay bands: 2017

Organisation	White	BME	Unknown
Health Education England	63.0%	5.6%	31.5%
NHS Digital	85.7%	0.0%	14.3%
NHS England	66.4%	11.8%	21.8%
NHS Improvement	86.3%	1.4%	12.3%
Public Health England *	72.1%	4.9%	23.0%
NHS trust average	**87.4%**	**5.7%**	**6.9%**

** Public Health England senior staff are paid on a combination of Senior Civil Service (SCS), Agenda for Change, Medical and Dental, and legacy terms and conditions following its creation as a Civil Service body in April 2013.*

- NHS England has the highest percentage (11.8%) of BME staff in VSM roles, whilst NHS Digital has none. See table 2.

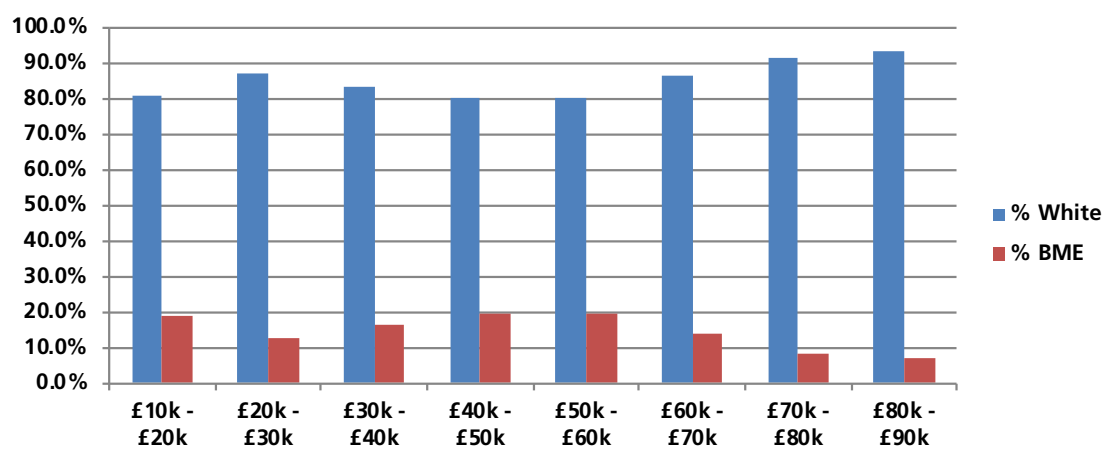
- For Public Health England, BME staff constitute 4.9% of all VSM and Senior Civil Service 1-3 grades, white staff make up just over 72% of these grades, with 23% as unknown or not stated. A significant number of senior managerial roles are undertaken by medical and dental consultants. See table 3 below.

Table 3. Medical and Dental staff ethnicity within Public Health England: 2017

	White	BME	Unknown
Consultant	62.8%	26.7%	10.5%
Non-consultant medical	55.6%	44.4%	0.0%

- As table 3 shows, across Public Health England, BME staff make-up 26.7% of consultants and 44.4% of non-consultant medical.

Figure 2. Percentage of staff ethnicity by pay band for Care Quality Commission: 2017



- At the Care Quality Commission, BME workforce comprises 18.8% of staff at the lowest salary range (£10k - £20k) and 6.8% of staff at the highest salary range (£80k - £90k). See Figure 2.

Table 4. Percentage of BME staff: 2016 compared to 2017

Organisation	2016	2017	Change
Health Education England	12.6%	13.5%	0.8%
NHS Digital	11.3%	13.1%	1.8%
NHS England	11.6%	14.0%	2.4%
NHS Improvement	19.1%	16.4%	-2.7%
Public Health England	17.7%	17.7%	0%
NHS trust average	**17.7%**	**16.3%**	**-1.4%**

- Table 4 shows that three organisations have seen an increase in the overall percentage of BME staff since 2016, one had no change and one saw a decrease:
  - NHS Digital had a 1.8 percentage point increase in its BME workforce between 2016 and 2017, whilst NHS England had a 2.4 percentage point increase in the same period.

- NHS Improvement has seen a 2.7 percentage point decrease in the percentage of BME staff in the same period, whilst for Public Health England there was no change.

- As noted above, NHS Improvement was the only organisation that saw a drop in the percentage of BME staff between 2016 and 2017. Further analyses of the data for this organisation show:

  - Between 2016 and 2017, there was a net decrease in numbers of BME staff by 18 and a net increase in white staff by 20.

  - There were increases in the percentage of BME staff in the AfC bands 4, 5, 7 and 8b; these were due to a decrease in white staff rather than an increase in BME staff.

  - At VSM level, there were 14 new members of staff. New BME staff accounted for 7.1% (1 person), whilst white staff account for 85.7% (12 people), and 7.1% (1 person) have not declared their ethnicity (i.e. unknown).

5.2 WRES indicator 2 – Relative likelihood of staff being appointed from shortlisting across all posts

5.2.1 Data sources and reliability

All six organisations submitted data for 2017; however for this indicator, NHS Improvement provided data for the period of September 2016 to December 2017.

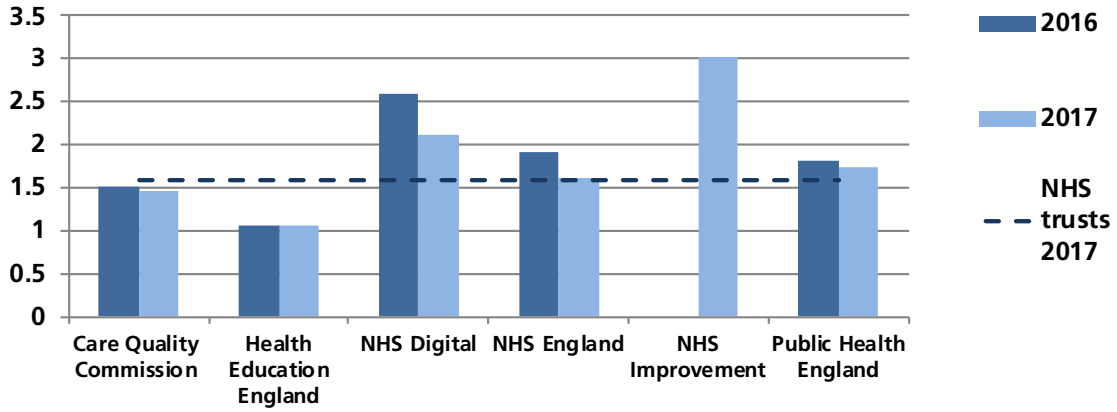
5.2.2 Overall results

- The relative likelihood of white staff being appointed from shortlisting compared to BME staff was as high as 3.03 for one organisation. The NHS trust average for 2017 was 1.60.
- In all six organisations there was a greater likelihood of white staff being appointed from shortlisting compared to BME staff.
- In two of the organisations, it was more than twice as likely that white staff would be appointed from shortlisting compared to BME staff.
- For all organisations that provided 2016 data, there was a decrease in the relative likelihood of white staff being appointed from shortlisting in 2017.

Table 5. Relative likelihood of white staff being appointed from shortlisting compared to BME staff: 2016 and 2017

Organisation	2016	2017
Care Quality Commission	1.51	1.47
Health Education England	1.06	1.05
NHS Digital	2.59	2.13
NHS England	1.93	1.60
NHS Improvement	-	3.03
Public Health England	1.82	1.73
NHS trust average	**1.57**	**1.60**

Figure 3: Relative likelihood of white staff being appointed from shortlisting compared to BME staff: 2017



- As figure 3 shows, the relative likelihood of white staff being appointed from shortlisting ranges from 1.05 for Health Education England to 3.03 for NHS Improvement.

- NHS Digital, NHS Improvement and Public Health England were the only three organisations with relative likelihoods of white staff being appointed from shortlisting being higher than the overall NHS trust likelihood (1.60) across England.

- For all organisations that provided data for 2016, there was a welcomed decrease in the relative likelihood of staff white staff being appointed from shortlisting in 2017.

- The Care Quality Commission regulates both health and adult social care. The majority of its work, and a higher proportion of its workforce, is concerned with adult social care. It is important to note that there are differences in the ethnicity profile of the adult social care workforce and health workforce; consequently, any comparison with other organisations should be made with this point in mind.

Table 6. BME shortlisting and appointments: 2017

Organisation	BME staff as a % of total shortlisted	BME staff as a % of total appointed
Care Quality Commission	20.0%	14.5%
Health Education England	29.9%	28.8%
NHS Digital	27.2%	13.3%
NHS England	30.0%	21.2%
NHS Improvement	63.9%	36.8%
Public Health England	39.4%	27.3%
NHS trust average	**31.3%**	**22.1%**

- Across the six organisations, BME staff comprise between 20.0% to 63.9% of total shortlisted staff. The NHS trust average is 31.3%. Table 6 also shows that BME staff appointments range from 13.3% to 36.8%; whilst the NHS trust average for the same is 22.1%.

Table 7. Likelihood of staff being appointed from shortlisting: 2017

Organisation	White staff	BME staff
Care Quality Commission	14 in 100	10 in 100
Health Education England	71 in 100	68 in 100
NHS Digital	13 in 100	6 in 100
NHS England	9 in 100	6 in 100
NHS Improvement	5 in 100	2 in 100
Public Health England	16 in 100	9 in 100
NHS trust average	**19 in 100**	**12 in 100**

- There are differences in the likelihood of staff being appointed following shortlisting between the various organisations. This may indicate significantly different recruitment processes. Each organisation should review its recruitment process in order to understand reasons for the variation.

- The likelihood of shortlisted BME staff that are appointed following shortlisting ranged from 2 in 100 for NHS Improvement, to 68 in 100 for Health Education England. In comparison, for white staff it ranged from 5 in 100 for NHS Improvement, to 71 in 100 for Health Education England. The high rate of appointment from shortlisting for Health Education England is, in part, likely to be reflective of its national role in the mass recruitment of apprentices and healthcare professionals.

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

5.3.1 Data sources and reliability

NHS Digital provided 2017 data only, for this indicator. Health Education England reported that no staff had entered their formal disciplinary process in 2016 or in 2017.

5.3.2 Overall results

- Across the five organisations that submitted 2017 data for this WRES indicator, the range of the relative likelihood of BME staff entering the formal disciplinary process is between 1.20 (NHS Digital) to 2.63 (NHS England). The NHS trust average likelihood for the same period is 1.37.

- For two organisations that provided both 2016 and 2017 data, there was a decrease in the relative likelihood of BME staff entering the formal disciplinary process compared to white staff in 2017.

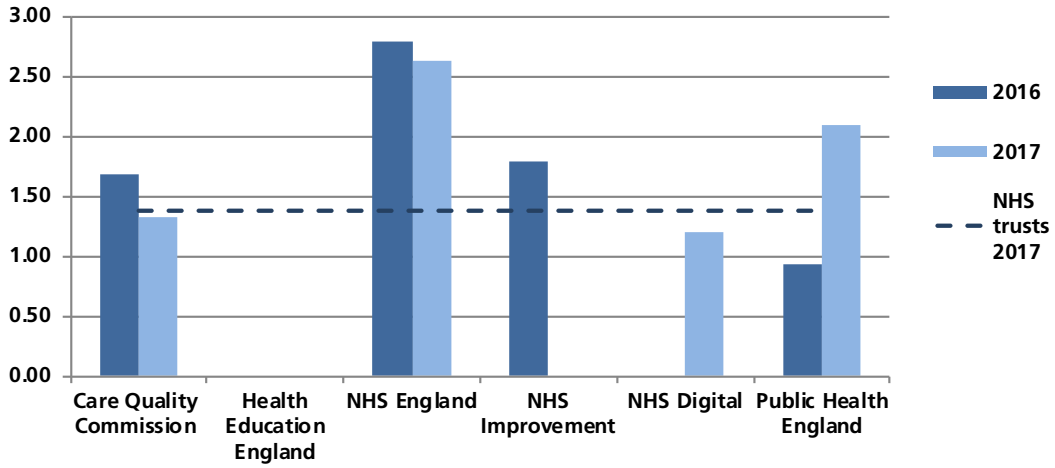
Table 8. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff: 2017

Organisation	2016	2017
Care Quality Commission	1.68	1.33
Health Education England	0.00	0.00
NHS England	2.79	2.63
NHS Improvement	1.79	N/A
NHS Digital	0.00	1.20
Public Health England	0.93	2.09
NHS trust average	**1.56**	**1.37**

- For four out of the five organisations that submitted data for 2017, BME staff were relatively more likely to enter the formal disciplinary process compared to white staff. See table 8.

- As only one person entered the formal disciplinary process in 2017 for NHS Improvement, the relative likelihood calculation could not be undertaken.

Figure 4: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff: 2016 compared to 2017



- As figure 4 shows, for two organisations that provided 2016 data, there was a decrease in the relative likelihood of BME staff entering the formal disciplinary process compared to white staff in 2017.

- Public Health England saw an increase in the relative likelihood from 0.93 to 2.09

Table 9. Likelihood of staff entering the formal disciplinary process: 2017

Organisation	White staff	BME staff
Care Quality Commission	1 in 117	1 in 102
NHS Digital	1 in 149	1 in 125
NHS England	1 in 251	1 in 96
NHS Improvement	0	1 in 168
Public Health England	1 in 218	1 in 104

**0 white staff at NHS Improvement went through the formal disciplinary process during stated period.*

- The likelihood of BME staff entering the formal disciplinary process varies significantly between the different organisations, ranging from 1 in 96 (NHS England) to 1 in 168 (NHS Improvement). See table 9.

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

5.4.1 Data sources and reliability

Only two organisations, Health Education England and NHS England, were able to provide data for this WRES indicator. This is due to the fact that data on non-mandatory training, courses and other career progression and development opportunities are not readily recorded within national healthcare organisations systems. We know this is also the case across local NHS organisations too, though perhaps to less an extent. It is nonetheless an area that needs further focus across all types of healthcare organisations.

5.4.2 Overall results

- For the two organisations that did provide data, BME staff are equally, or slightly more, likely to access non-mandatory training and career progression development (CPD).
- This compares favourably against the average for NHS trusts, where the relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff is 1.22.
- As BME staff are more likely to be located in lower AfC bands (see results for WRES indicator 1), access to CPD is an important enabler to career progression and promotion.

Table 10. Relative likelihood of staff accessing non – mandatory training and career progression development (CPD): 2016 and 2017

Organisation	2016	2017
Health Education England	1.05	1.00
NHS England	0.87	0.90
NHS trust average	**1.11**	**1.22**

- As table 10 shows, in Health Education England, BME and white staff were equally likely to access non-mandatory training and CPD. This finding being constant in both 2016 and 2017.

- At NHS England, white staff were less likely to access non-mandatory training and CPD compared to BME staff. Again, this finding is similar for both 2016 and 2017.

Table 11. Percentage of staff accessing non–mandatory training and career progression development (CPD): 2016 and 2017

Organisation	White staff	BME staff
Health Education England	44.0%	44.0%
NHS England	45.5%	50.7%
NHS trust average	**48.2%**	**39.5%**

- White staff in both Health Education England (44.0%) and NHS England (45.5%) were less likely to access mandatory training and CPD compared to the NHS trust average (48.2%).

- BME staff in both organisations were more likely to access mandatory training and CPD compared to the NHS trust average for BME staff. See table 11.

5.5 WRES indicator 5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

5.5.1 Data sources and reliability

Although the Care Quality Commission and NHS England provided some data for this indicator, due to the low number of responses, the data could not be analysed. This is not a data quality issue; rather it is a reflection of the fact that, in the main, the national healthcare organisations are not patient-facing.

5.6 WRES indicator 6 – Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

5.6.1 Data sources and reliability

The data for this indicator are taken from staff surveys carried out by the organisations. Five organisations provided data for this indicator: the Care Quality Commission, Health Education England, NHS England, NHS Improvement and Public Health England.

Staff surveys help employers measure and understand their employees' attitude, feedback, motivation, and satisfaction. This can provide a detailed picture of the current state of the organisation. Ultimately, these insights can be used as the foundation for improving organisations. National healthcare organisations are encouraged to carryout staff surveys, as a census across their entire workforce.

As with all survey-based indicators, the data and their comparisons can be limited by varying response rates between organisations.

5.6.2 Overall results

- BME staff are more likely to report experiencing harassment, bullying or abuse from staff compared to white staff in four out of the five organisations that provided data for this indicator.

- Compared to the NHS trust average, a lower percentage of staff across all national healthcare organisations reported experiencing harassment, bullying or abuse from staff in last 12 months – this was true for both white and BME staff.

- NHS England observed a decrease in the percentage of BME staff reporting the experience of harassment, bullying or abuse, whilst the Care Quality Commission saw a slight increase.

Table 12. Percentage of staff experiencing harassment, bullying or abuse from other staff in last 12 months: 2016

Organisation	White staff	BME staff
Care Quality Commission	11.0%	14.0%
Health Education England	22.0%	22.0%
NHS Digital	8.0%	13.0%
NHS England	18.0%	25.0%
NHS Improvement	N/A	N/A
Public Health England	10.0%	15.0%
NHS trust average	**23.0%**	**26.0%**

- As table 12 shows, in the Care Quality Commission, NHS Digital, NHS England and Public Health England, a higher percentage of BME staff reported experiencing harassment, bullying or abuse from staff in last 12 months compared to white staff.
- For Health Education England, an equal percentage of BME and white staff reported experiencing harassment, bullying or abuse from staff.
- NHS Improvement does not currently have an equivalent question on the experience of harassment, bullying or abuse in their staff survey.
- For all organisations submitting data on this indicator the percentage of staff that reported experiencing harassment, bullying or abuse from staff is lower than the national NHS trust average.

Table 13. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months: 2015 and 2016

Organisation	White staff 2015	BME staff 2015	White staff 2016	BME staff 2016
Care Quality Commission	10.0%	11.0%	11.0%	14.0%
NHS England	21.0%	31.0%	18.0%	25.0%
NHS trust average	**24.0%**	**27.0%**	**23.0%**	**26.0%**

- The percentage of BME staff in NHS England reporting the experience of harassment, bullying or abuse from staff fell from 31% in 2015, to 25% in 2016. For white staff it fell from 21% to 18%. For the Care Quality Commission, there were slight increases in both white and BME staff experiences for the same periods. See table 13.

5.7 WRES indicator 7 – Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion

5.7.1 Data sources and reliability

The data for this indicator are taken from staff surveys carried out by the organisations. Four organisations provided data for this indicator: the Care Quality Commission, Health Education England, NHS England, and NHS Improvement.

Two organisations, Care Quality Commission and NHS England, provided data for both 2015 and 2016. NHS Improvement provided data for 2016 as it became an organisation on 1 April 2016; hence data are not available prior to this date.

As with all survey-based indicators, data can be limited by varying response rates between organisations.

The importance of carrying out staff surveys on a routine basis, including questions such that which relates to this WRES indicator, is encouraged.

5.7.2 Overall results

- For all organisations that provided data, BME staff are less likely to report the belief that their organisation provides equal opportunities for career progression or promotion across.

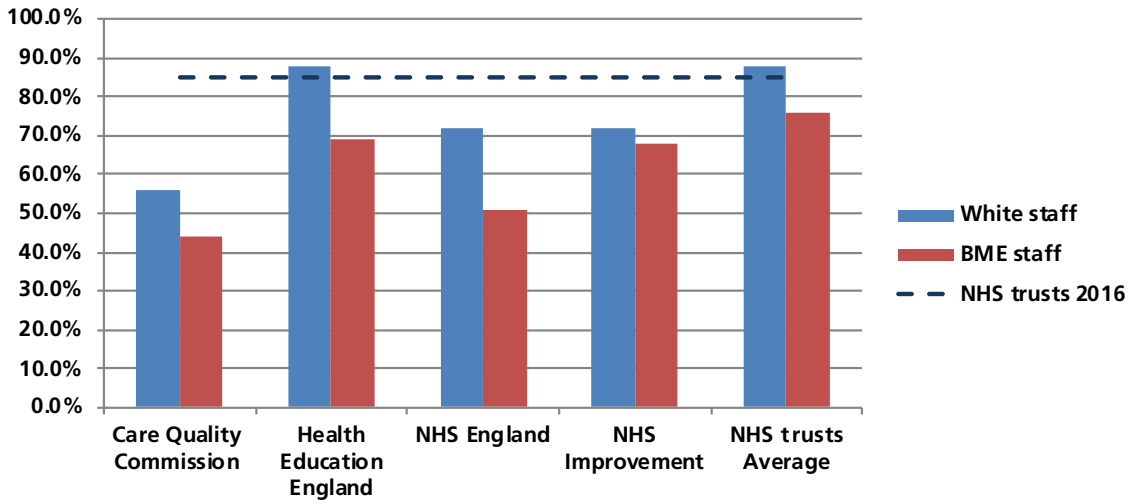
- The difference between white and BME staff believing that their organisation provides equal opportunities for career progression or promotion ranges from 4% to 21%.

Table 14. Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion: 2016

Organisation	White staff	BME staff
Care Quality Commission	56.0%	44.0%
Health Education England	88.0%	69.0%
NHS England	72.0%	51.0%
NHS Improvement	72.0%	68.0%
NHS trust average	**88.0%**	**76.0%**

- As table 14 shows, compared to the national NHS trust average, a lower percentage of staff in Care Quality Commission, NHS England and NHS Improvement believe that their organisations provide equal opportunities for career progression or promotion.

Figure 5: Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion: 2016



- At 21%, NHS England has the biggest difference between of BME and white staff on this indicator. Followed by Health Education England with a 19% difference.

- NHS Improvement has the smallest difference between white and BME staff (80% and 78% respectively).

- The Care Quality Commission has the lowest percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. This is true for both white and BME staff.

- Apart from white staff at Health Education England, the percentage of staff reporting that they believe that their organisation provides equal opportunities for career progression or promotion is lower for all other organisations compared to the NHS trust average of 85%.

Table 15. Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion: 2015 and 2016

Organisation	White staff 2015	BME staff 2015	White staff 2016	BME staff 2016
Care Quality Commission	61.0%	52.0%	56.0%	44.0%
Health Education England	0.0%	0.0%	88.0%	69.0%
NHS England	55.0%	37.0%	72.0%	51.0%
NHS Improvement	N/A	N/A	72.0%	68.0%
NHS trust average	**89.0%**	**74.0%**	**88.0%**	**76.0%**

- The Care Quality Commission has seen a decrease between 2015 and 2016 in the percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. This is true for both white and BME staff.

- NHS England has seen an improvement for both white and BME staff on this WRES indicator.

5.8 WRES indicator 8 – In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleague?

5.8.1 Data sources and reliability

The data for this indicator are taken from staff surveys carried out by the national organisations. Five organisations provided data for this indicator: the Care Quality Commission, Health Education England, NHS England, NHS Improvement and Public Health England.

Two organisations, Care Quality Commission and NHS England, were able to provide data for both 2015 and 2016. NHS Improvement became an organisation on 1 April 2016; hence data for this organisation are not available prior to this date.

Again, as with all survey-based indicators, data can be limited by varying response rates between organisations.

5.8.2 Overall results

- For all organisations submitting data, BME staff were more likely to report having personally experienced discrimination at work from a manager, team leader or other colleague.

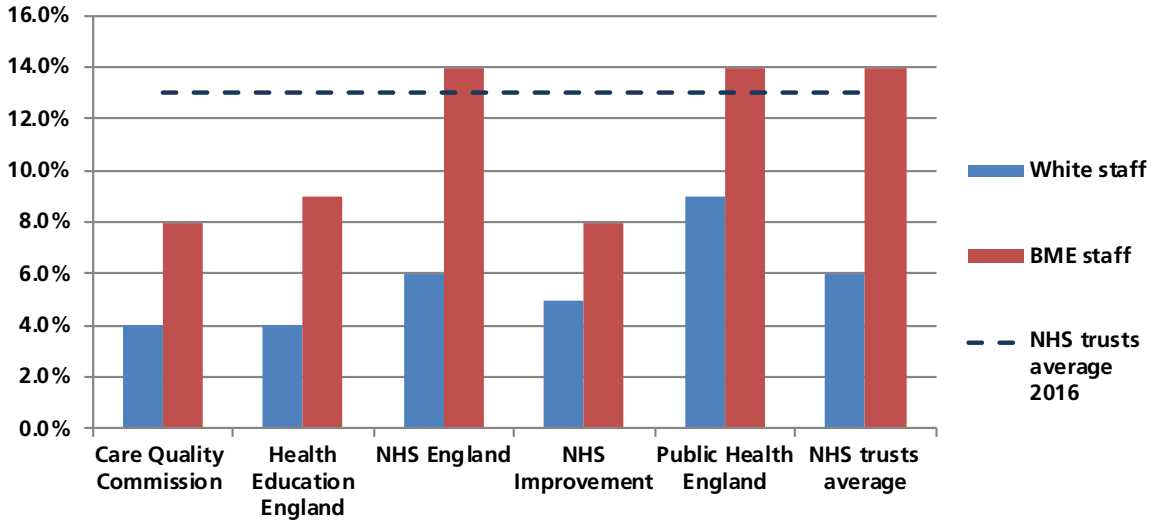
Table 16. Percentage of staff reporting have you personally experienced discrimination at work from a manager, team leader or other colleague: 2016

Organisation	White staff	BME staff
Care Quality Commission	4.0%	8.0%
Health Education England	4.0%	9.0%
NHS England	6.0%	14.0%
NHS Improvement	5.0%	8.0%
Public Health England	9.0%	14.0%
NHS trust average	**6.0%**	**14.0%**

- For all organisations BME staff were more likely to report having personally experienced discrimination at work from a manager, team leader or other colleague in the last 12 months.

- BME staff in Health Education England and in NHS England were more than twice as likely as white staff to report having personally experienced discrimination.

Figure 6: Percentage of staff reporting having personally experienced discrimination at work from a manager / team leader or other colleagues: 2016



- Public Health England staff reported the highest percentage of staff having personally experienced discrimination at work in the last 12 months for both white and BME staff.

Table 17. Percentage of staff reporting have you personally experienced discrimination at work from a manager, team leader or other colleague: 2015 and 2016

Organisation	White staff 2015	BME staff 2015	White staff 2016	BME staff 2016
Care Quality Commission	5.0%	7.0%	4.0%	8.0%
Health Education England	N/A	N/A	4.0%	9.0%
NHS England	9.0%	21.0%	6.0%	14.0%
NHS Improvement	N/A	N/A	6.0%	6.0%
Public Health England	N/A	N/A	9.0%	14.0%
NHS trust average	**6.0%**	**14.0%**	**6.0%**	**14.0%**

- NHS England showed a significant improvement between 2015 and 2016 in BME staff reporting the experience of discrimination at work from a manager, team leader or other colleague remained similar.
- For Care Quality Commission, the percentage of white staff reporting the experience of discrimination went down slightly (by 1%) between 2015 and 2016; however the percentage for BME staff went up slightly for the same period (also by 1%).

5.9 WRES indicator 9 – Percentage difference between the organisations' board membership and its overall workforce

5.9.1 Data sources and reliability

The data for WRES indicator 9 were submitted using the template provided by the WRES team. All six organisations were able to provide data for this indicator.

Care is needed when comparing the percentage of board members from each ethnic group in each board. Boards typically have between 11 - 24 members. Given these small numbers, differences in the number of board members declaring their ethnicity can have a large impact on the percentage of members in each ethnic group for each organisation. For this reason, we also present the percentage of members for whom we do not know ethnicity.

It should also be noted that Public Health England, as a Civil Service organisation, does not have an Executive Board. It has an Advisory Board that has no executive authority; it exists to advise, support and constructively challenge the Chief Executive of the organisation. The highest level of authority in Public Health England is the Management Committee of directors.

For all organisations submitting data, there was an exceptionally high number of staff with 'unknown' ethnicity. The quality and level of data capture is of critical importance and all organisations are encouraged to improve on this issue going forward.

5.9.2 Overall results

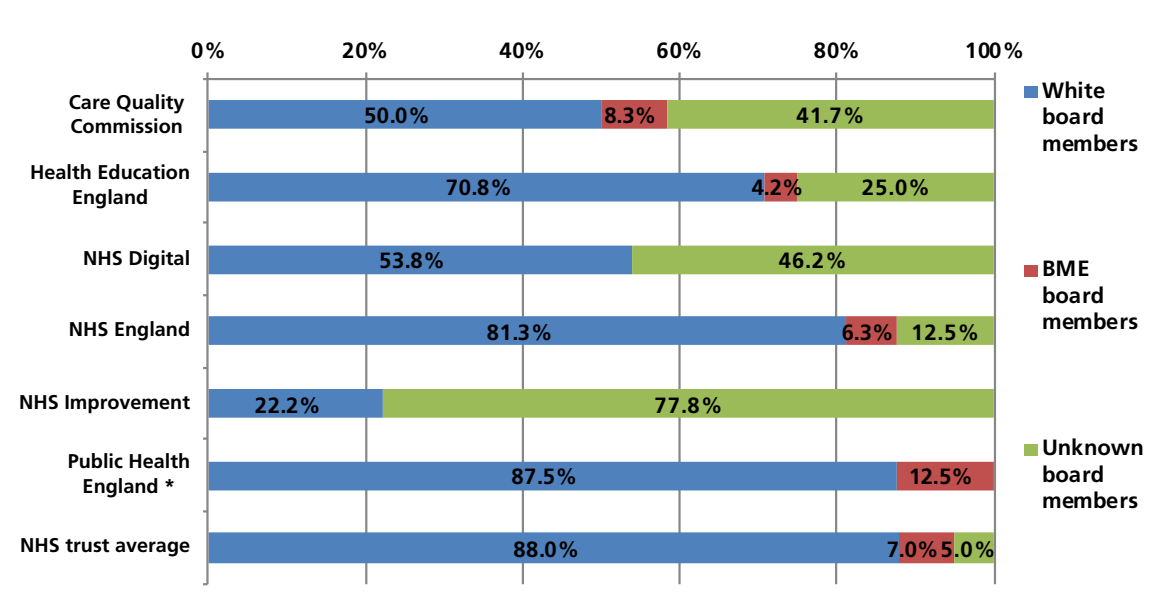
- For all organisations the percentage of BME staff on the board is lower than the overall percentage of the BME workforce in the organisation.
- Public Health England has two BME directors out of the total 16 directors that form the Management Committee. For all other organisations, there is no BME executive board member.
- NHS England has a BME voting board member, and Public Health England has two voting members on its Management Committee. No other organisation has BME voting members.
- Four organisations that submitted 2016 and 2017 WRES data for this indicator; there was no change in the number of BME executives for three of these organisations.

Table 18. Board membership by ethnicity: 2017

Organisation	White board members	BME board members	Unknown board members	Total board members
Care Quality Commission	6 (50.0%)	1 (8.3%)	5 (41.7%)	12
Health Education England	17 (70.8%)	1 (4.2%)	6 (25%)	24
NHS Digital	7 (53.8%)	0 (0%)	6 (46.2%)	13
NHS England	13 (81.3%)	1 (6.3%)	2 (12.5%)	16
NHS Improvement	4 (22.2%)	0 (0%)	14 (77.8%)	18
Public Health England*	14 (87.5%)	2 (12.5%)	0 (0%)	16
NHS trust average	**88.0%**	**7.0%**	**5.0%**	**-**

** Figures are for Public Health England's Management Committee*

Figure 7: Board members by ethnicity: 2017



** Figures are for Public Health England's Management Committee*

- As table 18 and figure 7 show, NHS Improvement and NHS Digital have no BME board members.
- Public Health England has two BME members on its Management Committee. All other organisations have one BME board member.
- NHS Improvement has a strikingly high proportion (77.8%) of membership with 'Unknown' ethnicity reported.

Table 19. BME voting board membership by ethnicity: 2017

Organisation	BME board members	BME voting	% BME
Care Quality Commission	1	0	0%
Health Education England	1	0	0%
NHS Digital	0	0	0%
NHS England	1	1	100%
NHS Improvement	0	0	0%
Public Health England*	2	2	100%
NHS trust average			**81.0%**

**Figures are for Public Health England's Management Committee*

- Public Health England has two voting members on its Management Committee. NHS England has one BME voting member on its board. The BME board member at the Health Education England is a non-voting member.

Table 20. Difference between the organisations' board membership and its overall workforce: 2017

Organisation	% BME board members	% BME workforce	Difference
Care Quality Commission	8.3%	12.7%	-4.3%
Health Education England	4.2%	13.5%	-9.3%
NHS Digital	0.0%	13.1%	-13.1%
NHS England	6.3%	14.0%	-7.7%
NHS Improvement	0.0%	16.4%	-16.4%
Public Health England	12.5%	17.7%	-5.2%
NHS trust average	**7.0%**	**16.3%**	**-9.3%**

** Figures are for Public Health England's Management Committee*

- As table 20 shows, all organisations have lower BME board representation compared to the proportion of BME staff in their organisation.

Table 21. BME board members by ethnicity: 2016 and 2017

Organisation	2016	2017
Health Education England	1	1
NHS Digital	0	0
NHS England	1	1
NHS Improvement	0	0

- For all organisations submitting data for this indicator, there is no difference in the number of BME board members between 2016 and 2017. See table 21.

- There is a clear ambition to increase BME representation across senior management and board level across the NHS. However, if we are to realise this ambition, we must develop critical workforce capabilities. Inclusive and compassionate leadership skills at all levels are important here; also crucial is effective talent management.

- Organisations, whether national or local, should strive towards filling current vacancies and nurturing future leadership pipelines with the correct numbers of diverse and appropriately developed people. And yet we know from data for WRES indicators 1 and 2, that this is currently not the case.

- Consequently, the leadership teams of all organisations should look again at their respective human resources and people development strategies to review priorities and target the building of these processes and capabilities.

06 Learning from effective interventions by WRES indicator theme

For the purpose of drawing upon good practice and effective interventions to support organisations with continuous improvement on workforce race equality, this section of the report groups the nine WRES indicators into four themes. A forthcoming publication from the WRES team, on good practice on workforce race equality in the NHS, will provide further in-depth evidence and examples of practical interventions across the WRES indicator themes.

The data for respective WRES indicators presented in section 5 of this report should be read alongside each of the themed areas. Triangulation of the data for these indicators facilitates a better, and more holistic, understanding of the relative treatment of white and BME staff in the workplace. The themed areas are:

- Recruitment and staff development (WRES indicators 1, 2, 4 and 7)
- Disciplinary action (WRES indicator 3)
- Bullying, abuse and discrimination (WRES indicators 6 and 8)
- Board representation and culture (WRES indicator 9)

6.1 Recruitment and staff development (WRES indicators 1, 2, 4 and 7)

Bias, whether conscious or unconscious, impacts upon every stage of the recruitment and promotion process: from how the job description and person specification are written, how positions are advertised, how secondment opportunities are made available and filled, how interviews and assessments are designed and conducted, and how the selection process is undertaken.

As we have stated in earlier WRES publications, unconscious bias training can be effective in prompting discussion on difficult issues, however on its own, it is unlikely to have the desired impact. Accountability and holding decision-makers to account for their actions is perhaps the best means of preventing bias in decision-making.

We know from research that there exist a number of ways to embed and reinforce accountability. Knowing that as a recruiting manager, shortlisting or interview panel member, you will have to justify your decision-making is likely to lead to more thorough thought processes. Indeed, holding individuals accountable for their personnel decisions is one way to reduce potential bias in recruitment and promotion.

Reducing bias in recruitment, promotion and staff development that often lead to inequality of opportunity between white and BME staff in the NHS, is essential if we are to meet the aspiration of realising representative leadership at all levels across the system. The approach of some NHS trusts to continuously improve on these WRES indicators has led to action planning that national healthcare organisations may want to look towards. Increasingly, NHS trusts are beginning to focus on strategic approaches and operational interventions in these areas.

Strategic approaches:

- Using WRES data to identify areas where there is a failure to recruit BME staff - deep dives within the organisation to spotlight directorates and divisions grades/ bands where blockages, 'glass ceilings' or 'sticky floors' are most prevalent. Quality Improvement (QI) methodology can be helpful in improving the patterns of appointments and promotion.

- Giving concerted focus on recruitment and promotion issues within their WRES action plans, and setting 'aspirational targets' for their organisation – some trusts are setting SMART equality objectives in these areas as part of their corporate response to the Public Sector Equality Duty.

- Reporting progress, on a regular basis, in this area to their trust board, analysing data by directorate, service, or occupation.

Operational interventions:

- Ensuring robust processes and procedures for recruitment are in place that will help to reduce any potential bias, and that such guidelines and good practices are adhered to and followed.

- Focussing upon levelling the playing field by providing equity of access to 'acting-up' (secondment) opportunities is a key enabler for career progression. Access to such opportunities should be especially encouraged amongst BME staff, and should focus on positions and grades that are under-represented within the organisation.

- Access to mentoring, reverse mentoring and shadowing should be encouraged. Senior leaders of the organisation have a critical role to play here as this is a unique opportunity to exhibit demonstrable leadership, not only in what is said, but also in what is actively undertaken.

6.2 Disciplinary action (WRES indicator 3)

There are occasions when disciplinary action is both appropriate and necessary within the NHS. Yet we know from WRES data for NHS trusts, and for the national healthcare bodies, that there are different rates of disciplinary action for white and BME staff, between similar types of organisations. Research suggests that very often, the disproportionate rate of entry into the disciplinary process for BME staff is due to the difficulty some managers may have in conducting informal conversations about practice or conduct.

Since the publication of the 2016 WRES data for NHS trusts, there has been a decrease in the overall likelihood of BME staff in the NHS entering formal disciplinary action, from 1.6 times more likely than white staff to 1.4 times more likely. Some trusts have carried out deep dives and root cause analyses within their organisations – including employing QI methodology to look at disciplinary rates within each directorate or division.

It will be interesting to observe the pattern of disciplinary action over time across the national healthcare organisations. They would benefit from looking towards models of standardised good practice in this area. There are, of course, a number of different good practice models. However, as a regional approach to this issue, the NHS trusts across London are undertaking an exercise to test the effectiveness of four such models in closing the gap in disciplinary action for BME and white staff:

- **Decision tree checklist –** an algorithm of structured questions to help managers decide whether formal action is required or whether alternatives may be feasible.
- **Reflective review –** at the conclusion of the formal disciplinary process, managers reflect on the case to discern any systemic weakness or bias.
- **Pre-formal action by a director –** a single person, at director level, reviews each case and decides whether it should proceed towards formal action.
- **Pre-formal action by a lay member –** a trained lay member of staff reviews each case and challenges any perceived bias in the process before cases go to the formal action stage.

Learning from exercises and intervention, such as that being undertaken across London NHS trusts, will be shared widely, including with the national healthcare bodies. The goal here is for the NHS, as a whole, to adopt a learning culture rather than a culture that is focussed upon blame and liability.

6.3 Bullying, harassment and discrimination (WRES indicators 6 and 8)

For all organisations submitting their data, the percentage of staff that reported experiencing harassment, bullying or abuse from colleagues is lower than the national NHS trust average – this is true for both white and BME staff. However for four of the six organisations, the level of harassment and bullying is higher for BME staff than for white staff.

We know that focusing on bullying and harassment alone is merely dealing with a symptom of a deeper cultural malaise that exists within an organisation and is unlikely to succeed. Consequently, attempts to eradicate bullying by introducing specific interventions have limited success.

We need to take a broader perspective and nurture cultures across the NHS in which bullying, harassment and discrimination are lessened. Although we are all responsible for nurturing culture within organisational systems, leaders (whether people or organisations) have a particular role to play. As we know, compassionate leadership is fundamental to a way of responding to the health and wellbeing of staff within the NHS.

The creation of Freedom to Speak Up Guardians is a critical contribution to supporting a more open culture within the NHS. We know, from Sir Robert Francis' 2015 report: 'Freedom to Speak Up – An independent review into creating an open and honest reporting culture in the NHS'[3] of the disproportionate bullying experienced by BME staff that raised concerns.

Therefore increasing the number of Guardians within organisations, particularly from BME backgrounds, is a welcomed approach. Some organisations are also funding and supporting broader action on establishing safe spaces for staff to raise concerns and on better support for staff health and wellbeing.

Those organisations that are taking steps to address bullying in a concerted manner are those that have agreed at board level that:

- Bullying of staff is linked to organisational effectiveness.
- Board members should model the behaviours that they expect of others and hold themselves to account.
- Sustained and meaningful staff engagement is important.
- There should be safe spaces for staff to raise their concerns and an endeavour to improve organisational climate.

3. http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

6.4 Board representation and culture (WRES indicator 9)

Across the national healthcare bodies, the proportion of BME representation on the board varies from 0% to 12.5%. Yet we know that organisations are more likely to be efficient, innovative and meet the needs of the workforce that they serve when leadership is drawn from diverse communities across the country.

The focus on workforce race equality is not a diversion from the urgent strategic challenges facing NHS organisations, whether local or national. Instead, race equality, and the wider inclusion agenda, can and must be a major part of the solution. We know that at board level, diverse teams make better and safer decisions. Organisations with more representative leadership are in a better position to engage the diverse workforce and communities they serve. Furthermore, at a time when 'business as usual' is not an option for any NHS organisation, not least a national body, the proven positive association between board diversity and innovation is persuasive.

Whilst we clearly need a greater diversity of people on boards, we also know that simply changing the demographics of a board is not enough. Boards need to be compassionate, values-driven and should uphold the following principles:

- **Awareness of bias:** A board committed to equality develops individuals' awareness and understanding of their own biases. It also assists its members in developing the skills to understand and moderate their behaviour and their decision-making.

- **Inclusivity:** A fair board is conscious of its collective behaviour. It challenges itself to see its functions from the perspectives of others, and its members recognise their role as leaders of culture, setting the values and behaviours they want others to acquire.

- **Shared decision-making:** A diverse board recognises that better decisions may arrive through diversity of thought and challenge. It also knows that a 'good' board is not always one where everyone agrees with one another and where decisions are easily made.

- **Modelling behaviour:** Board members, as leaders, must embody the values they want the organisation to uphold. An important way of doing this is to set out a clear organisational vision for equality, diversity and inclusion, one that shows how equality is linked to the organisation's core values and objectives.

As noted earlier in this report, the area of talent management is absolutely critical here. Organisations cannot establish diversity across boards if there are very few staff from diverse backgrounds already at senior management levels. There is a need to fill current vacancies and future leadership pipelines with the correct numbers of people from diverse backgrounds.

We need to move beyond an agenda traditionally led by equality and diversity champions to one led by the whole board. This means shifting the focus on 'making up the numbers', to also one where the culture of inclusive and compassionate leadership is a core competency for all senior staff. Accountability and monitoring the level of progress against these objectives will be critical, and will be a key area of attention for the WRES team going forward.

National healthcare organisations can take learning from a growing number of NHS trusts that are already setting themselves targets to align the BME representation of their board with the proportion of the BME workforce in their organisation. Some trusts are working towards developing SMART corporate equality objectives based upon such 'aspirational targets', as part of their response to the Public Sector Equality Duty.

07 Next steps and conclusions

The WRES is designed to help initiate continuous improvement in the treatment of, and opportunities for, BME staff across the NHS. The design and effective system alignment of the WRES has, to date, been planned around implementation by local NHS organisations. However, in the spirit of openness and transparency, the national healthcare bodies have taken the admirable decision to implement the WRES themselves.

Whilst the data for these organisations suggest that much work is needed, these organisations recognise the undeniable fact that tackling workforce race equality is no longer an optional extra. Returns on investment on this agenda are cumulative and measurable in terms of better outcomes for patients, greater employee engagement and satisfaction, and more productive and efficient use of resources.

This report is an important reminder of the opportunity facing the boards of national healthcare bodies to lead by example on this agenda. However, data and evidence is just one of the pieces needed to complete the jigsaw of conditions that require simultaneous attention in order to shift the dial on workforce race equality. Consequently, organisations should not be under the illusion that merely submitting their annual WRES data is the end stage of this process – rather it is merely the beginning.

Based upon evidence and the data presented in this report, the following 10 recommendations are made to the national healthcare bodies:

- Improve the quality of data collections, including ethnicity monitoring of staff at all levels
- Carryout routine staff surveys, ensuring a census of the entire workforce rather than sample surveys
- Conduct deep dives into the WRES data to fully understand the root cause of issues
- Ensure BME staff are involved in discussions regarding the WRES data and associated action plans
- Identify a board member responsible for the WRES (and for the equality agenda in general)

- Establish and support the development of a BME staff group or network within the organisation
- Set aspirational (and Specific Measurable Achievable Realistic Timley) targets in relation to the WRES indicators – including one to increase BME executive board membership
- Embed and mainstream equality, diversity and inclusion within the day-to-day business of the organisation
- Identify sufficient resources to work on, and lead, this complex agenda within the organisation
- Work closely with the other organisations within your healthcare footprint – to help facilitate learning and the sharing of replicable good practice

It is clear that it should not only be local NHS organisations that lead on the agenda to continuously improve and create lasting change; national action and support is also critical. And it would not be right if national organisations were monitoring, assuring and regulating this agenda with regard to local NHS organisations, and were not, at the same time, 'taking their own medicine'. The national WRES team is therefore committed to supporting the national healthcare bodies and their boards on the journey of continuous improvement in this area, just as it is currently doing for local NHS organisations across the country.

Having 'warmed-up' the system on the workforce race equality agenda, the next phase of the WRES programme will look to embed even greater accountability and the measurement of progress on these indicators – underpinned by amplifying cultures of continuous improvement across all local and national healthcare organisations.

Annex: The WRES indicators (2017)

	Workforce indicators For each of these four workforce indicators, compare the data for white and BME staff
1	Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM compared with the percentage of staff in the overall workforce disaggregated, if appropriate, by: • Non-clinical staff • Clinical staff, of which - Non-medical staff - Medical and dental staff Note: For organisations that do not use the AfC bandings, salary ranges were used instead
2	Relative likelihood of staff being appointed from shortlisting across all posts. Note: This refers to both external and internal posts.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year.
4	Relative likelihood of staff accessing non-mandatory training and CPD.
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff
5	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 their organisation 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