NHS England

Frequently Asked Questions on the NHS Workforce Race Equality Standard (WRES)

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Frequently Asked Questions on the NHS Workforce Race Equality Standard (WRES)

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The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

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NHS Workforce Race Equality Standard: Frequency Asked Questions (FAQs)

Q1: Why is the NHS now taking mandatory action to ensure race equality and fair treatment for its black and minority ethnic (BME) workforce?

A: The systemic discrimination against Black and Minority Ethnic (BME) staff within the NHS is highlighted in numerous reports and studies. These show that by every indicator BME staff have a less favourable treatment and a worse experience of working in the NHS than other members of staff. This is important not just because of the costs to those staff and the NHS as a whole of such treatment, but because, equally importantly, we also know through work done by Professor Mike West and Professor Jeremy Dawson that there is spiral of positivity in organisations that have an engaged, motivated and enthusiastic staff. Being undervalued and discriminated against leads to disengagement, unhappiness, depression, poor performance and ultimately reduced effectiveness. This is true for everyone but Professor West's (2011)[1] research shows that:

> 'the greater the proportion of staff from a black or minority ethnic (BME) background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction, the experience of BME staff is a very good barometer of the climate of respect and care for all within NHS trusts'.

The NHS Equality and Diversity Council which proposed the Workforce Race Equality Standard is NOT suggesting other forms of equality are less important but it is clear that race discrimination is an important issue within the NHS and there has been little if any improvement in recent years. 17% of NHS staff are from BME backgrounds, including 20% of nurses and 37% of doctors, and we now know that tackling their unfair treatment benefits patient care so it is clearly a priority.

[1] West, M. Dawson, J. NHS Staff Management and Health Service Quality, Aston Business School. (2011).

Q2: What steps has the NHS taken to tackle race inequality in the NHS workforce?

A: On 29 July 2014 the NHS Equality and Diversity Council pledged its commitment, subject to consultation within the NHS, to implement two measures to improve equality across the NHS, starting from April 2015.

The first was a Workforce Race Equality Standard (WRES) that would, for the first time, require organisations employing almost all of the 1.4 million NHS workforce to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.

Alongside the WRES, the NHS Equality Delivery System (EDS2) also became mandatory. EDS2 aims to help organisations improve the services they provide for their local communities and provide better working environments for all groups. Since April 2015, the WRES and EDS2 have been included in the NHS standard contract.

The regulators – including the Care Quality Commission – are also using the WRES as part of their inspection programme to help assess whether organisations are 'well-led'.

Q3: Is there a good summary of the case for such an approach?

A: There are several. In 2014, NHS Providers, which represents NHS Trusts, produced a report entitled *Leading by example: the race equality opportunity for NHS provider boards* which summarises the case and gives some examples of good practice.[2]

Q4: What was the response to the introduction of Workforce Race Equality Standard?

A: NHS and patient leaders welcomed the decision to have a Workforce Race Equality Standard. Simon Stevens, NHS England's Chief Executive and Chair of the NHS EDC, said: "We want an NHS 'of the people, by the people, for the people'. That's because care is far more likely to meet the needs of all the patients we're here

[2] *Leading by example: the race equality opportunity for NHS provider boards: (2014)* http://www.nhsproviders.org/resource-library/the-race-equality-opportunity-for-nhs-provider-boards

to serve when NHS leadership is drawn from diverse communities across the country, and when all our frontline staff are themselves free from discrimination."

Chris Hopson, chief executive of NHS Providers, said: "It is vital that Boards reflect the diversity of local populations and the NHS workforce. We are keen to ensure that early progress is made on improving levels of BME representation at Board level and in senior leadership positions across the NHS."

Katherine Murphy, Patients Association, said: "Diversity in leadership is associated with more patient-centred care, improved patient access, experience and outcomes and higher staff morale, which ultimately is the aim for everyone using and working across the NHS."

Q5: How does the Workforce Race Equality Standard complement the NHS Constitution?

A: 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 for race equality is rooted in the fundamental values, pledges and responsibilities of the NHS Constitution.[3]

[3] The NHS Constitution for England. Department of Health (2013) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

Q7: What are the nine Workforce Race Equality Standard indicators?

A: The focus and wording of nine indicators have been subject to extensive engagement since 2014. The latest (2018) indictors are below:

	Workforce indicators For each of the 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, if appropriate, by: • Non-clinical staff • Clinical staff, of which - Non-medical staff - Medical and dental staff
2.	Relative likelihood of staff being appointed from shortlisting across all posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	Staff survey indicators (or equivalent) For each of the four NHS 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 a 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

Q8: How can the Workforce Race Equality Standard be summarised?

A: The WRES is being implemented to gauge the current state of workforce race equality within NHS organisations and track what progress is being made to identify and promote talented BME staff as well as helping to eliminate wider aspects of discrimination in the treatment of BME staff.

The WRES takes a small number of indicators and requires NHS organisations to close the gap between the BME and white staff experience for those indicators. Organisations will be expected to do what the best ones already do, to scrutinise and understand the data and act on it, and then work towards a level playing field where the treatment of staff is not unfairly affected by their ethnicity.

All NHS organisations covered by the NHS standard contract are expected to collect this data as many already do and are now be required to do what many NHS organisations do not currently do, that is, to analyse the data and work out how to reduce the differences in treatment for which there is no objective justification.

Some organisations have already made strides in doing this and it shows in their data. Others are starting on this journey. The WRES requires all organisations to collect such data, and to analyse and act on it, seeking to narrow the metrics gap between the treatment of BME and white staff.

The second part of the WRES concerns data that is already published in the NHS national staff survey and which considers the differences between the white and BME staff responses on four indicators.

Finally, organisations are expected to consider whether their board membership is broadly representative of the overall workforce and this is explained further in the WRES Technical Guidance.

Q9: How does the Workforce Race Equality Standard work?

A: In its simplest form, the WRES gives local NHS organisations the tools to work out their workforce race equality performance, including BME representation at senior

management and board level. The WRES exposes differences between the experience and treatment of White staff and BME staff in the NHS. It enables organisations to focus on:

- How good they are now
- How good they should be
- How they can get there

There are nine indicators. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator considers the representativeness of the organisation's board. NHS organisations analyse their performance against the nine indicators and use the results to develop action plans to make continuous improvements.
At the heart of the WRES are nine indicators. The indicators cover the things that research and evidence tells us matter the most to NHS staff.

Q13: What are the implications for NHS organisations?

A: Firstly, NHS organisations will have to do what they are already required to do because of their public sector Equality Duty (PSED). NHS organisations have historically had a poor record in collecting, analysing and publishing data on equality, including on race equality.

Secondly, there will need to be a discussion with their commissioners to ensure that each organisation is collecting, analysing and publishing the data and to establish the base line data on each indicator. For NHS Trusts this will include the relevant NHS staff survey data – the staff survey data will be the last published data[4].

For other organisations, the WRES will include equivalent survey data alongside workforce data. Each organisation will need to decide how it is going to narrow the gap in the metrics between its own White and BME staff in the next year so that it can demonstrate to its local commissioner, to staff and its Board, and to the CQC,

[4] The latest NHS Staff Survey 2014 http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2014-Results.

that it is making progress. What that rate of progress is expected to be will be agreed locally, published, and inspected against.

Q14: Will it involve extra work for NHS organisations that are already hard pressed?

A: The collection and analysis of data on workforce race equality should involve no more work than is currently undertaken. Where the collection of data requires significant additional work it is likely that such organisations had not been addressing the issue of race equality sufficiently thoroughly.

What may require more work in understanding the data and listening to staff so that effective strategies to improve outcomes against these indicators can be reached? It is intended that considerable effort will be made to ensure good practice is shared nationally.

EDS2 and the WRES will complement each other, since EDS2 complements WRES data, and the WRES data can feed into EDS2 evidence. Both processes help organisations to identify the equality issues to be address and the means to address them.

Q16: What about commissioners such as CCGs?

A: 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. However, all commissioners of NHS services, including CCGs, are expected to have “due regard” to using the WRES to help 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 A 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. Indeed, the workforce of some CCGs will be too small to carry out the calculations on their staff without the risk of deriving person identifiable data as the outcome. Indeed, the CCG is recommended to implement as many of the WRES Indicators are appropriate, whilst giving fair consideration to the principles of the WRES within their day-to-day activities. However, in these situations, the CCG can aggregate data to such an extent that individuals cannot be readily identified, and/or a group of neighbouring CCGs may want to produce a joint WRES report and work together on an agreed action plan to improve on the WRES indicators over time. The WRES team will be looking into these possibilities going forward.

Q17: What about other workforce equality strands?

A: The NHSEquality and Delivery Council (EDC) made it clear that there are other challenges on equality to be met across the range of protected characteristics. The EDC is committed to promote equality for all, ensuring no one is left behind, and will ensure that patient, service user and carer perspectives are central to its work. It also plans to continue with existing work strands and initiate work to advance equality for other groups protected by the Equality Act. The Workforce Race Equality Standard is the first phase in a programme of work focussing upon workforce equality. Parallel work on gender and disability and the workforce has started.

One issue highlighted at the discussion, amongst others, was the treatment of staff with disabilities since available data suggests serious discrimination, similar in many ways to that against BME staff takes place. Although the Standard focuses on the treatment of BME staff, research shows that how all staff are treated impacts on patient care so further initiatives are planned across other protected characteristics. That does not prevent individual organisations continuing to develop work now around other equality strands and it is anticipated that by making sure one strand is

addressed in such a direct way it will encourage all organisations to focus more carefully on equality across the board.

NHS England is promoting a number of initiatives to address other protected characteristic including, in the first instance, supporting additional research and work on sexual orientation, disability and gender. The Equality Delivery System – EDS2 seeks to focus on all protected characteristics, and a number of specific initiatives of other equality strands as well as race are underway or planned. If successful, the approach used for the Workforce Race Equality Standard may be adapted for other equality strands.

Q18: What are the links between the Workforce Race Equality Standard and the Equality Delivery System – EDS2?

A: The Equality Act 2010 ascribes protection to nine characteristics. The nine characteristics are: age; disability; gender re-assignment; marriage and civil partnership; pregnancy and maternity; race (including nationality and ethnic origin); religion or belief; sex; sexual orientation.

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 about 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. The indicators used in the WRES, and the progress made in closing them, will assist organisations implementing the EDS2. Though the progress reports on the Standard and EDS2 will be made separately, local NHS organisations will want to check how the data

published for the Standard can assist and align with EDS2, and in particular with the outcomes under EDS2 Goals 3 and 4.

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 will assist organisations in meeting their Public Sector Equality Duty requirements.

It will be for local organisations to decide if the reporting dates for EDS2 and the WRES are the same, but if they are the reports should be made separately. Further information on the see Equality Delivery System – EDS2[5]

Q19: Isn't the WRES too much like micromanagement of local employers?

A: If an entirely voluntary system was enough to have made the progress needed, then we would have surely seen more progress ten years after the 2004 Race Equality Action Plan launched with Ministerial backing. It is clear that more of the same will not be enough.

[5] *The Equality Delivery System. A refreshed Equality Delivery System for the NHS – EDS2.* NHS England 2013. EDS 2 information :http://www.england.nhs.uk/ourwork/gov/equality-hub/eds

This proposal is intended to focus employers' attention on this issue with the intention that "the rest will be as good as the best". Lots of effort will hopefully go into encouraging and spreading good practice. But based on the experience of the last decade there may well be employers who will not prioritise this until it becomes part of the commissioning process with measurable, published, outcomes and the back stop of the regulators.

The evidence linking fair treatment of the 17% of NHS staff who are BME staff to improved care for patients is clear, as is the case for a more diverse leadership benefitting patients. So making this initiative work is in everyone's interest.

Q20: Will the WRES cost extra time or money?

A: There are three steps involved in meeting the standard. The first step is to ensure the appropriate data is being collected. All organisations, in accordance with the Public Sector Equality Duty (PSED) should be doing this across all protected characteristics. Those Trusts using the Equality Delivery System – EDS2 may well be collecting the data as part of EDS2, but up until now, there has been no mandatory requirement to do so.

The second step is to analyse and publish the data. Again the PSED requires organisations to do this and the data that the Standard considers is certainly data that any organisation wishing to make progress on equality should be collecting this across all protected characteristics. Organisations that use EDS2 may well be doing this already but up until now, there has been no mandatory requirement to do so. However the evidence of research is that too many Trusts are not yet analysing and publishing data.

For these two steps there will either be no extra cost or it is a cost they should already be incurring if they are to address inequality.

The third step is to act on the analysis and take steps to close the gap between the treatment of white and BME staff. This requires a determined effort to target those areas where there is a substantial gap, for example, on recruitment/promotion,

access to non-mandatory training, bullying and discipline. That must involve BME staff and staff organisations. This will cost staff time and possibly some external assistance but there are benefits too.

NHS Employers have highlighted the considerable cost of not being an equality employer[6]. The benefits will include less grievances, more likelihood of attracting and appointing the best staff, less bullying, less disciplinary cases, less turnover and sickness absence, and more importantly of all, better BME staff morale with benefits for all patients. There may be upfront costs but real benefits in the short to medium term.

Q21: What consequences will there be for service providers that fail to move to meet the WRES?

A: Unlike previous NHS initiatives on equality, this requires published measurable outcomes that are difficult to "game". Is it hoped that many (most) organisations will adopt the strategy of closing the gap between White staff and BME staff experiences because they want to, in the interests of patients and their staff. For those who don't there are three consequences.

Providers will need to confirm to commissioners in an Annual Report what progress they have made against the WRES. Failure to do so will be a breach of the NHS Standard Contract and should trigger robust discussions about how and why, and what steps will be taken to improve performance the following year. Ultimately a breach of a contract should be dealt with as any other breach of contract.

The progress made by trusts will be published and, as with much other data, will be available nationally in a form that enables organisations to benchmark themselves. It is likely that as well as encouraging trusts to do better, to find "buddying" arrangements and good practice, a poor performance will trigger Board level discussions.

[6]NHS Employers (2014). *The business case for diversity.* http://www.nhsemployers.org/SharedLearning/Pages/BusinessCaseForDiversity.aspx.

When regulators adopt progress towards the WRES as an element of their scrutiny from April 2015 onwards, then failure to progress on the WRES is likely to be taken into account in determining whether the trust is “well led” or not, with the normal range of consequences for the board.

Q22: What exactly is the CQC’s role?

A: 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 difficult to ‘game’ and the cultural challenges that the WRES unearths (bullying culture, blame culture, ‘club’ culture) are ones that all organisations proclaim they wish 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 will be considered as part of the “well led” domain in CQC’s inspection programme for all NHS trusts and independent healthcare providers contractual obliged to carry out the WRES. In 2015-16 the CQC piloted its approach to using the WRES in a number of their comprehensive inspections of NHS Trusts and independent healthcare providers. In particular, the organisation’s completed WRES Reporting Template and accompanying action plan were analysed as part of the evidence used in the inspections. Providers inspected are also asked how they were addressing any issues arising from their respective WRES data and a variety of methods were tested to engage BME staff – so the data is ‘triangulated’ by qualitative findings from both providers and employees.

The following initiatives have been underway to support the CQCs 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.

Q23: How will BME staff be involved in the process?

A: It is essential that the voice of BME staff is heard loud and clear through the process of identifying the challenges individual organisations face in meeting the WRES. Organisations are strongly encouraged to help establish and support BME networks of staff as an important source of knowledge, support and experience. Such work may well include providing a safe place for BME staff to share their concerns and be listened to.

An increasing number of trusts are recognising the importance of giving time and facilities to BME staff groups and a serious opportunity to engage with Board. In 'best practice' trusts, the CEO or Chair meet with, and listen to the concerns of, BME staff in a "safe space".

Q24: What is the role of trade unions?

A: To succeed in successfully implementing the WRES, it will be essential to engage with staff and their recognised trade unions. Organisations are more likely to successfully engage with staff and improve the impact of work, where the implementation of the WRES, and other equality initiatives such as EDS2, involve local social partnership with trade unions and staff organisations, to help draw on their knowledge, support and experience**.**

Q25: Who should lead on the WRES within organisations?

A: A report on equality and diversity published by NHS Providers[7] states:

> "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

[7] NHS Providers Booklet http://www.nhsproviders.org/resource-library/the-race-equality-opportunity-for-nhs-provider-boards/

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"

The Technical Guidance on WRES suggests that organisations will want to nominate a board member to lead work to meet the WRES, and other aspects of equality work, as some NHS trusts do now.

Q27: Has there been an Equality Analysis of the WRES?

A: An Equality Analysis[8] on the WRES has been completed and will be continuously reviewed and updated as required.

Q28: How were the definitions of "BME and white" decided and why?

A: The definitions of "Black and Minority Ethnic" and "White" used have followed the national reporting requirements of Ethnic Category in the NHS Data Model and Dictionary, and as used in Health and Social Care Information Centre data. "White" staff includes White British, Irish and Any Other White. The "Black and Minority Ethnic" staff category includes all other staff except "unknown" and "not stated."

To define BME employers should exclude A, B, C and Z from current values in the table below. Also exclude 0 and 9 from the old values of which there are around 500 records. Exclude all 'NULL' values. The category C 'Any other white background' contains minority groups including white European.

Ethnic Categories as per Office of National Statistics (ONS) 2011
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

[8] WRES Equality Analysis (EA) http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard/

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.
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

Q30: How does the WRES apply where small numbers of BME staff are employed?

A: There are a small number of organisations where there is either so small a number of BME staff that it is difficult to publish data without identifying individuals, or where the numbers of BME responses to the staff survey are too low to merit publication without potentially identifying individuals.

The presence of small number of BME staff does not mean that there may not be similar issues around the treatment and experience of BME staff as compared to organisations with larger numbers of BME staff – with implications for patient care. It does mean there may need to be some flexibility about how commissioners seek assurance that the WRES is being met and how the CQC inspect against the WRES. Further advice on this will be provided in due course.

Q32: How will the WRES apply to national NHS bodies?

A: National bodies include (but not exclusively):

- NHS England
- The Care Quality Commission
- NHS Improvement
- NHS Digital
- Public Health England
- Health Education England

These bodies are members of the Equality and Diversity Council and have committed themselves to the support of the WRES. They are applying the WRES provisions to themselves, and the WRES data for the above six ALBs was published in March 2018.[9]

Q33: How will the WRES apply to independent healthcare providers?

A: Implementation of the WRES also applies to all independent provider organisations that provide NHS services.
Many of the independent 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 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 providers will not be undertaking the NHS Staff Survey. In implementing the WRES, independent providers should focus upon their equivalent staff bandings, HR systems and electronic records, and relevant questions from surveys of their workforce. Indeed, a more tailored approach may be needed to support WRES implementation and use within the independent provider sector.

[9] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/2017-data-analysis-report-for-national-healthcare-organisations/

From April 2016 onwards, progress on the WRES will be 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.

Q35: Why the term "relative likelihood" has been chosen for WRES indicators 2 and 3?

A: It has been chosen because it is the most reliable and informative way of understanding the relative disadvantage of BME staff compared to white staff. How it is calculated for each metric is shown in the WRES Technical Guidance. [10]

Q36: How was the wording of WRES indicators 5 to 8 been chosen?

A: The wording is taken exactly from the NHS national staff survey questions that are referred to in each metric. Precisely what those words mean and how to best understand the data they reveal is explained in the WRES Technical Guidance.

Q37: How is an organisation's progress on meeting the WRES be verified?

A: The organisation's progress on meeting the WRES can be verified in three ways. Firstly, CCGs and other commissioners check, as part of their assurance in respect of the NHS standard contract which providers are complying with the requirements of the WRES. Secondly, from April 2016 provider progress on meeting the WRES is be included in the CQC "well led domain". Thirdly, all data required to demonstrate progress in meeting the WRES is published. It is published so that all staff can scrutinise progress, including local BME and staff side organisations. It is published for commissioners to consider, and because the CQC expect to be provided with the data.

In addition, work has been commissioned to determine a robust way of benchmarking the data for wider comparison to enable organisation to compare themselves with similar organisations and their progress.

[10] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/resources/

More generally, organisations covered by the WRES are strongly encouraged to be open at all stages of engagement with WRES. This means:

- Being open about the nature and scale of the challenge each organisation faces – sharing data however uncomfortable it may be initially
- Sharing with staff the approaches proposed and inviting real engagement about those processes
- Publishing to all staff the data from workforce analysis and staff surveys which indicates challenges around race equality
- Sharing progress and achievements and learning from how progress was made

Further advice on how the progress for each organisation will be published and work towards a benchmarking process will follow.

Q38: What does "non-mandatory training" include as this is currently not defined or measured in the same way across different organisations?

A: "Non-mandatory training and Continuing Professional Development (CPD)" means any training or CPD that is not a requirement of the post. Examples of mandatory training would include lifting, first aid, required professional updating and any other statutory or contractually required training.

"Non-mandatory training" means, in this context, training that is not a statutory or contractual requirement and which might reasonably be deemed to assist career or personal development, including continuing professional development. It would include, for example, any externally organised course or activity (such as attendance at conferences) where a place has been booked and paid for that might reasonably be deemed to assist career or personal development, including continuing professional development. It would also include externally organised activities which are NOT paid for as well as a range of other development courses and activity - including relevant study leave and mentoring – which are supported by the employer and where appropriate payment by the employer and paid study leave is agreed.

"Accessing" courses and CPD in the context means courses on which places were offered and accepted.

It is acknowledged that precisely how organisations define “non-mandatory training” may vary significantly between organisations, potentially making comparisons between organisational Indicators difficult. However**,** each organisation is expected to be consistent in how they define it year on year.

Employers will also note that each profession is regulated and assessed differently and that will need to be considered in the application of this standard.

Q39: What is the purpose of using an indicator for staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months?

A: Bullying and harassment by members of the public is a problem across the NHS, especially in certain departments (notably A and E) and in certain types of services (notably in mental health and ambulance Trusts). It was felt that where there were significant differences between BME and White experience it was important to highlight these, especially as in some trusts there is little difference and in others very significant differences between white and BME experience

Q41: Will WRES indicator 3 be adjusted to take into account that relatively small numbers may be involved in any one year?

A: In previous years many organisations have suggested they cannot draw any conclusions about a pattern of disciplinary action being potentially discriminatory because the numbers are relatively small.

To avoid that situation Indicator 3 will be calculated over a two year rolling period i.e. the last two years for which data is available. In some cases the number may still be small but that does NOT preclude conclusions being drawn especially as the pattern may be similar over even earlier years.

Q42: How can I submit WRES data for my organisation?

A: The completed template will be submitted through the Strategic Data Collection Service (SDCS) which replaces Unify 2. NHS Digital will contact the WRES data submission lead for each NHS trust, with instructions on how to submit your completed template via SDCS.

Q46: Do we include staff with unknown or null ethnic categories?

A: Yes. The prepopulated figures are broken down by White, BME and Ethnicity Unknown/Null. Trusts are encouraged to come up with a strategy to minimise the number of unknowns/nulls and increase ethnicity self-reporting.

Q48: How are the medical and dental sub categories defined?

A: The grade code is used to look up against the medical & dental sub category of each medical staff. This lookup matrix is used nationally

Q53: Will the General Data Protection Regulation (GDPR) affect WRES submissions and reporting going forward?

A: GDPR does not materially affect submission, reporting and publication of WRES data. All information governance (IG) related queries should be discussed with your local IG Team in the first instance.

Q54: What national support will be available to organisations?

A: NHS England has established a national WRES Implementation Team to help support the use of the WRES within the NHS. Discussions are underway to ensure that good practice is shared between NHS organisations in as systematic a manner as possible. Individual HR, equality and trade union networks may also share examples of good practice that will assist organisations in meeting the WRES. A dedicated web page has been set up to share news and developments: https://www.england.nhs.uk/about/gov/equality-hub/equality-standard/