NHS England

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NHS ENGLAND – PRIVATE BOARD PAPER

Title:

The NHS Workforce Race Equality Standard (WRES) strategy: Increasing black and minority ethnic (BME) representation at senior levels across the NHS

Lead Director:

Professor Jane Cummings, Chief Nursing Officer for England

Purpose of Paper:

To request the Board to:

- Note progress on WRES implementation to date and the need for accelerated improvement on BME representation at senior positions across the NHS;
- Approve the proposed strategic approach of ensuring leadership is representative of the overall BME workforce by 2028 – including the resources required to deliver on this ambition;
- Agree to the publication of the strategic approach and its communication to the wider system.

Patient and Public Involvement:

This paper covers workforce issues only.

The Board invited to:

I. Note progress on WRES implementation to date and the need for accelerated improvement on BME representation at senior positions across the NHS;

II. Approve the proposed strategic approach of ensuring leadership is representative of the overall BME workforce by 2028 – including the resources required to deliver on this ambition;

III. Agree to the publication of the strategic approach and its communication to the wider system.

The NHS Workforce Race Equality Standard (WRES) strategy: Increasing black and minority ethnic (BME) representation at senior levels across the NHS

Purpose

1. Since its introduction in 2015, NHS England's WRES programme has been providing direction and tailored support to the NHS, enabling local NHS organisations to continuously improve their performance in this area. The WRES has required NHS trusts to annually self-assess against nine indicators of workplace experience and opportunity (Appendix A), and to develop and implement robust action planning for improvement.

2. WRES data for the last three years shows year-on-year improvement for BME staff on a range of indicators. Increasing the representation of BME staff at senior and leadership levels across the NHS is an area that requires further accelerated support. The overall BME workforce in the NHS is increasing, yet this is not reflected at senior positions where there is an acute under-representation of BME staff.

3. This paper sets out an ambitious challenge of ensuring BME representation at all levels of the workforce, including leadership, is representative of the overall BME workforce by 2028. The paper outlines a comprehensive and holistic set of objectives to support the NHS, as part of the existing WRES programme of work. The Board is asked to support the strategic approach – including the resource needed to deliver on this ambition.

Background

4. The WRES programme provides direction and tailored support to NHS trusts, and the wider healthcare system, enabling local NHS and national healthcare organisations to:
   - identify the gap in treatment and experience between white and BME staff;
   - make comparisons with similar organisations on the level of progress;
   - take remedial action on causes of ethnic disparities in indicator outcomes.

5. An extensive programme of work (Appendix B), underpinned by evidence based strategy and operational interventions, is showing year-on-year improvements for BME staff across the NHS on a range of indicators, including:
   - appointment from shortlisting
   - reducing the disproportionate rate of BME staff disciplinary action
   - access to non-mandatory training and courses

6. The latest WRES data show:
   - the overall number and proportion of BME staff working in the NHS is increasing. In 2018 there were 25,812 more BME staff compared to 2016, an increase from 17.4% to 18.9%;
   - the number of BME staff at band 8a to VSM increased by 1,699, from 9.7% to 11.2%;
   - however, the gap between the percentage of overall BME staff and representation at band 8a to VSM has not increased at the same rate and has remained constant over time, at 7.7%;
   - in order to close the gap, we need to increase the recruitment of staff across the senior bands of the workforce pipeline.

Table 1: BME representation changes across NHS trusts and CCGs: 2016 – 2018

	2016	2017	2018
Total BME workforce	17.40% (204,377)	18.09% (216,644)	18.94% (230,189)
BME in AfC bands 8a to VSM	9.74% (6,447)	10.40% (7,207)	11.20% (8,146)
Gap	7.65%	7.69%	7.74%

7. There exists a huge reservoir of talent which is not being tapped into by virtue of the barriers that are often placed in the way of staff development and opportunities. Greater diversity and inclusion enhances opportunities to tap into that diverse talent pool. The NHS is at its best when it reflects the diversity of the country and where the leadership of organisations reflects its workforce.

8. Research shows that organisations that have diverse leadership are more successful and innovative than those that do not. Employees who feel valued are more likely to be engaged with their work, and diversity at senior levels increases productivity and efficiency in the workplace. Such organisations are better placed to reduce health inequalities of our diverse communities and leads to better patient care, satisfaction and outcomes.

Progress to date

Ambition for leadership representation

9. There is robust evidence for the effectiveness of having an ambition that is based upon a commitment to specific goals, monitored by frequent feedback.[1] Organisations are more likely to focus on an issue at hand if an official goal or aspiration exists to act as a reminder of what needs to be achieved. These should embody challenge, specificity, and need to be reinforced by accountability.

10. Although BME leadership across the NHS is improving as a result of the WRES, there is a clear need for further accelerated improvement. Aspirational goals to increase BME representation at leadership levels, and across the pipeline, will reinforce the existing WRES programme of work.

11. This approach is in line with the direction of travel highlighted by the WRES data for NHS organisations, and is aligned with the national goal set for the public sector by the government in October 2018, that leadership and senior management should match BME representation in the wider workforce within the next ten years.

Overarching aspiration for the NHS

12. Statistical analyses based upon current trajectory and data present three models: equality in representation across the AfC bands in the NHS (e.g. where the proportion of BME VSMs in NHS trusts and CCGs equals the proportion of BME staff overall) by 2023, 2028, and 2033. Using the example of the VSM band, these models are set-out in Table 2 below for NHS trusts and for CCGs.

[1] Jayne, M.E., & Dipboye, R.L. (2004). Leveraging diversity to improve business performance: Research findings and recommendations for organisations. Human resource management, 43(4), 409-424

Table 2: Options for BME VSM recruitment in NHS trusts and CCGs

	Proportion of BME workforce[1]	Proportion of BME VSMs[1]	Additional VSM recruitment activity per year in order to reach equality[3] by:		
			2023	2028	2033
NHS trusts	1 in 6	1 in 18	1 in 3 recruits from BME (56)[2]	1 in 4 recruits from BME (41)[2]	1 in 5 recruits from BME (36)[2]
CCGs	1 in 7	1 in 10	1 in 6 recruits from BME (18)[2]	1 in 7 recruits from BME (16)[2]	

[1] The analysis uses 2018 data for both NHS trusts and CCGs across all bands.
[1] BME proportions are recorded as a total of known ethnicities.
[2] Values in brackets are the number of BME VSM recruits required per year to reach equality.
[3] Reaching the value in column "Proportion of BME workforce" (note: by 2033 this may have changed).

13. A stretching, and yet achievable aspiration for the NHS would be to reach leadership equality across the pipeline by 2028. This is the recommended model in this area, it aligns with the timeframe announced by the government on this aspiration for the public sector, it is in line with the timeframe for the NHS Long Term Plan, and is the basis upon which this strategy is informed.

14. If we take VSM band as an example, the model will require 1 in every 4 of all VSM staff recruited in NHS trusts to be from a BME background; this is an additional 41 BME VSM recruits across all NHS trusts per year. For CCGs this will mean one in every seven VSM staff recruited in CCGs to be of a BME background; an additional 16 BME VSM recruits across all CCGs per year.

15. The aspiration to improve equality will be used to further galvanize action in this area, accelerating and extending the current WRES programme of work across the NHS.

Localised aspirations at organisational level

16. Locally defined goals across the pipeline, tailored to an organisation's circumstances and workforce composition, will support delivery of the overarching national goal of leadership across the NHS representing the workforce that it serves.

17. The above national model proposal, and the 2028 timeframe, can be applied to local NHS organisations. As an example, AfC band 8a recruitment aspirations for two NHS trusts (University College London Hospitals NHS Foundation Trust, and Newcastle Upon Tyne NHS Foundation Trust), based upon their respective BME workforce composition, are presented in Table 3.

Table 3: Goal setting for band 8a BME recruitment in two NHS trusts

	Proportion of BME workforce[1]	Proportion of BME band 8a[1]	Additional band 8a recruitment activity per year in order to reach equality[3] by:
			2028
UCLH NHS FT	1 in 2	1 in 4	6 in 10 recruits from BME (19)[2]
Newcastle Upon Tyne NHS FT	1 in 12	1 in 58	1 in 9 recruits from BME (3)[2]

[1] The analysis uses 2017 data for the specified hospitals.
[1] BME proportions are recorded as a total of known ethnicities.
[2] Values in brackets are the number of BME band 8a recruits required per year to reach equality.
[3] Reaching the value in column "Proportion of BME workforce" (note: by 2028 this may have changed).

18. Based upon their respective workforce composition, the 2028 model will require UCHL to recruit six in every ten of all band 8a staff from a BME background; this will be an additional 19 BME recruits to band 8a across UCHL per year. For Newcastle Upon Tyne NHS FT, the 2028 model will require one in every nine BME staff recruited to band 8a to be of a BME background; that's an additional three BME band 8a recruits across that trust per year.

19. Whilst data on the necessary increases in BME staff across the AfC bands will be made available to organisations, we acknowledge that individual trusts and CCGs will know their workforce and their populations best, and will therefore be best placed to develop their own robust action plans to support this agenda.

Arm's length bodies (ALBs) leading the way

20. As employers in their own right, the national arm's length bodies (ALBs) should be leading the way on the workforce race equality agenda. ALBs implement the WRES and their respective organisational WRES data are published annually. In the same spirit of transparency and continuous improvement, the ALBs should also work towards the system-wide aspiration of leadership reflecting the diversity of their respective workforce. NHS England will be continuing to do so.

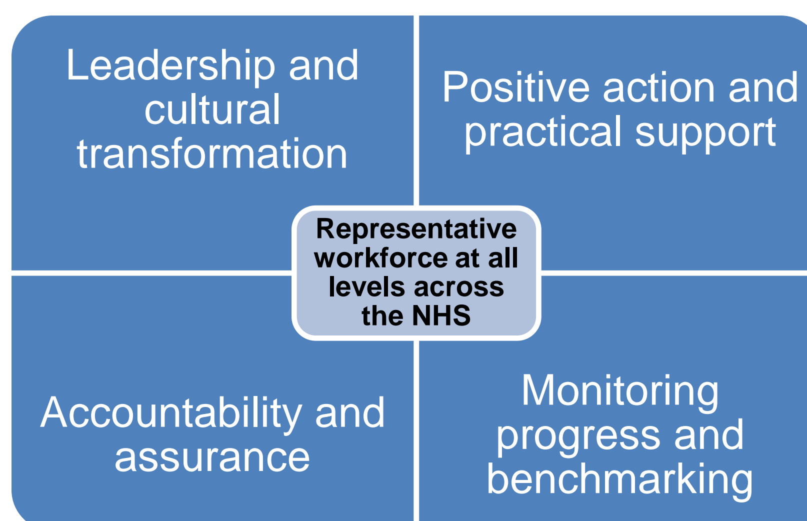
Supporting delivery of the ambition

21. We know that workforce race equality requires organisations to go beyond operational change as a result of compliance and regulation against metrics and targets. Whilst these features are critical, the parallel challenge here is that of cultural and transformational change on this agenda.

22. The WRES team will support the wider system to focus on driving improvements in BME representation at senior levels across the NHS – building a sustainable talent pipeline for the future. A clear focus will be upon both growing and supporting existing BME talent

from within the NHS, as well as attracting talent from outside of the NHS.

Figure: Evidence based model for improving BME representation across the NHS workforce



23. Although well-intentioned, one of the limitations of prior efforts to improve BME staff representation at senior levels across the NHS has been an over-focus on the "deficit"-model; the notion that there are inherent weaknesses or deficits amongst BME staff themselves, rather than deep-rooted issues within organisations. Instead, our current strategy is underpinned by both interventions that support BME staff to grow and flourish, as well as focussing upon transforming cultures and processes within the organisations for which they work.

24. This programme of work will require delivery of four interlinked components and associated priorities (Appendix C):

Leadership and cultural transformation

25. The current leadership across the NHS must lead the charge in bringing more ethnic minority staff into senior and leadership positions. Leaders need to be equipped to take personal responsibility for ensuring that they are able to fill their top positions with ethnic minority staff that are ready to step into senior leadership.

- Demonstrate commitment to becoming an inclusive and representative employer - role modelling on race equality – **work will be carried out to transform deep-rooted cultures of workforce inequality via organisational leadership strategies** – a focus here will be upon NHS Improvement's Culture and Leadership Programme; engage supporters and including stakeholders in the planning process and in helping to share messaging, rationale and process.

- Require VSMs and board members to mentor/reverse mentor and sponsor at least one talented ethnic minority staff at AfC band 8d or below – coaching skills and structured support will be made available to senior staff to carry this out. **Mentoring, reverse mentoring and sponsoring will be part of the senior leader's performance objectives** that will be monitored and appraised against.

- Recruitment drive on BME non-executive directors (NEDs) – as a starting point, **a drive to appoint BME NEDs will be encouraged**. Existing NEDs will be encouraged to play an active role in mentoring and sponsoring BME staff that have the potential to

get to an executive role within three years.

- Regions, STP and ICS work – the WRES team is supporting regional approaches to improving workforce race equality, including across London and the North of England. Innovative work is being carried out across Greater Manchester, where the WRES is being extended across health and social care, and beyond. **A key focus here will be upon the new and emerging healthcare architecture**, including Integrated Care Systems (ICSs), and Sustainability and Transformational Partnerships (STPs).

- Continued national focus – the WRES programme which supports the NHS to become a better and more inclusive employer – making full use of its diverse workforce, should be **embedded within key future workforce policies and strategies for the NHS**.

- Beyond the local NHS organisations, the national healthcare bodies, and leading policy and research and Think Tank organisations – that provide advice and support to NHS organisations – also need to model aspirations towards leadership that is representative of their respective workforce.

Positive action and practical support

26. Continued practical support and evidence based interventions will be critical to achieve workforce race equality and the desired ambition.

- Talent management – to meet set aspiration, concrete measures to remove barriers to our most talented ethnic minority staff succeeding, will be put in place. To enable this to happen, there needs to be a consistent narrative within organisations, based on a **fit-for-purpose national approach to effective talent management across the NHS**.

- From the diverse NHS workforce that we have, **we will identify the most talented staff and help them to progress quickly**. But this must not be a 'tick-box' exercise of simply increasing BME numbers; BME staff need to be supported to expand their experiences and skills, particularly where the opportunities to do this have not been made readily available.

- Diverse shortlisting and interviewing panels – **recruiting managers will be held accountable for institutionalising diverse shortlisting and interview panels**. There would seldom, if ever, be acceptable exceptions for not having a BME member on shortlisting and interview panels; this is firmly within the organisation's control. Where BME interviewees are not appointed, justification should be sent to the organisation's chair setting out, clearly, the process followed and the reasons for not appointing the BME candidate.

- Batch interviews should be considered where appropriate – panel interviews of single applicants may not always provide the optimum assessment of a candidate's skills and capabilities, and can contribute towards creating conditions for bias. **Organisations will be encouraged to examine the merits of interviewing a batch of candidates** for a number of different roles/positions.

- Technical WRES expertise at regional levels – the WRES Experts Programme aims to develop cohorts of race equality experts from across the NHS to support the

implementation of the WRES within their organisation. Participants become part of **a network of professionals across the NHS that advocate, oversee and champion the implementation of the WRES** at regional and local level. The work on meeting leadership aspirations at local level will be built into the existing WRES Experts Programme.

- Promote success and share replicable good practice – **identification and dissemination of models of good practice, evidence based interventions** and processes from across the NHS – from the wider public, private, voluntary and charitable sectors – will help support NHS organisations to achieve the required outcomes.

Accountability and assurance

27. Data driven accountability is a critical enabler.

- Build assurance and accountability for progress
NHS organisations across the country will be supported to **develop workforce race equality strategies and robust action plans that are reflective of their WRES data**. These action plans provide an ideal vehicle to continuously improve on the issues that, the data show, are of key concern for the organisation. Progress against the aspirations will form part of an organisation's action planning for the WRES.

- The support of assurance and regulatory bodies continues to be essential in achieving progress on WRES implementation, and will be critical going forward. As a start, progress against meeting the **BME leadership aspiration will be firmly embedded in NHS Improvement's Single Oversight Framework.**

- The Care Quality Commission (CQC) already reviews against the WRES as part of its inspections of the 'well-led' domain. Work will be carried out to **further strengthen the 'well-led' inspection framework to give greater weight to organisational progress in tacking workforce race inequality** through robust implementation of the WRES, and in promoting diversity more generally.

- As part of the CCG Assurance and Improvement Framework, **CCGs will be required to give assurance that their providers are implementing the WRES and progressing on the BME leadership aspiration**, and that they themselves are doing the same. The WRES team will ensure that progress on this agenda will be embedded within this existing lever of accountability and assurance.

- Senior leaders and board members will have performance objectives on workforce race equality built into their appraisal process – senior leaders should be held accountable for the level of progress on this agenda. Working with national healthcare bodies, **progress on workforce race equality will be embedded within performance reviews of chairs and chief executives** – including emphasis on WRES implementation and on progress in meeting the set goals for their respective organisation.

- Building the capability and capacity of BME staff networks across the NHS – to play a key part of the accountability and transparency approach will play a key role. There will be a concerted effort towards **supporting leaders of BME staff networks and trade union representatives, across the NHS to raise the visibility of their work**, and to provide a source of meaningful and sustained engagement with the WRES

programme of work.

Monitoring progress and benchmarking

28. WRES processes for data collection and publication – data will be an essential element of assessing organisational progress, as well as the progress of the NHS as a whole, against the goal for BME staff representation at senior levels across the NHS. Through the existing collection and publication of annual WRES data at local and national level, organisations will be able to ascertain where they are, where they need to be and, with robust action planning, how they will get there.

    - Benchmarking progress – **benchmarking and progress will be established and published as part of NHS Improvement's Model Hospital hub and WRES annual data reporting**, through which the monitoring of progress against set aspirations over time will be undertaken, and good practice shared.

    - Periodic update – due to the changing nature of BME workforce composition across the NHS, the right approach will be to **periodically update the assessment of the overall progress that has been made on meeting the aspirations** – starting at the end of 2020, and local organisations will be supported via the national WRES team to do the same.

    - Oversight – the lack of BME leadership is a system-wide issue that requires a system-wide response. **Collaborative working between the national healthcare organisations and key partners will be needed on this agenda.** This will require all relevant organisations to focus resource in a more intentional manner.

    - The **WRES Strategic Advisory Group will oversee the implementation of this strategy** as part of its oversight and advisory role for the WRES programme. Reporting to NHS England and NHS Improvement, the WRES programme director will be responsible for the successful delivery of the strategy and associated action plan.

Implications

29. Local NHS organisations and the wider healthcare system will require advice and guidance to help meet the ambition for their workforce. It is proposed that organisations are supported by the WRES programme to develop and agree the following with the national WRES team:
    - their own aspirational goals for the next three years, firstly to increase recruitment of BME staff to senior bands, and secondly to close the gap on white and BME staff experience;
    - a robust action plan to deliver the change required;
    - how to work with the national WRES team and track progress against these aims.

30. It is also proposed that the WRES strategic approach is implemented through the regional teams and at regional level; the WRES team is currently supporting a similar approach across health, social care and beyond in Greater Manchester and across the London region.

Legal/Regulatory

31. The proposed strategic approach will be embedded within the national WRES programme of work.

32. The current NHS standard contract requires all providers of NHS services to address the issue of workforce race inequality by implementing and using the WRES.

33. WRES implementation also features within the CQC inspection of the Well-led domain for hospitals, and within the CCG Improvement and Assurance Framework, requiring CCGs to give assurance to NHS England that their providers are implementing and using the WRES and that CCGs are committing to the principles of the WRES and applying it to their own workforce.

34. It is proposed that the BME leadership aspiration is also embedded within NHS Improvement's Single Oversight Framework.

Resources Required

35. The WRES team is currently funded by NHS England. The WRES programme is now to become permanent.

36. It is clear from the work that has been undertaken by the WRES team to date that good progress is being made, and much more work needs to be done to further improve workforce race equality in the NHS. This will require some targeted increases.

Recommendations

37. The Board is asked to:
    I. Note progress on WRES implementation to date and the need for accelerated improvement on BME representation at senior positions across the NHS
    II. Approve the proposed strategic approach of ensuring leadership is representative of the overall BME workforce by 2028 – including the resources required to deliver on this ambition
    III. Agree to the publication of the strategic approach and its communication to the wider system

Authors: **Yvonne Coghill and Dr Habib Naqvi**
Date: **November 2018**

APPENDIX A

WRES indicators of staff experience and opportunity

<table>
<tr><td></td><td>Workforce indicators
For each of the four workforce indicators, <u>compare the data for white and BME staff</u></td></tr>
<tr><td>1.</td><td>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</td></tr>
<tr><td>2.</td><td>Relative likelihood of staff being appointed from shortlisting across all posts</td></tr>
<tr><td>3.</td><td>Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation</td></tr>
<tr><td>4.</td><td>Relative likelihood of staff accessing non-mandatory training and CPD</td></tr>
<tr><td></td><td>Staff survey indicators (or equivalent)
For each of the four NHS staff survey indicators, <u>compare the outcomes of the responses for white and BME staff</u></td></tr>
<tr><td>5.</td><td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td></tr>
<tr><td>6.</td><td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td></tr>
<tr><td>7.</td><td>Percentage believing that trust provides equal opportunities for career progression or promotion</td></tr>
<tr><td>8.</td><td>In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleagues</td></tr>
<tr><td></td><td>Board representation indicator
For this indicator, <u>compare the difference for white and BME staff</u></td></tr>
<tr><td>9.</td><td>Percentage difference between the organisations’ board membership and its overall workforce disaggregated:
• By voting membership of the Board
• By executive membership of the Board</td></tr>
</table>

APPENDIX B

WRES implementation progress summary

Applicants from BME backgrounds are less likely to be appointed from shortlisting compared to non-BME people, more likely to be under-represented in senior and leadership positions, more likely to be bullied at work, and more likely to go through formal disciplinary action.

To help close the gaps in BME and white staff experiences and opportunities in the NHS WRES strategies and interventions to date have been underpinned by three internationally evidenced themes:

i. Enabling people: meaningful engagement; focused improvement, and sustainability. Amongst the interventions under this theme, the WRES team has established the **WRES Frontline Staff Forum**, to learn from the lived experience of frontline BME staff in the NHS. The team has delivered a series of **regional WRES round tables** for NHS CEOs and chairs, facilitating demonstrable leadership on this agenda at local level and supporting the establishment of regional WRES strategies. The **WRES Experts programme** was launched in 2018, training NHS staff from local organisations on the intricacies of the workforce race equality – thus decentralising WRES implementation support and supporting the sustainability of the agenda.

ii. Embedding accountability: policy alignment; assurance and regulation.
A key element of the WRES strategy is to embed the WRES within the key policy levers that cover providers of NHS services, as well as commissioners. The WRES features within levers such as the **NHS standard contract**, the **CCG Improvement and Assurance Framework**, **CQC's 'well-led' domain**, as well as within the **NHS Five Year Forward View**. In addition, the WRES team has been working with areas and parts of the NHS where data tell us more concerted focus and support is needed: the **nursing and medical** workforce, with organisations across the **London region**, and with regard to devolution in **Greater Manchester**.

iii. Evidencing outcomes: data and intelligence; replicable good practice, and evaluation of progress.
Since 2015, the WRES team has been undertaking the annual collection, analyses and **publication of WRES data** from NHS trusts across England. This was extended for the national healthcare organisations in 2018, and will also be extended across CCGs going forward. **Research and evaluation**, to amplify the narrative on this agenda, is a key feature of the WRES strategy. Consequently, numerous **reports and publications** have been published and made available by the WRES team.

APPENDIX C

Proposed summary implementation plan for increasing BME representation across the NHS

Strategic objective	Outcome	Operational deliverable	Timeframe	Collaborative organisations
1. Leadership and cultural transformation:				
1.1 Develop and communicate rationale for WRES and the leadership aspiration, aligned to national bodies	1.1 Leaders / staff are clear on their responsibility and expectations on delivery	1.1 Provide timely communication to the system	From December 2018 onwards	NHS England, NHS Improvement, NHS Employers, NHS EDC
1.2 Senior leaders mentor and sponsor BME staff at grades 8d and below	1.2 BME staff are supported with career progression	1.2 Resource / tool on mentoring and sponsorship for senior leaders	January 2019	NHS England, NHS Improvement, NHS Employers
1.3 Focus on culture and leadership across the NHS	1.3 All new staff are aware of WRES and compassionate leadership	1.3 Embed WRES within the appraisal process of senior managers	From January 2019	NHS England, NHS Improvement
1.4 Support for regional/STP/ICO leaders on WRES and leadership aspirations	1.4 Leadership of new architecture is fully informed on the agenda and ambition	1.4 Provide support on the agenda across the new and emerging healthcare architecture	From December 2018	NHS England, NHS Improvement, NHS Employers

Strategic objective	Outcome	Operational deliverable	Timeframe	Collaborative organisations
2. Positive action and practical support				
2.1 Support and development of fit-for-purpose talent management programmes for BME managers; nurses (linked to the CNO BME SAG); doctors, and other parts of the NHS workforce	2.1 BME staff are supported to progress in career development, ensuring talent pipeline at all levels	2.1 Revise / support existing talent management programmes and initiatives	From December 2018	NHS England, NHS Improvement, CNO BME Strategic Advisory Group, Health Education England, NHS Leadership Academy, NHS Employers
2.2 Good practice tool on recruitment and retention (shortlisting; interviews; appraisals and development)	2.2 NHS managers are equipped with the skills and knowledge to improve on recruitment and retention practice	2.2 Produce good practice guidance for the NHS	January 2019	NHS England, NHS Improvement
2.3 Establish WRES expert leads within each of the seven NHS regions	2.3 Organisations are supported to continuously improve on their WRES performance	2.3 Recruit WRES regional leads across the NHS	From April 2019	NHS England, NHS Improvement
2.4 Support for middle management staff across the NHS	2.4 Middle managers are supported on the agenda in particular	2.4 Dedicated workshops and interventions	From January 2019	NHS England, NHS Improvement, Health Education England, NHS Leadership Academy

Strategic objective	Outcome	Operational deliverable	Timeframe	Collaborative organisations
3. Accountability and assurance				
3.1 Ensure progress on this agenda is infused within key policy levers for providers and commissioners	3.1 Effective incentives and sanctions included within the minimum number of levers for the maximum number of NHS organisations	3.1 Implementation and progress to appear within: the NHS standard contract, CQC 'well-led' inspections; CCG IAF and the Single Oversight Framework	From April 2019	CQC; NHS Improvement; NHS England, Health Education England, GMC, trade unions.
3.2 Embed WRES performance and progress within performance objectives and appraisals of senior leaders	3.2 Senior leaders are held accountable for progress (or lack of)	3.2 Review and update senior leader objectives and appraisal processes	Work from December 2018 – implemented by April 2019	NHS Improvement; NHS Providers, NHS Confederation

Strategic objective	Outcome	Operational deliverable	Timeframe	Collaborative organisations
4. Monitoring progress and benchmarking				
4.1 Include monitoring of progress on WRES as part of existing WRES data reporting and the NHS Improvement Model Hospital hub	4.1 High quality data and intelligence that help support organisations to continuously improve on workforce race equality	4.1 Performance against WRES is monitored and published (via dashboard) to help aid concerted support to organisations that need it most	From January 2019	NHS England, NHS Improvement, NHS Digital
4.2 Produce ethnicity pay gap data as part of existing annual WRES data reporting	4.2 High quality data and intelligence that help support organisations to continuously improve on the WRES	4.2 Performance against the WRES is monitored and published (via dashboard) to help aid concerted support to organisations that need it most	From 2019	NHS England, NHS Improvement, NHS Digital