WORKFORCE RACE EQUALITY STANDARD

2019 WRES data analysis report for eleven arm's length bodies.

August 2020

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NHS Workforce Race Equality Standard

2019 WRES data analysis report for arm's length bodies

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1. Preface

The production of this, the third Workforce Race Equality Standard (WRES) data report for national healthcare organisations, is an important sign that those named are committed to understanding and sharing the experience of their black and minority ethnic staff. The WRES was set up by the NHS in 2015 to enable it to hold a mirror up to itself, to reveal the disparities in opportunity and experience between black and minority ethic staff and white staff working across the healthcare system. Empowered with that data, these organisations, with support from the WRES team, are taking steps to eliminate that disparity, ensuring that all staff have an enhanced work experience.

Although the national organisations in this report are not obliged to implement the WRES, they have provided their data in the spirit of openness and transparency, recognising that equality is a priority across the whole NHS, not just for those delivering frontline care.

Having received data from six national organisations in 2017, I am delighted to say that, in 2019, eleven organisations shared their data. The more data we have, and the longer we collect it for, the better understanding we can develop of the lived experience of our black and minority ethnic workforce.

And yet data collection is only the first step. If we are to continue to see positive changes to race equality across the NHS, it is vital that local and national leaders continue to sincerely invest in this policy agenda, using the WRES data as a tool to engage frankly with their staff and make a real difference to working lives.

This report is unique in that it will be released at a time when the NHS is engaged in the greatest challenge of its history – supporting the country in its battle against COVID-19. This is a major test for our workforce, and never has there been a more important time to understand the challenges faced by our black and minority ethnic staff.

Marie Gabriel CBE
Chair, WRES Strategic Advisory Group

2. Executive summary

- The implementation of the Workforce Race Equality Standard (WRES) is not a mandatory requirement for arm's length bodies (ALBs). Despite this, eleven ALBs voluntarily agreed to implement the WRES.
- The eleven organisations that submitted their WRES data were: Care Quality Commission, Health Education England, Health Research Authority, NHS Blood and Transplant, NHS Business Services Authority, NHS Digital, NHS England, NHS Improvement, NHS Resolution, National Institute for Health and Care Excellence, and Public Health England.
- Data from NHS Resolution are excluded from the bulk of analyses in this report, but will be included in next year's report.
- For the purpose of this report, WRES data for NHS England, NHS Improvement are combined and presented as one organisation.
- Data were collected for 2019 and analysed by comparing the differences in 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 ten analysed national healthcare organisations (excluding data relating to NHS Resolution) show:
    - BME workforce representation in the ALBs ranged from 6.4% to 19.9% compared to an average of 19.7% across NHS trusts.
    - For all organisations, BME staff were significantly underrepresented in senior and very senior management (VSM) pay bands.
    - For six organisations, there were zero BME staff in VSM roles.
    - In eight of the ten organisations, white applicants were relatively more likely to be appointed from shortlisting compared to BME applicants.
    - Most ALBs did not submit staff survey data (required to measure against WRES indicators 5 to 8). For the organisations that submitted data for indicator 7, the proportion of staff that believed in equal opportunities was low and significantly worse that the NHS trust average for this indicator.
    - Three of the ALBs had zero BME board members.
    - Seven of the ALBs had zero BME executive board members.
    - For the majority of the eleven ALBs, there has been very little significant improvement on the WRES indicators from the previous year.

- Local NHS organisations are being supported to set improvement targets, ALBs should consider doing the same.

- The WRES Implementation team will continue to engage with those national organisations that have not as yet provided data to this annual data analysis exercise, and will work with those who have on improving the consistency of reporting across all organisations.

3. Introduction

Since 2015, the Workforce Race Equality Standard (WRES) has led the way in supporting local NHS organisations to close the gap in workplace experiences and opportunities between black and minority ethnic (BME) and white staff. More recently, the WRES programme has also engaged with national healthcare organisations to analyse their WRES data and shine a light on areas for improvement.

In 2017, progress against the WRES indicators was reported for six national healthcare organisations. In 2019, eight organisations' WRES data were reported, and in this report, WRES data are presented for ten organisations[1]. The data presented in this report enable us to examine the level of progress for these organisations over a three-year period; we will continue to add to this wealth of insight year-on-year.

We need to be realistic about the challenges we face. Whilst the openness and transparency with which these organisations have made their WRES data public should be acknowledged, the data suggest that much more work is needed to be carried out on this agenda. It is positive to note that organisations recognise the undeniable fact that tackling workforce race inequality is no longer an optional extra.

There are no easy fixes; this agenda requires persistence and patience in equal measure. As the data in this report indicate, some organisations are beginning to embrace the challenge, whilst other organisations need further concerted effort. The WRES programme of work will focus upon collective action for improvement, which is proportionate and at scale.

1 An eleventh organization, NHS Resolution, did submit data on the WRES indicators but, the data are included as an annex and are not referenced in the bulk of the analysis.

4. Methodology

4.1 The WRES indicators

The WRES requires NHS provider 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 the board of directors.

For the third year in a row, ALBs have agreed to collectively report against the WRES indicators. This report presents data for ten national healthcare bodies, against the nine WRES indicators as at 31 March 2019 and, where available, compares it to their respective data for previous years

The WRES indicators were developed in partnership with the wider NHS and are 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 team. To help facilitate accuracy and consistency, a data collection template was provided to each organisation. Once returned, the data were reviewed further and checked for accuracy. Any anomalies or outliers in the data were raised with the respective organisation.

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

In relation to WRES indicators 5 to 8, which are based on staff survey responses, organisations submitted data from their most recent staff survey findings.

The submission of WRES data took place between October 2019 and November 2019.

[2] *https://www.england.nhs.uk/publication/workforce-race-equality-standard-technical-guidance/*

Data analyses

Data from eleven national healthcare organisations are presented against each of the nine WRES indicators. Where appropriate and possible, data is compared over time and against the national average for NHS trusts.

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.

Data were also subjected to statistical testing. For indicators 2, 3 and 4, statistical analyses included the "four-fifths" rule. The "four-fifths" ("4/5ths" or "80 percent") rule is used to highlight whether practices have an adverse impact on an identified group, e.g. a sub-group of gender or ethnicity. For example, if the relative likelihood of an outcome for one sub-group compared to another is less than 0.8 or higher than 1.25, then the process would be identified as having an adverse impact.

4.3 Data issues and caveats

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. Where this is the case, it has been highlighted in the 'detailed findings' section of the report.

Organisations submitting data do not use the same staff grading frameworks and not all have an executive board. In addition, not all 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.

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, none 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 its operational expression.

All averages presented in this report are unweighted and do not consider 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.

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:

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

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.

For NHS England and NHS Improvement, in the last quarter of 2018/19 and first quarter of 2019/20 was a transitional period with changes to the Executive Director roles and new joint director roles commencing. There was a review to the formal membership of the two boards. Non-voting members were excluded from the data because even though they attend the board meetings, they are not formal board members.

Data from NHS resolution are not included in the analysis but can be seen in Annex 1.

5. Detailed Findings

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

Data for WRES indicator 1 were submitted using the template provided by the national WRES team. All ten ALBs submitted data for this indicator. It should be noted that some staff did not declare their ethnicity.

Agenda for Change (AfC) pay bands were used to analyse the data for all organisations except for Public Health England and the Care Quality Commission. Public Health England workforce is made up of both civil service pay grades and AfC bands, while the Care Quality Commission has its own pay and grading framework. These pay scales are not always directly comparable to the AfC bands; as such additional data analyses have been carried out for these two organisations.

NHS Improvement has employees on legacy Monitor pay grades which were converted to AfC band equivalent. WRES data for NHS England and NHS Improvement are combined; data are therefore presented for nine ALBs.

5.1.2 Overall results

For eight of the nine ALBs, BME staff representation was lower than the average for NHS trusts (19.7%). BME representation ranged from 6.4% at NHS Business Services Authority to 19.9% at Public Health England.

Six of the nine organisations observed an increase in the number and proportion of BME staff over the past year.

For all organisations, BME staff are significantly underrepresented in senior and Very Senior Management (VSM) pay bands.

For six organisations there were zero BME staff in VSM roles.

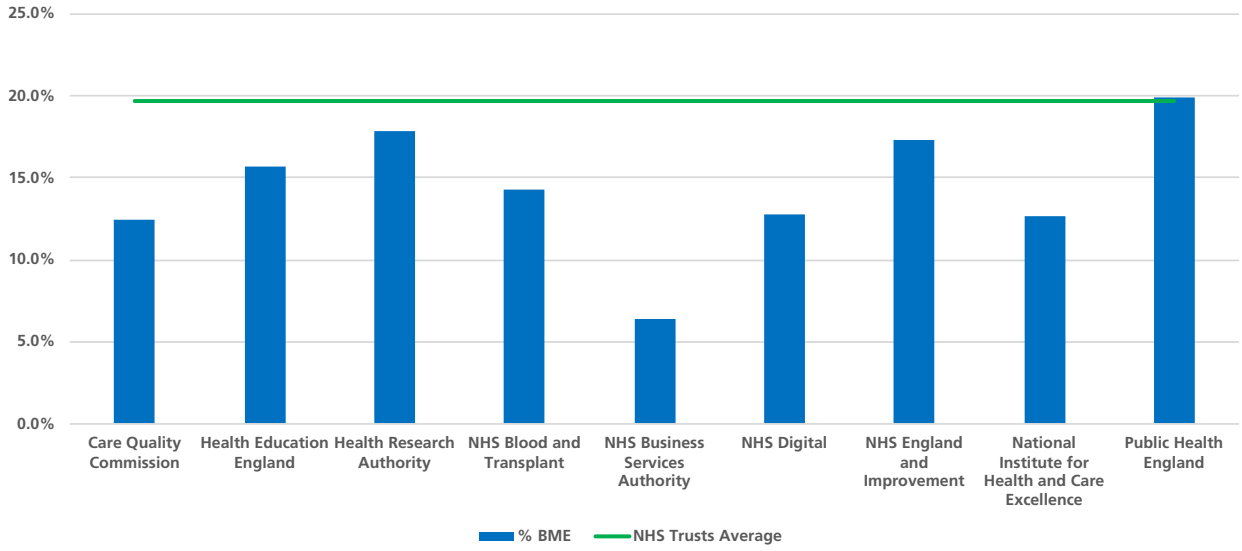
There has been no increase in the number of BME staff in VSM roles across the organisations where that data is available.

Table 1. Workforce by ethnicity: 2019

Organisation	% White	% BME	% Unknown
Care Quality Commission	78.5%	12.5%	9.0%
Health Education England	71.5%	15.7%	12.8%
Health Research Authority	76.5%	17.9%	5.6%
NHS Blood and Transplant	81.2%	14.3%	4.5%
NHS Business Services Authority	84.4%	6.4%	9.2%
NHS Digital	76.2%	12.8%	11.0%
NHS England and NHS Improvement	73.3%	17.4%	9.4%
National Institute for Health and Care Excellence	79.5%	12.6%	7.9%
Public Health England	66.5%	19.9%	13.5%
NHS trusts average	75.6%	19.7%	4.7%

- The percentage of BME staff in organisations ranged from 6.4% at NHS Business Services Authority to 19.9% at Public Health England.
- Except for NHS Blood and Transplant, all other organisations reported a percentage of ‘unknown’ staff ethnicity that was higher than the NHS trusts average of 4.7%.

Figure 1. Percentage of BME staff: 2019



- Eight of the nine organisations had BME staff representation that is lower than the national average for NHS trusts in England (19.7%). Only Public Health England (19.9%) had BME staff representation that was higher than the national average for NHS trusts in England.

- The discrepancies in BME staff representation is partly explained by the geographical location of some of the organisations. NHS Business Services Authority's main offices are in Newcastle, the population of which is 15% BME; and NHS Improvement's main office is in London, the population of which is 40% BME.

- CQC also has a large workforce based in Newcastle. It should also be noted that a large percentage of their staff are drawn from the adult social care workforce which has a different ethnic makeup compared to the health care workforce.

Table 2. Workforce by ethnicity: 2019

Organisation	White	BME	Unknown
Care Quality Commission	2610	416	300
Health Education England	1976	434	355
Health Research Authority	150	35	11
NHS Blood and Transplant	4442	785	246
NHS Business Services Authority	2608	198	284
NHS Digital	2139	358	309
NHS England and NHS Improvement	5877	1393	752
National Institute for Health and Care Excellence	534	85	53
Public Health England	3679	1103	747

NHS England and NHS Improvement, and Public Health England are the largest organisations. They also have the largest proportion and number of BME staff.

Table 3. BME and white staff headcount: 2018 compared to 2019

Organisation	White headcount change	BME headcount change
Care Quality Commission	75	1
Health Education England	242	85
Health Research Authority	-8	-2
NHS Blood and Transplant	106	69
NHS Business Services Authority	261	43
NHS Digital	-221	-44
NHS England and NHS Improvement	366	148
National Institute for Health and Care Excellence	17	-8
Public Health England	28	88

- Six of the nine organisations observed an increase in the number of BME staff members, over the past year. NHS Digital has seen a significant decrease in the number of both white and BME staff.

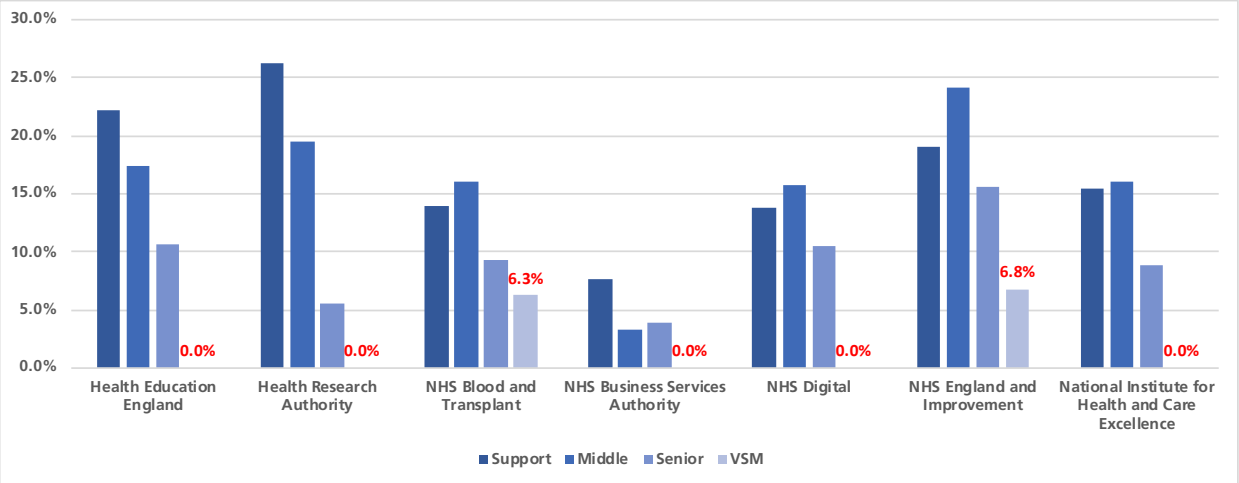
Table 4. Percentage of BME staff: 2018 compared to 2019

Organisation	2018 % BME	2019 % BME	Difference
Care Quality Commission	12.8%	12.5%	-0.3%
Health Education England	14.4%	15.7%	1.3%
Health Research Authority	17.8%	17.9%	0.1%
NHS Blood and Transplant	13.6%	14.3%	0.8%
NHS Business Services Authority	5.8%	6.4%	0.6%
NHS Digital	12.9%	12.8%	-0.2%
NHS England and NHS Improvement	16.5%	17.4%	0.9%
National Institute for Health and Care Excellence	14.0%	12.6%	-1.4%
Public Health England	18.6%	19.9%	1.4%
NHS Trusts Average	18.9%	19.7%	0.8%

Based on staff who declared their ethnicity.

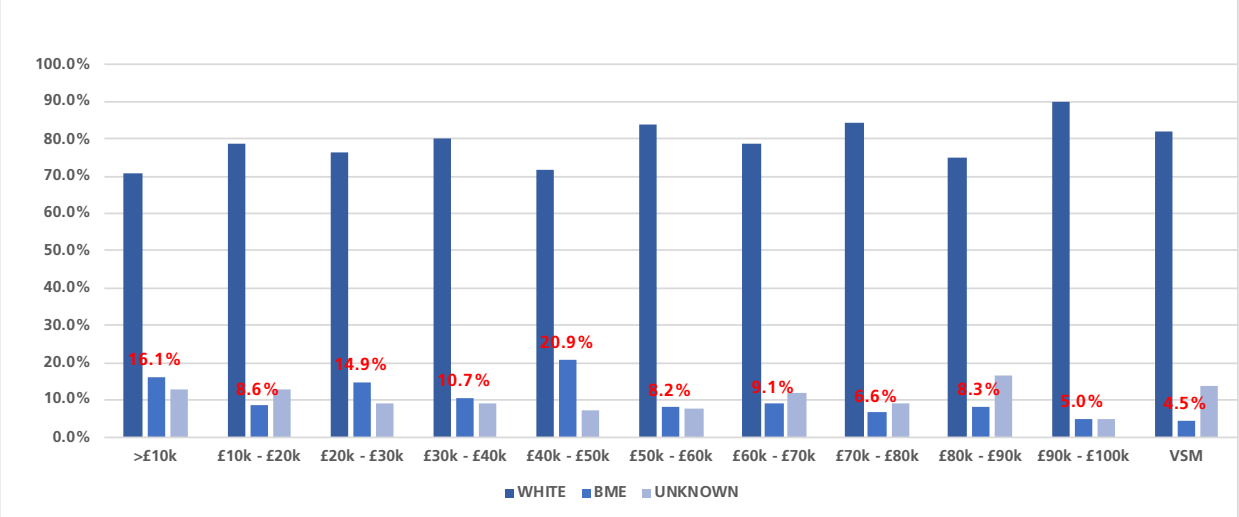
- For three of ALBs, the proportion of BME staff in the organisation decreased over the past year.

Figure 2. Percentage of BME staff by AfC pay bandings: 2019



For all seven organisations that use AfC pay bands, BME staff were underrepresented in the senior (AfC bands 8a-9) and Very Senior Management (VSM) bands.

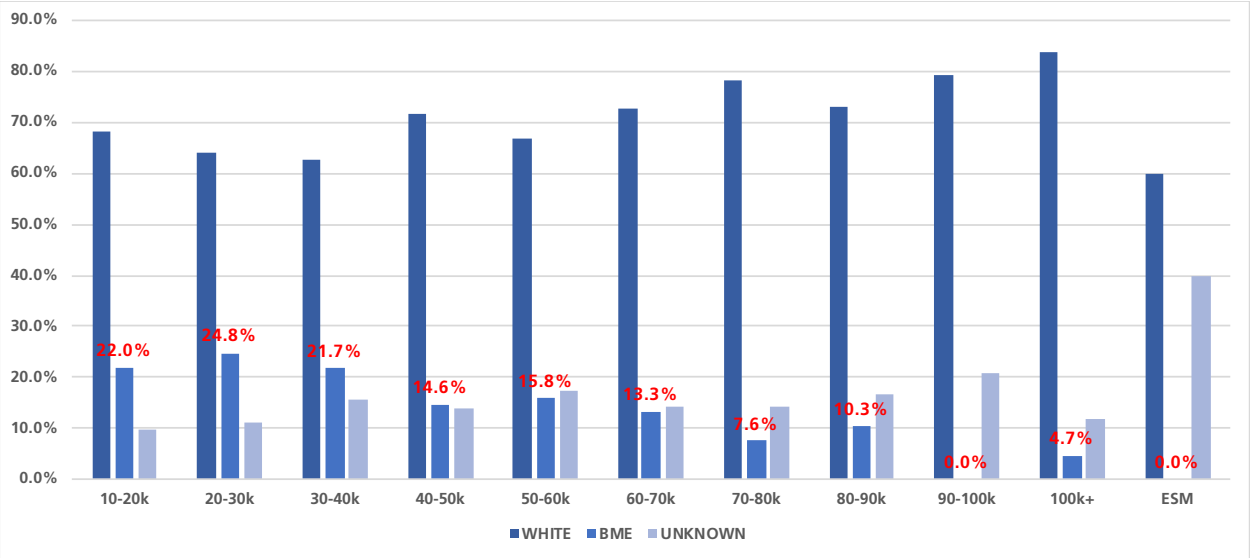
Figure 3. Percentage of staff by salary range for Care Quality Commission: 2019



- At the Care Quality Commission, BME staff were overrepresented in the less than £10k, £20k to £30k and £40k to £50k pay bands.

- BME staff were underrepresented in all pay bands above 50k.

Figure 4. Percentage of staff by pay bands for Public Health England: 2019



- At Public Health England, BME staff were overrepresented in all pay bands up to £40k, and underrepresented in all pay bands above that.

Table 5. Medical and Dental staff by ethnicity: 2019

Organisation	% White	% BME	% Unknown
Health Education England	64.1%	14.2%	21.7%
NHS England and NHS Improvement	60.9%	26.1%	13.0%
Public Health England	61.8%	28.8%	9.4%
NHS trusts consultants average	57.1%	36.9%	6.0%

Table 6. Medical and Dental staff ethnicity headcount: 2019

Organisation	White	BME	Unknown
Health Education England	441	98	149
NHS England and NHS Improvement	84	36	18
Public Health England	197	92	30

- For Health Education England, Public Health England and NHS England and NHS Improvement, a significant number of senior managerial roles are undertaken by medical and dental staff. BME staff were overrepresented in these roles compared to the overall BME representation in the respective organisations.

Table 7. Percentage of staff at VSM pay bands by ethnicity: 2019

Organisation	% White	% BME	% Unknown
Care Quality Commission	81.8%	4.5%	13.6%
Health Education England	84.0%	0.0%	16.0%
Health Research Authority	75.0%	0.0%	25.0%
NHS Blood and Transplant	75.0%	6.3%	18.8%
NHS Business Services Authority	61.1%	0.0%	38.9%
NHS Digital	85.0%	0.0%	15.0%
NHS England and NHS Improvement	85.5%	6.6%	7.7%
National Institute for Health and Care Excellence	100.0%	0.0%	0.0%
Public Health England	60.0%	0.0%	40.0%
NHS Trusts Average	84.5%	6.5%	9.0%

Based on staff who declared their ethnicity. For staff not on AfC pay scales, VSM refers to staff earning above £100k or staff who meet the definition as per the technical guidance.

PHE uses the ESM framework which starts at £90,900.

- Six ALBs had no BME staff at VSM level.

Table 8. Number of staff at VSM pay bands: 2019

Organisation	White	BME	Unknown
Care Quality Commission	18	1	3
Health Education England	21	0	4
Health Research Authority	3	0	1
NHS Blood and Transplant	12	1	3
NHS Business Services Authority	11	0	7
NHS Digital	17	0	3
NHS England and NHS Improvement	280	23	48
National Institute for Health and Care Excellence	6	0	0
Public Health England	3	0	2

- NHS England and NHS Improvement has the highest number of BME staff at VSM band.

Table 9. Number of staff at VSM pay bands: 2018 and 2019

Organisation	White headcount change	BME headcount change
Care Quality Commission	2	0
Health Education England	-9	0
Health Research Authority	0	0
NHS Blood and Transplant	-2	0
NHS Business Services Authority	-2	0
NHS Digital	2	0
NHS England and NHS Improvement	14	-1
National Institute for Health and Care Excellence	0	0
Public Health England	-1	0

- There has been no increase in the number of BME staff at VSM level in any of the nine organisations over the past year.
- Four ALBs have seen a reduction in the number of white VSM staff over the past year.

5.2 WRES indicator 2 – Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants

5.2.1 Data sources and reliability

All ten organisations submitted data for 2019. Some also provided data for 2018.

5.2.1 Overall results

- For eight organisations, white applicants were relatively more likely to be appointed from shortlisting compared to BME applicants. BME staff apply and get shortlisted in significant proportions across all the organisations.
- For six of the nine organisations, the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants was higher than the NHS trusts average of 1.46.
- Five organisations saw an improvement on this indicator in 2019 compared to 2018.

Table 10. Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants: 2018 and 2019

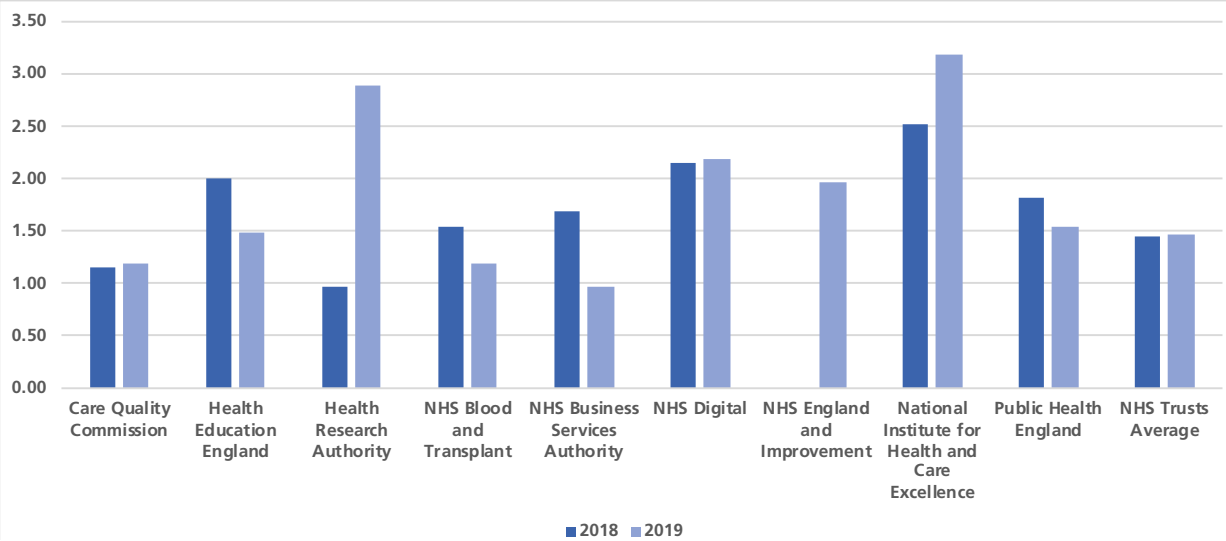
Organisation	2018	2019
Care Quality Commission	1.15	1.18
Health Education England	2.00	1.48
Health Research Authority	0.96	2.89
NHS Blood and Transplant	1.55	1.19
NHS Business Services Authority	1.70	0.97
NHS Digital	2.15	2.19
NHS England and NHS Improvement	-	1.97
National Institute for Health and Care Excellence	2.52	3.19
Public Health England	1.82	1.55
NHS Trusts Average	1.45	1.46

- For eight of the nine organisations, white applicants were more likely to be appointed from shortlisting.

- Care Quality Commission, NHS Blood and Transplant, and NHS Business Services Authority had a relative likelihood that was within the non-adverse range of 0.8 to 1.25 based on the four fifths rule.

- For Health Research Authority, NHS Digital and the National Institute for Health and Care Excellence, white applicants were more than twice as likely to be appointed from shortlisting compared to BME staff.

Figure 5: Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants: 2018 and 2019



- For six of the nine organisations, the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants was higher than the NHS trusts average of 1.46.

Table 11. Shortlisting and appointments: 2019

Organisation	White shortlisted	BME shortlisted	White appointed	BME appointed
Care Quality Commission	2008	482	296	60
Health Education England	3174	1969	793	333
Health Research Authority	56	12	27	2
NHS Blood and Transplant	5333	1684	992	263
NHS Business Services Authority	3018	403	605	83
NHS Digital	416	198	129	28
NHS England and NHS Improvement	8854	5754	815	269
National Institute for Health and Care Excellence	2740	2460	32	9
Public Health England	1791	1662	407	244

Table 12. BME shortlisting: 2019

Organisation	BME as a % of shortlisted applicants
Care Quality Commission	19.0%
Health Education England	36.1%
Health Research Authority	17.1%
NHS Blood and Transplant	23.5%
NHS Business Services Authority	11.6%
NHS Digital	28.7%
NHS England and NHS Improvement	37.9%
National Institute for Health and Care Excellence	44.5%
Public Health England	45.7%

- BME applicants ranged between 11.8% (NHS Business Service Authority) to 44.5% (National Institute for Health and Care Excellence) of total shortlisted applicants.

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

Eight organisations provided 2019 data for this indicator. Even if a small number of staff enter the formal disciplinary process, organisations must still review their policies and processes in this area to make sure that they are fair and appropriate.

5.3.2 Overall results

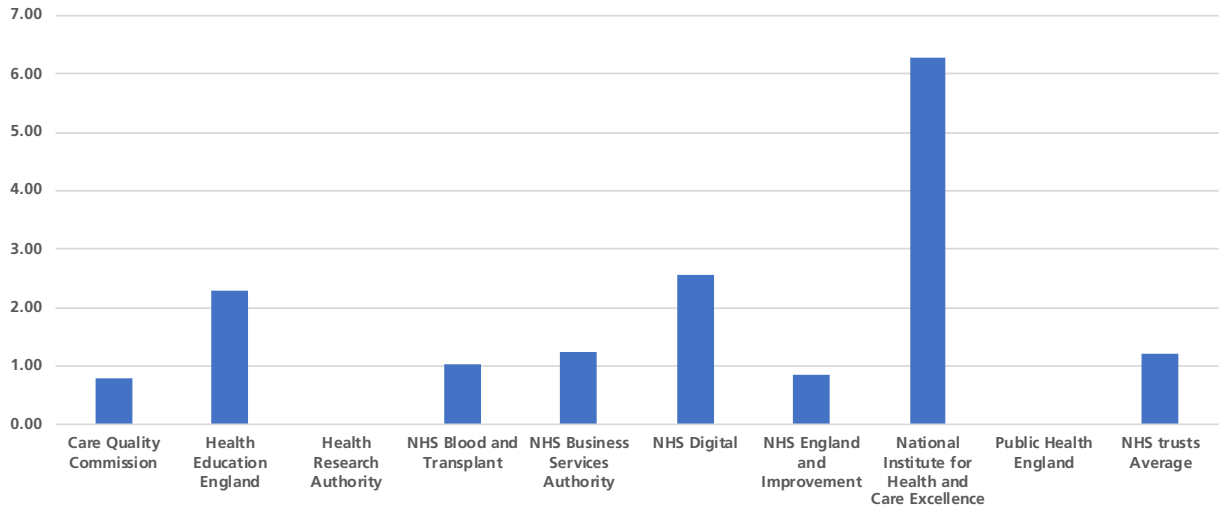
- For five of the organisations, BME staff had a higher relative likelihood of entering the formal disciplinary process compared to white staff.
- For most organisations the overall number of staff entering the formal disciplinary process has decreased since 2018.

Table 13. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff: 2018 and 2019

Organisation	2018	2019
Care Quality Commission	0.58	0.78
Health Education England	0.00	2.28
Health Research Authority	0.00	0.00
NHS Blood and Transplant	1.40	1.04
NHS Business Services Authority	0.80	1.23
NHS Digital	1.47	2.56
NHS England and NHS Improvement	2.01	0.86
National Institute for Health and Care Excellence	2.78	6.28
Public Health England	0.72	-
NHS trusts Average	1.24	1.22

- For five of the eight organisations, BME staff were relatively more likely to enter the formal disciplinary process compared to white staff.

Figure 6: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff: 2019



- Four organisations had a relative likelihood of BME staff entering the formal disciplinary process that was higher than the NHS trust average for the same indicator.

Table 14. Staff entering the formal disciplinary process: 2019

Organisation	2018		2019	
	White	BME	White	BME
Care Quality Commission	21	2	8	1
Health Education England	3	0	2	1
Health Research Authority	0	0	0	0
NHS Blood and Transplant	104	24	120	22
NHS Business Services Authority	19	1	32	3
NHS Digital	16	4	7	3
NHS England and NHS Improvement	11	5	29	6
National Institute for Health and Care Excellence	2	1	1	1

- Three organisations observed an increase in the number of staff entering the formal disciplinary process.

Table 15. Proportion of staff entering the formal disciplinary process: 2019

Organisation	2018		2019	
	White	BME	White	BME
Care Quality Commission	0.8%	0.5%	0.3%	0.2%
Health Education England	0.2%	0.0%	0.1%	0.2%
Health Research Authority	0.0%	0.0%	0.0%	0.0%
NHS Blood and Transplant	2.4%	3.4%	2.7%	2.8%
NHS Business Services Authority	0.8%	0.6%	1.2%	1.5%
NHS Digital	0.7%	1.0%	0.3%	0.8%
NHS England and NHS Improvement	0.2%	0.4%	0.5%	0.4%
National Institute for Health and Care Excellence	0.4%	1.1%	0.2%	1.2%
NHS trusts Average	1.1%	1.4%	1.1%	1.3%

- For both NHS Blood and Transplant and NHS Business Services Authority, the likelihood of staff entering the formal disciplinary process was higher than the average for NHS trusts. This was true for both white and BME staff.

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

5.4.1 Data sources and reliability

The following organisations provided data for this WES indicator: Care Quality Commission, Health Education England, Health Research Authority, NHS Blood and Transplant, NHS Digital, NHS England and NHS Improvement.

5.4.2 Overall results

- For three of the six organisations, white staff were relatively more likely to access non–mandatory training and CPD compared to BME staff. The inverse was true for the other three.

- There are significant variations in the proportion of staff accessing non–mandatory training and CPD. Ranging from 9.9% to 85.3%

Table 16. Relative likelihood of white staff accessing non – mandatory training and continuing professional development (CPD) compared to BME staff: 2018 and 2019.

Organisation	2018	2019
Care Quality Commission	1.00	1.09
Health Education England	1.06	*1.55
Health Research Authority	-	0.95
NHS Blood and Transplant	0.59	1.09
NHS Digital	0.82	0.88
NHS England and NHS Improvement	-	0.99
NHS trusts Average	1.15	1.15

**HEE provided data for online training only. This does not include all non-mandatory training.*

- For half of the organisations white staff were relatively more likely to access non–mandatory training and CPD compared to BME staff.

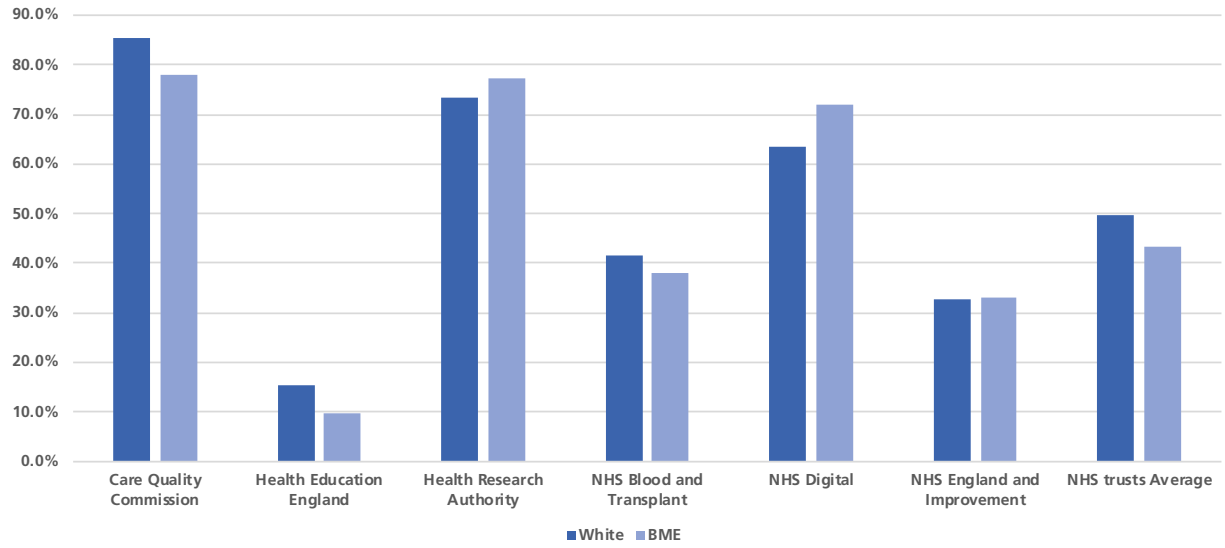
- Only Health Education England, and NHS England and NHS Improvement had a relative likelihood that was outside the non-adverse range of 0.8 to 1.25 based on the four fifths rule.

Table 17. Percentage of staff accessing non–mandatory training and continuing professional development (CPD): 2019

Organisation	White	BME
Care Quality Commission	85.3%	78.1%
Health Education England	15.3%	9.9%
Health Research Authority	73.3%	77.1%
NHS Blood and Transplant	41.5%	38.0%
NHS Digital	63.6%	72.1%
NHS England and NHS Improvement	32.7%	33.2%
NHS trusts Average	49.9%	43.3%

- The percentage of staff accessing non–mandatory training and CPD varied significantly, ranging from 85.3% for white staff at Care Quality Commission to 9.9% for BME staff at Health Education England.

Figure 6: Percentage of staff accessing non–mandatory training and continuing professional development (CPD): 2019



- Care Quality Commission, Health Research Authority and NHS Digital staff had a higher percentage of staff accessing non-mandatory training and CPD compared to the NHS trust average.

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, the data could not be analysed due to the low number of responses. This is not a data quality issue; rather it reflects 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. Four organisations provided data for this indicator: Care Quality Commission, Health Education England, NHS Blood and Transplant, and National Institute for Health and Care Excellence. Owing to reporting timeframes, the data listed in this report for 2019 refers to the 2018 annual survey and the data for 2018 refers to our 2017 survey.

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

Overall results

- BME staff are more likely to have experienced harassment, bullying or abuse from staff compared to white staff for three of the four organisations that provided data for this indicator.

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

Table 14. Percentage of staff experiencing harassment, bullying or abuse from other staff in last 12 months: 2018

Organisation	% White	% BME
Care Quality Commission	10.0%	14.0%
Health Education England	14.0%	15.0%
NHS Blood and Transplant	13.9%	13.9%
National Institute for Health and Care Excellence	5.8%	10.0%
NHS trusts Average	24.2%	29.0%

- For Care Quality Commission, Health Education England, and the National Institute for Health and Care Excellence, a higher percentage of BME staff reported experiencing harassment, bullying or abuse from staff in the last 12 months compared to white staff.
- For NHS Blood and Transplant, white and BME staff experienced the same levels of harassment, bullying or abuse from staff.

Table 15. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months: 2017 and 2018

Organisation	2018		2019	
	% White	% BME	% White	% BME
Care Quality Commission	11.0%	12.0%	10.0%	14.0%
Health Education England	13.7%	15.0%	14.0%	15.0%
NHS Blood and Transplant	16.2%	19.7%	13.9%	13.9%
National Institute for Health and Care Excellence	5.8%	11.0%	5.8%	10.0%
NHS trusts Average	23.3%	27.8%	24.2%	29.0%

- Only NHS Blood and Transplant observed a decrease in the percentage of both BME and white staff experiencing harassment, bullying or abuse from staff.
- All organisations have levels of harassment, bullying or abuse that are lower than the average for NHS trusts.

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. Only three organisations provided data for this indicator: Care Quality Commission, Health Education England, and NHS Blood and Transplant. Owing to reporting timeframes, the data listed in this report for 2019 refers to the 2018 annual survey and the data for 2018 refers to our 2017 survey

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

5.7.2 Overall results

- For all organisations that provided data, BME staff were less likely to believe that their organisation provided equal opportunities for career progression or promotion.

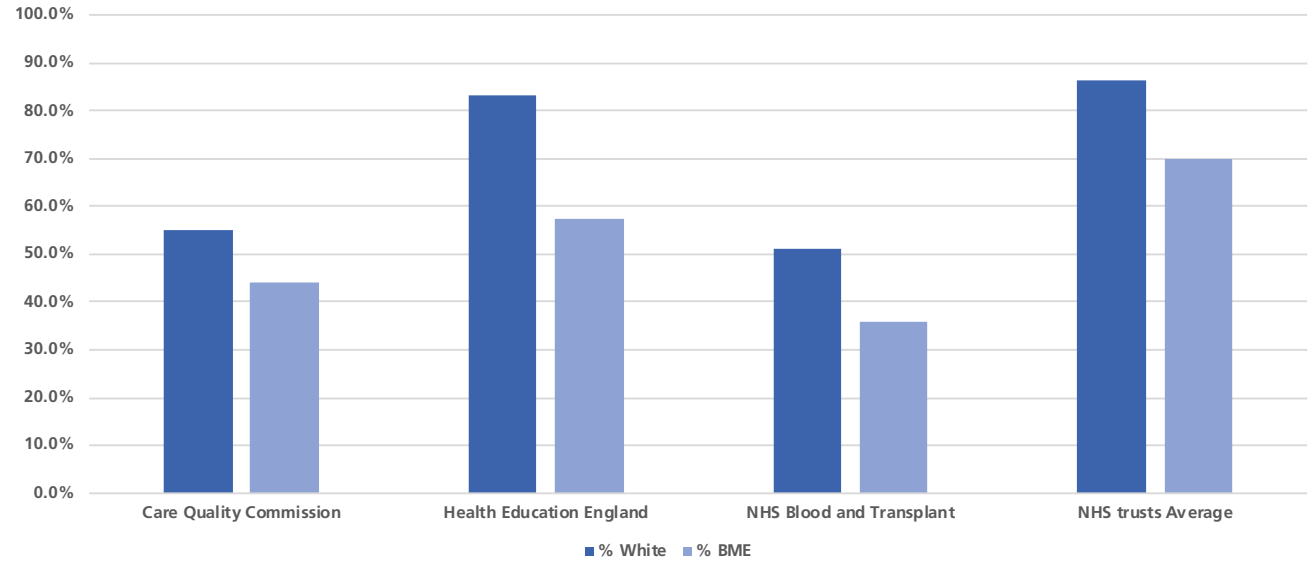
- Compared to the NHS trusts average, a lower percentage of staff believed that their organisation provided equal opportunities for career progression or promotion for all organisations that provided data for this indicator.

Table 16. Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion: 2019

Organisation	% White	% BME
Care Quality Commission	55.0%	44.0%
Health Education England	83.0%	57.3%
NHS Blood and Transplant	51.0%	36.0%
NHS trusts Average	86.3%	69.9%

- For all organisations a lower percentage of BME staff believed that their organisation provided equal opportunities for career progression or promotion compared to white staff.

Figure 6: Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion: 2019



- For all three organisations, a lower percentage of staff believed that their organisation provided equal opportunities for career progression or promotion compared to the average for NHS trusts.

Table 17. Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion: 2018 and 2019

Organisation	2018		2019	
	% White	% BME	% White	% BME
Care Quality Commission	55.0%	41.0%	55.0%	44.0%
Health Education England	-	-	83.0%	57.3%
NHS Blood and Transplant	47.8%	42.3%	51.0%	36.0%
NHS trusts Average	86.8%	71.9%	86.3%	69.9%

- There is a slight improvement in data over time for BME staff in the Care Quality Commission and for white staff at NHS Blood and Transplant.

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. Seven organisations provided data for this indicator: Care Quality Commission, Health Education England, NHS Blood and Transplant, and National Institute for Health and Care Excellence. Owing to reporting timeframes, the data listed in this report for 2019 refers to the 2018 annual survey and the data for 2018 refers to our 2017 survey.

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

5.8.2 Overall results

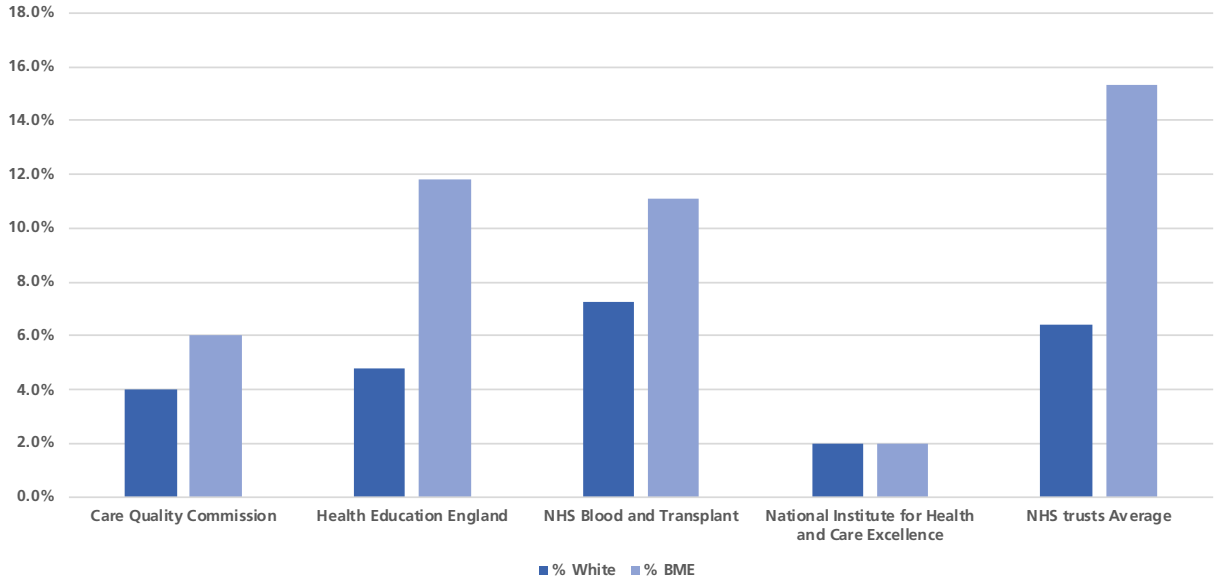
- For three organisations submitting data, BME staff were more likely to report having personally experienced discrimination at work from a manager, team leader or other colleague.
- The proportion of BME staff BME staff who personally experienced discrimination at work for ALBs was lower than the average for BME staff in NHS trusts.

Table 18. Percentage of staff reporting having personally experienced discrimination at work from a manager, team leader or other colleague: 2019.

Organisation	% White	% BME
Care Quality Commission	4.0%	6.0%
Health Education England	4.8%	11.8%
NHS Blood and Transplant	7.3%	11.1%
National Institute for Health and Care Excellence	2.0%	2.0%
NHS trusts Average	6.4%	15.3%

- For three of the four organisations, BME staff were more likely to report having personally experienced discrimination at work in the last 12 months compared to white staff.
- White and BME staff in National Institute for Health and Care Excellence personally experienced discrimination in equal proportions.

Figure 7: Percentage of staff reporting having personally experienced discrimination at work from a manager / team leader or other colleagues: 2019



- A higher percentage of white staff in NHS Blood and Transplant personally experienced discrimination at work in the last 12 months compared to the average for white staff in NHS trusts.

- The proportion of BME staff BME staff who personally experienced discrimination at work for ALBs was lower than the average for BME staff in NHS trusts.

Table 19. Percentage of staff reporting have you personally experienced discrimination at work from a manager, team leader or other colleague: 2018 and 2019.

Organisation	2018		2019	
	% White	% BME	% White	% BME
Care Quality Commission	4.0%	11.0%	4.0%	6.0%
Health Education England	4.8%	11.8%	4.8%	11.8%
NHS Blood and Transplant	6.0%	14.0%	7.3%	11.1%
National Institute for Health and Care Excellence	1.8%	8.6%	2.0%	2.0%
NHS trusts Average	6.6%	15.0%	6.4%	15.3%

- Care Quality Commission, NHS Blood and Transplant and National Institute for Health and Care Excellence saw a decrease in the percentage of BME staff who experienced discrimination at work. NHS Blood and Transplant and National Institute for Health and Care Excellence saw an increase in the percentage of white staff who experienced discrimination at work.

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 organisations were able to provide data for this indicator.

Consideration needs to be given 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 does not have an executive board. It has an advisory board that has no executive authority. Its role is to advise, support and constructively challenge the Chief Executive of the organisation. The highest decision-making body level of authority in Public Health England is the Management Committee of directors. Therefore, it is the data for this group which has been reported.

5.9.2 Overall results

- According to data provided three of the ALBs had no BME representation on the board.
- Three ALBs had one BME board member and three had more than one BME board member.
- Compared to the previous year, only one ALB saw an increase in the number of BME board members.
- Seven ALBs have no BME executive board members.
- There has been no change in the number of executive BME board members for eight of the ALBs. One organisation saw an increase in the number of executive BME board members.

Table 21. Board membership by ethnicity: 2019

Organisation	White	BME	Unknown
Care Quality Commission	81.3%	6.3%	12.5%
Health Education England	94.1%	5.9%	0.0%
Health Research Authority	40.0%	0.0%	60.0%
NHS Blood and Transplant	80.0%	5.0%	15.0%
NHS Business Services Authority	80.0%	0.0%	20.0%
NHS Digital	40.0%	13.3%	46.7%
NHS England and NHS Improvement	86.4%	13.6%	0%
National Institute for Health and Care Excellence	33.3%	0.0%	66.7%
*Public Health England	78.6%	21.4%	0.0%
NHS Trusts Average	86.6%	8.4%	5.0%

** Figures are for Public Health England's management committee*

- Health Research Authority, NHS Business Services Authority and, National Institute for Health and Care Excellence had no BME board member at the time of data collection. It should be noted that organisations have board members at the time who did not declare their ethnicity.

Table 21. Board membership by ethnicity: 2019

Organisation	White	BME	Unknown
Care Quality Commission	13	1	2
Health Education England	16	1	0
Health Research Authority	4	0	6
NHS Blood and Transplant	16	1	3
NHS Business Services Authority	8	0	2
NHS Digital	6	2	7
NHS England and NHS Improvement	19	3	0
National Institute for Health and Care Excellence	4	0	8
*Public Health England	11	3	0

** Figures are for Public Health England's management committee*

NHS Digital, NHS England and NHS Improvement, and Public Health England had more than one BME board member.

Table 22. Difference between the organisations' board membership and its overall workforce: 2019.

Organisation	BME board	BME %
Care Quality Commission	6.3%	12.5%
Health Education England	5.9%	15.7%
Health Research Authority	0.0%	17.9%
NHS Blood and Transplant	5.0%	14.3%
NHS Business Services Authority	0.0%	6.4%
NHS Digital	13.3%	12.8%
NHS England and NHS Improvement	13.6%	17.4%
National Institute for Health and Care Excellence	0.0%	12.6%
*Public Health England	21.4%	19.9%
NHS Trusts Average	8.4%	19.7%

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

- NHS digital and Public Health England had BME board representation that reflected the BME workforce in those respective organisations.

Table 23. BME board members: 2018 and 2019

Organisation	2018	2019	Difference
Care Quality Commission	1	1	0
Health Education England	1	1	1
Health Research Authority	0	0	0
NHS Blood and Transplant	1	1	0
NHS Business Services Authority	0	0	0
NHS Digital	2	2	0
NHS England and NHS Improvement	3	3	0
National Institute for Health and Care Excellence	0	0	0
Public Health England	1	3	2

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

- Only Public Health England saw an increase the number of BME board members between 2018 and 2019.

Table 24. Executive board members: 2019

Organisation	White	BME	Unknown
Care Quality Commission	85.7%	0.0%	14.3%
Health Education England	100.0%	0.0%	0.0%
Health Research Authority	66.7%	0.0%	33.3%
NHS Blood and Transplant	76.9%	7.7%	15.4%
NHS Business Services Authority	50.0%	0.0%	50.0%
NHS Digital	50.0%	0.0%	50.0%
NHS England and NHS Improvement	100.0%	0.0%	0.0%
National Institute for Health and Care Excellence	100.0%	0.0%	0.0%
*Public Health England	66.7%	33.4%	0.0%
NHS Trusts Average	89.6%	7.8%	2.7%

- Only NHS Blood and Transplant and Public Health England had executive BME board members.

Table 25. Executive board members: 2018 and 2019

Organisation	2018	2019	Difference
Care Quality Commission	0	0	0
Health Education England	0	0	0
Health Research Authority	0	0	0
NHS Blood and Transplant	1	1	0
NHS Business Services Authority	0	0	0
NHS Digital	0	0	0
NHS England and NHS Improvement	0	0	0
National Institute for Health and Care Excellence	0	0	0
Public Health England	0	2	2

- Between 2018 and 2019, there was no increase in the number of BME executive board members for eight of the nine organisations.

Only Public Health England observed an increase in the number of BME executive directors – an increase of two since 2018.

6. Next steps and conclusions

This report is a clear reminder of the challenge, and opportunity, facing national healthcare organisations. Boards of organisations recognise the fact that returns on investment on this agenda are cumulative and measurable in terms of greater staff engagement and satisfaction; better patient outcomes and more efficient use of resources. This is not just relevant to local NHS organisations, but also for the national healthcare bodies.

The WRES is designed to help initiate continuous improvement in the treatment of, and opportunities for, BME staff across the healthcare system. Holding up a mirror to organisations regarding their own data is an essential first step to realising that goal. The data are now enabling organisations to learn and put into place improvement plans, using the WRES as a catalyst for change.

ALBs have an important role to play when it comes to the development of strategy and leadership in the NHS. It is therefore important to ensure that all voices and ideas are represented in these organisations. We know that diversity in teams and leadership helps to break the negative consequences of "group think".

The chairs of national healthcare organisations recently committed to embarking on a collaborative approach on workforce race equality – working in partnership to improve their organisational performance on this agenda. The national WRES team will support these organisations, and their boards, on this journey of continuous improvement.

It is clear that, despite the work already undertaken, there is more to do. In the immediate term, we will work towards gathering data from all national organisations and encourage a greater degree of uniformity in how it is collected and reported.

More than ever before, there is now a clear focus on workforce race equality and inclusion in the NHS, this is reflected in the NHS Long Term Plan and in the Interim NHS People Plan; and alongside the national goal: that NHS leadership should be as diverse as the rest of the workforce within the next ten years, we have a strong direction for travel.

7. The WRES indicators (2019)

	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 by: • Non-clinical staff • Clinical staff, of which Non-medical staff Medical and dental staff Note: Definitions for these categories are based on Electronic Staff Record occupation codes except for medical and dental staff, which are based upon grade codes.
2.	Relative likelihood of staff being appointed from shortlisting across all posts Note: This refers to both external and internal posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator is 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.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for white and BME staff
9.	Percentage difference between the organisations' board membership and its overall workforce disaggregated: • By voting membership of the board • By executive membership of the board

Annex 1 NHS Resolution WRES data

As part of their Equality Diversity and Inclusion strategy, NHS Resolution have committed to publishing their WRES data for 2019, with the aim of being transparent in addressing any areas that will improve the workplace experience and representation at all levels for black and minority ethnic (BME) staff.

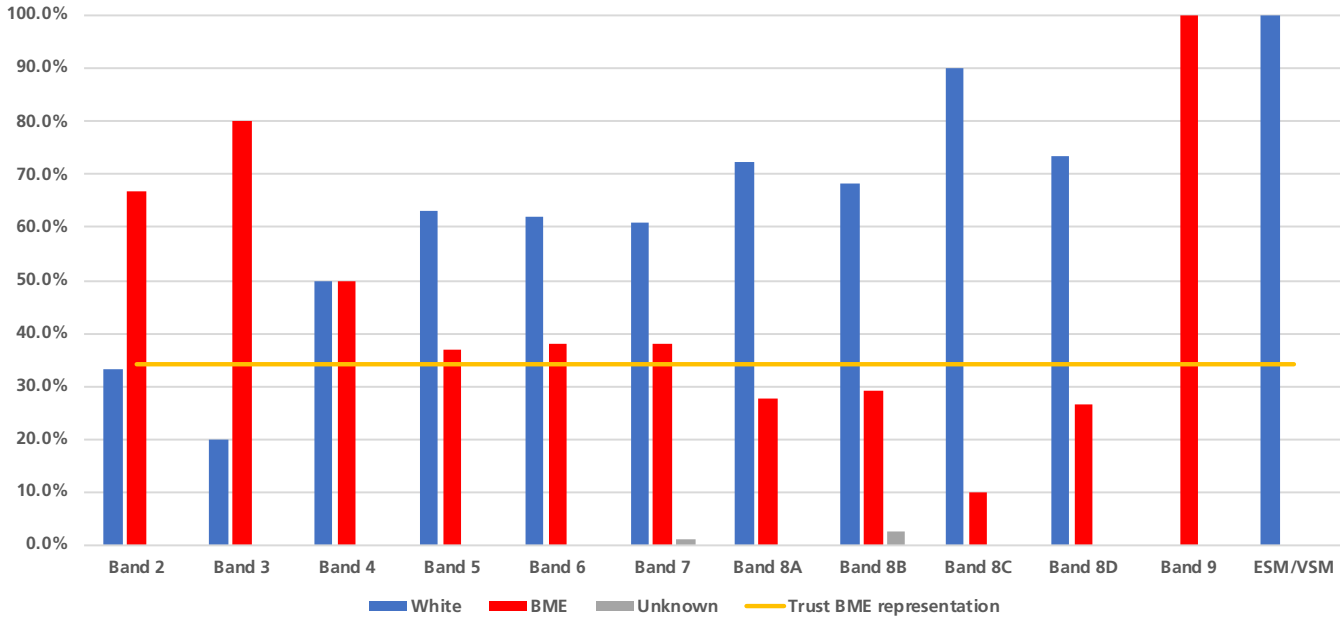
As this is their first year of reporting, there is no comparative analysis and so their data has been included in this report as an annex. For next year's submission, NHS Resolution's data will be part of the main report and will include year on year improvements or gaps, as well as comparisons against other national bodies.

Indicator 1

Year	White	BME	Unknown	Total	White	BME	Unknown
2019	192	103	2	297	64.6%	34.7%	0.7%

34.7% (103) of staff working for NHS Resolution are from a BME background.

Staff by Agenda for Change pay bands



- BME staff are underrepresented in AfC pay bands 8A, 8B, 8C and 8D.
- The two staff at band 9 are BME
- There is no BME representation at the ESM pay band.

Indicator 2 - 4

Organisation	2019
2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	1.15
3. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	-
4. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	0.68

- White staff are more likely to be appointed from short listing.
- BME staff are more likely to access non-mandatory training.
- No staff entered the formal disciplinary process this year.

Indicator 5 - 8

While NHS Resolution did complete a staff survey, they did not collate responses by ethnicity and were therefore unable to provide a breakdown on responses by White and BME staff. However, the overall results from their interim staff survey in 2019 showed that

• 14% of respondents reported that they had experienced harassment, bullying or abuse from their manager/team leader or other colleague. Of the harassment, bullying and abuse cases brought to the attention of the HR function within the reporting period, 100% were from a White background.

• 6% of respondents disagreed or strongly disagreed that the organisation provides equal opportunities for career progression or promotion specifically with regards to ethnicity.

• 8% of respondents stated they had experienced discrimination from their manager/ team leader or other colleague, although there were no formal cases of discrimination raised with the HR function informally or formally within this reporting period.

NHS Resolution is taking steps to ensure their 2020/2021 staff survey is commissioned to include the right questions and staff demographics in order to respond directly to the WRES indicators 5 to 8.

Indicator 9

WRES indicator	2019
9. BME board membership	0.0%

- NHS Resolution has a Board of 12 members, which comprises of:

- Four Executive Directors
- Four Non-executive Directors
- One non-executive Chair
- One Associate Executive Director
- Two Associate non-executive Directors

- There is no board member from a BME background.

Action Plan

NHS Resolution's EDI strategy, drafted ahead of the 2018/2019 WRES submission, had already identified areas the organisation needed to address to improve BME engagement, work experiences and representation. This strategy sets out their intended actions and areas of focus in order to ensure NHS Resolution has a culture where individual differences and diversity are welcomed. They hope to achieve this through:

- Promoting equal rights and opportunities;
- Pro-actively tackling discrimination or disadvantage in all its forms;
- Creating an open and inclusive culture where equality, diversity and inclusion can be comfortably discussed;
- Having an inclusive and diverse workforce, to reflect the rich diversity of London and Leeds.

Some of the areas, which will be reviewed as part of this strategy, include:

- Recruitment, selection and on-boarding
- Career development and talent management
- Staff welfare, health and wellbeing

In the last year, NHS Resolution have already taken several steps to improve the experiences and opportunities for its BME staff which include the following:

- Promoted and supported access to leadership development for all levels of staff
- Promoted and supported external leadership development opportunities aimed specifically at BME staff i.e. the 'Ready now' and 'Stepping up' programmes.
- Implemented the Junior Case Manager apprenticeships, which is a positive step in supporting career progression for BME groups.
- The HR & OD team have offered career coaching and interview skills to support and improve competency and confidence around large-scale recruitment campaigns

NHS Resolution are also in the process of establishing a BME staff network in order to maximise engagement with all staff from under-represented groups.