WORKFORCE RACE EQUALITY STANDARD (WRES)

Indicators for the NHS medical workforce

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Introduction

The NHS Workforce Race Equality Standard (WRES) was introduced in 2015 to to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. With five years' worth of data now collected, we have made significant progress in several areas. Even so, there is much more to be done and the NHS is committed to continued innovation and progress for the WRES, including a focus on staff groups of need, and parts of the country with greater race inequality.

The medical workforce has several issues particular to it, and so a bespoke set of WRES indicators have been developed. This document outlines the rationale for these indicators and explains how they will work. A full set of data against these indicators will be analysed and presented as part of the annual WRES data report for NHS trusts later this year.

Background

The UK's NHS is the fifth largest employer in the world, and nearly 20 percent of its workforce is of black and minority ethnic (BME) origin.[1] Yet there is substantial evidence showing that BME staff are less likely to be treated favourably than their white colleagues and have poorer experience and progression opportunities. Evidence shows that this disparity has a direct impact on patient experience and that there is a clear link between staff experience and patient satisfaction.[2]

To highlight and address discrimination against BME staff, the WRES requires all NHS trusts to demonstrate progress against nine indicators of workforce race equality.[3] Published annually, the WRES indicators have provided compelling evidence of ethnic variations in staff experience and have been a powerful driver of organisational change since 2015.

With 41 percent of the doctors in the NHS being from BME backgrounds, and to further boost the reach of the WRES, one of the key priorities for the WRES has been to develop a set of indicators that would enable ethnic variations in the experience of the medical workforce to be assessed.

Why are different data required for doctors?

There are several areas in which more granular data could help ascertain a better understanding of race disparities in the medical workforce. For one, the pay structure applied to other workforce groups does not apply to doctors. WRES indicator 7, a measure of equality in career progression for the rest of the workforce, is limited in its practicality in the medical context.[4]

1 WRES Data Report 2019 https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

2 https://www.england.nhs.uk/publication/links-between-nhs-staff-experience-and-patient-satisfaction-analysis-of-surveys-from-2014-and-2015/

3 https://www.england.nhs.uk/wp-content/uploads/2017/03/wres-technical-guidance-2019-v2.pdf

4 WRES Technical Guidance 2019 (page 17) https://www.england.nhs.uk/wp-content/uploads/2017/03/wres-technical-guidance-

The Agenda for Change (AfC) banding system does not apply to doctors. The career progression pathway for doctors does not follow a gradual progression from lower to higher pay bands (e.g. from AfC band 5 to band 9). Instead, junior doctors may progress to 'salaried' hospital doctors or consultants in NHS trusts. They may also have the option of becoming a GP, whose pay structures are different to those of NHS trust staff.

In England, doctors' opportunities for professional development, and appointments to substantive and postgraduate training posts and leadership roles, are influenced not only by the leadership of NHS trusts, but also by Health Education England, the General Medical Council and the medical Royal Colleges.

Indicators capable of illuminating racial inequalities in the medical workforce, and pin pointing areas for action, need to take account of these complexities and to include data and information collected by all these organisations.

Development of the WRES indicators for the medical workforce

The overall objective was to develop a set of WRES indicators for the medical workforce that fulfilled the following criteria

- broadly similar to the standard WRES indicators in terms of the dimensions of ethnic inequalities. They would also cover developmental opportunities, career progression, treatment by patients and employing organisations and representation.

- based on data already collected and published, which could reliably be assessed annually, thus enabling monitoring of trends over time.

A group of stakeholders have developed, refined and finalised eleven indicators for the medical workforce

- Indicators 1 to 4 reflect variation in career progression and pay, differential attainment at various stages of training and differences in treatment by the regulatory system. There is an additional indicator in this set, entitled revalidation which reflects the requirement for doctors to revalidate, and this will measure the differences in revalidation deferral rates.

- Indicators 5 to 10 represent medical staff perceptions of how they are treated by colleagues, employing organisations and patients.

- Indicator 11 highlights the diversity of the councils and boards of medical institutions, such as the medical royal colleges.

Background on the data behind each indicator is given in Annex B.

Publication of WRES data for the medical workforce

Data against these medical indicators, by region, NHS trust, and royal colleges will be collected and published within the annual WRES data report for NHS trusts – enabling the monitoring of progress towards race equality for the medical workforce over time.

The evaluation of medical workforce WRES is a 'world first' in creating an evidence base to expose racism and discrimination in the medical workforce at a national level and enable the NHS to translate that evidence into meaningful action.

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Annex A – Comparing the medical workforce WRES indicators with equivalent WRES Indicators

WRES indicator for the non-medical workforce	Indicator for the medical workforce
1: Percentage of staff by ethnicity in pay bands which cover all non-medical staff and very senior managers (VSM).	**1a: Percentage of BME and white staff in each medical and dental sub group in NHS trusts and clinical commissioning groups (NHS Digital data)** **Split by:** medical directors, clinical directors (directors of clinical teams), consultants, other doctor grades below the level of consultant, doctors in postgraduate training, student entrants to medicine, all doctors
	1b: Ethnicity pay gap: Average monthly earnings (NHS Digital data) **Split by:** all doctors, consultants, doctors in postgraduate training, other doctor grades
	1c: Clinical academics by ethnicity (UK Medical Schools Council data 2018) **Split by:** professors, senior lecturers, lecturers
2: Relative likelihood of white applicants being appointed from shortlisting compared to that of BME applicants.	**2: Consultant recruitment following completion of postgraduate training (Royal College of Physicians 2018 report)** **Split by:** average number of consultant posts applied for, percentage shortlisted, percentage offered post
3: Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process.	**3: Complaints received from 1 January to 31 December 2018 (General Medical Council data, According to Google this means state of medical education and practice)** **Split by:** doctors referred by employers, UK medical graduates referred by employers, international medical graduates referred by employers, complaints/referrals, GMC investigations, UK graduate investigations, international medical graduate investigations
Revalidation	**Revalidation percentage deferred (GMC data as of 30/1/2020)** **Split by:** UK medical graduates, EEA medical graduates, international medical graduates
4: Relative likelihood of white staff accessing non mandatory training and CPD compared to BME staff.	**4a: Differential attainment in medical schools (UCAS 2018 data)** Applications accepted for medicine and dentistry
	4b: Differential pass rates in royal college postgraduate examinations (GMC data 2018) **Split by:** UK medical graduates, EEA medical graduates, international medical graduates
	4c: Annual review of competence progression (ARCP) - unsatisfactory outcomes by primary medical qualification - core medical training (2019) **Split by:** UK medical graduates, EEA medical graduates, international medical graduates

5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**5: Staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.** **Split by:** all doctors, consultants, doctors in postgraduate training, others
6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	**6: Staff experiencing harassment, bullying or abuse from staff in last 12 months.** **Split by:** all doctors, consultants, doctors in postgraduate training, others
7: Percentage believing that trust provides equal opportunities for career progression or promotion.	**7: Staff believing their trust provides equal opportunities for career progression or promotion.** **Split by:** all doctors, consultants, doctors in postgraduate training, others
8: In the last 12 months have you personally experienced discrimination at work?	**8: Staff in the last 12 months having personally experienced discrimination at work.** **Split by:** all doctors, consultants, doctors in postgraduate training, others
N/A	**9: Staff feeling "motivated", otherwise known as work engagement; the extent to which individuals are fully engaged in their job while working (score out of 10)** **Split by:** consultants, doctors in postgraduate training, others
N/A	**10: Staff feeling "involved", also referred to as proactivity, or voice; the extent to which individuals are given (and take) the opportunity to contribute ideas and make changes at work (score out of 10).** **Split by:** consultants, doctors in postgraduate training, others
9. BME representation on boards	**11a: Percentage of BME doctors on royal colleges boards, compared to the BME percentage of the overall workforce**
	11b: Percentage of deans of medical schools, compared to the BME percentage of the overall workforce

Annex B – Data sources for each indicator

Indicator 1a: Representation in leadership roles

NHS Digital data highlight the lower proportion of BME doctors among medical and clinical directors of NHS trusts compared to their numbers in the overall medical workforce, as well as among medical academics. In due course, we anticipate having access to data for each of the NHS trusts, CCGs, medical royal colleges, medical schools, and Health Education England medical deaneries.

Indicator 1b: Ethnicity pay gap

Basic pay data extracted from the NHS electronic staff records will be coupled with doctors' self-identified ethnic categories to show any differences in median basic pay between white and BME doctors. The opportunity for discretionary pay enhancements are greatest in the consultant grade.

Indicator 2: Likelihood of being short-listed and appointed to a consultant post

Royal College of Physicians 2018 data on ethnic variations among (CCT) certificate of completion of specialist training holders showed that those of white British ethnicity applied for fewer posts but were more likely to be short-listed and to be offered a post. In due course, it is anticipated that similar data will become available for CCT holders from other royal colleges.

Indicator 3: Complaints to the GMC

Data will be sourced from the GMC. BME doctors are more likely than white doctors, and international medical graduates (IMGs) more likely than UK graduates, to be referred by employers to the GMC. More referrals by public bodies (including employers) are investigated vs patient complaints. There are greater proportions of IMGs than white doctors referred to and, investigated by the GMC and receive sanctions and warnings following investigations.

Revalidation:

Data will be sourced from the GMC. Higher deferral and lower revalidation rates are reported for doctors from BME backgrounds, regardless of where they obtained their primary medical qualification.

Indicator 4: Differential attainment in training

Data from the UK Medical Schools Council and the GMC highlight that BME medical students and junior doctors, as well as doctors from the EEA and IMGs, underperform academically compared with their white counterparts, and that the differences in performance are consistent across exam types, and in both undergraduate and postgraduate assessments. In the future, there will be access to data from individual medical schools, HEE regions and medical specialties.

Indicators 5-10: Bullying, harassment and discrimination

NHS staff survey data demonstrate ethnic variations in self-reports of bullying, harassment and discrimination among doctors similar to those found among all staff of trusts. In addition, indicators 9 and 10, which are linked to staff survey questions on motivation and involvement, highlight higher levels of motivation among BME doctors but lower levels of involvement and engagement by their organisation.

Indicator 11: Board membership

Variation in proportions of NHS trust BME and white medical directors nationally and compare to proportions of BME and white doctors in NHS trusts across England as a whole.