NHS

Medical Workforce Race Equality Standard (MWRES)

WRES indicators for the medical workforce 2020

July 2021

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NHS Medical Workforce Race Equality Standard (MWRES)

2020 data analysis report for the NHS medical workforce.

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Foreword

The COVID-19 pandemic has had a profound effect on the NHS, both during the height of the pandemic and in terms of the recovery of the service backlog. The findings of this inaugural Medical Workforce Race Equality Standard (MWRES) report indicate the urgent need for action by NHS trusts, educational institutions and regulatory authorities to address inequalities. With the challenges facing the NHS in recovery from the pandemic, having a just workforce culture is at the root of maintaining the trust and engagement of all healthcare professionals.

Black and minority ethnic doctors have served in the NHS throughout its history. In its early years, NHS recruitment of these doctors was largely from countries with which the UK has colonial links. The reliance on doctors from overseas to help deliver NHS services has been so significant that senior past political leaders have famously acknowledged that "the Health Service would have collapsed if it had not been for the enormous influx of doctors from overseas". In recent years, more of the black and minority ethnic doctors are trained within the UK.

The Workforce Race Equality Standard (WRES) was launched in 2015 to document the different experience of white and black and minority ethnic (BME) staff in the NHS, and to provide guidance on how to achieve better race equality in the workforce. However, there are several ways in which the medical workforce differs from the rest of the NHS workforce; hence the development of the Medical Workforce Race Equality Standard (MWRES) and its 11 indicators, introduced in September 2020.

This report is the first publication of the MWRES data, and will provide baseline evidence to quantify discrimination in the NHS trust-based medical workforce at the national level, and hence identify the targets for organisations to pursue with corrective action. The MWRES is a 'world first' in creating an evidence base to expose racism and discrimination in the medical workforce at a national level. It is the first step to breaking down structural barriers to race equality in this group and to enable the NHS to translate that evidence into meaningful action.

There is now decades of published evidence of these variations but this has been largely confined to the medical journals and hitherto unknown to much of the NHS leadership, including many parts of the medical leadership. The first step towards stimulating actions to address these inequalities was to design a set of indicators, which could be published annually and enable the NHS system as a whole to recognise the inequality and to start to act to address it. The indicators draw on the research evidence and contributors to this data collection included a wide range of organisations such as the General Medical Council, the medical royal colleges, the Medical Schools Council and Health Education England. Such collegiality reflects the commitment towards collective action, as doctors' opportunities for professional development, training, pay, appointments and leadership roles are influenced not only by the leaders of NHS trusts, but also by these organisations. For the MWRES to be capable of illuminating racial inequalities in the medical workforce, and pinpointing areas for action, it needed to take account of these complexities and to include data and information collected by all these stakeholder organisations. Their support for the design and data collection deserves to be acknowledged.

The starkest evidence of the disadvantages faced by BME doctors in the NHS was laid bare by the tragic deaths of doctors due to COVID-19 infection during this past year.

This launch edition of the MWRES dataset honours their memory, as it marks the start of the strategy to bring all the stakeholders together to root out racism and discrimination among doctors working in the NHS. Besides, getting the strategy right for these doctors could shed light on how to tackle race inequality faced by other workforce groups in the NHS.

Prerana Issar
NHS Chief People Officer

Executive summary

The data shows that across almost all indicators, BME doctors reported a worse experience at work compared to white doctors. This trend is seen across the whole career path from medical school to consultant level. Furthermore, even when BME doctors become consultants, they report greater levels of discrimination and harassment and lower levels of feeling 'involved' at work. Despite this, BME doctors reported greater or equal levels of 'motivation' at work.

As the medical workforce becomes more diverse, more must be done to make sure that BME doctors have the same positive experience and opportunities as their white colleagues. As the NHS moves to recovery post-COVID, our reliance on internationally trained staff will be indispensable. Optimising the work environment for these colleagues is right both morally and pragmatically. The consequences of racism are likely to have a toll on the staff affected, but also the wider workforce and patient outcomes.

41.9% (53,157) of the medical and dental workforce in NHS trusts and clinical commissioning groups (CCGs) in England are from a BME background compared to 14% BME in the population.

Compared to 2017, the number of BME doctors has increased by 21.1% (9,263). Over the same period the number of white doctors has increased by 2.4% (1,466), confirming the ever increasing diversity of the medical and dental staff in the NHS.

Compared to the overall proportion of doctors in NHS trusts and CCGs, BME doctors are:

- **underrepresented in consultant grade roles**
- **overrepresented in other doctor grades and doctors in postgraduate training**
- **underrepresented in academic positions**

The shortlisting and interview process discriminates against BME applicants for consultant appointments as will be shown in indicator 2.

BME doctors reported a worse experience than their white colleagues when it comes to harassment, bullying, abuse and discrimination from staff.

BME doctors have a worse experience when it comes to examinations (medical school and postgraduation examinations) and regulation (revalidation, referrals/complaints to GMC, Annual Review of Competence Progression). This discrimination begins early in the career, with BME students less likely to attain a place in medical school than white students.

In the coming years, concerted effort is needed from organisations to make the NHS a model employer and the best place to work. This process begins with addressing existing inequalities and disparities. The key areas of action to begin this change are described in this report.

Areas for action

- Organisations and institutions expressly communicating their intention to address inequality
- IMGs appropriate induction to ensure their integration
- Providing IMGs with development opportunities as a valued part of the workforce rather than just a clinical resource
- Ensuring institutional and organisational websites, prospectuses, application packs and monitoring forms are couched in inclusive language
- Stakeholder organisations to aim to have a workforce, in both voluntary and staff roles at all levels, that reflects the diversity of their membership
- Setting targets and timelines for reducing the ethnic disparity in representation at consultant, clinical director and academic levels
- Narrowing the ethnicity gap in appointment of consultants after shortlisting: a potential role for the royal college member often present on consultant interview panels.
- NHS trust based medical leaders to enhance local capacity and skills to resolve complaints and avoid their referral to the GMC if appropriate
- Enhancing the leadership diversity of the royal colleges and arm's length bodies.
- Having senior officers in these organisations include performance objectives for measurable delivery of diversity outcomes as part of appraisal
- Obtaining fuller and more granular data by clinical specialty and by region (including primary care)
- Obtaining detailed data on the performance of undergraduate medical students and postgraduate trainees in their assessments and examinations.
- Undertaking research to identify what works, in terms of addressing differential attainment in training and assessments

MWRES indicators (all data is for doctors in England)

Indicator type	WRES indicator	Medical indicator		Indicator description	2019		2020	
					BME	White	BME	White
WORKFORCE COMPOSITION, CAREER PROGRESSION AND REWARD	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)	Medical directors	18.8%	76.5%	20.3%	73.6%
				Clinical directors (directors of clinical teams)	22.7%	71.8%	26.4%	68.6%
				Consultants	36.9%	57.1%	37.6%	56.2%
				Other doctor grades below the level of consultant	48.8%	42.1%	47.0%	42.9%
				Doctors in postgraduate training	41.1%	46.9%	43.1%	44.6%
				Student entrants to medicine	41.0%	59.0%		
				All doctors	39.5%	51.6%	41.9%	49.1%
		1b	Ethnicity pay gap: Average monthly earnings (NHS Digital data)	All doctors	£5,381	£5,812		
				Consultants	£7,581	£7,821		
				Doctors in postgraduate training	£2,881	£2,830		
				Other doctor grades	£4,328	£4,265		
		1c	Clinical academics by ethnicity (UK Medical Schools Council data 2018)	Clinical academics - Professors	16.1%	77.0%		
				Clinical academics - Snr Lecturer	23.1%	70.4%		
				Clinical academics - Lecturer	24.4%	66.0%		
	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)	Average number of consultant posts applied for	1.66	1.29		
				Percentage shortlisted	66.0%	80.0%		
				Percentage offered post	57.0%	77.0%		
	3: Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process.	3a	Complaints received from 1 Jan to 31 Dec 2018 (GMC data, SOMEP)	Doctors referred by employers	8.0%	4.0%	No 2020 data	
				UK medical graduates referred by employers	3.0%			
				International medical graduates referred by employers	9.0%			
				Complaints/referrals	2.5%	2.2%		
				GMC investigations	29.0%	20.0%		
				UK graduate investigations	20.0%			
				International medical graduate investigations	32.0%			
		3b	Revalidation percentage deferred (GMC data as of 30/1/2020)	UK medical graduates	24.0%	18.0%	No 2020 data	
				EEA medical graduates	25.0%			
				International medical graduates	22.0%			
	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	10.8%	15.2%		
		4b	Differential pass rates in Royal College postgraduate examinations (GMC data 2019)	UK medical graduates	63.0%	75.0%	No 2020 data	
				EEA medical graduates	45.0%			
				International medical graduates	41.0%			
		4c	Annual review of competence progression (ARCP) - unsatisfactory outcomes by PMQ - core medical training (2019)	UK medical graduates	18.8%	12.9%	No 2020 data	
				EEA medical graduates	56.3%	24.8%		
				International medical graduates	36.2%	37.1%		

MWRES indicators (all data is for doctors in England)

Indicator type	WRES indicator	Medical indicator	Indicator description		2019		2020	
					BME	White	BME	White
NHS ANNUAL STAFF SURVEY	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.	Consultants	33.3%	37.5%	32.9%	37.3%
				Doctors in postgraduate training	35.7%	40.3%	34.4%	39.3%
				Others	34.5%	33.3%	34.0%	33.7%
	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.	Consultants	30.8%	29.0%	28.5%	27.8%
				Doctors in postgraduate training	30.9%	22.3%	29.2%	21.2%
				Others	33.1%	24.0%	32.1%	25.4%
	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.	Consultants	77.5%	91.0%	79.5%	91.4%
				Doctors in postgraduate training	87.6%	95.9%	89.3%	95.5%
				Others	69.7%	85.6%	73.4%	87.2%
	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.	Consultants	21.7%	10.5%	21.1%	10.2%
				Doctors in postgraduate training	24.6%	12.1%	24.5%	13.0%
				Others	26.3%	13.0%	26.4%	13.7%
		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)	Consultants	8.0	7.4	8.0	7.3
				Doctors in postgraduate training	7.5	7.1	7.4	7.1
				Others	8.0	7.3	8.0	7.2
		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)	Consultants	6.8	7.0	6.8	7.1
				Doctors in postgraduate training	6.6	6.6	6.6	6.5
				Others	6.5	6.5	6.5	6.5
	9. BME representation on councils	11a	Percentage of BME doctors on royal colleges' councils, compared to the BME percentage of the overall workforce		TBC	TBC	TBC	TBC
		11b	Percentage of deans of medical schools, compared to the BME percentage of the overall workforce		TBC	TBC	TBC	TBC

Introduction

The NHS Workforce Race Equality Standard (WRES) was introduced in 2015 to ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace. With six years of data already collected for NHS trusts, we can see progress in terms of improvements in ethnic variations in formal disciplinaries and representation in senior management including board representation. However, there remain significant challenges when it comes to harassment, bullying and discrimination. NHS England remains committed to continued innovation and progress, including a focus on vulnerable staff groups and in areas of the country with greater race inequality.

Background

The NHS is the fifth largest employer in the world, with more than 21% of its workforce of black and minority ethnic (BME) origin. Yet there is substantial evidence showing that BME staff are treated less favourably than their white colleagues and have poorer experience at work and fewer progression opportunities. Evidence has shown that this disparity has a direct impact on patient experience and that there is a clear link between staff experience and patient satisfaction.

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

The need for a bespoke medical WRES?

It has long been recognised that the medical workforce has several challenges which set it apart from the rest of the healthcare profession, and so a bespoke set of indicators, the MWRES, have been developed. In September 2020 an outline and rationale for these indicators and how they will work was published. This is the first report analysing and presenting these indicators. There are several areas in which more granular data could help ascertain a better understanding of race disparities in the medical workforce.

Foremost, the pay structure applied to other workforce groups does not apply to doctors. WRES indicator 1, which is a measure of equality in career progression for the rest of the workforce, is limited in its usefulness in the medical context as this is categorised by the Agenda for Change (AfC) grading system, which 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). Equally, hospital doctors in NHS trusts have a different pay structure to GPs.

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 individual employing NHS trusts, but also by Health Education England, the General Medical Council and the medical royal colleges. In light of these distinct complexities, it is essential that these organisations contribute to the indicators capable of illuminating racial inequalities in the medical workforce to allow metrics for change to be developed.

Methodology

Development of indicators

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 cover (developmental opportunities, career progression, treatment by patients and employing organisations, and representation).
- based on data already collected and published, and which could reliably be assessed annually, thus enabling monitoring of trends over time.
- A group of subject matter experts (Annex B) have developed, refined and finalised eleven indicators for the medical workforce (see Annex A):
- 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.
- 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.

Data reporting dates

The latest available data for each indicator was used. Much of the information represents data from 2019 or 2020, although for indicators 1c and 4a, data has been extracted from the latest available reports which were published in 2018.

Data analyses

For this launch report, the data was available only at the national level. In future years, it is intended to present the data at trust, royal college or specialty level as appropriate. The indicators may be modified on the basis of any constructive feedback received on this publication. The analyses of trends can begin as soon as the indicator set and methodology for data analysis are finalised, and the data completeness and accuracy permit valid comparisons.

Data caveats

Some indicators are drawn from questions in the national NHS staff survey. The reliability of the data drawn from those indicators is dependent upon the overall size of samples surveyed, the response rates to the survey questions, and whether the numbers of respondents is large enough to not undermine confidence in the data.

The number and proportion of BME staff responding to the NHS staff survey has increased year on year since 2015. 18,672 (24.5%) more BME staff and 47,178 (12.3%) more white staff completed the survey in 2019 compared to 2016. Overall 569,440 people completed the survey. This constituted an overall response rate of 48%. However, not all respondents completed the WRES questions in the staff survey. The response rate for the WRES questions was approximately 44.6% for white staff and 34.7% for BME staff. Of particular concern was the drop in the number of respondents for indicator 7 for both BME and white staff.

Where appropriate, the data in graphs has been rounded to the nearest whole numbers, and for this reason, aggregate percentages may not add to 100.

In some sections of indicator 1, supplementary data has been sourced from NHS Digital. This is marked clearly in the commentary.

As stated previously, we have managed to source data for some indicators from other organisations. The sources of the data and year of its collection will be cited in each section of the report.

The indicators will be reviewed and modified as appropriate, in light of any feedback received. Furthermore, they will continue to be reviewed regularly to ensure that they are fit for purpose, valid and reliable.

Methodology

MWRES Indicator	Data sources
1a	NHS Digital (taken from the Electronic Staff Record) NHS trusts and clinical commissioning groups
1b	Figures represent payments made using the Electronic Staff Record (ESR) system to NHS staff who are employed and directly paid by NHS organisations. Figures based on data from all English NHS organisations that are using ESR
1c	Data is taken from UK Medical Schools Council data 2019
2	Royal College of Physicians (RCP) Medical Certificate of Completed Training (CCT) Class survey. 2019 survey results (published October 2020)
3	From the General Medical Council (GMC), additional data from GMC Data explorer
4a	From Universities and Colleges Admissions Service (UCAS)
4b and 4c	From the GMC
5, 6, 7, 8 ,9,10	NHS staff survey
11	From each individual royal college

MWRES indicator 1a

Percentage of BME and white staff in each medical and dental sub-group in NHS trusts and clinical commissioning groups

Headlines

On 31 March 2020, 41.9% of the medical and dental workforce in NHS trusts and CCGs were from a BME background compared to about 14% of the population.

The number of BME doctors increased by 21.1% (9,263) from 43,894 in 2017 to 53,157 in 2020. Over the same period, white doctors increased by 2.4% (1,466). The number and percentage of unknown ethnicity also increased. This shows that the medical and dental staff group is becoming ever more diverse with BME representation going from 38.6% in 2017 to 41.9% in 2020.

- Compared to the overall proportion of doctors in NHS trusts and CCGs, BME doctors were:
  - underrepresented in consultant, clinical director and medical director roles
  - overrepresented in other grades and postgraduate training
- The data shows that senior doctor roles have a below average representation of BME doctors.
- In 2020, 26.4% of clinical directors were from a BME background. This is significantly lower than 41.9% of all BME doctors in NHS trusts and CCGs.
- The number of BME clinical directors increased by 16 between 2019 and 2020.
- In 2020, 20.3% of medical directors were from a BME background compared to 41.9% of all BME doctors in NHS trusts and CCGs.
- The number of BME medical directors increased by five between 2019 and 2020.
- It should be noted the number of medical directors coded on Electronic Staff Records (ESR) is lower than it should be. There are 222 trusts and each one has a medical director, yet on ESR there are only 182 medical directors.

Implications

- The disproportionality of progression of doctors through to consultant grade in the hospital system has many contributory causes, some of which are outlined in other sections of this report.
- A key metric to target as a performance indicator going forward is the progression rate of doctors in training to Consultant grade, and to managerial and executive positions (clinical and medical director).
- Future work may be required to address the situation in primary care, where the majority of patient consultations occur.
- Completeness of data entry on ESR is required to ensure accuracy of conclusions drawn.

MWRES indicator 1a

Table 1: Doctors headcount and percentage

There has been an increasing number and proportion of BME doctors and dentists year on year.

	Headcount			Percentage		
Year	White	BME	Unknown	White	BME	Unknown
2017	60,893	43,894	9,058	53.5%	38.6%	8.0%
2018	61,360	46,050	9,528	52.5%	39.4%	8.2%
2019	60,579	48,367	10,952	50.5%	40.3%	9.1%
2020	62,359	53,157	11,389	49.1%	41.9%	9.0%

Data source: NHS workforce statistics website.

Table 2: Clinical and medical directors in NHS trusts in England

Despite the increase in number and proportion of BME clinical and medical directors, the percentage remains significantly lower than the 41.9% of BME doctors in the workforce.

	Clinical directors headcount (Percentage)			Medical directors headcount (Percentage)		
Year	White	BME	Unknown	White	BME	Unknown
2019	250 (71.8%)	79 (22.7%)	19 (5.5%)	130 (76.5%)	32 (18.8%)	8 (4.7%)
2020	247 (68.6%)	95 (26.4%)	18 (5.0%)	134 (73.6%)	37 (20.3%)	11 (6.0%)

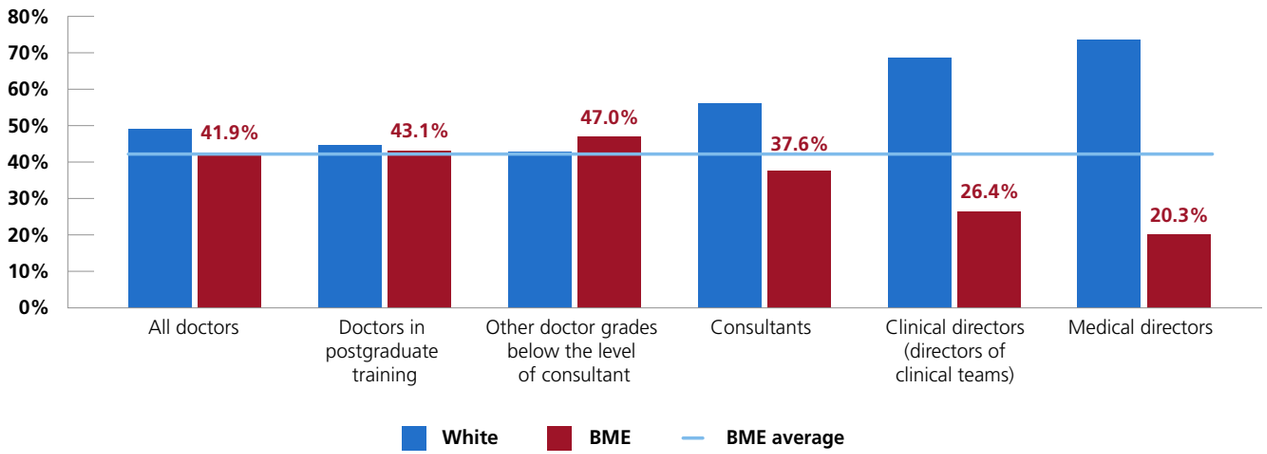


Figure 1: Doctors by pay grades in NHS trusts and CCGs in England

BME doctors are underrepresented in consultant, clinical director and medical director roles. In 2020, 26.4% of clinical directors and 20.3% of medical directors were from a BME background. This is significantly lower than the 41.9% of all BME doctors in NHS trusts and CCGs.

MWRES indicator 1b and 1c

Key supportive data

1b) Ethnicity pay gap: basic pay per full time equivalent by grade

Headline

- BME medical and dental staff earn on average 7% (£4,310) per year less than their white colleagues. The biggest gap is seen amongst consultants. This has implications for the lifetime earnings, pension and accumulated wealth over a lifetime.

Implications

- To take effective actions such as by showing salary ranges to encourage salary negotiation, and to introduce transparency about promotion, pay and reward processes as per the proposed actions to correct the gender pay gap.
- To consider appointing SROs and task forces to monitor talent management processes (such as recruitment or promotions) and diversity within the organisation.
- To specifically include development opportunities (leadership, academic, teaching) for all IMGs and SAS doctors in each trust.

Table 3: Ethnic pay gap by medical grades - full time equivalent (FTE) basic pay:

Dimension	Consultants	Other doctor grades	Doctors in training	All doctors
BME	£7,581	£4,446	£2,881	£5,381
White	£7,821	£4,593	£2,830	£5,812
Difference	-£240	-£147	£52	-£431
Pay gap	-3%	-3%	2%	-7%

Data source: NHS workforce statistics website.

1c) Clinical academics by ethnicity

Headline

- The proportion of BME clinical academics across all levels is not representative of BME representation in the medical and dental profession in trusts and CCGs.

Implications

- Implement monitoring and positive action initiatives to improve representation of BME staff on decision making boards and committees.

Table 4: Clinical academics by ethnicity:

Dimension Consultants	2019	
	BME	White
Clinical academics - professor	16.1%	77.0%
Clinical academics - senior lecturer	23.1%	70.4%
Clinical academics - lecturer	24.4%	66.0%

Data source: NHS workforce statistics website.

The percentage of BME professors, senior lecturers and lecturers is significantly lower than the 41.9% of all BME doctors in NHS trusts and CCGs. Under representation is worst at the level of professor, only 16.1% of whom are from a BME background.

MWRES indicator 2

Consultant recruitment

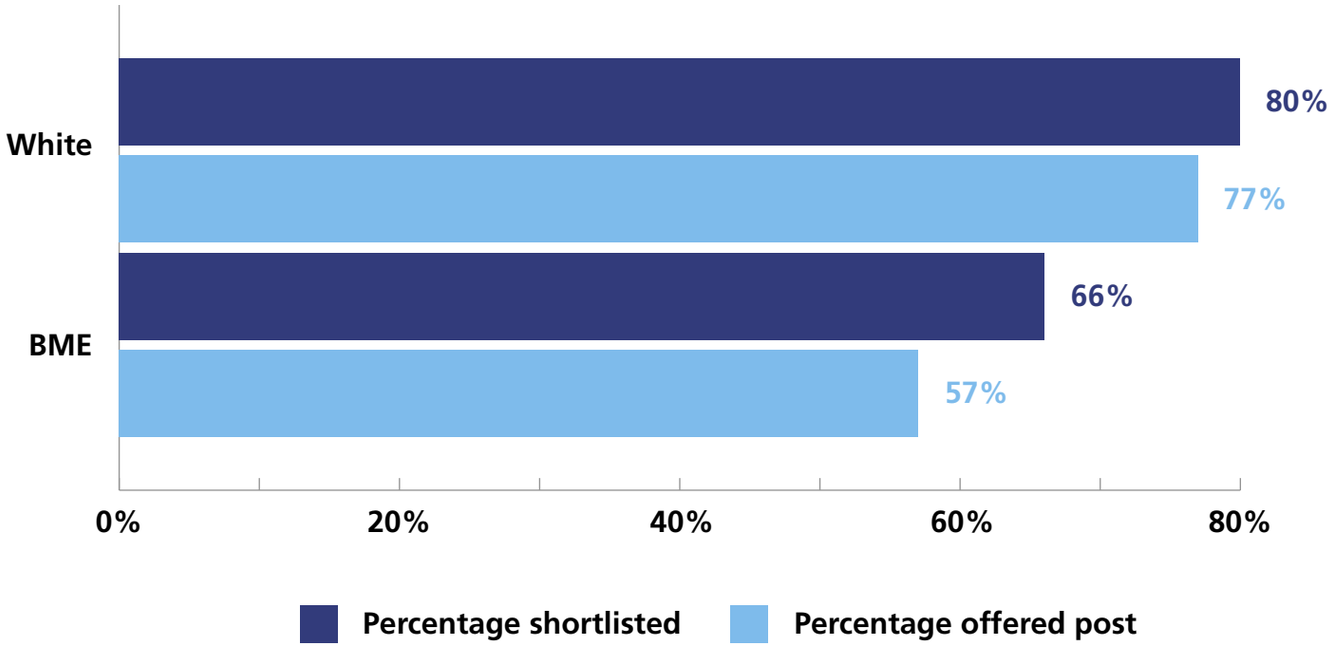
Headlines

- BME doctors have to apply for more posts before they are appointed to a consultant post. They are also less likely to be shortlisted and offered a consultant post.
- Data collected by the RCP shows that CCT holders who described themselves as white were more likely to:
  - apply for fewer consultant posts (mean 1.3 versus 2 for all other ethnic groups),
  - be shortlisted (80% versus 66% for all other ethnic groups) and
  - be successful at being offered a post (77% versus 57% for all other ethnic groups)

Implications

- Trusts need to overhaul their consultant recruitment policy, with royal colleges potentially having an important supervisory role in this process.
- We strongly advocate that all royal colleges provide similar data for recruitment in future years, to enhance the value of this indicator. The RCP is to be credited for having been at the vanguard of collecting such information on consultant recruitment to give a baseline dataset. We will also explore how we can work with NHS trusts on this indicator.

Figure 2: Consultant posts shortlisted for and offered by ethnicity



MWRES indicator 3

Referrals, complaints and investigations

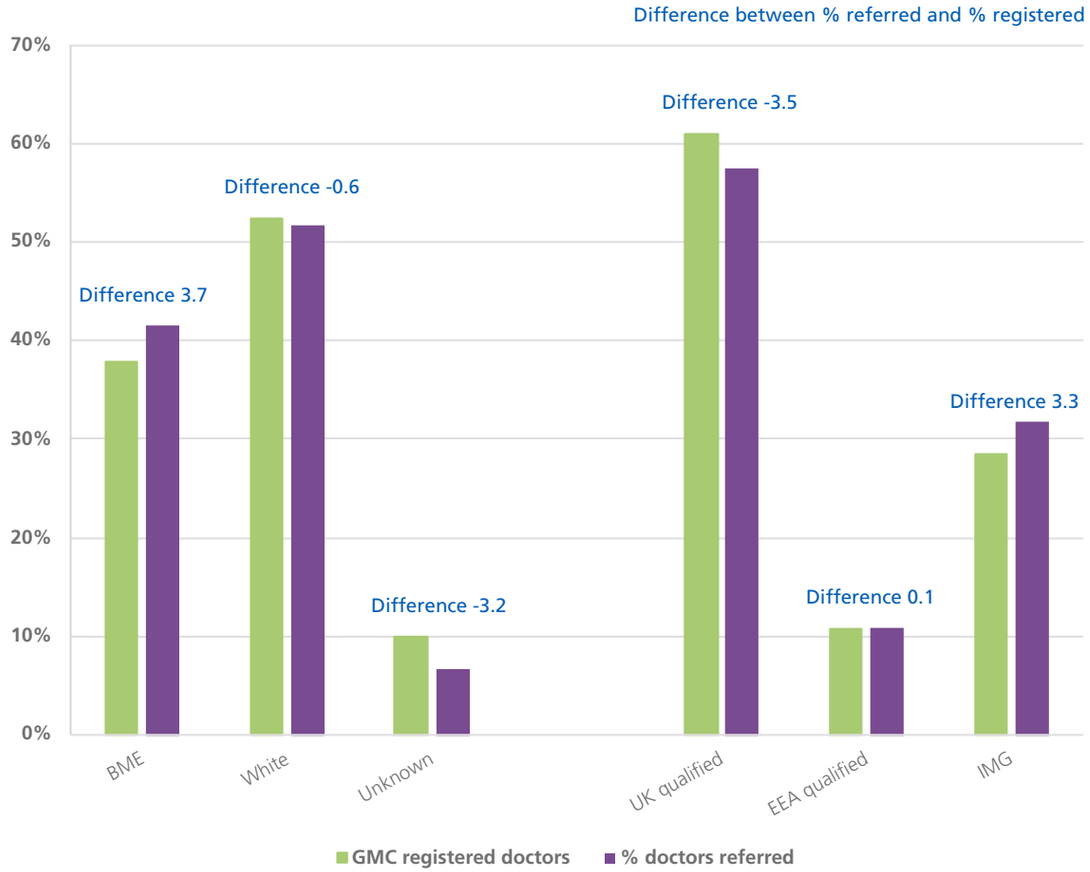
Headlines

- BME doctors were twice as likely to receive a complaint or be referred to the GMC compared to their white colleagues.
- This was especially true for international medical graduates (IMGs) compared to UK and European Economic Area (EEA) trained doctors.
- The biggest differences were seen in the proportion of referrals by employers.
- BME doctors were also more likely to be investigated by the GMC after they were referred or a complaint was received.

Implications

- Reducing the number of trusts with race disparity in referring doctors to the GMC is a key target.
- Studying the outcomes of disciplinary action, stratified by race, is a key consideration for future MWRES metrics.

Figure 3: GMC referrals by ethnicity and country of qualification – 2019



MWRES indicator 3

Referrals, complaints and investigations

Table 5: GMC referrals and complaints by employers – 2019

Referrals, complaints and investigations by employers 8.9% BME doctors compared to 4.3% white doctors were referred by their employers	**2019**	
	BME	**White**
Doctors referred by employers	8.9%	4.3%
UK medical graduates referred by employers	3.5%	
EEA	8.7%	
International medical graduates referred by employers	10.8%	

Table 6: GMC investigations of referrals and complaints – 2019

Indicator description Once referred, 29% of referred BME doctors were investigated compared to 20% of white doctors	**2019**	
	BME	**White**
GMC investigations	29%	20%
UK graduate investigations	20%	
International medical graduate investigations	32%	

MWRES indicator 4

Revalidation

Revalidation is the mandatory process that every licensed practising doctor has to complete every five years as part of clinical governance. Revalidation supports doctors to develop their practice whilst giving the public confidence that doctors are up to date with their knowledge and training. Each employing organisation is responsible for submitting recommendations to the GMC.

Headlines

- BME doctors are less likely to be revalidated compared to white doctors.
- BME doctors are more likely to have been deferred at least once as part of the revalidation process.

Implications

- Organisations need to collate data on the reasons for failure to revalidate and identify trends emerging for any racial disparity.
- The appraisal process should be audited at trust level to ensure that transparent and equitable processes are in place.
- Data on the protected characteristics of the reporting officer for each organisation should be collected.

Qualification	Ethnicity	Proportion of doctors given a revalidation recommendation by a designated body in England	
		including at least one 'revalidate'	including at least one 'defer'
UK Primary medical qualification (PMQ)	BME	92.8%	12.7%
	White	94.3%	10.2%
	Unknown	92.5%	11.7%
EEA Primary medical qualification (PMQ)	BME	88.7%	17.8%
	White	89.7%	15.4%
	Unknown	88.8%	16.9%
IMG Primary medical qualification (PMQ)	BME	92.5%	11.4%
	White	91.8%	12.2%
	Unknown	88.9%	14.8%

MWRES indicator 4a - 4c

Differential attainment in medical schools, differential pass rates in royal college postgraduate examinations, annual review of competence progression (ARCP)

Doctors in training every year undergo an ARCP to demonstrate satisfactory progression in that year in their assigned specialty against standards set out by their respective national training bodies. Successful completion permits progression through their specialty training programme.

Headlines

- BME applicants are less likely to be accepted into medicine and dentistry training compared to white applicants.
- BME doctors have lower pass rates compared to white doctors in postgraduate specialty examinations.
- This is true for both UK trained BME doctors as well as international medical graduates.
- For UK and EEA qualified doctors, a higher proportion of doctors had an unsatisfactory ARCP outcome.

Implications

- Individual medical schools, Health Education England (HEE) regions and medical specialties (royal colleges, Specialty Advisory Committees) should publish data on the race.
- Medical school application panels should have equality, diversity and inclusion training and panels should be representative.
- Recognising the above data,

Table 8: Differential attainment in applications to university

	BME	White
Applications accepted for medicine and dentistry	10.8%	15.2%

Figure 4: Postgraduate specialty exam pass rates in all royal colleges for BME and white doctors, disaggregated by primary medical qualification (PMQ)

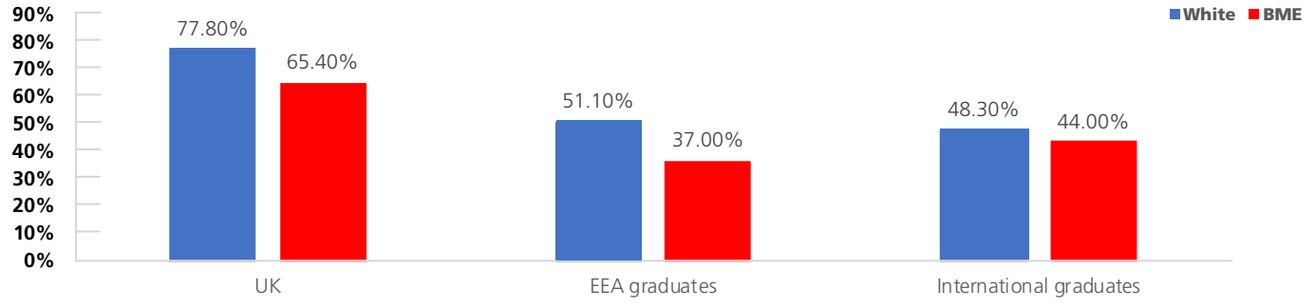
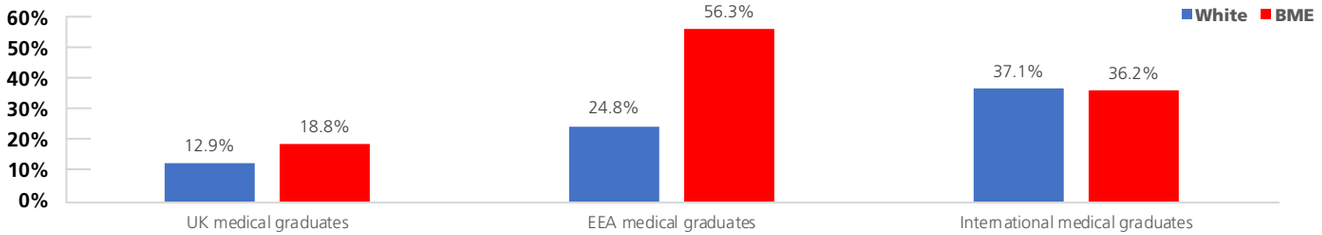


Figure 5: Annual review of competence progression for BME and white doctors, disaggregated by primary medical qualification (PMQ) unsatisfactory outcomes



MWRES indicator 5

Percentage of doctors experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Headlines

- BME doctors who are in training or consultant grades are less likely than their white counterparts to have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- For other grades of doctors, especially staff grade and specialty doctors, BME staff are more likely to have experienced harassment, bullying or abuse from patients, relatives or the public.

Implications

- Rates of abuse of frontline staff are increasing, and organisations should report on strategies they are adopting to address this, in line with Assaults on Emergency Workers (Offences) Act 2018.

Table 9: Percentage of doctors experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Indicator description	Consultants		In training		Other	
	White	BME	White	BME	White	BME
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	37.3%	32.9%	39.3%	34.4%	33.7%	34.0%

MWRES indicator 6

Percentage of doctors experiencing harassment, bullying or abuse from staff in last 12 months

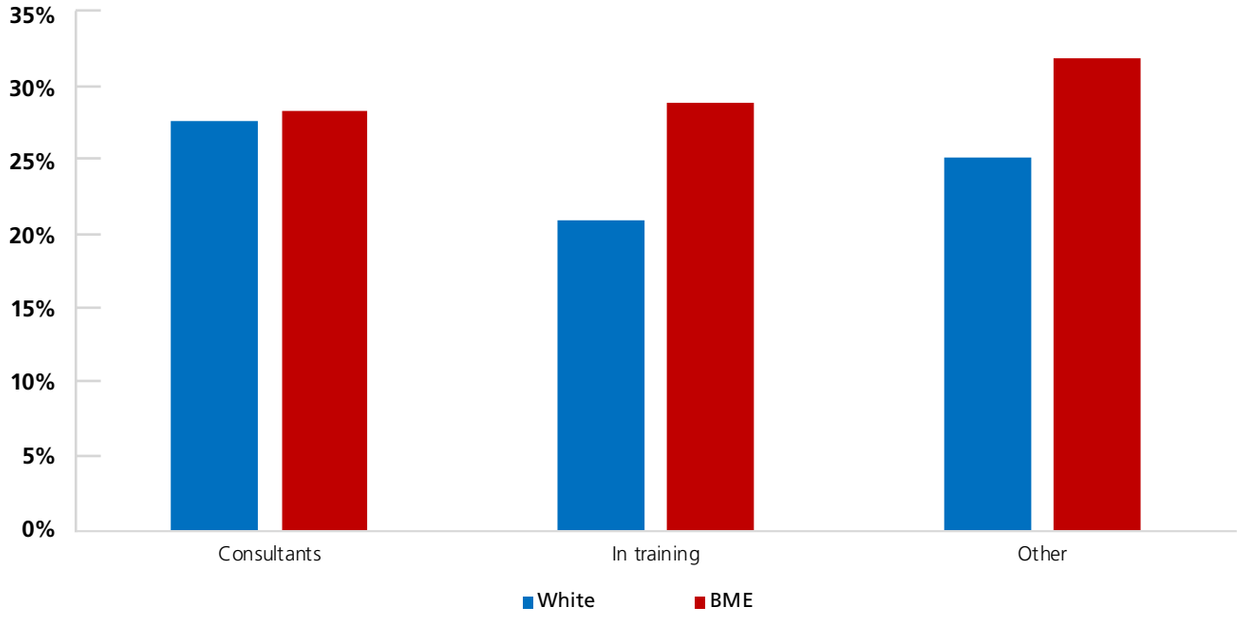
Headlines

- For all grades, BME doctors are more likely to have experienced harassment, bullying or abuse from staff in last 12 months.
- The widest disparities are seen in doctors in training and specialty or staff grade doctors.

Implications

- Develop a written policy on reporting, dealing with bullying and harassment at work and communicate the policy and procedure to staff (as per the RCN Bullying and Harassment Advice Guide)
- Development of civility and respect toolkit as per the People Plan

Figure 6: Percentage of doctors experiencing harassment, bullying or abuse from staff in last 12 months



MWRES indicator 7

Percentage of doctors believing that their trust provides equal opportunities for career progression or promotion

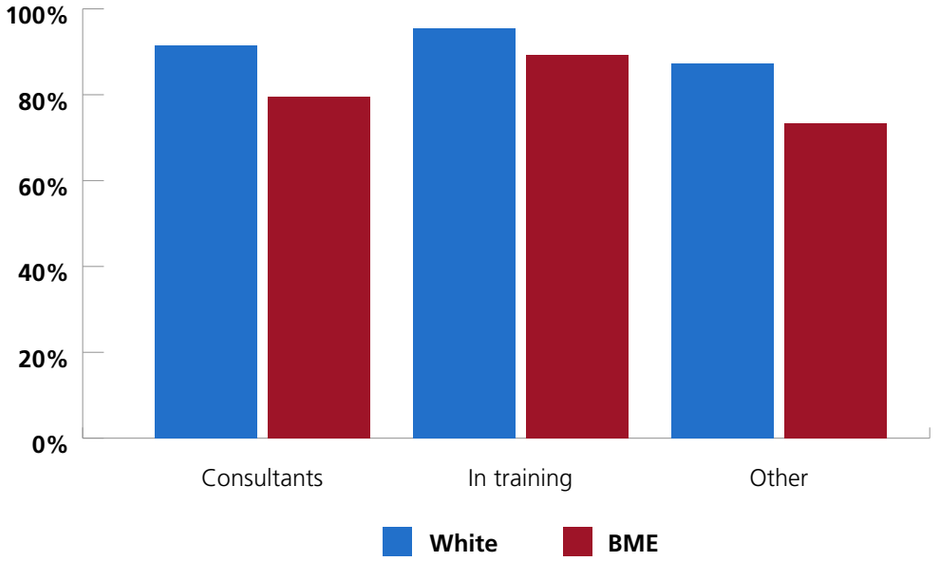
Headlines

- Across all the grades, BME doctors are less likely than white doctors to believe that their trust provides equal opportunities for career progression or promotion.
- For both BME and white doctors, staff grade and specialty doctors had the lowest proportion believing that their trust provided equal opportunities for career progression or promotion.

Implications

- Ensuring transparency and positive action is at the heart of the NHS People Plan and key to ensuring equality of opportunity to all staff. The People Plan sets targets for talent management, based on The Model Employer Framework (2019), whereby in 2025 the proportion of staff in senior grades will be the same as the then proportion of BME staff in the NHS as a whole (19%).

Figure 7: Percentage of doctors believing that their trust provides equal opportunities for career progression or promotion



MWRES indicator 8

In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleagues?

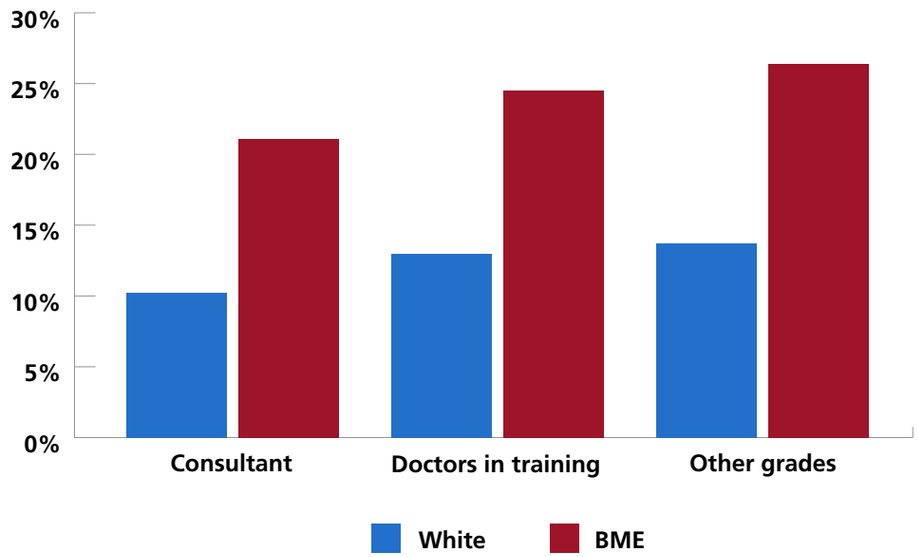
Headlines

- For all grades, BME doctors are almost twice as likely as white doctors to have personally experienced discrimination at work from a manager, team leader or other colleagues.
- For both BME and white doctors, specialty and staff grade doctors experienced the highest levels of discrimination.

Implications

- Trusts need to be proactive and preventative in tackling discrimination rather than responding to individual concerns or grievances.
- The NHS People Plan emphasises the need for organisation to develop system-level models of recruitment and retention; accordingly there should be focus on how to improve the way appraisals, feedback from interviews and performance assessments are undertaken.

Figure 8: In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleague



MWRES indicator 9

Staff feeling work engagement; the extent to which staff feel fully engaged in their job

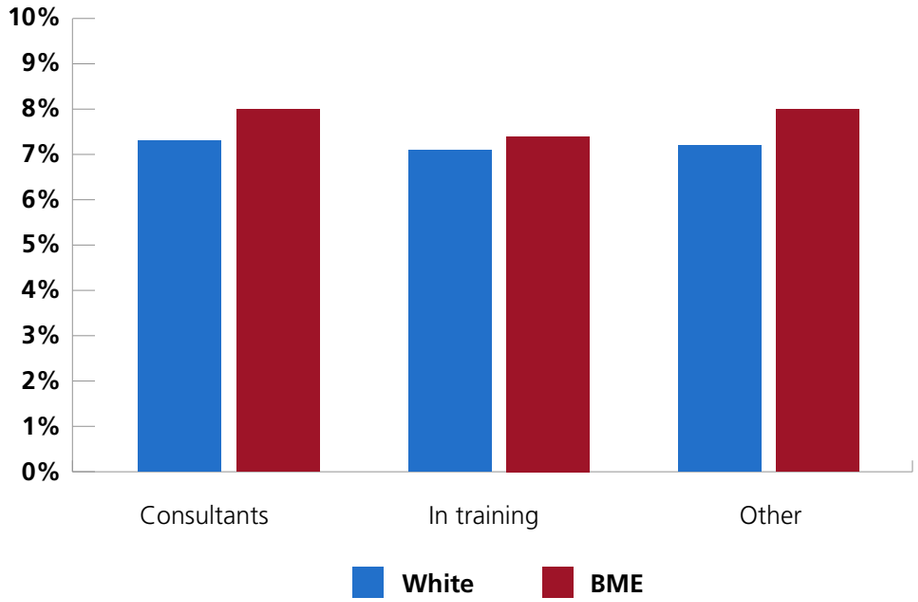
Headlines

- BME doctors felt more 'motivated' than white doctors for all grades.
- Across all grades, white doctors in training were the least 'motivated'.

Implications

- Greater understanding of what causes staff to feel a sense of engagement and belonging is needed.
- While BME staff report experiencing greater workplace discrimination with less opportunity for equal promotion, it is notable that they have higher levels of work engagement.

Figure 9: Staff feeling 'motivated', otherwise known as work engagement



MWRES indicator 10

Staff feeling 'involved': the extent to which individuals are given (and take) the opportunity to contribute ideas and make changes at work

Headlines

- Overall there was little difference in the levels of feeling 'involved' between BME (6.8%) and white doctors (7.1%) in the same grade.
- For both BME and white doctors, consultants felt most involved.

Implications

- Increasing agency for doctors should be an important target for all organisations to optimise their contribution and sense of involvement.
- It is notable that consultants' sense of involvement is not appreciably greater than that for training or other grades.

Table 10: Staff feeling 'involved', also referred to as proactivity, or voice

Indicator description	Consultants		In training		Other	
	White	BME	White	BME	White	BME
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).	7.1%	6.8%	6.5%	6.6%	6.5%	6.5%

MWRES indicator 11

Percentage of BME doctors on royal colleges councils, compared to the BME percentage of the overall workforce

Headline

- The data quality for the membership and council members for the majority of royal colleges was not robust enough to enable a valid analysis.

Implications

- Royal colleges must make a concerted effort to improve the disclosure rates for their members and council. The leadership and council of royal colleges have to reflect their membership not only to make sure that all voices are heard, but to also benefit from all the talent in the membership.
- It is intended in the next MWRES collection to obtain data on the percentage of deans of medical schools, compared to the BME percentage of the overall workforce.
- Complete data submissions from those colleges with no returns (and those with all unknown) is needed for future MWRES reports.

Table 11: Percentage of BME doctors on royal colleges councils

	Council members						
Royal college	Headcount				Percentage		
	BME	White	Unknown	Total	BME	White	Unknown
Faculty of Intensive Care Medicine	0	7	17	24	0.0%	29.2%	70.8%
Faculty of Occupational Medicine	2	8	2	12	16.7%	66.7%	16.7%
Faculty of Public Health	4	26	2	32	12.5%	81.3%	6.3%
Faculty of Sexual and Reproductive Healthcare	0	0	21	21	0.0%	0.0%	100.0%
Faculty of Sport and Exercise Medicine	4	26	0	30	13.3%	86.7%	0.0%
Royal College of Anaesthetists	4	16	4	24	16.7%	66.7%	16.7%
Royal College of Emergency Medicine	5	19	8	32	15.6%	59.4%	25.0%
Royal College of General Practitioners	17	49	7	73	23.3%	67.1%	9.6%
Royal College of Ophthalmologists	13	16	5	34	38.2%	47.1%	14.7%
Royal College of Paediatrics and Child Health	6	14	1	21	28.6%	66.7%	4.8%
Royal College of Pathologists	0	0	26	26	0.0%	0.0%	100.0%
Royal College of Physicians	9	32	14	55	16.4%	58.2%	25.5%
Royal College of Psychiatrists	11	29	1	41	26.8%	70.7%	2.4%
Royal College of Radiologists	0	0	18	18	0.0%	0.0%	100.0%
Royal College of Surgeons	4	18	21	43	9.3%	41.9%	48.8%

Conclusion and next steps

This report reflects the strenuous and diligent efforts of the WRES Implementation team and its partners in addressing inequality. More importantly, it highlights the commitment of organisations to work together to address racism and discrimination in the NHS.

Annex B lists the steering group members and acknowledges their contribution and collegiality in co-creating this indicator set to generate the evidence base for action. One limitation of the MWRES is that it does not yet include GPs, and plans are in place to develop a bespoke indicator set suitable for examining ethnic variations in that part of the medical workforce in future. This would be an especially timely synchronicity given the inclusion of CCG data for the first time in the 2020 WRES analysis.

Next steps

The MWRES is intended to be a regular data collection and publication. More importantly it is intended to hold a mirror up to NHS trusts, the medical royal colleges and other agencies, with a view to stimulating action to address the race inequalities within the sphere of influence of these organisations. In future years we aim to include case studies of replicable best practice from across the stakeholders, as a means of shared learning. The scale of the challenge to eliminate racism and discrimination in the medical workforce is located in the complex landscape of linked institutions and the race inequality which is baked into their structures and systems. But all stakeholders are already playing an active role to address these barriers and to drive positive change. The MWRES provides the essential foundation on which to develop and implement anti-racist action.

Much more detailed data on, for example, the performance of undergraduate medical students and postgraduate trainees in their assessments and examinations are routinely recorded by the stakeholder organisations. It is further hoped that the stakeholders will carry out deeper analyses of their data to pinpoint where they would be best to target action, as well as setting a timeline to realise those ambitions.

Conclusion and next steps

Communicating an intention to address inequality is a prominent way to demonstrate alignment with this agenda. Ensuring websites, prospectuses, application packs and monitoring forms are couched in inclusive language should be an early ambition.

The royal colleges, GMC and HEE have already begun working with the WRES Implementation team to systematically address each of the performance measures in their spheres of influence. Some may be slightly easier to address, such as enhancing the diversity of their leadership. NHS trust based medical leaders are also striving to enhance local capacity and skills to resolve complaints and avoid their referral to the GMC if appropriate. There is also substantial research underway to identify what works, in terms of addressing differential attainment in training and assessments. We do not yet have strong evidence to support specific interventions. Nevertheless the following are emerging as key risk factors: learning experience of BME medical students and junior doctors, a deficit of BME staff and teachers, training curricula which are not inclusive, an environment in which discrimination, microaggressions and negative behaviours from colleagues, other staff and patients remain a constant feature.

There are other risk factors which are known but have not previously been addressed. As far back as in 2011, the annual report of the GMC highlighted the higher rate of complaints against international medical graduates and its likely association with a lack of induction to facilitate their social integration into life in the NHS and in the UK. The report recommended better support for these doctors to enable them to practise safely, but induction has remained patchy and variable, and a standard comprehensive induction programme had not been developed until now.

This recommendation has been prioritised by the Medical Adviser to the WRES Implementation team who has worked with a group of IMGs and a wide range of stakeholders to develop induction programme guidance which is now ready to be piloted. Another ambition would be for all stakeholder organisations to aim to have a workforce, in both voluntary and staff roles at all levels, that reflects the diversity of their membership. The royal college member often present on consultant interview panels could also be developed as a role for ensuring fairer employment practice. Additionally, it is notable that the Royal College of Physicians, which has a Workforce Unit, is the one that is at the vanguard of data reporting and policy initiatives on equality, diversity and inclusion. Having senior officers in these organisations include the delivery of measurable diversity outcomes among performance objectives for appraisal would be a further desirable outcome.

Communicating an intention to address inequality is a prominent way to demonstrate alignment with this agenda. Ensuring websites, prospectuses, application packs and monitoring forms are couched in inclusive language should be an early ambition to showcase that progress is being made to counter race inequality.

We have outlined many essential actions on the previous pages to be completed before the next data collection. We encourage all organisations involved with the training and progression or work of doctors in our NHS to contribute with an openness to cultural change, a deep understanding of the agenda and importance of equitable management of the medical workforce, and sharing and learning from best practice. We are also in the fortunate position of being able to learn from the five years of experience of the development of the WRES as to what works and also what does not work, in terms of driving positive change. This knowledge is anticipated to help drive change faster in relation to the MWRES and the medical workforce. Stakeholder organisations are already beginning to prepare action plans and to publish these along with examples of best practice, starting from next year.

Annex A: The medical WRES indicators (2020)

WRES indicator for the non-medical workforce	MWRES 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)	Percentage of BME and white staff in each medical and dental sub-group in NHS trusts and clinical commissioning groups
	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 Jan to 31 Dec 2018 (GMC data, SOMEP) 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
Validation	Revalidation percentage deferred 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 PMQ - 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

Annex A: The medical WRES indicators (2020)

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 councils, 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: MWRES working group members 2019-2020

Professor Mala Rao (chair)	Medical Adviser, WRES Implementation Team, NHS England
Richard Watson	Analytical Manager, NHS England and NHS Improvement
Owen Chinembiri	Senior Analytical Manager, NHS England and NHS Improvement
Professor Anton Emmanuel	Lead of the WRES
Dr Nada Al Hadithy	Plastic and Reconstructive Specialist Trainee; National Medical Director's Clinical Leadership Fellow, Strategy Unit, DHSC
Jane Cannon	Head of Operations, GMC
Claire Light	Head of Equality, Diversity and Inclusion Strategy and Policy Directorate, GMC
Dr Katherine Woolf	Associate Professor of Medical Education, Research Department of Medical Education, UCL Medical School
Dr Katie Petty-Saphon	Chief Executive, Medical Schools Council
Clare Owen	Assistant Director, Medical Schools Council
Professor Jeremy Dawson	Professor of Health Management, University of Sheffield
Dr Subodh Dave	Consultant Psychiatrist, Derbyshire Healthcare Foundation Trust, Associate Dean, Royal College of Psychiatrists and Hon. Associate Professor, University of Nottingham
Dinesh Napal	Senior Policy Advisor, Equality, Inclusion and Culture, Policy Department, BMA
Dr Anthea Mowat	Honorary Secretary of Medical Women's Federation, and former Chair of Representative Body of BMA
Dr Henrietta Hughes	National Guardian for the NHS
Nina Newbery	Head of the medical workforce unit & AoMRC flexible careers committee manager, Medical Workforce Unit, RCP
Dan Sumners	Head of Policy and Campaigns (London), Royal College of Physicians
Bernard Horan	NHS Workforce Statistics, NHS Digital

Very special thanks to the following people whose input was instrumental to completing this report.

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