NHS England

Additional Information for the NHS Workforce Race Equality Standard (WRES)

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1 Foreword

The NHS was created in 1948 as an instrument of social justice. We collectively promised each other that everyone should have equal access to health outcomes, irrespective of income levels, sexual orientation, race, disability or gender.

Although we have made much progress to realise that promise, we still have a long way to go. In order to provide equality of health outcomes, we must also create equality within our NHS workforce. We come to work in the NHS because we believe that we can contribute towards improving lives, population health and health outcomes. It is through the commitment and dedication of our diverse and talented NHS workforce that we achieve these ambitions on a daily basis; yet we can only do so effectively by creating inclusive cultures in which all of our people can thrive. The continuing presence of discrimination is why we need to re-set the inclusion dial, together setting and attaining more ambitious leadership standards that demonstrably drive equitable outcomes for everyone. We must then build upon this progress year on year.

The Workforce Race Equality Standard (WRES) programme has now been collecting data on race inequality for five years, holding up a mirror to the service and revealing the disparities that exist for black and minority ethnic staff compared to their white colleagues. The findings of the 2020 report do not make for a comfortable read, and nor should they. The evidence from each WRES report over the years has shown that our black and minority ethnic staff members are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers. The persistence of outcomes like these is not something that any of us should accept. It is in recognition of these realities that the People Plan 2020/21 has ‘belonging’ as one of its four pillars.

Findings for WRES 2020 are impossible to separate from the context into which the report will be published. The country and the NHS have been challenged like never before by the COVID-19 pandemic, a disease that has been shown to disproportionately affect black and minority ethnic people. The murder of George Floyd in the USA spurred an immediate and long-overdue global conversation about race inequality. Attention has not been so sharply focussed on this agenda for decades,

and it is right that we examine these findings with a view to quickening the pace of change, against this backdrop.

The 2020 report shows that, at the point at which the pandemic struck, inequalities were already present in the NHS. It is of note that much of this is experienced by black and minority ethnic staff as subtle processes and behaviours, that are often undetected by others. Three things emerge as key lessons to take from the 2020 findings:

– First, that delivering equality of outcome and opportunity should be the professional and moral obligation of every leader in the NHS. If it is not already happening, senior and executive leaders need to be accountable for developing and delivering urgent plans to eliminate inequality in their organisations.

– Second, that no one organisation is doing everything well. There are pockets of good practice across all WRES indicators, but no single organisation is exemplary. Every organisation must face up to its limitations and, as set out in the People Plan, develop measurable strategies to overcome them.

– Thirdly, the disproportionate rate of death among black and minority ethnic staff is intrinsically linked to their over-representation in some of the most at-risk groups. Those who work on the front lines of public services are often more exposed to the risk of infection, just as they are more exposed to bullying, harassment and discrimination.

The 2020 WRES reports a welcome increase in the diversity of our senior leadership. There has been a 42% increase in BAME Very Senior Managers, and a 22% increase in BAME trust board members since 2017. Alongside improved representation at senior level, cultures must become more inclusive as leaders develop pipelines of talent across the grades and throughout organisations, if we hope to see equality across the entire workforce.

The publication of this report is a moment for humble reflection for national, regional, and local leaders alike. These findings, and the events of 2020, show the need for equality and inclusion to be intrinsic to everything we do in the NHS and the People Plan clearly sets out

the need to give these issues the same emphasis as we would any other NHS priority. We need to act now to ensure that the cumulation of events of 2020 spur us to improve both equality for our black and minority staff and the experience of patient care for all. This is within our collective gift.

Prerana Issar
NHS Chief People Officer.

2 Introduction

The NHS Workforce Race Equality Standard (WRES) was made available to the NHS from April 2015, following sustained engagement and consultation with key stakeholders including a widespread of NHS organisations across England. The WRES is included in the NHS standard contract, and since July 2015, NHS trusts have been producing and publishing their WRES data on an annual basis.

The main purpose of the WRES is:

a. to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
b. to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
a. to improve BME representation at the Board level of the organisation.

This document updates the June 2020 version of the *Technical Guidance for the NHS Workforce Race Equality Standard.* This document is part of a package of resources to support NHS organisations to make measurable and continuous improvements in workforce race equality.

In the ‘belonging’ section of the People Plan 2020/21 -

Leadership diversity:
Every NHS trust, foundation trust and CCG must publish progress against the Model Employer goals to ensure that at every level, the workforce is representative of the overall BAME workforce. From September 2020, NHS England and NHS Improvement

will refresh the evidence base for action, to ensure the senior leadership (very senior managers and board members) represents the diversity of the NHS, spanning all protected characteristics.

Tackling the disciplinary gap:

Across the NHS we must close the ethnicity gap in entry to formal disciplinary processes. By the end of 2020, we expect 51% of organisations to have eliminated the gap in relative likelihood of entry into the disciplinary process. For NHS trusts, this means an increase from 31.1% in 2019. As set out in A Fair Experience for All, NHS England and NHS Improvement will support organisations in taking practical steps to achieving this goal, including establishing robust decision-tree checklists for managers

3 The NHS Constitution and the WRES

The NHS is founded on a core set of principles and values that bind together the diverse communities and people it serves – the patients and public – as well as the staff who work in it. The NHS Constitution establishes those principles and values of the NHS across England. It sets out the rights, to which all patients, communities and staff are entitled to, and the pledges and responsibilities which the NHS is committed to achieve in ensuring that the NHS operates fairly and effectively. Working towards race equality is rooted in the fundamental values, pledges and responsibilities of the NHS Constitution.

4 Background and design

Commissioned and overseen by the NHS Equality and Diversity Council (EDC) and NHS England, the design and development of the WRES is underpinned by engagement with, and contributions from, the NHS and national healthcare organisations, including the WRES Strategic Advisory Group.

The EDC adopted the WRES as the best means of helping the NHS as a whole to improve its workforce race equality performance. There is considerable evidence that the less favourable treatment of BME staff in the NHS, through poor treatment and

opportunities, has a significant impact on staff well-being, patient outcomes and on the efficient and effective running of the NHS and that the measures needed to address such discrimination will benefit patient care and organisational effectiveness.

Research and evidence show, for example, that white shortlisted applicants are on average 1.61 times more likely to be appointed than BME shortlisted applicants. BME staff are more likely than white staff to experience harassment, bullying or abuse from other staff; are more likely to experience discrimination at work from colleagues and their managers, and are much less likely to believe that their organisation provides equal opportunities for career progression. In general, the proportion of NHS board members and senior managers who are of BME origin is significantly smaller than the proportion within the total NHS workforce and the local communities served.

The WRES is intended to provide real impetus, not just on workforce race equality, but on equality generally, for all those who experience unfairness and discrimination within the NHS. For sustained improvement in this area, the focus will not be upon compliance with implementing the WRES, but on using it as an opportunity to help improve the wider culture of NHS organisations for the benefit of all staff and patients.

The WRES has been welcomed as a positive step forward to help support and deliver the NHS' responsibilities under the wider equality and inclusion agenda and forms the first stage in a programme of work to address NHS workforce equality issues. The WRES was subject to an Equality Analysis, which can be found on the NHS England website.

5 A tool for healthcare providers, commissioners and national bodies

The WRES is a tool designed for both providers of NHS services (this includes NHS providers, independent sector, and voluntary sector providers of NHS services) and NHS commissioners. It can also be applied to national healthcare bodies; indeed, many national healthcare bodies are also implementing and using the WRES.

5.1 Providers of NHS services

The Workforce Race Equality Standard applies to all types of providers of non-primary healthcare services operating under the full-length version of the NHS Standard Contract, and so is applicable to NHS providers, independent sector providers, and voluntary sector providers.

Since April 2015, the WRES has been included in the full-length NHS Standard Contract, which is mandated for use by NHS commissioners when commissioning non-primary health services. The Contract requires all providers of NHS services (other than primary care) to address the issue of workforce race inequality by implementing and using the WRES. Service Condition 13.6 of the NHS Standard Contract 2020/21 states the following in relation to the WRES:

> The Provider must implement the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing that standard.

Service Condition 13.7 states that

> The Provider must work towards the achievement of its bespoke targets for black and ethnic minority representation amongst Staff at Agenda for Change Band 8a and above, as described in the NHS Model Employer Strategy

Schedule 6A of the NHS Standard Contract requires that providers report annually on their compliance with the WRES. These provisions do not apply to the shorter-form version of the NHS Standard Contract, which is typically used for commissioning lower value services with smaller providers.

5.1..1 NHS Providers

NHS providers comprise organisations providing community health services, ambulance services, and secondary and tertiary health services. Some organisations focus upon particular health conditions, such as mental health or learning disability or provide particular services – e.g. ambulance services.

Given the range of NHS provider organisations, any centralised benchmarking of WRES data will not only be carried out at individual organisation level, but also by type of organisation and by geographical region.

5.1..2 Independent sector and voluntary sector providers

In addition to NHS providers, there are also independent sector organisations and voluntary sector organisations which provide non-primary NHS services; these organisations are also subject to the NHS Standard Contract. Implementation of the WRES therefore also applies to independent sector and voluntary sector healthcare provider organisations, and the WRES requirements in the Contract quoted above also apply to these organisations.

Many of the independent sector and voluntary sector healthcare provider organisations have a national footprint, and some provide specialist services; however, the issues covered by the WRES, relating to the experiences of the workplace and representation at senior management and Board level for BME staff are as pertinent to non-NHS organisations as they are to NHS bodies.

Independent sector and voluntary healthcare provider organisations do not have a similar level of uniformity in the structure of staff bandings and electronic staff records as is the case within NHS organisations. Furthermore, independent sector and voluntary sector healthcare providers will not be undertaking the NHS staff survey.

In implementing the WRES, independent sector and voluntary sector healthcare providers should focus upon their equivalent staff bandings, HR systems and electronic records, and relevant questions from surveys of their workforce that provide evidence in line with the NHS staff survey questions which inform the WRES indicators.

From April 2016 onwards, progress on the WRES is considered as part of the “well led” domain in CQC’s inspection programme. This will cover all NHS trusts and

independent healthcare providers that are contractually obliged to carry out the WRES. Further details regarding this are given in Section 10.

5.2 Clinical commissioning groups

Clinical commissioning groups (CCGs) have two roles in relation to the WRES – as commissioners of NHS services and as employers. In both roles their work is shaped by key statutory requirements and policy drivers including those arising from:

- The NHS Constitution;
- The Equality Act 2010 and the public sector Equality Duty;
- The NHS standard contract and associated documents;
- The CCG Improvement and Assessment Framework.

In addition to the NHS standard contract, the CCG Improvement and Assessment Framework also requires CCGs to give assurance to NHS England that their providers are implementing and using the WRES. Implementing the WRES and working on its results and subsequent action plans should be a part of contract monitoring and negotiation between CCGs and their respective providers. If there is something amiss with the providers' implementation or use of the WRES, and/or what the results of WRES actually show, CCGs should have meaningful dialogue with those providers. However, the credibility of the CCGs relationship with its providers can only be meaningful if the CCG itself is taking serious action to improve its own performance against the WRES indicators.

CCGs should commit to the principles of the WRES and apply as much of it as possible to their own workforce. In this way, CCGs can demonstrate good leadership, identify concerns within their workforces, and set an example for their providers. Formally, of course, CCGs are not required by the NHS standard contract to fully apply the WRES to themselves as some CCG workforces may be too small for the WRES indicators to either work properly or to comply with the Data Protection Act. However, neighbouring or similar (comparator) CCGs may wish to submit a jointly co-ordinated WRES report and action plan; this can counter any potential risk of small workforce numbers. Further information regarding such approaches is provided further below.

At a minimum level however, all commissioners of NHS services, including CCGs, are expected to have “due regard” to using the WRES in helping to improve workplace experiences and representation at all levels for their own BME staff. The key case law principles related to the term “due regard” are commonly referred to as the Brown Principles and are often used to determine whether a public body has shown “due regard” to the Equality Duty. These principles have been drawn upon to underpin the approach commissioners of NHS services, including CCGs, should take to the application of the WRES to their own organisations. Annex A presents alignment between the Brown Principles and implications of “due regard” for WRES use by CCGs.

“Due regard” in this context refers to the CCG giving proportionality, relevance and sufficient attention to implementing the WRES. The CCG is recommended to implement as many of the WRES indicators as appropriate, whilst giving fair consideration to the principles of the WRES within their day-to-day activities. For example, the monitoring of information such as non-mandatory training is good practice, as it can help the organisation identify potential anomalies in the level and type of support offered to different groups within its workforce. Indeed, publication of workforce data in such ways can help the organisation demonstrate compliance with the general duty of the public-sector Equality Duty.

Only 66 (34.6%) of the 191 organisations took part in the NHS staff survey in 2019. this needs to improve, not least because as we move to ICS working, having the fullest data is essential for these new systems to bake in good EDI practice to these entities.

In practice, to aid due regard to the implementation of WRES, CCGs should:

- **Collect data on their workforce** - data should be collected by ethnicity (see Section 7 on ethnicity monitoring) as well as by other characteristics given protection under the Equality Act 2010. This should include both workforce data and staff survey data. Some CCGs already take part in the national NHS Staff Survey. Others may conduct their own equivalent survey. They should analyse that data for each of the relevant WRES metrics.
- **Carry out data analyses** - in many CCGs the numbers of staff employed are small. Hence very small changes in numbers on workforce and survey metrics

can result in substantial changes in percentage terms. Such changes should be treated with caution but should not be ignored since, especially where they signify a trend or indicate a concern, they may be extremely useful. It is also possible to aggregate data for some WRES indicators to such an extent that individuals cannot be readily identified. Additionally, similar or neighbouring CCGs may wish to bring together and present their data analyses jointly. In South East London, for example, a number of CCGs work together on many major initiatives.

- **Produce an annual report and action plan** – the report should show the results of their staff survey and workforce data for internal analyses. The report should indicate the steps CCGs are taking to improve their performance against the WRES indicators. The WRES Reporting template has been made available for this purpose; it should be accompanied by the organisation's WRES action plan. Again, similar or neighbouring CCGs may wish to bring together their WRES data and report jointly as a whole.
- **Publish the annual report and action plan** - CCGs will need to consider how such data is published and what conclusions are drawn. Where publication by individual CCGs might lead to the identification of individuals due to small numbers, caution may need to be taken and wider publication may not be appropriate. However, similar or neighbouring CCGs may wish to develop a joint action plan based upon their amalgamated WRES report. In such a situation, the responsibility of making improvements against the WRES indicators should not be delegated to other CCGs; each individual CCG has a responsibility to have due regard to implementing the WRES and to improving the experiences of its own workforce.

A WRES action plan, produced in accordance with principles highlighted above, will enable CCGs to understand workforce matters and the steps needed to help improve BME staff experience and representation at all levels of the organisation. The WRES Reporting Template is available for CCGs to use in this regard. From **1st July 2016 onwards**, CCGs are expected to produce an annual WRES report, accompanied by an action plan.

The CCG Improvement and Assessment Framework requires all CCGs, in their role as commissioners of NHS services, to provide data from their providers in relation to reported harassment, discrimination and lack of equal opportunities between white and BME groups in the workforce. The data are based upon responses to the NHS staff survey (Q13a, Q13b/c, Q14, Q15b) as reflected in WRES indicators 5-8. Some CCGs already participate in the national NHS staff survey; those CCGs that do not currently participate, are encouraged to do so, or should undertake a similar workforce survey as noted above.

5.3 Commissioning support units

5.3..1 Supporting CCGs

Commissioning support units (CSUs) provide a range of support services to CCGs and can play an important role in ensuring that CCGs successfully carry out their obligations with regards to the WRES. Where a group of local CCGs are working together on implementing the WRES, the CSU can have a pivotal role to play in helping to bring together and support such a collaborative approach. Below are three examples of the type of approaches being developed by CSUs in implementing the WRES across their respective geographies.

a. Regional workforce race equality trends across CCGs

Aggregating the data for all CCGs in the region for which the CSU has responsibility. The intention is that by aggregating individual CCG workforce race equality data, as part of their support for and assurance role with CCGs, CSUs will be able to identify regional workforce race equality trends within a cluster of CCGs that might not be apparent (or possibly to identify) by scrutiny of individual small CCGs. As highlighted above, this approach will be valuable where reporting by individual CCGs proves to be problematic.

b. Checklist for CCGs

CSUs may develop a checklist for use with CCGs, to include a number of key checks relating to the WRES indicator, subject to Data Protection Act considerations. The use of the Equality Delivery System (EDS2), in particular EDS2 Goals 3 and 4, will be useful here, see Section 7. The checklist may include:

- Equality analysis of the workforce profile and organisational leadership, compared with relevant population;
- Equality analysis of recruitment and other employment matters;
- Workforce diversity targets e.g. relating to senior leadership and Board membership;
- Equality breakdown of key staff survey questions, such as experience of violence, harassment, bullying and discrimination (including relevant indicators from the WRES);
- Details of policies and programmes in place to address equality concerns in the workforce.

c. Views of staff from across CCGs

For many CCGs, the numbers of BME (and white) staff may be too small to register on the NHS staff survey, for data protection and person-identifiable data reasons. In such circumstances, CSUs may consider gathering the essential views (using qualitative and quantitative methods) of staff from across a number of CCGs to help identify potential trends and to inform action. It is essential that any such engagement with staff is both meaningful and sustained.

5.3..2 CSUs implementation of the WRES

CSUs carry out public functions using public funding, and as such the general duty of the public sector Equality Duty applies to them. Whilst the specific duties of the Equality Duty (publishing equality information; setting and publishing equality objectives) do not apply to CSUs, carrying out exercises such as analysing, publishing and acting upon workforce data (as appropriate) are viewed as good practice.
Indeed, such exercises may also help the CSU demonstrate compliance with the general duty of the Equality Duty.

There are good practice reasons for CSUs to implement and apply the WRES to their own workforces. We know, as highlighted above, that CCG workforces are ‘small’; this is often the case because some functions, such as Human Resources, Finance Support and Equality and Diversity are rationalised and centralised within CSUs. For example, a group of neighbouring CCGs may not have Human Resources staff as they

are located within a CSU where they serve the group of CCGs. The same may apply to staff carrying out other organisational functions. Alongside CCGs, insight into the BME composition of CSU staff, and data related to the WRES indicator, will be important in order for the total 'commissioning workforce' to be properly analysed and issues identified. Simply focussing upon the workforces of CCGs alone will only present a partial picture of workforce race equality across commissioning organisations.

5.4 National bodies

National healthcare bodies, including the Care Quality Commission, Health Education England, NHS Digital, the NHS Confederation (that includes NHS Employers), NHS England, NHS Improvement, NHS Providers, and Public Health England, are members of the Equality and Diversity Council, and are committed to supporting the work on the WRES. Alongside local NHS organisations, national bodies are also implementing the WRES as appropriate, including publishing data and action plans, though they are not bound by the NHS contract or subject to regulatory inspection.

Although national healthcare bodies are not required to implement the WRES and report data against its indicators; in the spirit of transparency and continuous improvement, six national healthcare bodies agreed to do so in 2018. The six organisations were Care Quality Commission, Health Education England, NHS Digital, NHS England, NHS Improvement, and Public Health England.

Workforce race equality, and equality in general, is a challenge that requires organisations to go beyond behavioural change as a result of compliance and regulation. Board level commitment and leadership within NHS organisations are critical in transforming the culture of organisations in relation to this agenda. National healthcare bodies have an important role to play in setting the standard of practice for other, local, organisations to follow.

6 Definitions of ethnicity: people covered by the WRES

The definitions of "black and minority ethnic" and "white" used in the WRES have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and are as used in NHS Digital data. At the time of publication of this guidance, these definitions were based upon the 2001 ONS Census categories for ethnicity. These are presented in Annex B.

"White" staff include white British, Irish, Eastern European and any other white i.e. categories A–C in the table in Annex B. The "black and minority ethnic" staff category includes all others except "unknown" and "not stated." To aggregate data for BME staff, organisations should include categories D-S from current values and exclude category Z – "not stated" and any "NULL" values, as cited in the table in Annex B. (With regard

to the 'old' codes, white staff are represented by category 0; BME staff are represented by categories 1-8, not given is represented by 9. As at December 2015, there were approximately 430 'old' codes allocated to current staff in the NHS.)
In some organisations there may be differences between the likelihood of different staff groups self-reporting their ethnicity, with some organisations having low rates of self-reporting. This risk is greatly reduced where organisations are making concerted efforts to increase the overall self-reporting levels. If the proportion of 'not stated' is significant, this should be addressed as it may affect the reliability of WRES data – small numbers may make a significant difference to the published outcomes.

The treatment of staff from ethic categories [B – white Irish] or [C – Any other white background] i.e. Gypsies and Travellers, or eastern European who may, in some organisations, be a significant minority group and experience considerable discrimination, is considered in the WRES FAQs document. Where this is the case, organisations should also explore such discrimination using workforce and staff survey data and take appropriate action.

7 The links between the WRES and the Equality Delivery System (EDS2)

The Equality Delivery System (EDS2) is designed to help local NHS organisations, in discussion with local stakeholders, review and improve their performance for patients, communities and staff in respect to all characteristics protected by the Equality Act 2010.

The WRES seeks to tackle one particular aspect of equality – the consistently less favourable treatment of the BME workforce – in respect of their treatment and experience. It draws on new research on both the scale and persistence of such disadvantage and the evidence of the close links between discrimination against staff and patient care.

The WRES and EDS2 are complementary but distinct. Therefore, there should not be any unnecessary duplication in the collection of data for the two initiatives. The data and analyses for the WRES indicators will assist organisations when implementing EDS2, in particular, with the outcomes under EDS2 Goals 3 and 4, as shown below.

Goal 3: A representative and supported workforce – notably EDS2 outcomes:
3.1 – Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
3.3 – Training and development opportunities are taken up and positively evaluated by all staff
3.4 – When at work, staff are free from abuse, harassment, bullying and violence from any source
3.6 – Staff report positive experience of their membership of the workforce
Goal 4: Inclusive leadership – notably EDS2 outcomes:
4.1 – Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
4.3 – Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Both the WRES and EDS2 also assist organisations in meeting their public sector Equality Duty requirements. NHS organisations should refer to the Equality Act 2010 and related guidance for a full understanding of the public sector Equality Duty.

8 Key considerations when implementing the WRES

8.1 Leadership and governance

Work on WRES, and other equality initiatives such as EDS2, will only make an impact when it is located within mainstream business and governance structures, and when NHS boards and senior leaders lead the way through not only what they say but also what they do, within and outside of their organisations. Boards are encouraged to avail themselves to developmental initiatives and leadership programmes where the emphasis is on inclusive workforces and healthcare services.

Successful equality, diversity and inclusion work, including work to implement the WRES, requires specialist advice and support. It is increasingly recognised that without good leadership, work on these agendas is very often short-lived, or at best, has little organisation-wide impact.
Leadership must come from Board level, as highlighted by NHS Providers in 'Leading by example: the race equality opportunity for NHS provider boards':

'Our key message is that real and sustained change will only be made by determined board leadership and commitment. It requires a shift beyond an over-reliance on diversity managers and HR directors to drive change. In short, it means the whole board leading by example and championing race equality not to comply with a newly imposed standard, but as a strategic opportunity to demonstrate their commitment to diversity and to leverage its potential to improve patient care'.

At the outset, the organisation's Board and senior leaders should confirm their own commitment to workplaces that are free from discrimination – where all staff are able to thrive, and flourish based on their diverse talent. This is particularly important as the WRES may well challenge the leadership of the organisation to positively demonstrate their own commitment to equality and inclusion, and in particular, to race equality. Indeed, some organisations are increasingly identifying a Board member to lead or promote this and other equality initiatives, such as EDS2.

One of the most important resources available to NHS organisations is the staff they employ to drive forward equality for patients and in the workplace. Due to recent organisational restructures and financial pressures, the numbers of specialist staff with expertise in equality and diversity may have reduced in some organisations; smaller organisations may only have limited specialist equality expertise or resource.

In taking forward work on the WRES, and on equality in general, organisations should consider what support, development opportunities and training should be made available to their staff – at all levels. Board and senior management level support with regard to this will be critical.

Board-level sponsorship and support of this work, allied with shared ownership across the organisation, is essential if organisations are to meet their contractual and legal equality requirements, the expectation of regulators, the aspirations of staff and the best interests of their patients.

8.2 Engagement

In adopting and implementing the WRES, NHS organisations should engage with staff, staff networks and local staff-side organisations. This engagement will provide the organisation with the opportunity to ensure that staff feel valued and respected for the outstanding contribution they often make, and that their BME staff in particular, are fully involved in the organisation's work on implementing the WRES. Staff who are supported by their leaders will make the WRES work in the best way.

Organisations will be more successful in their implementation of the WRES, and other equality initiatives such as EDS2, when engagement with staff, staff networks, with trades unions and other staff organisations is both meaningful and sustained. In a number of organisations, Board members have met with their BME workforce to hear, at first hand, their experiences of the workplace.

In implementing the WRES, it is essential that the voice of BME staff is heard loud and clear during the processes of identifying the challenges in making continuous improvements against the WRES indicators. Organisations are strongly encouraged to help establish and support BME staff networks – alongside networks for the other protected characteristics – as an important source of knowledge, support and experience. Guidance on BME staff networks in the NHS is available on the WRES webpage at: http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard

As part of this, it will be critical for organisations to provide a safe place for BME staff to share their concerns and be listened to in a meaningful and sustained way. Such an approach has been seen to contribute significantly towards the overall success of the organisation's work on equality, diversity and inclusion. Staff side organisations can play an important role in providing intelligence within local organisations and helping to create robust local action plans.

8.3 Data and action plans

Accessing robust data and evidence by ethnicity for each of the 9 WRES indicator should not be a challenge for NHS organisations. Typically, data required for WRES indicator 1-4 and 9 can be sourced from the Electronic Staff Record, whilst the NHS Staff Survey (or local equivalent) presents the data for WRES indicators 5-8. Organisations should ensure that similar questions from the NHS Staff Survey used in Indicators 5-8 are factored into any equivalent local staff survey. 2019 NHS staff survey results can be found on the staff survey website:

https://www.nhsstaffsurveyresults.com/

The national WRES Implementation Team will prepare submission templates and make these available online for organisations to download and populate. The WRES suite on ESR will be updated and organisations can use this to download data for

indicator one and populate the ESR figures column. Organisations can then use their local knowledge and data to check and amend this data and complete the verified data column. A small amount of manual calculation will be necessary on calculating the numbers of Very Senior Managers, Senior Medical Managers (Indicator 1), and the disaggregation of Board membership data (Indicator 9).
Guidance on the 2016 national NHS Staff Survey made clear the expectation that small staff survey samples were no longer acceptable and that organisations should move towards full staff surveys. This both helps organisations make better use of staff survey data generally and will considerably reduce concerns about the confidence level for BME staff survey data where BME workforces are relatively small. As the annual data also indicate BME staff are often less likely to take part in staff surveys, organisations are strongly encouraged to increase response rates amongst all staff, and to have a concerted focus upon BME staff groups.

WRES data will point organisations towards the direction of focus and attention required to make continuous progress on workforce race equality. As such, of equal importance to an organisation's WRES outcomes against the 9 Indicators will be the action plans that will sit alongside the data.

The WRES is intended to provide a blueprint of what "good" looks like, and through the sharing of replicable good practice on how "good" may be achieved and sustained. It does this by providing the necessary platform and direction that encourages and enables NHS organisations to:
compare not only their progress in reducing the gaps in treatment and experience over time, but to make comparisons with similar types of organisations on the overall level of such progress;
undertake meaningful and sustained engagement with staff, staff networks, staff-side organisations and other stakeholders with regard to progress on this agenda;
produce organisational-level improvement plans to take necessary remedial action following further considerations on the causes of the disparities in the indicator outcomes;
reduce the differences in the workplace treatment and experience between white and BME staff on each of the WRES indicators.

To assist the development of good practice the WRES Implementation Team has undertaken a significant amount of work (field work and literature search) to identify the shared characteristics of effective interventions against each of the WRES indicator and across organisations as a whole – looking at good practice in the private sector, other parts of the public sector, and within the NHS itself. The results of this work will be shared from spring 2017 and should further assist organisations' WRES action plans, which in turn will be evidence-based.

8.4 Transparency

Organisations should apply the WRES with an open mind and an honest heart. This means:
Being open about the nature and scale of the challenge each organisation faces – sharing data however uncomfortable it may initially be.

Sharing with all staff and trade unions the approaches proposed and inviting real engagement about those processes will help foster good relations between staff that do not share similar characteristics.
Sharing with all staff, the data from workforce analysis and staff surveys which indicates the challenges around race equality.
Sharing progress and achievements within and beyond the organisation and applying that learning to other staff groups where applicable.

8.5 Reporting and benchmarking

8.5..1 Local reporting

Organisation's own boards or corporate leadership play a full part in signing-off the WRES data and agreeing the associated WRES action plans. They should be clearly seen to own this work and how progress is to be made and monitored. Organisations' WRES data and draft action plans can, in the first instance, be discussed with local interests including:
Organisational governance arrangements established for the purpose of WRES implementation;
Governors and members of NHS foundation trusts;
Staff, BME staff networks, local unions and other organised staff groups;
Local equality groups including Race Equality Councils or Equality Councils.

Organisations can use the WRES Reporting Template to publish their annual WRES data on their websites, alongside their WRES action plans by Friday 27 September 2021. The WRES Reporting Template, which has been amended to make it more user-friendly and printable, can be found on the WRES webpage at: https://www.engage.england.nhs.uk/register/7774b8cb/consultation/intro/. This template is not mandatory, and organisations are encouraged to use templates that comply with their local board reporting standards.

8.5..2 Wider reporting

From July 2016, NHS provider organisations have been provided with a simple process for uploading their WRES indicator data via the SDCS system, so that progress can be more easily measured, national/regional aggregates can be formulated, and good practice shared. Organisations will be given pre-populated WRES Excel templates to complete, verify and check. They are then required to upload their raw data for the WRES indicators into the SDCS system – the necessary calculations will be carried out automatically by the system. A short instructions guide relating to the reporting process is available on the WRES webpage: http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard

Each NHS provider organisation's data against the nine WRES indicator will also be published annually. Alongside the guidance on Good Practice being published in

spring 2017, this approach will assist the identification and sharing of replicable good practice and learning on improving workforce race equality across the country. It will also help similar types of NHS organisations to benchmark their performance against each other and seek peer support where appropriate.

Key milestones and issues relating to the reporting of WRES data and action plans by CCGs and CSUs are presented in Sections 5.2 and 5.3 respectively.

9 WRES and Care Quality Commission inspections

The WRES is designed to prompt, and where necessary require, inquiry and root cause analyses of the differences in the WRES indicator data for BME and white staff. The WRES indicators are designed to be difficult to 'game' and the cultural challenges that the WRES unearths (bullying culture, blame culture, 'club' culture) are ones that all organisations will want to tackle in the interests of patient outcomes and organisational performance. Inclusion of the WRES in Care Quality Commission (CQC) inspections is therefore appropriate and necessary.

From April 2016 onwards, progress on the WRES is considered as part of the "well led" domain in CQC's inspection programme for NHS trusts and independent healthcare providers contractually obliged to carry out the WRES. The organisation's completed WRES Reporting Template and accompanying action plan are analysed as part of the evidence used in the inspections. Providers inspected are asked how they are addressing any issues arising from their respective WRES data. In addition, a variety of methods are used to engage with BME staff – so that data are also 'triangulated' with qualitative findings from the workforce.

The following initiatives have been taken to support the CQC's use of the WRES as part of the inspection process:
Recruitment of Equality and Diversity 'specialist advisors' who can assist with the assessment of the WRES and other equality and diversity issues for patients or staff, as part of the CQC inspection team during inspection visits.
Production of short pre-inspection WRES briefings based upon the WRES data, and other relevant workforce race equality evidence, for the trusts being inspected. The briefings will aid CQC inspectors and be a useful source of reference during their inspection visits.
Ongoing training and development for CQC inspectors and the recruited Equality and Diversity 'specialist advisors' – providing the necessary guidance, skills and knowledge required to undertake the WRES related element of the 'well-led' domain assessment.
The WRES Implementation Team is working with CQC to develop a WRES composite score.

10 Milestones for WRES implementation

Milestone	Activity
Data to be submitted by 31 August 2021 and annually thereafter	Publication of 31st March 2021 workforce data and Autumn 2020 staff survey data against all 9 indicators. In addition, actions required to make continuous progress (the WRES Action Plan) should be set out, including where appropriate, analyses of the impact of the 2020 Action Plan. The WRES data report and the Action Plan should be: • shared with the Board, staff and other local interests • submitted centrally via SDCS (applies to NHS providers and CCG's only, and with regard to the WRES data report only) • presented to the lead commissioner (for NHS providers) • published on organisations' websites *CCGs should give consideration to the issue of publishing small numbers as highlighted in section 5.2.
April 2019 – March 2025	Work towards the ambitious challenge of ensuring equitable black and minority ethnic (BME) representation at all levels of the workforce. This includes leadership being representative of the overall BME workforce by 2025.

All organisations are expected to be able to demonstrate that they are starting to close the differences between the treatment and experience of white and BME staff that the 9 WRES indicator highlight. This may involve:

Considering the WRES indicator to "drill down" by department or profession and consider further disaggregation by individual BME groups.
For Indicator 1, publication of the organisations' workforce ethnicity data by each pay band – separate for clinical and non-clinical staff will assist in identifying specific areas of concern and barriers to career progression. For Indicator 2, organisations will have considered analysing data on appointment from shortlisting for specific departments, occupations, or pay bands. Organisations may also wish to look at the 'application to shortlisting' stage in a similar way. The data reported for this indicator should also include outputs from internal recruitment campaigns.
For Indicators 3 and 4, organisations will have ensured they have in place an organisation-wide monitoring process for discipline and non-mandatory training/CPD analysed by ethnicity and started to consider if there are specific issues relating to particular professional groups, departments or shifts. They will want to consider carefully how they treat career development opportunities such as acting up, secondment, stretch assignments, being mentored and coached, and shadowing, as these are crucial to effective career progression.

Using the opportunity highlighted in the national initiative to improve NHS Staff Survey sample sizes, and in particular, increase BME staff sample sizes, as this will aid a better understanding of the specific challenges facing BME staff.
Reviewing recruitment processes for posts at all levels of the organisation – including senior management and Board-level appointments.
Discussing with local staff organisations, and with BME staff networks, their understanding of the drivers behind each of the WRES indicator – and developing robust action plans that strive towards continuous improvement. If such networks do not currently exist, then Board level consideration should be given to how they may be established and supported.
Considering the establishment of a three-year retrospective comparison, as some trusts already do, to scrutinise trends over time.
Considering the requirement for more regular reports to boards on key goals within the organisation arising from WRES implementation (this will be aided by the availability of WRES data throughout the year via the WRES report within the Business Intelligence ESR Dashboard for each trust, as described above).

11 Annex A – The Brown Principles as applied to CCGs use of the WRES

Brown Principle	Requirement in respect of the equality duty	Implications of "due regard" for the WRES for CCGs
Knowledge	The decision makers must be aware of their duty to have 'due regard' to the three aims of the duty.	CCGs must be aware of the WRES, its aims and metrics.
Sufficient information	The decision maker must consider what information he or she has and what further information may be needed in order to give proper consideration to the Duty.	CCGs must consider what data they currently have about their own workforce, analysed by ethnicity, and what further information may be needed in order to give proper consideration to the WRES.
Timeliness	The Duty must be complied with before and at the time that a particular policy is under consideration or decision is taken – that is, in the development of policy options, and in making a final decision. A public body cannot satisfy the Duty by justifying a decision after it has been taken.	CCGs are expected to collect and analyse their workforce data using the WRES metrics and to use that data to consider the extent to which gaps exist between the experience and treatment of white and BME staff using both workforce and staff survey data. Where CCGs do not currently participate in the National Staff Survey they should consider what means they might use that are appropriate to determine staff views.
Real consideration (Decision making)	Consideration of the three aims of the Equality Duty must form an integral part of the decision-making process. The Equality Duty is not a matter of box-ticking; it must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.	Consideration of the WRES must form an integral part of the decision-making process. The WRES is not a matter of box-ticking; it must be exercised in substance, with rigour and with an open mind in such a way that it influences decisions on workforce treatment and experience.
Accountability (No delegation)	Public bodies are responsible for ensuring that any third parties which exercise functions on their behalf are capable of complying with the Equality Duty, are required to comply with it, and that they do so in practice. It is a duty that cannot be delegate.	Having due regard to the WRES is not to be delegated to another body.

Monitoring and review	Public bodies must have regard to the aims of the Equality Duty not only when a policy is developed and decided upon, but also when it is implemented and reviewed. The Equality Duty is a continuing duty.	CCGs must have regard to the aims of the WRES not only when a workforce policy is developed and decided upon, but also when it is implemented and reviewed.

12 Annex B – Office of National Statistics 2001 Ethnic Categories

Ethnic Categories 2001
A – White –British
B – White –Irish
C – Any other white background
D – Mixed white and black Caribbean
E – Mixed white and black African
F – Mixed white and Asian
G – Any other mixed background
H – Asian or Asian British –Indian
J – Asian or Asian British –Pakistani
K – Asian or Asian British – Bangladeshi
L – Any other Asian background
M – Black or black British –Caribbean
N – Black or black British –African
P – Any other black background
R – Chinese
S – Any other ethnic group
Z – not stated
Note: a more detailed classification for local use if required is contained in Annex 2 of DSCN 02/2001.
Old Ethnic Codes - staff employed after 1 April 2001 must have their ethnic group assessed and recorded using the new categories and codes as detailed above. The "old" codes shown below are for reference only.
0 – White
1 – Black – Caribbean
2 – Black – African
3 – Black – Other
4 – Indian
5 – Pakistani
6 – Bangladeshi
7 – Chinese
8– Any other ethnic group
9 – Not given

16. Annex C – References and sources

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NHS England (2013) A refreshed Equality Delivery System for the NHS – EDS2.

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NHS Equality and Diversity Council (EDC) information can be found on the NHS England website

NHS Providers (2014) Leading by example: race equality opportunity for NHS provider boards.

NHS Staff Survey Results

NHS standard contract and the CCG Improvement and Assessment Framework can be found on the NHS England website

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17. Support and queries

For resources, information and queries relating to the WRES, please contact the NHS England national WRES Implementation Team:

Email england.wres@nhs.net

Webpage http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard