Technical Guidance for the NHS Workforce Race Equality Standard (WRES)

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Contents

Applying the WRES indicators

Matrices for the nine WRES indicators, plus definitions of terms, and advice on which evidence sources and insight to consider are given in the following set of tables.

Trusts are only required to submit data for Indicators 1 - 4 and indicator 9. The staff survey results are taken from the WRES publications available on the NHS Staff Survey website.

The WRES indicators

There are nine WRES indicator. Four of the indicators focus on workforce data, four are based on data from the national NHS Staff Survey questions, and one indicator focuses upon BME representation on boards. The WRES highlights any differences between the experience and treatment of white staff and BME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.

Based on feedback from the WRES baseline data returns and from engagement with the NHS, the wording for Indicators 1 and 9 have been revised in relatively minor ways. The revisions seek to add clarity on progress against these three WRES indicator:

- WRES Indicator 1 now has a clearer definition of “senior medical manager” and “very senior manager”.
- WRES Indicator 2 and 3 have been simplified. The calculation has been changed from using a two-year rolling average to using the year end figure.
- WRES Indicator 9 now requires submission of data that disaggregate: (i) the voting and non-voting members of boards, and (ii) the executive and non-executive members of boards. **Trusts are encouraged to try and ensure that there are no board members with an unknown ethnicity**.

With regard to WRES Indicator 2, organisation’s annual data returns are expected to include the shortlisting for both internal and external recruitment activity.

As highlighted above, a number of the WRES indicator (5-8) have been taken directly from the NHS Staff Survey questions. The NHS Staff Survey is reviewed annually; to ensure that organisations' local staff surveys are aligned to the four WRES indicator based upon the NHS Staff Survey questions, organisations not partaking in the NHS Staff Survey should check the current survey questionnaire.

The use of the national NHS Staff Survey data should become even more useful from 2017 onwards as a result of important improvements in increasing survey response rates. The push towards eliminating the use of small staff survey samples should help increase BME staff responses to the survey and make the analyses of data locally more meaningful.

As a whole, the WRES indicator have been chosen to be as simple and straightforward as possible and are almost entirely based on existing data sources (Electronic Staff Records; NHS Staff Survey or local equivalent) and analysis requirements which good performing NHS organisations are already undertaking. The development of the nine WRES indicator owes a great deal to consultation with, and contributions from, the NHS and key stakeholders.

Table 1 The Workforce Race Equality Standard indicators

	Workforce indicators For each of these four workforce Indicators, compare the data for white and BME staff
1.	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-Clinical staff • Clinical staff - of which - Non-Medical staff - Medical and Dental staff Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of Medical and Dental staff, which are based upon grade codes.
2.	Relative likelihood of staff being appointed from shortlisting across all posts Note: This refers to both external and internal posts

	Data should be taken at year end.
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation **Note: Data should be taken at year end.**
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff
5.	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	Percentage believing that the trust provides equal opportunities for career progression or promotion
8.	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for white and BME staff
9.	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

WRES indicators in detail

WRES Indicator 1 - compare the data for white and BME staff: Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

Definitions:

"Bands 1-9" – staff paid using the national Agenda for Change (AfC) pay scales for these grades. Where local pay scales are in use, then for non-medical staff or Tupe staff, the equivalent basic salary level should be used to assign them to an equivalent AfC pay band.

Medical and Dental subgroups – staff paid using the Medical and Dental pay scales. Subgroups are identified by using the grade codes as recorded in the Electronic Staff Record Warehouse.

"Very Senior Managers (VSM)" are defined as exclusively including:

- Chief executives
- Executive directors, with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and the requirements of the post
- Other senior managers with board level responsibility who report directly to the chief executive.

"The overall workforce" refers to: all directly employed staff. Organisations should either include all bank and locum staff, staff in post who are on long-term secondment, or sabbatical, students on placement and staff employed by contractors or not include them altogether – as long as the approach is consistent over time.

"Senior medical manager" is defined as: a medical consultant who is either a Medical Director, a Deputy Medical Director or who reports directly to a Medical Director or Deputy Medical Director." This category cannot be currently pre-populated from ESR so it will need to be manually counted.

The organisation's approach:

- The SDCS system should be used to submit the organisation's data for this Indicator.
- Organisations should submit data for this calculation separately for non-clinical and for clinical staff and further disaggregated for non-medical and medical and dental staff.
- Compare the proportions of white and BME staff in the overall workforce with those in each of the AfC Bands, medical and dental subgroups and VSM.
- Scrutiny by each AfC Band, and for clinical staff, by ethnicity will help to identify where barriers to staff progression may be occurring, and to consider the action to address these barriers. This will be helped by the disparity ratios calculated by the WRES team and shared with your regional leads.
- Some trusts already also disaggregate and publish AfC Band data by ethnicity and consider what may be happening in shortlisting and appointment processes for each Band boundary. Such scrutiny is likely to involve examination of the data underlying WRES indicator 2 and 4.

Sources of evidence and insight will include: Electronic Staff Record (ESR); local NHS workforce data and insight

Calculating the Indicator outcome:

Please note that the SDCS template will calculate WRES Indicator outcomes automatically, following input of data by the organisation. The worked example given below is for AfC Band 6:

Number of BME staff in AfC Band 6 = 50. Total number of staff in AfC Band 6 = 500. Percentage of BME staff in AfC Band 6 = (50/500) 10%
Number of BME staff in overall workforce = 1000. Total number of staff in overall workforce = 4000. Percentage of BME staff in overall workforce = (1000/4000) 25%.

WRES Indicator 2 - compare the data for white and BME staff: Relative likelihood of staff being appointed from shortlisting across all posts
This indicator will be based on year end data.

Definitions:

- Relative likelihood – compares the likelihood of white staff being appointed with the likelihood of BME staff being appointed (ratio).
- Appointed – is used rather than "recruited". The two may well be the same, but it is "appointed" staff numbers which should be used, unless not available.
- All posts – means all directly employed posts. Organisations should take a consistent approach by either including all bank and locum staff, students on placement and staff employed by contractors or not including them altogether – as long as the approach is consistent over time.
- **Data should be taken at year end.**

The organisation's approach:

- The SDCS template should be used to calculate and submit the organisation's data for this Indicator.
- Consider if there are significant differences between professions or departments.
- Ensure staff who shortlist, and interview are appropriately trained, including in the impact of "unconscious bias".
- Review the role of "executive search" agencies.
- Carefully consider all the informal advantages some staff may have accrued over others through non-mandatory training and opportunities for acting up, leading projects, mentoring and shadowing.
- Organisations may also want to look at relative likelihood of white and BME staff being **shortlisted from application, for both internal and external recruitment campaigns.**

Sources of evidence and insight will include: Electronic Staff Record (ESR); local NHS workforce data and insight

Calculating the Indicator outcome:

Please note that the SDCS template will calculate WRES Indicator outcomes automatically, following input of data by the organisation

Number of shortlisted applicants: white = 780; BME = 210

Number appointed from shortlisting: white = 170; BME = 30

Relative likelihood of shortlisting/appointed: white = (170/780) 0.22; BME = (30/210) 0.14

Relative likelihood of white staff being appointed from shortlisting compared to BME staff (0.22/0.14) is therefore 1.57 times greater.

A figure above “1” would indicate that white candidates are more likely than BME candidates to be appointed from shortlisting.

WRES Indicator 3 - compare the data for white and BME staff: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. **This indicator will be based on year end data.**
Definitions: • Entering the formal disciplinary process as measured by entry into a formal disciplinary investigation – refers to staff who have entered a formal investigation as prescribed by the local disciplinary process. Any occasional cases where disciplinary action is not preceded by an investigation should also be included in this definition. Staff who have been subject to an investigation, but for whom no further action was taken should be counted. Cases where mediation has taken place rather than any kind of formal investigation or disciplinary action should not be counted. • Organisations should only count **new entries** into a formal process in each year's WRES annual report. • **Data should be taken at year end.**
The organisation's approach: • The SDCS template should be used to calculate and submit the organisation's data for this Indicator. • Organisations may wish to consider the findings of the 2017 update of the 2010 NHS Employers commissioned, Bradford University report on ethnicity and discipline. • Organisations may wish to consider whether (and if so, why) there are significant differences between the ethnicity of staff entering the disciplinary process and those receiving sanctions. • Organisations may wish to consider differential outcomes of disproportionate disciplinary action against BME staff. • Organisations may also wish to consider any impact of disproportionate disciplinary action on referrals to professional conduct bodies.
Sources of evidence and insight will include: Electronic Staff Record (ESR); local NHS workforce data and insight

Calculating the Indicator outcome:
Please note that the SDCS template will calculate WRES Indicator outcomes automatically, following input of data by the organisation

Number of staff in workforce: white = 800; BME = 200

Number of staff entering the formal disciplinary process: white = 30; BME = 20

Likelihood of white staff entering the formal disciplinary process (30/800) = 0.0375

Likelihood of BME staff entering the formal disciplinary process (20/200) = 0.1000

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff is therefore 0.100/0.0375 = 2.66 times greater.

A figure above “1” would indicate that BME staff members are more likely than white staff to enter the formal disciplinary process.

WRES Indicator 4 – compare the data for white and BME staff: Relative likelihood of staff accessing non-mandatory training and CPD

Definitions:

- *Non-mandatory training* – refers to any learning, education, training or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g. fire safety training) or mandated by the organisation (e.g. clinical records system training). Non-mandatory and CPD recording practice may differ between organisations. However, all are expected to maintain internal consistency of approach from year to year, so that changes in uptake trends can be compared over time. Trusts are required to keep a record of all included and excluded training.
- *Accessing non-mandatory training and CPD* – in this context refers to courses and developmental opportunities for which places were offered and accepted.

The organisation's approach:

- The SDCS template should be used to calculate and submit the organisation's data for this Indicator.
- Organisations will want to ensure that there is a robust organisation-wide system for collecting and analysing consistent non-mandatory training and CPD data for all staff.
- Good practice will include investigating potential differences in non-mandatory training and CPD access, by ethnicity, between professions and departments.
- Organisations will want to learn from and share best practice with other organisations.
- It is acknowledged that organisations may vary in what they include as "non-mandatory training and CPD". The current definition does not explicitly include access to acting up, shadowing, leading projects, secondments, coaching etc. which may be the most important aspects of staff development and which employers may consider including. However, all Trusts must keep a record of what they included as non-mandatory training.

- **Sources of evidence and insight will include:**
  Local NHS workforce data and insight; staff professional development reviews Some trusts are using additional means to access or obtain this information e.g. use of a survey monkey or use of the OLM programme linked to ESR to try to track data more effectively. Some providers also triangulate their data with staff survey data.

Calculating the Indicator outcome:

Please note the SDCS template will calculate WRES Indicator outcomes automatically, following input of data by the organisation

Number of staff in workforce: white = 600; BME = 400

Number of staff accessing non-mandatory training and CPD: white = 300; BME = 150

Likelihood of white staff accessing non-mandatory training and CPD is 300/600 = 0.50

Likelihood of BME staff accessing non-mandatory training and CPD is 150/400 = 0.375

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff = (0.50/0.375) 1.33 times greater.

A figure below “1” would indicate that white staff members are less likely to access non-mandatory training and CPD than BME staff.

WRES indicator 5-8 - compare the outcomes of the responses for white and BME staff:

- Q13a. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
- Q13b/c. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
- Q14. Percentage believing that trust provides equal opportunities for career progression or promotion.
- Q15b. In the last 12 months have you personally experienced discrimination at work from any of the following?
  (b) Manager/team leader or other colleagues

Definitions:

- The wording of these four indicators is taken directly from the national NHS Staff Survey questions: KF25; KF26; KF21 and Q17.
- With regard to Indicator 7, the word “trust” is taken verbatim from the national NHS Staff Survey (KF 21); in this context it refers to any organisation that is subject to implementing and using the WRES.

The organisation’s approach:

- The results are taken the WRES publications available on the NHS Staff Survey website.
- Organisations will want to compare their NHS Staff Survey responses against appropriate workforce data (e.g. recorded harassment, bullying or abuse from patients, relatives or the public in the last 12 months) and understanding any discrepancies.
- Organisations should look to listen to their BME staff in order to better understand the data.
- Organisations will want to compare their data with peer organisations, or similar types of organisations, with the aim of sharing best practice.
- Good practice will include drilling down to analyse the data by departments and professions as far as possible.
- Organisations will want to increase both their NHS Staff Survey sample size and response rate, particularly from their BME workforce.

Sources of evidence and insight will include: Organisation’s most recent responses to the national NHS Staff Survey or local equivalent survey questions.

Calculating the Indicator outcome: Please note that the SDCS template displays the organisation's most recent responses to NHS Staff Survey questions KF25; KF26; KF21 and Q17b. These results are taken the WRES publications available on the NHS Staff Survey website.

WRES Indicator 9 - compare the difference for white and BME staff: Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce

Definitions:

- Board – membership in this context includes all members of the Board irrespective of whether they are executive or non-executive members and whether they are voting or non-voting members of the Board who may have been co-opted.
- Voting membership – Voting members of the board are usually the executive board members – employed by the organisation. Generally, non-executive members are generally not voting members of the board.
- Executive membership **–** An executive board member is an employee of the organisation and sits on an organisation's board of directors and advises current organisational management on specific operations, e.g. Medical Director or Finance Director, as opposed to a non-Executive board member who is a member of the board of directors of the organisation who does not form part of the executive management team. They are not employees of the organisation or affiliated with it in any other way.

The definition was amended in 2017 to enable disaggregation by executive / non-executive members and by voting / non-voting members.

The organisation's approach:

- The SDCS template should be used to input and submit the organisation's data. It may be necessary to manually check Indicator 9.
- The Electronic Staff Record enables reporting on Board members (Executive and Non-Executive) if the appropriate Job Roles have been applied. This will enable comparison to be made against the organisation's workforce and the population being served. Job Roles: Chair, Chief Executive, Finance Director, Other Executive Directors, Board Level Directors, Non-Executive Directors, Medical Director, Nursing Director.
- Foundation trusts will want to consider whether the ethnicity of trust governors is also broadly representative of the local population.
- Organisations should ensure that their executive search agencies are committed to diversity in their policies and processes.

• Organisations should plan for and develop an equal playing field for future applicants for all Board positions from diverse backgrounds.
Sources of evidence and insight will include: Electronic Staff Record (ESR); local demographic data of the working age population
Calculating the Indicator outcome: *Please note that the SDCS template calculates WRES Indicator outcomes automatically, following input of data by the organisation* The trust has 40% BME workforce and 1 of its 8, i.e. 12.5%, voting members on the Board is of BME origin. On Indicator 9, the percentage difference between the organisations' Board voting membership and its overall workforce will be -27.5% The trust has 15% BME workforce and 2 of its 8, i.e. 25%, executive members on the Board are of BME origin. On Indicator 9, the percentage difference between the organisation's Board executive membership and its overall workforce will be +10.0%.