



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

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Publications Gateway R	eference: 05065
Document Purpose	Guidance
Document Name	Technical Guidance for the NHS Workforce Race Equality Standard
Author	Dr Habib Naqvi, Roger Kline and Yvonne Coghill
Publication Date	12 April 2016
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, CSU Managing Directors, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS Trust Board Chairs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's Services, NHS Trust CEs
Additional Circulation List	National healthcare bodies, Trades Unions and Royal Colleges, Third Sector Strategic Partners
Description	This Technical Guidance is one of the tools intended to support NHS organisations in implementing and using the NHS Workforce Race Equality Standard. Further information on the work of the national WRES Implementation Team can be found at: https://www.england.nhs.uk/about/gov/equality-hub/equality-standard/
Cross Reference	WRES Equality Analysis, WRES FAQs, WRES Reporting Template
Superseded Docs (if applicable)	Technical Guidance for the NHS Workforce Race Equality Standard 2015-2016
Action Required	N/A
Timing / Deadlines (if applicable)	N/A
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Document Statu	IS

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

Version number: 2

First published: March 2015

Updated: April 2016

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Classification: OFFICIAL

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## 1 Foreword

The Five Year Forward View sets out a direction of travel for the NHS which depends on ensuring the NHS is innovative, engages and respects staff, and draws on the immense talent in our workforce.

The evidence of the link between the treatment of staff and patient care is particularly well evidenced for BME staff in the NHS, so this is an issue for patient care, not just for staff. Yet it is strikingly clear that the NHS still has an immense amount to do to genuinely act on this insight. The lessons of previous efforts to tackle this challenge show that a focussed natural and local effort will be essential if we are to make the progress we need.

That is why, although we hope and expect NHS organisations will make the changes that research evidence and best practice suggest are needed, the Equality and Diversity Council - representing the major national organisations in the NHS - proposed the Workforce Race Equality Standard, which supports and requires organisations to make these changes.

The "business case" for race equality in the NHS, and for the Workforce Race Equality Standard, is now a powerful one. NHS England, with its partners, is committed to tackling race discrimination and creating an NHS where the talents of all staff are valued and developed – not least for the sake of our patients.

We cannot afford the cost to staff and patient care that comes from unfairness in the appointment, treatment and development of a large section of the NHS workforce. We also know that research shows that diverse teams and leaderships are better for innovation and increase the organisational effectiveness the NHS needs. We know that we do best when healthcare organisations' leadership broadly reflect the communities we serve.

I welcome the support the Workforce Race Equality Standard has received and look forward to seeing the changes it seeks to achieve.

Simon Stevens CEO NHS England

## 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 wide spread of NHS organisations across England. It was included in the NHS standard contract 2015/16, and NHS trusts produced and published their WRES baseline data on 1 July 2015.

The main purpose of the WRES is to help local, and national, NHS organisations to review their data against the nine WRES indicators, to produce action plans to close the gaps in workplace experience between White and Black and Ethnic Minority (BME) staff, and to improve BME representation at the Board level of the organisation.

This document brings together the March 2015 version of the *Technical Guidance for the NHS Workforce Race Equality Standard*, and the July 2015 *Supplementary Technical Guidance: Clinical Commissioning Groups and the Workforce Race Equality Standard*. This document is part of package of resources to support NHS organisations to make measurable and continuous improvements in workforce race equality.

## 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 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. In particular, the WRES Strategic Advisory Group (members of which include the Chairs of the national healthcare organisations) provides strategic and policy advice on the direction of travel for the WRES programme.

The EDC prioritised the WRES as the best means of helping the NHS as a whole to improve its workforce race equality performance. There is considerable evidence strongly suggesting 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.

Research and evidence show, for example, that that White shortlisted applicants are on average 1.74 times more likely to be appointed than are 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 simply 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 alike.

The WRES has been welcomed as a positive step forward to help support and deliver the NHS' responsibilities under the equality 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 at:

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

# 5 A tool for healthcare providers, commissioners and national bodies

The WRES is a tool designed for both providers of NHS services (this include NHS providers and independent 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 NHS providers

NHS providers comprise a range of types – there are organisations providing primary care, community health services, ambulance services, and secondary and tertiary health services. There are foundation trusts and providers in the process of acquiring foundation trust status. Some organisations focus upon particular health conditions, such as mental health or learning disability. Given the range of 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.

Since April 2015, the WRES has been included in the NHS standard contract for providers. The contract requires almost all providers of NHS services (other than primary care) to address the issue of workforce race inequality by implementing and using the WRES. The 2016/17 NHS standard contract states the following in relation to the WRES:

- 1.1 The full-length Contract (SC13.5-6) requires providers to implement the national Workforce Race Equality Standard (WRES).
- 1.2 It is obviously important that good monitoring data is available to track progress nationally in these areas. NHS England is seeking approval for a new Information Standard which will, in time, mandate WRES data

submissions by providers. In the interim, we strongly encourage providers to report during 2016/17, using the <u>WRES report template</u>, publishing this on their websites. The next national WRES return is due in July 2016, and providers should look out for separate guidance in the New Year on a simple process for uploading their WRES indicator data via the UNIFY 2 system, so that progress can be measured at national level.

The WRES applies to all NHS providers and any non NHS providers (including voluntary and private sector) subject to the NHS standard contract, except for "small providers", defined as:

"A provider whose aggregate annual income for the relevant Contract Year in respect of services provided to any NHS commissioners commissioned under any contract based on the NHS Standard Contract is not expected to exceed £200,000"

All providers of NHS-funded healthcare services (other than primary care) except "small providers" are expected to collect, analyse and publish relevant workforce data in respect of their staff providing NHS services.

A number of the WRES indicators (5-8) have been taken directly from the NHS Staff Survey questions. In implementing the WRES, providers of NHS-funded healthcare service, other than primary care, should participate in the NHS Staff Survey (this is a requirement for all NHS trusts) or should undertake a local equivalent. The latter may apply to independent healthcare providers and some CCGs.

In addition to the NHS standard contract, from April 2016, the Care Quality Commission will also be including the WRES as part of its inspection regime for hospitals. The hospital's WRES data, and other evidence, will be looked at and considered as part of the assessment on the degree to which the organisation is "well-led".

## 5.2 Independent providers

Implementation of the WRES also applies to all independent provider organisations that provide NHS services and whose aggregate annual income for the relevant Contract Year, in respect of services provided to any NHS commissioners, exceeds £200,000. The NHS standard contract also applies to these organisations. Many of the independent 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 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 providers will not be undertaking the NHS Staff Survey. In implementing the WRES, independent providers should focus upon their equivalent staff bandings, HR systems and electronic records, and relevant questions from surveys of their workforce. Indeed, a more tailored approach may be needed to support WRES implementation and use within the independent provider sector.

From April 2016 onwards, progress on the WRES will be 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 9.

# 5.3 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 Assessment and Improvement Framework.

The provisions of the NHS standard contract and the CCG Assessment and Improvement Framework require 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 coordinated 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. Indeed, the CCG is recommended to implement as many of the WRES Indicators are 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 be good practice, as it can help the organisations identify potential anomalies in the level and type of support offered to different groups within its workforce.

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 and cover 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 the report should show the results of their staff survey and workforce data for internal analyses. The report should indicate what 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.
- Report and action plan publication CCGs will need to give consideration to 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 CCG has a responsibility to have due regard to implementing the WRES and to improving the experiences of its workforce.

A WRES report associated 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 1<sup>st</sup> July 2016 onwards, CCGs will be expected to produce such an annual WRES report, accompanied by an action plan.

The 2016/17 CCG Assessment and Improvement Framework will require 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 will be based upon responses to the NHS Staff Survey (KF18, KF19, KF27, Q23) as reflected in WRES Indicators 5-8. Some CCGs already participate in the national NHS Staff Survey. Those CCGs that do not currently participate in the NHS Staff Survey, are encouraged to participate, or should undertake a similar survey, as noted above.

# 5.4 Commissioning support units

## 5.4..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.

## Regional workforce 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 data, as part of their support for and assurance role with CCGs, CSUs will be able to identify regional workforce trends within CCGs own workforces 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.

## Checklist for CCGs

The development of a checklist for use with CCGs, to include a number of key checks, subject to Data Protection Act considerations, and shared with the CSU. 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.

## 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, CCGs 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.

## 5.4..2 CSUs implementation of the WRES

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. Insight into the BME composition of CSU staff, and data related to the WRES Indicators, 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.

## 5.5 National bodies

National healthcare bodies, including the Care Quality Commission, Health Education England, Health and Social Care Information Centre, NHS Confederation (that includes NHS Employers), NHS England, NHS Improvement, NHS Leadership Academy, 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, though in an entirely voluntary capacity as they are not bound by the NHS contract or subject to regulatory inspection.

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 fundamentally 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 The WRES indicators

There are nine WRES indicators. 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 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, including via regional NHS WRES workshops conducted during 2015/16, the wording for two of the WRES indicators has been revised:

- WRES Indicator 1 now asks for the percentage of BME staff in each of the Agenda for Change bands and VSM (including executive Board members), as opposed to just in bands 8a-9 and VSM. This will help organisations to identify career progression blockages that surface within the bands 1-7, in addition to potential blockages within the senior management bands.
- WRES Indicator 9 now requires the percentage difference between the organisations' BME board voting membership and its overall BME workforce. The previous indicator 9 was vague and focused upon comparison of the Boards' BME representation with the BME population served. It is widely acknowledged that the 'population served' boundaries for many NHS organisations are not always clear. Many organisations cover a number of regions, or parts of regions. The revised Indicator is based upon the goal of organisations moving towards having workforces that are representative of the local populations served, and Boards that are reflective of those workforces.

As highlighted above, a number of the WRES indicators (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 indicators based upon the NHS Staff Survey questions, organisations not partaking in the NHS Staff Survey should check the current survey questionnaire.

As a whole, the WRES Indicators have been chosen to be as simple and straightforward as possible and are 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 indicators 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 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
	Note: Organisations should undertake this calculation separately for non- clinical and for clinical staff
2.	Relative likelihood of staff being appointed from shortlisting across all posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
	Note: This indicator will be based on data from a two year rolling average of the current year and the previous year
4.	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, compare the difference for White and BME staff
9.	Percentage difference between the organisations' Board voting membership and its overall workforce
	Note: Only voting members of the Board should be included when considering this indicator

# 7 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 Health and Social Care Information Centre 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 A.

"White" staff include White British, Irish and Any Other White i.e. categories A–C in the table in Annex A. 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 A. (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 as small numbers may make a significant difference to the published outcomes.

The treatment of Gypsies and Travellers, staff from an Irish background and staff from an eastern European background who may, in some organisations, be a significant minority group and experience considerable discrimination, is considered in the FAQs available on the WRES. Where this is the case, organisations should also explore such discrimination using workforce and staff survey data.

# 8 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 will 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.

# 9 Key considerations when implementing the WRES

## 9.1 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 their 2014 'Leading by example: the race equality opportunity for NHS provider boards' publication:

'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 will 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.

# 9.2 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 that 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.

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.

For staff, engagement will mean helping to respond to the WRES data; to plan, develop and manage workplaces and activities that aim to improve working lives. It will also mean working together in identifying the barriers and challenges that often restrict organisations from having senior management and Boards that are reflective of the total workforce.

# 9.3 Data and action plans

Accessing robust data and evidence by race for each of the 9 WRES indicators should not be a challenge for NHS organisations. Typically, data required for WRES indicators 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.

It is good practice for organisations to move from conducting the NHS Staff Survey with a sample of their workforce, to carrying out a full survey across the whole of their workforce. Sample surveys often result in data reflecting small sample size, especially when this is further disaggregated by ethnicity, thus questioning the validity of the data. Data also indicate BME staff as being 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. Implementing the WRES should therefore not be viewed as an academic or "tick-box" exercise. 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 maintained. 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.

# 9.4 Transparency

Organisations should be transparent and sincere at all stages of engagement with, and implementation of, the WRES. 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.

## 9.5 Reporting and benchmarking

## 9.5..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 reported to 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.

These interests can be invited to comment and contribute towards the organisations' data and associated action plan prior to publication and reporting. Organisations should use the WRES Reporting Template to publish their annual WRES data on their websites, alongside their WRES action plans. The WRES Reporting Template can be found on the WRES webpage at:

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

## 9.5..2 Wider reporting

From July 2016, NHS provider organisations will be provided with a simple process for uploading their WRES indicator data via the UNIFY 2 system, so that progress can be measured and good practice shared. Organisations will be required to enter their raw data for the WRES indicators into the UNIFY 2 system – the necessary calculations will be carried out automatically by the system. A short instructions guide relating to the reporting process will be made available. In time, an Information Standard for the collection of WRES data will be rolled-out across the NHS, to further ensure timely reporting of WRES data and action plans.

Each provider organisation's data against the nine WRES indicators will also be published annually on a national benchmarking dashboard. This will enable 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 are presented in Section 4.3.

# 10 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 difficult to 'game' and the cultural challenges that the WRES unearths (bullying culture, blame culture, 'club' culture) are ones that all organisations proclaim they wish 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 will be considered as part of the "well led" domain in CQC's inspection programme for all NHS trusts and independent healthcare providers contractual obliged to carry out the WRES. In 2015-16 the CQC piloted its approach to using the WRES in a number of their comprehensive inspections of NHS Trusts and independent healthcare providers. In particular, the organisation's completed WRES Reporting Template and accompanying action plan were analysed as part of the evidence used in the inspections. Providers inspected are also asked how they were addressing any issues arising from their respective WRES data and a variety of methods were tested to engage BME staff – so the data is 'triangulated' by qualitative findings from both providers and employees.

The following initiatives are underway to support the CQCs 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.

# 11 Milestones for WRES implementation

Milestone	Activity	
1 July 2015	Publication of 1 <sup>st</sup> April 2015 data* (the WRES baseline data) including actions required to make continuous progress (the WRES action plan).	
	*CCGs should give consideration to the issue of publishing small numbers as highlighted in section 4.3.	
April 2015 – March 2016	Work to address any data shortcomings and to understand and address the concerns raised in the organisation's WRES baseline data should be undertaken.	
1 <sup>st</sup> July 2016 – and annually thereafter	• submitted centrally via Unify 2 – together with a WRES action	

From July 2016, all organisations are expected to demonstrate that they are starting to close the differences between the treatment and experience of White and BME staff. This may well involve:

a. Considering the WRES Indicators to "drill down" by department or profession, and consider further disaggregation by individual BME groups.

- For Indicator 1, organisations should publish, as many do already, the ethnicity data by each pay band – separate for clinical and non-clinical staff.
   This this will assist in identifying specific areas of concern and barriers to career progression.
- c. For Indicator 2, organisations will have considered analysing data on appointment from shortlisting for specific departments, occupations, or pay bands. Organisations may also look at the 'application to shortlisting' stage in a similar way.
- d. 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.
- e. Taking action to increase their organisation's response rate to the NHS Staff Survey (or local equivalent), with a particular emphasis upon increasing the response rate from their BME staff.
- f. For Indicator 9, organisations should work towards having a workforce that is representative of the local population served, and a Board that is reflective of that workforce
- g. Reviewing recruitment processes for posts at all levels of the organisation including senior management and Board-level appointments.
- h. Discussing with their local staff organisations their understanding of the drivers behind each of the WRES Indicators and developing robust action plans that strive towards continuous improvement.
- Discussing with their local interests, including their BME networks, their understanding of the drivers behind each of the WRES Indicators and suggestions on how to improve the metrics. If such networks do not currently exist, then Board level consideration should be given to how they may be established,
- j. Considering establishing a three-year retrospective comparison, as some Trusts already do, to scrutinise trends over time.

# 12 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.

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

#### **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, the equivalent basic salary level may be used
- VSM Very Senior Managers (VSM) can be defined using the following methods:
  - Occupational Codes starting 'G0' = AfC Band 8a and over, most commonly 8d and above in larger organisations (such as acute trusts) and potentially from 8a in smaller organisations, and VSM. (See Occupational Code Manual for further guidance).
  - Occupation Code Z2E = Chair and Non-Exec Directors (Not necessary if identified using Job Roles as below.)
  - Job Roles: Chair, Chief Executive; Finance Director; Other Exec Director; Board Level Director; Non-Exec Director; Senior Manager (Reports to a Board Member)
- The overall workforce means all directly employed staff. Organisations should 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

## The organisation's approach:

- The Unify2 system should be used to calculate and submit the organisation's data for this Indicator
- Organisations should submit data for this calculation separately for non-clinical and for clinical staff
- Compare the proportion of BME and White staff in the overall workforce with those in each of the AfC Bands and VSM (Unify2 will calculate this automatically). And to repeat the exercise for its clinical staff
- 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
- Some Trusts already 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 Indicators 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 from July 2016, the Unify2 system will be developed to 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  $6 = (50/500) \, \underline{10\%}$  Number of BME staff in overall workforce = 1000. Total number of staff in overall workforce = 4000. Percentage of BME staff in overall workforce =  $(1000/4000) \, \underline{25\%}$ 

WRES Indicator 2 - compare the data for White and BME staff: Relative likelihood of staff being appointed from shortlisting across all posts

### **Definitions:**

- Relative likelihood compares the likelihood of BME staff being appointed with the likelihood of White 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

## The organisation's approach:

- The Unify2 system 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 BME and White staff being **shortlisted from application**

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

## Calculating the Indicator outcome:

Please note that from July 2016, the Unify2 system will be developed to 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 = 0.22; BME = 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 below 1 would indicate that white candidates are less 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 data from the most recent two-year rolling average)

### **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 from a two-year rolling average of the current year and the previous year means data from whichever two previous 12 month periods (i.e. 2 years) have been used as the basis of the reported data.

## The organisation's approach:

- The Unify2 system should be used to calculate and submit the organisation's data for this Indicator
- Small numbers being reported upon might result in the identification of individuals; however the Unify2 system will automatically obfuscate figures where less than 5 are present
- Organisations may wish to consider the findings of the 2010 NHS Employers commissioned, Bradford University report on ethnicity and discipline and the NHS London/RCM report on discipline and midwives
- 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

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

## Calculating the Indicator outcome:

Please note that from July 2016, the Unify2 system will be developed to 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 (40/200) = 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 below 1 would indicate that BME staff members are less 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

• 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 Unify2 system 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

Sources of evidence and insight will include: Local NHS workforce data and insight; staff professional development reviews

## Calculating the Indicator outcome:

Please note that from July 2016, the Unify2 system will be developed to 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 Indicators 5-8 - compare the outcomes of the responses for White and BME staff:

- KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
- Q17. In the last 12 months have you personally experienced discrimination at work from any of the following?
  - (b) Manager/team leader or other colleagues

#### **Definitions:**

- The wording of these four indicators is taken directly from the national NHS Staff Survey questions: KF18; KF19; KF27 and Q23.
- With regard to Indicator 7, the word "trust" is taken verbatim from the national NHS Staff Survey (KF 27); in this context it refers to any
  organisation that is subject to implementing and using the WRES

## The organisation's approach:

- The Unify2 system should be used to input and submit the organisation's data for these Indicators
- 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
- For WRES indicator 7 (KF27) organisations will also gain insight into the implications of the data if they compare the proportions of White and BME staff who do NOT believe their "trust provides equal opportunities for career progression or promotion"

**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 from July 2016, the Unify2 system will be developed to calculate WRES Indicator outcomes automatically, following input of data by the organisation

The organisation's most recent responses to NHS Staff Survey questions KF18; KF19; KF27 and Q23 (or equivalent data) should be inputted to the Unify2 system.

WRES Indicator 9 - compare the difference for White and BME staff: Percentage difference between the organisations' Board voting membership and its overall workforce

### **Definitions:**

- Board membership in this context includes all voting members of the Board irrespective of whether they are executive or non-executive members. It does not include non-voting members of the Board who may have been co-opted.
- Broadly representative means that the ethnicity (BME/White) make-up of the Board is expected to be similar to that of the overall workforce
  of the organisation. That does not mean there must be a mathematically identical ethnic composition within each Board, but it does mean that
  it would not be regarded as acceptable to have for example only 8% of voting Board members from BME backgrounds in an organisation
  where over 40% of the workforce is from BME backgrounds
- The overall workforce means all directly employed staff. Organisations should 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

## The organisation's approach:

- The Unify2 system should be used to input and submit the organisation's data for these Indicators
- 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
- This Indicator is based upon the goal that each organisation should work towards having a workforce that is representative of the local population served, and a Board that is reflective of that workforce

Sources of evidence and insight will include: Electronic Staff Record (ESR)

## Calculating the Indicator outcome:

Please note that from July 2016, the Unify2 system will be developed to calculate 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 <u>-27.5%</u>

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

Brown Principle	Requirement in respect	Implications of "due
	of the equality duty	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 boxticking; 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	Public bodies are	Having due regard to the
(No delegation)	responsible for ensuring	WRES is not to be
	that any third parties which	delegated to another body.
	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.	
Monitoring and review	Public bodies must have	CCGs must have regard to
	regard to the aims of the	the aims of the WRES not
	Equality Duty not only when	only when a workforce
	a policy is developed and	policy is developed and
	decided upon, but also	decided upon, but also
	when it is implemented and	when it is implemented
	reviewed. The Equality	and reviewed.
	Duty is a continuing duty.	

# 14 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

## 15 Annex C - References and sources

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http://www.cqc.org.uk/

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More information on the Equality Act 2010 and the public sector Equality Duty can be found on the Equality and Human Rights Commission website

http://www.equalityhumanrights.com/private-and-public-sector-guidance/public-sector-providers/public-sector-equality-duty

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

https://www.england.nhs.uk/about/gov/equality-hub/edc/

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http://www.nhsproviders.org/resource-library/the-race-equality-opportunity-for-nhs-provider-boards

NHS England (2013) *A refreshed Equality Delivery System for the NHS – EDS2.* <a href="https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf">https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf</a>

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http://www.nhsproviders.org/resource-library/the-race-equality-opportunity-for-nhs-provider-boards

NHS Staff Survey Results 2015

http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2015-Results

More information on the NHS standard contract and the CCG Assessment and Improvement Framework can be found on the NHS England website <a href="https://www.england.nhs.uk/">https://www.england.nhs.uk/</a>

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# 16 Support and queries

For further information and queries regarding 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