



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

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**Description**      This Technical Guidance is just one of the tools which are intended to support all NHS organisations in making measurable progress on workforce race equality. Other materials you may find useful include:

- Updated WRES FAQs on the Standard and useful links to any research referred to in this Guidance.
- Background research relating to the WRES Standard
- NHS Providers guide Leading by example: the race equality opportunity for NHS provider boards .
- The Standard and related materials on the NHS England web site
- A short joint NHS Leadership Academy and RCN guide to inclusive leadership

Over the coming months NHS England, alongside partner organisations that are members of the NHS Equality and Diversity Council, will be providing a range of practical support on this important issue.

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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 national 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 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 challenge to ensure black and minority ethnic (BME) staff are treated fairly and their talents valued and developed is one that **all** NHS organisations need to meet because:

- Research shows that unfair treatment of BME staff adversely affects the care and treatment of all patients
- Talent is being wasted through unfairness in the appointment, treatment and development of a large section of the NHS workforce
- Precious resources are wasted through the impact of such treatment on the morale, discretionary effort, and other consequences of such treatment
- Research shows that diverse teams and leaderships are more likely to show the innovation, and increase the organisational effectiveness, the NHS needs
- Organisations whose leadership composition bears little relationship to that of the communities served will be less likely to deliver the patient focussed care that is needed

NHS Providers<sup>1</sup>, who speak for many NHS provider Trusts, concluded:

*“Recent research on race equality in the NHS workforce makes challenging reading for boards in provider organisations. Evidence shows that if you are from a black and minority ethnic background you are less likely to be appointed once shortlisted, less likely to be selected for training and development programmes, more likely to experience harassment, bullying and abuse, and more likely to be disciplined and dismissed.*

*Black and minority ethnic staffs are significantly underrepresented in senior management positions and at board level. And in 2012, just 1 per cent of NHS chief executives came from a BME background, compared to 16 per cent BME representation in the NHS workforce.*

*Most worryingly, despite a multitude of race equality initiatives and examples of provider good practice since the 2004 Race Equality Action Plan, many of the key indicators are either static or actually getting worse. “*

<sup>1</sup> *Leading by example: the race equality opportunity for NHS provider boards: (2014)*

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

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This challenge is one that **all** NHS organisations, **not just providers**, need to meet.

In response to this challenge, the **2015/16 NHS Standard Contract** includes a new Workforce Race Equality Standard (“the Standard”) which will require almost all NHS providers of NHS services (other than primary care) to start to address this issue. It states at Service Condition 13:

‘The Provider must implement EDS2; and implement the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing the Standard’.

The **Care Quality Commission** will also consider the Workforce Race Equality Standard in their assessments of how “well-led” NHS providers are from April 2016.

At a time of rising pressures on healthcare services, making best use of the diverse talents and experiences of our workforce is essential. Part of this must involve treating all staff fairly, both in making the best use of the existing workforce, and when recruiting and developing new staff.

This is a challenge requiring Board level commitment and leadership within NHS organisations, not just to comply with the new Standard and future CQC inspection standards, but because race equality is good for patient care.

This **Technical Guidance** is just one of the tools which are intended to support all NHS organisations in making measurable progress on workforce race equality. Other materials you may find useful include:

- Updated WRES FAQs on the Standard<sup>2</sup>. These contain links to any research referred to in this Guidance.
- Background research relating to the WRES Standard Kline, R<sup>3</sup> (2014); West, M<sup>4</sup> (2011)

<sup>2</sup> WRES FAQs on the Standard - <http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard/>

<sup>3</sup> Kline, R. *The Snowy White Peaks of the NHS*. Middlesex University (2014)

[http://www.mdx.ac.uk/\\_data/assets/pdf\\_file/0012/59799/The-snowy-white-peaks-of-the-NHS.pdf](http://www.mdx.ac.uk/_data/assets/pdf_file/0012/59799/The-snowy-white-peaks-of-the-NHS.pdf)

<sup>4</sup> West, M. Dawson, J. NHS Staff Management and Health Service Quality, Aston Business School. (2011).



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- NHS Providers guide *Leading by example: the race equality opportunity for NHS provider boards*<sup>5</sup>.
- The Standard and related materials on the NHS England web site<sup>6</sup>
- A short joint NHS Leadership Academy and RCN guide to inclusive leadership<sup>7</sup>

Over the coming months NHS England, alongside partner organisations that are members of the NHS Equality and Diversity Council; will be providing a range of practical support on this important issue.

The **NHS Equality and Diversity Council** agreed in 2014 that an NHS Workforce Race Equality Standard (the Standard) should be consulted on, with a view to it being included in the NHS Standard Contract for 2015/16. During the latter part of 2014, extensive consultation and engagement took place with key stakeholders regarding the Standard. The Standard has been welcomed as a positive step forward to 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 Standard was subject to an Equality Analysis, which can be found at:

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

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

The Standard will, for the first time, require organisations employing almost all of the 1.4 million NHS workforce, to demonstrate progress against a number of indicators of workforce race equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) Board representation. All providers, subject to the

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<sup>5</sup> NHS Providers guide *Leading by example: the race equality opportunity for NHS provider boards*<sup>5</sup>. 2014

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

<sup>6</sup> WRES standard and related material <http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard/>

<sup>7</sup> A short joint NHS Leadership Academy and RCN guide to inclusive leadership

<http://www.leadershipacademy.nhs.uk/download/5155/>

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NHS Standard Contract 2015/16, except ‘small providers’ and primary care, will be expected to implement the Standard from April 2015.

A **Small Provider** in contract terms is one which expects to earn less than £200k in the relevant year from all the contracts it holds that are based on the NHS Standard Contract.

An **annual report** will be required to be submitted to the Co-ordinating Commissioner outlining the providers’ progress on implementing the Standard. Provider organisations should publish their Annual Report on the Standard as a separate report on their web site so that progress on implementing the Standard is easily accessible to all staff, patients and the wider public.

## 2.1 The NHS Constitution and Equality Initiatives

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 for race equality is rooted in the fundamental values, pledges and responsibilities of the NHS Constitution<sup>8</sup>.

## 2.2 The links between the Workforce Race Equality Standard (“the Standard”) and the Equality Delivery System (EDS2)

The Equality Act 2010 ascribes protection to nine characteristics. The nine characteristics are: age; disability; gender re-assignment; marriage and civil partnership; pregnancy and maternity; race (including nationality and ethnic origin); religion or belief; sex; sexual orientation.

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<sup>8</sup> NHS Constitution -

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/170656/NHS\\_Constitution.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf)

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 Workforce Race Equality Standard 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 about both the scale and persistence of such disadvantage and the evidence of the close links between discrimination against staff and patient care.

The Standard and EDS2 are complementary but distinct. The indicators used in the Standard, and the progress made in closing them, will assist organisations implementing the EDS2. Though the progress reports on the Standard and EDS2 will be made separately, local NHS organisations will want to check how the data published for the Standard can assist and align with EDS2, and in particular with the outcomes under EDS2 Goals 3 and 4.

**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 Standard and EDS will assist organisations in meeting their Public Sector Duty requirements.

It will be for local organisations to decide if the reporting dates for EDS2 and the Standard are the same, but if they are the reports should be made separately. Further information on the Equality Delivery System – EDS2<sup>9</sup>

### 2.3 What about other aspects of Workforce Equality?

The Equality and Diversity Council regards **all** aspects of workforce equality as important. NHS England is promoting a number of initiatives to address other protected characteristic including, in the first instance, supporting additional research and work on sexual orientation, disability and gender. EDS2 itself seeks to focus on all protected characteristics. If successful, the approach used for the Workforce Race Equality Standard may be adapted for other equality strands, so that over time, workforce equality can be progressed across all characteristics given protection under the Equality Act 2010.

### 2.4 Public Sector Equality Duty reports

Many (but not all) NHS organisations are required by legislation to produce and publish their equality information (including on their workforce) on an annual basis by January 31<sup>st</sup>. The Standard does not require organisations to change their current reporting date. The Standard along with data and evidence relating to other protected characteristics may help organisations with their response to the Public Sector Equality Duty (of publishing equality information annually). NHS organisations should refer to the Equality Act 2010 and related guidance for a full understanding of the Public Sector Equality Duty<sup>10</sup>.

<sup>9</sup> Equality Delivery System – EDS2 <http://www.england.nhs.uk/ourwork/gov/equality-hub/eds>

<sup>10</sup> NHS organisations should refer to the Equality Act 2010 and related guidance for a full understanding of the Public Sector Equality Duty. This can be found at <http://www.equalityhumanrights.com/private-and-public-sector-guidance/public-sector-providers/public-sector-equality-duty>

### 3 Why the Workforce Race Equality Standard is being introduced?

The systemic discrimination against Black and Minority Ethnic (BME) staff within the NHS is highlighted in numerous reports. These reports show that by every indicator BME staff experience less favourable treatment when working in the NHS than do their white colleagues. We know through the work of Professor Michael West and Jeremy Dawson that there is a spiral of positivity in organisations that have an engaged, motivated and enthusiastic staff. Being undervalued and discriminated against leads to disengagement, unhappiness, depression, poor performance and ultimately reduced effectiveness. Though this appears true for all groups, Jeremy Dawson highlights a particular relationship with ethnicity:

“the staff survey item that was most consistently strongly linked to patient survey scores was discrimination, in particular discrimination on the basis of ethnic background.” (Dawson J. 2009)<sup>11</sup>

Michael West also concludes there is a good link between the treatment of BME staff and patient satisfaction

‘the greater the proportion of staff from a black or minority ethnic (BME) background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction, the experience of BME staff is a very good barometer of the climate of respect and care for all within NHS trusts’. West, M et al 2011)<sup>12</sup>

On his return to the NHS after 10 years abroad, Simon Stevens, the CEO of NHS England, said in 2014:

“It can’t be right for example – as Roger Kline’s recent research has pinpointed – that ten years after the launch of the NHS Race Equality Plan, while 41% of NHS staff in London are from black and minority ethnic backgrounds (similar in proportion to the Londoners they serve) only 8% of

<sup>11</sup> Dawson, J. (2009) *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys*. Aston Business School.

<sup>12</sup> West, M. Dawson, J. *NHS Staff Management and Health Service Quality*, Aston Business School. (2011).

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trust board directors are, with two-fifths of London trust boards having no BME directors at all. Similar patterns apply elsewhere, and have actually been going backwards. Yet we know that diversity in leadership is associated with more patient-centred care, greater innovation, higher staff morale, and access to a wider talent pool”.

The Standard has been developed to improve workforce race equality across the NHS. It will help to improve the opportunities, experiences and working environment for BME staff, and in doing so, help lead towards improvements in the quality of care and satisfaction for **all** patients.

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## 4 What is the Workforce Race Equality Standard?

### 4.1 The Standard Indicators

There are nine indicators. Four of the indicators are specifically on workforce data, four are based on data from the national staff survey indicators, and one considers Board composition. The Standard will highlight any differences between the experience and treatment of White staff and BME staff in the NHS with a view to closing those metrics. Indicator 9 requires organisations to ensure their Boards are broadly representative of the communities they serve. These indicators were developed in partnership with the NHS. The final version of the Indicators is presented below.

It is intended to consider how best the data arising from the annual reports on the Standard can be benchmarked nationally. Such benchmarking is needed to enable realistic and robust comparisons to be made.

The Standard is not intended to provide a blueprint on how “good” can be achieved; however, it does provide the necessary platform and direction that encourages and enables NHS organisations:

- To reduce the differences between the treatment and experience of White and BME staff on each of indicators 1-8.
- To compare not only their progress in reducing the gaps in treatment and experience but to make comparisons with similar organisations about the overall level of such progress over time.
- To take necessary remedial action following further analyses on the causes of ethnic disparities in the indicator outcomes.

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## 4.2 Table 1 The Workforce Race Equality Standard indicators

<b>Workforce Race Equality Standard indicators</b>	
	<p><b>Workforce indicators</b> For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.</p>
1.	Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce
2.	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.
3.	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White 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 BME staff accessing non mandatory training and CPD as compared to White staff
	<p><b>National NHS Staff Survey findings</b> For each of these four staff survey indicators, the Standard compares the metrics for the responses for White and BME staff for each survey question</p>
5.	KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6.	KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7.	KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion
8.	Q23. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	<p><b>Boards.</b> <b>Does the Board meet the requirement on Board membership in 9</b></p>
9.	Boards are expected to be broadly representative of the population they serve.

The indicators have been chosen to be as simple and straightforward as possible and are based on existing data collection and analysis requirements which good performing NHS organisations are already undertaking.



## 5 Definitions of ethnicity

The definitions of “Black and Minority Ethnic” and “White” used in the Standard and in this Guidance 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 2011 ONS Census categories for ethnicity.

“White” staff include White British, Irish and Any Other White i.e. categories A, B and C in the table below. The “Black and Minority Ethnic” staff category includes all other staff except “unknown” and “not stated.” To aggregate results for BME, employers should exclude A, B, C and Z from current values in the table below and also exclude 0 and 9 from the old values of which there are around 500 records. They should also exclude all ‘NULL’ values. The category C. ‘Any other white’ contains minority groups including white European

In some organisations there may be differences between the likelihood of different staff groups self-reporting their protected characteristic. This risk is greatly reduced where overall self-reporting is at high levels. There may also be some differences between participation rates between White and BME staff in national NHS staff surveys.

If, the proportion of ‘not stated’ is significant that will need to be addressed, as it may affect the reliability of indicators where small numbers may make a significant difference to the published metrics.

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

**Table 2 Ethnic Categories as per Office of National Statistics (ONS)**

<b>Ethnic Categories as per Office of National Statistics (ONS) 2011</b>		
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.		
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		

## 6 Applying each indicator

It may be appropriate for local reporting processes to include, in addition to the Indicator information, **narrative information** such as context around any particular Indicator. However, in doing so, organisations will need to note that any such narrative would be open to scrutiny and potential challenge.

### 6.1 Indicator 1

<b>1.</b>	<b>Percentage of BME staff in Bands 8-9 and VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce</b>
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#### Definitions

**Defining Bands 8-9** is straightforward if staff are being paid using the national pay scales for these grades using a minimum salary value as the cut-off point i.e. the 1/4/2014 minimum of Band 8a = £39,239 (basic pay excluding any geographical allowances). Where local pay scales/descriptions are in use, then for non-medical staff basic salary level may be used.

**Defining VSM** may be done using the following Occupation Codes

- ‘G0\*’ = AfC Band 8+ and VSM. (See Occupational Code Manual).
- Z2E = • Chief Executive
  - Finance Director
  - Other Exec Director
  - Board Level Director
  - Non-Exec Director
  - Senior Manager (Reports to a Board Member)

Please note that there were previously national pay scales for Strategic Health Authorities and Primary Care Trust Very Senior Managers (VSMs) but although some are still in use, they cannot be relied on to identify all VSMs as many organisations use WQ00 ‘ad hoc’ grades to cover these and other groups.

**Senior Medical (and Dental) Staff**

It would have been preferable to be able to include all medical and dental staff that holds significant management responsibilities in the category of “Percentage of BME staff in Bands 8-9, VSM (including Executive Board members and senior medical staff)”. However, at present, neither the data held by HSCIC or through ESR, nor pay grades alone, allow any reliable conclusions to be drawn about the levels of management responsibility.

“**Senior medical staff**” is therefore defined, for the purposes of the Standard as medical/dental staff who are members of the Senior / Departmental Management Team (e.g. Clinical / Medical Directors).

“**The overall workforce**” means all directly employed staff, including temporary or part-time staff but excluding agency staff, students on placement and staff employed by contractors. The numbers for each pay band and the senior band employees (8-9, VSM and medical/dental staff) are those for directly employed staff as defined in the preceding sentence of this Guidance.

**Employers will want to:**

- a. Identify staff numbers (numbers, not whole time equivalents) by ethnicity in the overall workforce.
- b. Identify staff numbers (numbers, not whole time equivalents) in each Agenda for Change pay band within the overall workforce by ethnicity.
- c. Identify staff numbers (numbers, not whole time equivalents) by ethnicity in other senior management groups to be included within the AfC Band 8-9/VSM/senior managers staff category.
- d. Compare, by ethnicity, the proportion of staff in category a. above with those in category c. above.

In order to improve the metrics in this Indicator employer will want to scrutinise each pay band below Band 8 and within Band 8-9 to identify if there are disproportionate barriers to BME staff progression within each pay band and then consider how to

address these. They may also wish to examine whether job segregation by ethnicity contributes to barriers to appointment and promotion.

In nursing and midwifery grades for example, there are often significant barriers for BME nurses and midwives in making the transition from Bands 5 to 6, from Band 6 to 7, and from Band 7 to 8. Some Trusts already disaggregate and publish 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 indicators 2 and 4.

Similarly where there may be concerns about disproportionate barriers to BME consultants' staff progression through being appointed to more senior positions, the requirement to identify the ethnicity of both senior medical and other consultants in Indicator 1 will allow employers to consider that transition alongside the data in Indicator 2 on the transition from shortlisting to appointment, and the data on career progression support in Indicator 4.

### Calculating the indicator

The “percentage of BME staff in Bands 8-9 and VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce” metric is calculated as follows :

Descriptor	Indicator
Number of BME staff in Bands 8-9 and VSM*	50
Total number of staff in Bands 8-9 and VSM	500
<b>Percentage of BME staff in Bands 8-9 and VSM</b>	<b>10% (50/500)</b>
Number of BME staff in overall workforce	1000
Total number of staff in overall workforce	4000
<b>Percentage of BME staff in overall workforce</b>	<b>25% (1000/4000)</b>
<i>*As per definition within Indicator 1</i>	

The difference between the percentage of BME staff in Bands 8-9 and VSM (including executive Board members and senior medical staff) and the overall workforce is therefore 15%. If the overall number of staff in the workforce and in Bands 8-9 and VSM (including executive Board members and senior medical staff) remains the same, then there would need to be another 75 BME staff employed in Bands 8-9 and VSM (including executive Board members and senior medical staff) if the proportions of BME within those two groups of staff were to be the same.

## 6.2 Indicator 2

2.	<b>Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being recruited from shortlisting across all posts</b>
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### Definitions

The “**relative likelihood**” compares the likelihood of BME staff being appointed with the likelihood of White staff being appointed.

The word “**appointed**” is used rather than “recruited”. These may be almost the same, but it is “appointed” staff numbers which should be used, unless not available.

“**All posts**” means all directly employed posts, including temporary employees, but excluding contractors and non-executive directors.

### Employers will want to consider:

- If there are significant differences between professions or departments
- Ensuring staff who shortlist and interview are appropriately trained, including in the impact of “unconscious bias”
- What best practice they may learn from, or share
- Reviewing the role of “executive search” agencies

- Carefully considering all the informal advantages that some staff may have accrued over others through non mandatory training and opportunities for acting up, leading projects, mentoring and shadowing
- In the FAQs accompanying this Technical Guidance we reproduce the data from 2013 research which also looked at the relative likelihood of BME and White staff being **shortlisted from application**. Whilst this ratio is not used as an Indicator within the current Standard, organisations might find it instructive to calculate that ratio and then seek to understand the reasons for substantial differences in that ratio too. It is not used in the Standard because there are a significant number of variables that would impede benchmarking. This information is available at Trust level through NHS Jobs and should be used as part of the evidence to support evaluation of performance in EDS2 outcome.

### Calculating the indicator

The “relative likelihood” of **BME staff being appointed from shortlisting compared to that of white staff being recruited from shortlisting across all posts** is calculated as follows:

Descriptor	White	BME
Number of shortlisted applicants	780	210
Number appointed from shortlisting	170	30
Ratio shortlisting/appointed	0.22	0.14

Likelihood of White staff being appointed from shortlisting  $(170/780) = 0.228$

Likelihood of BME staff being appointed from shortlisting  $(30/210) = 0.143$

Relative likelihood of White staff being appointed from shortlisting compared to BME staff  $(0.228/0.143)$  is therefore 1.59 times greater.

### 6.3 Indicator 3

3.	<p><b>Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation</b></p> <p><b>Note. This indicator will be based on data from a two year rolling average of the current year and the previous year.</b></p>
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#### Definitions

Staff “**entering the formal disciplinary process as measured by entry into a formal disciplinary investigation**” means staff for which there has been a formal investigation as prescribed by the local disciplinary process. Any disciplinary sanction is presumed to have been preceded by such an investigation. 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 completed cases in each year’s Standard annual report in the year it was completed so that the data exit and entry points are clear.

“**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. Where organisations have merged or otherwise changed significantly in structure during the previous 2 year period, the 2 year period should still be used but a significantly changed structure which might have affected the data should be noted in any accompanying narrative.

**Employers** may find it helpful to adapt the current ESR BI Report “*Employee Relations Dashboard*.” ESR enables capture of the Nature of Allegation, Date Process Start/End, procedure used, Stage/Level of process, outcome, etc. To calculate the relative likelihood you also need the data for the whole



of the workforce which ESR can supply – but only assuming Trusts enter the data on the system as it is not mandatory that they do so.

**Small numbers** being reported upon might result in identification of individuals so organisations may wish to obfuscate figures where less than 5 are present, as HSCIC do.

**Employers will want to consider:**

- The findings of the 2010 NHS Employers report from Bradford University on ethnicity and discipline<sup>13</sup> and the NHS London/RCM report<sup>14</sup> on discipline and midwives
- Learning from, and sharing, best practice where disciplinary rates are similar and disproportionate discipline by ethnicity is being tackled
- The importance of listening to BME staff (and staff sides) about their experiences to better understand the data
- 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

**Calculating the indicator**

The “relative likelihood” is calculated as follows:

Descriptor	White	BME
Number of staff in workforce	800	200
Number of staff entering the formal disciplinary process	30	20

- Likelihood of White staff entering the formal disciplinary process (30/800) = 0.0375
- Likelihood of BME staff entering the formal disciplinary process (40/20) = 0.1000
- The relative likelihood of BME staff entering the formal disciplinary process compared to White staff is therefore  $0.100/0.0375 = 2.66$  times greater.

<sup>13</sup> 2010 NHS Employers report from Bradford University on ethnicity and discipline <http://www.brad.ac.uk/research/media/CfID-Briefing-9-BME-disciplinaries.pdf>

<sup>14</sup> NHS London/RCM report<sup>14</sup> on discipline and midwives <http://www.makingconnectionswork.com/wp-content/uploads/CATALYST-1-Report-2013-Midwifery-Leadership-Development-Group.pdf>

## 6.4 Indicator 4

4.	<b>Relative likelihood of BME staff accessing non mandatory training and CPD compared to white staff</b>
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### Definitions

“**Non - mandatory training and CPD**” means any training or CPD that is not a requirement of the post. Examples of **mandatory** training would include lifting and handling, first aid, required professional updating and any other statutory or contractually required training.

“**Non - mandatory training**” means, in this context, training that is not a statutory or contractual requirement and which might reasonably be deemed to assist career or personal development, including continuing professional development. It would include, for example, any externally organised course or activity (such as attendance at conferences) where a place has been booked and paid for that might reasonably be deemed to assist career or personal development, including continuing professional development. It would also include externally organised activities which are NOT paid for as well as a range of other development courses and activity - including relevant study leave and mentoring – which are supported by the employer and where appropriate payment by the employer and paid study leave is agreed.

“**Accessing**” **courses and CPD** in the context means courses on which places were offered and accepted.

It is acknowledged that precisely how organisations define “non - mandatory training” may vary significantly between organisations, potentially making comparisons between organisational Indicators difficult. However, each organisation is expected to be consistent in how they define it year on year.

Employers will also note that each profession is regulated and assessed differently and that will need to be considered in the application of this standard.

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**Employers will want to consider**

- Ensuring there is a robust Trust wide system for collecting and analysing such data
- Investigating what differences there may be, by ethnicity, between professions and departments
- Learning from, and sharing, best practice with other organisations

**Calculating the indicator**

The “relative likelihood” of White and BME staff accessing non mandatory training and CPD is calculated as follows:

Descriptor	White	BME
Number of staff in workforce	600	400
Number of staff accessing non mandatory training and CPD	300	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 and BME staff accessing likelihood of being appointed from training ( $0.50/0.375$ ) is therefore 0.33 times greater.

**Staff survey Indicators**

Organisations, as many do already, will want to compare staff survey results with the previous three years – to help identify trends and possible “hotspots”.

**Definitions**

The wording of these four indicators is taken directly from the NHS national staff survey.

**Employers will want to consider for each of these indicators:**

- comparing the 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 discrepancy.

- Listening to BME staff in order to better understand the data.
- Comparing the data with comparators in similar types of organisations and learning from, and sharing, best practice.
- Drilling down to analyse the data by departments and professions as far as possible.

### 6.5 Indicator 5

5.	<b>KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</b>
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### 6.6 Indicator 6

6.	<b>KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</b>
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### 6.7 Indicator 7

7.	<b>KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion</b>
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In analysing this indicator, organisations should compare the proportion of BME and White respondents who say they do **not** believe their Trust provides equal opportunities for career progression or promotion

In this indicator, the word “trust” is taken verbatim from the national staff survey and in this context means “any provider organisation that is subject to the Workforce race equality Standard”.

#### **An example for Indicator 7 ‘Percentage believing that trust provides equal opportunities for career progression or promotion’**

If 90% of White staff say that their Trust provides equal opportunities for career progress or promotion but only 80% of BME think so, then the proportion of BME staff saying they do **not** believe their Trust provides equal opportunities on career progression and promotion is **double** that of White staff (20/10), and Trusts would

want to understand and improve that Indicator

### 6.8 Indicator 8

8.	<b>Q23. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues</b>
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This indicator considers the gap between the survey responses of White and BME staff. It deliberately focuses on discrimination ascribed to managers and colleagues, not from any other source e.g. the public.

### 6.9 Indicator 9

	<b>Boards. Does the Board meet the requirement on Board membership in 9?</b>
9.	Boards are expected to be broadly representative of the population they serve.

#### Definitions

“**Board membership**” 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. It will include directors who are interim or acting up if they are voting members of the Board.

However employers may well want to distinguish between the two categories of executive and non-executive Board members since non executives are appointed on a rolling basis whilst the other executive directors are appointed as employees, and changing their composition takes place through different routes.

“**Broadly representative**” means that the ethnicity (BME/White) of the Board is expected to be **similar** to that of the community served. That does not mean there must be a mathematically identical ethnic composition within each Board to that of the population served, but it **does** mean that it would not be regarded as acceptable to have the sort of sharp differences research identified whereby, for example, 42%

of London's NHS Trust Boards had no BME members at all, or where only 8% of London's voting Board members are from BME backgrounds in a city where over 40% of the workforce and local population are from BME backgrounds.

The expectation would be that over England as a whole, the proportion of voting Board members from BME backgrounds would be no less than the proportion of BME people in England's population or the NHS workforce.

The expectation would also be that over time, the proportion of executive and non-executive directors from BME backgrounds would be similar.

**"The population they serve"** will vary by type of organisations, and will need to recognise that some organisations provide national services.

For national bodies it is the proportion of the national population in England from BME backgrounds as measured by the 2011 ONS Census or a more recent authoritative update.

For provider organisations and CCGs, it will be the population in the area(s) they serve. This may not always seem straightforward where provider organisations have additional contracts that extend beyond the geographical area the Trust covers. There are a number of Trusts that have provider catchments which extend to the whole of, or significant parts of, England notably some specialist providers. Where this is the case, it **may** be appropriate for the Trust to provide a narrative and context alongside a metric related to the immediate area in which it is based except where the catchment area is indisputably national (e.g. Moorfields Eye Hospital Foundation Trust).

**The Board composition is compared with the composition of the population served.** It is not directly related to the composition of the workforce, but organisations may well want to bear in mind the extent to which a Board's composition may act as role models for aspiring staff.

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In Foundation Trusts it would be good practice to consider whether the ethnicity of trust **Governors** is also broadly representative of the local population

**Note.** ESR 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.

### **Boards will want to consider:**

- Taking appropriate note of this Indicator when considering renewing non exec members terms of office or appointing new members
- Reviewing their criteria for appointments including ensuring executive search agencies are committed to diversity in their processes
- Having in place succession planning and development to ensure an equal playing field for potential future applicants for **all** Board positions from diverse backgrounds.

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## 7 Which organisations does the Standard apply to and how?

### 7.1 Providers

All organisations which provide NHS funded healthcare services (other than primary care) are subject to the requirements of the NHS Standard Contract in respect of the Standard except for “small providers”. The Standard therefore 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” who are 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” will be expected to collect, analyse and publish relevant **workforce data** in respect of their staff providing NHS services.

Providers of NHS-funded healthcare service (other than primary care) should either participate in the NHS **staff survey** (a requirement for NHS Trusts) or if they do not (i.e. all independent sector providers,) they should do something similar. The NHS staff survey is reviewed annually, and to ensure that organisations are aligned to the NHS questions related to the WRES, they should check the current staff survey questionnaire which is published every summer.

Note. Further discussions with national bodies, with CCGs, and with private and voluntary sectors, and providers are planned, and supplementary guidance may be issued as necessary.

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## 7.2 Commissioners

All Commissioners of NHS services will be expected to have due regard to NHS Standard Contract and to use the Standard (and the Equality Delivery System) themselves.

Some CCGs already participate in the NHS National Staff Survey. Further developmental work on the applicability of the Standard to CCGs is currently underway.

In 2015-16 each CCG will need to demonstrate the following:

- That they are giving due regard to using the indicators contained in the *Workforce Race Equality Standard* to help improve workplace experiences, and representation at all levels within their workforce, for Black and Minority Ethnic staff; and assurance, through the provision of evidence, that their Providers are implementing the NHS Workforce Race Equality Standard;
- That they are implementing *EDS2* to help meet the *Public Sector Equality Duty* and improve their performance for people with characteristics protected by the Equality Act 2010; and assurance, through the provision of evidence, that their Providers are doing the same.

## 7.3 National bodies

National bodies include (but not exclusively):

- NHS England (also has a role of a commissioner)
- Care Quality Commission
- Monitor
- Trust Development Authority
- Health and Social Care Information Centre
- National Institute for Health and Clinical Excellence
- Public Health England
- NHS Leadership Academy
- Health Education England

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The above national bodies are also members of the Equality and Diversity Council, and have committed themselves to support the work on the Standard. They will all be seeking to apply the Standard to themselves though not required to by the Standard Contract since they are not providers.

They will want to collect, analyse and publish relevant **workforce data** in respect of their staff.

These bodies are not covered by the NHS national staff survey and therefore there will need to be some flexibility, certainly in the first year, as to how their own survey indicators are applied. Some conduct their own staff surveys, though their questions may not align with those of the national NHS staff survey.

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## 8 The process of working towards the Standard

### 8.1 Boards

Successful equality, diversity and inclusion work, including work to implement the Standard, requires specialist advice and support; but it is increasingly recognised that leadership must come from Board level. As NHS Providers<sup>15</sup> stated:

‘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, prior to implementing the Standard, 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. Indeed, the Standard may well challenge the leadership of the organisation to positively demonstrate their own commitment to equality, and in particular, to race equality.

Some organisations are increasingly identifying a Board member to lead or promote this work. In a number of organisations, Board members have met directly with their BME workforce to hear, at first hand, their experiences of the workplace. This is strongly recommended.

Due to restructures, reorganisations and financial pressures the numbers of specialist staff with expertise in equality will have reduced in some organisations whilst small organisations may have only limited specialist equality expertise. Board level sponsorship and support of this work, allied to shared ownership across the

<sup>15</sup>NHS Providers (2014) *Leading by example: the race equality opportunity for NHS provider boards*.  
<http://www.nhsproviders.org/resource-library/the-race-equality-opportunity-for-nhs-provider-boards>

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organisation, is essential if Boards are to meet their contractual requirement, the expectation of regulators, the aspirations of staff and the best interests of patients.

## 8.2 Working with trade unions in partnership

To succeed in successfully implementing the Standard it will be essential to engage with staff and their recognised trade unions. Organisations are more likely to successfully engage with staff and improve the impact of work, where the implementation of the Standard, and other equality initiatives such as EDS2, involve local social partnership with trade unions and staff organisations, to help draw on their knowledge, support and experience.

## 8.3 Black and Minority Ethnic (BME) staff

It is essential that the voice of BME staff is heard loud and clear through the process of identifying the challenges individual organisations face in meeting the Standard. Organisations are strongly encouraged to help establish and support BME networks (alongside networks for the other protected characteristics) of staff as an important source of knowledge, support and experience. Such work may well include providing a safe place for BME staff to share their concerns and be listened to and where this occurred, it has significantly contributed to the success of Trust wide work around race equality.

## 8.4 Transparency

Organisations are strongly encouraged to be transparent and candid at all stages of engagement with, and implementation of, the Standard. 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 and applying that learning to other staff groups where applicable.

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Further advice on how the progress for each organisation will be published - including a benchmarking process - will follow in due course.

### **8.5 Local population data**

Organisations, as many do already, will want to use the ONS Census 2011 data for a comparison of the extent to which their workforce and leadership represent the local diverse communities they serve. In doing so, organisations will want to bear in mind that across the NHS as a whole there is a higher proportion of BME staff employed, notably amongst doctors, nurses and some support staff, than in the national population as a whole. Where a local community includes a BME population but very few BME staff are employed, as is the case in some organisations, then these organisations may wish to scrutinise not just appointments from shortlisting, but shortlisting from applications, and explore the reasons if there is a very low rate of applications or excessive turnover.

## 9 The future role of the CQC and the Standard

From April 2016 onwards, progress on the Standard will always be considered as part of the “Well led” domain in CQC inspections. The CQC is actively working to both apply the Standard to its own employment practices and to be prepared ahead of April 2016 to include inspection of progress against the Standard in its inspection schedule. NHS trusts are not inspected every year. In 2015-16 the CQC will be piloting its approach to using the Standard in inspections. Trusts inspected in 2015-2016 will also be asked how they are developing plans to address any issues arising from The Standard data. In line with CQC current practice, including published key lines of inquiry and ratings characteristics for the well-led domain, race equality for staff may be considered during inspections in 2015-16 where there are particular reasons to do so. Further information on this work will be published in the near future.

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## 10 Calendar milestones for meeting the Standard

Milestone	Activity
<b>April 1<sup>st</sup> 2015</b>	Baseline data for comparison with April 2016
<b>July 1<sup>st</sup> 2015</b>	Publication of 1 <sup>st</sup> April 2015 data including identification of any essential shortcomings
<b>April 2015 – March 2016</b>	Work to start to address any data shortcomings and to understand and address shortfalls identified by the WRES indicators
<b>April 2016</b>	Baseline data for comparison with April 2015 should be completed including steps underway to address key shortcomings in data, or significant gaps between the treatment and experience of white and BME staff.
<b>1<sup>st</sup> May 2016</b>	Baseline data to March 31 <sup>st</sup> 2016 should be published to Commissioner (for providers), on Trust web site and shared with Board and staff

### 10.1 Three sets of data comprise the Workforce Race Equality Standard:

#### 10.1.1 Workforce data

NHS organisations will already be (or should be) collecting workforce data for Indicators 1-4 over a 12-month period. The parameters of the period vary locally between organisations. The majority of NHS organisations collect data over a January-December period but some collect data over an April to March period. The Standard does not prescribe any preferred 12-month period.

#### 10.1.2 Staff survey data

National NHS Staff Survey data is collected each autumn and published in February of the following year. If organisations do not currently take part in the NHS national staff survey, they are encouraged to amend their existing local staff survey data so that, in respect of the four staff survey questions used, they use the same or similar wording.

### 10.1.3 Board composition

Board composition can change during the year. The data of April 1<sup>st</sup> each year should be used as the “census” date.

## 10.2 From April 1<sup>st</sup> 2015

**NHS provider organisations and national bodies should be able to demonstrate that they have a sufficiently high level of staff responses on ethnic self-monitoring to make data robust.**

Organisations will want to have the highest possible level of return on the ethnic monitoring of their workforce (and indeed on other protected characteristics) to make conclusions drawn from data as robust as possible. Many NHS organisations already have systems in place to try to increase the level of ethnicity monitoring data returns by staff. Failure to reach a high response rate may suggest the organisation has not sufficiently focussed on meeting the Public Sector Equality Duty in a robust way, although the Equality and Human Rights Commission do not prescribe nor recommend any specific minimum or preferred level of ethnicity monitoring data returns. Their statutory and non-statutory guidance provides some advice about trying to improve response rates to equality monitoring in general.

Key sources by the Equality and Human Rights Commission<sup>16</sup> *Employment Statutory Code of Practice* in particular Appendix 2, ‘*Equality Information and the Equality Duty: A Guide for Public Authorities*’

Where self-reporting levels are below best practice it is strongly recommended that organisations make this explicit and outline their approach to improving ethnicity data collection rates in their Standard Annual Report.

<sup>16</sup> *Employment Statutory Code of Practice*’

[http://www.equalityhumanrights.com/sites/default/files/publication\\_pdf/employercode.pdf](http://www.equalityhumanrights.com/sites/default/files/publication_pdf/employercode.pdf) in particular Appendix 2, ‘*Equality Information and the Equality Duty: A Guide for Public Authorities*’

[http://www.equalityhumanrights.com/sites/default/files/publication\\_pdf/Equality%20information%20and%20the%20equality%20duty.pdf](http://www.equalityhumanrights.com/sites/default/files/publication_pdf/Equality%20information%20and%20the%20equality%20duty.pdf)



### 10.2.1 Small numbers of BME staff employed

There are a small number of organisations where there is either so small a number of BME staff that it is difficult to publish data without identifying individuals, or where the numbers of BME responses to the staff survey are too low to merit publication without potentially identifying individuals.

The presence of small number of BME staff does **not** mean that there may not be similar issues around the treatment and experience of BME staff as compared to organisations with larger numbers of BME staff – with implications for patient care. It does mean there may need to be some flexibility about how commissioners seek assurance that the Standard is being met and how the CQC inspect against the Standard. Further advice on this will be provided in due course.

### **NHS organisations should note in respect of workplace self-reporting response rates:**

- a. For Indicator 1 that compares ethnicity across pay bands, Trusts should seek to ensure that staff response rates are similar for AfC Bands 8-9/VSM as for staff response rates as a whole and are as high as possible. In many Trusts 95% and above is the goal.
- b. For the Indicator 2 that relates to appointment from shortlisting, some organisations have a significantly lower response rate on appointed staff than on applications or shortlisted staff. Organisations should seek to ensure that the response rate on shortlisting and appointment in particular are similar and are as high as possible.
- c. For the Indicator 3 that compares the relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff, the rates of staff response need to be as similar as possible for staff as a whole and for staff who enter the formal disciplinary process.
- d. For the Indicator 4 that compares the relative likelihood of BME staff accessing non mandatory training and CPD compared to White staff, the responses for White and BME staff need to be as similar as possible to those for the organisation's workforce as a whole.

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For each of these Indicators, it is strongly recommended that organisations make explicit their approach to improving ethnicity data collection rates in their annual Standard reports if self-reporting of ethnicity is low.

Data from the September/October 2014 **NHS national staff survey** will have been published in February 2015. Organisations who take part in the survey will want to:

- a. Consider if their response rates are significantly below the average of appropriate comparators as indicated by the published survey response metrics.
- b. Consider whether the response rates to the NHS Staff Survey are significantly different for White and BME staff and seek to redress any imbalance.
- c. Share the full NHS Staff Survey results with their staff highlighting any concerns as well as successes.
- d. For each of the Staff Survey Indicators, understand, where possible, if there are specific issues relating to particular professional groups or departments. More detailed information may be available from the national staff survey providers.
- e. Consider whether there are any obvious discrepancies between their Staff Survey data and their workforce data. For example, how does Staff Survey data on bullying correspond to workforce data on bullying? Does Staff Survey data on career progress and promotion correspond to the workforce data on non-mandatory training and appointment from shortlisting?
- f. In a very small number of NHS organisations the number of BME staff employed is too low to provide full, or in some cases, any, returns on ethnicity within the staff survey. Organisations may well want to explore the reasons for this which in some cases will be that the response rates for BME staff are significantly lower than for White staff.

Any NHS organisations that do not take part in the national NHS Staff Survey may want to carry out steps (a-f) above in relation to their own staff survey

NHS providers will want to bear in mind that in 2015-16 the CQC will be piloting its approach to using the Standard in inspections. Trusts inspected in 2015-2016 will be asked how they are developing plans to address any issues arising from the

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Standard data. In line with CQC current practice, including published key lines of inquiry and ratings characteristics for the well-led domain, race equality for staff may be considered during inspections in 2015-16 where there are particular reasons to do so.

### 10.3. During 2015-16

#### Organisations will want to

- a. Consider the indicators used for Standard and where possible seek to “drill down” by department and profession, and consider further disaggregation by individual BME groups.
- b. For Indicator 1, publish the ethnicity data by all pay bands as that will assist in identify specific areas of concern.
- c. For Indicator 2, analyse data on appointment from shortlisting for specific departments, occupations, or pay bands.
- d. For Indicators 3 and 4, organisations understand if there are specific issues relating to specific professional groups or departments.
- e. Consider how their staff survey and workforce responses compare to those of the previous two years as some organisations already do.
- f. Compare how their staff survey results compare to those of comparators by type of organisation.
- g. Discuss with their local staff organisations their understanding of the root causes behind the differences between BME and White staff treatment and experience for each of the Indicators and suggestions on how to improve them.
- h. Ensure, as appropriate, that there exists a BME staff network to be consulted and represent the views of BME staff in their organisation.
- i. Discuss with their local BME networks, providing a safe place to do so, their understanding of the drivers behind each of the Indicators and discuss suggestions on how to improve any difference between White and BME treatment and experience;
- j. Consider making a three year retrospective comparison on their data, as some Trusts already do, to scrutinise trends.

## 10.4 From April 2016

By April 1<sup>st</sup> 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 indicators used for Standard and seek to “drill down” by department or profession, and consider further disaggregation by individual BME groups
- b. For Indicator 1, organisations may well have published (as many do already) the ethnicity data by each pay band as that will assist in identifying specific areas of concern
- c. For Indicator 2, organisations will have considered analysing data on appointment from shortlisting for specific departments, occupations, or pay bands
- 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. Considering how their staff survey and workforce responses compare to those of the previous two years
- f. Comparing how their staff survey compares to that of comparators by type of organisation
- g. Discussing with their local staff organisations their understanding of the drivers behind each of the metrics and suggestions on how to improve the metrics
- h. Discussing with their local BME networks, providing a safe place to do so, their understanding of the drivers behind each of the metrics and suggestions on how to improve the metrics. If such networks do not currently exist, then Board level consideration will have been given to how they may be established
- i. Organisations will have considered making a three year retrospective comparison, as some Trusts already do, to scrutinise trends.

Having published locally their Standard indicators, organisations will have commenced discussion with managers, staff side organisations and BME networks how best to improve the metrics for future years by understanding the root causes of specific shortcomings or how to maintain progress made.

In the first **Annual Report to Commissioners in April 2016**, organisations will want to set out their own assessment of the challenge and risks they face in closing the gaps between the metrics for White and BME staff, alongside their plans to close whatever gap between the treatment and experience the data reveals.

### 10.5 Support and queries

Discussions are underway to ensure that good practice is shared between NHS organisations in as systematic a manner as possible. Individual Human Resource, equality, and trade union networks may also share examples of good practice that will assist organisations in meeting the Standard. This is regarded by the Equality and Diversity Council as an essential part of this work. Further information will follow.

Part of the support will be a comprehensive communications strategy to explain the Standard and the research behind it, and to share best practice with regard to implementation and outcomes for the workforce.

A dedicated web page has been set up to share news and developments

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

For further information or queries please contact: [england.wres@nhs.net](mailto:england.wres@nhs.net)

## 11 Associated documentation

Regular WRES Updates

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

An extended, and regularly updated, set of WRES Frequently Asked Questions which complement this Technical Guidance

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

Equality Analysis of the WRES

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

NHS Standard Contract 2015/16

<http://www.england.nhs.uk/nhs-standard-contract/15-16>

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