Workforce Race Equality Standard (WRES)

Four Lessons

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NHS England and NHS Improvement

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Lesson one – the scale of the challenge

There is irrefutable evidence globally that people from black and minority ethnic backgrounds (BME) that live in white majority countries like the US, UK, Canada, Australia and New Zealand have poorer life chances and experiences compared to their white counterparts.

Across all indicators, evidence indicates that BME people are more likely to:

- Health – get chronic diseases and die sooner
- Wealth – make less money over their life course
- Housing – live in poorer areas and accommodation
- Justice –be convicted and imprisoned
- **Employment – have poorer experiences and opportunities in the workplace**

WRES indicators of workplace experience and opportunity

Indicator 1	Indicator 2	Indicator 3	Indicator 4
•Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM compared with the percentage of staff in the overall workforce	•Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts	•Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process	•Relative likelihood of BME staff accessing non mandatory training and CPD as compared to white staff

Indicator 5	Indicator 6	Indicator 7	Indicator 8	Indicator 9
•Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	•Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	•Percentage believing that trust provides equal opportunities for career progression or promotion	•In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager / team leader or other colleagues	•Percentage difference between the organisations' Board membership and its overall workforce

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What the WRES has taught us

8.4% of board members in NHS trusts were from a BME background; an improvement from 7.4% in 2018 and 7.0% In 2017

The relative likelihood of BME staff entering the formal disciplinary process compared to white staff has reduced year-on-year, from 1.56 in 2016 to 1.22 in 2019.

The number of BME board members in trusts increased by 35 in 2019 compared to 2018 – an additional 18 executive and 17 non-executive board members.

Across all NHS trusts and CCGs, there were 16,112 more BME staff in 2019 compared to 2018.

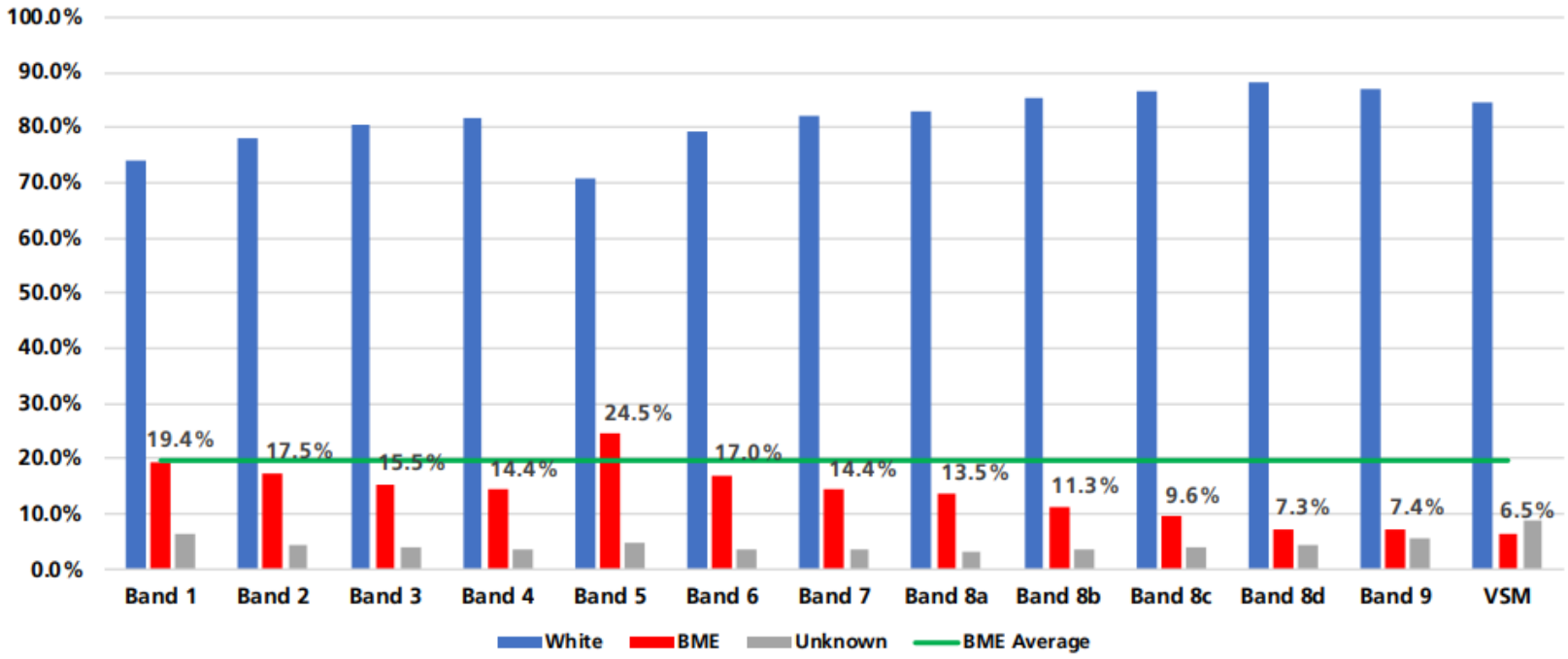
White applicants were 1.46 times more likely to be appointed from shortlisting compared to BME applicants; a similar figure to that reported in 2018, and an improvement on the 1.60 times gap in 2017 and 2016.

In 2019, 19.7% of staff working for NHS trusts and clinical commissioning groups (CCGs) in England were from a black and minority ethnic (BME) background; this has been increasing over time.

The total number of BME staff at very senior manager (VSM) pay band has increased by 21, from 122 in 2018 to 143 in 2019, and is up by 30% since 2016..

What the WRES has taught us

Percentage staff by AfC pay band and ethnicity for all NHS trusts and CCGs: 2019



Data source: NHS workforce statistics website.

Why is this the case?

> “The striking racial/ethnic disparities reported for COVID-19 infection, testing, and disease burden are a clear reminder that failure to protect the most vulnerable members of society not only harms them, but also increases the risk of spread of the virus, with devastating health and economic consequences for all. COVID-19 disparities are not the fault of those who are experiencing them, but rather reflect social policies and systems that create health disparities in good times and inflate them in a crisis.”

David Williams, Lisa Cooper, *COVID-19 and Health Equality – A New Kind of “Herd Immunity”,* May 2020

Structural racism.	Discrimination.	Unconscious bias.
Institutional racism.	Coulourism.	Biological weathering.

Lesson two - what works

Fundamental Principles:

- You need demonstrable and compassionate **leadership**.
- Equality needs to be **everyone's agenda**, and threaded through corporate objectives at all levels.
- **Accountability** is vital at all levels – from national contracts to individual relationships.
- People should be given the **time** to make a difference.
- Good practice cannot simply be imitated. **Every organisation is different**.
- **Continuous improvement** is vital. Race equality is not something to look at once a year.
- **Peer relationships** can drive change.

Lesson two - what works

Recruitment and senior representation

Review WRES indicators at a staff group and directorate level and target areas most in need.

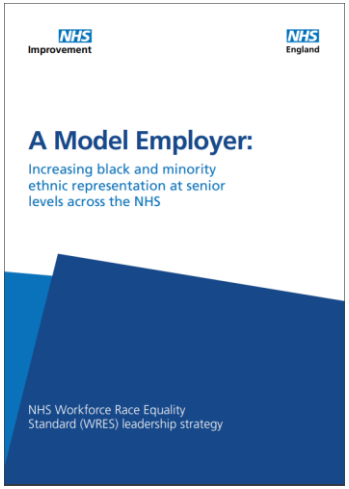
Ensure **interview panels are diverse** and consider batch interviews where appropriate.

Set **improvement targets** and monitor attainment on a regular basis (quarterly).

Always provide **written explanations**, justification and advice for non-appointment of internal candidates.

Blind interviewing, whereby the interview panel does not see the application/CV's of applicants. Shortlisting done by different people.

A Model Employer: increasing black and minority ethnic representation at senior levels across the NHS, January 2019



Lesson two - what works

Disciplinary action

Decision tree checklists – a series of structured questions guiding managers on whether formal action is appropriate.

Post action audits – disciplinary decisions are reviewed on an annual or bi-annual basis to check for biases and systemic weaknesses.

Pre-formal action check - an executive board member of the organisation – or a panel that includes an executive board member – review all cases and decide whether they should go to formal action.

A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce, July 2019

Lesson two - what works

Listening and Networking

The WRES Experts programme – sees people from across the system trained up on workforce race equality. This is both an opportunity for personal development, and a way to embed expertise across the system.

Frontline Staff Forum - a forum specifically designed to reach out to those on the frontline whose voices are not always heard.

BME and other staff networks should be established where they don't already exist and connected to broader organisational decision making structures.

Enhance data through surveys, deep dives and focus groups – this is especially important for staff not picked up in existing surveys or data collections (i.e. agency and bank staff).

Lesson three - what doesn't work (in isolation)

Interventions often fail because they are **too short term** - focusing on quick wins as opposed to a real structural change – or because they based on a **deficit model,** where the person who is the victim of structural discrimination is the target of an intervention. These interventions can help to build momentum, but evidence suggests they do not change things in isolation:

Reverse mentoring– in its traditional form, reverse mentoring is often seen as beneficial for participants, but evidence suggests it has little impact on equality on its own. Reverse mentoring is only effective when explicit targets and monitoring are in place to drive and track impact.

Unconscious bias training - training is useful in promoting a broad understanding of how bias can influence decision making, but it does not de-bias the processes themselves. It can even have the adverse affect of excusing biased behaviour.

Lesson four – there is always more to be done

The WRES has been effective in improving representation. But it has been less effective in changing the **culture** of organisations.

Next steps:

- The **Cultural Change Programme** will use deep dive qualitative research to understand what it feels like to work in an NHS organisation, with a focus on race and inclusion. We want to understand the less tangible elements of organisational culture.

- We are **expanding the data we collect**, including a new set of WRES indicators for the medical workforce, and a targeted date collection for bank and agency staff.

- We are seeking to embed the WRES nationally to **drive accountability**. This includes reporting on ALBs and working with CQC on their key lines of enquiry.

- **Monitoring and evaluating** the WRES indicators to ensure they're fit for purpose.