NHS England

Frequently Asked Questions on the Workforce Race Equality Standard (WRES)

March 2015

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Description	The WRES FAQs document aims to provide support and guidance to the WRES Technical Guidance on the implementation of the WRES. The Updated WRES FAQs on the Standard aim to replace the previous WRES FAQs on the NHS Leadership Academy website . The WRES FAQs provide updates on why the WRES is being introduced and explains in detail what the WRES is about. The FAQs covers the following: • Background research relating to the WRES Standard. • The Standard and related materials on the NHS England web site. Over the coming months NHS England, alongside partner organisations that are members of the NHS Equality and Diversity Council, I will be providing a range of practical support on this important issue. This will be through regular WRES Workshops, Regular WRES Updates and updates of the FAQs with key questions emerging from the implementation of the WRES for 2015/16.
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Contact Details for further information	Ruth Passman National Equality and Health Inequalties Team Quarry House Leeds LS2 7UE 0113 824 9198 http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard/

Document Status

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Frequently Asked Questions on the Workforce Race Equality Standard (WRES)

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Version	Date Published	Changes Made
WRES FAQ 1	October 2014	On NHS Leadership Academy website
WRES FAQ 2	March 2015 Updates	NHS England website with changes and updates

Contents

Frequency Asked Questions (FAQs) Workforce Race Equality Standard

1 Why is the Workforce Race Equality Standard being introduced?

Q1.1 Why is the NHS now taking mandatory action to ensure race equality and fair treatment for its black and minority (BME) workforce?

A: Recent research has demonstrated that the treatment and experience of BME staff within the NHS is very significantly worse, on average, than that of NHS white staff. The publication of "*The Snowy White Peaks of the NHS*" (2014)[1] demonstrated that BME staff were absent from the leadership of many organisations even where the workforce had substantial numbers of BME staff and where the organisation provided services to communities with large number of BME patients.
The report also summarised research over recent years showing that BME staff were treated less favourably by every measure, including promotion, grading, discipline, bullying, and access to non-mandatory training. It demonstrated that such evidence as exists showed little or no progress in recent years despite the growing number of BME staff employed as doctors, nurses and other staff.

West, M (2011)[2] and Dawson J (2009)[3], demonstrated the links between how NHS staff are treated and the care provided to patients, and the cost to both employers and patients of not treating staff well. Further research by Professor West and others has established the close link in particular between the treatment of BME staff and the care of all patients. Other research has shown the benefits to organisations of having diverse leaderships[4] and the serious impact of race discrimination on the health of the BME workforce[5]

[1] Kline, R (2014)*The Snowy White Peaks of the NHS*. Middlesex University

[2] West, M, Dawson, J. Admasachew, Topakas,A. (2011) *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data.* Aston Business School. (2011)

[3] 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.

[4] T Foresight Partnership (2013). *The Healthy NHS Board 2013.* Principles for Good Governance. NHS Leadership Academy

[5] Stevenson, J; Rao, M (2014) *Explaining levels off wellbeing in BME populations in England*. NHS Leadership Academy

During 2014, the Equality and Diversity Council (EDC) carefully considered the combined impact of this research and concluded that it was in the best interests of patients (as well as staff) that early and decisive steps be taken to remedy this situation.

Q 1.2 Why is the focus on race equality in particular?

A : The systemic discrimination against Black and Minority Ethnic (BME) staff within the NHS highlighted in numerous reports which show that by every indicator BME staff have a less favourable treatment and a worse experience of working in the NHS than other members of staff. This is important not just because of the costs to those staff and the NHS as a whole of such treatment, but because, equally importantly, we also know through work done by Professor Mike West and Jeremy Dawson that there is 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. This is true for everyone but Professor West's (2011)[6] research shows that:

> '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'.

The NHS Equality and Diversity Council which proposed the Workforce Race Equality Standard is NOT suggesting other forms of equality are less important but it is clear that race discrimination is an important issue within the NHS and there has been little if any improvement in recent years. 17% of NHS staff are from BME backgrounds, including 20% of nurses and 37% of doctors, and we now know that tackling their unfair treatment benefits patient care so it is clearly a priority.

[6] West, M. Dawson, J. NHS Staff Management and Health Service Quality, Aston Business School. (2011).

Q 1.3 What steps are the NHS now taking to tackle race inequality in the NHS workforce?

A: On 29 July 2014 the NHS Equality and Diversity Council pledged its commitment, subject to consultation within the NHS, to implement two measures to improve equality across the NHS, which would start in April 2015.

The first is a Workforce Race Equality Standard that would, 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 equality, including a specific indicator to address the low levels of BME Board representation.

Alongside the standard, the NHS considered whether the Equality Delivery System (EDS2) should also become mandatory. This is a toolkit, currently voluntarily used across the NHS, which aims to help organisations improve the services they provide for their local communities and provide better working environments for all groups. NHS England agreed to consult on incorporating the new standard and EDS2 for the first time in the 2015/16 NHS Standard Contract and this will now happen.

The regulators – the Care Quality Commission and Monitor – are also planning to use the Standard to help assess whether organisations are 'well-led'.

Q 1.4 Is there a good summary of the case for such change?

A: There are several. NHS Providers which represents NHS Trusts has produced a booklet entitled *Leading by example: the race equality opportunity for NHS provider boards* which summarises the case and gives some examples of good practice[7]

If you would like to read the original research that helped trigger the Equality and Diversity Council discussion you should read *The Snowy White Peaks of the NHS* (2014) [8]

[7] *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

[8] Kline, R. *The Snowy White Peaks of the NHS*. Middlesex University (2014)

Q 1.5 What response has the proposal for a Workforce Race Equality Standard had?

A: NHS and patient leaders welcomed the decision to have a Race Equality Standard. Simon Stevens, NHS England's Chief Executive and Chair of the NHS EDC (2014), said: "We want an NHS 'of the people, by the people, for the people'. That's because care is far more likely to meet the needs of all the patients we're here to serve when NHS leadership is drawn from diverse communities across the country, and when all our frontline staff are themselves free from discrimination."

Chris Hopson, chief executive of the Foundation Trust Network, said: "It is vital that Boards reflect the diversity of local populations and the NHS workforce. We are keen to ensure that early progress is made on improving levels of BME representation at Board level and in senior leadership positions across the NHS."

Katherine Murphy, Patients Association, said: "Diversity in leadership is associated with more patient-centred care, improved patient access, experience and outcomes and higher staff morale, which ultimately is the aim for everyone using and working across the NHS."

Q 1.6 How does the Workforce Race Equality Standard complement the NHS Constitution?

A: 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[9]

[9] The NHS Constitution for England. Department of Health (2013) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170656/NHS_Constitution.pdf

2 What is the Workforce Race Equality Standard?

Q 2.1 Following the consultation process what is the final version of the indicators?

A: Following the consultation process on the WRES in October 2014 the final version of the indicators is outlined below:

Table 1 – NHS Workforce Race Equality Standard Indicators

	NHS Workforce Race Equality Standard indicators
	Workforce indicators For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.
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
	National NHS Staff Survey findings. 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
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

	Boards. **Does the Board meet the requirement on Board membership in 9.**
9.	Boards are expected to be broadly representative of the population they serve.

The updated WRES Equality Standard Metrics:
http://www.england.nhs.uk/wp-content/uploads/2015/02/wres-metrics-feb-2015.pdf

Q 2.2 How can the Standard be summarised?

A: The proposal put to the EDC on July 29th 2014 was that there should be a National Workforce Race Equality Standard, built from a small number of indicators for which most Trusts already collect data (a mix of NHS national survey data and local workforce data). In addition there would be one Board membership metric linked to the diversity of the Board. This Standard would then be used to gauge the current state of race equality within NHS organisations and track what progress is being made to identify and promote talented BME staff as well as helping to eliminate wider aspects of discrimination in the treatment of BME staff.

The Standard takes a small number of indicators and requires NHS organisations to close the gap between the BME and white staff experience for those indicators. So for example, research[10] suggests the likelihood of BME staff being appointed from shortlisting is much less than the likelihood of white staff being appointed from shortlisting. Similarly there are significant differences in many Trusts between the likelihood of BME and white staff accessing non-mandatory training – the kind that improves career development and promotion opportunities.

Organisations will be expected to do what the best ones already do, to scrutinise and understand the data and act on it, and then work towards a level playing field where the treatment of staff is not unfairly affected by their ethnicity.

NHS Employers found it is twice as likely that BME staff will enter the disciplinary process as white staff yet whilst some Trusts seek to understand this and reflect on

[10] Kline, R. (2013) *Discrimination by Appointment*. Public World.
http://www.publicworld.org/files/Discrimination_by_appointment.pdf

how to change this, others do not[11]. One consequence of potentially discriminatory recruitment and promotion processes may be the imbalance in the representation of BME staff across pay grades, irrespective of the balance of the workforce within individual occupations. All NHS organisations covered by the NHS Standard Contract are now expected to collect this data as many already do and are now be required to do what many NHS organisations do **not** currently do, that is, to analyse the data and work out how to reduce the differences in treatment for which there is no objective justification.

Some organisations have already made strides in doing this and it shows in their data. Others are starting on this journey. What the Workforce Race Equality Standard will do is to require all organisations to not just collect such data, but to analyse and act on it, seeking to narrow the metrics gap between the treatment of BME and White staff.

The second part of the Standard concerns data that is already published in the NHS national staff survey and which considers the differences between the White and BME staff responses on four indicators.

Finally, organisations are expected to consider whether their Board membership i9s broadly representative of the population served and this is explained further in the Technical Guidance.

Q 2.3 What was the response to the formal consultation on the Standard that took place in December 2014?

A: The response to the consultation[12] was very positive with a range of helpful suggestions, including on the detail of the metrics to be used. As a result the following steps have been taken:

- The Standard itself has been amended slightly to take account of consultation responses

[11] Archibong, U. Darr, A. (2010) *The Involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings*. University of Bradford. (2010)
http://www.brad.ac.uk/research/media/CfID-Briefing-9-BME-disciplinaries.pdf.
[12] WRES Standard http://www.england.nhs.uk/wp-content/uploads/2014/12/wres-standard-041214.pdf

- The NHS Standard Contract for April 2015 will include a clause requiring NHS providers (Trusts and others except the very smallest providers) to demonstrate that they are closing the metrics between the indicators for BME and white treatment and experience
- CCGs will play a key role in the process in respect of the performance of providers
- Regulators are now developing a means of inspecting progress against the Standard.

Q 2.4 How the metrics were finally determined?

A: The two consultation processes produced a range of thoughtful comments. An expert group of HR and equality advisers was convened by NHS England and NHS Employers. As a result

- The metrics were amended, finalised and published [13]
- Technical Guidance and FAQs were commissioned

Q 2.5 Were alternative approaches to the WRES considered?

A: Alternative approaches were considered, and in particular, there was a discussion as to whether making the Equality Delivery System (EDS) mandatory could achieve the same end. The EDS2 is in use across many NHS Trusts but it was felt that whilst it may assist the systematic collection of data on workforce race equality, and potentially its analysis, the absence of a requirement to evidence measureable outcomes and certainly not ones than can be benchmarked across the NHS mean an additional approach was needed. It was felt that there is no conflict between the Standard and EDS2 not least because the Standard would require the collection, analysis and action on, data that organisations should be collecting for the EDS anyway.

The Equality and Diversity Council meeting of 29th July 2014 was informed that EDS2 covers 93% of NHS organisations and agreed to consult on whether to make it

[13] The WRES Equality Standard Metrics:
http://www.england.nhs.uk/wp-content/uploads/2015/02/wres-metrics-feb-2015.pdf

mandatory. This will now happen, so providers will need to demonstrate how they are implementing EDS2 whilst the results of the EDS grades will be taken into account by the CQC when carrying out inspections.

Q 2.6 What are the implications for NHS organisations?

A: Firstly, NHS organisations will have to do what they are already required to do because of their Public Sector Equality Duty. NHS organisations have historically had a poor record in collecting, analysing and publishing data on equality, including on race equality.

Secondly, there will need to be a discussion with their commissioners to ensure that each organisation is collecting, analysing and publishing the data and to establish the base line data on each indicator. For NHS Trusts this will include the relevant NHS staff survey data – the staff survey data will be the last published data[14].

For other organisations, the Standard will include equivalent survey data alongside workforce data. Each organisation will need to decide how it is going to narrow the gap in the metrics between its own White and BME staff in the next year so that it can demonstrate to its local commissioner, to staff and its Board, and to the CQC, that it is making progress. What that rate of progress is expected to be will be agreed locally, published, and inspected against.

At the end of the first year (April 1st 2016) the progress on the metrics with be shared with commissioners (and staff) and published. The data will be shared across the NHS so that organisations can benchmark themselves. It is hoped to develop a robust benchmarking process during the first year. Such benchmarking will help identify good practice organisations that others can learn from.

[14] The latest NHS Staff Survey 2014 http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2014-Results.

No central body will tell local organisations what their local targets should be or how to achieve them, but they will be expected to demonstrate measurable progress year on year.

To do that will require all NHS providers (except those who are “small providers” with turnover below £200,000) to do what the best Trusts do – collect and analyse reliable data and listen to their staff including especially BME staff, in order to understand how differences in treatment arise so that remedial action can be taken.

Q 2.7 Will it involve extra work for NHS organisations that are already hard pressed?

A: The collection and analysis of data on workforce race equality should involve no more work than is currently undertaken. Where the collection of data requires significant additional work it is likely that such organisations had not been addressing the issue of race equality sufficiently thoroughly.

What may require more work in understanding the data and listening to staff so that effective strategies to improve outcomes against these indicators can be reached? It is intended that considerable effort will be made to ensure good practice is shared nationally.

EDS2 and the Standard will complement each other since EDS would then complement and underpin the Standards data, and the Standard data would feed into EDS2 evidence. Both processes will help organisations identify the equality issues to be address and how to address them.

Q 2.8 What are the steps that should be taken in preparation for the Standard being introduced?

A: The NHS has now published Technical Guidance on the Standard[15] . It has been developed after consultation with a Technical Guidance group and after discussions with trade unions and others. It will set out specific steps organisations will want to consider and clarify the precise means of each of the metrics.

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

Organisations to which the Standard applies will need to publish their baseline data for April 1st 2015, no later than July 1st 2015.

Discussions are underway with other organisations (CCGs national organisations and private providers) about how the Standard will apply to them.

Q 2.9 - What should organisations be doing now in preparation?

A: A good start would be ensuring they know precisely what their own workforce and staff survey data shows and whether it has been published and been shared with relevant stakeholders such as BME staff and trade unions.

It would be worth considering what steps have been considered in the past to improve these indicators. It is expected that good practice will be shared across organisations,

All Trust Boards should consider directly asking BME staff what they think and following best practice by identifying a Board member to ensure the organisation will ready to implement the new Standard. This work should involve social partnership with recognised trade unions.

It would be good to compare your data and analysis with that of other organisations in your health economy – especially similar ones.

Q 2.10 What about commissioners such as CCGs and NHS England?

A: NHS England are committed to applying the NHS Workforce Race Equality Standard to themselves although their staff survey questions differ a little from the national staff survey.

In 2015-16 each CCG will need to demonstrate 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 doing the same.

Q 2.11 What about other workforce equality strands?

A: The Equality and Delivery Council meeting on July 29th 2014 made it clear that there are other challenges on equality to be met across the range of protected characteristics. The EDC is committed to promote equality for all, ensuring no one is left behind, and will ensure that patient, service user and carer perspectives are central to its work. It also plans to continue with existing work strands and initiate work to advance equality for other groups protected by the Equality Act. The Workforce Race Equality Standard is the first phase in a programme of work focussing upon workforce equality. Parallel work on gender and disability and the workforce has started.

One issue highlighted at the discussion, amongst others, was the treatment of staff with disabilities since available data suggests serious discrimination, similar in many ways to that against BME staff takes place. Although the Standard focuses on the treatment of BME staff, research shows that how all staff are treated impacts on patient care so further initiatives are planned across other protected characteristics. That does not prevent individual organisations continuing to develop work now around other equality strands and it is anticipated that by making sure one strand is addressed in such a direct way it will encourage all organisations to focus more carefully on equality across the board.

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. The Equality Delivery System – EDS2 seeks to focus on all protected characteristics, and a number of specific initiatives of other equality strands as well as race are underway or planned. If successful the approach used for the Workforce Race Equality Standard may be adapted for other equality strands.

Q 2.12 What are the links between the Workforce Race Equality Standard ("the Standard") and the Equality Delivery System (EDS2)?

A: 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.

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 Equality 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 see Equality Delivery System – EDS2[16]

Q 2.13 Isn't the Standard too much like micromanagement of local employers?

A: There will be no national "directive" as to how providers meet the Standard. Nor will there be any national setting of local targets. The requirement will be that demonstrable progress is being made with "stretch" goals to be agreed locally on the understanding that progress to be shared and published nationally.

If an entirely voluntary system was enough to have made the progress needed, then we would have surely seen more progress ten years after the 2004 Race Equality Action Plan launched with Ministerial backing. It is clear that more of the same will not be enough.

This proposal is intended to focus employers' attention on this issue with the intention that "**the rest will be as good as the best**". Lots of effort will hopefully go into encouraging and spreading good practice. But based on the experience of the last decade there may well be employers who will not prioritise this until it becomes part of the commissioning process with measurable, published, outcomes and the back stop of the regulators.

[16] *The Equality Delivery System. A refreshed Equality Delivery System for the NHS – EDS2*. NHS England 2013. EDS 2 information :http://www.england.nhs.uk/ourwork/gov/equality-hub/eds

The evidence linking fair treatment of the 17% of NHS staff who are BME staff to improved care for patients is clear, as is the case for a more diverse leadership benefitting patients. So making this initiative work is in everyone's interest.

Q 2.14 Will the Workforce Race Equality Standard cost extra time or money?

A: There are **three steps** involved in meeting the standard.
The **first step** is to ensure the appropriate data is being collected. All organisations, in accordance with the Public Sector Equality Duty (PSED) should be doing this across all protected characteristics. Those Trusts using the Equality Delivery System – EDS2 may well be collecting the data as part of EDS2, but up until now, there has been no mandatory requirement to do so.

The **second step** is to analyse and publish the data. Again the PSED requires organisations to do this and the data that the Standard considers is certainly data that any organisation wishing to make progress on equality should be collecting this across **all** protected characteristics. Organisations that use EDS2 may well be doing this already but up until now, there has been no mandatory requirement to do so. However the evidence of research is that too many Trusts are not yet analysing and publishing data.

For these two steps there will either be no extra cost or it is a cost they should already be incurring if they are to address inequality.

The **third step** is to act on the analysis and take steps to close the gap between the treatment of white and BME staff. This requires a determined effort to target those areas where there is a substantial gap, for example, on recruitment/promotion, access to non-mandatory training, bullying and discipline. That **must** involve BME staff and staff organisations. This will cost staff time and possibly some external assistance but there are benefits too.

NHS Employers have highlighted the considerable cost of not being an equality employer[17]. The benefits will include less grievances, more likelihood of attracting and appointing the best staff, less bullying, less disciplinary cases, less turnover and sickness absence, and more importantly of all, better BME staff morale with benefits for all patients. There may be upfront costs but real benefits in the short to medium term.

Q 2.15 What consequences will there be for service providers that fail to move to meet the Standard?

A: Unlike previous NHS initiatives on equality, this requires published measurable outcomes that are difficult to "game". Is it hoped that many (most) organisations will adopt the strategy of closing the gap between White staff and BME staff experiences because they want to, in the interests of patients and their staff. For those who don't there are three consequences.

Providers will need to confirm to commissioners in an Annual Report what progress they have made against the Standard. Failure to do so will be a breach of the NHS Standard Contract and should trigger robust discussions about how and why, and what steps will be taken to improve performance the following year. Ultimately a breach of a contract should be dealt with as any other breach of contract.

The progress made by Trusts will be published and, as with much other data, will be available nationally in a form that enables organisations to benchmark themselves. It is likely that as well as encouraging Trusts to do better, to find "buddying" arrangements and good practice, a poor performance will trigger Board level discussions.

When regulators adopt progress towards the Standard as an element of their scrutiny from April 2015 then failure to progress on the Standard is likely to be taken into account in determining whether the Trust being is "well led" or not, with the normal range of consequences for the Board.

[17]NHS Employers (2014). *The business case for diversity.* http://www.nhsemployers.org/SharedLearning/Pages/BusinessCaseForDiversity.aspx.

Q 2.16 What exactly will the CQC's role be?

A: 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.

Q 2.17 How will BME staff be involved in the process?

A: 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 WRES. Organisations are strongly encouraged to help establish and support BME networks 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

An increasing number of Trusts are recognising the importance of giving time and facilities to BME staff groups and a serious opportunity to engage with Board. In best practice trusts the CEO or Chair have met with and listen to the concerns of BME staff in a "safe space".

Q 2.18 What role will trade unions have?

A: 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**.**

Q 2.19 What will CCGs be expected to do in respect of their commissioning role?

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

- That they give due regard to 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 fully implementing the 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.

Supplementary information for commissioner planning, 2015/16[18] confirms that CCGs will be required to conduct an examination of how the organisation compares against the first NHS Workforce Race Equality Standard and confirm that providers are implementing EDS2.

Q 2.20 Who should lead on the Standard within organisations?

A: The booklet from the NHS Providers[19] states:
"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"

The Technical Guidance on WRES suggests that Boards will want to nominate a Board member to lead work to meet the NHS Workforce Race Equality Standard and other aspects of equality as many NHS Trusts do now.

[18] *Supplementary information for commissioner planning, 2015/16* (page 10, Annex A)

[19] NHS Providers Booklet http://www.nhsproviders.org/resource-library/the-race-equality-opportunity-for-nhs-provider-boards/

Q 2.21 What will organisations need to do by April 2015 what will organisations need to do by April 2016?

A: The following table summarises the timescales, more detail is contained in the Technical Guidance.

Table 2: WRES Milestones

Milestone	Activity
April 1st 2015	Baseline data for comparison with April 2016
July 1st 2016	Publication of 1st April 2015 data including identification of any essential shortcomings
April 2015 – March 2016	Work to start to address any data shortcomings and to understand and address shortfalls identified by the WRES indicators
April 2016	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.

Q 2.22 Has there been an Equality Analysis (EA) of the WRES?

A: An Equality Analysis[20] on the WRES has been completed and it will be continuously reviewed and updated.

Q 2.23 Will the metrics change in future years?

A: After its initial introduction, the Equality Delivery System was independently evaluated and subsequently "refreshed" and amended slightly following further engagement with the NHS. It is possible the same might occur with the WRES metrics but there are no plans to do so at the moment.

It is intended there will be an evaluation of the scheme.

[20] WRES Equality Analysis (EA) http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard/

Q 2.24 How were the definitions of "BME and white" decided and why?

A: The definitions of "Black and Minority Ethnic" and "White" used have followed the national reporting requirements of Ethnic Category in the NHS Data Model and Dictionary, and as used in Health and Social Care Information Centre data. "White" staff includes White British, Irish and Any Other White. The "Black and Minority Ethnic" staff category includes all other staff except "unknown" and "not stated."

To define BME employers should exclude A, B, C and Z from current values in the table below. Also exclude 0 and 9 from the old values of which there are around 500 records. Exclude all 'NULL' values. The category C 'Any other white background' contains minority groups including white European.

Table 3 – Ethnic Categories as per Office of National Statistics (ONS)

Ethnic Categories as per Office of National Statistics (ONS) 2011
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

Q 2.25 How will multiple discrimination be effectively addressed if the move is to focus on individual, separate protected characteristic groups?

A: A focus on one particular characteristic does not mean we should and will not, address issues of multiple discrimination. Many BME staff have other protected characteristics.

Parallel work and research on other characteristics is underway and in considering whether BME staffs are treated less favourably, root cause analysis may well identify that multiple causes exist including other protected characteristics.

A determined drive to improve the treatment BME staff will inevitably impact on the overall priority given to equality as a whole within the NHS.

Q 2.26 How does the Standard apply where small numbers of BME staff are employed?

A: 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.

Q 2.27 How will the Standard apply if any of the Staff survey metrics don't apply because there are fewer BME staff?

A: The workforce metrics will apply to almost all provider organisations, and national organisations. There will be a small number of organisations where there are either such small numbers 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 also too low to merit publication without potentially identifying individuals.

Less than 6% of Trusts have so few BME staff that there are no results on the national staff survey. In some cases that may be because there are very few BME staff in the local area. In others it may be that the small numbers raise questions about recruitment policies. This may particularly true in certain types of Trusts. Evidence suggests that even where are very few BME staff the very same issues of less favourable treatment of BME staff may well apply. Indeed in some cases it may be that due to the small numbers of BME staff they may be more isolated and feel even less able to raise their concerns than BME staff elsewhere.

So Trusts with few BME staff or where they don't even have metrics because of small numbers of BME staff need to consider:

- whether their recruitment policies may need reconsidering
- whether they need to find specific ways to ensure the BME staff voice is heard
- to pay special attention to the workforce metrics if national staff survey metrics are not available
- to pay particular attention to improving the response rates of BME staff since in some organisations the response rates are significantly lower for BME staff than for white staff

The presence of small number of BME staff does not mean there may not be similar issues around the treatment and experience of BME staff as in 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 the Standard is being met and how the CQC inspect against the Standard. Further advice on this will be provided.

Q 2.28: What would you expect NHS organisations to do now that the NHS staff survey for 2014 has been published?

A: In light of the publication of the NHS staff survey for 2014, we would expect NHS organisations to consider the following:

a. Consider if their response rates are significantly below the average of their comparator as indicated by the published survey response metrics
b. To 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 staff survey responses with their staff
d. For each of the staff survey metrics organisations will want to understand if there are specific issues relating to specific professional groups, departments or shifts
e. Consider whether there are any obvious discrepancies between their staff survey data and workforce data. For example, does 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.

Q 2.29 What should NHS organisations be doing in the period prior to April 2016?

A: Prior to April 2016 NHS organisations should:

a. Specifically consider the indicators used for Standard and seek to “drill down” by department, profession, shift, site, and consider further disaggregation by individual BME staff groups
b. For Metric 1: organisations will want to publish the ethnicity data by all pay bands as that will assist in identify specific areas of concern
c. For Metric 2: organisations may wish to consider analysing data on appointment from shortlisting for specific departments, occupations, or pay bands

d. For Metric 3 and 4 : organisations may well want to understand if there are specific issues relating to specific professional groups, departments or shifts
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 compares to that 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 metrics and suggestions on how to improve the metrics
h. Discuss with their local black and minority ethnic networks, providing a safe place to do so, their understanding of the drivers behind each of the metrics and suggestions on how to improve any difference between white and BME treatment and experience
i. Consider making a three year retrospective comparison on their data, as some Trusts already do, to scrutinise trends
j. Ensure, as appropriate, that there exists a BME staff network to be consulted and represent the views of BME staff in their organisation

Q 2.30 How will the Standard apply to national NHS bodies?
A: National bodies include (but not exclusively)

- NHS England (also a commissioner)
- Care Quality Commission (CQC)
- Monitor
- National Trust Development Authority (NTDA)
- Health and Social Care Information Centre (HSCIC)
- National Institute for Clinical Excellence (NICE)
- Public Health England (PHE)
- Health Education England (HEE)
- NHS Leadership Academy

These bodies are members of the Equality and Diversity Council and have committed themselves to the support of the WRES. They will all be seeking to apply the WRES provisions to themselves. It is acknowledged that, currently, these bodies are not

covered by the NHS national survey and therefore they will need to be some flexibility, certainly in the first year, as to how the survey indicators apply to these bodies, though many conduct their own staff surveys which they may wish to amend in the light of the Standard. The workforce indicators will **all** apply.

Q 2.31 How will the standard apply to the private and voluntary sector?

A: All provider organisations (except primary care) are subject to the requirements of the NHS Standard Contract in respect of WRES except for “small providers”. The WRES therefore applies to all NHS providers and any non NHS providers (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”

Some non NHS providers already participate in the NHS National Staff survey. All providers (except “small providers” and primary care) will be expected to collect, analyse and publish relevant workforce data in respect of their staff providing NHS services. All such providers will be expected to conduct staff surveys with similar questions to those used in the WRES or to participate in the NHS national staff survey.

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

Q 2.32 Who is included in the definition of “Board membership” used in Indicator 9?

A: 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 one is appointed on a rolling basis whilst the other executive directors are appointed as employees, and changing their composition takes place through different routes.

Q 2.33 What does "broadly representative" mean in respects of the ethnicity of organisation's Boards of directors?

A: "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 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.

Q 2.34 What is meant by "the population (Boards) serve"?

A: For national bodies it is the proportion of the national population in England from BME backgrounds as measured by the 2011 census or more recent authoritative update. For provider organisations and CCGs it will be the population in the area(s) they serve.

Q 2.35 Why the term "relative likelihood" has been chosen for metrics 2 and 3?

A: It has been chosen because it is the most reliable and informative way of understanding the relative disadvantage of BME staff compared to white staff. How it is calculated for each metric is shown in the Technical Guidance

Q 2.36 Why doesn't the Standard include specific metrics for issues where there are known problems, such as the transition of BME nurses and midwives from Bands 5, 6 and 7?

A: The entire purpose of the WRES is to stimulate, encourage and where necessary enforce accurate collection of data and rigorous analysis of the causes of any patterns of disadvantage related to ethnicity.

In nursing for example the WRES will help with underlying problems. Trusts will have to:

- Calculate what proportion of BME staff who are nurses and midwives are in Bands 5 to 9 as part of establishing their progress against metric 1.
- Calculate the relative likelihood of all staff, including nurses and midwives, being promoted from shortlisting.
- They will have to involve BME staff and their trade unions in discussions about the implications of such data and whether further investigation and action is necessary for specific occupations and grades
- They will have to collect and publish the data on access to non-mandatory training and CPD for all staff and in doing so should be able to provide specific data for nurses and midwives
- Where, as is often the case, there are real barriers for BME nurses and midwives progress across Grade Boundaries Trusts, faced with data on Metrics 1, 2 and 4 and staff survey metric 7 will need to address specific barriers if they are to improve their progress against the Standard.

BME nurses and midwives may have concerns about other matters. It is hoped that the WRES will prompt employers to examine, with their staff, all aspects of discrimination. For example, the data for metric 3 should prompt discussion about whether any discriminatory patterns there are reflected in patterns of referrals to regulatory bodies, and if so, that should be subjected to analysis too.

Any concerns this data throws up that are not being addressed can, of course, be raised with the CQC when, as may well be the case, they call meetings of BME staff as part of their inspections when the evidence suggests that might be

appropriate. That's why the Guidance emphasises that in each Trust BME staff groups should be listened to and indeed the CQC has started holding BME focus groups to that end

Q 2.37 Why has the wording of metrics 5 to 8 been chosen?
A: The wording is taken exactly from the NHS national staff survey questions that are referred to in each metric. Precisely what those words mean and how to best understand the data they reveal is explained in the Technical Guidance.

Q 2.38 How will the Standard address the numerous aspects of discrimination affecting BME doctors and dentists?

A: The entire purpose of the Standard is to stimulate, encourage and where necessary enforce accurate collection of data and rigorous analysis of the causes of any patterns of disadvantage related to ethnicity.

Eight of the nine metrics (2-9) directly include medical and dental staff in precisely the same way that they do nurses and other staff. Metric 1 requires employers to identify, by ethnicity, which doctors and dentists are in senior managerial roles

However, in constructing the metrics it became clear that neither job codes nor grades adequately captured levels of, for example, managerial responsibility in ways that were easily applied through a simple formula. As a result it was not easy to define how we might reasonably identify "senior managers" who are doctors and dentists. Neither job codes (ESR) not HSCIC data alone can be relied upon. That in turn presents problems for estimating nationally what patterns of disadvantage may exist for groups such as female or ethnic minority doctors and dentists, though it should not necessarily prevent such estimates being made within an individual employer.

In fact, the moment Trusts identify the ethnicity of doctors on departmental and senior management committees it is possible in each Trust to start to identify the patterns of seniority for BME doctors (and women).

The Guidance states: **‘**Senior Medical & Dental staff: It would have been preferable to be able to include, in Metric 1, all medical and dental staff who hold 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, the data held by HSCIC or through ESR does not allow any reliable data to be draw about the levels of management responsibility; nor are pay grades are necessarily a reliable guide to levels of responsibility either’.

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

There is a very good reason why doctors and dentists in their entirety are not included within the “Band 8 and above” category and why only senior doctors are. Had they been so included it would have given an entirely false impression of the treatment of BME staff such as nurses and others in senior grades by giving the impression that there were much larger numbers of BME staff from those groups in senior grades and thereby risking eliminating the need for further analysis of other occupations.

The issue of baseline data collection for future years is something that will need attention once the WRES is underway.

Trusts will have to

- Calculate what proportion of BME staff who are doctors and dentists are “senior managers,” and what proportion are not, in order to meet the requirements of metric 1.
- Calculate the relative likelihood of all staff, including doctors and dentists, being promoted from shortlisting.
- They will have to collect and publish the data on access to non-mandatory training and CPD for all staff and in doing so should be able to provide specific data for doctors and dentists

- They will have to involve BME staff and their trade unions in discussions about the implications of such data and whether further investigation and action is necessary for specific occupations and grades

The data that provides should enable serious discussions about any patterns of disadvantage in grading and promotion.

The data for metric 3 should prompt discussion about whether any discriminatory patterns there are reflected in patterns of referrals to regulators bodies and if so that should be subjected to analysis too.

BME doctors, alongside female doctors, may have concerns about other matters. It is hoped that the Standard will prompt employers to examine, with their staff, all aspects of discrimination.

Any concerns this data throws up that are not being addressed can, of course, be raised with the CQC when, as may well be the case, they call meetings of BME staff as part of their inspections when the evidence suggests that might be appropriate.

Q 2.39 How will the organisation's progress on meeting the standard be verified?

A: The organisations progress on meeting the standard can be verified in three ways.

Firstly, CCGs and other commissioners will need to check, as part of their assurance in respect of the National NHS Standard Contract that providers are complying with the requirements of the Standard

Secondly, from April 2016 provider progress on meeting the Standard will be included in the CQC and Monitor "well led domain" and will be inspected against.

Thirdly all data required to demonstrate progress in meeting the WRES will have to be published. It will need to be published so that all staff can scrutinise progress, including local BME and staff side organisations. It will need to be published for commissioners to consider. It will need to be published because the CQC will expect to be provided with the data.

In addition, work will be commissioned to determine a robust way of benchmarking the data for wider comparison to enable organisation to compare themselves with similar organisations and their progress.

More generally, organisations covered by the WRES are strongly encouraged to be open at all stages of engagement with WRES. This means:

- Being open about the nature and scale of the challenge each organisation faces – sharing data however uncomfortable it may be initially
- Sharing with staff the approaches proposed and inviting real engagement about those processes
- Publishing to all staff the data from workforce analysis and staff surveys which indicates challenges around race equality
- Sharing progress and achievements and learning from how progress was made

Further advice on how the progress for each organisation will be published and work towards a benchmarking process will follow.

Q 2.40 What does "non-mandatory training" include as this is currently not defined or measured in the same way across different organisations?

A: "Non-mandatory training and Continuing Professional Development (CPD)" means any training or CPD that is not a requirement of the post. Examples of **mandatory training** would include lifting, 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.

Q 2.41 What is the purpose of using a metric for staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months?

A: Bullying and harassment by members of the public is a problem across the NHS, especially in certain departments (notably A and E) and in certain types of services (notably in mental health and ambulance Trusts). It was felt that where there were significant differences between BME and White experience it was important to highlight these, especially as in some trusts there is little difference and in others very significant differences between white and BME experience

Q 2.42 What period will the metrics 2, 3 and 4 be measured against?

A: The initial baseline with be data for a previous 12 month period measured against the WRES. The 12 month period in many Trusts will be the year ending March 31st or in some cases December 31st. There is no requirement to align the 12 month period with the April 1st baseline.
In the first year there is a 3 month period of "grace" to allow organisations to get ready for the Standard so data for the April 1st 2015 deadline must be published no later than July 1st 2015. In the following years the baseline of April 1st must be published on that date or within one month i.e. by April 30th.

Q 2.43 Will Indicator 3 be adjusted to take into account that relatively small numbers may be involved in any one year?

A: In previous years many organisations have suggested they cannot draw any conclusions about a pattern of disciplinary action being potentially discriminatory because the numbers are relatively small.

To avoid that situation Indicator 3 will be calculated over a two year rolling period i.e. the last two years for which data is available. In some cases the number may still be small but that does NOT preclude conclusions being drawn especially as the pattern may be similar over even earlier years.

Q 2.44 Small' providers have been given exemption from the Standard. Please can you provide the definition of 'small provider' in this context?

A: In the NHS Standard Contract for 2015, as in the previous year, “Small providers” 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”

Q 2.45 What national support will be available to organisations?

A: Discussions are underway to ensure that good practice is shared between NHS organisations in as systematic a manner as possible. Individual HR, 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 both explain the WRES and the research behind it, and share best practice.

A dedicated web page has been set up to share news and developments http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard/what-were-doing

Q 2.46 A colleague who believes that GP practices will have a mandatory duty to complete EDS2 reports next year. Is this true?
A: GP practices will not have a mandatory duty to implement the EDS2 next year. GP practices are subject to the general duty and not the specific duties.

Q 2.47 What is NHS England's definition of who is to be included in the BME group? Is it just visible BME (those that do not fit into a white category so would not include European) or all staff that are not White British or is it categorised another way?

A: Please see the FAQ 2.1.23. This does not mean there may not be issues to consider in the treatment of some staff classed by the census and HSCIC as "other white" such as travellers and staff from Eastern Europe, but the Standard will seek to tackle the treatment of those staff classed as BME in the first instance. Where there are significant groups within "other white" being disadvantaged then employers should seek to address those issues anyway in accordance with their Public Sector Equality Duty.

Q 2.48 Why is there a specific emphasis on BME staff and not on other protected characteristics such as gender, disability or sexuality?

A: 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. The Equality Delivery System – EDS2 seeks to focus on all protected characteristics and a number of specific initiatives of other equality strands as well as race are underway or planned. If successful the approach used for the Workforce Race Equality Standard may be adapted for other equality strands.

The evidence, however, is that the NHS, like society, find some aspects of discrimination especially difficult to challenge. 20% of nurses and 37% of doctors are from BME backgrounds and their treatment, by every measure, is less favourable than that of white staff and with evidenced impact on patient care.

The EDC decided to start with race equality because the evidence is so clear and stark. That does not mean other forms of discrimination will not be tackled and a range of other work is underway.

Q 2.49 Many black people themselves object to quotas or standards making them feel like things may become more tokenistic so why do we need a separate race equality standard at all?

A: The data is unequivocal. BME staff are treated less favourably that white staff by every metric researchers have used. Discrimination on the basis of ethnicity unfortunately exists.
It is a serious problem not just because of the impact on the staff and the waste of talent for the organisation but because the research demonstrates an adverse impact on patient experience and care.
In any other challenge affecting staff or patient care we rely on data, supplemented by the views of staff and patients, to drive change by identifying the root causes and devising solutions.

The Workforce Race Equality Standard does not set quotas though it certainly sets aspirations which organisations must work towards. This is not about positive discrimination but it is about levelling the playing field of discrimination and enabling staff to develop their full potential and patients and employers to benefit from that full potential.
The Standard is not about token appointments but it is about removing the barriers which currently exist and giving as much support as possible to reverse disadvantage.

Q 2.50 Why doesn't the Standard say anything about disproportionate referrals of BME staff to professional regulators or the disproportionate singling out of BME whistle-blower's?

The Workforce Race Equality Standard is not the only means by which potential race discrimination in the NHS will be tackled. The Equality and Diversity Council recognises that there are a number of other aspects to race equality beyond those "captured" by the Standard.

The Francis Review on whistleblowing[21] suggests there may indeed be a justified concern about the disproportionate treatment of BME staff who were “whistle-blower’s” and further investigation of this may well be necessary to examine and stop this as a result of the Francis review recommendations.

The role of regulators in relation to apparently large numbers of referrals of BME staff is something else the EDC has said it may consider. If so that would link to the evidence of disproportionate disciplinary action against BME staff some of this may lead to disproportionate referrals to regulators such as the GMC, NMC, GDC and HCPC.

[21] Francis, R. (2015) Report on *the Freedom to Speak Up review*. Department of Health - http://freedomtospeakup.org.uk/the-report

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