EDC04 04/17

NHS Equality and Diversity Council

CONFIDENTIAL

Equality and Diversity Council Meeting Paper

19 April 2017

WRES Annual Data Report and Update

Purpose and context

A priority of the EDC is to focus upon ensuring that the gap between the treatment, opportunities and experience of BME and white staff is closed, and that NHS boards are broadly representative of the communities they serve. The development and implementation of the Workforce Race Equality Standard (WRES) is the EDC's agreed approach to realising this ambition.

EDC Theme and objective (s) the paper links to:

Theme 3: Workforce Equality – eliminating discriminatory practices by:

Key Goal: Improving workforce race equality through successful implementation of the WRES (with increased numbers of NHS BME leaders).

Key Goal: Developing workforce equality standards across protected groups.

Key Summary Milestones

The WRES annual data analysis report for NHS trusts is scheduled to be published on 19 April 2017. Key findings from the report are in the annex to this paper.

The report is the second annual WRES data report, and the first one to cover all nine WRES indicators. For the WRES indicators relating to workforce, this is the first time that a report presents reliable data related to NHS workforce race equality published in this form. For the staff survey indicators, we are able to compare the data year-on-year for 2015 and 2016.

Please note: The findings presented in the annex are confidential and should not to be shared as the final report is embargoed until 12-noon on 19 April 2017.

Progress Update

1. The report is the second annual WRES data report, and the first one to cover all nine WRES indicators. For the WRES indicators relating to workforce, this is the first time that a report presents reliable data related to NHS workforce race equality published in this form. For the staff survey indicators, we are able to compare the data year-on-year for 2015 and 2016.

2. As the report covers all nine indicators, and because indicator one has collected data with significantly more detail this year, we have taken a decision to include in the main report summary, data by region and type of trust. The detailed trust data analyses and comparisons are made available online, on a web page specifically devoted to the data. To have done otherwise would have made the printed report over 200 pages long.

3. As well as continuing to challenge NHS trusts, we have sought to emphasise good replicable practice in two ways. The first is to identify a number of trusts where data is significantly better than average. The second is to include a summary of the literature around the shared characteristics of good practice, which largely underpins the emerging good practice in NHS organisations and elsewhere.

4. NHS trusts have all responded to our request for the WRES data returns. We do not have data quality concerns to the same scale as we did last year. There is limited evidence on the emergence of tentative, but positive, outcomes. Such evidence should be treated with caution but appears to represent some early progress. However we remain in the foothills of the snowy white peaks, the challenge is to sustain and extend any early inclinations of improvement.

5. We have put in place a comprehensive communications plan to ensure every single leader within the NHS (not just in provider organisations) receives a copy of the report and that the report (and the online data) is widely disseminated through direct communications and social media. In addition, we are running a series of regional workshops in April, which have been heavily booked such that we have had to organise an additional one. These workshops will also be an opportunity to share report findings.

6. Above all, we intend that this annual data report helps to spur all NHS trusts (and other organisations including CCGs, CSUs and the ALBs) into further sustained work to help improve the treatment and experience of BME colleagues in ways that will benefit staff, organisations and the care and safety of all patients.

Next Steps

Going forward, the sharing of replicable good practice and the provision of support for NHS boards and leaders will be our priority. This will include providing strategic and operational support on this agenda to facilitate transformational culture change across local NHS organisations in England, including a focus on the new models of care – the Vanguards and through Sustainable and Transformational Plans (STPs).

This year's report is two months earlier than last year's report. It is hoped to bring forward the publication of the next annual WRES data report still further in the annual cycle. That would

enable us to do what we have not been able to do this year which is to incorporate the most recent (March 7) staff survey report.

Recommendation and action requested

The EDC is asked to note the report and to discuss the analysis.

Yvonne Coghill and Roger Kline
Joint Directors WRES Implementation

April 2017

Annex

Key findings from: NHS WRES 2016 Data Analysis Report for NHS Trusts

Confidential – not to be shared (embargoed until 12-noon on 19 April 2017)

- White shortlisted job applicants are 1.57 times more likely to be appointed from shortlisting than BME shortlisted applicants, who remain noticeably absent from senior grades within Agenda for Change (AfC) pay bands.

- An increase in numbers of BME nurses and midwives at AfC Bands 6 to 9 is observed for the period between 2014 and 2016.

- BME staff in the NHS are significantly more likely to be disciplined than white staff members.

- The proportion of very senior managers (VSMs) from BME backgrounds increased by 4.4% from 2015 to 2016 – an additional 9 headcounts. However, BME representation at board and VSM level remains significantly lower than BME representation in the overall NHS workforce and in the local communities served.

- BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers, although the percentage of BME staff reporting that in the last 12 months they have personally experienced discrimination at work from staff fell slightly.

- White and BME staff are equally likely to experience harassment, bullying or abuse from patients, relatives and members of the public in the last 12 months.

- BME are more likely than white staff to experience harassment, bullying or abuse from other staff though this fell very slightly last year.

- BME staff remain less likely than white staff to believe that their trust provides equal opportunities for career progression. However, the gap between white and BME staff on this indicator fell from 14.5 percentage points in 2014 to 12.6 percentage point in 2015.