"The publication of this report is a moment for humble reflection for national, regional, and local leaders alike. These findings, and the events of this year, show the need for equality and inclusion to be intrinsic to everything we do in the NHS and the People Plan clearly sets out the need to give these issues the same emphasis as we would any other NHS priority."

Prerana Issar
NHS Chief People Officer

Workforce Race Equality Standard

2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups

February 2021

Contents

NHS Workforce Race Equality Standard (WRES)

2020 data analysis report for NHS trusts and clinical commissioning groups

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Foreword

Prerana Issar
NHS Chief People Officer

The NHS was created in 1948 as an instrument of social justice. We collectively promised each other that everyone should have equal access to health outcomes, irrespective of income levels, sexual orientation, race, disability or gender.

Although we have made much progress to realise that promise, we still have a long way to go. In order to provide equality of health outcomes, we must also create equality within our NHS workforce. We come to work in the NHS because we believe that we can contribute towards improving lives, population health and health outcomes. It is through the commitment and dedication of our diverse and talented NHS workforce that we achieve these ambitions on a daily basis; yet we can only do so effectively by creating inclusive cultures in which all of our people can thrive. The continuing presence of discrimination is why we need to re-set the inclusion dial, together setting and attaining more ambitious leadership standards that demonstrably drive equitable outcomes for everyone. We must then build upon this progress year on year.

The Workforce Race Equality Standard (WRES) programme has now been collecting data on race inequality for five years, holding up a mirror to the service and revealing the disparities that exist for black and minority ethnic staff compared to their white colleagues. The findings of this report do not make for a comfortable read, and nor should they. The evidence from each WRES report over the years has shown that our black and minority ethnic staff members are less well represented at senior levels, have measurably worse day to day experiences of life in NHS organisations, and have more obstacles to progressing in their careers. The persistence of outcomes like these is not something that any of us should accept. It is in recognition of these realities that the People Plan 2020/21 has 'belonging' as one of its four pillars.

Findings for WRES 2020 are impossible to separate from the context into which the report will be published. The country and the NHS have been challenged like never before by the COVID-19 pandemic, a disease that has been shown to disproportionately affect black and minority ethnic people. The murder of George Floyd in the USA spurred an immediate and long-overdue global conversation about race inequality. Attention has not been so sharply focussed on this agenda for decades, and it is right that we examine these findings with a view to quickening the pace of change, against this backdrop.

This year's report shows that, at the point at which the pandemic struck, inequalities were already present in the NHS. It is of note that much of this is experienced by black and minority ethnic staff as subtle processes and behaviours, that are often undetected by others. Three things emerge as key lessons to take from this year's findings:

- First, that delivering equality of outcome and opportunity should be the professional and moral obligation of every leader in the NHS. If it is not already happening, senior and executive leaders need to be accountable for developing and delivering urgent plans to eliminate inequality in their organisations.
- Second, that no one organisation is doing everything well. There are pockets of good practice across all WRES indicators, but no single organisation is exemplary. Every organisation must face up to its limitations and, as set out in the People Plan, develop measurable strategies to overcome them.

- Thirdly, the disproportionate rate of death among black and minority ethnic staff is intrinsically linked to their over-representation in some of the most at risk groups. Those who work on the front lines of public services are often more exposed to the risk of infection, just as they are more exposed to bullying, harassment and discrimination. This years' WRES reports a welcome increase in the diversity of our senior leadership. There has been a 42% increase in BAME Very Senior Managers, and a 22% increase in BAME trust board members since 2017. Alongside improved representation at senior level, cultures must become more inclusive as leaders develop pipelines of talent across the grades and throughout organisations, if we hope to see equality across the entire workforce.

The publication of this report is a moment for humble reflection for national, regional, and local leaders alike. These findings, and the events of 2020, show the need for equality and inclusion to be intrinsic to everything we do in the NHS and the People Plan clearly sets out the need to give these issues the same emphasis as we would any other NHS priority.

We need to act now to ensure that the cumulation of events of 2020 spur us to improve both equality for our black and minority staff and the experience of patient care for all. This is within our collective gift.

Prerana Issar
NHS Chief People Officer.

Key findings

+2.9%

As at 31 March 2020, **21.0% (273,359)** of staff working in NHS trusts and clinical commissioning groups (CCGs) in England were from a black and minority ethnic (BME) background. This is an increase from **18.1%** in 2017. There were **56,715** more BME staff and **37,602** more white staff in 2020 compared to 2017.

+41.7%

The total number of BME staff at very senior manager (VSM) pay band has increased by **45 (41.7%)**, from **108** in 2017 to **153** in 2020.

x1.61

White applicants were **1.61 times** more likely to be appointed from shortlisting compared to BME applicants; this is worse than in 2019 **(1.46)**. which itself showed no improvement on the previous year. There has been year on year fluctuation but no overall improvement over the past five years. It was **1.60** in 2017.

x1.16

BME staff were **1.16 times** more likely to enter the formal disciplinary process compared to white staff. This is an improvement on 2019 **(1.22)** and a significant improvement from 2017 when it was **1.37**.

30.3%

30.3% of BME staff, and **27.9%** of white staff, reported experiencing harassment, bullying or abuse from patients, relatives or the public. This is an increase for both groups. In 2016 it was **28.4%** for BME staff and **27.5%** for white staff.

0

The WRES indicators relating to perceptions of discrimination, bullying, harassment and abuse, and on beliefs regarding equal opportunities in the workplace, have not improved over time for both BME and white staff (please see table 1).

+1.6%

10.0% of board members in NHS trusts were from a BME background. This is an improvement from **8.4%** in 2019. In 2017, **7.0%** of board members were form a BME background

+22.2%

The number of BME board members in trusts increased by **61 (22.2%)** between 2019 and 2020.

For CCGs

This is the first time that we are reporting data for CCGs

66

Only **66 (34.6%)** of the 191 organisations took part in the NHS staff survey in 2019.

40.7%

Just **40.7%** of BME staff believed that their organisation provides equal opportunities for career progression or promotion compared to **88.3%** for white staff.

16.8%

16.8% of board members were from a BME background.

Key findings

Table 1:

WRES indicators for NHS trusts in England: 2016–2020

WRES indicator			2016	2017	2018	2019	2020
1	Percentage of BME staff	Overall	17.7%	18.1%	18.9%	19.7%	21.0%
		VSM	5.4%	5.3%	5.8%	6.5%	6.8%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		1.57	1.6	1.45	1.46	1.61
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.56	1.37	1.24	1.22	1.16
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		1.11	1.22	1.15	1.15	1.14
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	29.1%	28.4%	28.5%	29.8%	30.3%
		White	28.1%	27.5%	27.7%	27.8%	27.9%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	27.0%	26.0%	27.8%	29.0%	28.4%
		White	24.0%	23.0%	23.3%	24.2%	23.6%
7	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	BME	73.4%	73.2%	71.9%	69.9%	71.2%
		White	88.3%	87.8%	86.8%	86.3%	86.9%
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	14.0%	14.5%	15.0%	15.3%	14.5%
		White	6.1%	6.1%	6.6%	6.4%	6.0%
9	BME board membership		7.1%	7.0%	7.4%	8.4%	10.0%

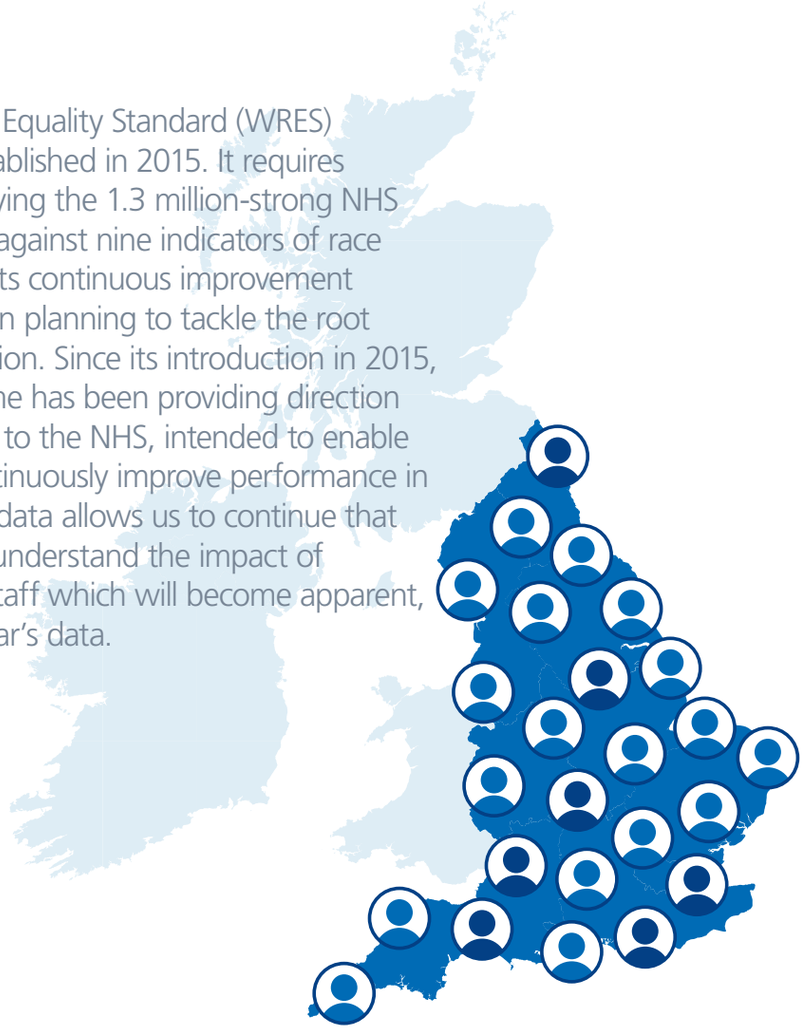
Key findings

Table 2:

WRES indicators for clinical commissioning groups (CCGs) in England: 2020

WRES indicator			2020
1	Percentage of BME staff	Overall	14.3%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		1.41
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.65
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff		0.71
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME	8.3%
		White	11.6%
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME	28.4%
		White	23.6%
7	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	BME	40.7%
		White	88.3%
8	Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues	BME	10.2%
		White	4.4%
9	BME board membership		16.8%

Introduction



The Workforce Race Equality Standard (WRES) programme was established in 2015. It requires organisations employing the 1.3 million-strong NHS workforce to report against nine indicators of race equality; and supports continuous improvement through robust action planning to tackle the root causes of discrimination. Since its introduction in 2015, the WRES programme has been providing direction and tailored support to the NHS, intended to enable organisations to continuously improve performance in this area. This year's data allows us to continue that process, but also to understand the impact of COVID-19 on BME staff which will become apparent, no doubt, in next year's data.

The Workforce Race Equality Standard (WRES) programme was established in 2015. It requires organisations employing the 1.3 million-strong NHS workforce to report against nine indicators of race equality; and supports continuous improvement through robust action planning to tackle the root causes of discrimination. Since its introduction in 2015, the WRES programme has been providing direction and tailored support to the NHS, intended to enable organisations to continuously improve performance in this area. This year's data allows us to continue that process, but also to understand the impact of COVID-19 on BME staff which will become apparent, no doubt, in next year's data.

Evidence from the Office of National Statistics and Public Health England shows that a disproportionate number of those who have died from COVID-19 are from black and minority ethnic (BME) backgrounds. In this way, the pandemic has shone a spotlight on the disparity of experience and opportunity between white and BME people in this country. While the majority of findings in this report are drawn from data collected before the pandemic, they are vital reminder of the context in which it struck. At the point at which the NHS staff needed support most, this report makes clear that many were already having worse experiences in the workplace than their white colleagues because of discriminatory systems and processes.

With five years of data collected against several of the indicators, we can now begin to take a long-term view of race equality for the workforce in NHS trusts. We can see more clearly than ever where there has been progress, and where more needs to be done. There are some positive findings in this report from 2020:

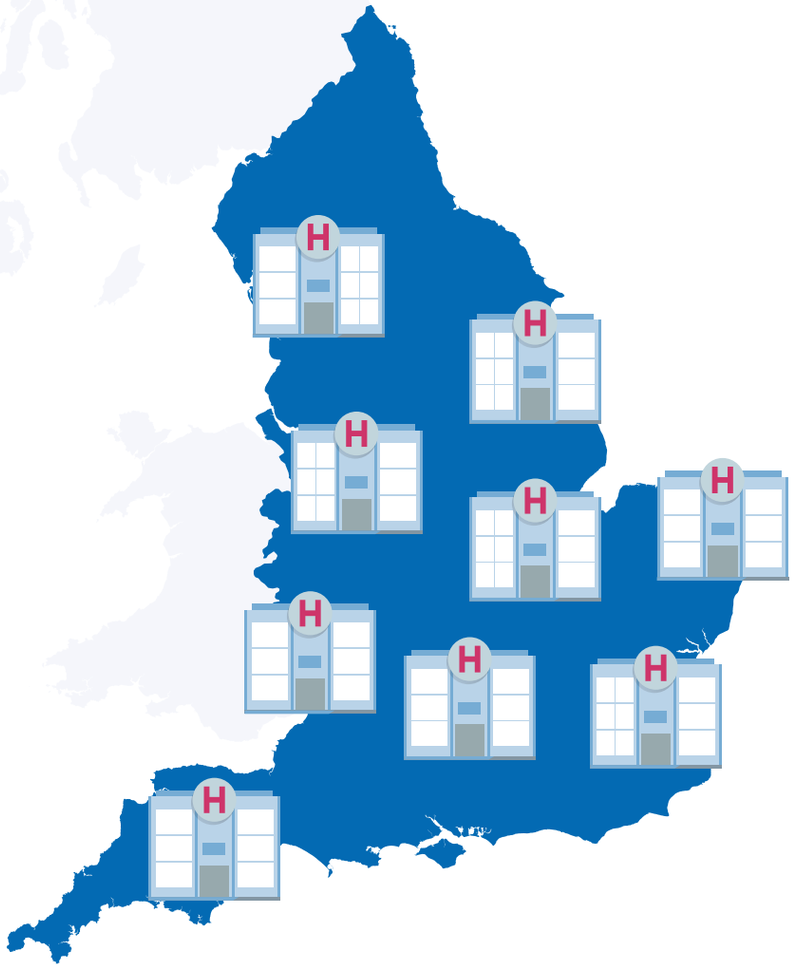
- **6.8% of very senior managers in NHS trusts are from a BME background (5.4% in 2016)**
- **10% of all trust board members are from a BME background (7.0% in 2017)**
- **the relative likelihood of BME staff entering the disciplinary process is at the lowest level since this data collection began**
- **the relative likelihood of BME staff accessing non-mandatory training is at the lowest level since this data collection began.**

Introduction

There remains striking regional disparity with gaps remaining as stark as in previous years in some regions, notably in London. There also remains wide variation between trusts, with some – such as the ambulance services – showing the greatest levels of inequality. In terms of trends with time, some are transforming to an outstanding degree, while others are making little or no improvement at all. **It is of particular note that no single organisation has results at the highest level for all the parameters.**

This year's report is also notable in that it is the first in which the WRES is publishing data for CCGs. CCG staff represent 2.1% of all NHS staff in trusts and CCGs, and this baseline data is key to mapping future trends for this cohort. At this time, it is apparent that BME staff in CCGs are significantly more likely to enter formal disciplinary process compared to white staff. Comparing BME with white staff in CCGs, half as many believe that they experience equal opportunities for career progression, and twice as many experience discrimination from a manager or other colleagues. For those CCGs who provided data, BME board membership stands at 16.1% (compared to 21% of the NHS workforce who identify as being from a BME background).

The data in this report is both a tool for improvement and a call to action. The insights contained here must be read and absorbed by all leaders in the system including HR Directprs, clinical leaders and boards and used to inform concrete policy interventions. Organisations are encouraged to work with the WRES resources and staff to help inform the adoption of local policies to reduce the existing disparities.



Introduction

The case for change has never been more profound and eradicating race inequality within the NHS workforce is, more explicitly than ever, a national priority. The NHS People Plan makes robust commitments on race equality, including an overhaul of recruitment practices, and specific targets to close representation and disciplinary gaps. But this is not an easy journey and will continue to require the committed and open-minded efforts of everyone in the system if we hope to make the NHS the employer its staff deserve.

Terminology

Throughout this report, we use the term "black and minority ethnic", expressed as the acronym BME, to refer to those members of the NHS workforce who are not white. This is largely driven by the data collection process. As set out in the WRES technical guidance, the definitions of "black and minority ethnic" and "white" used in the WRES have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and are as used in NHS Digital data. At the time of publication of this guidance, these definitions were based upon the 2001 ONS Census categories for ethnicity.

Methodology

The WRES requires NHS trusts and CCGs to self-assess against nine indicators of workplace experience and opportunity. Four indicators relate specifically to workforce data, four are based on data from the national NHS staff survey questions, and one considers black and minority ethnic (BME) representation on boards. Short definitions of the nine WRES indicators are presented in Annex A of this report. The detailed definition for each indicator can be found in the **WRES technical guidance**. The technical guidance also includes the definitions of "white" and "black and minority ethnic", as used throughout this report and within the narrative for the WRES indicators. This report presents data for all NHS trusts in England, against all nine WRES indicators, and where possible, makes comparisons to the 2016, 2017, 2018 and 2019 WRES data.

Data sources

WRES data for 2020 was collected through individual NHS trust and CCGs submissions via the NHS Digital Strategic Data Collection Service (SDCS). A return rate of 100% for trusts and 98% for CCGs was achieved. This report also includes workforce data from the NHS workforce statistics website. The NHS workforce statistics website data includes both CCGs and NHS trusts. This data is used because it is more robust and published on a regular basis. Using this data will make it possible to monitor changes more accurately. Unless otherwise stated, data was taken from the 2020 WRES SDCS submissions.

Data analyses

For the purpose of data analyses and presentation, organisations have been grouped by the new seven NHS geographical regions – East of England, London, Midlands, North East and Yorkshire, North West, South East and South West. Trend data analysis will be limited to 2017 data due to the better quality and reliable data starting that year.

For indicators 2, 3 and 4, statistical analyses included the "four-fifths" rule. The "four-fifths" ("4/5ths" or "80 percent") rule is used to highlight whether practices have an adverse impact on an identified group, e.g. a sub-group of gender or ethnicity. For example, if the relative likelihood of an outcome for one sub-group compared to another is less than 0.80 or higher than 1.25, then the process would be identified as having an adverse impact.

WRES indicator 1

Key supportive data

Table 3

Staff in NHS trusts and CCGs by ethnicity: 2016 – 2020

In 2020, the combined BME workforce in NHS trusts and CCGs was 21.0% (273,359). Across all NHS trusts and CCGs, there were 63,844 more BME staff in 2020 compared to 2016. Over the same period, the number of white staff increased by 43,656.

	Headcount			Percentage		
Year	White	BME	Unknown	White	BME	Unknown
2016	922436	209515	54105	77.8%	17.7%	4.6%
2017	928490	216644	52455	77.5%	18.1%	4.4%
2018	931704	230189	53780	76.6%	18.9%	4.4%
2019	943385	246301	58873	75.6%	19.7%	4.7%
2020	966092	273359	61119	74.3%	21.0%	4.7%

Data source: NHS workforce statistics website.

View more detailed data here

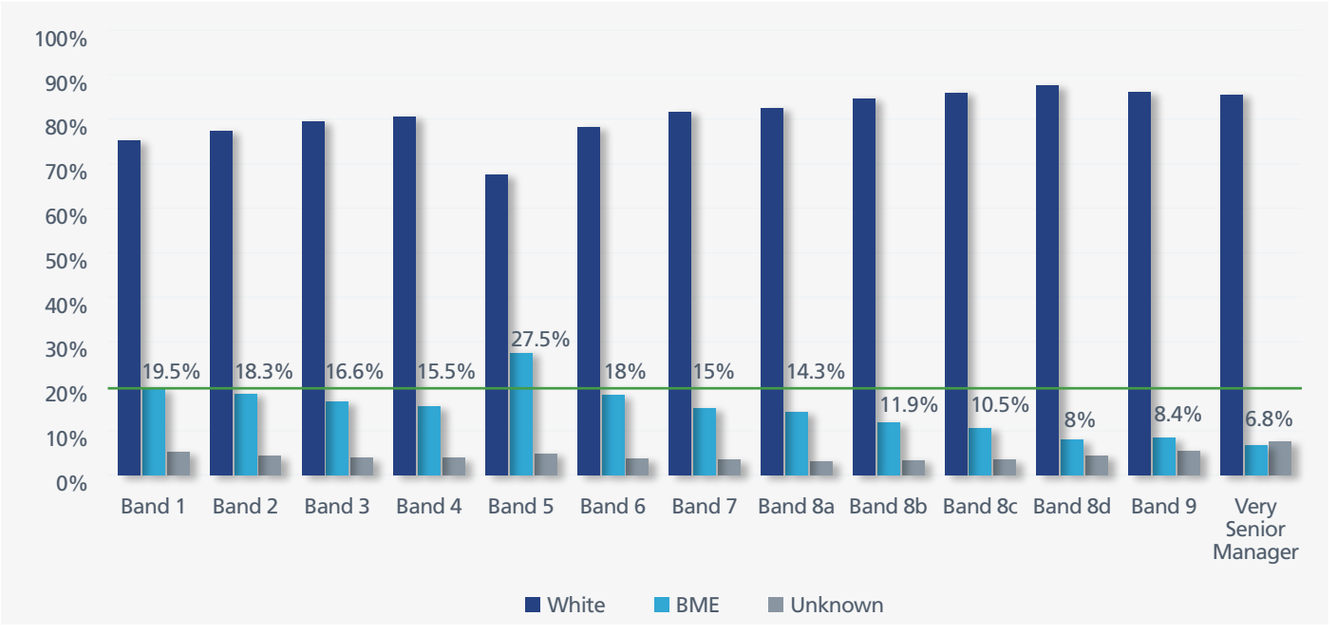
WRES indicator 1

Key supportive data

Figure 1

Percentage staff by AfC pay band and ethnicity for all NHS trusts and CCGs: 2020.

The green line represents the target of 19% representation at every pay band.



2020

21%

2019

19.7%

View more detailed data here

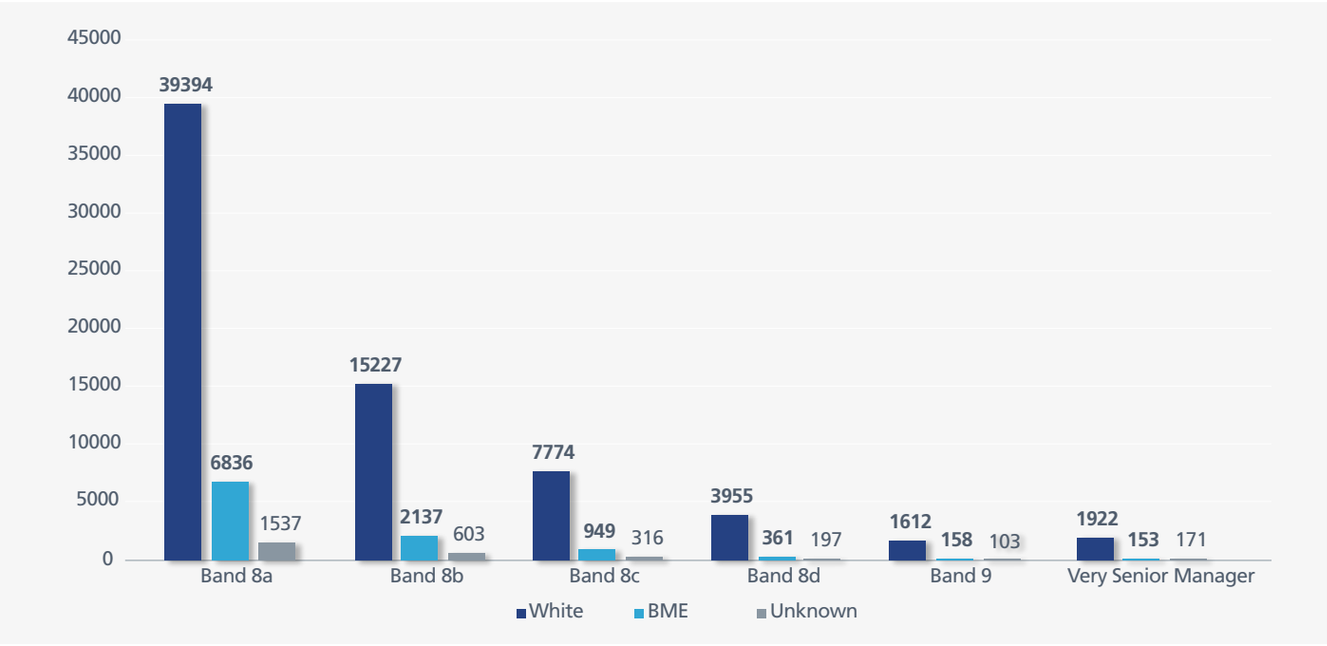
WRES indicator 1

Key supportive data

Figure 2

Number of staff by AfC pay bands (8a to VSM) and ethnicity for all NHS trusts and CCGs:

2020: 9.2% (1,621) of staff at AfC pay bands 8c and above are from a BME background. This is significantly lower than the 21.0% of all BME staff in NHS trusts and CCGs. NHS trusts and CCG organisations must do more to build the talent pipeline if they are to deliver the model employer ambitions.



View more detailed data here

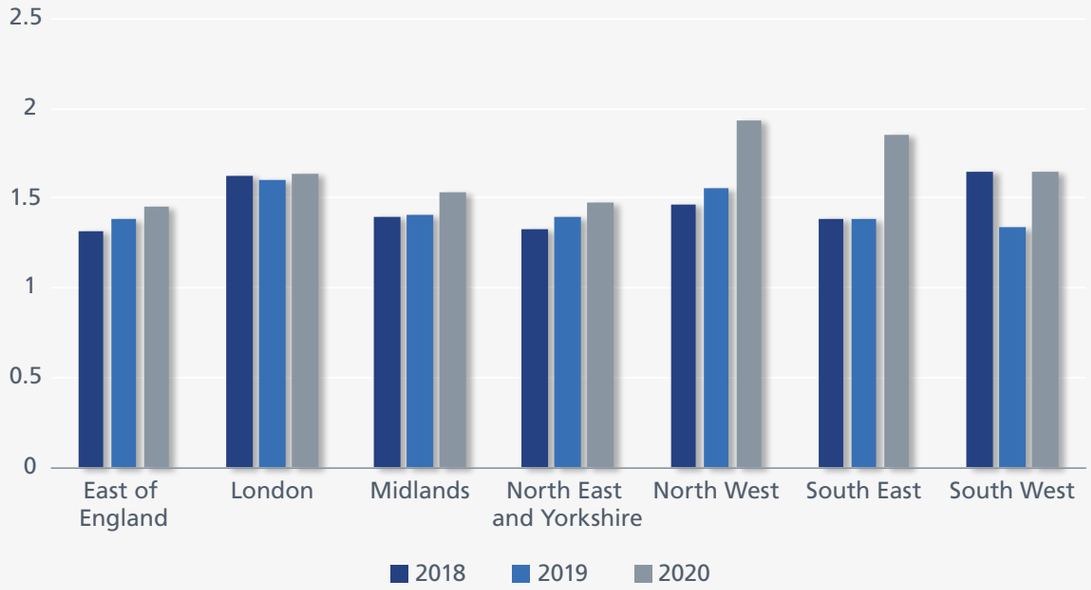
WRES indicator 2

Key supportive data

Figure 3

Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants by region: 2018 – 2020:

All regions have seen a deterioration for BME applicants, with the North West region being the worst performer, London had the smallest deterioration.



View more detailed data here

WRES indicator 3

Key supportive data

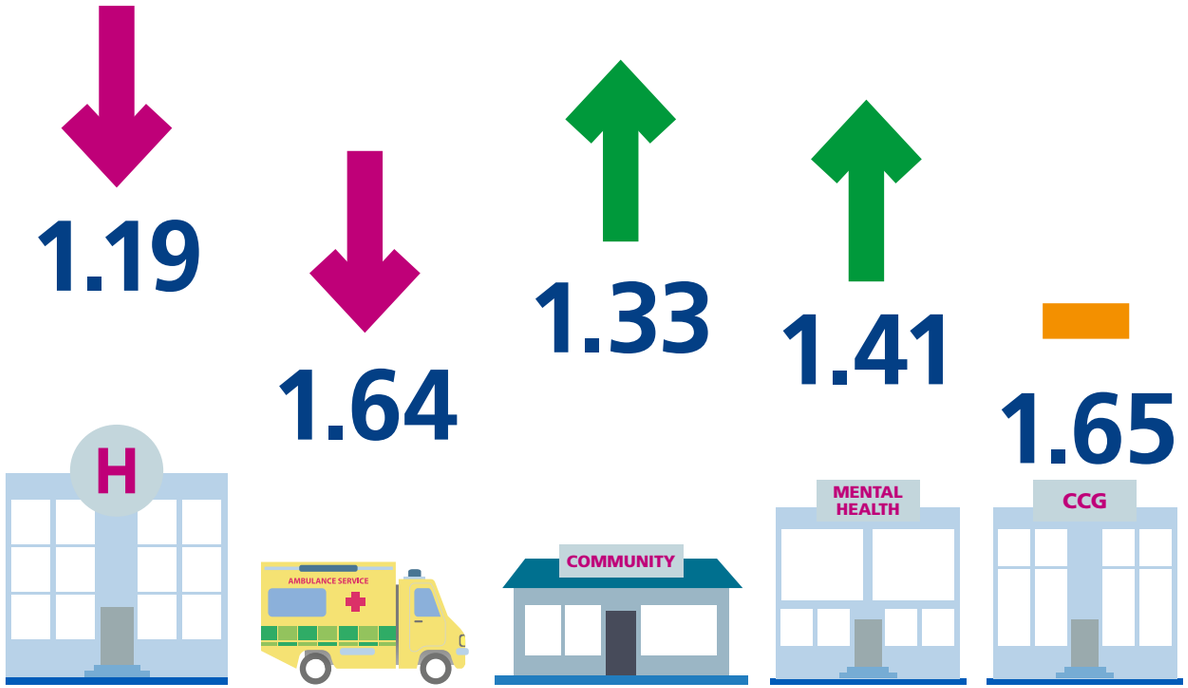
Table 4

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff by trust type: 2016 – 2020:

Acute trusts observed slight deterioration on this indicator in 2020 compared to 2019. Ambulance trusts had a significant deterioration from 1.39 in 2019, to 1.64 in 2020.

– For the CCGs that provided data for this indicator, BME staff were 1.65 times more likely to enter the formal disciplinary process compared to white staff.

Organisation type	2016	2017	2018	2019	2020
Acute	1.45	1.26	1.14	1.17	1.19
Ambulance	1.8	1.73	1.69	1.39	1.64
Community provider	2.48	3.35	2.7	1.5	1.33
Mental health	1.33	1.58	1.74	1.66	1.41
CCG					1.65



View more detailed data here

WRES indicator 4

Key supportive data

Table 5

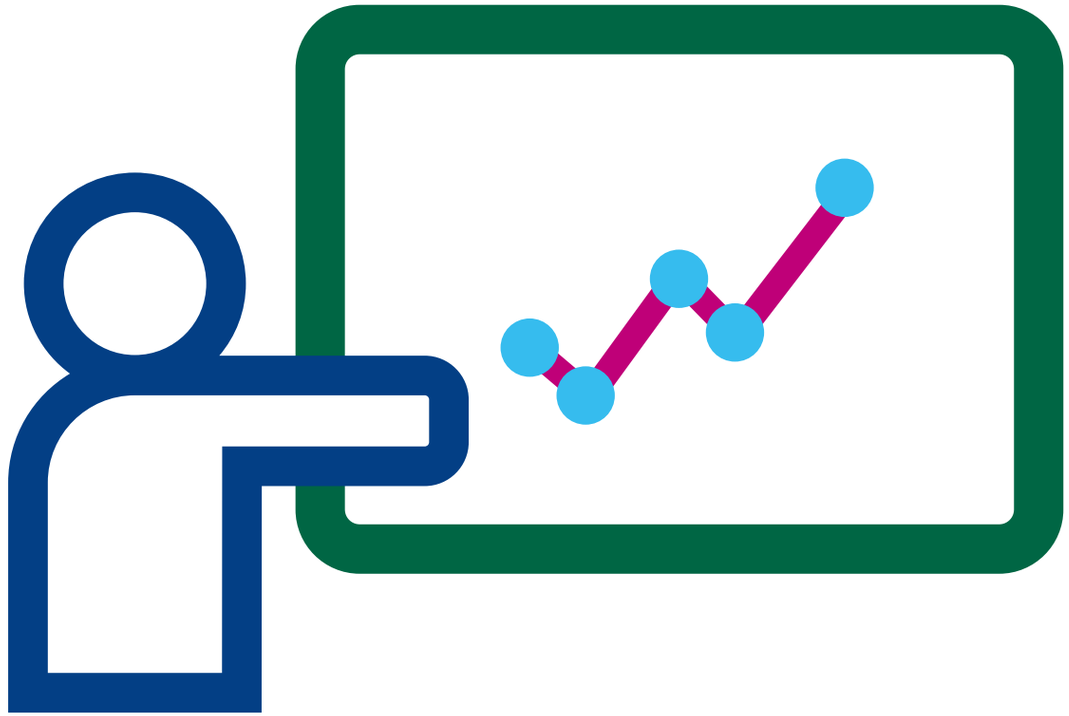
Relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff by region: 2019 – 2020:

For London, South East and South West regions, BME staff are relatively more likely to access non-mandatory training and CPD compared to white staff. For all regions the data now falls within the non-adverse range of 0.80 to 1.25, based on the four-fifths rule.

Trusts should consider how to use non-mandatory training and CPD to improve career progression and promotion for BME staff.

For CCGs that provided data for this indicator, BME staff were relatively more likely to access non-mandatory training and CPD compared to white staff.

Region	2019	2020
East of England	0.92	1.03
London	0.95	0.90
Midlands	1	1.11
North East and Yorkshire	1.05	1.04
North West	1.26	1.20
South East	0.99	0.96
South West	0.97	0.88



View more detailed data here

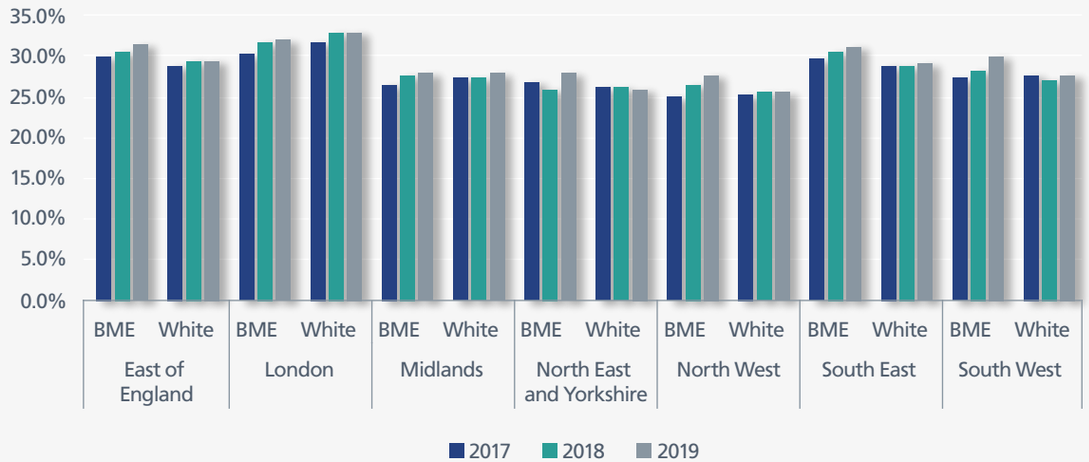
WRES indicator 5

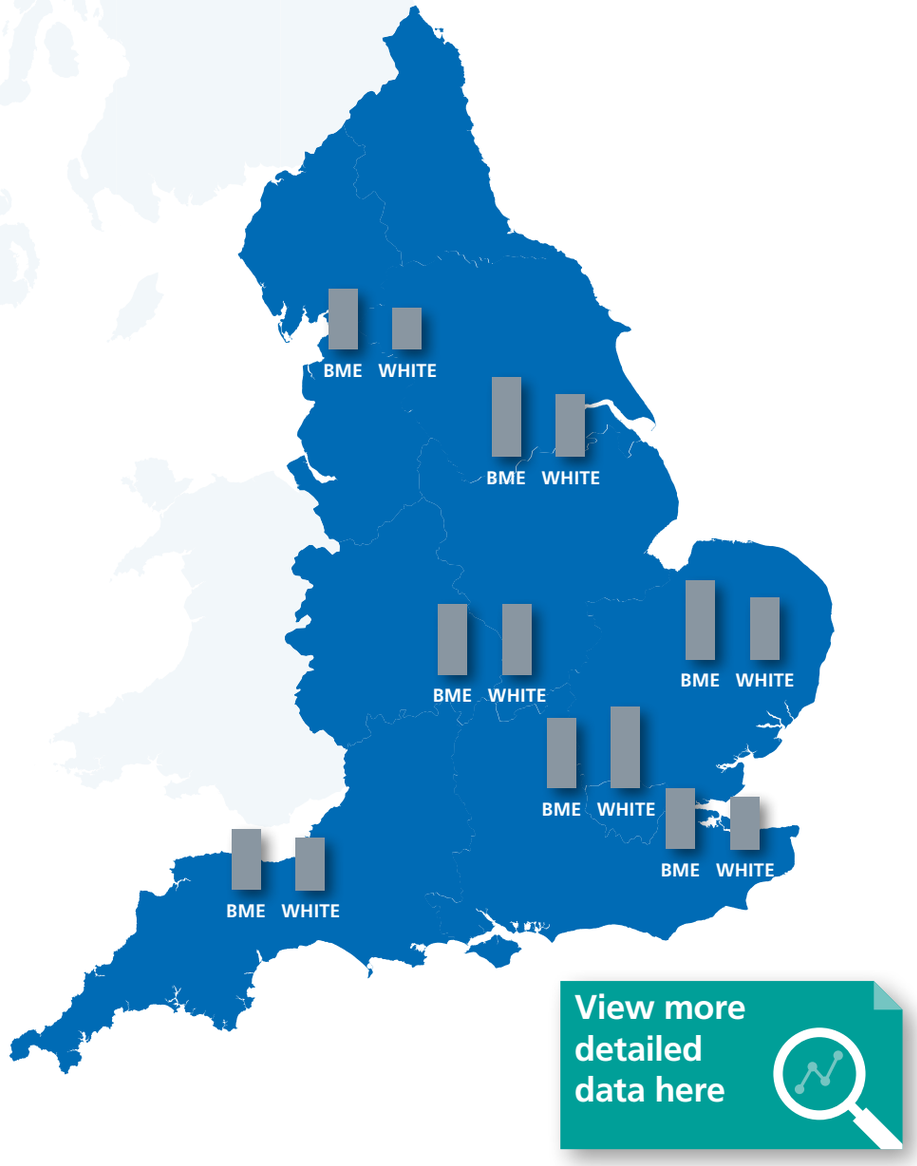
Key supportive data

Figure 4

Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months by region: 2017 – 2020

Across most of the regions, there has been an increase in the proportion of both BME and white staff who experienced harassment, bullying or abuse from patients, relatives or the public. With the exception of North East and Yorkshire, the same trend is seen for white staff. London has the highest percentages for this indicator, for both BME and white staff. For London, a higher percentage of white staff reported experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.





View more detailed data here

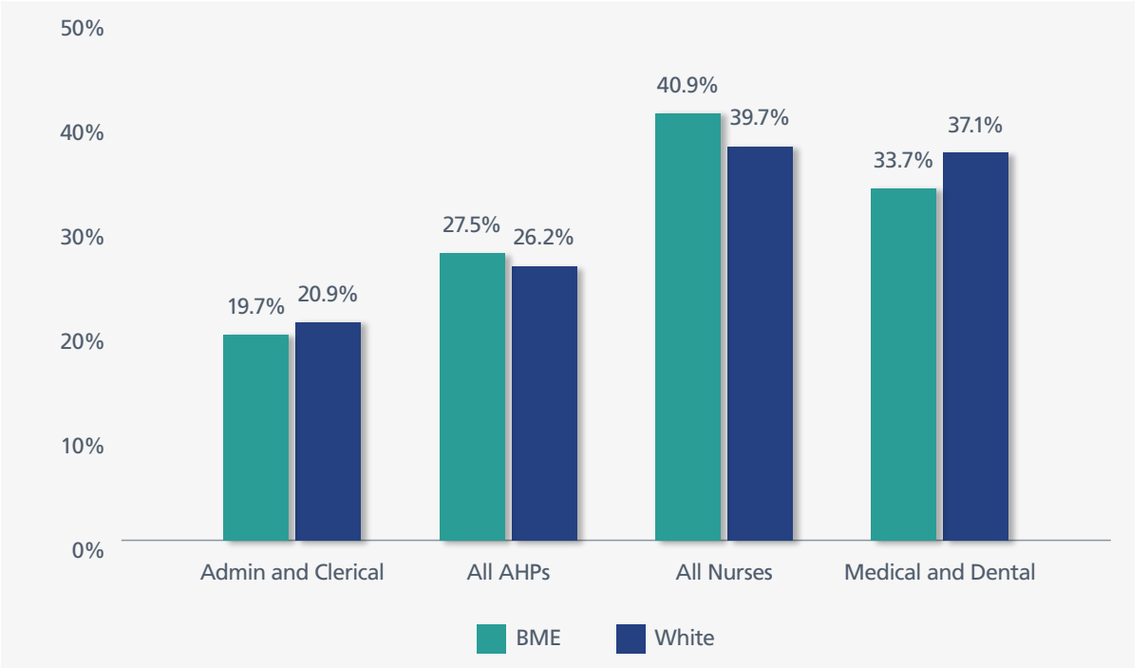
WRES indicator 5

Key supportive data

Figure 5

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months by staff group (2019)

BME nurses had the highest proportion of staff that experienced harassment, bullying or abuse from patients, relatives or the public. BME staff working in administration and clerical roles had the lowest proportion.



View more detailed data here

WRES indicator 6

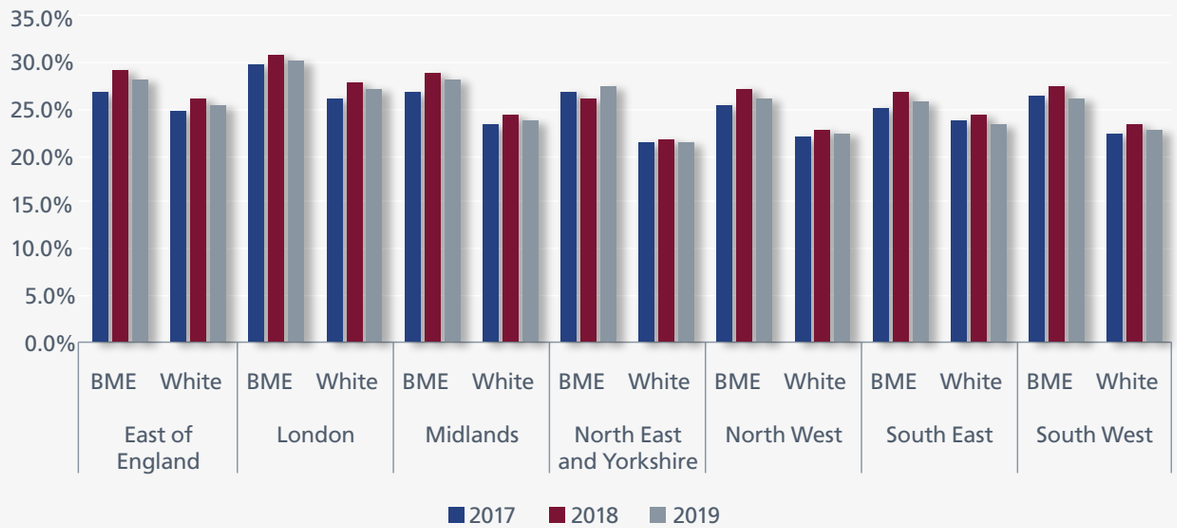
Key supportive data

For 82.7% of trusts, a higher proportion of BME staff compared to white staff experienced harassment, bullying or abuse from colleagues in the last 12 months.

Figure 6

Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months: 2017 – 2019

Across all regions except North East and Yorkshire, the proportion of BME and white who experienced harassment, bullying or abuse from staff decreased. The North East and Yorkshire region had the biggest percentage point difference (6%) between BME and white staff experiencing harassment, bullying or abuse from staff in the last 12 months.



View more detailed data here

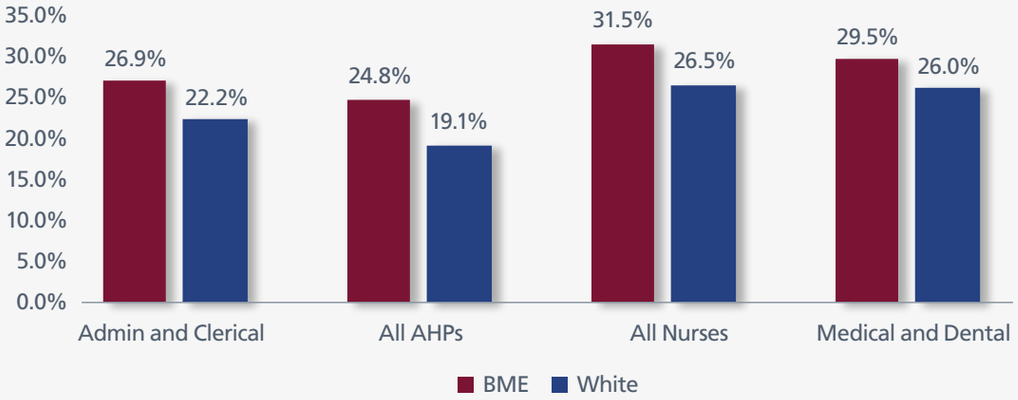
WRES indicator 6

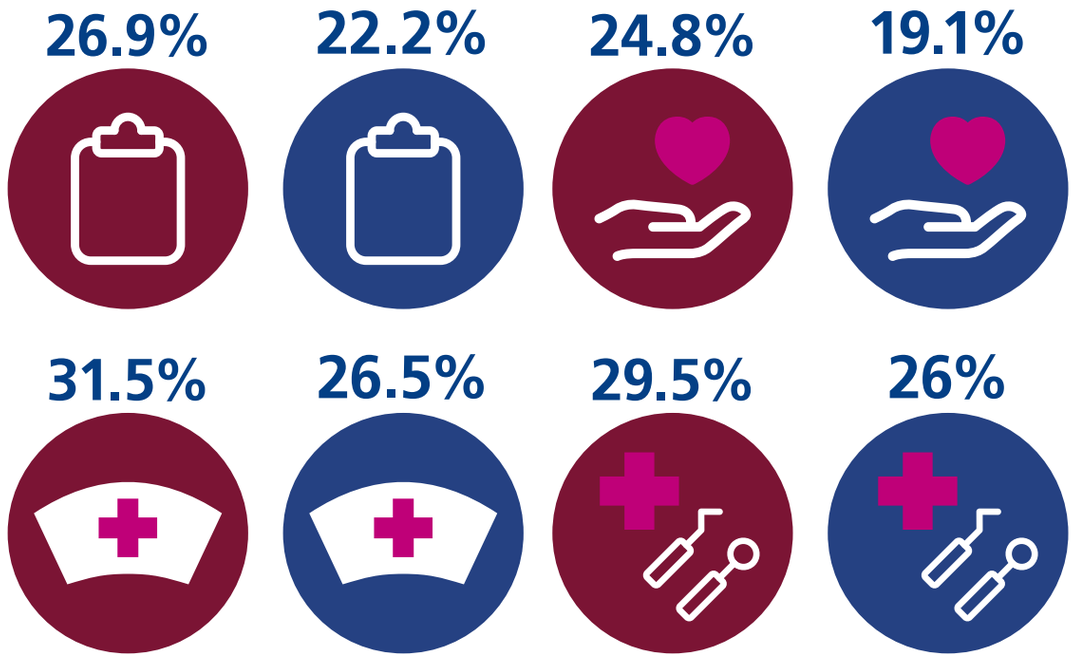
Key supportive data

Figure 7

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months by ethnicity by staff group (2019):

BME staff in nursing roles and in medical and dental roles reported the highest levels of harassment, bullying or abuse from staff.





View more detailed data here

WRES indicator 7

Key supportive data

Table 6

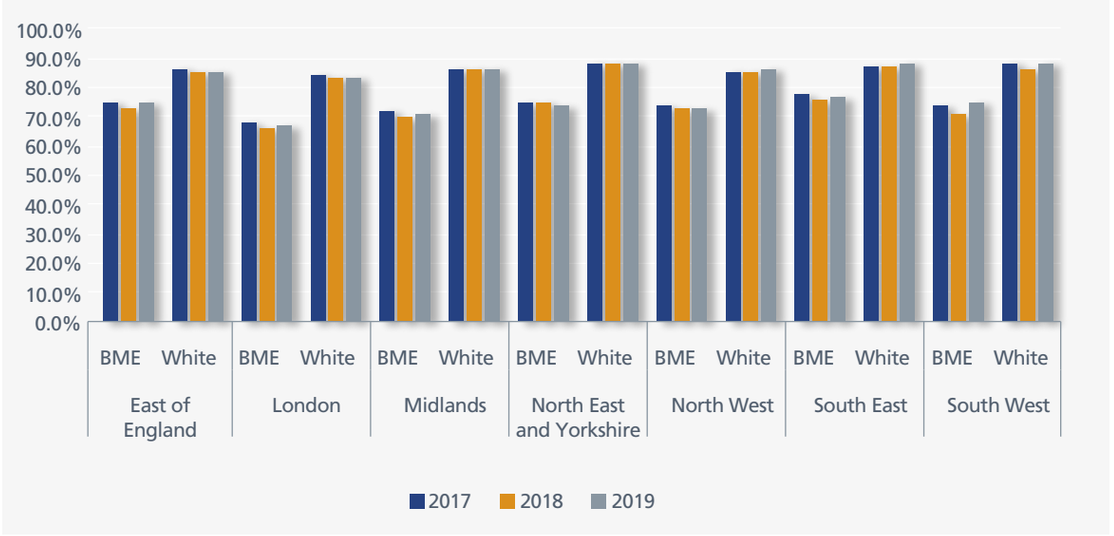
Percentage of staff believing that their trust provides equal opportunities for career progression or promotion: 2015 – 2019:

The proportion of BME and white staff that believed their trust provides equal opportunities for career progression or promotion increased slightly in 2019 compared to 2018.

	2015	2016	2017	2018	2019
BME	73.4%	73.2%	71.9%	69.9%	71.2%
White	88.3%	87.8%	86.8%	86.3%	86.9%

Figure 8

Percentage of BME staff believing that their trust provides equal opportunities for career progression or promotion by region: 2017 – 2019



View more detailed data here

WRES indicator 8

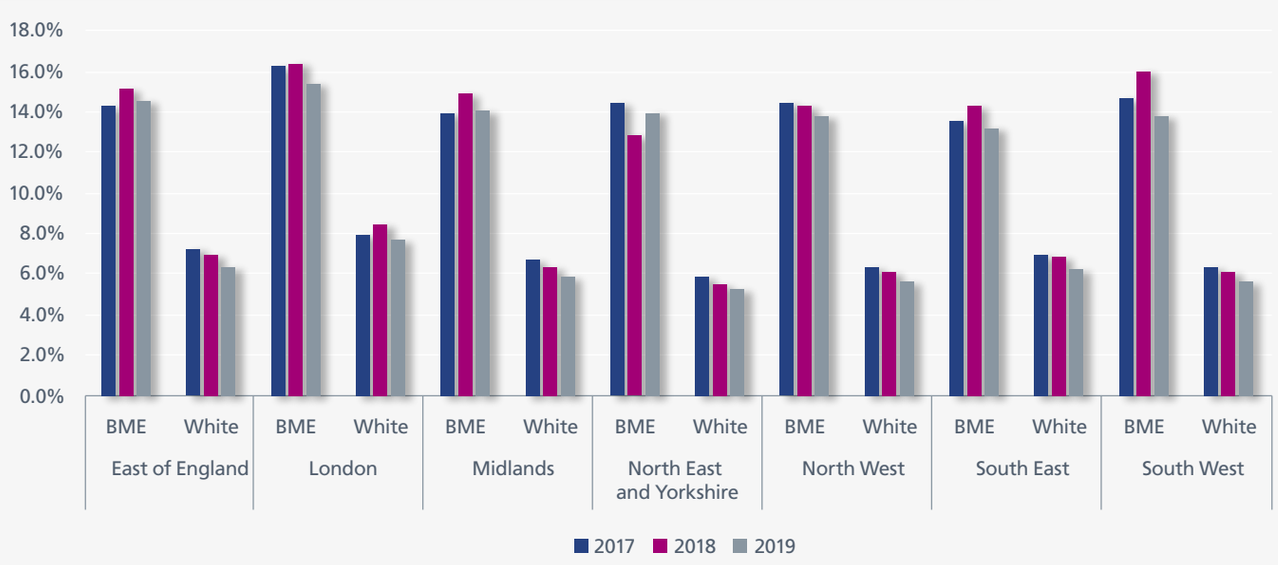
Key supportive data

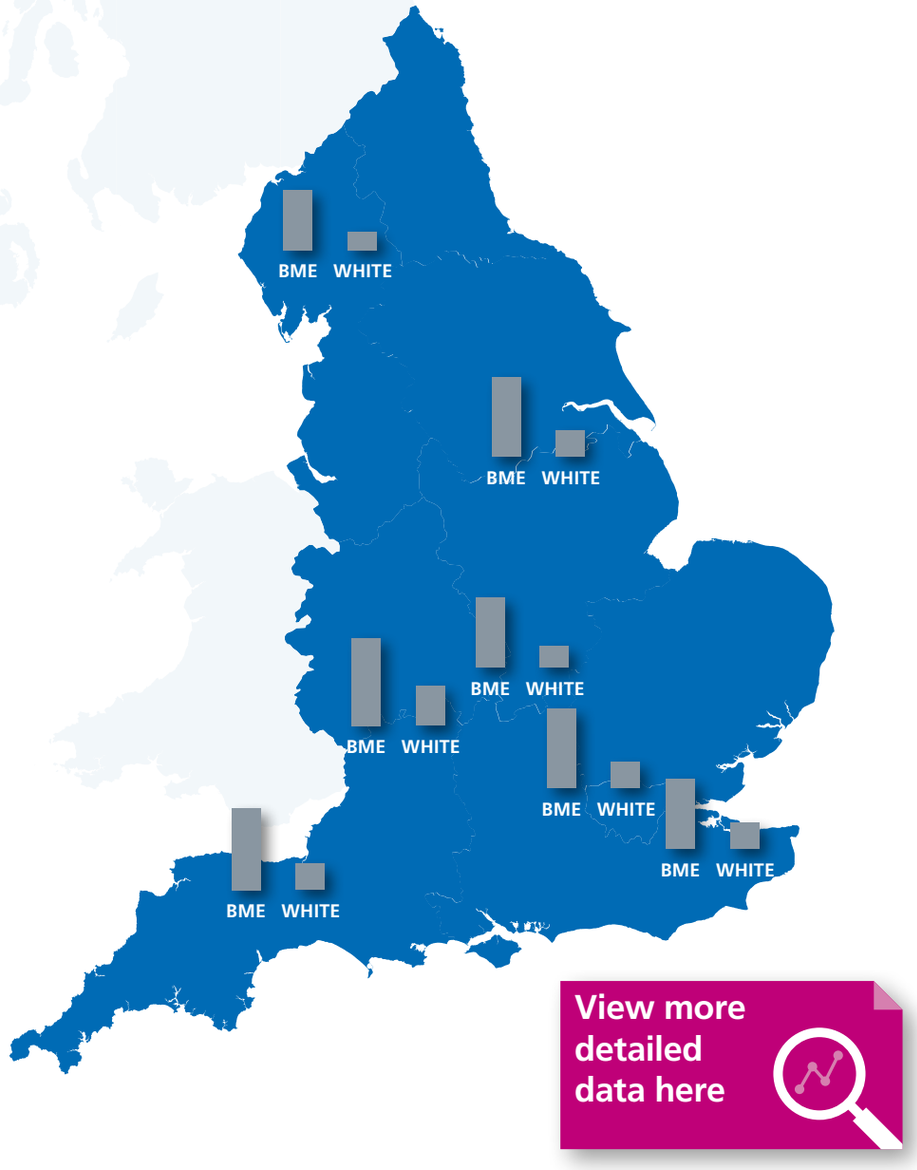
Figure 9

Percentage of BME staff that personally experienced discrimination at work from a manager, team leader or other colleagues by region: 2017 – 2019:

As a region, London had the highest percentage of BME staff and white staff that had experienced discrimination at work from a manager, team leader or other colleagues.

10.2% of BME staff and 4.4% of white staff in CCGs personally experienced discrimination at work from a manager, team leader or other colleagues.





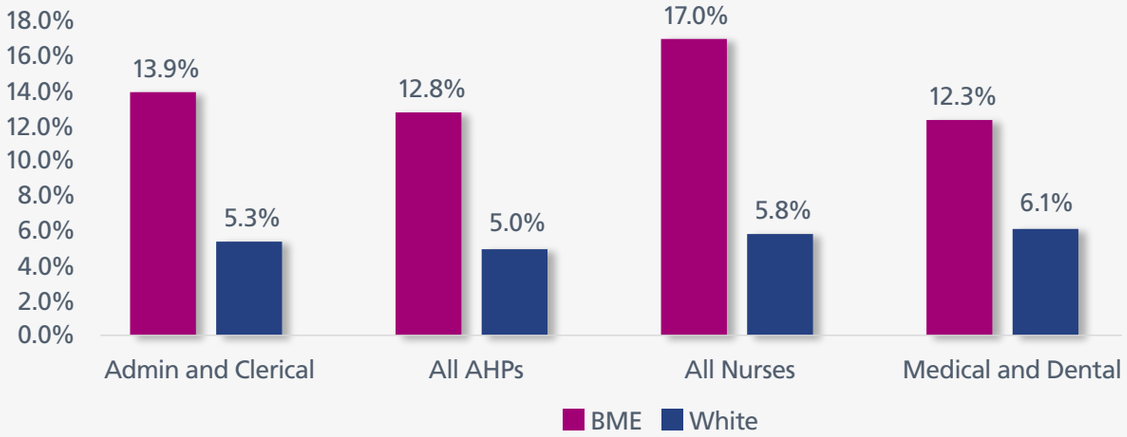
WRES indicator 8

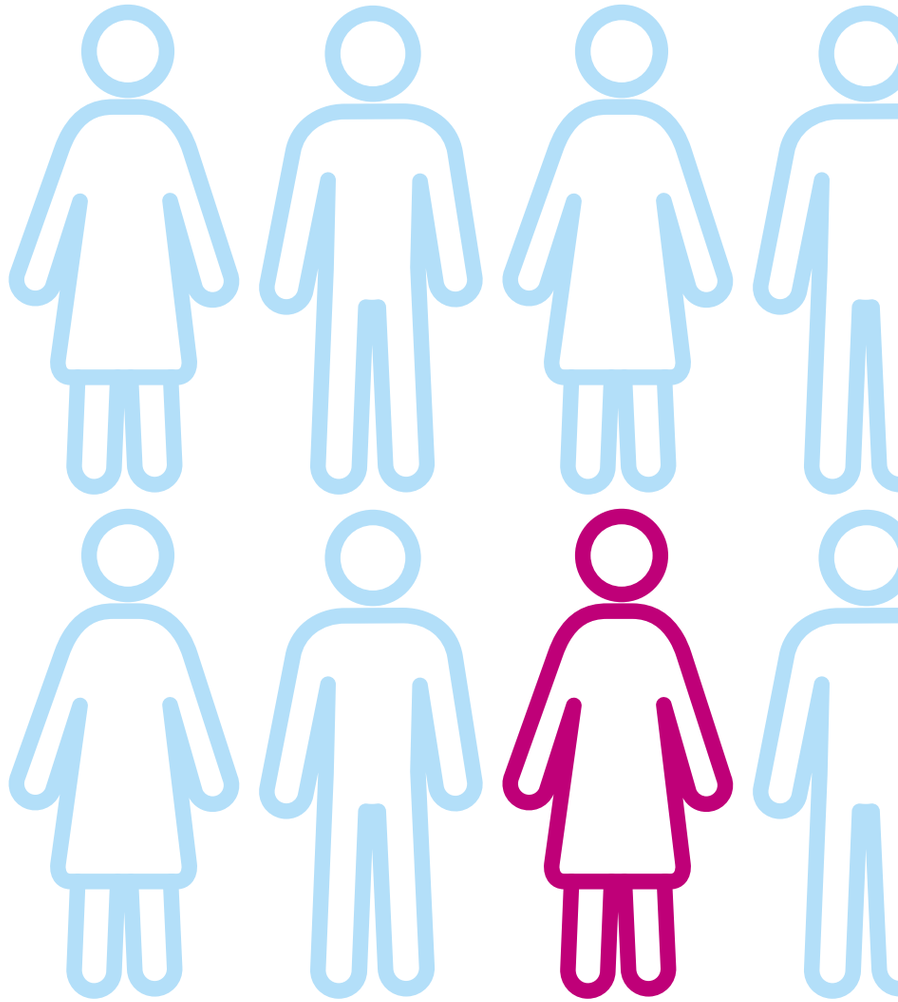
Key supportive data

Figure 10

Percentage of staff who experienced discriminations at work from – a manager team leader or other colleagues by staff group (2019)

BME nurses had the highest proportion of staff that experienced discrimination at work from a manager, team leader or other colleagues.





View more detailed data here

WRES indicator 9

Key supportive data

Table 7

Percentage of board members by ethnicity compared to BME workforce within NHS trusts by region (2020)

In all regions, there is a lower proportion of BME people on boards compared to proportion of BME staff.

Region	White	BME	Unknown	BME staff
East of England	89.4%	5.8%	4.8%	22.3%
London	74.9%	19.6%	5.4%	46.6%
Midlands	84.2%	11.2%	4.6%	20.4%
North East and Yorkshire	89.1%	6.0%	4.9%	11.3%
North West	88.2%	8.4%	3.4%	12.2%
South East	81.0%	10.6%	8.4%	20.6%
South West	91.0%	3.9%	5.1%	12.0%

Table 8

Percentage (number) of BME board members across NHS trusts: 2016 – 2020

There has been a decrease in the number and proportion of trusts with zero BME representation on the board. There were 22 trusts with four or more BME board members, compared to seven trusts in 2016.

	2016	2018	2019	2020
0 BME board members	43.5% (84)	41.6% (96)	32.2% (73)	23.4% (52)
1 BME board member	37.3% (72)	33.3% (77)	34.8% (79)	39.2% (87)
2 BME board members	10.9% (21)	12.6% (29)	19.8% (45)	16.7% (37)
3 BME board members	4.7% (9)	8.2% (19)	9.7% (22)	10.8% (24)
4 BME board members	2.6% (5)	2.6% (6)	2.2% (5)	5.4% (12)
5 BME board members	1.0% (2)	1.3% (3)	0.4% (1)	4.1% (9)
More than 5 BME board members	0.0% (0)	0.4% (1)	0.8% (2)	0.5% (1)

View more detailed data here

WRES indicator 9

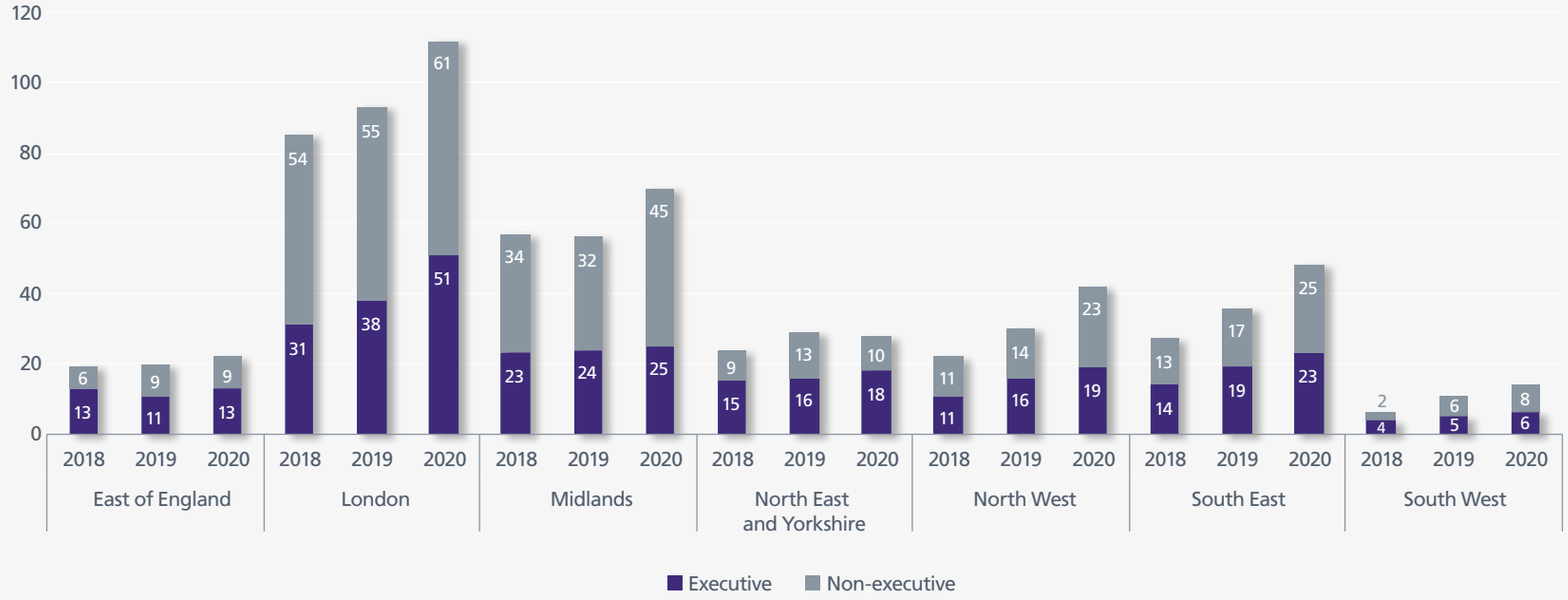
Key supportive data

Figure 11

Numbers of BME board members by region: 2018 – 2020

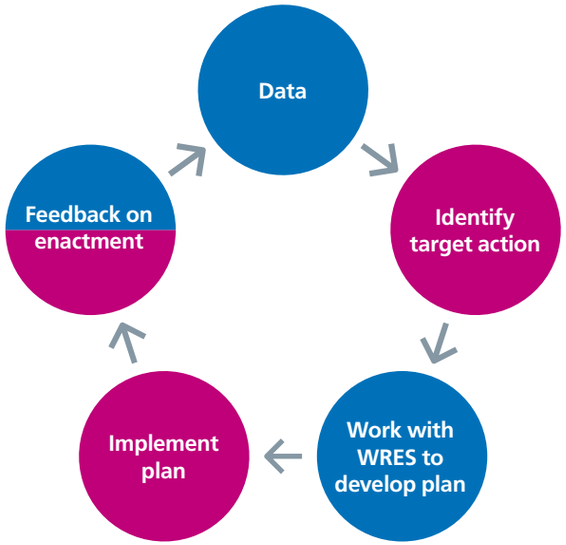
There was a total of 61 more BME board members across all NHS trust in 2020 compared to 2019. This represents a 22.3% increase in the gross number of BME representation at boards across England. All regions saw an increase in the overall number of BME board members.

The number of executive board members across NHS trusts increased by 26 in 2020, compared to 2019. London had the biggest increase over that period, with 13 more BME executive board members. There has been an increase of 35 non-executive board members across all NHS trusts in England.



Conclusion and next steps

This report contains some evidence of modest improvement, and that is testament to the work done both nationally and locally to de-bias recruitment and disciplinary systems; to increase senior representation; and to increase the numbers of BME staff accessing non-mandatory training and CPD. It is, however, still not enough.



Now is the time to translate the data to actions. In light of the disproportionate impact of COVID-19 on BME people, not least in our workforce, there is no time to waste in eliminating inequity and discrimination in our workplaces. The pandemic did not create race inequality, but it has thrown it into sharp relief. For those who follow the data and have been reading the WRES reports for the last five years, the unequal distribution of suffering between white and BME people will come as no surprise.

The plan of work (please see diagram left) for the WRES is to pivot significantly towards actions that begin to reverse these widespread racial disparities. Programmes like WRES operate nationally, but change needs to be made locally. The vision is that WRES (blue circles) will support organisations (pink) to understand their data and then to work with them through the regional networks to develop robust action plans in each organisation.

These plans will be based on the commitments in the People Plan and organisations will work with the WRES team resources to identify both the plan and the appropriate monitoring metrics. This will then be implemented and the learning from this process will be shared with the WRES team. The subsequent annual data gathering will identify how successful the actions have been in addressing the intended targets, and the cycle restarts. The plans developed will be held as a repository by WRES for future adoption and adaptation as necessary for other organisations with similar problems. WRES will thus become a vibrant library both of data and of actions to help move the dial of long-standing racial inequality.

Areas for action mapped to WRES indicators

Indicator	Actions
Percentage of staff in each of the Agenda for Change (AfC) Bands 1–9 and VSM (including executive board members) compared with the percentage of staff in the overall workforce	• Increase BME representation at AFC band 8 level and above. • Address the wide variation in BME under-representation according to region and trust type implementing tailored solutions to local population and workforce.
Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants	• Development of BME talent in the employment pipeline. • Overhauling recruitment practices to ensure the workforce reflects the diversity of their community, and to do this at pace and scale.
Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	• Understanding the reasons for the reduction of disciplinary proceedings. • Eliminating the ethnicity gap in formal disciplinary processes is a vital required action of the People Plan and studying the organisations which have made the most headway and developing summaries of what has proved most effective. • Reporting on the outcomes of disciplinary action, stratified by race.
Relative likelihood of white staff accessing non–mandatory training and continuous professional development (CPD) compared to BME staff	• Understanding the reasons for the improvement in training and identifying what has proved effective in successful organisations. • Understanding why there remains a disparity in career progression and promotion for BME staff despite this improvement in training access.
Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	• Report on strategies to target the increasing abuse of frontline staff in line with Assaults on Emergency Workers (Offences) Act 2018.
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	• Development of a written policy on reporting, dealing with bullying and harassment at work and communicating the policy and procedure to staff (as per the RCN Bullying and Harassment Advice Guide). • Development of civility and respect toolkit as per the People Plan.
Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	• Ensuring transparency and positive action as per the People Plan, which emphasises the importance of staff feeling a sense of belonging to their organisation • Working towards the The Model Employer Framework (2019).
In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleagues	• Trusts need to be proactive and preventative in tackling discrimination rather than responding to individual concerns or grievances. • The People Plan emphasises the need for organisation to develop system-level models of recruitment and retention, accordingly there should be focus on how to improve the way appraisals, feedback from interviews and performance assessments are undertaken. • Increasing training programme for freedom to speak up guardians on the topic of workplace race equality as per People Plan.
Percentage difference between the organisation's board voting membership and its overall workforce	• As set out in the 'NHS provider board membership and diversity survey: findings', improving leadership diversity is a significant priority for NHS Improvement and should be for every NHS board. • Working towards the percentage of BME board membership to match the proportion of BME staff in the workforce has been set.

Best performing organisations by WRES indicator

Indicator 5

- Airedale NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Hertfordshire Community NHS Trust
- Kent Community Health NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Liverpool Women's NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- Sheffield Children's NHS Foundation Trust
- Tavistock and Portman NHS Foundation Trust
- The Christie NHS Foundation Trust
- The Royal Marsden NHS Foundation Trust
- The Royal Orthopaedic Hospital NHS Foundation Trust

Indicator 6

- Cambridgeshire Community Services NHS Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Hounslow and Richmond Community Healthcare NHS Trust
- Leeds and York Partnership NHS Foundation Trust
- Luton and Dunstable University Hospital NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Royal Berkshire NHS Foundation Trust
- Solent NHS Trust
- South Central Ambulance Service NHS Foundation Trust
- South Warwickshire NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

Indicator 7

- Chesterfield Royal Hospital NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Devon Partnership NHS Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Dorset County Hospital NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- The Christie NHS Foundation Trust
- West Suffolk NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

Indicator 8

- Cambridgeshire Community Services NHS Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- Hertfordshire Community NHS Trust
- Liverpool Women's NHS Foundation Trust
- North West Boroughs Healthcare NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- South Warwickshire NHS Foundation Trust
- Surrey and Borders Partnership NHS Foundation Trust
- The Christie NHS Foundation Trust

Indicator 9

- Barnet, Enfield And Haringey Mental Health NHS Trust
- Coventry And Warwickshire Partnership NHS Trust
- East London NHS Foundation Trust
- Kent And Medway NHS And Social Care Partnership Trust
- Kingston Hospital NHS Foundation Trust
- London Ambulance Service NHS Trust
- North Middlesex University Hospital NHS Trust
- Oxleas NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Trust
- South West London And St George's Mental Health NHS Trust

Least well performing organisations by WRES indicator

Indicator 2

- Brighton And Sussex University Hospitals Nhs Trust
- Countess of Chester Hospital NHS Foundation Trust
- Cumbria, Northumberland, Tyne And Wear NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- East Midlands Ambulance Service NHS Trust
- Gateshead Health NHS Foundation Trust
- Liverpool University Hospitals NHS Foundation Trust
- The Christie NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust

Indicator 3

- Avon And Wiltshire Mental Health Partnership NHS Trust
- Devon Partnership NHS Trust
- Hounslow And Richmond Community Healthcare NHS Trust
- Kettering General Hospital NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- South London and Maudsley NHS Foundation Trust
- Southern Health NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Warrington and Halton Teaching Hospitals NHS Foundation Trust
- Wirral Community Health and Care NHS Foundation Trust

Indicator 5

- Avon and Wiltshire Mental Health Partnership NHS Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Greater Manchester Mental Health NHS Foundation Trust
- James Paget University Hospitals NHS Foundation Trust
- Kent and Medway NHS and Social Care Partnership Trust
- Lincolnshire Partnership NHS Foundation Trust
- London Ambulance Service NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- South Central Ambulance Service NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Sussex Partnership NHS Foundation Trust

Indicator 6

- Dorset County Hospital NHS Foundation Trust
- East Kent Hospitals University NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- North Cumbria University Hospitals NHS Trust
- Northampton General Hospital NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Royal Devon and Exeter NHS Foundation Trust
- The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- The Shrewsbury and Telford Hospital NHS Trust
- United Lincolnshire Hospitals NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Walsall Healthcare NHS Trust

Indicator 7

- Birmingham Community Healthcare NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- London Ambulance Service NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Northampton General Hospital NHS Trust
- Royal Papworth Hospital NHS Foundation Trust
- South East Coast Ambulance Service NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- Tavistock and Portman NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust

Indicator 8

- Bolton NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- North Cumbria University Hospitals NHS Trust
- Northampton General Hospital NHS Trust
- Northern Devon Healthcare NHS Trust
- Royal Papworth Hospital NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Walsall Healthcare NHS Trust
- Yorkshire Ambulance Service NHS Trust

Annex A: The WRES indicators (2020)

	Workforce indicators For each of the four workforce indicators, ***compare the data for white and BME staff***
1	Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-clinical staff • Clinical staff, of which – Non-medical staff – Medical and dental staff *Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.*
2	Relative likelihood of staff being appointed from shortlisting across all posts *Note: This refers to both external and internal posts*
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation *Note: This indicator will be based on data from a two-year rolling average of the current year and the previous year.*
4	Relative likelihood of staff accessing non-mandatory training and CPD
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, ***compare the outcomes of the responses for white and BME staff***
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Board representation indicator For this indicator, ***compare the difference for white and BME staff***
9	Percentage difference between the organisation's board membership and its overall workforce disaggregated: • By voting membership of the board • By executive membership of the board