Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of Directors

Report

Subject: **Workforce Race Equality Standard (WRES)**
Date: **18th June 2015**
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Executive Summary
The NHS Equality and Diversity Council consulted in 2014/15 on nine standards to improve workforce equality issues across the NHS. As from 1st April 2015 the Workforce Race Equality Standards (WRES) became mandatory. These standards are now included in the NHS Standard Contract and all NHS organisations are required to demonstrate progress against nine indicators; four workforce data metrics, four staff survey findings regarding White and BME experiences, and one Board metric to address low levels of BME representation (see Appendix A attached).

Drivers for WRES implementation
The research Snowy White Peaks by Roger Kline (2013) showed:
1) Unfair treatment of BME staff adversely affects the care and treatment of patients
2) Talent is being wasted through unfairness in the appointment, treatment and development of a large section of the NHS workforce
3) Precious staff resources are being wasted through the impact of such treatment on morale and discretionary effort
4) Diverse teams and leaderships are more likely to show the innovation and increased organisational effectiveness the NHS needs.
5) Organisations whose leadership composition bears little relationship to the communities they serve will be less likely to deliver the patient focussed care that is needed.

Nationally there has been a decrease in the proportion of BME Board members, Senior Managers and Nurse Managers in recent years; there are less BME Leaders and Managers in 2013 than in 2003 (Kline 2015). Statistically White staff are 1.74 times more likely to be appointed once shortlisted than BME staff (Kline, 2013); BME staff are twice as likely to enter formal disciplinary processes and be disciplined for similar offences than white staff (Archibong et al, 2010); black nurses take 50% longer to be promoted and are less likely to access national training programmes (NHSLA); BME staff experiences correlate to the staff survey results on bullying, career progression, promotion and discrimination. In 2014 Francis found BME Whistle-blowers are treated less favourably than white whistle-blowers.

The 2004 Race Equality Action Plan failed; it was voluntary and had no measurable outcomes. Improving race equality is part of and can trigger a wider change in culture and benefit patient care.
WRES should dovetail with the Trust's Equality Strategy and complement the Equality Delivery System2 (EDS2).

Process and timescale for implementation
1st April 2015 - WRES mandatory; trusts to undertake baseline data against 9 indicators, going back 3 years to identify trends.
1st July 2015 - Deadline for publishing baseline data, thereafter data and actions will be published annually.
1st April 2016 - CQC will formally inspect on progress against the standard under the Well-Led domain.

Action Required

1) Trust Boards need to lead WRES implementation; to lead to culture change and benefit patient care.
2) Any plan of action must have Board ownership.
3) Board sponsors will be held to account by the CQC.
4) The organisation need to undertake workforce base line data, to then understand what that data and the staff survey is telling us.
5) The Trust need to be open about shortcomings and publicise good news. We can learn from within the organisation and best practice elsewhere.
6) We must provide evidence of implementing WRES to the CCG.
7) The Trade Unions need to engage.
8) Staff need to be listened to especially BME staff, in a safe place; it is essential their voice is heard.
9) Be open, transparent and engage with staff.
10) We need to identify any specific challenges.
11) WRES should dovetail with the Trust's Equality Strategy which includes EDS2.

Once the baseline information has been collated, an action plan will be developed and presented to the Trust Board in October 2015.

Recommendation

The Board are asked to:

1) Provide a Trust Board sponsor
2) All Board members commitment to lead WRES
3) To listen to staff in a safe place, especially BME staff
4) Accept the responsibility of being held to account by the CCG

Relevant Strategic Priorities (please mark in bold)	
To consistently deliver a high quality patient experience safely and effectively	To develop extended clinical networks that benefit the patients we serve
To eliminate the variability of access to and outcomes from our acute services	To provide efficient and cost-effective services and deliver better value healthcare
To reduce demand on hospital services and deliver care closer to home	

How has organisational learning been disseminated	
Links to the BAF and Corporate Risk Register	
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	Failure to achieve CQC well-led domain Failure to meet NHS Standard Contract
Links to NHS Constitution	
Financial Implications/Impact	Enhanced engagement resulting in improved productivity
Legal Implications/Impact	Possible discrimination claims
Partnership working & Public Engagement Implications/Impact	Implementation requires Trade Union engagement and Partnership Working

Committees/groups where this item has been presented before	- Organisational Development and Workforce Committee - Diversity and Inclusivity Committee - HR Operational Meeting
Monitoring and Review	
Is a QIA required/been completed? If yes provide brief details	