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An independent appraisal of the NHS Workforce Race Equality Standard

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Introduction

The NHS seeks to monitor and control diversity and equality through a programme known as the Workforce Race Equality Standard (WRES). This is based on a series of statistical indicators pertaining to outcomes between white and non-white minority groups. However, close inspection of them reveals they do not withstand methodological scrutiny. The implication of this is that the NHS creates a rod for its own back, while misdirecting resources and talent away from where they are best needed and served. WRES is the creation of a cohort of ideologically-minded individuals who benefit from the programme, while the costs are left to patients and the taxpayer. Ultimately, this means money is wasted and not spent on improving health.

Background

There are nine indicators which are summarised in the table below, along with their scores for the last five years, this being the full range of available data.

NHS commissioners and healthcare providers have been contractually obliged to implement WRES since 2015, as have independent healthcare providers and contractors wishing to do business with the NHS, from 2017. This is important in that bureaucratic costs are imposed on both state and private sectors.

According to its stated aims,

> *'NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation'.*[1]

Bespoke targets are to be set against which progress is measured. Failure to comply will result in '…whether regulators judge them to be "well led".'[2]

The most recent WRES report offers some positive findings:

- The share of very senior management in NHS trusts has risen from 5.4 per cent to 6.8 per cent, since 2016;
- The share of trust board members has risen from seven to 10 per cent since 2017;

[1] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/

[2] https://www.candi.nhs.uk/sites/default/files/Documents/Board%20papers/3.2%20Workforce%20race%20equalty%20standard_0.pdf

- The relative likelihood of BME staff entering the disciplinary process is at a five-year low;
- 'the relative likelihood of BME staff accessing non-mandatory training is at the lowest level since this data collection began'.

That last claim does not appear to be true, judging by the table below. Furthermore, **eight out of nine indicators show no signs of meaningful change or improvement**, once you allow for growth in the minority share of workforce overall, when judging presence at the very top (WRES 1, 9). It is however not true to say that five years' worth of data are sufficient to 'take a long-term view of race equality'.[3] Five years is not long-term; we know nothing of what happened 10 or 20 years before, necessary to properly ground our judgement of change.

It is claimed, 'Although we have made much progress… we still have a long way to go'. This is one of the clichés of the genre, along with talk of 'shining spotlights', 'shifting the dial', and 'holding up a mirror'.[4]

[3] https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race-Equality-Standard-2020-report.pdf
[4] *Ibid.*

Table 1: WRES indicators – across all NHS trusts

	Indicator		2016	2017	2018	2019	2020
1	Comparison of percentage of BME staff at very senior management compared to overall	Overall	17.7%	18.1%	18.9%	19.7%	21.0%
		Very senior management	5.4%	5.3%	5.8%	6.5%	6.8%
2	Relative likelihood of white applicants being appointed from shortlists 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 the 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 the 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 manger/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%

Source: NHS WRES.

Official documentation reveals the purpose of WRES:

> *'It is intended that the metrics would encourage or oblige organisations to conduct root cause analyses as to the causes of the inequality that exists with the intention of driving change, rather than just compliance with the metrics. In so doing organisations would draw on best practice around the NHS and beyond.'* [5]

Once the data are published, healthcare providers are expected to draw up plans to bring about equality of outcomes based on input from the WRES team. Its latest report, however, reveals WRES has no clear idea of what will work, *ex ante*; instead, it is intended that WRES will learn through trial and error, so that it will 'become a vibrant library both of data and of actions to help move the dial of long-standing racial inequality'.[6]

Importantly, the NHS feels obliged to enact this programme under the 'Public Sector Equality Duty' of the Equality Act 2010.[7] Many diversity and inclusion schemes are justified or even compelled by this duty. This came into force in 2011 and compels public authorities to 'eliminate' discrimination, advance equality of opportunity, and foster 'good relations'. Significantly for our story, the duty compels public authorities to publish 'equality objectives' at least every four years and 'information to demonstrate their compliance'.

Note also that the duty makes no mention of equality of outcomes, only that is how it is being interpreted by many, including within the NHS.[8]

Methodological critique

What commences is an inspection of the WRES indicators, grouped according to their similarities.

Indicators 1 and 9

Both of these indicators look to compare the BME (black and minority ethnic) shares in elite positions to those of the workforce overall. Percentages are calculated for the BME share of 'very senior management' and boards. 'Very senior management' is defined as chief executives, executive directors, and other senior managers. Figures are produced both for the NHS as a whole and for individual healthcare providers (NHS trusts).

The first problem is that it appears WRES is including in the denominator all those for whom there is no data on their ethnicity – the 'unknowns'. What this means is that headline figures of 6.8 per cent (WRES 1) and 10 per cent (WRES 9) are to be interpreted as the

[5] https://www.england.nhs.uk/wp-content/uploads/2015/01/wres-update-jan-15.pdf
[6] https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race-Equality-Standard-2020-report.pdf
[7] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
[8] https://www.gov.uk/government/publications/public-sector-equality-duty

minimum BME share, meaning the actual figures are *at least* 6.8 and 10 per cent, respectively.

The NHS has set a target of 19 per cent BME across all its pay bands.[9] The problem is that due to the level of unknown data, it may underestimate what is actually there. Overall, the shares of unknowns are low, but this is more of a problem in individual trusts. For example, at Guy's and St Thomas' NHS Foundation Trust, zero per cent of very senior management is BME but 18.6 per cent are 'unknown'.

The next issue is the appropriateness of the comparison. It is reasonable to expect senior management to deviate from the workforce overall since we are not comparing like with like. Senior managers have a unique skill set, while the NHS staff overall includes doctors and nurses, as well as caterers and cleaners. Each occupation has its own unique route in, with many staff recruited from overseas to fill jobs that are undesired by those already here. Such people are not likely candidates for positions of leadership. Moreover, there is obviously especial prestige placed on medical careers among Asians, with 30.2 per cent of senior doctors being Asian.[10] Doctors are often precluded from being 'very senior' managers by their skill-set, since they are not trained administrators. Differences in the average age between groups may also have an impact, since it is known ethnic minority groups tend to be younger, while positions of seniority go naturally to those who are older.

Instead, we need to take into account the ethnic minority share of people likely to be in positions of leadership. A target of 19 per cent, evenly imposed across the hierarchy of the NHS, will likely not be appropriate, given the variation in many variables between groups.

A better benchmark for leadership, as suggested by Policy Exchange, is the share of ethnic minority individuals leaving Russell Group universities at the turn of the century, put at around nine to 10 per cent, since these are natural candidates for leadership, who should have made it to the top by now.[11] Against this benchmark, NHS boards are already sufficiently ethnically diverse, while very senior management is not too far off. In fact, the most recent data put NHS senior management at 10 per cent BME, falling to seven per cent at 'very senior' level.[12] This latter figure is in line with the share of the senior civil service, which in turn is in line with those entering the civil service fast stream in the late 1990s and early 2000s.[13]

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[9] https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race-Equality-Standard-2020-report.pdf

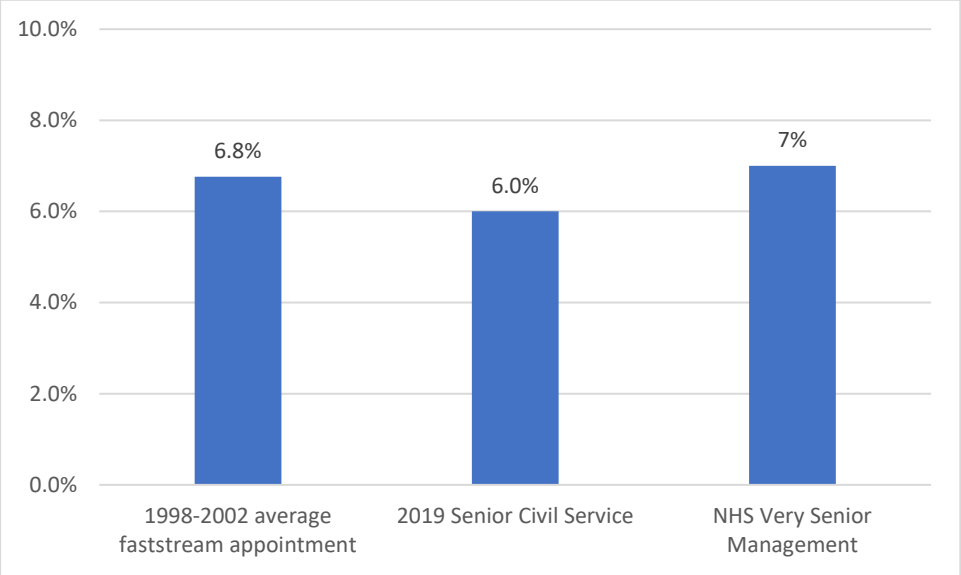
[10] https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities/employment-fairness-at-work-and-enterprise

[11] https://policyexchange.org.uk/wp-content/uploads/2016/11/PEXJ5011_Bittersweet_Success_1116_WEB.pdf

[12] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2020

[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767789/Civil_Service_Fast_Stream_Annual_Report_2017_-_2018.pdf;

Figure 1: Benchmarking diversity among NHS very senior management – non-white share



Source: Official Statistics/NHS WRES.

Similarly, if we look at diversity among doctors, then we see the most senior positions are both more diverse relative to the national population, as well as in line with the shares of ethnic minority individuals that entered the profession at the turn of the century. This implies diversity of leadership in line with the historic supply of likely candidates for positions of responsibility.

Figure 2: Benchmarking diversity among doctors – percentage non-white

Source: NHS Digital/Policy Exchange.

https://www.gov.uk/government/publications/public-appointments-data-report-201819/public-appointments-data-report-201819

There is a wider objection, one that can be made to all WRES indicators, in that by focusing on 'BME' alone, it obscures differences between minority groups. For instance, a seven per cent figure for very senior management hides the fact that this includes four per cent Asian, one per cent black, and one per cent mixed race, with just one out of 2,249 being Chinese.[14] The term 'Asian' itself obscures all differences between Indian, Pakistani and Bangladeshi, and will likely be dominated at the top by Indians, often Gujarati in origin with ties to East Africa. Also, 'white' obscures differences between the ethnically English, Scottish, Welsh and Irish, as well as Eastern Europeans, Jews, and Gypsies, among whom there will be considerable variation.

'White' and 'BME' are purely statistical categories that are useful and enough to say something about workforce ethnicity. But the match is not so strong as to supply the knowledge sufficient to control things to bring about a desired equality of outcomes. Moreover, by the time they will have reached the WRES central office, they will already be out of date, which is particularly concerning when looking at boards, where just one person joining or leaving, can have a remarkable impact on percentages.

Indicators 2,3,4

These indicators all work on comparing outcomes for BME and white individuals, encompassing short-listing for promotion, receiving training, and disciplinary proceedings. Scores are arrived at by dividing one group's share of experiencing these, by the other's. The major flaw relates to a quirk of mathematics, namely that when probabilities or proportions are low, relative disparity tends to be high. This can lead to some counter-intuitive conclusions. This mathematical quirk, that relative disparity is susceptible to prevalence, has been pointed out by American attorney James Scanlan, and has been termed 'Scanlan's Rule' in the academic literature.[15]

Consider the following two NHS trusts: Liverpool University Hospitals scores 2.87 in the latest data on WRES 2 – the relative likelihood of white applicants being promoted from shortlists, compared to BME – while Poole Hospital scores 1.66. It would be easy to conclude Liverpool is worse; in fact, that is what WRES would encourage us to believe. However, as seen in the table below, the shares promoted for both whites and non-whites are much higher for Poole. Most importantly, the absolute difference is far greater – a 30-point gap compared to a seven-point gap. Intuitively, you would say Poole is the worse hospital, something not revealed by the WRES indicator.

[14] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics
[15] http://jpscanlan.com/;
https://www.mse.ac.in/wp-content/uploads/2016/09/Working-Paper-84..pdf

Table 2: WRES Indicator 2 – relative likelihood of being promoted from shortlists – white vs BME

Trust	White share promoted	BME share promoted	Relative difference (WRES 2)	Absolute difference (percentage points)
Liverpool University Hospitals	11%	4%	2.87	7
Poole Hospital	75%	45%	1.66	30

Source: NHS WRES.

The problem becomes more evident when looking at the same trusts over time. For example, take Bradford District Care, which provides mental health services (see table below). In 2020, WRES 2 was higher than in 2016, while the absolute difference was just one percentage point lower. All that had changed was that there were fewer candidates appointed in that particular year, yet by the terms of WRES, alarm bells would be ringing, necessitating time spent on pointless bureaucratic inquiry.

Table 3: WRES Indicator 2 – relative likelihood of being promoted from shortlists at Bradford District Care NHS Foundation Trust – white vs BME

	2016	2017	2018	2019	2020
White	17%	20%	18%	18%	6%
BME	13%	20%	16%	11%	3%
Relative difference (WRES 2)	1.3	1	1.2	1.7	2.1
Absolute difference (percentage points)	4	0	2	7	3

Source: NHS WRES.

This matters in that the current flawed approach leads the focus away from trusts where there are massive gulfs, such as Poole, while focusing attention on trusts where there are minor differences, or where fewer promotions are handed out. On WRES 2, of those 148 trusts with a score greater than 1.3, meaning a relative disparity in being promoted of more than 30 per cent in favour of white candidates, 104 had low absolute differences of less than 10 percentage points – 70 per cent.[16]

[16] Based on 2020 data sourced: https://www.england.nhs.uk/publication/workforce-race-equality-standard-2020-supporting-data/

The other implication of Scanlan's rule is that when we compare probabilities of things *not occurring*, between groups, then relative disparity is invariably negligible. For example, at Liverpool University Hospitals, the probability of BME staff not being promoted, compared to white staff, is just 1.07 times greater, which is a much less alarming figure.

The above discussion focused on WRES 2, but the problem of Scanlan's Rule will hold just as much for WRES 3 and 4. A further, specific flaw of WRES 2 is that it is also susceptible to the size of its denominator. It is calculated by the comparing the white and non-white ratios of appointees to shortlisted applicants.

Consider the following hypothetical example: A trust employs 100 people, 20 of whom are BME. It has six promotions to offer. Twenty white people apply, as do five non-white. A short-list of 20 is drawn up, 15 white and five non-white, from which five white people and one minority applicant are promoted. This produces a WRES 2 score of 1.67. The management could easily avoid this if they simply had shortlisted two fewer minority applicants, producing a WRES score of one. There is thus potential for manipulating this statistic, as well as the incentive to do so.

It is very difficult to know why disparity exists between groups, especially when looking at aggregate group-level statistics, not just the facts surrounding individual cases. Consider WRES 2 – relative differences in the likelihood of disciplinary action. Why would this not simply encourage NHS managers to turn a blind eye to poor practice?

Indicators 5,6,7,8

These indicators pertain to differences in self-reported experiences of abuse and harassment, as well as perceptions of fairness. They stem from the NHS Staff Survey, which is a survey of employees. According to the NHS, 1.2 million people were invited to participate, of which 47.3 per cent did.[17] This may entail selection effects, meaning bias, since the survey is not randomly sampled. Indeed, we know the NHS staff to be 23 per cent non-white, while the unweighted response to the Staff Survey is 17 per cent.[18] This may be corrected by weighting (we do not know if WRES does this) but if those who are disgruntled are more likely to respond, then adjusting to make the data demographically representative will only achieve so much.

The bigger problem is that these data are subjective. Respondents are asked if they experience things such as 'discrimination' and 'abuse', but such terms may encompass a wide variety of behaviours that differ in their gravity.

'Discrimination' may mean being passed over for promotion, experiencing racial name calling, or 'micro-aggressions' that are often just simple mistakes, poorly chosen words, or cultural misunderstandings. Moreover, analysis of the Crime Survey has shown that people

[17] https://www.england.nhs.uk/statistics/2021/03/11/2020-national-nhs-staff-survey/
[18] https://www.nhsstaffsurveys.com/results/national-results/

may attribute a racial motivation to a crime often with little grounds. For instance, around 12 per cent of crimes classified as 'race hate crimes' by the survey were on the grounds that the victim stated 'because some people pick on minorities'.[19]

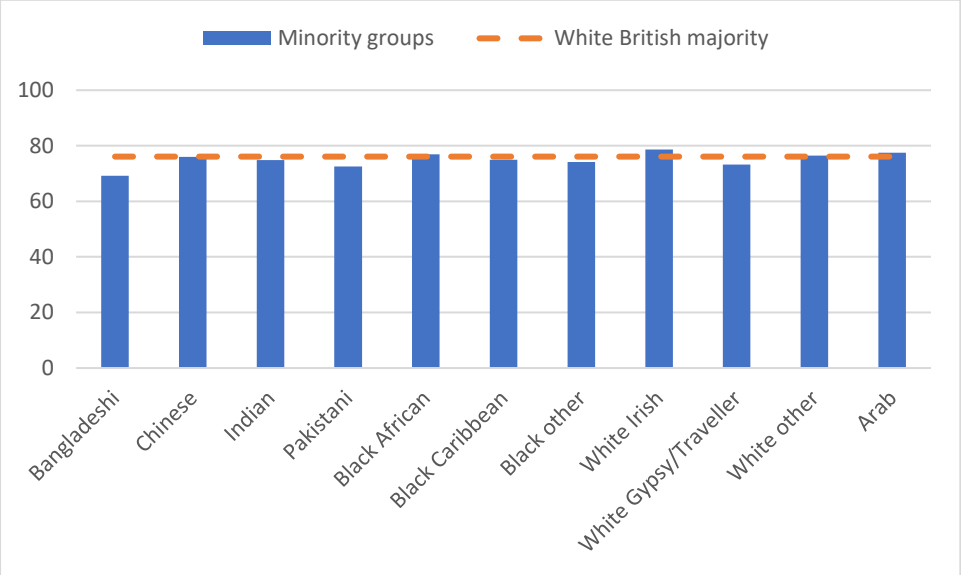
We also further know black people are more likely to perceive discrimination in hiring and promotion than Asians, with the Citizenship Survey showing 18 per cent of black Caribbean people believing they were discriminated against compared to eight per cent of Bangladeshis.[20] Perception is not everything, so it should not be taken as gospel, which, unfortunately, is the approach of WRES.

Again, presenting differences between white and BME will obscure these gradations within the non-white minority. For instance, patient satisfaction with GP services for black people is the same as for white people, but for Asians, substantially less. Since there are more Asian people than black in the United Kingdom, then aggregating them together would produce a 'BME' score less than that of whites. This would imply a different conclusion from what the facts actually suggest.[21]

Moreover, those responsible for WRES, who present a picture of a workforce riven with unfairness and inequality, must square this with the fact that nearly all minority groups are *as satisfied* as the white British in terms of their hospital care. The picture from WRES, based on subjective staff surveys, does not square with the data from subjective patient surveys, as presented in the graph below.[22]

[19] https://www.civitas.org.uk/content/files/2572-A-Hate-Crime-Policy-WEB.pdf
[20] https://policyexchange.org.uk/wp-content/uploads/2016/11/PEXJ5011_Bittersweet_Success_1116_WEB.pdf
[21] https://www.ethnicity-facts-figures.service.gov.uk/health/patient-experience/patient-experience-of-primary-care-gp-services/latest
[22] https://www.ethnicity-facts-figures.service.gov.uk/health/patient-experience/inpatient-satisfaction-with-hospital-care/latest

Figure 3: Average patient satisfaction score for hospital care, by ethnicity (100-point scale)



Source: Ethnicity Facts & Figures.

Validity

If the WRES indicators are indeed indicators of racial equality within the NHS workforce, then we can expect them to correlate across trusts. Moreover, we can conceive of them as manifestations of the same 'latent variable' – race equality. Statisticians assess the validity of their measurements by comparing them empirically to other conceptually related measurements. The method used is factor analysis, which looks to measure the extent to which observed variables measure latent variables or 'factors'. If measurements 'load' onto common factors, then they are said to meet the test for 'convergent validity', meaning they are valid measurements of what they purport to measure.[23]

Results of the factor analysis of the 2020 WRES data for NHS trusts are presented in the table below – for details of variables used, see the Appendix. Provisional analysis (scree test) confirmed a four-factor solution. Thus, the indicators were not loading onto a single dimension, meaning they are not all measuring the same thing.

WRES 1 and WRES 9 all load substantially onto Factor 1 (defined as a factor loading with an absolute value of around 0.4 or more), measuring the extent to which leadership reflects trusts' overall ethnic diversity. However, WRES 6, 7 and 8 form a separate factor, measuring the extent to which white and non-white have differences in subjective perception of treatment. WRES 2, 3, and 4 all have high 'uniqueness' scores, meaning they are largely independent of all other variables; hence they do not load onto any factors. WRES 5 loads

[23] https://www.analysisinn.com/post/convergent-validity/

weakly onto factor 1, but in the opposite direction from what would be expected theoretically.

Since the WRES indicators do not converge onto each other, they cannot be said to be valid indicators of the same concept, namely 'race equality'.

Table 4: Exploratory factor analysis of WRES indicators (N=183, varimax rotation)[24]

	Factor				Uniqueness
	I	II	III	IV	
WRES 1a	**0.757**			0.215	0.46
WRES 1b	**0.611**		**0.786**		0.01
WRES 2		-0.112	-0.183		0.95
WRES 3				0.238	0.99
WRES 4		0.115	-0.274	-0.172	0.90
WRES 5	**-0.463**	0.145		0.164	0.79
WRES 6	-0.247	**0.598**			0.56
WRES 7	0.339	**0.562**			0.41
WRES 8		**0.742**			0.46
WRES 9	**0.756**		0.183	**0.624**	0.01
SS loadings	1.73	1.19	0.78	0.76	
Proportion variance	0.17	0.12	0.08	0.08	
Cumulative variance	0.17	0.29	0.37	0.45	

Another way to look at this is to look at the correlations between the indicators, as presented in the table below.

There are moderate to strong correlations between WRES 1 and WRES 9. Other than that, there are only moderate correlations at best between other variables, and nothing like consistency. WRES 2, 3 and 4 clearly have nothing to do with anything, likely down to Scanlan's Rule. Notably, greater representation in senior leadership reflective of the ethnic diversity of the ranks is not empirically related to equality of outcome, and on some indicators is weakly but negatively correlated. The subjective measures (WRES 5, 6, 7 and 8) have, at best, only weak to moderate correlations.

[24] Trusts/organisations with missing data on any of the variables were omitted. On WRES 3, there were trusts that had no individuals disciplined in a particular year, from a particular group. These were coded as 0 in the original data, but were treated as 'missing' in this analysis. Since the available data contain measurements of leadership germane to non-clinical and clinical staff, both are incorporated in the model, thus we have two measures of WRES 1. Analysis based on 2020 data alone.

Table 5: Correlation matrix of WRES indicators 2020 (N=183)

	1a	1b	2	3	4	5	6	7	8	9
1a	1.00	0.52	-0.03	0.04	0.02	-0.31	-0.12	0.29	-0.02	0.72
1b	0.52	1.00	-0.13	0.03	-0.17	-0.20	-0.11	0.17	-0.01	0.64
2	-0.03	-0.13	1.00	-0.01	-0.02	-0.09	-0.06	-0.03	-0.10	0.00
3	0.04	0.03	-0.01	1.00	-0.09	0.07	-0.01	0.12	-0.04	0.17
4	0.02	-0.17	-0.02	-0.09	1.00	-0.03	0.00	0.14	0.05	-0.09
5	-0.31	-0.20	-0.09	0.07	-0.03	1.00	0.23	-0.08	0.12	-0.23
6	-0.12	-0.11	-0.06	-0.01	0.00	0.23	1.00	0.24	0.47	-0.14
7	0.29	0.17	-0.03	0.12	0.14	-0.08	0.24	1.00	0.40	0.23
8	-0.02	-0.01	-0.10	-0.04	0.05	0.12	0.47	0.40	1.00	-0.05
9	0.72	0.64	0.00	0.17	-0.09	-0.23	-0.14	0.23	-0.05	1.00

The factor and correlation analyses confirm that the WRES indicators do not measure the same thing, they are not all manifestations of the same underlying variable, namely 'race equality'.

While there are some patterns of correlation, implying some (weak) dimensions of equality, it is incumbent on the designers of WRES to explain why their chosen indicators do not conform to each other. In layman's terms, they must explain why a hospital with leadership that resembles its staff overall, in terms of ethnicity, may or may not report equal treatment, as well as equal or unequal outcomes in terms of training, promotion or discipline. Why might the same employer advantage whites in promotion chances, but not necessarily in either disciplinary matters or access to training? Why is it that where minority individuals believe themselves to be discriminated against, they may, or may not, get promoted less?

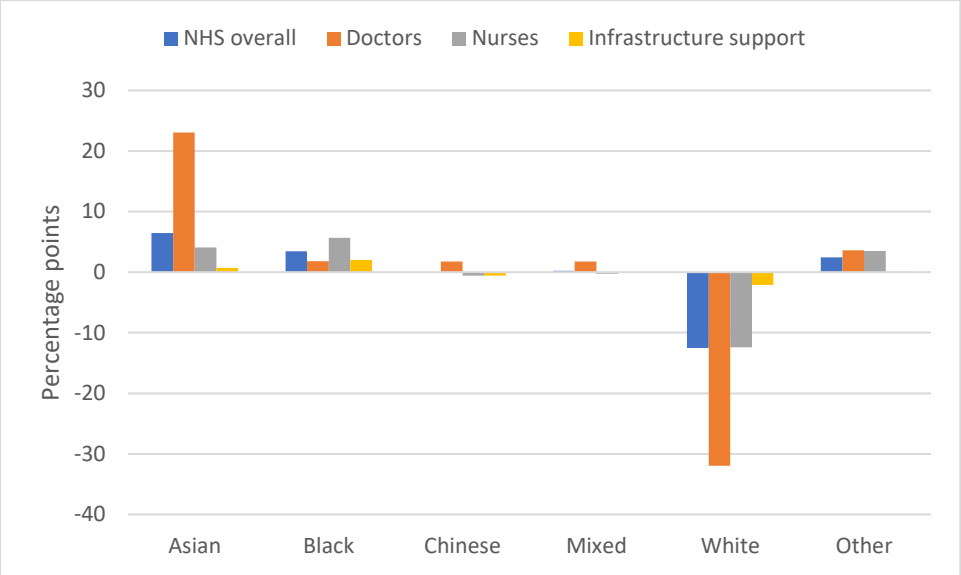
Unrealistic expectations

Judging from the metrics chosen, the WRES designers believe 'equality' will have been reached when there is equality of outcome for white and non-white groups. There is, however, a compelling argument for why this is an unreasonable expectation; in effect something that is impossible without authoritarian enforcement. That would only produce perverse outcomes, namely ill-equipped individuals in positions of responsibility.

Firstly, ethnic minority groups are *overrepresented* in the NHS, relative to their share of the working-age population. What this will entail is a higher degree of selectivity for the white group, meaning it would be reasonable to expect that this group will perform better on the job. If, say, the top five per cent of individuals from one group are selected into a profession,

compared to the top 10 per cent of another, then it is likely the former will have better outcomes. The graph below shows the extent of the disproportionality.

Figure 4: Minority presence in the NHS relative to their share of the working-age population (absolute difference)



Source: Adapted from NHS Digital, NHS Hospital & Community Health Service (HCHS) workforce statistics/ Ethnicity Facts & Figures.

Secondly, groups do not have equality of outcomes at the point of entering into the NHS. Candidates for medical school must sit the UK Clinical Aptitude Test (UKCAT), which tests them on their suitability for the profession. Analysis by Tiffen et al. (2014) shows differences between ethnic groups in UKCAT scores as well as A-level tariffs (see graph below).[25]

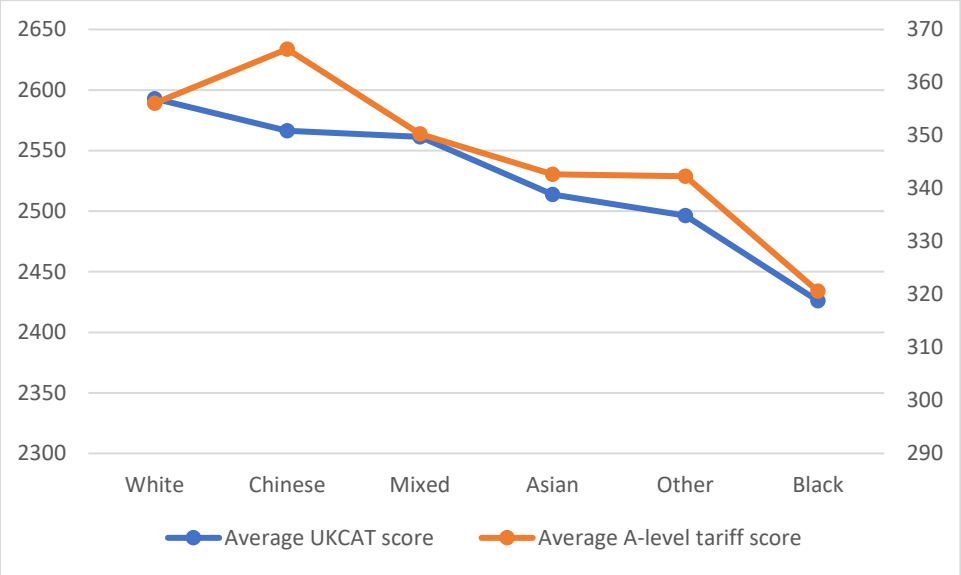
The implication of this is that there will be differences in the levels of aptitude of those selected into the profession. This will likely manifest itself in variation in on-the-job performance, with those more able, more likely to get a promotion and less likely to be disciplined. For the avoidance of any doubt, this is not a comment on groups, but rather the individuals selected from within them into the professions of medicine and healthcare provision.

It is a categorical error to assume the cause of any given statistical disparity is *necessarily* to be found in the place where the statistics are collected, yet this is the assumption behind

[25] https://clok.uclan.ac.uk/14819/1/14819_mclachlan.pdf

WRES. Ethnic groups have disparate outcomes before they have even entered the NHS, meaning the expectation of equal outcomes is naïve.

Figure 5: Measures of aptitude of applicants to medical school



Source: Tiffin et al. (2014).

Similar results have been observed in candidates taking the Membership of the Royal College of General Practitioners (MRCGP) examination, which is a postgraduate qualification needed to become a general practitioner. The test has three components – an applied knowledge test, a clinical skills assessment, and a workplace-based assessment. The failure rate, at first attempt, on the clinical skills assessment for UK-educated white candidates is 4.5 per cent, compared to 17.1 per cent of UK-born non-whites.[26]

This finding comes from research by Aneez Esmail and Chris Roberts. (Esmail is one of the instigators of WRES – see below.) The clinical skills assessment is an appraisal of the candidate's suitability for the job, including practical skills and communication. Since there is an element of subjectivity to this, it is possible there may be bias, something Esmail and Roberts point out.

But the failure rates for the applied knowledge test are similar, at 9.1 per cent and 21 per cent, respectively, for the same groups, again at the first attempt. This test is machine marked, meaning there is no bias. If a test with an element of subjectivity produces similar results to another test with no such element, then this is hardly evidence of bias.[27]

[26] https://www.gmc-uk.org/-/media/documents/mrcgp-final-report--18th-september-2013_pdf-53516840_pdf-71399574.pdf
[27] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3898419/

To reiterate, the WRES expectation of equal outcomes is unrealistic. Group-level inequality of outcome is demonstrable before individuals have even entered into the NHS, in this case aspiring doctors, and so it is likely it will continue therein, having nothing to do with the institution of the NHS itself. The imposition of equality of outcomes is not what is needed relative to the actual talents, qualifications and circumstances of the individuals concerned.

Flawed evaluation

This analysis has revealed that WRES indicators are poorly conceived, mathematically flawed, and have little validity in the sense that they do not all measure the same intended thing – 'race equality'.

Yet, WRES has been externally evaluated by a team of specialists, led by Jeremy Dawson of the University of Sheffield, with a report published in 2019.[28]

The evaluation found, 'The nine WRES indicators are broadly considered as appropriate, and are thought to demonstrate accurately the inequalities that BME staff face'. It noted some 'concerns' about some of the indicators: that WRES 4 was not measuring the same thing across trusts, that WRES 5 and 6 were 'too blunt', and that survey response rates were low. Nevertheless, 'it is vital to retain the same indicators and methodology so that trusts can learn as much as possible from their data'. The evaluators miss the fact that the indicators largely do not correlate and therefore lack validity, as well as the impact of Scanlan's Rule.

The conclusion that WRES indicators are useful, rests on the methodology of the evaluation. It is largely based on qualitative interviews with, among others, people working within WRES. Thus, the 'concerns' reported are those of individuals for whom there is a vested interest – to criticise the programme *too much* is to imperil their job. Focus groups were held with BME regular staff, who likely will have little statistical expertise, while the opinions of white regular staff were not solicited.

The quantitative element to the evaluation is not an empirical analysis of validity but rather an analysis of change in the WRES indicators over time. There is no mention of face validity, convergent/discriminant validity, or criterion variables, these being the methodological standards.[29] In other words, the evaluators are analysing what they take to be valid, based on the say-so of those who are likely partial or have limited expertise. The section of the evaluation report on validity and reliability is based on repeating the opinions of interviewees, not an independent statistical evaluation, which is what should have been done.

[28] https://www.england.nhs.uk/wp-content/uploads/2019/09/wres-evaluation-report-january-2019.pdf
[29] Adcock, R. & Collier, D. (2001). 'Measurement Validity: A Shared Standard for Qualitative and Quantitative Research' in The American Political Science Review. Vol.95, No.3.

Nevertheless, the evaluation quotes one interviewee but overlooks the importance of what that person had to say:

> *'Although once again there is a sort of one size fits all feeling about it. […] the numbers we were using were so small for one of two of the indicators. They were virtually meaningless but when you put it down on paper, the ratio looked awful. When you actually dug down it was next to meaningless…'.*[30]

Responsibility

The latest WRES report contains a foreword by Prerana Issar, who is the NHS Chief People Officer. She is reportedly paid at least £230,000 per year; more than the Chief Executive who hired her.[31] She is ultimately in charge of diversity and inclusion, and actively promotes WRES online as well as 'Pride in the NHS Week' and 'International Non-Binary Day'.[32] She sits on the WRES advisory board.

Yet she seems to be unaware of what the NHS is for, describing the NHS as 'created in 1948 as an instrument of social justice', and that, 'We collectively promised each other that everyone should have equal access to health outcomes, irrespective of income levels, sexual orientation, race, disability or gender'. She adds, 'delivering equality of outcome should be the professional and moral obligation of every leader in the NHS…'.[33]

This is a re-writing of history. Here is what the NHS architect, Aneurin Bevan, had to say:

> *'The National Health Service had two main principles. One, that the medical arts of science and of healing should be made available to people when they needed them, irrespective of whether they could afford to pay for them or not. The second was that this should be done not at the expense of poorer members of the community, but of the well to do.'*[34]

There was never any intention of equality of outcomes, but rather equality of opportunity, that healthcare be comprehensive and free at the point of demand. The implication of the re-writing is that the NHS moves into matters of social engineering rather than healthcare provision, something which it has no competence in and would only engender waste. It is there to provide us all with the same assurance of care, not the same health.

She speaks of equality of outcomes as 'within our collective gift', but as Thomas Sowell has argued, groups differ in all manner of ways and so there is no reason why we should expect

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[30] https://www.england.nhs.uk/wp-content/uploads/2019/09/wres-evaluation-report-january-2019.pdf
[31] https://www.dailymail.co.uk/news/article-10004111/NHSs-diversity-tsar-paid-35-000-chief-executive.html
[32] *Ibid.*
[33] https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race-Equality-Standard-2020-report.pdf
[34] https://beastrabban.wordpress.com/2016/05/10/nye-bevan-speech-about-the-nhs-in-audio-and-text/

them to have the same outcomes, nor is there any evidence for the state's competence in bringing it about.[35]

Issar writes in her foreword, that the WRES report presents a sobering picture of racial inequality that is a 'moment for humble reflection', necessitating that we 'need to re-set the inclusion dial' and that work cultures need to become more 'inclusive'. That it is 'right that we examine these findings with a view to quickening the pace of change'.

Given the substantial flaws with the data, however, such utterances are alarming, since they entail intervention at cost without any valid metric of success. This is especially true when considering her statement that we 'give these issues the same emphasis as we would any other NHS priority'.

She is, however, relatively new to the game. WRES began around 2014, and its instigation can be traced to a group of individuals that includes Yvonne Coghill, Aneez Esmail, and Roger Kline.

Esmail was advocating for greater monitoring of data around 2005.[36] He is a professor of general practice at the University of Manchester. On his website, he writes, 'In 2014 I was part of a small group that campaigned for and got agreement from the NHS to implement the Workforce Race Equality Standard (WRES)'.[37] But early minutes from the WRES Strategic Advisory Group show the true instigators to be Coghill and Kline. Coghill is a nurse by training and was, until recently, director of WRES implementation, as well as deputy president of the Royal College of Nursing. She is both a CBE and OBE.[38] She has recently joined the board of directors at the Institute for Healthcare Improvement.[39]

Kline was the WRES director of research and engagement until 2017, and is an academic at Middlesex University. He describes himself online as a 'disruptive innovator'. He led on drawing up the original guidelines for WRES reporting and is credited with its 'design'.[40]

It should further be pointed out that WRES was backed from the very top of the NHS. It was sponsored by the then-NHS chief executive, Sir Simon Stevens, who Coghill called its 'champion'.[41] Another prominent figure is Habib Naqvi, who was a protégé of Sir Simon

[35] https://www.amazon.co.uk/Discrimination-Disparities-Thomas-Sowell/dp/154164560X
[36] http://www.aneezesmail.co.uk/PDF%20files/HealthFoundReport.pdf
[37] http://www.aneezesmail.co.uk/racism.html
[38] https://www.england.nhs.uk/author/yvonne-coghill/
[39] https://www.nursingtimes.net/news/leadership-news/nurse-and-former-wres-director-joins-board-of-global-health-organisation-19-05-2021/
[40] https://web.archive.org/web/20151013164752/https://www.england.nhs.uk/wp-content/uploads/2015/04/wres-technical-guidance-2015.pdf
[41] https://www.nhsbmenetwork.org.uk/wp-content/uploads/2020/10/HSJ-Interview-with-Yvonne-Coghill-re-WRES.pdf

('reverse mentor') as well as a director of WRES. He has since been promoted to head the NHS Race and Health Observatory.[42]

An article authored by Esmail, Coghill, and Kline, plus academics Naomi Priest (lead author), David R. Williams, and Mala Rao (also on the WRES advisory board – see below), titled 'Promoting equality for ethnic minority NHS staff – what works?' gives us some insight into their thinking. It was published in *The British Medical Journal* with the purpose being to promote WRES, as well as lay out what interventions have proven successful in bringing about equality of outcomes, increasing diversity, and ending discrimination.[43]

Their argument is one in favour of mandatory diversity measures, including affirmative action programmes. As they say, 'mandated diversity policy with contractual consequences is supported by the available evidence' while claiming 'that the previous voluntary approaches have failed.'

The problem for Priest et al. is, after publication, two of the authors they cited later came out against mandatory/compulsory diversity programmes. In an article titled 'Why most diversity programmes fail' (2016), Frank Dobbin and Alexandra Kalev report on their study, drawing on data from around 800 US companies over 30 years. They concluded that mandatory measures tended to be associated with lessening levels of diversity in company management. This was largely because they tended to prove antagonistic and foster resentment. As they wrote, 'You won't get managers onboard by blaming and shaming them with rules and re-education.'[44]

The preference for an unevidenced compulsory strategy that has been shown by other scholars to prove self-defeating is clearly there. Moreover, Priest et al.'s own chosen mandatory policy – WRES – counts against their thesis.

Oversight

Oversight for WRES is provided by its Strategic Advisory Group. Its membership can be adjudged from the minutes of its meetings that are freely available online.[45] Its composition, as of 2019, is presented in the table below.

The most recent minutes offer some insight into what is going on. The meeting was mostly devoted to growing the WRES programme, as well as expanding membership of the advisory group. The purpose of bringing new members onboard from organisations such as Public

[42] https://healthcareleadernews.com/news/people-moves/dr-habib-naqvi-appointed-as-director-of-nhs-race-and-health-observatory/

[43] Priest, Naomi, Aneez Esmail, Roger Kline, Mala Rao, Yvonne Coghill, and David R Williams. 2015. "Promoting equality for ethnic minority NHS staff—what works?" BMJ: British Medical Journal 351 (1): h3297. doi:10.1136/bmj.h3297. http://dx.doi.org/10.1136/bmj.h3297.; https://dash.harvard.edu/bitstream/handle/1/24984037/4707526.pdf?sequence=1&isAllowed=y

[44] https://hbr.org/2016/07/why-diversity-programs-fail

[45] https://www.england.nhs.uk/wp-content/uploads/2020/02/SAG2_WRES-SAG-Minutes-17-Oct-2019.pdf

Health England is to get people talking about WRES therein, thus encouraging its growth. The most concerning action listed was to 'Scope links between race equality and being an "outstanding" organisation'. While this may appear ostensibly laudable, judging the quality of hospitals on invalid statistics such as the WRES indicators, in addition to patient care, will only skew priorities to the detriment of health.

WRES places special emphasis on the ethnic composition of leadership. If you read its documentation, you will see something like:

> *'NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.'*[46]

Why is board membership given such prominence and not, say, the share of minority staff reporting discrimination, this being ostensibly the most flagrant breach of modern liberal values?

[46] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/

Table 6: Members of the WRES Strategic Advisory Group, based on minutes of its meeting in October 2019

Name	Role/Title	Organisation
Present		
Lord David Prior	Chair	NHS England
Karen Bonner	Director of Nursing	Chelsea and Westminster Hospital
Dr Buki Adeyemo	Medical Director	North Stoke Combined NHS Trust
Dr Habib Naqvi	Deputy Director – WRES	North England / NHS Improvement
Yvonne Coghill	Director – WRES	NHS England / NHS Improvement
Jabeer Butt	CEO	Race Equality Foundation
Sir David Dalton	CEO (retired)	Salford Royal NHS FT
Prof Mala Rao	Senior Clinical Fellow	Imperial College London / Public Health England
Dr Henrietta Hughes	National Guardian for the NHS	National Guardian's Office
Dame Gill Morgan	Chair	NHS Providers
Prerana Issar	Chief People Officer for NHS	NHS England / NHS Improvement
Sir David Behan	Chair	Health Education England
Prof Ted Baker	Chief Inspector - Hospitals	Care Quality Commission
Jon Restell	CEO	MiP
Prof Stephani Hatch	Academic	Kings College London
Dr Michelle Drage	CEO	London-wide LMCs
Absent		
Marie Gabriel	Chair	East London NHS FT
Baroness Dido Harding	Chair	NHS Improvement
Danny Mortimer	CEO	NHS Employers
Saffron Cordery	Director	NHS Providers
Prof Jacqueline Dunkley-Bent	Chief Midwifery Officer	NHS England / NHS Improvement
Stephen Hart	Managing Director	NHS Leadership Academy
Garrett Emmerson	CEO	London Ambulance Service NHS Trust
Joan Saddler	Deputy Director	NHS Confederation
Lord Victor Adebowale	CEO	Turning Point

Source: NHS WRES.

Moreover, the correlation between the ethnic minority presence on boards and the share of referrals for breast cancer being seen within two weeks is 0.01.[47] This goes against the conventional notion of the 'business case for diversity', showing no material benefits, no matter how laudable the aim of greater presence might be in terms of fairness.

'WRES Experts'

WRES also seeks to grow through its 'WRES Experts' programme. The experts are NHS workers who sit a course that leads to a 'Level 5: Race Equality in the Workforce qualification', awarded by the Open College Network. According to Anton Emmanuel, who is the current Head of Workforce Race Equality Standard, 'we aim for participants to leave with an in-depth knowledge and a skill-set to effectively advocate for race and health equality.'[48]

The 'experts' are there to assist with a 'concerted emphasis on the cultural change and transformation within organisations and parts of the NHS', with their 'knowledge and capabilities to close the gaps in experience and outcomes between BME and non-BME staff'.

According to official documentation, a WRES expert is:

- 'conversant and an expert on all aspects of the WRES and is equipped to share that knowledge with others to effect change.
- has a wealth of knowledge on best practice in implementing WRES and is aware of the latest evidence in what works in closing the race equality gap.
- has an in-depth understanding of how the WRES indicators were developed and how they work with your organisation and the NHS
- has developed and improved their ability to confidently and clearly articulate the reasons for workforce race equality and implement change.
- is part of a network of professionals across the NHS who will advocate, oversee and champion the implementation of the WRES and improving the experiences of BME staff and patients.
- has increased knowledge, capacity and confidence to lead strategies for systemic and cultural change that will embed the WRES within your organisation.
- is able to explore the understanding of the psychology of individuals within organisations as a means of gaining greater understanding of individual responses to diverse existence – racial identity, multicultural competence.

[47] Breast cancer referral rates are sourced from here: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/09/Cancer-Waiting-Times-Provider-Time-Series-Oct-2009-Jul-2021-Provisional.xlsx
Data are weighted averages of the percentage of referrals seen to within 2 weeks across the months of 2019, weighted by the number of referrals. N=123.

[48] https://www.england.nhs.uk/wp-content/uploads/2021/06/WRES-Cohort-3-bios-booklet.pdf

- has a deep understanding cultural intelligence and competence enhancing the expert's ability and capability to work effectively in culturally diverse situations.
- has unique personal influencing and negotiating skills to use day-to-day that will inspire confidence with senior leaders and the workforce about the potential for change.'[49]

In truth these people are not experts as such, since their claim to expertise rests on the WRES indicators. These are invalid statistical measures of the things they purport to measure. Moreover, they seem to be charged with instilling the *politically correct* way of thinking. They are tasked with applying an ideology of equality of outcomes in a society where the facts do not match.

There are, by my count, 106 'WRES experts' to date, passing through the programme over three years. They are likely ordinary, decent people, many the first in their families to have gone to university, hoping for a better standard of life. That is commendable. But there is something amiss in how they have been treated, being equipped with misleading statistics and asked to implement an ideological policy on their basis. This is a recipe for conflict and at the expense of meaningful developments in their careers that stand to benefit everyone, being that we are discussing healthcare here.

Awards and attempts at self-criticism

WRES has been recognised by the *Health Service Journal* (*HSJ*), winning its award for 'Workforce Initiative of the Year' in 2019. WRES staff were photographed celebrating the award, presented to them by actor James Nesbitt, the star of television dramas *Cold Feet* and *Murphy's Law*.[50]

Yet there are signs of discontent. For instance, Yvonne Coghill gave a recent interview to the *HSJ*, the purpose of which appears to be to fend off criticism for a lack of progress on the WRES indicators. Largely, she appears to blame other people, mainly NHS bosses:

> *'If they don't know what to do, [firstly] they have not been asking the right questions and [secondly] they just don't want to. End of. Because how much more spoon-feeding can you give these people?*
>
> *'How much more do you have to give them to get them to be able to do what they should be doing anyway as leaders?'*

She further significantly lowered expectations for the kinds of changes the WRES programme was supposed to bring about:

[49] *Ibid.*
[50] https://awards.hsj.co.uk/workforce-initiative-year

'Am I confident that we are going to change it within the next five, 10 years? Nah. Not a chance. Not a hope in hell. That's worldwide, that's not just the NHS, so we can put initiatives in place, we can move things slowly'

She further alleged that NHS executives were 'gaming' the WRES indicators and called for their review. She attributed the drop in WRES 3 – the relative likelihood of minority staff being disciplined – to trusts opting to discipline people informally.[51]

Here are some reactions to her interview from anonymous online commentators:

'It feels paranoid to say that trusts are 'gaming the system' - in all honestly, so little thought is given to the metrics other than by a small number of people and once a year, that this sort of system-wide coordination is laughable (as it usually is).'

'One of the issues with WRES (and WDES) is they're not standards (ie. incorporating best, evidence-based practice) but a set of data metrics. We watch them year-on-year: they go up (yay!) and down (oh!) or some go up and others down (err?) We don't know what this means, or what to do about it, or what effect any particular action has had.'[52]

While these criticisms are anonymously made, they are worth quoting in that they seem to show some level of familiarity with the WRES programme, being mutterings of informed dissent at odds with the image of WRES presented to the public.

Coghill recently wrote an article, again for the *HSJ*, in which she sought to explain the reluctance for the promises of WRES to materialise, saying, '… unsurprisingly the data showed little movement in terms of improvements of the experiences of non-white staff in the NHS'.[53]

She writes that 'we were all a bit naïve' but that the world has changed, citing the pandemic, Brexit, Trump and Boris Johnson. What these have to do with WRES is unclear. She notes criticism from, surprisingly, Roger Kline, that WRES requires a 'reboot'.[54] If its designers are calling for new designs, then this means their initial ones were inadequate. Coghill, however, is not content to blame WRES but rather the wider culture of 'years of individual, institutional and systemic racism'; she suggests instead we 'reboot the society we live in'.

Despite these criticisms and finger-pointing, the NHS is persisting with WRES. In an interview with the *HSJ*, Jenni Douglas-Todd, who is a director of equality and inclusion at NHS England,

[51] https://www.nhsbmenetwork.org.uk/wp-content/uploads/2020/10/HSJ-Interview-with-Yvonne-Coghill-re-WRES.pdf
[52] https://www.nhsbmenetwork.org.uk/wp-content/uploads/2020/10/HSJ-Interview-with-Yvonne-Coghill-re-WRES.pdf
[53] https://www.hsj.co.uk/workforce/blame-intolerant-britain-for-the-nhs-lack-of-progress-on-racial-equality/7029617.article
[54] https://www.hsj.co.uk/workforce/wres-time-for-a-reboot/7029580.article

said, 'Rebooting is not getting rid of the WRES or coming up with something else'. Instead, she promises it will be used in a 'real, targeted way', which raises the question of how it was being used before. She calls for more money for 'equality and inclusion'.

Especial focus on recruitment and promotion will follow, we are told, with the possibility of introducing 'intersectionality' into the WRES data. This means we would no longer look just at ethnicity, but also interactions between ethnicity and disability, say.[55] This leads us to the 'intersectionalist's dilemma', whereby the more ways the data are cut, the more they appear contradictory, ruling out the glib but orthodox explanations of disparity being explained by one group dominating and oppressing another. Such disaggregation further introduces problems pertaining to small sample sizes, from which meaningful inferences cannot be made.

Cause for conflict

The case of Brighton and Sussex University Hospitals NHS Trust (BSUH) offers an important cautionary tale. In 2016, official papers show the trust was inspected by the Care Quality Commission (CQC). The inspection found the trust to be 'inadequate', with concerns noted about its leadership. Following the report, the trust was placed in 'special measures', a condition in which it, so much as could be discerned, still stands.

Notably, the CQC report read:

> *'Staff in general reported a culture of bullying and harassment and a lack of equal opportunity. Staff survey results for the last two years supported this. Staff from BME and protected characteristics groups reported that* ***bullying, harassment and discrimination was rife in the organisation with inequality of opportunity. Data from the workforce race equality standard support this.****'*[56] *[Bold font added for emphasis.]*

It noted that the trust's diversity programme had 'fallen into dismay amidst a culture of disciplinary action and grievance', and it was also critical of the board. This is of importance in that it shows the consequences that WRES may have, contributing to an NHS trust being committed to remedial actions.

But were the claims true? Do the data support a picture of an organisation 'rife' with discrimination?

WRES data for BSUH in 2015, that would have been available to the CQC, show that 6.6 per cent of very senior management was non-white compared to 15.2 per cent of the overall

[55] https://www.hsj.co.uk/workforce/nhs-england-reboots-race-work-to-focus-down-hard-on-laggard-trusts/7029631.article
[56] https://www.gov.uk/employment-tribunal-decisions/dr-vivienne-lyfar-cisse-v-western-sussex-hospitals-nhs-foundation-trust-and-others-2301877-2017

workforce (WRES 1).[57] While the top may be disproportionate to the whole, it is proportionate with the minority share entering the senior civil service fast stream in the late 1990s/early 2000s (see above). Again, proportionality at the top should be judged according to the historic supply of suitable and likely candidates, not the contemporary workforce on the whole.

The share of white applicants being appointed from shortlists relative to non-white was 1.26, based on probabilities of 0.234 and 0.186, respectively (WRES 2). The absolute difference is arguably slight, while the relative score is low compared to the national average of around 1.4 to 1.6.

The share of non-white staff being disciplined relative to white in 2014/15 was 2.13. This was based on probabilities of 0.0153 and 0.0072, respectively (WRES 3). However, the year before, the ratio was 1.1, with the rise attributable to a decrease in the number of white people disciplined. It is hard to argue that this stems from attempts to 'game' the numbers when it results in a worse picture. In any case, the inconsistency over two years does not fit with a picture of entrenched bias. Again, note how small the absolute difference is.

It is with WRES 4 that things start to get interesting – relative differences in the shares having access to training.

The 2015 BSUH WRES report states that in 2014/15, the relative difference was 1.45 in favour of whites. However, the absolute difference is tiny when comparing probabilities of 0.0299 and 0.0206, respectively. It is also shown that while non-white staff apply *more* for funding for training, by a factor of 1.18, white applicants are more likely to be funded, by a factor of 1.07.

That is a trivial relative difference, with an absolute difference shown of 0.01. Moreover, this is contradicted by the WRES report of 2016, which showed that in 2014/15, the likelihood of white staff being funded relative to non-white was 0.89, meaning they were *less likely* to be funded. It also, again, showed they were *less* likely to apply for funding, with a ratio of 0.83. These discrepancies *increased* in the favour of non-white staff in 2015/16 (c. 0.60).[58]

Concerning the attitudinal indicators, the most alarming statistic is 44 per cent of non-white staff believing the trust provides equal opportunities for career progression or promotion, compared to 86 per cent of white, in 2014 (WRES 7).

[57] https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/NHS-Workforce-Race-Equality-Standard-WRES-Report-2015.pdf
[58] https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/NHS-Workforce-Race-Equality-Standard-WRES-2016.pdf

There are two problems with this statistic. The first is that it jumps up to 68 per cent the following year (2015).[59] Such radical shifts in real perceptions will not take place over the course of a year. Secondly, the perception may have been prompted as a result of the survey itself. We already know ethnic minority staff are *more* likely to apply for training. If they genuinely believed there was not equality of opportunity, why should this be the case? Why would they bother? This is the difference between a *stated* belief and a *revealed* belief.

The BSUH WRES report (2015) does not say what the share reporting discrimination from colleagues was, as broken down by ethnicity (WRES 8). You have to read the next year's to find out it is 18 per cent for non-white colleagues and eight per cent for white colleagues, respectively.[60] Certainly, the threshold for what qualifies as 'discrimination' is remarkably low. Activists in October 2015 denounced BSUH senior management for overseeing an environment where minority staff felt under 'siege'. Yet examples raised and reported in *The Argus* were sometimes mild, pertaining to words poorly chosen and little more:

> *'At the October meeting, one doctor spoke of hearing another doctor suggesting finding a Polish translator for a patient on a nearby building site. An Italian doctor spoke of feeling under-supported given English was not his first language.*
>
> *'A nurse said she had heard staff referring to other staff as "coloured" and the "integrity of cleaning staff being brought into question by the fact they may not be British."'*[61]

Moreover, the BSUH board was 14 per cent non-white, compared to 15.2 per cent of the workforce (WRES 9). That entailed two non-white appointments.

It is clear that the data hardly supports the charges of the CQC investigation. At the very least, they are equivocal. Yet they were sufficient to sway its findings, while one BSUH trust senior manager felt justified on their basis in claiming there was 'institutional racism' within the trust.[62] That claim is made in official NHS publications. A BSUH WRES report was able to demand 'organisational transformational change' with a strategy document published on its basis.[63]

Reading the demanded changes that constitute the 'WRES Action Plan', it is clear that what was being sought was increased bureaucratic power to bring about equality of outcomes within BSUH – more meetings, more teams, more 'BME leads'. Yet many of the measures

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[59] https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/NHS-Workforce-Race-Equality-Standard-WRES-2016.pdf
[60] https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/NHS-Workforce-Race-Equality-Standard-WRES-2016.pdf
[61] https://www.theargus.co.uk/news/14029359.hospital-trust-in-racism-row-as-black-and-minority-ethnic-staff-call-on-leaders-to-stand-down/
[62] https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/NHS-Workforce-Race-Equality-Standard-WRES-Report-2015.pdf
[63] https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/NHS-Workforce-Race-Equality-Standard-WRES-Report-2015.pdf

entailed special support for minority staff as though this would not foster resentment instead of allaying it. It also seemed to make room for political activists within BSUH management, specifying roles for a 'Race Equality Commission', a 'BME taskforce', and an organisation named 'BME Network'.

That organisation has claimed that the 'greatest chance of success' was the 'Race Equality Workforce Engagement Strategy' with its 'top down, bottom up approach'.[64] It can be pointed out that whatever was done by this strategy, little changed, at least in regard to the WRES perceptions/attitudinal data (WRES 5-8).[65]

The more one reads, the more it becomes apparent that there has been a power struggle going on at BSUH. The BME Network at BSUH was established in 2004 and openly proclaims the trust to be 'institutionally racist'. BSUH was paying £21,000 per annum for the BME Network, as well as providing at cost, office space for its activities. NHS staff who were members of the Network were given at least one day a week to work on BME Network activities, plus a further three days per year to attend its events.[66] A petition drawn up by the group shows it freely presents WRES data as 'examples of institutional racism'. For example, that 6.6 per cent of very senior management is non-white compared to 15.2 per cent of staff overall, is evidence of 'institutional racism'.[67]

More recently, BSUH has suspended its dealings with the BME Network. Chief executive Dame Marianne Griffiths argued that the BME Network was offered the chance to participate, only it insisted on its own approach and instead 'publicly derided the board.' She called for a 'new approach'.[68] This has entailed BSUH creating an alternative organisation called the SOAR (BAME) Network. This is chaired by Yvonne Coghill.[69] Recall that she has publicly questioned the fruits of her own past endeavours while blaming others.

Her appointment was denounced by the BME Network BSUH on Twitter.[70] Similarly, Dame Marianne's action was further denounced by anti-racist campaigners as an example of

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64 https://drive.google.com/file/d/1zILC6KdYsDvKiUIOoHbLByxIsEnfy1mb/view?fbclid=IwAR2P6SOHhITYXuGmErJFnRzegHoH9QwR1UcoOOwbB6dQL33InneHR8jzv-I

65 https://cms.nhsstaffsurveys.com/app/reports/2020/RXH-benchmark-2020.pdf

66 https://drive.google.com/file/d/1zILC6KdYsDvKiUIOoHbLByxIsEnfy1mb/view?fbclid=IwAR2P6SOHhITYXuGmErJFnRzegHoH9QwR1UcoOOwbB6dQL33InneHR8jzv-I

67 https://www.change.org/p/matthew-kershaw-julian-lee-stop-racism-at-brighton-and-sussex-university-hospitals-nhs-trust?recruiter=424110110&utm_source=share_petition&utm_medium=facebook&utm_campaign=share_page&utm_term=mob-xs-share_petition-no_msg

68 https://www.brightonandhovenews.org/2020/08/31/brighton-hospital-bosses-reject-call-to-recognise-bme-network/

69 https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/BSUH-Trust-Board-in-Public-Combined-Papers-PUBLIC.pdf

70 https://twitter.com/BMENetworkBSUH/status/1321186855598067715

'institutional racism'.[71] It should be pointed out that Prerana Issar has 'set a challenge for every NHS organisation to have a BME staff network' to be 'driving, thriving and influencing', but it seems this may only encourage activists with their own sets of ideological demands, not to mention private interests.[72]

It has further been reported that just two individuals were responsible for 90 per cent of BSUH's legal recent spending on race-related employment tribunals, put at around £1.4 million and rising. According to *The Argus,* both were believed to be members of the BME Network.[73]

The trust has paid staff hundreds of thousands of pounds to oversee a programme that offered little improvement. At the heart of this is WRES, which some were only too happy to present as evidence of institutional racism, when rather it is nothing more than a series of statistical constructions with little bearing as to facts on the ground.

As a final word on the matter, here is Charles Moore writing in *The Spectator*, by coincidence about his daughter's experience with a concussion, treated at one of the hospitals that makes up BSUH. His account reveals the basic operation there to be shambolic:

> *'The next day, it was decided to transfer her to the Royal Sussex County Hospital in Brighton, but such was the administrative confusion that she did not get into a ward bed there until 4 a.m. From then on, for two days, she lay for many hours with nothing happening.*
>
> *'Eventually, after tests, it was decided that she could be safely discharged, but it took more than a day for this to be implemented. Going to pick her up, I waited for two more hours for the discharge papers and test results, and then a further hour for a referral that had been promised in "five minutes".'*[74]

Reputational damage

There is a strong sense that through WRES, the NHS is merely creating a rod for its own back. Take for example the reaction to the publication of the MWRES (Medical Workforce Race Equality Standard – a variant focusing on medical staff) from Chaand Nagpaul, who is chair of the British Medical Association's council:

[71] https://www.brightonandhovenews.org/2020/08/31/brighton-hospital-bosses-reject-call-to-recognise-bme-network/
[72] https://www.brightonandhovenews.org/2020/08/31/brighton-hospital-bosses-reject-call-to-recognise-bme-network/
[73] https://www.theargus.co.uk/news/14120838.two-individuals-behind-most-of-hospitals-spending-in-racial-discrimination-cases/
[74] https://www.spectator.com.au/2021/10/the-spectators-notes-214/

> *'It has also shone a light on the devastating scale and breadth at which ethnic minority doctors are being unfairly disadvantaged throughout their career, from training to appointment to representation in senior roles and higher incidences of bullying and harassment.'* [75]

Of course, it does nothing of the kind, but if the NHS are producing statistics that can be so readily misrepresented, then there is a problem. We know there are issues with trust, particularly around black men with mental health problems, as well as issues of vaccine hesitancy for minority groups. In this light, WRES and individuals like Nagpaul may not be helping.

A programme for work, endless work

Despite what mutterings of dissent there might be, it seems WRES is moving forward, at full steam. Phase 1 of WRES entailed the establishment of data collection, as well as supposedly 'supporting the system to understand the nature of the challenge of workforce race equality and for leaders to recognise that it was their responsibility…'.[76]

Phase 2 involves 'enabling people to work comfortably with race equality'. It is promised that '[c]ontinuous embedding of accountability' will 'ensure key polices have race equality built into their core, so that eventually race becomes everyday business'.

There are offshoots of WRES – the aforementioned Medical Workforce Race Equality Standard (MWRES)[77] and a Social Care Workforce Race Equality Standard (SCWRES) launched on 1 April 2021. This marks the spread of WRES from the NHS into local authorities. We were promised on its inauguration that 'The best is yet to come!'[78]

There is further an NHS Workforce Disability Equality Standard (WDES)[79] and a Sexual Orientation Monitoring Information Standard.[80] There is also scope for development for programmes for other 'protected characteristics' mentioned in the Equality Act, only there is nothing to prevent the NHS going beyond them at a whim.

It is not easy to estimate what the costs are for WRES, only to say they will be large, are growing, and have significant opportunity costs, while building up a vested interest that will not go quietly. The problem is that WRES commands significant moral power, regardless of competency, meaning it would be very painful to disband it. Few politicians or NHS executives would relish the chance to be portrayed as being against 'race equality'.

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[75] https://www.bma.org.uk/bma-media-centre/new-report-shows-devastating-scale-and-breadth-of-discrimination-against-ethnic-minority-doctors-working-in-the-nhs-says-bma
[76] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
[77] https://www.england.nhs.uk/wp-content/uploads/2021/07/MWRES-DIGITAL-2020_FINAL.pdf
[78] https://socialworkwithadults.blog.gov.uk/2021/06/09/social-care-wres-in-praise-of-the-phase/
[79] https://www.england.nhs.uk/publication/nhs-workforce-disability-equality-standard-wdes-metrics/
[80] https://www.england.nhs.uk/about/equality/equality-hub/sexual-orientation-monitoring-information-standard/

However, there may be an opportunity to harness what discontent there might be, by highlighting the promises made that failed to deliver, while salaries for those responsible are large and failure is overlooked.

The WRES team itself has a budget of around £1 million per annum. We know one regional NHS boss overseeing WRES was earning around £100,000 per annum, illustrating the potential for money to be spent on salaries. We further know that every NHS trust has staff to collect and process the WRES data, as well as draw up strategies for closing gaps. This also eats into the time of *very expensive* NHS executives such as Prerana Issar, as well as providing justification for more diversity and inclusion officers, whose salaries can reach as much as £75,000 per annum, not to mention the assortment of funded 'BME Networks'.[81]

Additionally, this will also impact on NHS contractors, who are bound to comply, which will be met through raising prices, picked up by the taxpayer. We might also consider the unintended consequences, whereby WRES data is misconstrued as evidence of 'institutional racism', fuelling costly litigation, ineffective remedies, and institutional in-fighting. In terms of opportunity costs, it might also be pointed out that the average salary of a nurse is £31,000 per annum, while the NHS is currently facing a massive backlog of appointments and operations.[82]

It is thus possible that spending on WRES, its offshoots, and associated costs run into the tens of millions per annum, although no exact figures are available. Given it is at least five years in operation, we may be looking at as much as £50-60 million to date. This should be borne in mind against a backdrop of clapping for 'NHS heroes' and tax hikes.

We are now arguably moving into Phase 3 of WRES. Minutes from the advisory group back in 2015 reveal the idea of a '5-year plan for cultural change' was mooted.[83] That is now coming to pass, with work currently being completed on a 'Race Equality Strategy' for the next five years. To date we do not know what this will entail, but it will likely be demands for more power and resources, coated in the language of identity politics and psychological fragility, and geared towards a greater entrenchment of WRES into the everyday workings of the NHS. WRES is an ideological programme since equality of outcomes is not an appropriate condition for real peoples who differ in so many ways. This is a problem in that unelected bureaucrats are enacting political programmes through ideological capture of the state that force, at great expense, political expectations that are not settled, onto free individuals.

[81] https://www.spiked-online.com/2021/09/01/why-does-the-nhs-need-diversity-managers/
[82] https://uk.jobted.com/salary/nurse
[83] https://www.england.nhs.uk/wp-content/uploads/2016/08/wres-sag-mins-17-03-15.pdf

The WRES programme's current head has accused NHS bosses of 'pussyfooting around' the release of the new strategy, in what is an attempt to increase the pressure to comply.[84] But they are right in their hesitance and it is a pity more was not shown before.

Conclusion

What we have is a programme of work that is designed with the intention of bringing about equality of outcomes between two groups – white and non-white.

It rests on statistical indicators that on inspection are flawed, being either misleading through inappropriate benchmarks or susceptible to prevalence. They further fail to satisfy conventional tests of validity, in that they do not all inter-correlate. These statistics were endorsed after an evaluation by academics who did not test their validity empirically. The programme is subsequently lauded publicly, winning an award for excellence. The great and the good wish to be associated with this programme, only it is demonstrably flawed.

Moreover, it can be shown that the expectation of equality of outcomes is unrealistic, since groups enter the NHS with already unequal outcomes.

In any case, the chosen metrics on the whole, stubbornly refused to budge. When the interventions fail to bear fruit, the buck is passed or 'society' is blamed. Instead of humility and contrition, further demands for more power and money are made. But there are considerable costs to all this, most significantly at the expense of patients.

It is estimated that the money spent on the programme and its offshoots, in sum, runs to the tens of millions each year. It can be further demonstrated that it has contributed to acrimonious power struggles in at least one NHS trust, fuelling costly litigation.

All this is backed by NHS executives and politicians who suffer none of the costs. Often, we are talking about the collusion of Conservative politicians with programmes underwritten by the ideological assumptions of the radical left. Ordinary, well-meaning people are enlisted into becoming the vanguard for the programme, given dubious qualifications at the expense of meaningful training that might benefit their careers as well as the general public. The programme grows and grows, spreading to other branches of the state.

If this is being fuelled by legislation, notably the Public Sector Equality Duty, then that should be reformed, particularly to remove the sections that necessitate the publication of data. It may require scrapping, since all that is required is a legal commitment to equality of opportunity and the means to enforce it; these exist elsewhere in legislation. The unintended consequence of this legal duty is to push public authorities into areas where they have no competence, at the expense of the provision of services that are genuinely

[84] https://www.hsj.co.uk/nhse-is-pussyfooting-around-race-strategy-amid-wokery-media-storm-says-lead/7031189.article

needed. The effect of Harriet Harman's higher moral calling, she being the architect of the Equality Act, has been to distort the incentives of public authorities away from their bread and butter, which, particularly in healthcare, hardly seems moral.

The NHS Workforce Race Equality Standard is a failure. Its only *general* benefit is to prove the wisdom of the adage that power is much more easily centralised than knowledge. A vested interest grows, whose premise rests on the assumption that there is sufficient knowledge to bring about the kinds of outcomes desired. Ultimately, there is nothing by way of knowledge, let alone the wisdom to wield it. Rather what they have are a series of statistical constructions that masquerade as such.

Recommendations

It is therefore recommended that government act to achieve the following objectives:

1. Wind up the WRES programme.
2. Conduct a government review into the suitability of existing discrimination complaints procedures, ensuring they are fit for purpose, including the extent to which charges of discrimination are used simply as bargaining tools in litigation. This should be as part of a wider review of the Equality Act 2010.

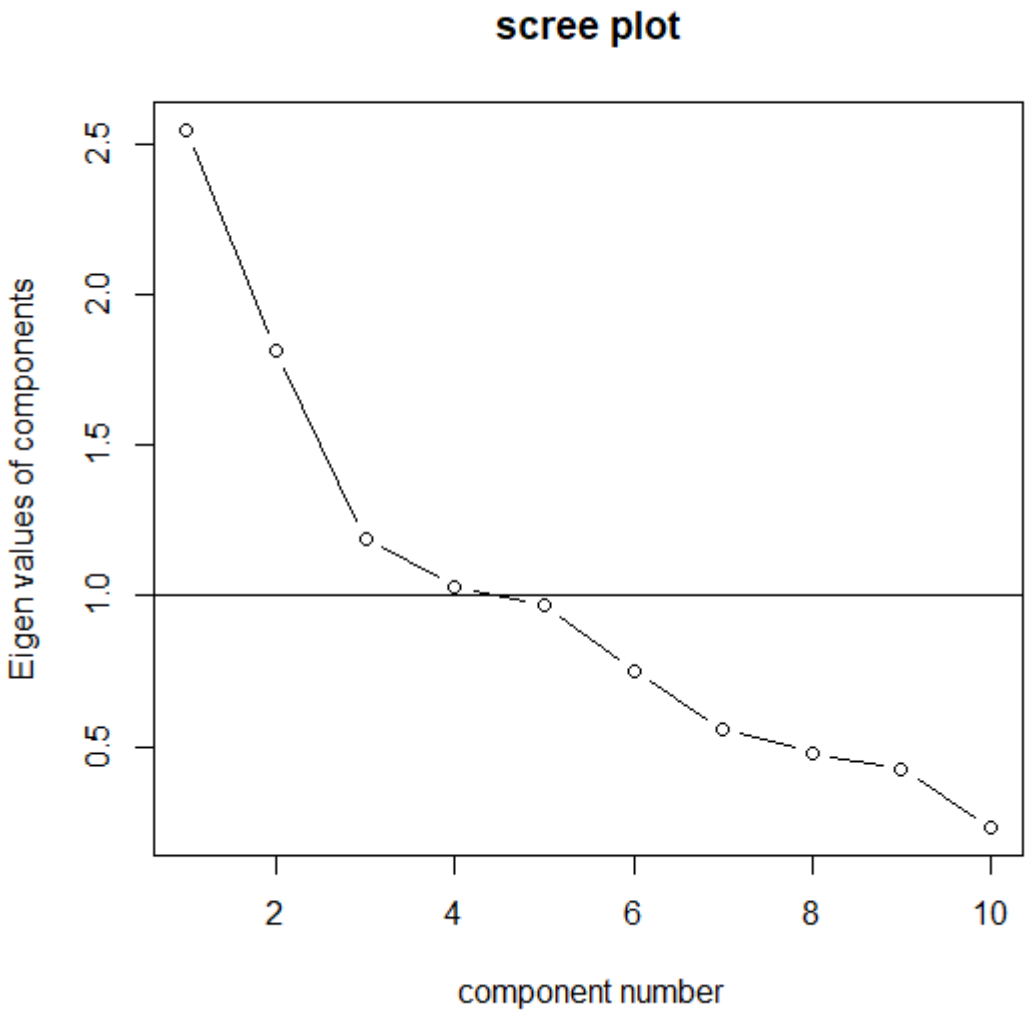
Appendix

Table 7: Description of variables used in factor analysis (Table 4)

Indicator	Description	Operationalisation	Interpretation
1a	Percentage of BME staff	BME non-clinical middle ranking share - BME very senior management share (no data on workforce overall were available at individual trust level, so the intermediate level is used instead)	More +ve, more unequal to detriment of BME
1b		BME clinical middle ranking share - BME clinical senior ranking share (there were a lot of 0s at VSM level, so senior level was used instead)	"
2	Relative likelihood of white applicants being appointed from shortlists across all posts compared to BME applicants	White likelihood / BME likelihood	More +ve, more unequal to detriment of BME
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	BME/White	"
4	Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff	White/BME	"
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME percentage - white percentage	More +ve, more unequal to detriment of BME
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	"	"
7	Percentage of staff believing that trust provides equal opportunities for career progression or promotion	White percentage - BME percentage	More +ve, more unequal to detriment of BME

8	Percentage of staff personally experiencing discrimination at work from a manger/team leader or other colleagues	BME percentage - white percentage	"
9	BME board membership	BME non-clinical middle ranking share - BME board share	More +ve, more unequal to detriment of BME

Figure 6: Results of scree test, confirming a four-factor solution



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