GIG CYMRU NHS WALES

Gofal Cymdeithasol Cymru
Social Care Wales

Llywodraeth Cymru
Welsh Government

Annual National Report 2024-2025 NHS Wales

Safon Cydraddoldeb Hil y Gweithlu (SCHG)
Gweithlu cynhwysol sy'n darparu'r gofal gorau

Workforce Race Equality Standard (WRES)
An inclusive workforce provides the best care

Contents

Foreword

Judith Paget
Chief Executive NHS Wales

The second annual Workforce Race Equality Standard (WRES) report marks another important milestone in our collective journey to improve the quality, consistency, and analysis of workforce data providing a stronger evidence base to support the development of truly anti-racist NHS organisations. This national level report provides us with valuable insights to inform and strengthen NHS Wales organisations ongoing efforts to advance equity, equality, and inclusion across their workforce.

For the first time, the national report also reflects our ambition to better understand the experiences of all staff who provide NHS care for our patients and includes data beyond our directly employed NHS workforce. This report includes some analysis of the experiences of our Black, Asian and Minority Ethnic colleagues who work in primary care for independent contractors. This work is at an early stage and is shared with a view to understand what is needed, and what is possible.

Over the past year, it has been encouraging to see some examples of good anti-racism practice emerging across NHS Wales. NHS organisations have reported back to the Welsh Government on areas of progress and the challenges they face in delivering on the ambitions of the Anti-Racist Wales Action Plan (ArWAP).

Organisations that have been able to identify intentional actions which will mean tangible improvements in the experience of our Black, Asian and Minority Ethnic Staff, have seen improvements in their monitoring data. It is encouraging that this year's WRES findings show early signs of progress, which we need to see maintained and disseminated.

For instance, where inclusive and targeted recruitment practices are implemented with intention, equity in progression improves. Intentional reviews of workforce processes have led to focussed actions that have resulted in positive changes, including improved outcomes in disciplinary and capability procedures for Black, Asian and Minority Ethnic staff.

Other data indicators remain static and have not improved. This may reflect our understanding that meaningful change takes time to be fully reflected in the data. However, it is critical we remain steadfast in our commitment and harness learning about what works across all NHS organisations. Let us continue to use our NHS peer groups, partnerships, and staff networks to ensure that actions are strengthened in response to this year's WRES data are informed by both evidence and the lived experiences of those affected by racism and discrimination.

Key Findings

10.6% representation

The Black, Asian and ethnic minority population of the NHS in Wales has increased by 10.4% over the past year and now makes up 10.6% of the total workforce (from 9.6%).

Band 5 bottleneck

There is worsening under-representation or Black, Asian and ethnic minority staff above Band 5, and falls progressively above that. 51.5% of ethnic minority staff are Band 5 or lower (compared to 49.6% last year).

Disciplinary variation

There remains wide variation between organisations in NHS Wales in their rates of referral of minoritised staff into formal disciplinary processes.

4 (previously 2) organisations had inequality disadvantaging ethnic minority staff.

9.9% undeclared

Non-declaration of ethnicity rates still high at 9.9%, albeit 8.3% improved from last year's figure. Rates remain especially high in senior positions and Board representation.

53.2% perceived equality

Notable 29.8% improvement in Black, Asian and ethnic minority staff feeling their organisation provides equal career progression opportunity, compared to 20.7% improvement for White staff.

1.9x capability inequality

There has been an improvement in this inequality by 45% overall from 3.5x to 1.9x greater likelihood.

5 (previously 4) organisations had inequality disadvantaging ethnic minority staff.

6.7% Board deficit

Black, Asian and ethnic minority representation on Boards is only 3.9%, which is 6.7% below their workforce representation (13.6% worse than last year).

In 7 (previously 9) out of 13 organisations there are no ethnic minority Board members.

2x appointment inequality

Of short-listed applicants, White colleagues are 2-times more likely to be appointed than Black, Asian and ethnic minority ones (14.3% deterioration from last year); this remains especially true for non-clinical posts.

Intersectional bias

There remains high levels of bullying, harassment and discrimination of staff in NHS Wales, and this is experienced more by women than men, especially from Black, Asian and ethnic minority backgrounds.

Introduction

The Workforce Race Equality Standard (WRES) for Health and Social Care in Wales is a key priority action in the Anti-racist Wales Action Plan, created in response to evidence received from the consultation on the Draft Race Equality Action Plan for Wales in 2022. The WRES is a data tool designed to drive radical improvement in the treatment of, and opportunities for, Black, Asian and Minority Ethnic staff in health and social care in Wales.

The starting point of that process is that organisations held a mirror to themselves to identify what their local data told them about the experience of their racially minoritised staff. The WRES enables Health and Social care organisations to reflect on the evidence presented within their local WRES analysis and what this tells them about the experience of their racially minoritised staff.

It enables organisations to identify areas of racial disparity in their workforce experience, to take action to address disparity and consistently monitor the impact of these actions.

The WRES also promotes a learning culture, allowing organisations to compare themselves with similar organisations, and identify actions which are most successful in delivering impactful change.

Finally, the WRES will provide a robust evidence base to underpins existing planning and performance frameworks, providing an accountability and monitoring system that sees leaders be the drivers of change in their organisations.

Used iteratively, the ambition is to see incremental improvements in the experience of the entire workforce in health and social care in Wales, with leaders having clear targets, actions driving measurable improvements, and ultimately all contributing to improved experience of health and care for the Welsh public.

This ambition requires the dismantling of deep-rooted workplace cultures. This report shows some areas of progress, but there remains much to do, and It is clear action is still required, and that employers across need to work together with the regulators to drive the necessary change.

This second national WRES report is a chance to understand that the data seen in last year's inaugural report reflected this engrained inequality, and see where steps are being taken to improve the situation. The report will present the situation in the healthcare sector in Wales, with a separate inaugural social care report published. Embedding the work of the WRES as a tool of workforce inclusion practice is critical to ensuring patient safety, to fulfilling the duty of care to staff and ultimately to meeting the productivity targets of our stretched systems.

Anton Emmanuel

Methodology

Directly Employed Workforce

Data collection

Data was sourced from the all the organisations which deliver NHS services in Wales:

7 local Health Boards

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Powys Teaching Health Board
- Swansea Bay University Health Board.

3 NHS trusts

- Public Health Wales
- Velindre University NHS Trust
- Welsh Ambulance Services University NHS Wales Trust
- Plus the NHS Hosted Body – NHS Wales Shared Services Partnership

2 Special Health Authorities

- Digital Health and Care Wales
- Health Education and Improvement Wales

The WRES mandates all NHS Wales organisations listed above to report against twelve indicators of workforce experience. Six are based on data derived from the NHS Wales electronic staff record (ESR), one on data from the electronic recruitment system and five on data from the national NHS Wales staff survey.

The staff survey data used in this report was collected in October 2024; the ESR and recruitment data was collected as of April 2025.

Data collection was undertaken by NHS Wales Shared Service Partnership (NWSSP) and Health Education and Improvement Wales (HEIW). Data collection was undertaken by NHS Wales Shared Service Partnership (NWSSP) and Health Education and Improvement Wales (HEIW).

Data analyses

We have analysed the data for all 13 organisations against 11 of the 12 indicators: the indicator on compliance with staff completion of the mandatory anti-racism module was not assessed as the module had not been available for a full year since the last collection. The data is presented for all the organisations together (titles ‘NHS Wales’ and generally displayed in purple), but also disaggregated to show the data for (a) the 7 Health Boards (titled ‘HBs’ and displayed in orange), (b) the Trusts+SSP, i.e. Public Health Wales, Velindre and NHS Wales Shared Service Partnership (titled ‘Trusts+NWSSP’ and displayed in yellow), (c) the 2 Special Health Authorities, Health Education and Improvement Wales and Digital Health and Care Wales (titled ‘SHAs’ and displayed in blue) and (d) the Welsh Ambulance Services University NHS Trust (titled ‘WAST’ and displayed in green).

The reason for this disaggregation is that while there are some common data trends, these four sectors differ from each other in terms of the particular domains where there is discrepancy. The complete data analysis table is shown in Appendix B. We have presented the data as granular as possible, to assist understanding of what the indicators reveal. This disaggregation is by gender (men and women) and by ethnicity (broken into sub-categories of Black, Asian and Mixed/Other). When further disaggregation was not possible due to the risk of displaying small numbers (i.e. data points with less than 10 individuals) this has been marked as '<10'.

HEIW have undertaken the data warehousing of the WRES information in line with their national responsibility as the statutory body for workforce planning and workforce intelligence. Data analysis was led by Professor Anton Emmanuel, Head of Strategy and Implementation Health and Social Care for the WRES for Wales, in collaboration with HEIW.

Data caveats

Five of the WRES indicators (3, 4, 10, 11, 12) are drawn from questions in the national NHS Wales staff survey. Staff survey response rates remain low at 21.9%, with lowest rates of response from Health Boards. The reliability of the data drawn from those indicators is dependent upon the overall size of samples surveyed, the response rates to the survey questions, and whether the numbers of Black Asian and Minority Ethnic staff are large enough to not undermine confidence in the data.

The national score was not adjusted based on the number of staff employed by each organisation. Instead, the results in relation to the number of survey respondents, accounting for disaggregated comparisons by ethnicity and gender were considered. Therefore, caution must be exerted in drawing conclusions about the data trends from the survey indicators.

The data for indicator 5 is from the Trac, the recruitment administration system used by NHS Wales, and only includes Agenda for Change (AfC) recruitment processed by NWSSP Recruitment.

There is no data available for indicator 7, since the anti-racism e-learnng module had not been available for a full year at the time of data collection.

For indicators 8 and 9, the calculation uses a review of the period April 2024 to April 2025.

Terminology

Throughout this report, we use the term 'Black, Asian and Minority Ethnic'. For the purpose of brevity and visualisation, this is abbreviated to 'BME' in some figures and tables but written in long-form in the text. Where possible we have followed guidance to disaggregate into more specific categories but avoid the information governance risks associated with small numbers we have kept to categorisations of 'Black', 'Asian', and 'Mixed/Other' to refer to those members of the NHS Wale workforce who are not White. This is largely driven by the data collection process.

Primary Care Workforce

Data collection

The data that makes up this report comes from two sources.

1. Wales National Workforce Reporting System (WNWRS) Hosted by NHS Wales Shared Services Partnership (NWSSP), the WNWRS is a platform for collecting workforce data on contracted primary care staff. It currently provides robust workforce intelligence for General Medical Services (GMS) and is expanding to collect data on the whole of the Primary and Community Care workforce in Wales. Data on the GMS workforce was extracted to populate specific WRES indicators 1 and 2, as of 31 March 2024.

2. **Primary Care Inclusion and Belonging Survey:** Voluntary survey sent to all primary care contracted staff in general practice, dentistry, optometry and pharmacy. Accessed via weblink or QR code to the Learning@Wales website, the short, anonymous survey included questions about fairness and equality in the workplace, experiences of progression and training and wellbeing in the workplace. Data collection was as of 31 October 2024 for the survey derived indicators.

This was the first year of data collection, and there are clear limitations with the data currently available. Rather than waiting for data quality and quantity to improve, we are using the data available to begin the process in an attempt to elucidate key themes and help drive the collection of future more detailed analysis. In sharing this report, we are expressly stating our ambition to produce a comprehensive mapping of the primary care workforce in Wales and the conditions they experience.

We have compared the data to the population census of Wales to identify the relationship between primary care workforce and the population of the country.

Terminology

Throughout this report, we use the term ‘Black, Asian and Minority Ethnic’. For the purpose of brevity and visualisation, this is abbreviated to ‘BME’ in some figures and tables, but written in long-form in the text.

Where possible we have followed guidance to disaggregate into more specific categories, but avoid the information governance risks associated with small numbers we have kept to categorisations of ‘Black’, ‘Asian’, and ‘Mixed/Other’ 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 ethnicity used in the WRES have followed the national reporting requirements in the NHS data model and dictionary.

Domain 1: Leadership and Workforce Representation WRES Indicator 1

Percentage difference by ethnicity between the organisations' Board membership and its overall workforce.

Table 1: NHS Wales data, i.e. all 13 organisations for ethnicity composition; data in brackets is from the year preceding, to show difference in time. The first column (in bold) displays the data for Indicator 1, and the subsequent columns show the detail behind that data.

Data Display

	Difference between Board and workforce %	Workforce composition %	Board composition %	Executive Board composition %	Non-executive Board composition %
Asian	**-4.0%** (-3.1%)	5.9% (5.4%)	1.9% (2.3%)	2.7% (2.3%)	0% (2.4%)
Black	**-0.8%** (-0.7%)	1.8% (1.6%)	1.0% (0.9%)	0% (0.8%)	3.3% (1.2%)
Mixed/Other	**-1.9%** (-2.1%)	2.9% (2.6%)	1.0% (0.5%)	1.4% (0.8%)	0% (0%)
Total BME	**-6.7%** (-5.9%)	10.6% (9.6%)	3.9% (3.7%)	4.1% (3.9%)	3.3% (3.6%)
White	**0.2%** (-8.7%)	79.5% (79.7%)	79.7% (71.0%)	82.3% (77.3%)	73.3% (61.0%)
Undeclared	**6.5%** (14.5%)	9.9% (10.8%)	16.4% (25.2%)	13.6% (18.9%)	23.3% (35.4%)

Data Summary

- Black, Asian and Minority Ethnic people make up 10.6% of the NHS Wales workforce, but only 3.9% of the board composition [Figure 1].
- This inequality is seen in all sectors, and is true of both executive and non-executive ('independent') board members [Table 1, Figure 1].
- 7 of 13 organisations have no Black, Asian or Minority Ethnic board members at all, 9 of 13 have no non-executive directors, and 11 of 13 have no non-executive ('independent') directors.
- There has been no improvement in this indicator in the last year – there were 8 Minority Ethnic board members (out of 214) last year, and there are 8 this year (out of 207) [Table 1].
- There is still a high rate of non-declaration of ethnicity among Board members, at 16.4% albeit this is an improvement from last year (25.2%) [Table 1].

Figure 1: Combined Black, Asian and Minority Ethnic composition of workforce and Board (executive and non-executive) for NHS Wales and each sector expressed as a percentage of each group showing reduced representation in all sectors except for Welsh Ambulance Services University NHS trust (WAST). The red arrow shows the deficit in % representation of Black, Asian and Minority Ethnic people between workforce and Boards in each sector.

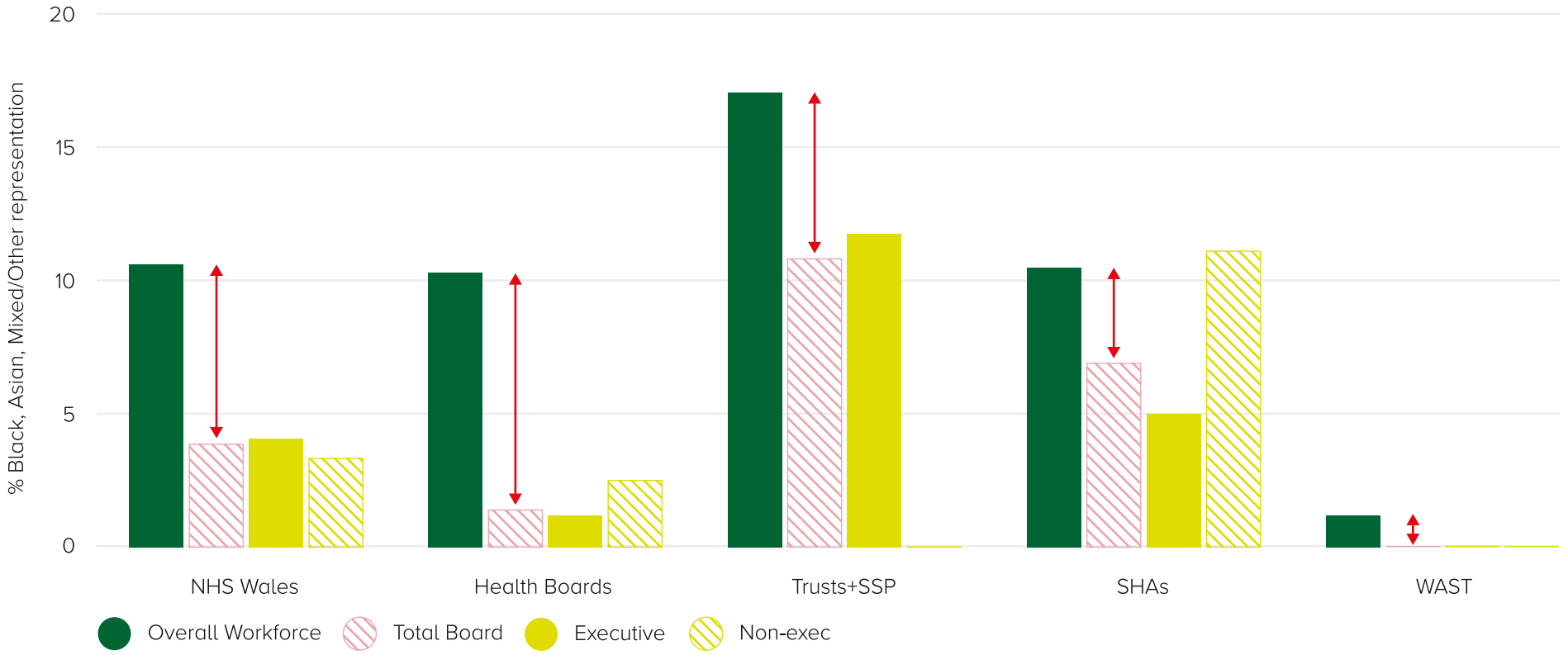

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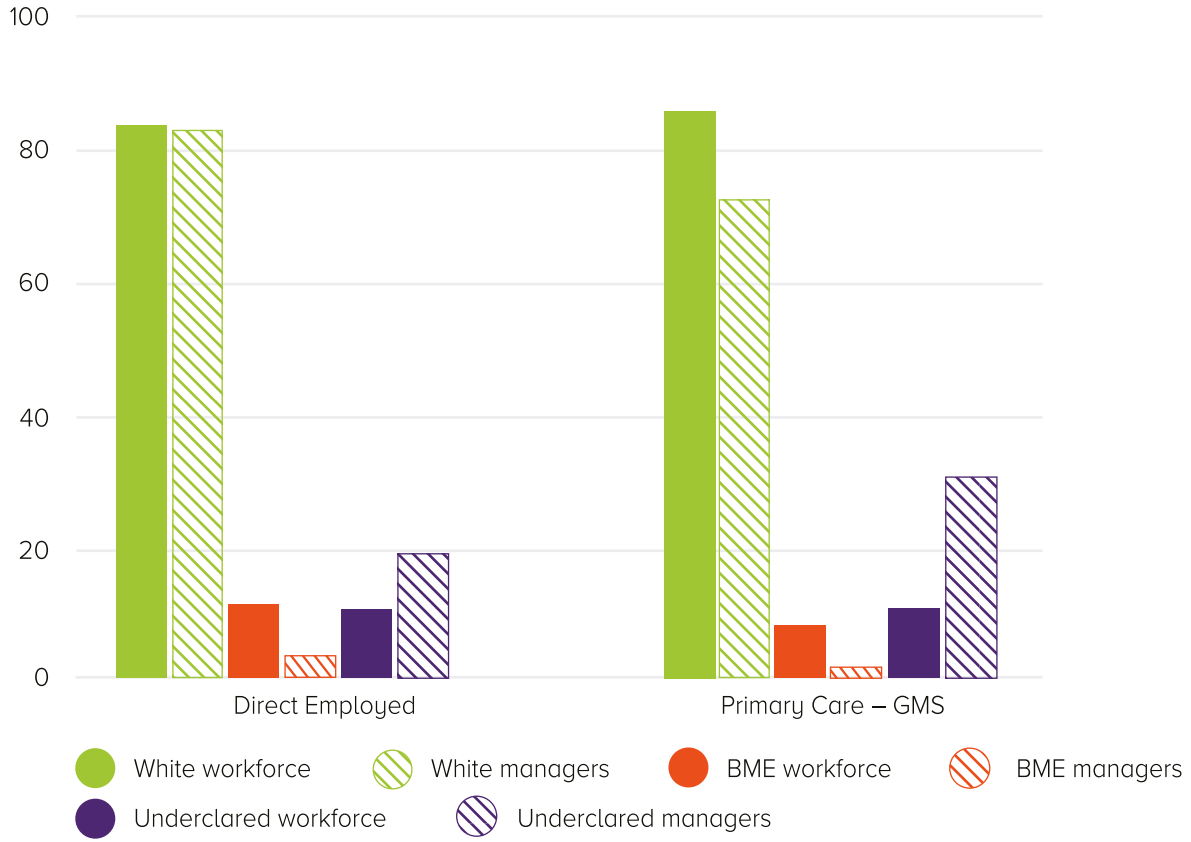
Figure 1a: The comparison across sectors for percentage of workforce and manager representation, stratified by ethnicity (including undeclared). For the directly employed sector, managers are defined as Band 9 and Executive Senior Positions (ESP).

Data Display; Comparing Across Healthcare Sectors



Data Summary: Comparing Across Healthcare Sectors

- Black, Asian and Mixed/Other staff are under represented at managerial level compared to their representation in the workforce. In the directly employed sector it is 3.1% and 10.6% respectively (a deficit of 71%); in primary care GMS it is 1.6% and 7.6% respectively (a deficit of 79%).
- Among managers in the directly employed and primary care sectors there are higher rates of undeclared ethnicity among managers than there are in the workforce.

Targets for Action

- To achieve parity of Board representation of Black, Asian and Minority Ethnic people compared to workforce representation, there would need to be 22 Board members, compared to the current 8.
- With the similar high level of under-representation of racially minoritised leadership in primary care, similar actions to appropriately talent manage, equitably promote and fairly appoint leaders is needed in that sector too.

WRES indicator 2

Representation of staff by ethnicity in each of AfC Bands 1-9 compared with the percentage of staff in the overall workforce.

Table 2: Composition of the workforce in NHS Wales (in bold) and for each sector. Data in brackets is from the year preceding.

Data Display

AfC Workforce

	NHS Wales	Health Boards	Trusts +SSP	SHAs	WAST
White	**79.5%** (79.7%)	79.6% (80.4%)	74.8% (69.5%)	80.6% (80.3%)	88.4% (87.4%)
Aggregated Black, Asian, Mixed Other	**10.6%** (9.6%)	10.3% (9.2%)	17.1% (16.6%)	10.5% (9.8%)	1.7% (1.4%)
Asian	**5.9%** (5.4%)	5.8% (5.2%)	8.7% (8.8%)	6.0% (5.3%)	0.3% (0.3%)
Black	**1.8%** (1.6%)	1.7% (1.4%)	3.5% (3.3%)	2.1% (2.3%)	0.3% (0.2%)
Mixed/Other	**2.9%** (2.6%)	2.7% (2.5%)	4.8% (4.4%)	2.4% (2.2%)	1.0% (0.9%)
Undeclared	**9.9%** (10.8%)	10.1% (10.5%)	8.2% (13.9%)	8.9% (10.0%)	10.0% (11.2%)

Figure 2: Workforce distribution by ethnicity across all NHS Wales. BME = Black, Asian and Minority Ethnic. The dotted line at 8.1% reflects the average percent of BME staff on AfC bands (8.1%)

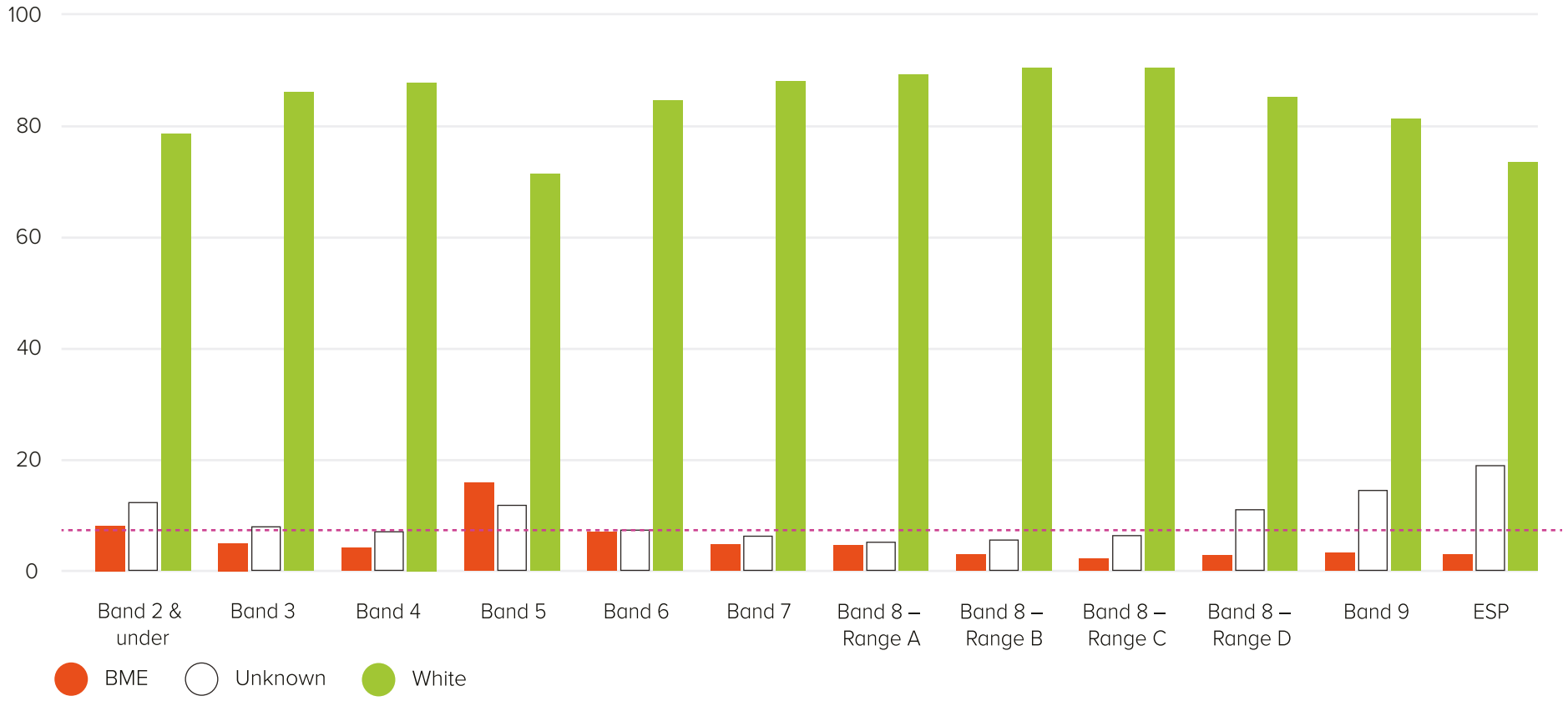


Figure 3: Workforce composition by ethnicity for Health Boards, Trusts+SSP, Special Health Authorities and Welsh Ambulance Service. BME = Black, Asian and Minority Ethnic. Each graph has a dotted line reflecting the percent of BME staff on AfC bands in each sector.

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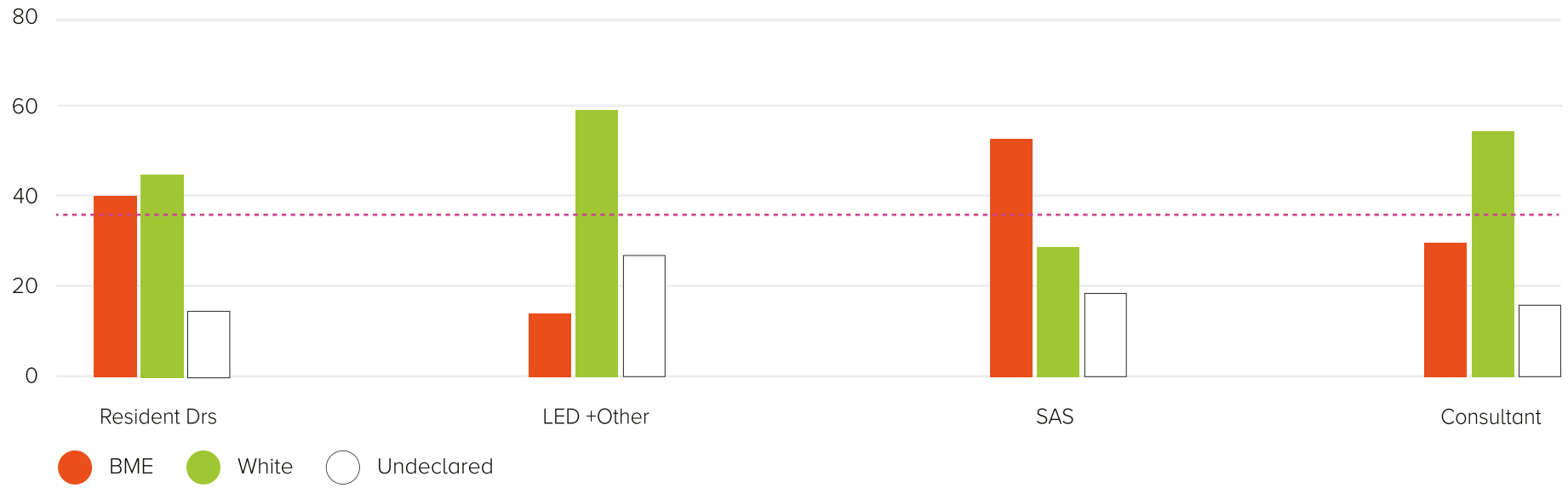
Medical and Dental Workforce

Figure 4: Workforce composition by ethnicity of Doctors and Dentists (non AfC contracts) of various grades in NHS Wales as a whole (Resident Drs = Doctors and Dentists In Training, LED = Locally Employed Doctors, SAS = Specialty and Associate Specialist). The dotted line represents 36.1%, the % of Black, Asian and Mixed/Other doctors and dentists in Wales.



Data Summary

- There has been an increase of 1% of Black, Asian and Minority Ethnic staff in the NHS Wales workforce, up to 10.6%; this 1 percentage-point increase, represents an approximately 10% increase in ethnic minority representation, presumably reflecting international recruitment [Table 2].
- Black, Asian and Ethnic Minority staff are less likely to be seen at higher levels of organisations, the bottleneck occurring at Band 5 in NHS Wales as a whole [Figure 2] and in Health Boards [Figure 3], but at higher Bands in Trusts and SHAs.
- WAST has a small Black, Asian and Minority Ethnic workforce, at 1.7% this represents less than a third of the population prevalence of Minority Ethnic people in Wales as a whole; but those staff who are in WAST tend to progress more equitably through to senior ranks [Figure 3].
- Although there have been modest improvements, there remains a high rate on non-declaration of ethnicity for higher banded staff [Figures 2 and 3].
- Black, Asian and Minority Ethnic doctors and dentists account for 36.1% of all doctors and dentists in Wales; they are under-represented at Consultant grade (29.7%), and over-represented at SAS grade (52.6%) [Figure 4]. The corresponding figures for the preceding year were 28.7% Consultant and 51% SAS doctor.

Data Display

- The disparity ratio (DR) for AfC bands is a measure of representation at different levels of seniority in an organisation. Lower bands are defined as Band 5 and below, Middle as Bands 6, 7, Upper as Bands 8a to 9, and Senior as Executive and Senior posts. A representation ratio for each ethnicity group is calculated by dividing the total number of staff at each band with another, and the DR is determined by comparing the figure with White as the reference group. A ratio of 1 indicates parity of progression (statistically, the four fifths rule proposes that a ratio of 0.8 to 1.25 reflects parity); a value above 1.25 reflects inequality with a disadvantage for minoritised staff.

Table 3: Disparity ratio (DR) calculations for Black, Asian and Mixed/Other staff aggregated, for NHS Wales (in bold) and the other four sectors. Data in brackets is from the year preceding.

	NHS Wales	Health Boards	Trusts +SSP	SHAs	WAST
Lower to Middle	**1.65** (1.51)	1.73 (1.58)	1.24 (1.17)	1.11 (1.06)	0.83 (0.69)
Middle to Upper	**1.71** (1.81)	1.82 (1.90)	1.72 (2.34)	1.73 (1.79)	1.18 (0.92)
Upper to Senior	**1.13** (0.77)	1.99 (1.55)	0.33 (0.36)	0.90 (0.78)	No staff (0.23)
Lower to Senior	**3.18** (2.12)	6.27 (4.66)	0.71 (0.97)	1.72 (1.48)	No staff (0.14)

Table 4: Disparity ratio (DR) calculations for Black, Asian and Mixed/Other staff disaggregated by ethnicity for NHS Wales as a whole; in bold is the aggregated data. Data in brackets is from the year preceding.

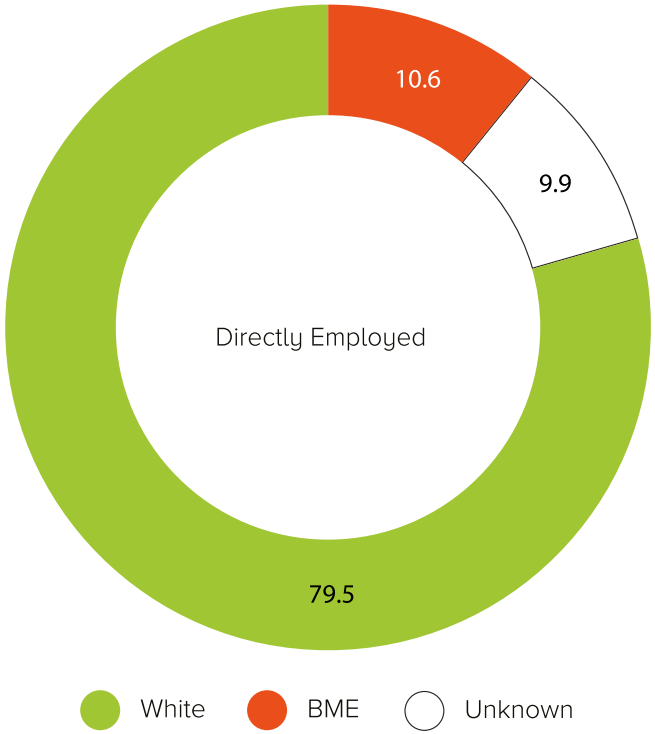
	NHS Wales	Asian	Black	Mixed/Other
Lower to Middle	**1.65** (1.51)	1.82 (1.62)	1.87 (1.64)	1.28 (1.29)
Middle to Upper	**1.71** (1.81)	2.17 (2.27)	1.95 (2.14)	1.23 (1.32)
Upper to Senior	**1.13** (0.77)	0.68 (0.45)	0.53 (0.40)	1.60 (2.56)
Lower to Senior	**3.18** (2.12)	2.67 (1.65)	1.94 (1.39)	2.54 (4.34)

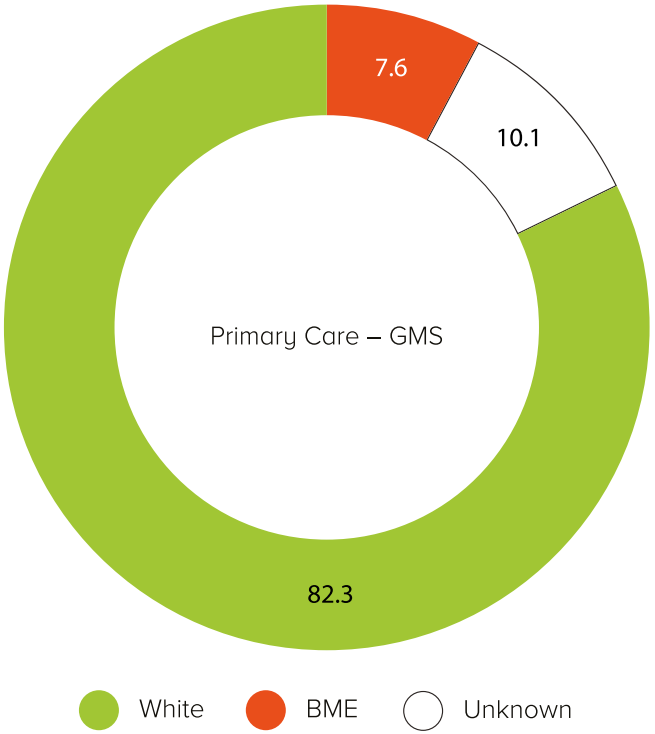
Data Summary

- Black, Asian and Minority Ethnic workforce are under represented at all levels above the lowest Bands (Bands 5 and below) [Table 3].
- This inequality is especially true in Health Boards and SHAs; in Health Boards uniquely among the sectors, there is a particular hurdle from Upper to Senior posts [Table 3].
- WAST remains the organisation with the most equitable representation across the Bands; the small number of minoritised people who are in the service are seemingly able to have a good chance of progression to senior roles, but it is notable that there are no minoritised staff in senior positions in WAST [Table 3].
- The inequality reflected in the Disparity Ratio calculation has got worse in the last year for Middle to Upper representation, and improved for other representations [Table 3].
- Black and Asian staff experience the greatest inequality in Lower to Middle and Middle to Upper progression, whereas for Mixed/Other staff the inequality is across all levels and highest in the Upper to Senior category [Table 4].

Date Display: Comparing Across Healthcare Sectors

Figure 4a: Make up of the workforce across sectors, stratified by ethnicity.





Data Summary: Comparing Across Healthcare Sectors

- The Black, Asian and Minority Ethnic composition of the healthcare workforce is broadly similar in the primary (7.6%) and directly employed sector (10.6%).
- Undeclared ethnicity is also similar in primary care (10.1%) and directly employed (9.9%) sectors.

Targets for Action

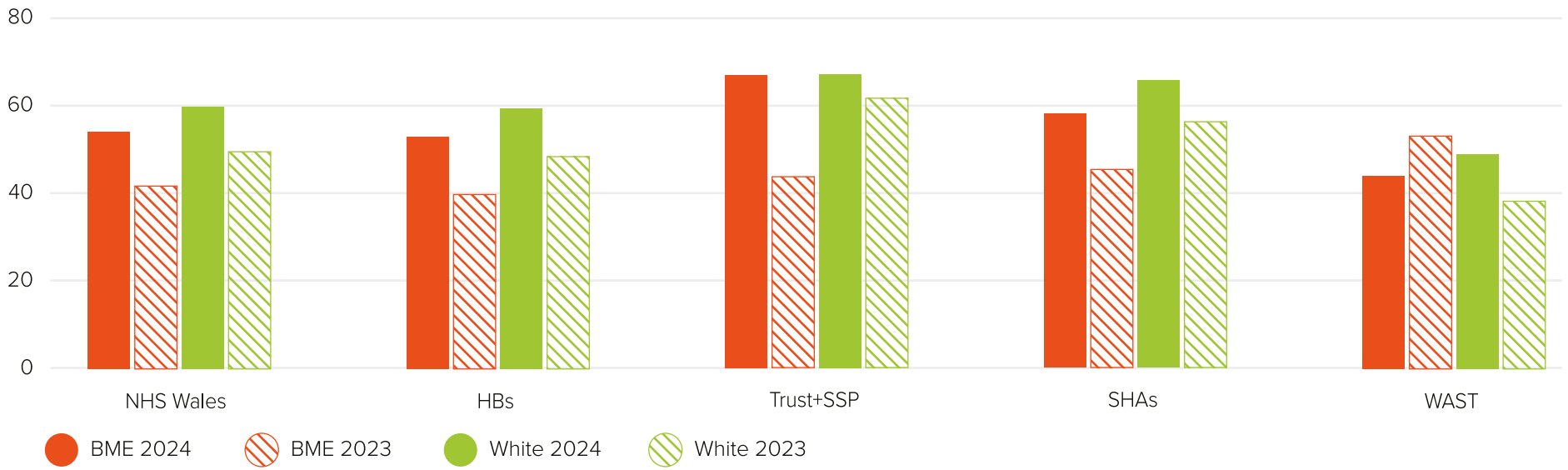
- There is a need for introduction of impactful interventions to reform recruitment and promotion processes. This is true for all sectors. In addition talent management needs to be addressed to develop individuals into senior positions, whose experience is otherwise lost to the service. Across NHS Wales, an estimated 25 Upper and Senior (i.e. above Band 7) appointments per year of Black, Asian and Minority Ethnic staff would progress equity by 2030.

WRES indicator 3

Percentage of staff by ethnicity believing their organisation provides equal opportunities for career progression or promotion.

Data Display

Figure 5: Percentage of staff, compared by ethnicity, believing their organisation provides equal opportunities for career progression; shaded bars show data from previous year.



Data Summary

- Black, Asian and Minority Ethnic staff in 11 of 13 organisations are less likely to feel that their organisation provides equal opportunities for progression compared to White staff.
- There has been an approximately 10% increase in staff confidence that their organisations provide equal progression opportunities in all sectors, with overall over 50% of staff having this sense of equality; the exceptions are for Black, Asian and Minority Ethnic staff in one Health Board, and all staff in WAST.

Figure 5a: Percentage of staff, compared by ethnicity, believing their organisation provides equal opportunities for career progression.

Data Summary: Comparing Across Healthcare Sectors

- Black, Asian and Mixed/Other staff in the GMS sector of Primary Care are less likely to feel that their organisation provides equality of progression opportunities compared to their White counterparts; this is in overall contrast to the situation in the directly employed sector.

WRES indicator 4

Percentage of staff by ethnicity who have sought a progression opportunity in the last 12 months, or are considering seeking progression in the next 12 months.

Data Display

Figure 6: Percentage of staff, compared by ethnicity, who have sought a progression opportunity in the past year; shaded bars show data from previous year.

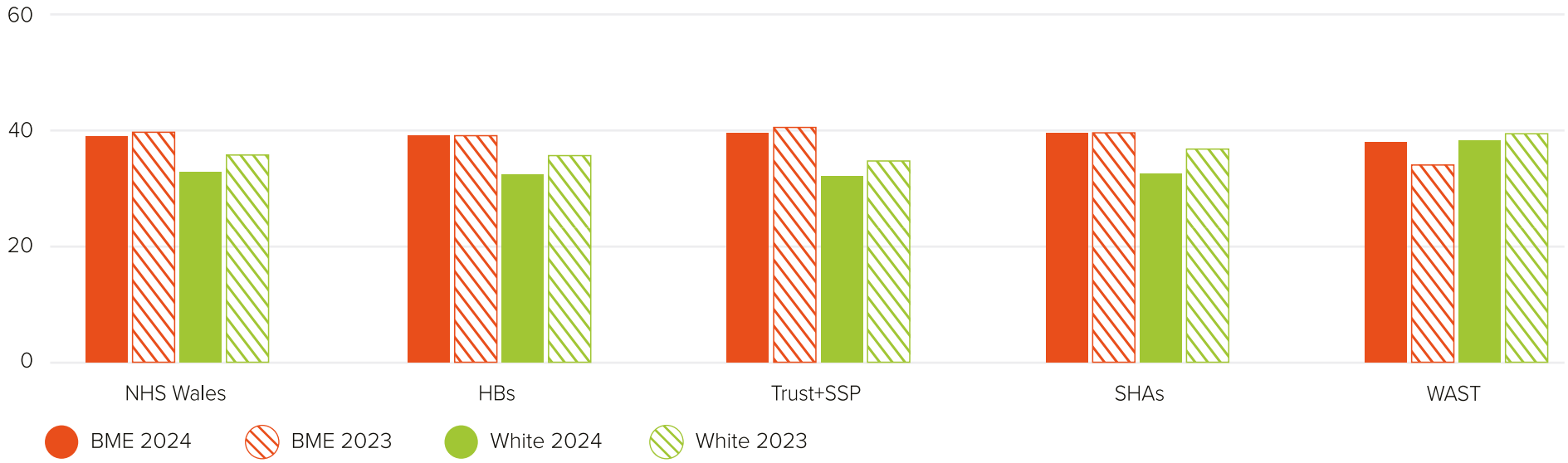
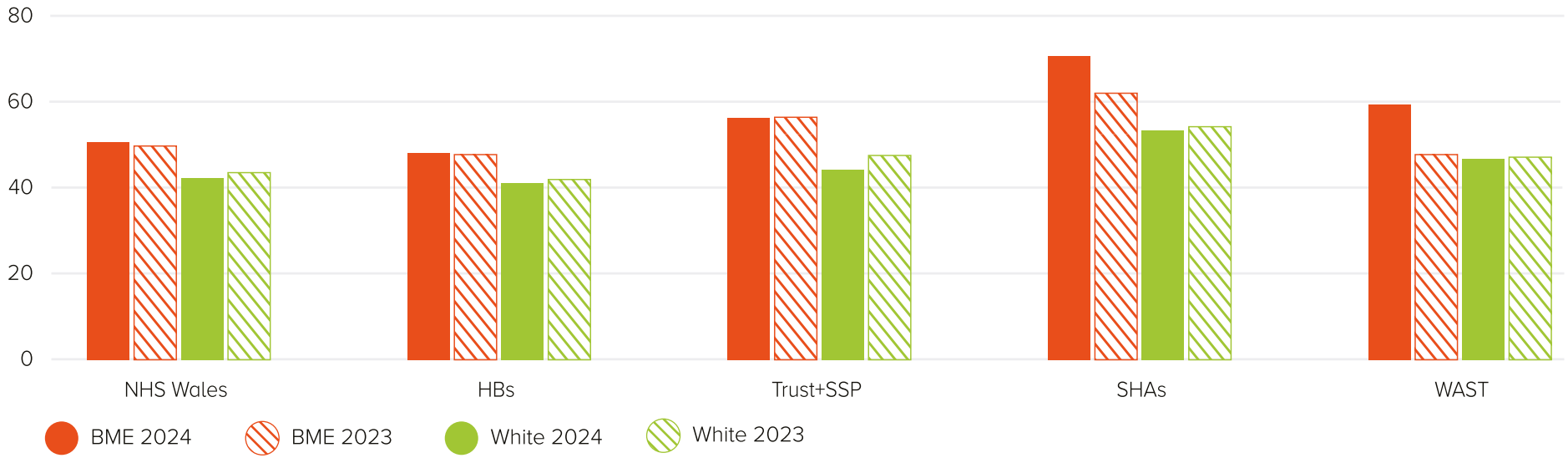


Figure 7: Percentage of staff, compared by ethnicity, who would consider seeking a progression opportunity in the next year; shaded bars show data from previous year.



Data Summary

- Overall, Black, Asian and Minority Ethnic were more likely than White staff to report having sought progression; this was seen across all sectors, and was similar in frequency to the previous year [Figure 6].
- Similarly, Black, Asian and Minority Ethnic were more likely than White staff to report planning to seek progression [Figure 7].
- There was an increase in planning to seek progression seen especially in the SHAs and WAST [Figure 7].
- Comparing those who planned to seek progression in the previous year's data with those who reported seeking progression in the current year showed that 10% fewer actually followed through with progression plans; this trend was seen in all sectors but most marked in SHAs and Trusts+SSP [Figures 6 and 7].

Figure 7a: Percentage of staff, compared by ethnicity, who sought a progression opportunity in the preceding year, comparing across healthcare sectors.

Data Summary: Comparing Across Healthcare Sectors

- Black, Asian and Mixed/Other staff were more likely to have sought progression from their current position.

WRES indicator 5

Relative likelihood of staff being appointed from shortlisting across all posts, classified by ethnicity.

Data Display

Figure 8: Data for NHS Wales aggregated showing likelihood ratio (LR) of staff being appointed after shortlisting, stratified by ethnicity and standardised to White peers as likelihood ratio of 1; applying the four-fifths rule, a LR of <0.8 (dotted line) represents a significant inequality.

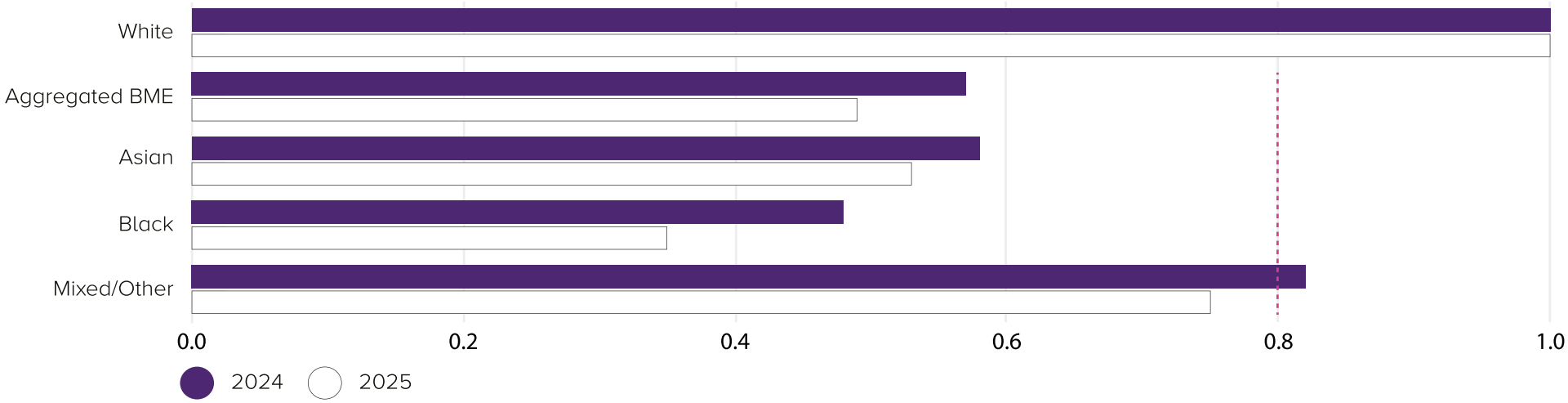
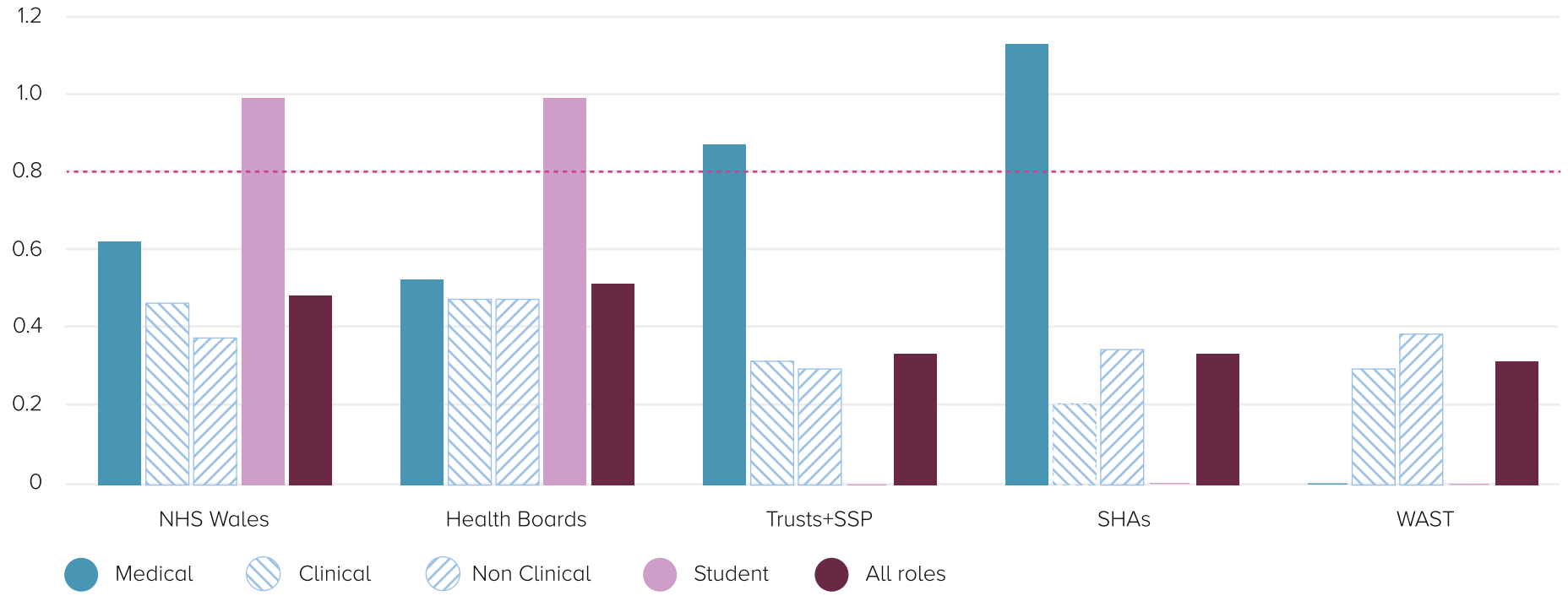


Figure 8a: Data for NHS Wales disaggregated by sector showing likelihood ratio (LR) of staff being appointed after shortlisting, stratified by ethnicity and standardised to White peers as likelihood ratio of 1; applying the four-fifths rule, a LR of <0.8 (dotted line) represents a significant inequality.



Data Summary

- Black, Asian and Minority Ethnic staff are less likely to be appointed to posts after shortlisting, compared to White peers, this is especially true for Black staff [Figure 8, Figure 8a].
- This likelihood ratio averages as 0.5, in other words a shortlisted White applicant is 2 times more likely to be appointed than a Black, Asian or Mixed/Other colleague.
- This figure has got worse compared to the previous year, when the likelihood ratio was 0.57, amounting to a 1.75-times greater likelihood that White rather than minoritised applicants would be appointed.
- This inequality is seen in all sectors, in both clinical and non-clinical roles. Medical appointments are the least inequitable, except in health boards where there is a significant inequality [Figure 8a].

Targets for Action

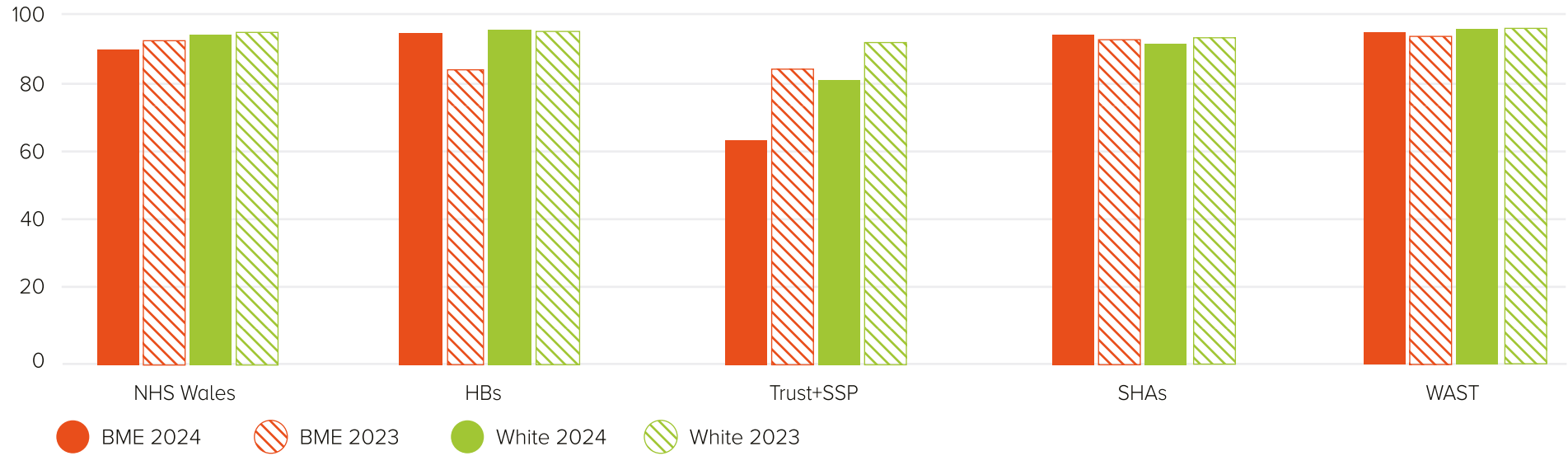
- Debiasing appointment processes is a priority for all sectors and all organisations. The deterioration in likelihood ratio may reflect a more complete dataset this year but highlights the urgency of this. Using positive action and evidence-based inclusive recruitment needs prompt implementation for all appointments, possibly starting with those at Band 7 and above. Unlike some of the earlier proposed measures which require a stepwise targeting, equity for this target needs to be aimed for immediately.

WRES Indicator 6, Domain 2: Professional Development and Training

Relative likelihood of Black, Asian or Minority Ethnic staff accessing non-mandatory training and Continuing Professional Development (CPD) compared to White colleagues.

Data Display

Figure 9: Data for NHS Wales and all sectors showing likelihood ratio (LR) of staff accessing non mandatory training; shaded bars show data from previous year.



Data Summary

- Equal proportions of White and Black Asian and Minority Ethnic staff had enrolled on non-mandatory training or CPD across NHS Wales [Figure 9]; the likelihood ratio for 2025 was 0.96 (compared to 0.98 for 2024).
- There was a notable drop of 20.6% in the percentage of Black, Asian and Minority Ethnic staff in the Trusts+SSP sector who had accessed such training – from 85.5% to 64.9%; there was also a drop of 10.3% for White staff from 93.2% to 82.9% [Figure 9].

Data Summary: Comparing Across Healthcare Sectors

- Compared to the directly employed workforce, in the primary care workforce there seemed to be a racial inequality in accessing training: 36.4% of Black, Asian and Minority Ethnic staff felt that their organisation acted fairly with regard to acquiring additional skills compared to 83.7% of White colleagues.

Targets for Action

- There should be a local exploration of why the mandatory training figure has fallen in that one sector; ideally comparison with appraisal completion and understanding the level of staff where the deficit occurs should be undertaken at the same time. This is the basis for taking remedial action.
- In primary care, sharper wording of future survey questions will help home in on where the bottleneck occurs for Black, Asian and Minority Ethnic staff accessing educational opportunities.

Domain 3: Disciplinary and Capability Processes WRES Indicator 8

Relative likelihood of Black, Asian, or Minority Ethnic staff compared to White colleagues entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Data Display

Figure 10: Likelihood ratio for Black, Asian or Mixed/Other workforce to be referred into disciplinary process compared to White workforce. Each NHS organisation is shown as one dot: Green = Health Boards, Blue = Trusts +SSP, Red = SHAs, hatched = WAST (non-alphabetised random order). Dotted line at 1.2 shows parity, organisations above that line have an inequality affecting ethnic minority staff.

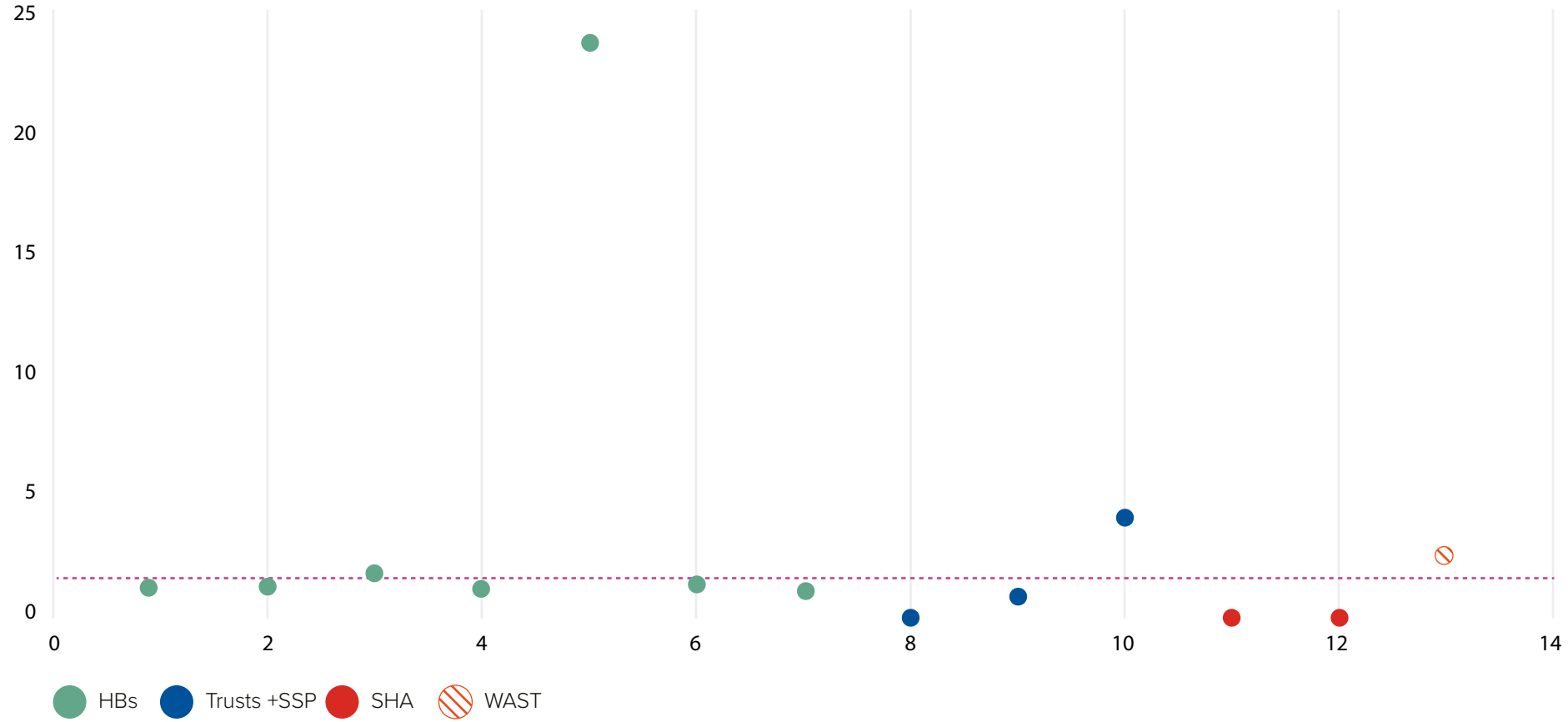


Table 5: Data for all NHS Wales organisations showing likelihood ratio of entering the disciplinary process, according to professional staff group; data is shown for current and previous year, with change in final column. Values above 1.2 reflect inequality affecting ethnic minority staff in that professional group.

Staff Group	2024-2025	2023-2024	Change
Additional Clinical Services	0.9	1.6	-0.8 ▼
Additional Professional, Scientific & Technical	1.7	0.0	+1.7 ▲
Administrative and Clerical	1.0	1.2	-0.3 ▼
Allied Health Professionals	0.6	2.3	-1.7 ▼
Estates and Ancillary	0.7	1.4	-0.7 ▼
Healthcare Scientists	3.7	0.0	+3.7 ▲
Medical and Dental	1.2	0.9	+0.3 ▲
Nursing and Midwifery Registered	1.1	1.3	-0.3 ▼
Total	**0.9**	**1.1**	**-0.2 ▼**

Data Summary

- There is a wide variation in rates of disciplinary referral, varying from no cases reported from the SHAs at one extreme, to a near 25-fold greater likelihood of Black, Asian and Minority Ethnic staff being referred in one HB [Figure 10].
- Overall, 4 out of 13 organisations had a likelihood ratio >1.2 suggesting an inequality adversely targeting ethnic minority staff, two HBs, one Trust+SSP and WAST [Figure 10].
- Although still showing inequity, there has been a significant improvement in WAST [Figure 10].
- The national likelihood ratio for ethnic minority staff being referred into the disciplinary process was 0.88, but there was a striking racial inequality in referral for some professions, namely Healthcare Scientists and Additional Professional Scientific and Technical professionals [Table 5].

Data Summary: Comparing Across Healthcare Sectors

- In the directly employed sector there is data from locally held records of staff entering the disciplinary process and in primary care, the data for this indicator is derived from self-report in the staff survey.
- In the directly employed sector comparing the likelihood of Black, Asian and Mixed/Other staff compared to White staff going through the disciplinary process was 0.9 (a ratio of between 0.8 and 1.2 reflecting equality.
- For primary care staff there was a self-reported 9.6 fold greater likelihood for Black, Asian and Mixed/Other staff reporting being put through a disciplinary process in the last year compared to White staff.

Targets for Action

- The four organisations with excessively high likelihood ratios should undertake local exploration of the context and process of referrals. Learning from examples of best practice and making process changes in line with the revised NHS Wales Maintaining Standards at Work and Disciplinary Policy is key for all organisations.
- The national WRES function will also undertake cross correlation of data with national regulators (General Medical Council, Nursing and Midwifery Council, Health and Care Professionals Council) as an important national action.
- Eliminating racial inequity in referrals while maintaining patient safety should be an immediate target for all organisations.

WRES indicator 9

Relative likelihood of Black, Asian, or Minority Ethnic staff compared to White colleagues entering local capability processes.

Data Display

Figure 11: Likelihood ratio for Black, Asian or Mixed/Other workforce to be referred into capability process compared to White workforce. Each NHS organisation is shown as one dot: Green = Health Boards, Blue = Trusts +SSP, Red = SHAs, Hatched = WAST (non-alphabetised random order). Dotted line at 1.2 shows parity, organisations above that line have an inequality affecting ethnic minority staff.

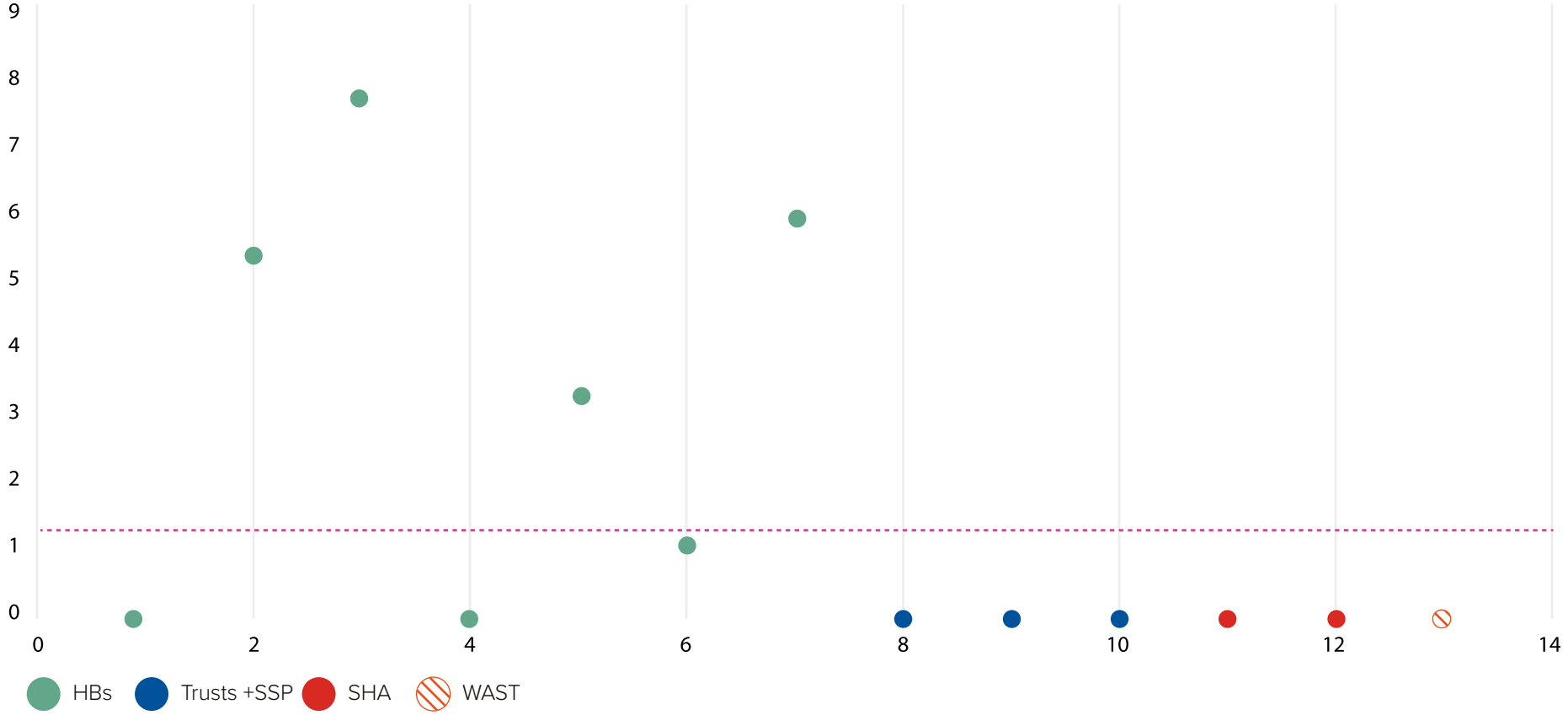


Table 6: Data for all NHS Wales organisations showing likelihood ratio of entering capability processes, according to professional staff group; data is shown for current and previous year, with change in final column. Values above 1.2 reflect inequality affecting Minority Ethnic staff in that professional group.

Staff Group	2024-2025	2023-2024	Change
Additional Clinical Services	3.8	6.7	-2.9 ▼
Additional Professional, Scientific & Technical	0.0	6.8	-6.8 ▼
Administrative and Clerical	6.7	6.5	0.2 ▲
Allied Health Professionals	4.4	9.5	-5.1 ▼
Estates and Ancillary	0.0	0.0	0
Healthcare Scientists	4.4	7.2	-2.8 ▼
Medical and Dental	0.0	0.0	0
Nursing and Midwifery Registered	1.5	2.2	-0.7 ▼
Total	**2.2**	**3.5**	**-1.3 ▼**

Data Summary

- There is a wide variation in rates of capability referral, with 8 organisations reporting no cases and 4 Health Boards showing a greater likelihood of Black, Asian and Minority Ethnic staff being referred compared to White staff [Figure 11].
- The national likelihood ratio for ethnic minority staff being referred into the capability process was 2.22, which represents an improvement in the previous year's data [Table 6].
- This inequality in capability referrals affects both non-clinical (Admin & Clerical) as well as clinical (Allied Health Professional, Healthcare Scientists, Additional Clinical Services staff and Nurses/Midwives) staff [Table 6].

Data Summary: Comparing Across Healthcare Sectors

- In the directly employed sector there is data from locally held records of staff entering the capability process and in primary care, the data for this indicator is derived from self-report in the staff survey.
- In the directly employed sector comparing the likelihood of Black, Asian and Mixed/Other staff compared to White staff going through the capability process was 2.22 (a ratio of between 0.8 and 1.2 reflecting equality). In primary care staff there was a 8.4 fold greater likelihood for minoritised staff reporting being put through a capability process in the last year compared to White staff.

Targets for Action

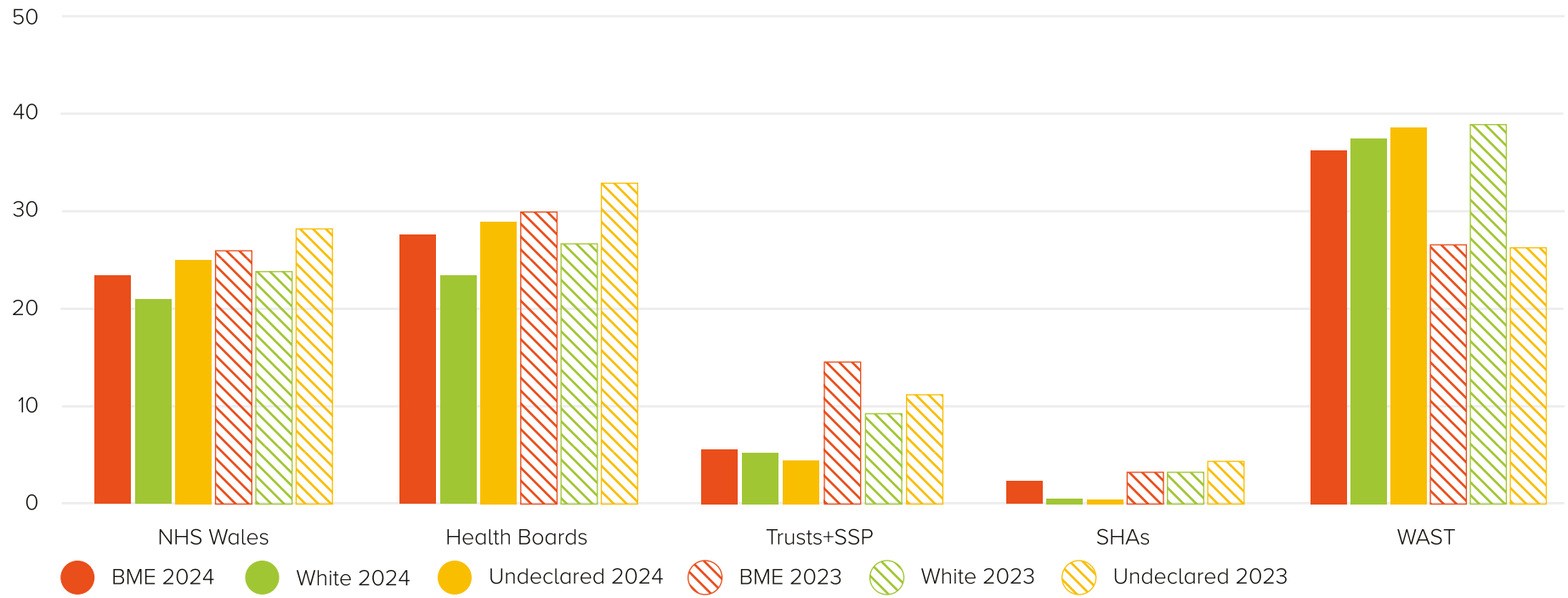
- Local interrogation of capability referral data and processes should be undertaken in the four organisations with high likelihood ratios of Black, Asian and Minority Ethnic staff being referred. This local investigation should interface with the review of disciplinary processes. It is important to understand whether the disproportionality in the 4 Health Boards primarily affects internationally educated staff, and if so, what mitigation is planned. Aiming to reduce racial inequity in referrals should be an immediate target for all organisations.

Indicator 10, Domain 4: Organisational Culture

Percentage of staff, by ethnicity, experiencing harassment, bullying or abuse from patients or public in preceding 12 months.

Data Display

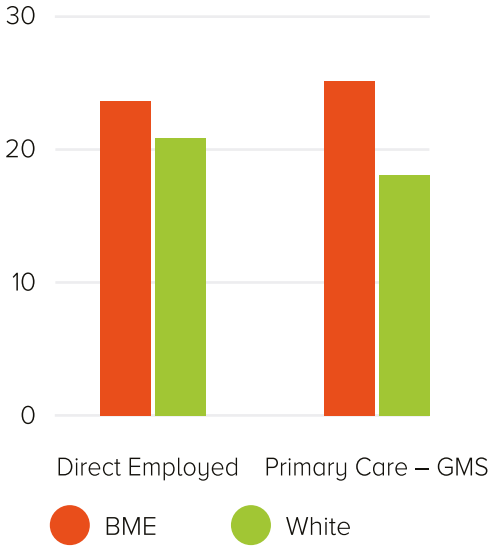
Figure 12: Data for NHS Wales and all sectors showing percentage of staff according to ethnicity (and staff with no declared ethnicity) who reported experiencing harassment, bullying or abuse from patients or public in staff survey; shaded bars show data from previous year.



Data Summary

- Over 1 in 5 NHS Wales staff report experiencing harassment from patients or the public, and this is especially true in public-facing organisations (Health Boards and WAST) [Figure 12].
- The figures for harassment from the public have improved in all organisations compared to the previous year, except for WAST [Figure 12].
- A large proportion of individuals reporting being harassed do not divulge their ethnic origin [Figure 12].

Figure 12a: Percentage of staff according to ethnicity who reported experiencing harassment, bullying or abuse from patients or public in staff survey, comparing across healthcare sectors.



Data Summary: Comparing Across Healthcare Sectors

- Black, Asian and Mixed/Other staff were more likely than White colleagues to report experiencing harassment, bullying or abuse from patients or the public. Higher levels of reported abuse was in primary care.

Targets for Action

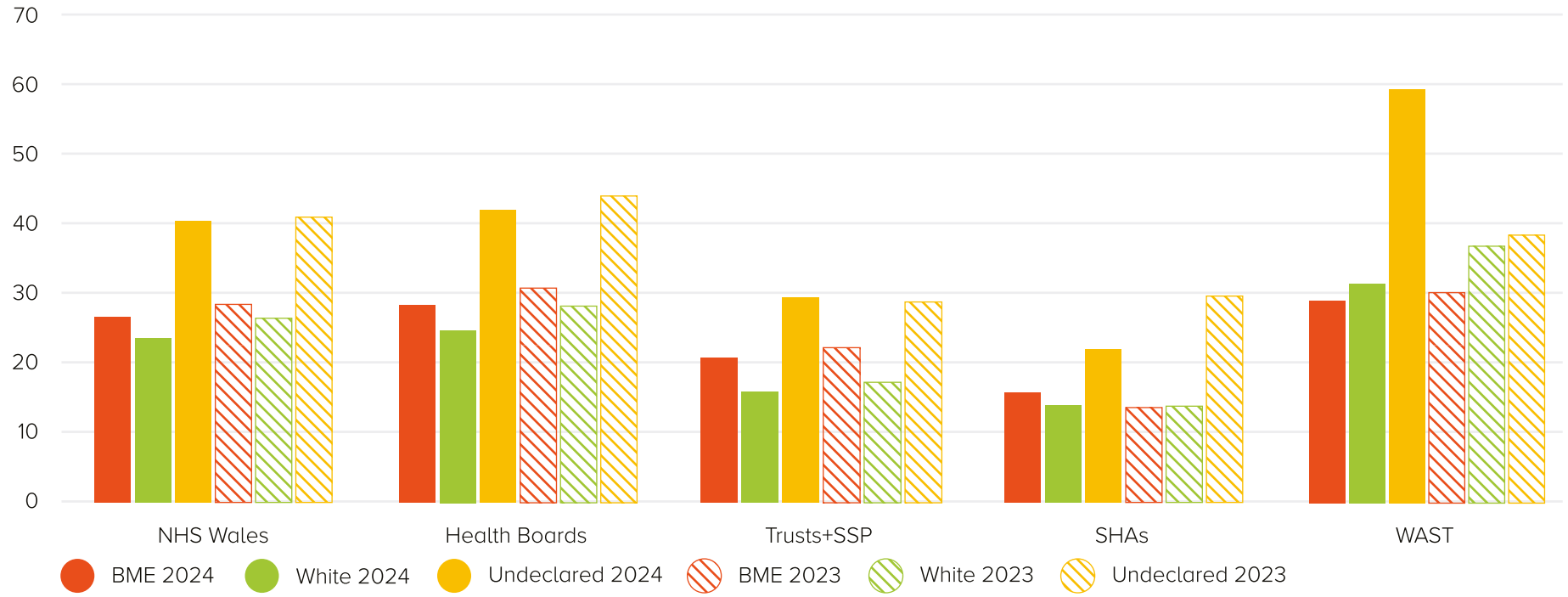
- With low response rates in the staff surveys, it is not possible to draw meaningful conclusions from these data, but they do display an overall trend. Although there is slight improvement, there is still an excess of individuals who are experiencing harassment and bullying from the public, and in this context the true implementation of ‘zero tolerance’ should be addressed in patient-facing organisations.

Indicator 11

Percentage of staff, by ethnicity, experiencing harassment, bullying or abuse from colleagues in preceding 12 months.

Data Display

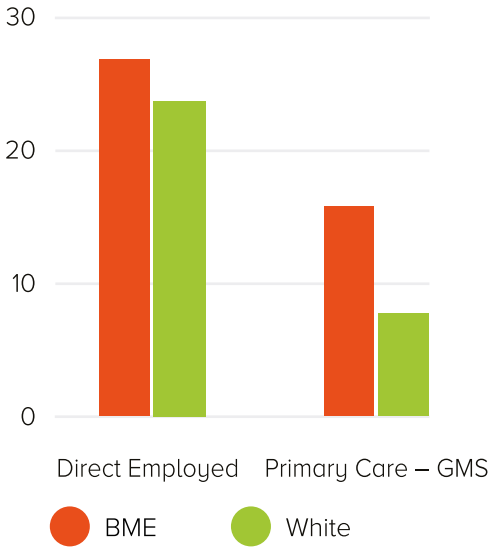
Figure 13: Data for NHS Wales and all sectors showing percentage of staff according to ethnicity (and staff with no declared ethnicity) who reported experiencing harassment, bullying or abuse from colleagues in staff survey; shaded bars show data from previous year.



Data Summary

- Staff report experiencing harassment from colleagues are seen in similar proportions in all sectors [Figure 13].
- Black, Asian and Mixed/Other staff tend to report experiencing harassment more often than White staff [Figure 13].
- There has been little change in the incidence of reported harassment from colleagues compared to the previous year, for either White nor ethnic minority staff [Figure 13].
- A large proportion of individuals reporting being harassed do not divulge their ethnic origin [Figure 13].

Figure 13a: Percentage of staff according to ethnicity who reported experiencing harassment, bullying or abuse from work colleagues in staff survey, comparing across healthcare sectors.



Data Summary: Comparing Across Healthcare Sectors

- Black, Asian and Mixed/Other staff were more likely than White colleagues to report experiencing harassment, bullying or abuse from work colleagues. The highest levels of reported abuse was in the directly employed sector. The greatest proportional likelihood of minoritised staff compared to White staff reporting this harassment was in primary care (2 fold difference).

Targets for Action

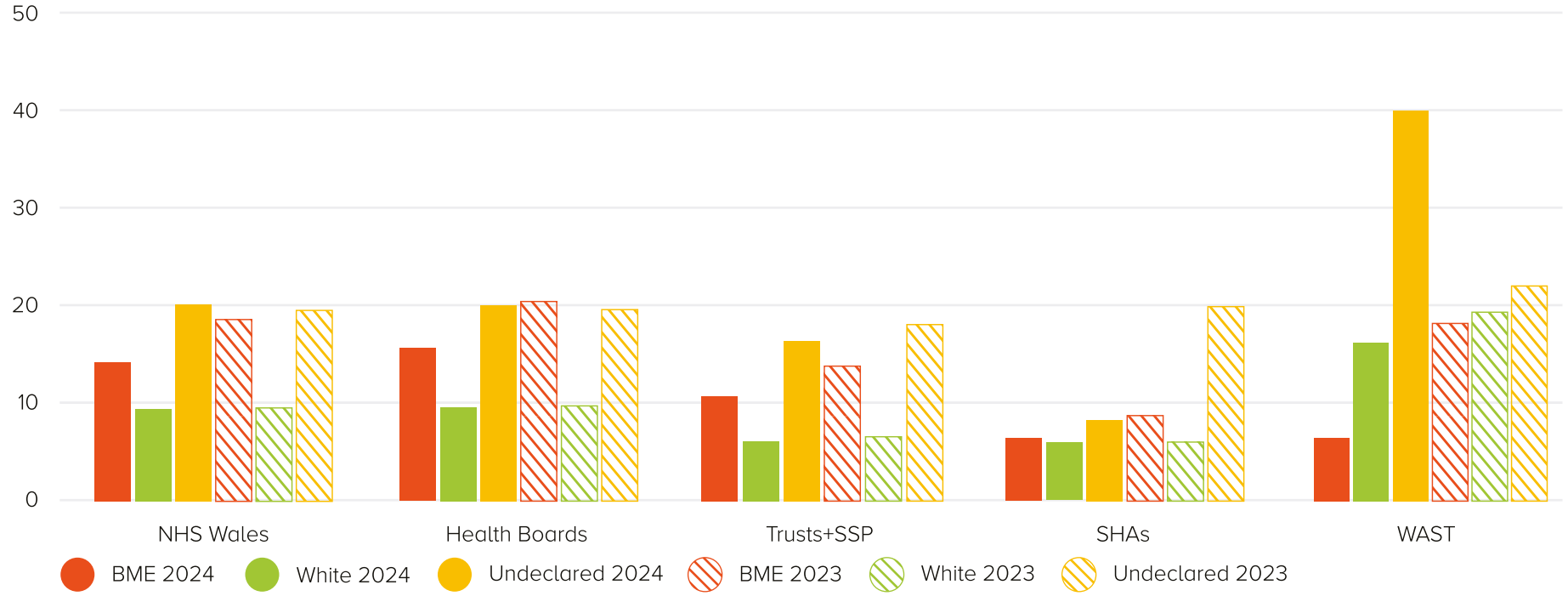
- With low response rates in the staff survey, it is not possible to draw meaningful conclusions from these data, but they do display an overall trend. There remains an excess of individuals who are experiencing harassment and bullying from colleagues, and in this context all organisations should review their steps taken to prevent harassment, in line with the Equality and Human Rights Commission Technical Guidance revised in September 2024.

Indicator 12

Percentage of staff, by ethnicity, experiencing discrimination from a manager or colleagues in preceding 12 months.

Data Display

Figure 14: Data for NHS Wales and all sectors showing percentage of staff according to ethnicity (and staff with no declared ethnicity) who reported experiencing discrimination from a manager or colleagues in staff survey; shaded bars show data from previous year.



Data Summary

- The frequency of staff reporting the experience of discrimination from a manager or colleagues has fallen in all sectors except WAST – the exception to this is the increase seen for staff with unknown ethnicity [Figure 14].
- Despite this reduction, Black, Asian and Mixed/Other staff tend to report experiencing such discrimination more often than White staff [Figure 14].
- A large proportion of individuals reporting being harassed do not divulge their ethnic origin [Figure 14].

Figure 14a: Percentage of staff according to ethnicity who reported experiencing discrimination from leaders and line managers in staff survey, comparing across healthcare sectors.

Data Summary: Comparing Across Healthcare Sectors

- Black, Asian and Mixed/Other staff were more likely than White colleagues to report being discriminated by leaders. The highest levels of reported abuse was in primary care, where the greatest proportial likelihood of minoritised staff compared to White staff reporting this harassment was in primary care (3.3 fold difference).

Targets for Action

- With low response rates in the staff survey, it is not possible to draw meaningful conclusions from these data, but they do display an overall trend. There remains an excess of individuals who are experiencing discrimination from mangers and colleagues, and prioritising inclusive leadership and speaking up culture should be priorities for all organisations, including reviewing steps that they are taking to protect staff in line with the legal requirements in the Equality Act 2010.

Conclusion and Next Steps

1. Underrepresentation of Minority Ethnic Staff in Senior Leadership

Proactive leadership – at all levels – uses data insights and sets the culture of the workplaces that make up an organisation as a whole. A leadership cohort which is reflective of the workforce is well described as being critical to improvements in process and culture. It is therefore distressing to report that despite making up 10.6% of the NHS Wales workforce, Black, Asian and Minority Ethnic staff comprise only 3.9% of Board members. More than half of NHS organisations lack any Minority Ethnic representation on their Boards, and progress has stagnated over the past year.

- **Immediate action is required to increase ethnic diversity in senior leadership. This includes implementing targeted recruitment strategies, setting Board-level diversity goals, and strengthening succession planning and leadership pipelines for Black and Minority Ethnic staff. Progress will be monitored annually by the WRES.**

2. Persistent Barriers to Career Progression and Biased Appointment Processes

Minority Ethnic staff face systemic bottlenecks to progression, particularly from Band 5 upward. WAST is a notable exception, showing equitable progression despite low minority representation. Black, Asian and Minority Ethnic applicants are significantly less likely to be appointed following shortlisting compared to White peers (likelihood ratio of 0.5). This figure has worsened from the previous year.

- **Organisations need to introduce structured talent development programmes, coaching, mentorship, and leadership training specifically aimed at supporting under-represented staff to progress from Band 5 and higher.**
- **Progression pathways must be audited and modified as necessary to ensure fairness across all organisations. Debiasing recruitment and appointment processes is a critical and urgent need. This should involve inclusive recruitment training, structured interviews, and mandated use of diverse panels.**
- **Appropriate use of positive action policies in underrepresented roles is also key, and linking unsuccessful shortlisted candidates into appropriate talent management streams is important.**

3. Racial Inequities in Disciplinary and Capability Referrals

Black Asian and Minority Ethnic staff face disproportionate disciplinary and capability referrals in several organisations, with particularly high disparities in specific professional groups and regions.

- **There needs to prompt implementation of safeguards against discriminatory disciplinary practices. This includes standardising processes, ensuring senior oversight, and reviewing historic cases.**
- **External reviews and cross correlation of data with national regulatory bodies (General Medical Council, Nursing and Midwifery Council Health, and Care Professionals Council) should be part of this systemic reform.**

4. Disparities in Training Access and Career Development

There has been a decline in CPD/training participation among Black, Asian and Minority Ethnic staff in some sectors (notably Trusts+SSP), even though the overall access rate is near parity.

- **NHS Wales organisations must monitor training uptake by ethnicity and ensure equitable access.**
- **Investigations should be undertaken in sectors with declining access, and CPD should be more explicitly linked to career development for the whole workforce.**

5. Inequality in Staff Experience and Perceptions of Fairness

Despite some improvements, Black, Asian and Minority Ethnic staff are consistently less likely to feel that they have equal opportunities for career progression and more likely to report harassment, bullying, and discrimination – especially staff in public-facing healthcare organisations.

- **Embedding inclusive leadership, mandating anti-racism training, and improving the reporting culture must be top priorities.**
- **Action must be taken to empower staff to safely raise concerns and see tangible organisational responses. This would be complemented by speaking-up mechanisms being strengthened and independently evaluated.**

6. Data Completeness and Transparency

High non-disclosure rates of ethnicity and survey non-responses, particularly in sensitive areas like harassment or progression, limit the ability to fully assess and act on inequities.

- **Leaders must spearhead initiatives to improve data collection practices and staff confidence in declaring ethnicity. Emphasising the anonymity of reporting systems, better communication about data use, and a clear commitment to confidentiality and change are needed to address this gap.**

With more than one in ten of the staff working in the NHS being from a Black, Asian or Minority Ethnic background it is invidious that the treatment and opportunities they get in our organisations often do not correspond with the values of the NHS. This has a significant adverse impact on the efficient running of health care.

The intention of this second WRES report is that organisations use the data and insights contained to drive the targeted change that is required locally, developing and implementing evidence-based responses to the challenges their data reveal.

Appendix A: The Workforce Race Equality Standards indicators

Domain		Indicator
Leadership and Representation	1	Percentage difference by ethnicity between the organisations' Board executive and non-executive membership and its overall workforce.
	2	Percentage of staff by ethnicity in each of AfC Bands 1-9 and ESP compared with the percentage of staff in the overall workforce; presented as (a) Disparity Ratio and (b) number of Black, Asian or Minority Ethnic ESPs.
	3	Percentage of staff by ethnicity believing their organisation provides equal opportunities for career progression or promotion (*staff survey*).
	4	Percentage of staff (a) who have sought a progression opportunity in the last 12 months and (b) who would consider seeking a progression opportunity, comparing Black, Asian and Minority Ethnic staff compared to White colleagues (*staff survey*).
	5	Relative likelihood of staff being appointed from shortlisting across all posts.
Professional development and training	6	Relative likelihood of Black, Asian or Minority Ethnic staff accessing non-mandatory training and CPD compared to White colleagues.
	7	Percentage of staff by ethnicity (a) completing anti-racist training and (b) having inclusion objectives set during appraisal.
Disciplinary and capability	8	Relative likelihood of Black, Asian, or Minority Ethnic staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation compared to White colleagues.
	9	Relative likelihood of Black Asian or Minority Ethnic staff entering capability processes compared to White colleagues.
Discrimination, bullying and harassment	10	Percentage of Black, Asian or Minority Ethnic staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months compared to white colleagues (*staff survey*).
	11	Percentage of Black, Asian or Minority Ethnic staff experiencing harassment, bullying or abuse from staff in last 12 months compared to White colleagues (*staff survey*).
	12	Percentage of Black, Asian or Minority Ethnic staff compared to White colleagues, experiencing personally experiencing discrimination at work from either manager/team leader or other colleagues (*staff survey*).

Appendix B: Data Summary

	NHS Wales	HBs	Trusts +SSP	SHAs	WAST
Ethnicity composition of workforce					
Asian	5.9%	5.8%	8.7%	6.0%	0.3%
Black	1.8%	1.7%	3.5%	2.1%	0.3%
Mixed/Other	2.9%	2.7%	4.8%	2.4%	1.0%
BME	10.6%	10.3%	17.1%	10.5%	1.7%
White	79.5%	79.6%	74.8%	80.6%	88.4%
Unknown	9.9%	10.1%	8.2%	8.9%	10.0%
Indicator 1: Percentage difference, by ethnicity, between the organisations' Board (executive and non-executive) membership and its's overall workforce					
Overall Board difference	-6.74%	-8.66%	-6.25%	-3.60%	-1.67%
Executive Board difference	-6.52%	-9.08%	-5.30%	-5.49%	-1.67%
Non-executive Board difference	-7.27%	-7.80%	-17.06%	0.62%	-1.67%
Unknown rates Overall Board	16.43%	18.03%	10.81%	17.24%	26.32%
Indicator 2: Percentage of staff by ethnicity in each of the AfC Bands 1-9 and ESP compared with the percentage of staff in the overall workforce: a) disparity ratio (>1 = inequality)					
Lower to Middle	1.65	1.73	1.24	1.11	0.83
Middle to Upper	1.71	1.82	1.72	1.73	1.18
Upper to Senior	0.87	1.99	0.33	0.9	0
Lower to Senior	2.45	6.27	0.71	1.72	0

	NHS Wales	HBs	Trusts+NWSSP	SHAs	WAST
Indicator 2: Percentage of staff by ethnicity in each of the AfC Bands 1-9 and ESP compared with the percentage of staff in the overall workforce: b) % BME ESPs					
Percentage ESPs who are Black, Asian or minority ethnic	2.83%	1.88%	5.00%	7.40%	0%
Percentage Unknown ESP	21.46%	23.75%	15.00%	14.81%	25%
Indicator 3: Percentage of staff by ethnicity believing their organisation provides equal opportunities for career progression or promotion					
Asian	54.3%	52.8%	56.0%	66.7%	55.6%
Black	45.5%	42.7%	53.8%	52.6%	66.7%
Mixed/Other	54.0%	53.4%	58.2%	69.4%	40.3%
BME	53.2%	52.1%	56.9%	65.6%	43.2%
White	58.8%	58.3%	64.3%	65.8%	48.2%
Unknown	31.9%	31.1%	43.0%	32.1%	18.9%
Indicator 4(a): Percentage of staff who have sought a progression opportunity in the last 12 months comparing Black, Asian and ethnic minority staff to White colleagues					
Asian	42.1%	42.1%	45.1%	38.7%	33.3%
Black	44.8%	41.7%	55.9%	55%	66.7%
Mixed/Other	37.1%	37.8%	34.2%	30%	38.1%
BME	39.7%	39.8%	40.4%	37.9%	38.7%
White	33.4%	33%	32.8%	33.2%	39.0%
Unknown	28.8%	26.7%	32.4%	34.5%	42.5%

	NHS Wales	HBs	Trusts+NWSSP	SHAs	WAST
Indicator 4(b): Percentage of staff who would consider seking a progression opportunity in the next 12 months comparing Black, Asian and ethnic minority staff to White colleagues					
Asian	55.4%	52.7%	61.5%	76.2%	44.4%
Black	59.5%	53.2%	76.3%	80.0%	100.0%
Mixed/Other	45.9%	44.0%	47.9%	60.0%	59.7%
BME	50.8%	48.1%	56.4%	70.7%	59.5%
White	42.4%	41.1%	44.2%	53.4%	46.8%
Unknown	33.9%	33.3%	36.8%	41.6%	29.9%
Indicator 5: Relative likelihood of staff being appointed from shortlisting across all posts (<1 = inequality)					
Overall likelihood ratio (LR) BME staff appointed	0.49	0.52	0.34	0.34	0.32
Non-clinical LR BME staff appointed	0.38	0.41	0.3	0.35	0.39
Clinical LR BME staff appointed	0.47	0.48	0.32	0.21	0.3
Medical LR BME staff appointed	0.63	0.53	0.88	1.14	NA
Student LR BME staff appointed	1	1	0	NA	NA
Indicator 6: Relative likelihood of white staff accessing non-mandatory training and CPD compared to Black, Asian or Minority Ethnic colleagues (<1 = inequality)					
Overall LR	0.96	0.99	0.78	1.03	0.99
% BME staff accessing training	91.29%	95.96%	64.86%	95.54%	96.90%
% White staff accessing training	95.57%	96.86%	82.92%	92.79%	97.01%

	NHS Wales	HBs	Trusts+NWSSP	SHAs	WAST
Indicator 8: Relative likelihood of Black, Asian, or Minority Ethnic staff entering the formal disciplinary process compared to White colleagues (>1 = inequality)					
Overall LR	0.88	0.95	0.95	0	2.17
% BME entering formal disciplinary process	0.58%	0.65%	0.18%	0%	2.70%
% White entering formal disciplinary process	0.67%	0.68%	0.19%	0.52%	1.25%
% Unknown	0.57%	0.56%	0.40%	0%	2.03%
Indicator 9: Relative likelihood of Black, Asian, or Minority Ethnic staff entering local capability process compared to White colleagues					
Overall LR	2.22	2.29	00	0	0
% BME entering local capability process	0.00	0.00	0.00	0.00	0.00
% White entering local capability process	0.00	0.00	0.00	0.00	0.00
% Unknown	0.00	0.00	0.00	0.00	0.00

Indicator 10: Percentage of Black, Asian or Minority Ethnic staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months compared to white colleagues

Asian% (women:men:other)	24.7%	20.3%	28.6%	28.3%	25.4%	33.3%	10.9%	0%	0%	6.1%:	0%	0%	50.0%	28.6%	0%
Black% (women:men:other)	21.8%	13.4%	37.5%	28.7%	16.9%	50.0%	0%	6.3%	0%	0%	0%	0%	0%	0%	0%
Mixed/Other% (women:men:other)	24.7%	21.7%	6.3%	27.7%	23.9%	9.1%	5.8%	5.7%	0%	0%	4.3%	0%	39.4%	40.0%	0%
White% (women:men:other)	21.9%	16.1%	21.2%	24.3%	17.8%	25.2%	5.5%	4.4%	0%	0.5%	1.8%	0%	39.6%	33.1%	18.2%
Unknown% (women:men:other)	28.3%	24.2%	25.0%	32.5%	26.1%	28.1%	5.3%	0%	0%	0%	0%	0%	37.5%	62.5%	41.7%
Total (BME:white:unknown)	23.3%	20.6%	24.6%	27.1%	23.0%	28.4%	5.5%	5.2%	4.4%	2.3%	1.1%	0.9%	35.6%	36.8%	37.9%

	NHS Wales			HBs			Trusts+NWSSP			SHAs			WAST		
Indicator 11: Percentage of Black, Asian or Minority Ethnic staff experiencing harassment, bullying or abuse from staff in last 12 months compared to white colleagues															
Asian% (women:men:other)	27.5%	18.8%	42.9%	27.7%	22.6%	50.0%	30.9%	2.9%	0%	18.2%	6.7%	0%	50.0%	14.3%	0%
Black% (women:men:other)	31.1%	22.4%	37.5%	31.4%	25.4%	50.0%	33.3%	17.6%	0%	30.0%	11.1%	0%	0%	0%	0%
Mixed/Other% (women:men:other)	28.1%	25.9%	31.3%	28.9%	28.3%	45.5%	23.8%	11.1%	0%	19.2%	18.2%	0%	32.4%	32.0%	0%
White% (women:men:other)	23.6%	22.9%	22.5%	24.6%	24.6%	25.4%	16.2%	15.9%	0%	14.9%	11.3%	25.0%	30.9%	31.9%	9.1%
Unknown% (women:men:other)	38.8%	39.2%	40.6%	39.8%	40.6%	41.2%	31.6%	35.0%	23.8%	47.4%	15.8%	33.3%	29.4%	55.6%	66.7%
Total (BME:white)	26.8%	23.7%	40.7%	28.5%	24.9%	42.3%	20.9%	16.0%	29.6%	15.9%	14.0%	22.1%	29.3%	31.7	59.8
Indicator 12: Percentage of Black, Asian or Minority Ethnic staff compared to white colleagues, experiencing personally experiencing discrimination at work from either manager/team leader or other colleagues															
Asian% (women:men:other)	16.8%	9.6%	0%	17.1%	11.2%	0%	18.2%	0%	0%	12.1%	6.7%	0%	0%	14.3%	0%
Black% (women:men:other)	15.4%	10.1%	25.0%	17.5%	12.5%	33.3%	14.3%	5.9%	0%	0%	0%	0%	0%	0%	0%
Mixed/Other% (women:men:other)	12.3%	13.3%	18.8%	13.6%	14.7%	27.3%	8.6%	11.1%	0%	4.0%	4.3%	0%	3.0%	12.0%	0%
White% (women:men:other)	8.7%	9.6%	12.7%	8.8%	10.8%	13.7%	5.8%	4.8%	8.3%	6.5%	3.1%	9.1%	14.8%	14.3%	9.1%
Unknown% (women:men:other)	19.0%	16.4%	14.3%	20.0%	14.8%	14.1%	12.3%	15.0%	13.6%	10.5%	5.3%	0%	29.4%	44.4%	25.0%
Total (BME:white)	13.7%	9.1%	19.4%	15.1%	9.3%	19.3%	10.1%	5.8%	15.4%	6.1%	5.2%	8.0%	6.8%	15.5%	39.4%