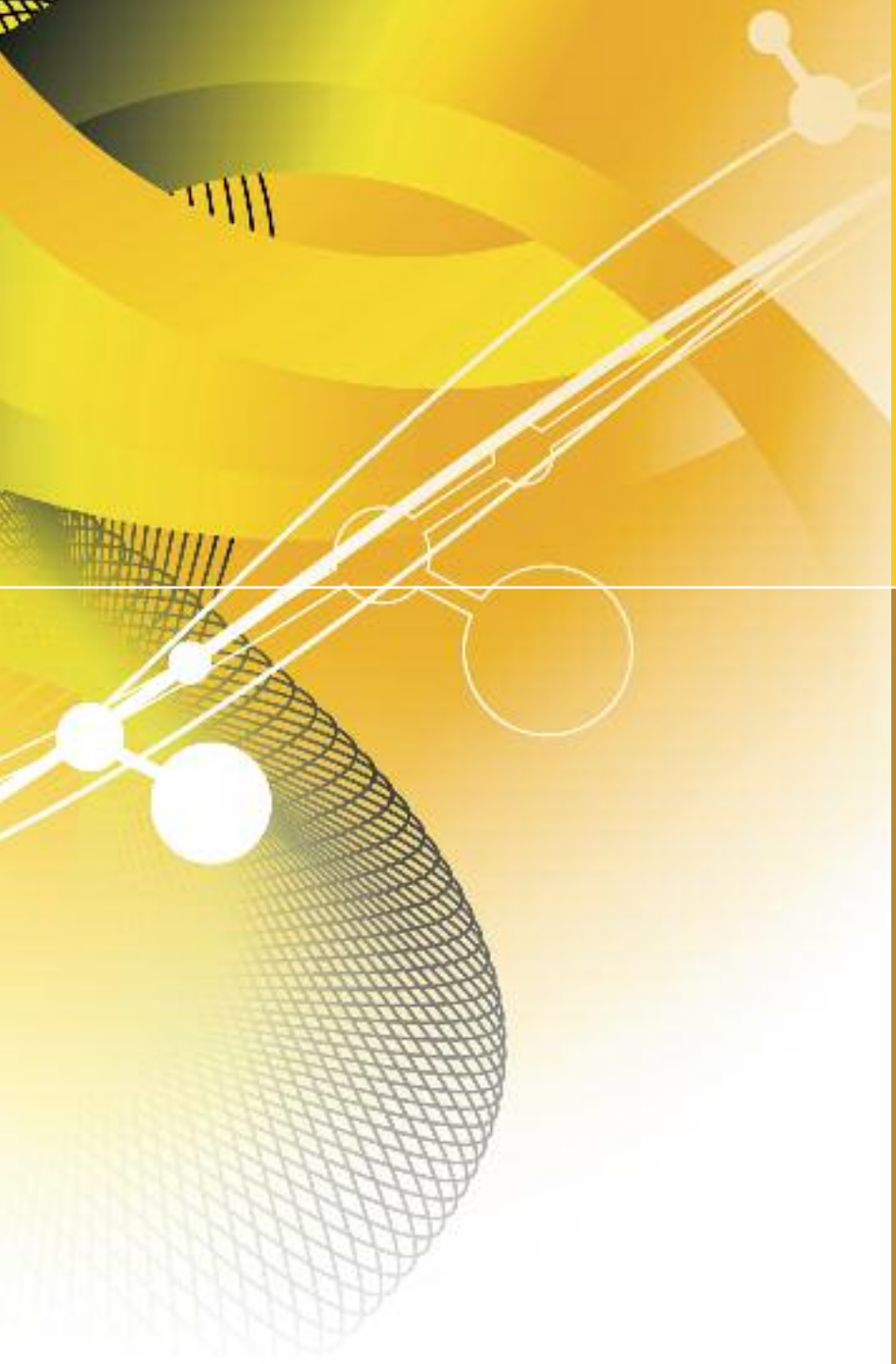

Better Health Briefing 39

Beyond the snowy white peaks of the NHS?

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Key messages

1. The National Health Service (NHS) is England's largest employer of black and minority ethnic people. 37 per cent of doctors, 20 per cent of nurses and 17 per cent of all directly employed staff are from black and minority ethnic backgrounds. Research shows the NHS treats black and minority ethnic staff less favourably than white staff in their recruitment, promotion, discipline and career progression, whilst black and minority ethnic staff are also significantly more likely to be bullied at work. The leadership positions of the NHS – both in executive and non-executive positions - are disproportionately white and often unrepresentative of the local populations served by NHS Trusts.

2. Despite previous efforts to tackle discrimination, notably the NHS 2004 Race Equality Action Plan, such discrimination has remained and shows little, if any, sign of improvement. The 2004 strategy, the Race Equality Action Plan, though characterised by ministerial support and some initial success, appeared to fail, at least in part, due to an absence of measurable, benchmarked outcomes and the absence of sanctions or incentives which meant little accountability or transparency as other priorities held sway.

3. New research demonstrating the scale and persistence of discrimination comes at a time when research evidence has demonstrated the link between the treatment of staff and patient experience and outcomes and, in particular, the links between patient experience and the treatment of black and minority ethnic staff. Such research provides a powerful business case for tackling discrimination to improve patient care, especially when further strengthened by evidence that diversity in leadership benefits innovation and the likelihood that NHS organisations whose leadership more closely resembles that of the communities being served will be more sensitive to their needs.

4. A major new initiative to improve race equality in the NHS and better draw on the talents of its workforce was launched in April 2015, with the introduction of a Workforce Race Equality Standard (WRES), mandated by the NHS Standard Contract and to be inspected by the Care Quality Commission (CQC). This approach draws on UK and international evidence of other successful approaches to tackling discrimination and is introduced in the expectation that it will have greater likelihood of success than previous NHS efforts. It is intended that this approach should complement existing efforts such as the Equality Delivery Scheme (EDS2) and may be extended to other protected characteristics.

Introduction

The NHS is England's largest employer of black and minority ethnic staff. In the wake of the Macpherson Inquiry (1998), the NHS launched a major national initiative, the Race Equality Action Plan (Department of Health, 2004), to address the striking absence of black and minority ethnic staff from senior positions. Research a decade later, in 2013 and 2014 (Kline, 2013, 2014d), suggested that little progress had been made, notwithstanding research demonstrating a powerful business case linking workforce race discrimination to patient experience (e.g. Dawson, 2009; West *et al.*, 2012). The NHS Workforce Race Equality Standard (WRES) is a new national initiative which commenced in 2015. It holds a mandatory element with measurable benchmarked outcomes. The WRES metrics have three main groupings:

1. Workforce (recruitment, seniority, disciplinaries and non-mandatory training)
2. Staff experience (staff survey indicators)
3. Board composition

1 Leadership and equality in the NHS

The NHS Constitution (2013) states that staff have the right to *'Be treated fairly, equally and free from discrimination'* (Staff Right 5). In 2005, Esmail *et al.* concluded that *'the NHS must embrace diversity as a central facet of its business plans. This requires leadership that recognises the centrality of diversity as a management practice'* (Esmail *et al.*, 2005). Key guidance for NHS Boards reiterates equality as one of the *'hallmarks of an effective strategy'* (NHS Leadership Academy, 2013). More recently, NHS Guidance suggested that *'organisations are best served by boards drawn from a wide diversity of backgrounds and sectors. This includes the expectation that board composition reflects the diverse communities they serve'* (NHS Leadership Council, 2010). Reflecting a concern over the monocultural nature of many Boards, The Healthy Board 2013 (NHS Leadership Academy, 2013) highlighted there is *'a tendency to 'opaque and subjective' board appointment processes.'*

National NHS bodies

The most important decisions about how the NHS should be run, and what services should be prioritised, are taken by NHS Trusts, NHS England, Clinical Commissioning Groups (CCGs) and three regulators (Monitor, TDA and CQC).

Reliable comparative historical data on the ethnic composition of national NHS bodies is not available due to numerous restructures. Currently, the Boards of the main national NHS leadership bodies fail to reflect the ethnic composition of their wider workforce or the population they serve. For example, there are just two black and minority ethnic non-executive directors across NHS England, the CQC, Monitor, and the TDA, and not one minority ethnic executive director.

Trust Boards

The Appointments Commission (2009) set Board appointment targets for the NHS for women at 44 per cent for chairs and 50 per cent for all appointments, whilst black and minority ethnic targets were set at 8 per cent for chairs and *'at least 10%'* for all appointments. National data suggests meeting these goals remains elusive. The targets were not met in any subsequent year for either women or minority ethnic appointments, and, by 2013, black and minority ethnic NHS Trust Board appointments had dropped to 5.8 per cent overall, the lowest proportion since 2006.

This decline in minority ethnic representation coincided with the reduction in the number of Primary Care Trusts between 2006 and 2013, and their subsequent abolition and replacement with CCGs in 2013. Whilst the relationship between these changes and the declining number of black and minority ethnic Trust Board members is unclear, the NHS England Board heard concerns that such changes might lead to a loss of senior black and minority ethnic staff from Strategic and Regional Health Authorities and Primary Care Trusts (NHS England, 2012).

There is little correlation between the ethnic composition of the surrounding population and the ethnicity of Board members in many parts of the country. Although black and minority ethnic people constitute approximately 45 per cent of London's population[1] and 41 per cent of the London NHS workforce, just 7.9

[1] The ONS census 2011 reports this as 40 per cent. There is significant under-reporting in London by the census of "illegal immigrants" and their families. See Para 16 Table 2 of www.london.gov.uk/mayor/economic_unit/docs/irregular-migrants-report.pdf which estimated the mid-range of "illegal immigrants" in London at 432,000 in 2007. Many such migrants will not have provided a census return and the numbers are likely to have increased since, hence the conservative addition of 5 per cent to the actual numbers of London's minority ethnic population.

per cent of London NHS Trust Board members came from a black and minority ethnic background in 2013 (Kline, 2014d). Kline (2014d) also showed that, for London:

- The proportion of chief executives and chairs from a minority ethnic background decreased from 5 per cent in 2006 to 2.5 per cent in 2014.
- Over two fifths of NHS Trust Boards had no black and minority ethnic members at all, with no significant change in appointments in recent years.
- White staff are three times more likely than black and minority ethnic staff to hold senior managerial positions and the proportion who are minority ethnic has fallen slightly in the last three years.

Clinical Commissioning Groups

The NHS England report, *Clinical Commissioning Group Workforce Equality and Diversity Profile (2013b)*, did not report on the ethnicity or gender of the chief executive and other executive CCG Board members. It does show that 12 per cent of CCG Governing Board members nationally and 18 per cent of London CCG Governing Board members are from a black and minority ethnic background. While such data suggests that the Governing Boards better reflect the growth in numbers of black and minority ethnic General Practitioners (GPs) (HSCIC, 2012), there is no published evidence on whether or not the absence of black and minority ethnic senior employees in CCGs reflects the pattern elsewhere in the NHS.

Senior managers

The NHS Agenda for Change regrading exercise means that any comparisons with pre-2008 grading data are unreliable. From 2008-2013 there was no significant change in the proportion of black and minority ethnic staff in senior bands 8a-9, at 5.7 per cent in 2008 and 5.9 per cent in 2013 (HSCIC, 2014), though both the national and London data suggests the proportion may have peaked in 2010.

Between 2008 and 2013, there was no national increase in the proportion of black and minority ethnic nurse directors (HLOPQ44, 2014). Increasing the proportion of Executive Directors from these backgrounds could be challenging due to the lack of representation at senior NHS management levels: the proportion of minority ethnic nurse managers fell to 7.8 per cent in 2012, from a peak of 8.7 per cent in 2008. This figure was lower than the 8.2 per cent in 2003, despite a substantial increase in the number of black and minority ethnic nurses and midwives in the intervening decade (HLOPQ44, 2014). In 2007, Pike and Ball found that black and minority ethnic nurses work, on average, 15.1 years to reach senior ward sister level, compared to an average of 11.8 years for white nurses.

2 Why does workforce race equality matter in the NHS?

Services provided by NHS organisations which discriminate against black and minority ethnic staff may be adversely affected in seven ways.

Firstly, patients may be prevented from getting the best clinicians and support staff if candidates' ethnicity unfairly influences recruitment and promotion. All available indicators suggest systemic patterns of disadvantage for black and minority ethnic candidates in recruitment and promotion (Kline, 2013; Pike and Ball, 2007). For example, research from 2013 showed that the likelihood of a white shortlisted applicant being appointed was 1.78 times greater than that of a black and minority ethnic applicant (Kline, 2013). A number of studies suggest that these findings are reflected nationally (Lyfar-Cisse, 2008; Kline, 2013).

Secondly, there is evidence of a link between diversity in teams and innovation. At a time when the NHS needs to transform care, lack of diversity may carry a cost in patient care for everyone. Health care teams are generally more innovative when they have a more diverse set of backgrounds represented (Fay *et al.*, 2006). Greater gender and race diversity at board level is positively associated with greater innovation (Bennington, 2010).

Diversity enables organisations to draw on a larger pool of talent, increasing their capacity to innovate and better satisfy customer needs (Cox and Blake, 1991; Hunt *et al.*, 2014).

Thirdly, leadership bodies which are significantly unrepresentative of their local communities, such as NHS Trust Boards, may have more difficulty ensuring that care is genuinely patient-centred. This can result in failings in the provision or quality of services to specific local communities that have particular health needs, including black and minority ethnic communities and patients (NHS Leadership Academy, 2013). Recent work suggests that the ethnic representativeness of a workforce has an influence on the perceptions of service receivers and in turn upon organisational performance (King *et al.*, 2011).

Fourthly, less favourable treatment of black and minority ethnic staff diverts resources from patient care through grievances, sickness absence, turnover, loss of discretionary effort, lowered morale, employment tribunals and reputational damage. Black and minority ethnic staff are almost twice as likely to be disciplined as white staff (Archibong and Darr, 2010) and scrutiny of midwifery disciplinary action in London found a similar pattern (Royal College of Midwives, 2014). Minority ethnic staff are disproportionately referred to professional regulators. (Sprinks, 2014a; Sprinks, 2014b; Wilmshurst, 2013; and Stirling, 2013). NHS Leadership Academy data showed that black and minority ethnic staff were substantially under-represented on key development courses (Calkin, 2013). The NHS National Staff Survey (2014) reported that almost one quarter of the black and minority ethnic workforce experienced discrimination, a significantly higher rate than for white staff. Almost one quarter of minority ethnic staff did not believe their employer provided equal opportunities for career progression or promotion. Moreover, these disparities between white and black and minority ethnic staff appear to be consistent with bullying, career progression and discrimination survey indicators over the past six years.

Fifthly, race discrimination adversely impacts on staff well-being and health (Rao, 2014). West *et al.* (2011) found that bullying, discrimination, and overwork lead to disengagement and *'are likely to deprive staff of the emotional resources to deliver compassionate care'* with a strong negative correlation between harassment, bullying or abuse from other staff and overall patient experience.

Sixthly, there is a good correlation between the treatment of black and minority ethnic staff and the care that patients receive. The Department of Health (2014) has acknowledged:

> *"…a strong relationship between staff wellbeing and performance outcomes, with evidence demonstrating a causal link. How patients experience care can be just as important as the actual medical treatment they receive. Staff wellbeing is important in its own right (for example in relation to stress, bullying, and harassment) and it can improve the quality of both patient experience and their health outcomes."*

Dawson (2009) examined the links between staff treatment and clinical outcomes, and found that discrimination, 'in particular discrimination on the basis of ethnic background,' was most consistently strongly linked to patient experience. Three years later, Michael West and colleagues found that:

> *"…the experience of black and minority ethnic (BME) NHS staff is a good barometer of the climate of respect and care for all within the NHS. Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received. Conversely, the greater the proportion of staff from a BME background who reported experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction"* (West *et al.*, 2012).

Finally, evidence that workforce race discrimination impacts on patient safety was reported in the Freedom to Speak Up Report (Francis, 2015) which reported that black and minority ethnic staff who raised concerns at work are:

- More likely to be victimised by management than white staff raising concerns
- More likely to be ignored than white staff raising concerns
- More likely to be victimised by co-workers for raising concerns
- Less likely to be praised than white staff by management for raising concerns
- Less likely to raise a concern again having done so once, than white staff were

If the NHS (and other public sector organisations) becomes a fairer employer and the barriers to black and minority ethnic staff progression are removed, this will contribute to reducing the social and economic disadvantage experienced by minority ethnic communities and reduce the associated health inequalities (Nazroo, 2014).

Taken together, such research provides an additional and powerful narrative. Ending discrimination against black and minority ethnic staff becomes not just a moral issue and a means of drawing on the talents of all staff. It is essential to end discrimination because less discrimination benefits patient care – all patients and not just those from black and minority ethnic backgrounds.

3 Learning from the past?

The 2004 Race Equality Action Plan was launched with good intentions, Ministerial support and some early impact. The focus was on process, including: mentoring, expansion of training, development and career opportunities, systematic tracking, personal 'stretch' targets on race equality in rust objectives. After some initial impact, the effect of those processes declined such that a decade later little, if any progress, was evident.

The Plan also had no measurable outcomes that could be benchmarked. As other priorities for NHS chief executives came along, there were no incentives to maintain momentum, nor sanctions to ensure that all organisations addressed the challenge.

There was no systematic national monitoring of workforce race equality, as this was not seen as a role for the Department of Health, but rather as the responsibility of individual employers (Kline, 2014b).

The outcome was a series of reports over the last decade highlighting serious statutory monitoring deficiencies by NHS Trusts, many of which appeared to be in breach of their Race Relations (Amendment) Act (2000) and the Equality Act 2010 duties (Healthcare Commission Race Equality Audit, 2009; South East Coast BME Network, 2008; Archibong and Darr, 2010; EHRC, 2012; Kline, 2013). Though the NHS Institute for Innovation and Improvement (2009) found some evidence of progress in four English regions, they expressed reservations about the reliability of the data.

In 2009, the NHS Institute for Innovation and Improvement (2009) noted a *'lack of consistency in the way that the Department of Health, Healthcare Commission and Commission for Race Equality view race equality'* with a clear contrast between the *'considerable progress in addressing race equality'* described in the Department of Health's Annual Report (2006) and the lack of *'due regard to the Race Equality Duty'* indicated in a formal investigation by the Commission for Racial Equality (2007).

In his final interview before retirement as outgoing England NHS chief executive, Sir David Nicholson said he regretted *"not making more progress in increasing the number of black and minority ethnic senior NHS*

leaders", that senior NHS management was *"too monocultural"*, and he described the barriers to improvement as a *"systemic problem"* (West, 2014).

Moving forward?

Esmail *et al.* (2005) undertook a rapid evidence review of the reasons for the lack of ethnic diversity in senior level positions. They identified the following:

- Racially biased recruitment and selection practices particularly at times of merger or restructuring;
- Undervaluing of relevant experience and overseas qualifications;
- Tokenism;
- Circumventing of established procedures when appointing part-time staff or covering maternity leave;
- Discrimination against black and minority ethnic groups and women in the allocation of excellence awards;
- Institutional culture seen in individual/group behaviour, formal and informal networks;
- Lack of mentors/role models;
- Exclusion from informal networks and communication;
- Stereotyping and preconception of roles and abilities; and
- Lack of significant line management experience/challenging assignments.

They suggested:

> *"Models of diversity management that have gained widespread recognition in the private sector are only in their embryonic form in the NHS. Diversity management requires an organisational change in culture that goes beyond just an acceptance of the need to increase the representation of black and ethnic minorities in leadership positions. First and foremost, it requires a change of leadership style."*

Despite the evidence of race discrimination, Alastair McClellan, (2013) editor of Health Service Journal pointed out:

> *"…there is little evidence of any sense of urgency or priority attached to this issue in strategic policy at NHS England, Monitor or the NHS Trust Development Agency. Indeed there is almost no discussion at national level about [the] ethnicity of the workforce and indeed it is unclear precisely who has the responsibility for helping to transform the "snowy peaks" of the NHS despite the clear evidence that this would benefit patients."*

4 Next steps

The NHS is not alone amongst public sector employers in struggling to address workforce race equality. The Police Service (Macpherson, 1998; EHRC, 2012), and the civil service (Wright, 2014) continue to face challenges despite rigorous scrutiny (Kline, 2014c). Wider international evidence suggests mandating change linked to clear accountability may be an essential element in challenging discrimination (Syal, 2014; Priest *et al.*, Forthcoming).

The arrival of a new Chief Executive of NHS England, Simon Stevens has seen the adoption of an approach that goes well beyond the 2004 strategy. He has drawn on the methods adopted by the Chief Medical Officer, Sally Davies, who oversaw significant improvements in the presence and status of women in science, and cognisant of evidence that a purely voluntary approach without measurable outcomes has made little or no sustainable change. The new mandatory Workforce Race Equality Standard (2015) uses both commissioning and regulatory levers to help achieve race equality in the NHS workforce (NHS

England, 2015). The new Standard was unanimously approved by the NHS Equality and Diversity Council, which has overarching responsibility for equality in the NHS.

Fig 1: The Workforce Race Equality Standard indicators

	Workforce Race Equality Standard indicators
	Workforce indicators For each of these four workforce indicators, the Standard compares the metrics for White and BME staff.
1	Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce
2	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* **Note. This indicator will be based on data from a two year rolling average of the current year and the previous year.*
4	Relative likelihood of BME staff accessing non mandatory training and CPD as compared to White staff
	National NHS Staff Survey findings For each of these four staff survey indicators, the Standard compares the metrics for the responses for White and BME staff for each survey question
5	KF 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	KF 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	KF 27. Percentage believing that trust provides equal opportunities for career progression or promotion
8	Q23. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
	Boards Does the Board meet the requirement on Board membership in 9.
9	Boards are expected to be broadly representative of the population they serve.

Source: NHS England (2015c) *Technical Guidance for the NHS Workforce Race Equality Standard (WRES) 2015-2016*

NHS employers at all levels will be required to close the gap in these key metrics, highlighting any differences between the experiences and treatment of white staff compared to minority ethnic staff – covering issues including grading, appointment from interview, disciplinary action, bullying, career progress and promotion and discrimination. Boards will be expected to be *'broadly representative'* of the local communities served and their progress (or otherwise) will be published (NHS England, 2015d). Commissioners expect to see such progress through a clause in the NHS Standard Contract. Regulators, notably the CQC, will inspect against progress within their *'well led domain'* (Care Equality Commission, 2015). The Standard Contract was introduced in April 2015 and progress will be published from May 2016 (NHS England 2015a).

The Standard was developed to focus on key indicators of workforce inequality for which data was available (or should be, in accordance with Equality Act duties) and was tested with a group of human resources and equality leads. The categories of "white" and "black and minority ethnic" were used in accordance with the national reporting requirements of Ethnic Category, as defined in the NHS Data Model and Dictionary and as used in Health and Social Care Information Centre data and the NHS Electronic Staff Record. "White" staff include staff from White British, Irish and any Other White backgrounds. The "black and minority ethnic" staff category includes all other staff except "unknown" and "not stated"." Details of how the metrics are defined and are to be used, is contained in the Technical Guidance, which can be accessed online (NHS, 2015c).

Examples of good practice will be collated on the NHS England Equality Hub, which is now being extended to include information relating to the Standard, and some examples can be found in a supporting guide from the lead organisation for NHS Trusts (NHS Providers, 2014). This approach is accompanied by making the Equality Delivery System (EDS2) a broader approach to health and workforce equality, mandatory. EDS2 is a tool developed for NHS organisations to review, rate and improve their equality performance with staff, patients, and the public, encapsulated by the protected characteristics in the Equality Act 2010 (NHS England, 2013a).

Will the standard make a difference?

To succeed, the Race Equality Standard will require implementation, monitoring and wider cultural change across the NHS, as well as significant investment in the sharing of good practice and learning from Trust-wide examples where race discrimination has been successfully challenged.

There is also widespread acceptance that the NHS needs a radical change of leadership culture. The Francis report on the Mid-Staffordshire scandal (Francis, 2013) has helped recalibrate the relationship between clinical priorities and financial ones, whilst the work of Michael West and colleagues has evidenced the importance of cultures in which all staff (including minority ethnic staff) are valued, respected and cared for.

NHS Providers, the lead organisation representing NHS Foundation Trusts, has stated that:

> *"a new drive on race equality is not a diversion from the urgent strategic challenges facing trusts. Instead, we believe race equality and the wider diversity agenda can and must be a major part of the solution"* (NHS Providers, 2014).

They have set out a number of steps regarded as necessary for making progress on race equality, including:

a. Organisations that are making real headway have changed equality from being *'an agenda led solely by equality and diversity managers to something that commands leadership and support from the whole board'*.
b. *'Systematically collecting, analysing and publishing comprehensive workforce and service user data, and using this to critically assess how the organisation is performing, are the first challenges for NHS provider boards.'*

c. *'Finding ways to get beyond what can be a culture of defensiveness or reticence in talking about race and racism, is an essential part of the journey… In a number of our case studies, it was only when the board created spaces where staff could talk about their experiences of racism in the workplace that the extent of the problem became clear'*.
d. Employers will need to *'agree with staff and stakeholders what targets should be set; and devise implementation plans that reflect an ambition to make tangible, measurable improvements year on year'*.

Conclusion

The Macpherson Report (1998) defined institutional racism as *'the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people'*.

The NHS has been very reluctant to consider whether all or parts of it might be institutionally racist. The response to the Workforce Race Equality Standard will make clear whether the NHS, as the largest employer of black and minority ethnic people in England, is serious about challenging workforce race equality and its impact on patient care.

Resources

Workforce Race Equality Standard metrics 2015
www.england.nhs.uk/wp-content/uploads/2015/02/wres-metrics-feb-2015.pdf

Workforce Race Equality Standard Technical Guidance 2015
www.england.nhs.uk/wp-content/uploads/2015/04/wres-technical-guidance-2015.pdf

Workforce Race Equality Standard FAQs
NHS Workplace Race Equality Standard
www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard

NHS England (2015) EDS Case Studies
www.england.nhs.uk/ourwork/gov/equality-hub/eds-case-studies

NHS Providers Leading by Example Report 2014
www.nhsproviders.org/resource-library/the-race-equality-opportunity-for-nhs-provider-boards

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