EDC1 07/14

Proposal to introduce a National Workforce Race Equality Standard

Purpose of paper

1. This paper proposes a National Workforce Race Equality Standard, to tackle the lack of black & minority ethnic (BME) representation at senior levels in the NHS, and to galvanise cultural and organisational change. The Standard, underpinned by commissioning and regulatory action, will also help to address the treatment of BME staff including adverse outcomes throughout recruitment and promotion, access to non-mandatory training, over-representation in disciplinary procedures, bullying and harassment.

Actions required by the EDC

2. EDC is asked to:

- agree the proposal to introduce a Workforce Race Equality Standard across the NHS, and commit to the action required to introduce this from 2015/16

- support the work necessary to include a relevant clause in the 2015/16 standard contract,

- support explicit use of the Standard by regulators in considering whether an organisation is “well-led”

- agree a collective narrative and support the work necessary to ensure coherent, cross-system promotion of this initiative

- agree organisational commitment to the action plan and consider how to make available the required resource

Introduction

3. EDC is committed to advancing equality and diversity for patients, communities and the NHS workforce. At the 6 May EDC meeting, it was agreed that a Working Group should develop proposals to tackle the treatment of BME staff and their lack of representation at senior levels in the NHS, for EDC to consider at its 29 July meeting.

4. To take this work forward, a Working Group of EDC members, and other invited experts, met on 23 June. A note of the meeting is at Annex A. The Group considered papers from Roger Kline/Aneez Esmail, and from Unison/NHS Employers, alongside material from Caroline Alexander on the experience in London. This note summarises the Group's proposals for an ambitious, but proportionate and deliverable response.

Recommendations

5. The Group agreed the following 10 recommendations:

    a. **There should be a clear, coherent narrative** for all partners to use which explains why this initiative is important: not just to tackle the obvious inequity, but also because improving the diversity of senior leadership and the treatment of BME staff strengthens organisational resilience and improves the quality of care, for all patients. A sustained "call to action" to explain the importance of this would be needed and EDC's communications sub-group may be well-placed to help co-ordinate this. Sustained and meaningful engagement beyond the NHS – e.g. with the community and voluntary sector - should be included.

    b. **Delivery of this work should be project managed in a supportive way, drawing on best practice and exemplars and developing materials to support a powerful narrative to ensure progressive narrowing of the differences between the experience and treatment of BME and white staff.** This would be achieved using stretching but achievable timetables and should be done in a way that encourages employers to own the work.

    c. **The scope of this work should be limited to race equality,** and it ought to be possible to do this in a way which a) did not prejudice the interests of other protected groups, and b) had broader benefits for other protected groups. For example, improvements in recruitment, training, promotion and board membership would benefit all protected groups.

d. **There should be a National Workforce Race Equality Standard**, built from seven indicators for which most Trusts already collect data (a mix of NHS national survey data and local workforce data). In addition there would be one Board membership metric linked to the diversity of the Board. This would be used to gauge the current state of race equality within employers and track what progress they are making to identify and help eliminate discrimination in the treatment of BME staff. A new standard will be more credible, once finalised, if it is accredited and - potentially - hosted by an independent body, working with the national NHS organisations.

e. **A clause should be inserted into the NHS standard contract for 2015/16 requiring compliance with the Standard.** Similar expectations should be placed on commissioners (CCGs and NHS England) and potentially other national bodies.

f. **The development and implementation of a national standard should draw on the learning from credible indices** that are already operating across the system in relation to other characteristics (e.g. Stonewall). This will increase alignment and improve prospects of success.

g. **New measures should augment, and not contradict, existing equality -focused approaches**. The revised Equality Delivery System (EDS2) is still bedding in, and will evolve over time, it is being implemented by the majority of NHS organisations across the country. And there are also opportunities to build on the Compassion in Practice work. Both the 6Cs and EDS2 promote equality in the workplace, neither is mandated, but both have very good traction.

h. **EDC's System Alignment Subgroup should be invited to help ensure alignment of the standard with other approaches** – that sub-group shares an interest in how to use all the potential system levers to deliver on this agenda. For example, Annual Governance Statements can also help to shine a light on comparative performance between organisations.

i. **NHS regulators should be invited to include compliance with the standard as part of their consideration of whether an organisation is "well led".** CQC, Monitor, TDA are already discussing a consistent agreed approach to "well led" and this proposal could feed in to these discussions.

j. **NHS Boards should be engaged and supported to make continual improvements, and allowed time to make the necessary change**, with the

clear expectation that failure to make progress will result in contractual/regulatory action. NHS provider organisations would be key to successful implementation and should be engaged both directly and through their representative organisations.

6. Annex B sets out a draft action plan for taking this work forward. Subject to EDC decisions this action plan will be further developed and programme managed with partners, reporting to the EDC, to ensure delivery.

Risks and issues

7. In formulating these proposals, and in subsequent correspondence, Working Group members also acknowledged risks and issues, which the EDC will wish to bear in mind. The main concerns raised were:

- There is a risk that however strong the argument for a focus on race, there will inevitably be concerns expressed that other protected groups have been left behind. The mitigation for this risk could include a clear narrative in support of the proposals, explaining how other protected characteristics benefit from this work and are also supported through other initiatives.

- There is a risk that formulating a standard and embedding it through the contract and regulation will be perceived as an "old world", blunt performance management tool, whereas transparency and benchmarking can be more effective levers than crude "sticks and carrots". The mitigation for this risk could include honest recognition in the narrative that leaving the system to "put its house in order" simply has not worked. At the same time it should be possible to support implementation of the standard with support and advice, and allow a grace period for improvement, so that enforcement is a last resort not a first step – and in the meantime the greater transparency and data sharing will enable benchmarking and system-led improvement. A wider range of additional actions and programme of support, beyond mandatory and contractual approaches, will be needed to help tackle this issue and the Working Group felt some existing examples of good practice in Trusts and other approaches which had worked or are working e.g. Improving Working Lives, Compassion in Practice, the Equality Delivery System for the NHS (*EDS2*), and CNST.

- There is also a risk that the proposed approach may alienate providers who resent "micro-management" – they are already subject to a legal duty on equality, which is

highlighted in the current standard contract. The mitigation for this risk could include the narrative which explains the lack of progress/worsening position on race equality and therefore the need to demonstrate seriousness of purpose, at the same time allowing time and support for providers to comply. This message could potentially be reinforced through explicit backing from provider representative bodies, and sharing any examples of best practice and the benefits which flow from this. It will also be important to show how commissioners are being held to account, as well as providers. Moreover the proposal involves no sense of national "directive" as to how providers are met the Standard. Nor will there be any setting nationally of local targets. The requirement will be that demonstrable progress is being made with "stretch" goals to be agreed locally on the understanding that progress to be shared nationally.

- There is a risk that introducing a new standard will "reinvent the wheel" and so could cause confusion/duplication because of the overarching legal duty, overlap with the Equality Delivery System (*EDS2*), and the existing contract clause relating to equality. The mitigation for this risk could include some delivery testing by the EDC System Alignment sub-group to help ensure that implementation achieves best fit with existing initiatives. Implementation of *EDS2* is likely to support progress toward the standard.

Resourcing

8. The EDC and its secretariat will take this work forward, with help from partner organisations and external support either directly – e.g. an adviser and project manager seconded as part of the project team – or indirectly, e.g. promoting this work through their own conferences, meetings, guidance documents, communications and social media, as appropriate. It will be important that the work dovetails, for example, with the work of other agencies, notably the NHS Leadership Academy's inclusion work. It will be essential that the work set out has effective overall project management such that the individual strands are delivered in a coherent, complementary and timely manner drawing on existing structures but recognising that this challenge requires a dedicated focus

Next steps

9. Subject to EDC's agreement and detailed steers, the EDC secretariat will further develop the action plan including roles responsibilities, resourcing and timescales.

Annex A – Summary notes of the BME Leadership and Workforce Working Group

Meeting held on 23 June 2014 at Richmond House, London

Attending the meeting

See end of summary notes

Exec Summary

- Scope of the work should be Race Equality in the NHS, with a focus upon senior BME representation, cultural change and the treatment of BME staff.

- Important role of communications – explaining how other characteristics will be protected, and emphasising the wider rationale (i.e. not just promoting equality but also securing patient safety, improved outcomes and NHS resilience)

- Consensus on the development of a workplace 'Standard' for the system – more credible if accredited and - potentially - hosted by an independent body

- Should work with what we already have in the system – e.g. existing metrics - and what is working well, and build upon good examples of values in action

- Learn from credible indices that are operating across the system in relation to other characteristics (e.g. Stonewall)

- Use local commissioning and contracting routes to improve workplace representation and fair treatment.

- Insert a clause in the standard contract; should be mirrored in CCG and NHS England accountability – with a clear expectation of progress/escalation over time.

- Regulators should use the "well led" domain to examine Trust progress in moving towards the Standard

- NHS Boards to be engaged and supported to make continual improvements, and allowed time to make the necessary change, but there must also be some element of regulation to ensure traction – a balance will be needed

Setting the scene

The Chair explained that the Equality and Diversity Council (EDC) had agreed in May that a working group should come together to produce a draft proposal for EDC to consider in July, in response to the "Snowy White Peaks of the NHS" report.

There was consensus among attendees of the Working Group that the issues raised were compelling and in urgent need of attention. Two papers outlining proposals had been received, from Roger Kline/Aneez Esmail and from Unison/NHS Employers. The objective of this meeting was to discuss the proposals, alongside material from Caroline Alexander on the experience in London, and the contributions of all present, with the aim of recommending to EDC an approach that was proportionate, deliverable, but also had some "teeth". It was agreed that the task was ambitious: there was no lack of goodwill, but previous efforts had not delivered the desired change, and what was needed now was a firm commitment to act, underpinned by incentives, levers and sanctions.

Scope of the approach

The Group discussed whether the scope of this work should be race equality alone, or equality as a whole i.e. taking into account other groups/protected characteristics. Some attendees were concerned that focusing on one characteristic might distort the overall equality programme, but there was consensus that an initiative focused on one characteristic did not preclude other work on other characteristics. If race were to be singled out for special attention, it should be done in a way that was not to the detriment of other groups/protected characteristics. The Group recognised that in practice efforts to promote any one characteristic would very likely benefit others by shining a light on behaviours and processes which affected all, e.g. recruitment practice, training opportunities, promotion boards etc. Boards would benefit from a vision/narrative which explained the logic for this work (starting with quality of care, including patient safety as well as patient outcomes) and underlining the values.

This was nonetheless a sensitive issue and the Group felt that communication would be important. For example, if EDC were to focus solely on race for this initiative, then it would also be necessary to describe when and how other protected characteristics would benefit either from this work or from other initiatives. The Group also agreed that addressing this issue was about more than just tackling the inherent unfairness of discrimination; it was also about acting on the evidence that diversity of leadership helps ensure patient safety, drives better outcomes and strengthens the resilience of the service. This broader rationale is an important part of the narrative.

Any action plan produced would need to have 'general' and 'specific' areas of focus – making the links and sharing the learning with other areas and groups, and recognising synergies in the work that will be subsequently carried out.

Framework for the approach

The Group considered the respective merits of workforce standards and targets. The consensus was for the development of some kind of standard as a means of ensuring shared measurable outcomes of progress. The Group felt that EDC should, as far as possible, work with what we already have to hand in the system and what is working well.

This would be important to secure buy-in and willing co-operation from providers. The Kline & Esmail paper proposed a national standard built from seven indicators for which most Trusts already collect data – a mix of NHS national survey data and local workforce data.

The Group agreed the need to work collegiately with other organisations that have a proven track record in this area. This would give greater credibility and confidence in our work – also ensuring that we do not re-invent the wheel. We can learn a lot from credible indices that are already operating in relation to other characteristics – such as the Stonewall Index that focuses upon sexual orientation and the workplace.

It was argued that if we do introduce a dedicated 'Race Equality Workforce Standard' – whether mandated or not – we should work in the spirit of co-production and identify a reputable national organisation that can accredit the Standard and/or help run it, with the backing and support of national NHS bodies such as NHS England.

The focus should be on using the Standard to support continuous improvement. NHS Boards had the principal responsibility to act and the greatest potential to make a difference, and nothing agreed by the Working Group or EDC would change that. But some Boards may require help to identify what needed doing; they might need to be given the tools to support them; and in some instances they might need system levers to encourage them.

Careful handling would be required so that the approach adopted is not portrayed as "command and control" – in general the NHS has moved away from top-down performance management. Boards need to be engaged and encouraged to act, but there will also need to be some element of standards/regulation/escalation to ensure that there is meaningful progress over time – a balance will be needed.

The Group discussed the specific proposal to include a clause in the standard NHS contract, requiring the adoption of and progress against the standard. There was some apprehension about the implications of making this a contractual requirement (in particular singling out race when all organisations already had a legal duty in respect of equality).

Mandatory, contractual approaches were not the only model, e.g. as the work on *Improving Working Lives* and CNST had shown. Furthermore, it was argued that in the first instance, before CCGs begin to tell much larger providers how to organise their workforces, CCGs themselves would need to understand and act upon the issues.

The Group also recognised that progress on race equality to date – relying on NHS organisations "putting their own house in order" – had simply not been good enough. Therefore the addition of a clause in the contract could be justified provided that the narrative explained the ways in which other characteristics were to be addressed, and the messaging emphasised support for providers to make the necessary changes. This

would mean probably one or two years before any realistic challenge over non-compliance.

Although the draft contract would not be consulted on until the autumn it was suggested that work should start now with policy officials and lawyers to discuss wording, and with Boards across the service to share the narrative. Finally, the Group suggested that any contractual requirement on providers should be mirrored by parallel expectations of CCGs and NHS England.

The Group agreed that regulators' use of the "well led" domain could be used to examine progress made by Trusts in implementing the Workforce Race Equality Standard. CQC, Monitor and TDA were already working together to develop a shared approach to the "well led" domain, so this was timely.

Content of the approach

There was agreement that this work should draw on good practice examples already in the system – i.e. those organisations that are doing well or making progress on these issues.

Similarly in designing standards, communications, monitoring and escalation, the work should draw on existing equality-focused approaches. The revised Equality Delivery System (EDS2) is still bedding in, and will evolve over time; however, it is being implemented by the majority of NHS organisations across the country. And there are opportunities to build on the Compassion in Practice work. Both the 6Cs and EDS2 promote equality in the workplace, neither is mandated, but both have very good traction.

The ongoing work of the EDC System Alignment Subgroup was mentioned – that group shares an interest in how to use all the potential system levers to deliver on this agenda. For example, Annual Governance Statements can help to shine a light on comparative performance between organisations – and we know from other sectors that transparency and benchmarking is often a more effective lever than crude "sticks and carrots".

It was noted that the EDC has a communications group that could potentially shape the communications required in this area. The importance of engagement beyond the NHS was highlighted – in particular it was argued that sustained and meaningful engagement with the community and voluntary sector should not be neglected.

The Group acknowledged that the approach may evolve over time – what was important was to make a start and put the metrics and standard into use.

Conclusion

The Group supported a multi-track "pincer" approach which:

i) described a compelling vision for Boards, explaining how progress on this issue was not only about fairness, but particularly important for patient quality/safety, innovation and vital to organisational resilience. The use of established metrics to build a standard, to be independently accredited, and informed by existing best practice and other successful indices, would help ensure adoption and compliance.

ii) put in place the means to ensure there is real progress, through the insertion of a clause in the standard contract, with clear expectations of agreed progress against the national standard, and the consistent approach of regulators using the “well led” domain

iii) addresses a range of specific proposals to take aspects of the work forward that were contained in the Esmail/Kline proposals, those from Caroline Alexander and from UNISON/NHS Employers, and the project group would need to draw on these to ensure a comprehensive programme of work to ensure success.

Attendance at the meeting

John Holden (Chair; NHS England)

Gail Adams (Unison)

Victor Adebowale (NHS England, and Turning Point)

Caroline Alexander (NHS London)

Jabeer Butt (Race Equality Foundation)

Tom Cahill (Hertfordshire Partnership University NHS Foundation Trust)

Yvonne Coghill (NHS Leadership Academy)

Jane Cummings (NHS England)

Paul Deemer (NHS Employers)

Roger Kline (Middlesex University)

Felicia Kwaku (Barts and the London NHS Trust)

Joan Myers (Goodmayes Hospital)

Habib Naqvi (NHS England)

Ruth Passman (NHS England)

Umesh Prabhu (Wrightington, Wigan and Leigh NHS Foundation Trust)

Jan Sobieraj (NHS Leadership Academy)

Ray Warburton (NHS Lewisham Clinical Commissioning Group)

Annex B – Draft outline action plan

Activity	Support / Resources	Lead(s)	Milestone	Timeframe
Ongoing engagement upon all activities related to this work	NHS England and partners	EDC secretariat	To engage with all key stakeholders throughout the process of this work	Ongoing
Development of a National Workforce Race Equality Standard	NHS England, EDC members / secretariat, external partners, seconded team members eg adviser/ project manager	NHS England; EDC; external partners EDC System Alignment Subgroup NHS England, EDC and partners NHS England, EDC secretariat	Scoping and learning from existing initiatives, tools and indices Ensure alignment of the Standard with other approaches across the system First draft of National Workforce Race Equality Standard Engagement on the Standard (with EDC, NHS, partner organisations)	August 2014 August 2014 September 2014 September 2014

Clause inserted into the NHS standard contract for 2015/16 requiring compliance with the Standard	NHS England, EDC	NHS England	Engagement on text of clause Finalised clause text Sign-off clause Publication for 2015/16 Contract	August 2014 October 2014 November 2014 December 2014
Development of a programme of work using the various proposals and ideas for good practice contained in the proposals from Esmail/Kline, UNISON/NHS Employers and Caroline Alexander which will assist providers and others in making progress towards the Workforce Race Equality Standard	NHS England and EDC partners as appropriate	NHS England and EDC partners	Development of a prioritised programme of work by September 2014	Ongoing

Implementation of the Standard	NHS England, CQC, TDA, Monitor, EDC	EDC System Alignment Subgroup CQC, Monitor, TDA, EDC	Ensuring that the Standard is embedded within the key system levers in the NHS NHS regulators invited to include compliance with the Standard as part of their consideration of whether an organisation is “well led”	October 2014 October 2014
NHS Boards engaged and supported to make continual improvements	FTN, NHS Confederation, EDC	FTN, NHS Confederation, EDC	NHS provider organisations engaged both directly and through their representative organisations	From March 2015
Effective communications on the development and roll-out of the	EDC, partner organisations	EDC Communications Subgroup Communications	Promotion of the Standard prior to roll-out	November 2014 From March 2015

Standard		teams of partner organisations	Communication of the Standard at point of roll-out	
Review of the Standard	EDC, NHS England, and partner organisations	NHS England	Reviewing the effectiveness of the Standard via returns/feedback from organisations	March 2016 onwards