NHS England

Briefing for NHS Boards on the NHS Workforce Race Equality

NHS workforce race equality delivers better care, outcomes and performance

Research strongly suggests that less favourable treatment of Black and Minority Ethnic staff in the NHS through poorer treatment or opportunities has significant impact on the efficient and effective running of the NHS.

1. Ethnicity adversely affects the likelihood of the best people being appointed which means that patient care is not as good as it could be.

2. There is a strong correlation between how staff are treated and higher staff turnover and absenteeism, higher mortality rates and lower patient satisfaction. (1) There is in turn a cost attached to employing new or agency staff, Employment Tribunals and disciplinary hearings all diverting NHS resources away from patient care.

3. Discrimination makes people ill which can mean NHS staff members have to take sick leave or can't work to their full capacity and use health services as patients – further cost to the health service. (2)

4. Robert Francis' report "Freedom to Speak Up", a review of whistleblowing within the NHS found that BME whistleblowers are treated significantly worse than White whistleblowers with a likely impact on patient safety. (3)

5. BME staff are also more likely to be bullied at work. Bullying impacts on whether staff report concerns and work in effective teams, also impacting adversely on patient safety. (4)

6. Organisations which have a diverse leadership are more successful and innovative than those who do not. Recently McKinsey examined data for a range of companies in Canada, UK, Latin America and USA and found, in particular, that companies in the top quartile for racial and ethnic diversity are 35 percent more likely to have financial returns above their respective national industry medians. (5) Diverse leaderships are likely to be more innovative, an important consideration for the NHS. (6)

7. Organisations that don't reflect local communities in their own leadership may fail to be sensitive to local health needs, including those linked to reducing health inequalities linked to ethnicity. (7)

8. The Five Year Forward View says delivery of high quality, safe, patient focused care is dependent on professional commitment, strong leadership and a caring culture. We know that managing staff with respect and compassion correlates with improved patient satisfaction, infection and mortality rates, CQC ratings and trust financial performance (8). We know that bullying and discrimination are "likely to deprive staff of the emotional resources to deliver compassionate care." (9) We also know that this is especially true for the treatment of BME staff.

   "The staff survey item that was most consistently strongly linked to patient survey scores was discrimination, in particular discrimination on the basis of ethnic background." (10)

Climates of trust and respect characterise the top performing trusts, and rates of ethnic discrimination are a good marker for this. So, for example, the percentage of staff reporting their trust provides equal opportunities for career progression was related to CQC ratings of quality of care provided and use of resources as well as with levels of staff absenteeism. (11)

NHS staff survey results and patient survey results

> *"suggest that the experience of 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."* (12)

The evidence that Black and Minority Ethnic staff are less favourably treated in the NHS is indisputable.

One in five nurses, more than one in three doctors and one in six of all NHS staff are from black and minority ethnic (BME) backgrounds. Analysis of NHS workforce and NHS staff survey data across England shows that:

- White shortlisted job applicants are, on average, much more likely (1.74 times more likely) to be appointed than are Black and Minority Ethnic (BME) shortlisted applicants. (13)
- The proportion of NHS board members and senior managers who are BME is significantly smaller than the proportion of the NHS workforce or local communities that are from BME backgrounds. (14)
- BME NHS staff members are much more likely to be disciplined than White staff members. (15)
- NHS staff survey data shows that BME staff are more likely than White staff to experience harassment, bullying or abuse from other staff (but not from patients, relatives of the public); are more likely to experience discrimination at work from colleagues and their managers; and are much less likely to believe that the trust provides equal opportunities for career progression. (16)

Evidence suggests such inequality exists just as strongly where there are relatively small numbers of BME staff as where there are larger proportions of BME staff in the workforce.

Patients have better experience in NHS organisations where workforce race equality is good.

The case for organisations tackling workforce race discrimination is therefore **not** just about the treatment of BME **staff** but is crucially about the care of **all** patients irrespective of ethnicity. The best Boards and system leaders already understand and act on this powerful evidence.

When the NHS faces other factors adversely impacting on patient care we collate and analyse relevant data, listen to staff and patients to better understand the data, look for good practice that addresses such adverse factors and adapt that practice to our own environment.

That is what the NHS Workforce Race Equality Standard (WRES) seeks to do.

For each of its nine indicators the Standard seeks to prompt inquiry to better understand why BME staff often receive much poorer treatment or opportunities that White staff so that the gaps in treatment and experience can be closed.

Gathering the data is an important step as "you can't change what you don't know." However it is only the first step. Understanding the data and the root causes behind it should prompt NHS organisations to seek examples where good practice has tackled such gaps successfully. Widespread anecdotal evidence suggests it is already prompting NHS employers to scrutinise their workforce and staff survey data, to start to listen to their BME staff, to ask why there are such sharp differences between the treatment and experience of white and BME staff and, above all, ask **how** they can reduce the gaps.

By using the WRES, we expect that all NHS organisations, year on year, all NHS organisations will improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime. Progress made will be benchmarked and published, organisation by organisation. As the WRES gathers momentum, published performance data will generate publicity and discussion, inside and outside organisations.

The national focus on these nine aspects of workforce race equality provides a great opportunity for NHS organisations to work together on specific interventions and to share good practice.

The costs of implementing the WRES are relatively small. It is designed to require no additional data capture or analysis beyond that which NHS organisations should already be undertaking as part of using the Equality Delivery System (EDS2) and meeting the public sector Equality Duty.

The benefits can be considerable for staff, for organisational finances and productivity, and above all for patient care. Simon Stevens NHS England CEO agrees.

> *"The chronic lack of non-white faces in senior positions meant the NHS was missing out…;. Yet diversity in leadership is associated with more patient-centred care, greater innovation, higher staff morale, and access to a wider talent pool"* (17)

NHS Providers agree:

> *"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. In the face of our workforce challenges, it can ensure the NHS is capitalising on the best available talent and drawing on the innovation we know diverse teams can bring. And in a context where organisational success will increasingly depend on more personalised care, it can help keep NHS staff connected to the diverse needs of the communities they serve."* (18)

How NHS organisations meet this challenge will vary depending on local circumstances and the specific issues that need to be addressed. Key to progress will be learning from the growing examples of good practice across the NHS. If this approach is successful – and international evidence suggests it is the approach most likely to succeed – then it will decisively reduce inequality and poor treatment amongst the NHS workforce.

More information on the Workforce Race Equality Standard and the evidence that led to it can be found at http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard.

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