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WORKFORCE RACE EQUALITY STANDARD

An overview of workforce data for nurses, midwives and health visitors in the NHS

March 2019

NHS Workforce Race Equality Standard

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Foreword

Nurses, midwives and health visitors are a critical part of the NHS workforce and have been since the inception of the NHS more than 70 years ago. Although the number of nurses continues to rise, demand is greater than ever; we are seeing more people with more complex conditions than ever before. The challenge is to deliver consistent and improving high quality care, despite this growing demand.

To deliver high quality care for people and communities, we need a supported and fully engaged workforce. Yet evidence shows that the treatment and opportunities of black and minority ethnic (BME) staff still far too often do not correspond to the values and principles that the NHS represents.

It was in direct response to this that the NHS Workforce Race Equality Standard (WRES) was developed and made available to the NHS in April 2015. Implementing the standard requires challenging and sometimes difficult work and sustained, committed leadership on this agenda from the top of every NHS organisation is essential. We are grateful for the leadership shown by Professor Jane Cummings, our previous CNO, and are committed to ensuring that the WRES baton continues to be held firmly and carried forward. Implementation of the WRES is a stated commitment of the NHS England and NHS Improvement boards and is a clear priority in the Long Term Plan, with £1m additional investment pledged.

We are delighted to be sharing this report from the WRES team which presents data illustrating the experience and opportunities gap for BME nurses, midwives and health visitors. The report also outlines some of the work in train and planned to address this gap and deliver the 2028 commitment of ensuring the leadership of our organisations is representative of the overall BME workforce.

Successful delivery of the Long Term Plan is dependent upon our workforce. We must continue to strive to ensure that we have a supported and fully representative workforce at all levels. The WRES team continues to be committed to supporting the NHS in this endeavor – helping individual organisations to role model the changes we must see across the wider NHS over the next ten years.

Ruth May   Yvonne Coghill CBE
Chief Nursing Officer for England   **Director, WRES Implementation**

Context for this report

Key facts:

- One in five nurses, midwives and health visitors in NHS trusts and clinical commissioning groups (CCGs) is from a BME background.

- People from a BME background are significantly more likely to be nurses, midwives and health visitors compared to their representation in the population.

- Since 2016, the numbers and proportion of BME nurses, midwives and health visitors in NHS trusts and CCGs increased, whilst the headcount of white counterparts decreased.

- BME nurses, midwives and health visitors are under-represented in senior Agenda for Change (AfC) pay bands across the NHS.

- The number of BME nurses, midwives and health visitors at senior AfC pay bands is increasing, but this is not happening at a pace that will ensure equality in representation across the workforce pipeline.

- Improving race equality across the NHS workforce is cited as a priority in the NHS Long Term Plan and is a key element of the national WRES programme strategy.

One in every five nurses, midwives and health visitors in the NHS is from a black and minority ethnic (BME) background. However, evidence shows that the experiences of staff within this 20% of our workforce and their access to opportunities for development and progression still do not yet correspond with those of their white colleagues; the gap is still stark in many places.

These issues have been prominent for decades; one of the earliest research publications outlining the challenge was in 1982. A qualitative study on the experience of black nurses, midwives and health visitors found that "they all told the same story of continual job rejections, difficulties getting accepted for post basic training, and poor promotion prospects".[1]

1. Hicks, C. (1982) Racism in Nursing. Nursing Times, Vol 78 (18), 743-744

The impact of persistent discrimination on the physical health and mental well-being of our nursing, midwifery and health visitor colleagues cannot be underestimated, nor the impact on patient care[2] and organisational efficiency[3]. Although BME leadership representation amongst this part of the workforce is showing signs of improvement over time, with only 3.5% of provider chief nurses coming from BME backgrounds compared to 20.5% of the nursing, midwifery and health visitor workforce, there is a clear need for further accelerated improvement in this area.

The NHS Long Term Plan[4] sets the ambitious challenge of ensuring the leadership of our organisations is representative of the overall BME workforce by 2028. In the WRES 'A Model Employer' strategy',[5] we have outlined the approach to help accelerate this work across the NHS.

Aspirational goals to increase BME representation at leadership levels, and across the workforce pipeline, are a key component of the WRES programme of work. The WRES team will continue to work with individual providers and other parts of the NHS system to facilitate the setting of aspirational goals and provide the comprehensive support required to enable their realisation.

This report outlines: where we are now on improving BME progression into senior nursing, midwifery and health visitor positions across the NHS; work already underway; and the next steps planned to support organisations to make continuous improvements over time and ultimately to deliver the 2028 commitment.

2. https://www.england.nhs.uk/publication/links-between-nhs-staff-experience-and-patient-satisfaction-analysis-of-surveys-from-2014-and-2015/
3. https://www.england.nhs.uk/publication/employee-engagement-sickness-absence-and-agency-spend-in-nhs-trusts/
4. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
5. https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf

4 What the data tell us

4.1 Workforce numbers

Data presented in this paper are for NHS trusts and CCGs in England, and were taken from the NHS workforce statistics website.

Table 1: Nurses, midwives and health visitors: workforce data by ethnicity, 2018

	BME	White	Unknown	Total
Headcount	71,648	263,065	13,965	348,678
Percentage	20.5%	75.4%	4.1%	

As at 31 March 2018, 20.5% (71,648) of the 348,678 nurses, midwives and health visitors in NHS trusts and CCGs were from a BME background.

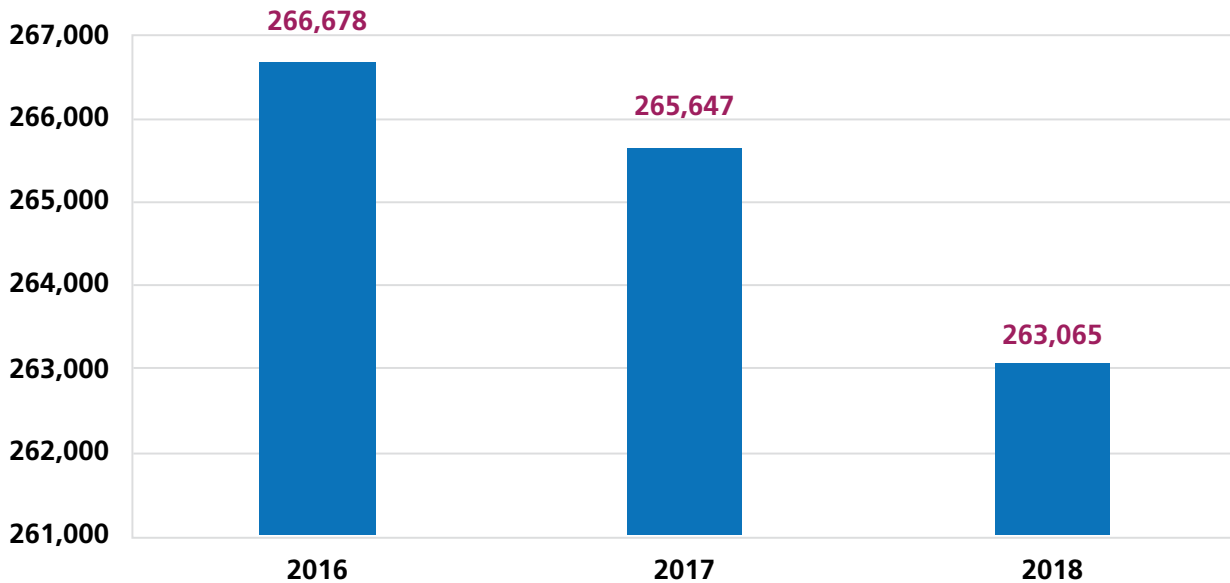**Table 2: Nurses, midwives and health visitors by ethnicity, 2018**

Staff ethnicity	Percentage of nurses in NHS trusts and CCGs	2011 Census
BME	20.5%	13.6%
White	75.4%	85.4%
Unknown	4.1%	1.0%

As a group, nurses, midwives and health visitors across the NHS in England are more diverse than the population they serve. In many regions and parts of the country where there are few BME people in the local populations, the proportion of BME nurses, midwives and health visitors is higher than the local BME population.

According to data published by the Royal College of Nursing (RCN) in October 2018, there are now more BME nurses than white nurses in London.[6] The research shows that in London's NHS there are now 27,982 nurses from a BME background with 24,847 nurses identifying as white.
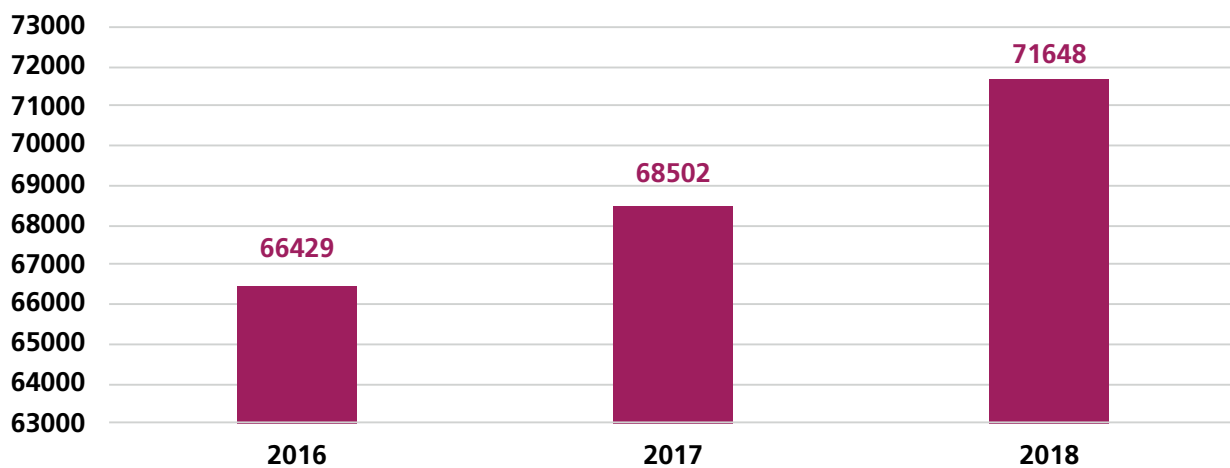
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6. *https://www.rcn.org.uk/news-and-events/news/rcn-london-research-into-bame-numbers*

Figure 1: White nurses, midwives and health visitors: headcount, 2016 - 2018

The overall number of white nurses, midwives and health visitors working in NHS trusts and CCGs declined between 2016 and 2018. There were 2,582 (1.0%) fewer white nurses, midwives and health visitors in 2018 compared to 2017.
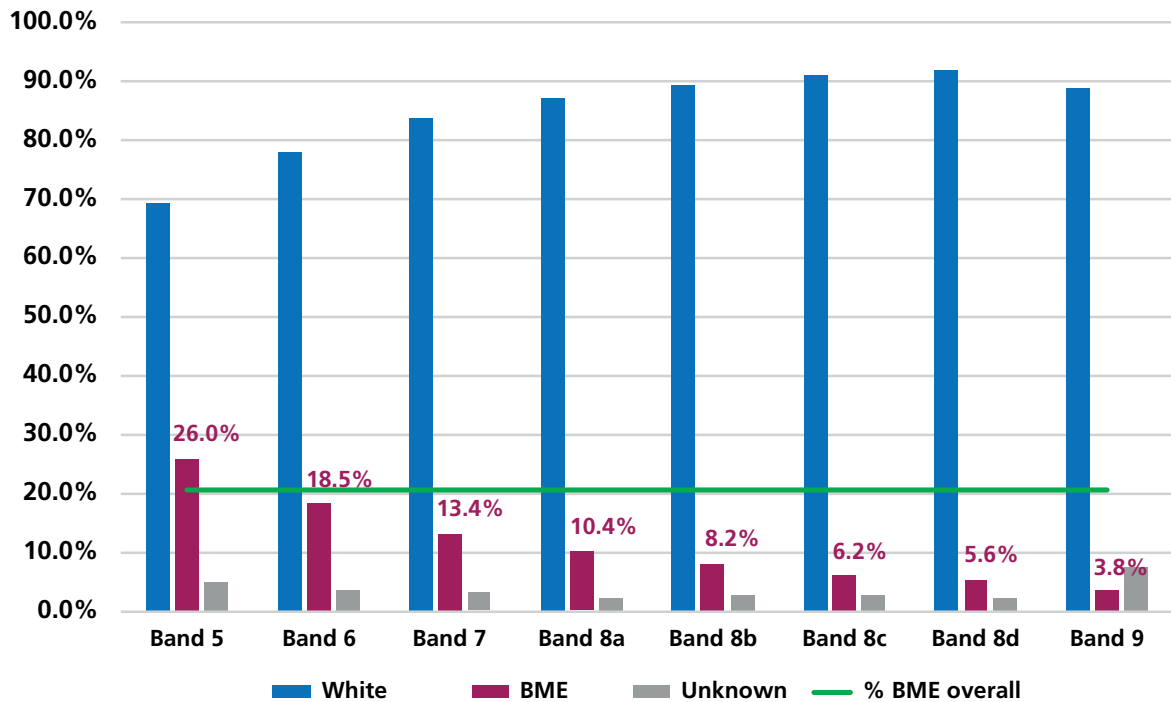
Figure 2: BME nurses, midwives and health visitors: headcount, 2016 – 2018

In contrast, the number of BME nurses, midwives and health visitors working in NHS trusts and CCGs has been increasing over time. There were 3,146 (4.8%) more BME nurses, midwives and health visitors in 2018 compared with 2017.

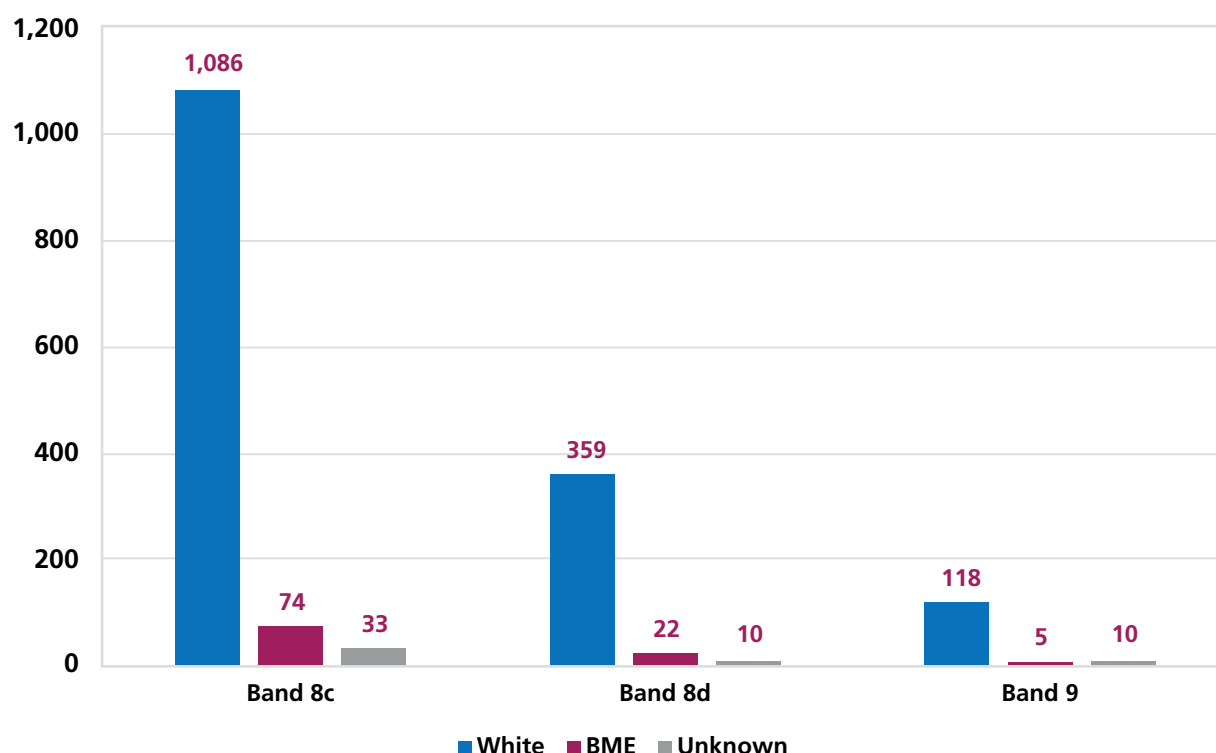# 4.2 Representation across the workforce pipeline

Figure 3: Percentage of nurses, midwives and health visitors by AfC bands and ethnicity, 2018

BME nurses, midwives and health visitors are over-represented in AfC pay band 5 and under-represented across the rest of the pay bands.

Figure 3 above shows that the higher the pay band, the lower the proportion of BME nurses, midwives and health visitors. Across the 231 NHS trusts in England, in January 2019, there were only eight (3.5%) BME chief nurses (in most cases, these are executive board positions).

Figure 4: Numbers of nurses, midwives and health visitors by AfC bands and ethnicity, 2018

When we look at actual numbers, we see that there were 101 (5.9%) BME nurses, midwives and health visitors at AfC bands 8c to 9, compared to 1,563 who are white and 53 unknown. There were only five (3.8%) BME nurses, midwives and health visitors at AfC band 9 positions across NHS trusts and CCGs.

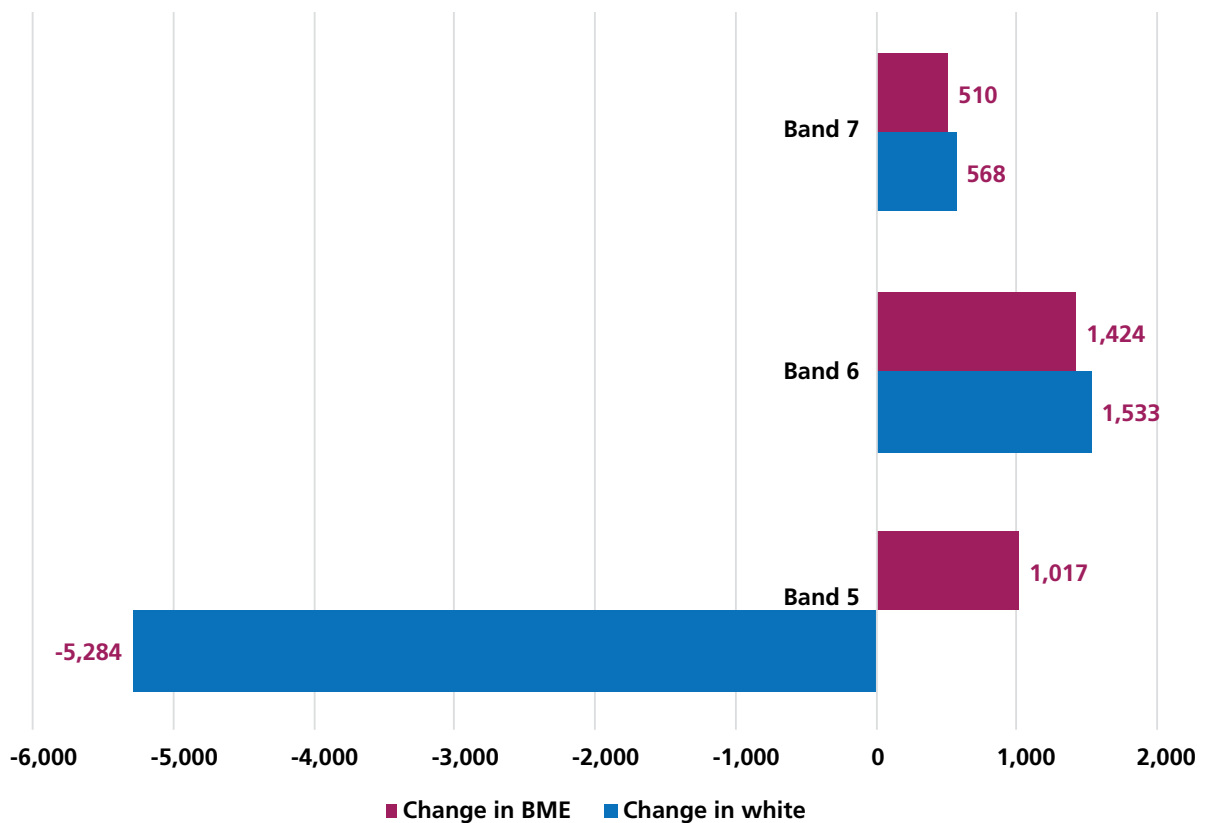**Table 3: Numbers of nurses, midwives and health visitors staff by AfC bands and ethnicity, 2017-2018**

AfC pay band	2017		2018		Change in white	Change in BME
	White	BME	White	BME		
Band 5	111.133	38,814	105,849	39,831	-5,284	1,017
Band 6	91,771	20,692	93,304	22,116	1,533	1,424
Band 7	47,036	7,159	47,604	7,669	568	510
Band 8a	9,995	1,091	10,551	1,263	556	172
Band 8b	2,495	211	2,576	237	81	26
Band 8c	1,041	68	1,086	74	45	6
Band 8d	311	15	359	22	48	7
Band 9	108	4	118	5	10	1

In 2018, there were 103 more white nurses, midwives and health visitors at AfC bands 8c to 9, and 14 more from a BME background. Even though there were increases in the number of BME nurses, midwives and health visitors at these senior bands, there was still a comparatively disproportionate increase in the number of white nurses, midwives and health visitors.

At AfC bands 8c to band 9, 88.0% (103) of the extra nurses, midwives and health visitors were white compared to an increase of 12.0% (14) BME. At band 9, only one (9.1%) of the 11 newly promoted senior nurses, midwives and health visitors was of a BME background.

The rate of increase in the progression of BME senior nurses, midwives and health visitors must be accelerated if the under-representation at senior AfC bands is to be improved.

Figure 5: Nurses, midwives and health visitors by AfC bands: 2017-2018

There was a sharp decrease in the number of white AfC band 5 nurses, midwives and health visitors in NHS trusts and CCGs in 2018 compared with 2017.

In contrast, the number of BME nurses, midwives and health visitors increased across all AfC bands, particularly at bands 5 and 6.

5 Recruitment, development and progression: key points for improvement

The WRES was introduced in 2015 to make visible the equalities gap between BME and white staff working in the NHS and to launch the programme of work to help to close it. The WRES programme was designed to help organisations to initiate continuous improvement in the treatment of, and opportunities for, BME staff across the NHS, including in areas requiring concerted focus.

The data make clear that an area of particular focus must be the nursing, midwifery and health visitor workforce across the NHS. Consequently, supporting improvements for this part of the workforce is a key element of the WRES strategy. To date, the WRES team has:

- Identified the challenge at organisation, sector and regional levels by presenting WRES data for this part of the workforce

- Amplified the narrative on the importance of workforce race equality – including the link with patient outcomes, satisfaction and safety

- Started sharing replicable good practice to facilitate continuous improvements

- Created strong working relationships and collaborations – including with the eight existing BME NHS provider chief nurses

- Established robust communications and engagement with this part of the NHS workforce

5.1 Learning from experience: an appreciative enquiry

In December 2017, NHS England and NHS Improvement reported on an appreciative enquiry into improving the representation of BME nurses and midwives across the higher 'agenda for change' pay bands.[7] The 'Enabling BME Nurse and Midwife Progression into Senior Leadership Positions' report set out the picture of representation in the higher pay bands at the time, and described key areas of replicable good practice.

The report presented six key priorities to help support organisations to progress in this area:

- Ensure trust boards review their WRES data and know how well they are performing

- Create an improvement strategy and set aspirational targets that are owned by the trust and monitored by the board

- Set-up a programme of development that includes: stretch projects; shadowing opportunities; coaching sessions; and, action learning sets

- Ensure middle-manager engagement by incorporating targets in their objectives

- Review recruitment processes to ensure full equal opportunities are being adhered to and innovative initiatives to improve BME progression are established

- Establish a BME staff group / forum that has a direct line to the board

- The report led to a series of regional workshops, led by NHS Improvement and supported by the WRES team, to help share good practice across the areas of recruitment, staff development and board representation.

7. *https://www.england.nhs.uk/wp-content/uploads/2017/12/enabling-bme-nurse-midwife-progression-into-senior-leadership-positions.pdf*

5.2 Recruitment and staff development

Bias, whether conscious or unconscious, impacts upon every stage of the recruitment and promotion process: from how the job description and person specification are written, how positions are advertised, how secondment opportunities are made available and filled, how interviews and assessments are designed and conducted, and how the selection process is undertaken.

Unconscious bias training can be effective in prompting discussion on difficult issues. However, on its own, it is unlikely to have the desired impact. Accountability and holding decision-makers to account for their actions is perhaps the best means of preventing bias in decision-making.

We know from research that there are a number of ways to embed and reinforce accountability. Knowing that, as a recruiting manager, shortlisting or interview panel member, you will have to justify your decision-making is likely to lead to more thorough thought processes. Indeed, holding individuals accountable for their personnel decisions is one way to reduce potential bias in recruitment and promotion.

Reducing the bias in recruitment, promotion and staff development that often leads to inequality of opportunity between white and BME staff in the NHS is essential if we are to meet the aspiration of realising representative leadership at all levels across the system. The approaches being employed by some NHS providers to continuously improve on the WRES indicators have generated examples that organisations across the NHS can learn from.

Strategic approaches:

- Using WRES data to identify areas where there is a failure to recruit BME staff - deep dives within the organisation to spotlight directorates and divisions grades / bands where blockages, 'glass ceilings' or 'sticky floors' are most prevalent. Quality Improvement (QI) methodology[8] can be helpful in improving the patterns of appointments and promotion.

- Setting 'aspirational targets' for BME representation at leadership levels and across the workforce pipeline in NHS organisations. In January 2019, the WRES team published 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS'[9] – the strategic approach that builds on the commitments of the NHS Long Term Plan to ensure the leadership of NHS organisations reflects the diversity of their respective workforce.

- Reporting progress in this area to the trust board on a regular basis, analysing data by directorate, service, and occupation.

8. https://www.england.nhs.uk/wp-content/uploads/2018/12/wres-quality-improvement-methodology.pdf
9. https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf

Operational interventions:

- Ensuring robust processes and procedures for recruitment that will help to reduce any potential bias are in place, and adhered to.

- Focussing upon levelling the playing field by providing equity of access to 'acting-up' (secondment) opportunities is a key enabler for career progression. Access to such opportunities should be especially encouraged amongst BME staff and should focus on positions and grades that are under-represented within the organisation.

- Access to mentoring, reverse mentoring and shadowing should be encouraged. Senior leaders of the organisation have a critical role to play here as this is a unique opportunity to model demonstrable leadership, not only in what is said, but also in what is actively undertaken.

5.3 Board representation and culture

Organisations are more likely to be efficient, innovative and meet the needs of the workforce that they serve when leadership is drawn from diverse communities across the country. The focus on workforce race equality is not a diversion from the urgent strategic challenges facing NHS organisations, whether local or national. Rather, race equality, and the wider inclusion agenda, can and must be understood as a major part of the solution.

We know that, at board level, diverse teams make better and safer decisions. Organisations with more representative leadership are in a better position to engage the diverse workforce and communities they serve. Furthermore, at a time when 'business as usual' is not an option for any NHS organisation, the proven positive association between board diversity and innovation is persuasive.

Whilst we clearly need a greater diversity of people on boards, we also know that simply changing the demographics of a board is not enough. Transforming deep-rooted cultures of discrimination within organisations is critical.[10] Boards need to be compassionate, values-driven and uphold the following principles:

- Awareness of bias: A board committed to equality develops individuals' awareness and understanding of their own biases. It also assists its members in developing the skills to understand and moderate their behaviour and their decision-making.

- Inclusivity: A fair board is conscious of its collective behaviour. It challenges itself to see its functions from the perspectives of others, and its members recognise their role as leaders of culture, setting the values and behaviours they want others to acquire.

10. *https://www.hsj.co.uk/workforce/bme-staff-are-still-struggling-heres-what-you-can-do-about-it/7024327.article*

- Shared decision-making: A diverse board recognises that better decisions may arrive through diversity of thought and challenge. It also knows that a 'good' board is not always one where everyone agrees with one another and where decisions are easily made.

- Modelling behaviour: Board members, as leaders, must embody the values they want the organisation to uphold. An important way of doing this is to set out a clear organisational vision for equality, diversity and inclusion, one that shows how equality is linked to the organisation's core values and objectives.

6 Conclusion and next steps

Nursing, midwifery and health visitors represent the largest collective professional group in the NHS; they also represent one of the most diverse parts of the workforce. It is vital that we do more to ensure that the 20% of staff from BME backgrounds have the same opportunities as white colleagues to become leaders of the future. This will be one of the key areas of focus in the forthcoming Workforce Implementation Plan for the NHS.

We know that some organisations are embracing the workforce race equality agenda and are continuing to act on plans for improvement; yet at the same time, we also know much more work is required.

The national WRES team will continue to support NHS providers and other parts of the NHS on this endeavour and, as the focus shifts further from the 'why' to the 'how' of addressing workforce race equality, there will be further provision of support and guidance will be made available.