NHS England

# Equality Analysis on the Workforce Race Equality Standard

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| **Description** | This document aim to provide an Equalty Analysis of the Workforce Race Equality Standard (WRES). The Equality Analysis is a live document, which considers the potential impact of the WRES on the Public Sector Equality Duty. Included in this analysis is an action plan that highlights next steps, further work, and the mitigation of any potential negative impacts identified. |
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# Equality Analysis on the Workforce Race Equality Standard

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# 1 Introduction to the Equality Analysis

This Equality Analysis assesses the evidence for and potential impact of a Workforce Race Equality Standard.

The development of a Workforce Race Equality Standard (WRES) was proposed by NHS England and the Equality & Diversity Council (EDC) in July 2014. Its aim is to improve workplace experiences and employment opportunities for Black and Minority Ethnic (BME) people in the NHS, or those who want to work in the NHS, by taking positive action to help address workforce race inequalities.

This analysis uses research, data, and consultation feedback to understand the impact or potential impact of the proposed WRES on groups given protection under the Equality Act 2010. The Lesbian and Gay Foundation and the Race Equality Foundation have also contributed to this analysis. The analysis aims to capture positive impact and identify any negative effects or discrimination arising from the implementation of WRES, ensuring it is in line with the Public Sector Equality Duty of the Equality Act 2010.

The WRES will be informed by this analysis, and previous analyses, consultations and engagement feedback. Included in this analysis is an action plan that highlights next steps, further work, and the mitigation of any potential negative impacts identified.

## 1.1 About the Public Sector Equality Duty

The Public Sector Equality Duty, as set out in the Equality Act 2010, requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not.

These are sometimes referred to as the three aims of the general equality duty. The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.

- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- tackle prejudice, and
- promote understanding

Compliance with the duties may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under the Equality Act 2010.

The characteristics given protection under the Equality Act 2010 are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The Equality Analysis is a way of considering the effect on different groups given protection under the Equality Act. There are a number of key reasons for conducting an Equality Analysis, including:

- To consider whether the policy will help eliminate unlawful discrimination, harassment and victimisation
- To consider whether the policy will advance equality of opportunity between people who share a protected characteristic and those who do not
- To consider whether the policy will foster good relations between people who share a protected characteristic and those who do not

- To inform the development of the proposed policy

## 2 What is the Workforce Race Equality Standard?

"Positive action is one way of trying to counteract deep-rooted or historic disadvantage by providing under-represented or disadvantaged groups with help to ensure they have the same chances as others.[1]"

The Equality & Diversity Council (EDC) has prioritised the development of a WRES as the best means of helping the NHS to improve BME representation at senior management and Board level and to provide better working environments for the BME workforce.

The WRES aims to improve work experiences and employment opportunities of BME people in the NHS or wanting to work in the NHS by taking positive action to help address race inequalities in the workplace.

The WRES is a tool for identifying a number of key gaps, referred to as metrics, between White and BME staff experience of the workplace - gaps which must be closed. Closing these gaps will achieve tangible progress in tackling discrimination, promoting a positive culture, valuing all staff for their contributions to the work of the NHS. This will in turn positively impact on patients, as it is known that a decrease in discrimination against BME staff is associated with higher levels of patient satisfaction. An NHS environment that values and supports the entirety of its diverse workforce will result in high quality patient care and improved health outcomes for all.

The metrics proposed for inclusion in the WRES will:

- address issues of discrimination and better representation of BME staff at senior levels of NHS organisations, and closing the gap between BME and White staff regarding workforce experience

- help facilitate learning from good practice and applying this learning to other groups and protected characteristics

- support delivering the Government's commitment to fairness and equality-focusing on the rights and pledges of the NHS Constitution

- compliment the Equality Delivery System – EDS2, and help NHS organisations to deliver services that are more personal fair and diverse through a supported and diverse workforce at all levels

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[1] Positive Action, the Law Society, 2014 - *https://www.lawsociety.org.uk/support-services/advice/practice-notes/positive-action/*

- Help NHS organisations highlight good practice and progress on workforce race equality as part of the evidence for the NHS Trust Development Agency, and the Care Quality Commission and Monitor inspection standards relating in particular to the 'well-led' domain.

# 3 Setting the scene: Why we need a Workforce Race Equality Standard

> "Recent research on race equality in the NHS workforce makes challenging reading for Boards in provider organisations. Evidence shows that if you are from a Black and Minority Ethnic background you are less likely to be appointed once shortlisted, less likely to be selected for training and development programmes, more likely to experience harassment, bullying and abuse, and more likely to be disciplined and dismissed. Black and Minority Ethnic staff are significantly under-represented in senior management positions and at Board level. In 2012, just 1 per cent of NHS chief executives came from a BME background, compared to 16 per cent BME representation in the NHS workforce.
>
> Most worryingly, despite a multitude of race equality initiatives and examples of provider good practice since the 2004 Race Equality Action Plan, many of the key indicators are either static or actually getting worse."[2].

The NHS is the largest employer in the UK and employs the largest number of people from BME backgrounds – about 8.4 per cent of the NHS workforce (NHS workforce statistics 2002)[3]. However, the distribution of the workforce in the NHS is concentrated mainly in the lower levels of the organisation, with only 1 per cent of Chief Executives emerging from BME groups. As a result of recent initiatives to increase the representation of BME groups in senior positions, there has been a gradual increase in the number of non-executive directors and executive directors from minority ethnic groups. However, there are still wide disparities in their distribution, both geographically and within directorates (Department of Health 2004)[4].

The decision to develop a WRES is based on a comprehensive body of evidence available from over the last twenty years which demonstrates that compared with White staff, BME people do not fare well in their employment experiences and opportunities with the NHS, or indeed in most other public service organisations.

Furthermore, research by West, M[5] and Dawson, J[6] shows that, the greater the proportions of staff from a BME background who report experiencing discrimination

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[2] Kline, R (2014) *The Snowy White Peaks of the NHS.* Middlesex University
[3] Esmail, A, Kalra, V. and Abel, P., University of Manchester, (2005) *A Critical Review of Leadership Interventions Aimed at People from Black and Minority Ethnic Groups.* The Health Foundation
[4] *Ibid.p4*
[5] West, M, Dawson, J. Admasachew, Topakas, A. (2011) *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data.* Aston Business School. (2011)

[6] Dawson, J. (2009) *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys.* Aston Business School.

at work, the lower the levels of patient satisfaction. They state that the 'experience of BME staff is a very good barometer of the climate of respect and care for all within NHS trusts.' Therefore, addressing workforce race inequalities will help us to create productive teams which in turn will result in better service delivery.

## 3.1 The Evidence - research and reviews

Over the last ten years, a number of initiatives have been developed within the NHS that have aimed to tackle workforce race inequalities, including the Race Equality Ten Point Action Plan, Breaking Through and elements of the Race for Health programme. Irrespective of these initiatives, however well intended, little appears to have changed for the better – suggesting the potential for systemic failings and weaknesses being responsible for the lack of system-wide progress on this agenda.

In 2004, the Independent Inquiry into the death of David Bennett[7], revealed serious failings in the care and treatment of BME patients in mental health settings. The report identified organisational cultures and systematic shortfalls that required further examination. Since that Inquiry, it is increasingly recognised that institutional policies, practices and cultures can have a detrimental impact upon BME workforce opportunities and experiences, as well as service provision for BME patients and communities.

The following presents the key evidence highlighting the need to focus on workforce race equality, and in particular, the need for the development of a WRES.

### 3.1.1 The Health Foundation Review

In 2005, the Health Foundation's *Critical Review of Leadership Interventions Aimed at People from Black and Minority Ethnic Groups*[8] stated:

- The ability of the NHS to nurture and develop its BME workforce has, to date, been inadequate. Numerous reports, many commissioned by the Department of Health (e.g. Alexander 1999; King's Fund 2001; Lemos and Crane 2000) have painted a depressing picture;

- a lack of senior management commitment to race equality issues, poor accountability in ensuring that equality targets are met, widespread bullying and harassment, and a deep-rooted perception among BME staff that the NHS does not value their contribution

The Review recommended:

- establishing a definitive picture of the current status of black and minority ethnic managers;

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[7] *Independent Inquiry into the Death of David Bennett, 2004,* Norfolk, Suffolk and Cambridgeshire Strategic Health Authority
[8] *A.Esmail et al,* A *Critical Review of Leadership Interventions Aimed at People from Black and Minority Ethnic Groups,* 2005, The Health Foundation.

- developing a programme of long-term monitoring;

- Gathering data about the current status of BME managers in the NHS

The researchers noted that there was insufficient information on which interventions are successful, nor any benchmarks for what might constitute successes. At that time, there was no information on which NHS trusts had managed to develop successful policies and programmes that could be replicated in other NHS organisations.

In addition, the Review argued for the language of diversity to permeate all areas of the NHS, with a clear understanding that diversity is critical to business success and better health outcomes for all patients. The Review suggested that a regular workforce survey should be conducted as a significant resource for evaluating interventions and charting the progress of BME staff in the NHS.

The WRES mirrors some of this thinking and uses the NHS Staff Survey and a specific set of metrics to address workforce race equality issues.

### 3.1.2 NHS Management and Health Service Quality research

In their research, West & Dawson[9] (2011) made the following key observations:

- The degree to which teams are structured is a predictor of patient mortality, staff absenteeism and turnover, and Annual Health Check performance.

- Supportive leadership from line managers is linked with patient satisfaction, patient mortality and staff turnover.

- Training is another important predictor: where more employees receive training, learning and development that is felt to be relevant for the job, the better the outcomes. There are also effects of some specific elements of training: the number of staff having health and safety training in the previous 12 months is associated with patient satisfaction and with staff turnover. Training in equality and diversity is associated with lower levels of absenteeism.

- Having a safe working environment is critical. Where staff feel under too much work pressure, outcomes are generally worse.

- When aggression is experienced – either physical violence or bullying, harassment or abuse – from patients, members of the public or colleagues, this creates poorer outcomes, not just in terms of staff turnover and

[9] West, M, Dawson, J. Admasachew, Topakas,A. (2011) *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data.* Aston Business School.

absenteeism, but also in terms of patient satisfaction. The same is true for discrimination experienced by staff.

In summary, the unfair treatment of BME staff:

- prevents patients from getting the best staff to care for them;
- results in racism, causing stress, creating poor teams dynamics therefore diverting resources and energy away from patient care;
- leads to staff illness and how staff are cared for impacts on care they provide;
- compromises innovation and teamwork

West and Dawson[10] also reported that there is a 'spiral of positivity in organisations that have an engaged, motivated and enthusiastic staff. Being undervalued and discriminated against leads to disengagement, unhappiness, depression, poor performance and ultimately reduced effectiveness.'

### 3.1.3 The Snowy White Peaks of the NHS

Kline, R[11] (2014) research identified the following key factors:

- Only 1 in 40 chairs and no CEO in London is BME;
- 17 of 40 Trusts have all white Boards but over 40 per cent of workforce and patients are BME;
- There are no BME Exec Directors in Monitor, Care Quality Commission, NHS Trust Development Agency, NHS England, NHS Litigation Authority, or Health Education England;
- Decreases in BME Senior Managers and Nurse Managers in recent years
- White staff are 1.74 times more likely to be appointed once shortlisted than are shortlisted BME staff;
- BME staff twice as likely to enter disciplinary process and more likely to be disciplined for similar offences compared to White staff;
- BME nurses take 50% longer to be promoted and are less likely to access national training courses compared to White nurses.

[10] West, M, Dawson, J. Admasachew, Topakas,A. (2011) *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data.* Aston Business School.

[11] Kline, R (2014) *The Snowy White Peaks of the NHS*. Middlesex University

Chand, K (2014) writing for the Guardian Health Network[12] stated:

> "International medical graduates are over-represented in the lowest paid, least glamorous specialties in the least popular parts of the country. Some of them have face racism, less recognition for awards and slow promotion in their working life. International Medical students from BME background are likely to be dealt with more harshly by the General Medical Council; they are three times more likely to be charged with serious professional misconduct, and therefore have a higher rate of receiving high-impact decisions than their white counterparts".

## 3.2 The Debate - where we are now?

During the second part of 2014, there have been wide ranging discussions at the NHS Equality & Diversity Council, with key stakeholders and during WRES consultation workshops across the country, on the value of focusing on one protected characteristic ('race'), on the content of a standard and its metrics.

Throughout these discussions, consideration has been given to potential positive and negative impacts of having a specific focus on 'race' and how this can be applied to other protected characteristics. From the outset these discussions have continued to inform the iterations of this equality analysis.

Indeed, positive action is one way of trying to counteract the experience of deep-rooted or historic disadvantage, by providing under-represented or disadvantaged groups with the support to help ensure they have the same, or similar, chances to opportunities as others.

Discussions to date have concluded that we have an exceptional body of evidence to take positive and proportionate action on workforce race equality. This evidence, coupled with the most recent findings from Roger Kline's work[13] has cemented the view of senior NHS Leadership that it is no longer prepared to ignore the realities of what is happening to BME staff in the NHS. Nor is it prepared to have a lack of BME representation on Trust Boards, and therefore positive steps to address workforce race inequalities must be taken.

Though individual NHS organisations' progress on implementing the WRES will be measured separately and will have its own reporting mechanism, such progress will be considered a vital component of the ongoing work throughout the NHS designed to address inequalities. The wider system will be informed that the WRES is not a replacement for other equality work. Organisations must continue to deliver on their

[12] http://www.theguardian.com

[13] Kline, R (2014) *The Snowy White Peaks of the NHS*. Middlesex University and Kline, R. (2013) *Discrimination by Appointment*. Public World

duties to meet the needs of groups with protected characteristics as defined in the Equality Act 2010.

The WRES is the first stage of a programme of work on workforce equality that is being developed with the support and close involvement of the most senior leadership across the health sector. The aspiration is to make real quantifiable differences for the benefit of BME staff, patients and local communities, in the first instance, and applying the learning from that work to the other protected characteristics.
Indeed, it is anticipated learning from the WRES will be used to make real tangible progress in tackling discrimination, promoting a positive culture and valuing all staff for their contributions to the work of the NHS. Work in parallel to the WRES is being developed to take forward disability and sexual orientation equality in the workplace.

The WRES metrics have taken the above evidence and consultation feedback into account.[14]

# 4 Engagement

The engagement and consultation on the WRES began in August 2014 and ended in December 2014. The engagement included a number of discussions held at the Equality and Diversity Council and related working groups, four regional engagement workshops, a national webinar, and two national surveys which included feedback from CCG's, Trusts, equality leads, staff side and a range of medical and managerial staff, and meetings with key stakeholders.

The outcome of the final consultation has led to the mandating of the WRES in the NHS Standard Contract 2015/16.

Key themes from the engagement and consultation included:

- The scope of the work should be race equality, but not to the detriment of other groups/protected characteristics, with the learning to be extended to other protected group;

- There is an 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) ;

- We 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;

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[14] *The WRES Equality Standard Metrics*: updated February 2015

http://www.england.nhs.uk/wp-content/uploads/2015/02/wres-metrics-feb-2015.pdf

- A need to learn from credible benchmarking exercises that are operating across the system in relation to other characteristics (e.g. Stonewall);
- Regulators should use the "well led" domain to examine Trust progress in moving towards the WRES;
- NHS Boards should be engaged and supported to make continual improvements, and allowed time to make the necessary changes, but there must also be some element of regulation to ensure traction – a balance will be needed.

## 4.1 Feedback regarding impact on other protected characteristics

Throughout the engagement phase there was clear recognition of the need for focused initiatives and overwhelming support for the WRES, as part of an inclusive approach to improving workforce representation and experience for all groups.

As explored earlier in this analysis, it was noted that several protected characteristics can apply to any one individual. Feedback from engagement particularly requested that:

- When looking at training opportunities for BME staff we will also consider age and the other protected characteristics;
- When exploring the promotion prospects of staff we will also consider sex and the other protected characteristics;

# 5 Impact and risk mitigation

This section looks at how the WRES will help fulfil our overarching duties and impact on specific protected characteristics – assessing the positive and negative impact of the WRES and any mitigating actions required.

> 'The law does not define 'disadvantage' but it may include exclusion, rejection, lack of opportunity, lack of choice and barriers to accessing employment opportunities. It is generally understood to relate to barriers or obstacles which make it difficult for a person to enter into, or make progress in, a trade, sector or workplace.'
> (Equality and Human Rights Commission, 2014)[15]

By establishing a WRES positive action will be taken to help address workforce race inequalities. Indeed, the WRES can contribute towards NHS organisations meeting

[15] The Equality and Human Rights Commission, Private and Public Sector Guidance, 2014 http://www.equalityhumanrights.com/private-and-public-sector-guidance/employing-people/managing-workers/career-development/using-positive-action-target-training-or-promote-wider-range-people

their equality duties. But there are some potential areas of low level risk which will require mitigating action and further exploration.

## 5.1 Equality Act 2010

### 5.1.1 Eliminating discrimination, harassment and victimisation

The WRES is likely to have a positive impact on those with other protected characteristics. For example it can help:

- Provide  positive impact on BME staff who are gay, or older BME staff etc.;
- Improve organisational culture, reporting systems and staff support for people who experience discrimination, harassment and victimization. It is designed to have a positive impact across the whole organisation and therefore across all staff groups and protected characteristics;
- Reflect awareness that discrimination and harassment and victimisation faced as a result of one's disability, sexual orientation or other protected characteristic, must also be taken into account. In this situation, the lead officer will be expected to take advice and support from appropriately skilled staff.

There are existing programmes of work that will continue to safeguard all staff across the protected characteristics, including having zero tolerance and anti- bullying policies in place. Current equality initiatives, such as the Equality Delivery System – EDS2, will continue to receive support from senior NHS leadership and the Equality and Diversity Council. This is not an either or situation.

BME staff will also experience discrimination as result of other protected characteristics (the notion of 'multiple jeopardy'). This work requires further exploration in partnership with trade unions, staff networks, the Equality and Human Rights Commission, NHS Employers, the NHS Strategic Partners Programme, as well as other organisations and bodies representing the different protected characteristics.

It is possible, that in times of economic hardship, some staff, and indeed the public, may view the WRES as 'favouritism' towards BME staff – this may result in an increase in discrimination, harassment and victimization towards BME staff and communities.

Furthermore, it could be argued that reporting of discrimination, harassment and victimisation against BME staff may initially increase, as BME staff feels more confident to raise such concerns and report incidents.

However, the learning from positive action directed towards people with a BME background can be applied directly to people with other protected characteristics. Focusing on race in the first instance can have an impact on creating a positive

environment for all other protected characteristics. For example, if the WRES produces successful outcomes for BME staff, its principles can be applied to other groups and similar evidence-based Standards can be developed for protected characteristics.

To help reduce any potential negative impact, the following actions are to be taken:

- Ensure that all staff teams are engaged, can understand the rationale of the WRES, and can see the value of the work for everyone. It is essential there is clarity about positive action i.e. this is not about giving BME staff an unfair advantage – which is illegal. Rather, the WRES helps to highlight potential differences in workforce representation and workplace experiences between White and BME staff, and encourages organisations to close any such gaps through continuous improvement.

- NHS England and local NHS organisations will be asked to demonstrate strong leadership on this agenda, share WRES findings and plans of action which involve and engage staff across the range of characteristics

- Develop a comprehensive 'knowledge bank' and record of what works and what doesn't work so that learning can be taken from good practice and applied to other characteristics.

### 5.1.2 Advance Equality of Opportunity

The WRES will have a direct positive impact in advancing equality of opportunity for BME groups. The WRES may also have an indirect positive impact for BME individuals where other protected characteristics apply, but only when these characteristics apply in conjunction with race.

In addition, it is anticipated the WRES will result in positive organisational changes that will help spread equality of opportunity across all staff, bringing to the fore the values of the NHS as enshrined in the NHS Constitution.

As highlighted above, the learning from the positive action directed towards people with a BME background could be applied to people with other characteristics, and in doing so, advance the equality of opportunity for other groups. Focusing on race in the first instance can have a cumulative effect on creating a positive environment for all other protected characteristics. For example, if the WRES produces successful outcomes, its principles can be applied to other groups and similar evidence-based Standards can be developed for other protected characteristics.

White staff and or those with other protected characteristics, who may not benefit directly or indirectly from the WRES, may be concerned about the 'unfair' 'equality of opportunity' that BME staff are receiving. However, as noted above there will be careful handling of the key messages of the WRES outlining that it is not a substitute for other equality initiatives or fair practice, rather it is complementary to them.

To help mitigate against risk, organisations should develop a baseline assessment of current resources and initiatives allocated for staff support across protected characteristics. This baseline will be separately identified to the resources required for the WRES implementation. Both allocations of resources should be reviewed annually.

#### 5.1.3 Promote good relations between groups

The WRES will have a positive impact on BME people working or wishing to work for the NHS, and therefore promote good relations between groups. The WRES may also have an indirect positive impact for individuals where other protected characteristics apply, especially when these characteristics apply in conjunction with race.

White staff, and or those with other protected characteristics, who will not benefit directly or indirectly from the WRES may feel BME staff are being favoured. Therefore, there may be a small potential risk of inducing negative impact on relations between groups, though the WRES is certainly designed to have a positive impact on BME groups.

Furthermore, it is felt that negative impact is unlikely because of the mitigating action to be taken with regard to the careful handling of the key messages on the WRES - outlining that it is not a substitute for other equality initiatives or fair practice; rather it is complementary to them. In addition the NHS workforce is expected to adhere to the principles and values of the NHS Constitution – once staff understand the rationale behind this programme of workforce equality, it is felt that any potential risks will be mitigated.

NHS staffs are passionate about patient care and should be encouraged to understand the evidence that confirms the empirical link between well supported staff that feel happy and cared for create better working environments and better health outcomes for all patients.

To help mitigate any negative impact, the way in which the WRES is endorsed and communicated is crucial. It must be made explicit that WRES is linked to improvements in staff experiences, their welfare and patient care, and aims to create a ‘well led’ organisation as defined by the regulators – a positive NHS values-based culture for the benefit of all staff groups and patients. It should also be communicated that WRES is the first phase of a programme of work that will look at workforce equality across all equality strands.

To further help mitigate potential risks, training and information should be provided to staff as part of organisational development. Such training and information should illustrate the business benefits of having a diverse workforce at all levels, and the positive impact this can have on staff wellbeing and upon health outcomes for all patients.

## 5.2 Other groups and protected characteristics

The WRES does not replace or reduce the need for organisations to continue fulfilling their legal duties regarding other protected groups as detailed in the Equality Act 2010. A clear message will be sent across the system reminding organisations that they must ensure that the WRES does not impinge or detract from other equality groups' areas of need.

In addition, work will continue with the community and voluntary sector, the NHS Strategic Partners, and staff networks to ensure a fully inclusive approach is taken to addressing BME staff inequalities. Advice regarding this is being taken from community and voluntary sector, trade unions and charitable organisations that represent the equality strands.

Everyone has at least a minimum of five protected characteristics.

Through creation of the WRES, the needs of BME staff who are also members of other protected groups for example because of gender, their age, disability or sexual orientation has been carefully considered. In addition, the impact of the WRES on staff who are not BME but have other protected characteristics has been considered. Reviews and evaluations of the impact of WRES on all protected groups will continue to be on-going conversations.

To ensure a full understanding of the impact of the WRES, analyses have been undertaken on the proportion of the NHS workforce with each of the characteristics given protection under the Equality Act 2010. Assessment has also been made on workplace experiences of those with each characteristic. This can help form a picture of how specific characteristics impact upon experience.

### 5.2.1 Age

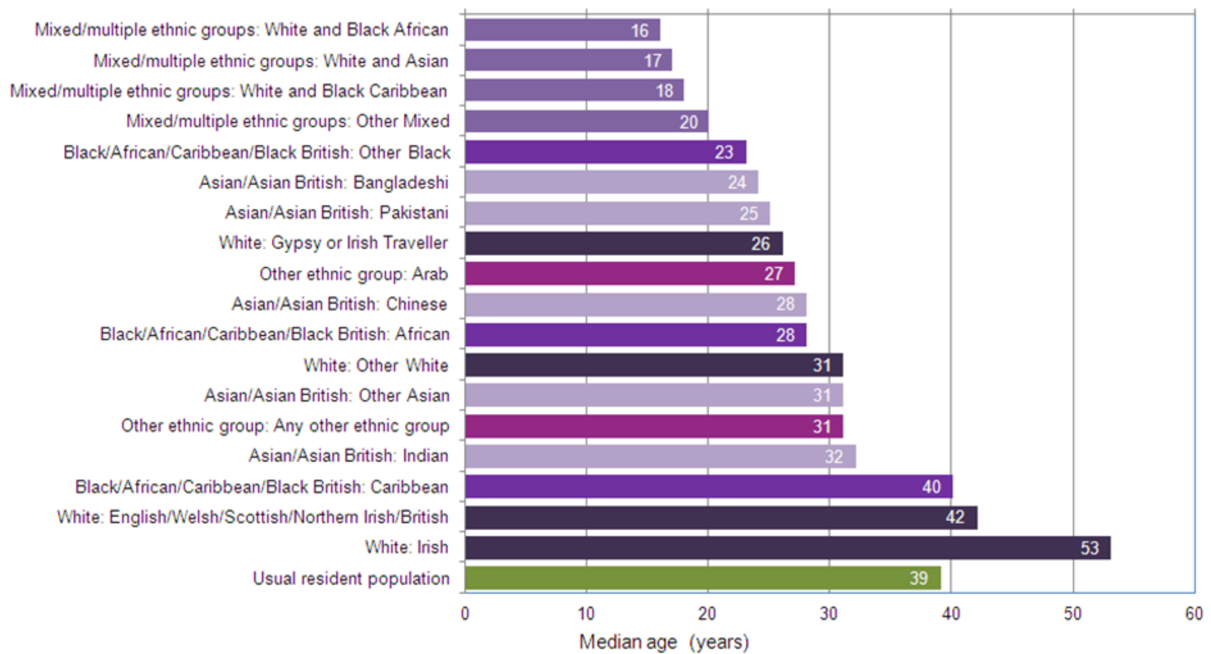
Population changes are important to consider for both future service provision and workforce planning. BME populations are generally of younger age groups than White groups. Specific areas of the country may for the first time begin seeing BME groups settling in significant numbers than currently is the case. Based on population growth and changes by age it makes sense that local Trusts and providers consider the make-up of their communities for resource planning, re-design services that are appropriate to the needs of their varied population groups and put plans into place to attract staff from within these communities - diverse and varied skill sets.

Health and Social Care Information Centre NHS Workforce statistics for October 2013, published in January 2014

| Age group | % of population in England (2011 census) | % of non-medical NHS workforce (October 2013) |
|---|---|---|
| 16 – 25 | 19.2% | 5% |
| 26 – 34 | 18.3% | 21% |
| 35 – 44 | 19.8% | 26% |
| 45 – 54 | 20.8% | 30% |
| 55 – 64 | 16.7% | 16% |
| 65 – 67 | 5.2% | 2% |

The table below demonstrates the point.

Figure 2: Ethnic group: median age Census - Office for National Statistics (2012)




These results show that the different ethnic groups have very different age-profiles:

- The median age of the largest ethnic group (White British) is 42 years of age.
- The ethnic group with the highest median age is White Irish, with the central person in this ethnic group being 53 years of age.
- The 'Black/Black British: Caribbean' group was the only other ethnic group to have a median age (40) above the England and Wales median of 39 years of age.

**Impact and mitigation**

The WRES metrics and subsequent findings will help prevent unfair treatment to significant proportions of the population, by ensuring appropriate systems are in place so that the NHS is seen as an employer of choice for all communities.

The WRES does not compromise the legal duties on equality. This is an area that will require advice and support from HR colleagues to ensure NHS employers remain within legal boundaries when considering training opportunities and forward planning workforce requirements.

### 5.2.2 Disability

Nearly 7 million people of working age in the UK are disabled or have a health condition. Historically there has been a significant gap between the proportion of disabled people employed compared with non-disabled people.

The costs of making reasonable adjustments to accommodate disabled employees are often low. The benefits of retaining an experienced, skilled employee who has

acquired impairment are usually greater than recruiting and training new staff. It is also good for the individual.

Public bodies must take steps to take account of disabled people's impairments; they must not discriminate against disabled people by treating them less favourably than other people, and must make reasonable adjustments, both anticipatory and individual. They must also promote equality of opportunity between disabled people and those that are not disabled. It is permissible to treat disabled people 'more favourably' than others, where to do so would not breach a competence standard.

The Equality Act 2010 defines a person as disabled if they have a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

'Normal day-to-day' means things that people do on a regular or daily basis, such as reading, writing, using the telephone, having a conversation and travelling by public transport. 'Long-term' usually means the impairment should have lasted or be expected to last at least a year.

According to data from the Health & Social Care Information Centre (HSCIC), 3% of non-medical staff declares that they have a disability. Data quality is an issue, as information is unknown / not disclosed for 45% of all staff.

According to the Family Resources Survey (2010/11)[16], there are over 11 million people in UK (or 17% of the population) with a limiting long term illness, impairment or disability. The Labour Force Survey (2012)[17]shows that 46.3% of working-age disabled people are in employment compared to 76.4% of working-age non-disabled people. We would expect around 8-10 per cent of the NHS workforce to have some form of disability.

There is no significant variation in the number of disabled/non-disabled staff in senior management posts. The percentage of people on AfC bands 8a and above is 5% for disabled staff and 6% for non-disabled staff.

Disabled NHS staff are more likely to report bullying and harassment from members of public. Thirty-four per cent have reported such an incident while the national average is 28%[18]. In addition, 13% of disabled staff has experienced discrimination by managers - while the national average is 7% - this is a stark statistic.

**BME communities and long-term conditions**

BME people are more likely to experience ill health relating to diabetes and coronary heart disease.  There is also good evidence to suggest that as a result of racism, and

[16]Family Resources Survey 2010/11 cited in https://www.gov.uk/government/publications/disability-facts-and-figures/disability-facts-and-figures

[17] The Labour Force Survey 2012, ibid.

[18] NHS Staff Survey 2013

stressor in their daily lives which impacts on mental wellbeing. This is a concept referred to as ‘weathering’.[19]

These illnesses are long-term conditions and depending on the severity and impact on daily life they can be classified as a disability. Therefore, as the BME staff workforce gets older it is likely that they will experience greater ill health with chronic long-term conditions. Taking this into account BME communities are likely to be at greater risk of having a disability.

Further work will be required to explore the implication of ethnicity, health inequalities and its impact on BME staff and work patterns.

**Supporting Disability Rights**

The NHS is fully committed to supporting initiatives which challenge disability discrimination and make it easier for disabled people to take-up employment opportunities and access services. The ‘Two Ticks Symbol’ programme makes five commitments:

- We guarantee to interview all applicants with a disability who meet the essential criteria for a job vacancy and to consider them on their abilities;
- We will discuss with employees who have disabilities what we and they can do to make sure they can develop and use their abilities;
- We will make every effort when employees develop a disability to make sure that they stay in employment;
- We will take action to ensure that all employees develop the appropriate level of disability awareness needed to make our commitment work;
- We will review the five commitments every year to see what has been achieved. We will plan ways to improve and we will let employees know about progress and future plans.

**Impact and mitigation**

The WRES does not compromise the legal duties on equality. This is an area that will require advice and support from HR colleagues to ensure NHS employers are not in breach of their duties for reasonable adjustments and guaranteed interview schemes when implementing the WRES.

### 5.2.3 Gender Reassignment

The health care system in England is key to many Trans* people[20] managing to fulfil their lives. For the majority, the interaction with the NHS will be on the receiving end

[19] *Biological Weathering* – American Journal of Public Health, May 2006

of help and care they receive in the process of obtaining gender reassignment surgery, or other relevant services. Indeed, Trans* people also make-up the NHS workforce.

Data on workforce composition or on experience within the work environment by gender reassignment is not readily collected within the NHS or beyond, for example through the Office of National Statistics (ONS) Census. We therefore have no direct information on the numbers of Trans* people working in the NHS.

Statistics relating to the general population indicate that between April 2005 and September 2013, over 3,344 Gender Recognition Certificates (GRC) were issued – whilst this figure may be used as a proxy for the total number of Trans* people, not all Trans* individuals acquire a GRC.

Research findings published as part of the Equalities Review[21] in 2007, showed that Trans* people were three times more likely to work in a professional occupation than the national average (33%:10.8%). Trans* people also have higher educational attainment than the general population (29.2% of Trans* people have a first degree compared to the national average of 21.1%).1

The Equalities Review found that 42% of people were not living permanently in their preferred gender role and were prevented from doing so because they feared it might threaten their employment status. It found that 1 in 4 Trans* people were:

- Made to use an inappropriate toilet in the workplace, or none at all, in the early stages of transition.
- At work over 10% of Trans* people experienced being verbally abused and 6% were physically assaulted.
- As a consequence of harassment and bullying a quarter of Trans* people will feel obliged to change their jobs.

The Trans* Mental Health Study[22] found that 52% of study participants had experienced problems with employment due to being Trans* or having a Trans* history (N=544). The most common issue was harassment or discrimination, with19% experiencing this. 18% believed that they had been unfairly turned down for a job, whereas 16% had not applied for one due to fears of harassment and discrimination.

**Impact and mitigation**

Whilst little is known of Trans* people's experiences of working in the NHS, it is very often the 'transphobic' response of other members of society that results in Trans*

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[20] To note: *Trans includes but is not limited to: transgender, transsexual, genderqueer, non-binary, gender-fluid, gender nonconforming, intersex, third gender, twin spirited, transvestite, cross-dresser, bi-gender, trans man, trans women, agender, gender independent, and non-gender, as well as other non-binary identities.

[21] The Equalities Review (2007), Cabinet Office, http://webarchive.nationalarchives.gov.uk/20100807034701/http:/archive.cabinetoffice.gov.uk/equalitiesreview/upload/assets/www.theequalitiesreview.org.uk/equality_review.pdf.

[22] *Trans* Mental Health Study* (2012), J. McNeil et al, Scottish Transgender Alliance with TransBareAll and partners.

people experiencing the levels of inequality, discrimination and victimisation in the workplace, as highlighted above.

Indeed, further research is needed to look at the needs of Trans* staff and BME Trans* people with the aim of making the NHS an employer of choice.

### 5.2.4 Marriage and Civil Partnership

Marriage and civil partnership discrimination is unlawful in the UK and occurs where a person who is married or in a civil partnership is treated less favourably than other persons would be treated because they are married or in a civil partnership. Same-sex couples who register as civil partners are entitled to the same rights and benefits as married people.

Currently, data on the NHS workforce composition or on experience within the work environment, by marriage and civil partnership, is not available. However, anecdotal evidence suggests that often, marriage – and the subsequent likelihood of having children – is likely to have a negative impact upon women's chances of promotion within careers. It can also be argued that same sex marriage and entering into a civil partnership can be as threatening to career aspirations as opposite sex marriage, if not more.

**Impact and mitigation**

Further work will be required to examine any potential adverse impact on BME staff as a result of marriage or civil partnership.

### 5.2.5 Pregnancy and Maternity

Although data on workforce composition or experience within the work environment by pregnancy and maternity is not readily available, research studies have been conducted in this area. Research carried out by the National Childbirth Trust[23] found that 39% of mothers rated their return to work as "difficult" or "very difficult". It also showed that 11% changed employer or became self-employed on or shortly after returning to work.

Despite legislation and regulation giving protection to the characteristics of Pregnancy and maternity, concepts such as the 'maternal wall bias' remain prevalent. This bias stems from assumptions that becoming a mother may result in decreased commitment to careers, and therefore opportunities within the workplace are restricted.

A number of court cases over the last few years have concerned pregnancy and maternity discrimination. A wide range of questions have been considered, including the employer's obligation to conduct risk assessments of pregnant employees, and the handling of redundancies during the protected period.

[23] National Childbirth Trust[23] (2007)

**Impact and mitigation**
Further data will be required to explore the impact of pregnancy and maternity rights by Race and how this captured in the WRES metrics and their analysis.

### 5.2.6 Race

Ethnic discrimination in the NHS recruitment process was first publicised by a landmark study in 1993, when researchers found that identical applications for medical posts were twice as likely to be shortlisted, if they were made with an English name, than with an Asian name.[24] Two decades later, the situation appears no better.

The study by Stevenson &Rao[25] revealed that:

- White doctors are almost three times more likely to be successful in applying for hospital jobs than doctors from ethnic minorities (Jaques, 2013).
- In 2012, 13.8% of White applicants to senior hospital doctor jobs in England were successful in securing the role they applied for, compared with 4.8% of doctors from BME backgrounds.
- Black or black British applicants were the ethnic group least likely to secure hospital doctor jobs (2.7% success rate), followed by doctors of mixed ethnicity (3.5%), and Asian and Asian British doctors (5.7%).
- White doctors were also more likely to be both shortlisted for jobs and appointed to roles once they had been shortlisted.

Data from the Health and Social Care Information Centre (HSCIC) indicates that 14% of non-medical staff and 38% of medical staff are from a BME background; this includes 5% Black or Black British staff and 6% Asian or Asian British staff. Comparisons with the population make up (as per 2011 Census) are shown below:

| Ethnic Group | % of population in England | % of medical NHS Workforce | % of non-medical NHS workforce |
|---|---|---|---|
| White | 85.5% | 55% | 82% |
| Mixed | 2.2% | 3% | 1% |
| Asian | 7.7% | 28% | 6% |
| Black | 3.4% | 3% | 5% |
| Other Ethnicity | 1.0% | 4% | 2% |
| Unknown ethnicity | N/A | 7% | 4% |

[24] Esmail, A & Everington,S. *Racial Discrimination against Doctors from Ethnic Minorities* British Medical Journal 1993;306:691-2
[25] Stevenson, J; Rao, M (2014) *Explaining levels of Wellbeing in BME populations in England*, University of East London

| NHS hospital and community health services: Non-Medical staff in England by pay band and ethnic group as at 30 September 2013 All Staff | | Total ethnic minority groups | Total ethnic minority groups %(1) |
|---|---|---|---|
| England | 1,075,035 | 148,396 | 14.4% |
| Band 1 | 41,168 | 6,322 | 16.2% |
| Band 2 | 174,336 | 21,449 | 12.9% |
| Band 3 | 143,074 | 15,845 | 11.6% |
| Band 4 | 92,481 | 8,864 | 10.0% |
| Band 5 | 244,092 | 49,717 | 21.3% |
| Band 6 | 187,994 | 26,966 | 15.0% |
| Band 7 | 115,540 | 12,406 | 11.1% |
| Band 8a | 37,985 | 3,728 | 10.2% |
| Band 8b | 17,143 | 1,388 | 8.4% |
| Band 8c | 9,164 | 592 | 6.7% |
| Band 8d | 5,017 | 270 | 5.7% |
| Band 9 | 1,474 | 68 | 4.8% |
| Unknown | 16,040 | 1,748 | 11.7% |

- Excluding staff assigned to clinical pay grades
- Staff from minority ethnic groups represent 14.4% of non-medical staff.
- High representation of ethnic minority groups in staff with pay band 5 (21.3%)
- Low representation of ethnic minority groups in staff with pay bands 8c (6.7%), 8d (5.7%), and band 9 (4.8%).

The HSCIC 2013 data presented above conclusively demonstrates that ethnic minorities are under-representation at senior levels of the NHS.

As a large and complex employer, the NHS operates with a defined hierarchy offering career progression and recognition. Barriers to progression were identified in the study by Stevenson and Rao[26] by all participants, in particular noting the issue of the lack of ethnic diversity in the senior leadership, as well as challenges at all levels to staff attempting to further their careers.

It should be noted that the Health and Social Care Information Centre data currently include people from Eastern Europe and Gypsy Roma and Travellers under the “White” category. Law Courts have ruled that Gypsy Roma and Irish Travellers are minority ethnic groups and are protected under equality legislation. There are, as yet, no such rulings for people from Eastern Europe. This will have implications upon the groups and communities that are, and are not, likely to directly benefit from a proposed WRES.

[26] Stevenson, J; Rao, M (2014) *Explaining levels of Wellbeing in BME Populations in England*, University of East London

With regard to senior NHS posts, the percentage of non-medical staff on AfC bands 8a and above is:

- 7% for White staff compared to 3% for Black and 4% for Asian staff
- The exception to this rule is people of Chinese origin who are 9% on Bands 8a and above.
- For medical staff, consultants make up 43% of White doctors, compared to 34% of Asian staff and 28% of staff of mixed race.[27]

In the 2013 NHS Staff Survey:

- 39% of Black staff compared to 63% of White staff felt that their organisation acted fairly with regards to career progression and promotion.
- The survey findings also showed that 29% of BME and 34% of Black African staff have experienced harassment and bullying from members of public.
- Pakistani staff are less likely to report harassment and bullying from members of public (32% compared to a national average of 37%).
- Black staff are four-times more likely to experience discrimination from patients (23% compared to a national average of 6%).
- Black staff are also twice more likely to experience discrimination from managers (14% compared to national average of 7%).

Most recently, Kline's report[28] reveals:

- The proportion of chief executives and chairs from a BME background amongst London's Trusts has decreased such that there is currently one BME chair and no BME chief executive
- Two fifths of London's 40 NHS Trust Boards had no BME members (executive or non-executive) on them at all, whilst over half of London's Trust Boards either had no BME executive members or no BME non-executive members.
- There has been no significant change in the proportion of non-executive BME Trust Board appointments in recent years, continuing the pattern of under-representation compared to both the workforce and the local population.

[27] Health and Social Care Information Centre, 2012
[28] Kline, R (2014) *The Snowy White Peaks of the NHS.* Middlesex University

- The proportion of senior and very senior managers who are BME has not increased since 2008, when comparable grading data was last available, and has fallen slightly in the last three years. The likelihood of white staff in London being senior or very senior managers is three times higher than it is for black and minority ethnic staff.

- The ethnicity and gender diversity of the leadership of national English NHS bodies is poor, with BME executives being entirely absent, and women being disproportionately absent, from the Boards of all the key national bodies - NHS England, Monitor, the NHS Trust Development Authority, Heath Education England, and the Professional Standards Authority.

Stevenson & Rao[29] (2014) reviewed levels of wellbeing in BME communities which are lower than the White population. With respect to the residual deficit in wellbeing for BME populations, interviewees pointed towards likely explanations such as higher mental distress and experiences of exclusion, racism and discrimination within the workplace.

Research suggests that the experience of BME NHS staff is a good barometer of the climate of respect and care for all within the NHS. West, M et al (2011)[30] highlighted that 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.

**The impact of population changes, workforce and service planning**

The following data is taken from Office of National Statistics (Ethnicity and National Identity in England and Wales 2011).

The 1991 Census first introduced a question on ethnic group to enable private and public organisations to monitor equal opportunities /anti-discrimination policies and to plan for the future through resource allocation and provision of services. To summarise the changes since 2001 and 2011

- the Any Other White category had the largest increase across the ethnic groups, with an increase of 1.1 million (1.8 percentage points) between the 2001 and 2011 Censuses. This includes people from Poland
- 80 per cent (45.1 million) of all usual residents in England and Wales in 2011belonged to the ‘White: British’ ethnic group. This is a seven percentage point decrease since 2001when 87 per cent (45.5 million) of the usually resident population belonged to the ‘White: British’ group.
- The largest other ethnic groups in 2011 were ‘Asian/Asian British: Indian’ (3 per cent, 1.4million), ‘Asian/Asian British: Pakistani’ (2 per cent, 1.1 million) and

[29] Stevenson,J; Rao,M (2014) *Explaining levels off wellbeing in BME populations in England*. NHS Leadership Academy

[30] West, M, Dawson, J. Admasachew, Topakas,A. (2011) *NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data.* Aston Business School.

- ‘Black/Black British: African’ (2per cent, 990,000) as a country of birth, who were the second largest group of non-UK born residents in 2011 and increased by 0.5 million (a nine-fold increase) between 2001 and 2011.

• The Asian/Asian British ethnic group categories had some of the largest increases between the 2001 and 2011 Censuses. People identifying as Pakistani and Indian each increased by around 0.4 million (0.5 percentage points and 0.6 percentage points respectively).

• The remaining ethnic groups each showed small increases of up to 1 per cent.

As a service-delivery organisation with a remit for the whole population, it is crucial that the NHS engages with the communities that it serves. The Wanless Report (Securing Our Future, 2002)[31] identified the need for healthcare trusts to engage with their community and develop networks with the local population in order to do this.

**Impact and mitigation**

The focus of WRES is on ‘race’. Research work should be planned to fully capture the impact of the WRES across BME groups and upon patient experience. The impact of discrimination and prejudice on ‘new’ minority ethnic communities, including people from Eastern Europe also requires further examination.

### 5.2.7 Religion or Belief

The quality of data on staff composition by religion or belief is an issue. Data are not currently available for 47% of staff. 39% of non-medical staff identifies as Christians, 6% atheists and 8% other religions.

The 2011 ONS Census shows that 60% of people living in England identify as Christians, 7% atheists, 6% Hindus and 6% Muslims.

With regard to representation at AfC bands 8a and above within the NHS workforce, atheists are slightly over-represented (8%) and Muslims are under-represented (4%), compared to their respective population figures.

The 2013 NHS Staff Survey shows variation in staff experience by religion or belief. 37% per cent of people identifying their religion or belief as ‘any other religion’ have experienced harassment and bullying or abuse from members of the public in the last12 months, compared with the overall figure of 28% for all staff.

The Survey shows that 31% of Buddhist staff has reported harassment, bullying and abuse from their manager, team leader or other colleague in the last 12 months, compared with the overall figure of 22% of all staff reporting the same.

The 2013 NHS Staff Survey also shows that compared to 37% of all staff, only 30% of Jewish staff follow-up on an incident of harassment and bullying at work by reporting it.

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[31] *Securing our Future*, Wanless, D., 2002 Cabinet Office, http://www.hm-treasury.gov.uk/wanless

Strikingly, 13% of Buddhist staff and 13% of Muslim staff have experienced discrimination from a manager, team leader or other colleague within the last 12 months; this is almost double the rate of the overall staff figures for the experience of discrimination from a manager, team leader or other colleague (7%).

**Impact and mitigation**

Indeed, some of the evidence of poor workforce experience for people of a faith other than Christianity is worrying and on a proportionate par with the experience of BME staff. It may be argued that a workforce Standard focused upon 'race' may also, indirectly, make things better for BME staff who are Muslim or Buddhist etc. But, regardless of 'race', if prejudice against those religions persists, additional benefit for those people may not emerge. When using the WRES, organisations should be mindful of religious discrimination, as not to do so may run the risk of negating its positive effects. Local implementers should analyse their findings by protected characteristics and look at any correlations between the two characteristics. This can be shared and reported back to the national team leading on the WRES.

### 5.2.8 Sex

The composition of the working age population in England, by sex, is 51% women and 49% men. According to HSCIC data, 81% of non-medical and 45% of medical staff are women. However, despite making up the significant majority (81%) of the NHS workforce, women remain under-represented in the 'upper echelons' of NHS leadership.

A major analysis carried out by the Health Survey Journal (HSJ)[32] in 2013 found that men constitute the majority in the leadership teams of all but 12 per cent of provider organisations and 10 per cent of Clinical Commissioning Groups.

Just 37% of senior roles on clinical commissioning group governing bodies and NHS provider boards are held by women. The work conducted by the HSJ also found that found that where women hold executive level responsibilities these tend to be traditional female roles such as lead nurse or director of human resources.

In contrast, three quarters of NHS finance directors are male:

| 2014 | Women | Men |
|---|---|---|
| All NHS staff | 81% | 19% |
| NHS boards | 37% | 63% |
| Chair | 30% | 70% |
| Chief Executive | 36% | 64% |
| Finance | 26% | 74% |
| Medical Director | 24% | 76% |

[32] Local Government Chronicle, *Women Still in the Minority in NHS Leadership Roles, findings of Health Survey Journal Survey*, 2013 – http://www.lgcplus.com/opinion/health/more-on-health-and-social-care/women-still-in-the-minority-in-nhs-leadership-roles/5061328.article

Furthermore, HSCIC data indicates that within senior management NHS roles, there are twice as many men (10%) in Agenda for Change Bands 8a and above compared to women (5%).

The balance between men and women in senior NHS positions is deemed important for a number of reasons:

- It broadens the talent pool and will increase success
- It ensures Boards are more representative of their staff and of the wider population
- Could be one of the levers the NHS can use to address the culture change called for by Francis, Keogh and Berwick, in their respective report
- Women are stronger than men on a number of competencies[33]
- It's the "right" thing to do

Research identifies 'work-life balance' as an important concept with regard to the striking gender disproportion within the NHS workforce. This was also raised as an issue and reason why it may be difficult to attract women to apply for leadership roles.

Research indicates that since 2010, the gap between male and female pay, generally, has been closing at a rate of just 0.3% per year. With the pay gap currently19.7%, it could take over 60 years to deliver equal pay for women.

**Impact and mitigating**

The evidence on sex is stark. It delivers a bleak indictment on the NHS and confirms the poor prospects for women who make up the great majority of NHS staff. The WRES should consider the difference in pay scales by gender as well as ethnicity.

### 5.2.9 Sexual Orientation

The 2012 ONS survey showed, 1.5 per cent of adults in the UK identified themselves as Gay, Lesbian or Bisexual (LGB). According to HSCIC data, sexual orientation monitoring data is available only for53% of NHS staff. Nationally only 1% of staff has its sexual orientation recorded as lesbian, gay or bisexual.

Sexual orientation information is also not currently collected on the ONS 10-year Census. However, research suggests that the gay, lesbian and bisexual population is

[33] Harvard Business School Review , *'Are Women Better Leaders than Men*?', Jack Zenger & Joseph Folkman, March 2012

estimated to be 5-7% of the total population, which is also the estimate used by the UK government.

There is a slightly higher percentage of "out" lesbian, gay and bisexual staff in AfC Bands 8a and above 9%; compared to 6% of heterosexuals.

2013 NHS Staff Survey indicates:

- 36% of gay and 34% of lesbian staff have experienced harassment or bullying from members of the public compared to a national average of 28%.
- Gay men are close to 3-times more likely to experience discrimination from patients, at 15% compared to a national average of 6%.

In 2014, the Manchester Business School published a report summarising the findings of a large national study into the workplace experiences of LGB employees[34]. The report used personal experiences and witness observations to illustrate how LGB people encounter bullying and discrimination and what effects these have upon individual psychological and mental health.
The report shows that:

- LGB staff were more than twice as likely to be bullied and discriminated against as heterosexual employees
- One in five (19.2%) bisexuals report the highest levels of bullying with a third reporting regular bullying
- One in six (16.9%) lesbians report bullying at work with approximately a third reporting regular bullying
- Gay men report more than double the levels of bullying compared to heterosexuals
- LGB people are one and half times more likely to experience a range of negative acts compared to heterosexuals and these were highest for lesbians and bisexuals.

In some cases, LGB people were nearly three times more likely to encounter certain negative acts compared to heterosexuals. These include:

- 'People avoiding physical contact with you at work'
- 'Experiencing unwanted physical contact e.g. touching, grabbing, groping'

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[34] *Lesbian, Gay and Bisexual Workplace Experiences Survey*, 2014, the Manchester Business School

- 'Being confronted with unwanted jokes or remarks which have a sexual undertone'

Some interviewees felt pressured to 'play down' their sexuality to fit in. In the absence of an LGB network, many LGB people looked out for and after each other. Somewhat disturbingly it emerged that managers were unwilling or unsure about handling severe cases of harassment involving sexuality.

Overall, LGB people in the NHS case study felt strongly that they did not want their sexuality to be disclosed to patients, possibly because many felt they were often exposed to homophobic comments from patients and their relatives. Many of the interviewees also felt they were not always respected by their colleagues, with one reporting a comment from a colleague "you gay guys are very promiscuous aren't you."

A recent Stonewall survey[35] (2012) showed that over a quarter (26 per cent) of lesbian, gay and bisexual staff are not at all open to colleagues about their sexual orientation. For the last decade, the Stonewall Healthcare Equality Index has set the standard for employers who want to provide the best possible working environment for their LGB staff. The Index is based on a range of key indicators which include a confidential questionnaire of LGB staff and evidence provided by the organisations participating.

Nottinghamshire Healthcare NHS Trust, for example, was placed fourth in Stonewalls Workplace Healthcare Equality Index for 2013. Participation in the Index has led the Trust to strengthen its work in the development of strategies to meet the needs of under-represented LGB staff, via initiatives such as policy development, the executive mentoring scheme and the bespoke leadership development programme.

In addition, the Stonewall Equality Index can be used to promote diversity and equality across the protected characteristics.

**Impact and mitigating**

Further work with Stonewall and the Lesbian and Gay Foundation is recommended to identify good practice NHS organisations. Good practice examples that highlight successful engagement with BME LGBT staff and communities should also be showcased as part of the WRES work.

# 6 Implementation

It is proposed that the WRES will be mandated as part of the 2015/16 NHS Standard contract for NHS Providers and potentially, and will also feature in the CCG Assurance Framework for 2015/16.

NHS commissioners will be required to give due regard to metrics of the WRES and to give assurance that their Providers are implementing the WRES. Advice and

[35] *Gay in Britain, Lesbian, Gay and Bisexual People's Experiences and Expectations of Discrimination*, (2012), Stonewall.

support will be available to help benchmark progress from the national team leading on WRES design and implementation.

WRES best practice will be shared with organisations and staff working on equality standards as well as with HR Directors and the EDC. The knowledge gained from WRES can be used to develop workforce Standards for other protected groups. However, for each protected characteristic it will essential that leadership input from people with lived experience is used to help inform and direct the work.

# 7 Conclusion

The WRES can help to deliver upon the Public Sector Duty under the Equality Act 2010 by providing a proportionate response, grounded in solid evidence.

This Equality Analysis shows that there will be no significant negative impact across other protected characteristics as a result of implementing the Workforce Race Equality Standard. The implementation guidance and communications messages will make it clear that this work does not take precedence over other equality based initiatives. To further reduce any potential risks:

- It has been agreed for the NHS Equality Delivery System – EDS2 to be included in the NHS Standard Contract 2015/16;
- CCGs as commissioners are asked to report to NHS England the actions they have taken to advance equality and reduce inequalities;
- NHS organisations will be reminded that although the WRES can help deliver elements of their Public Sector Equality, they must continue to take responsibility in assuring that the Duty is met with regard to all protected characteristics.

# 8 Next Steps

- There is a need to ensure that the strategic approach to improve workforce representation and workplace experience across the spread of protected characteristics is equitable, timely and evidence-based.
- A clear plan needs to be set that presents timetabled and equitable action for each of the protected characteristics facing inequalities in workforce representation and in the reporting of workplace experiences.
- Through using the Equality Delivery System – EDS2, NHS organisations should be encouraged to provide evidence-based focus on issues in the workplace for all protected characteristics, including race, sex, sexual orientation, disability and religion or belief, as highlighted in this Equality Analysis.

- The Standard should be complemented by efforts to promote cultural competence at all levels, and by the actions of local NHS employers and wider support network, to help empower those who may experience discrimination.

- The Standard itself should be developed by:
  - (i) drawing upon this Equality Analysis and the consultation upon the Standard;
  - (ii) agreeing an action plan for the implementation of the Standard across the NHS and related activity across other protected characteristics;
  - (iii) Collecting and analysing further evidence and insight through research.

- This Equality Analysis on the proposed Standard will be shared with the following groups for the purpose of input, comments and feedback:

  - Membership of the Equality and Diversity Council, including the Workforce and Leadership, System Alignment, EDS2, Communications, and the Data Measurement subgroups of the Council

  - NHS Staff Council and the Social Partnership Forum

  - NHS Employers and their Equality Partners

  - NHS England Strategic Partners

  - Regional NHS Equality and Diversity Networks

This Equality Analysis will be kept updated and reviewed every time changes are made to the Workforce Race Equality Standard. It will be reviewed at least annually.

**Risk and impact mitigation plan February 2015 - March 2016**

| Mitigate potential risk | Task | WHO | When |
|---|---|---|---|
| Marketing and Communications | 1) Effective communications management across the system of WRES | Project Team | Feb. 2015 – ongoing review and feedback |
| | 2) Reiterate PSED duties across protected characteristics for all NHS Organizations<br>3) Staff engagement workshops | Equality & Health Inequalities Team<br><br>Project Team & Local providers | March 2015<br><br>June – March 2015 |
| | | | |
| Data Improvement | 1) Work on WRES metrics split by protected characteristics<br><br>2) Explore as with race metrics NHS Staff survey across protected characteristics and evaluate staff survey metrics by characteristics<br><br>3) NHS staff salary banding by protected characteristics | Individual Trusts, centrally supported by Equality & health Inequalities Team and Health and Social Care Information Centre. Human Resources. (Independent research?) | Sept. 2015 – Dec 2015 |
| Benchmarking progress | Advice to Trusts on baselines and benchmarking progress | Project Team | Sept 2015 |
| Research | Research into employment experiences of NHS Trans staff and employment opportunities in the NHS – developing the NHS as employer of choice | Equality Delivery Council Central HR NHS England, workforce leads. NHS Employers | |

| Training | 1) Organisational training on 'healthy' and diverse teams and the business benefit to patient care<br>2) Cultural bias / reflective practice training ( or as agreed) | Project Team / local providers | Dec. 2015 |
|---|---|---|---|
| Follow-up of General Duty | | | |
| Recommendations | | | |
| 5.1 Eliminate discrimination, harassment and victimization | Recommendation: To mitigate risk -BME staff will also experience discrimination, harassment and victimization as a result of other protected characteristics and this work requires further exploration in partnership with trade unions, staff networks, Lesbian & Gay Foundation, Race Equality Foundation, Equality and Human Rights Commission, Disability Two Ticks Programme, NHS Employers, NHS Strategic Partners. As stated above organizations will continue to take<br>legal responsibility for all protected characteristics | | |
| Advance Equality of Opportunity | Recommendation: To mitigate risk - organizations develop a baseline assessment of current resources and initiatives allocated for staff support across protected characteristics. This baseline will be separately identified to the resources required for the WRES implementation. The allocation of resources to both is reviewed annually. | | |
| Promote Good Relations Between Groups | Recommendation:1) To reduce any negative impact: Marketing the message and making sure that staff teams are engaged and can understand the rationale and see the value of work . Clarity about positive action i.e. not 'giving BME staff an unfair advantage' – which is illegal. That NHS England and the local organization demonstrate strong leadership. Share findings and plans of action to engage and involve a range of staff<br>2) To develop a comprehensive knowledge bank and record of what works and what doesn't so we can learn from good practice to apply to other groups and avoid future mistakes. | | |
| | | | |
| Feb.2015 | | | |