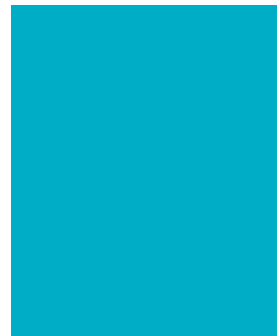
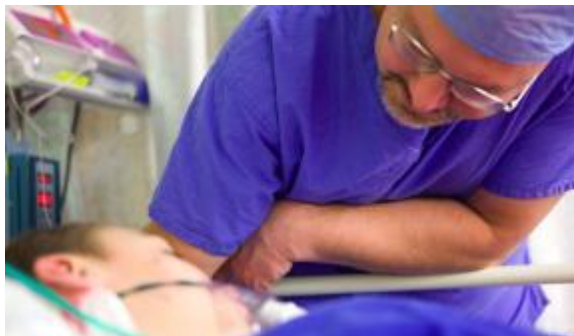
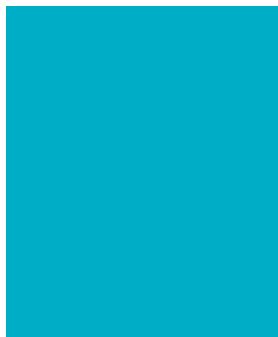


# Race Equality in the NHS

Why the NHS Workforce Race Equality Standard is being introduced



Yvonne Coghill OBE  
WRES Implementation



# The NHS Constitution

## **The NHS belongs to the people.**

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.



# The 1<sup>st</sup> Principle of the Constitution

**The NHS provides a comprehensive service, available to all** irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to diagnose, treat and improve both physical and mental health. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

# NHS Inequalities

- Nursing students from a BME background (particularly black Africans) 50% less likely to secure a first job first time than white nurses – **Professor Ruth Harris, Kingston University**
- People from a lack or ethnic minority background are less likely to be selected for development programmes ( **Bradford University Report – Dr Udy Archibong**)
- More likely to be performance managed (**Diversity Issues Among Managers - Juliette Alban-Metcalf**)
- You are less likely to be shortlisted and appointed if you are from a BME background (**Discrimination by Appointment, Roger Kline**)
- You are more likely to be in the lower bands of AfC (**HSCIC**)
- Over your career you will be paid less and afforded fewer opportunities
- BME doctors are more likely to be struck off. (**GMC E&D Group**)
- BME patients report receiving a poorer service (**NHS patient satisfaction 4surveys**)

## BME people are...

- More likely to get a long term disease (Diabetes, CHD, Stroke, mental illness)
- Be more stressed
- Be less satisfied with my life
- Earn less
- Likely to die earlier

***Explaining levels of wellbeing in BME populations in England***

***Professor Dr Mala Rao July 2014***

# The consequences for people

- Disillusionment
- Unhappiness
- Depression
- Lack of confidence
- Anger/Rage
- Lack of belief in the system
- Depression
- Sadness
- Lack of engagement and buy in
- Resentment
- **POOR PERFORMANCE**



# Professor Mike West – NHS Quality and Staff Engagement 2009

- Patient satisfaction is highest in NHS trusts that have clear goals at every level of the organisation. Where staff have clarity of purpose they provide good quality care.
- Leadership by senior managers and immediate managers helps to ensure clarity of purpose and it is not surprising that when staff see their leaders in a positive light that this is strongly related to patients' perceptions of the quality of care they receive.
- There is a spiral of positivity in the best performing NHS trusts. The extent to which staff are committed to their organisations and to which they recommend their trust as a place to receive treatment and to work is strongly related to patient outcomes and patient satisfaction. Climates of trust and respect characterise these top performing trusts.

This is best evidenced by the link between ethnic discrimination against staff and patient satisfaction. **The greater the proportion of staff from a black or minority ethnic (BME) background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction.** Where there is less discrimination, patients are more likely to say that when they had important questions to ask a nurse, they got answers they could understand and that they had confidence and trust in the nurses. Where there was discrimination against staff, patients felt that doctors and nurses talked in front of them as if they weren't there; that they were not as involved as they wanted to be in decisions about their care and treatment; and that they could not find someone on the hospital staff to talk to about their worries and fears. Most importantly, they did not feel they were treated with respect and dignity while in hospital. **The experience of BME staff is a very good barometer of the climate of respect and care for all within NHS trusts.**



## 7 reasons why workforce race equality benefits patients

- Prevents patients getting best staff
- Impact diverts resources from patient care
- Discrimination makes staff ill
- Diversity improves innovation + teamwork
- Poor treatment of BME whistleblowers affects patient safety
- Unrepresentative Boards less likely to provide patient focussed care
- How staff are cared for impacts on care provided:

## A report by Sir Robert Francis QC *Freedom to speak up - a report into whistleblowing in the NHS*

- Further confirmation that discrimination against BME staff directly impacts patient care and safety.
- BME staff are more likely to be ignored by management 19.3% in comparison with their white colleagues 14.7%.
- 40.7 % BME staff compared to 27% less satisfied with if they are white
- BME staff are more likely 21% to be victimised by management than white staff 12.5%
- The number of both BME and white staff who are praised by management after raising a concern is 3% 7.2 per cent for white staff.
- 24% of BME staff compared to 13% of white staff did not raise a concern for fear of victimisation

# Data, listening, learning, action?

- In other NHS patient care challenges
  - collect and analyse the data,
  - listen to patients and staff,
  - find good practice,
  - take action, monitor and learn
- Best employers accept there is a problem on workforce race inequality and are taking action
  - But some
    - don't understand the **business case** is now driven by patient care, or
    - are in **denial** or don't think it's a **priority**, or believe it is all **too difficult**

# What works?

- The evidence is that if the following is put into action then change will occur
- Leadership
- Measurable outcomes (WRES)
- Communications (a steady drum beat of..)
- Role models
- Resources
- Celebration of success

Source: Dr David Williams

## The Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard is a set of metrics that would, for the first time, require all NHS organisations with contracts over £200k, to demonstrate progress against a number of indicators of race equality, including a specific indicator to address the low levels of BME Board representation.

# NHS Workforce Race Equality Standard

- Mandatory for all NHS organisations
- Uses key indicators as measures of progress
- Expects progress on closing metrics between white and BME experience and treatment
- Best Trusts already making progress but from April 1<sup>st</sup> 2015 all NHS organisations will be required to
- Metrics seek to drive inquiry, behaviour attitudinal and sustained change

# Process and timescale

- September: Informal stakeholder consultation
- October: Formal consultation
- April 1<sup>st</sup> 2015: Agreed approach introduced and guidance, support. Sharing of good practice and resources and benchmarking developed
- 2015-16 CQC pilots its approach to using the Standard in inspections. Trusts inspected in 2015-2016 will also be asked how they are developing plans to address any issues arising from Standard data .
- July 1<sup>st</sup> 2015 Deadline for publishing baseline data
- April 2016: CQC formally begins role
- **EDS2** is being mandated in parallel – they complement each other

## Workforce Race Equality Standard indicators

### Workforce metrics

For each of these three workforce indicators, the Standard compares the metrics for white and BME staff.

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



## A challenge for all parts of sector

- Commissioners through the Standard Contract
- Regulators through inspection against the “well led domain”
- National bodies will apply Standard to themselves
- CCGs will have due regard
- HR and Boards will need to lead
- Trade unions should engage
- Essential BME voices are heard loud and clear

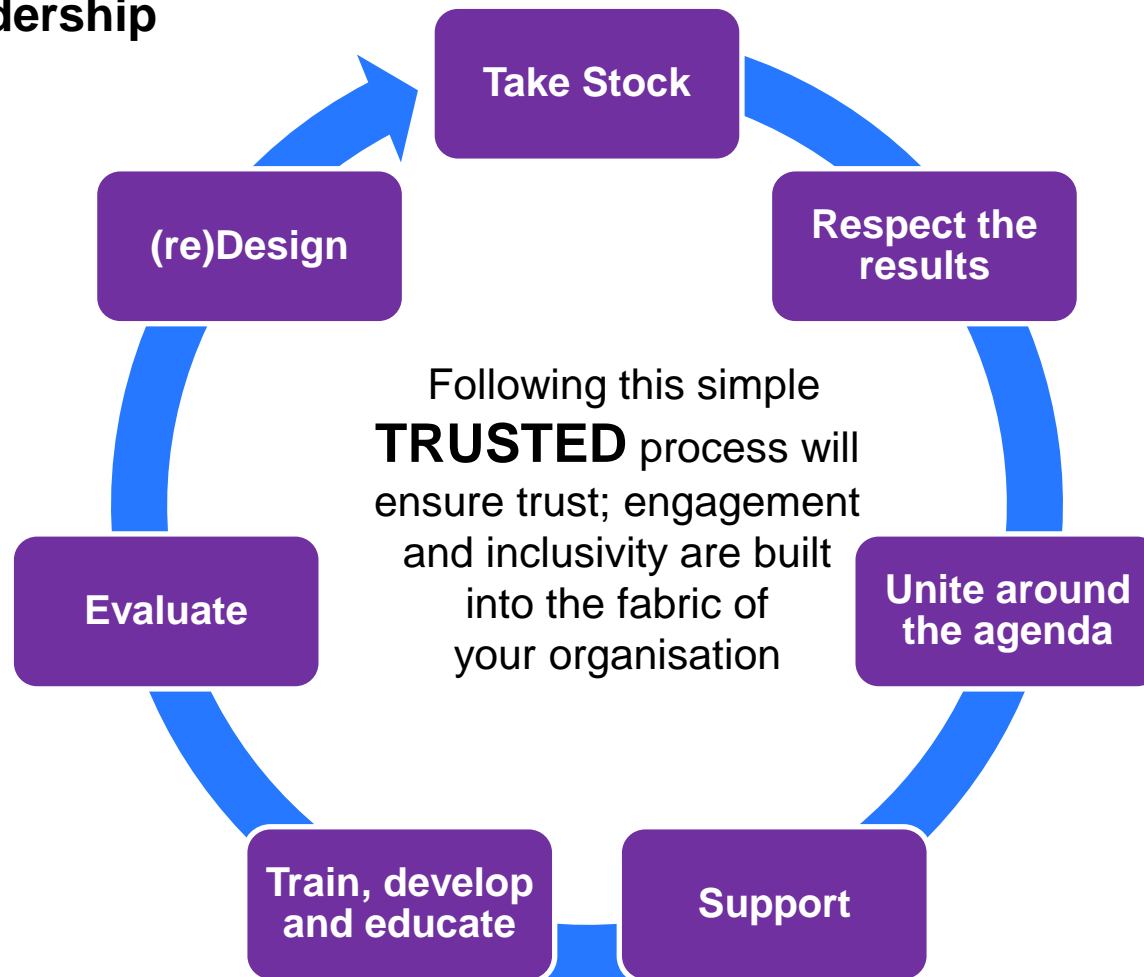
## Please remember

- The metrics are mandatory because a voluntary approach without measurable outcomes failed
- Improving the metrics requires an understanding of the underlying challenge since they are difficult to game
- Improving race equality is part of, and can help trigger, a wider change in culture
- Improving the care of staff improves the care of patients
- The Workforce Race Equality Standard should dovetail with the wider Trust Equality strategy inc EDS

## Steps to take

- Understand the workforce and survey data
- Be open about shortcomings and publicise good news (but without spin)
- Listen to staff especially BME staff – and in a safe space
- Identify specific challenges
- Learn from within each organisation and from best practice elsewhere
- Any plan of action must have ownership

# TRUST – An essential guide for effective and inclusive leadership



# The CQC role

## **Before April 2016**

- CQC will include inspection of progress against the Standard in its inspection schedule.
- CQC will be piloting its approach to using the Standard in inspections. Trusts inspected in 2015-2016 will also be asked how they are developing plans to address any issues arising from The Standard data.
- In line with CQC current practice, including published key lines of inquiry and ratings characteristics for the well-led domain, race equality for staff may be considered during inspections in 2015-16 where there are particular reasons to do so.

## **From April 2016**

- progress on the Standard will always be considered as part of the “Well led “domain in CQC inspections.

# The Standard Contract and CCGs

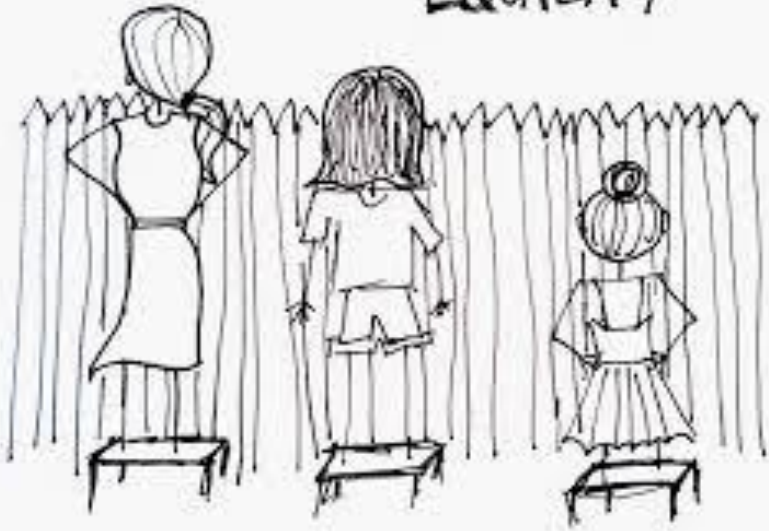
**From 2015-16** each CCG will need to demonstrate:

- Assurance, through the provision of evidence, that their Providers are implementing the NHS Workforce Race Equality Standard;
- An annual report will be required to be submitted to the Co-ordinating Commissioner outlining progress on the WRES.
- That they themselves are giving due regard to using the indicators contained in the *Workforce Race Equality Standard* to help improve workplace experiences, and representation at all levels within their workforce, for Black and Minority Ethnic staff; and
- That they are implementing *EDS2* to help meet the *Public Sector Equality Duty* the provision of evidence, that their Providers are doing the same.
- Further developmental work on the applicability of the Standard to CCGs is currently underway.

## The key elements

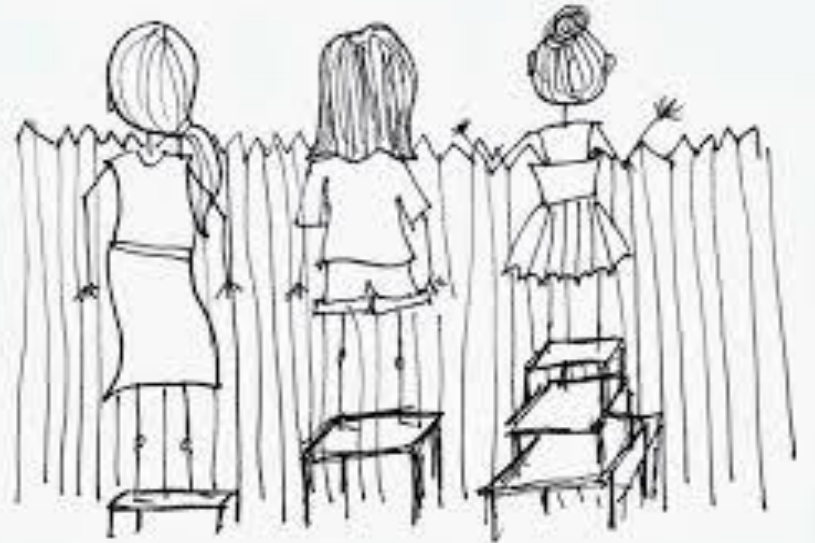
- Understanding WHY
- Understand the data (drill down and check trends) and intelligence from BME staff especially
- Identifying the underlying issues and challenges
- Start to identify specific responses to metrics and wider cultural issues
- Find the good practice and adapt it
- Be open, transparent and engage with staff

EQUALITY



Fairness = Doing the same thing for everyone regardless of who they are

EQUITY!



Justice= making allowances and adjustments for certain people



## Group discussion

- What are the challenges you think you will encounter in implementing the WRES
- What help, support or guidance do you need/want from NHS England

# Thank you

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- <http://www.england.nhs.uk/ourwork/gov/equality-hub/equality-standard>