Implementing race equality in the NHS: what next?

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I would like to:

• Summarise the evidence of race discrimination in the NHS
• Summarise why race equality is not only morally right but essential for patient care and safety
• Recap what the WRES is and why it took the form it did
• Place race discrimination in the context of wider NHS culture change
• Look at what root cause analysis suggests is the key to good practice
• Ask you to ask questions of your employers
No comment

• “BME representation on the Trust Board has been discussed and considered as an issue, with wider diversity having been sort.

• However, it has been decided that all situations should be appointed to on merit.”

• Trust report on the WRES July 2015
Birmingham is similar to London

- London
  - 1 in 40 chairs
  - No CEO
  - 8% Boards are BME
  - 40% of workforce BME
  - 40% patients are BME

- Birmingham/Wolverhampton
  - 1 in 13 chairs
  - No CEO
  - 14% of Boards are BME
  - 40% of workforce BME

Population

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<tr>
<th></th>
<th>45% BME</th>
<th>35% BME</th>
<th>22% BME</th>
<th>30% BME</th>
<th>11% BME</th>
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<td>Birmingham</td>
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- Decrease nationally in BME Board members and nurse managers in recent years
- No BME exec directors in Monitor, CQC, NHSTDA, NHS England, NHSLA, HEE
The treatment of staff.

• White staff 1.74 times more likely to be appointed once shortlisted than are shortlisted BME staff (Kline 2013)
• BME staff twice as likely to enter disciplinary process and more likely to be disciplined for similar offences (Archibong et al 2010)
• Black nurses take 50% longer to be promoted (RCN) and are less likely to access national training courses (NHSLA)
• Appendix D.11 of Robert Francis’ recent whistleblowing report shows that, in a survey of 20,000 NHS staff, BME staff who raise concerns are much less favourably treated even that white staff who raise concerns by every indicator
### National staff survey confirms what the 2014 workforce data shows (%)

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<tr>
<th>Key Finding</th>
<th>Description</th>
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<th>BME</th>
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<td>18</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>19</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>27</td>
<td>Percentage believing that trust provides equal opportunities for career progression or promotion</td>
<td>89</td>
<td>76</td>
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<tr>
<td>28</td>
<td>Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>8</td>
<td>24</td>
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Why workforce race inequality impacts adversely on patient care

1. Prevents patients getting best staff
2. Impact diverts resources from patient care
3. Discrimination makes staff ill
4. Diversity improves innovation + teamwork
5. Bullying and poor treatment of BME whistleblowers affects patient safety
6. Unrepresentative Boards less likely to provide patient focussed care
7. Treatment of BME staff good barometer of overall climate of respect
If those who care are not cared for, then all patients may suffer

- Bullying, discrimination, and overwork lead to disengagement and “are likely to deprive staff of the emotional resources to deliver compassionate care.”

  West, M. Improving NHS Care by Engaging Staff and Devolving Decision-Making

“The staff survey item that was most consistently strongly linked to patient survey scores was discrimination, in particular discrimination on the basis of ethnic background.” Dawson, J. Does the experience of staff working in the NHS link to the patient experience of care? 2009

The percentage of staff reporting their Trust provides equal opportunities for career progression was related to CQC ratings of quality of care provided and use of resources as well as with levels of staff absenteeism.

Respect, equality and care

- The percentage of staff reporting their Trust provides equal opportunities for career progression was related to CQC ratings of quality of care provided and use of resources as well as with levels of staff absenteeism. West, M and Dawson, J. NHS Staff Management and Health Service Quality. 2011.

- A strong negative correlation between whether staff report harassment, bullying or abuse from other staff in the NHS staff survey and overall patient experience in 2011. Improving NHS Care by Engaging Staff and Devolving Decision-Making. Kings Fund 2014

- “Managing staff with respect and compassion (is important) since doing so correlates with improved patient satisfaction, infection and mortality rates, CQC ratings and trust financial performance.”

Data and discourse

- In other NHS challenges we
  - collect and analyse the data,
  - listen to patients and staff,
  - find good practice,
  - take action, monitor and learn

- The research evidence now compels NHS Boards to adopt this approach to workforce race discrimination

- Tackling race equality is not an optional extra but an excellent way to address deeper culture challenges impacting on patient care and safety
We find these difficult conversations

- Black and minority ethnic staff are reluctant to share concerns about their treatment
- NHS employers have often been reluctant to explore the issues or their own bias
- The parallel discourses can be difficult to bridge
- The challenge is just as great if smaller BME staff numbers
- The BME staff voice is rarely heard and hardly ever listened to
A wider wilful blindness?

• “There lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism.”

• Robert Francis. Launch of 2013 report

• “an institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern”

• Robert Francis. Launch of 2013 report
The new Standard – not a tick box but driving inquiry

- Evidence shows this approach is the one that works
- WRES is mandated through the NHS Standard Contract with a requirement to provide evidence that progress is being made year on year
- WRES is included in the CQC’s “well led domain”
- WRES reports will be published and benchmarked

- It is intended as a means of driving inquiry and change into the root causes of discrimination
“You can have an all-singing all-dancing policy, but it is worthless without a culture that believes in and supports it. Any policy must be effectively implemented and form part of a drive to shift culture in a positive direction. The policy needs to be “owned” at every level of the organisation and people should lead by example. This requires buy-in from the chief executive down.”

E.g. Root causes and discrimination

**Recruitment**: Informal advantage: access to professional development, secondment, mentoring, coaching, encouragement, secondments, leading projects

**Discipline**: Informal processes: discipline may substitute for lack of support and performance management as

**Bullying**: High levels are an indicator of a blame culture

**Accountability** and **transparency** are key

**Unconscious bias** training can be helpful but will **not** end discrimination on its own because....
Good practice is possible

- **Boards** – appointment and culture
- **Recruitment** – transparency and accountability
- **Discipline** – ending bias and blame
- **Support** – metrics and a level playing field
- **Bullying** – leadership and transparency
- **Staff survey results** – facing the facts

A culture of learning and listening without fear
The WRES provides an opportunity to:

• Finally get the facts of discrimination out in the open
• Insist that root cause analysis takes place to improve the metrics
• Level the playing field on the informal processes that underpin much discrimination
• Stop relying on “policy” and “process” and focus on culture and outcomes
• Ensure the BME staff voice is heard
• Hold local leaders to account and get local leaders to hold managers to account
Next steps for the WRES team

• Complete recruitment to our team
• Run 11 regional workshops on next steps
• Complete an analysis of the July 2015 reports
• Publish the Kings Fund report on benchmarking
• Support the CQC inspection approach
• Run 6 workshops on good practice with accompanied by evidence based guidance
• Complete our preparations for April 2016
• Support nursing/midwifery pilot sites on shared good practice
How to raise all this - and safely?

- Para 8.3 NHS WRES Technical Guidance

It is essential that the voice of BME staff is heard loud and clear through the process of identifying the challenges individual organisations face in meeting the Standard. Organisations are strongly encouraged to help establish and support BME networks (alongside networks for the other protected characteristics) of staff as an important source of knowledge, support and experience. Such work may well include providing a safe place for BME staff to share their concerns and be listened to and where this occurred, it has significantly contributed to the success of Trust wide work around race equality”

- CQC inspections
6 Questions: In your Trust:

• Do you know what your WRES metrics (including staff survey metrics) are?
• Is your Board representative of the local population?
• Are the demographics of senior management representative of the workforce?
• Is it more likely that White staff will be appointed from shortlisting than BME staff are?
• Are BME staff more likely to be disciplined?
• Has your Trust discussed its WRES report (and action plan) with staff inc. your BME network?
6 Questions: Next steps

• Is there a Board member responsible for race equality including WRES in your organisation? If not why not? If so, do they meet with BME staff?

• For each WRES indicator showing a significant gap between the experience, treatment and opportunities for BME and White staff, what course of action has been chosen?

• What steps is your employer taking to ensure
  • (a) that the of ethnicity self-reporting levels are at least 95% and
  • (b) that the proportion of BME staff responding to the next staff survey is as high as the levels of White staff responses?

• If a CQC inspection is due in the next 12 months how will BME staff concerns be heard by Inspection Teams?
In conclusion

Race equality is a right for staff and a necessity for patient care

Some organisations have shown the change we seek is possible

The WRES enables and requires all organisations to adopt best practice

Accountability and transparency are key to improvement on equality

BME staff must be part of the solution not spectators whilst Trusts ponder what to do – both locally and nationally
Links

• england.wres@nhs.net
• NHS Providers: Leading by Example
• @rogerkline