

Here are the initial responses to questions some of you are already asking and potentially might be asked by participants on our programmes and beyond.

What steps is the NHS taking to tackle race inequality in the NHS workforce?

On 31 July 2014 the [NHS Equality and Diversity Council pledged its commitment](#), subject to consultation with the NHS, to implement two measures to improve equality across the NHS, which would start in April 2015.

The first is a Workforce Race Equality Standard that would, for the first time, require organisations employing almost all of the 1.4 million NHS workforce to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.

Alongside the standard, the NHS will be consulted on whether the Equality Delivery System (EDS2) should also become mandatory. This is a toolkit, currently voluntarily used across the NHS, which aims to help organisations improve the services they provide for their local communities and provide better working environments for all groups.

[NHS England has agreed to consult on incorporating the new standard and EDS2 for the first time in the 2015/16 standard NHS contract.](#)

The regulators – the Care Quality Commission and Monitor – will also consider using the standard to help assess whether organisations are ‘well-led’. The proposal would be applicable to providers, and extended to clinical commissioning groups through the annual CCG assurance process

The move follows [recent reports which have highlighted the relative absence of BME people in senior leadership positions across the NHS](#), as well as [lower levels of wellbeing amongst the BME population](#).

What response has the proposal had?

NHS and patient leaders broadly welcomed the decision to have a Race Equality Standard. Simon Stevens, NHS England’s Chief Executive and Chair of the NHS EDC, said: “We want an NHS ‘of the people, by the people, for the people’. That’s because care is far more likely to meet the needs of all the patients we’re here to serve when NHS leadership is drawn from diverse communities across the country, and when all our frontline staff are themselves free from discrimination.”

Chris Hopson, chief executive of the Foundation Trust Network, said: “It is vital that Boards reflect the diversity of local populations and the NHS workforce. We are keen to ensure that

early progress is made on improving levels of BME representation at Board level and in senior leadership positions across the NHS.”

Katherine Murphy, Patients Association, said: “Diversity in leadership is associated with more patient-centred care, improved patient access, experience and outcomes and higher staff morale, which ultimately is the aim for everyone using and working across the NHS.”

What exactly is the NHS Workforce Race Equality Standard?

The proposal put to the EDC on July 29th was that there should be a National Workforce Race Equality Standard, built from a small number of indicators for which most Trusts already collect data (a mix of NHS national survey data and local workforce data). In addition there would be one Board membership metric linked to the diversity of the Board. There may also be a metric linked to the Patients Survey. This Standard would then be used to gauge the current state of race equality within NHS organisations and track what progress is being made to identify and promote talented BME staff as well as helping to eliminate discrimination in the treatment of BME staff.

The crucial element of the proposal is that it takes a small number of indicators and requires NHS organisations to close the gap between the BME and white staff experience for those indicators. So for example, [currently the likelihood of BME staff being appointed from shortlisting is much less than the likelihood of white staff being appointed from shortlisting.](#)

Similarly there are significant differences in many Trusts between the likelihood of BME and white staff accessing non mandatory training – the kind that improves career development and promotion opportunities. Organisations will be expected to do what the best ones already do, to scrutinise data and act on it, and then work towards a level playing field with fair measurable outcomes. NHS Employers found it is twice as likely that BME staff will enter the disciplinary process as white staff yet whilst some Trusts seek to understand this and reflect on how to change this, others do not. One consequence of potentially discriminatory recruitment and promotion processes may be the imbalance in the representation of BME staff within grading processes, irrespective of the balance of the workforce within individual occupations. All NHS organisations would be expected to collect this data as many already do. However they would then be required to do what many NHS organisations do not currently do, that is to analyse the data and work out how to reduce the differences in treatment for which there is no objective justification.

Some organisations have already made strides in doing this and it shows in their data. Others are starting on this journey. What the National Workforce Race Equality Standard will do is to require all organisations to not just collect such data, but to analyse and act on it, seeking to narrow the metrics gap between the treatment of BME and white staff.

The other part of the Standard concerns data that is already [published in the NHS national staff survey](#) and will probably consider the differences between the white and BME staff responses on three indicators. The likely indicators (but this may change after the consultation) are shown below:

	White responses*	BME responses*	Comment
Key Finding 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	21	26	More likely that BME staff have experienced harassment, bullying or abuse from other staff in last 12 months
Key finding 27. Percentage believing that trust provides equal opportunities for career progression or promotion	90	77	More than twice as likely BM staff do not believe trust provides equal opportunities for career progression or promotion
Key Finding 28. Percentage of staff experiencing discrimination at work in the last 12 months	9	25	Almost three times more likely BME staff experiencing discrimination at work in the last 12 months

*2013 national staff survey returns shown – national average

Many trusts do significantly better and in some trusts the data for BME and white staff is similar or the same. So if those Trusts can close these metrics, it shows what is possible. The Standard will expect the gap between BME and white treatment and survey results to narrow.

Why is it felt to be necessary?

The latest data shows that there has been little positive or no change in the treatment of BME staff or their representation at senior grades in the NHS in recent years. [Most NHS Boards are overwhelmingly white even in areas where large numbers of patients and staff are from BME backgrounds.](#) Until now the NHS has relied on a voluntary approach which expects NHS organisations to treat BME staff fairly and ensure BME staff are properly represented on Boards. Ten years ago the 2004 Race Equality Action Plan tried to radically improve diversity. [There was some initial progress but a decade later there appears to be very little if any evidence of progress.](#)

Although some NHS organisations have made a real effort during that period, overall progress has been at best minimal. In the light of [strong evidence that diversity benefits innovation and service delivery and that the treatment of BME staff correlates with overall patient experience](#) it is now undoubtedly in the interests of all patients that BME staff are treated fairly and that the leadership of organisations becomes more representative and diverse.

Were alternatives considered?

They were. In particular, there was a discussion as to whether making the Equality Delivery System (EDS) mandatory could achieve the same end. [The EDS2 is in use across many NHS Trusts](#) but it was felt that whilst it assists the systematic collection of data on workforce race equality, and potentially its analysis, as a self assessment tool there is no requirement to evidence measureable outcomes and certainly not ones that can be benchmarked across the NHS. It was felt that there is no conflict between the Workforce Standard and EDS2 not least because the Standard would be using data that organisations should be collecting for the EDS anyway. The difference was felt to be that the Standard is focussed on measurable outcomes underpinned by commissioning and regulation. In the light of the experience of the previous decade such an approach was felt to be much more likely to bring about change.

The meeting of 29th July was informed that EDS2 covers 93% of NHS organisations and agreed a consultation on making it mandatory.

What are the implications for NHS organisations?

Firstly NHS organisations will have to do what they are already required to do because of their [Public Sector Equality Duty](#). NHS organisations have historically had a poor record in collecting and [analysing and publishing data on equality, including on race equality](#).

Secondly there will need to be a discussion with their commissioners to ensure that each organisation is collecting, analysing and publishing the data and to establish the base line data on each indicator. For NHS Trusts this will include the relevant NHS staff survey data – the staff survey data will be the last published data. For other organisations, it will include equivalent survey data alongside workforce data. Each organisation will need to decide how it is going to narrow the gap in the metrics between its own white and BME staff in the next year so that it can demonstrate to its local commissioner it is making progress. What that rate of progress is expected to be will be agreed locally.

At the end of the first year (2016) the progress on the metrics will be shared with commissioners (and staff) and published. The data will be shared across the NHS so that organisations can benchmark themselves and such benchmarking will help identify good practice organisations that others can learn from.

No central body will tell local organisations what their local targets should be or how to achieve them, but they will be expected to demonstrate measurable progress year on year.

To do that will require all Trusts to do what the best Trusts do – analyse reliable data and listen to their staff including especially BME staff, to understand how differences in treatment arise so that remedial action can be taken. The forthcoming NHS Leadership Academy and RCN document TRUSTED will help in this.

Will it involve extra work?

The collection and analysis of data on workforce race equality should involve no more work than is currently undertaken.

What may require more work is understanding the data and listening to staff so that effective strategies to improve outcomes against these indicators can be reached.

It is intended that considerable effort will be made to ensure good practice is shared nationally.

If both EDS2 and the Standard are made mandatory they will complement each other since EDS would then complement and underpin the Standards data and outcomes.

What issues might NHS organisations and individuals want to consider during the consultation?

NHS organisations – and individuals – might want to consider;

Do these feel like the best indicators – do they need to be amended?

Are additional indicators needed – for example one reflecting patient experience?

How ready is your own organisation (on data collection and analysis in particular) for the Standard?

What are the steps that should be taken now, ahead of April 2014 in preparation for the Standard being introduced in some form

Do you have a view on whether the Standard and EDS2 should be made mandatory?

What about boards of NHS organisation?

There is a wealth of evidence that diverse boards are better Boards (The Healthy Board 2013).

Increased Board diversity is important. It can assist improvements in patient experience and care.

In part this can be achieved by reviewing current appointment processes and criteria and that process is already underway nationally led by the Trust Development Agency but it will be important that all organisations, not just those the TDA influences, adopt similar principles. This should be one measure where relatively rapid progress can be made.

What is the timescale for its introduction?

A draft clause for the NHS National Contract 2015-16 will be out for consultation this Autumn.

An equality impact assessment is being undertaken.

Depending on the consultation outcome, there may be refinements to the Standard itself.

Discussions will take place with regulators to consider how best to refer to the Standard within their “well led domain”.

By December 2015 it should be clear what the expectations of commissioners and providers will be from April 2016.

National organisations will be preparing support for local organisations to help ensure the Standard can be met.

What should organisations be doing now in preparation?

A good start would be ensuring they know precisely what their own workforce and staff survey data shows, and whether it has been published and been shared with relevant stakeholders such as BME staff and trade unions.

It would be worth considering what steps have been considered in the past to improve these indicators. It is expected that good practice will be shared across organisations,

Every Trust Board should be directly asking BME staff what they think and perhaps identifying a Board member to ensure the organisation will be ready for the new contract clause.

It would be good to compare your data and analysis with that of other organisations in your health economy – especially similar ones.

What about national bodies and commissioners themselves?

The proposal would be extended to clinical commissioning groups through CCG assurance processes and the timescale for that is not yet confirmed

It will also apply to national bodies though how it is applied may differ and will also need discussion.

What about private contractors?

All organisations providing services funded by the NHS are covered by the NHS national contract. There is provision within the NHS contract for very small contracts to be exempted.

What about other equality strands?

The Equality and Delivery Council meeting on July 29th 2014 made it clear that there are other challenges on equality to be met across the range of protected characteristics.

The EDC is committed to promote equality for all, ensuring no one is left behind, and will ensure that patient, service user and carer perspectives are central to its work. It also plans to continue with existing work strands and initiate work to advance equality for other groups protected by the Equality Act.

One issue highlighted at the discussion, amongst others, was the treatment of staff with disabilities since available data suggests serious discrimination, similar in many ways to that against BME staff takes place. Although this initiative focuses on the treatment of BME staff, research shows that how all staff are treated impacts on patient care so further initiatives are planned across other protected characteristics.

That does not prevent individual organisations continuing to develop work around other equality strands and it is anticipated that by making sure one strand is addressed in such a direct way it will encourage all organisations to focus more carefully on equality across the board.

What about regulators?

The Care Quality Commission, Trust development Authority and Monitor will also consider using the standard to help assess whether organisations are 'well-led'. Those discussions are as part of the current discussions on updating the "well led" domain of their scrutiny process and will be completed well ahead of the 2016-17 cycle. This gives provider organisations a full year to start the process of improvement.

Isn't this too much like micromanagement of local employers?

There will be no national "directive" as to how providers meet the Standard. Nor will there be any setting nationally of local targets. The requirement will be that demonstrable progress is being made with "stretch" goals to be agreed locally on the understanding that progress to be shared nationally.

If an entirely voluntary system was enough to have made the progress needed we would have seen more progress ten years after the 2004 Race Equality Action Plan launched with Ministerial backing. It is clear that more of the same will be enough.

This proposal is intended to focus employers' attention on this issue in the hope that "the rest will be as good as the best". Lots of effort will hopefully go into encouraging and spreading good practice. But based on the last decade there may well be employers who won't prioritise this until it becomes part of the commissioning process with measurable outcomes and the back stop of the regulators.

An interesting blog on the evidence that more than voluntary measures alone are needed can be found on this recent blog by the author of *The Snowy White Peaks of the NHS*.

The evidence linking fair treatment of the 17% of NHS staff who are BME staff to improved care for patients is clear, as is the case for a more diverse leadership benefitting patients. So making this initiative work is in everyone's interest.

Will the Workforce Race Equality Standard cost extra time or money?

There are three steps involved in meeting the standard.

The first step is to ensure the appropriate data is being collected. All organisations, in accordance with the Public Sector Equality Duty (PSED) should be doing this across all protected characteristics. Those Trusts using the Equality Delivery System may well be collecting the data as part of EDS2 but there is no requirement to do so at present so not all do.

The second step is to analyse and publish the data. Again the PSED requires organisations to do this and the data that the Standard considers is certainly data that any organisation wishing to make progress on equality should be collecting this across **all** protected characteristics. Organisations that use EDS2 may well be doing this already but there is no

requirement to do so at present so not all do. However the evidence of research is that many Trusts are not yet necessarily doing this.

For these two steps there will either be no extra cost or it is a cost they should already be incurring if they are to address inequality.

The third step is to act on the analysis and take steps to close the gap between the treatment of white and BME staff. This requires a determined effort to target those areas where there is a substantial gap for example on recruitment/promotion, access to non mandatory training, bullying and discipline. That must involve BME staff and staff organisations. This will cost staff time and possibly some external assistance but there are benefits too. NHS Employers have highlighted the considerable cost of not being an equality employer. The benefits will include less grievances, more likelihood of attracting and appointing the best staff, less bullying, less disciplinary cases, less turnover and sickness absence, and more importantly of all, better BME staff morale with benefits for all patients. There may be upfront costs but benefits in the short to medium term

What consequences will there be for Trusts that fail to move to meet the Standard?

Unlike previous NHS initiatives on equality, this requires published measurable outcomes that are very difficult to “game”. Is it hoped that many (most) organisations will adopt the strategy of closing the gap between white and BME staff experiences because they want to, in the interests of patients and their staff. For those who don't there are three consequences:

Providers will need to confirm to commissioners that they are ready for the Standard and what progress they have made. Failure to do so will be a breach of the contract and should trigger robust discussions about how and why, and what steps will be taken to improve performance the following year. Ultimately a breach of a contract will be dealt with as any other breach of contract.

Secondly, the progress made by Trusts will be published and, as with much other data, will be available nationally in a form that enables organisations to benchmark themselves. It is likely that as well as encouraging Trusts to do better, to find buddying arrangement and good practice, a public poor performance will trigger Board level discussions if the Trust is at the wrong end of the benchmarking table.

Thirdly, if regulators adopt progress towards the Standard as an element of their scrutiny then failure to progress on the Standard will be a contributor to the Trust being identified as not “well led” with the normal range of consequences for the Board.

Clinical commissioning groups will undergo a similar process through their CCG assurance processes. National organisations will be expected to also collect, monitor, analyse, publish and act upon the indicators within the Standard and will be subject to a considerable degree of scrutiny once that happens.

In every organisation it is hoped that an identified lead Board member will be the custodian of the work.