Why has the NHS Workforce Race Equality Standard (WRES) been introduced?

There are significant inequalities linked to ethnicity within the NHS workforce

Recent analysis of NHS workforce and staff survey data across the country shows that, for example:

- White job applicants are more than three times more likely to be appointed than Black and Minority Ethnic (BME) applicants (3.48 times more likely) and White shortlisted applicants are nearly twice as likely (1.78 times more likely) to be appointed as white applicants[i]

- The proportions of NHS board members and senior managers who are BME are significantly smaller than the proportion of the NHS workforce that is BME[ii]

- BME NHS staff members are more likely to be disciplined than White staff members[iii]

- NHS staff survey data shows that BME staff are more likely than White staff to experience harassment, bullying or abuse from other staff (but not from patients), more likely to experience discrimination at work and less likely to believe that the trust provides equal opportunities for career progression.

These inequalities have a significant impact on the efficient and effective running of the NHS

1. Ethnicity currently adversely affects the likelihood of the best people being appointed which means that patient care is not as good as it could be.

2. If staff members are not treated well, this leads to higher staff turnover and absenteeism, lower morale and discretionary effort and that has

measurable costs to the organisation. There is a cost attached to employing new staff, Employment Tribunals and disciplinary hearings. University College Hospital Trust calculated that being a good employer in terms of equality would save the trust £3.8 million each year.[iv] So, these inequalities lead to a diversion of NHS resources away from patient care.

3. Discrimination makes people ill[v] which can mean NHS staff members have to take sick leave or can't work to their full capacity and use health services as patients; so a double cost to the health service.

4. In February 2015 Robert Francis published his "Freedom to Speak Up" report, a review of whistleblowing within the NHS. He found that BME whistleblowers are treated even worse than White whistleblowers. 40.7% of BME staff members who have raised a concern about suspected wrongdoing are dissatisfied with the response to their concern compared to 27% of White staff who raise a concern. BME staff also reported that they were less likely to raise a concern again (59% of BME staff compared to 73.4% of White staff). This has an adverse effect on patient safety.

5. There is much evidence that organisations with a diverse leadership are more successful than those without. Recently McKinsey examined data for a range of companies in Canada, UK, Latin America and USA and found that companies in the top quartile for racial and ethnic diversity are 35 percent more likely to have financial returns above their respective national industry medians.[vi] More diverse companies are more likely to attract top talent, have satisfied employees, meet their customer needs and make better decisions.

6. Healthcare commissioning rarely aims to reduce health inequalities linked to ethnicity. There are a broad range of reasons for this, including ambivalence about race equality at the national and strategic levels, uncertainty and a lack of confidence about ethnicity and inequalities on the part of commissioners combined with the fact that those advocating for action to reduce ethnic inequalities often lack skills in accessing and applying evidence.[vii] A more ethnically diverse commissioning workforce could help to improve this.

7. Michael West's comparison of staff survey results and patient survey results "suggest that the experience of BME NHS staff is a good

barometer of the climate of respect and care for all within the NHS. Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received. Conversely, 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."[viii] So patients have better experience in NHS organisations where workforce race equality is good.

The above evidence has been pulled together by Roger Kline, a researcher who has worked with Yvonne Coghill to design and introduce the WRES. It shows that there are many ways in which improving workforce race equality in the NHS will improve healthcare for everyone and make better use of NHS resources.

How will WRES help to improve workforce race equality in the NHS?

The nine WRES indicators measure the key inequalities found in national research. Indeed, they reflect the key inequalities found across the health economy where I worked when we looked at workforce equalities data in 2012 as part of our Equality Delivery System work.

Gathering the data is an important step as "you can't change what you don't know."[ix] However it is only the first step. Some NHS organisations (by no means all) have been gathering these statistics and publishing them for some years in the belief that this makes them compliant with equalities legislation. A fairly quick look at the published statistics showed exactly the inequalities described above but almost all NHS organisations did not identify the inequalities and did not plan or take any action to reduce them.

NHS England has introduced WRES as a new approach that will involve national benchmarking of organisations. There is an expectation that year on year all NHS organisations will improve workforce race equality and that these improvements will be measured and demonstrated through the annual publication of data for each of the WRES indicators. The requirement to do this forms part of CCG assurance frameworks, the NHS standard contract and the CQC inspection regime.

The national focus on these nine aspects of workforce race equality provides a great opportunity for NHS organisations to work together on specific interventions and to share good practice.

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[i] *Discrimination by appointment*. Roger Kline. Public World June 2013
[ii] *The snowy white peaks of the NHS*. Roger Kline Middlesex University's Research Repository 2014
[iii] *The involvement of BME staff in disciplinary hearings*. Udy Archibong et al, University of Bradford
[iv] NHS Employers *Business case for diversity*
[v] *Ethnicity, work characteristics, stress and health.* Health & Safety Executive, 2005
[vi] *Diversity Matters.* McKInsey February 2015
[vii] *Towards equitable commissioning for our multi ethnic society: a mixed methods qualitative investigation of evidence utilisation by strategic commissioners and public health managers*. Salway, S et al 2013
[viii] *NHS Staff Management and Health Quality Results from the NHS staff survey and related data.* West, M et al 2012
[ix] *The snowy white peaks of the NHS*. Roger Kline Middlesex University's Research Repository 2014