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# The “snowy white peaks” of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England.

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March 2014

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## Executive summary

There is increasingly robust evidence that a diverse workforce in which all staff members' contributions are valued is linked to good patient care. (West 2012, Dawson 2009). It is national policy that NHS Trust Boards should be as representative as possible of the communities they serve and that this is likely to benefit the planning and provision of services (NHS Leadership Academy 2013). There is evidence (Salway et al 2013) that when Trusts commission services they often fail to cater to the most deprived communities including black and minority ethnic (BME) populations. One of the strategies that Trusts can use to mitigate this is to ensure that decision makers are drawn from a diverse pool.

The NHS recruitment processes has been shown to disproportionately favour white applicants (Kline 2013). Previous research (Esmail 2007, NHS Institute for Innovation and Improvement 2009) has highlighted concerns about the absence of black and minority ethnic staff from senior NHS roles including Trust Boards.

Ten years after the launch of The Race Equality Action Plan (DH 2004), we carried out a survey of the leadership of NHS Trusts in London to assess progress against this plan. London was chosen for this survey as a health "region" in which the relationship between the ethnicity of the workforce and local population on the one hand, and the leadership of its health service providers on the other, might be worth particular attention. London is a city where 41% of NHS staff, and 45% of the population are from black and minority ethnic backgrounds.

The report considers the extent of the gap between the diversity apparent in the workforce and the local population, and that visible among Trust leaderships and senior management. That gap is then considered in the light of growing evidence about the impact of staff and Board diversity on the effectiveness of healthcare provision and the patient experience. Whilst we were especially concerned with tracking ethnicity, we also considered the under-representation of women.

Our findings show:

- That the proportion of London NHS Trust Board members from a BME background is 8%, an even lower number than was found in 2006 (9.6%);
- That the proportion of chief executives and chairs from a BME background has decreased from 5.3%; it currently stands at 2.5%.

- Two fifths of London's 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.
- The proportion of senior and very senior managers who are BME has not increased since 2008, when comparable grading data was 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 proportion of women on Boards is 40%; while this is a slight improvement on the past, the proportion is still well below that of the NHS workforce or the local population. Women are especially under-represented at chair and chief executive level.

We then examined the extent to which the issues we explored within London were reflected nationally. We found that they were, in every respect.

The ethnicity and gender diversity of national English NHS bodies at senior level is similarly poor, with BME executives being entirely absent and women being disproportionately absent, from the Boards of NHS England, Monitor, the NHS Trust Development Authority, Health Education England, and the Professional Standards Authority. The historical trends nationally mirror those within London and display similar patterns of under-representation both within the workforce as a whole and within the governance of the NHS.

The data demonstrates that there remains a very significant gap between the composition of Trust Boards and national NHS bodies, and the rest of the workforce and the local population to whom services are provided. Research evidence suggests this may well adversely impact on the provision of services across the capital and denies the NHS the potential contribution a diverse leadership could make.

There is, following the Francis report on the scandal of Mid Staffordshire, a widespread acceptance that the NHS needs a radical change of culture and leadership style (Francis (2013), Alimo Metcalf 2012, Keogh (2013) and Berwick (2013)), creating a culture in which staff are more valued. Now would seem a good time to apply that approach to the treatment of the most undervalued and least rewarded section of the NHS workforce – its BME staff – not least since the evidence is that their treatment is a good predictor of the quality of patient care. At a time when there appears to be a consensus on the

benefits of diversity for all those receiving health services there can be no better time to change, once and for all, the “snowy peaks” of the NHS. There can surely be no better place to start than London.

**Note.** Throughout this report, we have followed the national reporting requirements of Ethnic Category as are currently defined in the NHS Data Model and Dictionary, as used in Health and Social Care Information Centre data. “White” staff include White British, Irish and Any Other White. The “Black and Minority Ethnic” staff category includes all other staff except “unknown” and “not stated.”

## Introduction

Exactly ten years ago a major national initiative was launched to tackle race discrimination in the provision of health services and the employment of health service staff. The Race Equality Action Plan (DH 2004) stated

*The NHS and Department of Health must give even greater prominence to race equality as part of our drive to improve health. We must:*

- *pay greater attention to meeting the service needs of people from ethnic minorities. This will help us to meet the standards both for improved services and health outcomes in the long term and to hit our short term targets*
- *make race an important dimension of our strategy for the next five years through more focus on helping people with chronic diseases - where morbidity is high amongst people from black and minority ethnic backgrounds - and on health inequalities - where ethnic minority communities are often disadvantaged*
- *target recruitment and development opportunities at people from different ethnic groups whose skills are often underused. This will assist our drive to recruit more staff, increase our skill base and introduce new working patterns.*

*We need to tackle this in a systematic and professional way. Equality and diversity need to be explicitly acknowledged and integral to all NHS corporate strategies.*

Four years later, in 2008, NHS staff were told

*Current NHS chief executive David Nicholson has latterly taken up the mantle, calling for 30 per cent black and minority ethnic representation at the top tiers of the service. (Santry, C 2008a)*

Ten years on from the launch of the race equality Action Plan-, our survey of the leadership of NHS Trusts in London, where 41% of staff and 45% of the population are from black and minority ethnic backgrounds, suggests that little or no progress has been made in meeting those goals. Matters of diversity in the leadership, workforce and service delivery of the NHS appear to receive little attention. Monitoring often still falls short of the statutory minimum (EHRC 2012). As with other aspects of the NHS, such as patient safety, the attitude to diversity displayed by many in the senior echelons of the NHS seems to be a mixture of indifference and denial. This report explores the extent to

which Board composition reflects that of the local population or the employed workforce – and the possible implications for service provision.

We set out to stimulate debate by exploring the level of diversity, and especially BME membership, at Trust Board level, and senior manager level, in the NHS Trusts that provide the capital's health services. The report then considers the evidence that the governance, the treatment and composition of the workforce, and the planning and provision of services are linked.

This report only considers the membership and governance of NHS Trusts. A subsequent survey may usefully consider CCGs. Although CCGs are a very recent innovation, initial data on their governing body membership suggests that some of the questions posed about NHS Trust Board governance and membership may also be relevant to CCGs. This is discussed further in Section 4.

# 1. The challenges that London's NHS Trust Boards must meet

## London's population

London is the most diverse, and largest, city in the UK. About half of Inner London's population belongs to an ethnic group other than White British, compared to about one in ten of the population outside London. In Outer London, about a third of the population is from a group other than White British. According to the 2011 Census 44.9% of London's residents are "White British" (Census Update, 2011).

In the UK, people from BME backgrounds are more likely to live in poverty (Platt, L. 2007). The London boroughs with the highest proportion of black and minority ethnic residents have poorer health outcomes than those boroughs with the highest white British population on seven of the eleven key indicators (including infant mortality, diabetes, TB and early death from heart disease and stroke).

Reducing health inequalities has been an explicit policy objective in the UK for the past 15 years, (Marmot, M. et al 2010) yet explicit attention has not been paid to ethnic diversity. (Salway, S. et al 2010).

## London's NHS staff

London's NHS workforce is as diverse as the city's population. More than two in five of London's NHS workforce are from a black and minority ethnic background. By every measure, London's black and minority NHS staff fare less well than their white counterparts. They are to be disproportionately found in lower grades; are treated less favourably in recruitment, promotion, incremental and performance awards and bonus payments; are more likely to experience bullying and harassment; and are more likely to face disciplinary action or be reported to professional regulators. They are also radically under-represented at senior manager levels. The evidence for this is discussed further in Section 4 below.

**Table 1. Ethnicity of London's NHS workforce (excluding doctors)**

Category	Total
White	55%
Asian or Asian British	12%
Any other ethnic group	29%

Source. HSCIC. March 2012



## 2. NHS Trust Boards and their directors

### Boards and equality

Many of the most important decisions about how the NHS should be run, and what services should be prioritised, are taken locally either by NHS Trusts or by Clinical Commissioning Groups (CCGs).

CCGs are membership organisations primarily led by representatives of local GP practices who are elected to the local CCG Governing Body. This body includes some other representatives of local health organisations with limited non-GP membership of their Boards. CCGs are responsible for planning and purchasing NHS healthcare locally. They were established very recently under the new Health and Social Care Act 2011 after being "authorised" by the new NHS Commissioning Board (NHS England).

NHS Trusts run hospitals and provide most other services, whilst CCGs commission services. NHS Trusts are by far the main NHS employers.

NHS guidance on NHS Trust Board governance states the "hallmarks of an effective strategy" include:

- Inclusion at its heart so that services that are delivered produce accessible, fair and equitable services and outcomes for all sections of the population served
- Commitment to treating patients, service users and staff with equity"

The Healthy NHS Board (2013)

*The Healthy NHS Board (2013)* outlines the personal accountability of the Chief Executive and executive directors for ensuring the organisation's compliance with equality and human rights legislation, alongside the Chair's responsibility to ensure equality is central to board activity and the Non Executive Directors' (NED) general responsibility to challenge executive proposals with an equality focus. (Ramsay R and Fulop N et al. 2010)

Almost a decade ago, when the evidence base was weaker, Aneez Esmail and colleagues (Esmail A, et al 2007) found that, though there were demonstrable benefits of a diversity approach in other sectors, such as a decrease in staff litigation and an increase in customer satisfaction, *"there was only weak support for the hypothesis that workforce*

*diversity improves the effectiveness and performance of an organisation, although there were some cases studies that did show benefits.” They went on to argue:*

*What this means for the NHS is that the business case alone will not be sufficient to drive forward this agenda and that moral arguments relating to reducing inequalities will continue to be important. We would argue, therefore, that in the public sector the motivation for organisations to engage with diversity is, as in the private sector, an improvement in the services that the organisation delivers. We argue that, in order to improve the quality of services delivered to BME patients the NHS must embrace diversity as a central facet of its business plans. This requires leadership that recognises the centrality of diversity as a management practice.*

(Esmail et al op cit. 2007)

Almost a decade later, as section 4 below demonstrates, we can be rather more confident about the links between good diversity management and improved service delivery. Those charged with training NHS Trust Board members reflect that confidence in their Guidance:

*“We know that diverse teams make better and safer decisions and there is a large body of evidence to support this. And yet we know that senior teams in NHS organisations are under representative of the communities they serve and staff they lead. This is something that must change.*

*Inclusive and diverse senior teams are essential if the NHS is to achieve ‘equality of health outcomes for all’. Delivering this is an important part of work that the NHS Leadership Academy will be doing. We will champion inclusion, equality and diversity and encourage innovation in leadership and through this improve people’s health and their experience of the NHS.*

*I urge all boards and senior leaders to challenge themselves honestly about the lack of diversity at the top of NHS organisations and to use this guide to build equality, diversity and inclusion into the senior recruitment process. “*

Sobieraj, J. (2012),

Of course, and as the NHS Leadership Academy Guidance underlines, it is not enough to simply change the membership or diversity of Trust Boards to make them more representative of local communities and the workforce they lead. But, as we discuss below, the case for an inclusive and diverse leadership at Trust Board level – and indeed

across the NHS - is now a convincing one. If the NHS is to achieve the 'equality of health outcomes for all' that the NHS Constitution demands then the NHS needs all Board members to help lead equality and diversity.

The NHS Guidance on selection processes for Board members states

*"Boards are responsible for ensuring the delivery of better outcomes for patients from all sections of society, acting as a champion for all patients and their interests, ensuring delivering or commissioning of high standards of quality and consistency of service for all. This includes promoting integrated care for patients, promoting equality and diversity and reducing inequalities.*

*Board members' responsibility to promote Equality, Diversity and Inclusion and adhere to the Human Rights Act also form part of the Council for Healthcare Regulatory Excellence (CHRE) standards for Board members.*

*The EDS (Equality Delivery Scheme) Outcome 4.3 also indicates that organisations will be assessed against their use of the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes."*

NHS Leadership Academy. (2012)

The guidance reminds Boards that the more representative they are of the local communities they serve, and of the workforce, the better for healthcare services in general.

*"Health need and demography including diversity and equality issues.*

*Although these aspects are generally considered to be particularly important for commissioners, this understanding is critical in informing strategic processes for providers and in ensuring that provider boards are able to forge constructive collaborative relationships in the local health and social care economy. It includes intelligence to assist boards to understand the local population, its demographic and health profile, particularly health status, healthcare needs, behaviours and aspirations; and the key equality gaps experienced by different groups within the community, both in relation to each other and compared to similar groups in other localities. This aspect of intelligence should be based on shared analysis and monitoring with local government as well as commissioners.*

*Guidance and research suggests that organisations are best served by boards drawn from a wide diversity of backgrounds and sectors. This includes the expectation that board composition reflects the diverse communities they serve."*

NHS Leadership Academy. (2012)

The Regulatory Impact Assessment for the Public Sector Equality Duty on the NHS Equality Delivery System reiterated that

*the NHS Constitution is very clear: "everyone counts" be they patients or staff. This means the NHS needs to consider the outcomes that different people experience: taking different or extra steps to improve access and design services so that their health outcomes and experience are equitable..... The new NHS (has) the aim of patient-centred care, to involve patients, carers, local communities and staff in improving the NHS. For staff, the NHS needs to build working environments where all staff are confident in their skills, thriving in workplaces that are fair and free of discrimination. To do that effectively, NHS Trusts need leadership that understands such challenges. A diverse Board more representative of communities and staff may be more likely to enable that to happen. Research looking at the extent to which Primary Care Trusts who previously commissioned services achieved this found serious shortcomings.*

The Equality Delivery System for the NHS STATEMENT ON COSTS AND BENEFITS (2013)

## **Directors**

All NHS Trusts have a Board of directors. There are two categories of director – executive and non executive. Executive directors, including the chief executive, are employees of the Trust and are appointed following an open selection process, similar in principle to that of any other employee. They will normally be appointed on open-ended contracts for specific positions, though some may be interim appointments. In particular each Trust Board will have a medical director, a nursing director, a finance director and one or more other directors with portfolios, such as a HR director, a facilities director and so on. The senior executive director will be the chief executive. In addition to core directors with voting rights, there may be additional directors who sit on the board but do not vote. The NHS Leadership Academy Guide emphasises

*The Board selection process provides a defining moment in the development of an organisation. It is the opportunity to ensure that the right people with right*

*competencies are at the helm of affairs, providing leadership and governance that will secure the future of the organisation, fulfil the objectives of the business and deliver long lasting sustainable benefits / results.*

*It is also the opportunity to try to ensure that from the outset as many people as possible appointed to the Board have the Equality, Diversity and Inclusion leadership competencies, commitment and confidence to deliver on the explicit Public Sector and Specific Duties to promote equality and tackle inequalities in access to healthcare.*

*The need for organisational awareness and support of equality and diversity identified in our original review remains. Most recently, it is set out in the new English NHS Constitution (Department of Health, 2013a), the UK Government's Equality Act (Department of Health, 2010) and corporate guidance (Financial Reporting Council, 2012, Financial Reporting Council, 2011).*

NHS Leadership Academy. (2012)

The number of non-executive directors of an NHS Trust is defined in the Trust's establishment order, or in a Foundation Trust's constitution. Chairs and non-executive directors of NHS Trusts serve a maximum of 10 years in the same NHS post (or two 3 year terms for Foundation Trusts). Within this period, any second reappointment must be through open competition. *The Healthy Board* states:

*'Recent research (Chambers, N., Pryce, A., Li, Y. & Poljsak, P. (2011)) identified a tendency to 'opaque and subjective' board appointment processes. To counteract this the recommendations include proactively putting diversity on the agenda in the recruitment process, focussing more on underlying competencies than prior experience, creatively expanding the talent pool and offering support through the appointment process.'*

The Healthy Board 2013

The *NHS Equality Delivery System 2* Outcome 4.1 (NHS England 2013) expects NHS Trust Boards and Senior Leaders to conduct and plan their work so that it advances equality and fosters good relations in all their activities. Outcome 4.3 also states that organisations will be assessed on their use of the "Competency Framework for Equality and Diversity Leadership" to recruit, develop and support strategic leaders to advance equality outcomes. It is unclear, however, how this assessment is undertaken and who by, and what sanctions follow if a poor assessment results.

The Guidance on the NHS Board selection process states the obvious:

*133 Formal, rigorous and transparent procedures for both the appointment and the remuneration of directors must be in place.*

*134 The appointments process must ensure that all appointments are made on merit and against objective criteria. Appointments panels for executives should always include an independent external assessor.*

NHS Leadership Academy (2012)

There is one caveat to this public exhortation to improve the diversity of NHS trust Boards. A little known but critical DH document may give an insight into the mindset of those responsible for the framework within which the Board Governance is established. In the Board Governance Assurance Framework for Aspirant Foundation Trusts *Board Governance Memorandum (DH 2011)* the Department of Health sets out its ground rules for Trusts seeking to become Foundation Trusts. The DH makes clear that “all aspirant FTs are required to use the Board Governance Assurance Framework prior to submitting their FT application to the Department of Health. This is an important aspect of a Trust’s application”

In the opening section on “Board composition and commitment” “the various Red Flags included throughout this document are designed to highlight governance risks”. These “Red Flag” risks include situations where:

- There are no NEDs with relevant financial background
- There is no NED with current or recent experience in the private commercial field

However, there is no “Red Flag” to emphasise the necessity of having a diverse Board. Instead, Boards are simply told that it would be “good practice” for the Board to give “given due consideration to the diversity of its composition in terms of the protected characteristic groups in the Equality Act 2010.” One consequence of this Guidance is that every Trust has at least one accountant (sometimes more) on the Board and at least one member with private sector experience, but may be very distinctly not diverse.

Our survey set out to establish what the outcomes of national guidance and processes for the composition of Trust Boards has been.

### 3. The audit of Board membership

#### Methodology

An initial literature search was conducted, primarily focused on current and previous policies on ethnicity and NHS leadership and the implications for service provision. We found no published recent analysis of the ethnicity of London's NHS Board leadership and its implications.

The web sites of all London NHS trusts previously falling within the remit of NHS London were reviewed. All Trusts were then written to with a Freedom of Information request (see Appendix 1). A minority of Trusts refused to provide the requested information. These were then written to again, assuring them that individual Board members would not be identified by ethnicity, in some cases setting out what we believed the ethnic composition of the Trust Board might be and inviting them to agree or disagree. They were referred to advice received in the course of the research from NHS England (see Appendix 1) that such data be provided. All but three of the 40 Trust web sites provide photos and short biographies of Board members but these were only considered if Trusts failed to provide the data requested within the statutory period allowed for responding to a Freedom of Information request. Trust Boards were also analysed by gender.

Just one Trusts eventually completely refused to respond to the FOI. The refusal of a small number of Trusts to willingly provide this data is commented upon in Section 4 of this report.

One unexpected complication was the difficulty in ensuring that Trusts only provided the ethnicity of voting Board members. Except where the data was not clear, only voting members were included, not co-opted or non-voting Board members. Two complications ensued, neither of which, we are confident, affect the findings in any significant way. There is a small potential for error in our data but not one which affects our overall findings because when the data Trusts had provided was cross referenced with the Trust's own web site data, two sorts of discrepancy were found. In some cases voting members appeared to not be included in the ethnicity returns. In other cases some non-voting members had been included in the returns. There is therefore a difference (small but to be noted) between the total numbers of directors that Trusts reported as being voting members in their FOI returns and the numbers recorded on the Trust web sites. To further complicate matters, not all the web sites indicated whether Board members were voting members of the Board. There is no reason to assume this would have made

any significant difference to the overall conclusions reported from the survey, but it does mean the total number of directors differs slightly from that on the FOI returns.

The ethnicity and gender of newly appointed (2013) Non Executive directors in London was obtained by cross referencing NHS Trust Development Board data with Trust data. This enabled conclusions to be drawn as to any significant changes to the composition arising from new appointments.

Comprehensive data on Trust board membership by ethnicity in 2006 was compared with that for 2014, enabling a historical comparison to be made.

We also looked at nationally published data on the composition of the NHS workforce in London, including that for senior managers and very senior managers for 2013 and the earliest comparable data from 2008. These results are tabulated in Section 5. In that section we also summarise the trends over time in the appointment of non executive directors.

Previous work (Kline 2013) has considered the extent to which recruitment practices in the NHS discriminate against NHS applicants and staff on the basis of ethnicity. This latest research primarily sought to consider the extent to which the most senior levels of the NHS in London, the Trust Boards, reflected the ethnicity and gender of the local population or that of their staff.

The reason initially given by Trusts for their refusal to provide data was that the information requested was personal information that the Trust was not therefore required to provide. The following response from one Trust was typical:

*After careful consideration we have upheld our decision not to provide information on the ethnicity of Trust Board members .....the trust recognises that there is a public interest in knowing the ethnicity of the Trust Board members but this does not outweigh the data protection act rights of the individuals concerned. In reaching our decision we have consulted with our director of inclusion who shares the opinion that the information should not be made public.*

*(Letter 19<sup>th</sup> December 2013)*

In fact, with the exception of the Chair and Chief Executive, Trusts were not asked to identify the individual ethnicity of Board members and could have responded by aggregating all executive and all non executive members. Moreover it was not, and never had been, the intention of the survey to identify individual board members' ethnicity, which is why individual Trusts are not named in this report. The survey sought no more information, and on no different a basis, to that expected of employees who are



asked to self declare for interview panels. This particular Trust like almost all others, publishes colour photos of its Board members on the web. The Trust was written to, setting out our estimation of the ethnicity of the Board and inviting them to confirm or disconfirm the estimate. This trust did eventually provide the data.

Curiously this Trust's view was not shared by the directly neighbouring Trust, which is quite happy to publish the ethnicity, as requested by the survey, in its annual Report which can be easily found on its web site.

The response of Trusts who initially refused to provide the information requested was unexpected for three reasons:

- Trusts expect their staff to declare their ethnicity as an essential precondition of any ethnic monitoring to determine the success or otherwise of their employment practices. A high return rate is judged essential for such data to be reliable enough to inform policy. It is hard to see how Trusts can encourage staff to self declare when they refuse to do so themselves
- In any case, almost all Trusts provided colour photos of their entire Board, thus risking viewers making assumptions about ethnicity which, though likely to be correct, might not be
- All seem to accept there is a public interest in knowing the ethnicity of Board members but regard the Data Protection Act confidentiality rights of all or some of their Board members as over-riding the public interest.

All new non executive appointments during 2013 were analysed by gender and ethnicity to consider the extent to which the composition of Trust Boards might be changing.

The level of understanding at Board level was in some cases quite surprising. For example, one (all white) Board's Secretary responded to the survey by stating that "all Board members declare their ethnicity as "British". When the Board was written to, this response was corrected to their Board members all being "White British", since there is no such "ethnicity" census category used in the NHS (or elsewhere). It is unclear what black "British" members of the Board would have been classified as.

Please note that throughout this report we have followed the Health and Social Care Information Centre categories. Specifically:

- White includes White British, White European and any other white ethnic origin
- BME includes any ethnicity other than white
- Unknown indicates not available or nul
- London regions include NW London, SW London, North Central and E London

The trust Board ethnicity data for 2014 is January 2014. Unless otherwise indicated, HSCIC data is from October 2013.

The analysis which follows does not distinguish between Foundation Trusts and Trusts without that status.

## Results

### (a) Survey on Board Membership in London

Table 1 summarises the survey findings.

**Table 2. London Trust Board membership (voting) analysed by ethnicity. 2014**

	White	BME	Unknown	Total	% BME
Chair	39	1	0	40	2.5
Chief executive	38	1	1	40	2.5
Executive members	197	16	3	216	7.4
Non executive members	190	22	5	217	10.4
<b>Board total(1)</b>	<b>464</b>	<b>40</b>	<b>9</b>	<b>513</b>	<b>7.9</b>

Source. FOI and Trust web sites

(1) Note the earlier comments on “voting” and “non-voting” members

Black and ethnic minority people constitute 44.9% of London’s population (2011 national census). The workforce is 41% BME. London’s Trust Boards are thus significantly unrepresentative of both their workforces and the local populations in terms of ethnicity.

The proportion of Chairs and Chief executives who are BME is strikingly low. The proportion of Executive members who are BME is significantly lower than the proportion of Non Executives who are BME.

**Table 3. London Trust Board membership analysed by ethnicity and gender 2014**

	Non-Executives inc Chair	Executives inc Chief Executive	Whole Board
<b>No BME Board members (1)</b>	<b>21</b>	<b>22</b>	<b>17</b>
<b>No female Board members</b>	<b>0</b>	<b>1</b>	<b>1</b>

(1) Source. FOI and Trust web sites

(2) Note. "unknown" Board members are discounted in this table

More than two fifths of all London NHS Trusts had no voting BME member on the Board. This included several inner city Trust Boards; indeed there appeared to be little obvious correlation between the ethnic composition of the surrounding population and the ethnicity of Board members.

Trust Board membership, analysed by gender, also revealed a disproportionately male Board composition.

**Table 4. London Trust Board membership analysed by gender 2014**

	Male	Female	Unknown	Total	% female
Chair	26	14	0	40	35.0
Chief exec	31	9	0	40	22.5
Non executive members	137	80	0	217	36.9
Executive members	117	99	0	216	45.8
<b>Board total</b>	<b>311</b>	<b>202</b>	<b>0</b>	<b>513</b>	<b>40.2</b>

Source. FOI and Trust web sites

The gender gap was particularly noticeable for Chairs and Chief executives. Though female representation amongst executive Board members (40%) was closer to the local proportion of women in the local population, it fell well short of the proportion of women in the NHS workforce. In England, almost 80 per cent of non-medical health service staff (HSCIC, 2008) NHS Staff 1997-2007 (non medical) are women. The gap between Board representation and the gender of the workforce is very significant and, as in the case of ethnicity, adds to the shortfall in diversity of Board membership. The rate of recruitment of female non executives to NHS Trust Boards has been more rapid than that of BME appointments to Boards. This is consistent with the national Appointments Commission strategy (see Section 5.)

### **Diversity and senior managers below Board level.**

The number of BME staff in senior and very senior staff grades within London is low both in comparison to the ethnicity of the overall workforce and the local population.

**Table 5. Senior and very senior managers analysed by ethnicity 2013 (London, non medical)**

Year	White	BME	Not known	Total (excluding not known)	% BME
2013	709	118	27	827	14.3%

Source. HSCIC

Note. Senior and very senior manager grades in Table 4 and other Tables drawn from HSCIC data refer to staff in Agenda for Change bands 8a-9. The aggregated category includes managers on pay scales from £39,000 to £98,000. Kline (2013) noted that BME senior managers were disproportionately to be found in the lower pay bands within these senior and very senior management scales.

Analysis of this data against the overall NHS London workforce ethnicity shows that the likelihood in 2013 of a non-medical BME employee being a senior manager or very senior manager in London was three times less than that of a white employee occupying such a position.

Such findings for senior and very senior manager posts are similar to other NHS recruitment findings. In 2008 the Race Equality Service Review (South East Coast BME Network 2008) found a similar pattern and produced proposals (not implemented by local Trusts) to address the discrimination they found. Also in 2008, the Health Service Journal surveyed NHS Trusts and found that black and minority ethnic applicants for NHS

posts were three times less likely to be appointed than white applicants, and one and a half times less likely to be appointed even if they had been shortlisted. (Santry C 2008)

Kline (2013) analysed a national sample of NHS Trusts' recruitment practices, including those of six London Trusts. He found that, nationally, even once BME applicants had been shortlisted (and presumably met the person specifications for the job) white shortlisted applicants were 1.78 times more likely to be appointed; it was 3.48 times less likely that BME applicants would be appointed than white applicants. The figures were similar for London where white shortlisted applicants were 1.64 times more likely to be appointed. Kline concluded:

*The glacial pace of change (if there is any at all) is not through any lack of initiatives, but in too many local employers race discrimination against staff is simply not accorded the priority it should be, and ministers largely look the other way.*

*A generation ago the Macpherson Report defined institutional racism as "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people."*

The data in this report might invite discussion as to whether such a collective failure might be said to exist in the NHS

## **(b) Medical staff**

The total number of BME consultants and registrars has increased significantly in the last decade, though such staff members remain under-represented at senior medical grades. Nevertheless, the change is noteworthy, particularly compared to the instance of non medical staff (including nurses), where there has been virtually no change.

**Table 6. Consultants and registrars analysed by ethnicity. England.**

	2013	
	Registrars	Consultants
White	4934	5065
BME	4290	2772
Total	9224	7837
% BME	47%	35%

Source: HSCIC

The number of employed BME doctors in England has increased steadily in recent years as Table 6 summarises.

**Table 7. Consultants and registrars analysed by ethnicity. England 2006-13.**

	2006		2006. % each ethnic group who are consultants	2013		2013. % each ethnic group who are consultants
	Registrars	Consultants		Registrars	Consultants	
White	2597	4916	65%	4934	5065	51%
BME	2254	1749	44%	4290	2772	39%
Total	5851	6665		9224	7837	
% BME	38%	26%		47%	35%	

Source: HSCIC

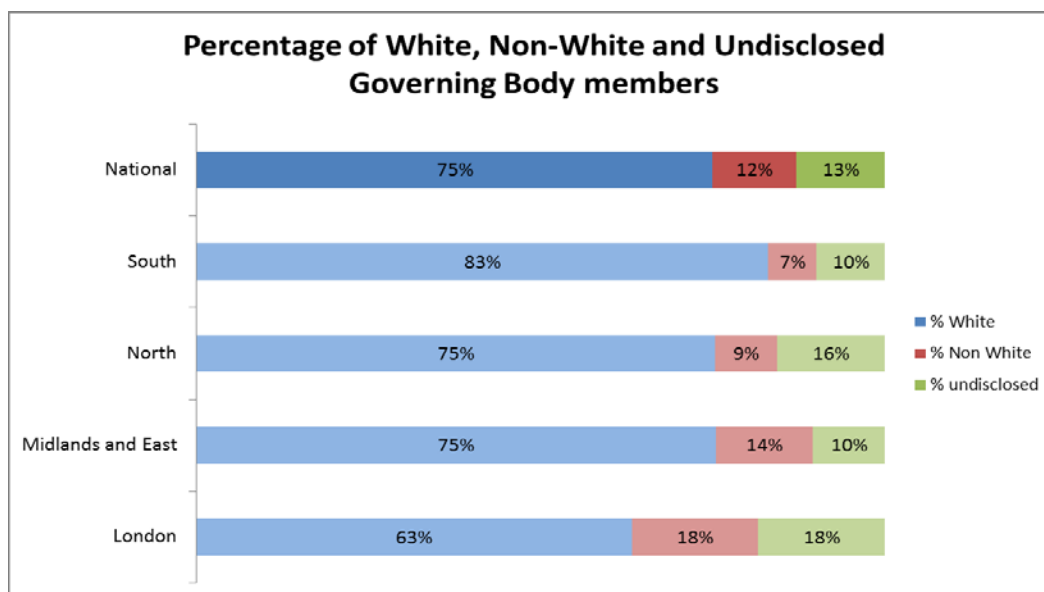
The changes that have occurred over time are important. In 2006, 26% of consultants were BME. By 2013 that had increased to 35%. In 2006, 38% of registrars were from a BME background. In 2013, the proportion of registrars who were from a BME background had increased to 47%. Due to the substantial increase in registrars, the proportion of BME doctors who were consultants (rather than registrars) had declined, albeit at a slower rate than that for white doctors, though a higher proportion of consultants were white. Nonetheless, the proportion of medical directors who are BME remains low. In London 15% of medical directors are BME, a lower number than the proportion of BME consultants and registrars.

## (c) Clinical Commissioning groups

There are no comparable figures held by HSCIC for GPs since such GPs are overwhelmingly self employed, or partners. However, the overall increase in BME doctors may explain the rather more impressive diversity record of CCG Boards whose governance is dominated by GPs. At least 18% of CCG Governing Body members in London are BME, approximately double the proportion of BME members of Trust Boards. It is NHS Trusts, however, not CCGs who employ the overwhelming majority of London's NHS staff and provide London's health service outside GP practices.

Regrettably, the NHS England report *Clinical Commissioning Group Workforce Equality and Diversity Profile* does not touch on the ethnicity or gender of the chief executive and other executive CCG Board members. As such, further inquiry would be necessary to ascertain whether or not the changes in non-executive CCG Board members were accompanied by similar changes for senior staff.

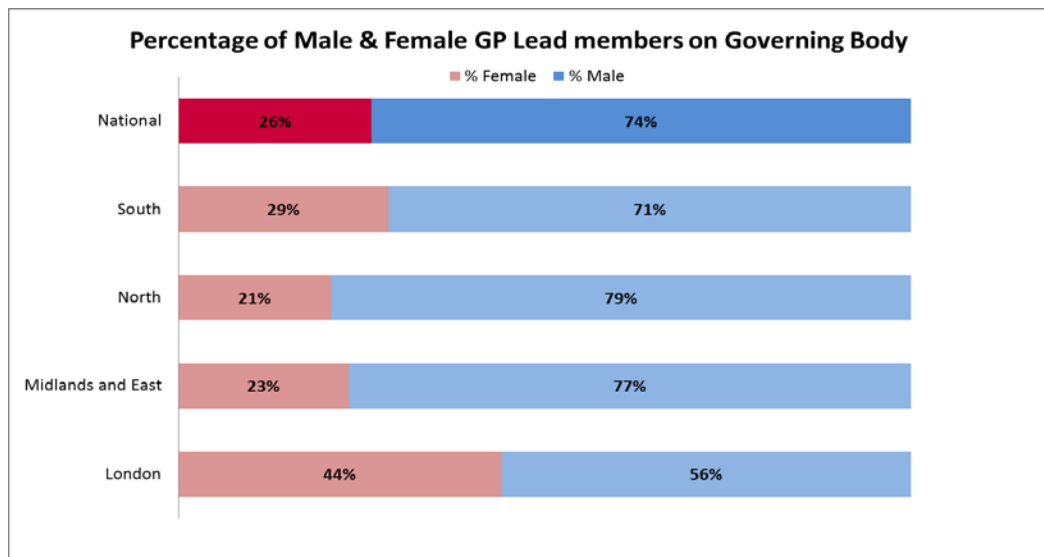
**Fig 1. Clinical Commissioning Boards members analysed by ethnicity**



Source: Clinical Commissioning Group Workforce Equality and Diversity Profile. NHS England. November 2013.

The proportion of CCG Board members who are female is slightly higher than the proportion of NHS Trust Board members who are female, no doubt reflecting the fact that 43 per cent of doctors are women (HSCIC, 2012)

**Fig. 2. Clinical Commissioning Board members analysed by gender.**



Source: Clinical Commissioning Group Workforce Equality and Diversity Profile. NHS England November 2013.



## 4. Have things changed for the better?

### Trust Boards

In 2000, the DoH reported:

*"A diverse workforce also means a diverse leadership. We must change the current situation where NHS leaders are drawn from a narrow section of the workforce and the community.*

- *only 23% of chief executives in the NHS are women - and only 16% of finance directors;*
- *17% of chief executives in the North West Region are women compared with 35% in London Region;*
- *only 2.5% of NHS non-executive directors have a disability.*
- *an estimated 1% of nurse executive directors are from black and ethnic minority communities;*
- *28% of hospital doctors are from black and ethnic minority communities but these doctors hold only 16% of consultant posts;"*

DoH (2000).

Nine years later, one senior nurse wrote:

*In 2009, Access of BME staff to senior positions in the NHS told us that BME staff comprised 10.1% of NHS management staff in 2008. This was an increase from 7.3% in 2007. However, it was below the national average of 12.1% since BME staff groups in the NHS comprised 8.3%.*

Nola Ishmael (2009).

Analysis of the data for Trust Board membership shows that its composition is disproportionately male and white in comparison with that of both the local population and the NHS workforce.

Subsequently, the Appointments Commission undertook to improve the diversity of Trust Boards:

*For the period up to its closure, the Appointments Commission monitored the diversity of appointments made using delegated authority from the Secretary of*

*State for Health. The aspiration of the government is that by 2015, 50% of those appointed will be women.*

*Embedding and integrating Equality, Diversity and Inclusion into core or mainstream business is a competency organisations have struggled with in the past, but Boards have a really important leadership and governance role to play in getting this right.*

*The capability for getting this right must include the knowledge, skills and experience of engaging and partnering with individuals and groups of patients, carers, employees and social and professional bodies from the protected characteristic groups<sup>1</sup> and the integration of their views and information into the decision making of the Board.*

*The Equality Act 2010 (contained) an explicit duty to promote equality and tackle inequalities in access to healthcare as core to NHS governance.*

Appointments Commission (2013)

In its 2008-09 Annual Report, the Commission stated

*The Commission has a range of current targets set by ministers to cover the appointment of women, people from black and minority ethnic (BME) communities and disabled people. One set of targets exists for appointments to local NHS boards and another for Department of Health national bodies, to reflect the specific challenges of appointing to each. There has been an increase in the number of people appointed from BME populations overall compared with last year, when 11% of those appointed were from those areas. However, there remain areas where particularly large BME communities are not adequately reflected on their local boards. We will continue to focus on these areas.*

The Appointments Commission (2009).

The female targets of five years ago were 44% for chairs and 50% for all appointments whilst the BME targets were 8% for chairs and "at least 10%" for all appointments. The most recent national data, compiled five years later, suggests that this goal remains elusive.

**Table 8. NHS Trust Board appointments (England) by gender. 2006-13**

	Male	Female	Total	% Female
2006	126	70	196	35.7
2007	134	46	180	25.5
2008	119	50	169	29.6
2009	127	71	160	44.4
2010	127	71	199	35.7
2011	164	81	244	33.2
2012	166	59	229	25.8
2013	161	116	278	41.7

Source. NHS Trust Development Authority

In London there does appear to have been some recent progress with regard to female appointments.

**Table 9. 2013 London NHS Trust Board non executive and chair appointments by gender**

Female appointees	Male appointees
22	23
49%	51%

Source. NHS Trust Development Authority

For BME applicants, however, progress is glacial or has stopped altogether. Five years ago the Appointments Commission stated:

*There has been an increase in the number of people appointed from BME populations overall compared with last year, when 11% of those appointed were from those areas. However, there remain areas where particularly large BME communities are not adequately reflected on their local boards. We will continue to focus on these areas.*

Table 10 summarises the appointments of BME Trust members in recent years.

**Table 10. NHS Trust Board appointments (England) by ethnicity. 2011-13**

	BME	White	Total	%BME
<b>2006</b>	17	177	196	8.7%
<b>2007</b>	13	166	180	5.6%
<b>2008</b>	10	159	169	5.9%
<b>2009</b>	10	149	160	6.3%
<b>2010</b>	17	180	199	8.5%
<b>2011</b>	16	228	244	6.6%
<b>2012</b>	16	208	229	7.0%
<b>2013</b>	16	257	278	5.8%

Source. NHS Trust Development Authority

Note: The difference in totals for each year is due to the variable, "ethnicity not known".

In 2013 the proportion of BME NHS Trust Board appointments was the lowest since 2006. In London, though the proportion of BME appointments is higher than elsewhere, the gap between these appointments and the local population and workforce density is also higher. The proportion of new non-executive Trust Board members from an ethnic minority background, even after a slight increase in numbers in 2013, remains at 9%.

**Table 11. 2013 London NHS Trust Board non executive and chair appointments by ethnicity**

White	BME	Not known
36	6	3
80%	13%	7%

Source. NHS Trust Development Authority

The current London representation of BME Board members is 8%, a startling statistic in a city whose local population is 45% BME and where 41% of NHS Trust staff are BME. The picture has not changed since 2007 when London's Boards were the least reflective of its BME population:

*with a gap of a difference of 24.5% between the proportion of non-white individuals in the working age population and the proportion of NHS senior managers that are from BME backgrounds. (Institute for Innovation 2009)*

It is unclear what impact the abolition of Primary Care Trusts and the creation of CCGs has made at Trust Board level. The number of Trusts was reduced between 2006 and 2014, primarily through the abolition of Primary Care Trusts in 2013. Though there is a reported average of 13% BME CCG Board representation, the NHS England Board have discussed concerns that there may have been a loss of senior BME staff from Strategic and Regional Health Authorities and Primary Care Trusts. (See below). Data for Executive Board composition in 2006 suggests there has been little or no progress since then.

**Table 12. Executive Board members London and England. Ethnicity. 2006**

Ethnicity	England			London		
	Chief executive	Board Executive	Other senior managers	Chief Executive	Board Executive	Other senior managers
<b>White British</b>	273	1089	3255	57	311	1674
<b>White Irish/ O White</b>	5	57	205	4	38	209
<b>Black and Minority Ethnic</b>	3	64	363	3	39	333
<b>Not known</b>	3	33	108	2	8	43
<b>Total</b>	284	1243	3921	66	397	2259

Source. HSCIC

Table 13 compares the ethnicity of London NHS Trust Board Executive members (only) between 2006 and 2014.

**Table 13. London Trust Boards Executive membership. 2006/2014**

Ethnicity	2006			2014		
	Chief Executive	Board Executive	Other senior managers	Chief Executive	Board Executive	Other senior managers
White *	61	368	1883	38	197	n/a
Black and Minority Ethnic	3	39	333	1	16	
Not known	2	8	43	1	3	n/a
<b>Total</b>	60	396	2259	40	216	n/a
<b>%age BME</b>	5.0%	9.6%		2.5%	7.4%	

Source: HSCIC and 2014 FOI returns

Note. The 2006 data includes the Executives of the four strategic health authorities all of which had been abolished by 2014

For both Chief Executives posts and Executive Directors posts there was a decrease in the proportion of BME postholders.

In a separate analysis, Esmail et al (2007) found that 12% of the non-executive positions in 2005 were taken by non-white staff, a slightly higher proportion than exists today. The NHS Institute for Innovation and Improvement (2009) suggested that there was some improvement in 2007; if this is true, there does not appear to have been any further improvement in the subsequent years.

## Senior managers

As a result of the NHS Agenda for Change regrading exercise, any comparisons with pre 2008 grading data are sure to be unreliable. Band 8a includes many managers and some clinical specialists, particularly in nursing and midwifery. Band 9 is the highest Agenda for Change band.

The proportion of BME staff in Senior and Very Senior Manager positions reflects the more general recruitment findings of Kline (2013), Santry (2008) and Lyfar-Cisse V (2008). In the period 2008-2013 there was no significant change in the proportion of BME staff in these bands though both the national and London data suggests the proportion may have peaked in 2010. Ball J and Pike G (2010) found a decade ago that

BME nurses have to work longer to reach higher grades than white UK nurses such that on average BME nurses worked 15.1 years to reach senior ward sister level, with white nurses taking an average of 11.8 years.

**Table 14. Senior and very senior managers analysed by ethnicity 2008-2013 (England)**

Year	White	BME	Not known	Total (excluding not known)	% BM
2008	6,910	420	347	7330	5.7%
2009	8,165	518	436	8683	5.2%
2010	7,874	538	344	8412	6.4%
2011	7,333	420	338	7753	5.4%
2012	7,189	440	344	7629	5.8%
2013	6,273	393	590	6666	5.9%

Source HSCIC 2014

The data suggests that developing any significant increase in the number of BME Executive Directors would be a challenging goal, since BME staff are very significantly under represented at the management levels from which Board members would generally be recruited. The trend is very similar for London, again peaking at 2010.

**Table 15. Senior and very senior managers analysed by ethnicity 2008-2013 (London)**

Year	White	BME	Not known	Total (excluding not known)	% BM
2008	1,127	178	50	1305	13.6%
2009	1,306	231	51	1537	15.0%
2010	1,261	231	31	1492	15.5%
2011	1,022	159	33	1181	13.5%
2012	997	147	35	1144	12.8%
2013	709	118	27	827	14.3%

Source HSCIC 2014

## Nursing

There has been no increase nationally in the proportion of BME nurse directors for the last decade.

**Table 16. Nurse directors analysed by ethnicity. England. 2008-2013**

Year	Directors of Nursing	Black & Minority	White	Not Stated / Empty Field
2008	180	5 (3%)	165	5 (3%)
2009	180	5 (3%)	165	10 (6%)
2010	190	5 (3%)	175	10 (5%)
2011	200	5 (2.5%)	190	5 (2.5%)
2012	195	5 (3%)	180	10 (5%)
2013	195	5 (3%)	180	10 (5%)

Source. HLOPQ44 10 February 2014

Note. Totals have been rounded and so may not tally. These are Headcount Figures.

The Government claimed earlier this year that

“The 2012 NHS Workforce Census identified 8,082 Nurse Managers and 1,241 Nurse Consultants. Of these 606 Nurse Managers (7.8%) and 77 Nurse Consultants (6.6%) classified themselves as being from a Black or Ethnic Minority Background. For Nursing Managers this shows a rise of 0.3% and for Nurse Consultants a rise of 1.2% since 2004. Although these are not substantive rises, this demonstrates that we are travelling in the right direction.”

The data provided by Earl Howe’s statement shows that the number of BME nurse managers actually peaked at 8.7% in 2008 and fell back to 7.8% in 2012, even lower than it had been in 2003 (8.2%), when his own data starts. According to Earl Howe’s data, not only has there not been an increase of 0.3%, there has been no increase at all since 2003 and a fall of 0.9% since 2007, the year after Nigel Crisp left office as NHS CEO.



**Table 17. Nurse managers by ethnicity 2003-2012. England.**

New Ethnic Codes									Head count
Nurse Managers	White	Mixed	Asian or Asian British	Black or Black British	Chinese	Other	Unknown	Total ethnic minority groups <sup>1</sup>	All groups
2012	7,211	49	131	338	29	59	261	7.8%	8,082
2011	7,339	46	160	346	29	69	265	8.2%	8,260
2010	7,808	52	158	350	31	71	259	7.9%	8,735
2009	7,237	52	150	325	34	74	299	8.1%	8,177
2008	6,532	48	148	269	36	62	489	8.0%	7,595
2007	6,587	38	133	362	39	55	341	8.7%	7,604
2006	6,172	37	126	235	41	54	411	7.5%	7,158
2005	6,194	41	129	218	44	66	286	7.5%	7,096
2004	6,679	48	155	220	59	76	313	7.5%	8,008
2003	4,628	28	130	150	49	50	368	8.2%	6,750

Source HLOPQ44 10 February 2014

Earl Howe's data (HLOPQ44) also showed, contrary to his Lords statement, that the number of BME nurse consultants has risen since 2003 but that the proportion peaked in 2007 (again), since which time it has not increased at all.

## National NHS bodies

Due to numerous changes of structure over the years, we were unable to obtain comparative historical data on the composition of national bodies.

Currently, the Boards of the main national NHS leadership bodies (with the partial exception of NHS England) fail to reflect the ethnic composition of their wider workforce or the population they serve, as Table 21 shows.

**Table 18. The Boards of NHS England and the three main service regulators**

	Chair	Chief Executive	Non executive directors (white)	Non executive directors (BME)	Executive directors (white)	Executive directors (BME)
<b>NHS England</b>	White	White	3	2	9	0
<b>NHSTDA</b>	White	White	4	0	9	0
<b>Monitor</b>	White	White	6	0	7*	0
<b>CQC</b>	White	White	10	0	5**	0
<b>PSA</b>	White	White	6	0	n/a	n/a

Source: FOI

- Monitor Board membership does not include executive directors
- \*\* Includes chief inspectors

The composition of senior managers below Board level is overwhelmingly white. For example, staffing at the largest Trust regulator, Monitor is summarised in Table 22

**Table 19: Staffing composition at Monitor**

Band	white	Asian	Black	Mixed	Other/not recorded	Total
<b>1</b>	19	0	0	0	0	19
<b>2</b>	64	7	1	0	6	78
<b>3</b>	105	25	3	3	15	151
<b>4</b>	34	1	4	1	2	42
<b>Total</b>	222	33	8	4	23	290

Source Monitor: FOI January 2014.

As such, the apparent failure to create a diverse national leadership is consistent with the failure to make progress locally or within specific occupations.

## **5. What implications do the recruitment and treatment of BME NHS staff and Board members have for patient care?**

### **Summary**

Research suggests that NHS organisations which discriminate against black and minority ethnic staff may lose out in five main ways:

- a. Patients may be prevented from getting the best clinicians and support staff if candidates' ethnicity unfairly influences recruitment and promotion or leads to BME staff being unfairly treated in the disciplinary process or in other aspects of their working life.
- b. If BME staff are treated unfairly then that is likely to have an impact on morale, absenteeism, productivity, and turnover. It will also lead to the loss of time and money through grievances, employment tribunals and reputational damage.
- c. There is an established link between the treatment of BME staff and the care that patients receive. Research shows the workplace treatment of BME staff is a very good barometer of the climate of respect and care for all within NHS trusts and correlates with patient experience.
- d. There is evidence of a link between diversity in teams (at every level including Boards) and innovation. At a time when the NHS needs to transform its care, lack of diversity may carry a cost in patient care for everyone
- e. Leadership bodies which are significantly unrepresentative of their local communities, such as NHS Trust Boards, will have more difficulty ensuring that care is genuinely patient centred – with resultant failings in the provision or quality of services to specific local communities that have particular health needs, including BME communities and patients.

Each of these is considered below.

#### **a. Recruitment and promotion**

The less favourable treatment of BME staff in recruitment, nationally and across all NHS occupations, has been much discussed. Kline (2013) concluded that when all occupations and grades were considered, even shortlisted BME candidates (who could presumably all meet the job specification) were 1.74 times less likely than white shortlisted candidates to be appointed. Moreover, this pattern had apparently not improved for several years yet was not acknowledged as a serious problem by the large majority of NHS employers

examined. This report concluded that this risked a considerable waste of talented BME candidates at a cost to patients whose clinicians and support staff were not necessarily being appointed on the basis of ability alone. Those conclusions matched previous surveys (Lyfar-Cisse, V. 2008; Santry C 2008) and other research on, for example, the recruitment and promotion of BME nurses (Pike G, Ball J. 2007). The most recent published survey found that though BME nurses make up 19 per cent of the nursing workforce in England, in 33 of 50 organisations surveyed, BME nurses accounted for fewer than 5 per cent of all band 7 nurses and in 19 organisations, there were no BME nurses at band 8. (Sprinks, J. 2014)

The black and ethnic minority workforce (excluding doctors) is substantially under-represented in senior grades (Bands 8a-9), to the extent that African and Caribbean staff are more than three times less likely to be in Bands 8a-9s.

**Table 20. Percentage of each main ethnic group within grouped pay grades (excluding doctors). London.**

	Grade 1-4	Grade 5-7	Grade 8-9	Total
<b>Ethnicity</b>				
White	31%	55%	<b>14%</b>	55%
Asian or Asian British	33%	60%	<b>7%</b>	12%
Any other ethnic group	36%	60%	<b>4%</b>	29%

Source: HSCIC

The NHS categorises bands 8a-9 as “senior managers” and very senior managers” based on their Agenda for Change pay bands. Data on these pay bands is only comprehensive enough to be reliable from 2008. They show that, on a national level, there has been no improvement in the proportion of BME staff in these grades since 2008; indeed, it appears it may have peaked in 2010.

The proportion of BME medical staff who were registrars and who were consultants increased significantly in the period 2006-13 though BME staff are still under-represented at senior levels. Nor is such progress reflected in the way BME doctors are treated, with evidence of discrimination in training (Esmail 2014) and clinical excellence awards.

## **b. Less favourable treatment**

### **Disciplinary action**

A report commissioned by NHS Employers, (Archibong et al. 2010) found that BME staff were almost twice more likely to be disciplined than white staff. The researchers also found that 80% of Trusts did not publish data that would enable them to analyse and respond to discrimination. The Royal College of Midwives examined disciplinary procedures for midwives in London and found a similar pattern of disproportionate disciplinary action against BME midwives (Lintern, S. 2012).

The most recent survey of nurses found that, among the one third of the employers who provided 2013 nurse disciplinary data, BME nurses accounted for more than 25 per cent of the cases. In seven Trusts, BME nurses comprised more than 50 per cent of disciplinary cases of the organisations, mainly in London and the south east of England. Almost one third of relevant cases showed BME nurses as accounting for more than 40 per cent of referrals to the Nursing and Midwifery Council in 2013. (Sprinks, J 2014) Those findings complement concerns that BME staff are more likely to be referred to professional regulators than white staff (Wilmshurst, P. 2013 and Stirling, A. 2013).

Employers have a key role in determining whether staff apply and are accepted to national management training programmes. In 2013, a new nursing leadership course was established at the request of the prime minister. NHS Leadership Academy data shows that 94% of the course's first 315 recruits were white with a British or Irish background. A further 2% were white but from other backgrounds. Only 4% of recruits are from a non-white background. Candidates need their employers' approval to undertake the course. (Calkin, S. 2013).

One small scale unpublished study of the local impact of such treatment found significant numbers of BME nurses left the NHS in just one year (Shaw, P 2014)

### **Harassment and bullying**

The 2012 NHS Staff Survey found that harassment, bullying or abuse from colleagues was experienced more by disabled staff (33%) and black staff (31%), than by non-disabled (21%) and white British staff (22%), and at higher rates than reported in previous staff surveys. Giga, S.I. (2009) confirmed these findings. Jeremy Dawson et al found that as a result of "staff experiencing discrimination, bullying and harassment from fellow colleagues, patients and their families, the NHS experiences very high staff

absences and a high turnover rate, which is costing the NHS approx. £1,682,048,391 and £766,077,482.6 respectively a year.”

The cost of grievances, disciplinary processes and tribunal claims arising from alleged discrimination is likely to be considerable. In 2012, having experienced race discrimination, senior scientist Elliott Browne was awarded £1 million damages from a Manchester NHS Trust (Furness H. 2012). In that case, despite the unanimous and scathing tribunal decision, the Trust Board continued to deny that any such discrimination had occurred. The financial cost of increased turnover, accelerated retirement and lower morale has not been calculated, but is also likely to be considerable.

### **c. The link between discrimination and patient care**

Dawson and colleagues (Dawson J. 2009), were commissioned by the Department of Health to research the links between staff treatment and clinical outcomes, in particular to consider whether staff satisfaction and patient experience were linked, using the NHS staff and patients surveys to identify possible pairs of variables. They found that

*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. This was calculated as a proportion of staff from a black or minority ethnic (BME) background who reported they had experienced discrimination at work in the previous 12 months on the basis of their ethnic background, so was not simply a result of the number of BME staff within trusts.*

*It must be noted here that this research cannot draw conclusions on the reasons behind the correlations observed.*

The researchers also concluded that

*... the bullying, harassment and abuse of staff is generally related to poor patient experience*

Dawson J. 2009.

Michael West and colleagues found similar links:

*There is also a clear link between discrimination, and aggression 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:*
  - o doctors and nurses talked in front of them as if they weren't there*
  - o they were not as involved as they wanted to be in decisions about their care and treatment*
  - o they could not find someone on the hospital staff to talk to about their worries and fears*
  - o they were not treated with respect and dignity while in hospital*

They further noted that:

*"the experience of BME staff is a very good barometer of the climate of respect and care for all within NHS trusts."*

Michael West and colleagues concluded that:

*Research suggests that the experience of black and minority ethnic (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.*

*NHS Staff Management and Health Service Quality Results  
from the NHS Staff Survey and Related Data West, M et al,(2012)*

The NHS National Staff Survey 2013 indicated some ways in which discrimination might be affecting morale and thus patient care.

**Table 21. NHS national staff survey summary (extract on treatment)**

	2009		2010		2011		2012		2013	
Key finding	W %	BME %	W %	BME %	W %	BME %	W%	BME %	W%	BME %
Key Finding 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	19	17	13	14	13	13	29	31	28	29
Key Finding 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	16	20	14	16	13	20	22	27	21	26
Key Finding 27. Percentage believing that trust provides equal opportunities for career progression or promotion	93	79	92	78	91	77	90	76	90	77
Key Finding 28. Percentage of staff experiencing discrimination at work in the last 12 months	5	14	10	23	10	23	9	27	9	25

Source: National NHS Staff Survey 2013

Note. (1) Key finding 27 and 28 were not asked prior to 2009.

(2) Key Finding 18 and 19. The question changed between in 2012

The differences in staff responses on three of the four indicators are the significant and remarkably similar over the last five surveys. They contrast with the almost identical responses to the finding on harassment, abuse and bullying by patients.



Such data does not tell the whole story; some organisations are self-evidently much better than others. On many other staff survey indicators white and BME responses were similar and on some indicators BME staff yielded more positive results than white staff – notably on more positive recommendations on their hospital as a place to work, and on the existence of well structured appraisals and communications from senior management.

The data do show that on average one quarter of the BME workforce experienced discrimination in the previous 12 months, and almost one quarter do not believe their employer provides equal opportunities for career progression or promotion that is a very serious challenge. Moreover the disparity between white and BME staff is consistent across the five year period.

#### **d. The link between discrimination in recruitment and innovation.**

Research suggests that diversity in teams at every level of an organisation may better enable innovation and improve performance. Reviews of the evidence indicate that greater gender and race diversity at board level is positively associated with greater innovation (Bennington, L. 2010).

Two decades ago, Cox & Blake demonstrated that diversity enables organisations to draw on a larger pool of talent, increases their capacity to innovate and better satisfy customer needs (Cox, T. H., & Blake, S. (1991).

A recent study found that 'high performing' healthcare organisations were more likely than 'low performing' organisations to have a board with at least 50% female membership (Chambers, N., Pryce, A., Li, Y. & Poljsak, P. (2011). Research suggests that boards featuring a higher proportion of women may perform more effectively: identified benefits include better decision making, sensitivity to other perspectives, greater transparency, and more efficient governance processes (Alimo-Metcalfe, B. (2012).

Nicholas van der Walt and Coral Ingley (July 2003) concluded that diversity was good for organisational performance.

Health care teams are generally more innovative when they have a more diverse set of backgrounds represented (Fay, D., Borrill, C.S., Amir, Z., Haward, R., & West, M. A. 2006). At a time when the NHS faces resources constraints, it is important to utilise the

knowledge that members of ethnic minorities have of innovations that have happened in places such as India, for example in the use of IT in health services. Most recently, Sylvia Ann Hewlett, Melinda Marshall, and Laura Sherbin (2013) summarise their research:

*“(It) provides compelling evidence that diversity unlocks innovation and drives market growth—a finding that should intensify efforts to ensure that executive ranks both embody and embrace the power of differences.*

*In this research, which rests on a nationally representative survey of 1,800 professionals, 40 case studies, and numerous focus groups and interviews, we scrutinized two kinds of diversity: inherent and acquired. Inherent diversity involves traits you are born with, such as gender, ethnicity, and sexual orientation. Acquired diversity involves traits you gain from experience....: We refer to companies whose leaders exhibit at least three inherent and three acquired diversity traits as having two-dimensional (2-D) diversity.*

*By correlating diversity in leadership with market outcomes as reported by respondents, we learned that companies with 2-D diversity out-innovate and out-perform others. Employees at these companies are 45% likelier to report that their firm’s market share grew over the previous year and 70% likelier to report that the firm captured a new market.*

*2-D diversity unlocks innovation by creating an environment where “outside the box” ideas are heard. When minorities form a critical mass and leaders value differences, all employees can find senior people to go to bat for compelling ideas and can persuade those in charge of budgets to deploy resources to develop those ideas. Leaders who give diverse voices equal airtime are nearly twice as likely as others to unleash value-driving insights, and employees in a “speak up” culture are 3.5 times as likely to contribute their full innovative potential.*

Such research is not yet conclusive. But it supports the business case for NHS Boards to take steps to not only ensure their composition is diverse, but to consider to what extent, if at all, Board members as a whole have “acquired diversity”.

NHS Trust Boards have a particular responsibility to build on this evidence base since the expected organisational growth associated with growing diversity does not always occur; in some cases, organisations fail to “leverage” diversity and build on its potential benefits (Kochan, T. Bezrukova, K., Ely, R., Jackson, S., Joshi, A., Jehn, K. A., Thomas, D. (2003). Whilst diversity can lead to improved performance and reduced turnover

(Gilbert, J. A., Stead, B. A., & Ivancevich, J. M. (1999), it may only do so if effective diversity management is in place (Avery, D. R., & McKay, P. F. (2010).

There is ample empirical evidence supporting the suggestion that a diversity climate or culture leads to positive work outcomes, such as improved performance, decreased absenteeism and greater customer satisfaction (McKay *et al.* 2008). Recent work suggests that the ethnic representativeness of a workforce has an influence on the perceptions of service receivers and in turn upon organizational performance (King, E. B., Dawson, J. F., West, M. A., Gilrane, V. L., Peddie, C. I., & Bastin, L. (2011).

**e. Unrepresentative Trust Boards may be less likely to focus on the needs of local communities**

*We know that diverse teams make better and safer decisions and there is a large body of evidence to support this. And yet we know that senior teams in NHS organisations are under representative of the communities they serve and staff they lead. This is something that must change.*

(Jan Sobieraj, 2012)

NHS Guidance on Board selection processes argues that recruitment that takes proper account of equality considerations:

- *Creates a Board with shared values; and with an understanding and commitment about the role and importance of Equality, Diversity and Inclusion in commissioning and providing positive health outcomes, excellent patient experience for all and in working to reduce health inequalities.*
- *Ensures that right from the start Equality, Diversity and Inclusion is built into the way of thinking and decision making with regards to the business of Board.*
- *Places Equality, Diversity and Inclusion as a core value at the heart of the business of the Board.*
- *Ensures the Board is equipped to address the business of reducing health inequalities and improving health outcomes for all patients, leading to improved quality and cost effective service delivery*

NHS Leadership Academy 2012.

Unfortunately, many Trust Boards are some way from giving proper consideration to equality, both in their workforce and in their service delivery strategies. In respect of their workforce, remarkably few of the Trust diversity reports examined in researching *Discrimination by Appointment* (2013) acknowledged serious challenges in recruitment, promotion or discipline, let alone identified strategies to tackle them. In respect of service provision, extensive research concluded that:

*...there is ambivalence at national and local level regarding the importance of addressing ethnic inequality. This is reflected in its marginalisation from other key policy priorities, the limited resources allocated, and the lack of performance monitoring.*

Salway S et al (2013)

Salway et al conclude elsewhere:

*Though patterns of ill-health are complex, people from Black and Minority Ethnic (BME) backgrounds have poorer health outcomes than the White British majority across a range of indicators. For example, people identifying themselves as Pakistani, Bangladeshi and Indian have much higher risk of diabetes than the general population.*

*A variety of factors contribute to poor health among BME people. In particular, people in minority communities are more likely to live in poverty than the White British majority.*

*Access to high quality, appropriate preventive and curative health services should have the potential to ameliorate inequalities in health outcomes. However, people from BME backgrounds generally have a poorer patient experience than White British patients, and may be actively or passively discriminated against in the health system. Health services may not be provided in an appropriate language, services can be inappropriate or insensitive to minority needs, and health workers may treat BME patients poorly.*

Salway, Sarah, Allmark, P and Tod, A (2009)

Guidance on commissioning to reduce inequalities notes that local need is an essential factor to be aware of. (Dr Foster Intelligence. 2009).

## **Patient survey evidence**

The Healthcare Commission (2008) provided extensive evidence that the health service experiences of black and ethnic minority patients are frequently worse than those of white British patients, something confirmed by both GP and Hospital Patient surveys. GP Patient Survey results in 2012/13 show variation by ethnicity in patient confidence and trust in their GP: British (67%), compared with Chinese (42%), and Bangladeshi (52%). This variance by ethnicity was replicated in the same survey in terms of the percentage of patients who would definitely recommend their GP surgery to someone else: White British (51%), compared with Chinese (30%), and Pakistani (34%). Evidence from the 2012 Adult Inpatient Patient Survey shows that the overall patient satisfaction score varies significantly by ethnicity. White British had an overall score of 76.7 whilst six of the black and minority ethnic groups had significantly lower scores.

## **Some examples of the relevance of equality to service provision.**

### **i. Sickle cell**

The National Confidential Enquiry into Patient Outcome and Death. (A Sickle Crisis? 2008) reported that the serious health needs of 12,000 people with sickle cell disease in the UK are being neglected by the NHS because not enough is known about the condition or its treatment.

Notwithstanding that warning, five years later a major peer review of services for patients with sickle cell disease and thalassaemia in England found that just a fifth had adequate numbers of staff with the right skills.

*"The review by the West Midlands Quality Review Service looked at 34 services across England. Many patients described being made to feel like "second class" patients as they regularly lost out on beds on specialist wards to patients with white blood cell disorders such as leukaemia. Elaine Miller, national co-coordinator at the UK Thalassaemia Society, told HSJ red cell haematology was the "poor relation" to white cell haematology. She said: "If these conditions affected the white mainstream population rather than ethnic minority communities, maybe they wouldn't be so badly overlooked." Sickle Cell Society chief executive John James told HSJ race definitely had "a role to play" in the variability of services and the fact they appeared to be "neglected", even in high prevalence areas.*

*About 80 per cent of sickle cell patients are in London. However, the review found the makeup of teams in the capital was “extremely variable.” The review also found many emergency departments were not following National Institute for Health and Clinical Excellence guidelines on sickle cell crises, meaning patients were often left in agony awaiting pain relief.*

(Calkin. S. 2013)

## **ii. Mental health services**

In 2006, Ministers acknowledged that *“Black and minority ethnic mental health service users [were] being discriminated against in ways that [were] unethical and unlawful”*.

*In a letter to strategic health authority chief executives, Rosie Winterton said: ‘The quality of mental healthcare for BME communities in England is not acceptable. To be blunt, services are discriminating in a way that is arguably both unethical and unlawful. Communities feel alienated from NHS services and many are deeply mistrustful of them.’ A further letter from commissioning director Duncan Selbie and national mental health director Professor Louis Appleby slams SHAs for failing to oversee the recruitment of enough community development workers. Primary care trusts were supposed to have recruited 500 CDWs by December 2006. The roles are meant to improve relations between BME communities and services and improve access to care.*

(Emma Dent 2006)

Six years later an NHS Confederation report on mental health services and race equality concluded that:

*national teams and local services, together with service users and carers, had exerted significant effort in attempting to make improvements. However, that effort has not resulted in significant change overall in terms of measurable outcomes.*

(NHS Confederation. 2012)

### iii. Maternity

The Public Accounts Committee recently concluded that

*The NHS has failed to address persistent inequalities in maternity care. The NHS has had a specific objective to promote public health with a focus on reducing inequalities in maternity care since 2007. However, the latest available data (from 2010) on women's experiences showed black and minority ethnic mothers were less positive about the care they received during labour and birth than white mothers. They were also significantly more likely to report shortfalls in choice and continuity of care. The Department intended to address inequalities through improved early access to maternity care, but data also show regional and demographic inequalities in the proportion of women receiving an antenatal appointment within 12 weeks of conception.*

Public Accounts Committee (2014)

Ethnicity is significant for both the workforce and for service provision. Bharj, K K & Salway, S (2008) explored the links between ethnicity and maternity service experiences. The discriminatory treatment of BME midwives in London was reported by the Royal College of Midwives (Lintern S 2012).

The Healthcare Commission's investigation into maternity services at Northwick Park Hospital in North West London discovered "racist behaviour" in the unit. (Batty, D 2008)

Following the maternity services scandal at Furness General Hospital, Cumbria, which is currently at the centre of a major police investigation, it was reported that, according to the hospital, research was launched into baby deaths. Though only two percent of all mothers treated at the maternity unit in 2008 came from ethnic minorities, 83 per cent of "serious untoward" cases at the unit involved ethnic minorities. (Baby deaths at Cumbria hospital maternity ward 'linked to race" (Daily Telegraph 2011).

In London, over half (57%) of the total births in 2012 were from mothers born overseas, more than double the UK average. Moreover, BME women in minority ethnic groups, especially from a socially deprived background, have higher rates of complication in pregnancy. (RCM 2014). Infant mortality in England and Wales for children born to mothers from Pakistan is double the national average.

#### **iv. Cancer**

Black people have significantly higher rates of multiple myeloma and stomach cancer than people from white ethnic groups. In the UK as in the USA, black men have higher rates of prostate cancer. Asian women have increased rates of cancers of the mouth. Black and Asian women with breast cancer have a poorer survival rate. For many other cancers there are relatively low rates amongst BME groups. There is a lower uptake of cancer screening services in BME communities. Late presentation and late diagnosis, leading to poorer cancer survival rates in BME communities, may be increased as a result of poor uptake. The incidence of some cancer types is growing exponentially in specific minority ethnic groups and the overall risk is predicted to rise as these populations age. (Thomson C, Forman D. 2009).

#### **The cost of inequality**

The Marmot Review (2010) reckoned that the healthcare costs associated with inequality were in excess of £5.5 billion per year, and that if no action was taken the cost of treating the various illnesses resulting from inequality would increase significantly. One London NHS Trust has attempted to estimate the cost of not being a good equality employer.



**Box. 1. The cost of not being an exemplary employer**

*“University College Hospital NHS Trust considered the cost of not being a good equality employer.*

*With its current reputation that discourages applicants and a working environment that means staff leave at a rate faster than those elsewhere – high turnover and recruitment difficulties would mean £1 million in lost productivity extra advertising and agency costs.*

*Legal action taken out by staff has evidence of discrimination – say 10 per year – adds £0.3 million to the trust's legal fees and compensation payments.*

*There is a direct impact on the quality of patient services when diversity is low on the agenda. Patients find services less accessible – faulty communication leads to inaccurate diagnoses and treatment plans. And as patients choose other providers, revenue drops and mistakes need rectifying, adding unnecessary costs. All this affects 5 per cent of patients - another financial blow of £2m.*

*When talented staff do not get promoted, leadership and decision making is weaker as a result. Teams which value diversity are more productive and better places to work. Lack of teamwork is inefficient and increases unit labour costs, resulting in another cost of £.5 million.*

*At this trust – if it knew it would do something about it – the business case for equality and diversity would save it £3.8 million each year.*

*The trust now manages diversity as a guiding business principle, integrated into its various business units. Managing diversity is integral to business planning, of which workforce planning is a part. Above all, it is critical to the performance - revenue and quality outcomes - and viability of the trust.”NHS Employers (Undated).*

<http://www.nhsemployers.org/SharedLearning/Pages/BusinessCaseForDiversity.aspx>

## 6. The importance of data: you can't change what you don't know.

The Race Relations (Amendment) Act (2000) required NHS organisations, as public authorities, to monitor their staff by ethnicity across a range of indicators, including within recruitment processes, and to publish the resulting data in the organisation's annual report, or on its web site. NHS organisations were required to collect and analyse data relating to recruitment, divided by ethnicity, to be used to inform policy.

The Equality Act 2010 replaced that framework with a single Public Sector Equality Duty covering the 'protected characteristics' (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation), which commenced in April 2011. In England, previously detailed specific duties comprised within the race, gender and disability duties were replaced with weaker duties to set objectives and publish information.

The Public Sector Equality Duty consists of the general equality duty, which came into force in April 2011 (section 149 Equality Act 2010), and the specific duties, which came into law in September 2011 in England. Those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment, 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.

Guidance from the Equality and Human Rights Commission (EHRC 2012) states:

*"Because the general equality duty requires you to analyse the effect of your organisation's functions on all protected groups, public authorities will not be able to meet the duty unless they have enough usable information." (my emphasis)*

The evidence that Trust Boards have not taken this issue seriously is overwhelming:

- The Race Equality Service Review published by the South East Coast BME Network in 2008 reported that of the region's 24 acute trusts, mental health trusts and primary care, using the Healthcare Commission's own assessment criteria, all but nine organisations failed to collect ethnic monitoring data for patients, even though only three officially admitted to failing the related standard in self-declarations for the health check ratings. (Lyfar-Cisse, V. 2008)
- Similar shortcomings in compliance with core duties were recorded by the Healthcare Commission Race Equality Audit (2006). Healthcare Commission chief executive Anna Walker commented: "SHAs (strategic health authorities) need to ask themselves where their trusts are on race equality, as it's such an important issue." (Santry. C. 2009)
- The 2010 study on disciplinary processes commissioned by NHS Employers found that only one-fifth of all NHS Trusts published recent disciplinary data that could be included in their study. They said that "a further concern was the failure of Trusts to collect data even under the Race Relations (Amendment) Act when the requirement was specific and clear." (Archibong et al op cit)
- The Equality and Human Rights Commission survey concluded in April 2012 that approximately half of English public authorities were fulfilling the Equality Duty requirement to publish equality information on their staff and service users, although more were partially meeting this new requirement (EHRC 2012).
- Kline (2103) found considerable gaps in published information on workforce ethnicity data.

In November 2012 a report commissioned by DH reported

*"undoubtedly, the biggest impact that EDS implementation has had in this way has been to identify the gaps in equality data that NHS organisations currently collect. 76% of organisations who responded to the survey stated the EDS has had an impact in this way, and there are many examples of how organisations have begun to fill these gaps." (NHS England November 2013). This report invites the question: how did these organisations think they could commission or provide services effectively, and treat their workforce fairly, without collecting and analysing such data to inform policy?"*

The Equality Delivery System (EDS2) is presented as the means of not only addressing this shortcoming but driving wider improvements in NHS equality. It is indeed essential that Trusts and other NHS bodies collect, and analyse data, but it is unclear to what

extent EDS2 is assisting that process, because there is no central monitoring of whether Trusts are implementing EDS2 and if so, what difference it is making to race equality, if any.

The weakening of the specific requirements for collecting and analysing data on ethnicity set out in the Race Relations (Amendment) Act 2000 has, anecdotally, already led to less information on race discrimination being placed in the public domain.

Five years ago the Healthcare Commission reported

*“Compliance with the legal requirements of race equality legislation continues to be a problem, particularly when one considers that trusts (like other public bodies) should have been producing this information since 2002. This work prompted the Commission to undertake a more detailed review in a small number of trusts. All this is happening when the population is becoming increasingly ethnically diverse and when understanding the needs of this diverse population has particular significance for the commissioning and delivery of healthcare services.”*

Santry C. 2009

## 7. A discussion that needs to take place.

In recent years, the NHS has tended to shy away from honest discussion on race discrimination. With the exception of the Brighton and Sussex Hospitals NHS Trust which accepted the existence of institutional racism, there has been a serial unwillingness to confront the scale and depth of race discrimination, let alone the potential impact on service commissioning and delivery.

Remarkably few local NHS trusts acknowledge the scale of potential discrimination their own data showed and then develop credible responses. In researching Discrimination by Appointment, Kline (2013) noted the almost complete absence of good data, critically analysed leading to credible practical responses on recruitment. In Kline (2014) despite clear evidence of discrimination in pay, discipline, bullying and NHS staff surveys, the Trusts produced no acknowledgement of analysis of possible discrimination and instead published Equality Impact Assessments which repeatedly denied any disproportionate impact in the Trust's practices. Similarly, despite numerous claims that BME staff who "whistleblow" on poor clinical practice are maltreated both as whistleblowers and as BME staff, there is no published acknowledgement or analysis of the issue.

The recruitment practices of the national body NHS England, launched in April 2013, which leads the NHS and has the designated lead for NHS equality, were subject to criticism even as it was formed. Large numbers of senior managers were appointed in 2012-2013 but BME applicants were much less likely to be appointed than white applicants. According to NHS England none at all had been appointed by then. (NHS England. 2012). The HR lead for NHS England said that the ethnicity data "does not make for easy reading". (Williams, D. 21 Health Service Journal September, 2012). It certainly does not.

NHS England were warned of the potential adverse impact of the 2013 national NHS restructure on BME senior staff

*"Black and minority ethnic NHS staff risk being "significantly disadvantaged" in the transfer of employees to the health service's new structure, senior NHS Commissioning Board executives have said. NHSCB transformation director Jim Easton warned the board's July meeting yesterday of a "potential reduction in black nursing directors" in the transition.*

*“On one level it’s completely understandable,” he said. “There are fewer directors of statutory organisations by some margin, so therefore it is likely that in any particular group you mention that the numbers in absolute terms will go down.*

*“But we shouldn’t use that for false assurance. So, for example, it appears as though one of the places which have been relatively accessible for people from BME backgrounds to get director posts has been the commissioning system.....Therefore they are at risk of being significantly disadvantaged as we downsize director posts in the commissioning system. We’ll need to pay very close attention to our own process – otherwise we will be seeing, inadvertently, a loss of opportunity for people from a range of backgrounds.”*

*The comments came as the board announced it had recruited 47 very senior manager posts. During the meeting non-executive director Lord Adebowale asked human resources director Jo-Anne Wass “how are we doing” in recruiting from ethnic minority backgrounds. Ms Wass replied that she had not “cut the data just yet”. “What I’m trying to do at the moment is trying to work out how we’re going to collect it and what sort of things we should be looking for.”*

(NHS England 2012)

The wider picture is no better. The executive teams of NHS England and the three main regulators are entirely white British. With the exception of NHS England, the non executive members are entirely white. A similar pattern of overwhelmingly white senior management and Board membership exists in other national bodies.

The patterns of Board membership reflect a hierarchy in which BME staff are disproportionately employed in low numbers and in junior grades. There is no evidence that the 2013 restructure enabled organisations to increase the number of senior posts held by BME staff. Insofar as the evidence has been monitored and published it suggests the opposite. Some 193,000 staff – 16% of the NHS workforce – are from BME backgrounds. Of these staff, 19% of nurses and midwives and 37 per cent of hospital doctors are from BME backgrounds. However, only 5% of senior managers, excluding chief executives, are from BME backgrounds. In 2012, just 1% of NHS chief executives nationally came from a BME background.

In the Health Service Journal “HSJ 100” for 2013, there were only two BME leaders in the top 100 for the NHS and 27 women (HSJ 2013). The HSJ “Rising Stars” of 2014 shows a significant improvement with an almost equal gender balance and more than a

quarter coming from a BME background. It remains to be seen how these “rising stars” progress. (HSJ 2014)

In 2004 there were four BME chief executives in England. Five years ago the same number of BME chief executives in England’s NHS Trusts had not changed. The proportion of BME staff has increased over the last decade, as has the proportion of the population who are BME. The number of BME chief executive has not significantly changed.

The NHS Institute for Innovation and Improvement (2009) found some evidence of progress in four English regions with large BME communities, though they expressed reservations about the reliability of the data. Whereas in 2004 non-white managers held 5.4% of senior NHS posts, including as executive members of NHS boards and assistant directors, by 2007 the figure had risen to 8.3%. Among middle managers, the proportion of BME staff had risen from 7.3% of posts heading departments below assistant director level to 10.1% in 2007. By 2007, BME staff made up 25% of doctors at consultant level and 47% of registrars. That report concluded:

*“this suggests there may be a pool of talent of non-white staff at middle management level available to increase the population of non-white senior management, but which would appear to be hitting a glass ceiling.”*

The Institute's report, *Access of BME Staff to Senior Positions in the NHS*, suggested that it is time to move on from the moral case for diversity in NHS leaderships, and that Trusts should acknowledge the business case, recognising that a balanced board is more likely to appreciate the needs of patients and retain the loyalty of staff. It concludes:

*“If these links are not made or seen to be material, it is unlikely that much more progress will be made.”*

In 2008 almost 14 per cent of nurses were BME but only three of 400 nursing directors were black. Unfortunately the DH spokesman responded defensively, denying that the NHS was institutionally racist and claiming

*“We're reflective of society at large.....the NHS is "doing well.....the private sector is just as bad if not worse".....the DH is providing clear leadership on race equality; regulators need to give it priority too”.*

Santry, C. (2008) Why are there so few BME managers? HSJ. 3 March, 2008

Later that year, the HSJ survey of NHS trusts across England found evidence of systemic discrimination in the treatment of BME staff, (Calkin, S. 2008). These findings were similar to those of the detailed regional survey undertaken by the South East Coast BME Network survey of 24 NHS trusts in the same year (Lyfar-Cisse V 2008). The Department of Health told HSJ in response that:

*Managers will be given a target on the proportion of trust board members coming from black and minority ethnic backgrounds under plans being drawn up by the Department of Health. ....DH director for equality and human rights Surinder Sharma told HSJ the issue was being treated as a priority to make boards more representative of their local populations.*

*He said: "We're working with the Cabinet Office to set a target for a public service agreement... and looking at how they'll be set locally."*

*It would not be treated as a centrally imposed quota, he said.*

*Responding to [HSJ's survey of NHS trusts and primary care trusts](#), he said: "The figures speak for themselves. We have got some work to do but we're going down the right road and we need to work together with our BME staff and managers to find the solutions together."*

*The issue would be addressed by the new diversity and equality board being set up, which will be chaired by NHS chief executive David Nicholson. Mr Sharma said the number of BME managers had leapt by 67 per cent since 2006-07, disproving the "myth" that non-white senior managers had disproportionately lost out as a result of reconfigurations.*

Santry, C. 2008

In fact, as the HSJ report pointed out, contrary to the DH assurances, the number of BME executive directors dropped by 7 per cent, compared with 9 per cent of those who were white.

It is unclear what happened to this initiative. Moreover, whereas the Appointments Commission had a goal of enabling public Boards to achieve gender parity in new non executive appointments may have had some limited success, the equivalent drive to increase the proportion of BME non executive members of NHS Trust Boards failed. The appointment of senior BME managers and Board executives appears to be skewed as

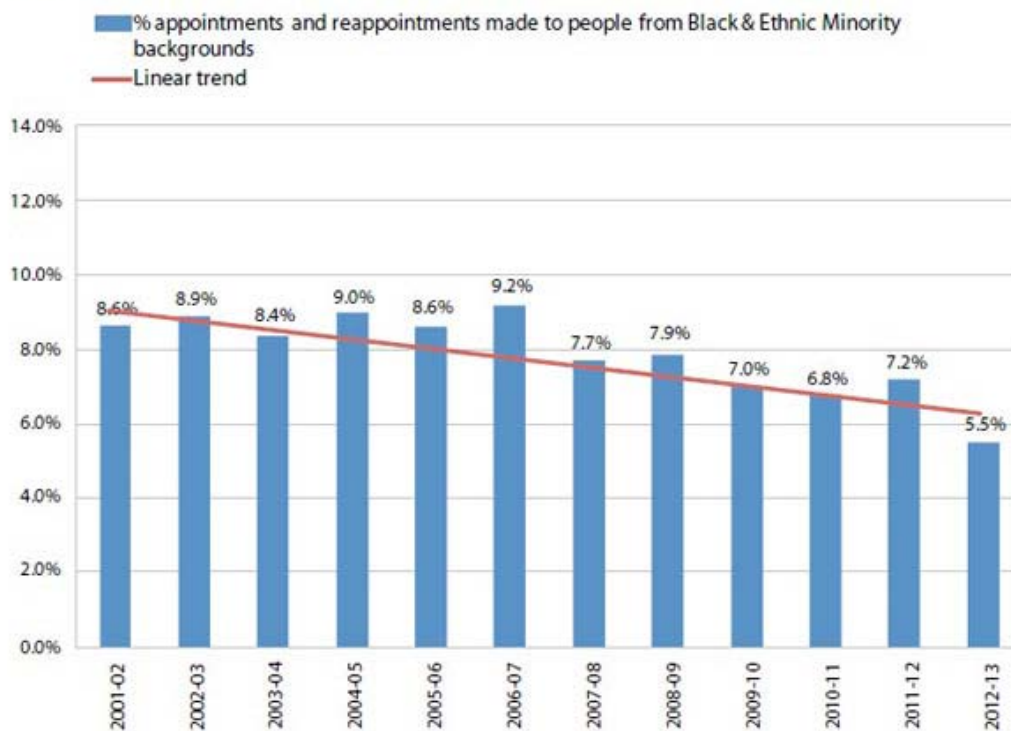


was other recruitment as reported in Kline (2013) and exemplified by NHS England's 2012-2013 recruitment of very senior managers.

CCG governing body membership is indeed better than that of NHS Trusts but that makes the absence of any analysis of NHS Trusts even more surprising. NHS England has yet to consider the ethnicity of Trust Boards, the ethnicity of senior NHS managers or that of national NHS bodies in any publicly critical manner, if at all. It has neither produced nor commissioned any strategic analysis of race discrimination in the NHS. It now appears that this is, in part, because no one in the NHS has had clear responsibility for doing so, as Appendix 1 suggests.

Developments elsewhere mirror those in the NHS. In 2012 the Appointments Commission reported that the overall make up of its appointments (not just NHS) was 3% disabled 11.7% BME and 34.2% women, no significant change over the previous year. The proportion of overall BME appointments made by the Appointments Commission declined steadily in the last decade.

**Figure 2** Black and Minority Ethnic public appointments 2001-13



Source Channel 4

The relative absence of women, and especially of black and minority representation, at Board level is not a phenomenon confined to the NHS or to the public sector. Race for Opportunity showed in its 2009 report *Race to the Top* that “our British black, Asian and minority ethnic (BAME) workers are simply not gaining the share of management or senior level jobs that their population would justify.” (Race to the Top (2008).

Earlier this year ministers bemoaned the absence of female directors in major companies (Vince Cable 2014). The proportion of women and BME directors in the FTSE 100 companies showed a similar pattern of exclusion.

### **Fig 3. Diversity in the private sector**

Amongst 289 key executives in the FTSE100 who occupy the posts of Chairman, CEO and CFO, just a dozen are women

More than half of FTSE100 companies have no non-white leaders at board level, whether executive or non-executive; and two-thirds have no full-time minority executives at board level

Women and minority leaders feature disproportionately as non-executive board directors: as a consequence their true level of influence is far smaller than their numbers suggest <http://www.green-park.co.uk/diversity/downloads/leadership-report>

Even more recently the official in charge of promoting diversity in Whitehall stated, in an echo of this report’s findings that:

*“The Civil Service has a “disgraceful” record of promoting ethnic-minority candidates into senior positions and has no strategy to improve the situation, the official in charge of promoting diversity in Whitehall has warned. In a remarkably frank admission, Sir Paul Jenkins said he felt a “strong sense of failure” at the lack of black and Asian civil servants rising to the top of their profession. And he admitted that the Government had little hope of achieving its aspiration of creating a Civil Service that was even close to being representative of the people it served.*

*“[The] figures are quite frankly disgraceful, and we are struggling to make any improvement at all,” he said. “I remain profoundly depressed about that, and I feel quite a strong sense of failure... We have not got a strategy. It [has] stalled, and it’s now getting worse.”*

*He said while progress had been made in promoting more women to the top of the civil service the same progress had not been made with ethnic minority candidates or people with a disability."*

(Wright, O. 2014)

There is little evidence that the NHS currently recognises the scale of the challenge. Indeed, the recent ministerial response to scrutiny about BME nurse managers data (see above) suggests it is arguably more defensive and vague about its response than it was a decade ago.

## Conclusion

A decade ago the NHS was told that it had consistently failed to implement the minimum employment standards required for compliance with the 1976 and 2000 Race Relations (Amendment) Act. (Commission for Racial Equality 2004.) Even after the Commission for Racial Equality (CRE) published good practice guidelines for employers (CRE 1984); NHS organisations have not implemented them. Reports commissioned by the Department of Health (Alexander Z (1999) described a lack of senior management commitment to race equality issues, and a corresponding view amongst the BME NHS workforce that the NHS does not fully value their contribution.

The Race Equality Action Plan (DH 2004) programme has withered on the vine:

- “Mentoring: Senior leaders to show their commitment by offering personal mentorship to a member of staff from an ethnic minority - All senior leaders in DH and NHS.” No one now has any idea how many staff are receiving such mentoring. The Chief Nursing Officer has just launched a new scheme but there is no requirement on Trusts to run such schemes
- “Leadership Action: Senior leaders to include a personal 'stretch' target on race equality in their 2004/5 objectives - NHS Chairs and CEs; DH Board members. “ No one now knows how many Trusts are still producing such targets – probably no more than a handful.
- “Expansion of training, development and career opportunities” The most important national programme, *Breaking through*, has been abandoned entirely, without any risk assessment of the consequences.
- “Systematic tracking. Build systematic processes for tracking the career progression of staff from ethnic minorities including local and national versions of the NHS Leaders scheme - All senior leaders and NHS Leadership Centre.” These no longer exist.

The Regulatory Impact Assessment for the Public Sector Equality Duty on the NHS Equality Delivery System (2013) concluded:

*Not all NHS organisations take a systematic approach to identifying who is using their services and who may need to use their services. This results in services that*

*may appear to be fully utilised, but not by all the patients that might need to use them, which can cause some protected characteristic groups to experience differential health care that may lead to health inequalities. Health inequalities can be addressed by providing quality prevention services and better-targeted public health promotions, such as smoking cessation, screening programmes, cardiac rehabilitation, and self-management of diabetes. Some people with protected characteristics need extra resources to enable them to access or use prevention and other services, so that they do not add to the productivity challenge.*

More recently, Salway et al (2013) considered the role of both commissioners (previously PCTs) and providers trusts in the planning of services and concluded:

*Despite the rhetoric of strategic and transformational commissioning, and significant investment in commissioning skills over the past few years (particularly under the banner of World Class Commissioning, DH, 2007), it is widely recognised that structural factors (particularly the power imbalance between PCTs and large provider Foundation Trusts and the momentum of historical contracts) severely constrain commissioners' room for manoeuvre (Smith et al., 2010; Checkland et al., 2012). This means that the bulk of expenditure by Primary Care Trusts continues to be straightforward or passive 'purchasing' - that is, simply buying what is on offer (Woodin, 2006; Smith et al., 2006).....most healthcare commissioners do not view identifying, understanding and tackling ethnic inequalities in healthcare access, experience and outcomes as part-and-parcel of their job. It found that organisational cultures did not penalise or reward (in) attention to ethnic inequality.*

*Strong leadership, a diverse workforce, effective partnership working, meaningful engagement of local black and minority ethnic communities, and a reflective, learning culture, could help to create more enabling strategic environments*

This conclusion – that the provider trusts decisively influence what is commissioned – underlines the importance of ensuring that provider trusts (those considered in this report) engage competently and seriously with equality.

The NHS Confederation (the employers) agree on the importance of diversity.

*A diverse workforce is well placed to build trust and confidence with service users, showing inclusiveness. This will help organisations to understand the local community and aid the delivery of outstanding patient care. It is vital to embed a culture of respect in NHS organisations, where colleagues, patients and visitors*

*are respected and valued for their diversity. This will show that the NHS is personal, fair and diverse, where everyone counts.*

NHS Confederation (2011)

The Darzi Next Stage Review (DH, 2008) sought to ensure services were designed around the characteristics and needs of the patients they serve, providing care that is 'personal, effective and safe'. In London, that would presumably have included taking proper account of poverty and ethnicity and associated health conditions and characteristics of patients in the light of the qualitative and quantitative evidence that black and minority ethnic patients frequently have poorer service experiences than others. In fact, the EEiC project (2011) found that

*quality and equality were worlds apart in the PCTs studied. Quality indicators were not regularly broken down by ethnic group and CQUINS were rarely defined in terms of gains for minority ethnic patients. The quality assurance documents that were reviewed made no reference to equalities issues. Further, while guidance on the Department of Health's newly adopted Equality Delivery System (EDS) alerts managers to the alignment between the equality objectives and quality and safety standards (DH, 2012), this appears to be an afterthought....., commissioners exploring efficiency issues overlooked the relevance of ethnic diversity and inequality and tended to assume that giving attention to ethnicity would add cost and complexity, rather than that such consideration might improve their understanding of the issues and increase the potential for finding effective, efficient solutions.*

None of this establishes a conclusive link between the lack of diversity in Trust Boards and the poor commissioning and provision of services to particular communities or types of patients. However, given that the evidence does strongly suggest that the treatment of the BME workforce and the lack of diversity at Board level are closely related to service provision and innovation, one would expect greater attention to be paid to Board composition and the treatment of the BME workforce in particular. Our data suggests that there has been little or no progress at all in the most senior levels of London's NHS in recent years.

Both Aneez Esmail et al (2007) and the NHS Institute for Innovation and Improvement (2009) argued that two types of interventions were needed if there was to be a step change in the diversity of leadership in the NHS – programmes to support individuals and changes to organisational culture to include the accepting and embracing of difference.

*The barriers to career progression for BME staff in the NHS are well documented and are similar to those for other private and public sector organisations. One of the core barriers to the lack of representation of black and ethnic minorities in senior leadership positions is stereotyping and the preconceptions of others.*

*Mentoring schemes and leadership development programmes such as the Breaking Through run by the National Institute of Innovation and Improvement are part of the attempts by the NHS to challenge the stereotypes and preconceptions about BME staff, but are insufficient to tackle this widespread problem that permeates all parts of the NHS. Cultural changes, which include challenging traditional leadership models and embracing diversity management, are essential if progress is going to be made in this area.*

NHS Institute for Innovation and Improvement (2009)

Yvonne Coghill, who led the Breaking Through programme agrees:

*Years of strategies, ideas and initiatives have not been effective in resolving the problem of underrepresentation. Most initiatives have focused on supporting leaders from BME backgrounds to “fit in” and be more like the leaders already in senior positions.*

*These well meaning initiatives have not fully understood the complexities of race and inequality. Inequities are embedded in our cultures and systems; and attitudes and behaviours are the consequence of beliefs about certain groups. Models, tools and processes cannot change how people perceive each other. Something more radical is needed.*

Yvonne Coghill (2013)

Esmail et al (2007) undertook a rapid evidence review which identified the following organisational barriers as typically being reasons why there is a lack of senior level diversity:

- Racially biased recruitment and selection practices particularly at times of merger or restructuring.
- Undervaluing of relevant experience and overseas qualifications.
- Tokenism.

- Circumventing of established procedures when appointing part-time staff or covering maternity leave.
- Rewards: some evidence suggested that the allocation of excellence awards is discriminatory against BME groups and women.
- Institutional culture seen in individual/group behaviour, formal and informal networks.

In addition, the following individual barriers were identified:

- Lack of mentors/role models.
- Exclusion from informal networks and communication.
- Stereotyping and preconception of roles and abilities.
- Lack of significant line management experience/challenging assignments.

They suggest

*Models of diversity management that have gained widespread recognition in the private sector are only in their embryonic form in the NHS. Diversity management requires an organisational change in culture that goes beyond just an acceptance of the need to increase the representation of black and ethnic minorities in leadership positions. First and foremost, it requires a change of leadership style.*

### **Confusion**

In the course of this research we sought to clarify who was responsible for what, and how, in respect of tackling workforce race inequality. Responses to Freedom of Information questions to both NHS England and the Department of Health suggested that there was deep confusion at the heart of the NHS about who was responsible for helping ensure workforce race equality was taken seriously. Neither were able to provide evidence of a coherent strategy beyond encouraging NHS Trusts and other employers to monitor their workforce, analyse deficiencies and act to encourage equality. Responsibility is placed firmly within individual employers with no performance management or even national monitoring in place to track systemic progress or otherwise. (Kline 2014)

### **Denial**

The national Healthy Board 2013 guidance from the NHS Leadership Academy asserts the necessity of a more diverse leadership within Trusts and provides evidence to underpin that assertion. Yet, as Alastair McClellan recently pointed out



*there is little evidence of any sense of urgency or priority attached to this issue in strategic policy at NHS England, Monitor or the NHS Trust Development Agency. Indeed there is almost no discussion at national level about ethnicity of the workforce and indeed it is unclear precisely who has the responsibility for helping to transform the “snowy peaks” of the NHS despite the clear evidence that this would benefit patients. But despite the significant record of BME leaders within the NHS, nervousness is the abiding emotion when exploring why, in former chief executive Sir Nigel Crisp’s redolent phrase, the service’s upper echelons are dominated by “snowy peaks”.*

*Any group of leaders will tend to recruit in their own image, meaning those who do not fit that image will struggle for a peer group and support. But the “snowy peaks”*

McLellan, A (2013)

It is hard not to conclude that in some quarters there is an element of denial that there is a problem. In a similar vein the NHS Institute for Innovation and Improvement (2009) noted:

*Further, whilst the Department of Health’s Annual Report 2006 stated that ‘NHS organisations have generally made considerable progress in addressing race equality’, a formal investigation by the Commission for Racial Equality (January 2007) concluded that the Department of Health did not have ‘due regard’ to the Race Equality Duty in the way in which it developed policies. This review consequently indicates a lack of consistency in the way that the Department of Health, Healthcare Commission and Commission for Race Equality view race equality.*

At a local level, the concerns were exemplified by the response of one Trust when recently challenged about disproportionate disciplinary action against BME staff. It stated that “there was no indication that managers focused more on BME staff, and that its data was broadly in line with national figures, citing a report from NHS Employers in 2010”. (BBC News 18<sup>th</sup> March 2014). It does seem a curious response to an allegation of discrimination to say that the Trust in question is no worse than a questionable national average of discrimination.

Earl Howe’s explanation to the House of Lords in February 2014 (see above) presenting retreat on BME representation in nurse leadership as progress encapsulates a decade of denial. In his final interview before retirement as outgoing England NHS chief executive,

Sir David Nicholson said he “said he regrets not making more progress in increasing the number of black and minority ethnic senior NHS leaders,” that senior NHS management was “too monocultural”, and described the barriers to improvement as a “systemic problem”. (West, D 2014)

At a time when there is a more widespread acceptance that a more transformational rather than transactional leadership style is needed (Alimo Metcalf 2012)) and when the Francis (2013), Keogh (2013) and Berwick (2013) reports have all highlighted the shortcoming of a culture that fails to value staff, it is surely time to urgently and decisively address the widespread, deep-rooted, systemic and largely unchanging discrimination that black and minority ethnic staff within the NHS face. The evidence is now clear that their treatment is a good predictor of the quality of patient care.

There can be no better time to change, once and for all, the “snowy white peaks” of the NHS.

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## **Appendix 1. The FOI and follow up letter**

### **a. December 2013.**

*Dear sir or madam*

*FOI request*

*Please provide me with an analysis of voting Board members of your Trust analysed **by ethnicity** for each of*

- 1. Chair*
- 2. Chief executive*
- 3. Executive board members*
- 4. Non executive board members*

*Please provide the information by email to this email address*

*I look forward to your response within the statutory time limit.*

*Many thanks*

### **b. January 2014 to those Trusts who had failed or refused to provide data.**

*Dear sir or madam*

*It may be helpful if I clarify my request in response to your refusal to provide the data requested.*

*My request specifically does not ask for names. I am only interested in anonymised data and will be satisfied if you provide sufficient data that would ensure that individuals cannot be identified, or alternatively explain in writing why this cannot be achieved.*

*In the absence of a response I need to place the trust on notice that, if you do not respond further, or if you respond with a disclosure so anonymised as to be useless, then a referral to the Information Commissioner's Office will follow.*

*In the light of this can I ask you to reconsider your decision? If you are unable or unwilling to do so please regard this letter as a formal notice of appeal and please forward it to the appropriate trust officer.*

*Many thanks*

### **c. February 2014 to those Trusts who had still failed or refused to provide data.**

*Dear sir or madam*

*Any news on my FOI request? I have previously set out why, in the light of how I have phrased my FOI request, I cannot see any good reason why the DPA rights of individual Board members should override the public interest in knowing the ethnicity of the Trust Board.*

*I have sought clarity from NHS England and their view is as follows:*

*"it is our view that it is good practice for Boards to operate transparently in making such information available and publishing it in a rolling programme of data in accordance with the legal requirement to provide and publish workforce equality data from 31 January 2014.*

*"I understand, however, that a number of organisations have raised concerns about data protection act rights or privacy; concerns and I believe that these should be addressed via an aggregated ethnicity profile being published to protect individuals from the release of their individual data. With the caveat of this protection, it would seem that the public interest in transparent information being available with regard to the ethnicity of Board members is strong and paramount in this instance. "*

*In the light of this statement of policy for the NHS as a whole can I again ask that you reconsider your refusal to comply with my request and feed that into your review?*

*Many thanks*