SPECIAL REPORT

INTRODUCTION

Why a voice for staff is just a click away

The power of social media for LGBT and BME workers takes centre stage in Equality, Diversity and Human Rights Week, writes Dean Royles

I am delighted to be introducing this diversity special report ahead of NHS Equality, Diversity and Human Rights Week (12-16 May). This is the third time we have organised and showcased this event – we have a lot to be proud of and the concept goes from strength to strength.

In our first year, the focus was very much on creating a nationally driven initiative – as a demonstration of the commitment many in the NHS have to the diversity and inclusion agenda. Last year, we focused much more on the local aspects of the agenda – and the response from the service was fantastic – with hundreds of locally organised events and activities taking place during one week in May.

This year, we want to combine the national with the local and at the same time build contacts and networks which we hope will be sustained by the service and stand the test of time. The past year or so for the NHS has been monumental and the diversity agenda has not been unaffected by this. We have seen massive organisational change at a local, regional and national level, which has led to many of the previously well established networks struggling.

We have also seen the loss of a number of equality and diversity posts across the service in the last year – and the loss of some significant organisational memory as people have left the NHS. But at the same time we have seen a groundswell movement develop of support and interest in the diversity agenda. At a national level, the Equality Delivery System (EDS2) has been relaunched by NHS England, coupled with a new approach by the Equality and Diversity Council.

Regionally, the newly established leads within the NHS Leadership Academy and Health Education England among others have picked up the baton and taken on the challenges of creating a workforce that is representative of the communities they serve. And locally, many health and social care trusts have used tools like our Personal, Fair and Diverse campaign and new concepts like unconscious bias to tackle the issues of organisational culture by challenging poor and unacceptable behaviour.

All of this has been underpinned by a growing influence of social media in the way that NHS staff and NHS leaders interact and engage with each other.

We want to capture this spirit of enthusiasm this year but channel it into developing some sustainable networks, which will continue to thrive long into the future. This is why the two events that we have organised this year are themed around networks and social media. We want to help the BME and LGBT staff networks that have been affected by the changes of the last year to re-establish themselves and build a strengthened voice.

Social media gives people a worldwide voice but networks give them a local point of contact. So join us. Click and connect – think global, act local.

Dean Royles is chief executive of NHS Employers.

WORKFORCE MIX

DIVERSITY MAKES A DIFFERENCE

The drive for a diverse NHS workforce is about more than being seen to do the right thing – there’s good evidence that achieving one results in better patient care, writes Ingrid Torjesen

<table>
<thead>
<tr>
<th>BME</th>
<th>12% of England’s working population are BME</th>
<th>16% of the NHS workforce are BME</th>
<th>5% have not disclosed ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
<td>14% of England’s working population are disabled</td>
<td>2% of the NHS workforce are disabled</td>
<td>45% have not disclosed</td>
</tr>
<tr>
<td>Sexuality</td>
<td>No accurate figures exist on the sexuality of England’s working population</td>
<td>1% of the NHS workforce whose sexuality is not heterosexual</td>
<td>47% not disclosed</td>
</tr>
<tr>
<td>Gender</td>
<td>66% of England’s working population are women</td>
<td>77% of the NHS workforce are women</td>
<td></td>
</tr>
</tbody>
</table>

Those in England’s working population whose religious belief is:

- Christianity 61%
- Islam 4%
- Hinduism 1%
- Undisclosed 7%

Those in the NHS workforce whose religious belief is:

- Christianity 37%
- Islam 1%
- Hinduism 1%
- Undisclosed 48%

Data supplied by NHS Employers
In association with

NHS Employers

There is increasing evidence that there is a strong link between having a diverse NHS workforce, in which all staff members’ contributions are valued, and good patient care.

Diverse teams have been found to outperform teams in which people are more similar, both in terms of productivity and creativity. This is because diverse teams bring different skills, experience and knowledge to the table.

So how representative is the NHS in terms of the patient population it serves? Paul Deemer, head of equality, diversity and human rights at NHS Employers, says that it is generally good.

“BME representation across the workforce is about 16 per cent, which fits in with the national percentage.”

But, inevitably not every trust reflects that diversity. It’s about every one of the 500-600 organisations within the NHS striving individually to represent the community it serves.

Representation at senior levels is particularly concerning, he says. “As you go up the hierarchy that representation gets less. Certain groups, including black and minority ethnic groups and women, are not well represented at senior levels.”

Research led by Dr Jeremy Dawson at Aston University Business School in 2009 matched staff and patient survey results and found that where NHS staff experience discrimination, particularly on grounds of ethnicity, patient care suffers. More recent research by Dr Dawson, now based at Sheffield University, found that where the ethnic diversity of frontline staff is similar to that of the local population, patients report better outcomes.

The civility of staff in their dealings with patients seemed to be a crucial factor and this is greater where the ethnic mix of staff and patients are similar.

In April this year Middlesex University published Snowy White Peaks, the results of a survey of NHS trusts in London assessing trusts’ progress in the 10 years since publication by the Department of Health of The Race Equality Action Plan in 2004.

London is a city where 41 per cent of NHS staff are from BME backgrounds, compared to 45 per cent of the population at large. However, the report reveals that the proportion of London NHS trust board members who are from a BME background is just 8 per cent, and that rather than increasing the proportion is falling, because in 2006 it was 9.6 per cent.

In the same period the proportion of chief executives and chairs from a BME background has decreased from 5.3 per cent to 2.5 per cent, and today two fifths of London’s NHS trust boards do not have a single BME member (executive or non-executive) on them.

The proportion of senior and very senior managers from BME backgrounds has not increased since 2008, and has fallen slightly in the last three years. White staff in London are three times more likely than BME staff to be senior or very senior managers.

Snowy White Peaks also looked at gender and found that the proportion of women on boards is 40 per cent, and that women are especially underrepresented at chair and chief executive level. This underrepresentation at senior level is not limited to ethnicity and gender. Mr Deemer believes it also applies for sexual orientation, disability and religion, although this is more difficult to demonstrate because of a reticence among staff to disclose this sort of information.

“Around 40-50 per cent of NHS staff haven’t actually disclosed whether they have a disability or what their sexuality is,” he says.

“When it comes to the staff survey, which is anonymous, the levels of reporting of disability and sexuality are much higher and way above the figures that are given in staff monitoring,” he says. Not having evidence of the full extent of the problems makes it more difficult to try to tackle.

In 2010, The Equality Act 2010 simplified anti-discrimination law in employment by bringing together existing statutory instruments in areas such as race, gender, sexual orientation and disability equality under one act.

The challenge for organisations is to keep working on existing programmes and introducing new ones to act on the issues that data clearly highlights. Snowy White Peaks reported the problem was less the lack of data and more the lack of decent recommendations made because of it.

Mr Deemer says: “The future is going to lie in terms of the equality delivery system.”

Although the equality delivery system is not mandatory, NHS organisations are strongly encouraged to implement it. It offers a toolkit and framework for assessing how they are performing with regard to equality, diversity and human rights, how they can improve. The majority of NHS organisations are working to the equality delivery system. Mr Deemer says this is because there is “a very strong system imperative” to do so.

“More than anything, the EDS is a simple and straightforward framework that trusts can use to evidence their commitment to diversity and inclusion in a way which reads across to other parts of their organisational patient and employee engagement strategies.”

For clinical commissioning groups, an expectation that they will use it is also written into the authorisation process.

The responsibility for regulating compliance with the Equality Act falls to the Equality and Human Rights Commission, but the Care Quality Commission has strong elements of equality and diversity written into its quality standards.

“It was only a few years ago the commission used to conduct themed inspections,” says Mr Deemer. “There were race equality and disability inspections, which were both quite useful. They obviously looked at the service and they looked at the quality of care from a race or disability perspective.

“The CQC probably needs to take a more proactive role in this area and look at the other strands of equality, diversity and human rights.”

FIND OUT MORE

- NHS Equity, Diversity and Human Rights Week, 12-16 May. This will include two conference events: “Connect with Pride” on 13 May will focus on bringing together LGBT networks and is supported by Stonewall and the StandUp Foundation. “Building Meaningful Engagement” on 15 May will look at BME networks and how they can support staff.

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JAMES TAYLOR, HEAD OF POLICY AT STONEWALL

If you look at the latest NHS staff survey, the proportion of staff who are willing to declare that they are lesbian, gay or bisexual is less than 1 per cent, yet government estimates put the proportion within the population at around 5-7 per cent. So if the NHS was reflective, we would expect around 5-7 per cent.

Non-disclosure also makes it very difficult to determine the proportion of gay senior staff. Anecdotally the situation appears similar to that for BME staff: gay people are not getting the top jobs.

Why are people not disclosing their sexuality? It is because despite the Equality Act and employment protection that have been in place for the last 10 years or so, bullying and harassment at work remains a significant concern for gay people. Research conducted by YouGov for Stonewall found that one in five (19 per cent) lesbian, gay and bisexual employees have experienced verbal bullying from colleagues, customers or service users because of their sexual orientation in the last five years, and in most cases (15 per cent) it has been by a work colleague. Almost a third bullied at work have been bullied by their manager, more than half by people in their team and a quarter by people junior to them. So there is still work to do.

Gay staff who feel able to be themselves in the workplace, feel able to talk about their same-sex partner, for example, perform a lot better and are a lot more effective.

But while there is certainly room for improvement, there are many examples of good practice within the NHS from which other organisations can learn.

Stonewall runs the Workplace Equality Index, which benchmarks employers on how gay friendly they are. This year we had an NHS trust – Nottinghamshire Healthcare Foundation trust – in second position. The trust is beating some of the biggest organisations in the world in how they support their lesbian, gay and bisexual staff. The Nottinghamshire trust has a huge network group for lesbian, gay and bisexual staff. It has openly lesbian, gay and bisexual people at all levels of the organisation who act as role models and demonstrate to more junior staff, who are identifying as lesbian gay and bisexual, that you can progress in the organisation.

Around 400 employers take part in the Workplace Equality Index each year – this year there are 32 NHS organisations – and all, bar one I think, has a network group for lesbian gay and bisexual staff.

All of our Top 100 employers have a staff network group. It’s something that we strongly advocate that employers should help facilitate and put in place, because traditionally gay staff have faced discrimination and one of the most effective ways of supporting gay staff is to formally bring them together and allow them to have a voice, to influence not only the organisation but also how services are delivered.

As part of the NHS Employers Equality, Diversity and Human Rights Week, Stonewall and NHS Employers are bringing LGBT staff in the NHS together to establish a national LGBT network.

Dr Krishna Kasaraneni, Chair of the BMA’s Equality and Diversity Committee

If an NHS organisation is to be a truly representative organisation that serves the needs of the local population, it needs to reflect the population locally.

Certain groups come across barriers progressing in their careers and we need to identify the barriers and break them down. It is not going to be one single thing and it is not going to change overnight. We need a huge cultural shift in how we perceive different groups within our society and within the leadership roles of the NHS.

This is something that the British Medical Association takes seriously. We monitor the characteristics of our members, when they use our website or contact the BMA with problems by telephone to see how well we are representing our members in different groups. Are there particular problems faced by certain groups, such as women doctors in a certain part of the country, ethnic minority doctors at a particular hospital, or international medicine doctors in a certain specialty? If we pick up a trend that BME doctors in a certain hospital are always ringing for help, clearly there is an issue and we want to be able
‘There needs to be a way of mentoring women and BME doctors because we don’t want extra barriers’

to help our members through in a more pre-emptive way.

Organisations shouldn’t be reactive, they should be proactive, and I sincerely hope that other organisations take a leaf out of our book. We don’t need to wait for things to go wrong to raise a problem or concern and tackle it.

Within the BMA itself we are also looking at the make-up of our committees and leadership. We want to make sure that as an association, we represent and reflect our membership better than we have in the past.

The BMA has not been great at promoting women leaders, but we now have a work stream about mentoring women in leadership. We are also working on breaking down barriers for BME doctors. We are hoping to hold an event soon where we invite BME leaders within the NHS to share good practice.

Within the NHS there needs to be a way of mentoring women and BME doctors because we don’t want good leaders within the NHS having to face extra barriers. This is not just about their careers, it is about improving the way that the NHS is run and I think that a truly diverse leadership will go a long way to achieving that.

GAIL ADAMS, HEAD OF NURSING AT UNISON
For me the top two areas for the NHS in terms of improving representation at senior levels are gender and ethnic diversity.

There are less than a dozen female chief executives and I think there is one black chief executive in England. That is appalling and has to be addressed.

One of the challenges is about having much stronger data and working with staff to help them understand why the data is important. If you give an equality monitoring form to a member of staff and ask them to divulge their sexual orientation, their ethnicity or their faith, especially at the moment when immigration continues to be the number one story, they are apprehensive about the security of that information and the relevance.

There is a job of work to do reassuring staff about why we’re collecting it.

Two-hundred-and-ten countries of origin are represented in the NHS workforce and that’s an amazing success, but when we look at pay bands there are differences. We know that people who give their diversity background as being Asian Chinese/Japanese tend to be better represented in more senior positions and Asian Bangladeshi/Pakistani tend to be represented in lower pay grades.

Unless we’ve got accurate data we can’t explore why those things might be and we can’t put strategies in place to ensure that there are adequate career pathways to address what could be conceived as inequity, but is not necessarily evidence of inequity.

We know from the staff survey that there is a major issue with bullying and harassment, but we know this isn’t just based on ethnicity. We would like to be able to use data to be able to look at that more clearly to see if there are places or occupational groups where it’s more prevalent.

There is a perception that you are more likely be disciplined if you come from a BME background, but we don’t have hard evidence on that because not every organisation publishes equality information by disciplinary and capability procedure. Unless we collect the data, we can’t put the data in the context of general employment data to see if there is a difference. If there is a difference it doesn’t mean there is discrimination, but I want to be able to make sure that we can look at the data in a meaningful way to find the causes so we can resolve them.

At service level, collecting data on diversity and equality will not be given the same level of priority as reducing your overspend because the government doesn’t require it. Unless the equality delivery system and equality monitoring are made mandatory, certain organisations will get away with not doing it.

Cuts in administrative roles has made collecting quality data harder because they were really important at doing the number crunching and data entering. Entering accurate quality information is of vital importance at the front door to ensure that what we get out at the other end is strong.

We were starting to make steady progress towards addressing diversity and gender inequity in leadership, but the NHS reorganisation last year has decimated that. We were starting to see, in particular, more BME staff in relatively senior Agenda for Change pay bands.