Presentation to Chief Nursing Officer's Black and Minority Ethnic Advisory Group

17 March 2015

Data, dialogue and development

A vision for achieving the aims of the Workforce Race Equality Standard

Brendan Martin
bmartin@publicworld.org

Thank you for this opportunity to speak to you about Public World's vision for achieving the aims of the Workforce Race Equality Standard (WRES), which we strongly support. Ideally one of my colleagues, Grace Makonyola or Veena Vasista, would be making this presentation, as they worked with me to develop our approach and both have stronger credentials than mine on this subject. Grace is a nurse and midwife with many years experience at frontline and management level in the NHS, while Veena is the author of *Snowy Peaks -- ethnic diversity at the top*. Both are among our team working to support NHS culture change through staff involvement, but unfortunately both are currently overseas caring for sick parents.

Our approach is expressed in a document called *Race and Organisational Culture in the NHS*, which Grace, Veena and I drafted. It is very much a work in progress and we would welcome your feedback about it. In fact, our approach to culture change generally is that it requires open dialogue and staff involvement at all levels. So, of course, anything we offer is always going to be improved and enriched through experience and dialogue, and it is in that spirit that we offer our support to your efforts to improve equality and inclusion in the National Health Service.

In all our work, Public World starts from the fundamental values of equality, diversity and inclusion. There are no grounds for treating people unfairly on the basis of race, gender or any other of the 'protected characteristics'. That doesn't mean we do not accept the reality of difference -- on the contrary, we celebrate it. But diversity does not justify inequality or exclusion.

Those principles will be obvious to you but need explicit expression because, as you know only too well, the reality does not live up to those values. A couple of years ago, Public World published a report called *Discrimination by Appointment*,

Public World is an international social enterprise working to improve public services through staff involvement.

We conduct research and evaluation, and provide consultancy, training, dialogue facilitation and change management services.

Our clients have included international institutions, governmental agencies, private employers and civil society organisations, and our diverse team members have worked in more than 100 countries.

Public World
34b York Way
London N1 9AB

020 3092 4789

Twitter: @public_world

www.publicworld.org

based on research by Roger Kline, which apparently stimulated NHS England's renewed focus on racial discrimination in the NHS, which in turn has now produced the WRES.

Our report looked at data published by 30 NHS trusts of various types in various parts of England. It showed that, in all but one of those 30, there was a lower percentage of Black and Minority Ethnic (BME) appointments than of BME shortlisted applicants, and a lower percentage of shortlisted applicants than of applicants. In other words, the further a candidate got in the selection process, the less likely she or he was to be BME. We did not draw any specific conclusions about what explains those data, but we did argue that they add to other evidence suggesting a pattern of racial discrimination in the NHS.

You are probably all aware of the evidence, which includes not only our report but also research by NHS Employers and the Royal College of Nursing showing that BME staff are more likely to face disciplinary procedures and less likely to be offered training opportunities than white staff, and that BME people are vastly under-represented on NHS trust boards.

Evidence from the latest NHS staff survey shows similar patterns in some key findings.

NHS Staff Survey 2014

Some unsurprising results

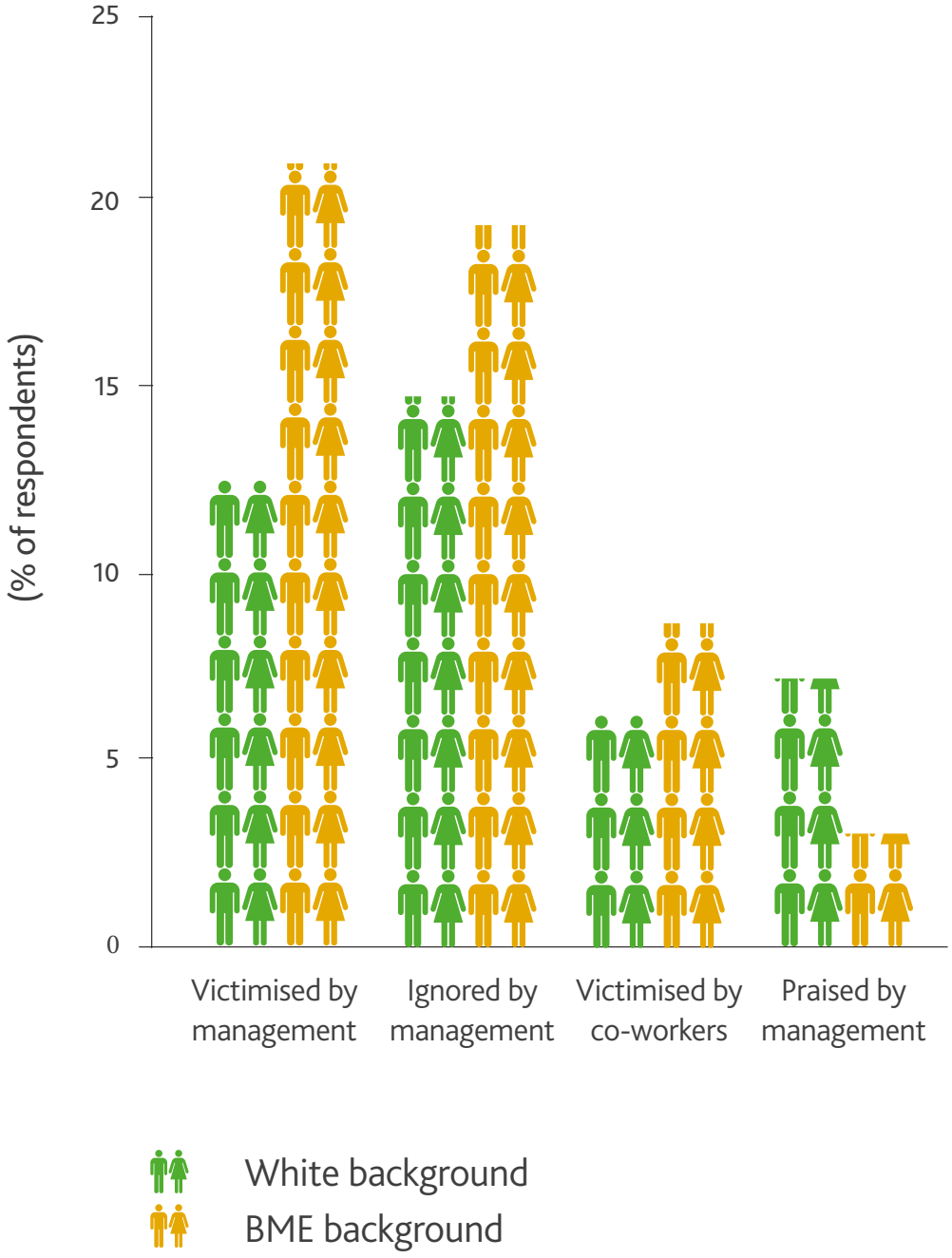
	White	BME
Key Finding 27. Percentage of staff believing that trust provides equal opportunities for career progression or promotion	***89%***	***76%***
Key Finding 28. Percentage of staff experiencing discrimination at work in the last 12 months	***9%***	***24%***
Key Finding 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	***21%***	***25%***
Key Finding 22. Percentage of staff able to contribute towards improvements at work	***71%***	***69%***

Source: NHS Staff Survey 2014

Statistics in last month's Speak Up Review, chaired by Sir Robert Francis, add a further dimension to those staff survey findings. They underline that the broad cultural challenge inhibiting many NHS staff from raising concerns about patient safety and other matters is significantly worse for BME staff. (See charts on pages 3 and 4.)

Figure 3f – Reaction of management and co-workers to BME staff raising a concern

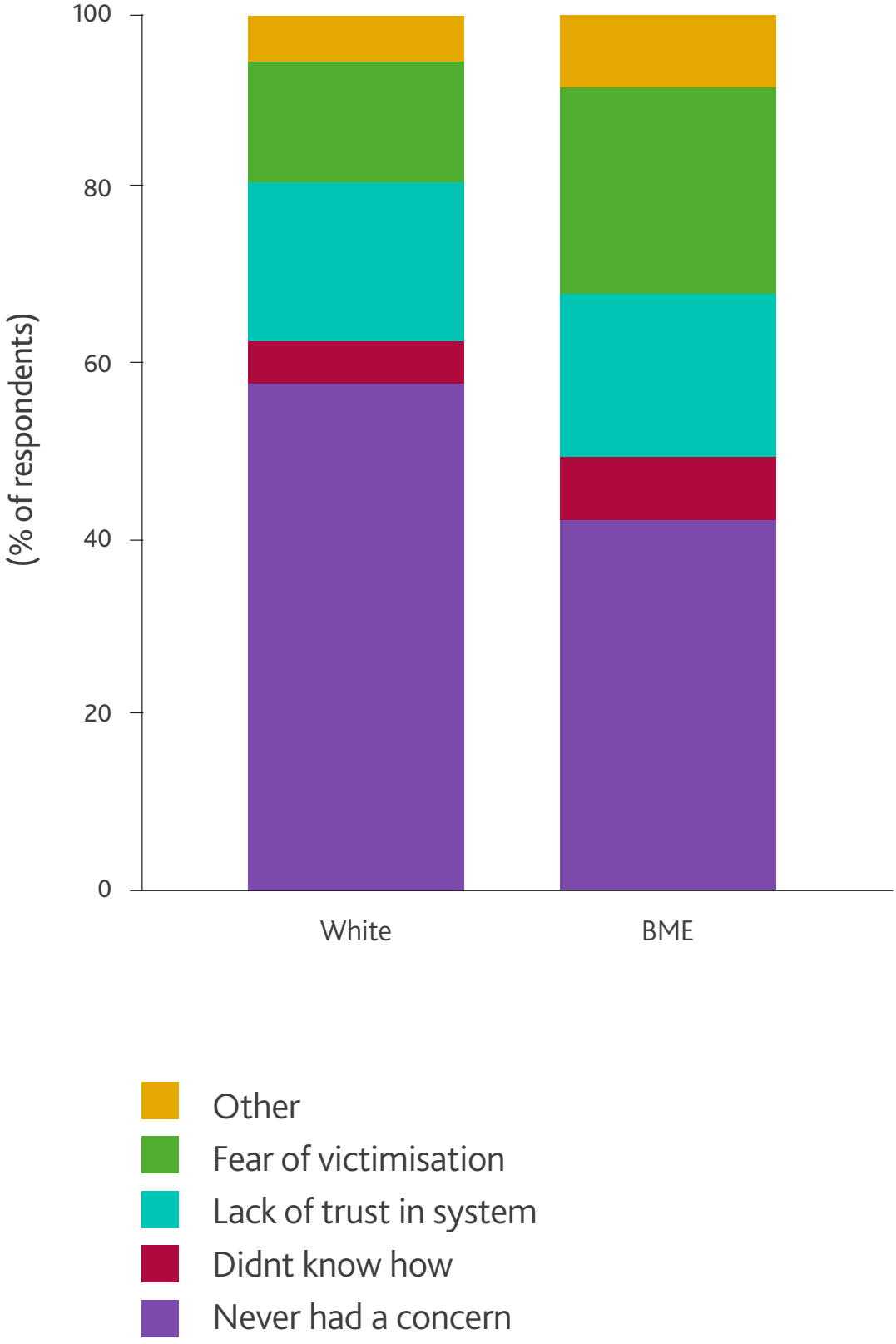
Source: Freedom to Speak Up staff survey



Source: *Freedom to Speak Up – A review of whistleblowing in the NHS*, Sir Robert Francis, QC, 11 February 2015, page 66.

Figure 3e – Reasons for not raising a concern

Source: Freedom to Speak Up staff survey



Source: *Freedom to Speak Up – A review of whistleblowing in the NHS*, Sir Robert Francis, QC, 11 February 2015, page 65.

The numbers from the Francis Speak Up Review show clearly that there is a more general challenge to be tackled, in which a large minority of all staff feel intimidated about raising concerns, and that this is significantly worse for BME staff. This underlines that we should understand NHS culture not in a monolithic way but rather as being composed of interlocking characteristics. Some of those reinforce others, but some perhaps push back against others in various ways. We can illustrate the latter point by looking at the following data from the 2014 NHS staff survey, which are less predictable than those we saw earlier.

NHS Staff Survey 2014

Some confounding results

	White	BME
Key Finding 24. Staff recommendation of the trust as a place to work or receive treatment	***3.67***	***3.86***
Key Finding 25. Staff motivation at work	***3.82***	***4.03***
Overall staff engagement score (KFs 22, 24 and 25)	***3.74***	***3.86***
Key Finding 2. Percentage of staff agreeing that their role makes a difference to patients / service users	***88%***	***92%***
Key Finding 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	***75%***	***83%***

Source: NHS Staff Survey 2014

You might think, intuitively, from the first key findings we looked at, that BME staff would be less engaged at work than white staff, on average, but the reverse is true. What explains that? What are we to make of the evidence that, although BME staff in the NHS are more likely to experience discrimination, bullying and harassment at work than white staff are, they are also more likely to recommend their trust as a place to work, and to feel more motivated and that their work makes a difference to service users and is of high quality.

I don't know the answers to those questions, but I am convinced that we should be as interested in those positive findings as we are in the negative ones, because they suggest there are cultural strengths among BME staff that can be harnessed and mobilised to challenge and change the

cultural weaknesses from which they especially suffer. This is very important from the point of view of the kind of organisational culture we need in the NHS, which -- as the Francis Reports into the Mid Staffs scandal and much other evidence has shown -- requires less command and control and more team work, staff involvement and dialogue.

These points have implications for how NHS trusts respond to the WRES itself. When he talked about it at the CNO BME conference in London in November, Simon Stevens described the standard as a 'mirror' to reflect back at trusts their own performance in relation to race equality and inclusion. In terms of that metaphor, the issue is how they respond to what they see in the mirror. If they go for cosmetic changes -- -- and we all know examples of how performance metrics can be distorted and gamed -- a great opportunity will be missed to tackle this fundamental cultural challenge. But if they truly and openly engage with their staff in a process of real change, the results could be profound in terms of tackling not only racial discrimination but also other negative aspects of NHS culture, by building on strengths to tackle weaknesses.

It was form that point of view that I wrote an article for the Guardian's Healthcare Network in January, in which I expressed strong support for the aims of the WRES but raised three concerns about the way in which it was being introduced. The article expressed those concerns as follows:

> *"1. Recent NHS history is littered with examples of unforeseen consequences of well-intentioned, centrally imposed and punitively enforced targets. Command and control has its place in emergencies but a poor track record in shaping NHS culture.*
>
> *2. The WRES indicators have been designed without deep engagement within NHS organisations. According to NHS England, "key stakeholders" have been consulted, but there was only a two-week period for feedback, with a Christmas Eve deadline.*
>
> *3. I wonder about some of the metrics, including the one that appears to have been influenced by the analysis in our own report. Employers will be required progressively to close the gap between the "relative likelihood of BME staff being recruited from shortlisting compared to that of white staff being recruited from shortlisting across all posts". Without digging into the reasons for that gap – which may or may not be intrinsic to the NHS – isn't there a danger of treating the symptoms rather than the causes?"*

I stand by the first two points, because the signals sent by national NHS leaders to local NHS leaders must be consistent with expectations about how trust leaders should behave towards their own staff. Therefore those signals must include not only the outcomes intended but also the importance of engagement and dialogue.

That is important in general, but also specifically in the context of defeating racial discrimination in particular, because that cannot be done in an administrative

* **Please note** that the text in italics to the left summarises my response at the advisory group meeting to a question raised in discussion following my presentation. I have placed it at this point in this document because that is where it seems to fit best.

way. It requires harnessing those positive aspects of NHS culture that we have seen expressed by the evidence of engagement among BME staff cited earlier and mobilising the knowledge that has come with their experience.

In relation to the third concern I raised in the article, this was not a statement but a question intended to stimulate discussion, which it has done. But there is a connection with the first two points, which is that performance measures imposed from the top without proper engagement with staff are less likely to achieve their aims. So dialogue and engagement are not only matters of general principle but also influence results, and if that is true about other areas of NHS culture it is also true about the challenge of ending racial discrimination.

The importance of analysing evidence and being open to having our assumptions challenged can be illustrated also by some results from a survey we have recently analysed for the NHS Leadership Academy. The questionnaire for the survey, which was sent to all trusts in England by the Academy but with the responses sent to Public World for analysis, was aimed at gathering the same information as in our *Discrimination by Appointment* report.

We asked about the ethnic composition of trust boards and for numbers of applicants, shortlisted candidates and appointees across all Agenda for Change pay bands for the last financial year (2013-14), broken down by self-declared ethnicity. Unfortunately we received too few responses to the survey to allow statistically robust analysis beyond the trust level. (And perhaps the low response rate to a survey on this subject tells a significant story in itself.)

However, individual trust results did show the same tendency as *Discrimination by Appointment* revealed -- namely, that, particularly in some pay bands, the proportion of BME candidates being shortlisted having applied, and appointed having been shortlisted, was lower than that of white applicants, even in trusts with relatively high levels of BME board representation.

When we looked at staff survey data for the same trusts we found some more confounding and counter-intuitive evidence. The numbers showed that relatively low reported experience of discrimination, bullying and other indicators in some cases co-exist with wide differences between shortlisting and appointments of BME job applicants.

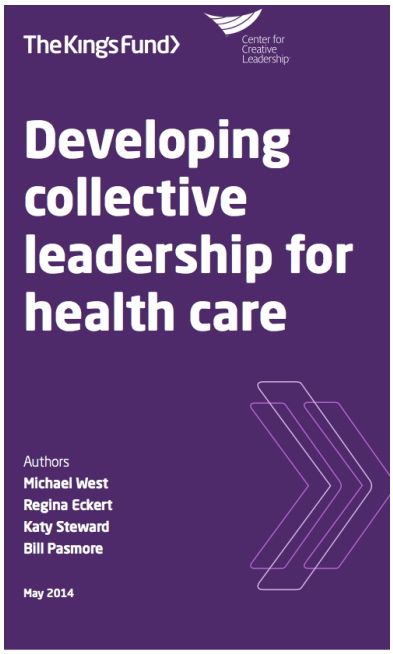
We don't know what explains these numbers and apparent contradictions between them and we don't want to speculate about it. But I am sure the trusts concerned will want to look into it, particularly as the metrics concerned are among those that will be used from 1 April to evaluate performance against the WRES. Our hope is that they will explore the issues in open dialogue with staff and their representatives with a view to developing a shared narrative of what is going on and what needs to be done about it.

The data tell a story but by no means the whole story, and suggest that while the hard numbers are important in ensuring that dialogue is well informed they are no substitute for that dialogue. They underline that it is important that we analyse, discuss and develop understanding about the dynamics at work when we see racially skewed outcomes, rather than assuming that we already understand them. In that way trusts will be able to make

much better informed judgements and decisions about the changes they need to make to procedures, training and whatever else might be affected by bias, conscious or unconscious.

In pursuing the aims of the WRES, NHS employers can learn a lot from the ideas about collective leadership expressed in a King's Fund report by Michael West et al last year.

Leadership and organisational culture



1 Key messages

- The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the emerging culture of an organisation.
- Boards are responsible for ensuring their organisation develops a coherent, effective and forward-looking collective leadership strategy for their organisation and assuring themselves that it is implemented. This strategy comes from purposefully describing the leadership culture desired for that organisation.
- Collective leadership means everyone taking responsibility for the success of the organisation as a whole – not just for their own jobs or work area. This contrasts with traditional approaches to leadership, which have focused on developing individual capability while neglecting the need for developing collective capability or embedding the development of leaders within the context of the organisation they are working in.
- Collective leadership cultures are characterised by all staff focusing on continual learning and, through this, on the improvement of patient care. It requires high levels of dialogue, debate and discussion to achieve shared understanding about quality problems and solutions.
- Leaders need to ensure that all staff adopt leadership roles in their work and take individual and collective responsibility for delivering safe, effective, high-quality and compassionate care for patients and service users. Achieving this requires careful planning, persistent commitment and a constant focus on nurturing leadership and culture.

To me, this emphasises that we need to see all staff as both leaders and followers, and that everyone in an organisation has responsibility for improving quality of service, resource use and the working lives and wellbeing of all staff. It also underlines the importance of continual learning and dialogue.

I began this presentation with a simple statement of principle: that equality is non-negotiable, diversity inevitable (thanks goodness!) and inclusion essential. I have tried to argue that the challenges involved in changing NHS culture to eliminate racial discrimination are everyone's concern and that cultures of resilience among NHS staff and of resistance by many BME staff should be seen as strong positive foundations from which the negatives can be tackled.

That is why, in the document I mentioned earlier, Public World has set out a three-pronged vision for working with NHS trusts to achieve the aims of the WRES. It starts with gathering data, including the information that trusts are supposed to collect and publish as part of the Public Sector Equality Duty, but not limited to those. We believe that in some cases it would also be effective to use network analysis, in which we have a specialist in our team, to explore what might lie behind some of the biases revealed.

The second prong is to support trusts in talking about biases, including racial biases, in purposeful ways, with careful and skilled facilitation, so that the norms, beliefs and narratives that inform behaviour, consciously or otherwise, can be better understood. These are not easy conversations, of course, since they are revealing about ourselves if we are honest participants in them, but we will not build a shared understanding of the cultural challenges we face in the

NHS without them. Public World's team of experienced facilitators are available to support this.

However, although dialogue can be valuable in itself it must also have an action-oriented purpose, which is a third prong of our approach. Through data collection and open discussion about the norms, beliefs and narratives that lie behind discriminatory behaviour we can identify changes that need to be made in recruitment and selection procedures, in access to training and promotion opportunities, and in approaches to performance management and discipline. These concrete steps are essential to ensure that data and dialogue leads to sustained development of better organisational culture with mutual respect and dignity for all at its heart.

We believe such an approach will contribute not only to defeating racial discrimination in the NHS but also to tackling more general cultural challenges, such as the high levels of bullying and harassment experienced by many in the NHS, especially but not exclusively BME staff, and the urgent need to develop organisational climates that enable all staff to raise concerns. As my colleague Veena put it in a blog post earlier this year:

> *"Let's receive the NHS Workplace Race Equality Standard as a welcome nudge to kick-start people into doing the work of rooting our creativity (ability to bring into being) and power (capacity to take action) in love (or compassion if the word 'love' makes you feel uncomfortable) and justice."*

Thank you again for this opportunity to share our vision with you. As I said earlier, we offer it in the spirit of learning together and in the hope of feedback from the frontline. I hope we can continue the conversation in the months and years ahead, and that it will lead to fruitful collaboration.

34b York Way,

London N1 9AB

admin@publicworld.org

020 3092 4789

@public_world

www.publicworld.org