June 2013

Discrimination by appointment

How black and minority ethnic applicants are disadvantaged in NHS staff recruitment

Table of Contents

Public World offers a range of services to improve service quality and working lives through user and staff involvement in design, governance and management.

Our consultants have worked all over the world with international institutions and civil society organisations, and in the British public, private and voluntary sectors.

This report is based on research by Roger Kline, and was edited by our managing director, Brendan Martin. You are welcome to download it subject to conditions of use.

www.publicworld.co.uk

34b York Way, London N1 9AB

Twitter: @public_world

1. Summary

Discrimination against black and minority ethnic (BME) staff in the UK in access to employment, in opportunities once employed, and treatment in employment, is longstanding and well evidenced. Specific statutory changes, such as the Race Relations Amendment Act 2000, and a stream of policy initiatives have sought to encourage equality in the recruitment and treatment of BME staff by the NHS.

Yet little has changed, and the time has come for the NHS to begin a serious conversation with itself about why not.

We decided to stimulate this conversation by carrying out a brief but informative survey of published selection data in 60 randomly selected NHS trusts in England. (Of those 60 trusts, it turned out that only 30 had data available in a form that enabled our analysis, and therefore the results in this report are drawn from those.)

This was prompted not only by our awareness that the problem of discriminatory selection is continuing but also by two recent developments that could make the problem less visible: the radical changes ushered in by the Health and Social Care Act 2013; and the review, also this year, of the Public Sector Equality Duty.

Ten years on from a Prime Ministerial promise of an end to discrimination in the labour market seemed an appropriate time to consider what is happening in one very large employer over which the Government has significant influence, the NHS. Moreover, there is clear evidence of correlation between the treatment of BME staff in the NHS and the experience of patient care. So this is not only an issue of access to public service jobs but also of the quality of services.

The data we gathered indicated that in the 30 trusts for which usable published data were available the likelihood of white applicants being appointed is more than three times (3.48) greater than that of BME applicants, and the likelihood of white shortlisted applicants being appointed approaches twice (1.78) that of BME applicants. These are similar likelihoods of being appointed to those identified five years ago in a survey by *Health Services Journal*.

In a separate study we also looked at the recruitment of staff to the new institution set up to run the NHS by the Health and Social Care Action, NHS England (previously NHS Commissioning Board). As NHS England has started from scratch by recruiting its management and staff mainly from other parts of the NHS, and as it has a declared goal of promoting an ethnically representative NHS workforce, we might have expected to see that goal reflected in its own selection data. However, our analysis shows that the proportion of white applicants appointed to those new positions is between four and six times (depending on grade) greater than that of BME applicants.

The results suggest little or no improvement in the overall pattern of discrimination in NHS recruitment in recent years despite numerous initiatives, with adverse implications for both NHS patients and staff.

We really do have to talk about this. We need to find out what is going on, why it is going on, and what can be done about it, so that the NHS workforce is as good as it can be and at all levels reflects the population it serves.

“The likelihood of white applicants being appointed is more than three times greater than that of BME applicants, and the likelihood of white shortlisted applicants being appointed approaches twice that of BME applicants.”

2. Background

The 1999 Macpherson Report, which looked into police failures to properly investigate the murder of London teenager Stephen Lawrence, articulated the concept of 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."

In 2003, the then Prime Minister Tony Blair (*Ethnic Minorities and the Labour Market, 2003*) asserted:

> "It is nearly 40 years since the first Race Relations Act. It is clear that racial discrimination in the labour market still persists….. in ten years' time, ethnic minority groups should no longer face disproportionate barriers to accessing and realising opportunities for achievement in the labour market."

In 2004, NHS Chief Executive Sir Nigel Crisp announced (DH, 2004)) that the NHS and Department of Health would:

- pay greater attention to meeting the service needs of people from ethnic minorities, "to help them to meet the standards both for improved services and health outcomes in the long term and to hit their short term targets";
- make race an important dimension of their 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."

The 2004 "Race for Health" programme was then launched which stated:

> We believe that the time for simply talking about race inequality is over. We support real change across the NHS, with the implementation of legislation as a starting point.

In 2009, delegates at a London summit for NHS leaders were warned the NHS must not allow current political uncertainties and the looming public spending squeeze to derail hard won progress towards race equality. (White, C., 2009)

The 2012 NHS staff survey reported that, although the numbers having equality and diversity training in the last 12 months increased by 7%, 8% of staff reported that they had experienced discrimination at work from other colleagues in the last twelve months, of whom half (4%) reported race discrimination.

Bullying and harassment (including that linked to a 'protected characteristic' in equality law) from colleagues and managers was reported by 24% of staff, a much higher level than that reported outside the NHS, and rising. (Part of this increase might be attributable, however, to a change in reporting criteria in the NHS staff survey.)

In 2012 there were some 193,000 staff from black and minority ethnic backgrounds in the NHS constituting some 14% of the total 1,358,295 staff in the NHS workforce. (HSCIC, 2013). Whilst a proportion of the staff reporting discrimination by ethnicity may have been BME staff reporting discrimination by other BME staff, or white staff reporting discrimination, the large majority were likely to be BME staff reporting discrimination by their employer through their manager or the organisation as a whole.

Moreover in 2012, just 1% of NHS chief executives were from a BME background whilst there was just one non-white face in the 2012 Health Service Journal list of the one hundred most influential people in healthcare.

In 2013 Putting Patients First The NHS England business plan for 2013/14 – 2015/16 stated:

- A detailed organisation development strategy is in place, which aims to deliver the following objectives:
- To attract and retain the best people, from diverse backgrounds, with values which are congruent with our vision
- To develop …..a set of clear strategies to make significant improvements in the diversity of our workforce

That strategy followed, rather than preceded, the recruitment whose outcomes are reported below.

"Within the NHS, studies over the past two decades have shown racial discrimination in pay and grading, promotion and career advancement."

3. Discrimination in the NHS

Evidence of discrimination against BME staff, job applicants and patients is nothing new. Following the Macpherson report and the subsequent Race Relations (Amendment) Act 2000, public bodies were placed under a statutory general duty to promote race equality.

Within the NHS, studies over the past two decades have shown racial discrimination in pay and grading, promotion and career advancement. (Beishon et al, 1995; Coker, 2001; Pudney and Shields, 2000).

In the light of such evidence the NHS has sought to develop initiatives such as *Positively Diverse*, *Improving Working Lives*, *Race for Health* and more recently the *Equality Delivery System (EDS) Framework*, which many NHS Trusts now use to try to improve equality for patients, carers and staff, to analyse performance, and to identify equality objectives.

When he launched the EDS, NHS chief executive Sir David Nicholson said:

> "Equality must lie at the heart of the NHS - its values, processes and behaviours - if we are to create a service that is personal, fair and diverse, that meets the needs of every patient and all staff."

Such an approach is right not only in principle but also for two reasons associated with the effect on care quality: firstly, that unless the workforce reflects the local population it is less likely to be sensitive to its needs; and secondly because of the correlation between staff satisfaction and patient experience.

The revised NHS Constitution, published this year, reminds staff and employers that staff must be treated fairly, equally and free from discrimination. The evidence suggests that in almost every aspect of employment that commitment is breached.

The impact of NHS initiatives to counter race discrimination is unclear. When the Healthcare Commission (2006) carried out a Race Equality Audit it found that only 1 per cent of NHS Trusts had fully met the requirements of the Race Relations (Amendment) Act 2000, and only 6 per cent had even met two of the three requirements. Despite this, in the same year, the Department of Health (2006) claimed that "NHS organisations have generally made considerable progress in addressing race equality".

Earlier this year, however, the National Institute for Innovation and Improvement reported:

> "Since the Breaking Through programme began in 2003 the numbers of BME staff at an executive director level or higher has not significantly increased."

The available evidence suggests, therefore, that race discrimination, at least in employment, continues in the NHS.

This report and our research does not examine appraisal, training and promotion, disciplinary data, or grading data by ethnicity. (It does refer briefly to the evidence of discrimination in disciplinary processes.) However, the available data about those issues suggests BME staff are treated less favourably than white staff in those respects.

Nor do we examine the significance of recent high profile race discrimination cases such as Elliot Browne (Furness, H.,10 January 2012) or consider the extent to which national and regional BME leadership initiatives may, or may not, have been successful (Andy Dangerfield 7 November 2012.)

Finally, no information was sought from private or voluntary sector employers whose role in the NHS is likely to grow. (It is unclear, incidentally, to what extent, notwithstanding the Public Sector Equality Duty, such employers will collate and analyse equality employment data especially if not all their employees undertake public functions.)

"The available evidence suggests, therefore, that race discrimination, at least in employment, continues in the NHS."

The scale of the challenge

The 2008 HSJ survey (Santry, C. 2008) and the South East BME Network Survey (op cit) both suggested race discrimination in recruitment remained a significant problem.

In late 2012, NHS England (then the NHS Commissioning Board) published the outcomes of its management recruitment. It is the most powerful body in the NHS whose remit includes that of promoting equality in staffing and service provision. Health Service Journal reported that the NHS Commissioning Board's Human Resources director accepted that this data "does not make for easy reading". (Williams, D. 21 September, 2012)

As Table 1 suggests, the outcomes of the NHS England management appointments and recruitment practices remained problematic.

NHS England's announcement of these figures was self-critical but it did not apparently anticipate, or seek to question in advance, recruitment processes in which the chances of a white applicant being appointed to these management positions was almost six times, or over four times (depending on grade) higher than those of a BME applicant. Indeed those ratios were not mentioned by NHS England in their public comments.

Table 1. NHS England: initial published recruitment outcomes

Senior managers			Proportion of appointees to applicants	Greater likelihood of white applicant being appointed
	Applicants	Appointed		
White	64.7%	88.7%	1.37	
BME	32.1%	7.4%	0.23	
				5.95
Very senior managers				
White	81.3%	95.8%	1.18	
BME	15.2%	4.2%	0.28	
				4.21

It is worth noting that 58 per cent of NHS England employees were transferred directly from predecessor organisations by "lift and shift" or by a job matching process. A further 31 per cent were appointed by "ring fenced recruitment/ redeployment" from predecessor organisations. The remaining 11 per cent were appointed by external recruitment.(West, D. 2013). If BME staff were disproportionately excluded from recruitment it suggests that they may have been disproportionately included in the 10,000 NHS redundancies arising from the changes on April 2013, or by being transferred to lower graded posts elsewhere in the NHS.

"The group has to confront any worries about change. Some members will be more worried than others, and different members may have different worries."

4. The challenge facing the NHS on race equality in employment

In 2008 Health Service Journal surveyed every NHS Trust in England and concluded:

> "The bleak plight of black and minority ethnic staff across the NHS has been exposed in an exclusive HSJ analysis of recruitment rates, employment relations and workforce figures.
>
> The (survey) proves BME workers are grossly under-represented among senior management but disproportionately involved in disciplinaries, grievances, bullying and harassment cases and capability reviews.
>
> Responses from the 231 organisations that provided figures show BME staff make up around 16 per cent of the workforce but are involved in more than twice as many bullying and harassment cases and capability reviews."
>
> *Santry, C. 6 November, 2008*

In summary, its survey reported that BME staff made up:

- 16% of the workforce
- 8% of non-executive directors
- 5% of executive directors
- 34% of capability reviews
- 44% of bullying and harassment cases
- 31% of grievances
- 29% of disciplinaries

It also found that BME staff constituted 39 % of applicants for jobs, 24% of those shortlisted and 17% of those appointed.

More recent NHS surveys have shown similar patterns. Concerns were expressed by a group of NHS human resources managers who were members of NHS Employers' Equality and Diversity Core Reference Group (CRG) about perceived disproportionate representation of BME staff involved in their Trust disciplinary proceedings.

This led to research funded by the NHS Institute for Innovation and Improvement, with NHS Employers supporting the implementation of the research plan and facilitating access. The research published in 2010 showed that "overall, BME staff were almost twice as likely to be disciplined in comparison (to their white counterparts)".(Archibong et al op cit).

The Race Equality Service Review published by the South East Coast BME network in 2008 found that although BME people comprise 15 per cent of the workforce in that region, they are involved in more than half the bullying and harassment cases in the region's mental health trusts and 25 per cent of disciplinary cases. (Santry, C., 2009)

When the composition of local Boards was considered by the same survey it found 3 per cent of the region's 193 executive directors and 2.5 per cent of the 160 non-executive directors were BME, although 10.5 per cent of residents were estimated to be BME.

Table 2. Application, shortlisting and appointment in HSJ survey 2008

	1	2	3	4	5
	% applicants	% shortlisted	% appointed	Ratio appointed from shortlisted (column 3/2)	Ratio appointed from application (column 3/1)
BME	39	24	17	0.71	0.44
White	61	76	83	1.09	1.36

The data from Table 2 enables us to calculate the relative chances of white and BME applicants and shortlisted applicants being appointed, and shows that white people were 3.09 more likely to be appointed having applied, and 1.56 times more likely to be appointed having been shortlisted, than BME people.

Similarly, the Race Equality Service Review published by the South East Coast BME network found that BME people account for 31 per cent of those shortlisted for acute trust jobs but only 16 per cent of those appointed. At mental health trusts only around a third of shortlisted BME candidates got jobs, while for PCTs the proportion was half.

Table 3. BME shortlisting and recruitment

Type of Trust	% BME shortlisted	% BME appointed	Likelihood of White staff being appointed compared with BME shortlisted staff
Acute	31	16	**2.34**
Mental	37	13	**3.94**
PCT	16	8	**2.19**

Race Equality Service Review South East Coast BME network, 2008

A more recent report commissioned by the NHS Institute for Innovation and Improvement (2009) reported:

> "Only 8 per cent of senior managers are from non-white backgrounds compared with 12 per cent of the working-age population. The problem is caused by "racially biased recruitment" practices, overseas qualifications being undervalued and the "institutional culture" found in the NHS, according to the report, Access of BME Staff to Senior Positions in the NHS.

> Institutional racial discrimination is blocking black and ethnic minority NHS staff from senior positions, an independent study has confirmed.”
>
> *Santry, C. 2009; Matrix Knowledge Group 2009*

In the wake of extensive evidence, (Beishon et al, 1995; Coker, 2001; Pudney and Shields, 2000) and in the light of the legislation, the NHS has sought to develop initiatives such as Positively Diverse and Improving Working Lives, and more recently the Equality Delivery System (EDS) Framework. Many NHS Trusts now use the Equality Delivery System (EDS) Framework to raise equality performance for patients, carers and staff to analyse performance and to identify equality objectives.

However, our survey of 60 randomly selected NHS Trusts in England (approximately one third of the total), which we conducted in March this year, suggests little has changed since the Health Service Journal’s more comprehensive survey in 2008.

> “Only 8 per cent of senior managers are from non-white backgrounds compared with 12 per cent of the working-age population.”

5. Our research methods and results

The research exercise we conducted in March 2013 sought to examine two aspects of potential race discrimination, both also relevant to the concurrent Government Review of the Public Sector Equality Data:

- Did the available data suggest that the NHS still has a serious problem with discrimination in recruitment?
- Did there appear to still be significant data shortcomings in respect of this aspect of discrimination?

In the NHS in England there are 162 acute trusts (including 100 foundation trusts), 58 mental health trusts (including 41 foundation trusts), 36 community trusts and 11 ambulance trusts (including 5 foundation trusts). We conducted research of a random sample of 60 of those trusts. They were identified from the results of a Google search using the term “NHS + equality + workforce”. Of the 60 identified through this method, only 30 yielded published data that could be analysed in terms of the number of white and BME applicants, shortlisted candidates and appointees to vacancies during the last three years. The other 30 were discarded because the available data were:

- less recent than 2010;
- expressed without actual numbers of percentages;
- did not include all three categories of “applicant, shortlisted, and appointed”
- did not include data from a full year (as opposed to monthly or quarterly data). (One exception for a 9 month period was made.)

Where more than one year's data were available, the most recent year's data were used. This does mean the data is not all from the same period but covers the period 2010 - March 2013. This data base would impede year on year comparisons but does not invalidate the use we have made of the data.

The data collated is summarised in Appendix 1. The data was then aggregated to produce overall average results for this sample of Trusts. Table 4 shows the aggregate of the individual Trust data.

Table 4: Aggregated data: success rates of white and BME applicants

Proportion of white shortlisted candidates appointed compared to BME shortlisted candidates appointed	**1.78**
Proportion of white applicants appointed compared to BME applicants appointed	**3.48**

The data reveal that, for the most recent year of available data of the 30 trusts whose published records we examined:

- In only one Trust was the chance of a BME applicant being appointed from shortlisting (slightly) higher than for a white member of staff
- In the remaining 29 Trusts (97% of sample) the chance of a BME applicant being shortlisted were less than those of a white applicant
- The chance of a white applicants being shortlisted varied, but on average was 3.48 times higher than for BME applicants
- The chance of a white shortlisted applicant being appointed was 1.78 times higher than that of a BME shortlisted applicant
- In all 30 Trusts (100%) BME applicants were less likely than white staff to be shortlisted
- In one Trust no shortlisted BME applicant was appointed.

> "It seems that at least part of the explanation for the findings is that racial discrimination is being practiced in some form."

6. Explanations for the findings

There might be plausible reasons other than racial discrimination to explain the findings. For example, the higher proportion of BME applicants than shortlisted candidates could be partially explained by applicants from abroad who lack either work permits or appropriate qualifications.

However, that seems unlikely to explain the entire differential and certainly cannot also apply to the remarkable finding that the chance of a white shortlisted applicant being appointed approaches twice (1.78) the chance of a BME shortlisted applicants being appointed. After all, applicants who have been shortlisted must have met the selection criteria for the post.

Therefore, it seems that at least part of the explanation for the findings – particularly since they concur with much more comprehensive research, such as the survey carried out by the Health Service Journal in 2008 -- is that racial discrimination is being practiced in some form.

We are by no means the first to arrive at such a conclusion. In 2009, the NHS Institute for Innovation and Improvement, considering the under-representation of BME staff in senior management positions, reported the findings of two earlier studies and the conclusions each had reached:

> "The problem is caused by "racially biased recruitment" practices, overseas qualifications being undervalued and the "institutional culture" found in the NHS, according to the report, Access of BME Staff to Senior Positions in the NHS. Institutional racial discrimination is blocking black and ethnic minority NHS staff from senior positions, an independent study has confirmed."
>
> *Santry, C. 2009; Matrix Knowledge Group 2009*

We have also found an internal memo by an equality officer in one NHS Trust, included in a report on workforce equal opportunities monitoring in for 2008- 2009 obtained through a Freedom of Information Act request, which stated:

> "There could be two reasons for this: firstly that they are not performing adequately at the interviewing stage; and secondly that the interviewing panel are biased in their choices and recruiting from similar backgrounds to themselves. It is therefore important for managers responsible for recruitment decisions to recognise how bias might influence their thinking."

Two patterns emerged from the individual Trust Workforce Equality reports examined in the course of our recent research. The first is denial. Some of the 60 Trusts examined made no reference at all in workforce reports to the evidence of apparent significant race discrimination in recruitment. Not a single Trust reported the actual ratio of the different chances of shortlisting and appointment of white and BME applicants. Secondly, where there was a reference to the need to consider how to improve the apparent differences in appointment success, few went on to identify specific measures to be taken.

7. Have the patterns of recruitment improved?

The most recent comprehensive data set on recruitment is that published by Health Service Journal in 2008 following a Freedom of Information request to all NHS Trusts of which 231 responses were usable.

Our research not only drew on a much smaller sample size but was also dependent on data being available on the Trust's web site. It encountered similar problems to the Archibong (2010) study commissioned by NHS Employers, in that published data

was inadequate or simply not available on the Trust web site of half the Trusts selected.

The sample of 30 Trusts that did publish usable data remains a random sample broadly representative of Trusts both geographically and by type of Trust with one exception, that none of the three ambulance Trusts among the original 60 published usable data.

Therefore, although our findings for the 30 Trusts with published usable data are robust for those Trusts, we need to be cautious about wider extrapolation. However, there is no reason to believe that the trusts whose published reports we examined have worse recruitment practices than others. Indeed, if anything, the fact that they do published usable data on this subject would tend to suggest a higher level of awareness of the issues involved. Moreover, our research yielded findings broadly similar to those of both the 2008 HSJ survey and of research undertaken by South East BME Network survey in 2008.

Table 5. Comparison of our findings with 2008 HSJ survey

	Our 2013 research	2008 survey by HSJ
Likelihood of white shortlisted applicants being appointed compared to BME shortlisted applicants	1.78	1.56
Likelihood of white applicants being appointed compared to BME applicants	3.48	3.09

It would be unsafe from this data to conclude that matters have got worse across the whole NHS, though they may have done. It is safer, given the shortcomings in data, to conclude that the patterns of discrimination are broadly the same now as then (2008).

8. Race and the NHS – the importance of data

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. This information was required to be made public in the organisation's annual report, or on its web site. Within individual NHS organisations, data relating to recruitment should have been available, analysed by ethnicity so that employers could use the trends identified to inform policy to meet their statutory requirements.

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), started to operate 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. (In May 2012, the Government announced a review of the Public Sector Equality Duty, combining a review of the General Duty with a review of the Equality Act (Specific Duties) Regulations 2011. The review arose out of the government's "Red Tape Challenge spotlight on equalities".) Those subject to the equality duty must, in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment and 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 by 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.
>
> If public authorities have not yet achieved a culture where employees or service users are ready to be asked about their sexual orientation, gender identity or religion or belief, they should take steps to engender a culture of trust in which this information could be collected. There may be other means of identifying the issues faced. Analysing national or local research and engagement with people from those groups can be useful for identifying potential issues of concern."

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. Our research suggests that the need to collate employment data analysed by ethnicity remains as important as ever. Any further weakening would undermine both the understanding of race discrimination and remedying it.

Central to meeting the continuing Public Sector Equality Data is the need to collect, analyse and act upon reliable data around the various protected characteristics. This has historically been a challenge for the NHS. 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 truts, 16 claimed to be complying with the Healthcare Commission's core requirement to challenge discrimination, promote equality and respect human rights in 2006-07.

"Our research suggests that the need to collate employment data analysed by ethnicity remains as important as ever."

But in-depth analysis carried out by the BME Network, using the Healthcare Commission's own assessment criteria, suggested the organisations were failing to do so, with all but nine organisations failing 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.

Similar shortcomings in compliance with core duties were recorded by the Healthcare Commission Race Equality Audit (2006), following which Healthcare Commission chief executive Anna Walker said: "SHAs (strategic health authorities) need to ask themselves where their trusts are on race equality, as it's such an important issue." She called for trusts to recognise problems around race equality and to systematically collect workforce data.

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 reported "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 (EHRC) survey of public authorities' implementation of the duty to publish information showed that in April 2012 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).

In November 2012 Shared Intelligence 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."
>
> *Shared Intelligence 2012*

9.Discrimination in employment and the impact on NHS services

Dawson and colleagues (Dawson J. 2009), were commissioned by the Department of Health , as part of an extensive research project exploring links between staff treatment and clinical outcomes, to explore whether staff satisfaction and patient experience were linked. They used the NHS staff and patients surveys to identify possible pairs of variables, concluding with pairs where the relationships appeared most substantial.

Though no inference about causality can be drawn from the analysis, findings included correlation between reported discrimination against staff in the workplace (as opposed to in appointment procedures) with several areas of patient experience, particularly their perceptions of nursing staff.

Moreover, if staff are being chosen, in part at least on the basis of ethnicity rather than as the best candidate for the post, that in turn seems likely to have an adverse impact on whether patients are looked after by the best available people. In addition, if recruitment procedures are flawed in respect of BME staff and applicants then similar concerns about the recruitment and treatment of other staff with protected characteristics are reasonable, and the data surely needs similar interrogation for those groups.

The conclusions of Dawson were echoed by the Healthcare Commission's conclusions in the same year:

> "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.
>
> There appears to be an uneven response across the NHS to meeting race equality duties and promoting equalities more generally. Seeking to understand why there is a patchy response is important to guide the future race equality work of the NHS. There is an absence or incompleteness of data. Although there has been a steady growth in the collection of information about ethnicity, levels of full collection of data remain low. In the last few years, there has been a growing awareness among trusts that the collection of statistics on ethnicity and other equality data is an activity that falls within their scope."
>
> *Healthcare Commission 2009*

The challenge of making progress in employment has been mirrored through recent decades by the challenge in ensuring services address the needs of ethnic minority patients and service users. The most recent report on one such initiative 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 Employers 2012*

"More of the same will not be good enough. There is a cost to the NHS in terms of talent not appointed and to patients deprived of care by that talent."

10. Conclusion

Notwithstanding a plethora of policy initiatives, the largest single Government employer appears to continue to significantly discriminate against BME staff at both shortlisting and appointment stages.

That failure extends to the lead organisation, NHS England, particularly in respect of management positions. Moreover there appears to have been a failure to make significant progress in recent years in reducing race discrimination in recruitment or even to explain its causes.

In 2003 the then Prime Minister promised:

> “In ten years’ time, ethnic minority groups should no longer face disproportionate barriers to accessing and realising opportunities for achievement in the labour market.”

This promise has not been met and indeed it seems likely that in the last half of that decade no progress at all has been made in ensuring that BME staff would have broadly equal chances in the recruitment process in the NHS.

Why does a pattern of discrimination identified many years ago, and which has been the subject of successive initiatives aimed at tackling it, remain so stubbornly deep rooted in the NHS?

What steps need to be taken at national and local levels to finally face up to and deal with the problem?

This report does not offer answers to those questions, but it does suggest that they need to be tackled by NHS trusts, in consultation with their staff. More of the same will not be good enough. There is a cost to the NHS in terms of talent not appointed and to patients deprived of care by that talent.

Appendix 1. Analysis of the data

In analysing the data on applications, shortlisting and appointments by ethnicity:

- "White" was deemed to include White British and White Irish but not Other White
- Staff whose ethnicity was not identified, though these were relatively small numbers, were not counted, which is why the percentage totals do not always reach 100%. (Curiously, undeclared ethnicity increases as a percentage in both shortlisting and appointment data, suggesting those appointed were less willing to disclose their ethnicity than those applying, or that the data was not collected.)
- The data are represented as percentages only, as not all employers provided actual numbers, and include applicants or all posts.

Table 6: Applicants, shortlisted applicants and appointment by ethnicity.

(BME numbers and ratios in shaded rows, White in unshaded rows)

1	2	3	4	5	6	7	8
Employer	*App-licants*	*Short-listed*	*Appointed*	*Appointed as % of shortlisted*	***Ratio 4/3***	*Appointed as % of applicants*	***Ratio 4/2***
Avon and Wilshire	28	9	8	0.89	**1.13**	0.28	**4.56**
2011-12	72	91	92	1.28		1.01	
Berkshire Healthcare	44	39	23	0.59	**2.01**	0.52	**2.53**
2011-11	54	60	71	1.18		1.31	
Camden and Islington	64	59	45	0.76	**2.01**	0.70	**2.24**
2012	35	39	55	1.41		1.57	
Calderdale and Huddersfield	44	28	20	0.45	**1.41**	0.71	**3.25**
2011-12	54	71	79	1.11		1.46	
Central Manchester University FT	40	28	24	0.85	**1.19**	0.60	**2.01**
2011-12	58	69	70	1.01		1.20	
Christie	38	30	23	0.77	**1.45**	0.60	**2.11**
2010 - 11	60	68	76	1.12		1.27	
Derby	38	24	18	0.75	**1.44**	0.47	**2.87**
2011	60	75	81	1.08		1.35	

Derbyshire	24	15	8.	0.53	**2.04**	0.33	**3.67**
2012 -13	76	85	92	1.08		1.21	
Hillingdon	64	55	49	0.89	**1.27**	0.76	**1.91**
2012 -13	35	45	51	1.13		1.27	
Kings College	66	60	41	0.68	**2.21**	0.62	**2.87**
2011-12	32	38	57	1.50		1.78	
Leicester Hospitals	55	47	29	0.62	**2.16**	0.53	**2.98**
2011-12	45	53	71	1.34		1.58	
Mid Yorks Hospitals	32	19	8	0.42	**2.70**	0.25	**5.41**
2011-12	68	81	92	1.36		1.35	
Norfolk County	13	11	5	0.45	**2.37**	0.28	**2.87**
2011	87	89	95	1.07		1.09	
North Yorks and York	31	22	17	0.77	**1.39**	0.55	**3.75**
2011	68	77	82	1.06		2.06	
Notts	30	11	0	-	**-**	0.30	**3.74**
2010 - 11	69	88	93	-		1.35	
Oldham	30	17	5	0.29	**3.05**	0.17	**8.00**
2010 - 11	70	83	95	1.14		1.36	
Royal Liverpool	33	16	8	0.50	**2.19**	0.24	**5.75**
2011-12	66	83	91	1.10		1.38	
Royal Free	65	57	47	0.82	**1.51**	0.72	**2.12**
2012	34	42	52	1.14		1.53	
Royal Marsden	62	38	31	0.81	**1.67**	0.50	**3.94**
2010	35	51	69	1.35		1.97	
Sheffield Childrens	31	21	13	0.62	**1.76**	0.42	**2.98**
2011 (1)	68	78	85	1.09		1.25	
S Devon Healthcare	20	9	5	0.55	**1.78**	0.25	**4.35**
2011	79	88	86	0.97		1.09	
S. Staffs and Shropshire	30	21	9	0.43	**2.68**	0.30	**4.29**
2011	70	78	90	1.15		1.29	
SW London & St Georges	74	62	35	0.93	**1.19**	0.78	**2.19**
2011-12	24	37	57	1.11		1.71	
S.Staffs & Shropshire	41	22	10	0.45	**2.59**	0.24	**6.42**
2011	59	78	91	1.67		1.54	
Stockport	39	29	18	0.62	**1.87**	0.46	**2.98**
2011-12	59	70	81	1.16		1.37	

Surrey and Borders Partnership	47	42	27	0.64	**1.97**	0.57	**2.41**
2011-12	53	58	73	1.28		1.38	
Trafford	28	16	12	0.75	**1.41**	0.42	**2.92**
2011	70	83	88	1.06		1.26	
West Herts Hospitals	70	55	57	1.04	**0.92**	0.81	**1.77**
2011	30	45	43	0.96			**1.43**
Yeovil	32	21	11	0.52	**2.17**	0.34	**3.85**
2011	68	79	89	1.13		1.31	
Average					**1.78**		**3.48**

Notes: (1) For Jan-Sept only.

No ambulance trusts are included due to selection criteria

Percentages do not always total 100 due to some staff ethnicity not being declared or collected

Nottinghamshire County NHS did not recruit any BME staff in the year analysed.

References

Archibong U. and Darr A. **2010** *The Involvement of Black and Minority Ethnic Staff in Disciplinary Proceedings*, Centre for Inclusion and Diversity, University of Bradford

Beishon, S. et al 2003 *Nursing in a Multi-Ethnic NHS*, London: Policy Studies Institute Cabinet Office. Ethnic Minorities and the Labour Market. Final Report

Coker, N. (ed) 2001 . *Racism in medicine: an agenda for change*. London: Kings Fund

Dangerfield, Andy. 2012 *"Institutional racism is an issue" in the NHS, says ex-executive*. BBC News (7 November)

Dawson, J. 2009 *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys*, Institute for Health Services Effectiveness, Aston Business School

Department of Health 2006 *Annual Report*

Department of Health 2004 *Leadership and Race Equality Action Plan* **Department of Health 2012** *NHS Race Equality Action Plan*

Department of Health 2013 *NHS Constitution for England*

Equality and Human Rights Commission 2012a *The essential guide to the public sector equality duty England (and non-devolved public authorities in Scotland and Wales) Revised (third) edition*

Equality and Human Rights Commission 2012b *Publishing Equality Information - Commitment, Engagement and Transparency*

Esmail A., 2004. *The prejudices of good people*. BMJ 328: 1448-1449.95

Furness, Hannah, 2012. £1m for NHS manager Elliot Browne who was targeted for his colour Daily Telegraph, 10 January

Grainger, H., and G. Fitzner 2007 *The First Fair Treatment at Work Survey: Executive Summary – updated*. DTI

Health and Social Care Information Centre 2013. *NHS Workforce: Summary of staff in the NHS Results from September 2012 census.*

Healthcare Commission 2006 *Healthcare Commission Race Equality Audit* Healthcare Commission *Tackling the challenge. Promoting race equality in the NHS in England.* 2009

Lintern, S. 2012 *Commissioning board struggles to improve diversity.* Health Service Journal, 21 November

Macpherson, W., 1999 *The Stephen Lawrence Inquiry: Report of an inquiry*, London. Home Office

Matrix Knowledge Group. *Access of BME Staff to Senior Positions in the NHS*.

NHS Employers 2012. *Race equality in mental health* May, Issue 239

NHS Confederation 1998 *Equal Opportunities and Monitoring in NHS Trusts*, Briefing No. 14

NHS Employers 2005a. *Positively Diverse*

NHS Employers 2005b *Positive Action in the NHS*

NHS Employers 2006 *Equity in Implementing Organisational Change*

NHS Equality and Diversity Council 2011 *Toolkit to promote equality and fairness in the NHS*

National Institute for Innovation and Improvement 2013 Building capability, breaking through

NHS England 2013. *Putting Patients First The NHS England business plan for 2013/14 – 2015/16*

NHS Staff Council 2009 *Improving Working Lives in the NHS*

NHS staff survey 2012 *http://www.nhsstaffsurveys.com/cms*

Pudney, S. and M. Shields 2000. *Gender, race, pay and promotion in the British nursing profession: estimation of a generalised ordered probit model*, Journal of Applied Econometrics, 15, pp. 367–99

Santry C., 2008a *Minority staff get worse deal on jobs, pay and grievances.* Health Service Journal, 7 August

Santry C., 2008b *HSJ survey shows 'racism alive in NHS'.* Health Service Journal, 6 November

Santry C., 2009 *Minority staff blocked from senior NHS roles, study finds* Health Service Journal, 14 January

Shared Intelligence 2012 T*he Evaluation of the EDS for the NHS. Phase One. The Final Report*

South East Coast BME network 2008. *Race Equality Service Review*

West, D., 2013 *One in 10 NHS England posts unfilled as system went live*" Health Service Journal 29 April

White, Caroline, 2009 *NHS staff told to maintain pressure towards race equality* BMJ2009;339doi: 21 October