The Newcastle upon Tyne Hospitals
NHS Foundation Trust

The Surash Pearce report

A comprehensive review into ethnic pay-gap and workforce development at The Newcastle upon Tyne Hospitals NHS Foundation Trust

October 2019

Healthcare at its best
with people at our heart

Contents

Introduction from Dame Jackie Daniel

'Talking about race equality is still much harder than it should be – across society and specifically in the NHS.

That needs to change, and it's why I have been so committed to supporting the publication of this report.

Some of the information here makes difficult and uncomfortable reading. I would like us all to study this report, reflect on it, be challenged by it and think very deeply about the active role that all of us can play in making the NHS a more equal place for all of our staff.

Action will come from awareness and understanding, and importantly it should be led by empowered BME leaders at every level throughout the Trust and the wider NHS.

Our 'Flourish at Newcastle Hospitals' programme aims to ensure that every member of staff is able and supported to liberate their full potential at work, and it's vitally important that we are able to clearly understand and act on the lived experience of staff from different cultural groups.

I would like to thank Surash Surash and Karen Pearce for their passion and tireless work in developing this report and for shining a light on this important element of staff experience.'

Dame Jackie Daniel
Chief Executive Officer

Foreword

This is the first comprehensive review looking into the pay gaps and career progression experienced by Black and Minority Ethnic (BME) staff at a single NHS organisation in England.

The Workforce Race Equality Standard (WRES) team have been producing BME reports across NHS organisations for the last few years, but this report looks at individual staff groups working within Newcastle Hospitals, and to understand what, if any, the current differences in pay and career progression amongst its BME staff are, and what we can do to improve that experience.

The data produced by this report is not set out to undermine the current or previous efforts made by Newcastle Hospitals to address these problems thus far. But rather, for the report to be read in the spirit in which it was undertaken; to attempt to find ways to make workforce development and pay a true meritocracy for the future.

This report was first inspired by an enthusiastic Tweet back in 2018.

It is hoped that it will generate similar reports from all NHS organisations, and will inspire positive dialogue in tackling race inequality in the workforce.

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Headlines

Workforce race equality indicators

- Indicators 2, 3 and 4, Newcastle is performing **better** than the national data.
- BME staff are more likely to pursue CPD and non-mandatory training.
- Indicators 5 to 8, Newcastle Hospitals BME staff are doing **marginally better** than BME staff nationally.
- BME staff at Newcastle Hospitals are **more likely** than white staff to be bullied/harassed by other members of staff, with **less opportunity** to progress in their careers, with **high rates** of discrimination from managers.
- White staff experience more **abuse** from service users compared to BME staff at Newcastle Hospitals.
- Work place discrimination was **far greater** for BME staff (14.4%) compared to white staff (4.4%).

Consultants

- A white applicant to a consultant job in Newcastle is more likely to be shortlisted and more likely to be successful at interview (relative likelihood 1.53 times)
- A white consultant at Newcastle Hospitals is more likely to be appointed as a consultant manager than a BME consultant (relative likelihood 1.22 times).
- BME make up 16.7% of consultant Managers, **one of only two staff** groups to achieve this.
- Additional PA payments: female consultants lag behind male consultants, and some directorates are **significantly awarding** white consultants higher PA remuneration compared to BME staff.
- CEA: Locally - a BME consultant makes 24.5% less than a white consultant, compared to national awards which is only 5.4% less.
- 2017/2018 Local awards: BME staff are more likely to apply (1.2 times), white staff more likely to be awarded (1.3 times).
- More female BME consultants applied for the local CEA award (2017/18) and were more likely to be awarded CEAs, however the value of their award was the lowest.
- Responsibility allowance payments: female BME staff fair worse in financial terms.

Nurses

- 100% of BME nursing staff are at Band 5-7.
- 9.9% of BME nurses are at band 6, compared to 28% of white nurses.
- 1.6% of BME nurses are at band 7, compared to 16.4% of white nurses.

- There are **no** BME nursing staff at Band 8 or above.

- Band 6 BME nurses achieves BME representation, **second of two staff groups** to achieve this.

- Nursing recruitment (to all bands), a white nurse is more likely to be appointed from shortlisting compared to a BME nurse (relative likelihood 1.77 times).

- For bands 6 and 7, this relative likelihood is 1.73 times greater for a white nurse compared to a BME nurse for being appointed from short-listing.

Very senior managers

- No staff in senior non-clinical management groups are from a BME background.

Background

BME stands for people whose ethnicity identifies as Black and Minority Ethnic (previously termed BAME - Black, Asian and Minority Ethnic). In the United Kingdom in 2016, people from a BME background accounted for 14% of the working age population, which by 2051 is set to rise to 21%[1].

Racial equality for the UK population has been on the legislative agenda for the last 50 years. The premise of the Race Relations Act 1976 (which incorporated the Race Relations Acts of 1965 and 1968) was to prevent discrimination on the grounds of race, colour, nationality, ethnic and national origin in the fields of employment, the provision of goods and services, education and public functions. The Act also set up the Commission for Racial Equality (now the Equality and Human Rights Commission), which introduced the need for ethnic monitoring in order to achieve equal opportunities.

Ethnic monitoring in the public sector was catalysed by Sir William McPherson's Inquiry[2]. The McPherson Inquiry looked into the murder of Stephen Lawrence (an 18-year old, black student killed by a white racist gang in south-east London), and labelled the London's police force as 'institutionally racist'.

One year later in 2000, an amendment to the Race Relations Act 1976 laid the legal basis for ethnic monitoring. Under the Race Relations (amendment) Act 2000, ethnic monitoring became compulsory for public bodies, contrary to the private sector which at that stage was still not legally obliged to keep ethnic records.

Although maintaining ethnic records became part of legislation, recognising its interpretation and therefore value to change things took much longer. The Baroness McGregor-Smith report[3] in 2017 found that 1 in 8 of the UK workforce in 2015 were from BME backgrounds, with an employment rate of 62.8% (compared to 75.6% for white workers).

The report also found that the under-employment rate was 15.3% for BME workers compared to 11.5% for white workers[4] (meaning working at a level below their capabilities). The potential benefit to the UK of including the full BME workforce via improved participation and career progression, is estimated to be £24 billion a year (1.3% of GDP).[5]

[1] Wohland, Pia ; Rees, Phil ; Norman, Paul ; Boden, Peter and Jasinska, Martyna 'Ethnic Population Projections for the UK and Local Areas, 2001-2051' [July 2010]
[2] Macpherson, William 'The Stephen Lawrence Inquiry' [February 1999]
[3] McGregor-Smith, Ruby 'Race in the workplace: The McGregor-Smith review' [28 February 2017]
[4] McGregor-Smith, Ruby 'Race in the workplace: The McGregor-Smith review' [28 February 2017] 6
[5] BEIS Analysis (2016) 'BME individuals in the labour market analysis of full representation'

The McGregor-Smith report also recommended that any organisation that employed more than 50 employees (public or private) should produce BME reports, improve reporting rates from their BME staff, and this should be supported by a change in government legislation[6].

In 2018, the government announced plans to compel private companies and public sector employers to reveal their ethnicity pay gap[7]. This was set to mirror the gender pay gap that had been introduced in 2017. However, only 11% did this by 2018, hence the move to make this a legal requirement.

The NHS has its own standards to follow, which are set out in legislation[9]. The NHS Equality and Diversity Council (EDC) and NHS England commissioned the NHS Workforce Race Equality Standard (WRES), which became available to the NHS in April 2015[10]. This is now part of the NHS Standard Contract[11], which asks that employing Trusts improve, 'the experience, treatment and career progression of black and minority ethnic staff, closing any inequality gaps and ensuring that the leadership of NHS organisations better reflects the communities they serve[12].'

The Workforce Race Equality Standard is a set of 9 indicators that assists NHS organisations to meet their duties as set out in legislation in s9 of the Equality Act 2010.

The main purpose was to help local and national organisations to review their data against the nine WRES indicators (matrices), to produce action plans to close the gaps in workplace experience and improve BME representation at all levels of NHS organisations[13]. In addition, schedule 6A of the NHS Standard Contract requires all NHS providers to produce annual reports on their WRES indicators[14].

The nine WRES indicators are set out in appendix one. Its objective is to ensure that the voices of BME staff are listened to in understanding the challenges and continuously seeking to improve the outcome of the nine WRES indicators[15]. Indicators 1 to 4 and 9 are obtained from Electronic Staff Records (ESR), however indicators 5-8 come from staff survey data[16].

The 2018 NHS Workforce Race Equality Standard found that BME staff made up 19.1% of the total NHS workforce (this had improved from 16.3% in 2017[17]). The proportion of very senior management (VSM) staff also improved from 5.7% to 6.9% from 2017 to 2018[18]. Yet the percentage of BME staff reporting discrimination rose from 13.8 to 15% in the same time-frame.

Part of this process has recommended the establishment of local BME networks within individual NHS Trusts.

[6] McGregor-Smith, Ruby 'Race in the workplace: The McGregor-Smith review' [28 February 2017] 16
[7] Hurst, Greg 'Employers must reveal ethnic pay gap of staff' The Times 11 October 2018
[8] Hurst, Greg 'Employers must reveal ethnic pay gap of staff' The Times 11 October 2018
[9] Equality Act 2010 s9
[10] NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 5
[11] NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 6
[12] NHS Standard Contract 2019/20 General Conditions p65
[13] NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 5
[14] NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 7
[15] NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 22
[16] NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 22
[17] NHS Equality and Diversity Council, 'NHS Workforce Race Equality Standard: 2018 Data Analysis Report for NHS Trusts' [January 2019] 12
[18] NHS Equality and Diversity Council, 'NHS Workforce Race Equality Standard: 2018 Data Analysis Report for NHS Trusts' [January 2019] 6

The Newcastle Hospitals BME network was formed in May 2014 and now has around 400 members. Membership is open to all BME staff and those with a positive interest in driving forward race equality within the Trust.

The staff network holds focus groups which look at; bullying and harassment, improving training and opportunities, mentoring and interview techniques.

Within the last 12 months, the network together with HR have arranged a variety of landmark events for the trust and the region.

These include:

- October 2018 staff network invited external speakers;
    - Lynn Cole, director GLT partners Ltd - '25 years after Stephen Lawrence' focussing on the challenges and reflections for minority ethnic people working in England.
    - Chi Onwurah, MP for Newcastle – presenting her personal experience around 'BAME leadership.'
- August 2018 - WRES subgroup formed - monitors progress against the WRES action plan, meets monthly.
- January 2019 - the Trust welcomed Yvonne Coghill and Owen Chinenbri from the National WRES Team. They confirmed the view that the Trust was in a good position overall, when compared to the national position, although still with more progress to make. Data relating to career progression within the Trust was reviewed (the National WRES Team indicated no other Trust had looked specifically at this data).
- March 2019 – BME staff network recruitment film - sharing experiences of working in the NHS.
- April 2019 - BME recruitment event with 5 NHS partner organisations (attracting over 400 attendees).
- July 2019 - 5 BME staff network members training to become cultural ambassadors.
- October 2019 - Inaugural BME conference, the first of its type in the region with local, regional and national keynote speakers.

The case for change is based not just on numeric discrepancies of BME staff representation within the NHS, though also on evidence that shows staff satisfaction is related to patient experience. In a paper by West et Al. (2011), they demonstrated a link between BME staff that reported discrimination with lower levels of patient satisfaction[19]. In a further report in 2018 by NHS England, they found a positive correlation between BME staff experience and patient satisfaction, and where BME staff experienced a higher degree of discrimination, patient satisfaction was lower[20].

This Report will seek to perform a comprehensive review of the current problems facing the BME workforce across medical, nursing and senior non-medical management employed at Newcastle Hospitals. Its aim is to look at pay gaps, recruitment and career progression of BME staff compared to white staff employed, and consider appropriate additional action plans to address any workforce inequalities in the future.

[19] West, Michael, Dawson, Jeremy, Admasachew, Lul and Topakas, Anna 'NHS Staff Management and Health Service Quality' [2011] 9
[20]NHS England 'Links between NHS staff experience and patient satisfaction: Analysis of surveys from 2014 and 2015' [February 2018] 17

Objectives

This report aims to look at the current (31 March 2019) staffing levels within Newcastle Hospitals and determine if there is a pay gap between BME and white staff, and also determine whether there is an objective problem with recruitment and career progression.

In particular this report will look at specific staff groups; medical consultants, nursing staff and non-medical senior managers and very senior managers (VSM).

Categorisation of BME staff in this report adheres to the technical data guidelines as set out by the WRES action team[21]. They have used the definition of white as per the 2001 ONS Census categories, which includes white British, Irish, Eastern European and any 'other white' (appendix two). For purposes of ensuring that this report produces data that can be used as a comparator to other organisations within the UK, we have used the same data nomenclature.

There is an obvious dilemma in incorporating white European, North American, etc into the white staff cohort for first generation members of staff. However, this is based on the visual bias that BME staff experience based on the colour of their skin, and in part on the generational dilution effect that second and so forth white 'other' generations will have in integrating into white British society without any skin colour differences that act as a visual bias.

The WRES action team have separate recommendations for this subset population, however, for purposes of comparative data, this report shall stick to BME and white groups as per the WRES technical data guidelines.

Workforce data was taken from the following data sources:

a. Electronic staff records - 31 March 2019 (staffing numbers, pay).

b. WRES data – 2018/19 data[22] (released June 2019).

c. National staff survey – 2018 (published 2019).

d. Recruitment data from TRAC recruitment management system- April 2018 to May 2019.

[21]NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 18
[22]WRES data for 2018 released by WRES team to Newcastle Hospitals in June 2019.

Demographics

The Newcastle upon Tyne Hospitals NHS Foundation Trust (Newcastle Hospitals) is one of the largest and most successful teaching hospitals in England. It provides academically led acute, specialist and local community services to patients from Newcastle and across the North East and Cumbria, across the UK and internationally. The Trust currently employs 14,707 staff[23] (data as of 31 March 2019).

The principle population served is Newcastle upon Tyne, which according to the 2011 National Census data, had a population of 280,166[24], of which 14.7% were BME, the highest geographically for the Tyne & Wear area. For the North East as a whole, BME representation drops down to 4.5%. This is a much lower percentage when compared to other larger cities where the percentage of BME residents are greater, for example, the population of the Greater London area is 8.2 million with a BME population that accounts for 40% of people that live in the capital[25].

The Trust stands within the top 12 NHS employing organisations within the UK for staffing numbers (Table 1), and is one of the North East's major employers. The organisation has an annual income of around £1.1 billion, and is in the top 10% of best performing Trusts within the UK.

Table 1: Top 12 NHS employing organisations in the UK for staffing numbers.

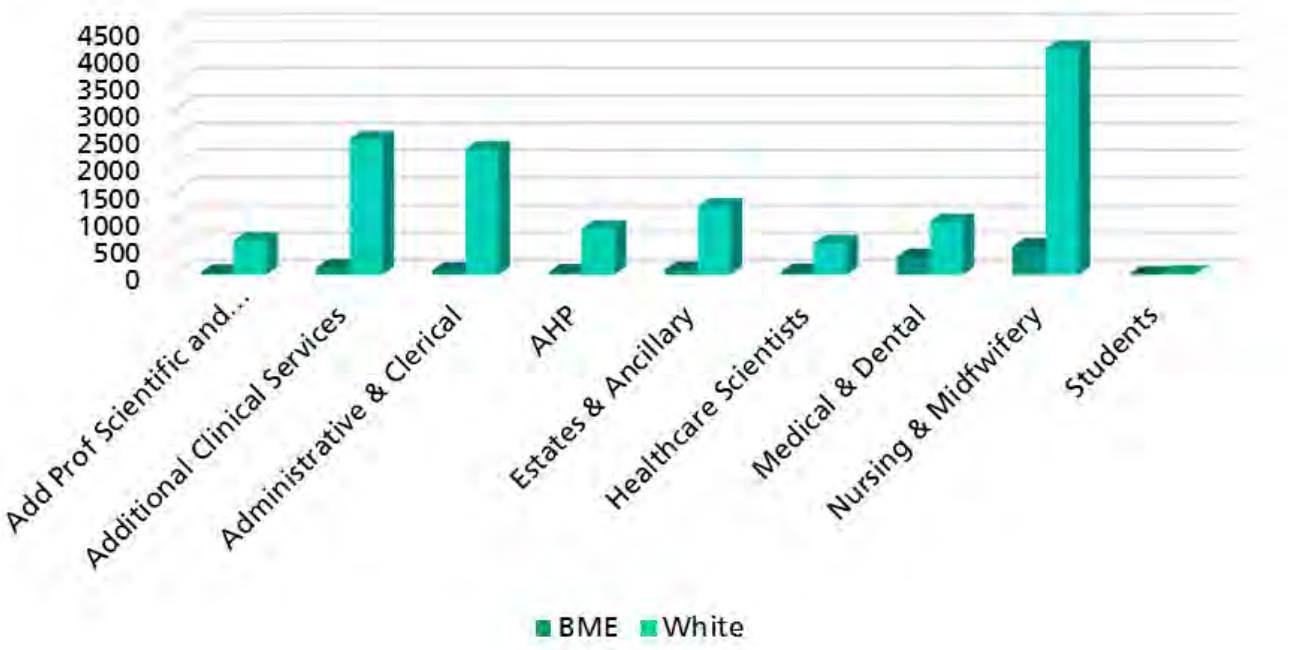
NHS Trust	Staffing Number
Cardiff & Vale	14,675
Newcastle	**14,707**
Leicester	15,370
Nottingham	15,555
Abertawe Bro Morgannwg University LHB	16,005
Barts Health	16,305
Guy's & Thomas'	16,840
Sheffield	17,145
Betsi Cadwaladr Uni LHB	17,780
Leeds	18,095
Birmingham	21,025
Manchester	21,090

As of 2019, 8.52% of the Newcastle Hospitals workforce were coded as BME staff[26], 89.43% white staff and 2.05% undefined. Graph 1 illustrates the spread of BME by staff group as of 31 March 2019.

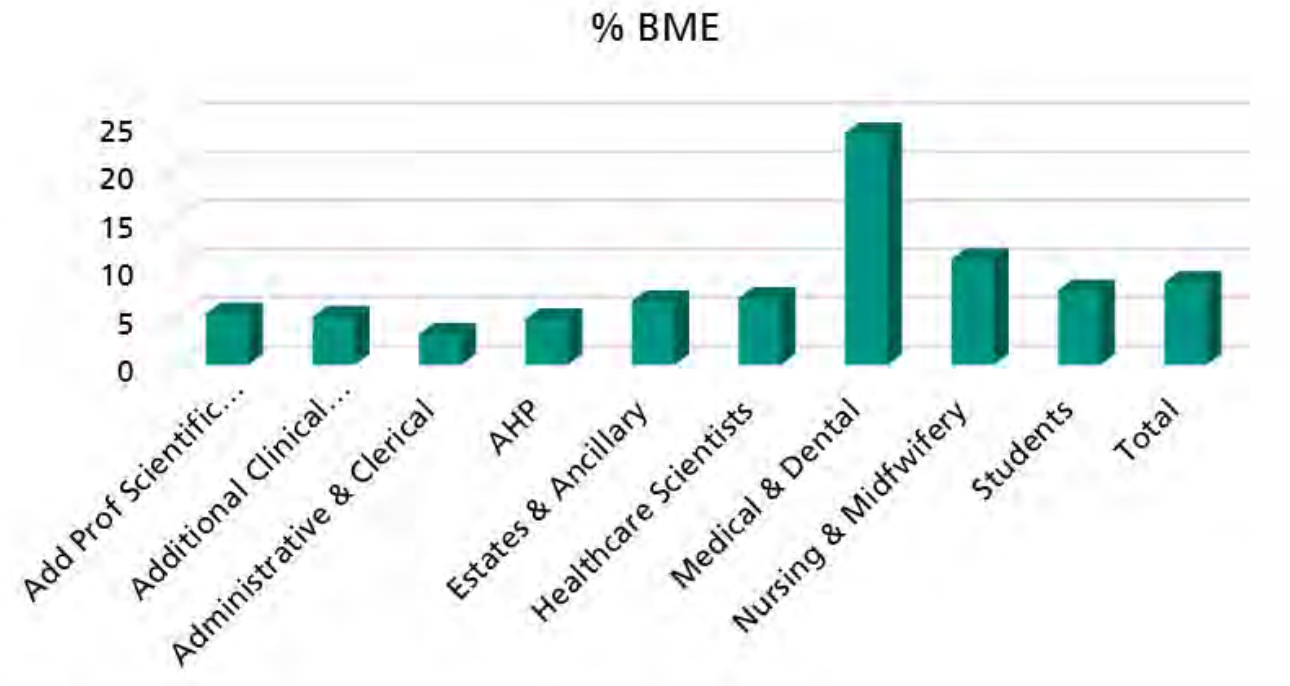
The highest staff groups with BME representation are 'nursing and midwifery' and 'medical and dental,' - however as a percentage of each staff group, "medical and dental' have 23.9% of its group as BME staff, with 'nursing and midwifery' at 10.9% (Graph 2).

[23]Excludes Bank Staff, Honorary staff and volunteers
[24]https://www.ons.gov.uk/census/2011census
[25]https://fullfact.org/crime/does-metropolitan-police-reflect-londons-ethnic-diversity/
[26] Based on headcount data as of 31st March 2019 – as used by WRES

Graph 1: Numbers of BME staff employed by staff group (2019).



Graph 2: Percentage distribution of BME staff amongst all staff groups (2019).

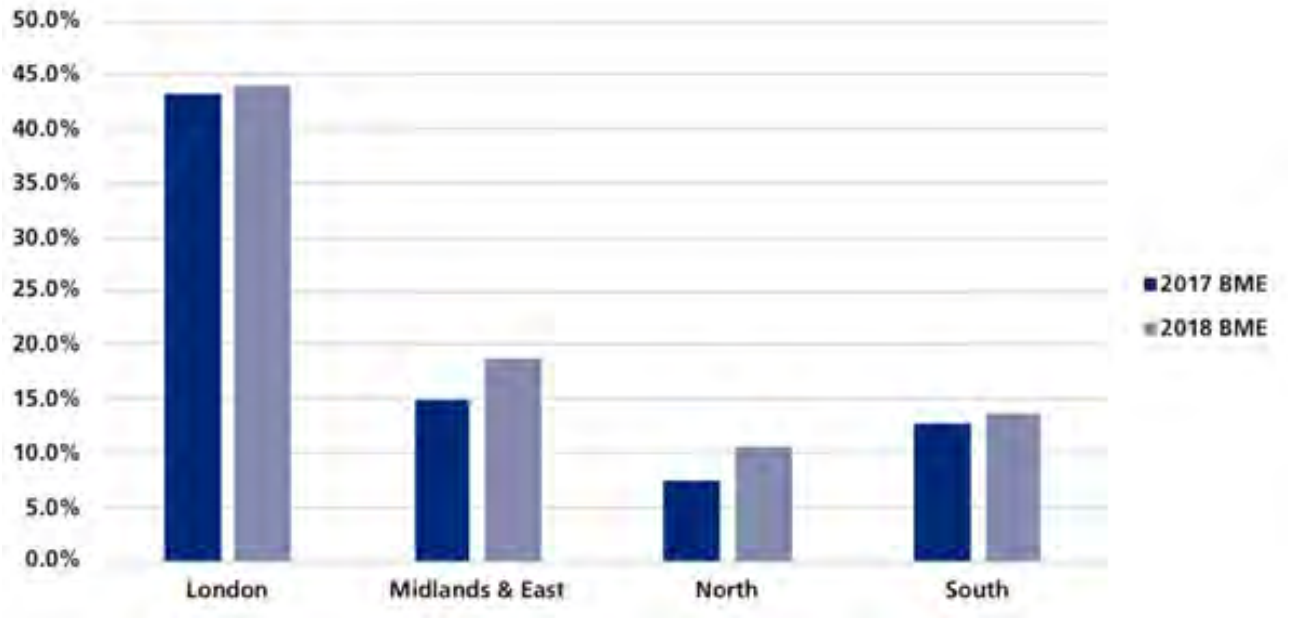


Within the wider NHS, BME staff make up 19.1% of the workforce[27]. Table 2 shows the spread of BME staff across major regions within England for 2018. The North had by far the lowest proportion of BME staff in 2018 at 10.5%, compared to London at 43.9%. However, graph 3 shows the percentage of NHS BME staff had actually increased in all regions from 2017 to 2018[28].

Table 2: Staff representation by ethnicity and region for 2018[29].

Region	White	BME	Null
London	50.2	43.9	5.9
Midlands & East	76.3	18.8	5.0
North	86.0	10.5	3.5
South	81.6	13.8	4.5

Graph 3: Percentage of NHS BME staff across various regions of England in 2017 and 2018.



Undefined groups

This report does have a cohort of undefined groups (2.05%) that we are unable to retrospectively identify the data on. This is multi-factorial, though takes into account individual rights to not provide this data. This report shall therefore state what the undefined amounts are[30], but compare white versus BME groups in its analysis.

[27]NHS Equality and Diversity Council, 'NHS Workforce Race Equality Standard: 2018 Data Analysis Report for NHS Trusts' [January 2019] 6
[28]NHS Equality and Diversity Council, 'NHS Workforce Race Equality Standard: 2018 Data Analysis Report for NHS Trusts' [January 2019] 14
[29]NHS Equality and Diversity Council, 'NHS Workforce Race Equality Standard: 2018 Data Analysis Report for NHS Trusts' [January 2019] 14
[30] Undefined groups will be stated only where the data is present.

Relative likelihood

For data sets, this report will state relative likelihoods of an event happening (e.g; being appointed to a job) between BME and white staff groups. An example of how this is calculated is in Table 3 (data is for demonstration purposes only).

	White	BME
Number of shortlisted applicants	780	210
Number appointed from shortlisting	170	30
Number appointed/ number shortlisted	0.22	0.14

Therefore, 'relative likelihood' of white staff being appointed from shortlisting compared to BME staff (0.22/0.14) is therefore 1.57 times greater.

Subjective experience

There is a difficulty with analysing and interpreting anecdotal subjective data. However, its importance in being able to set the scene for understanding the difficulties that BME staff face is not without merit.

The BME staff network canvassed opinions from BME staff working within Newcastle Hospitals to identify personal experiences during their employment. The examples given below have been anonymised and were gathered from April to June 2019.

Examples of staff treatment within the Trust:

Career progression

1. Been in the Trust over 15 years. … been a band 5 all this time, have applied on numerous occasions for band 6 roles and never been successful.

2. Have applied for numerous band 3 posts (35 in total) across the organisation. Been appointed once but the offer was withdrawn after line manager sent a reference.

3. Excuse [is] that her English isn't very good however, she speaks fluent English albeit with an accent.

4. A number of [BME] staff have left the department as there is no chance of progression.

5. They [BME nurses] are asked to train the new nurses coming in.

6. A number of locums have come into the department and given band 6 roles. Asked to train them. Each time it's raised [career progression], she is told "just do your job."

7. BME nurses have not been made aware of opportunities as they arise so unable to apply for band 6 posts as they are not advertised consistently across the department. Often, it's when their white counterparts are introduced as the new band 6 that they are aware of the opportunities.

8. Treated less favourable than white colleagues when asked for time to attend hospital appointments.

9. Not given the same CPD opportunities as white colleagues. Always told they are short staffed and unable to be released.

Verbal abuse

10. Staff being called 'Pakis' by their colleagues and then told it's a joke when they challenge it.

11. Often scolded and humiliated in public before other staff in the staff room. Locked in office and shouted at.

12. Systematically bullied and harassed. Has asked on a number of occasions for copies of her completed appraisal documentation and ignored. Feeling marginalised.

13. [BME] nursing staff being told "you are here to work, not to progress."

Miscellaneous

14. No input from band 2 staff as they have not been released to attend any of the meetings.

15. Fear of reprisal so won't report it in any forum as they have a lot riding on their ability to keep their jobs so just keep their heads down and work.

16. A friend of mine is a white doctor who feels there is 'assumed competence' every time he walks into a room. But his wife who is Asian, same specialty and grade, is treated like she's 'incompetent' until she proves herself.

The purpose of this report is to objectively understand whether the experience of BME staff does support these limited examples. To do this, we shall next examine the WRES indicators for corroborative evidence.

WRES indicators

As discussed previously, WRES have 9 indicators that assist NHS organisations to meet their duties in supporting BME staff.

The most recent data comes from the staff survey 2018. Indicators 1, 2, 3, 4 and 9 are taken directly from the ESR database. We shall consider each indicator separately.

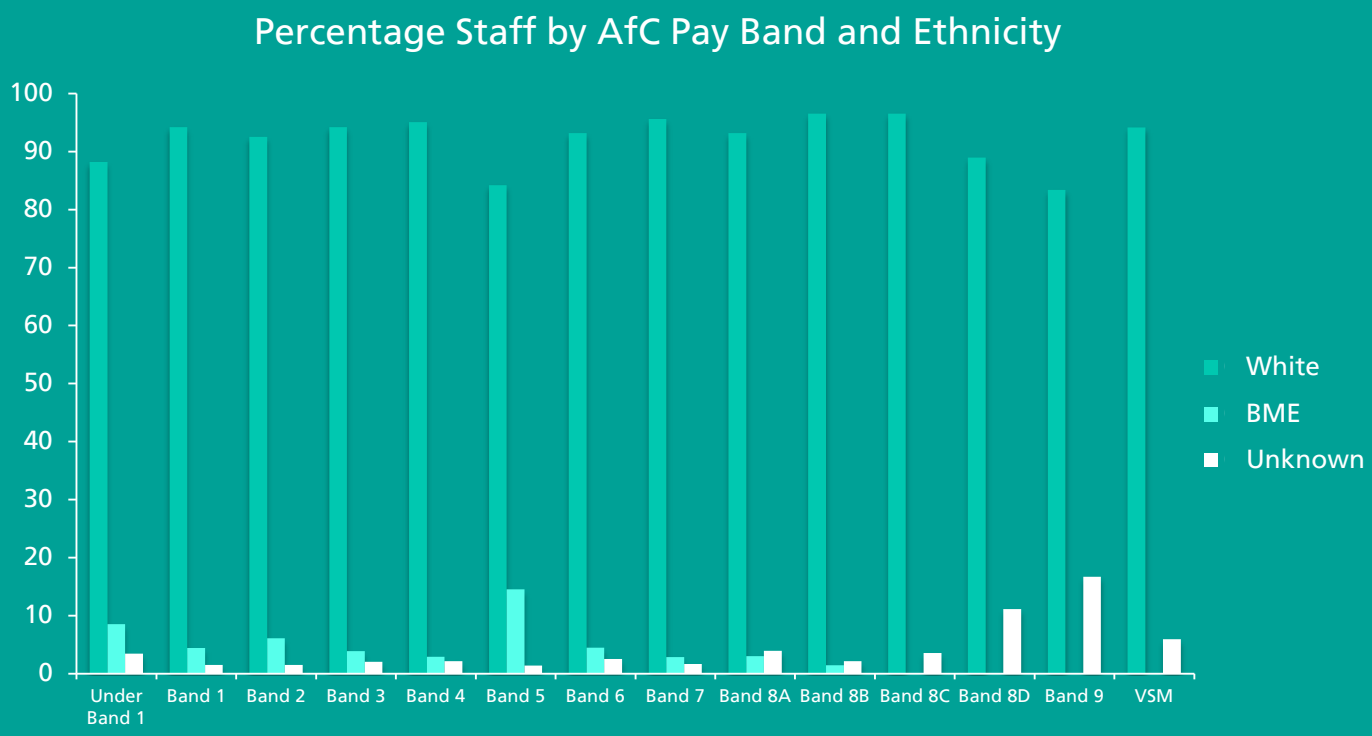
Indicator 1

Indicator 1 examines the distribution of staff by Agenda for Change (AfC) pay band and ethnicity.

What this shows is that the highest representation of BME staff are in Band 5, with no BME representation in Bands 8C and above.

Other areas that Indicator 1 deals with include 'medical staff' and 'very senior managers' which is dealt with later.

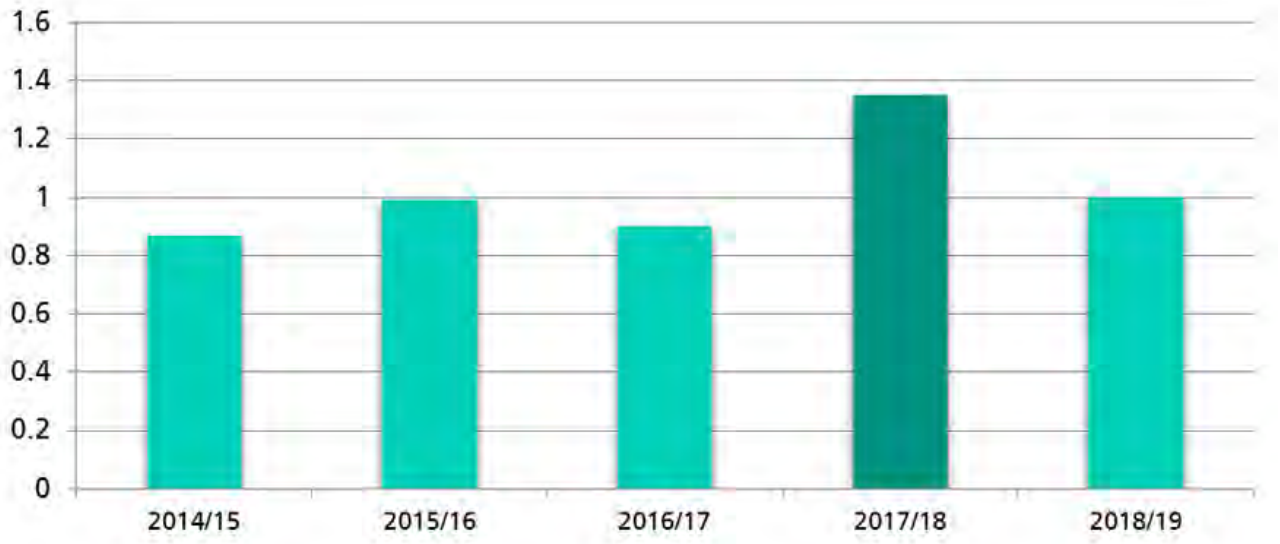
Graph 4: Indicator 1 – percentage staff by AfC pay band and ethnicity.



Indicator 2

Graph 5 demonstrates that overall, by 2018/19, white staff are as likely as BME staff to be appointed to a job compared to previous years. This is for all jobs across all staff groups across the Trust. In 2017/18 however (dark green bar), white staff were more likely to be appointed than BME staff.

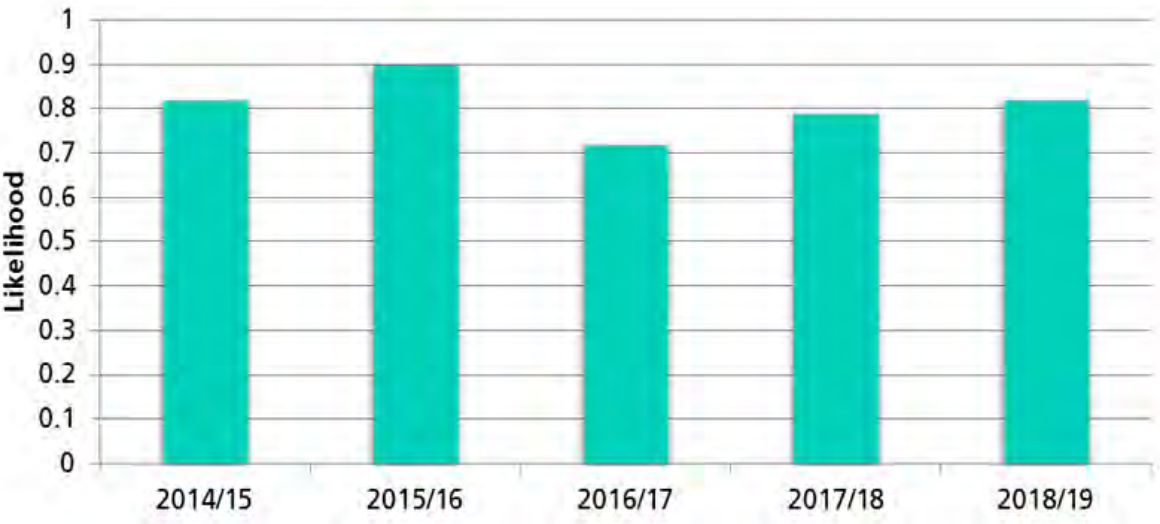
Graph 5: Indicator 2 - Relative likelihood of white staff being appointed from shortlisting compared to BME staff.



Indicator 3

Graph 6 is the relative likelihood of BME staff entering formal disciplinary process compared to white staff. Across each year, white staff are more likely to enter a formal disciplinary process. However, the trends over the last 3 years shows this affect is heading towards a more equal experience for both BME and white staff.

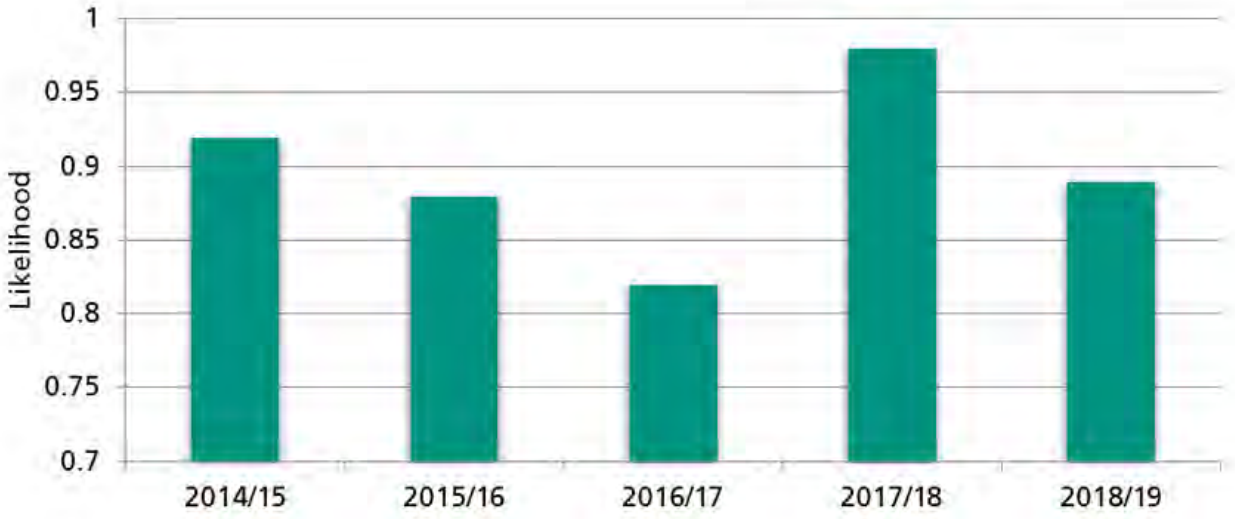
Graph 6: Indicator 3.



Indicator 4

Graph 7 demonstrates the relative likelihood of white staff accessing non-mandatory training and CPD compared to a BME member of staff. This demonstrates that BME staff are more likely to access non-mandatory training and CPD than a white member of staff, which is especially true in 2016/17.

Graph 7: Indicator 4.



Indicator 9

Graph 8 shows the percentage difference between the Trust board voting membership and its overall workforce. This essentially reflects how well the Trust board reflects its BME workforce.

What this trend shows is that the separation between the board's BME representation and the whole Trust BME representation is getting worse over time, i.e.; the board is not representing the growing BME representation across the Trust.

Graph 8: Indicator 9.

Headline

The WRES Indicators demonstrate that being appointed and entering a formal disciplinary process is almost the same for white and BME staff.

Headline

BME staff are more likely to pursue CPD and non-mandatory training, (could be a surrogate marker for a behaviour that shows a willingness to learn above their white peers).

Headline

The board is not representative of the wider organisations BME workforce.

Comparing to national data

To compare how Newcastle Hospitals performs against the national average, table 4 illustrates this for 2017 (published 2018)[31].

For the WRES indicators 2, 3 and 4, Newcastle Hospitals is performing better than the national average data.

It also shows that BME staff are more likely to be appointed from shortlisting compared to the national average for BME staff.

Entering disciplinary procedures is less likely in Newcastle compared to nationally if you are a BME member of staff.

However, in terms of accessing non-mandatory training and CPD[32], BME staff are more likely to access this compared to the national data for BME staff.

Table 4: National comparators - Newcastle vs. national data for 2017 (published 2018).

WRES Indicator	National data	Newcastle data
2. Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants.	1.45	1.35
3. Relative likelihood of BME applicants entering formal disciplinary processes compared to white staff.	1.24	0.79
4. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff.	1.15	0.98

Headline

For indicators 2,3 and 4, Newcastle Hospitals is performing better than the national data.

[31]Note that this is for White staff accessing compared to BME staff. Mistake on WRES data has this the other way around. <https://www.england.nhs.uk/wp-content/uploads/2018/12/wres-2018-report-v1.pdf>
[32] Note that this is for White staff accessing compared to BME staff. Mistake on WRES data has this the other way around. <https://www.england.nhs.uk/wp-content/uploads/2018/12/wres-2018-report-v1.pdf>

Staff survey data

WRES Indicators 5 to 8 are included in the National Staff Survey. The results presented are from the 2018 survey data, which looks at the experience of local staff compared to the national experience (national comparator).

We shall also examine the experience of BME and white staff amongst the different staff groups in Newcastle compared to all staff employed at the Trust (Trust average = BME and white) and the national comparator data (combined white and BME staff experience nationally).

The following indicators are covered:

(5) Inappropriate behaviour from service users (public/patients),

(6) Inappropriate behaviour from managers,

Inappropriate behaviour from other colleagues,

(7) Career progression,

(8) Experienced discrimination at work.

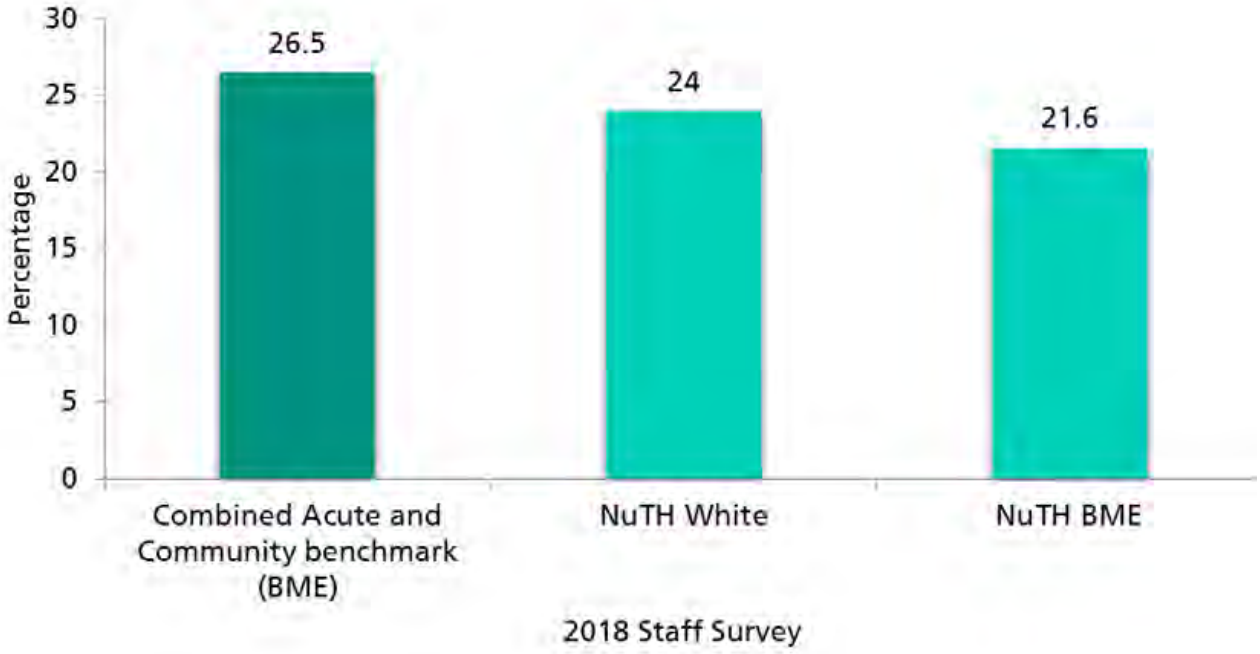
Indicator 5

Indicator 5 looks at the percentage of staff who have personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public within the last 12 months. This is illustrated in Graph 9 which shows the overall BME/white experience in Newcastle compared to national combined BME experience, and Graph 10 which is the breakdown by staff group in Newcastle.

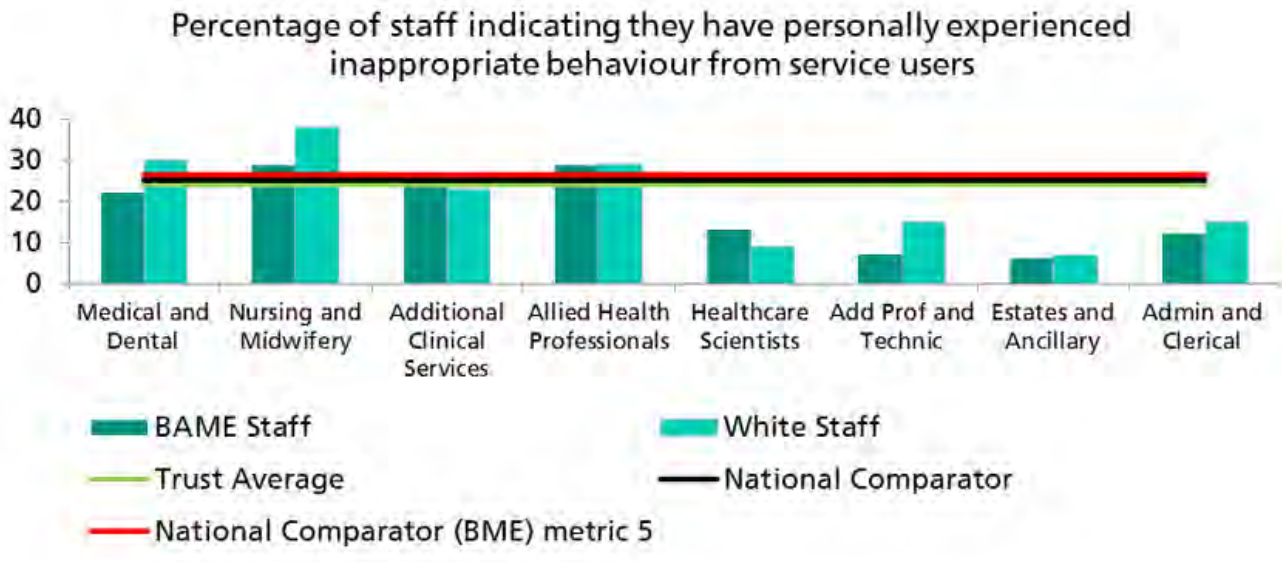
Graph 9 shows that in Newcastle, white staff fair slightly worse compared to BME staff, although better than the national data for BME staff.

Whereas Graph 10 reflects the experience from different staff groups. From this data, white staff fair the worst for 'medical and dental', and 'nursing and midwifery'. The area that BME staff fair worse than white staff is for 'healthcare scientists'. Overall, the Newcastle data (Trust average) is fairly similar to the national comparator data, although the BME experience for 'nursing and midwifery' and 'AHP' are above this.

Graph 9: Indicator 5 – staff experiencing inappropriate behaviour from service users.



Graph 10: Affect by staff group.



Indicator 6

Indicator 6 looks at inappropriate behaviour from other staff (Graph 11) compared to the National combined BME experience, and also from managers (Graph 12), or from other colleagues (Graph 13) by staff group.

Graph 12 demonstrates that BME staff in 'medical and dental', 'healthcare scientists', 'estates and ancillary' and 'admin and clerical' fair worse than white staff from inappropriate behaviour from 'managers'.

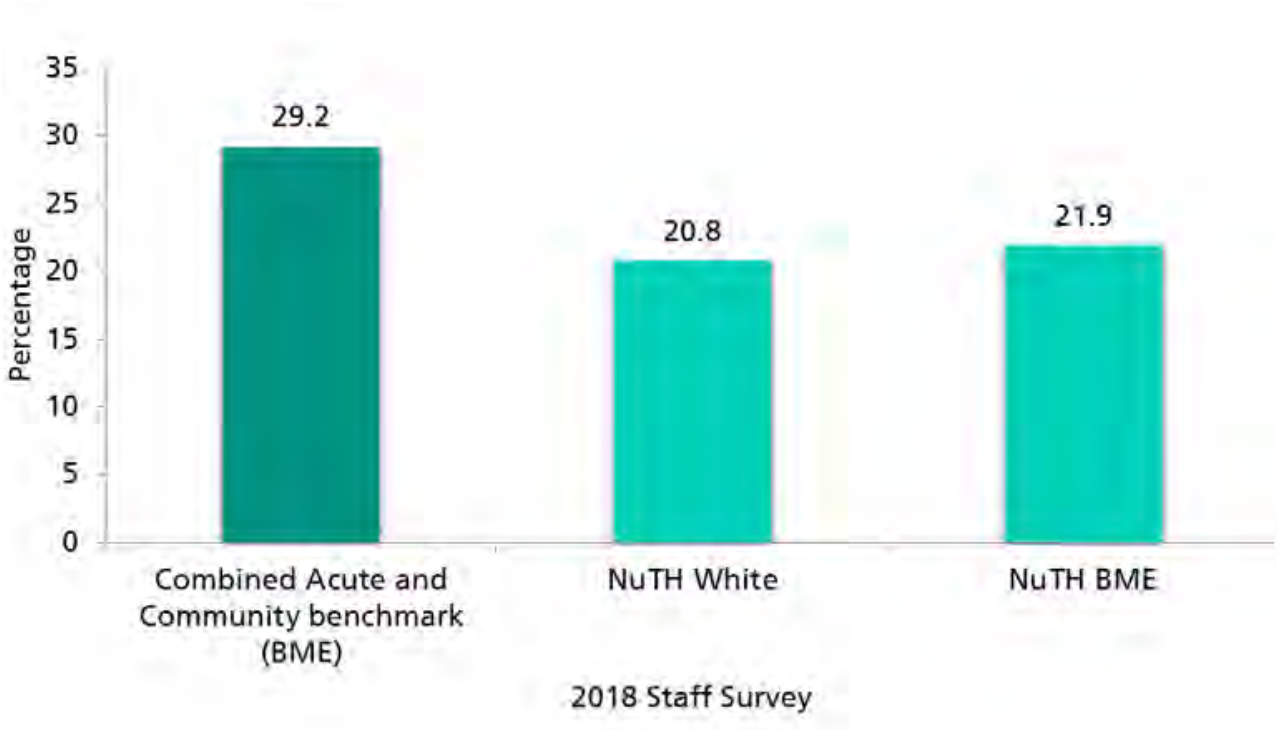
'Medical and dental' BME experience was 12% compared to white at 6% (double). Whereas 'nursing and midwifery' the experience is the same for both BME and white staff. Overall, the Trust average data (9%) is below that of the national comparator (11%).

Graph 13 reflects the inappropriate behaviour (harassment, bullying or abuse) that Newcastle staff have experienced from other 'colleagues'. This shows that BME staff fared badly compared to white staff in 'nursing and midwifery', 'additional clinical services', 'allied health professionals' and 'healthcare scientists'.

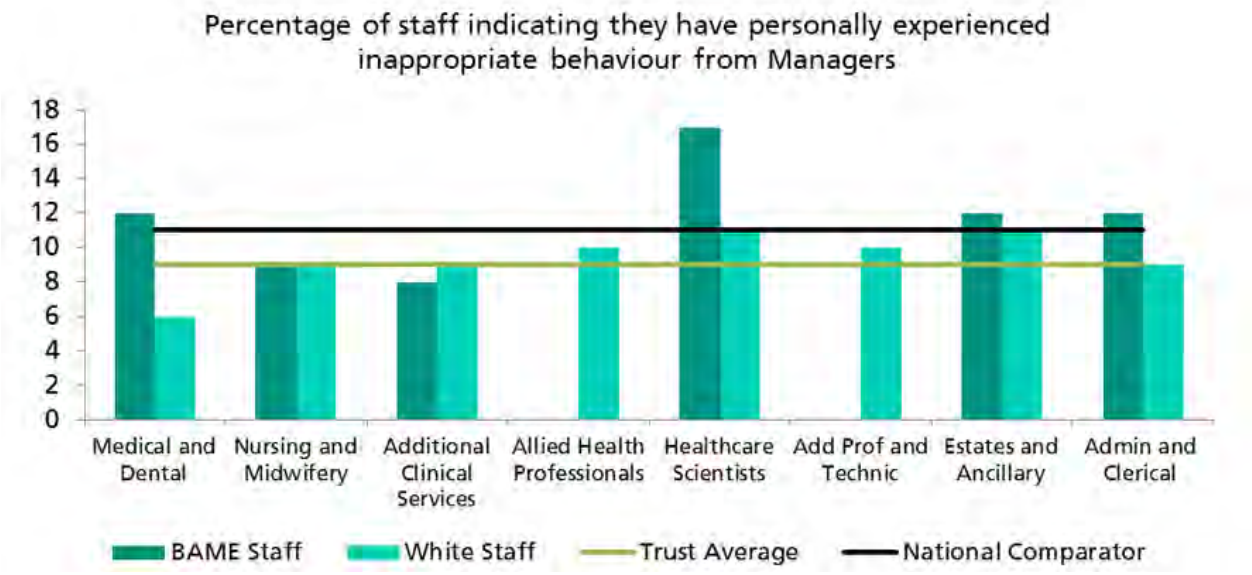
For 'medical and dental' the experience was equal. And in the remaining groups, white staff fared worse compared to BME staff.

The Trust average fell slightly below the national comparator data.

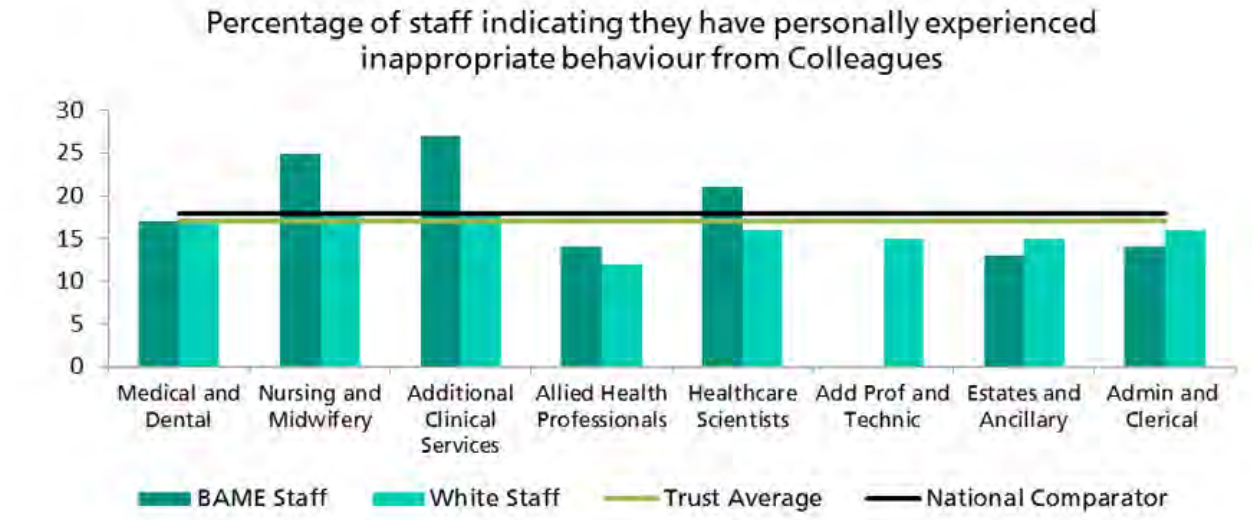
Graph 11: Indicator 6 – staff experiencing inappropriate behaviour from other staff.



Graph 12: Staff members experiencing inappropriate behaviour from 'managers'.



Graph 13: Staff members experiencing inappropriate behaviour from other 'colleagues'.



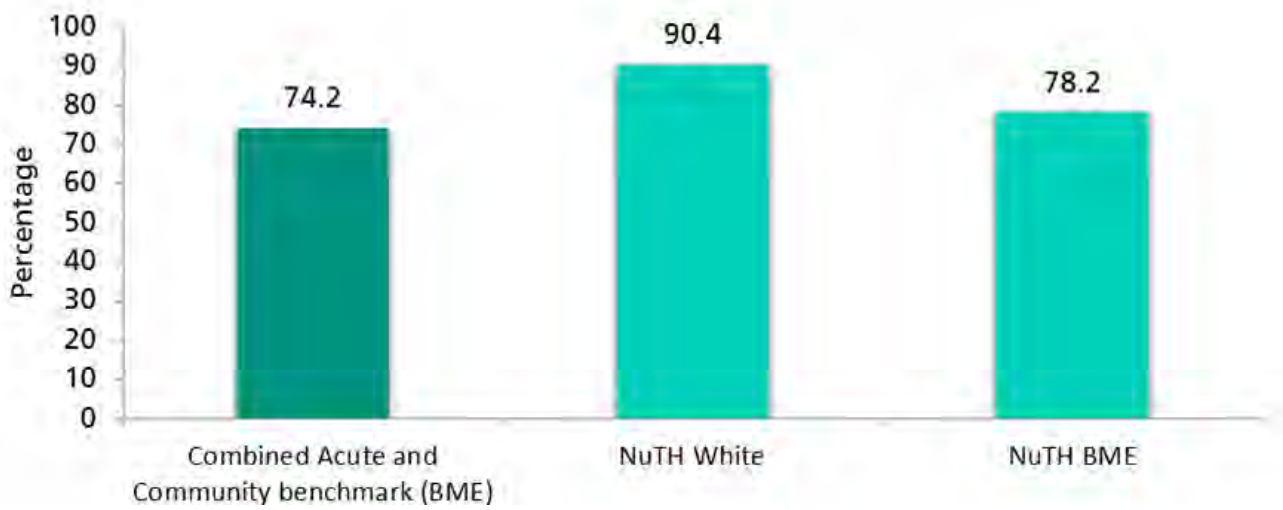
Indicator 7

Indicator 7 reflects how staff in Newcastle perceive the way the Trust acts regarding career progression, regardless of background. Overall (Graph 14), white staff feel that the Trust acts fairly in career progression (90.4%), with BME staff lagging behind in its confidence with the organisation (78.2%). Although slightly better than the National BME experience (74.2%).

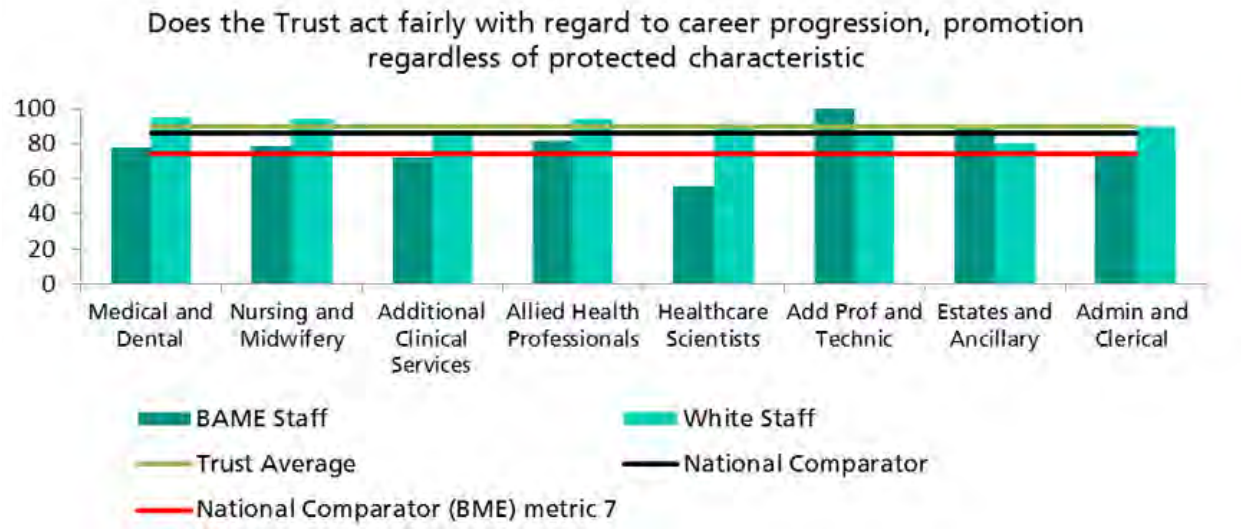
By staff group (Graph 15), BME staff feel that the Trust does not support their career progression compared to white staff in all domains except 'add prof and technic[33]' and 'estates and ancillary' staff.

[33]'Add Prof and Technic' includes; Dental Nurses, ODP's, Pharmacists and Pharmacy Technicians.

Graph 14: Indicator 7 – Staff members who feel their organisation provides equal opportunities for career progression or promotion.



Graph 15: Indicator 7 by staff group.

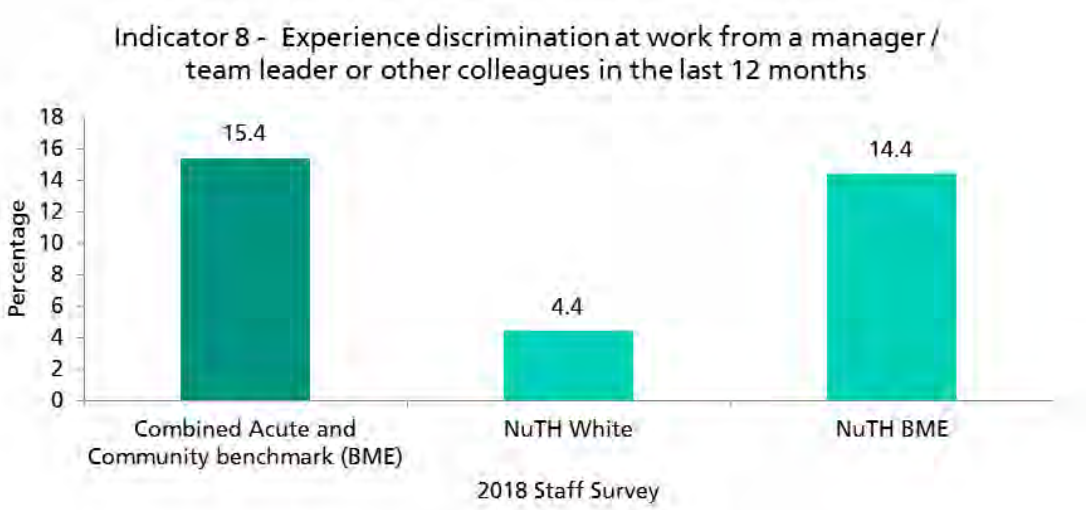


Indicator 8

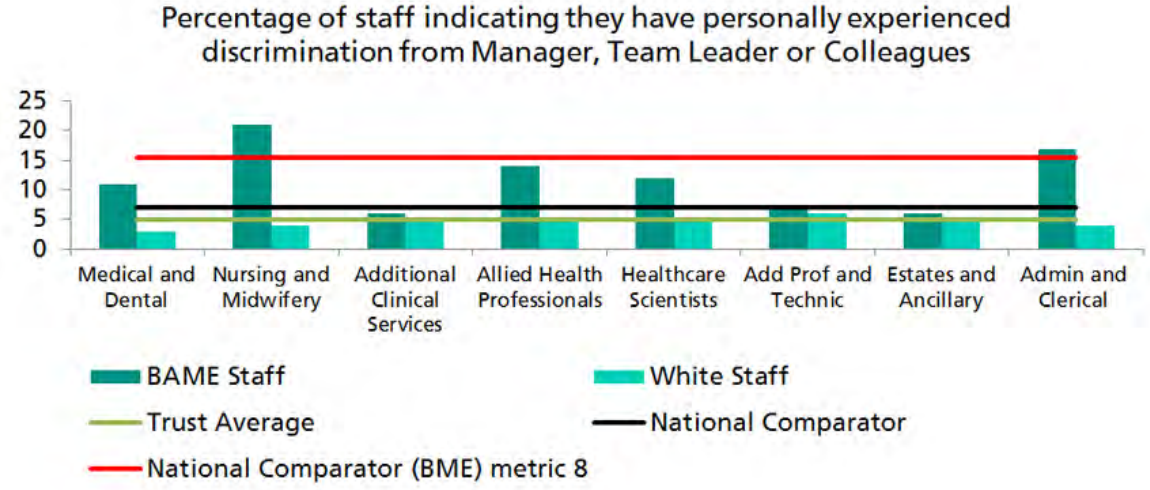
Indicator 8 reflects the experience that Newcastle staff experience from discrimination from managers, team leaders or other colleagues. Overall (Graph 16), BME staff have experienced discrimination greater than white staff at Newcastle Hospitals (14.4% versus 4.4%), although slightly lower than the national BME data (15.4%).

Amongst the individual staff groups (Graph 17), discrimination amongst BME staff was greatest and significantly worse than white staff experience in 'medical and dental', 'nursing and midwifery', 'allied health professionals', 'healthcare scientists' and 'admin and clerical'. However, the overall experience of staff (5%) was slightly below the national comparator (7%).

Graph 16: Indicator 8.



Graph 17: Indicator 8 – staff groups experiencing discrimination at work from a manager.



Headline

The overall message from the staff survey data for BME staff is that they are doing marginally better than BME staff nationally in indicators 5 to 8.

Headline

BME staff in Newcastle are more likely to be bullied/harassed by other members of staff.

Headline

BME staff are less likely to feel Newcastle Hospitals provides equal opportunities for career progression and promotion.

Headline

White staff experience more abuse from service users compared to BME staff.

Headline

Work place discrimination from managers, team leaders or other colleagues was far greater for BME staff (14.4%) compared to white staff (4.4%).

Organisation structure

As of 31st March 2019, 14,707 staff were employed at Newcastle Hospitals, of which 8.52% were from a BME background.

This report shall now consider specific occupational cohorts within the organisation.

Medical

Nursing

Senior non-clinical groups

Board of Directors
Very senior management
Directorate teams
Senior managers
Other senior staff
(band 8c AfC and above)

Medical

Medical staffing levels

9.1% of all the workforce are 'medical and dental' of which, 23.9% are BME (data as of 31 March 2019).

Within the group of medical, there are currently 787 consultants, of which 19.7% are BME (see Tables 5 and 6). BME staff are less represented in the consultant group (23.9% down to 19.7%), although this proportion is still much higher than the overall workforce of 8.52%.

Table 5: Proportion of BME consultants.

Ethnic origin	(%)
BME	19.70 %
White	78.14 %
Undefined	2.16 %

Table 6: Proportion of consultants by gender and ethnicity.

	(%)
BME	19.70%
Female	4.96%
Male	14.74%
Undefined	2.16%
Female	1.02%
Male	1.14%
White	78.14%
Female	32.40%
Male	45.74%

Recruitment of consultants

Table 7: Recruitment data for application to consultant posts from April 2018 to May 2019.

Ethnic group	All applications	Shortlisted (No.)	Shortlisted (% of All applicants)	Successful (No.)	Successful (% of Shortlisted)
BME	119	54	45.38%	15	27.78%
White	142	106	74.65%	45	42.45%
Not disclosed	67	62	92.54%	45	72.58%
Grand total	328	222	67.68%	105	47.30%

In terms of recruitment to a consultant job (Table 7), of all applicants, 36.3% were from a BME background. A BME applicant had a 45.38% chance of being short-listed from application, compared to a 74.65% if they were from a white background. Of those shortlisted, 27.78% of BME shortlisted applicants were successful at interview compared to 42.45% from a white background that had been shortlisted.

Of note is the high level of 'not disclosed' which is also reflected in the nursing recruitment data. Reasons behind this remain unclear.

Headline

A white applicant to a consultant job is more likely (relative likelihood of 1.65 times) to be short-listed and more likely (relative likelihood of 1.53 times) to then be successful at interview to be appointed.

Senior medical managers

The medical manager hierarchy is illustrated in Figure 1. This encompasses the medical director, deputy medical director, associate medical director, directors of services and clinical and corporate clinical directors. This cohort of senior medical managers are part of WRES indicator 1 – which is defined as the 'medical director, deputy medical director or a consultant that reports directly to the medical director[34].'

In total there are 36 appointed consultant managers, of which 16.7% are from a BME background. This is just below the BME consultant demographic of 19.7%, or the overall 'medical and dental' cohort of 23.9%. However, despite this representation, the relative likelihood of a white consultant being appointed to a consultant manager role is 1.22 times greater than a BME Consultant.

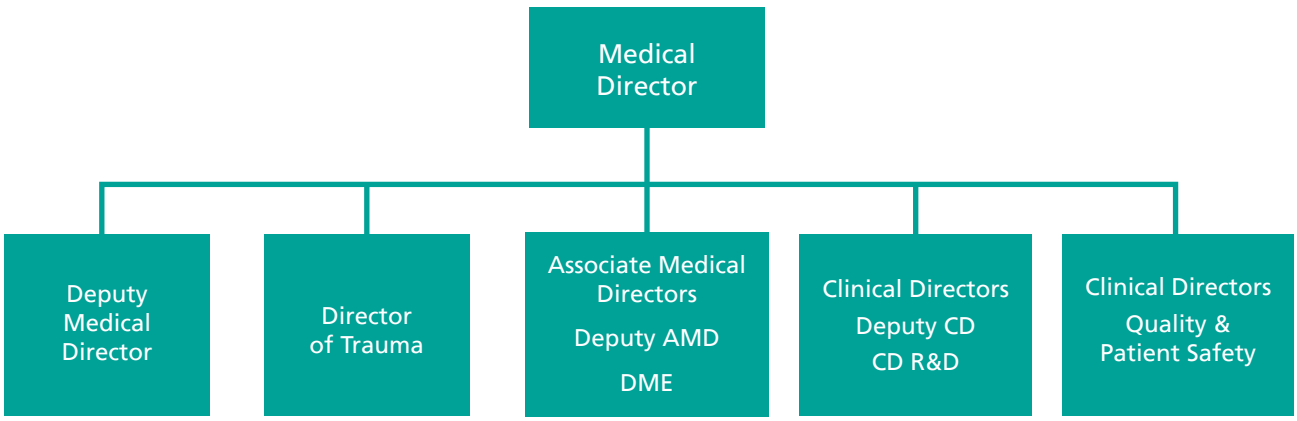
Headline

A white consultant has a relative likelihood of being appointed to a consultant manager role 1.22 times greater than a BME consultant.

Headline

BME consultants make up 16.7% of consultant managers, **one of only two** staff groups to achieve this.

Figure 1: Corporate structure for Medical Managers at Newcastle Hospitals.



[34]NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 29

Consultant Pay Gap

For consultant staff, pay progression is based on nodal increments which are not affected by ethnicity. These are fixed and are paid depending on number of years in service.

However, there are areas where consultants can earn additional income; additional programme activities, clinical excellence awards and responsibility allowances. Analysis will therefore be made up of three parts:

a. A typical full-time consultant's job plan will have 10 programmed activities. Additional programme activity (PA) can be paid to those undertaking additional clinical/ service commitments. The analysis will be made upon additional PA activity above 10 PA[35].

b. The second area are clinical excellence awards (CEA). These are awarded locally and nationally for clinical excellence. For the purposes of this report, we have looked at the local CEA awarded in the most recent round and the combined income from both local and national CEA awards across all consultants.

c. And finally, are responsibility allowances (RA) given for additional work, which includes; consultant managers, appraisers and educational work (tutors, programme directors).

Additional PA activity

Table 8 illustrates the spread of consultants over the 8 nodal points.

These nodal points are fixed payment progression points based on the number of years of service.

Therefore, no discretionary earnings can be achieved via this mechanism.

Consultants can earn additional PA payments based on additional clinical commitments (clinics, operating, etc.) as part of the job planning process. Table 9 shows that the average number of additional PAs for both BME and white staff is of a similar monetary value (slightly higher in the BME group). On face value, this is very encouraging.

Table 10 illustrates the breakdown of PAs amongst ethnicity and gender, and Graph 18 illustrates the differences amongst directorates.

What this data shows is that a female BME consultant makes more financially in additional PA (£13,396) compared to a female white consultant (£12,335). However, both values are still less than their male counterparts where the figures are similar for male white and male BME consultants (£15,958 and £15,934 respectively).

Additionally, Graph 18 shows some significant discrepancies in the way individual directorates have awarded PAs. 'Dental services' and 'Freeman peri-op' award white consultant staff on average 78% and 67% more in additional PA awarded compared to BME staff. On the other end of the spectrum, children's services award white consultants less than a BME Consultant (by 20%).

[34] The report had considered those who are on part-time contracts, staff on less than 10 PA, e.g.; 8 PA though work additional PA, however, there is no way of detecting this and therefore we were unable to analyse this as a sub-group.

Headline

In additional PA payments, female consultants lag behind male consultants, and some directorates are awarding white consultants significantly higher PA remuneration compared to BME staff.

Table 8: Consultant nodal points.

Ethnic origin	Pay threshold							
	1	2	3	4	5	6	7	8
BME	9.55%	6.37%	6.37%	7.01%	27.39%	21.66%	14.65%	7.01%
White	6.36%	6.20%	4.57%	5.22%	21.53%	17.94%	18.92%	19.25%
Undefined	5.88%	17.65%	0.00%	17.65%	11.76%	17.65%	23.53%	5.88%

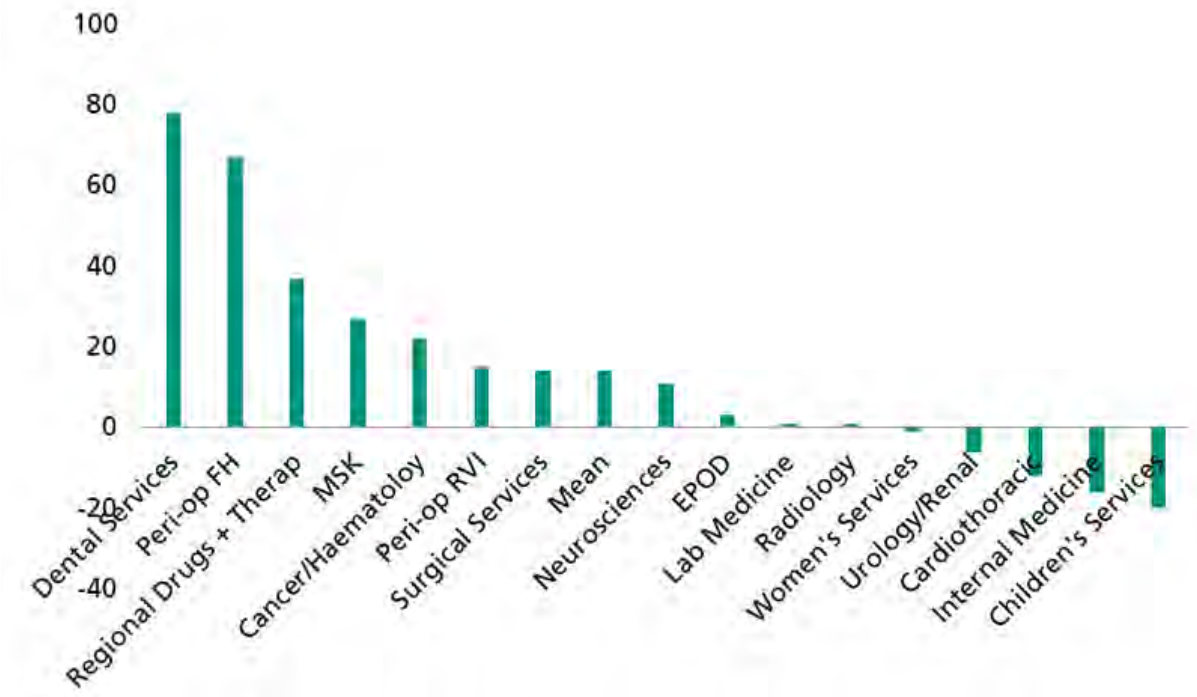
Table 9: Additional PA payments over standard 10 PA job plan for consultants.

Ethnic origin	PAs above 10 (%)	Average annual monetary value (£)
BME	70.44%	£15,435
White	55.06%	£15,060
Undefined	35.29%	£15,854

Table 10: PA awards spread by gender and ethnicity.

Ethnic origin	Female		Male	
	PAs above 10 (%)	Average annual monetary value (£)	PAs above 10 (%)	Average annual monetary value (£)
BME	55.00%	£13,396	75.63%	£15,934
Undefined	12.50%	£4,018	55.56%	£18,221
White	33.33%	£12,335	70.11%	£15,958

Graph 18: Percentage difference pay between white and BME consultants amongst the directorates.



Clinical Excellence Awards (CEA)

The report first looked at the average total earnings from CEA amongst all consultants in Newcastle (Table 11). This shows that on average, a BME consultant earns £8,860 a year from a local CEA, which is 24.5 % less than a white consultant. For national awards (Table 12), a BME consultant earns £44,400 a year, compared to £46,925 a year for a white consultant (only 5.4 % less).

We next looked at CEA awarded at the most recent local rounds (2017/18) (Table 13), and then by gender; male (Table 14), and female (Table 15).

Table 13 reflects the most recent local awards (2017/18). This data shows that the relative likelihood of a BME consultant applying for a CEA for 2017/18 is 1.2 times greater than a white consultant. And yet, the relative likelihood of a white consultant being awarded a CEA compared to a BME consultant being 1.3 times greater. Financially, this represents an average award of £3,290 for a BME consultant, compared to £3,740 for a white consultant.

Table 14 illustrates that a higher proportion of male BME consultants applied for the local CEA awards for 2017/18 (relative likelihood of 1.2 times greater). However, male white consultants were more successful at earning awards (relative likelihood of 1.5 times greater), with an average annual award difference of £293 (i.e.; an additional value of 8.6%).

Examining female consultants for the 2017/18 award (Table 15), there was a marginal increase in female BME staff (30.3%) compared to female white staff (28.57%) applying for a CEA award

(relative likelihood 1.1 times greater). BME staff were more successful at application (30% compared to 26.92% of white staff – relative likelihood 1.1 times greater), however, this did not equate financially with female white consultants yielding £3,878 per annum on average compared to a female BME consultant being awarded £3,016 per annum. This is an annual earning difference of £862, which represents an increase of 28.6% of a female BME consultant award compared to a white female consultant.

On grouping the awards by gender and ethnicity, further differences can be seen (Table 16). Table 16 demonstrates that for the 2017/18 awards, the best performers were female white consultants. The worst performing cohort were female BME consultants followed closely by male BME consultants.

Taking this further, we looked to see if the differences from the recent 2017/18 awards were reflected in the cumulative awards consultants receive from both local (Table 17) and national (Table 18) awards. This demonstrates that for both local and national CEA awards, female BME Consultants fair the worst, followed by male BME, then female white, with male white consultants earning the highest CEA awards by monetary value per year.

Headline

Cumulative CEA: Locally, a BME consultant makes 24.5% less than a white consultant compared to national awards which is only 5.4% less.

Headline

2017/2018 local awards: BME staff more likely to apply (1.2 times greater), white staff more likely to be awarded (1.3 times greater).

Headline

Despite more female BME consultants applying for a local CEA award than female white consultants in 2017/18 and more likely to be awarded one, the monetary value of their award was the lowest amongst any of the demographics.

Headline

For both local and national CEA awards, female BME consultants fair the worst, followed by male BME, female white and then male white consultants.

Table 11: Local CEA awards for consultants.

Ethnic Origin	Average Annual Monetary Value
BME	£8,860
White	£11,736.89

Table 12: National CEA awards for consultants.

Ethnic Origin	Average Annual Monetary Value
BME	£44,400
White	£46,925

Table 13: CEA awards for all consultants for 2017/18 local awards.

Ethnic origin	Eligible consultants	Applicants	Applicants (%)	Successful applicants	Successful applicants (%)	Average annual monetary value
BME	104	41	39.42%	11	26.83%	£3,290
White	436	147	33.72%	50	34.01%	£3,740
Undefined	14	4	28.57%	0	0.00%	N/A
Grand total	**554**	**192**	**34.66%**	**105**	**54.69%**	**£3,659**

Table 14: CEA awards for male consultants for 2017/18 local awards.

Ethnic origin	Eligible consultants	Applicants	Applicants (%)	Successful applicants	Successful applicants (%)	Average annual monetary value
BME	71	31	43.66%	8	25.81%	£3,393
White	254	95	37.40%	36	37.89%	£3,686
Undefined	9	3	33.33%	0	0.00%	N/A
Grand total	**334**	**129**	**38.62%**	**44**	**34.11%**	**£3,659**

Table 15: CEA awards for female Consultants for 2017/18 local awards.

Ethnic origin	Eligible consultants	Applicants	Applicants (%)	Successful applicants	Successful applicants (%)	Average annual monetary value
BME	33	10	30.30%	3	30.00%	£3,016
White	182	52	28.57%	14	26.92%	£3,878
Undefined	5	1	20.00%	0	0.00%	N/A
Grand total	**220**	**63**	**28.64%**	**17**	**26.98%**	**£3,726**

Table 16: Summary of gender/ethnic average annual monetary value from 2017/18 local awards.

	Male	Female
BME	£3,393	£3,016
White	£3,686	£3,878

Table 17: Cumulative local awards by gender/ethnicity.

Ethnic origin	Gender	Average annual monetary value
BME	Female	£7,917
	Male	£9,174
White	Female	£9,208
	Male	£13,021

Table 18: Cumulative national awards by gender/ethnicity.

Ethnic origin	Gender	Average annual monetary value
BME	Female	£0
	Male	£44,400
White	Female	£46,595
	Male	£46,981

Responsibility allowance

Responsibility allowance (RA) payments have been classified into three main roles; 'appraisers,' 'educational' roles within the organisation (education tutors, programme directors) or for 'management' positions. Tables 19-21 detail the percentage of consultants that this applies to for each of these three categories.

Appraisers

For appraisers, a white consultant has a relative likelihood of becoming an appraiser 1.22 times greater than a BME consultant. However, the average annual allowance is the same for both groups (£2,300).

Educational roles

A BME consultant has a relative likelihood of 1.91 times greater than a white consultant for having a paid educational role. However, a BME consultant earns less on average (£4,069 per year) compared to a white consultant (£4,617 per year).

Consultant managers

The relative likelihood of a white consultant receiving a 'management' RA is 1.53 times greater than a BME consultant. Additionally, a white consultant earns on average £14,976 per year, compared to a BME consultant who earns £11,778 per year.

Gender and ethnicity

When sub-classifying this by gender and ethnicity, appraisers (Table 22), both male/female, and BME/white, earn the same amount (£2,300 per year). The relative likelihood of a female BME consultant being an appraiser compared to a female white consultant is 2.7 times greater. Whereas the relative likelihood of a male white consultant being an appraiser compared to a male BME consultant is 2.8 times greater.

For 'educational roles' (Table 23), there are zero female BME consultants (as

defined in ESR) in this position. Whereas the relative likelihood of a male BME consultant being in an 'educational role' compared to a male white consultant is 4.1 times greater. Yet, the earnings of a male white consultant are £5,685 per year compared to £4,069 for a male BME consultant, £3,920 for a white female, and £0 for a BME female.

Taking this further to 'management' RA (Table 24), the relative likelihood of a female white consultant having a management RA compared to a female BME consultant is 1.5 times greater. Whereas the relative likelihood of a male white consultant with a management RA compared to a male BME consultant is 1.7 times greater. The monetary value varies with a female BME consultant making £3,821 more than a female white consultant. Whereas a male white consultant makes £5,626 more than a male BME consultant.

As a purely hypothetical model of combining all three types of RA together (appraisers, educational and management), the potential combined monetary value (Graph 19) for a female BME consultant receiving payments for all three types of RA, would be £13,300 per year, followed closely by a female white consultant at £13,399. There is then a jump to a male BME consultant at £18,319, and then a further jump to a male white consultant at £25,561.

Headline

RA payments for appraisers, educational roles and management roles, shows that in certain roles, there are more BME staff than white staff, however, financially, female BME staff fair the worst.

Tables 19-21: Responsibility allowances for (19) appraisers, (20) educational roles and (21) management.

Table 19: Responsibility allowances for appraiser roles.

Ethnic origin	Appraiser (%)	Average of resp. Allowance
BME	6.84%	£2,300
White	8.36%	£2,300
Undefined	12.50%	£2,300

Table 20: Responsibility allowances for educational roles.

Ethnic origin	Educational (%)	Average of resp. Allowance
BME	9.47%	£4,069
White	4.96%	£4,617
Undefined	20.83%	£4,267

Table 21: Responsibility allowances for management roles.

Ethnic origin	Management (%)	Average of Resp. Allowance
BME	5.79%	£11,778
White	8.88%	£14,976
Undefined	4.17%	£21,078

Table 22: RA for 'appraisers' by gender/ethnicity.

Ethnic origin	Appraiser (%)	Average of Resp. allowance
BME female	15.09%	£2,300
White female	5.67%	£2,300
Undefined female	11.11%	£2,300
BME male	3.65%	£2,300
White male	10.09%	£2,300
Undefined male	13.33%	£2,300

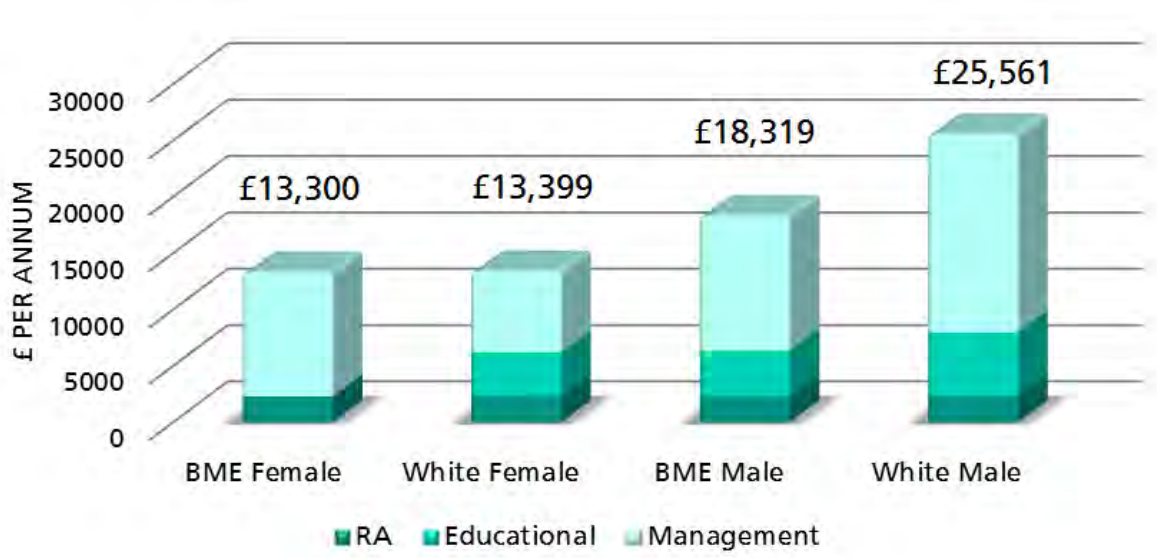
Table 23: RA for 'educational roles' by gender/ethnicity.

Ethnic Origin	Educational (%)	Average of resp. Allowance
BME female	0.00%	£0
White female	7.67%	£3,920
Undefined female	22.22%	£3,083
BME male	13.14%	£4,069
White male	3.22%	£5,685
Undefined male	20.00%	£5,056

Table 24: RA for 'Management Roles' by gender/ethnicity.

Ethnic origin	Management (%)	Average of resp. Allowance
BME female	3.77%	£11,000
White female	5.67%	£7,179
Undefined female	0.00%	£0
BME male	6.57%	£11,950
White male	10.94%	£17,576
Undefined male	6.67%	£21,078

Graph 19: Total earnings combining RA for 'appraisals', 'educational roles' and 'management.'



Summary medical

In summary, a BME member of staff applying for a consultant post is less likely to be short-listed and less likely to be successful than a white applicant.

Pay progression

- Pay progression is fixed.
- Overall additional PA payments are fairly equal amongst both BME and white consultant staff.
- Female consultants fair worse than male consultants.
- Looking across all directorates there are significant discrepancies over additional PA allocation.

Senior clinical managers

- A white consultant has a greater relative likelihood of 1.22 times of being appointed as a senior clinical manager than a BME consultant.
- BME consultants represent 16.7% of this cohort. This is marginally smaller than the overall consultant cohort of 19.7% but much larger than the overall workforce of 8.52%.
- This consultant staff group is **one of only two** staff groups that comes close to achieving BME representation.

However, the devil is in the detail, and this is reflected by the additional pay awards that consultants can work for.

CEA awards

- CEA awards demonstrate significant discrepancies, with female BME consultants fairing the worst for the 2017/18 awards, and overall accumulated CEAs over time.
- BME consultants are more likely to apply, however white consultants are more likely to be awarded than BME colleagues.
- The discrepancy in pay is greater for local awards than for national awards.

Responsibility allowances

- RA for appraisers, educational roles and management roles, show that in certain roles, there are more BME staff than white staff, however, financially, female BME staff fair the worst.

The report had also considered waiting list work. However, for the defined time periods we are unable to include payments earned for specific work carried out during the study period. Therefore, we have excluded waiting list work from the narrative.

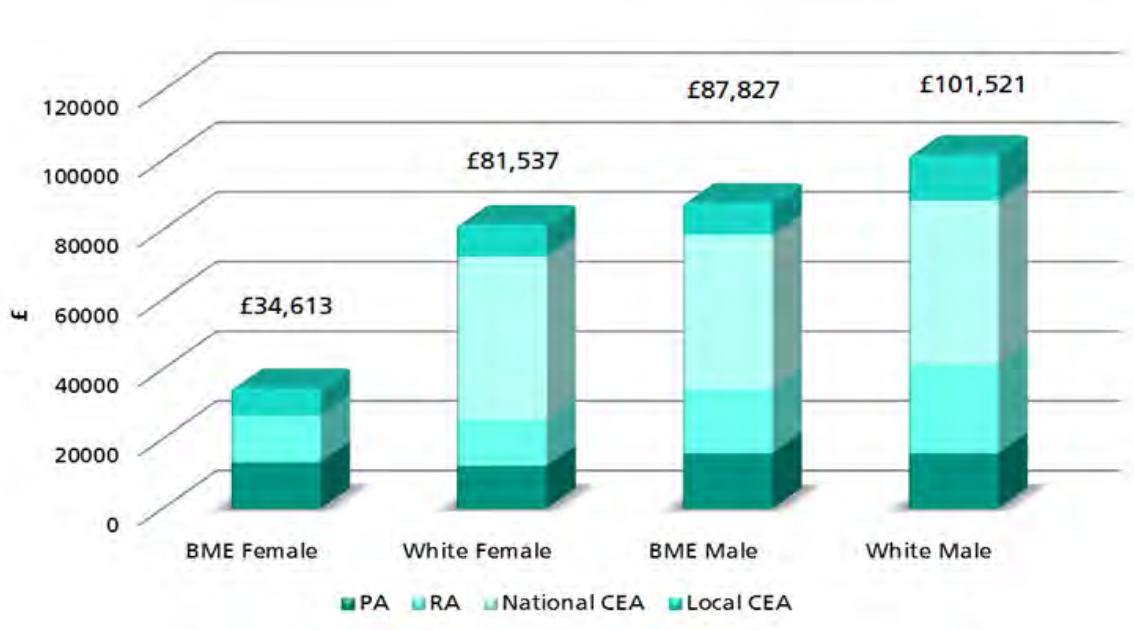
Reasons for the disparity for gender pay differences amongst consultants may be multi-factorial. One such factor is that women are more likely to care for children. The gender pay gap increases after childbirth and it is estimated that the gender differences in rates of part-time and full-time work account for more than half the pay gap among the 'highly-educated[36].'

Therefore, some of the data and results may be driven by and identify a gender pay gap, but examining this is not in the remit of this report.

In order to illustrate what the ethnic/ gender pay gap would look like in an extreme form, we have looked at what a consultant employed by Newcastle Hospitals would earn above their base pay if receiving average earnings per year for; additional PA, CEA and RA (Graph 20). What this graph shows is that the lowest income group would be female BME consultants, followed by female white consultants, male BME consultants and then a significant jump to a male white consultant (more than doubling their base NHS salary).

Although this is an extreme way of illustrating pay differences, overall, what this does demonstrate is a trend which can be seen by gender and ethnicity.

Graph 20: Combined earnings from additional PA, CEA and RA.



[36]Gascoigne, Charlotte 'The real reasons behind the gender pay gap' < https://timewise.co.uk/article/article-real-reasons-behind-gender-pay-gap>

Nursing

Newcastle Hospitals employs 4,700 Nursing staff, of which 512 (10.9%) are from a BME background[37].

Of these 512 nurses, there are **zero** in the senior nurse managers cohort (band 8 and above – Figure 2, Table 25). Of those remaining (Table 26), 100% (512) of BME nursing staff are at band 5-7.

Table 27 shows the breakdown of nursing staff in bands 5-7. This shows that 453 BME nurses are at band 5, 51 BME nurses at band 6 (9.9%), and 8 BME nurses are at Band 7 (1.6%). Contrast this to 28% of white nurses in this cohort are at band 6, and 16.4% at band 7 (Graph 21).

The BME representation at band 6 level for nursing staff at 9.9 % therefore comes close to the overall BME representation in the 'nursing and midwifery' staff group (Graph 2) which is 10.9%, and is above the Newcastle rate of 8.52%. This is therefore only the **second of two** staff groups to achieve BME representation.

Of the BME nurses at band 6 and 7, Table 28 shows the range of jobs that they perform. Within this cohort, there are no senior ward sisters (Band 7), however, there are 37 Band 6 ward sisters/charge nurses.

At band 7, these posts include; nurse practitioner (n=4), senior research nurse (n=1), senior IP&C nurse (n=1) and nurse specialist (n=1) roles. Contrast this to the senior nurse positions (Table 29/Figure 2), where there are no (zero) BME staff.

Table 25: Number of nursing staff employed (all AfC bands).

Ethnic origin	All nurses	Nurse managers
BME	512	0
White	4,121	47
Undefined	67	0
Grand total	**4,700**	**47**

[37] Data as of 31st March 2019.

Figure 2: Corporate structure for nursing managers at Newcastle Hospitals.

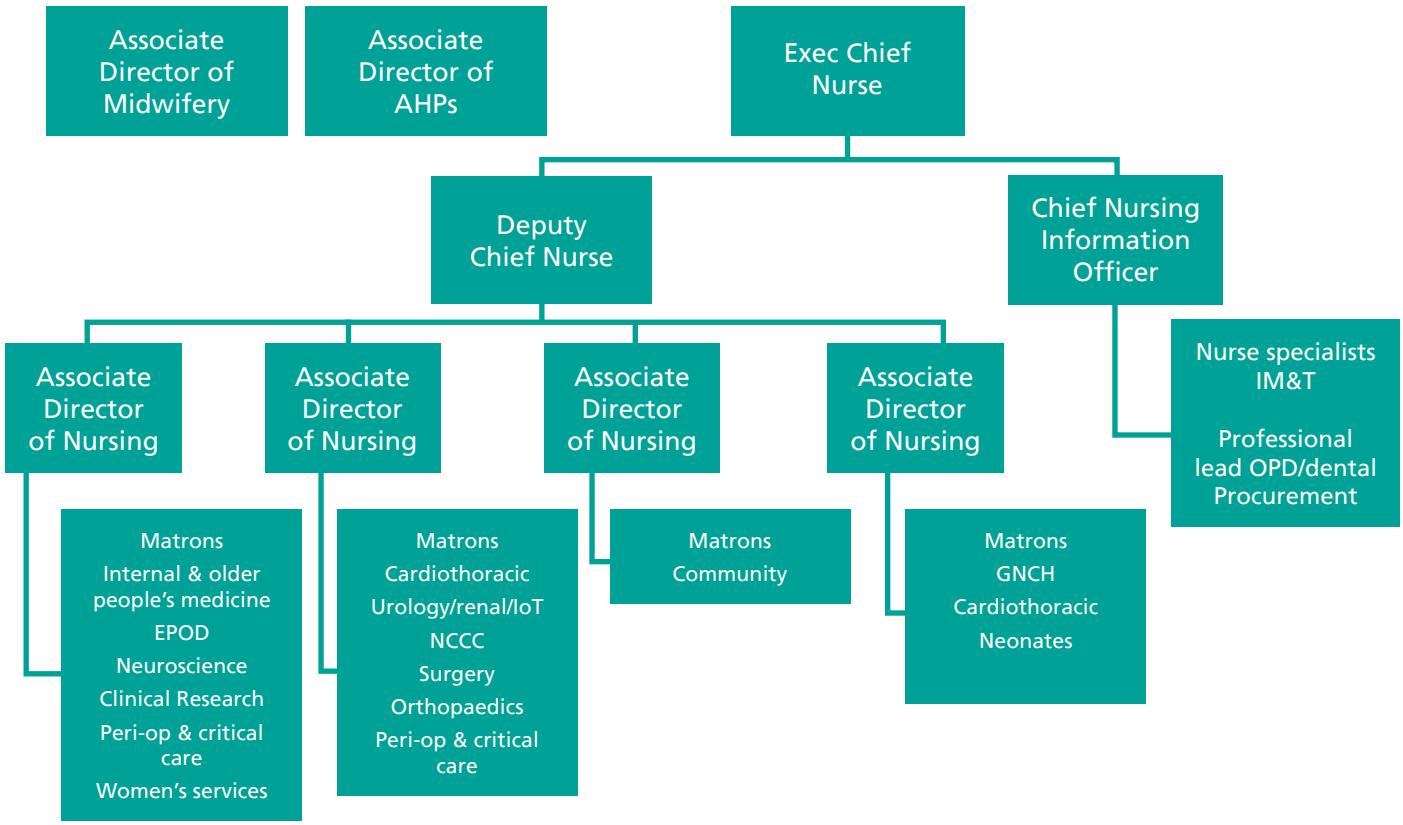


Table 26: Numbers of nursing staff at AfC bands 5-7.

Ethnic origin	All nurses	Nurses (Bands 5 - 7)	%
BME	512	512	100.00%
White	4,121	4,018	97.50%
Undefined	67	66	98.51%
Grand total	**4,700**	**4,596**	**97.79%**

Table 27: Breakdown of AfC bands 5, 6 and 7 nursing staff.

Ethnicity	Band 5	Band 6	Band 7	Grand Total
BME	453	51	8	512
White	2,231	1,127	660	4,018
Undefined	36	20	10	66
Grand Total	**2,720**	**1,198**	**678**	**4,596**

Graph 21: Percentage distribution of nurses across AfC bands 5-7.

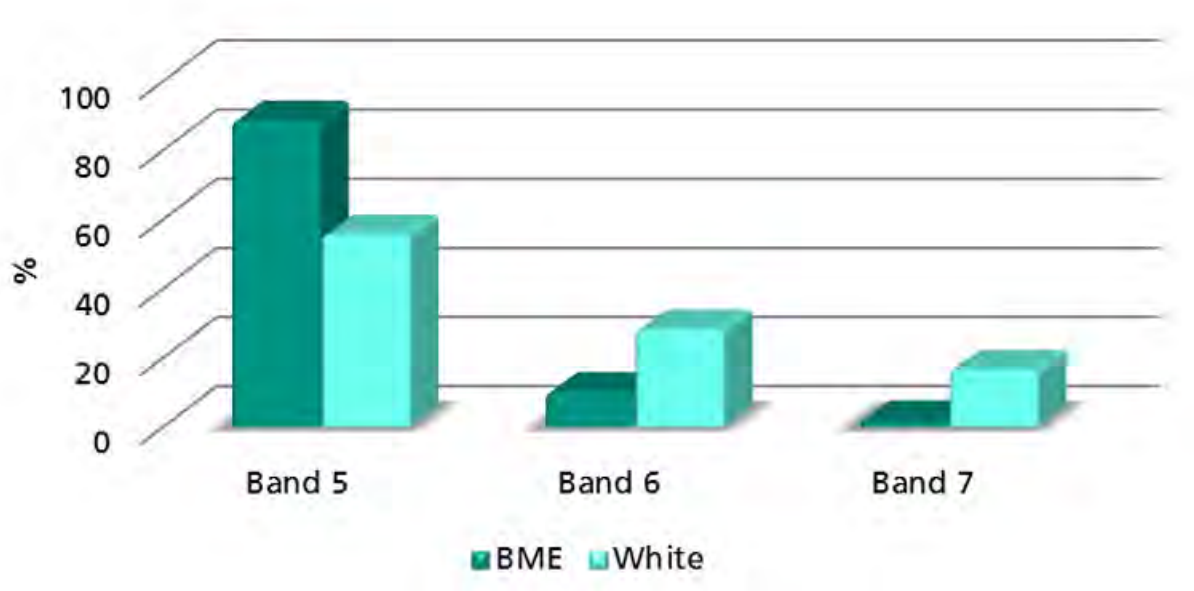


Table 28: Range of jobs performed by band 6 and band 7 BME nursing staff.

Sister/ Charge Nurse Band 6	35
Nurse specialist Band 6	7
Nurse practitioner Band 7	4
Midwife Band 6	3
Nurse practitioner Band 6	2
Senior research nurse Band 7	1
Senior IP&C nurse Band 7	1
Senior staff nurse Band 6	1
Senior staff nurse/team lead Band 6	1
Nurse specialist Band 7	1
Surgical care practitioner - nurse Band 7	1
Research midwife Band 6	1
Research nurse Band 6	1
Grand total	**59**

Table 29: Senior nursing positions (band 8 and above).

Position	Numbers
Chief nurse	1
Deputy chief nurse	1
Associate director of nursing	3
Associate director of midwifery	1
Deputy director of nursing & patient services	1
Acting matron	2
Community matron	1
Matrons	36
Research matron	1
Grand total	**47**

Recruitment of nurses

For the period April 2018 to May 2019, recruitment data for all nurses (to all bands) showed that 53.24% of BME applicants are shortlisted, compared to 68.22% of white staff (Table 30). Of those that are short-listed, 17.39% of BME staff are successful, compared to 30.78% of white staff. This gives a relative likelihood of a white nurse being appointed from shortlisting compared to a BME nurse being 1.77 times greater.

During this same time period, 1,504 nurses applied for Band 6 and 7 positions. Of those that applied (Table 31), 54.55% of BME staff were short-listed, compared to 69.08% of white staff. However, 17.59% of BME staff that were short-listed were successful at interview, compared to 30.37% of white staff. This represents a relative likelihood of a white nurse being appointed from short-listing compared to a BME nurse being 1.73 times greater.

Compare this to recruitment data for all Band 8 vacancies (Table 32), where 4 BME nurses applied, of which 2 were short-listed and none were successful. In contrast, 77.22% of white nurses were short-listed from application, and 37.7% were successful from the short-listed group. However, what this does represent is a 100% white nursing workforce at band 8 and above.

Summary

In summary, band 6 nursing staff are only the **second staff group** to reach BME representation at Newcastle Hospitals. However, from band 7 this changes with **zero** representation at band 8 and above.

Table 30: Recruitment of all nurses.

Ethnic group	All applications	Shortlisted (No.)	Shortlisted (% of all applicants)	Successful (No.)	Successful (% of shortlisted)
BME	216	115	53.24%	20	17.39%
White	1,457	994	68.22%	306	30.78%
Not disclosed	22	15	68.18%	4	26.67%
Grand total	**1,695**	**1,124**	**66.31%**	**330**	**29.36%**

Table 31: Recruitment to Band 6 & 7 Nursing staff jobs.

Ethnic group	All applications	Shortlisted (No.)	Shortlisted (% of all applicants)	Successful (No.)	Successful (% of shortlisted)
BME	198	108	54.55%	19	17.59%
White	1,287	889	69.08%	270	30.37%
Not disclosed	19	13	68.42%	3	23.08%
Grand total	**1,504**	**1,010**	**67.15%**	**292**	**28.91%**

Table 32: Recruitment to all Band 8 nursing staff jobs.

Ethnic group	All applications	Shortlisted (No.)	Short-listed (% of all applicants)	Successful (No.)	Successful (% of shortlisted)
BME	4	2	50.00%	0	0.00%
White	79	61	77.22%	23	37.70%
Not Disclosed	1	0	0.00%	0	0.00%
Grand total	**84**	**63**	**75.00%**	**23**	**36.51%**

Senior non-clinical groups

The report shall now consider the demographics of the senior non-clinical management teams.

This will cover the following cohorts:

- Board of directors
- Very senior management
- Directorate teams

Board of directors

Included within this cohort are the chair of the board of directors, the chief executive, the chief operating officer, the medical director, the executive chief nurse, director of finance, and 7 non-executive directors.

Of these 13 members of the Executive Team; 100 % are White, 0% are BME.

Very senior management

Within this cohort, exist the very senior management (VSM) team. This is composed of:

- Chief information officer
- Director of quality & effectiveness
- Director of estates
- Director of HR
- Director of communications
- Director of pharmacy
- Deputy director of business development
- Deputy director of finance
- Head of clinical management
- Trust secretary

Of these 10 members of the VSM; 9 are white, 0 are BME, and 1 is undefined.

This is indicator 1 of the WRES data and VSM includes, 'chief executives, executive directors (not consultants) and other senior managers with board level responsibility reporting directly to the chief executive[38].

Nationally, 6.9% of BME staff held VSM positions in 2018 (this remains lower than the national proportion of BME staff at 19.1% in all NHS Trusts[39]).

Directorate (non-clinical managers) teams

This group includes the directorate management teams. Of which 100% are white, 0% BME (Table 33).

Senior managers

29 staff members are included within the 'senior manager' cohort (Table 34). Of this group, 86.21% are white, 13.79% undefined, 0% BME.

Other senior staff

Within this cohort (Table 35) of 44 'other senior staff,' 90.91% are white, 9.09% are undefined, 0% are BME.

[38]NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 29
[39] NHS Equality and Diversity Council, 'NHS Workforce Race Equality Standard: 2018 Data Analysis Report for NHS Trusts' [January 2019] 6

Table 33: Directorate teams.

Row labels	Count of full name
Directorate manager	17
Assistant directorate manager	10
Deputy directorate manager	2
Directorate administration manager	2
Matron/ deputy directorate manager	1
Grand Total	**32**

Table 34: Senior managers.

Row labels	Count of full name
Consultant clinical psychologist	8
Assistant director of pharmacy	3
Consultant clinical scientist	2
Director of pharmacy for regional drug & therapeutics	1
Head of therapy services	1
Head of nuclear medicine	1
Clinical scientist	1
Chief executive officer of academic health science network	1
Clinical scientist - head of laboratory	1
Head of human resource services	1
Assistant director production & preparation	1
Head of section - physiological measurement	1
Head optometrist	1
Head of unit	1
Lead pharmacist	1
AD contracting & performance	1
Regional QA specialist/ lead for Newcastle therapeutics	1
Consultant paediatric neuropsychologist	1
Deputy head of section - radiotherapy	1
Grand total	**29**

Table 35: Other senior staff.

Positions	Numbers
Laboratory manager	3
Consultant clinical scientist	3
Assistant director of finance	2
Deputy chief operating officer	2
Clinical Lead - talking helps newcastle	2
Head of section - nuclear medicine	2
Estates corporate services manager	1
Senior project manager - transformation	1
Head of workforce development	1
Head of service - psychology in healthcare	1

Positions	Numbers
Consultant clinical psychologist-paed cardiac & tx	1
Assistant director of pharmacy - quality assurance	1
Head of medi & den resourcing & trust reward	1
Head of prescribing support	1
Project director - financial improvement	1
NAATTC operations manager	1
Emeritus professor	1
Assistant director - business strategy & planning	1
Deputy director of estates	1
Head of unit	1
Head of IT service management	1
Assistant finance director - financial mgt	1
Head of strategy, planning & capital development	1
Assistant finance director - financial planning	1
Operational director	1
Head of radiotherapy physics	1
Quality improvement programme manager	1
Head of section	1
Deputy head of nuclear medicine	1
Consultant clinical psychologist - C, L & P	1
Data and informatics director	1
Assistant finance director - R&D	1
Head of REAL	1
Asst director - urgent care, Integ. & out of hospital care	1
Consultant clinical psychologist	1
Chief operating officer of LCRN	1
Grand total	**44**

Summary

Within the senior non-clinical members of the organisation, against a total cohort of 128[40], there are 0% from a BME background. This falls far short of the 8.52% of the overall workforce.

Considering the 2018 WRES national data which found 6.9% of the VSM group to be BME, with the Newcastle data for VSM at 0% for 2019, and the overall representation remaining at 0% for BME across all platforms of senior non-clinical roles, demonstrates a significant under-representation of BME staff within this broader more senior cohort

[40] Note: some jobs have been coded into more than one group

National WRES Action Plan: 'A Model Employer'

The 'WRES Action Team' aspirations include ensuring BME representation at 'all' levels of the workforce, including leadership positions by March 2028[41]. All organisations must be able to demonstrate that they are actively improving WRES indicator data; by publishing their data, by reviewing recruitment processes for all posts across their organisation, using comparison data to understand trends over time and producing regular reports to boards to indicate what they have achieved[42].

The WRES action team published 'A Model Employer[43]' earlier this year, which argues for a clear need for 'accelerated improvement[44].' They have set 5-year hurdles (2023, 2028 and 2033[45]), with the objective of achieving full BME representation across the workforce by 2028[46].

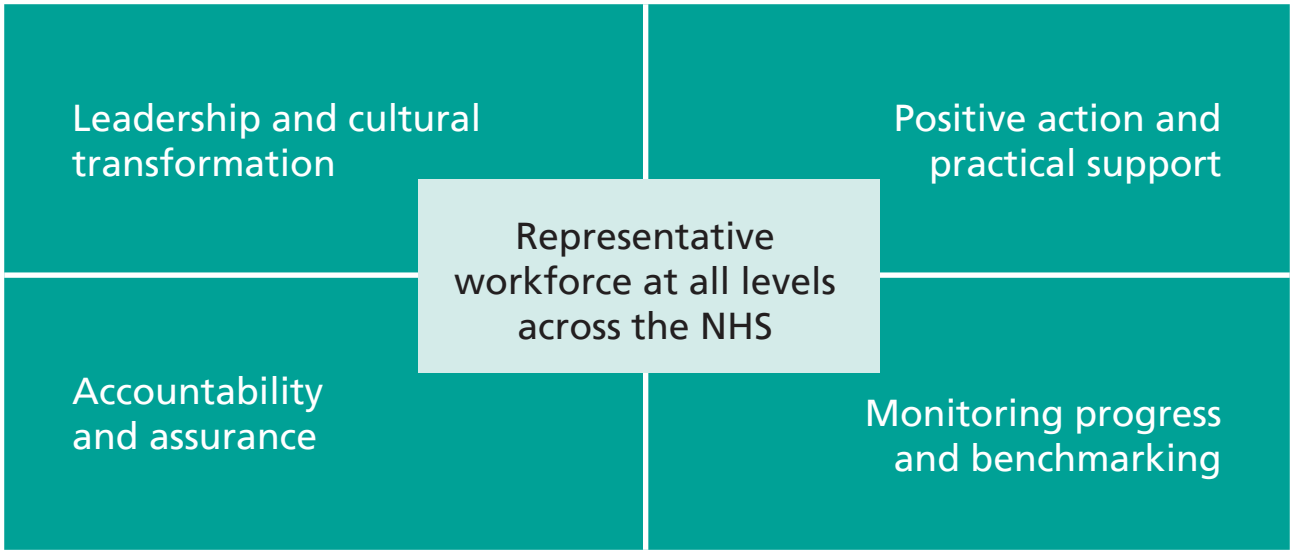
For Newcastle Hospitals, this would mean employing 1 in every 9 staff recruited to band 8a from now on from a BME background[47]. For VSM across the NHS, this would mean ensuring 1 in 4 of all new VSM appointed are from a BME background[48].

For these goals to be achieved, Trusts will have to agree their targets for BME representation with a workable WRES action plan to deliver it[49]. This can be achieved by developing existing talent from within the NHS, though also bringing talent in from outside the NHS. The WRES team would act to support local NHS Trusts in achieving this.

The next phase is moving from the 'why' to the 'how[50].' The WRES action team have outlined various strategies to achieve this (Figure 3).

[41]NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 27
[42]NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 28
[43]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019]
[44]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019] 8
[45]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019] 9
[46]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019] 9
[47]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019] 10
[48]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019] 9
[49]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019] 10
[50]NHS Equality and Diversity Council, 'NHS Workforce Race Equality Standard: 2018 Data Analysis Report for NHS Trusts' [January 2019] 8

Figure 3: Evidence based model for improving BME representation across the NHS workforce[51].



Leadership

- Demonstrate commitment.
- Develop mentors.
- Recruitment drive for non-executive directors from BME backgrounds.
- Regional approaches and national focus.

Positive Action

- Talent management – help progression by expanding experience.
- Diverse shortlisting – holding to account recruiting managers.
- Diverse interview panels – having BME members on both shortlisting and interview panels (and where BME staff are not appointed, provide reasons to the Chair of the Trust).
- Develop regional WRES experts to help oversee and champion WRES implementation.
- Promote success and replicate good practice.

Accountability and Assurance

- Build accountability, using CQC and CCGs.
- Performance objectives for senior leaders and board members built into their appraisal process.
- Develop BME staff networks.

[51]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019] 11

Monitoring

- WRES annual data collection.
- Benchmarking processes.

The aim will be to develop a WRES Strategic Advisory Group to oversee the above implementation that would report to NHS England and NHS Improvement[52].

Further advice will be produced by the WRES action team over the next few months with a detailed action plan to deliver these ambitions[53].

[52]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019] 15
[53]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019] 16

Report recommendations

The authors recognise that the Trust has already started its journey to improve the experiences of BME staff. 'Flourish at Newcastle Hospitals', is now the cornerstone framework through which the Trust aims to build, shape and develop ideas which can enhance the working environment for all staff.

The need for the development of mentors, ensuring diversity in talent management strategies, including BME representation on interview panels and seeking greater diversity in executive and non-executive positions is already recognised within the Trust. A new equality, diversity and inclusion workstream has been formed as part of the 'great place to work delivery board', a central pillar of the wider North East & North Cumbria Integrate Care System (ICS). Membership will include partners from across the system.

What this report sets out to do is to recommend additional targets to the current WRES action plan[54], and the national WRES action team's proposed model to help generate a model that we can use locally going forward. These recommendations have been produced with the help of the Trust's BME staff network committee.

Our report recommends an interim 5-year target (2024) within the overall ambition of meeting the 10-year targets as set-out by the 'a model employer[55]' document. This initial 5-year target does not require specific number/quota targets, however, looks at mechanisms that can be used to promote staff development, ensuring appropriate reflection and further action if required. This first stage is intended to change the culture and behaviour within the organisation.

One of the Trust's strategic objectives is to be 'the recognised employer and educator of choice with a diverse, engaged and motivated workforce'. As a significant employer in the North East, and an anchor organisation within the NHS, there is a need to signal our assertion that promoting equality and inclusion is a key enabler in achieving that objective.

[54]http://www.newcastle-hospitals.org.uk/downloads/HR/Workforce_Race_Equality_Standard_Action_Plan_2019-20.pdf
[55]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019]

Reviewing the data alone will not achieve the change we want to see in our workplace – as an 'exemplar' employer, we need to take bold steps to affect change and achieve our aspiration.

The Report recommends establishing the following pathways:

- Local steering group
- People committee
- BME freedom to speak up guardian
- North of England regional BME network
- Talent management
- Mentoring
- Corporate performance reviews and directorates
- Training
- Accountability

Local steering group

A WRES sub-group already exists which currently monitors progress against the Trust's WRES action plan.

This report recommends establishing a 'representative workforce' group formed alongside the WRES sub-group, to achieve the first 5-year plan of this report. It will be established by drawing upon members of the local BME staff.

On this committee, representatives from various staff groups will be appointed (Table 37).

Table 37: Membership of the local steering group.

Staff Group	Numbers
Medical	2x consultants
Nursing & midwifery	2x Band 6 and above
AHP	2x Band 6 and above
Management	2x
Board level	1x
HR	1x

The function of this committee is to be responsible for implementing the first 5-year plan, overseeing annual audits and review of targets.

Members of this committee should be involved in **all** interviews for any Band 7 and above vacancies for; senior managers, nursing and midwifery, consultant, senior consultant managers and Board appointments. The committee's remit is to enable and facilitate progression and ensure diverse representation on recruitment panels.

It is recommended that members of the committee are represented on local CEA panels and any panel involving the interview of a senior clinical, nursing or management position.

All future vacancies (band 7 and above, consultant, senior clinical manager, very senior management) should be advertised for a recognised accepted period of time. Relevant departments and networks (local and regional) should be notified to ensure any relevant

applicant has the opportunity to apply. Directorate managers/clinical directors/ Matrons will be required to notify (email) all eligible staff within their directorates a link to the advert on NHS jobs with a notification of closing date.

To overcome bias from members partaking in interviews for their own staff group, a member from a different staff group should participate as a panel member. The purpose is to ensure parity in any appointment. The outcome of any appointment will take part of an annual review.

Any failure to appoint a BME candidate should be fed back to their line manager to facilitate appropriate training for any future applications. This should be replicated for all internal candidates, regardless of demographic.

People committee

A member of the local steering group to attend the 'people committee.' To promote dialogue and participation on a different platform.

BME freedom to speak up guardian

A point of contact for all BME staff to be able to confidentially discuss concerns regarding discrimination, who can then act as their advocate. This concept has already been incorporated into the Trust's WRES action plan. The recommendation of this report is to implement the role with a primary focus on bullying, harassment and abuse.

North of England regional BME network

The Trust is currently seeking representation from NHS partner organisations to form a regional BME staff network.

This report is recommending that a member of the local steering group shall work with neighbouring NHS organisations as part of a larger North of England regional network. Initially, the aim is to replicate the data sets for each individual NHS employing organisation (including CCGs) in the region. Data can then be benchmarked across all NHS employers across the North of England.

The advantage of a regional network is to pursue a common goal for the region. It will also help develop 'talent management' across the local networks to improve selection into appointments and develop common career progression themes for the region.

Talent management

Aim to promote and nurture career progression amongst BME staff.

Annual regional events will be held. To ensure staff attendance, these events should become part of mandatory staff development (once in a 5-year cycle). If staff are unable to attend within any given 5-year cycle, then their line manager must account for their absence.

In these annual events, staff development sessions will be held. These will target junior doctors, nurses, AHP and managers. Each session will be chaired by a member of the local steering committee and will have clinical educators in support.

The aims of each session are to inform staff on the following:

- How to proceed in their career.
- What courses to attend.
- How to apply for jobs.
- Interview skills.
- Mentoring opportunities.

Mentoring

Local steering group members to act as mentors for junior BME staff to act as role models and encourage staff development.

'Reverse mentoring' already forms part of the WRES action plan and there are plans in place to bring together more senior members of staff to engage with junior BME staff to understand the needs of the local BME community.

Corporate performance reviews and directorates

In the current WRES action plan, an equality dashboard is in development that will form part of each directorate's performance review. This report recommends that this should also be part of the annual performance reviews for clinical directors, directorate managers and matrons.

An equality dashboard with the annual staff survey WRES results will be given to each directorate (where they are available) on an annual basis. Clear equality and diversity objectives part of annual appraisals.

Each directorate to appoint a BME representative to attend quarterly BME staff network meetings, who can then report back via existing directorate communications. Directorates should be supported by local clinical educators to ensure staff have access to training and career progression.

Training

Training workshops for senior staff and line managers. The WRES action team will be invited to also facilitate training.

Accountability

The local steering group will be responsible for undertaking annual reviews which will be reported to the board of directors. This will include:

- Annual updates of data from this report.
- Report and analyse trends over 5 years.
- Integration with the regional network.

Summary

In the event that this initial 5 year approach does not make significant changes to BME representation across all staff groups by 2024, then further measures should aim to achieve the WRES action plan targets as set out in their document 'a model employer.'

The report recognises that to partake in all short-listing and all interviews is not achievable in the first 5-year target but may have to be considered if there is a failure to achieve a culture change by 2024.

Conclusion

The NHS Constitution is founded upon a core set of values that binds together the diverse communities that the NHS serves; the patient, the public and the staff that work within it[56]. Evidence demonstrates that improving staff experience does improve patient outcomes and organisational efficiency[57].

A key commitment within the NHS Long Term Plan and more recently, the Interim People Plan, is to create an inclusive and compassionate culture, focussing on promoting equality, inclusion and widening participation.

However, there must be a very careful and well thought-out balance between the need to drive a meritocracy, from what could be perceived as positive discrimination. There must be a simple goal of appointing the right person for the job, without any ethnic, gender or sexual bias.

What this report does not seek to achieve is an imbalance to the BME community over other demographics. Indirectly, this report has reflected the problems that female staff also face in particular with additional payment awards for consultants. Data on sexual preference (LGBT) have not been analysed due to the inherent difficulties of obtaining true data sets on this.

The 'Flourish at Newcastle Hospitals' framework has given increased impetus to creating an environment in which all staff are able to realise their potential and build a more diverse and representative workforce. This is, in-part, reflected in the staff survey results which are encouraging when benchmarked nationally. However, there is still much to do to positively encourage, support and facilitate career progression and develop BME 'role model' leaders.

What this report has not been able to achieve is to examine 'white' groups that originate from non-UK countries. For first generational members there are clear cultural and language differences, although not visual. However, in order to have comparative data, this report has kept with the 2001 ONS guidelines on this (appendix two).

There is also scope to consider generational affects for members from BME backgrounds to determine whether second and subsequent generation BME staff have differing career and financial advantages compared to a first generation BME member of staff, and whether those differences end up heading towards a comparable white member of staff.

Finally, the reasons for bias are multi-factorial, and encompass both the conscious and unconscious bias. This was beyond the remit of this report. However, it is how we change the narrative that is important here; in making progress to ensure equality for the workforce.

In conclusion, the aim of this report is to simply establish a true meritocracy that would benefit everyone. The mechanism by which this is driven must not be seen as a divisive force that produces a 'them and us' culture, but rather a culture that promotes talent management that is blinded to bias, and financial reward that reflects an individual's personal capabilities and not their peer group demographic.

The 5-year approach that this report recommends serves this purpose. The momentum for change should be used to generate a true 'Northern Powerhouse' that reflects its diverse population.

[57]NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 5
[56]NHS Equality and Diversity Council, 'NHS Workforce Race Equality Standard: 2018 Data Analysis Report for NHS Trusts' [January 2019] 8

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Metropolitan Police diversity data <https://fullfact.org/crime/does-metropolitan-police-reflect-londons-ethnic-diversity/>

NHS Staff Survey Results <http://www.nhsstaffsurveyresults.com/local-workforce-equality-standards-wres/>

NuTH WRES Action Plan <http://www.newcastle-hospitals.org.uk/downloads/HR/Workforce_Race_Equality_Standard_Action_Plan_2019-20.pdf>

Legislation

Equality Act 2010

Race Relations Act 1965, 1968, 1976 and 2000

Appendix one: WRES indicators[58]

	Workforce Indicators
1.	Percentage of staff in each of the AfC Bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce disaggregated by: • Non-clinical staff • Clinical staff - of which - Non-medical staff - Medical and dental staff • Note: Definitions are based on electronic staff record occupation codes with the exception of medical and dental staff, which are based upon grade codes.
2.	Relative likelihood of staff being appointed from shortlisting across all posts Note: This refers to both external and internal posts
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. Note: This indicator will be based on data from two year rolling average of the current year and the previous year. For consistency, organisations should use the same methodology as the have used.
4.	Relative likelihood of staff accessing non-mandatory training and CPD.
National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BAME staff	
5.	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6.	Percentage of staff experiencing embarrassment, bullying or abuse from patients, relatives or the public in the last 12 months.
7.	Percentage believing that trust provides equal opportunities for career progression or promotion

[58]NHS England, 'WRES Technical Guidance for the NHS Workforce Race Equality Standard (WRES)' [May 2019] 17

	Workforce indicators
8.	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
Board representation indicator For the indicator, **compare the difference for white and BME staff**	
9.	Percentage difference between the organisations' board membership and its overall workforce disaggregated: • By voting membership of the board • By executive membership of the board Note: This is an amended version of the previous definition of indicator 9.

Appendix two: WRES technical data categories for coding

Ethnic categories 2001
A - White British
B - White - Irish
C - Any other white background
D - Mixed white and black Caribbean
E - Mixed white and black African
F - Mixed white and Asian
G - Any other mixed background
H - Asian or Asian British - Indian
J - Asian or Asian British - Pakistani
K - Asian or Asian British - Bangladeshi
L - Any other Asian background
M - Black or black British - Caribbean
N - Black or black British - African
P - Any other black background
R - Chinese
S - Any other ethnic group
Z - not stated
Note: a more detailed classification for local use if required is contain in Annex 2 of DSCN 02/2001

Old ethnic codes
Staff employed after 1 April 2001 must have their ethnics group assessed and recorded using the new categories and codes detailed to the left. The "old" codes shown below are for reference only
0 - White
1 - Black - Caribbean
2 - Black - African
3 - Black - Other
4 - Indian
5 - Pakistani
6 - Bangladeshi
7 - Chinese
8 - Any other ethnic group
9 - Not given

Appendix three: WRES action plan in supporting ambition[59]

Leadership and cultural transformation

Demonstrate commitment to becoming an inclusive and representative employer -role modelling on race equality - work will be carried out to transform deep-rooted cultures of workforce inequality via organisation leadership strategies. A focus here will be upon NHS Improvement's Culture and Leadership Programme. Leaders should engage stakeholders in helping to share rationale and process for improvement.

Require VSMs and board members to mentor/reverse mentor and sponsor at least one talented ethnic minority staff at AfC band 8d or below - coaching skills and structured support will be made available to senior staff carry this out. Mentoring, reverse mentoring and sponsoring will be part of the senior leader's performance objectives that will be monitored and appraised against.

Recruitment drive on BME non-executive directors (NEDs) - as a starting point, a drive to appoint BME NEDs will be encouraged. Existing NEDs will be encouraged to play an active role ion mentoring and sponsoring BME staff that have the potential to get to an executive role within three years.

Regions, STP, and ICS work - the WRES team is supporting regional approaches to improving workforce race equality, including across London and the north of England. Innovative work is being carried out across Greater Manchester, where the WRES is being extended across health and social care, and beyond. A key focus here will be upon the new and emerging healthcare architecture, including integrated care systems (ICSs), and sustainability and transformational partnerships (STPs).

Continued national focus - the WRES programme which supports the NHS to become better and more inclusive employer - making full use of its diverse workforce, should be embedded within key future workforce policies and strategies for the NHS, including within the Long Term Plan for the NHS.

Positive action and practical support

Talent manager - in order to meet the set aspiration, concrete measures to remove barriers for our most talented BME staff succeeding will be put in place. To enable this to happen, there needs to be

[59]NHS England, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS' [January 2019]

consistent narrative within organisations, based on a fit-for-purpose approach to effective talent management across the NHS.

From the diverse NHS workforce that we have, we will identify the most talented staff and help them to progress. But this must not be a 'tick-box' exercise of simply increased BME numbers; BME staff need to be supported to expand their experiences and skills, particularly where the opportunities to do this have not been made readily available.

Diverse shortlisting and interviewing panels - recruiting managers will be held accountable for institutionalising diverse shortlisting and intevriew paenls. There would seldom, be acceptable exceptions for not having a BME member on shortlisting and interview panels; this is firmly within the organisation's control. Where BME interviewees are not appointed, justification should be sent to the organisation's chair setting out, clearly, the process followed and the reasons for not appointing the BME candidate.

Batch interviews should be considered where appropriate - panel interviews of single applicants may not always provide the optimum assessment of the candidate's skill and capabilities, and can contribute towards creating conditions for bias. Organisations will be encouraged to examine the merits of interviewing batch of candidates for a number of different roles or positions.

Technical WRES expertise at regional levels - the WRES experts programme aims to develop cohorts of race equality experts from across the NHS to support the implementation of the WRES within their organisation. Participants become part of a network of professionals across the NHS that advocate, oversee and champion the implementation of the WRES at regional and local level. The work on meeting leadership aspirations at local level will be built into the existing WRES experts programme.

Promote success and share replicable good practice - identification and dissemination of models of good practice, evidence based interventions and process from across the NHS - from the wider public, private, voluntary and charitable sectors - will help support NHS organisations to achieve the required outcomes.

Accountability and assurance

Build assurance and accountability for progress - NHS organisations across the country will be supported to develop workforce race equality strategies and robust action plans that are reflective of their WRES data. These action plans provide an ideal vehicle to continuously improve on the issues that, the data show, are the key concern for organisation. Progress against the aspirations will form part of an organisation's action planning for the WRES.

The support of assurance and regulatory bodies continues to be essential in achieving progress on WRES implementation, and will be critical in going forward. As a start, progress against meeting the BME leadership aspiration will be firmly embedded in NHS Improvement's Single Oversight Framework.

The Care Quality Commission (CQC) already reviews against the WRES as part of its inspections of the 'well-led' domain. Work will be carried out to further strengthen the 'well-led' inspection framework to give greater weight to organisational progress in tackling workforce race inequality through robust implementation of the WRES, and in promoting diversity more generally.

As part of the CCG Improvement and Assurance Framework, CCGs will be required to give assurance that their providers are implementing the WRES and progressing on the BME leadership aspiration, and that they themselves are doing the same. The WRES team will ensure that progress on this agenda will be embedded within this existing lever of accountability and assurance.

Senior leaders and board members will have performance objectives on workforce race equality built into their appraisal process - senior leaders should be held accountable for the level of progress on this agenda. Working with national healthcare bodies, progress on workforce race equality will be embedded within performance reviews of chairs and chief executives - including emphasis on WRES implementation and on progress in meeting the set goals for their respective organisation.

Building the capability and capacity of BME staff networks across the NHS - to play a key part of the accountability and transparency approach will place a key role. There will be concerted effort towards supporting leaders of BME staff networks and trade union representatives, across the NHS to raise the visibility of their work, and to provide a source of meaningful and sustained engagement with the WRES programme of work.

Monitoring progress and benchmarking

WRES processes for data collection and publication - data will be an essential element of assessing organisational progress, as well as the progress of the NHS as a whole, against the goal of BME staff representation at senior levels across the NHS. Through the existing collection and publication of annual WRES data at local and national level, organisations will be able to ascertain where they are, where they need to be and, with robust action planning, how they will get there.

Benchmarking progress - benchmarking and progress will be established and published as part of NHS Improvement's Model Hospital hub and WRES annual data reporting, through which the monitoring of progress against set aspirations over time will be undertaken, and good practice shared.

Due to the changing nature of BME workforce composition across the NHS, the right approach will be to periodically update the assessment of the overall progress that has been made on meeting the aspirations - starting at the end of 2020, and local organisations will be supported via the national WRES team to do the same.

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