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Citation
Priest, Naomi, Aneez Esmail, Roger Kline, Mala Rao, Yvonne Coghill, and David R Williams. 2015. "Promoting equality for ethnic minority NHS staff—what works?" BMJ : British Medical Journal 351 (1): h3297. doi:10.1136/bmj.h3297. http://dx.doi.org/10.1136/bmj.h3297.

Published Version
doi:10.1136/bmj.h3297

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BMJ 2015;351:h3297 doi: 10.1136/bmj.h3297 (Published 8 July 2015)

ANALYSIS

Promoting equality for ethnic minority NHS staff—what works?

NHS organisations are now being judged on indicators of ethnic diversity. **Naomi Priest and colleagues** look at the international evidence on how they should tackle discrimination

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For decades research has shown that discrimination, harassment, and exclusion are pervasive experiences for staff from black and minority ethnic (BME) backgrounds in the National Health Service.[1-6] In recognition of limited progress in achieving the goals of the now decade old NHS Race Equality Action Plan,[7] the NHS has agreed a mandatory workforce race equality standard. The standard requires NHS organisations to collect baseline information from April 2015 on nine indicators of workforce equality for ethnic minority staff, including representation on boards, and to publish annual updates on these metrics (box). Organisations that fail to make progress on these metrics will be in breach of the NHS standard contract, and this will affect whether regulators judge them to be "well led."[8 9] We review the international evidence on the effectiveness of diversity initiatives to assess how best to achieve the standard's intended outcomes.

Discrimination experienced by NHS staff

Discrimination against BME staff within the NHS reflects wider discrimination, racism, and health inequalities in the UK[10-14] and globally.[15] Ethnic minority NHS staff experience discrimination in training and recruitment and are three times less likely to secure a hospital job than white doctors,[16] a situation that has changed little in 20 years.[17] Inequities also exist for clinical excellence awards (performance related bonuses for consultant staff) and career progression opportunities, with evidence of substantial under-representation of BME staff in senior leadership positions.[1-18] Rates of discrimination, bullying, and harassment are higher among ethnic minority NHS staff than among white staff, and the behaviour may be perpetrated by managers, team leaders, colleagues, or patients and relatives.[1 19] BME staff also witness discriminatory treatment of BME patients[1] and employers are less aware of bullying and harassment problems experienced by minority staff than they are of incidents among white employees.[19]

Discrimination is harmful not only to the individual but to the wider NHS. Surveys of NHS staff and inpatients of acute trusts show that the prevalence of discrimination against BME staff is one of the strongest predictors of lower scores on multiple indicators of patient satisfaction and quality.[20] The quality of healthcare and economic efficiency can also be reduced when the senior leadership of healthcare organisations does not reflect the ethnic diversity of the communities they serve.[21 22] Self reported discrimination is adversely related to a broad range of health outcomes, preclinical indicators of disease (such as cortisol and inflammatory dysregulation, visceral fat, and shorter telomeres), and health risk behaviours.[23-26]

Evidence of effective strategies

Diversity in teams has many benefits, including improved innovation, creativity, and decision making, which can lead to breakthrough discoveries and improve corporate profits.[27-30] Several studies show that racially diverse groups outperform homogenous groups in decision making tasks that require information sharing.[28] Positive staff experiences within an NHS trust also predict better outcomes for that trust, including employee engagement, improvements in workforce, and job satisfaction.[31] So what is the best way to tackle discrimination

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Indicators for the workforce race equality standard

Workforce metrics

For each of these four workforce indicators, the standard compares the metrics for white and BME staff

- Percentage of BME staff in bands 8-9 (very senior managers, including executive board members and senior medical staff) compared with the percentage of BME staff in the overall workforce
- Relative likelihood of BME staff being appointed from shortlisting compared with that of white staff being appointed from shortlisting across all posts
- Relative likelihood of BME staff entering the formal disciplinary process, compared with that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. (Based on data from a two year rolling average of the current year and the previous year)
- Relative likelihood of BME staff accessing non-mandatory training and continuous personal development compared with white staff

National NHS staff survey findings

For each of these five staff survey indicators, the standard compares the metrics for each survey question response for white and BME staff

- Percentage of staff experiencing harassment, bullying, or abuse from patients and relatives or the public in past 12 months
- Percentage of staff experiencing harassment, bullying, or abuse from staff in past 12 months
- Percentage believing that trust provides equal opportunities for career progression or promotion
- In the past 12 months have you personally experienced discrimination at work from:
  Your manager or team leader?

  Other colleagues?

Boards

- Boards are expected to be broadly representative of the population they serve

and promote diversity? Research suggests it requires multilevel, multistrategy, mutually reinforcing action.[32]

Evidence for mandatory standards

Studies from a range of contexts indicate that mandated policy interventions to promote diversity that have legal or funding consequences are associated with better outcomes than non-mandated polices without seeming to harm significantly the economic wellbeing of white men.[29-34] For example, in 2011 the UK National Institute for Health Research announced it would not shortlist any NHS or university partnership for grants unless the academic department held at least a silver Athena Swan award (recognising policies to promote sex equality). Institutions were given a limited time to achieve this equality standard. Early findings suggest large increases in women in leadership roles and in applications for Athena Swan awards since the announcement. [35] Similarly, a series of controlled experiments found compulsory diversity strategies to be effective in recruiting women for environments requiring competitive behaviour without reducing efficiency.[36] Compulsory diversity policy has also been found to be effective in the US and Australian private sector,[37 38] medical school enrolment,[39] higher education,[40-43] the police force,[44] corporate boards in Norway,[45] local government in India,[46] and public administration in Macedonia.[47]

Mandatory diversity policies can take multiple forms.[48] Quotas and numerical targets are often criticised because they may result in selection of unqualified candidates. Alternatively, threshold systems require all final candidates to meet clearly established minimum qualification standards, with only the ultimate selection favouring candidates from disadvantaged groups. Here the potential minority candidate is not compared with the highest achiever but assessed against a required benchmark for the job. Similarly, a tie break system, as included in the UK Equality Act of 2010,[48] can be used when there are two or more equally qualified candidates, with selection based on a demographic characteristic (sex, race or ethnicity, disability, etc). A final approach that has had striking results in the US is the "Rooney rule."[49] Implemented in 2003 by the National Football League (NFL) after the failure of two decades of voluntary efforts, it requires all NFL teams to interview at least one minority candidate before a head coach or general manager job can be filled. Within three years, the number of black coaches recruited increased substantially, and three of six division titles went to teams with black coaches.[49]

Research also indicates that mandatory policies are more effective at achieving diversity than alternative approaches. Systematic analysis of corporate diversity policies of 708 US private sector organisations from 1971 to 2002 found legal establishment of leadership responsibility for representation of women and ethnic minorities in management positions had greater effects on managerial diversity than other strategies.[37] In the UK voluntary reporting programmes have been ineffective in redressing gender pay gaps.[50]

Other predictors of success in increasing diversity in higher education in the US are core leadership support, resource allocation, evaluation, and rewards for diversity.[51 52] For example, in less than a decade, a mandate implemented at the University of Michigan in 1988, doubled enrolment of minority students, increased minority faculty, improved rates of promotion, and increased appointments of minorities to university leadership positions.[53] With this initiative, the university president had linked diversity and excellence as the two most compelling goals of the institution, established a campus-wide implementation committee comprising the second highest ranking official in each academic unit, and allocated 1% of the university's budget, annually, to diversity initiatives.[54]

Beyond mandates

Workplace diversity training programmes are ubiquitous but do not improve diversity in isolation.[18] However, such programmes that move beyond awareness raising to focus on development of practical personal skills, ownership, and commitment should be part of a comprehensive diversity strategy alongside organisational processes and policies.[18 55] Recruiting a critical mass of minorities is also important to reduce negative experiences of minority staff and see benefit.[56 57] A Norwegian study of 317 corporate boards found at least three women were needed on boards for increased innovation.[56]

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It is also essential to support minority staff and deal with the effects of any workplace discrimination. Organisational leaders need to create environments that are psychologically safe, support diversity through policies and processes that encourage open communication between employees without fear of negative consequences,[58] and reduce isolation and exclusion. All staff should be trained in strategies to reduce conscious and unconscious biases, stereotypes, and discriminatory behaviour.[59]

Lessons for the NHS

Most evidence on interventions to promote diversity comes from studies outside healthcare. Nonetheless, the consistency of findings across a broad range of organisational, national, and cultural contexts suggests there is much that may be applicable to the NHS. The evidence shows that success depends on the following:

- Core leadership support that articulates diversity as a high institutional priority and organisational investment in supportive communication to all relevant stakeholders
- Multiple strategies at organisational, workplace, interpersonal, and intrapersonal levels used simultaneously over a long period
- Mandated targets or actions.

At a minimum, the race equality standard states that NHS organisations should reflect the diversity of the nation at all levels within the organisation. Although some local communities may lack ethnic diversity, national organisations should strive to reflect the diversity of the wider UK population to optimise innovation and decision making. Use of a mandated diversity policy with contractual consequences is supported by the available evidence and is a recognition that the previous voluntary approaches have failed. However, a mandate is not sufficient to ensure that staff feel respected, valued, engaged, and supported. Implementation of multilevel policies should be underpinned by research documenting the experiences of staff and consequences of discrimination across the NHS for individuals, teams, and organisations and to examine the effectiveness of different strategies. Committing to change is imperative to ensure that the NHS is a workplace and healthcare provider that upholds human rights and social justice principles and is safe and healthy for all staff regardless of their backgrounds. Doing so is likely to benefit all patients, irrespective of their ethnic origin, as well as help redress ethnic health inequalities across the UK.

Competing interests: We have read and understood BMJ policy on declaration of interests and declare AE and RK have both been involved in the development of the WRES since its announcement. NP was supported by an Alfred Deakin Research Fellowship, Deakin University, and by the Victorian Health Promotion Foundation (VicHealth). DW was supported by grant P50 CA 148596 from the National Cancer Institute.

Provenance and peer review: Not commissioned; externally peer reviewed.

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Summary points

Discrimination is harmful not only to individuals but to the wider NHS

The workforce race equality standard has set measures of ethnic diversity for the NHS

Mandatory policies have been shown to work elsewhere and to be more effective than voluntary measures

Such policies need to be backed by committed leadership and strategies across all levels of an organisation

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Accepted: 12 May 2015

Cite this as: *BMJ* 2015;350:h3297

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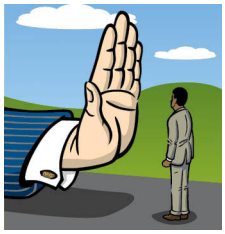

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