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THE BOTTOM LINE

Partha Kar: NHS progress on diversity will need regulation and fines

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It's that time of the year again—when the Workforce Race Equality Standard programme publishes its data.[1] And, like clockwork, it's also time for the annual reflections, soul searching, and pledges to improve things. In due course we'll have webinars or perhaps a dedicated hashtag campaign on social media—someone may even throw in some TikTok videos. And then we'll move on, until next year.

If you want to convince yourself of improvement, let your confirmation bias take over and you'll find some bits to help you: 10% of board members in NHS trusts are now from minority ethnic backgrounds, up from 7% in 2017. And 21.0% of staff in NHS trusts and clinical commissioning groups (CCGs) in England are now from a minority ethnic background, up 2.9 percentage points since 2017. Surely cause to rejoice?

I suspect that it depends on your outlook—on whether you think that being offered crumbs from the table is a win, or that continuing with the "Please sir, may I?" approach will deliver results in some dystopian future. Or whether you recognise that, in 2021, after all of the datasets and evidence about outcomes in the pandemic, we're way past the time for soul searching: we need to recognise that the methods the NHS relies on to improve equality simply don't work.

It's worth noting that only about a third of CCGs submitted any data—perhaps showing how important they find the datasets. White applicants were 1.61 times as likely as ethnic minority applicants to be appointed from shortlisting across all posts. This was worse than in 2019 (1.46), which itself was no improvement on the previous year. In fact, the past five years have seen fluctuation but no overall improvement in this measure. Let that sink in: no improvement in four years.

Just 40.7% of ethnic minority staff, compared with 88.3% of white staff, believe that their organisation provides equal opportunities for career progression or promotion. The recent NHS staff survey shows even further evidence of the inequity, more pertinently during the pandemic. Ethnic minority staff bore the brunt, with 47% working in covid roles, compared with 31% of all staff.[2] Those who reported facing discrimination rose from 16.5% to 19.4% in black ethnic groups and from 13.7% to 15.6% among Asian ethnicities.

And we wonder why, when discussing the biggest intervention to help a population in a pandemic—vaccination—any mention of prioritising minority ethnic populations is seen as provocative. To add to the mixture, the few people from ethnic minorities who do make it to top positions in healthcare rarely speak publicly about the fact that systemic racism exists—that they see it daily but look away or feel powerless to intervene because of hesitancy, a need for career progression, or preferring to avoid controversy.

My tip to the NHS would be either to drop the charade—and use the money currently allocated to this work for something else that may benefit lives—or to move beyond box ticking and bring in targets, regulation, accountability, financial penalties, and mandatory data collection. Look at how the NHS has used such measures to improve patient flow in busy emergency departments or performance against cancer targets, and then think about whether racial discrepancy is important enough to tackle with similar approaches—or whether a yearly glossy document, accompanied by sombre pronouncements of learning, is all that's needed.

Unfortunately, the present approach continues to falter, and recent events have shown how naive it is to expect that publishing datasets and pandemic outcomes would prompt a leadership overwhelmingly skewed towards one ethnic group to ensure that a population of mixed ethnicity was given equal attention. One fundamental problem is the gnawing realisation that plan A for tackling racial inequality is based on a mixture of cajoling, coaxing, and showing data, yet when that doesn't work there's no plan B—bar implementing plan A with renewed vigour.

So, what next? I would suggest continued data gathering, but on a mandatory basis, on established markers—most notably, leadership representation among staff—and giving the relevant organisations some teeth to impose penalties. And, if progress is still incremental, hold the people in those roles to account, on the basis of further outcomes in the Workforce Race Equality Standard. Leadership is about being judged by outcomes and change to lives—or, at least, that's what it should be in a healthcare setting. Until our leadership reflects this with strong, bold policies, we'll never improve outcomes in the minority ethnic population.

The question is whether, after all of the post-covid data that have shown these inequalities in sharp focus, the NHS has the will to tackle this with the importance it deserves. "Privilege is when you think something is not a problem because it's not a problem to you personally": plenty in leadership roles need to consider putting that quote on the wall when they consider their next strategy to improve racial inequalities in the NHS.

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1 NHS. Workforce race equality standard 2020. 25 Feb 2021. https://www.england.nhs.uk/publication/workforce-race-equality-standard-2020-supporting-data/.

2 Lintern S. More than 4 in 10 NHS staff "made ill by stress" during pandemic. *Independent* 2021 Mar 11. https://www.independent.co.uk/news/health/coronavirus-nhs-staff-survey-stress-pay-b1815836.html.

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