Royal College of Nursing

Royal College of Nursing submission to the Commission on Racial and Ethnic Disparities (CRED) call for evidence

1. Introduction

1.1. The Commission on Racial and Ethnic Disparities (CRED) review is an important part of the work underway to better understand racial and ethnic inequalities and disparities in the UK. It provides the potential to deliver a degree of much-needed social justice. The RCN welcomes the opportunity to submit information to the Commission's call for evidence. We look forward to the recommendations arising from CRED's work being implemented in full and informing future policy decisions for achieving racial equality.

1.2. Nursing is a profession that is both complex and demanding. In order to deliver holistic care to diverse communities, it requires the skilful deployment of a wide range of clinical knowledge and expertise in promoting health, preventing illness and caring for those who are unwell as well as those who are dying. As such nurses and nursing as a profession is well-placed to provide insight into the impact of racial and ethnic disparities.

1.3. Our focus in this submission is driven by the availability of reliable data sets in the English National Health Service (NHS) as a result of the publication of the NHS Workforce Race Equality Standard (WRES) and therefore makes primary reference to the English context. However, where we are able make references and draw conclusions to the wider UK context in terms of our evidence and recommendations, we will do so.

1.4. Our submission focuses on three of the questions in the Commission's call for evidence:

1.4.1. ***Q2****: What can be done to improve the representation, retention and progression opportunities for people of different ethnic backgrounds in public sector workforces?*

1.4.2. ***Q7****: How could inequalities in the health outcomes of people in different ethnic groups be addressed by government, public bodies, the private sector, and communities?*

1.4.3. ***Q10****: Can you suggest other ways in which racial and ethnic disparities in the UK could be addressed?*

1.5. Given the importance of focusing on tackling the structural nature of racial and ethnic disparities, we have used the current provisions of the Equality Act 2010 and the specific public sector equality duties in England, Scotland and Wales as well as section 75 of the Northern Ireland Act 1998 to help frame our response to the consultation questions.

1.6. Throughout this submission, we make repeated use of the term 'BAME' to refer to Black, Asian and Minority Ethnic nurses, students and nursing support workers. Whilst we recognise that there is currently significant debate over the use of this term, we note that it is widely used throughout the public sector. We

are also conscious that the term itself encompasses the vast array of beliefs, cultural norms, faith and religious practices and customs that shape different ethnic and 'racial' traditions. These differences also mean that people within these groups face a wide range of different barriers to accessing the labour market and securing career progression.

1.7. Our submission is based on an explicit acknowledgement of the impact of structural, institutional and interpersonal forms of racism and discrimination and their distinctive and sculpting influence on the life chances and lived experiences of nurses, students and health care support workers from BAME backgrounds. We believe that it is critical to acknowledge the existence and impact of these influences and structures in order to implement and undertake the necessary long-term actions which are vital to achieving meaningful and sustained change.

1.8. There is no magic bullet or single short-term solution to tackling racial and ethnic disparities and the journey to progress will need to be properly resourced if it is to win and maintain the trust and confidence of all communities. It is an undertaking that will require honesty, engagement, the political will to prompt change and the ability to maintain a clear focus on these issues in the long-term. This work will necessarily require detailed audit and review of both formal and informal processes, practices and cultures and a clear chain of accountability for identifiable progress.

2. **Recommendations:**

2.1. **The Government and devolved administrations must prioritise the development and implementation of a coherent and fully funded strategies to reduce health inequalities in the UK.** This strategy must:
   2.1.1. Be grounded in understanding of the social determinants of health and include specific actions to reduce and ultimately eliminate health inequalities based on race or ethnicity
   2.1.2. Cover the full range of health inequalities such as but not limited to mental health and maternal mortality outcomes
   2.1.3. Be bold and decisive in tackling health inequalities and be actively co-produced with communities of interest including front-line health care professionals, service-users and other appropriate stakeholders
   2.1.4. Have clear objectives, measurable targets and clear timeframes to support accountability and transparency.

2.2. **The Government and devolved administrations must also prioritise the development and implementation of a fully funded, cross-departmental race equality strategy that is appropriate to the specific national context.** This must:
   2.2.1. Respond substantively to the sixty-six recommendations contained in both the Baroness McGregor Smith Review (2017) and the Lammy Review[1] (2017). We recognise that the scope of the Lammy Review is limited to England and Wales.

[1] Tackling racial disparity in the criminal justice system: 2020 Update. Includes progress responding to the Lammy Review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System. February, 2020. Online. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881317/tackling-racial-disparity-cjs-2020.pdf

2.2.2. Include specific action to require public sector bodies and services commissioned on behalf of the public sector to transparently design out bias and forms of racism and discrimination within the scope of their operational activity and strategic decisions and intent

2.2.3. Require inspectorate bodies like the Care Quality Commission to build progress against delivery of these outcomes into their inspectorate frameworks and to strengthen their reporting standards

2.2.4. Make specific recommendations about improving key employment outcomes such as recruitment, retention and progression as well as reducing and eliminating disparities in critical employment relations processes such as disciplinary and grievance processes.

2.2.5. Set a clear timeline and accountability framework for delivering parity in outcomes. It should also be designed in close consultation with trade unions, professional bodies, community and grass roots organisations as well as other formal and informal voice mechanisms across the breadth of the public sector.

2.3. **The government and devolved administrations should consider what further action needs to be taken on the part of employers to comply fully with the spirit and letter of the Equality Act 2010 and the requirements of section 75 of the Northern Ireland Act 1998.**

2.3.1. In England, Scotland and Wales, the Public Sector Equality Duty (PSED) remains a potentially powerful tool in managing the impact of structural, institutional and interpersonal forms of racism and discrimination. However, there is scope for the duty to be strengthened by requiring the practical and demonstrable delivery of clear and defined outcomes which goes beyond the current 'due regard' requirement on the part of nursing employers and publicly funded service providers.

2.4. **The Commission on Racial and Ethnic Disparities should recommend the steps that the UK Government and devolved administrations across the UK should take to ensure that there is clear accountability and compliance with key legislation such as the Equality Act 2010, the Northern Ireland Act (s.75) and the Race Relations Amendment Order, 2009.** This is necessary in order to strengthen assurance that it remains fit for purpose and delivers activity and outcomes that reduces and eliminates racial and ethnic disparities.

2.4.1. In England for example, this should include mandating better-quality reporting on equality and diversity performance. One area that remains vital to transparency is pay gap reporting and intersectional pay gap reporting requirements should be developed to cover disability and ethnicity alongside gender as a minimum with the threshold for required reporting reduced from 250 to 50 employees.

2.4.2. In addition, the provisions relating to third-party harassment should be reinstated. Section 40 of the Equality Act 2010 was removed in 2013 which has left a significant gap in the protections that BAME nurses face in the workplace and leaves them vulnerable to harm and limited access to justice as there is a lack of clarity around employer liability.

3. *Consultation question 2: What can be done to improve the representation, retention and progression opportunities for people of different ethnic backgrounds in public sector workforces?*

3.1. Health and social care services remain woefully unrepresentative when viewed through the lens of BAME representation at senior levels within organisations. Roger Kline's publication entitled Snowy White Peaks[i] pointed to both denial of the issues and confusion in how to approach this issue systematically. Alongside this is a pattern of over-representation in the presentation of BAME nurses in disciplinary and fitness-to-practice regulatory processes. Challenging and changing this must be central to a structured and long-term programme of activity designed to deliver systemic change.

3.2. A number of organisations have sought to remedy the under-representation of BAME staff in senior leadership positions with distinctive programmes ring-fenced for BAME staff whilst leaving inherently discriminatory systems intact and unchanged. While we welcome the commitment to addressing these issues, often these activities are confined to short-term initiatives and delivered without seeking to identify and change existing institutional patterns that continue to reinforce and reproduce inequality. Consequently, gains have tended to be short-term and temporary in nature. It is therefore vital that employers actively seek to understand how their processes and cultures work to create compassionate, psychologically safe and inclusive workplaces for staff that are free from discrimination on any ground.

3.3. There is mixed evidence that such programmes have long-term success in substantively changing outcomes for BAME staff at the scale needed and further investment in research about what activities are most impactful given a particular sector would be welcomed. This is in part due to a failure to implement such programmes as part of a wider package of institutional change, including reviewing policies and processes to determine how they reflect and embody the commitment to equality and diversity. This is important to ensure and support better quality and robust systems, policies, processes and cultures which can facilitate the full range of talent, skill, and knowledge of BAME staff and deliver better health outcomes for all.

3.4. Failure to take this approach runs the risk of wasting valuable opportunity to make much needed change at a point when the UK is facing critical shortages in the supply, recruitment and retention of qualified nurses. There are almost 40,000 registered nurse vacancies in the UK and a recent survey of RCN members found that over a third (37%) were thinking about leaving the profession[2].

3.5. Racial and ethnic disparities have for too long been an accepted and often unchallenged feature of the operation of many public and private sector services.

3.6. At every stage of the nurses' career, from pre-registration education experiences through to the end of their careers, nurses from BAME ethnic backgrounds experience the culminative impact of both subtle and covert disadvantage. BAME nursing staff report experiences of 'every-day discrimination' and desiccating regularity of racial micro-aggressions that often remain unmeasured and normalised as a legitimate part of delivering nursing care whilst Black, Asian or minority ethnic[3].

[2] Building a Better Future for Nursing. Royal College of Nursing. October 2020
[3] The King's Fund. Workforce Inequalities and inclusion in NHS providers. July, 2020

3.7. There is a paucity of publicly available data about the experiences and outcomes experienced by BAME nurses across the UK. There remains a strong argument about the need for similar levels of data to be made available across the UK context. Our main sources of data are generated by the NHS WRES which shows that 19.7% of all staff working in the NHS[4] are from a BAME background. In nursing, 21.8% of registered nurses, health visitors and midwives are from a BAME background.[5]

3.8. The Workforce Race Equality Standards (WRES) data published annually by NHS England since 2015 highlights the stark differences in the bands at which BAME staff work, compared to their White British counterparts. Data from the NHS WRES Nursing report published in March 2019[6] shows that BAME nurses are heavily concentrated at Agenda for Change band 5, which is the entry-level grade for qualified nurses in the NHS. The data shows that the higher the pay band, the lower the proportion of BAME nurses, midwives and health visitors. Data from the report shows that 'as the pay bands increase, the proportion of BME staff within those bands decreases, from 24.5% at band 5, to 6.5% at very senior manager pay band (VSM). Only 8.4% of staff at AfC bands 8c and above are from a BAME background compared to 19.7% overall representation of BAME staff in the NHS workforce.

3.9. We believe that this stratification of BAME nursing staff does not mirror the true distribution of skills, talent, experience and aptitude for delivering and shaping outstanding nursing care across the nursing population. Our view is that it is the result of an array of complex, dynamic and intersecting social factors which include the defining impact of structural and institutional racism.

3.10. Across the 231 NHS trusts in England in January last year, there were only eight BAME chief nurses comprising 3.5% of the total number of senior nursing leaders[7]. In recent weeks, this number has increased slightly with the appointment of three senior nurse leaders at Health Education England. It is also important to consider the wider context of the nurse staffing crisis affecting the health and care services in the UK when services can ill-afford to waste valuable and increasingly scarce nursing skill and talent. The rate of increase in the progression of BAME nurses throughout leadership levels needs to be accelerated significantly if the under-representation at senior pay bands is to be credibly addressed.

3.11. The 2019 WRES data report for the NHS in England highlighted markedly worse experiences and outcomes for BAME staff in comparison to white staff. The data established that 29 per cent of BAME staff reported being bullied or abused by other NHS workers compared to 24 percent among white staff, up from 28 and 23 per cent in 2017, respectively. It also showed that BAME staff are 1.22 times more likely to enter the formal disciplinary processes compared to White staff.

[4] NHS England Workforce Race Equality Standard, Accessed June 2020, Available here: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf
[5] Skills for Care, Adult Social Care Workforce Data, Nurses in Social Care, Accessed June 2020, Available here: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/Nurses-in-social-care.aspx
[6] NHS Workforce Race Equality Standard. 2019 Data analysis report from NHS Trusts. February 2020
[7] Ibid.,15

3.11.1. In addition, research from the Nursing and Midwifery Council (NMC) which acts as the professional nursing regulator found that across the UK:

3.11.2. Nurses and midwives from a Black and minority ethnic background are more likely to be referred to fitness to practise by employers, while White professionals are more likely to be referred by the public.

3.11.3. Black practitioners are more likely to see their case go to the adjudication stage, although they're not more likely to be removed from the register than White nurses and midwives.

3.11.4. In addition, the research found that Black and Asian students are less likely to be accepted onto NMC-approved nursing and midwifery courses.

3.11.5. This data demonstrates how institutional racism weaves a tight pattern of disadvantage around the careers and lived experiences of BAME nurses at every stage of their pre-registration experience through to their time in practice.

3.12. Employers have a vital role to play in reshaping and redesigning this pattern. One particular area that requires further research in England, Scotland and Wales is whether employers are confident about using the full scope of powers under the Equality Act 2010. There is little information about the use of positive action in relation to recruitment and selection and it is unclear whether employers need further support to fully understand the conditions and criteria under which these provisions can be legally implemented. Employers may need to be reminded of the scope of what is currently possible under the Equality Act 2010 and be supported to fully operationalise its current provisions.

3.13. Employers should be proactively completing comprehensive and continuous equality impact assessments on their operations and strategic decision-making to ensure that the risk of unfair discrimination is reduced significantly. Across the UK, governments and devolved administrators should be ensuring that their activity is effective and impactful in reducing and ultimately eliminating ethnic disparities.

3.14. A number of organisations have sought to remedy this with distinctive programmes for BAME staff such as the Stepping Up programme run by the NHS Leadership Academy.[8] We recognise the popularity of such programmes with both staff and employers and believe that this reflects a significant appetite for change to be substantively delivered across the health and social care sector.

3.15. However, in some cases their activity is often confined to short-term initiatives which, in some cases, is not informed by a robust evidence base regarding which interventions will be most effective in generating systemic change. This has resulted in any gains tending to be short-term and dissipating once organisational restructures are completed or when key figures who have driven the change leave or are required to focus their attention elsewhere.

3.16. Some approaches that have been designed to improve the representation of BAME staff at senior levels have tended to work within a 'deficit-model' which assumes that there is a quality or competency inherently lacking in BAME nurses, students and healthcare support workers. Such programmes often deliver useful insight to staff but may occasionally be unbalanced as they

[8] https://www.leadershipacademy.nhs.uk/programmes/the-stepping-up-programme/

require little or no structural change on the part of the employer or health care system itself. These programmes when delivered separately from and outside of a clear and structured programme that requires systemic reflection, transparency and change on the part of the organisation; leave both structural and institutional forms of racism unchallenged and unchanged within an organisation.

3.17. Further evidence is required to assure that such programmes have yield long-term success in substantively changing outcomes for BAME staff at the scale needed. This is in part due to a failure to implement such programmes as part of a wider package of changes, including reviewing policies and processes to determine how they reflect and embody the commitment to equality and diversity. This is important to ensure and support better quality and robust systems, policies, processes and cultures which can facilitate the full range of talent, skill, and knowledge of BAME staff and deliver better health outcomes for all.

3.18. Failure to take this approach could waste opportunity and time at a point when the supply, recruitment and retention of qualified and experienced nurses faces some of the most acute shortages: there are almost 40,000 registered nurse vacancies in the NHS across the UK. A recent survey of RCN members found that over a third (37%) were thinking of leaving the profession[9].

3.19. The RCN has found some promising results from supporting individuals to build the skills and knowledge that enables the identification and challenge of some of the more subtle and insidious forms of racism in recruitment and selection scenarios. These individuals within an organisation often require dedicate time and resourcing to build their 'race literacy' in order to constructively disrupt patterns of inequality in recruitment processes. It is also important that employers fully embrace and embed these roles into their processes, structure and culture. It is also important that employers commit to working closely with trade unions and commit to analysing the root causes of discrimination within their processes in order to complement this work.

4. The COVID-19 pandemic

4.1. The context of the COVID-19 pandemic provides a poignant backdrop for understanding the lived experiences of BAME nursing staff. Analysis published by the Health Service Journal in April 2020 revealed 63% of UK health and social care workers who died from Covid-19 were from BAME backgrounds[10].

4.2. Throughout the first wave of the COVID-19 pandemic, some RCN BAME members reported feeling unsafe, unsupported and very real concerns about safety and professional sovereignty remaining unheard and unanswered in the workplace.[11]

[9] Building a Better Future for Nursing. Royal College of Nursing. October 2020
[10] https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article
[11] Royal College of Nursing 'Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the COVID-19 pandemic' May 2020 https://www.rcn.org.uk/professional-development/publications/rcn-second-ppe-survey-covid-19-pub009269

4.3. Reports also indicated that BAME staff were being asked ahead of others to care for people with COVID-19[12]. Our members reported feeling invisible, dispensable and not valued[13]. Furthermore, the Baroness Lawrence review highlighted how our members also reported that risk assessments were not being consistently carried out and/or are not bespoke to their needs. Very few reported having confidential discussions about safe redeployment, especially during the wave one of the COVID-19 pandemic.[14]

4.4. During the Summer, the RCN undertook a number of surveys to better understand the lived experiences of our members in the context of the COVID-19 pandemic, particularly in relation to accessing personal protective equipment (PPE).

4.5. In May 2020, the RCN conducted a survey on accessing (PPE)[15] which found that:

4.5.1. For nursing staff working in high-risk environments (including intensive and critical care units), only 43% of respondents from a BAME background said they had enough eye and face protection equipment. This contrasts with 66% of white British nursing staff.

4.5.2. 70% of BAME respondents said that they had felt pressured to care for a patient without adequate protection as outlined in the current PPE guidance, almost double the 45% of white British respondents who had felt this pressure. We know that many BAME people are employed in social care where PPE has also been slow to be distributed.

4.5.3. Sadly, nearly a quarter of BAME nursing staff said they had no confidence that their employer is doing enough to protect them from COVID-19, compared with only 11% of white British respondents.

4.5.4. Worryingly, respondents reported that they did not feel comfortable speaking out about their concerns and we know that in some places, organisational cultures may inhibit BAME staff from raising concerns for fear of reprisal. Additionally, migrant nursing staff on tier-two visas report feeling inhibited about raising concerns as a result of their immigration status.

4.5.5. The most common reason respondents told us for not reporting concerns was because they did not believe any action would be taken (68%) and almost a third (29%) were fearful of speaking out.

4.5.6. In May 2020 the RCN also conducted an all-member survey on their perceptions of nursing pay and feeling valued[16], this revealed that:

4.5.7. Over half of BAME staff (54%) said that the way nursing staff have been treated during the pandemic has made them consider leaving the profession, compared to 42% of white respondents.

4.5.8. BAME respondents are more likely than white respondents to cite bullying and harassment, unsafe working environments and lack of opportunities as reasons for considering leaving nursing. 30% of those working at the

[12] COVID-19: how can we protect BAME nurses during the crisis? Erin Dean 19 May 2020 https://rcni.com/nursing-standard/newsroom/analysis/covid-19-how-can-we-protect-bame-nurses-during-crisis-160956

[13] Royal College of Nursing. Building a Better Future for Nursing. Royal College of Nursing. October 2020

[14] An avoidable crisis. The disproportionate impact of Covid-19 on Black, Asian and minority ethnic communities. A review by Baroness Doreen Lawrence. October, 2020

[15] Royal College of Nursing 'Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the COVID-19 pandemic' May 2020 https://www.rcn.org.uk/professional-development/publications/rcn-second-ppe-survey-covid-19-pub009269

[16] Building a Better Future for Nursing. Royal College of Nursing. October 2020

most senior level gave this as a reason compared to 48% of those working in Bands 1-4 and Bands 5-6 (or equivalent)

4.5.9. Nearly a quarter (23%) of BAME respondents reported an increase in bullying/ harassment compared to 15% of those who are white.

4.6. BAME members have reported that they feel uncomfortable and uneasy speaking to management about their concerns because managers are disproportionately from White British backgrounds. The obvious bias and prejudice they witness in opportunities available to BAME staff to progress into management roles means that they are then discouraged from engaging with the system. This structural exclusion of BAME staff is unacceptable and is not conducive to ensuring patient safety as well as staff wellbeing and support.

4.7. The WRES data highlights the stark differences in the lived experience of BAME staff in comparison to white staff, particularly within the NHS, point to further action needing to be taken on the part of employers to comply with the spirit and letter of the Equality Act 2010 and the public sector equality duty in order to restore trust and confidence across the workforce.

4.8. The RCN expects that all employers must proactively carry out comprehensive and continuous equality impact and risk assessments on staffing issues relating to COVID-19 and in response to a second-wave of the virus emerging across the UK, including reviewing the allocation of shifts, access to PPE and to fit testing for BAME workers to ensure that BAME staff are properly protected and fully supported. There should be clear governance oversight that this activity does not have inequitable and/or discriminatory consequences.

4.9. All employers should complete and report on comprehensive equality and inclusion audits which review how effective their current policies and practices are in addressing and eradicating racism and other forms of bias and unlawful discrimination in decision-making processes such as recruitment behaviours, retention policies and progression practices. Where their approaches are found to be ineffective, there must be a requirement on employers to change and adapt to the best evidenced practice across their relevant sector.

4.10. Many of our members from BAME backgrounds have shared their views that recruitment and selection processes for senior roles remain and that patronage plays a significant role in determining career progression.

4.11. Our own experience as a trade union and professional body suggests that where employers have sought to undertake root-cause analysis and transparently review their entire recruitment and progression processes and outcomes, they are in a better position to deliver on these issues than those who do not.

4.12. In England, NHS trusts that have improved their practices in this area have adopted closer partnership working with trade unions and professional bodies through the RCN Cultural Ambassadors programme - this supports organisations to critically triage their disciplinary processes.[17] In those organisations where this programme has been established there is promising evidence of change for example, a reduction in the frequency and severity of

[17] RCN Cultural Ambassador Programme https://www.rcn.org.uk/professional-development/professional-services/rcn-cultural-ambassador

sanctions against BAME staff as well as a reduction in overall sickness rates[18]. Such programmes require employers to work closely with the range of trade unions represented in their workforce and actively seek to embed these roles into their structures and practices.

5. *Consultation question 7: How could inequalities in the health outcomes of people in different ethnic groups be addressed by government, public bodies, the private sector, and communities?*

5.1. In early 2020 Sir Michael Marmot published his second report on health inequalities: 'Health Equity in England: The Marmot Review 10 years'.[19] It highlighted extensive and deepening health inequalities in England that now require urgent attention on the part of government and public bodies through the development and implementation of a coherent cross-governmental health inequalities strategy. Key findings included:

5.1.1. In the poorest and most deprived areas in England, health is poorer, preventable mortality rates are higher and life expectancy and healthy life expectancy is lower than in richer areas. Those in poorer areas are now spending more of their shorter lives in ill health.

5.1.2. Life expectancy is lower in the North and higher in the South. It is now lowest in the North East and highest in London.

5.1.3. Since 2010, life expectancy for men in the most deprived 10 percent of neighbourhoods decreased in the North East, Yorkshire and the Humber and the East of England whilst life expectancy for women in the most deprived 10 percent of neighbourhoods decreased in every region except London, the West Midlands and the North West.

5.1.4. It also highlighted that health outcomes are even worse for many BAME groups and communities. However, there remain barriers to understanding this in full, such as the fact that up until very recently data on ethnicity is not routinely collected at death registration. This has prevented comprehensive analysis which should be used to plan, design and deliver appropriate health care and other interventions.

5.2. The COVID-19 pandemic has exposed and exacerbated longstanding inequalities affecting BAME groups in the UK.[20] Factors such as excess weight and obesity and underlying health conditions such as hypertension, diabetes and respiratory conditions are known risk factors for severe illness and death from COVID-19, but these health conditions are also linked to factors such as where people live and their level of deprivation. These in turn contour the dimensions of structural racism and the way in shapes access to housing, employment, wealth and health outcomes.

5.3. A recent report on the impacts of COVID on equality in Scotland argued that people from minority ethnic backgrounds are most likely to be in poverty and are

[18] The Social Partnership Forum https://www.socialpartnershipforum.org/case-studies/cultural-ambassadors-project-birmingham-and-solihull-mental-health-nhs-foundation-trust-royal-college-of-nursing

[19] Professor Sir Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison 'Health Equity in England: The Marmot Review 10 Years On', February 2020 https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

[20] PHE 2020 Understanding the impact of COVID-19 on BAME groups https://www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities

less likely to be employed than White adults. The evidence also suggests 'that 'overcrowding and housing conditions may have contributed to the increased spread of coronavirus, morbidity and mortality among some minority ethnic communities'[21].

5.4. Understanding the disproportionate impact of COVID-19 on BAME communities in the UK requires an understanding of the effects of systemic discrimination and disadvantage in our society. These create and sustain systemic barriers to the conditions needed to live a healthy life and so contribute to poorer health outcomes among many BAME communities in the UK.

5.5. In June 2020, Public Health England[22] published their report into the impact of COVID-19 on BAME communities. The report recommended a number of actions which included the need for further research, learning from others and developing cultural competent approaches to health promotion. These recommendations and insights from engagement are important in building lasting solutions to the issue of ethnic disparities.

5.6. Nursing plays a pivotal role in tackling health inequalities and in identifying unmet healthcare needs. This includes designing and delivering effective and inclusive health and care services, advocacy and activism, education and training, and as leaders. Examples of this emerge regularly and are supported by the main health care trade unions (the RCN, The Royal College of Midwives, Unison and Unite the Union) who have partnered with the NHS to deliver the Mary Seacole Leadership and Development Awards.[23]

5.7. Since 1994, these awards have supported front-line nurses, midwives and health visitors to identity and meet the often unexplored and under researched health care needs of BAME communities. Recent graduates from this innovative programme have sought to reduce the higher maternal mortality rates experienced by women from Black, Asian and minority ethnic backgrounds as well as seek to improve access to prostate cancer screening for males from Black, African and Caribbean backgrounds who face an elevated risk profile.

5.8. However, there is a need for clear UK-wide commitment and action to address health inequalities. In particular, there is a need for a coherent cross departmental health inequalities strategy which is properly implemented and fully funded. This must aim to reduce disparities in health outcomes and access to services, including on the grounds of race or ethnicity.

6. *Consultation question 10. Can you suggest other ways in which racial and ethnic disparities in the UK could be addressed?*

[21] The impacts of COVID-19 on equality in Scotland. https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2020/09/the-impacts-of-covid-19-on-equality-in-scotland/documents/full-report/full-report/govscot%3Adocument/Covid%2Band%2BInequalities%2BFinal%2BReport%2BFor%2BPublication%2B-%2BPDF.pdf :

[22] Beyond the data: Understanding the impact of COVID-19 on BAME groups. Public Health England (2020) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

[2323] https://www.rcn.org.uk/professional-development/scholarships-and-bursaries/mary-seacole-awards

6.1. The Equality Act 2010 provides a framework for addressing racial and ethnic disparities alongside the range of other protected characteristics. Since its enactment this legislation has undergone some changes that have arguably weakened its impact on addressing racial and ethnic disparities. This has included repealing elements that tackle third-party harassment as well as removing employment tribunals' power to make wider recommendations in discrimination cases. The failure to commence the dual discrimination provisions alongside the socio-economic duty in England remain problematic too.

6.2. UK and devolved administrations should take steps to strengthen employer responsibilities to respond decisively to all forms of harassment including third-party harassment in order to keep staff safe at work in all care settings and to maintain trust and confidence in the safety of the work environment.

6.3. The Commission on Racial and Ethnic Disparities should ask the government in England to take steps to trigger the full implementation of the public sector socio-economic duty as part of any review of the Equality Act 2010, where it is not currently implemented. The socio-economic duty requires public bodies to adopt transparent and effective measures to address the inequalities that result from differences in occupation, education, place of residence or social class.

6.4. Anti-racist as well as anti-discriminatory practice across organisations that is clearly structured, funded and woven through operational and strategic activity remains central to delivering sustainable progress. The challenge for both systems and institutions is to be transparent and accountable for the implementation of these programmes Across the UK there are examples of both good and poor practice in this but we recognise that there needs to be a critical mass of organisations proactively working towards systemic improvement in this arena. This can be plotted across five key areas of activity which are briefly summarised below:

6.4.1. Leadership: Employers should be required to develop clear competency frameworks that are sophisticated enough to support and sustain the development of compassionate and inclusive workplace cultures, systems and processes. These should support psychological safety and equip leaders and managers at every level to design workplace processes and interactions that are characterised by equality in dignity of condition and equitable outcomes. Such skills are likely to blend both transformative and transactional styles of leadership together. Visible, skilled and committed leadership is necessary to securing change.

6.4.2. Narrative: Employers should focus on ensuring that both the internal and external communications provides a clear focus on rationale for this work both in terms of the importance of the well-being of staff and in delivering better patient outcomes and tackling health inequalities. This work fixes race equality as an integral part of an organisation's value structure and should clearly and explicitly articulate what the organisation intends to do in order to deliver and maintain a zero-tolerance approach to racism and other forms of unlawful discrimination.

6.4.3. Voice: Employers must be able to listen and respond intelligently to the wide range of experiences of the full diversity of service users and staff about their lived experience as well as their outcomes. This can provide

valuable data about the effectiveness of work designed to tackle racism within the workplace and enable employers to concentrate their activity in areas of greatest impact. Within this arena, employers should focus on enabling all staff to connect through the creation and support of safe spaces which should deeply inform and shape improvement plans and delivery.

6.4.4. **Metrics**: Many organisations have a large number of key performance indicators– few if any of those focus on inclusion (defined as the ability of individuals to feel valued and supported to deliver their best work over the longest period of time).Typical approaches to developing equality indicators often focus on measuring the frequency of harms which is very important but often fails to contour the paths organisations need to take to create safer and more equitable workplaces that have successfully designed out and make deliberate interventions to tackle structural, institutional and interpersonal forms of racism and discrimination.

6.4.5. **Accountability:** Making sure that should an organisation fail to deliver on its anti-discriminatory and anti-racist commitments, ways to address and fix this are clearly in place. This should be part of the focus of established regulatory and inspectorate processes. An important element of accountability domain also requires organisations to take responsibility for developing a systemic approach to scrutinising and critically appraising the entirety of their operational processes, methods and ways of working both formal and informal as well as their suite of people management policies and practices; for their impact on delivering equity.

About the RCN

The Royal College of Nursing (RCN) is the largest trade union and professional body in the world, representing more than 450,000 members across the UK.

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[i] The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. Kline, Roger (2014) Middlesex University https://www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf
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