BME people, work, & the NHS in Scotland 2015

progress monitoring of Scotland’s public sector in meeting the specific equality duty on gathering, using and publishing data on the protected characteristics of the workforce – two years on as at 2015
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
<td>4</td>
</tr>
<tr>
<td>Findings</td>
<td>5</td>
</tr>
<tr>
<td>Appendix A</td>
<td>13</td>
</tr>
<tr>
<td>Comparison of published equality profiling</td>
<td></td>
</tr>
<tr>
<td>data across all NHS Boards</td>
<td></td>
</tr>
<tr>
<td>Appendix B</td>
<td>14</td>
</tr>
<tr>
<td>The specific equality duty on</td>
<td></td>
</tr>
<tr>
<td>workforce profiling</td>
<td></td>
</tr>
</tbody>
</table>
Context

One of the clear measures of equality is to be found in the profile, by protected characteristic, of those in employment.

Being in employment can bring multiple, potentially positive, impacts on the lived experiences of many people who share particular protected characteristics. It can reduce dependence on the less than generous state welfare system and the increasing stigma attached to what little support is provided to people who are jobless for whatever reason. It provides the opportunities for those previously excluded from key areas of society to be able to influence change and the future shape of societal structures from within. Being in work instead of being marginalised, excluded and discriminated against can also help start to slowly foster good relations between those who erect barriers and discriminate, and those who are discriminated against.

Scotland’s specific equality duties, adopted in May 2012, recognised this and set a clear goal for public bodies in Scotland. Amongst other things, the duties required that public bodies gather data on their workforce by protected characteristic and use it to help them better perform their general equality duty to eliminate discrimination, advance equality of opportunity, and foster good relations. April 30th 2013 was the first date by which public bodies were required to publish a report on their efforts in meeting this particular part of the specific equality duties.

This research report aims to track what progress has been made from the baseline established in 2013 and so provide real information with which to initiate and inform a debate around whether changes in the law on equality have made a positive, real and measureable difference to the lived experiences of BME people and their all too regular encounters with discrimination in and around the world of work.

The scope of this particular report deals with the data made available by the NHS in Scotland on the employment of people from Black Minority Ethnic [BME] communities.

Wladyslaw Mejka
Equality Here, Now

June 2015

1 See Appendix B for specific equality duty extract
Findings

Publishing workforce data

Public bodies are required by the specific equality duties to gather workforce data annually and report progress every two years on how they have used the data to meet the general equality duty.

For the purposes of this research, I searched web sites in early May this year. Very few reports offering workforce profiling data were readily available or easily found and most Boards had to be contacted directly with requests for the data.

At the time of drafting this report, all but 1 of Scotland’s 22 NHS Boards had provided the data. It became clear in the exchanges with that Board that the Mainstreaming Equality Progress report it had published should have contained the required data. It did not. This report is published later than scheduled in order to allow opportunity for the last of the 22 Boards, NHS Fife, to provide the required report with relevant data on workforce profiling. At the time of publishing – 10th June 2015 – this was still not available.

Context

The purpose of this research report is to check whether the NHS workforce data required to be published by end-April 2015 reveals any measureable progress being made on delivering employment equality for disabled people from the data baseline published by Boards in 2013. That baseline can be found in this research report: BME people, work, & the NHS in Scotland.

It is important to note in making any use of the data uncovered by this research that the majority [17] of the Boards have published data captured at some point in 2014, with just 4 Boards publishing data captured from 2015.

One of the 17 Boards tried to explain why this is:

As you know, it takes several months to collect and collate all of the information required to produce an Equality and Diversity Workforce Monitoring Report for a large organisation such as NHS ********. This work involves different departments and large numbers of staff. The Report then has to go to various Committees for formal approval, before being published. Accordingly, on our web site you will find our Equality

It would appear this Board was unaware that the biggest [in terms of staff employed and patients served] Board in Scotland, NHS Greater Glasgow & Clyde, is one of the 4 Boards who did manage to publish workforce data from 2015.

This basic dislocation across the NHS in Scotland on the fundamentals of providing reports in compliance with the letter and the spirit of the law would suggest that work on equality is yet another area in which the NHS struggles to deliver joined up working. The NHS has had for some years now a dedicated Equality Directorate providing support, guidance and advice to all Boards on meeting the general and specific equality duties. This continued dislocation in basic performance in meeting the specific equality duties across Boards would suggest there is a need to review whether that directorate is fit for purpose or even offers any added value.

For the purposes of analysis in this research report of the data published by Boards, the figures used will always be the latest data published by each Board, with 17 data sets from 2014 and 4 data sets from 2015.

**Overview of progress**

In 2013, the NHS in Scotland was reporting there were 4,378 employees identifying as BME, amounting to just 2.77% of the workforce of 158,326.²

The cumulative figures for 2015 reveal that the average percentage of BME employees was 2.44%,³ a drop of just over 0.3% from the 2013 figure of 2.77%. The average percentage of employees not wanting to reveal their ethnic identity has increased marginally from 28.12% in 2013, to 29.29% in 2015.

In the wider context provided by this research also looking at the protected characteristics of disability, sexual orientation and religion, it is noteworthy that whilst the decline to identify rate for employees in terms of BME has remained stubbornly at just below 30%, the comparative rates for the other protected characteristics have all fallen over the same period.

---

² This reflects the workforce of 19 NHS Boards. 3 Boards did not publish data in March 2013.
³ This reflects the workforce of 20 NHS Boards, with 2 Boards having trouble publishing data.
The full detail on employment data for 2015 in the NHS is available at Appendix A.

**Trends and Patterns in data gathering, using and reporting**

**Accessibility** - Most of the 22 Boards have published data on their workforce which is presented as percentages, whether in text form or graphs or both. Not all Boards accompanied this approach to data presentation with the total body count to which all the percentages related. This has the effect of rendering the reports difficult to access and understand for the public – in contravention of the requirements of the specific equality duties which [in regulation 11] require that public bodies publish reports in a manner “which makes the information published accessible to the public”.

Of course, accessibility is a multi-layered concept and is not always confined to any single report published by a Board. Accessibility is also being able to compare and contrast the performance of different Boards. This would empower individual citizens to check the progress [or lack of it] their local Board is making in delivering measurable race equality against that of other Boards in Scotland. This would be possible if Boards, perhaps assisted by the Equality Directorate in NHS Health Scotland, had agreed to adopt a degree of commonality in how reports were constructed and published. Thus far, no such easily accessible compare and contrast is readily available to the public in Scotland.

Another dimension to accessibility is the language used and the extent to which NHS jargon-creep is allowed. NHS 24’s workforce profile report on an initial read appears to offer an accessible insight to the data gathered, until one gets to such as page 38 where data is presented on something called ‘Capability Procedure’. Employees are apparently ‘supported through the capability procedure’ but for those readers not privy to NHS jargon it is impossible to know if the outcome for employees is a medal or a P45. No matter the outcome, no analysis is offered to the reader on what NHS 24 has learned from the data gathered as to any differential experience of BME and white employees in NHS 24’s use of the ‘Capability Procedure’ and what it will do, if anything, differently in future years to make race equality happen in this area of its function as an employer..

**Analysis : workers in post** - Few of the reports published by Boards offer an analysis of what conclusions can be drawn from the data they have gathered [to ‘better perform the equality duty’ as the specific duties require in regulation
6]. The NHS Health Scotland report is another where analysis of what the data means to it as an employer is entirely absent and with the bulk of the report given over to colourful graphic presentation of what the data is, and nothing on what the data means.

On page 9, the report offers a graph summary of employment rates over the last 4 years, up to and including 2015, with BME slipping from 4% to 1% in 2014 and then back to 2% in 2015. No analysis is offered either of the 2015 figure of 2% or of the trend since 2012, or indeed of the wider context for any analysis provided by such as government demographic data offered in its equality evidence finder web resource where the 2011 census figures shows that the BME population has doubled since 2001 from 2% to 4%.

Given that the proportion of NHS Health Scotland workers identifying as BME is 2.18%, and that the Scottish government demographic statistics advises that 4% of the population identifies as BME, it would be reasonable to expect an analysis of such data to conclude that there are likely to be barriers to BME people securing employment with NHS Health Scotland and that an action plan is to be put in place to identify and remove these so that the proportion of staff identifying as BME is increased to something closer to the figure of 4%. No such analysis is offered, no conclusion reached, no action plan is in place, and no goal agreed which would help NHS Health Scotland know it has reached a place where racial discrimination in employment has been eliminated from its system and culture.

Analysis : People applying for work and leaving – Given discrimination has its roots in the robust defence by the status quo of the current hierarchical distribution of power and privilege, including access to paid work and career progression, the gathering of data on the recruitment of new workers and on the departure of existing workers, as required by the specific equality duties, will provide Boards with invaluable insights as to where in their systems and cultures discrimination might be most prolific and require action to eliminate it.

In NHS Health Scotland’s report, the data provided on page 18 for recruitment to 47 posts in the last year shows that white people secured 45 of those posts, 1 appointee refused to identify their BME status and just 1 appointee identified as BME. Surprisingly, given NHS Health Scotland hosts the Equality Directorate and from which one would expect an exemplary report reflecting exemplary work in making equality a reality, no data is offered on who is leaving the employment of NHS Health Scotland by protected characteristic. This would seem to suggest that NHS Health
Scotland does not look too closely at who is leaving employment and why, never mind by protected characteristic and length of service.

In the report published by NHS Ayrshire & Arran on workforce profiling, the data on recruitment for the protected characteristic of ethnicity provides the insight that between application, shortlisting and job offer to any of the 8,904 posts advertised in the year examined, BME people represented 3.93% of those who applied, 1.37% of those interviewed and 1.17% of those offered a job. White people represented 91.1% of those who applied, 94.79% of those interviewed, and 94.61% of those offered a job.

This data can be re-stated to be more accessible. For white people, applying for a job at NHS Ayrshire & Arran means your chances of securing a job increase as you progress through the recruitment system and culture. For BME people, the reverse is the case, with a steep fall-off between being part of the 3.93% of those who applied for the 8,904 jobs, to being part of just 1.17% of those actually offered one of the 8,904 jobs.

On leavers in the year, 2.49% of those who left employment in the year identified as BME. No analysis is offered as to whether this is acceptable to NHS Ayrshire & Arran. Given the Board’s current workforce has an employment rate of 2.09% of people identifying as BME and the demographics of Scotland showing that 4% of the population identifies as BME, it would be reasonable to expect the recruitment and leavers data sets, when read alongside the core employment data, to lead the Board to take specific actions to attain an employment rate close to 4% than the current 2.49%. There is no analysis and no plans for specific actions to increase the employment rate of BME people.

One element of the data on leavers which would provide a crucial dimension to understanding the story behind the figures on those leaving an organisation, is the length of service of those leaving by protected characteristic. If BME people who leave employment have markedly shorter service than that of non-BME workers, this should act as a clear prompt for the employer to dig much deeper into understanding why that is so and what must be done to stop it. In the course of this research, such refinements to data gathering were conspicuous by their absence.

Process versus person-centred change – The recurring pattern in workforce profiling reports published across the NHS in Scotland would suggest that NHS Boards have become bogged down in what the specific duties were designed to avoid – a focus on process. It does appear that
Boards are making various efforts to gather and publish data on the workforce, but that this has become an end in itself. There is very little evidence on offer in the current range of reports that the data is being used, through analysis, to identify potential discrimination and, in turn and when needed, to trigger action to eliminate it [what the general equality duty requires]. This focus on process rather than on person-centred change [the identification and elimination of discrimination] creates a fundamental failure in performance. The lack of data analysis in the context of better performing the general equality duty means it is simply not possible for the public, or even for government ministers, to assess whether year on progress is being made with the elimination of racial discrimination in Scotland’s NHS.

**Missing links in enabling analysis of workforce data** – While this research has failed to uncover evidence that all NHS Boards are routinely using the data gathered on their workforce to conduct a thorough analysis and so check whether discrimination is taking place around the employment and career development of BME people, it is of equal importance to note that none of the Boards have in their reports shown evidence of having constructed a strategic picture of what their workforce would look like once all racial discrimination had been eliminated and the barriers to equality of opportunity removed.

There is an almost total absence of any clear understanding of how Boards have arrived at the workforce profiles they have today, the absence of a willingness to analyse the data in terms of identifying the possibility of discrimination being the cause of certain current workforce profiles, and the complete absence of an understanding of what each Board’s workforce should look like in terms of the protected characteristics were all discrimination eliminated.

Put another way, it is possible to conclude that NHS Boards do not know how they have arrived at the workforce they have today, show no real interest or awareness in knowing why the workforce is what it is in terms of equality, and have no coherent plan for achieving a workforce where racial discrimination is evidenced as having been eliminated.

**Holistic context** – the majority of NHS Boards in Scotland have patients to whom they have a general equality duty and to provide all people with protected characteristics access to services free from discrimination, experience of those services free from discrimination, and achieving outcomes from those services which are free from discrimination.
The focus of this research is in relation to the role of the NHS Boards as employers and so no detailed scrutiny of the reporting of Boards on meeting the general equality duty in relation to their function as service providers has taken place. That said and given the nature of many reports on workforce profiling published as being appendices to the Mainstreaming Equality reports published by Boards, a cursory read has taken place as a by-product of trying to find employment data. On this basis it is observed that few if any Boards appear to have systems in place for gathering evidence on patients/service users cross-referenced to their identity by protected characteristic and checking whether their experience of access to, experience in and outcome from health services has been free from discrimination.

In the same way that it is possible to conclude that the prevailing culture in the NHS on meeting the specific equality duties on employment is one focused on the process rather than on change to the lived experiences of people from the protected characteristics as employees or would-be employees, so too can the absence of joined up work/evidence gathering between NHS Board functions as employers and service providers be regarded as a fundamental and fatal flaw in work to deliver race equality. Such an attitude and approach ignores the ineluctable synergy between the two functions and the cultures of organisations where discrimination exists. A health board delivering services inaccessible to BME people in unlikely to be an employer where BME people find they are free from discrimination or have equality of opportunity – and vice versa.

**Conclusion**

The conclusion in the 2013 research report was that the NHS in Scotland appeared to have significant problems with institutional discrimination in the employment of BME people.

The data from two years on in the NHS would suggest little has changed in the NHS in its employment of BME people. There has been a fall in the

4 Institutional discrimination has been and will be defined in a range of ways. The following definitions relate to race in the UK but can be amended to equally apply to all other protected characteristics.

"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people."

The Macpherson report

"If racist consequences accrue to institutional laws, customs or practices, that institution is racist whether or not the individuals maintaining those practices have racial intentions."

The Commission for Racial Equality
average percentage of BME people employed across the NHS in Scotland from 2.77% in 2013 to 2.44 % in 2015. At the same time the average percentage of people unwilling to identify their ethnicity within the NHS has increased slightly from 28.12 to 29.29%.

For the benefit of those readers, students, elected members and public servants who come to race equality with a limited understanding on the backstory and history of race equality, an important context to this area of research is to be aware that the law on race equality and the obligations it places on public bodies to be seen to be eliminating race discrimination is not something new to this century, but has roots which reach well back into the last century. It is now some 50 years since the Race Relations Act of 1965 first outlawed discrimination on the grounds of colour, race, ethnicity or national origin. It was extended in the 1968 Act to include a remit in the spheres of employment and housing. In the Race Relations Act of 1976, almost 40 years ago, the Commission for Racial Equality was created to make sure the even more robust provisions of that Act on racism and discrimination were implemented. More legislation on race equality followed in 2000, 2003, 2006, and in the Equality Act 2010.

When asking NHS Boards about progress made with race equality, it is not about progress made since 2010 [which many of the reports reference], but the progress made since 1965. If the performance of NHS Boards on making race equality happen [as opposed to being absorbed by the process of making it happen] had been paralleled in progress made with telephone technology, it is likely our mobile phones would still be the size of bricks and still only affordable to those with sizeable expense accounts.

Early in January 2015, the Scottish Parliament’s Health & Sport Committee published the results of an Inquiry into health inequalities in Scotland. It found that despite significant investment in tackling health inequalities in Scotland since devolution, the gap between rich and poor remains persistently wide. The Committee Convener said : “Since devolution, successive Governments have made this a political priority and invested significant amounts of public money in tackling this complex issue. But sadly none have made any significant difference.” In the same way that the NHS’s failure to eliminate health inequalities means that the man in Shettleston continues to die years before the man living in Barnton, so too does the NHS’s continuing failure to act decisively on institutional discrimination mean that some BME people alive today will live out their lives and die before demonstrable equality of employment opportunity exists in the NHS.

END
### Appendix A

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS 24</td>
<td>1,555</td>
<td>1,505</td>
<td>25</td>
<td>49</td>
<td>3.26%</td>
<td>1,022</td>
<td>1,111</td>
<td>508</td>
</tr>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>10,242</td>
<td>10,695</td>
<td>214</td>
<td>224</td>
<td>2.09%</td>
<td>6,635</td>
<td>7,154</td>
<td>3,393</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>3,224</td>
<td>3,043</td>
<td>84</td>
<td>63</td>
<td>2.07%</td>
<td>1,528</td>
<td>1,527</td>
<td>1,612</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>4,575</td>
<td>4,774</td>
<td>89</td>
<td>47</td>
<td>0.98%</td>
<td>3,220</td>
<td>3,662</td>
<td>1,266</td>
</tr>
<tr>
<td>NHS NES</td>
<td>1,213</td>
<td>1,211</td>
<td>149</td>
<td>154</td>
<td>12.72%</td>
<td>1,027</td>
<td>1,009</td>
<td>37</td>
</tr>
<tr>
<td>NHS Fife&lt;sup&gt;5&lt;/sup&gt;</td>
<td>8,633</td>
<td>0</td>
<td>78</td>
<td>0</td>
<td>0.00%</td>
<td>5,459</td>
<td>0</td>
<td>3,060</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>5,903</td>
<td>5,575</td>
<td>112</td>
<td>110</td>
<td>1.98%</td>
<td>4,940</td>
<td>4,719</td>
<td>851</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>15,665</td>
<td>16,029</td>
<td>780</td>
<td>266</td>
<td>1.66%</td>
<td>9,519</td>
<td>10,074</td>
<td>5,366</td>
</tr>
<tr>
<td>NHS GG&amp;C</td>
<td>38,484</td>
<td>39,314</td>
<td>1,311</td>
<td>1,355</td>
<td>3.45%</td>
<td>26,479</td>
<td>28,646</td>
<td>10,694</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>308</td>
<td>275</td>
<td>12</td>
<td>6</td>
<td>2.18%</td>
<td>290</td>
<td>223</td>
<td>6</td>
</tr>
<tr>
<td>NHS Highland&lt;sup&gt;4&lt;/sup&gt;</td>
<td>10,445</td>
<td>9,895</td>
<td>225</td>
<td>0</td>
<td>0.00%</td>
<td>8,425</td>
<td>6,910</td>
<td>1,795</td>
</tr>
<tr>
<td>NHS Lanarkshire</td>
<td>11,510</td>
<td>11,763</td>
<td>319</td>
<td>329</td>
<td>2.80%</td>
<td>7,334</td>
<td>7,811</td>
<td>3,857</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>23,026</td>
<td>24,110</td>
<td>695</td>
<td>800</td>
<td>3.32%</td>
<td>12,153</td>
<td>13,896</td>
<td>10,178</td>
</tr>
<tr>
<td>NHS NSS</td>
<td>3,340</td>
<td>3,449</td>
<td>90</td>
<td>107</td>
<td>3.10%</td>
<td>3,151</td>
<td>3,225</td>
<td>99</td>
</tr>
<tr>
<td>NHS Golden Jubilee</td>
<td>1,431</td>
<td>1,583</td>
<td>163</td>
<td>87</td>
<td>5.50%</td>
<td>859</td>
<td>1,156</td>
<td>409</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>0</td>
<td>756</td>
<td>0</td>
<td>6</td>
<td>0.79%</td>
<td>0</td>
<td>628</td>
<td>0</td>
</tr>
<tr>
<td>NHS Healthcare Improvement Scotland</td>
<td>294</td>
<td>318</td>
<td>7</td>
<td>10</td>
<td>3.14%</td>
<td>241</td>
<td>294</td>
<td>46</td>
</tr>
<tr>
<td>NHS Shetland</td>
<td>641</td>
<td>656</td>
<td>12</td>
<td>11</td>
<td>1.68%</td>
<td>0</td>
<td>605</td>
<td>629</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>13,624</td>
<td>13,887</td>
<td>0</td>
<td>129</td>
<td>0.93%</td>
<td>0</td>
<td>10,398</td>
<td>0</td>
</tr>
<tr>
<td>NHS Scottish Ambulance Service</td>
<td>4,213</td>
<td>4,407</td>
<td>13</td>
<td>11</td>
<td>0.25%</td>
<td>3,484</td>
<td>3,445</td>
<td>716</td>
</tr>
<tr>
<td>NHS State Hospital</td>
<td>0</td>
<td>675</td>
<td>0</td>
<td>4</td>
<td>0.59%</td>
<td>0</td>
<td>353</td>
<td>0</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>0</td>
<td>1,039</td>
<td>0</td>
<td>7</td>
<td>0.67%</td>
<td>0</td>
<td>800</td>
<td>0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>158,326</strong></td>
<td><strong>154,959</strong></td>
<td><strong>4,378</strong></td>
<td><strong>3,775</strong></td>
<td><strong>2.77%</strong></td>
<td><strong>95,766</strong></td>
<td><strong>107,646</strong></td>
<td><strong>44,522</strong></td>
</tr>
</tbody>
</table>

<sup>5</sup> NHS Fife has been unable to provide and publish up to date workforce data as at 8<sup>th</sup> June 2015.

<sup>4</sup> NHS Highland data sets on ethnicity are inaccurate. The Board is working to find the correct data sets.
Duty to gather and use employee information

6.—(1) A listed authority must take steps to gather information on—

(a) the composition of the authority”s employees (if any); and

(b) the recruitment, development and retention of persons as employees of the authority,

with respect to, in each year, the number and relevant protected characteristics of such persons.

(2) The authority must use this information to better perform the equality duty.

(3) A report published by the listed authority in accordance with regulation 3 must include—

(a) an annual breakdown of information gathered by it in accordance with paragraph (1) which has not been published previously in such a report; and

(b) details of the progress that the authority has made in gathering and using that information to enable it to better perform the equality duty.