Summary

Firstly, the issue of race has been festering for many years within the NHS and as such in order to move this important agenda forward it is necessary that we first undertake a 'reality check', as outlined more fully below. Secondly, as an ***independent and effective voice*** for BME people we will undertake the following actions, also outlined in more detail below, notably:

- The NHS BME Network will continue to provide support and guidance to Local BME Networks who wish to be affiliated with the national network.

- The NHS BME Network will seek to establish how the evidence gathered from the risk assessments undertaken by health providers will be used to protect BME staff in the future.

- The NHS BME Network will seek to establish how NHS organisations are addressing the under-representation of BME senior staff by undertaking a review of their published action plans.

- The NHS BME Network will seek to shine a spotlight on NHS organisations which continue to fail to address the disproportionate number of BME staff facing disciplinaries.

- The NHS BME Network will seek to shine a spotlight on NHS Trusts, Foundation Trusts and Clinical Commissioning Groups who fail to ensure that at every level the workforce is representative of the overall BME workforce.

- The NHS BME Network will work with BME Communities to ensure NHS organisations and/or health providers are proactively addressing the ethnic health inequalities that exist locally.

- The NHS BME Network will work with Mental Health Support Groups to ensure that NHS Trusts and Mental Health Providers are proactively addressing the mental health inequalities that exist.

- The NHS BME Network will liaise with the 'establishment' and/or 'system' to seek to progress the interest of BME people.

- The NHS BME Network will seek to establish links with other like-minded organisations and/or Networks in its endeavour to progress the race equality agenda.

A Reality Check

The events surrounding the disproportionate death of BME people from COVID-19 undoubtedly exposed the institutional racism which exists in the NHS that has blighted the lives of BME staff and BME patients for decades.

The response from the establishment and/or the 'system' over the past few months has been to promise change for the better and a whole raft of announcements have been made in an attempt to convince BME people that this time round things will be different including by way of examples the following:

- 29 May 2020-Creation of a NHS Race and Health Observatory to investigate the impact of race and ethnicity on people's health.

- 2 June 2020-Publication of Public Health England (PHE) Report which reiterated the findings of other bodies that BME people were disproportionately adversely impacted by COVID-19.

- 4 June 2020-Annoucement of a review by the Government's Equalities Office into the government's response in COVID-19 infection and death rates.

- 5 June 2020-Annoucement by the Equality and Human Rights Commission (EHRC) that it will use its legal powers to launch an inquiry into long-standing structural race inequality exposed by the coronavirus pandemic.

- 14 June 2020-Boris Johnson writing in *The Daily Telegraph* announced he will establish a cross-government commission (Commission on race and ethnic disparities) to look into racial inequality whilst at the same time making the condescending comment *"What I really want to do as prime minister is change the narrative so we stop the sense of victimisation and discrimination".*

- 16 June 2020-Publication of the section of the PHE report omitted on 2 June 2020 whereby BME stakeholders pointed to racism and discrimination experienced by BME communities and BME keyworkers as a root cause of affecting health, and exposure risk and disease progression risk.

- 30 June 2020-A study undertaken at Oxfordshire hospitals, where almost 10,000 staff were tested both for the presence of the virus and antibodies indicating they had already had it, showed that BME staff were twice as likely to get the coronavirus as their White colleagues and that staff working in acute medicine were most at risk based on their roles (27.4%) followed by porters and cleaners (18%).

- 28 July 2020-The CEO of the General Medical Council (GMC) stated that the NHS must tackle the discrimination faced by overseas medics to improve retention as fewer overseas doctors arrive in the UK and also address the fact that BME doctors are more than twice likely to be referred to the GMC by their employers than White doctors.

- 29 July 2020-The National Institute for Health Research (NIHR) announced that six new projects to improve our understanding of the links between COVID-19 and ethnicity have been funded (£4.3 million) by the NIHR and UK Research and Innovation (UKRI)

- 30 July 2020-Publication of the NHS People Plan 2020/21 which sets out how it intends to address the discrimination of BME people in the workplace.

- 31 July 2020-Letter from NHS England to NHS Leaders outlining the third phase of the NHS response to COVID-19 effective from 1 August 2020 which includes a requirement for NHS Trusts to publish action plans to ensure its leaders are representative of the BME workforce by 2025. In addition, it also sets out how NHS Leaders and General Practitioners are required to address health inequalities and prevention.

- 5 August 2020-A number of NHS Leaders backed the UK's first national pledge to reduce ethnic inequalities in mental health care, and transform medical systems to be less institutionally racist.

- 13 August 2020 -Statement by the NHS Chief Executive Owen Williams, published in the Health Service Journal, that Firms should not be able to readily access public money if they cannot demonstrate diversity among their senior leadership and that it was time for the NHS to *"put up or shut up"* about diversity in leadership.

- 14 August 2020- A Herefordshire GP Dr. Simon Lennane, who undertook research together with the Bristol University Professor Tim Cook which showed that 95% of all deaths among medical doctors were from a BME background and that 65% of all deaths of other NHS staff were from BME backgrounds (despite the fact that they make up 44% and 21% of these groups respectively) stated the ***"The NHS is trying to dampen down the story. But it's a story that must be told".***

Although these announcements on the face of it seem encouraging we believe it is necessary for us (BMEs) to pause and undertake a reality check, because we know only too well that we have been here before and nothing changed. It is also noteworthy that despite these announcements the outgoing Chairman of the EHRC David Isaac, in an interview with the BBC on 28 July 2020, accused the Government of *'dragging its feet'* on tackling racism as he called for a coherent race strategy to be implemented.

I am sure you are aware that it was some four years after the tragic and untimely death of Stephen Lawrence that Sir William Macpherson, a retired high court judge, was asked by the Government to undertake an inquiry into the matters arising from the death of Stephen Lawrence on 22 April 1993. The Macpherson report concluded that the investigation into the killing had ***"been marred by a combination of professional incompetence, institutional racism and a failure of leadership".*** A total of 70 recommendations designed to show zero tolerance for racism in society were made.

As already mentioned the NHS has been in denial about institutional racism for decades and this is also true of the establishment and/or the 'system' as a whole. As such it comes as no surprise that Mr. Isaac should also state in his leaving message that:

"I sense uncertainty in some quarters about the reality of institutional racism. *While economic inequality is a defining factor in limiting the life chances and opportunities of people from all backgrounds, it is clear that such inequality is compounded by negative attitude towards race, even when those attitudes are not overtly racist and are unconsciously-rather than deliberately-entrenched into organizational behaviours.*

It is also important to note that the Chair of the Government's Commission on race and ethnic disparities informed the Prospect magazine in 2010 that *"much of the supposed evidence of institutional racism is flimsy".*

In 2004 Sir Nigel Crisp (now Lord Crisp), Chief Executive of the NHS and Permanent Secretary of the Department of Health (2000-2006), published his Ten Point Race Equality Plan. Half of his plan was about improving services for the minority ethnic communities and the other half was about developing BME staff. He also asked 500 Chief Executives of hospitals and primary care trusts at the time to mentor BME staff. A particular aim and objective was to address the under-representation of BME staff in leadership positions in the NHS.

It was also around the same time that the Improving Working Lives initiative published guidance on the establishment of local BME Networks to assist NHS organisations to deliver on their statutory obligations concerning race equality.

In 2014, a decade later Lord Crisp told the Nursing Standard *"Potentially this issue seems to be getting worse than before so I want to raise the profile of this problem. If the NHS is going to serve people well we need to make the best of everyone and the talent of all NHS staff and I feel we are not getting the best out of BME staff".*

There have been a number of initiatives over the years supposedly to address the 'disadvantages' faced by BME staff in the NHS. It cannot be denied that improvement in the national Workforce Race Equality Standard (WRES) is slow. It is evident that progress

on increasing the number of BME people in leadership roles has been imperceptible at best, although communicated as giving hope for the future.

It is also noteworthy that in June 2019 the NHS Confederation published its research which showed that the percentage of Chairs and Non-Executive Directors of NHS Trusts from a BME background has nearly halved in the last decade from 15% in April 2010 to 8 percent in 2019. One of the recommendations made by NHS Confederation is that NHS England and NHS Improvement should appoint a lead Chair to work with NHS Confederation to make recommendations to ministers for addressing the diversity deficit in NHS Boards.

There can be no doubt that these findings are due in part to the failure of NHS Leaders to take race equality seriously. It is noteworthy that the Chief Executive of Birmingham and Solihull Mental Health NHS Foundation Trust, Roisin Fallon-Williams, in writing to her staff on 5 June 2020 admitted her failings in this regard. In her letter she states:

'I write this to us all from what I now know and understand to be an ignorant and incompetent stance. I believed I was a good person, a compassionate and dedicated nurse and health professional who sought to understand and care for others and in doing so always sought to do the right thing. I interacted and responded to colleagues and service users who were victims of discrimination from a perspective of believing this to be about others' behaviours, attitudes and beliefs, understanding that the right and expected role for me to take was one of empathy giver. ***Whilst I remain ignorant and incompetent, I do now better understand that I am culpable. I have been complicit, I have made individuals' trauma worse through my words, my actions and inactions.*** *In this knowledge I have a duty to educate myself and share my learning with others, to work to change my behaviours, be mindful of my impact on others, seek feedback to act upon.'*

However, we all know that Ms. Fallon-Williams is not alone. The very same Chief Executives who are now scrambling to meet with their BME employees via their local BME Networks where they exist and/or seek to establish BME Networks in haste so they can meet with their BME employees are the very same Chief Executives who in the main have failed to acknowledge and/or value the contribution of their BME staff and/or the difficulties they have faced in the workplace for years. It is also these same Chief Executives who have failed to put any mechanisms in place to address the ethnic health inequalities that exist.

It is important that we do not forget these particularly important facts, in seeking to address the institutional racism in the NHS this time round and particularly so given it is the same NHS Leaders who have being tasked by the centre to bring about change. Change that will require a large-scale dismantling of advantage, privilege and structural inequality and some very difficult discussions with BME people (staff and patients) who have a right to hold them to account.

A National Action Plan

The NHS BME Network was established to provide:

"An independent and effective voice for BME staff, BME patients, BME carers and BME service users to ensure the NHS delivers on its statutory duties regarding race equality.

We have set out below the actions that we will be taking forward henceforth with your continued support. These actions are not listed in any order of priority and we will add whatever actions deemed necessary as the work progresses.

In addition, we are also looking for BME volunteers who will work alongside the Executive Committee to assist with the delivery of our action plan.

1. **The NHS BME Network will continue to provide support and guidance to Local BME Networks who wish to be affiliated with the national network.**

It is evident that more recently NHS Leaders across the board have scrambled to either revive existing local BME Networks and/or to establish BME Networks where they do not already exist. It is also a fact that many BME Leads have contacted us to review the Terms of Reference for their Networks and sadly it would appear that many are being set up to fail.

Over the years local BME Networks have struggled to sustain their membership given the lack of support from their organisations. Routinely BME staff were not given protected time to both manage the work of the Network and/or to attend meetings. Even when there was an understanding that BME staff could attend meetings many managers refused to release staff because of service requirements. In addition, many BME Networks were given no funding and/or given so little funding to be of any use.

It is also particularly disappointing that the NHS People Plan 2020/21 published on 30 July 2020 states that all NHS organisations have until **December 2021** to review their governance arrangements to ensure that staff networks are able to contribute and to inform decision making processes. Given more recent events it is evident that it would be more appropriate that local BME Networks are in a position to contribute and inform decision making processes as soon as possible.

That said, we will continue to support local BME Networks affiliated with us and/or wish to become affiliated to ensure that they are 'fit for purpose'.

2. The NHS BME Network will seek to establish how the evidence gathered from the risk assessments undertaken by health providers will be used to protect BME staff in the future.

One of the recommendations outlined in the PHE report was for the development of culturally competent occupational risk assessment tools which can be used to reduce the risk of employee's exposure to and acquisition of COVID-19.

On 24 June 2020 NHS England wrote to all NHS Leaders asking them to complete their risk assessments within the next month and it was accepted that the cut-off date was 22 July 2020. However, not all organisations complied such that on 24 July 2020 a publication in the Health Service Journal reported that more than a quarter of BME staff had not been risked assessed.

A survey by the Runnymede Trust and ICM published this month titled *"Over-Exposed and Under-Protected The Devasting Impact of COVID-19 on Black and Minority Ethnic Communities in Great Britain"* found that half of Bangladeshi key workers (50%), more than four in 10 Pakistani (42%) and Black African (41%) key worker respondents reported they had not been supplied with adequate PPE. Furthermore, BME people were more likely to feel they were being given tasks that exposed them to the virus, and to say they had been ignored after raising concerns about safety.

The report outlined a range of urgent policy recommendations to protect minority groups from COVID-19, including equality impact assessment of emergency measures rolled out by the government during the pandemic.

In light of the evidence it is important we seek to determine notably:

(i) what additional measures, if any, are organisations putting in place to protect the health of their BME staff?

(ii) how/will the evidence from the risk assessments influence the management of a second wave of COVID-19 and/or another pandemic in the future and

(iii) whether the risk assessment data is now part of the Board Assurance Framework (or equivalent in a primary care context) and has received board level scrutiny and ownership. For primary care providers, this would be a senior partner or the business owner as the employer with overall responsibility for their workforce?

3. **The NHS BME Network will seek to establish how NHS organisations are addressing the under-representation of BME senior staff by undertaking a review of their published action plans**

On 31 July 2020 NHS England wrote to NHS Leaders regarding the third phase of the NHS response to COVID-19 effective from 1 August 2020. The letter states that Trusts are given five years for leadership to match workforce diversity and reads:

"Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher".

In fact, this directive brings this requirement forward by three years given initially NHS England and NHS Improvement required this target to be met by 2028.

However, we believe five years is still too long given this could be achieved in a much shorter timescale with commitment from the top.

Whilst UK law does not allow for affirmative action operable in the USA it does allow for membership in a protected and disadvantaged group to be considered in hiring and promotion when the group is under-represented in a given area and if the candidates are of equal merit. The controlling logic is that the person must not be chosen simply because of their group membership but rather that the relevant authorities are allowed to use disadvantage group status as a 'tie-breaker' between two candidates of equal merit.

This is not the same as Positive Action whereby the focus tends to be on ensuring equal opportunity for example targeted advertising campaigns to encourage BME candidates to apply for certain positions.

Furthermore, the precedent has already been set given on 30 July 2020 the Health Service Journal reported that on 22 July 2020 Leeds Clinical Commissioning governing body agreed to formally adopt the recommendations of West Yorkshire and Harrogate Integrated Care System (ICS) for BME people to be appointed to around 20% of senior leadership roles across its organisations so that they are reflective of the communities they serve. To achieve its goal the ICS has asked all its member organisations to involve BME representatives in the recruitment and selection of all senior leadership appointments. Furthermore, this target has been set against a backdrop where trusts in the ICS area are more likely to hire white people and discipline BME staff.

4. **The NHS BME Network will seek to shine a spotlight on NHS organisations which continue to fail to address the disproportionate number of BME staff facing disciplinaries.**

The WRES data for many Trusts consistently show that BME staff are more likely to be disciplined than their white colleagues.

NHS England and NHS Improvement have set a stretch target to reach equality in terms of the likelihood of staff entering the disciplinary process for both White and BME staff across at least 90% of all NHS organisations by 2022. For 2020 this is 51% of NHS organisations and for 2021 76% of NHS organisations.

However, given the NHS can no longer deny that it is institutionally racist it is our position that these stretch targets do not go far enough. There is absolutely nothing stopping NHS organisations from making this long-standing injustice as a priority.

5. **The NHS BME Network will seek to shine a spotlight on NHS Trusts, Foundation Trusts and Clinical Commissioning Groups who fail to ensure that at every level the workforce is representative of the overall BME workforce.**

The NHS People Plan 2020/21 published on 30 July 2020 makes reference to the need for NHS Leaders to take action to address the systemic inequality experienced by BME staff. The report reads:

"The NHS was established on the principles of social justice and equity. In many ways, it is the nation's social conscience, but the treatment of our colleagues from minority groups falls short far too often. Not addressing this limits our collective potential. It prevents the NHS achieving excellence in healthcare, from identifying and using our best talent, from closing the gap on health inequalities, and from achieving the service changes that are needed to improve population health.

Given recent national and international events, it has never been more urgent for our leaders to take action and create an organisational culture where everyone feels they belong-in particular to improve the experience of our people from black, Asian and minority ethnic (BAME) backgrounds".

The Plan also requires all NHS Trusts, Foundation Trusts and Clinical Commissioning Groups to publish their progress against targets to have representative leadership to ensure that at every level the workforce is representative of the overall BME workforce. The South East Coast Race Equality Review published in 2008 clearly showed based on evidence that BME staff were over-represented at lower paybands and under-represented at higher paybands and more than a decade later nothing has changed.

6. **The NHS BME Network will work with BME Communities to ensure NHS organisations and/or health providers are proactively addressing the ethnic health inequalities that exist locally.**

It is well documented that ill treatment leads to ill health and non-inclusive health services can exacerbate the socioeconomics determinants of health inequalities. The evidence shows that too often health outcomes and satisfaction for BME service users fall significantly below those of the White community.

We will be working with local BME communities to assist them with addressing this issue starting with a pilot study working with a BME group in Lewisham, South London. The work we will undertake will take into account the directive outlined in the letter from NHS England to NHS Leaders dated 31 July 2020 regarding the third phase of the NHS response to COVID-19 effective from 1 August 2020 (already mentioned above) concerning health inequalities and prevention. This requires organisations to:

(i) Better engage those communities who need more support to mitigate the risks associated with relevant protected characteristics.

(ii) Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes.

(iii) Start to monitor the use of services and outcomes by the most deprived neighbourhoods and BME communities by 31 October 2020

(iv) Have a named executive board member responsible for tackling inequalities in every organisation by September 2020.

(v) Ensure the completeness of patient ethnicity data by no later than 31 December 2020, with General Practice prioritising those groups at significant risk of Covid-19 from 1 September 2020.

It is noteworthy that the Health and Social Care Act of 2012 made it a legal duty for NHS England; Clinical Commissioning Groups (CCGs) and the Department of Health and Social Care to *"have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved".* However, it is evident that in practice this duty has not led to any effective action(s) on reducing inequalities and/or ethnic health inequalities in particular.

7. **The NHS BME Network will work with Mental Health Support Groups to ensure that NHS Trusts and Mental Health Providers are proactively addressing the mental health inequalities that exist.**

   It is a well-established fact that black and other ethnic minority groups are over-represented in the Mental Health system. The evidence shows that the causes of inequality include structural and institutional racism such that BME people face stereotyping or prejudice in assessments at a basic level and/or that mental health services are not accessible, welcoming or responsive to people from BME groups.

   The evidence also shows that rather than improving the inequalities and injustices faced by BME people appear to be getting worse. Data published by the Race Disparity Audit in June 2020 showed that:

   (i) In the year March 2019, Black people were more than 4 times as likely as White people to be detained under the Mental Health Act.

   (ii) Out of the 16 specific ethnic groups, Black Caribbean people had the highest rate of detention out of all ethnic groups (excluding groups labelled 'Other').

   (iii) The highest rate of detention was for people in the Black Other ethnic group, followed by those in the Mixed Other ethnic group.

   (iv) The actual rates of detention of people in the ethnic groups not labelled as 'Other' may be an underestimate, particularly those within the Black ethnic groups.

   We will be working with local BME communities to assist them with addressing this issue starting with a pilot study working with a local Mental Health support group in Southampton.

8. **The NHS BME Network will liaise with the 'establishment' and/or 'system' to seek to progress the interest of BME people.**

It is important that we liaise with the 'establishment' and/or 'system' in order to ensure that it delivers on its statutory obligations concerning race equality and as such we intend to make it aware of our plan of action and to use the opportunity to press for change that will benefit BME people. For example the PHE report makes reference to the fact that it was a clear ask from BME stakeholders for ethnicity to be included on death certification. However, there is evidence that the Government is reluctant to make this change despite the fact that the absence of this information has led to delays in identifying the inequalities

of COVID-19 mortality. It is noteworthy that the Scottish government has required the capture of ethnicity data in deaths' registration since 2012.

9. The NHS BME Network will seek to establish links with other like-minded organisations and/or Networks in its endeavor to progress the race equality agenda.

Both Physical and Mental Health is linked with other factors such as employment, education, housing and justice to name a few. Furthermore, the reality is institutional racism is also an unfortunate feature of these institutions and therefore we need joined up thinking to be in the best position to both challenge and hold the 'system' to account.

Conclusion

The COVID-19 pandemic has, without question, triggered the worst public health crisis for a generation. In addition, it has also exposed the institutional racism that exists in the NHS which has blighted the lives of BME staff for decades and has contributed to health inequalities being a fact of life for minority ethnic groups.

The evidence from the past shows that at times like these the normal response from NHS Leaders is to make it 'safe' to talk about race and raising concerns and placing staff on development programmes. It is noteworthy that their response this time round also includes public admissions of ignorance and incompetence concerning race equality.

The NHS People Plan 2020/21 published on 30 July 2020 makes reference to the fact that from September 2020 NHS England and NHS Improvement will support NHS Leaders by arranging for expert-led seminars on health inequalities and racial injustice, and action learning sets across health and social care. At the very least let's hope that this will mean NHS Leaders will no longer be able to claim ignorance and incompetence as a defence.

That said, it is clear that if the NHS Leadership wants to gain the trust and confidence of BME people it has to take action which is co-created to ensure that the changes that takes place are significant and sustainable to end the systemic and entrenched racial discrimination that currently exists.

However, we know from our personal experiences this will not be an easy task, and especially so given the very same NHS leaders that have resisted change to date are the very same leaders who have been tasked with delivering on the various commitments made by the centre to address the racism that exists in the NHS. Furthermore, NHS Leaders whilst tasked with the delivery of this important agenda are secure in the knowledge that no mechanism has been put in place to hold them to account if they fail.

Nevertheless it is in spite of the odds that we the NHS BME Network give our commitment to our members and to the wider BME community to be the ***independent and***

effective voice we were established to be to enable us to continue to challenge the institutional racism that exists in the NHS.

Dr. Vivienne Lyfar-Cissé 15 August 2020
Chair
NHS BME Network