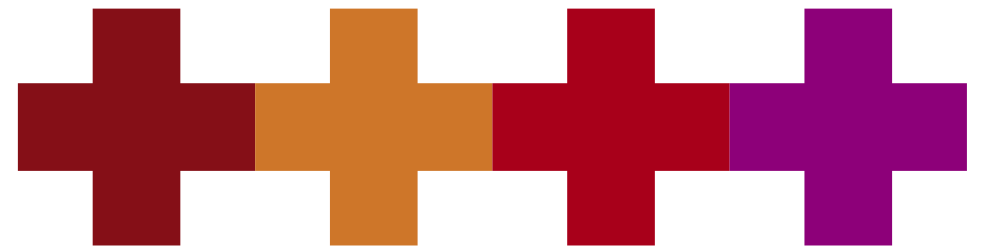


# Towards Race Equality in Health



race for health



A Guide to Policy and Good Practice for  
**WORKFORCE DEVELOPMENT**

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## About Race for Health

The Race for Health programme is led by primary care trusts (PCTs). It aims to create an NHS in which the health needs of black and minority ethnic (BME) people drive the health services they receive. The programme's national director is Professor Helen Hally, and its chair is Evelyn Asante-Mensah, OBE, chair of Manchester PCT.

Race for Health enables PCTs to deliver measurable improvements in the health of BME people. Prompted by the findings of the Stephen Lawrence Inquiry, Race for Health was a Department of Health initiative, spearheaded by health minister Lord Hunt. The programme continues to be sponsored and funded by the Equality and Human Rights Group at the Department of Health.

Race for Health now supports a network of PCTs across England, in the belief that these organisations are best able to make significant progress in this arena by working with each other in three key areas:

- Workforce development
- Commissioning
- Service improvement

### **All the trusts involved are committed to working with BME communities to:**

- Improve health
- Modernise services
- Increase choice
- Create a more diverse workforce in the NHS, its contractors, and social services

### **There is a growing network of PCTs in the Race for Health programme:**

- Berkshire East PCT
  - Bradford and Airedale Teaching PCT
  - Bristol PCT
  - Ealing PCT
  - Haringey Teaching PCT
  - Lambeth PCT
  - Leicester City PCT
  - Liverpool PCT
  - Manchester PCT
  - Shropshire County PCT
  - South Birmingham PCT
  - Wandsworth Teaching PCT
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- Westminster PCT
- Wolverhampton City PCT

The changing nature of the NHS and the increasing diversity of the population make Race for Health ever more relevant. Modern, dynamic health and social services should reflect the experiences and aspirations of all their users. Closing the health gap for black and minority ethnic communities will be a real measure of success.

Further information is available from:

[www.raceforhealth.org](http://www.raceforhealth.org)

Contact Race for Health:

[enquiries@raceforhealth.org](mailto:enquiries@raceforhealth.org)

0161 958 4081

## How to use this guide

This guide is designed to provide practical pointers and examples of good practice for everyone involved in the recruitment and retention of staff.

It is one of a series of three guides. The others in the series deal with service improvement and commissioning.

Based on the experience and knowledge of human resource directors, equal opportunities officers, and those involved in workforce planning in the Race for Health PCTs, this guide aims to share experience and encourage innovative employment practice.

It is not designed to provide definitive answers, and the examples it contains are not intended as templates to be replicated across the NHS and its partner organisations. Rather, the guide sets out approaches that might be worth developing and adapting to suit local circumstances. The focus is on race equality, but the issues raised apply to other areas of equality and diversity.

**This guide will help human resource directors, commissioning directors, and managers at all levels to:**

- Comply with the relevant policy and legal requirements
- Ensure that the workforce of the NHS and its contractors reflect the diverse communities they serve
- Promote diversity at all levels
- Understand how to support good employment practice

- Identify measurable outcomes for reducing inequalities in workforce development
- Involve diverse communities in creating employment opportunities
- Develop an understanding of the economic benefits of boosting diversity in the workforce

**For ease of reference the guide is divided into the following sections:**

1. Introduction
2. The business case
3. Routes into employment
4. Recruitment
5. Keeping and developing existing staff
6. Managing conflict
7. Organisational development
8. Monitoring and measuring progress
9. A summary of relevant equality legislation

**Where appropriate each section contains:**

- A list of relevant legislation/policy documents
- Useful resources
- A checklist of helpful prompts and tips
- Case studies

**Useful questions to bear in mind when using this guide are:**

- Why is it important to employ a diverse workforce?
- What sort of people do you need to deliver your services?
- Are you recruiting for the person best suited to deliver your services or for the role?
- How can you deploy people differently to meet the needs of an increasingly diverse population?
- How can you gain the confidence and commitment of existing staff to promote diversity?
- How can race equality be incorporated into procurement arrangements for independent/voluntary sector organisations?
- How can race equality be incorporated into the new commissioning structures?

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## 1 Introduction

It is 30 years since the Race Relations Act came into force, and seven years since it was amended. Yet black and minority ethnic (BME) groups continue to face significant inequalities in educational achievement, employment opportunities, income, health, and quality of life.

In 2003 the public spending watchdog, the Audit Commission, stated that the NHS had made slower progress than other public sector organisations in working towards achieving race equality. But as the largest employer in Europe, the NHS should be leading the way in best employment practice.

In August 2006, the health services watchdog, the Healthcare Commission, published its web-based review of trusts' compliance with the Race Relations (Amendment) Act. It found that just seven (1%) were fully compliant, with a further 6% meeting two out of the three criteria.

Not only are there moral rights, human rights and legal imperatives to promote and sustain race equality, but there are also sound economic reasons for doing so.

BME people currently make up around 8 per cent of the UK population. They will account for half the growth in the working age population between 1999 and 2009, so it is important that they perceive the NHS as an employer of choice.

Unemployment rates among BME communities are, on average, two to three times higher than those among white people. By creating job opportunities and removing the barriers to employment for BME people, the NHS can help boost local economies and improve the health and wellbeing of local residents.

BME people do not comprise one homogenous group. Just as rates of disease and ill health vary from group to group, so too do employment prospects and aspirations. Generic solutions will not always be appropriate, and more targeted action, based on a thorough understanding of the local ethnic profile, will often be needed.

BME staff continue to be disproportionately clustered at the lower rungs of the NHS career ladder. They are under-represented in senior posts, and over-represented in employment tribunals and referrals to regulatory bodies.

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This wastes talent and undermines confidence, which is not only to the detriment of individuals, but also to the development of the NHS as a modern, progressive organisation.

Acknowledging the existence of these barriers and accepting our responsibility to support people into progressive employment in the NHS and its partner organisations is a key first step to breaking them down. But developing a more diverse culture in the workplace is not a single-issue process.

Changing the way things are done can be difficult and time consuming. Strong, committed leadership from the top, and at every level of the organisation, is essential to create a culture that promotes an understanding of why diversity matters, and to translate it into positive action, irrespective of other financial and operational pressures.

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## 2 The business case

Promoting race equality in the workforce is essential to building the public confidence of BME communities in the reputation of the NHS and its contractors.

- It makes sound economic sense
- It improves the health of people in areas of deprivation
- It fits with national policy
- It is morally and legally right

### A diverse workforce benefits:

- The organisation
- Its employees
- Service users
- The wider community

### Harnessing change in the working population

Between 1991 and 2001, the BME population grew by 48%. Almost half of the BME population is under the age of 25 compared with only a third of the white population, and current estimates suggest that BME people will account for over half the growth in Britain's working age population by the end of this decade. Health and social care services cannot afford to miss out on this pool of potential workers.

The NHS workforce is also ageing. Some 73,000 nurses are due to retire within the next decade, and almost half of GPs say they intend to retire before they are 60.

### Widening the pool of available talent

Overall, people from certain ethnic minority groups have higher educational levels than those of white people. Five per cent of white men have a degree or an equivalent qualification, compared with 7% of those of Indian origin and 12% of Chinese origin. Ethnic minority students are more likely to study subjects that lead to professional qualifications.

BME staff know what it is like to be in communities in which they are the "majority" and in communities in which they are the "minority". This experience offers the NHS and its partner organisations new approaches to problem solving, and brings different perspectives and skills.

### Improving service delivery

The NHS is a people business, for which good communication is pivotal to delivering the right service to all its various communities. A multicultural workforce is therefore an essential component of that.

Employees from different races and cultures can act as "ambassadors" of good health across the community, and help make patient and public involvement forums more representative.

The knowledge of local people provides valuable access to untapped information about BME communities' health needs and beliefs. And it can be harnessed to help shape responsive and culturally appropriate services and generate creative solutions, such as the Berks East/Slough initiative, which sited a sexual health advisory service in a local African Caribbean hairdressers.

### Improving health and wellbeing

The NHS can boost the health and wellbeing of its local economy by recruiting locally and enabling people from disadvantaged groups to enter careers in health and social services.

A report from the former Birmingham and Black Country Strategic Health Authority states: "The NHS is one of the largest employers in the area, so we can have a significant impact on the health and social wellbeing of disadvantaged communities. We will benefit from the differing perspectives offered, and services will become more responsive as a result. Indeed, it is difficult to envisage services becoming more responsive and patient-centred unless we increase the number of BME staff."

Unemployment rates are low in England, but the numbers of people out of work and claiming benefits are heavily concentrated in certain areas of the country. In the worst affected 1% of streets more than half of all resident adults are out of work and on benefits.

There is strong evidence that living in an area of concentrated "worklessness" damages the life chances of children and young people in particular, because it lowers their expectations and chances of finding employment and breaking out of poverty.

- Half of working-age adults in these pockets of worklessness have no qualifications
- Black people are more than twice as likely as the general population to live in these areas
- Half of all households in these areas have at least one person with a limiting long-term illness
- A third of carers in these areas provide more than 50 hours of unpaid care each week

Another advantage of employing local people is that they have to travel less, which is better for the environment and better for their quality of life, and there is no need to provide relocation expenses.

## Cutting costs

A workforce that draws on all the available talent and which has fair, equitable, and transparent employment and development policies is more productive and cost-effective. This is because it:

- Improves staff motivation and productivity
- Enhances an organisation's reputation and attracts a broader range of applicants
- Minimises employment tribunal cases on the basis of discrimination
- Reduces staff turnover and the associated costs
- Retains valuable talent, experience, and knowledge

## National policy

Promoting equality and diversity in the workforce is a core dimension of *Improving Working Lives*. This standard stipulates that every NHS staff member is entitled to work in an organisation which can prove that it is investing in improving diversity, tackling discrimination and harassment, and developing the skills of staff to improve outcomes for patients.

### The national framework to support local workforce strategy development states that:

"All employers should have effective and widely understood policies and procedures in place to ensure they develop workplaces that promote fairness, dignity and respect for people from all sections of society. Continuing to manage equality and diversity as mainstream workforce and business issues is important and should be actively promoted both locally and nationally."

### The Leadership and Race Equality Action Plan contains three core dimensions:

- Meeting the particular health needs of BME people should become part of the core business of the NHS
- Race and ethnicity should be an important dimension of strategy over the next five years, particularly in the areas of chronic disease and health inequalities
- Targeting recruitment and career development opportunities for BME people and ensuring that practices do not inadvertently disadvantage BME people

*Standards for Better Health* (updated April 2006) describes 24 essential or "core" standards that all healthcare organisations in England treating NHS patients should already be achieving,

and 13 developmental standards that they should be working towards achieving in the future.

Under the domain of governance, core standard C7e specifies that all healthcare organisations should:

- Challenge discrimination
- Promote equality
- Respect human rights

The Healthcare Commission will assess trust performance against these standards as part of its annual health check.

The government's public service agreement sets out several health objectives for 2010, including increasing life expectancy at birth in England to 78.6 years for men and 82.5 years for women, improving outcomes for people with long-term conditions, and improving the patient and user experience. Meeting these targets will require a focus on BME communities.

The government recognises that third-sector organisations in the voluntary and community sector have a track record of innovation and effectiveness, with the potential to deliver services, such as employment training, education, and services for children and health. Moreover, in many areas of the country the third sector provides significant job opportunities for BME communities.

The expertise of these agencies and staff can be used to help people develop the skills to improve services for patients and address health inequalities in new roles. For example, local people with the necessary language and cultural skills could become health trainers who can more effectively deliver on the *Choosing Health* objectives for the more disadvantaged and excluded sectors of a local community.

New roles will also be needed to meet the government's vision for improved community and school services, set out in *Our Health Our Care Our Say* and the *Chief Nursing Officer's Review*.

## Legal obligations

The Race Relations (Amendment) Act 2000 places a duty on the NHS and other public sector authorities to:

- Eliminate unlawful racial discrimination
- Promote equality of opportunity
- Promote good relations between people of different racial groups

### All public authorities are also legally required to monitor, by racial group, the numbers of:

- Staff in post
- Applicants for employment, training and promotion
- Those who receive training
- Those who benefit or are disadvantaged as a result of performance assessment procedures
- Those involved in grievance procedures
- Those who are the subject of disciplinary procedures
- Those who leave their jobs

Authorities must publish the results of this monitoring annually.

### The duty is not just about numbers. Public authorities must use monitoring information to:

- Detect any differences in the way different racial groups are treated
- Investigate the underlying reasons
- Deal with any unfairness, disadvantage, or possible discrimination

The *SHA Race Equality Guide* aims to help NHS organisations meet their statutory duty under the Act and contains a performance framework for managers and healthcare professionals to agree goals for race equality and organisational performance.

The wider equalities legislative agenda places a duty on public organisations to promote other areas of equality. (See Section 9.)

### Useful resources and relevant legislation/policy

- *A Wider View 2004 – 2010*. Birmingham and The Black Country Strategic Health Authority.
- *The SHA Race Equality Guide*. Commission for Racial Equality June 2004.
- *Improving Working Lives Standard*. Department of Health.
- *A national framework to support local workforce strategy development: a guide for HR directors in the NHS and social care*. Department of Health December 2005.
- *Leadership and Race Equality Action Plan*. Department of Health February 2004.
- *Standards for Better Health*. Department of Health July 2004, updated April 2006.
- *Our Health Our Care Our Say. A new direction for community services*. Department of Health January 2006.
- *Choosing Health White Paper*. Department of Health November 2004.
- *Chief Nursing Officer's Review of nursing, midwifery and health visiting's contribution to vulnerable children and young people*. Department of Health August 2004.
- Race Relations (Amendment) Act 2000.
- Commission for Racial Equality: [www.cre.gov.uk](http://www.cre.gov.uk)

## 3 Routes into employment

### Where we are now

- Government figures indicate that despite progressive falls in the numbers of people out of work, the employment rate for BME people has remained about 15% below that of the overall population.
- There are significant variations in employment rates among different ethnic groups, which do not appear to be directly related to differing levels of education and skills.
- Annual Labour Force Survey statistics show that Bangladeshi men have the lowest rates of employment at 55 per cent, compared with 73 per cent for Indian men and 80 per cent for white men.
- Unemployment rates are disproportionately higher among Pakistani, Black Caribbean, and Black African men while Pakistani and Black African women also face higher unemployment rates than white women.
- Although more acute among first generation people, second generation people from these particular ethnic groups, who are born and educated in the UK, are also disadvantaged in terms of unemployment, earnings and career achievement.
- A Cabinet Office report published in 2003 concludes that gender, generation and geography have key roles in the job prospects of BME communities and account for some of the variations seen in employment rates. But the most important factors remain education and skill levels, access to employment opportunities, and discrimination in the workplace.

### Breaking down the barriers

#### External factors

Perceived language and cultural barriers, unfamiliarity with the paper work, lack of confidence or work experience can all deter potential applicants.

Certain types of career may simply not be perceived as attractive to certain ethnic groups, and the lack of BME role models in senior posts in the health service may deter some BME people from considering it as an employer of choice. People may also be unaware of the wide range of clinical and administrative/managerial careers available.

Areas such as the allied health professions and school nursing tend to be dominated by white women, and this may be because training and higher education establishments are not advertising the range of training opportunities widely enough or recruiting a diverse range of students to their courses.

In areas of deprivation, where a higher proportion of BME people live, the availability of affordable childcare may further hinder access to employment opportunities.

### Internal factors

Barriers on the inside include setting the bar too high for certain jobs, such as insisting on certain minimum qualifications over skills and experience, irrespective of whether these are relevant to the post.

There are several ways in which the NHS can boost the employment prospects and aspirations of BME communities. These include:

- Developing a sound knowledge of the local ethnic profile served by the trust, its skill base and aspirations, through effective community relations
- Improving access to job vacancies by more targeted and culturally appropriate advertising
- Providing “pre-recruitment” training to help potential applicants navigate their way through the recruitment process, from filling in application forms to interview skills
- Helping marginalised groups with existing skills, such as nurses and doctors who are refugees or asylum seekers, to fulfill the language and further training criteria for entry onto professional registers
- Creating new roles for local people, which will help to increase access to health services and decrease health inequalities, as part of service improvements
- Working with third sector BME organisations to deliver education and training opportunities for BME people
- Marketing the NHS as an employer of choice to children and young adults who might not have considered it as a career option, in areas with high BME populations and social and economic disadvantage

### 1 Develop a sound knowledge of the local community

A sound understanding of the ethnic profile of the local community is an essential first step to boosting access to employment.

The local authority will have information on local ward profiles. These are based on the 2001 census and provide a more detailed break-down of the communities in a particular locality.

Population changes, such as an influx of new migrants can make this information out of date, so you could ask a group of frontline staff to draw up a local community “map”, highlighting where different communities are located. This would ensure that both longstanding as well as newer communities are taken into account when formulating recruitment strategies.

Effective community relations are key to a thorough understanding of the local ethnic profile, as well as finding out how health and social services are perceived, both as employers and service providers. Public consultation on service design is also a statutory requirement under Section 11 of the Health and Social Care Act 2001.

Meaningful community engagement should be more than a tick-box exercise where only the most vocal people are heard. The easy option is to talk to those who put themselves forward, but it’s important to engage more marginalised communities (see Section 5 of the Commissioning Guide).

### Communities need to be able to understand why their views are being sought, and about what.

- They need to feel that they will be heard
- Consultation alone is not enough; feedback and action are essential
- Events and meetings need to be accessible, with support such as childcare provided
- Events should not clash with religious festivals
- The process needs to be cyclical and ongoing

South Birmingham PCT recently undertook a community listening exercise to find out more about the activities of local and voluntary community organisations. This prompted the appointment of “bridge-builders” to link up the trust and the local community more effectively.

## 2 Consider providing pre-recruitment support

This can help an individual successfully navigate the recruitment process. It's important because, according to the Commission for Racial Equality, white graduates are three times more likely to be offered a post by leading British companies than a BME candidate. And British Afro-Caribbean applicants are four times more likely to be refused a job interview than a white person.

### Pre-recruitment support could include some or all of the following:

- Providing information about where jobs are advertised and highlighting the range of opportunities that might be available
- Identifying a range of roles and job opportunities that might be suitable for an individual
- Taking individuals through the format required to complete an application form and clarifying the phrases and "jargon" used in the NHS
- Helping potential applicants understand the structure and ethos of the NHS
- Supporting applicants to "market" their skills and talents effectively
- Preparing people for job interviews

It may also include screening for literacy and numeracy skills, confidence building and practical support, such as childcare.

Partnerships with voluntary- and community-sector (third-sector) agencies can be an effective means of pooling resources to carry out pre-recruitment support and training. These organisations have a wealth of experience and knowledge and often have good links with local communities, including those who are more marginalised.

Organisations, such as the Black Training and Enterprise Group (BTEG), which works with employers to enhance community-based skills and create routes for unemployed people to get into work, or the government's New Deal, JobCentrePlus and SureStart, are all worth considering.

## Access to employment service, South Birmingham PCT

The Access to Employment (A2E) service helped people find work in health and social care. It aimed to provide a one-stop-shop for potential applicants to local health services, by providing access to information and support on how to navigate the system more effectively. Every job applicant was sent a flyer about the service.

Located in a local community drop-in centre in the town, it opened every Monday morning, supplying information on all local job vacancies in health and social care. The sessions included presentations from PCT staff from human resources and learning and development, supported by local JobcentrePlus staff.

Training was also advertised and signposted at A2E. Mock interviews were available, and applicants encouraged to complete sample application forms at home and bring them in for feedback.

Applicants were also screened for literacy and numeracy, which helped them identify what types of job they could apply for or what additional training they might need. Confidence-building courses were also offered.

## NHS Job Shop, Bradford and Airedale Teaching PCT

Bradford and Airedale Teaching PCT, in partnership with local regeneration organisations, has taken job opportunities to community centres and hubs used by local people. This includes the NHS Job Shop in partnership with the REGEN 2000 Employment Link project, where local people can also receive help to complete application forms and prepare for interviews, and the SALT PATS (Speech and language therapy positive action training scheme), developed in partnership with the local Sure Start Programme. The scheme has enabled local BME people to access professional training.

### Mentoring programme, Bristol PCT

A mentoring programme was set up for BME people considering jobs and improved careers in the NHS. Thirty volunteer mentors at all levels and from a range of backgrounds were trained and assigned mentees, who had either approached the trust at careers fairs or who had been nominated by outreach recruitment workers.

Potential applicants attended a pre-employment course, "Get That Job!", with the aim of demystifying the recruitment process and equipping people with the skills to present well at interview.

Bristol PCT was an early supporter of the Pathways to Work scheme, which aims to help people from under-represented communities into work by offering work placements.

Although not all roles are available as work experience placements, and not all mentees end up working in the NHS, it has proved a useful exercise in raising people's awareness about the career opportunities available in the NHS.

### Gateway Family Services, Birmingham

Gateway is a community interest company (CIC), profits from which are reinvested in the local community.

It runs a community family worker programme to enable people to take up jobs in health, social care, and children's services. All participants are recruited locally and given an individual learning plan, ranging from essential skills to professional training.

The programme applies a skills escalator approach so that achievement and qualifications can be used to access work at different points as skills and abilities are developed. The course has been matched to the NHS Knowledge and Skills Framework and the common core of competencies for the children's services sector.

Each participant is mentored and supported throughout their training and early employment. The courses are targeted at BME communities.

Gateway also offer learners paid traineeships as part of training contracts. These provide work-based learning in addition to classroom learning.

### 3 Help marginalised groups use their existing skills

Many healthcare professionals seek asylum in the UK. Many would like to use their skills and find work here, but several obstacles lie in their path. According to the British Medical Association there are in excess of 10,000 medically qualified refugee doctors in the UK alone.

Refugee doctors and dentists must pass the academic English exam (IELTS). There is some debate as to the relevance of the content of this exam to practise, and failing one part requires the whole exam to be taken again.

Refugee doctors have to complete clinical attachments before they can enter the medical register. But there is no standard route for this process, and in areas such as London, where the number of migrant healthcare professionals is high, demand outstrips supply.

To qualify for benefits, refugee doctors are required to attend often lengthy training courses set up by JobcentrePlus, irrespective of the relevance to their profession.

Regulations introduced by the Home Office in March 2006 mean that trusts can only employ a doctor from outside the EU if the post cannot be filled by someone from the UK. Although refugee doctors have exceptional leave to remain, which means the rule does not apply to them, many trusts have assumed that they cannot employ them.

### Refugee Health Professionals Scheme, Westminster PCT

Westminster PCT funds a local voluntary organisation, the Migrant and Refugee Community Forum, to help doctors and dentists meet UK registration requirements through weekly study sessions.

The scheme helps participants find clinical attachments and provides limited bursaries towards travel expenses and exam fees. The Forum advocates on behalf of refugee healthcare professionals to improve employment policies and break down the barriers hindering access to jobs.

Between April 2002, when the project was set up, and May 2005, 166 refugee doctors and 98 refugee dentists have gone through the scheme. However, only 17 of the doctors and six of the dentists are working in the NHS, and most have not found work locally.

[www.mrcf.org.uk/refdev.htm](http://www.mrcf.org.uk/refdev.htm)

#### 4 Consider creating new roles

Redesigning services to narrow health inequalities will generate the need for new roles and new ways of working (see Service Improvement Guide).

The government's vision for community services, outlined in *Our Health Our Care Our Say*, includes improvements in community support for people with long-term conditions, mental health needs, and disabilities, all of which will affect service provision.

Trusts can encourage a broader cross-section of people to apply for jobs by reviewing the types of roles for which they are recruiting. Fixed ideas about what roles and competencies are required for jobs may not benefit the organisation or address the health needs of BME communities.

External funding can be used to pilot new roles using the community development competencies (Lifelong Learning UK National Occupational Standards in Community Development Work approved by the Qualification and Curriculum Authority April 2006).

Alternatively, commissioning services from local businesses or third sector organisations can produce many positive spin-offs, including increased employment, better community links, and improvements in service access and public health.

#### Family support, South Birmingham PCT

A new post was designed to provide outreach and support for families with children who had disabilities, and provide a bridge to the very busy health team working in schools and child development centres. The recruitment criteria for the job included local knowledge and fluency in one or more languages spoken locally other than English.

#### Language link-worker, Haringey TPCT

The needs assessment team created a new role in Haringey. A link-worker role was created by the trust to be on call for GPs for when they see patients whose first language is not English. The link-workers are trained to communicate both ways between the doctor and the non-English speaker and are based at North Middlesex Hospital from where they can travel to surgeries on a sessional basis.

#### 5 Market the NHS to children and young people

Working in public services is not the leading career option to which most young people aspire. Young people tend to associate the NHS only with ill health.

Working in collaboration with schools and colleges, voluntary schemes and careers days are all ways of countering this trend and providing some genuine skills and experience that can be used in future employment. Good guidance is available from NHS Careers about insurance and legal issues around the employment of young people.

#### Structured work experience, South Birmingham PCT

South Birmingham PCT set up a two-week structured work experience programme in July 2004, to give year 10 students from different local schools some idea of the breadth of careers available in the NHS and social services.

The programme has now been mainstreamed and there are plans to extend the length of the "work placement" and to increase its reach through "taster" days at schools/colleges.

The programme directly targets schools in the regeneration areas of Birmingham to ensure that children from less affluent backgrounds are included. Demand for work experience placements has outstripped supply, but over 150 have been placed in the past year.

A Young Carers programme has also been run in one school, with 14 students taking part; all of them from a BME background.

A vocational programme for 14-to-16-year-olds, which is funded by a cluster of local schools, aims to raise awareness of the broad range of careers available in health and social care. Students have the opportunity to meet both professionally qualified staff and other students on vocational programmes while gaining "on the job" experience.

The programme provides competencies that relate to the six core dimensions of the Knowledge and Skills Framework, and closely matches the common core of skills required for working with children and families. In 2005, 90 young people enrolled on the programme.

### Raising awareness, Bradford and Airedale TPCT

The POSH (Promoting Opportunities in Social Care and Health) Project is funded by the European Social Fund, hosted by Bradford and Airedale TPCT, and works with a partnership of health and social care providers. It aims to develop a workforce that is representative of the local communities and adequately skilled to provide high-quality services.

It consulted widely with young people and their families on their career aspirations and worked with schools, colleges and the University of Bradford to provide the skills and knowledge applicable to a career in the NHS, and access to good careers advice.

The project has produced a range of materials to raise awareness about career paths in the NHS, including a booklet featuring local employees as role models and a DVD for teachers and other professionals, including human resource managers, on how to achieve a diverse workforce.

A coaching and mentoring scheme, primarily for BME students aged 16 and above, who are interested in pursuing a career in the NHS, has also been developed.

The PCT has used local radio to promote the NHS as an employer actively seeking to develop a diverse and representative workforce, and as offering a broader range of careers other than just nursing and medicine.

### Checklist

- Do you know the ethnic profile of your communities? Are you keeping up with demographic change?
- Is your community engagement ongoing and cyclical?
- How do you market your job vacancies and the NHS?
- Could you set up managed voluntary placements for young people?
- How might you design roles for members of the local community, or to cater for cultural differences?
- What are the barriers to employment in your organisation, and how have you gone about addressing them?
- Does service improvement link closely to workforce planning in terms of recruiting to meet the needs of service users, rather than continuing to advertise for traditional jobs?
- Have you thought about using a “skills-mix” approach?
- What sort of support does your organisation provide for potential applicants?

### Useful resources and relevant legislation/policy

- *The vital connection: an equalities framework for the NHS*. Department of Health April 2000.
- *Leadership and Race Equality Action Plan*. Department of Health February 2004.
- *Our Health Our Care Our Say: A new direction for community services*. Department of Health January 2006.
- Health and Social Care Act 2001.
- *Skills: Getting on in business, getting on at work*. White Paper. Department for Education and Skills July 2005.
- *Moving on up? Bangladeshi, Pakistani and Black Caribbean women at work*. Interim report by the Equal Opportunities Commission, September 2006, available at [www.eoc.org](http://www.eoc.org)
- The Association of Public Health Observatories produces reports, which highlight where certain ethnic groups have worse health indicators. [www.aphp.org.uk](http://www.aphp.org.uk)
- Labour force information, tied into the 1991 and 2001 censuses is available from the Department of Work and Pensions website: <http://asp.ccsr.ac.uk/dwp>
- *Work Experience Building the future of the team. Guidelines for managers*. NHS Careers April 2004.
- *The changing face of Britain: Ethnic minorities in the UK. Race for Opportunity*. September 2004.
- *Ethnic Minorities and the Labour Market*. Cabinet Office 2003.
- *Strengthening Communities. A guide to capacity building for communities and the public sector*. Skinner S. Community Development Foundation February 2006.
- *Promoting Equality and Human Rights in the NHS. A Guide for Non-Executive Directors of NHS Boards*. Department of Health July 2005.
- *The Journey to Race Equality. Delivering improved services to local communities*.

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Audit Commission January 2004.

- Commission for Racial Equality [www.cre.gov.uk](http://www.cre.gov.uk)
- Equal Opportunities Commission [www.eoc.org](http://www.eoc.org)
- NHS Careers [www.nhscareers.nhs.uk](http://www.nhscareers.nhs.uk)

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## 4 Recruitment

### Principles of effective recruitment

- Despite the benefits to the organisation and patient care of effective recruitment, too often insufficient attention is paid to the process - from drawing up the job specification to how people are appointed - risking inappropriate appointments and indirect discrimination.
  - For those not used to applying for jobs in the public sector the recruitment process can seem daunting and often overly bureaucratic. For example, the “person specification” can put off potential applicants and unintentionally exclude diverse cultures because of the way in which information or criteria are presented.
  - If the NHS is to recruit a diverse workforce it needs to consider more innovative and less intimidating approaches to increase its attractiveness to potential BME employees and to widen its criteria.
  - An equal opportunities statement is not enough on its own to convince any applicant that an organisation is committed to diversity and race equality. It requires taking the long view, including raising awareness in the community among students in schools and colleges, in third sector agencies and in the organisation itself.
  - Thought should be given to not simply replacing members of staff in the same job role when people leave, but instead looking at what services need to be provided and considering who can best provide them.
  - Measures need to be put into place to ensure that everyone has an equal opportunity to be considered, and that a fair and consistent approach is systematically applied throughout the entire process – from where and how a vacancy is advertised, to what level of support is provided once in post.
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### Examples of a skills mix approach

The Children's Specialist Service Directorate in South Birmingham PCT created new roles to meet the needs of the changing population of the area.

A community family worker, who had undertaken a community-based training course in family support, was employed to assist the highly trained specialist school nurse.



The school nurse had been spending a considerable portion of each day feeding children through a nasogastric tube, but could have been using her time more effectively on other high-level tasks if she had had an assistant to take this on.

The school nurse listed the tasks she wanted this new worker to carry out, Gateway Family Services turned these into competencies, to be completed in the workplace and assessed by the specialist nurse.

The competencies complied with the Knowledge and Skills Framework and were accredited as part of a National Open College Network qualification.

The language support service of Bradford and Airedale TPCT looked at how people who do not have English as their first language access and use services. The project discovered that family members and neighbours were being used inappropriately to communicate personal and sensitive health information, prompting a redesign of the language support service.

The project revised existing training and development opportunities to help staff working as interpreters or translators move on to become language support workers and community health development workers.



	The recruitment process	
		
	<p><b>Vacancy arises/new role identified</b> When a vacancy arises the first step to consider is what job requires doing, and why. Is it the same job as before, is it fundamentally different, or is it a completely new role?</p>	
<p>Agenda for Change.  The wording should be concise and to the point.</p>	<p><b>Job/role defined</b> Job descriptions record the important facts about a job. They are important documents, both to the manager as well as to the applicant because they provide a way of stating simply and clearly what the job entails.</p>	
<p>Agenda for Change.  Check that the requirements and criteria are not helping to create significant disparities between the success rates of different racial groups.  Are the qualifications, skills, knowledge and experience stated in the person specification really necessary for the role?</p>	<p><b>Criteria for selection defined</b> <i>The person specification</i> identifies and summarises the skills, knowledge, experience and qualifications required by the successful candidate to carry out the duties of the job to an acceptable standard of performance.  It enables the panel to assess candidates at shortlisting and interview stages in a focused, unbiased and accountable way.  If certain qualifications are considered, do not automatically assume that qualifications gained overseas are invalid. Check to see whether these have been acknowledged by the relevant UK academic or professional body.</p>	<p>Don't include unreasonable criteria.  Challenge implicit assumptions about criteria.  Beware of writing a person specification to fit the internal candidate whom you want to appoint!</p>

<p>It is OK to specify a certain level of spoken English</p>	<p><b>Person specification criteria should:</b></p> <ul style="list-style-type: none"> <li>● relate to the needs of the job</li> <li>● be objective, unambiguous, quantifiable</li> <li>● specify each requirement in precise job-related terms</li> <li>● integrate equalities issues</li> <li>● be patient focused.</li> </ul>	
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**Training for managers, Bristol PCT**

Bristol PCT runs courses for managers involved in the selection and recruitment process – a 2-day and a half-day course – to ensure that recruitment is fair and works towards increasing diversity. A top-up course is also available. Since 2002, around 1000 managers have been trained.

Managers can be reluctant to try out new ways of recruiting or recruiting people who are different, because they are often struggling with a heavy workload and perceive these moves as risky. Co-opting managers to deliver equality and diversity training, including induction, can help.



	<p><b>Recruitment panel identified</b></p> <p>All those involved in recruitment panels must have been appropriately trained.</p> <p>A mixed and culturally diverse interview panel is essential. You may wish to consider BME community representatives, if there are no suitable internal candidates. If so, ensure they have been properly trained and have as full and equal a role as other panel members.</p>	
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<p>Think about options other than the customary outlets when advertising posts.</p>	<p><b>Advertise</b></p> <p>The text should be attractive. It is often difficult for people to see themselves as anything other than a patient when they think of the NHS, so job adverts need to take account of this.</p> <p>Job vacancies might be being advertised in too narrow a selection of outlets and simply not reaching the diverse groups in the local population.</p> <p>Think about the sorts of people you want to attract to the post. Have you thought about flyers sent out to community centres, email alerts to specialist associations, adverts in local newsletters and other specialist and culturally specific media, or using the web? How widely will the ad be made available internally, and how will you do this?</p> <p>The NHS has an Equal Opportunities Policy and reference to this should be included in adverts.</p>	<p>Ensure the advert is jargon free.</p> <p>Beware of relying on e-recruitment alone, especially for entry-level posts. This could exclude people who may not have access to, or be comfortable with, new technology.</p>
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**Consequences of poor advertising**

**Gulsher v Gateway Foodmarkets Ltd, Case No.17036/92 [1994] DCLD 19**

An employer appointed a worker to a new post without advertising the vacancy internally. As a result, no-one in the organisation was given the opportunity to apply, and the case went to tribunal. The tribunal ruled that the employer had unlawfully discriminated against a black worker who was qualified for the post, and who would have applied, had he known about it. The complainant was awarded damages for injury to feelings.

		
The wording should be clear. It should contain a "Where did you hear about this post?" and ethnicity monitoring questions	<b>Review application form</b> Review the wording and structure of the forms regularly to ensure they enable applicants to present themselves in the best light.	
Will written guidance be sent with the pack? Will support be offered for those who require help?	<b>Send out recruitment information</b> Instead of referring to essential criteria for the job, ask the applicant to read the information about the post and explain why s/he thinks they would be suitable. Are there any local voluntary groups and/or networks from which applicants can get help?	Remember to make reasonable adjustments for applicants with disabilities, including providing support with completing application forms.
Make sure that test dates don't clash with religious festivals.	<b>Agree methods for selection</b> Will candidates be required to take tests? If so, how will they be validated? Are you sure that the tests are not culturally or gender biased?	
	<b>Shortlist</b> You may wish to have a long list depending on the number of applicants.  Shortlisting should involve more than one person, and external panel members should be given the opportunity to participate if they wish. Scoring systems should be applied consistently and uniformly to all applicants.	

	Obtain feedback from the candidates on what it was like to fill in the application form.  Consider giving feedback to candidates who didn't make it on to the shortlist about why they failed to do so.  If 20 application forms are sent out, but only eight are returned and four candidates shortlisted, it is probably worth looking at the reasons why this might have happened. You might consider asking potential applicants why they did not apply.	
Are there other forms of support available to help candidates manage the interview?	<b>Informal briefing for candidates</b> Thought needs to be given as to whether shortlisted candidates are invited in for a briefing before the interview. The purpose and status of this visit needs to be clear. Who will be involved? Will anything said by the candidate be used in their assessment?	
Offer to pay expenses.	<b>Interview</b> Discuss the areas of questioning in advance to avoid questions that could result in discriminatory treatment.  Think about the optimal number of interviews to fit into a day – probably 5-6.	
Take up references, Criminal Record	<b>Selection</b> At the end each interviewer should make their assessments of the candidates	If no candidate meets all the criteria don't

<p>Board checks, and their eligibility to work in the UK.</p>	<p>separately, then discuss these and come up with a collective decision, as to who is above and below the line.</p> <p>The panel should also consider whether anyone can be retained on a waiting list and/or whether unsuccessful candidates can be considered for other roles.</p>	<p>be tempted to appoint anyway. References should be sought on job related information. They should not be used to support discriminatory practice.</p>
<p>Tell candidate that appointment will be subject to usual checks/references.</p>	<p><b>Appoint</b> Offer the job to the successful candidate</p>	
<p>Prepare colleagues for the new arrival.</p>	<p><b>Induct</b> Induct the successful candidate into the job, the team and the organisation.</p> <p>New staff need to be clear about the importance of keeping information confidential. This may be potentially problematic if there are small/close-knit BME communities involved. Make this explicit in employment contracts.</p>	
	<p><b>Review process</b> The chair of the panel should offer to give feedback to unsuccessful candidates. Remember, the purpose is to help interviewees improve their performance the next time they have an interview. Good feedback should ensure candidates reapply</p>	<p>If you cannot appoint don't be tempted to rewrite the person specification to fit the person you want and don't</p>

	<p>and/or go away feeling they have been fairly treated. If the panel has not been able to appoint, then it should consider interviewing again or re-advertising. Feedback should be against specific criteria and given by those who are appropriately trained.</p>	<p>re-advertise internally only. This could be indirectly discriminatory.</p>
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### Legal pitfalls

- Employment law covers decisions made during the recruitment process.
- Disseminate widely any job vacancies within your organisation.
- Make sure that the person specification clearly states that degrees or diplomas obtained abroad are acceptable, if they are of an equivalent standard to UK qualifications.
- Although intended to put candidates at ease before an interview, small-talk such as asking where someone comes from or commenting on an accent can be seen as discriminatory and lead to claims that these put the candidate off.
- Claims of discriminatory treatment often arise in relation to the selection interview. Provide clear guidance on how to conduct interviews in a non-discriminatory manner.
- Don't make assumptions about a candidate's eligibility to work in the UK. Ask all candidates this question, not just some of them.
- It is illegal to employ someone purely on the grounds that they are from a particular ethnic or target group rather than that they are the best candidate for the job. This could lead to claims of discrimination from other groups.
- There will be occasions when you may need to employ a specific worker for personal services or for his/her language skills, for example. It is legal to specify and employ a particular BME worker under a Genuine Occupation Qualification.

### Checklist

- Does the way you recruit unintentionally exclude people by using media that may not reach certain sectors of the local community or by focusing on qualifications over skills and experience?

### Useful resources and relevant legislation/policy

NHS Employers. [www.nhsemployers.org](http://www.nhsemployers.org)  
Race Relations Act 1976.

## 5 Keeping and developing existing staff

Failure to develop existing staff and create a progressive and safe working environment compromises individual progress. Labour force statistics show that one in 20 working Indian men is a medical practitioner, a figure that is almost 10 times the national average. Yet they are disproportionately clustered on the lower rungs of the NHS career ladder. Only three out of 400 directors of nursing are black, and there are only four black chief executives in the NHS.

Lack of staff development also hinders an organisation's progress and increases staff turnover. Organisations that want to retain staff need to invest in them and earn a reputation for doing so.

The availability of training opportunities and development are attractive to both prospective and existing employees. Over the past five years, the financial services company Nationwide has saved an estimated £1.2 million by focusing on the retention of its BME staff.

### Lack of representation in a broad spectrum of job roles

A report from the former Birmingham and Black Country Strategic Health Authority showed that people from BME backgrounds are recruited disproportionately into low paid jobs or into more highly graded clinical jobs, but are largely absent from middle management, technical roles and in the wide range of new roles becoming available in the NHS. As of August 2004 a total of 403 staff were employed by the Authority, 13 per cent of whom are from BME groups, but 20 per cent of the population served are BME.

### Staff turnover:

- Can be extremely expensive as it costs an estimated £10,000 to replace a member of staff, taking account of the recruitment process, the need for temporary cover, induction, and the impact on patients and service provision
- Affects training and development budgets, because training is potentially wasted if individuals keep leaving
- May damage the trust's reputation as an employer of choice
- Affects morale – both of staff as well as of patients who lose continuity of care and faith in the organisation's ability to deliver a consistent service
- Leads to a loss of individual and organisational knowledge and skills, and can have a deleterious impact on the wider team

- Can affect the organisational culture, including membership of the BME network and the general visibility of BME staff.

### What encourages staff to stay?

- A commitment to driving through race equality requires strong leadership from the top and a clear vision of what needs to be achieved in the organisation.
- What a trust does to support “new” and “different” staff – including preparing existing staff about changing workforces – can have a significant impact on ensuring that new staff stay. Trusts also need to consider how they manage induction, whether there is a buddying system for new staff and whether there are role models in leadership positions.
- Creating an environment where people feel comfortable and able to progress, because access to training and promotion are equitable, and religious and cultural differences are respected.
- Ensuring that jobs are well designed and that job descriptions and titles are accurate, so that people do not leave soon after joining, because they feel the post was “misrepresented” or “oversold”
- Celebrating the achievements of BME staff and those involved in improving their recruitment opportunities and career advancement.
- Making certain that there are transparent processes in place for training, promotion and monitoring to ensure that policies are applied consistently.
- Ensuring that equality and diversity officers are properly resourced, trained and given appropriate authority. They also need to be properly qualified to take on the job, which involves changing values and beliefs. This can be very challenging and take some time to achieve.
- Developing effective BME networks, which are organised from within, with clear terms of reference and a remit linked to the organisation's goals.
- Providing regular positive and constructive feedback so that staff feel motivated. Honest feedback ensures that people's expectations are managed properly. Some BME staff may have unrealistically high expectations of what they are able to achieve, while others may need to be challenged, because previous discrimination has persuaded them to limit themselves and their aspirations.

**Constructive feedback lets recipients know:**

- What the standards are
- How they are doing
- What needs to change in order to meet the standards
- How long they have to improve
- What support they can expect from their manager.

**It is:**

- Objective and based on facts or observations
- Specific
- Focused on behaviour that the recipient is able to change
- Balanced
- Clear about the positive aspects and includes praise where it is deserved
- Timely
- Given in a respectful, non-judgmental and unemotional way
- Regular and informal, so that it is not only given as part of an annual or six monthly appraisal process

**Ealing BME Network**

The network was set up in 2002, and is a joint venture between Ealing PCT, Ealing Hospital and West London Mental Health NHS trusts.

**It is divided into subgroups:**

- Training and development
- Employment issues
- Newsletter and publicity
- Events organisation

Speaker topics have included the sustainability of BME networks and effective personal marketing inside and outside the organisation.

The events aim to ensure that staff achievements are recognised, cultural taboos are tackled, and that everyone is aware of religious festivals and celebrations.

- Coaching and mentoring to support personal development are offered.
- Staff and managers need to know how a diverse workforce can positively contribute to achieving effective service outcomes. Regular training or team discussions can increase

awareness about different religious requirements or practices – the need for staff to fast during Ramadan, for example – as well as build confidence to challenge discrimination.

- Making effective use of non-executive directors, and using their expertise and networks in the community positively, will enhance the trust's reputation externally and internally.
- Terms and conditions of employment can have a significant impact on how people, especially BME staff who may have specific cultural and religious needs, feel about an organisation.

**The differences between coaching and mentoring:**

Coaching is a one-to-one relationship between two people which involves developing a person's skills and knowledge so that their job performance improves, hopefully leading to the achievement of organisational objectives. It targets high performance and improvement at work, although it may also have an impact on an individual's private life. It usually lasts for a short period and focuses on specific skills and goals, enabling individuals to achieve their potential. Coaching can be delivered by external coaches, full-time and part-time internal coaches who may be line managers, or human resources staff.

Mentoring tends to describe a relationship in which a more experienced colleague uses their greater knowledge and understanding of the work/tasks or workplace to support the development of a more junior or inexperienced member of staff.

**Checklist**

- How far has the PCT come in terms of achieving the Improved Working Lives Standard?
- What types of flexible working arrangements are there, and do they take account of religious requirements?
- Is there equitable access to all development opportunities – secondments, for example?
- Are parking spaces allocated on the basis of need or status?
- Is the contribution of BME staff recognised at award ceremonies or by nominations for external awards?
- Do the catering facilities take account of different needs, such as halal or vegetarian?
- Are there appropriate facilities, such as a prayer room?
- Do special leave arrangements take account of religious needs?
- Agenda for Change may have ironed out some anomalies in pay scales, but there are still some issues around doctors, dentists, senior managers, and academics who are excluded from it.
- Are equal value principles applied, and is there fairness around job matching and evaluation processes?

- Is the Performance Related Pay (PRP) process being applied equitably at the director level?
- Are processes around developmental opportunities such as secondments, shadowing, projects work, sabbaticals, acting up and deputising, fair and transparent?

Few BME staff enjoy the benefits of Performance Related Pay, as they are often not in posts to which it applies. Equity Impact Assessments should be used to monitor for discriminatory practice in PRP.

### Positive action or positive discrimination?

Positive action can play a significant part in both developing existing BME staff and improving levels of retention. NHS Employers' working definition of positive action is:

*"a range of lawful actions which seek to address an imbalance in employment opportunities among targeted groups which have previously experienced disadvantage, which have been subject to discriminatory policies and practices, or which are under-represented in the workplace."*

The lawful actions include targeted training, provision of facilities and encouragement to apply for specific posts.

Positive discrimination, on the other hand, involves redressing the balance of under representation of previously disadvantaged groups in the workforce by preferential recruitment or promotion regardless of competencies, skills and experience, and is unlawful.

In its report on the implementation of positive action in the NHS, NHS Employers identified certain key criteria for success. These were:

#### 1. Organisational culture

- Support for a diverse culture at all levels
- Celebration of success
- Preparedness to take risks
- Flexibility and adaptability

#### 2. Leadership

- Passion and drive
- Commitment across the organisation
- Team work

- Perseverance

#### 3. Good communication

- Understanding the local communities through consultation and effective engagement
- Sharing good practice
- Good marketing of the policy within the organisation, making clear what its aims are, and why it's not unfair to other groups

#### 4. Strategic management

- Strategic framework
- Sound planning
- Managing expectations
- Local partnerships
- Monitoring

#### 5. Adequate resources

- Long-term funding
- Dedicated posts
- Targeted resources
- Project management

The report recommends that organisations considering positive action should:

- Provide evidence that the proposed target group has previously been disadvantaged and/or subject to discriminatory policies or practice
- Or
- That it has been under-represented in the workforce compared with the local population of that target group over the past 12 months
- And
- Ensure that everyone else is not prevented from taking advantage of the potential benefits of the proposed initiative.

### Experience of the Breaking Through Programme, Ealing PCT

This accredited programme is primarily aimed at junior and middle managers in Ealing PCT, West London Mental Health Trust, and Ealing Council. Participants learn and practise leadership skills across health and social care boundaries, with the aim of developing confidence to deliver integrated services.

The programme is delivered in partnership with the consultancy group, the Hay Group, and requires 96 hours of face-to-face learning time, plus additional time for action-learning sets. The focus is on practical learning on the job rather than in taught classes. Participants need to commit to directing their own development and to investing in others' learning.

A bid for further funding has been made to develop BME managers in key policy change areas, such as practice-based commissioning.

### Practice Nurse Bank, Haringey TPCT

Faced with a shortage of practice nurses, the trust set up a practice nurse bank in 2002. It offers training and development to nurses wishing to take up or develop a career in primary care. This includes career guidance, work-based learning programmes, core training, learning sets, access to support groups, in-house training programmes, and specialist training, such as nurse prescribing.

The bank has over 100 practice nurses, who offer a range of services from nurse practitioner sessions to treatment room work. Most general practices covered by the trust use the bank for short- or long-term cover. It won the 'Making the Difference' category of the Practice Nurse of the Year award in 2004.

## What discourages staff from staying?

Creating a welcoming environment, in which people want to stay, means tackling the issues that hinder retention.

### These include:

- Concern about the impact of PCT restructuring. Managers need to be able to show that the process is being managed fairly and equitably. This can only be done if effective

monitoring systems are in place, race equality is mainstreamed into job descriptions and person specifications, and BME staff are not disproportionately bearing the brunt.

- A mismatch between the stated values of the organisation - commitment to race equality - and people's experiences of it, particularly where BME staff experience bullying, harassment or discrimination.
- Staff not feeling able or having the time to challenge heavy workloads or ask for further help or skills enhancement.
- The perception that there is undue emphasis on race equality rather than on individual talent and skills.
- Exclusion from what are perceived to be "the rules of the game", for accessing training and development opportunities.

### Useful resources and relevant legislation/ policy

- Agenda for Change NHS Employers [www.nhsemployers.org](http://www.nhsemployers.org)
- Improved Working Lives Standard.
- *A new statutory code of practice on racial equality in employment*. Commission for Racial Equality April 2006.
- *Positive Action in the NHS*. NHS Employers October 2005.
- *A wider View 2004 - 2010*. Birmingham and The Black Country Strategic Health Authority.
- *Training in racism awareness and cultural diversity*. Home Office Development & Practice report 3, 2002.
- ACAS [www.acas.org.uk](http://www.acas.org.uk)

## 6 Managing conflict

The NHS is a “people” business and, inevitably, conflict or disagreement will arise when different people work together, or when people work in close proximity for any length of time.

Conflict only becomes negative when it is avoided or ignored and remains unresolved. If handled constructively, and in a timely manner, conflict can be healthy and creative.

Most workplace conflict is caused by tension between individuals. But it is not always obvious or explicit and can show itself in several different ways.

### Signs of conflict can include:

- Anger, irritability or sarcasm
- Withholding or unwillingness to share information needed for the task
- Lack of enthusiasm
- Avoidance of responsibility
- Unwillingness to cooperate
- Taking frequent sick leave.

### Conflicts can arise when:

- Individuals feel undervalued
- Excessive authority is used in the guise of “tough” management
- Roles are poorly defined, leading to “grey” areas of responsibility
- Communication is poor and misunderstandings arise about what needs to be done
- Individuals don’t know how to manage their anger appropriately
- Feedback on tasks is perceived as a personal attack
- A personality clash occurs
- An employee has little experience in the role
- Cultural or religious differences become apparent
- Competition for the same resources arises
- People are harassed or bullied.

Harassment refers to “*unwanted conduct that has the effect of violating dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment. It may be related to gender, sexuality, ethnicity, religion or belief, disability or age, and may be persistent or an isolated incident.*” (Sex Discrimination Act 1975 (as amended)).

### Examples of harassment include:

- Unwanted physical contact, ranging from touching to serious assault
- Offensive jokes, banter; language, gossip; slander; racist, sexist or sectarian songs or remarks
- Offensive posters, pictures or written material; graffiti; obscene gestures, flags or emblems
- Undue pressure – for example, for sexual favours or to participate in political, religious or social groups
- Isolating or excluding behaviours, or refusal to cooperate with a colleague/colleagues.

Bullying is defined as offensive, intimidating, malicious or insulting behaviour and/or an abuse or misuse of power through means which are intended to undermine, humiliate, denigrate or injure the recipient.

### Examples of bullying include:

- Not allowing a person to speak or express him/herself. This may be accompanied by loud criticism
- Giving someone meaningless tasks or no work
- Withholding information
- Social exclusion and isolation
- Repeated dressing down in front of others
- Manipulation of the person’s reputation through rumours, gossip, ridicule, etc.
- Actual or threatened physical abuse.

A survey on pay and conditions, published by the Royal College of Nursing in 2006, shows that almost twice as many BME nurses as white nurses said they had changed jobs because of bullying and harassment. BME nurses were also significantly more likely to say that they were acting up to a higher grade and to consider that their grading was inappropriate for their roles and responsibilities, particularly at more senior levels.

One in six felt discriminated against on the grounds of race. This is echoed in the National Survey of NHS Staff, published in March 2006, which shows that 7 per cent of all staff had experienced some form of discrimination during the previous 12 months. Of these, 17 per cent of BME staff said they had been discriminated against on the grounds of race.

The finding prompted the Healthcare Commission to state that this was “a cause of real concern”. They concluded that: “NHS organisations need to renew efforts to address discrimination in the workplace.”

## Tensions between different faiths and ethnic groups

### Examples might include:

- Patients refusing to have a service provided to them by someone of a different race or gender
- Religious beliefs precluding working with people of different gender or sexuality
- Particular groups of staff speaking in their first language, which is not English, to the exclusion of other staff or service users
- A perception on the part of some staff that Positive Action benefits one group only and that they don't belong to it.

Religion or belief can crop up in a wide range of staffing policies, including dress codes, rotas, single sex and mixed wards, annual and special leave. And it may not always be easy to differentiate customs and traditions from religion or beliefs. Managers need to balance the conflicting demands of the needs of individual members of staff and the service user or organisation.

NHS Employers warns that it is easy to indirectly discriminate through ignorance on the basis of race and religion. It recommends that trusts draw on the expertise of existing staff as well as external agencies.

### It recommends:

- Awareness-raising events
- Disseminating examples of good practice
- Inclusion in performance management
- Setting up faith support networks
- Monitoring policies for which there is scope for legal challenge.

## Performance management

Another area of potential conflict is performance management. Managers use informal and formal performance management frameworks, particularly for disciplinary and capability procedures.

Managers who are not confident about working with diversity in the workforce tend not to deal effectively or early enough with issues of poor performance or poor working relationships where this is between black and white staff. This is not uncommon in organisations where BME staff are poorly represented at all levels of management.

When this type of conflict arises, training in working with diversity and in conflict resolution as well as the provision of peer support for staff are helpful. The local BME staff network and the human resources team at Westminster PCT tackled this issue by including equality and diversity in all management training and developing a peer support programme, which includes conflict resolution training.

When using formal processes, managers need to ensure that their actions are appropriate, as research in parts of the public sector indicates that BME staff are disproportionately involved in formal procedures.

The Institute for Employment Studies looked at why disproportionately high numbers of BME staff were the subject of disciplinary action in eight London boroughs. They found that the disciplinary procedures themselves were not discriminatory, but two patterns were identified, which led to higher numbers of BME staff being involved in formal procedures.

The first was that managers strove “at all costs” to avoid taking any action to manage the performance of BME staff and “bent over backwards” to be seen to be fair, in a bid to avoid being labelled “racist”.

Unfortunately, this resulted in BME staff not being given clear feedback about standards and expectations informally, and not early enough for them to change or improve their behaviour. This allowed matters to deteriorate to the point where managers had no option but to invoke the formal process.

The second was that managers tended to initiate formal disciplinary action immediately to “keep it all on record from the start”, on the grounds that informal approaches could be interpreted as harassment or bullying.

## Working towards resolution

- Generally, conflict is best resolved informally and as close to the point of origin as possible, to prevent escalation into a more serious dispute. Managers should not therefore automatically resort to formal procedures until attempts at informal resolution have proved unsuccessful.
- The exceptions are serious incidents, which merit prompt, formal action.
- A successful outcome in conflict resolution is less about apportioning blame and more about achieving a way forward that is acceptable to all sides.

- A starting point for dealing with conflict is to create a positive and safe working environment where everyone is treated fairly, irrespective of their level, status or position in the organisation.

#### This can be done by:

- Having clear, consistent and explicit standards of behaviour
- Clear policies on handling conflict and the use of internal/external processes for resolution
- Ensuring that staff are fully aware of their rights and duties
- Supporting staff to understand cultural differences and customs
- Documented informal processes
- Availability of sources of support, including union representation
- Open discussions with staff about what might be acceptable and unacceptable behaviours in the workplace
- Prompt action when complaints/concerns arise
- A policy of zero tolerance on violence and racism
- Well developed monitoring policies
- Confidentiality around the issues arising between parties, but transparency over the outcome.

Some of these issues may be perceived as difficult or “politically correct”, but they still need to be discussed. For example, flexible or alternative working arrangements can cause tension in teams. Rather than the manager taking a unilateral decision, it may be a good idea to discuss this with the team involved so that the decision can be based on what works for the organisation, the business and the individual.

#### Checklist

- Accept the fact that conflict is inevitable. Discuss any conflict openly with the team, although you will need to handle this carefully if there are issues of confidentiality involved as in a case of harassment.
- Deal with one issue at a time. There may be several issues involved in the conflict, but addressing them one by one will help make the problem more manageable.
- Timing is crucial. Deferring potentially difficult discussions can avoid conflict initially, but may also allow it to erupt further down the line. Tackling conflict too soon might mean that not all parties are ready for an honest discussion. Choose the right moment.
- Avoid emotive responses. Emotion will escalate the conflict rather than bring it closer to resolution.
- Avoid quick fixes. People need time to think about all possible solutions and their impact. Quick answers may not address the real underlying problem. All parties need to feel satisfied with the resolution if they are to accept it. Conflict resolution should not be rushed.

- Ensure decisions and outcomes are communicated clearly.

#### Useful resources and relevant legislation/policy

- *Resolving conflict in Organisations*. Ronnie Ritchie, Malcolm Leary. Limos & Crane, London 1998.
- *A new statutory code of practice on racial equality in employment*. Commission for Racial Equality April 2006.
- *National Survey of NHS Staff 2005*. Healthcare Commission March 2006
- Improving Working Lives Standard.
- ACAS [www.acas.org.uk](http://www.acas.org.uk)
- *The Problem of minority performance in organizations*. IES Report 375. The Institute for Employment Studies 2001.
- *A guide for overseas nurses working in the UK*. Unison August 2004.
- *Managing to work differently. Results from the RCN Employers Survey 2005*. Royal College of Nursing March 2006.
- Sex Discrimination Act 1975 (as amended).

## 7 Organisational development

### Relevance to race equality

Organisational development may be defined as “the planned intervention to bring about significant improvements in organisational effectiveness. Its goal is to enable organisations to enhance their effectiveness; to continually mature in response to changes in the external environment, to improve business performance through positive changes to people management, competence, communication, systems and structure.” (Office of the Deputy Prime Minister)

As NHS organisations adapt to change, and to meet the needs of an increasingly diverse population and workforce, any steps to improve the way they work must take account of diversity and be “culturally competent”.

There are several tools and models that can help you analyse the current state of the trust in terms of race equality and decide what further action needs to be taken to improve performance in this area.

### SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis

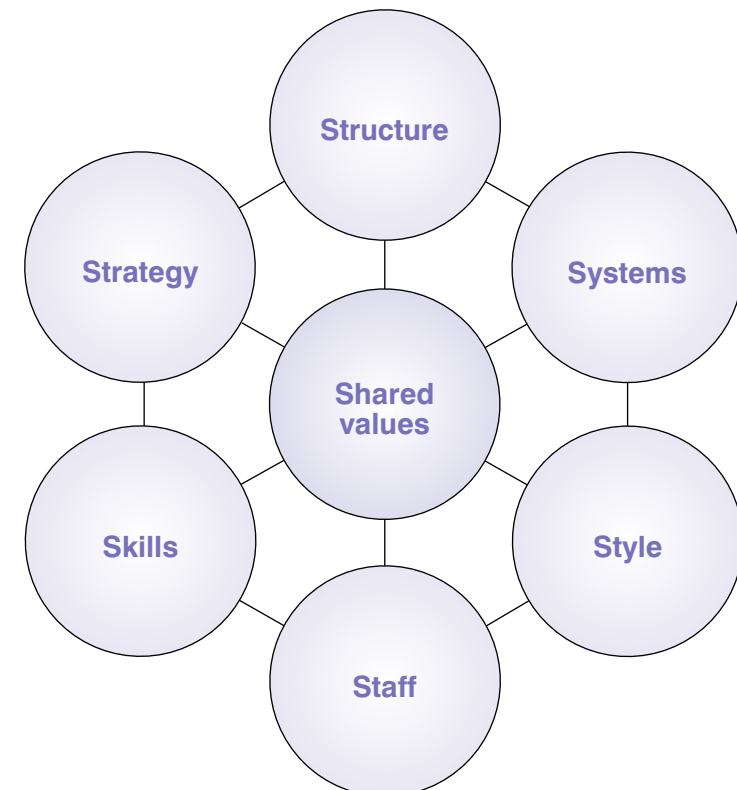
This is designed to assess and communicate the current position of an organisation. It provides a clear basis on which to build on strengths, minimise weaknesses, take opportunities and deal with threats.

- Analyse documents and interview staff to gather and summarise what information you have about current race equality in the trust.
- Organise the information in the format below.
- Note that many strengths can also be weaknesses when viewed from different perspectives. The same applies to opportunities and threats.
- Develop strategies based on that analysis.

Strengths	Weaknesses
Opportunities	Threats

### The 7-S model

The 7-S framework, which was developed by Peters and Waterman, describes seven key interdependent organisational factors, which need to be taken into account when considering organisational improvement. The framework forces you to think not only about the “hardware” of an organisation, such as strategy and structure, but also about its “software” - its style of management, systems and procedures. This model is useful for analysing internal issues in the organisation and its commitment and capability to deliver race equality.



## Checklist for 7-S

- Is race equality mainstreamed into the organisation's **S**trategy and business plan and its performance management processes?
- What **S**tructures are in place to ensure that race equality outcomes can be delivered in terms of people and resources? Where do the people responsible for race equality sit in the organisation?
- What monitoring and accountability **S**ystems are in place?
- Does the management **S**tyle of the organisation promote race equality?
- Are **S**taff committed? Do they understand what race equality means?
- Do people in the organisation have the **S**kills and competence to deliver race equality?
- Are the **S**hared values of the organisation clear that race equality is important? How are those values communicated?

## Race Equality Impact Assessments

The Race Relations Act 1976, as amended by the Race Relations (Amendment) Act 2000, makes it unlawful to discriminate against anyone on grounds of race, colour, nationality (including citizenship), or ethnic or national origin (See Section 2).

Under the requirements of the Act, public authorities have a duty to assess the impact on race equality of everything they do, using Race Equality Impact Assessments (REIAs). These anticipate and identify the discriminatory or negative consequences for a particular group on the grounds of race, of any proposed or existing policy, strategy and activity, including any gaps in policy or service provision.

An REIA involves the systematic analysis of any proposed or existing policy or strategy to identify what the impact will be of implementing it on different racial groups in the community. The process enables organisations to take counter measures, which eliminate, minimise or balance those discriminatory or negative consequences.

### To fulfill the general duty under the Act, public authorities need to:

- Identify which of their activities are relevant
- Prioritise activities based on their relevance to racial equality
- Assess how these activities and any related policies affect racial equality
- Consider how policies may need to be changed to meet the duty and make those changes.

The general duty aims to ensure that race equality is at the centre of policy making, service delivery, regulation, procurement and employment practice, with the intention of improving public services for everyone by eliminating discrimination and promoting race equality.

Decide who will be responsible for carrying out the REIA and who else will contribute to the process. Carry out a systematic checklist of issues that need to be addressed (See Section 9 of the Commissioning Guide).

## Checklist for REIA

- What are the aims of the policy or service?
- What needs or priorities is the policy designed to meet?
- What are the current priorities?
- What procedures are/will be involved in its implementation?
- Do/might they result in quantifiable or different quality outcomes for different groups?
- Could any aspects of the policy or service contribute to inequality?
- How does the policy/service meet the needs of the different racial groups in the community?
- Do different outcomes arise from unlawful discrimination, or failure to take into account the needs, experiences or priorities of different groups?
- Is there any evidence of higher or lower participation or uptake by different groups?
- Is there any evidence that different groups have different needs, experiences, issues and priorities in relation to the particular policy/service?
- What does data from existing sources tell us about the policy or service?
- What does consultation with stakeholders and patients tell us about the policy or service?
- What evidence is there that the policy or service may be having a differential impact across different groups in the community?
- What practical measures can be taken to reduce the adverse impact?
- Could altering the policy or working with stakeholders and others in the larger community better promote equality of opportunity or better community relations?
- What action needs to be taken as a result of the Race Equality Impact Assessment?

## The Positively Diverse Programme

This was developed to encourage equality and diversity in the NHS. The programme transferred to NHS employers in November 2004. The process takes up to a year, and is divided into six stages:

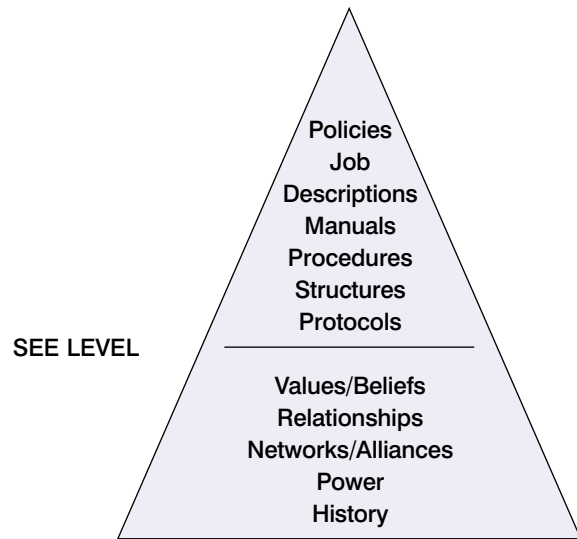
- Planning and preparation
- Mapping the organisation – finding out “where we are now”
- Creating a picture for where we would like to be
- Designing and prioritising actions to achieve our aims
- Implementing solutions
- Measuring progress and ensuring that momentum is maintained

## The Organisational Iceberg

This analyses an organisation’s visible and hidden cultures to ensure that values and systems are aligned.

The overt organisation is easily observed and can be gauged through “artefacts”, such as job titles and descriptions, published policies, planning and monitoring systems.

The covert organisation is much more difficult to observe, and is often described in intuitive or subjective terms. It covers issues such as emotions and feelings, quality of working relationships and power and influence patterns.



Organisations seem to have clear strategies on race equality embodied in their Race Equality Schemes. But when the “covert” aspects of how the organisation operates are uncovered it is clear that the real commitment to race equality is limited. An analysis of whether the overt and covert aspects of organisational behaviour align will help you to pinpoint the potential problem areas, and decide the best way forward.

### Checklist for Organisational Iceberg

- Are the organisation’s values aligned with policy statements and strategies?
- Are the people with power in the organisation really behind the need to promote race equality?

- Does the organisation have a history of making commitments to race equality but then not delivering on them?

## Burke Litwin Model

The “Burke-Litwin model” looks at organisational change and performance. It is based on the following:

- The external environment is the most powerful driver for organisational change.
- Changes in the external environment lead to significant changes in an organisation in terms of mission and strategy, organisational culture, and leadership.
- Changes in these key factors lead to other changes, in structure, systems, and management practices.
- Together these changes affect motivation, which in turn affects individual and organisational performance.
- The model describes 12 organisational variables (incorporating the 7 variables of the 7-S model) and the relationships between them. Each of the variables interacts and a change in any one of them can eventually affect the others.

Dimensions of Model	Key Questions
1. External environment	What are the key external drivers? How are these likely to impact on the organisation? Does the organisation recognise these?
2. Mission and Strategy	What do top management see as the organisation’s mission and strategy? Is there a clear vision and mission statement? What are employees’ perceptions of these?
3. Leadership	Who provides overall direction for the organisation? Who are the role models? What is the style of leadership? What are the perspectives of employees?
4. Organisational culture	What are the overt and covert rules, values, customs and principles that guide organisational behaviour?
5. Structure	How are functions and people arranged in specific areas and levels of responsibility? What are the key decision making, communications and control relationships?

6. Systems	What are the organisation's policies and procedures, including systems for reward and performance appraisal, management information, human resources and resource planning, etc?
7. Management practices	How do managers use staff and resources to carry out the organisation's strategy? What is their style of management?
8. Work climate	What are the collective impressions, expectations and feelings of staff? How do staff relate to each other?
9. Task and individual skills	What are the task requirements and individual skills/abilities/knowledge needed? How appropriate is the organisation's "job-person" match?
10. Individual needs and values	What do staff value in their work? What are the psychological factors that would enrich their jobs and increase job satisfaction?
11. Motivation	Do staff feel motivated to take the action necessary to achieve the organisation's strategy? Of factors 1-10, which have the greatest impact on motivation?
12. Individual organisational performance	What is the level of performance in terms of productivity, customer satisfaction, quality, etc? Which factors are critical for motivation and therefore performance?

### Useful resources and relevant legislation/policy

- *Transforming Your Authority, Creating Real and Lasting Change*. An organisational development resource document for local government. Office of the Deputy Prime Minister November 2005. [www.communities.gov.uk](http://www.communities.gov.uk)
- *In Search of Excellence. Lessons from America's best run corporations*. Tom Peters, Robert Waterman jr. Harper Collins 1995.
- *Positively Diverse*. NHS Employers, [www.nhsemployers.org](http://www.nhsemployers.org)

## 8 Measuring and monitoring progress

There are three different (but related) dimensions to monitoring:

1. How far can we show that we are recruiting fairly and providing equal opportunities for all?
2. How effective are we in recruiting a workforce with the right mix of skills and knowledge to provide services which meet the diverse needs of the population we serve?
3. How effective are we in using our organisation's economic leverage to promote equality and reduce health inequalities in the local community through commissioning and procurement?

And there are three questions for each of these dimensions:

- What are we trying to achieve?
- How do we measure it?
- How do we use the data to improve our practice?

### Equitable employment practice

A key outcome is a workforce which reflects the diversity of the community it serves at all levels, and in which all staff are treated equally and feel as if they are treated equally.

We therefore need to measure (i) where we are at any given time in relation to this objective; and (ii) whether the position is changing and, if so, how?

A good starting point is compliance with the Race Relations (Amendment) Act 2000. This requires organisations to regularly monitor all aspects of employment practice, including data on ethnicity, and to publish the results at least annually and include this as policy in their Race Equality Schemes.

The baseline information needed for this is the ethnicity for:

- Job applications
- Shortlisted candidates
- Appointments
- The proportions of different BME staff throughout the organisation
- Career development opportunities, including access to training, mentoring, coaching, secondment
- Grievances and disciplinary hearings
- Information from staff surveys and staff feedback, including reported experience of harassment and bullying and overall satisfaction levels.

## Checklist

- Do your senior management and board show a clear commitment to ethnic monitoring?
- Do you make it clear, and is it widely known, how monitoring is used and what has been, or is being done, to address workforce gaps and biases?
- Do you publish the results of your monitoring and publicly state what actions are being taken to address any shortcomings?
- Are staff consulted about how ethnic monitoring is undertaken? Are they told why it's needed?
- Have the business drivers for monitoring been identified? For example, employing the best people regardless of racial group, and spelling out the benefits to the community and existing employees of a representative workforce?
- Are you using the CRE recommended classification? Is everyone asked to state their ethnic group from an appropriate list of codes? Racial monitoring applies to everyone.
- Is monitoring viewed as important in your trust regardless of the ethnic make-up of your area? It is not the sole preserve of trusts serving large BME populations.
- Is the collection and reporting of data built in to your routines as standard? It is clearly more economical to collect information from staff, application forms, and other routes, such as management supervision and appraisal.
- Do you record religion and ethnic group separately? We cannot assume a correspondence between the two. For example, people with a South Asian ethnicity include Hindu, Sikh, Muslim, Jain, Buddhist and Christian faiths.
- Do you monitor where your job applicants are coming from? The catchment area of applicants may be much wider than your local community.
- What are the levels of turnover across the trust and are there particular patterns emerging in just one part of it? What are the associated costs? What is being done to reduce levels?
- How is information from staff surveys analysed and used?
- Is there an easily accessible monitoring database so that information can be used effectively?

## Benchmarking

The target is that the proportion of different BME groups should broadly reflect the make-up of the local community, so this raises the question of which community forms the benchmark.

The most appropriate benchmark is the ethnic breakdown of the local area. But this is not always the same as the catchment area from which employees are drawn, especially in urban areas, and for particular professions. An exact percentage point match between the representation of BME groups in the workforce and in the population is therefore not always achievable and is an unrealistic goal. But the overall level of match between the proportion

of different BME groups in the workforce as a whole and those applying from the local catchment area is an important measure.

Different benchmarks apply to different areas. The measure of truly equitable employment practice is whether there are any differences in the proportions of BME people between the different stages of the recruitment process.

The information won't provide solutions on its own, but it will highlight gaps and prompt more questions. Any differences between the proportions of BME staff for each of these measures and the relevant comparator suggests that further exploration of the underlying issues is required.

For example, if there is a significant difference between the numbers of shortlisted BME applicants and those being appointed, perhaps the interview process should be reviewed. This will include the composition of interview panels, the content of person specifications, and the systematic application of equitable selection processes.

If the analysis indicates a glass ceiling for BME nurses above a particular grade, or an under representation of BME staff taking up management training, for example, then this should prompt a further look at what the obstacles might be.

Timescales for changing workforce profiles need to be realistic and allied to workforce planning.

### “Soft” data

Our own experience and feedback from staff about their experiences will help us better understand the statistical data and provide useful pointers in the absence of “hard” data.

For example, there may be insufficient data on grievances and disciplinary hearings to show a clear pattern of disproportionate representation. But BME staff may nevertheless be reporting that they feel unfairly treated at an informal stage and there may well be one or two local cases where lack of resolution informally has escalated to a formal process.

## Interpreting and using the data

If service monitoring statistics or patient feedback point to issues around access and quality of healthcare, then we need to think about how effectively we are using person specifications to recruit the right mix of staff to do the job.

For example, is a higher incidence of diabetes among a BME group with particular language or cultural needs adequately catered for in the team?

Are these issues considered and reflected in the job design and specification?

### Effective economic leverage

The NHS has considerable economic muscle, which can be used to good effect to encourage contractors to employ a diverse workforce drawn from the local community. We should expect the same requirements of our contractors as we do of ourselves. (See Section 8 of the Commissioning Guide.)

And by using local businesses, directly employing a diverse workforce drawn from the local community, and by enabling disadvantaged groups to take up a career in the health service, the NHS can itself contribute to the health of the local economy.

This can be measured by:

- Stipulating equality and diversity in the contract conditions for commissioned services, and monitoring it.
- Postcode monitoring of where our staff live.
- Monitoring the number of initiatives which boost access to employment for local people, such as pre-employment training or careers advice.
- Monitoring the take-up of these initiatives and placements in work.

### Useful resources and relevant legislation/policy

- Guidance on Procurement at: [www.cre.gov.uk](http://www.cre.gov.uk)
- *A Practical Guide to Ethnic Monitoring in the NHS and Social Care*. Department of Health July 2005.
- Guide to Ethnic Monitoring at: [www.cre.gov.uk](http://www.cre.gov.uk)

## 9 A summary of relevant equality legislation

The following summary is taken from *Promoting Equality and Human Rights in the NHS: A guide for non-executive directors of NHS boards*, published by the Equality and Human Rights Directorate of the Department of Health in July 2005.

### The Gender Recognition Act 2004

The purpose of this Act is to provide transsexual people with legal recognition in their acquired gender. Legal recognition will follow from the issue of a full gender recognition certificate by a Gender Recognition Panel. In practical terms, legal recognition will have the effect that, for example, a male-to-female transsexual person will be legally recognised as a woman in English Law. On the issue of a full gender recognition certificate, the person will be entitled to a new birth certificate reflecting the acquired gender and will be able to marry someone of the opposite gender to his or her acquired gender.

### The Civil Partnership Act 2004

This Act creates a new legal relationship of civil partnership, which two people of the same sex can form by signing a registration document. It also provides same-sex couples who form a civil partnership with parity of treatment in a wide range of legal matters with those opposite-sex couples who enter into a civil marriage.

### Employment Equality (Religion or Belief) Regulations 2003

These regulations outlaw discrimination (direct discrimination, indirect discrimination, harassment and victimisation) in employment and vocational training on the grounds of religion or belief. The regulations apply to discrimination on grounds of religion, religious belief or similar philosophical belief.

### Employment Equality (Sexual Orientation) Regulations 2003

These regulations outlaw discrimination (direct discrimination, indirect discrimination, harassment and victimisation) in employment and vocational training on the grounds of sexual orientation. The regulations apply to discrimination on grounds of orientation towards persons of the same sex (lesbians and gay men) and the same and opposite sex (bisexuals).

## Sex Discrimination (Gender Reassignment) Regulations 1999

These regulations are a measure to prevent discrimination against transsexual people on the grounds of sex in pay and treatment in employment and vocational training. They effectively insert into the Sex Discrimination Act a provision to extend the Act, insofar as it refers to employment and vocational training, to include discrimination on gender reassignment grounds.

## The Human Rights Act 1998

The Human Rights Act came fully into force on 2 October 2000. It gives further effect in the UK to rights contained in the European Convention of Human Rights.

### The Act:

- Makes it unlawful for a public authority to breach Convention rights, unless an Act of Parliament meant it could not have acted differently;
- Means that cases can be dealt with in a UK court or tribunal; and
- Says that all UK legislation must be given a meaning that fits with the Convention rights, if that is possible.

## The Disability Discrimination Act 1995

This Act prohibits discrimination against disabled people in the areas of employment, the provision of goods, facilities, services and premises, and education; and provides for regulations to improve access to public transport to be made.

## The Race Relations Act 1976 (as amended by the Race Relations (Amendment) Act 2000)

The Race Relations Act (RRA) makes it unlawful to treat a person less favourably than another on racial grounds. These cover grounds of race, colour, nationality (including citizenship), and national or ethnic origin.

The Race Relations (Amendment) Act outlawed discrimination (direct and indirect) and victimisation in all public authority functions not previously covered by the RRA, with only limited exceptions. It also placed a general duty on specified public authorities to promote race equality and good race relations. There are also specific duties for listed organisations including the production of Race Equality Schemes.

## The Sex Discrimination Act (as amended) 1975

This Act (which applies to women and men of any age, including children) prohibits sex discrimination against individuals in the areas of employment, education, and in the provision of goods, facilities and services and in the disposal or management of premises.

## The Equal Pay Act (as amended) 1970

This Act gives an individual a right to the same contractual pay and benefits as a person of the opposite sex in the same employment, where the man and the woman are doing like work or work related as equivalent under an analytical job evaluation study; or work that is proved to be of equal value.

## Disability Discrimination Act 2005

This Act makes substantial amendments to the Disability Discrimination Act 1995. The 2005 Act places a general duty on public authorities to promote disability equality and to have due regard to eliminate unlawful discrimination. Those listed bodies within the public sector will also be subject to a specific duty of the 2005 Act. The specific duty provides a clear framework for meeting the general duty and includes the requirement to produce a Disability Equality Scheme. The Disability Equality Duty for the public sector took effect in December 2006.

## The Equality Act 2006

This legislation amended the Sex Discrimination Act 1975 to place a statutory duty on all public authorities, when carrying out their functions, to have due regard to the need to:

- Eliminate unlawful discrimination and harassment
- Promote equality of opportunity between women and men.

### It also:

- Created the Commission for Equality and Human Rights (CEHR) which will give individuals suffering from discrimination easier access to support, and provide employers and service providers with improved advice and information in a one-stop-shop;
- Makes unlawful discrimination on the grounds of religion or belief (which includes non-belief) in the provision of goods, facilities and services, education, the use and disposal of premises, and the exercise of public functions;
- Enables provision to be made for discrimination on the grounds of sexual orientation in

the provision of goods, facilities and services, education, the use and disposal of premises and the exercise of public functions.

## The Employment Equality (Age) Regulations 2006

These took effect in October 2006 and cover employment and vocational training. It is unlawful to discriminate against anyone on the basis of age, and to include certain specifications relating to age in job adverts.

The Act also specifies that:

- Direct and indirect discrimination by employers on the grounds of age is prohibited in the areas of recruitment, promotion and training
- The only compulsory retirement age will be 65
- Employees over 65 have the right to claim unfair dismissal and redundancy
- Employers are obliged to notify employees at least six months in advance of their retirement date
- Employers must consider a request by an employee to continue working after age 65.

## Definitions of discrimination

Direct discrimination is defined by the Race Relations Act 1976 as treating a person on racial grounds, less favourably than others are, or would be, treated in the same or similar circumstances.

**Indirect discrimination (colour or nationality) occurs when:**

- a. a person applies a requirement or condition
- b. which is such that the proportion of persons of the same racial group who can comply is considerably smaller than persons who are not of that racial group, and
- c. it cannot be shown that the condition is justified irrespective of the racial origins of the person concerned, and
- d. it is to the person's detriment that s/he cannot comply.

**This is further defined in the Race Relations (Amendment) Regulation 2003 as occurring when a person, A, applies to another person, B:**

- a. a provision, criterion or practice which person A applies to everyone; and
- b. the provision, criterion or practice puts (or would put) people from person B's race or ethnic or national origin at a particular disadvantage; and
- c. the provision, criterion or practice puts person B at a disadvantage; and
- d. person A cannot show that the provision, criterion or practice is a proportionate means of achieving a legitimate aim.

## Single Equality Scheme

Single Equality Schemes should be a core part of all plans and activities in an NHS organisation, and published on its website, either separately or as part of another document, such as a business plan. Individual elements of the separate duties should be clearly identifiable.

Each organisation will need to pursue an approach that best fits with its organisational culture and its current level of compliance with equalities legislation.

The Department of Health has developed guidance to help NHS organisations comply with current race, disability, and gender public sector duties, and future duties in respect of age, religion and belief and sexual orientation.

The guidance sets out 10 steps focusing on:

- Responsibility and accountability
- Information gathering
- Identification of differences and common activities
- Data intelligence and analysis
- Involvement and consultation
- Equality Impact Assessments
- Action plans
- Disseminating information
- Monitoring and review
- Single Equality Scheme

Further information can be obtained from:

<http://www.dh.gov.uk/PolicyAndGuidance/EqualityAndHumanRights/fs/en>

## Useful websites

Commission for Racial Equality [www.cre.gov.uk](http://www.cre.gov.uk)

The Disability Rights Commission [www.drc.org.uk](http://www.drc.org.uk)

Equal Opportunities Commission [www.eoc.org.uk](http://www.eoc.org.uk)

Department for Work and Pensions [www.dwp.gov.uk](http://www.dwp.gov.uk)

Communities and Local Government [www.communities.gov.uk](http://www.communities.gov.uk)

ACAS [www.acas.org.uk](http://www.acas.org.uk)

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