OUR NHS OUR CONCERN – WRITTEN EVIDENCE PSR0035

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Our NHS Our Concern

Think Tank Paper: ***NHS Board Accountability – a time for change.***

This Paper has been drafted by a '**Our NHS Our Concern'** working group. We are also grateful to several NHS Non-executives for peer reviewing the paper. The views are of course the responsibility of **Our NHS Our Concern working** in association with the British Association of Physicians of Indian origin (BAPIO).

Background

The NHS has been under pressure in recent years to be able to manage increasing demand on a background of fiscal constraints and workforce pressures. The COVID-19 pandemic has increased the strain on the system and whilst this has been challenging, it has also provided opportunities to improve the governance of the system with a greater focus on accountability. Though it is evident that the response has been 'heroic', it has also exposed other aspects of the health and care system such as inequalities in outcome, especially for those from lower socio-demographic backgrounds and BAME groups. There is also increasing recognition of the need to value and support staff.

NHS boards are responsible for the design, delivery and performance of healthcare and health care settings for their local population. NHS Boards must ensure they fulfil this duty within the hospital and on discharge to a place of safety whilst expecting their staff to act in accordance with the relevant standard of care. Employer expectations may at times conflict with the professional duty of care, for example through excessive or unsafe workloads, tasks for which staff are not trained or competent and being expected to work in an unsafe environment. Staff must balance these pressures with their duty of care while preventing any 'poorer' practices becoming the new norm.

The Health and Social Care Act 2012 introduced the first legal duties ascertaining to health inequalities for England. It includes specific duties for all relevant health bodies including the requirement to have due regard to reducing health inequalities. Of note, the CQC in England has a statutory duty of candour. Organisations may run the risk of criminal sanctions (fines and/or possible de-registration) if they fail to comply with the requirement to be open and honest when issues of concern are raised. Across all four UK countries there are specific legal duties pertaining to health Inequalities. The World Health Organisation (WHO) defines health inequalities as "differences in health status or in the distribution of health determinants between different population groups".

The basis of UK health and safety law is the Health and Safety at Work Act 1974. The Act (the regulations and approved codes of practice) places a duty on employers to ensure the safety, health and welfare at work of their employees and to ensure their activities do not endanger others. The Management of Health and Safety at Work Regulations of 1999 establish what employers are required to do to manage health and safety under the Act. The main employer requirement is to carry out risk assessments, i.e. a careful examination of what, in a workplace, could cause harm to people, so that measures can be identified that eliminate or significantly reduce risk of harm.

This group believe there is a need to further improve the accountability of the boards to their staff and local population and to inform government policy with an emphasis on moving from rhetoric, or merely describing the challenges, to action and improvements. This should be accompanied by healthcare systems regulation and accountability, adopting a robust approach to ensuring compliance and improvement with the relevant legislative acts and standards. One aspect of this is organisational transparency. Whether the information is positive, negative or neutral, organisational transparency means sharing and keeping employees in the loop, because they care about the state and success of the organisation as much as the Board. The more the staff, patients and local population know, the more they feel part of the system. Transparency also implies visibility into the functions of the organisation for its stakeholders. This is best achieved through institutionalising transparency in an organisation's policies, articulates and practices through well-defined processes.

Whistleblowers from the health sector outweigh those from all other sectors at employment tribunals and were the largest group giving evidence to the 'All Party Parliamentary Group for Whistleblowing'. A common issue was the absence of transparency in the investigation of concerns, with perceived lack of accountability for those investigating concerns. Over 50% of whistleblowers contacting WhistleblowersUK are from BAME groups, and during the COVID-19 pandemic this has risen to 70%.

Improving wellbeing prospects for all staff and service users, including career development for staff, through a focus on BAME as a mechanism to improve equality and diversity for all.

In relation to the specific challenges of the BAME workforce, the GMC Fair to Refer report (2019) provides guidance based on the study of the patterns of disproportionate referral to the GMC of non-white Caucasian doctors. The paper describes challenges for BAME doctors and is an example of the need to improve equality, diversity and inclusivity at all levels across the NHS including the delivery of care equitably to the population. This GMC report made four recommendations; three are generalisable and the first is a

specific issue which applies to a proportion of BAME doctors working in the NHS:

1. Providing comprehensive support for doctors new to the UK or the NHS or whose role is likely to isolate them (including SAS doctors and locums);

2. Ensuring engaged and positive leadership more consistently across the NHS;

3. Creating working environments that focus on learning and accountability rather than blame;

4. Developing a programme of work to deliver, measure and evaluate the delivery of these recommendations

Our NHS Our Concern wishes to work in partnership with NHS Boards throughout the UK to support improved accountability, exploring aspects of diversity throughout organisations from the Board to frontline staff and reflecting the needs of the local population. It is proposed to work directly with NHS boards with an emphasis on the roles of the Chairs, Executives, Non-Executives and Clinical leaders. The goal being to improve organisational accountability building on the recognised concerns within the BAME community while informing other associated areas of NHS board working.

The focus will be on Board function and the roles of the board team (Executive and Non-Executive), recognising; the need to influence upwards to Government and Policy Makers; the potential tension between autonomy and accountability; the importance of a two-way engagement between board, staff, key partners and local populations to address their needs.

Why is this important now?

The COVID-19 pandemic has highlighted inequalities in the NHS in access to healthcare, PPE and patient related outcomes. The government-commissioned Public Health England (PHE) report 'Disparities in the risk and outcomes of COVID-19 (2020)' described the risk as "disproportionate" for those with Asian, Caribbean and black ethnicities - for example people of Bangladeshi background in England are twice as likely as white Britons to die if they contract Covid-19 and other BAME groups face an increased risk of up to 50%.

Boards are accountable for the safety of staff, contractors, visitors and patients. Various reports suggest we now need a more proactive approach to risk assessment and management. Boards will need to have shown they have acted reasonably and in the light of evidence. Improvements and mistakes will have occurred during the 2020 COVID-19 pandemic. Lessons will be required to be learnt and communicated transparently and Boards must be at the forefront of this work and will not be excused if they have not taken on board lessons from this experience. This paper and the proposed

offer of support from BAPIO, including a deep dive guide, offer a mechanism for both NHS Institutions and to regulators to gain assurance that all is working well.

The broader challenges for NHS Boards

Our NHS Our Concern recognises the broader challenges for NHS Boards which include;

- The significant pressure on NHS Boards to meet 'demands' of central government, which can result in excessive pressure to 'feed the machine' rather than have a problem-based approach to management and 'evidence-based solutions'
- Financial constraints
- Shortage of health and care workforce
- Lack of equality and diversity in board structures, processes and the need for improvement and acknowledgement that institutional racism is a problem
- The need for effective approaches to actively engage staff in change programmes and to listen and respond to staff concerns including not marginalising some individuals who voice concerns. **'Just doing my Job'** is a common refrain from those who whistle blow.
- The need to improve the use of data, to use it effectively and the 'sin of omission' that permits inaction or ineffective action

Board constitution and succession planning should reflect the BAME make up of their catchment area and staff complement. Boards must have effective recording and risk assessment systems in place with appropriate behaviours to match. This would include challenging and pursuing why some groups of patients or staff are disproportionally affected by illness, complaints, grievances, disciplinaries, whistleblowing, career opportunities, pay inequalities and dismissals.

Solution based approach

This paper attempts to adopt a solution-based approach using an equality, diversity and inclusivity lens underpinned by the accepted challenges that relate to the BAME population and staff as an exemplar for high quality board governance. Solutions will involve work on board structures, behaviours and processes which increase the transparency of decision making at all levels. This will require to be informed by data to drive and monitor change for the benefit of patients and staff and to improve accountability.

Our NHS Our Concern Offer

- **Our NHS Our Concern** recommend and will support the establishment of an **independent training programme** for current and future Board Members. This should have an international training faculty to deliver, be a CPD certified programme and include mentoring and advice
- Offer an **Our NHS Our Concern** toolkit of key question/challenges in relation to BAME; with exemplar 'good' and 'poor' answers (appendix 1) working with Governance Benchmarking
- Offer **independent support** for individuals with concerns including signposting to relevant support
- Offer a **whistleblowing capability assessment tool** working with WhistleblowersUK
- Offer **Deep Dive expertise/training** in areas of interest to Board, including BAME (partner with Governance Benchmarking)
- Promote improved accountability and transparency through the roles of a **Board Secretary and Senior Board member**
- Offer **guest speakers and facilitators** for Board Development 'away days' to promote the benefits for diversity and inclusivity in Board decision making, based on better decisions as a result of recognising and including diversity of opinion

Working group

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Acknowledgements

We would like to acknowledge Whistleblowers UK and Governance Benchmarking for contributing to the development of this document and supporting the use of assessment tools.

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Views of the chairs of Scottish health boards on engagement with quality management and comparisons with English trusts. Bream E, Jha AK, Epstein AM, Black N. *J R Coll Physicians Edinb*. 2013;43(3):215-221

Appendices:

Appendix 1

Proposed BAPIO toolkit for discussion at Board level with a focus on BAME.

	Key Questions	Poor answers	Better Answers
1.	Does the board and executive team reflect the composition of local population/staff demographic	Unfortunately, we can only recruit from those who apply, and candidates tend to be White males	We recognize the need to better reflect our stakeholders and have actively sought to recruit from BAME and other underrepresented groups. We have had some success but are looking at offering associate roles.
2.	Do we collect and analyse staff numbers with BAME background in relation to overall staff demographic		
	a. Permanent	Yes. Data is collected but not made available to Board on regular basis unless called for.	Yes. Data is collected and made available to Board on a regular basis. Our HR /staff committee has analysed the data and made recommendations for improvement
	b. Temporary	No	
	c. Locum	No	
3.	Do we analyse BAME staff comparators in relation to overall demographic		
	a. salary,	Yes. Data is collected but not made available to Board on regular basis unless called for.	Yes. Data is collected and made available to Board on a regular basis. Our HR /staff committee has analysed the data and made recommendations for improvement
	b. seniority,	No	
	c. complaints including whistleblowing	Only if information is volunteered by complainant	

d. sickness levels.	Yes. Data is collected but not made available to Board on regular basis unless called for	
4. What plans do we have in place to improve BAME staff opportunities and safety?	We are an equal opportunities employer and candidates are judge on merit. Our safety procedures have won awards for compliance with national standards	We have started a campaign to actively recruit BAME groups to senior positions, put succession planning in place for all staff and in future will actively screen staff with higher risk profiles from hazardous duty.
5. Have we conducted a deep dive or internal audit review to verify these details and progress against any action plans and risk registers	No, reporting is adequate and proportionate	Yes; first review highlighted some gaps in data collection, which we have rectified. Future study should highlight areas for action
6. How have BAME staff and their families faired with COVID infections/shielding/ recovery/deaths	We do not collect that information systematically	We recognize that BAME groups have suffered disproportionally and have created an action plan to make improvements for the future. Progress will be provided against the planned trajectories to equalize numbers for infections/shielding/ recovery/deaths

Appendix 2

Case studies

a) SAAD BAME risk assessment scorecard 2020

A group of General Practitioners have created a Covid-19 risk assessment scoring system for general practice to help identify and redeploy the most vulnerable staff. https://abmacademy.com/saad-risk-scoring-for-bame/ for a copy of the template.

b) NHS England Deep Dive BME Staff Survey 2017

This identified many examples of inequality and argued that the victim is often made to feel they are the problem

The report made recommendations on Zero Tolerance for Bullying, Training, Mediation and complaint resolution, creating a safe space to speak up, move from blame to support and move to values-based recruitment.

https://minhalexander.files.wordpress.com/2018/04/nhs-england-deep-dive-bme-staff-survey-report-v-8-disclosed-18-april-2018.pdf

c) HQIP 2020

National Confidential Inquiry into Suicide and Safety in Mental Health – Suicide by female nurses report

The National Suicide Prevention Strategy (NSPS) for England identified female nurses as an occupational group at increased risk of suicide. A report by the Office for National Statistics (ONS) in 2017 identified female nurses as having a risk of suicide 23% above the risk in women in other occupations. 6% of female nurses committing suicide came from a black & minority ethnic group; the figure for female: other occupations were 8%

d) The Ubele Initiative April 2020

Impact of COVID-19 on the BAME Community and voluntary sector.
Report of the surveys conducted between 19 March and 4 April 2020

This report provides the results of surveys conducted between 19 – 23 March (Wave 1) and between 27 March-4 April (Wave 2). From the two phases, 182 responses from organisations and individuals were received, which represented 165 different organisations. The surveys focused particularly on the impact of COVID-19 on the BAME organisations delivering services to the BAME communities.

The report illustrates the impact on small organisations with few reserves to survive the pandemic. Recommendations included support packages, partnerships and the establishment of a transformational sector wide

'National BAME Infrastructure' arrangement to provide the coordination, support and development of the sector.

https://static1.squarespace.com/static/58f9e59244024341205131 4a/t/5eaab6e972a49d5a320cf3af/1588246258540/REPORT+Impact+of+COVID-19+on+the+BAME+Community+and+voluntary+sector%2C+30+April+2020.pdf

e) MBRRACE

MBRRACE-UK (2018) published their report on women who died in childbirth in the UK and Ireland between 2014 and 2016

A main finding was that women from BAME communities were more likely than white women to die during birth or within the first year of their baby's life. Black women were almost 5x more likely to die from pregnancy and childbirth related causes, and Asian women were nearly twice as likely compared with white women.

MBRRACE-UK is national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry in Maternal Deaths (CEMD).

https://www.aims.org.uk/journal/item/mbrrace-bame

Chairs and non-executives in the NHS: The need for diverse leadership

f) NHS Confederation 2019

There has been a reduction in the percentage of chairs and non-executives from a BAME background, despite today 19 per cent of the NHS workforce being BME. The percentages from BAME backgrounds in these roles peaked at 15% (for all chair and non-executive roles) in 2010. Today, only 8% (all chair and non-executive roles) and 6% of chairs are from a BME background. Workforce Race Equality Standard (WRES) data shows that in almost half of all NHS trusts (including foundation trusts) there are no BME board members.

https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Chairs-and-non-executives-in-the-NHS.pdf

The Nuffield Trust 2020

Investigated the proportion of people with black ethnicity across different NHS professions and compared this with the proportion of black people in senior grades within these groups. One might expect the proportion of black people at senior levels in each group to match the overall proportion of people of a black background in that same group. However, the proportion of

those in senior pay grades is lower than the overall proportion, with midwifery the one exception. The difference is particularly stark for nurses, doctors.

The overall proportion of people of black ethnicity is very low for ambulance staff and ambulance support staff (0.6% and 2.2% respectively). Given the evidence of high levels of discrimination in the ambulance service, this may in part explain the low representation of black people in this profession.

While midwives of black background have comparatively high levels of representation there are other issues involving discrimination against BAME midwifery staff. For example, midwives from ethnic minority backgrounds in London are disproportionately more likely to face disciplinary proceedings and dismissal than their white counterparts.

https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-black-nhs-staff-are-underrepresented-in-senior-management-roles?utm_source=Nuffield+Trust+weekly+newsletter&utm_campaign=e8a612067a-EMAIL_CAMPAIGN_2020_03_19_04_06_COPY_01&utm_medium=email&utm_term=0_39741ccd5c-e8a612067a-92250891