Wales Centre for Public Policy
Canolfan Polisi Cyhoeddus Cymru

Policy Briefing
March 2021

Improving Race Equality in Health and Social Care

Background

The Welsh Government has made a commitment to publish a Race Equality Action Plan designed to tackle structural racial and ethnic inequalities in Wales (Welsh Government, 2020a). This policy briefing summarises one of six reports produced by the Wales Centre for Public Policy to provide independent evidence to inform the Action Plan's development. It focuses on evidence and recommendations for action related to race equality in health and social care.

Introduction

In Wales, there are persistent racial inequalities in health and access to health and social care, and in levels of loneliness, among other social and economic disparities (EHRC, 2018).

The Coronavirus pandemic has increased the urgency of actions to eliminate racial disparities in Wales and highlighted the importance of health and social care as key policy areas through which inequalities can be addressed. For example, in Wales the Coronavirus mortality rate (2nd March to 15th May 2020) was two times higher for Black men compared to White men, and nearly one and a half times higher among Black women compared to White women, even after accounting for differences in population density, household and socio-economic factors (ONS, 2020).

This policy briefing identifies actions to tackle racial inequality in health and social care which feature strongly in academic studies and policy reports. The first section focuses on ways to improve the experiences and outcomes of health and social care staff, whilst the second focuses on racial and ethnic minority service users.

Health and social care staff

The health and social care sectors tend to be more racially and ethnically diverse than the Welsh population as a whole (Welsh Government, 2020b). Racial and ethnic minority health and social care staff are over-represented in lower paid and lower status health and social care jobs in the UK (Autonomy, 2020; GOV.UK, 2020).

> **Racial and ethnic minority people in Wales experience disparities in mental health and wellbeing and access to mental health care, particularly among refugees and asylum seekers.**

Evidence specifically in health and social care contexts about what works to improve workforce diversity is limited, but key strategies that have been identified are detailed below. At their forefront needs to be a commitment to unpicking structures, policies and procedures (both formal and informal) which maintain the status quo (e.g. practices around access to promotion opportunities and migration-related policies).

Debiasing recruitment, development and secondment opportunities

While data are not available from Wales, evidence from stakeholder engagement (Ogbonna, 2020) and data from NHS trusts in England over the past five years illustrate that White healthcare staff are more likely to be appointed from shortlists to all posts and are more likely to access non-mandatory training and professional development than racial and ethnic minority applicants (WRES Implementation Team, 2020). Debiasing recruitment, development and progression opportunities is therefore key to reducing workforce racial and ethnic inequalities.

Recommendations

- Utilise a combination of recruitment and progression practices (such as anonymised job applications, (reverse) mentoring, role modelling, succession planning, and leadership programmes) at individual, workplace and institutional levels and ensure they are sustained and visibly supported by management.
- Publish locally meaningful targets for representation and sector-specific targets for progression for racial and ethnic minorities which are underpinned by sustained positive action, and for which leaders are held to account.
- Provide specific support and guidance for health and social care employers to implement positive action and to collect data to support targeted action.
- Consider making funding dependent on particular initiatives or practices, such as the implementation of the Race Equality Charter.
- Take a systems approach and intersectional perspective to avoid unintentionally creating new, or exacerbating existing, inequalities.

Promoting inclusive, psychologically and physically safe workplaces

Debiasing recruitment and progression practices and implementing targets will have only limited effect if the workplace environment remains hostile to racial and ethnic minority staff (Kline, 2020). Ensuring psychological safety means fostering a work climate which instils in all staff a sense that they are able to, and should, speak up about issues at work, to question decisions, raise concerns and any mistakes they make (Edmondson and Lei, 2014).

Tackling staff discrimination is essential to the health and social care sectors because it is associated with poorer psychological health and well-being, lower job satisfaction and increased intention to leave (Rhead et al. 2020) – in short, an environment free of all forms of discrimination is essential for staff psychological safety.

Recommendations

- Scrutinise and transform existing approaches to diversity training, mindful of and actively pre-empting unintended effects, such as the risk of focusing on individual behaviours rather than systemic issues.
- Actively involve racial and ethnic minority staff in training development but ensure it is mandatory for all staff at all levels. Training should be on-going and incorporate experiential, perspective-taking, and reflective approaches with a priority focus on action and behaviour change. Importantly, it should have an explicitly anti-racist lens, incorporating a focus on acknowledging the role of – and challenging – whiteness as the institutional norm, white privilege, and white fragility.
- Combine training with a broader institutional and workplace commitment to psychological safety and inclusivity, with a

clear focus on covert, everyday microaggressions; encourage allyship and bystander intervention which is visibly supported by senior leadership.

- Outline expectations for and support all staff at all levels to have open discussions about race and racism in the workplace and beyond.
- Create specific forums (e.g. Schwartz rounds, staff networks, Freedom to Speak Up Guardians) for staff to share experiences, raise concerns, and have their opinions heard with clear and transparent channels of communication and accountability to middle and senior management.
- Enhance access to culturally sensitive psychological interventions for staff, such as counselling and bereavement support, alongside broader health, and wellbeing support.
- Actively unpick and de-bias disciplinary procedures as part of a more collaborative and person-centred approach to human resources processes.
- Provide sufficient and adequately fitting Personal Protective Equipment (PPE) tailored to fit diverse racial and ethnic minority communities.
- Support research and evaluation (including collection of appropriate data) to identify what works in what contexts to change behaviour in a sustained way.
- Promote risk assessments that specifically and sufficiently consider the physical and mental health of all Black, Asian and minority ethnic staff.

Terminology

- **Anti-racist** approaches move beyond reducing bias and increasing cultural competence to explicitly encompass action taken to resist and tackle racism.
- **White privilege** refers to the systemic and systematic advantage associated with being White, or the systematic disadvantages afforded to other racial groups which is embedded within some societies.
- **White fragility** refers to when discomfort is experienced by White people when confronted with racialised challenges which leads to them minimising, ignoring, defending against, or withdrawing from engaging with racial issues in a way that preserves the status quo or seeks to protect from discomfort.
- **Allyship** describes a process in which a person of privilege works in solidarity and partnership with the members of a marginalised or oppressed group to which one does not belong.

Overarching principles

Overarching principles to ensure the creation of a workplace climate which is open to and welcomes racial and ethnic diversity include:

- Senior leadership commitment and resource allocation;
- Incorporation of multiple, multi-level and sustained diversity strategies; and
- The collection, publication and monitoring of workforce race and ethnicity data, building in mandated and/or incentivised collection of data.

Case study: WRES

The Workforce Race Equality Standard (WRES) was mandated in England in 2015. It requires NHS organisations to demonstrate progress against nine indicators of workforce race equality, e.g. in relation to access to training opportunities, disproportionality of disciplinary actions, and prevalence of racial discrimination, bullying and harassment. The WRES also supports improvement action planning to

address the underlying causes of discrimination. Using a data collection framework such as the WRES is one way to monitor under-representation of racial and ethnic minority staff and to develop targeted quality improvement methods to address this (Naqvi et al., 2018).

It is important that any such standard be adapted to the Welsh context and considers the distribution of racial and ethnic minority staff across Wales.

Recommendations

- Visible, sustained, senior management support which includes clear lines of social accountability and adequately resources initiatives to reduce racial disparities is essential.
- Leaders need to implement multiple, multi-level approaches that target institutions and not just individuals. These approaches need to actively unpick underlying structures which maintain and perpetuate inequality and focus on action. They would usefully be informed by systems-thinking[1] that considers wider influences on desired change and to identify and pre-empt any unintended consequences.
- Collection of locally relevant and contextually meaningful workforce data, which is informed by active engagement with racial and ethnic minority staff in Wales.
- This includes collection of data on workforce, career progression, job satisfaction, experiences of discrimination and disciplinary proceedings (e.g. the indicators collected by the WRES) which is disaggregated appropriately by ethnicity (e.g. including Black Welsh and Asian Welsh categories); and by other key social statuses (in particular gender and migration status).

Racial and ethnic minority service users

Non-discriminatory and culturally sensitive mental health provision

Racial and ethnic minority people in Wales experience disparities in mental health and wellbeing (e.g. greater levels of loneliness) and access to mental health care, particularly among refugees and asylum seekers (EHRC, 2018). Based on Hatch et al.'s (2020) research, prior engagement work and review of the literature, three examples of approaches which specifically aim to meet the needs of racial and ethnic minority communities in mental health services are put forward:

- Organisational competency frameworks;
- Culturally competent mental healthcare; and
- Explicitly anti-racist mental healthcare delivered by all staff from all racial and ethnic backgrounds.

Recommendations

- Engage racial and ethnic minority service users and their carers in the design and development of a Wales-specific organisational competency framework. This should include a set of local and national competencies to enable mental health providers to understand and meet the needs of their local populations and reduce racial disparities in care and outcomes for service users and their carers.

  Support and extend accreditation schemes such as Diverse Cymru's 'BME Mental Health Workplace Good Practice

[1] Systems approaches encourage taking a look at the 'bigger picture', e.g. by focusing 'on how different agents - people, services, organisations, or whatever - interconnect and influence each other' (NIHR, 2019, p.6).

Certification Scheme', which engages with practitioners so that they are able to deliver culturally competent services.

- Support culturally competent models of care provision on the basis of engagement with service users and carers, evaluation and ongoing quality improvement.
- Incorporate explicitly anti-racist approaches to service delivery into training curricula and professional development of all staff at all levels within mental health services.
- Create structures to support research, evaluation and quality improvement to assess and enhance the impact of provision on racial and ethnic minority service users and their carers. Engage with service users and carers to inform how and which data are collected.

Data collection, monitoring and reporting

Improvements to data collection on race and ethnicity are essential to understand and reduce racial and ethnic inequalities experienced by service users in health, mental health, and social care (Ogbonna, 2020). Improved data collection is also essential to disaggregating information within and between racial and ethnic groups to better reflect the diversity of experience and needs.

Missing and incomplete ethnicity data can lead to inaccurate interpretations; and prevents the evaluation and monitoring of initiatives which disproportionately affect, or which are targeted at racial and ethnic minority groups. In addition, under-representation of Black, Asian and minority ethnic participants in research, as well as a lack of specific evaluation evidence focusing on the impact of diversity initiatives on racial and ethnic minority service users, further limits the capacity of policy and practice improvements (Hui et al., 2020).

To avoid replicating existing structural inequalities, it is important to ensure that data are transparent and accessible (Butt, 2006).

Recommendations

- Building in mandated and/or incentivised collection of standardised data on ethnicity to reduce missing and incomplete data (Butt et al., 1994). At minimum, standardise ethnicity data recording using the census categories to allow comparison across datasets. Where possible, use finer-grain, more disaggregated categories relevant to local circumstances (Toleikyte and Salway, 2018) and collect data at both national and local levels to reflect the diversity of health and social care experience and needs among racial and ethnic minority groups.
- Incorporate mandatory data collection to support intersectional analysis and research. This includes data on migration status (whether or not UK born and length of stay), sexual orientation and religion/belief alongside data on race and ethnicity in health and social care datasets to better understand patterns of health and social outcomes (Byrne, 2020; Moriarty, 2020 [personal communication]).
- For key indicators, use over-sampling to increase the numbers of racial and ethnic minority groups represented in research, national population datasets and evaluation, with inclusion of data on migration status (Berthoud et al., 2009; Lynn et al., 2018).
- Engage with racial and ethnic minority groups locally to improve the relevance, appropriateness and acceptability of questions asked and data collected.
- Improve data sharing and data linkages across partner organisations, including between health and social care, with local

authorities and with voluntary and community sector organisations supporting racial and ethnic minority communities (Toleikyte and Salway, 2018).

- Collect data on local service outcomes, their effectiveness, quality, safety, and service user/carer satisfaction by ethnicity. This includes publicly accessible yearly audits of local mental health services focusing on service experience and outcomes by ethnicity (Joint Commissioning Panel for Mental Health, 2014).
- Record ethnicity at death registration to improve data on racial and ethnic inequalities in life expectancy and mortality (Public Health England, 2017; 2020; Ogbonna, 2020).[2]
- Create a national dataset for the work of approved mental health professionals who carry out a number of functions under the Mental Health Act (MHA) to inform planning and improvement, to understand and better support those disproportionately affected by the MHA (MHA Review Team, 2018).
- Develop a national baseline of use of the MHA in Wales in line with recommendations set out for NHS England in the Mental Health Act Review (MHA Review Team, 2018).
- Publish timely policing data on use of detention powers under the MHA broken down by ethnicity (MHA Review Team, 2018).

Equitable public health approaches

The Coronavirus pandemic has highlighted the essential and urgent need for disease prevention and health promotion campaigns that more effectively reach racial and ethnic minority groups (Baggaley et al., 2020; Public Health England, 2020; Ogbonna, 2020; Public Health Wales, 2020; Saltus, 2020).

Evidence suggests effective strategies include adapting messages to specific audiences. This includes translation as well as utilising culturally relevant channels of communication e.g. involving faith and community leaders (Netto et al., 2010; Toleikyte and Salway, 2018).

Recommendations

- Engage racial and ethnic minority community members and representatives from voluntary, community and social enterprise sectors, faith organisations, and other stakeholders in designing and implementing communications and prevention strategies which are relevant to the local population.
- Based on this engagement work, identify and tailor appropriate multiple channels of communication to local communities, while also acknowledging and addressing any community concerns about specific strategies.
- Adequately resource Black, Asian and minority ethnic community organisations to enable them to be involved in engagement work and to take an active role in public health promotion and messaging.
- Address barriers to digital inclusion which disproportionately affect racial and ethnic minorities including resource-based, motivational, and skills-based barriers.

[2] The recording of births and deaths is a reserved to the UK Government. This recommendation has been called for by the Deputy Minister and Chief Whip Jane Hutt MS many times. Consideration of different ways to effectively collect and use ethnicity data has begun and the Home Office has confirmed that the Welsh Government will be engaged in this work. See: **https://gov.wales/covid-19-bame-socio-economic-subgroup-report-welsh-government-response-html**

Conclusion

This briefing considers the evidence for what works to reduce racial disparities experienced by health and social care staff, mental health, and social care service users, and increasing the reach of public health campaigns. Underpinning all the recommendations is the need to **systematically unpick the policies, processes, procedures, norms and attitudes operating within and across institutions that systematically disadvantage people from Black, Asian and minority ethnic backgrounds**. This is essential for building trust and to avoid returning to the status quo.

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Find out more

For the full report see Hatch, S., Woodhead, C., Moriarty, J., Rhead, R., and Connor, L. (2020). **Improving Race Equality in Health and Social Care**. Cardiff: Wales Centre for Public Policy.

About the Wales Centre for Public Policy

Here at the Centre, we collaborate with leading policy experts to provide ministers, the civil service and Welsh public services with high quality evidence and independent advice that helps them to improve policy decisions and outcomes.

Funded by the Economic and Social Research Council and Welsh Government, the Centre is based at Cardiff University and a member of the UK's What Works Network.

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