



Research report November 2021

# Attracting, supporting and retaining a diverse NHS workforce

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Commissioned and supported by



nuffieldtrust

## Acknowledgements

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As a health policy think tank, we seek to understand and play our own part in tackling racism, sexism, ableism and other forms of discrimination by seeking out and promoting the evidence around inequality and health care, listening to and learning about the experiences of those affected by discrimination and structural inequalities, and taking responsibility as both an employer and a policy research organisation to address them.

# Key facts

More than **1 in 8** NHS staff (13%) reported experiencing **discrimination** at work in 2020

The proportion of NHS staff experiencing discrimination at work from their colleagues varies, from 7% among administration and ancillary staff to **11%** among **ambulance staff**

Comparing between NHS trusts, **higher satisfaction with inpatient care** is statistically significantly associated with more staff reporting equal opportunities for progression and with fewer staff experiencing discrimination<sup>1</sup>

Men account for 12% of the nursing and health visitor workforce but **62%** of **medical consultants**

Male nurses with nine years' continuous service are **twice** as likely to have **progressed** up two pay bands (41%) than female nurses (20%)

While posts vary, the **typical NHS pay band** of an equality, diversity and inclusion lead is **Band 7** (starting salary £40,057), equivalent to an advanced speech and language therapist or communications manager

**Nearly half** (47%) of Black and minority ethnic NHS staff have **worked in Covid-19** roles compared with less than a third (31%) of all staff<sup>2</sup>

Only **2 in 5** deaf health care professionals report having had their **reasonable adjustments met** during the Covid-19 pandemic<sup>3</sup>

Candidates with **Bangladeshi ethnicity** are, on average, **half** as likely to be appointed from an NHS shortlist than a White British person

Those from the **least affluent** socioeconomic backgrounds are **half as likely** to study undergraduate physiotherapy than children's nursing and the average across all allied health courses, which are broadly representative on that measure

The **NHS** in England employs some **1.5 million** people, with the wider human health and social care sectors accounting for **3.6 million** people

1 Dawson (2018).

2 Nuffield Trust (2021).

3 Grote and others (2021).

# Key findings

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- The moral and legal cases for NHS trusts to increase the diversity and inclusivity of their workforce are indisputable. There is also a robust evidence base demonstrating the benefits, including: improved quality of care for patients; a more sustainable workforce supply; and increased efficiency of services.
  - However, discrimination and other forms of unfair treatment are evident within the NHS – at every stage of the career pipeline – despite efforts to identify and eradicate them.
  - The Covid-19 pandemic has had a direct effect on equality in the workplace, and at no other time in recent history has the NHS’s duty of care to secure the health, safety and welfare of all its employees been as pressing.
  - Our research suggests that there are at least three conditions necessary to address these challenges but currently there is scope for the NHS to improve on them:
    - sufficient information and data to enable a more nuanced understanding of the challenges that staff experience, including within and across specific groups
    - clarity on ‘what works’ to address specific challenges, particularly in NHS settings
    - resources, skills and clear responsibilities within and across organisations to both implement and evaluate their interventions
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# Summary

The NHS in England employs some 1.5 million people (Rolewicz and Palmer, 2021). This equates to around 1 in 19 of the total workforce in England. The work that the NHS does would not be possible without the critical contribution of a broad diversity of people, covering different genders, ethnicities, disabilities, religions, national origins, sexual orientations, ages and other characteristics.

However, there appears to be scope for the NHS to become a more inclusive, diverse and equitable workforce at every level. Across an array of characteristics – including ethnicity, disability, gender and religion – some groups are under-represented in certain NHS careers. For instance, men account for only 1 in 9 (12%) of the nursing and health visitor workforce whereas women account for little more than a third of medical consultants (38%) (NHS Digital, 2021b).

More than 1 in 8 NHS staff (13%) reported experiencing discrimination at work in 2020, with sharp differences between some occupations. These inequalities continue to be apparent across a range of different characteristics as well as different aspects of the career pathway, starting from the underrepresentation of certain groups in education for, and recruitment to, the health care workforce; through to inequalities in experiences and opportunities when employed. For example, Black and minority ethnic staff are more likely than other staff to experience harassment, bullying or abuse and enter a formal disciplinary process, but less likely to access training, be appointed from a recruitment shortlist or become a senior manager (see Figure 2).

Despite endeavours to improve equality and inclusion in the workforce and some improvements around diversity – such as in terms of minority ethnic representation in very senior roles – progress has been limited, including across some key outcome measures. For example, in 2020, while White, male and non-religious staff and those without longstanding disabilities all reported similar levels of discrimination at work from their manager, team leader or other colleagues in the previous year as they had done in 2016, performance

against this indicator had got worse for people with almost every other characteristic for which data were available.

Notwithstanding the limited progress, discrimination is not an intractable problem – we heard of pockets of good progress throughout our research. The limited success, however, suggests there are some systemic barriers to improvements. Our research points to shortcomings against three conditions necessary to drive improvement, namely having:

- sufficient understanding of the issues
- evidence-based solutions
- the resources for implementing them.

That final condition includes leadership and governance. We are conscious that, in common with other institutions, the NHS has made a number of attempts to tackle overt discrimination over a long period of time. However, the fact that discrimination still clearly exists within the NHS suggests that unless boards and individual leaders within organisations recognise and accept their responsibility to own and address structural discrimination, progress will continue to stall.

## Understanding the issues

Much of the existing research on diversity has relied on using publicly available datasets and broad demographic categories. But more often than not, these lack the quality, granularity and nuance needed to fully understand the problems that staff experience. For example, much previous research has relied on comparing proportions of White staff with an umbrella ‘Black, Asian and minority ethnic’ (BAME) category. However, this approach overlooks striking differences among groups who share protected characteristics (see Figure 7). Our novel analysis using data from bespoke data requests reveals blunt differences in the likelihood of being shortlisted for, or appointed to, NHS jobs – with Bangladeshi, African, and people with a Mixed White and Black African ethnic background appearing to have lower success rates (see Figure 8). In fact, that analysis also highlights the importance of looking beyond just ethnicity, with the likelihood of Sikhs, Muslims and Hindus being shortlisted or appointed from the shortlist all significantly below the average (see Figure 9).

There is general consensus that one of the key conditions for being able to address discrimination is the ability to monitor progress and benchmark. While some issues are evident across the NHS in England and can potentially be addressed with national interventions, there needs to be greater understanding of patterns of inequality at regional, system, local and even service levels. Some data are made readily available at an organisational level but being able to drill down below national indicators is not always possible. Local variation against key diversity measures can be substantial. For example, there were 36 NHS trusts where, on average, White staff were at least twice as likely to be appointed from a shortlist as a Black or minority ethnic member of staff, whereas there were a similar number of trusts (32) where White staff had no higher likelihood.

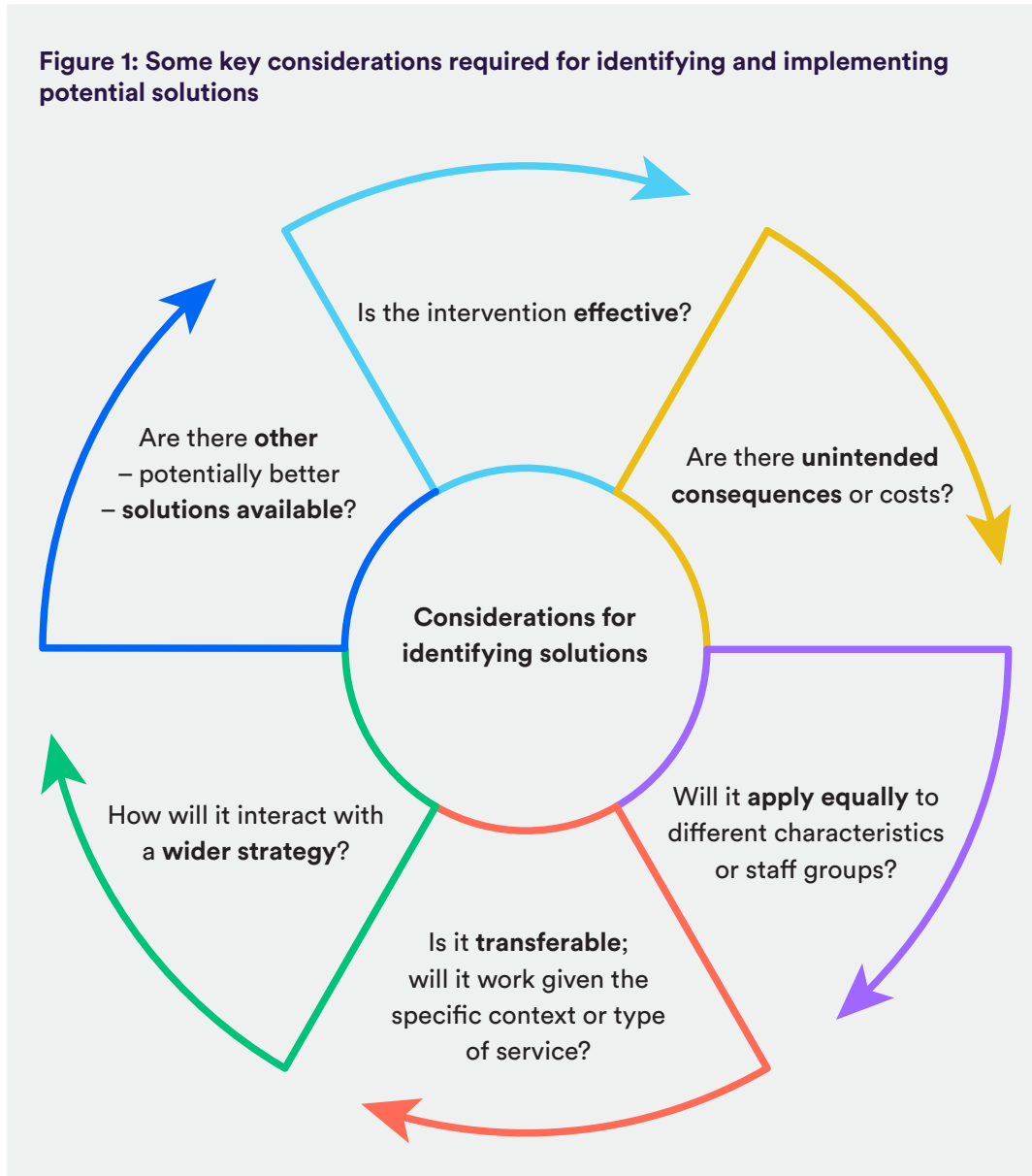
In reality, exploring all the considerations around diversity is a sizeable undertaking. As we highlight in this report, to get a sufficiently good understanding, this requires investigating the range of areas where workforce inequalities can exist and the influencing factors, and doing this for all occupations and characteristics. We outline the complexity of the task by highlighting some key considerations for understanding the scale of workforce inequality challenges in Chapter 2. Employers will be key in this but cannot be expected to take on the task alone; at times there may be a bewildering array of data for employers to make sense of. While there has been a marked push in recent years to drive up local and regional understanding, and analysis of inequalities in the workforce through, for example, regional NHS England equalities leads and Workforce Race Equality Standard (WRES) equality leads, this remains a work-in-progress.

## Identifying solutions

There is no repository of evidence-based interventions for addressing the inequalities evident in the workforce that are reliably effective in NHS settings. In fact, there is some concern about the unintended consequences of implementing interventions that have not been adequately evaluated. This is not to say there are no apparent pockets of good practice that are being shared and developed iteratively.



As each context is different, it is important that initiatives are designed to suit local needs. However, predicting the likely impact of a potential solution can be difficult given there are, for example, sometimes unintended consequences and changing schools of thought on what works. A number of considerations need to be taken into account (see Figure 1).



Many have stressed the importance of addressing and mitigating bias at every stage of the NHS career pathway – from job design, through to shortlisting, interviews, appointment, development opportunities and promotion. However, we heard that, to date, interventions around equality, diversity and inclusion have typically focused on policies, procedures and training. In isolation these are unlikely to make a material difference (Dobbin and Kalev, 2016) and so employers need to think more broadly, for example investing in analytics and further embedding accountability and transparency at organisational, team and individual level (Kline, 2021a).

Local equality, diversity and inclusion teams are not always equipped with the skills, responsibilities, capacity or support to systematically evaluate the impact of programmes. And despite the importance of evaluation, there has been no central funding committed to support trusts to independently evaluate and monitor their initiatives so that their effectiveness can be understood, improved upon and scaled to other settings.

## Resources for implementing interventions

Many efforts to improve the diversity and inclusivity of the NHS workforce are being hamstrung by a lack of resources. From the trusts we spoke to, there appear to be substantial differences in funding available for equality, diversity and inclusion programmes of work. Our conversations suggest that equality, diversity and inclusion leads can sometimes be under-resourced and exposed to significant responsibility without sufficient support or seniority. Staff networks appear to be a key resource; however, staff report often lacking protected time to contribute to them.

There is an indisputable moral case and a clear business case for NHS trusts, as ‘anchor institutions’, to invest in an equitable, diverse and inclusive workforce. Beyond compliance with statutory and contractual requirements, there is a robust evidence base demonstrating that the benefits of such a workforce are wide-ranging (see Figure 6). These include:

- improved quality of care for patients, in terms of access, choice and satisfaction, for example

- a wider talent pool and more sustainable workforce supply
- improved efficiency of services, through better productivity and innovation
- cost savings from, for example, reduced staff sickness and formal disciplinary processes.

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**I think having the resources to properly measure the impact is non-negotiable for me. But whether that will happen, I don't know.**

(Director of people and organisational development)

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**I think we never have enough resource. But you've always got to make... the business case really, really clear.**

(Equality, diversity and inclusion lead)

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Decisions on where to invest additional resources for addressing inequalities need to be led by a clear understanding of where particular roles, responsibilities and accountabilities fall, including whether at national, regional, system or local levels. Employers will be key, given they can more readily influence the day-to-day practices that directly affect equality, diversity and inclusion. However, given the nature of the challenge, some responsibilities should fall at other levels with, for example, integrated care systems potentially playing a significant role. While the additional scrutiny at different levels may have some benefits, there is a risk that unclear responsibilities between local, regional and national bodies will result in overlaps in efforts, leading to silos. To counteract this, there is scope for national and regional bodies to play a greater role in advancing joint working – such as through NHS Employers' Diversity and Inclusion Partners Programme – to ensure, for example, that the efforts of various stakeholders and key employers align.

The existing literature points towards the importance of leadership in addressing discrimination. And there have been nationally set ambitions for NHS trust boards to take on more responsibility. However, we heard

frustration about a lack of organisational and national support, which should be put in place if this is genuinely a priority. While we heard that some chief executives had embraced responsibility for this agenda, at some trusts the leadership team appear to show less, or fluctuating, interest. Particularly in the light of the expected changes in the organisational structure of the NHS, there will need to be greater clarity on where accountability sits across individual organisations, local systems and regional and national bodies, and how leaders will be held to account for addressing discrimination.

## Conclusion

The events of 2020 – including the murder of George Floyd, the Black Lives Matter movement and the Covid-19 pandemic – have helped to propel the significant, longstanding issues of structural and institutional discrimination and systemic inequalities to the forefront of political and public debate. In addition, the pandemic has had an undeniable impact on equality, diversity and inclusion in the workplace, with additional disruption and health risk for NHS staff disproportionately affecting some groups, such as those from minority ethnic backgrounds. However, the pandemic has also provided a lens to better explore the support that some staff need, an impetus for some to speak up and a renewed sense of compassion for colleagues.

The NHS is not alone in having diversity issues. However, this should not be an excuse for the shortcomings. In fact, there is scope not only to positively impact many of those directly employed by the NHS but also, by setting an example, to raise standards for the 3.6 million people working across health and social care. Moreover, by acting as inclusive recruiters from their local area, NHS organisations, as anchor institutions, can also help to resolve wider societal problems around diversity.

The NHS should strive to be an exemplar in terms of equality, diversity and inclusion, which will require a more nuanced understanding of the issues, clarity on what works in addressing them and the resources to ensure evidence-based solutions are implemented at pace throughout the health service. This needs investment at local, system, regional and national levels but the business case for doing so – and doing so urgently – is incontestable.

In Chapter 5, we outline some specific recommendations, including the following:

- NHS England and NHS Improvement should conduct a stocktake of data and information systems to determine which would support a more detailed analysis of variation by sub-groups within the protected characteristics, taking into account the effect of intersectionality.
- NHS trusts should report publicly on their estimated annual budget and full-time equivalent staffing levels specifically for improving equality and diversity.
- Integrated care systems should consider pooling funding specifically for independent evaluations and work with trusts to ensure that evaluations are planned from the outset of any major interventions they undertake.
- The Cabinet Office should consider the establishment of a new ‘What Works’ centre, to develop the evidence base and coordinate learning across the public sector, with a single accessible repository for evidence-based solutions.
- NHS trusts should ensure their equality, diversity and inclusion teams have access to continuing professional development, and are equipped with the skills, knowledge and leverage (for example, appropriate seniority) to support and challenge their organisations.
- Every integrated care system should have a substantive equality and diversity lead, to help provide enhanced specialist support for trusts on key challenge areas.

# About this report

To ensure a sustainable workforce, both now and in the future, the NHS needs to ensure that it attracts, recruits and retains a diverse staff reflective of the local community it serves. Of course, we are not the first to recognise this – many reports have been written on this topic. However, as an independent policy think tank, in this report we set out to build on this existing work to develop some practical policy recommendations that can improve the current situation. Some will contend that this is the time to act rather than research and, conscious of this, we hope that by looking at the practical conditions necessary to make meaningful changes, we are contributing to both the understanding of the issues and the delivery of actual improvements.

While we have not attempted to cover the subject areas exhaustively, we did seek to keep the scope broad so as not to miss any key practical levers or mechanisms. We looked – where possible – across the range of protected characteristics as well as other demographics such as socioeconomic status. We also considered barriers and opportunities across the career pathway, from education for and recruitment into the NHS, through to promotion into senior roles. This report pays particular attention to representation and pathways into employment for underserved groups, and to combatting bullying and discrimination and improving staff experience once in post.

Following a chapter setting out the context and importance of addressing discrimination (Chapter 1), we explore – in turn – three key conditions which we contend are fundamental to improving the current situation around inclusion, diversity and equality, namely having: sufficient understanding of the issues (Chapter 2); evidence-based solutions (Chapter 3); and the resources to implement them (Chapter 4, which also covers leadership and governance). We do not argue that these are the only conditions needed to address discrimination, but they are probably necessary. We end the report with recommendations for action, stating the lead organisation and examples of key stakeholders for each one (Chapter 5).

To explore the issues, we reviewed existing literature, conducted scoping calls and semi-structured interviews with trusts and analysed a range of data. In this report we focus on NHS trusts and NHS foundation trusts although some of the findings and recommendations are relevant to national bodies, primary care and commissioners. This research was conducted at a unique time and our findings need to be interpreted in the landscape of a number of significant events that have brought inequalities and their root causes to the forefront of public and political debate. These include the Covid-19 pandemic, the murder of George Floyd and the prominence of the Black Lives Matter movement in the UK. The challenges and negative outcomes our interviewees encountered and the analyses highlighted in this report cannot be divorced from the wider structural discrimination and other systemic inequalities prevalent in society, which are heavily documented (Acheson, 1998; Department for Business, Energy and Industrial Strategy, 2017; Department of Health and Social Security, 1980; Macpherson, 1999; Race Disparity Audit, 2017).

# 1 Call for action

## The state of the problem

The NHS in England employs around 1 in 19 of the total workforce in England. A broad diversity of people contributes to the delivery of health care to the population, covering different genders, ethnicities, religions, sexual orientations and ages.

However, it is widely agreed that there is more the NHS can do to be an inclusive, diverse and equitable employer. Unfortunately, there are often stark differences in the experiences of different demographic groups. In the 2020 NHS Staff Survey, more than 1 in 8 staff (13%) reported experiencing discrimination at work. This can be from colleagues or patients, and can be for the array of protected characteristics set out in the Equality Act 2010 (see Box 1).

Inequalities persist across different aspects of staff experience. The NHS Staff Survey and other data show that across the range of protected characteristics, some groups are less well-represented at senior levels, have worse day-to-day work experiences and face more challenges in progressing in their careers. Figure 2 shows that Black and minority ethnic staff are more than twice as likely to experience discrimination at work from a colleague and nearly a quarter as likely to be a senior manager than White staff. Recent research also points to continuing pay inequities, with considerable variation in pay between ethnic groups across all NHS staff (Appleby and others, 2021).



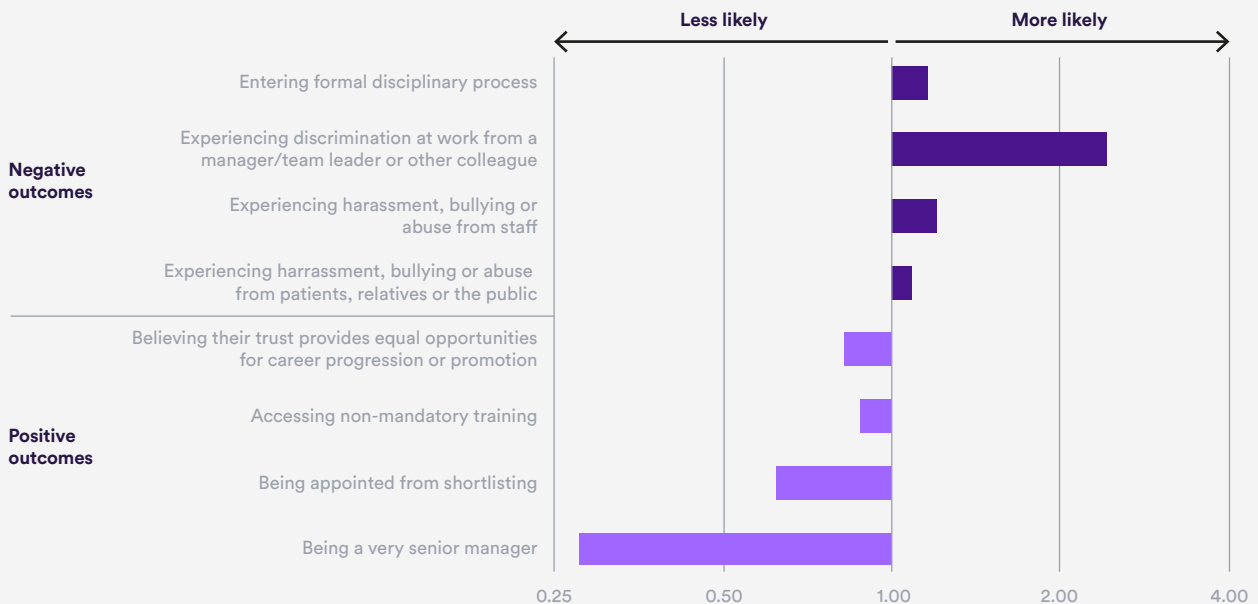
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### **Box 1: Nine protected characteristics under the Equality Act 2010**

The Equality Act 2010 offers protection to nine characteristics:

- age
  - race
  - sex
  - gender reassignment status
  - disability
  - religion or belief
  - sexual orientation
  - marriage and civil partnership status
  - pregnancy and maternity.
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**Figure 2: Relative likelihood of different career experiences for Black and minority ethnic staff compared with White staff, 2020**

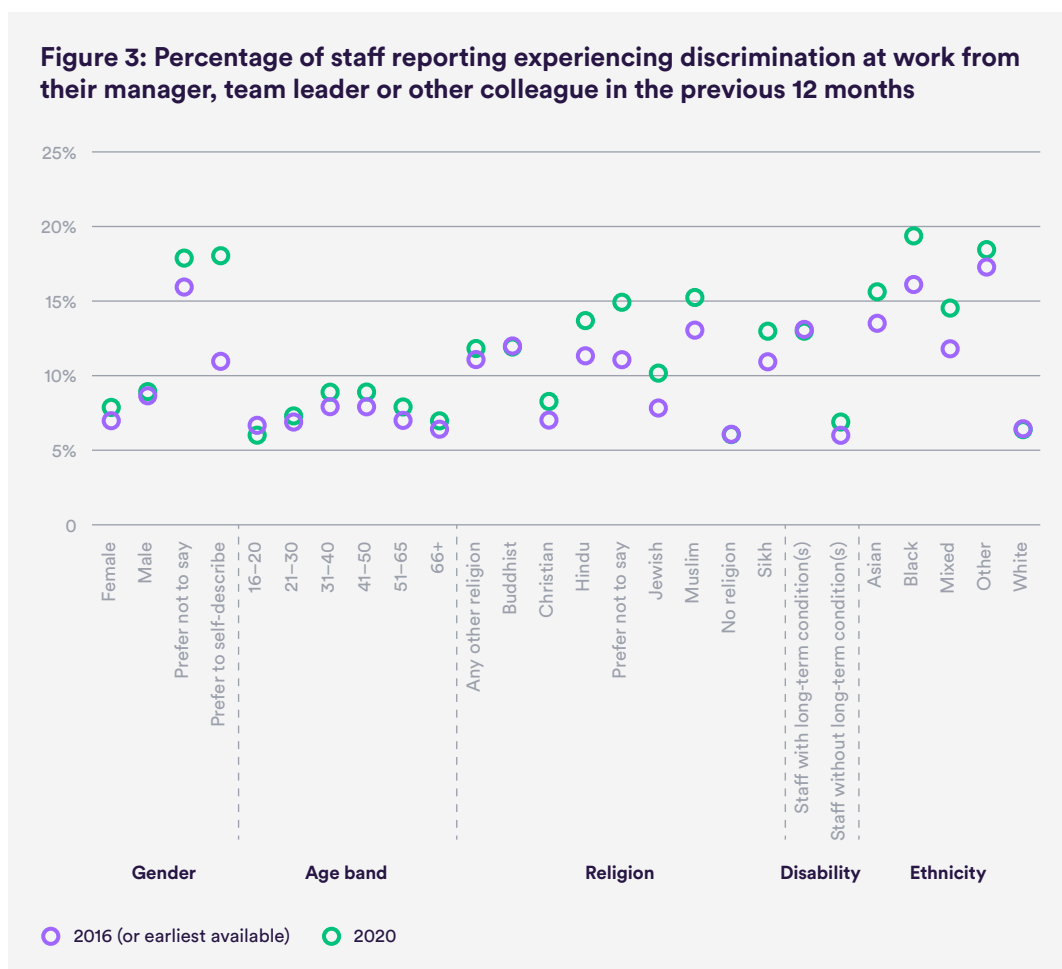


Notes: Those symbols above 1 indicate a greater likelihood than White people (with 2 representing twice the likelihood) and those below 1 indicate a lesser likelihood (with 0.5 representing half the likelihood). A logarithmic scale is used so that double the likelihood is the same distance as half the likelihood from the line representing equal likelihood. Source: Nuffield Trust analysis of data on NHS trusts from WRES Implementation Team (2021b).

These issues appear across different professions. For example, despite being as likely as staff from other ethnic groups to study psychology and work in NHS psychology professions, people from Black or Asian ethnic groups are far less likely to be in more senior NHS roles and be accepted onto a clinical psychology training course (see Figure 18 in Appendix 2). Inequalities are also evident across different characteristics. For example, novel data tracking new nurses with nine years’ continuous service highlight that female nurses were significantly less likely than male nurses to be employed in a pay band above their starting one. In fact, male nurses were twice as likely to have progressed up two pay bands (41%) than female nurses (20%).<sup>4</sup>

4 Based on Nuffield Trust analysis of NHS Digital data on the grade progression of Band 5 nurses as at September 2009, aged 21–23, with continuous service in NHS hospital and community settings to September 2018.

There have been some improvements with, for example, the total number of Black and minority ethnic staff at the very senior manager (VSM) pay band increasing from 108 in 2017 to 153 in 2020 (WRES Implementation Team, 2021b). However, despite efforts to address the issues, overall progress, including across key outcome measures, has been limited. For example, in 2020, while White, male and non-religious staff all reported, on average, similar levels of discrimination at work from their manager, team leader or other colleagues in the previous year as they had done in 2016, performance against this indicator got worse – denoted by green dots above purple dots in Figure 3 – for almost every other characteristic. As NHS England and NHS Improvement have noted, in the context of ethnicity, although it applies more broadly, ‘the persistence of outcomes like these is not something that any of us should accept’ (WRES Implementation Team, 2021b).



Source: NHS staff survey.

Despite limited progress overall, discrimination is not an intractable problem. We saw pockets of good progress throughout our research (see Chapter 3). For example, one trust had demonstrably – although admittedly not easily – tackled the relative likelihood of some staff groups, such as minority ethnic staff, entering formal disciplinary proceedings (see Case Study A). In fact, there have been concerted efforts to address issues around inequalities in disciplinary processes through, for example, the ‘just culture guide’, which aims to encourage managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way (NHS England and NHS Improvement, no date c).

The NHS is not the only sector to struggle with issues over diversity, inclusion and equality. Other public services also appear to face similar problems. For example:

- In the education sector, Indian and Black African teachers are underrepresented compared with the working-age population, and 93% of all headteachers identify as White British (Department for Education, 2021).
- In the Fire and Rescue Service, 95% of all staff identify as White British (Home Office, 2021).
- A recent report has highlighted that almost three-quarters (72%) of those in senior Civil Service posts are from ‘high’ socioeconomic backgrounds, which is a higher proportion than in the 1960s (Easton, 2021).

There may potentially be some learning for the NHS from initiatives in higher education, such as the Athena Swan Charter (Graves and others, 2019), and in the fire and rescue service (Local Government Association, 2019). The nature of the NHS could give it an advantage for delivering change and the scope for improving people’s lives cannot be overlooked – improving conditions in the NHS could have a positive knock-on effect on the wider health and social care sector, which employs some 3.6 million people. The health service, as one of the largest employers globally, should be seeking to be an exemplar and to maximise their potential as anchor institutions within their local communities (p.53).

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## Case Study A: Tackling the disciplinary gap at Coventry and Warwickshire Partnership NHS Trust

In 2019, Coventry and Warwickshire Partnership NHS Trust took a number of steps to address the disciplinary gap for all staff, including minority ethnic staff. Initially, the trust piloted the RCN Cultural Ambassador Programme (Royal College of Nursing, no date) but it was not formally adopted. Instead, the trust carried out a joint deep-dive exercise, with local staff-side representatives reviewing all the disciplinary information over a two-year period, engaging with managers, the Freedom to Speak Up Guardian and finance colleagues. The review found that, over a period of 18 months, the trust held 90 disciplinary investigations, with 36 staff (40%) then being suspended from duty.

As a result of this review, a business case was developed, proposing an *Investigation Team* approach. Funding was secured for a two-year pilot, agreed in the summer of 2019. The team are formally commissioned to carry out investigations and comprise of a Band 7 team manager and two Band 6 casework advisers, all of whom are chartered members of the Chartered Institute of Personnel and Development (CIPD).

A review of progress in the first year found a number of improved outcomes:

- The team investigated 61 cases in total (47 of which were disciplinary related). Staff were suspended in seven of the disciplinary-related cases (15%), with other restrictions such as temporary redeployment and removal from night shifts being more appropriately used during the investigation process.
- There was a reduction in the timescales for investigation: 89% of cases investigated were closed in less than 12 weeks, a reduction in time compared with previously.
- There was a reduction in the cost of agency cover (£50,000 during the review period compared with around £200,000 a year previously) and in the cost of suspension (£53,000 during the review period compared with more than £200,000 a year previously).

Following the submission of a further business case, substantive funding for the team was approved from June 2021, with all three staff members now being made permanent members of the team.

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## Policy context

The health service has been described as a microcosm of wider society (Coghill, 2020a; Naqvi, 2020) and more than a decade ago, in 2009, the NHS Constitution for England stated that the NHS must ‘make sure nobody is excluded, discriminated against or left behind’ (NHS England 2009; Department of Health and Social Care, 2021b). Subsequent policies have reiterated a longstanding intention to improve equality, diversity and inclusion for NHS staff (see Figure 4), which dates back to the Race Relations (Amendment) Act 2000 (Equality and Human Rights Group, 2006; Siva, 2009). For example, demonstrating and ensuring a diverse workforce is a statutory requirement under the public sector equality duty, and trusts are required to implement and comply with the national Workforce Race Equality Standard (WRES) and the national Workforce Disability Equality Standard (WDES), as stipulated in the NHS Standard Contract.<sup>5</sup> They are also expected to meet the equality objectives for 2016–20 (NHS England and NHS Improvement, no date b).

**Figure 4: Timeline of selected key legislation, policies and initiatives relevant to equality and diversity in the NHS since 2009**

2009	The NHS Constitution for England states the intention to eliminate discrimination
2010	The Equality Act 2010 is passed The NHS Equality Delivery System (EDS) is launched – a toolkit to help trusts monitor their progress on equality metrics (NHS England and NHS Improvement, no date a)
2011	The public sector equality duty comes into force
2015	The paper <i>Beyond the Snowy White Peaks of the NHS?</i> is published (Kline, 2015)
	The NHS EDS2 toolkit (a streamlined version of the Equality Delivery System) and the Workforce Race Equality Standard (WRES) are made mandatory for all NHS providers in the NHS Standard Contract (NHS England and NHS Improvement, no date a; no date d)

<sup>5</sup> NHS commissioners use the Standard Contract for most contracts for health care services.

2017	The policy paper <i>Improving Lives: The future of work, health and disability</i> is published; government sets a target of one million more disabled people in work by 2027 (Work and Health Unit, 2017)
	The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 come into force
2019	The Workforce Race Equality Standard Implementation Team publish targets for representation at senior levels (WRES Implementation Team, 2019)
	The Workforce Disability Equality Standard (WDES) is introduced (NHS England and NHS Improvement, no date e)
	An NHS chief people officer role is created (NHS England and NHS Improvement, 2019)
2020	NHS Chief Executive Simon Stevens pledges to ensure the NHS England and NHS Improvement head office is representative of the wider NHS, at every pay band (NHS England and NHS Improvement, 2020a)
	The NHS People Plan for 2020/21 is published (NHS England and NHS Improvement, 2020b)
	NHS England and NHS Improvement appoint two joint directors of equality and inclusion (Kituno, 2021)
2021	NHS England and NHS Improvement publish further resources to support the Workforce Race Equality Standard work programme (NHS England and NHS Improvement, no date e)
	NHS England and NHS Confederation launch the NHS Race and Health Observatory
	Building Leadership for Inclusion, Stepping Up and Ready Now Programmes continue (NHS Leadership Academy, no date c)
	NHS Employers publishes: <ul style="list-style-type: none"> <li>• <i>Inclusive Recruitment: Leading positive change</i> (NHS Employers, 2021a)</li> <li>• <i>Inclusive Recruitment: Supporting economic recovery</i> (NHS Employers, 2021b)</li> <li>• <i>Inclusive Recruitment: Increasing supply, widening access to employment and addressing inequality</i> (NHS Employers, 2021c)</li> </ul>

Recent national policies such as the NHS People Plan 2020/21 (NHS England and NHS Improvement, 2020b) have reinforced commitments to improve diversity and inclusion (see Box 2). However, some have highlighted shortcomings in these policy documents. Roger Kline – who brought issues around ethnic inequalities to many people’s attention in *Beyond the Snowy White Peaks of the NHS?* (Kline, 2015) – noted recently (Kline, 2021c) that the closest policy paper to a national strategy regarding the recruitment of minority ethnic staff only came in 2019 in the Workforce Race Equality Standard Model Employer guidance (WRES Implementation Team, 2019) and fell short of setting out how bias would be mitigated, accountability enforced and a national repository of good practice created.

The events of 2020 – including the murder of George Floyd and the Covid-19 pandemic – sparked a broader societal reckoning and awareness around structural, institutional and interpersonal discrimination (Durairaj, 2020) and have placed issues of equality, diversity and inclusion at the forefront of political and public debate. For example, the pandemic has had a direct effect on equality in the workplace; the 2020 NHS Staff Survey suggested that Black and minority ethnic staff bore the brunt of Covid-19, with 47% working in Covid-19 roles compared with 31% of all staff (Nuffield Trust, 2021) (see also Figure 5 on p. 22). Research suggests these staff were more likely to take frontline roles on Covid-19 wards “due to fear that their contract may not be renewed or shifts reduced, especially if they were agency staff or had a vulnerable immigration status” (Farah and Saddler, 2020). Minority ethnic health care staff were also disproportionately likely to have died from Covid-19 (Chaudhry and others, 2020). A survey of health and care staff found that 80% of women respondents reported that their job had a greater negative impact than usual on their emotional wellbeing as a result of the pandemic, and 65% said their job has caused a greater negative impact on their physical health” (Strauss and Patel-Campbell, 2021). At no other time in recent history has the NHS’s duty of care to secure the health, safety and welfare of all its employees been as pressing.



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**Box 2: Selected diversity commitments in the NHS People Plan 2020/21**

From September 2020, line managers should discuss equality, diversity and inclusion as part of health and wellbeing conversations.

By October 2020, employers, in partnership with staff representatives, should overhaul recruitment and promotion practices to make sure their staffing reflects the diversity of their community, and regional and national labour markets.

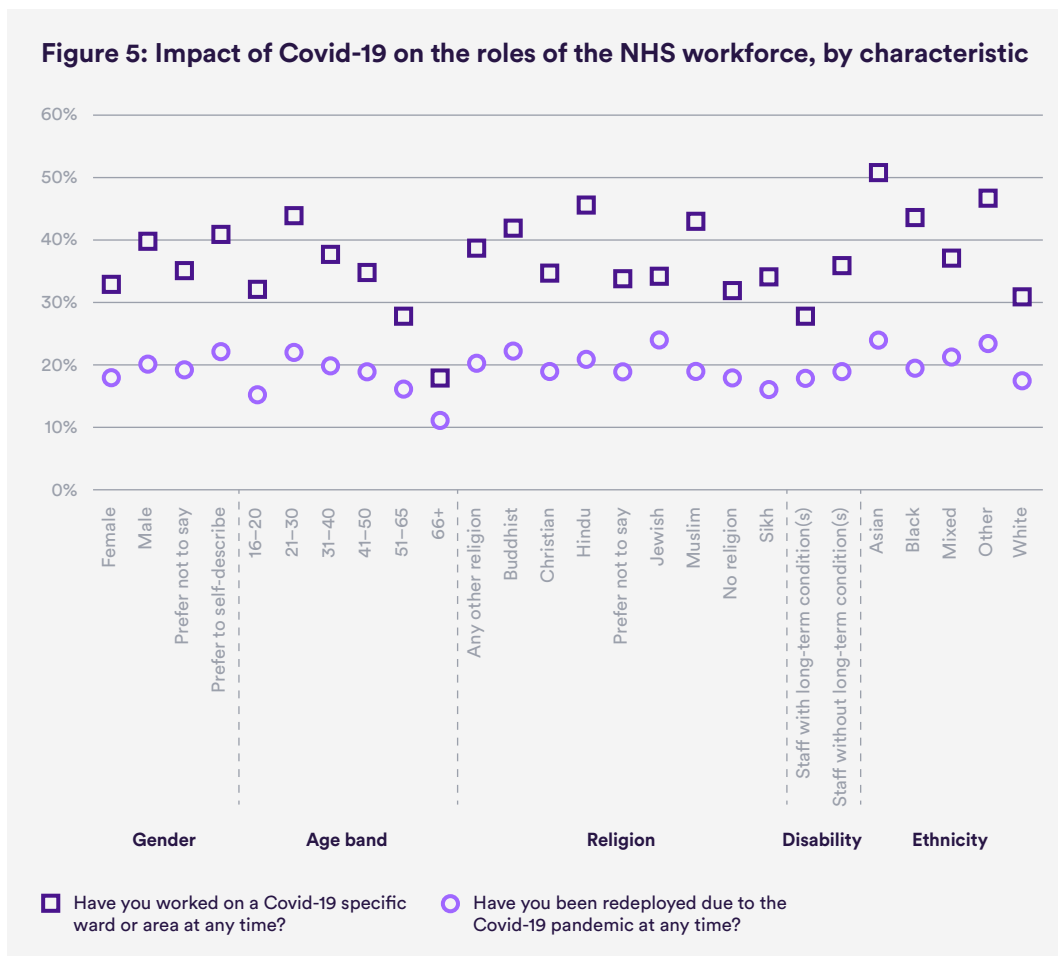
By March 2021, competency frameworks for board-level positions in NHS providers and commissioners will reinforce that it is the explicit responsibility of the chief executive to lead on equality, diversity and inclusion.

Every NHS trust, foundation trust and clinical commissioning group must publish progress against the Model Employer goals to ensure that, at every level, the workforce is representative of the overall Black, Asian and minority ethnic workforce.

By the end of 2020, 51% of organisations to have eliminated the gap in the relative likelihood of entry into a disciplinary process.

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The pandemic has also required new ways of working by staff, many of whom are likely to need increased or new forms of support in order to fulfil their roles. For example, a recent survey of deaf health care professionals during the pandemic found that only 2 in 5 had their reasonable adjustments met, 17% had to be removed from clinical roles due to a lack of reasonable adjustments and a third felt they would need to switch career if improvements were not made (Grote and others, 2021).



Source: Nuffield Trust analysis of the 2020 NHS Staff Survey; NHS Survey Coordination Centre (2021b).

The ongoing impact of Covid-19 on the labour market reiterates the importance of the NHS in England (and of the education sector training future health care staff) in combatting inequalities through inclusive recruitment, both as the largest employer and in its potential to set a precedent for other public sectors. Many trusts are successfully implementing inclusive recruitment schemes such as the Prince’s Trust, and Project Search. However, notably in the past year the unemployment rate for Black African and Black Caribbean young people rose to 35%, for Indian, Pakistani and Bangladeshi young people it rose to 24% and for White British, White Irish and White ‘Other’ young people it rose to 13% (Henehan, 2021).

## Benefits of diversity and inclusion

The NHS Constitution for England (Department of Health and Social Care, 2021b) states that ‘high-quality care requires high-quality workplaces’ and makes a pledge to provide ‘a positive working environment’ to staff in addition to the legal right that ‘you are treated fairly, equally and free from discrimination’. NHS trusts therefore have a duty to meet equality and diversity commitments set out in legislation and guidance, as discussed earlier and illustrated in Figure 4.

However, compliance is not the only rationale to act: there is also an undeniable moral obligation on the NHS to address inequalities among staff. In addition, the benefits of a diverse and inclusive workforce suggest a clear organisational business case to take action (see Figure 6). For example, there is strong evidence that a more diverse workforce results in improved staff outcomes, retention and engagement. It can also improve the efficiency and effective running of the NHS, through better productivity and enhanced innovation (NHS Employers, 2015). By reducing discrimination, bullying and harassment from colleagues, patients and families and promoting inclusion, the NHS can improve its staff absences and turnover rate. The total cost of these and other wider effects (including diminished productivity and litigation costs) were previously estimated as costing around £2.3 billion a year in total (Kline and Lewis, 2019).

The Care Quality Commission (2018a) has recognised evidence on the link between workforce equality and inclusion, and the quality of care for patients. The correlation between diversity and quality of care is also suggested in the 2019 Workforce Race Equality Standard, with better-performing trusts reporting a greater percentage of staff recommending care at their trust as part of the Staff Friends and Family Test (WRES Implementation Team, 2020). Similarly, analysis of the NHS Staff Survey suggests that, in organisations where staff experience discrimination or harassment from colleagues, or perceive unequal opportunities for career progression or promotion, patients are less likely to be satisfied (Dawson, 2018).

**Figure 6: Some of the benefits of a diverse workforce**



Notes: WDES = Workforce Disability Equality Standard; WRES = Workforce Race Equality Standard. This graphic shows benefits to the NHS as a whole unless otherwise stated. Note that the graphic is a simplification of the benefits and does not intend to be comprehensive. Sources: Reproduced from Palmer and others (2021). A: NHS Employers (2015); B: Fanshawe (2018); C: Lång (2020); D: Hunt and others (2018); E: WRES Implementation Team (2020); F: Dawson (2009; 2018); G: NHS England and NHS Improvement (2020b).

## 2 Understanding the issues

There is general consensus that one of the key conditions for being able to address discrimination is good-quality data and the ability to monitor progress and benchmark (Darling and the WRES Implementation Team, 2017; Kline, 2015). In this chapter we explore some of the challenges to, and opportunities for, a better understanding of equality and inclusion in the NHS workforce. Some related aspects – particularly the resources needed to research and understand such issues – are also covered in Chapter 4.

The Equality Act 2010 and the NHS Equality Delivery System created structures to support data gathering, which enabled some degree of benchmarking and further research (NHS Employers, 2015). For some aspects of diversity, these (and other) data have been used to highlight the stark realities, as in the previous chapter. However, as we outline in this chapter, shortcomings remain in our understanding: at local, system, regional and national levels; for some aspects of the career pathway; and for some characteristics.

### Coverage of different characteristics

While the overall numbers of staff in the NHS reporting discrimination on the basis of some characteristics may appear low, this is only because a small minority of staff identify with those characteristics; for staff who do identify with them, the likelihood of experiencing discrimination on the basis of the characteristics may be very high.

To date, there has been relatively little research on protected characteristics among NHS staff other than gender and ethnicity. In part, this has been due to obstacles faced in collecting viable data (NHS Employers, 2015). Key protected characteristics, as well as other factors such as national origin, are often not recorded in existing data sources, including the NHS Staff Survey. Similarly,

the published data on apprenticeships – a key government policy to promote inclusion – only include broad categories for ethnicity and health-limiting conditions or disabilities (Department for Education, 2020). It is striking that socioeconomic status is typically not collected for inclusion monitoring purposes, with one obvious exception being (albeit difficult to access) university data.

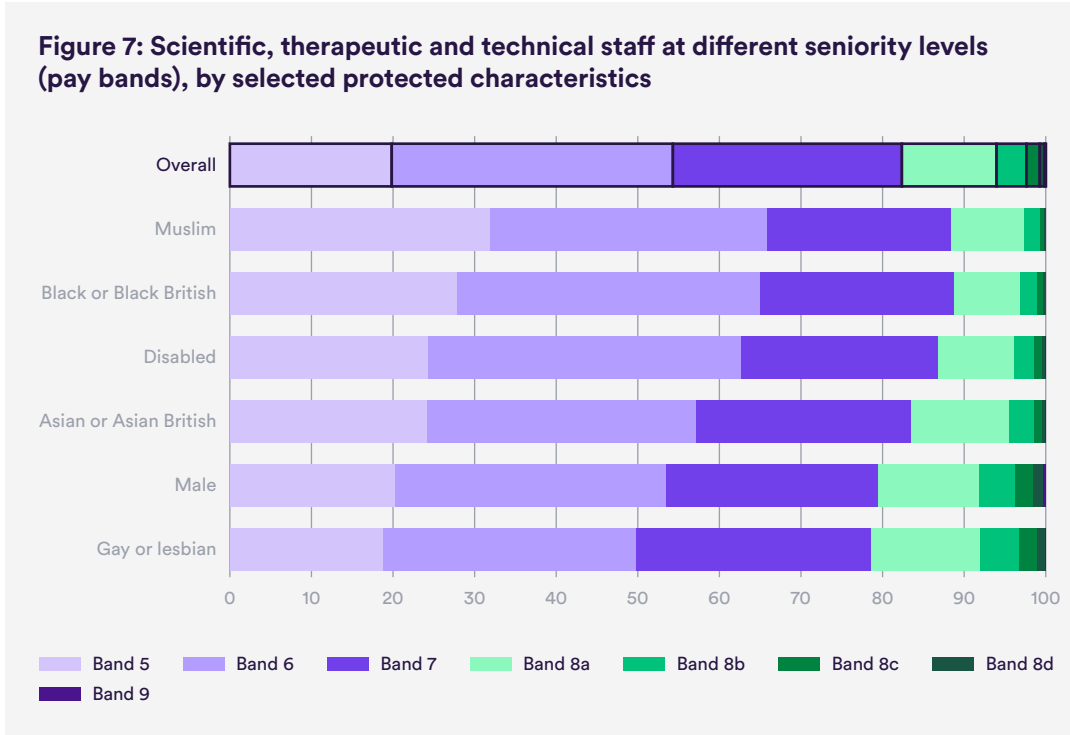
Some recent progress has been made to address these data gaps. For example, partnerships of national bodies have established the UK Medical Education Database and the UK Medical Applicant Cohort Study to help monitor social diversity among medical school students (Heller, 2020). The 2020 NHS Staff Survey collected data on carer status, which revealed that a third of all NHS staff deliver some form of unpaid care (NHS Survey Coordination Centre, 2021a). Elsewhere, some gaps have been filled with bespoke data collections; however, these are piecemeal and often extremely resource-intensive exercises. This can be an issue with local as well as national data. Without such data, important inequalities might go unnoticed or unproven.

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**We've got one system for [bullying] incident reports and one system with all the protected characteristics information, and actually marrying that up is really tough. (Equality, diversity and inclusion lead)**

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There are high-level data covering multiple protected characteristics, making it possible to gain a more comprehensive understanding of inequalities. For example, NHS Digital publishes data on different staff groups within hospital and community services, which show differences in proportion from Grade 5 (the typical entry level for qualified clinical professionals) up to Band 9 (which may include chief finance manager and podiatric consultants). Using the scientific, therapeutic and technical staff group – which accounts for more than 170,000 people – as an example, the likelihood of being in a senior grade (for example, Band 8a and above) does appear to differ for certain groups across a range of different characteristics, including religion and belief, disability and sexual orientation. This reiterates the importance of looking across all characteristics (see Figure 7).



Notes: Based on the workforce in NHS trusts and clinical commissioning groups in England, as at December 2020. Data are for ‘scientific, therapeutic and technical staff’ within ‘professionally qualified clinical staff’, although Band 4 and Non-Agenda for Change grades are excluded. Groups shown were selected simply to demonstrate variation across different characteristics rather than be comprehensive or fully representative.

Source: NHS Digital (2021a).

There are particular challenges around interpreting differences when the absolute numbers for certain outcomes are small. Given the size of the data presented above, we can assert that, for example, the proportions of disabled, Black or Black British, or Muslim staff in the highest grades (Bands 8d and 9) are statistically significantly lower than for all staff. However, if looking at regional or organisational levels or for a more specific staff group, then it becomes difficult to determine whether differences are due to random chance. Unpicking the signal from the noise can be hard in this context.

## Accuracy

Even where data on NHS staff protected characteristics are collected, they can be incomplete or inaccurate. This is also true of patient data, with recent

research noting the poor quality and consistency of patient ethnicity coding in hospital datasets (Scobie and others, 2021). We heard that data on visible or non-visible disabilities are especially poor. Very few respondents to NHS Staff Surveys self-identify either as lesbian, gay, bisexual or transgender, or as having a disability, meaning data on these groups can be less reliable (NHS Employers, 2015). For example, we heard that, at local and national levels, there are big gaps between the number of people with disabilities reporting in annual NHS Staff Surveys and actual staff records. One trust we spoke to has sought to address this by using interventions such as an ‘Embrace the Difference’ initiative to post disability stories on its intranet, and introducing a self-service electronic staff record. Some interviewees also noted historically low disclosure rates for sexual orientation but expressed optimism that, for example, staff wearing rainbow lanyards can create a supportive environment where people are more willing to record their characteristics.

Even analysing experiences by ethnicity can be challenging. In particular, staff from Black and minority ethnic backgrounds are less likely than other staff to take part in staff surveys, and so participation among these staff needs to be improved (NHS Employers, 2015).

However, several trusts spoke of the impact that Covid-19 had in unearthing and bringing to the fore support needs among staff. In conducting risk assessments for colleagues during the pandemic, one trust spoke of the impact Covid-19 may have had in nudging people to disclose a disability or health condition, for example among colleagues who were shielding but who may not have been part of the disability network as they may have felt they could previously manage their condition sufficiently by themselves.

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**Having to work from home or do things differently, might have meant that conditions that they managed and didn't tell people about, they may have had to also take that step... and say 'actually, I need a bit of help' that they haven't felt the need to do before. And that's quite a big thing for people... they've got to feel that they were being looked after and supported to be able to do that.**

(Workforce adviser)

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## Detail of existing analyses

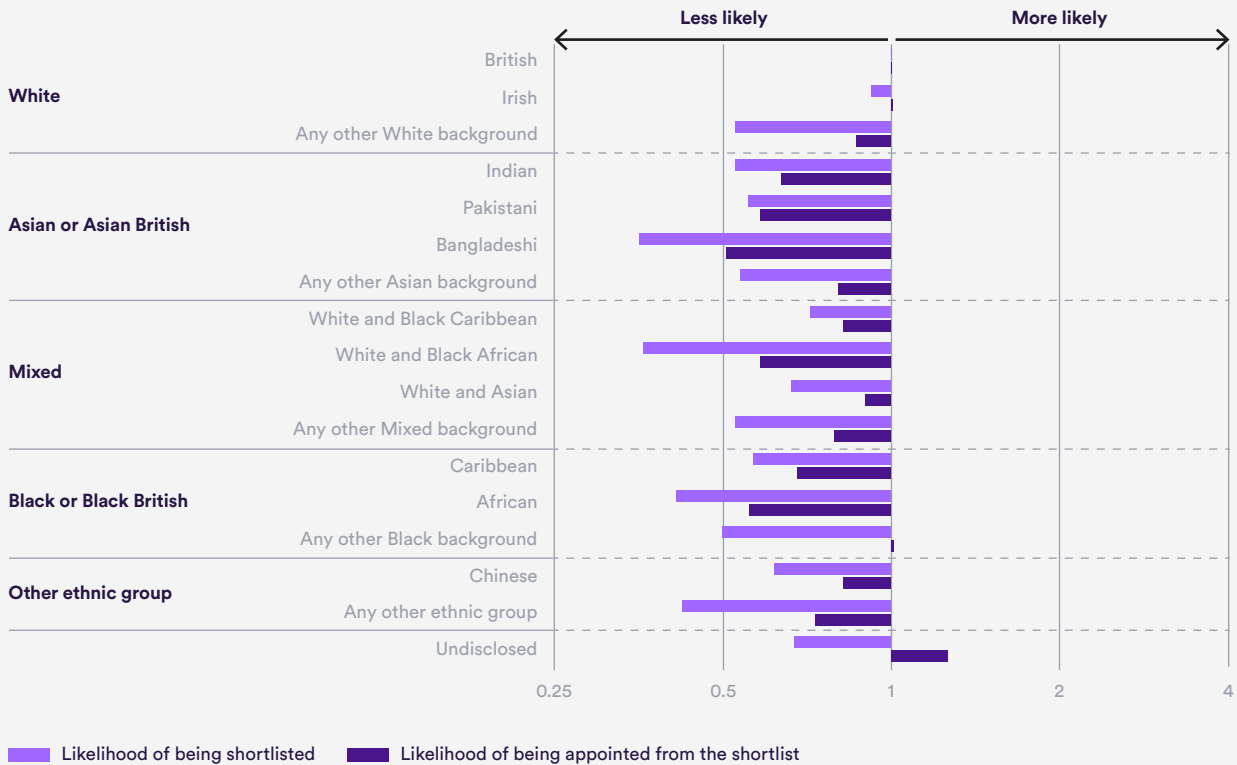
Broad demographic categories can miss the detailed issues. For example, the inaugural Medical Workforce Race Equality Standard (MWRES) notes that while the number of minority ethnic doctors has increased by 21% since 2017, these doctors remain underrepresented in consultant-grade roles and in academic positions (WRES Implementation Team, 2021a).

To highlight this issue, we looked at data on people applying, being shortlisted and being appointed for NHS jobs, which also feed into metrics that both the Workforce Race Equality Standard and the Workforce Disability Equality Standard use. Covering the two years to June 2019, the data include some 8.2 million applications and 160,000 appointments. Since not all employers use the system from which the data are derived to record numbers shortlisted and appointed, the absolute levels at which people are shortlisted and then appointed are underestimates; however, comparing these levels across characteristics highlights disparities that warrant further investigation.

There was a clear signal that those with White ethnicity were more likely than those from minority ethnic groups to be both shortlisted and appointed from the shortlist (see Figure 8). However, as shown in the chart, there was considerable variation when the data were disaggregated into more specific ethnic groups. For example, those with Bangladeshi, African or White and Black African ethnicities appeared to have lower success rates. Such analysis needs to be treated with a degree of caution, however, given, for example, that some groups may be more likely to apply for competitive roles, which may bias the results to some degree.

In fact, many have noted that aggregated data (for the Black ethnicity group, for example) can mask differences in outcomes for detailed ethnic groups (the Black Caribbean and Black African groups, for example) and suggested avoiding using high-level aggregated groups except where absolutely necessary (Commission on Race and Ethnic Disparities, 2021; Platt and Warwick, 2020).

**Figure 8: Relative likelihood of applicants being shortlisted and of those shortlisted being appointed compared with White British applicants, 2017–19**

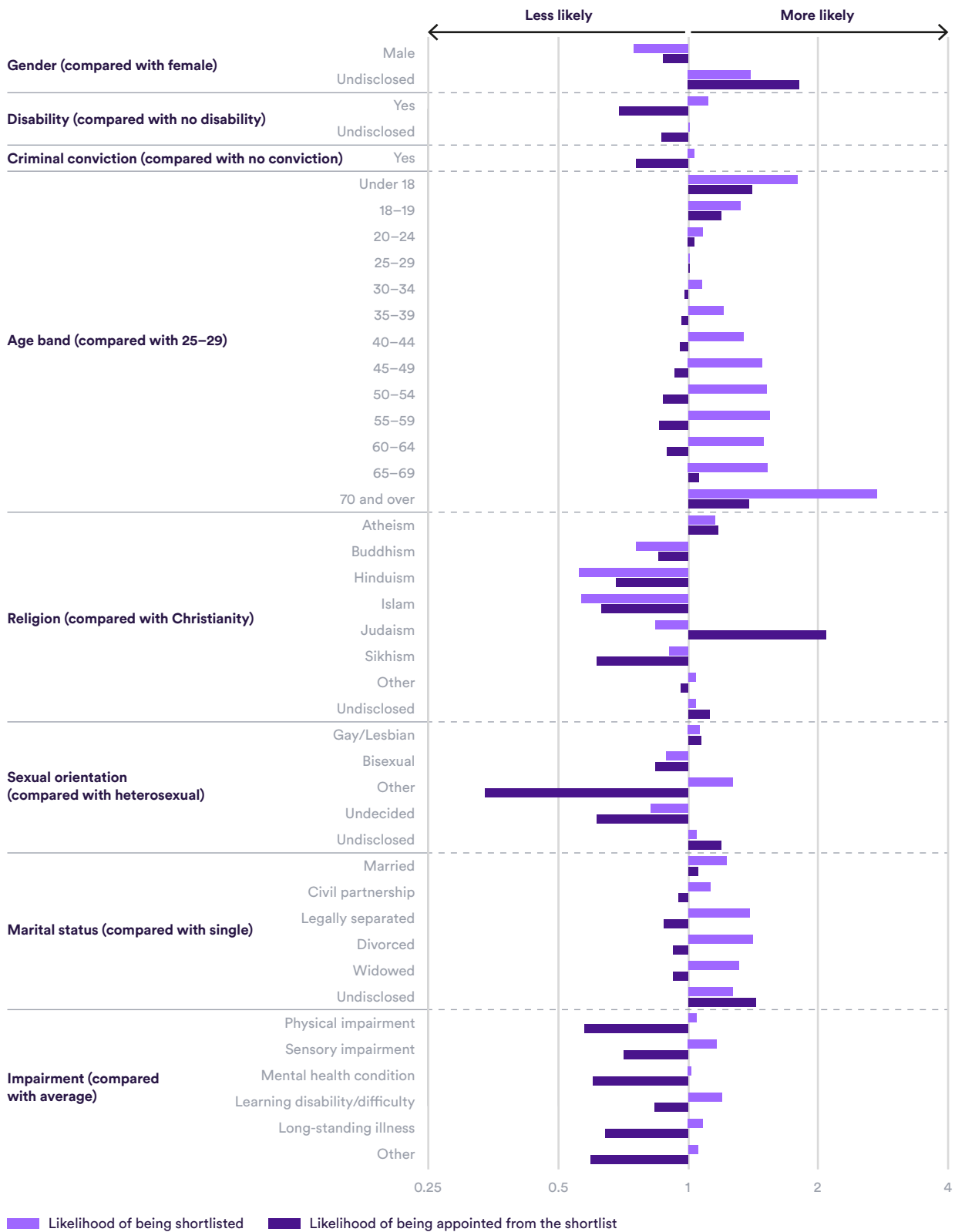


Notes: Based on NHS Jobs applications, June 2017 to June 2019. For groups with more than 65,000 applications; excludes ‘Other’ ethnicity and ‘Other’ religion. A more detailed discussion about the limitations of the data and how they should be interpreted is available on the NHS Digital website (NHS Digital, 2018). Plotted on a logarithmic (base 2) scaled axis so that half likelihood (that is, 0.5) and double likelihood (that is, 2) are equidistant from equal likelihood (that is, 1).

Source: Freedom of Information request.

There are also stark apparent disparities when looking at other characteristics. For example, the likelihood of Sikhs, Muslims and Hindus being shortlisted or appointed are all significantly below the average (see Figure 9). Such detailed understanding is important. For example, the average-or-higher likelihood of people with a physical impairment, mental health condition, learning disability or difficulty, or longstanding illness being shortlisted may perhaps suggest that the Disability Confident employer scheme that most NHS trusts use is supporting people in these groups to get interviews. However, even if so, the far lower likelihood of actually being appointed from the shortlist still needs further investigating.

**Figure 9: Relative likelihood of applicants being shortlisted and of those shortlisted being appointed, by characteristic, 2017–19**



Notes: Based on NHS Jobs applications, June 2017 to June 2019. For groups with more than 65,000 applications; excludes 'Other' ethnicity and 'Other' religion. A more detailed discussion about the limitations of the data and how they should be interpreted is available on the NHS Digital website (NHS Digital, 2018). Plotted on a logarithmic (base 2) scaled axis so that half likelihood (that is, 0.5) and double likelihood (that is, 2) are equidistant from equal likelihood (that is, 1). Source: Freedom of Information request.

## Accounting for a complex array of factors

### Intersectionality

Even when published data are available for different characteristics, it is rarely possible to explore, for example, the interplay between them. Yet many interviewees pointed to the importance of intersectionality (Box 3), with one noting that only through an intersectional lens can “you get a much better picture of what’s actually going on”.

Some limited analysis of compounded discrimination is possible through, for example, the NHS Staff Survey.<sup>6</sup> Other research by our colleagues at the Nuffield Trust explored the pay gap by gender and age (Appleby and Schlepper, 2018). Examining the combined impact of gender and ethnicity on pay and position in the workforce will lead to a deeper understanding of pay inequalities and actions to address them (Appleby and Schlepper, 2021). Yet trusts spoke of the continued difficulty of extracting sufficient nuance from the electronic staff records to explore these issues. Where they were able to, some trusts’ experience was of “moving a stone to find a crater”.

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#### Box 3: Intersectionality

The concept of intersectionality (Crenshaw, 1989) acknowledges that people’s identities are not one-dimensional, but that social categories (for example, sex, ethnicity, religion and socioeconomic status) simultaneously overlap. Individuals can be discriminated against on the basis of not just one of these characteristics but a combination of them.

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6 For example, Bolden and others (2019) found that only 68% of disabled minority ethnic staff reported that adequate adjustments had been made for them, compared with 75% of disabled White staff.

Identifying and understanding compounded discrimination and its effects will be integral to gaining a holistic picture of the challenges facing different groups of staff and the bespoke measures that are needed to ensure the workforce is genuinely inclusive. For example, a study on the impact of dress codes in operating theatres, as experienced by hijab-wearing Muslim women, noted that the way in which trusts manage workplace uniform policies can lead to instances of bullying and increased anxiety, and can determine people’s career choices (Malik and others, 2019). Others have highlighted issues around ‘gendered racism’ in the nursing profession, including for British South Asian male nurses (Qureshi and Randhawa, 2020). Furthermore, ‘black female leaders are disproportionately sanctioned for making mistakes on the job, particularly under conditions of organisational failure’ (Rosette and Livingstone, cited in Bolden and others, 2019, p. 17).

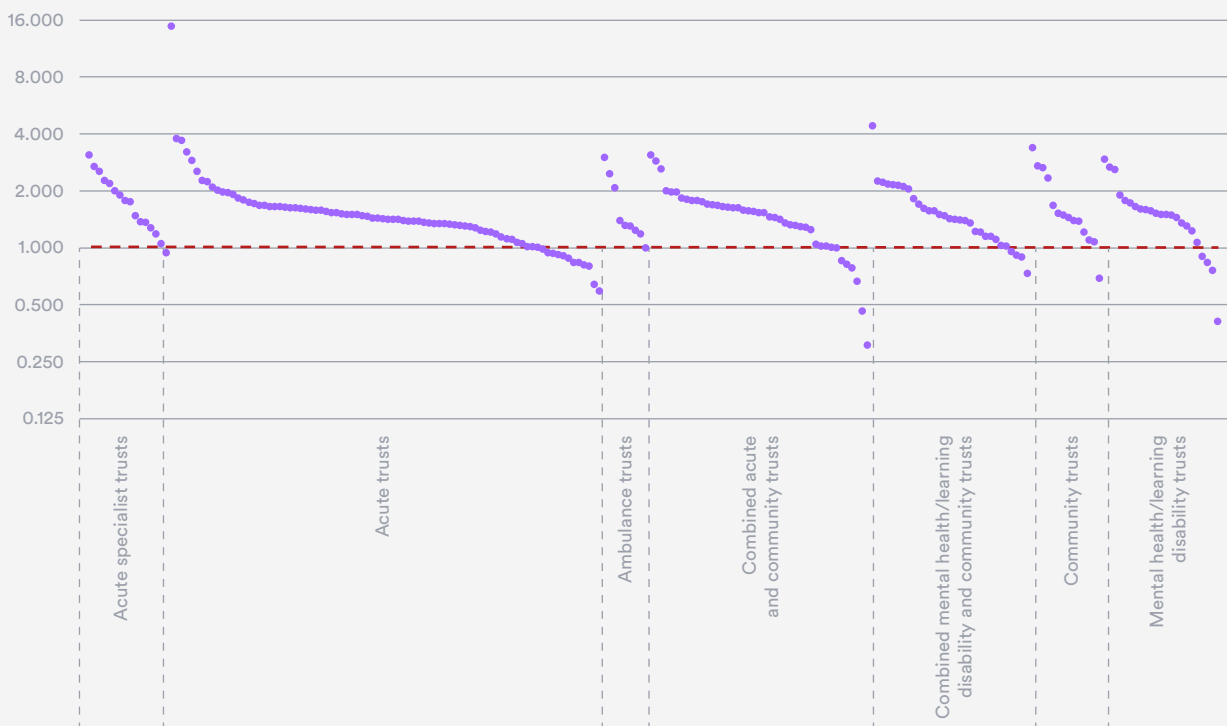
That said, some people we spoke to described the need to take “baby steps” in accounting for intersectionality, with concerns around capacity and the need to first take stock of disparity for just single protected characteristics. For them, the main focus remained on continuing to capture and measure the core ethnicity and disability data (on the Workforce Race Equality Standard and Workforce Disability Equality Standard respectively). One trust had gone further and established its own Workforce Equality Standard for lesbian, gay, bisexual and transgender (LGBT+) staff. As we imply in the recommendations we put forward in Chapter 5, if individual employers do not have the data collection tools, or the capacity to look at intersectionality or other confounding factors that might influence headline figures, then – given its importance – this role could be assumed at the system, regional or national level.

### **Regional, sector and organisational trends and variation**

National figures are unlikely to suffice for driving actual improvement in equality, diversity and inclusion. Some data – including the Workforce Race Equality Standard measures – are made readily available at an organisational level. In recent years, there has also been a marked push to drive up local and regional understanding, and analysis of inequalities in the workforce through, for example, regional NHS England equality leads and Workforce Race Equality Standard equality leads. But being able to drill down below national indicators is not always possible and interviewees recognised that the nature

of the challenge will vary by sector and organisation. This is problematic. For example, stakeholders noted that there were particular issues around participation within the ambulance sector, which has a low proportion of minority ethnic staff (WRES Implementation Team, 2020). Where there are data at sector and organisational levels, there is wide variation; for example, the likelihood of Black and minority ethnic staff being appointed from a shortlist differs starkly when compared with that of White staff (see Figure 10).

**Figure 10: Relative likelihood of White staff being appointed from a shortlist compared with Black and minority ethnic counterparts**



Notes: Each dot represents data from a Trust; they are presented categorised by Trust type and ordered by level of apparent disparity. The data did not include the numbers shortlisted or appointed – rather the percentage – so we are not able to account for random chance. Plotted on a logarithmic (base 2) scaled axis so that half likelihood (that is, 0.5) and double likelihood (that is, 2) are equidistant from equal likelihood (that is, 1).

Source: WRES Implementation Team (2020).

So the challenge of understanding discrimination should not stop at just sector-level analysis. Organisational, service and even more granular-level factors also influence levels of discrimination. But as highlighted earlier, when disaggregating data, the numbers can get small and it is difficult to interpret

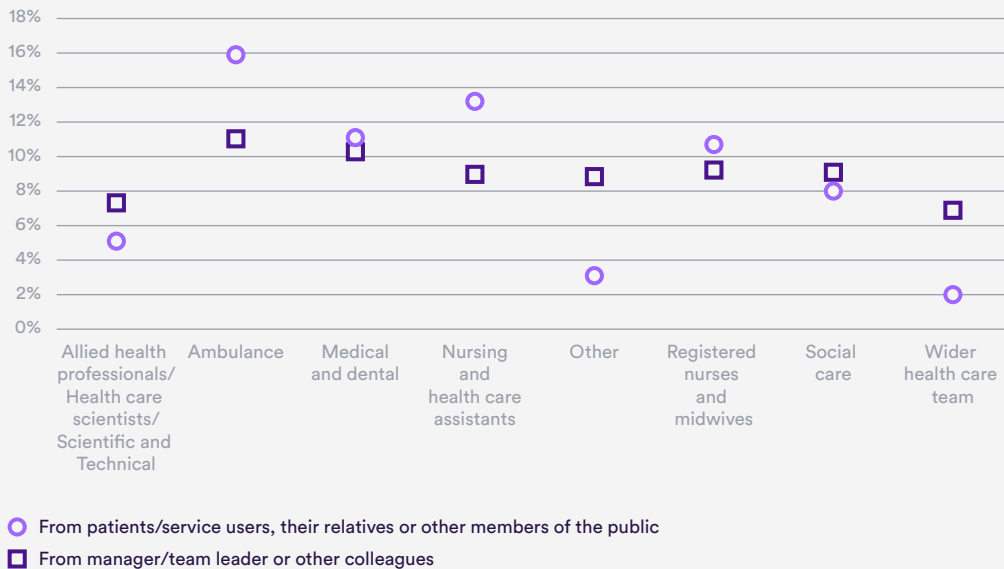
differences in these instances. Quantitative data alone will therefore not be sufficient to investigate potential issues and organisations will have to use a range of other measures and sources, including but certainly not limited to: post-recruitment interviews at three and six months; exit interviews; staff focus groups; speak-up ambassadors; staff-side chairs; and staff networks.

## Understanding challenges by staff group

Discrimination also needs to be understood at the level of individual staff groups. Taking data from the 2020 NHS Staff Survey, the proportion of staff experiencing discrimination at work from their colleagues varies, from 7% in the wider health care team (for example, administration and ancillary staff) to 11% for ambulance staff (see Figure 11; see Figure 20 in Appendix 2 for a more detailed chart disaggregating the data by basis of discrimination). Our previous analysis revealed that, while most staff groups have an under-representation of Black and Black British staff in senior management roles, it is particularly stark for nurses, doctors and those working in hotel, property and estates (Rolewicz and Spencer 2020).<sup>7</sup> The analysis also highlighted the much lower proportion of Black ethnicity staff in some professions, such as ambulance staff (1%) and ambulance support staff (2%).

<sup>7</sup> Agenda for Change Band 7 and above, or at consultant level for doctors.

**Figure 11: Percentage of staff experiencing discrimination at work in the previous 12 months, by staff group**



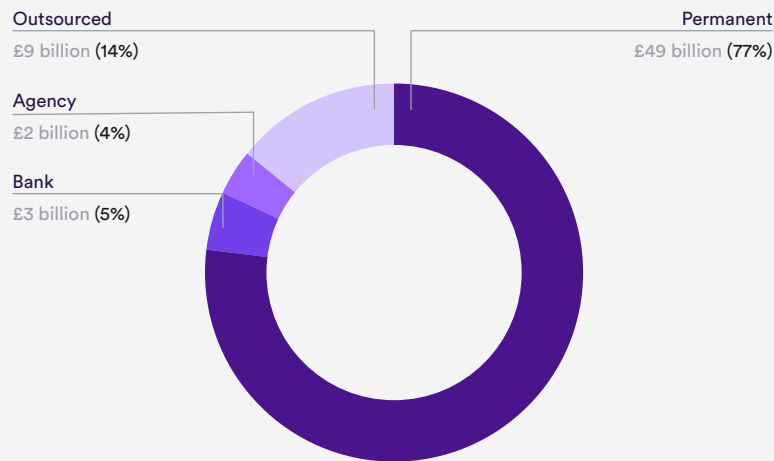
Note: Wider health care team refers to administration and clerical, central functions/ corporate services and maintenance and ancillary staff.

Source: NHS Survey Coordination Centre (2021a).

Discrimination across staff also needs to be considered by type of employment. While exact numbers of such staff are unclear, more than £1 in every £5 of employee costs may be spent on temporary or outsourced staff (see Figure 12). One interviewee noted that regarding their organisational work on equality, diversity and inclusion, outsourced staff received less attention as a specific group, and that their trust had previously had a clinical lead (a nurse matron) to support bank staff. Where a subsidiary that the trust wholly owns provides a service, there may be clearer sight of, and attention to, diversity issues but we heard that this is often not the case for outsourced staff.



**Figure 12: Estimated employee costs, by type of contractual engagement, 2018–19**



Notes: For the purpose of indicating the order of the magnitude of costs, we assume ‘outsourced’ includes: purchase of health care from other providers; purchase of social care; clinical supplies and services (excluding drugs costs); general supplies and services; premises; and consultancy.

Source: Nuffield Trust analysis of 2018–19 provider financial returns: NHS Improvement (2020).

As discussed later in this report, the NHS Standard Contract sets out a number of conditions that trusts are expected to meet with regards to equality, diversity and inclusion in their workforce. It does not draw a distinction between the directly employed workforce and staff sourced through other means (NHS Standard Contract Team, 2021). Although one might reasonably assume that the conditions are intended to cover all staff, this absence of clarity is unhelpful.

Trade unions such as UNISON have made calls for NHS trusts to go further in advancing equality and diversity in their workforce. They recommend that NHS trusts take responsibility – as anchor institutions – for the local labour economy that they draw from, which includes casual and temporary staff, and embed criteria and board-level scrutiny of the impact on underrepresented groups into key decisions on outsourcing. NHS Employers have also noted that the health service, as the largest employer in England, can play a key role in providing good employment opportunities for all (NHS Employers, 2021c).

## Understanding causation and the nature of the problem

Given the complexity of the challenges – considering confounders and unclear causation in some areas – the NHS at national, regional, system and local levels needs to have greater qualitative understanding. A key example of this is understanding why the likelihood of being appointed from interview remains low for disabled compared with non-disabled candidates, for example by examining the management of the Disability Confident scheme at trusts (Moore and others, 2020). Some interviewees reported working with external experts to understand staff’s reasons and motivations for applying for jobs and surface other challenges to inform future recruitment. In some trusts this includes surveys in place for new hires at induction, at three months and at six months to understand the extent to which organisational values are lived in practice. Other trusts have relied on focus groups to gain a deeper insight into harassment, bullying and discrimination. One interviewee noted that regarding disabled applicants, “the drop from shortlist to appointment was so stark... that you knew there was a human factor at work, and I’m using these words consciously”. Qualitative approaches or other safeguards are therefore particularly important where statistical approaches to identifying issues are less useful and also when absolute numbers in a staff group are low.

## Understanding the range of outcomes

As noted earlier, discrimination is apparent throughout the career pathway and work experiences. While attention has focused on increasing the proportion of diverse staff at senior and very senior bands, the entire pipeline merits investigation to draw out where similarly critical stages are, whether that be at the start – attracting people to apply for clinical training – or later down the line, in terms of progression and retention.

However, there are only limited data on some aspects of the career pathway. For example, national apprenticeship data only measure starts and completions, not the number who gain subsequent employment in their intended role (Department for Education, 2020). More broadly, information on participation and – at the other end of the career pathway – reasons for

leaving is patchy even in overall terms, let alone disaggregated by protected (or other) characteristics and by region or employer.

Just taking selected questions from the 2020 NHS Staff Survey, it is clear there is a mixed picture regarding the experiences of discrimination across different measures, even for the same characteristic (see Figure 13). While there are typically some stark disparities, the whole message is often nuanced and this is even before trying to look at the interplay between and influence of other characteristics. The picture is complicated further given there may be particular local equality, diversity and inclusion measures. This was reflected in interviews with trusts, who identified particular challenges within and across their sites.

Figure 13: Relative likelihoods of various responses to the 2020 NHS staff survey responses, by selected characteristic

		Satisfaction with...				(Q17b): I would feel secure raising concerns about unsafe clinical practice	(Q10c): On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	(Q11c): During the last 12 months have you felt unwell as a result of work related stress?	(Q15a): In the last 12 months have you personally experienced discrimination at work from patients/ service users, their relatives or other members of the public?	(Q15b): In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?	(Q20a): Have you worked on a Covid-19 specific ward or area at any time?	(Q20b): Have you been redeployed due to the Covid-19 pandemic at any time?
		(Q5b): The support I get from my immediate manager	(Q5f): The extent to which my organisation values my work.	(Q5g): My level of pay	(Q5h): The opportunities for flexible working patterns							
Gender (vs male)	Female	0.99	1.00	0.95	1.04	1.04	0.97	1.13	0.77	0.88	0.83	0.89
	Prefer not to say	0.71	0.55	0.60	0.77	0.78	1.02	1.53	1.22	2.00	0.88	0.95
	Prefer to self-describe	0.87	0.82	0.76	0.89	0.90	0.99	1.37	1.65	2.02	1.03	1.10
Age band (vs 31–40)	16–20	1.03	1.23	1.05	0.98	0.92	0.36	0.87	0.66	0.68	0.85	0.77
	21–30	0.99	1.02	0.88	0.85	1.00	0.81	1.09	1.21	0.82	1.16	1.11
	41–50	0.98	1.00	1.07	1.01	0.99	1.08	0.98	0.79	1.00	0.92	0.95
	51–65	0.96	0.94	1.05	0.94	0.96	1.02	0.91	0.53	0.89	0.74	0.81
	66+	1.01	1.15	1.27	1.05	0.95	0.75	0.56	0.36	0.78	0.47	0.56
Religion (vs no religion)	Any other religion	1.00	1.02	0.84	1.00	0.99	0.92	1.09	2.29	1.96	1.21	1.13
	Buddhist	1.01	1.14	1.06	1.04	0.99	1.00	0.98	2.57	1.97	1.31	1.24
	Christian	1.03	1.11	1.04	1.06	1.01	1.03	0.93	1.62	1.37	1.09	1.06
	Hindu	1.04	1.30	1.14	1.09	1.01	1.00	0.69	2.48	2.26	1.43	1.17
	Prefer not to say	0.81	0.69	0.75	0.82	0.82	1.10	1.25	1.97	2.47	1.06	1.05
	Jewish	1.02	1.09	1.16	1.08	1.01	1.25	0.93	1.20	1.68	1.07	1.34
	Muslim	1.02	1.24	0.98	1.01	0.99	0.85	0.89	2.92	2.52	1.35	1.06
Sikh	1.02	1.24	0.93	1.07	0.97	0.95	0.80	2.19	2.15	1.07	0.90	
Disability (vs no such condition)	Staff with long-term condition(s)	0.92	0.77	0.79	0.89	0.92	1.03	1.55	1.13	1.88	0.77	0.94
Ethnicity (vs white)	Asian	1.02	1.26	0.97	1.06	1.00	0.82	0.86	3.91	2.45	1.64	1.37
	Black	1.01	1.14	0.71	1.04	0.98	0.90	0.87	5.19	3.03	1.41	1.12
	Mixed	0.95	0.98	0.87	0.95	0.96	1.00	1.11	3.35	2.28	1.20	1.22
	Other	0.93	1.03	0.92	0.94	0.91	0.95	1.08	3.61	2.89	1.51	1.34

Note: Red denotes negative performance compared to the reference group, whereas green is for more positive outcomes.

Source: 2020 NHS Staff Survey: NHS Survey Coordination Centre (2021a).

## 3 Identifying the solutions

Many of the actions that trusts are taking to improve diversity and inclusion in the NHS are beginning to gain traction and wider recognition. For example, the majority of trusts have signed up to the government's Disability Confident employer scheme;<sup>8</sup> many are part of regional equality, diversity and inclusion networks; and two trusts and the NHS Business Services Authority were recognised in Stonewall's Top 100 UK Employers for 2020 (Stonewall, 2020).<sup>9</sup> While less is known about improvements regarding the employment of people from low-income backgrounds, two trusts were recognised in the Social Mobility Foundation's annual Employers Index between 2017 and 2019 (Social Mobility Foundation, 2019).

However, there remains more work to be done. In this chapter we explore the opportunities available to NHS bodies in their journey to identify effective initiatives and strategies that advance diversity and inclusion. We also highlight some of the challenges they have encountered in determining what works in their local communities.

### Range of mechanisms

Our document review and interviewees pointed to a number of interventions and initiatives that trusts are involved in. Many have stressed the importance of addressing and mitigating bias at every stage of career pathway – from job design, through to shortlisting, interviews, appointment, development opportunities and promotion.

8 Designed to get employers to take action to improve how they recruit, retain and develop disabled people.

9 Based on the benchmarking of employers' progress on LGBT+ inclusion in the workforce.

However, as each context is different, it is important that initiatives are designed to suit local needs. We heard that, to date, interventions around equality, diversity and inclusion have typically focused on policies, procedures and training; in isolation these are unlikely to make a material difference (Dobbin and Kalev, 2016) and so employers need to think more broadly. For example, culture change that creates collective engagement from individual experience is likely to be imperative (Bolden and others, 2019; Moore and others, 2020), alongside investing in analytics and further embedding accountability and transparency at organisational, team and individual level (Kline, 2021a).

Figure 14 is not comprehensive but designed to illustrate the art of what is possible and, more than that, the potentially overwhelming array of options available. It assumes that key decision-makers within trusts have identified the problems and opportunities, accepted them and have the will and resources to address them. It is important to note that individual employers do not have full control over some of the options included – for example, accessibility of job listings on NHS recruitment websites – but may be able to apply their influence to advocate for broader system changes and approaches in other ways (NHS Business Services Authority, no date; Trac, 2020). Further examples of initiatives to improve fair recruitment and career progression have been documented in a recent review (Kline, 2021a).

**Figure 14: Examples of initiatives to address inequalities**

 <h3>Governance and oversight</h3>	
Recruitment strategy	'Recruiting for difference' programme for key senior posts
Roles and responsibilities	Clear line of sight from EDI managers to CEO; board adoption of Yvonne Coghill's 7 A's of Allyship model
Capacity	Work with experts/charities/consultancies
Priority	Dedicated sessions at Operational Board and Clinical Management Board meetings
Monitoring and data	Task groups using QI methods (eg Plan Do Study Act approach)
 <h3>Attraction (pool of candidates)</h3>	
Outreach	Partnerships with higher education institutions/schools/FE academies
Campaigns	Social media channels
Job preview resources	Shadowing
Incentives	Refer a friend/golden hello and monitor usage by groups sharing protected characteristics
Developing own pool	Pre-employment programmes
 <h3>Job design, advertising post and applications</h3>	
Medium for job advertising	Social media postings and use of trade publications that may reach wider or underserved pool
Job advert wording	Offer (hybrid) flexible working; Embracing Difference campaigns with existing staff biographies
Experience and qualification requirements	Years of experience not dates on CV
Accessible format for applications	Paper application forms in easy read or large print



## Shortlisting

Scoring and decision-making	Monitor effectiveness of positive action initiatives, such as the Disability Confident Employer (ie. Guaranteed Interview Scheme) and Model Employer targets for minority ethnic representation at band 8a and above
Number shortlisted	Ensure more than one woman is shortlisted
Demographic data collected and reviewed	Internal HR checks on whether guaranteed interview scheme met and challenges brought to recruiting line manager if needed



## Interviews/assessment process and selection

Encourage and support requests for reasonable adjustments	British Sign Language interpreter; allow interviewee to bring their own interview answer cards
Scoring and decision-making	Standardised scoring forms for assessment centres, to offer candidate feedback
Approach and exercise types	Values, strength-based; group-based, role play, work sample tests and verbal and numerical reasoning
Training, standards and tools used	Diversity training and cultural competence training for recruiting managers
Panel composition	Diversity of panel; Inclusion Ambassador on panel



## Appointment

Agree pay level	If salary is negotiable, communicate the salary range on offer
Agreeing conditions	Work patterns
Feedback	By panel and by candidates, provided in a timely manner



## Induction/'onboarding'

Support	Buddying/mentorships/preceptorships
Regular interviews	To seek feedback and offer support, at 3 and 6 months to identify any issues
Data collection	Self-service ESR





## On-going support

Clarity on expected behaviours and support available	Regular reviews of zero tolerance policies and social media policies
Service-wide	Dignity at work campaigns; anti-racism influencers groups
Individual	'Gold standard' risk assessment tools to support organisations to undertake meaningful occupational health assessments; staff-side chair
Group based/specific characteristics	Staff networks
Ad hoc	BAME Covid-19 Speak Up ambassador



## Pay and conditions

Appraisal	EDI content in appraisal training and EDI element to talent management training for managers
Pay progression	Organisational reporting on ethnicity pay gap in line with gender pay gap reporting
Flexible work opportunities	Flexible leave for carers
Review disciplinary cases/formal capability processes	Just Culture approach and accountability nudges; Cultural Ambassadors program



## Staff development and progression

Training and CPD	Analysis of uptake of CPD by demographic groups
Leadership opportunities	Bespoke talent management schemes; succession planning (including review of demographic projections)
Reward and benefits	Transparency over promotion, pay and reward processes



## Leavers

Opportunities for older staff or those who have taken extended career break	Return to work schemes
Understanding reasons	Review of exit interviews

Sources: Appleby and others (2021); Coghil (2020b); Dorset Healthcare University NHS Foundation Trust (2020); Durairaj (2020); Government Equalities Office (2017); NHS Employers (2021a); NHS England and NHS Improvement (no date c); Nuffield Trust interviews; Sealy (2020); Sheffield Teaching Hospitals NHS Foundation Trust (2017); The Behavioural Insights Team (2020); Women and Work All Party Parliamentary Group (2020).

## The difficulty of understanding what works and the importance of evaluation

Trusts are using a multiplicity of interventions to address challenges at each stage of the career pipeline. However, it can be hard to isolate and understand the impact of strategies, which may vary between staff groups, protected characteristics, pay bands, settings and services (Kline, 2021a). Understanding the impact of any single intervention is made more complex by the fact that trusts are implementing a number of interventions simultaneously. Moreover, the Chartered Institute of Personnel and Development (CIPD) reported ‘a paucity of rigorous and relevant research on how to meaningfully advance D&I [diversity and inclusion] in organisations’ and that while this should not prevent employers taking action, further robust evaluation of the effectiveness of strategies is needed (Chartered Institute of Personnel and Development, 2015; 2019).

Despite the importance of evaluation, there has been no central funding committed to support trusts to independently evaluate and monitor their initiatives to determine their effectiveness, identify improvements and find out how appropriate they are for other settings. In the absence of funding for this purpose, one trust was exploring the potential to partner with a local university in order to evaluate their interventions. Furthermore, local equality, diversity and inclusion staff can lack the skills, responsibilities, capacity or support to systematically evaluate the impact of the programmes and initiatives they implement.

Many (especially small-scale) interventions are not easy to evaluate due to challenges such as limited data against which to measure outcomes.<sup>10</sup> Such challenges limit opportunities for making a strong business case for further funding to sustain and mainstream interventions, and to embed them into business as usual. Developing the skills and capability of equality, diversity and inclusion teams in monitoring and evaluation, and quality improvement, has the potential to generate good-quality evidence, strengthen the case for embedding interventions into practice, encourage organisational buy-in (Chartered Institute of Personnel and Development, 2019) and facilitate

<sup>10</sup> See for example *Planning Evaluability Assessments* (Davies, 2013).

the adaptation of interventions for other settings. Evaluation and quality improvement skills development for equality, diversity and inclusions leads could furthermore help address some of the career development and progression barriers discussed in the next chapter (Alderwick and others, 2017; Worsley and others, 2016).

In this light, the success of previous efforts to embed quality improvement methods suggests that making funding and capacity available to support such skills development is worth revisiting. In 2018, the national Workforce Race Equality Standard team worked with five trusts, piloting a way to make improvements on a number of indicators relating to workforce race equality (WRES Implementation team, 2018). These trusts adopted a Model for Improvement methodology, where changes are tested on a small scale using Plan-Do-Study-Act (PDSA) continuous cycles (Institute for Healthcare Improvement, no date). We also heard that some interviewees were taking their own steps to use quality improvement methodologies to strengthen their evidence base. One trust had started to move away from using historical data on staff satisfaction, to instead regularly collect data on staff experience and wellbeing through a quality improvement app, in order to measure staff self-reported happiness and the number of contacts with the trust's wellbeing prescribing service.

Interviewees pointed to a number of promising initiatives they felt represented good practice, although few have been independently evaluated. For example, one trust had trained inclusion ambassadors to support equality and diversity in the recruitment process (see Case Study B). Across the literature more broadly, the strength of evidence is mixed with, for example, an apparent divergence of views on the effectiveness of recruitment without names or any other identifying factors (The Behavioural Insights Team 2020; Makoff-Clark, 2019), while evidence on the effectiveness of various interventions to improve gender equality appears more advanced (The Behavioural Insights Team, 2018).<sup>11</sup>

11 These include targeted referrals inviting women to apply; listing experience in terms of years rather than dates; highlighting support for shared parental leave; and advertising salary ranges to encourage salary negotiation.

There is no single, coordinated repository of evidence-based interventions for addressing the inequalities evident in the workforce that are reliably effective in NHS settings. As part of our recommendations (p.73), we suggest that given the nature of the issue this gap could in fact be addressed by the Cabinet Office, so more directly benefitting all public services. Such an endeavour might help address concerns of a growing number of experts who advocate for an end to evidence-free interventions (Kline, 2021b). We did not seek to provide a library of proven equality initiatives. However, recent case examples can be found in the following publications:

- *Workforce Race Inequalities and Inclusion in NHS Providers* (Ross and others, 2020)
- *Inclusive Recruitment: Leading positive change* (NHS Employers, 2021a)
- *Understanding LGBT+ Employee Networks and How to Support Them* (Einarsdóttir and others, 2020)
- Cochrane reviews of workplace interventions, for example Geoffrion and others (2020).

There may also be some learning for the NHS from initiatives in higher education, such as the Athena Swan Charter (Graves and others, 2019), and in the fire and rescue service (Local Government Association, 2019).

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### Case Study B: Inclusion ambassadors

In 2019, Barts Health piloted an Inclusion Ambassadors programme in its nursing and midwifery service. It started training inclusion ambassadors to sit as equal members of recruitment panels for all nursing and midwifery appointments at Band 8 and above. These individuals were trained to identify bias or discrimination, and where necessary to clarify and challenge decisions that the interview panel made. While the chair of the panel has the final say regarding appointment, the inclusion ambassador role offers an opportunity and route to flag any concerns.

After one year of the programme, the trust saw increased movement for minority ethnic staff compared with White staff for clinical Bands 8b and 8c (Barts Health NHS Trust, 2020).

After two years, the trust deemed the intervention successful in helping to address longstanding disparities in the likelihood of the appointment of minority ethnic staff. Recognising that there is still much more to do, there was an appetite to scale the intervention further within the trust, and it was therefore adopted into the standard operating procedure for the trust for all appointments at Band 8a and above. To date, 170 inclusion ambassadors have been trained and two challenges have been made during recruitment processes, resulting in two changes to recruitment decisions.

The trust has not yet independently evaluated the programme but considers there to be limited repercussions in the event that the inclusion ambassador disagrees with the senior officer in charge of recruitment. However, Barts Health recognises that this is only one lever, which it believes must be complemented by mandatory training on equality and inclusiveness in recruitment practice, for any staff sitting on a recruitment panel.

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Source: Barts Health.

## Unintended consequences and unexpected challenges

Evaluation can also be critical to identifying and understanding the unintended consequences of different options (Scott and others, 2003), and allows trusts to change course. For example, one interviewee reflected on how their talent management plan benefited already privileged groups, resulting in “more White, male, middle-class leaders across the organisation, the complete opposite of what we wanted”. As a result, they focused on identifying talent much earlier in the career pathway. Another interviewee recognised that, as a result of limited progression opportunities at their trust, individuals who had successfully completed career development programmes would move on to roles at new employers (albeit usually still within the NHS). Employing an iterative process to understanding what works was suggested as a way of identifying risks and unintended consequences and allowing organisations to adapt accordingly.

There is also a challenge for the NHS to keep abreast of emerging evidence and changing schools of thought. Unconscious bias training has commonly featured in many organisations’ strategies to build more inclusive workplaces. However, recent reports suggest that it may not be effective in changing attitudes in a lasting way, with evidence on whether it changes behaviours or improves workplace equality inconclusive and suggestions that in some instances it may cause unintended backfiring effects (The Behavioural Insights Team, 2020). This uncertainty around the effectiveness of unconscious bias training highlights a need to ‘continually evaluate the effectiveness of diversity and awareness training’ (Chartered Institute of Personnel and Development, 2019, p. 28). The challenges in navigating and understanding the evidence base were reflected in our interviews, with different opinions expressed around the effectiveness of unconscious bias training.

Interviewees reiterated the need to gain staff buy-in when implementing interventions and some of the challenges of doing so. We heard that the Covid-19 pandemic has “shown up real rifts”, with resistance from existing staff who perceived interventions such as staff Covid risk assessments as ‘unequal’ treatment. Similar reports of ‘animosity and stigma’ regarding risk assessments have also been documented in recent research (Farah and Saddler, 2020). Even

before the pandemic, interviewees cited examples of resistance to diversity initiatives, which had been perceived as exclusionary or inappropriate, such as: a job advert explicitly inviting applications from people with protected characteristics; a talent management programme designed for minority ethnic staff; and a staff newsletter about an LGBT+ history month. Engaging with staff about the design of interventions can help to bring resistance and individual and systemic biases to light, which can then be worked with as part of implementation (McKimm and Wilkinson, 2015; Ross and others, 2020). For example, one trust described how its LGBT+ network had established a two-part agenda, with a closed agenda for the core membership, followed by an open agenda for all staff, which was felt to encourage allyship. Positioning staff as the owners and drivers of change has been identified as a key component in achieving high staff engagement with new initiatives, mitigating resistance to change and ensuring their success (Bolden and others, 2019; Scott and others, 2003).

## Transferring and adapting promising practice to new settings

To date, the roll-out of initiatives has been uneven and further research is needed to understand which interventions are transferrable between people sharing protected characteristics and between different services, occupations and pay bands; and whether interventions are deliverable to outsourced (non-directly employed) staff.

Some stakeholders recognised an opportunity to scale initiatives within-sector, with one noting the greater similarities between ambulance trusts compared with other trusts in a region. However, they noted that this would require the sharing of practice and resources across system boundaries and it would therefore need to involve regional or national forums. Certainly, there appears scope for more work to ensure that evaluated good practice is well communicated and accessible to equality, diversity and inclusion teams across the NHS.

## Networks

Much policy attention has been focused on staff networks, with all trusts now required, through the People Plan 2020/21, to have governance processes for their networks in place so that they can contribute to decision-making. Networks are also encouraged to ‘look beyond the boundaries of their organisation to work with colleagues across systems, including those working in primary care’ (NHS England and NHS Improvement, 2020b). However, across the trusts we spoke to, we heard that scaling initiatives to new settings can present challenges. The effort and process of establishing a staff network where no similar forum existed before, and maintaining engagement, should not be underestimated.

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**What my board decided to do was persuade our staff to form staff networks, supporting the trust to better deal with inequalities... Now we have very powerful staff networks; we’re in the process of forming one for spiritual and pastoral care in addition to our BAME [Black, Asian and Minority Ethnic], Disability and LGBTQ networks. We’re moving fast in the right direction.**  
(Chair)

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It is important therefore that initiatives such as networks are not ‘one size fits all’ but supported to suit local needs (Chartered Institute of Personnel and Development, 2019; Ross and others, 2020), with the flexibility to shape their own aims, agenda and format. This is particularly true given that a multiplicity of initiatives will often have to be adopted concurrently and there may well be unexpected interactions across broad strategies. One trust described its minority ethnic staff network evolving into a weekly lunchtime peer support group during the pandemic, and the use of its disability network as a forum for testing inclusive recruitment initiatives. Another trust spoke of its LGBT+ network focusing on education raising and “myth-busting”; its Black and minority ethnic network being “issues-led”; its disability network focusing on “small differences” achieving impact; and its Armed Forces network emphasising celebration and remembrance and creating opportunities to recognise other skillsets. Such differences may be welcome but come with challenges:



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[Each network has] their own sort of personality... So, it's quite an eclectic mix that can be quite challenging at times in terms of managing and sometimes can be frustrating for me...

(Director of people and organisational development)

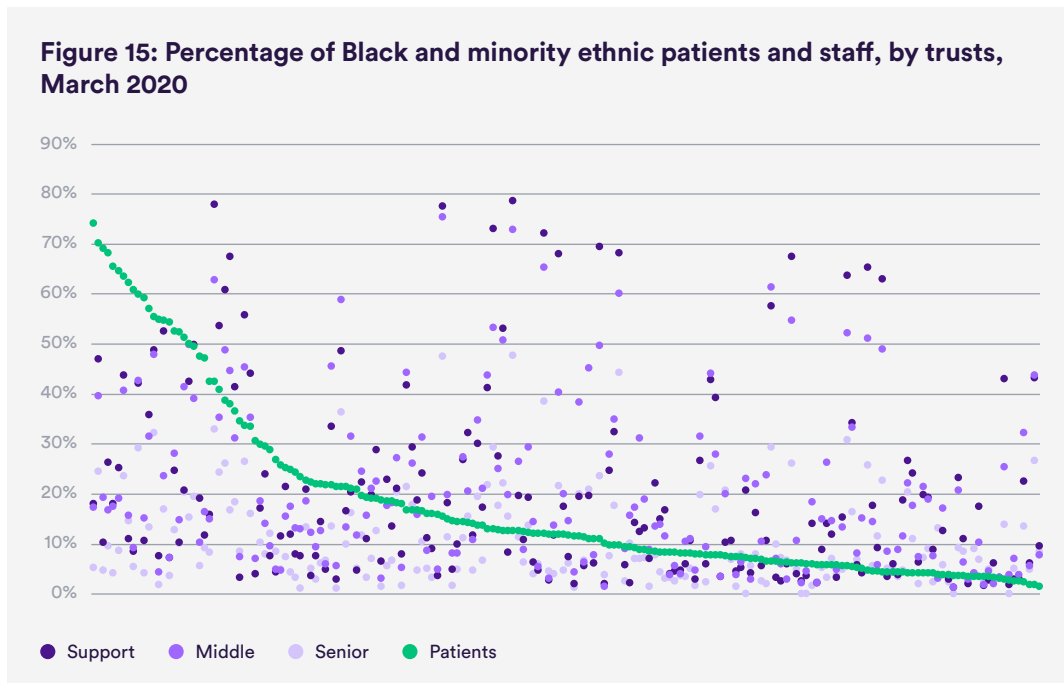
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## The NHS as a solution

NHS employers as organisations themselves can also offer solutions to wider issues. The term 'anchor institution' refers to large, typically public sector organisations unlikely to relocate, whose long-term sustainability is tied to the wellbeing of the population they serve. Previous work has noted the potential for NHS organisations to act as anchor institutions in their local communities to 'positively influence the social, economic and environmental conditions in an area to support healthy and prosperous people and communities' (The Health Foundation, no date). This has obvious potential benefits for inclusion and diversity, as seen at a number of trusts and integrated care systems (NHS Employers, 2021c).

One union has recommended that the NHS should undertake 'active outreach to local communities to create high quality career pathways targeting excluded or under-represented groups, ensuring routes such as apprenticeships are high quality with good pay and commitment to onward employment' (UNISON, no date). Our interviews and stakeholder calls suggest that many trusts are taking this potential role seriously. For example, one trust's ambition is to advance its social values agenda through the creation of 1,000 pre-employment opportunities with further education partners by 2025, and a key performance indicator on the recruitment of people from the local community considered furthest away from employment (Northern Care Alliance NHS Group, 2021). However, as we discuss later, many trusts are hamstrung by limited resources and challenges in coordinating with a large number of organisations, including those in the education sector. Integrated care systems – new partnerships between the organisations that meet health and care needs across an area – have the potential to exploit their larger footprint and influence to have an even greater impact as anchor organisations.

To explore inclusion further, we looked at how the characteristics of patients compared with staff, disaggregated between support, middle and senior grades. Overall, roughly half of trusts had more Black and minority ethnic support staff and middle-grade staff (49% and 55% respectively) than patients, although their senior staff were more diverse than patients in just a third (33%) of organisations. However, as Figure 15 shows, the variation between trusts is vast, suggesting there is further scope to improve as anchor institutions and, in doing so, ensure an appropriately diverse and inclusive workforce.



Notes: Definitions: support (Bands 1–4), middle (Bands 5–7) and senior (Bands 8a–9). Excludes 34 mental health, ambulance and community trusts where we did not have patient data.

Sources: Hospital Episode Statistics (HES), Inpatient spells from 1 February 2020 to 31 January 2021, Table 1.2: Clinical (Non-medical) Workforce Skill Mix by Skill Mix and Ethnicity; Workforce Race Equality Standard 2020 Strategic Data Collection Service returns (NHS Digital Strategic Data Collection Service, 2021).

## 4 Resources for implementing interventions

Trusts we spoke to typically had bold ambitions for addressing inequalities but interviewees acknowledged that they would need sufficient time, staff and resources in order to collect and analyse data on their unique challenges, establish initiatives and interventions, monitor and evaluate their impact, and sustain them. Certainly, where the conditions outlined in the previous two chapters are in place – that is, the issues are understood and the solutions have been identified – which in itself will require resources, there is still a challenge to implement them.

We do not seek to describe methods for implementation – such as the need for clear and consistent communications and clarity around the rationale for change (NHS Confederation, 2019) – as the exact approach will be specific to the context. However, we make the case that there needs to be sufficient resources and appropriate governance in place.

We heard that the pandemic presented challenges in terms of implementing improvements. Some planned and existing work to deliver on equality action plans, such as inclusive recruitment initiatives and pre-employment programmes, were halted or paused as a result of the pandemic. That said, some interviewees noted that the focus had merely shifted, with other equality, diversity and inclusion-focused activity happening as a result of the pandemic. We draw out some specific effects of the pandemic below.

## Governance

It may seem irrelevant to discuss governance in a chapter about capacity but it is about how resources are organised and incentivised and, therefore, good governance is again a key condition to address equality, diversity and inclusion issues.

### Leadership and priority

The culture of an organisation is set from the top. As we noted earlier in this report, the NHS operates within the context of a wider society in which structural discrimination is real. Leadership visibility and engagement are crucial to driving change and managing competing organisational priorities (Kilbane and others, 2020). To be successful in establishing cultures within their organisations that are inclusive and which value diversity, leaders within the NHS will need to acknowledge and address their own learning needs, and to take informed action alongside their system partners (Amin and others, 2018; Bolden and others, 2019).

The importance of, and power held by, leadership in addressing discrimination is stated clearly in policy ambitions. The NHS People Plan 2020/21 sets out an expectation that:

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**By March 2021, NHS England and NHS Improvement will have published competency frameworks for every board-level position in NHS providers and commissioners. These frameworks reinforce that it is the explicit responsibility of the chief executive to lead on equality, diversity and inclusion, and of all senior leaders to hold each other to account for the progress they are making.**

(NHS England and NHS Improvement, 2020b, p. 26)

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The role of leadership in driving cultural and organisational change has been recognised in the development of various leadership programmes over the past decade. Programmes developed by the NHS Leadership Academy, such as Building Leadership for Inclusion, have explicitly focused on equality,

diversity and inclusion through skills and capacity building to enable leaders to create and support inclusive cultures and systems at all levels (Hart, 2019; NHS Leadership Academy, no date a). Some, such as the Stepping Up and Ready Now Programmes (NHS Leadership Academy, no date c), have also been open specifically to applicants from Black and minority ethnic backgrounds, in an attempt to address the barriers to progression for diverse staff at a senior level. The Culture and Leadership Programme, recently expanded with a stronger commitment to addressing equality, diversity and inclusion issues, has highlighted the value of compassionate and person-centred leadership in supporting staff to lead and own culture change within trusts (NHS Leadership Academy, no date b).

However, while we heard that some chief executives had embraced this responsibility, this is not always the case. One interviewee noted that in the year they had been in post, “if I’m honest with you, I’ve had zero senior leaders reach out to me”. At another trust, we heard there was potential for more consistent engagement from senior leaders: “As one consultant said... ‘Does everybody need to be a Mandela? Before we get heard?’”

The priority given to equality, diversity and inclusion among senior managers and leaders remains a key challenge. Some interviewees stressed the importance of having an executive sponsor present at the networks, enabling “the direct link to the board... [to demonstrate] we weren’t just paying lip service”. In order to address inconsistent ownership from senior NHS leaders on equality, diversity and inclusion matters, the ‘Our NHS people profession’ consultation (NHS England and NHS Improvement, 2021) proposed including equality, diversity and inclusion as an essential criterion for all levels of the recruitment, selection and appointment process for board and non-executive director roles; and the development of equality, diversity and inclusion metrics in annual appraisal processes for board-level accountability, with some suggesting that this should be monitored through 360-degree feedback from different staff groups.

Some trusts highlighted that the pandemic had served as both an enabler and a barrier, perceiving an increased focus and priority placed on equality and diversity initiatives, but at the same time, that staff capacity to implement more ambitious programmes of work had been impeded. Others interviewees spoke of a renewed sense of momentum that the pandemic had catalysed:

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**It has focused attention... it has highlighted the issues for people who haven't maybe seen them before. It has brought the issues into real clarity so that they can be addressed as a priority and that I think that is going to have fantastic impact... So there is absolutely that focus, because of Covid... but equally, we can't possibly deliver on that, because of the same thing.**

(Director of people and organisational development)

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**In the last year with Covid, with Black Lives Matter, particularly the BAME [Black, Asian and Minority Ethnic] network has seen an enormous increase in engagement, lots and lots more active members now who are who are speaking up and speaking to us.**

(Equality, diversity and inclusion lead)

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**Covid has amplified what we already knew anyway, and business cannot be as usual anymore.**

(Equality, diversity and inclusion lead)

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## **Accountability and regulation**

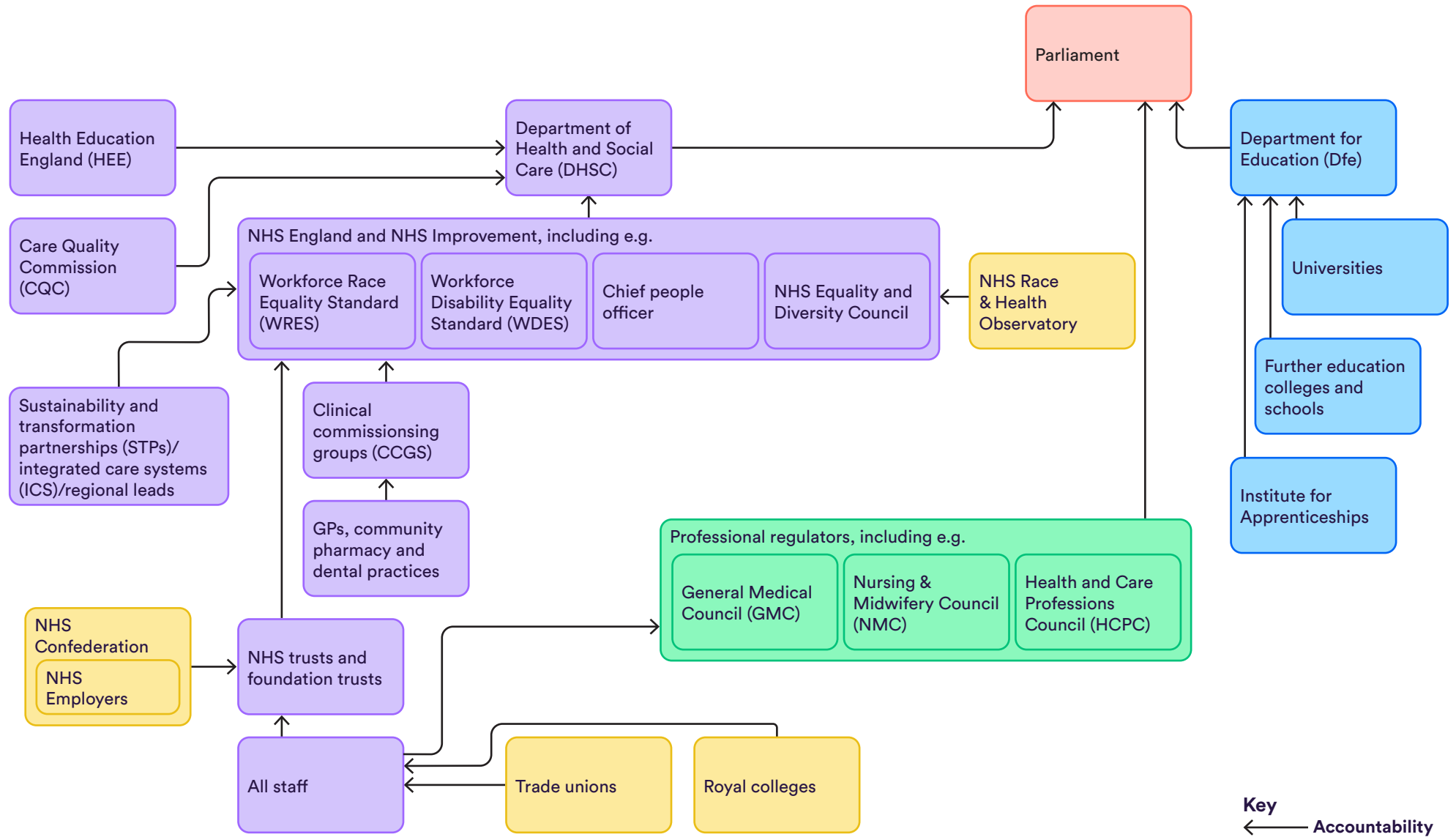
One way to get sufficient leadership buy-in is through appropriate accountability and regulation. Indeed, the existing literature points towards the importance of accountability and assurance in addressing discrimination (Kline, 2015; NHS Confederation, 2019; WRES Implementation Team, 2019). We have not sought to prescribe a theory of change, or recommended governance arrangements, for addressing equality, diversity and inclusion issues. Rather, we suggest that the basic principle of ensuring that responsibility, role, funding, influence and accountability are all aligned and transparent should strongly lead such considerations. While accountability is important, it must be applied in a reasonable, productive way. Much

as there is evidence that moving towards a just and learning – rather than blame – culture can help address the inequalities some staff groups face in the likelihood of facing formal discipline (Kline, 2021c), there is good reason to think that those with accountability for improving diversity within NHS employers should also be treated in primarily a supportive way.

Interviewees gave a number of reflections on the responsibilities of national and regional bodies (see Figure 16). One interviewee noted the disparate nature of accountability across the central bodies and national stakeholders, including NHS England and NHS Improvement, the NHS People Plan team, the national Workforce Race Equality Standard and Workforce Disability Equality Standard teams, and the NHS Confederation. In particular, we heard “there’s no shortage of money – the shortage is lack of structure”; one interviewee suggested that ownership of the inequalities agenda is a cross-governmental issue, which should sit at Cabinet Office level. Another interviewee noted that NHS England and NHS Improvement had appointed seven regional equality, diversity and inclusion leads, but queried the extent to which they collaborate. Another interviewee felt that support from the regional Workforce Race Equality Standard leads could be enhanced, with regional leads being appointed with availability and sufficient competencies to act as a ‘first port of call’ on specific challenges that individual trusts in their region faced. While these were individual opinions and we did not speak to their respective regional leads, the issues raised warrant further exploration.

Other national bodies and stakeholders also have vital roles to play. For example, the General Medical Council has set targets to address the disproportionate number of complaints from employers brought against minority ethnic doctors and to eradicate discrimination from medical training and education (Lacobucci, 2021). An independent review of the Royal College of Surgeons also proposes a number of recommendations to improve diversity among surgical staff and trainees (Kennedy, 2021). Some stakeholders, including the Health and Care Women Leaders Network, have also questioned the adequacy of the role of Care Quality Commission inspections with respect to equality, diversity and inclusion (Sealy, 2020).

Figure 16: Some key responsibilities



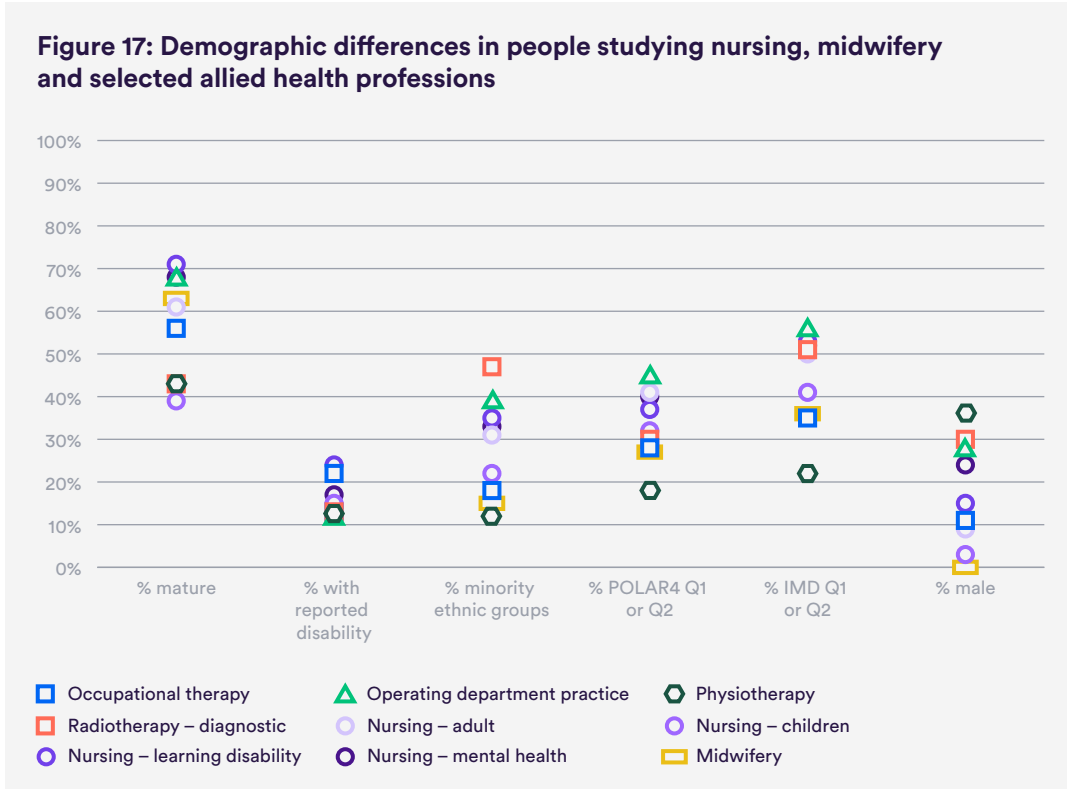
Notes: For the purpose of demonstrating some of the key responsibilities and relationships, we have not sought to include an exhaustive list of organisations.

Source: Nuffield Trust.



The changing organisational landscape and impending reforms to health and care also make pinning down accountability more challenging. The *Integration and Innovation* White Paper (Department of Health and Social Care, 2021a) makes no direct reference to equality, diversity and inclusion in the context of integrated care systems other than to recognise the importance of improving data, and equality is not referenced within the Secretary of State for Health and Social Care’s specific accountabilities on workforce.

Responsibility does not just sit within the health care sector; the data suggest that education is an important area too. For example, minority ethnic students are around four times less likely than other students to secure a place on an undergraduate physiotherapy course (12%) than a diagnostic radiology course (47%). Physiotherapy also has the highest levels of male participation (36%) and the lowest levels of staff from a lower socioeconomic class (just 22% fall within Index of Multiple Deprivation quintiles 1 and 2). Stark differences are also apparent for other characteristics such as gender, with low participation among men in nursing and midwifery in particular (see Figure 17). In addition, the lack of social diversity in medical schools persists, with the proportion of entrants to medicine coming from the most deprived areas increasing by only 5% in the decade to 2018 (Medical Schools Council Selection Alliance, 2018). The Department for Education and various representative bodies for education organisations must therefore be sufficiently involved in strategic discussions around equality, diversity and inclusion. For example, this may include ensuring that degree apprenticeships are a viable option for trusts to offer; our previous research noted that while apprenticeships hold clear potential to support wider participation and career progression, a number of financial and other barriers still remain which need to be comprehensively addressed (Beech and others, 2019).



Notes: Data on age relate to applications to undergraduate courses in 2019, whereas for other characteristics they are for placed students in 2016–17. POLAR4 Q1 and Q2 (quintiles) are a measure of local area participation in higher education while IMD is the Index of Multiple Deprivation. Mature is defined as over 25 years of age.

Source: Analysis of undergraduate data from the Office for Students and Health Education England.

At a local level, the NHS Standard Contract (NHS Standard Contract Team, 2021) – which is set nationally but commissioners use it for all contracts for health care services other than primary care – makes a number of stipulations in relation to equality, diversity and inclusion. These include a requirement for individual health services to implement the Equality Delivery System, to comply with both the Workforce Race Equality Standard and the Workforce Disability Equality Standard, and to submit annual reports both to commissioners and to

“ensure that it has in place effective procedures intended to prevent unlawful discrimination in the recruitment and promotion of Staff and must publish:

- a five-year action plan, showing how it will ensure that the Black, Asian and minority ethnic representation a) among its Staff at Agenda for Change Band 8a and above and b) on its Governing Body will, by the end of that period, reflect the Black, Asian and minority ethnic representation in its workforce, or in its local community, whichever is the higher; and
- regular reports on its progress in implementing that action plan and in achieving its bespoke targets for Black, Asian and minority ethnic representation amongst its Staff, as described in the NHS Model Employer Strategy.”

(NHS Standard Contract Team, 2021)

While we welcome the inclusion of these clauses, it would be good to have assurance that they are applied consistently and effectively. The contract has a very wide range of requirements on providers and, in practice, it is effectively impossible for commissioners or providers to pay close attention to every clause. It is also natural that focus will be placed on areas where there are known local issues or particular interest and/or expertise. In a scenario where a trust has not been overtly identified as having diversity-related issues within its workforce, or where commissioners do not have particular expertise in equality, diversity and inclusion, there is a risk that the trust can comply with the contract by producing the relevant action plans, with little effective scrutiny of the quality of those action plans or their implementation.

This is not to suggest that the inclusion of these clauses within the Standard Contract is inappropriate. But as integrated care systems take on commissioning responsibility from clinical commissioning groups, it will be as important to ensure that commissioners have the expertise required to support and challenge improvement work within trusts as it is to ensure that there is the expertise within the trusts themselves. In this respect, we note that some integrated care systems have begun to appoint their own system-level equality, diversity and inclusion leads as part of the development of local workforce strategies (NHS Frimley Clinical Commissioning Group, 2021). Given the Standard Contract applies to all providers of NHS-funded services, it is equally important that commissioners ensure that non-NHS providers are paying appropriate attention to the diversity of their workforce.

The ‘well-led inspection framework’ of the Care Quality Commission (CQC) – the independent regulator of all health and social care services in England – entails interviews and/or focus groups with key trust staff, including equality, diversity and inclusion leads, chairs of diversity networks and staff who share protected characteristics (Care Quality Commission, 2018b). However, some have called for the process to be improved (Commission on Race and Ethnic Disparities, 2021). Others have recommended that the framework should also include reviews of board appointment processes, especially whether and how chairs have acted to improve diversity by protected characteristics (Sealy, 2020). We also note that the Commission on Race and Ethnic Disparities (2021, p. 129) ‘heard feedback that more needs to be done by the CQC to ensure disparities are better understood and considered in inspections’ and recommends that the Department of Health and Social Care commissions a review into the CQC’s approach to scoring equality and inclusion in its inspection process (Commission on Race and Ethnic Disparities, 2021).

The NHS People Plan 2020/21 sets out the expectation that the CQC will place increasing emphasis on real and measurable progress on equality, diversity and inclusion in its inspections (NHS England and NHS Improvement, 2020b). While strengthening the statutory inspection process may have the ‘potential to be one of the strongest tools for encouraging change and progress’ (Commission on Race and Ethnic Disparities, 2021, p. 129), it is not a silver bullet. The 2019 Workforce Disability Equality Standard annual report, for example, states that it is instead ‘the culture of each trust... which will have the greatest impact on Disabled staff’ (Moore and others, 2020, p. 58).

## Funding

Understanding the nature and extent of equality, diversity and inclusion issues requires resources. Our interviewees stressed that funding and resources were pivotal to both fulfilling their professional responsibilities and delivering on trusts’ action plans. From the small number of interviews conducted, there appear to be substantial differences in the funding available for equality, diversity and inclusion programmes, with one suggesting they had an annual budget of only £500 to implement, evaluate and embed initiatives in the long term. In response, some trusts have shared resources to enable

the establishment and maintenance of, for example, sector-wide learning networks or resources to aid with international recruitment.

We heard that having dedicated central budgets (as opposed to local budgets) may better support spending on reasonable adjustments. However, the 2019 Workforce Disability Equality Standard annual report (Moore and others, 2020) suggests that only 6% of trusts are currently funding reasonable adjustments in this way. Careful attention should be paid to the impact at trusts that have implemented central budgets – along with greater support for line managers and staff on how to access and put in place reasonable adjustments – such as Surrey and Borders Partnership NHS Foundation Trust (2020).

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**I think having the resources to properly measure the impact is non-negotiable for me. But whether that will happen, I don't know.**

(Director of people and organisational development)

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**I think we never have enough resource. But you've always got to make... the business case really, really clear. The difficulty sometimes comes in being able to identify the tangible benefits that gets delivered... we need to be really clear 'for the investment of this, we will give you that'.**

(Equality, diversity and inclusion lead)

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## Staffing

Addressing shortfalls in funding will likely improve levels of staffing dedicated to reducing discrimination, given workforce accounts for the majority of health providers' expenditure. However, there are particular aspects of staffing that warrant specific attention, as set out below.

Our research was conducted at a particularly challenging time for trusts, with the Covid-19 pandemic both creating additional focus on the importance of equality, diversity and inclusion, while also removing capacity within some equality, diversity and inclusion teams. However, one trust we spoke to had designed a temporary new role in response to the pandemic: a ‘Covid-19 BAME Speak Up Ambassador’, a lead for staff to turn to principally on Covid-related issues, and acting as a line of communication to signpost advice and guidance. Following the perceived success of the role, the trust extended the post with a broader remit.

### **Equality, diversity and inclusion teams**

There was unexplained variability across the trusts we spoke to around how many staff were allocated to supporting the equality, diversity and inclusion role. Our desk research suggests this includes differences in the seniority (pay band) at which the equality, diversity and inclusion lead was recruited and the existence and size of an equality, diversity and inclusion team to support with planned activities. One trust noted the importance of appointing equalities roles at Band 8a and above, in order to enable conversations with senior decision-makers within the trust. This challenge was noted in the ‘Our NHS people profession’ consultation, which highlighted the importance of ensuring that the expertise of equality, diversity and inclusion specialists is reflected in their roles, levels of responsibility and banding (NHS England and NHS Improvement, 2021).

In some trusts we spoke to, resources were being allocated to expand the equality, diversity and inclusion function. One trust had recently recruited new officers, expanding the team from a single person to seven. Another trust had expanded its team over time through changes to role portfolios, while one interviewee described their role as equality, diversity and inclusion officer as “living under a rock” and wished they had the wider support of a team.

While we did not seek to survey all employers, we did hear of specific risks around the challenging nature of working within equality, diversity and inclusion in NHS trusts. Equality, diversity and inclusion leads spoke of their personal motivations and commitment to improving equality and diversity within their trust, but some felt this was often at a cost to their career progression. Looking at job adverts for these roles suggests a potentially

overwhelming set of responsibilities; a recent advert for an equality, diversity and inclusion manager with a starting salary of under £39,000 stipulated more than 20 job responsibilities, covering but not limited to:

- providing advice to staff on equality, diversity and inclusion issues, across the trust
- designing and delivering equality, diversity and inclusion training to staff across the trust
- coordinating equality, diversity and inclusion activity.<sup>12</sup>

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**I've chosen to stay whatever length of time in the role... to the detriment of our career... There is the possibility of markers being placed upon the EDI [equality, diversity and inclusion] person... if you look at the structures, career progression... you're usually told you're in a specialist area, if you want to progress come out.**  
(Equality, diversity and inclusion lead)

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Another interviewee also recognised this and they perceived limited training, qualifications and support for equality, diversity and inclusion leads – including limited career structure and development – as an oversight.

<sup>12</sup> While posts vary, the typical NHS pay band of an equality, diversity and inclusion lead is Band 7 (starting salary £40,057), equivalent to an advanced speech and language therapist or communications manager. The job mentioned in the text was advertised before the recent pay settlement.

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**And that is so sad to note we have no real Continuing Professional Development or career structure for our ED&I leads; for every other NHS role we have very clear career structures so why not for ED&I leads? Our ED&I leads go to a dead-end job...can we name one person who was an ED&I lead in the NHS who has ended up chief executive or moved to a Very Senior Manager role.**

(Chair)

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However, another interviewee voiced concern regarding whether equality, diversity and inclusion should become a professionalism in itself, as it risked siloing the issues; instead they viewed their role as an “HR professional with inclusion at my core”. One trust stressed the importance of having a multidisciplinary team with diverse skills, such as campaign skills and communication skills, to influence senior decision-makers. Another trust had recently appointed a programme manager with a skillset around monitoring and evaluation, which was enabling the trust to build up its evidence base and reputation as a leader in the field. Having dedicated roles, with appropriate skills, to support the implementation of equality, diversity and inclusion activities was seen to be a clear benefit. Notably, some interviewees valued the partnerships that national bodies facilitated, such as the Diversity and Inclusion Partners Programme hosted by NHS Employers, in providing a forum to share learning between more mature alumni trusts and those new to the programme, and supporting staff through guidance and advice.

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**Their title is programme manager... a day job, and that all feeds into the strategy, the tracking, the monitoring, the evaluation. That’s not the skillsets that we’ve had over the years, but quite valuable in the place where we are... leading in quite a number of areas where we’ve been recognised nationally influencing policy in certain areas.**

(Equality, diversity and inclusion lead)

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There also needs to be clarity on the way in which the team are expected to contribute and trusts need to ensure that the team have sufficient capacity and resources to do so. We heard that equality, diversity and inclusion roles may have historically focused on compliance rather than improving outcomes by focusing on determining risks through equality impact assessments and providing advice.

### Staff networks

Although they have not yet been widely evaluated, we heard that staff networks are a promising initiative. Many interviewees highlighted staff networks as a key resource, with forums created for various staff including those who are: minority ethnic; female; disabled; shielding during the pandemic; LGBT+; carers; with certain faiths and beliefs; or with a background in the Armed Forces. One trust also spoke of ‘inclusion networks’ – forums linked with external organisations and the public.

Trusts spoke of the fundamental importance of inclusion and diversity workforce advisers and equality, diversity and inclusion managers in supporting networks – in terms of their commitment, drive and sometimes personal dedication or humility. For example, one interviewee noted:

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**The challenge with networks is you need someone to keep it going. And because people are doing it on a voluntary basis.**

(Equality, diversity and inclusion lead)

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A common problem was staff finding the time to be released to attend networks. In recognition of this, some but not all trusts we spoke to intended to ask their boards to better equip staff and network leads with protected time, resources and organisational support. One trust had managed to secure protected time for their staff network leads but they felt “the number of days we’ve agreed is not enough” and should be more akin to the time given to trade union representatives. Trusts may wish to consider mechanisms to protect dedicated time to organise and attend networks, for example through: stipulations in staff contracts, which release staff for regular, defined periods

to organise or attend networks; or requirements for line managers to recognise contributions to networks as part of continuing professional development.

Trusts described how the shift to greater remote working during the pandemic has enabled greater participation – they can now join virtually for as little or as long as they choose.

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**Because of technology, I've seen that network develop and evolve into, quite regularly now having external speakers coming and doing a development session with people... I think there are definitely efficiencies and the accessibility has led to... a greater participation and actually more meaningful meetings, as well.**

(Assistant Director)

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**That is partly because technology has enabled that but that is also partly because people have been nervous; people have been wanting to be kept abreast of changes and involved in those changes and how they're going to keep each other safe.**

(Director of people and organisational development)

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While none of the trusts we spoke to had formally evaluated their networks, we heard that where networks had been sufficiently supported to become longstanding, they had realised a number of achievements (see Case Study C).

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### Case Study C: Supporting and celebrating LGBT+ staff at South East Coast Ambulance Service NHS Foundation Trust

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) has pioneered a number of initiatives to support and celebrate its LGBT+ staff.

The trust's LGBT+ network, Pride in SECAmb, was established ahead of the Brighton & Hove Pride Parade in 2008. That first event in 2008 was attended by 15 members of staff. In 2018, SECAmb's Brighton & Hove Pride Parade entry boasted more than 187 people, making it the largest Pride group in the whole of Europe.

SECAmb's LGBT+ staff network has a strong focus on education and awareness, with input into the appointment of board members and trust consultations.

One early area of work in the trust was an educational programme on transgender awareness with experts by experience, which included myth-busting and increasing understanding and empathy, leading to more than 100 managers being successfully trained.

The trust and its LGBT+ network have also been key to the development of the National Ambulance LGBT Network (NALGBTN) (see the website at: [www.ambulancelgbt.org](http://www.ambulancelgbt.org)). In 2015, the then deputy chair of Pride in SECAmb approached the inclusion team to request their support in relaunching a national ambulance network. The team agreed and brought together 30 colleagues from across UK ambulance trusts to scope a relaunch of the NALGBTN. The network was funded, supported by and co-chaired by SECAmb until the election of its own chair and deputy chair in May 2016. The support provided by SECAmb in administration, funding of the first UK NALGBTN conference (South East Coast Ambulance Service NHS Foundation Trust, 2016) and other large-scale events was instrumental in establishing the national network.

SECAmb also hosted the second conference for the national network in 2017 and worked with sector partners to co-produce the Trans Z-card resource, with initial rollout of this also part-funded by SECAmb (National Ambulance LGBT Network, 2018). The trust has capitalised on being geographically close

to Brighton, which has helped drive its equality, diversity and inclusion efforts in a number of ways, including in seeking public engagement in the development of this resource. The cards were launched at the 2018 conference. They have captured the attention and interest of health professionals in the UK and abroad, and have been published in Polish and Dutch as well as dyslexia-friendly versions.

SECAmb, as part of the national network, participates in a 10-step pyramid toolkit to support its members to establish and monitor the progress of their staff networks. The Care Quality Commission (CQC) has praised this as excellent practice and has expressed an interest in making the toolkit accessible to trusts in other sectors.

Lastly, the trust has developed continuing professional development training on transgender awareness, delivered by the network's deputy chair. Staff and volunteers from within the trust have completed the course, which has also been delivered to external organisations, including the CQC.

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Source: South East Coast Ambulance Service NHS Foundation Trust.

## 5 Recommendations

This research was conducted at a unique time and our findings need to be interpreted in the landscape of a number of significant events that have helped to propel the significant, longstanding issues of structural discrimination and inequalities to the forefront of public and political debate. At no other time in recent history has the NHS's duty of care to secure the health, safety and welfare of all its employees been as pressing.

To truly deliver on its duty of care to the workforce and to its patients, both now and in the future, the NHS needs to recruit, support, retain and promote people from all backgrounds. Doing so will require more than the circulation of apparent (but often unevaluated) good practice and a reliance on the goodwill of a small number of staff; the systemic barriers need to be overcome so that there are the right conditions to make meaningful progress. Where there are well-evidenced solutions, trusts should be supported to implement these at pace throughout the health service. To this end we make a number of recommendations, as set out below.

Recommendation	Detailed action	Lead organisation(s)	Examples of other key stakeholders
<b>On identifying the scale of problems and understanding their causes</b>			
<b>Employers need a more comprehensive understanding of equality issues across all the protected characteristics and demographics of interest.</b>	Regularly provide information to employers on their relative and absolute performance on equality and diversity, covering age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, as well as socioeconomic status, national origin and carer status. These indicators – mindful of the importance not to identify individuals – should cover recruitment, experience of work, progression and retention.	NHS England and NHS Improvement	NHS Business Services Authority, NHS Digital and other data repositories
<b>In addition, there needs to be a more sophisticated understanding of the nature of equality issues.</b>	Undertake a stocktake of data systems and sources of information to determine which would support a more detailed analysis of both variation by sub-groups within the protected characteristics and the effect of intersectionality, whereby characteristics combine to create different modes of discrimination and privilege.	NHS England and NHS Improvement supporting trusts	NHS Business Services Authority, NHS Digital and other data repositories and key stakeholders, such as Department for Education, NHS Race & Health Observatory, People Plan teams, WDES and WRES teams
<b>Identifying evidence-led solutions</b>			
<b>While there are a range of interventions available, the evidence on effectiveness, transferability to different services and generalisability across characteristics is often patchy.</b>	<p>Set aside a budget for commissioning independent, published evaluations of ‘what works’, not limited to any particular characteristic. In the spirit of honesty and continual learning, this should include examples of interventions that did not go as expected, to explore causes of unintended consequences or unexpected outcomes.</p> <p>Work with trusts to ensure that evaluations are planned from the outset of any major interventions for addressing equality and diversity issues.</p>	NHS England and NHS Improvement	Health Education England, NHS Confederation/NHS Employers, People Plan teams

Recommendation	Detailed action	Lead organisation(s)	Examples of other key stakeholders
<p><b>Best practice for addressing equality, diversity and inclusion issues needs to be more readily available to employers.</b></p>	<p>The Cabinet Office should consider the establishment of a new ‘What Works’ centre with a portfolio including equality, diversity and inclusion inequalities and discrimination. Such a centre would be well positioned to develop the evidence base on ‘what works’ and coordinate learning across public sectors, including health, education, the Civil Service, the Fire and Rescue Service and policing.</p> <p>The centre should be funded to:</p> <ul style="list-style-type: none"> <li>• collate existing evidence on the effectiveness of interventions, working with research and membership bodies such as NHS England and NHS Improvement, the NHS Confederation and NHS Employers</li> <li>• co-produce research with staff most impacted by structural inequalities, acknowledging that understanding ‘what works’ requires involvement from the communities that these interventions are intended to benefit</li> <li>• assess the effectiveness of policies and practices against an agreed set of outcomes to address common challenges that public sector staff face</li> <li>• fill gaps in the evidence base by commissioning high-quality synthesis reports, systematic reviews, new trials and evaluations</li> <li>• share findings in an accessible way, and support practitioners, commissioners and policy-makers to use this evidence to inform their strategies.</li> </ul> <p>In time, this evidence could be used to form the basis for a single accessible repository<sup>13</sup> for evidence-based solutions that clearly indicate the evidence around effectiveness and generalisability.</p>	<p>Cabinet Office</p>	<p>NHS Confederation/NHS Employers, People Plan teams, unions, WDES and WRES teams</p>

13 Roger Kline recently called for this (see NHS Providers, 2020).

Recommendation	Detailed action	Lead organisation(s)	Examples of other key stakeholders
<p><b>Support equality, diversity and inclusion teams to build skills in monitoring and evaluation to strengthen the evidence base of ‘what works’ from the bottom up and develop competencies linked to career growth for this staff group.</b></p>	<p>While advancing equality, diversity and inclusion is a responsibility for all, trusts should ensure that equality, diversity and inclusion teams have access to continuing professional development, including any relevant qualifications where this would be advantageous, and have the skills, knowledge and leverage (for example, appropriate seniority) to support and challenge their organisations, up to and including their board.</p> <p>Equality, diversity and inclusion teams should be supported and adequately resourced to consider monitoring and evaluation routinely in programme design and throughout implementation. This will require developing the monitoring and evaluation skills of these staff and ensuring they have sufficient capacity to apply them – these competencies could be linked to career development/competency frameworks where trusts feel this would be beneficial. Trusts also have a role in identifying and encouraging relationships with existing teams that can support with methodology and analysis (for example, quality improvement).</p>	<p>NHS trusts</p>	<p>NHS Confederation/NHS Employers, NHS England and NHS Improvement</p>
<p><b>Implementing best practice</b></p>			
<p><b>All areas need to promote a positive perception of and opportunities for NHS employment.</b></p>	<p>Integrated care system people boards should review their current approach to recruitment and work collectively to understand their local labour market, their collective vacancy gaps and their ‘offer’ for entry into careers for local people, particularly those furthest from employment, to support economic recovery and improve local health inequalities.</p> <p>Specifically, all areas should publish ‘preparation for work’ programmes – including work experience and pre-employment initiatives – jointly agreed with relevant partner organisations such as colleges and universities. Progress should be measured to ensure participation from all groups in the local community.</p>	<p>Integrated care systems</p>	<p>Further education colleges, higher education providers, Institute for Apprenticeships and Technical Education, NHS trusts</p>



Recommendation	Detailed action	Lead organisation(s)	Examples of other key stakeholders
<b>Any potential disincentives and barriers to the recruitment, participation and retention of a diverse workforce must be removed.</b>	<p>While there are numerous, complex reasons that affect the recruitment, participation and retention of a diverse workforce, there are some simple actions that can be addressed more straightforwardly. For example:</p> <ul style="list-style-type: none"> <li>the NHS Jobs website should be reviewed to ensure that it is accessible</li> <li>NHS Employers should draw up a code of practice for organisations to follow when advertising jobs, including what adjustments can be made for people to attend interviews and how long adverts are posted for</li> <li>all organisations should commit to a sufficient, central budget for reasonable adjustments.</li> </ul>	Various	
<b>Capacity</b>			
<b>Roles and responsibilities need to be clear to underpin the allocation of additional resources and improve joint working.</b>	<p>Decisions on where to put additional resources need to be led by a clear understanding of where particular roles, responsibilities and accountabilities fall, including whether at the national, regional, system or local level. By March 2022, the Department of Health and Social Care should clearly articulate the governance of and accountability for delivering on the broad equality, diversity and inclusion agenda. If necessary, the NHS Standard Contract should be revised to reflect these responsibilities.</p>	Department of Health and Social Care, NHS England and NHS Improvement	Care Quality Commission, NHS Confederation/NHS Employers
<b>Staff networks need to be supported.</b>	<p>By December 2021, all NHS organisations are expected to review the governance arrangements of their staff networks. As part of this, organisations must ensure that staff have protected time to engage in them inside normal working hours and that they have sufficient, dedicated resources and opportunity to contribute.</p>	NHS trusts	NHS Confederation/NHS Employers

Recommendation	Detailed action	Lead organisation(s)	Examples of other key stakeholders
<p><b>Some providers have insufficient resources to monitor equality, diversity and inclusion, to implement interventions and to evaluate them to address any shortcomings.</b></p>	<p>Each year, employers should report publicly on the estimated amount of their budget and full-time equivalent staffing levels specifically for improving equality and diversity.</p> <p>Every integrated care system should have a substantive equality and diversity lead, to help provide enhanced specialist support for trusts on key challenge areas; for trusts that have not yet published WRES and WDES action plans; and for better oversight of the quality and feasibility of WRES and WDES action plans. Integrated care systems should also consider pooling resources to undertake evaluations of key diversity initiatives.</p>	<p>NHS trusts</p> <p>Integrated care systems</p>	

Note: WDES = Workforce Disability Equality Standard; WRES = Workforce Race Equality Standard.

# Appendix 1: Methodology

## About the research team

The Nuffield Trust research team comprised one lay board member of the Workforce & Education sub-committee of an NHS trust and three members of the Nuffield Trust's Diversity and Inclusion working group, one of whom is also a member of the NHS Confederation's Health and Care Women Leaders Network. The report was subject to internal review by three members of staff, to encourage researcher reflexivity.

## Our approach

We conducted a manual, non-comprehensive literature review of academic, grey and policy papers, alongside six stakeholder scoping calls with national and local organisations, to identify what is known about the advancement of staff groups who share protected characteristics, at each stage of the career pipeline – employment, participation, progression and retention – and what gaps in the evidence base exist. We sought to identify particular areas of challenge across NHS staff roles (for example clinical, non-clinical and management), Agenda for Change pay bands and the outsourced workforce.

Findings from the literature review and scoping calls informed a series of semi-structured interviews with five NHS foundation trusts (n= 11 individuals in total). These comprised three acute trusts, one ambulance trust and one mental health and community trust. Interviewees included those working specifically in equality, diversity and inclusion roles, and those working in human resources or workforce/organisational development. Interviews sought to understand:

- the demographics of the local population
- the challenges facing trusts, and interviewees' perceptions of where the greatest risks and opportunities lie
- interventions trialled at trust or regional level and evidence on how effective these have been
- interviewees' views on how transferrable these interventions are across different staff groups, NHS roles and employer types.

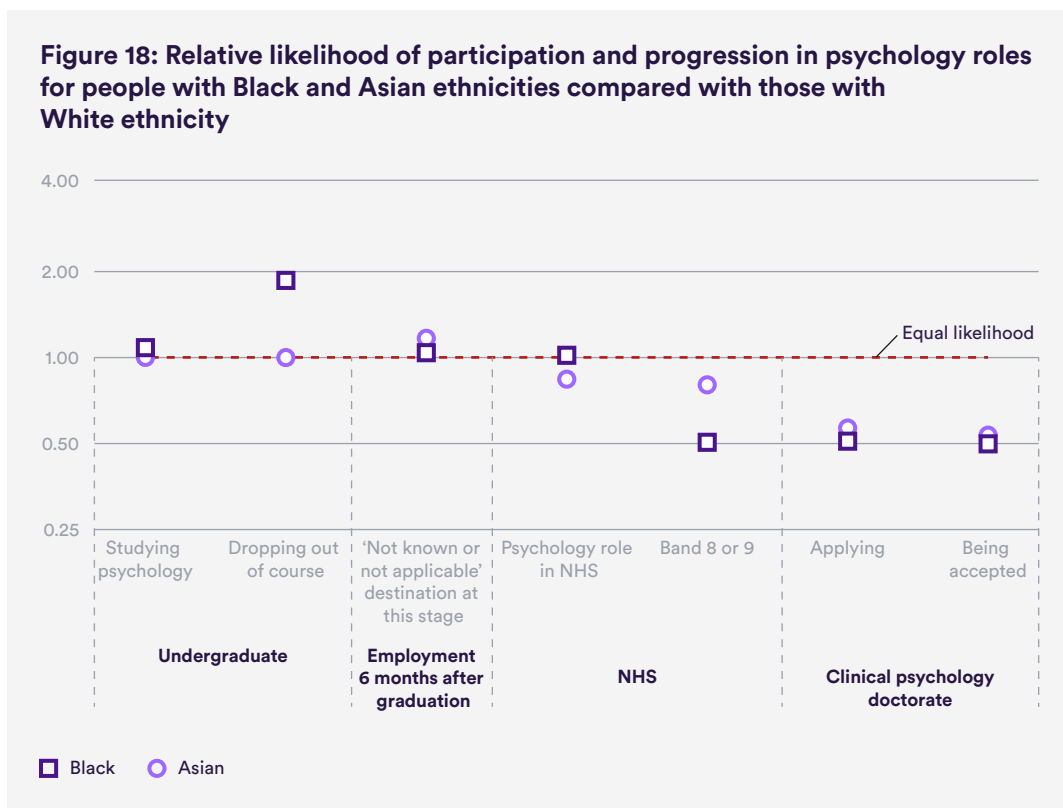
As far as possible, we sought to draw out detail on the various mechanisms that might affect the employment, participation, progression and retention of all groups across the protected characteristics. At all stages of the research we sought to use the terms that staff referred to themselves, as opposed to commonly used shorthands.

Comparisons between different professions and demographic characteristics were conducted using existing data from, for example, the Higher Education Statistics Agency (HESA), NHS Digital, the NHS Business Services Authority (NHS Jobs) and the NHS Staff Survey. We also received data on the relative likelihood of applicants being shortlisted and appointed from shortlisting (June 2017 to June 2019) in relation to the NHS Jobs service, through a Freedom of Information request to the NHS Business Services Authority.

## Limitations

A purposive sampling strategy for the interviews was developed with NHS Employers to gather insights from across the range of provider types, geographies and staff roles. However, in the current climate of the Covid-19 pandemic, in order to secure interviews, the research team resorted to convenience sampling and snowballing for further interviewees at the trusts. Our review of publicly available data highlighted that demographic data were insufficient for meaningful analysis at some grades (for example, ethnicity data for apprenticeships). Due to time constraints, the literature review was pragmatic (snowballing from informants' recommendations) rather than systematic.

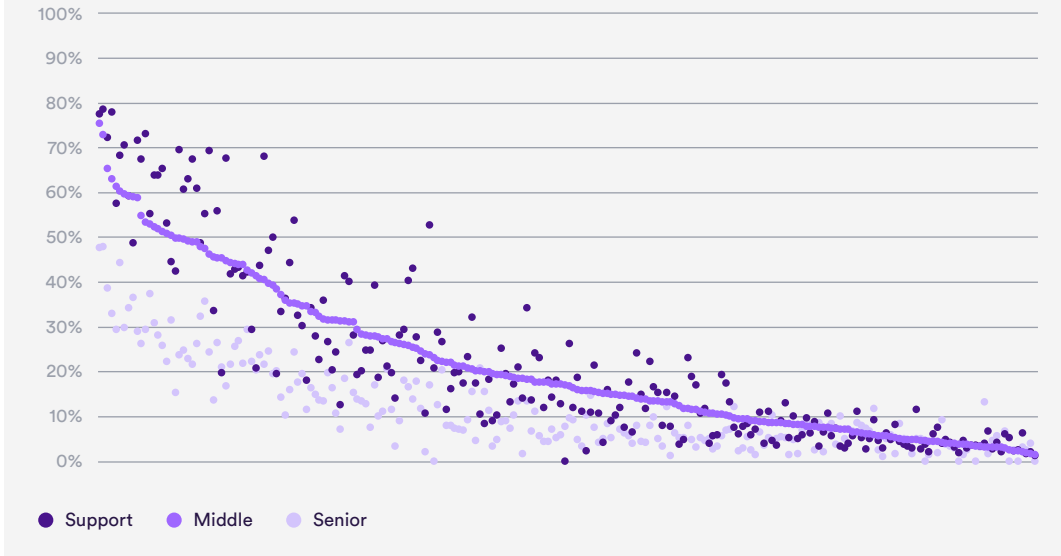
# Appendix 2: Additional graphs



Notes: Those symbols above 1 indicate a greater likelihood than White people (with 2 representing twice the likelihood) and those below 1 indicate a lesser likelihood (with 0.5 representing half the likelihood). A logarithmic scale is used so that double the likelihood is the same distance as half the likelihood from the line representing equal likelihood. 'Studying psychology' compares to studying any degree subject; 'Psychology role in NHS' compares to the working adult population in England and Wales; and 'Applying' compares to students studying psychology. Data cover various years and are taken from different sources and so they should be treated with caution.

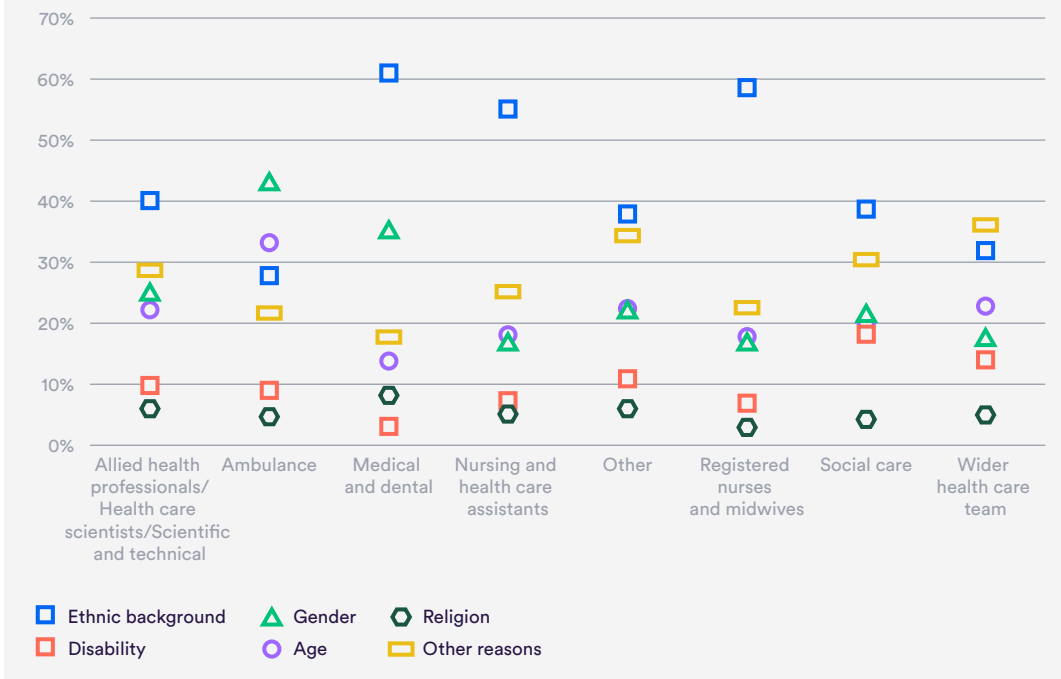
Source: Clearing House for Postgraduate Courses in Clinical Psychology, Higher Education Statistics Agency (HESA), NHS Digital and Office for National Statistics.

**Figure 19: Percentage of support, middle and senior staff from minority ethnic groups**



Source: NHS Digital Strategic Data Collection Service (2021).

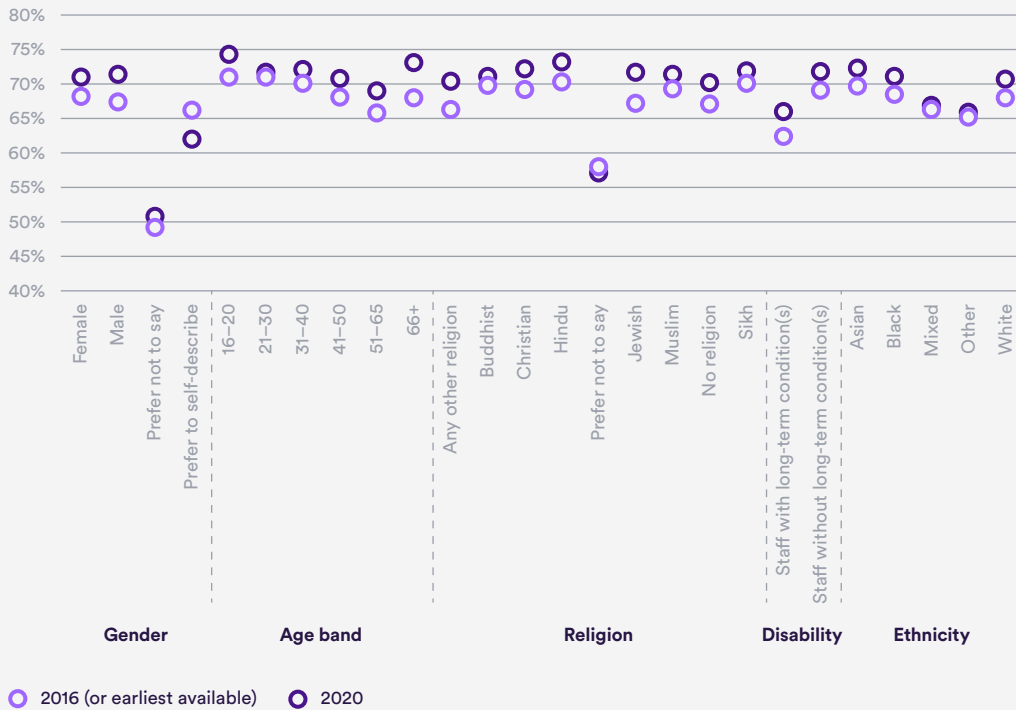
**Figure 20: Percentage of staff reporting experiencing discrimination on the basis of different characteristics, by staff groups**



Source: NHS Survey Coordination Centre (2021a).

**Figure 21: Selected graphs from the NHS staff survey**

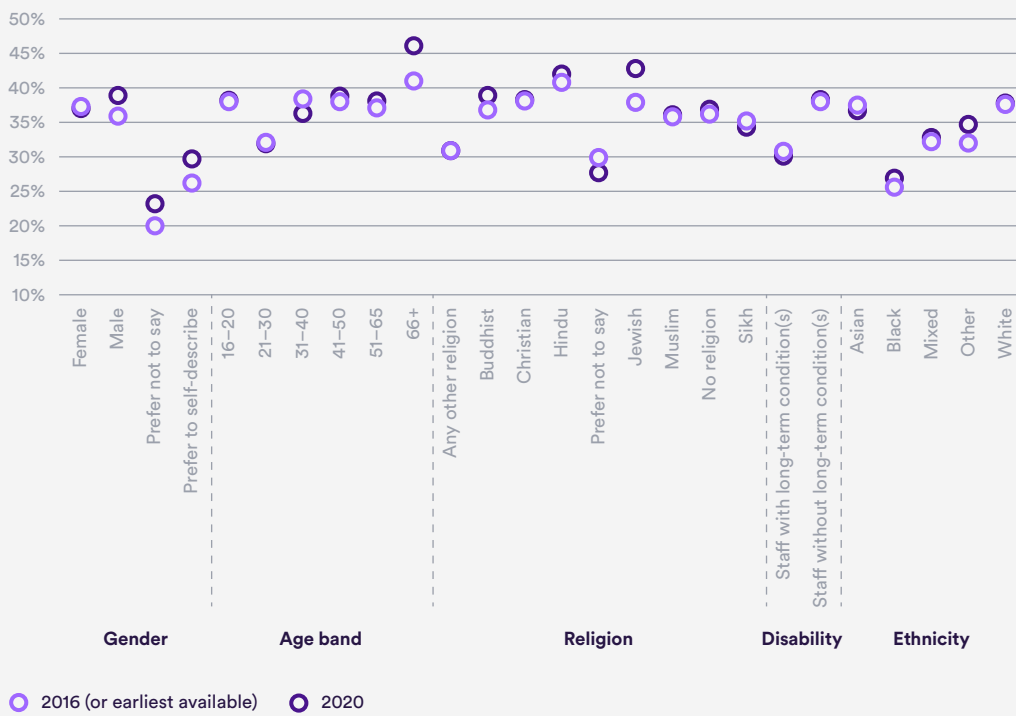
**Staff satisfied with the support they get from their immediate manager**



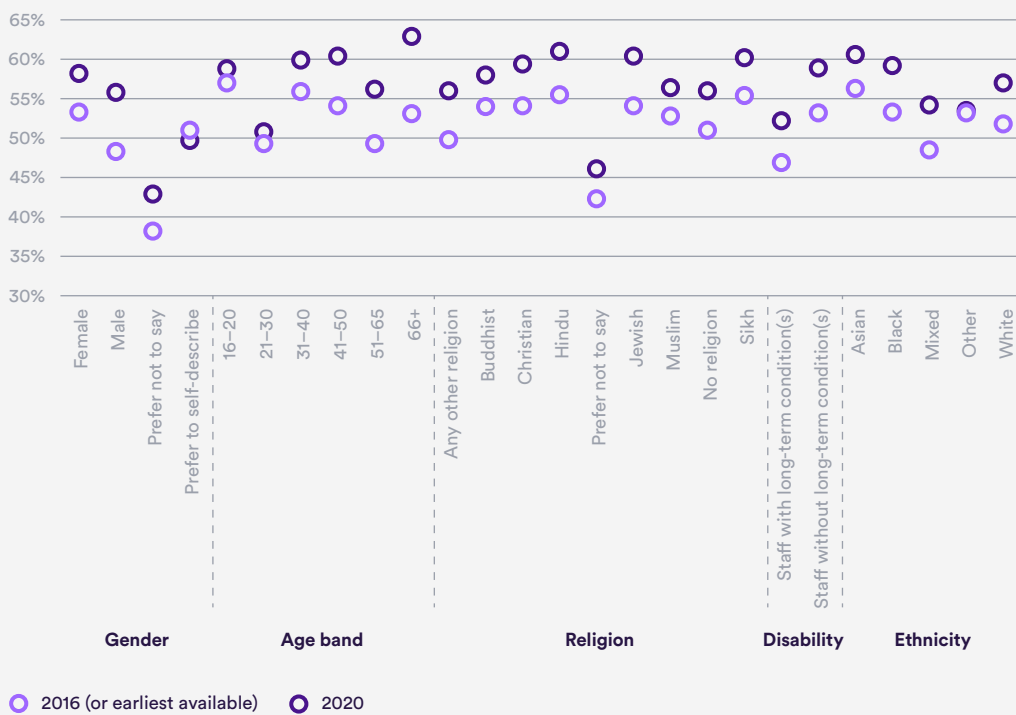
**Staff satisfied with the extent to which their organisation values their work**



### Staff satisfied with their level of pay

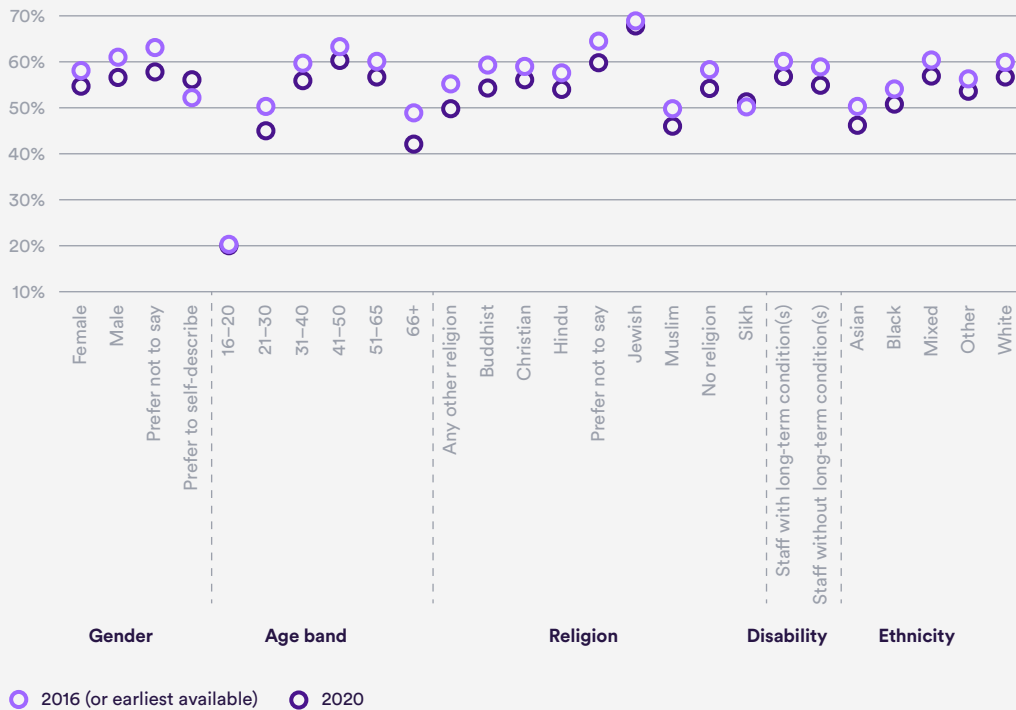


### Staff satisfied with the opportunities for flexible working patterns

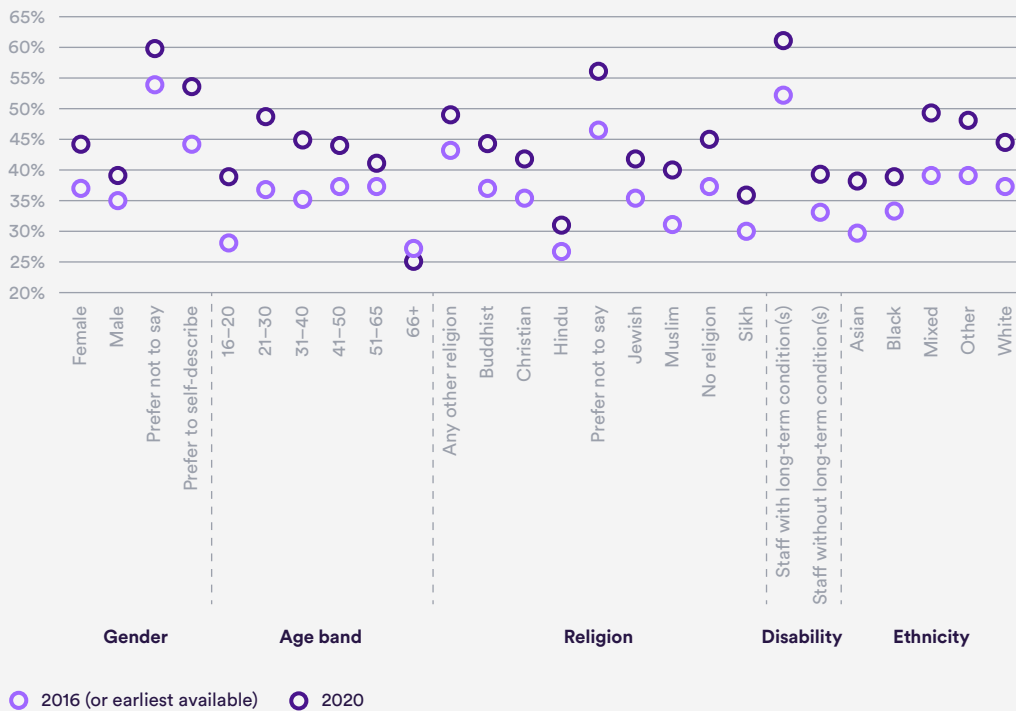




### Staff working additional unpaid hours for their organisation, over and above their contracted hours



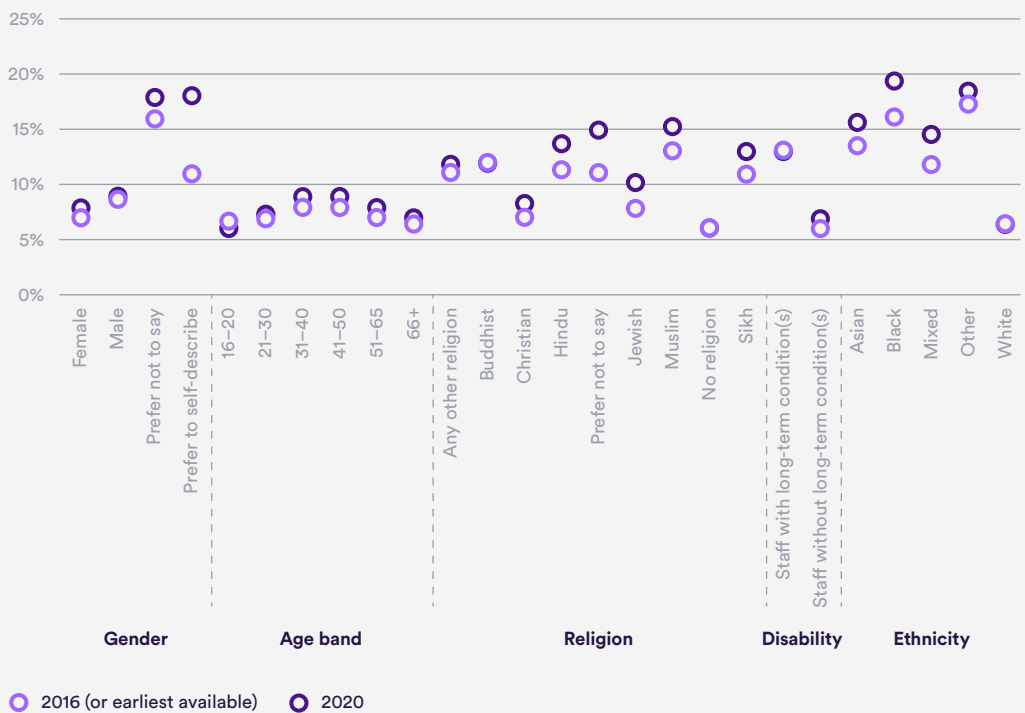
### Staff who felt unwell as a result of work-related stress in the previous 12 months

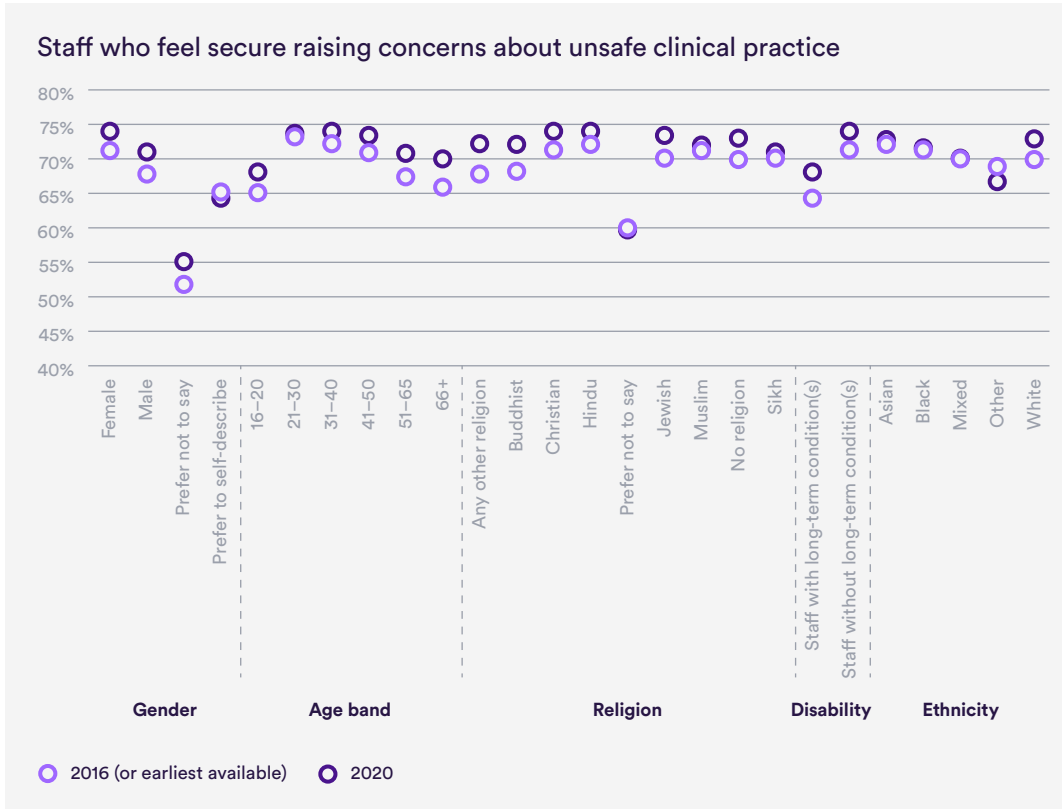


### Staff who experienced discrimination at work from patients/service users, their relatives or other members of the public in the previous 12 months



### Staff who experienced discrimination at work from their manager/team leader or other colleagues in the previous 12 months





Source: NHS Survey Coordination Centre (2021a).

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