

# Workforce race inequalities and inclusion in NHS providers

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*There is definitely one rule and tolerance for one group and one for another. This is made worse by the close relationships between very senior managers who appoint their own former staff or friends to roles, or managers who work together for a while. BME [Black and minority ethnic] staff without strong professional representation (in particular BME non-clinical managers) are vulnerable and unsupported... [My experience is] Realising that no matter how hard I worked, people I train will be promoted above me or given opportunities that the organisation denies me. When [I challenge this], I am dismissed, gas-lighted or the implication is that I'm making trouble.*

*I came into nursing as a mature woman in my late 30s... I heard reports of patients refusing to allow Black nurses [to] look after them. I reported this to the nurse recruiter for bank [staff] at my hospital. She felt this was perfectly in order. If the patient didn't want a Black nurse, let them have a white one.*

*As a female ethnic minority in the NHS, I feel that I encounter situations every day that remind me I am different and that I have to overcome people's perceptions of me. As a clinical member of staff, this varied from not asking how to pronounce my name to assumptions about my upbringing. In my current role, it is about not seeing anyone like myself in senior positions. The biggest negative impact was being told I was the 'diversity' recruit early in my career. The biggest positive impact is being part of the BAME [Black, Asian and minority ethnic] network and not feeling alone.*

*(Responses from three interview participants)*



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# Foreword

*I cannot be an optimist, but I am a prisoner of hope*

Professor Cornel West

The NHS was founded more than 70 years ago, is the UK's largest employer and is one of the biggest employers globally. The NHS Constitution for England ([Department of Health and Social Care 2015](#)) 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'.

Research for this report commenced in 2019, but since then the impact of the Covid-19 crisis in the UK has replicated existing health inequalities, and a report by Public Health England on disparities in the risk and outcomes of Covid-19 shows that death rates from Covid-19 have been highest among ethnic minority groups. As I sat to write this foreword, we had just witnessed the shocking murder of George Floyd, the protests in the UK and around the world, and the efforts of the Black Lives Matter movement which once again underline the injustice, discrimination and racism faced by Black people in society.

It was in 1968 that the Race Relations Act extended the prohibition of discrimination 'on the ground of colour, race, ethnic or national origin' to the fields of employment. Presenting the Bill to Parliament, the Home Secretary, Jim Callaghan, said, 'The House has rarely faced an issue of greater social significance for our country and our children.'

Yet, 51 years on, the NHS Staff Survey in England ([NHS England 2020b](#)), which has been running since 2013, shows that people from ethnic minority groups face continued discrimination and higher levels of bullying, harassment or abuse from other staff compared with white staff. The key finding relating to equality, diversity and inclusion shows a decline since 2015. NHS staff are also subjected to racism by patients and other members of the public during their work with predictable consequences for their health and wellbeing.



When you read the personal stories in this report, remember that we are directly harming people by not addressing race inequalities in the NHS to create safe, inclusive work cultures. There are physiological, psychological and behavioural consequences for people and their families from the chronic stress caused by racism and discrimination.

To be clear about the UK law on race relations, it imposes a positive duty on institutions to pre-empt unlawful discrimination before it occurs. This means the NHS should not just deal with racism when it occurs but be pro-active in preventing it happening in the first place. So, if the moral case is clear and the legal position has been clear for decades, what more is needed?

Our report and so very many that precede it demonstrate the importance of leadership to achieve equality, diversity and inclusion so this needs to be core business for boards and senior leadership teams. Leaders must act on this at every level of the health service including learning how to listen better to staff and their experiences. This requires personal action from every manager and supervisor of staff whatever their grade or role in the service. The cultural change required will not be quick and as our case studies demonstrate, it will not be easy. At The King's Fund, we recognise that we have much to learn and a long way to go to becoming a more diverse and inclusive organisation. We are committed to tackling inequalities through the work we do and by using our voice to encourage change within the health and care system.

So, will this report tell you anything new? Many of our findings will be of no surprise, but we hope they help to illustrate the reality and complexity of culture change, to challenge and inspire you to go further in your workplace. Looking at the workforce data and the progress against the Workforce Race Equality Standard (WRES) is important, but it is only part of the story. What matters fundamentally is the lived experience of staff in their everyday work. We wanted to learn more about the experience of ethnic minority staff working in the NHS, the stories behind the data, and to understand what some NHS organisations were doing to make better progress in addressing inequalities and inclusion in everyday work. In each of the case studies – from Bradford District Care NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust and East London NHS Foundation Trust – you will learn about the different ways these organisations are tackling race inequalities,



as well as some of the actions they are all taking including the introduction of staff networks and enabling better staff development and career progression.

I would have described myself as an optimist, but reading Professor Cornel West's work, I now realise it's hope that I was talking about. As leaders we must be prisoners of hope but turn that desire for improved outcomes into real action. We must therefore ask ourselves some searching questions on race inequality: Will we commit to continue to reflect on our own role and complicity in systemic racism? Will we commit to learning and doing better on race inequality? Will we accept that we will fall short and but will learn from our mistakes when we do? Will we truly commit to being ceaseless in our pursuit of inclusivity in our workplaces?

As Professor Don Berwick says, "Some" is not a number and "soon" is not a time' so in renewing individual and organisational commitments to address race inequalities we will also need to get specific about what we are going to do, by how much and by when. We cannot continue to damage the lives of ethnic minority people in the workplace, we must act now and stay on the long road to lasting change.

**Suzie Bailey**

Director of Leadership and Organisational Development  
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# List of abbreviations

BAME	Black, Asian and minority ethnic
BAPIO	British Association of Physicians of Indian Origin
BDCFT	Bradford District Care NHS Foundation Trust
BLFI	Building Leadership for Inclusion
BME	Black and minority ethnic
CHFT	Calderdale and Huddersfield NHS Foundation Trust
EDC	Equality and Diversity Council
EDI	Equality, diversity and inclusion
EDS	Equality Delivery System
EDS2	Equality Delivery System 2
ELFT	East London NHS Foundation Trust
FTSUG	Freedom to Speak Up Guardian
GMC	General Medical Council
IAPT	Improving Access to Psychological Therapies
LGBT	Lesbian, gay, bisexual and transgender
NHS	National Health Service
UK	United Kingdom
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard



# Key messages

- The National Health Service (NHS) has one of the most ethnically diverse workforces in the public sector ([Race Disparity Unit 2019](#)). However, year after year, ethnic minority staff report worse experiences in terms of their lives and careers, when compared with white staff ([WRES Implementation Team 2020](#)). For example, ethnic minority staff are more likely to report bullying, harassment and abuse from patients and colleagues; and they are more likely to enter into the formal disciplinary process.
- People from an ethnic minority background are also under-represented in senior positions in the NHS. According to analysis carried out by the WRES Implementation Team ([2020](#)) (WRES stands for Workforce Race Equality Standard):
  - 29.0 per cent of ethnic minority staff report that they have experienced bullying, harassment or abuse from other staff in the past 12 months, compared with 24.2 per cent of white staff
  - 15.3 per cent of ethnic minority staff report experiencing discrimination at work from a manager, team leader or other colleague – more than double the proportion of white staff reporting discrimination (6.4 per cent)
  - 69.9 per cent of ethnic minority staff report that they believe their trust (employer) provides equal opportunities for career progression or promotion, compared with 86.3 per cent of white staff
  - people from an ethnic minority background make up only 8.4 per cent of boards in NHS trusts across England.
- Addressing race inequalities in the NHS workforce is critical on multiple levels. First, as we outline in this report, experiences of discrimination can cast a long shadow on ethnic minority NHS staff; the impact on people can be profound. There are also wider implications for the health service. At a basic level, inequalities are incongruous with the values upon which the NHS was founded. In addition, evidence shows that fair treatment of staff is linked to a better experience of care for patients ([West et al 2011](#)). Moreover, the NHS is in the midst of a workforce crisis and improving its performance on diversity and inclusion will play an important role in the NHS becoming a better place to work and build a career ([Beech et al 2019](#)).



- This report explores workforce race inequalities and inclusion in NHS providers. There is a considerable amount of quantitative data on this issue but a relative lack of independent qualitative research about the issue in different types of NHS organisations. In this report we discuss how three NHS provider organisations have sought to address workforce race inequalities and develop positive and inclusive working environments. We have focused on the personal accounts and recollections of members of staff and on what ethnic minority staff told us they have experienced in their working lives (see [www.kingsfund.org.uk/nhs-stories](http://www.kingsfund.org.uk/nhs-stories)). This helped us to understand the reality and complexity of culture change.
- Perhaps unsurprisingly, what we learnt was that the three case studies were still in the foothills of addressing race inequalities and making the working environment more inclusive; progress against the key metrics on race equality in the three case studies has been slow – as with the wider NHS. There were no quick solutions and therefore the three case studies were thinking strategically and preparing for the ‘long haul’ because change of this nature and at scale cannot happen overnight. We found that everyone has a role to play in an organisation’s race equality and inclusion effort – through leadership, participation or ‘allyship’.
- The case studies used different approaches to make it safer to talk about race, for example staff networks that could benefit both ethnic minority and white staff. In addition, leadership or career development programmes targeted at ethnic minority staff aiming to be promoted to more senior positions were popular. We discuss some of the advantages and disadvantages of the approaches and offer numerous points for consideration for other organisations that are working towards addressing workforce race inequalities and inclusion.
- We found reasons to be hopeful about the potential for culture change in the NHS; members of staff in the case studies were able to point to some signs of progress even if that progress did not show up in the national dataset on workforce race inequalities. This highlights the importance of looking for a range of data, including the lived experience of staff, so that you know whether or not you are heading in the right direction.



- Although each organisation's approach to addressing race inequalities and inclusion will be defined and designed locally depending on the circumstances, the case studies offer some key learning points for the rest of the sector to consider.
  - There are no magic solutions to an age-old issue. The work is not straightforward (for example, there can be resistance to change among members of staff) and there can be unintended consequences to implementing initiatives, which must be kept in mind.
  - Approaches to race equality and inclusion are not 'one size fits all'. There is a lack of proven interventions and it is down to individuals and organisations making a concerted effort at a local level to iterate the approach that 'works' for them.
  - Addressing inequalities and inclusion needs to be an ongoing, 'moment-by-moment' activity that engages with and responds to people's lived experiences.



# 1 Introduction

The NHS has one of the most ethnically diverse workforces in the public sector ([Race Disparity Unit 2019](#)). Of the 1.2 million NHS staff whose ethnicity is known, 79 per cent are white (including white ethnic minorities) and 21 per cent are from all other ethnic groups. Across individual NHS trusts in England, the proportion of ethnic minority staff employed varies from 1.2 to 62 per cent. The London region has the most diverse NHS workforce (44.9 per cent of NHS trust staff are from an ethnic minority background) compared with the South West region, which is the least diverse (9.3 per cent). Ethnic minority staff are over-represented in the NHS Agenda for Change pay band 5 (including, but not limited to, nursing and administrative roles, as well as some clinical roles) and significantly under-represented above band 8a, which includes very senior managers (that is, chief executives, executive directors and other senior managers with board-level responsibility who report directly to the chief executive). In other words, as the pay bands increase, the proportion of ethnic minority staff within those bands decreases, from 24.5 per cent at band 5 to 6.5 per cent at very senior manager level ([WRES Implementation Team 2020](#)). Thus, it is possible for someone to be very much in a minority in their situation within a diverse whole.

For many years, white and ethnic minority staff have reported significantly different experiences in terms of their lives and careers in the NHS (Hughes *et al* 1984). There is no shortage of high-profile national data to illustrate these different experiences ([West \*et al\* 2015](#); [Kline 2014, 2013](#)). Compared with their white colleagues, ethnic minority staff are more likely to report bullying, harassment and abuse from patients and colleagues; they are more likely to enter into the formal disciplinary process; and they are less likely to be employed in senior positions. Key metrics from the most recent analysis of national data on the Workforce Race Equality Standard (WRES) in NHS trusts ([WRES Implementation Team 2020](#)) show that:

- 29.0 per cent of ethnic minority staff have experienced harassment, bullying or abuse from staff in the past 12 months, compared with 24.2 per cent of white staff



- 15.3 per cent of ethnic minority staff report experiencing discrimination at work from a manager, team leader or other colleague – more than double the proportion of white staff reporting discrimination (6.4 per cent)
- 69.9 per cent of ethnic minority staff believe their trust (employer) provides equal opportunities for career progression or promotion, compared with 86.3 per cent of white staff
- the relative likelihood of ethnic minority staff entering the formal disciplinary process compared with white staff is 1.22.

Even though the data is relatively well known, there is a fundamental question about why progress has been frustratingly slow in terms of addressing workforce race inequalities in NHS organisations. There are probably several reasons for this – particularly the fact that all types of culture change take time and addressing inequalities will require persistence and determination in the long term. A ‘do-once’ approach will be insufficient. Further, there is a lack of proven interventions to tackle race inequalities and it is down to individuals and organisations making a concerted effort at a local level to iterate the approach that ‘works’ for them.

### Why does race equality matter?

Writing as a team of mostly ethnic minority researchers, it is a strange thing to spell out what is, for us, quite obvious. There are multiple reasons to address race inequalities in the NHS workforce; there are both moral and practical arguments. And to be more blunt about it, being on the receiving end of racist behaviour or institutionally racist policies is hurtful and can have long-term damaging effects ([The Synergi Collaborative Centre 2018](#); Williams and Mohammed 2013; Williams 1999).

The NHS is founded upon the principle of fairness, providing access to health care on the basis of need, ‘irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status’ ([Department of Health and Social Care 2015](#)). The NHS Constitution for England makes clear that every person (patients, families, carers and staff) is valued and everyone counts ([Department of Health and Social Care 2015](#)). If these fundamental principles are not reasons enough to treat all people equally,



research shows that poor morale and engagement among NHS staff have an impact on the quality of patient care (Dawson 2018; West *et al* 2011). This suggests that tackling equality and inclusion issues for staff will benefit patients too; it should improve patient care and help the NHS, at least in part, to address its workforce crisis (Beech *et al* 2019). The NHS plays a vital role in enabling social justice both as an employer and as a public service.

### Lived experiences of ethnic minority staff in the NHS

As outlined above, there is data showing that ethnic minority staff are more likely than white staff to report having negative experiences at work. However, our review of the evidence showed that there are relatively few studies that have focused qualitatively on exploring the experiences of ethnic minority staff in the NHS. One study of ethnic minority nurses' views (Pendleton 2017) highlighted negative experiences, such as:

- barriers to career progression – for example, being denied career development opportunities and receiving inadequate feedback about why progression has not occurred
- a lack of respect from more junior staff
- being ignored by more senior staff or excluded from networks of 'power'
- being more likely than white nurses to be reprimanded or punished.

Another study about doctors' experiences of being referred to the General Medical Council (GMC) for fitness-to-practice concerns suggests that some managers avoid having difficult feedback conversations with doctors from a different ethnic background to themselves, and there are 'in groups' and 'out groups' in medicine relating to ethnicity and qualifications (by country – and within the United Kingdom by medical school) (Atewologun *et al* 2019).

Our own research about the lived experiences of ethnic minority people working in the NHS offers insights into how bias, inequalities and discrimination are perceived and experienced (see [www.kingsfund.org.uk/nhs-stories](http://www.kingsfund.org.uk/nhs-stories)).



## Ethnic minority staff in the NHS describe their lived experiences

In a short survey that was sent out via our network of contacts and on Twitter, we asked ethnic minority staff working in any role in the NHS: How would you describe your lived experience of being an ethnic minority (or 'BAME') person in the NHS?

We received 173 responses, including the following examples, and based on their responses we invited 20 people to take part in an in-depth interview and 12 of them agreed:

*I see no one like myself in this organisation. I moved here from London and this company is [the] most 'culturally ignorant' [sic] environment [I] have worked in. I hear racist, racially insensitive comments all the time, sometimes with actual malice in mind, but mostly because out here there are no BAME [Black, Asian and minority ethnic] people so there is no awareness of us as people, only what they see on TV and in the news.*

*Being a BAME person in the NHS have [sic] many challenges with limited job opportunities to progress to junior/senior management. The biggest impact on me is the feeling of been [sic] silenced and not good enough to lead/manage a team regardless of one's knowledge or experience or qualification. It's a feeling that my only value is to service others with no job opportunities.*

*I am an immigrant which makes it very difficult to integrate with the general UK/NHS working culture. While NHS managers are talking about E&D [equality and diversity], they do not provide further support for us and often when we are [a] victim of bullying, managers are either ignoring it or dealing with it as if race and culture is [sic] not part of the problem.*

(Responses from three interview participants)

All this said, addressing race inequalities in workplaces is by no means an easy undertaking. Race equality initiatives require leaders and staff to move beyond their comfort zones, confront painful truths and have open discussions about race and racism. To be clearer, the truth hurts because it means having to understand and accept that the NHS as an employer has fallen short of the values set out in its Constitution and elsewhere and because many NHS leaders (as most people) see themselves as 'good' people, working to support equity. This tension between aspiration and reality will be uncomfortable.





Successful race equality initiatives require organisation leaders to make clear that race equality is a high priority (following up with investment where needed) and multiple strategies will be needed at 'organisational, workplace, interpersonal and intrapersonal levels used simultaneously and over time' (Priest *et al* 2015).

## Our research

The King's Fund has undertaken a research study of workforce race inequalities and inclusion in NHS providers. As mentioned previously, we as authors have a vested interest in this issue.

We felt there was an opportunity for us to add value to existing research and we have done this in two ways.

First, we have undertaken in-depth interviews with 12 NHS staff to gain a detailed understanding of what discrimination looks and feels like in health care settings and what impact it has on individuals, teams and organisations. Hearing people's lived experiences has given us valuable *qualitative* insight and individual stories that might be overlooked when thinking about inequalities through metrics or best-practice guides (see the quotes on inside front cover and page 15 for examples).

The lived-experience interviews we conducted brought home the depth and strength of feeling about how ethnic minority people experience inequalities in different NHS work environments. These powerful first-person accounts can be found on our website (see [www.kingsfund.org.uk/nhs-stories](http://www.kingsfund.org.uk/nhs-stories)). This information adds greater depth and meaning to the quantitative information obtained from the NHS Staff Survey and research on the Workforce Race Equality Standard (WRES, discussed in section 2) in NHS trusts, and greater insight into the impact of inequalities.

Second, through three case studies we have sought to identify NHS provider organisations that have made continued improvements in terms of workforce race inequalities and to explore how they have gone about doing so (see Appendix 1 for more information on our methodology). Instead of looking at individual improvement initiatives or pockets of good practice, we have looked at the totality of the actions these organisations are taking to reduce race inequalities. And we have explored the practical issues these organisations have encountered over years of improvement efforts, and how they have sought to overcome these challenges.



It is important to note that we did not set out to evaluate any of the techniques or interventions used in the case studies. This was partly because our research is exploratory; we had little prior knowledge about what the case studies were doing to address race inequalities. Moreover, given the long history of race inequality, if there were simple solutions, we think NHS provider organisations would have found them by now. Noticing this made us think about what more there might be to learn about the complexity and everyday dilemmas of working to reduce race inequality. And seeing a deeply entangled relationship between individual experience and the perpetuation of structural inequality, led us to start with the perspectives of a sample of organisations and people who have been involved in the race equality and inclusion activity or have observed it happening.

The issues and experiences described in this report are therefore necessarily local and are unlikely to show up in exactly the same way in other NHS organisations. In so far as these experiences reflect wider social patterns – locally, nationally and globally – we think that exploring commonalities and points of difference, what seems to be working along with the unintended consequences of actions to reduce inequalities, helps to expose some of the reality of what on paper may seem to be simple interventions.

In this report, we try to go beyond the good-practice recommendations and summary metrics that have started to become the mainstay of debate around race inequalities in the NHS. We asked our participants to be candid in their accounts of efforts to reduce race inequalities in NHS organisations so that we could explore aspects of this work that are rarely discussed. We have tried to be candid in sharing what we have learnt too, so that others can benefit from understanding the complexity of work in this area.

We hope that, as a result, organisational leaders in the NHS will have more to think about in relation to working towards greater race equality. We also hope that people throughout organisations will read this report and feel more hopeful about the possibility of fairer workplaces.

We hope this report will therefore help readers in NHS organisations to see or anticipate more of what might happen as they design or implement their own local approaches to creating fairer workplaces, drawing on the experiences of



others. We encourage readers to engage with the examples and analyses presented with curiosity, and ask themselves: How might this be true where I work, and what difference might that make to the approach we are taking, or could take?

We also encourage readers to think about how they are responding to this report – with excitement, frustration or anything else – and ask themselves: How is my reaction part of the way I think and feel about race inequality in general, and how might this be helping or hindering us in our work?

More than anything, we want this report to provoke conversations about the structural and personal aspects of race inequality, and to serve as the starting point for organisations' own deeper explorations of how they are thinking about it and working on it.

## Structure of the report

In section 2, we discuss the background and context in terms of workforce race inequalities in the NHS. In section 3, we present information about the three case study organisations, including what prompted them to act and what they are hoping to achieve. Sections 4 and 5 focus on the practical steps taken to address race inequalities and inclusion, what has enabled or impeded progress and reflections from the people involved in the development of workforce culture. Section 6 explores the importance of leadership and allyship in sustaining race equality and inclusion initiatives. Section 7 examines what has changed in the three case studies as a result of their interventions. Finally, section 8 brings together key learning points and considerations about the reality of addressing race inequalities.

It is important for us to reflect the voices of NHS staff in this report and we have included numerous quotations to illustrate the detail and nuances of their lived experiences in terms of race inequalities. We have not attributed the majority of quotes to individuals in this report as we did not want them to be identifiable. For those quotes that are attributed to an individual, that person has given their permission for us to do so.



## Definitions

Language is an important ‘carrier’ of bias and prejudice. Therefore, conversations about equality, diversity and inclusion can be challenging and awkward – not least because there are many ways to describe the same or similar things, where some phrases are considered correct and others as causing offence (intentionally or unintentionally). See the box below for how we have defined key terms and concepts in this report.

### Our definitions of key terms and concepts

‘**Ethnicity**’ is a complex, multi-layered and changing concept. Typically, an ‘ethnic group’ refers to a group of people who identify with each other through common heritage, language and culture (which can include religion). In our research, we are referring to the 18 ethnic groups that the UK government has recommended ([Institute of Race Relations undated](#); [Race Disparity Unit undated](#)).

Who we are talking about in this report: **ethnic minority groups**, that is, people belonging to ethnic groups that are in the minority in the context of the population of England. In our analysis of the national WRES data (see our methodology in Appendix 1), we have used the same classification of ‘white’ as the UK government ([Race Disparity Unit undated](#)). In our research, our case study sites, in their use of ethnic categories, generally followed the WRES guidance on defining ‘Black and minority ethnic’ and ‘white’ (based on the Office for National Statistics 2011, cited by [NHS England 2018a](#), p 18).

There are some strong views against using the terms ‘Black, Asian and minority ethnic’ (‘BAME’) and ‘Black and minority ethnic’ (‘BME’) as general, catch-all terms for groups that are culturally and ethnically distinct ([Saeed et al 2019](#)).

All three case studies commonly used the terms ‘BAME’ and ‘BME’ (for example the ‘BAME network’ or ‘the leadership development course for BME staff’). However, we have decided against using them and will instead refer to ethnic minority people in recognition of the fact that experiences will vary between Black, Asian and other minority ethnic groups.

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### **Our definitions of key terms and concepts** *continued*

We make no judgement about the widespread use of 'BAME' or 'BME' and we do not want our choice to detract from the more important issue at hand; essentially, we are talking about groups of people whose ethnicity is more likely to be a factor in experiencing discrimination at work and undoubtedly in other aspects of life as well (McGregor-Smith 2017; Stevenson and Rao 2014).

The terms '**diversity**' and '**inclusion**' are sometimes used to mean the same thing, but we see a key difference between them. Diversity is a description about differences of background, thought and experience, and there can be no question that the NHS has an ethnically diverse workforce. Inclusion is much more subjective, and has been defined in various ways. We see it as relating to the 'commitment to treat everyone with equal respect and significance' (West *et al* 2015) and therefore key to making the most of a diverse workforce. In other words: 'Diversity is being invited to the party. Inclusion is being asked to dance' (Myers, undated, cited in Sherbin and Rashid 2017).



## 2 Background: workforce race inequalities in the NHS

In this section we present some background information about how workforce race inequalities in the NHS are currently being addressed. We also discuss some of the initiatives that have been introduced to try to bring about change.

### What is the NHS doing to address race inequalities in its workforce?

Throughout history there have been many shock moments when it comes to race equalities and race relations. These moments have galvanised national policy-makers into action. This includes legislation – such as the Equality Act 2010 and the Race Relations (Amendment) Act 2000 – to provide legal protection from discrimination in the workplace and wider society.

More specifically to the NHS, there have been a number of policy initiatives to raise awareness of inequalities of experience, and to share good practice to reduce these inequalities. For example, the Equality Delivery System 2 (EDS2) was launched in 2013 to help local NHS organisations review and improve their performance in terms of people with characteristics protected by the Equality Act 2010 ([NHS England undated](#)). Also since 2013, NHS England has set up the NHS Equality and Diversity Council (EDC), which is now co-chaired by Sir Simon Stevens. The purpose of the council is to ‘drive whole system equality improvement’ ([NHS Equality and Diversity Council 2019a](#)).

The most recent high-profile policy initiative for driving race equality is the Workforce Race Equality Standard (WRES). The WRES, introduced in 2015, mandates the collection of key indicators that cover different aspects of equality, diversity and inclusion in the NHS (see Appendix 2 for more details on these indicators). The WRES has given the issue of workforce race inequalities a national focus and visibility ([Dawson et al 2019](#)) and allows for greater scrutiny of how the NHS is performing on race equality over time. The national WRES Implementation



Team and very senior leaders in NHS England and NHS Improvement have also made a concerted effort to embed the use of WRES data in local organisations, to focus attention and catalyse action. NHS England and NHS Improvement have also committed to monitoring their own performance on race equality ([NHS Equality and Diversity Council 2019b](#)). In March 2020, Sir Simon Stevens announced that NHS England and NHS Improvement would be committing to a target of 19 per cent representation of ethnic minority employees at every pay band within the joint organisation by 2025 to reflect the make-up of the wider NHS, where 19.7 per cent of NHS trust and commissioning staff are from an ethnic minority background ([NHS England 2020a](#); [WRES Implementation Team 2020](#)).

The WRES has drawn attention to the race equality agenda in a way that the NHS is used to thinking about organisational performance and may therefore be a helpful catalyst for action: NHS organisations are very used to measuring how well they are doing against various standards and targets, which has been shown to play a role in improving certain aspects of performance within the NHS ([The King's Fund undated](#)). Over time there has been a degree of improvement in some of the WRES indicators – such as the relative likelihood of ethnic minority staff entering the formal disciplinary process compared with white staff ([Coghill 2020](#); [WRES Implementation Team 2020, 2019](#)). However, significant cultural challenges remain in ensuring ethnic minority staff have equal access to career development opportunities and increasing the diversity of people employed in the most senior bands in the NHS ([WRES Implementation Team 2020](#)).

A recent evaluation of the WRES showed that the impact of its work (including changes in the metrics) on ethnic minority staff depended on how well trusts had been engaging with the race equality agenda before the standard was introduced ([Dawson et al 2019](#)). Thus, it is questionable how well the annual reporting of WRES data alone prompts reflection about the root causes of inequalities and how to make the experience of work more equal between all groups.

Considering the wider historical, sociological, political, economic and cultural factors involved in the race agenda, we think it is local action in response to WRES metrics and other data on the experiences of race inequality that become important. As we will describe in later sections, such action needs to take account of local history and context as well as good-practice guidance and support.



## Resources and support to address workforce race inequalities in the NHS

Before we take a look at specific interventions in the NHS, it is worth noting that the research indicates there are five key enablers for addressing race inequalities in NHS and non-NHS settings ([Darling and the WRES Implementation Team 2017](#)). These provide helpful pointers in terms of laying the foundations for race equality initiatives at a local level:

- clarity around the rationale for change
- accountability and responsibility
- senior leadership support and advocacy
- good-quality data
- clear and consistent communications.

In terms of practical actions or interventions, our review of the existing evidence shows that there have been a low number of formal or independent evaluations of initiatives in the NHS. The lack of evidence on impact and effectiveness is a source of frustration to NHS employees tasked with making changes in their organisations ([Dawson \*et al\* 2019](#)).

Understandably, most good-practice guidance comes directly from NHS England and NHS Improvement around implementing staff networks, setting targets for representation at senior levels and reducing referrals to formal disciplinary processes when informal interventions might be sufficient ([NHS England 2019a, 2019b, 2017](#); [NHS England and NHS Improvement 2019](#); [Warmington 2018](#)). Other resources available to NHS organisations are listed below (most of which are specific to addressing race inequalities):

- the WRES experts programme, which aims to develop ‘in-house’ expertise to improve workforce race equality (see [www.england.nhs.uk/publication/workforce-race-equality-standard-wres-experts-programme-cohort-one-biographies](http://www.england.nhs.uk/publication/workforce-race-equality-standard-wres-experts-programme-cohort-one-biographies))
- the NHS Employers diversity and inclusion partners programme, which aims to embed equality and diversity in NHS organisations (see [www.nhsemployers.org/retention-and-staff-experience/diversity-and-inclusion/partners-programme](http://www.nhsemployers.org/retention-and-staff-experience/diversity-and-inclusion/partners-programme))





- leadership development programmes for ethnic minority staff in the NHS aspiring to progress to more senior roles (for example, 'Stepping Up' and 'Ready Now' run by the NHS Leadership Academy – see [www.leadershipacademy.nhs.uk/programmes/the-stepping-up-programme](http://www.leadershipacademy.nhs.uk/programmes/the-stepping-up-programme) and [www.leadershipacademy.nhs.uk/programmes/the-ready-now-programme](http://www.leadershipacademy.nhs.uk/programmes/the-ready-now-programme) respectively)
- the 'Building Leadership for Inclusion' (BLFI) programme led by the NHS Leadership Academy, which aims to accelerate and strengthen NHS capacity for inclusive leadership development, among other things (see [www.leadershipacademy.nhs.uk/resources/inclusion-equality-and-diversity/blfi-2](http://www.leadershipacademy.nhs.uk/resources/inclusion-equality-and-diversity/blfi-2))
- an independent taskforce launched in February 2020 by the NHS Confederation to support NHS organisations to increase non-executive diversity on their boards and governing bodies
- various independent consultancies offering support on recruiting for diversity and implementing equality, diversity and inclusion interventions.

As with all interventions, the applicability of these resources to local contexts will vary, and there has been no attempt at formal evaluation that would help to establish the contexts in which they may be more or less helpful. At the least, they provide ideas that organisations can consider in thinking about how they can go about working on race equality, appreciating that decisions about what to do need to take account of local circumstances.

There are some commonly used equality, diversity and inclusion 'interventions', such as staff networks, unconscious bias training and reverse mentoring (McGregor-Smith 2017), which we describe below. (We will look at the three case studies' experiences of using these interventions in later sections.)

The NHS has numerous equality-based **staff networks**. There are overarching ones encompassing multiple employers (for example, the British Association of Physicians of Indian Origin – or BAPIO – and the NHS Confederation's BME Leadership Network) and it is increasingly common for individual NHS commissioning and provider organisations to implement multiple in-house networks for staff belonging to ethnic minority groups or identifying as lesbian, gay, bisexual and transgender (LGBT) or disabled (of course, an individual could identify as all three) (NHS England 2017).



The purpose of staff networks is to bring employees together to share experiences, learning and development and ultimately to ‘assert equity for their members’ (NHS England 2017, p 7). For members, staff networks can help promote a sense of solidarity and create ‘psychologically safe spaces’ for discussing aspects of identity and issues related to equality, diversity and inclusion (Bolden *et al* 2019). For the wider organisation, staff networks can offer insight and challenge around inequalities and inclusion.

According to the findings of a survey that NHS England undertook, the key benefits of staff networks can be categorised as:

- a mechanism for raising ‘voice’ and employee engagement
- a pipeline of talent and potential future leaders
- a way to foster empathy and collaboration among staff
- a way to foster innovation.

The same survey shows that implementing a staff network is not always a smooth process, for example where some staff reject the idea that such a thing is necessary or feel that staff networks are a form of segregation (NHS England 2017). Network approaches can risk being a tokenistic endeavour where groups act in isolation and lack the ability to influence wider change. Also, it can be argued that membership of a network and taking on actions to progress the race equality and inclusion agenda on behalf of the organisation is unpaid labour – particularly unfair for people who have been on the receiving end of discrimination or marginalisation in the first place (Bolden *et al* 2019).

**Unconscious bias training** has been introduced in the NHS and other organisations (The King’s Fund included), but it can lead to mixed results (Bolden *et al* 2019; McGregor-Smith 2017). That is, the training can raise awareness of issues around equality and diversity (Atewologun *et al* 2018) but the approach relies heavily on individuals identifying and addressing their own biased behaviours and takes the focus and attention away from how well an organisation as a whole does or does not support a culture of openness and learning (Bolden *et al* 2019).

Another intervention focused on promoting race equality and inclusion at the individual level is **reverse mentoring**, which involves pairing a junior employee with



a more senior one (ideally from different backgrounds) in a mutually developmental relationship. The aim is to redress power differences and address ‘advantage blindness’ among leaders through sharing lived experiences (Fuchs 2019). A few chief executives in the NHS have shared information on Twitter about their experience of being reverse mentored (for example, see <https://twitter.com/BWCHBoss/status/1174738608714133506>); however, we could not find any formal evaluations of the intervention in the NHS and the evidence of impact is mostly anecdotal. Despite this, the experience of senior leaders appears to have been a positive one. The benefits for the junior person in the pairing are less known.



## 3 The case studies

As we set out in section 1 (Introduction) and in Appendix 1 (Methodology), there are no claims to overall excellence in the NHS with regards to workforce race equality and inclusion, and the chief executives at all three case studies in our research told us there is much further for their organisations to go. What the case studies can demonstrate is the lived reality of implementing measures to address race equality and inclusion issues. All three case studies implemented similar key interventions, which we describe in more detail in sections 4 and 5:

- staff networks
- psychologically safe routes for raising concerns
- enabling staff development and career progression.

In this section, we present profiles of the case studies, including the impetus for action and the 'measures' put into place.

In terms of 'drivers' for action, the three case studies have the following ones in common. How the drivers interact with certain barriers and enablers will be explored in later sections.

In all three case studies, individuals' beliefs and attitudes about race equality and inclusion motivated them to get involved in different ways, and champions were found at all levels taking a visible and hands-on approach. For some, there were moral reasons for taking action, such as wanting to promote equality and fairness for staff and patients, or seeing that happy and engaged staff are more likely to provide compassionate, person-centred care to patients. Some had personal experiences of discrimination or marginalisation that led them to get involved, while others wanted to act as allies to those who had these experiences. They also used different types of data, such as the WRES as well as focus groups or individual conversations with staff throughout the organisation.

*As chair of the network, we took the lead on the harassment of staff by service users... this was before WRES... This was me taking on a situation which had been*



*going on for quite a long time where a member of staff had been racially abused and the managers not knowing what to do, either dismissing it as banter, ignoring it, telling staff, 'Well, you're obsessional, just get on with it, it's part of your job'.*

Just before we profile each case study, we would like to give an indication of what interview participants told us about the impact of experiencing discrimination at work and how such negative experiences can cast a long shadow. As we discussed earlier, the psychological and emotional impact of being discriminated against should not and cannot be underestimated. Often these negative experiences stick clearly in the minds of staff for many years and it can take many years of interventions to 'undo' and reverse them. Examples such as the following one provided part of the impetus for action.

An ethnic minority member of administrative staff told us how a senior manager had tried to block a professional development opportunity:

*I completed my application [for a development programme] and gave it to [my manager's] colleague to sign it off and the comments that I got from her were quite belittling. She asked, 'What makes you think you're going from a band 4... to a band 7...?' Asking why I was going for this big jump, that I'm not experienced... Why would you do it? I'm thinking why wouldn't I? I want to make progress with my life. She [made me question my decision to apply for the programme] and was putting everything negative in my head. And, in the end, she turned around to me and she said, 'Well managers are not even on that, so what makes you think you can jump from a band 4 to a band 7 or 8?' So that bit got frustrating, so I turned around to her because by then I'd already started attending meetings with assistant directors. And as soon as I said that she looked stumped so she signed off my application. But prior to that she kept questioning [my decision to apply]... [telling me], 'Well [there are other] people in our organisation that deserve to be on this... programme that I'm thinking of putting through...' So as soon as I had the conversation with her I phoned [the programme provider] and I spoke to them and I said, 'I've been told that because I don't have a degree I can't go forward for [programme name]'. And she said, 'Don't believe anything they say, this is about you as an individual wanting to make progress with your life and move forward. And don't let anything... some of these things that are happening to you are some of the things that we're going to be addressing'.*



## Bradford District Care NHS Foundation Trust

### Profile of the trust

Bradford District Care NHS Foundation Trust (BDCFT) provides mental health services, community services, services for children and young people aged 0–19 years and learning disability services across Airedale, Bradford, Craven, Wakefield and Wharfedale. BDCFT employs approximately 3,100 people. According to the most recent data on the diversity of the workforce (July to December 2019), of those who stated their ethnicity, around 70.4 per cent were white British and 23.3 per cent were from ethnic minority groups ([Bradford District Care NHS Foundation Trust undated](#)). The highest proportion of ethnic minority staff were on Agenda for Change contracts, and the numbers employed in bands above 8c were relatively low. At board level, there were no executives from an ethnic minority background. Two of the six non-executive directors were from an ethnic minority background.

BDCFT is one of the small number of NHS providers we identified through our analysis of the WRES data in the 'equality of opportunity' grouping (see Table 1 in Appendix 1). Our initial discussion with the Director of Human Resources and Organisation Development revealed there had been efforts to drive more career progression for ethnic minority staff for some time, specifically the launch of a bespoke leadership development programme called 'Moving Forward' for staff in band 5 and 6 roles in 2015. Also, in 2014, the trust set a target to have 35 per cent of its workforce from an ethnic minority background. Leaders and other staff recognised the need for the make-up of the workforce to better reflect the diversity of the local population too. A more diverse workforce could work more effectively with local people to understand their health care needs as well as any barriers or issues in accessing services.

According to the Chief Executive of BDCFT (at the time of interviewing):

*There are two aspects... One is our role as an employer and looking to ensure that our staff and governance processes are more representative of the communities that we work in... The second issue is that... there isn't an even distribution of the population across our, kind of, structures and hierarchy. So if you're a BAME [Black, Asian and minority ethnic] member of staff, you're more likely to be bands 1 to 4, or to be a medic. So it's quite extreme within our workforce profile [in terms of]*



*where you will find BAME members of staff... The other thing then from a service perspective here is that we need to ensure that our services are more appropriately focused on the needs of the specific community that we work in. [There is a] massive concentration of [ethnic minority groups] in [the] Bradford CCG [clinical commissioning group] area. And we know that health outcomes are poorer in those areas.*

### Key features of the trust's strategy

The strategic aims and vision for race equality and inclusion at BDCFT have emerged over time. In 2016, the trust's objectives were derived from the NHS Equality Delivery System (EDS) process and spanned race, disability, age, sexual orientation and gender. An equality, diversity and inclusion workforce strategic reference group was launched in 2018, chaired by the Director of Human Resources and Organisation Development, to oversee the delivery of the three-year strategy, with the aim of being an outstanding organisation that recognises the 'direct link between outstanding care and good staff satisfaction and experience and equal opportunities' (source: internal BDCFT strategy document shared with the research team). The group uses data from the WRES, the Workforce Disability Equality Standard (WDES), the gender pay gap regulations and the Stonewall Unhealthy Attitudes survey (Somerville 2015) to inform its approach and to track progress. Objectives include:

- creating a diverse and inclusive culture – for example, delivering 'Sharing Perspectives' workshops to teams to help people understand each other, drawing out insights about diversity and opening up conversations among staff
- reviewing and improving policies and procedures and introducing new ones – for example, launching a policy on managing racial abuse from patients.

Looking forward, BDCFT is targeting schools with high numbers of ethnic minority pupils to talk to them about careers in health and care to encourage future applicants from a range of ethnic and socio-economic backgrounds. Also, BDCFT is part of the Bradford Health and Social Care Economic Partnership, which is engaging the local community with an aspiration to create 'One Workforce'. Part of this involves engaging local women from South Asian backgrounds who might



not have been formally employed before to encourage them to apply for jobs in health and care.

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## Calderdale and Huddersfield NHS Foundation Trust

### Profile of the trust

Calderdale and Huddersfield NHS Foundation Trust (CHFT) provides acute care from its two hospital sites in west Yorkshire. According to the most recent data, CHFT employs more than 6,000 people and 15 per cent are ethnic minority members of staff ([Calderdale and Huddersfield NHS Foundation Trust undated](#)). Ethnic minority staff are employed in all non-clinical bands; however, very few are employed in clinical bands above 8a or in very senior manager roles, according to the most recent data available on the workforce. The highest proportion of ethnic minority staff are employed in 'other' medical roles, followed by 'career grade' medical roles. One executive director (the Chief Executive) and one non-executive director are from an ethnic minority background.

Dr Owen Williams OBE has been Chief Executive of CHFT since 2012 and he is one of a relatively small number of ethnic minority chief executives in the NHS. We were keen to understand how CHFT experienced this and it was a factor in our decision to include CHFT in our case study sample.

### Key features of the trust's strategy

From our discussions with staff at CHFT, we understand that Owen has been credited as starting a frank dialogue about race inequalities in the workforce. Owen described those discussions as leading to a turning point:

*I put together, with the help of a few other colleagues, about eight or nine focus groups of Black, Asian and minority ethnic colleagues here and they were... a slice of the organisation – clinical, non-clinical, consultant, cleaning colleague, porter, a*





*real rich mix of colleagues... From these focus groups, a whole series of things came out... there were people carrying issues that dated back two decades about how they felt... And I think... that... was very important for people to feel that they had a space to share that. Then what we did is stood in the future: What's the result look like? What would 'good' look like? And then we... collated those together... And then we had a private board meeting... where we dedicated the session, the whole entirety of the board to two colleagues from the focus groups [who] came, they'd never been to the board meeting before... they wanted to own it, too... afterwards, they were in tears actually because it was quite a seminal moment for them and some of them had been carrying hurt and just the fact that this information was being listened to...*

Those discussions led to a series of actions for board members and other staff, including setting up a staff network for ethnic minority staff in 2016 (referred to within CHFT as the 'BAME network'). Initially, Owen took on the chairing of the network, but he was keen for another colleague to take on the role – someone who could engage staff at different bands and in different roles to take forward actions. A category manager working in the procurement department volunteered and has held the position of network chair since then. Momentum continued to build around race equality and inclusion (and the wider equality, diversity and inclusion agenda) and, early in 2019, CHFT created a new dual role for an equality, diversity and inclusion manager and 'Freedom to Speak Up Guardian' (Freedom to Speak Up Guardians offer an independent and confidential alternative to raising concerns directly with line managers or supervisors and can 'escalate' any concerns to the appropriate person or department in the organisation). This has led to the development of a five-year equality, diversity and inclusion strategy, combining the trust's aims for race equality with its aims to make the trust more diverse and inclusive of all minority groups, so that ultimately the workforce reflects the local population it serves and is responsive to its needs.

As well as the ethnic minority network, CHFT has implemented various other initiatives in order to advance its equality, diversity and inclusion agenda:

- developing routes for staff to raise concerns – for example, 'Talk in Confidence' groups (linked to the Freedom to Speak Up function) and 'Ask Owen', which is a direct way for members of staff to ask the Chief Executive any question



- encouraging colleagues from ethnic minority groups who are aspiring for leadership roles to take part in leadership programmes such as Stepping Up (run by the NHS Leadership Academy) or Moving Forward (run by neighbouring BDCFT)
- strengthening in-house training to include cultural awareness
- ensuring that 70 per cent of decision-makers have participated in the unconscious bias 'Stand in their Shoes' programme
- adopting a training programme for line managers about addressing bullying, harassment and abuse concerns
- introducing diverse interview panels for all posts above Agenda for Change pay band 6.

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## East London NHS Foundation Trust

### Profile of the trust

East London NHS Foundation Trust (ELFT) provides mental health and community health services to people in Bedfordshire, the City of London, Hackney, Luton, Newham and Tower Hamlets. It also provides Improving Access to Psychological Therapies (IAPT) services in Richmond in London. Currently, ELFT employs more than 5,500 people. Somewhat unusually compared with other NHS providers, ethnic minority staff at ELFT slightly outnumber white staff overall. However, similar to other NHS providers, there are relatively fewer ethnic minority staff in more senior clinical and non-clinical pay bands (7 and above).

ELFT is known for having a strong focus on culture and quality improvement (Ross and Naylor 2017). Dr Navina Evans CBE has been the Chief Executive at ELFT since 2016 and leads on work on making the NHS a better place to work – and, more specifically, work on implementing key commitments made in the *NHS long term plan* (NHS England 2019c) and the *Interim NHS people plan* (NHS Improvement 2019). In March 2020, Health Education England announced that Navina would join the organisation as its Chief Executive, making her the first



woman from an ethnic minority background to take on such a role in a national health care body (Health Education England 2020).

In terms of workforce race issues, we were particularly interested in ELFT because it bucks the national trend in terms of having the highest number of executive and non-executive board members from an ethnic minority background in the NHS (eight at the time of writing, including the Chief Executive, Chief Nurse, Director of People and Culture and chair) (WRES Implementation Team 2019).

Therefore, a combination of all these factors influenced our decision to include ELFT in our case study sample.

### **Key features of the trust's strategy**

Since 2017, ELFT has implemented five separate staff networks: one for staff from an ethnic minority background (called the 'BAME network'); one for staff identifying as lesbian, gay, bisexual or transgender; one for staff identifying as having a disability; one for female staff; and, late in 2019, an 'intergenerational' staff network. One or two members of staff lead each network. All the network leads are members of staff employed in different clinical and non-clinical roles. Each network has an executive sponsor and access to financial resources to support the running of the network, for example conferences, venue costs and paying for external speakers. Network leads have protected time (approximately one day a week) to focus on co-ordinating the network meetings and activities.

There is a multifaceted approach at ELFT to developing safe spaces in which members of staff are encouraged to raise concerns (for example, via the Freedom to Speak Up Guardian). Linked to this sense of safety is fostering a sense of mutual respect and understanding among staff. To address issues around staff experiencing bullying, harassment and abuse from patients, the public and other staff, ELFT launched an internal 'Respect and Dignity @ Work' campaign. This involved the trust hosting a pop-up exhibition run by the Empathy Museum called 'A Mile in My Shoes' as well as running a series of 'Through My Eyes' focus groups for staff to share their stories and foster empathy and personal connections. Stories have been shared at executive meetings and with the joint staff side committee, leading to executive pledges being made. Part of the project is to work with line managers in sessions called 'Through Someone Else's Eyes'.



In 2018, the people and culture (formerly human resources) team undertook a quality improvement project to reduce the length of time taken to conclude disciplinary proceedings. By analysing the data through a 'deep dive', the team discovered a consistent pattern of Black nurses in pay band 5 or 6 with approximately three years of service being more likely to be disciplined than other staff ([East London NHS Foundation Trust 2018](#)). The trust has continued to review the data on staff entering the formal disciplinary process to draw out learning. It has implemented a 'Fair Treatment' process and this has reduced the number of suspensions. ELFT will continue to embed some learning for managers about fair treatment; appoint an investigator; recruit someone to a pastoral role to support staff going through human resources processes; and generally ensure there is an emphasis on compassion and safety for staff.

ELFT was also a pilot site to help co-design NHS Improvement's Culture and Leadership programme, in partnership with The King's Fund. Part of the purpose of this collaboration between ELFT, NHS Improvement and The King's Fund during the diagnostic phase was to gain a better understanding of the experiences of ethnic minority staff ([NHS Improvement 2016b](#)).

Numerous actions are directed at increasing race diversity in the workforce. For example, ELFT is focusing on how to increase the proportion of ethnic minority staff in senior positions and is undertaking succession planning for all executive director and clinical director roles to try to diversify the talent pipeline.

Finally, another key focus for ELFT is encouraging career development and progression. Staff are encouraged to participate in both in-house and external leadership development programmes and the trust has sent targeted communications to consultants in under-represented groups to invite them to apply for clinical excellence awards, following up with workshops to support with the completion of application forms. This activity saw a 4 per cent increase in clinical excellence awards awarded in 2018.

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## What would race equality and inclusion 'success' look and feel like?

One of the issues that may affect staff in organisations undertaking race equality and inclusion actions is knowing whether or not they are on the right track. We wanted to understand what 'success' looks and feels like within the case studies.

Interviewees were asked to reflect on the overall aims or vision for race equality and inclusion in their organisations. Some spoke about the quantifiable outcomes associated with the WRES they would like to see, including:

- a reduction in levels of bullying, harassment and abuse
- a reduction in the percentage of ethnic minority staff referred to the formal disciplinary process
- an increase in the representation of ethnic minority staff overall (including in leadership positions)
- an increase in the percentages of ethnic minority staff accessing non-mandatory training and continuous professional development.

There were also signs that the case study organisations were considering how to address deeply ingrained, systemic inequalities such as the gender pay gap (for example, ELFT was targeting female consultants to invite them to apply for clinical excellence awards and supporting them with the application) (Schlepper and Appleby 2018).

*And I think... having some of those changes at the senior leadership has given a sense of... I hate to use this word, a sense of hope for people who might feel, oh, gosh, it's always the same face at the top, you know, it's always male or it's always white male, you know. And the trust is so diverse, so it's really important that our leaders represent that diversity, which I think it does, and it continues to examine itself, I would say.*

*And I kind of veer towards, well, the inclusivity bit is about understanding that you've got a range of colleagues with a range of, you know, backgrounds and experiences, and all those other characteristics, and actually everyone's valued. I think that's the hardest bit is that I think any work that is done around the*



*EDI [equality, diversity and inclusion] side of things is done sort of in parallel to creating an environment through which colleagues are valued as individuals and as teams.*

In addition, it was clear that individuals in the three case studies were seeking a change in the working environment – a place that *feels* inclusive and welcoming. It has been noted in recent years that the weight of the emphasis on equality, diversity and inclusion has shifted more to the ‘inclusion’ aspect, that is, a better understanding of ‘culture, behaviours, resources, processes and structures, which either promote or inhibit the full and equal engagement of all individuals’ (Bolden *et al* 2019, p 23).

*I think the goal is to become very inclusive and for everyone to feel comfortable working for our trust... What it means to me is that any... person... just anyone can feel comfortable working, and having different avenues, like different support networks that they can go to ... without feeling uncomfortable.*

*We’re all here for the patients. I think sometimes we lose track of that. Ultimately, it will be [a] better workforce, better patient care. I think ultimately it will be a better place to work – fairness for all.*

Interviewees described other hard-to-measure changes, including:

- a sense of psychological safety (for example, being empowered to talk about incidents of racial harassment and being believed and taken seriously)

*...the vision is that we can have those difficult conversations and that people are not worried about bringing things up... I think the vision is to not kind of pretend that there isn’t a problem.*

- greater empathy towards and inclusion of colleagues from all backgrounds

*I think for me, if we’re starting to get to a stage where Black, Asian, minority ethnic colleagues themselves feel that there’s real opportunity for themselves but also white colleagues feel a part of that as well... ‘cause, you know, people talk about ‘EDI’ [equality, diversity and inclusion], I always [feel]... the ‘I’ is the word that people always focus the least on... for me, it’s about people feeling*



*inclusive, being a part of something... Getting to a stage where, regardless of your cultural background, people feel a part of something.*

- making equality, diversity and inclusion conversations more mainstream, meaningful and purposeful

*...my personal experience is that it's a culture through the workforce... that people are trying to really harness a positive culture that's inclusive and diverse. And I hear about these things being discussed openly, honestly within our organisation.*



## 4 Interventions to make it safer to talk about race

In this section, we describe two key interventions that our case study sites told us seemed to make it easier to have conversations about race equality and inclusion: the creation of staff networks and psychologically safe routes for raising concerns.

### Staff networks

#### What are staff networks?

All the NHS provider trusts involved in this research have ethnic minority staff networks operating across different sites. These networks are intended to support ethnic minority staff by giving them the opportunity to discuss race-related issues in an inclusive and 'safe' space, to have their concerns heard and for the organisation to respond to them. In our case study sites, we heard examples of new training and development programmes launched as a direct result of the conversations that had taken place at network meetings, as well as access to coaching and mentoring opportunities.

*I think those network groups have been very instrumental in... addressing issues that we might have with those particular groups, and trying to change or bring more sort of voice [sic] to those groups as well.*

An ethnic minority member of staff chairs the network in all the case study sites and they carry out this extra work alongside their core roles. The networks meet regularly throughout the year. Often the networks had been running for a few years and built momentum and support as they became more established.

#### How organisations support the implementation of staff networks

We heard lots of positive experiences of staff involved in staff networks, at both an individual and an organisational level. First and foremost, the networks are seen as safe spaces for ethnic minority staff and signal the importance of race-related





issues to the wider organisation. At ELFT, we heard that organisational support for networks is fundamental, in terms of both senior leadership sponsorship and ensuring staff have ‘cover’ to attend network meetings and be involved. For example, the chair of the ethnic minority network (as well as the chairs of other staff networks) had time built into their schedule for running the network. This exemplifies the organisation’s commitment to the various staff networks.

*...over the years, there’s been the odd BAME [Black, Asian and minority ethnic] network sort of pop up, but they’ve always kind of failed, I suppose, because it’s been something that people have had to run on top of their normal day job. And I know how much work I put into the network and if I had to do that without the support of having that [dedicated day per week] I don’t think it would be anywhere near as successful as it is now.*

Organisations can also support their staff networks through support from the communications team, for example ensuring the visibility of the networks and the outcomes from discussions.

*So we have very good support for all of the networks from our People and Culture, which is our HR [human resources] team, support for organising meetings, for running conferences or organising conferences, and we have a really good communications team for supporting with when we want to send things out to people and putting articles out and telling people what’s going on.*

### **Benefits of staff networks in the case studies**

We also heard about the networks contributing to building trust and understanding among staff – particularly as a vehicle to educate and inform white staff about personal experiences:

*At the BAME network we all sort of share our lived experiences. They had the other week the inclusion and diversity week and I came and gave my lived experience to explain why I’m the person that I am, a bit about my childhood, what I’ve endured through work and why I’ve come out the other side the way I am.*

These discussions can be very empowering for participants, giving voice to difficult feelings and at the same time informing and educating others. For example, we



heard about a powerful experience of a network bringing together ethnic minority and white staff to share their experiences:

*The BAME network... it's powerful, some of the mindsets that you change on your journey... it was powerful. The learning from basically hating each other to actually coming together and supporting [one another], and the colleague, the white colleague actually said something... about the relationship and how it's developed [for the better].*

Networks represent an opportunity for all staff to understand the perceptions and lived experiences of people from ethnic minority backgrounds. In hearing those perceptions and experiences first-hand, staff can have more empathy towards people with different characteristics from their own. People found this aspect of the networks fascinating as well as fundamental for understanding how people from ethnic minority backgrounds both experience and feel about things.

We heard that the networks could also be enriching and beneficial in practical ways. This was through presenting new opportunities to lead, mentor and coach others, as well as providing an access point to training (ranging from 'building confidence' to successful interview techniques) and the introduction of a formal training and development programme for ethnic minority staff in one case study site.

### **Challenges for staff networks**

Although interviewees regarded the staff networks as largely positive interventions, there were some challenges for the organisations and individuals involved in setting up and running them. For example, chairing networks typically falls to a few individuals to put in a lot of hard (unpaid additional) work, and involves continued motivation and commitment to keep the network going, so it is important that organisations support them in the ways described above.

On a practical level, we heard that the time commitment to attend or be involved with the network was not always possible. For example, it was harder for some clinical staff to take time out of their schedules to attend meetings and engage with the network in the way they wanted to. In more worrying examples, we heard of staff being actively discouraged (or even blocked) from attending the network meetings, or having to provide 'evidence' as to why they should be involved in the network.



In some cases, we heard that the creation of a network had led to some negativity or resentment among colleagues, specifically some staff feeling excluded. Some felt that the existence of a network for ethnic minority staff meant that those staff were being 'given something extra' – and that it was fundamentally unfair. This resonates with the findings of NHS England's survey research, mentioned in the 'Resources and support' subsection in section 2 of this report (NHS England 2018b, 2017).

One interviewee told us how the creation of the ethnic minority network had uncovered racial tensions within her team. She overheard another member of staff asking if they needed to 'black up' so they could attend a network meeting:

*There was actually a Sister, a Black Sister, who was in an office with some of the senior people and they were talking in a corner, two white Sisters, and they said, 'Oh, have you heard about that BAME network group? What do I need to do? Do I need to black up to get on that?' And in front of a Sister who was Black, actually talking and saying that.*

Another interviewee noted:

*So I think some managers need to understand why certain groups are formed... they see us getting privilege because we're in a BAME network group, [and ask], 'Why isn't there one for our group?' That's just some people, it's not everyone because some people are on board and they're interested to learn and understand about the different cultures and ethnicities... but there's certain ones where they probably think, 'Well why are you lot doing all this? Why can't I go on it?'*

Thus, creating a safe space for ethnic minority staff to talk about race-related issues could inadvertently create new (or exacerbate old) divisions between different groups. And, at worst, ethnic minority staff could find themselves having to justify why this type of recognition of difference is needed.

One way that organisations might mitigate this impact is to ensure that networks, or some of them some of the time, are open to all staff (which they were in the three case study sites).

*The BAME network and those other forums, need to include more of the people who aren't or who don't possess those characteristics. So, actually it's not [seen*



*as] an area where people can talk about how bad it is for them or how bad it isn't for them or the problems they've had, [but instead] how people can constructively engage... in making a change.*

We would point out that opening up ethnic minority networks to white staff needs careful consideration given it may inhibit ethnic minority staff members from participating. Based on what we were told, we do not think that there is a 'one size fits all' intervention here – rather, organisational approaches to networks may need to flex over time according to how they are received.

### **Key learning points about staff networks**

Staff networks have developed and grown in strength in all three case study sites. Through our discussions with the sites it is clear that ethnic minority staff have benefited from having a safe space in which to discuss issues affecting them, alongside their white colleagues. This suggests that the creation of a network can be a positive step in tackling discrimination. This was particularly important in sites where networks were used as a space to enable conversations – both negative and positive – to find ways of moving forward while being sensitive to the issues raised. Therefore it seems important to consider the following points when setting up a staff network.

- Try to get buy-in from ethnic minority *and* white staff.
- Ensure that sufficient time and resources are allocated to the network for it to be effective.
- Be prepared to engage with and work through resistance and tensions where they arise.

Below we offer some key considerations for NHS organisations to take into account.

- What is the main driver for setting up a network for ethnic minority staff?  
Is it the best intervention to suit local needs?
- What are the ways to engage all staff in the network?



- Does the network have appropriate sponsorship from the leadership team so that it has some power to effect change and not become a remote or insular ‘talking shop’?
- How can staff be given adequate time and flexibility to engage with network meetings?

### Psychologically safe routes for raising concerns

Psychological safety has been framed in different ways. In the workplace context, the definition we found most helpful is that psychological safety is a belief that you will not be punished or humiliated for speaking up with ideas, questions or concerns or making mistakes. This involves feeling able to take risks and being vulnerable in front of others and it provides a space in which differences will be valued and welcomed with curiosity. Trust and support are likely to characterise the interpersonal relationships involved (Edmondson 1999).

#### How did the case studies create psychologically safe routes for raising concerns?

In all three case study sites, staff were provided with a number of informal avenues to speak up and out about racial discrimination. All three were promoting Freedom to Speak Up Guardians (FTSUGs) or other equality, diversity and inclusion champions as routes. For example, CHFT had trained 12 members of staff as ‘inclusion representatives’ who wear special badges or lanyards to signal they are approachable and happy to talk to staff or patients. The rationale at CHFT is that peer-to-peer conversations and engagement are a powerful way to learn from each other and work better together.

Introduced four years ago throughout the NHS, FTSUGs act as an intermediary between the organisation and individual members of staff who want to raise concerns about when care has not been delivered appropriately, or when they have been mistreated themselves. These discussions are intended to be less formal than raising a formal grievance or complaint (although this might be the ultimate outcome). FTSUGs represent a move away from a climate in which staff are afraid of the repercussions of speaking up, to one of support and conflict resolution. FTSUG training covers common barriers to speaking up and makes clear that some groups of staff (including those from ethnic minority groups) can find it particularly difficult to raise concerns through regular or formal channels ([National Guardian's Office 2019](#)).



## Benefits of psychologically safe routes for raising concerns

In all sites, staff we spoke to told us about the many positive aspects of having informal routes to speak out about racism in the workplace, both for themselves individually and for the organisation more widely. We heard that ethnic minority staff see FTSUGs as safer to talk to about concerns and less formal than going through human resources channels, and we were given examples of FTSUGs being very visible and approachable. We also heard that establishing and embedding the FTSUG role had taken time, and had required organisations to commit to the continued support of FTSUGs.

*We call them Freedom to Speak Up Guardians... if you see them and you want to raise a topic to them or want to have a conversation, you can stop and have that conversation. So that's something that wasn't here two-and-a-half years ago. And... people are stopping, people are now willing to talk, so it's good that people are feeling comfortable to do so. Which probably two-and-a-half years ago, we didn't have that in place, so it might not have happened, might not have had that conversation.*

These routes for raising concerns can also be ways to determine wider, systemic issues across teams or parts of an organisation. According to FTSUGs we spoke to, the informal conversations they have can highlight a wider problem that needs an organisational (as opposed to an individual) response:

*...the more concerns I get from... an area, then I start thinking, 'What's going on here?' I keep getting nurses [coming] to me and I keep getting staff from certain backgrounds coming to me. And, you know, we need to then sit down to say, 'Are we treating people differently, in a way that we're not even conscious of?' But certainly it's coming to [the] surface that it's the same people that are going through this experience.*

## Considerations for implementing psychologically safe routes for raising concerns

While we heard that staff thought that having informal and safe routes to disclose concerns was a positive thing, we also noticed that FTSUG roles were not problem free. For example, ensuring complaints and issues are heard builds confidence among staff that FTSUGs offer safe opportunities to effect change – but this can create a sense of individuals' responsibility to 'fix' problems that might require whole organisational intervention.



Generally, the sites used multiple formal and informal routes to encourage staff to speak up about difficult things they were going through. A (staff side) union representative pointed out that this could be confusing and so it should be made clear to staff what the different channels ‘offer’ so that people get the support they need as quickly as possible.

### **Key learning points about routes for raising concerns**

FTSUGs or inclusion officers can empower NHS staff to raise concerns. However, this requires:

- an ongoing commitment to having FTSUGs available for issues to be addressed (perhaps through multiple FTSUGs working in different sites)
- adequate training for FTSUGs on how to deal with race equality and inclusion issues
- support (both time and emotional) for FTSUGs to carry out their role sensitively and appropriately
- a willingness by FTSUGs and the organisation to hear the challenges that ethnic minority staff raise – in some cases, this requires the organisation to acknowledge patterns of behaviour when ethnic minority staff raise similar concerns and to respond accordingly.



## 5 Interventions to enable development and career progression

There is a pattern throughout the NHS of ethnic minority staff reporting barriers to development and career progression. Data from the WRES Implementation Team (2020) suggest that for NHS trusts in 2019:

- the relative likelihood of white applicants being appointed from shortlisting across all posts compared with ethnic minority applicants was 1.46
- the relative likelihood of white staff accessing non-mandatory training and continuous professional development compared with ethnic minority staff was 1.15.

Therefore, development and career progression for ethnic minority staff seem to be particularly important, especially given that the WRES data also indicates the lack of ethnic diversity at more senior levels within the NHS. In our case studies, frustration about the perceived lack of opportunity to progress was a strong theme in the experience of the ethnic minority staff we interviewed.

For example, several ethnic minority interviewees told us they have been repeatedly 'knocked back' when applying for more senior roles or they felt they had been overlooked for developmental opportunities, such as secondments or projects in which they could showcase their whole potential.

*I haven't progressed in my organisation. I did say I'd love to do a secondment within this [organisation], but nothing really has happened there. It would be good to be able to do a secondment because I've not had experience in the other areas, but having the experience within the trust in an area of seeing how the trust actually works would be beneficial... So I'm expanding myself, expanding my knowledge in the hope that I'm going to find something that's going to be ideal for me.*





Therefore, an ongoing commitment to training and development for ethnic minority staff is important. We think this should be framed as primarily about redressing historical imbalances concerning access – that is, encouraging those who have felt less able or enabled to do so, to take up opportunities their colleagues have enjoyed as a matter of course, rather than implying that ethnic minority staff are somehow lacking compared with their white colleagues. Further, if race equality is to be everyone’s responsibility, then all leadership development programmes need to deal with the topics of diversity and inclusion and how everyone is involved in perpetuating structural inequality. A further step would be for providers of development programmes to address the issues of diversity and inclusion in relation to the recruitment of both participants and facilitators, ensuring that inclusive ways of working are embedded in all aspects of the programme work. At The King’s Fund we are striving to do this in relation to our leadership development programmes. That is, in our ‘Building Your Authority’ and ‘Top Manager’ programmes respectively we cover learning on diversity and inclusion and use multiple methods to encourage access and participation from a wide range of participants, including those from an ethnic minority background (for the latter programme, see [www.kingsfund.org.uk/courses/top-manager-programme#who-is-it-for](http://www.kingsfund.org.uk/courses/top-manager-programme#who-is-it-for)).

## Development programmes

### Outcomes from career development programmes

In Bradford we heard about the ‘Moving Forward’ programme. This was developed following the publication of WRES data, which showed that most ethnic minority staff at the trust were employed in band 4–6 roles and that there was a significant lack of ethnic diversity at senior levels. The programme aims to equip staff in band 5 and 6 roles with leadership skills and learning experiences to help them apply for and be successful in securing more senior positions. In this case, the data highlighted a problem to the trust, and it was the trust’s willingness to accept the problem and find a solution that led to the development of the programme.

A participant on the Moving Forward programme told us about the positive impact it had had on their life and career:

*...we looked at resilience, interview techniques, all kinds of different things. In terms of measuring those outcomes as well... I’ve been promoted twice since, and that’s*



*that empowerment that [it's] given me to be able to be focused, be positive, to go for things more.*

Due to a lack of vacancies at senior levels at BDCFT, not all career progression was possible 'in house', meaning some Moving Forward graduates moved on to other organisations.

Moving Forward has proven to be popular with staff at BDCFT; four cohorts have participated since it was introduced and staff have expressed a clear wish for the programme to continue to run in its annual cycle because it is perceived as a 'flagship' initiative in the trust's work on race equality and inclusion. The programme is also available to two other NHS trusts in the local area, suggesting it can be a scalable intervention.

### **Resistance**

Generally speaking, ethnic minority staff who we interviewed received the development programmes such as Moving Forward positively, and white interviewees were very supportive of their ethnic minority colleagues having an opportunity to go on bespoke programmes, understanding the need for protected space to explore issues related to race and identity and how they play into career development. But there was also potential for this to be seen as a divisive move. A white interviewee recalled feeling shocked when there was an announcement that a leadership development programme was opening up at the trust and only ethnic minority staff could participate. They said that team members (some of them from ethnic minority backgrounds) were similarly surprised and felt the decision was unfair and exclusionary. After some probing from the interviewer about those feelings of shock, the individual then shared some of the reasons for their misgivings about programmes only for ethnic minority people.

Their opinion holds important insight in regard to the sources of resistance or scepticism about the impact of 'exclusive' leadership development programmes, and more generally about race equality and inclusion interventions.

*Like I say, for me I got quite upset because I felt suddenly, well, where I had a leadership programme before for everybody, now there's no leadership programme for me... there's only a leadership programme for the BAME [Black, Asian and*



*minority ethnic] candidates... Everybody received an email [announcing the programme], which we were absolutely just appalled at the wording of the email... I was like wow that felt like a step back in time... We shouldn't be segregating, we should be inclusive and bringing everybody together... For the [ethnic minority] leadership programme, it's well, 'What [have you] been taught which I couldn't be taught?' What is actually being said [to programme participants]? Is it, this sounds really bad and really racist, but is it, 'Don't listen to the white man'? It's not, I know it's not but... For me, understanding comes like I say from talking to people of many races and ethnic backgrounds, bring them altogether.*

Such examples of resistance can help to illuminate structural biases that may never otherwise come to light. As such, we think examples of resistance can usefully be seen as something to be sought out, understood and inquired into – rather than being ignored or eliminated. Frank conversations about why development is being offered to particular groups, and being open to exploring some of the dilemmas, challenges and opposing views that may result from choosing to implement these kinds of interventions, may help. This could include, for example, involving others in exploring questions about how development programmes aimed at ethnic minority staff might create a sense that they somehow need to be 'brought up' to the same level or standard as white people. Or about how development programmes might serve to help ethnic minority people 'fit in' to predominantly white working environments, thus creating a sense that some things about ethnic minority people have to change or be given up, rather than everyone engaging with what they might need to do differently to create a more equal workplace.

### **Addressing organisational obstacles to career progression**

As we note above, committing to race equality and inclusion is in the gift of everyone. While development programmes can help individuals to feel more confident, sometimes obstacles lie with recruitment practices or a lack of awareness of race equality issues.

In all three case study sites, multiple training and development opportunities have been opened up especially for ethnic minority staff as well as for white staff with regards to understanding difference of experience (for example, 'Sharing Perspectives'-type workshops).



One example we heard about was through different forms of unconscious bias training, which we noted in section 2 has some limitations but helps to raise awareness about diversity and inclusion issues. We heard that it was a popular initiative among leaders and other staff in the case studies because it opened people up to some of the dynamics at play in decision-making.

*...we've had a 'time-out' day about unconscious bias, and for me it really hit home. There was so much that I learnt from that and took from that in the sense that it's what I don't know [that] I need to improve on. And... how different cultures influence how [people] might come across at work. ... I think we all learnt a lot from that, so it was really good.*

In one trust, following the publication of data showing lower-than-average recruitment of people from ethnic minority groups, unconscious bias training was introduced for all staff involved in recruitment processes. During a sustained three-year period of this training programme, the trust reported improved figures for the recruitment of ethnic minority people. However, alongside a catalyst such as WRES data, we found that it was imperative to keep up the momentum. Having run unconscious bias training for three years, the trust decided to stop offering the programme, which some interviewees felt prompted a decline in the recruitment of ethnic minority people.

Another intervention that case study sites had introduced was reverse mentoring. Such initiatives have garnered a lot of support and increased understanding of the differences of experience for those involved. People expressed some positive views about leaders' willingness to engage and learn:

*I would say the most impactful part of one of the things that we've done would be inclusive mentoring. So the inclusive mentoring when we first launched that, what we [members of the ethnic minority network] said is we wanted the executive directors to be part of that programme... to be paired up with somebody who might've been a band 5 nurse or a band 3 admin person. I think [it] was a real eye-opener particularly for the exec directors because... whilst... they... will walk around and they'll do the leadership walkabouts and they've got the open-door policies and stuff. But actually to do that on a one-to-one basis and to hear from a BME person... what it's really like to be BME in this organisation and what is their experience, your living experience day to day... I think was the biggest shift for us in terms of buy-in from the exec team.*



## Key learning points about development and career progression

In summary:

- Targeted programmes can help to address historic imbalances in access to development and career progression for ethnic minority staff.
- Careful thought is needed about how such development interventions might exacerbate old or create new divisions.
- Engaging with a range of staff about the design of interventions may help to bring resistance/systemic biases to light, which can then be worked with as part of implementation.
- Interventions to address organisational obstacles or biases that influence the outcomes of recruitment processes are also important.



## 6 The importance of leadership and allyship

The role of senior leaders and demonstrating leadership for race equality came through as very strong themes in our interviews regarding how race equality and inclusion efforts can play out. This is perhaps unsurprising given the national focus on leadership and culture in the NHS in recent years ([NHS Improvement 2016a](#)) and the growing evidence base that links it with outcomes for patients ([West et al 2014](#)).

In this section, we consider five themes that arose in our interview data:

- the impact of diverse leadership
- the importance of allies
- board leadership and distributed models of leadership
- leaders 'holding' the tensions around race equality and inclusion
- support for leaders working on race equality.

### The impact of diverse leadership

As we noted in section 1, the latest WRES data shows that ethnic minority staff are significantly under-represented in very senior manager positions – that is, 6.5 per cent (given that 19.7 per cent of the NHS workforce is made of ethnic minority staff) ([WRES Implementation Team 2020](#)). However, it should be noted that the percentage of ethnic minority very senior managers and board members is increasing year on year. This is welcome news given that we heard that the diverse make-up of boards, or of others at very senior leadership levels, can have a profound impact on staff, whether those staff are from an ethnic minority background or not.

*I think [seeing a more diverse board of directors] shows that equality is working. Yes, I think it would inspire other staff. You'll find that there's somebody you can speak to, somebody you can relate to, somebody to talk to.*



The most senior leaders in NHS organisations clearly have an important role to play in setting priorities and role modelling the behaviours and practices they wish to see in their organisations. In our interviews, we heard about senior leaders ‘leading by example’ on race equality and inclusion issues, which members of staff felt very powerfully; this was described as inspirational, motivating and creating a sense of the importance of the work. Some leaders took on a more ‘visible’ approach by chairing staff network meetings (or sharing personal lived experience in those meetings), or unblocking barriers to participation in staff networks (for example, contacting line managers to encourage them to give members of staff time to go to network meetings), or addressing some of the sceptical views that some members of staff expressed about race equality and inclusion.

Conversely, we heard how the lack of a diverse executive and leadership team can also affect how ethnic minority staff in particular feel about being at work. For example, one interviewee said it was difficult to see how race equality and inclusion efforts driven by a largely white executive team would be able to change things for ethnic minority staff in a meaningful way.

*I don't see anybody of my kind there [on the board], it's just all white faces. So they don't fully understand, I don't think they understand the difficulties that BME [Black and minority ethnic] people go through, you know, which is slightly different to our white colleagues. And so our profile is a lot lower because there's not many of us.*

### The importance of allies

Of course, the visible (or vocal) demonstration of leadership is not only in the gift of leaders from ethnic minority backgrounds; and if race inequality is seen as something that everyone in an organisation or society participates in perpetuating, then the responsibility for tackling race inequality sits with all leaders whatever their ethnic background.

The term ‘allyship’ has been used to describe how those with relative advantages due to their background or experience, can use those advantages to further the cause of marginalised groups. It is a contested term, but definitions often involve the concepts of:

- acting to promote marginalised groups, for example through sponsorship or advocacy



- taking on the struggles of marginalised groups as one's own, rather than being a bystander, which may inadvertently perpetuate divisions
- taking responsibility for increasing understanding of the structural aspects of inequality and the part we each play in it, through studying the issues and oneself (Carlson *et al* 2019).

Put this way, allyship is no easy task and involves personal risks that people may not have encountered before.

*So, we've had to be quite bold on a lot of our EDI [equality, diversity and inclusion] messages in terms of what we do and what we don't tolerate. That... really says to people we are going to be mixing things up a bit and if you don't like it, this ain't for you. I think that sends a very positive message to people who we want here, who are up for that. But it sends a very clear message to people who are not up for that and we have found that whilst it's important to hear everybody's views, people need to know what their organisation stands for.*

However, the impact of taking a stand can be profound: if the challenge to longstanding patterns of behaviour comes from less expected sources, then this may shine a light on the assumptions that underpin structural biases in a way that might not be possible otherwise. This may offer new opportunities for conversation and action.

## Board leadership and distributed models of leadership

Modelling a commitment to creating a more diverse and inclusive organisation does not stop with board composition or the acts of individual leaders. Significant organisational processes that are perceived to be the remit of senior leaders can be felt as powerful messages about those commitments. For example, interviewees highlighted the very difficult reality of working on equality, diversity and inclusion in the NHS. Some noted that their race equality and inclusion strategy had been created at executive level with the best of intentions, but without the participation of those who will be implicated in the strategy. While this may be interpreted as the executive taking responsibility for tackling inequalities, staff may interpret it as the executive team avoiding having to engage with the real stories of discrimination and having robust debate, and unconsciously preserving the status quo. This can compound the sense of inequalities in the workplace.





*Because the trust itself, it's having that confidence and stuff and going forward you can get there, but I think if you're looking to support a certain group, you've got to get in and amongst the guys and understand what it is that's... and then that's the starting point, because if you're setting the starting point from behind a closed door, I'm not sure that you're going to get it.*

Further, it is important not to place all of the emphasis on boards; while an organisation's most senior leaders clearly influence what people pay attention to and value, every interaction in an organisation goes towards creating the working environment. Perhaps acknowledging this, we found that all of our case study sites saw moving towards collective leadership as important. This means creating an environment where people at all levels in the organisation have responsibility for improving aspects of trust performance, including on race equality and inclusion. This reflects a wider move towards the aspirations of compassion and inclusion that have been associated with better outcomes for patients and staff wellbeing (West *et al* 2014).

### Leaders 'holding' the tensions around race equality and inclusion

The reality of competing priorities in an understaffed and under-resourced system, however, means the ambition of everyone taking responsibility for race equality and inclusion is itself challenging. For example, in ward teams, team leaders will have a range of priorities that could be competing with the time and resources needed to support race equality and inclusion activities, such as ensuring shifts are 'filled' versus releasing people to participate in the activities. Generally, in the three case studies, interviewees regarded team leaders as being supportive of their participation in race equality and inclusion work. However, some staff did not always feel their team leaders, managers or peers fully valued race equality and inclusion work and had to seek the help of equality, diversity and inclusion champions to gain permission to attend network meetings, for example.

If it is assumed that the range of responses described above reflect the complexities of trying to provide high-quality care for patients, then they are likely to include valid concerns that need to be addressed. Left unaddressed, these concerns can lead to feelings of resentment, lack of recognition or lack of fairness, which may work against organisational efforts to increase inclusion. Taking this further, it may be helpful to consider how resistance to race equality and inclusion interventions



might be engaged with. For example, one interviewee told us that they saw resistance as a 'gift', as it presented the starting point for inquiry and dialogue, even though it may sometimes be uncomfortable. A further step may be to explore the responses of team managers as interventions are designed, so that issues can be pre-empted and addressed at an organisational level rather than being left to individuals.

### Support for leaders working on race equality

What starts to emerge from exploring how organisations are moving towards making the most of the diversity of their employees, is that leadership, and allyship, are ongoing activities that need to keep taking account of each organisation's history, context and responses to equality, diversity and inclusion interventions. Staff are likely to expect a lot from those in formal leadership positions, and from officers who take on formal roles in relation to race equality and inclusion. We heard that standing by commitments made to making progress seemed to be of particular importance given the long history of, and slow progress in addressing, race inequality. For example, some of our interviewees reported that 'good' initiatives, once out of the spotlight, can get quickly forgotten, especially if there is high turnover of staff. This can make well-intentioned activities feel tokenistic, regardless of the actual commitment of those instigating them.

One consequence of this need for ongoing effort is the personal cost of being a diversity champion or leader. Tackling the longstanding systemic problem of race inequality can easily become located with individuals (for example, chairs of staff networks), particularly those from marginalised groups and/or without the appropriate level of seniority to influence decision-makers such as board members (Dawson *et al* 2019). Therefore, we think organisations may benefit from thinking about what support leaders or officers working on race equality and inclusion may need – in the form of peer support or supervision – so that they can maintain their resilience and the ability to keep distributing responsibility back to all levels of the organisation.



## Key learning points about leadership and allyship

In summary:

- Everyone has a role to play in an organisation's race equality and inclusion effort – through leadership, participation or allyship.
- Pre-empting resistance and treating it when it does arise as an opportunity for inquiry may help everyone to feel included.
- If making workplaces more inclusive really is everyone's responsibility, then leaders need to think about how the design and implementation of strategies or interventions model the principles of inclusion.
- Leadership for race equality and inclusion is an ongoing activity that creates an emotional burden. Leaders may need support, for example through peer networks or supervision.



## 7 How did race equality and inclusion change in the case studies?

As part of our research we were interested in understanding what, if any, impact the race equality and inclusion interventions had had according to the reflections of members of staff. Most importantly, we wanted to understand what it felt like to staff to be part of an organisation that was starting to acknowledge and tackle workforce race inequalities.

### What was it like before the introduction of race equality and inclusion interventions?

We asked interviewees what their experience was of the culture in their organisation before any work in this area had begun. Unsurprisingly (to us at least), we heard a range of experiences, which highlighted cultures of denial (about there being a problem with racism in the trust), examples of staff being on the receiving end of 'casual' racism or micro-aggressions, and examples of staff from ethnic minority backgrounds being actively 'blocked' from developing or progressing in their careers.

In one of the case studies, we heard about racism directed at some staff, for example a monkey toy being left on the locker of a Black member of staff. One interviewee talked about appearing on television as part of a feature about fundraising for different charities and how his colleagues reacted to this:

*[I'm part of] a group of Black cyclists who raise funds [for charities] and create awareness. The BBC saw us at an event and they wanted to film us... and we did an interview. I was in the kitchen [at work] and [somebody said], 'I'm sure I saw you on the TV the other day.' Now there was [another] guy [who] must have been listening to this and he turned around and he said, 'What was that? Crimewatch UK?' Later on, I asked some of the secretaries, 'Who's that guy there?' [They replied,] 'That was*



*a consultant.' So what chance do we have in a diverse country, diverse community, when you've got a consultant, a white consultant, actually making comments like that?*

We also heard how some race equality and inclusion initiatives had been started, but due to a lack of support or real 'will' to take them forward, they had not taken root. For example, in one of the case studies, a previous attempt at setting up an ethnic minority staff network failed because of lack of support and understanding from the wider organisation or the senior leadership team. However, it was encouraging that when relaying their experiences to us, many interviewees could articulate that they felt there was a difference between 'then and now':

*I would say 16-and-a-half years ago it were a very different climate to the climate we're in now. I would like to think that there's been some advances. Sixteen-and-a-half years ago I would find it more uncomfortable as a person of colour in the trust. If I look back at the interview process and thinking about why people were recruited, sometimes you felt like you were the token Black face. So, you were a tick-box recruitment is how I probably felt with my staff nurse role. Now, when I went for my Sister's post... I felt that when I got this post that I'm in now, that it was because I deserved it and not because of the colour of my skin.*

### **What impact have race equality and inclusion interventions had on staff at an individual level?**

When we spoke to interviewees in the case study sites, we were struck by some of the examples people gave about experiencing discrimination. The following example shows how important it is to tackle race inequalities and inclusion issues, but also how remarkable (if subtle) progress has been in the case studies. Albeit that progress is neither linear nor continual at all times, changes in the culture of an organisation are likely to be felt as powerful ones on different levels.

One interviewee told us about what had happened to her early on in her career as a nurse at the trust and how, many years later, she felt this kind of treatment would not occur in the present day in her organisation:

*A year or 18 months into my staff nurse role, there was another staff nurse who was renowned for being... well racist, there's no other word for it. I was picked on, felt*



*like I needed to [with]draw... there [used to be] a staff room that was centred in the middle of the ward, so on nights and things you could navigate into that room and come out to do what you needed to do. So, you didn't have nurses' stations as such. I would withdraw out of there if that lady was working and sit on my own because... sitting with her was really uncomfortable... And then there was an incident... where I'd had a childcare issue... and [this staff nurse] made that an issue and said I'd sworn at her, which I hadn't... I actually got frogmarched off the premises... I came in for my shift two days later, I was brought into the office and asked to leave whilst they investigated it. All over being told that I'd swore at this one person. And I just think if that had been now, that wouldn't have happened. In hindsight... it should have been dealt with at a ward level and I should never have been marched off the premises. I had four months off work because of that. But I don't think that would happen now.'*

When talking to interviewees about the impact of the interventions discussed above, it was clear that some of the interventions had had a deep and lasting impact on them. We heard how being given the space and freedom to express one's voice – for example, in the staff network or as part of a development programme – was hugely important in building confidence and feeling valued. One interviewee told us how the Moving Forward programme had given them confidence and the desire to 'find the better version of me and... I will keep striving and moving forward'. We also heard from staff that being listened to – particularly by senior leaders – meant that they felt able to speak out: 'I think it's easier saying things out loud having the board of directors on board and having their support.'

The power of race equality and inclusion interventions to have an impact on individuals is not solely felt by ethnic minority staff. We heard how being involved in race equality and inclusion work (particularly through reverse mentoring, and through sharing of the lived experiences of ethnic minority staff) had had an impact on white staff. Through reverse mentoring, one interviewee felt able to raise their mentee's awareness that racial discrimination was a real issue in the organisation:

*She [the mentee, an executive director] said she did not believe that there was anything wrong in this trust, there was no discrimination, there was none of that, you know? So I was, like, okay... but then I put myself in her shoes where you're an exec director and you're focusing on what you need to focus on and you don't see anything that's going on, you're not aware of that, but at the same time as an*



*exec director, you should be making sure you know what is going on within your organisation, you know? I mentioned about monkeys on a locker ... and she had to deal with all that and so then she became more aware. I think the whole [reverse] mentoring programme was fantastic... When you see those exec directors, they've learnt so much about what is actually going on, because when you're at that level, and then you're speaking to people at that level, you don't know what's going on here, actually on the ground floor, and then when you get to understand that then you can actually do your work better at that level and vice versa, because we can assist them at what they're doing.*

We wanted to hear whether members of staff in the case studies felt the focus on inequalities and inclusion had made any difference. We heard about a noticeable change within the organisations' culture. This was described as a feeling of things changing for the better for ethnic minority staff.

Often when talking to interviewees they described an ambition for the organisation to be more inclusive and fairer, and that it was an ambition felt and understood widely across the case study sites. For example, in one case study site, an interviewee noted that the direction for the trust was quite clear: '[The goal is] very much whole inclusion, equality, diversity, irrespective of who you are, culture, background, religion, sexual orientation, you know, it's fair, it needs to be fair across the board.'

Another interviewee noted that they felt that the growing numbers of ethnic minority and white people attending their ethnic minority network meetings was a clear indication of the shift in attitude towards race equality and inclusion work in their organisation. Further, they had noticed a shift in the relationship between them and their manager, indicative (for them) of the wider change in the organisation:

*There's definitely been a shift. Even my manager... I don't think she's fully understood what [equality, diversity and inclusion work is] about and I do believe that she may have been spoken to at that point for her to gain some understanding about why these packages are being introduced. I think she [now] understands it's an investment into a member of her team. So, she's shifted.*

Finally, it is worth noting that interviewees all acknowledged that achieving equity will take time, but that for any changes to have an impact on the culture of the organisation, there must be a maturity and acceptance that things are not



perfect. There has to be a willingness to hear staff when they raise concerns about discrimination or to actively look into how discrimination might be showing up in the workplace – above and below the surface. In one organisation, this involved closer examination of how the formal disciplinary process was working and how staff were being affected.

*...we surveyed staff who'd been through the disciplinary process... Are these people that are going through these processes, do they feel like they've been treated fairly? Do they feel like the chair listens to their mitigation? Did they feel that the sanction was just? Did they feel like if their white counterpart had done that, would they have got the same sanction? And that just snowballed, so we got valuable feedback from that. I think there is a maturity and an acceptance that we haven't got it right.*

### The 'ripple effect' of race equality and inclusion interventions

When ethnic minority staff are empowered through race equality and inclusion interventions, a powerful 'ripple effect' can be created. For example, we heard about ethnic minority staff feeling energised by the momentum created in their organisations and wanting to pass that on to others:

*I can see the change in myself, I'm a lot more positive, I'm empowered by what I do, yes. There's just so much energy. Even inside of work and outside of work, I just feel really empowered, full of energy, and I want to pass that on. It's about passing on the knowledge that I've got and the positivity... I was kind of disillusioned with the whole organisation at one point. It was like where can I go from here? I feel like I want to take a step forward and I'm getting pushed back all the time, you know? It felt like I was being suppressed, but I take that energy now and use it in a positive way, you know. What I can't influence, I leave that alone, and I move with what I can influence, because there's always going to be people that are going to be there to block it, you know? Just go around and get to where I want to go. So yes, at this present moment, I'm empowered.*

Another interviewee told us:

*[As an ethnic minority staff member] I think my role is... making sure that I can empower Black and Asian colleagues, and also a safe forum for them to be able to come and discuss, be empowered, you know, and all different levels, I think it's very*





*important it's all different levels... Whether you're a domestic or a porter or you're a band 6, 7, I want everybody to be in there talking about their journey and learning from others, taking all these different opportunities that you can get, and empower each other, I think that's what is very important, it's fairness for all.*

### Key learning points about how race equality and inclusion changed

We have deliberately presented rich, qualitative accounts about the impact of race equality and inclusion work in the case studies in order to give a sense of how change unfolded and how it was felt. This data shows us the following.

- Being on the receiving end of racial discrimination and harassment is painful and can have a deep and lasting impact.
- It is important to make it safer to talk about race, but this will inevitably mean being prepared to hear about and confront some ugly truths about behaviours between colleagues.
- Addressing race inequality and inclusion issues can have a notable impact on individuals and on organisations.
- Measuring progress in an organisation will not necessarily be as straightforward as referring to WRES metrics; more qualitative data on staff experience will offer essential indications of how change is felt.



## 8 Key lessons and questions to consider

We were privileged through this research to be able to take a detailed look at what three NHS providers are doing to address workforce race equality and inclusion issues. Participants in the three case study sites told us they are in the relatively early days of addressing workforce race inequalities. They agreed to participate in the research as part of a learning process – to aid their own learning and to offer insights to other organisations in this space.

The three case studies are working hard towards achieving their aims of developing more equity and inclusive working environments for ethnic minority staff. Everyone has a role to play in an organisation's race equality and inclusion effort – through leadership, participation or allyship. Interventions such as staff networks – particularly when well resourced and supported – are leading to meaningful changes for individuals and for the wider organisations (albeit such 'ripple effects' can be hard to measure and track through standard metrics). There are, however, various considerations for organisations to factor in to their thinking about addressing race inequalities and inclusion – for example, working with and through resistance to race equality and inclusion initiatives.

In this final section, we draw together some of the key lessons that emerged from our research, and we pose some key questions we think may help readers to reflect on our report and their own organisation's approaches to working on race equality.

### **There are no magic solutions to an age-old issue**

The first lesson for us was the difficulty in objectively identifying examples of NHS providers making sustained improvements against key WRES metrics. This suggested that no organisations had achieved equality in what ethnic minority and white staff report across the different indicators. That was a troubling (but perhaps not unexpected) finding and re-emphasised the reality of working towards fairer workplaces in the NHS: that, to date, it has not been easy, quick or straightforward.



This would correspond with the heartfelt statement that the director of the national WRES Implementation Team made in response to the latest WRES data, pointing out how race inequality is ‘one of the most complex, difficult and intractable problems’ we have had to face this century. She highlights where progress has been made and how even improvements that seem small should be celebrated as important signs of evolutionary (if not revolutionary) change (Coghill 2020).

Questions to consider:

- What are your most important local issues regarding race equality? How do you know?
- What are your expectations around the impact of your work on race equality? Where have these expectations come from? How ambitious are they?

### Approaches to race equality and inclusion are not ‘one size fits all’

The history of race inequality has long and deep roots, which means race equality and inclusion may be unamenable to simple applications to evidence-based interventions that do not take into account the subtleties of local context and history. A ‘do-once’ attitude, or well-intended processes that do not model the spirit of the outcome, may even be harmful.

Working on race equality and inclusion needs to be an ongoing, moment-by-moment activity that engages with and responds to people’s lived experiences of how interventions are being received – positive and negative. This might mean that approaches change over time, in innovative ways, to keep up with the speed of habituation.

Questions to consider:

- What do you know about the history of race inequality locally? How is your work on race equality responding to that history?
- How will you know if your interventions are ‘working’? Who are you involving in your thinking about this and who is monitoring it?
- Who are you expecting to do the work? Why?



## Addressing race equality and inclusion in organisations can make a difference – with a sustained commitment, over time

In our interviews we heard about some people's painful experiences of discrimination at work; for some, incidents dating back a number of years could still feel raw and 'live'. Emotions were palpable and we could see and hear first-hand the scale of the challenge facing case study sites. Therefore, it was heartening to see examples of trusts taking race equality and inclusion seriously and dedicating time, energy and resources to it. This was helping to develop positive and inclusive cultures, for example by creating safe spaces to explore race-related issues.

However, none of these changes would be possible without staff at all levels giving the interventions their constant attention and being prepared for things not going quite as planned. Of course, senior leaders need to demonstrate strong commitment to and support for race equality and inclusion (including being 'hands-on' when appropriate and ultimately accountable), but initiatives lend themselves well to more distributed models of leadership, with staff from across the organisation playing a central role in the work (for example, chairs of staff networks). Emphasising the *judgements* that leaders at all levels make as to what to do, modelling curiosity, admitting mistakes, encouraging participation and showing genuine commitment seem to be important so that interventions do not come across as tokenistic or inauthentic.

Questions to consider:

- How are you supporting your colleagues to think about and act on race inequality? What happens when the pressure is on or the work gets particularly challenging?
- How are you identifying, understanding and working with resistance as a way to understand structural inequality? How might you see it as a 'gift'?
- How are you thinking about your own role in relation to race equality? What actions or risks are you prepared to take personally to create fairer workplaces?



## What next?

It was encouraging to see examples of individual NHS provider organisations taking positive steps towards developing a more inclusive culture. There are signs the NHS is responding to the call to action around race inequalities. The King's Fund is in the early stages of working with the provider trust chief executives and CCG accountable officers in London on how, as the heads of the capital's anchor institutions, they are leading for race equality.

At a national level, the forthcoming NHS people plan offers a unique opportunity to transform NHS culture, with equality, diversity and inclusion as a golden thread throughout its five themes of making the NHS the best place to work, improving leadership culture, tackling the nursing challenge, delivering 21st-century care and a new operating model for the workforce ([West 2020](#)). This form of strategic focus on equality, diversity and inclusion at a national level would likely help the NHS system, which has been struggling to achieve an inclusive, people-centred culture over many years – so long as organisations are ready and willing to reflect deeply on what staff are telling them and work hard to make a difference for the current and future NHS workforce.

This report suggests that it is local action in teams, departments and organisations (big and small) where the work is, because that is where the people are. We hope that the report will help NHS organisations to continue – or open up – crucial conversations about race inequalities and inclusion.



# Appendix 1: Methodology

To select three case studies, we initially set out by looking at the national NHS Staff Survey data for NHS providers where there had been sustained improvements against the Workforce Race Equality Standard (WRES) indicators since these were first published in 2016. The WRES compares ethnic minority and white ethnic groups and we adopted the same focus – that is, we did not split ‘white’ into its component groups. Further, we opted to focus on NHS providers, or NHS trusts (as opposed to NHS commissioners), in line with what the annual WRES reporting focuses on.

We wanted to establish which NHS providers consistently reported a statistically similar and above-average experience for white and ethnic minority staff over the whole time period of the data, or improved towards doing so. Interestingly, analysis of the data showed that there were no providers that either consistently reported above-average and statistically similar experience scores for ethnic minority and white staff, or who saw a move towards equal experience over time across all the indicators collected within the WRES (at both the 95 and 90 per cent confidence levels). Some providers demonstrated some improvement across some, but not all, of the dimensions within the WRES collection.

In consultation with members of the project’s external advisory group (see the Acknowledgements section), we gathered the indicators in the WRES collection into groupings with broad themes (as shown in Table 1) and identified providers that either demonstrated a move towards equality of experience for ethnic minority and white staff in terms of those groupings, or consistently showed a statistically similar and above-average experience for staff across the whole period of data (2016–18).

We created the groupings based on the themes of the variables within them, bringing together: the indicators on experiencing discrimination or abuse from other staff individually into ‘experience of discrimination from other staff’; the indicators around recruitment and development in role into ‘equality of opportunity’; and the indicators on corporate policies towards discrimination into ‘other indicators of discrimination’. Having already seen the lack of positive results returned at the 95 and 90 per cent confidence levels, we moved to an 80 per cent threshold (that



is, the point at which there was a less than 20 per cent probability of the reported results being similar due to chance) for the rest of our analysis.

As shown in Table 1, we identified only a small number of NHS providers across the three groupings. This is indicative of how difficult it is to find examples of NHS providers reporting sustained improvements against WRES metrics year on year (albeit within a two-year period).

**Table 1 Grouping of WRES variables for case study identification**

WRES variable	Our grouping	Number of trusts identified across all variables in the grouping (with 80 per cent confidence intervals)
NHS Staff Survey Q15b: 'In the last 12 months have you personally experienced discrimination at work from any of the following: manager/team leader or other colleagues?'	Experience of discrimination from other staff	1
NHS Staff Survey Key Finding 26: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months		
NHS Staff Survey Key Finding 21: Percentage of staff believing that their trust provides equal opportunities for career progression or promotion	Equality of opportunity	2
WRES indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts		
WRES indicator 4: Relative likelihood of staff accessing non-mandatory training and continuous professional development		
WRES indicator 9: Percentage difference between the organisation's board voting membership and its overall workforce		
NHS Staff Survey Key Finding 25: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Other indicators of discrimination	2
WRES indicator 3: Relative likelihood of staff entering the formal disciplinary process compared with white staff		



Because our initial data-led approach did not conclusively point to case study sites that demonstrated sustained and comprehensive improvement on race equality, we combined the five sites identified through the data with a list of 15 other NHS providers where there were anecdotally promising signs of improvement in workforce culture (based on suggestions from members of the national WRES Implementation Team and individuals in our own network) – albeit this was not demonstrated through a statistically significant change in the WRES data.

We contacted all providers on our list. Six providers responded and shared some information about their approaches to race equality and inclusion with us. Following this initial scoping, we selected three NHS providers of different types, in different locations and using different techniques to improve the experiences of ethnic minority people in their workforce. It was important to look at race equality and inclusion in different contexts.

We took one of the three providers in our case study sample from the data analysis – Bradford District Care NHS Foundation Trust – and the other two were recommended (*see* Table 2). With formal action plans linked to the WRES only being required since 2016, all three providers can be described as being in the fairly early days of working towards race equality and inclusion.

In each provider we interviewed a range of individuals, including:

- members of staff (a combination of those directly involved in race equality work and those not)
- Freedom to Speak Up Guardians
- a local trade union representative
- an organisation development manager
- equality, diversity and inclusion managers or leads
- board members (typically the chief executive and director of human resources)
- any relevant external stakeholders.





**Table 2 Selected case studies**

Name of NHS provider case study	Provider type	How selected	Number of individuals interviewed
Bradford District Care NHS Foundation Trust	Community, mental health and learning disabilities	Our data analysis	16*
Calderdale and Huddersfield NHS Foundation Trust	Acute	Recommended	16
East London NHS Foundation Trust	Mental health, community	Recommended	9

\* Includes two 'joint' interviews, that is, individuals who chose to be interviewed in pairs.

A combination of face-to-face and telephone interviews were carried out between September and November 2019. We asked participants to give their reflections on the current culture within their organisation; the specific things that have happened to address equality, diversity and inclusion; and what they had learnt from the experience. We analysed the interview data thematically, aided by specialist qualitative data software (Dedoose).

In addition, we requested relevant strategy documents or action plans directly from the case studies for analysis.

We also reviewed existing evidence on race equality, diversity and inclusion in the workplace in order to put our findings into context.



# Appendix 2: The nine Workforce Race Equality Standard (WRES) indicators\*

**Workforce indicators** (comparing the data for white and ethnic minority staff):

1. Percentage of staff in each of the NHS Agenda for Change bands 1–9 or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce disaggregated, if appropriate, by:
  - non-clinical staff
  - clinical staff, of which non-medical staff and medical and dental staff.
2. Relative likelihood of staff being appointed from shortlisting across all posts.
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. Relative likelihood of staff accessing non-mandatory training and continuous professional development.

**NHS Staff Survey indicators, or equivalent** (comparing the outcomes of the responses for white and ethnic minority staff):

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

\* Since 2018. The focus and wording of the indicators have been subject to extensive engagement since 2014.



7. Percentage believing that trust provides equal opportunities for career progression or promotion.
8. In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleagues?

**Board representation indicator** (comparing the difference for white and ethnic minority staff):

9. Percentage difference between the organisation's board membership and its overall workforce, disaggregated by:
  - voting membership of the board
  - executive membership of the board.

Source: NHS England (2018a).



# Appendix 3: Getting our own house in order

The King's Fund is committed to becoming a more diverse and inclusive organisation. We want to be able to talk about equality, diversity and inclusion in health and care, openly and confidently. To do this credibly, we need to challenge ourselves (or, as a stakeholder more frankly pointed out, 'The King's Fund needs to get its own house in order' on equality and diversity) and learn from our own experiences, as well as those of others.

## What are we doing?

To improve our gender and ethnic diversity, we are developing a diversity and inclusion work programme, which includes:

- ensuring our recruitment and selection practices attract more diverse applications and reduce bias
- increasing the depth of staff understanding of diversity and inclusion issues through learning and development and open conversations to help us value difference
- creating intern roles targeted at people from under-represented groups
- setting targets, first on gender and ethnicity, aimed at increasing the diversity of our senior decision-makers, spokespeople and event speakers
- reflecting transparently on our progress and learning and feeding this back to the board of trustees, who are accountable, with our senior management team, for this progress
- ensuring that our building and resources are accessible to all
- piloting a diversity mentoring scheme to deepen understanding of diversity and inclusion issues among our senior leaders, which took place during 2019.



We hope this information will be taken in the spirit of sharing, not preaching. We recognise we have some issues and dilemmas in common with health and care, which we are trying to address (see [www.kingsfund.org.uk/about-us/who-we-are/diversity-and-inclusion](http://www.kingsfund.org.uk/about-us/who-we-are/diversity-and-inclusion); Hills 2019; Nguyen 2019). We hope to engage health and care providers on this critical issue from a place of understanding.



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The NHS has one of the most ethnically diverse workforces in the public sector. However, year after year, ethnic minority staff report worse experiences in terms of their lives and careers, when compared with white staff.

Addressing race inequalities in the NHS workforce is critical. The impact of discrimination on people can be profound. The fair treatment of staff is also linked to better patient experience and would play an important role in addressing the workforce crisis the service is currently experiencing.

*Workforce race inequalities and inclusion in NHS providers* draws together findings from three case study sites that have sought to address workforce race inequalities and develop positive and inclusive requirements, focusing on the personal accounts and recollections of members of staff.

The report highlights the importance of key interventions, including:

- establishing staff networks, which can lead to meaningful changes for individuals and organisations
- ensuring psychologically safe routes for raising concerns so that staff feel able to share their experiences and raise issues
- enabling staff development and career progression to support staff and address historic imbalances.

However, the report concludes that there are no magic solutions to an age-old issue. Approaches to race inequality require individuals and organisations to make a concerted effort over time, in order to make a difference for the current and future NHS workforce.

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