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**DIVERSITY AND INCLUSION
THE POWER OF RESEARCH
IN DRIVING CHANGE**

**USING RESEARCH AND DATA TO
PROMOTE INCLUSIVE WORKPLACES**



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EXECUTIVE SUMMARY

Purpose

With an increasingly diverse population, staff from minority groups now make up the majority of the NHS workforce. Therefore, providing a workplace that celebrates and is inclusive of diversity is now essential for the NHS to operate effectively for both staff and patients.

In order to monitor this, research has become an essential tool in allowing us to benchmark how effective the NHS is performing within the standards set by equality legislation.

A number of different research papers and projects have been influential in enhancing equality and inclusion within the NHS. These projects include quantitative and qualitative data, results of NHS employee surveys, academic research commissioned by the NHS and the findings of individual staff members and staff groups.

This report is an analysis of past research into workplace diversity and inclusion across the NHS to determine how effective it has been in bringing about change with regard to the NHS becoming a more diverse and inclusive employer.

Background and scope

Understanding how past research has driven change to date, will be essential in helping to formulate ongoing research that will not only benchmark progress made so far, but drive future innovation in equality recruitment and employment practices within the NHS.

Historically there has been more research undertaken into race and gender, as legislation on sexual orientation, religion, belief and age was not introduced until 2000. These two groups have been more visible than other protected groups, due to increased activism in these areas which has led to comparatively more research.

Collecting data on other protected groups has proved problematic as NHS staff do not tend to reveal information such as their sexual orientation or if they have a disability in staff surveys or in other research.

There are also difficulties in collecting workplace data regarding ethnicity, as BME staff are less likely to participate in NHS staff surveys than staff from other protected groups. There is evidence that staff can be worried about being singled out if they raise concerns about equality issues.

Research has shown that despite various initiatives to increase diversity within the NHS, there are still inequalities that are experienced by staff who belong to protected groups. These inequalities affect staff at every level, and include bullying and harassment, increased likelihood of being involved in disciplinary proceedings, and being at a disadvantage in terms of being recruited and promoted. This has resulted in a lack of diversity at senior levels across all areas of the NHS, most notably for gender and race.

Addressing these inequalities and monitoring any progress that has been made is now a mandatory requirement for all NHS trusts under the terms of the Equality Act 2010.

Organisational benefits

As well as being a statutory requirement, research has highlighted a number of organisational benefits for the NHS in providing a more diverse and inclusive workplace.

These include improved innovation and leadership strategies, as well as increased efficiencies, productivity and staff engagement, better staff health, wellbeing and retention, and decreased staff absenteeism and sickness. Patient care and experience has also been shown to improve where staff are more representative of the communities they serve, and in a workplace that is free from discrimination.

Creating a culture where issues are taken seriously, and where equality is seen as a priority, has been shown to positively impact staff engagement and increase participation in the collection of workplace diversity data from all of the protected characteristics.

Recommendations

A greater emphasis on collecting diversity data on all protected groups, particularly at local trust level, needs to take place. Despite the fact that the collection of this data is now a statutory requirement for NHS trusts, some have performed much better than others. In papers reviewed in this report, researchers have found that between 50-80 per cent of trusts are not collecting workplace diversity data in a format that was usable for these researchers.

Staff makeup varies a great deal in regard to the protected groups, and it is therefore essential for each trust to successfully collect data on their workforce in order to understand where actions are needed.

Where workplace diversity data has been collected by trusts it has, in some instances, been successfully used to drive initiatives aimed at enhancing staff diversity, tailored specifically to the trust. A top-down genuine commitment to equality is essential for the collection of this data, as well as the proactive implementation of appropriate actions based on locally collected evidence.

Greater collaboration is also needed between academics, regulators, membership bodies, think tanks, practitioners and NHS organisations to facilitate research into areas that will now have the most positive impacts for the NHS in becoming a more diverse employer.

There have been a number of initiatives and actions that research has shown improves workplace diversity and inclusion. For example, increased peer-to-peer networking opportunities for NHS staff from protected groups can have positive impacts. Providing and facilitating access and communication channels for staff based on shared experience can greatly enhance the effectiveness of equality initiatives, and reinforce the importance that equality is seen to have at an organisational level. Providing well-organised, formalised structures can help to provide a platform where the collective voices of individuals from diverse groups can be heard.

Leadership programmes that identify and develop talent from protected groups have also been shown to be effective in increasing diversity, particularly at senior levels. However, as no comparison has yet been made between such groups those who benefit may well be the people who are more likely to want to develop their careers and therefore participate in such groups.

Increasing the number of senior staff and board members from protected groups raises the profile of these individuals, which in turn provides much needed, high-profile champions. In addition, taking a proactive approach to increasing leaders from diverse groups helps challenge the prevailing culture, providing further momentum to the diversity agenda, which in turn facilitates even greater change.

Working with stakeholders, such as local and national groups and charities, can provide vital insight and direction on how to best engage and connect with diverse communities. Developing better relations with organisations that represent diverse communities can also increase job applications from a more diverse talent pool.

Addressing the culture of the NHS so that it values diversity, and recognises success and achievement in all its forms, will be increasingly important as it has been shown to positively impact equality, enhance diversity, and facilitate inclusion. Acknowledging the innovation and efficiencies that diversity can bring, and communicating these effectively and consistently, both internally and externally, will be essential for the NHS if it is to continue its improvements for an increasingly diverse workforce.

Conclusion

The barriers that exist for the NHS in delivering a more diverse and inclusive workforce are significant but not insurmountable. The collection and analysis of workplace diversity data has been shown to be a useful resource when used effectively.

Understanding where inequalities exist cannot in itself bring about the change that is needed, and only by demonstrating an authentic commitment to equality can this be achieved.

Proactive actions, based on the evidence provided by research undertaken to date, both at local trust and national level, has proved to have the greatest impact. Collecting ongoing, in-depth workplace data on all of the protected groups will be essential in understanding how to best deliver the improvements that are still needed to provide a truly inclusive NHS.

Key findings

1. Diversity and inclusion interventions in the NHS have resulted in organisational benefits. These include better productivity, enhanced innovation/leadership strategies and better staff engagement.
2. The introduction of the Equality Act 2010, and the NHS Equality Delivery System, has created structures to support data gathering which will enable better benchmarking and further research.
3. Existing research on race and gender has provided a strong foundation for further research examining other protected characteristics.
4. More detailed research at both national and local levels, across all protected characteristics, would support improved policy and practice.
5. Structures and cultures within organisations can be important barriers to implementing evidence-based practice.

Key recommendations – for policy makers, practitioners and researchers

NHS organisations will need to adopt multiple strategies to facilitate and promote the use of diversity and inclusion evidence, including:

- support organisations to improve data collection at all levels
- continue to promote the NHS diversity and inclusion agenda by reference to other sectors and the business case
- foster further collaboration between practitioners, academics, members of protected groups, and regulators to identify where research needs to be undertaken
- invest and explore further the importance of staff networks as a resource for data and organisational development
- work towards having a leadership that embraces, embodies, and champions diversity
- integrate diversity and inclusion as part of existing organisational cultural change initiatives.

INTRODUCTION

The *Diversity and Inclusion – The Power of Research in Driving Change* report has been commissioned by NHS Employers, Imperial College London, enei (Employer's Network for Equality and Inclusion) and North West Coast Academic Health Science Network.

The report assesses how effective past research into diversity and inclusion issues in all sectors has been in achieving change with regard to the NHS becoming a more diverse and inclusive employer. It considers the types of research that have been undertaken and identifies the elements of that research which has prompted action.

This report looks at a variety of research initiatives, although these have not been identified for all of the protected characteristics. While there is a need for further workplace equality research for all protected groups, the largest body of research currently exists on ethnicity and gender, largely due to the availability of data, access to funding, the visibility and activism of these groups and historical precedence. Much can be learned from the work that has been done on ethnicity and gender and applied to equality work for other protected groups, and the ongoing collection of equality data in all areas is still vital.

In 2010, the NHS Equality Delivery System (EDS) was commissioned by the Equality and Diversity Council, which first launched in July 2011. This system was designed to help NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

Following a review by Shared Intelligence, which looked at how the EDS had been adopted across NHS organisations, a refreshed EDS – known as EDS2 – was made available in November 2013.

The main purpose of the EDS2 was, and remains, to help local NHS organisations in discussion with local partners, including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS2, NHS organisations can also be helped to deliver on the Public Sector Equality Duty.

Research regarding issues concerning diversity and inclusion in the NHS have been an important catalyst in the formulation of The Equality Act, EDS and the Workforce Race Equality Standard (WRES). Research has also shown that there is a strong correlation between good patient care and a well-motivated, engaged and diverse NHS workforce. As such there are not only legislative and legal requirements for organisations under the NHS umbrella to deliver on their obligations concerning diversity and inclusion, but also very strong and well-proven benefits in terms of improved innovation, efficiency and productivity at organisational, team and individual levels.

The Equality Act 2010 offers protection to nine characteristics. These are:

- Age
- Race
- Sex
- Gender reassignment status
- Disability
- Religion or belief
- Sexual orientation
- Marriage and civil partnership status
- Pregnancy and maternity



METHODOLOGY

The methodology used for this report was not to conduct any new research, but rather to understand which previous research projects have been effective in bringing about change with regard to diversity and inclusion in the NHS.

Key research projects and initiatives were identified as having been conducted in this area which are outlined in the literature review. This includes results from NHS employer surveys, case studies, individual experiences, workforce monitoring data, academic research, action orientated research, awards, and summaries of the discussions of leadership forums.

Analysis of these projects sought to identify any outcomes that had brought about change, be it for patients and/or workforce, and identify research that has been influential or provided momentum with regard to workplace equality in the NHS. Outcomes were identified as including enhanced recruitment strategies, retention, reputation, performance, engagement, and service delivery, as well as other measurable criteria and key performance indicators.

Interviews were also carried out with members of NHS Employers' strategic thinking forum, as well as with researchers, academics and practitioners who are involved with, or have carried out work in this field.

These interviews were useful in identifying the reasons why research into particular areas had been carried out, and to ascertain whether this work had been effective in not only identifying where inequalities exist, but if any actions were taken based on the findings and recommendations of this research.

A number of possible motivating factors were identified as having potential to provide necessary momentum and impetus prior to the interviews. These included actual need of improvement/change in specific areas due to budget/regulatory changes, credibility of research because of researcher or research institute, robust and credible methodology, affinity of decision makers with research projects and/or outcomes, change of structure to NHS trust or other internal changes, political need, under representation of a specific group within a geographical area or using a particular NHS department, and legislative requirement.

In addition, case studies were identified of initiatives that had been successful in enhancing diversity recruitment efforts within the NHS. Contact was made with the specific trusts or NHS organisations where these initiatives had been carried out to learn what research, if any, had been utilised or influenced their decision making before the commencement of each of these projects. These case studies start on page 39.

A BRIEF HISTORY OF EQUALITY LEGISLATION

Since the introduction of the Equality Act by parliament in 2010, there has been a new wave of legislation aimed at embedding equality in both public and private sector organisations.

Legislation such as the Public Sector Equality Duty (PSED), which was created under the Equality Act, has now imposed a statutory duty on public authorities to address inequalities experienced by their workforce and the communities that they serve.

New systems such as The Equality Delivery System (EDS), which was commissioned by the national Equality and Diversity Council in 2010, and the Workforce Race Equality Standard (WRES), now provide frameworks for organisations to monitor and benchmark their progress against a number of indicators of workforce equality and diversity.

The Equality Act brings together over 116 separate pieces of legislation into one single Act. It is useful to understand the progress of equality legislation in the UK to gain some context, and a line-of-sight as to how legislation has developed, and how this now effects organisations such as the NHS.

Contemporary equality legislation can be traced back to the 1960s and 1970s and the Labour Government of Harold Wilson. The first Race Relations Act in 1965 was followed by the Equal Pay Act in 1970. The Sex Discrimination Act was introduced in 1975, which was followed by a more comprehensive Race Relations Act in 1976, both of which echoed similar legislation introduced in the United States in the previous decade.

A later Conservative government passed the Disability Discrimination Act in 1995, which used different language and ideas than 1970s sexual discrimination law. It was not until Tony Blair's New Labour government of 1997 that the UK opted in to the social provisions of EU law. New reforms promoting equality were also introduced under New Labour, in part due to legislation that was challenged by various groups in the European Court of Human Rights after Britain joined the European Community.

Existing EU law was reviewed in 2000, when new equality legislation was introduced explicitly protecting people on the grounds of their sexual orientation, religion, belief and age, as well as updating the legislation on disability, race and gender discrimination. In the UK, these reforms were tacked on to often already heavily amended acts of Parliament, which increased the volume and complexity of equality legislation.

Because of the piecemeal way in which this evolved, equality legislation in the UK was overly complicated and lacked consistency. The limitations were exposed during the Stephen Lawrence enquiry with the publication of the Macpherson Report in 1999. The recommendations of that enquiry led to the Race Relations (Amendment) Act 2000, which introduced the concept of a statutory duty to eliminate race discrimination and promote better relations between racial groups. It came into effect in 2002. This Act placed the first of the Public Sector Equality Duties (PSEDs) on public bodies which covered race, and later disability (2005) and gender (2006).

Before the introduction of the Race Equality Duty, the priority of equality legislation was on rectifying cases of discrimination after they took place, not preventing them happening in the first place. The race equality duty was designed to shift the onus from individuals to organisations, placing for the first time an obligation on public authorities to positively promote equality, not merely to avoid discrimination.



Over the next ten years, similar legislation was introduced in relation to disability through the Disability Discrimination Act 2005 and gender through the Equality Act 2006. Whilst the PSEDs contained in these Acts each had differences, the underpinning principles were broadly similar in nature.

By this time, there were over 200 different pieces of legislation relating to equalities providing a complex (and often confusing) legislative framework. As such, the Government committed to rationalising the legislation which resulted in the Equality Act 2010.

On 5 April 2011, the Public Sector Equality Duty (the equality duty) came into force, which was created under the Equality Act 2010, and which replaced the race, disability and gender equality duties. The three equality commissions were also replaced with what is now the Equality and Human Rights Commission.

To meet the new requirements of the Equality Act, the Equality Delivery System (EDS) was commissioned by the national Equality and Diversity Council in 2010, which launched in July 2011. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice, in particular the Equality Performance Improvement Toolkit (EPIT) which was developed by NHS North West and is widely regarded as the precursor to the EDS.

Alongside EDS, the NHS Equality and Diversity Council introduced the first Workforce Race Equality Standard (WRES) in 2015. This new reporting framework for the first time requires organisations to demonstrate progress against a number of indicators of workforce equality concerning NHS staff from black and minority ethnic (BME) backgrounds.

The WRES Standard and the EDS2 will be included in the 2015/16 Standard NHS Contract. The regulators, the Care Quality Commission (CQC), National Trust Development Agency (NTDA) and Monitor, will use both standards to help assess whether NHS organisations are well-led.



LITERATURE REVIEW

Summary

This review summarises research papers that have been published since 2008, which have been influential in bringing about actual change, and/or have raised awareness regarding equality and diversity within the NHS across all of the diversity strands. Collectively, the reports included in this review highlight much of the most influential recent work that has been done to date, as well as many of the barriers that the NHS faces in providing a workplace that is equitable for everyone as determined by the Equality Act 2010 and the Public Sector Equality Duty 2011.

This review is not a comprehensive list of research regarding workplace equality within the NHS, and represents later work which is more relevant currently. It does contain significant pieces of work that highlight the current situation facing the NHS in delivering its obligations under the Equality Act (EA) and the PSED. These works have all to some extent facilitated the ongoing conversations around workplace diversity within the NHS, have influenced and helped to shape policy, and have in some instances been the catalyst for action taken in the case studies given from page 40.

The work included in this review also gives context to the current state of play regarding workplace diversity within the NHS, and provides background concerning equality initiatives to date and the impact that these research works have had on creating a more diverse NHS workforce.

A list of further research and reading that has informed the content of this report can be found in Appendix 1.

As part of this review, phone interviews were undertaken with some of the authors of the papers featured. These included researchers from a number of well-regarded academic institutions, practitioners, members of staff groups and members of professional medical organisations. The interviews were conducted to ascertain the reasons why research work was undertaken in a particular area, what, if any, were the drivers and motivations for the research, and where any momentum, inspiration and impetus might have come from in informing the subject and direction of these works.

Rationale for equality

As well as there being a statutory requirement for NHS bodies to comply with the EA and PSED, there is growing evidence for the business case for well implemented workplace equality policies and procedures. This includes improved innovation and leadership strategies, as well as increased efficiency, productivity and staff engagement, better staff health, general wellbeing and retention, and decreased staff absenteeism and sickness.

There is also now strong evidence that where a NHS workforce is representative of the community that it serves, patient care and the overall patient experience is more personalised and improves. It is now national policy that NHS trust boards should be as representative as possible of their communities. Research too has shown that where NHS staff experience discrimination, particularly on grounds of ethnicity, (although this is true for other minority groups) patient care suffers.



There are, therefore, many compelling legal, practical and moral reasons for the NHS to deliver a workplace free from discrimination, where opportunities are equally available to everyone, and where talent is fully identified, developed and retained. A more inclusive NHS not only delivers on the values of the NHS constitution for both staff and patients, but can also help to deliver the efficiencies and innovation needed to meet the structural, social and financial changes that are currently facing the NHS and will continue to do so in the future.

Availability of data

The issue of workplace equality within the NHS is not a new one, and there has been a string of policies and initiatives aimed at addressing equality issues in the NHS workplace for several decades. These policy initiatives have mainly focused on race and gender, largely due to the precedence they have taken historically, and also because of the availability of workplace data on these topics. It is also likely that where there are visible differences people are more likely to address the agenda. Therefore equality issues around ethnicity and gender have progressed more rapidly as they are more visible and active than some other diversity strands.

To date, there has been comparatively little research on other diversity strands with regard to workplace equality within the NHS. This has been for various reasons, not least because of the obstacles faced in collecting viable data. Very few respondents to NHS employer surveys self-identify as either lesbian, gay, bisexual or transgender, or as having a disability. Therefore there is less reliable workplace data regarding disability and sexual orientation than gender or ethnicity. Staff from BME backgrounds are also less likely to take part in staff surveys, and participation needs to be improved for BME staff.

Age Similarly there is a need to gather NHS staff information on the employment arrangements that would be attractive to older employees. The NHS Working Longer Group presented preliminary findings and recommendations for health departments in March 2014. The group reports that while there is substantial data available it is not consistent enough across a range of organisations to draw robust conclusions from.

The report does conclude that as the average age of NHS employees continues to rise, a well-managed, employer-led approach that takes account of employee work preferences is needed to tackle this issue. Many of the solutions that are proposed in the Working Longer Group report are similar to those proposed in reports for other groups, most notably gender. These include flexible/part-time working, more tailored training and development opportunities and better personalised support.

The benefits to an organisation of providing this structural support are the same as those stated earlier for other groups and include better retention of staff and knowledge, increased engagement and lower absenteeism.

Inclusion It is widely recognised in the research reviewed in this report, as well as elsewhere, that creating a workplace environment where people feel valued increases the number of staff who will self-identify when completing staff surveys, and so reveal potentially sensitive personal data such as their sexual orientation or having a disability. Creating a culture and atmosphere where diversity is seen as a priority is critical in being able to collect robust and reliable diversity data.

This is to some extent a chicken and egg situation. Data is essential in monitoring the effectiveness of diversity initiatives, but collecting diversity data is more successful when diversity policy has already been successfully put into practice. Monitoring for the sake of it is generally unsuccessful. Before any kind of monitoring is introduced,

it is important that employers identify why they want the data, what they want to find out and what they will do with the information. Establishing a clear set of aims and objectives for monitoring is essential. This should feed into a business case, which will ensure senior buy-in.

The experience and accumulated evidence that has been gained to date has been invaluable in providing insight, experience and best practice that can now be applied across all diversity strands. Implementation of diversity initiatives that include all protected characteristics could be one way of embedding a culture where diversity is seen as a priority. Increasing numbers of staff who self-identify in staff surveys as lesbian, gay, bisexual, transgender (LGBT) or as having a disability can be seen as a barometer of the success of embedding this inclusive culture within the NHS.

Race Response rates to NHS staff surveys also vary according to the ethnicity of respondents, with a significantly lower percentage of BME staff taking part than staff from other ethnic backgrounds. While there is likely to be a variety of reasons for lower participation rates, the fact that BME staff are at a significant disadvantage when it comes to career progression and other opportunities within the NHS, and therefore may be less engaged, cannot be ignored. Research has found that not all trusts have been collecting diversity recruitment data that is in usable formats for researchers. This was particularly notable concerning workplace data for race, although most of the research has been conducted in this area and so the absence is more evident.

Barriers Budgetary and financial constraints have had an impact on the quality and quantity of diversity recruitment data that is recorded across the NHS, which has suffered due to cuts to administrative staff and also because of conflicting priorities. Existing NHS staff data has contributed to some of the most influential and insightful research papers to have been published on the issue of workplace diversity within the NHS. The use of individual trust data has been essential in providing a broader national picture of workplace diversity in the NHS as well as providing these individual trusts with a clearer picture of their own situation with regard to workforce diversity.

Analysis of big data in this way can be an extremely economical use of an existing resource to identify potential issues, reduce costs and introduce efficiencies. Some of the research papers reviewed here have found that between 50-80 per cent of trusts have not been collecting staff diversity data as required, or that was in a usable format for the researchers. The National Leadership Council and Institute for Innovation and Improvement have said that there needs to be a shift from 'data compliance to valuing individuals'. (*Innovation in inclusion project report June 2010*). The strategic use of existing staff data when it is collected can be used as an effective tool to demonstrate that value.

With the introduction of the EDS and WRES, the collection of diversity recruitment data should greatly improve across the NHS. The collection of accurate recruitment data is essential for the successful monitoring of the effectiveness of diversity policy and legislation. The recommendations of much of the research reviewed here suggests that this is best achieved in NHS trusts and organisations where the leadership demonstrates that there is a top-down, board level commitment to ensuring that equality and diversity is an organisational priority.

A genuine commitment to equality at every level of an organisation is essential for the effective collection of diversity data. Analysis of this data also requires a solid commitment to ensuring that diversity is prioritised within an organisation. The allocation of resources is also needed to implement strategies based on any research findings that can improve equality and diversity within individual NHS trusts.

Driving factors for research

During the interviews conducted as part of this review, several academic researchers acknowledged that there is a discrepancy between what academics are researching, and what NHS organisations now need in terms of diversity data. There are several reasons why this is the case. The motivation for academics to undertake research is primarily for their work to be published, and impact work, where research is shown to make a difference in organisations or society, can be an effective way to achieve publication.

This is however not the most effective way for organisations such as the NHS to obtain the research that is most beneficial, or that there is greatest need for. This also tends to lead to more research being conducted on some areas of diversity than others, and with limited resources and researchers working on diversity topics, especially concerning the NHS, some diversity strands remain under researched and reported on.

There are an increasing number of events, such as the Equality, Diversity and Human Rights Week (May 2015) and NHS R&D North West Conference – Let's Talk Research (17-18 September 2015, Macron Stadium, Bolton) that are seeking to address the gap that exists between the need for diversity data and researchers' outputs.

Organisations such as The King's Fund and the National Institute for Health Research are also playing their role in helping to plug the gaps that exist for diversity research. NHS Employers has recently worked with Disability Rights UK (DR UK) to undertake research that looks at the issue of workplace experience and staff with disabilities. The findings of this work were presented at a disability summit in Leeds in May 2015.

It was generally accepted by the researchers interviewed that there is still a need for more workplace diversity research on the NHS across all of the protected characteristics, and particularly for under-researched categories such as age, disability and sexual orientation. The current momentum and visibility that has been accomplished for race and gender has been generated at least in part by the availability of good quality data and credible research on these topics. Creating similar awareness around the issues for the other protected characteristics needs to be achieved by commissioning and publication of research on all diversity strands. This would maintain the current momentum and increase the prominence of diversity within the NHS, further underlining the commitment to equality at an organisational level.

Champions Publication of research is by no means a guarantee that it will gain the recognition that it deserves. A number of factors were identified as having influence over the impact and circulation that a piece of research can obtain. The credibility of the researcher can be a strong factor as to whether work is published, or not. The work of academic researchers that have a strong track record of diversity research is hard to ignore, and these researchers are often championed by high profile senior leaders within the NHS. This high profile support is important not only to get work noticed, but also for effective distribution. Social media and staff networks can be central in helping research to get noticed. The access that researchers and sponsors may have to these networks can be crucial. Timing and subject matter can also be critical to how widely research is distributed and the impact that it might have.

Roger Kline's *Snowy white peaks of the NHS* (Middlesex University 2014) is a prime example of research that gained widespread recognition and attention. The report

was released to coincide with the tenth anniversary of the publication by the Department of Health of The Race Equality Action Plan in 2004 and was supported by Simon Stevens, NHS England's chief executive. The findings of the report revealed that there has been little improvement in meeting the goals of the action plan with regard to increasing the numbers of BME leaders in the NHS. The combination of credibility, executive sponsorship, timing, and subject matter as well as important findings, all contributed to the substantial impact that his report has achieved.

The affinity that a researcher may have to a particular subject matter can also be a strong factor for research in that area to be carried out. This is particularly noticeable among practitioners who are more likely to have personal reasons for undertaking research. This has led to some insightful qualitative and quantitative data on both gender and race specifically regarding the NHS workforce. Personal motivation to highlight issues which are seen to be unfair and/or not being addressed have been extremely compelling for certain individuals to undertake work that they feel is important, and is not being covered elsewhere.

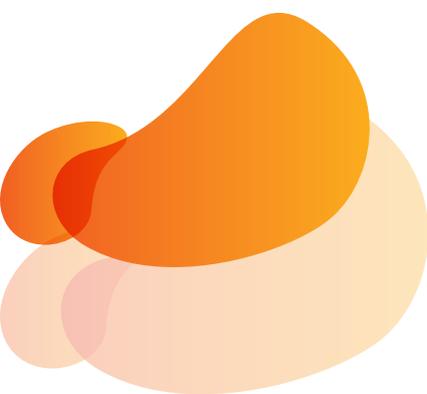
Two individuals who have undertaken such work and were interviewed for this report are Dr Penny Newman and Dr Vivienne Lyfar-Cisse. While their passion, commitment and dedication cannot be emphasised enough, both received the opportunity and support to be able to devote time and resources to their research work. The availability of coaching, leadership programmes and the strong platform of staff networks were all mentioned as being invaluable in providing the support required to help them achieve their research work on top of various other commitments.

Availability of, and access to, similar resources and development opportunities has been identified as an essential part of successfully implementing diversity recruitment policy- findings that are backed up by Dr Newman and Dr Lyfar-Cisse's comments, research and personal experiences.

Barriers to research

There are a number of factors that were found to hinder research being undertaken, particularly in certain areas. Creating a culture where staff feel that their concerns are taken seriously, and where they will not be singled out for raising these concerns is essential. The difficulty in obtaining data regarding sexual orientation and disability due in part to self-identification, and lower participation rates for BME staff, are examples. There are also limited resources available for diversity research and so work in areas where there are gaps needs to be prioritised.

The bulk of diversity research work that has been undertaken to date, and the research that has had the greatest impact, has concentrated on race and gender as these two areas have historically gained greater prominence for a longer period of time. The percentage of BME and female NHS staff working for the NHS is also greater than average when compared to the overall population. Female staff make up a total of 77 per cent of the workforce – (source NHS Employers estimates September 2014). The total BME population of London is 39 per cent, the BME workforce of the NHS in London is 43 per cent. The overall BME population of England is 15 per cent, while the BME workforce in England is NHS 17 per cent – (source NHS staff and patient surveys in 2012).



The findings of the Macpherson Report and the fact that women now make up the majority (77 per cent) of the NHS workforce have made the now well-evidenced issues faced by BME and female NHS staff hard to ignore. There have also been a number of visible senior champions, both inside and outside the NHS, who have supported and lobbied for research in these two areas of diversity. The predominance of the research in these two areas has also come about due to do the activism, visibility, and size of both the female and BME communities within the NHS and more widely in the UK.

There has been a great deal of proactive engagement on diversity issues by these two groups which has driven the need for more research on workplace equality for race and gender. Ongoing research will be essential to monitor the progress made against equality legislation for all groups, but particularly for race and gender as the NHS is dependent on the labour of women and staff from BME backgrounds.

In comparison, the other diversity strands tend to be less visible, with fewer champions, and also have less precedence historically. This, combined with the reticence of NHS staff to reveal information about their sexual orientation or disabilities, goes some way to explaining why there is less research for these protected groups. While there is limited research that has been done on disability and sexual orientation, the research that does exist suggests that LGBT and disabled NHS staff suffer significant discrimination, harassment and bullying because of their minority status.

The NHS' Working Longer Group has commissioned a review of existing research regarding the impact of working beyond the age of 60, which was published in June 2013. With an ever increasing average age of NHS workers, and the raising of the state pension age, the issue of an ageing NHS workforce and population, and the impact it will have on the organisation is a subject that requires more in-depth research.

National averages Although there is now an increasing amount of diversity data, the evidence that has been collected to date is very broad in scope, and mostly collates local trust information to give the picture nationally. There is a great variation regionally in the makeup of staff in NHS trusts, and so national averages may not represent the picture at a local level across all trusts. The need to collect diversity data and analyse it at a local trust level is therefore essential to allow for the effective implementation of diversity policy. Current research has shown, for example, that the experiences of staff of differing ethnic backgrounds, or the experience of lesbians and gay men can vary greatly. The collection and analysis of this data requires an allocation of resources at a time when resources across the whole of the NHS are diminishing.

In some cases, researchers have found that as few as 50 per cent of trusts have been collecting diversity data in a usable format. The introduction of the EDS, which has been mandatory since April 2015, should provide much more detailed equality data at a local trust level. This will help to shape local policies to address diversity recruitment issues locally, subject to resources being allocated for analysis, and action taken based on the findings.

Credible research Another potential barrier to research having the desired impact is that empirical evidence, NHS staff surveys, and academic studies may not be held in the same regard as clinical medical research. As many medical staff will be familiar with this area of healthcare science, other research that is not carried out to the same standards may be discounted or not receive the attention that it may deserve. This is particularly true of qualitative evidence, which may lack statistical validity, but still gives validation for a more diverse NHS workforce.

Credible researchers The credibility of the researcher/s may possibly have an impact on how well a piece of research is received, especially when a researcher has a particular interest or affinity with the subject that they are researching. Academic researchers are generally not as personally involved in their research topics and so maintain a degree of professional distance, as they do not work directly for the NHS. The research work of medical bodies, such as the Royal Colleges, has institutional credibility whereas research that is based on personal experience could be detrimental to the researcher's perceived impartiality. While credibility and accuracy of data is essential, the reputation of the researcher could be seen as the replication of the inequalities that are seen in the NHS workplace.

Culture Organisational culture was also flagged as a potential barrier to effective research, particularly in relation to the participation of staff in surveys. The National Leadership Council's inclusive leadership workstream included The Proof of Concept work which was undertaken during late 2008, and involved four strategic health boards (SHAs). This study revealed that a fear of being labelled 'difficult' for raising issues or concerns about discrimination was a key finding of the work.

This finding was echoed in the work carried out at Bradford University by Professor Uduak Archibong and Dr Aliya Darr on the involvement of black and minority ethnic staff in NHS disciplinary proceedings. This report highlighted that 'human resources managers and BME staff also mentioned the existence of attitudes within their trusts that fostered a culture which could not be easily challenged and which castigated individuals whose behaviour did not conform to accepted organisational norms.'

Trusts should work to ensure that staff are supported and encouraged to participate in research, and do not feel that they may be singled out for voicing any concerns that they may have.

Impact of research

The NHS is an excellent example of an organisation that has invested a great deal of resource in the area of workplace diversity. This commitment has been underlined since the introduction of the Equality Act and the new Public Sector Equality Duty by the introduction of the Equality Delivery System and the Workforce Race Equality Standard. To date, however, research has shown that although there have been some improvements with regard to workplace diversity, there is still a long way to go, particularly in relation to establishing a more diverse senior leadership within NHS organisations.

To date the most positive changes have been seen for the NHS's female workforce, but although women make up 77 per cent of the NHS workforce the male/female ratio is not represented at more senior levels. According to figures from NHS Employers for 2014, women account for:

- 42 per cent of chief executives (up from 23 per cent in 2000)
- 32 per cent of finance directors (up from 16 per cent in 2000)
- 85 per cent of nursing directors
- 68 per cent of HR directors
- 24 per cent of medical directors.

Data from the Health and Social Care Information Centre released in October 2014, estimates that 70 per cent of people in bands 8a-9 are female, with 85 per cent of bands 5-7 and 81 per cent of bands 1-4 also being women. The Health and Social Care Information Centre staff census of September 2014, which includes general practitioners, found that 34 per cent of consultants and 52 per cent of general practitioners (GPs) are female. The current percentage of doctors in training who are women is 54 per cent.

Although these figures show that there is not yet parity between genders in the NHS workforce, there is movement in the right direction. Many of these gains can be attributed to leadership strategies and programmes but also, as the changing makeup of the NHS workforce shifts, so has the organisational culture, away from a more traditional male dominated norm, to one that is more flexible, values people irrespective of gender, and accommodates their needs in the workplace.

Quotas To date, these improvements have been achieved without quotas, but there has been high-level support for quotas in some areas of medicine. In a letter to the Medical Schools Council on 29 July 2011, the Chief Medical Officer, Professor Dame Sally C Davies, outlined her intention that all medical schools who wish to apply for National Institute for Health Research (NIHR) biomedical research centres and units funding, need to have achieved an Athena SWAN Charter for women in science silver award.

In contrast, there has been very little progress in the actual numbers of BME staff being appointed at board level to NHS trusts. Since 2006, the percentage of trust board appointments for BME members has dropped from 8.7 per cent to 5.8 per cent. In London, where the population is 45 per cent BME and where 41 per cent of NHS trust staff are BME, the representation of BME board members is 8 per cent, and has not changed since 2008.

Source. NHS Trust Development Authority – *Snowy white peaks report* – Roger Kline.

Leadership programmes This lack of progress has been despite a number of national initiatives such as Breaking Through which was launched by the Leadership Academy in 2003, to tackle poor representation of BME staff at senior levels in the NHS. In 2010, it was reported that in excess of 500 people have been trained, with 75 per cent of its alumni going on to secure more senior roles in the NHS. Nearly 20 per cent of the 1.3 million people that work in the NHS are from BME backgrounds.

In October 2014, the NHS Leadership Academy launched a new Ready Now programme aimed at BME leaders. This programme is expected to build on the successes of Breaking Through and support staff from BME backgrounds to realise their full potential. One of the limitations acknowledged by the Leadership Council of the work of Breaking Through was that it did not change the system or attitudes and behaviours that have been shown to exist within the NHS that disadvantage people from BME backgrounds.

The predominance of data on race could be attributed to the comparative lack of progress that has been made in the NHS workplace with regard to ethnicity when compared to gender. Some of this difference has been attributed to unconscious bias and this issue is being addressed to some degree with training, but this can only solve part of the problem. If you have a culture where blame is an element of it, it is more likely that those who are singled out for attention are those who are different. This is inherently un-inclusive and therefore on its own could be counter-productive.

In the *Innovation in inclusion* report published in June 2010, the National Leadership Council states: “Promoting inclusion is a broader enterprise than securing implementation of equality and diversity legislation, which relates in practice to designing policy and providing mandatory training. Promoting inclusion is a transformational endeavour, which builds new ways of working and secures shifts in organisational cultures. It seeks to engender respect, honesty and fairness for colleagues and patients alike. It demands high levels of interaction and reflection, as well as a deep commitment to act.”

Such a shift in organisational culture based on respect would in theory, provide a fairer environment where opportunity is available more equitably, and would also facilitate improved staff engagement. This in turn would allow for increased monitoring of workplace diversity through the collection of better quality data on minority issues due to increased engagement and participation.

There is much that has been learned from the progress that has been made to date. Using these lessons and applying them across all diversity strands could not only save resources, but help to embed the culture of respect that the NHS is striving for. Many of the issues of concern can cross multiple strands such as gender, age, race, disability, faith and sexual orientation, and assigning NHS staff to one characteristic when they may belong to several could be problematic and confusing.

The plurality with which the diversity strands are dealt with could be seen as something that is actually part of the problem. The impact of research to date has been not only to highlight where there are problems concerning diversity, but to build consensus that the most effective way to a more inclusive NHS is to foster a culture based on respect, where equality and inclusiveness are values that are demonstrated at every level of each organisation. This cultural change would facilitate improved staff engagement, which in turn would allow for better monitoring of workplace diversity through the collection of better quality data on minority issues due to increased participation.

RESEARCH EXAMPLES

Ethnicity, gender, disability, sexual orientation and faith

'Diversity makes a difference'

Health Service Journal – May 2014

This special report was published before the NHS Equality, Diversity and Human Rights Week (12-16 May 2014), and was the third consecutive year that this event was featured in the Health Services Journal (HSJ).

In the first year, the focus was on creating a national initiative, with the local agenda being the focus of the second year. In 2014, the importance of social media was recognised in being crucial to building and sustaining contacts and networks to help support and develop the diversity agenda at a time when the NHS is going through challenging changes and transformations.

BME and LGBT staff networks were seen as being particularly important to help re-establish themselves and help give BME and LGBT staff a voice locally. Figures supplied by NHS Employers illustrate why these networks are needed – 12 per cent of England's working population are BME, but 16 per cent of the NHS workforce are from BME backgrounds.

Data for LGBT NHS staff is unreliable with only 1 per cent of respondents identifying as LGBT, and 47 per cent of respondents not disclosing their sexual orientation. Similarly, while 14 per cent of England's working population have a disability, only 2 per cent of NHS staff are disabled, and 45 per cent do not disclose if they have a disability in the NHS staff survey.

Research led by Dr Jeremy Dawson at Aston University Business School in 2009, matched staff and patient survey results and found that where NHS staff experience discrimination, particularly on grounds of ethnicity, patient care suffers.

More recent research by Dr Dawson found that where the ethnic diversity of frontline staff more closely reflects that of the local population, patients report better outcomes. The report also references Roger Kline's *Snowy white peaks of the NHS*, a survey of NHS trusts in London assessing trusts' diversity recruitment progress in the ten years since publication by the Department of Health of The Race Equality Action Plan in 2004. The report finds underrepresentation of women, particularly at chair and executive level, with white staff in London being three times more likely than BME staff to be senior or very senior managers.

Reluctance of NHS staff to disclose personal information such as sexual orientation, disability and religion makes it more difficult to measure on these metrics. Around 40-50 per cent of NHS staff haven't actually disclosed whether they have a disability or what their sexual orientation is in NHS staff surveys.

The introduction of the Equality Delivery System should reveal where the gaps in this data are at a local level, and provide a straightforward framework to more effectively collect diversity data. This information can also be used by NHS organisations to assess quality of care from a race, sexual orientation and disability perspective, as well as improve employee engagement strategies.

Three interviewees give their opinions on the barriers to achieving greater equality in the NHS as an employer.

James Taylor, head of policy at Stonewall points out that non-disclosure of sexual orientation due to harassment and bullying at work remains a significant concern for LGBT workers in the NHS. Nottinghamshire Healthcare Foundation's leadership with regard to LGBT inclusion is given as an example, largely because of the high priority this issue receives thanks to well-run support networks and visible LGBT senior staff within the trust.

Dr. Krishna Kasarneni, chair of the British Medical Association's (BMA) Equality and Diversity Council says a huge cultural shift within the NHS is needed, together with trusts being more proactive in their approach to becoming more diverse employers, especially at senior levels.

Gail Adams, head of nursing at UNISON, points out the necessity of collecting and analysing good quality data on this issue. She highlights the fact that issues may differ for staff across a variety of differing ethnic backgrounds, or working in different regions and/or occupational groups. Collecting accurate data is not the only barrier to obtaining quality research. Cuts in administrative staff has also meant that collecting and collating data is now not only more difficult, but has become less of a priority as reductions in spending have taken effect and priority.

Ethnicity and gender

Embedding inclusive leadership in the NHS

Determining the factors that enable success

Report to the NHS Institute for Innovation and Improvement

Chloe Cook, Lauren Roberts and Stefan Cantore – July 2010

Commissioned by the NHS Institute for Improvement and Innovation (NHSI), on behalf of the National Leadership Council (NLC), this report was an appreciative inquiry (AI) looking at how to embed inclusive leadership in the NHS. The report sought to identify successful strategies with regard to developing and enhancing inclusive leadership, and help senior leaders to build on this momentum to affect change within their own organisations. The study explored four areas of inclusive leadership in relation to workforce diversity – clinicians, women, BME people and external talent.

Researchers first undertook 37 indepth appreciative interviews with individuals from the four participating strategic health authority (SHA) areas. Interviewees shared their personal experiences of what had worked well for them in embedding inclusive leadership in the NHS. Key themes identified from these interviews were then used during four events that took place in each of the participating SHAs. The events explored what the practice of senior leaders across the NHS would be like if all their best past experiences were implemented in their day-to-day routine.

Several layers of leadership were identified as having an impact on the development of inclusive leadership. These include personal leadership factors, organisational factors, community and patient factors and societal, political and economic factors.

A number of suggestions were made as a result of the report for both boards and senior management. These were as follows:

For boards:

- director representation on the equality and diversity board
- diverse senior role models in place
- mix top down and bottom up approaches
- adopt an outcome-led approach and measure inclusive leadership outcomes
- monitor and reward contributions towards embedding inclusive leadership
- ensure transparency in board decisions
- ensure inclusive recruitment policies and practices are in effective operation
- consider equality implications as a standard board agenda item
- develop actions plans with milestones and clear accountabilities.

For senior leaders:

- build your own cultural competence
- promote and demonstrate a transparent and consistent leadership style
- consciously adopt an open and empathetic approach
- take risks and demonstrate ‘moral courage’
- invite others to contribute wherever possible
- be visible and spend time ‘on the floor’
- keep language real and simple
- maintain and promote reasonable work-life balance
- accept the challenge ahead and start small if needed
- seek out and explore opportunities to learn from elsewhere
- learn from personal stories and experiences
- seek and make use of feedback, from staff at all levels as well as from patients
- establish and address individual development needs
- demonstrate how individuals add value
- enhance staff networks and joint working within the organisation
- increase awareness of the organisation’s values.

Ethnicity

**Leading by example: The race equality duty for NHS provider boards
NHS Providers – December 2014**

Published by NHS Providers, this report includes case studies from members who have already undertaken actions and made improvements with regard to race equality.

The publication of the 2015/16 NHS contract, introduces the new Workforce Race Equality Standard (WRES), which requires organisations to demonstrate progress against a number of indicators of workforce equality. With tightening budgets and conflicting priorities, this report argues that while race equality may not be a top priority for NHS boards, this, and the broader diversity agenda, can deliver some of the savings and streamlining that are now required by harnessing the best available talent and delivering innovative solutions that diverse teams have been proven to achieve.

This report gives a number of case studies of trusts that are already taking steps to leverage the benefits of a more diverse workforce by improving their performance against metrics included in the WRES.

The report further argues that the onus to date has been on HR and diversity managers to bring about change within this area. Rather than viewing this as an HR issue, the report suggests that initiatives driven at board level are more effective, and should be viewed as an opportunity to comply with the WRES, but also as a strategic opportunity to harness the potential that a more diverse NHS workforce can bring including better engagement, productivity, innovation and patient experience/outcomes.

Research from the NHS 2012 staff survey by Michael West, found that the experience of black and minority ethnic NHS staff is a good barometer of the climate of respect and care for all within the NHS. Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received.

It is also documented in this report that BME people are significantly under-represented at senior levels in the NHS, particularly in the boardroom, and are also discriminated against in the recruitment processes of the NHS. This is despite a multitude of race equality initiatives and examples of provider good practice since the 2004 Race Equality Action Plan.

The report calls for three areas of action to facilitate this advancement: greater clarity on the case for change, a renewed focus on leadership from boards, and effective national support to facilitate good practice sharing across the NHS.

As well as being in contrast to the values of equality, inclusion and access that the NHS stands for, the case for race equality now includes better quality services, financial savings, safer decision making, better staff retention and engagement, less absenteeism and increased innovation.

The report calls for a change in organisational attitude and culture where the diversity agenda is led by the whole board as a strategic opportunity and necessity, instead of by individual diversity champions. Tailoring strategies to fit local situations while utilising the new EDS framework will be key, as will the sharing of best practice by local leadership at a national level.

The WRES now challenges trusts to have a more joined-up approach to their race equality strategies, and work with local communities and stakeholders to tailor these strategies accordingly.

Several case studies are given of trusts that are tackling race equality at a local level from their own points along this trajectory. Three of these case studies can be found on page 39 of this report. Further case studies are available in the full *Leading by example: the race equality duty for NHS provider boards* report.

Disciplinary and Fitness-to-Practice Data, Policies, and Practices in the NHS Trusts and Health Professional Bodies in the UK

Professor Archibong, Professor Baxter, Aliya Darr, Shaun Walton and Mohamed Jogi

This paper published the findings of the Bradford University report (2010) on *The involvement of black and minority ethnic staff in NHS disciplinary proceedings* research. The paper sought to further investigate evidence-based research which showed that BME doctors and nurses were more likely to be disciplined and/or on suspension than staff from other/white ethnic backgrounds. At the time that the



research was carried out (June 2008–November 2009), less was known about BME staff working in other roles in the NHS. The study compared and audited disciplinary data and procedures from 398 NHS trusts to gain a clearer picture of the disciplinary rate of BME staff compared to their white counterparts across the whole of the NHS.

Despite requirement under the Race Relations Amendment Act (2000) to collect data, only one fifth of the trusts surveyed published data on the number of disciplinaries carried out, broken down by ethnicity as required. Overall, in the 80 trusts where data was published, it was found that BME staff were nearly twice as likely to be involved in disciplinary proceedings than their white counterparts.

Although there were inconsistencies in the collection of disciplinary data, the study found that BME staff were disproportionately represented in disciplinary proceedings across all but one trust. This was an NHS ambulance trust where the difference in data was not statistically significant.

As well as highlighting the over-representation of BME staff in disciplinaries, the report also raised the need for better collection and monitoring of disciplinary data. The report suggested that collection of data could be improved to include different ethnic groups, as well as collected and analysed for all diversity strands. Comparative benchmarking and root cause analysis was recommended to better understand the reasons for this disproportionality.

Better engagement and involvement with BME staff networks, trust boards, diversity and HR officers, trade unions and professional bodies in this process was also suggested.

The report brings to light the fact that BME staff are more likely to be disciplined over insignificant matters, and that there is a tendency among managers to formalise the disciplinary process too quickly, rather than being dealt with informally. There were several reasons suggested as to why this could be the case.

A lack of confidence of managers to deal with BME staff informally, as well as managers using disciplinary processes incorrectly, for performance related issues were both identified as being problematic. Better training for managers and streamlining of disciplinary procedures was recommended.

Analysis of the findings also highlighted that issues of diversity were not always considered by managers when implementing policies, and that organisational culture was often difficult to challenge and did not favour individuals who did not conform to the norm. Better support for BME staff was also suggested, as those undergoing disciplinary proceedings could often feel isolated and traumatised by the impact such action could have on them and their careers, and they lacked access to informal support networks

The report highlights that areas of work for BME staff, and managerial practices in these areas, could account for some of the reported discrepancies. Cultural and language barriers were also seen as potentially disadvantageous for BME staff from other countries.

The pattern of over-representation of BME staff in disciplinaries within the NHS is consistent with other public sector organisations, most notably the police service and local government. Strategies that have been put in place to address the issues raised in the report include the introduction of reverse mentoring, access to mediation, clearer performance appraisal systems, simplification of the disciplinary policy and improved training around equality and diversity issues.

Discrimination by appointment

How black and minority ethnic applicants are disadvantaged in NHS staff recruitment

Roger Kline – June 2013

This report was published by Public World, an international social enterprise providing consultancy services to improve jobs, livelihoods and services through better civic and employee engagement. The work was carried out to highlight ongoing discriminatory selection processes in the NHS, despite a raft of policy initiatives aimed at ending discrimination in the labour market.

The report highlights that despite the first Race Relations Act coming into force 50 years ago, little has changed for people from BME backgrounds in the NHS, and was published ten years on from Tony Blair's promise to end discrimination in the labour market in 2003.

Mr. Blair's comments were echoed in 2004 by NHS chief executive Nigel Crisp, who stated that the NHS and Department of Health would 'target recruitment and development opportunities at people from different ethnic groups whose skills are often underused.'

The paper reports that despite an increase in NHS staff receiving equality and diversity training over the last 12 months, 8 per cent of staff had reported discrimination in the past year, with half (4 per cent) being race related discrimination.

In 2012, 14 per cent of approximately 1.4 million NHS staff are from BME backgrounds, which equates to 193,000 people, with the majority of reported cases of discrimination coming from BME staff. Also during 2012, the ethnic diversity of the NHS workforce was not reflected in the NHS leadership, with just 1 per cent of NHS chief executives being from BME backgrounds, with only one non-white person listed in the 2012 Health Service Journal's list of the 100 most influential people in healthcare.

The report acknowledges that the outcomes reported precede the Putting Patients First – NHS England's business plan for 2013/14 – 2015/16, which outlined 'a set of clear strategies to make significant improvements in the diversity of our workforce'.

This however, is not the first initiative aimed at addressing discrimination of BME staff with relation to pay and grading, promotion and career advancement. *Positively diverse, improving working lives, race for health* and more recently the *Equality Delivery System (EDS)* framework have all sought to address these issues.

Tackling these problems is not only the right thing to do as a matter of principle, but also effects quality of care for patients. Workforces that reflect the local populations that they serve are more likely to be sensitive to the needs of that community, and there is also a strong correlation between staff satisfaction and patient experience.

The paper presents results of an extensive survey carried out in 2008 by the Health Service Journal of every NHS trust in England which concluded that 'BME workers are grossly under-represented among senior management but disproportionately involved in disciplinaries, grievances, bullying and harassment cases and capability reviews'. These findings were corroborated in later research by the NHS Institute for Innovation and Improvement in 2010, and by the South East Coast BME network's Race equality review in 2008.

The report analyses data from 60 NHS trusts to ascertain if the NHS still had a serious problem with discrimination in recruitment, and if there were any data shortcomings to determine this. Of the 60 trusts initially approached, only 30 had sufficient relevant data, which revealed a similar pattern of discrimination to the earlier research and concludes that racial discrimination is being practiced in some form or other.

The report also highlights the lack of data available for half of the NHS trusts in the survey and acknowledges it is impossible to accurately determine the position for the BME staff who work at these trusts. It does however make the point that the trust who accurately record data on diversity recruitment are more likely to be aware of the potential issues, and could therefore be performing better with regard to diversity recruitment for BME staff than those trusts that do not collect and publish this data. The Equality Delivery System and the Workforce Race Equality standard should now identify where the gaps in this data exist.

Does the experience of staff working in the NHS link to the patient experience of care?

Jeremy Dawson – 2009

This report uses the NHS staff and acute in-patient surveys of 2007 to highlight the relationship between staff experience and patient satisfaction.

The research link has long been made in various sectors on how employee attitudes and experiences are linked to customer/client satisfaction. Lord Darzi's *High quality care for all* report (2008) links the development of staff with the wellbeing of patients, and this report examines that relationship in more detail.

The report finds that several areas of the two surveys have close correlations.

- bad treatment of staff by patients (whether via bullying, harassment, abuse or discrimination) is associated with poorer patient experiences
- clear staff goals and greater commitment to the organisation are associated with better communication with patients
- an emphasis on health and safety and on patient confidentiality are associated with patients' feelings of respect and dignity
- perceptions of insufficient staffing levels lead to poorer patient experiences.

The findings also conclude that organisations where staff have clear, planned goals are more likely to have patients who report positive experiences of communication, in particular around patients being involved in decisions on care/treatment, family members being able to speak to doctors, the medical information patients were given, and doctors acknowledging the presence of the patient directly when talking about their case with others.

The results are particularly relevant in the context of this report when considering the benefits of creating a more inclusive and diverse working environment, which not only benefits members of the workforce, but patient experience and care.

Other key findings from the report noted that:

- the more staff who have had health and safety training, the better the patient perceptions of greater conscientiousness and availability of staff
- when employees are considering leaving their organisation, it is more likely that there are poor levels of communication with patients, particularly around medicine
- patient perceptions of staffing levels and the respect and dignity shown towards them are correlated to employee's feelings of work pressure and staffing levels
- prevalence of discrimination against staff is related to several areas of patient experience, particularly their perceptions of nursing staff
- high levels of bullying, harassment and abuse against staff by outsiders relates to many negative patient experiences
- staff views on the confidentiality of patient information are mirrored by patient views of the privacy they are given.

Race equality service review

South East Black and Minority Ethnic Network – October 2008

The South East Coast BME Network carried out a race equality service review of all 27 NHS organisations in the South East Coast region which was published in July 2008. The review provided compelling baseline information to demonstrate that many, if not all, NHS organisations in the region were failing to deliver fully on their obligations under the Race Equality Duty.

This was the first race equality service review of NHS organisations which highlighted the disadvantages faced by BME staff concerning recruitment; disproportionate representation on HR procedures, over-representation at band 5, and under-representation at the higher pay bands and on trust boards.

The review made 36 recommendations and suggested approaches that could act as catalysts to initiate institutional and personal change.

The executive committee for the South East Coast BME Network devised an action plan towards an overarching regional strategy for developing an integrated and inclusive approach to the effective delivery of race equality for staff, patients and the whole community in Kent, Surrey and Sussex.

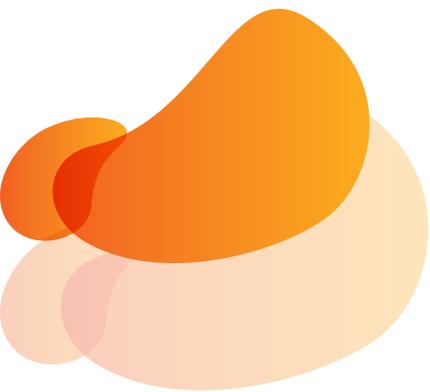
Its intention was that the action plan should guide the work programme for the South East Coast BME Network, local BME networks and all NHS organisations in the region, including the South East Coast SHA, for the period 2008-09.

The report states that for this task to be undertaken, local BME Networks would need to be developed, and the recommendations call for the appointment of an external consultant to support local BME Networks in this way.

The action plan was also intended as a tool to measure progress on the delivery of the Race Equality Agenda for subsequent service reviews carried out by the network.

The headline recommendations made in the report were as follows:

- manage the performance of trusts in delivering the race equality agenda
- ensure the SHA workforce strategy addresses the findings of the review



- ensure the SHA's strategy to deliver the next stage
- NHS organisations to address the under-representation of BME non exec, exec directors and BME staff at paybands 6 and above
- NHS organisations to address the reasons for a disproportionate number of BME staff involved in disciplinary, grievances, bullying, capability, tribunals, redundancy
- NHS organisations to determine the proportion of BME staff recruited, promoted, trained for professional and personal development
- NHS organisations to undertake race equality impact assessments (REqIA)
- NHS organisations to monitor the ethnicity of their patients
- NHS organisations to establish a programme to engage and consult with BME communities
- NHS organisations to provide training for all staff on the race equality duty
- NHS organisations to support the development of a local BME Network & involve BME staff in the delivery of the action plan
- Each NHS organisation undertake a review of its race equality scheme or single equality scheme.

The snowy white peaks of the NHS

Roger Kline – 2014

This paper follows on from Jeremy Dawson (2009) and Michael West's (2012) work which links diverse NHS workforces to enhanced patient care. Although it is national policy that NHS trust boards should be as representative as possible of the communities they serve, previous research (Esmail 2007, NHS Institute for Innovation and Improvement 2009) has highlighted concerns about the absence of black and minority ethnic staff from senior NHS roles including trust boards.

Ten years after the launch of The Race Equality Action Plan (Department of Health 2004), this paper reports on the leadership of NHS trusts in London. This region was chosen because of the large ethnic population and number of people from BME backgrounds in the NHS workforce.

Given the now well evidenced impact on patient experience, the report considers the gap between the local population and NHS workforce, and trust leadership and senior management. As well as focusing on ethnicity, the report also looked at the under-representation of women on NHS boards.

The report finds that board members from a BME background on London trust boards fell from 9.6 per cent in 2006 to 8 per cent in 2014, and that the proportion of chief executives and chairs fell from 5.3 per cent to 2.5 per cent.

The report also found that two fifths of London's NHS trust boards had no BME members, and over half either had no BME executive members or no BME non-executive members. Overall, the likelihood of white staff in London being senior or very senior managers is three times higher than it is for black and minority ethnic staff.

The report found that the women made up 40 per cent of boards which represents a small improvement. This is still well below the level of both the local population and NHS workforce. Women were also found to be under-represented in senior leadership roles, particularly at chair and chief executive level.

This under-representation was also found to be repeated nationally for ethnicity and gender, on the boards of NHS England, Monitor, the NHS Trust Development Authority, Health Education England, and the Professional Standards Authority.

The data illustrates the significant gap that exists between NHS trusts, national bodies and the NHS workforce. Given that the treatment of BME staff is a good predictor of patient care, the report calls for a change in culture where staff are more valued, and well-implemented practices to address this imbalance.

London's BME NHS staff also fare less well than their white counterparts. They are to be disproportionately found in lower grades, are treated less favourably in recruitment, promotion, incremental and performance awards and bonus payments, are more likely to experience bullying and harassment, and are more likely to face disciplinary action or be reported to professional regulators.

The report points out the obligation of trust boards to The Healthy NHS Board which was published by the NHS Leadership Academy in 2013 and outlines the chief executive and executive directors responsibility to comply with equality and human rights legislation, and non-executive directors' (NEDs) responsibility to challenge executive proposals with an equality focus.

The NHS guidance on selection processes for board members states: "Board members' responsibility to promote equality, diversity and inclusion and adhere to the Human Rights Act also form part of the Council for Healthcare Regulatory Excellence (CHRE) standards for board members."

Despite these requirements, the paper points out that Department of Health guidance (Board governance assurance framework for aspirant foundation trusts board governance memorandum 2011) includes red flags where NEDs are required to have relevant financial or commercial experience, yet consideration for a board's diversity is merely referred to as good practice.

Despite this governance and guidance, the report concludes that there has been very little, if any, progress on race equality within the NHS over the last decade.

Innovation in Inclusion

National Leadership Council, Institute for Innovation and Improvement – June 2010

Innovation in Inclusion is a project funded by the National Leadership Council through the Breaking Through transformational leadership programme (TLP) which seeks to identify the needs – and the potential solutions – to addressing the barriers to promoting inclusion in the NHS. Breaking Through has commissioned an independent evaluation of its key programmes and the one which has emerged as delivering the most results is TLP.

The project stimulated discussions about how to nurture inclusive and effective leaders in health services. As a result, the project secured a valuable return on investment. Its success lay in the fact that it was an initiative for the NHS by the NHS. Participating organisations and delegates at the national inclusion summit indicated that there is an appetite for further work. A number of NHS organisations have asked to extend the project beyond the six initial sites.

The project was devised because systematic and transparent leadership development programme linked to the inclusion agenda did not commonly exist. Organisations were unable to demonstrate a system which identified, at all levels, the development of staff linked to the inclusion strands. Therefore it was not possible to identify the number of men or women, BME, or clinical staff, who had undertaken leadership programmes.

Examples of good practice, particularly related to patient care, exist and should be celebrated. However, there is little evidence that this exists for staff. Staff do not appear to treat themselves and their colleagues with the same level of enthusiasm, commitment and passion as they do the services they provide to the public.

There were common challenges in all of the six participating organisations, characterised by required shifts in local cultures:

- distrust to trust
- fear to empowerment
- collusion to valuing diversity
- restrictive and stifled to empowered and ambitious
- data compliance to valuing individuals.

Recommendations from the report:

- boards need to have open and constructive dialogue about inclusion in a safe environment, with external support where necessary to understand their roles and responsibilities
- champions of this agenda in local organisations need to be networked, supported and effectively developed in order to strengthen their ability to make change stick
- organisations need to collect information about access to and uptake of development opportunities as well as promotion and recruitment outcomes by each of the equality strands and review progress regularly
- chief executives should be actively and visibly involved in leading on this agenda
- organisations should use the powerful questions set out in the assessment checklist as tools to help them regularly take stock of where they are
- coherent and embedded plans should be developed and used to monitor progress
- approved facilitators working to a set of well-defined standards should be identified to support change.



Race equality at a glance

at a glance RACE EQUALITY IN THE NHS



Research on NHS staff and patient surveys in 2012 by Michael West found:



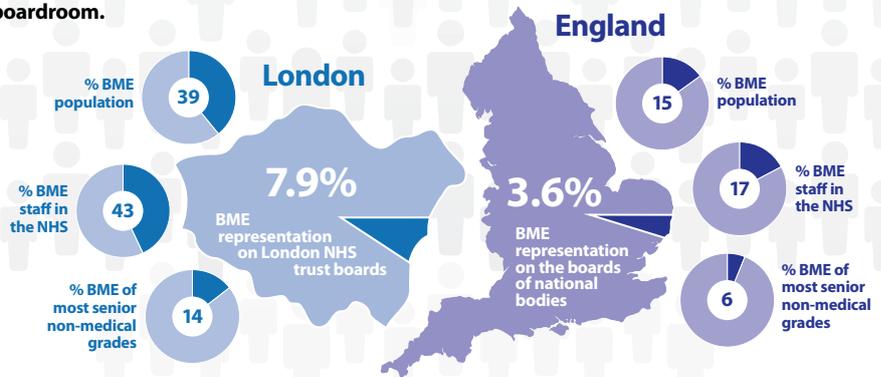
The experience of black and minority ethnic NHS staff is a good barometer of the climate of respect and care for all within the NHS. Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received.

Source: NHS Staff Survey and Related Data West, M et al 2012

WORKFORCE REPRESENTATION

Black and minority ethnic (BME) people are significantly under-represented at senior levels in the NHS, particularly in the boardroom.

Sources: National Census 2011, HSCIC 2013/14, Stony White Heals, Roger Inne 2014



RECRUITMENT

% of shortlisted BME applicants who are then appointed



Source: Discrimination by appointment - Public World 2013. Based on a sample of 30 trusts and data between 2010 and 2013

WORKING CULTURE

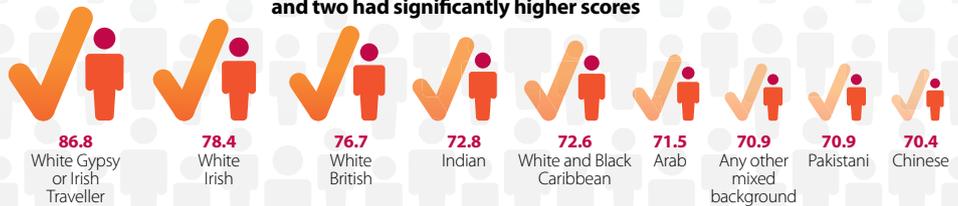
% of staff that have personally experienced discrimination at work from



Source: NHS staff survey 2013

PATIENT EXPERIENCE

In the 2012 adult inpatient survey, of 18 ethnic groups six had significantly lower patient satisfaction scores than white British patients and two had significantly higher scores



Sources: Adult inpatient survey 2012, The relationship between cancer patient experience and staff survey results, Macmillan Cancer Support 2013

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Gender

Releasing potential: Woman doctors and clinical leadership. Women in Medicine

Dr Penny Newman – 2012

Dr Newman's report provides qualitative data in the form of in-depth interviews to further highlight the under-representation of women in leadership roles in the NHS.

The report follows numerous quantitative research papers (National Working Group on *Women in Medicine's report Women Doctors: Making a Difference 2009*) which finds that despite women making up the majority of entrants to medical school since the early 1990s, few female doctors have reached senior leadership positions compared to their male counterparts. Women doctors remain under-represented in academia, at the BMA, in Royal Colleges, and as clinical and medical directors, as well as on newer clinical commissioning group (CCG) boards.

The report outlines the many benefits of having a diverse NHS workforce at all levels, specifically with regard to women in the NHS. Better patient representation and care, talent retention, innovation and new leadership styles, improved quality and better and safer decision making, all echo research regarding BME workers, and highlight the return on investment that can be expected from well-implemented equality legislation and initiatives.

To fully realise this potential, female NHS staff need to have the opportunity to participate at the most senior levels. A range of organisational barriers can impede the progress of female doctors including a lack of role models, juggling domestic and work commitments, and working within a perceived male orientated working environment.

The report points out that while there are common issues with the other diversity strands, women make up the majority of the NHS workforce and this is therefore a majority, not a minority issue. Also, many female doctors are from BME backgrounds, have disabilities, religious beliefs, and are of varying ages and sexualities. To address these issues, the report calls for a cultural and organisational change across the entire NHS to address this issue.

A range of recommendations are included in the report which include proactive measures to assist in the development of female talent. These include:

- coaching and mentoring for female doctors where female doctors are a minority
- identification of senior female role models to encourage women into leadership roles, offering them coaching opportunities and greater recognition of their achievements
- identifying potential talent and assuring sufficient development opportunities
- greater online and peer-to-peer networking opportunities and information made available including interactive social platform/s for female leadership and leadership development
- greater transparency in appointments and better tracking of appointments of women to leadership roles

Women and medicine. THE FUTURE

Royal College of Physicians – 2009

This report was commissioned to provide an objective analysis into the changing makeup of the medical profession, and to stimulate debate around the dramatic increase in the number of female doctors.

The Royal College of Physicians (RCP) published the results of two years' analysis of a comprehensive data set relating to various aspects of a medical career – entry, choice of specialty, and modes of working. The aim of the report is to guide and inform policy makers of a workforce that uses the most of all available talent, and enables the large number of women doctors to be productively incorporated into the NHS workforce.

Currently, more than half of medical students are female and, on current trends, women now make up the majority of general practitioners (GPs) since 2013, and will make up the majority of all doctors sometime after 2017.

Findings from the report note the different areas of practice that women generally have preferences for which include specialties that offer more 'plannable' working hours and a relatively greater amount of patient interaction. Female doctors are also much more likely to prefer part-time or flexible working when compared to male doctors.

The proportion of women among consultants varied between specialty groups, from more than 40 per cent in paediatrics and public health, to less than 10 per cent in the surgical group.

This is already having implications for the health profession and the report argues that the barriers for women entering the medical profession, and delays to career progression, are no longer issues. The equitable and fair incorporation of the increasing number of female doctors into the NHS workforce for the benefit of patients is now the main area that needs to be addressed.

These changes may well have connotations for advancement prospects of those doctors, especially those seeking flexible working arrangements. For example, the possible emergence of either an expanded non-consultant career grade, multiple tiers within the consultant grade, or similar.

The evidence on advancement in hospital specialty medicine indicates that, among female UK graduates over the last two decades, a very high proportion have achieved consultant status compared to the female success rates in achieving partnership in comparable private sector service professions.

Whether this will be maintained in the future, with less resources and increased supply of UK medical graduates relative to posts, is still unclear. Despite this, there are very few women doctors on NHS trust boards as medical directors.

Unless current trends change, women doctors are likely to continue to work part-time in large numbers and to take more time off during a career than doctors as a whole have traditionally done in the past. This will mean that more doctors will be needed to provide the same amount of cover in future.

A second concern is leadership capacity. Senior leaders are required to devote a significant amount of time to work outside clinical care. Part-time or flexible workers, and those taking career breaks, could be at a disadvantage when it comes to career progression.



An increase in part-time doctors may at some point also compromise patient care, as organisations deal with more complex staffing requirements. Also the comparative preference for women to work in certain specialities may have implications in the future that are unclear at present.

The need for better data collection will be critical to knowing the impact of the changing demographic of doctors. Particularly, data regarding doctors' specialities, those working part-time and flexible contracts, attrition and career progression.

More information will also need to be collected on entry patterns and motivations to medicine both for men and women. Greater collaboration regarding the sharing of data will be required between multiple agencies and trusts to assure better long-term workforce planning.

- more flexible training that recognises non-linear career trajectories and values part-time working
- more accessible return to work schemes.

Dr Newman's own work is, in part, testament to these recommendations. The research project was funded by a National Leadership Council (NLC) emerging leaders' bursary, that came about from the author's participation in an NHS East of England senior clinical leaders development programme.

The report acknowledges work done in the private sector to benchmark and monitor the number of women at corporate board level. At present 13.9 per cent of the Financial Times Stock Exchange (FTSE) 100 board positions are held by women, with just 8.7 per cent of FTSE 250 boards being female.

There are significant differences in countries around the world with regard to female board representation. Interestingly Norway, which records the highest percentage of women on boards, introduced a quota system in 2003 and now has 31.9 per cent of women taking up board room appointments.

Countries that are showing little or no progress with regard to female board appointments include the USA, Canada and the UK. In February 2011, the UK's Davies Report recommended voluntary targets of at least 25 per cent for the top 350 FTSE-listed companies.

Women doctors: making a difference

Report of the chair of the National Working Group on Women in Medicine Baroness Deech – 2009

This report was commissioned from the National Working Group on Women in Medicine which reviewed a number of studies that have previously looked into the issues regarding female doctors, and the increasing number of women in medicine. The report identifies common threads in these studies and recommends a programme of action to improve opportunities for women in every field of medicine.

In the forward to the report, Sir Liam Donaldson, the former Chief Medical Officer for England, quotes his 2006 Annual Report and his comments regarding the increasing number of women working in the NHS where he said that: "the problem is not access to medical school but rather how we ensure that the female medical workforce is able to fulfil its potential once in employment".

Sir Liam also acknowledged that greater access to mentoring, recognition by the medical Royal Colleges that time alone does not indicate competence to practice

independently, and improved feedback from the clinical excellence awards scheme are all designed to help all doctors realise their potential. However, there are additional areas where support needs to improve, such as childcare and greater opportunities for alternative working patterns such as flexible and part-time working.

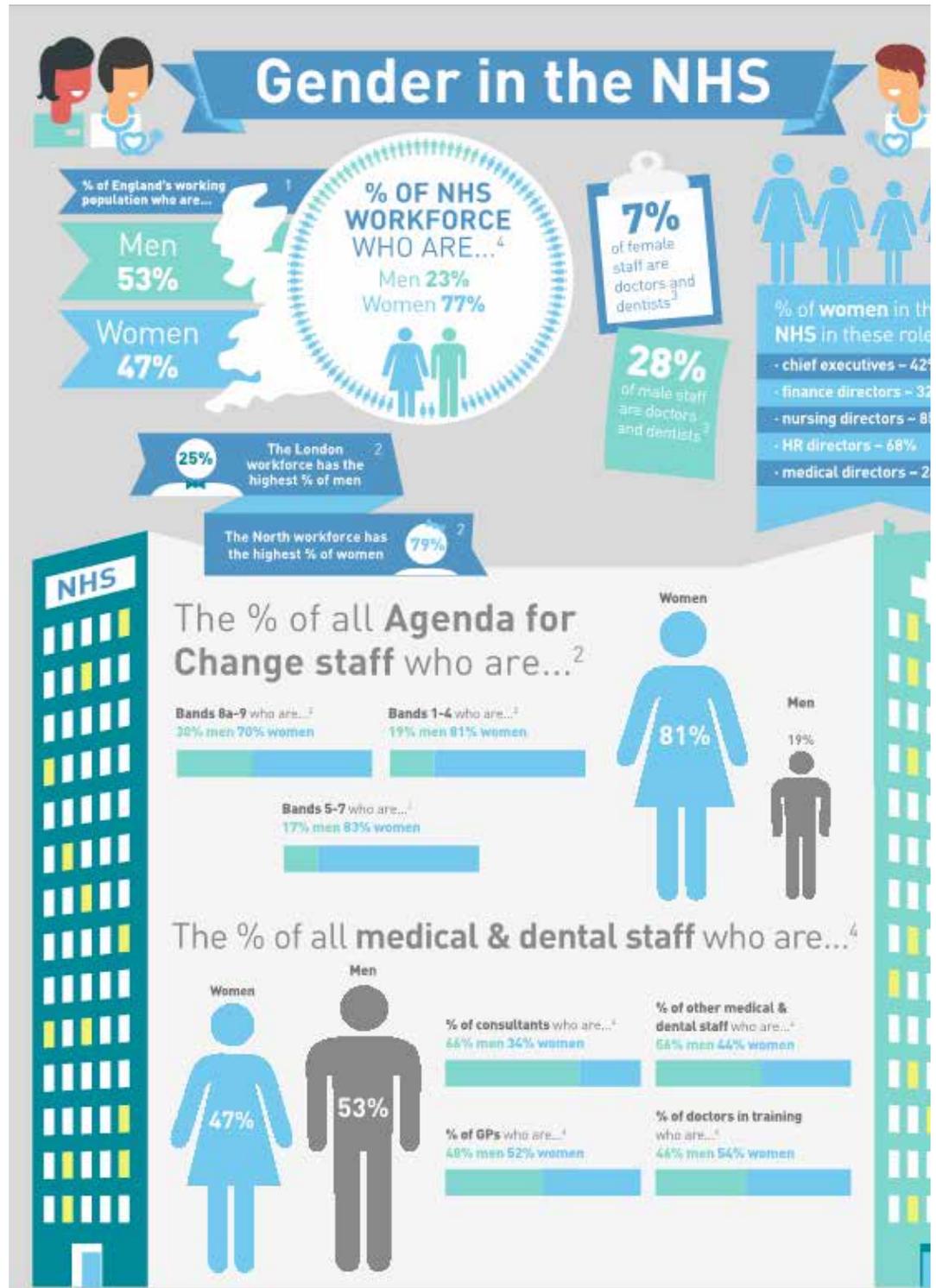
Some important steps have already been taken in this area, such as the NHS childcare strategy for example. These and other changes will be necessary if the NHS is to meet the demands to create the changing workforce so that it meets clinician needs without compromising patient care while also meeting expectations.

The report outlines recommendations for changes to meet the ever increasing number of women doctors working in the NHS which include:

- improve access to mentoring and career advice
- encouraging women in leadership including academic and clinical committees and boards, and a more transparent appointment process
- improve access to part-time working and flexible training
- ensure that the arrangements for revalidation are clear and explicit
- women should be encouraged to apply for the clinical excellence awards scheme
- ensure that the medical workforce planning apparatus takes account of the increasing number of women in the medical profession
- improve access to childcare
- improve support for carers
- strenuous efforts should be made to ensure that these recommendations are enacted through the identification of champions.



Gender in the NHS at a glance



Disability

Findings for NHS Employers' disability summit Disability Rights UK – April 2014

The NHS has a workforce of 1.7 million people, making it the fifth largest employer in the world and the largest in Europe. There are currently 31,322 people who have disclosed and identified themselves as disabled employed in the NHS, which represents 2.6 per cent of the workforce (a further 40 per cent is unknown or not disclosed). The data is not broken down by type of disability and so it is not yet possible to establish, for example, the number of employees with learning disabilities.

In April 2014, NHS Employers came together with Disabilities Rights UK to look at the issue of workplace experience and staff with disabilities.

Disability Rights UK (DR UK) works to create a society where everyone with lived experience of disability or health conditions can participate equally as full citizens and they are the leading charity of this kind in the UK. Improving employment opportunities and work place conditions are a key driver for the charity.

Consistently, NHS staff surveys have reported the poor workplace experience of disabled staff working in the NHS. Both parties wished to get behind the figures and in doing so capture the experience of disabled staff working in the NHS.

Method of data collection

- 1 DRUK analysed the 2013 staff survey and used the key findings as the basis for further fact finding exploration as explained below.
- 2 A disability survey targeting disabled staff only, designed by DR UK, geared at understanding the attitudes toward and experiences of disabled people in the NHS (quantitative). The response was over 900.
- 3 DR UK interviewed/ met with 15 individuals with a disability and who had completed the survey. They were able to provide specific examples, anecdotal evidence and an understanding of challenges (qualitative) which formed the basis of the disability summit. DR UK then produced a summary report from the research which formed the basis of the disability summit.

Key findings:

- 75 per cent of responders were disabled people – the remainder being allied health professionals, interested parties and failed responses
- The mix of reported impairment included physical (61 per cent); mental ill health (18 per cent); hearing loss (16 per cent); learning disability (9 per cent); visual impairment (5 per cent)
- 77 per cent of responders were female
- The geographic spread of response was reasonable, although a better and higher balance in the South and South West of England would have been helpful
- 14 per cent of responders reported a dual identity – eg disability and sexual orientation
- 25 individuals cited a failure to implement a reasonable adjustment which has led to a loss of productivity and poor health
- 67 disabled colleagues reported being bullied at work

- 16 per cent of responders choose not to declare their disability, largely through fear such a declaration might affect their career.
- 41 per cent reported that their disability and the barriers put in their way meant their career progression was negatively affected
- disability related sick leave featured very clearly as an issue that needs further thought and action – this replicated some of the comment recorded during the earlier telephone interviews
- 9 per cent of all respondents had learning disabilities and 18 per cent per cent had mental health issues.
- 53 per cent of responders reported a good experience at work.
- 84 per cent said they were open about their disability.
- there is clear evidence that, when a disabled member staff group exists, senior management listens to what it has to say, however, the numbers reporting such existence were low.

NHS England Commissioned Research (2015)

Disability Rights UK – May 2015

In March 2015, NHS England decided to build upon DRUK's work by commissioning a further piece of research. This is primarily a quantitative piece of research, focusing upon disabled staff working within the NHS, and drawing primarily upon two national data sets:

- 2014 NHS staff survey data
- Electronic Staff Record (ESR) data held by the Health and Social Care Information Centre (HSCIC) describing the NHS workforce across England by region and various other categories.

Initial findings include:

- levels of disability were around 17 per cent in the NHS Staff survey, and around 3 per cent in the ESR.
- It was not possible in the data sets analysed to distinguish between different types of disability.
- It has not yet been possible to differentiate levels of disability across staffing bands so additional analysis has been requested for this.

In the NHS staff survey, staff with disabilities reported:

- slightly more physical violence from patients, their relatives, or managers (1–2 per cent more) (Q20)
- substantially more bullying and harassment from patients, their relatives (7 per cent more) and in particular from managers, team leaders or colleagues (12 per cent more)
- somewhat more discrimination at work from patients, their families or their managers or team leaders (7 per cent more)
- feeling under pressure in the last three months from managers to attend work while feeling unwell (11 per cent more)
- rates of appraisal between disabled and non-disabled staff were broadly comparable.

However, there were substantial differences in how the value of appraisal was rated. Disabled staff seem to be less satisfied with the effects of their appraisal. A total of 7 per cent fewer disabled staff felt that appraisals improved their performance. Moreover, 9 per cent fewer disabled staff felt valued by their organisation for their work and 41 per cent reported that their trust has not made a reasonable adjustment in their place of work to their reported disability.

In addition, disabled staff:

- felt more dissatisfied with the recognition, support, responsibility and opportunities they have in their jobs, even though there is no difference in the satisfaction they report in the quality of care they give to patients
- felt less recognised for their good work undertaken (8 per cent fewer)
- felt less supported by their immediate managers (5 per cent points fewer)
- felt less supported by their work colleagues (3 per cent points fewer)
- were more unsatisfied with their levels of responsibility they had been given (4 per cent points fewer)
- felt they had less opportunity to use their skills (5 per cent points fewer)
- felt they were substantially less satisfied with their level of remuneration and with being valued by their organisation for the contribution they were making (both 9 per cent fewer).

Age

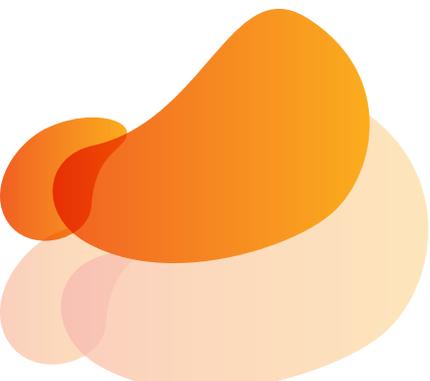
Extending working life

Audit of research relating to impacts on NHS employees University of Bath 2013

The NHS Working Longer Group commissioned Bath University to undertake an audit of existing research into the impact of working beyond age 60. This was published in June 2013 and provided the Working Longer Review group with an understanding of what evidence is available in relation to the impact of people working beyond 60. The audit focused on a number of key areas:

- What factors influence employee decisions to extend working life such as pension choices, retirement planning, transitions to alternative employment?
- What support do older workers need to stay in work and/or change career and how does this differ from younger employees?
- What are the implications on physical, psychological and emotional health and wellbeing?
- What are the implications on multi-generational working?
- What does good employer practice look like for managing the impact of working longer?
- What is the current age demographic of the NHS workforce and how is this likely to change?

The average age of NHS employees (currently 43 years) is rising, year on year. A high proportion of NHS employees leave the NHS significantly before their pension age, many in their 50s. Important push influences appear to be attributable to the configuration of work, in particular the limited availability of part-time employment and current shift-working practices. If current patterns of



early withdrawal continue, in the context of a rising average age as these demographics come into alignment, there is a risk of future staff shortages. To counteract this, there is a need to mitigate the impact of factors that motivate early withdrawal.

The evidence on retaining (and recruiting) older employees highlights the need for a managed, employer-led approach that takes account of employee work preferences and retirement objectives (eg the availability of flexible work) in later (50 years +) working life, combined with a bespoke, person-centred, approach to workability and rehabilitation focused on supporting people to stay in work longer. More fundamentally, there is a need to go beyond a focus on individuals, to address the scope for reconfiguring established systems and methods of working such that push factors that are known to motivate early withdrawal are mitigated.

Some of the key findings include:

- capacity and performance – the dominant finding is that older people (in good health, with up-to-date skills sets) perform as well as their younger counterparts
- NHS demographics – the average age of NHS employees is 43.7 years which is projected to rise to 47 years by 2023
- 50+ employment migration – a significant proportion of staff over the age of 50 leave NHS employment with many moving to alternative health related employment with less hours
- push and pull variables – there are many factors that influence an individual's decision over when to retire including health status, financial status, family commitments, peer retirement norms (what their colleagues have done), job characteristics (job satisfaction, working hours, employer attitudes/ norms) and structural influences (availability of work, state benefits, tax arrangements)
- staff retention – retention is driven more by the features of the job than the capabilities of the individual, where the fit is poor this tends to result in people leaving work.

The report also provides the key areas of employer good practice and recommendations for further research. The Working Longer Group considered these recommendations and what NHS specific evidence could be collated that could be used to create national policy on how the ageing workforce should be managed and how the NHS Pension Scheme flexibilities should be applied to support this.

Sexual orientation

The ups and downs of LGBs workplace experiences

Discrimination, bullying and harassment of lesbian, gay and bisexual employees in Britain.

Helge Hoel, Duncan Lewis and Anna Einarsdóttir – January 2014

Conducted by the University of Manchester Business School, this report gives the findings of a national survey of 1,222 individuals conducted as face-to-face and online interviews. This survey covered the private, public and third sectors, including some NHS employees, although the results are not broken down specifically by industry or sector. Researchers did undertake two focus groups with heterosexuals and a number of in-depth interviews with LGBs as well as

interviews with HR and trade union officials at an undisclosed NHS trust with 13,000+ staff. The focus groups provided insights into how heterosexuals view non-heterosexual experiences through the discussion of a number of scenarios.

Generally, focus group attendees did not feel LGBs were discriminated against in the three stories that were presented to them, or that there was an intention to discriminate. Joke telling was seen as human nature and telling gay jokes was a sign of LGB acceptance by heterosexual workers in NHS workplaces. Acceptance was also seen in the form of a healthy curiosity, asking about a colleague's sexual orientation.

Several participants were volunteered to take part in the survey by their NHS colleagues even though they were not LGB. This did not happen in any other focus groups, suggesting that sexual orientation was seen as fair game or humorous to some NHS employees. In the absence of an LGB network at the trust, researchers were told by LGB respondents that many LGBs looked out for and after each other.

With regard to the larger research project, the researchers had some difficulty in obtaining a robust LGB sample, particularly from lesbian respondents and because of the privacy concerns for LGB people. Although previous research has provided evidence of bullying and harassment of LGB people at work, it has been smaller in scale and therefore does not show the whole picture. Similar problems in gathering data for this group have been encountered by the NHS, as less than 1 per cent of respondents to staff surveys say their sexual orientation is not heterosexual.

The methodology for this research sought to better address the privacy concerns of LGB respondents and provide a robust number of participants by using Negative Acts Questionnaire Sexual Orientation (NAQ-SO). The final sample consisted of 722 heterosexuals, 147 gay men, 122 lesbians, 151 bisexuals (40 men and 111 women), 24 people who labelled themselves 'other sexual orientation' and 56 who labelled themselves 'unsure'. The research sets out to find whether LGBs experience more or less bullying, negative workplace behaviours and discrimination compared to heterosexuals, and how heterosexuals perceived negative treatment, bullying and discrimination of LGBs. Key findings from the research were as follows:

- 55 per cent of LGBs are open about their sexual orientation at work, one in five remain closeted about their sexual orientation, 21 per cent only reveal their sexual orientation if asked specifically LGBs were more than twice as likely to be bullied and discriminated against than heterosexuals
- among LGBs, lesbians and bisexual women are even more likely to be bullied, discriminated against and to be exposed to negative and destructive behaviours at work than gay and bisexual men
- LGBs are nearly three times more likely to be exposed to intrusive and sexualised behaviour than heterosexual employees and also more likely to be exposed to social exclusion
- LGBs' physical health is substantially worse than the health of heterosexuals – lesbians and bisexual women report the worst psychological and physical health
- while the majority of LGBs are open about their sexual orientation at work, one in five remains closeted and having the desire to be more open about one's sexual orientation showed significant associations with negative outcomes
- LGBs who would like to be more open about their sexual orientation reported higher levels of bullying, discrimination and poorer health

- a supportive line manager who can encourage openness about sexual orientation might buffer the effects of bullying and reduce its occurrence, whereas a workplace where E&D is not taken seriously can exacerbate bullying at work.

Employee engagement

Employee engagement and NHS performance

Michael A West Lancaster University

Jeremy F Dawson University of Sheffield – 2012

This paper explores the growing evidence that employee engagement is strongly linked to job performance, specifically within the NHS. The NHS staff survey has included questions relating to employee engagement since 2009, and the report highlights how this is related to a variety of outcomes including staff absenteeism and turnover, patient satisfaction and mortality, and safety measures, including infection rates.

As a more engaged workforce increases with organisational outcomes such as effectiveness, productivity and innovation, there is a strong business case for encouraging positive employee attitudes. The results presented in this paper are described in more detail in the report *NHS staff management and health service quality*, published by the Department of Health (Dawson et al 2011).

Engagement was measured using three different dimensions.

- 1 Psychological engagement. 'I look forward to going to work', 'I am enthusiastic about my job', and 'Time passes quickly when I am working'.
- 2 Advocacy. 'I would recommend my trust as a place to work' and 'If a friend or relative needed treatment, I would be happy with the standard of care provided by this trust'.
- 3 Involvement 'I am able to make suggestions to improve the work of my team/department', 'There are frequent opportunities for me to show initiative in my role', and 'I am able to make improvements happen in my area of work'.

Antecedents of engagement, appraisal and team working were also measured, as previous work has indicated that these have a strong link with engagement.

Health outcomes for individuals included general health, absenteeism, work-related stress pressure to attend work when not fit to do so. Organisational (trust) level outcomes were taken from sources other than the NHS staff survey and included patient satisfaction and mortality, annual health check ratings, staff absenteeism and turnover, and MRSA infection rates.

The results showed significant differences between types of trusts, and staff groups, in terms of engagement levels. Ambulance trusts generally had the lowest engagement scores with ambulance staff having the lowest scores of any staff group. General managers reported the highest levels of engagement.

Those employees who had received a well-structured appraisal had far higher engagement than those who had not. Employees who reported higher engagement (in all three dimensions – motivation, involvement and advocacy) were more likely to rate their own health and wellbeing more highly. High levels of engagement were associated with much lower absenteeism

Patient satisfaction is significantly higher in trusts with higher levels of employee engagement. Engagement is also significantly linked to patient mortality in acute trusts.

The results reported give a clear message about the importance of staff engagement. The more positive the experiences of staff within an NHS trust, the better the outcomes for that trust. Engagement has many significant associations with patient satisfaction, patient mortality, infection rates, annual health check scores, as well as staff absenteeism and turnover. The more engaged staff members are, the better the outcomes for patients and the organisation generally.



THE IMPACT OF RESEARCH IN DRIVING CHANGE

Overview

Research has contributed to achieving change across all areas of the NHS with regards to the organisation becoming a more diverse and inclusive employer. The impact of this research is broad and wide ranging, and has contributed to an enhanced understanding of equality, diversity and inclusion and the impact that this has on the NHS as an employer and a national health service. Research has also influenced and informed national policy and legislation, and provided supporting evidence for the implementation of diversity initiatives and leadership programmes. At a local trust level, research is an essential tool to record and benchmark how effective diversity initiatives have been, and report on progress as required by legislation such as the PSEDs. The impact that research has had can be broken down into a number of different areas.

Informing legislation

Since the first equality laws were introduced over fifty years ago, the importance of quality workplace data has been essential in informing the direction and content of equality policy and legislation. The first Public Sector Equality Duties for race (2002), disability (2005) and gender (2006) were introduced in part because of evidence of inequalities that came to light because of research and the collection of diversity data. The importance of gathering this diversity data is underlined in the PSEDs, which require the publication of diversity information as part of compliance with the duties. This is also the case for the new public sector equality duty which replaces the earlier PSEDs, and came into force on 6 April 2011 to legislate how public authorities can meet the requirements of the Equality Act 2010.

It is difficult to imagine just how such legislation would have come about had not there been sufficient evidence to justify its drafting and implementation. The ongoing collection, review and analysis of diversity data would also seem essential to measure the success and impact that any such legislation will have.

In order to meet the requirements of the Equality Act 2010, and to comply with the new PSED, the NHS developed The Race Equality Action Plan in 2004 as well as the Equality Delivery System (EDS) and EDS2. One of the nine steps of implementation of the EDS2 for NHS trusts is the assembling evidence, which again is essential for benchmarking and the monitoring of progress against diversity criteria for both staff and patients. Alongside EDS2, the Workforce Race Equality Standard (WRES) has also been introduced to tackle issues raised by research, specifically regarding BME employees at more senior levels. The standard requires organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.

These frameworks and toolkits have been developed to help NHS organisations improve the services they provide for their local communities and provide better working environments for all groups. While these frameworks cannot deliver the change needed themselves, they are powerful tools that are now at the disposal of NHS trusts to help them meet their equality objectives.

The need for these frameworks was established due to the evidence provided by workplace equality research data. As well as ensuring that diversity data will be better recorded in the future, this legislation and policy also emphasises that equality is a priority within the NHS, and so helps to drive cultural change at an organisational level. Such a shift in culture has been repeatedly identified as an essential element in driving forward equality and inclusion within the NHS.

Understanding the issues

The understanding of the importance and relevance of equality to the NHS has changed dramatically due to research on diversity topics. This in turn has had a huge impact on the way that equality is managed.

One of the biggest changes has been brought about due to research that has highlighted the negative impact harassment and discrimination can have on patient care and experience. This has dramatically changed the understanding that the effect of well-implemented equality policy and procedure can have for NHS trusts. As well as improved patient care, research has also shown that a more engaged NHS workforce increases organisational outcomes and reduces inefficiencies.

This research added to the already overwhelming evidence of the need for change. The link between patient care and staff equality established the business case for workplace diversity and gave increased momentum and visibility to equality initiatives. At a time of decreasing NHS funding and resources, research has helped to keep equality on the agenda and help trusts to prioritise diversity initiatives by highlighting the savings that could be made by their effective implementation.

Challenging and changing culture

The makeup of the NHS workforce has become increasingly diverse in terms of all of the protected characteristics, and understanding and meeting the needs of this changing workforce has been essential. Research has played a part in not only revealing a more complete picture of the NHS workforce, but also challenging the existing culture and ways of thinking to better meet the needs of individuals across all of the protected groups.

Research has provided invaluable insight as to how the prevailing culture can provide barriers to some staff because of their ethnicity, gender, disability, sexual orientation or age. Research has been essential in understanding that these barriers exist and how the NHS as an organisation can help its people to overcome them.

Traditional career paths and ways of working have been found to disadvantage some NHS employees. In particular, some women and older staff have been found to prefer more flexible working hours to suit their individual needs. Staff who have trained abroad may find that their qualifications do not have the same weight as in their own countries, and staff from BME backgrounds have been shown to be disadvantaged by a culture that formalises disciplinary proceedings too quickly.

The insight gained from research has shown how important it is to engender a culture of respect, honesty and fairness for NHS staff and patients. This type of culture is essential if all staff are to be as fully engaged as possible, and the NHS is to benefit from the positive outcomes that can be achieved from providing a more equal working environment.



Research has challenged the NHS to find and develop new ways of working that take into consideration the needs of all staff. The research has also shown that for such a culture to be as effective as possible, a top-down, organisational-led approach has been shown to be most effective.

Understanding the future

The ongoing collection of diversity data is not only providing evidence about current diversity projects, but also giving vital insight into how the NHS workforce is changing and will change in the future. NHS organisations are required to record and publish this data in order to comply with the PSED.

The recording and publication of equality information is now a requirement for all public sector organisations in the UK. With regard to publishing information on both staff and service users, probation services (71 per cent) and police forces (69 per cent) performed particularly well. National organisations (25 per cent) and NHS service commissioners (36 per cent) were the worst performers although there are significant variations in performance between trusts.



THE POWER OF DIVERSITY DATA

Summary

The following case studies illustrate how diversity data has been effectively used as a tool to drive diversity within the NHS, and enhance the visibility of diversity within the organisations featured. These examples have been highlighted because of the proactive approach that has been taken by these trusts, and because they are current examples of best-practice diversity in action within the NHS.

The five examples given here represent a variety of organisations across different regions in England that work in varying areas of healthcare. Where possible interviews were carried out with individuals working at the trusts who were involved with the diversity initiatives featured. The purpose of these interviews was to better understand the motivations and inspiration for the work carried out, and if previous research work was influential in the undertaking of these diversity initiatives.

Sussex Partnership NHS Foundation Trust

Sussex Partnership NHS Foundation Trust was established in 2008 and is represented by 5,000 clinicians and support staff, working hand in hand with partners in the community to care for and support vulnerable people. The trust started as Sussex Partnership NHS Trust in April 2006 and became a foundation trust with teaching status in August 2008. The trust provides NHS care across Sussex for people with mental health problems, learning disabilities or an addiction to drugs or alcohol as well as providing a range of specialist services across south east England.

In 2014, Sussex Partnership NHS Foundation Trust was named as Diverse Company of the Year (2014) at the National Diversity Awards, and was rated second in Stonewall's top ten healthcare organisations. These awards were in recognition of the trust's achievements over the past six years in the field of equality, diversity and human rights, and the trust's implementation of its equality objective scheme which commenced in 2010 and has achieved 95 per cent of its objectives. This was a four-year plan outlining the trust's priorities regarding equality which was followed by the equality performance scheme 2014–18.

As part of these schemes the trust has developed the Equality Performance Hub, a clear and comprehensive online tool which captures and publishes information on the diversity of the organisation. This tool enables the trust to identify the experience and outcomes of their staff and those who use the trust's services.



Bradford Teaching Hospitals NHS Foundation Trust

Bradford Teaching Hospitals NHS Foundation Trust's hospitals include Bradford Royal Infirmary, St Luke's Hospital, Westbourne Green, Westwood Park, Shipley Community Hospital and Eccleshill Community Hospital. The trust also provides other services in the community (doctors, nurses, midwives and physiotherapists) and at various locations, ranging from GP practices to other neighbouring hospitals in Airedale, Halifax and Huddersfield.

In 2010, the four largest NHS organisations in Bradford and Airedale began working in partnership with local people to take a new approach to improving equality for local people (patients, service users, staff and community members) from the Equality Act's protected groups. This group includes representatives from over 30 local groups and staff ERGs.

The group has agreed priority equality objectives and will be monitoring progress in meeting them by using the new Equality Delivery System (EDS) to measure the local NHS against four key goals:

- better health outcomes for all
- improved patient access and experience
- empowered, engaged and well supported staff
- inclusive leadership at all levels.

The group has formed equality delivery system assessment panels to consider and moderate the equality and diversity performance of each NHS trust using the EDS framework in their area.





North East London NHS Foundation Trust

North East London NHS Foundation Trust (formerly known as East London and The City University Mental Health NHS Trust) formed in April 2000 and brought together mental health services from three community trusts in Tower Hamlets, Newham, The City and Hackney to become a large specialist mental health trust. It now provides community health and specialist mental health, learning disability and substance misuse services for people living in Barking and Dagenham, Havering, Redbridge and Waltham Forest, and community health services for people living in south west Essex.

The trust's Going for Gold: Delivering Equality for All advisory group has gone from strength to strength involving stakeholders in driving forward improvements in diversity. These have focused on a range of areas such as working with the police to improve support to service users they come into contact with, LGB equality monitoring to see if services are reaching all groups, improving access to psychological services for BME communities, developing faith and spiritual belief services that can support service users, and ensuring that people with a learning disability have the appropriate support when accessing healthcare.

The trust was successful in its bid in 2013 to become a Stonewall Health Champion to develop initiatives to advance and improve the support it offers LGB service users to improve their experience. The trust has re-launched its equality staff networks and has retained its two tick award status to demonstrate its commitment to improving the number of disabled people in the workforce.

Southern Health NHS Foundation Trust

Southern Health NHS Foundation Trust employs around 7,200 staff. Its equality, human rights and diversity strategy describes the trust's approach to providing high quality services to a diverse population and to being an exemplar employer for their staff. The strategy was launched in 2010 and provides a clear picture for five years in terms of what the trust wanted to achieve.

The strategy is a public commitment of the trust plans to convert their values on equality, human rights and diversity and meet the duties placed upon it by the equality legislation. The action plan includes measurable actions that provide evidence for real improvement to services taking into account the needs and wishes of local people and trust staff.

The trust has made a strategic commitment to adopting a single equality scheme (SES) approach which also includes actions on age, religion and belief, and sexual orientation in addition to race, gender and disability.

The strategy and SES sets out how Southern Health NHS Foundation Trust recognises the differences between people, and sets out how they aim to ensure that (as far as possible) any gaps and inequalities are identified and addressed.

The trust states that the greatest impact on services will only be experienced if the values and actions on equality, human rights and diversity are embraced by everyone within the trust and that delivering on equality measures is the responsibility of everyone. The strategy and action plan provides a framework for all areas of the trust to own and develop further.

Frimley Health NHS Foundation Trust

Frimley Health NHS Foundation Trust's equality and diversity steering group presents to the board an annual equality report covering employment and service issues including progress on equality objectives. The reporting year is April to March and the report is made to the board in July of each year.

Throughout 2013/14, the trust has had two leads for equality and diversity. The assistant HR director has acted as the employment lead for equality and the head of corporate affairs as the service lead for equality.

The trust's equality and diversity steering group (EDSG) meets quarterly and has an executive lead, the director of HR and facilities. The two equality leads jointly chair the steering group and membership is drawn from all directorates. Membership includes the chaplain, the chair of unit staff council, the BME network chair, complaints manager, information manager and staff development adviser. The key purposes of the group as outlined in its terms of reference are as follows:

- ensuring the trust maintains and monitors appropriate equality information and objectives
- ensuring the agreed objectives are publicised and circulated within their departments
- monitoring the trust responses to any request for equality and diversity data
- reviewing and monitoring national equality and diversity standards within the trust with regard those documented by the Care Quality Commission
- developing and assisting with equality analysis
- giving advice on the practical projects necessary to implement the equality schemes for the staff and service users
- advising on training for equality and diversity and human rights which is planned for staff
- actively assisting the trust to identify local groups and communities who should be consulted as new policies and service developments are commenced.

Planning, coordinating and participating in events to raise awareness of equality issues and human rights issues and celebrate the diversity of the workforce and service users.

External motivating factors

There are a number of common factors that have influenced these trust's actions with regard to their diversity recruitment and workplace equality efforts. The first is legislative change. The Equality Act 2010 has raised the priority and visibility of workplace equality, and the trusts featured here have taken a very pro-active approach in meeting their obligations under the Act. As well as having to provide legal protections for people from discrimination in the workplace, improved patient care and better health outcomes for both patients and staff have also been cited as being important for the diversity initiatives given in these case studies.

The Public Sector Equality Duty (PSED), which was created under the Equality Act has also been influential in advancing diversity recruitment efforts within the NHS. The Equality Delivery System (EDS) has also provided a framework that trusts have used to monitor and benchmark their progress against diversity

criteria, and this along with the Workforce Race Equality Standard (WRES) has made sure that not only are the tools now available, but equality within the NHS has never been more of a priority as it is at the present moment.

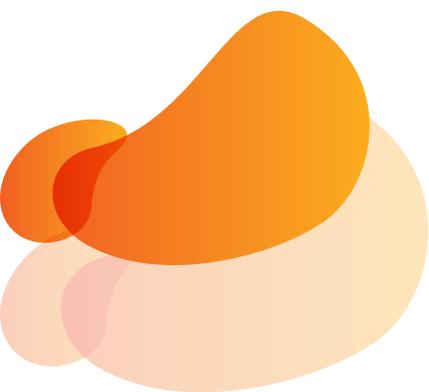
The majority of the case study examples given here focus primarily on race, with individual trusts committing significant resources to their diversity recruitment efforts in this area since 2010. This is likely to be for a number of reasons, not least because of the legacy and influence of the Macpherson Report and the EA, but also the large body of research and evidence on diversity issues that focus on race within the NHS. This research on ethnicity has largely focused on two key areas; research regarding discrimination and harassment in the workplace, and more latterly (Mary Dixon-Woods, Jeremy Dawson (2009) and Michael West (2012) research that has evidenced the negative impact on patient care in NHS workplaces where discrimination exists.

Undoubtedly this entire body of research has been a strong catalyst for the implementation of diversity recruitment initiatives for the trusts featured here. Current research not only provides evidence of discrimination and harassment of BME and other minority staff, but also now provides a strong business case for well implemented diversity policy. A well supported and diverse NHS workforce is more likely to be more fully engaged, and so will deliver much needed efficiencies and innovation. It has also been shown to improve patient experience and care, and also staff health, so meeting NHS trusts' obligations to staff and patients under both the Equality Act 2010 as well as the NHS Constitution.

As the treatment of BME staff is largely seen as a barometer of both patient care and overall staff engagement and wellbeing, the focus on BME workplace equality is understandable. The lessons that can and have been learned when addressing equality issues about race should effectively be applied to other diversity strands. The case study given here of the Frimley Health NHS Foundation Trust shows that the approach that was successfully used to increase the number of disabled staff at the trust uses similar actions to trusts where the focus has been on race. These actions include the analysis of trust diversity recruitment data, matching data to the local demographic and engaging with local stakeholders to ensure opportunities are available to local people with, in this case, disabilities.

The combination of new legislation and compelling research has been instrumental in driving positive change within the NHS as a more diverse employer, but this change has taken place over several decades and continues to evolve. The introduction of the EA and associated legislation in 2010, coupled with the research outlining the business case for workplace diversity released at around the same time appears to have given a great deal of additional impetus to the advancement of workplace equality in the NHS. Prior to this, despite existing legislation and initiatives such as Positively Diverse, Improving Working Lives, Race for Health and Opportunity 2000, the frameworks for measuring the effectiveness of equality policy were not as efficient as at present. It has been acknowledged by the Leadership Council of Breaking Through that at the time this programme did not tackle the system or attitudes and behaviours that have been shown to exist within the NHS.

The case studies given are all of examples of work that took place after the introduction of the Equality Act 2010 when a new wave of equality drives started at a local trust level. As well a new act of parliament there was also new NHS guidance and monitoring frameworks for trusts in the form of the new PSED and WRES, as well as the EDS. These new tools not only reinforced the importance of monitoring diversity practices at a trust level, but also made it easier for trusts to record and monitor their diversity recruitment data.



It was also at this time that the research that highlighted the business case for equality within the NHS was being published and gaining widespread recognition and acknowledgement. This happened at a time when budgets were decreasing across the NHS, and so the rationale for diversity after 2010 became much broader in scope. Equality and diversity was not then just a recruitment/human rights issue, but an organisational issue that could potentially help to streamline services, deliver innovation, improve patient care and deliver for staff and patients under the terms of the Equality Act.

These developments came about after there had already been a great deal of well publicised research on inequalities that existed for the NHS workforce. This research had created visibility concerning equality issues within the NHS, and the introduction of new legislation, frameworks and business case evidence provided further impetus and direction for trusts to develop their own diversity recruitment initiatives tailored to their own specific needs and requirements.

Internal motivating factors

While the evidence existed that there were discrepancies in the experiences of staff from different backgrounds in the NHS, there were little or no clear outlines or guidance on how to address these issues or change attitudes and behaviours at an organisational level. Much of the research that had been undertaken to date had used the data of multiple trusts to give an overall average national picture. For individual trusts it is essential for them to analyse their own recruitment data in order to obtain a clear picture for their particular trust, as regionally there are variations in the makeup of the NHS workforce. The collection of data and monitoring of progress against diversity metrics is key for trusts looking to implement new strategies and benchmark progress.

Obtaining senior leadership/board level buy-in and making sure that diversity is seen as a priority has been an essential component in the success of all of the case studies. The business case evidence for equality has been vital in ensuring that trusts prioritise diversity and allocate funds and resources in this direction. At a time of decreasing budgets diversity can be seen as an emotive issue that is not essential for organisations. This research has been invaluable in moving diversity up the agenda.

As Michael West and Jeremy Dawson conclude in *Employee engagement and NHS performance* “The findings make it clear that cultures of engagement, positivity, caring, compassion and respect for all – staff, patients and the public – provide the ideal environment within which to care for the health of the nation. When we care for staff, they can fulfil their calling of providing outstanding professional care for patients.”

Board involvement has included executive sponsorship of LGBT networks, appointment of board level diversity champions, and setting up of steering committees to implement and drive the agenda and activities forward. For many trusts there has often been an individual who is motivated to take on responsibility for diversity within an organisation.

While having well-motivated coordinators and diversity representatives is essential, responsibility and accountability should be held at an organisational rather than an individual level.

The involvement of stakeholders was also a key element for trusts that had effectively developed their own practices for diversity recruitment and retention. Setting up and engaging with employee resource groups was an essential element

for trusts needing to learn about the attitudes and experiences of their own staff. Local groups and organisations were also invaluable channels for learning about patient experience and expectations, communicating a trust's core values as widely as possible, and as direct channels for advertising potential vacancies to a more diverse audience.

Consultation with patients was another tactic that was used to address patient concerns, especially from diverse groups whose voices may not necessarily have been heard.

Creating a culture where staff feel that they are heard and valued and where they feel that their issues are valid has also been a success factor in the trusts featured in these case studies. Cultivating a workplace environment that is supportive and where staff services are as accessible as possible has also shown to have impacted positively. Where there is a top down, organisational-led strategy that communicates the value that a trust places on diversity, staff and patients engage more fully with their colleagues, patients and the diversity initiatives themselves.

Sussex Partnership NHS Foundation Trust

Equality, diversity and human Rights have consistently been a priority for the trust in all of their work. Since the introduction of the equality objective scheme, it has made discernible progress with the scheme, developing and supporting staff networks and forming partnerships with organisations locally and nationally such as Stonewall, the Tutu Foundation, MindOUT, Time to Change, Rethink and others.

There has been high level support and participation from within the trust for this diversity initiative. Former chief executive, Lisa Rodrigues took responsibility as chair of the equality, diversity and human rights steering group which was set up to provide direction, governance and scrutiny for the development and delivery of the trust's equality performance scheme. The scheme was built on a framework of three sub action plans, the strategic action plan, the operational action plan and the new service action plan which all went through regular reviews. The strategic action plan focused on five key areas in both equality of opportunity and health inequality:

- better health outcomes for all
- improved patient access and experience
- empowered, engaged and well supported staff
- inclusive leadership at all levels
- protection and promotion of human rights.

Operational reference groups were set up by the trust to support the delivery of the operational action plan, and each group was chaired by an executive director. The groups focused on a particular area or protected characteristic; disability, gender, relationship and family, race, religion and belief, sexual orientation and gender identity, age, staff/people/legal and a relationship with strategic action plan group.

The new service action plan ensured compliance with the action plan acquisition in the provision of new services. The plan delivered on Sussex Partnership's commitment to transparency, how it assessed their own progress, and how it was accountable for its actions.

Two measures were primarily used to measure the effectiveness of the plan. Firstly, direct feedback from patients and their families and secondly, direct feedback from trust staff. Ensuring that patients' and their families' as well as staff's voices were heard was essential to guarantee that no community was left behind or disadvantaged.

Community outreach initiatives by the trust were also implemented and included an outreach team at Brighton Pride, and providing equality and diversity training to other organisations, including advice to the RAF on launching the Ministry of Defence's first lesbian, gay, bisexual and transgender (LGBT) mentoring scheme.

This provided a unified governance structure for tackling discriminatory practice to help the trust to deliver world class services. In 2014, the equality, diversity and human rights team worked with all of the trust's services to improve the quality of data held on their systems. They have now collected data across the protected characteristics which has revealed that it is apparent from the data contained within the hub that colleagues require training, knowledge and confidence in asking the questions and ensuring that the data is then captured correctly.

Brighton and Hove has a high proportion of younger people as well as a high proportion of single population compared to the national statistics (ONS 2011).

It has larger than average gay, lesbian and transgender communities and higher rates of homeless people than the national average. Brighton and Hove has also significantly higher percentage of people across ethnic groups other than white British.

Local demographics

The population in East Sussex is older than the national average with a decreasing proportion of children and young people. The proportion of people who are married or in a civil partnership is higher than the national or regional averages.

About 20 per cent of the local population have a disability, which is higher than the national and regional average (ONS 2011).

The population of West Sussex is older than the national average (2011 ONS). Priorities in this area include start of life, workplace health and dementia.

The Partnership NHS Foundation Trust provides child and adolescent mental health services in Hampshire. This area is large and the demographics vary depending on the region.

Being a provider of children and young people's services in Kent, the trust considers the demographics of the local area while designing and delivering its services. Even though the area is large and the demographics vary depending on the region.

Drivers and motivating factors

The actions of the trust were developed with an understanding that there was a need for change and that the timing was right based on organisational factors within the NHS and broader societal changes. Shifting priorities for health service providers meant that there was an increasing focus on embedding patients' opinions into the heart of trust's activities and services. For trust staff this meant shifting priorities to meet the needs of the people who access the trust's services.

A strategic aims of the plan for the trust was to embed equality of opportunity, including compliance with the Equality Act 2010 and the PSED, and so embed equality considerations into the day-to-day work of public authorities so that they

tackle discrimination and inequality and contribute to making society fairer. The trust also cited The Human Rights Act 1998 as being a driver for the scheme. The Care Quality Commission's new regulations for health and social care services outlined in its strategy for 2013-2016 were also a driver for the scheme. These regulations include the development of a new approach to regulating specialist mental health services.

Bradford Teaching Hospitals NHS Foundation Trust

Published in Leading by example

The Race Equality Opportunity for NHS Provider Boards.

Gathering the data Evidence in 2012 that BME shortlisted candidates at bands 8 and 9 had a one in 17 chance of appointment compared to one in four for white candidates was one of the catalysts for a major drive on workforce race equality at Bradford Teaching Hospitals NHS FT.

Combined with figures showing BME staff were under- represented in the workforce compared to the wider population, and an entirely white heritage trust board, the directors were clear that things had to change.

Recruitment review The board initiated a programme of work to review recruitment practices at the trust, focused particularly on senior management positions and board appointments.

To start to build a more diverse board, the head of equality worked with an external consultant to review and amend NED job descriptions and the accompanying recruitment packs. New briefings were also given to the executive search team to underline the trust's commitment to a leadership team more reflective of Bradford's diverse communities.

To tackle the different recruitment outcomes at bands 8 and 9, equality briefings were devised for all senior recruiting managers. The sessions focused on the workforce and recruitment data and the potential reasons for the disparity in outcomes, including looking at conscious and unconscious bias.

Following evidence in the 12 months to March 2013 that no BME candidates were appointed to posts at band 8 and 9, even though 23 BME candidates had been shortlisted, further action was taken.

It was agreed that wherever possible, all band 8 and 9 posts would be externally advertised to help ensure the widest possible range of candidates. The board also decided that the head of equality or an assistant director of human resources should sit on all interview panels for these posts for a trial period. Whilst no specific issues were identified by this process, it was considered that the short amount of time given between shortlisting and interview could lead to a perception that there was an internal/local candidate bias. Wherever possible, all adverts now include an interview date at the outset to give candidates time to manage their diaries.

The head of equality for the trust also contacted every BME candidate who had been shortlisted but failed to attend interview to see if there were any patterns to non-attendance. One candidate gave permission for a telephone interview and shared her frustrations of working for the NHS as a black woman. It was the first time she had ever been asked about her experience. This was incorporated into the senior manager training as a powerful case study of the consequences for individuals of maintaining the status quo.



Measuring impact The concerted action taken over the last two years has had a real impact. The trust recruited a chair from a BME background in July 2014. In autumn 2014, the foundation trust advertised for two additional NEDs and included the following statement:

“We are keen to hear from individuals who can contribute to shaping our organisation’s strategic direction, who have strong links to the diverse communities that we serve and who bring a depth of understanding of their different and changing healthcare needs”.

All six shortlisted candidates were BME, and two NEDs from minority backgrounds have now been appointed.

Over 300 staff have taken part in the equality briefings, with the majority taking place between April and September 2013. During this same period, BME candidates for bands 8 and 9 had a 1 in 4 chance of appointment – the same as their white counterparts.

Comments from Lorraine Cameron, Head of Equality and Diversity, Bradford Teaching Hospitals

In 2010 the trust started working with the four largest NHS organisations in Bradford and Airedale and local organisations which gave a new opportunity to work together on a range of shared equality objectives. Working collectively it was believed that this group could deliver a wide range of expertise and collectively would have the greatest impact.

One area that was of particular interest was race, and the trust decided to start looking at the number of job applications from BME people and their chances of getting appointed compared to white applicant and monitor their performance. Over a 12 month period the trust found that at bands 8&9, 26 per cent of candidates were from BME people, but none that applied got these jobs.

The trust set another objective that the board would reflect the local population which at the time was all white. 2011 census data shows that the local population in the trust’s region is 27 per cent Asian or Asian British heritage and 25 per cent Muslim.

Six monthly updates were given to the board on progress that was made in this area. The trust reviewed the job descriptions of the non-executive directors and found that the specification was very business focused and that the balance of the essential criteria did not give knowledge of the diverse local population the priority that it needed. These and other concerted actions resulted in a change to the board make-up which more accurately reflects the local population, with 23 per cent of board members and the chair now coming from BME backgrounds.

The trust’s shared equality objectives were seen as being invaluable in bringing about these changes, as they took in the concerns of a wide variety of stakeholders from within the community.

Board leadership was also said to be another critical factor in driving many of the improvements. The board has an equality champion who helped keep the initiative firmly on the agenda, with equality updates to the entire board every six months.

It was the senior manager training which took place from April–Sept 2013 that was thought have made the biggest impact, and culminated with BME applicants being appointed at that level is the rate as white applicants. It was also noted that these results did slip back after the training had culminated and so renewed efforts to keep equality initiatives in the minds of senior managers.

In February 2015 the board set employment targets until 2025 so that the staff makeup more accurately reflects the local population. These results will now go into the performance suite for each Division so that the board can keep track of progress across the organisation.

Monitoring was found to be key to regularly assessing progress of these initiatives, which have also improved recruitment results across lower pay bands.

Highlighting that there was an issue by looking at recruitment data was the first step to tackling this issue. Board support, constant monitoring and keeping up momentum were all essential in realising and fulfilling the shared objectives set out at the beginning of this project.

North East London NHS Foundation Trust

Published in Leading by Example The Race Equality Opportunity for NHS Provider Boards.

Agreeing priorities

The challenge of implementing the new Equality and Delivery System proved a turning point in tackling equality and diversity issues at North East London NHS Foundation Trust.

Recognising the need for a more focused approach, the trust board identified tackling the absence of people from black and minority ethnic backgrounds at bands 8 and above as one of three priorities, alongside addressing issues facing LGBT staff and staff with a disability.

Tackling the glass ceiling

The Ethnic Minority Staff Network established in 2012 with strong board support has been critical in driving change. Following discussions with staff across the organisation it devised a three year strategy, endorsed by the board and overseen by a steering group including staff from each directorate.

Tackling the glass ceiling for BME staff was the clear priority for the first year. At a network conference and subsequent workshops, members identified a wide range of barriers for progression including:

- staff feeling excluded from the organisational culture, lack of confidence among BME staff in applying for jobs
- need for interview skills training
- lack of transparency by interviewing panels and failure to provide constructive criticism to unsuccessful applicants
- access to training, including continued development programmes for lower bands
- lack of appropriate mentoring and coaching.

To begin to address this feedback, the action plan included a review of the recruitment process. It was agreed that a member of the BME network would be involved at all recruitment stages for positions at band 8 and above. Network members were given training to support their involvement, including HR good practice and interviewing skills.

The chief executive ensured senior staff attended an event to discuss the changes and the workforce and recruitment data that had prompted the action plan. All recruiting managers were then trained on anti- discriminatory practices.



To increase the chances of promotion for existing BME employees, it became a mandatory requirement for all senior staff, including board members, to mentor a member of the BME network on a six monthly basis. The trust also signed up to the national Breaking Through top talent programme and sponsored BME staff identified as high performers to join the scheme.

All BME applicants not appointed to a senior position were contacted for their views on the process, as well as being offered more in-depth feedback on their performance. Where appropriate, interview skills training was offered, and all BME candidates were given the option of coaching from an existing senior staff member to support their future applications.

A more open culture

Two years on progress has been made, with five deputy, assistant or associate directors employed at band 8c from a BME background out of a total of 26 staff at this level in the organisation.

Staff report a more open culture where people feel more able to talk about issues of race and racism not just in relation to staff, but how they impact on the care provided to patients and service users.

Next steps

The trust is clear that there is still a long way to go to ensure BME staff are proportionately represented amongst the senior leadership team. HR procedures have been amended to ensure the changes to the recruitment process are sustained and further work is taking place, including ongoing monitoring of the number of BME applicants who are then shortlisted and appointed, and a focus on developing and supporting BME staff at bands 6 and 7.

Comments from Harjit Bansal, Equalities Lead, North East London NHS Foundation Trust

Harjit has been the equality and diversity manager for the last five years. On presenting his second annual report to the board he highlighted three key issues that were a concern:

- lack of senior leadership from BME backgrounds (not just on the board, but at bands 8 overall)
- lack of diversity monitoring for patients
- lack of data for staff for the 9 protected characteristics.

It was decided that the trust wanted to focus on just two or three objectives to deliver some strategic actions for. It was important to deliver on these objectives for the public as well as staff. The board asked for the development of a strategy for senior leadership that year, and in 2012, a number of key staff members, set up a small steering group of staff from across different services and levels within the organisation. All of the members were passionate about the BME agenda and wanted change. The steering group also included a medical staff member, a governor representative, an associate director, HR and E&D leads. The launch the strategy was then signed and agreed by the chief executive.

Key factors that were decisive in allowing for the implementation and success of the plan included:

- lack of senior leadership from BME backgrounds (not just on the board, but at Bbands 8 overall)
- used data as evidence (although there has been a great deal of research in this area – what these reports did not give was any recommendations on how to shift change and behaviours)
- support from our chief executive – the most crucial aspect (you don't need a network if you have the support from the CEO)
- buy-in from the Executive management team (convincing them that having senior leaders and changing culture would be an asset to the trust)
- Wellington Makala and the members of the steering group – who are passionate and working towards this agenda
- the strategy is the first with real actions that would make a difference
- the chair now sits on the board, and gives updates on our progress
- the CEO supports our annual event every year
- in the first year the focus was on having more BME staff at staff on bands 8 at all levels – there are currently 9 BME staff at band 8c and 8d at the trust
- in 2015, the focus will be on reducing the number of bullying and harassment cases for BME staff.

The trust is also working on the other equality issues including disability and sexual orientation. It is the view of the board that if issues around race can be addressed then the others will be included automatically.

Frimley Health NHS Foundation Trust

Supporting job applications from disabled people: improving confidence and work experience for disabled people – Frimley Park Hospital

Background

In its employment equality compliance report for 2010/2011, the Frimley Park Hospital NHS Foundation Trust noted that it had received fewer job applications from disabled people than might be expected, given that eight percent of the population in its catchment area is estimated as having a disability.

Although disability is generally underreported among applicants in the job market, the Trust felt that a specific commitment was needed in order to encourage more disabled people to apply for jobs at the Trust. Mindful of the specific duties (under the Public Sector Equality Duty), the hospital defined the following objective to fulfil this aim:

Work with organisations such as the Shaw Trust to place disabled people with the aim of developing skills and confidence to support long-term employment prospects. This included provision of support for applying for permanent posts within the organisation.

Action

In 2012/2013, the hospital contacted the Shaw Trust to ask for curriculum vitae of disabled people who were looking for work placements. The Shaw Trust put forward three curriculum vitae and the hospital identified placements that would best suit the skills of these individuals. Assistance with job applications/interviews was given at the end of the placements so that the three individuals could apply for temporary and permanent positions within the Trust.

Outcomes

In 2012/13, the trust reported the following progress: out of the three disabled people appointed through Shaw Trust on work placements, two have now been appointed as temporary staff, and one to a permanent post.

The work placements at the hospital made a significant difference to the lives of those involved. In particular, it has enabled participants to gain skills and confidence to apply for jobs afterwards. One participant stated that it has enabled him to demonstrate his skills in a real workplace which gave him the confidence to apply for a permanent post in the Trust. 'At the interview, I could talk about real work skills I had developed in my placement, something I had previously been unable to do'.

The hospital is still working with the Shaw Trust to continue providing more disabled people with potential job opportunities in the coming years.

Research has provided invaluable insight as to how the prevailing culture can provide barriers to some staff because of their ethnicity, gender, disability, sexual orientation or age. Research has been essential in understanding that these barriers exist and how the NHS as an organisation can help its people to overcome them.

Southern Health NHS Foundation Trust

A new equality standard

At Southern Health, the board's initial focus was to get the organisation to sign up to the business case for equality and diversity, and to create trust-wide ownership of this agenda.

Having set out a new equality plan more clearly aligned to the trust's strategic priorities, the board endorsed a new Equality Standard devised by their equality and diversity lead. Based on the outcomes in the EDS2 and modelled on the NHS Litigation Authority's three levels of assessment, it was designed to enable each directorate to review their progress on equality and diversity and to set stretching goals each year.

The trust launched the initiative with their clinical divisions in March 2012 and with corporate services in March 2013. Performance against the Equality Standard is managed locally at mainstream business meetings and overseen by equality impact leads in each clinical and corporate area. Each service is required to submit evidence against the criteria in the standard to determine whether they are eligible for a bronze, silver or gold award and progress reports are submitted to a trust-wide equality impact group before going to the board.

Evidence that the standard had begun to embed equality and diversity at every level of the organisation came in March 2013 when over 55 individual submissions were made by clinical services to qualify for the bronze award. Each clinical area is now working towards the silver award by February 2015.

A diversity scorecard

Alongside this focus on organisational buy-in was a board commitment to a data driven approach, captured in a new diversity scorecard. This tracks qualitative and quantitative metrics on workforce equality and diversity, analysing the workforce profile across the nine protected characteristics and triangulating this with key employee relations data, such as information on bullying and harassment, grievance, disciplinary, sickness absence, employment banding, and education and development.

The trust also publishes equality information relating to patient access by protected characteristics, with plans in place to further strengthen this reporting.

The scorecard is a powerful tool, bringing the trust's equality and diversity performance into sharper focus, enabling and encouraging greater boardroom challenge, and identifying how actions should be prioritised to address inequalities.

Beyond the boardroom, staff increasingly recognise the importance of better data and feel confident that equality and diversity is now a firm trust priority. The 2013 scorecard showed a 24 per cent increase in staff disclosing disability status, 20 per cent disclosing religion or belief status, and 19 per cent disclosing sexual orientation.

Reviewing disciplinary procedures A practical example of how the scorecard has driven improvements can be seen in Southern Health's focus on BME staff involvement in disciplinary procedures. The scorecard highlighted a stark discrepancy in line with national trends: 16 per cent of BME staff had been involved in the disciplinary process despite comprising only 3.4 per cent of the trust's workforce.

Using a more detailed analysis of figures, the equality and diversity lead devised a programme of engagement with band 7 and 8 managers in their mental health division who were unaware of this discrepancy. Each locality manager received training on the trust's values and conscious and unconscious bias and the issue was discussed at a quarterly meeting of the trust's 350 strong diversity champions' network, Vox Pop, to raise awareness of the figures and to discuss staff views on the underlying causes.

The equality and diversity lead also conducted an equality impact analysis of the bullying, harassment, disciplinary and grievance policies and reviewed recent disciplinary cases involving BME staff.

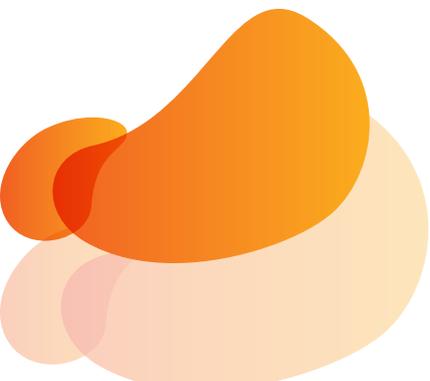
As a result of this work, the 2014 scorecard showed a 50 per cent reduction in the number of BME staff subject to a disciplinary. The trust is now waiting for the end of year dataset to see if this trend has continued.

Next steps

The board continues to use the scorecard to track progress and to oversee the architecture now in place to make equality and diversity firmly part of the mainstream agenda throughout the trust. A review of recruitment and selection to board positions is underway to start to build a more diverse board. And a major programme of patient and public engagement has just been launched with other local NHS providers and clinical commissioning groups to assess how services can be made more responsive to the needs of their diverse communities.

Comments from Ricky Somal, Equality Diversity and Inclusion Lead, Southern Health NHS Foundation Trust

Ricky has professional lead responsibility for devising and delivering the EDI strategy for Southern Health NHS Foundation Trust (7000+ employees). Having designed and launched an Integrated Equality Service (IES) service in March 2014, Ricky leads on EDI for Portsmouth Hospitals NHS Trust (7000+ employees), Solent NHS Trust (4000+ employees) and Buckinghamshire Healthcare Trust (7000+ employees) across all areas of the business, including managing all governance, strategy management and reporting requirements.



A diversity and inclusion standard

Having set out a D&I plan aligned to the organisations values and strategic objectives, the board endorsed a new D&I Standard. Based on the national EDS2 framework and modeled on the NHS Litigations Authorities' three levels of assessment, it was designed to enable each business area to review their progress on D&I and to set stretching goals each year.

D&I Standard performance is managed locally at mainstream business meetings overseen by nominated equality impact leads in each business area. Each business area is required to submit evidence against standard criteria to determine whether they are eligible for a bronze, silver or gold award. Progress reports are submitted to a trust-wide equality impact group (EIG) before going to the board. Over 55 individual submissions were received in the launch year from services for the Bronze award. Key objectives include: Improving customer experience; Empowered, engaged and supported staff and Inclusive leadership at all levels.

Workforce diversity scorecard Alongside a focus on organisational buy-in for E&D is a board commitment to a data driven approach, captured in a new workforce diversity scorecard. This tracks qualitative and quantitative metrics on workforce equality and diversity, analysing the workforce profile across the nine protected characteristics and triangulating this against employee relations data. This includes recruitment and selection, bullying and harassment, grievance, disciplinary, sickness absence, employment banding, and access to learning, education and development.

The scorecard is a powerful tool, bringing the trust's equality and diversity performance into sharper focus, enabling and encouraging greater boardroom challenge, and identifying how actions should be prioritised to address inequalities. Beyond the boardroom, staff increasingly recognise the importance of better data and feel confident that equality and diversity is now a firm trust priority.

The 2014 scorecard showed a 24 per cent increase in staff disclosing disability status, 20 per cent disclosing religion or belief status, and 19 per cent disclosing sexual orientation and a 50 per cent reduction in the involvement of BME staff subject to a disciplinary.

The board continues to use the scorecard to track progress and to oversee the architecture now in place to make equality and diversity firmly part of the mainstream agenda throughout the trust. A review of recruitment and selection to board positions is underway to start to build a more diverse board.

Awards and recognition

- 2014 Leading by Example: Southern Health cited in national EDI report (NHS Providers)
- 2014 Equality Standard case study published in Equal Opportunity Review magazine
- 2014 Personal Fair Diverse (PFD) Organisation Winner Award (enei)
- 2014/15 National Equality and Diversity Partner (NHS Employers)
- 2014 International Diversity Champion Award (Diversiton)
- 2014 100 Best places to work (HSJ)
- 2014 UK Baby Friendly Initiative (UNICEF)
- 2 ticks – Positive about disability symbol (Job Centre Plus)

CONCLUSION

Shining a light on the hidden corners

Despite the increased priority that has been given to the collection of staff workplace data, the diversity initiatives that have resulted because of insights gained from research have had mixed results.

The greatest results have been achieved where individual trusts have collected and analysed their own diversity data successfully. In such cases, the analysis of staff data at individual trust level has identified where issues may exist so that appropriate action can be taken based on the findings. Allocating adequate resources to implement action is also essential for trusts to achieve enhanced equality outcomes.

There is a great deal that can be learned from what has been achieved so far, and the sharing of knowledge and best practice will be invaluable in achieving results.

Greater access to networking and mentoring opportunities through staff networking groups and associations, as well as the publication of case studies can help to distribute the expertise that has been gained. While the experiences of people from different protected groups differ, the approaches that have been used successfully for one group can be used across all of the protected characteristics. Taking a holistic approach to equality and inclusion, while taking into account the needs of individuals, is optimal.

Demonstrating a commitment to equality at the most senior levels of an organisation has also been shown to be effective in engaging staff in equality initiatives. Creating a culture where personal information regarding sexual orientation or a disability, for example, is not seen as a barrier to career progression is essential.

Communication of the importance of diversity for an organisation to all staff, not just those from protected groups, is one way to help to achieve this buy-in and engagement. An emphasis and greater clarity on the need for change, a renewed focus on leadership from boards with regard to equality and diversity, and effective support at a national level to facilitate good practice sharing across the NHS, are needed.

Ultimately, to fully deliver on its equality objectives, the NHS needs better collection and analysis of good quality workplace data for all protected groups. The analysis of this data at both a local trust and national level is essential to benchmark current progress as well as provide insight into the future direction of equality recruitment and workplace procedure.

Finally, greater cooperation is needed between academics and NHS organisations to identify where research resources should be allocated to gain the insights that are now most needed and would have the most potential ongoing value and benefit.

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NHS Employers

The NHS Employers organisation is the voice of employers in the NHS, supporting them to put patients first. Our vision is to be the authoritative voice of workforce leaders, experts in HR, negotiating fairly to get the best deal for patients.

We help employers make sense of current and emerging healthcare issues to ensure that their voice is front and centre of health policy and practice. We keep them up to date with the latest workforce thinking and expert opinion, providing practical advice and information, and generating opportunities to network and share knowledge and best practice.

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