Exploratory research project:

Removing structural barriers to representation in recruitment, progression, and retention

Dr Asta Medisauskaite

Senior Research Fellow, UCL Medical School
Researcher in Residence, OHID, London region

Table of Contents

Introduction 3
Scope 3
Exploratory research project: Methods 3
Findings: Metrics 4
Key findings 4
Public Health 15
Data 15
Limitations 16
Stakeholders' reflections 17
Findings: Interventions 18
Key findings 18
Effectiveness 31
Findings: Stakeholders' views on EDI 32
Why is EDI important? 32
Reflections on metrics and interventions 33
Achieving change: Recommendations 34
Conclusions and recommendations 37
EDI: How to improve? 37
Metrics 37
Interventions 39
Reference list 40
Appendix 1. Methods 44

Introduction

Scope

1. The London Public Health Workforce Collaborative sets out **Ambition C** to deliver workforce outcomes that are equitable, seek representation of all backgrounds and support inclusion. The identified **challenge** was needing to bring together existing workforce intelligence and understand actions already taken and the gaps, where the collaborative can add value to ensure equitable workforce outcomes.
2. **Priority action** is to agree on a set of actions and core principles to remove structural barriers to representation in recruitment and retention. This will be informed by intervention B1 (Ambition B) and a stocktake of existing actions by system partners:
    a. Part 1: Review metrics used in the health and care system to monitor and assess ethnic minority workforce recruitment success, progression, experience, and pay;
    b. Part 2: Identify interventions that improve race equity in the workforce.
3. This report presents findings from the **exploratory research project** which aimed to collect evidence for Part 1 and Part 2 but took a broader view to inequality in the workforce and included other protected characteristics in addition to race.

Exploratory research project: Methods

1. The findings presented in this report are from the following three explorations: (i) desk-based research (29 documents and 3 standards); (ii) online searches of initiatives to improve inequalities; and (iii) discussions with key stakeholders working in the health and social care system (11 semi-structured interviews). Diversity in this exploratory project is understood as described in the Equality Act 2010 covering nine protected characteristics. The methodology is described in more detail in Appendix 1.
2. This report consists of four parts:
    i. findings on metrics to monitor and assess how equitable organisations are (Part 1: findings from the desk-based research supplemented with the limitations identified through discussions with stakeholders);
    ii. findings on interventions to address inequalities (Part 2: findings from online searches and discussions);
    iii. findings from discussions with stakeholders on why diversity in the workforce is important, reflections on metrics and interventions, and recommendations (making changes);
    iv. this report concludes with the summary of the key findings and recommendations.

Findings: Metrics

1. This section of the report focuses on metrics to monitor how equitable and inclusive the health and care workforce is. To identify relevant metrics the main health and social care websites (e.g., NHS England, Health Education England, Department of Health and Social Care) were systematically explored searching for guidelines/standards and documents reporting on workforce diversity.
2. This section starts with the key findings from the desk-based research, then presents a summary of the results for Public Health specifically (full details can be found in Supplementary Material 2) and discusses what data were used to produce the documents. The last sub-section lists key limitations.

Key findings

1. The three standards were found through the desk-based research: *the NHS Workforce Disability Equality Standard, the NHS Workforce Race Equality Standard, and the Social Care Workforce Race Equality Standard* (NHS England, 2022a, 2022b; Skills for Care, 2021). These standards were, first, used to extract the key work areas/processes that metrics should cover, and this list was then supplemented with the findings from the 29 relevant documents. All identified metrics were grouped into the following four areas: **workforce overview/pay, recruitment/selection, promotion/progression, work experience/retention**. Table 1 presents indicators for each of these areas and provides examples on how these can be reported on. The summary of indicators is presented in Figure 1. Table 2 details which protected characteristics are explored for which monitoring indicator and in which healthcare areas/organisations/roles. The list of all resources identified through the desk-based research with the key data extracted from each resource is provided in Supplementary Material 1.
2. The level of details varied between reviewed documents. Some documents undertook more detailed investigation looking at regions (see for example, West et al., 2015; Skills for Care, 2022), registration types (see for example, Liu, 2021), work patterns (see for example, Charlesworth, 2017; Dacre & Woodhams, 2020), or types of contracts (see for example, Equality and Human Rights Commission, 2022), etc.




Overview/pay	Recruitment	Progression	Work experience
Representation/ pay gap	Appointments	Accessing training	Discrimination
Board membership	Representation in education	Opportunities for promotion	Voicing concerns
Experience of regulation		Entering disciplinary process	Adjustments
			Presenteeism
			Engagement/ Feeling valued
			Wellbeing/ Satisfaction
			Participation in staff networks
			Working in unfavourable work conditions
			Leaving

Figure 1. Four areas of metrics identified through the desk-based research.

3. **Workforce overview/pay:**
    a. A substantial number of documents reported on staff representativeness/pay gap.
    b. Various comparisons were made, such as a percentage of staff at each level/subgroup/pay band (including very senior management and board membership) compared with the percentage of staff in the overall workforce, other staff groups, wider NHS, general population, population that is served.
    c. One measure was not a part of the three standards - experiences of regulation. The Care Quality Commission (CQC) report looked at the differences in perceived impact and experience of CQC regulation between ethnic minority-led GP practices and other practices (Care Quality Commission, 2022c; see Table 1). It was observed that certain types of practices experienced more challenges when going through the inspection and that these were "*more commonly associated with being ethnic minority-led*" (e.g., more often single-handed or individually led practices, serve a socio-economically deprived population). This observation might help to explain at least a part of the differences observed between practices in perceived impact and experience of CQC regulation. The report also looked at the makeup of the inspectors and inspection managers (e.g., 21% of inspectors and 17% of inspection managers identified as being from ethnic minority backgrounds). Similar analyses could be performed to explore experiences of other types of regulation.

4. **Recruitment/selection:**
    a. The most reported measure in this area was around shortlisting and appointments (e.g., relative likelihood of staff being appointed from shortlisting). As part of this indicator a couple of documents looked at how many posts applicants applied for before gaining their first post (Kapadia et al., 2022) or if employers take positive action to support particular groups when recruiting (NHS Employers, 2021).
    b. An additional indicator that was not covered by the three standards - representation in education (Hemmings et al., 2021; Charlesworth, 2017; *note*: postgraduate medical training is considered to be a part of the workforce and therefore associated measures are not linked to this indicator). For example, Hemmings et al. (2021) reported that those with a lower socioeconomic status were half as likely to study undergraduate physiotherapy than children's nursing. This indicator highlights the importance of looking at and addressing disparities at the education level.
5. **Promotion/progression**:
    a. Three measures in this area include: accessing training (e.g., relative likelihood of staff accessing non-mandatory training and CPD), promotion opportunities (e.g., percentage believing that their workplace provides equal opportunities for career progression or promotion), and entering the disciplinary/capability process (e.g., relative likelihood of staff entering the formal disciplinary/capability process).
    b. Some of the documents expanded on the indicators noted in the standards. For example, for promotion, Johnson et al. (2021) in Kapadia et al. (2022) looked at the perceived level of managerial support for progression, who applies for promotion, and success rates.
6. **Work experience/retention**:
    a. This area covered such measures as discrimination, wellbeing, job satisfaction, and adjustments (see Table 1). Harassment, bullying, abuse, discrimination at work (from patients, relatives, the public, or managers/team leaders, other colleagues) was the most widely reported on measure. Some documents expanded their exploration of this indicator and analysed such factors as the impact of discrimination (e.g., considering leaving due to discrimination or harassment; Health Education England, 2022b), the type of discrimination (e.g., subtle comments vs confrontational behaviour; Health Education England, 2022b; being ignored by patients or allocated responsibilities reflecting managers' lack of confidence; Likupe & Archibong, 2013 in Kapadia et al., 2022; not permitted leave for religious holiday, Equality and Human Rights Commission, 2022), and roots of discrimination (e.g., Filipino nurses attacked at the beginning of the pandemic, House of Commons, 2022).
    b. The documents further explored some of the other measures too. Regarding voicing/reporting concerns, the documents reported on how many felt that concerns had been (or would be) dealt with well, and how many knew that they would get help/knew about their rights (Health Education England, 2022b; Equality and Human Rights Commission, 2022). Another aspect that was considered when analysing voicing concerns was feeling secure to raise concerns

(Health Education England, 2022b; Equality and Human Rights Commission, 2022). This aspect is crucial to consider as if a certain group does not feel secure to raise concerns, disparities will be underestimated as issues will not be reported.

c. The following measures were presented just in *the NHS Workforce Disability Equality Standard 2022* and therefore compared just between disabled and none disabled staff: adjustments, presenteeism, engagement, and feeling valued. It could be argued that these measures might also be used to explore the experiences of staff with other protected characteristics, especially such measures as engagement or feeling valued.
d. Even though the indicator of who is leaving the organisation is a part of *the Social Care Workforce Race Equality Standard,* no documents reporting on this indicator were found.
e. Four measures that were identified through the relevant documents were not a part of any standard: (i) job satisfaction (Hemmings et al., 2021), (ii) wellbeing (e.g., comparison of burnout, mental well-being, work-life balance scores; Hemmings et al., 2021; Kapadia et al., 2022), (iii) participation in staff networks (including who are more likely to be aware of staff networks; Einarsdóttir et al., 2020), and (iv) working in unfavourable work conditions (Hemmings et al., 2021; House of Commons, 2020, 2021; Equality and Human Rights Commission, 2022; Kapadia et al., 2022; Public Health England, 2020). The measure of working in unfavourable work conditions was about experiences of the pandemic; e.g., who worked on a Covid-19 specific ward or area or redeployed due to the Covid-19 pandemic, tested positive, had access to personal protective equipment, etc. Despite the focus being on the pandemic, it might be useful to explore disproportionalities of working in other unfavourable work conditions.

Table 1. Indicators to monitor how equitable organisations are with illustrative examples from the documents.

Area	Indicator	Examples from the documents
Workforce overview/ Pay	Representation at different levels AND Pay gap	10% of NHS staff at AfC pay bands 8c and above were from an ethnic minority background. This is significantly lower than the 22.4% of all ethnic minority staff in the NHS (NHS England, 2022c). AND Gender pay gap for Hospital and Community Health Service doctors were 24.4%, GPs 33.5%, and 21.4% for clinical academics. These pay gaps narrow when accounting for hours worked, grade, experience, and specialty, however, they remain substantive for many doctors, especially GPs (Dacre & Woodhams, 2020).
	Board membership	3.7% of board members have declared a disability, the same figure as the overall workforce (NHS England, 2022d).
	Experience of regulation	A larger proportion of ethnic minority-led GP practices experienced adverse impact as a result of the inspection process: on their mental (38% vs 26%), physical health (23%

		vs 7%), and personal and/or family life (51% vs 41%) (Care Quality Commission, 2022c).
Recruitment/ Selection	Shortlisting/ Appointments	White applicants were 1.61 times more likely to be appointed from shortlisting compared to applicants from ethnic minority groups (NHS England, 2022c).
	Representation in education	Minority ethnic students were around 4 times less likely than other students to secure a place on an undergraduate physiotherapy course (12%) than a diagnostic radiology course (47%) (Hemmings et al., 2021).
Promotion/ Progression	Accessing training	White applicants were 1.14 times more likely to access non-mandatory training and continuous professional development (the non-adverse range; NHS England, 2022c).
	Equal opportunities for career progression/ promotion	78.4% of disabled staff believed that they had equal opportunities for career progression or promotion vs 85% of non-disabled staff (NHS England, 2022d).
	Entering disciplinary/ capability process	At 50% trusts, staff from ethnic minority groups were more than 1.25 times more likely to enter the formal disciplinary process (NHS England, 2022c).
Work experience/ Retention	Experiencing harassment, bullying, abuse, discrimination from patients, relatives, the public, or staff	16.7% of staff from ethnic minority backgrounds had personally experienced discrimination at work from a manager, team leader or other colleagues vs 6.2% of White staff (NHS England, 2022c).
	Voicing/reporting concerns (including feeling secure raising concerns)	Those from White backgrounds (51%) were more likely than those from Black (7%), Asian (10%) and other backgrounds (6%) to say that they had reported discrimination or harassment against themselves, and it had been dealt with well (Health Education England, 2022b). AND Lower-paid ethnic minority workers in health and social care were less likely to raise concerns out of fear that they might lose their jobs, particularly if they were in insecure roles or on zero-hours contracts (Equality and Human Rights Commission, 2022).
	Reasonable adjustments	77% of mental health trusts made adequate adjustments to enable disabled staff carry out their work (Palmer et al., 2021).
	Presenteeism: Pressure to work, despite not feeling well	A large proportion of disabled staff (nearly a third) say that they have felt pressure from their manager to come to work, despite not feeling well enough (8.2% gap with non-disabled staff) (NHS England, 2022d).

	Engagement (including facilitating the voices of minority staff to be heard)	Disabled staff felt less engaged than non-disabled staff (appr 0.5 point lower) (NHS England, 2022d). AND Facilitating the voices of disabled staff to be heard has improved – in 2020 six trusts reported that no actions had been taken in comparison to 34 in 2018 (NHS England, 2022d).
	Job satisfaction	A measure of satisfaction with work conditions (e.g., pay, support provided, opportunities for flexible work patterns). E.g., Asian staff are more likely than White staff to feel satisfied with the extent their organisation values their work (Hemmings et al., 2021).
	Wellbeing	Asian psychologists reported higher wellbeing scores relative to all other ethnic groups (Kapadia et al., 2022).
	Feeling valued	Approximately 1 in 3 disabled staff feel valued by their employer vs over half of non-disabled staff (NHS England, 2022d).
	Participation in staff networks	Men were more likely than women to be involved in staff networks (Einarsdóttir et al., 2020).
	Working in unfavourable work conditions	Minority ethnic staff were more likely than other staff to work in a Covid-19 specific ward or area (47% compared to 31% of all staff) (Hemmings et al., 2021).
	Leaving	Comparative rate of employees from ethnic minorities leaving the organisation during the last year (from *the Social Care Workforce Race Equality Standard;* no examples were found).

Table 2. Protected characteristics and areas/organisations/roles that the reviewed standards and documents covered.

Area	Indicator	Protected characteristics	Area/organisations/roles
Workforce overview/ Pay	Representation at different levels and pay gap	Ethnicity (Care Quality Commission, 2022b; Edbrooke-Hyson, 2021; Equality and Human Rights Commission, 2022; Hemmings et al., 2021; Health Education England, 2022a, 2022b; House of Commons, 2021; Local Government Association, 2019; Kapadia et al., 2022; NHS Employers, 2021; NHS England, 2019, 2022b, 2022c; Shembavnekar, 2020; Skills for Care, 2021, 2022; Palmer et al., 2021; Rolewicz, Palmer, & Lobont, 2022) Disability (Care Quality Commission, 2022a; Hemmings et al., 2021; Health Education England, 2022a; Local Government Association, 2019, NHS England, 2022a, 2022d; Skills for Care, 2022; Palmer et al., 2021) Gender (Appleby & Schlepper, 2019; Charlesworth, 2017; Dacre & Woodhams, 2020; Edbrooke-Hyson, 2021; Hemmings et al., 2021; Health Education England, 2022a; House of Commons, 2022; Local Government Association, 2019; NHS employers, 2021; Shembavnekar, 2020; Skills for Care, 2022; Palmer et al., 2021) Religion (Hemmings et al., 2021; Palmer et al., 2021) Sexual orientation (Hemmings et al., 2021; Palmer et al., 2021) Age (Edbrooke-Hyson, 2021; NHS employers, 2021; Shembavnekar, 2020; Skills for Care, 2022; Palmer et al., 2021)	NHS workforce (Appleby & Schlepper, 2019; Hemmings et al., 2021; House of Commons, 2022, 2021; NHS England, 2022a, 2022b, 2022c, 2022d; Rolewicz, Palmer, & Lobont, 2022) National healthcare organisations (NHS England, 2019) Groups: • Mental health clinical support staff (Palmer et al., 2021) • Apprenticeships (NHS Employers, 2021) • Healthcare staff (Kapadia et al., 2022) • Health Education England (HEE) staff (Health Education England, 2022a) • Social care (Skills for Care, 2021) • Adult social care (Skills for Care, 2022) • London adult social care (Shembavnekar, 2020) • GPs (Charlesworth, 2017) • CQC (Care Quality Commission, 2022a; Care Quality Commission, 2022b) • Public health (Edbrooke-Hyson, 2021; Liu, 2021) • Medicine (Dacre & Woodhams, 2020) • Lower-paid staff from health and social care (Equality and Human Rights Commission, 2022) • Local government (Local Government Association, 2019)
	Board membership	Ethnicity (Care Quality Commission, 2022b; NHS England, 2019, 2022b, 2022c)	NHS workforce (NHS England, 2022a, 2022b, 2022c, 2022d) National healthcare organisations (NHS England, 2019)

		Disability (Care Quality Commission, 2022a; NHS England, 2022a, 2022d; Palmer et al., 2021)	Groups: • Mental health clinical support staff (Palmer et al., 2021) • CQC (Care Quality Commission, 2022a; Care Quality Commission, 2022b)
	Experiences of regulation	Ethnicity (Care Quality Commission, 2022c)	GP practices (Care Quality Commission, 2022c)
Recruitment/Selection	Shortlisting/ Appointments	Ethnicity (Care Quality Commission, 2022b; Bury & Pinder, 2022; Hemmings et al., 2021; Health Education England, 2022a; Kapadia et al., 2022; Skills for Care, 2021; NHS England, 2019, 2022b, 2022c) Disability (Care Quality Commission, 2022a; Hemmings et al., 2021; Health Education England, 2022a; NHS England, 2022a, 2022d) Gender (Bury & Pinder, 2022; Hemmings et al., 2021) Age (Bury & Pinder, 2022; Hemmings et al., 2021) Socioeconomic status (Bury & Pinder, 2022) Religion, sexual orientation, marital status (Hemmings et al., 2021)	NHS workforce (Hemmings et al., 2021; NHS England, 2022a, 2022b, 2022c, 2022d) National healthcare organisations (NHS England, 2019) Groups: • HEE staff (Health Education England, 2022a) • CQC (Care Quality Commission, 2022a, 2022b) • Social care (Skills for Care, 2021) • Public health (Bury & Pinder, 2022; Liu, 2021) • Mixed (Kapadia et al., 2022)
	Representation in education	Disability, ethnicity, gender, socioeconomic background (Hemmings et al., 2021) Age (Charlesworth, 2017; Hemmings et al., 2021)	Nursing, midwifery and selected allied health professions (Hemmings et al., 2021) Groups: 1. Nursing students (Charlesworth, 2017)
Promotion/ Progression	Accessing training	Ethnicity (Care Quality Commission, 2022b; Equality and Human Rights Commission, 2022; Hemmings et al., 2021; Health Education England, 2022a, 2022b; Kapadia et al., 2022; Skills for Care, 2021; NHS England, 2019, 2022b, 2022c)	NHS workforce (Hemmings et al., 2021; NHS England, 2022b, 2022c) National healthcare organisations (NHS England, 2019) Groups:

			• HEE staff (Health Education England, 2022a) • Social care (Skills for Care, 2021) • London Primary Care (Health Education England, 2022b) • Healthcare staff (Kapadia et al., 2022) • CQC (Care Quality Commission, 2022b) • Lower-paid staff from health and social care (Equality and Human Rights Commission, 2022)
	Equal opportunities for career progression/ promotion	Ethnicity (Care Quality Commission, 2022b; Equality and Human Rights Commission, 2022; Hemmings et al., 2021; Health Education England, 2022a, 2022b; Kapadia et al., 2022; NHS England, 2019, 2022b, 2022c) Disability (Care Quality Commission, 2022a; Health Education England, 2022a; NHS England, 2022a, 2022d)	NHS workforce (Hemmings et al., 2021; NHS England, 2022a, 2022b, 2022c, 2022d) National healthcare organisations (NHS England, 2019) Groups: • HEE staff (Health Education England, 2022a) • London Primary Care (Health Education England, 2022b) • Healthcare staff (Kapadia et al., 2022) • CQC (Care Quality Commission, 2022b; Care Quality Commission, 2022a) • Lower-paid staff from health and social care (Equality and Human Rights Commission, 2022)
	Entering disciplinary/ capability process	Ethnicity (Care Quality Commission, 2022b; Hemmings et al., 2021; Skills for Care, 2021; NHS England, 2019, 2022b, 2022c) Disability (Care Quality Commission, 2022a; NHS England, 2022a, 2022d)	NHS workforce (Hemmings et al., 2021; NHS England, 2022a, 2022b, 2022d, 2022c) National healthcare organisations (NHS England, 2019) Groups: • CQC (Care Quality Commission, 2022b; Care Quality Commission, 2022a) • Social care (Skills for Care, 2021)

Work experience/Retention	Experiencing harassment, bullying, abuse, discrimination from patients, relatives, the public, or staff	Ethnicity (Care Quality Commission, 2022b; Equality and Human Rights Commission, 2022; Hemmings et al., 2021; Health Education England, 2022b; House of Commons, 2022, 2021; Kapadia et al., 2022; Skills for Care, 2021; NHS England, 2019, 2022a, 2022b, 2022c; West, Dawson, and Kaur, 2015) Disability (Care Quality Commission, 2022a; Equality and Human Rights Commission, 2022; Hemmings et al., 2021; NHS England, 2022a, 2022d; West, Dawson, and Kaur, 2015) Gender (Hemmings et al., 2021; West, Dawson, and Kaur, 2015) Age (Hemmings et al., 2021; West, Dawson, and Kaur, 2015) Religion (Hemmings et al., 2021; West, Dawson, and Kaur, 2015) Sexual orientation (West, Dawson, and Kaur, 2015)	NHS workforce (Hemmings et al., 2021; House of Commons, 2022, 2021; NHS England, 2022a, 2022b, 2022c, 2022d; West, Dawson, and Kaur, 2015) National healthcare organisations (NHS England, 2019) Groups: • London Primary Care (Health Education England, 2022b) • Healthcare staff (Kapadia et al., 2022) • CQC (Care Quality Commission, 2022a; Care Quality Commission, 2022b) • Lower-paid staff from health and social care (Equality and Human Rights Commission, 2022) • Social care (Skills for Care, 2021)
	Voicing/reporting concerns (including feeling secure raising concerns)	Disability (Care Quality Commission, 2022a; Health Education England, 2022b; NHS England, 2022a, 2022d) Ethnicity (Equality and Human Rights Commission, 2022; Health Education England, 2022b; Hemmings et al., 2021) Gender, age, religion, disability (Hemmings et al., 2021)	NHS workforce (Hemmings et al., 2021; NHS England, 2022a, 2022d) Groups: • HEE staff (Health Education England, 2022b) • London Primary Care (Health Education England, 2022b) • CQC (Care Quality Commission, 2022a) • Lower-paid staff from health and social care (Equality and Human Rights Commission, 2022)
	Reasonable adjustments	Disability (Care Quality Commission, 2022a; Hemmings et al., 2021; Health Education England, 2022a; NHS England, 2022a, 2022d; Palmer et al., 2021)	NHS workforce (Hemmings et al., 2021; Health Education England, 2022a; NHS England, 2022a, 2022d) Groups: • Mental health clinical support staff (Palmer et al., 2021)

			• CQC (Care Quality Commission, 2022a)
	Presenteeism: Pressure to work, despite not feeling well	Disability (Care Quality Commission, 2022a; NHS England, 2022a, 2022d)	NHS workforce (NHS England, 2022a, 2022d) Group: • CQC (Care Quality Commission, 2022a)
	Engagement (including facilitating the voices of minority staff to be heard)	Disability (NHS England, 2022a, 2022d)	NHS workforce (NHS England, 2022a, 2022d)
	Job satisfaction	Gender, Age, Religion, disability, ethnicity (Hemmings et al., 2021)	NHS workforce (Hemmings et al., 2021)
	Wellbeing	Gender, Age, Religion, disability (Hemmings et al., 2021) Ethnicity (Hemmings et al., 2021; Kapadia et al., 2022)	NHS workforce (Hemmings et al., 2021) Groups: • Healthcare staff (Kapadia et al., 2022)
	Feeling valued	Disability (NHS England, 2022a, 2022d)	NHS workforce (NHS England, 2022a, 2022d)
	Participation in staff networks	Gender (Einarsdóttir et al., 2020) Socioeconomic status (education; Einarsdóttir et al., 2020)	NHS workforce (Einarsdóttir et al., 2020)
	Working in unfavourable work conditions	Ethnicity (Equality and Human Rights Commission, 2022; Hemmings et al., 2021; House of Commons, 2021, 2020; Kapadia et al., 2022; Public Health England, 2020) Gender, age, religion, disability (Hemmings et al., 2021)	NHS workforce (Hemmings et al., 2021; House of Commons, 2021, 2020) Groups: • Healthcare staff (Kapadia et al., 2022) • Lower-paid staff from health and social care (Equality and Human Rights Commission, 2022) • Nurses, midwives ,and nursing associates (Public Health England, 2020)
	Leaving	Ethnicity (Skills for Care, 2021)	Social care (Skills for Care, 2021)

Public Health

1. Five documents reported specifically on Public Health; mainly on workforce representation and recruitment, and one document reported on other measures. A few examples (see more details in Supplementary Material 2):
    a. In the Health Education England (HEE) report, Liu (2021) reported that 15% of Public Health trainees were from ethnic minority backgrounds, the same as in the population. However, in London 24% of trainees were from ethnic minority backgrounds in comparison to its population of 41%. Breakdown by professional registration and ethnicity in 2018-20 showed that 5% of trainees with UKPHR/no registration were from ethnic minority backgrounds in comparison to 20% of trainees with the General Dental Council and 22% with the General Medical Council registration. 41% of all doctors in training in 2020 were from ethnic minority backgrounds.
    b. Women earn less than men in local government (on average 5% on a median basis; Local Government Association, 2019). In the London borough specifically, 40% of the first-tier managers were women (60% - chief executives), 11% were from ethnic minority backgrounds (0% - chief executives), 6% disabled (0% - chief executives).
    c. Bury and Pinder (2022) analysed representation in recruitment to the Public Health specialty training scheme in the UK and reported that success rates declined with increasing age (e.g., 25% for under 30 and 5% - over 45) and varied by ethnicity (e.g., 22% for White British, 4% Black, and 9% Chinese candidates). Different groups are affected at different stages of the process, but that the greatest impact is seen at the Assessment Centre stage.
    d. White staff in Public Health England had a higher relative likelihood of entering the formal disciplinary process compared to staff from ethnic minority backgrounds (0.72) (NHS England, 2019). However, a year before the opposite was reported - staff from ethnic minority backgrounds were 3.72 more likely to enter the formal disciplinary process compared to White staff. It is noted in the report that "*a small number of staff enter the formal disciplinary process, and this can skew the figures*".

Data

1. The key data sources at national level that were used to produce the reviewed documents were: Electronic Staff Records (ESR), NHS Digital, NHS Staff Survey, Office of National Statistics, and the Adult Social Care Workforce Data Set. While these national datasets can provide valuable data for monitoring purposes, information about some workforce processes will not be covered in these datasets (e.g., shortlisting information). Hence, organisations also analysed HR data and staff survey data. See Supplementary Material 3 to find the full list of data sources.
2. Metrics are often thought about as numerical measurements (often using administrative, routinely collected data). These data, however, are limited, especially in explaining disparities (answering a question *why*?). In a few documents from the desk-based research, data from interviews (including exit interviews), focus groups, online discussions, and surveys were

analysed or suggested to be collected to understand inequalities and the reasons for inequalities better. For example, in the Nuffield trust report Hemmings et al. (2021) suggested surveying new hires at the start of their job and three and six months later to understand their work experiences. The authors also suggested engaging with speak-up ambassadors, staff networks to gain a deeper insight into such work experiences as discrimination.

3. Lastly, the HEE (2022a) report identified barriers for those from minoritised groups to participate in monitoring processes (e.g., not offered exit interviews, lack of trust in the process, a lack of belief that any feedback will be meaningfully used). Therefore, analysing how monitoring is planned and implemented is important as might highlight inequalities in these processes.

Limitations

1. Most of the reviewed information was reported on ethnicity or disability, and gender was the third characteristic which was more widely explored (Table 2). No information was found on gender reassignment and pregnancy, and little was found on sexual orientation, marriage status, and religion (*Note*: the search on each protected characteristic separately was not performed). In the Nuffield reports it was also questioned why other characteristics related to inequalities are not recorded in national datasets, such characteristics as socioeconomic status and national origin (Hemmings et al., 2021; Palmer et al. 2021).
2. The information presented in the desk-based research documents varied in detail and quality. Some of the information was limited and, therefore, more challenging to interpret.
3. Reported data challenges include inaccurate and incomplete data, for example, a substantial number of staff not reporting their demographic details (see Hemmings et al., 2021; Palmer et al., 2021; Care Quality Commission, 2022c); small sample sizes, low response rates, and representativeness (e.g., 50% response rate in the West et al., 2015 report is substantial but raises a question of how representative sample is of the overall population). These aspects are important to consider when interpreting the findings. Improving how data is reported and collected might help to better understand staff experiences.
4. The reviewed documents also emphasised the importance of intersectionality and analysing disaggregated data (see NHS England, 2019; Hemmings et al., 2021; Kapadia et al., 2022). For example, the comparison is often made between White vs ethnic minority staff. Nevertheless, this approach might overlook significant differences among ethnic minority groups or even mask disproportionalities (e.g., the odds of experiencing any discrimination among non-White staff are more than twice what they are for White staff. Among Black staff, the odds of experiencing discrimination are more than three times higher (3.75) than for White staff and 5.23 times higher when discrimination comes specifically from the public; West et al., 2015). Hemming et al. (2021) also highlighted the need to explore data at different levels: national, regional, system, local and even service. The limitation of detailed analyses was mentioned, however, saying that it might result in small numbers and a challenge of understanding what the differences mean actually. The reflection was that quantitative data alone might not be enough to sufficiently investigate potential issues (as mentioned above in the Data section).
5. It was mentioned in the documents that just limited data are available for some career pathways and some groups of health and care staff, such as apprenticeships (Hemmings et al., 2021); lower-paid, bank and outsourced workers (Kapadia et al., 2022; Equality and Human Rights Commission, 2022).

Stakeholders' reflections

1. Stakeholders recognised the importance of all monitoring measures described in Table 1. Stakeholders also listed the key aspects that are, in their opinion, missing in the current approach to metrics (similar to the ones identified through the desk-based research):
    a. **Nuanced view**. Stakeholders emphasised that a more nuanced view was needed. This included a closer look at different groups (e.g., ethnic minority groups, disability types), regions (e.g., London is different from other regions in people who work in health and care and the population that they serve), and more complex explorations including intersectional approaches (e.g., pay gap by gender and ethnicity). Stakeholders recognised that the aggregated view might mask the true disproportionalities (i.e., challenges experienced by Black staff were mentioned multiple times).
    b. **Robust analysis**. Stakeholders stated that descriptive representation is not enough. Sophisticated/robust analyses would help to explain why certain patterns and results are seen and identify if there are any other reasons or explanations for disparities. Stakeholders also highlighted analysing data in context, that is, identifying trends and understanding the changes.
    c. **Data**. The challenges of reporting were identified by stakeholders highlighting the need for more data and more accurate data (e.g., issues of incomplete data) recorded for all processes of a job.
    d. **Broader focus**. Stakeholders recognised that more attention is given to some processes than others. That is, recruitment, attracting people receive more attention than retention. Stakeholders also talked about the focus being on gender or ethnicity and missing a broader view to diversity that would include other protected characteristics.
    e. **Exploring *why***. The value of understanding the disparities better was mentioned by almost all stakeholders. This, first, included understanding the reasons behind the numbers and patterns; evaluating how the processes and systems work and unpacking their impact on EDI. For example, when exploring disparities in recruitment the following questions might be asked: Are jobs advertised appropriately to attract a diverse pool of applicants? Are there unnecessary requirements to apply (e.g., degree)? Second, in order to attract and retain diverse staff, stakeholders talked about understanding how people think, behave, what barriers they experience, and their experiences of work systems. Therefore, approach to metrics might need to go beyond hard numbers and include wider explorations (as mentioned above in the Data and Limitations section).
    f. **Mandatory collection of exit data.** Stakeholders highlighted that exit data can help to understand the challenges people experience in their workplaces by exploring who are leaving and why. Stakeholders highlighted though that for exit interviews it is important to ensure that staff feel safe and, therefore, such process should be independent.

Findings: Interventions

> "*In times of financial constraint, we often see equality and human rights as a challenge. We rarely look at equality and human rights as a solution*."
>
> - Care Quality Commission, 2018

1. This section of the report focuses on interventions to address inequalities in the health and social care workforce. The first part of this section presents examples of interventions found through online searches and suggested by stakeholders and stakeholders' reflections on priorities. The second part discusses the evidence on effectiveness of different interventions based on the findings from online searches and stakeholders' discussions.

Key findings

1. Table 3 lists initiatives to address inequalities in the health and care workforce mapped against the four areas mentioned above: workforce representation/pay, recruitment/selection, promotion/progression, and workplace experience/retention. These interventions were identified through online searches. Multiple examples of initiatives were found on the NHS England, Health Education England, councils' websites and in the Nuffield Trust report by Hemmings et al. (2021) (references are provided below). Many of the interventions focused on addressing ethnic and disability inequalities; however, these interventions could potentially be used to address other inequalities. Where available, the information on effectiveness and challenges are presented in the table. Table 3 also includes examples of interventions that were mentioned as successful or suggested as important to implement by stakeholders. These interventions mainly focus on recruitment and addressing discrimination/harassment.
2. **Workforce representation/pay and Progression/promotion**:
    a. Organisations offered training/development and mentoring programmes to address inequalities, such as leadership or career development programmes for minority staff or reverse/reciprocal mentoring (challenges of these activities are presented in Table 3 and in the Effectiveness section). Training and development programmes were suggested for the regulatory staff too "*to consider and act on equality and human rights*" (Care Quality Commission, 2018).

> *"if you are not at the table, you are on the menu*".
>
> -Stakeholder

b. Leadership representation at different levels, from mid-level managers to board membership, was emphasised by stakeholders as crucial as it "*sets the tone for the rest of the organisation*". The importance of such a representation is powerfully stated by one of the stakeholders saying, "*if you are not at the table, you are on the menu*". Stakeholders also said that patients and juniors need to see people like them ("*You can't be what you cannot see*"). Stakeholders, however, highlighted that the role should not be just a tick box, the role should be earned.

c. Stakeholders shared that more attention should be given to complaints, i.e., on how complaints are made and dealt with and exploring the work of the regulators. Stakeholders talked about changing the approach to complaints by shifting the focus from the individual to the system as complaints might reflect the work culture (e.g., understaffing; a lack of supervision might result in a person operating in an unsafe environment; a person might not feel valued, able to speak up, burnt-out, treated with the expectation that they will fail). While stakeholders did not suggest any concrete interventions to address this, they advised to explore why people get to these situations or why people fail and develop interventions based on these findings. A couple of examples of interventions to address inequalities in disciplinary processes were found on the NHS England website and presented in Table 3.

3. **Recruitment/Selection**:
    a. Organisations engaged in various initiatives to ensure inclusive recruitment, such as providing reasonable adjustments, offering alternative formats of interviews, and having a diverse recruitment panel. NHS England (2021), for example, produced a handbook on *How to recruit and support disabled staff in the NHS* which includes multiple tips.
    b. Stakeholders shared that all stages of recruitment, from attracting a diverse pool of candidates to interview practices, should be addressed. Stakeholders suggested that recruitment to entry levels and boards especially needs more attention. Even in the cases when recruitment might look standardised, stakeholders reflected that it still could contain discriminating elements (e.g., disabilities are different, but provided support/adjustments are the same).
4. **Work experiences/Retention**:
    a. Organisations created roles and systems to support staff with voicing their concerns and creating safe spaces to do so (challenges of these activities are presented in Table 3); e.g., Cultural ambassadors, staff networks, Freedom to Speak Up Guardians, Safe Space Clinics, and Carer Forums. When presenting these interventions, it was noted that the response to concerns was crucial as staff would feel discouraged to speak up if their voiced concerns would not result in any changes. Stakeholders also talked about psychological safety, creating safe spaces where staff feel comfortable speaking

up. Stakeholders said that what was small for one person, could be significant for another, and so all complaints should be taken seriously.

   b. Organisations developed policies and tools to improve work experiences and retention; for example, work and wellbeing passes to record individual needs, risk assessment tools, and anti-harassment policies. Some organisations also presented their initiatives to address specific wellbeing challenges reported by staff, e.g., setting breaks at the beginning of each shift to encourage staff to think about the significance of rest.
   c. Stakeholders mentioned the value of allies who are comfortable calling out inappropriate behaviour. Open support is crucial to show what is acceptable in the workforce and for everyone to feel safe at work. One stakeholder shared that some might feel voiceless, and they need support; they may need someone to be their voice until they get their voice back. There needs to be allies who can support others. West et al. (2015) in their report also mentioned the ally training (see Table 3).

5. Stakeholders reflected that protected characteristics might be hidden and so having a non-judgmental and inclusive approach will mean covering all characteristics and creating a positive organisational culture for all. This would mean, for example, that there is no need for applicants to disclose their disability for adjustments. This might be important as some might not even know that they need adjustments (e.g., not know if they are neurodivergent). To create an inclusive culture, stakeholders suggested that organisations should be less rigid, more flexible and listen to their employees and their needs.
6. Stakeholders suggested focusing on the positive side too. For example, have awards for being an inclusive organisation; putting together what was learnt from the pandemic. Another idea was to have a smart platform to share good practices/interventions where a person chooses what resources to explore (e.g., recruitment). This platform would include information on what was done, how it worked, where it was implemented and who to approach for more information.
7. Stakeholders suggested co-designing interventions with people whom the interventions are created for and said that interventions should not be imposed on. Interventions also should be tailored to each organisation and their needs.
8. Stakeholders highlighted that if policies/guidelines are suggested, it should be checked if these were followed. For example, by completing a form after recruitment interviews to review the process.
9. Stakeholders noted that when planning interventions, evaluation should be incorporated, impact assessment performed, and how it was implemented should be considered.
10. Diversity training or any other type of intervention in isolation will not be enough to make a substantial change. It is crucial to consider multiple initiatives systematically; addressing all levels of an organisation or career pathways and covering all processes

Table 3. Examples of interventions to address inequalities in the workplace.

Area	Indicator	Examples of interventions
Workforce overview/ Pay	Representation at different levels and pay gap / board membership	**Leadership development programme "Moving Forward"** This programme for ethnic minority staff was implemented in Bradford District Care NHS Foundation Trust to "*equip staff in band 5 and 6 roles with leadership skills and learning experiences to help them apply for and be successful in securing more senior positions".* <u>Evidence</u>: The positive impact of the programme was visible in interviews ("*I've been promoted twice since, and that's that empowerment that [it's] given me to be able to be focused, be positive, to go for things more*"). Staff expressed a wish to continue with this programme. <u>Challenges:</u> The programme can be seen as a divisive move questioning if this does not lead to segregation and further exclusion. Actions should be taken if such programmes are implemented (e.g., open conversations about why development is being offered to particular groups). Ross et al. (2020). The King's Fund
		Setting targets Setting targets which would be monitored. For example, increase representation at higher bands by 10% in three years with the board monitoring the progress every six months. Jarvis & Reeves (2017). NHS England
	Experiences of regulation	**Equipping regulatory staff to consider and act on equality and human rights** For example, learning and development activities for staff with British Institute for Human Rights; provide methods, tools and information that cover equality and human rights (e.g., guidance, specialists on hand to answer technical queries). Care Quality Commission (2018)
Recruitment/ Selection	Shortlisting and appointments	Suggestions for the recruitment process: • Adverts, job specifications and application forms should help to attract the right talent. Information that is **easy to read and understand** is important for those with learning disabilities but other groups too; e.g. simple words, include images to support text, making it larger print. • **Holding events** to attract specific under-represented groups. • **"Application buddy**" (first point of contact) who provides additional support to the applicant throughout the process.

		• **Alternative formats** as part of/instead of an interview (e.g., working interview). NHS England (2021a)
		Diverse and non-discriminatory recruitment panel • Assistant Director of Human Resources (or equivalent) sitting on all interview panels for posts 8a and above. • Including an ethnic minority staff member on interview panels. **Supporting applicants from minority groups** • Contacting candidates who did not attend the interview to ascertain any trends in non-attendance. • Getting local ethnic minority networks to offer informal support to applicants from minority groups. • Meeting with minority staff and talking about their experiences of recruitment, shortlisting, and interviewing processes. • Analysing reasons for not shortlisting or appointing to a post. **Reports** Provide equal opportunities recruitment reports that include equal opportunities monitoring at application, shortlisting, appointment stages, and rejected applications (e.g., every 6 months). Jarvis & Reeves (2017). NHS England
		Checklist/recruitment tools for inclusive recruitment This tool could be used by managers to plan recruitment processes and include such aspects as thinking about the role and what it requires, criteria, placement of advertising, accessibility of an application, consideration of flexible recruitment practices and flexible working. **Collaboration with other organisations** Different organisations working closely together was highlighted by stakeholders as important. Collaborations might take various shapes. For example, working with local communities; different networks working together to present/advertise career paths (e.g., Public Health – ADPH, BMA, GMC, etc.). **Multiple aspects to recruitment** If feasible and appropriate, stakeholders suggested using multistage and multi-station recruitment involving multiple trained recruiters and potentially a lay person. **Anonymous recruitment (i.e., blind hiring)** Even though anonymous recruitment is not new to many organisations, stakeholders mention that it is not consistently practiced. **Adjustments** Offer adjustments, such as more time, hearing adjustments or bigger screens.

		Sharing interview questions in advance Stakeholders mentioned this to be especially important for certain types of candidates, e.g., neurodiverse candidates. **Notes** Stakeholders suggested that applicants should be allowed to have notes with them during an interview. Applicants should be informed about this in advance when they are invited to an interview. **Training for all panel members** Stakeholders suggested that training for all recruitment panel members would develop skills needed to make appropriate decisions and increase confidence to raise issues. An inclusive panel will not work, stakeholders warn, if people cannot challenge each other. **Evaluating recruitment practices** Stakeholders suggested having regular discussions about recruitment practices and challenging these practices. For example, it should be considered what is needed for the role; if interview restrictions represent the reality of the job or it just measures how good a person is in interviews. **Management approval** In some organisations, above a certain level, the senior management approval is needed if no applicants from minority groups are appointed. **Assessment/reflective practices** That would include assessing how decisions are made, collecting information about the process, and taking action based on the feedback. **Feedback to applicants** Constructive (specific) feedback given to those who were not successful, that they could do better next time. Stakeholders
	Representation in education	**Apprenticeship programme (*disability*)** Hampshire Hospitals NHS Foundation Trust offers apprenticeships for those with learning difficulties and disabilities. Programme is tailored to the group and is longer than other programmes to support pace of learning. It provides support with learning skills and includes reasonable adjustments (e.g., alternative assessments). NHS England (2021b)

Promotion/ Progression	Training/ Promotion	"**Temporary transfer window**" Scheme to staff that enables them to try out different jobs for one day a week for a short period to gain new skills. Jarvis & Reeves (2017). NHS England
		Turning the Tide programme This programme is developed by the Royal College of Midwives and offers "*mentoring and interview preparation for non-White midwives to support their career progression*". The Royal College of Midwives (2021)
		Pre-application support It could include webinars, coaching sessions, 1-2-1 conversations (such as watercooler chats with managers/higher managers) for/with potential applicants (e.g., how to prepare an application, presenting different career paths, career advice). This could be provided for external applicants too as it was questioned by stakeholders if internal candidates might be more successful because they use certain terminology. Stakeholders
		Reverse/reciprocal mentoring Pairing junior employees with more senior ones; ideally from different backgrounds. Through sharing lived experiences the aim is to "*redress power differences and address 'advantage' blindness*" among leaders. <u>Evidence</u>: Positive views were expressed in interviews where participants shared increased understanding of different experiences ("*a real eye-opener particularly for the exec directors*"). Ross et al. (2020). The King's Fund Health Education England (2022a) **Mentoring** Stakeholders stated that differential attainment can be partly explained by the differences in networking ("*who you know*") and coaching/mentoring schemes might be helpful in addressing this issue. Mentorship can also provide a space for an open conversation and help to move through the processes and systems and navigate careers. Mentor who is someone like a mentee might be a good role modelling example. Mentoring could be offered to external people too. Stakeholders
		Career development programme

		This programme for female staff and staff from ethnic minority backgrounds was implemented in Barts Health NHS Trust and consisted of a series of three half-day workshops on personal effectiveness, career planning, and job interviews. Evidence: To date from 349 programme participants 89 (26%) were promoted. NHS England (2018)
	Disciplinary/ capability process	**Models for reducing disproportionality** Examples: 1) decision tree checklist: algorithms, guidelines, and structured questions to help managers decide whether formal action is essential; and 2) pre-formal action check by a trained lay member to review and challenge any perceived biases. **Board-level oversight** Data related to investigations and disciplinary procedures should be "*collated, recorded, and regularly and openly reported at board level*"; including justifications for suspensions, the impact on patient care and employee, and lessons learnt. NHS England (2019b)
Work experience/ Retention	Harassment, bullying, abuse, discrimination	**Cultural ambassadors** This programme is a Royal College of Nursing initiative to recognise areas where staff may be treated unfairly or face discrimination. Cultural ambassadors are being trained for the role. **Staff networks** These networks can have various benefits; e.g., safe space to raise concerns, encourage collaboration, and foster innovation. Evidence: In interviews staff reported that these networks were key in addressing issues and contributed to building trust and understanding among staff. Networks also were a safe space to share difficult experiences and educate others. Challenges: Responsibility of chairing sessions often fell to a few members and that required a lot of hard work (usually unpaid). Some staff felt excluded ("*staff "given something extra" – and that it was fundamentally unfair*") and this can result, for example, in racial tension (if staff networks are for ethnic minority staff). To overcome that, networks (or part of it) could be open to all. Health Education England (2022a) Ross et al. (2020). The King's Fund
		Special interest groups

		Such groups (e.g., informal groups for ethnic minority staff) were mentioned by stakeholders as important as they provide "*a safety net*" for employees. **EDI discussions** These discussions are open to all staff and encourage important conversations about EDI (could be mandatory). Stakeholders highlighted that there needs to be a skilled person to manage such conversations. **Learning soft skills** Stakeholders noted that people are from different backgrounds and have different experiences and that might lead to misunderstandings. Stakeholders talked about acceptance and willingness to understand. If discussions are initiated, communication should be genuine and not organised to achieve one's own ends (coming with preconceived ideas). Staff should be offered training on effective communication, valuing colleagues, different cultures, etc. **Public Health messaging** Stakeholders suggested that to minimise discrimination initiatives should focus on the public too (especially if staff is more diverse than the population they serve). Stakeholders
		Ally training Training could be provided to those in non-minority groups (non-target groups; e.g., men or White staff) on how to confront those who express discriminatory behaviour against a target group member. <u>Evidence</u>: Allies from non-disadvantaged/discriminated groups can have an impact on others' discriminatory behaviour. It is said that this is particularly valuable when identities are invisible, e.g., sexual orientation. Lindsay et al. (2013) in West et al. (2015). The King's Fund **Support for managers** Stakeholders suggested providing leaders with support to take action regarding EDI issues by, for example, creating spaces to talk about the challenges they encounter. Stakeholders
		Memorandum of Understanding Camden Council's adult social care service has articulated a zero tolerance to racism and developed a Memorandum of Understanding (MoU) as a way to put this approach to practice. MoU sets out shared principles and requirements; e.g., managers

		are responsible for ensuring that all racist incidents are reported and actioned in a timely manner; a "safe space" at work is provided to share experiences and challenge organisational practices. London Councils (unknown)
	Voicing/reporting concerns (including feeling secure raising concerns)	**Freedom to Speak Up Guardians (FTSUGs) or other equality, diversity, and inclusion champions** Calderdale and Huddersfield NHS Foundation Trust had "*trained 12 members of staff as 'inclusion representatives' who wear special badges or lanyards to signal they are approachable and happy to talk to staff or patients*". <u>Evidence</u>: In interviews staff reported that FTSUGs were seen as a safe route to raise concerns and "*can also be a way to determine wider, systemic issues across teams or parts of an organisation*". <u>Challenges:</u> It takes time to embed these roles and these roles need continued support. Hearing about issues also might create a sense of individuals' responsibility to make a change while a change requires organisational level interventions. Ross et al. (2020). The King's Fund Stakeholders noted that FTSUGs can be internal (internally recruited person) or external (externally commissioned confidential service when issues are fed back to management in themes). It might be useful to consider which service would be more trusted and believed to be "*safe*". Stakeholders
		Safe Space Clinics This initiative was set up by the Waltham Forest council to address inequalities by working together with senior managers. Safe Space Champions helped to arrange meetings with seniors to raise staff concerns. London Councils (unknown)
	Engagement/ Job satisfaction / Wellbeing / Feeling valued	**Building symbol of gratitude** This initiative in Blackpool Teaching Hospitals was the installation of a "*gratitude rainbow*" which was a clear screen where patients and staff posted messages recognising the efforts of staff. This initiative created "a *sense of unity*" and increased staff engagement and morale. NHS England (2021c)
		Carers forum (*caring responsibilities*) This initiative was from Sheffield Teaching Hospital NHS Foundation Trust. Monthly meetings were organised with a guest speaker (e.g., tips for caring for someone following a stroke) and peer support.

		Evidence: Based on initial findings (methods are not specified), staff attending the forum felt better supported by the organisation and less isolated. Challenges: Workload pressures prevented some from supporting and engaging with the network. NHS England (2022e)
		Rest, rehydrate and refuel initiative Sherwood Forest Hospitals NHS Foundation Trust introduced this initiative based on the Royal College of Nursing work: hydration stations with easy access, promoting rest (setting breaks at the beginning of the shift encouraging staff to think about breaks as essential on their to do list), creating access to food outlets and providing more/healthier options (machines providing hot food, restaurants extend working hours and provide more options). Each activity included information provided to staff about the importance of hydration/rest, tips, etc. Evidence: Staff feedback was positive. Staff hydration, rest breaks improved, usage of vending machines increased, and mindset of why missing breaks was detrimental changed. Challenges: Engaging staff to prioritise their health and wellbeing was challenging due to their workload. Another challenge was changing culture and busting myths of what was allowed to happen on wards. Senior leaders' support was "*the biggest determining factor of the success for the project*". NHS England (2021d)
		Health and wellbeing conversations The NHS People Plan asks that all NHS staff are supported to develop a personalised wellbeing plan. As an example, annual appraisal in North Cumbria Integrated Care NHS Foundation Trust was replaced with quarterly discussions between managers and staff covering a range of topics including wellbeing. Managers are given prompts to discuss elements of wellbeing; for example, identifying things that could improve wellbeing. More examples can be found on the NHS England website. NHS England (2022f)
	Adjustments	**Health passport**

		This passport "*allows individuals to easily record information about their condition, any reasonable adjustments they may have in place and any difficulties they face*". The editable health passport is developed for NHS staff with disabilities, long term health conditions, mental health issues or learning disabilities/difficulties. **Work and wellbeing passport** This passport is implemented in Kent Community Health NHS Foundation Trust and helps to record individual needs for: • a member of staff with a disability or long-term condition; • those who have caring responsibilities for a relative with a disability or long-term condition; parents with young children; • staff who observe religious festivals or celebrations such as Ramadan or daily prayers; • staff who are in the process of gender reassignment. **Access to Work** This is a free government scheme that reimburses the cost of adaptations to support disabled staff (e.g., travel to/from work if this would otherwise be a barrier to employment). NHS England (2022g) NHS England (2022h) Kent Community Health NHS Foundation Trust (unknown) NHS England (2021a)
	Presenteeism	**Disability leave policy** Such policy helps to set out the conditions for leave and provides clarity to managers and staff (examples are provided on the NHS England website). NHS England (2021e)
	Unfavourable environment	**Risk Assessment Tool** This tool was developed in 2020 to understand the reasons why ethnic minority workers in health and social care were disproportionately affected by the COVID-19 virus. This tool identified the level of risk and the right action; included the review of PPE or workplace adaptation. Welsh Government (2020a) Welsh Government (2020b)
		Covid-19 BAME Speak Up Ambassador

		This role was created for staff to be able to approach someone with pandemic related issues. An ambassador provided advice and guidance. Hemmings et al. (2021). Nuffield Trust
	Participation	**Encouraging participation in staff networks** When encouraging participation in staff networks organisational level support is crucial: sponsorship from leaders, support from the communication team (for the visibility of staff networks and the outcomes from discussions) and ensuring that staff time for the involvement is covered. In East London NHS Foundation Trust, for example, time dedicated to run staff networks were built in the chairs' schedules. <u>Evidence</u>: In interviews, staff said that having dedicated time contributed to the success of staff networks and that many networks failed when staff needed to run them on top of their workday. Ross et al. (2020). The King's Fund
	Leaving	Interventions will depend on the reasons for leaving. An example related to harassment issues: **Anti-Harassment policy** Deery and colleagues' work was cited in the NHS Race & Health Observatory report saying that when staff believed that their organisations had effective anti-harassment policies in place, they were less likely to experience burnout or express intentions to leave their jobs. The impact of the policies on intentions to leave was greater for nurses from ethnic minority backgrounds. Kapadia et al. (2022). NHS Race & Health Observatory
		Retaining leavers Inviting leavers to move to different positions in the health and care system. An example given by stakeholders was a large number of those employed in vaccination posts (or volunteers) staying in the NHS (a substantial proportion being from ethnic minority backgrounds). Webinars were organised to introduce different career pathways, to provide career advice, and to teach how to fill in the NHS application form (or advocating for using alternative applications). Stakeholders

Effectiveness

1. There is a need to better understand the impact of interventions to address inequalities. Limited evidence shows that some of the interventions have a positive effect but also pose challenges, while others might result in unintended negative consequences. For example:
    a. Conventional diversity training can increase knowledge but has little impact beyond that (West et al., 2015). Stakeholders also reflected that EDI training should be thought through thoroughly as it might be badly done or have no effect. For example, consider how messages are shared and delivered; what form it takes; how engaging training is.
    b. Highlighting that unconscious bias is common might normalise that bias and legitimise it with people being less motivated to change their attitudes and behaviours (West et al., 2015). Stakeholders also recognised these challenges saying that it might encourage some to hide behind the "unconscious" part; people need to own their actions. Stakeholders suggested focusing on a balanced conversation – what discrimination is and different types of biases, i.e., unconscious vs conscious/blatant discrimination.
    c. Training programmes that focus on goal-setting/changing behaviours are reported to be more effective than educational interventions (Madera et al., 2013 cited in West et al., 2015).
    d. Training programmes that shame participants for discriminatory ways are not likely to be effective while those that focus on recognising and valuing all colleagues may have a stronger impact on long-term attitudes (Lindsay et al., 2015 cited in West et al., 2015).
    e. Staff might be putting substantial efforts and time to make interventions effective (e.g., staff networks) which might be seen as unpaid labour (Ross et al., 2020).
    f. Training programmes for minority groups might be met with resistance if goals are not clear. Some might question if this does not lead to further segregation (Ross et al., 2020).
2. When discussing the impact of interventions, stakeholders reflected that all interventions could have unintended consequences. For example, interventions that are perceived as "*tick boxes*" will be viewed negatively. Stakeholders gave an example saying that having a representative panel for every interview can be viewed as tokenistic. Stakeholders shared that in some organisations having a representative panel worked well and in others less so. Hence, organisational contexts might be important aspects to consider. Stakeholders also added that:
    a. There are different approaches to understanding protected characteristics. Stakeholders highlighted the need to reject the deficit/medical models (medical model "*looks at what is 'wrong' with the person, not what the person needs*";[1] deficit model "*attributes failures such as lack of <..> success in gaining employment to a personal lack of effort or deficiency in the individual, rather than to failures or limitations of the education and training system or to prevalent socio-economic trends*"[2]). An example was given showing that based on a medical model, if someone is in a wheelchair they are disabled because they are in a wheelchair while based on a social model, a person is disabled because the building does not have a ramp. In the

[1] Scope=Equality for disabled people – "Social model of disability" (https://www.scope.org.uk/about-us/social-model-of-disability/)
[2] Oxford references – "Deficit model" (https://www.oxfordreference.com/display/10.1093/oi/authority.20110803095707115)

social model, the problem is shifted from a person to a building, to society ("*people are disabled by barriers in society, not by their impairment or difference*"[3]). When considering interventions, creating a special programme for a group of people with protected characteristics comes under the deficit model and stakeholders noted that the better approach might be ensuring representation in the existing programmes and supporting people to attend these (e.g., taking positive action – if a person cannot attend due to finances required for travel, cover travel expenses).

b. When considering adjustments, the approach is often based on a medical model and relies on occupational health: need to prove that there is a disability before making any adjustments. Stakeholders encouraged organisations to be more flexible and less rigid as adjustments are usually small but can have a significant impact on productivity. Focus should be less on evidence that an individual needs to provide but more on what one needs to do their job well.
c. Interventions which encourage open communications will not work if concerns reported will not be taken seriously and addressed. This can have a significant negative impact.

Findings: Stakeholders' views on EDI

Why is EDI important?

1. Stakeholders talked about the importance of Equality, Diversity, and Inclusion (EDI), saying that the level of diversity in the health and care workforce represents the values an organisation holds. Having a diverse workforce also means incorporating different perspectives which helps organisations to improve. A diverse workforce benefits patients, community and the population as patients see health and care professionals who are like them, whom they can create trusting relationships with. Hence, based on stakeholders' views, if a patient is the centre of the health and care system, then EDI issues in the workforce are crucial to address. The workforce is a part of addressing health inequalities.
2. Stakeholders recognised that with a new generation the approach to work is changing. That is, people think more about how work could be planned around their lives than vice versa, life being planned around their work. Stakeholders discussed that to attract new talent organisations need to be seen taking care of their employees, having a person-oriented approach, and that includes being inclusive.
3. Improvements in the NHS as the biggest employer goes beyond personal or organisational impact. Stakeholders shared that enabling people to have "*great careers*" in the NHS might have a strong generational impact (e.g., changing society).
4. Lastly, EDI was described as the right thing to do, morally important, and socially just.

[3] Scope=Equality for disabled people – "Social model of disability" (https://www.scope.org.uk/about-us/social-model-of-disability/)

Reflections on metrics and interventions

1. A number of challenges were identified around monitoring how equitable the workforce is and around interventions to address inequalities:
    a. **Resources.** Stakeholders talked about a lack of capacity and available skills (e.g., to perform appropriate/detailed exploration and interpretation of EDI data). Stakeholders mentioned that activities related to EDI are often done by those who are affected (minority staff) and in their own time. Another challenge that was observed regarding the limited involvement was that some might feel like it is not their place to be involved or some avoid EDI related activities as they have assumptions of what it is. Open events, safe spaces to ask questions, or lectures that anyone can attend might be useful to encourage involvement.
    b. **Complexity**. Some health and care systems, career paths in these systems are complex and have multiple components which makes implementation of interventions more challenging. Stakeholders also said that measuring work experiences might be more difficult for temporary posts and positions (for example, trainees changing their placements) as it is not clear if findings reflect the position or the organisation.
    c. **Accepting the need for improvement**. At the individual level, stakeholders mentioned that people should be able to identify areas for improvement without being judged, as not knowing something does not mean that a person cannot do their job. Stakeholders suggested that there should be a culture of learning where people would be open to change and be supported in doing so. Professional development programmes covering diversity perspectives could be put in place for this purpose. At the system level, stakeholders noticed that national organisations want to be presented in the most positive light which sometimes meant "*glazing over*" the imperfections and things that need improvement, instead of accepting that some things are not going well and being willing to change it.

> "There are "*fundamental strategic reasons why representation matters*"
> -Stakeholder

    d. **Articulating why EDI is important.** Stakeholders talked about several aspects *why* EDI is important but highlighted that the improvements will not be made if the perception of EDI importance will not move beyond the focus on an individual and individual experience. Stakeholders shared that there are "*fundamental strategic reasons why representation matters*". Stakeholders emphasised the importance of understanding that helping staff to reach their potential will significantly contribute to the success of the business. One stakeholder suggested case studies to show how EDI links to such measures as productivity, business success and finances might be helpful.

e. **Linking data and interventions**. Stakeholders talked about developing interventions based on EDI data. Nevertheless, there is a danger of requiring more and more data and evidence which delay action. This can be especially challenging if data are limited. As one of the stakeholders stated, we know that there are disparities and "*doing nothing is not an option*".

2. Stakeholders were asked about priorities and listed a number of areas of metrics and interventions which are important to focus on, such as recruitment, pay gap, board/leadership representation, progression/development, disciplinary procedures (referrals, outcomes, grievances), work experience (like discrimination, wellbeing), and collecting exit data.
3. Despite listing different areas of importance, in order to make a positive change in all parts of the health and care system, stakeholders emphasised the importance of rethinking how EDI is presented and approached.

Achieving change: Recommendations

> *"ticking a diversity box*"
> -Stakeholder

1. Many stakeholders talked about a mismatch between what is said and what is done, especially by leadership, and the challenge of EDI being a tick box ("*ticking a diversity box*"), "*fashionable*". One stakeholder used a term "*diversity washing*" in reference to "*green washing*" used in the fashion industry (*"the intersection of two firm behaviours: poor environmental performance and positive communication about environmental performance"*).[4] Stakeholders encouraged the move from what is "fashionable" making EDI a centre of the business with the routine interest and broad view.
2. According to stakeholders, EDI might be misinterpreted by some. Some might think that issues with EDI are related just to a blatant, active discrimination against a group of people, and not consider the impact of the system where structural barriers and a lack of opportunities result in disparities.
3. The key change that stakeholders identified was to make **EDI a business priority,** a measure of how well a business is doing. EDI should be embedded in the business priorities and organisational strategy with ownership from leadership. That is, stakeholders expressed that responsibilities should lie under business itself and not under a separate entity especially created to deal with the EDI issues and separated from the core of the business (being somewhere "*over there*"). The following changes were suggested by stakeholders:
    a. **EDI as a performance measure**. Stakeholders agreed that EDI should be measured as "*what gets measured, gets done*". Important distinction was made between measuring EDI under separate entities and discussing EDI as a business priority. It was suggested that EDI would be a part of the performance measure (e.g., how are we doing and what needs to change). Stakeholders stressed the need to publish data and

[4] Delmas M, Burbano V (2011) The drivers of greenwashing. Calif Manag Rev 54(1):64–87. https://doi.org/10.1525/cmr.2011.54.1.64

trends regularly, in a transparent, simple, and understandable way. It was suggested having guidelines (potentially at the national level) with aims and hard targets/ambitions including ways to address them and timelines.

b. **Discuss EDI routinely**. Stakeholders stressed the importance of EDI being a part of regular conversations at the top; e.g., a standard item on the board meeting agenda and discussed in a similar way as a financial performance or being a part of the quality improvement conversation (using quality improvement approaches to make changes).

> *"the reason it's not working is because nobody is being held accountable*"
>
> -Stakeholder

c. **Legislation/accountability/meaningful penalties**. Stakeholders reflected that if there are no legal requirements then things most likely will not be done and gave an example of not looking at disability/ethnicity data for the pay gap analysis. Additionally, stakeholders talked about the need of being clear about whose job is EDI improvement. Stakeholders mentioned that a lot is done by volunteers and that should not continue. Stakeholders also talked about accountability to improve EDI which should be held by leaders and include "*meaningful penalties*" to make sure that tasks will be taken seriously. One stakeholder said that there are various standards in place but "*the reason it's not working is because nobody is being held accountable*".
d. **EDI built into all processes/systems**. Stakeholders said that instead of relying on everyone in the system to do the right thing, EDI should be embedded in the system/processes with clear guidance on how things need/are expected to be done.
e. **Leadership**. Almost all stakeholders emphasised the importance of leadership as leaders have a decision power and can raise EDI as a priority initiating changes. Visible actions, genuine commitment, and taking accountability for EDI at all levels was highlighted as crucial. Stakeholders talked about "*dinosaurs of leadership*" who refuse to accept that diversity is a good thing and that needs to change. Stakeholders discussed that communication and action from leaders set expectations and have a symbolic meaning as 1) leaders are role models, 2) leaders speaking about diversity promote diversity and 3) encourage speaking up/action from others. Different approaches to leadership and what a good leader was were also highlighted arguing that people do not need to change who they are to become leaders. Stakeholders mentioned the value of authentic and compassionate leadership.
f. **Open and transparent commitment.** Stakeholders talked about open and transparent commitment, saying that "*justice has to be done and has to be seen to be done*". One stakeholder shared that "*off the record support*" is not helpful. That is, someone saying that observed discriminatory behaviour was inappropriate and they understand why the receiver might feel negative about it but saying that in private and not calling out that behaviour.
g. **Alignment**. Stakeholders suggested having agreement at all levels as to how EDI is approached, and issues dealt with. Stakeholders mentioned that they had seen

situations where management at different levels reacted differently to the same EDI issue. This, according to stakeholders, sends a conflicting message of what is appropriate.

h. **Culture change**. Stakeholders talked about the value of culture, which is compassionate, open to different views, and eager to learn and improve. Some stakeholders suggested shifting from a task-oriented culture (focusing on an outcome) to a person-oriented culture (helping staff to succeed). Investing in people will lead to higher productivity and better outcomes, stakeholders shared. This would include systems being more flexible. Stakeholders discussed that in a culture which is supportive and positive, improvements would happen naturally, and interventions would be more effective because of EDI values embedded in the systems, behaviours, and norms.

i. **Working together**. Stakeholders talked about the significance of working together. First, for people at different levels in the same organisation. For instance, managers and HR personnel should be able to have open conversations about the best processes to recruit/retain staff and work together on implementations. Second, for different organisations to work together. Stakeholders reflected on the tendency of thinking ”*in silos*” and focusing just on what is happening in one organisation. Nevertheless, experiences of a person which influence their careers are not defined by one organisation/system. For example, some of the EDI problems in organisations should be addressed much earlier, e.g., thinking about the school system. Another more concrete example was provided about a challenge in Public Health. Stakeholders talked about the challenge of responsibilities for training and examination sitting with two organisations: Faculty of Public Health (FPH), responsible for running the training programme, and by Health Education England (now NHS England), responsible for the entrance to training exams. The FPH report recognised the EDI issues with examination and to improve that a better integration is needed linking two organisations.

Conclusions and recommendations

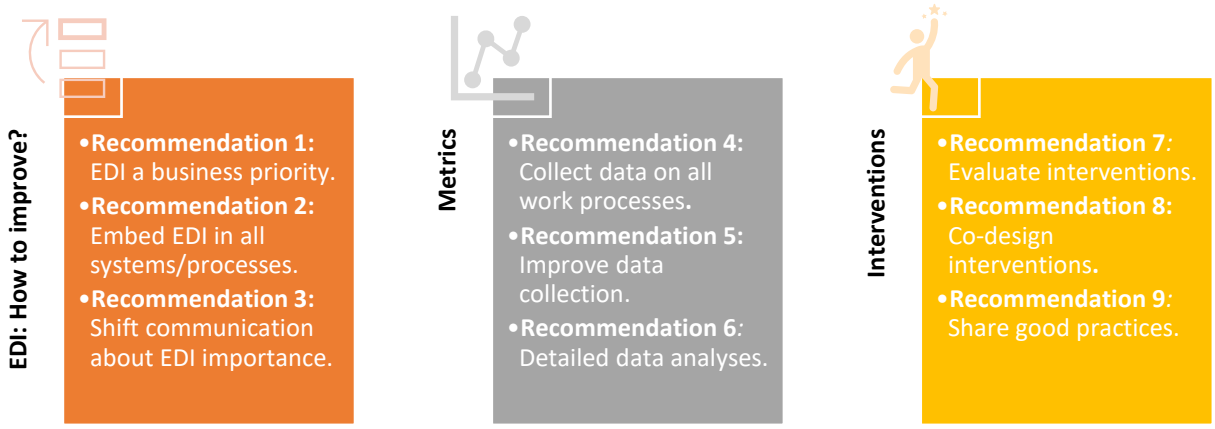

Figure 2. Recommendations.

EDI: How to improve?

1. The key message from discussions with stakeholders was that the way we understand, discuss, and therefore act upon EDI needs to move beyond the focus on an individual and an individual's experience. Stakeholders talked about a mismatch between what is said and what is done, and that EDI should be made a business priority with ownership from leadership. Stakeholders reflected that activities related to EDI are often done by those who are affected (i.e., minority staff) and in their own time.
    a. **Recommendation 1: EDI a business priority**.
        i. EDI should be embedded in the business priorities and organisational strategy with leadership accountability which might include "*meaningful penalties*". EDI should be routinely measured, reported, and discussed at the top (management//board) levels, and treated as a performance measure (how well a business is doing).
    b. **Recommendation 2: Embed EDI in all systems/processes**.
        i. EDI should be embedded in all systems/processes with clear guidance on how things are expected to be done (including organisational alignment).
    c. Recommendation 3: Shift communication about EDI importance.
        i. changing the narrative about the importance of EDI; communicating why EDI is important beyond it being morally right and socially just. This might include presenting case studies showing how EDI links to such measures as productivity, business success and finances.

Metrics

2. Three standard documents and 29 documents reporting on workforce diversity were found through the desk-based search identifying four areas of metrics to monitor how equitable and inclusive the health and care workforce is: (i) **workforce overview/pay** (e.g., percentage of staff across pay bands compared with the percentage of staff in the rest of the workforce or population served), (ii) **recruitment/selection** (e.g., relative likelihood of staff being appointed from shortlisting across all posts), (iii) **promotion/progression** (e.g., percentage of staff

believing that their workplace provides equal opportunities for career progression or promotion), and (iv) **work experience/retention** (e.g., percentage of staff experiencing discrimination from manager/team leader or other colleagues).

3. The three standards (*the NHS Workforce Disability Equality Standard, the NHS Workforce Race Equality Standard, and the Social Care Workforce Race Equality Standard*) provide guidelines on what experiences of ethnic minority/White or disabled/non-disabled staff to compare and how. Many of the documents identified through the desk-based search report findings on these suggested by the standards monitoring measures and focused on ethnicity or disability. Some documents cover additional processes, such as exploring the experience of regulation, investigating representation in education, analysing job satisfaction and wellbeing, and who is working in unfavourable work conditions. Some documents also expanded their explorations from what is suggested in the standards. Regarding voicing concerns, for example, it was reported on feeling secure to raise concerns or how many felt that concerns had been (or would be) dealt with well. These explorations might help to understand the disparities better.
4. Even though the indicator of who is leaving the organisation is a part of the Social Care Workforce Race Equality Standard, no documents reporting on this indicator were found, no examples of the use of this metric were found. Discussions with stakeholders though highlighted the importance of collecting exit data.
5. Stakeholders called for broader and more nuanced investigations. Nevertheless, data limitations should be acknowledged and considered (e.g., missing data, small sample sizes, inability to provide answers to why disparities exist). Stakeholders also reflected that the emphasis was more often on recruitment processes instead of other areas.
6. Some groups might be less engaged in monitoring processes potentially due to lack of trust in processes and organisations.

    a. **Recommendation 4: Collect data on all work processes.**
        i. a broad view should be taken when addressing workforce disparities: covering all work processes (recruitment and retention as presented in Table 1 and Table 3) and protected characteristics (and potentially beyond; e.g., sociodemographic background). Stakeholders highlighted the need to collecting exit data. If collecting interview data, ensuring that staff feel safe is crucial and so impartial/independent data collection should be prioritised. Stakeholders in this study reflected that "*what is measured is done*" which poses the question if standards for other characteristics beyond ethnicity and disability should be considered.

    b. **Recommendation 5: Improve data collection**.
        i. improving how data is collected and reported would help to better understand staff experiences. This includes exploring how monitoring is planned and implemented and if all staff have equal opportunities to participate.

    c. **Recommendation 6*:* Detailed data analyses.**
        i. monitoring equality in the workforce should go beyond descriptive data: robust/sophisticated and disaggregated data analyses and looking at intersectionality. To understand the reasons for disparities, collection of qualitative data should be considered.

Interventions

7. This report provides examples of interventions to address inequalities in health and social care. These examples include training/development programmes, creating new roles, and developing policies and tools. Examples of interventions might be helpful when planning how to address inequalities. Nevertheless, it is unlikely that one intervention in isolation will make a substantial change.
8. Commitment from leaders was highlighted as especially important when making changes.
9. Studies show that some interventions have just a limited impact or may have unintended negative consequences, e.g., highlighting that unconscious bias is common might normalise and legitimise this bias. Stakeholders also proposed being cautious about special programmes for those with protected characteristics (as it comes under the deficit model) and suggested instead considering how to support those with protected characteristics to attend the existing programmes. However, generally, there is a lack of evidence regarding the effectiveness of interventions addressing inequalities
    a. **Recommendation 7*:* Evaluate interventions.**
        i. it is important to understand the impact of initiatives to address inequalities: when planning interventions, evaluation should be incorporated, impact assessment performed, and how it was implemented should be considered.
    b. **Recommendation 8: Co-design interventions.**
        i. interventions should be co-designed with those for whom the interventions are being developed and interventions should be tailored.
    c. **Recommendation 9*:* Share good practices.**
        i. considering the limited resources about good practices, collaborations and sharing experiences might be beneficial. One of the stakeholders suggested a smart platform to share good practices/interventions where a person chooses what resources to explore (e.g., recruitment). This platform would include information on what was done; how it worked; where it was implemented and who to approach for more information.
10. Positive changes will happen naturally in organisations which are compassionate, open to different views, and eager to learn and improve. Stakeholders encouraged organisations to be more flexible and less rigid when making adjustments/changes and invest in their people.

Reference list

Desk-based research:

1. Appleby, J., & Schlepper, L. (2019). *The gender pay gap in the English NHS Analysis of some of the underlying causes.* Nuffield Trust. https://www.nuffieldtrust.org.uk/files/2019-05/gender-pay-gap-briefing-ne1883-5.pdf
2. Bury, F., & Pinder, R. J. (2022). *Equality, diversity and inclusion in recruitment to Public Health specialty training in the United Kingdom*. Imperial College London, London, United Kingdom
3. Care Quality Commission (2022a). *Our Workforce Disability Equality Standard (WDES): Annual Report 2021.* https://www.cqc.org.uk/about-us/our-strategy-plans/equality-human-rights/data-standards/wdes-report-2021
4. Care Quality Commission (2022b). *Our Workforce Race Equality Standard (WRES): Annual Report 2021*. https://www.cqc.org.uk/about-us/our-strategy-plans/equality-human-rights/data-standards/wres-report-2021
5. Care Quality Commission (2022c). *Ethnic minority-led GP practices: impact and experience of CQC regulation*. https://www.cqc.org.uk/publications/themed-work/ethnic-minority-led-gp-practices-impact-experience-cqc-regulation#RQ
6. Charlesworth, A. (2017). *Rising pressure: the NHS workforce challenge*. Health Foundation. https://www.health.org.uk/publications/rising-pressure-the-nhs-workforce-challenge
7. Dacre, J., & Woodhams, C. (2020). *Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England.* Department of Health and Social Care. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944246/Gender_pay_gap_in_medicine_review.pdf
8. Edbrooke-Hyson, V. (2021). *A Capacity Review – Public Health Specialists in 2021.* Health Education England. https://www.hee.nhs.uk/sites/default/files/documents/Public%20Health%20Capacity%20Review%20-%202021%20v26.pdf
9. Einarsdóttir, A., Mumford, K., Birks, Y., Lockyer, B., & Sayli, M. (2020). *Understanding LGBT+ employee networks and how to support them*. https://www.nhsemployers.org/system/files/media/Understanding-LGBT%2B-employee-networks-in-the-NHS_0.pdf
10. Equality and Human Rights Commission (2022). *Experiences from health and social care: the treatment of lower-paid ethnic minority workers*. https://www.equalityhumanrights.com/sites/default/files/inquiry-experiences-and-treatment-of-lower-paid-ethnic-minority-workers-in-health-and-social-care-report_0.pdf
11. Hemmings, N., Buckingham, H., Oung, C., & Palmer, W. (2021). *Attracting, supporting and retaining a diverse NHS workforce.* Nuffield Trust. https://www.nuffieldtrust.org.uk/files/2022-10/1636121852-nhs-workforce-diversity-web.pdf
12. Health Education England (2022a). *Diversity and Inclusion annual report 2021-2022.* https://www.hee.nhs.uk/our-work/diversity-inclusion/diversity-inclusion-annual-report-2021-22
13. Health Education England (2022b). *Experiences of Racial Discrimination and Harassment in London Primary Care.* https://www.hee.nhs.uk/sites/default/files/documents/Pan-LondonDiscrimination%26RacismPrimaryCareSurvey_Final.pdf
14. House of Commons. Health and Social Care Committee (2021). *Workforce burnout and resilience in the NHS and social care*. https://committees.parliament.uk/publications/6158/documents/68766/default/
15. House of Commons. Health and Social Care Committee (2020). *Delivering core NHS and care services during the pandemic and beyond*. https://committees.parliament.uk/publications/2793/documents/27577/default/

16. House of Commons. Health and Social Care Committee (2022). *Workforce: recruitment, training and retention in health and social care.* https://committees.parliament.uk/publications/23246/documents/171671/default/
17. Kapadia, D., Zhang, J., Salway, S., Nazroo, J., Booth, A., Villarroel-Williams, N., Bécares, L., & Esmail, A. (2022). *Ethnic Inequalities in Healthcare: A Rapid Evidence Review.* NHS Race & Health Observatory. https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf
18. Liu, D. (2021). *Profile of the Public Health Workforce in England and the UK: Region of Primary Medical Qualification and Ethnicity.* Health Education England.
19. Local Government Association (2019). *Workforce focus. Taking stock of the local government workforce – Sharing HR ideas for the future*. https://www.local.gov.uk/sites/default/files/documents/11%20170%20Workforce%20Focus_03_web.pdf
20. NHS England (2019). *Workforce race equality standard. 2018 WRES data analysis report for eight national healthcare organisations* (Report No. 000215). https://www.england.nhs.uk/wp-content/uploads/2019/05/wres-data-anaylsis-report-eight-national-healthcare-orgs.pdf
21. NHS Employers (2021). *Inclusive recruitment into apprenticeship.* https://www.nhsemployers.org/system/files/2021-07/Inclusive-recruitment-into%20apprenticeships.pdf
22. NHS England (2022a). *NHS Workforce Disability Equality Standard Technical Guidance 2022 for NHS Trusts and NHS Foundation Trusts.* https://www.england.nhs.uk/wp-content/uploads/2019/03/B1710_i_WDES-Technical-Guidance-2022-for-NHS-Trusts-and-NHS-Foundation-Trusts_June-2022.pdf
23. NHS England (2022b). *Technical Guidance for the NHS Workforce Race Equality Standard (WRES).* https://www.england.nhs.uk/wp-content/uploads/2022/03/NHS-Workforce-Race-Equality-Standard-technical-guidance-2021.pdf
24. NHS England (2022c). *NHS Workforce Race Equality Standard 2021 data analysis report for NHS trusts.* https://www.england.nhs.uk/wp-content/uploads/2022/04/Workforce-Race-Equality-Standard-report-2021-.pdf
25. NHS England (2022d). *Workforce Disability Equality Standard 2021 data analysis report for NHS trusts and foundation trusts.* https://www.england.nhs.uk/wp-content/uploads/2022/05/Workforce-Disabilty-Equality-Standard-2021-data-analysis-report-NHS-trusts-foundations-trusts.pdf
26. Shembavnekar, N. (2020). *The adult social care workforce in London.* Health Foundation. https://www.health.org.uk/news-and-comment/charts-and-infographics/the-adult-social-care-workforce-in-london
27. Skills for Care (2021). *Social Care Workforce Race Equality Standard (SC-WRES).* https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Supporting-a-diverse-workforce/Workforce-Race-Equality-Standard.aspx#:~:text=The%20initial%20phase%20of%20the%20Social%20Care%20Workforce,address%2C%20evidence%20and%20make%20progress%20in%20race%20equality.
28. Skills for Care (2022). *The State of the adult social care sector and workforce in England 2022.* https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2022.pdf
29. Palmer, W., Rolewicz, L., Hemmings, N., & Appleby, J. (2021). *Untapped? Understanding the mental health clinical support workforce*. Nuffield Trust. https://www.nuffieldtrust.org.uk/files/2021-08/clinical-support-workers-web.pdf
30. Public Health England (2020). *Disparities in the risk and outcomes of COVID-19.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_

data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

31. Rolewicz, L., Palmer, B., & Lobont, C. (2022). *The NHS workforce in numbers.* Nuffield Trust. https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers#2-how-diverse-is-the-nhs-workforce
32. West, M., Dawson, J., & Kaur, M. (2015). *Making the difference: diversity and inclusion in the NHS.* The King's Fund. https://www.nwpgmd.nhs.uk/sites/default/files/Making%20the%20difference%20diversity%20and%20inclusion%20in%20the%20NHS%20pdf.pdf

Search for interventions:

1. Care Quality Commission (2018). *Equally outstanding Equality and human rights – good practice resource.* https://www.cqc.org.uk/sites/default/files/20181010_equally_outstanding_ehr_resource_nov18_accessible.pdf
2. Hemmings, N., Buckingham, H., Oung, C., & Palmer, W. (2021). *Attracting, supporting and retaining a diverse NHS workforce.* Nuffield Trust. https://www.nuffieldtrust.org.uk/files/2022-10/1636121852-nhs-workforce-diversity-web.pdf
3. Health Education England (2022a). *Diversity and Inclusion annual report 2021-2022.* https://www.hee.nhs.uk/our-work/diversity-inclusion/diversity-inclusion-annual-report-2021-22
4. Jarvis, D., & Reeves, P. (2017). *Enabling BME Nurse and Midwife Progression into Senior Leadership Positions*. NHS England. https://www.england.nhs.uk/wp-content/uploads/2017/12/enabling-bme-nurse-midwife-progression-into-senior-leadership-positions.pdf
5. Kapadia, D., Zhang, J., Salway, S., Nazroo, J., Booth, A., Villarroel-Williams, N., Bécares, L., & Esmail, A. (2022). *Ethnic Inequalities in Healthcare: A Rapid Evidence Review.* NHS Race & Health Observatory. https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf
6. Kent Community Health NHS Foundation Trust (unknown). *Work and Wellbeing Passport.* https://www.kentcht.nhs.uk/wp-content/uploads/2017/01/Work-and-wellbeing-passport.pdf
7. London Councils (unknown). *Race Inequality: Good Practice*. https://www.londoncouncils.gov.uk/node/38395
8. NHS England (2018). *NHS workforce race equality standard Quality improvement methodology; The journey of five NHS trusts*. https://www.england.nhs.uk/wp-content/uploads/2018/12/wres-quality-improvement-methodology.pdf
9. NHS England (2019b). *A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce*. https://www.england.nhs.uk/wp-content/uploads/2019/07/closing-the-ethnicity-gap.pdf
10. NHS England (2021b). *Supporting learning difficulties and disabilities apprenticeships.* https://www.nhsemployers.org/articles/supporting-learning-difficulties-and-disabilities-apprenticeships
11. NHS England (2021a). *Handbook: How to recruit and support disabled staff in the NHS.* https://www.nhsemployers.org/publications/how-recruit-and-support-disabled-staff-nhs

12. NHS England (2021c). *Case studies: COVID-19 shared learning from NHS trusts.* https://www.nhsemployers.org/case-studies/covid-19-shared-learning-nhs-trusts#c-table-of-contents__list-blackpool-teaching-hospitals-building-a-symbol-of-gratitude-2
13. NHS England (2021d). *Rest, rehydrate, refuel project.* https://www.nhsemployers.org/case-studies/rest-rehydrate-refuel-project
14. NHS England (2021e). *An inclusive approach to disability leave.* https://www.nhsemployers.org/articles/inclusive-approach-disability-leave
15. NHS England (2022e). *Case studies: Improving support for staff with caring responsibilities the Sheffield Teaching Hospitals way.* https://www.nhsemployers.org/case-studies/improving-support-staff-caring-responsibilities-sheffield-teaching-hospitals-way
16. NHS England (2022f). *Article: Health and wellbeing conversations.* https://www.nhsemployers.org/articles/health-and-wellbeing-conversations
17. NHS England (2022g). *Guidelines: NHS health passport.* https://www.nhsemployers.org/publications/nhs-health-passport
18. NHS England (2022h). *Supporting disabled staff in the workplace.* https://www.nhsemployers.org/articles/supporting-disabled-staff-workplace
19. Ross, Sh., Jabbal, J., Chauhan, K., Maguire, D., Mandip, R., & Dahir, S. (2020). *Workforce race inequalities and inclusion in NHS providers.* The King's Fund. https://www.kingsfund.org.uk/sites/default/files/2020-07/workforce-race-inequalities-inclusion-nhs-providers-july2020.pdf
20. The Royal College of Midwives (2021). *We are Turning the Tide: RCM champions career development and support for Black, Asian, and minority ethnic midwives.* https://www.rcm.org.uk/media-releases/2021/october/we-are-turning-the-tide-rcm-champions-career-development-and-support-for-black-asian-and-minority-ethnic-midwives/
21. Welsh Government (2020a). *Launching risk assessment to support BAME workers.* https://www.gov.wales/launching-risk-assessment-support-bame-workers
22. Welsh Government (2020b). *Guidance: COVID-19 workforce risk assessment tool.* https://www.gov.wales/covid-19-workforce-risk-assessment-tool
23. West, M., Dawson, J., & Kaur, M. (2015). *Making the difference: diversity and inclusion in the NHS.* The King's Fund. https://www.nwpgmd.nhs.uk/sites/default/files/Making%20the%20difference%20diversity%20and%20inclusion%20in%20the%20NHS%20pdf.pdf

Appendix 1. Methods

This exploratory research project considered the following protected characteristics (based on the Equality Act 2010):

1. Age
2. Disability
3. Race
4. Religion or belief
5. Sex
6. Sexual orientation
7. Gender reassignment
8. Marriage and civil partnership
9. Pregnancy and maternity (and paternity)

Phase 1: Desk-based research

Relevant websites were systematically explored identifying metrics to monitor and assess how diverse the health and care workforce is.

Two types of documents were included in this desk-based research: guidelines/standards and reports/documents. Guidelines/standards were reviewed to identify recommendations for relevant metrics. Reports/documents were deemed to be relevant if explored workforce diversity in health and care. The aim of looking through relevant reports/documents was to (i) learn about what organisations measure and explore and extract relevant monitoring measures, (ii) understand what data are used and (iii) understand potential gaps. Documents which provided just an overview of demographic characteristics of staff (without any comparisons) or provided an overview of findings that were reported in other documents (primary sources) identified through this review were not included in this exploratory study.

The list of explored websites: Health Foundation, King's Fund, Nuffield Trust, NHS Employers, NHS England, Health Education England, NHS Race & Health Observatory, Skills for Care, UK Parliament (House of Common Library, House of Lords Library, Bridging research and policy, Health and Social care Committee), Department of Health and Social Care, Care Quality Commission, UK Health Security Agency, The Equality and Human Rights Commission, Local Government Association, Greater London Authority, UK Research and Innovation, Institute of Health Equity, Faculty of Public Health, documents provided by Office for Health Improvement and Disparities. Sources considered as relevant if published in 2015 or later.

The search strategy was to identify relevant sections of the website (e.g., publications/reports/guidelines; workforce, Equality Diversity Inclusion and/or health and social care) and review all documents under these sections. If none of these sections were available (or were too broad) the key words were typed in the search engine, such as "equality", "diversity", "disparities", or "workforce". The strategy depended on the website. For example, all documents were reviewed on

the Local Government Association website in the section “Publications” choosing “Workforce”; all documents were reviews on the Nuffield Trust website, section “Workforce”.

In total three guidelines/standards and 29 documents were deemed relevant.

The relevant information was extracted from guidelines/standards and reports/documents. The findings then were mapped out grouping them into the four categories representing the key workplace processes/aspects: workforce overview/pay, recruitment/selection, promotion/progression, work experience/retention. Each category consists of measures that could be used for monitoring and exploration purposes. The extracted information from each document is provided in Supplementary material 1. *Note*: in cases where reports are extensive just examples for each sub-category are provided.

Phase 2: Online searches for interventions

This Phase was to collect examples of initiatives to address inequalities in the workforce. It used the “framework” of work systems/experiences developed in Phase 1, i.e., looked at the same areas of workplace processes/aspects. The two types of searches were conducted: (i) reports/documents identified as relevant through the desk-based research (Phase 1) were explored; however, most of the documents included recommendations which are not implemented yet; (ii) an online search typing relevant key words (e.g., “health”, “social care”, “workforce”, “addressing inequalities” and/or specific area, like “bullying” or “recruitment”). These reports and websites were explored identifying interventions that have already been implemented/tested or if no concrete examples of implemented initiatives were found recommendations that were specific/detailed were presented. At least one intervention was identified for each metrics group and, if information was available, more details regarding evidence and challenges were extracted.

Phase 3: Interviews

Discussions (semi-structured interviews) were conducted with 11 stakeholders. To collect diverse views and experiences, stakeholders from various organisations were invited to participate: Health Education England, NHS England, Department of Health and Social Care, UK Health Security Agency, NHS trusts, Greater London Authority, Local Authorities, Association of Directors of Public Health, universities in London. Stakeholders included Public Health consultants and registrars (all involved in diversifying recruitment and/or retention activities), people officers, those working specifically in EDI areas, human resources, or workforce/organisational development roles.

All stakeholders signed a consent form agreeing to take part in this exploratory research study. The interviews focused on:

- Reflections on metrics to monitor how equitable the workforce is (problematic areas, what is missing).
- Examples of interventions/initiatives and their effectiveness.
- Which measures and interventions should be prioritised, why and how to achieve that.