Supplementary material 1. Key findings.

Table 1. Standards (*Note*: wording is not amended).

Resource	Metrics
NHS England (2022a). Disability	Workforce metrics: 1. Percentage of staff in AfC (Agenda for Change) paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. 2. Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. 3. Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. National NHS Staff Survey metrics: 1. Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse (patients, managers, colleagues). 2. Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. 3. Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. 4. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. 5. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work. 6. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. NHS Staff Survey and the engagement of Disabled staff: 1. The staff engagement score for Disabled staff, compared to nondisabled staff. 2. Have you taken action to facilitate the voices of Disabled staff in your organisation to be heard? Board representation metric: 1. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce.
NHS England (2022b). Race	Workforce metrics: 1. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce (including pay).

	2. Relative likelihood of staff being appointed from shortlisting across all posts. 3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. 4. Relative likelihood of staff accessing non-mandatory training and CPD. National NHS Staff Survey metrics: 1. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. 2. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. 3. Percentage believing that the trust provides equal opportunities for career progression or promotion. 4. In the last 12 months have you personally experienced discrimination at work? (from manager/team leader or other colleagues). Board representation indicator: 1. Percentage difference between the organisations' Board membership and its overall workforce.
Skills for Care (2021). Race	1. Percentage of staff from ethnic minorities across pay bands compared with the percentage of staff in the rest of the workforce. 2. Comparative rate of staff from ethnic minorities being appointed from shortlisting. 3. Comparative rate of staff from ethnic minorities entering a formal disciplinary process. 4. Comparative rate of staff from ethnic minorities entering a fitness to practice process. 5. Comparative rate of staff from ethnic minorities accessing funded non-mandatory CPD. 6. Percentage of staff from ethnic minorities experiencing harassment, bullying or abuse from service users, relatives or the public in last 12 months. 7. Percentage of staff from ethnic minorities experiencing harassment, bullying or abuse in the last 12 months from managers, colleagues or senior staff. 8. Comparative rate of employees from ethnic minorities leaving the organisation during the last year. 9. Composition of the organisations' senior management.

Table 2. Documents (*Note*: the key findings are extracted from the documents leaving original terms and wording; a minimum reworded/rephrasing).

Resource	Metrics/key findings
NHS England (2022d)	**Overview/Pay** <u>Representation/Pay gap:</u> • 3.7% (52,007) of staff working for trusts declared a disability and since 2019 this has increased by 0.6 percentage points (equating to a headcount increase of 12,823). • In 2021, over half of trusts (128 out of 217 – 59%) have five or fewer disabled staff in senior position. • Declaration rates in the lowest pay band cluster (under band 1 to band 4) compared to the next cluster (bands 5 to 7) are very similar (4.1%). However, there is then a decrease as the pay bands increase across all employment types and salary bands, to 2.8% at the highest pay band cluster. • Declaration rates at individual trusts range from 0.9% to 13.4%. <u>Board membership</u>: • Overall, 3.7% of board members have declared a disability, the same figure as the overall workforce. 58.5% of trusts have no board members who have declared a disability. In 2019, there were 63 board members who declared a disability; this has nearly doubled to 121 in 2021. **Recruitment/Selection** <u>Shortlisting/Appointments:</u> • The overall relative likelihood ratio of 1.11 (a result suggesting the difference is not statistically significant) was found for the disability staff. The overall relative likelihood has changed very little over three years. **Promotion/Progression** <u>Promotion:</u> • In 2020, 78.4% of Disabled staff believed that they had equal opportunities for career progression or promotion. This is 6.6 percentage points lower than the figure for non-disabled staff. <u>Disciplinary/Capability process:</u> • Disabled staff are nearly twice as likely to enter the capability process as their non-disabled colleagues (1.91 likelihood). **Work experience/Retention** <u>Harassment, bullying, abuse, discrimination:</u> • The disparity between Disabled and non-disabled staff experiencing harassment, bullying or abuse from the public, managers and colleagues has remained around 6.5-9% since 2016. <u>Engagement:</u> • The staff engagement score has been consistent over five years, with Disabled staff scoring just under 0.5 less than their non-disabled colleagues.

	• Six trusts reported that no actions had been taken to facilitate the voices of Disabled staff to be heard - an improvement from 16 trusts reporting this in 2019, 34 in 2018. <u>Voicing/Reporting concerns:</u> • The level of reporting is largely unchanged over five years, with very little difference between Disabled and non-disabled staff. <u>Feeling valued:</u> • Over a third of Disabled staff feel valued by their employer: this compares to just over half of non-disabled staff (11% gap). <u>Adjustments:</u> • Nearly one in four Disabled staff in the NHS do not believe that they are getting the necessary equipment and support needed for them to perform their role as effectively as possible. <u>Presenteeism:</u> • Nearly a third of Disabled staff say that they have felt pressure from their manager to come to work, despite not feeling well enough. The gap between Disabled and non-disabled staff has declined slowly from 10% in 2017 to 8.2% in 2020, but the gap remains significant.
NHS England (2022c)	**Overview/Pay** <u>Representation/Pay gap:</u> • 10% (1,752) of staff at AfC pay bands 8c and above were from a BME background. This is significantly lower than the 22.4% of all BME staff in the NHS. The total number of BME staff at very senior manager level has increased by 48.3% since 2018 from 201 to 298. <u>Board membership:</u> • 12.6% of board members in NHS trusts were from a BME background. This is an improvement from 10.0% in 2020. **Recruitment/Selection** <u>Shortlisting/Appointments:</u> • White applicants were 1.61 times more likely to be appointed from shortlisting compared to BME applicants. In 71.5% of NHS trusts, white applicants were significantly more likely than BME applicants to be appointed from shortlisting. **Promotion/Progression** <u>Training</u>: • White applicants were 1.14 times (within the non-adverse range) more likely to access non-mandatory training and continuous professional development (CPD) compared to BME staff. <u>Promotion:</u> • The proportion of BME staff that believed their trust provides equal opportunities for career progression or promotion decreased in 2020 (69.2%) compared to 2019 (71.2%). • There was 18.1% difference between BME and white staff in believing that their trust provides equal opportunities for career progression or promotion. • 57.5% of staff from a black background believed their trust provides equal opportunities for career progression or promotion.

	• As a profession, ambulance staff (operational) were least likely to believe that their trust acts fairly with regard to career progression and promotion (70.7%), with the lowest levels of belief again amongst BME women (62.1%) and BME men (60.5%) in this profession. <u>Disciplinary/Capability process:</u> • BME staff were more than 1.25 times more likely to enter the formal disciplinary process at 50.0% of trusts. **Work experience/Retention** <u>Harassment, bullying, abuse, discrimination:</u> • For 72.3% of trusts, a higher proportion of BME staff compared to white staff experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. • 28.9% of BME staff experience harassment, bullying or abuse from patients, relatives or the public in comparison to 25.9% of white staff. BME women were most likely to have experienced harassment, bullying or abuse from patients, their relatives (29.5%) or the general public or staff (28.6%) in the last 12 months. • 36.2% of staff from an "other" Asian background (i.e., other than Bangladeshi, Chinese, Indian, or Pakistani) experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. • Ambulance (operational) staff (54.2%) experienced the highest level of harassment, bullying or abuse from patients, relatives or the public in the last 12 months. • 16.7% of BME staff had personally experienced discrimination at work from a manager, team leader or other colleagues (6.2% of white staff). 19.4% of staff from a black background and 20.5% of black women in particular, had experienced discrimination from other staff in last 12 months.
NHS England (2019)	**Overview/Pay** <u>Representation/Pay gap:</u> • BME staff representation ranged from 5.5% at NHS Business Services Authority, to 19.9% at NHS Improvement. • Seven of the eight organisations had BME staff representation that was lower than the national average for NHS trusts (19.1%). Only NHS Improvement had BME representation (19.9%) that is higher than the NHS trusts average. • For Health Education England, NHS Blood and Transplant, NHS Business Services Authority, NHS England and NHS Improvement, BME staff were over-represented in the support bandings (AfC bands 1 - 4) and under-represented in the senior (AfC bands 8a - 9) and very senior management (VSM) bands. • Seven organisations saw the number of BME staff increase from 2017 to 2018. Only NHS Business Services Authority had a decrease in the number of BME staff in the organisation, from 6.2% to 5.5%. <u>Board membership:</u> • In the eight organisations, from 0% to 16.7% (0-2 members) of board members were BME staff. **Recruitment/Selection** <u>Shortlisting/Appointments:</u>

	• For all eight organisations, white applicants were relatively more likely to be appointed from shortlisting compared to BME staff. The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants ranged from 1.15 for Care Quality Commission to 3.11 for NHS Improvement. • For six of the eight organisations the relative likelihood of white applicants being appointed from shortlisting compared to BME applicants was higher than the NHS trusts average of 1.45. **Promotion/Progression** <u>Training:</u> • For four out of six organisations, BME staff were more likely to access non-mandatory training and CPD compared to white staff. • The percentage of staff accessing non–mandatory training and CPD varied significantly, ranging from above 95% for staff at Care Quality Commission to 17.3% for white staff at NHS Blood and Transplant. <u>Promotion:</u> • BME staff were less likely to believe that their organisation provided equal opportunities for career progression or promotion (difference varied from 2% to 25.8%). • Four out of five organisations saw a decrease in the percentage of staff believing that their organisation provided equal opportunities for career progression or promotion. This was for both white and BME staff. <u>Disciplinary/Capability process:</u> • For NHS Blood and Transplant, NHS Digital and NHS England, BME staff had a higher relative likelihood of entering the formal disciplinary process compared to white staff. For Care Quality Commission, NHS Business Services Authority and Public Health England, white staff had a higher relative likelihood of entering the formal disciplinary process compared to BME staff. **Work experience/Retention** <u>Harassment, bullying, abuse, discrimination:</u> • BME staff are more likely to have experienced harassment, bullying or abuse from staff compared to white staff for all organisations that provided data for this indicator (difference varied from 1% to 7%). • Compared to the NHS trust average, a lower percentage of staff across all national healthcare organisations reported experiencing harassment, bullying or abuse from staff in the last 12 months – this was true for both white and BME staff. • BME staff were more likely to report having personally experienced discrimination at work from a manager, team leader or other colleagues (difference varied from 3.8% to 7%).
Rolewicz et al. (2022). Nuffield Trust	**Overview/Pay** <u>Representation/Pay gap:</u> • One quarter (25%) of NHS staff are of Asian, black or another minority ethnicity, compared to 13% of all working-age adults in the UK. However, these proportions vary considerably by staff group and staff grade. Across nurses and health visitors, ambulance staff and scientific, therapeutic and technical staff, Asian, black, mixed and those categorised as any other ethnic minority are, in most cases, less likely to hold a post at Agenda for Change band 6 or above (equivalent to experienced paramedics and clinical psychology trainees)

	compared to their white colleagues. This pattern is particularly evident for bands 8 and above, where nurses with a reported black ethnicity are half as likely to work at this grade, and Asian nurses and those with an ethnicity categorised as "other" were only a quarter as likely to hold senior nurse positions.
Hemmings et al. (2021). Nuffield Trust	**Overview/Pay** <u>Representation/Pay gap:</u> • Male nurses with nine years' continuous service are twice as likely to have progressed up two pay bands (41%) than female nurses (20%) • The proportions of disabled, Black or Black British, or Muslim staff in the highest grades (Bands 8d and 9) are statistically significantly lower than for all staff ('scientific, therapeutic and technical staff' within 'professionally qualified clinical staff). • Roughly half of trusts had more Black and minority ethnic support staff and middle-grade staff (49% and 55% respectively) than patients, although their senior staff were more diverse than patients in just a third (33%) of organisations. However, the variation between trusts is vast. **Recruitment/Selection** <u>Shortlisting/Appointments:</u> • Those with White ethnicity were more likely than those from minority ethnic groups to be both shortlisted and appointed from the shortlist. Bangladeshi, African or White and Black African ethnicities appeared to have lower success rates. Candidates with Bangladeshi ethnicity are, on average, half as likely to be appointed from an NHS shortlist than a White British person; The likelihood of Sikhs, Muslims and Hindus, male candidates, bisexual being shortlisted or appointed are all significantly below the average; The average-or-higher likelihood of people with a physical impairment, mental health condition, learning disability or difficulty, or longstanding illness being shortlisted, but the far lower likelihood of actually being appointed from the shortlist. Those with criminal conviction was also less likely to be appointed from the shortlist. <u>Representation in education:</u> • Those from the least affluent socioeconomic backgrounds are half as likely to study undergraduate physiotherapy than children's nursing. • Minority ethnic students are around four times less likely than other students to secure a place on an undergraduate physiotherapy course (12%) than a diagnostic radiology course (47%). Physiotherapy also has the highest levels of male participation (36%) and the lowest levels of staff from a lower socioeconomic class (just 22% fall within Index of Multiple Deprivation quintiles 1 and 2). Stark differences are also apparent for other characteristics such as gender, with low participation among men in nursing and midwifery in particular. **Promotion/Progression** <u>Training:</u> • Black and minority ethnic staff are less likely to access training. <u>Promotion:</u> • Black and minority ethnic staff are less likely to believe their trust provides equal opportunities for career progression or promotions.

	Disciplinary/Capability process: • Black and minority ethnic staff are more likely than other staff to enter a formal disciplinary process. **Work experience/Retention** Harassment, bullying, abuse, discrimination: • Black and minority ethnic staff are more likely than other staff to experience harassment, bullying or abuse; older employees are less likely than age 31-40 to experience discrimination from patients/service users, their relatives or other members of the public; those with religious believes are more likely to experience discrimination than those without religion. Voicing/Reporting concerns: • Those who reported their gender as "prefer not to say" are less likely to voice concerns about unsafe clinical practice than male staff. Job satisfaction: • Satisfaction with the following: the support from managers, the extend organisations value their work, the level of pay, the 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. Wellbeing: • Those with long term condition(s) are more likely to feel unwell as a result of work-related stress in comparison to those with no such condition. Adjustments: • A recent survey of deaf health care professionals during the pandemic found that only 2 in 5 had their reasonable adjustments met, 17% had to be removed from clinical roles due to a lack of reasonable adjustments and a third felt they would need to switch career if improvements were not made (Grote and others, 2021). Unfavourable work conditions: • Black and minority ethnic staff were more likely than other staff to work in a Covid-19 specific ward or area; nearly half (47%) of Black and minority ethnic NHS staff have worked in Covid-19 roles compared with less than a third (31%) of all staff. **Suggested additional indicators from interviews and authors:** • Surveys for new hires at induction, at three months and at six months to understand the extent to which organisational values are lived in practice. • Staff's reasons and motivations for applying for jobs. • Focus groups to gain a deeper insight into harassment, bullying and discrimination. • Exit interviews; staff focus groups; speak-up ambassadors; staff-side chairs; staff networks.
Palmer et al. (2021). Nuffield Trust	**Overview/Pay** Representation/Pay gap:

	• *Age*. More than a quarter (27%) of the mental health support workforce were aged 50–59, similarly for support staff working outside of mental health provision (26%). That being said, there were still a large proportion of people aged up to 29 years old in both, mental health support staff groups and those in other settings (both 23%). This age group also saw the biggest increase in staff in the year to June 2020 (+37% for the mental health support workforce and +26% for support staff working outside of mental health). Progression is far higher in younger age groups than older age groups with, for example, mental health clinical support workers who are on band 2 and under the age of 25 some four times as likely to progress bands than those aged 50–54. • *Gender*. Mental health workforce is still predominantly female, but male members of staff account for a higher proportion of clinical support staff in mental health services compared with other hospital and community services. More than a quarter (27%) of support staff working in mental health services are male, compared with just 17% of non-mental health support staff. Across all 22 main staff groups, median basic pay per full-time equivalent was higher for women than for men in support to doctors, nurses and midwives (2%) and support to scientific, therapeutic and technical staff (4%). In comparison, the equivalent figure for senior managers was 14% in favour of men (Appleby and others, 2021). • *Ethnicity*. Compared with all NHS staff, the mental health support workforce have a greater number of Black/Black British staff. There is more than twice the level of Black/Black British representation in mental health (14%) compared with the demographics of non-mental health staff (6%) and the whole NHS workforce (6%). However, more Asian/Asian British staff make up the support workforce in non-mental health settings (8%) compared with the proportion working in mental health (6%). Across the NHS mental health sector, the proportion of minority ethnic board members has increased to 11.9%, the highest proportion of all NHS sectors. There were no obvious differences in progression between different ethnicities – that is, the probability of moving up pay bands. Across staff working in a supporting role to doctors, nurses and midwives (in mental health and other settings), there is an ethnicity pay gap in favour of white staff. • *Disability*. Around one in 18 mental health support staff (6%) declared a disability, which is slightly higher than for those working outside of mental health (4%). These levels are much lower than the overall proportion of employed working-age adults in the UK with a disability (19%) (Powell, 2020), although it is not clear how comparable these figures are, given differences in how the data are collected. • *Religion*. Christianity was the biggest faith, declared by 43% of mental health support staff, and atheism was the second largest group (14%). These proportions were almost identical to support staff working in non-mental health settings. • *Sexual orientation*. 4% of mental health support staff and 3% of non-mental health support staff described their sexual orientation as LGBTQ+, which suggests greater LGBTQ+ representation in the mental health support workforce (compared with 3% in the NHS overall and 3% nationally). <u>Board membership</u> • *Disability*. Mental health trusts had the highest overall percentage of disabled board members compared with other trust types, although this remains at just 3%. **Work experience/Retention** <u>Adjustments:</u>

	• *Disability*. Mental health trusts reported the highest proportion (77%) of disabled staff who felt their employer made adequate adjustments to enable them to carry out their work compared with other trust types.
Appleby & Schlepper (2019). Nuffield Trust	**Overview/Pay** <u>Representation/Pay gap:</u> • The median gender pay gap for directly employed staff in the English NHS in December 2017 was 8.6% in favour of men, equivalent to an earnings gap of £207 over that month. • Within staff groups, gender pay gaps range from 3.7% in favour of women for support to scientific and technical staff to 16.2% in favour of men for central functions staff. Women tend to be on lower pay bands within the same occupation. • For the 12% (around 135,000) of NHS staff not covered by Agenda for Change – who are mainly doctors and some managers – the overall pay gap is 47% in favour of men. • For younger age groups the pay gap favours women, but this reverses between the ages of 30 and 34, and continues to widen across older age groups. The gender pay gap for women and men aged between 55 and 59 is 29.1% in favour of men. • The gender pay gap varies by ethnicity and is in favour of men for most ethnic groups. Asian/Asian British and Chinese women experience the largest gender pay gap at 21.3% and 20.9% respectively, followed by those of Mixed Ethnicity (13.5%), White women (6.1%) and women of Any Other Ethnic background (2.1%). Only for Black/Black British staff is it in favour of women. • 80.9% of the difference between men's and women's mean pay can be statistically explained by group differences in the following characteristics: age, ethnicity, staff group and primary area of work. Nearly a fifth of the gap remains unexplained. Even if women had, on average, the same characteristics as men (in terms of the factors in our analysis), they would earn less.
NHS Employers (2021)	**Overview/Pay** <u>Representation/Pay gap:</u> • During Q1 (2019/20) there were 12,220 apprenticeship starts across the health, public services and care areas: 70% were female and 30% male, almost two-thirds (65%) were aged 25+, and 14.2% who disclosed and identified as being from an ethnic minority, of those 9.7% were female and 4.5% were male. As a comparison, for apprenticeship starts across all sectors in England for 2018/19 there were almost equal numbers of women and men, with slightly more starts by women at 50.1% and 49.9% by men, 46% were by people aged 25+, and the overall number of learners who declared were from an ethnic minority was 12.3%. • There were 3,540 starts in apprenticeship standards relevant to health. Of those who declared: 80% (2830) were female and 20% (710) were male, 75% were aged 25+, and 9% (320) identified as being from an ethnic minority (of those 7% were female and 2% were male). • 79% of employers said their apprenticeship workforce reflects the community they serve while 21% reported not at all or they "don't know". **Recruitment/Selection** <u>Shortlisting/Appointments:</u>

	• Almost a third (30%) of employers engaged in this project said that they do not take positive action to support particular groups when recruiting as they were unsure or worried as to whether it would be seen as positive discrimination. • There are four prominent characteristics where employers take specific steps to attract people: Race (18%), Age (14%), Disability (13%), and Gender (8%).
Einarsdóttir et al. (2020)	**Overview/Pay** <u>Participation in staff networks:</u> • Minority groups are more likely to be aware of staff networks. For example, significantly more LGBT+ employees are aware of staff networks in their trust (74%) than heterosexual/cisgender employees (44%). A similar pattern was evident for ethnic minorities (66% vs 45% employees from a white background). • Men were more likely than women to be involved in staff networks, but there was no particular age profile. • Employees who are involved in staff networks are more likely to have a higher educational level (at least a first degree) than those who are not involved in staff networks. • Individuals in higher paid roles are more likely to be in a staff network.
Health Education England (2022a)	**Overview/Pay** <u>Representation/Pay gap:</u> • 76.1% of HEE staff in the lowest quartile are women, compared with 51% in the highest quartile. The overall distribution of male and female staff has remained largely consistent since HEE was first established in 2013. The difference between the median hourly rate of men/women was 14.61% in 2021/22 (in 2020/21 the difference was 27.78%). The overall difference in hourly pay is primarily driven by a greater proportion of men in the highest quartile compared to the overall population. In turn, this is also affected by the higher number of men than women within Medical and Dental roles (highest paid roles). • The overall BME representation within HEE was 24.5% in 2022, compared to 22.1% in 2021. • Colleagues with declared disabilities make up 7.5% of the workforce in 2022, compared with 7.1% the previous year. **Recruitment/Selection** <u>Shortlisting/Appointments:</u> • White applicants are 1.43 times more likely to be appointed from shortlisting across all posts than BME applicants. • Non-disabled applicants are 1.43 times more likely to be appointed from shortlisting across all posts than disabled applicants. Whilst this is an improvement from the previous year (1.53), it is still higher than the wider NHS (1.2). **Promotion/Progression** <u>Training:</u> • White staff are 1.25 times more likely to access non-mandatory training and CPD than BME staff. <u>Promotion:</u>

	• In 2020, 59.6% of BME staff believe that HEE provides equal opportunities for progression or promotion (85% of white colleagues). The average results for BME colleagues in 2020 Trusts and CCGs were 71.2% and 40.7%, respectively. • In 2021, 69.1% of disabled staff believe that HEE provides equal opportunities for career progression or promotion (over 14% fewer than those declaring no disparities; significantly lower than the figure reported across the NHS at large – 78.2%). <u>Disciplinary/Capability process</u> *(no comparison and therefore not in Table 2):* • No disabled staff have entered the formal capability process. **Work experience/Retention** <u>Adjustments:</u> • 81.4% of disabled staff say HEE has made adequate adjustments to enable them to carry out their work. **Suggested additional indicators:** • Developed the Cultural Barometer. A self-assessment diagnostic tool that can be used to stimulate reflection and understanding of the culture in a team. • Bullying and harassment anonymous reporting tool. ***Highlight***: • Evaluation of the existing process, including feedback from staff networks and colleagues leaving HEE identified significant barriers for those with protected characteristics to using the process, including, a failure to be offered an exit interview, a lack of trust in the current custodians of the process and a serious lack of belief that any feedback given will be used in any meaningful way.
Health Education England (2022b)	**Promotion/Progression** <u>Training:</u> • 44% of people from Black and 27% from Asian backgrounds felt that they had reduced opportunities for training because of their ethnicity (in comparison to 3% White British). <u>Promotion:</u> • 94% of people from White ethnic backgrounds vs 58% from Black backgrounds felt that their organisation had acted fairly regarding promotions and progression over the past 12 months, regardless of people's ethnicity. Whereas people from Black and Asian backgrounds (50% and 33%, respectively) were more likely to believe that their ethnicity had reduced their opportunities for promotion and training over the past 12 months (in comparison to 4% White British). **Work experience/Retention** <u>Harassment, bullying, abuse, discrimination:</u> • Half of those taking part said that, in the past year, they had been harassed or discriminated against at work based on their personal characteristics (49%). 1 in 3 of those surveyed reported racial discrimination or harassment from patients in the past 12 months and about 1 in 5 from staff they worked with (18%).

	• 12% left or considered leaving their role last year due to racial discrimination or harassment. Amongst people from Black backgrounds, the figure was 1 in 4 (27%), and 1 in 7 people from Asian backgrounds (15%). • There was a trend towards those from minority ethnic groups being more likely to say they had experienced discrimination based on age, gender and religion than those from White British or Irish groups. • Half of all people from Black ethnic backgrounds (53%) and 4 out 10 people from Asian backgrounds felt they had been racially discriminated against or harassed by patients (45%). The difference was even greater regarding perceived racial discrimination and harassment by colleagues or managers, with 4 out of 10 Black people describing this (42%) compared to 2 in 10 of those surveyed overall (18%). • Two thirds of recent incidences of racial discrimination or harassment involved subtle or underhand comments or actions, rather than overt or confrontational behaviour. This may make it more difficult for people to question, address or complain about. This led some to feel that they were working in a 'hostile environment' or unsupportive culture, where negative attitudes were part of 'business as usual' and often not openly challenged. <u>Voicing/Reporting concerns:</u> • 1 in 3 people who said they had experienced racial discrimination or harassment in the past year said they had reported it. Of these only 1 in 10 said it had been dealt with well from their perspective. • People 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, though this was based on small numbers. • Although one third of Black people who experienced racial discrimination or harassment said they had reported it, most did not feel that the issue had been dealt with well. People from Asian (53%) and other (59%) ethnic minority backgrounds were less likely to have reported the racial discrimination or harassment, most commonly because they said they did not think anything would be done. • Over half of people from minority ethnic groups knew where to get help (e.g., 61% of Black staff in comparison to 89% White staff). • Nearly half of people from minority ethnic groups felt confident that something would be done if they reported an issue (e.g., 47% of Black staff in comparison to 87% White staff). • People from White backgrounds were more likely than Black or Asian people to say that they felt secure to raise issues (e.g., 46% of Black staff in comparison to 87% White staff).
Shembavnekar (2020). Health Foundation	**Overview/Pay** <u>Representation/Pay gap:</u> • London had a significantly more diverse adult social care workforce than the rest of England in 2018/19 in terms of both ethnicity (67% being Black and minority ethnic staff relative to the England average of 21%) and nationality (25% non-EU (non-British) and 14% EU, relative to the corresponding England averages of 10% and 8% respectively).

	• Ethnic minority groups accounted for nearly three-quarters (72%) of direct care roles in the capital, with the West Midlands being a distant second at 23%. • Skills for Care data indicate that women account for 81% of the care workforce in London, which is very similar to the corresponding figure for England (83%). • 94% of London's care workforce is aged 25 and over (relative to 91% across England).
Charlesworth (2017). Health Foundation	**Overview/Pay** <u>Representation/Pay gap:</u> • In 2016, the GP workforce consisted of more females under 50 and more male over 50. With an ageing male workforce (more than two-fifths of male GPs are aged 50 or over) the number of leavers is likely to rise further. • Women make up an increasingly large proportion of the GP workforce, rising from 43% in September 2015 to 47% in March 2017, but are more likely to work part time so the replacement number required is even greater. About half of all male GPs work the equivalent of full time, which compares with a fifth of female GPs. <u>Representation in education:</u> • In England in 2017, nursing student applications from those aged 20–24 and 25–29 fell by 23% and 31% respectively. This may reflect the reduction in numbers of potential students in the age groups that nursing education has traditionally recruited from, because a growing proportion of this population has already been through higher education.
West et al. (2015). The King's Fund	**Work experience/Retention** <u>Harassment, bullying, abuse, discrimination:</u> • The highest levels of discrimination are reported in ambulance trusts (19.7%) and the lowest levels are in 'other' trust types (5.3%) followed by community trusts (8.9%). • Reported discrimination rates are higher in London (16.9%) than elsewhere (under 12.5%). • Women are less likely to report experiencing discrimination than men (10.8% vs 14.3%). • Older staff are less likely to report experiencing discrimination than younger staff. Discrimination is experienced more by people towards the middle of the age range - 13.6% and 13.2% of those in the 21-30 and 31-40 brackets report discrimination. • Reported levels of discrimination are highest for Black employees (30.9%) and lowest for White employees (9.5%); all other non-White groups are far more likely to report experiencing discrimination than White employees. 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. • For discrimination on the basis of religion, Muslim staff experience a far higher rate of discrimination than any other religion, and all religions have a higher rate than those of no religion (after controlling for other factors).

	• Discrimination is considerably higher for non-heterosexual groups (20.9%) than for heterosexual staff (12.3%). LGBTQ+ community staff are 1.76 times more likely to experience discrimination than heterosexual staff. • The odds of experiencing any discrimination among disabled staff are more than twice what they are for non-disabled staff (2.15).
Kapadia et al. (2022). NHS Race & Health Observatory	**Overview/Pay** <u>Representation/Pay gap:</u> • Ethnic minority nurses and midwives had spent longer working at the entry-level grade (Band 5) over the previous 10 years and less time working at more senior grades (Bands 6 and 7) (Johnson et al., 2021). • Ethnic minority GPs had lower income (6.9% less) but worked similar hours to White GPs (Morris et al., 2011). **Recruitment/Selection** <u>Shortlisting/Appointments:</u> • Ethnic minority nurses and midwives had to apply for a higher number of posts before gaining their first post at their current grade (White mean=0.81, ethnic minority mean=1.22; t=-2.28, p=0.026) (Johnson et al., 2021). **Promotion/Progression** <u>Training:</u> • Ethnic minority nurses and midwives were significantly less likely to have received professional training in the previous year (White rate=66.6%, ethnic minority rate=53.0% (Chi squared test statistic=5.90, p=0.015) (Johnson et al., 2021). <u>Promotion:</u> • There were no ethnic inequalities in the perceived level of managerial support for progression and ethnic minority staff were as likely to have applied for promotion in the previous year as White nurses and midwives. For those who had applied for promotion in the previous year, there was no significant ethnic difference in their success rate (Johnson et al., 2021). **Work experience/Retention** <u>Harassment, bullying, abuse, discrimination:</u> • Nurses perceived being ignored by patients and their relatives as racism as they thought that it implied that Black nurses were incompetent. Black African nurses were prevented from performing some procedures even when they were competent. Nurses said that allocation of responsibilities reflected managers' lack of confidence in Black African Nurses (Likupe & Archibong, 2013). • Black (OR=3.08, 95% CI=2.00–4.74) and Asian (OR=1.95, 95% CI=1.23–3.08) staff (London-based healthcare practitioners) were more likely to say they had experienced discrimination compared to their White counterparts (Rhead et al., 2021). • Ethnic minority nurses and midwives were three times as likely to have experienced discrimination in the workplace (OR=3.04, 95% CI=1.68-5.54) (Johnson et al., 2019). • Nurses experienced of verbal harassment were higher among ethnic minority nurses compared to White nurses (but only for experiences of verbal harassment from managers and colleagues, not patients) (Deery, Walsh, & Guest., 2011). <u>Wellbeing:</u>

	• Rates of burnout were lower for the Asian Group (OR=0.74, 95% CI=0.60-0.91) but higher for staff reporting their ethnic background as 'Other' (OR=2.19, 95% CI=1.37-3.52), although there were no further details in the paper about which specific ethnic groups comprise this group (obstetricians and gynaecologists; Bourne et al., 2019). • Asian psychologists reported higher wellbeing scores (as measured by the Psychological Practitioner Workplace Well-being Measure (PPWWM) and Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS)) relative to all other ethnic groups (Summers et al., 2021). • Among pharmacists in Great Britain, relative to the White group, Indian, Pakistani, Asian Other and Mixed and Other (combined category) ethnic groups had greater problems maintaining a work life balance. There were no ethnic inequalities for Black and Chinese groups (Seston & Hassell, 2014). <u>Unfavourable work conditions:</u> • Covid-19 outcomes: • Ethnic minority frontline workers were nearly five times (4.88) as likely to report a positive Covid-19 test compared with a White general population reference group. The risk for ethnic minority frontline healthcare workers was also higher than for White frontline healthcare workers who had a risk of three and half times that of the White general population (HR=3.52, 95% Cl=3.48–3.56) (Nguyen et al., 2020). • Black (OR= 2.08, 95% CI=1.25 to 3.45, p=0.005) and Asian (OR=1.61, 95%CI=1.27 to 2.04, p<0.001) staff (clinical and non-patient facing roles who volunteered for SARS-CoV-2 antibody testing) were more likely to test positive for antibodies than White staff (Shorten et al., 2021). • Ethnic minority HCWs were more likely to report post-traumatic stress disorder (PTSD) symptoms compared with White HCWs (Gilleen et al., 2021). • There was a significant difference in mean total wellbeing scores during the pandemic across ethnic groups, with Black people reporting the highest scores [better wellbeing] (McFadden et al., 2020). • Impact of Covid-19: • Ethnic minority workers were more likely to be worried about Covid-19 related deaths in health care workers (HCWs) ('BAME': 76%, 'Non-BAME:' 63% (p<0.001) (Ali et al., 2021). • 47% of trainee doctors identifying as White reported receiving sufficient information on PPE, compared with 33% of those identifying as 'BAME/mixed ethnicity' (Norton et al., 2021). • Successful fit of protective equipment was less likely in all ethnic minority groups compared with White HCWs (Asian OR=0.47, CI=0.38–0.58, Black OR=0.54, Mixed OR=0.50, Other OR=0.53) (Carvalho et al., 2021). • Ethnic minority staff in senior roles were nearly four times as likely to be working in patient-facing roles as their White counterparts (OR = 3.83, 95% CI=1.05 to 13.77, p=0.04), suggesting that White HCWs in senior roles were less exposed than senior ethnic minority HCWs. Ethnic minority HCWs were twice as likely (OR = 2.68) as White HCWs to work in areas with Covid-19 cases (Kapilashrami et al., 2021).

Care Quality Commission (2022a)	**Overview/Pay** Representation/Pay gap: • Overall disabled representation has increased by 0.7 percentage point to 8.4%. • Current percentage of staff who have self-reported they are disabled on ESR (8.4%) is greater than the 3.5% of staff working for NHS Trusts who have self-reported having a disability on ESR, and the 4.7% of staff who have self-reported a disability in other ALBs. • Disabled staff continue to be underrepresented in the Exec grades, where there is also a higher number of "Not Stated" self-reporting of disability. • 3% of executive grade staff who self-reported a disability is similar to the NHS Trust's figure where 2.8% of Very Senior Managers have self-reported a disability. • Cluster 2 (Grade C, D, and E) saw an increase in representation, whilst the previously above-average represented Cluster 1 (Grade F) saw a decrease, bringing the figure in line with the organisational average. Board membership: • The overall percentage difference between Board and overall workforce is a negative figure (-8.3%) as there are no Board members who are disabled. 100% of the Executive team have self-reported not having a disability. However, 50% of Non-Executive members have not stated whether they have a disability or not. **Recruitment/Selection** Shortlisting/Appointments: • Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts was 1.197 (non-significant; similar to the NHS Trusts' figure of 1.20 but lower than the overall ALBs' figure of 1.28). The figure for disabled candidates' likelihood of being appointed from shortlisting compared to non-disabled candidates has improved since 2020 report (1.377). **Promotion/Progression** Promotion: • Disabled respondents are less likely to believe that CQC provides equal opportunities for career progression or promotion than non-disabled respondents (37.4% vs 53.2%). • Within the NHS report, 78.2% of disabled staff believed their trust provided equal opportunities for career progression or promotion, compared to 85.2% of non-disabled staff. • CQC's figures also score lower than other ALBs where across four ALBs (including CQC), 46.9% of disabled staff believe there are equal opportunities for progression (8.6 percentage points lower than non-disabled staff). Disciplinary/Capability process: • Relative likelihood of disabled staff entering process compared to non-disabled staff was 1.486 in 2020/21 (slightly lower than the NHS Trusts' figure of 1.54); 0.692 in 2019/20. **Work experience/Retention** Harassment, bullying, abuse, discrimination:

	• Disabled respondents, compared to non-disabled respondents, are more likely to experience unacceptable behaviour from others external to CQC (11.5% vs 7.1%), as well as CQC colleagues (16.9% vs 6.7%); all figures have improved since 2020. • The percentage of disabled staff experiencing bullying, harassment or abuse from external people (11.5%), is less than the NHS Trusts figure of 34.2%. The percentage of disabled staff experiencing bullying, harassment, or abuse from colleagues (16.9%), is less than the NHS Trusts figure of 22.4%. • For the NHS Trust's report, there is a gap of 6.8% between disabled and non-disabled staff experiencing harassment, bullying or abuse from people other than colleagues. This gap is wider than 4.4% gap at CQC. • For the NHS Trust's report, there is a gap of 8.4% between disabled and non-disabled staff experiencing harassment, bullying or abuse from colleagues (managers and colleagues). This gap is less than 10.2% gap at CQC. <u>Voicing/Reporting concerns:</u> • In 2021, 50.9% of disabled staff said that the last time they experienced bullying/harassment from other than CQC staff, they or a colleague reported it (49.6% non-disabled) and 40.5% reported bullying/harassment from CQC staff (39.8% non-disabled). All figures have declined since 2020 reports. <u>Adjustments:</u> • 67% of disabled respondents answered "yes" when asked if CQC made appropriate reasonable adjustments to enable them to carry out their work. The figure has improved since 2020 by 16.1 percentage points. • 73.8% of disabled staff within NHS Trusts felt their employer had made adequate adjustments, slightly higher than CQC's figure of 67%. The NHS Trusts' figure has remained largely unchanged for five years, as opposed to CQC's figure which has increased over the past year. 42% of Trusts, and five out of nine national healthcare organisations, have not yet introduced a reasonable adjustments policy. <u>Presenteeism:</u> • 8.4% of disabled respondents reported that in the last 3 months, they felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. The figure has improved since 2020 (by 6.6 percentage points).
Care Quality Commission (2022b)	**Overview/Pay** <u>Representation/Pay gap:</u> • Overall ethnic minority representation has increased by 1 percentage point to 13.8%. This percentage is close to 13% which is the economic percentage of ethnic minority people employed in the UK (out of total workforce). • There is under-representation of staff from ethnic minority groups at Grade A and above (e.g., executive level - 8.2%). Compared to 2020 report, minor increases to ethnic minority representation are seen in all grades, including Grade A and Executive Grades. • At Grades C, D, and E, staff from ethnic minority groups are equal or more well-represented compared to the organisational average. Compared to 2020 report, there has been an increase of 4.2 percentage points in staff from ethnic minority groups at Grade D.

	• 6.8% of staff at very senior management positions are from an ethnic minority background in NHS Trusts (although the figure has been slightly increasing year on year). This is significantly lower than the 21% of all ethnic minority staff across all bands of the NHS. The CQC has a slightly higher self-reported figure of ethnic minority staff at very senior management band of 8.2%. Board membership: • There has been an increase in Non-Executive Board Members who are ethnic minority (increased by one, up to two). This is now above the organisation's overall percentage of ethnic minority staff (overall board membership: 16.7% and overall workforce: 13.8%). In all NHS Trust regions, there is a lower proportion of ethnic minority people on Boards compared to the proportion of ethnic minority staff in the Trust. **Recruitment/Selection** Shortlisting/Appointments: • The overall relative likelihood of white staff being appointed from shortlisting compared to staff from ethnic minority groups is 1.432. The figure has got worse compared to the year before which was 1.088. • Within the NHS Trust report, the relative likelihood of ethnic minority applicants being appointed from shortlisting, compared to white applicants, has declined over the past three years. **Promotion/Progression** Training: • There is little difference between the groups for this indicator. Overall relative likelihood of white staff accessing non-mandatory training and CPD compared to staff from ethnic minority groups is 1.041. • The data suggests that almost all staff have accessed non-mandatory training. • The NHS Trust report declares for all regions that the data now falls within the non-adverse range between the figures 0.88 to 1.20 (not significant). This means there is little difference between the ethnic minority staff and white staff accessing non-mandatory training and CPD within NHS Trusts for this indicator, similar to CQC. • Relative likelihood of white staff accessing the individual learning request (ILR) process compared to staff from ethnic minority groups is 0.667. In 2020/2019, the overall relative likelihood of white staff accessing the ILR process compared to staff from ethnic minority groups was 1.467. • Based on headcount, staff from ethnic minority groups were more likely to submit an ILR this year than in 2019-20 (18.4% of applications were from staff from ethnic minority groups compared to 9.2% for the previous year). There is little difference in having an ILR approved between the groups (85% for white, 84% for ethnic minority). Promotion: • Ethnic minority respondents are less likely to believe that CQC provides equal opportunities for career progression or promotion than white respondents (38.2% vs 51.7%). Ethnic minority respondents' score has improved from 2020's report (by 2.6%) whereas the equivalent score for white respondents saw a minor decrease (by 0.4%). From the NHS report, the proportion of ethnic minority and white staff believing their Trust provides equal opportunities for career progression or promotion has increased slightly over the years

	(staying around the 72% mark for ethnic minority staff, and 87% for white staff). Although the NHS Trust's figures have a gap of 15.7% (taken from the most recent 2019 stat of ethnic minority staff 71.2% and white staff 86.9%) between the two experiences, which is wider than CQC's 13.5% gap, both of CQC's figures are considerably lower than NHS Trusts' findings. <u>Disciplinary/Capability process:</u> • The overall relative likelihood of staff from ethnic minority groups entering the formal disciplinary process compared to white staff is 3.646. In 2020/2019, the overall relative likelihood of staff from ethnic minority groups entering process compared to white staff is 2.534. The overall relative likelihood figure has increased but this is mainly due to the low number of cases reported here (six staff from ethnic minority groups in 2019 and two in 2020), and as a result of the decrease in the number of cases for white colleagues. **Work experience/Retention** <u>Harassment, bullying, abuse, discrimination:</u> • Ethnic minority respondents are less likely to experience harassment, bullying or abuse at work from others external to CQC, compared to white CQC respondents (6.3% vs 8.2%). Scores from both groups have improved from 2020's report (decrease by 2.8 and 1.4 percentage points respectively). According to the NHS Trusts report, across most of the regions there has been an increase in the proportion of both ethnic minority and white staff who have experienced unacceptable behaviour from people other than staff. Ethnic minority staff are also more likely to experience unacceptable behaviour than white staff (a trend that has increased over the last three years). This makes CQC's figure of staff from ethnic minority groups experiencing unacceptable behaviour from people other than CQC colleagues compared to white staff both unique in that it has declined and that it is lower than the figure for white colleagues. • Ethnic minority respondents are more likely to experience harassment, bullying or abuse at work from other CQC colleagues, compared to white CQC respondents (10.7% vs 8.4%). Scores for both groups have improved from 2020's report (decreased by 2.7 and 2.1 percentage points respectively). For 82.7% of NHS Trusts, a higher proportion of ethnic minority staff compared to white staff experience unacceptable behaviour from fellow staff. The CQC has a lower percentage figure (10.7% and 8.4%) compared to all NHS Trusts regions which range from ethnic minority staff 26% - 30% and white staff 22% - 27%. • Ethnic minority respondents are more likely to experience discrimination from managers, team leaders or other colleagues, than white respondents (11.5% vs 4.9%). This figure has increased since last year and has resulted in the gap widening between ethnic minority and white staff and their experiences.
Care Quality Commission (2022c)	**Overview/Pay** <u>Impact and experience of regulation:</u> • The majority of CQC inspectors (57%) did not agree that ethnic minority-led practices were more likely to have an inspection triggered by information of concern, but 26% agreed that ethnic minority-led practices were more likely to have poorer ratings. • Ethnic minority GPs' experiences of CQC's inspection processes and outcomes appear to be poor: • In the GP practice survey, ethnic minority-led GP providers perceived that they had a poorer inspection outcome based on their ethnicity: 31% (124/400) of ethnic minority-led practices agreed or strongly agreed that their inspection outcome was adversely affected by ethnicity, compared with only 0.3% (1/304) of non-ethnic minority-led practices.

	• A higher proportion of ethnic minority-led practices than non-ethnic minority-led practices disagreed or strongly disagreed that the final inspection report and rating accurately reflected their practice (57% vs 65%). • From the online research community of ethnic minority GPs, there was a feeling that their inspection outcomes could be "harsh" and "unfair". Most also had concerns about racial discrimination in regulation leading to unfair treatment, and felt that CQC, among others, does not understand or appreciate the unique challenges that ethnic minority doctors face. Some felt that assumptions are made about what an ethnic minority-led practice is like, leading to inspectors seeking information to confirm their low expectations and ignore positive evidence, resulting in a "predetermined outcome". • The GP practice survey highlighted that ethnic minority-led practices were more likely to report that GPs in their practice experienced adverse impacts on their mental health (38% vs 26%), physical health (23% vs 7%), and personal and/or family life (51% vs 41%), and report that they had seen an increase in staff sickness (23% vs 7%) as a result of the inspection process. • A number of factors that might be associated with differences in ratings, outcomes, and experiences are listed. A few examples: • Certain types of practices are more commonly associated with being ethnic minority-led – for example, single-handed or individually-led practices. The time-consuming nature of inspections can be harder for smaller practices. • 65% (267/410) of practices that identified as ethnic minority-led stated that they served a socio-economically deprived population, compared with 32% (113/349) of non-ethnic minority-led practices. Of all the respondents, 45% did not feel that their most challenging factor was reflected in their inspection/rating. For ethnic minority-led practices, this proportion was 52% (199/382), whereas for non-ethnic minority-led practices it was 38% (119/314). • 31% (117/381) of ethnic minority-led practices felt negatively affected by indicators that were used. For non-ethnic minority-led practices, this was 12% (37/313). • GPs who participated highlighted that ethnic minority-led practices often struggled with patients with complex long-term health needs, such as cancer, diabetes, heart disease and mental ill-health. They also mentioned challenges of low staffing levels, barriers to accessing care, and being over-subscribed to deliver care. • Differences between GP and GP inspection teams in CQC's Primary Medical Services (PMS) directorate characteristics. 28% of GPs were from an ethnic minority background, 21% of inspectors and 17% of inspection managers identify as being part of an ethnic minority group. In the GP practice survey, practices were asked whether they agreed that they would have achieved the same inspection outcome with a different inspection team. Forty-one per cent of ethnic minority-led practices indicated that they would, and 25% indicated they would not. For non-ethnic minority-led practices, 50% indicated they would have achieved the same inspection outcome with a different inspection team, and 20% indicated they would not. • 69% (37/54) of respondents did not agree that ethnic minority-led GP practices were treated less favourably by quality assurance panels because of unconscious bias and discrimination; 9% (5/54) agreed. Also, 44% (24/54) disagreed that ethnic minority-led GP practices were treated less favourably by quality assurance panels because of the types of practices or environments they work in (for example, areas of deprivation or being single handed GPs). However, 37% (20/54) of respondents agreed with this statement.

Edbrooke-Hyson (2021). Health Education England	**Overview/Pay**
	<u>Representation/Pay gap:</u>
	• Local authorities: 69% of the workforce is female; 42% is aged between 45-54; 82% is white (under 10% filled by people within Black 'African Caribbean Black British', 'Other' and Mixed Ethnic Groups), compared to 51.5% of the medical workforce in the NHS in England;
	  • for directors of public health - 58% of the workforce is female (increased from 53% in 2019); median age is 50-54 (younger in comparison with 55-59 in 2019); 85% is white;
	  • for public specialist workforce - 73% of the workforce is female (decrease from 74% in 2019); median age is 45-49; 81% is white.
	• OHID/UKHSA: 61% is female; median age is 55-60; 54% is white.
	• NHS: 65% is female; median age is 55-60; 62% is white.
	• HEI: 46% is female (dental clinical academic: 55%; medical clinical academic: 45%; there has been a proportionate increase of women in medical clinical academia, however, the proportion of women decreases with academic seniority and more men (59%) than women (41%) are reported in medical clinical academic roles overall; this differs in dental clinical academia: the data highlight the gradual decline in male clinical academics at more senior levels); median age is 56-65 (dental: 43% is aged 36-45; medical: 41% is aged 56-65); 83% is white.

Skills for Care (2022)	**Overview/Pay** <u>Representation/Pay gap:</u> • *Ethnicity*. The adult social care workforce (23% Black, Asian and minority ethnicity) was more diverse than the population of England (14% Black, Asian and minority ethnicity) in 2021/22. The largest difference can be seen for people of black ethnicity, who made up 12% of the adult social care workforce and 3% of the total population. There were large variations by region, with London having the most diverse workforce (68% from black, Asian and Minority Ethnic groups) and the North East the least diverse workforce (5%). 'Registered nurse' remained one of the most diverse job roles, with 42% of workers identifying as Black, Asian and minority ethnic (in comparison to 14% of occupational therapist). 76% of direct care providers were white in comparison to 84% of managerial role. Workers identifying as being of Black, Asian and minority ethnicity were less likely to be in managerial roles (16% Black, Asian and minority ethnic groups) compared to direct providing roles (24% Black, Asian and minority ethnic groups). The proportion of workers with a Black, Asian or ethnic minority background has increased slowly over the period from 20% of all workers in 2012/13 to 23% in 2021/22 and 12% of all managerial roles in 2012 to 16% in 2021/22. • *Gender*. The adult social care workforce comprised of 82% of workers identifying as female, compared to 48% of the economically active population. Workers identifying as female were less likely to be in managerial roles (79%), especially in senior management roles (68%), compared to direct care-providing roles (83%). • *Age*. The age distribution of the adult social care workforce was older than the economically active population. 28% of adult social care workers were aged 55 and over compared to 21% of the economically active population. The average age of the workforce had marginally increased over the previous nine years (from age 42.5 in 2012/13 to age 44.4 in 2021/22). Older mean age was reported for

	senior roles (senior management: 49.5) and registered nurses (49) than care or social workers (43.2 and 44.3 respectively). The average age of workers in the wider economy had also increased over this period (from 40 to 43), highlighting that it's not exclusively the adult social care sector that is experiencing a marginally ageing workforce. • *Disability*. The 2011 UK census reported that there were 9.4 million people with a disability living in England (18% of the population). Within social care occupations, the Labour Force Survey (LFS) identified 24% of workers as disabled according to the Disability Discrimination Act 1995 (DDA) definition. The adult social care workforce estimate showed a lower prevalence of disability among workers, at 2%. The LFS and ASC-WDS use different definitions of disability; this may account for some of the variation in results. The ASC-WDS likely only captured the LFS equivalent of 'work-limiting' disability (2%).
House of Commons. Health and Social Care Committee (2022)	*Note:* This report reviews findings from other documents which are already reviewed as part of this desk-based research and therefore are not presented again. An additional, not covered elsewhere, information includes: **Overview/Pay** <u>Representation/Pay gap:</u> • Professor Carol Woodhams, Professor of Human Resource Management at the University of Surrey, said that the NHS is "certainly sexist, and certainly in some specialties". She told that this tendency can be exacerbated in certain specialities, for example in surgery, because although many female medical students "set off to undertake" a surgical training path, they are "actively discouraged" from doing so whilst in medical school, suffer from a lack of role models, and face "micro aggression during training". This point was echoed by The Royal College of Surgeons of England, who told that the NHS should develop a strategy to attract and retain more women into surgery. At present, just 34% of surgical trainees and 14% of consultant surgeons are female. Professor Woodhams called for "greater transparency in how people are paid and much more consistency across general practice in allocating a wage". **Work experience/Retention** <u>Harassment, bullying, abuse, discrimination:</u> • Dr Wang testified that "discrimination from managers and co-workers" was a "direct cause of burnout" for ethnic minority workers. • International ethnic minority staff in health and social care can be poorly treated by patients and colleagues. Prema Fairburn-Dorai, Director of Primary Homecare, told that when she employed new staff from India her "existing all-UK staff [were] intolerant, judgemental and unhelpful to the new recruits" and that "clients in the community have been overtly racist in some of their comments and have refused to allow overseas staff to care for them." Dr Wen Wang told that the NHS employs 20,000 Filipino nurses, but "at the beginning of the pandemic, they were considered as carriers instead of carers. They were attacked because of Covid."
House of Commons. Health and Social Care	*Note:* This report reviews findings from other documents which are reviewed already as part of this desk-based research and therefore are not presented again. An additional, not covered elsewhere, information includes: **Overview/Pay** <u>Representation/Pay gap:</u>

Committee (2021)	• White staff made up 77.9% of the NHS workforce, Asian staff 10.7%, Black staff 6.5%, staff from the Other ethnic groups 2.6%, staff with Mixed ethnicity 1.9% and staff from the Chinese ethnic group 0.6%. • Among medical staff (junior and senior doctors, and other doctors working for hospitals and community health services) a higher percentage of junior doctors than senior doctors were from the Black, Chinese and Mixed ethnic groups. • Among non-medical staff (clinical staff - for example, nurses and midwives, health visitors, and ambulance staff - and staff working in managerial, administrative and support roles), there was a higher percentage of people from Asian, Black, Mixed and Other ethnic backgrounds in 'support' and 'middle' grades compared with 'senior' and 'very senior manager' grades. • Tricia Pereira, Head of Operations Adults Social Care & Adult Safeguarding, London Borough of Merton, highlighted the fact that the "visibility, the value and the parity" was not in place in social care as it was in the NHS, adding that "When you talk about leadership and aspiration, there are very few visible senior leaders in social care, even less so perhaps than in the NHS. For people who are aspiring, if the visibility is not there, they feel that perhaps they would not belong in those particular roles. If the systems are not there, but there are barriers or challenges for you to progress into certain roles, that is what we need to address and tackle." **Work experience/Retention** <u>Harassment, bullying, abuse, discrimination:</u> • The Royal College pointed to data from 2019 indicating that 42% of midwives had reported experiencing discrimination based on their ethnic background. <u>Unfavourable work conditions:</u> • The Royal College of Psychiatrists' May 2020 member survey found that staff from Black, Asian and minority ethnic groups were disproportionately affected by Covid-19 compared to professionals from white backgrounds. • The Royal College of Midwives (RCM) said that there was evidence to suggest that requests from staff from BAME backgrounds for personal protective equipment (PPE) were more likely to be refused, and that healthcare workers from BAME backgrounds had felt more pressure to work with covid-19 patients than their white counterparts. • A report from the Royal College of Nursing found that healthcare staff from Black, Asian and minority ethnic backgrounds were less likely to be able to secure PPE, and less likely to receive PPE training compared with their white colleagues. • The Royal College of Emergency Medicine's (RCEM) June 2020 membership survey found that 30% of staff from BAME backgrounds were "very concerned" about their health, compared with 8% of White staff, and the BMJ reported in April 2020 that 63% of healthcare workers who had died from covid-19 were from BAME backgrounds. Dr Chaand Nagpaul told that over 90% of the doctors who have died have had come from Black, Asian and minority ethnic backgrounds.
House of Commons. Health and Social Care	**Work experience/Retention** <u>Unfavourable work conditions:</u> • Chris Hopson told that: "[O]ne of the consistent issues that is raised with our Trust Chief Executives is that some of the different types of mask do not fit particular types of face. You are right to identify that that has been raised as an issue particularly for certain groups of

Committee (2020)	Black and ethnic minority staff. I had heard that east Asian nurses in particular were finding that some brands of mask did not fit in the right way. I have heard variants of your anecdote about some of it being built for 6-foot-3 rugby players".

Dacre & Woodhams (2020). Department of Health and Social Care	*Note:* The report is extensive and therefore just the key findings are presented.
	
	Overview/Pay
	<u>Representation/Pay gap:</u>
	• Analysing payroll data reveals basic gender pay gaps of 24.4% for Hospital and Community Health Service (HCHS) (mostly hospital) doctors, 33.5% for GPs and 21.4% for clinical academics. They narrow when statistical methods are used to create hypothetical like-for-like comparisons of men and women across hours worked, grade, experience and specialty. After this adjustment pay gaps would be expected to narrow, however, they remain substantive for many doctors, especially GPs.
	• The observed gender pay gaps are explained by:
	  • Women are more likely to work less than full-time (LTFT). Adjusting for contracted hours alters the picture: HCHS doctors now have the largest gender pay gap at 18.9%, with GPs at 15.3% and clinical academics at 11.9%.
	  • Men doctors are more likely to be older, have more experience and hold more senior positions – all of these characteristics lead to higher pay. Decomposition analysis indicates that a quarter of the gender pay gap among HCHS doctors is related to differences in age. Analysis reveals that the pay gap grows with age – it is narrow when doctors start their training, and it increases steadily with age.
	  • Among hospital doctors, gaps in total pay – which include Clinical Excellence Awards (CEAs), allowances and money from additional work – are larger than gaps in basic pay alone. The analysis shows that non-basic, additional, payments are seen to vary with gender after adjustments are made, with women in specialty doctor, staff and local grades receiving 10% less. Decomposition analysis for total pay demonstrates that specialty effects account for 3.4% of the gender pay gap in total pay for the whole workforce.
	  • Men and women are found in different specialties, grades and roles, which might have different pay. Pay differences across male-dominated and female-dominated HCHS specialities tend to be explained by differences in age, grades and hours.
	• Almost all of the gender pay gap in trusts and clinical academia can be explained, but about 50% of the gender pay gap in primary care is not predicted by typical factors (age/experience, grade, hours, location and so on). The possibility of direct pay discrimination within individual practices cannot be discounted.

Equality and Human Rights Commission (2022)	*Note:* This report reviews findings from other documents which are reviewed already as part of this desk-based research and therefore are not presented again. An additional, not covered elsewhere, information includes: **Overview/Pay** <u>Representation/Pay gap:</u>

	• Data from England and Wales show an increase of ethnic minority staff in the low-paid workforce and slight decrease in Scotland (e.g., England: from 15.6% in 2011 to 17.8% in 2020).
	• The percentage of very senior management positions held by BME staff has grown in recent years (from 5.3% in 2017 to 6.8% in 2020) but it remains well below the NHS target of 19%.
	• Ethnic minority care workers in the independent care sector were more likely to be on zero-hours contracts than their White British colleagues:
	  • The use of zero-hours contracts results in fewer employment rights and less job security. For example, workers may have insufficient contractual hours to qualify for statutory sick pay.
	• Stakeholders, including unions, perceive that lower-paid ethnic minority workers are significantly over-represented in NHS England's outsourcing operations (not possible to verify due to the lack of workforce data collected):
	  • This can lead to workplace hierarchies, with those employed directly on open-ended contracts and fixed hours having better terms, conditions and pay than agency workers and those on zero-hours contracts or employed by private companies.
	Promotion/Progression
	<u>Training:</u>
	• *Independent providers*: Working in the NHS and in local authority-provided care often is seen to offer better training opportunities than in independent-provided care. This affects lower-paid ethnic minority social care workers especially, who are over-represented in the independent sector and less likely to be employed directly by local authorities.
	<u>Promotion:</u>
	• Ethnic minority staff often felt they had little support for career progression from management. They felt that managers had occasionally blocked their development deliberately. This had led to over-qualified ethnic minority staff getting stuck in junior positions for long periods.
	• *Outsourced staff*: Research with workers in Scotland and Wales suggested the existence of a two-tier workforce, in which outsourced staff struggled to gain new qualifications and progress in their careers. While this can affect staff from all backgrounds, those from ethnic minorities are over-represented in outsourced roles.
	Work experience/Retention
	<u>Harassment, bullying, abuse, discrimination:</u>
	• 18% of ethnic minority staff in all pay bands across the NHS reported experiencing discrimination from patients or other members of the public, compared with 4.6% of White staff.
	• 14.5% of ethnic minority staff reported experiencing discrimination from a manager or other colleague, compared with 6% of White staff.
	• Reports were received of ethnic minority staff facing excessive criticism and reproach for mistakes, which they felt was unfair. Some felt that White staff were treated more favourably.

	• Evidence contains examples of lower-paid ethnic minority workers who felt they were treated differently to their White or White British colleagues when allocating working hours, particularly when requesting extra hours. Some ethnic minority respondents said they had not been permitted annual leave or time off for religious holidays, unlike White colleagues, or had struggled to find someone to cover their shift. Some staff felt their employers lacked a sense of fairness, understanding and even-handedness when handling such requests. • Social care workers frequently experienced subtle, underhand forms of racism from colleagues and managers, which were difficult to prove or act upon. Evidence provided in a focus group indicated that lower-paid ethnic minority workers are perceived to be given fewer shifts than their White colleagues and are criticised for their language skills (particularly migrant workers, who felt these criticisms were often unjustified) (Hussein, 2022). <u>Voicing/Reporting concerns:</u> • *Outsourced staff*: In healthcare, many lower-paid roles, including hospital cleaners, porters and caterers, are outsourced to private companies (especially in England). This has led to workers feeling isolated and detached from their place of work. Generally speaking, those working in outsourced roles in healthcare often were unaware of their rights. In healthcare, some outsourced and agency workers told they were unable to access information circulated by their employer (for example, because they were not given an official NHS email address). • The large number of providers, as well as the use of zero-hours contracts and agency workers, made it more difficult for workers to be aware of their rights. This has a greater impact on ethnic minority workers who, as previously noted, are more likely to work in the independent care sector while being on zero-hours contracts. • Lower-paid ethnic minority workers in health and social care are less likely to raise concerns out of fear that they may lose their jobs, particularly if they are in insecure roles or on zero-hours contracts. There are limited opportunities for them to have their voices heard in the workplace, particularly in social care. <u>Unfavourable work conditions:</u> • Ethnic minority workers reported being given higher-risk tasks and being redeployed to COVID-19 wards during the pandemic more often than their White or White British colleagues. They said that they had no choice but to continue working at increased risk because they were unable to afford to take time off. • UNISON's analysis of a union members' survey, which was submitted to this inquiry, found that between March and December 2020, 67% of Black workers in bands 1 and 2 (the lowest paid) said they had worked in COVID-19 wards, compared with 51% of their White colleagues in the same pay bands (according to responses from members working in healthcare). • Some lower-paid ethnic minority social care workers highlighted the shortages and inadequate distribution of suitable personal protective equipment (PPE) at the start of the COVID-19 pandemic. • Analysis of records at the start of the pandemic found that 6 in 10 healthcare workers who died from COVID-19 were from an ethnic minority group (Hussein, 2022).
Bury & Pinder (2022)	**Recruitment/Selection** <u>Shortlisting/Appointments:</u>

	• *Gender*. Male and female candidates are equally likely to be successful in recruitment to training (17% male and 14% female, not statistically significant difference). • *Age*. Success rate declines with increasing age; e.g. 25% under 30, 17% - 30-34; 5% - over 45. Older candidates had lower probability of passing the Assessment Centre. Candidates 45+ had lower likelihood of being deemed appointable at the Selection Centre. • *Ethnicity*. Success rates vary by ethnicity: White British - 22%; White Other- 16%; Asian - 6%; Black - 4%; Chinese - 9%; Mixed - 21%; Other - 13%. Differential attainment by ethnic group appears to be operating even within the sub-cohort of UK medical graduates, with White British candidates forming an increasing share of the candidates left in the recruitment process at each stage except being deemed eligible and being offered a post. Black and Asian candidates had statistically significantly lower probability of passing the Assessment Centre. White Other candidates had lower likelihood of being deemed appointable at the Selection Centre. • *Socioeconomic status*. Success rates did not vary by parental education level: No qualifications - 15%; Qualifications below degree level- 14%; Degree level or above - 16%. • Different groups are affected at different stages of the process, but the greatest impact is seen at the Assessment Centre stage. The largest variation in likelihood to progress by age and ethnicity occurs at this stage.
Liu (2021). Health Education England	**Overview/Pay** <u>Representation/Pay gap:</u> • From 2018 to 2020, 5% of trainees with UKPHR/no registration were from ethnic minority backgrounds vs 20% of trainees with General Dental Council and 22% with General Medical Council registration. • The composition of the PH trainee group (from 2018 to 2020) is comparable to the ethnicity of the overall population in England (2016) – 85% White and 15% BME (trainees include medical, dental and non-medical qualified trainees; *NOTE:* not included are 120 of 552 trainees (22%) whose ethnicity is not recorded). No or very small comparative differences exist in the Asian/Asian British, Mixed/Multiple Ethnic, White and Other Ethnic groups. Black/African/Caribbean/Black British PH trainees (1%) are underrepresented when compared to the overall population (4%). • Some differences, however, are noticed when looking at regions; e.g., in London, BME trainees (24%) are under-represented in comparison to its population (41%). • The percentage of BME trainees in PH training (15%) is less than what is observed in many other NHS staff groups (medical and non-medical; 2009-2020). Across the NHS workforce of 1.3 million, 23% of staff are from a BME background compared to the population figure of 15%. Significant differences can be observed between the 15% BME people in PH training and 27% of BME people working as NHS professionally qualified staff, 46% as doctors and 27% as nurses and health visitors. • The PH trainee workforce is predominantly White with 85% from this background. This figure should be compared to the 54% for NHS doctors and 50% for NHS specialist registrars. Whereas the Asian/Asian British group comprise 33% of the NHS specialist registrar workforce, the figure for public health training is 9%. Some 8% of NHS specialty registrars are from a Black/African/Caribbean/Black British background compared to only 1% in PH training.

	• In 2020, 22% of GMC registered public health trainees and 25% of GMC licenced public health doctors were from ethnic minority backgrounds in comparison to 41% of all doctors in training and 43% of all registered doctors. PH training has the smallest percentage of BME staff at 15% (data derived from TIS) when compared to the different medical specialty training groups listed by the GMC State of Medical Education report 2020 (data collected by the GMC). • 15% of clinical academics in public health medicine from 2015 to 2019 were from ethnic minority backgrounds (20% of researchers; 24% of lecturers, 24% of senior lecturers and 11% of professors) in comparison to 21% of clinical academics in all specialties (24% of researchers; 24% of lecturers, 23% of senior lecturers and 16% of professors). **Recruitment/Selection** <u>Shortlisting/Appointments:</u> • 41% of applicants to the PH training programme were from a BME background compared to 47% across all specialty training programmes. The 3-year average rate for appointable BME applicants in PH was 21% compared to 57% across all specialties (the rate for White applicants was 39%). A difference also existed across all specialty training programmes where 57% of BME and 78% of White applicants were deemed appointable (Iacobucci, 2020).
Public Health England (2020)	**Work experience/Retention** <u>Unfavourable work conditions:</u> • A total of 10,841 diagnosed COVID-19 cases were identified in nurses, midwives and nursing associates registered with the Nursing and Midwifery Council. Among those who are registered, this represents 3.9% of Asian ethnic groups, 3.1% of Other ethnic groups, 1.7% of White ethnic groups and 1.5% of both Black and Mixed ethnic groups. The median age of cases was 45.5 and 45.1 for males and females, respectively. • An analysis of 119 deaths of NHS staff showed a disproportionately high number of BAME staff among those who had died (Cook, Kursumovic, Lennane, 2020).
Local Government Association (2019)	**Overview/Pay** <u>Representation/Pay gap:</u> • Gender pay gap analysis from 2018 shows that on average women were paid 5% less than men on a median basis in local government (across the whole economy the median gap is 9.7%; London Boroughs – 1.2%). • In 2016/17 on average 48.8% of the top 5% of earners were women, 3.7% were Black, Asian or from other minority ethnic groups and 2.5% had a disability. By way of comparison, in 2009/10 an average of 40% of the top 5% of earners in councils were women, an average of 2% came from BAME groups and an average of 3% had a disability. • For London borough: 40% of first tier managers were women (60% - chief executives), 11% were from ethnic minority backgrounds (0% - chief executives), 6% disabled (0% - chief executives).

Supplementary material 2. Public Health.

Five documents reporting on the Public Health workforce diversity were found through the desk-based research:

1. **Public Health England**: NHS England (2019). *Workforce race equality standard. 2018 WRES data analysis report for eight national healthcare organisations.*
2. **Public Health Specialty Training**: 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. **Public Health Specialists**: Edbrooke-Hyson, V. (2021). *A Capacity Review – Public Health Specialists in 2021.* Health Education England.
4. **Public Health Workforce:** Liu, D. (2021). *Profile of the Public Health Workforce in England and the UK: Region of Primary Medical Qualification and Ethnicity.* Health Education England.
5. **Local Government**: Local Government Association (2019). *Workforce focus. Taking stock of the local government workforce – Sharing HR ideas for the future*.

Summary findings

Workforce overview/Pay

18.6% of Public Health England (PHE) staff in 2018 were from ethnic minority backgrounds (increased from 17.7% in 2017) and this percentage was close to the national average for NHS trusts in England which was 19.1% (NHS England, 2019). However, those from ethnic minority backgrounds were overrepresented in pay bands lower than £40k and underrepresented in all pay bands above that. 6.7% of those on the management committee were from ethnic minority backgrounds which was lower than 18.6% of all staff. There were just six individuals on the executive senior management (ESM) framework and just four declared their ethnicity (white) (NHS England, 2019).

HEE provided an overview of the composition of the Public Health Specialists workforce (Edbrooke-Hyson, 2021), including gender, age and ethnicity for NHS, Local Authorities, OHID/UKHSA, and HEI. A higher proportion of female specialists worked in all organisations, except for HEI (46%). In Local Authorities, gender differences between Public Health Specialists (73%) and Directors (58%) were particularly visible. In HEI, a higher proportion of females worked in dental clinical academia (55%) in comparison to medical (45%). It was also reported that the proportion of female medical clinical academics decreased with academic seniority while in dental clinical academia the gradual decline was seen in male clinical academics at more senior levels. Age differences were noticed between organisations. For example, the median age for Local Authorities was 45-54 (42%) and 55-60 for OHID-UKHSA and NHS. For HEI, dental clinical academics were younger (43% age 36-45) than clinical academics (41% age 56-65). Regarding ethnicity, over 80% of Local Authorities and HEI staff were White while 54% of OHID/UKHSA staff were White.

Another HEE produced document reported on the profile of the Public Health workforce in England and the UK (Liu, 2021). Regarding ethnicity, the Public Health trainee group was comparable to the overall population in England – in both groups 15% were individuals from ethnic minority backgrounds (*NOTE:* ethnicity was not recorded for 22% of Public Health trainees). Black/African/Caribbean/Black British Public Health trainees (1%) were underrepresented when compared to the overall population (4%). Some differences were observed regionally (e.g., 24% of London trainees were from ethnic minority backgrounds in comparison to London's population of 41%) and when making comparisons

with other NHS staff groups (e.g., 27% of NHS professionally qualified staff were from ethnic minority backgrounds). The breakdown by professional registration in 2018-20 showed that 5% of trainees with UKPHR/no registration were from ethnic minority backgrounds, while 20% of trainees with General Dental Council and 22% with the General Medical Council registration were from ethnic minority backgrounds. In comparison, 41% of all doctors in training in 2020 were from ethnic minority backgrounds.

In Local Government, women earn on average 5% less on a median basis than men (1.2% in London borough; Local Government Association, 2019). In comparison, across the whole economy the median gap is 9.7%. In 2016/17, 48.8% of the top 5% of earners were women, 3.7% from ethnic minority backgrounds, and 2.5% had a disability. In comparison, in 2009/10, 40% of the top 5% of earners were women, 2% from ethnic minority backgrounds, and 3% had a disability. For London boroughs specifically: 40% of first tier managers were women (60% - chief executives), 11% were from ethnic minority backgrounds (0% - chief executives), 6% disabled (0% - chief executives).

Recruitment/Selection

Iacobucci (2020) cited in the Liu (2021) review reported that 41% of applicants to the Public Health training programme were from ethnic minority backgrounds compared to 47% across all specialty training programmes. The average rate for appointable applicants from ethnic minority backgrounds in Public Health was 21% (39% for White applicants) compared to 57% across all specialties (78% for White applicants).

Bury and Pinder (2022) explored the Public Health Specialty Training recruitment process and reported that success did not vary by gender (17% male and 14% female, no statistically significant difference) or parental education (e.g., 15% with no qualification and 16% with degree level or above). They 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 and that the greatest impact was seen at the Assessment Centre stage (for age and ethnicity). For example, Black and Asian candidates had lower probability of passing the Assessment Centre while White Other candidates had lower likelihood of being deemed appointable at the Selection Centre.

NHS England (2019) also explored the recruitment process at national healthcare organisations and reported the relative likelihood of White applicants being appointed from shortlisting compared to candidates from ethnic minority backgrounds for PHE in 2018 of 1.83 (increased from 1.73 in 2017; NHS average was 1.45 in 2018).

Other measures

For PHE in 2018, a similar percentage of White staff (78%) and staff from ethnic minority backgrounds (80%) believed that their organisation provided equal opportunities for career progression or promotion. Regarding disciplinary procedures in 2018, White staff had a higher relative likelihood of entering the formal disciplinary process compared to staff from ethnic minority backgrounds (0.72). However, in 2017 the opposite was reported - staff from ethnic minority backgrounds were 3.72 more likely to enter the formal disciplinary process compared to White staff. In comparison to other national healthcare organisations, the highest percentage of PHE staff reported experiencing discrimination at work from a manager, team leader or other colleague – 14% of staff from ethnic minority backgrounds and 9% of White staff (however, the NHS trusts average was 15% for staff from ethnic minority backgrounds).

Supplementary material 3. Data.

Table 1. Data sources used to produce the documents on monitoring diversity in the health and care workforce

Citation	Data sources
Appleby, J., & Schlepper, L. (2019). *The gender pay gap in the English NHS Analysis of some of the underlying causes.* Nuffield Trust.	NHS Electronic Staff Record (ESR) held by NHS Digital
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	Data provided by Health Education East Midlands
Care Quality Commission (2022a). *Our Workforce Disability Equality Standard (WDES): Annual Report 2021.*	Electronic Staff Record (ESR) CQC HR data People survey Pulse survey
Care Quality Commission (2022b). *Our Workforce Race Equality Standard (WRES): Annual Report 2021*.	Electronic Staff Record (ESR) Pulse survey People survey
Care Quality Commission (2022c). *Ethnic minority-led GP practices: impact and experience of CQC regulation*.	Survey (GP providers and inspectors) Electronic Staff Record (ESR) Online discussions Focus groups and interviews Review of regulatory methods, practices, and decision-making process GMC data
Charlesworth, A. (2017). *Rising pressure: the NHS workforce challenge*. Health Foundation.	Electronic Staff Record (ESR)
Dacre, J., & Woodhams, C. (2020). *Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England.*	Literature review Payroll data from the Electronic Staff Record (ESR) Survey Interviews
Edbrooke-Hyson, V. (2021). *A Capacity Review – Public Health Specialists in 2021.*	Electronic Staff Record (ESR) Data collected from Local authorities Medical Schools Council Clinical Academic Survey, 2020 Dental Schools Council Clinical Academic Staff Survey, 2018
Einarsdóttir, A., Mumford, K., Birks, Y., Lockyer, B., & Sayli, M. (2020). *Understanding LGBT+ employee networks and how to support them*	The Human Resources & Equality and Diversity Survey NHS Employee Engagement Survey
Equality and Human Rights Commission (2022). *Experiences from health and social care: the treatment of lower-paid ethnic minority workers*.	Interviews with stakeholders Desk-based research Online call for evidence Rapid review Interviews and focus groups with health care workers

	Data (Skills for Care workforce data; NHS England workforce data; NHS England and Wales Staff Surveys; Labour Force Survey data)
Hemmings, N., Buckingham, H., Oung, C., & Palmer, W. (2021). *Attracting, supporting and retaining a diverse NHS workforce.* Nuffield Trust.	Literature review Stakeholder scoping calls and interviews with NHS Foundation Trusts Data from HESA, NHS Digital, NHS Business Service Authority, NHS Staff Survey
Health Education England (2022a). *Diversity and Inclusion annual report 2021-2022.*	Nor reported
Health Education England (2022b). *Experiences of Racial Discrimination and Harassment in London Primary Care.*	Survey conducted in 2021 (3% of London's total primary care workforce; 1025 people – community pharmacy, community dentistry, general practice, community optometry)
House of Commons. Health and Social Care Committee (2022). *Workforce: recruitment, training and retention in health and social care.*	Review of evidence from other sources *(not included in the review as primary sources were included already)* Evidence from stakeholders
House of Commons. Health and Social Care Committee (2021). *Workforce burnout and resilience in the NHS and social care*	Review of evidence from other sources *(not included in the review as primary sources were included already)* Evidence from stakeholders Interviews with frontline staff
House of Commons. Health and Social Care Committee (2020). *Delivering core NHS and care services during the pandemic and beyond*.	Review of evidence from other sources *(not included in the review as primary sources were included already)* Evidence from stakeholders
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	A rapid review of ethnic inequalities in the NHS workforce
Liu, D. (2021). *Profile of the Public Health Workforce in England and the UK: Region of Primary Medical Qualification and Ethnicity.* Health Education England	HEE Trainee Information System (TIS) dataset GMC reference tables supplementing The State of Medical Education and Practice in the UK 2020 report GMC List of Registered Practitioners Data requested from the GMC on ethnicity of doctors in public health training (unpublished data) NHS Digital Hospital and Community Health Services (HCHS) workforce statistics: equality and diversity in NHS Trusts and CCGs in England, 2009 to 2020 Electronic Staff Record (ESR) Medical Schools Council clinical academic survey dataset (2019) ONS annual population survey for 2016
Local Government Association (2019). *Workforce focus. Taking stock of the local government workforce – Sharing HR ideas for the future*	Workforce survey Office for National Statistics The local government data for 319 councils submitted to the Government's gender pay gap service
NHS England (2019). *Workforce race equality standard. 2018 WRES data analysis report*	Data provided by organisations (from Electronic Staff Record or alternative data systems, staff surveys)

for eight national healthcare organisations (Report No. 000215).	
NHS Employers (2021). *Inclusive recruitment into apprenticeship.*	Government data (public) Survey - 70 responses, which represents 30% of Trusts across England Follow-up calls
NHS England (2022c). *NHS Workforce Race Equality Standard 2021 data analysis report for NHS Trusts.*	Data from Trusts and CCGs submissions NHS Staff Survey
NHS England (2022d). *Workforce Disability Equality Standard 2021 data analysis report for NHS Trusts and foundation Trusts.*	Data from Trusts (e.g., on workforce overview, recruitment) NHS Staff Survey (e.g., promotion, discrimination)
Palmer, W., Rolewicz, L., Hemmings, N., & Appleby, J. (2021). *Understanding the mental health clinical support workforce*. Nuffield Trust.	Literature review Stakeholder discussions Data from NHS Digital, NHS Business Services Authority, NHS Staff Survey
Public Health England (2020). *Disparities in the risk and outcomes of COVID-19*	Nursing and Midwifery Council (NMC) register data
Rolewicz, L., Palmer, B., & Lobont, C. (2022). *The NHS workforce in numbers.* Nuffield Trust.	NHS digital
Shembavnekar, N. (2020). *The adult social care workforce in London.* Health Foundation.	Data from Skills for Care
Skills for care (2022). *The State of the adult social care sector and workforce in England 2022.*	Skills for Care workforce estimates for 2021/22 from The Adult Social Care Workforce Data Set (ASC-WDS) The population of England (UK Census) Labour Force Survey Census 2021
West, M., Dawson, J., Kaur, M. (2015). *Making the difference: diversity and inclusion in the NHS.* The King's Fund.	NHS Staff Survey (including 157 Acute Trusts, 57 Mental health/learning Disability Trusts, 40 Clinical Commissioning Groups, 19 Community Trusts, and 11 Ambulance Trusts)