London Workforce Race Strategy

Race equality.
A better NHS for us all.

October 2020

"There should be more senior decision makers who look like me, who make choices that don't disadvantage me and my future. The leaders who don't look like me would be understanding, authentic, and committed to inclusion through their actions, and how they speak. My difference would be valued.

It would be a buzzing place to work. Everyone would feel uplifted, and part of a shared vision to deliver high quality patient care."

J'nelle James
Inclusion Manager, Central and North West London NHS Foundation Trust

Contents

Welcome

3 Forewords
5 London Workforce Race Strategy Development team
7 Executive summary

This is an interactive report.
The sections on this page are all navigation links, just click to go straight to the section you want.

The menu icon at the top of the page will bring you back to this contents page and the paperclip icon will take you to the annexes.

Use the arrows at the bottom of each page to navigate you to the next or previous page.

Photography
A selection of the images contained within this strategy have been kindly donated by Bafta award winning filmmaker and photographer, Hassan Akkad. These images were taken at the start of the pandemic, during his time working in a London hospital as a cleaner in a Covid-19 ward.

Hassan Akkad: "I am glad that my photos will play a small role in bringing this important document to life".

Part1 Setting the scene

14 Introduction
16 Overarching principles
17 Strategic principles
19 National context
21 The NHS in London
23 Terminology and key concepts

Part 2 Data and Evidence

30 Introduction
31 Demographics
32 The WRES in London
36 Workforce Race Equality Standard (WRES): Indicators for the NHS medical workforce
37 Allied Health Professionals (AHPs)
38 Variation of experience within BME ethnicities
39 Covid-19 in London
40 London Covid-19 – Senior leadership at a time of crisis

Part 3 Interventions

44 Principles of intervention
45 Impact-effort matrix
47 Interventions in focus
47 In focus – HR processes
50 In focus – System Working
51 In focus – Cultural Change Programme
52 In focus – Recruitment, secondments and professional development
56 In focus – Agency, bank, locum and temporary staff
57 In focus – Primary Care and Multi-Professional Teams
58 In focus – Nursing and midwifery for London
61 Key recommendations for London
67 A Case Study: London Ambulance Service

Part 4 Taking this forward

72 Introduction
73 Everyone's issue – introducing The 7 As of Authentic Allyship
75 The importance of staff networks – using what we already have
78 Evaluation
79 Resources
80 Funding and Governance
81 Planning our journey
82 Progress and success indicator time line
83 Conclusion

Annexes

85 Annex A – Resources
92 Annex B – Key Recommendations
93 Annex C – Intervention Menu

Forewords

The last few months have shown the NHS at its best. Colleagues working across London have faced the impact of the global pandemic and shown incredible support for each other to care for patients and the public.

I am proud those teams include the most diverse workforces in the capital. Over 44% of our staff are from a Black and Minority Ethnic (BME) background and the majority of our doctors, nurses and midwives bring global experience to their roles. Without them, London and our NHS would not be as special as they are.

Yet many BME colleagues working in London do not have an equitable experience working in the NHS. This is not acceptable. We need to make a step-change.

Making this step-change is one of my top priorities for London.

In June 2020, I invited Yvonne Coghill to help develop a strategy that will make a significant and tangible difference to the experiences of our BME staff. I have been encouraged by the positive engagement of colleagues across London, including CEOs for each of our trusts and integrated care systems, in its development.

Our strategy will provide us with impetus. It will be the driver for a future where we face up to discrimination based on race, creed or background. It will help us ensure leaders demonstrate true understanding of the lives and experiences of our colleagues and patients.

I ask you to join me in committing to making the NHS in London a fairer and more equitable place to work for all our teams.

Sir David Sloman
London Regional Director, NHS England and NHS Improvement

Forewords (continued)

On October 10th, 1977, I started my career as a student nurse at Central Middlesex Hospital. The hospital and the area have undergone so many changes, it is totally unrecognisable from how it looked back then. I mention this because I am absolutely delighted to be back in London at the tail end of my career, invited by Sir David Sloman, Regional Director for NHS London, to lead work on developing a strategy to make substantive and permanent cultural change for the many thousands of non-white staff working in London.

Prior to developing this strategy, I was the Director of the Workforce Race Equality Standard (WRES) Implementation Team and, after years of collecting data for the WRES annual report, it became clear that even though London has the highest number of staff from diverse backgrounds working in it – 44.9% black and minority ethnic (BME) staff – these people have much poorer experiences than their white counterparts. That's true for 7 out of the 9 indicators the WRES is based on.

For many years, the NHS has started and stopped race equality initiatives, all designed to improve the experiences for this group of staff, but none have had lasting effect or impact. I suspect that the problem has been a lack of understanding of the depth and complexity of the issue we are dealing with. Race inequalities have been hard wired into our institutions and people's way of thinking over many years. These inequalities were specifically and carefully designed to ensure some people get better chances in life than others. It starts with what people believe to be true, which then shapes their attitudes, and ultimately their behaviours. These are not issues that a simple framework or policy can improve. There must be a sustainable programme of education, enablement, empowerment and change. We are talking about decades as opposed to a few years. The global system of racial inequalities did not occur overnight and unpicking centuries of embedded racism will take time to undo.

This strategy is aimed at starting a coordinated, consistent, and sustainable programme of work to make that change. To the best of our ability we have included evidence-based and well-researched interventions, as well as new concepts that are as yet untried and untested. I believe that, ultimately, if we are all committed to the recommendations in the strategy, we will make the changes we desire and are very much needed in the NHS.

It was a delight to do this work alongside staff from all backgrounds and professions from across London. We have some amazing individuals working in our NHS and this work aims to be fully inclusive and a force for good for all staff across London.

People might think that some of the interventions are radical. Yes they are, and we don't apologise for that because we know that unless we do things very differently, are bold and courageous, we are not going to make the changes we all want to see. There has been a real sense of excitement and hope surrounding this work in the belief it will help improve the lived experience of our BME staff. Its ultimate success will be up to you.

Yvonne Coghill
Director of Workforce Race Equality for London, NHS England and NHS Improvement

London Workforce Race Strategy Development team

Janine La Rosa

Head of Equality and Inclusion, Workforce, London

Black Caribbean

Samantha Rashid

Programme and Quality Lead, London

Asian Bangladeshi

John Brouder

Specialist Advisor on Diversity and Inclusion

White British

Charles Rukwengye PhD

EDI Lead, Whittington Health NHS Trust

Black African

Sam Rodger

WRES Policy and Strategy Lead

White British

Owen Chinembiri

WRES Implementation Lead

Black African

Richard Watson

WRES Implementation Manager

White British

London Workforce Race Strategy Development team (continued)

Strategy Development Advisory Group – Core members

Vinice Thomas
Director of Nursing, Direct Commissioning/CNO BAME Network Chair – NHS England and NHS Improvement London

Melissa Berry
Diversity Consultant – London Ambulance Service, South West London STP

Felicia Kwaku
Associate Director for Nursing – King's College Hospital NHS Foundation Trust

J'nelle James
Equalities Diversity and Inclusion Manager – Central North West London NHS Trust

Daniel Collard
WRES Implementation Team – NHS England and NHS Improvement

Mark Farmer
Operational Manager, Royal College of Nursing, London region

Lisa Elliot
Regional Director, Royal College of Nursing, London region

Karyn Richards
Freedom to Speak up Guardian, St George's University Hospitals NHS Foundation Trust – London Region FTSU Guardian Chair

A message from Vin Diwakar Regional Medical Director & Chief Clinical Information Officer

"As the Regional Medical Director and Chief Clinical Information Officer for NHS England and NHS Improvement in London, I have the honour of leading a multi-professional clinical directorate of regional leaders of primary care, allied health professionals, healthcare scientists, pharmacists, GPs, dentists, digital experts and optometrists. We are wholeheartedly committed to leading progress and tackling racial inequality for all of London's workforce. This document is the beginning of the journey, we will move quickly to support and implement recommendations whilst also working to develop specific interventions for groups that have for too long been underrepresented. Through the effective use of our professional networks we will develop strategies to attract, recruit, develop and retain staff within all of our professions. I am of Indian origin and have been immensely privileged throughout my career but I have also seen, at first hand, the impact that the issues surrounding race and equity have on my family and loved ones. My hope is that everyone has access to the same opportunities as I had. This is the beginning of the journey but one that I believe will make a real and lasting difference to the lives of our staff and Londoners."

With thanks to the many individuals from all roles and professions across London's NHS who have taken the time to input, feedback and collaborate in the development of this strategy.

Executive summary

By almost every possible measure, black and minority ethnic (BME) staff in the NHS in London have a worse experience than their white colleagues.

44.9% of all NHS Trust staff are BME

BME staff are underrepresented above Band 8A and across the 14 allied health professions

London does worse than any other region on 7 of the 9 WRES indicators

BME candidates are 1.6 times less likely than white candidates to be appointed after shortlisting

BME staff are significantly more likely than white staff to go through formal disciplinary processes than their white colleagues

Despite some improvements in recent years, there is no sign of the paradigm shift we need to really change things. Every survey over the last decade and every workforce race equality standard (WRES) report has shown that in shortlisting, appointment, promotion, and disciplinary processes, the effects of discriminatory systems are undeniable for BME staff.

London has the most ethnically diverse NHS workforce in the country. In the nursing profession, and across entire organisations, the NHS in London is majority BME. This year, the disproportionate mortality rates of Covid-19 amongst BME staff and communities has brought into stark and urgent focus the layered impacts of years of disadvantage and inequality. It is vital for London, and the experience of our patients and the communities we serve, that this gap is closed. Not only are these inequalities incongruous with our NHS values, but we know that the fair treatment of staff is directly linked to better clinical outcomes and better experience of care for patients.

An NHS culture that demonstrably recruits, develops, treats and disciplines staff on the grounds of their ethnicity fundamentally denies patients the best possible care.

This strategy, developed in partnership with staff across London's NHS and at the request of Sir David Sloman, Regional Director for London, outlines clearly the challenge and complexity involved in addressing race inequality, while recognising that this will require a long-term commitment.

Setting the Scene

The successful implementation of this race strategy will improve the experiences of BME staff, and therefore the experiences of all staff, in the London region. The strategy has been co-produced and co-designed by staff from across the region with input from all levels, roles and professions.

Understanding and reflecting the genuine lived experience of our BME workforce sits at the core of this strategy and is intended to act as a guiding light for this work. To support this, part one of the strategy outlines the issues that are inherent in race inequality and presents the guiding principles and values used to develop the work, as well as setting it within the national and regional context. Importantly, it also explores some of the fundamental terminology and concepts used within race equality work globally. It is hoped that this part of the document will encourage readers to want to find out more about the issue and its complexity.

Executive summary (continued)

This strategy takes into account existing NHS developments and programmes such as the Long-Term Plan, the People Plan, and the requirements of the Equality Act 2010 and the Public Sector Equality Duty. It builds on the success of the Workforce Race Equality Standard (WRES). Reporting since 2015 on progress against nine key indicators in the NHS, WRES has held a mirror up to the system, and helped reach a point where inaction is no longer a tenable position.

It would be impossible to write a strategy in 2020 without reference to Covid-19. Tragically, the disparity between white and non-white Covid-19 deaths has been particularly stark among the NHS workforce. As of July 2020, 227 NHS staff deaths had been recorded across England. Of these, 33% were in the London region and nationally 60.8% of staff deaths were from a BME background. The pandemic will change the ways we all live our lives, and, in its spread, it has highlighted more starkly than ever the need for action on racial disparity in health outcomes

Data and Evidence

This strategy is based on evidence and research, without which it could not hope to be successful in tackling race inequality. Over the last 5 years, thanks to the Workforce Race Equality Standard, we have been able to gain a profound understanding of the impact of race for staff within London's 36 foundation, community and mental health trusts. There is a need to apply the principles of the WRES indicators to all areas, including primary care. **Part two** of the strategy highlights data that outlines the impact of race inequality across London with particular focus on nursing and the London Ambulance Service – both identified as high priority areas in the very first WRES report.

Despite having the highest proportion of BME staff, London has significant issues in terms of racial equality. On several WRES indicators, London is the worst performing region in the country. Data from the WRES 2019 data report and other research shows:[1]

- BME staff are significantly under-represented at senior pay bands. 44.9% (92,487) of all staff working across London trusts are from a BME background, compared to only 12.5% (54) of BME staff working at AfC band 9.
- White applicants are 1.6 times more likely to be appointed from shortlisting compared to BME applicants – making London the worst performer in the country on this indicator.
- BME staff are more likely to go through the formal disciplinary process than white staff – again with London being the worst performer on this indicator.
- London was the worst performing region for WRES indicator 5 (experiences of bullying and harrasment). However, it should be noted that London was one of the only regions where a higher percentage of white staff, compared to BME staff, reported experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
- For both BME and white staff, the London region had the highest levels of harassment, bullying or abuse from staff (WRES indicator 6). This was higher for BME staff
- Only two thirds (65.8%) of BME staff believe their trust provides equal opportunities for career progression or promotion, compared with 83.3% of White staff

> "Leading on race equality must be top priority for London"
>
> **Sir David Sloman (June 2020)**

1. https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

Executive summary (continued)

- BME representation on London boards is improving – and is much better than the national picture – but is still significantly lower than BME representation elsewhere.
- In 2014, two-fifths of all NHS trusts in London had no BME board members. As of 1 December 2019, all London trusts have at least one BME board member. 14.7% of very senior managers in London are now from a BME background.
- Almost four in ten (11,006) medical staff are from a BME background, but BME doctors tend to be overrepresented in non-consultant career grade roles and underrepresented in consultant and senior medical manager roles.
- Of the gold command teams – the most senior level teams at trust and regional level, responsible for dealing with the most serious events, such as Covid-19 – just 16.6% are from BME backgrounds. At the height of the pandemic, seven of the 36 London trusts had no BME representation on the gold command structures. Ten trusts had just one BME member.

All this has implications in attracting and retaining staff, as can be seen by the response when the NHS called for those who had recently retired or otherwise left frontline care to register their interest in coming back to help with Covid-19. London had the lowest number of nurses and midwives expressing an interest to return.

This stark data and evidence call for steps to be taken through our response to Covid-19 to address BME representation in decision making. Diversity of thought brings benefits when faced with unprecedented challenges and the disproportionate deaths of BME health and care staff during the coronavirus pandemic brings this into sharp relief and calls for immediate action.

Executive summary (continued)

> "These are not issues that a simple framework or policy can improve. There must be a sustainable programme of education, enablement, empowerment and change."
>
> **Yvonne Coghill,**
> Director Workforce Race Equality

Interventions and Recommendations

All the data in the world is meaningless if we are not prepared to act on it. In **part three**, the document introduces practical interventions for individuals and organisations. Whoever you are, and whatever you do for our NHS in London, you should be able to see something here for you.

We have not sought to impose a specific regime but create a framework of ideas and options for individuals and the system. This cannot be a one-time or fixed solution. It must be dynamic and evolve with time and new learning.

We acknowledge that some of the interventions are conceptual and long term, but these will come to fruition as systems come together and opportunities for collaboration and new ways of working form. This strategy has not been designed to sit on shelves to gather dust, but to be the impetus for the region to work and think differently.

Not all interventions are equal. Many steps taken in the past to combat inequality have fallen down either because they are too short term – focusing on quick wins as opposed to a real structural change – or because they are based on what is known as a "deficit model", where the person who is the victim of structural discrimination is the target of an intervention. A simple example is a training programme to help BME candidates improve their interview technique. It might mean more BME candidates do well at interview, but it fails to address the cause of the inequality – the interview process itself.

We look at ongoing good practice, alongside new proposals and long-term conceptual thinking. The aim is, in one sense, to understand what works and what does not work, but this chapter should also serve as a call to action to leaders across London. In particular we have focused on work already in progress, and what still needs to be done, including:

- HR processes – in all London trusts BME staff are more likely to go through a formal disciplinary process,[2] while BME doctors are twice as likely as their white counterparts to be referred to the GMC.
- London People Board – which aims to make the NHS in London a better, more equal place to work
- Cultural Change Programme – the next phase of the WRES programme, focusing on the less tangible culture of an organisation that can be the difference between feeling empowered to do your job and feeling excluded or demoralised.
- Recruitment, secondments and professional development – with white applicants nearly twice as likely (1.60 times) to be appointed from shortlisting compared to BME applicants, we are calling for organisations to commit to overhauling and actively de-biasing recruitment and selection processes.
- Multi-professional leadership groups for primary care and for individual professions – Establish multi-professional leadership groups who will work with primary care to co-design specific race equality strategies for this vital pillar of the NHS to ensure that this vision is realised for their staff. The groups will work through existing networks, including primary care networks, CCGs, federations, dentists, pharmacists, optometrists, local professional networks, STP/ICSs and London's Local Medical Committees. The multi-professional leadership groups will also work with AHPs, finance, healthcare scientists, doctors, dentists, optometrists, pharmacists and other regulated professions to co-design specific strategies for their professions.
- After 40,000 add; nursing vacancies. As such, keeping nurses, attracting new nursing applicants, and encouraging nurses to return to the NHS are of crucial importance. However, London staff, including nurses, report the worst experiences nationally for most of the WRES indicators and their experiences vary significantly from those of their white counterparts.

2. https://www.england.nhs.uk/publication/workforce-race-equality-standard-data-reporting-2019/

Executive summary (continued)

Recommendations

The strategy presents **15 key recommendations** for London. These arose from a range of requests for action from our stakeholders and partners. They point to areas where commitment and focus could make a significant difference and lasting improvement to the lived experience of our BME workforce. While some will belong to regional and national teams, many are aimed at organisations and system leadership, with support from the regional Equality and Inclusion Team. These recommendations will take the NHS in London a step closer to being the organisation all its staff deserve.

The recommendations can be categorised in a number of ways. Some are quick wins; some are slow burns. Some are high impact; some less so. But to provide an overarching framework through which to understand them, we will be using the one developed by the national WRES team, which itself was informed by the work of Dr David Williams. Each intervention will be characterised based on the following themes:

- **Encouraging Transformation** Including the development of compassionate and learning cultures; the mobilisation of system leaders; and a particular focus on supporting core managers.
- **Enabling People** Including genuine meaningful engagement with individuals across the system; focussed support for those who need it; and the sharing of replicable good practice.
- **Embedding Accountability** Including ensuring alignment across systems; robust regulation and scrutiny; and a focus on emerging healthcare architecture.
- **Evidencing Outcomes** Including the gathering of data and intelligence; benchmarking organisations; and making evaluation and sustainability a priority.

Summary of recommendations

1 Modernise HR processes to ensure a more collaborative and person-centred learning approach

2 An executive on each board should complete the WRES Advisor Programme

3 Launch cultural transformation programmes for London

4 Increase BME representation among Freedom to Speak Up Guardians and champions and ensure support is available across the system, including within primary care

5 Establish Sustainability and Transformation Partnerships/Integrated Care System Workforce Race Equality panels

6 Commissioners should work collaboratively, and as peers with, all providers in enhancing their performance against indicators of race inequality

7 Work with the Care Quality Commission to develop specific race related key lines of enquiry for inspections

8 Develop a competency framework and development programme for all core managers, supervisors and line managers throughout the system

9 Implement a white allies programme

10 Make available a local Frontline Staff Forum

11 Establish a London-specific WRES Experts programme to build London's capacity and capability

12 De-bias recruitment, secondments, and professional development opportunities

13 Identify and close the gap in experience for agency, bank and temporary staff

14 Establish a multi-professional leadership group who will work with staff working in primary care, AHPs, finance, healthcare scientists, doctors, dentists and pharmacists to co-design specific strategies for their professions

15 Implement the key recommendations from the London Nursing and LAS priority plans

Executive summary (continued)

In launching this strategy, the NHS in London is entering into a **10-year commitment** to addressing racial inequality. Even so, we recognise that we cannot wait 10 years for the NHS in London to start to feel inclusive. It is urgent that all staff, in all roles and at all levels, feel valued, safe and respected at work. Some recommendations, such as modernising HR processes, are already underway or planned to begin in the near term, others are conceptual and will be nearing implementation towards the end of the 10-year timeframe.

Taking this work forward

Part four discusses next steps, including an implementation plan that will be developed in collaboration with the system to expand and develop the recommendations, making meaningful change for all of London. With this in mind, we introduce the 7 As of Authentic Allyship. This model has been specifically developed for this strategy by Yvonne Coghill, Director of the Workforce Race Equality Standard, to help colleagues take the practical steps needed to make race equality a reality for the NHS in London. Where steps are required at a system or organisation level, the London team stands ready to support with resources, and will ensure that the implementation planning phase takes account of all the varied needs of the region.

Finally, the resource section at the end of this document draws together a collection of resources useful in tackling race inequality. Some have been instrumental in the development of this strategy, and some are vital in their own right. We hope that our readers will engage with this resource willing to have their assumptions challenged and their mind changed.

The vision, on the front of the strategy is a real-world articulation of what a truly inclusive workplace might feel like. It is a powerful statement of the desire to be included, valued and treated fairly and with respect. This is all the more important because a valued and appreciated workforce is a workforce that delivers high quality patient care.

My Experiences as a BME NHS staff member in London

"I was exposed to explicit racism growing up, which consciously and unconsciously shaped the way I interacted with others. Throughout my schooling, I learned and adopted the social expectations and norms of my era. I knew my place. Looking back, I realise that my survival strategy was to make myself as non-threatening as possible. As an employee of the NHS, I became well practiced in the art of not offending white colleagues, to the point that I ceased to become outraged and became complicit with unacceptable behaviours. I looked the other way when racist comments and jokes were said in my presence. I sucked it up and took it on the chin when told to lower my profile. The pivotal moment for me was when a director saw me as his successor. He believed in me and my ability to progress. Over the years that followed I started a personal journey of unlearning the protocol that was expected of a black person in the NHS. What I discovered was myself, my authentic self, my voice.

Merely counting diverse heads won't guarantee sustainable progress or deliver the NHS reforms we are all striving to achieve. The reason I say this is because, when individuals routinely experience discrimination, their ability to be compassionate to themselves is impaired and that has an impact on their ability to give compassionate care."

Director

Part 1
Setting the scene

14 Introduction
16 Overarching principles
17 Strategic principles
19 National context
21 The NHS in London
23 Terminology and key concepts

Introduction

The NHS workforce is more diverse in London than in any other part of the country, and yet there remain critical disparities between workforce groups based on their ethnic and racial background.

Leadership in the NHS in London is not representative of the workforce it leads, or the communities it serves and the Workforce Race Equality Standard (WRES) shows that, by many measures, black and minority ethnic staff continue to have a worse experience of working life than their white counterparts. In the data, explored in detail in Part 2 of the strategy, we continue to see recruitment, development, and career progression weighted in favour of white colleagues.

There has always been a fundamental need to change these realities, but this extraordinary year has seen a shift in rhetoric and understanding around race disparity in England and worldwide. The disproportionate impact of Covid-19 on BME people in the UK and elsewhere, combined with the increased awareness of the Black Lives Matter movement, have shone a spotlight on structural inequalities and institutional racism in British society that have been tolerated for too long.[3]

The NHS, although a treasured institution, is not immune from these forces, and the WRES continues to show disparities. This is critical, because a diverse workforce has a positive impact upon staff experience, patient outcomes and on organisational efficiency.[4]

According to data published by the Royal College of Nursing (RCN) in October 2018, there are now more BME nurses than white nurses in London.[5] A recent Office of National Statistics (ONS) report has found that black people are as many as 4 times as likely to die from Covid-19 than white people.[6] The large proportion of BME staff in the NHS in London, and the disproportionate concentration of these staff in patient facing and front-line roles, requires a focussed examination of race equality in the London healthcare system.

3. https://www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities
4. New research is currently underway at Imperial College London (endorsed by the Patient Safety Leadership Forum) to better understand factors that influence patient safety, including the correlation between WRES scores and patient safety outcomes. This research will be shared when finalised.
5. https://www.rcn.org.uk/news-and-events/news/rcn-london-research-into-bame-numbers
6. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020

Introduction (continued)

There is an opportunity to learn from this crisis and use it to accelerate the work already being done to deliver race equality in the NHS. The health and care system in London is on a journey towards operating in Integrated Care Systems (ICSs). These systems are designed to bring NHS organisations, local councils, and others into strategic partnership, taking collective responsibility for improving the health of the local population. This means collaborating on, among many other things, workforce. It is vitally important that a commitment to race equality is embedded in these structures in both spirit and letter. The development of anchor institutions – organisations that, alongside their main function, play a significant and recognised role in the local economy – further unlocks the opportunity for the NHS in London to take a leading position in addressing racial disparity at a community and social level.

The WRES can hold up a mirror to parts of the system in London, but it is for the leadership across the region to take ownership of the problems in their healthcare system, to deconstruct racially discriminatory systems, and to be a part of rebuilding them in a form more befitting a modern employer.[7]

The high quality data provided by the WRES has been instrumental in identifying areas of focus, quickly flagging London, nursing and the London Ambulance Service as areas for initial attention at a national level. The WRES data until recently has been focused on NHS trusts, with the medical and primary care workforce largely out of scope. This has changed with the launch of the WRES indicators for medical staff but the amount of data we have access to and our ability to evaluate the impact of interventions at a professional level is more limited. However the data we do have, both quantitative and qualitative, highlights the need to develop additional and specific strategies for all professional staff– approaching the needs of our Allied Health Professions, healthcare scientists, finance, dentists, pharmacists, optometrists, GPs and non-professional staff in a tailored and focused way. These strategies, to be developed in partnership with our people, are to follow as part of the implementation phase. It is important to note that while the specific strategies are developed the majority of the recommendations within this strategy will apply to all groups, enabling rapid progress towards our vision for inclusion.

My Experiences as a BME NHS staff member in London

"My line manager treats me less equitably than my white colleagues.

Opportunities are preferentially given to colleagues who are less experienced than me.

Earlier in the year, when a team member was needed to link to national colleagues on the Covid response, two peers were allocated as leads despite my role being specifically linked to infection. I appealed to a director who helped revert the decision but shortly after I was moved to a role outside my portfolio.

More recently, my line manager has repeatedly undermined me by treating my direct report as if they are senior by repeatedly communicating to my direct report on work to be undertaken by the team and excluding me from these conversations. My confidence has been impacted. Following recent changes, I feel upset, undermined and weary of inequity in this organisation which has been ongoing."

Regional Manager

7. https://www.england.nhs.uk/publication/workforce-race-equality-standard-data-reporting-2019/

Overarching principles

This London strategy, to be honed and implemented over a span of 10 years, has been developed based on the values of the NHS Constitution.[8]

We have ensured the values of fairness, justice, equality, inclusion, dignity and respect are woven throughout the work. We have taken into consideration our responsibilities and available provisions under the Equality Act 2010 and the Public Sector Equality Duty.[9]

It has been designed and co-created in partnership with colleagues who have shared their lived experience from all professions and backgrounds across the NHS in London, as well as input from the national WRES team. The strategy and the lived experiences within it are a call for everyone, at all levels within the NHS to come together to understand and address race inequality.

Core principles have guided the work throughout. These principles have been shared with contributors at every stage of the strategy development and will be carried forward into our next steps.

- Race equality is everyone's business and we all have a responsibility to eliminate inequality
- This strategy is based on evidence, both quantitative and qualitative, including testimonies from NHS staff across London
- The strategy focuses on performance improvement and outcomes
- There will be clear accountability with consequences for lack of action and rewards for progress
- We need bold and brave conversations with system partners and associated commitment to action
- Stakeholder learning and insights should be leveraged to drive improvement efforts
- Cultural transformation – how it feels to work in and use the NHS – should be at the heart of improvement efforts
- Recommendations will cover the short, medium and long term

8. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf
9. https://www.legislation.gov.uk/ukpga/2010/15/contents

Strategic principles

In addition to the overarching principles outlined above, we have been guided by key strategic principles and values, building on work developed by others in the field of racial equality.

Theoretical Frameworks

It is vital that change be based on evidence and this has been the guiding principle of the work the national Workforce Race Equality Standard (WRES) has been doing since 2015. The WRES team has engaged with the work of Professor David R Williams who writes extensively on the impacts of discrimination on racial disparities in health[10]; James Nazroo's work on health inequality and its interactions with social class[11]; Naomi Priest's work on racism as a determinant on health[12]; among many others. These thinkers have influenced the direction the WRES has taken over the years, but it is for the NHS itself to turn that learning into action.

When it comes to recommending specific interventions (Part Three), this strategy has drawn heavily on principles of successful interventions outlined by Professor Williams – leadership, measurable outcomes, communication, resources, role models, and celebrating success.

Furthermore, each intervention will be categorised by its contribution to one of the four pillars of the national WRES framework:

- **Encouraging Transformation,** which includes the development of compassionate and learning cultures; the mobilisation of system leaders; and a focus on supporting core management
- **Enabling People,** which includes genuine meaningful engagement with individuals across the system; focussed support for those who need it; and the sharing of replicable good practice
- **Embedding Accountability,** which includes ensuring alignment across systems; robust regulation and scrutiny; and a focus on emerging healthcare architecture
- **Evidencing Outcomes,** which includes the gathering of data and intelligence; benchmarking organisations; and making evaluation and sustainability a priority

The importance of lived experience

Hard data can only tell us so much. The NHS is not just buildings and infrastructure and processes. It is millions of humans interacting on a day to day basis. We need to understand a person's lived experience to appreciate how the NHS is actually serving people, either as a care provider, or as an employer. We knew it was essential that these experiences be heard in this document. Throughout the process of developing this strategy, we have spoken to people from across London about their experiences of life in the NHS. Not only have these personal testimonies informed the interventions and recommendations, but we have included individual testimony throughout the document so that people's voices can be heard first-hand.

These testimonies are not all happy ones. They speak of discrimination and hardship; they contain painful and powerful truths. Our job is not to shy away from this, but to accept that this is the context we are living and working in and to commit ourselves to fixing it.

10. Williams, David R., Jourdyn A. Lawrence, and Brigette A. Davis. "Racism and health: evidence and needed research." *Annual review of public health* 40 (2019): 105-125.
11. James Nazroo; Class and Health Inequality in Later Life: Patterns, Mechanisms and Implications for Policy – Int J Environ Res Public Health. 2017 Dec; 14(12): 1533. – Int J Environ Res Public Health. 2017 Dec; 14(12): 1533.
12. Paradies, Yin, et al. "Racism as a determinant of health: a systematic review and meta-analysis." *PloS one* 10.9 (2015): e0138511.

Strategic principles (continued)

The importance of co-design – "Nothing about me without me"

A unifying principle for this strategy, and for all the interventions identified, is co-design. The principle of co-design accepts that no one person alone can be expected to solve a problem, especially where that problem affects people from diverse backgrounds. Co-design is about accepting that shared understanding, dialogue and collaboration are all essential for genuine change. Nothing should be done regarding staff members without their involvement in the design process. By including the voices of those who will be impacted at design stage, you create a sense of ownership, give people a genuine voice, and dramatically increase the chance of an intervention making a difference.

Intersectionality

No person can be reduced to a single categorisation. We are not just our race, nor gender, nor sexual orientation or class. We are a combination of all these things, and many more. Although this strategy focusses on the challenges and discriminations faced by NHS staff because of their ethnicity, the authors of this report acknowledge that identity is complex, and discrimination more so. Intersectionality is a term coined by black feminist scholar Kimberlé Williams Crenshaw in 1989.[13] The concept attempts to encapsulate the idea that each individual is a combination of many different indicators of identity, and so any one person's experience of privilege and discrimination is unique.

The process of pulling together a strategy document like this one can occasionally require the authors to use broad terminology that collapses these differences. Terms like BME, BAME, or people of colour, though useful for indicating disparity of experience in the workplace, also threaten to homogenise the people we're talking about. Even so, in the development of this document, and the interventions it recommends, we never lost sight of the fact that each person is an individual, with their own intersectional experience of the world. As part of this strategy, we hope that system leaders will embody this same principle.

As we move forward into implementation, we will engage with colleagues from all groups to ensure that, whilst the focus on race is maintained, the strategy considers individual needs through an intersectional and nuanced lens. This strategy will be part of the wider Equality and Inclusion programme for London.

My Experiences as a BME NHS staff member in London

"I grew up with racist comments at school so have become used to it. I have been asked when I was planning to go back to my own country when I was a healthcare student by a patient. But also, being told I wasn't a proper Indian by other Indian doctors because I was born and grew up in the UK.

It's frustrating that some senior directors think that skin colour is the only thing that differentiates white people from BME people… we need a culturally competent workforce that knows not all people of a black, Asian and minority ethnic background are the same. We shouldn't be lumped together on the basis of skin colour."

Medical Director

13. Crenshaw, K: Mapping the Margins: Intersectionality, identity politics, and violence against women of color. https://www.racialequitytools.org/resourcefiles/mapping-margins.pdf

National context

The NHS is an enormous organisation, employing over 1.4 million people. As such, it is important to acknowledge what other system interventions have been published and planned, in order that this strategy can be viewed as part of that complex national context.

The Long-Term Plan (LTP)

The NHS Long Term Plan (LTP) was published in January 2019 and developed to give the NHS its overarching priorities and objectives over the subsequent decade.[14] Chapter 4 of the plan committed the NHS to getting the staff it needed for it to continue delivering a world class service. Chapter 4.42 states that respect, equality and diversity would be central to changing the culture in the NHS and would be at the heart of the forthcoming workforce implementation plan (the People Plan). The plan also committed additional investment to support the work of the WRES. This strategy aims to support the LTP objective of all staff, regardless of background, being treated with dignity and respect.

People Plan

In August 2020, the NHS launched *We are the NHS: People Plan for 2020/21 – action for us all*, also known simply as the People Plan.[15] The People Plan focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as actions to grow our workforce, train our people, and work together differently to deliver patient care. It outlines actions for leaders across the NHS for 2020/21 and includes some significant steps with regard to race equality, including the launch of the NHS Race and Health Observatory.[16]

This strategy is aligned with the spirit and actions of the People Plan and there is a great deal of interconnection between the two documents. Equally, there are recommendations and actions mentioned in both documents. Where relevant, these connections are made clear.

Covid-19

It would be impossible to write a strategy in 2020 without reference to Covid-19. The pandemic will change the ways we all live our lives, and, in its spread, it has highlighted more starkly than ever the need for action on racial disparity in health outcomes. Tragically, the disparity between white and non-white Covid-19 deaths has been particularly stark among the NHS workforce.

14. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
15. https://www.england.nhs.uk/wp-content/uploads/2020/07/We_Are_The_NHS_Action_For_All_Of_Us_FINAL_24_08_20.pdf
16. https://www.england.nhs.uk/2020/05/nhs-england-and-nhs-confederation-launch-expert-research-centre-on-health-inequalities/

National context (continued)

Prior to the publication of this strategy, Sir Simon Stevens and Amanda Pritchard – NHS Chief Executive and NHS Chief Operating Officer sent a letter to the whole of the NHS signalling the start of "phase three" of the NHS Covid-19 response, setting out priorities for the rest of 2020/21.[17] Crucially, among many other plans, it recommends that all relevant organisations should have a named executive board member with responsibility for tackling inequalities. Furthermore, it asks all NHS boards to publish an action plan showing how over the next five years its board and senior staffing will, in percentage terms at least match the BME composition of its overall workforce, or its local community, whichever is the higher. This is a significant ambition, and one that the authors of this strategy fully endorse.

Workforce Race Equality Standard (WRES)

The WRES gathers data on racial disparity of experience and opportunity in trusts, CCGs and Arms Length Bodies (ALBs) across the NHS. The WRES does not, at present, capture race inequality within primary care and community providers but has recently launched a new set of indicators designed to more thoroughly examine the experiences of the medical workforce.[18]

The WRES is the most powerful tool the NHS has in tackling racial inequality. Through the sustained reporting of progress against nine key indicators, it has held a mirror up to the system since 2015 and helped us reach a point where inaction is no longer a tenable position. This strategy seeks to build upon the success of that program, and two of its more recent published ambitions. *A fair experience for all*[19] outlines practical ways in which employers can tackle the racial gap in referral to disciplinary proceedings; and *A Model Employer*[20] gives trusts locally individualised aspirational goals to increase BME representation at senior levels. These documents should be read alongside this strategy.

Equality Act 2010 and the Public Sector Equality Duty[21]

The Equality Act 2010 offers legal protection from discrimination in the workplace and society. This vital legislation brought previous anti-discrimination laws under a single Act, strengthening protections and making the law easier to understand – clearly setting out the ways in which it's unlawful to treat someone.

It is against the law to discriminate against anyone on the basis of any of these protected characteristics:

- Age
- Being married or in a civil partnership
- Being pregnant or on maternity leave
- Disability
- Gender reassignment
- Race including colour, nationality, ethnic or national origin
- Religion or belief
- Sex
- Sexual orientation[22]

The Act makes provision for positive action.[23] Positive discrimination, however, is unlawful. The Act sets out an explicit duty for public authorities to actively consider how our policies or decisions affect those the Act protects. We do this by having due regard in seeking to:

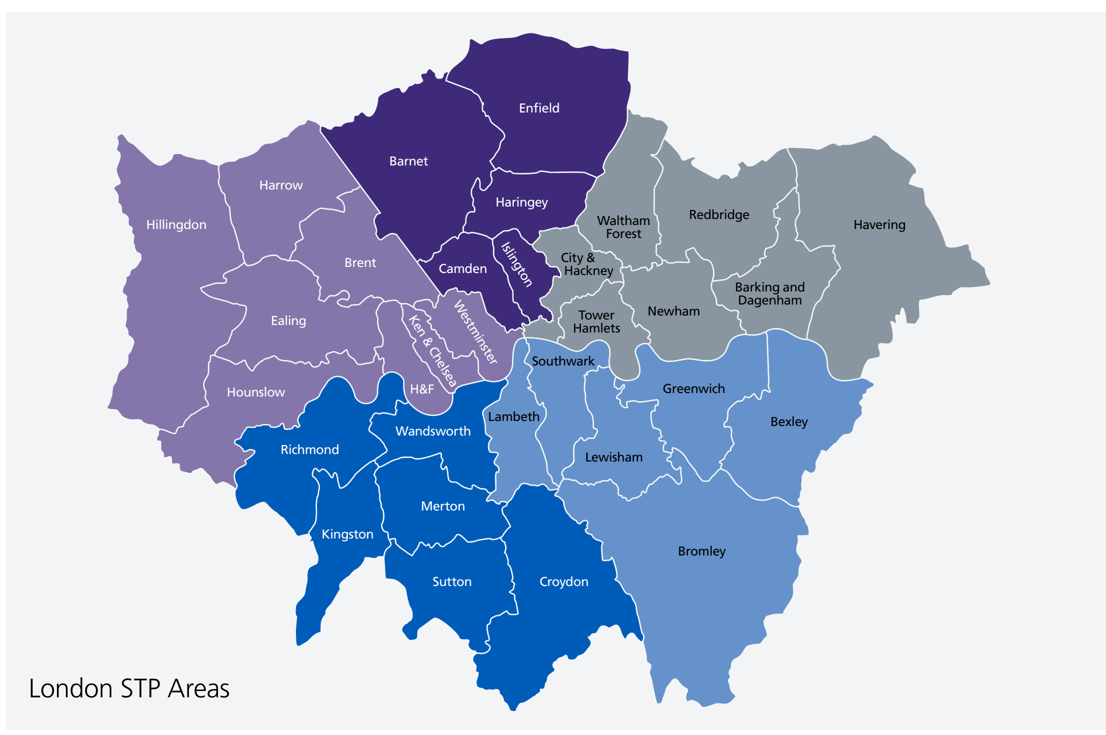
- Eliminate unlawful discrimination
- Advance equality of opportunity between people who share a protected characteristic and those who don't
- Foster or encourage good relations between people who share a protected characteristic and those who don't

We have significant evidence of the increased risk of discrimination and disadvantage faced by our colleagues from a BME background and, under the Public Sector Equality Duty, organisations have an obligation to address this. This strategy further enables us to take action to advance equality of opportunity. This means we can explicitly work to remove or reduce disadvantage, meet the needs of our BME staff, and encourage increased participation in all areas of the NHS. This approach may include positive action and will enable us to ensure that the NHS is a great place to work for people from all backgrounds.

17. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf
18. https://www.england.nhs.uk/publication/workforce-race-equality-standard-wres-indicators-for-the-nhs-medical-workforce/
19. https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/fair-experience/#:~:text=One%20of%20the%20key%20aims,staff%20across%20the%20healthcare%20system.
20. https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf
21. https://www.legislation.gov.uk/ukpga/2010/15/contents
22. https://www.gov.uk/discrimination-your-rights
23. https://www.legislation.gov.uk/ukpga/2010/15/section/158

The NHS in London

NHS England and NHS Improvement London is responsible for distributing more than £18bn on health and care services.



London STP Areas

The NHS in London is made up of hundreds of organisations of different sizes each with their own unique organisational culture. While this structure enables us to support the health and wellbeing of over 8.8 million residents in London, the experience of London's NHS workforce is hugely variable. This strategy highlights this variability and aims to move toward a consistent standard.

Sustainability and Transformation Partnerships and Integrated Care Systems

In 2016, NHS organisations and local councils joined forces in every part of England to develop proposals for improved health and care. These were drawn up by senior figures from different parts of the local health and care system, following discussion with staff, patients and others in the communities they serve. These areas are called sustainability transformation partnerships (STPs). London was divided into the following five areas:

- East London (pop. 2m)
- North London (pop 1.5m)
- North West London (pop 2.4m)
- South East London (pop 1.9m)
- South West London (pop 1.4m)

These partnerships are designed to "evolve" into more sophisticated integrated care systems (ICS), a form of even closer collaboration, which gives local partnerships greater financial freedom to focus organisations' efforts on a holistic management of their population health. As of May 2020, around half of England is now covered by an ICS. In London, South East London and South West London are now integrated care systems, serving a population

The NHS in London (continued)

of 3.3 million people. The NHS Long Term Plan is clear that integrated care systems (ICSs) should be the main organising unit for local health service and that the NHS will support all local health systems in becoming ICSs by 2021.[24]

The People Plan is clear about the role these ICSs should have in workforce management. The benefit for systems is that they can pool capacity and expertise and more rapidly spread good practice in recruiting, retaining, developing and deploying their local workforce. In return, they will take on the leading role in developing and overseeing population-based workforce planning for local health services. The Interim People Plan also makes clear that the responsibilities of ICSs will include:

- developing initiatives to make the local NHS a better place to work and improve recruitment and retention, working closely with local government on shared priorities for health, social care and public health services
- ensuring system-wide leadership development and supporting regional talent boards.[25]

Currently, there is no uniform approach to gathering workforce data at system level, nor is there a robust system for ensuring that system leadership is representative of the communities it serves.

As system leaders, it is imperative that NHS England and NHS Improvement London lead by example on this agenda and model positive behaviours. This means a genuine, committed, and concerted effort to collect, publish and improve its own workforce race equality data. Unless it can make its own internal processes and systems fairer for BME people and improve the day to day experiences of BME staff, its ability to hold the system to account will be limited. Along with the hard data, the organisation needs to understand the lived experience of staff and build the culture of the organisation in a way that reflects the needs of the diverse workforce as well as the wider London community it serves. This includes diversity and representation across its leadership and decision-making roles.

Health Education England (London) is a key stakeholder in developing a regional approach to:

- Improving and amplifying workforce intelligence and insight across the region and through all professions
- Addressing inequity in access to learning and development
- Ensuring alignment with the work of the NHS Race and Health Observatory

London Anchor Network

Both the recent NHS phase three Covid-19 guidance and the NHS People Plan referenced the important local role the NHS plays as an 'anchor institution'. Anchor institutions are usually large public sector bodies that, alongside their main function, play a significant and recognised role in a place through their strategic contribution to the local economy as employers, purchasers, estate owners or managers and civic actors.

In London, we are clear that this concept matters. The impact of Covid-19 in the city reaches far beyond the immense pressure on the NHS to provide care to patients and the devastating mortality rates. The breadth of the impact on individuals, communities and the economy has yet to be truly realised, but we do know that a long journey to economic recovery and community prosperity lies ahead. We are also aware that the burden of illness and death due to Covid-19 has not been shouldered equally, adversely affecting those with long term health conditions, black and minority ethnic communities and people living in socio-economically deprived areas, thus widening health inequalities that communities already faced.

NHS London are developing a London Anchor Network which will look to understand how NHS organisations – alongside local partners – can work to proactively improve local socio-economic conditions and tackle the underlying drivers of poor health and health inequalities. Central to this work will be an explicit focus on skills and employment – supporting Londoners into the breadth of local roles the NHS can offer, aligning recruitment plans with population health and ensuring our organisations reflect the communities they serve. This work will engage partners at London, system and local levels.

24. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf
25. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

Terminology and key concepts

It is useful to look at some of the fundamental terminology and concepts used in race equality work and in this report.

Why BME?

Several terms are used in public policy, and in wider society, to refer to collective ethnic minority populations. These include black, Asian and minority ethnic (BAME), black and minority ethnic (BME), people of colour, and racialised minorities.

During our work, we came across some strong views on the use of terms such as BME and BAME. All of these terms have their limitations, including:

- Implying that BME/BAME individuals are a homogeneous group
- Singling out specific ethnic groups, which can be divisive and exclusionary
- Being a label applied from the outside that limits the ability of people to choose how to identify themselves

We recognise that this is a complex and multifaceted debate, but also that it is not one that can be decisively settled in this document. For the purpose of this strategy we will be using the term BME to describe groups of people whose ethnicity or racial background is a key factor in their experience or risk of discrimination at work in the NHS. This is not an endorsement of this term into the future, but an effort to ensure consistency with other NHS workforce race equality publications.

We also acknowledge the different approaches taken to capitalising the words black and white when referring to ethnicity. For consistency, we have used the non-capitalised forms in most cases, while sometimes using the capitalised forms in quotations, or when referring to specific categories from data sets (i.e. Black British, White British).

If organisations are trying to decide on the appropriate terminology to use, then we strongly suggest that it is best to involve and engage with staff. This will ensure you are using the appropriate terms and highlight an awareness of the sensitivities and complexities involved.

Racism

Racism is often misunderstood as treating someone unfairly or holding prejudiced views. Racism is a combination of racial prejudice plus the power – whether through authority or social structure – and conventions to act on the prejudice.

When we think about racism, we tend to consider individual racism, meaning the behaviours (including discrimination) arising from an individual's racist assumptions or beliefs.

Terminology and key concepts (continued)

This strategy though, focuses primarily on the eradication of systemic racism, where established policies and practices result in advantage or disadvantage to specific racial groups. This is different from individual racism because there may not be individual intent. Systemic racism can be viewed as:

- **Institutional racism** – The individuals involved may not themselves have racially prejudiced beliefs or behaviours, but are carrying out policies, processes, or procedures that disadvantage people from specific racial groups. The Macpherson report's definition of institutional racism is "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people"[28]
- **Structural racism** – inequality rooted across the operation of a system or society that excludes and/or has a significant negative impact on large numbers of a particular racial group and their ability to participate

Therefore, it is not enough to simply not be racist as an individual, there is a need for a conscious and deliberate effort to promote racial tolerance and dismantle racist structures, becoming an active agent of change, rather than a passive bystander. This is commonly referred to as being **anti-racist** and is a fundamental part of being an authentic ally.

Equally, it is important that white allies do not fall into the trap of **paternalistic racism**, whereby the 'majority race has the right to define what is good for the minority race'.[29] There is a risk that, even when trying to improve the working lives of BME people or fight discrimination, white leaders impose policy change, as opposed to working alongside BME people to co-design that change.

Discrimination

Discrimination happens when someone is treated unfairly or less favourably due to an actual or perceived protected characteristic and is unlawful under the Equality Act 2010.[30]

There are four types of discrimination as set out below. Examples given are in the race context:

1. **Direct discrimination** – Treating someone worse than someone else, for example not inviting someone for an interview because you believe them to be from a particular racial background
2. **Indirect discrimination** – Rules, policies, or ways of doing things which have a worse impact on someone with a particular characteristic than someone from another group, for example Friday team meetings taking place in a pub
3. **Harassment** – violating someone's dignity; creating a hostile, humiliating, degrading or offensive environment. For example, making fun of someone's name or how it is pronounced
4. **Victimisation** – This is treating someone unfairly if they are taking action under the Equality Act or supporting someone else who is doing so. For example, a white ally can be victimised if they are supporting someone bringing a harassment claim

28. The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny, February 1999
29. Hall, L. E. (2005). Paternalistic racism. In Dictionary of multicultural psychology: Issues, terms, and concepts (Vol. 1, pp. 133-134). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781452204437.n170
30. https://www.legislation.gov.uk/ukpga/2010/15/contents

Terminology and key concepts (continued)

My Experience as a white ally

"As a white woman I needed to do my own 'work'. Find out for myself what discrimination means, check myself for my intentions, to understand the history around the social construct of race and gender. To become really self-aware and notice what is happening, really see the micro aggressions rather than ignore them. To make a stand and call things out, even (especially) when it is uncomfortable. Do my work and don't be advantage blind. Understand that we are all biased, and try to be more aware of my biases. Don't stop working at it, even though it can be hard work, whilst recognising that it is work that doesn't have an end. There will **always** be more to do."

Director

White Privilege

Coined by the black civil rights activist William Du Bois in the 1930s and later coming to further prominence in Peggy McIntosh's 1988 groundbreaking paper White Privilege: Unpacking the invisible knapsack, the term white privilege is used to describe how having white skin gives an individual an advantage in life. White privilege does not mean that white people have never struggled, but in Britain they do not experience racial discrimination on an institutional or societal basis. Having white privilege and recognising it is not racist. But white privilege exists because of historic, enduring racism and biases and is the "power of accumulated power"[31]

The term **white fragility** was devised by Sociologist Robin DiAngelo after her experiences when facilitating diversity workshops in the US. It's defined as discomfort and defensiveness on the part of a white person when confronted by information about racial inequality and injustice. In her book, *White Fragility: Why It's So Hard for White People to Talk About Racism,* she describes in depth the phenomenon and explains that "responses include emotions such as anger, fear, guilt and behaviours such as argumentation, silence and withdrawal from the stress-inducing situation…though white fragility is triggered by discomfort and anxiety, it is born of superiority and entitlement."

Within NHS organisations, it is necessary to explore how white privilege has been exerted in day to day life and the impact on career progression.

Colourism

Colourism, also known as shadeism, is defined as "prejudice or discrimination against individuals with a dark skin tone, typically among people of the same ethnic or racial group."[32] This kind of discrimination, based on skin colour, often sees members of the same race treated differently based on the social implications which are attached to their skin colour.[33]

In our society, the default for good, well educated, capable and acceptable is white. White people are accepted as the norm when it comes to beauty norms as well cultural norms, thus the further you are away from that norm, the more you are discriminated against, not only by people from white backgrounds but by BME people who have less melanin in their skins and are nearer to the default position of being white.

31. https://www.tolerance.org/magazine/fall-2018/what-is-white-privilege-really
32. https://en.oxforddictionaries.com/definition/colourism
33. Calla Reed: Colorism and Its Correlation with Implicit Racial Stereotyping: An Experimental Action Research Study

Terminology and key concepts (continued)

Colourism is a seed that was planted by white colonists, used to divide and rule black populations, with lighter skinned slaves being used in the big plantation houses to serve and darker skinned people in the fields.[34] Colourism is very much alive today, with sales of skin lightening and bleach creams booming worldwide. Its roots lie in the mainstream idea that the lighter you are the better. This myth is replicated in society every day.

Skin tone affects employability rates, promotion prospects, being stopped by the police, and suspension rates from school. With women's worth so heavily tied to appearance, and lighter skin so heavily tied to beauty standards, it is not surprising that it is usually women of colour who are hit hardest. In the NHS, we are not immune from this phenomenon. Many of our most senior BME leaders have lighter skins, however we have no way of quantifying this phenomenon and the impact it has as we do not categorise individuals by skin tone.

Hierarchy of Preference

The 'hierarchy of preference' describes the way our unconscious preferences and biases affect how we relate to people. Stereotypes, and people's beliefs about different groups of people, play a large part in how those groups are perceived and reacted to. For example, we are all aware of the much-used harmful stereotypes of the aggressive African woman and the passive Asian woman. These stereotypes matter and they carry weight. Our beliefs shape our attitudes and ultimately our behaviours. In the NHS, it isn't something that is often spoken about but, in 2015, Professor Michael West and Professor Jeremy Dawson's Document Making the difference brought the issue into popular consciousness.[35] It showed that, by far, the people that reported being discriminated against the most in the NHS were people from black backgrounds, followed by people of Asian origin, though we know that people of Indian descent are discriminated against less than those of Pakistani or Bangladeshi descent. We also recognise within the hierarchy of preference the impact on people of East Asian and Southeast Asian descent of being seen as 'model minorities'.[36]

It is important that the complexity of the issue of race is understood by us all, that we understand how it manifests itself in all corners of our daily and work lives, and how it impacts people from all races and all sections of society.

Internalised Racism

Internalised racism is defined as acceptance and belief by members of stigmatised races of negative messages about their race's own abilities and intrinsic worth.[37] Williams & Williams-Morris have also added that it is "the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves."[38] This is characterised by people not believing in others who look like them and, more importantly, not believing in themselves. It involves accepting limitations to one's own humanity, including one's dreams, one's right to self-determination, and one's range of allowable self-expression. It saps an individual's self-esteem and lowers their confidence in themselves and in their own race.[39]

It often manifests as the embracing of "whiteness" as being the ultimate and the best. Self-devaluation is common, and many will use derogatory and deeply offensive terms about themselves and others of their own race. They might disown their own cultures on the basis that the white man's world is better, and aspire to being a part of that world.

34. Howard Bodenhorn, "Colorism, Complexion Homogamy, and Household Wealth: Some Historical Evidence" in The American economic review [0002-8282] 2006 vol. 96/2, p. 256.
35. Michael West Jeremy Dawson Mandip Kaur: Making the difference Diversity and inclusion in the NHS – The Kings Fund December 2015, https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Making-the-difference-summary-Kings-Fund-Dec-2015.pdf
36. https://openaccess.city.ac.uk/id/eprint/14481/1/
37. T Camara Phyllis Jones: Levels of Racism: A Theoretic Framework and a Gardener's Tale – https://www.health.state.mn.us/communities/practice/resources/equitylibrary/docs/jones-allegories.pdf
38. Williams & Williams-Morris, 2000, p. 255; Taylor & Grundy, 1996).
39. For further reading please see: Lennox K. Thomas Empires of mind: Colonial history and its implications for counselling and psychotherapy – British Association of Psychotherapists, Refugee Therapy Centre 1a Leeds Place, London, UK – January 2013)

Terminology and key concepts (continued)

Internalised racism often leads to resignation, helplessness, and hopelessness and can lead to people engaging in risky health practices, dropping out of education and not engaging in society. The evidence suggests that internalised racism is more common than we think, with a third of people from BME backgrounds having some level of internalised racism in their makeup.[40]

The concept is explored in Camara Jones' 2000 paper entitled *Levels of Racism: A Theoretic Framework and a Gardener's Tale*. Despite this landmark piece of work, the concept is rarely spoken about.

Biological Weathering

In her work, *"Weathering" and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States*, Arline Geronimous showed that chronological age doesn't only capture the length of time you have been alive, but also the experiences you have had during that time.[41] She found that black people experienced greater physiological "wear and tear", and were ageing, biologically, more rapidly than white people. This effect is driven by the cumulative impact of repeated exposures to psychological, social, physical, and chemical stressors in their residential, occupational and other environments. She found that coping with these stressors, now commonly called microaggressions, meant that, compared to white people, black people had many more negative experiences. The accumulation of these experiences ultimately weakens them physiologically.

The impact of discrimination can be physically observed in telomere length. Telomeres are sequences of DNA at the end of chromosomes. Telomere length is viewed as an overall marker of biological ageing. In her study, Arline Geronimous found that black women had shorter telomeres than white women, meaning that at the same chronological age, black women had accelerated biological ageing of about 7.5 years more than their white counterparts.

Arline Geronimous called the phenomena "biological weathering" – the wearing out or erosion of an individual physiologically, leading to more susceptibility to illness and death at a much younger age than their white counterparts. Understanding this concept is essential when considering the impact of discrimination and inequality in the NHS.

40. Jones, Camara Phyllis. "Levels of racism: a theoretic framework and a gardener's tale." *American journal of public health* 90.8 (2000): 1212.
41. Geronimus, Arline T., et al. ""Weathering" and age patterns of allostatic load scores among blacks and whites in the United States." *American journal of public health* 96.5 (2006): 826-833.

Terminology and key concepts (continued)

Microaggressions

Derald Wing Sue has defined microaggressions as everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership. It is possible that perpetrators of microaggressions are often not aware that they are engaging in communication that is derogatory to people from the BME communities. Whether intentional or not, microaggression is a form of racism that has negative impact on those impacted and is a significant risk factor for diminishing wellbeing and productivity at work.

My Experiences as a BME NHS staff member in London

"I am aware doing my job as a black woman in a senior position and when I look around me at senior level, I do not see people that look like me. At senior level meetings, I am aware that I am the only black person in the room. I feel that I have to have a mask on as I can't be myself. Covid-19 has magnified this even more, I never used to think much about microaggressions and during Covid-19 I have experienced it and seen this with my own two eyes. It made me reflect a lot and I have spoken out about it to my white colleagues. When I have raised this with the white CEO and other directors' colleagues, they said they don't know what 'white privilege' is and what microaggressions are. Through Covid-19, I have found my voice and have actually said to them, it's not for me to teach you so I have sent them information and they have embraced it. So much so, that they came to the Nigerian Nurses & Midwives event which they found really helpful so it's great that people are speaking about it, but I want the actions. Since March, I have reflected personally and professionally, and it has brought up many emotions. I have had counselling because I felt there was a rage in my belly, there was a fire really burning and I didn't think I was going mad but felt really frustrated as I hadn't processed that.

What was really inspiring with Covid-19 is that I've met other black women and men not physically but virtually and it has been so liberating not having to explain myself and the overwhelming thing was to cry and it's been a relief to see people that look like me. Unfortunately, I had a bereavement and I am a woman of faith and took some leave as I felt God needed me to step away as in addition, the racism and discrimination, Covid-19 just magnified it. With the event of George Floyd's death, the whole world was talking about it. I remember in my workplace; we were talking about #Black Lives Matter and someone said what can't we talk about all lives matter? And I explained that, and I had spoken to another director that day on the Covid-19 call and during the call they had said #Black Lives Matter and they even quoted Martin Luther King. Why can't organisations say #Black Lives Matter, why do they keep on saying BME? These events have made me speak out more and I want actions. As a result, I have set up a Black Women's forum. I'm tired now, I want to see actions in the NHS and other organisations."

Social worker

Part 2
Data and evidence

30 Introduction
31 Demographics
32 The WRES in London
36 Workforce Race Equality Standard (WRES): Indicators for the NHS medical workforce
37 Allied Health Professionals (AHPs)
38 Variation of experience within BME ethnicities
39 Covid-19 in London
40 London Covid-19 – Senior leadership at a time of crisis

Introduction

This strategy is based on evidence and research, without which it could not hope to be successful in tackling race inequality.

Collecting data has been key to the success of the WRES over the past five years. Here, we have sought to go even deeper into the structures that impact race equality in London. This section gives an overview of the evidential context in which this strategy has been written acknowledging that we have further to go to ensure we have the same rich data for all, including primary care.

Demographics

London is the most ethnically diverse part of the country. In mid-2015, London had a population of 8,674,000, representing 5.7% population growth since the 2011 census.[44] At the 2011 census, 59.8% were White, and 44.9% were White British. The highest proportion of white population is found in Richmond Upon Thames (86.7%) and the lowest proportion in Brent (31.1%).

Race inequality in London is not limited to health outcomes. People from BME backgrounds are, on average, paid less than their white counterparts. Research by the GLA in 2017 showed that the mean ethnicity pay gap in London is 21% for BME people when compared to white people. When specific ethnic groups are separated out, the lowest ethnicity pay gap is among the Asian or Asian British group (16%) and highest within the Black or Black British group (26%).[45]

At the 2011 census, 22.1% of people in London reported a first language that was not English. The London borough of Newham had the lowest proportion of people reporting their main language as English at 58.6%. Other London boroughs, Brent (62.8%), Tower Hamlets (65.8%), Ealing (66.1%) and Westminster (69.2%), also had some of the lowest proportions where English was the main language. These areas were also shown to be some of the most ethnically diverse.[46]

44. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/populationdynamicsofukcityregionssincemid2011/2016-10-11
45. https://www.london.gov.uk/sites/default/files/gla-ethnicity-pay-gap-report-2017.pdf
46. https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/language/articles/languageinenglandandwales/2013-03-04

The WRES in London

The WRES data shows that, despite having the highest proportion of BME staff in the country, London has significant issues in terms of its WRES indicators.

The following insights are drawn from the 2019 data report and associated data collection:[47]

- As with the rest of the country, BME staff are significantly under-represented at senior pay bands. 44.9% (92,487) of all staff working across London trusts are from a BME background, compared to only 12.5% (54) of BME staff working at AfC band 9. This is a slight increase from 11.9% (48) in 2018
- London was the worst performing region on WRES indicator 2, with white applicants being 1.6 times more likely to be appointed from shortlisting compared to BME applicants. In 34 of the 35 London trusts that provided reliable data for this indicator, white applicants were relatively more likely to be appointed from shortlisting compared to BME applicants
- London has the worst performance for WRES indicator 3. In all 36 London trusts, BME staff were relatively more likely to go through the formal disciplinary process than white staff
- London was the worst performing region for WRES indicator 5 (experiences of bullying and harrasment). However, it should be noted that London was one of the only regions where a higher percentage of white staff, compared to BME staff, reported experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
- For both BME and white staff, the London region had the highest levels of harassment, bullying or abuse from staff (WRES indicator 6). This was higher for BME staff
- London has the worst performance for WRES indicator 7, with only 65.8% of BME staff believing that their trust provides equal opportunities for career progression or promotion, compared with 83.3% of white staff
- London has the highest reported rates of discrimination for both BME and white staff (WRES indicator 8). In every London trust, a higher percentage of BME staff reported personally experiencing discrimination at work in the last 12 months compared to white staff

47. https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

The WRES in London (continued)

WRES data for the last four years have identified London as a region that requires concerted focus and support to improve performance on this agenda. Despite these challenges, there are steps in the right direction. In 2014, two-fifths of all NHS trusts in London had no BME board members. As of 1 December 2019, all London trusts have at least one BME board member. 14.7% of very senior managers in London are now from a BME background.

The proportion of BME staff in London STP/ICS areas ranges from 15.4% in the London Ambulance Service, to 49.1% in North East London.

For London as a whole, WRES indicators 2, 3 and 4 have been broadly improving since the WRES data collection began in 2016, but they do not all compare favourably to the national average. In the 2019 WRES report London was the worst performing region for indicators 2 and 3, with BME applicants for NHS posts less likely to be appointed from shortlisting than white applicants, and more likely than white staff to enter the formal disciplinary process.

	Headcount				Percentage		
STP/LAS	Sum	White	BME	Sum	White	BME	Unknown
London Ambulance Service	4718	879	128	5725	82.4%	15.4%	2.2%
North Central London	20397	18887	2015	41299	49.4%	45.7%	4.9%
North East London	17269	18731	2140	38140	45.3%	49.1%	5.6%
North West London	24362	24288	4072	52722	46.2%	46.1%	7.7%
South East London	22211	19885	2948	45044	49.3%	44.1%	6.5%
South West London	12174	9817	1223	23214	52.4%	42.3%	5.3%

Indicator Type	WRES Indicator	Metric Description	2016	2017	2018	2019	Direction	2019 National
			Score	Score	Score	Score		
Workforce	2	Relative likelihood of white applicants being appointed from shortlisting compared to that of BME applicants	1.80	1.81	1.63	1.60	▼	1.46
	3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process.	1.99	1.80	1.77	1.67	▲	1.22
	4	Relative likelihood of white staff accessing non mandatory training and Continuing Professional Development compared to BME staff	0.93	1.13	1.02	0.95	▼	1.15

The WRES in London (continued)

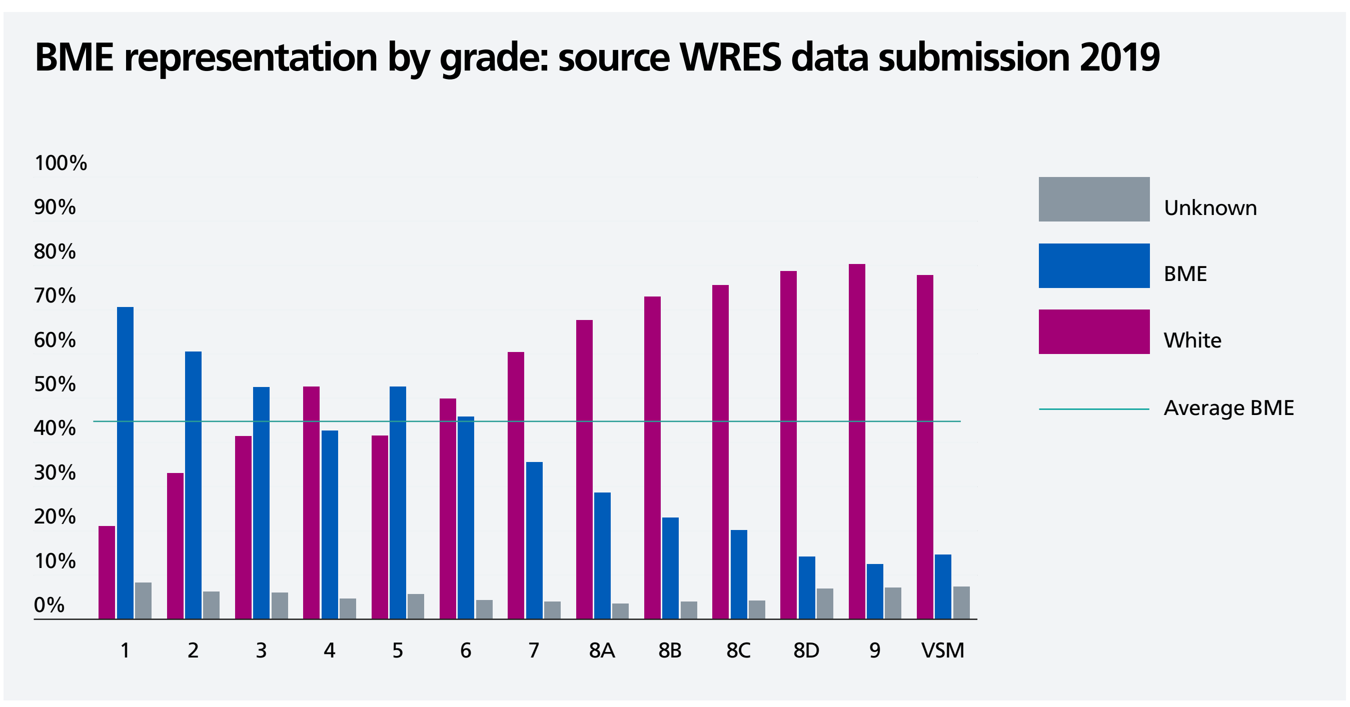
For WRES indicators 5-8, London data is broadly consistent with the national picture. However, BME staff continue to rate lower than their white colleagues in terms of their lived experience. While both BME and white staff experience higher than average bullying, harassment or abuse from the public, patients or relatives, more BME staff experience this treatment from colleagues (although for all staff the figures are higher than the national average). BME staff are considerably less likely to feel that their employer provides opportunities for career progression. Compared to white staff, BME staff in the NHS are almost twice as likely to experience discrimination at work.

In London, the representation of BME people on boards is improving over time and appears much better than the national picture. However, when compared with the proportion of BME staff at other grades, there is clearly still a significant gap between board level representation and representation elsewhere.

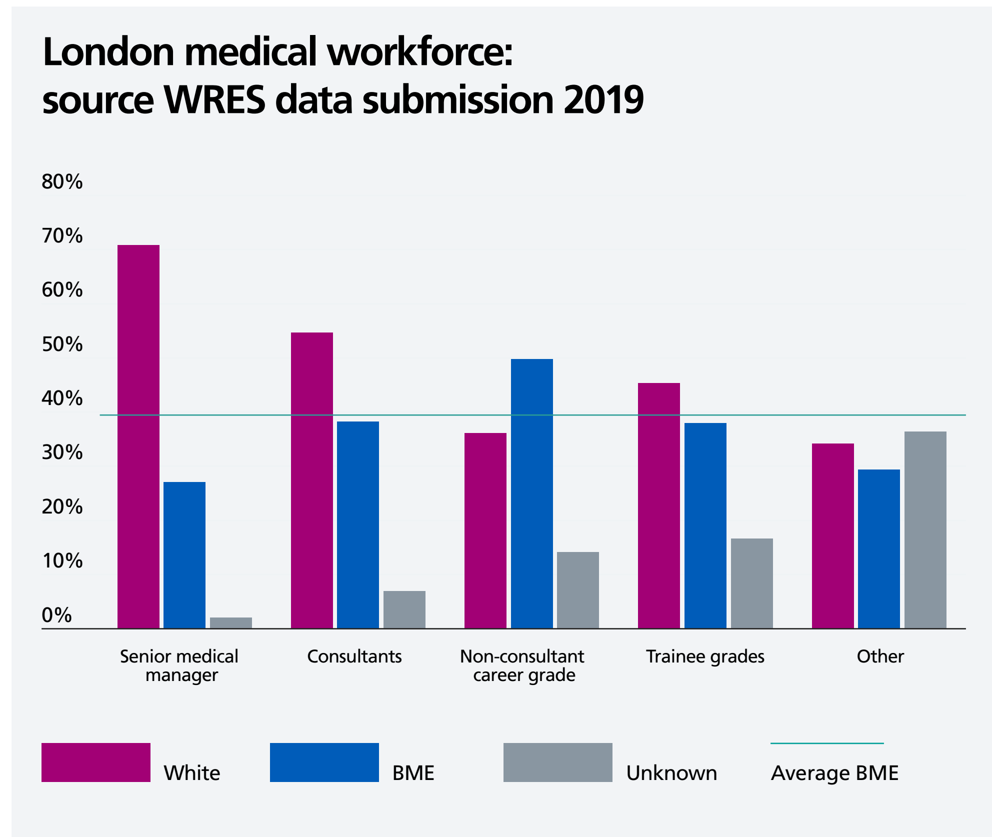
Indicator Type	WRES Indicator	Metric Description	BME 2017	White 2017	BME 2018	White 2018	National BME 2018	National White 2018
Staff survey	5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	30.4%	31.8%	31.7%	32.8%	29.8%	27.8%
	6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	29.9%	26.1%	30.9%	27.8%	29.0%	24.2%
	7	Percentage believing that trust provides equal opportunities for career progression or promotion.	67.6%	84.0%	65.8%	83.3%	69.9%	86.2%
	8	In the last 12 months have you personally experienced discrimination at work?	16.3%	7.9%	16.4%	8.4%	15.3%	6.4%

Indicator Type	WRES Indicator	Metric Description	2016	2017	2018	2019	Direction	2019 National
			Score	Score	Score	Score		
Board	9	Percentage of BME Board membership	12.4%	14.0%	15.9%	17.1%	▲	7.4%

This leads to a so-called 'cliff-edge' whereby the number of BME staff drops off significantly from Band 5 upwards. This trend is observable in the graph.



Workforce Race Equality Standard (WRES): Indicators for the NHS medical workforce



With 41 percent of the doctors in the NHS being from BME backgrounds, and to further boost the reach of the WRES, one of the key priorities for the WRES has been to develop a set of indicators that would enable ethnic variations in the experience of the medical workforce to be assessed.

There are eleven indicators for the medical workforce. Four of the indicators reflect variation in career progression and pay, six represent medical staff perceptions of how they are treated by colleagues, employing organisations and patients, and one highlights the diversity of the councils and boards of medical institutions. A draft publication has recently been released, outlining this new data set.

In London, 39.4% (11,006) of medical staff are from a BME background. However, BME doctors tend to be overrepresented in non-consultant career grade roles and underrepresented in consultant and senior medical manager roles (see table below).

My Experiences as a BME NHS staff member in London

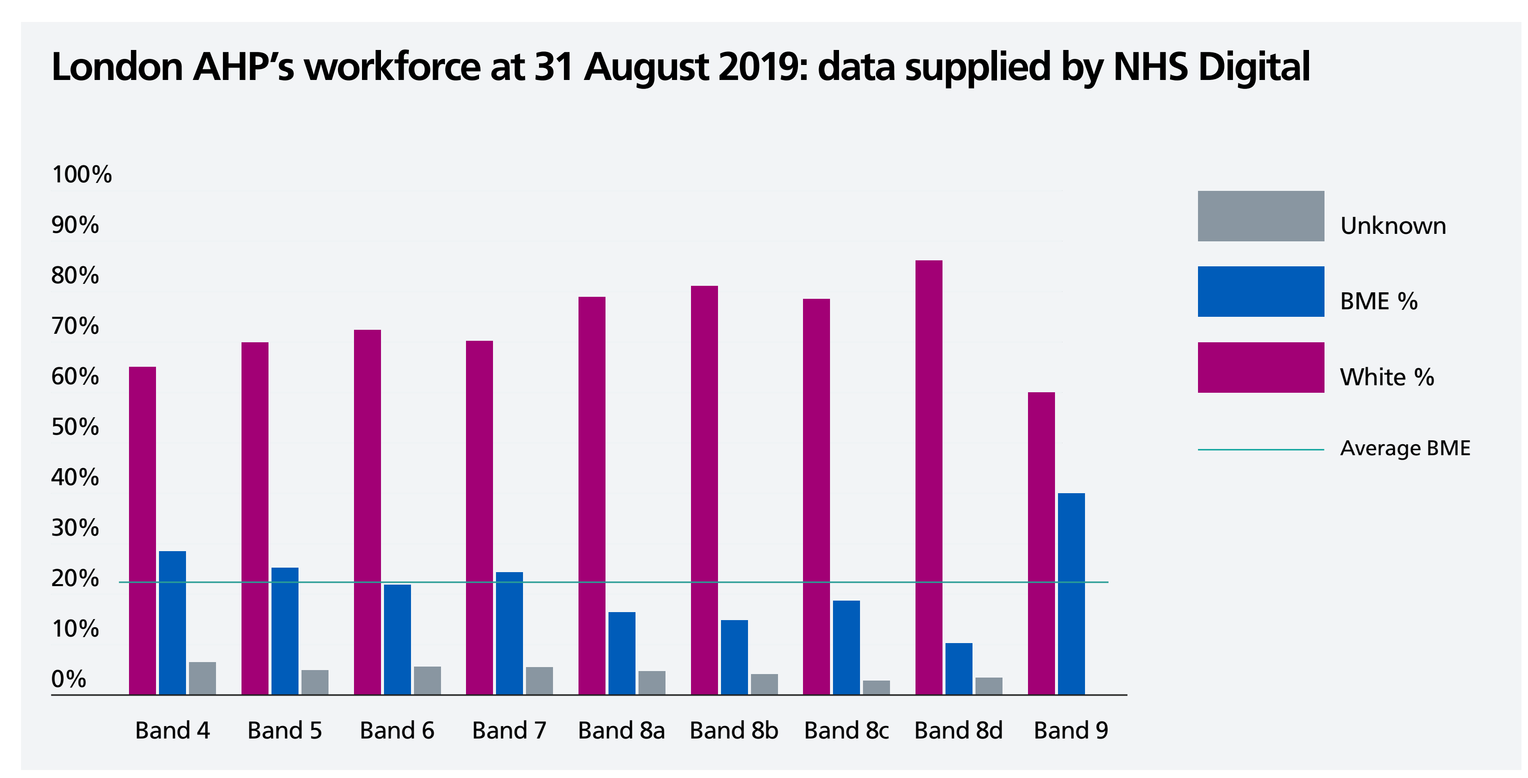
"There are many examples of structural racism in the NHS; a very topical one is non-training grade doctors. It is worth looking at the creation of non-training grade doctors and their use (or abuse) within the context of BAME staff. When I was applying for training posts I was told, "Don't bother, it is not for you, you should apply for non-training jobs and stop dreaming of consultant positions". I didn't listen to such advice; I worked even harder, and I achieved what I have and received high accolades. However, I see every day the plight of the non-training grade doctors. They are competent but are stopped systematically in their progression by institutional racism."

Consultant

Allied Health Professionals (AHPs)

AHPs – encompassing a broad range of professions – are the third largest workforce in the NHS. They also have the lowest ethnic diversity of the three largest NHS clinical workforce groups, the others being nursing and medicine.

London AHP's workforce at 31 August 2019: data supplied by NHS Digital



The BME representation within the AHP workforce is lower than BME regional demography in all seven NHS regions, including London.

In London, 22.6% (3,686) of AHPs are from a BME background. The representation of BME AHPs is slightly higher than this at AfC pay bands 4, 5 and 9 but lower in all other pay bands (see table). Please note that there are only five AHPs at AfC pay band 9 in London.

The national NHS England and NHS Improvement AHP leadership team is currently developing an Equality, Diversity & Inclusion focus for this staff group. From a race perspective, the overarching aims are:

- to increase BME representation of the AHP workforce across the 14 professions, grades and sectors
- to understand the diversity of those applying for and being admitted to pre-registration AHP programmes along with attrition from these

The team is currently bringing together a Chief Allied Health Professions Officers Ethnic Minority Strategic Advisory Forum to help shape and influence development of the strategy.

Variation of experience within BME ethnicities

Data, including staff survey results, show that there are significant differences in the opportunities and experiences of the ethnic groups that make up the overall BME category.

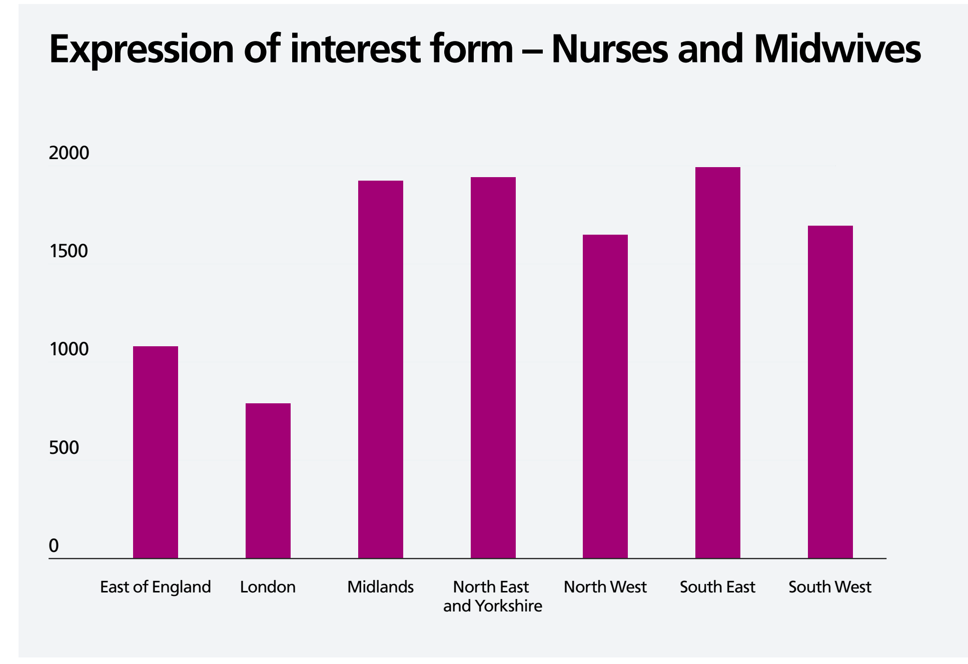
This was highlighted in Making the difference: diversity and inclusion in the NHS written by Professor West et al in 2015.[48] When looking at discrimination, they found that "Discrimination is reported far more by people in non-white groups (25.6%) than by white staff (9.5%). The highest level of discrimination was reported by staff from black groups (30.9%)".

We do not currently report WRES data by specific ethnic group. However, staff survey questions can be reviewed at an ethnic group level. Those WRES indicators based on staff survey questions (WRES indicators 5 to 7) can therefore be broken down, and organisations are able to analyse this and develop local action plans to address unwanted variation in experience.

48. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Making-the-difference-summary-Kings-Fund-Dec-2015.pdf

Covid-19 in London

As of 12 August 2020, London was one of the most adversely affected areas of England in terms of Covid-19 cases and deaths, with 36,538 confirmed cases, a rate of 407.7 cases per 100,000 population.[49] The total number of deaths of those who had tested positive for Covid-19 had reached 6,912.



As of July 2020, 227 NHS staff deaths had been recorded across England. Of these, 33% were in the London region and nationally 60.8% were from a BME background.

Though exact regional figures are difficult to find, we know that ethnic minorities are significantly over-represented in both Covid-19 cases and deaths, even after controlling for socio-economic factors. We also know that London has a significant proportion of BME people in both the population at large, and among the NHS workforce. There have been significant anecdotal reports of adverse experiences for BME staff on the front lines in the NHS, particularly among bank, agency and locum staff. For all these reasons, despite London's progress in ensuring that all staff have had and are able to access risk assessments. A process that going forward will include ensuring that risk assessments are conducted and kept up to date for all staff, including bank, agency and interim. It is also necessary to ensure that staff are not adversely affected as a result of their Covid-19 risk status, applying all reasonable mitigation so staff can remain safe at work.

It is vitally important that Covid-19 continues to be an active consideration in all future planning around race equality in the NHS in London.[50]

Returning Staff

In order to respond to the anticipated increase in demand for clinical staff to help combat the Covid-19 pandemic, the NHS called for those who had recently retired or otherwise left frontline care to register their interest in coming back to the frontline. From the available data we know that more than 11,000 **nurses and midwives** completed the survey to express an interest.

Despite London being the most adversely affected by Covid-19, it had the lowest number of nurses and midwives expressing an interest to return.

At a national level, ethnicity data was available for 2182 of the nurses and midwives expressing an interest in returning. Overall, 6.7% were from a BME background. This is significantly lower than the c.20% of nurses from a BME background in the NHS.

49. https://coronavirus.data.gov.uk/#category=regions&map=rate
50. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020

London Covid-19 – Senior leadership at a time of crisis

Covid-19 was declared a Level Four incident by the NHS on 30 January 2020. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services. This required all trusts and regional offices to establish an incident command structure at local level.[51]

The most senior team to lead this response is commonly referred to as "gold command". Gold command structures are responsible for determining the overall management, policy, and strategy during major incidents and emergencies. They are also responsible for maintaining organisations normal services during any incident.

This group of people are the most senior leadership for managing at a time of greatest organisational strain. They are drawn from the executive of each organisation and supplemented with subject matter expertise. The diversity of these teams is therefore already predetermined by the diversity within the organisation.

The London workforce race strategy team surveyed all London trusts, asking them about the diversity of their senior leadership at the height of the pandemic.

The gold command structures varied in size and, as expected, overall were not representative of the staff nor the populations that they serve. Across the 36 London trusts, 82.8% (370) of the gold command members were white. Just 74 (16.6%) were from a BME background. Three (0.7%) were reported as unknown ethnicity. This is not representative of the London BME population (40.8% – ONS data) or BME workforce (44.9%). Women make up 53% of the gold command structure membership. However, triangulation of all the data indicates that BME women are significantly underrepresented.

The proportion of BME staff on the gold command structures (16.6%) in London is in line with BME board representation (17.1%). Asian/Asian British have the highest BME representation at 9.2% (41). This is more than double Black/Black British representation which is 4.3% (19).

51. https://www.legislation.gov.uk/uksi/2005/2042/contents/made

London Covid-19 – Senior leadership at a time of crisis (continued)

Ethnicity

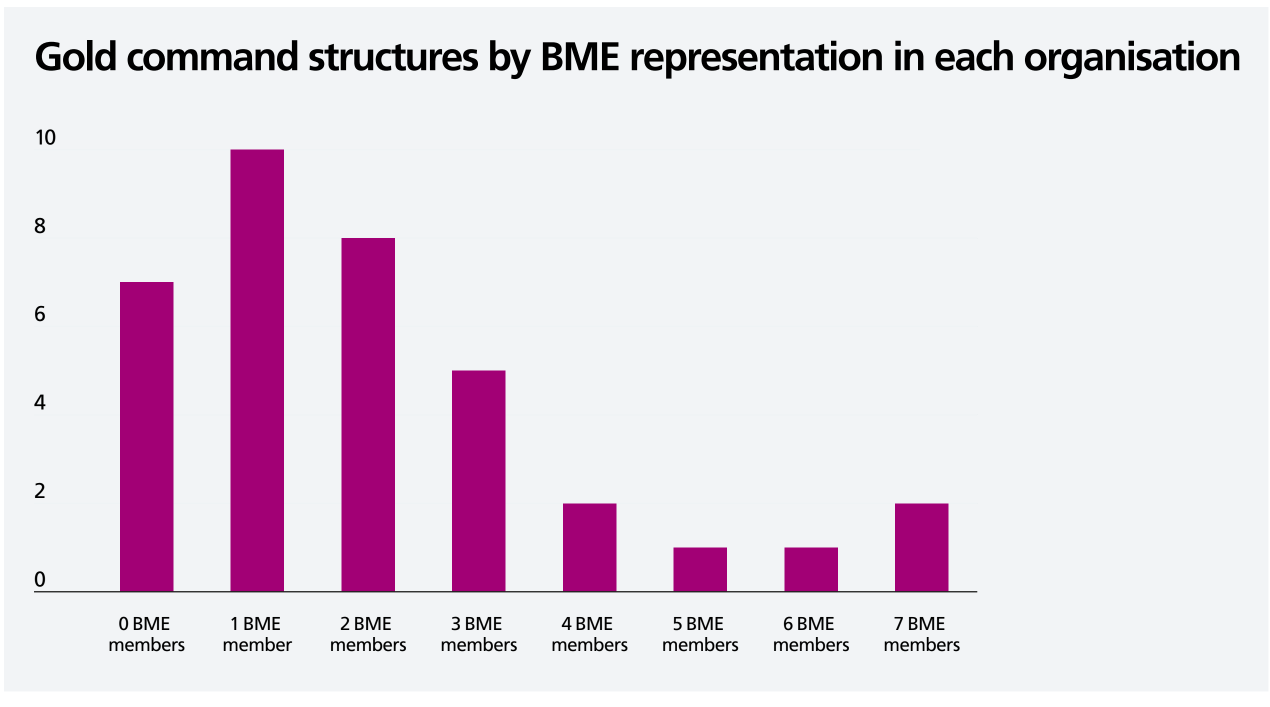
Seven trusts had no BME representation on the gold command structures. Ten trusts had one BME member. At seven (53%), East London NHS Foundation Trust had the greatest number of BME staff and the most ethnically diverse gold command structure.

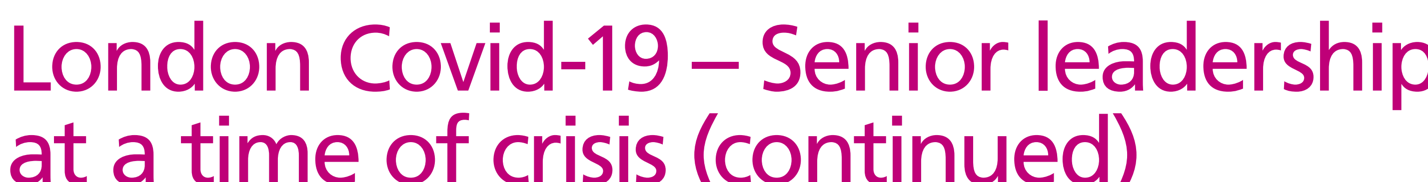
Why it matters – making better decisions

The stark data and evidence call for steps to be taken through our response to Covid-19 to address BME representation in decision making. Diversity of thought brings benefits when faced with unprecedented challenges and the disproportionate deaths of BME health and care staff during the coronavirus pandemic brings this into sharp relief and calls for immediate action.

If the NHS in London is to have the greatest impact when dealing with the next major incident, then it needs a diverse leadership from the top down to ensure that the voices of all communities are heard. This needs to run through all that we do – even more so in times of national crisis. This requires long term structural changes across the NHS.

Ethnicity	White	Asian or Asian British	Black or Black British	Mixed	Other	Unknown
Grand total	370	41	19	8	6	3
Percentages	82.8%	9.2%	4.3%	1.8%	1.3%	0.7%





London Covid-19 – Senior leadership at a time of crisis (continued)

My Experiences as a BME NHS staff member in London

"I think your experience is impacted by where you work, and I have worked in London for most of my medical career. Where I work is very multicultural, but I do not think or feel that the executive within my hospital trust really understands race and cultural diversity. I say this, as when I look at the executive board, it is predominantly 'white' in a major London hospital. When I look across my hospital trust, many staff are from an ethnic background. I think the terminology is wrong, we talk about black and minority staff but actually we are the majority in my hospital trust. We feel like when the hospital trust held engagement sessions with BME staff, it was clear that the executive team do not quite understand the nuances of racism and discrimination structures and the different ways that people work. It's cultural that senior people of Indian origin, who grew up with uncles and aunts, that if anything happened to them, would have to take sick leave to care for them. The structures within the NHS are not designed to culturally take into account the way staff live and work. Obviously, you cannot do that all the time, but the NHS is designed around one size fits all which is not sensitive to people from different cultures. It is difficult for you, if you are Muslim or wear a hijab as people's attitude towards you changes. I suffer less from this as I am a big Asian male and do not have an ethnic accent. If you are from overseas and have an ethnic accent, you are taken less seriously.

During Covid-19, I have observed porters and domestics, especially our porters who are mainly male, African-Caribbean, who are overweight and fit the demographic for increased risk of Covid-19. The porters transferred many patients across wards and hospitals, increasing their risk. Who was looking out for and caring for them? Where was the executive board? They were not visible, and they are in such positions of power. I'm not suggesting that the executive board are obviously racist, but these are important issues to raise."

Doctor

Part 3 Interventions

44 Principles of intervention
45 Impact-effort matrix
47 Interventions in focus
47 In focus – HR processes
50 In focus – System Working
51 In focus – Cultural Change Programme
52 In focus – Recruitment, secondments and professional development
56 In focus – Agency, bank, locum and temporary staff
57 In focus – Primary Care and Multi-Professional Teams
58 In focus – Nursing and midwifery for London
61 Key recommendations for London
67 A Case Study: London Ambulance Service

Principles of intervention

All the data in the world is meaningless if we aren't prepared to act on it. This chapter introduces practical interventions for individuals and organisations. It examines how we can make a difference over the next decade by actively intervening to improve and reform the NHS, and ends with a series of recommendations. Whoever you are, and whatever you do for our NHS in London, you should be able to see something here for you.

The interventions identified have been a product of intensive engagement with key stakeholders and partners from across the system.

Our engagement focused on both front-line staff, including equality diversity and inclusion (EDI) leads and WRES Experts, and leaders of organisations. Collaboration and co-design have been central to this process. The London Workforce Race Equality Strategic Group, with representation from stakeholder organisations, was a principle vehicle through which we have been able to develop thinking, test ideas and co-design the interventions and recommendations laid out in this strategy.

We have not sought to impose a specific regime but create a framework of ideas and options for individuals and the system. We recognise that different people and organisations will all have different needs and the resource element of the strategy is rich in ideas that will be continuously developed and added to over time to incorporate any new interventions found to be useful. This cannot be a one-time or fixed solution. It must be dynamic and evolve with time and new learning. We acknowledge that some of the interventions are conceptual and long term, but these will come to fruition as systems come together and opportunities for collaboration and new ways of working form. This strategy has not been designed to sit on shelves to gather dust, but to be the impetus for the region to work and think differently.

We look at ongoing good practice, alongside new proposals and long-term conceptual thinking. The aim is, in one sense, to understand what works and what doesn't work, but this chapter should also serve as a call to action to leaders across London. Where an intervention is already in use, you should consider whether it will work in your organisation, and act to implement it. Where a programme is just coming together, you should consider whether you want to get involved. Where the suggestions below are conceptual, and just forming, it might be that you have the insights and experience to help shape it in the future. Varied though they appear, the interventions below all have one thing in common: they all seek to eradicate institutional racism and its impact on the lives of NHS staff.

Impact-effort matrix

Many potential interventions have been identified and considered in the development of the core recommendations. An impact-effort matrix methodology has been applied to help chart the potential value of the interventions. The matrix takes account of the effort to implement an intervention, and its potential impact on the workforce, and can be used as a way to prioritise interventions nationally and locally. Some interventions may be adopted immediately, others will require development from a conceptual phase.

	Low effort	High effort
High impact	**Quick wins** ▲ Use of a London dashboard ▲ CEO Action Learning Sets ★ Nurse Development Programme ● 'Walking in My Shoes' model ▲ In-depth review of EPRR structures ▲ Engagement between boards and BME staff networks ● Webinars, lunch and learns, podcasts ▲ More Freedom to Speak Up Guardians in London ▲ Representative ICS Leadership ● Psychological Safety forums ● Re-imagining inductions ● De-bias recruitment process ● Closer links between CQC rating and race equality ▲ Regional WRES Experts programme ▲ Development of robust comms plan ▲ Better feedback loops – you said, we did ● Raise profile of race equality in trusts	**Transformational** ★ Succession and Talent Pipeline ● Central Communications platform ▲ WRES Model employer programme ● WRES Cultural Change Programme ● HR Leaders programme ● Identification of 8c+ staff ★ Race in procurement ★ Bank and agency staff review ★ ICS Panels ● De-bias appraisals ● Overhauling management processes ★ More qualitative metrics ▲ Annual trust conferences ● WRES experts on boards ▲ Formalising process for secondments ● Competency Framework for Managers ● Supervising Managers Programme ● Board level race awareness programme ▲ Ongoing funding commitment ● Aligning race data with performance ★ Rewards and sanctions ● Review of EIA process ★ Media training for BME staff ★ White allies programme
Low impact	**Momentum building** ▲ Reverse mentoring ▲ Unconscious bias training	**Derailers**

▲ In flight
● In development
★ Conceptual

Impact-effort matrix (continued)

A note on momentum building interventions

Not all interventions are equal. Many steps taken in the past to combat inequality have fallen down either because they are too short term – focusing on quick wins as opposed to a real structural change – or because they are based on what is known as a "deficit model", where the person who is the victim of structural discrimination is the target of an intervention. A simple example is a training programme to help BME candidates improve their interview technique. It might mean more BME candidates do well at interview, but it fails to address the cause of the inequality – the interview process itself.

This is also true of reverse mentoring, where senior staff or those from majority groups are mentored by more junior staff or those from a minority background – reversing the traditional mentor/mentee relationship. We would encourage organisations that wish to introduce reverse mentoring to ensure that mentors and mentees are well supported with structures in place such as the Reverse Mentoring for Equality, Diversity and Inclusion (ReMEDI) programme sponsored by the University of Nottingham[52]. With the addition of explicit monitoring of impact, we refer to this as Reverse Mentoring Plus.

Unconscious bias training is useful in promoting a broad understanding of how bias can influence decision making, but it is not enough on it own to remove bias. It is vital for us to go a step further and seek to actively de-bias our processes and procedures. We also need to monitor outcomes to ensure that the training doesn't have the adverse impact described in some studies in which interviewers use it to excuse biased behaviour. In its report on the effectiveness of unconscious bias training, the Equality and Human Rights Commission noted that its ability to effectively change behaviour is limited.[53]

We therefore advocate a focus on 'perspective taking' e.g. 'walking in my shoes' and increasing opportunities to work with diverse groups.[54] This would improve cultural awareness and through relationship building provide meaningful insights in a similar way to that intended by reverse mentoring. Crucially, these insights would be attained in the work context without the requirement for emotional labour from the minority group that is inherent in reverse mentoring.

These interventions are not totally without value, and should not be abandoned wholesale, but we need to accept that they alone will not fix inequality. They can be used as a small part of a race equality strategy, but any intervention that focusses on deficit may only ever paper over the cracks, without ever truly making a difference.

52. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7032576/
53. Equality and Human Rights Commission Research report 113 – Unconscious bias training: An assessment of the evidence for effectiveness – https://www.equalityhumanrights.com/sites/default/files/research-report-113-unconcious-bais-training-an-assessment-of-the-evidence-for-effectiveness-pdf.pdf
54. Unconscious bias training 'has no sustained impact' on behaviour, says report: https://www.peoplemanagement.co.uk/news/articles/unconscious-bias-training-has-no-sustained-impact-on-behaviour

Interventions in focus

This section explores several interventions in detail, outlining some of the work already happening in London today, as well as the challenges that still lie ahead.

In focus – HR processes

Since the inception of the WRES, it has been clear that existing capability, disciplinary and sickness procedures adversely impact our colleagues from BME backgrounds. The 2019 WRES data confirms that, in all 36 London trusts, BME staff were relatively more likely to go through a formal disciplinary process.[55]

The 2019 General Medical Council (GMC) Fair to Refer[56] report by Dr Doyin Atewologun and Roger Kline found that BME doctors were twice as likely as their white counterparts to be referred to the GMC.

Qualitative feedback also illustrates the negative impact that adherence to these processes has on BME staff engagement, trust and productivity.[57]

Work has been ongoing to close this gap, particularly centred on formal disciplinary processes. Targets have been set at a national level in the People Plan with the expectation that 51% of organisations will have eliminated the gap in relative likelihood of entry into the disciplinary processes by the end of 2020.[58] NHS England and NHS Improvement will support organisations in taking practical steps to achieve equity in formal disciplinary rates. As set out in the A Fair Experience for All guide this includes establishing robust decision-tree checklists for managers, post-action audits on disciplinary decisions, and checks that should be carried out before taking formal action.[59]

Within London, our aim is to eliminate the use of disciplinary procedures, except where these are strictly necessary, for example in the event of patient safety, theft and violence.

A research project has been initiated in partnership with Kings College London working with several trusts to assess the effectiveness of different approaches in reducing the likelihood of BME staff entering formal processes relative to white staff. As with all of our interventions this will improve the experience of all staff.

55. https://www.england.nhs.uk/publication/workforce-race-equality-standard-data-reporting-2019/
56. https://www.gmc-uk.org/news/news-archive/fair-to-refer
57. Ibid
58. https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/
59. https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/fair-experience/#:~:text=One%20of%20the%20key%20aims,staff%20across%20the%20healthcare%20system.

Interventions in focus (continued)

There are 4 different approaches currently in use across trusts in London. These are:

1. Immediate use of National Patient Safety Just Culture Guide[60]
2. Pre-formal action review at director level
3. Pre-formal action review by trained lay member of staff
4. Audits post action to review learning and improve future practice

Use of these methods is currently being reviewed and new research supported by King's College Hospital NHS Foundation Trust will hopefully provide further insight into their effectiveness.

There are now several positive examples within London, including the new Imperial policy developed by Imperial College Healthcare Trust following the 2018 inquiry[61] into the case of nurse Amin Abdullah, who set himself on fire after being dismissed from his post. The inquiry brought to light how disciplinary cases are managed in the NHS, including the apparent absence of accountability for staff managing cases, and behaviour described as the worst form of bullying. The growing evidence is that such processes can be damaging to people's mental wellbeing. Research has also highlighted how vulnerable groups, such as BME staff and whistle-blowers, suffer the most when such unfair systems are in place.

The 2018 inquiry findings led to a call to action from Baroness Dido Harding, Chair of NHS England NHS Improvement, who wrote to all trusts in July 2019 asking them to review their processes and calling for clear justification of formal action.[62]

Our strategic recommendation is that we go further and accelerate this work across London through the following:

– The continuation of alternative approaches outlined above supported by research and insight
– A regional pilot of an alternative approach to formal action

  This work has already begun with Barnet Hospital and King's College London Foundation Trusts identified as Vanguard Pilots. The precise details of the pilot are being developed. The work will be overseen by the London People Board. It is likely that the Just Culture Guide will form the basis of the approach with other wrap-around actions focusing on pastoral care, learning and development, and quality improvement to support the individual and to implement lessons learned from case studies and incidents.
– A review of terminology and positioning of processes to focus on learning rather than sanction
– Establishing Panels at STP/ICS level to which BME staff can raise grievances outside of their trust's authority. Panel members will be drawn from each trust in the system, and will include staff from HR, staff side, WRES Experts and Speak Up Guardians. The panels will monitor race performance within the STP/ICS area, seeking to identify best practice and encourage collaborative learning

Similar interventions will be developed through the WRES implementation plan to be adopted at a local level for sickness and capability management. Early examples of potential interventions include the use of a checklist for managing capability issues developed by North West London Collaboration of CCGs.

60. https://improvement.nhs.uk/resources/just-culture-guide/
61. https://www.imperial.nhs.uk/about-us/news/investigation-disciplinary-process-actions-and-learning-for-trust
62. https://www.health-and-care-update.co.uk/2019/07/new-guidance-to-help-trusts-deal-with-investigations-and-disciplinary-procedures-.html

Interventions in focus (continued)

My Experiences as a BME NHS staff member in London

"The air conditioning/heating unit in our office has been broken for 2 months. A workman who has been coming back and forth to this office to fix the air conditioning/heating unit made an offensive comment in front of myself and my team members which greatly offended me; I subsequently argued with him that his comment was offensive, and the discussion became heated.

He commented that "If people want to work in the heat they should go back to the Caribbean and they are working in the wrong place". Although he initially tried to deny it, he later admitted it, but said it was not meant to offend and as my colleagues were laughing, it showed it wasn't really offensive.

When I approached my manager to make a complaint, she was unsupportive and there was just no empathy there for me. She kept saying it would have to be investigated.

The fact that my colleagues found this man's comment funny and openly laughed, made me feel upset and so alone in the team. I am made to feel that I am a complainer and that my behaviour is the cause of the problems. I let my manager know that I was not happy with my colleagues laughing at the engineer's comments which made me feel worse.

Eventually my manager reported my reaction to HR, and I was disciplined for my conduct.

I took out a grievance at the same time and HR did not really acknowledge my grievances.

I was going through personal bereavements at the time and didn't have the emotional strength to take these things further. I wanted to sue the contractor and the trust.

Initially I was highly upset and angry. I became depressed and ultimately asked to be moved to another role in the trust as I couldn't work with my colleagues any more. It took personal counselling and reflection over many years to feel safe and valued in the trust."

Administrator

Interventions in focus (continued)

In focus – System Working

For NHS trusts and Clinical Commissioning Groups (CCGs), improving workforce race equality in London has so far largely centred on the outputs from the annual WRES data collection process. Having four years of data has allowed comparisons and trend data to be produced which allows individual organisations to track their progress.

However, the establishment of STPs and continued progress to ICSs has added an additional dimension to the need to ensure equality, diversity and inclusion issues are at the forefront of designing new services. Working across sectors and co-creating new services will place different expectations on the role of health care professionals. Achieving race equality in these circumstances will be challenging but necessary, especially in a post Covid-19 context where the NHS is likely to play a greater role in local communities.

Ultimately, systems need to be accountable for the WRES being properly implemented in their constituent organisations. With greater focus being put on ICSs as the primary unit of workforce planning, there will inevitably be an impact on the working of the WRES. There will be both challenges and opportunities. Working within ICSs, the WRES indicators and data collection will need to be considered on a much larger footprint than before. There will also be opportunities for trusts and other organisations to consider recruitment, retention and talent development on a larger scale, giving us an unprecedented opportunity to address race inequality at a system level.

London People Board
The London People Board has been established to implement priorities for the current and future NHS workforce. It aims to make the NHS in London a better, and more equal, place to work by:

- increasing the diversity of the workforce and promoting equality, diversity and inclusion strategies
- redesigning ways of working
- improving the leadership culture
- growing and training the workforce. The London People Board is representative of the racial diversity of London, an explicit aim in its development. The intent is that the STP/ICS People Boards will also reflect the diversity of their workforces.

STP/ICS equality approach
There are 5 STP/ICSs in London and each has appointed a senior leader for all equality matters. Their work will encompass both the design of services and the role of the system as an employer of health and care staff. Some of the STP/ICS equality work streams are at the early stages of formation. Most have identified key stakeholders, and some have had initial listening events or fact-finding surveys to determine the scope of work required.

Cross-system working is being established for many care pathways and the impact of new ways of working on the health and care workforce will be part of the design process for these services. There will be opportunities for improvements to racial equality as all parts of the system seek to work together more closely and share scarce staffing resources.

Some workforce projects are at a mature stage of development. Examples are:

- Cross STP/ICS apprenticeship programmes, e.g. care navigation, supported by a competency framework and clear career progression (South London and North East London)
- Establishment of sector-wide training opportunities for health and care professionals (Central London Community Healthcare Academy)
- Cross-system rotation of staff to enhance career opportunities (North Central London)
- Establishment of training hubs to bring community healthcare provider education across systems (pan-London)

STP/ICS Race Equality Panels
It is proposed that London establishes independently chaired Race Equality Panels within each STP/ ICS to monitor race performance within the STP/ICS area. The panels will work to identify best practice and encourage collaborative learning.

Panel members would be drawn from each organisation in the system, including trusts, local care partnerships and primary care networks, and will include staff from HR, staff side, community voices, WRES Experts and Speak Up Guardians.

The panels will act as a powerful "critical friend" to STP/ICS People Board and the organisations and networks within the partnership, supporting BME staff to speak up.

The intent is that panels have an important impartial role in preventing and supporting the resolution of grievances.

Interventions in focus (continued)

In focus – Cultural Change Programme

The WRES has seen some significant successes over the past five years, especially in terms of increased representation at senior levels. Even so, the problems of race inequality in the NHS are still very real. The WRES indicators relating to the culture of an organisation have in many cases still not changed significantly.

That's why the next phase of the WRES programme will focus on improving that culture – the less tangible things about an organisation that can be the difference between feeling empowered to do your job and feeling excluded or demoralised.

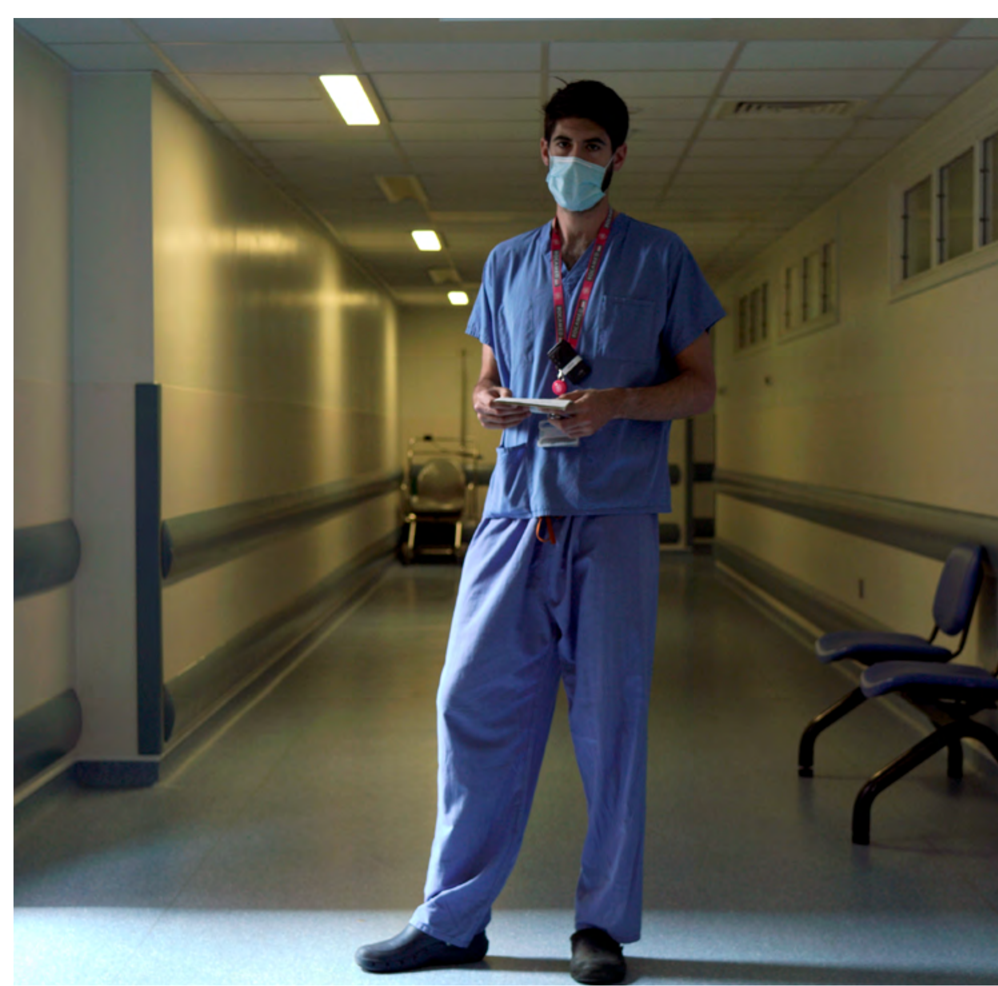
The Cultural Change Programme represents a new and innovative approach. The national WRES team aim to work with a cohort of trusts to carry out an extensive diagnostic on the culture of each organisation, and especially how that culture is felt and experienced by BME staff. As well as analysing quantitative data, we will also be talking to people at all levels, reviewing internal communications, and deconstructing job descriptions and HR policies.

This diagnostic will provide the basis for a series of bespoke and targeted interventions aimed at instilling a culture of genuine inclusivity. The work will aim to ensure that a person's experience of work doesn't vary based on their colour of their skin.

There is work ongoing with Whittington Health NHS Trust which will help to inform the programme. This will be evaluated by colleagues at Sheffield University and, if successful, rolled out to further trusts in the future. The specific aims of the programme are to:

- Work with Whittington Health to help transform workplace cultures so all staff can thrive and are able to provide the compassionate high-quality care that patients need and deserve
- Share good practice models of improvement across organisations and the NHS
- Identify the root causes and consequences of variable perceptions of trust culture (including discrimination, bullying, harassment and abuse, as well as career progression) between BME and white staff
- Identify and implement robust solutions for closing the gaps between BME and white experience

Learning from the Whittington Health programme will help inform cultural transformation for the whole of London. Without truly understanding what makes an organisation inclusive, we cannot move the dial on those more difficult WRES indicators.



Interventions in focus (continued)

In focus – Recruitment, secondments and professional development

Evidence shows that where a CV has a name that appears to come from a BME background, that person is less likely to be shortlisted or hired.[63] This is just one among many social biases that can influence recruitment.[64]

The 2019 WRES data tells us that, nationally, white applicants are 1.46 times more likely to be appointed from shortlisting compared to BME applicants. Although London has shown some improvement in this area, it is still worse than the national picture, with white applicants nearly twice as likely (1.6 times) to be appointed from shortlisting compared to BME applicants.[65] There needs to be a radical shift for London to ensure that its recruitment is fair and inclusive.

As a region, we are calling for organisations to commit to overhauling and actively de-biasing recruitment and selection processes, in line with the national priorities outlined in the People Plan.[66]

It is necessary for us to go beyond the minimum standard of anonymised applications and basic unconscious bias briefings for recruiting managers.

Based on our analysis of recruitment practices, while there has been a gradual shift to values-based recruitment, the emphasis remains on technical skills and organisation fit. We strongly recommend the focus is shifted to take into consideration the ability and expertise of the individual to demonstrate and encourage an inclusive culture when in role. Recruiting managers should be encouraged to look for those who *add* to the culture, rather than those who *fit* with the culture.

When recruiting to roles with significant underrepresentation of BME staff we would encourage organisations to utilise the positive action provisions within the Equality Act 2010.[67] This might take the form of equal merit. Where you have two or more candidates with an equal score and are therefore of equal merit, you may be able to offer the position or promotion to the BME candidate under the positive action provisions.[68]

63. Bertrand and Mullainathan (2003): 'Are Emily and Greg More Employable than Lakisha and Jamal? A Field Experiment on Labor Market Discrimination'. http://www.nber.org/ papers/w9873
64. Ashley, L et al – A qualitative evaluation of non-educational barriers to the elite professions – June 2015 – Social Mobility and Child Poverty Commission https://dera.ioe.ac.uk/23163/1/A_qualitative_evaluation_of_non-educational_barriers_to_the_elite_professions.pdf
    Bohnet, I. et al – When Performance Trumps Gender Bias: Joint Versus Separate Evaluation – Faculty Research Working Paper 2012 Series https://www.hbs.edu/faculty/Publication%20Files/12-083.pdf
65. https://www.england.nhs.uk/publication/workforce-race-equality-standard-data-reporting-2019/
66. https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/
67. https://www.legislation.gov.uk/ukpga/2010/15/contents
68. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/85014/positive-action-recruitment.pdf

Interventions in focus (continued)

Furthermore, focus on inclusion should apply at each stage of the recruitment process:

1. **Job design** – Carefully consider what skills are actually required for the role and avoid merely duplicating the skills and qualifications of the previous role holder
2. **Advert** – An employer can explicitly state that they encourage applications from BME candidates. You should also consider the messaging of the advert – use inclusive terminology where possible, consider the use of inclusive images and where the advert can be placed to reach underrepresented groups, moving beyond the limitations of NHS Jobs
3. **Executive search agencies** – Our recommendation is that senior roles are filled from within the NHS, utilising succession planning and regional talent pools. Where this is not possible and executive search agencies are engaged, it is vital that inclusion goals are clearly stated and where possible built into the contract. For example:

   Procurement – requirement for agencies to demonstrate a track record in diverse selection processes

   Agency diverse shortlists – at least 2 BME candidates to be shortlisted by the agency
4. **Diverse recruitment shortlist** – Where possible, selection processes to remain open until at least 2 BME candidates have been shortlisted[69]
5. **Interview** – Consider interview formats and ensure BME representation on panel (with equal scoring weight). Whilst work related testing may be useful, be mindful of the impact of testing on people from BME backgrounds, including the risk of biases within the tests themselves[70]

In addition to the above, there are several interventions taking place in London at organisation and regional level to support inclusive recruitment, including:

- **Role modelling** – The recruitment of BME staff at senior levels is not only important for quality decision making and supporting better patient outcomes. BME representation at the top of organisations sends a signal about the culture of that organisation. This does not mean that BME senior staff are expected to play a token role, but that the organisation should make every effort to showcase the diversity of skill and experience of their senior teams and the fact that the community is fully represented
- **BME representation on panels** – mitigate the risk of bias and have a positive impact on all candidates by diversifying panels
- **Launch of Heads of Resourcing Network** for London, bringing together recruitment leads to share best practice and work to ensure consistency of standard and approach across the region (allowing for organisation needs)
- **Review of job descriptions** to ensure that they do not have inherent biases written into them, including use of images, examples and minimum training required
- **Training** members of staff and BME networks to sit on senior appointment interview panels and assessments
- **Introducing leadership programmes** to encourage BME staff into non-executive posts and support existing Non-Executive Directors (NEDs). An example is the development of the Seacole Group: NHS BME NED Network, which is working with NHS England and NHS Improvement NExT director programme, to create the pipeline of experienced candidates from underrepresented backgrounds to be ready for their first board appointment.
- **Introducing mentoring, sponsorship and coaching programmes** to encourage and support internal promotion of BME staff into more senior roles

69. https://hbr.org/2016/04/if-theres-only-one-woman-in-your-candidate-pool-theres-statistically-no-chance-shell-be-hired
70. https://nrcgt.uconn.edu/newsletters/winter052/

Interventions in focus (continued)

We are calling for organisations to have equality of access for all staff to opportunities for promotions, acting up roles and secondments, based on their abilities. Some key initiatives are emerging around this, including the London Ambulance Service recruiting manager model. This has provided a transparent process for managing secondments and clarity around the recruitment process for all staff with recruiting managers now required to advertise and process all secondments through a recruitment system such as TRAC.

NHS Jobs London secondment portal for staff during Covid-19
This initiative will utilise the NHS Jobs website to create a London-wide portal to share secondment opportunities transparently, equitably and rapidly to staff at risk due to Covid-19 to ensure efficient, effective and fair recruitment to the role. The programme aims to create an open and transparent process for organisations to advertise suitable opportunities, increasing the accessibility and visibility of these roles.

Phase 1 of the initiative will focus on staff identified for redeployment through the Covid-19 risk assessment. Phase 2 will build on the foundations to create a mechanism to share development and stretch opportunities for all NHS organisations to support their talent, ensuring equity of opportunity.

Professional Development
It is important to note that variable access to professional development, stretch assignments, secondments and career opportunities can limit career progression. Employers are not the only influence on these opportunities. They are shaped by regulators, commissioners and professional bodies such as the General Medical Council, Nursing and Midwifery Council and the Health and Care Professions Council, Health Education England, the Royal Colleges and NHS England and NHS Improvement.

Access to professional development and appointments to postgrad training posts, substantive roles and leadership positions are influenced by a number of factors beyond immediate leadership in an NHS trust. For doctors these include Health Education England, the General Medical Council and 24 medical royal colleges.

Work is underway in partnership with Health Education England to make progress in ensuring equity of access to development opportunities. 2020 saw the introduction of a personal Continuing Professional Development budget of £1000 per person over three years for nurses, midwives and AHPs. This is a key innovation that will empower individuals to take responsibility for their own development and support progress. In addition, workforce development funds are invested across the system to support wider workforce development and transformation, increasing the opportunities to develop all our people and ensure they are properly equipped with the skills and knowledge to progress their careers.

Interventions in focus (continued)

My Experiences as a BME NHS staff member in London

"I have found that there are limited opportunities for BME staff to progress and reach their fullest potential in the workplaces I have worked. Personally, I have experienced not being valued and being overlooked for opportunities and leading on pieces of work. I have been overlooked in terms of career progression compared to other colleagues who are not from BME backgrounds. I have seen similar situations with other colleagues which has led to them leaving the organisation.

There have not been any mentorship or coaching opportunities, although this is something I had highlighted in my appraisals. I have also seen favouritism in the workplace, and colleagues who have been selected and who have received extra attention to rise through the ranks.

When I have applied for jobs, I have been invited for the interview but it's just to add to statistics, as someone less qualified and who is the right fit has been given the role. In order to progress I have to apply for jobs elsewhere and move jobs whereas my peers from a different background seem to progress quicker. I've had 5 line managers in my career and only 1 of them truly understood how to manage someone from a BAME background and things to look out for.

There is not enough representation in senior management. Sometimes it feels like they did not push for equality as they do not want to compromise their positions and do not have enough support. I have also found that where opportunities are available, not much is done to promote these for the BME community.

In order to be promoted or progress, I've had to move to another organisation. Had I stayed in my initial jobs I would not be in the band that I am now. When issues are raised with line managers/colleagues you are told you moan too much or it's a cultural issue."

Manager

Interventions in focus (continued)

In focus – Agency, bank, locum and temporary staff

Temporary workers who undertake work in the NHS, whether on NHS banks or working through external agencies, have at times been seen as "outsiders" when it comes to providing care. It is widely recognised that many of the temporary workers the NHS engages with come from a BME background. Given anecdotal feedback and concerns that Covid-19 has highlighted, it is an important time to focus attention on this often-overlooked staff group.

Data on bank, agency and locum staff is poor, and our understanding of their experience of working within the NHS is not yet good enough. Improving the experiences of this workforce will further support more productive and efficient ways of working, improve patient care and, above all, help workers feel more included and empowered.

Thinking about our own banks

Working on a bank is recognised as a key gateway into a career in the NHS and, if the experience at this stage is positive, the bank could prove to be a consistent recruitment pipeline for the system. The People Plan has committed to supporting more flexible ways of working in our NHS. Bank work provides a stepping stone from temporary to permanent work.[71] However, trust and local organisation culture can be a major barrier.

The WRES currently does not gather data relating to bank, agency and locum staff, making it difficult to understand the experience of BME workers who choose to work in this more flexible way. Given the nature of temporary work, it may be that this cohort has unique insights into the inclusivity of an organisation. But until we have a benchmark for how temporary staff feel, we cannot know.

Furthermore, we have anecdotal evidence to suggest that some BME staff choose to work through bank and agency precisely because the culture of the NHS, or a specific trust, makes them feel excluded..

The truth is that, currently, not enough is known about this element of our workforce, and steps should be taken across the region to rectify this. We believe that a targeted, large-scale, survey of bank, agency and locum staff should be undertaken across the region, supported by the WRES Implementation Team. In addition, there are several actions that should be considered by trust leaders now to ensure that this workforce group gets the consideration it needs:

1. Non-NHS employers providing NHS services should be asked to report data to trusts based on the WRES indicators and should provide action plans regarding how they will address any inequalities based on race. In addition, NHS England and NHS Improvement should mandate trusts to provide this data as part of their WRES data return each year and examples of best practice by non-NHS employers should be promoted via the national WRES team
2. NHS organisations and Primary Care providers should consider what bank and agency providers are doing to reduce inequalities as part of any options appraisal regarding the commissioning of services and as part of the general equality duty under the Equality Act 2010. Contract monitoring should include progress on addressing race inequalities
3. NHS organisations and Primary Care providers should further consider insourcing contracts so that they are in direct control of reducing race inequalities for the workforce; including, the inequalities relating to pay, terms and conditions and pension provision in comparison to NHS staff

In addition to these considerations we would urge all organisations to consider race inequality when procuring third party contracts for ancillary and support services, requiring all providers to demonstrate their commitment – sharing representation data and associated action plans.

71. https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/

Interventions in focus (continued)

In focus – Primary Care and Multi-Professional Teams

Primary care
Primary care lies at the heart of the NHS, accounting for 90% of all patient contact and providing holistic care to the entire population of London. The workforce encompasses many roles, including general practitioners, nurses, practice managers, allied health professionals, receptionists, link workers, dentists, optometrists, pharmacists and volunteers.

Across London, we have around 8500 GPs and 2600 nurses working with their support staff across over 1200 GP surgeries who collaborate through over 200 primary care networks. The range of job roles in general practice is widening. In addition, around 5000 dentists, 2500 optometrists and 1850 community pharmacies provide NHS services.

Individual primary care providers are currently out of the scope of the Workforce Race Equality Standard and, as such, data on workforce ethnicity in primary care is incomplete. We can however observe that the workforce is diverse and the data that we do have for some of our professional groups suggests London's primary care workforce is more diverse when compared to other regions. We also see variation in the percentage of workforce from BME backgrounds across London subregions.

For example, North East London has 47% GP and 37% nurse BME workforce compared to South West London which has 37% GP and 22% nurse BME workforce.

This strategy calls for a national approach to capturing and understanding the experience and needs of all our people, through a systematic survey and analysis akin to the WRES, and for an increase in 'safe spaces' for staff from primary care to be able to raise concerns and to receive support in regard to issues of WRES.

Our intent is for the work of this strategy, along with its values and principles, to be tailored to the needs of primary care. We propose the establishment of a multi-professional leadership group who will work with primary care to co-design specific race equality strategies for this vital pillar of the NHS to ensure that this vision is realised for their staff. The group will work through existing networks, including primary care networks, CCGs, federations, dentists, pharmacists, optometrists, local professional networks, STP/ICSs and London's Local Medical Committees. The group would develop a specific programme of work with associated resources.

My Experiences as a BME NHS staff member in London

"In my role as a rehabilitation assistant in a community team, I worked with a client, a gentleman who was an elderly frail white man with a hearing impairment who had lost confidence in his mobility. My role was to support him with walking with supervision. On one occasion when he was feeling ready to walk around the block of his flats, I stood far enough away to give him confidence but close enough to support him if he lost balance. As I did this, I noticed a man watching me across the street. He approached my client asking if he was ok and if I was bothering him. He then said to me that there had been a lot of robberies in the area and he was watching out for his own kind. He then dismissed me. The irony is the client asked me if it was a friend of mine totally oblivious to what had just happened. When I later told a colleague at work, she looked at me in disbelief and questioned that I must have done something to warrant the attention. I felt humiliated and worse had no one to go to for support."

Occupational Therapist

Healthcare Professions
Several strategic interventions specific to AHPs, finance and healthcare scientists are currently underway or in development at a London level. Key strategic objectives include increasing the diversity of AHPs through the development of clear career pathways. Although the national strategy identified nursing and ambulance services as early priorities, we want race equality for all our professions. We propose the establishment of a multi-professional leadership group who will work with AHPs, finance, healthcare scientists, doctors, dentists, optometrists, pharmacists and other regulated professions to co-design specific strategies for their groups

Interventions in focus (continued)

In focus – Nursing and midwifery for London

Nursing is the largest profession in the NHS; London has approximately 52,000 nurses, 27,000 of whom are from non-white backgrounds.

In London, there are only 3 executive directors of nursing from BME backgrounds and only 123 nurses at band 8c and above across the 40 provider organisations and STPs/ICSs, with most nurses in London at agenda for change band 5. In addition, London staff, including nurses, report the worst experiences nationally for most of the WRES indicators and their experiences vary significantly from those of their white counterparts. Nurses from BME backgrounds are more likely to work on the bank or join agencies as they say they can choose where they work as opposed to being in one organisation, thus costing the NHS more.

The NHS currently has approximately 40,000 nursing vacancies, 9000 vacancies in London. As such, keeping nurses, attracting new nursing applicants, and encouraging nurses to return to the NHS are of crucial importance. It is worth repeating that despite London being the region most adversely affected by Covid-19, it had the lowest number of nurses and midwives expressing an interest to return when asked.

In 2015, when the first WRES data collection took place, nursing was one of the three priorities identified. It remains a priority area in enabling people from BME backgrounds to realise their potential and have a good experience in the NHS and therefore a specific race strategy for nursing in London has been developed. Health Education England (HEE) and NHS England and NHS Improvement in London are working together to deliver the nursing workforce strategy for London, which incorporates a strong focus on addressing racial inequality and senior underrepresentation. The two strategies will work to complement each other.

Our Values and Vision

Providing the best possible high-quality care for our patients and communities within London sits at the very heart of our values within the nursing and midwifery profession. We can not achieve this without valuing our workforce and demonstrating this in how they are respected, supported, protected and developed. Our ultimate goal is to provide harm-free, patient centred, evidence-based care with good health outcomes and experiences for all. In order to achieve this, we need to harness the skills, contribution and expertise of all members of our workforce, at all levels.

Our vision is for London to be seen as a city providing the best clinical and career opportunities within the UK for BME staff, with demonstrable improvements in patient and staff experience of health and social care.

BME staff are well trained and equipped for seniority but are not provided with the same opportunities as those given to white colleagues. Consequently, climbing up the career ladder can be a difficult process for BME staff. Our vision is to release, at pace, the leadership capability that already exists within London and, at the same time, develop conducive organisational cultures.

Interventions in focus (continued)

Increasing BME nurse and midwifery Leadership at all levels

Senior Level Leadership

Our ambition is to increase the number of BME nurses and midwives across London in senior and executive leadership positions. We are proposing the introduction of an innovative development programme that will provide on-the-job senior leadership and experiential learning opportunities for BME staff from bands 8c – 9. This cohort will be sponsored and supported to complete pieces of work, gain experience and learn how systems work at the most senior levels in their organisations, giving them the experience and knowledge they need to help them progrress to very senior roles.

The programme framework will be co-designed and co-created with existing senior and chief nurses using some of the learning from programmes such as the National Breaking Through programme and the NHS Graduate Scheme. The aim will be to produce a pipeline of nurses ready to perform effectively and efficiently at the most senior levels in an organiation, including at board level.

Front Line Level Leadership

Consideration will need to be given to the development of nurses at lower bands. The revised London People Board will be developing a new programme to nurture, develop and support the nursing and midwifery talent pipleline across all agenda for change bandings. This will be a priority to meet the model employer targets.

Future Leaders – Pre-Registration

We will work with our HEE colleagues and the Capital Nurse initiative to support the recruitment and development of pre-registration BME nurses. The national initiatives around making nursing the career of choice for university leavers will be incorporated into our workplan. Key to this will be attracting volunteers from BME backgrounds to experience working within the NHS as a stepping stone to a future career.

Wider Healthcare Settings

We will look at similar initiatives within NHS Digital, Research and Innovation, primary care and other areas of the NHS within London. A mapping exercise will be required for these other clinical areas and collaboration with partners to identify a bespoke package of development.

Interventions in focus (continued)

Championing our BME nursing and midwifery staff
We will champion our BME workforce by continuing to promote their worth and value nationally and regionally, by ensuring they are recognised for their contribution to health care and our profession.

BME nurses and midwives will be encourged to publish articles in professional and leadership journals and nominate themselves and others for national and regional awards as well as representing London at national events.

The above outlines some of our aspirations to change the face of nurse leadership and organisations so that they are more reflective of our population and communities within London. This is not just our business, but everyone's business. This work will be aligned to the broader strategy for London and we will work collaboratively with colleagues across the NHS, and wider partners such as NHS Leadership Academy, Capital Nurse, the integrated care systems, HEE and other agencies to achieve these goals. There is an important need for change and change at pace. The necessary investment of resources in terms of finance, effort and time to achieve is set out in *Releasing Capabilities – The London Strategy for our BME Nursing and Midwifery Workforce.*

My Experiences as a BME NHS staff member in London

"Moving to London from Yorkshire as an 18-year-old to begin my nurse training I was really proud and curious and had dreams of being the 'best nurse ever ' to patients and very excited to form life-long friendships.
In the early years of my career, I truly did not notice or recognise that there were differences in the treatment of BME nurses. I suppose it was only when I became a matron and was the only BME nurse at senior meeting that I began to notice a difference, I would often wonder how a big teaching hospital had only one BME nurse in a senior position. However, learning and developing in the role was my focus and I was extremely well supported and coached by the senior team in medicine. Fast forward to 2020, in fact in the last 10 years of my nursing career, I feel changes in terms of opportunities, promotion in leadership roles for BME people have not progressed.
There are many highly skilled and competent BME staff and it is evident that BME staff have to work harder before their worth is recognised and acknowledged which is a shame in a profession that promotes inclusion and especially in London where diversity in the patient population should be fully represented in all areas of the nursing field."

Matron

Key recommendations for London

The following recommendations are drawn from the full menu of interventions (Annex C) and have been identified as key priorities for the NHS across London. They have been selected by the London Workforce Race Equality team and endorsed by the London People Board and regional leadership.

While some of these recommendations will belong to regional and national teams, many are aimed at organisation and system leadership. Eradicating structural racism and embedding a truly equitable system is the responsibility of the entire system working together in a spirit of sincere allyship. The following recommendations will take the NHS in London a step closer to being the organisation its staff deserve.

National WRES Framework

The recommendations can be categorised in a number of ways. Some are quick wins; some are slow burns. Some are high impact; some less so. But to provide an overarching framework through which to understand them, we will be using the one developed by the national WRES team, which itself was informed by the work of Dr David Williams. Each intervention will be characterised based on the following themes:

Encouraging Transformation

Including the development of compassionate and learning cultures; the mobilisation of system leaders; and a particular focus on supporting core managers.

Enabling People

Including genuine meaningful engagement with individuals across the system; focussed support for those who need it; and the sharing of replicable good practice.

Embedding Accountability

Including ensuring alignment across systems; robust regulation and scrutiny; and a focus on emerging healthcare architecture.

Evidencing Outcomes

Including the gathering of data and intelligence; benchmarking organisations; and making evaluation and sustainability a priority.

Key recommendations for London (continued)

Encouraging Transformation

1. Modernise HR processes to ensure a more collaborative and person-centred learning approach

Our aim is to eliminate the use of punitive disciplinary procedures in London, except where these are strictly necessary for, among other things, patient safety, theft and violence. The evidence is that these processes place a strain on people's mental health and wellbeing and, tragically, have led to the death of colleagues.

Research supported by King's College London on the different approaches currently being used will provide further insight into their effectiveness. Our strategic recommendation is that we accelerate this work through the development and pilot of an alternative approach to formal action. This work will be accountable to the London People Board. It is likely that the Just Culture Guide, developed to encourage NHS managers to treat staff involved in a patient safety incident in a consistent and fair way, will form the basis of the approach with other wrap-around actions focusing on pastoral care, learning and development, and quality improvement to support the individual.[73]

Enabling People

2. An executive on each board should complete the WRES Advisor Programme

It is clear from the People Plan and our work in London that there is a need for greater challenge at board meetings and a need to ensure that an understanding of race and inequality is woven through both discussion and decision making. At least one board member (outside of Human Resource responsibility) from each organisation should enrol on the new WRES Advisors programme. This will be a condensed version of the WRES experts programme and include an expectation that delegates make an explicit commitment to identifying and sponsoring BME talent to attend the board.

Encouraging Transformation

3. Launch cultural transformation programmes for London

NHS England and NHS Improvement London will build on the transformation programme work that is currently being done by the national WRES team at Whittington Health. This approach aims to change and improve cultures within organisations. The aim would be to work with the WRES team to continue the development of a robust, evaluated programme of work to support trusts to build an effective, evidence-based improvement plan around their workforce race agenda.Consideration needs to be given to how this can be delivered at scale regionally, including using existing trust resources.

Embedding Accountability

4. Increase BME representation among Freedom to Speak Up guardians and champions, and ensure support is available across the system including within primary care

Our engagement work with Freedom to Speak Up (FTSU) Guardians in London revealed that most BME staff do not use the guardian service because they do not trust the system and fear that they will be victimised for raising concerns. BME staff doubt the confidentiality of the FTSU guardians service and look at it as an extension of the trust's management system.They fear that raising concerns will make their situation even worse than it was in the first place. Individuals feel more confident talking about the issues they face when they can feel that the person they are talking to can relate, through lived experience, to the issues and problems they are facing. There is therefore a need to build trust among BME staff by increasing the number of BME guardians in London to reflect the London race demographics in the NHS. This recommendation for London aligns with the national priority as outlined in the People Plan.

73. https://improvement.nhs.uk/documents/2490/NHS_0690_IC_A5_web_version.pdf

Key recommendations for London (continued)

Embedding Accountability

5. Establish STP/ICS Workforce Race Equality panels

Establish an independently chaired Race Equality Panel within each STP/ ICS to monitor race performance within the STP/ICS area, identify best practice and encourage collaborative learning. Panel members would be drawn from each organisation in the system, including trusts, local care partnerships and primary care networks, and will include staff from HR, staff side, community voices, WRES Experts and Speak Up Guardians. The panels will support BME staff to speak up and the panels will act as a powerful "critical friend" to STP/ICS People Board and the organisations and networks within the partnership. The panels could also have an important and impartial role in preventing and supporting the resolution of grievances.

Evidencing Outcomes

6. Commissioners should work collaboratively and as peers with, all providers to enhance their performance against indicators of race inequality.

The engagement of providers alone will likely not achieve the sort of outcomes that we expect to see delivered through this strategy if commissioners too do not see this as a priority and act accordingly. Commissioners will need to collaborate and learn from each other to enhance their performance against the strategy. This collaboration might call on organisations beyond the ICS who have demonstrated greater traction to bring their learning to the group. ICS members will jointly manage the programme and set the agenda but commissioners would be expected to support and facilitate this process as peer members. It is acknowledged that there is a lack of understanding of the issues experienced by some staff, and work will need to be done with all members of the collaborative, including the commissioners, to enable them to improve practices across the breadth of the ICS.

Embedding Accountability

7. Work with the Care Quality Commission to develop specific race related key lines of enquiry for inspections

There is an expectation in the People Plan that the CQC will place increased emphasis on whether organisations have made measurable progress on equality, diversity and inclusion as part of their 'well led' assessment. This would include whether an organisation is able to demonstrate the positive impact of this progress on staff and patients.

For London, we are recommending that the CQC have conversations with commissioners prior to an organisation achieving a Good/Outstanding rating, to discuss how they are performing against the WRES indicators. This may include the development of key lines of enquiry for commissioners during inspections on performance against this agenda.

Topics covered may include:

- How they are progressing against model employer targets
- How they are progressing against WRES indicators and whether there has been sustained improvement on their performance
- How they are progressing against other key London WRE indicators/standards

We are in discussion with our CQC colleagues to develop meaningful next steps, including a potential London-wide pilot.

Key recommendations for London (continued)

Encouraging Transformation

8. Develop a competency framework and development programme for all core managers, supervisors and line managers throughout the system

March 2021 will see the publication of a national competency framework for board level leaders. We recommend taking a broader approach, including core managers, supervisors, and line managers.

Analysis of staff survey data demonstrates that a person's immediate line manager or supervisor is the single biggest factor determining perceptions of inclusion within an organisation.

This indicates an immediate need to develop and implement a programme for supervisors and core managers at all bands which will aim to:

- Build a consistent standard of race and cultural awareness
- Provide 360 degree feedback and coaching
- Build diversity & inclusion objectives into Personal Development Plans
- Build understanding of personal impact
- Develop key skills around conversations that make a difference
- Offer peer support and space for reflection

As part of this work, a competency framework for core managers will be developed by NHS England and NHS Improvement's London Region and shared with organisations so they can identify local areas of focus.

Encouraging Transformation

9. Implement a white allies programme

Whatever progress we make in the pursuit of race equality, the fact will remain that we have a majority white senior workforce in the NHS. For this reason, a robust allies programme is critical to the success of this strategy. Only those in power can make the necessary changes. We need white allies to take up the responsibility for change so that we can look towards a better future with a much more diverse leadership group.

Enabling People

10. Make available a local Frontline Staff Forum

Systems should replicate the successful frontline staff forum (FSF) programme pioneered by the national WRES team. Forums should give frontline staff the opportunity to feedback on the progress of this strategy and any other aspects of life in NHS London.

Key recommendations for London (continued)

Enabling People

11.
London-specific WRES Experts programmes to build London's capacity and capability

WRES Experts' cohorts should be developed for London, ensuring each NHS trust in London has at least one WRES expert to support its work in improving the experience of BME staff. These cohorts will target key staff, the first aimed at senior HR and nursing leaders and the second will be tailored to equality diversity and inclusion (EDI) leads in London trusts and other healthcare providers. Once certified these experts,can in turn support their trusts to deal with the various challenges of racial inequality, including those highlighted by the pandemic. In addition, WRES experts should be encouraged by boards to actively engage in board discussions. This approach does two things – it brings a richness and diversity to meetings, and it supports the individual expert to understand board level work and processes, thus enabling and supporting individuals to seek progression to senior roles. We would expect to see this in action and evident in board papers.

Embedding Accountability

12.
De-bias recruitment, secondments and professional development opportunities

As a region, we are calling for organisations to commit to overhauling and actively de-biasing recruitment and selection processes. Furthermore, we would advocate for the review of internal secondment processes to create a transparent process for organisations to promote suitable opportunities, increasing the accessibility and visibility of these roles. Focus should be shifted to take into consideration the ability and expertise of the individual to demonstrate and encourage an inclusive culture when in role. Recruiting managers should, in particular, be encouraged to look for those who add to the culture, rather than those who fit with the culture.

In addition, we recommend a review of how organisations use agencies, including striking off executive search agencies or head-hunters if they are not meeting contractual targets representative of trust ambition around the BME workforce agenda. This approach reflects the national priorities as outlined in the People Plan and will help organisations meet their Model Employer targets.

Evidencing Outcomes

13.
Identify and close the gap in experience for agency, bank and temporary staff

To help make steps toward a more inclusive working culture across the NHS for temporary workers, we need to take into consideration the large data gap in the knowledge held about temporary staff experiences within the NHS. Thus, a key recommendation is to conduct a London NHS Bank Staff survey for trusts that manage their own internal banks. This would encompass lines of questions that closely mirror the well-established NHS national survey and would also generate WRES metrics. Conducting this level of work would also bring new information sets to trusts which in turn would help further drive efficiencies, reduce staffing costs, help improve patient care and support staff and patient safety, to name but a few key outputs.

Closing the gap in experience is a key priority of the London Workforce Transformation Cell. A pay framework is due to be launched in 2021/22, along with guidance on consistency of experience and staff recognition. Further consideration will need to be given to the support offered to locum doctors and bank and agency staff to address the disparities in referrals to GMC, NMC and other professional bodies.

Key recommendations for London (continued)

Evidencing Outcomes

14.
Establish a multi-professional leadership group who will work with staff working in primary care, AHPs, finance, healthcare scientists, doctors, dentists and pharmacists to co-design specific strategies for their professions

Developing a multi-professional leadership group who will work with primary care to co-design specific race equality strategies for this vital pillar of the NHS to ensure that this vision is realised for their staff. The group will work through existing networks, including primary care networks, CCGs, federations, dentists, pharmacists, optometrists, local professional networks, STP/ICSs and London's Local Medical Committees.

Establish a multi-professional leadership group who will work with AHPs, finance, healthcare scientists, doctors, dentists, optometrists, pharmacists and other regulated professions to co-design specific strategies for their professions.

These groups will develop a specific programme of work with associated resources.

Encouraging Transformation

15.
Implement the key recommendations from the London Nursing and LAS priority plans

At a national level Nursing and London Ambulance Service have been identified as areas for focus and specific action plans have been developed.

My Experiences as a BME NHS staff member in London

"I was told by the national director that I would have nothing to do with the Covid response for our programme. I was amazed as it was obvious this was not going to be a singular event given that it was a pandemic. I was efficiently excluded from regular SMT meetings which very quickly became all Covid and our business as usual. This left me to manage work on the fringes. I was disenfranchised and left totally disconnected from the work of the programme. I became demoralised and shared with my line manager that I had been disconnected from the programme. There was no subsequent response. To compound the situation, when our cell was stood down, I began receiving emails to pick up management of risks and issues as cell members were returning to their substantive roles. The national director did not share his decision with programme colleagues which meant that for some colleagues I have been perceived as being "difficult". My confidence has been shaken and I am none the wiser regarding the rationale behind the decision."

Operations Lead

A Case Study: London Ambulance Service

The London Ambulance Service (LAS) is unique in the region given its sheer geographical scope of operation. It is responsible for communities across the city, employs over 7,500 staff and volunteers, and handles over 3 million 999 and 111 calls a year.

The trust employs an array of professional practitioners, including paramedics, nurses, doctors and many support or clerical service staff. It provides a broad range of services from low-key interventions and transport services all the way up to major terror attack response.

The performance of this organisation against the WRES standards has been disappointing historically, but LAS has taken some bold steps towards creating a truly diverse and integrated environment in which people from all backgrounds are valued and embraced in the organisation. They are determined to set out plans that establish the trust as a positive role model for peers and an exemplar employer as outlined in this case study.

Covid-19

LAS has been front and centre during the Covid-19 crisis. Staff have experienced a kind of sensory overload which will have an enduring impact on both individuals and the service, not least where staff have encountered first-hand the differential impact of this disease and the disproportionate suffering of BME communities. Although it has been a difficult time, it also provides a rich learning opportunity. There is now a far greater awareness and sensitivity to differences in communities, and the service feels better placed than ever to cultivate more appropriate and inclusive attitudes, knowledge and skill sets for the future of London.

A Case Study: London Ambulance Service (continued)

The Challenge – WRES in LAS

In the past, LAS has performed poorly against the WRES standards. In 2019, BME staff were relatively less likely to be appointed from shortlisting, and more likely to enter disciplinary processes. BME staff were shown to be more likely to access mandatory training and CPD than white staff, though the difference was not significant. In addition, BME staff in the trust are almost twice as likely to experience discrimination than white staff.

Whilst the Capital itself, and indeed the NHS in London as a whole, has a large and diverse BAME population, LAS has historically struggled to recruit and retain a diverse workforce. It currently has a BAME workforce of 16.5%, which is up 7% on five years ago, but significantly less than London's overall BAME population of 40%.

Progress – 2015 to 2019

LAS has taken some bold actions in the past few years, including writing to staff outlining a plan for an anti-racist organisation with zero tolerance for racist behaviours. Changes include:

- Changing and improving recruitment practices.
- Ensuring there is always BME representation on interview panels at band 7 and above, and a diversity consultant at band 8d and above.
- Reviewing disciplinary processes.
- Engaging extensively with the national ambulance BME Forum, WRES CEO group, and the Greater London Authority.
- Reviewed and enhanced a diversity programme for current leadership.
- Delivered a successful sponsorship and reverse mentoring programme.
- Rebranding the BME staff network.

As the table below shows, this has led to good progress in a number of areas, including across WRES indicators 6, 7 and 8. There has also been a particularly marked improvement for the Board level indicator 9, from no BME representative on the board in 2015/16 to 29% in 2019/20.

Acknowledgement from LAS leadership

We recognise the importance of acknowledging our past performance for the sake of our staff and the people we serve. We know we have not always got this right in the past and we openly apologised at Board level for the poor experiences some back and minority ethnic staff have had to endure in the workplace in the past. In doing so we hope we can create a platform where we can all come together to build a better, more diverse and inclusive organisation that characterises meaningful and enduring change. This is our overriding commitment and is being driven forward proactively by our Chair, Heather Lawrence, and our CEO, Garrett Emmerson, who have been outspoken and publicly committed to change.

A Case Study: London Ambulance Service (continued)

								2018/19 Benchmarking Data		
	WRES Indicators	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**Movement**	**Nationally**	**London**	**Ambulance Trusts**
National staff survey indicators	**Indicator 6** % of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White 38% BME 40% Difference: 2%	White: 32% BME: 32% Difference: 0%	White: 31% BME: 38% Difference: 7%	White: 28% BME: 32% Difference: 4%	White: 27.7% BME: 30% Difference: 2%	▼	White: 23% BME: 28% Difference: 5%	White: 26% BME: 30% Difference: 4%	White: 28% BME: 35% Difference: 7%
National staff survey indicators	**Indicator 7:** Percentage of staff believing that the Trust provides equal opportunities for career progressing and promotion.	White: 63% BME: 42% Difference: 21%	White: 74% BME: 57% Difference: 17%	White: 62% BME: 47% Difference: 15%	White: 68% BME: 51% Difference: 17%	White: 72% BME: 56% Difference: 16%	▲	White: 87% BME: 72% Difference: 15%	White: 84% BME: 68% Difference: 16%	White: 69% BME: 52% Difference: 17%
National staff survey indicators	**Indicator 8:** In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / Team Leader or other colleagues	White: 13% BME: 25% Difference: 12%	White: 9% BME: 18% Difference: 15%	White: 11% BME: 19% Difference: 8%	White: 10% BME: 17% Difference: 7%	White: 10% BME: 16% Difference: 6%	▼	White: 7% BME: 15% Difference: 8%	White: 8% BME: 16% Difference: 8%	White: 11% BME: 18% Difference: 7%
Board representation indicator	**Indicator 9:** %difference between the Organisations Board voting membership and its overall workforce. NB. Only voting members of the Board should be included when considering this indicator.	White: 100% BME: 0%	White: 100% BME: 0%	White: 100% BME: 0%	White: 93% BME: 7%	White: 71% BME: 29%	▲	White: 88% BME: 7.4%	White: 83% BME: 15.6%	N/A N/A

A Case Study: London Ambulance Service (continued)

They are seeing progress in the WRES data but recognise that this alone is not enough. LAS is determined to create a truly diverse and integrated environment and set out plans that establish it an exemplar employer. There are some very clear and measurable achievements to date and the trust's action plan outlines the further actions to be taken.

Lived Experience
The trust has worked hard on ensuring that staff feel safe in speaking out and are seeking to shift their culture and create a sense of psychological safety where leaders can learn from staff and build back that learning into meaningful organisational change.

LAS are especially committed to understanding the lived experience of staff and building the culture of the organisation in a way that reflects the needs of the different staff and the community they serve and makes clear that bullying and racism will not be tolerated.

Building our future reputation
LAS recognises that the long-term success lies in a broader relationship with the people of London and they are already working to build relationships with partners, schools and communities. If they are to succeed, then they will need to take learning from within the trust and replicate that progress in the community relationships and the many critical partnerships with other emergency and partner organisations across London.

Part 4
Taking this forward

72 Introduction
73 Everyone's issue – introducing The 7 As of Authentic Allyship
75 The importance of staff networks – using what we already have
78 Evaluation
79 Resources
80 Funding and Governance
81 Planning our journey
82 Progress and success indicator time line
83 Conclusion

Introduction

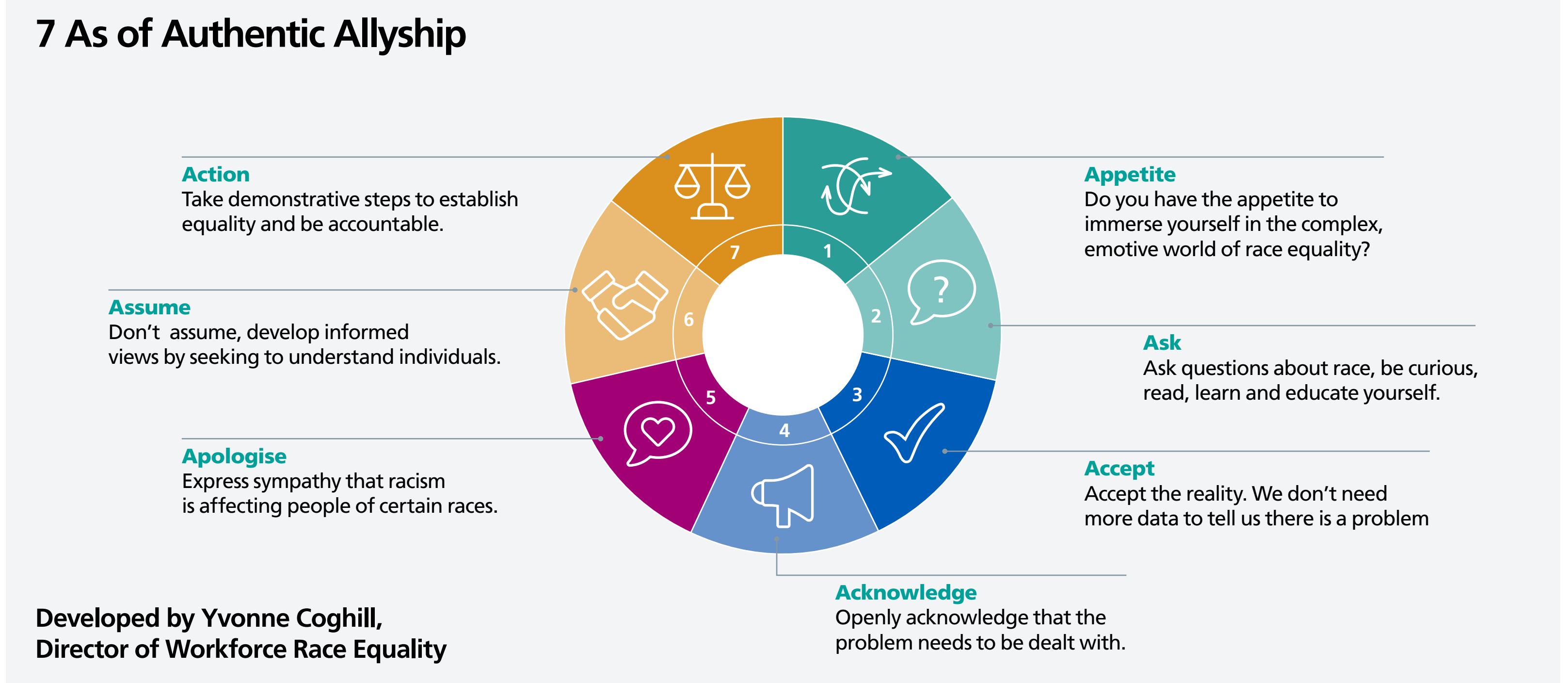
This strategy represents a commitment by the NHS London leadership that a change is coming.

A new regional team has been established and many programmes of work, research projects, and pilots are already underway. The strategy will be supported by an implementation plan that will be developed in collaboration with the system to expand and develop the recommendations, making meaningful change accessible to all.

There is no time to lose in eradicating race inequality and we recognise that nobody can do it alone. This section of the strategy outlines some key next steps for the region, as well as providing some tools and vital principles for the successful implementation of the recommendations.

Everyone's issue – introducing The 7 As of Authentic Allyship

Underwriting all of our thinking and recommendations is the need for authentic allyship. The NHS is a diverse employer, and everyone, BME and white, needs to work together to make it change.



Some staff don't know where to start on the journey to authentic allyship and organisations are keen to begin to make progress. Yvonne Coghill, Director of Workforce Race Equality, developed the 7 As of Authentic Allyship to help:

Appetite

This is the first and probably the most important A. Asking yourself whether you have the appetite to immerse yourself in the world of race equality, which is complex, convoluted and extremely emotive. Spend some time thinking about whether you will be in it for the long haul or whether this is just a fad. Allyship is forever, not just during crises.

Ask

This is where you have to be brave and actually ask questions about race, your race included. Be curious, look things up, read. Question all your received wisdom about race and other people. Be prepared to be surprised and even shocked at what you hear.

Everyone's issue – introducing The 7 As of Authentic Allyship (continued)

Accept

Having done your homework on the issue and spent time reflecting, it's now time to accept, really accept that there is an issue for people of colour in our society. This acceptance is an internal process.

Acknowledge

Acknowledgement is external. People will now know where you stand on race inequality because you will openly acknowledge that there is an issue that needs to be dealt with.

Apologise

The apology is not about saying you are sorry for any individual wrong doings, but saying you are sorry about what is happening globally to people of certain races. That apology needs to come from the heart and be authentic.

Assumptions

Don't make assumptions. Too many plans and ambitions – personal or corporate – are driven by assumptions that are wrong. Plans like these are doomed to fail. Full and informed views are critical prior to making any plans. Always seek the views of others and understand the implications of your actions across all interested parties. By doing so you will be better informed, and you will have gathered the intelligence and ownership of individuals or groups for whom your endeavours have implications and you will significantly enhance your chances of success.

Action

The final A is taking some sort of demonstrable action on the agenda. It can be sponsoring someone, it can be making a difference via policy changes, it can be any action that shows that you are indeed a true committed and authentic ally.

My Experience as a white ally

"For me as a leader of people in our NHS it was never possible to overlook the fact that our BME friends and colleagues are persistently treated differently – all too often badly. This is neither fair nor morally right. I saw friends from around the world to whom we called in times of need as the mother country. I saw people who came willingly and in good faith who were then betrayed and treated as second class citizens. I felt it to be a fundamental injustice. It was personally painful for me to see and does not make for a healthy thriving corporate culture. As a responsible public servant invested with public trust I was at the very least duty bound to act to ensure that people were treated fairly and equally. For these and my own personal reasons I became a 'White Ally' many years ago and my journey in listening to the lived experiences of the people to whom we owe so much has systematically reinforced that decision. Not for economic or institutional reasons but because as an ally we learn to listen and understand something of the very personal wrongs we do to people and the pain we systematically inflict on a major part of our population for no other reason than their skin colour. This is profoundly wrong and implies a fundamental lack of human kindness in what should be a caring institution.
There is no lens that we can look through and seek to justify this, I could not stand by and allow it to continue."

London Chief Executive

The importance of staff networks – using what we already have

It is tempting, when developing a strategy like this one, to focus on the new, to develop new programmes and pilots, to recommend new answers. But it is also essential to recognise and maximise the skills and resources we already have and to maximise the exposure and impact of these networks.

What's out there

London has an Equality and Inclusion team operating at a regional level, responsible for implementing the Workforce Race Strategy, cascading best practice and working with individual organisations. This team also maintains wider Equality and Inclusion plans for London, ensuring that all staff feel valued and supported.

The availability of resources at an organisation level at the moment is variable. NHS trusts will usually have access to a dedicated Equality, Diversity and Inclusion (EDI) specialist, some are able to employ a workforce EDI specialist alongside a patient services/commissioning EDI specialist, but in smaller trusts, this is often combined into one role and will cover all protected characteristics. It is therefore usual practice for employers to establish **staff networks** to inform their equalities work and understand how trust policies impact the experiences of their employees. In smaller primary care and community organisations there may not be access to even limited Equality, Diversity and Inclusion resources. In these cases, we would encourage organisations to come together at ICS level, utilising Primary Care Networks and encouraging staff collaboration.

For race equality issues specifically, all trusts and CCGs will have a **WRES action plan** following publication of their annual data collection. This will be supported by interventions from the national WRES team, and where possible the specialist knowledge of a WRES expert who has been trained to support this work and influence at a senior level. Not all London trusts have a WRES expert and work is underway to ensure every London Trust has a WRES expert that is able to influence at Board level. We encourage CCGs to develop their capability around race and consider how they might best support organisations outside of the remit of the WRES to understand and improve their performance in race equality. This is vital for their own staff and also improves healthcare outcomes.

A **Pan-London Equality, Diversity and Inclusion (ED&I) Leads network** exists, co-chaired by the Head of Equality and Inclusion for the region. This is a well-attended network but has previously lacked influence in setting policy direction.

The importance of staff networks – using what we already have (continued)

The **London HR Directors Network** meets regularly and is well engaged regarding race equality, sharing best practice and offering peer support. Members are key influencers, however their knowledge and confidence regarding race is variable

FTSU Guardian Service

The National Guardian's Office and the role of the Freedom to Speak Up (FTSU) Guardian were created in response to recommendations made in Sir Robert Francis' report "The Freedom to Speak Up". Although it covered the wider NHS workforce, the report particularly noted that there were structural hindrances that prevented BME staff from raising concerns on issues that affected them at work.

Guardians work proactively to support their organisation to tackle barriers to speaking up. They are appointed by the organisation they support, and each organisation decides who is best placed to take on the role. Guardians come from a wide range of professional backgrounds and seniorities. Their role is independent and impartial.

The negative experiences of BME staff during the Covid-19 pandemic has put the work of the Freedom to Speak Up Guardian service under spotlight, since it was specifically created to provide NHS staff with a channel through which they can raise their concerns and have their voices heard. Yet anecdotal evidence has suggested that BME staff feel marginalised and unable to raise concerns on issues that affect their welfare at work. This in turn has had a negative impact on their lives and mental wellbeing. A recent engagement exercise undertaken by the London Workforce Race Strategy team to explore the uptake of the FTSU Guardian Service by BME staff in London NHS trusts highlighted that:

- 87% of all FTSU Guardians are white (nationwide)
- The issue of trust was a key theme throughout the responses; BME staff do not want their ethnicity revealed because they do not trust the system and are concerned that they will be victimised for raising concerns
- Culture plays a role in speaking up; some members of BME communities do not want to be seen as 'complaining' and staff have stated that they feel the only support available is prayer.

Maximising impact

There are several programmes underway designed to maximise the use of current resources but also to educate senior leaders in engaging with staff and system partners on race equality:

- King's Fund programme for chief executives
- Refresh of Pan-London ED&I Leads Network to raise profile across London and increase ability to support and influence
- Additional cohort of WRES Experts for London
- WRES Experts programme for London EDI leads
- WRES Advisor programme for Board members
- Establishment of WRES 3 (Employment Relations) group to share good practice
- London BME Nurses Network
- BME Network of Networks
- Spotlight on Race Workshop for Human Resources Directors (HRDs)
- Culture transformation pilot (Whittington Health)
- Local Interventions driven by Head of Equality and Inclusion e.g. North Middlesex spotlight on Recruitment

To maximise the impact of the above resources and networks, organisations should look at the profile of workforce race equality within the trust, especially at board level, including the proximity of the WRES lead to the board and the seniority of the WRES lead. We believe this is a key factor in enabling open conversations, building trust and developing meaningful action plans.

The importance of **BME Staff networks** is that they provide a safe space for BME staff to come together, share their experiences and celebrate their differences. We recognise that BME staff network chairs are often carrying out this vital role on a purely voluntary basis alongside their substantive roles. Moving forward, there will need to be a concerted effort towards supporting leaders of BME staff networks across London to raise the visibility of their work, and to provide a source of meaningful

The importance of staff networks – using what we already have (continued)

and sustainable engagement with the wider workforce race equality agenda.

There is a need to strengthen the processes within organisations whereby staff can report concerns through channels such as the **Freedom to Speak Up Guardians** or BME staff networks. Going forward, the WRES team and the National Freedom to Speak Up Guardians' office will be working in collaboration to support: (i) increases in BME FTSU guardians, and (ii) further psychologically safe spaces in the workplaces for all staff to speak up. Organisations need to demonstrate commitment through meaningful engagement on this agenda including resourcing. Whistleblowing procedures also need to be reviewed to determine how accessible, well embedded and utilised these channels are.

As we increase the level of resources and expertise within organisations, it is vital that due consideration is given to governance and responsibilities to ensure best use of resources and maximise their impact.

Priorities and future ambition

The programmes and equalities work outlined in this report are important, but with Integrated Care Systems (ICSs) taking on more and more responsibility, it is vital that we also focus on the future. The following ambitions are central to ensuring race equality remains a priority at all levels of the NHS:

- Full Equality Impact Assessment (EIA) of interventions arising from Covid-19 to ensure no disproportionate impact
- ICS-level and regional redeployment and secondments to support the careers and access to stretch opportunities for BME staff
- ICS People Boards to develop action plans that consider oversight of racial equality, and an ambition to be a safe space for people to escalate concerns. As they develop ICSs to be able to meaningfully hold organisations to account
- Adoption and spread of successful good practice in systems to be shared across London
- Greater involvement of community providers (including voluntary sector and private providers) in delivery of care will require greater co-operation on all workforce issues. Shared expertise from larger to smaller providers may be required where subject matter expertise is not available in smaller organisations.
- Explore the adoption of WRES for non-statutory organisations and across ICS partnerships
- The use of educational budgets and the apprenticeship levy to ensure training provision is system-wide, including sharing educational/training opportunities.

Evaluation

When the interventions in this paper are put into action, they should change the lives of BME people in London and, we hope, change the NHS in London forever.

In order that these changes be sustainable and replicable, it is important that the processes of implementation and the subsequent impacts of these interventions are monitored and evaluated.

The London Equality and Inclusion team will monitor the delivery of this strategy, and the direction of travel for London as a whole, against the WRES indicators, Interim People Plan Goals and local metrics of success. We will work with academic partners to develop these to ensure that the evaluation has the necessary rigour to enable broader application of the strategic recommendations across the NHS and London as a whole.

At the same time, we would expect trusts, systems and others to be embedding evaluation into each intervention as they are implemented locally, in order to capture successes and learn from mistakes in keeping with quality improvement methodology.

Resources

This strategy and the actions within it are only one step towards making a difference. The path to real and lasting change lies in understanding, reflection, and compassion.

Annex A of this strategy contains a number of vital resources – reports, websites, books, articles – to help readers truly understand the challenges we're facing. Racism and discrimination are endemic in this country and around the world. If we're going to fight it, we need to learn about it.

In addition, the region will be supported by an Equality and Inclusion team who will be responsible for developing and mobilising the strategy implementation plan – supporting organisations across the system, enabling collaborative design and learning.

Funding and Governance

The Race and Inclusion agenda for London is an ambitious one and success will be dependent on a knowledgeable, engaged and responsive central programme team to support the region to deliver these recommendations.

Additional funding and resources have been approved to enable this. A formal governance structure is still to be developed. It is proposed that the implementation of this strategy and administration of associated budget is accountable to the London People Board.

The Equality and Inclusion team in London will continue to engage with and work through existing key stakeholder networks including but not exclusively:

- HRD Network
- Pan London EDI Network
- BME Network of Networks
- FTSU guardians
- The new Health and Race Observatory
- London CNO BME group
- Local Medical Committees
- Social Partnership Forum
- Professional clinical networks

My Experiences as a BME NHS staff member in London

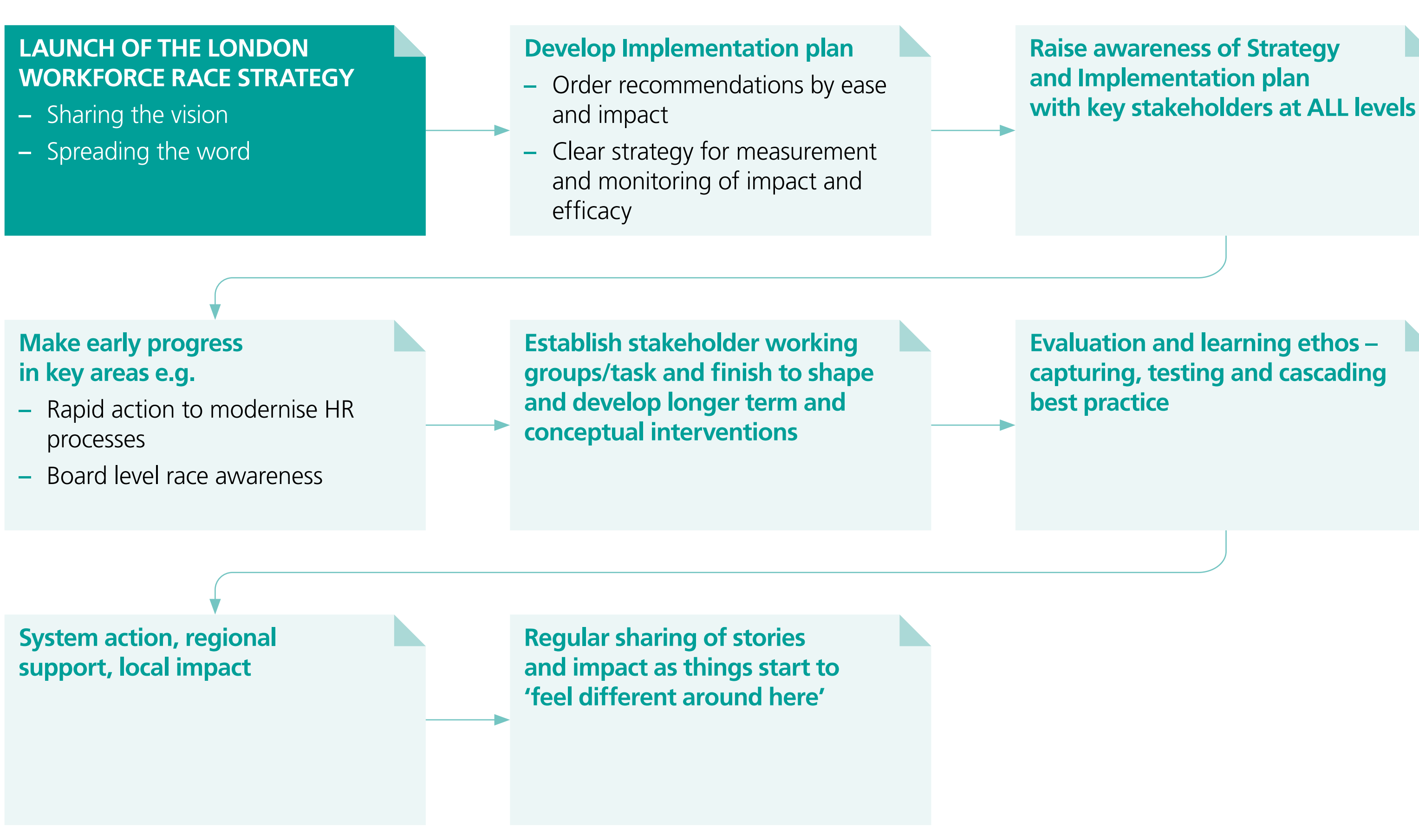
"As a current BME member of staff working as an administrator for the NHS, I must say the last few months have been challenging not just for us but for all colleagues. I have continuously been committed to working whether that be at work or from home, whilst also battling the reassurance that we are safe at work considering the fact that I am classed as being a vulnerable member of staff. In times like this, I think we are now being exposed to areas of support that we never even knew existed.

The introduction of the BME Network has shown me that our health and wellbeing is at the centre of the trust's development as a whole. The introduction of risk assessments and reassurance from management I must say has contributed significantly to the wellbeing of staff not only physically but also mentally, as some of our colleagues have experienced this virus and their family members and it is about offering support to help these people get through these challenging times. For me, personal development and opportunity is very important and so to have an internal network steering this within the trust I am all for it."

Administrator

Planning our journey

The London Workforce Race Equality Strategy and its compelling vision is our goal. We expect the journey to be long and we have sought a commitment of ten years to deliver the recommendations identified. The next step is to plan and organise the journey that we will take to to tackle race inequality across the NHS in London.



Progress and success indicator time line

October 2020

- Launch of the London Workforce Race Strategy
- Stakeholder engagement and awareness raising at system level
- Effective governance established
- EDI dashboard available
- Implementation activity begins for recommendations identified as immediate

Year 1

- London Equality and Inclusion team in place
- All organisations have plans in place to address race inequality
- Immediate recommendations in place/available
- Agreed qualitative and quantitative metrics
- All provider boards have a WRES advisor
- All organisations have WRES Experts or individuals enrolled to attend the programme
- London Race Pay Gap published at organisation and ICS level
- Core Manager Programme launched

Year 3

- 75% of organisations on track to meet VSM and Board model employer goals
- 50% of organisation on track to meet model employer 2028 targets
- Monitoring of progress against agreed metrics
- All organisations in London have a WRES advisor
- WRES indicator 2 – likelihood to be appointed and indicator 3 – formal disciplinary – have reached equity within London
- Establish stakeholder working groups/task and finish to shape and develop longer term and conceptual interventions
- FTSU Guardians at representation
- Temporary staff experience monitoring established

Year 5

- VSM and Board model employer goal complete and region at representation
- 70% of organisation are on track to meet their wider model employer targets
- Monitoring of progress against agreed metrics
- Maintenance of equity for indicators 2 & 3 for the last 2 years
- Race pay gap reduced significantly
- Half of longer term and conceptual interventions in implementation
- BME likelihood to formal disciplinary at parity in London
- Clear link between Trust performance rating and race equality performance

Year 7

- Maintenance of equity for indicators 2 & 3 for the last 4 years
- All London organisations have a non-white executive on the board
- Monitoring of progress against agreed metrics
- Cultural transformation programme complete
- Differential in experience between temporary and permanent staff closed

Year 10

- Model employer goal complete
- Achievement of equity in indicator 1,2,3
- Gaps on indicators 5,6,7,8,9 significantly closed
- Monitoring of progress against agreed metrics
- Race pay gap at 0
- All interventions implemented

Conclusion

The NHS workforce in London is incredibly diverse, and this reflects the population it serves. However, it is clear that there are many areas in which London needs to improve.

> "Every voice raised against racism chips away at its power. We can't afford to stay silent."
>
> **Reni Eddo-Lodge**

London is the worst performing region on almost every WRES indicator and, even where it is not, there is more work to be done to improve BME representation at senior levels, to make internal systems fairer for BME people, and to improve the day-to-day experiences of BME staff.

There are also issues that make London unique. The density of the city, and the proximity of one trust to another, make retention more difficult as staff have a greater choice of roles both within and outside of London. Our understanding of London's healthcare system should also be overlaid with patterns of education access, cost of housing, crime, and other social factors that influence the lives of those who work in our hospitals and surgeries.

At the time of writing this strategy, Covid-19 continues to present a major challenge to healthcare providers in England, with London among the most severely hit parts of the country in terms of case numbers. The system is also grappling with the growing evidence of a major disparity in infection and death rates between BME and white people. This disparity is reflected for the NHS workforce, and should be a cause for deep concern for healthcare leaders in London and beyond.

The WRES data provides a mirror to parts of the London NHS, but making real change is the responsibility of the entire system and, in particular, its leadership. It is time now to fully recognise that there is a racism problem in the NHS. Not in the individuals who have made it the treasured institution it is, but in the biased systems, often hangovers from previous regimes, that need now to be examined, deconstructed and rebuilt in a form more befitting a modern employer.

We are asking organisations to reflect and take stock of what their workforce race data and the lived experience of their staff is telling them. We are asking organisations to bring people together to discuss the strategy, to help inform what their priorities are and to help facilitate the brave conversations that need to be had.

The advent and evolution of integrated care systems and the anchor institution concept provide an opportunity for leaders to come together and think holistically, not just about the populations they serve, but the workforce who they rely upon to deliver excellent care. With a broader remit, and greater financial freedom, ICSs can think about recruitment, retention and talent development in ways that would previously have been impossible.

NHS leaders in London have an opportunity to be part of an incredible renewal. The challenge now is to adopt this strategy. Not to see it as personal criticism of one's leadership or organisation, but as an opportunity to make an affirmative break from the discriminatory systems in the NHS that make it a harder and less pleasant place to work for people from BME backgrounds.

Annexes

85 Annex A – Resources
92 Annex B – Key Recommendations
93 Annex C – Intervention Menu

Annex A – Resources

The strategy is based on four domains, as in the framework shown. We have gathered together some of the work and resources – evidence, guidance, research and legislation – available to help as we move towards our goal.

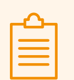
Encouraging Transformation

Including the development of compassionate and learning cultures; the mobilisation of system leaders; and a particular focus on supporting core managers.

Enabling People

Including genuine meaningful engagement with individuals across the system; focussed support for those who need it; and the sharing of replicable good practice.

Embedding Accountability



Including ensuring alignment across systems; robust regulation and scrutiny; and a focus on emerging healthcare architecture.

Evidencing Outcomes

Including the gathering of data and intelligence; benchmarking organisations; and making evaluation and sustainability a priority.

Annex A – Resources (continued)

Enabling People

Atewologun, et al: 2018 – Unconscious bias training: an assessment of the evidence for effectiveness: Equality and Human Rights Commission Research report 113 – and Fatima Tresh
https://www.ucd.ie/equality/t4media/ub_an_assessment_of_evidence_for_effectiveness.pdf

Cleary, S: 'My journey as a white WRES Expert.'
http://www.bhamcommunity.nhs.uk/about-us/news/latest-news/suzanne-cleary-blog-white-wres-expert/

Coghill, Y: 'As BME people we need to put ourselves forward'. (By Thelma Agnew 18 Dec 2018)
https://rcni.com/nursing-standard/features/bme-people-we-need-to-put-ourselves-forward-142961

COGHILL, Y: 'Racial inequality cannot be denied any more' – (By Gemma Mitchell1 JULY, 2020)
https://www.nursingtimes.net/news/leadership-news/yvonne-coghill-racial-inequality-cannot-be-denied-any-more-01-07-2020/

Crenshaw, K. Williams: 1993 – Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color – 43 Stan. L. Rev. 1241 (1990-1991)
https://www.racialequitytools.org/resourcefiles/mapping-margins.pdf

Estacio, E, V and Saidy-Khan, S: 2014 – Experiences of Racial Microaggression Among Migrant Nurses in the United Kingdom. Global Qualitative Nursing Research
https://journals.sagepub.com/doi/pdf/10.1177/2333393614532618

Geronimus, A, et al: 'Weathering" and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States'. Am J Public Health. 2006 May; 96(5): 826–833.
https://pubmed.ncbi.nlm.nih.gov/16380565/

Gifford, J: Jul, 2020 – Unconscious bias training is not the go-to solution
https://www.cipd.co.uk/Community/blogs/b/jonny_gifford/posts/unconscious-bias-training-is-not-the-go-to-solution

Hall, R. E: Skin Color as Post-Colonial Hierarchy: A Global Strategy for Conflict Resolution – The Social Science Journal, Volume 41, 2004 – Issue 3
https://www.semanticscholar.org/paper/Skin-color-as-post-colonial-hierarchy%3A-a-global-for-Hall/7d522c3120c0967fae038bef7a3325184a655026

Inko-Tariah, C: ALLYSHIP MAKING NHS WHITES STRONG ALLIES FOR RACIAL JUSTICE
https://chronicleworld.co.uk/2020/06/29/3166/

Annex A – Resources (continued)

Enabling People

Jones, C: Levels of racism: a theoretic framework and a gardener's tale – Am J Public Health. 2000 August; 90(8): 1212–1215
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446334/

Morris, N: 13 Mar 2020 – Microaggressions are not a 'harmless' form of racism – they have a huge impact – Metro – London
https://metro.co.uk/2020/03/13/microaggressions-sneaky-form-racism-often-goes-radar-12194093/

Nazroo, J – December 2017 – Class and Health Inequality in Later Life: Patterns, Mechanisms and Implications for Policy – Manchester Institute for Collaborative Research on Ageing and Sociology, School of Social Sciences, University of Manchester, Int. J. Environ. Res. Public Health 2017.
https://www.mdpi.com/1660-4601/14/12/1533

Naqvi, H. (15 July 2020) – 'It's no longer enough to know, we must act: workforce race inequality in the NHS'
https://www.kingsfund.org.uk/blog/2020/07/workforce-race-inequality-nhs

New guidance to help trusts deal with investigations and disciplinary procedures
https://www.health-and-care-update.co.uk/2019/07/new-guidance-to-help-trusts-deal-with-investigations-and-disciplinary-procedures-.html

Reed, C: 2017 Colorism and Its Correlation with Implicit Racial Stereotyping: An Experimental Action Research Study – THE YOUNG RESEARCHER, VOL. 1, NO. 1, 2017
http://www.theyoungresearcher.com/papers/TYR_V1_N1.pdf#page=18

Sander-Jackson, S – 2020 – Microaggression: what it really means
https://www.nursingtimes.net/opinion/microaggression-what-it-really-means-05-06-2020/

Santana, J (October 18, 2019) – Turning Your Subconscious Enemy into Your Inclusion Ally
https://www.insightintodiversity.com/turning-your-subconscious-enemy-into-your-inclusion-ally/

Sue, D. W: Examples of Microaggressions in the Classroom
https://www.messiah.edu/download/downloads/id/921/Microaggressions_in_the_Classroom.pdf

Sue, D. Wing et al: – Racial Microaggressions in Everyday Life Implications for Clinical Practice
https://www.cpedv.org/sites/main/files/file-attachments/how_to_be_an_effective_ally-lessons_learned_microaggressions.pdf

Thomas, L. K: Empires of mind: 2013 – Colonial history and its implications for counselling and psychotherapy – *British Association of Psychotherapists, Refugee Therapy Centre 1a Leeds Place, London, UK 12 January 2013
https://www.researchgate.net/publication/263592371_Empires_of_mind_Colonial_history_and_its_implications_for_counselling_and_psychotherapy

Annex A – Resources (continued)

Enabling People

Video/Podcast

Changing the culture of conversation (14 Jun 2020); Senior AHP Leaders and Managers: Part One
https://youtu.be/YdGPTxnsB18

Just culture and staff wellbeing
https://www.magonlinelibrary.com/doi/full/10.12968/bjon.2020.29.6.381

King's Fund: NHS workforce race equality – A podcast about big ideas in health and care
https://www.kingsfund.org.uk/audio-video/podcast/race-equality-nhs-workforce

Leary, J. D – Post-traumatic Slave Disorder (Long Video)
https://www.youtube.com/watch?v=BGjSday7f_8

Leary, J. D – Post-traumatic Slave Disorder (Short Video)
https://www.youtube.com/watch?v=Rorgjdvphek

Encouraging Transformation

Belonging in the NHS
https://www.england.nhs.uk/ournhspeople/online-version/belonging-in-the-nhs/

Interim NHS People Plan
https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

We are the NHS: People Plan for 2020/2021 – action for us all
https://www.england.nhs.uk/ournhspeople/

West, M et al,: Making the difference Diversity and inclusion in the NHS – December 2015
https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Making-the-difference-summary-Kings-Fund-Dec-2015.pdf

WORKFORCE RACE EQUALITY STANDARD – Exemplar for embedding and sustaining continuous improvements – North East London NHS Foundation Trust
NHS England and NHS Improvement July 2019
https://www.england.nhs.uk/wp-content/uploads/2019/11/nelft-case-study.pdf

Devesh Sinha Blog series, Everyday racism, my lived experience
https://www.bhrhospitals.nhs.uk/news/everyday-racism-my-lived-experience-2581
https://www.bhrhospitals.nhs.uk/news/everyday-racism-my-perception-of-equality-changes-2588

Annex A – Resources (continued)

Embedding Accountability

A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS – NHS Workforce Race Equality Standard (WRES) leadership strategy – January 2019
https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf

A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce – 3 July 2019
https://www.england.nhs.uk/publication/a-fair-experience-for-all-closing-the-ethnicity-gap-in-rates-of-disciplinary-action-across-the-nhs-workforce/

Bass, David: Implementing an effective Strategic Equality Impact Assessment (SEIA) 10 Jun 2020
https://www.advance-he.ac.uk/news-and-views/implementing-effective-strategic-equality-impact-assessment-seia?utm_source=Advance

Equality Act 2010
https://www.legislation.gov.uk/ukpga/2010/15/section/4

NHS Constitution for England – 2012
https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Public Sector Equality Duty
https://www.legislation.gov.uk/ukpga/2010/15/section/149

Evidencing Outcomes

Colour of Power: A Visual Depiction of the Diversity Composition of Britain's Most Powerful Leaders – Green Park – REPORT INSIGHTS-27TH JULY 2020
https://thecolourofpower.com/

Coronavirus: Racism 'could play a part in BAME Covid deaths' – BBC News – 13 June 2020
https://www.bbc.co.uk/news/health-53035054

COVID-19: understanding the impact on BAME communities – Public Health England – 16 June 2020
https://www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities

Ethnicity pay gap reporting: March 2017 data
https://www.london.gov.uk/sites/default/files/gla-ethnicity-pay-gap-report-2017.pdf

Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland – 24 June 2020
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

Ethnicity and National Identity in England and Wales: 2011 – Office of National Statistics – December 2012
https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11

Annex A – Resources (continued)

Evidencing Outcomes

Impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) staff in mental healthcare settings. 13 May 2020 – Royal College of Psychiatrists
https://www.rcpsych.ac.uk/docs/default-source/about-us/covid-19/impact-of-covid19-on-bame-staff-in-mental-healthcare-settings-report-2020.pdf

Kotecha, S.: 28 July 2020. 'Government failing to prioritise tackling racism', says watchdog boss' BBC News
https://www.bbc.co.uk/news/uk-53556519

NHS Staff Survey
http://www.nhsstaffsurveyresults.com/local-breakdowns-questions/

NHS Workforce Statistics – February 2020
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/february-2020

Paradies, Y. et al: 'Racism as a determinant of health: a systematic review and meta-analysis.' PloS one 10.9 (2015): e0138511.
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0138511

PHE data series on deaths in people with COVID-19: technical summary – April 2020
https://www.gov.uk/government/publications/phe-data-series-on-deaths-in-people-with-covid-19-technical-summary

Prof Donna Kinnair on racism in the NHS: 'In every community, BAME patients suffer the most' (as told to Sirin kale) UK News – The Guardian Newspaper
https://www.theguardian.com/world/2020/jun/10/

Serafini, K. et a l: Racism as Experienced by Physicians of Color in the Health Care Setting. Family Medicine. Fam Med. 2020;52(4):282-287.
https://doi.org/10.22454/FamMed.2020.384384
https://journals.stfm.org/familymedicine/2020/april/serafini-2019-0305

Williams, D. R. et al – 'Racism and health: evidence and needed research.' Annual review of public health 40 (2019): 105-125.
https://www.annualreviews.org/doi/abs/10.1146/annurev-publhealth-040218-043750

Annex A – Resources (continued)

Further reading

Akala: Natives: Race and Class in the Ruins of Empire. 2018. Two Road, UK

Baldwin, J: I am not your Negro. 2017. Penguin Classics, USA

Banaji, M and Greenwald, A: Blindspot: Hidden Biases of Good People. 2016. Bantam Books, USA

Boakye, J: Black, Listed: Black British Culture Explored. 2019. Little, Brown Book Group, UK

Cousins, S: Overcoming everyday racism: Building Resilience and Wellbeing in the Face of Discrimination and Microaggressions. 2019. Jessica Kingsley Publishers, UK

Craigo-Snell, S and, Doucot, C: No innocent bystander: Becoming an Ally in the Struggle for Justice. 2017. Westminster John Knox Press, USA

DiAngelo, R: White Fragility. 2018. Beacon Press, USA

Eddo-Lodge, R: Why I'm No Longer Talking to White People About Race. 2014. Bloomsbury Publishing PLC. UK

Kendi, I. X. How To Be an Antiracist. 2019. Vintage Publishing, UK

Lawal, E: The Clap Back: Your Guide to Calling out Racist Stereotypes. 2019. Hodder and Stoughton, UK

Oluo, I: So you want to talk about race. January 2018. Basic books, NY, USA

Olusoga, D: Black and British: A Forgotten History. 2017. Pan Macmillan, UK

Rosen, M: These are the hands – poems from the heart of the NHS. 2020. Fair Acre Press, UK

Rutherford, Adam: How to Argue With a Racist: History, Science, Race and Reality. 2020. Orion Publishing Co. UK

Saad, L: Me and White Supremacy: Combat Racism, Change the World, and Become a Good Ancestor. 2020. Sourcebooks (USA) Quercus Books (UK)

Sarsour, L: We are not here to be Bystanders: A Memoir of Love and Resistance. 2020. Simon and Schuster, Inc.

Tatum, B. D: Why Are All the Black Kids Sitting Together in the Cafeteria? 2017. Basic Books, UK

Ware, V: Beyond the place – white women, racism, and history. 1992. Verso Publishing, UK

Annex B – Key Recommendations

- Conceptual
- Planned
- In flight
- Long term opportunity
- Medium term plan
- Immediate action

P = Provider Organisations
S = System Partners ICS/STP
NL = NHSEI London

Key Recommendation	Progress Stage	Prioritisation	System Lead
1. Modernise HR processes to ensure a more collaborative and person-centred learning approach	Planned	Medium term plan	NL P S
2. An executive on each board should complete WRES Advisor Programme	Planned	Medium term plan	P S
3. Launch cultural transformation programmes for London	Planned	Immediate action	NL
4. Increase BME representation among Freedom To Speak Up Guardians and champions and ensure support is available across the system including within Primary Care	In flight	Immediate action	P NL
5. Establish STP/ICS Workforce Race Equality panels	Conceptual	Medium term plan	NL S
6. Commissioners should work collaboratively and as peers with all providers in enhancing their performance against indicators of race inequality	Conceptual	Long term opportunity	NL S
7. Work with the Care Quality Commission to develop specific race related key lines of enquiry for inspections	Planned	Immediate action	NL
8. Develop a competency framework and development programme for supervisors and line managers throughout the system	Planned	Long term opportunity	P NL
9. Launch a white allies programme	Conceptual	Long term opportunity	NL
10. Launch a local Frontline Staff Forum	Conceptual	Medium term plan	S
11. Develop a London-specific WRES experts programme – Building London's Capacity and Capability	In flight	Immediate action	NL P
12. De-bias recruitment, secondments and professional development opportunities	In flight	Medium term plan	NL P
13. Identify and close the gap in experience for agency, bank and temporary staff	Conceptual	Long term opportunity	NL S
14. Establish a multi-professional leadership group who will work with staff working in primary care, AHPs, finance, healthcare scientists, doctors, dentists and pharmacists to co-design specific strategies for their professions	Conceptual	Long term opportunity	S NL
15. Implement key recommendations from the London Nursing and LAS priority plan	Conceptual	Long term opportunity	P S NL

Annex C – Intervention Menu

Full menu of all interventions considered, including impact and effort rating.

7 = High Impact Low Effort
6 = High Impact High Effort
4 = Low Impact Low Effort
3 = Low Impact High Effort

Conceptual | Planned | In flight
Long term opportunity | Medium term plan | Immediate action

WRES Framework	Dr Williams Themes	Associated with key recommendations – number means this is a key recommendation	Where there are mulitple links primary recommendation indicated	intervention description	Impact and Effort Rating	Progress Stage	Prioritisation
Evidencing Outcomes	Resource and measurable outcomes	Yes	1	**Model Employer** – National goals monitored at an organisation level representation relative to employee population. Indicator 1 – Board and VSM representation by 2025. BME Workforce across AfC band 8a-9 by 2028. NHS E/I London internal representation goal 33%.	6	In flight	Immediate action
Encouraging Transformation	Leadership and role models	3	3	**Cultural Transformation Program** – NHS England and NHS Improvement London will build on the transformation programme work currently being done by the national WRES team at Whittington Health. Development of a robust and evaluated programme of work to support trusts to build an evidence base improvement plan around their workforce race agenda. Objective of this intervention is to operationalise the approach so that all trusts in the region can complete this activity	6	Planned	Immediate action
Encouraging Transformation	Leadership and role models	Yes	9	**CEO and allies Program** – King's Fund Leaders Programme with associated action sets, commissioned and underway. Also aligning to Workforce Priority 6 – Caring for and celebrating our people. Building a culture of compassionate and inclusive leadership	7	In flight	Immediate action
Encouraging Transformation	Leadership and role models	15	15	**Nursing** – leadership, talent management and role modelling program (8c and above). Similar to the current King's Fund programme. Action learning sets for Exec DONs also aligning to Workforce Recovery priority 6 & Capital Nurses and Midwives Programme.	7	Conceptual	Medium term plan

Annex C – Intervention Menu (continued)

7 = High Impact Low Effort
6 = High Impact High Effort
4 = Low Impact Low Effort
3 = Low Impact High Effort

Progress Stage: Conceptual (light blue) · Planned (blue) · In flight (purple)

Prioritisation: Long term opportunity (yellow) · Medium term plan (orange) · Immediate action (dark red)

WRES Framework	Dr Williams Themes	Associated with key recommendations – number means this is a key recommendation	Where there are mulitple links primary recommendation indicated	intervention description	Impact and Effort Rating	Progress Stage	Prioritisation
Encouraging Transformation	Leadership and role models	Yes	11	**WRES experts on all London Boards** – Demonstrable involvement and influence. Every Board to have a confident BME Leader with ability to challenge and advise the Board as critical friend to ensure that the race perspective is woven through both Board discussions and decision making. Expect to see this in action and evident in Board papers. This will also enable reciprocal learning and development opportunities for BME staff. To initiate after completion of EDI Lead WRES experts programme.	6	Planned	Medium term plan
Embedding Accountability	Communication and celebrating success	Yes	3	The profile of workforce race equality – Organisations to make explicit about the proximity of Workforce Race Leads to the Board. Evidence provided via Board Papers and also role descriptions and governance structures	7	Conceptual	Medium term plan
Evidencing Outcomes	Measurable Outcomes	12	12	**Succession and talent pipeline** – Focused work to grow talent pipeline in London through succession planning, inclusive recruitment and active sponsorship e.g. +1 scheme To be aimed at band 4 and above development	6	Conceptual	Long term opportunity
Embedding Accountability	Resource and measurable outcomes	12	12	**Secondments** – Review of region secondment processes to create a transparent process and equality of access to increase the accessibility and visibility of roles.Solution framework to be delivered via an accessible website e.g. NHS Jobs. Willl require resource to supoprt implementation and uptake	6	In flight	Immediate action

Annex C – Intervention Menu (continued)

7 = High Impact Low Effort
6 = High Impact High Effort
4 = Low Impact Low Effort
3 = Low Impact High Effort

Conceptual
Planned
In flight

Long term opportunity
Medium term plan
Immediate action

WRES Framework	Dr Williams Themes	Associated with key recommendations – number means this is a key recommendation	Where there are mulitple links primary recommendation indicated	intervention description	Impact and Effort Rating	Progress Stage	Prioritisation
Encouraging Transformation	Leadership and role models	Yes	3	**'Walking in my shoes'** model in place or monthly team visits by all Executives to keep in touch with staff and prevalent issues on the ground. Shadowing the CEO, see through the CEO lens and feedback experience	7	Planned	Medium term plan
Encouraging Transformation	Leadership and role models	Yes	3	**HR Leaders program** – Promoting this staff cohort as agents of change. Development of a King's Fund programme aimed at increasing race awareness and encouraging reflective practice. Also aligns to Workforce Recovery priority 6	6	Planned	Medium term plan
Encouraging Transformation	Leadership and role models	8	8	**Competency framework** – For all managers including following aspects; – Build a consistent standard of race and cultural awareness – 360 feedback and coaching – Build in D&I objectives in PDPs – Build understanding of personal impact – Develop key skills around conversations that make a difference – Offers peer support and space for reflection	7	Planned	Medium term plan
Encouraging Transformation	Leadership and role models	Yes	8	**Supervising Managers Program** – Analysis of staff survey data demonstrates that immediate line manager/supervisors are the single biggest factor in levels of inclusion within organisations. Development of a Peer support and learning network around Workforce Race Equality	6	Planned	Medium term plan

Annex C – Intervention Menu (continued)

7 = High Impact Low Effort
6 = High Impact High Effort
4 = Low Impact Low Effort
3 = Low Impact High Effort

Conceptual
Planned
In flight

Long term opportunity
Medium term plan
Immediate action

WRES Framework	Dr Williams Themes	Associated with key recommendations – number means this is a key recommendation	Where there are mulitple links primary recommendation indicated	intervention description	Impact and Effort Rating	Progress Stage	Prioritisation
Encouraging Transformation	Leadership and role models			**Reverse mentoring** – Moving to a sponsoring lens. Organisations to consider how this helps shift the dial on workforce race equality and the Impact for BME junior staff involved. Positive model includes the LAS sponsorship mentoring approach. A key outcome includes move of at least one pay band in 12 months for BME staff. This is being rolled out across NHS E/I. London region have developed an enhanced model in line with LAS approach	4	In flight	Medium term plan
Encouraging Transformation	Leadership and role models	Yes	12	**Stretch opportunities** – Identification of all BME staff band 8C and above for all staff groups and ensuring fair access to stretch opportunities	6	Planned	Medium term plan
Encouraging Transformation	Leadership and role models	9	9	**White allies programme** – Development of white allies through learning, mentoring and reflective practice. Unlocking the capability of active bystanders to apply white privilege to address racism and bias where it occurs, reducing the load carried by the BME workforce	6	Planned	Medium term plan
Encouraging Transformation	Leadership and role models	Yes	1	**BME Leadership** – Representation within STP's/ICS's – work with these leads to push this agenda across the system and help motivate and support providers. Representation to be monitored as ICS form and governance is established	7	In flight	Immediate action

Annex C – Intervention Menu (continued)

7 = High Impact Low Effort
6 = High Impact High Effort
4 = Low Impact Low Effort
3 = Low Impact High Effort

Conceptual
Planned
In flight

Long term opportunity
Medium term plan
Immediate action

WRES Framework	Dr Williams Themes	Associated with key recommendations – number means this is a key recommendation	Where there are mulitple links primary recommendation indicated	intervention description	Impact and Effort Rating	Progress Stage	Prioritisation
Enabling People	communication and celebrating success	Yes	3	**Psychological Safety** – Forums and 'safe spaces' where staff can share lived experience. Examples include Schwartz rounds, compassion circles, safety huddles and other forms of reflective practice.	7	Planned	Medium term plan
Embedding Accountability	Leadership and role models	3	3	**CEO attending inductions** – Significant time and being present. Laying down boundaries and expectations and raising this agenda to new staff including organisational values. NSUG and Union reps invited to be part of inductions. Staff encouraged to join them and use them constructively	7	Planned	Immediate action
Embedding Accountability	Resource and measurable outcomes	12	12	**De-bias recruitment processes** – Overhauling and actively de-biasing recruitment and selection processes including the development of inclusive panels, skill based, check and challenge and Rooney Rule. Agencies – Considering striking off head hunter agencies if they are not meeting contractual targets which is representative of trust ambition of the BME workforce agenda. Delivering a mandatory selection criteria for the procurement of management recruitment including scoring system and promoting those agencies that do this well.	7	In flight	Immediate action
Embedding Accountability	Resource and measurable outcomes			**Financial commitment** – Funding workforce race equality expertise at an ICS and regional level. Funding agreed as £20k per organisation per Trust and LAS per year with match funding from NHS E/I. From 1 April 2021	7	In flight	Immediate action

Annex C – Intervention Menu (continued)

7 = High Impact Low Effort
6 = High Impact High Effort
4 = Low Impact Low Effort
3 = Low Impact High Effort

Conceptual
Planned
In flight

Long term opportunity
Medium term plan
Immediate action

WRES Framework	Dr Williams Themes	Associated with key recommendations – number means this is a key recommendation	Where there are mulitple links primary recommendation indicated	intervention description	Impact and Effort Rating	Progress Stage	Prioritisation
Evidencing Outcomes	Resource and measurable outcomes	13	13	**Agency and Bank staff** – London workforce priority 3; race pay gap. Staff experience survey data for this group and closing the experience gap. Consideration to fair rates of pay and commitment to living hours	6	In flight	Medium term plan
Enabling People	Resource and measurable outcomes	11	11	**London WRES expert programme** – Development of regional WRES expert development programme for both EDI leads and senior staff. Building London's Capacity and Capability. Commissioned to: Inspiring Hope	7	In flight	Immediate action
Embedding Accountability	Resource and measurable outcomes	5	5	**ICS / STP Panels** – Built into STP/ICS strategic plans development of STP/ICS level scrutiny panels providing a safe channel through which BME staff can raise concerns around bullying and harassment. Dependent on ICS establishment and engagement	6	Conceptual	Long term opportunity
Encouraging Transformation	Resource and measurable outcomes	Yes	3	**London Boards** – At ICS level a programme specifically for London boards focusing on race	6	Planned	Medium term plan
Embedding Accountability	Resource and measurable outcomes	7	7	**CQC** – Specific race related key lines of enquiry with CQC Commissioners. CQC to have conversations with commissioners prior to Good/Outstanding rating. Developing a set of KLOE's for London around performance against this agenda – Model Employer targets, WRES performance and regional targets and standards	7	Planned	Immediate action

Annex C – Intervention Menu (continued)

7 = High Impact Low Effort
6 = High Impact High Effort
4 = Low Impact Low Effort
3 = Low Impact High Effort

Progress Stage: Conceptual; Planned; In flight

Prioritisation: Long term opportunity; Medium term plan; Immediate action

WRES Framework	Dr Williams Themes	Associated with key recommendations – number means this is a key recommendation	Where there are mulitple links primary recommendation indicated	intervention description	Impact and Effort Rating	Progress Stage	Prioritisation
Evidencing Outcomes	Resource and measurable outcomes	Yes	All	**Equality Diversity and Inclusion data dashboard** – developed in partnership with HEE. Enables monitoring of EDI performance by race and AfC band (amongst other demographics) at regional and organisational level, to a role specific level of detail. Complete and available immediately	7	In flight	Immediate action
Embedding Accountability	Resource and measurable outcomes	Yes	3	**Meaningful EIA process** – multi stage and best practice, with rigorous check and challenge	6	Planned	Medium term plan
Evidencing Outcomes	Resource and measurable outcomes	Yes	All	**Equality Diversity and Inclusion data dashboard** – developed in partnership with HEE. Enables monitoring of EDI performance by race and AfC band (amongst other demographics) at regional and organisational level, to a role specific level of detail. Complete and available immediately	7	In flight	Immediate action
Embedding Accountability	Resource and measurable outcomes	Yes	3	**Meaningful EIA process** – multi stage and best practice, with rigorous check and challenge	6	Planned	Medium term plan
Encouraging Transformation	Leadership and role models	Yes	12	**Gold Command structures** – Collecting data around the structures across the system in London with aim to have Gold Command representative – complete	7	In flight	Immediate action
Evidencing Outcomes	Measurable Outcomes	Yes	7	**Aligning race data with performance** – key indicator of organisation success (CQC and regulators)	6	Planned	Medium term plan

Annex C – Intervention Menu (continued)

7 = High Impact Low Effort
6 = High Impact High Effort
4 = Low Impact Low Effort
3 = Low Impact High Effort

Conceptual · Planned · In flight

Long term opportunity · Medium term plan · Immediate action

WRES Framework	Dr Williams Themes	Associated with key recommendations – number means this is a key recommendation	Where there are mulitple links primary recommendation indicated	intervention description	Impact and Effort Rating	Progress Stage	Prioritisation
Evidencing Outcomes	Resource and measurable outcomes	1	1	**Staff Appraisals, capability and perform**ance – De-biasing these processes also relating to pay increments process. Example includes North West London Collaboratives of CCGs pre-capability/performance management checklist	6	Planned	Medium term plan
Evidencing Outcomes	Resource and measurable outcomes	Yes	All	**Metrics** – Combination of hard data with qualitative lived experience data. Race dashboard, listening events	6	In flight	Immediate action
Evidencing Outcomes	Resource and measurable outcomes	Yes	6	**Reward and Sanctions** – Working with providers. Rewards including organisational reputation and awards. Sanctions aligned to CCG/STP performance oversight framework. Options for sanctions for commissioners for providers who are not compliant	6	Conceptual	Long term opportunity
Evidencing Outcomes	Measurable Outcomes	1	1	**Modernising HR processes** – Ensuring a more collaborative and person-centred learning approach. This will have a direct impact on disciplinaries and grievances	6	In flight	Immediate action
Encouraging Transformation	Leadership and role models	Yes	3	**Open door to CEO and Board members** – For Chairs of staff networks	7	In flight	Immediate action
Enabling People	Communication and celebrating success	Yes	3	**Communications plans** – Development of robust plans around this agenda to promote the work within organisations and regionally	7	In flight	Immediate action

Annex C – Intervention Menu (continued)

7 = High Impact Low Effort
6 = High Impact High Effort
4 = Low Impact Low Effort
3 = Low Impact High Effort

Progress Stage: Conceptual, Planned, In flight
Prioritisation: Long term opportunity, Medium term plan, Immediate action

WRES Framework	Dr Williams Themes	Associated with key recommendations – number means this is a key recommendation	Where there are mulitple links primary recommendation indicated	intervention description	Impact and Effort Rating	Progress Stage	Prioritisation
Enabling People	Communication and celebrating success	Yes	3	**Webinars, lunch n' learns and podcasts.** Trust webinars with panel of executives and moderator where staff can ask questions/ put their views/ share experiences	7	In flight	Medium term plan
Encouraging Transformation	Leadership and role models	Yes	3	**Pool of media ready BME talent** – Ensuring diversity of onscreen and media BME representation of NHS London beyond discussion around race or EDI	6	Conceptual	Long term opportunity
Enabling People	Communication and celebrating success	Yes	All	**Central Workforce Race Equality digital platform** – who's doing what, what's working, innovation peer support and driving social movement	6	In flight	Medium term plan
Embedding Accountability	Resource and measurable outcomes	4	4	**Freedom to speak Guardians** – increase number of BME Guardians in London	7	In flight	Immediate action
Enabling People	Communication and celebrating success	Yes	10	**Staff influencing chan**ge – Evidence that staff are influencing change in the organisation 'You said we did' type of mechanisms in place	7	In flight	Immediate action
Enabling People	Communication and celebrating success	Yes	All	**Celebrating success events** – Annual conferences for all Trusts sponsored by the Board celebrating success but learning for the future from staff stories	6	In flight	Immediate action

NHS England and NHS Improvement – London

Wellington House
135-155 Waterloo Road
London SE1 8UG

E janine.larosa@nhs.net

@nhsengland
@NHSEnglandLDN

www.england.nhs.uk/london

Other formats of this document are available on request. Please send your request to: janine.larosa@nhs.net