Sheffield Race Equality Commission

Briefing Note on employment

1. Employment issues to consider

Workforce context: STP

There are
- 72,000 staff in health and social care
- 40, 000 staff in the NHS
- 10 NHS trusts plus 2 ambulance Trusts of which by far the largest is Sheffield Teaching Hospitals
- 5 local authorities of which by far the largest is Sheffield City council

Sheffield Teaching Hospitals NHS FT has over 16,500 employees. The local population of Sheffield is 19% BME (2011 census though it is almost certainly larger now), whilst the Trust BME workforce is 13% (2019) which is unusual in the NHS as most NHS Trusts have a larger BME workforce than in the local population it serves. Sheffield City Council workforce was 14.5 BME% in 2017-18 (the most recent figure easily accessible online)

Workforce context: ACP

The Sheffield Accountable Care Partnership (ACP) originally published a Workforce Strategy in October 2019. Its 36 pages contained three brief mentions (6 lines in all) of race equality. It has since reviewed this strategy significantly, considerably strengthening that aspect. It has been assumed the Commission will be provided with that and additional relevant documents, some of which I have read in preparing this Briefing Note.

I have not examined the data, action plans or future strategies of each NHS Trust or local authority in detail since that was not required as part of this briefing.

The questions to consider asking

The priority will be to identify

- Whether there is appropriate intelligence on the baseline for work going forward
- Whether the measures being taken capture the appropriate priorities for work going forward to address workforce race equality
- Whether the interventions and overall strategy are underpinned by sufficient evidence to be able to explain why there can be some confidence the interventions and strategy have a reasonable likelihood of success
- What success is planned for and looks like

There is comprehensive data within the NHS (especially at Trust level) in terms of data and the new national NHS People Plan strategy highlights race equality as a key challenge. It will be important to nuance the questions to ensure they also capture the work the Sheffield City Council is doing and plans to do.

The ACP has no statutory status but nationally ICSs are becoming more confident (although at different stages of development) in taking a strategic overview of this agenda and in coordinating the work going forward.
Within the NHS, there are clear strategic expectations with targets on a number of the key issues. These are referred to as appropriate when framing the questions

The evidence base for strategic interventions on race equality

There is a growing evidence base which challenges many of the assumptions that have framed NHS work on race equality until recently. The NHS Workforce Race Equality Standard was itself designed using literature evidence on accountability to underpin it.

It is now well embedded as a means of collecting data and requiring action plans. However it has not been used nationally as originally intended to then identify and share the research evidence, and then evaluate and disseminate good practice. That has neither been done via NHS Employers or anyone else.

Sheffield Hospitals Teaching Trust was identified for intensive support around WRES from 2017-2019 and published a report on progress but it is not clear how effective that intervention was beyond raising the profile of the issue within the Trust.

The Briefing Note is in two parts.

1. A very brief summary (a typology) of some of the evidence around recruitment, development and promotion and separately a reference to helpful national review of interventions around disciplinary action.

2. The suggested questions and summary rationale which partly compare the expectations of the NHS People Plan against local delivery – there is no local government national equivalent

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November 2020

2. The evidence base on tackling race discrimination: a summary.

There is an extensive evidence base exploring the causes of race discrimination in employment and how to mitigate it. The research both considers strategic issues (how to tackle bias, how significant is accountability, the overall methodology) and specific granular aspects of employment where bias impacts such as recruitment, development and treatment of Black and Minority Ethnic (BME) staff.

Unfortunately there is little evidence that until recently this evidence base has been systematically applied across UK employment including within the public sector. That is changing and that will be evidenced in some of the interventions proposed arising from the NHS People Plan in themes such as talent management, disciplinary action and bullying.

The following typology draws on that evidence base in respect of recruitment, development and promotion, including, in part, work by the Government Equalities Office. It is in three sections.

A supplementary note refers to evidence around disciplinary action.

A. <u>Good evidence of effectiveness</u>

1. **Introduce a system of "comply or explain" on recruitment, development, promotion and turnover data.** That requires a means of transparently collecting, analysing and publishing data on recruitment, development opportunities, promotion and turnover, analysed by protected characteristic. In the NHS there is robust data by gender and ethnicity, less so by disability. For each strand, analysis by departments and professions (and possibly site) will enable Boards and senior managers to discuss why patterns of less favourable treatment appear to exist and suggest specific interventions and to support more junior managers to implement them.

   Some of those interventions are discussed below. This approach must be led by very senior managers preferably at Board level. (*Dobbin, F., & Kalev, A. (2016). Why diversity programs fail. Harvard Business Review, 94(7/8), 52-60.)* https://hbr.org/2016/07/why-diversity-programs-fail) A number of NHS organisations (e.g. Royal Free Hospital NHS Trust) have implemented such an approach requiring panel chairs, for example, to explain why women or BME candidates who were interviewed were not appointed and requiring them to set out an individual development plan for all such internal candidates.

2. **Emphasise debiasing of processes rather than focussing primarily of debiasing panels.** Alongside the evidence that diversity training, including unconscious bias training, is of limited effectiveness in tackling biased decision making, is the evidence that reshaping processes

underpinned by an understanding now bias influences decision making can be more effective. It requires granular attention to the causes of bias and how to mitigate it. (*Ruth Bohnet (2018) What works: gender equality by design (Harvard University press).*

3. **Set KPIs and targets linked to recruitment, development opportunities, promotion and turnover.** There is robust evidence on the use of targets. What gets measured is what tends to get done. Trusts will already have KPIs on other HR measures (such as sickness absence) so introducing them on recruitment etc should be entirely acceptable. Such KPIs and targets must be time limited, specific and linked to incentives or sanctions - but also to the provision of support to local managers. *(Mento, A.J., Steel, R.P. & Karren, R.J. (1987). A meta-analytic study of the effects of goal setting on task performance: 1966–1984. Organizational Behaviour and Human Decision Processes, 39(1), 52-83).* *https://econpapers.repec.org/article/eeejobhdp/v_3a39_3ay_3a1987_3ai_3a1_3ap_3a52-83.htm*

4. **Hold recruitment panels to account.** Specifically this requires independent members to raise concerns (and to be expected and supported to do so) and by requiring panel chairs to explain outcomes to a very senior manager where a candidate who was female, BME or disabled was not appointed. *(Valian Virginia. 1999. Why So Slow? The Advancement of Women.* See also *https://www.bmj.com/content/351/bmj.h3297.abstract*).A number of Trusts (eg W London Mental Health Trust) have put in place an expectation that BME panel members are required to alert the HRD or equivalent if they have any concerns about interview processes or outcomes. The awareness of that seems to impact beneficially on panel behaviours.

5. **Use structured interviews for recruitment and promotions** Structured and unstructured interviews both have strengths and weaknesses, but unstructured interviews are **much** more likely to allow unfair bias to creep in and influence decisions. (*Health Education England: Values Based Recruitment Framework (2016)).* *https://www.hee.nhs.uk/our-work/values-based-recruitment).* That requires organisations to invest in the careful creation of a relevant competency mix for each post and the application of a "success profile" and scoring to implement effective and fair recruitment.

6. **Where possible also use skill-based assessment tasks (work samples) in recruitment** Rather than relying only on interviews, ask candidates to perform tasks they would be expected to perform in the role they are applying for. *(Levashina, J., Hartwell, C. J., Morgeson, F. P., & Campion, M. A. Situational judgment tests: A review of practice and constructs assessed. International Journal of Selection and Assessment, 9(1-2), 103-113. 3 (2014)).* *http://www.people.vcu.edu/~mamcdani/Publications/McDaniel%20%26%20Nguyen%202001%20IJSA.pdf* See also *M A. McDaniel Cabrera, N T. Nguyen Situational Judgment Tests: A Review of Practice and Constructs*

Assessed https://onlinelibrary.wiley.com/doi/abs/10.1111/1468-2389.00167)

7. **Include multiple women in shortlists for recruitment and promotions and wherever possible include multiple BME candidates.** When putting together a shortlist of qualified candidates, make sure more than one woman is included. Shortlists with only one woman or BME candidates hardly increase the chance of a woman or BME candidate being selected. (*Johnson, S. K., Hekman, D. R., & Chan, E. T. (2016). If there's only one woman in your candidate pool, there's statistically no chance she'll be hired. Harvard Business Review, 26(04). https://hbr.org/2016/04/if-theres-only-one-woman-in-your-candidate-pool-theres-statistically-no-chance-shell-be-hired .*

8. **Ensure transparency and positive action in relation to stretch developments.** The NHS has adopted the "70.20.10 model" of staff development which suggests that "stretch developments" and their consolidation are the most important driver of career progression. So for acting up posts, secondments, involvement in project teams, they should never be filled informally, and at the least be filled fairly with monitoring and accountability of outcomes *(Developing People: Improving care (2017) NHSi. https://improvement.nhs.uk/documents/542/Developing_People-Improving_Care-010216.pdf)* Where appropriate, such posts can be filled preferentially through positive action for under-represented groups.

9. **Introduce transparency to promotion, pay and reward processes** Transparency means being open about processes, policies and criteria for decision-making. This leads to employees are clear what is involved, and that obliges managers to make objective and evidence-based decisions since those decisions can be reviewed by others. Introducing transparency to promotion, pay and reward processes may also reduce pay inequalities by encouraging staff, especially women, to negotiate in the way men are more likely to. The same may apply to BME and disabled staff, though there is no robust research on this. (*Leibbrandt, A., & List, J. A. (2014). Do women avoid salary negotiations? Evidence from a large-scale natural field experiment. Management Science, 61(9), 2016-2024. Castilla, E. J. (2015). Accounting for the gap: A firm study manipulating organizational accountability and transparency in pay decisions. Organization Science, 26(2), 311-333.) http://houdekpetr.cz/!data/papers/Leibbrandt%20List%202014.pdf).*

B. Some evidence of effectiveness which may be improved by inclusive leadership and accountability

1. **Offer mentoring but with caution.** Although quite similar roles, mentors provide guidance and advice to their mentee while sponsors support the advancement and visibility of the person they are sponsoring. There is conflicting evidence on how effective mentoring is and in particular best to organise mentoring programmes to be effective. *(CIPD.*

2019 Diversity management that works: an evidence-based view https://www.cipd.co.uk/Images/7926-diversity-and-inclusion-report-revised_tcm18-65334.pdf). Some evidence suggests that mentoring programmes work very well for some women but not for others. Mentoring may particularly benefit women, including BME women but with less impact on BME men. Research found that mentoring programmes had some impact on making managerial echelons significantly more diverse notably for women, including women of colour but less so for men of colour. *(Alexandra Kalev, Frank Dobbin, Erin Kelly 2006. Op cit. https://journals.sagepub.com/doi/abs/10.1177/000312240607100404 See also DA Thomas (2001). The truth about mentoring minorities. Race matters https://pubmed.ncbi.nlm.nih.gov/11299697/*).

Caution also needs to be exercised as to whether mentoring "across difference" triggers "protective hesitancy", notably for BME staff. Mentoring programs (as with all other forms of positive action) were found to more effective in firms with accountability structures Yet even with those in place, none of these programs showed the sort of consistent pattern across outcomes that forms of accountability introduced. *(Kalev and Dobbin 2006 op cit. See also Thomas DA op cit.)*

2. **Improve how appraisals, feedback from interviews and performance assessments are undertaken.** These key stages in career development are all prone to bias and approaches which hinder the career development of women and BME staff. Appraisals and feedback are prone to being subject to "protective hesitancy" or benevolent sexism" whereby a lack of honest robust feedback hinders career development.

   Performance appraisals of BME and female staff are prone to discrimination, especially when they include an element of self-assessment. Disabled staff may experience a paternalistic response which impedes there career progression. Outcomes should be monitored and disproportionality challenged, whilst managers should be given support and clear expectations on having honest but difficult and supportive conversations with staff. Evidence from another aspect of NHS culture – disciplinary processes - show that where accountability is inserted in such decision making, the outcomes are fairer.

3. **Joint evaluation and batch recruitment.** Joint evaluation of candidates – seeing more than one CV at a time, side by side has been found to decrease gender biases and increased the likelihood that assessment would be based on performance and potential, rather than stereotypes (*Bohnet et al 2012. When performance trumps gender bias: joint versus separate evaluation. Working Paper No 12-083. Harvard Business School. https://www.hbs.edu/faculty/publication%20files/12-083.pdf).* It may well similarly reduce race biases. A further step to reduce interview bias might be to remove (as Google do) the future line manager from the interview process to prevent affinity bias

4. **Offer informal discussions and support in preparing for an application or interview**, especially to those who may not get such support from their manager, or feel they are not familiar with the interview tests to be used. To be effective this must be sustained, and involve senior management's active support.

   5. Improve workplace flexibility for men and women. This could include advertising all jobs as having flexible working options, such as part-time work, remote working, job sharing or compressed hours; allowing people to work flexibly, where possible; encouraging senior leaders to role model working flexibly and to champion flexible working; encouraging men to work flexibly, so that it isn't seen as only a female benefit. This is set out as a priority in the NHS People Plan.

   2. Recruit returners. Returners are more likely to be women who have taken an extended career break for caring or other reasons and who are either not currently employed or are working in roles for which they are over-qualified. It will be important, for success, that the recruitment process is returner-friendly with support before and during the assessment.

5. <u>Limited evidence of effectiveness, especially when undertaken in isolation</u>

1. **Unconscious bias training.** While some types of unconscious bias training may have some limited positive effects, there is currently no robust evidence that this training changes behaviour or improves workplace equality. It may be of some use, conducted face to face, to increase cognitive awareness. *(Doyin Atewologun, Tinu Cornish and Fatima Tresh Unconscious bias training: An assessment of the evidence for effectiveness EHRC 2018 https://www.equalityhumanrights.com/en/publication-download/unconscious-bias-training-assessment-evidence-effectiveness)*

2. **Diversity training** Diversity training, similarly may help raise awareness but is unlikely to change behaviour. US research found mandatory diversity training either has no effect on the number of women in management positions, or may even reduce it. The largest study of diversity initiatives found that 'attempts to reduce managerial bias through diversity training and diversity evaluations were the least effective methods of increasing the proportion of women in management'. *(Dobbin, F., & Kalev, A. (2016). Op cit; Bezrukova, K., Spell, C.S., Perry, J., & Jehn, K. (2016). A meta-analytical integration of over 40 years of research on diversity training evaluation. Psychological Bulletin, 142(11), 1227–1274 https://scholarship.sha.cornell.edu/cgi/viewcontent.cgi?article=1973&context=articles*

3. **Leadership development training.** There is an extensive literature on healthcare leadership, but relatively little conducted to a high academic

standard. (*West M, Armit K, Lowenthal L, et al. Leadership and leadership development in health care: the evidence base, 2015). https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-leadership-development-health-care-feb-2015.pdf*). There is currently no high-quality evidence as to whether such programmes help women or BME staff progress.

4. **Networking programmes.** Some evidence suggests that formal networking programmes where members meet and share information and career advice can be helpful for some women but not others. More work is needed to understand the effects of networking programmes, and whether they need to have particular features in order to be successful. (*Dobbin, F., & Kalev, A. (2016). Op cit.)*

5. **Improved policies, procedures and training (in isolation) to encourage staff to challenge decisions or ensures fairer outcomes.** Research suggests that across culture change generally, reliance on policies, procedures and training in isolation to improve outcomes is much less effective than changing the organisation climate (*Evesson, ACAS 2015 Seeking better solutions: tackling bullying and ill treatment https://www.acas.org.uk/seeking-better-solutions-tackling-bullying-and-ill-treatment; also Kalev and Dobbin 2006 op cit).*

6. **Diverse selection panels.** Having selection panels with a mix of men and women seems to help women's prospects sometimes and harm them at other times. Some studies show that the more women there are on a panel, the more likely women are to be selected for a role, while some studies find the opposite. The effect can also depend on the role being recruited for20 or the role of women on the committee. More research is needed to understand the conditions under which a diverse selection panel is or isn't effective for improving gender equality. (*Beyer (1990). The implications of research on gender differences in self-assessment and 360 degree appraisal. Human Resource Management Journal, 9(1), 39-46; https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1748-8583.1999.tb00187.x Gender differences in accuracy of self-evaluations of performance. Journal of Personality and Social Psychology, 59(5), 960-970. https://www.researchgate.net/profile/Sylvia_Beyer/publication/232546479_Gender_Differences_in_the_Accuracy_of_Self-* De Paola, M., & Scoppa, *V. (2015). Gender discrimination and evaluators' gender: evidence from Italian academia. Economica, 82(325), 162-188.). Evaluations_of_Performance/links/55e0c63008ae2fac471cb8fe/Gender-Differences-in-the-Accuracy-of-Self-Evaluations-of-Performance.pdf https://econpapers.repec.org/article/blaeconom/v_3a82_3ay_3a2015_3ai_3a325_3ap_3a162-188.htm*

   Increasing diversity of panels may make the process seem more welcoming but evidence of its effectiveness is limited. Inserting accountability into diverse panels rather than assuming more junior women or BME staff alone can effectively challenge a more senior chair may incre4ase the likelihood of diverse panels being more effective (see above).

7. **Reverse mentoring.** This may have some benefits for mentees but mixed benefits for mentors. How it is done, what the expectations are, and the potential burden on BME staff suggest the evidence is mixed and how it is done is crucial to effectiveness. (*Antonia J Clarke, Annette Burgess, Christie van Diggele, and Craig Mellis. The role of reverse mentoring in medical education: current insights Adv Med Educ Pract. 2019; 10: 693–01. doi: 10.2147/AMEP.S179303*) The CIPD concluded that "we find little research in the scientific literature on the diversity impacts of based on supporting and developing individuals to progress, such as coaching, mentoring and sponsoring".

8. **Sponsorship.** There is some evidence of the effectiveness of sponsorship but it is prone to reproducing the patterns of networking and favouritism that already existing within recruitment and development. (CIPD 2019 op cit).

A note on disciplinary action.

Being fair: supporting a just and learning culture for staff and patients following incidents in the NHS aims to help the NHS to create an environment to better support staff when things go wrong and to encourage learning from incidents. https://resolution.nhs.uk/2019/07/04/new-guidance-calls-on-nhs-to-embed-a-learning-and-just-culture-to-support-staff-patients-and-carers/ It considers the evidence base and examples of good practice on:

- Fear: The substantial fear of being inappropriately blamed following an incident, the effect on future employment and what peers will think risks preventing NHS staff from sharing and learning.
- Equity and fairness: Research reveals that there is inequity and discrimination at an individual level and disproportionate disciplinary action is experienced by black, Asian and minority ethnic (BAME) staff, with women making twice as many claims as men.
- Bullying and harassment: Sadly compound the understandable stress when things go wrong, leading to burnout and a loss of productivity

This evidence summary should be read as complementing Guidance from NHS improvement (24th May 2019) setting out principles on disciplinary action that all NHS employers are expected to follow https://i.emlfiles4.com/cmpdoc/9/7/2/8/1/1/files/56794_letter-to-chairs-and-chief-executives-24-may-2019.pdf

Section 3. Possible questions to ask

1. **Recruitment.**

   Unusually for the NHS, in ACP employers there is generally a lower proportion of Black and Minority Ethnic staff employed within the NHS than in the wider population. It is also more likely that White applicants for posts who are shortlisted will be appointed than BME applicants who are shortlisted.
   In respect of recruitment locally, the NHS People Plan states:
   "Systems should make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles.
   "Systems should actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.

   Questions.
   a) Why do local employers think the proportion of BME staff is lower relative to the local population that in other regions?
   b) Can the ACP share the relevant data across its constituent organisations?
   c) What steps are being taken to ensure better access to NHS employment for BME people?
   d) Can the ACP set out the evidence base underpinning its recruitment strategy to meet the goal of ensuring the proportion of BME staff employed in the NHS as a whole is no less than in the local population?

2. **International recruitment.**
   The NHS People Plan states: "NHS England and NHS Improvement and HEE are working with government to increase our ethical international recruitment. This will include work to remove barriers to recruitment and increasing capacity for induction and support."

   Question
   a) What steps is the ACP planning to improve induction and support including on career progression – for international recruits?

3. **Career progression and talent management.**
   Once employed, it is less likely that BME staff will progress to higher grades. There is an ethnicity gradient in Trusts and councils across the ACP whereby the higher the grade, the less likely it is that BME staff will be employed. The NHS People Plan sets targets, based on *The Model Employer* Framework (2019), whereby in 2025 the proportion of staff in senior grades will be the same as the then proportion of BME staff in the NHS as a whole (19%).

   The NHS People Plan states each Trust's plans "should include creating accountability for outcomes, agreeing diversity targets, and addressing bias in systems and processes. It must be supported by training and

leadership about why this is a priority for our people and, by extension, patients”

It also states “Systems should also make much greater use of secondments and rotational roles across primary and secondary care to improve integration and retention”.

Questions

a) Can the ACP share its strategy and the evidence base underpinning its approach to “creating accountability for outcomes, agreeing diversity targets, and addressing bias in systems and processes”.
b) Specifically can the ACP share how its members interventions on essential requirements and competencies include “inclusion and compassion” and how these will be tested for
c) Specifically can the ACP share how its members have used or will be using this approach to assure their shortlisting, interviewing, and decision making processes are underpinned by evidenced interventions
d) Can the ACP demonstrate how its members have used or will use (a) positive action and (b) “stretch opportunities” to improve the likelihood of more diverse recruitment.

4. **Leadership diversity**.

The NHS People Plan states “Every NHS trust, foundation trust and CCG must publish progress against the Model Employer goals to ensure that at every level, the workforce is representative of the overall BAME workforce. From September 2020, NHS England and NHS Improvement will refresh the evidence base for action, to ensure the senior leadership (very senior managers and board members) represents the diversity of the NHS, spanning all protected characteristics.”

Questions

a) What is the current position on BME representation as reported in the 2020 WRES data report for each of its constituent organisations or the equivalent report for organisations outside the NHS?
b) What steps are the ACP and its member organisations taking to meet the NHS goals on leadership representation?
c) What steps are the ACPs constituent organisations taking to ensure their Boards (executive as well as non-executive members) and senior management teams are diverse and representative of the workforce and community?

5. **Inclusion and retention**

Evidence shows that to leverage the benefits (creativity, innovation, productivity, risk awareness, retention and staff engagement) that a more inclusive workforce and leadership can bring, it is essential to have inclusive teams at every level.

a) To what extent can the ACP evidence that this is understood and being acted upon by constituent organisations?

Questions

a) Do the constituent organisations of the ACP, or the ACP as a whole, collect and publish data on the turnover of BME staff compared to White staff?
b) Do the constituent organisations of the ACP, or the ACP as a whole, have a strategy underpinned by research to ensure this happens?

6. **Talent management**

The NHS People Plan states "By December 2020, NHS England and NHS Improvement will update the talent management process to make sure there is greater prioritisation and consistency of diversity in talent being considered for director, executive senior manager, chair and board roles. This will include clearer guidance on the recruitment process, and metrics to track progress".

Question

a) What steps is the ACP taking to ensure its constituent organisations and the ACP prepare for this development or its parallel outside the NHS?

7. **Governance:**

The NHS People Plan states: "By December 2021, all NHS organisations should have reviewed their governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes….. Staff networks should look beyond the boundaries of their organisation to work with colleagues across systems, including those working in primary care."

Questions

a) Do all ACP constituent members have a BME network established?
b) Is there a pan-ACP BME network?
c) What level of resource and senior management support do these networks have?
d) How are Board members, Governors and senior managers helping BME networks to engage effectively?
e) What steps have been taken across the ACP to implement the letter from Simon Stevens and Amanda Prichard (29th April 2020) setting out an expectation of BME involvement in Gold Command and other leadership positions

8. **Information and education**

The MHS People Plan states: "From October 2020, NHS England and NHS Improvement will publish resources, guides and tools to help leaders and individuals have productive conversations about race, and to support each other to make tangible progress on equality, diversity and inclusion for all staff."

Question

a) What steps is the ACP taking to ensure its constituent organisations and the ACP prepare for this development?
b)

9. **Using data to be preventative and proactive.**

Research suggests it is essential that employers are proactive and preventative in tackling discrimination rather than responding to individual concerns or grievances.

Questions

a) Is data used as if racism as a public health issue?
b) Does the ACP triangulate the hard data and soft intelligence, listening to staff to anticipate problems?

10. **Tackling the disciplinary gap**
The People Plan states "By the end of 2020, we expect 51% of organisations to have eliminated the gap in relative likelihood of entry into the disciplinary process." Steps to achieve this goal will include "establishing robust decision-tree checklists for managers, post action audits on disciplinary decisions, and pre-formal action checks."

Questions

a) What does the current data on the relative likelihood of White and BME staff entering the disciplinary process show for each ACP constituent organisation over the last two years?
b) To what extent such as an approach implemented across ACP organisations?
c) What confidence is there that this target will be achieved?

11. **Building confidence to speak up**:
12. A significant contributor to the disproportionate infection rates of BME staff in the NHS was a reluctance to speak up for reasons set out in the Francis Speak Up Report (2015) The NHS People Plan says "NHS England and NHS Improvement are seeking to recruit more BAME staff to Freedom to Speak Up Guardian roles, in line with the composition of our workforce."

Questions

a) What is the current ethnic composition of Speak Up Guardians across the ACP
b) What steps are being taken to recruit more BME Speak Up Guardian?

13. **Treatment at work**
The NHS People Plan states "By March 2021, NHS England and NHS Improvement will provide a toolkit on civility and respect for all employers, to support them in creating a positive workplace culture". Bullying levels of BME staff by both members of the public, patients and relative, and by managers and colleagues appear to be high across many parts of the ACP, potentially to the detriment of staff health and well-being, organisational effectiveness and patient care and safety.

Question

a) To what extent is this acknowledged and understood across the ACP?
b) What evidenced interventions are in place to reduce the likelihood of staff, especially BME staff, being bullied, harassed and abused at work?
c) How will you know if you are being successful
d) When do you expect to see sustained progress?

14. Covid19.

Over 600 health and social care staff died in the first wave of Covid19. Public Health England researchers (May 12th) suggested up to 92% of infections were due to "occupational exposure".

Questions

a) What were the staff deaths rates within ACP organisations and local care homes, disaggregated by ethnicity?
b) What steps have ACP organisations taken for Wave 2 of Covid19 to prevent similar rates of infection and death for NHS staff?
c) What steps have been taken to support, secure retention and retain career paths for staff affected by Covid19 whose risk assessments may have removed them from the normal role, or who have been impacted by Long Covid?

15. Front line managers.

Most managers are on Band 7 (or equivalent) or lower pay scales. They make many of the decisions about recruitment, development, career progression, discipline and bullying. Too often Action Plans may assume these front-line managers will "do as they are told" rather than meet with their own managers to discussion the rationale behind the Action Plan, its implications for them, the support they'll get and how it will help them manage better and help them provide better care.

Questions

a) How is the ACP and constituent organisations making sure junior managers, understand the intended benefits of local Action Plans and their role in them?
b) What support, including OD support, are they being given?

16. Contractor staff

Substantial number of staff in healthcare and local government are employees of contractors. Some may work for Wholly Owned Subsidiaries of NHS Trusts. Covid19 confirmed how important the role of staff working for contractors is for healthcare as a whole. They may also be more likely to be Black and Minority Ethnic staff than employees are. Some staff in Wholly Owned Subsidiaries are covered by the WRES.

Questions

a) What data on race equality do contractors provide to NHS and local government employers?
b) What oversight do NHS Trusts exercise over how their contractor staff, especially BME staff, are treated?

c) What does the ACP strategy set out as goals to improve the treatment of contract staff?

17. Agency staff

The NHS and the care sector in particular are reliant on agency staff. They may be more likely to be Black and Minority Ethnic staff. Agency staff in some areas were especially vulnerable to Covid19.

Questions

a) What data do ACP members have on agency staff within individual employers, and is it disaggregated by ethnicity?
b) Who has responsible for both their risk assessments and PPE during Covid19? Are local NHS employers aware of the new national guidance on who is responsible for their risk assessments?
c) What payment arrangements were in place during self-isolation for agency staff across the ACP?

18. WRES in social care

A number of pilot schemes, sponsored by the DH and supported by Skills for Care are being trialled to explore the introduction of a Social Care Workforce Race equality Standard.

Question

a) Have any applications been submitted locally that impact on ACP organisations?

19. Evaluation.

An effective strategy relies on effective evaluation to enable continuous improvement and learning.

Question

a) What steps are in hand to evaluate each of the initiatives and the race equality strategy as a whole within the ACP?

Roger Kline

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His long term focus is on workforce culture and designing evidenced interventions to improve it. Roger is

- co-author with Dr. Doyin Atewologun of *Fair to Refer* (2019) a report to the General Medical Council on the disproportionate referrals of some

groups of doctors, all of whose recommendations have been accepted.

- co-author of the recent NHS Resolution report *Being Fair* (2019) looking at disciplinary action in the context of patient safety and human factors.
- co-author with Prof Duncan Lewis of *The Price of Fear* (2018), the first detailed estimate of the cost of bullying in the NHS.
- co-author with Michael Preston Shoot of *Professional Accountability in Social Care and Health: Challenging Unacceptable Practice and its Management* (Sage 2012)
- co-author with Karen Linde of the *Scoping Report on Developing Race Equality in Social Care for Skills for Care* (2019)
- the author of *The Duty of Care* (2013)

Roger was joint inclusion adviser to the NHS national talent management programme for Aspiring Directors 2017-2020.

He is a member of a number of the NHSE/I national expert groups on Health and Well Being, and on Cultural Transformation and was a contributor to *Testing times: an ethical framework and practical recommendations for COVID-19 testing for NHS workers* for the DHSC. He is a member of the NHS BAME Clinical Advisory Group and the NMC EDI Advisory Panel.

Roger writes for Health Service Journal, Nursing Times, Nursing Standard, the British Medical Journal, The Guardian and The Independent.