

NHS WORKFORCE **RACE EQUALITY** STANDARD

Quality improvement methodology;
The journey of five NHS trusts



NHS Workforce Race Equality Standard

Quality improvement methodology; The journey of five NHS trusts

Version number: 1

First published: October 2018

Prepared by: WRES Implementation team, with expert guidance from the
Institute for Healthcare Improvement (IHI), and in collaboration with
five NHS trust pilot sites

Classification: OFFICIAL

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.
Please contact: england.wres@nhs.net

Publication Gateway Reference Number: 08579

Contents

Contents	4
01 Foreword	7
02 Preface	9
03 Executive summary.....	10
Barts Health NHS Trust.....	10
East London NHS Foundation Trust	10
Sheffield Teaching Hospitals NHS Foundation Trust	11
The Royal Free London NHS Foundation Trust	11
University Hospitals of Leicester NHS Trust	11
04 Introduction.....	12
05 Quality improvement methodology.....	13
06 Findings from the pilot sites	14
6.1 Barts Health NHS Trust.....	14
6.1.1 . Setting the aim.....	15
6.1.2 What is the trust trying to accomplish?	16
6.1.3 . Methodology	17
6.1.4 How will the trust know a change is an improvement?	17
6.1.5 What changes can the trust make that will result in an improvement?	17

6.3.6 . Lessons learned	33
6.4 The Royal Free London NHS Foundation Trust	34
6.4.1 . Setting the aim.....	34
6.4.2 . Methodology	35
6.4.3 . How will the trust know change is an improvement?	36
6.4.4 . Lessons learned	37
6.5 University Hospitals of Leicester NHS Trust	39
6.5.1 . Setting the aim.....	39
6.5.2 . Lessons learned and next steps	46
07 Conclusion	48
8 Annex A: The WRES indicators	49
9 Annex B: The Institute for Healthcare Improvement (IHI)	50
About IHI	50
The identified gap and approach	50
A new direction for equity	51
10. Annex C:	54
2017 WRES data for the five pilot sites.....	54

01 Foreword

Healthcare is changing at a breath-taking pace. From new technologies and treatments, to new sites of care, and changing expectations by patients and family members, the changes are profound and require new ways to work. But perhaps the most important change is the new workforce in healthcare.

We have numerous distinct generations and a workforce that is diverse in ethnicity and nationality. Perhaps the greatest challenge of our time is building and leading effective teams in this diverse workforce to assure that we provide best care to every patient, every day. Building on the assets of each staff member and building teams that see and use those assets is the key leadership opportunity for us all.

This new way to lead means seeing the challenges and then, improving on them. The work underpinning the NHS Workforce Race Equality Standard (WRES) is critical in seeing the challenges. The aim to ensure that staff from BME backgrounds have equal access to career opportunities and receive fair treatment at work is key. An engaged and inclusive workforce is the foundation to safer, more effective care and improved patient and staff engagement. The data and aims set out by the WRES are helping us all to see the work ahead.

These bold and vital aims need action now to improve, and the work in the five pioneering organisations will make the first changes to close the gaps. The work of these leaders means taking on some challenges that have been recognised for some time, but in a new way, using quality improvement to build and test new models and measure results. Each of the five organisations has taken on a different part of the challenge and is using the science of improvement to measure and test changes to a better outcome. The way the group is working together will also ensure a learning system that can accelerate the pace of sharing and uptake to all.

And this learning system is blending the scientific approach with a deep way to understand the assets of the population. Gloria Steinem, the founder of the women's movement, says: "If you want people to listen to you, you have to listen to them. If you want people to see you, you have to sit down with them, eye to eye". And indeed, the learning that comes from listening and understanding will give new ideas for change.

I remember well my first meeting as a young female chief executive officer of a hospital. I was 34 years old in a room filled with older men, and being the only woman and younger than most, I remember the pain of not being heard, and of having no voice. Though I had ideas and knowledge that would have helped the decision making, it took me a while to find the way to contribute and be respected for my skills and perspective. It is why I feel so passionate about this work today. We will never accomplish all we can without an inclusive and engaged workforce, and this work opens doors to a new frontier.

Maureen Bisognano

*President Emerita and Senior Fellow,
Institute for Healthcare Improvement*

02 Preface

The 70th anniversary of the NHS provides us with an opportunity to reflect on the significant contributions that black and minority ethnic (BME) staff have made to our health service over the years. A health service which has been built upon the core values and principles of the NHS Constitution – dignity and respect and ensuring everyone counts. Yet, it is clear that the experiences and opportunities that BME staff encounter in the workplace, do not always correspond with those values.

We now have three years of WRES data from all NHS trusts in England. The emerging picture shows some improvements for BME staff across the country in a number of areas, such as appointments from shortlisting; entry into disciplinary processes, and representation at board level. However, whilst some organisations and parts of the NHS are making continuous improvements, there is much more work to be done.

To help them on this journey of continuous improvement, five NHS trusts from across England took part in piloting a quality improvement methodology in relation to WRES indicator themes such as recruitment and disciplinary action. We are grateful to all five organisations and to the individuals within those organisations that worked tirelessly on this pilot. In the spirit of sharing learning and good practice, we share the findings of all five pilots in this report.

We view this report as providing NHS organisations with the impetus to focus on their own respective journeys of continuous improvement on workforce race equality. The improvement we continue to seek on this agenda is not improvement for political correctness. We now know that alongside the moral and legal cases, there is the financial case, and most importantly, the quality of patient care case for change.

Yvonne Coghill CBE and Dr Habib Naqvi

*Workforce Race Equality Standard (WRES) Implementation team
NHS England*

03 Executive summary

This report outlines the actions of five NHS trusts from across England, who took part in piloting a quality improvement (QI) methodology in relation to WRES indicator themes such as recruitment and disciplinary action.

Barts Health NHS Trust, East London NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust, The Royal Free London NHS Foundation Trust, and University Hospitals Leicester NHS Trust, undertook QI methodology on indicators they needed to make a concerted effort to improve on.

Barts Health NHS Trust

Barts Health identified WRES indicator 1, (Percentage of staff in each of the Agenda for Change (AfC) bands 1-9 or medical and dental subgroups and VSM compared with the percentage of staff in the overall workforce) and indicator 7, (Percentage believing that trust provides equal opportunities for career progression or promotion) BME and female staff as points of focus.

Over a series of half-day workshops, focussed on personal effectiveness, career planning and job interview skills, out of 349 participants, 89 have already benefitted from promotions. An added benefit to the organisation has been identifying lessons which have strengthened their approach to improvements.

East London NHS Foundation Trust

East London NHS Foundation Trust chose to focus on disciplinary processes. There was a wealth of data available and a real desire in the trust to improve on process, resolution times and the over representation of BME staff. Using quality improvement methods the trust aimed to reduce the length of time taken to conduct disciplinary processes.

A number of change ideas were tested including reducing the preliminary report to a one page document, changing the disciplinary policy and how they are managed have resulted to notable improvements. With the changes and improvements, the outcomes of disciplinary processes have been reduced from an average of 107 to 52 days saving the trust £429,000 a year based on an average of 29 cases per annum.

Sheffield Teaching Hospitals NHS Foundation Trust

Sheffield Teaching Hospitals NHS Foundation Trust focussed on WRES indicator two; staff recruitment from shortlisting. In 2016, WRES data showed that white applicants were 1.35 times more likely to be successful than their BME counterparts after shortlisting. Using a multi-disciplinary team made up of human resource (HR) and service improvement teams, a working group was established. The identified outcome was to ensure the people employed at the trust, reflected the local population served. After a period of implementing quality improvement methods, the likelihood of white applicants being more successful than their BME counterparts has significantly declined to 0.99 the following year.

The Royal Free London NHS Foundation Trust

Royal Free London NHS Foundation Trust committed to WRES improvement and believed using quality improvements approach will help understand better how to reduce and minimise the number of disciplinary cases across the trust.

The key driver was to ensure that only those cases that needed to proceed to a disciplinary hearing went forward and avoid staff going through a disciplinary process resulting in “no case to answer”.

With a strong and committed support from the board, the trust used the Transplant and Specialist Services (TASS) as a pilot due to the number of cases in the division. Over the subsequent period the overall number of employee relation cases reduced from 727 in 2016 to 534 in 2017, a reduction of 193 cases (26%) over a period of 12 months (26%).

University Hospitals of Leicester NHS Trust

University Hospitals of Leicester NHS Trust chose to focus on its BME representation in leadership positions. In the first three months of 2017/18 – the figure was 30.72% BME people in the workforce with 12.2% in medical leadership and 8a-9 AfC bands 8a - 9. To improve and organically grow, a model was developed (figure 10 in this report) including leadership development, mentoring and coaching. With gaps identified and a plan in place to meet the targets, the pipeline of recruitment, development and progression is in place and there is anticipation that the ambitions set out will be met in the coming years.

04 Introduction

In 2014, NHS England and the NHS Equality and Diversity Council agreed action to help ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace. It was agreed that a Workforce Race Equality Standard (WRES) should be developed. The WRES was introduced to the NHS in April 2015.

The WRES requires organisations employing up to 1.4 million NHS staff to demonstrate progress against nine indicators (Annex A) of workforce race equality. The indicators focus upon differences between the experience and treatment of white and BME staff in the NHS, with regard to appointments from shortlisting, entry into formal disciplinary processes, experience of bullying and harassment, and representation at board level.

In 2015, the WRES was included in the NHS standard contract for NHS providers, and since July 2015, provider organisations have been submitting their respective data against the nine WRES indicators, and have been action planning to continuously improve on these measures.

Three years on, we have seen vast improvements in the quality of data submitted and some steady improvements in data against the nine indicators. The 2017 WRES data report for NHS trusts showed that there have been continuous improvements against the low baseline we started off from in 2015, albeit with room to improve further.

This report presents the learning from the application of quality improvement methods and more specifically the model for improvement, to the WRES work within five NHS trusts in England: Barts Health NHS Trust, East London NHS Foundation Trust, Sheffield Teaching Hospital NHS Foundation Trust, The Royal Free NHS Foundation Trust, and University Hospitals of Leicester NHS Trust.

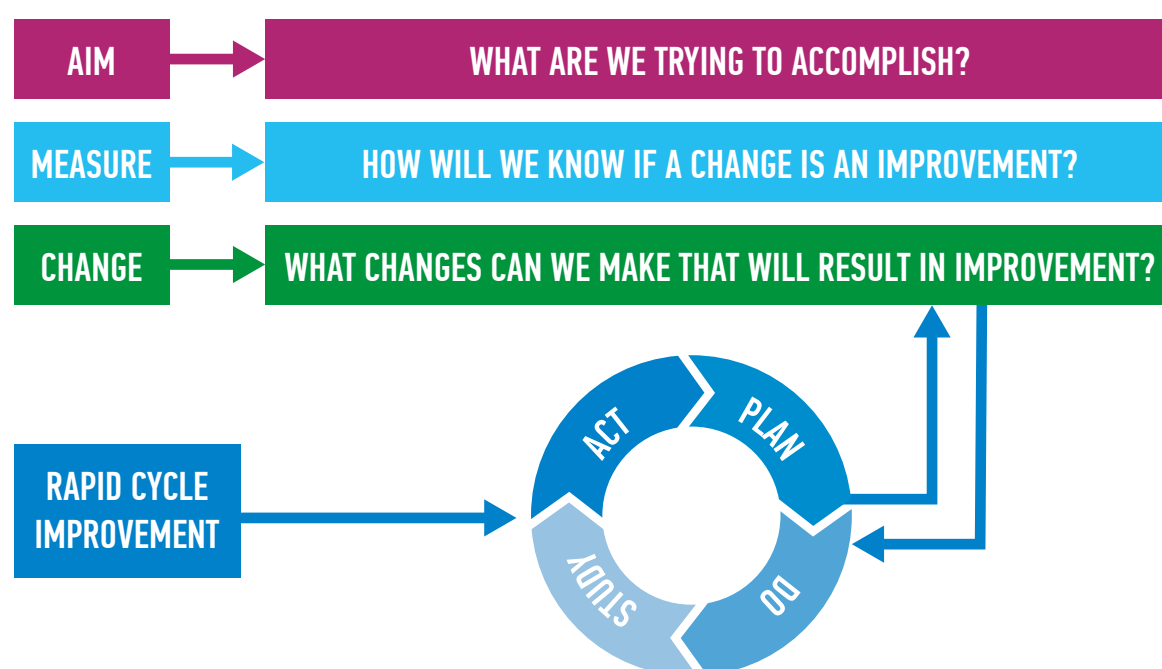
It is important to note that this is not a 'how to' guide on WRES and quality improvement methodology. Instead, it offers some common approaches used to improve workforce race equality – in particular, particular learning from organisations closing the gaps in the experience and opportunities between white and BME staff within NHS trusts.

05 Quality improvement methodology

There is no single definition of quality improvement. However, a number of definitions describe it as a systematic approach that uses specific techniques to improve quality. One important ingredient in successful and sustained improvement is the way in which the change is introduced and implemented; of course, taking a consistent approach is important. The key elements are the combination of a 'change' (improvement) and a 'method' (an approach with appropriate tools), while paying attention to the context, in order to achieve better outcomes.

The national WRES team sought to pilot and apply this approach to help make improvements in the area of workforce race equality in the NHS. The Institute for Healthcare Improvement (IHI) quality improvement experts at five NHS trusts were asked to consider the Associates in Process Improvement (API) model for improvement (referred to as the 'model for improvement' throughout the rest of this report), and to apply it to at least one of the nine WRES indicators of staff experience and opportunity. Further information regarding the IHI can be found in Annex B.

Figure: Model for improvement



¹ The model for improvement was created by Associates in Process Improvement and now serves as the QI methodology shared by the Institute for Healthcare Improvement

06 Findings from the pilot sites

This section of the report presents the findings taken directly from five NHS trusts that have applied the model for improvement to the WRES and its implementation.

6.1 Barts Health NHS Trust

Created on 1 April 2012, Barts Health NHS Trust brings together three legacy trusts to become a group of five hospitals and is one of the largest NHS trusts in England. The group of hospitals are based in east London boroughs which are among London's youngest, most diverse and most deprived communities, with pockets of affluence. Based on reports by the Office of National Statistics (ONS) there is anticipation for the increase in residents aged over 65, and with this comes the consequential implications for healthcare provision.

The trust provides both acute and community-based healthcare services across four core London boroughs, serving approximately 2.6 million patients from east London and beyond, each year. The trust is a regional and national centre of excellence for cardiac and cancer care, with an internationally renowned trauma team and surgical facilities. It is home to the London Air Ambulance service and has one of the UK's busiest children's hospitals. The trust has over 2,000 beds and employs around 16,000 staff, of which somewhere in the region of 1,500 are clinical or service managers from the front-line (including consultants and ward managers) through to senior management roles.

40% of the workforce live locally; with a 95% ethnicity disclosure rate, 50% of workforce state they are from BME background and 49% disclose as being white or white other (Barts Health Electronic Staff Records, March 2018).

With the equality and inclusion board led by the chief executive, and each hospital site having an equality and inclusion group established, there continues to be a focus on strengthening the governance of the equality agenda within the trust. There is also the participation in the NHS England WRES experts programme and active executive championing of the trust's staff diversity network.

Barts Health is committed to the equality and inclusion agenda and the following statement from the trust chair is further testimony: 'It's not about compliance, it's about improvement'.

In 2015, the trust developed an improvement plan in response to feedback from staff, partners and inspectors from the Care Quality Commission (CQC). The trust has come a long way in its improvement journey; embedding the model for improvement approach to improving WRES performance is one of the many strides the trust is taking as part of its improvement journey.

At Barts Health NHS Trust, the key programme of intervention in place that seeks to “shift the dial” with regards to WRES indicator 1, (Percentage of staff in each of the AfC bands 1-9 or medical and dental subgroups and VSM compared with the percentage of staff in the overall workforce) and indicator 7, (Percentage believing that trust provides equal opportunities for career progression or promotion) is the internally established career development programme for BME and female staff.

The career development programme for BME and female staff invites a cohort of participants to take part in a series of three half-day workshops covering:

- i. Personal effectiveness;
- ii. Career planning; and
- iii. Job interview skills.

Participants include both clinical and non-clinical staff ranging across the different pay bands, with workshops taking place across different hospital sites.

6.1.1 Setting the aim

To date, 349 participants have completed the programme at Barts Health with 89 participants already moving up a pay band or Agenda for Change (AfC) band.

346 (100%)

TOTAL NUMBER OF PARTICIPANTS ON CAREER DEVELOPMENT PROGRAMME

89 (26%)

TOTAL NUMBER OF ‘PROMOTIONS’ REPORTED

Figure: Promotion activity as a result of the career development programme

Movement within the AfC bands forms part of the measurement of WRES indicator 1 and indirectly influences the response to the NHS Staff Survey question that is also WRES indicator 7, as outlined below:

WRES indicator 1
Percentage (%) of staff in each of the AfC bands 1-9 and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce (this calculation is undertaken separately for non-clinical and for clinical staff)
WRES indicator 7
Percentage (%) of staff believing that the trust provides equal opportunities for career progression or promotion

It is envisaged that with a deliberate focus on WRES indicators 1 and 7, and building on the achievement of total cohort participants moving into higher AfC bands, especially band 7 and above, the trust will begin to see the desired change on this agenda.

With regards to these indicators and the action taken, the trust continues to challenge itself as to whether these interventions are sufficient to create the impact, over time, which delivers improvement in the experience of staff from BME backgrounds. To this end, focussing on WRES indicators 1 and 7, and using the QI methodology in building on the success of the career development programme for BME and female staff, with the view of scaling up reach and increasing targeted outcomes, the Associates in Process Improvement (API) model for improvement was adopted at Barts Health NHS Trust.

It is anticipated therefore that increasing the intake of participants, especially at AfC bands 5 to 7, will have a positive impact on percentage of BME staff moving into higher bands. However a note of caution is that there is a limited 'pool' of BME staff at band 7 that could possibly experience the transition within any reasonable timescale.

Yet, in setting itself a 'stretch goal' and using this methodology, consideration is given by the trust to a targeted number or percentage of BME staff in bands 5 - 7 that will need to go through the programme for the trust to see an improvement in WRES indicator 1. In addition, implementation of the associated actions shown in the driver diagram will influence WRES indicator 7.

6.1.2 What is the trust trying to accomplish?

Global aim:

To address the under representation of BME staff in senior positions, ensuring that our workforce at Barts Health NHS Trust is representative of the population we serve.

Specific aim:

To increase the intake on the career development programme with a targeted focus on bands AfC 5 to 7 with the aim of achieving a 10% increase in number of BME in bands AfC 8a and above by July 2018.

6.1.3 Methodology

- Reviewing secondary data; workforce information and staff survey responses and establishing a baseline for the trust.
- Multidisciplinary steering group drawing from membership of established staff diversity network.
- An empowering programme of practical and motivational workshops co-designed and delivered by a leading life coach and motivational speaker.
- Data on staff achievements gathered and compared to baseline assessment and feedback and evaluation sheets analysed.

6.1.4 How will the trust know a change is an improvement?

To start with, an increase in the number of BME staff at AfC band 8a and above is an improvement; not only is this directly linked to WRES indicator 1, but also indirectly to indicator 7. Due to the under representation of BME staff especially nurses in senior positions of the trust, we aim to measure number of BME staff in the pipeline i.e. AfC bands 6, 7, 8a and above; we also measure the outcome for each participant.

6.1.5 What changes can the trust make that will result in an improvement?

The following tests have been tried out with the objectives and outcomes outlined below:

1. To identify impact of listening to a guest speaker talk about how they overcome barriers though their career journey, on motivating staff to apply for jobs in higher bands.

Objective of the plan, do, study, act (PDSA) cycle: To improve experience of participants on the programme

Outcome: Adapt practice of inviting a guest speaker and adopt; guest speaker now a permanent feature of the programme.

2. To determine the impact of awareness of and or completion of the career development programme on future completion of NHS Staff Survey questionnaire.

Objective of PDSA cycle: To increase percentage completion of NHS Staff Survey by BME and female staff, as four of the nine WRES indicators are based on NHS Staff Survey results

Outcome: Links between NHS Staff Survey and the trust's WRES information explained to participants.

3. Design questionnaire that invites people managers to provide details of what form of support to junior staff they can offer e.g. to mentor, opportunity to shadow etc.

Objective of PDSA cycle: To formalise mentoring offer and support available to participants on completion of career development programme improve

Outcome: People manager awareness of career development needs

6.1.6 Lessons learned

- Leadership buy-in and visible leadership is essential for promotion of equality and inclusion in the workplace
- Staff engagement and involvement is key for the development of effective and sustainable staff development programmes
- Effective communication of rationale required for significant take-up
- Career development and talent management is required for addressing retention and wellbeing of staff
- Value of staff networks and collaborative working
- Communication – there cannot be enough of communication at each stage of the journey to the wider Barts Health community.

Going forward, the trusts' vision continues to focus us towards leading the way in patient care, with a reputation that is built on excellence and delivering safe and compassionate care for patients. Improving WRES performance is a key enabler of this vision.

6.2 East London NHS Foundation Trust

East London NHS Foundation Trust (ELFT) is a provider of mental health, community health services, primary care and some specialist services to a population of 1.5 million people in east London, Bedfordshire and Luton. The trust has over 5,500 staff working across over 120 locations.

The trust partnership with the Institute for Healthcare Improvement (IHI) is ongoing to provide support along its long-term organisational improvement journey. The trust utilises the model for improvement as its improvement methodology, and encourages teams of staff and service users and carers to tackle issues that matter most to them through QI. The use of QI allows staff to develop their own ideas about what might help improve the service, and enables them to initiate changes from the 'bottom' up in order to achieve the collectively agreed goal, test these out and learn from the use of data.

6.2.1 Setting the aim

The ELFT approach incorporates extensive efforts to engage and involve staff, service users and carers to build improvement capability at scale and embed continuous improvement efforts into daily work. The challenge for organisational leaders is to try and remove as many barriers as possible for teams working to solve complex quality issues in this way. Building skills is an important enabler for this process, as most healthcare staff have had little exposure to systems thinking and improvement methods. A variety of training is offered at ELFT, tailored to suit the different levels of improvement knowledge and skill each role requires.

There is also a concerted effort to share and celebrate stories from the improvement work taking place – both successes in achieving improvement in outcomes, but also the experience of being empowered to find solutions and test them out. An online platform supports the learning system by making all work transparent across the trust.

Significant achievements at the trust have closed gaps in indicators using quality improvement methodology, including a reduction in violence in in-patient areas, and improving patient flow. However, whilst ELFT has a culture of inclusion supported by a highly diverse board, it also faces similar challenges to other London trusts across a range of WRES indicators.

Descriptor	White staff	BME staff
Number of staff in workforce	2298	2388
Number of staff entering formal disciplinary process	27	101
Percentage	1.2%	4.2%

Table: Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff at ELFT

6.2.2 Methodology

The trust chose to focus on disciplinary processes as there was a wealth of data available and a real desire in the trust to improve the process and reduce the amount of time taken in resolving disciplinary issues and also the over representation of BME staff in the process.

QI methodology was used to introduce a series of change ideas which reduced the length of time that a disciplinary process took.

The team used the QI framework to guide their work through not only the design and implementation phases of their project, but also to ensure sustained levels of engagement from all those involved. The driver diagrams show clear identification of key drivers to achieve the reduction of missed doses and form part of a shared, overall strategy for the work.

6.2.3 How will the trust know change is an improvement?

The trust wanted to reduce the length of time taken to conclude 80% of disciplinary processes in 115 days or less. To achieve this, a number of change ideas were tested including reducing the preliminary report to a one page document, introducing a meeting between the commissioning manager, line manager and HR, pairing experienced investigation officers with non-experienced investigation officers, changing the disciplinary policy and streamlining all guidance and documentation available to support the process.

The combination of a number of change ideas including offering a hearing date at the outset of the process culminated in a reduction of time it takes to conclude a case from 107 days to 52 days.

In the year prior to the project, the average number of days that staff were suspended was 104 with an average cost of £296 per day. By reducing the length of time that a case took to be heard by 50 days, resulted in a saving of £429,200 in a year based on a case rate of 29 per year.

A review of all employee relations cases in the past three years was undertaken alongside the project with the aim of reducing the disproportionate rate of BME staff entering the formal disciplinary process. The increased focus on recruitment, disciplinary processes has led to a higher awareness and interest in how the trust deals with hiring staff, performance and conduct. This has paved the way for the implementation of a performance framework which aims to improve the quality of the recruitment, on-boarding process for new staff, and the development of on-going feedback between managers and staff.

In the three year period up to November 2015, there were 179 disciplinary cases spanning a three year period. Between January 2016 and January 2018, there have been 194 disciplinary cases, of which 63 are closed cases. In the 2015 exercise, 16% of cases that progressed to a hearing resulted in no case to answer, whereas based on the current figures only 2% of cases resulted in no case to answer. This has improved.

The trust has introduced an agreed outcome process where staff admits the alleged misconduct; they can agree to accept a written warning without the need to go to a formal disciplinary process. Agreed outcome represents 19% of the disciplinary cases.

Whilst there is a significant increase in the number of disciplinary cases across the trust overall:

- There has been a shift in the organisations culture in terms of taking formal disciplinary action against medical and dental staff;
- The number of cases that result in no case to answer has reduced significantly from 16% to 2%;
- 19% of cases avoided going to a formal hearing as a result of the agreed outcomes process;
- There is still a disproportionate effect of disciplinary processes for BME staff which has increased; the proportion of white staff has remained the same. In terms of the internal processes, we have centralised ER activity to improve the consistency of disciplinary sanctions.
- The trust is in the process of rolling out a fair treatment process to triage disciplinary cases before they progress to formal investigation. The trust have moved towards a more performance culture by implementing performance rating for AfC staff, as part of the annual appraisal forms to enable managers to have performance conversations;
- The trust disciplinary policy and procedure has been reviewed and relaunched;
- There has been a significant reduction in the number of suspensions and where practicable assigning staff to have alternative and/or restricted duties.

- The trusts has seen a reduction in the number of employment tribunal cases. The previous report showed that there were 13 'live' employment tribunal cases; the following report indicated just five 'live' cases.
- An intervention trialling service-users to attending our joint staff-side policy sub-committee meetings is underway. This will obtain services-user input on HR policies and procedures and equality impact assessments (EIAs) – at the point of reviewing, negotiating and implementing policies and procedures.
- In addition, where employee relations cases involve staff with mental health issues, the trust is trialling a service-user panel to review the case. This enables the services user to advise us as the employer to consider issues that perhaps were apparent and to help us to identify another other support that the trust can offer.

Table: Summary of disciplinary case outcomes by ethnicity

	No. of cases to answer	Meeting of concern (informal)	Agreed outcomes	Final written warning	Dismissal (with notice)	Summary dismissal	Totals	%
White	1	2	3	4	1	3	14	22%
Black	3	0	6	11	1	14	35	55%
Asian	0	1	2	6	0	2	11	17%
Other	0	0	1	1	0	0	2	3%
Mixed	0	0	0	0	0	1	1	3%
Total	4	3	12	22	2	20	63	

6.2.4 Lessons learned

- The importance of really delving into the data to understand the differences between types of staff who are being disciplined – the trust learned through analysis of three years' worth of employee relations data that it was black or black British nurses in band 5 and 6 positions who had been with the organisation for over three years that were more likely to be disciplined than other staff, so were able to develop working hypothesis for further work and discussions with leaders in the organisation;

- Both the project team and change team are crucial to the success of the project, ensuring the right people are in the team, and that they have some ground work as a team about how they will work together, as well as what they will be doing. Team functioning process is critical, which is why using organisational development (OD) skills alongside the QI methodology was useful;
- The project team trialled changes to see if they worked before incorporating them into policy. Trialling changes that were outside of policy had implications; hence they had to be clearly communicated, particularly to staff-side colleagues;
- You do not always get what you expect – it was anticipated that a reduction in overall cases would impact positively on the number of BME staff being disciplined. However, whilst cases reduced, the gap on this indicator between white and BME staff has not shifted in the way we would expect. Therefore, a more targeted aim statement will be developed in the next iteration of the QI work on disciplinary action and a new driver diagram developed to support this;
- Supporting staff by giving them time and space to focus on QI work is absolutely essential to the success of this approach.

6.3 Sheffield Teaching Hospitals NHS Foundation Trust

Sheffield Teaching Hospitals NHS Foundation Trust (STH) is one of the biggest providers of hospital and community based healthcare. The trust provides a comprehensive range of local services to the residents of Sheffield, South Yorkshire, Mid Yorkshire and North Derbyshire and also some highly specialist services to all parts of England.

Sheffield is an ethnically diverse city, with around 19% or 107,112 people of its population from BME groups. The largest BME group is the Pakistani community. The rest of the BME population is made up of Caribbean, Indian, Bangladeshi, Somali, Yemeni and Chinese communities (census 2011). In recent years, Sheffield has seen an increase in the number of overseas students and economic migrants from within the enlarged European Union.

6.3.1 Setting the aim

The group decided to focus on WRES indicator 2: staff recruitment from shortlisting. The focus is on centralised recruitment (activity which is managed centrally where we recruit large numbers through an assessment centre process) because the trust has more control over the process and it takes place regularly. It also provided an

opportunity for comparison, and because of the larger number of candidates there could potentially be a bigger impact on the results. In this trust, the 2016 WRES data confirmed that white applicants were 1.35 times more likely to be successful after shortlisting than BME applicants.

6.3.2 Methodology

In order to progress this work, service improvement and HR teams reviewed options and sought to establish a working task group. It was identified from the beginning that the trust needed a multidisciplinary team that would help the work progress at pace.

This group was established to bring together different views of those involved in recruitment. It was also important that we included colleagues from a BME background. Group membership consisted of service improvement, recruitment, learning and development, data analyst and nurse director representation.

It was also agreed that it was essential to use regular weekly meetings to keep the momentum of the work. With the support of a microsystems coach from service improvement, the team used effective meeting skills to help ensure the meeting was both productive and effective with all members of the team having the opportunity to have a role in the meeting at some point.

The team used three roles to help structure the meeting – leader, timekeeper and note-taker. This is agreed at the beginning of each meeting with an evaluation at the end scoring the actual meeting on a scale of 1 – 10 (10 being the best). This allows the facilitator to ensure that the meetings are hitting the mark and the team is happy with the progress and pace. An online SharePoint site was also set-up to store data, documents, meeting minutes and any other information that needs to be shared with the team.

Using the Associates in Process Improvement (API) model as a framework, the team considered the question ‘what are we trying to accomplish?’ Due to the short time frame of the pilot project, the national WRES team suggested that the trust may wish to focus on WRES indicators 1 – 4, as these are more process-driven and therefore easier to impact upon.

By following the QI methodology approach, the team interrogated the data to gain a better understanding of the problem they were trying to improve. As you will see from the graphs, white candidates have higher likelihood of being appointed at each stage of the recruitment processes from application to shortlist and appointment. It was therefore decided to focus on WRES indicator 2 – Relative likelihood of staff being appointed from shortlisting across all posts.

This indicator was chosen for a number of reasons. Firstly, because it is an area in which both employees and managers can relate to. Secondly, there are already a number of controls in place which will allow us to examine the process carefully.

Thirdly, recruitment is a regular event which provides opportunity for frequent review, and finally if we are to improve overall in terms of the WRES, and is it critical that we establish a diverse workforce.

Figure 3: Data analyses



The group considered options and agreed to focus attention on the assessment centres for entry level staff, clinical support workers and administrative and clerical, band 2 roles. This defined group provides regular activity and opens the process to a wide range of candidates as their roles naturally attracts a high proportion of external candidates.

6.3.3 How will the trust know a change is an improvement?

After agreeing on the areas for improvement the team set a global aim: 'To ensure that the workforce at Sheffield Teaching Hospitals is representative of the population served (19%)'.

The team acknowledged that this would not be achievable within the scope of the project; however the group were clear that they wanted to use this opportunity to create a legacy and wanted to set a global aim that they want to achieve over the coming years. The group then agreed on a specific aim that fitted within the time constraints of the project and also provided a measureable outcome.

'We aim to have the same proportion of BME staff appointed as are short listed from each AfC band 2 assessment centre at Sheffield Teaching Hospitals by January 2018'. The agreement of a specific aim helped the team to focus on changes of practice that could show an impact in a relatively short space of time.

Before starting to consider ideas for improvement, it was important that the team understood the issues and problems within the recruitment process. Therefore the first step was a meeting dedicated to understanding the process that the candidates go through from application to appointment by completing a recruitment process map. This session helped the team to gain a deeper understanding of the process, and also raised some questions that may have not been highlighted without the group input.

Following on from the process mapping session, the team started to think about the problems that they felt could be impacting on the likelihood of BME candidates being appointed at STH. In order to generate as many ideas as possible the team reviewed the issues / problems (secondary drivers) using post-it notes, which they then grouped into themes (primary drivers). The team then went on to review change ideas. From this information the team constructed a driver diagram (figure 6) which informed an understanding of the breadth of the problems, and also linked it back to the overall aim; in addition, this provided the team with a tool to track progress of the project.

Figure 6: Driver diagram example

Global aim	Specific aim	Primary drivers	Change ideas
Ensure that our workforce at Sheffield Teaching Hospitals is representative of the population of Sheffield (19%)	We aim to have the same proportion of BME staff appointed as are shortlisted for each band 2 assessment centre at Sheffield Teaching Hospitals by January 2018	Education	Unconscious bias training
			Cultural education
			Info to be given to panel members e.g. basic awareness
			On hour session on WRES metrics to educate panels
			Understanding/awareness training of BME candidates (interviewers/panel members/trust staff)
			High impact equality and diversity training for all assessors
			Online training - self assessment
		Assessment process	Review and get expert advice of the assessment criteria
			Assessment forms to have a tick box - global descriptions for development requirements / gaps in performance
			Setting the scene at the start of the assessment to include if you are unsuccessful it is ok to ask for feedback - it will help next time
		Follow-up	Follow up - provide feedback in a timely manner
			Feedback from candidates
		Pre-interview	Candidate confidence building
			Advertising in the right places - NHS Jobs?
			Letter explaining assessment process - explaining our PROUD values
			Video showing candidates what to expect at assessment
			Update of job descriptions
		Panel make-up	BME panel members
			More assessors from a BME background

The results of the driver diagram were reviewed with the team and it was agreed that the first two primary driver's education and assessment process would be the ones we would start to work on. The decision to start with these two areas was based on the financial limitations of the project and what they felt was in their control.

Using the model for improvement as a framework, the team followed the Plan, Do, Study, and Act (PDSA) cycle. The study element of this cycle is really important, so we ensured that we were able to analyse data for each change idea. Following this cycle changes were made to the following areas:

- Candidate assessment forms
- Assessors briefing session
- Candidate pre-assessment workshops
- Unconscious bias training

6.3.3.1 Candidate assessment forms

Changes were made to the clinical support worker assessment centre, with the intent of ensuring that assessors apply consistency when marking and also providing a clear framework for more detailed feedback whether candidates were successful or unsuccessful. This consequently created nudge points for assessor's personal biases and increased accountability of decision making for appointment or rejection. The team utilised the meetings to look at the original form, and then devised a new form that could be tested on one of the smaller assessment centres.

6.3.3.2 Assessors briefing session

The assessors briefing sessions were reviewed to introduce the awareness of unconscious bias (halo and horns effect), and to improve information regarding WRES indicators and outcomes for BME candidates during the recruitment process. The intention here was to educate and raise awareness.

6.3.3.3 Pre-assessment workshops

The team invited the community recruitment lead from South Yorkshire Police (SYP) to one of our meetings and then members of the team visited SYP to look at their proven systems for improving BME recruitment.

SYP was attracting BME applicants to apply for their jobs but, these applicants were

not always successful at interview, as was the case at STH. SYP established a series of pre-assessment workshops which proved very successful in helping applicants to prepare for the assessment process and interviews. The group at STH therefore decided to develop a session for clinical support workers.

The pre-assessment workshop the group developed was an hour long interactive workshop that provided the opportunity for candidates to see videos explaining the role and an introduction to the trust, a talk about the day in the life of a clinical support worker and an explanation of the process of interview and assessment. The candidates were told they were welcome to ask questions and seek further information.

6.3.3.4 Unconscious bias training

The team next began to look at training and education options which could improve the metric; we decided to develop unconscious bias training as this had been one of our initial change ideas.

The team reviewed the options available and, following guidance from the NHS Leadership Academy, purchased an e-learning system. It was important that this system was accessible, transferable, and engaging, however we recognised that e-learning alone would not be sufficient. Following a trial of the e-learning system, it was decided to spend some time looking at a variety of blended approaches which incorporated the e-learning system and half-day face-to-face classroom learning.

While the uptake of this approach in clinical areas has been challenging during the winter months, we have seen over 100 people complete the e-learning package and the uptake in non-clinical areas has been considerably better. For this reason the team decided to encourage all assessors who participated in our central admin and clerical assessment centre to complete the both sessions.

The success of this approach was evidenced in our January 2018 administrative and clerical assessment centre, where 13 of the 16 assessors had completed the full unconscious bias training that the team had developed. The feedback from these sessions has been very positive, as evidenced in the following comments:

- “Very interesting session, has made me think more about what, how, we see people and how I can sometimes judge. Would really recommend this training to all staff in the trust”
- “It has opened my mind to my own bias but also other peoples and given me confidence to try and challenge these”
- “Should be widespread so all staff are aware of their own bias”

These changes were implemented into clinical support workers and administrative and clerical assessment centre vacancies.

6.3.3.5 Clinical support worker assessment centres

The following changes were cumulatively introduced into each cohort as follows:

- Cohort one – improved assessors briefings to include education around unconscious bias (improved halo and horns), which included WRES information video clips, data and discussions around effective written feedback.
- Cohort two – same as above plus altering the feedback sheet to highlight and comment against common failing criteria, plus comments noted on how candidates could improve ultimately improving accountability.
- Cohort three and four – same as above plus lengthened the interview questions to enable one-to-one discussion and deeper interview to improve candidates' ability to perform better individually, as opposed to in a group.
- Cohort five – new unconscious bias training which includes e-Learning tutorials and face-to-face facilitated sessions.

6.3.3.6 Administrative and clerical assessment centres

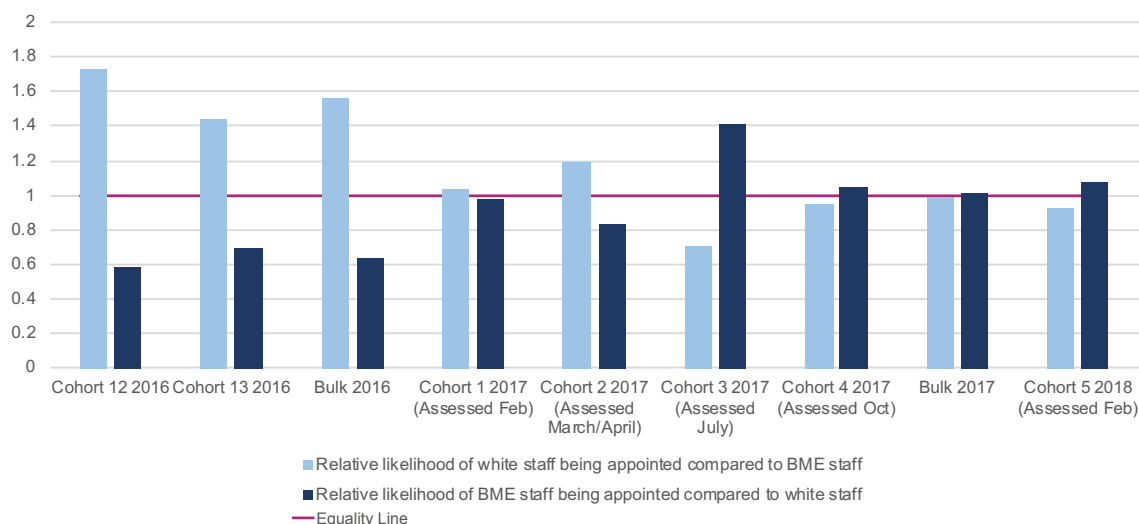
The following changes were introduced to cohort one only:

- Recruitment forms
- Unconscious bias training (online and face-to-face)
- Assessors briefing session

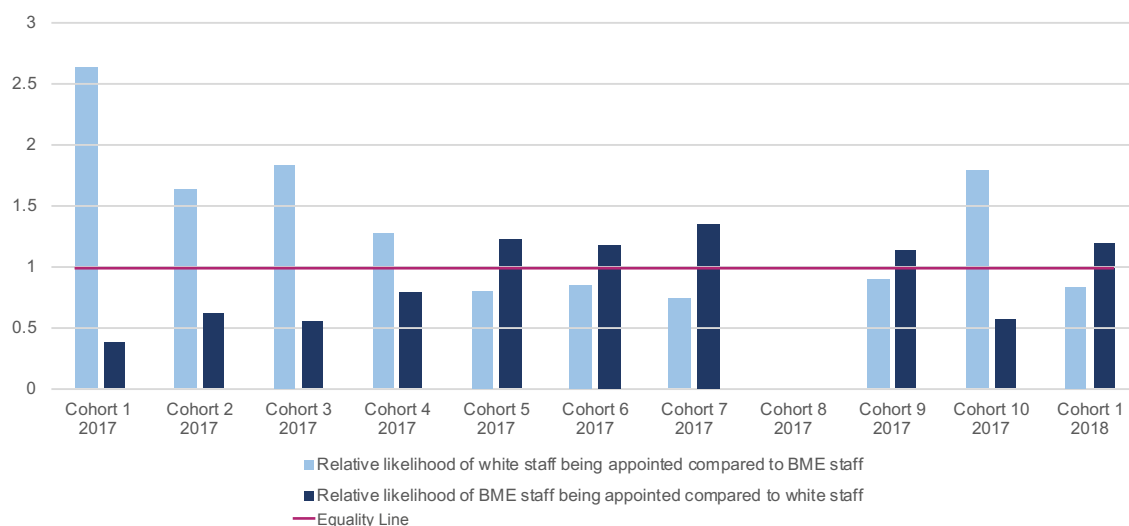
6.3.4 Data and evidence

The trust has demonstrated that a culmination of changes in the recruitment process has resulted in improvements in the likelihood of BME candidates being appointed from shortlisting, thus resulting in a fairer and more equal outcome.

The bar charts show the relative likelihood for both white and BME candidates for each assessment centre cohort for clinical support workers and administrative and clerical staff. White bars are white candidate scores and blue bars are BME candidate scores. The red line in the bar charts denotes the benchmark for equal relative likelihood (target is 1.00), and results closer to this line are positive.

Figure 7: Clinical support worker recruitment**Clinical support work - bulk recruitment**

	Cohort 12 2016	Cohort 13 2016	Bulk 2016	Cohort 1 2017 (Assessed Feb)	Cohort 2 2017 (Assessed March/ April)	Cohort 3 2017 (Assessed July)	Cohort 4 2017 (Assessed Oct)	Bulk 2017	Cohort 5 2018 (Assessed Feb)
Number of shortlisted applicants (white)	200	199	399	13	135	65	30	243	91
Number of appointed from shortlisting (white)	100	102	202	10	66	32	19	127	28
Ratio figure white	0.50	0.51	0.51	0.77	0.49	0.49	0.63	0.52	0.31
Number of shortlisted applicants (BME)	45	45	90	4	34	13	6	57	9
Number of appointed from shortlisting (BME)	13	16	29	3	14	9	4	30	3
Ratio figure BME	0.29	0.36	0.32	0.75	0.41	0.69	0.67	0.53	0.33
Equality line	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Relative likelihood of white staff being appointed compared to BME staff	1.73	1.44	1.57	1.03	1.19	0.71	0.95	0.99	0.92
Relative likelihood of BME staff being appointed compared to white staff	0.58	0.69	0.64	0.98	0.84	1.41	1.05	1.01	1.08

Figure 8: Admin and Clerical recruitment**Administrative & clerical - bulk recruitment**

	Cohort 1 2017	Cohort 2 2017	Cohort 3 2017	Cohort 4 2017	Cohort 5 2017	Cohort 6 2017	Cohort 7 2017	Cohort 8 2017	Cohort 9 2017	Cohort 10 2017	Cohort 1 2018
Number of shortlisted applicants (white)	44	75	36	62	62	74	54	41	54	67	117
Number of appointed from shortlisting (white)	21	35	11	21	18	14	8	12	16	16	34
Ratio figure white	0.48	0.47	0.31	0.34	0.29	0.19	0.15	0.29	0.30	0.24	0.29
Number of shortlisted applicants (BME)	11	7	6	15	14	18	15	10	3	15	29
Number of appointed from shortlisting (BME)	2	2	1	4	5	4	3	0	1	2	10
Ratio figure BME	0.18	0.29	0.17	0.27	0.36	0.22	0.20	0.00	0.33	0.13	0.34
Equality line	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Relative likelihood of white staff being appointed compared to BME staff	2.63	1.63	1.83	1.27	0.81	0.85	0.74	0.00	0.89	1.79	0.84
Relative likelihood of BME staff being appointed compared to white staff	0.38	0.61	0.55	0.79	1.23	1.17	1.35	0.00	1.13	0.56	1.19

6.3.5 Key findings

Figure 7 shows data for clinical support worker assessment centre by each cohort. The chart shows the relative likelihood of white candidates being appointed has decreased from 1.57 in 2016 down to 0.99 in 2017, which means the process has fairer outcomes when compared to the previous year. The chart also shows that all cohorts, since cohort one appear to have likelihoods which are closer to the equality line.

Figure 8 shows data for administrative and clerical assessment centre by each cohort. We only made changes to the last cohort, which is cohort one 2018. However, the likelihood for the cohort was positive and close to the equality line. It is important to note that other cohorts such as five to seven and nine, had similar positive results and were not subject to any changes in recruitment processes, and that the likelihood for both white and BME candidate's across all cohorts has been variable and inconsistent. We have demonstrated that there appears to be a correlation between interventions and outcomes.

Future cohorts will need to be monitored over a longer period of time to see if the results remain consistently positive. Each cohort has a variable outcome in terms of relative likelihood, so we need to do more research into why this happens.

6.3.6 Lessons learned

- The setting of clear boundaries, expectations and ground rules from the start to provide a safe environment for members to share and respect each other's viewpoints is important.
- Succession planning is critical. At one point the group was reliant on one member of the team to work on a large part of the project and this unfortunately held back the progress of the work when the member was away from the workplace for an extended period of time.
- The use of sub groups to work on different parts of the project outside of the meeting may have helped to speed up the progress of the work.
- The use of data was critical to understanding where we need to focus the improvement work.
- A diverse multi-disciplinary approach has helped to drive the work and is strongly recommended. We have had a good balance of different roles and skill sets, and leadership from roles such as nurse director and lead nurse has allowed the group move forward.
- You need the freedom to be able to test ideas using small trials without having to ask permission.

- The use of a service improvement facilitator to co-ordinate the meetings and provide QI support, resources and methodology i.e. effective meeting skills.
- The use of a flat hierarchy help all members of the team feel comfortable to speak-up.

This project has been of benefit to the trust in terms of providing a forum for stakeholders who may by default not normally have the opportunity to share ideas and thoughts, and in introducing a rigorous framework against which the group were able to try out new approaches. The scene has been set in terms of expectations of progress; this work will now be shared more widely across other roles and staff groups and we will continue to review outcomes.

6.4 The Royal Free London NHS Foundation Trust

The Royal Free London is one of the UK's biggest trusts, where 10,000 diverse staff deliver care to more than 1.6 million patients each year, with a breakdown of 4,795 white staff (51%) and 4457 BME staff (48%) and 86 undeclared accounting for 1%. The trust continues to play a leading role in the care of patients and our mission is to provide world class expertise and local care.

The trust operates at three main hospitals: Royal Free Hospital, Barnet Hospital and the Chase Farm Hospital, and attracts patients from across the country and beyond to its specialist services in liver, kidney and bone marrow transplantation, haemophilia, renal, HIV, infectious diseases, plastic surgery, immunology, vascular surgery, cardiology, amyloidosis and scleroderma. The trust's mission is to provide world class expertise and local care as well as lead improvements in healthcare.

6.4.1 Setting the aim

Royal Free London NHS Foundation Trust is committed to WRES improvement and believes that the QI approach will help understand better how to reduce and minimise the number of disciplinary cases across the trust.

Suspensions, investigations, statement taking meetings, disciplinary hearings, disciplinary appeal hearings and disciplinary related sickness absence all take staff and managers away from focusing on patient care.

The key driver is to ensure that only those cases that needed to proceed to a disciplinary hearing went forward. The benefits would be more time to spend on providing high quality patient care thereby resulting in efficiency savings, reducing stress levels at work, and improving team working.

In addition, the irreparable human cost i.e. the health and wellbeing of staff that go through disciplinary process resulting in “no case to answer” could be avoided. In 2003, the National Audit Office (NAO) found that the cost of 1000 clinical staff going through suspension was at a cost of £40 million to the NHS.

6.4.2 Methodology

In July 2015, the trust acquired Barnet and Chase Farm Hospitals and a lot of employee relations systems and processes were merged in order to have a more cohesive management of disciplinary cases. There was a catalyst for this piece of work. The director of nursing following an intervention in a disciplinary case sent out a message to all nursing and midwifery clinical leads that she will be reviewing all disciplinary cases before they proceed to a disciplinary hearing for consistency and equity.

As a result a regular employee relations review meeting took place every two weeks by the director of nursing and the head of employee relations focusing on nursing and midwifery cases which were the biggest occupational staff group in the trust hence had the highest number of disciplinary cases.

Strong board leadership gave gravitas to this piece of work which then led to a visible and rigorous approach to disciplinary across all sites. This high level review led to further work with the NHS England WRES team whereby the trust became involved in using the model for improvement to address reduction of BME staff proceeding to disciplinary hearings.

In 2016, the trust agreed that the Transplant and Specialist Services (TASS) division due to the high number of disciplinary cases would be appropriate for the pilot QI WRES initiative. So far, the trust has recorded improvement in WRES indicator 3, in 2016, the trust recorded a 2.21 relative likelihood for BME staff to proceed to formal disciplinary hearing and by 2017 it has fallen to 1.76.

A QI working group was set up in TASS led by the head of nursing for the division. The objective of the group firstly was to have the right people in the room, line managers who investigated cases, managers who chaired disciplinary hearings, managers who commissioned investigations and those who chaired appeal hearings all participated in the agreeing a specific objective to reduce the relative likelihood to 1.10. This is within the context of trust workforce constituting 51% white staff, 47% BME and 2% undisclosed. The QI working group met regularly within its time constraints and developed a driver diagram, please see attached.

The workforce information team supplied the disciplinary data and the clinical leads in TASS went for their QI training within the trust to ensure that they acquired the knowledge and skills required to develop a Plan Do Study Act (PDSA) cycle, the primary and secondary driver diagrams. The QI working group looked at the trends of the disciplinary cases, the pay bands, the type of cases, the experience of the managers involved, the outcomes, those with no cases to answer at the end of the process and what lessons were learnt. This was the first time such data was shared and discussed with this level of insight and scrutiny.

A QI fact-finding meeting was also set up for employees by the investigation managers to help staff who had gone through disciplinary process to find out what could have helped them in hindsight to avoid going through a disciplinary process.

6.4.3 How will the trust know change is an improvement?

By using the QI approach, all parties involved were able to discuss and shed more light on why staff were going through these processes and they were also able to agree a range of interventions which they have put in place and are able to regularly review through the use of a PDSA to check if they are working.

Key themes pivotal to the QI WRES disciplinary work:

- Catalyst / trigger
- Specified pilot area for QI WRES indicator 3
- QI training for managers involved in disciplinary process
- QI working group for managers involved in disciplinary process
- QI fact finding meetings with employees involved in disciplinary process

Key QI led improvements in TASS as a result of this work has been the following:

- Matrons have put in place a “development framework for health care assistants (HCAs)” as they were more likely in TASS to go before a disciplinary at the time the QI work commenced.
- Healthcare workers are invited to participate in the multidisciplinary team meetings to enable them have more clarity about their roles and responsibilities, promote inclusion in the team so that they can feel they belong and be more confident to ask for help when they need support.
- Group supervision where healthcare workers and matrons attend to discuss all their concerns with a view to address them swiftly.
- A fortnightly employee relations review meetings between HR and line managers to discuss appropriateness of cases, consistency of approach and equitable outcomes.
- Supervision workshops organised by HR for line managers to actively encourage engagement with staff to aid resolving issues at an informal level and at the earliest opportunity.
- Sharing best practice with other managers in administrative and clerical roles

Work on WRES indicator 3 was not without its challenges. Obtaining WRES data on a regular basis competed with other trust priorities. The work has now enabled the workforce information team to provide the disciplinary data on a monthly basis as part of the regular workforce metrics received by managers.

Influencing employees to come forward to discuss and participate to inform the process of learning required patience and time to get them on board as this had never been done before and employees were initially reticent. However once they realised that there were no reprisals they came forward with their human stories and ideas to work more closely with the managers to improve and reduce the number of cases.

Across the trust, QI work on WRES has triggered other multiplier effects for the overall employee relation cases, due to the review of all employee relation cases both informal and formal triggered by the group director of nursing with the employee relations team. The overall number of employee relation cases has reduced from 727 in 2016 to 534 in 2017. This is a reduction of 193 cases (26%) over a period of 12 months (26%).

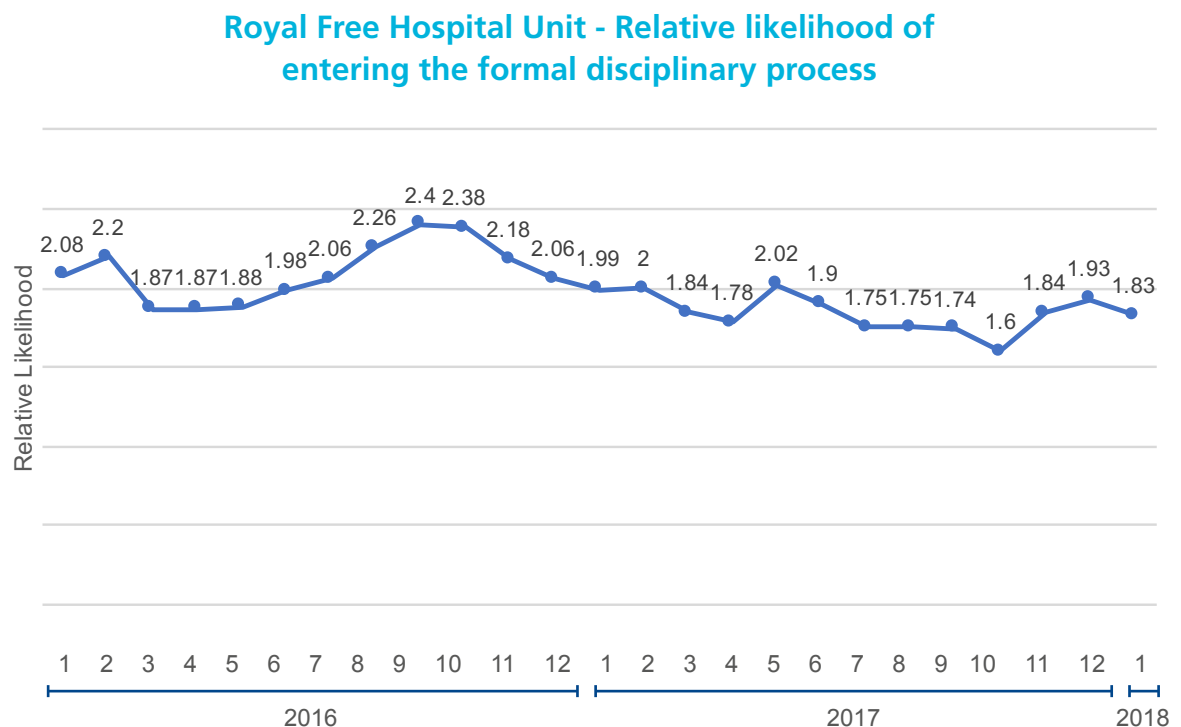
6.4.4 Lessons learned

- Set time aside to make QI WRES working group discussions take place in the division on a regular basis bearing in mind there would always be competing priorities at all times.
- Make the employee relations data visible in the organisation, it will be an eye opener, share data with managers conducting investigations, chairing hearings and appeals, involve them in the discussions, many only know the outcome of the cases they managed but not the overall trends. The power of data awareness cannot be underestimated.
- Allow operational managers working on the actual cases to scrutinise the data, they are more likely to notice anomalies quicker than anyone else.
- Do not be afraid to try something new even if no one else has done it before, you are bound to learn something and you may be pleasantly surprised that a few nuggets may also come up!
- Discuss findings with employees, collaborate and discuss case scenarios with new managers to embed knowledge.
- Accept that this is a long term work that will reap better staff experience and working culture on the long run.
- Continue to embed learning from WRES indicator 3 in other areas of employment cycle as well as in management development programme to help sustain the model for improvement as the way we do things now and in future.

- If some interventions do not work, try another, find out what is working in other trusts and try it.

There are areas where we could also do things differently, for example, work collaboratively to understand better how cases can be resolved swiftly rather than have lengthy investigation with a no case outcome.

Figure 9: WRES indicator 3 tracker



The relative likelihood baseline data for TASS was 2.08 in February 2016 before the QI WRES work commenced as well as the QI WRES working group discussion TASS division commenced their Plan, Do, Study, and Act (PDSA) cycle by April 2016 (1.87), the data was now shared across the division. The employee relations team fortnightly surgeries with line managers were also put in place.

During this period there was a high increase in cases from a unit where there were higher numbers of BME staff, therefore, the relative likelihood increased and started to reduce towards the end of the year.

The new HCA framework, group supervision and more involvement in multidisciplinary meetings were introduced as key interventions by September 2016 (2.26). This helped improve a two way communication and staff seeking help much earlier to avoid errors and incidents.

The best relative likelihood achieved so far occurred in November 2017 (1.60), the TASS division is using this initiative as a wider discussion to resolve cases informally where in the past there was no cases to answer.

As at January 2018, the relative likelihood is at 1.83, this highlights the fact that there is still much work to do in order to sustain improvement.

6.5 University Hospitals of Leicester NHS Trust

University Hospitals of Leicester NHS Trust (UHL) serves a diverse population. The ethnic minority population, as measured by non-white residents, increased between 1991 and 2011 by 34,000 in Leicestershire and 79,000 in Leicester City.

- Indian is the largest ethnic minority group in Leicestershire (4%) and Leicester City (28%). The group is clustered in the eastern parts of the city in the wards of Latimer, Belgrave, Spinney Hills, Rushey Mead and Coleman.
- The second largest ethnic group is white other, which has grown rapidly during the 2000s in Leicester City (growth of 160%) and in Leicestershire (growth of 57%).
- People of an African background has grown faster than any other comparable group during the past two decades, but accounts for less than 10% of the population in all wards in Leicestershire and Leicester City.
- The Indian group is growing most rapidly in areas neighbouring those in which they are most clustered in Leicester, including Humberstone; and in some rural parts of the county, including Great Glen and Houghton on the Hill.

University Hospitals of Leicester utilised the expertise of Dr Jay Banerjee, quality improvement fellow, to understand how the QI methodology could be applied in the context of the WRES. The project was sponsored by the director of workforce and organisational development, and commitment was offered by the chair of the trust.

6.5.1 Setting the aim

In accordance with the WRES, data had already been collated on the percentages of BME at a leadership level within the trust; this data was broken down by clinical management group in order that this target was embedded within trust key performance indicators (KPIs). In 2016, a target was set for BME representation to mirror the overall trust BME baseline position of 28%, which was reflective of the community served. In quarter one of 2017/18 – the figure was 30.72% BME overall with 12.2% in medical leadership and 8a-9 AfC bands 8a - 9.



By the end of march
2018 we aim to
reduce the
differential between
bme and white staff
in band 8a and
above posts by 25%



Outcome measure
Number of bme staff in band 8a+ positions
Annual change in numerator will reflect
recruitment, retention and internal
movement

Balancing measure
Proportional change in investment for new
posts, as well as changes in existing posts
proportion of staff released for
development/mentorship/service
improvement programmes



Pulse check broken down by ethnicity
(displaying negative perceptions amongst
white staff - 3 monthly)
data on application, shortlisting,
recruitment and retention (3 monthly and
6 monthly by consultants and band 8a -
owing to volume of recruitment)
Staff survey
Safety data (incidents, harms,
complaints)
recruitment panel data (composition)
trainee survey data from deanery

Development

1. Targeted development programmes for BME staff (with East Midlands Leadership Academy)
2. Networking events for BME staff and senior leaders ("visible leaders")
3. Prepare BME staff for interviews and help with applying for senior roles
4. Examples of BME staff experience widely shared across the trust
5. Introduce opportunities for BME staff to shadow senior leaders relevant to their area of work or aspirations
6. Reverse mentoring
7. Unconscious bias training for staff

Recruitment

8. Application/interview preparation courses for BME staff
9. Job adverts to be explicit about the needs for representation from specific ethnic groups to reflect the ethnicity of the local population
10. Positive action

Scrutiny

11. Report trust-wide performance against BME representation (Consultants to Band 7)

12. Share performance data on the WRES at quarterly intervals (CMG)

13. Share performance data on the WRES every 6 months with the trust board

Engagement

14. Promoting benefits of having a representative workforce at senior leadership positions
15. Understanding and acting on BME staff experience in the trust
16. Ensure that all promotional material for any trust event facilitates BME participation
17. Support BME staff in service improvement projects

Leadership (structure)

18. Agree on improvement actions within UHL trust board
19. Support improvement methodology for delivering WRES by CMGs (Trust Board)
20. LLR wide strategy for addressing "health and inequality" and will include strand on workforce in equality→

An initial review of starters and leavers information for 12 months prior to the project start date showed that there would only be a limited opportunity for interventions in the recruitment process for roles at AfC band 8a and above. This suggested that we should therefore include AfC band 7 roles as they are an important pipeline for more senior positions. Changes in BME representation figures for AfC band 7 and above, over a five-year period, are seen in Figures 11-13 – showing levels of improvement against a mean in the five year period; Figure 14 presents an aggregate view of percentage change in representation.

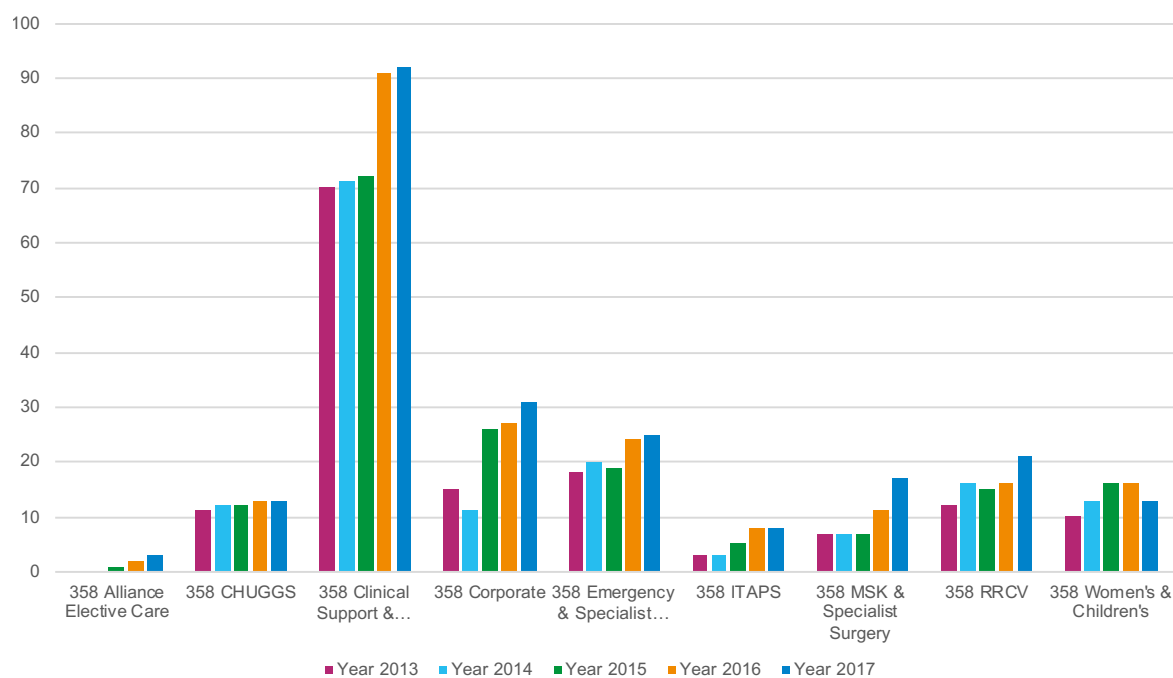
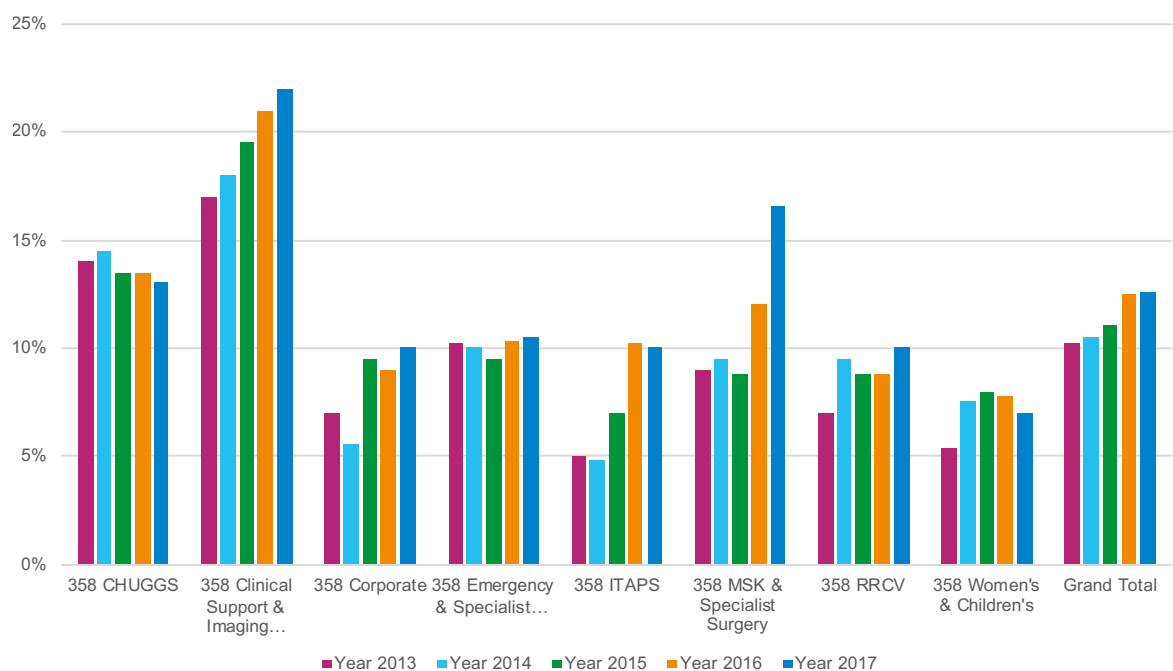
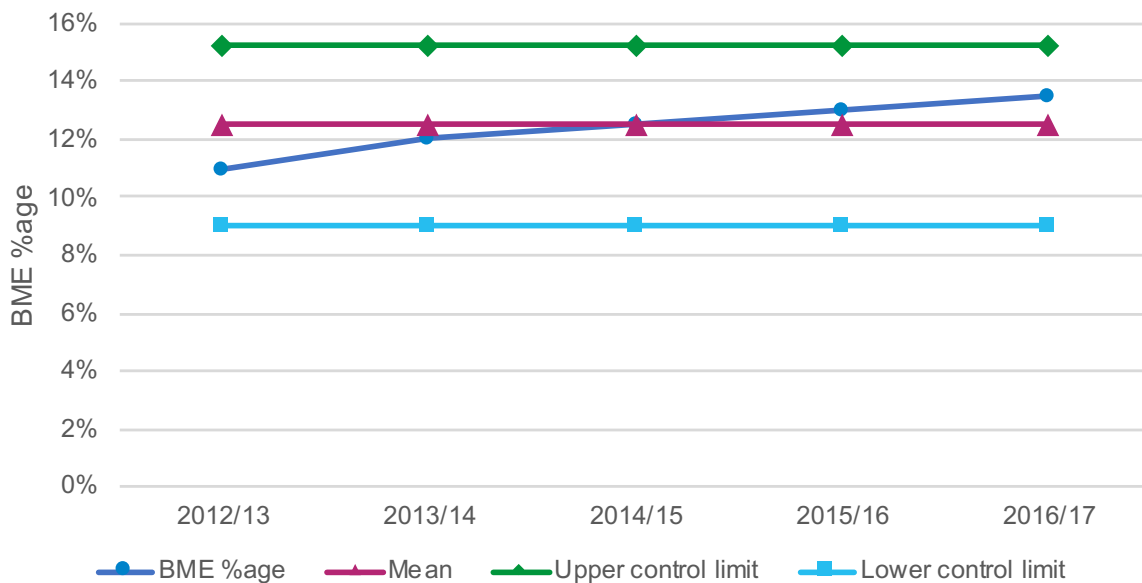
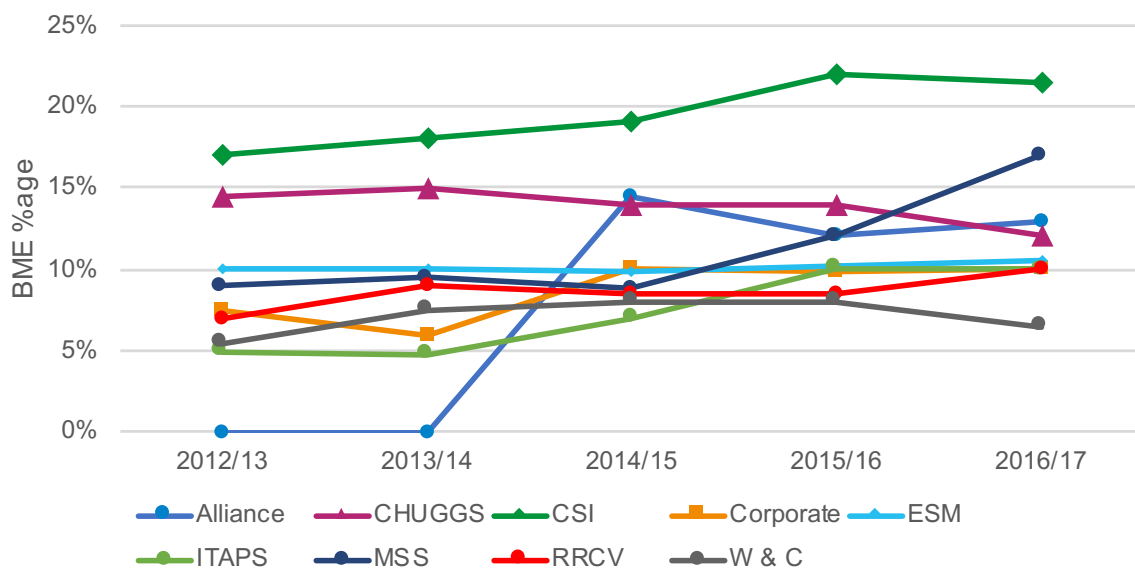
Figure 11**Headcount of BME staff in leadership roles 2013-2017****Figure 12****Percentage of BME staff in leadership roles 2013-2017**

Figure 13

Statistical process control showing improvement in
BME representation at trust level
SPC Chart - BME % at band 7 and above

**Figure 14**

Aggregate view showing improvement in BME representation at CMG Level
Aggregate view of BME % at band 7 and above - UHL by CMG



A secondary part of the data analysis was to review potential retirements and staff turnover to ascertain how many recruitment opportunities there may be at band 7 and above. These opportunities provide an opening to take positive action to improve BME representation at the leadership level. The data shows that there are 60 individuals at band 7 and above over the age of 60 and therefore it would be reasonable to commence succession planning over a five year timeframe.

Another part of the data analysis was to produce a report of annual turnover (which includes retirements) to further ascertain the opportunity for increasing our BME representation at a senior level.

Within one year, there would be 119 opportunities to recruit at AfC band 7 and above, although not all of these posts represent progression routes to band 8a and above roles. These are mainly specialised posts within the allied health professional category (20 posts) and therefore it is reasonable to assume there are approximately 100 roles to be recruited to within a one year timeframe.

A further part of the data analyses was to review the relative success rates of staff at different stages in the recruitment process. Although we are able to produce overall trust data for this showing white staff are twice as likely to be successful at appointment stage than BME staff (UHL Workforce Equality and Diversity Report 2017), the trust recognises that there is work to do on capturing internal promotions and ensuring that within our TRAC system recruitment episodes can be closed down correctly to show relative success of applicants throughout all stages of the recruitment process. This work has therefore been carried forward into the next steps section of this report.

The final part of the data analyses was to review patient complaint data in order to test our hypothesis that improving BME representation at the leadership level has a positive impact on patient safety. An initial review of such data proved inconclusive as the experience of BME patients was generally more positive than that of white patients. The project team concluded that there was a range of other variables impacting on this outcome but that the national research should be sufficient evidence to drive our view that we need to prioritise improving representation at the senior level.

Initially, a multidisciplinary project team, supported by the trust's QI fellow, was established to review changes that could be implemented in one of our clinical management groups; Renal Respiratory and Cardiology and Vascular (RRCV) as this group has particularly poor levels of BME representation at a senior level but also leadership who were skilled in improvement methodology. Following two workshops, the team produced the driver diagram.

An early review of recruitment opportunities for RRCV showed that there would be limited opportunities to undertake PDSA cycles in order to prove that any proposed changes would impact of improved representation and quality of care. In addition, membership of the project team changed on numerous occasions affecting the ability

to design and implement the PDSA cycles which we believed would have the greatest impact. The team therefore reviewed trust wide opportunities for intervention based on the opportunities evident.

A reverse mentoring scheme commenced in February 2017 with four of our executive directors agreeing to act as “mentees” for the four BME mentors. The principle aim of the scheme was for mentors to provide the directors with the personal experiences of their career journeys at the trust. The findings from the scheme are as follows:

- The topics chosen seem to have been useful as a catalyst for the one to one discussions between mentors and mentees. Conversations have been centred on culture, recruitment and selection, the appraisal process, training and promotion opportunities and any experience of discrimination.
- Many useful insights have already been highlighted via this project process which can be used to review, continue and improve processes currently in place in the trust. In one case the mentee was from a different generation and therefore the conversations have included discussions on different work and life influences across the generations.
- It is positive to note that the project is also highlighting areas of good practice in the trust that we need to be proud of and continue to build on and/or roll out elsewhere.
- The small group of mentors are all committed to continue with the process and also develop into a steering group at the end of the process to support the equality and OD teams in publicity, recruitment and support for this type of programme in the future.
- Mentors and mentees have engaged in discussions in differences in experiences and expectations particularly as a result of the generational gap.

Unconscious bias training is now a supplementary module of the ‘UHL Way’ leadership programme currently being rolled out to all middle and senior managers (offered to cohorts one to four). Ad-hoc sessions are also available on request. The clinical management group human resource business partners have all been trained and are able to deliver short sessions as required within their CMG’s / corporate areas.

A people capability framework is being drafted and the corresponding development programme will ensure unconscious bias training forms part of this. The trust’s new people capability framework will be launched in 2018 following pilot in the selected area.

The learning and development team is working with Leicestershire Education Business Company (LEBC), Sector Work Based Academies, Leicester Apprenticeship Hub, and Leicester Enterprise Partnership, to promote the NHS, through schools and colleges, community settings, direct mailing to year 12 and 13 students across the city and county to promote health based careers within BME communities.

As part of the Leicester, Leicestershire and Rutland sustainability and transformation partnership (STP) work is underway to address the gaps identified within the triple aims of the STP. During 2017-18, partners across health and social care have been exploring collaboration opportunities working towards developing a joint Leicester, Leicestershire and Rutland wide equality action plan. In July 2017, the trust appointed a clinical fellow across the same geographical patch to support the joint action plan.

A change in the leadership of equality and diversity at trust level has given new impetus to this work which has now been incorporated into an overarching WRES task and finish group which will adopt QI methodology in a more systematic way. The group has broader representation and is chaired by a non-executive director to ensure we are held to account for the actions to be determined. Most critically, the group has BME representation to challenge what interventions might have greatest impact on the WRES indicators.

6.5.2 Lessons learned and next steps

Much of the early stages of implementation were impacted upon by a lack of appropriate data to pinpoint where interventions are best targeted particularly that relating to internal promotion data. An approach has since been developed and requires review to ensure it is appropriate for monitoring our internal recruitment practices.

Further work is required on prioritising the actions in the driver diagram as part of the WRES action planning working directly with stakeholders from the BME community. This will help support the development of the PDSA cycle and how we will measure whether it is making a difference.

Work will commence on the following specific interventions:

- Monitor the impact of a targeted approach to improving BME representation for the new role of graduate management trainees. Initial cohort of nine (recruited in 2015) was 66% BME and all BME candidates have secured permanent roles at band 7 and above with the exception of one remaining on the scheme. A new cohort of six attracted 50% BME candidates. This was achieved through targeting our local universities.
- Review of the interview documentation (also part of the gender pay gap action plan) to give greater transparency of selection decisions.
- Review of the recruitment and selection course to reinforce the equality and diversity elements.
- Increase the capacity for delivery of unconscious bias training for all panel members.
- Review of selection panels to ensure BME representation.

-
- There is significant learning to be taken forward into the WRES task and finish group to ensure that interventions deliver real change, including:
 - Rigorous data collection and analysis to inform decision making and track progress
 - Consistency of membership of project teams with clarity of purpose and detailed tracking of actions and implementation
 - Systematic adoption of [QI methodology](#).

07 Conclusion

It is increasingly clear that the future of the NHS relies on the people who deliver health and care services, providing care all day, every day. It is the largest employer in England – health and care jobs currently represent nearly 12% of all jobs across the country – and it is also the largest employer of people from BME backgrounds.

As we move beyond seven decades of the NHS, the leadership, innovation and creativity of the NHS will be essential in adapting the service to current and future challenges. Workforce race inequality in the NHS is one such challenge that needs to be tackled head-on.

The introduction of the WRES across the NHS has amplified the narrative on the importance of workforce race equality for improved staff and patient outcomes, as well as for organisational efficiency. Through the collection and analyses of WRES data, and associated action planning, organisations are able to understand where they are on this agenda, and what is needed to make continuous improvements.

As part of WRES implementation, some organisations are adopting the model for improvement in order to adopt a systematic and structured approach to the analysis of performance and efforts to continuously improve on closing the workplace experience and opportunity gaps between white and BME staff.

As shown in this report, NHS organisations that are using the principles of the model for improvement are beginning to show initial progress against WRES indicators. What is clear is that regardless of the approach used, how the change is implemented – including factors such as leadership and resources – is vital.

8 Annex A:

The WRES indicators

Workforce indicators For each of the four workforce indicators, compare the data for white and BME staff	
1	<p>Percentage of staff in each of the AfC bands 1-9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce disaggregated by:</p> <ul style="list-style-type: none"> • Non-clinical staff • Clinical staff, of which <ul style="list-style-type: none"> - Non-medical staff - Medical and dental staff <p>Note: Definitions for these categories are based on Electronic Staff Record (ESR) occupation codes with the exception of medical and dental staff, which are based upon grade codes.</p>
2	<p>Relative likelihood of staff being appointed from shortlisting across all posts</p> <p>Note: This refers to both external and internal posts</p>
3	<p>Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation</p> <p>Note: This indicator will be based on data from a two year rolling average of the current year and the previous year.</p>
4	<p>Relative likelihood of staff accessing non-mandatory training and CPD</p>
National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff	
5	<p>KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</p>
6	<p>KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</p>
7	<p>KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion</p>
8	<p>Q17. In the last 12 months have you personally experienced discrimination at work from any of the following?</p> <p>b) Manager/team leader or other colleagues</p>
Board representation indicator For this indicator, compare the difference for white and BME staff	
9	<p>Percentage difference between the organisations' board membership and its overall workforce disaggregated:</p> <ul style="list-style-type: none"> • By voting membership of the board • By executive membership of the board

9 Annex B:

The Institute for Healthcare Improvement (IHI)

About IHI

The Institute for Healthcare Improvement (IHI) is a leading innovator in health and health care improvement worldwide. For more than 25 years, we have partnered with visionaries, leaders, and front-line practitioners around the globe to spark bold, inventive ways to improve the health of individuals and populations. Recognised as an innovator, convener, trustworthy partner, and driver of results, IHI provides expertise and encouragement for organisations and ministries of health across the globe that want to change health and health care profoundly for the better.

The identified gap and approach

In autumn 2011, IHI launched the Diversity and Inclusion Council, recognising the need to increase racial diversity amongst our staff at all levels of the organisation. The percentage of staff of BME backgrounds at 12% did not reflect the percentage of BME people in our surrounding community at approximately 30%.

A quality improvement approach to this challenge provided several useful tools and methods. Using an improvement lens, we understood this problem as a systems problem. Every system is perfectly designed to get the results it gets, and our system produced a disproportionately high number of white staff hired and a disproportionately low number of BME people hired. A systems approach required that we understand the processes that contributed to the inequitable outcomes we were seeing. We needed a team, a clear aim, a way of measuring, and a theory of change, as well as specific ideas for changes we could test in our system to yield a different outcome.

We brought together a team including those who ran the hiring process in human resources, those who led internal diversity efforts, and a broader cross-cut of the organisation representing several different departments who could provide input through the Diversity and Inclusion Council. We met regularly with our chief executive

officer to share updates on progress and challenges. Our aim was to improve our overall staff diversity by revising our hiring system to operate more equitably. Our initial theory included two key drivers: hiring processes and retention processes. We began with hiring and used a process map to identify phases of the hiring process including: CV review, phone interviews, and in-person interviews. Next, we tested changes, for example, slowing down the process for the next hire to ensure a benchmark of at least 20% candidates of colour at each phase and posting positions in spaces catered to professionals of colour. For each test, we utilised a Plan-Do-Study-Act (PDSA) approach: we made a plan, carried it out with one candidate, studied how the result compared to our prediction, and debriefed on whether to adapt for another test, abandon the test, or adopt the change.

After changing our hiring process, we understood that improving our inequitable hiring system was necessary, but not sufficient. What was the experience of BME staff once they were at IHI? By asking this question of why we had low racial diversity, and what happened after staff were hired, we began to broaden and deepen our understanding of the problem. Diversity or a lack thereof, is a symptom of institutional racism and requires reviewing policies, procedures, and norms for ways in which they disproportionately impact people of colour.

A new direction for equity

IHI now has a two-pronged aim:

- Develop a workforce that is representative of the communities served by IHI's work;
- Cultivate a working environment where all staff can thrive and achieve their full potential, with a specific current focus on determining and reducing ethnic or racial inequities.

This dual aim represents diversity and equity which are mutually dependent. Diversity without equity is tokenism. And, equity without diversity is impossible. To have an impact on our interactions, systems, and processes, IHI's internal equity team focuses on three drivers and our work will require that we test and learn our way to improvement at each of the following levels:

- Individual – our personal beliefs, attitudes, and opinions;
- Interpersonal – the way we relate to each other in our behaviour and treatment;
- Institutional – our organisational policies, practices, and systems
- In service of work in these key drivers, IHI is concentrating its tests in these process areas:

- Employee life cycle: Every employee moves through phases of the employee life cycle, including recruitment, hiring, on-boarding, professional development, promotion, retention, and departure. Across all of those phases, there are opportunities for an equity focus in the systems and operations of the employee life cycle. In addition, each of these phases provides opportunities for individual staff members to develop their equity understanding and capabilities.
- Employee relations: We aim to improve conflict resolution and employee relations processes to ensure staff have a clear mechanism and support to navigate interpersonal conflict, micro-aggressions, and harassment. In addition, we aim to improve underlying systems and interpersonal relationships that yield these kinds of encounters.
- Development, training, and coaching: Discussions around equity, racism, and sexism present new paradigms and concepts that are new for many. And, many of us have been taught that talking about these issues explicitly is not appropriate in the workplace. However, to make meaningful improvements, organisations and individuals have to set aside intentional time to learn about equity issues and develop the capabilities to make improvements. IHI staff participate in several trainings including:
 - ◊ Undoing racism – a training offered by the People’s Institute for Survival and Beyond which provides an overview of the history of racism and oppression with a focus on the systemic nature of these concepts.
 - ◊ Equity tools training – a training offered by IHI’s equity coaches and consultants that focuses on tools and methods for individuals to apply in their day to day interactions in service of creating a more equitable working environment.
 - ◊ Affinity groups or employee resource groups – a series of regular meeting times for staff to organise in groups based on their identity to discuss their experiences and find support in developing their equity skill set.

Our theory is that the combination of these efforts will advance IHI’s culture of equity resulting in a more representative and diverse staff that experience a working environment where they can thrive, ultimately for us to better reach our mission of improving health and health care worldwide.

To make all of this happen, a few requirements are necessary. Here are our lessons learned:

- Leadership at the very top must champion the work. Staff need clarity on where the organisation stands in its commitment to improving equity. This only happens when the president or CEO, board of directors, and the rest of the leadership team are steadfast in their communication and personal development towards equity goals.

-
- Dedicated resources in staff time and investments in trainings are necessary. Without dedicated individuals who have the responsibility to drive the work forward, it is all too easy for equity work to be left behind. Additionally, everyone in the organisation must see equity as their work.
 - Flexibility and continued tests of change. As equity work develops, expected and unexpected issues will arise. Responding to issues as they arise while also maintaining a focus on long term goals is necessary.
 - Accepting that the journey is not linear or easy. Beginning the conversation around equity requires addressing difficult realities. As issues arise, some of them will be handled well, while others will be mishandled. These short-term set backs are inevitable and should be met with humility and a further commitment to equity efforts.

10 Annex C:

2017 WRES data for the five pilot sites

Organisations name	% BME	Unify 2017 submission		
		Ind 2	Ind 3	Ind 4
Barts Health NHS Trust	52.2%	1.66	1.91	0.79
East London NHS Foundation Trust	50.2%	1.09	3.19	0.94
Sheffield Teaching Hospitals NHS Foundation Trust	13.0%	1.22	1.57	1.01
Royal Free London NHS Foundation Trust	46.5%	1.32	1.87	1.19
University Hospitals Of Leicester NHS Trust	29.4%	2.29	1.56	1.75
Peer Trust Median	46.5%	1.32	1.87	1.01
National Average	20%	1.57	1.37	1.22

Staff survey 2017				% BME Board
Ind 5	Ind 6	Ind 7	Ind 8	
31.9%	34.2%	63.2%	18.8%	22.2%
32.6%	22.6%	72.6%	13.0%	40.0%
21.5%	24.3%	74.8%	12.7%	0.0%
30.6%	35.5%	65.4%	17.4%	13.3%
21.7%	25.4%	71.1%	11.9%	13.3%
30.6%	25.4%	71.1%	13.0%	13.3%
28.0%	23.7%	85.5%	12.6%	7.0%