Evaluation of the NHS Workforce Race Equality Standard (WRES)

Report on Initial Evaluation, January 2019

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Report Summary

Background

The NHS Workforce Race Equality Standard (WRES) is a nationally-mandated system for NHS trusts to report the relative experiences of Black and Minority Ethnic (BME) staff compared with the rest of their workforce, on nine specific metrics. These results are then published and comparisons made between trusts in this respect. The WRES started in 2015, and at the time of this report data from the first three years are available. Much of the data shows relatively poor experience of BME staff compared with White staff.

This report details an evaluation of the WRES conducted mainly in 2018. This is an independent evaluation, conducted at the University of Sheffield, in conjunction with Lancaster University, with funding provided by NHS England. The evaluation seeks to answer the following questions:

1. What were the reasons for the introduction of the WRES?
2. How successful has the implementation of the WRES been (e.g. clarity of documentation, clarity of purpose, clarity of reporting, adherence by trusts to requirements)?
3. To what extent is the WRES accepted as a valid and reliable measure by relevant staff in NHS trusts?
4. How accurate and reliable is the data that trusts provide in relation to the dimensions assessed in the WRES?
5. Which trusts are doing least well in relation to levels of discrimination and climates of inclusion and what might be the reasons for their poor performance?
6. To what extent is change occurring across the NHS as a whole, following the introduction of the WRES?
7. To what extent has the WRES been responsible for that change?
8. Are there case studies within the NHS or elsewhere that can help guide improvement on workforce race equality within the NHS?

In this report, we present findings from four different streams of work seek to answer these questions. A further stage of this evaluation, to be completed in 2019, will investigate some specific related initiatives including the WRES experts programme.

Methods

There are four principal work streams that we have used in the production of this interim report:

- Telephone interviews with 12 senior stakeholders, including current and former members of the WRES implementation team, WRES strategic advisory group, and NHS Equality and Diversity Council

- Telephone interviews with members of staff in 15 trusts with full or partial responsibility for the WRES in their trust
- Telephone interviews with 16 senior leaders in case study sites and focus groups with BME staff in five case study sites
- Documentary research: analysis of minutes from WRES strategic advisory group meetings and NHS Equality and Diversity Council meetings, as well as other official publications; also, a rapid literature review on interventions in organisations to reduce inequality between racial groups in the workforce
- Quantitative analysis of WRES data from 2015 to 2018 alongside other NHS data

These methods are described in more detail in the relevant sections of this report.

Main findings

Introduction and implementation of the WRES

The NHS Workforce Race Equality Standard (WRES) was introduced in 2015. Its introduction followed a series of events and reports that highlighted issues with comparatively poor experience of NHS staff from a Black and Minority Ethnic (BME) background. A variety of reports demonstrated problems with race equality in the NHS, with one particular report, "Snowy White Peaks of the NHS", highlighting shockingly low representation from Black and Minority Ethnic (BME) groups at senior levels of the NHS in London, particularly on trust boards. Together these reports formed a clear argument that this needed addressing in order to promote better patient care. Following this, the introduction of a system of reporting on relevant metrics (which would become the WRES) was proposed to the EDC in July 2014, and ultimately the WRES (along with the Equality Delivery System 2, which focussed more on patient care) was included in the standard NHS contract for 2015/16. The WRES Strategic Advisory Group (SAG) was set up and first met in 2015 to guide and evaluate the implementation of the WRES.

A WRES implementation team was set up at NHS England. This team was designed to both direct what should be done by trusts in terms of data collection/submission, and provide support for doing this and for broader race equality improvement. In its first year, trusts needed to submit data on data from the NHS staff survey only – four indicators, based on existing survey "key findings". In each case the WRES looked at the difference between the experiences of BME and White staff:

- Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
- Indicator 7: Percentage of staff believing that their organisation provides equal opportunities for career progression or promotion
- Indicator 8: Percentage of staff experiencing discrimination at work in last 12 months

From 2016, these were supplemented by five other indicators, which would need to be recorded by trusts by other means:

- Indicator 1: Percentage of BME staff in each band and Very Senior Managers (VSM) compared with the percentage of staff in the overall workforce
- Indicator 2: Relative likelihood of BME staff being appointed from shortlisting across all posts
- Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process
- Indicator 4: Relative likelihood of BME staff accessing non-mandatory training and career progression development (CPD)
- Indicator 9: Percentage BME vs. White board membership

These indicators were based on a wide variety of research suggesting that these issues can be significant for organisational outcomes. Our findings to date show that the implementation of the WRES has largely been viewed positively. Most trusts have managed to submit their data fully, and in recent years in a timely fashion (which has been helped by the use of a central system for submission). There are some concerns about specific indicators, however, which are covered below. In addition, while the WRES has been welcomed as a positive force for change, there were also concerns about the speed at which the early development of the WRES took place, resulting in insufficient consultation.

The support for trusts provided by the central team at NHS England has been viewed positively. The relatively high profile of the WRES nationally has been key in establishing its acceptance within individual trusts. Several participants in the evaluation commented on how it was impossible for trust boards to ignore what was going on in the light of the data produced. The extent to which this is acknowledged further down organisational hierarchies is unclear. Our impression is that NHS staff at the "sharp end" generally are not aware of the WRES, or what it is trying to achieve. This is supported by the five case studies we have done in organisations from different parts of the NHS, which included focus groups with BME staff.

Acceptability and quality of WRES data

The nine WRES indicators are broadly considered as appropriate, and are thought to demonstrate accurately the inequalities that BME staff face. In general the data for each indicator are described as being easy to collect, with appropriate technical guidance, although there were some exceptions. The use of the pre-populated spreadsheets and the staff survey questions enabled easy data collection and there was evidence that trusts changed practice over the years in order to improve the quality of evidence provided, particularly in relation to the quality of staff survey data (where more trusts have been moving to larger samples or censuses to enable greater numbers of responses from BME staff).

There was some variation in how respondents felt about the appropriateness of some of the indicators, however. In particular, the staff survey indicators were seen by some as being too broad and insensitive to change (it can be very difficult to make a difference to staff perceptions on equal opportunities, for example). Some respondents felt that the focus on easily collected quantitative data was limiting and more should be done to measure the

broad cultural position of organisations. Overall, the expression of these contrasting views suggests more consideration would be helpful. We will explore these issues further but it would be wise for NHS England to continue to test and develop the WRES indicators to ensure they become more sensitive and helpful over time.

Concerns about individual indicators largely focussed on indicator 4 (non-mandatory training), where it was felt that the data would not be collected equivalently between trusts and the fact that there was not a standard definition of training that left responses open to (possibly biased) interpretation, and on indicators 5 and 6 (bullying, harassment and abuse from patients, and from staff respectively), where combining bullying with harassment and abuse was thought to make this indicator too blunt. Moreover, the lack of differentiation between sources of abuse (specifically combining "managers" and "other colleagues") in indicator 6 meant this was seen by some as unhelpful. In addition there were concerns raised about the low response rates to the staff survey in some trusts, particularly from BME staff.

There were additional concerns raised about the very specific focus of the WRES – examining only race at the expense of other characteristics. In addition, some participants commented on a "London-centric" focus of the WRES, meaning that it was felt to be less relevant for some other parts of the country where the ethnic mix in the population is different. One specific issue was that the WRES does not differentiate between White British staff, and White other – for example, Eastern Europeans who form a significant part of the workforce in some areas, and whose experience may be very different from that of other White staff.

Changes in performance across the NHS as a whole

Our analysis showed that, for three of the nine indicators, there was some statistically significant evidence of improvement over the three or four years of the WRES data collection.

Specifically, indicator 2 (relative likelihood of appointment from shortlist) dropped from about 1.69 to 1.56, meaning that whereas in 2016 White candidates were 69% more likely to be appointed from a shortlist than BME staff, by 2018 they were 56% more likely. Although a substantial improvement, this demonstrates that there is still a long way to go before parity is reached. In addition, virtually all of this change happened between 2016 and 2017, with very little change from 2017 to 2018. Moreover there is a need to ensure that the data match accurately what is happening in trusts perhaps by validating the data against other measures in a sample of trusts.

Indicator 7 (percentage of staff believing that their organisation provides equal opportunities for career progression or promotion) also changed significantly, from a ratio of 1.23 in 2015 to a ratio of 1.18 in 2018. This means that White staff were about 23% more likely to believe their trusts provided equal opportunities in 2015, but this gap had narrowed slightly to 18% in 2018. This drop was particularly strong in ambulance trusts. Again, though,

much of this change occurred early on in the period, specifically between 2015 and 2016 in this case.

Indicator 9 (proportion of board membership that is BME) had no significant change overall, but there was evidence of greater increase in London than elsewhere: over the three years, this had increased from 13% to 16% BME board membership, with no meaningful change in any other regions. In addition, there was a very slightly greater level of increase for trusts with a higher proportion of BME staff overall.

None of the other changes in indicators reached statistical significance. However, this is not a sign that things are not changing: in particular, it would be highly unlikely for changes made on the basis of the WRES results to take effect so quickly, and the instability of the change (e.g. more occurring in some years than others) is an indication that it would likely take several years to be able to view consistent changes. It is highly feasible that changes that are in progress may result in improvements in WRES scores in future years.

The WRES as a catalyst for change

Many of the participants in the evaluation thought that the process of data collection and reflection on its own was a worthwhile exercise because some trusts are now gathering information that has "opened the eyes" of many in the system, particularly board members to the situation in their organisations.

We also sought evidence of changes implemented as a result of the WRES. The extent to which trusts have acted on their data is extremely varied. Some have changed recruitment processes, including specific targeting of BME candidates for board membership, introduction of unconscious bias training, and inclusion of BME members on interview panels; some have introduced measures to create cultures of inclusion, including setting up BME networks and celebratory events; and some have increased the capacity for dealing with BME-related issues in the trust, including setting up specific job roles and teams to support and monitor equality and inclusion. As before, the WRES implementation team at NHS England are seen as highly proactive and supportive of such endeavours.

Despite this, there were various concerns raised about how much change would actually be achievable due to the WRES. One of the main issues highlighted was a lack of capacity, especially in smaller trusts. Another was about the (lack of) seniority of people responsible for the WRES in Trusts, particularly where WRES leads were lower grade staff who may not have the necessary experience or confidence to promote the WRES agenda. One danger of such situations is that they may reinforce rather than solve problems of discrimination in the NHS. And although some leaders were clearly strongly supportive of the WRES agenda, there were other trusts where the leadership was thought not to understand the issue, or not to be engaged enough to ensure a change of culture.

The five case study sites we looked at confirmed many of these issues. There was significant evidence of organisations taking steps to improve the experience of BME staff – either as a

direct result of performance on the WRES, or as a response to more general indicators of staff experience such as the NHS staff survey. Some of this has borne fruit already; some is in progress; but other efforts are proving more of a struggle, and in several cases BME staff on the ground in these sites were either unaware of such initiatives of sceptical about them. In particular the arms-length body included, which has only had one round of data collection so far, is at a much earlier stage in its journey. All of this indicates clearly that some efforts to improve the situation can require substantial time, effort and resources if they are to be successful.

Key messages

The findings show that many aspects of addressing race inequality are specific to individual trusts and the historical and local context in which the organisations operate is important. It is particularly important to consider that it is too soon to expect to see significant change in healthcare delivery and outcomes as a result of the WRES; this will take years to bear proper fruit, and it is still the early stages of that journey. However, there are some early indications of positive change, and there are some key lessons that can be drawn from the work as a whole:

- It is important that the WRES continues with the same commitment and momentum; it is vital to retain the same indicators and methodology so that trusts can learn as much as possible from their data, by monitoring change over time, and to help them embed the culture change that is needed to ensure greater race equality within the NHS
- It is essential that the future leadership of the WRES is considered a priority, both in terms of ensuring continuity at the national level in advance of the retirement of Yvonne Coghill, and in terms of decentralised leadership so there is more expertise at a local level
- In order to maintain positive views of the WRES, steps should be taken to ensure that "monitoring fatigue" is kept to a minimum by allowing greater use of existing data and procedures. This may be particularly important for other initiatives such as the new Workforce Disability Equality Standard (WDES).

1. Detailed findings from interviews

1.1 Methods for qualitative interviews

Interviews were conducted by telephone with 12 stakeholders and 15 WRES leads from NHS trusts, including Acute Trusts, Ambulance Trusts, Specialist Trusts and Community & Mental Health Trusts. Stakeholders included persons identified as instrumental in development of the WRES, and members of the WRES Strategic Advisory Group (SAG). Telephone interviews were also conducted with 16 staff (to date) within 5 case study sites, alongside focus groups with BME staff in each of the case study sites. Interviews were audio-recorded and transcribed verbatim. Transcripts were checked and analysed thematically, following the principles of Braun & Clarke. Analysis was undertaken at a descriptive rather than interpretative level, due to the nature of the commissioned research. Consequently, themes reported reflect the interviews schedules and were designed to address the specific research questions addressed within the proposal.

Invitations for Stakeholder interviews were sent out to 29 members of the EDC/SAG and 4 other people who were considered to be key to the initial development of the WRES.
Stakeholder interviews took place between November 2017 and January 2018 and interviews with trust leads took place between January and April 2018. Interviews and focus groups in case study sites took place mainly between April 2018 and November 2018.

Simultaneously, we conducted a documentary analysis of minutes from the EDC and SAG. Much of the material duplicated what we were told in the interviews, albeit with some extra detail provided. Therefore we do not present a separate analysis of this, but instead supplement the findings from the interviews below with information from the documentary analysis where appropriate.

1.2 Findings from interviews

This section of the report summarises findings from interviews with key stakeholders and trust WRES leads. This included 12 stakeholder interviews (referenced as SH01-SH12), 15 WRES lead interviews (referenced as WS301-WS3_15), and 20 interviews with senior leaders and five focus groups with BME employees at case study sites.

Themes are reported broadly in relation to the research questions and objectives set out within the proposal.

1.2.1 Understanding the rationale and reasons behind the WRES.

The understanding of the need for the WRES from both stakeholders and WRES leads was broadly categorised into 3 factors; the need to 'do the right thing' for BME staff in response to a wide range of evidence that demonstrated the gaps in experience between BME and white staff, an understanding of the impact that improved

experience for BME staff could have on the trust and patient care, and the need for 'something different' to previous attempts to address racial inequalities.

The majority of the stakeholders who were interviewed had some involvement with the setting up and initial implementation of the WRES. WRES leads were largely not involved in the setting up of the WRES and had varied knowledge of the history of the WRES, although some had some involvement with the wider WRES Strategic Advisory Group (SAG). A common understanding of how the WRES had come about related to the publication of the "Snowy White Peaks" report and other research highlighting inequalities that provided an understanding that BME staff were having a worse experience than white staff. In particular, consideration by the EDC in July 2014 in response to this report, and a working group considering multiple other sources of relevant evidence, led to the proposal for the introduction of a WRES, and the proposal to embed this, and the Equality Delivery System 2 (EDS2), into the NHS Standard Contract.

Several respondents, when explaining their understanding of the reasons for the introduction of the WRES, quoted indicators around the absence of BME staff on trust boards, and the need to 'close the gap' in experience. Other sources of evidence, including the work of West and Dawson, were referenced in recognition that improving BME staff experience was not only the 'right thing' to do, but could also benefit the trust due to links to improved patient care and staff retention.

Participants also understood the need for the WRES based upon their own personal or professional experience, or more often from knowledge of, or working within other environments where disparities had been addressed. Staff also brought their own experience from other settings and cultures, to help them understand how things could work better within the NHS.

WS3_06: We employ a lot of people from the local area, and so we're missing a huge trick really so my previous organisation was [Name] City Council and when I worked there we had a very strong focus on equality and diversity. We had the BME staff network and when I came here there was nothing like that in place

1.2.2 How did it happen?

The need for a different approach and less of the 'same old, same old' of previous approaches to dealing with race inequalities in the NHS was widely recognised by stakeholders and WRES leads, in particular a need for a move away from the previous 'deficit model' (i.e. the idea that race inequality is caused by a lack of knowledge or skills of BME people, and is best addressed by providing training and education to them to make up the deficit). This recognition of the need to undertake more decisive action was identified by key stakeholders in particular, and was critical to the decision to move from "training champions and warm words" (SH07) to providing a mandate, and linking with CQC to force change. This mandate was widely recognised by both stakeholders and WRES leads as a key enabler to making change, due to the NHS culture of "what gets measured gets done" (SH03).

SH06: So we've got the evidence base on one side which should be winning hearts and minds and getting people to do it for the right reasons, but we've also got the teeth to bite them up the back side if they don't do it for the right reasons.

Whilst some stakeholders reported changes beginning under previous NHS leadership, the influence and commitment of the NHS England Chief Executive Simon Stevens was widely recognised as a key catalyst. The development of the WRES was described as the culmination of a 'perfect storm' of volume of evidence, committed leadership from NHS England and the commitment of other key personnel who would go on to lead the WRES team and drive the initiative forward. The commitment from the NHS England Chief Executive meant that the project could get the mandate that was needed to make a change and, importantly, the funding to help work get underway.

SH02: So with the plethora of reports that are telling us that compelling story about BME people within the NHS, and the inequity as to how they're treated... I can't think of a particular event really that, I think it's more the data and the evidence. I think it's important to stick to the evidence.

1.2.3 Implementation

The initial conception and development of much of the detail of the WRES were largely recognised as having been initiated by key members of the WRES Implementation Team (initially led jointly by Yvonne Coghill and Roger Kline) and the Strategic Advisory Group (SAG). Whilst several participants praised the development of the WRES as a much-needed positive force for change, some mentioned areas where stakeholders and members of the SAG disagreed. Some participants perceived the early development of the WRES as having been conducted too quickly and without sufficient consultation. Participants reported some initial resistance e.g. from Trade Unions, and people who were concerned that race was selected over other protected characteristics. Resistance was also reported from some who advocated for broader cultural and behavior change to happen rather than focusing on a small number of measurable indicators.

Whilst most stakeholders expressed similar views regarding the rationale behind the WRES, and the need for the different approach propounded by the team who set up the WRES initially, there were some dissenting voices who were more skeptical of the 'just do it' approach, and advocated wider cultural change initially.

Participants reported that some senior NHS leaders had expressed concern about a perceived London-centric nature of the WRES, and of some of the evidence that led to it. This was essentially an observation that the issues highlighted by the WRES are most germane in those organisations that have a substantial proportion of BME staff, which are more highly weighted in London and some other large cities. In other areas (e.g. more rural areas with a lower BME population) concerns about race inequality, although still important, were seen as less salient than other concerns, e.g. disability inequality. Some participants felt that decisions had been made at a central level and

did not necessarily take account the different culture and demographics of London compared to the rest of England. It is important to note, however, that even in areas with lower BME representation, the clinical (particularly medical) workforce often has a higher proportion of BME staff, which gives rise to a greater importance of the WRES.

Despite these concerns, there were relatively few worries about the implementation of the WRES overall, and it was considered to have been a successful implementation. The WRES Implementation Team were widely recognised as having done a substantial job in embedding use and understanding of the WRES both within trusts, and within national bodies such as the Care Quality Commission. In particular the embedding of the WRES within the standard NHS contract, within the Five Year Forward View, and within the CQC well-led inspection domain were seen as major achievements, as were other partnerships developed by the WRES implementation team. There were some more concerns about specific details within it, which are explored in the following sections.

1.2.4 Accuracy and reliability of data

Are WRES indicators considered valid measures?

Decisions about the content of the WRES were understood to have been made in response to evidence, but were also principally "driven by the data" (SH02). The evidence considered included both published research evidence (the WRES web site includes links to a range of papers and reports that underlie many of the decisions), and also from regional workshops carried out across the wider NHS. To some extent, though, the content was informed by pragmatic considerations of the use of readily available evidence to ensure trusts could provide data easily and enable implementation.

WRES leads understood the indicators to have been chosen to cover a range of experiences that were different for BME and white staff, based upon readily available data, and frequently quoted the experiences that they were designed to highlight (e.g. BME staff less likely to be appointed from interview). The indicators were broadly considered an appropriate group of indicators that demonstrated the inequalities that BME and white staff were facing and were generally described by WRES leads as being easy to collect, with appropriate technical guidance, although there were some exceptions (detailed below). The use of the pre-populated spreadsheets and the staff survey questions enabled easy data collection and there was evidence that trusts changed practice over the years in order to improve the quality of evidence provided, particularly in relation to the quality of staff survey data.

Indicators were defined as being useful in terms of both how accurately they highlighted the problem, and how they actually promoted action i.e. how they could lead to actions that could change performance, without the need to further explore the stories behind the indicators. Whilst some indicators (e.g. likelihood of appointment) were felt to provide enough information to enable action ('you can't argue with them'), other indicators (e.g. bullying & harassment, training) were

considered less useful as they were too broad to provide a meaningful picture and too insensitive to enable action.

WS3_09: So questions that produce an opportunity to understand what's going on and therefore provide solutions are good. If they're just questions for the sake of questions it doesn't help anybody

The broad measures were recognized as lacking sensitivity, particularly for certain indicators, and were considered to be just a 'starting point' for understanding the problem. Some participants expressed frustration at the limitations of the measures in terms of enabling action, perceiving the data to be too basic and of limited use. Others accepted the insensitivities within the WRES as they perceived the indicators to be there to 'paint a picture', and provide the data that would highlight inequalities. The indicators were described as enabling discussions, and their value was to highlight problems, prompt further (qualitative) research to understand how they could be improved and enable actions to be developed.

WS3_02: I think the process is fine. I think the attention is right, a limited group of metrics is very useful way of establishing some statistical facts. What you need then is the casework and the context to go round it

Are indicators measuring what they are supposed to be measuring and being measured in a comparable way across organisations?

Indicators that were seen as less appropriate were those that were considered to be more insensitive, and which needed further exploration in order to understand how they could be improved. Some indicators appeared to have limited internal validity (i.e. they were not considered to measure what they intended to measure), whilst there was just one indicator (4) that was considered to lack external validity (i.e. may not be providing comparable data across all organisations).

Indicator 4 (staff training) was considered to be useful in that it could measure supportive management, but too broad a measure, and not sensitive enough to incorporate consideration of, for example, unconscious bias (i.e. the limited self-belief that may stop BME staff applying for training), or BME staff being given less encouragement than their white counterparts. The data in itself was not considered accurate, partly due to different ways in which trusts collected the data and differences in measures included due to the broad definition of the indicator. The data was described as "a bit made up" and open to interpretation as to "what's in and what's out" (WS3_03) and was therefore not considered an accurate measure with which to benchmark.

Indicator 3 (formal disciplinary process) was similarly reported as difficult to collect due to differences in recording between trusts, and may lack sensitivity as the data focuses solely on formal disciplinary procedures, and doesn't capture other important aspects of disciplinary action, such as performance management. Similarly, indicators relating to bullying and harassment (indicators 5 & 6) were felt to provide limited useful data due to the broad definitions used. The amalgamation of 'bullying' and

'harassment' was considered inappropriate, partly due to different interpretations of what the terms could mean, but also due to the different experiences of a member of staff who has been bullied, and one who has been harassed. Again, this indicator was felt to fail to account for normalised harassment, in which BME staff normalise levels of harassment that white colleagues may not consider acceptable. Importantly, it was felt that indicator 5 should separate out bullying and harassment from peers or from senior colleagues.

Are WRES indicators appropriate for benchmarking all trusts?
There were some concerns about the 'one size fits all' nature of the WRES, which was considered to be London-centric and not necessarily as appropriate for other communities. trusts with few BME staff felt that the impact of the small numbers used to generate percentages did not provide appropriate benchmarking data. Most trusts within this sample had moved from undertaking the staff survey on samples of their population to their whole workforce, partly to get round the problems associated with low numbers. However at trusts with very low numbers of staff identifying as BME changes in indicators could be skewed significantly by individual cases and it was not felt that statistics were 'like for like' with larger trusts with large BME workforce.

WS3_02: Although once again there is a sort of one size fits all feeling about it. […]the numbers we were using were so small for one of two of the indicators. They were virtually meaningless but when you put it down on paper, the ratio looked awful. When you actually dug down it was next to meaningless […] whilst I understand in an area like London, […]if it's a two to one ratio in London, that's considerably different than a two to one ratio here. Not that it justifies anything. It has to be proportionate and I think sometimes you look at the results of the WRES and it's slightly out of context

These concerns about 'one size fits all' were also related to WRES definitions of 'BME', which were felt to exclude experiences of racial discrimination faced by white non-British staff who may be experiencing similar inequalities as staff who were defined as BME. This was particularly considered problematic at trusts whose workforce included low proportions of BME staff, but high proportions of white ethnic groups (e.g. eastern European).

Some WRES leads were frustrated at the perceived requirement to spend a disproportionate amount of their time on one protected characteristic, potentially to the detriment of other protected characteristics that were more prevalent within their organisations. However others at organisations with higher proportions of BME staff reported that improving benefits for BME staff would improve awareness of E&D issues and provide indirect benefits for staff with other protected characteristics.

Other characteristics of particular types of trust emerged as potentially not enabling comparable data between different trust groups. For example, the low numbers of staff at grades 8+ within ambulance trusts overall meant that reporting data into individual grades was not considered appropriate.

Do the indicators represent an accurate picture of BME experience?

Whilst the WRES indicators were broadly described as a useful set of indicators, they were not always considered comprehensive in terms of covering the spectrum of experiences that are different for BME and white staff. There were some concerns that the WRES data was too narrow, "not granular enough" (SH09) and needed wider data collection, although the limited number of indicators was largely recognized as being necessary in order to retain the balance between usefulness of data and burden of data collection

Some participants suggested additional indicators which they felt may be of value. An additional indicator relating to retention was considered to be a potentially useful indicator of staff experience which could demonstrate cultures of inclusion; "you can't have recruitment without retention" (WS3_03). Further indicators also included a indicator reporting whether the workforce represents the local community, and the "sticky floor" (SH01) indicator; how long BME staff stay in post compared with white counterparts.

There appeared to be a level of dissatisfaction with the purely quantitative approach of the WRES from some participants, arguing that the need to measure experiences that were measurable, necessarily excluded less measurable but equally important experiences that may represent experiences of BME staff more accurately.

WS3_01: So a lot of the things I mentioned earlier, about the things that aren't so easy to measure are actually the more meaningful things and but I don't think any time's been invested in learning how to measure those things, it's just been a case of, well we can't do that now, so we'll get on with what we can do. But actually, if we're really going to change the culture of, you know, what we're, of the NHS as a whole, I think that's some of the stuff we need to invest some time in and understanding how we measure what we think is unmeasurable.

However, within case studies, senior leaders discussed the importance of using the WRES metrics to highlight where problems were, then use these indicators to explore the problems in more detail, by engaging with BME staff and understanding what the metrics meant in terms of lived experience. Staff spoke of the need to 'triangulate' the WRES metrics with qualitative data using staff stories and not use the metrics as an end in themselves.

Overall, therefore, the indicators were seen as useful and appropriate, and despite some specific concerns (particularly around indicator 4), others were widely praised, including the use of staff survey indicators which are gathered with a very solid methodology and often considered as very high quality data.

1.2.5 How successful has the WRES been in initiating change?

Participants characterised the success of the WRES in terms of implementation of the indicators, and changes made in practice as a result of the WRES. Success was defined on four levels: collecting the data, using the data to demonstrate the

problem, acting on the data, and engendering change for staff on the ground. Whilst there was variety in perspectives of the degree to which the WRES has achieved its aims, there was a widespread perception that it was the best attempt to deal with race equality that has happened to date.

WS3_09: But I think it's been very progressive, I think it's achieved far more in the 3 years that it's been in place, far more than it, than anything else

The degree to which WRES had an impact on BME experience appeared to depend on the level of prior trust engagement with the E&D agenda. Trusts who were already engaged and making changes felt that WRES added focus and increased the priority of E&D at board level. Others felt more strongly that changes would not have happened without WRES as the catalyst.

Collecting data and enabling benchmarking
Achieving the task of obtaining comparable benchmarking data for the 9 indicators across all NHS trusts was broadly seen as worthwhile and a success in itself. Despite some frustrations at initial teething problems and small changes to how indicators were collected over the first two years, the processes for collecting data were generally seen to be straightforward and not too onerous, with the exception of the training indicator (indicator 4). Some trusts did not have the means to collate data for indicators 2, 3, and 4 prior to the WRES and were unable to submit adequate data in year 1 but had set up processes to enable easier data collection for years 2 and 3. The process of completing the WRES return and the problems highlighted in terms of low numbers of staff survey returns led to some trusts changing their processes for collecting staff survey data. In particular, several trusts moved from sample surveying to whole population surveying. One trust described how they ran focus groups with BME staff to enable them to understand how their staff data fed into the WRES itself, in order to encourage completion.

SH03: What I think is important is that we're gathering the data. I almost think, it's almost a measure of importance that we are gathering some data and we will continue to spiral down and improve the nature of that data and the indicators

However, there were some concerns that the data collection was being seen as an end in itself, and not generating actions that could help staff on the ground, with participants reporting other trusts to be using it as a benchmarking exercise, but not drilling down into the data to try to understand and take action.

WS3_04: I don't think it's perhaps maybe been what it was intended to be.
Interviewer: Right, in what way?
WS3_04: I think for a lot of trusts it's turned into a little bit of a tick box exercise and a reporting exercise but I don't think it was ever intended – my impression is it was intended to support and help, whereas it's turned into a bit more of a statistics gathering exercise and, I suppose, really, it's turned into a little bit of a - shall we say – a scoring for the trust.

The use of WRES as a benchmarking tool also enabled staff in poorer performing trusts to look elsewhere to understand what other trusts had done to reduce race inequalities. In particular, both senior leaders and BME focus group participants within the case studies talked about other trusts who they considered to be examplars to understand what they had done to make a difference.

WS5_10: It's useful because it allows us, for example, to compare with peers, for example 'why is x hospital doing better than Y hospital'? Again, it allows us to go back and have some of those conversations [...] bothe at board level in terms of with our senior managers, but also across, for example, with other HR directors in [Region].

Opening eyes and raising the profile

There was a widespread perception that the WRES had been successful in terms of translating the rhetoric around race inequalities into facts that could no longer be disputed by Senior Leaders within their own organisations. Stakeholders and WRES leads described how senior board members may not feel that the problem was applicable to them, but were not able to dispute it when confronted with the raw data of the WRES. They described how they had "become blind to things that are shocking" (WS3_03) and WRES had forced them to accept that there were problems. In particular, BME focus group participants reported the WRES as giving them a voice as the data supported the stories that they had been trying to explain to managers for years previously.

Similarly, WRES leads described how the information from WRES had 'opened their eyes' personally to what was going on, and revealed areas of discrimination that they had not considered previously, even when undertaking Equality and Diversity (E&D) lead roles.

WS3_14: The disciplinary one really shocked me, in terms of what it is telling us nationally, that more BME appeared to be going through the disciplinary process than non-BME, and that was the one that I thought before 'I don't know why we're collecting that one because is that really going to tell us much?'

This raising awareness was felt to enable staff to have the 'race conversations' (WS3_03) that had previously been avoided, and encourage staff to think about what the indicators meant. In particular, WRES was described as "getting the attention of the board", helping to put race equality on the agenda at board level, or push it further up the agenda for the board at trusts where this was already being discussed. WRES was described as a "great conversation starter" and enabled E&D leads in trusts who had previously struggled to get engagement from the board to take this seriously.

WS3_09: So for me what WRES has done is it's opened up a discussion at board levels for the most part and every trust is now having to give some thought to it. Whereas before they never did.

Acting on the data

WRES leads described a wide range of actions undertaken to try to improve the WRES indicators and the experience of BME employees. There were considerable differences in the level of action that had been undertaken in response to the WRES data, possibly related to the degree to which the race agenda had been considered prior to the WRES, but also due to the level of engagement of senior management. Actions undertaken included specific actions to encourage BME board recruitment (changes in recruitment processes, identifying specific BME staff), actions to improve indicator 2 (unconscious bias training, BME representatives on interview panels) and interventions to improve BME experience and creating cultures of inclusion (e.g. setting up BME networks, celebratory events around different cultures, black history month). Some trusts also described improving the resources available to undertake work relating to E&D within the trust, including recruitment of staff to oversee the E&D portfolio.

WS3_07: So one of the other actions that has come out of the WRES, which is very clear and I think is financial investment from the organisation, so we are recruiting an equality, diversion and inclusion team, which we don't previously have.[…] It's a commercial investment which we're making in times where financially we are under a lot of constraint. So that's another clear indicator. It's come purely from the WRES by doing that, because it's raised its profile.

Although a range of actions were described by WRES leads, there appeared to be some lack of clarity around the actions that could initiate change, and some participants reported frustration that organisations were undertaking certain interventions which they perceived to have little impact, e.g. unconscious bias training. Despite a wealth of research underpinning the rationale for the WRES and significant research into how organisations may improve their performance, some participants felt that there was a need for more comprehensive understanding of what works and what doesn't work.

Has WRES made a difference to staff on the ground?

Stakeholders generally reported that whilst WRES had been successful in terms of highlighting the problems, it was too early to expect changes to have had significant impact for staff on the ground. However, some WRES leads described how they felt staff may notice some impact of the WRES, largely due to improvements in communications regarding inclusion, feeling more 'listened to' and more able to speak out against discrimination. The WRES programme has established the WRES Frontline Staff Forum to address the lived experience of race inequality upon frontline staff, and the impact that the WRES is having at that level. Other participants recognised that although staff may perceive some differences to their experience, it was unlikely that they attribute these changes to the WRES. Within the case studies, focus group participants had been involved in implementation of WRES due to their involvement in BME staff networks but felt that staff who were not involved in the networks were not aware of WRES.

There appeared to be a lack of clarity around timescales for change or time objectives relating to expected changes in indicators. Some trusts used quotas or targets (e.g. for BME board representation) within their strategic objectives in order to impose a measurable timescale for change. Whilst some participants spoke of disappointment at the lack of change on the ground, others perceived that it was far too soon to expect to see any change. Indicators 1 and 9 in particular were expected to require longer before changes in indicators could be expected, due to the need for opportunities for promotions to arise, and the need to expand the pool of BME staff who could be given opportunities for promotion. Similarly, other indicators were expected to take longer to demonstrate change due to the need for an underlying culture shift.

SH06: I still think it's a ten year journey, I kind of don't think it's been successful in other, in many regards, it's kind of got the early groundswell but it hasn't got the output that we want to achieve yet. It needs more sustained funding for a period of time which as you know, culture change takes ten years and we've been doing it for just over two.

Again, uncertainty around how long interventions would take to produce results led to concerns as to when changes should be expected. Some WRES leads reported attempts to increase, for example, BME board participation, but still being unable to recruit BME staff to the board or recruit BME staff. They were unsure whether this was because the measures taken were ineffective, or because the timescale was too short. In other areas, staff reported that WRES indicators had already changed due to specific work that they had undertaken in that domain as part of their WRES action plan.

WS3_09: So all in all we've done quite a bit of work around that [recruitment] and we've now got that figure [indicator 2] down to 1.4 times less likely. So it's moving in the right direction and that's what I was saying about when you produce an action plan. If year on year nothing's changed, then the action plan's not worth the paper.

Within the case studies, the BME focus group participants from the trust who had made more significant and sustained changes referenced most improvement in BME staff experience (case study 1). Staff felt that the collective actions to improve race equality had increased the visibility of the E&D agenda, and made 'difficult conversations' about race more acceptable and easier to instigate. Importantly, they felt that the higher visibility of E&D agenda coupled with the presence of BME board members made it easier for them to speak up about discrimination. However, BME staff at other case study sites where the action plans had yet to be fully implemented felt there was little discernible change to their experiences, with further work required to change ingrained cultures.

Attributing success to the WRES
There was universal agreement from all data sources that WRES was helpful in opening eyes and putting race equality on the Board agenda. However, attributing any changes to staff experience to the WRES was complex, as changes made due to WRES occurred within the context of wider E&D change programmes that were taking

place to different extents within trusts. Trust leads described different levels of engagement in the agenda prior to the WRES, with some trusts already having action plans in place and undertaking initiatives to improve workforce race equality.

Other trusts described developing initiatives as a direct consequence of the WRES, having 'opened our eyes' (WS3_02). However, even when the E&D agenda had already led to actions prior to WRES, leads attributed some of their success to the WRES, which was described as giving them 'extra oomph' (WS3_06), and enabled them to integrate their existing work with the WRES action plans.

WS3_07: So, it's not necessarily because of the WRES, it's because as I've said it was an agenda we were already working on, so I wouldn't like to give the WRES the credit for it, we were doing it anyway. So some of the things, but what it helped us to do, it helped us to use that as a vehicle to piggy back on to raise its profile in the organisation. So for instance at the board it gets more actively discussed where previously it wouldn't have been discussed.

In particular, the WRES was seen as giving a focus to the board and a specific mandate to action, particularly when race inequality had been "on the agenda for years" without any changes actually being made (WS3_15).

1.2.6 Barriers and enablers to implementation and embedding of the WRES

A number of barriers and enablers to the implementation of WRES were reported within the interviews and may give some insight as to how WRES may have enabled change, and barriers to further change. The case studies demonstrated that the level of action in response to WRES within each trust was variable, with some action plans maturing and making a difference to staff on the ground, and others still in embryonic stages. These differences could be attributed to a number of factors which are discussed below.

Enablers were reported in terms of influential people who supported the WRES, passionate people who implemented it, and data to support the theory and narrative behind the WRES. Barriers related to problems with engagement, resource implications, and concerns about the wider environment.

Engagement of leadership

Leadership was widely referenced as the driving factor in enabling WRES, and engaged leadership and commitment at board level were seen as critical for driving change. Commitment at board level was felt to enable E&D leads to progress beyond developing an action plan, to implementing the action plan. However, there was a clear distinction between leaders who were perceived as paying lip service to promotion of race equality, and those who were doing it because they really believed it was the right thing to do, and whose personal values were aligned with the E&D agenda. One focus group participant explained 'it comes from within', and there was some suggestion from staff interviews that lived experience of inequalities helped leaders to really understand the agenda.

WS3_09: But actually for me the bigger point here is that, as I said, if you think about a well led domain, if a chief exec is demonstrating commitment to it, then it's likely to have more chance of success. Because where the leader leads people follow, you'd be a brave person to challenge if he's [chief executive] saying this is important.

Participants who described high levels of engagement from their board talked about how the WRES was being embedded; true engagement from the board led to them really listening and taking action. This participant describes how having true engagement from the board has moved the focus on from just knowing about what needs to be done, to caring about what needs to be done.

WS3_07: So it's no longer me talking about it, other colleagues at the board are saying 'how are we doing on it'?

Two of the case studies with poor WRES metrics and more embryonic action plans described how the stabilisation of the board was key to establishing the leadership that was needed to take the E&D agenda forward. Case study 2 described a previous board who had had little commitment to E&D, whereas case study 3 described a board that relied entirely on interim positions and similarly had not made E&D a priority. Both case studies had new boards who had appointed new senior E&D leads to move WRES forward. They recognised the need to demonstrate commitment to the agenda, and to commit resources to enable action.

CS5_10: I think we've got a different team who have got a prioritised focus in the BME space. The data that at the present moment we've got, it is for a period that actually none of us were here. I think for an organisation that employs [x] employees, for the organisation as it got into financial trouble, it started taking all vacant posts out. To take out the only post that was focussing on diversity just was an own goal. [...] So, we've had nobody really looking at this and driving the agenda. So, one of the first tasks is I had to make a business case as to why I'm putting another post into the establishment when we're in £83m of debt.

Wider staff engagement

WRES leads reported different levels of engagement from senior leadership teams, and particularly the chief executive but also revealed some differences within their own engagement with the WRES agenda. The degree of commitment to driving through change appeared to differ between participants, with some being passionate advocates of the need for change, and others feeling frustrated at the focus on WRES to the detriment of other protected characteristics, particularly in areas where there were low BME populations.

Continued perceptions of the WRES advocating positive discrimination and a lack of understanding of the differentiation between positive discrimination and positive action may hinder engagement with the WRES. This was noted particularly within BME groups who were reported by some WRES leads to be reluctant to participate in BME staff networks and engage with the WRES due to a perception of being 'singled out'.

WS3_07: P: I think the barriers are a lot, not all BME staff think it's actually the right thing to do. I've had feedback on that.
Interviewer: Can you elaborate on that?
WS3_07: Because they've said there's not a problem, why are you raising it, you're making out there is a problem by starting to come out with these issues. So some BME staff are not actually keen on it, whereas others may be. So some of the barriers are getting that complete engagement.

Some participants were also wary of appearing to favour race over other protected characteristics, although others understood equality as a value that should be promoted regardless and expressed frustration that people were treating different characteristics as a 'competition'. They felt that an improvement in experience for any protected characteristic will contribute to improved experiences and equality for all.

WS5_05 To me, equality is a value and it's something deep in your heart and you live it and you breathe it and it extends to anybody with a difference. There was a conversation informally with my peers in the office that I was in, and it came up again because there was something about race equality, and somebody said, 'Oh well, what about the LGBT community, or the disability community? It's our staff with disabilities who have an even worse experience', and it's that same theme though, it's about competition. So, it's recognising inequality but then there's people with even deeper inequalities, why do we just have to focus on this? I remember saying, 'But we need to get the Disability Network up and running and the LGBT Network just as quickly now. I hope one day we move to a Humanity Network so that we can all be in it', because I think fundamentally it is about human values, isn't it? We have far more in common than we have in difference, but it's about creating enough safe space for us to feel and be comfortable in our difference as well.

The case studies reported problems in ensuring that the values and commitment from senior leaders were enacted throughout their organisations. In particular, they reported difficulties with middle management, who did not have the same level of commitment that was being described by senior leaders. BME focus group participants described how bullying and harassment was being tolerated by middle management and the clear policies that were advocated by senior leaders were not recognised further down the organization. Even where there appeared to be committed leadership and widespread actions, staff felt there needed to be increased visibility of E&D and stronger messages from the board in order for middle management to engage.

Understanding lived experience to understand the agenda
Communication of stories and evidence were reported to be important in engaging staff who did not fully understand the agenda and key to countering perceptions of positive discrimination. Understanding of the research underpinning the WRES was considered important, but also the value of the narrative around why improving the experience of BME staff should benefit the organization. Communication of stories of lived experience, both from the WRES team and from individual BME staff within trusts was considered to be key to achieving engagement and change from Board members, and wider staff.

I think having the theoretical knowledge behind it has been important so, you know, I keep talking about this but I do think Mike's stuff is really brilliant. So that's important, you know, and having and using that to have the right narrative around this as to why we're doing it. It's not just 'so you're good to black people', honestly it's not. I think has been a really important enabler too.

One senior leader at case study 5 felt that the WRES statistics alone were seen as shocking, but not personal enough to generate sufficient shock to prompt action, and needed to be backed up with stories that 'pull at the heartstrings' (WS5_20). BME interviewees also reported how understanding the agenda helped them to personally understand inequalities, and to understand how they are not being 'singled out' as a group, but being given opportunities to experience improved equality.

I: so just going back to what you said about the you know it's interesting that that you didn't want to do it [fast track programme] because you perceived it as positive discrimination. So do you think something about really understanding the story behind what it all means? WS5_12: At that time you know, I was a lot more you know junior and I just didn't understand it so whether you know those, it was a number of years ago now, whether the messaging wasn't quite right because it didn't resonate with me. I didn't want to be put in that group, needed fast tracking or needed additional support because I felt I needed to do it on my own merit and that's. But that could be just my understanding at that time or the message wasn't right and like I said it took something like that powerful slide to make me understand it actually. But maybe some people would understand it from the beginning anyway and maybe it was just me. I can't believe it would just be me.

Interestingly, at case study 4 there was no BME network due to staff resistance to being singled out. Here, the BME focus group participants had limited knowledge of WRES or race inequalities and did not provide significant evidence of discrimination that were described at other case studies, despite inequalities being highlighted within WRES data.

Proximity to the board

The proximity of the WRES lead to the board, and the seniority of WRES lead also emerged as potentially important factors in enabling implementation of the WRES and developing meaningful action plans. WRES leads described having to be 'brave' in talking to the board about reporting facts that the board may not be comfortable with. Participants who reported directly to a board member were reported to have fewer "blockers" (WS3_05) to being listened to by the board and trusted to make changes needed.

WS3_03: …So therefore if you're asking a band 5 to go and challenge a board about its data how successful are you really going to be. You know, I literally met a band 5 who's expected to go to the board, not that Band 5's are not capable of that, but what I'm saying is how do you expect them to challenge the board and hold the board to account? I used to say to my previous chief exec, 'treat me like a critical friend, you're not going to like everything I say!' (laughs) […] But he didn't, he really didn't like everything I said. So that is my role. But lots

of equality leads have not got that kind of courage because at the end of the day it's your job and you can't pay your mortgage.

Both case studies 2 and 3 referenced the seniority of their new E&D leads as key to achieving success in moving the WRES data and the E&D agenda forward, as well as demonstrating commitment.

Resistant culture
Whilst most WRES leads spoke positively about the impact of WRES upon their ability to get the board to 'sit up and listen', some spoke of a culture that was too entrenched to change, where even the demonstration of data could not prompt the 'pale, male, stale' boards to act. This WRES lead spoke of the 'cliquey' nature of the board, in which board roles were given as 'jobs for the boys'.
.
WS3_12: There's a real boys club culture and I still see that even today. You know, even in the Trusts that I've been in there's a lot of not getting what this is agenda about and there's a lot of white pale male stale people up there too. And I'm not saying that they're not doing a good job in other areas, they just haven't been able to grasp what this agenda is about and you kind of have to shock them into looking at the data and actually thinking what it means and what it means is not good. So yes, I understand why it's there and I think it's been a really good thing to happen, It's really great to have the benchmarking data and to be able to explain to people what it means - and there's an aspect of denial. I think it's trying to tackle the clubiness and the denial that is going on

This same lead spoke of frustration at even the use of stories not being able to get the full commitment and engagement of the board.

WS3_12: Even though we've got this amazing tool, why aren't people still listening?

The difficulties with overcoming resistant culture was referenced throughout the case studies. BME focus group participants talked about how attempts to change recruitment processes in order to improve equal opportunities were sidestepped as people continued to offer job opportunities to friends and family, and how middle management were not challenging inappropriate behaviours. The culture of widespread racism reported within some trusts meant BME staff morale and expectations were low, and they had limited trust that change would be forthcoming. Even where the leadership were considered to be committed, and changes had started to take place, staff appeared to need convincing that actions were not tokenistic.

Importance of senior engagement from NHS Leaders/WRES team
Senior buy-in to the WRES, both at Trust level and NHS leadership level were seen as enablers to the success of the WRES. The high profile leadership from the NHS Chief Executive, and the 'trusted brand' of the WRES team and SAG were felt to empower WRES leads to get the backing from the board that they needed. Wider talk about workforce race inequalities from senior government leaders on various platforms,

including the governmental response to the Windrush scandal, also helped to increase the profile of the E&D agenda at a wider cultural level.

The engagement work from the WRES team at NHS England was considered beneficial to implementation of the WRES, partly because of the dissemination of the "lived experience" (WS3_13) stories which helped boards understand the narrative behind the data, but also due to the "consistent language" (WS3_06) that WRES provided, along with opportunities to network and learn from E&D colleagues. The opportunity to attend forums and be involved with the national steering group were felt to be useful learning opportunities for E&D leads, who welcomed the opportunities for collaboration that WRES provided.

WS3_01: I guess coming up with the WRES has spawned a conversation amongst organisations just to give you something more tangible to use sort of when you're looking at measuring equality and diversity

Engagement of arms-length bodies

In contrast to the commitment of Simon Stevens and the WRES team, concerns were raised about the commitment of arms-length bodies. In particular, the racial profile of arms-length bodies and issues of 'cliqueyness' within their boards meant that some participants questioned the commitment and engagement from the organisations who were holding them to account.

SH06: I think they've [arms-length bodies] given us symbolic leadership but they've not been transparent about their own data. And I don't think they're role modelling what we are preaching to the rest of the system.

One of our case studies was in an arms-length body (see section 2.5). In this organisation there were clear problems for BME staff working within it, and poor WRES metrics in 2017 resulted. By including arms-length bodies in the WRES (and publishing their results separately) it may be that they are forced to take greater notice of what is going on more widely within the NHS, which may alleviate some of the above concerns.

Wider cultural influences and resource implications

Wider environmental changes that had emerged alongside implementation of the WRES were cited as barriers to the success of the WRES. Wider societal change, notably an increase in racial intolerance, attributed partly to Brexit and a wider culture in which racism was unchallenged were felt to be counter to the work of the WRES. Some participants highlighted the need for WRES to take place within a programme of wider multifactorial work to address race inequalities that exist throughout other areas of the public sector and wider society. One participant described WRES as "trying to fix the problem that lies within the whole of society" (WS5_20), with WRES addressing the symptoms, but not the causes of racism.

The impact of resource restraints within the NHS and pressures within individual Trusts and the wider NHS were felt to detract from the priority being given to the WRES. External pressures were perceived not only to affect implementation due to a

reduced focus from senior leadership teams, (including the Chief Executive of the NHS) but also due to the lack of funding for E&D leads, and staff to undertake some of the action plans generated from the WRES. This was particularly noted at smaller Trusts where funding for specific E&D leads was not available and HR staff were expected to subsume the role into their job.

The impact of financial restraints and other pressures were reported particularly within case studies 2 and 3, who had both been in special measures and had recently undergone significant board restructures to try to address problems within the organization. At case study 3 in particular, the pressures of resources and being in special measures were felt to have significantly detracted from the E&D agenda, although staff recognized the importance of improving BME staff experience in improving wider trust efficiency.

Having said all that we haven't made much progress. It would be dishonest of me to pretend that we'd made the kind of progress I would have wanted. We haven't, and that's partly because the agenda is so crowded when you're in double special measures and you're being held to account by the regulator on twenty different things. I have to say the WRES is not one of them. That's not a criticism of the regulator, but I suppose if there are issues about your safety you have to get those, you have to address those straight away, and we had no money either. (WS5_13)

1.2.7 Lessons for the future

Participants spoke of how they saw the future of the WRES, and lessons they had learned that could contribute to the development of other initiatives (e.g. the Workforce Disability Equality Standard, WDES).

Keeping up momentum

Participants strongly supported continuation of the WRES as it stands, without any changes to the indicators or the methodology in order for them to continue to benchmark and understand areas where they may have made improvements or need to improve. Whilst staff expressed that the WRES should be self-limiting, in that in order to be successful it should no longer be needed, this was felt to be some way into the future and the culture change that was required in order for race equality to be embedded was perceived as a long way off. However, pressure needed to be maintained in order for long term changes to happen and to address the raised expectations for race equality that WRES may have given BME staff.

Future direction and leadership

There was evidence of some discordance in particular between stakeholders with regards to the future direction of the WRES. Some stakeholders expressed frustration at the perceived return to "thinking about champions and changing culture" (SH07) whilst they advocated for a stronger focus on accountability and implementing ratios or targets to ensure change occurred. A number of participants expressed concerns about the direction and leadership of the WRES at the end of the initial funded period, particularly due to the impending retirement of Yvonne Coghill.

SH05: Because you're not quite sure what's gonna happen next you know without people like Yvonne [Coghill] and Habib [Naqvi] really working away in earnest on this, and a really small but expert team you wouldn't be sort of having the success that you're having at the moment

Monitoring fatigue and lessons for future E&D development

Whilst WRES leads were encouraging about the development of WDES and the perceived broadening of the WRES to other protected characteristics, there was a concern about 'monitoring fatigue', with E&D leads expected to collate increasing amounts of data relating to protected characteristics.

Staff expressed concerns about the resource implications of implementing new standards for other protected characteristics, in terms of the workload implications of undertaking the work required in a climate of limited resources. Several expressed a desire to see equality and diversity agenda integrated, with similar indicators collected across all protected characteristics. One WRES lead described how the excessive data collection requirements were impacting upon the time available to undertake action.

This study was not designed to test which interventions were effective in improving BME experience. However, some lessons around interventions that staff considered to be of value emerged from the case studies.

- *Role modelling:*
The recruitment of BME staff at senior levels was referenced throughout the focus groups as beneficial to BME staff lower down the organization. Seeing BME staff at a senior level was reported to make staff feel as though they had development opportunities at the trust, and provided a voice at senior management level who could understand their agenda. Senior BME leaders reported staff asking them 'how they got there' and using them as a source of inspiration for their career development. One BME senior leader reported the inclusion of BME staff on recruitment panels as instrumental in their decision to take the job.

- *Freedom to speak up guardians*
Channels for safe reporting of racial harassment and discrimination were welcomed by staff at case study 1 as improving their ability to speak out and enable discrimination to be dealt with. However, at case study 3 BME staff were concerned about the independence of the freedom to speak up guardians and needed reassurance that their concerns would be treated sensitively.

- *Development of BME staff networks.*
BME staff networks had been redeveloped and were involved with the WRES reporting and E&D agenda to some degree within case studies 1-3. At site 2 in particular, BME staff spoke about the importance of the network in giving them a space to understand each other, celebrate their differences and be 'stronger

together' in dealing with race inequalities. Senior leaders at case study sites described how active BME staff networks provided opportunities to engage with BME staff and used them to gain a deeper understanding of the lived experience behind the WRES metrics. At case study site 4, where there was no existing BME staff network, one senior leader reported this as a barrier to gaining access to BME staff to help develop the E&D agenda.

2. Evidence from Case Studies

We undertook both interviews and focus groups at five case study sites to explore issues that arose during the earlier work in more detail.

Within the interviews (mostly with senior managers, including chief executives and chairs) we asked how the organisation was performing according to WRES metrics, what the interviewer thought WRES data was saying about BME staff's experience in the organisations, what had been done, whether changes had been made and what changes could be attributed to WRES, how WRES had influenced perceptions of BME staff experience, and what lessons had been learned from the implementation of WRES.

The focus group participants were typically non-managerial staff, and were selected to be from a BME background themselves. They were asked what they knew about the WRES, whether they perceived any differences in the way BME staff are treated compared to white staff, whether this has changed and what had contributed to the changes, what they thought might help close the BME equality gap, and whether they felt WRES had had any impact on BME staff's experience in their organisation. Within these brief case summaries we do not list the actions undertaken in response to WRES (i.e. action plans), but report on initiatives that participants discussed as potentially having an impact on BME experience.

Although we believe that the stories arising from the case studies give a reasonable picture of what is happening at these sites, we need to emphasise that it is only part of the picture: a limited amount of information can be gathered from a handful of interviews and a single focus group with staff that may or may not be representative of BME staff in that organisation. Therefore these case studies are not intended to be in-depth analyses of the specific situations at each site, but instead give indicative information about what can work (or not work) within different contexts, and the extent to which actions taken at more senior levels affect the day-to-day working lives of BME staff on the ground.

2.1 Case study 1: A community mental health trust

Case study 1 was a community mental health trust, with generally improving WRES metrics (across all but one indicator) over the period 2015-2017. Data sources include interviews with 5 senior staff and a focus group with 4 BME members of staff.

WRES was referenced by both senior staff and focus group participants as key to highlighting the inequalities experienced by BME staff, and instigating further work to explore reasons for the disparities and potential solutions. The action plan included a

number of initiatives to improve recruitment, training opportunities and reduce bullying and harassment. This included:

- Revitalising the BME equality staff network, supporting them to be self-directed.
- Training members of the network to sit on senior appointment interview panels and assessments. Introducing leadership programmes to encourage BME staff into non-executive posts and give them experience (e.g. Building Leadership for Inclusion, Mary Seacole programme, Insight programme)
- Introducing mentoring programmes trying to encourage internal promotion of BME staff into more senior roles,
- Working with universities to try to widen access, Positive Action Training scheme targeting local BME communities
- Revising bullying and harassment procedures.
- Running celebration events, black history months and increasing communications to increase the visibility of diversity events.
- Developing wider wellbeing strategies and health teams programmes.

Whilst some of these initiatives were already underway prior to WRES, WRES was felt to give focus and drive to the agenda and ensure that people were talking openly about race inequalities. WRES was also described as a useful tool for informing wider wellbeing and workforce strategies. The leadership team appeared to be strongly committed to the E&D agenda, and recognised that, despite recent improvements, there was still a way to go to improving BME experience but felt that there was higher visibility and awareness of E&D agenda at board level, and throughout the trust since the introduction of the WRES. Focus group participants similarly recognised improvements and referenced the initiatives that had been put in place to improve race equality, but felt that there was still ingrained culture that needed to change within some pockets of the organisation. They reported examples of where the organisation had been "receptive and supportive" to BME staff concerns, and provided evidence of positive action which they felt had positively influenced their experience (e.g. risk-free speak up cards).

The values based culture was considered important in improving race equality, particularly in terms of attracting BME staff to senior positions within the organisation. This was heavily referenced by senior leaders, and also raised by focus group participants, although there was some concern that the values and ethos proposed at board level were not being propagated throughout the organisation, particularly in relation to middle management. Bullying and harassment incidents were referenced as a key area that needed to be addressed by senior staff and focus group participants but middle management were criticised by participants for not challenging poor behaviour. Participants described how middle management were unsure of policies for example those relating to giving staff time to attend BME group meetings, despite having received guidance from HR that this should be enabled. Staff suggested that middle management did not fully engage with the agenda or recognise the problems, and still felt that some BME staff were just 'pushing their own

personal agendas'. This contributed to a perceived lack of consistency in experience, particularly for more junior staff and non-clinical staff.

Changes to recruitment practices and the inclusion of BME staff within panels for senior roles was strongly advocated as being instrumental in attracting senior BME staff to the trust, and making BME staff within, and outside, the organisation feel welcome. One BME board member described the recruitment process as fair and transparent, with the panel being 'probably the most representative panel I've ever been in, in 25 years' (WS5_05). This was reflected by focus group participants, although they suggested this policy should be extended to middle management and more junior roles in order to decrease perceived inequalities between senior roles and other roles.

Senior staff perceived that the values of the organisation were strongly supported by the Chief Executive, and that the leadership and genuine will of the leadership team would drive forward the WRES data. One BME senior leader described the "genuine open culture" of the trust, yet there was still a level of scepticism and concern from the BME staff network that the changes were not going far enough, and evidence that they remained to be convinced that the board were not just paying lip service to the E&D agenda. Although they acknowledged that changes were happening there were concerns that the experience had deteriorated in recent months, partly due to the financial pressures the trust were under and time pressures which meant that the focus was moving away from the WRES. Focus group participants reported that problems were not being dealt with in a timely manner, which meant staff were reluctant to report incidents and left the organisation.

There was evidence that some of the initiatives referenced by board members as key to improving BME experience were not being reflected on the ground. For example, E&D training was seen as key to improving the culture of the organisation and referenced as mandatory by senior leaders, yet focus group participants expressed concerns that E&D training was no longer being undertaken. Similarly, participants reported that they did not feel supported to attend training such as leadership programmes which were referenced by senior leaders as key to enabling BME progression, and felt as though they still had to put themselves forward for opportunities. Senior leaders appeared to recognise that the stories of experience that they were hearing from staff did not always reflect improvements seen within the WRES data, and they need to continue to triangulate WRES data with stories of staff experience to understand how the trust was performing in relation to race inequalities.

Summary: Overall the trust board were considered committed to the E&D agenda and had used WRES to develop existing initiatives and increase focus on E&D. However, problems with the values and messages filtering down through middle management meant that there were inconsistencies in improvements for BME staff within the organisation. Senior leaders and staff on the ground recognised the need for ongoing commitment and further work to improve BME experience, and not allowing other pressures to detract from the E&D agenda.

2.2 Case study 2: An ambulance trust

Case study 2 was an ambulance trust with incomplete reporting of WRES data, poor performance of reported metrics across the board, and no improvement over the time period 2015-2017 Data sources included interviews with 3 senior leaders and a focus group with 7 participants.

The trust had been in special measures and had undergone significant restructure of the leadership team within the past year, including the recent appointment of one BME board member. The WRES metrics, combined with criticism from CQC were reported to have been a 'wake-up call' to address race inequalities and cultural difficulties within the trust. Senior leaders reported that WRES was instrumental in increasing the priority of E&D agenda at board level and in enabling conversations to take place around race inequalities to understand how BME staff experience could be improved. However, the action plan that had recently been developed was described as 'not very mature' with WRES highlighting areas that needed further exploration (via listening to the lived experiences of BME staff) rather than yet producing meaningful actions. Focus group participants described WRES as 'ammunition' and felt that the WRES data had given them power and a voice; the WRES data backed up the stories that they had been trying to report for years.

In response to WRES, the senior leadership team had appointed a new E&D lead at a senior level, from outside the organisation. This appointment was felt to be instrumental to improving E&D from both senior leaders and focus group participants, with staff recognising the need to 'establish the basics' and the significant amount of work to be done in the area. Senior leaders reported a wide range of initiatives that had been implemented in recent months or were about to be introduced, including:

- Undertaking community engagement and outreach recruitment events
- Undertaking staff engagement events and focus groups
- Refreshing and supporting the BME network
- Introducing positive action programme to recruit BME paramedics
- Altering recruitment processes to enable blind shortlisting
- Launching mentoring programme
- Building bullying and harassment education into the induction programme

Senior leaders felt that changes were yet to be embedded sufficiently to show up within the WRES metrics, or to have made a significant impact on BME experience. In particular, they recognised the need to address unconscious bias and educate staff. Focus group participants described the culture of the trust as 'debilitating' and 'suppressing', and felt that entrenched institutional racism permeated throughout the trust. Interviewees

referenced a 'far right' minority whose ingrained behaviour and entrenched views regarding race had been tolerated and unchallenged at all levels of management.

Focus group participants asserted the need for a clear zero tolerance policy in order for behaviours to change, but still did not feel this was forthcoming from board level. However, they felt that whole scale changes in board members and recent changes to organisational structures meant that some of these resistant staff were leaving because they did welcome these changes to the organisation. Whilst the new board were seen as more amenable to change and willing to work on the E&D agenda than the previous board, participants perceived that the chair and E&D lead were strong advocates for change, but questioned the level of commitment from other members.

Optimism from some senior leaders that recent changes had led to a more open culture and that the trust was strongly committed to tackling inequalities was not strongly reflected by BME participants. Focus group participants described morale and confidence amongst BME staff as being very low, due to years of the suppressing culture. They felt that the ability to speak up was improving but that staff within the lower bands were still reticent, and this culture was going to take time to change. Participants reported recent incidents where staff had experienced harassment but had not reported them due to a belief that they would not be taken seriously or dealt with. In particular, they described a lack of understanding of cultural differences and awareness of E&D agenda within middle management. They felt this was reinforced by the culture of cronyism and 'jobs for life' which led to staff being promoted to managers without having the necessary leadership skills.

Focus group participants reported that the trust had not run diversity and equality training for over 10 years, and cultural differences were not appreciated. Participants valued the BME forum as somewhere where they were able to articulate themselves but felt that they needed further BME representation at a senior level in order for senior staff to really hear and understand the 'race conversation'. However, low levels of confidence and trust in the cultural awareness of the organisation meant that some BME staff were reluctant to be seen to be involved in the network. The appointment of a BME director, and the BME E&D lead were welcomed as visible signs of acceptance.

BME staff felt that the culture of the organisation contributed to low retention rates, and reported that although BME staff were being recruited to the organisation, they were leaving at similar rates. They suggested that retention interviews should be carried out to help understand why staff were leaving, as staff still didn't have confidence to speak out. Although BME recruitment had been improved, the new recruitment processes were reported to be bypassed by members of staff, with colleagues informing their chosen candidates of the availability of jobs prior to them being released and candidates getting insufficient feedback to encourage future promotion.

Summary: Overall, the WRES had highlighted problems but actions in response to WRES were relatively recent and changes were yet to be demonstrated. The ingrained behaviours and culture meant that the organisation was struggling to implement initiatives. More

visible commitment and leadership from the board may enable the new E&D lead to demonstrate improvements.

2.3 Case study 3: An acute trust

Case study 3 was a large acute trust with a high proportion of BME employers and poor performance in WRES metrics across the timeframe 2015-2017. Data sources included interviews with 4 senior leaders and a focus group with 9 BME staff members. The trust was in special measures and had undergone significant restructuring of the senior leadership team within the past year, being dependent on interim directors previously. The E&D lead post had been removed by previous leadership due to financial pressures. None of the senior leaders who were interviewed had been in post longer than 12 months and reported the trust to be performing 'terribly' on WRES metrics and E&D agenda.

Senior staff described how the WRES had highlighted how badly the trust was performing in terms of E&D, but also gave them an opportunity to learn from other trusts with improved race equality. The senior leadership team had recently appointed a new E&D lead at a senior level to "drive forward the agenda" (WS5_15), which was referenced by focus group participants and senior leaders to be key to enabling change. Both focus group participants and interviewees reported that the WRES and E&D agenda had 'stagnated' and were relying on this new appointment to make changes. They felt that little progress had been made because they had not yet resourced people to do the work, and the establishment of a permanent leadership team was an important first step to enabling consideration of WRES. Changes had also been made to the governance structures to support the agenda at board level.

Senior leaders referenced a number of initiatives which had been introduced, and would be developed under the new E&D lead. These included:

- Freedom to speak up initiatives / listening to action.
- Revising whistleblowing procedures
- Holding equality events for Diversity & Inclusion week
- Introducing diversity training for managers undertaking shortlisting.

Focus group participants and some senior leaders felt that there had been insufficient action and talked about a need for listening, visible action, targets and 'bold statements' to counter concerns about tokenism. Staff reported systemic racial discrimination throughout the trust and focus group participants spoke vociferously of discrimination that they had experienced and witnessed. They discussed failings of middle management to deal with abuse and harassment but also a lack of support at Executive level to deal with the culture in which inequalities were unchallenged. Staff felt the response to WRES had been

inadequate, with focus group participants reporting a complete lack of action from the board until 'tokenistic' consultations took place during the week of CQC inspections.

Senior staff recognised the difficulty of incorporating the E&D agenda into the work that needed to be done due to the trust being in special measures, with difficulty in particular in 'creating space' to talk about WRES. The chief executive and chair both felt that there was not enough discussion of WRES and E&D agenda at board level, and there was some question of whether all members of the board were equally committed to the agenda. Focus group participants were strongly focussed on explaining the problems they had experienced and there was little discussion of improvements or changes that had happened at board level. Whilst there was some acknowledgement that the agenda was moving in the right direction, there was agreement from both senior leaders and focus group participants that there had been insufficient action to date.

The low level of resource attributed to E&D was felt to demonstrate a lack of commitment, even with the recent E&D lead appointment. Focus group participants reported a lack of commitment to some of the initiatives and felt that the tokenistic action would need further work to address the ingrained culture of the trust. Initiatives that had been introduced were not yet felt to be making impact as staff were using 'workarounds' to bypass official recruitment procedures and continue recruiting friends and family. Similarly, the Freedom to Speak Up Guardians were referenced by board members as an important initiative to counter the high levels of discrimination within the trust, were not trusted by FG participants, who reported concerns that previous interactions had not been treated as confidential.

Summary: The difficulties faced by the trust, and particularly lack of personnel committed to dealing with E&D meant that actions undertaken in response to WRES were basic and not yet fully implemented. Renewed commitment from the board meant that the agenda was moving in the right direction but there was recognition that further commitment, leadership and resources would be required before any significant improvements could be made.

2.4 Case Study 4: An acute specialist trust

Case study 4 was an acute specialist trust with generally good performance on the staff survey metrics (indicators 5-8); at or above the national averages for acute trusts. Of the workforce data metrics, indicators 1, 2, and 3 were worse than the national average, although indicator 4 was more similar to national average. Data sources included interviews with 5 senior managers and a focus group with 5 BME members of staff.

Senior managers reported some deterioration in WRES metrics between 2016 and 2017 but attributed this to a change in data collection in indicators 5-8, having moved from surveying a sample to the whole workforce over that period. Overall, senior staff described their performance in relation to the WRES metrics as doing well, particularly in relation to other

trusts, but with some need still to improve, particularly in relation to staff progression. However, there was a lack of shared perspective between senior leaders in the level of recognition that there might be any differences in BME and white staff experience, and in understanding how much of the work that has been undertaken to improve BME experience was as a consequence of the WRES.

> *"We look in general terms at how the staff feel about things at every board meeting, and there is nothing that jumps out to say that BME staff are unhappy in any way compared with anybody else, if you see what I mean?"* (WS5_09)

> *"And so if I'm honest, what it's [WRES data] telling me that there possible, there is a feeling, or that the data is showing, that it may not be as good for BME staff as it is for our white staff"* (WS5_04)

WRES was reported to be discussed widely at board level and staff reported a range of initiatives that had been developed to improve E&D. Participants talked about creating an inclusive culture and improving wider staff engagement for all protected characteristics, with less focus on addressing race inequalities than other sites. Actions included:

- Recruitment of Head of Talent, to develop talent management plan
- Appointed Head of Engagement
- Changes to governance procedures and mediation processes
- Procurement of new recruitment system and inclusion of independent person to sit on staff interviews (not BME).
- Community work to support public health initiatives for different ethnic groups and support recruitment of BME staff from the local community
- Development of management programme to help support positive work environment and career development.
- Initiatives to improve disciplinary action and access to training

The information from WRES was reported to be useful, particularly when used alongside other qualitative data to achieve greater understanding of the staff experience. There was evidence of senior leaders using staff surveys and anecdotal evidence to back up data from WRES and triangulate the findings to understand how they needed to improve. Although some of the initiatives that were developed were ongoing from earlier E&D work, some policies were referenced as being implemented as a direct consequence of the WRES data (e.g. development of respect at work policy). However, communication relating to WRES appeared to be inconsistent, with differences in understanding of the work related to WRES between senior leaders and staff on the ground. In particular, there was a disconnect between stories reported by members of HR/OD team, who described the work that was being done to address inequalities, and other board members and BME focus group participants who appeared unaware that there were problems that needed addressing

Senior staff described the organisation as a good place to work for all staff and described a 'can do', inclusive culture, with staff who felt a sense of pride in the organisation and an engaged board who recognised the importance of staff satisfaction in creating a good

environment for both staff and patients. Focus group participants similarly reported good experiences within the trust, and felt that it was a good organisation to work for. The specialist status of the trust was particularly felt to engender pride in staff.

Focus group participants were unaware of the WRES and appeared to be unaware of any of the experiences described by the WRES metrics, such as bullying and harassment or lack of access to training. They reported having paid little attention to issues of race inequality, with one participant stating that she had only just thought about issues of progression within the meeting, feeling that differences were due to coincidence. Some participants referenced racism they had seen or experienced in other trusts that they had worked in, and only when questioned further suggested some awareness of issues around recruitment, or lack of progress for BME staff within this trust. Focus group participants had little awareness of the purpose of a BME staff network or of the race equality agenda, and did not mention any of the actions to improve BME staff experience that were reported by senior staff (listed above). Their concerns regarding inequalities related more to problems relating to staff moving into the UK from overseas, and the difficulties faced with having their qualifications recognised, rather than racial prejudice per se.

Notably, all staff referenced the lack of BME staff network, and discussed multiple previous attempts to get BME staff involved in a network. Interviewees reported there to be no call for any group that was attributable to protected characteristics, with staff being reluctant to be singled out into labelled groups. They were considering developing an inclusion network for all protected characteristics. One participant felt that the lack of BME network made understanding BME experiences and enabling action difficult, although another senior leader felt that the trust was small enough to be able to access BME voices directly.

Focus group participants expressed concern about positive discrimination, and not wanting BME staff to be appointed due to quotas, rather than having the right people for the job, which resonated with reports by senior leaders that staff consistently resisted forming networks due to a reluctance to be seen as different. One senior leader suggested that staff identified themselves in relation to the specialist status of the trust, rather than their individual characteristics: "*A lot of people will join us because they feel pride or a connection to [organisation name]. It's almost that their protected characteristic may be a secondary thing to them*" (WS5_08)

However, during the focus group, some members of the group decided to make moves to formulate a BME network after discussion of the purpose of a network.

Summary: The trust appeared to have an inclusive, supportive culture, with little qualitative evidence or stories of race inequalities, although some senior leaders recognised the WRES data as demonstrating inequalities existed. Participants were unaware of poorer experience for BME staff, although it is unclear whether this was due to inequalities not existing, or to lack of forum in which inequalities could be discussed and addressed. There was evidence of changes made to address inequalities that were highlighted within WRES data, but a lack of shared awareness of these initiatives, suggesting more could be done.

2.5 Case Study 5: An Arms-Length Body

Case study 5 is an Arms-Length Body, with generally poor WRES metrics reported in 2017, and no data reported for 2016. In particular, poor performance on indicators 1, 2 and 9 seemed to tell a story about barriers for recruitment and progression for BME staff. Staff survey indicators 5 and 6 were mostly not reported as they were either not applicable (not a patient-facing service) or the relevant question was not on the staff survey. Staff survey indicators 7 and 8 both showed worse experiences for BME staff compared to white staff. Data sources included interviews with 5 senior managers and a focus group with 10 BME members of staff.

Senior leaders described the WRES metrics as poor, and recognised the need to do more work to improve the experience of BME staff, although there were disparities in the degree to which senior leaders recognised the scale of work that needed to be done. The data completion rate was inadequate in previous years, and work was still ongoing to ensure people completed personal data on ESR, which led some senior leaders to question the validity of the existing data, needing to see further data to understand what the metrics mean, and whether there has been any change. There was little evidence within either interviews or focus group of attempts to explore the experiences of BME staff that lay behind the WRES metrics.

Staff described the organisation as just starting out with their action plan, with small changes happening or in the pipeline but no tangible, systemic changes occurring. The Chair of the board was referenced by both senior leaders and some focus group participants as being a champion of diversity and keen to promote it at every opportunity, advocating the connection between diversity of employment culture and safety outcomes. However, some senior leaders felt that the board had been shocked by the WRES results, but that the response had been underwhelming, and they had not felt pressure from the board to take action in response to WRES. They described how WRES had "*pricked the conscience*" of the board (WS5_21) but had not had a meaningful response. "*I don't think it's [WRES] created sufficient shock that's translated into enduring momentum and a kind of heartfelt change or a real examination of what it is upstream that needs to be done*" (WS5_20).

Interviewees explained that the response to the WRES had been perfunctory due to ongoing re-organisation that will lead to significant change in the leadership teams. This reorganisation was felt to be a significant factor in stalling progress with WRES, and described as a 'distraction' from undertaking actions to reduce race inequalities. However, the restructuring of the leadership team was also seen as a potential opportunity for the future, with senior leaders being asked to demonstrate how they had taken action in relation to E&D within their interviews.

Senior leaders reported that WRES had led directly to a commitment to improving data quality, and an increase in the profile of E&D and race inequalities. They reported that WRES had moved E&D up the agenda of the board and helped to incorporate E&D into the

'psyche' of the organisation. However, there was a recognised need to move beyond the "data collection and publication exercise" but with some uncertainty around the actions required to reduce inequalities and a need for practical support in terms of culture development.

Some actions had been undertaken, including:

- Reverse mentoring and setting up schemes to encourage diversity on boards.
- Celebrating different events, celebratory festivals (environmental factors)
- Setting up networks (LGBT, Muslim) (done before the WRES results)
- Unconscious bias training
- Incorporating inclusion objective in business plan, senior leadership of inclusion partnership

The implementation of WRES was felt to have improved data quality and availability and senior leaders hoped to see some small improvement in this years' metrics. Some senior leaders perceived that there had been some change in mentality and culture shift resulting from raised awareness, which they felt BME staff may have noticed, whilst others recognised that BME staff on the ground may be frustrated at a lack of progress.

Focus group participants demonstrated awareness of the benefits of diversity and the actions required to improve but expressed frustration that this wasn't happening within their organisation. Participants reported that WRES data had not been communicated or shared with staff, and there was a perception of inaction from senior management in response to WRES; one participant stated "*I feel like it wasn't even lip service, it was just ignored.*" The sole participant who was aware of the WRES statistics and the organisation's relative position had learnt about it from an external source (Health Services Journal).

The perceived lack of progress in relation to the E&D agenda, in particular race inequality, was reported to be representative of a number of other wider management problems within the organisation. Again, there was a suggestion that other wider management issues were distracting from the need to improve race equality: as one participant said, "*Either someone is, I don't know, choosing to ignore it or maybe they've got other fishes to fry? Maybe bigger fishes to fry*". A reduction in staff numbers in HR roles was perceived to be detrimental to action, as the organisation did not have the manpower to support the agenda.

Focus group participants described a culture with an "underbelly of toxicity" in which they felt staff were not comfortable talking about, or having difficult conversations about race. They felt that the organisation doesn't currently accept the benefits of diversity and the different approaches of different cultures. Focus group participants who had worked in the private sector were particularly aware of limitations of opportunity, fewer BME staff at higher echelons and a culture of networking that was difficult to break through. This led to concerns about the safety of BME staff jobs within the upcoming reorganisation due to not fitting within the right cliques that are built from socialising and "having a face that fits".

Focus group participants felt that BME staff had to do more than peers did to get the same recognition but don't know how to 'navigate the politics in the organisation' and that teams of BME staff were poorly resourced but unable to complain "and if you complain, they say you're not capable". They reported a lack of role modelling and mentoring which left BME staff feeling as though they have nowhere to turn, and not feeling safe enough in their jobs to speak up and air their grievances. Within the focus group participants related examples of direct racism they had experienced or witnessed in relation to training opportunities, but felt that racist incidents were not dealt with and managers were not considered to be held accountable. They reported that BME staff were leaving because bullying was not being dealt with and staff would rather move on than 'face the battle'. One participant expressed their own desire to leave; "*I cannot see a future here*".

One focus group participant expressed cynicism and wariness towards the WRES evaluation, and how this may help, "because we've sort of been here before". However, another participant felt the fact that they were having the conversation was progress in itself.

Summary: There was widespread acknowledgement that the organisation performance against the WRES metrics was poor, and that the response to the WRES had been perfunctory. Senior management did not appear to have explored the WRES results to understand the negative experiences that the BME focus group participants reported. Wider organisational issues were reported to have stalled progress, alongside some uncertainty about what action should be taken.

3. Detailed findings from quantitative analysis

3.1 Methods

In this section of the evaluation we examined data from the first four years of the WRES (data from 2015-2018 for indicators 5-8, and data from 2016-2018 for the remaining indicators), to examine how much change there has been on the nine different indicators over this period, and to determine what factors are most associated with this change.

Analysis was conducted at a trust level; that is, data from the three/four years were matched by trust, and then changes across time modelled with longitudinal growth analysis, which looks at the average annual change within organisations across the years, and tests the hypothesis that the average change across trusts is different from zero.

The models were then extended to test whether the type of trust, geographical region, or extent of BME workforce were related to the extent of change. Further models were then run to examine whether other scores from the NHS staff survey relating to trust culture might explain differential rates of change[1].

Data were available from 236 trusts, specifically 154 acute trusts (including 39 combined acute and community trusts, and 19 acute specialist trusts), 55 mental health/learning disability trusts (including 28 combined mental health and community trusts), 17 community trusts, and 10 ambulance trusts. However, not all indicators were available for all trusts in all years; in most cases, at least 90% of trusts' data were available, although in the case of indicator 4 in 2016, as few as 162 trusts had available data. In addition, because of some reorganisation of trusts (e.g. mergers) not all trusts could be matched across the four year period.

3.2 Descriptive statistics

The following table shows the average level of each indicator across each of the four years, as well as demonstrating how the indicators are scored in this particular analysis. Note that in each case, a higher score represents a situation that is more favourable towards White staff, and less favourable towards BME staff.

The figures suggest that, in general, there has been a move towards a more equal position over time, although some of these changes are very small compared with the size of the current inequality. In addition, two other trends are noteworthy:

1. There were bigger improvements between 2016 and 2017 than there were between 2017 and 2018. This can be read in two different ways: either that the improvements made between 2016 and 2017 have largely been retained, or otherwise that the

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[1] Specifically, these were considered as cross-level predictors in the model. Details of all models are available on request.

direction of travel has stalled and fewer improvements have been made more recently.

2. In general, there have been bigger improvements in the indicators that can be affected by specific management practices, e.g. around recruitment or disciplinary procedures. There have been smaller or no improvements in those that are measured by the NHS staff survey: staff experience of bullying, harassment, discrimination and equal opportunities etc.

The only indicators where there has not been any long-term move towards a more equal position are indicator 1 (the % staff at band 8 or above from a White background), which actually increased slightly from 2016 to 2017 and has returned to its initial level in 2018; and indicator 6 (ratio of BME to White staff experiencing harassment, bullying or abuse from staff in last 12 months), which had shown some improvement earlier but returned to 2015 levels in 2018. For indicator 9 (proportion of the Board that is from a BME background) there has been a very slight improvement but is still closer to 7% than to 8%.

	2015	2016	2017	2018
Indicator 1: % staff at band 8 or above from a White background (non-medical staff only[2])	-	92%	93%	92%
Indicator 2: Ratio of White to BME staff being appointed from shortlists	-	1.69	1.55	1.56
Indicator 3: Ratio of BME to White staff entering the formal disciplinary process	-	1.88	1.63	1.60
Indicator 4: Ratio of White to BME staff accessing non-mandatory training and career progression development (CPD)	-	1.10	1.08	1.01
Indicator 5: Ratio of BME to White staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	1.06	1.05	1.04	1.03
Indicator 6: Ratio of BME to White staff experiencing harassment, bullying or abuse from staff in last 12 months	1.17	1.13	1.13	1.17
Indicator 7: Ratio of White to BME staff believing that their organisation provides equal opportunities for career progression or promotion	1.23	1.18	1.17	1.18
Indicator 8: Ratio of BME to White staff experiencing discrimination at work in last 12 months	2.35	2.33	2.29	2.22
Indicator 9: % board membership from BME background	-	7%	7%	7%

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[2] Before 2018 only data for non-medical staff were available here; the 2018 data were therefore calculated using the same staff groups to ensure comparability.

The following plots show how these changes over time differ by the four main types of trust:

Indicator 7

Indicator 8

Indicator 9
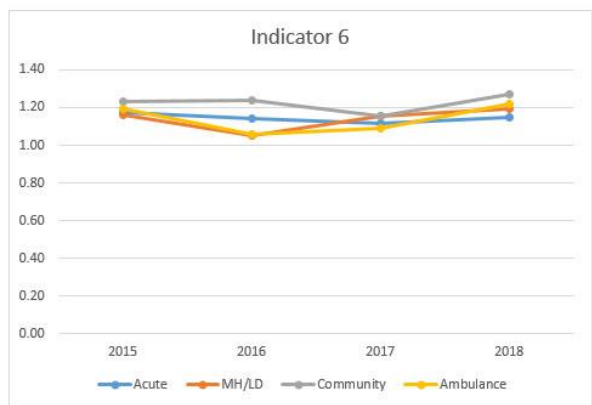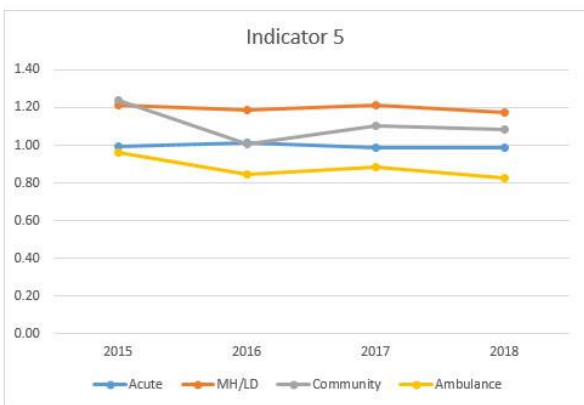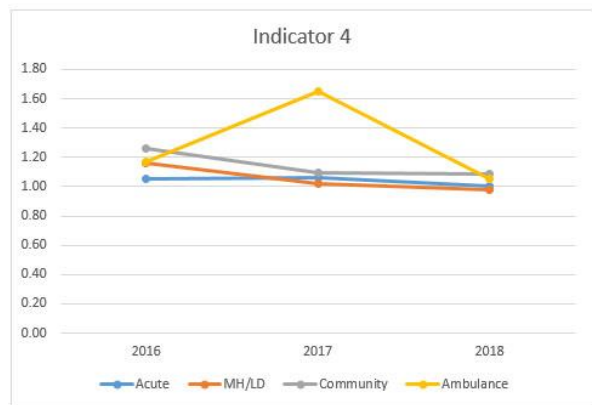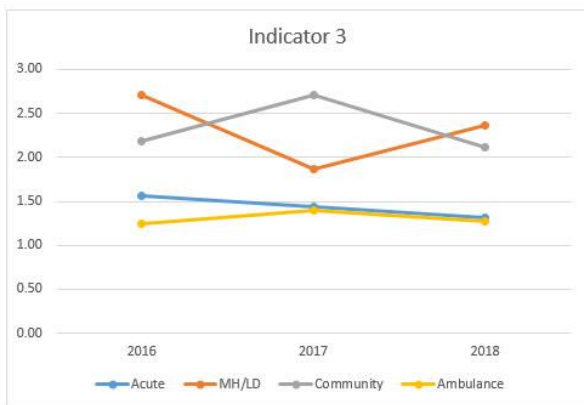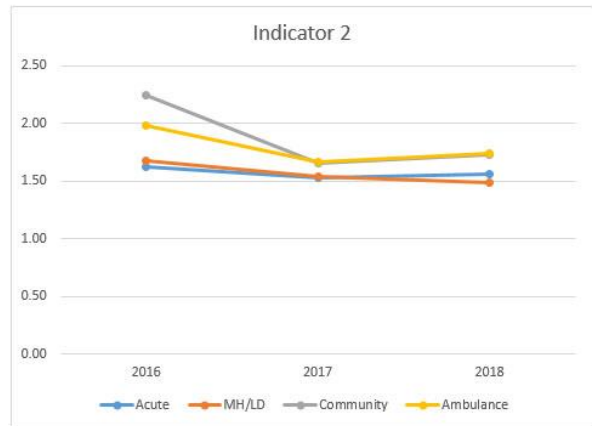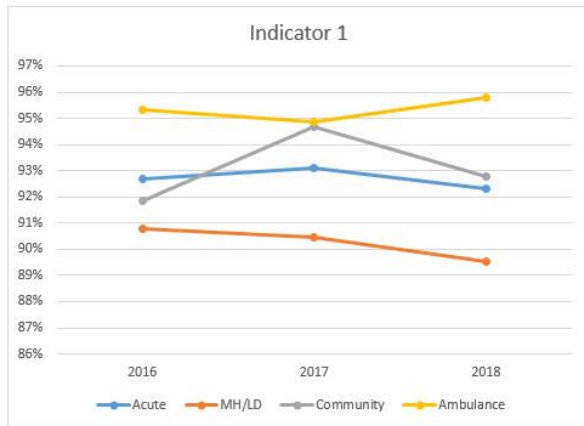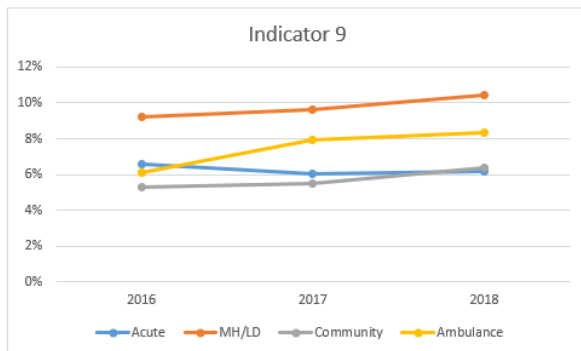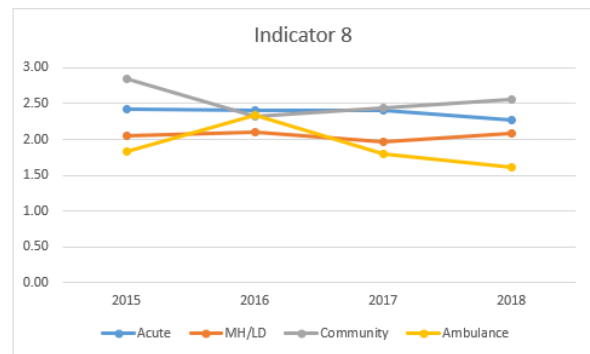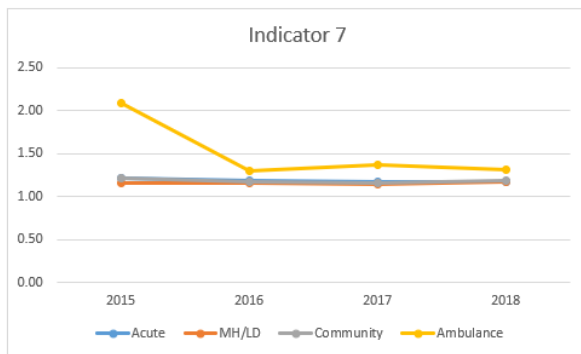
It should be noted that, due to the inconsistent numbers of trusts providing data across the years, relatively little can be read into the actual levels of change from one year to the next with these descriptive statistics. The longitudinal models in the next section overcome this by looking at within-trust changes and averaging across these. These then provide a more reliable pattern of how much change is happening at the trust level from one year to the next.

3.3 Longitudinal models

Two sets of models were run:

- Models examining change in indicators over time only
- Models with trust background factors (trust type, region, extent of BME representation in workforce) explaining extent of change

The findings for these models are summarised as follows by indicator. Only statistically significant findings are shown.

3.3.1 Indicator 1: % staff at band 8 or above from a White background

There was no evidence of significant change over time in this indicator. However, it did appear that there may be a slightly greater move towards more BME representation at this level in trusts with a higher proportion of employees from a BME background.

3.3.2 Indicator 2: Ratio of White to BME staff being appointed from shortlists

This indicator had a significant decrease over time, meaning a slight improvement: specifically, the average change between 2016 and 2018 was 0.06 per year (95% confidence

interval 0.01 to 0.11). Given that in 2016 in the average trust White staff were 69% more likely than BME staff to be appointed from a shortlist, this represents an average drop in this figure to 56% in 2018 (all else being equal), although in reality most of this change occurred within the first year. There was no evidence that this change was related to any of the background factors.

3.3.3 Indicator 3: Ratio of BME to White staff entering the formal disciplinary process
There was no evidence of significant change over time in this indicator, or of differential change over time by trust background factors.

3.3.4 Indicator 4: Ratio of White to BME staff accessing non-mandatory training and career progression development (CPD)
There was no evidence of significant change over time in this indicator, or of differential change over time by trust background factors.

3.3.5 Indicator 5: Ratio of BME to White staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
There was no evidence of significant change over time in this indicator, or of differential change over time by trust background factors.

3.3.6 Indicator 6: Ratio of BME to White staff experiencing harassment, bullying or abuse from staff in last 12 months
There was no evidence of significant change over time in this indicator, or of differential change over time by trust background factors.

3.3.7 Indicator 7: Ratio of White to BME staff believing that their organisation provides equal opportunities for career progression or promotion
This indicator had a significant decrease over time, meaning a slight improvement: specifically, the average change between 2015 and 2018 was 0.02 per year (95% confidence interval 0.00 to 0.03). Given that in 2015 White staff were 23% more likely than BME staff to believe this, this is equivalent to that dropping to around 18% more likely by 2018 (all else being equal), although in reality the majority of that drop was between 2015 and 2016 (and particularly in ambulance trusts).

3.3.8 Indicator 8: Ratio of BME to White staff experiencing discrimination at work in last 12 months
There was no evidence of significant change over time in this indicator, or of differential change over time by trust background factors.

3.3.9 Indicator 9: % board membership from a BME background

This indicator had no overall significant change over time. However, there was some evidence of significant change by two of the background factors. In particular, there was evidence of greater improvement in London than elsewhere: over the three years, this had increased from 13% to 16% BME board membership, with no meaningful change in any other regions. This has to be interpreted in conjunction with the fact that BME representation on the workforce of London trusts is far higher than this, however.

In addition, there was a slightly greater level of increase for trusts with a higher proportion of BME staff overall, but this was very modest in comparison: for a trust with 10% more of its staff from a BME background, the rate of annual increase in BME board membership would increase by around 0.5% compared with a trust with fewer BME staff.

4. Rapid Literature Review

A rapid literature review was conducted to identify articles published that evaluated interventions within (or across) organisations, designed to improve race equality (either directly or indirectly, e.g. by implementing training schemes).

Fifteen articles were identified. These are summarised in the following table.

The majority of the articles were set in different countries, particularly in the USA. Therefore some of the cultural and legal context is somewhat different. Even ignoring that, there are relatively few findings that could be used as evidence for the beneficial effect of specific interventions.

Paper	Country	Population	Intervention	Evaluation method	Findings / Outcomes	Study design
Acosta, D., & Olsen, P. (2006).	USA University of Washington Medical School (UWSOM)	American Indian / Alaskan Native AI / AN	Pipeline and minority recruitment programs run by the Native American Centre of Excellence at UWSOM designed to recruit and retain (AI/AN) applicants to medical schools.	Some elements only described such as a social group (listed under Mentorship) which brings AI/AN students together in culturally germane events. Other elements have data such as the number of summer school (a national 6 week educational enrichment programme) students who get a place at med school: from 1989 - 2004, 54% of all summer school participants nationwide apply to medical school and 61% are accepted.	"These programs have increased the numbers of AI/AN medical students; developed the Indian Health Pathway; worked to prepare students to provide culturally responsive care for AI/AN communities; researched health disparities specific to AI/AN populations; provided retention programs and services to ensure successful completion of medical training; developed mentorship networks; and provided faculty development programs to increase entry of AI/AN physicians into academia." "A total of 477 AI/AN students have participated in UWSOM pipeline programs from 1989 to 2005. Ninety seven have participated in the UDOC program and 380 in the Summer Medical/Dental Education Program. Of these, approximately 102 have matriculated into medical school somewhere in the United States. Thirty four have entered medical school at UWSOM."	Review of programs, describing interventions and summarising outcomes data, challenges and lessons learned.
Anderson et al, 2003	USA	Health care staff	Five interventions to improve cultural competence in healthcare systems: "programs to recruit and retain staff members	Narrative synthesis. Data is reported from all included studies (6 papers)	Authors conclude that "We could not determine the effectiveness of any of these interventions, because there were either too few comparative studies, or studies did not examine the outcome measures evaluated in this review: client satisfaction with care, improvements in health status, and inappropriate racial or ethnic	Systematic Review

Paper	Country	Population	Intervention	Evaluation method	Findings / Outcomes	Study design
			who reflect the cultural diversity of the community served, use of interpreter services or bilingual providers for clients with limited English proficiency, cultural competency training for healthcare providers, use of linguistically and culturally appropriate health education materials, and culturally specific healthcare settings"		differences in use of health services or in received and recommended treatment."	
Fisher, Z. E., Rodriguez, J. E., & Campbell, K. M. 2017 No full text, info from abstract only.	USA	Under-represented minorities in medicine (URMM) faculty in academic medicine.	Articles on tenure status published in the last 20 years, in English, that discussed recruitment or retention of women, URMM faculty, and tenure in academic medicine, and were of high quality based on data were included in the study. Narrative reviews, opinion, editorials, and letters to the editor were excluded.	Narrative synthesis Of the 21 articles that met inclusion criteria, 13 (67%) were cross-sectional studies, 4 (19%) were analyses of AAMC data, 1 (4.7%) was a qualitative study, 1 (4.7%) was a mixed-methods study, 1 (4.7%) was a case study, and 1 (4.7%) was an outcomes comparison study	Tenure was associated with leadership, higher salaries, and comfort in the work environment. URMM faculty comprised the lowest percentage of tenured faculty in academic medicine, with the highest percentage pertaining to white men. In an educational setting but could be transferred to refer to length of employment contract in health care organisation?	Literature review

Paper	Country	Population	Intervention	Evaluation method	Findings / Outcomes	Study design
				Used Strength of Recommendation Taxonomy (SORT) to assess quality and exclude papers		
Gilliss, C. L., Powell, D. L., & Carter, B. (2010).	USA	Nursing workforce	1.Target funding to support education for careers in Nursing.. 2. Resource educational programs for retention of underrepresented groups 3. Expand the support for the HRSA Division of Nursing's Workforce Diversity initiatives	Reviews "the evidence that supports the impact of a diverse workforce on patient outcomes and delivery services. Assuming a positive social value in the absence of the data, the authors review the approaches that have been successful in diversifying the nursing workforce. "	The authors conclude that "the absence of data on the impact of a diverse nursing workforce on health care outcomes and service development limits our understanding of the specific ways in which the diverse workforce can improve the health of the public and eliminate health disparities. Assuming that the impact can be better understood or that the social good of promoting diversity in the workforce outweighs the need for evidence, we have proposed approaches to promoting nursing workforce diversity. Although some evidence points to the usefulness of these approaches, again, evidence is limited."	Literature review
Jeon, Y. H., & Chenoweth, L. (2007).	AUS	Overseas Qualified Nurses (OQN) who are a culturally and linguistically diverse group (CALD)	Interventions to retain OQN staff.	"This paper has considered the factors that both constrain and enhance employment experiences for OQNs within the Australian health care system, and their opportunities to contribute to both the development of contemporary Australian	The authors conclude that: "OQN staff need support to acculturate to unfamiliar work conditions, and make a smooth transition to the health team. Australian trained nurses also need to be supported in terms of being given opportunities to develop cultural competence and to learn how to work collaboratively within the CALD work setting. The role of the team leader in the CALD work setting must be critically examined, acknowledged and supported."	Literature review

Paper	Country	Population	Intervention	Evaluation method	Findings / Outcomes	Study design
				nursing practice and the quality of care for the CALD health population. OQNs, in particular those who are newly employed, often experience difficulties with language, communication styles, unfamiliar nursing practice and work environment as well as cultural difference. "		
Kalra, V. S., Abel, P., & Esmail, A. (2009).	UK	Black and minority ethnic staff	Leadership interventions Focussed on individuals such as setting up networks for BME managers, mentoring schemes, and identifying "high fliers" to support career development Interventions focussed on the organisation, based on robust data collection to monitor ethnicity of workforce. Also cites the importance of leaders to act as mentors for BME staff and training. Generic diversity training runs the risk of being "an organisationally imposed process that	Using a conceptual lens of institutional racism the authors explore barriers to BME staff progression and interventions to facilitate progression. Integrates data from lit review and stakeholder interviews.	The authors conclude that "The literature review found that there were a range of initiatives which could be implemented by public organisations such as the NHS to increase the presence of Black and Minority Ethnic (BME) staff in senior management positions. Most of these interventions were largely focused on the individual. Much more progress on institutional or organisational change needed to be made before the NHS could be perceived as a model employer in this area. The literature review also indicated that there is little published research on such initiatives within other European Union countries."	Lit review and stakeholder interviews

Paper	Country	Population	Intervention	Evaluation method	Findings / Outcomes	Study design
			lacks individual ownership and commitment." also cites specific training such as management training for BME staff such as graduate training schemes and leadership programmes.			
Mittman, I. S., & Downs, K. (2008)	USA	genetic counselling workforce	Numerous diversity initiatives of different types for the genetic counselling workforce focussed on different groups such as "the entire [genetic counselling] society, its leadership, the membership committee, training program directors, special interest groups, and individual members." Also reports initiatives to increase diversity in medical and nursing education.	Aims to identify published and unpublished initiatives to increase ethnic and racial diversity in the profession. It also provides a review of national data and diversity initiatives in the US health workforce in General. Presents data on effectiveness of individual schemes where found in primary studies.	Presents recommendations based on the review to cover: 1. institutional recommendations; (need for diversity lead to oversee initiatives at the top level, need for accurate and robust systems of data collection on workforce ethnicity) 2. research recommendations; (needs assessment of barriers for BME staff accessing the profession) 3. educational recommendations. (recruitment strategies, the educational pipeline, mentoring for students, role of programme directors to ensure BME students' learning is supported)	Literature review
Otto, L. A., & Gurney, C. (2006)	USA	Nursing and healthcare workforce	Healthcare workforce recruitment, retention, and other strategies educational strategies such as mentoring, programmes to support school students pre-college enrolment	The authors explored the literature on academic and career factors influencing diversity; and recruitment, retention, and other strategies employed to diversify the workforce	The authors conclude that the "literature has tended to focus on cultural competency of the healthcare worker, and includes numerous calls for action to diversify the nurse workforce, [but] very little scholarly work has been conducted that rigorously evaluates such diversification activities"	Lit review (narrative)

Paper	Country	Population	Intervention	Evaluation method	Findings / Outcomes	Study design
				Presents data on effectiveness of individual schemes where found in primary studies. But this amounts to only 2 or 3 studies. No explicit methodology or detailing of methods, e.g search strategy, PRISMA diagram etc.		
Poss, J. E. (1999).	USA	Nursing workforce	Health promoters: workers who assist clients to understand and negotiate the health care system and help health care providers to work more effectively with clients from different cultural backgrounds.	Presents research that gives examples supporting (but not evaluating) this practice and an exemplar of a health promoter programme. The examplar is in North Western New York that trains "bilingual, bicultural health promoters to work with Mexican migrant farmworkers who reside in 3 counties that are designated Health Care Professional Shortage Areas." The exemplar includes some evaluation that associates patient outcomes with health promoters, such as "In 1994 and 1995, 853 migrant farmworkers in 2 counties were screened for	Aims to introduce nursing profession to idea of health promoters. Includes an exemplar which has recorded patient outcomes and links role of health promote in achieving them.	Lit review on one intervention

Paper	Country	Population	Intervention	Evaluation method	Findings / Outcomes	Study design
				tuberculosis. Of those screened, 843 (99%) were located for skin test readings, which demonstrates the diligence and effectiveness of the health promoters.		
Rodriguez, J. E., Campbell, K. M., & Mouratidis, R. W. (2014).	USA	Medical community	Based on a review of the literature recommendations include "implementing proven pipeline programs to increase the number of minority medical students, a systemwide adoption of proven culture change initiatives, reexamination of assignments to ensure equitable time distribution, and a reduction of medical school debt."	Identified literature using standard searching methods, retrieved 548 studies of these, 15 met inclusion criteria for this literature review. Of the 15, 9 were cross-sectional studies and 6 were analyses of existing Association of American Medical Colleges workforce data. Used Strength of Recommendation Taxonomy (SORT) to assess quality and exclude papers	Reviews evidence on factors that attribute to low numbers of BME staff in academic medicine. Concludes that "racism, promotion disparities, funding disparities, lack of mentorship, and diversity pressures exist and affect minority faculty in academic medicine."	Systematic review
Serrant-Green, L. (2001)	UK	Nurse educators	The author suggests that there is a focus on the patient as "different to self" rather than pre-determining either's race in nurse transcultural training scenarios. Also advises taking a broader approach to nurse training, rather than a reductive,	Author takes a "view from within" as a black nurse / nursing lecturer. From the literature on transcultural education for nurses/nursing students, identifies three themes encapsulating common	Critiques transcultural education in nurse degrees/programmes, suggests that these are delivered using a single ethnocentric approach which is sub-optimal.	Article

Paper	Country	Population	Intervention	Evaluation method	Findings / Outcomes	Study design
			"menu" approach which has a too narrow focus on diet, language, religious practices etc.	approaches: "The positioning of minority ethnic persons as `other'; The minority ethnic nurse as `expert'; The issue of homogeneity and the `menus' approach to teaching."		
Smith et al (2009)	USA	Medical community	Promotes the use of "pipeline" programmes (educational interventions) to recruit and retain under-represented groups to the medical profession.	Describes the problem of BME groups being under-represented in medicine and the use of pipeline programmes to address this, including examples of several successful programmes. Such programmes have been challenged by "anti-affirmative action" challengers. No more detail available in abstract.	"Programs at universities and academic medical centers must develop innovative partnerships with underserved communities, adopt strategies that demonstrate a strong commitment to increasing racial and ethnic minorities in the health professions, and develop viable funding mechanisms to support diversity enrichment programs."	Part one of two papers on pipeline programmes. 2nd part is on legal initiatives so excluded.
Woolfolk, (2012)	USA	Health care educators	Lists interventions aimed at increasing student diversity such as "Judicial and Legislative Actions" (by law race can be considered in order to increase diversity of a cohort of students)	Describes the problem of lack of BME students applying to dental schools. Students have the required first degree qualification but are not applying to these schools.	Suggests two new approaches in addition to what has been reviewed 1st Pipeline programmes that start earlier in students' careers such as at high school; refers to	literature review

Paper	Country	Population	Intervention	Evaluation method	Findings / Outcomes	Study design
			"Health Careers Opportunity Program" such as outreach and enrichment programmes. Pipeline programmes Student efforts to promote the profession to their own community. Dental school Standards on cultural competence		one by Kellogg foundation, cited in a number of these papers. 2nd approach to harness other communication channels, such as career websites to reach potential audiences : high school students, their teachers, careers and advisors. (This does not seem like a new thing!?) Also suggests joining with other health professions educators to share best practice on this recruitment problem.	
Wren-Serbin, 2016	USA	Health care educators, midwifery and health care clinical community	Suggests the theory of structural competency as a potential framework to guide efforts to increase diversity in the profession. .	The main body of this paper is a review of the literature to demonstrate the impact of racism and lack of racial diversity in midwifery. 7 papers reviewed, 3 from on the patients' perspective and 4 on the experience of providers	Three key findings: "racism (interpersonal and institutional) is commonplace in midwifery education, professional organizations, and clinical practices. Second, racism in midwifery and lack of racial diversity act as barriers to further diversifying the profession. Third, both patients and midwives of color identify midwives of color as uniquely positioned to provide high-quality care for communities of color." Promotes the use of Metzl and Hansen's theory of structural competency as a way to understand and plan new interventions. This suggests reframing inequalities as a result of social	Literature review

Paper	Country	Population	Intervention	Evaluation method	Findings / Outcomes	Study design
					constructs such as race, class, gender etc. This is in contradistinction to a cultural competency approach (this was critiqued in a similar way in the Serrant-Green paper above) *Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. Soc Sci Med. 2014;103:126-133.*	
Zambrana, 1996	USA	Medical community	Presents a number of recommendations to increase representation of Hispanic women in the health workforce	Describes the problem of under-representation of Hispanic people, especially women in the medical and professions in the USA. Aims to review literature on this problem and identify underlying factors and barriers to increasing representation of Hispanic women in the workforce. No information on methods in abstract.	Based on the review, the author recommends "a call for institutional changes and commitments in data collection, early math and science preparation, access to financial resources, and improvements in community linkages and the academic environment."	Literature review