RACE EQUALITY

NHSProviders

Race 2.0

TIME FOR REAL CHANGE

MARCH 2022


RACE
EQUALITY

RACE 2.0
Time for real change

CONTENTS

FOREWORD

Following the murder of George Floyd and amplification of inequalities by COVID-19, race equality is now on the agenda of NHS boards in a way it has never been before.

A real opportunity has presented itself but at the same time so has the urgency of the challenge. Despite successive initiatives in the NHS, the data still paints a stark and depressing picture of the ongoing racial injustice faced by staff as well as patients and service users.

This report provides an honest playback of member views on where their organisations are in the journey towards racial equality. Drawing on interviews with chairs, chief executives and non-executives and a survey across our membership, it provides a snapshot of where NHS boards feel they have made most and least progress, and what both NHS Providers and the national bodies can do to accelerate the pace of change. While there will be different views on these self-assessments, trust leaders recognise the scale of the task ahead: only 4% of our survey respondents judged race equality to be fully embedded as a core part of their board's business.

Board members we spoke to recognised that race equality can no longer be the preserve of directors of workforce and equality, diversity and inclusion leads. It requires strong leadership by the whole board and a much greater sense of urgency, with all board members equally accountable for progress. This means boards taking very deliberate action to address some of the challenges highlighted in this report, to show that tackling race inequality is central to their organisations' core aims.

This report also highlights what trust leaders have told us about what works. That this is about being proactive: in engaging all staff, but particularly getting closer to the lived experience of ethnic minority staff and service users, being courageous about having difficult conversations and ensuring all colleagues know leaders are genuinely hearing their concerns and ideas for change. It is also about creating space for meaningful discussions to be had and ideas to be shared within organisations and across the NHS. Although the evidence base is not as strong as it should be, there is still more scope to learn from what is really making a difference.

Structural racism is an issue which, by definition, affects every sector of society, and NHS Providers of course is no exception. We recognise how important it is for us to also face up to and address how racial inequality shows up within our own organisation. We began a process of internal reflection last year with a starting point that we are not where we should be, particularly in the very low levels of ethnic minority staff represented at senior levels of the NHS Providers team. By commissioning expert advice and embarking on an internal review, we are approaching a position of much greater strength to embed a focus on race equality work within our support to members, and in our core policy and influencing work on trusts' behalf.

Our ambition is to get to a place where we are genuinely leading by example as an actively anti-racist organisation, and to effectively support trusts to do the same. We now know that making the business case for action is not enough. And we know that more data gathering is not a sufficient catalyst. It's increasingly clear that it's about a much more profound hearts and minds challenge: for us all to take personal ownership, to really interrogate our assumptions and behaviours, and to demonstrate that this time it's deeds not words that will make this a time of real change.

Chris Hopson
Chief Executive
NHS Providers

Saffron Cordery
Deputy Chief Executive
NHS Providers

KEY MESSAGES

Areas of most and least progress

- Only 4% of respondents felt that race equality is fully embedded as a core part of their boards business.
- All respondents we spoke to described their ambition to listen more closely to staff about their experiences: 85% said that they have made the most progress in increased leadership focus on staff networks.
- 63% said they had progressed in building a more diverse board, and most leaders agreed this was not only a key priority for the board but a personal priority. However, just less than a third (32%) have incorporated race equality into their board assurance framework.
- Leaders recognised the need for greater support for their workforce, particularly for those experiencing discrimination. 77% said that they have made progress on actions to improve workforce wellbeing. However, only 22% have made progress in actions to retain ethnic minority staff. Even fewer (6%) felt they had made progress on procurement, which includes monitoring all suppliers by race and seeking commitment from service providers on race equality.

Challenges

- One of the biggest reported challenges for leaders is having the time and capacity to make an impact on race equality. This is particularly the case if they experience an uphill struggle in persuading other board members that race equality should be a priority. Some leaders describe having to subsume a focus on race equality within other topics to stop boards becoming disinterested.
- Attracting diverse talent, particularly where local communities are less diverse, is described as a challenge. Few trusts described proactively developing their ethnic minority talent pipeline in response.
- Engaging middle management in meaningful change was described as a key barrier.
- Ethnic minority leaders face a double burden of experiencing discrimination whilst also feeling pressure to lead on race, especially when their white peers are not comfortable playing a leadership role. A key challenge from their experience is how to foster a sense of shared responsibility and ownership.
- Some highlighted their boards' frustration that they were yet to see evidence of real change. They wanted to know about the evidence base for high impact interventions that had worked in trusts like theirs.

Good practice

Examples of good practice given by respondents revolved around the following 10 areas:

NHS Providers support offer

- NHS Providers was perceived as being "late to the party". Trust leaders also highlighted the lack of diversity of staff at senior level as well as among those delivering NHS Provider sessions. One ethnic minority leader noted the lack of conversation and engagement when race is mentioned at NHS Provider member meetings in comparison to other topics.
- Members felt NHS Providers could make more use of its agency and influencing, challenging national bodies and regulators to ensure race equality is genuinely prioritised. There was also an opportunity for NHS Providers to use its convening power to share learning and good practice, and to genuinely embed a focus on race equality through its existing support offer.
- Almost three out of four respondents (72%) said that evidence-based case studies of how individual trusts have made progress would help their board accelerate their pace of change, followed by two thirds (67%) who wanted NHS Providers to support their learning from best practice in other sectors.

What national bodies could do differently

- Trusts said that the national bodies could help their board take effective action on race equality by providing challenge, sharing best practice resources, and holding boards to account. Chairs in particular felt that the national bodies must lead by example and promote national work on race equality.

INTRODUCTION

NHS Providers new four-year strategy has made race equality a key priority. We have embarked on two closely related workstreams as a result.

Our first internal workstream intends to ensure we are embedding a focus on tackling racial injustice and structural racism through all our influencing and support activity, and in our culture and processes. Starting with an internal diagnostic exercise, the work has involved a programme of staff engagement, including understanding key data such as our staff survey results and internal policies and processes. The diagnostic exercise will inform an internal action plan which we will finalise in spring 2022.

Our second member facing workstream focuses on supporting provider boards to address race inequalities impacting both staff, patients and service users within their organisation, as well as helping boards to actively champion an anti-racist approach in their neighbourhood, place and system partnerships. Our starting point for scoping this support offer has been stakeholder engagement and a horizon scan of other initiatives to ensure we complement rather than duplicate work being done elsewhere and learn from what has worked.

Given the critical role of board leadership in driving real change on race equality and wider health inequalities, we then asked chairs, chief executives and NEDs to contribute to an NHS Providers survey[1] on these two closely related challenges and interviewed 18 chairs and chief executives to gather a more in-depth perspective.

This report summaries our survey and interview findings, providing an honest playback of where trusts say they are in terms of race equality. It:

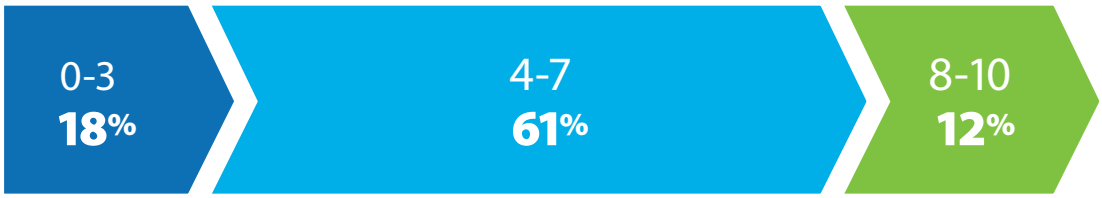
1. Explores the **areas where boards feel they have made most/least progress**.
2. Describes some of the **challenges** members say they experience in trying to drive forward the race equality agenda.
3. Identifies what trust leaders see as the key elements of **good practice**.
4. Captures member views on what an **NHS Providers support** offer could look like to help boards accelerate the pace of change.
5. Reports what trust leaders think the **national bodies** could do differently to help NHS boards in this task.

The report concludes by setting out the next steps in ensuring NHS Providers is leading by example on race equality, and how we will use these survey and interview findings to develop a support offer which helps our members to do the same.

1 There were 254 responses to the survey. The responses were from 134 trusts, representing 63% of our membership and all trust types. 28% (71) of responses were from chairs, 14% (33) were from chief executives, 45% were from non-executive directors and 11% were other job roles.

1 WHAT PROGRESS HAVE BOARDS MADE?

Current position on race equality

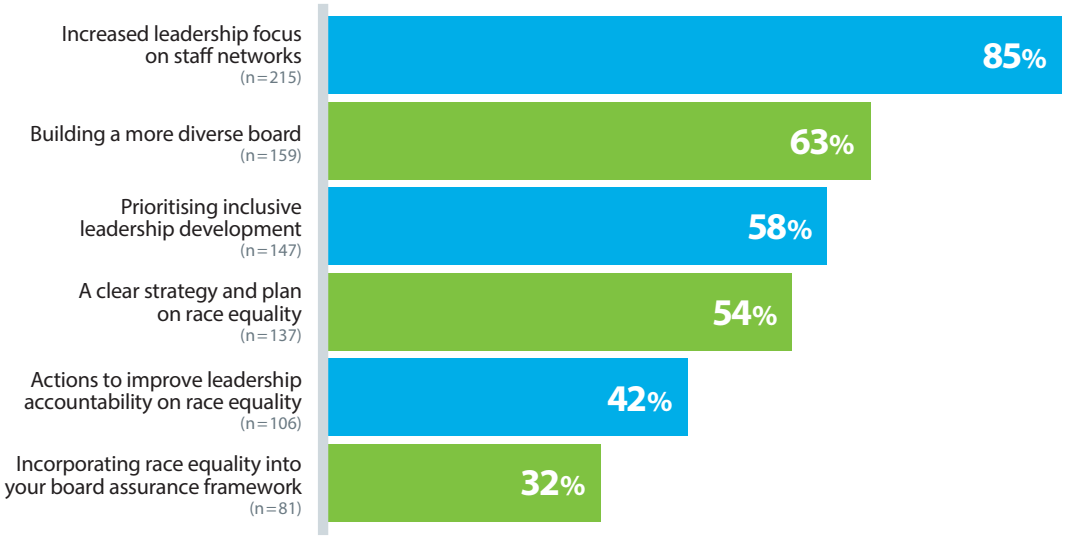


We asked survey respondents how they would describe their boards current position on race equality on a scale of 0-10 (early in your journey to fully embedded). Most felt they were mid-way in their journey, with an average rating of 5.6 overall (6.2 for chairs). Only 22% of respondents scored their progress highly (between 8-10), including just 4% who said that race equality is fully embedded as a core part of the board's business

Leadership and governance

Figure 1 shows the areas where trust leaders feel their trust has made the most progress on leadership and governance actions on race equality. Just over four out of five respondents (85%) said an increased leadership focus on staff networks and 63% said they had progressed in building more diverse boards. Just less than a third felt that they have incorporated race equality into their board assurance framework.

Figure 1
Leadership and governance – areas of progress



Increased focus on staff networks and feedback

All respondents we spoke to described their ambition to hear directly from staff about their experiences with the aim of using this insight to prioritise actions and judge impact. Staff networks are also increasingly being used to feed back on board thinking and EDI initiatives.

Staff networks ascribed to job role e.g. EDI leads, are also being used to develop and share good practice and help translate learning into tangible change, often supported by active sponsorship of the network by board members. All have helped foster good relationships and good discussions with the board as well as engendering greater trust among staff. Some staff network chairs are directly involved in senior leadership appointments. Reverse mentoring was mentioned by some as an important way of, "*hearing from the people who experience the problems on the ground*" and understanding different backgrounds and cultures.

> ***One chair led sessions called, "Pull up a chair with the Chair", where any staff could have a conversation with her. A lot of the conversation was about the impact of the pandemic but a significant proportion of the staff came to talk about their experience of racism. The chair noticed that when the staff survey came out, people had become more willing to speak up.***

Building a more diverse board

Most leaders agreed that building a more diverse board was not only a key priority for the board but a personal priority. How people achieved this varied. Some ethnic minority leaders felt 'leading from the top' was an advantage in terms of being able to talk about their lived experience, as well as relate to the experience of ethnic minority staff; that it sent a powerful message. Others talked about striving for their board to be reflective of the local community, 'needing something different', and taking active steps to achieve this. Another trust focused on proactive development of their internal talent, acknowledging that there were current senior ethnic minority staff at the trust who would benefit from being a NED.

Prioritising inclusive leadership development

Trusts talked about the good progress they have made with implementing inclusive leadership development programmes. Most were targeted at specific pay bands or groups, with some leaders describing how they extended programmes out to further groups after initial success. The programmes described ranged from six to 18 months. One leader described having to call up people individually to ask them to sign up, while another made sure the cohorts were a mix of people they knew were fully on board and others who were not, so they could help and influence one another.

A clear strategy and plan on race equality

Some trust leaders talked about the challenge of ensuring they had a coherent action plan that drove impact on race equality. For most, an action plan rarely ventured beyond the Workforce Race Equality Standard (WRES) data to look at embedding EDI throughout the organisation. However, for some this ranged from: '*a comprehensive programme of work with clear expectations set by board and individual commitments from each of them*'; '*a diverse board covering a range of protected characteristics*'; to inclusive management strategies and '*empowered staff networks*.' Leaders describe using very specific workstreams or a small number of priority areas to achieve their aims.

For one chief executive, listening events and interviews with minority staff asking, 'did they feel as if they belonged, did they feel heard?' set off a culture review. They then created a set of findings from these interviews and fed them back to the board. Although she was committed to an EDI strategy, this was a key strand of a wider cultural review. Their work started with race but on the understanding that the leadership and competencies would be applicable to all inclusion areas.

When the pandemic hit, one chair developed a sub-group of the board called the BAME council consisting of five to six people which met every week for a few hours. This was a safe space where people talked about race and racism. They had five to six specific areas of focus, such as WRES.

Actions to improve leadership accountability on race equality

Actions to improve leadership accountability on race equality started with a desire to have more meaningful conversations about race. Often driven by the chair, some leaders describe facilitating conversations internally, while some appointed an external facilitator. Some of the discussions, described as '*tense*', involved myth-busting perceptions around positive discrimination practices and '*all lives matter*' narratives.

One leader described how some of his board only engaged with the topic intellectually and not emotionally, but programmes were modified as people's engagement and understanding changed. Another leader described how a cultural intelligence programme at his trust included self-assessment of the board and involved training colleagues to become ambassadors. This helped individual board members understand their position and where they were on their own journey of awareness, confidence and capability to lead on race.

For one trust, meaningful board conversations about race only started when they moved on from talking about inclusion to more difficult conversations about discrimination, drawing on the trust's data on appointments, disciplinaries, and career progression. Conversations also included the structural and historical aspects of racism to help the board understand the root causes of racism and discrimination.

One NED set up an annual 'Big Conversation' at his trust, which covers each protected characteristic. Last year, the focus was on race and this year, the focus is on disability. For race, he was able to listen to the stories shared by staff which provided a powerful narrative, ranging from examples of overt racism to racism in recruitment and retention.

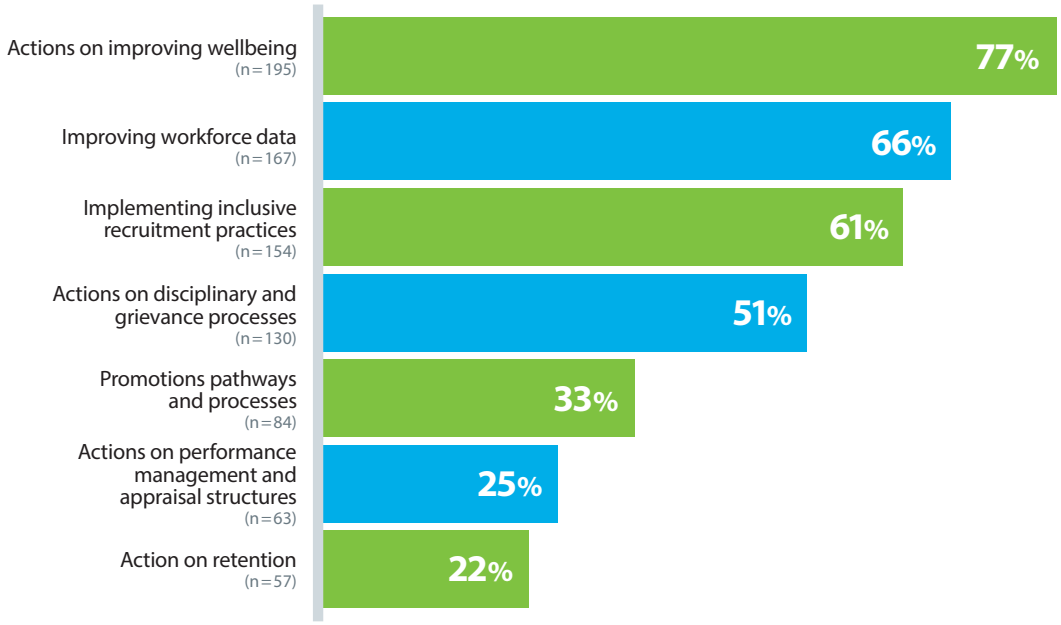
At one ICS, the leadership group tasked junior ethnic minority staff to interview senior executives and ask them a difficult question. This was uncomfortable at first but helped start meaningful conversations on race.

One trust has a shadow board, made up of people from black and Asian backgrounds, for both the ICS and trust. The shadow board receives the same papers as the real board, and feeds in their decisions to bring more diverse voices into the room.

Workforce

Respondents were asked what progress they had made on race equality via workforce initiatives. Nearly four out five respondents (77%) felt that they have made the most progress in actions on improving workforce wellbeing. Only a fifth (22%) felt that they have made progress on retention.

Figure 2
Workforce – areas of progress



Leaders recognised the need for staff wellbeing support particularly for those experiencing discrimination. One trust, for example, now requires all staff members below band 6 to participate in a *Dignity at work* programme as part of wider measures to address bullying and harassment. Another trust that focused on growing its BAME staff network saw an improvement in how staff were impacted by racism

A number have trusts have introduced work to support an ambition to be actively anti-racist. Initiatives include: leadership development to support an anti-racist ambition; internal anti-discrimination campaigns; and proactively calling out structural racism in the organisation and in services. Many leaders described driving improvements in workforce data, such as collecting more specific data on the makeup of the ethnic minority workforce and bullying and harassment. For example, one chair describes the introduction of inclusion days, where staff and external stakeholders were invited to review and discuss the WRES data together.

One trust's data showed there is an issue around racial discrimination in the organisation although there has also been some resistance, with individuals claiming this is not a problem. As part of a programme to become an anti-racist organisation, the trust looked at their data in a workshop with ethnic minority colleagues, drawing on their lived experience. As a result, six areas of improvement were identified including actions around communications, management, and leadership.

For some, developing inclusive recruitment practices arose from conversations with staff, which drove a different set of questions around recruitment such as, who do we engage with, and how do we involve a wider range of communities in the recruitment process? Others described how a staff network member sits on every senior recruitment appointment, and how changing criteria around recruitment has been critical in building a more diverse board and cohort of governors.

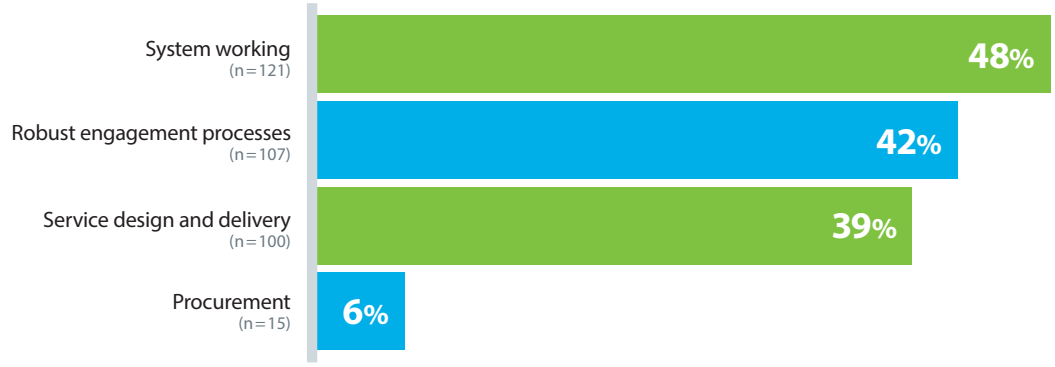
Using WRES data results as a guide, some leaders implemented specific actions on improving disciplinary and grievance processes and retention of ethnic minority staff. For example, one trust rewrote all HR policies – recruitment, appraisal, disciplinary and succession – with an emphasis on soft interventions and disciplinaries as a last resort.

System working, community engagement, service design and delivery, procurement

Just under half of respondents (48%) felt that they had made progress in embedding an anti-racist approach into their work with system partners. A similar proportion (42%) felt they had robust engagement processes in place to involve ethnic minority communities in for example, monitoring levels of satisfaction, dissatisfaction, and access to services.

Just over a third of respondents (39%) felt that they had progressed with the redesign and delivery of services to local diverse communities for example, using data on local communities to inform strategies, policies and practice and assessing their impact. Only 6% (15 respondents) said that they felt they had made the most progress on procurement. This included monitoring all suppliers by race, including recruitment companies, and seeking commitment from service providers on race equality.

Figure 3
Other areas of progress



One trust carried out deep dive work into its maternity services, understanding there was a sub-culture that needed to be explored and to address what the data was saying – that black women have poorer experiences, outcomes, and are more likely to die.

WHAT ARE THE CHALLENGES?

2

Pace of change and capacity

There was a strong recognition that it takes time to make an impact on race equality – with no quick fixes to build trust with ethnic minority colleagues. Similarly, there was an acknowledgement that it takes time to "*establish a consistent culture across the organisation*". Many leaders felt "*capacity is the greatest barrier to being able to deliver against our action plans*".

Prioritising race equality

Despite the positive response from some boards and governors who are receptive to change and may have taken part in broader EDI work, some trusts experience resistance to prioritising ethnic minority groups or EDI in their work. To combat this some leaders describe having to package work on race equality within a wider context: "*if it was solely about race equality, the board may become disinterested – instead, it should be a mixed session, for example, include improving patient outcomes, systems etc.*" This is made worse by "*learned behaviours or culture that hasn't in the past embraced racial equality*".

One chair explains she has not seen much movement at the board level in terms of how they think about race. She describes conversations around the board table as "muted" and "correct" but outside the board table, members say they are tired of the agenda and the lack of impact.

Not being able to have meaningful conversations about race was cited by a number of trusts as a challenge. For one leader, conversations about race remained 'nice' conversations, with a focus on inclusion rather than race equality. Moving the conversation onto discrimination was difficult for some as was educating the board on the historical legacy of racism in the NHS and its impact on culture and decision making today. Some board members only engaged with the topic of race inequality intellectually and not emotionally, again, making it harder for leaders to prioritise race.

"*Organisations cannot survive when there are only few individuals fighting for change.*" Chair

Ethnic minority leaders are concerned about their white peers not being comfortable leading the race agenda. One respondent describes having 10 white chairs reach out to him privately for advice over the course of a year. They feel that their white colleagues are nervous about saying the wrong thing, offending ethnic minority colleagues or saying something that is taken out of context; they instead say nothing. Another ethnic minority chair described having very difficult conversations with board members around changes

to recruitment as people expressed their concerns around "positive discrimination". This led to a few, "*what about me?*" and "*all lives matter*" conversations with white NEDs in particular, causing on-going tension on the board.

This could explain why ethnic minority board members describe feeling pressured to lead on race because of their ethnicity. A key challenge for them is how to convey the importance of white colleagues being proactive in tackling race inequality and fostering a sense of shared responsibility and ownership. Ethnic minority leaders describe various tactics to counter this. One chair, although happy to be vocal on race equality, does not want the "*shortcut*" of being seen as the go to person of colour who is already well versed on the race agenda. Another chair signposts to other leaders on the topic rather than her.

A number of leaders highlighted the failure to translate talking about race equality into meaningful actions.

"*They did a good piece of work looking at racism within our trust and provided some hard-hitting evidence of the reality, as well as a large number of recommendations. Sadly no progress yet in making these into an action plan with milestones and responsibilities.*" NED, combined acute and community trust

"*We do a lot of talking about race equality and anti-racism, but this has resulted in almost no concrete actions and we have not been able to show progress at all. I couldn't answer the questions above because I don't think we have made any real progress.*" NED, combined acute and community trust

Where intentions had been translated into action plans, other leaders describe the continued lack of measurable progress.

X explained that the board are frustrated as they are yet to see a big impact despite the work they have been trying to do. She gave the example of their WRES data not changing. Many of the board members have been exposed to equality training at different organisations and some within the NHS, but some believe, "they've heard it all before" and it is still not making a difference.

Knowing your community and attracting diverse talent

Another common theme was the lack of diversity in trusts' local community or population relative to the rest of the country, as a reason for a lack diversity in their organisation. Leaders described not knowing enough about their local communities for example, not having a sufficiently granular understanding of local demographics or the challenges posed by transient populations. Similarly, there was a realisation that trusts did not know enough about their staff, particularly in terms of their protected characteristics.

"*The area we cover is large, with many smaller more rural and coastal communities which are not as ethnically diverse as a more compact urban area with ethnic minority patients and staff quite isolated*." Chair, combined mental health, learning disability and community trust

Foundation trusts describe having to work hard with their local communities and community leaders to encourage their interest in becoming members and governors in an organisation they know little about. Many members also expressed concerns about a lack of suitable and diverse applicants for senior staff roles, although some recognised the need for much more proactive engagement to develop a pipeline of ethnic minority talent rather than relying on a simple statement that 'applications from underrepresented groups are welcome'.

Members also questioned whether ICS boards are likely to be sufficiently diverse given the lack of diversity amongst existing system leaders. There was a perception that ICBs in particularly needed to do much more to build a cohort of diverse applicants.

Middle management

Some respondents highlighted middle management and their resistance to change as being a barrier for their trust. However, engaging middle managers in change that was more "meaningful" was described as difficult. This could be due in part to entrenched, "*middle management customs and practices*" and senior leaders not adequately managing this group, as one NED suggested. Chief executives felt leadership training and development should be made more of a priority and more widely available, for example to operational leaders.

X said it is important to define 'talent'. Currently, looking for "fit" excludes talent from people in ethnic minority communities. He says defining "fit" is predominately done by white colleagues who look like them and have similar socioeconomic backgrounds. He believes it is important to challenge the use of the word "fit" and that boards must define the skills needed for senior roles and think about where they can actively find people with these skills in local communities.

Experience and impact of discrimination

There were concerns about the challenges experienced by ethnic minority leaders and staff, in particular the double burden of experiencing discrimination whilst having to continue to lead the race equality agenda, not to forget the emotional burden of having to draw on personal experiences of discrimination. One ethnic minority leader described the personal challenge of having to explain structural racism to white colleagues who would not have experienced inequality in the same way.

Leaders describe the challenges for ethnic minority staff having to work in services that did not acknowledge inherent racism in the NHS and processes that were a legacy of systemic racism. Some members described staff in their trusts who did not understand the barriers that ethnic minority staff experience despite overt racism among staff and patients. Within this context it was important for leaders that staff believed that 'appropriate action' would be taken against racism and that boards acknowledge the problem.

"There is a tendency for a subconscious belief that there is no problem with racism and having an external person hold up a mirror to the board is very useful indeed."

NED, acute trust

"We are a trust where race issues are not as obvious as in others. So we have to be more alert to them being less observed. There is inadvertent racism and a lack of confidence in addressing this and calling out unacceptable behaviours. As a board we have had some development but could do more."

Chair

WHAT GOOD LOOKS LIKE, IN YOUR WORDS...

3

1 Encourage accountability

- Identify what you are trying to achieve and how you are holding yourself and the organisation to account.
- You are accountable to the population you serve, and the workforce you lead, so seek assurance from them on whether you're making meaningful progress.
- It is one thing to say you've got a "zero tolerance" approach but if there are no consequences then there is no point.
- Embed EDI into an accountability framework.

2 Education on race

- Make race education a priority to ensure people understand the external and internal context.
- Encourage people to join the dots on their own (self learning).
- Give people the literature and then challenge them.
- Tell people the session starts with the literature, so they know they must read it.

3 Foster safe spaces

- Create space for honest conversations.
- Ensure conversations are confidential.
- Find skilled facilitators. Shouldn't always be the HR director.
- Consider external coaching, particularly for chairs, to build confidence and capability to lead on race.

4 Focus on personal values and behaviours

- White leaders taking the lead on this agenda is essential.
- Be fully committed to EDI as you cannot drive change without the support of the board.
- Recognise leadership is fundamentally about prioritisation.
- Listen to people's lived experience. Understand what it feels like to be excluded.
- Get people to express their vulnerabilities.
- Be humble and admit that you don't know everything and hold biases. Recognise and acknowledge where you haven't done well.
- Personally believe in it and role model it.
- Behaviours and actions speak volumes to colleagues from diverse communities.

5 Challenge discrimination as a priority

- Call out and challenge things that are discriminatory.
- Listen to the experiences of minority communities and the micro-aggressions that aren't called out.
- Support staff to stand up to unacceptable behaviour from patients – yellow carding demonstrates that abuse won't be tolerated.

6 Create a culture of challenging yourselves

- Where the board is not cohesive, this is a positive thing – only by understanding the core views of board members can you start to have more challenging conversations.
- Draw on external support so you have someone who can look objectively and challenge your thinking.

7 Closer engagement with staff and community networks

- Staff networks are like a social movement – they can speak truth to power inside the NHS. A crucial way of checking what is going on.
- Networks give people a place to share. This is best done in specific groups i.e. not all BAME people experience prejudice in the same way.
- Buddy executive champions with your staff networks to help foster trust between staff and the board.
- Co-design programmes with board members and the BAME network.
- Reverse mentoring – it can be a powerful tool with white colleagues.
- Don't just talk to staff about their lived experience, talk to your communities about how they experience your services. Put them in the driving seat in how to tackle inequity.
- Link into community groups through their trusted voices and run community-based workshops.
- Do more as an anchor institution to offer employment opportunities to the most deprived communities.

8 Improve HR processes

- Look at all HR processes, recruitment and retention – embed EDI.
- Comply or explain accountability.
- Be proactive – we introduced an associate NED post on our board as a development post offered only to candidates from BAME background.
- Clear policies and position on allyship, intersectionality, promoting psychological safety within the organisation.
- Positive action especially in recruitment.
- Criteria used for recruitment searches are as open as possible to encourage diverse applicants.
- BAME representative on all band 7 and above interviews.

9 Better use and understanding of data

- It is not about what you say, it is about what is found when research is done on the organisation.
- Be an evidence-based organisation which is held to account by hard data. But recognise data alone will not drive change.
- Address and make links between data and personal experiences.
- Implement systems to cut all data by different characteristics.
- Cut waiting list data by ethnicity and deprivation – do more work to discover why ethnic minorities are waiting longer.
- Look at the staff survey – recognise that one person's informal performance management conversation is another person's bullying conversation.

10 Link with health inequalities interventions

- Make tackling health inequalities a central part of any organisational strategy – the golden thread.
- Put health inequalities into the annual planning cycle.
- Provide support for the board on understanding health inequalities across the system – how to prioritise and address.

Trust leaders described initiatives that didn't work for them

> ***There are still many NHS trusts that believe equality and diversity can be achieved by a part-time HR director.***

> ***Fatigue on knowing that action plans don't work.***

> ***A half day or one day board workshop isn't going to crack it.***

> ***Reverse mentoring may just be for show.***

> ***Personal testimonies may not be useful – they are emotionally draining.***

4 HOW NHS PROVIDERS CAN HELP

> ***"I'd like to see you speaking up too on this agenda."***
> Chair, combined mental health, learning disability and community trust

Perceptions of NHS Providers

"*Will NHS Providers be appropriately challenging to individual trusts – and how they think, understand, and most importantly ACT to address this agenda? How is NHS Providers going to change hearts and minds in a way that leads to action*?" Chair

We felt it was important to ask respondents about their perception of NHS Providers, particularly as we are on a similar journey to that of our members and invested in making improvements towards becoming an anti-racist organisation. NHS Providers was described by some as "late to the party". Some leaders highlighted the lack of diversity among staff at NHS Providers, particularly at a senior level. There was also a perception that there was little diversity in people leading and facilitating NHS Provider events. One leader was "yet to see an NHS Providers session run by a black individual."

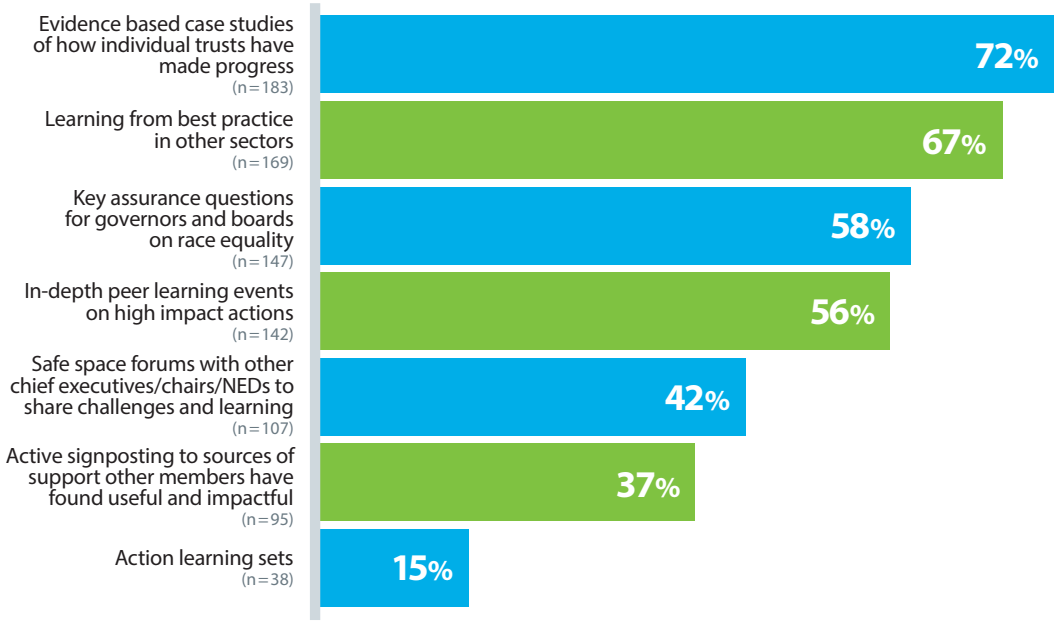
Some members felt NHS Providers was not in a confident position to talk about race, with one commenting that we have been "*caught in the headlights, as have all other white leaders*". It was felt that we needed to "*be more comfortable having uncomfortable conversations and asking the questions* [about race]". Others describe having to "*dig a long way on the website before you find anything on inclusion*". Some members notice the lack of conversation and engagement when race is mentioned at member meetings in comparison to other topics.

Support needs

We asked leaders what support they needed from NHS Providers to help their boards accelerate the pace of change on race equality. Almost three out of four respondents (72%) said that evidence-based case studies of how individual trusts have made progress would help their board, followed by two thirds (67%) who wanted to learn from best practice in other sectors. A majority of respondents thought key assurance questions on race equality would be helpful and in-depth peer learning events on high impact actions.

Figure 4

Areas NHS Providers can support to help boards accelerate the pace of change



Evidenced based best practice, in depth peer learning

Leaders would like NHS Providers to share best practice and provide a platform for members to learn from each other as well as other sectors. Members stressed the need for a body to promote what good looks like from commissioning and planning through to intervention and impact. Effective signposting to the work of other organisations and available resources was also a key theme.

Some felt NHS Providers should provide advice on the most impactful actions to tackle race inequality. For others, the NHS Provider value-add was seen more in our convening and peer learning role, including facilitating access to board members who already lead on the race agenda who can act as mentors.

One of the key areas where leaders would like support is help understanding the data, particularly as a way of making the case for change. This ranged from a basic understanding of disaggregated data on ethnicity to using intersectional data and combining quantitative data with lived experience testimony. Some leaders felt boards are not good at knowing what to do with WRES data and NHS Providers could help share good practice. Trusts would also like help understanding the variation of ethnic minority populations across the country. Effective use of data and digital approaches was highlighted by some as a specific area of support.

An awareness that not one size fits all led many leaders to suggest NHS Providers has a role to play in sharing solutions to tackling race inequality tailored to very specific contexts.

This included sharing case studies of organisations with different types of staff and population profiles.

Some leaders would find it useful for NHS Providers to create materials around the case for culture change that could be delivered by them as well as by NHS Providers via one off board sessions. A few leaders called for mid to long-term tailor-made development programmes including for specific subsets of leadership such as governors, chairs and HR professionals.

Accountability and challenge

Sharing good practice about how boards have incorporated accountability for tackling race equality into their existing ways of working is a key area where leaders have asked for support. Areas of challenge for leaders include developing effective accountability frameworks, encouraging accountability through personal development plans and understanding how change gets embedded right through an organisation.

Trusts felt NHS Providers could make more use of its agency and influencing, challenging national bodies and regulators to ensure race equality is genuinely prioritised. Similarly, NHS Providers could challenge white chairs and chief executives to have conversations about race, helping to develop a greater understanding of what it means to be anti-racist and the chair/chief executive role in leading the EDI agenda more widely.

"*...the perpetual reinforcement that this "isn't somebody else's job, this is your job" could be very powerful.*" Chief Executive

Collaborative working and networks

There was a unanimous feeling that it is important to support and engage with other organisations and their work on race equality, and that NHSP could help embed this focus through their existing support offer, including their networks, board development and induction programmes. More specifically to help understand how other trusts have embedded values around race equality and make sense of wider work on race equality by facilitating allyship with organisations like the Leadership Academy, Seacole Group, Race and Health Observatory and NHS WRES, and working with them to develop a diverse pool of speakers and trainers.

Safe spaces

The importance of creating safe spaces emerged as an overarching theme across all areas of potential support. There is a recognition that people are concerned about exposing their vulnerabilities. NHS Providers was seen to have a key role in creating safe opportunities to have difficult conversations that build confidence and trust and enable people to open up. We can build and sustain allyship and define the function and responsibilities of safe spaces within our various networks, for example, building a forum/network for chairs specific to race equality.

5 ROLE OF NATIONAL BODIES AND EXTERNAL SOURCES OF SUPPORT

> ***"Make this a national priority and as part of the national scorecard, which is visible, measured and hold boards to account for achieving these priorities."***
>
> Chief Executive, acute trust

There was a consensus that the national bodies such as NHS England and the Care Quality Commission (CQC) could do more to help boards take effective action on race equality. Chairs in particular stressed that national bodies must lead by example and clearly prioritise and promote work on race equality.

One chair said what was needed was: "*strong, consistent and meaningful messaging with demonstrable initiatives that genuinely bring leading by example rather than the risk of mere lip service.*"

Echoing the support needed from NHS Providers, many of the respondents mentioned that sharing best practices, resources and high impact interventions would help their boards, for example: case studies of what works and what has not worked, a central reference library resource, including equality and diversity matters in every publication, encouraging debates and sharing of good practice at all events. Many respondents stressed the importance of trusts, boards and ICSs being held accountable and challenged for further progress to be made.

"*Challenge boards directly to "Do the work of challenging themselves, personally and collectively, constantly rehearse their 'Why' to avoid tokenism and box ticking.*" Chair, acute trust

NEDs highlighted the importance of making race a key performance indicator and setting specific goals or targets to achieve good outcomes. They felt the CQC had a specific role here:

> ***"CQC should include progress/the status of a trust's race equality work in their scoring framework. NHS England and NHS Improvement should rework role descriptions and appraisal documents to include goals and targets on race equality for chief executives, chairs, NEDs and governors."***
>
> NED, acute trust

Just under half of respondents (42%) said they have used external consultancy support for their work on race equality. These members felt it was important to have external challenge and expertise on race, but consultants needed to be carefully selected and managed.

"*I think external challenge is valuable. It has also enabled staff to feel safe being open and challenging. But eventually it's about what we do with what we hear.*" NED, combined mental health, learning disability and community trust

The use of specialist commercial consultancies was highlighted, alongside accessing NHS offers such as the NHS Leadership Academy. An example of work with charities and local community organisations included the Leeds Community Healthcare NHS Trust allyship programme and West Yorkshire and Harrogate Health and Care partnership's anti-racist programme (movement co-created by over 100 of the partnership's ethnic minority colleagues).

Leaders mentioned the positive work that the Seacole group does on recruiting NEDs and the work of the Royal College of Psychiatrists in advancing diversity in mental health provision. Some trusts also drew upon support from academia such as using external speakers from universities to talk about slavery and the black experience or collaborating on a senior management reverse mentoring programme.

However, despite knowing that there were a range of offers available one of the main barriers described was the work required to "*find what suits the needs of our organisation*."

6 NEXT STEPS

NHS Providers has made tackling race equality a key strategic priority.

We acknowledge that in order for this to be a meaningful commitment, we must start with ourselves. Now is the time to be really clear on our ambitions and what we think is the task ahead. We know it requires us as white leaders to not just understand and acknowledge our privilege, but to be proactive in how we interrogate structural racism and strive for racial justice.

We are in the process of developing an anti-racism statement to set out what good looks like on race equality for us as an organisation as a key means of publicly demonstrating our focus on this agenda and our willingness to be held to account.

We are also in the process of developing an internal action plan to ensure we are hard-wiring a focus on race equality throughout all that we do – from our policy influencing and media commentary to our member networks, events and board development offers.

We know from our member interviews that genuinely mainstreaming a focus on race through our existing offer will be a major part of our contribution to addressing racial injustice. But we also know there is appetite from members for us to develop a specific programme to support our members to make further, faster progress on this agenda. We will use the findings in this report from our scoping research to inform the key elements of that offer, to ensure it genuinely meets the needs of trusts.

Our offer of support to our member trusts will be tightly focused on the strategic leadership role of boards and on what has had the greatest impact. It will ensure we're using our convening power to encourage the honest and often challenging conversations required to really change hearts and minds with a strong focus on self as an instrument of change, as well as our ability to share evidence based good practice about what works and why in very different trust contexts.

It will ensure our focus is on not reinventing the wheel, but working in partnership wherever we can and amplifying and signposting to the work of others where this has had proven impact. It will look at how we can improve understanding of the lexicon of race, anti-racism and racial justice, the links between race, intersectionality, and the wider EDI agenda, and between race and health inequalities. And crucially, it will be based on the principle that the responsibility of leading work on race equality should not be placed on ethnic minority board members but focus on white leadership and promoting effective and authentic allyship.

We know for many of our members and staff that *real*, meaningful change has been a long time coming! We acknowledge with this report that past actions have just not have gone far enough. There is an opportunity now to engender a much greater sense of accountability and personal responsibility, a real hearts and minds commitment to creating workplaces and services that are fair for all, and where race equality is genuinely prioritised. Our colleagues and members will be the ultimate judge of whether this opportunity for real change has been seized.

Suggested citation

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Interactive version

This report is also available in a digital format via:
www.nhsproviders.org/race-2-0-time-for-real-change

For more information

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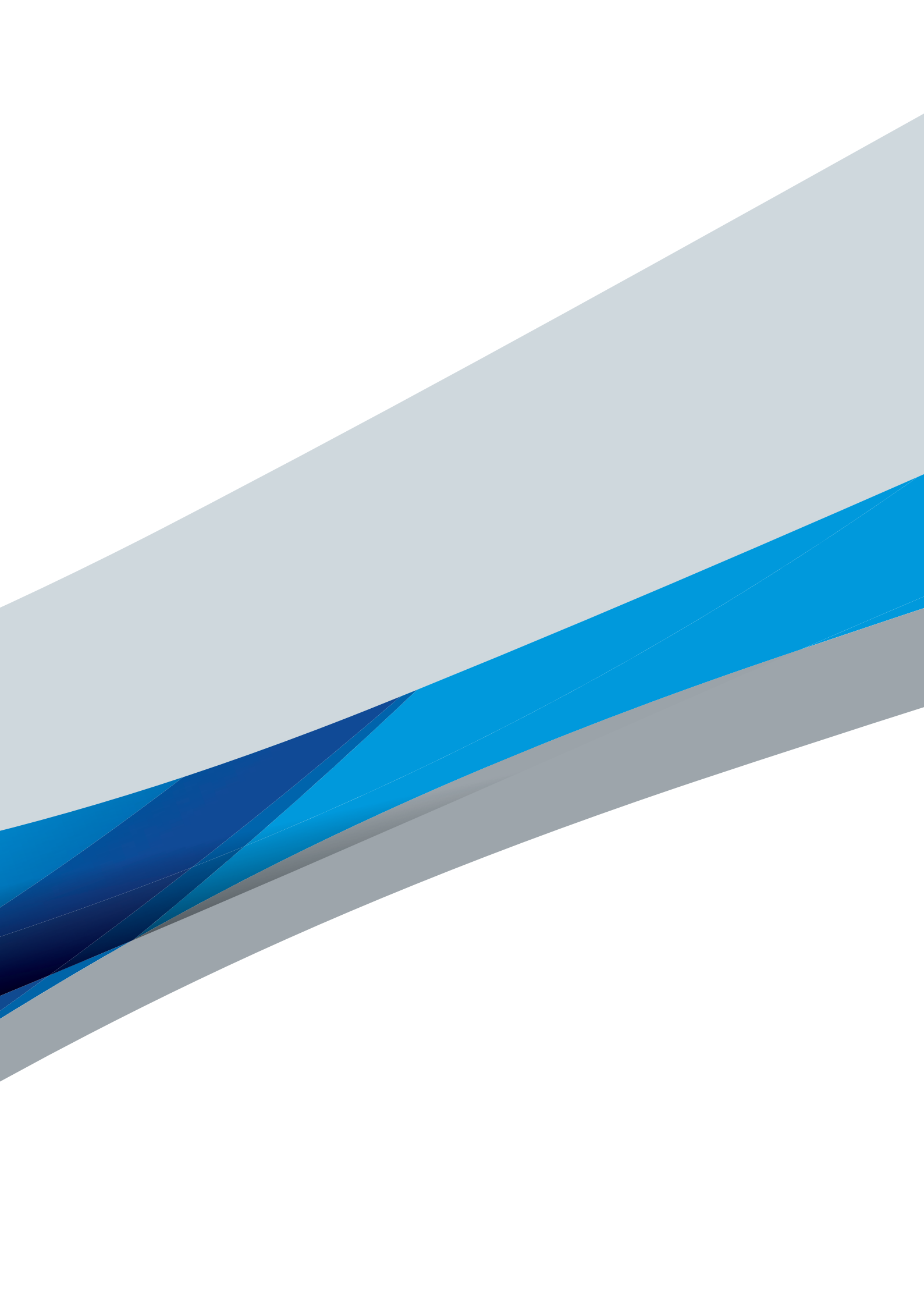

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

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