Peer learning event: A data driven approach to tackling workforce inequalities.

Chair:

Mahmud Nawaz, chair, Chesterfield Royal Hospital NHS Foundation

Speakers:

Sandra Eismann, head of Equality, Diversity and Inclusion (EDI) policy implementation unit, NHS England

Gugu Ndebele, implementation unit lead EDI policy, NHS England

Riyaz Patel, EDI mandate principal lead, NHS England

Khalida Wilson, EDI policy development principal lead, NHS England

Plenary presentation

The NHS EDI Plan sets out six high impact actions (HIA) for NHS trusts and foundation trusts to evidence action and progress on. Within these, Sandra Eismann highlighted HIA 1, 3 and 6, which include specific sub actions on how data must be reviewed and analysed to support the development of appropriate actions.

Objective	Data specific actions
HIA 1 - chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.	• Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025). • NHS boards must review relevant data to establish EDI areas of concern and prioritise

	actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).
HIA 3 - Develop and implement an improvement plan to eliminate pay gaps.	Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.
HIA 6 - Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.	Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set (by March 2024) and plans implemented to improve staff experience year-on-year.

Gugu Ndebele presented a demonstration of the EDI dashboard, hosted on the Model Health System and available to all with an NHS email address.

The dashboard supports the tracking of organisation specific actions in relation to EDI, alongside aggregation and triangulation of multiple workforce datasets including the National Staff Survey (NSS), Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), the gender pay gap and the National Education and Training Survey (NETS). NHS organisations are able to benchmark their organisational performance at system, regional and national level. Gugu also shared an overview of the, 'National People Pulse Survey', a voluntary tool developed to support listening and engagement events across organisations, and encouraged trusts to adopt this if not already implemented.

Riyaz Patel shared a brief update on the current status of EDI reporting, with NHS trusts having submitted their latest WRES and WDES data to NHS England in May 2024. Detailed organisation level reports are due to be returned imminently, and the national report published in 2025. Riyaz demonstrated how leaders can utilise the data within the organisational reports to identify priority areas for focus and action.

Khalida Wison outlined the scope of the EDI Repository, hosted on the NHS Futures platform. The repository consists of three distinct types of content under each HIA, including case studies, resources and toolkits and research and evidence.

The following areas were also discussed:

- Identification of good practice through published league tables. The EDI dashboards provide an indication of how your own trust is performing in relation to system, regional and national performance. 'League tables' will not be published, and delegates were encouraged to submit good practice to the EDI repository to support wider peer learning.
- Role of non-executive directors (NEDs). The panel emphasised a need for accountability from trust boards as well as a collective responsibility for progress. There was emphasis on the role of NEDS in providing challenge and seeking assurance case studies, resources and toolkits and research and evidence as effective levers for progress, based on feedback from EDI leads within provider trusts.

Access to both the Model Hospital and the EDI repositorys are available via:

- Model Hospital repository
- EDI repository

Breakout discussion key themes

Delegates were invited to join facilitated breakout groups to discuss two questions:

1 What does the data tell you about the risks/impact/successes within your organisation to support your strategic decision making/influence as a board?

You discussed

There was variation in how delegates were utilising available data within their organisations. However, many identified a need for:

- Clarity on and support navigating technical guidance and data analysis, taking into consideration the issues experienced by smaller trusts and those with lower diversity.

- Support on peer learning on improving diversity monitoring with a particular focus on disability declaration.
- Greater alignment between mandated reporting and analysis of data from NHS England to inform action planning.
- Cross platform interoperability to enable a more holistic analysis.
- Inclusion of population health data within Model Hospital EDI dashboards.
- Greater board ownership and engagement with the EDI data.

Some members also spoke of not having previously accessed the EDI dashboard through the Model Health system and a need to explore how this differs to locally developed dashboards.

Challenges	Impact	Local intervention
Data quality and volatility due to low diversity or declaration rates. Multiple delegates reported low declaration rates in relation to WDES data. Nationally, 4.9% of NHS staff have declared a disability on the Electronic Staff Record (ESR) (WDES NHS England, 2023). This is in comparison to an anonymised declaration rate of 23.4% in the NSS. Within smaller trusts and those with lower diversity, there is a higher level of volatility within the metrics as small changes within the data can present as a large disproportionate ratio.	Poor disability declaration rates result in low confidence in the data and challenges identifying a strategic evidence-based way forward, or to make longer-term actionable change.	Delegates shared actions they have taken to improve declaration rates including: • Providing ESR self-serve access for all staff and ensuring staff confirm their data is correct. • Development of trust-wide internal communications to raise awareness on disability declaration. • Working with staff networks to understand barriers and support needs. • Delegates reported triangulating the more volatile data with insights from pay gap (gender, ethnicity etc) data to help pursue the right actions.
Clarity and consistency within technical guidance across WRES and WDES.	A lack of confidence in benchmarked data, and good practice	Delegates discussed a need for a greater level of technical support for NHS trusts reporting against mandated EDI requirements.

Multiple organisations reported concerns about the lack of consistency in how metrics are measured across both WRES and WDES, in particular citing metric 3 across both data sets.	interventions as some trusts may be (unknowingly) working under different rules.	
Data analysis and subject matter expertise. Delegates reported challenges in identifying and understanding the causes of disparities and where interventions are working well.	Difficulty in identifying the causes of inequity and action planning appropriately.	Utilisation of power business intelligence (Power BI) tools to support detailed analysis, and development of directorate and team level dashboards was given as an example by multiple delegates.
Nonalignment between data collection and reporting and national analysis. • Lack of alignment between reporting periods for trusts and publication of organisational and national reports from NHS England (NHSE), present challenges for many trusts. Delegates reported data within reports from NHSE being at times over a year on from the date of collection. Where these reports contain analysis to support local action	Whilst the national team provide helpful analysis and insights on which areas should be prioritised for action, the value of this work is reduced due to the time elapsed since original data collection, submission and analysis.	Delegates discussed using local data and dashboards to inform their actions rather than awaiting analysis from NHSE. However, for those trusts who await the analysis by NHSE, it leaves little time to drive progress ahead of the next reporting cycle.

planning, this can result in a knock-on impact on available time to drive action before reporting recommences.		
Triangulation of workforce and patient data across platforms. • Delegates discussed data triangulation across the multiple platforms within NHS organisations including incident reporting, ESR, employee relation systems, patient data systems, Trac etc. as a challenge. • Delegates also expressed a need to link local population demographic data within the Model Hospital dashboard to support a granular understanding of how the organisation is representative of the communities it serves across all levels and specialities.	Due to the lack of cross platform connectivity, delegates reported not feeling assured that they had the full insights to support decision making.	Delegates reported using Power BI to develop interconnected dashboards. However, these solutions are having to be developed locally in the absence of nationally developed solutions.
Low board engagement. Existing governance arrangements within some organisations lead to data	Lack of strategic oversight and ownership from the board to drive progress.	Actions taken by trusts to increase board engagement included:

being reported to middle management tiers, subsequently lower engagement at board level.		• Strengthening of existing governance frameworks through the requirements of HIA 1. One trust has embedded the six HIAs within the trust strategy. • Challenging the board to publicly acknowledge the disparity in workplace experience, with one trust reporting the board accepting they were a structurally racist organisation at public board. • Divisional directors chair localised committees with oversight of local action plans and data.

2 What support would help you have a deeper conversation around your data to support your strategic decision making/influence as a board?

You discussed

Do less but do it well. Delegates agreed that there is a need to commit to fewer actions and complete these to a higher standard. As part of this there needs to be recognition, locally and nationally, that equality-based metrics may not improve at a rapid pace or consistently. They are often linked to culture and process change which can take more than one reporting cycle to embed.

Clarity on how to measure impact. Greater consideration and support to help measure success was highlighted by delegates. Success measures should be both quantitative and qualitative.

Greater disaggregation of the national data on the EDI dashboard and within reporting. Delegates shared concerns that higher ethnic diversity within clinical roles and international recruitment presented skewed data and 'false positives'. This should be addressed through disaggregation to provide a more nuanced image of trends within an organisation.

Timely and more sophisticated analysis. Delegates felt annual measures of progress provided only a snapshot in time. Quarterly internal reports pulled from 'live' systems would support local conversation better, whilst this is being implemented in some organisations through Power BI, the available of this functionality within the national EDI dashboard would be preferable. Alongside this

there is also appetite for more sophisticated analysis through the use of statistical process control (SPC) charts, to help monitor and assess the effectiveness of interventions over time.

Publication of benchmarking tables to support peer learning. Delegates felt it was important to have benchmarking available more widely and the ability to identify high performing trusts to support peer learning and improvement, especially for like for like trusts. The addition of population health data to dashboards would further enable delegates to identify like for like organisations that have a similar population makeup.

Data is important and drives action plans. Agreeing actions and moving forward, the 'So what?' question is key for example 'how are we going to tackle X?', 'What do we want to achieve?' With so many papers it's difficult to have time for this.

Resources

Presentation slides
Race Equality roundtable: NHS England's equality, diversity and inclusion improvement plan