NHS England

Rapid review of inclusion in NHS recruitment and promotion practices (IRPP) programme

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Scope of the review

This rapid review of inclusive recruitment and promotion practices in the NHS was intended to:

A. Review the current national work on IRPP and overhauling recruitment from an equality, diversity and inclusion (EDI) perspective

B. Interview individually or by virtual round tables, a cross section of EDI, organisational development (OD) and HR practitioners

C. Draw where appropriate on experience in other sectors and within the NHS (notably civil service, NHS Providers, NHS Employers)

D. Produce a short report setting out priorities to support deliverables

E. Determine what key outcomes NHS organisations are expected to deliver against within the next three years

F. Identify the framework NHS organisations must adopt in order to move towards those outcomes in a sustainable way

G. Identify priority areas for support to be provided at national and regional level, to enable employers to reach these outcomes

H. Determine who is best placed to provide that support – national, regional or other networks

Methodology

Thirty eight colleagues were interviewed, mostly one to one and some in groups. In addition, a special meeting of the NHS IRPP stakeholders' group was held to consider the proposals and some of the early findings. Of the 38 colleagues, 19 were chief people officers (CPOs), two deputy CPOs and the others were subject matter experts, senior recruitment team members and colleagues from NHS Providers and NHS Employers. They were selected to be a reasonable cross section by geography and type of organisation. For reasons of time, it was not possible to interview private sector colleagues as planned but previous NHS England research was drawn on.

The starting points for the interviews were two presentations made by the national team in relation to the Overhaul of Recruitment and inclusive recruitment and promotions programme, outlining the deliverables, approach, and combined governance and oversight of the work. The notes below summarise key inclusion points raised.

A number of other points were made which will be signposted elsewhere.

01
PART ONE

Ensuring inclusion end to end: Feedback on the revised approach to inclusive recruitment and promotion practices

1. Interviewees were unanimous that the broad approach outlined in overhauling recruitment and inclusive recruitment and promotion practices and in Overhauling recruitment: summary of sprint scope was a substantial, more coherent, improvement on the previous NHS strategy documents on inclusive recruitment and career progression. However, a number of points were made, some by way of commentary and some as specific proposals.

2. Numerous interviewees felt the documents need to attach much greater importance to the need to ensure that the **local leadership** (at NHS trust and integrated care boards (ICB level):

- understood the importance of tackling discrimination;
- were seen to be personally and very publicly committed to promoting equality, diversity and inclusion and to tackling discrimination so that this work was not something simply delegated to the CPO but was a CEO/Board priority linked to accountability across the organisation;
- understood that improvements in diversity and representation would not be sustainable without creating and embedding inclusive teams
- were prepared to specifically and publicly address racism (as a particularly challenging recruitment and career progression issue) based on their personal understanding and commitment – raised by providers even where BME numbers were relatively small.

Highlighting this issue is evidenced by the research literature and complements the Messenger Review recommendation that the NHS should "Embed inclusive leadership practice as the responsibility of all leaders" and thus commit to promoting equal opportunity and fairness standards and more stringently enforce existing measures to improve equal opportunities and fairness.

Recommendation one

There are a small number of inclusive leadership courses run for significant numbers of very senior leaders by Leadership Academy as well as by external organisations such as Healthcare People Management Association (HPMA) that were referenced by interviewees that appeared to have a substantial impact in terms of understanding and motivation. A trust CPO interviewed, has plans to roll out the course across the trust's own managers. Consideration should be given to how that model might be expanded at scale including "training the trainers". But it is crucial to evaluate such courses to ensure alignment with evidence on diversity training and are not a substitute for the debiasing of processes and insertion of accountability into recruitment and career progression.

3. A number of interviewees felt that the two documents needed to be much more explicit about the **underlying approach** to be used to implement them. For example, an emphasis on accountability, debiasing processes and the role of board leadership. CPOs and others interviewed were not looking for a "one size fits all" model in terms of specific actions or processes. There was an indication of real risk that organisations could end up with a "shopping list" of things to do, which was not coherent and would not succeed unless the underlying evidence base was not sufficiently widely understood.

The evidence base and good practice around debiasing of processes, accountability and inclusive leadership needed dissemination

Recommendation two

It was suggested a number of times that a very short summary of No More Tick Boxes for use especially with boards and with HR/OD staff would be helpful. If so, it might offer deep dive sessions into elements so organisations can build understanding and talk through challenges. It should draw on some excellent local work already underway.

Recommendation three

Data driven accountability requires all organisation to have some form of real time data to enable scrutiny, accountability and improvement. This would require national support with a core set of metrics which could be adapted and enhanced locally

4. Concerns were raised by almost all interviewees that **a coherent approach** that addressed the end-to-end challenges of IRPP was very considerable. There was a welcome for the **joint approach** bringing the NHS England HR development and OD and EDI teams together on recruitment, career progression and possibly other issues.

Recommendation four

Serious consideration should be given to how HR and EDI teams would work much more closely together thus ensuring a joined up approach with a single approach on IRPP. That would apply to how a number of the suggestions in this document are developed and rolled out to the wider system.

5. Concerns were raised by almost all interviewees that a coherent approach that addressed the end-to-end challenges of IRPP required support on how to **"eat the elephant"** bit by bit without losing the coherence needed since it was clear that not everything could be tackled at once.

Linked to that was a concern about the **available resources** to support the programme of work, particularly if EDI might move towards an improvement lens not just compliance. Providers were clear the resources to tackle this work "in one go" are not currently available. See paragraph 12.

There was a further concern that unless the evidence that EDI and inclusion were understood as essential to recruitment, retention, effective team working and patient safety, rather than as an optional extra, it could undermine each of those priorities.

Recommendation five

Drafting and dissemination of materials to underline the importance of EDI to current NHS workforce priorities should be seen as a priority. This should be supported by codifying and sharing examples of good practise from across the service. The resources should reflect impact on patient care/experience/outcomes as well as on staff and organisational effectiveness.

6. It was felt the approach outlined should more explicitly include the use of **positive action and developmental opportunities** within both recruitment and promotion. Stretch opportunities and positive action are well referenced in the sprint document but not in overhauling recruitment and inclusive recruitment and promotion practices. Discussion of these issues led into discussion about talent management and succession planning across the NHS. It was felt this was under-resourced with a need for clarity as to the relative roles of NHS employing organisations and the Leadership Academy.

Examples were given of positive action in attracting applicants, giving them encouragement and confidence. It was felt that the importance of "stretch opportunities" needed to be explicitly highlighted as a key developmental issue, often linked to positive action though some interviewees felt that there was still nervousness about what counted as legal positive action and what did not. A number of middle ranking and senior managers had benefitted from Leadership Academy courses though it was felt the follow up to these locally (and nationally) was inconsistent. There is good practice underway though it was stressed by several interviewees this must **not** be framed as a deficit model nor as an alternative to challenging institutional and process barriers that the two documents were seeking to address.

There was a recognition that **appraisals and feedback** were important issues where practice required improvement.

Recommendation six

Consideration should be given to a short guidance note on what forms of **positive action** are possible.

Sharing examples of evidenced good practice on inclusive approaches to development opportunities, effective succession planning and talent management is a priority. An emphasis on inclusion and the treatment of diverse staff was seen as crucial since high turnover seriously undermined talent management and succession planning. "Those who don't stay cannot be promoted" as one interviewee put it. Retention should therefore be an explicit part of a strategy on recruitment and career progression. Similarly, we need to prevent adverse consequences for those who query or challenge local actions (or omissions) on discrimination.

National good practice guidance on inclusive appraisals should be developed, alongside ongoing work on "difficult conversations", building on the robust evidence base and integrated locally into provider accountability. These should be linked to manager development and Messenger's recommendations. Consideration of what national metric might be further developed around inclusion.

02
PART TWO

Feedback on deliverables planned for each stage of the recruitment pathway

7. Attraction

Repeated concerns were raised that several aspects of the NHS recruitment process especially NHS Jobs and TRAC undermined effective inclusive recruitment process – as summarised in the overhauling recruitment and inclusive recruitment and promotion practices and sprint slides. The current work being undertaken to simplify, streamline and make these systems more user friendly through the "sprints" were welcomed as long overdue.

The job descriptions driven by Agenda for Change were also seen as seriously problematic – extraordinarily long (deterring applicants) and inappropriate because AfC contains no factors for inclusion or speaking truth to power – key inclusive criteria which need careful descriptors. A number of organisations had tried "workarounds" with mixed success for lower graded staff. The streamlining (including by digitalisation) of the attraction and application process was already underway in some providers. Examples of innovative work by local providers to attract applicants from marginalised and under-represented groups were highlighted.

Recommendation seven

Good inclusive practice existed which should be collated and shared, particularly emphasising the plusses of working in the NHS at a time when there are plenty of work pressures.

Work should be undertaken in the medium term on trying to amend Agenda for Change (presumably via the NHS Staff Council) to create e.g. a factor for "inclusion" and ensure values are thus represented in job descriptions.

8. Shortlisting

Some interviewees raised major concerns about the risks of using artificial intelligence (AI) in shortlisting given the risk of reproducing or creating bias which would be both problematic and reputationally damaging for the NHS. There is significant new research now available (e.g. Equality and Huma Rights Commission's (EHRC) artificial intelligence in public services and the Centre for Data Ethics and Innovation review of bias in algorithmic decision-making).

Recommendation eight

Immediate consideration should be given to how AfC was used in job descriptions, shortlisting and interview processes, including how "non-NHS experience" might be better reflected alongside or equivalent to formal qualification or formal experience and more formal experience.

9. Selection

No concerns were raised about this section (which was felt to capture the key issues well other than some confusion about whether the implementation of the six high impact actions on inclusive recruitment was subsumed within this new work programme (it is referenced in page four of the sprint scope summary). The pilots and the evaluation of the six high impact actions were not well regarded by those CPO interviewees who had been involved.

In general, evaluation of selection interventions was felt to be important and there was clearly room to disseminate good practice around both well-structured interviews and the use of other data points such as Situational Judgement Tests or Work Samples.

Recommendation nine

Best practice advice on interviews and selection processes should be shared.

10. Pre-employment checks

No concerns were raised about this section which was felt to capture well the key issues of time and "clunkiness" and the importance of streamlining it.

11. Onboarding

This section was felt to need strengthening. There were some concerns about the role of agencies which have some involvement in international recruitment. However, there were also several examples of good practice (significantly better than in the past) and substantial investment by providers was reported in their induction and onboarding but it was not clear that this was universal.

Interviewees were conscious of the wider need for inclusion to underpin improved representation if it was to become sustainable. There is a strong evidence base that teams that are not inclusive may struggle to retain staff with different protected characteristics and leverage the benefits they bring without it.

Recommendation ten

Best practice guidance on onboarding would be helpful – there is good practice around but certainly not universally. It was suggested collation of data on turnover rates for staff, especially in more senior roles, by protected characteristic might be helpful to organisations.

12. Model recruitment team

This was felt to be rather high level. Talent management was flagged as a crucial aspect of inclusive recruitment and promotion but in many organisations were felt to be under-developed and under-resourced which ran the risk of "tap on the shoulder" practices. The relation between trust talent management work and that done nationally via the Leadership Academy was not always clear – see recommendation 5. above.

13. Specific protected characteristics

Interviewees were clear the proposed IRPP approach benefits the **vast majority of staff**, but specific concerns were raised about gender, race and disability within IRPP.

The absence of any identified national subject matter expert with responsibility for **gender** was commented on and it was felt that had there been then there would have been (and should be) more emphasis on **flexible employment practices** at the attraction stage in particular and in later career stages in terms of flexibility to ensure retention. There remain issues around how part time staff are regarded and access to excellence awards. It was also noted that the experience of female staff (how harassment was dealt with, support during menopause and with caring responsibilities etc) all had implications for career trajectories and retention.

Recommendation eleven

A stocktake of current initiatives and those under consideration could be done through the NHS and Social Care Women Leaders Network, with attention to be paid to ensuring an identified person to lead on gender issues existed. Guidance and support on tackling the gender pay gap should be linked to intersectionality and that should be linked to wider sharing of available data by the national team. Specific attention should be paid to flexible working, including if possible, the collation of data on its effectiveness on attraction and retention.

It was felt that the steps being taken by some employers to address issues of **disability and reasonable adjustments** at the attraction and shortlisting stage should become standard practice and be explicitly noted. There are continuing issues reflected in the workforce disability equality standard (WDES) about the experiences of disabled staff once appointed.

Recommendation twelve

The **WDES team** should be asked to advise on how best practice can be shared and supported. NHS Digital publishes a national disability pay gap. Support for local efforts to do so should be provided.

Almost all interviewees stressed that **racial inequality** was particularly challenging. It was felt important to explicitly name and address the issue (including in interviews) since otherwise there was a risk it would be not addressed or filed under "too difficult". All the interviewees were seeking to do that but felt it was important the national framework (and leaders) continued to do so. The workforce race equality standard **(WRES)** annual data was felt to be helpful, including the ability to take a more granular look. Including identifying good and poor outliers in practice.

Recommendation thirteen

Consideration to be given to national production of materials that could be adapted locally to improve confidence about why anti-discrimination is so important for the NHS.

14. Bank and agency staff

Very substantial number of staff are employed through agency and bank arrangements. The former is very expensive and both contain very large number of staff not included in IRPP conversations. Both groups are likely to be disproportionately black or other ethnic minority and female by demographic.

Recommendation fourteen

There are initiatives underway to address this as an integral part of improving inclusive recruitment and career progression work. These staff groups should be explicitly recognised within the inclusive recruitment and career progression strategy, and work undertaken to identify good practice which can be shared.

03
PART THREE
Feedback on delivery and implementation

15. Capacity and skills

The future of NHS human resources and organisational development (NHS England) highlighted the importance of EDI and of leadership by HR but many interviewees were too overwhelmed by immediate transactional pressures to focus sufficiently on inclusive recruitment whilst HR staff – and EDI staff - were often felt to not have the current capacity to drive improvement. Interviewees mentioned the importance of HR modelling the progress it expects elsewhere through the work of the HPMA, NHS Employers and the #InclusiveHR initiative. Capacity to drive inclusive recruitment and career progression (including across HR, OD and EDI) needs resourcing and undertaken through an improvement lens.

16. Front line managers

Numbers of interviewees stressed the importance of meaningful engagement with front line managers on the EDI agenda. The literature is clear: unless front line managers (who make most recruitment and progression decisions) understand this agenda and serious effort is made to co-produce implementation, then "workarounds" or silent disengagement are likely.

Recommendation fifteen

Engagement (discussion, leadership and literature) is a priority alongside accountability – and that wherever possible accountability should be driven by an improvement approach. It would be useful to collate good practice or supporting pilots of this approach

17. NHS England

NHS England was seen as having a crucial role if the inclusive recruitment and career progression work was to succeed.

Clarity was needed as to what NHS England can do best that other parts of the system cannot do or cannot do as well. Those functions were felt to include data collection, analysis and dissemination and making it available; improvement of national functions (TRAC, NHS Jobs, AfC); standardisation (either directly or as templates) linked to pre-employment checks, exit interviews, leadership development etc; support (getting it right first time (GIRFT), evidencing and sharing good practice); support for research and evaluation; and setting expectations of ICBs.

Its role in identifying strategic goals and performance measures was crucial. The WRES and WDES are embedded in the NHS standard contract and the Model Employer was formally endorsed by NHS England. Whilst one CPO said "what gets measured gets done" there was equally a concern that multiple goals and performance measures, especially if linked to process not outcomes, would be counterproductive. See recommendation eighteen below

National and regional priorities should focus much more on delivery support and much less on "policy" with appreciation of the pressures CPOs and provider level EDI staff were under. It needs clear prioritisation whilst recognising local circumstances differ.

Recommendation sixteen

The well-received work of the WRES and WDES teams should be particularly focused on supporting this delivery agenda using their data and skills to assist, working closely with national and local delivery, and where possible aligned with the CQC.

Numerous professions have national forums or networks which are driving specific national interventions e.g., pharmacy, nursing, doctors, allied health professions (AHP), finance, HR and their work, together with the graduate management trainee scheme (GMTS) e, need to be working in tandem on IRPP

Recommendation seventeen

Creating an evidenced IRPP strategy is crucial but the literature is clear: neither motivation on its own, nor "command and control" on its own, will be successful. Getting the balance right early on is vital for the effectiveness of this programme as is some means of prioritising work to avoid unmanageable shopping lists. A national EDI role is crucial to support this work but with its role well defined.

18. Care Quality Commission (CQC)

The role of the CQC in including the WRES and WDES in its well led assessment frameworkwas mentioned several times. Current CQC practice was not felt to be reliable or well informed, often focussed on matters which may not be a good indication of whether the provider is making, or is likely to make, good progress on workforce equality. It was felt to not be aligned with good practice nor recognised the building of good foundations nor the problems with relying on one year's data. The Messenger Review recommendation to "enhance the Care Quality Commission's role in ensuring improvement in EDI outcomes" is directly relevant here.

Recommendation eighteen

The CQC could play a very helpful role in supporting accountability for sustainable strategies locally. National discussions with the CQC to discuss and improve their approach so providers were clear about expectations and judged them to be credible and effective were judged important as part of the national accountability framework.

19. Traction

Interviewees were all concerned that for this work to gain serious traction a credible strategy underpinning the framework set out (as amended following this review) was essential. Points made included:

- Providers need a clear steer and advice not just on **what** to do but **how** it might best be done – not prescriptively on many issues but where to start and what to prioritise. Alongside that should be space for new initiatives and longitudinal evaluations
- Continuing work was needed to "make real" statements about EDI being part of the DNA of the NHS since that was still not clear to parts of the NHS and was not helped by a widespread perception that arm's length bodies (ALBs) do not always model the equitable recruitment and promotion practices they espouse.
- There was a need to accept that whilst some progress can (and must) be made in the short term, substantial sustainable change will take time and there are no quick fixes. Working collaboratively with staff side and with staff networks should be the norm on such work.

Recommendation nineteen

Consideration should be given to a core national team to identify, collate and share good practice – numerous examples were given. This team needs delivery skills not policy skills but will need both an understanding of the research around effective practice and hands on experience of delivery. One of their roles should be to be able to showcase evidence of good practice to demonstrate EDI improvement is being taken seriously and that step change is possible.

Recommendation twenty

Consideration needs to be given to what additional resources can be made available to what are often understaffed and overworked recruitment and talent management teams alongside upskilling on evidence based IRPP.

Recommendation twenty one

A good example of a specific initiative around agency staff was given, directly linked to inclusion which would indirectly significantly benefit ethnic minority agency staff – and save providers money. There may be similar examples which should be collated and shared.

The **role of EDI staff** was raised noting such staff who are generally not well graded with no clear career paths and over-focused on compliance. There was some discussion about whether EDI staff should be upskilled to be more involved in improvement work as well as compliance work. It was also suggested that drawing in senior experienced EDI leads (especially those currently freed up to work in an improvement lens) to provide feedback in a more structured way could be helpful

Recommendation twenty two

Task and finish groups (led by front line EDI staff) might helpfully explore how this could assist this programme of work.

21. Evaluation

The programme of work as developed and amended by this review is underpinned by an evidence base but it would benefit from consideration as to how elements of this programme might be evaluated in a credible manner.

Roger Kline, Research Fellow Middlesex university and specialist adviser to NHS IRPP team.

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Annex 1. Schematic summary

Fig 1. Key elements of inclusive recruitment & career progression

Theme	Key elements
Data	Real time end to end disaggregated data
Leadership	Proactively inclusive and anti-discrimination
Attraction	Proactive, inclusive, innovative
Talent management	Positive action, stretch opportunities, appraisals, succession planning, adequately resourced
Pre-employment checks	Streamlined
Shortlisting	Evidenced methods only
Selection	Evidenced methods only
Onboarding into inclusive teams	Specific support for international recruits and clarity that inclusive teams crucial for sustained diversity
Recruitment teams	Appropriately resourced with clarity and support on evidenced methodology

Fig 1. Key elements of inclusive recruitment & career progression

Theme	Key elements
Narrative	Ensuring clarity and dissemination of rationale
Clear goals	Embedded nationally and locally
Support with improvement lens	Evidenced interventions, GIRFT team, clarify role of national, regional, ICS, providers and prioritising sharing evidenced good practice and "how to eat the elephant"
Focus	Providers, specific professions, front line managers, HR, OD. EDI staff
EDI function	National shift towards delivery and improvement with similar shift locally
Internal accountability	Data driven improvement, nudge and internal KPIs
System accountability	Clarify alignment of NHS England and CQC