Raising The Curtain On The “Equality Theatre” In Recruitment To The Healthcare Workforce

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Abstract

Background: In the UK National Health Service (NHS) provider organisations are mandated to assure racial equality in job appointments and career opportunities. However, recruitment continues to discriminate against ethnically diverse candidates (British and overseas) and NHS providers are failing to attain the many benefits associated with an ethnically diverse workforce.

Aim: To explore the extent to which an employer-led open market recruitment approach to first jobs in nursing and the allied health professions is perpetuating racial inequality.

Methods: Survey data from newly qualifying students and qualitative interviews with 12 clinical recruiting managers in 2 NHS trusts. Semi-structured face-to-face interviews used a non-judgemental approach. A conceptual lens was developed, a healthcare workforce diversity lens, to explore racial equality issues by drawing on structured searches of the research and policy literature. Questions were devised to examine issues about organisational workforce diversity goals, workforce diversity data, recruitment diversity data, diversity-led recruitment practices, strategies for effective allyship, and transformative change.

Results: While recruiting managers appreciated the benefits of an ethnically diverse workforce, they adhered to organisational policies for recruitment and selection that emphasise objectivity and standardization. Some recruiting managers sense there is “an uneven playing field” but lacked information about ethnic diversity in the workforce or recruitment to make informed judgements. In the context of a pressurised health system, recruiting managers prioritise candidate selection of those who can “fit in” and “hit the ground running” rather than taking the long view and building workforce diversity.

Conclusion: A recruitment approach optimized for objectivity and standardization, masquerades as equality, while preserving racial inequality in first job success. Inadvertently, recruiting managers are unwittingly complicit in an ‘equality theatre’ that discriminates against candidates from diverse ethnic backgrounds. The lens could help get a grip on race equality and a shift towards asset-based and diversity-led recruitment approaches.

What This Study Adds

▣ Evidence before this study

Since the inception of this programme of employability research, in 2012, we have systematically searched the academic literature (using MEDLINE, CINAHL, PsycINFO and EMBASE) for studies that examined the equality of employment opportunities for newly qualified healthcare professionals. None have been found online. Our work remains the only research we are aware of, internationally, to highlight ethnic inequality in first job success, racial differences in confidence and preparedness for job seeking^{19,20}, and the behaviour modification strategies job seekers from ethnically diverse backgrounds adopt (“being proactive”, “fitting in”, pre-empting discrimination) to attain a job in unfair systems²¹.

▣ Added value of this study

These accounts from 12 recruiting managers, give a backstage view into recruitment to first healthcare job post qualification in 2 NHS trusts in London. Seeing these views through the *healthcare workforce diversity lens* we have developed, highlights that treating everyone the same maintains ethnic inequalities, fails to meet workforce race equality standards, and does not optimise the benefits of an ethnically diverse workforce for patients, staff, or provider organisations.

▣ Implications of all the available evidence

Recruitment at entry level to one of the largest UK employers is a crucial opportunity to build workforce diversity and to improve patient care quality. The model of recruitment needs to change so that provider organisations can fulfil their racial equality duties as a fair and just employer. An ethnically diverse workforce can be built with asset-based and diversity-led approaches to recruitment.

Introduction

Nurturing and sustaining a healthcare workforce that reflects the diversity of patients and populations served is an important social justice goal¹ and an assurance that the workforce is sustainable and fit-for-purpose². Evidence shows that an ethnically diverse workforce benefits staff, patients, and health systems through improved quality of care^{3,4}, access, choice, and satisfaction⁵, a wider talent pool and more sustainable workforce supply⁴, increased efficiency in services, wider productivity, and innovation⁶, cost saving, reduced staff sickness and formal disciplinary processes⁷. The positive impact of workforce diversity on health inequalities and social determinants of health⁸ occurs through various mechanisms that include improvements in organisational learning⁹, more culturally competent care¹⁰, and better multicultural health⁴.

In the UK the NHS Workforce Race Equality Standard (WRES) requires NHS trusts to measure their performance annually against indicators, which are informed by our research¹¹. WRES data shows that in March 2020, 21.0% (273,359) of NHS staff in England were from an ethnically diverse background. This is an increase from 18.1% in 2017, however White applicants were 1.61 times more likely to be appointed from shortlisting than ethnically diverse applicants. This is worse than in 2019 (1.46) and there has been no overall improvement over the past five years. A disproportionate number of ethnically diverse staff are working in jobs at lower pay grades¹² and two-thirds of staff who died with COVID-19 were from ethnic minority backgrounds¹³. In the 2021 NHS Staff Survey 60% of registered nurse and midwives reported experiencing ethnicity-based discrimination, including gendered racism¹⁴.

Racial discrimination is known to begin with the pipeline to professional training¹⁵, continue in applications and selection to the NHS¹¹, through to inequalities in experiences and opportunities when employed¹². Understanding of what actually works to support workforce diversity, at all career levels, is currently limited to certain fields or clinical specialisms, for example, emergency medicine¹⁶ and

oncology¹⁷, and more could be done to build upon learning in further and higher education about widening access and equality monitoring¹⁸.

The present study explores an employer-led open market approach to recruitment to first healthcare job post-qualification, which is the current standard approach in NHS trusts (historically it has not always been this way in nursing or other professions). This approach differs from recruitment to medical posts in the NHS, which uses an allocation model for first job after degree to provide a 2-year foundation course. The medical recruitment model is not perfect as it creates challenges for some graduates who are less able to travel or to relocate near to their allocated post. In contrast recruitment to posts in nursing and AHPs (including physiotherapy, occupational therapy, radiography, speech and language therapy) is undertaken by NHS recruiting managers who are senior clinicians dealing with large numbers of applicants while balancing clinical pressures. The views presented here may be challenging for people working in already difficult situations and we have sought to protect participant confidentiality by not naming individuals or the NHS trusts.

Methods

In light of the lack of progression in race equality in recruitment¹² and a call for urgent action to prevent further deterioration⁷, we returned to our programme of studies¹⁹⁻²¹ and the data to explore the impact of recruitment approach on ethnic inequalities in recruitment to first job. The exploratory approach involved critically examining the key concepts that would underpin the study and developing definitions informed by our exploration of the literature. This questioning of assumptions, theorizing and conceptualisation work (group discussions on Microsoft Teams and via email) helped us to explore standard recruitment practices through a new social justice lens (Box 1).

Box 1: Key concepts in workforce race equality

- **Recruitment approach** - A set of policies and practices designed to support the appointment of candidates to an organisation. Various approaches include employer-led selection, allocation of jobs, targeting of specific types of candidates (headhunting), or positions such as placements, internships, volunteering, or apprenticeships that lead to paid appointment. Appointments might be prearranged, guaranteed, or awarded by fulfilling training criteria or by competitive selection. Choices between candidates could be based on applications, interviews, technical or group exercises, algorithms, or other criteria such as evidence of competencies or experience.
- **Workforce diversity** - In a healthcare context, workforce diversity means that a health provider's employment practices shape an inclusive workplace for people of "visible characteristic of difference", different gender, age, religion, race, ethnicity, cultural background, sexual orientation, languages, and education. Improving workforce diversity relies on creating a more diverse and accepting culture, which values migrants and ethnically diverse groups for their own unique assets, skills, attributes, and potential. An ethnically diverse workforce is known to support sustainable

staffing, enrich the quality of patient care, improve staff morale, and facilitate organisational change and innovation in practice.

- **Workforce race equality** - Action to ensure employees from ethnically diverse backgrounds have equal access to career opportunities and receive fair treatment in the workplace is enshrined in Equality Legislation. In the UK NHS providers are mandated to show progress against a number of indicators of the Workforce Race Equality Standard (WRES) based on evidence that a motivated, included, and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety. Equality aims to reduce bias, prejudice, and discrimination to ensure there is parity in the processes and outcomes.
- **Social justice** - Specific individuals and groups may encounter systemic, attitudinal, and physical barriers to equality because of their personal circumstances and visible characteristics. Social justice describes a belief, action, or movement, that aims to address inequalities by re-distribution or creation of resources, policies, opportunities, or privileges, to achieve fairer societies. In a workforce context, social justice is based on the concepts of human rights and equality and can be defined as the way in which human rights are manifested in the everyday working practices of an organisation.
- **Equity intervention** - The difference between equality and equity must be emphasised. Although both promote fairness, equality achieves this through treating everyone the same regardless of need, while equity achieves this through treating people differently dependent on need. However, this different treatment (sometimes called positive discrimination or affirmative action) may be the key to reaching equality. Equity provides everyone with an opportunity to reach their full potential and have an equal chance to live their life as they choose. In the context of recruitment, equity focuses on closing the 'equity gap' and can include, for example, the use of equity information based on information giving, evidence-based practice, or data, strategies to offer differentiated support to specific groups, strategies for promoting inclusion, and targeted approaches to engage underrepresented or marginalized groups, or widen access to job opportunities.

[INSERT BOX 1 NEAR HERE – see end of manuscript for Box]

Recruiting manager interviews

In the NHS, recruiting managers are responsible for implementing organisational recruitment and selection policy, that includes analysis of vacant jobs and new posts, job descriptions/person specification, Agenda for Change banding (AfC is the national pay system for all NHS staff), job advertisement, fair assessment of applications and appointments. They are expected to undertake training in recruitment and selection processes, ensure interview notes are factual, clear, and legible, make offers of appointment, give candidates feedback, and ensure new staff receive an induction. Qualitative research was chosen as a way to explore recruiting manager's experiences²² and the complexities of race equality issues in NHS contexts²³. We gained ethics approval and R&D approval in two NHS trusts in London. Semi-structured face-to-face interviews used a non-judgemental approach²⁴ to explore the

sensitive issues surrounding ethnic inequalities in recruitment. An interview schedule covered questions about recruitment and selection processes, the role of the recruiting manager, and awareness of ethnic inequalities in job success.

Sample and participants

A purposive sample²² was selected according to NHS trust, recruiting manager role to clinical jobs at post-qualification level (i.e., local/unit clinical managers not Human Resource or corporate managers), and consent to participate. We aimed to recruit 12 recruiting managers in nursing and physiotherapy (influenced by the Access Agreement funding). The sample was achieved by developing recruitment materials (participant information letter) and consent process to dispel any fear of accusations of racism. Participants were 9 nurse recruiting managers (bands 7-8c) and 4 physiotherapy recruiting managers (bands 8a-c). Interviews lasted between 18-56 minutes, were audio recorded and transcribed verbatim. An initial thematic analysis²² pursued issues about candidate attributes associated with inequalities in job success²⁰, 'getting in' and 'fitting in'²¹, favouritism²⁵, and organisational factors associated with workforce race equality¹¹.

Development of a healthcare workforce diversity lens

Development of a conceptual lens to analyse racial inequalities was informed by our experiences on the employability programme and related work on student attainment and staff disparities in higher education^{15,26}. We have drawn on a wide range of social theory and equity perspectives but in particular Fraser's (1995) framings of justice as affirmative and transformative²⁷, Kaiser et al's (2013) observations of the ironic effects of organisational diversity structures²⁸, Patton's (2010) developmental evaluation for organisational change²⁹, and Belle et al's (2000) assertions about mentoring for work and careers³⁰. Dimensions of the lens were developed using multiple searches for literature, online information, and policy papers with defined search terms (Appendix 1) and inclusion criteria.

Search strategy and key search terms

To inform the lens we undertook multiple searches of Web of Science (a platform which enables simultaneous cross-searching of various citation indexes and databases including MEDLINE, CINAHL, PsycINFO and EMBASE) PubMed and Google Scholar, between Nov 11, 2021, and Jan 11, 2022, using search terms relating to the concepts 'workforce diversity' 'social justice' and 'equity' (see Appendix 1 for Medical Subject Headings and key words). We searched for primary research, opinion articles, and reviews published in the English language between 2000 and the search date. Web-based organisational information (policy, corporate, public, and voluntary sector reports, or webpages) using key words ("social justice" "equity" and "workforce diversity"). A pragmatic selection process in this developing area of knowledge and research, was to sift through first 500 returns. Information from 90 items (Appendix 2, bibliography) was retrieved, scrutinized against criteria for quality (article source, underpinning evidence) and validity (relevance to aims, consistency with emerging themes).

Analysis

Information from included items (see bibliography, Appendix 2) were extracted to Microsoft Word, synthesized into issues and relevant phrases or concepts, and developed into categories using an inductive thematic approach²². Categories were further refined through team discussions to identify six core dimensions:

- organisational workforce diversity goals
- workforce diversity data
- recruitment diversity data
- diversity-led recruitment practices
- strategies for effective allyship
- transformative change

The six dimensions interact and are interconnected, rather than being linear or sequential, as illustrated by the arrows in figure 1 (Figure 1).

Figure 1. Healthcare workforce diversity lens

[Figure 1 to go near here]

To apply the conceptual lens to the perspectives of recruiting managers, we developed 6 questions that reflect each dimension of the lens:

1. *Are there clear organisational/unit workforce diversity goals?*
2. *How are workforce diversity problems and solutions tackled in recruitment?*
3. *Is recruitment diversity information available and how is it used?*
4. *Are candidates seen as unique individuals that have different skills and abilities to contribute to a diverse workforce?*
5. *How are the concerns and interests of underrepresented groups voiced in recruitment?*
6. *Are there ways to raise awareness between groups or institutions, build understanding or resilience to support racial justice in career opportunities?*

Results

The results address each of the 6 questions above. Key findings are illustrated with verbatim quotes from Recruiting Managers in nursing (NRM) and physiotherapy (PRM). The ethnicity and gender (M/F) of each participant is indicated after each quote.

1) Are there clear organisational/unit workforce diversity goals?

Recruiting managers in this study indicated that they value ethnic diversity in the workforce and reflected on the ethnic diversity of local populations and the need for staff to understand how ethnicity relates to health. Workforce diversity was perceived as a positive asset to delivering high quality care to diverse patient groups:

“we’re wanting diversity, you want people to represent the communities in which they serve.” [Int 2: NRM band 7 White M]

However, workforce diversity was not seen as a recruitment goal and the need to understand and relate to diverse candidates was noted by only one manager:

“Our unit as a whole is quite diverse, it’s a benefit for incoming candidates, because obviously when the candidates come in you can actually, you know, you’re gonna relate to them on so many different levels and the culture, language and our experience is part of that [Int 6: NRM band 7 Black F]

In our earlier work on newly qualified student’s experiences and the present study, participants commented on the tendency of candidates from diverse backgrounds to prefer working with diverse communities, or the notion of ‘mirroring’:

“[the local] population is BME and its very diverse [...] It mirrors their background, mirrors what they see normally, and you know, it’s easy to serve the population that you mirror.” [Int 12: NRM band 8 Black F]

Overall, there was a sense that workforce diversity was desirable but not deemed essential. In some cases, the impact of recruitment practices created a less ethnically diverse workforce.

“It’s a really interesting one and I’ve got to be so careful what I say, when I came here the majority of my staff were black and probably Filipino, that has changed completely and I feel very conscious of that and I actually feel a little fearful and I’m surprised no one has pulled the racist card and I have a very black but also older workforce, but they don’t want to further themselves [...] I’ve recruited 50 new members of staff in the last 12 months and lots of them have been young, white dynamic nurses.” [Int 11: NRM band 8 White F]

2) How are workforce diversity problems and solutions tackled in recruitment?

Although some recruiting managers were aware there was “not a level playing field” for ethnically diverse applicants, they did not perceive there to be a need, or reason to modify current practices. Many recruiting managers had complete confidence in their adherence to organisational policies for recruitment and selection, designed to treat everyone the same as an assurance against racism, illustrated by the claim by one manager:

“In my years of doing interviewing appointment that I could honestly say that I’ve [n]ever experienced that there is any discrimination at any point in the interview process.” [Int 5: PRM band 8 White F]

The emphasis on equality rather than equity perpetuates recruitment practices that fail to meet diversity standards, even though these two trusts are slightly better than average (1.3 and 1.4 compared to 1.6 nationally) on race equality in appointments from shortlisting¹². All recruiting managers explained that a competitive market meant it was necessary to judge candidates by unwritten criteria, that included a professional appearance and confidence, extra-curricular or outside interests, a sense of vocation, and commitment to health service values:

"Some of them stand out, you know, they've done additional pieces of work, or they've travelled, or they've done, you know, and they've got keen interest in different things" [Int 12: NRM band 8 Black F]

There was no suggestion that candidates from ethnically diverse backgrounds might have other unexplored, but equally usefully, life experiences or that they might be disadvantaged from engaging in extra curricula activities such as voluntary work or travelling overseas³². As one recruiting manager put it:

"... have they been to Cambodia voluntarily, you know, working in an orphanage or something like that? Have they been to Africa or have they helped out in the London Marathon? Have they done something additional outside maybe voluntarily?" [Int 3: PRM band 8 White M]

Favouritism was show to candidates who were recommended by colleagues and those from particular universities:

"they're basically guaranteed an interview." [Int 2: NRM band 7 White M]

While recruiting managers tended to see these practices as ensuring there is a competitive pool of candidates, these biases could be conceptualised as 'opportunity hoarding'²⁵. As one nurse manager explained:

"We're supposed to be, or we are a progressively more integrated society, there's no two ways about that one, but some things intrinsically are there, way back sometimes beyond what people actually are consciously thinking, and sometimes that affects their decision making" [Int 6: NRM Black F].

Writing application forms, making visits to units, attending technical assessments for English and maths, group assessment exercises, and individual interviews, add up to a lengthy recruitment process for candidates that have already been deemed competent to practice by qualified supervisors.

3) Is recruitment diversity information available and how is it used?

All but two of the recruiting managers expressed disbelief to hear about our survey findings that showed ethnicity is a predictor to success in securing a first healthcare job²⁰ and were quick to defend their own

practice.

"I honestly don't know, it's not something I've ever thought about or come across." [Int 8: NRM band 8 White M]

One nurse manager wanted to know more detailed information about ethnic inequalities:

"It'd be interesting to know what the actual ethnic minority and whether that has an impact on whether they're then selected or not as I say, because that's not something that we're aware of" [Int10: NRM band 8 White F]

One nurse manager who was unsurprised by the findings, could not explain the reason for the discrepancy, but reflected on her own experience of recruiting good candidates from ethnically diverse backgrounds:

"Anecdotally yes, yes, it doesn't surprise me, I can't tell you why ... there were girls from BME groups, and they were pretty good ... we had exceptional talent ... in terms of the, of saying why others don't get the job, I have no idea, no, no because the ones I've seen were really good." [Int 12: NRM band 8 Black F]

For all interviewees there was a degree of personal reflection in the response and perhaps discomfort with a perceived implication that their recruitment practices might be perceived as racist:

"Oh God no, not at all. Not for me anyways, no, not at all, no.No, I can't even think...No, not at all. It doesn't factor at all, to be honest with you, we're all from somewhere else, do you know what I mean, I'm Irish... so no. " [Int 4: NRM band 8 White F]

4) Are candidates seen as unique individuals that have different skills and abilities to contribute to a diverse workforce?

Lack of available information about ethnicity and workforce diversity led some recruiting managers to make prejudiced stereotypes of ethnically diverse candidates as being less able, confident, professional, or career focused:

"I think those candidates who find it difficult, in all honesty, would have to look at themselves to say is there, issues within themselves?" [Int 2: NRM band 7 White M]

"In all honesty I don't know whether it was a bad year they [referring to ethnically diverse candidates] qualified and there was so many people looking for jobs, maybe they left it too late, maybe they failed their drug test". [Int4: NRM band8 White F]

"It's about the individual, I think if you prepare yourself, you come in, you give us what we want, there's no way, because to turn somebody down you have to be 100%, you know, I can't say 'just because the way you look' I'm not going to offer you a job' [Int 9: NRM band 8 Asian M]

One recruiting manager suggested that there could be prejudices against British ethnically diverse candidates because of the unrelated view that overseas qualifications are of a lesser quality than UK qualifications, and a lack of valuing of the unique assets that migrants contribute to the workforce:

"I know, there are issues with some overseas training courses and whether they're [British graduates from ethnically diverse backgrounds] potentially getting lumped in with that and actually whether there's been a judgement made that actually they're not coming from an English [university]." [Int 8: PRM band 8 White M]

Other reasons offered for racial discrepancies included competition for places because of the prestige of an organisation or clinical field, but again these views overlook structural discrimination. A recruiting manager, from an ethnically diverse background, suggested that older generations implicitly knew they would have to work harder to demonstrate their abilities and strengths, but second-generation migrant candidates are not aware of this unwritten code:

"Obviously having come up from that pool of candidates myself I've always been aware that I will have to present myself as more able, I don't know how to sort of put it correctly, maybe there is no correct way, I know potentially I will have to be a stronger candidate [...] I think that still stands in some regard. [Int 6: NRM band 7 Black F]

5) How are the concerns and interests of underrepresented groups voiced in recruitment?

Opportunities to consider social justice and equity approaches appeared to be limited by notions of neutrality and objectivity in recruitment practice and a strong belief that treating everyone the same is fair:

"I don't agree with positive discrimination, I think I treat everyone equally." [Int 11: NRM band 8 White F]

However, one nurse manager pointed out that names are not given on an application form and that "everybody's treated exactly the same" but then went on to explain:

"I'm thinking, okay, that's obviously not an English name, although I'm sort of judging them on the name but it might be they're married and I try thinking, okay, is there anything on this paper that can actually get me to get this person to come and be shortlisted, I would try my utmost first to get that person and obviously if they don't come up to scratch then I won't shortlist them... I'd will them to do well, I'm always willing them to do well." [Int 1: NRM band 8 Black F]

Unfortunately, willing diverse candidates to do well was not enough to attain racial justice or workforce diversity.

6) Are there ways to raise awareness between groups or institutions, build understanding or resilience to support racial justice in career opportunities?

While many of the recruiting managers acknowledged that racial discrimination might occur, they are complicit within a system that does not question unjust recruitment practices. Instead, they wrongly attributed racial discrepancies to a few imagined racist colleagues with recruitment responsibilities, or the misperceived weaknesses or failings of ethnically diverse candidates (upholding the cultural deficit model³¹). None questioned recruitment or the accumulation of barriers to appointment. There was no suggestion from recruiting managers that it was within the remit, or responsibility of their employing organisation to support ethnically diverse candidates. Instead, they located responsibility for such actions outside of the employing institution, specifically seeing interview preparation as a responsibility of the university:

"I think it would help in, you know, to give that sort of guidance to them, you know, professional trends, you know, how they face so that students are aware when this is what you will be expected, some sort of preparation." [Int 7: NRM band 8 Asian F]

Some recruiting managers stated quite clearly that there was no organisational capacity to support candidates or newly appointed staff:

"It's just not a luxury we have [...] we need somebody to come in and just get on with the job, not have lots and lots of supervision, training, and things." [Int 8: NRM band 8 White M]

Discussion

These findings help to address the question of why NHS trusts across the UK are struggling to meet race equality standards¹², and the pressing issues of "how bias might be mitigated, accountability ensured, and a national repository of good practice created"⁷. Although the sample of recruiting managers in our study was small, the methods qualitative, and the data are arguably historical in a rapidly shifting service context, the study has pulled open the curtains on the equality theatre. Recruiting managers and candidates have previously come under the spotlight but attributing cause or apportioning blame to individuals fails to see the problems with recruitment approach. To reiterate, the two participating NHS trusts in this study were performing better than average on WRES indicators, suggesting the issues are systemic. Instead, recruitment needs to be approached as the strategic valuing of collective human diversity¹ for patient benefit¹³, service efficiency² and sustainability³⁻¹⁰.

There are clearly sensitive challenges and changes needed to see an ethnically diverse workforce as an asset and source of resilience, enrichment, and creativity^{1,7}. Candidates may not know what their own talents or potential are, or how to demonstrate them, and recruiters might not know what to ask, or how to ask, so as to respect what is personal/private. These issues suggest new types of allyship, cross-cultural mentorship, and networking could support equity (see Fig. 1). Diversity goals and achievements in one area of healthcare may not translate or compensate for lack of diversity in another, so this requires a strategic and systemic view which can be supported by the *healthcare workforce equity lens* developed here. This study did not aim to find or assess alternative models of recruitment, however, approaches to broadly consider include the allocation of places through university/institution agreements, job

guarantees for locally trained candidates, outreach to those connected to specific underserved communities, or recruitment directly from health contexts, such as refugee health. Whatever decisions are taken, these need to be vigilant against creating further unintended discrimination.

Conclusion

A healthcare workforce recruitment approach optimized for objectivity and standardization, masquerades as equality, while preserving racial inequality in first job success. Inadvertently, recruiting managers are unwittingly complicit in an 'equality theatre' that discriminates against candidates from diverse ethnic backgrounds. Interventions that pertain to "open up" the stage, such as anonymising applications and being 'colour blind', are potentially masking the deeper issues at play, preventing progress and meaningful change on racial equality and workforce diversity. The conceptual lens developed here could help get a grip on race equality and a shift towards asset-based and diversity-led recruitment approaches.

Declarations

Ethics approval and consent to participate

Research ethics approval was granted by FHSCE Kingston University REC by Chairs action (RH/26.7.2013). The two NHS trusts participating in the study granted R&D permission for the research. All interview participants gave their informed consent to participate.

Consent for publication

All participants gave consent for publication of anonymised verbatim quotes.

Availability of data and material

Survey data and anonymised verbatim transcripts are stored in accordance with the R&D policies of Kingston University.

Competing interests

We declare no competing interests.

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Authors' contributions

RH conceived the study 'Equality of employment opportunities: a study to explore why graduating health professionals from ethnic minority groups are less likely to get a job'. RH, JH, and FR contributed to the study design. ND did the data collection and tabulated key themes in the data. ND, RH and JH undertook

the initial analysis, with colleagues below. All authors contributed to online group discussions (Nov 2021 to Jan 2022) about the work. EM led the development of the lens and wrote the first full draft of the Article. All authors contributed to analysis and subsequent revisions.

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Declaration of interests

The authors declare no competing interests.

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Figures

INTELLIGENCE GATHERING

- *Organisational workforce diversity goals* can be explicit and transparent either for whole organisations, service areas, departments, or units e.g., Workforce Race Equality Standards and organisational key performance indicators^(a-d)
- *Workforce diversity data* can help to identify areas for improvement and inform discussions about diversity problems and solutions in specific areas of contexts of practice^(e,f)
- *Recruitment diversity data* can capture information about recruitment practices that might not be working for underrepresented groups, and feedback loops for candidates and recruiting managers to highlight good experiences or issues for improvement^(g-h)

EQUITY INTERVENTIONS

- *Diversity-led recruitment practices* value candidates as unique individuals that have different skills and abilities, assets, potential and strengths, to serve diverse patient groups and populations (e.g., attention to social capital, life experiences, and cultural competencies)^(h)
- *Strategies for effective allyship*, aim to create a supportive association between identities with power and privilege and marginalized identities⁽ⁱ⁾ (e.g., cross-cultural mentorship) to magnify the voices of underrepresented groups and bring their concerns and interests to the forefront of a discussion e.g., about workforce diversity⁽ⁱ⁾
- *Transformative change* involving new types of understanding, relationships or resilience building between groups or organisations that connects to a racial justice perspective of career opportunities e.g., organisational initiatives to understand and acknowledge racial history, create a shared affirmative vision of an inclusive organisation/approach that values workforce diversity and human potential^(m,n)

Figure 1

Healthcare workforce diversity lens

Key sources: (a) The Nonprofit Association of Oregon Equity & Inclusion Lens Guide. (b) A Voice for the Reduction of Poverty Nashville. (c) Philanthropic Initiative for Racial Equity (d) Race Matters Institute. (e) Be Loved Community Equity Lens Map. (f) The Salvation Army Racial Equity Lens. (g) NHS Workforce

Research Equality Standard and Equality Delivery System. (h) The Aspen Institute Education & Society Program Racial Equity Lens. (i) Government Alliance on Race and Equity Racial Equity Toolkit. (j) Housing Development Consortium Race Equity Toolkit. (k) Albany Medical College medical allyship module. (l) University of Kent effective allyship resources. (m) The Impact Foundry. (n) Access, Equity, and Acceleration Unit equity lens. (see Appendix 2, bibliography for weblinks).

Supplementary Files

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