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Access of BME staff to senior positions in the NHS

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- ☑ Directors of Nursing
- ☑ Local Authority CEs
- ☑ Directors of Adult SSs
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- ☐ Directors of Finance
- ☐ Allied Health Professionals
- ☑ GPs
- ☐ Communication Leads
- ☑ Emergency Care Leads
- ☑ Directors of Children's SSs
- ☐ Other

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- ☐ GPs
- ☐ Communication Leads
- ☐ Emergency Care Leads
- ☐ Directors of Children's SSs
- ☐ Other

8 Description: *(50 words max.)* A cross sector and industry evidence review with case studies and data analysis to help managers and to develop recommendations to promote leadership diversity.

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Foreword

It is right that NHS staffing should reflect the population that it serves, particularly in senior leadership and management roles. Having recently joined the NHS Institute for Innovation and Improvement as Head of Building Leadership Capacity, which includes responsibility for the Breaking Through programme led by Yvonne Coghill, I believe it is essential that we understand the barriers to career progression for Black and Minority Ethnic (BME) staff in the NHS and learn from best practice examples elsewhere.

This report was commissioned towards the end of 2007, and it is clear to me that there has been a great deal of progress since then. There has been further recruitment to the Top Talent Programme for BME staff; there are four regional pilots underway looking at inclusion; and the Breaking Through conference in October 2008 was both a celebration of the contribution of BME staff to the NHS and a call to focus our efforts on delivering on this agenda. We must work across the NHS system to understand best practice and drive improvement in this area, moving from 'nice to do' to a real integration and advancement for this group of staff. We at the NHS Institute recognise the need to work in partnership to deliver the diversity agenda and we know that it is local ownership that will lead to real success in this area.

This report demonstrates that progress can be made. We need to reframe our initiatives that focus on BME staff as a means of truly realising the benefits of a diverse leadership and management population. At the same time we must balance the challenges of targeting against perceptions of segmentation.

The NHS Institute, through the work of Yvonne and her team, has advanced our thinking and practice in this area. We need now to consider the recommendations in this report to take further action to implement the vision of High Quality Care for All and to demonstrate our commitment to increased diversity in senior positions.

Kate Lobley
Head of Building Leadership Capacity
NHS Institute for Innovation and Improvement

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1

1.0 Purpose

The purpose of this study is to examine the organisational barriers to black and minority ethnic (BME) staff rising to positions of authority and influence in the NHS, and to develop recommendations to promote leadership diversity. It uses data analysis and case studies from PCTs and best practice organisations from healthcare and other sectors.

Successful organisations have established a clear business case for diversity, which in turn forms a key element of their broader development and talent management strategy. Organisations seeking transformational change have used a broad range of approaches combined in coherent and focused programmes, which have been led from the top.

Focus on and commitment to diversity can lead to the realisation of clear benefits for staff, service users and the wider community. This study seeks to enable the NHS to realise more of these benefits.

2

2.0 Executive summary

The NHS Institute for Innovation and Improvement's Breaking Through team commissioned the Matrix Knowledge Group to *'look specifically at the organisational barriers to black and minority ethnic (BME) staff rising to positions of authority and influence in the NHS'* in order to inform future developments.

2.1 Method

A mixed method approach was taken including:

- A rapid evidence review.
- Case studies of high performing comparator organisations.
- Case studies with selected Primary Care Trusts.
- Data analysis of BME appointment profiles within the NHS.
- Validation workshops at the national Breaking Through Conference held in Manchester in October 2008.

A particular focus was given to the comparison of the NHS against high performing sector and industry comparator organisations in the UK and overseas.

2.2 Establishing how well the NHS is doing

We endeavoured to establish a numerical baseline across the NHS and the case study sites in order to:

- Assess the levels of BME presence within the NHS in management positions.
- Comment on any apparent trends and available NHS employment data.
- Benchmark against high performing comparator organisations.
- Identify different approaches to diversity monitoring.

The phrase 'positions of authority and influence' was made operational to include Board i.e. executive posts, although challenges regarding consistency of categorisation at senior levels have necessitated extending the definition at some points to include associate director posts.

Systematic, comprehensive and consistent ethnicity employment data for the NHS is not yet available. The data that was considered clearly suggests that at executive and associate director level, Boards are failing to achieve broad representation when organisations are benchmarked against ethnicity levels within their catchment population or their workforce.

Comparator organisations such as the US health insurer Aetna have achieved Board diversity levels significantly in excess of the NHS, but this has not been replicated at the equivalent to associate director level. Further, if equal representation at all levels within an organisation is used as a primary measure of success, then this evidence base suggests that no industry or sector has achieved this goal.

2

2.3 Organisational drivers and resistors for senior workforce diversity

Our interviews with PCT staff and workshops identified a variety of potential benefits of applying a business case approach to workforce diversity in the NHS. These benefits were financial (including the reduced cost of litigation), improved performance (better quality of provision and impact on health), and potentially, a reduction in health inequalities.

"If you speak to the finance director, emphasise the pure business case. If it is the public health representative then emphasise the impact on health inequalities. If you are speaking to frontline staff delivering the service, then emphasise making a difference to the way care is delivered; there is a business case for workforce diversity, but it is sold to different people in different ways".

"Promoting diversity will improve performance, help in improving health of local population".

"The main benefit of the business case would be to reduce bullying and harassment but this outcome would be difficult to measure, unless it goes to litigation, it is a more qualitative dimension".

"Business case for diversity is related to health inequalities and impact assessments – how can you have a patient-centred service that does not look at health inequalities between diversity groups? We have to ensure mandatory tracking of this though, just now we have no baseline to work with, nobody is pulling this together to highlight inequality".

However, not all interviewees were confident about successfully applying the business case approach to diversity in the NHS.

"...so there should be benefits of applying the business case to diversity in the NHS - improved performance in finance and quality, but the NHS does not have the same stringent standards as other organisations. The business case is well-proven, it is just a problem putting it into practice. It is not costly, it is entirely attitudinal, and would require change in individual and organisational culture to change. Selling the benefits of improved performance in finance and quality has more chance of success than other elements because it is related to the expectations of the Agenda for Change."

In terms of delivering this, the rapid evidence review identified the following organisational barriers as typically being reasons why there is a lack of senior level diversity:

- Racially biased recruitment and selection practices particularly at times of merger or restructuring.
- Undervaluing of relevant experience and overseas qualifications.
- Tokenism.
- Circumventing of established procedures when appointing part-time staff or covering maternity leave.
- Rewards: some evidence suggested that the allocation of excellence awards is discriminatory against BME groups and women.
- Institutional culture seen in individual/group behaviour, formal and informal networks.

In addition, the following individual barriers were identified:

- Lack of mentors/role models.
- Exclusion from informal networks and communication.
- Stereotyping and preconception of roles and abilities.
- Lack of significant line management experience/challenging assignments.

Similar drivers and resistors were found in the case studies.

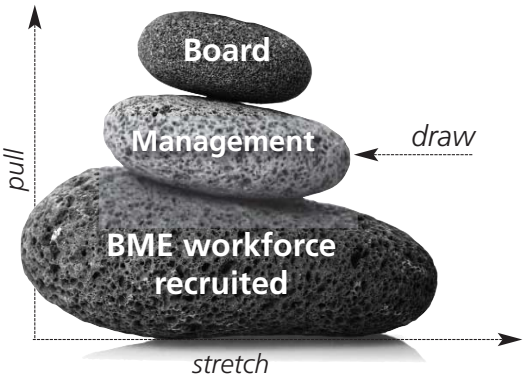
2

2.4 Realising the benefits of senior workforce diversity

The NHS has a range of local, regional and national policy responses to the challenge including those with a focus on:

- Services e.g. Delivering Race Equality.
- Human resources e.g. Breaking Through Programme.
- Organisations e.g. Race for Health.

It is apparent that the impact of programmes such as these, alongside a much broader range of local, regional and national programmes, has impacted on the BME employment profile of NHS organisations. We find three broad development strategies to support senior workforce diversity, as illustrated in the diagram.



Organisations such as the NHS, who have stretched overall representation through higher levels of BME recruitment at lower levels, have been more likely to respond to the challenge of increasing BME representation at more senior levels by 'drawing' recruitment in from outside as opposed to 'pulling' existing BME staff through. Such an approach is likely to have a consequent impact on long-term sustainability.

The combined impact of adopting a piecemeal approach to increasing ethnic diversity in organisations has been to:

- Create organisations where ethnic diversity is not sustainable.
- Fail to realise the full benefits of ethnic diversity across an organisation.

This latter point relates to what may be described as the first level benefits of diversity: reduced health inequalities, more responsive and appropriate service delivery and a high quality and well motivated workforce. The lack of sufficient structure and focus to delivering a diverse senior workforce has also hampered the ability of greater diversity to positively impact on the process of governance at the most senior levels in organisations, be that improved cultural sensitivity, increased levels of creativity or lateral thinking or more effective engagement with communities.

2

2.5 Conclusion

The NHS has never shied away from changing its leadership agenda in order to shape the future of service delivery. Over the last 60 years the shifts through clinical leadership and administration, to the introduction of general management in the 80s, has seen the leadership landscape ebb and flow, responding to budgetary concerns, new technologies, and research opportunities.

World class commissioning and the development of the new era of partnerships, community engagement and choice bring new dimensions to the leadership landscape. Well-being, case management, and personalised care are now on the agenda for all populations. Competition for patients also brings its own challenges as providers strive to define the service areas in which they excel and make themselves attractive to different cohorts of patients. Consequently PCT and Trust Boards will increasingly need to be seen to be making tangible headway with all communities through improving services and fostering new ways to promote effective communication. World class commissioning recognises the transformational shift in the way that organisations do their business and suggests that this will not happen overnight. It will be a journey for boards and workforces as they develop and sustainably embed their new business processes – focusing on getting closer to patients, fostering new community relationships, understanding markets, defining products and transforming the way they do their business. This will only be achieved if successful talent management is delivered from the whole workforce.

In order for Boards to understand what this transformation will mean in practice, and quickly deliver benefits to foster this new era of innovation, it is unlikely that training in 'diversity' will be enough. In the short term boards with a broader range of experience and networks are needed to:

- Change how the needs of diverse populations are understood.
- Provide greater insight into the nature of effective service innovations for these communities.
- Identify mechanisms to reprioritise investments and engage with the communities.

Furthermore, role models from diverse backgrounds will provide greater hope for staff from a variety of backgrounds to reach senior positions. As a consequence, the argument is strong for having board members with diverse backgrounds in the NHS.

Whilst there is a moral argument for increasing the senior BME workforce, a number of initiatives such as Race for Health and Breaking Through and a legal duty to introduce equality based employment procedures, there is still a long way to go to recognise and realise the benefits of ethnic diversity in positions of influence in the NHS. Consequently, there may be a case for reframing/refocusing the initiatives as supporting the realisation of benefits of diverse leadership and management of the NHS. This calls for the existing leadership of the NHS to be engaged in identifying these benefits and crucially identifying the links between these benefits and organisational success. If these links are not made or not seen to be material, it is unlikely that much more progress will be made beyond ensuring that NHS organisations meet with their statutory duties, unless more drastic action is taken.

2

2.6 Recommendations

The following recommendations are of relevance to the NHS Institute and the Department of Health as well as organisations delivering leadership interventions, Strategic Health Authorities, commissioners and provider organisations.

1. Evaluate and reposition if necessary, all existing Board development, leadership development and diversity leadership programmes to focus on improvement in NHS performance and corporate social responsibility, as opposed to purely focussing on individual performance, numbers and representativeness.

2. Work together with NHS organisations and other diversity initiatives such as Pacesetters and Race For Health, to create a consensus and systematic monitoring process to ensure a sustainable way forward. This process should cover all aspects of diversity including legal requirements, business case benefits, and incorporate both baseline and aspirational target indicators.

3. Deliver support to organisations to identify and realise the benefits of diverse leadership.

4. Co-develop transformational stories with all leaders in the NHS to own and share the new leadership agenda for the NHS, incorporating the value of diversity and innovation to facilitate and accelerate NHS performance.

5. Strengthen the evidence base for the benefits of diverse leadership.

6. Establish cross industry and country links concerning diversity and leadership to share practice.

7. Highlight and monitor the requirement that all Trusts meet their statutory race equality obligations, in employment and other areas.

8. Explore whether all diversity and inequalities related initiatives should be brought together within an overall initiative to deliver improved quality, reduce inequalities and engage communities.

3

3.0 Introduction

The NHS Institute for Innovation and Improvement's Breaking Through team commissioned The Matrix Knowledge Group, in late 2007, to 'look specifically at the organisational barriers to black and minority ethnic (BME) staff rising to positions of authority and influence in the NHS' in order to inform the future plans for the team.

This project had five elements:

- A rapid evidence review focusing on barriers to BME staff accessing senior positions.
- A review of publicly available data (covering England and four SHA areas) to illustrate the proportion of BME staff currently occupying senior NHS positions.
- Workforce diversity case studies with six organisations from the public and private sector in the areas of healthcare (United States), finance and retail (United Kingdom), local government, policing and transport (London): Aetna; Lloyds TSB; Asda; Greater London Authority; Metropolitan Police Service; Transport for London.
- Case studies from eight primary care trusts (PCTs) (two in each of four SHA areas) reviews, focusing on the access of BME staff to senior positions.
- Validation workshops at the national Breaking Through Conference held in Manchester in October 2008.

The following sections of this report present:

Section 4:
The method

Section 5:
Establishing how well the NHS is doing

Section 6:
Organisational drivers to senior workforce diversity

Section 7:
Organisational and individual barriers to senior workforce diversity

Section 8:
Analysis

Section 9:
Conclusion

Section 10:
Recommendations

Appendix A:
Organisational case studies

4

4.0 Method

The research was undertaken over a nine month period and took a mixed method, multi-sectoral comparative approach using both quantitative and qualitative data. The conclusions were validated through workshops with stakeholders in the senior workforce diversity field. The approach to the cross sector and PCT case studies is described below.

4.1 Cross sector diversity case studies

The six cross sector diversity case study organisations (described briefly in Table 1 below) were chosen because of their reputations for best practice in recruitment, retention and promotion of a diverse workforce, especially employees from BME groups (evidenced by awards and other forms of recognition advertised in their promotional publications) and/or the relevance of their experience to the NHS.

The aim of the case studies was to highlight learning which may be transferable to the NHS in general e.g. in illustrating how leaders can realise the full benefits of diversity, or transferable to specific initiatives e.g. the Breaking Through programme. They were compiled from each company or organisation's diversity 'history', collateral (promotional material etc), workforce statistics, other literature, and interviews with their national or regional diversity/workforce leads. They are not comprehensive, but indicative of the steps these organisations have taken to improve workforce and senior workforce diversity. Information has been drawn from the case studies to inform all sections of the report. Two of the case studies are included in the appendix.

Table 1: Description of the case study organisations

Organisation	Sector	National or regional	Type	Case study type
Aetna Healthcare	Private	International (USA)	Health	All*
Asda	Private	National (UK)	Retail	Company collateral only
Greater London Authority (GLA)	Public	Regional (London)	Local Government	All*
Lloyds TSB	Private	National (UK)	Finance	All*
Metropolitan Police Service (MPS)	Public	Regional (London)	Law Enforcement	Company collateral, workforce statistics and literature only
Transport for London (TfL)	Public	Regional (London)	Transport	All*

** 'All' indicates the use of interviews, literature, and company collateral and workforce statistics to create the case study.*

4

4.2 Primary Care Trust case studies

Eight PCTs (two in each of four SHAs) were randomly selected from a sample stratified according to their published performance ratings (Healthcare Commission's Annual Health Check 2006 – 2007). PCTs were selected, rather than Acute Trusts or Mental Health Trusts, as they have both a role in delivery and in commissioning, with potentially even greater reason for ensuring diversity in senior management positions.

Their experiences in the promotion of workforce diversity, especially the access of BME staff to senior positions, were constructed from confidential interviews with employees responsible for Equality and Diversity in the PCT (listed below), additional interviews, publicly available data and other information supplied by the PCT.

- Director of Human Resources.
- Director of Human Resources & Organisational Development.
- Equality and Diversity Manager (shared).
- Head of Equality and Diversity.
- Head of Equality, Diversity and Human Rights.
- Head of Human Resources and Workforce Development.
- Human Resources Manager (Equality and Diversity Employment Strategy lead).
- Human Resources Manager (Lead for Equality and Diversity).

Again the results are indicative rather than comprehensive.

5

5.0 Establishing how well the NHS is doing

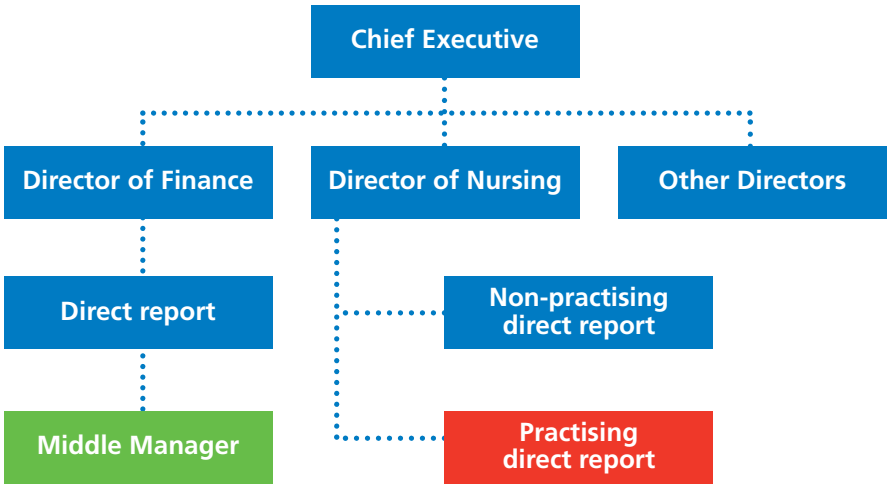
We endeavoured to establish a numerical baseline across the NHS and the case study sites in order to:

- Assess the levels of BME presence within the NHS in management positions.
- Comment on any apparent trends and available NHS employment data.
- Benchmark against high performing comparator organisations.
- Identify different approaches to diversity monitoring.

Rather than undertake primary data collection, we reviewed national NHS data sources to establish the "true" position, and compared the data with case study organisation analysis.

5.1 National NHS workforce analysis

A national NHS workforce census is undertaken annually and is collated by the National Information Centre. The census splits the workforce into two groups – those individuals deemed as having non-clinical roles, and those deemed as being clinical. Clinicians who are not practising are deemed as being non-clinical. We analysed both the clinical and non-clinical data. Within the non-clinical workforce, the figure below shows the definitions of senior and middle managers. Senior managers include the staff in blue, middle managers are in green. Practising staff, in red, are not included in these figures. It should also be noted that there is no relationship between these levels and Agenda for Change pay grades.



5.2 Differences in ethnicity between the clinical and non-clinical workforce

Whilst the focus of this study is senior management positions, the role of senior clinical leadership as a driving force for change is an important consideration. Our review showed that in 2007, 47% of registrars and 25% of consultants were from non-white backgrounds. This compares with 14% of the total NHS workforce being from a non-white background. This indicates the need for further investigation because of the step reduction of non-white registrars becoming consultants. It also indicates that the medical route (and indeed the nursing route), offers opportunities for BME staff to obtain clinical director and subsequently board level positions as medical and nursing directors. However, anecdotal evidence would suggest that relatively few are currently achieving board positions.

5

5.3 BME representation in senior and middle management

We reviewed the proportion of senior NHS managers from BME backgrounds, and compared this to the proportion of the general working age population from non-white backgrounds in England, and then London, West Midlands, East Midlands and Yorkshire and Humberside (the four SHAs involved in the study). This data is given in Table 2.

Year	England		London SHA		West Midlands SHA		East Midlands SHA		Yorkshire & Humberside	
	Senior Managers	Working age pop	Senior Managers	Working age pop	Senior Managers	Working age pop	Senior Managers	Working age pop	Senior Managers	Working age pop
2004	5.4%	10.5%	14.1%	31.8%	5.8%	11.5%	3.2%	7.6%	4.2%	7.6%
2005	5.3%	11.0%	12.7%	33.3%	7.0%	12.3%	3.6%	7.9%	2.2%	7.8%
2006	5.2%	11.6%	14.0%	34.4%	6.2%	13.9%	3.9%	7.8%	2.4%	8.0%
2007	8.3%	12.1%	15.1%	39.6%	7.0%	14.2%	5.0%	7.8%	6.5%	8.3%

Table 2: Table showing the proportion of senior NHS managers from BME backgrounds[1], when compared to the proportion of the general working age population[2] from non-white backgrounds in England, London, West Midlands, East Midlands and Yorkshire and Humberside.

In summary, with respect to senior managers:

- Nationally, in 2007 approximately 8.3% of senior managers were classified as being from non-white backgrounds, compared to 12.1% of the working age population and 14.1% of the total workforce. This would appear to be an improvement since 2006 when 5.2% of senior managers were from non-white backgrounds. It is unclear why this improvement has occurred, as this proportion is not borne out by qualitative insights - this may be due to health service reorganisation[3], or impact of initiatives such as Breaking Through, but is more likely to be due to different interpretation of data definitions/other groups being included (such as PEC committees). Consequently it is recommended that this is further explored to assess whether this change is more than a data artefact.
- London is the least reflective of its BME population, with a difference of 24.5% between the proportion of non-white individuals in the working age population and the proportion of NHS senior managers that are from BME backgrounds. Although there was a noticeable improvement in the percentage of non-white senior managers in London in 2007, following a slight decline in the three previous years, the ethnicity of senior managers is still well short of reflecting the BME working age population in London (39.6% in 2007). The ethnicity of senior managers in West Midlands, East Midlands and Yorkshire and Humberside SHAs is more reflective of the general population of these areas. There has been continuous improvement since 2004, apart from in the West Midlands (where there was a slight decline in 2006) and in Yorkshire and Humberside (which experienced a considerable downturn in 2005 but the largest improvement in 2007). However, all continue to have shortfalls when compared to the proportion of the working age population from BME backgrounds.

[1] Source: NHS Information Centre (2007). NHS hospital and community health services: Administrative managers in England

[2] Source: NOMIS (2007). Annual population survey. ONS Crown Copyright Reserved

[3] However, such a finding is inconsistent with the literature review which indicated the reverse trend at times of reorganisation.

5

We also reviewed the make-up of NHS middle managers[4] from BME backgrounds[5], when compared to the proportion of the general working age population[6] from non-white backgrounds in England, and then the same SHAs.

This data is shown in Table 3:

Year	England		London SHA		West Midlands SHA		East Midlands SHA		Yorkshire & Humberside	
	Middle Managers	Working age pop	Middle Managers	Working age pop	Middle Managers	Working age pop	Middle Managers	Working age pop	Middle Managers	Working age pop
2004	7.3%	10.5%	19.5%	31.8%	8.0%	11.5%	5.3%	7.6%	4.8%	7.6%
2005	8.0%	11.0%	20.3%	33.3%	8.4%	12.3%	5.8%	7.9%	4.2%	7.8%
2006	7.3%	11.6%	22.0%	34.4%	9.1%	13.9%	5.5%	7.8%	4.5%	8.0%
2007	10.1%	12.1%	21.9%	39.6%	11.1%	14.2%	6.8%	7.8%	6.6%	8.3%

Table 3: Table showing the proportion of NHS middle managers from BME backgrounds, when compared to the proportion of the general working age population from non-white backgrounds in England, London, West Midlands, East Midlands and Yorkshire and Humberside.

In summary, with respect to middle managers:

- Nationally, 10.1% of NHS middle managers are from non-white backgrounds, compared to 12.1% of the working age population in 2007 – this is a considerable improvement since 2006 in which a slight decline had occurred. However, again we believe there is scope for further validation of this finding and data.
- There has been an overall improvement in the percentage of middle managers from BME backgrounds since 2004 in the four SHA areas.
- BME groups are relatively well represented in non-medical middle management positions in the NHS, when compared to senior managers.
- This suggests that there may be a pool of talent of non-white staff at middle management level available to increase the proportion of non-white senior management, but which would appear to be hitting a glass ceiling.

In a separate analysis we found that 12% of the non-executive positions are taken by non-white staff. This is representative of the overall working age population, but also reflects the impact of central intervention to ensure that such positions are representative of national populations.

[4]These data are generally seen as being more subjective than the senior manager analysis. For further information contact the NHS Information Centre.

[5]Source: NHS Information Centre (2007). NHS hospital and community health services: Administrative managers in England

[6]Source: NOMIS (2007). Annual population survey. ONS Crown Copyright Reserved

5

In conclusion this analysis shows that:

- In 2007, it was estimated that BME groups made up 12% of the national working population. If this is taken to be the ideal proportion of the NHS management workforce that should be represented by BME groups, then improvements would appear to have been made over recent years. However, we believe that there are concerns with this data, and anecdotally perceive that a lower proportion of executive positions are taken by BME staff than is shown from this analysis.
- There are greater shortfalls in representation at senior levels than middle manager levels, with only 8% of senior managers[7], including staff at executive level, and 10% of middle managers (2007) coming from BME backgrounds. This indicates a glass ceiling between middle management and senior management ranks.
- BME groups are well represented in the medical profession, with 25% of consultants coming from BME backgrounds, and 47% of registrars (2007). This is an improvement on 2006 when 24% of consultants and 40% of registrars came from BME backgrounds. This indicates a greater likelihood of BME executive positions being made up from clinical backgrounds, but also the potential presence of another glass ceiling for the clinical professions moving through the ranks, to reach clinical director, and medical director positions. Whilst nursing positions have not been analysed, the workshops we undertook involving senior nurses from BME backgrounds, suggested that there were similar challenges for this staff group.
- In 2007, 12% of Non-executive directors in the NHS were from BME backgrounds and therefore representative of the national BME population, reflecting the impact of national targets/intervention.

[7]Senior management includes all staff at executive level Chief Executive, Board members and PCT Professional Executive Board (PEC) members who do not need to be clinically qualified, plus those (non-clinical) managers who report directly to the members of the executive. Middle Managers are those non-clinical and functional managers who report directly to senior managers.

5

5.4 Monitoring diversity in senior management - case study insights

There are opportunities for the NHS to learn from how other organisations monitor workforce diversity. All the organisations we reviewed[8] routinely tracked the representation of diverse groups at different levels of the organisation. This generally included a breakdown by:

- application pool.
- the selection of applicants.
- representation in the current workforce.
- workforce by pay grade.

Some organisations also routinely monitored:

- the cost of labour turnover.
- absenteeism and recruitment and litigation costs.
- secondments.
- promotion.
- training opportunities according to ethnic group to successfully track performance and address any inequalities.

Although these were seen as important measures, measuring the attitudes and behaviours of employees with regard to equal opportunities, as well as their attitude to the organisation more generally, was seen as important in terms of their commitment, loyalty, motivation and satisfaction. Less common was an assessment of market penetration, i.e. tracking diversity in their customer base, as well as in the companies they work with[9].

Although it was not possible to obtain comparable data from each organisation, a number of general observations can be made which offer a useful comparison with the NHS. This is illustrated using workforce statistics from Aetna and Transport for London.

In the case studies we found that:

- The total number of BME staff within each organisation was above that of the average working age BME population in the area covered by that organisation.
- Within all organisations, a 'glass ceiling effect' was present, with a lower percentage of BME employees in higher positions (senior and middle management). This distribution is similar to that found within the NHS. Occasionally, the highest levels in the organisation (i.e. non-executive director level) showed a slight increase in BME representation.

[8]Aetna, Asda, Lloyds TSB, Metropolitan Police, Greater London Assembly, Transport for London.
[9]This exercise was undertaken by Aetna Healthcare

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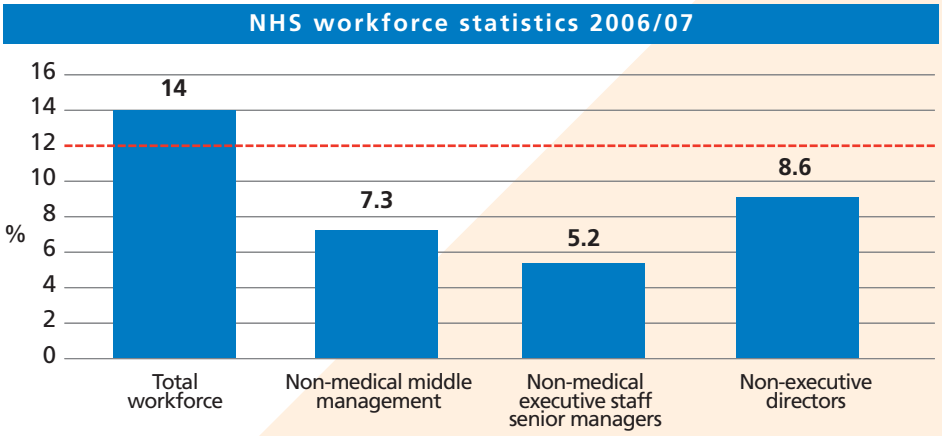
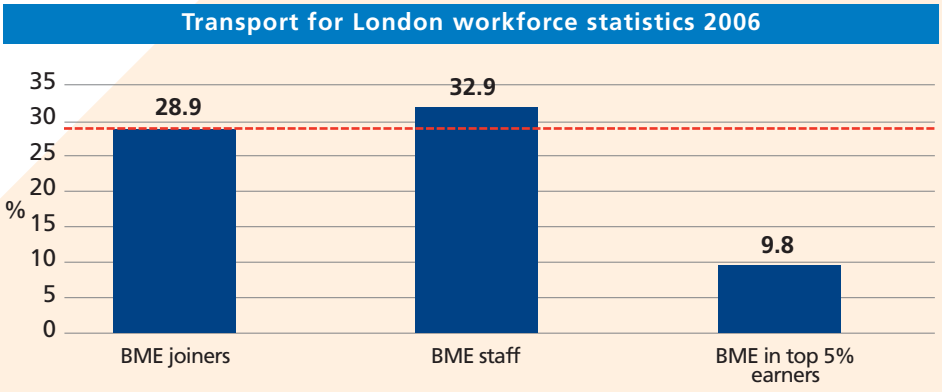
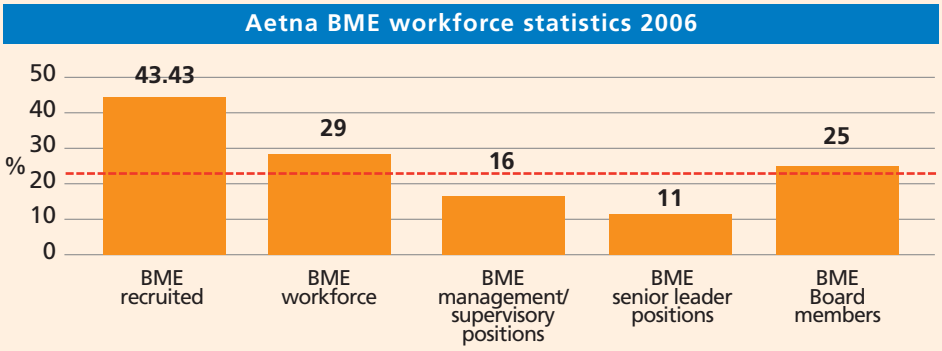


NB: The dotted red line denotes the national BME working age population (12%)



NB: The dotted red line denotes the London BME working age population (29%)



NB: The dotted red line denotes the USA national average BME working age population (22.2%)

5.5 Conclusions

Systematic, comprehensive and consistent ethnicity employment data for the NHS is not yet available, which compares poorly with the other organisations reviewed. The data that has been considered clearly suggests that at executive and associate director level, boards are failing to achieve broad representation when organisations are benchmarked against ethnicity levels within their catchment population.

Whilst comparator organisations, such as the US health insurer Aetna, have achieved board diversity levels significantly in excess of the NHS, this has not been replicated at the equivalent to associate director level. Further, if similar representation at all levels within an organisation is used as a primary measure of diversity, then this evidence suggests that all industries or sector have not achieved this goal.

6

6.0 Organisational drivers supporting senior workforce diversity

The case study sites identified business reasons for achieving senior workforce diversity alongside the regulatory drivers. These drivers are described, along with some of the initiatives which have been introduced to promote senior workforce diversity.

6.1 Organisational instigators of change

PCTs and case study organisations reported significant events that led to their diversity policy being initiated/further developed. These included:

- change in client population demographics leading to an increased BME customer-base.
- organisational merger or restructuring leading to a re-assessment of diversity-focused policies.
- specific adverse event (i.e. legal action as a result of workforce discrimination).
- amendments to legislation making change obligatory.

Some organisations also referred to an historic shift in organisational mindset, from viewing diversity as an issue of social responsibility to a concept that makes sound commercial sense.

An organisation's business case for diversity most often reflected a desire to best meet the needs of a diverse client base. Diversity was thought to enhance an organisation's ability to deal more sensitively with multicultural customers, thereby increasing customer satisfaction and, as such, retaining and attaining market share. Interviewees commented that there may be a general preference for customers to purchase from individuals similar to themselves: *"People prefer to deal with individuals they can relate to. People are diverse, so our workforce should be diverse too"*. Therefore there may also be a preference to purchase from organisations that actively promote diversity.

Interviewees indicated that a strong workforce diversity policy is required to ensure the recruitment of the most talented individuals to meet future needs because, as one highlighted, "an employee pool of white, 20–40 year old, able-bodied males would cause huge problems for the future… as the working age population becomes more and more diverse".

Employers who successfully manage diversity were believed to be better at attracting and retaining skills and talent, because employees are often drawn to companies which embrace diversity. Furthermore, workforce diversity may improve organisational performance, through increased organisational creativity and innovation, and improved decision-making and problem-solving, due to the varied perspectives within diverse groups.

There were some expected differences in 'drivers' between public and private sector organisations – in the public sector, the emphasis was on legal obligations and improved delivery of services to diverse communities; in the private sector, there was an emphasis on recruiting and retaining talent and improving competitiveness in the marketplace, as well as increasing company reputation. Interviewees commented:

"We've gained lots of recognition as a company through our commitment to diversity. This makes people want to work with us and for us."
- Private sector organisation employee.

"Our workforce should reflect the population we serve… this will help us provide an inclusive service."
- Public sector organisation employee.

6

6.2 NHS 'Business' drivers

The interviews with PCT staff and workshops identified a variety of potential benefits of applying the business case approach to workforce diversity in the NHS. These benefits focused on financial benefits (including reducing the cost of litigation), improved performance (better quality of provision and impact on health), and potentially, a reduction in health inequalities.

"If you speak to the finance director, emphasise the pure business case. If it is the public health representative then emphasise the impact on health inequalities. If you are speaking to frontline staff delivering the service, then emphasise making a difference to the way care is delivered; there is a business case for workforce diversity, but it is sold to different people in different ways".

"Promoting diversity will improve performance and help in improving health of the local population".

"The main benefit of the business case would be to reduce bullying and harassment but this outcome would be difficult to measure unless it goes to litigation, it is a more qualitative dimension".

"The business case for diversity is related to health inequalities and impact assessments – how can you have a patient-centred service that does not look at health inequalities between diversity groups? We have to ensure mandatory tracking of this, just now we have no baseline to work with, nobody is pulling this together to highlight inequality".

However, not all interviewees were confident about successfully applying the business case approach to diversity in the NHS.

"….so there should be benefits of applying the business case to diversity in the NHS - improved performance in finance and quality, but the NHS does not have the same stringent standards as other organisations. The business case is well-proven, it is just a problem putting it into practice. It is not costly, it is entirely attitudinal, and would require change in individual and organisational culture. Selling the benefits of improved performance in finance and quality has more chance of success than other elements because it is related to the expectations of the Agenda for Change."

Other benefits were described in terms of:

- Better public image;
- Promotion of the NHS as an inclusive employer, an employer of choice, leading to raised staff morale and increased likelihood of recruitment from BME and other under-represented groups;
- Sensitivity to the needs of patients, leading to better needs assessments, leading to improvements in sensitivity and quality of services to the needs of diverse populations, with the potential to reduce health inequalities.

6

6.3 Improvement initiatives

Since the Race Relations (Amendment) Act 2000, there has been a plethora of NHS national, local and internal initiatives designed to promote diversity in the NHS workforce in general, and in senior positions in particular. PCTs are involved in this range of initiatives, but there appears to be a lack of evaluation – there was no evidence of them having been individually evaluated for impact or measured for likely success. Breaking Through was the most referred to national programme (from the majority of PCTs) but it was largely considered to be 'too early to measure its impact'.

PCT initiatives

At a local level, initiatives identified included:

- Mentoring and training programmes instigated by SHAs.
- Training, recruitment and diversity events to share good practice.
- Events to recruit young people and students, especially via universities.

The most popular internal initiatives appear to be training and mentoring schemes, usually targeted at specific employees e.g. managers, new starters or HR personnel so they are more likely to impact on individuals or small groups rather than have an organisational impact. This is because there is no guarantee that 'learning' will cascade down or act as a catalyst for a change in attitudes and behaviour throughout a PCT. Although mentoring, provision of and support by role models and training all help PCTs and the NHS to be an employer of choice, they only really address the individual barriers to workforce diversity.

There also appear to be differences between PCTs in how active or proactive they are in terms of the number of internal initiatives, although number is no guarantee of a successful outcome i.e. one initiative focused on organisational change may have more impact than four targeted at specific individuals.

Initiatives used to promote diversity were classified into three distinct groups. Those that promote:

- 'Race-diverse' recruitment.
- A positive working environment for BME employees.
- Development of BME staff to facilitate their access to more senior positions.

Initiatives that promote 'race-diverse' recruitment were present in all organisations. These included advertising in ethnic media, changing application and recruitment procedures to reduce race-bias in recruitment and establishing links with academic institutions with a high proportion of BME attendees. However, only two of the six organisations we interviewed had specific recruitment initiatives to address diversity in senior positions, and even in these cases, the initiatives were focused on graduate recruitment, i.e. those who would start off at a mid-level position in the organisation and hopefully be promoted to senior management.

A number of initiatives were aimed at BME staff development, including the creation of 'talent pools' to identify and develop able individuals, management training schemes and senior mentorship.

As important as the recruitment and development of BME staff in the organisations, was a commitment to improve the experience of BME groups when working within the organisation. In this way, the organisation could improve its reputation as a good employer for BME groups, which should aid recruitment in the future. As one interviewee highlighted:

"This (promoting a positive working environment) is just as important as everything else (the recruitment and development). If we are seen as a fair employer this will attract ethnic minorities to the organisation, and if they feel respected and valued, they are more likely to want to stay with the company".

6

Initiatives to promote a diverse working environment included compulsory diversity training for all staff, social networks for diversity groups and the recognition of BME cultures and beliefs in work practices.

Initiatives in case study organisations

A variety of initiatives were identified from the case study organisations including:

- The use of 'talent pools' specifically for their ethnic minority workforce. When such talent is identified these individuals receive appropriate training to aid their development.
- Representation at ethnic events.
- The inclusion of diversity and equality management in performance-related pay.
- Diverse discoveries: a training programme providing leadership for BME, talented individuals who are mid-level in the organisation.
- Increasing visibility of talented individuals by introducing them to senior employees in head office.
- Mentoring: mentoring programmes are available from senior to lower-level 'employees of colour'[10].

These initiatives focus on integrated strategies to manage talent, with a particular focus on the diversity business case.

Initiatives from the literature

The literature identifies further examples:

- Mentoring and leadership programmes.
- Social support networks for BME leaders.
- Identification and development of top talent.
- Diversity management.
- Manager accountability.
- Monitoring.
- Training and education.
- Senior management commitment to diversity.

However, their individual or cumulative impacts have not been evaluated, leaving scope for differing views of the value of such initiatives. A key challenge here is to demonstrate their relevance and focus in terms of concrete and positive outcomes to business goals, otherwise the establishment of such initiatives could be perceived as being ends in themselves, rather than a means to an end.

This is further supported by Healy and Oikelome 2006[11] who state that although a genuine effort has been made to address problems of recruitment and retention of BME staff (including access to senior positions) at a national level, it appears that the benefits are not cascading down to BME staff, which may be related to the culture inherent within organisations that are resistant to change. They emphasise that in order for policy initiatives at the national level to translate into meaningful outcomes at the local level, and not just become a 'tick-box' exercise, middle and senior managers must also unequivocally embrace and be accountable for the organisational change agenda. Hitherto, trusts have tended to focus on individual initiatives e.g. mentoring and personal development, rather than those which seek to change the organisational culture e.g. diversity training for all staff.

[10]The term 'employees of colour' is the language used by the interviewee, and is frequently used by organisations in the United States in workforce descriptions and data.

[11]G Healy & F Oikelome (2006). Ethnicity, Career, Work and the Health Services. Research Report, UK: European Social Fund

6

6.4 Regulatory drivers

The Race Relations Amendment Act (RRAA) 2000 placed public bodies under a statutory general duty to promote race equality and publish a Race Equality Scheme (RES), but its effectiveness has been questioned. For example, whilst there was considerable evidence of NHS organisations developing their RES, the Race Equality Audit carried out by the Healthcare Commission in 2006 indicated that only 1% of trusts had fully met the requirements of the RRAA and only 6% had met two of the three requirements[12]. This brings into question the priority, or otherwise, of this measure as part of the overall assessment of PCT/Trust performance. Further, whilst the Department of Health's Annual Report 2006 stated that 'NHS organisations have generally made considerable progress in addressing race equality', a formal investigation by the Commission for Racial Equality (January 2007) concluded that the Department of Health did not have 'due regard' to the Race Equality Duty in the way in which it developed policies. This review consequently indicates a lack of consistency in the way that the Department of Health, Healthcare Commission and Commission for Race Equality view race equality, and is an area for further development.

[12] However, an audit carried out by the Kings Fund (2007) found that many PCTs are hampered in publishing their assessment of how services are structured to meet local health needs by poor data about the ethnicity of users of services (including those in hospitals and at GP practices).

7

7.0 Organisational and individual barriers to senior workforce diversity

The literature[13] and interviews identified a variety of barriers to BME staff accessing senior positions. These included:

- Racially biased recruitment and selection practices, particularly at times of merger or restructuring.
- Undervaluing of relevant experience and overseas qualifications.
- Tokenism.
- Circumventing of established procedures when appointing part-time staff or covering maternity leave.
- Rewards: some evidence suggested that the allocation of excellence awards is discriminatory against BME groups and women.
- Institutional culture seen in individual and group behaviour, formal and informal networks.

Although organisational barriers are of more obvious relevance to the NHS, individual barriers are also important because of the influence of individual behaviour on institutional culture. NHS reforms are based on the idea that cultural change must be secured alongside structural and procedural change if desired improvements are to be achieved. The individual barriers to BME staff attaining senior posts identified in the literature were:

- Lack of mentors/role models.
- Exclusion from informal networks and communication.
- Stereotyping and preconception of roles and abilities.
- Lack of significant line management experience/challenging assignments.

According to Oikelome[14], evidence on the recruitment and retention of BME staff in the NHS suggests that racial discrimination remains a feature of the internal market, and the examples given below may be a particular barrier to the attainment of senior positions.

BME people are less likely to:

- Be invited for interviews or be selected after the interview process.
- Find a position commensurate with their qualifications.
- Gain promotion or advance on the career ladder at work.

They are also:

- Under-represented in professional and managerial occupations and over-represented in semi-routine and routine occupations.
- Likely to earn less.
- More likely to feature disproportionately on the wrong end of grievance and disciplinary procedures.

These issues were further explored in the PCT case studies.

[13] Majority of relevant references identified by our literature search were included in "A critical review of leadership interventions aimed at people from Black and Minority Ethnic Groups", a report for the Health Foundation – A Esmail, V Kalra and P Abel, University of Manchester, June 2005. The aim of this project was to assess and evaluate different strategies for increasing the diversity of the workforce at senior levels in the NHS in order to deal with the problems of BME staff disaffection and health inequalities amongst BME populations. It involved an extensive review of the literature and interviewing key stakeholders from the public and private sectors.

[14] F Oikelome, March 2007. The recruitment and retention of black and minority ethnic staff in the National Health Service. Better Health Briefing 4A. Race Equality Foundation Briefing paper.

7

Challenges

All PCTs encountered problems in the recruitment, promotion and retention of BME staff in senior posts, especially in non-clinical roles and in smaller trusts where the opportunity for internal upward mobility was restricted.

A challenge described by many PCTs, was how and from where to successfully source/recruit the required 'number' of senior BME staff, e.g. which diverse group, media, recruitment agencies, in collaboration with which other PCTs or LAs in their SHA area, and/or via BME networks. This pre-occupation with reaching targeted numbers of BME senior staff and the self-satisfaction derived from achieving these targets, may prove an obstacle to sustaining workforce diversity. This study suggests that the aims should be to:

- Make the promotion of workforce diversity self-directed, ensure that it is an integral part of the institutional culture and thus attractive to individuals who can occupy senior posts.
- Represent all BME populations and other under-represented groups.
- Embrace diversity as a central tenet of their individual work and institutional management practices to deliver organisational success.

BME networks were cited as initiatives to promote workforce diversity, including access of BME staff to senior positions, at an internal, local and wider level. However, the potential negative effects of segmentation, initiatives targeted at BME groups especially within single PCTs, were highlighted.

These suggested negative effects of BME networks found resonance in other responses, especially in questions concerning barriers to promoting workforce diversity. Comments made by interviewees whose main or key responsibility was to drive the Equality and Diversity agenda within their PCTs, suggested that racial discrimination did exist in some areas - on an individual, group, and at an institutional level.

"Negative stereotyping is not an issue here and there is no racial discrimination on an individual level".

"There are no barriers, none except having the right skills and behaviour and drive. People who can manage change, deliver and have a history of achievement are not ignored. Good people do get supported, the right behaviour gets promoted regardless of colour".

"We have a predominantly white male workforce and efforts to change this have led to pockets of resentment".

"The large number of staff who are white UK in the PCT influences perceptions of the NHS as an employer".

"People on the ground are afraid to challenge issues, or raise their heads about the parapet".

"I think there is subtle discrimination which current policies do not pick up".

"I went to Fitness for Purpose training and one lady walked out saying I cannot believe the discrimination in this room".

"Even the XXXXX (organisation anonymized to protect confidentiality) do not set a good example – e.g. they invited steering group of 10 BME staff to a meeting on a Friday – they did not take account of the needs of Islamic and Jewish participants".

8

8.0 Analysis

A key tenet of this paper is that diversity of senior management should be seen as a means to an end, rather than an end in itself. Unless such links between diverse senior management and successful health organisations are made, it will be difficult for the challenges and barriers described to be overcome. This section describes some of the key benefits and outcomes of diversity in senior management positions from both case studies of "best practice" organisations, and in PCTs, resulting in the development of the "Business case approach to workforce diversity."

The central benefit of a diversity policy and ensuing initiatives in the non NHS case study organisations, was that it led to a steady rise in the number of BME employees in each organisation. This was viewed as beneficial to the organisation in a number of ways. Firstly, having a diverse workforce was believed to lead to increased market share and increased sales to minority groups or other companies with strong diversity policies. Secondly, a workforce that reflected the diversity of the population led to an enhanced customer 'service' (communication and profitability). For example, the employment of Bangladeshi staff at a LloydsTSB branch led to a large reduction in customer complaints and a 30% increase in sales. It was also thought that management quality increased as a result of a stronger anti-discrimination policy: managers who sustained equality and respect in their team were rewarded with a stimulated and contented workforce.

Other key benefits of a diverse workforce were the range of positive outcomes of a culture that respects diversity including a decreased labour turnover as a result of their diversity policy and increased levels of satisfaction and motivation.

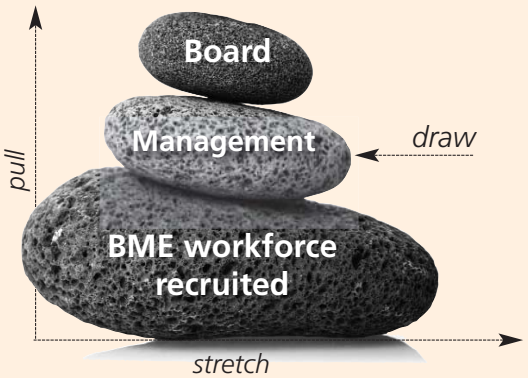
8.1 Barriers, improvement and sustainability

Our analysis has established that the variety of recruitment, development and retention programmes introduced in the NHS, as well as in other so-called 'higher performing' organisations, have had different levels of impact. In broad terms, the organisations that have been considered as part of this study have found the immediate challenge of achieving broad workforce representation for BME communities achievable. The figure below presents a 'typical' pattern of BME recruitment in the organisations considered for this study. Such a typical model demonstrates the following attributes:

- Proportional over-representation of BME staff at lower grades.
- Proportional under-representation of BME staff at management and supervisory grades.
- Highest levels of proportional under-representation of BME staff at executive/board level.

This 'typical' profile may in turn reflect the interaction of the following three broad recruitment strategies:

- Stretch
- Pull
- Draw



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Stretch

Stretch occurs where an organisation seeks to increase the ethnic diversity of its workforce through general recruitment processes. Currently there is over representation of BME communities in lower skilled jobs and at lower organisational grade levels.

Pull

Pull strategies are focused on supporting BME staff development within an organisation, with the aim being to increase BME staff representation at all levels. Breaking Through is an example of a pull strategy.

Draw

A draw strategy relates to an organisation that has not been able to achieve appropriate levels of BME representation and responds by targeted external recruitment, most particularly at Board level. Whilst such an approach is common in human resource terms, the impact for BME communities where it is not accompanied by 'pull' programmes can be to develop an organisation which has higher levels of BME representation, but where long term sustainability may not be achievable.

The combined impact of adopting a piecemeal approach to increasing ethnic diversity in organisations has been to:

- Create organisations where ethnic diversity is not sustainable.
- Fail to realise the full benefits of ethnic diversity across an organisation.

This latter point relates to what may be described as the first level benefits of ethnic diversity: reduced health inequalities, more responsive and appropriate service delivery and a high quality and well motivated workforce.

8

8.2 Business case approach to workforce diversity

It is clear from the experience of PCTs that there are many areas of overlap with the findings from the business case approach described in the workforce diversity case studies. For example:

Drivers and instigators

- Market share and competition.
- Population demographics.
- Restructuring.
- Allegations of discrimination.
- Legislation.

Enablers and initiatives

- Reliable and valid workforce data to monitor talent management and address inequalities.
- Increased recruitment of BME senior staff via links with academic institutions, identification of talent pools, recognition of BME culture and beliefs in the workplace.
- Compulsory diversity training.

Benefits

- More responsiveness to needs of a diverse client base seen in provision of quality services.
- Improved organisational performance.
- Enhanced reputation.
- Increased staff satisfaction and motivation.
- Reduced labour turnover.

The majority of interviewees were aware of the business case approach to workforce diversity and acknowledged the potential benefits:

- Financial (including reduced cost of recruitment, dealing with staff grievances and litigation).
- Improved performance (better quality of provision and impact on health).

They also went on to make the link between improved use of resources and quality of services (NHS performance indicators) and the possibility that applying a business case approach to the NHS could lead to a reduction in health inequalities.

While some interviewees believed that they were already applying a business case approach to diversity in their trust (although it may not be called this), others were sceptical that this approach was, in practice, transferable to the NHS. This was not because of the financial cost of instigating it (indeed this was considered to be minimal), but because it would require a change in both individual and organisational culture, it was unknown how much it would cost to change attitudes and behaviour and how long it would take.

'….so there should be benefits of applying the business case approach to diversity in the NHS – improved performance in finance and quality - but the NHS does not have the same stringent standards as other organisations. The business case is well-proven, it is just a problem putting it into practice. It is not costly, it is entirely attitudinal, and would require change in individual and organisational culture.'

8

8.3 Additional learning

From the case studies, it is clear that workforce diversity has become less of a choice and more of a requisite for any successful workforce strategy. This is due to the competitive pressures on organisations to sustain and improve economic performance and the changing expectations and aspirations of society. Diversity will become an increasingly important issue as the numbers of people in the UK's BME communities continue to rise in the coming years.

Organisations that embrace equal opportunities and diversity gain advantages through increased effectiveness, satisfaction and market share. The benefits of diversity are not just attributable to a more flexible and effective workforce; an organisation which establishes an open and comfortable culture will also benefit from a workforce which feels valued, respected and will 'do its best' for the organisation.

9

9.0 Conclusions

The NHS has never shied away from changing its leadership agenda in order to shape the future of service delivery. Over the last 60 years the shifts from clinical leadership and administration, to the introduction of general management in the 80s, has seen the leadership landscape ebb and flow, responding to budgetary concerns, new technologies, and research opportunities.

World class commissioning and the development of the new era of partnerships, community engagement and choice bring new dimensions to the leadership landscape. Well-being, case management, and personalised care are now on the agenda for all populations. Competition for patients also brings its own challenges as providers strive to define the service areas in which they excel and make themselves attractive to different cohorts of patients. Consequently PCT and Trust Boards will increasingly need to be seen to be making tangible headway with all communities through improving services and fostering new ways to promote effective communication. World class commissioning recognises the transformational shift in the way that organisations do their business and suggests that this will not happen overnight. It will be a journey for boards and workforces as they develop and sustainably embed their new business processes – focusing on getting closer to patients, fostering new community relationships, understanding markets, defining products and transforming the way they do their business. This will only be achieved if successful talent management is delivered from the whole workforce.

In order for boards to understand what this transformation will mean in practice, and quickly deliver benefits, it is unlikely that training in 'diversity' will be enough to foster this new era of innovation. In the short term, boards with a broader range of experience and networks are needed to:

- Change how the needs of diverse populations are understood;
- Provide greater insight into the nature of effective service innovations for these communities;
- Identify mechanisms to reprioritise investments and engage with these communities.

Furthermore, role models from diverse backgrounds will provide greater hope for staff from a variety of backgrounds to reach senior positions. As a consequence, the argument is strong for having board members with diverse backgrounds in the NHS.

Whilst there is a moral argument for increasing the senior BME workforce, a number of initiatives such as Race for Health and Breaking Through and a legal duty to introduce equality based employment procedures, there is still a long way to go to recognise and realise the benefits of ethnic diversity in positions of influence in the NHS. Consequently, there may be a case for reframing/refocusing the initiatives as supporting the realisation of benefits of diverse leadership and management of the NHS. This calls for the existing leadership of the NHS to be engaged in identifying these benefits and crucially identifying the links between these benefits and organisational success. If these links are not made or not seen to be material, it is unlikely that much more progress will be made beyond ensuring that NHS organisations meet with their statutory duties, unless more drastic action is taken.

10

10.0 Recommendations

NHS Board and Executive diversity is not simply a 'numbers game', it is a challenge and opportunity for an NHS which embraces leadership diversity as part of a broader strategy to improve quality, reduce health inequalities, increase organisational performance, and reduce the gap between the NHS and communities. This provides an opportunity for the NHS to set the tone across businesses and globally for delivering organisational success.

The following recommendations have relevance to both national organisations such as the Department of Health and NHS Institute for Innovation and Improvement as well as Strategic Health Authorities, commissioners and provider organisations:

1. Evaluate and reposition existing board development, leadership development and diversity leadership programmes to focus on improvement in NHS performance and corporate social responsibility, as opposed to purely a focus on individual performance, numbers and representativeness.

Whilst programmes focusing on supporting particular staff groups are of value as part of a balanced suite of leadership development initiatives creating a high quality "pipeline" of leaders, they should be seen as a means to an end, rather than ends in themselves. These ends are described in the Next Stage Review, which focuses on quality and delivering patient benefits. As a consequence, all programmes should be evaluated to ensure that they demonstrably contribute to both patient and community benefit, through board and leadership diversity. Each of the programmes will have a role in supporting better decision making, valuing contributions of different leaders, breaking glass ceilings, and embedding integrated initiatives to sustainably create high performing organisations.

2. Co-create a diversity performance monitoring process with engaged Trusts and PCTs, generated out of the types of data analyses identified in this report from the case studies. These indicators should cover all aspects of diversity, including legal requirements, business case benefits, and incorporate both baseline and aspirational target indicators linked with talent management.

There is a strong case to develop both lead and lag performance indicators for diversity in leadership positions to answer the questions:

- Are the mechanisms in place to sustainably realise the benefits of leadership diversity?
- Are the mechanisms in place to deliver leaders from diverse backgrounds?
- Are the proposed benefits being realised?
- Are the legal requirements being met?

A diversity performance monitoring process should be created with Key Performance Indicators which establish the health or otherwise of the on-going development of diverse leadership capacity and capability, reflecting answers to these questions at a national, regional and local level. Potentially this could be delivered with Local Authority partners. This should be delivered in consultation with the Department of Health Equality and Human Rights Group in both agreeing the classifications, improving data collection and reporting so as to facilitate the establishment of organisational baselines alongside appropriate stretch targets in outcomes and processes.

3. Deliver support to organisations to identify and realise the benefits of diverse leadership

The development of transformational leadership stories is one aspect of implementation. Initiatives to share good practice, evaluate the benefits of the diverse leadership culture (such as health inequalities, quality and recruitment and retention), identify how well organisations are doing to overcome

challenges should be supported/promoted. For example leadership collaborative workshops, collaborative web forums focussing on creating the high performing leadership teams of the future, and overcoming the cultural challenges should be introduced.

4. Co-develop positive transformational stories around the importance of a diverse leadership across the NHS, which Chief Executives can own and share. This needs to incorporate the value of diversity and innovation to facilitate and accelerate NHS performance.

A key strategy to embed the transformational change in performance of the NHS will be to establish leadership behaviours which demonstrably value and promote quality, diversity and innovation as ingredients of improved performance. This challenge should not be underestimated, and requires some investment through workshops and mentoring. Without such a focus, the existing leadership culture, which does not embrace diversity, is likely to overwhelm the strategic intent. Evidence suggests that the use of transformational stories is one of the most powerful means to establish such change and should be considered as a key part of leadership development interventions and assessments.

5. Build the evidence base for diverse leadership

We found no studies concerning the relative impact and effectiveness of leadership teams with diverse backgrounds. Whilst causal links may be difficult to establish, observational studies describing the different interactions, costs and benefits of groups of diverse leaders/boards vs. more homogenous groups and the impact on organisational performance would be of benefit. Currently the evidence base does not exist, and such studies would lend weight to the argument for diverse leadership.

6. Establish cross industry and country links concerning diversity and leadership to share practice

Diversity and leadership are two areas of international and cross industry interest. The change programme promoted through the Next Stage Review etc. puts the NHS in a unique position to be able to take the lead in identifying and promoting the benefits of diverse leadership. The NHS should engage with the international network concerning diversity and leadership in order to promote and share good practice with other sectors and industries. This is likely to lead to a far broader and richer experience base from which the NHS can draw. If such initiatives do not already exist, the NHS could establish a hub for such a network and share practice.

7. Highlight and monitor the requirement that all Trusts meet their statutory equality obligations, in employment and other areas.

There is evidence that the legal requirements concerning diversity and employment practices etc. are not being met. In order to lead by example, the Department of Health and regulators should ensure that these laws are being rigorously implemented through increasing the importance of meeting these legal requirements.

8. Explore whether all diversity and inequalities related initiatives should be brought together within an overall initiative to deliver improved quality, reduce inequalities and engage communities.

There is the potential to develop and present a more integrated strategy concerning diversity and inequalities at a national, regional and local level. This will allow leaders to reduce the fragmentation of initiatives such as inequalities impact assessments, needs assessments of minority populations, community engagement, leadership initiatives focussed on diverse groups, and corporate social responsibility developments. Such a framework would be a natural next step from the Next Stage Review and would be consistent with the need for public organisations to assess and consult on the likely impact of proposed policies on equalities groups[15].

[15] These responsibilities arise from section 71 of the Race Relations (Amendment) Act 2000 (2), Section 3 of the Disability Discrimination Act 2005 (3) and Part 4 of the Equality Act 2006 (4).

appendix

Appendix A: Organisational case studies

The Aetna and Lloyds TSB case studies are presented in detail, with diagrams reflecting the key components of the business cases for all the other organisations at the end of the section.

Aetna

Aetna is one of the United States' (US) leading diversified health care benefits companies. It offers a broad range of traditional and consumer-directed health insurance products and services, including medical, pharmacy, dental, long-term care and disability plans. Aetna's long-standing commitment to diversity has led to national recognition of the organisation as a leader in diversity management, and to their achievement of a number of prestigious diversity awards[16].

Instigators and business case

Aetna formally crafted its diversity policy in the 1960s. At this time, the policy reflected diversity-focused social responsibility issues, rather than a diversity-focused business case. However, in recent years, the drivers for their diversity initiatives altered. With a shift in customer-base (from large health-care provider organisations to individual patients), Aetna became focused on ensuring that individuality and diversity was reflected in its workforce. This fitted into their increased drive for consumerism[17] and segmentation[18], which emphasises the company's need to provide an offer for the increasingly diverse population. Further to these internal changes, Aetna was strongly influenced by the successes of other organisations with a diverse marketing strategy (such as Coca-cola[19]).

Aetna's business case for diversity is based on a fundamental principle: to meet the diverse needs of its clients, diversity should be mirrored in its workforce.

Aetna believes a workforce reflective of the population will lead to:

- Effective communication with customers;
- More flexible, creative and individualised business processes and methodologies;
- Processes which take into account cultural contexts that may better reflect customer base ideals;
- The identification of talented individuals regardless of race.

All of the above will lead to increased profitability and productivity for the company.

Initiatives to increase BME recruitment

Aetna has a number of initiatives supporting diverse recruitment and selection. These include:

- Established relationships with educational institutions and other organisations that traditionally serve African Americans, Hispanics and Asians.
- The 'executives in training' program: Aetna executives work with black and Hispanic-serving colleges. This includes speaking at university career events, directly mentoring students, conducting mock employment interviews and performing resume (CV) reviews.
- Partnerships with local and national organisations to provide internship programs.

[16] "Top 40 companies for diversity," in 2006 and 2007, "15 Best in Corporate Board Diversity" and "15 Best in Senior Management Diversity" 2007 (Black Enterprise); "Top 50 Companies for Black MBAs To Work", 2007 (National Black MBA Association); "Top 50 Places to Win for black business professionals", 2004 (Savoy professionals magazine) among many others. http://www.aetna.com/about/aetna/aag/awards_and_recognition.html

[17] The belief that the free choice of consumers should dictate the economic structure of a society.

[18] An economic and business term, market segmentation is the process in marketing of dividing a market into distinct subsets (segments) that have similar needs. In this case, the interviewee is referring to the growth in the market segment of racially diverse persons due to the growth in the racially diverse population in the US.

[19] Coca-cola were the pioneers of national campaigns within black media, and were one of the first consumer marketers to engage public relations specialists to build relationship with African Americans. The Coco-cola "hilltop" commercial is internationally recognised as a successful diversity-focused commercial. It shows peoples from many different races holding coco cola bottles on a hilltop and singing lyrics incorporating "coke is what the world wants today".

Initiatives to promote a positive working environment

At Aetna, creating an inclusive working environment is "everyone's responsibility, not just the job of a single diversity lead". To do this, managers take responsibility for diversity in their workforce. 'Representativeness and diversity' is a specific section of their 'managers' scorecards', which are used to evaluate how successful the manager is performing. Success in this scorecard is related to their annual bonuses. Aetna also ensures that both their lower and higher level employees receive annual 'diversity training'.

Aetna has tried to be as innovative as possible in their approach to a diverse working environment. An initiative which is exceptionally creative is their award winning black African celebration calendar. This calendar celebrates Black-Africans in business, profiling a different black African business professional each month. Similarities can be drawn here to a Department of Health initiative undertaken in 2005, where the contribution of the NHS Caribbean workforce was celebrated[20]. Aetna also has a number of diversity networking groups.

Initiatives to promote BME career development

Aetna's approach to career progression incorporates the early identification of talent, increasing the visibility of such talent, and ensuring they receive the support and training they need in order to progress within the organisation.

Aetna has a number of 'talent pools', by which talented individuals are identified and their progression throughout the organisation monitored. Aetna has recently set-up a talent pool specifically for their ethnic minority workforce. When such talent is identified, Aetna has a number of initiatives to ensure these individuals receive appropriate training to aid their development. These include:

- Diverse discoveries: a training programme providing leadership for BME, talented individuals who are mid-level in the organisation.
- Visibility: increasing visibility of talented individuals by introducing them to senior employees in head office.
- Mentoring: mentoring programmes are available from senior to lower-level 'employees of colour'[21].

Monitoring diversity

Aetna uses a variety of methods to both monitor their workforce diversity and to evaluate their initiatives, both regionally and nationally.

Aetna monitors the presence of a representative labour force regionally by the monitoring of individual managers' scorecards, administering surveys around inclusiveness and using focus group feedback. They also review regional workforce statistics.

On a national level, Aetna looks for opportunities to benchmark against other organisations[22]; internal organisational sectors (i.e., IT, HR, finance etc), and population demographics. Poor performing sites are flagged, leading to site visits.

As well as reviewing internal diversity statistics, Aetna assesses its business statistics regarding market penetration. This is both in terms of ensuring its workforce is reflective of its market, but also about ensuring the diversification of its customer base.

[20] Jane Elliott; (2005). "NHS book honours Caribbean heroes". Retrieved 20th May, 2005, from BBCNEWS website, https://news.bbc.co.uk/1/hi/health.4218579.stm

[21] The term 'employees of colour' is the language used by the interviewee, and is frequently used by organisations in the United States in workforce descriptions and data.

[22] This is achieved by looking at other organisations performance on Diversity Inc's diversity benchmarking tool http://www.diversityinc.com/

appendix

Benefits/outcomes

Aetna believes that their diversity policy and initiatives has led to a number of positive changes in their company. Aetna also feels that their commitment to diversity is responsible for a more representative workforce, with workforce statistics showing a general increase in diversity in their organisation. Their relationship with educational institutions with a strong ethnic presence has led to an increase in BME graduates, who will be encouraged to progress throughout the organisation. Diversity has also increased in the higher levels of their organisation, with 'people of colour' holding 11% of senior leadership positions, and 25% of board levels positions (2006).

Aetna believes that promoting a positive and inclusive working environment played a key role in Aetna's success. The interviewee said:

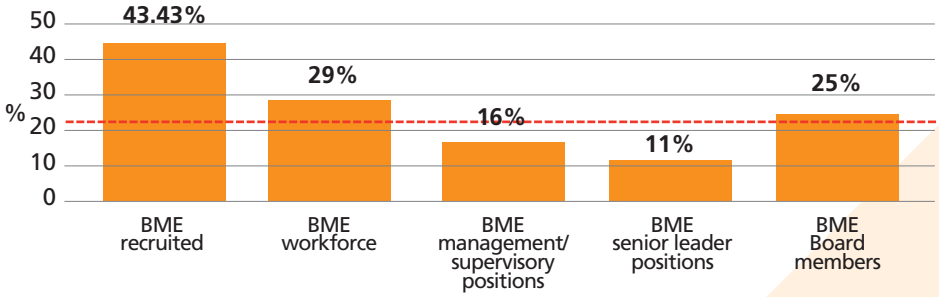
"An inclusive diversity climate increases performance and productivity levels of employees through increased job satisfaction and commitment".

Aetna also believe that anti-discrimination policies have improved the quality of management in the organisation. By making managers accountable for ensuring an inclusive work environment, managers were more successful in controlling the workforce.

Total number of people of colour hired by Aetna (2001-2006)

Year	Number	Percentage
2006	3,532	43.43%
2005	1,886	42.80%
2004	1,634	41.40%
2003	1,317	37.60%
2002	1,604	36.80%
2001	1,518	37.30%

Aetna ethnic minority workforce statistics (2006)



NB: The dotted red line denotes the USA national average BME working age population (22.2%)

LloydsTSB

LloydsTSB Group provides an extensive range of financial products and services, both in the United Kingdom and overseas. In June 2006, the Group's Equality & Diversity Race Equality Programme triumphed over 100 companies to come first for the second year running in the Race for Opportunity's annual survey. As such, the Group is increasingly recognised as an industry leader in promoting diversity, and has won a number of national and international endorsements and awards.[23]

Instigators and business case

The merger of Lloyds Bank and TSB in 1995 resulted in an organisation with a strong presence in areas with high BME populations. This meant that adjustments needed to be made to the merged organisation's Equality and Diversity policy. The two Equal Opportunities models were reviewed and it was decided to base the new policy on TSB's more comprehensive and established policy and norms. From this, diversity initiatives were established, also taking into consideration company-wide research on the career experiences of BME employees, undertaken in 1998[24].

LloydsTSB business case for diversity is built upon four key points:

1. The desire to be an employer of choice. LloydsTSB needs to appeal to the widest possible audience to fulfil its recruitment needs and attract required skills. Employees who feel valued and respected are more likely to be motivated and committed to the organisation. A mix of different talents, skills and perspectives allows creativity and innovation.

2. The need to meet the requirements of their diverse customers. The interviewee commented: *"….an employee pool of white, 20-40 year old, able-bodied males would cause huge problems for the future… as the working age population becomes more and more diverse. Lloyds needs its staff to mirror the diverse needs of its customers. Over 50% of Lloyds new customers are from people who are new to the UK and there are a growing number of financial services for diverse markets (Islamic banking services, the India banking service). LloydsTSB must retain their competitive edge, it now offers an international service; globalisation calls for a multi-cultural and multinational workforce."*

3. The need to comply with national anti-discrimination legalisation.

4. The desire to create a strong corporate reputation and community profile.
Having a strong brand profile is key to Lloyd's success, as is winning and retaining the commitment of local stakeholders. There is also an element of competition in their agenda, with strong overseas competition also being recognised in their approach to diversity[25].

[23] Race for Opportunity annual survey winner, 2003, 2005, 2006

[24] This research suggested that despite high recruitment of BME individuals, there were retention issues among ethnic minority junior and middle managers.

[25] Bank of America was ranked "no. 1 company for diversity" by diversity inc. (2007), and National Black MBA Association awarded Bank of America the "2006 Company of the Year" for recruiting, retaining and providing advancement opportunities for blacks in the workplace.

appendix

Initiatives

LloydsTSB's diversity initiatives were based upon their company research into diversity.
Focus groups with senior and middle management highlighted a number of issues of concern:

- Top management seemed to represent white, non-disabled, middle-aged men. This raised the question of how committed the company was to equality;
- Some managers had reservations about how supported they felt in their development;
- Many spoke of a sense of isolation, being the only ethnic minority in their team;
- The capability of managers to manage people different to themselves was questioned.

A number of positive action initiatives were introduced to reflect these concerns.

Initiatives to increase BME recruitment

In their East London branch, there were a high number of Bangladeshi customers, but LloydsTSB discovered that they employed no Bangladeshi staff there. As such, misunderstandings and communication difficulties were common, leading to high levels of customer complaints. To address this issue, job advertisements were translated into Bengali and placed within community groups to attract Bangladeshi applicants. In addition, a 13 week work experience programme was run, to provide members of the Bangladeshi community with the opportunity to decide whether the position in Lloyds was suitable and to develop the necessary skills to be ready for interview. As a result of the programme, a number of those who had taken part in the work experience successfully applied for jobs with Lloyds TSB. Well over a hundred people have taken part in the programme over the last couple of years, 70% of those who want to work for the Bank have obtained permanent employment, and over 60% of those are from BME groups.

Initiatives to promote a positive work environment

LloydsTSB Group's Ethnic Minority Network was launched at a conference in 2001. The network is both a support network for ethnic minorities, and a forum for how to best use cultural understanding of issues to advise on improving service to customers and improved marketing. The network has influenced the recent LloydsTSB's television advertisements featuring well-known ethnic minority personalities.

LloydsTSB provides a range of training courses and development tools to ensure staff understand diversity and why it is essential for the company's success. This helps raise awareness at every level of the organisation. All LloydsTSB staff are expected to complete a multi-media training package called 'Diversity – Achieving Success Through Valuing Difference'. The Equality and Diversity Team also offers two intensive face-to-face management training programmes to raise awareness and understanding of diversity and the benefits of adopting a progressive diversity strategy as both an employer and service provider. These give senior and middle managers the opportunity to identify and practice the skills needed to positively manage difference.

Initiatives to promote BME career development

Initiatives include the career development programme for ethnic minority employees, which is a five-day programme for junior and middle managers. The programme is distributed over 6 months and groups of 12 join each programme. After a day's pre-briefing, a month later the programme enters its second phase - a three day workshop at the corporate University of LloydsTSB. An important part of this is a lecture from the guest speaker - a BME employee at a senior position in the bank who can act as a role model for other BME employees. At the end of six months a follow-up one day workshop is undertaken. Those who have undertaken the career development programme select mentors from the Bank's senior management population.

Monitoring diversity

LloydsTSB continually monitors its workforce profile and benchmarks extensively against external demographics, competitors and other companies. Since the launch of its diversity strategy more than 20 business units have completed a comprehensive equality review and implemented equality action plans.

Benefits/outcomes

Over 40% of employees working in East London are now from BME communities. As a result of this work, there has been a 30% increase in sales in the area. There has also been a significant decrease in the number of customer complaints. Local line management believe that this is a direct result of having a more diverse workforce and therefore being able to understand the needs of their customers more effectively.

The beneficial results of the various initiatives were visible in a short period of time. For example, BME graduate recruitment increased from 2.5% of the total intake in 1995 to 20% in 1999, 2000 and 2001. The percentage of managers and senior managers of BME origin increased between 2004 and 2005 (Table 6.4a). On an individual level, a Nigerian employee was promoted from Grade 8 (entry level) up to Grade 6 and then to Grade 5 (junior manager) after mentoring. A Briton of Indian parentage who had taken part in the career development programme was promoted from Grade 5 to Grade 3 (senior manager) within 11 months. LloydsTSB's overall reputation was also reported to have improved through its recognition in a variety of equal opportunity awards[26].

Senior workforce national statistics, LloydsTSB.

Position	2004	2005	2006
BME Managers	3.50%	4.10%	4.10%
BME Senior Managers	1.20%	1.80%	1.80%

[26] Lloyds TSB is a member of Race for Opportunity (RfO) an organisation of 150 businesses that puts forward the business case for race. Lloyds came first place in the annual RfO survey (2003, 2005, 2006).

Data from Lloyds TSB Annual report and accounts, 2006.
http://www.investorrelations.lloydstsb.com/ir/company_reports_page.as

case studies

AETNA - Case study analysis

INSTIGATOR

- Changing consumer: from insurance organisation to individual patient

Change from moral issue to business case

BUSINESS CASE

- Need to represent customer base to:
- Give better communication
- Cultural processes
- Identify top talent
- Increased profitability

INITIATIVES

- Black colleges: increasing visibility of organisations to black students'
- Diversity "talent pools" monitoring identified diverse talent through their career
- Increasing "visability" taking diverse workforce to headquarters to meet senior persons

Working environment

- Afro-American calendar
- Networks
- Training
- Diversity "scorecards" managers are scored on their commitment to diversity and this forms part of their bonuses
- Annual diversity company update

Monitoring

- National and regional monitoring
- Sector monitoring (i.e. IT)
- Position monitoring (i.e. senior and lower-level positions)
- National population monitoring
- Benchmarking against other top companies using diversity inc'c benchmarking tool
- Monitoring % of workforce against previous annual workforce statistics and oncoming targets
- Supplier diversity monitoring

OUTCOMES/BENEFITS

- More work from diversity-led clients = increased profitability
- Better identification of top talent
- Recognition (awards) named no.1 company for diversity in US (black enterprise)
- More accepting working environment leading to incresed creativeness in responding to cultural differences
- More cultural work processes
- Positive public image

ASDA - Case study analysis

INSTIGATORS

- 96-97: open Hulme store - many other stores in the area were closed down/relocated. High unemployment rates and high BME pop. Decided this needed to be reflected in store

Change from moral issue to business case

BUSINESS CASE

Regional Hulme:

- Representation of customer base
- Recruit local population to reduce unemployment and reduce dislike of population as a 'white' employer

National

- Changing demographics led to access to more diverse workforce skills/talent. These need to be used to retain talented BME employees, improve customer satisfaction and increase market penetration

INITIATIVES

- Hulme: local recruitment drive, working with community leaders and residents association
- Targeting intake of graduates from BME backgrounds: intake from local population
- 'Talent race' campaign 2000: BME promotion and development programme

Working environment

- Advertising: targeted advertising for different areas, i.e. high representation of BME in high BME groups.

Monitoring

- Analysis of profiles of successful and unsuccessful job applicants
- BME workforce targets discussed monthly at board level
- Listening groups with staff
- Equality assessed in regular attitudinal surveys

OUTCOMES/BENEFITS

- Hulme: 50% of recruited workforce from BME
- Nationally: 8.4% of employees from BME
- Nationally: 4.28% middle management

GREATER LONDON AUTHORITY - Case study analysis

INSTIGATORS

- Need to comply with Race Relations act (1975)

- The GLA has a duty to reflect the population in its workforce, to ensure all its needs are met

Change from moral issue to business case

BUSINESS CASE

- Representation of London's population will provide a service that identifies need

INITIATIVES

- Workshops explaining GLA short-listing and inerview procedures

- Presence at job fairs and careers events to discuss opportunities with potential applicants

- Interviewee qualification not shared with interviewer panel

- Advertising jobs in Asian media

- Commissioned research within the Asian community to inform future recruitment practices

Working environment

- Race Equality Scheme Integration Programme training staff at all levels about diversity in response to workforce and equality impact assessments.

Monitoring

Monitors:
- Number of staff in post;
- Applications, shortlists and selection for employment
- Applications of work-related training and/or study leave
- Promotion applications;
- The performance assessment process (probation);
- Grievance procedures;
- Disciplinary procedures; and
- Leavers

OUTCOMES/BENEFITS

- 2 BME Directors

- BME 25% of workforce

- 26% of BME employees seconded to a higher paid post within the GLA

LloydsTSB - Case study analysis

INSTIGATORS

- Merger of Lloyds and TSB in 1985 = stronger presence in ethnic minority areas

- East London; high Bangladeshi population but no Bangladeshi staff

Change from moral issue to business case

BUSINESS CASE

- Representation of customer base
- Identify top talent

- To reduce communication difficulties

- Better understand customer need to reduce number of complaints

INITIATIVES

- East London branch job advertisements in Bengali

- East London 13 week work experience programme for local population

- Positive Action Career Development Programme
5 day programme for junior/middle managers
- Training, identifying mentors

- One-to-one career coaching

Working environment

- Ethnic minority networks

- Diversity led advertising

Monitoring

- Monitoring workforce profiles

- Benchmarking against external demographics

- Benchmarking against competitors

- Benchmarking against other companies

OUTCOMES/BENEFITS

- 40% more BME employees working in East London and 30% increase in sales in this area

- Decrease in customer complaints managers suggest that this is due to better understanding of customer needs

- BME recruitment increased from 2.5% of total workforce intake to 20%

case studies

METROPOLITAN POLICE - Case study analysis

INSTIGATORS

- Legal drivers
Home office requirements

- Strategic drivers
Acknowledge existing commitments

Change from moral issue to business case

BUSINESS CASE

- Better relationships with communities
- Greater co-operation from communities
- Eliminate tension between police and residents
- Harness positive aspects of difference
- Win trust and confidence of the communities

INITIATIVES

- Recruitment events for female and BME groups
- Promoting skill-based recruitment
- Support positive action activities

Working environment

- 'Developing diversity and capability' programme
- Enhance quality initiatives

'Equal Opportunity Commission' established

- Identifying gender related HR issues
- Female and BME detective training programme

Monitoring

- Collect, analyse and assess relevant data to measure performance and consider how improvements could be made
- Staff monitoring through secondment, recruitment, selection, performance management, retention, training etc..
- Monitoring information will be assessed and reported to equal opportunities and diversity board and HR committee

OUTCOMES/BENEFITS

- BME representation increased from 4.3% to 7.3% from 2005/2007
- Female PCSO's constitute 30% in 2004
- 16% of BME members are in different stages of recruitment process

TRANSPORT for LONDON - Case study analysis

INSTIGATORS

- On agenda in 1970's under race relation act (76) and sex discrimination act (75)
- When TfL was created in 2000, all different London transport organisations in a different place in their diversity journey. There was a need to create a single policy, and have specific targets/action plan for each organisation

Change from moral issue to business case

BUSINESS CASE

- Ensure identification of top talent
- Ensure top talent sees TfL as a place they would like to work
- Example of bad practise: not recruiting as phenomenal female engineer due to lack of flexible working hours

INITIATIVES

Recruitment/career development

- 'Breakthrough programme' identifying the barriers to BME groups entering more senior positions. Reviewed psychometric testing procedures, reviewed interview arrangements to reduce biased recruitment
- Women: a specific problem for TfL. Too large a problem to address organisationally. Therefore, targeting specific work areas i.e. customer services, to get women in lower level positions to then target their progression to senior positions
- Mentoring scheme targets women and BME groups. 47% from BME groups currently

Working environment

- Creating 'faith rooms,' available throughout all TfL transport organisations
- Higher use of flexible working patterns to attract female workforce
- 5 staff networks with senior sponsorship at D/MD level
- Diversity 'action plans' created at D/MD level, with budgets given for diversity objectives

Monitoring

- Diversity reports created monthly, covering
- Transport organisation
- Position held
- Diversity groups (gender, faith disability, BME, age)
- Movement (turnover, absenteeism, disciplinary, dismissals, promotions, secondment)

-Working environment perceptions (from staff networks/surveys)

- Workforce targets (for each diversity group, based on population projections, turnover, headcount and initial representation)

OUTCOMES/BENEFITS

- 33% BME recruitment (2006). above the 25% target from London's working population
- A slower but steady increase in the number of women recruited into all types of positions in TfL
- Rise in female train operators from 2.6% (2002) to 6.6% (2004)
- Women and BME groups are starting to see TfL as an inclusive organisation and so in time attracting these groups into TfL will become less challenging

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