MANCHESTER
1824

The University
of Manchester

A critical review of leadership interventions aimed at people from Black and Minority Ethnic Groups

A report for the Health Foundation

Aneez Esmail
Virinder Kalra
Peter Abel

Contents

Leadership interventions aimed at people from Black and Minority Ethnic Groups: A critical review.

Executive Summary

The Health Foundation commissioned this project. It was carried out by Aneez Esmail, Virinder Kalra and Peter Abel from the University of Manchester.

Aims

The aim of the 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 black and minority ethnic (BME) staff disaffection as well as health inequality amongst black and minority ethnic populations. The main methods used were interviewing key stakeholders from both the public and private sectors who were involved in schemes to improve the diversity of the workforce in their organisations and an extensive review of the literature.

The report considers the context of current diversity strategies in the NHS, argues the business case for developing a coherent strategy on diversity management and then reviews the literature on barriers to career progression and the strategies to overcome them. Recommendations for the future development of interventions are then developed.

Context and Business Case

Black and minority ethnic (BME) groups make up 7.9% of the population in the UK and about 8.4% of the NHS workforce. However the distribution of the workforce is concentrated mainly in the lower levels of the organisation with only 1% of chief executives and 3% of executive directors from BME groups. There has however been a recent improvement in the number of executive directors from BME groups. The differences are even greater in the professional groups, for example doctors and nurses, where BME groups make up nearly 30% of the workforce. Therefore even within the professional groups where many doctors and nurses have the appropriate credentials BME staff continue to be vastly under-represented in senior professional positions in the NHS.

Ethnic monitoring data about the existing workforce within the NHS is not sufficiently detailed to map out the reasons why some staff are able to gain promotion and others are not. The lack of accurate information about promotions combined with a career progression system that is based on informal methods of assessment (such as belonging to peer networks) ensures that certain groups are excluded from senior posts. Challenging this status quo requires better management systems for monitoring and a commitment from NHS leaders to use the information to change the situation.

The ability of the NHS to nurture and develop its BME workforce has hitherto been inadequate. Numerous reports, many commissioned by the Department of Health, have painted a variable picture of lack of senior management commitment, poor accountability, widespread bullying and harassment and a deep-felt perception amongst BME staff that the NHS does not value their contribution.
Nearly two thirds of cases in the Employment Tribunals are from the NHS and nearly 80% of these are related to allegations of racial discrimination.

Health inequalities amongst BME populations have been well documented. The business case for diversity in the top management of the NHS recognizes that in order to improve the quality of services delivered to BME patients, the organisations that constitute the NHS need to embrace diversity as a central facet of their business plans. This requires leadership that recognises the centrality of diversity as a management practice. The demonstrable benefits of a diversity approach, in other sectors, have been a decrease in staff litigation and an increase in customer satisfaction.

The business case for developing a coherent strategy for diversity management works alongside the legal framework that ensures equal opportunities and a moral argument for social justice. The effective implementation of these approaches should ensure that the NHS identifies its future leaders from the widest possible backgrounds.

As a service delivery organisation with a remit for the whole population, the NHS needs to engage with the community to leverage improvement in public health. As identified in the Wanless report, the need for healthcare trusts to engage with their community and to develop networks with the local population is essential to the development of an engaged community. In the context of stark health differentials and poor satisfaction with service provided, BME communities should be a particular focus for NHS institutions. This is particularly important when one considers the distribution of the BME population in the UK. Although making up nearly 8% of the population, most are concentrated in the major conurbations of the UK. For example London's profile of its BME population shows that nearly 60% of the population in Newham, Brent and Tower Hamlets are from BME populations. Similarly, nearly one third of the population of Leicester, Birmingham and Manchester is made up of BME groups. The challenge for the NHS in these areas in developing an engaged community is even greater. The business case benefits do not only relate to the public health benefits. If the NHS can be seen to represent its local community at all levels of the organisation, the benefits for recruitment, retention and fundraising can also be realised.

Barriers to progress and strategies to overcome these barriers

The review of the literature together with comments from our interviewees identified the barriers to career progress for BME groups occurring at both the individual level and at the organisational level. Strategies for overcoming these barriers were also identified.

Evidence from companies and organisations that have developed successful diversity management strategies identified two areas where interventions need to be targeted. At the individual level, programs to support individuals within the system included networks and mentoring, and identification of top talent. These companies included succession planning within their organisational objectives including high potential identification and individual career planning. Many of these components have been developed within some parts of the NHS. The other areas that required intervention were programs designed to change organisational culture so that the culture was more accepting and embracing of difference.
These interventions included senior management commitment, manager accountability and training and education. This is the area where the NHS has to do much more.

The table below summarises the findings:

Barrier to career progression	Strategies for overcoming barriers
Individual	
Lack of mentors and role models	Mentoring
Exclusions from informal networks of communications	Mentoring and networks
Stereotyping and preconceptions of roles and abilities	Leadership development programs
Lack of significant line experience/challenging assignments	Succession planning and identification of talent
Commitment to personal and family responsibilities	Work life balance initiatives
Organisational	
Culture	Institutional commitment Leadership, mainstreaming, monitoring and target setting and management accountability
Systems and procedures Systems for reward and advancement	Policies and legal obligations
Tokenism	Institutional commitment and legal obligations
Type of leadership *Transactional vs. transformational leade*rs	Rethinking training and development in leadership development programs

Recommendations

Taking account of current initiatives in the NHS and those that have been developed by the Health Foundation we identified recommendations for further action.

- **Continue with existing programs**

Short term interventions such as support for mentoring program and networks need to continue but the greatest challenges are related to organisational changes.

- **Establish a definitive picture**

One of the key early tasks relates to establishing a baseline audit of BME managers in the NHS, similar to the five yearly surveys carried out by the American College of Health Care Executives. Linked to this should be a plan to encourage those trusts with high BME populations to implement the development of Staff Individualised Records. This is one of the guidelines suggested by the Commission of Racial Equality. Staff Individualised Records are a management tool for monitoring staff progress. Only with clear monitoring and the linking of monitoring to management accountability will trusts be able to assess its policies and the impact that they have on BME staff. If this is achieved then the potential exists for evaluating the impact of such changes on patient related outcomes.

- **Identify talent**

The Health Foundation should formally develop a network for identifying talent amongst BME staff in the NHS, similar to that which exists for the National Endowment for Science Technology and the Arts (NESTA) in the UK. Such staff should be then supported to apply for fast stream management development programs such as the Health Foundation's own management development program as well as other well-regarded NHS programmes. Consideration should be given to identifying future leaders from existing BME staff who can be fast-tracked into established leadership development programs including those that exist in other countries – for example the Commonwealth Fund Minority Leadership Development Program.

- **Leadership and training**

The Health Foundation needs to ensure that its own management development program incorporates management training for diversity as an integral part of its curriculum. Such training should encourage the development of transformational leaders because evidence suggests that this style of leadership is better equipped to meet the challenges of diversity. This is a critical development, as an understanding of diversity issues is needed by *all* leaders within the NHS, not just those from BME backgrounds.

- **Develop beacon sites where diversity management is central to the organisational culture**

Using a model of development that the Health Foundation has pioneered in relation to patient safety and diabetes care (Shared leadership for change), consideration should be given to identifying a NHS Trust in an area where there is a large ethnic minority population and resourcing it so that it can develop its management team using principles of diversity management. Evaluating the process and measuring outcomes in relation to both staff and patients would be an essential part of the process. The aim would be to develop an exemplar site that could then share its experience with other NHS organisations, disseminating good practice and building the business case for diversity.

LEADERSHIP INTERVENTIONS FOR BLACK AND MINORITY ETHNIC STAFF IN THE NHS.

Introduction

"We must improve the ways that services are planned and delivered to meet the needs of our different communities. I stress that understanding and responding to the health needs of all our communities will determine our progress now in improving health. It is core business. This means a workforce skilled to do this. It also means opening up the workforce to the diversity of experience from the whole community'"

Sir Nigel Crisp, speaking at Human Resources in the NHS Conference, 5 May 2004:

The Health Foundation, as part of its Leadership Programme, has stated that one of its priorities is to develop and support a greater diversity amongst those in leadership positions in the NHS. It hopes to achieve this by focusing on the development needs of professionals from black and minority ethnic (BME) groups. The need to improve senior management diversity has not only been recognised by Sir Nigel Crisp who in the above quote, drew the link between the central requirement of a diverse workforce and tackling health inequalities, but has also been recognised by the Chairman of the Commission for Racial Equality, Trevor Phillips(Carvel, 2003). He used the term "snow capping" to describe how the NHS in England looks. Quoted in the Guardian Newspaper on 30 April 2004 he said, when describing the NHS,

"It is a mountain of an organisation. At the base among its 1.3m employees, there is a wide ethnic diversity. People from black and minority ethnic communities make up 35% of its doctors and dentists, 16.4% of the nurses and 11.2% of non-medical staff. However at the top of each NHS organisation, the boss is almost always white. There are more than 600 NHS trusts, health boards, local health boards and health and social services boards in England, Scotland, Wales and Northern Ireland, and fewer than 1% of them have a black or minority ethnic chief executive. The contrast between snow-capped summit and the mountain base could hardly be more stark."

The purpose of this report is to inform the Health Foundation of the range of interventions that are available, as it seeks to develop a programme of work to increase representation of black and minority ethnic staff in leadership positions in the NHS. The information that underpins this work is derived from an extensive literature review, interviews with key stakeholders from the public and private sectors in the UK and the USA, and the extensive experience of the authors.

In addition to the discussion of leadership interventions, the report also discusses, at the request of the Health Foundation, the business case for diversity. We were asked to make the case as to why an increase the representation of black and minority ethnic staff in leadership positions in the NHS should be an important policy objective for the NHS and the Health Foundation.

The report also suggests a way forward for the Health Foundation looking specifically at how it can include better representation of black and minority ethnic staff on its programmes and to ensure that diversity management becomes an integral part of the leadership development of the future generation of NHS leaders and managers.

The report is structured in three parts. The first reviews the context within which this debate is taking place together with a discussion of the business case for diversity. The second part discusses the information on leadership interventions derived from the literature together with information obtained from the people that we interviewed. The final part discusses the recommendations for action. We have included several appendices with the report. Appendix A includes a brief summary of our interviews with the key stakeholders. Appendix B is the bibliography derived from our literature search and Appendix C includes a collection of key articles and web based resources that we believe informs the debate on leadership interventions.

Section I: The Context and Business Case for Diversity in the NHS

NHS and Race Equality

The Health service is the largest employer in Britain and employs the largest number of people from black and minority ethnic backgrounds. As an institution funded by public money it has a legal responsibility to provide leadership in the area of equality and diversity. However, even by its own admission, highlighted in a series of reports, it has consistently failed to even institute the minimum standards required for compliance with the 1976 and 2000 Race Relations Acts, let alone take on the status as a beacon. Focusing on equalities and diversity issues needs to become a core business activity of the NHS and initiatives that ensure fair treatment in the workplace need to be written into the mainstream organisational policies of PCTs, SHAs and the organisation as a whole in order for them to fulfil their basic legal obligations(Anon, 2000)

The historical legacy of failure speaks for itself. Since the guidelines issued by the Commission for Racial Equality in 1984 on good practice for employers were released, NHS organisations have consistently failed to comply with or implement the guidelines. A 1993 report by the CRE(Commission for Racial Equality, 1996) into the appointment of consultants and senior registrars found glaring inconsistencies between equal opportunities policies and practice. These were demonstrated by the fact that the success rate for equally qualified minority ethnic applicants for senior medical posts were disturbingly low compared with those of white applicants. Significantly, the reason for this was due to employment practices that involved informal recruitment.

In 1998, NHS trusts were surveyed by the CRE(Anon, 2000) about the state of their racial equality policies and their implementation. While, the overwhelming majority of trusts responding to the survey had formal written equal opportunities policies, only 5% had moved on to implementation of action plans in this area. In the arena of promotion and selection which emerged from the 1993 report, a certain number of trusts had begun to monitor internal procedures. Nearly two-thirds of trusts (63%) monitored grade and directorate by ethnic origin; 68% monitored recruitment selection and 20% monitored internal promotion. Only 2% monitored appraisal scores and performance related pay.

In 2002, a sample of Strategic Health Authorities were interviewed in a report commissioned by the CRE (2004b). The main focus of this was their preparation for meeting the requirements of the Race Relations Amendment Act (2000). The report found that awareness of the legislation and preparations for its implementation were in their embryonic stage. Indeed, in the twenty years since the CRE commissioned the 1984 study, it seems that the NHS has not been able to effectively respond to the race equality agenda. This is reflected in the low levels of BME staff in senior positions within the organisation, despite continued international recruitment in areas of shortages and the presence of British trained minority ethnic staff.

The Case for Diversity in the NHS

In a 1993 survey of NHS Trusts carried out by the CRE, 63% of trusts said their racial equality initiatives had improved appreciation of equality issues and led to better staff morale; 43% thought their efforts had succeeded in attracting more ethnic minority applicants; Increased good will from patients and staff was cited by most trusts (43%) as the factor that encouraged them to develop their racial equality action plans or programmes. According to Dreachslin (Dreachslin, Weech-Maldonado & Dansky, 2004) in the US, the 'business case for diversity' in both business and health care

management literature is still in a nascent stage. Indeed, little evidence of the positive impact has been gathered in the health world.

The argument for applying a diversity approach to the NHS is the same as it is for other organisations. If it is related to health organisations, whether a hospital or Trust, diversity strategies have a business argument which is to make the health service more efficient in dealing with various groups in society, thereby restoring public confidence and making the health service more effective. There are three dimensions to the necessity for a business approach for the NHS: Improved patient care; improved performance; demographic imperatives.

Improved Patient Care

One of the strongest reasons for adopting a diversity approach in the NHS is the need to tackle the persistent health inequalities that continue to exist along the lines of ethnicity. Although differences in health across ethnic groups have been widely documented in the USA and the UK, the causes of these inequalities is contested. This wide body of literature has been usefully summarised by James Nazroo(Nazroo, 2003).and by Karlsen and Nazroo(Karlsen & Nazroo, 2002). In particular, Nazroo argues that there is a new body of evidence that suggests that social and economic inequalities, underpinned by racism are fundamental causes of ethnic inequalities in health. Nazroo effectively argues against a simple cultural and genetic argument to explain away health inequality. For example the fact that South Asians living in the UK have a disproportionately high premature death rate from coronary heart disease is well documented. However, the explanation that this is due to genetic propensity and poor lifestyle ignores the crucial significance of NHS service delivery as well as wider factors such as the experiences of racism.

It is in BME patients' experiences of the health service that the issues of health inequality need to be most seriously tackled. Continuing with the example of coronary heart disease, it has been shown that while South Asian people with coronary heart disease are more likely to seek immediate care than whites(Adamson, Ben-Shlomo, Chaturvedi & Donovan, 2003) they have to wait longer for referral to specialist care. In general terms there is evidence of persistent inequalities in access to health services, from GP waiting times to access to specialist services. It is not surprising then that the recent report by the Commission for Health Improvement titled: *Unpacking the patients' perspective: Variations in NHS patient experience in England*, February 2004, reveals wide discrepancies in satisfaction of the NHS by ethnic group. South Asian (Indian, Pakistani and particularly Bangladeshi) respondents reported the poorest experience in all the surveys, followed by those of Chinese origin, mixed origin, and white origin other than British or Irish. Although Caribbean and African participants also responded more negatively than the white British and Irish, the differences were smaller and less consistent. These differences persisted despite taking into account other variables such as gender, age and educational background.

Tackling health inequalities requires a recognition that the NHS as an institution needs to be more responsive to its patients and the communities it serves. At the heart of increasing the diversity of senior management is a recognition that the NHS has failed to provide adequate services to what is - in certain areas- a considerable proportion of the population. An approach to diversity which makes it indispensable to the provision of quality services is therefore required.

Improved performance-Workforce Issues

Organisationally the NHS faces a significant amount of litigation from its BME staff. One of the reasons for this is the presence of discrimination and harassment in the NHS(Alexander, 1999).This is further amplified in the Wanless Report (April 2002)

which identified that the NHS *'faces significant capacity constraints in terms of its workforce'* and that the service is '*not yet sufficiently patient-centred.'* At present 80% of cases to the CRE for racial discrimination are against the NHS. It is estimated that if the NHS can save just 1% of the costs associated with contesting these cases it would make a saving of £8.8 million pounds per year (*personal communication* – The Health Network). Over half of the doctors appearing before the GMC's Professional Conduct Committee qualified overseas and there are significant costs associated with this as well in terms of low morale resulting from a perception of discrimination, senior management time and associated legal costs(Allen, Perkins & Witherspoon, 1996; Allen, 2000; Allen, 2003; Esmail, 2004).

Improved performance- Organisational Issues

As demonstrated previously the link between quality and equality is key to delivering improved patient outcomes. The modernisation agenda within the NHS explicitly recognises the need to change the ways in which services are delivered to patients. One aspect of this is greater patient involvement, which in the business model converts into engagement with and responsiveness to customers or clients. Equality and diversity indicators potentially enable better delivery on the modernisation agenda as a whole and for them to succeed they need to be embedded in the overall management of the NHS.

Demographic imperatives

Despite the requirement for ethnic monitoring of staff within various grades of the NHS, the actual quality of data gathered and the use made of it is uneven across the various institutions of the organisation. While the headline figures are available, there is little detailed information about promotion routes and of mobility within and across organisations of the NHS. Indeed, the lack of availability of data makes it almost impossible to evaluate the impact of leadership programmes such as the Breaking Through initiative. This is not to say that this programme is not succeeding in its aims but these cannot be quantified in terms of the NHS as a whole.

What is clear from the statistical data available is that the spread of BME staff throughout the NHS is uneven, concentrated in certain areas and sparse in others. At the macro level black and minority ethnic staff make up 7.9% of the population and 8.4% of the NHS workforce. As pointed out earlier, they are under-represented within the management hierarchy of the NHS. Only 1% of chief executives and 3% of executive directors are from black and minority ethnic groups (although more recent figures suggest that the proportion of BME staff at Executive Director level has increased to 7%) (Carvel & Shifrin, 2004). This is despite the fact that almost 35% of doctors, GPs and dentists are from black and minority ethnic backgrounds and would form a significant recruitment pool, especially for medical director level posts (2005). Within the hierarchy of medical posts, there is an unevenness in the distribution of BME doctors at senior levels with 66% of staff grade doctors and 61% of doctors in associate specialists grades having qualified outside the European Economic Area (EEA), mostly from South Asia (2005). As an example of the uneven pattern of employment within the NHS, only 2.2% of the ambulance staff were from BME backgrounds, which indicates that there is both under and over representation in the organisation as a whole.

These figures are further complicated by the spatial concentration of BME groups in England. Most BME groups are concentrated in the major conurbations of England. Even within London there are major differences in populations with over 50% of the populations from Newham, Brent and Tower Hamlets identified as being from black and minority ethnic communities compared to between 5-11% in Bexley, Havering, Richmond, Bromley and Sutton. Outside London the distribution also varies widely with the populations of black and ethnic minorities in populations in Leicester,

Slough, and Birmingham ranging from 37-32%. Manchester and Bradford have a BME population of 19 and 21% respectively. In nearly 80% of local authority areas outside of London, BME populations are below the national average of 7.9% and in 75% they represent less than 5% of the population. Within Wales, the highest population of BME groups is in Cardiff where they represent 8% of the population. This compares with the average BME population in Wales of 2%. In Scotland, the highest BME population is in Glasgow where they represent 5% of the population compared to the Scottish average of 2%.

The following table shows the distribution of BME populations in the UK, across selected unitary local authority districts, and highlights the uneven spread.

Table of ethnic breakdown in selected unitary/local authority areas 2000-2001

District	Total	White	BME	BME as percentage of those with known ethnicity
Greater London Districts				
Newham	242,910	81,469	161,441	66.46%
Brent	249,717	100,166	149,551	59.89%
Tower Hamlets	183,562	79,634	103,928	56.62%
Ealing	311,754	174,134	137,620	44.14%
Harrow	211,282	121,043	90,239	42.71%
Hackney	198,583	113,784	84,325	42.56%
Lewisham	240,429	156,503	83,926	34.91%
Slough	106,293	72,459	33,834	31.99%
Bexley	221,314	209,478	11,836	5.35%
Brentwood	69,998	65,358	4,640	6.63%
Conurbations outside London				
Leicester	277,964	174,991	102,973	37.05%
Birmingham	999,867	681,942	317,049	31.83%
Wolverhampton	235,530	62,295	235,530	26.45%
Manchester	450,483	354,611	95,872	21.28%
Bradford	483,279	381,858	101,421	20.99%
Leeds	717,422	656,128	60,960	8.5%
Liverpool	451,476	426,849	24,627	5.45%
Exeter	110,825	107,536	3,289	2.97%
Scotland				**2%**
Glasgow	577,869	546317	31,436	5.44%
Edinburgh	448,624	430,365	18,348	4.09%
Wales				**2%**
Cardiff	279,624			8.4%
Swansea	218,495			2.2%

The distribution of the BME population across the United Kingdom has considerable significance when considering the challenge of tackling equality and diversity issues in the NHS because it clearly identifies the areas that have the greatest challenges. In the Wanless report on financing the NHS, Wanless described the benefits of an 'engaged' community in improving public health and reducing the burden of illness and disease. In areas of the country with high BME populations the links between the NHS and the communities it serves are critical to developing this scenario of an engaged community. Wanless argues, that if the NHS can represent the community it serves, then this allows for the development of a confident community which identifies with the local NHS presence; it encourages the development of networks with the local population; it also provides a large pool of graduates and other workers from which the NHS can recruit and it can help in local fundraising efforts. It is estimated that by 2010 Birmingham and Leicester will have an ethnic mix of population in which the terms minority and majority will have no meaning. In this context NHS organisations will have to recruit from an increasingly diverse population, which in turn will necessitate organisational change, before the problems that have historically dogged the NHS become overwhelming.

Reflecting the local community in terms of staff employed is only one step in addressing the problems of health inequalities. As Ian Law points out (Johns, 2004):

The NHS provides the strongest case to refute the common argument that opening up an institution to black minority ethnic staff leads to organizational change in favour of black minority ethnic clients, users, customers, or in this case patients.

Indeed, the numerical propensity of medical BME staff in the NHS only serves to indicate that location in marginal parts of the service and lack of access to key decision making positions has meant that their presence alone has not been able to change the organisational culture of the NHS. Leadership is crucial in this context, as it is only through the presence of champions of equality in senior positions that change for both staff and patients will occur.

Benefits for the organisation in developing a business case for diversity

Diversity management is a recognition that all individuals have unique skills and backgrounds that need to be recognised, respected and valued. In terms of clients or patients this means recognising that each person comes from a particular background and being sensitive to their needs. In terms of organisations the harnessing of workforce diversity can enable the creation of a more dynamic and flexible organisations.

"The basic concept of managing diversity accepts that the workforce consists of a diverse population of people. The diversity consists of visible and non-visible differences which will include factors such as sex, age, background, race, disability, personality and workstyle. It is founded on the premise that harnessing these differences will create a productive environment in which everybody feels valued, where their talents are being fully utilised and in which organisational goals are met."(Kandola & Fullerton, 1998)

The primary motive for businesses to engage with diversity is because it will give them competitive advantage over other companies which will ultimately improve their profit margins. In the public sector the motivation is for an improvement in the services that the organisation delivers. In health care, it is argued that the disparity in care between ethnic groups can be overcome by adopting a diversity agenda. If an NHS organisation adopts diversity strategies this will make the health service more efficient in dealing with various groups in society, thereby restoring public confidence and making the health service more effective.

The 'business case' is largely based on the premise that working proactively with cultural diversity, not in reaction to it, can yield superior business results - i.e. increased efficiency and productivity. Although managing diversity has come to mean more than the business paradigm, it actually started life in the United States and Japan where multi-national companies needed to respond to market effects, changing demographic profiles and globalisation. In other words, they needed to review whom their services and products were intended for and whom they were reaching.

An extensive research project funded by the European Union attempted to assess the costs and benefits of adopting a diversity approach (Anon, 2003).
The research consisted of a survey of 200 companies in four EU countries, an extensive literature review as well as eight in depth case studies. The study concluded that 'Companies that implement workforce diversity policies identify important benefits that strengthen long-term competitiveness and, in certain instances, also produce short and medium-term improvements in performance.' The main benefits arose from strengthening organisational and human capital. In other words the capacity of the organisation to deal more effectively with its customers

increased. There were costs of implementation and these were associated with directing internal resources to the creation of a diverse workforce as well as issues of changing an organisational culture.

According to Kandola and Fullerton, the benefits of a diversity approach can be divided into three segments: proven, debatable and indirect.

> Proven benefits: - including employment of 'best' candidate; organisational culture which enables employees' potential to be realised; flexible working arrangements; employees are valued, motivated and developed employees reluctant to leave.

> Debatable benefits: - including employees 'give their best'; employees more in tune with customer base; enhanced innovation, creativity and problem solving; better customer service; improved quality.

> Indirect benefits: - including better public image; satisfying work environment; improved staff relations; increased job satisfaction and morale; increased productivity; competitive edge (Kandola & Fullerton, 1998).

In the business world the case for diversity has been demonstrated by organisations such as Lloyds TSB (see Interviews) and those involved in the 'Race for Opportunity' initiative which is a network of 180 private and public sector organisations who work to develop their initiatives on racial equality. The list of organisations who have signed up to be part of Race for Opportunity range from public sector organisations such as Newcastle City Council to companies such as PriceWaterHouseCoopers. There are no NHS institutions in the membership as of yet.

Lloyds TSB is seen as a beacon in developing diversity strategies. It undertook the following actions as an organisation:

- A mentoring scheme for managers and senior managers, particularly those undertaking career development programmes. ·

- High potential ethnic minority managers to be identified by each Business Unit and supported in their career development, i.e. a residential career development programme for managers with the potential to progress to more senior positions. ·

- Career counselling for senior ethnic minority managers. ·

- A managing difference programme for the group's top managers. ·

- Cross cultural awareness training for senior management teams in key locations.

- A cultural awareness component as a core part of customer service training.

- Regular monitoring of workforce race statistics at board level. ·

In London, when the bank decided to diversify its branch workforce, it saw many of its banks going from the worse performing to the best performing in the region over a period of18 months. Their internal monitoring indicators showed dramatic increases in business as well as customer satisfaction. [1]

---

[1] See interview with Lloyds TSB for more details.

Arguments against the business case

One of the reasons why there has been a reluctance to incorporate diversity initiatives into the management performance framework of the NHS could be philosophical. Diversity management is a relatively new tool to combat discrimination and follows a trend that was developed in North America. As explained earlier its primary emphasis is on business benefits and there has been a downplaying of moral reasons for incorporating equal opportunities as one of the key activities of the organisation. Inevitably, and this is borne out by the growth in diversity training which will be described in the next section of the report, there is an overemphasis on issues such as intercultural awareness and training rather than on positive action targets to produce a workforce that reflects the ethnic makeup of the locality. Diversity management is also not specifically aimed at BME groups or at women but embraces the whole workforce and its impact on BME groups may therefore be diluted. This can have a positive impact in that it becomes easier to sell diversity to parts of the workforce and the organisation which may not accept some of the measures being proposed. However the reality is that BME groups as well as women have suffered historically from prejudice and exclusion and have been marginalized since the inception of the NHS. Groups like overseas qualified doctors and nurses have been marginalized for so long that there is a strong and negative social meaning attached to this group of highly qualified staff. This will not necessarily be the same for other groups who may benefit from the implementation of diversity management.

 But perhaps more tellingly, the evidence for a business case for diversity is mixed and the benefits are not necessarily self-evident. One would expect that when arguing for the business case for diversity in the NHS, it will be possible to link ethnic and racial diversity to outcomes such as financial performance, customer satisfaction, productivity, absenteeism, turnover and job satisfaction. However, we were unable to find such information in the literature review that we carried out. Dreachslin (Dreachslin et al., 2004) quotes a study by Hartenian and Gudmundson (Hartenian & Gudmundson, 2000) in which they suggest that there is only weak support for the hypothesis that workforce diversity improves the effectiveness and performance of the organisation. In the same paper Dreachslin also quotes a study by Richard (Richard, 2000) which found that there was no overall support for the hypothesis that racial diversity was positively associated with financial performance. However, Dreaschslin also refers to some case studies which suggest that there are positive links. The overall conclusion however is that the research evidence is in the nascent phase. Wrench (Wrench, 2005) quotes a major review by Williams and O'Reilly (Williams & O'Reilly, 1998) which states that the diversity is good for you mantra has been overstated. Williams and O'Reilly point out that most of the research that claims that diversity is beneficial for groups has been conducted in the classroom or laboratory settings. In such idealised settings, increased diversity may have a positive impact for example through the increase in skill and knowledge that diversity brings. However, Wrench points out that they also argue that under other conditions diversity is just as likely to impede group functioning. Dreachslin (Dreachslin et al., 2004)refers to the work by Williams and O'Reilly quoting the same point that the preponderance of empirical evidence suggests that diversity is most likely to impede group functioning. Wrench (Wrench, 2005) also quotes an extensive review by Wise and Tschirhart which suggested that given the weakness in the body of research on diversity, public administrators cannot be told that diversity has any clear positive or negative effects.

What this means for the NHS is that the business case alone will not be sufficient to drive forward this agenda. Giscombe and Matis (Giscombe & Mattis, 2002) in their survey point out that most women of colour judged their companies' training efforts inadequate in helping managers to effectively manage a diverse workforce. This was

a perception repeated by many of the interviewees who felt that there needs to be a greater acknowledgement of institutionalised racism and the resultant power that this gives white managers in the NHS. The ethical framework provided by equalities legislation needs to work along with diversity management approaches.

Tackling any form of health inequality requires an understanding of the basis of that inequality, the development of policy to tackle it and then the implementation of plans to decrease it. Minority ethnic health inequalities require the same approach. Tackling issues around equalities and diversity provides the potential to deal with health outcomes, but this goes far beyond the simple employment and promotion of minority ethnic staff. A change in organisational culture and general management is required which will benefit all users of the NHS and specifically targeted measures within these general changes to benefit those suffering from the poorest health outcomes.

SECTION II: THE NHS AND CAREER PROGRESSION FOR BLACK AND MINORITY STAFF.

Finding the information - how we approached the task of reviewing the literature

The first stage of the literature search was to identify the major search concepts and terms (keywords) for use when searching the reference databases. Subsequently, a series of search terms and phrases were developed (See Appendix 1 for the full list).

These search terms were systematically applied to 13 different sources which included: Medline, Embase, ISI Web of Knowledge (Social Science Citation Index), ABI Inform (Management information), Psyc Info (Psychological), SIGLE (Grey Literature), Science Direct, Ingenta, EBSCO (Business information), J-STOR, CINAHL (Cumulative Index Nursing & Allied Health Literature), Swetwise and ZETOC (British Library). Appendix B also provides details of the number of "hits" or articles that were identified for each term within the different databases. These figures provide a very basic indication of the "usefulness" and relevance of each database for literature on this area.

The literature search strategy also made use of the citation indexes to search in greater depth for research work by specific researchers and citations of key articles as well as the "bullseye" search technique of identifying key articles and following up the articles referred to in those articles.

All the databases searches where carried out between February – May 2005 and all the references identified were organised within the Reference Manager citation software programme.

How we categorised the articles that we found
Whilst, the literature search identified a significant body of research in the United States on leadership interventions and leadership development programmes, it was also clear that a far smaller body of work had examined the impact of such schemes on issues of ethnicity, race and diversity.

The initial literature search found that almost no research papers examining "leadership interventions" had been published in journals indexed within the two key bio-medical databases, Medline and Embase. Therefore the literature search included databases from a range of other disciplines including sociology, psychology, management and economics.

Overall, the literature search found that there has been very little published research on "leadership interventions" within the health service in the United Kingdom.

The literature search identified 210 papers of which 194 where obtained for the purposes of this project.   These 194 articles were sorted into the 4 broad concepts. Whilst, the grading or categorising the papers was subjective it was a useful process for focussing on the key concepts. In addition, it was also clear that some of the papers could be classified under more than one of the broad concepts.

The concepts used were as follows:

1)   Leadership Interventions (and this category was further sub-divided to include:

            Individual based interventions - papers concentrating on leadership interventions aimed at individual managers or leaders.

            Team-based interventions

2)   Networks / Networking

3)   Mentoring

4)   Diversity in terms of values

5)   Key Documents

6)   Noted.

The Noted category was included for the papers that were read but not assigned to a specific concept. Table 1 provides details of the number of papers within each concept.

Table 1. Number of papers within each concept.	
Total References identified	210
References not obtained	26
Total number of references obtained	194
Leadership Intervention	56
Individual	18
Team-based	9
Networks / Networking	5
Mentoring	35
Diversity – in terms of values	2
Key documents	20
Noted	85

The Bibliography provides citation and abstract details of all the articles (by concept) together with a summary table of the process of how the articles were identified.

Limitations of the information sources and the databases
The strengths and weaknesses of the information sources being utilised should inform any literature search process. Not understanding the weaknesses and omissions of citation databases can lead to partial or ineffective literature searches. As the following example illustrates.

With today's online access to powerful medical reference databases, such as Medline and Embase, it is easy to forget that such databases do not contain all the answers. For instance, in 1999 it was reported that Medline abstracted from some 3,957 journals (serials) and Embase some 3,772 journals. The number of "unique" journals for each database were 2,117 and 1,993 respectively[2]. Thus the two databases between them abstracted from some 4110 journals. Whilst, this is a very large number of journals, it has also been estimated that there are at least 20,000+[3] mainstream bio-medical journals which means that these two databases are abstracting from about 20% of the available bio-medical journals. In other words, any search only has a 1 in 5 chance of finding an article published within the mainstream bio-medical journals.

Similar limitations apply to all reference databases.

Finding the information – interviewing key stakeholders

The purpose of interviewing key stakeholders was twofold. We wanted to identify and interview key stakeholders who were involved either as individuals or as organisations in initiatives to increase the representation of BME staff in the senior levels of their organisation. We also wanted to identify the type of interventions that were being used by organisations to increase the representation of BME staff in leadership positions.

Our selection of interviewees was based on our own knowledge of individuals and suggestions made by the Health Foundation. We also attended two seminars organised by the Economic and Social Science Research Council and the Heath Network which discussed some of the issues that we were investigating.

The interviewees were all asked the same questions and we made notes of our conversation. All interviews were carried out on the telephone. The questions covered four main areas:

1. How the respondent identified the problem of BME promotion in the NHS.

2. A brief overview of programmes that had initiated to tackle this problem.

3. Which programmes (either ones that knew about or had initiated/been involved in) had been a success and which had been failures. For those that have failed, the reasons for failures.

4. How should one monitor the progress of organisations in this area and how would we know if they had been effective.

---

[2] Anon. 1999, 'Biomedical Literature Searching: A Comparison of BIOSIS Previews, EMBASE and Medline, *Biosis Evolutions*, vol.6, no..3.

[3] Women Association of Medical Editors website, "Medical journals, of which there are an estimated 20,000 worldwide, are the principal medium for primary communication of the outcome of this massive public investment." http://www.wame.org/rep-back.htm. [Accessed 26 October 2003].

5. What would be the ideal programme from getting Black and Minority Ethnic Staff into leadership positions (assuming that there were no resource limitations).

We interviewed the following people:

Naaz Coker	Formerly responsible for ethnicity and diversity at the Kings Fund and now Chair, St George's Hospital NHS Trust and independent consultant.
Melba Wilson	Chair, Wandsworth PCT Trust
Elizabeth Anionwu	Director Mary Seacole Centre and Professor of Nursing, Thames Valley University
Marguerite Johnson	Vice President for Programs, Kellogg Foundation, USA
Joan Reede	Dean of Faculty Diversity and Development, Harvard Medical School, USA
Anne Beal	Senior Program Officer, Commonwealth Fund, USA
John Batchelor	Breaking Through Program, NHS Leadership Centre
Shearon Williams	Race Equality Scheme Desk Officer, Ministry of Defence
The role of legal regulation in promoting race equality in the private sector	Seminar organised by the ESRC
Diversity & Leadership – is the NHS on track?	Seminar organised by the Health Network
Lynette Phillips	Organiser North London BME network
Sally Gorham	Director, London PCT
Stephen Pegge	Lloyds TSB

Barriers to Career Progression

Institutional and Individual Issues in assessing barriers to career progression
It is not the purpose of this report to make the case that racism is a problem in the NHS. The Macpherson report of an inquiry into the racist murder of Stephen Lawrence found that the failure of the Metropolitan Police to solve this murder resulted from incompetence and 'institutional racism'. The report defined institutional racism as the collective failure of an organisation to provide appropriate and professional services to people because of their colour, culture or ethnic origin (MacPherson, 1999) The Stephen Lawrence case and the Inquiry Report stimulated extensive debate on the existence of institutional racism and the inadequacies of equal opportunities policies throughout the public sector in Britain, including the National Health Service (McKenzie, 1999). The Department of Health commissioned its own report to examine the nature and extent of issues facing minority ethnic communities in health and social care and to assess the strengths and weaknesses of what it was doing (Alexander, 1999). The issues affecting racism and the medical profession is usefully summarised in a book published by the Kings Fund (2001) and in the body of work published by Esmail (Esmail & Carnall, 1997; Esmail, 2004).

However the recognition that institutional racism is a problem is critical to understanding not only mechanisms by which black and minority ethnic staff are under-represented in leadership positions but also in devising programmes for interventions which take account of race. King provides a useful conceptual analysis of institutional racism and the medical health complex (King, 1996). King argues that the concept of institutional racism helps to clarify and distinguish between the actions of individuals who discriminate and racial stratification resulting from structural impediments and processes. Institutional racism is less of an indictment of individuals working within institutions than it is of the systematic operation of an institution. However, because managers possess a considerable amount of influence, autonomy and decision-making authority, the actions and consequences rather than intent of individual authority figures should not be minimised.

The institutional racism paradigm addresses the issue of effect and practice rather than intent and by doing so emphasises the group as opposed to the individual consequences of racial discrimination. It examines the impact of external factors and incorporates history and ideology as major determinants of racial inequality. This means that issues external to the organisation, such as the perception of black and minority ethnic staff, the problems they face in career progression within the NHS can be shown to exert an influence on the organisation and how its minority ethnic staff are perceived and perceive themselves. There is also a need to recognise the importance of national and historical context on the way in which ethnic minorities came to Britain, their experiences in this country and they way they continue to perceive themselves.

However there is a problem with using institutional racism as a paradigm to understand why minority ethnic staff are not achieving promotion to the highest posts in the NHS. Institutional racism is less overt, far subtler and less identifiable when it comes to cases of specific individuals. It is therefore difficult to quantify and therefore assess its impact on individuals. Because it originates in the operation of established and respected forces in society it receives far less public condemnation than individual racism. Dovidio and Gaertner described the rise of 'aversive racism', characterised by people who 'endorse egalitarian values, who regard themselves as non-prejudiced, but who discriminate in subtle rationalisable ways' {Dovidio & Gaertner 1996 2557 /id}. To some extent it is this kind of racism that operates at the higher levels of the NHS, as all of the current management hierarchy will have been

trained in equal opportunities legislation and will have been forced to acknowledge the issue of diversity. Esmail(Esmail, 2004) describes it as the prejudice of good people. It is these subtle barriers to promotion which are the hardest to tackle.

Barriers to Promotion

It is useful to conceptualise barriers to promotion into two interdependent parts: those related to individuals and those related to the organisation. The most useful summary of problems related to promotion are provided by Kilian and colleagues (Kilian, Hukai & McCarty, 2005). Kilian makes the point that the major barriers to upward mobility are no longer at the recruitment level but at the advancement stages. This is almost certainly the case within the NHS and is clearly described by the snow-capping analogy referred to earlier. This is something which was clearly highlighted by Joan Reede who directs the Minority Leadership Development Program at Harvard Medical School. The Harvard Program describes it self as a career development programme, providing on-going mentoring and the development of formal and informal networks to help advance the career progression of alumni who take part in the program. Several of our interviewees also commented on the fact that there were many examples of BME individuals in management positions but very little representation at director level, confirming the point that it is at advancement stages where the barriers seem to exist. DoH statistics also confirm that in terms of recruitment into management programmes, the NHS appears to be getting things right – managing to draw talent from a range of backgrounds. In 2002, 18% of the intake into the Graduate Management Training Scheme came from black and minority backgrounds. However, only 7% of director level positions are currently held by BME staff. Although this is a huge improvement on the situation from even 2 years ago, it gives an indication of the barriers that the NHS has to overcome if BME staff at senior level are going to be representative of the workforce within the organisation.

The problem of BME representation in senior positions in healthcare is of course not restricted to the NHS. Most of the research quoted in this report is derived from the USA where the literature has consistently demonstrated the under-representation people of colour in healthcare management and gaps in compensation and satisfaction between white managers and managers from minority ethnic groups (Weil, 2003),(Dreachslin et al., 2004). American organisations have therefore also carried out a significant amount of research in terms of interventions to improve representation and this will be drawn on in the recommendations that we make to the Health Foundation. Particularly relevant will be the experience of philanthropic organisations such as the Commonwealth Fund, The Kellogg Foundation and the Robert Wood Johnson Foundation who have been involved in programmes to increase the representation of minorities in healthcare settings for some time.

Research conducted by the NHS of black and minority ethnic staff highlights several issues that are important as part of their working experience. These are:

- Harassment and victimisation at work

- Lack of perceived fairness within the organisation

- Lack of consistency and opportunities

- Lack of representation and influence at senior level leading to lack of involvement and consultation
- Sense of isolation with the result that they feel that they are singled out and unable to challenge inappropriate behaviour and raise concerns.

Of most concern here is the issue of harassment at work. Eighty percent of Black respondents in a US study reported experiencing racial discrimination at some time in their lives (Krieger & Sidney, 1996). Findings in the UK's Fourth National Survey of Ethnic Minorities suggested widespread experiences of racial harassment and discrimination among minority ethnic people in the United Kingdom. This experience has also been documented for minority ethnic staff in the NHS (Lemos & Crane, 2000). Qualitative investigations of experiences of racial harassment and discrimination in the United Kingdom have found that for many people experiences of interpersonal racism are part of everyday life; that the way that they lead their lives is constrained by fear of racial harassment; and that being made to feel different is routine and expected (Virdee, 1995; Chahal & Julienne, 1999). The experience of minority ethnic staff in the NHS is no different and has been documented in several reports commissioned by the Department of Health (Anon, 2002b; Lemos & Crane, 2000).

Conceptually it is useful to consider the barriers faced as those related to the individual and those related to the organisation. Each will be discussed in the next sections.

Individual barriers

Individual barriers can be categorised into five areas:

- lack of mentors and role models

- exclusion from informal networks of communication

- stereotyping and preconceptions of roles and abilities

- lack of significant line experience/challenging assignments

- commitment to personal and family responsibilities

Lack of mentors/personal networks of communication

Our own literature review confirms the importance of mentoring for every professional grouping. Based on a survey of minority executives carried out in the USA in 2002, it seems that mentoring has been particularly important in their career development. The lack of diverse role models and leaders in influential positions invariably leads to a lack of mentoring or sponsorship opportunities(Giscombe & Mattis, 2002). Not having a mentor remains a significant barrier for minority employees(Catalyst, 2002; Ragins & Cotton, 1996). Similarly, membership in informal groups or networks is often based on racial and gender lines and the exclusion of black and ethnic minorities from these networks perpetuates the barriers to advancement. In relation to mentoring, it is important to point out that having multiple mentors is strongly correlated with high promotion rates. This is particularly important in relation to advancement into more senior management positions where multiple mentors are a necessity in developing the varied requirements for careers advancement(de Janasz, Sullivan & Whiting, 2003) . There are some specific issues related to mentoring for BME leaders that can be a problem(Thomas, 2001). As identified below, stereotyping and preconceptions of the competence of BME's is one of the individual barriers identified as a block to career progression.
Mentors therefore need to understand specific issues related to cross-race mentoring, including the impact of race as a potential barrier.

Stereotyping and preconceptions of roles and abilities

Although not well studied in mangers in the UK, there is considerable evidence of the impact of stereotyping and preconceptions on black and minority ethnic doctors working in the NHS (Esmail & Everington, 1993). The stereotyping was also described in the recent William Pickles Lecture given by Esmail at the 2005 Spring Conference of the Royal College of General Practitioners. The stereotyping of the abilities of overseas qualified nurses and doctors is a well researched example of how this barrier operates in the NHS. Research commissioned by the NHS highlights the problems of bullying and harassment and the impact that this has on BME staff in the NHS (Lemos & Crane, 2000). A recent study in the USA, replicating the methodology of the original study by Esmail found that resumes with white sounding first names elicited 50 percent more responses than ones with African-American sounding names (Bertrand & Mullainathan, 2002) quoted in (Kilian et al., 2005). The number of cases brought before employment tribunal alleging discrimination may in itself be an indication of the extent of the problem, because much of the problem of discrimination has its roots in perceptions about the abilities of BME staff.

Lack of career progression and under-representation of black and minority ethnic staff in the NHS is often explained by locating the problem within black and minority ethnic communities and by suggesting that individuals lack key skills and experience. Yet research suggests that Britain's minority ethnic communities are often better educated than their white counterparts but are paid significantly less than their white colleagues. Unemployment is also greater amongst black and minority ethnic graduates (Department of Education and Employment, Press Notice: 4 April 2001).

Within the USA context, it has been suggested that the reasons for outright discrimination is based on the assumption of competence of the BME employee and the employees perception of the 'leader-follower fit' (Walters, Sivanesaratnam & Hamilton, 1995). This means that BME mangers may have their competency questioned by others in the organisation who may assume that they were selected on the basis of special criteria. Although more clearly defined in the USA under programs of 'affirmative action', the increasing number of special programs in the NHS aimed at black and minority ethnic have the potential for creating precisely this situation where white staff may resent the promotion of black and minority ethnic staff. The concept of 'leader-follower fit' suggests that because interpersonal attraction is the basis for perceived competence, subordinates of a different race may translate the difference into a perception of the minority manager as a potential source of conflict, threat or stress. This is borne out by the Lemos and Crane study (Lemos & Crane, 2000) which showed that a common complaint against black and minority ethnic managers is the accusation of bullying and harassment by subordinates and this obviously works as a source of resistance to or outright discrimination against minority managers.

Lack of line experience and challenging assignments

The Catalyst survey in the USA(Catalyst, 2002) suggested that giving minority leaders high-visibility assignments was a critical to their success. This is a double edged sword because minorities are more likely to move in order to find a better job rather than remain within the organisation and fighting for opportunities for promotion. Yet research also suggests(Hurley, Fagenson-Eland & Sonnefeld, 1997) that length of tenure in an organisation is an important determinant of top management career attainment. The monitoring of staff turnover in management positions may therefore be an important indicator of the extent of perceived discrimination, especially by black and minority ethnic managers.

Even where black and minority ethnic managers are given challenging assignments, failure may result in a disproportionate impact on their career progression(Catalyst, 1999),(Thomas, 2001).

Commitment to personal and family responsibilities
The impact of family responsibilities on career progression has been well documented especially for women. The introduction of work life balance initiatives within the NHS is a recognition of this and will undoubtedly make a difference in the long term. However role models of women who have risen to the top having taken career breaks and family leave are still few. Although we have not found evidence specifically related to black and minority ethnic leaders, evidence from the USA suggests that black and minority ethnic women may face a 'double marginalisation' because of their gender and minority status (Giscombe & Mattis, 2002).

Organisational barriers

Organisational barriers are less easy to conceptualise and are not specifically related to problems associated with the progression of black and minority ethnic leaders. One of the problems is that whilst there is a significant body of research on individual barriers there is very little on organisational behaviour particularly in terms of how organisations can ensure that leadership, staff and the health services organisation's culture represent and value the communities they serve. In Dreachslin's review (Dreachslin et al., 2004), she found that there were only 20 works published in referred health services management journals between 1990 and May 2002 related to diversity and organisational change.

Organisational barriers can be divided into those related to culture; a consideration of systems and procedures which may act as barriers; tokenism and finally the type of leadership. There is however an overlap between all these areas and it is useful to consider organisational barriers within the context of organisational culture.

Organisational culture is usually used as a metaphor to describe the beliefs, values ideologies, attitudes and norms of behaviour of an organisation. It includes the routines, traditions, symbols and reward mechanisms of the organisation. These shared ways of thinking and behaving help define what is legitimate and acceptable within the organisation and guides the discretionary behaviours of its members. It is important to acknowledge how widespread the perception of the NHS as a racist organisation, that does not value the potential of its black and minority staff, is. It is well documented amongst the medical and nursing professions (Coker, 2001; Esmail, 2004). In a telling report by the Amicus (Anon, 1997) trade union published in 1997, a survey of black and minority ethnic health visitors gave the perceived racism of the NHS as a reason for not encouraging their children to enter the same profession. Most recently, the Bennet report (Blofeld, 2003) highlighted the widespread institutional racism within the NHS.

The organisations systems and procedures can also act as a barrier to the advancement of black and minority ethnic leaders. Although many practices related to selection and recruitment are covered by legislation, there are still many examples where discriminatory practices can take place. Examples of this include

- the circumvention of established procedures when appointing part-time staff or covering maternity leave,

- racially biased recruitment and selection practices particularly at times of merger or restructuring,

- the undervaluing of relevant experience and overseas qualifications

- 'tokenism' where black and minority ethnic staff are used as a form of organisational 'window-dressing', without giving them access to positions of genuine influence. Example include the use of untrained staff on interview panels in order to present a favourable image of the organisation, the promotion of individuals because of the colour of their skin and their perceived cultural links and the use of isolated, powerless and unrepresentative individuals on committees in order to claim representation of minorities.

- Rewards. The discrimination faced by ethnic minorities and women in the allocation of discretionary points now clinical excellence awards) has been documented by Esmail (Esmail, Abel & Everington, 2003; Esmail, Everington & Doyle, 1998). Although there has been significant reform of the system so that the documented discrimination is now less than it was, differences in the allocation of awards still persist and according to Esmail represent structural problems which will be difficult to reform. A report by the MSF Union (Adkins & Kline, 2000) also highlighted the problems with regrading of black and minority ethnic nursing staff.

Overcoming barriers

There is now a significant body of literature that describes the experience of organisations in overcoming the barriers faced by black and ethnic minorities. Our interviews with key stakeholders also identified current strategies which are being used in the NHS and in other UK organisations. What is clear is that there is a striking similarity on interventions used by organisations which are recognised for successful diversity efforts. The interventions can be classified as those that are designed to support individuals within the system and those that are designed to change organisational culture to be more accepting and embracing of difference. The programs designed to support individuals include networks, mentoring and the identification of individuals with high potential through the use of mechanism such as succession planning . Those related to changing organisational culture include senior management commitment, manager accountability and training and education about gender/race.

Programs to support individuals within the system

Networks
Networks have been used quite widely as a management tool to encourage black and minority ethnic staff to overcome the informal networks and the sponsorship and patronage that may exist amongst work based groups of senior executives and directors. Perhaps the most widely known network is the Lloyds TSB scheme which has encouraged, with senior management support the development of networks for black and minority ethnic managers who are seeking to become senior executives within the organisation. The NHS has followed this model and several networks are funded through organisations such as the NHS Confederation BME Forum (funded by the Health Foundation), the Kings Fund and the NHS executive. The networks provide social support, professional development and access to mentors and role models of the same race/ethnicity or gender. Although aimed primarily at individuals, they also allow members to act in concert, reducing the risk for individuals when they identify deficiencies in the system leading to discrimination or when they make suggestions for changing aspects of the organisational culture.

Mentoring programs
Mentoring has now become such an established part of management development programs that we had little difficulty in identifying literature in this area. The NHS even has its own guidelines on mentoring and its Chief Executive, Nigel Crisp has raised the profile of mentoring by setting a challenge to every senior executive in the NHS to agree to mentor someone form a black or minority ethnic background. Mentoring of course is not only relevant to minority ethnic staff and research provides evidence of the benefits of mentoring which includes higher productivity, better performance ratings, development of leaders, advancement of black and minority ethnic staff and reduced turnover (Alleman & Clarke, 2000),(Kilian et al., 2005). There has been no evaluation of the impact of mentoring in the NHS and several of our stakeholders identified some problems with the mentoring schemes that they had been involved in. These include a lack of commitment by senior leaders, lack of training and unrealistic expectations. It is likely that as formal mentoring develops and becomes established in the NHS, it will lead to the development of levels of commitment which are found in informal mentoring relationships. This will provide an important vehicle of sponsorship and patronage for black and minority ethnic staff.

Identification and development of top talent
If we identify the lack of black and ethnic minorities in senior leadership positions as one of the problems that the NHS needs to address, then we also need to identify the problems in the pipeline – specifically the number of black and minority ethnic managers at director level. Two of our interviewees commented on the lack of black and minority ethnic managers at this level in their organisations and more importantly identified sections of their organisation in which they were almost no black and ethnic minorities at any management level. Good career development programs should include succession planning and identification of future talent. Individual career planning and the lack of such elements is partly due to the ineffective state of leadership development and consistent professional development strategies within the NHS. There have of course been significant developments in the NHS (2003) and the issue is also addressed in the NHS Leadership Qualities framework (2004a) but tellingly in a survey of CEOs in the private sector in the USA found that whilst 77 of multinational companies had formal leadership development programs, only 32 percent actually believed that their objectives were being achieved (Kilian et al., 2005). So simply having a good framework does not mean that the principles espoused in it will be followed or implemented.

Best practice in the development of future talent suggests that a targeted focus on women and black and minority ethnic managers is necessary if the lack of these groups in positions of power and influence is going to be addressed (Kilian et al., 2005). The need for diversity needs to be explicitly recognised in succession planning including the controversial policy of requiring diverse slates and then appointing qualified women and minorities whenever possible. This involves some level of risk, including the potential of a backlash from white males. However, the experience of companies which have adopted such a policy is dramatic. Wells (Wells S. 2001) quoted in the paper by Kilian (Kilian et al., 2005) describes the experience of American Express which increased its representation of women in senior executive positions from 19 per cent in 1990 to 31 percent in 2000 by following such a policy. This compares with an average of 12.5 per cent women in senior positions in the largest companies in the USA.

Programs to change organisational culture

Developing Diverse Leadership
It is only recently (within the last 7 years) that diversity and equal opportunities has become part of the mainstream of NHS management activity. However, as pointed out earlier, implementing the principles of diversity management is only in its embryonic form. Diversity management stresses the need to recognise cultural differences between groups of employees and make practical differences in organisational policies (Wrench, 2005). It differs from approaches that primarily focused on increasing representation of ethnic minorities in the workforce and avoiding transgression of anti-discrimination laws to emphasising business benefits, organisational efficiency and market performance. The key principle of diversity management is the positive notion of encouraging a culturally diverse workplace where differences are valued so that people are able to work to their full potential in a more creative and productive work environment. By its very nature, diversity management is not solely directed to black and ethnic minorities but encompasses the interests of all employees.

Diversity management requires a change in culture of the organisation which goes beyond just an acceptance of the need to increase the representation of black and ethnic minorities in leadership positions. First and foremost, it requires a change of leadership style. The reality is that the dominant leadership model in the NHS is still based on the personality characteristics of the leader – for example the charismatic/visionary leader model (Powell, 2004). Many of these leadership models are derived from the private sector and are not only not suited to public sector organisations but also to the demands of diversity management which relies more on models such as transformational leadership. The NHS Leadership Qualities framework (2004a) goes some way towards recognising the differing needs of the NHS but is not sufficient in terms of developing the specific needs of diversity management. In a review of strategies and attributes for diversity leadership Chen and Van Velsor (Chen & Van Velsor, 1996), contrast traditional leadership theories with suggested models for diversity leadership. They emphasise the need for leadership development programs to place a greater recognition on the impact of social group identities which are embedded within the organisation; the effects of unconscious sociopsychological processes; the political aspects of leadership and the need to take account of follower perspectives. These are not dissimilar to the strategies suggested by Alimo-Metcalfe and Lawler (Alimo-Metcalfe & Lawler, 2001).

Senior Management commitment
The sustained, co-ordinated commitment of senior leadership is a critical element of a successful effort to increase diversity in senior positions in the NHS. The high profile given to this area by Sir Nigel Crisp and Minster's needs to be applauded but

the same commitment to diversity management at SHA level or in high profile trusts is difficult to elicit. Kilian (Kilian et al., 2005) quotes evidence which shows that at the majority of companies with successful track records in developing diverse talent, the CEO is directly involved, either formally or informally in promoting events, holding diversity reviews with senior executives and linking the overall strategy to the overall business strategy. Giscombe (Giscombe & Mattis, 2002), also points out that effective committed CEOs also express a desire to achieve social justice, even though these arguments are often tagged on to the end of a financial business case. She points out that a survey of the literature showed that most corporate communications about diversity are almost entirely devoid of references to social responsibility, moral obligations or distributive justice.

Manager accountability
The Leadership Qualities Framework (2004a) recognises the importance of the developmental role of managers and this is particularly important for black and ethnic minorities who do not have access to mentors and networks. Managers in such roles need to act as both mentor and sponsor, focusing not only on current performance but also on career planning and providing opportunities for their sub-ordinates to become involved in challenging assignments.

However none of this will be meaningful unless managers are held directly responsible for developing black and minority ethnic talent with clearly defined diversity objectives. Measurement tools for achieving this include 360 degree feedback, employee attitude surveys and monitoring. Giscombe and Matis (Giscombe & Mattis, 2002) point out that three-quarters of the companies that they surveyed linked diversity to the use of bonuses and incentives. They quote the experience of Motorola which makes it a requirement for three people to be considered for senior positions which must include a woman or minority ethnic candidate. Two of our interviewees emphasised the importance of Trust Boards receiving regular feedback on ethnic monitoring at all levels in the organisation and in particular in appointments at director level which within the NHS is the stepping stone to senior executive appointments.

Monitoring
In July 2003, the Commission for Racial Equality published the results of research that it had commissioned that examined the progress that public bodies in England and Wales had made in meeting their monitoring obligations under the RR(A)A 2002. (Race Relations (Amendment) Act 2000).

The CRE stated that its research had established that:

> "While one third of Britain's public bodies are leading the way with focused action, just under a third have given weak 'off-the peg' responses to the new duties. A significant number had not done anything to comply with the law [4]

The legal imperatives mean that any continued failure by public bodies to effectively monitor the impact of their recruitment, training and promotion practices would be a failure to meet their obligations under the RR(A)A 2002. Furthermore, as discussed in the business case for diversity, it would also mean that public organisations are not making the best use of their current and potential workforce.

---

[4] CRE Press Release, 3/7/2003. 'CRE Chair Challenges Public Sector to Deliver on Race.'

It would be an unusual company that did not monitor its turnover and profit & loss balance. Any businesses that did not measure and monitor such capital figures would probably go out of business very quickly. If we consider an organisations workforce in terms of human capital then it is equally important to monitor staff turnover and the reasons why staff remain with the organisation, improve their skills through training, obtain promotion or leave the organisation.

It is therefore a truism that if an organisation does not effectively measure and monitor how its recruitment, training and promotion practices are operating then it cannot ensure that it is meeting its obligations under the Race Relations (Amendment) Act 2000 or that it is making the best use of its human capital.

The history of the NHS in terms of ethnic monitoring is mixed. Data on the hospital workforce is now well developed but there is still no data collected on the ethnicity of general practitioners. It is still not possible to obtain information on key employment variables such suspensions and discipline, length of time in post before promotion or on rewards by ethnicity. The same is true of data collected on the nursing workforce. The problem is that data collection was developed to fulfil management requirements at a financial level rather than as a mechanism for workforce development. Data on patients is still poorly collected so that attempts to assess services by their impact on different ethnic groups is still not possible, despite several guidelines which have been developed to encourage trusts to collect information on the ethnicity of patients they treat as inpatient, outpatients and in primary care.

What needs to be monitored ?
Organisations do not need to re-invent the wheel when considering what monitoring systems to introduce or update to ensure that they are measuring the necessary data to meet their obligations.

In June 2004, the NHS Strategic Health Authority and the Commission for Racial Equality published the 'Race equality Guide 2004 – A performance framework' document. The Race Equality – Demonstrating Progress section
provides a series of tabulated "measures of evidence of progress" for a range of outcome areas including:

- Leadership and Corporate commitment
- Strategy and Services
- Patient and Public Involvement & Consultation
- Health outcomes
- Partnerships
- Finance and Procurement
- ICT Information and communication technology

With regards to workforce monitoring the report recommends that the organisation has
- Made arrangements to meet the employment duty of the RR(A)A;

- Set targets to improve accuracy and completeness of ethnicity monitoring of;
  - Staff in post
  - Applicants for employment, training and promotion
  - Staff receiving training; benefiting or experiencing detriment as a result of performance assessment procedures; involved in grievance or the subject of disciplinary procedures, and who cease employment

- Made arrangements to

- Review findings of monitoring and take necessary action
- Publish an annual monitoring report.

- Arranged for all staff to be trained on their rights and responsibilities under the RR(A)A)

In February 2005, the CRE also published an "Assessment Template. For Race Equality Schemes and the Employment Duty"[5] which provides details of an organisations statutory obligations for monitoring and what monitoring schemes and IT systems the organisation has established to meet these obligations. The document states that:

(i) It shall be the duty of such a person to monitor, by reference to the racial groups to which they belong, the numbers of:

- Staff in post.
- Applicants for employment, training and promotion from each such group, and where that person has 150 or more full-time staff, the numbers of staff from each such group who:
- Receive training.
- Benefit or suffer detriment as a result of its performance assessment procedures.
- Are involved in grievance procedures.
- Are the subject of disciplinary procedures.
- Cease employment with that person.

The Assessment Template lists the following "Minimum standards for compliance" for that any assessment of the organisations ICT and other monitoring systems should take intro account:

- The monitoring system(s), for example IT, that they use to monitor their service delivery and employment practices by ethnicity.

- The different function and / or policy areas that the authority has ethnic monitoring systems in place.

- Where no system exists to ethnically monitor relevant functions / policies, adequate arrangements to address these gaps are still set out, with realistic deadlines for remedying these gaps.

- The internal structures and teams that the authority has for the periodic collation and analysis of both their service delivery and employment data.

- What success measures / monitoring criteria the authority have in place for measuring their race equality performance.

- The different monitoring methods – consultation, statistical quantitative analysis, qualitative analysis and so on – that the authority uses to gather and analyse data.

- Details of what it will do when its monitoring data presents adverse impact.

---

[5] http://www.cre.gov.uk/res_3yr_review_assess_templ.doc

They key to developing monitoring systems is therefore to ensure that current systems are modified so that the requirements developed by the CRE are implemented. The benefits will not only accrue to BME staff but will significantly improve the human resources function within the NHS by providing human resources departments with access to valuable information on all their staff, allowing managers to look at issues such as training and development, succession planning and management accountability.

Training and education
One of the core barriers to the lack of representation of black and ethnic minorities in senior leadership positions is stereotyping and preconceptions of the abilities of this group of people. These stereotypes have been well documented in doctors where there is a failure amongst the medical profession to acknowledge that there is discrimination in the workplace (Esmail & Carnall, 1997). The standard response for most companies is to organise diversity training but as Naaz Coker points much of current training concentrates on increasing employees' awareness and challenging any negative preconceptions they have of minority groups. However, in her experience, there was a lack of practical solutions for management interventions with the result that many managers were well meaning but did not have a clue on how to effect the changes required for diversity management. The NHS needs to move beyond standard diversity training which is so ubiquitous that it is beginning to loose its effectiveness. Unless the training for extends beyond the phase of enhancing intellectual awareness of diversity it simply becomes an organisationally imposed process that lacks individual ownership and commitment.

There is also a need to identify the specific training needs of black and minority ethnic staff so that at least they obtain the relevant credential to progress up the ladder. The NHS has a well developed graduate training scheme and it seems that the intake into this scheme reflects the diversity of its workforce. However there is a whole group of black and minority ethnic managers who have entered the NHS through other routes and it is this group that may need further training and development. In response to this the NHS has developed the Breakthrough Leadership programme targeted specifically at black and minority ethnic staff. The contribution of such schemes to leadership development cannot be underestimated but there is also a danger that such training may further isolate black and ethnic minorities because it is seen as something special for staff 'who could not quite make it on their own'. Paradoxically it can increase the negative stereotyping that already exists about the capabilities of this group of staff. Contrast this will the universal acknowledgement of high profile leadership training schemes such as the Kings Fund Leadership Programme.

 The barriers to career progression for black and minority ethnic staff in the NHS are well documented and are similar to those which have been well described in the literature for other private and public sector organisations. What is also clear is that there are a range of strategies within the NHS which have been developed to address many of these barriers. The following table summarises these approaches:

Barriers to career progression	NHS responses
Sponsorship and Patronage	Encouraging mentoring Clear guidelines on the benefits of mentoring and how to do it High profile commitment to this strategy
Informal networks	Black and minority ethnic networks (e.g. funded by the Health Foundation)
Stereotypes and preconceptions of roles and abilities	Leadership development programmes targeted at black and ethnic minorities (Kings Fund and NHS Breakthrough programme)
Traditional views of leadership development	Leadership Qualities Framework and greater emphasise on transformational styles of leadership development, though developments are still in their infancy. Not a clear commitment to the principles of diversity management.
Systems and procedures	Policies and legal obligations
Organisational culture	Variable

This table shows that whilst there is a clear recognition of the problems and a commitment to developing some of the solutions, the greatest challenge remains in leveraging diversity into the mainstream activity of the NHS. Culture change and leadership development are the two areas where there is scope for improving the ability of the NHS to mainstream this activity. The initial groundwork has already been developed – the legal framework through the requirement of the Race Relations Amendment act is in place. The problem has been recognised at the highest levels within the organisation, at least with the Department of Health, but it has been difficult to get a sense of commitment from other areas of the NHS. The language of diversity needs to permeate all areas of the NHS and its senior executives need to articulate the message that diversity is critical to its success. What is clearly lacking within the management performance framework is the need to hold senior executives directly responsible for the diversity initiatives within their organisations. Clear objectives and expected results which are rewarded appropriately can drive success in this area.

The North American Experience

Medical schools and the medical profession, like most other institutions in America were until the early 1970's highly segregated and overwhelmingly white institutions. Although Black Americans were able to qualify as doctors, the majority did so in black medical schools. From the time of the first world war, till 1964, between 2 and 3 percent of students entering American medical schools were black, and the great majority of them attended the black universities of Howard or Meharry. As recently as 1968, fewer black students entered the total first-year classes of all the predominantly white medical schools than of Howard and Meharry, despite the far greater resources in faculty, facilities and public funding enjoyed by the mainstream schools(Shea & Fullilove, 1985). The pattern of racial discrimination that characterized medical education was also widespread in other areas of American medicine. The American Medical Association only prohibited racial discrimination by its member organizations in 1964 (until that time many of its affiliated organizations, particularly in the South, barred black physicians). The hospital system was also segregated and it was not until 1955 that the Veterans Administration ordered full desegregation of its facilities.

Following the Civil Rights Movement of the 1960's and the passage of the Civil Rights Act in 1964, outlawing discrimination in employment and other fields, many areas of American society, including the medical establishment, which had previously been closed to black Americans began to open their doors. Hospitals that received reimbursement from Medicare and Medicaid were required to integrate patient care both in the hospital as a whole and in individual room assignments. The impact of this legislation was almost immediate. Whereas, in 1966 whites were hospitalized 27 per cent more frequently than blacks, by 1968, this had fallen to 18 per cent and by 1974 to 4 per cent (Shea & Fullilove, 1985).

America's universities, its business leaders and the federal government instituted a system of explicit racial preferences which rapidly opened up whole sections of American society and its professions to black Americans. This, combined with the concurrent expansion in higher education, resulted in a large increase in the number of black students enrolled in medical schools (Shea & Fullilove, 1985). Between 1968 and 1974, the number of black students enrolled in the first year classes, increased from 266 (2.7 per cent of the total) to 1,106 (7.5 per cent). In the same period, the percentage of all black students enrolled in the two historically black medical schools declined from 76 per cent to 18 per cent. The federal government and private foundations played a major role in assisting medical schools in their efforts to support, recruit and retain minority students. The funding from the federal government and private foundations enabled the newly formed Offices of Minority Affairs to work with undergraduate colleges to ensure that students knew about opportunities in medical schools. Schools also helped minority students financially and set up programs that tied their minority students into a system of social and academic support to enable them to graduate.

Although the goal of 12 per cent of minority enrolment set by the Association of American Medical Colleges (AAMC) in 1970 has never been achieved, there can be no doubt that the policy of affirmative action had a major impact in increasing the number of black Americans who qualified as doctors in that period. It is also unlikely that any other policy would have had such a dramatic and rapid effect in increasing minority representation in the medical profession. However, the policy of affirmative action was also helped by the expansion in medical school intake (together with increased funding for all higher education institutions) that coincided with this period. Increased opportunities were being made available to all Americans in higher education through this expansion, and black Americans benefited without the public perception that whites were being denied places at the expense of other minorities.

Several legislative challenges have reduced the ability of institutions to use affirmative action policies but philanthropic foundations have continued to highlight the lack of minorities in leadership positions and have developed a huge array of programs targeted at improving the representation of minorities in under-represented areas of the medical profession and also in leadership positions. The programs have tended to follow a set pattern in so far as the private foundation links up with an academic institution and then targets specific groups by encouraging them to apply for these positions. Programs may target clinicians with a view to providing them with skills and expertise in administration, policy making or research. The aim is to use their funding and contacts to leverage individuals into networks and mentoring relationships with senior academics and policy makers so that they develop the skills, contacts and experience necessary to apply for leadership positions. The Robert Woods Johnson Clinical Scholars program has been running for over 30 years. This program is designed to augment clinical training by providing new skills and perspectives necessary to achieving leadership positions both within and outside the walls of academia.

The program stresses training in the quantitative and qualitative sciences underlying health services research essential to improving health and medical care systems. Although not specifically aimed at minorities, many under-represented minorities have gone through the program and are now in significant leadership positions in healthcare. This particular program illustrates several important aspects of such schemes – it represents a long term commitment by the foundation and many clinicians and scientists plan their career trajectories on the basis of applying for such programs – they have become part of the established career paths for many aspiring leaders. The program also recognises that it may take 10-15 years before their fellows reach leadership positions. There is now an extensive alumni network of Clinical Scholars who are in a position to help and encourage the current generation of fellows.

Several foundations have developed similar schemes – targeting different areas of health care. The Kellogg Foundation currently has a program in collaboration with the University of North Carolina which targets minorities in mid-level positions in public health. It has also had a number of long standing fellowship programs similar in scope to the Robert Woods Johnson Clinical Scholars program. Interestingly however they are re-appraising their commitment to such programs because unlike the RWJ clinical scholars program, very few continue to be sustained once the foundation withdraws it funding. Their program officer responsible for these programs (Marguerite Johnson) believes that greater emphasis should be placed on early interventions, identifying potential candidates for their programs in medical school and offering them mentoring and access to networks at an early stage in their careers. The Kellogg Foundation supported the Sullivan Commission(Anon, 2004) (Chaired by Louis Sullivan, a former RWJ Clinical Scholar and Secretary for Health and Human Services) on increasing representation of under-represented minorities in the healthcare professions. The Commissions conclusions regarding the causes, benefits for a diverse workforce and recommendations for change represent the most recent thinking on improving the representation of minorities in the medical workforce and could equally apply to the challenges that we have identified in this report. Marguerite Johnson also suggested that an additional mechanism which has rarely been used in the USA in respect of increasing the representation of minorities in the medical workforce and in clinical leadership positions (apart from the use of affirmative action) was the use of the regulatory framework – requiring federally funded institutions including educational establishments to set up programs similar to those funded by the private foundations which targeted under-represented minorities.

Perhaps the most interesting program aimed at targeting under-represented minorities is the Commonwealth Fund Minority Leadership Development Program which is run in collaboration with Harvard University. Set up in 1997, it has now been running for eight years, and has just recruited its 10th cohort of fellows. Nearly 90 graduates have gone through the program. It is interesting for several reasons. Although it is a traditional program, similar to that set up by other private foundations, what is unusual is that it explicitly set out to place its graduates into leadership positions at state or federal level. Aimed at clinicians, it offers a program which requires its fellows to complete the MPH at Harvard University and also offers a tailored program of additional training which provides additional skills and networking opportunities for its fellows. Many fellows are identified at an early stage in their career – some even whilst they are medical students - and encouraged to apply for the program once they graduated and obtained the relevant experience. Once they have completed the fellowship program, many fellows with the help of the program then obtain attachments working with either federal or state based health organisations, further enhancing their skills and networks. The commitment of the program to its fellows long after they have completed the formal part of the training represents one of the strengths of the program.

Joan Reede, Associate Dean at Harvard University and the Director of the program describes it as a career development program with a strong alumni network – fellows continue to meet and support each other acting as role models and most importantly as mentors and part of an informal network- so that they begin to help each other enhancing their career prospects. The Commonwealth Fund in its own assessment believes that the success of the program in placing its fellows in leadership positions in healthcare has exceeded their expectations – there are now three fellows working as health advisors in the Senate and many more hold senior positions at state level. Interestingly, the fellows now act as important 'door openers' for the Fund as its continues its work of helping to influence policy on healthcare. Because of its success the Fund is committed to long term funding of the program so that it becomes, like the RWJ Clinical Scholars program, part of the road map for aspiring minority leaders of the future. However, Anne Beal, co-ordinator of the program at the Commonwealth Fund admits that without the support of the Fund, the program would not be sustainable and echoes the sentiments of Marguerite Johnson at the Kellogg Foundation in expressing disappointment that Harvard University, although an obvious beneficiary of the program has not contributed more resources.

The success of the Commonwealth Fund program may have some important lessons for the Health Foundation. Firstly it is important to recognise that any program takes a long term view in relation to the expected outcomes and therefore in order to achieve those outcomes, commitment to a specific program needs to be long term. Secondly the value of developing alumni networks should not be under estimated. In the earlier part of this report, we identified lack of access to informal networks and mentoring as an important barrier to career progress. The alumni network that has been set up by the Commonwealth Fund program represents and important network that is now benefiting its current and past participants. From the Health Foundations' point of view consideration should be given to linking in more directly to this program and explicitly selecting ethnic minorities from the UK to join the program. Currently there are no specific programs aimed at minorities except the Breaking Through initiative by the Leadership Centre and it would be worth identifying BEM staff from this initiative who would benefit by being part of an established program. Because the focus of the Commonwealth Fund Program is about developing minority leaders so that they can achieve leadership positions with a view to improving the health of minorities, the added value for minorities from the UK would be clearly defined. They would immediately tap into an established network and would be exposed to new ideas in relation to the delivery of services to minorities where the USA is clearly in the lead in policy terms. The benefit to the USA participants will be about being exposed to social models of healthcare delivery where the UK has the greatest experience and expertise.

Section III: Recommendations for change

Defining the long term vision

It is clear that there are many initiatives within the NHS which address the problems identified in the barriers to career progression for black and minority ethnic staff. The issue for the Health Foundation is to determine what interventions are required in order to leverage the greatest change. Networks and mentoring schemes are well established in the NHS. Although there are concerns about the impact of leadership development targeted at minority ethnic groups such as Breaking Through, within the context the development of diversity strategies in the NHS, they probably still have a role to play. These in effect are short term objectives which are primarily targeted at developing the potential for individuals. However, what is currently lacking is a greater coherence about the long terms objectives which are more about the fundamental organisational changes that need to take place within the NHS.

In the short term therefore the Health Foundation should continue supporting its current initiatives such as support for the networks but should plan to develop longer term strategic objectives. Consideration should be given to targeting further leadership development for talented individuals who may be identified through the Breaking Through Initiative and linking these individuals with the Minority Leadership Development Program of the Commonwealth Fund. The existing Health Foundation/Harkness Fellowship Scheme could be the mechanism for doing this.

Long term objectives

- **Establish a definitive picture of the current status of black and minority ethnic managers and develop a programme of long term monitoring**

One of the problems that we faced was in establishing a clear baseline of where black and minority ethnic managers were within the NHS, their career history and how they were progressing within the organisation. As a result there is a paucity of information on what interventions are successful and more importantly there is no information of which Trusts have managed to develop policies and programmes that can be used as examples for others to follow. Currently the most elementary ethnic monitoring takes place – centrered mainly around recruitment and selection. A survey that Esmail carried out in 1997 (Esmail & Everington, 1997) showed that even though it was a requirement under race relations regulations, only 10% of Trusts were actively monitoring recruitment and selection. The position will certainly have improved but Esmail's survey showed that legislation itself was not a sufficient incentive to make trusts carry out the most basic levels of monitoring. The passage of the race relations amendment act 2000 changes the landscape significantly and the possibility exists that public organisations that do not fulfil their requirements will be prosecuted. We are aware of an initiative by the Commission for Racial Equality which is going to attempt to review how effective public sector organisations are in fulfilling their obligation under the current race relations regulations.

The lack of baseline data in the UK can be contrasted with an ongoing survey that is carried out by the American College of Healthcare Executives (Anon, 2002a). The most recent survey in 2002 was the third such study (earlier studies were carried out in 1992 and 1997) which measured the career attainments of race/ethnic minorities. The survey results in 2002 showed that there continued to be significant disparities in remuneration between whites and minorities, that gender gaps in income persisted, that with the exception of women, minorities have made little headway in holding senior-level management positions since 1997, that minorities are less satisfied than whites with pay, level of respect, and on the job treatment. Minorities also showed

lower levels of attachments to their jobs than whites and felt that discrimination remained a major problem within their organisations. The longitudinal nature of the study meant that progress in some areas could be charted but it was also able to highlight areas of continuing problems.

The lack of such data in the NHS is striking and represents an area where the Health Foundation can, in partnership with the organisations such as Positively Diverse, the NHS Confederation and the NHS Alliance, commit to a 5 yearly survey which can provide a significant resource for evaluating interventions and charting the progress of black and minority ethnic staff in the NHS.

Linked to a 5 yearly survey is the need to encourage Trusts to establish their own monitoring schemes. A recommendation by the CRE as part of an organisations duty to comply with the race relations amendments is to develop staff individualised records (SIRS).The value of these were clearly demonstrated in the report of the Commission for Black staff in Further Education (2002). Consideration should be given to resourcing several trusts to carry out such an exercise.

- **Identify talent**

A common refrain which is frequently used to explain why there are so few BME applicants for establish leadership development programs is there just aren't enough people with the right skills and credentials to apply for such schemes. The experience in the USA where there is no shortage of talented individuals is quite contrary to this. Most private foundations in the USA working in this area have established networks and contacts to direct talented individuals into applying for high profile programs – some even starting in medical school. Part of the problem is that BME people don't have the formal and informal networks that make them aware of such schemes so it is hardly surprising that they do not automatically become aware of development opportunities. More emphasis therefore needs to be placed on developing a network whose primary purpose is to identify talented BME staff in the NHS who can be encouraged to apply for existing leadership development opportunities. Examples already exist in the UK of good practice in this area.

The Health Foundation should formally develop a network, similar to that which exists for the National Endowment for Science Technology and the Arts (NESTA) in the UK.

The NESTA scheme consists of a UK-wide network of nominators. Nominators are experts in their field who are likely to come across fresh and developing talent. If developed by the Health Foundation, it would enable the Foundation to build in refereed recommendations from the outset and to seek a range and spread of awards across disciplines and communities. The pool of nominators should be continually refreshed and there should be a limit on the number of nominations that each nominator can make. The nominators should remain anonymous (primarily to prevent unwelcome lobbying).

To complement the nationwide network of nominators, consideration should also be given to experimenting with new ways of finding outstanding talent - ways that will increase accessibility to the Foundations' programmes without resulting in a growing bureaucracy. Options that NESTA has considered include

• Talent scouts whose task is to draw NESTA's attention to any outstanding individuals in who may be operating nearer to the grass roots.

• Organisations as nominators. A small number of organisations are offered a time-limited period in which to make one nomination. Organisations are chosen by NESTA which are largely serving 'niche' communities and unusual fields of endeavour.

The Health Foundation should consider the use of such methods to identify potential talent amongst BME staff mainly in middle management positions who would benefit from further development. Such staff should be then supported to apply for fast stream management development programs such as the Health Foundation's own management development program as well as other well-regarded NHS programmes.

- **Leadership and training**

The Health Foundation needs to ensure that its own management development program incorporates management training for diversity as an integral part of its curriculum. Such training should encourage the development of transformational leaders because evidence suggests that this style of leadership is better equipped to meet the challenges of diversity. This is a critical development, as an understanding of diversity issues is needed by *all* leaders within the NHS, not just those from BME backgrounds. The changes that must take place within the dominant group are a recognition that performance management, succession planning, the need to develop mechanisms for monitoring change and holding managers accountable for results are essential. These are the areas that need the greatest development and should be integral to the development of diversity management.

Because this area is relatively underdeveloped in the UK, consideration needs to be given to training the trainers. The experience of management trainers in dealing with and developing concepts such as diversity management which includes developing transformational leaders is not known. The trainers themselves need to be aware of the business case for diversity and the importance of social justice and moral justifications for diversity management and the role it can play in reducing health inequalities. An audit of current Health Foundation leadership fellows and their views and understanding of concepts such as diversity management will give an the Foundation an indication of how effective its current programme is in delivering this agenda. Consideration should therefore be given to including this in the evaluation of the current scheme.

- **Develop beacon sites where diversity management is central to the organisational culture**

The distribution of the BME population across the United Kingdom has considerable significance when considering the challenge of tackling equality and diversity issues in the NHS because it clearly identifies the areas which have the greatest challenges. In the Wanless report on financing the NHS, Wanless described the benefits of an 'engaged' community in improving public health and reducing the burden of illness and disease. In areas of the country with high populations of BME the links between the NHS and the communities it serves are critical to developing this scenario of an engaged community. If the NHS can represent the community that it serves, it allows the development of a confident community which identifies with the local NHS presence, it encourages the development of networks with the local population, it also provides a large pool of graduates and other workers from which the NHS can recruit and it can help in local fundraising efforts. The Health Foundation should therefore consider using a model which it has already pioneered in the Shared Leadership for Change Programme to develop a site where the principles of diversity management are integrated into the organisation. The site which would be chosen through open competition but restricted to Trusts with a significant ethnic minority population. The selected trusts would pioneer the use of tools such as Staff Individualised Records, succession planning, identifying talent from BME staff, use innovative training methods for its senior managers and experiment with strategies to

involve its local community. The evaluation of staff and patient outcomes would be an essential component of the programme. The purpose would be to develop an exemplar site where good practice would be developed, evaluated and then disseminated.

REFERENCES

1. Equal values: equal outcomes. A partnership action plan for the medical and dental workforce. 1-43. 2005. NHS Employers. London.

2. Challenging racism: further education leading the way. The full report of the Commission for Black Staff in Further Education. 1-113. 2002.

3. NHS Leaders A Career Development and Succession Planning Scheme. 1-28. 2003. NHS Executive.

4. The Strategic Health Authority : Race Equality Guide 2004 - A performance framework. 1-40. 2004b. London, Commission for Racial Equality.

5. NHS Leadership Qualities Framework. 1-40. 2004a. London, NHS Executive.

6. (2001). *Racism in Medicine. An Agenda for change.* London: Kings Fund.

7. Adamson,J., Ben-Shlomo,Y., Chaturvedi,N., & Donovan,J. (2003). Ethnicity, socio-economic position and gender—do they affect reported health—care seeking behaviour? *Social Science & Medicine 57*(5), 895-904.

8. Adkins,C., & Kline,R. What's the Point? Discretionary points of Discriminatory points. July. 2000. London, MSF, CPHVA.

9. Alexander,Z. The Department of Health: A study of Black, Asian and ethnic minority issues. 1-108. 1999. London, Department of Health.

10. Alimo-Metcalfe,B., & Lawler,J. (2001). Leadership development in UK companies at the beginning of the twenty-first century: Lessons for the NHS? *Journal of Management in Medicine 15*(5), 387-404.

11. Alleman,E., & Clarke,D. (2000). Accountability: Measuring Mentoring and Its Bottom Line Impact. *Review of Business 21*(1/2), 62-67.

12. Allen,I. A Report of the Race, Equality and Diversity Committee on the preliminary analysis of the nature and outcome of complaints received by the GMC. 6a. 2003. London, General Medical Council.

13. Allen,I. The Handling of Complaints by the GMC. A study of decision-making and outcomes. 2000. London, Policy Studies Institute.

14. Allen,I., Perkins,E., & Witherspoon,S. *The Handling of complaints against doctors.* Report by the Policy Studies institute for the Racial Equality Group of the General Medical Council. ISBN 0 85374 691 5 1996 80. 1996. London, Policy Studies Institute.
    Ref Type: Report

15. Anon. The Tables are Bare: a Briefing on the Continuing Inability of the NHS to Meet its Own Equal Opportunities Goals in respect of Ethnic Minority Staff. 1997. London, Manufacturing Science and Finance (MSF).

16. Anon. Racial Equality and NHS Trusts. A Survey by the Commission for Racial Equality. 1-41. 2000. London, Commission for Racial Equality.

17. Anon. A Race/Ethnic Comparison of Career Attainments in Healthcare Management. 1-162. 2002a. Foundation of the American College of Healthcare Executives.

18. Anon. Race Equality in Medicine : A draft report for the Chief Medical Officer. Sir Liam Donaldson. 2002b. London, Department of Health.

19. Anon. The Costs and Benefits of Diversity. A Study on Methods and Indicators to Measure the Cost-Effectiveness of Diversity Policies in Enterprises. Executive Summary. 1-20. 2003. European Commission Directorate-General for Employment, Industrial Relations and Social Affaris, D/3.

20. Anon. Missing Persons: Minorities in the Health Professions : A Report of the Sullivan Commission on Diversity in the Healthcare Workforce. 1-208. 20-9-2004. Sullivan Commission on Diversity in the Healthcare Workforce.

21. Bertrand,M., & Mullainathan,S. "Are Emily and Brendan more employable than Lakisha and Jamal? A field experiment on labor market discrimination" - Working paper. 5-11-2002. University of Chicago Graduate School of Business and Massachusetts Institute of Technology.

22. Blofeld,J. Independent Inquiry into the death of David Bennett. 1-75. 2003. Cambridge, Norfolk, Suffolk and Cambridgeshire Strategic Health Authority.

23. Carvel,J. NHS is race biased says Phillips. Guardian , 10. 30-4-2003.

24. Carvel,J., & Shifrin,T. Society: Wasted talent: Less than 1% of chief executives within the NHS are drawn from black or minority ethnic groups, depriving promotion to such individuals and the organisation of their experience. So how can the service tackle 'snowcapping'? Guardian , 2. 23-6-2004.

25. Catalyst. Women of Color in Corporate Management: Three Years Later. 2002. New York, NY, Catalyst.

26. Catalyst. Women of Color in Corporate Management: Opportunities and Barriers. 1-88. 1999. New York, NY, Catalyst.

27. Chahal,K., & Julienne,L. "We can't all be white!": Racist victimisation in the UK. 1999. Joseph Rowntree Foundation.

28. Chen,C., & Van Velsor,E. (1996). New directions for research and practice in diversity leadership. *Leadership Quarterly 7*(2), 285-302.

29. Commission for Racial Equality. Appointing NHS consultants and senior registrars: report of a formal investigation. 1996. London, Commission for Racial Equality.

30. de Janasz,S., Sullivan,S., & Whiting,V. (2003). Mentor networks and career success: Lessons for turbulent times. *The Academy of Management Executive 17*(4), 78-91.

31. Dovidio,J., & Gaertner,S. (2000). Aversive racism and selection decisions: 1989 and 1999. *Psychological Science. 11*(4), 315-319.

32. Dreachslin,J., Weech-Maldonado,R., & Dansky,K. (2004). Racial and ethnic diversity and organizational behavior: a focused research agenda for health services management. *Social Science & Medicine 59*(5), 961-971.

33. Esmail,A. (2004). The prejudices of good people : Leadership is needed to combat continued institutional racism [Editorial]. *British Medical Journal 328*(19 June), 1448-1449.

34. Esmail,A., Abel,P., & Everington,S. (2003). Discrimination in the discretionary points award scheme: comparison of white with non-white consultants and men with women. *British Medical Journal 326*(29 March), 687-688.

35. Esmail,A., & Carnall,D. (1997). Tackling racism in the NHS. *We need action not words . British Medical Journal 314*(1 March), 618.

36. Esmail,A., & Everington,S. (1997). Asian doctors are still being discriminated against [Letter]. *British Medical Journal 314*(31 May), 1619.

37. Esmail,A., & Everington,S. (1993). Racial discrimination against doctors from ethnic minorities. *British Medical Journal 306*(13 March), 691-692.

38. Esmail,A., Everington,S., & Doyle,H. (1998). Racial discrimination in the allocation of distinction awards? Analysis of list of award holders by type of award, specialty and region. *British Medical Journal 316*(17 January), 193-195.

39. Giscombe,K., & Mattis,M. (2002). Leveling the Playing Field for Women of Color in Corporate Management: Is the Business Case Enough? *Journal of Business Ethics 37*(1), 103.

40. Hartenian,L., & Gudmundson,D. (2000). Cultural diversity in small business: Implications for firm performance. *Journal of Developmental Entrepreneurship 5*(3), 209-219.

41. Hurley,A., Fagenson-Eland,E., & Sonnefeld,J. (1997). Does cream always rise to the top? An investigation of career attainment determinants. *Organizational Dynamics 26*(2), 65-71.

42. Johns,N. (2004). Ethnic Diversity Policy: Perceptions within the NHS. *Social Policy and Administration 38*(1), 73-88.

43. Kandola,R., & Fullerton,J. (1998). *Diversity in Action: Managing the Mosaic.* London: Institue of Personnel Development.

44. Karlsen,S., & Nazroo,J. (2002). Relation between racial discrimination, social class, and health among ethnic minority groups. *American Journal of Public Health 92*(4), 624-631.

45. Kilian,C., Hukai,D., & McCarty,C. (2005). Building diversity in the pipeline to corporate leadership. *The Journal of Management Development 24*(2), 155-168.

46. King,G. (1996). Institutional racism and the medical/health complex: a conceptual analysis. [Review]. *Ethnicity & Disease 6*(1-2), 30-46.

47. Krieger,N., & Sidney,S. (1996). Racial discrimination and blood pressure: the CARDIA Study of young black and white adults. *American Journal of Public Health 86*(10), 1370-1378.

48. Lemos & Crane. Tackling Racial Harassment in the NHS: Evaluating Black and Minority Ethnic staff's Attitudes and Experiences. TRH (00) 12. 8-9-2000. London.

49. MacPherson,W.S. The Stephen Lawrence Inquiry. Chapter 6. Racism. Cm 4262-I. 24-2-1999. London, The Stationary Office.

50. McKenzie,K. (1999). Something borrowed from the blues? *We can use Lawrence inquiry findings to help eradicate racial discrimination in the NHS. British Medical Journal 318*(6 March), 616-617.

51. Nazroo,J. (2003). The structuring of ethnic inequalities in health: Economic position, racial discrimination, and racism. *American Journal of Public Health 93*(2), 277-284.

52. Powell,S. (2004). Interview with Beverly Alimo-Metcalfe. *Journal of Health, Organisation and Management 18*(6), 393-398.

53. Ragins,B., & Cotton,J. (1996). "Jumping the hurdles: barriers to mentoring for women in organizations". *Leadership and Organization Development Journal 17*(3), 37-41.

54. Richard,O. (2000). Racial diversity, business strategy, and firm performance: A resource-based view. *Academy of Management Journal 43*(2), 164-177.

55. Shea,S., & Fullilove,M.T. (1985). Entry of black and other minority students into US medical schools. Historical perspective and recent trends. *New England Journal of Medicine 313* 933-940.

56. Thomas,D. (2001). The Truth about Mentoring minorities: race matters. *Harvard Business Review 79*(4), 98-107.

57. Virdee,S. Racial Violence and Harassment. 1-95. 1995. Policy Studies Institute.

58. Walters,W.A., Sivanesaratnam,V., & Hamilton,J.D. (1995). External examiners. *Lancet 345*(April 29), 1093-1095.

59. Weil,P. (2003). A race/ethnic comparison of career attainments in healthcare management. *Healthcare Executive 18*(6), 22.

60. Williams,K., & O'Reilly,C.I. (1998). Demography and diversity in organizations: A review of 40 years of research. *Research in Organizational Behavior 20* 77-140.

61. Wrench,J. (2005). Diversity management can be bad for you. *Race & Class 46*(3), 73-84.