DIVERSITY BY DESIGN

Diversity solutions
to strategic questions

Good Governance Institute

DIVERSITY
THE NEW PRESCRIPTION FOR THE NHS

By Simon Fanshawe OBE
Co-founder Diversity by Design

"Recognising difference and working out how to combine it to the advantage of the NHS's central purpose lies at the core of achieving a diversity dividend for the NHS.

Engaging staff in diversity is to actively connect them with the idea that patient-centred care can only be a reality when the NHS uses, and learns to combine, to the full, the range of skills and abilities, life experiences and approaches it has within all of its staff"

AIM OF THE REPORT

The purpose of this report is to reframe the debate about diversity in the NHS, for boards and executives of trusts, in terms of the dividends it can deliver for patient health and staff success.

PURPOSE OF THE REPORT

To give boards and executives a framework to:

• link diversity to patient health, staff success and innovation
• understand in local detail the reasons for their Trust's diversity deficits
• develop practical changes to the processes of recruitment, promotion and retention
• set different measurements of success in diversity

WHO IS THE REPORT FOR?

This report is aimed at board members and chief executives /executive teams of acute NHS trusts in England. You are the leaders who have the responsibility and the power to make the changes needed.

This report is designed to open up a new approach to diversity that makes it central to an NHS trust because it delivers a dividend to patients and staff – in terms of health, and clinical and personal success - in line with the NHS Constitution: the NHS *"is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives"*.

While the diversity deficits must be tackled, the motivation to enhance diversity should be widened beyond compliance and tackling injustice. As talent is unblocked by dealing with the deficits, diversity should be pursued for the considerable added value which it can bring to the core purposes of the NHS.

METHODOLOGY OF THE REPORT

The author interviewed 15 senior executives and chairs in NHS trusts – across geography, ethnicity, gender, role, and length of service. A range of desk research was undertaken on the diversity data and on the widest questions of diversity in the NHS and on some experience in the USA. In addition, the daily practice and the research base of the author's work in diversity (through Diversity by Design - www.diversitybydesign.co.uk) with clients across all the public, private and third sectors has provided a testing ground for the implementation of the proposed changes in process.

Dame Jackie Daniel	Chief Executive of University Hospitals of Morecambe Bay NHS Foundation Trust
Paul Deemer	Head of Equality, Diversity and Human Rights NHS Employers
Raj Jain	Salford Royal NHS Foundation Trust Group Chief Strategy and Organisational Development Officer
Lord (Bob) Kerslake	then Chair of King's College Hospital NHS Foundation Trust
Roger Kline	Research Fellow, Middlesex University Business School, former Director of the NHS Workforce Race Equality Standard
Dr Nadeem Moghal	Medical Director, Barking Havering and Redbridge University Hospitals NHS Trust
Dame Julie Moore	Chief Executive of University Hospitals Birmingham NHS Foundation Trust
Kevin Moynes	Director of Human Resources East Lancashire Hospitals NHS Trust
Sian Payne	Equality Specialist Advisor at Salford Royal NHS Foundation Trust
Don Richards	Chief Financial Officer West Herts Hospitals NHS Trust
Steve Russell	Executive Regional Managing Director (London) NHS Improvement
Deborah Sanders	Group Chief Nursing Officer Royal Free London NHS Foundation Trust
Joan Sadler OBE	Associate Director of Patients and Communities at the NHS Confederation
Hein Scheffer	Director of Workforce, Herts Valleys CCG
Michael West	Head of Thought Leadership at the King's Fund and Professor of Work and Organisational Psychology at Lancaster University Management School

The first draft of the report was sent to a number of other senior colleagues, past and present and some inside the NHS and some now independent, for their comments, which have been included. The expertise of the Good Governance Institute (GGI) research team was also brought to bear on the drafts. Those who read and commented on the first draft:

Keiran Brett	Director of Health at iMPOWER
Rachel Cashman	Chief Executive (Age UK B&H) formerly responsible for the Clinical and Scientific Policy and Strategy Development at NHS England
Andrew Corbett-Nolan	Chief Exec at the Good Governance Institute
Prof Paul Corrigan CBE	former senior health policy adviser to the Prime Minister Tony Blair. Now consultant and Board member of the CQC
Prof Michael Farthing	Gastroenterologist, former VC of Sussex University, Vice-Chair for the UK Panel for Research Integrity in Health and Biomedical Sciences, member of the GMC
Roger Kline	Research Fellow, Middlesex University Business School, former Director of the NHS Workforce Race Equality Standard
Michael Macdonnell	National Director, transforming health systems at NHS England
Prof Michael West	Head of Thought Leadership at the King's Fund and Professor of Work and Organisational Psychology at Lancaster University Management School

It is intended that this Report will not reach any final conclusions but rather be used to stimulate discussions between a wide range of NHS staff at all levels leading to a refinement of the analysis and the actions and only then to act as a practical guide to change, rooted in the daily experience and wisdom of staff and patients.

Summary of recommendations

Recommendation One

Board members to commit to:

- debate, agree and articulate why an increase in the diversity of their staff will increase the Trust's ability to deliver on the broad strategic aims of:

  - safe, personal and effective patient-centred care and enhanced health outcomes
  - innovation both in medicine and in the design and delivery of services
  - staff career success

- creating an approach to talent development which shows how greater diversity will meet the ambitions of the Five Year Forward View and the Sustainability and Transformation Partnerships (STP) or the accountable care system (ACS)

The Executive commit to

- examining the Trust's Diversity Rationale as agreed by the Board and explore what operational changes are required to put it into practice

Recommendation Two

Board members commit to:

- detailed discussions, as the precursor to any action, on the exact nature of the diversity deficits in their organization and then to researching exactly why that is happening in all its local detail
- commission, from HR or an outside partner, detailed verbatim insight into the feelings and attitudes of their staff in relation to promotion, career development, ambition, opportunities etc. in order to understand the exact nature and operation of the deficits which lie beneath the headline conclusions of data like the WRES and Staff Surveys
- Executive to receive the results of the INSIGHT and draw up a plan of action on the issues that it uncovers. Report to Board

Recommendation Three

The Executive and HR directors review their processes of recruitment and promotion with a view to:

- changing to processes (like Joint Selection – see below 12.0 - or another form of fundamental change) that explicitly create teams and groups of staff based on diversity of experiences, identity, background and skills, as the norm
- ensuring that all appointments and promotions (including interims, internships, acting up etc.) go through a formal process, while still remaining flexible enough to provide opportunities to develop talent
- re-directing resources away from 'diversity awareness' training to mandatory leadership training for all those who lead teams and groups – the training to have at its core:

  - diversity as a talent management and development tool
  - an understanding of unconscious bias
  - compassionate and collective leadership
  - accountable decision making

- The strategic objectives of these changes, and proposed measurement of their success, to be reported to, discussed and agreed by the Board

The Board should use a similar process to outline (and governance) a succession plan which creates appropriate diversity among the members to meet the Trust's current and future challenges and opportunities.

Recommendation Four

- Executive to set goals to define an appropriately representative shape of their staff in relation to the population they serve and, by opening up opportunities, to achieve this at every level within five years. Board to sign these off.

- Trust to develop measurement of their progress in diversity at all levels paying attention both to:

  o demographic measurement
  o proxies for progress like patient experience satisfaction scores, deep focus work with newly constituted teams on their satisfaction at work, levels of safety and reporting, clinical effectiveness, patient health outcomes, retention, successful and equal promotion of staff etc.

- Executive to take immediate action to set goals to ensure, within one year, groups of staff are not discriminated against in promotion, recruitment or disciplinaries. Report progress to Board

1. WHY ANOTHER REPORT?

1.0   This report came out of conversations between Andrew Corbett-Nolan of The Good Governance Institute and Simon Fanshawe OBE of Diversity by Design.

Change in diversity in the NHS has been small and slow

1.1   In their work with various NHS organisations both were aware of the good intentions of good people in the NHS to achieve greater diversity. But they were equally aware of the extent to which these good intentions were just not delivering results in middle and senior management, where the lack of diversity is statistically so shocking, given, for instance, the large numbers of women and staff with Black and Minority Ethnic (BME) backgrounds on the front line. (Source WRES 2016 Data analysis report for NHS Trusts *(https://www.england.NHS.uk/wp-content/uploads/2017/03/workforce-race-equality-standard-data-report-2016.pdf)*

1.2   While there are considerably more senior women of late in the NHS there are depressingly small numbers of senior people with bme backgrounds. In addition, people with bme backgrounds at all levels of the NHS experience unacceptable discrimination in promotion and progression. (Anecdotal reports also raised worrying questions about whether the NHS can sustain staff who have their own mental health issues and/or visible disabilities).

        One interviewee said to us with disarming candour: "I think that there's an unconscious perception that black people aren't as good as white people, if I was to be blunt".

1.3   And our work in other sectors and organisations makes it clear that, while gender, race and ethnicity may be where the most glaring of all the discriminatory outcomes are in the NHS, failure to open up opportunities for the talents of women and people with bme backgrounds stands as a proxy for failing to open up those opportunities to all staff.

        It is striking that, while the NHS as a service is free at the point of need and doesn't discriminate against those who walk through the door to receive care, it seems, from the evidence, to discriminate against some who walk through the door to give care.

1.4   And shifting this is difficult, not least because the NHS has developed an unhelpful internal narrative of well-intentioned but defensive happy talk. Over and over one hears it said from conferences to Parliament to the front line in the wards: "the NHS is the best in the world, "Nurses are angels" etc. as if that makes the world OK. But this kind of sentimentality blocks positive change. If we go on just telling ourselves that the NHS is the best, what incentive or room is there for reform or redesign?

Extending the NHS's approach to diversity

1.5   So 'why another report?', as one of our interviewees wearily and rather pointedly demanded. Well, our intention is not to rehearse again the brilliant work of Roger Kline and Yvonne Coghill and the WRES (Workforce Race Equality Standard) Implementation Team or of Professor Michael West at the King's Fund or Professor Jeremy Dawson of Sheffield University and many others, all of whom have articulated, from detailed research, both the level of the diversity deficits and why they should be tackled.

1.6   The focus of this piece of work will be to recommend for discussion not so much the What? of diversity, but the Why Bother? And the How? Our conversations have been with, and so will shine the spotlight on, acute NHS trusts in England – not General Practices, Clinical Commissioning Groups or any of the other organisations in the wider family of the NHS. Focus must turn to them next.

1.7   The report is designed to be of primary value to trust board members and executive directors, as their role as leaders in this is crucial to achieving the kind of changes we recommend in order to make a significant impact on diversity in their respective organisations and reap the dividend.

2. SOME BASIC IDEAS BEHIND THE APPROACH

2.0   There are some key ideas behind the report, which derive from the extensive and recent research on the failure to move the dial sufficiently on diversity over the last decade, in all kinds of organisations across the public and private sector and all segments of industry and services – public and private.

- the first recognises that good intentions are simply not what makes change. We have to acknowledge that our assessments of people are driven by preferences that we cannot counteract –even when we know about them. Awareness does not change our behaviour. The data show clearly that there are barriers for members of certain groups of people to the fulfilment of their talent in the NHS. This is the result of both conscious and unconscious bias. So, trusts need to re-design how they promote and recruit so that they can clearly assess evidence from applicants about the contribution they can make enabling the appointment of truly the best people, rather than just the ones who appeal to our preferences. Research and experience is showing that nothing short of a substantive change in these processes will achieve the shift in diversity the NHS says it wants

- the second counter-acts the all too prevalent 'heroic' model of success. Increasingly research and practice are showing how success in organisations in achieving their goals is driven by well led teams and groups of people. Not the one heroic leader. As one senior anaesthetist said to us during the report "It's not the doctor's name at the end of the bed, it's the hospital's. We are responsible as a team". We should recruit and promote into teams and groups those people who will add the significant difference that the groups and teams need to succeed. And there is a growing body of research that is showing that the *combination of difference* is where you get the dividend from diversity

- Working with boards, executives and staff to develop and put into practice fresh and effective ways of changing the diversity of their organisation, Diversity by Design has found it important to focus separately on two different aspects of diversity which are often elided: the diversity dividends and the diversity deficits

  o   the diversity dividends, research and practice tells us, come from the combination of difference, drawing from the talent available once the deficits are being tackled
  o   the diversity deficits will be described by the data – both numerical and verbatim. Both need to be fully understood in local detail. It often too easy draw conclusions from what the diversity deficits look like. But further examination through insight which produces verbatim responses from the staff more often than not reveals different patterns and causes of discrimination, illuminates culture and identifies the exact nature of the problem to be solve

3. THE DIVERSITY DIVIDENDS FOR THE NHS – THE EVIDENCE

3.0 In 2004 the WK Kellogg Foundation in The States commissioned a study by the Institute of Medicine (IOM) to assess institutional and policy-level strategies for achieving greater diversity among health care professionals. Their seminal report was called "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce".
www.ncbi.nlm.nih.gov/pubmed/25009857

3.1 Coming out of the intense debate over almost a decade in America, where several State referendums and Federal Court decisions had limited the ability of many universities to consider race and ethnicity in admissions processes, the Committee's assignment was:

- to examine the question of whether we, as a nation, are properly utilising the pool of applicants to training in the health professions that we already have or will have in the future
- (given) the need and desire of the American people for competent, compassionate health professionals who have the necessary communication skills for an increasingly diverse society … are we getting all of the qualified students and faculty that we should from the available applicant pool?
- to answer the very important, but usually unspoken, question of how does the broader society benefit by having increased diversity among health care professionals, aside from the gratification of doing what is morally right?"

3.2 That last question is less "unspoken" than it was. More organisations are asking what is the broader benefit to them (let alone to society) from greater diversity and how does it enhance their ability to achieve their overall strategic goals and mission.

When that question was asked by the IoM Committee in relation to diversity and health, they concluded:

Increased racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with:

o *improved access to care for racial and minority ethnic patients, with health care professionals with bme backgrounds more likely to serve minority and medically under-served communities than their white peers*
o *interactions between health care professionals helping to challenge assumptions and broaden perspectives regarding racial, ethnic and cultural differences*
o *greater patient choice and satisfaction*
o *better educational experiences for all health professions students*
o *different problem-solving skills found by combining those with diverse ethnic and cultural backgrounds leads to more creative thinking about clinical, research, patient satisfaction and/or cost problems*

The dividend that comes from diversity, in broad terms, helps with access to and quality of health care, patient satisfaction and the ability to innovate.

3.3   More recently in the UK, energy and intellect have been invested in similar questions. What can we tell about the link between diversity and better patient outcomes?

3.4   One such important work, in 2011, which pursued this line of inquiry was "Why Organisational and Community Diversity Matter: Representativeness and the emergence of incivility and organisational performance" – Eden B King (George Mason University), Jeremy F Dawson (Sheffield University), Michael A West (Lancaster University), Veronica L Gilrane and Chad I Peddie (George Mason University) and Lucy Baston (Aston University). *http://amj.aom.org/content/54/6/1103.abstractM*

3.5   In their report the authors proposed that "researchers have …moved past the question of whether diversity affects outcomes and have instead begun to address the question of when and how diversity can facilitate positive outcomes". And they suggested that "one of the potential value propositions espoused by researchers and practitioners of diversity management: diverse employees may be particularly effective in serving similarly diverse populations (Richard, 2000) by bringing unique cultural sensitivity that appeals to a diverse customer base (Cox & Blake, 1991). This reasoning can be grounded in social identity and social categorisation theories, which suggest that people unconsciously favour members of their own social groups (Tajfel & Turner, 1979). On its face, this rationale implies that diversity in an organisation will yield positive effects when it matches the demography of the customers or clients the organisation serves".

3.6   In non-academic language, Michael West explained it thus:

"what we found was that much of the explanation resided in patients' reports of civility. What appears to be the case is that when the diversity and mix of front line staff matches that of the surrounding population, the staff behave more civilly in total to the people that they interact with because they cover the range of 'people like me'. Because we behave unconsciously more civilly to people like us than we do to people who are not like us.

What that does is create a culture of civility. And that civility does not, stop at the boundaries of staff-patient interactions. What it is likely to do is to spread across other relationships as well"

He went onto say *"I don't think the implication of our finding is that we need to somehow construct an exact match between front line staff and the local population. That would not be practical. What we need to do is raise awareness about the importance of civility of our interactions because that transforms the occupation".*

3.7   Michael and his team's work uncovered that one of the behaviours that gets in the way of good communication and understanding is each group's unspoken (and often unconscious) hostility to those who are not like us. In addition, the work considered how we can turn that to the advantage of the NHS, by recognising that when treating "our own" with civility, we role model civility to our colleagues. Diverse hiring can thus create an increase in civility.

3.8   And that "civility" is being practised extensively on the frontline. It is quite clear that, whatever the disadvantages women, people from bme backgrounds and other groups experience in the NHS in being promoted and getting into more senior roles, diversity and its consequent dividends is thriving in many patient/ staff interactions. Whether it's using the diverse backgrounds of staff to understand and interpret languages and cultures from increasingly diverse patients, or the provision of sexual health advice to gay men by gay male NHS staff or deploying women staff to care for women who have been sexually assaulted, there are many very successful examples.

3.9   This use of diversity, recognising difference and working out how to combine it to the advantage of the NHS's central purposes, lies at the core of achieving the diversity dividend. We need to express it and implement it that simply.

And when thinking about this simplicity recently, I recalled, at the London NHS Values Summit & EDS2 Launch on November 4th 2013, hearing a wonderful presentation by Tammy Horrocks, who is an Equality Advisor at Salford Royal NHS Foundation Trust. She said that she had gone to talk to nurses at

Salford Royal about "diversity". But they didn't really know what she meant. They don't use that language. Then she went back and asked them whether they'd ever had to think about how to approach patients who needed to be treated differently for cultural, gender or other reasons and if so, how had they gone about it? The nurses had many examples and stories.

3.10   This simple application of diversity and its combination of skills, experiences and identities to serve patients does not stretch much further than the front line, however.

Engaging the whole organisation in pursuing diversity means engaging a trust in the idea that patient-centred care can only be a reality when it uses, to the full, the range of skills and abilities, life experiences and approaches it has within in all of its staff. Most of us know this intellectually. But, as in so many organisations, the NHS does not actively apply it.

In order to begin to realise the health dividends for the UK we have to take the lessons that the IoM committee in the US learned about access and effectiveness of care in relation to minorities in the population and apply it to all individuals (from majority to minority) coming through the system. The diversity dividend comes through seeing, enjoying and using difference in both staff and patients to provide better care, innovate more and redesign services so that they answer the ever more complex challenges presented by our fast changing demography.

4. WHERE THE NHS IS FAILING TO REAP THIS DIVIDEND

4.0   It's not at the frontline where the NHS is failing to realise the diversity dividend. It is in promoting staff from groups that are under-represented in the higher levels of trusts into middle and senior management.

The most arresting diversity statistics are still that:

- while the 2017 analysis reports an increase in the number of Very Senior Managers (VSM) – above Band 9 – from BME backgrounds of 1.2%, for NHS trusts nationally, across the non-medical workforce (clinical and non-clinical), the proportion of BME staff in Bands 8a-9 and VSM was still only 10.4% compared with 16.3% in the workforce as a whole
- While there is a significant increase in the number of BME board members in trusts, this increase is primarily amongst non-executive members, not employed executive board members
- for BME staff the likelihood of being appointed from shortlisting has not improved at all. It is still the case that white staff (across all grades) who have been shortlisted are 1.6 times more likely than BME staff to be appointed even once shortlisted
- NHS staff survey data reports that, despite an improvement, it remains twice as likely that BME staff, compared to white staff, do not believe there are equal opportunities for career development and progression

(Roger Kline commentary on NHS Workforce Race Equality Standard (WRES) Data Analysis for 2016-17)

5. WHY THE NHS COULD REAP THE DIVIDEND

5.0   In their submission to the McGregor Smith Report ("The Time For Talking Is Over. Now Is The Time To Act - Race in the Workplace", 2017 *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/594336/race-in-workplace-mcgregor-smith-review.pdf*), the WRES Implementation Team, identified three related reasons why diversity can benefit the overall performance of the NHS:

- organisations which have a diverse leadership are more successful and innovative than those who do not. (See below para 4.2 for the conclusions of the McKinsey study on this)
- organisations that do not reflect local communities in their own leadership may fail to be sensitive to local health needs, including those linked to reducing health inequalities associated with equality groupings. As NHS England's CEO Simon Stevens put it: "The chronic lack of non-white faces in senior positions means the NHS is missing out…. diversity in leadership is associated with more patient-centred care, greater innovation, higher staff morale, and access to a wider talent pool"
- There are wider demographic imperatives for challenging discrimination. Changing demographics not only herald a changing composition of the workforce but necessitate workplace cultures that allow every employee to contribute to their maximum potential. (only 20% of the UK working population is now white, male, able-bodied and under 45; from 2010 onwards, the number of young people reaching working age in the UK began to fall by 60,000 every year; between 2010 and 2020, the UK will need 2.1 million new entrants to the adult workforce)

In summary the WRES team concluded: "organisations will better serve and develop strategies for patients, clients, customers, residents and communities by having an inclusive workplace that attracts, engages, and retains a diverse workforce at all levels".

5.1   Some of the best work on the general benefit to organisations from diversity can be found in the McKinsey Diversity Matters project (Hunt, V, Layton D, and Prince, S. (2015). The most often quoted conclusions from the study are two correlations between diversity and performance:

- Companies in the top quartile for diversity financially outperform those in the bottom quartile: gender diverse companies are 15% more likely to outperform and ethnically diverse companies 35% more likely (Results show likelihood of financial performance above the nationality median. Analysis is based on composite data for all countries in the data set. Results may vary by individual country)
- In the UK greater gender diversity on the senior executive team corresponded to the highest performance uplift in our data set: for every 10% increase in gender diversity, Earnings Before Interest & Tax (EBIT) rose by 3.5%

The project went on to make an insightful and crucial observation:

- While correlation does not equal causation it does indicate that when companies commit themselves to Diverse leadership they are more successful

5.2   The benefits from diversity are correlative. They are not causative. What they indicate most powerfully is really quite logical: when the leadership of an organisation concentrates policy and action on the removal of the blocks to advancement that people from certain groups typically experience, and supports their ambitions and potential, they are developing and using the talents of their staff to the full. And if they are also deploying those different talents and backgrounds effectively then their organisation will perform better. Advancing all talent is the first step in enhancing performance.

5.3   However two things arise from this for the NHS and other organisations:

- it is becoming more and more clear that, for the argument to be wholly effective, the general case for the dividend needs to be made specific to the organisation, the sector and to their particular goals
- we need to tackle the issue of the correlation between diversity and health dividends

HOW THE NHS COULD REAP THE DIVIDEND

6. MAKING THE CASE SPECIFIC

6.0 Recently BHP Billeton, the largest mining company in the world, set, in the words of its CEO, Andrew Mackenzie, "an ambitous and aspirational goal.. to achieve gender balance globally by 2025"
What provoked this? Firstly, all mining companies are facing a significant talent pipeline issue because 75% of the current workforce is over 50. Secondly, mining is being fundamentally disrupted by technology in the form of robotics and AI and the sector needs a different combination of skills for the future.

So what better way to widen and develop the sector pipeline than to double it and make mining appealing to women?

6.1 But, compelling as those facts were in provoking the company's thinking about diversity, the general case didn't get real traction until, as their Group Treasurer Vandita Pant said at the POWERful Women Ambassador's Reception in December 2017 in London: "BHP has its own data that shows how diversity really impacts the bottom line. Our top 10 most inclusive sites perform at least 15 per cent better than company average – on safety, production, cost efficiency and employee engagement, to name a few key areas.

For example, in these operations we have seen a reduction in injury frequency of up to 68 per cent and up to 15 per cent greater accuracy in production forecasting. The reason is that in our most inclusive sites, people are more engaged, share ideas and collaborate to make things better. They respect and value diverse views and experiences. Hence, the business case is open and shut. It is logical then, that we would want to replicate the benefits of our most inclusive sites across the company".

7. CONVINCING NHS STAFF OF THE LINK BETWEEN DIVERSITY AND ACHIEVEMENT OF CORE OBJECTIVES

7.0   That causation/correlation issue presents us with some difficulty in the NHS, especially with clinicians. As one old hand at diversity in the NHS pointed out: "Clinicians look for almost a direct, hierarchical causation between 'if you do this you get that'. And in the equality and diversity world, with the best will in the world, you have to look outside of a straight-line kind of causation between action (a) will give you (b). So," she continued, *"I wouldn't necessarily start with the argument that says diversity and equality, and having more people with bme backgrounds in our staff team, will increase better care for people we're giving services to. I'd start with our experience that when we increase our ability to engage better with those people who are using our services, we are able to increase the quality of care, the safety of care, and we get different clinical outcomes because they're engaged in their own care."* And to do that we have not only to have diversity on the front line, but in service design and management and innovation.

7.1   One of the chief executives of one of the country's largest trusts said *"So, we may have started with a very clear idea about how a service transformation should look but actually, where we were willing to just listen with a bit more intent, we got a completely different design solution. The transformation of a service as a result of getting different people round the table was really powerful".*

7.2   If that is the case, how do we frame our approach to realising the dividends from diversity? The starting point has to be that diversity must be seen as a service improvement tool. So there needs to be the right combination of talent not just delivering the services on the frontline, but designing them, leading them, managing them in the current fast changing environment for the NHS where demand is both increasing and changing.

7.3   The NHS clearly recognises the vital importance of innovation in services as "Innovation into Action - Supporting Delivery of the NHS Five Year Forward View (2015)" makes quite clear:

       "Supporting innovation across the healthcare system is more important than ever, and will be central to securing transformation and improved patient outcomes.... From the Small Business Research Initiative, which provides grants to small and medium-sized enterprises (SMEs) to solve NHS identified problems, to the New Care Models leading the way in new forms of integrated care which will become blueprints for the NHS as a whole, innovation is integral to all our work".

       Valuing difference has to be seen as a way of designing, leading on and creatively managing healthcare so that it can innovate to match the specific needs of the patient.

7.4   But do boards and executives see it that way? So often diversity is the Cinderella board agenda item, relegated to the reporting of bad or disappointing news which is received with frowns and the admonition that there must be improvement before the next time. And it usually comes lower down than, to extend this metaphor for fun, the Ugly Sisters of 'Finance' and the 'Performance DashBoard'.

7.5   As one senior HR director said to us: *"do you think boards really get it and expect that we will perform better with a diverse workforce at all levels which can bring a unique and special blend of quality and service to the organisation? I think we are fighting a very challenging battle especially in times where finances are tough and pressures are very high".*

       Another executive member we spoke to added: *"there is a pretty long tail of organisations where it is not seen as important.....places that just don't get it, can't be bothered, they've got too many other problems and..",* the interviewee added crucially, *"they don't see pursuing diversity as a way out of those problems".*

7.6   The problem with just putting "diversity" on the board agenda is that, to mint a new cliché, 'diversity is not a thing you do, it must be the way that you do things'. Diversity must not be a separate agenda item, but rather the trust talent strategy, which permeates all aspects of the organisation and enhances the organisation's ability to deliver on its core purpose.

       This will mean engaging the staff with the ideas and research on the interaction between diversity and health outcomes and innovation. And there are an increasing number of studies, but their learning will need to be localised to the particular trust.

7.7   The consulting group BCG and the Technical University of Munich conducted an empirical analysis in 2017 to understand the relationship between diversity in management (defined as all levels of management, not just executive management) and innovation. Although the research is concentrated in a particular geographic region, they believed "that its insights applied globally". The following are their major findings:

- The positive relationship between management diversity and innovation is statistically significant, meaning that companies with higher levels of diversity get more revenue from new products and services
- The innovation boost isn't limited to a single type of diversity. The presence of managers who are female or from other countries, industries, or companies can cause an increase in innovation.
- Management diversity seems to have a particularly positive effect on innovation at complex companies—those that have multiple product lines or that operate in multiple industry segments. Diversity's impact also increases with company size
- To reach its potential, gender diversity needs to go beyond tokenism. In our study, innovation performance only increased significantly when the workforce included a nontrivial percentage of women (more than 20%) in management positions. Having a high percentage of female employees doesn't do anything for innovation, the study shows, if only a small number of women are managers
- At companies with diverse management teams, openness to contributions from lower-level workers and an environment in which employees feel free to speak their minds are crucial in fostering innovation

"The Mix that Matters - Innovation through diversity" – April 2017 Rocio Lorenzo, Nicole Voigt, Karin Schetelig, Annika Zawadzki, Isabell Welpe, and Prisca Brosi published by BGC - Global Management Consulting

7.8   And a 2014 study for the US National Library of Medicine National Institutes of Health concluded: *"More than ever, our efforts to improve our health-care system's quality and effectiveness through innovation depend upon a health workforce that comes from a diversity of backgrounds and experiences, with a mix of research and practice orientations. It is evident that we can't accelerate our pace of change without diversifying racial/ethnic, socioeconomic, or otherwise culturally monolithic learning environments".* US National Library of Medicine National Institutes of Health - Public Health Reports 2014 Jan-Feb by Marc A Nivet and Anne Berlin.

7.9   Organisations who learn to combine the differences in their talent at all levels will equip themselves to perform measurably better in achieving their strategic goals in relation to individual patients and their populations as a whole.

7.10   The best place for boards to start might, as one Chair of an NHS Foundation Trust put it to us, simply to be pragmatic: *"The question I asked about the Five Year Forward View would be the question we should ask ourselves as a Trust. I will go back and ask it of my Board following this conversation. "How do we think delivering on diversity will help us deliver our (5 year) plans?".*

Recommendation One

Board members to commit to:

- debate, agree and articulate why an increase in the diversity of their staff will increase the Trust's ability to deliver on the broad strategic aims of:

  o   safe, personal and effective patient-centred care and enhanced health outcomes
  o   innovation both in medicine and in the design and delivery of services
  o   staff career success

- developing an approach to talent development which shows how greater diversity will meet the ambitions of the Five Year Forward View and the Sustainability and Transformation Partnerships (STP) or the accountable care system (ACS)

The **Executive** commit to:

- examining the Trust's Diversity Rationale as agreed by the Board and explore what operational changes are required to put it into practice

8. TACKLING THE (DIRE) STATE OF DIVERSITY IN THE NHS - THE DEFICITS

8.0   Although we don't want to dwell so much on the 'What?', it's worth reminding ourselves how worrying the NHS data are.

8.1   Although, Roger Kline's analysis of the NHS Workforce Race Equality Standard (WRES) Data Analysis for 2016-17 makes the point that the news is not all bad!

"For the third year running since the WRES was agreed in 2014, there was a significant increase in the number of black and minority ethnic (BME) nurses and midwives on more senior grades (Para 6.1.9). About half of all nurses and midwives are on Band 5, the entry Band, where the proportion of BME staff has been steady. However, the number of BME nurses and midwives joining Bands 6 and 7 in 2015-17 was double that of 2014; whilst for Band 8a the number of BME nurses and midwives joining trebled in 2015-17 compared to 2014, though improvement in the most senior grades was less marked. Almost 2000 more BME nurses and midwives have been appointed to more senior grades over this three-year period than would have been the case if appointments had not markedly increased since 2014-15.

While the precise reasons for this improvement need further inquiry, the only significant driver since 2014 that might have impacted on the grading of BME staff was the WRES. There were no obvious demographic reasons to explain this change".

8.2   And, at management level, the 2016-17 analysis shows that very senior managers from BME backgrounds increased by 4%. But the reality of that is just an additional nine appointments.

8.3   It's also important to point out that there remain marked differences in the data between regions and types of trusts.

8.4   While there are slight improvements in staff data, we can see, from the research in "Action not words – Making NHS Boards more representative" by The Rt Hon. the Lord Hunt of Kings Heath OBE - August 2016, that:

- Only 2% of NHS trusts are chaired by people from a BME background, while 15% of England's population is of BME heritage
- While 80% of NHS staff are women, women make up just 28% of trust chairs, outnumbered three to one by men
- People from a BME background make up just 4% of the executive directors and 7% of non-executive directors on trust boards
- While 47% of trusts' executive directors are female, women comprise just 38% of the non-executive roles on boards
- Three-quarters (75%) of NHS trust chairs are aged 60 or over, while just under half (46%) of non-executive directors are in the same age bracket

8.5   As we said above in para 4.0, the patterns of discrimination are mirrored in perceptions by staff with bme backgrounds of the degree to which their employer provides equal opportunities for career progression or promotion (Indicator 7 of the Workforce Race Equality Standard.) It is more than twice as likely that staff with BME backgrounds do not believe their employer provides equal opportunities for career progression or promotion. (Source WRES 2016 Data analysis report for NHS Trusts. (https://www.england.NHS.uk/wp-content/uploads/2017/03/workforce-race-equality-standard-data-report-2016.pdf)

8.6   Within medicine, some increase in senior staff with BME backgrounds has arisen from the substantial growth in the numbers of junior doctors and consultants with BME backgrounds. Thus, it would have been astonishing if there had not been at least a small increase in clinical directors and medical directors from BME backgrounds. However the numbers are still surprisingly small.

8.7   Patterns of disproportionate exclusion from the most senior grades, and Board level positions, continues for women. In NHS provider trusts, although 77 per cent of NHS staff are women, only 36 per cent of chief executives, 26 per cent of finance directors and 24 per cent of medical directors are female. (source: NHS Women in Leadership: plan for action by Penny Newman http://www.NHSemployers.org/~/media/Employers/Publications/NHS Women in leadership_Br1322_WEB.pdf)

8.8   It's worth reflecting on whether those data on gender and race and ethnicity tell us anything about the diversity and the NHS more widely. Paul Deemer, Head of Equality, Diversity and Human Rights at NHS Employers, who are responsible for the NHS wide staff survey suggests they can: *"There is certainly something there that's stopping staff with BME backgrounds getting into senior positions…. there is clearly a deficit there. We've got something like almost 50% representation of women now on Boards, but that isn't fantastic in an organisation that's got 80% women in the workforce. But as we look wider we are now also seeing deficits around disability and sexual orientation"*.

8.9   Put bluntly, lack of diversity is widespread in the NHS and if we can understand and tackle the blocks that limits the contribution of women and staff with BME backgrounds we can use that as a prism through which to look at the support and development of all staff and their talents.

8.10   This approach is similar to the conclusions we have reached in our work on the lot of students with BME backgrounds in UK Universities. The data tell us that across all Universities in the UK, there is a 16.1% attainment gap between students with BME backgrounds and their white friends. (This varies considerably between black heritage students at 29.4% and Indian heritage students at 8.8%) However, not all students with BME backgrounds underachieve at degree level and not all those who underachieve are from BME backgrounds. It is vital therefore that solutions neither stigmatise all BME students from BME backgrounds as potential under-achievers nor exclude white students who are in danger of underachieving, from the support they need. (source Equality Challenge Unit *http://www.ecu.ac.uk/guidance-resources/student-recruitment-retention-attainment/student-attainment/ degree-attainment-gaps/)*

        Solutions to the attainment gap have to focus on support for all students, while recognising that there might be BME background - specific issues behind the under-achievement – eg the content of the curriculum being predominantly white European, the race or ethnicity of the teachers making it more distancing for students with BME backgrounds or the cultural issues around learning etc.

        Similarly, any measures to equalise the opportunities and experience for staff with BME backgrounds in the NHS must operate to the benefit of all staff, through understanding the needs of particular groups of staff.

8.11   There is furthermore an important underlying principle in diversity work: to tackle the issue of the lack of opportunities for certain groups of staff in the NHS is not to privilege those groups. The accusation is often levelled at those of us who work in diversity - "you're positively discriminating", "you're discriminating against me because I am white" or "they are only getting the job because they are black, female, gay etc.". We have to take on these anxieties and discuss them. But opening up opportunities for people from groups who the data tell us are being discriminated against is to level the playing field, not to tilt it in their favour. It is to create the situation in which everyone has the opportunity to compete equally and show their skills and capabilities to the best and be recruited or promoted for what they can do, rather than who they are. It is genuinely to enable the NHS to employ the best people for the jobs. And right now the data show us that that is not the case.

9. TO GET THE DIVIDENDS YOU HAVE TO TACKLE THE DEFICITS. AND TO TACKLE THE DEFICITS, YOU HAVE TO UNDERSTAND THEM FIRST

9.0 In work Diversity by Design has done with organisations across the public and private sectors one thing has emerged as crucial – the importance of understanding the particular character of the deficits in each different organisation.

Diversity deficits often look the same. There is, for instance, (as noted above) across all the NHS organisations a remarkable consistency in the degree to which it is more likely that white people will be selected for jobs than candidates with bme backgrounds.

But behind the headline there will lie specific issues in each NHS organisation that need to be understood in detail in order to tackle the issue effectively. It's rather obvious to say it, but if you don't know precisely what the problem is, you'll end up trying to solve the wrong thing.

9.1.1 Two examples:

While co-writing a report not so long ago for the Institute of Public Policy Research, called "You Can't Put Me In A Box', https://www.ippr.org/publications/you-cant-put-me-in-a-box-super-diversity-and-the-end-of-identity-politics-in-britain I came across an eloquent example which illustrates the point:

In his fascinating study on youth gangs called Reluctant Gangsters, carried out in Waltham Forest, John Pitts (2007), the Vauxhall Professor of Socio-legal Studies at the University of Bedfordshire set out to understand the formation, operation and effect of youth gangs in this London Borough. He delved deep and asked questions about the nature of the conflicts between gangs. He reached some startling conclusions:

> *"The Pan-London Gang Profile indicates that 48% of the gangs surveyed were 'African Caribbean' and 21% 'Asian', but the nature of the data collected means that these young people may well have been Black British, African or of Mixed Heritage. In Waltham Forest, there are few single ethnicity gangs. Gangs are estate based and their ethnic make-up reflects the ethnic make-up of their estates… It is important to remember that in Waltham Forest, while Black and Mixed Heritage young people are over-represented in youth gangs, White and Asian young people sharing a similar social and economic profile and living on the same estates, and in the same neighbourhoods, are also more likely to become involved."*

The point that Pitts is making is that the formation of gangs is primarily about location and poverty, not ethnicity. There are many cultural factors that can be attributed to the behaviour of the gangs, especially the 'black gang culture' of America, but the essential issue here - why young people get involved in gangs - is to do with life chances and prospects. It is not associated with being black or asian.

As a result of Professor Pitts' insights, the work to tackle the gangs in Waltham Forest was pivoted away from race onto strategies dealing in exclusion and opportunities and extricating young people from gangs, with considerable success.

9.1.2 One of the 'Magic Circle' Law Firms, recently discovered that they had more partners called David than they did women! 14% Davids and 11% women. In order to solve this, they worked on two aspects of the issue.

- The first was to analyse whether there was bias in selection for partnership. And there clearly was a fixed (male) idea of what a partner 'looked like'.
- And secondly, when the company researched the ambition of those wanting to be partners – and the applicants were 50:50 men and women - they found that the women as a group were 'less ambitious' than the men. Looking to the top and realizing their lack of prospects, the ambitious women had left.

9.2 The point of both examples is that the solution lay in the precise understanding of the particular issues, not in generalized assumptions. In the first they switched to an aspiration focused approach around jobs and opportunities. And in the latter they looked not just to de-biasing the partner appointment processes but also they focused on a retention strategy to keep the ambitious young women in the firm and realise a return on the very considerable investment they were making in training them.

9.3 Understanding the deficits in local detail is a first step towards tackling them because it enables organisations to understand where the blocks to talent really lie. There is value to the work done across the whole NHS, of course. The WRES Implementation Team have shone a powerful light on the egregious experience of staff with BME backgrounds. Without the WRES, as a number of our interviewees said to us, they wouldn't have discussed the issue locally at Executive and Board at all. But the conclusion of our work over the last years is that, once the issue has been put on the agenda, solutions lie locally within each organization, understanding the specifics with both numerical and verbatim data.

9.4 In one Health Trust where we have worked, 15% of the workforce is from a BME background. But of the 24 'Very Senior Managers' (who are not clinical directors) none are from a BME background. Out of 26 Matrons, none are from BME backgrounds. The relative likelihood of White staff being appointed from shortlisting compared to staff with BME backgrounds is 1.95 times greater.

What is happening? Are people with BME backgrounds not being encouraged to apply? Are they applying and not getting selected? Are they not applying at all? Is the solution in de-biasing the process of selection and/or in supporting and mentoring talented nurses with BME backgrounds to apply? What is the level of ambition among nurses with BME backgrounds? Is it comparable or less than the level among white nurses? Is there an overall problem of ambition among all nurses? And if it's low, why? Are the nursing shifts in this NHS Trust flexible enough to attract potential nurses away from agency nursing etc.? The answers to these detailed questions will lead to effective local solutions.

9.5 Problems are not always as presented. A well-known High Street retailer we worked with had a problem with what is known as 'presenteeism' - emails at crack of dawn, people coming into the HQ office earlier and earlier in the morning. On investigation, while there was pressure to be seen always to be working in order to be seen as promotable, the accompanying reason why people were coming in earlier and earlier (and therefore emailing at 6am) was because their HQ is only really easily reached by car, and they didn't have enough car parking space! So, people were getting in earlier just to park. Problems are not always what they seem. We have to frame them right.

9.6 These precise findings come from detailed work with staff, which drills down into their feelings and attitudes. We have found in our work that the verbatim data is as, if not more, powerful than the figures. It is important therefore to investigate the nature of the issue by asking Open Questions about their experience and how the staff feel.

9.7 With one client, in a project to look at the imbalance between men and women in middle and senior management and change their method of selection and promotion, we asked, among others, questions about the extent to which they agreed or disagreed with the following statements:

1   My individual skills, way of working, personality, background and experience mean that I can be ambitious at work.

Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Please tell us why you feel this way

2   My individual skills, way of working, personality, background and experience would be valued if I went for promotion.

Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Please tell us why you feel this way

3   My age, ethnicity, disability, sexual orientation, gender, faith, educational or social background - does not act as a barrier to my opportunities and ambition within the organisation.

| Strongly disagree | Disagree | Neither agree or disagree | Agree | Strongly agree |

Please tell us why you feel this way

Some very distinct themes emerged, particularly about the relationships among men and women in that department. We discovered an environment of what one of the (shocked) Executive directors described as "unfettered behavior". There was a culture of (i) persistent sexism allied to (ii) informality in appointments, favouring 'who you know'. Before re-designing their processes of promotion and recruitment, first it was important to get a grip on the culture so that women felt supported and valued for their work.

9.8   In one NHS trust we attached to their staff survey a 'free text' box for the questions about discrimination at work. What emerged was, against a background of discriminatory outcomes for women and staff with BME backgrounds similar to the national picture, two sets of unprompted forms of words: the first was 'if your face fits'; and the second were variations on 'the job is already unofficially taken', 'favouritism', 'it's who you know'.

The outcomes for female and staff with bme backgrounds in that Trust are emphatically discriminatory, but that appears to result as much from a lack of rigorous formality in appointments as it does from any intentional outright bias. In part it is a failure of attention to proper process, rather than malign intention, that appears to be causing the unfair results for staff. A formal, redesigned process of recruitment and promotion applied universally across the Trust would help to open opportunities for staff with bme backgrounds and female staff. There also needs to be a change in recruitment processes overall that would allow people appointing to design out their biases.

9.9   In our conversations for this report again and again this issue of informality in appointments came up. For instance:

- "the NHS operates like this as I'm sure you know, but the senior positions, you know if you've got a chance of getting the job or not. You almost get that tap on the shoulder saying I think you should apply"
- "you just know that you're not going to get it. And you have to invest quite a lot to go for that next position. This may sound lazy, but when you know that you really haven't got a chance, you think well why should I put myself through all this pain?"
- "at chief executive level, the NHS is very careful about who they put in. You would think not from the turnover, but it does. It picks people out and plonks them in and then everybody else just has to live with it. Then we talk about equal opportunities. But that doesn't really happen at that level"

9.10   The lack of process is designed to fill appointments as swiftly as possible and this is driven primarily by two pressures:

- if the post isn't filled, you are likely to lose the money. A Finance Director under pressure to find savings will alight on an unfilled post - without any of the difficulties associated with redundancy or redeployment - with some enthusiasm. It's a no cost saving
- there is a 'life and death' culture (as one interviewee put it) which creates an atmosphere of constant urgency. However, it is often illusory and a more considered and timely process would considerably benefit the team into which the person is being recruited. This was described to us as frequently the case in promotions

Trusts should develop formal processes which are swift yet rigorous and where adhering to that process is rewarded. (See below Recommendation 3)

Recommendation Two

Board members commit to:

- detailed discussions, as the precursor to any action, on the exact nature of the diversity deficits in their organization and then to researching exactly why that is happening in all its local detail
- commission, from HR or an outside partner, detailed verbatim insight into the feelings and attitudes of their staff in relation to promotion, career development, ambition, opportunities etc in order to understand the exact nature and operation of the deficits which lie beneath the headline conclusions of data like the WRES and Staff Surveys

Executive to:

- receive the results of the INSIGHT
- draw up a plan of action on the issues that it uncovers
- report plan to Board for discussion and agreement

10. TO ACHIEVE GREATER DIVERSITY TRUSTS NEED A NEW APPROACH TO RECRUITMENT AND PROMOTION

"The race equality standard is a pretty blunt instrument. I'm not against doing it. But we have to recognise that simply publishing the data and scaring the hell out of people, the Board and the executive team is not the solution. What we've got to do, rather than just telling people you're dreadful, is to find ways of helping them" Professor Michael West

10.0   Above we have alluded to the failure across all sectors, public and private of too much of their work on diversity The pace and scale of change has been disappointingly slow and small. Almost every organisation that we work with demonstrates the same pattern. Taking the numbers of women and people with BME backgrounds as an indicator, many of them have increased the pipeline from those groups at entry level, but as you look at the more senior roles the numbers decline significantly. It is still the case that white men dominate the upper-middle and senior ranks of UK organisations.

- At the top of British business, of the 297 CEOs CFOs and Chairs of the FTSE 100 companies, at the time of writing, I counted more men called John, David and Andrew than women or people with BME backgrounds
- In December 2015 the FT noted that while "women hold 31.4 per cent of non-executive Boardroom roles at FTSE 100 companies…the executive pipeline has barely moved. Women executives represented 9.6 per cent of Boards, a slight rise from four years ago"
- In the House of Commons on 28th October 2015, the Shadow Business Secretary quoted the latest annual survey of 10,000 top business leaders by executive recruiter Green Park "It shows that the number of visible ethnic minority CEOs is falling, and the number of all-white Boards is increasing, at a time when 14 percent of our population is from a black or minority ethnic background"

Without being cute about it, it is just statistically unlikely that the majority of the talented senior people across the world of work in this country are all white men, called John, David and Andrew! The NHS, in common with other organisations, is not making the most of the available talent.
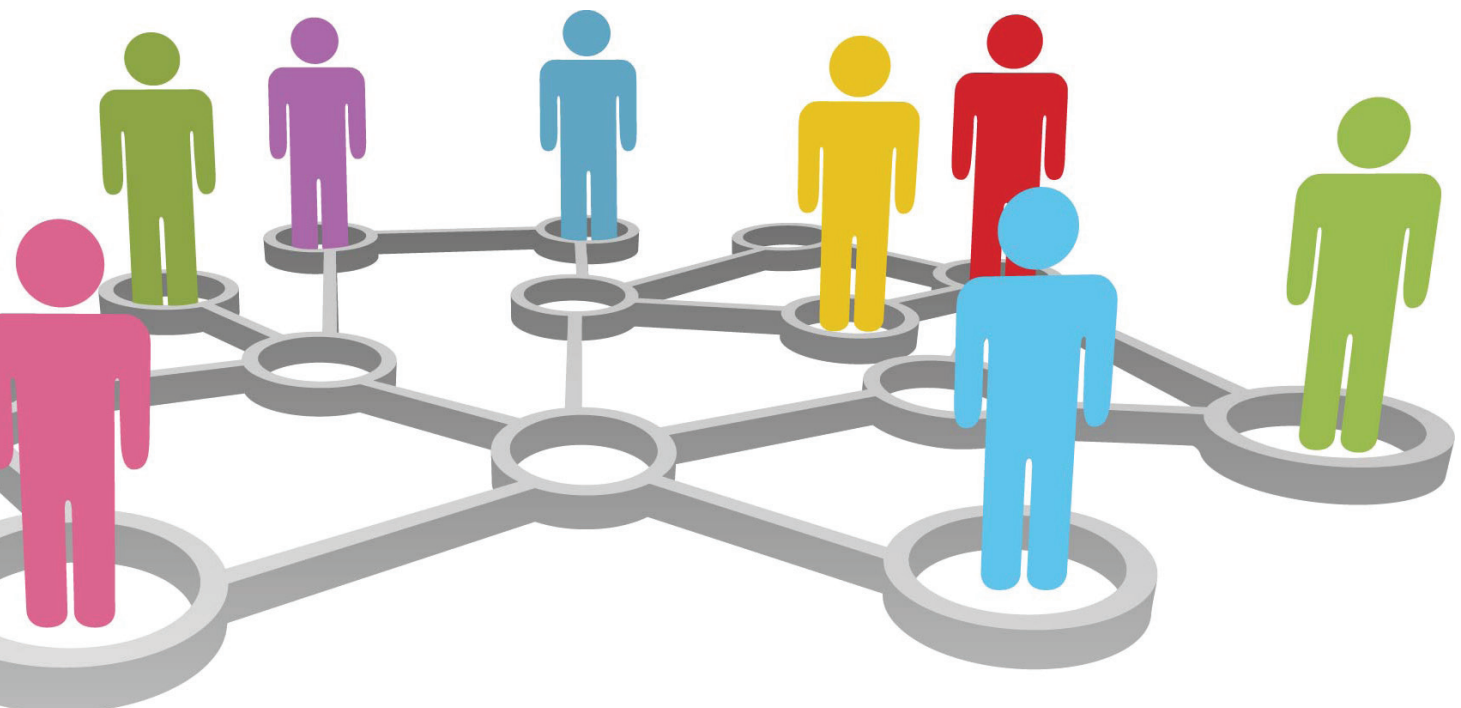
11. WHY HAS THERE BEEN SO LITTLE CHANGE IN DIVERSITY?

11.0 This is the case despite considerable energy, good will and money being applied to the problem. So, what has been going wrong? There are two bodies of emerging work that propose an answer.

- the first recognises that in order to change the way we make judgements about each other, we have to recognise that we make these assessments driven by preferences that we cannot counteract just by knowing about them. However awareness does not change our behaviour. The only way to change the outcome of the judgements we make in appointing, promoting and retaining staff is to **design the processes we use differently**. In the words of the most persuasive researcher on the subject, Professor Iris Bohnet of Harvard University, where she is the Co-Chair of the Behavioural Insights Group and Professor of Public Policy at the Kennedy School of Government, "we need to create situations where our biased minds can make unbiased choices". If we want to appoint 'the best person for the job', we need to design processes where we can eliminate as much noise from our own biases and preferences as possible so we really can appoint 'the best'

- the second area is the investigation into what produces the highest performance in organisations. In his 2007 book The Difference, Scott E Page, the Leonid Hurwicz Collegiate Professor of Complex Systems, Political Science, and Economics at The University of Michigan - Ann Arbor, set out the fascinating idea that, simply put, the highest performing teams are not necessarily made up of groups of high performing individuals. High performance comes from diverse teams. And there have been a number of other persuasive studies since that support his thesis. (eg Google's Project Aristotle (2012); Anita Williams Woolley (Carnegie Mellon University, Tepper School of Business) and others "Evidence for a Collective Intelligence Factor in the Performance of Human Groups")

11.1 The consequences for organisations of these two areas of research and their associated field trials are:

- that we need to change the processes we use to recruit and promote in such a way as to eliminate bias and really appoint the best
- and secondly our assessments about people's suitability for a role need to be based on the contribution they can bring to teams through the difference that results from their identity, background, experiences and perspective as well as their technical expertise. So, once candidates have reached or exceeded the required level of professional excellence, appointments and promotions should be on the basis of their relative contribution not their individual skills and expertise in isolation

11.2 Iris Bohnet's latest book ('What Works – Gender Equality by Design') starts with a very famous example. In the 1970's only 5% of musicians in US orchestras were women. Today it is nearer 35%. What they did to achieve that is now well known. They put a curtain between the auditioning players and the people who were listening. That way those choosing really could just listen to how those auditioning played. When they then appointed the best players, they were not all, as before, white and male, but much more mixed. This tells us two very important things:

- In order to appoint the "best person for the job", we have to give ourselves the opportunity really to listen to 'how they play'. Without the curtain (or the equivalent) we don't get that
- And the second thing is that our preferences play out in such a way that they drive us to make choices on the basis of assessments that reflect our preferences rather than their skills. In the case of the orchestra, the peculiar thing was that the fact that the musicians auditioning were white and male resulted in the choosers hearing them play better. The visual clue influenced the aural judgement

11.3 We all have preferences. We all operate on them without being conscious of them and so we all need help to make better choices. Our intentions may not be to exclude women or people with BME backgrounds or those with disabilities from the more senior jobs in the NHS, but the data tell us that is exactly what is happening. We need to face up to it and make the appropriate changes.

12. SO, WHAT DO WE NEED TO DO TO REALISE THE DIVIDEND?

12.0   In her book Professor Bohnet develops the basis of a method called Joint Selection

- explicit criteria are drawn up from a discussion about the difference that would be needed to add to the ability of the group/team to do its job - 'who you really need'
- gateway questions are established as a threshold for technical expertise or the experience that is a must-have
- candidates submit evidence against explicit criteria
- they are assessed just on that evidence without any biographical information - CVs are only used for a third party to check facts
- candidates are assessed (in the way a primary school teacher would mark Maths). Selecters evaluate the evidence submitted by all candidates against criterion one, then all the evidence against criterion two and so on.
- interviews are rigorously carried out as an opportunity to probe further the evidence against the criteria that the candidate has supplied

12.1   Joint Selection is one solution to the complex problem of the way our preferences throw us off the scent of talent. It is one way of eliminating as much bias as is possible. What the research reveals is that bias influences the process of recruitment and promotion immediately when a selecter sees the 'whole person' either in the flesh or through a CV and that impairs our ability to assess their suitability for the role on their evidence.

Bohnet's research strongly suggests that HR departments need to put their recruitment, promotion and retention processes under a very critical lens. And then embed the kind of fundamental changes that would deliver this kind of solution. And in our experience this kind of radical change does produce very different, and more diverse, outcomes. In the appointment of one Professor in Engineering, for instance, the applicants were (not unusally) 87:13% men to women, the short list against the criteria was 65:35% almost tripling the proportion of women in with a chance.

13. TECHNICAL ABILITY SHOULD BE A GIVEN.....WE NEED TO CONCENTRATE ON COMBINING 'WHO' AND 'HOW' PEOPLE ARE AT WORK TO ACHIEVE GREAT PATIENT HEALTH

13.0   Having accepted that we can help ourselves to make better decisions by designing NHS recruitment and promotion processes differently – by putting in the 'curtain' - it is useful to investigate how we achieve the diversity dividend through working in effective teams. This is a particularly thorny issue for NHS trusts because staff work less and less in stable teams, as a result of flexible working, shift patterns, agency workers and a range of other changes to staffing. But the principle of Joint Selection can be applied. The Trust may, instead focus on diversifying bands of staff, or particular functions (like Matrons) and so on. The key underlying principle is that staff are valued and assessed beyond their technical competence/ brilliance and once that has been established the trust needs consciously to recruit and promote on the basis of who and how they are – their identity and their style of working.

13.1   The NHS is understandably concerned about the technical ability of staff. They deal, after all, on a daily basis with life and death. However, as one senior NHS Trust Board member put it: *"when there is a culture where what is mainly valued are qualifications and what's seen as hard knowledge, and that dictates the hierarchy...I'm just wondering whether part of the problem is that when you only value that, what you miss is the completeness that you need in a team, which makes a patient get better and delivers better care"*.

A senior Executive from NHS Improvement said to us: *"I think it's really simple. People from different backgrounds, which are not just the traditional ones ……simply bring different experiences, perspectives and lenses. For me it's a really straightforward sum of the parts. If everyone's the same, you will just get the same - you won't get a variety of sorts and that to me is the key dividend"*.

When "hard knowledge" dictates status and power in an organisation what can be lost is:

(i)   the breadth of understanding that provides greater engagement with the range of different patients,

(ii)   the different voices contributing to deciding on a course of action that is in the best interests of the patient

(iii)   the levels of understanding and empathy that comes from the awareness of difference.

All of these emphasize the value of difference to patient health.

13.2   The crucial understanding of the research on diversity is not that one group (men or women, people with BME backgrounds or white people...) is 'better', 'more empathetic' and so on, but that the combination of difference in teams is where you get the dividend from diversity.

14. THE WELL-LEAD TEAM – REALLY VALUING DIVERSITY AND DIFFERENCE

14.0   In his lab in the Weitzmann Institute of Science, Professor Uri Alon has spent some time understanding how to build a motivated research group. He described in a 2010 article in 'Molecular Cell' (admittedly not everyone's holiday reading) three conditions to inspire what he called "self-determined behaviour", which is the great motivator:

- competence
- autonomy and
- social connected-ness.

14.1   His conclusions are very similar to two other studies:

- Project Aristotle at Google, where they analysed the characteristics of their highest performing teams
- "Evidence for a Collective Intelligence Factor in the Performance of Human Groups by Anita Williams Woolley (Carnegie Mellon University, Tepper School of Business) and Christopher F. Chabris (Union College, NY) and others, published in 2010, whose goal was "to test the hypothesis that groups, like individuals, do have characteristic levels of intelligence, which can be measured and used to predict the groups' performance on a wide variety of tasks"

The conclusions of this research are broadly similar. Teams perform at their highest when they have:

- an understanding of each other
- an equality in the contribution (verbal and otherwise) to the work and
- a level of well-managed diversity

14.2   Combining the insights of these different strands of research leads us to the need for a change in processes in three ways:

- that design in 'the curtain'
- which recruit people to teams
- that the teams value difference and are 'well led'

14.3   The challenge for the NHS is the complexity of the organisation of work. People do not work in one team or group. As one Board member, long experienced in creating change in diversity, said to us: *"what you're talking about, when you bring that down to more granular levels and you segment it, is 'can we work on this basis of having teams who are made up of different people who then can complete the task?' I think that's pretty new for the NHS. Yes, I've seen it work in other sectors. The question for the NHS is how appropriate that might be in different clinical settings, because they're so complex"*.

14.4   There is clearly a need to re-evaluate the progressive splintering of working in more stable teams in the NHS that has taken place over the last decades or so. Particularly since Michael West's work on effective teams has clearly revealed the significant health dividends they deliver. In "Illusions of team working in health care" (Michael A West, Joanne Lyubovnikova (2013), Journal of Health Organization and Management, Vol. 27 Issue: 1) the authors revealed that, while "91% of people in the NHS say they work in a team....the true estimate is probably nearer 40% at best". Furthermore "around 50% of NHS staff say they work in teams but also say their teams do not have clear objectives or don't work closely together or don't meet regularly to review their performance. These are basic characteristics of teams". In a blog for NHS Employers that Michael wrote in August 2013 - "NHS team work - apple pie in the sky" – he wrote "Our research over the last 25+years shows that good team work in health care requires clarity about the basics of good team work and focused and sustained effort to achieve those basics in practice. The pay offs of such good team working are enormous".

14.5   According to his research, good teams display the following characteristics:

- are clear about their task as a team and state this as an inspiring (and where appropriate) patient-centred purpose
- are clear about what skills they need in the team to achieve this purpose and therefore make appropriate choices about who should be the team members
- should be clear about who the members of the team are. Most teams we encounter in NHS organisations do not agree about who is in their team
- do not go above 8 or 9 members as effective communication and coordination become more difficult
- members understand clearly their roles and the roles of other team members, so there is no ambiguity about who is responsible and accountable for what tasks.
- set five or six clear, challenging, measureable objectives every year. The aim is not just to get the job done but to achieve significant improvements year on year in quality, safety and in patient experience (in the case of front line teams; but the need for improvement applies to all teams in the NHS)
- improve the effectiveness with which they work with other teams within (and sometimes outside) the trust
- have a positive supportive, humorous, appreciative atmosphere which can be measured by West's 'Team Positivity Ratio'
- meet regularly, reflect on the quality of care they provide and how to improve it

14.6   This is a challenge to the way the NHS has come to work. There is no doubt about it. But one of the ways it can be broken down is by using the idea of 'team' in both a wide and a narrow way.

There are:

- teams that operate as teams – clinical, admin / executive and services
- groups of people - middle and senior management for instance – where the deficit, as referred to above, is glaring across the group, and who then are part of management teams
- Boards

14.7   These differences require a flexible approach to the issue. Just as diversity is not the silver bullet solution to every issue in the NHS, the application of a single approach to diversity is also not enough. We are trying to do two things at once:

- to rebalance the deficits so that there are equal opportunities for all talent in the NHS, and ensure that we appoint and promote people on their individual suitability for the role not on the basis of our own preferences
- to create teams and groups of staff that are both 'demographically' fair, and also reflect what has come to be called 'deep level diversity', which focuses on the individual and allows a more granular understanding of human diversity through psychological and personal qualities - personality, approach, style, values, and abilities

14.8   We need to right the wrong of the deficits to gain the value of the talent we are missing out on. And we also need to develop and satisfy individual ability and aspiration. Diversity – both group and individual – then becomes a lens through which we look at all talent acquisition and development and how to create teams right up to the executive and the board.

14.9   The teams that explicitly work as such are often pulled together for a day, a shift or an hour, but staffing them in a way in which diversity, rather than habit or convention, guides a manager's thinking will change the combinations of people that they put together and, in time, feel comfortable to rely on.

14.10   This latter point is significant. Our preferences push us towards creating teams of people we already know and "trust". Working in one of the main Broadcasters a few years ago, a Director of News was quite open to us about the fact that they wanted to work "with people like me", because they said "it was a whole lot easier under pressure. I know how they think, we speak the same language and I am short on time." Then they added "It's not very good is it really?!" It's not. Although it's understandable.

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14.11   As Michael West and Jeremy Dalton's work shows, this behaviour can be understood through "social identity and social categorization theories, which suggest that people unconsciously favour members of their own social groups (Tajfel & Turner, 1979)". As one HR director said to us: "We've seen that, haven't we? So, if somebody is different to them, sometimes that gets mistaken for not being able to operate efficiently in that environment".

One female chief executive added: *"So, no one actually says to you I'm not appointing you because either you're a woman or you're gay…But of course, this is the whole point of what staff will tell me about how they feel working in other organisations. You just feel as though you're not valued and like you belong. You feel like there are judgements being made about what you're able to contribute because of that. People say 'they're just a difficult team member'. Actually, when you start to dig underneath that a bit more, usually what you find is they're just different".*

14.12   It is fundamentally important that if you create diverse teams, they are led well. Someone ultimately needs to make sure that the right decisions are taken and carried out. One of the most beguiling things about diversity is the tensions it creates. Often the gains produced by higher team diversity are disrupted by the inherent social conflict and decision-making deficits that less homogeneous teams experience. Leadership is the only force that can mitigate the tension between "the divergent thinking, openness to experience, and mind wandering (that) are needed to produce a large number of original ideas" and "the convergent thinking, expertise, and effective project management, (which ensures) those ideas will become actual innovations" (source: "Does Diversity Actually Increase Creativity?" June 28th 2017 Harvard Business Review by Tomas Chamorro-Premuzic CEO Hogan)

As one medical director said to us: *"I am curious about people because I ask about who they are, where they come from. I try to understand some of their journey in order that I can understand what values they bring to work and therefore what is it I need to do to be able to engage with them. That's simply, I would argue, good engagement, good leadership. Turn it around, if you don't do that, how are you ever going to understand the person in the team?"*

He told us a story that illustrated the challenges of teams of difference: *"I know somebody who was appointed into a team three years ago simply because he was different for the team. It was quite a hard challenge to get him appointed because he didn't fit the mirror image of all that had been going on for several years. He was really keen to be part of the team because he felt it was an opportunity to build and to contribute because of his difference. But a year ago, he was about to leave simply because, despite the good intent in the beginning, nobody made the effort to say this isn't just one off, this is something we're doing strategically as an organisation and adapt the team accordingly"*

14.13   The composition of teams, of boards and of bands of mid and senior management matters. And leadership needs to set the tone and direction to lead on the diversity of their composition.

One senior member of NHS Employers made the point to us that: "the best solutions are those that are led by an active and committed chief executive and Board. What happens in those organisations is that they don't just take a piecemeal approach to diversity. So, they don't just say, we're going to run a development program for women or a BME leaders program. They take a generally holistic approach to this and they take an approach that is value-based, that is inclusive and that is around changing the whole organisational culture".

14.14   Of late – resulting especially from the very effective work of the 30% Club and the 2015 government sponsored Davies Report on Women on Boards - there have been numerous research papers, comment pieces and expressions of intent that emphasize the importance of real diversity round the Board table.

In 2017 the headline question for Russell Reynolds, the head hunters, in their report "Different Is Better: Why Diversity Matters in the Boardroom" was 'why it is important to have a diversity of perspective in the boardroom?' And in answering that, and starting from the perspective of greater gender diversity, they "realised that (their) findings on this issue transcend gender to address a broader subject. How does diversity of perspective in the boardroom lead to a good dynamic and better governance? How can boards better structure themselves to benefit their constituents? Finally, how can candidates and nominating committees respond to the opportunities and needs that already exist?"

Their findings are common to all of the research:

- A wide range of perspectives, not merely token representation, is critical to effective corporate governance.
- The trend toward diversity is essential as boards look to navigate the complex and dynamic issues that companies now face.
- Boards become greater advocates for diversity as they have more direct beneficial experiences with it.

14.15   It is not the intention of this report to go into greater length on the necessity of diversity on Boards, as there is all this current material, other than to say that diversity to be effective must not just be a tick-box exercise – "we must get a woman"! – but subject to the same rigour as recruiting the most senior executive team as detailed above.

And the development of the Board's appropriate diversity needs to be pursued and overseen with governance as rigorous as those senior appointments. The Good Governance Institute's "governance of diversity and inclusion: Maturity Matrix" outlines the following key elements:

- the board has a talent development plan
- the chair uses the appraisal of directors and board recruitment opportunities to retain and attract board members from diverse backgrounds and communities
- the board's systematic process for recruitment and retention has led to greater diversity within the board
- the board, through the appointments committee, has evaluated the impact of its talent development plan

https://www.good-governance.org.uk/services/the-governance-of-diversity-and-inclusion-maturity-matrix/

14.16   The pursuit of diversity (both demographic and deep level) in the staff and in governance as an overall approach throughout trust, will give the exec and the Board all a lens through which to look at:

- recruitment and promotion
- development of talent
- the formation of teams
- the good management of teams
- overall leadership

Recommendation Three

The **Executive** and **HR directors** review their processes of recruitment and promotion with a view to:

- changing to processes (like Joint Selection – see above at 12.0 - or another form of fundamental change) that explicitly create teams and groups of staff based on diversity of experiences, identity, background and skills, as the norm
- ensuring that all appointments and promotions (including interims, internships, acting up etc) go through a formal process, while still remaining flexible enough to provide opportunities to develop talent
- re-directing resources away from 'diversity awareness' training to mandatory leadership training for all those who lead teams and groups – the training to have at its core:

  o   diversity as a talent management and development tool
  o   an understanding of unconscious bias
  o   compassionate and collective leadership
  o   accountable decision making

- The strategic objectives of these changes, and proposed measurement of their success, to be reported to, discusses and agreed by the Board

  The Board should use a similar process to outline (and governance) a succession plan which creates appropriate diversity among the members to meet the Trust's current and future challenges and opportunities

Recommendation Four

- Exec to set goals to define an appropriately representative shape of their staff in relation to the population they serve and, by opening up opportunities, to achieve this at every level within five years. Board to sign these off
- Trusts to develop measurement of their progress in diversity at all levels paying attention both to:

  o   demographic measurement and
  o   proxies for progress like patient experience satisfaction scores, deep focus work with newly constituted teams on their satisfaction at work, levels of safety and reporting, clinical effectiveness, patient health outcomes, retention, successful and equal promotion of staff etc.

- Exec to take immediate action to set goals to ensure, within one year, groups of staff are not discriminated against in promotion, recruitment or disciplinaries. Report progress to Board

15. CONCLUSION

15.0   The role of this report is to stimulate discussion that leads to fundamental change in the way that the NHS recruits, promotes, creates teams and leads its staff. It is a catalyst not a catalogue of ready-made solutions. These challenges are both considerable and vital to the NHS. But as one senior Trust Board member said to us: *"it's actually not that hard to do if you're bringing the capability to do it and you have the will to do it"* They continued *"if it's a service improvement tool, then actually that needs governance around it. If you don't see it as either a tool or it hasn't got any governance around it, then people are not going to understand how to use it."* Intelligent measurement and a commitment to progress in the quality of care, innovation and engagement of staff are vital.

15.1   The recommendations included in this report form a basis for discussion. It is the first part in an iterative debate which will reach some conclusions by tempering the raw material of this draft on the experience of those who contribute to the next round of discussions, whom we invite to debate the ideas and recommendations fearlessly with only the opening up of opportunity for all talent in the NHS as our goal. We ask only that you don't just consume this report but, through rigorous discussion, give birth to a next draft, strengthened by your wisdom and service in the NHS.

Questions for consideration

1. What have been the biggest blocks to delivery of greater diversity in your Trust?

2. What have you done to understand them?

3. How will you set about assessing the patient health and staff dividends of diversity

4. Where is your missing diversity dividend? How can you get hold of it? How can you spend it?

5. How stable and effective are the teams in the Trust and what can be done to stabilise them and diversify them to achieve better performance?

6. What are the best examples of stable teams in your Trust and how can the rest of the Trust learn from them?

7. When you look round every committee, task group, leadership meeting etc. do you see that you have only brought together people who are the same or have you created a group that reflects the diversity you need for the outcome?

8. What is the role of the Board in pursuing diversity?

9. What measurements should the Board be using as a framework to evaluate progress on tackling the diversity deficits and reaping the diversity dividends – in the staff and themselves?

10. What it the role of the trust senior management in doing the same?

11. How can a whole local health system be accountable (for creating greater appropriate diversity STPs, ACSs, CCG, Acute Hospitals, Local Government, Healthwatch, academic institutions where relevant) for increasing diversity?

12. Should there be more regulation? Should CCGs make it part of the commissioning process that money is partly dependent on progress on the targets above in 9?

Simon Fanshawe
March 2018

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