In light of the NHS Workforce Race Equality Standard and its incorporation into CQC inspections, are we truly developing more inclusive leaders and ultimately- a more inclusive NHS?

Friday 30th September, 2016

How was the session managed?

The event was facilitated by Deputy Director of the East Midlands Leadership Academy (EMLA), Lyndsay Short, and began with an introduction to the context for the day which covered background on what the Workforce Race Equality Standard (WRES) is and how it is being incorporated into the CQC inspections as part of the "Well Led" domain. Delegates split into three groups and were asked to consider the following questions:

1. What's our definition of inclusive leadership in the NHS? What's the outcome we are looking for?

2. What more (if anything) do we need to do to promote inclusive behaviours?

3. How does this discussion help us to recommend actions to support and underpin the Workforce Race Equality Standard (WRES) in practice?

Attendance and participation

The event was reasonably well attended (18 participants). Amongst the audience there was representation from the East Midlands Leadership Academy, a range of NHS Trusts and independent leadership consultants. Their names are listed later in the document and we would like to thank them all for their valuable contributions to the discussions.

What we learned

The 2014 published report by Roger Kline entitled, "The snowy white peaks of the NHS" found that the BME population is largely excluded from senior management and trust board positions to a degree that is serious and systemic. The report suggested that despite a multitude of interventions across the years, institutional discrimination in the NHS remains an issue.

In 2015, the WRES was launched as a gold standard for inclusive practice within the NHS and organisations were asked to consider their position in relation to these standards. In 2016, the standards became part of the inspections undertaken by the CQC and their implementation is now mandated as part of the "Well Led domain". Organisations are now expected to produce evidence to illustrate their performance in achieving the standards.

During the session we watched the two short clips on the NHS England website that explained the background and intentions behind the WRES. You can find them by following this link, https://www.england.nhs.uk/about/gov/equality-hub/equality-standard/

With this context in mind we asked ourselves some key questions and developed some recommendations that would help our Health and Care communities to implement and move beyond the WRES.

1. What's our definition of inclusive leadership in the NHS? What's the outcome we are looking for?

Participants acknowledged that race was only one area of the inclusion agenda but that we haven't got our actions on race right yet. It is the appropriate time to focus on this area and the statement in the snowy white peaks report is helpful in confirming that there are still issues of institutional racism that we need to face.

The group also reinforced a statement made in the video that the WRES should not be simply about tick box numbers. It should enable us to get the right insight and leadership at board level so that we can start to develop the necessary cultural changes.

There was a lot of commonality across the group in terms of how we define inclusion and the key attributes of what an inclusive NHS would look like. These attributes appeared to centre around five core themes.

- Accessibility- An inclusive service is one that has no barriers to treatment and where health inequalities are minimalised. Everyone should be able to use the service free in line with the NHS constitution and the founding principles of the NHS.

- Cultural competence- An inclusive NHS is one in which the culture promoted by its leaders creates a safe place for everyone to bring their whole authentic selves to work. In order to create this cultural competence, individuals need to feel that they can ask questions, listen and support as well as being open, honest and constructively challenging and encouraging. We need to develop a collective responsibility that helps us to not just "do" what needs doing but "think" about how we are doing it.

Our cultural competence can be enhanced by using lived experiences and perspectives to gain insight, role modelling and sharing inclusive practice and celebrating difference in all its many forms.

- Engagement and representation - We need a service that is engaging with and representative of its local communities and patient needs. The voice of patients, carers and staff should all be equally heard in the development and transformation of the service.

- Recruitment and talent management- Health and Care need to harness the potential of their employees and work towards being an "Employer of choice" with equal employment opportunities and an objective, inclusive recruitment process. There should be an awareness of unconscious bias and all staff should be open and honest in their beliefs and values.

- Innovation - An inclusive health and care service should be innovative. We should identify and prioritise where new approaches are required. Health and care should be leading and driving change through being an exemplar or beacon for the benefits of a truly inclusive service.

2. What more (if anything) do we need to do to promote inclusive behaviours?

The fact that the WRES is now part of the CQC inspections was applauded as a firm step towards developing our vision of an inclusive health and care service. However there was also a sense that it won't be enough on its own to get us to where we need our services to go. The group's ideas on this question considered the following:

Our Staff

Our workforce is committed to delivering effective patient care and there was a sense that if we could get them to understand the link between high quality patient care and an appreciation of race and difference then we would be able to start changing our culture. The key staff groups to this are middle managers who have a very influential role in translating the vision of senior leadership into practice.

Our Service Users

We need to reach out and meet with BME communities both in our workforce and in our local communities including our local refugees. The group considered that having a less contentious and unifying subject, such as food, to rally around could be a useful engagement technique. Food is often linked with culture and race but engenders a curiosity and fun that can be a unifying point of discussion.

We considered the use of inclusion data. The decision on which issues that the service measures and collects data on are not always patient led and sometimes don't need to be. Easy jet was used as an example.It offered its customers a choice between extra safety checks or a hot drinks service. The customers chose the hot drinks service. Consequently the organisation decided that the priority was to ensure the safety of its passengers and decided against the course of action recommended by their customer engagement data.

Our Practice

Data was discussed and it was agreed that the data requested to comply with the WRES is helpful but gives limited information on quality. For instance, reporting on the number of BME staff who have accessed training is important, but without the detail it's not clear if this was the right training, the most useful training or indeed the requested training. We need to understand the data further and ensure that it captures what we need and then act assertively and appropriately on it.

We need to ensure that all of our leaders have the necessary leadership skills to take forward inclusive practice and to do this, we need to have a coaching and person centered approach. The group discussed but didn't come to a clear conclusion as to whether and in what format inclusion training should be part of the induction of every new staff member. It was strongly felt that the benefit of inclusion should be clearly spelt out to managers and leaders but that this needs to be meaningful process and not a tokenistic, sheep dip approach.

Our Thinking

We need to understand the conscious/ unconscious bias and discrimination inherent in all of us and by understanding this, we can address it and be more transparent in our thinking and practice. We need to create the space for us all to be aware of this and have the time to understand each other better too.

Our Actions

It's no longer acceptable for people to simply not be racist. To develop the inclusive culture we need, these non-racists must take an active role in shifting the language from "what I CAN do" to "what I AM DOING" to make a difference. Actions speak louder than words in this respect.

By challenging the way things are done, with curiosity and bravery, we will be better to understand and translate the WRES into practice. Mentoring, coaching and sponsoring our staff will help us to transform the service in the way we now need it to change.

Our Communication

We need to develop our communication skills at all levels. Easy, simple questions, listening, and promoting open, honest conversations will help to increase confidence in talking about issues of difference. Another simple way of understanding each other's lives is through the use of

social media where we can read about how others experience the world and learn more about different cultures.

We also need to better harness the potential of events such as black history month and use story telling techniques to express the meaning and personal connections with inclusion issues which can help to ignite the fires of burning desire for change.

Our Responsibility

It is the personal responsibility of every individual, every leader to reflect on their actions, challenge the behavior and thinking of others and to develop their own competence. Everyone should be held accountable for their own actions and responsible for striving to understand and expand their own inclusive practice.

Recommendations

In answering the final question posed, the group suggested the following recommendations for anyone interested in considering how to implement the Workforce Race Equality Standard and promoting an inclusive NHS.

1. **DATA-** Use data metrics and impacts to drill down into what has changed in practice and what more might be able to be changed. Act on data by making meaningful recommendations.
2. **PERSPECTIVES-** Encourage shadowing/ volunteering across and into other organisations which meet the needs of different sectors of the community so that staff get a broader view of the communities we serve.
3. **COMMUNICATION-** Establish conversation ground rules to create a safe and inclusive environment these could include encouraging questioning, curiosity and bravery in how we approach difficult or “wicked” situations and open constructive discussions.
   Story telling
4. **RECRUITMENT AND TALENT-** Establish recruitment processes based on the demonstration of values and competency rather than regurgitating them parrot fashion. Prospective employees should be required to give examples of what they have done rather than say they can do it.
   We need to develop our own organisational talent maps and encourage these to be shared and peer reviewed so that we can identify gaps and patterns in representation across our own organisations and across our regional health and care provision. We should also offer coaching, mentoring and sponsoring more systemically across our organisations to encourage and support diverse talent to emerge and flourish.
5. **PURPOSE AND MEANING**- Encourage clarity of purpose at an individual level by creating role modelling champions and encouraging people to move from non-racist to activists. Engaging people to develop burning fires for change based in a personal connection with the issues and a desire for change.

6. **RESPONSIBILITIES-** The NHS constitution and the principles of the NHS are fundamental cornerstones of our practice and they embody a service that is inclusive and which embraces everyone. We need to reinforce the individual and collective responsibilities of everyone to treat people fairly and equitably by stressing that inclusion involves all of us.

Lyndsay Short
Deputy Director
East Midlands Leadership Academy

FOOTNOTE- Excerpt from the NHS Constitution

"The NHS belongs to the people. It 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. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most. The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it."

"It is available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population"

Reflections

How is this topic relevant to your area of work?

What surprises you about this "Think Tank" topic?

What have you learned from this summary?

How has it/ will it change your own leadership practice?

If you keep a professional portfolio you might like to use this reflection as evidence towards revalidation or reregistration.

With thanks to our contributors

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