

# **The Leicestershire Inclusion Leadership Development Programme - IncLeaD**

## **The Toolkit - a guide for NHS leaders**

**June 2012**

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## Forward

The IncLeaD Toolkit is designed to be a guide for NHS leaders seeking to make inclusion a more substantial part of their service delivery and development.

Inclusive practice and leadership for inclusion are increasingly important in the context of the current health and social care reforms which herald a substantial shift in the way in which health and social care services will be delivered in the future. Inclusion of service users, their carers and local communities is at the heart of the new system. Health and social care organisations including both providers and commissioners will be increasingly judged on the degree to which they can demonstrate being inclusive in their approach to service planning and delivery.

Inclusion is not a soft option; it requires strong leadership and needs to be matched with resources and commitment. However, the rewards are immense. Health and social care organisations that make inclusion part of their day to day business will be able to demonstrate that they are adding public value and that the voices and opinions of those who use and rely on health and social care services matter and are being taken account of in decision making throughout the organisation.

For leaders in the NHS and in particular the Boards of NHS and Foundation Trusts making inclusion a key part of their strategic goals and aspirations is a challenge but is one well worth undertaking. Having been personally involved in the Leicestershire Inclusion Leadership programme I have experienced at firsthand how powerful and empowering this approach can be. It is possible, even in the midst of the most difficult economic circumstances to build relationships of trust across communities and to give patients and service users sense of belonging and pride in the organisations they use and need.

Placing inclusion at the heart of leadership in the NHS will help ensure public trust is maintained and will have a direct bearing on the aspirations we all share to raise standards and quality in all our services. By using this toolkit it is possible to develop a coherent and strategic approach to inclusion that will bring about change and positive developments for the organisation's leaders including the Board and executive, for all staff and for service users, their carers and local communities.



Professor Lord Patel of Bradford

March 2012.

## Who is this toolkit for?

This toolkit is intended for use by NHS and Foundation Trust leaders including:

- NHS Trust and Foundation Trust Chief Executives and their direct reports on the executive management team;
- NHS and Foundation Trust Board Directors including Non-Executive Directors with lead roles for inclusion, equality and human rights;
- Senior managers and those with lead responsibilities for equality, inclusion and human rights.

The toolkit should also be of interest to:

- Local Authority Social Services Directors;
- PCT Cluster and Clinical Commissioning Group Board Directors and executive leaders;
- Directors of Public Health;
- Lead directors for equality and human rights in health and social care services.

It is intended that rather than use the toolkit in isolation individual leaders will collaborate with others in the area to create an integrated approach to inclusion leadership which is a defining feature of the IncLeaD model.

## Why use the toolkit - key drivers

The toolkit is designed to provide a mainstreaming approach to inclusion leadership that supports a range of drivers in health and social care legislation and policy. This is especially important in the current time of significant change and reform as IncLeaD enables a focused and coherent response to the dominant organisational change dynamics.

The toolkit should be used to provide a coherent framework to leadership development that specifically seeks to address the current drivers for inclusion including:

- patient and public involvement in health care including decision making about the commissioning and provision of services;
- reducing health inequalities and meeting the Public Health Outcomes Framework priorities;
- fulfilling the Public Sector Equality Duty and other regulations under the Equality Act 2010;

- meeting the goals for inclusion leadership under the Equality Delivery System.

## What will using the toolkit achieve?

The toolkit provides a framework for leadership development that uses the focus of inclusion as a key driver and organising principle. This has the advantage of ensuring that a values based approach is embedded in the leadership development programme that places inclusion, engagement and involvement of service users and communities at its heart. By using the toolkit health and social care organisations can achieve the following:

- ❖ having a clear strategy for inclusion that encompasses the leadership role of the Board and senior managers through to all staff, service users, carers and local communities;
- ❖ meeting a number of policy and legislative goals including delivering on:
  - the Government's commitment to localism and local decision-making (DH, White Paper, "**Equity and excellence: liberating the NHS**", 2010);
  - the Government's commitment to fairness and personalisation, including the equality-focused rights and pledges of the **NHS Constitution** (DH, 2010);
  - improved and more consistent performance on equality for patients, carers, communities and staff. In particular, delivering better outcomes for patients, carers and communities with regard to the **NHS Outcomes Framework** (DH, 2010); **Public Health Outcomes Framework** (DH, 2012)
  - the principles, objectives, requirements of the **Human Resources Transition Framework** (DH, 2011)
  - the **Public Sector Equality Duty**;
  - the **CQC Essential Standards**.
- ❖ Improving patient experience amongst a more diverse range of community groups;
- ❖ Improving staff morale at a time when faith and trust in health and social care services is being challenged;
- ❖ Demonstrating that commissioning and service provision is in the interests of the communities where services are situated by reducing the most acute health inequalities.

# The IncLeaD Toolkit

## *Introduction*

The IncLeaD Toolkit has been developed from the experience of the Leicestershire Inclusion Leadership programme. The key findings and lessons learnt from that programme have been incorporated into a framework for action using a staged model.

The staged model consists of a narrative based approach to organisational change that uses the organisational conversations about inclusion as a key driver for change and organisational development. These conversations take place at all levels of the organisation and consist of the various ways in which Board Directors, senior managers, individual staff members and external stakeholders including service users and local communities make sense of how the organisation is addressing inclusion.

Without leadership these conversations can become negative and counterproductive resulting in resistance to change and even reputational damage if the organisation is perceived not to be inclusive. The IncLeaD Toolkit seeks to enable a process whereby inclusion is recognised as a core value of the organisation. This is key to understanding public service provision as being about creating and adding value.

## *The stages*

The stages for the IncLeaD Toolkit are based on the levels and types of conversations that influence organisational change and development. These are:

1. ***The Board room:*** the strategy discussion - how inclusion informs strategic thinking and planning.
2. ***From the Board room to the office:*** the management discussion - how inclusion is implemented and managed.
3. ***From the office to the staff room:*** the water cooler discussion - how staff groups informally interpret and make sense of inclusion.
4. ***From the staff room to the consulting room:*** the clinical discussion - how service users are empowered to be involved in their care.

5. ***From the consulting room to the bus stop:*** the community discussion - how local communities perceive the value of the organisation and their engagement with it.

Although the toolkit addresses each stage discretely they are not intended to be linear as each one has a direct influence on the other e.g. how the Board develops and expresses its strategy on inclusion will influence and determine the way in which managers implement this and how staff communicate with and involve service users. Also, the ways in which local communities perceive the organisation will have an increasing influence on how the Board makes decisions as public accountability and transparency become more significant in addressing the democratic deficit in health care services.

Each of the stages is described more fully below.

### ***Stage 1: The Board room***

Facilitating the Board room discussion on inclusion depends on a number of factors including:

- how the Board uses its development sessions e.g. is there a culture of exploring the underpinning values behind strategy and planning about services?
- how insulated are the Board from direct discussions with staff, service users and local communities?
- have the Board identified an inclusion or equality lead person and how does this influence the way in which other Board members respond to the issues?
- has the business case for inclusion been made at Board level e.g. what data on inclusion are included in the performance dashboard?
- in the case of Foundation Trusts, do the Council of Governors take an active interest in issues about inclusion and are there regular meetings between the Board and the Governors?
- how do the Board manage their outward facing communications e.g. are Board sessions held in public and what degree of engagement is there with local communities?

The following table provides some actions that can be taken in addressing the above factors as part of the preparation for the Board room discussion on inclusion.





**Table 1: The Board room discussion - Factor, issues, action and outcome**

Factor	Issues	Action	Outcome
<b>Culture of debate</b>	Some Boards are more comfortable with strategy, planning and discussing the business rather than values. This can make the introduction of a values based discussion about inclusion problematic.	<p>Undertake some 1:1 work with individual Board members prior to the development session. Use these sessions to explore their understanding about inclusion and what specific learning and development needs they identify.</p> <p>Make the issues personal by encouraging the Board members to relate their own experiences about inclusion e.g. an experience that left them feeling excluded.</p>	<p>The Board sessions can be tailored to meet individual needs and preferences including reflective feedback to the Board on the readiness to address the issues.</p> <p>Board members share their personal experiences and engage on a level of lived experience that brings their personal values to the fore.</p>
<b>Insularity</b>	Board members will have varying degrees of contact with staff, service users and local communities. Some may undertake regular visits to services and talk with people but others may be more insular and lack this experience.	Bring materials into the Board session that emphasise personal experiences of working in the organisation, using services and caring for someone who uses services. These should be in the form of directly related stories about experiences rather than facts and figures.	The Board are thinking about what it feels like to work in the organisation and to use the services provided either as a patient or a carer. Using real stories about people's experiences engages the Board at an emotional level which strengthens the commitment to the values of inclusion.
<b>Board leads for inclusion and equality</b>	Some Boards have identified leads for inclusion or equality. This can be useful in ensuring there is a continual focus on the issues but it can also prevent other Board members from feeling fully involved.	If there is a Board lead for inclusion or equality involve them in the preparation and planning for the session. Also discuss with them how they are going to use their role in the session e.g. how to encourage other Board members to take a full and active role rather than defer to the lead member.	All Board members are equally engaged in the discussion and where there is a lead Board member for inclusion or equality they understand how best to use their role in the context of Board development.

Factor	Issues	Action	Outcome
<b>The business case for inclusion</b>	Sometimes the business case for inclusion has not been made robustly and the performance dashboard may not adequately reflect the full range of inclusion data and issues.	Review the performance dashboard and identify gaps or weaknesses from the perspective of inclusion. Use the assessment to prepare the business case for inclusion making direct links between key performance indicators and the evidence for different target groups and communities. The equality analysis should inform this process and be used as part of the evidence.	The Board understand the business case for inclusion and have been able to review the evidence including the equality analysis that speaks directly to their particular organisation and service user and community demographics.
<b>Foundation Trust status</b>	All Trusts are to become Foundation Trusts and will have a Council of Governors. Engagement with the Governors on inclusion is just as important as engaging the Board.	Consider whether the development session should include Governors. If the Trust is working towards Foundation status include time in the session to explore the way in which the Board will engage with Governors on the issue of inclusion.	Council of Governors and Boards are able to jointly agree the approach to inclusion and share the same value base.
<b>Public engagement</b>	There are various ways in which Boards engage with the public. Some hold their meetings or part of the meeting in public and it is expected that all Boards should increasingly be more accountable and transparent.	Inclusion needs to be understood from the perspective of creating and adding public value. Boards need to consider how they engage with the public and how being open and transparent can assist them in sustaining public support. These issues and ways in which the Board can develop more open ways of communicating with the public and local communities should be part of the session.	The Board understand the perspective of inclusion as being about creating and adding public value.

## Facilitating the Board discussion

There is no single method for facilitating the Board discussion as this will depend on the style and culture of each Board and available resources. There may be an advantage in having an external facilitator conduct the session as this can bring fresh eyes and experience and also additional expertise. However, it can be equally valuable to engage existing staff and managers in conducting the session especially where there is a good programme of work on inclusion and equality. This also has the advantage of being able to showcase to the Board examples of local work and expertise in this area.

## Chief Executive and Chair engagement

Chief Executive and Chair engagement in the Board discussion and in every stage of the IncLeaD Toolkit is essential to success. Factors that are likely to increase Chief Executive and Chair engagement include:

- **demonstrating added value** - inclusion is increasingly an area where commissioners are looking for added value e.g. organisations need to show that they can reach all sections of the local community including those traditionally less well engaged;
- **partnership working** - inclusion is best done in cooperation with others acting in partnership especially local voluntary sector and community groups;
- **reducing health inequalities** - the Public Health Outcomes Framework is about reducing health inequalities and this will only be achieved if services can reach those sections of the community who are most affected;
- **quality and standards** - the regulatory and inspection frameworks for health and social care are increasingly concerned with the way in which Quality Accounts and assurance on standards is reaching all service users;
- **public accountability** - the Chief Executive and Chair are the public faces of the organisation and have to demonstrate an ability to communicate with a wide range of audiences and stakeholder groups.

The following template provides an example agenda and learning outcomes that can be used in establishing the development session.

## **Sample Agenda - Board development session on inclusion**

### **Aims**

The aim of the session is to facilitate a discussion about the value of inclusion as an organising principle and strategic objective. The session will promote the development of a shared value base for inclusion that can be used as the basis for strengthening public engagement and accountability, service user and carer involvement and staff development.

### **Agenda**

1. Introduction - What does inclusion mean to us? Feedback on personal experiences
2. Understanding the legislative and policy drivers - Health and Social Care reform, Equality Act 2010, Public Health Outcomes Framework, Localism and the Big Society
3. The business case for inclusion - Trust specific data on inclusion and review of the performance dashboard
4. Feedback from staff, service users, carers and communities - examples of lived experience
5. Creating and adding public value - strategic implications for inclusion and public accountability

### ***Learning objectives***

At the end of the session Board members will be able to:

- articulate the shared value base for inclusion and how this relates to the current legislative and policy drivers for health and social care;
- understand the current legislative and policy drivers for inclusion;
- understand the business case for inclusion and how this relates to the Trust strategic objectives and performance management;
- develop the Board's strategic thinking about inclusion and creating public value and accountability

## ***Stage 2: From the Board room to the Office***

### ***Five steps for managers on inclusive practice***

While it is important that inclusion leadership starts at the top with the Board and executive implementation of a coherent strategy for inclusion requires the full and active engagement and support of managers. How the vision for inclusion is interpreted and understood by those in middle management positions has a significant influence on the way in which they make decisions that impact on the experience of inclusion amongst staff and service users.

Moving the inclusion vision from the Board room to the Office requires some specific supportive actions and development opportunities. Some managers are more comfortable with an inclusive approach than others and this is not always addressed through standard management and leadership training and development programmes. It is also important that the policy framework is updated to reflect an inclusive approach and that managers are actively involved in establishing the inclusion strategy action framework.

The following steps are designed to support managers in developing the inclusion vision into practice. The steps are inter-dependent and may overlap rather than being followed in a strictly linear fashion.

#### **Step 1: Making the vision for inclusion operational**

The Board strategy for inclusion needs to be translated into an operational action framework for managers. The action framework needs to be created by managers themselves and it should be linked directly to their existing business planning and performance monitoring processes. In developing the action framework managers should ask themselves the following questions:

- which of my current business planning objectives have the most direct impact on inclusion?
- which performance monitoring data most clearly demonstrate progress on inclusion?
- in the business planning cycle where is the best point to next formally assess the impact of objectives on furthering inclusion?
- what understanding do the staff I manage have of inclusion and how can this be improved?

In making the visions for inclusion operational managers should be asked to review their current business plan and to ensure that inclusion is more explicitly incorporated. This may include the addition of actions or objectives that bring out a specific inclusion goal e.g. ensuring the development of a new care pathway incorporates a target community group known to have experienced lower access.

## **Step 2: Monitor for performance on inclusion**

Being able to measure progress on meeting inclusion goals is essential to the management and implementation process. However, existing performance monitoring systems are often restricted in scope and have only partial inclusion components.

Nevertheless, it is often the case that there is a lot of relevant data being collected such as postcodes which can be used as proxy measures for disadvantage and other data can be analysed in greater depth than standard performance dashboards allow. Monitoring for performance on inclusion is a key management function and needs to be undertaken on an ongoing basis. Some of the positive impacts of monitoring include:

- increased understanding about the ways in which service and quality outcomes can differ across communities and groups;
- early awareness about service blind spots where key communities and groups may be failing to appropriately access services;
- increased capacity to improve service responses to key health inequality targets;
- ability to demonstrate to staff, service users, Board and public that the commitment to inclusion is being realised.

## **Step 3: Personal competencies for inclusion**

Managers need to align their management and leadership personal competencies with those for inclusion. Personal appraisal of strengths and weaknesses in undertaking a leadership role for inclusion can be undertaken using the management core competencies framework and matching this with related frameworks for equality and inclusion.

## Personal qualities

### Self belief

LQF <sup>1</sup>	Inclusion competency matching	LF <sup>2</sup>
Relishing a challenge.	Not all managers feel confident about inclusion, relishing the challenge involves recognition that this may be a steep learning curve.	1.3.1 – Demonstrating Personal Qualities/Continuing Personal Development - Actively seek opportunities and challenges for personal learning and development 3.4.3 – Managing Services/Managing Performance - Take responsibility for tackling difficult issues
Being prepared to stand up and be counted.	Inclusion is about fairness for all and having the confidence to stand up for those who need additional help.	3.3.3 – Managing Services/Managing people - Support team members to develop their roles and responsibilities 3.4.3 – Managing Services/Managing Performance - Take responsibility for tackling difficult issues
Working beyond the call of duty, where this is required.	The challenge of inclusion means being prepared to go the extra mile and understanding the additional demands that will this will make.	4.4.2 – Improving Services/Facilitating Transformation - Articulate the need for change and its impact on people and services 6.4.2 – Creating the Vision/Embodying the Vision - Demonstrate confidence, self belief, tenacity and integrity in pursuing the vision
Speaking up if this is needed.	Working towards inclusion can result in resistance amongst staff and service users, managers need to speak up against discrimination whenever it happens.	1.4.4 – DPQ/Acting with Integrity - Take appropriate action if ethics and values are compromised. 2.3.3 – Working with others/Encouraging contribution - Employ strategies to manage conflict of interest and differences of opinion 6.4.2 – Creating the Vision/Embodying the Vision - Demonstrate confidence, self belief, tenacity and

<sup>1</sup> NHS Leadership Qualities Framework (LQF) was decommissioned in 2011 and replaced by the Leadership Framework (LF). We have included the LQF competencies here as this was used when this project was undertaken. We have also included relevant LF elements on the right hand side of the table.

<sup>2</sup> NHS Leadership Academy (2011) Leadership Framework [www.leadershipacademy.nhs.uk/LF](http://www.leadershipacademy.nhs.uk/LF)



		integrity in pursuing the vision 6.4.3 - Creating the Vision/Embodying the Vision - Challenge behaviours which are not consistent with the vision
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### **Self awareness**

<b>LQF</b>	<b>Inclusion competency matching</b>	<b>LF</b>
Being aware of own emotions.	Leadership for inclusion can place managers in positions of conflict e.g. mediation between groups or communities with opposed interests and values. Self awareness in this context requires recognition of the values framework for inclusion.	1.1.1 – DPQ/ Developing self awareness - Recognise and articulate their own values and principles, understanding how these may differ from those of other individuals and groups 1.1.3 – DPQ/Developing self awareness - Identify their own emotions and prejudices and understand how these can affect their judgment and behaviour 1.2.1 – DPQ/Managing yourself - Manage the impact of their emotions on their behaviour with consideration of the impact on others
Being aware of personal impact on others, particularly when under pressure - having an understanding of the ‘triggers’ to which you are susceptible.	Standing up for inclusion can produce internal conflicts with personal values and culture. Managers need to be aware of their own value base and how this may influence decisions and behaviour.	1.1.2 - DPQ/ Developing self awareness - Identify their own strengths and limitations, the impact of their behaviour on others, and the effect of stress on their own behaviour 1.2.1 DPQ/ Managing Yourself - Manage the impact of their emotions on their behaviour with consideration of the impact on others

### **Self management**

<b>LQF</b>	<b>Inclusion competency matching</b>	<b>LF</b>
Being tenacious and resilient in the face of difficulty.	Making inclusion a reality is not a quick fix and needs continual attention. Managers need to be prepared for the long haul and to plan for change over the	1.2.3 - DPQ/ Managing Yourself - Ensure that their plans and actions are flexible, and take account of the needs and work patterns of others

	medium to long term.	(Also 1.2.3 stage 3 contextual indicator - Demonstrates tenacity and resilience) 6.4.2 – Creating the Vision/Embodying the Vision - Demonstrate confidence, self belief, tenacity and integrity in pursuing the vision
Being able to cope with an increasingly complex environment – with the blurring of organisational boundaries and the requirement to work in partnership across the health and social care context.	Inclusion is not something that individuals or single organisations can achieve on their own. Managers need to recognise the role of partnership working and collaboration in making inclusion a reality including working across traditional boundaries.	5.1.1 – Setting Direction/identify the contexts for change - Demonstrate awareness of the political, social, technical, economic, organisational and professional environment 1.2.3 – DPQ/ Managing Yourself - Ensure that their plans and actions are flexible, and take account of the needs and work patterns of others 2.1.1 – Working with Others/Developing networks - Identify opportunities where working in collaboration with others within and across networks can bring added benefits 4.2.3 – Improving Services/Critically evaluating - Identify healthcare improvements and create solutions through collaborative working

***Drive for improvement***

<b>LQF</b>	<b>Inclusion competency matching</b>	<b>LF</b>
A deep sense of vocation for public service driven by an identification with the needs of patients and service users.	Recognition of the values in public service means having a focus on the full diversity of communities and the wide range of interests and groups that make up local communities.	2.3.2 – Working with others/encouraging contribution - Respect, value and acknowledge the roles, contributions and expertise of others 2.3.4 - Working with others/encouraging contribution - Keep the focus of contribution on delivering and improving services to patients 4.2.1 - Improving Services/Critically evaluating - Obtain and act on patient, carer and service user feedback and experiences
A primary focus on achievement of goals for the greater good of others, and not the leader's own	Inclusion is about creating and sustaining public value. Managers need to be able to articulate public value for the general good.	2.3.4 - Working with others/encouraging contribution - Keep the focus of contribution on delivering and improving services to patients

reputation.		
Investing their energy in bringing about health improvements – even to the extent of wanting to leave a legacy which is about effective partnership, inter-agency working and community involvement.	The approach to inclusion should be about sustainable change and improvement. Managers can build the legacy for inclusion from partnership development with both stakeholder agencies and communities.	4.2.3 - Improving Services/Critically evaluating - Identify healthcare improvements and create solutions through collaborative working 6.2.2 - Creating the Vision/Influencing the vision of the wider healthcare system - Work in partnership with others in the healthcare system to develop a shared vision 7.2.2 - Delivering the Strategy/Developing the Strategy- Strive to understand others' agendas, motivations and drivers in order to develop strategy which is sustainable 7.4.1 – Delivering the Strategy/Embedding the strategy - Support and inspire others responsible for delivering strategic and operational plans, helping them to overcome obstacles and challenges, and to remain focused

***Personal integrity***

<b>LQF</b>	<b>Inclusion competency matching</b>	<b>LF</b>
Believing in a set of key values borne out of broad experience of, and commitment to, the service which stands them in good stead, especially when they are under pressure.	The values of inclusion, equality and human rights run through public service. Managers need to recognise this explicitly in their articulation of service values.	1.4.1 - DPQ/Acting with Integrity - Uphold personal and professional ethics and values, taking into account the values of the organisation and respecting the culture, beliefs and abilities of individuals 6.1.3 – Creating the Vision/Developing the vision for the organisation - Create a vision which is bold, innovative and reflects the core values of the NHS
Insistence on openness and communication, motivated by values about inclusiveness and getting on with the job.	Making inclusion the day job means openness in communications and being explicit about the value base of service	1.4.2 – DPQ/Acting with Integrity - Communicate effectively with individuals, appreciating their social, cultural, religious

	delivery and planning.	and ethnic backgrounds and their age, gender and abilities 7.4.3 - Delivering the Strategy/Embedding the strategy - Establish a climate of transparency and trust where results are discussed openly
Acting as a role model for public involvement and the dialogue that all staff, including the front line, need to have with service users.	Managers need to lead inclusion through their words and actions. Being a role model means being able to express the aims and values of inclusive practice.	6.4.1 - Creating the Vision/Embodying the vision - Act as a role model, behaving in a manner which reflects the values and principles inherent in the vision
Resilience that enables them to push harder, when necessary, in the interests of developing or improving the service.	Resilience comes through inclusive practice as managers build their resilience through enacting the values of inclusion and in making partnership part of the foundation for improvement.	1.4.4 - DPQ/Acting with Integrity - Take appropriate action if ethics and values are compromised. 6.4.3 - Creating the Vision/Embodying the vision - Challenge behaviours which are not consistent with the vision 7.3.3 - Delivering the Strategy/Implementing the Strategy - Establish clear accountability for the delivery of all elements of the strategy, hold people to account and expect to be held to account themselves

#### Step 4: Making strategic alliances for inclusion

Inclusion will only be fully achieved through effective partnership working. However, this should not be random or solely based on historical relationships. Breaking patterns of ingrained discrimination and disadvantage will require new ways of thinking and fresh strategies for partnerships.

Managers are at the front line of making partnership work as they are the ones most often engaged with other stakeholders and peer managers in other organisations. In the new commissioning framework there is a duty for integration which will strengthen the drive for healthcare organisations to collaborate more closely and formally. Managers need to have a clear strategy for thinking through their partnership development in light of the new drivers and in order to develop a position that will have maximum impact on working for inclusion.

Making strategic alliances for inclusion also involves the community and voluntary sector. Partnership working with these groups and agencies is often built over time in response to local issues and/or campaigning and advocacy. In times of economic hardship a number of community and voluntary sector agencies are facing severe funding shortfalls and there is a danger that NHS organisations will be faced with difficult decisions in taking up the gap caused by reduction across the community and voluntary sectors.

Managers may also find that they come under increasing pressure to act as an advocate for community groups or voluntary sector agencies who are seeking allies in their fight against budget cuts and restrictions. This can place managers in difficult positions with respect to other partner organisations and with commissioners in health and local authorities.

Making strategic alliances for inclusion is a way of dealing with these pressures and challenges so that managers are acting pro-actively and are not caught out by the rapidly changing environment in which they are working. Managers need to address the following in making strategic alliances for inclusion:

#### ***Reviewing existing partnerships***

Reviewing existing partnerships should be undertaken on a periodic basis regardless of changes in policy and environment. However, the review provides an opportunity to consider the impact of partnerships on inclusion goals. Fitness for purpose in partnerships should include review of:

- the degree to which there is a shared value base on inclusion;
- how far partnership working has extended to sharing information about work with target inclusion groups and reducing health inequalities;
- history of shared projects and bidding - degree to which relationships have enhanced development and quality improvements in reaching diverse communities;
- contribution to developing service user, carer and community involvement;
- reputation of partners amongst local community groups.

### **Scoping potential new partnerships**

Scoping for new potential partners is something that should be an ongoing activity in recognition of the changing dynamics of community populations and to reflect service changes and improvements. While the same factors for existing partnerships will apply to any new partnership e.g. having a shared value base and the reputation of the partner amongst local community groups or service users and carers some additional factors should also be considered:

- the additional value a new partnership will bring to working for inclusion;
- the degree to which a new partnership can bridge a gap in meeting the needs of a target inclusion group;
- the potential contribution to longer term strategy development and meeting business planning imperatives over the medium to long term.

Development of strategic alliances for inclusion should involve a protocol framework that sets out the strategic priorities and enables a robust assessment of partnership gains for inclusion. This will also ensure that partnership development is in line with procurement strategies in general and ensures that there is a fair and transparent process in operation.

### **Step 5: Performance management and appraisal for inclusion**

Performance management and staff appraisal is one of the key management functions and this is especially important with respect to inclusion. It is not uncommon for appraisal discussions and Personal Development Plans (PDPs) to involve discussion about equality and diversity. However, managers and staff often struggle to link this to specific performance targets and progress measures. As a result performance management for inclusion often consists of monitoring attendance on equality and human rights mandatory training or testing awareness of the equality and human rights policy framework.

Performance management and appraisal for inclusion needs to be directly linked to PDP development and aligned with the strategy action plan for inclusion. This should include specific recognition of the skills base and competencies for inclusion. The following is adapted from the NHS Knowledge and Skills Framework (KSF), Core Dimension 6 on Equality and Diversity:

### **Key skills for inclusion practice development**

<b>Indicators</b>	<b>Examples of practice development</b>
Acting in accordance with the value base and strategy for inclusion	Able to articulate to others the value base for inclusion and to link this to relevant strategies, policies and legislation
Challenges discrimination and restrictive practices	Able to promote a culture of inclusion by being clear about boundaries for inclusion and non-discriminatory

	practice e.g. appropriate challenge of others and use of reflective practice to explore own prejudice
Understands and makes use of the data and information on inclusion	Able to analyse and interpret data on service use amongst diverse community groups and service users with protected characteristics
Takes steps to involve service users and carers in decision making about service development	Able to actively progress service user and carer involvement in all aspects of decision making about the service they use
Builds relationships with target community groups	Able to build and sustain relationships with external community groups and use this to promote partnership working and inclusion in service delivery

### **Stage 3: From the office to the staff room**

#### ***The water cooler discussion - how staff groups informally interpret and make sense of inclusion.***

Much has been learnt since the Macpherson report into the death of Stephen Lawrence on the role of institutional discrimination and what Macpherson referred to as the 'canteen culture'. The definition provided by Macpherson on institutional racism provides a very useful reference point for understanding the wider dynamics of institutional discrimination. Institutional racism was defined by Macpherson in that report as consisting:

*“...of the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amounts to discrimination through unwitting prejudice, ignorance and thoughtlessness and racist stereotyping which disadvantage minority ethnic people”* (Macpherson, 1999:6.34)

The key words are 'unwitting prejudice', 'ignorance and thoughtlessness' and 'stereotyping'. Macpherson is describing the back room culture which was perceived to have existed amongst rank and file staff members and which reinforced the poor decisions that resulted in failures in the investigation. Organisational culture and in particular the informal culture that prevails between staff groups as they interact in the organisation is one of the hardest things to influence. It is also one of the most important things to influence in terms of inclusion and developing a culture that values and promotes inclusion. In the words attributed to Peter Drucker '*Culture eats strategy for breakfast*'.<sup>3</sup>

Institutional racism is a contested term and there have been very few attempts to operationalise it for the purposes of organisational research. In fact, within the field of organisational studies as a whole, issues of institutional discrimination in particular have

<sup>3</sup> Although attributed to Peter Drucker the phrase was made popular in 2006 when used by Mark Fields, president of the Ford Motor Company.

been neglected<sup>4</sup>. This has left organisations with very few tools with which they can address the formation and continuation of informal staff cultures that are discriminatory and act against embedding the values of inclusion. Macpherson identified the ways in which unwitting discrimination can arise:

- *Lack of understanding, ignorance and mistaken beliefs;*
- *Patronising words or actions (even if well intentioned);*
- *Uncritical self-understanding arising from an inflexible ethos of traditional ways of doing things;*
- *A collective failure to detect and outlaw the above*

(Macpherson, 1997. 6.17)

By using the Macpherson definitions and understanding about organisational culture and change management it is possible to identify the key factors for influencing informal organisational cultures and the nature of the dialogue in the staff room. These factors include:

### ***Having clarity about the terms used***

Misunderstanding about inclusion often arises because the terms and definitions are not clear enough. While there has undoubtedly been a shift in the language of equality and human rights in healthcare towards talking about inclusion the meaning of this shift in terminology is not always explained well.

Just as equality of opportunity has sometimes been misinterpreted to mean treating everyone the same, so too inclusion is at risk of being misunderstood. Being inclusive does not mean that everyone is included in the same way; it means that the barriers to inclusion are addressed in appropriate ways. It is important that in developing the strategy and approach to inclusion organisations take steps to ensure that everyone understands what is meant. The terms and explanations used need to be simple enough for anyone either working in or using the services provided by the organisation to grasp easily.

Strategy documents and publicity including annual reports and other publications need to provide a clear definition about what inclusion means to the organisation and how this is being developed. An example definition used by the Leicestershire IncLeaD programme for an aspiring Foundation Trust is as follows:

What inclusion means for us:

- becoming an organisation that understands the healthcare needs of local and diverse communities and works with them as an equal to make sure they have access to the right services to meet those needs;

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<sup>4</sup> Bashford, J. 2008. *An investigation into the effectiveness of organisational change management processes for implementing race equality post the Race Relations (Amendment) Act 2000*. PhD Thesis.



- making the protection and promotion of civil, legal and human rights and equality part of our everyday practice as an employer and service provider;
- providing services that will actively promote and support the inclusion of those with particular health problems including disabilities as active citizens who are able to participate fully in the life of the local community; and
- becoming a Foundation Trust that is responsive to local emerging needs by having a diverse membership that is reflective of the local population and feels empowered to make an active contribution to strategy and planning processes for the design and delivery of services.

The way in which each organisation explains how inclusion is central to its strategy and function will differ according to their particular priorities and target communities e.g. a mental health and learning disability Trust will specially address the meaning for these service users and communities.

### ***Organisational structure versus personal agency***

Some models for organisational change that seek to address culture make the mistake of reifying the organisation e.g. referring to the organisation as if it equates to the individuals who comprise its members. This has the result of emphasising structure over individuals. People are not automatons and they bring into the work situation all their individuality and potential for acting as individuals. While this is to a degree filtered through organisational custom and practice and in professional standards of behaviour individuals still act according to their own personal beliefs and values.

There are two approaches to addressing organisational culture that reflect these tensions, standard organisational change models based on a positivistic account of human behaviour and one that recognises personal agency and the dynamics of how individuals continually interpret and reinterpret organisational culture. The following table contrasts the two approaches.

Standard organisational change models	Dynamic change models using personal agency
Focus on policy	Focus on behaviour
Talks about the organisation	Talks about individuals
Is value neutral	Uses values as a key change driver
Uses metaphors of the machine or an organism	Uses metaphors of relationships
Assumes people are rational actors acting in the best interest of the organisation	Assumes people act for diverse motivations which may or may not be in the best interest of the organisation
Relies on mechanistic processes and tools for change	Relies on personal stories and narratives for change

While structural changes cannot be ignored e.g. policy development will need to take account of inclusion there is a need to ensure that more dynamic change models are used to address informal cultures.

## ***Group difference and homogeneity***

A culture of inclusion values and recognises group difference rather than one that seeks homogeneity and uniformity. Organisations often fail to develop cultures that value group differences by ignoring those group differences e.g. not having an equality monitoring system that encompasses all groups with protected characteristics.

If used well equality monitoring can be a powerful tool in establishing a culture of inclusion. Some of the ways this can be achieved are:

- make preparations for a fully inclusive monitoring system that encompasses all of the relevant protected characteristics e.g. age, ethnicity, sex, sexual orientation, religion or belief, disability, gender reassignment, marriage or civil partnership, maternity and pregnancy;
- have a comprehensive communications strategy to explain the purpose of equality monitoring including how the data will be used and why;
- provide training for staff who collect the monitoring data including handling sensitive issues such as sexual orientation and disability;
- ensure that the data is analysed and that staff and managers receive intelligible reports for their areas of work.

One of the key failings in equality monitoring systems is that staff do not recognise its value and importance because they do not receive feedback on the data and analysis. By strengthening the feedback loop on equality a clearer message about inclusion can be disseminated and the links between equality and inclusion can be made more robust.

## ***Professional and personal boundaries***

One of the ways in which informal organisational structure is influenced is through the interface between professional and personal boundaries. Organisations often address culture through professional dialogues e.g. negotiations with professional bodies on training, development, pay and conditions. Codes for professional conduct are also used to influence behaviour and can be used as sanctions or rewards.

Most professional bodies such as nursing and medical associations and colleges have strong commitments to the values of inclusive practice, equality and human rights. These are valuable in leading discussions with professional staff groups about inclusion and how to translate these values into practice. However, there can also be a source of conflict between personal or public discourses on inclusion and professional identities:

*"As professionalisation has spread as an organisational framework for intellectual work, the power attached to exclusive knowledge and the institutions which control them has come under attack. Professional omniscience and omnipotence are routinely questioned by critics speaking on behalf of client publics"<sup>5</sup>.*

This has been seen for example in the mental health field amongst psychiatrists concerned about the direction of travel on moving from illness models to health and wellbeing:

*"...use of the term 'mental health' to describe services for those with mental illness risks undermining the real importance and impact of these conditions on patients"<sup>6</sup>.*

It is important that this discourse within the organisation is managed and that professional resistance and barriers to inclusion are addressed in order to prevent conflict between the organisational culture for inclusion and the professional culture for exclusivity in expertise. This is central to the next stage moving from the staff room to the consulting room.

#### ***Stage 4: From the staff room to the consulting room***

***The clinical discussion - how service users are empowered to be involved in their care.***

For inclusive practice to be truly embedded in the organisation it needs to be a hallmark of clinical practice. This is epitomised by the recent mantra on health reform '*no decision about me without me*'. Service user involvement and personalisation have come a long way in healthcare over the last few years and few would argue against the desirability of increased service user involvement in their own care delivery. However, we are still some way from making this the common experience of all service users and not all professionals support the shift in relations that personalisation and service user empowerment represents.

The previous stage started to address the potential barriers to inclusion that can arise from conflicts between professional and personal or organisational commitments to and understanding about inclusion. This is most evident in the clinical encounter but the private nature of that encounter can make it challenging for organisations to judge the degree to which inclusion is becoming the norm. Patient satisfaction surveys reveal some information about the experience of inclusive practice and it is possible to compare and contrast service user experience across different groups. This should be a routine part of equality monitoring.

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<sup>5</sup> Bacon et al, 2000 p. 7

<sup>6</sup> *Wake-up call for British psychiatry. BJPsych. 2008 193, 6-9)*

Other ways in which service user inclusion can be measured include:

- complaints and compliments - the nature and volume of complaints and compliments can reveal particular issues about inclusive practice;
- service user forums - all service areas should have a forum for service users to raise issues about quality and care received;
- independent advocacy - systems and processes to support local advocacy schemes can also provide valuable information about inclusive practice;
- carers surveys - carers are often key sources of information with respect to inclusion as they can provide insights into the way in which care has been inclusive of family and friends.

It is also important for the inclusion strategy to distinguish between patient and public involvement. Patient involvement concerns what happens in the clinical encounter and public involvement concerns the degree to which people from local communities who may or may not be service users or carers are involved in decision making about how services are designed and delivered. One of the ways in which inclusion in the clinical encounter is improved is through development of cultural competencies.

### ***A framework for cultural capability***

Various terms have been used to describe cultural competency including cultural sensitivity, cultural capability and anti-discriminatory practice. These are terms that have been increasingly used in healthcare but there is no single definition or agreement about their meanings. The content of training programmes on these areas varies considerably with some largely concerned with legal compliance with anti-discriminatory practice and others on increasing understanding about different community cultures. Training is normally delivered to groups of individuals but there is also a need for frameworks that address organisational competence e.g. the systems and support required to make inclusive practice a reality.

The following table outlines an approach to individual and organisational cultural competency.

## Framework for cultural competency<sup>7</sup>

Individual competencies	Organisational competencies
<p>Individual competence is based on the skills of acknowledging, accepting and valuing cultural difference in others – that is, between and among culturally diverse groups and individuals. Individual competence is built up through a developmental process that includes:</p> <ul style="list-style-type: none"> <li>• <b>Improving knowledge of local communities</b>, such as demographics, religious beliefs, sects and practices, common languages, migration and settlement patterns, health and social care needs, diet and cultural norms.</li> <li>• <b>Developing skills in reflective practice</b> including empathy, the ability to challenge assumptions and prejudices in self and others, and the ability to work through communication difficulties and differences with a sensitive aptitude and attitude.</li> <li>• <b>Developing communication skills</b> in working with people whose first language is not English and the ability to work sensitively and competently with interpreters.</li> </ul>	<p>Organisational competence is demonstrated through a clear commitment to recognising diversity and the development of proactive policies which embed equality and skills in working with diverse communities throughout the organisation. This process includes:</p> <ul style="list-style-type: none"> <li>• <b>A clear commitment to equality</b>, valuing diversity and human rights, which is articulated in the aims and objectives of the organisation.</li> <li>• <b>Provision of staff training programmes</b> that meet the needs of a range of personnel, from basic induction through to higher-level learning.</li> </ul> <p><b>A system for engaging and consulting with local communities</b> and ensuring that services take account of local diversity.</p>
	<ul style="list-style-type: none"> <li>• <b>Leadership and management</b> of equality and diversity through performance and monitoring systems.</li> </ul>

Both individual and organisational cultural competence are required. The framework recognises that individual competence will only be successful to the extent that the organisation is effective in supporting and promoting cultural competence. In the same way, not matter how well articulated the organisation’s inclusion strategy it will not make the desired impact if staff do not have the skills and support to carry it out.

<sup>7</sup> Fountain, J and Hicks, J. 2010. *Delivering race equality in mental health care: report on the findings and outcomes of the community engagement programme 2005-2008*. Preston: UCLAN. Section 4. Page 77.

## **Stage 5: From the consulting room to the bus stop**

### ***The community discussion - how local communities perceive the value of the organisation and their engagement with it.***

Inclusion is about creating public value and the measure of success is how communities view the organisation and their involvement with it. All of the previous four stages contribute to making public engagement a reality e.g. how the organisation's leadership establish and articulate their strategy for inclusion, the way in which managers build relationships with local community groups and how staff groups are perceived to hold the values of inclusion both informally and in clinical encounters with patients and with their carers.

Building public confidence in healthcare organisations has become even more significant following the scandals at South Staffordshire and Winterbourne View. The failures in these organisations speak directly to the issue of inclusion as they concerned the way in which patients and carers were treated with dignity and respect. How an organisation treats its most vulnerable service users is indicative of how it treats everyone.

Public consultation on healthcare changes and reforms is becoming more important in particular with the development of policies and legislation on localism. Within this context the arguments for inclusion have to be articulated as part of the broader policy objective e.g. inclusion has to speak to local communities and public and strengthen their ability to influence healthcare delivery:

***“...for a public enterprise to be judged worthwhile, it must pass a test beyond the mere demonstration that the value of its products exceeds the value of the resources used...it must explain why the enterprise should be public rather than private.”***

(Moore, Mark H. 1995. *Creating Public Value: strategic management in government* p.42).

This stage is not about consultation and neither is it about community development, making inclusion part of adding public value requires effective community engagement. The model for community engagement needs to address a wide range of issues including:

- awareness raising about issues;
- reducing stigma, denial and fear;
- addressing needs;
- increasing trust;
- articulating need;
- building capacity in services and communities;
- workforce development;
- sustaining engagement;
- generating ownership.

The process for community engagement needs to be facilitated, supported, resourced and include training. It involves communities and agencies working together to make equitable and inclusive services which improve access, experience and outcomes.



(Community Engagement model as developed by Professor Lord Patel of Bradford, 2010).

### ***Awareness raising about issues***

Awareness raising is a two way process as health organisations need to lead the process of raising awareness about services and health promotion initiatives and communities help raise awareness amongst organisations about health needs and culturally appropriate responses.

### ***Reducing stigma, denial and fear***

One of the biggest barriers to inclusion is the stigma associated with certain health problems such as mental health or drug addiction and denial and fear in communities about the issues and how services are perceived to respond. Breaking down these barriers can only be achieved through direct engagement.

### ***Addressing needs***

Inclusion is not done for its own sake it is about meeting needs. However, there needs to be explicit recognition that addressing needs requires the active involvement of communities. In this way inclusion is firmly placed within a public health context of reducing health inequalities.

### ***Increasing trust***

Adding public value means bringing more to the process of inclusion than increasing numbers of people accessing services. It is about increasing trust in the ability of healthcare services to meet needs and serve the interests of the wider public.



### ***Articulating need***

Through the processes of raising awareness, reducing stigma, addressing needs and increasing trust it becomes possible to better articulate needs in a way that speaks to the inclusion agenda. This may involve new ways of articulating need that are understood by the wider public for example, using non-medical jargon.

### ***Building capacity in services and communities***

Further to the process of adding value is using the opportunity for engagement to build capacity. This may involve education programmes about health issues and service access or supporting smaller community groups to develop management capacity and infrastructure.

### ***Workforce development***

Community engagement is an opportunity to involve the workforce in a way that can help develop skills and competencies for inclusion. There is a key role for managers in building relationships with community groups but all of the workforce will benefit from direct involvement with communities.

### ***Sustaining engagement***

From the outset it is important to build in a plan for sustaining engagement. Ad hoc and tokenistic engagement risks undermining the relationship of trust and threatens identification of future needs. Building in sustainability requires more than resources it is about enabling relationships over the long term.

### ***Generating ownership***

The success of the process of engagement is that it generates ownership. Services and communities come together in the engagement process to jointly own the issues and solutions. This in turn strengthens the engagement e.g. continuing to raise awareness, increasing trust and addressing and articulating needs.

## **Public engagement, HealthWatch and the Equality Delivery System**

With the development of HealthWatch and the Equality Delivery System (EDS) public assessment of how well services meet the needs of the whole population including the full range of diversity amongst communities is increasingly important. This is also reflected in the guidance on authorisation for Clinical Commissioning Groups (CCGs) which states:

*“CCGs need to be able to show how they will ensure inclusion of patients, carers, public, communities of interest...It should be evident how the views of individual patients are translated into commissioning decisions and how the voice of each practice population will be sought and acted on. CCGs need to promote shared decision-making with patients, about their care”. (Developing Commissioning Groups Towards Authorisation. DH. 2011)*

The guidance also states that CCGs must secure effective engagement, and respond to the views raised e.g. feedback is measured and analysed effectively, and is used to influence decision making. They need to have mechanisms in place for involving patients and their representatives in the redesign of pathways and they need to ensure providers involve patients in decisions about their own care. This includes supporting them in making choices about where, when and how they are treated.

In summary CCGs need to demonstrate that:

- ✓ They can **effectively engage** with and gather insight from patients, carers and the public, including **disadvantaged groups**;
- ✓ The results of their engagement and insight are reflected in their **decision-making** processes;
- ✓ They set out how they intend to engage patients, carers and the public **throughout the commissioning cycle** and in the major commissioning decisions they anticipate they will need to make; and
- ✓ Their plans set out how they intend to **involve patients in decisions** about their health and care, and support them to make choices about where, how and when they will be treated.

The assessment process for the EDS is to be undertaken across four goals:

1. **Better health outcomes for all**
2. **Improved patient access and experience**
3. **Empowered, engaged and included staff**
4. **Inclusive leadership**

The assessment must include the views of stakeholders and especially local community groups representing the protected characteristics. It should not be assumed that these groups have the capacity and ability to undertake the assessment; they must be supported to do so:

*"Before embarking on the assessments and using the grades, NHS organisations should be certain that local interests, especially patient and community groups have been supported to understand the grades and how the process will work". (EDS, Main text. Page 39)*

The EDS is also clear that the assessment of commissioners will be dependent on how progress is being realised amongst providers they commission:

*"No matter how fair, transparent and excellent a commissioner's processes are of themselves, if its providers cannot demonstrate excellent results, then the commissioner should be prepared to downgrade its assessment of its own performance".*

(EDS Main Text. Updated 10/11/11. Page 20)

Undertaking the EDS assessment in a robust and comprehensive way will help secure the additional benefits of demonstrating compliance with the Public Sector Equality Duty and ensuring that CCG authorisation is in keeping with the guidance. The following check list can be used to guide the engagement process:

### **Check list for community engagement as part of the EDS assessment process**

The following check list is intended as a guide to inform the process of securing appropriate and relevant community engagement:

- ✓ ensure that a wide range of community groups are brought into the process by reaching out to those groups that have been less well engaged;
- ✓ use the equality analysis to identify community groups that have particular needs and issues with respect to access, experience and outcomes in using health and social care services;
- ✓ provide clear, easy to read documentation that explains the process and the outcomes you are seeking to achieve from the assessment (the EDS provides an easy read document on the steps for fulfilling the EDS goals)
- ✓ hold a series of workshops to enable different groups and individuals with protected characteristics to engage in the process;
- ✓ use the process of engagement as an opportunity to raise issues and awareness about services;
- ✓ provide additional support in the form of individual contact with senior managers and engagement workers to talk through the EDS process and goals;
- ✓ ensure that senior managers and Board members are present at community workshops and demonstrating that there is leadership and commitment from the top;
- ✓ use the EDS engagement process to bring on staff members who need to increase their understanding and skills in community engagement;
- ✓ provide feedback after the event including written and verbal information on the outcomes from the engagement process;
- ✓ prepare action plans when particular contentious issues are raised by community groups so that it is possible to return quickly with information about ways in which the concerns raised are to be addressed;
- ✓ keep the Board informed about the process and outcomes through written reports and presentations before the final assessment decisions are taken.

## *Summary and conclusions*

The IncLeaD Toolkit has been developed from the learning and experiences of the inclusion leadership programme in Leicestershire. The programme was comprehensive and involved four NHS Trusts and one local authority working together with staff, service users, carers and local communities to establish a new way of approaching the issues of inclusion. This new way entailed greater partnership working, regular involvement by the various Boards and leadership forums, master classes for staff development and capacity building for local community groups.

The IncLeaD Toolkit can only act as a guide to establishing a comprehensive inclusion programme and it is intended to help NHS leaders think through the issues involved and develop a coherent programme that acts across the organisation and reaches into the community.

Although the toolkit is presented in five stages these are not linear and actions need to be taking place across each stage simultaneously. In this way the whole adds up to more than the parts and economies of scale can be realised as different stages can be used to achieve a variety of goals.

No single toolkit can provide all the answers and it is sometimes the case that more questions are raised than are answered. But the key to the approach set out by the IncLeaD Toolkit is the ethos and values base in which it places organisational change for inclusion. The primary focus is on the various ways in which individuals working in organisations and those using services interact to create value and meaning.

Understanding the value base for inclusion is key to its success and this goes beyond standard approaches to organisational change to encompass not only the leaders of the organisations, the staff, the service users and carers but fundamentally the communities in which services are located. In this way inclusion becomes not only a guiding principle and a way of articulating strategy it is the measure of quality and service improvement.