Inclusive Leadership and Culture in the NHS

November 2020

Deeds × Words

‘If not now, then when?’[1]

Caroline Ellis, Ruth Hunt and Faye Davies

With thanks to the participants of the Inclusive Leadership Project for their time, commitment and energy expended in helping us create this report.

‘The NHS badge is a badge of honour.’[2]

[1] Chapman, T. (1988) ‘If Not Now’, Tracy Chapman. California: Elektra Records ; Hillel The Elder. (No date) Pirkei Avot. 1:14.

[2] Hassan Akkad, cleaner, Whipps Cross Hospital, https://www.bartscharity.org.uk/news/hassan/

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'The most important determinant of the development and maintenance of an organisation's culture is current and future leadership. Every interaction by every leader at every level shapes the emerging culture of an organisation.'[3]

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[3] West, M., Eckert, R., Stewart, K. and Pasmore, B. (2014) Developing collective leadership for health care. London: The King's Fund. Available at: https://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care (Accessed: 10 November 2020)

Introduction

In October 2020, the NHS Leadership and Lifelong Learning Academy commissioned Deeds and Words to conduct a series of focus groups with 80 leaders[4] from across the NHS.

The 80 leaders were asked to identify three people to talk to about our work together, and to let us know what they thought of the issues we raised.

We wanted to know the extent to which:

- NHS leaders led inclusively and collectively
- NHS leaders were supported to lead inclusively
- Leaders from minority backgrounds felt able to succeed and lead in the NHS
- Existing leadership provision (provided by the Academy and beyond) was addressing any gaps identified.

The findings from our work with NHS leaders were considered, alongside extensive work undertaken by Tracie Jolliff, Head of Inclusive System Development, Equality and Inclusion Function of the People Directorate at the NHS Leadership and Lifelong Learning Academy. Together, we produced a chapter for the recent Strategic Review of the Academy. The chapter provided a summary of our collective key findings and recommendations.

Deeds and Words made a commitment to the 80 NHS leaders who took part in our webinars to provide them with a more in-depth report reflecting the evidence they shared with us and expanding on the recommendations we made to the Academy. This report provides that detailed analysis.

Since at least 2010, the NHS has produced a considerable number of resources on the experiences of minority staff within the NHS. Many of these resources have been produced by network groups and individuals alongside their day jobs. There is no shortage of evidence about the experiences and needs of minority staff within the NHS. This report does not replicate that excellent work. If you would like to know about the differential experiences of working for the NHS, we would recommend the following excellent resources:

Bolden, R., Adelaine, A., Warren, S., Gulati, A., Conley, H. and Jarvis, C. (2019) Inclusion: The DNA of Leadership and Change [online]. Available at: *https://uwe-repository.worktribe.com/output/852067/inclusion-the-dna-of-leadership-and-change (Accessed: 9 November 2020)*

NHS Employers. (No date) Tools and Resources [online]. Available at: *https://www.nhsemployers.org/retention-and-staff-experience/diversity-and-inclusion/tools-and-resources (Accessed: 9 November 2020)*

NHS England. (No date) The Equality and Health Inequalities Hub [online]. Available at: *https://www.england.nhs.uk/about/equality/equality-hub/ (Accessed: 9 November 2020*

[4] Full information about our approach can be found in Part Three.

About Deeds and Words

Deeds and Words has over 30 years' experience supporting individuals, teams, organisations and communities to think differently about leadership and culture. Like many, over the last six months, Deeds and Words has moved all leadership programmes and interventions online and supported clients to have rich and collaborative conversations about improving their cultures and ways of working.

We believe inclusive leadership is relevant and of benefit to everyone, and that how we treat each other is key to organisational effectiveness, team morale and well-being.

Deeds and Words is a close-knit team of six. Caroline Ellis (a director and co-founder) has a background in health and social care and has worked to tackle injustice in all her work. She has designed award-winning interventions that emphasise co-production (such as her work with Cardiff University to design an LGBT inclusive health curricula). Caroline draws on approaches and models from across disciplines and sectors.

Ruth Hunt (a director and the other co-founder) worked at Stonewall (the LGBT charity) for 14 years and was CEO for five of those years. Since leaving Stonewall, Ruth has worked closely with a number of Deeds and Words' clients on embedding inclusive leadership into work and practice. Ruth is also a cross-bench peer in the House of Lords.

Delia Barker joins Deeds and Words in January 2021 as our third director. Delia is currently Programmes Director at the Roundhouse and a Clore Leadership fellow. She has a wealth of knowledge and experience of co-production and culture change, and is one of very few Black women in senior leadership in the arts in the UK.

Deeds and Words has two exceptional project managers. Faye Davies and Stacey Dale ensure all our work runs on time, budget and above specification. We are all supported by Renu Mehto, who ensures we are all in the right place at the right time.

If you have any questions, drop us a line.
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Executive Summary

The evidence base is stark, extensive and has existed for decades: **our health, well-being and life expectancy are directly affected by who we are and where we live**[5]. Health inequalities blight individuals and communities across the country and are 'divisive and socially corrosive'[6]. Racial injustice, poverty and COVID-19 have exacerbated all existing social inequalities, over many years and in recent months, and this inequality is directly and disproportionately experienced by many of the staff and volunteers who contribute to the work of the NHS.[7] **This evidence base should be at the heart of every intervention, strategy and output of the NHS Leadership and Lifelong Learning Academy.**

At the same time, the NHS Constitution clearly outlines how the NHS can and should play a key role in tackling inequality, in order to improve the health and well-being of everyone.

> *'The NHS 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.'*[8]

What the consultation exercise with under-represented communities from across the NHS[9] has confirmed, once again, is that the social determinants of health[10] are mirrored within the NHS and are culturally and systemically embedded. As Prerana Issar (NHS Chief People Officer) reflected in her blog on COVID-19 and Black, Asian and Minority Ethnic (BAME) communities:

> *'We heard from staff network members who had engaged directly with those whose voices are not always heard – the lowest-paid agency workers, porters, cleaners and security staff, including those whose first language is not English – with some of the themes including concern for their safety, not being sure how or whether to speak up, and in some cases, this was compounded by loss or difficulties at home.'*[11]

The NHS as an organisation is not fulfilling its social duty to many of its own staff and volunteers, making its wider social duty an aspiration at best. There is, therefore, a fundamental misalignment between the stated aims of the NHS and its internal working cultures. This is, of course, not a universal experience and there are some clear examples of creative and thriving workplaces, with inspiring and inclusive leaders at all levels.

[5] Pion and its Licensors. (2012) 'Lives on the line: mapping life expectancy along the London Tube network', Environmental and Planning A, 44, pp.1525-1528. Available at: https://journals.sagepub.com/doi/pdf/10.1068/a45341 (Accessed: 10 November 2020) ; Marmot, M (Prof, Sir)., Allen, J., Boyce, T., Goldblatt, P. and Morrison, J. (2020) Health Equity in England: The Marmot Review 10 Years On [online]. Available at: https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on (Accessed: 10 November 2020)

[6] Wilkinson, R. and Pickett, K. (2010) The Spirit Level: Why Equality is Better for Everyone. London: Penguin Books.

[7] 'The experience of racism, discrimination, stigma, fear and trust among Black and ethnic minority communities, including key workers within the National Health Service, made BME groups more vulnerable to COVID-19'. Independent SAGE Committee. (2020) Disparities in the impact of COVID-19 in Black and Minority Ethnic populations: review and recommendations [online]. Available at: https://www.independentsage.org/disparities_bme_final_jul2020/ (Accessed: 10 November 2020)

[8] Crown. (2012) Guidance: NHS Constitution for England [online]. Available at: https://www.gov.uk/government/publications/the-nhs-constitution-for-england (Accessed: 10 November 2020)

[9] Deeds and Words worked with a group of 80 staff from across the NHS, who in turn worked with a further 240 individuals to explore inclusive leadership in the NHS. Further information about our approach can be found in Part Three.

[10] See the 1991 Dahlgren and Whitehead model of health determinants. Available at: https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health (Accessed: 10 November 2020)

[11] Issar, P. (2020) Blog: Keeping our colleagues safe through more than a million conversations [online]. Available at: https://www.england.nhs.uk/blog/keeping-our-colleagues-safe-through-more-than-a-million-conversations/ (Accessed: 10 November 2020)

As one leader shared:

> **'It was good when our CEO made a public and quite vulnerable communication about their own journey in learning about inclusion – this was really helpful in encouraging others to learn, and reassured others they were learning.'**

However, addressing the misalignment between stated social purpose and the lived experience of many staff and volunteers within the NHS remains a key and strategic leadership challenge that requires a radical shift. Responding to this challenge is a social, moral and economic imperative for the NHS and the UK.

As the Independent SAGE Committee report into the disparities of the impact of COVID-19 in BAME communities concludes:

'A reoccurring theme throughout the evidence on the impact of COVID-19 on ethnic minority communities is the issue of racism and discrimination within the health and social care system, including within the NHS. We therefore recommend that the NHS reiterates its commitment for increasing diverse leadership at all levels in health and care systems, reflecting the communities which it serves. It is also critical for NHS Trusts to review processes by which BAME staff are able to raise concerns about occupational risk and safety.'[12]

[12] The Independent Scientific Advisory Group for Emergencies (SAGE). (2020) The Independent SAGE Report 6. Disparities in the impact of COVID-19 in Black and Minority Ethnic populations: review of the evidence and recommendations for action [online]. Available at: https://www.independentsage.org/wp-content/uploads/2020/07/Independent-SAGE-BME-Report_02July_FINAL.pdf (Accessed: 11 November 2020)

Key findings

In spite of significant efforts to develop collective models of leadership, which acknowledge that leadership happens at all levels in an organisation, and relies on collaboration between individuals and teams, the NHS retains a very traditional and hierarchical model of leadership.

One leader explained:

> **'Leadership is conceptually intertwined with hierarchy and is not considered something that anyone can do.'**

This exacerbates and embeds the very social inequalities it could and should be playing a leading role in tackling.

- Senior leadership remains dominated by individuals who are least affected by the social and economic inequalities that result in poorer health outcomes. This results in strategies, policies and services which, at best, seek to incorporate or retrofit the lived experience of the very communities and groups most affected by health inequalities.

As one leader put it:

> **'inclusion isn't seen as everyone's job, it's just the job of equality, diversity and inclusion people'.**

Systems perpetuate the problem; CQC assessments, for example, don't measure or reward inclusive practice and leadership. In an overworked NHS, leaders inevitably focus on the things they must do. There is also a sense of a lack of accountability; action plans are drawn up but few questions are asked about how well the NHS has delivered against these actions.

- Inclusive and collective leadership are widely considered to be vital to building and sustaining effective workplace cultures in the NHS and many are frustrated at the slow pace of change, as is powerfully highlighted in the University of the West of England (UWE) commissioned review[13]. In the multiple leadership development interventions available, there is little evidence of a focus on how to build an inclusive culture and little attention paid to how to embed inclusive practice into the design and delivery of these interventions. Instead, the negative outcomes that continue to result from a rigidly hierarchical and excluding leadership[14] – and a reluctance or inability to examine this – tend to lead to a call for more equality, diversity and inclusion-focused training (e.g. cultural competency and trans awareness training) rather than seeking to embed inclusion into all leadership interventions.

- Equality, diversity and inclusion (EDI) training and interventions tend to focus on knowledge development (about particular groups of people) or is confined to limited information about legal frameworks, compliance and risk avoidance. It rarely examines power, hierarchy and authority. It is experienced by many as an addition to fundamental leadership development (a 'nice to have') rather than a core element of effective leadership. One leader shared that he attempted to bring Stonewall accreditation as an objective in his appraisal but was told by his manager 'we don't have time for this'. If inclusion isn't in your remit, you're not necessarily encouraged to pursue work to advance it. The outcome is that many devalue and deprioritise EDI-led interventions, which results in calls for such training to be made mandatory. As one leader said, 'inclusion was presented as something HR leaders needed to be

[13] Bolden, R., Adelaine, A., Warren, S., Gulati, A., Conley, H. and Jarvis, C. (2019) Inclusion: The DNA of Leadership and Change [online]. Available at: https://uwe-repository.worktribe.com/output/852067/inclusion-the-dna-of-leadership-and-change (Accessed: 9 November 2020)

[14] As reflected in the report into Mid Staffs scandal: Campbell, D. (2013) 'Mid Staffs hospital scandal: the essential guide', The Guardian, Wednesday 6 February [online]. Available at: https://www.theguardian.com/society/2013/feb/06/mid-staffs-hospital-scandal-guide (Accessed: 11 November 2020)

aware of as a "risk" to be taken to tribunal, rather than an opportunity to meet business needs'.

- This side-lining of inclusive leadership is critically influenced by an ongoing failure to connect the outcomes of increasingly diverse and inclusive workplace cultures to the ability of the NHS to achieve its fundamental purpose. Until NHS leadership interventions enable people to work together to build workplace cultures that empower staff and volunteers to thrive and do their best work, the NHS will be unable to ensure the health and well-being of individuals and communities in the UK. As one leader said, 'current leadership programmes are training people to have a voice but then not allowing them to use it'. In other words, until NHS leadership interventions focus the relevance of the long-standing and very recent evidence about the social determinants of health and well-being to its own workforce, at an individual, team, community and societal level, leadership interventions are unlikely to result in success by any measure.

- What counts as success in relation to existing leadership interventions does not currently encourage a focus on inclusive, transformative and collective leadership. Measures of success tend to focus on individual career success only, rather than measuring impact on health and well-being outcomes for staff, volunteers and patients, and how individual successes further these outcomes. Those who succeed in the NHS are particularly adept at navigating the systems that value individual success. They go on to lead and maintain the status quo. There are no leadership standards relating to inclusion or creating inclusive cultures. One leader said that 'current leaders do not take responsibility for a lack of inclusivity'.

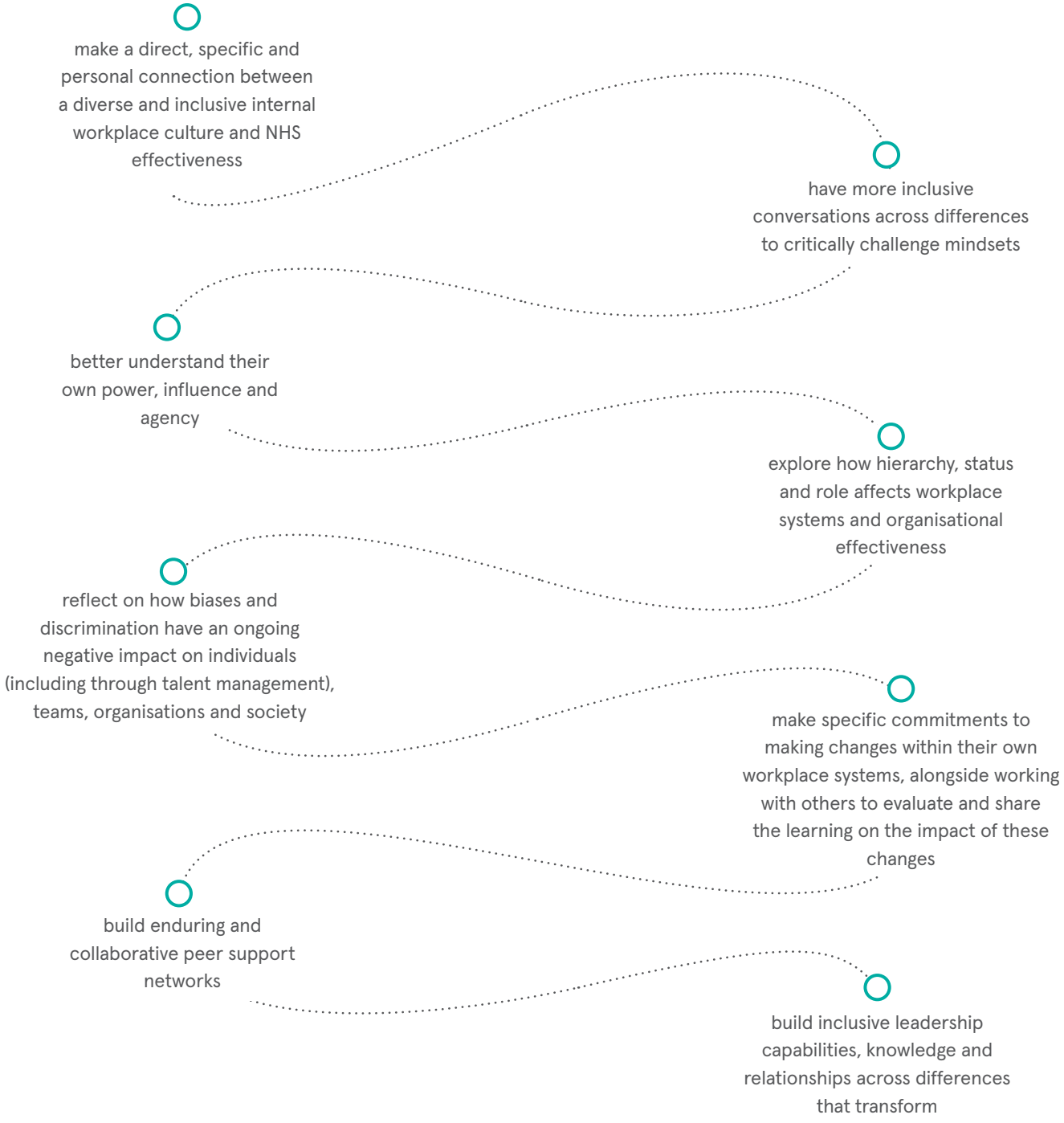
- Many staff and volunteers continue to find it difficult or impossible to challenge decisions made by senior leaders in their area, when they often have insights which could improve a service, build a more sustainable working culture or save the NHS money. The rigid hierarchy means that, often unintentionally, the input of lower-paid and more precarious staff is not valued or recognised. It also means people are more likely to make mistakes because they're anxious about the hierarchy. One leader said: 'BAME input into strategic processes is often tokenistic – members of my group report a number of experiences where their opinions weren't counted.' Another shared that 'it's exhausting trying to feel included and worthwhile'. Others reflected that when their ideas were taken on board, their involvement and contribution was unacknowledged or forgotten. They felt unable to acknowledge their own individual successes.

- Many individuals from under-represented groups face a number of circular challenges, making it significantly more difficult for them to progress into leadership roles, in which they would have more strategic power to influence change. In particular, intersecting biases about who is generally trusted as a leader, who sees themselves as a leader and how we tend to recruit in our own image, means that in spite of leadership interventions aimed at particular groups, senior leadership remains stubbornly monolithic. One leader reported she had been told that 'inclusivity dumbs down the talent pool' and another said 'you can feel it in your skin when people don't want you to go higher'.

Recommendations

1. In order to fulfil the objectives of the People Plan, the NHS Leadership and Lifelong Learning Academy must empower people to play an active part in building and sustaining a positive and inclusive culture. Inclusion, collaboration and purpose should be at the heart of all leadership development interventions.

Successful interventions are likely to require content that enables leaders to:



2. Develop leadership interventions that are inclusive and collaborative in their design and delivery, as well as in their content. This means reviewing the overall approach to learning and development, building in greater accessibility and ensuring that conversation is at the heart of how people learn. The move to online learning must take into account how people with limited or no access to appropriate technology will access materials. Any programme must also be designed in a way that enables disabled people to participate. A leader shared how a colleague had been left for months without speech-to-text software, preventing them from engaging in any learning.[15]

3. Support programme designers and facilitators to have an in-depth understanding of inclusive leadership and design. Test this knowledge and capability through procurement processes and ongoing evaluation and impact measures. As a minimum, all leadership programmes should have inclusion explicitly referenced in programme content, there should be inclusion-focused strategies in place for recruiting and encouraging under-represented communities to participate, as well as in the monitoring and evaluation of interventions and leaders.

4. Develop interventions that empower staff and volunteers at all levels of the NHS to play a role in building and sustaining an inclusive culture. Successful interventions are likely to involve assigned and senior leaders in the delivery and ongoing support of emerging leaders.

5. Continue to invest in leadership interventions which specifically support individuals from groups that remain under-represented in assigned leadership roles and who are disproportionately affected by health inequalities. Involve assigned and senior leaders in the delivery and ongoing support of emerging leaders. These interventions should explicitly aim for the career progression of individual leaders, as well as empowering individuals to play a more specific and valued role in building and sustaining an inclusive and collaborative workplace culture.

6. Develop and embed impact evaluation methodologies into all leadership development interventions. The Academy should be able to demonstrate how every leadership intervention impacts on leaders from under-represented communities, and the long-term impact of any intervention on future leadership in the NHS. Furthermore, evaluation should include an assessment of the extent to which an intervention enables leaders to make a direct, specific and personal connection between a diverse and inclusive internal workplace culture and NHS effectiveness, and to translate that understanding into concrete, positive change within their workplace.

7. Stop seeking more evidence from under-represented groups within the NHS, as an add-on to strategy policy and service development. Start centering and valuing those insights and experiences within all leadership interventions to inform strategy policy and service development. Link increased diversity at all levels and in all roles to greater effectiveness in the NHS.

8. Support network groups to professionalise and to play a more strategic leadership role in shaping local, regional and national approaches to reducing health inequalities. Support network groups and

[15] *Deeds and Words provided extensive technical support to leaders, including specialist IT support and speech-to-text services, to enable all leaders to participate in the webinars.*

equality, diversity and inclusion specialists more broadly to influence decision makers and to make strategic interventions. Ensure these interventions are fully valued, recognised and rewarded.

9. Put an understanding of health inequalities and how they impact staff, volunteers and patients at the heart of all activity. Systems and services should be designed, delivered and led by those who best understand the communities who will be accessing them. For example, the Independent SAGE Committee calls for co-creation of COVID-19 find, test, trace, isolate and support programmes targeted at BAME communities. This, of course, includes people with lived experience. Everyone should better understand the link between equality, health and well-being inside the NHS and in achieving our shared purpose. Systems and services should be designed, delivered and led by those who have technical expertise, learning and qualifications, but also those who understand how that service or system will be used or accessed.

10. Take a lead within society in developing leadership as a collective, social and purpose-driven endeavour, rather than an individual and hierarchy-driven one. Role model a consideration of leadership more broadly by investing in interventions to empower staff at all levels to positively challenge and influence.

Part One: The Problems We Are Trying to Solve

The leaders who worked with us on this report reflected on a number of barriers that prevent inclusive and collective leadership being an integral part of the NHS.

Who has the expertise?

The NHS is the biggest public sector employer in England and Wales and, at its heart, is a social justice organisation. Senior leadership within the NHS remains dominated by individuals who are least affected by the social and economic inequalities that result in poorer health outcomes. Senior leaders do not experience levels of poverty in a way that impacts on health outcomes, for example, and people from particular communities are also under-represented at senior leadership level, for example women and Black people.[16]

One leader said:

> **'Socio-economic factors and wider social inequalities, stemming back to primary education, mean that the pipeline of those ending up in leadership positions is not a diverse representation of the community.'**

In 2010, Professor Marmot stated that the NHS should be:

> **'Engaging people and communities in the co-production of world-class commissioning for patient-focused, integrated health services in partnership with local councils, third and private sector organisations.'**[17]

Professor Marmot recognised that although reducing health inequalities required multi-agency and local, regional and national interventions, the NHS had a key role to play in preventing ill-health as well as responding to it. In 2010, the Equality Act was introduced in England that required all public bodies to take positive active steps to respond to, and prevent, discrimination. It also placed a duty on public bodies to engage people and communities.

Over the last decade, the NHS has changed the way it thinks about communities and their involvement in delivering NHS services, yet leaders felt that the NHS often failed to see its own staff as an invaluable resource to shape services and provide insight as to how patients experience and access services.

As one leader said:

> **'current leadership programmes are training people to have a voice but then not allowing them to use it'.**

Leaders felt that NHS leadership interventions should support teams to work together, pool knowledge and resources, and build cultures that support health and well-being.

As highlighted in the report *Tackling Poverty, by The King's Fund and the Joseph Rowntree Foundation*[18], NHS staff have to consider the causes of health inequalities when treating the consequences of health inequalities. The best way to ensure an understanding of the social and economic inequalities is embedded into strategies, policies and services is to ask patients themselves, but also to involve staff who live, work, socialise, pray and play in the communities most impacted by health inequalities.

[16] For full data on gender and other protected characteristics see: NHS Digital. (2019) The number of women in Very Senior Manager, Chief Executive or Non-Executive Director roles in the NHS [online]. Available at: https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/staff-numbers/non-clinical-and-support/the-number-of-women-in-very-senior-manager-chief-executive-or-non-executive-director-roles-in-the-nhs (Accessed: 11 November 2020)

[17] Marmot, M (Prof, Sir). (2010) Fair Society, Healthy Lives [online]. Available at: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf (Accessed: 11 November 2020)

[18] Buck, D. and Jabbal, J. (2014) Tackling poverty: Making more of the NHS in England [online]. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/tackling-poverty-research-paper-jrf-kingsfund-nov14.pdf (Accessed: 11 November 2020)

A leader explained that inclusion needs to be woven through everything:

> **'In healthcare this means from any patient's first contact with services (pronouns, language/communication) through education of staff (cultural competence), employee experience (bullying/harassment, opportunities) through to senior leadership and vision. We also know in no uncertain terms, from struggles like women's suffrage to Black Lives Matter, that inclusion is about life and death, not just a few "minority promotions".'**

The diversity of staff within the NHS means that there is the expertise and resource available to really shape effective policies, practices and procedures. At present, leaders felt that the expertise and insight into communities, held by staff, wasn't valued in any comparable way to professional qualifications. All leaders agreed that professional qualifications are essential, but more likely to be impactful if coupled with the expertise that comes with lived experience.

As one leader explained:

> **'Where people's lived experience is not acknowledged as being of equal value to professional qualifications, we simply replicate what we already have rather than inviting challenge into the system.'**

This failure to invite 'challenge into the system' leads to inefficiencies. Some leaders felt that the inability to recognise the value of different perspectives was replicated in teams. The failure to see different perspectives, and adhere to strict notions of hierarchy, is creating very real risks for patients.

A leader said:

> **'In the NHS, the fear/reluctance to celebrate the diversity of protected characteristics is often aligned with poorly functioning multidisciplinary teams, which don't value the different professional perspectives, or which have a hierarchy which means that certain perspectives dominate and others are not fully heard. We know that this is a patient safety issue and that groupthink leads to risks not being highlighted or addressed.'**

A lack of time and space

Leaders felt that inclusive and collective leadership are fundamental to the NHS, but the pace of change and adoption of such principles has been painfully slow.

Most leaders spoke of how they had been describing what inclusive leadership looks like for some time, taking part in consultations and exercises, with little or no change taking place in the NHS. They felt that senior leaders didn't reflect on the resources already available to create inclusive cultures, most notably the NHS Leadership and Lifelong Learning Academy commissioned review by University of the West of England[19] and The King's Fund research into, and resources around, inclusive leadership[20].

During the consultation exercise, leaders felt that thinking and working inclusively simply wasn't prioritised by staff. Some of this was due to the sheer volume of work undertaken by individuals and teams across the NHS. Finding new ways to work is hard. It means that often the 'lived experience' perspective is retrofitted into policies, practices and procedures, and responsibility for that retrofitting rests with community liaison teams or equality and inclusion teams.

As one leader put it:

> **'inclusion isn't seen as everyone's job, it's just the job of equality, diversity and inclusion people'.**

Leaders felt that such attributes were integral to a high-functioning NHS but felt that leadership training rarely reflected, taught or embedded these attributes. One said: 'We don't see this included in leadership training in the NHS.' Instead, leaders felt that leadership training only offered a surface-level analysis of 'diversity' issues – often concerned with basic facts, compliance or the law – failing to provide the time or skills to support self-reflection on values and behaviours. It was felt that this meant leaders sometimes failed to demonstrate positive and active actions and behaviours that lead to the creation of inclusive cultures.

This failure was thought to be a result of two things: first, some leaders felt that the NHS was so rigidly hierarchical that there wasn't much appetite amongst leaders of the NHS to change their perspectives or ways of thinking about inclusion. Second, the leaders in the NHS are simply too busy and overworked.

One leader commented that:

> **'innovation and creativity can be hard to achieve when people are feeling scared, frustrated, tired...uncertain situations often lead to people battening down the hatches and entrenching themselves in what they know'.**

Leaders reflected that pressures across the NHS meant priority was given to processes over people.

[19] Bolden, R., Adelaine, A., Warren, S., Gulati, A., Conley, H. and Jarvis, C. (2019) Inclusion: The DNA of Leadership and Change [online]. Available at: https://uwe-repository.worktribe.com/output/852067/inclusion-the-dna-of-leadership-and-change (Accessed: 9 November 2020)

[20] The King's Fund. (2020) NHS leadership and culture: our position [online]. Available at: https://www.kingsfund.org.uk/projects/positions/NHS-leadership-culture (Accessed: 11 November 2020)

The status of equality, diversity and inclusion

Leaders spoke about how inclusive and collective leadership was often conflated with 'diversity'.

A diversity of staff, perspectives, approaches is a product of inclusive and collective leadership and cannot exist without a culture that allows self-reflection and growth across the NHS. Instead, leaders felt that Human Resources departments, diversity leads and even network groups were given the 'task' of diversity rather than being asked to be part of a broader conversation about culture change.

Many of the leaders spoke how they had tried to take personal responsibility for bringing in new perspectives, initiatives and ways of working to help shift culture and improve inclusion. One leader shared that he attempted to bring Stonewall accreditation as an objective in his appraisal but was told by his manager, 'we don't have time for this'. Their experience was not unusual. Leaders spoke of how they sometimes had relatively little power and influence in their organisation, where culture change was felt to be the responsibility of those assigned leadership. Those with assigned leadership, however, did not see the relevance of inclusion to organisational effectiveness and culture.

Leaders felt that this perspective led to the devaluing and deprioritising of equality, diversity and inclusion interventions, and the only way it was thought possible to disrupt the deprioritisation within NHS settings was to make diversity training mandatory.

Systems perpetuate the problem. CQC assessments, for example, don't measure or reward inclusive practice and leadership. In an overworked NHS, leaders inevitably focus on the things they must do.

A leader said:

> **'Inclusion needs to be hardwired, by which I mean linked to money and controls, funding and regulation. For example, we could commission and reward effective inclusion. We could have it as a core strand of regulatory frameworks – safe, caring, effective, responsive, well-led and inclusive.'**

Mandatory diversity training exacerbates the idea that inclusion is about compliance, not culture change.

As one leader said:

> **'Inclusion was presented as something HR leaders needed to be aware of as a "risk" to be taken to tribunal, rather than an opportunity to meet business needs.'**

This risk-averse approach means that patterns of behaviour and incidents, which speak to an overall culture, are instead responded to as micro issues that need to be managed.

> **'The processes don't facilitate change and HR staff do not always know how to do it [shift cultures]. Many people raising discrimination and bullying want someone to act on their behalf to solve it, but it ends up in a confrontational, microscopic process.'**

What does a successful leader in the NHS look like?

What counts as success in the NHS does not seem to currently encourage a focus on inclusive, transformative and collective leadership. Measures of success tend to focus on individual career success only, rather than measuring impact on health and well-being outcomes for staff, volunteers and patients, and how individual successes further those outcomes. Those who succeed in the NHS are particularly adept at navigating the systems that value individual success. They go on to lead and maintain the status quo. There are no leadership standards relating to inclusion or creating inclusive cultures.

One leader said that:

> **'current leaders do not take responsibility for a lack of inclusivity'.**

Another leader felt that senior leaders in the NHS weren't ready to give up their power or authority:

> **'What stops leaders from being inclusive? Their own self-interest – why would they relinquish power and privilege voluntarily? Nothing will change until inclusion is mandated and made part of regulatory agenda and financially incentivised...money, performance and efficiency competes with other agendas.'**

Many leaders therefore felt that as collective leadership wasn't valued in the NHS, the conditions didn't exist for them to challenge decisions made by senior leaders, even if they had insights that might lead to improved services. Leaders felt that it was risky to challenge or even suggest new ways of doing something and that the input of lower-paid and more precarious staff is not valued or recognised.

A leader said:

> **'Black, Asian and Minority Ethnic (BAME) input into strategic processes is often tokenistic – members of my group report a number of experiences where their opinions weren't counted.'**

Part Two: The Recommendations and *How* to Implement Them

In order for the NHS to become an inclusive organisation, leaders need to be supported to:

- make a direct, specific and personal connection between a diverse and inclusive internal workplace culture and NHS effectiveness
- have more inclusive conversations across differences to critically challenge mindsets
- better understand their own power, influence and agency
- explore how hierarchy, status and role affects workplace systems and organisational effectiveness
- reflect on how biases and discrimination have an ongoing negative impact on individuals (including through talent management), teams, organisations and society
- make specific commitments to making changes within their own workplace systems, alongside working with others to evaluate and share the learning on the impact of these changes
- build enduring and collaborative peer support networks
- build inclusive leadership capabilities, knowledge and relationships across differences that transform.

Any leadership intervention – whether provided locally, regionally or nationally – has to have one or more of these objectives reflected in the programme, with robust research and evaluation methodologies built-in to test progress against these objectives from the outset.

There are 10 ways to achieve this:

1. Leadership interventions should empower individuals

Traditional training programmes teach people what to do. Effective leadership interventions support individuals to draw on their unique strengths, apply knowledge and skills, and find ways of working that put collaboration and inclusion at the heart of decision making and action. This is the case if someone is learning how to administer a clinical intervention or talk to a family about the health of a patient. It's the case for the manager who is trying to balance the books and the CEO of a Trust who is attempting to shape the culture.

The principle of **'see one, do one, teach one'**[21] still has its place in medical teaching, but increasingly it is understood that it must be supplemented by communication skills support, mentoring, behavioural feedback and group learning and practice. Similarly, leadership training needs to provide far more than a 'how to' list of leadership. Vitally, diversity and inclusion training must go much further than compliance, data and the law. Basic inclusion training does not create inclusive leaders.

As one leader said:

> **'An obstacle to progress is the acceptance that leaders and NHS organisations are delivering on inclusion simply because they are now talking about it. For some people, learning a few more inclusive terms or going on a two-hour training course in inclusive leadership appears to be enough evidence.'**

When commissioning any leadership intervention (not just diversity sessions) you should consider asking:

- How will this programme demonstrate the link between inclusive cultures and NHS effectiveness?
- How will leaders work with each other and how will they be supported to hold inclusive conversations? How will they form networks?
- To what extent will hierarchy and power be explored in this programme?
- How will leaders be supported to think about bias (including their own) and how it impacts the NHS?
- What are the tangible actions leaders will take after the programme and how will success be measured?

[21] Kotsis, S.V. and Chung, K.C. (2013) 'Application of the "See One, Do One, Teach One" Concept in Surgical Training', Plastic and Reconstructive Surgery, 131(5) [online]. Available at: https://www.researchgate.net/publication/236580871_Application_of_the_See_One_Do_One_Teach_One_Concept_in_Surgical_Training (Accessed: 11 November 2020)

2. Inclusive design

Any leadership intervention needs to be inclusive from the point of design. This means reviewing the overall approach to learning and development, building in greater accessibility and ensuring that conversation is at the heart of how people learn. The move to online learning must take into account how people with limited or no access to appropriate technology will access materials. Any programme must also be designed in a way that enables disabled people to participate. A leader shared how a colleague had been left for months without speech-to-text software, preventing them from engaging in any learning.[22]

Inclusive design cannot be retrofitted into a programme but should be demonstrable during procurement and commissioning.

Leadership course providers should be able to demonstrate how they will:

- establish the needs of leaders, empower leaders to reflect on their needs, and design around those needs.

> **'Leaders struggle to include neuro-diverse people because few of us know enough about our differences or the benefits of accommodations to ever ask. I don't know what life would be like if I was accepted, so how do I ask for what I need? We have all had to become self-sufficient and take second/third/fourth /just survive best – with silent gratitude.' – Leader**

- Make materials accessible to those who are disabled – in a range of formats and styles.
- Reflect the different approaches to adult learning – for example, trio work, action learning sets, large group presentations, self-driven working – and explain why each methodology is being employed at each point in a programme.
- Demonstrate an understanding of neuro-diversity and the different ways it can impact learning.
- Demonstrate an understanding of inclusive language and why it's important – for example, name pronunciation, correct use of pronouns – and how to create an environment where leaders understand this too.
- Deliver interventions to part-time workers/shift workers/parents and carers.
- Support their own ongoing learning about inclusion and inclusive practice.

Increasingly, programmes are delivered online. Platforms such as Microsoft Teams, WebEx and Zoom do not facilitate conversations. Instead, they encourage a transmit-and-receive approach to delivering content.

Leadership course providers should be able to demonstrate how they will:

- design around the limitations of online learning to support conversation between leaders
- resource the additional facilitation requirements of online learning
- support leaders to access online content, recognising the range of technology available to NHS leaders and the inconsistency of firewalls and security across the NHS
- support leaders who have less experience of online learning
- create a psychologically safe environment online, including how they will manage chat and side sessions
- support deaf people to take part in webinars
- support blind and partially sighted people to take part in webinars
- resource the adjustments required for full participation.

[22] Deeds and Words provided extensive technical support to leaders, including specialist IT support and speech-to-text services, to enable all leaders to participate in the webinars.

3. Support programme designers

It is sometimes assumed that leadership training providers and facilitators are intrinsically inclusive in their approaches and ways of working. This is not the case, and training providers should be learning and reflecting on inclusion in the same way as other leaders. Commissioners should test the knowledge and capability of providers during procurement processes and look for evidence that providers understand inclusive practice and procedures.

As a minimum, those tendering to provide leadership interventions should demonstrate:

- how they will address inclusion in their programme content – even if the programme is not a 'diversity initiative.'
- a commitment to their own ongoing learning and understanding about inclusion and how they have changed their content as a result of their learning.
- how they will support the commissioning organisation to recruit and encourage under-represented communities to participate in the programme.
- the diversity of the delivery team and how staff from different backgrounds are involved in programme design.
- their own approach to inclusion and how they develop that approach.
- a willingness to attend internal inductions around inclusion, or other programmes as required by the organisation, to help the provider deliver inclusive content.

> **'BAME staff should also be encouraged to attend the general leadership programmes available, and not always those that are only targeted at BAME staff. It can also feel like these programmes are set up as a 'tick box' exercise – rather than being meaningful. It is important to look at whether these translate to career progression (e.g. are they monitored and evaluated?).'** – Leader

4. Not just the leaders

> **'Leadership shouldn't be hierarchical. Leaders come in all shapes and sizes with a wealth of different skills, knowledge and experiences.'** – Leader

Leadership programmes are often targeted at those in assigned leadership roles but it's clear that all staff, and volunteers, should have the potential to shape culture and create inclusive ways of working and behaviours. This isn't necessarily achieved through general diversity training courses or skills-based courses. As standard, any training and development initiative should demonstrate how it will be open to people from under-represented communities, be inclusive in its content and delivery, but also provide mechanisms for leaders to discuss inclusive cultures and how to create them.

> **'The number of times I have been told *"but inclusion isn't your job, it's the inclusion team's job"* – no, it is everyone's job! This stuff just won't change unless EVERYONE takes up the mantle.'** – Leader

5. Run leadership interventions for under-represented communities

Continue to invest in leadership interventions which specifically support individuals from groups that remain under-represented in assigned leadership roles and who are disproportionately affected by health inequalities. The Equality Act asks public bodies to take positive action to reduce inequalities. High-quality interventions, targeted explicitly at under-represented communities, can make a demonstrable difference to leadership in the NHS.

> **'BAME staff are not offered the same opportunities and resources to non-BAME staff. Training is blocked or made more difficult than needs be. Gatekeepers appear when BAME staff are self-motivated and seek development. Training for BAME staff is seen as a reward for good behaviour rather than an enabler for doing a job more efficiently. There is a perception that spending money or resources on BAME staff cannot be justified.'**
> – Leader

When commissioning targeted interventions, providers should demonstrate how the programme will:

- support the career progression of the individual leaders, including specific plans and actions
- empower individual leaders to play a more specific and valued role in building and sustaining an inclusive culture
- involve senior leaders from the organisation in the delivery of the programme and ongoing support of the emerging leaders
- be inclusive of all communities; for example, a programme for Black NHS leaders should be demonstrably inclusive of trans Black people, and an LGBT leadership programme should be inclusive of different ethnicities
- provide an ongoing mechanism for leaders to network and work together outside and beyond the parameters of the programme itself.

> **'There is a lack of support following attending stepping-up programmes. There should be alumni networks and associated accelerated development pools; some Trusts have these, others don't. Where they exist, they are starting to have an impact on accelerating participants into higher-banded positions and leading to better inclusivity and representation for BAME colleagues.'**
> – Leader

6. Impact and evaluation methodologies

NHS organisations should be able to demonstrate how every leadership intervention impacts on leaders from under-represented communities, and the long-term impact of any intervention on future leadership in the NHS. Furthermore, evaluation should include an assessment of the extent to which an intervention enables leaders to make a direct, specific and personal connection between a diverse and inclusive internal workplace culture and NHS effectiveness, and to translate that understanding into concrete positive change within their workplace.

This cannot be achieved through an evaluation form at the end of a programme, but requires designed methodologies for before, during and after a programme, and group data analysis measuring trends for groups of cohorts.

7. Involve the experts

Leaders expressed an ongoing frustration with being asked what their needs are as under-represented communities. Instead, they wanted to be involved in the designing and commissioning of services and leadership interventions.

The NHS is familiar with co-production principles[23], that is, engaging communities in the design of services. For example, the Independent SAGE Committee[24] calls for co-creation of COVID-19 find, test, trace, isolate and support programmes targeted at BAME communities.

The principle of co-production does not seem to extend to engaging staff in the design of leadership interventions.

The key is to ensure leaders and potential leaders are included in the commissioning and design of leadership interventions. This does not mean providing focus group evidence for trainers about needs, but explicit co-production and co-delivery of interventions.

Nesta describes the six principles of co-production as[25]:

- recognising people as assets
- building on people's capabilities
- developing two-way, reciprocal relationships
- encouraging peer support
- facilitating rather than delivering.
- blurring boundaries between delivering and receiving services

These principles should be applied to the commissioning, design and delivery of any leadership intervention.

[23] McNally, D. (2016) Blog: Joining up 'co-production' and 'patient leadership' for a new relationship with people who use services [online]. Available at: https://www.england.nhs.uk/blog/david-mcnally/ (Accessed: 11 November 2020)

[24] Independent SAGE Committee. (2020) Disparities in the impact of COVID-19 in Black and Minority Ethnic populations: review and recommendations [online]. Available at: https://www.independentsage.org/disparities_bme_final_jul2020/ (Accessed: 10 November 2020)

[25] Boyle, D. and Harris, M. (2013) The Challenge of Co-Production [online]. Available at: https://www.nesta.org.uk/report/the-challenge-of-co-production/ (Accessed: 11 November 2020)

8. Support network groups to professionalise

Network groups play a vital role in transforming cultures and ways of working. They are near universally under-resourced and rely on the goodwill of under-represented communities to do the work. Network groups can provide a means for accessing expert experience to help shape the policies, practices and interventions that are commissioned.

> **'Do the networks have any influence, though? Are they consulted? Invited? Active participants in decision making/reviewing?'** – Leader

There are five ways to strengthen network groups:

- Establish terms of reference and business plans for local, regional and national networks and make sure those plans ensure networks set objectives across differences and consider intersectionality as a matter of course.
- Provide leadership development opportunities, influencing, networking skills and support for network group officers.
- Provide budget for activity and agree how time can be spent on network group-related work – reflect network group activity in performance and appraisal systems.
- Create opportunities for network groups to work together on common activities and goals. Support network groups to work together to influence.
- Provide senior sponsorship and clear mechanisms for network involvement in activity.

9. Understand health inequalities

> **'How diversity and inclusion is sold as a business case – priorities for those in leadership positions need to be thought through and tailored into any training around inclusive practice and culture. For example, linking diverse workforce and inclusive culture into better patient care outcomes, stronger attraction, recruitment, retention and motivation of staff. Showing leaders how diverse practice can be cost effective, such as recruiting service users (e.g. Recovery Academies).'** – Leader

Any leadership intervention should put an understanding of health inequalities and how they impact staff, volunteers and patients at the heart of all activity. Systems and services should be designed, delivered and led by those who best understand the communities who will be accessing them. This, of course, includes people with lived experience. Everyone should better understand the link between equality, health and well-being inside the NHS and in achieving our shared purpose. Systems and services should be designed, delivered and led by those who have technical expertise, learning and qualifications, but also those who understand how that service or system will be used or accessed. The NHS should also look to the past for good practice in this area. The involvement of HIV positive people in the design and delivery of many early services is just one example where the NHS has learnt from the communities most affected by HIV.

10. Take a lead within society

The NHS unites this country more than any other institution.

It is a significant employer and most of the population will come into contact with it in some way or another. The NHS has the power to set a new leadership standard – one that is collective, social and purpose-driven. The NHS can role model to every other institution in this country what good leadership looks like and how to achieve it. Every workforce plan, talent management strategy and leadership programme should aim towards the goal of creating and sustaining a truly inclusive organisation that can lead to a healthier, more united country. If not now, then when?

Part Three: Methodologies

Our approach

The NHS Leadership and Lifelong Learning Academy undertook a range of approaches to involve leaders from across the NHS in its strategic review. The Academy recognised that leaders from minority communities and backgrounds were less likely to take part in traditional consultation methods. They therefore decided to supplement traditional approaches by engaging Deeds and Words to work directly with NHS leaders from minority backgrounds and communities.

Despite a tight timetable (the work was commissioned in August and the Inclusive Leadership Project conducted throughout September), Deeds and Words received over 80 individual expressions of interest to join a webinar series that would explore inclusive leadership in the NHS. The webinars were scheduled over six weeks and leaders were informed that the series would cover:

1. **Introduction to the Inclusive Leadership Project – 19th August, 3pm–5pm**
2. **A shared understanding of inclusive and collective leadership – 26th August, 3pm–5pm**
3. **What is inclusive and collective leadership in the NHS? – 2nd September, 3pm–5pm**
4. **Existing leadership and learning support – 9th September, 3pm–5pm**
5. **Our shared findings for the strategic review – 23rd September, 3pm–5pm**

Deeds and Words believes strongly that any request to individuals to participate in a process of co-production should provide reciprocal benefits to the individuals. Deeds and Words therefore made a commitment to share insights and approaches around inclusive leadership with the leaders on the programme.

All 80 leaders were accepted onto the programme. Each webinar provided content from Deeds and Words and then leaders were split into 10 groups of eight, where they were encouraged to reflect on core questions.

In addition, the leaders were all encouraged to identify three people outside the webinar series. The leaders were asked to talk to the three people about our work together, sharing the content of the webinars and asking their views on the questions we raised. The intention behind this extended outreach was to encourage all leaders to look beyond their own experiences and work to hear from those who were unable or unwilling to take part in a webinar series or consultation exercise. The leaders submitted evidence from their trio, and these findings shaped the final chapter and this report.

After webinar four, Deeds and Words worked with Tracie Jolliff to draft the chapter for the strategic review. The chapter was shared with all leaders and they had the opportunity to comment and amend the final text. The final webinar provided an opportunity for leaders to reflect on the process and on the final chapter. The final chapter was submitted to the Academy at the end of September 2020.

What worked well

Our collective ways of working on this project have been beneficial and we think there are lessons to be learnt to help the NHS more broadly develop and embed a way of working that is itself inclusive and aligns with organisational values. In particular, a combination of sufficient time, challenging and respectful facilitation and a diverse group drawn from across the NHS, enabled us to discuss complex and often personal experiences in a collaborative and effective way.

Leaders reported that the way of working encouraged staff to think differently, one of the key benefits of an inclusive workplace culture. The task of identifying a trio outside the webinar encouraged leaders to think about their own power and influence and what voices were missing.

We encouraged leaders to submit evidence in any format that suited them. We therefore received typed notes, pictures of handwritten notes, word clouds, sound files and posters. Each small group submitted notes via email at the end of each webinar or uploaded their thoughts into Chat. As evidence came in, Deeds and Words were able to codify it along thematic lines and change the content of the next webinar in response. The layered evidence shaped the final key findings and recommendations submitted to the Academy, and reflected here.

Webinars were conducted online because physical meeting was impossible due to COVID-19 restrictions. We think that led to greater participation across the NHS, but we also recognised that online collaborative exercises are very difficult to run. Deeds and Words involved more staff in each webinar, ensured papers were circulated in advance and recordings of the webinar were uploaded into the Teams folder. We now, as standard, provide IT support before, during and after sessions, speech-to-text services and small group facilitators for every programme we run.

What worked less well

Some leaders found it hard to identify and work with their trios. It took time to seek out people different from themselves, listen carefully to what was said and report back their findings. Inclusive and collaborative co-production can be difficult and take time.

Many leaders were not able to access Microsoft Teams outside the NHS. Deeds and Words employed IT support to help individuals and we all experienced some teething problems when moving in and out of breakout rooms. These were resolved by the third webinar, but provided valuable learning about the limited access to technology experienced by some NHS staff.

The small groups sometimes found it hard to keep on track and work collaboratively and inclusively with each other. Perhaps inevitably, the issues that exist in the wider NHS were sometimes replicated in the small groups. On reflection, each group should have had a facilitator – supported by Deeds and Words.

What we learnt

- Co-production, when done well and inclusively, needs time and resource to make it work. Deeds and Words, and those who advocate co-production, need to better demonstrate to those in power why this is the case and how it can lead to better outcomes.

- Online webinars have the potential to be inclusive but are not automatically so. Working collaboratively online requires greater allocation of resource than is usually required in face-to-face interactions. IT support, speech-to-text services and skilled facilitation are essential if online ways of working are to become the norm. This requires more resource than face-to-face delivery.

- Looking beyond ourselves to those who have less power takes time and is difficult to do, especially when working to a deadline. Everybody needs support to demonstrate generous and collective leadership, regardless of their identity, protected characteristic or assigned leadership status. Deeds and Words needs to take more time to help individuals do this well.