Royal College of Nursing
Inclusive Leadership

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The NHS Constitution

The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.
The 1st Principle of the Constitution

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

Our strategic aims in relation to inclusion are to:

- Raise the level of aspiration on inclusion
- Quicken the pace of change towards inclusion
- Ensure that leadership is equipped to leave an ever increasing and sustainable legacy of inclusion
Knowledge formation – the norms of experience
Inclusive leadership is the practice of leadership that carefully includes the contributions of all stakeholders in the community or organization. Inclusion means being at the table at all levels of the organisation, being a valued contributor and being fully responsible for your contribution to the ultimate result. Inclusive leadership creates an organizational culture that consistently produces results that benefit all of those stakeholders.’

Human rights, political struggle and progress

“If there is no struggle, there is no progress…”

Power concedes nothing without a demand. It never did, and it never will.”

Frederick Douglass (1857)
Attending to the gaps

Need to identify interventions that move beyond compliance to innovation, creating inclusive cultures and organisations through leadership.

“Our work is the work of translation”.

Making the demand clear within a compelling and transforming narrative…
Why is inclusive leadership important for patient care
The Snowy White Peaks” found…

- 1 in 40 chairs and no CEO in London is BME
- 17 of 40 Trusts have all white Boards but over 40% of workforce and patients are BME
- Decrease in BME Board members
- Not one BME exec director in Monitor, CQC, NHSTDA, NHS England, NHSLA, HEE
- Decrease in BME senior managers and nurse managers in recent years
The treatment of staff

- White staff 1.74 times more likely to be appointed once shortlisted than are shortlisted BME staff (Kline 2013)
- BME staff twice as likely to enter disciplinary process and more likely to be disciplined for similar offences (Archibong et al 2010)
- Black nurses take 50% longer to be promoted (RCN) and are less likely to access national training courses
- Less BME nurse managers now than a decade ago but more BME nurses but… Earl Howe says

  “Although these are not substantive rises, this demonstrates that we are travelling in the right direction.”
Staff survey confirms what the data shows

• Key Finding 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
  - W%: 28
  - BME %: 29

• Key Finding 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
  - W%: 21
  - BME %: 26

• Key Finding 27. Percentage believing that trust provides equal opportunities for career progression or promotion
  - W%: 90
  - BME %: 77

• Key Finding 28. Percentage of staff experiencing discrimination at work in the last 12 months
  - W%: 9
  - BME %: 25
...and for patients...
Six reasons why workforce race discrimination is bad for all patients

- Prevents patients getting best staff
- Impact diverts resources from patient care
- Discrimination makes staff ill
- How staff are cared for impacts on care they provide
- Diversity improves innovation + teamwork
- Unrepresentative Boards less likely to provide patient focussed care
Race discrimination can prevent patients getting best possible staff

Patients may be prevented from getting the best clinicians and support staff if candidates’ ethnicity unfairly influences recruitment and promotion, or leads to BME staff being unfairly treated in the disciplinary process and in other aspects of their working life.
Race discrimination makes staff sick

Everyday Discrimination: positively associated with:

- coronary artery calcification (Lewis et al., Psy Med, 2006)
- C-reactive protein (Lewis et al., Brain Beh Immunity, 2010)
- lower birth weight (Earnshaw et al., Ann Beh Med, 2013)
- cognitive impairment (Barnes et al., 2012)
- poor sleep [object. & subject.] (Lewis et al, Hlth Psy, 2012)
- visceral fat (Lewis et al., Am J Epidemiology, 2011)
- Discrimination, like other stressors, can affect health through both actual exposure and the threat of exposure
If those who care are not cared for, then patients will suffer

- An established link between the treatment of BME staff and the care patients receive.
- “Research suggests that the experience of black and minority ethnic (BME) NHS staff is a good barometer of the climate of respect and care for all within the NHS.
- “Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received”.

NHS Staff Management and Health Service Quality Results from the NHS Staff Survey and Related Data West, M et al,(2012)
Healthcare innovation hindered

- There is evidence of a link between diversity in teams (at every level including Boards) and innovation. At a time when the NHS needs to transform its care, lack of diversity may carry a cost in patient care for everyone

*The Healthy NHS Board 2013: Review of Guidance and Research Evidence*
Identifying barriers
Programmes –
professionalising leadership

• Barriers identified through data (counting).
• Barriers identified through the lived experience – a willingness to hear and accept this narrative in the first instance.
• Understanding psychological processes, cultures, climates and relational dynamics....
New organisational forms, shifting power and ensuring that the voice of nursing is heard
Shifting the paradigms

- Liberal normative ideals of neutrality and gender/sexual orientation/disability/colour blindness have reproduced and perpetuated hierarchies and privilege rather than annihilating them.
- A particular discomfort around race.
- The meritocracy is illusionary.
- For change to take place, methods and approaches must reject the charade of a meritocracy.
- Paradox - challenge power relationships and engage power.
An alternative Gaze

A beginning with impact…
How the story is told and Who’s telling it?

Sustained scrutiny – trying to find the deficit or problem - Culture, nationality, ethnicity, colour and many forms of ‘othering’

Organisation

White majorities are not scrutinised in the same way. Whiteness not discussed as though this group have no racial identity. THE DOMINANT ORGANISATIONAL DISCOURSE IS SHAPED HERE.

T. Jolliff 2013
Inclusion and Systems Leadership

- Visionaries – changing society
- Involvement of patients, users, carers
- In for the medium/long term
- Diminished hierarchy, ego,
- Enablers, co-creators (working with others)
- Coalition of the willing and the powerful
- A constancy of purpose with a degree of flexibility
- Learning & cooperation over competition
And to finish...

• Nursing that continues to inspire hope
• Leadership for us