Reddenhill Consulting Limited

The Intercultural Hospital Project Report of the English Partners

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In particular Birmingham and Solihull Mental Health Foundation Trust

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1. Introduction

In response to demographic changes, western society has to look for ways to balance the growing numbers of older people who need care, with that of the falling numbers of people of working age to care for them. For Germany, this overall situation is further compounded by regional differences. Whereas the East German region is finding it more difficult to attract staff (it is predicted that over the next 20 - 30 years some parts of Germany will lose about 20% - 30% of residents); the Western region is experiencing greater net immigration with the subsequent increased pressures on its health services. These dynamics have brought about a disparity between healthcare systems in the different regions of Germany and with this, an increasing need to look outside of the country for all levels of staff.

As is the case in the rest of Europe, migrant workers are now playing an increasing role in Germanyôs healthcare economy. With only a recent history of recruiting migrant workers, the challenge facing Germany is the retention of these workers. For example, in one hospital 80% of those recruited had returned to their country of origin. As independent economic units, with little experience of dealing with incoming migrant workers, hospitals recruit independently of each other and have different approaches.

As Germany moves towards meeting the challenges of an increasingly interconnected and diverse country, the need for a coordinated approach to the management of ethnic and cultural workforce diversity has been brought into sharper focus.

With the support of Germanyôs Labour and Health Ministries, the Intercultural Hospital Project is a working group established in 2013 to study this issue with a view to finding models of integrating migrant workers into its health care systems and to ultimately address its workforce challenges. Under the leadership of the host Project Group made up of a number of independent partners Reddenhill Consulting Limited was identified as the English Partner.

As the fifth largest employer in the world the NHS is also a ñworld employerò currently being a significant net importer of labour. Its success in utilising such a workforce has added to an acknowledgement of the NHS as a world leader both in terms of clinical excellence and in workforce management. It is also a major provider of training which impacts significantly on the healthcare workforce globally.

Given the size of the NHS and its historical experience of international recruitment it was felt that the English experience would be an ideal starting point for this work. The primary context is the UK Health and Social Care Act (2012) which seeks to bring about radical restructuring of the sector, with real implications for ensuring quality patient care within tight budgetary controls. Other national health policies highlight the need for flexibility of the workforce allied to

security of supply and seek to challenge the perspective of traditional ways of working within professional silos.

Furthermore, in light of the differing English and German contexts, it is important to clarify from the outset that the term Black and Minority Ethnic people (BME) is mostly used in Britain to describe people who are from non-white origins. A Migrant Worker is technically someone who moves between countries to find work on a temporary basis. These terms are however often used interchangeably. Whereas Black and Minority Ethnic people are more likely to be migrant workers; being a migrant worker is not necessarily about being black or from a minority ethnic group.

This scoping report presents the findings of the projects English partner (Reddenhill Consulting Ltd) the work of which has drawn heavily from both primary and secondary research that can be found in the attached references and bibliography at appendix 5.

It is structured to cover:

- Methodology
- Overview of the New NHS
- Workforce Profile of Migrant Workers
- Challenges of Integration
- Models of Responses
- Case Study Examples
- Questions for Germany to reflect on

2. Methodology

The overall aim of the English contribution to the project was to establish what works well and not so well for the NHS with regard to recruiting and managing an ethnically and culturally diverse workforce.

It is however recognised that different histories and contexts makes transferring lessons difficult, so our aim was to look across a number of observations to identify those which stand out as relevant to the projectôs core areas of interest. In addition to a review of the relevant literature, qualitative methods were used in order to find out about the perspectives and lived experiences of both staff and managers and to explore practical solutions and applications.

A multi-method approach was thought to be the best way of addressing this complex, sensitive and potentially contested and contestable issues where stakeholders might have different perspectives. Such an approach also provides the opportunity for findings to acquire a practical meaning of use in developing interventions and identifying best practice. By combining organisational and professional contexts with the views of individuals, we wanted to provide a rounded picture.

We therefore employed a range of activities as follows:

2.1 In-depth discussion

In-depth discussions were held between the German and UK partners. This was designed to enable the German Partners to further clarify their needs and the expected outcomes. Discussions also proved extremely useful in helping to refine the approach to the English aspect of the study (Appendix 1).

2.2 Attendance at a Black and Minority Ethnic (BME) Staff Network Conference

The project team also attended a scheduled regional BME Staff Network Conference as participant observers. The conference is an annual event held in an NHS Trust venue and was attended by 130 people who were all members of these networks together with representatives from health care Trade Unions and Professional Bodies (Appendix 2). This enabled the project team to gain an initial insight in order to facilitate a better understanding of the practical working of staff networks groups; a firsthand understanding of the issues as they occur for staff; and the role and relationships of Trade Unions and Professional Bodies (Royal College of Nursing) in this context.

2.3 Meeting the Human Resources Team of a Mental Health Trust

In order to gain a detailed pictured of what this means from an organisational perspective an extensive analysis within an NHS Trust was also undertaken. A mental health Trust was selected as an appropriate area for a case study - The nature of this discipline (traditionally known as an ñunpopular specialismò) thus having the potential for greater challenges with staff shortages. Mental health Trusts in the NHS are also known for their greater sensitivity to employee relations issues such as staff engagement and managing diversity.

The project team partners met with Human Resource Managers in Birmingham and Solihull Mental Health Foundation Trust. The meeting took a workshop/ focus group format; designed to promote discussion in order to gain a deeper understanding of this Trustôs experiences. It was hosted by members of the Trustôs Human Resources team (Associate HR Director and Mangers and its two equality and diversity practitioners). The workshop was centred on an initial overview of the Trustôs workforce data and organisational priorities and programmes. Subsequent discussions revolved around exploring the challenges and benefits of recruitment and retention of migrant workers in the Trust in particular and on the international recruitment agenda more generally (Appendix 3).

2.4 Literature Reviews

A review of most recent publications focusing on BME people experience of the NHS especially the Human Resource point of view and NHS responses in relation to the management of Intercultural issues specifically and diversity management more generally was undertaken. The aim of this review was not simply to present a body of collected literature but to synthesize information within the context of broader theoretical and policy debate. What we describe below therefore draws heavily from the literature bibliography.

3. Overview of the NHS

An overview of the structure and function of the NHS will be important in order to put some context around what is probably one of the worldôs most qualified, diverse and complex workforces. This section provides brief and basic details of the workings of the NHS; describing the entitlements, funding arrangements and approach to delivery. Key issues for health and social care specifically in relation to the projects interest are also highlighted. Where appropriate, differences between the English and the German systems are highlighted.

The UK's National Health Service (NHS) came into operation at midnight on the fourth of July 1948. It was the first time anywhere in the world that completely

free healthcare was made available on the basis of citizenship rather than the payment of fees or insurance premiums. It is now underpinned by the NHS Constitution which sets out the rights of NHS patients. These rights cover how patients access health services, the quality of care they receive, the treatments and programmes available to patients, confidentiality, information and rights to complain if things go wrong. The NHS grants patients rights that are intended to be legally enforceable, and it also makes other non-binding pledges. These are in the areas of access, quality of care and environment, access to treatments, medicines and screening programmes, respect, consent and confidentiality, informed choice, patient involvement in healthcare and public involvement in the NHS and complaints and redress. It does not provide any new means of redress for breaches of the constitution.

Box 1 below presents a summary of the key principles that guide the NHS in all that it does:

- The NHS provides a comprehensive service, available to all irrespective of age, gender, disability, race, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to diagnose, treat and improve 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
- Access to NHS services is based on clinical need, not an individualôs ability to pay (except in exceptional circumstances sanctioned by Parliament)
- The NHS aspires to the highest standards of excellence and professionalism to provide high quality care that is safe, effective and focused on the patient experience
- The NHS aspires to put patients at the heart of everything it does. NHS services must reflect the needs and preferences of patients, their families and their carers
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
- The NHS is accountable to the public, communities and patients that it serves. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff

3.1 Entitlements

Healthcare in the NHS covers everything from antenatal screening and routine screenings, treatments for long-term conditions, transplants, emergency treatment and end of life care - that is ñ*From the cradle to the grave*ò

Social care (including children's services, learning disabilities, some aspects of mental health and elderly care amongst other services) are often delivered through partnerships between the NHS locally and a Local Authority with the Local Authorities being the employer.

The new NHS has been an incremental change based on a recognition that the model that was developed in 1948 needed to be modernised to meet public expectation, advances in technology and employment practices. The past 2 ï 3 years has seen the most impactful changes, underpinned by the Health and Social Care Act.

This new system became operational from 1 April 2013 and is designed to bring accountability and responsibility closer to delivery by having funds going directly to clinicians and to give local communities and patients more say.

A key change has been in the measurement of the patient and staff experiences. The capturing of these experiences contributes a great deal to the picture of how effective the NHS is in meeting patients and staff requirements. There is also increased opening up of the NHS to a wider range of health care providers (including independent/ private and charitable organisations and social partnerships).

Whilst most countries in Europe provide more comprehensive coverage of health than social care needs, the gap between the two is generally less stark than in England where social care support is considered to be heavily means tested in comparison to other countries in the OECD that cover both health and social care needs through social insurance.

3.2 Funding

The UK spends about 9.4 percent of it GDP on health, just above the OECD average - The budget for 2015/16, is was around £115.4 billion.

Healthcare in the NHS is free at the point of use for anyone who is a UK resident. With the exception of some contributory charges (such as prescriptions, optical and dental services). All residents pay tax and health care is one of the recipients of this tax through National Insurance; residents pay this according to their income. Receipt of health care is not dependent on earnings.

In recent years there has been an inclusion of some elements of private healthcare evolving, for example, some health care is delivered through contracts between the NHS and private providers.

Since the NHS transformation in 2013 the NHS payment system has become underpinned by legislation. The Health and Social Care Act 2012 moves responsibility for pricing from the Department of Health, to a shared responsibility for two new organisations - NHS England and Monitor.

The role of the Department of Health in the new system is to lead, shape and fund health and care in England. It sets objectives and budgets and holds the system to account on behalf of the Secretary of State for Health who has ultimate responsibility for ensuring the whole system works together.

General Practitioners (GPs) in England are seen as the key to delivering health services.

Whereas in some other OECD countries patients can go directly to consultants, one of the NHSôs distinctly unique features is the extent to which General Practitioners act as gate keepers.

Sixty million of the NHS Funding goes to Commissioning Groups made up of General Medical Practitioners and representatives from other professions and public representatives. Within the new NHS their main role is to try to improve the health of local populations. They do this through commissioning (buying services for the population from a range of different providers), NHS Hospitals and Community Services, Voluntary and Private Sectors can all bid for contracts. These Commissioning Groups are looking for value for money and quality service provision. This has introduced competition with measurable delivery outcomes

within a monitored system. The process is overseen by regulators (Monitor and the Health Care Commission) which oversee quality and effectiveness of service provision.

Commissioning Groups take into account all the supporting infra-structure needed to ensure that their local populations can access the service provisions. They are supported by organisations (Commissioning Support Units) that provide the technical support. They are also supported by the Technical Senate made up of a range of Medical Experts to advise and guide GPs on particular diseases.

There are a number of general indicators and specific indicators that guide the commissioning and monitoring of service - the main ones being: NHS Outcomes Frameworks; Public Health Outcomes Frameworks; Adults and Social Care Outcomes Frameworks; Health Educations Outcomes Frameworks. These are the key tools for the measurement of performance of the system, providing a national overview of how the system is performing and allowing some comparisons, encouraging a change in culture and behaviour focusing on outcomes rather than process. The Outcome Frameworks are the main way in which NHS England is held to account for improvements by the Department of Health in health outcomes.

3.3 How the New NHS Works

It is a large complex organisation made up of many separate organisations catering to a population in England of 53.9 million at mid 2013 and dealing with over 1 million patients every 36 hours. It is currently undergoing a radical change in the face of shifting strategy and the consequential overhaul of traditional organisational structures, across both the private and public sectors resulting in new boundary-less forms of organisations. Tables below attempt to describe the main accountability and governance structures within the NHS and how they relate to each other at national and local level.

How health and care organisations work together nationally	
NHS England	Å Supports NHS services nationally Å Ensures that money spent on NHS services provides the best possible care for patients • Funds local Clinical Commissioning Groups to commission services for their communities and ensures that they do this effectively Å Commissions some specialist services centrally Å Ensure national standards are in place across the country
Public Health England	Å Provides national leadership and expert services to support public health Å Works with Local Government, the NHS and other key partners to respond to health protection emergencies

How health and care organisations work together nationally	
The NHS Trust Development Authority	Å Supports NHS Trusts to improve (so they can take advantage of the benefits of Foundation Trust status when they are ready.
Health Education	Å Makes sure the healthcare workforce has the right skills and training Å Supports a network of Local Education and Training Boards that plan education and training of the workforce to meet local and national needs
The National Institute of Clinical Excellence	Å Provides guidance to help health and social care professionals deliver evidence based care Å Involves patients, carers and the public in the development of guidance and other products
The National Institute for Health Research (NIHR)	Å A clinical health research network system in which the NHS supports research focused on the needs of patients and the public
The Health and Social Care Information Centre	Å Supports the health and care system by collecting, analysing national data and statistical information Å Delivers national Information Technology systems to support health and care providers
NHS Blood and Transplant Authority	Å Manages the supply of blood, organ donation and transplants across the UK to the NHS
NHS Litigation Authority	Å Handles Litigation claims against the NHS
NHS Business Services Authority	Å Carries out a range of support services to the NHS, Patients and Public Å Payment for Community Pharmacist filling prescription and dentists who carry out NHS treatment

How health and care organisations work at a local level	
Clinical Commissioning Groups	Å Made up of doctors, nurses and other professionals Å Buy services for patients, (while local councils formally take on their new roles in promoting public health).
Health and Wellbeing Boards	Å Bring together local organisations to work in partnership

Local Healthwatch	Å Comprised of local lay people from the local community Å Represented on Health and Wellbeing Boards Å Report their views to Healthwatch England Å Protects the interest of patients and the public
Local Authorities	Å Commission care and support services Å Responsible for protecting and improving health and wellbeing Å Use their knowledge of their communities to tackle challenges such as smoking, alcohol and drug misuse and obesity

Health and Care Regulators whose role is to safeguard the interest of service users and the wider public are outlined below:

- Å The Care Quality Commission (CQC) measures whether services meet national standards of quality and safety.
- Å Healthwatch England works as part of the CQC.
- Å Monitor issues licenses to healthcare providers.
- Å The Health Research Authority to protect and promote the interests of patients and the public in health research.
- Å The Medical and Healthcare Products Regulatory Agency ensures that medicines and medical devices work and are safe to use.
- Å The Human Tissue Authority regulates human tissue, such as donated organs, to ensure it is used safely and ethically, and with proper consent.
- Å The Human Fertilisation and Embryology Authority regulates fertility treatment and the use of embryos in research.
- Å Most health and social care professionals must be registered with one of the independent regulators, such as the General Medical Council who help protect patients and public by ensuring that professional standards are met.

3.4 NHS Staff

In terms of workforce planning, each year Trusts produce annual work plans in order to ensure they are employing the workforce to meet the needs of current patients/ local populations. Trusts also forecast future demands to inform decisions about future workforce supply.

Recruitment of staff into the NHS in England and Wales is coordinated through an online recruitment service known as ñNHS Jobsòwhere most NHS organisations advertise vacancies. It is a comprehensive service covering the full range of available roles - whether this be hospital, community-based roles, flexible contracts, and/ or permanent jobs.

A related organisation NHS Professionals offers programmes, in partnership with NHS organisations, which allow people to translate clinical learning into practice. By joining one of the preceptor/ instructor programmes people are able to start their career in the NHS with the opportunity to develop new skills.

One of the key issues is the recruitment of General Practitioners, in particular with the ageing population of GPs.

3.5 International Recruitment

England has a history of international recruitment which has resulted in a more settled population of Black and Minority Ethnic people in the NHS Workforce. This population is younger in age group and hence an important pool from which to draw. However, given the size, rapid growth and demand on the NHS workforce recruitment is always a challenge.

International recruitment is an option mainly used by employers trying to fill vacancies in certain geographical areas or professions with recognised shortages. For example, a recent poll of three clinical commissioning groups, one special health authority and one social enterprise providing NHS services, found that 42 organisations estimated they have between one and 50 full-time equivalent hard to fill nursing vacancies, a further 39 said they have between 50 and 100. In addition more than half of respondents are considering recruiting nurses from abroad because they believe that there are not enough in the UK.

Similarly, the employers led body NHS Employers revealed in a recent report the huge vacancy rate within NHS organisations where almost half are actively recruiting nurses from outside the UK. The review, based on questionnaires filled out by 104 NHS Trusts; found that 83% of organisations are experiencing qualified nursing workforce supply shortages. And 45% said they have actively recruited from outside the UK in the last 12 months to fill vacancies. The majority were focusing their recruitment campaigns in Europe. With Spain, Ireland and Portugal most commonly targeted the report states.

NHS organisations are first required to fill vacancies from the resident labour market (including a national of a country in the EEA and Swiss nationals) before looking further afield to non EEA candidates.

The shortage occupation list is an official list of occupation for which there are not enough resident workers to fill the identified vacancy. This list is regularly updated by the Migration Advisory Committee. Employers who wish to recruit an individual from outside the EEA and Switzerland, to fill a vacancy, may issue a Tier 2 Certificate of Sponsorship.

People who are not eligible will need to be issued with a visa from the Home Office UKVI which is responsible for managing migration in the UK and governing the way individuals from outside the EEA can work, train or study in the UK. This is done through a points-based system. This is designed to only allow entry to those whose skills will benefit the UK. The different education and employment routes are outlined below. The number of points required, and the way the points are awarded, depend on the tier under which individuals apply, but will reflect their qualifications, experience, age, previous earnings and language competence. Health professionals from outside the UK can apply to take employment and training posts that may qualify for sponsorship under Tier 2 (General)

Below are the 4 main routes of the points-based system

Tier 1	Applies to high value skilled individuals (previously the Highly Skilled Migrant Programme). This route is now closed to all new applicants. *(exceptional talent, general, entrepreneur, investor, graduate entrepreneur)*
Tier 1 (Post-study work)	Previously granted individuals, who had graduated from a UK university under Tier 4, two years of leave to remain with the ability to work without a sponsor. This route is now closed to all new applicants.
Tier 2:	Applies to skilled workers who are offered a sponsorship to fill gaps in the UK labour force (previously the work permit route). *(intra-company transfers, general, minister of religion or sportsperson)*
Tier 4:	Applies to students who wish to come to the UK to study. Individuals will need to be sponsored by the educational establishment to undertake their studies. *Tier 4 (General) student and Tier 4 (Child) student*
Tier 5:	Applies to individuals on a youth mobility scheme and temporary workers who are allowed to work in the UK for a limited period of time to satisfy primarily non-economic objectives such as exchange schemes. *Temporary migrants (Youth Mobility Scheme, temporary workers)*

In terms of refugees and asylum seeking health care professionals, there is an online information portal which provides easily accessible advice and information on the requirements for UK registration and resources to help them become safe practitioners in the UK. It also provides advice and guidance to help NHS organisations on employing this section of the population.

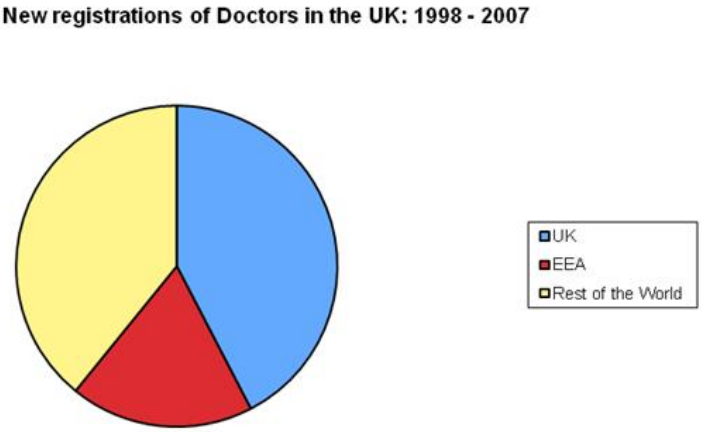
In terms of the wider societal view there are ongoing debates around the ethics of recruiting health professionals from low income countries (depleting the capacity of their home country). Guidance on ethical recruitment have been developed by key organisations for example the Royal College of Nursing and the Department of Health. NHS Employers (the employerôs organisation for the NHS) plays a key role in providing employers with advice on ethical international recruitment.

The support provided is guided by the evidence that there is mutual benefit for the NHS and source countries, those professionals returning home with NHS experience will bring clinical and training skills acquired in the NHS, and it is also well known that remittance sent home by migrants is a vital source of revenue for low income countries.

4. Workforce Profile of Migrant Workers

The English health and Social Care Sector employs one in seven of all immigrants in the UK. In terms of doctors: analysis of data from the Labour Force Survey indicates that in the UK almost a third of medical practitioners and approximately a fifth of dentists, pharmacist and nurses were born outside the EEA. Based on registration data for the General Medical Council - 11% of all medical practitioners working in the UK received their qualifications in India. Others qualified in South Africa (3%), in Nigeria (1.4%) and Pakistan and Egypt.

Figure 1: Area of Origin of New Doctor Registrations in the UK: 1998 - 2007



Source: Bach in Anderson, Ruhs

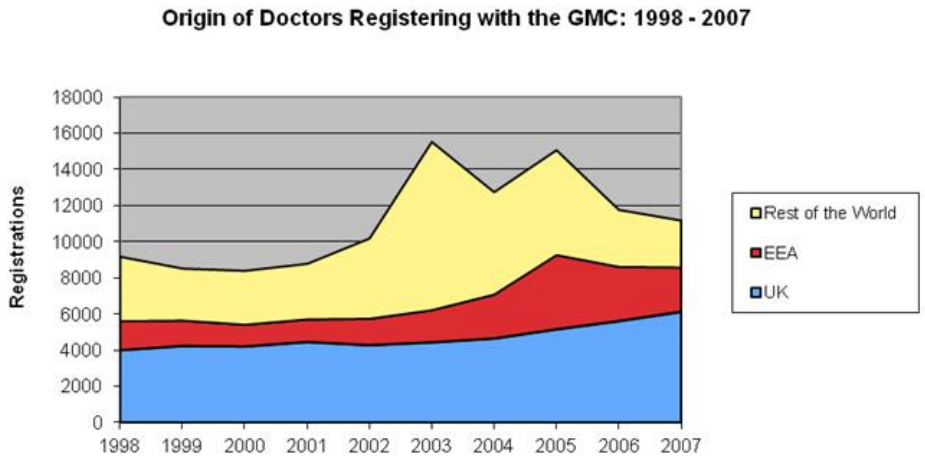
Table 1: New Registrations of Doctors in the UK (based on location of medical qualification), 1998 ï 2007

Year	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
UK	4010	4242	4214	4462	4288	4443	4658	5164	5620	6133
EEA	1590	1392	1192	1237	1448	1770	2419	4103	2994	2446
RoW	3580	2889	2993	3088	4456	9336	5683	5825	3163	2609
Total	9180	8523	8399	8787	10192	15549	12760	15092	11777	11188

Source: Stephen Bach in Anderson, Ruhs – Who Needs Migrant Workers? ; RoW = Rest of the World

Since 2007 however, there has however been a sharp contraction of doctors from outside the EEA and a corresponding increase of doctors trained either in the UK or the EEA.

Figure 2



Source: Bach op.cit

The extent of foreign trained doctors is much higher than most other countries in Europe.

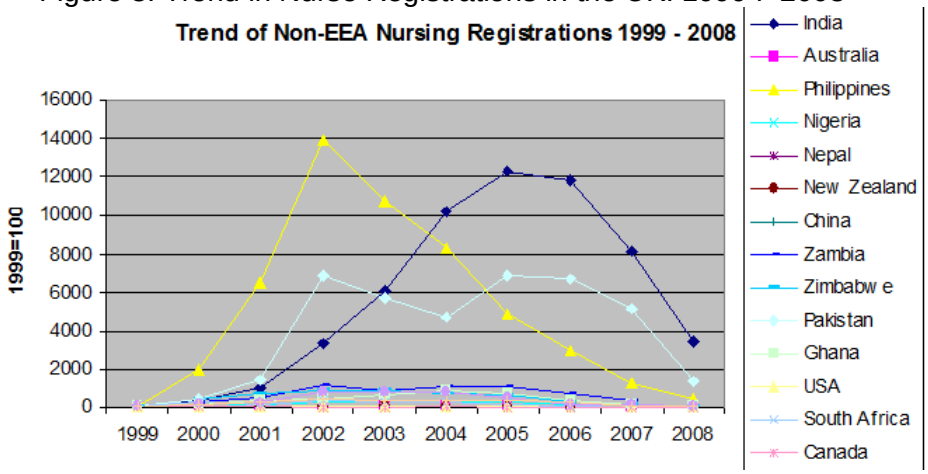
Table 2: Foreign Trained Doctors as Share of all Doctors ï Various European Countries ï 2004 ï 2007

Country	Percentage
Austria	3.3
Denmark	10.9
Finland	7.2
France	5.8
Germany	4.9 *
Ireland	30.1
Italy	3.5 *
Netherlands	6.2
Poland	0.7
Switzerland	18.8
UK	37.5

Source: WHO Europe
** Foreign doctors (no data on where they were trained)*

In terms of nurses; the numbers from the EEA working in the UK has always been significantly lower than those outside Europe due to language and other barriers.

Figure 3: Trend in Nurse Registrations in the UK: 1999 ï 2008



In all, 16% of NHS Hospital and Community Health Service staff are from BME backgrounds including 37% of hospital doctors and 19% of nursing staff. There are now an estimated two hundred different nationalities in the NHS.

BME backgrounds currently make up 14% of the NHS workforce and the NHS is the largest employer of BME staff in England.

Table 3 below shows the breakdown by specialisation of EEA and non EEA health professionals in the UK.

Table 3: EEA and Non-EEA Origins of Selected Health Professionals

Employees Born Non-EEA (%)	Employees Born EEA (excluding UK - %)	Estimated Numbers of Working-Age UK Population in this Occupation	
Medical Practitioners	32	5	184,000
Psychologists	19	4	23,000
Pharmacists	21	5	40,000
Ophthalmic Opticians	4	1	13,000
Dental Practitioners	20	5	27,000
Nurses	19	3	500,000
Midwives	12	9	37,000
Paramedics	8	2	17,000
Medical Radiographers	8	4	25,000
Chiropodists	9	0	10,000
Dispensing Opticians	5	8	5,000
Physiotherapists	9	4	32,000
Occupational Therapists	5	6	31,000
Speech and Language Therapists	4	0	14,000

Source: Bach.

5. Challenges of Integration

Since the last century migrant workers have been helping to shape the culture and direction of the NHS**.** Their presence alone has been and is instrumental in ensuring that services are accountable and responsive to local needs - by helping to create more accessible, locally responsive and culturally competent services. For example, the establishment of Haemoglobinopathy services, culturally specific mental health initiatives, language support, catering and engagement with the community are some of the more obvious ways in which this section of the population have helped to shape the NHS.

Some have demonstrated exceptional leadership abilities with global international reach. For example Jamaican born Mary Seacole, was one of the most famous nurses in Victorian England recognised both nationally and internationally for her humanitarian work caring for soldiers and prisoners from both sides of the Crimean war. Another Jamaican - Dame Karlene Davis (General Secretary of the Royal Colleague of Midwives 1995 ï 2010) went on to become director of the World Health Organisation collaborating centre for midwifery and president of the International Confederation of Midwives.

5.1 Differential Experiences

However, it is now well recognised and supported by all the available data that the full capacity of this section of the workforce is not being appreciated. In comparison to their white counterparts, BME staff have worse experience as employees in the NHS. Harassment and bullying (a phenomenon usually associated with minority status) appears higher amongst BME staff[1]. They are least likely to secure senior hospital posts[2], doctors from this section of the population are under-represented in the allocation of consultant distinction awards and over-represented amongst those referred to the General Medical Council[3]. A recent study indicated that staff from BME backgrounds are overrepresented in disciplinary procedures[4]. There is segregation within different parts of the profession with ethnic minorities occupations over-represented in

subspecialties with lower standing in terms of career opportunities, income and prestige[5].

The reasons frequently cited in the literature for the disparity in the experience of black and minority ethnic employees are communication barriers brought about by language and cultural differences and organisational deficits in managing a diverse workforce.

5.2 Communication Barriers

Different styles of communication amongst staff for whom English was not their first language is frequently cited as a key challenge for the NHS. Not only does it form the predominant reason for patient complaints against them but also the reason for their over-representation in disciplinary procedures. The different ways in which individuals from this section of the workforce express themselves and the different approaches they bring based on training they received in a different health system is often open to negative interpretation by their colleagues and line managers.

This situation is further compounded by existing language testing rules. For example, whilst medical graduates from non-EU countries are expected to undergo the Professional and Linguistic Assessment Board (PLAB) test to demonstrate their competency in terms of clinical and communication skills, there is an assumption that individuals recruited from countries within the European Union possess an acceptable level of language competency and therefore do not need to be tested. However, following concerns about the English language competence of medical staff from Europe working in the UK, the then Health Secretary announced that doctors from Europe who wished to work in the NHS in England would be tested to ensure their language skills are adequate. Doctors from non-European countries, like India and the Philippines, are already tested for language competencies.

The following quote from the Nursing and Midwifery Council bears this out:

> *...now we have this issue where we have people coming from EU countries who do not always speak English well. The majority of referrals for English language issues haven't been from outside the EU but are from inside the EU. For example people from Australia we have to ask them to take an English test but someone from Poland doesn't take an English test. Now the Equality and Human Rights Commission are looking into this for us because they think it may be bad advice from the EU. The English language does crop up in Fitness to Practice (FTP) cases quite a lot.*

Closely linked to communication is the issue of cultural difference. Differences in the way people from other cultural groups behave and interact with patients quite often appear to serve as grounds for taking disciplinary action. Not making eye contact with patients (usually a mark of respect/ deference in some cultures) was the most commonly cited example that could be interpreted negatively. Other behaviours influenced by culturally specific norms related to particular working styles as a representative from the Nursing and Midwifery Council illustrated:

> *…. Nurses from Eastern Europe were coming over here and finding it difficult to act autonomously and were constantly asking for*

reassurance and feedback and they were just culturally unaware that over here the role of a nurse now is far more – go ahead and do it- we've got nurses managing whole clinics and managing doctors and that to them was just something that they were terrified by.

5.3 Organisational Culture/ Management Practices and Competencies

The literature also points to the fact that attitudes towards minority ethnic staff is often shaped by ingrained stereotypical views, leading to decisions that did not necessarily relate to prevailing professional standards, as the following example illustrates:

There were some cases where we got emails from employers and from a nurse saying that she had been banned from speaking Polish in the work place. But it was all again down to the fact that one of the reasons she was speaking Polish was because it was part of her support network to sit in her break with her friends. Now if she was denied that, she was being denied her support network that her white British colleagues had while they sat round and had a cup of tea and could talk about things.

For internationally trained health professionals, isolation and a lack of support and guidance were also identified as factors contributing to their negative experiences and the Regulators recognised that they themselves had a limited role in providing informal support to their members.

In concluding, it is well recognised that there are many benefits to be gained from the recruitment of health professionals from abroad, the most significant being greater cross-cultural understanding and improved practices in workplaces across NHS organisations in England. However, this section of the workforce fare less well than their English counterparts across a range of dimensions ï in terms of unemployment levels, of access to privileged occupations in the occupational structure, and of experiences of discrimination at work. The role played by language and cultural barriers and by organisational culture is also acknowledged and understood as is the compounding factors of prejudice and bias (unconscious or otherwise).

Over the last two decades various commentators at governmental, professional and academic level have drawn attention to the fact that in order to harness the full potential of this section of the workforce, the NHS will need to pay close attention to their workplace experience. This is in light of emerging evidence from patient and staff surveys that where staff report to feel valued, patient satisfaction is greater.

It is therefore now well recognised that there are hidden complexities to diversity. It is not sufficient to ñ*just throw a lot of people that are different, together".* Health services are a microcosm of the wider society and discrimination and disadvantage remains deeply embedded in its workforce norms. Left unmanaged, the existence of ñin and out groupsòwill invariably increase conflict and reduce cohesion.

6. Models of Responses

The drivers for inclusion and integration of migrants and black and minority ethnic staff within the NHS is part of a wider agenda of inclusion and is underpinned by the NHS Constitution and legal obligations. At a practical level, organisations will be at different stages in terms of commitment and action - overall a lot is being done to ensure that the NHS addresses the equality, diversity and human rights issues brought about by a diverse workforce.

To this end there is a systems wide approach at a number of levels; ranging from Governmental, Hospital, Community level and covering both staffing and service delivery issues.

6.1 Governmental Response

At the highest level of Government - strategic imperatives are underpinned by Legislation and Policy as follows:

6.1.1 Legislation

The NHS is bound by the Public Sector Equality Duty of 2010 which has been passed to ensure that all public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all. It requires public bodies such as the NHS to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities. In doing so they need to consider the needs of all individuals in their day to day activities: The following characteristics are protected characteristics under the Act: Age, Disability, Gender, Marriage and Civil partnership, Race, Religion or Belief, Sex, Sexual orientation.

6.2 Policy

Policy is addressed through the Equality and Diversity Council. The EDC works to bring people and organisations together to realise a vision for a personal, fair and diverse health and care system, where everyone counts and the values of the NHS Constitution are brought to life.

The Council provides visible leadership on equality and health inequalities issues across health and social care. Its purpose is to shape the future of health and social care from equality, health inequalities and human rights perspectives and to improve the access, experiences, health outcomes and quality of care for all who use and deliver health and care services.

The Council does this by establishing and sharing a clear evidence-base to understand and address key and emerging issues, by strengthening opportunities for Council members and its networks to participate in challenging and strategic conversations to influence change, and by raising awareness of the personal, fair and diverse vision among patients, communities and the workforce. The Council is chaired by the Chief Executive of NHS England, with a diverse membership made up from across the NHS, social care, partner organisations, as well as from patient, carer and staff groups.

Key national project implemented by the EDC are:

Å The Equality Delivery System; a toolkit to improve equality performance that has been widely implemented across the NHS and is being used by both

providers and commissioners of services. In supporting NHS organisations to improve equality performance and embed equality into mainstream NHS business in the current and new NHS structures, the EDS assists NHS in meeting the requirements of the Public Sector Equality Duty, the equality aspects of the NHS Constitution, the NHS Outcomes Framework, Care Quality Commissionôs Essential Standards, and the Human Resources Transition Framework.

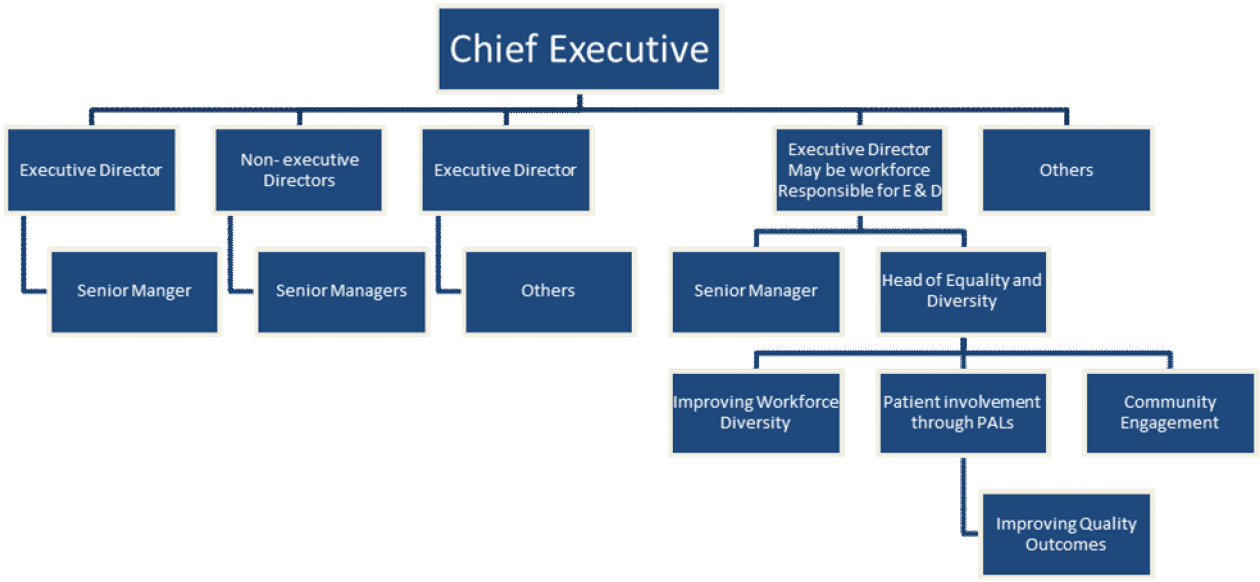
Å The Personal, Fair and Diverse Champions campaign; an NHS-wide staff network that is committed to making change happen.

Å The development of a strong communications strategy to keep the profile of equality issues high within the healthcare service. This includes providing guidance and informing the NHS of its legal duties and obligations to ensure that equality is built into the fabric of the NHS.

The EDC also recently announced an initiative which focusses specifically on race and ethnicity. It has pledged its commitment, subject to consultation with the NHS, to implement the Workforce Equality Standard (WRES). WRES will require organisations to demonstrate progress against a number of indicators to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace, including a specific one to address low levels BME Board representation.

At local level, those Trusts which take their responsibility for managing equality, diversity and Human rights within their organisational structures seriously will have in place systems and structures not dissimilar to the one outlined in the diagram below:

Figure 4. A possible Trust structure



Trusts will also have a range of appropriate policies and practices in place to set direction and guide delivery of Equality, Diversity and Human Rights as an embedded part of how the organisation delivers inclusion. This will often include a Strategy, Policy and Action Plan against which progress and impact can be

measured. These link to broader Trust policies for example Human Resources policies, and Service Review Policies. All of which are required by law to go through an equality analysis; the purpose of which is to identify any potential for adverse impact brought about by the change.

There is usually a Head of Equality and Diversity or similar position as a lead person for Equality, Diversity and Human Rights within a Trust. This is not an untypical structure in a Trust. Most leads tend to have a specialist advisory role to the Trust at board level and the services at delivery level. (It should be borne in mind that, Equality and Diversity Practitioners job role titles reflect national and international variations including Head of E&D, E&D Principal Officer, E&D Adviser, E&D Coordinator, Inclusion officer or manager, Director of Diversity, E&D manager, or Chief Diversity Officer.

6.3 National Programme

One national programme delivered at Trust level is the NHS Equality and Diversity Partners programme. NHS organisations are awarded Partner status after they demonstrate that they are delivering against measurable criteria.

Working directly with the Trustôs Equality and Diversity Leads, the programme supports participating Trusts to develop equality and diversity performance and build capacity in this area. This includes support on detailed strategic policy and personal development, as well as an opportunity to network. The programme provides an opportunity for Partners to offer advice, guidance and demonstrations of good practice in equality and diversity management to the wider NHS. Partners are supported to achieve this via:

- Continuous improvement around equality and diversity within their own organisation.
- Raising awareness of what constitutes sustainable, outcome-focused improvement in managing equality and diversity across their region.
- Acting as a thermometer by which NHS Employers can determine the key issues facing the wider NHS, so that advice and guidance is relevant and up to date.
- Contributing to the development of emerging good practice and providing a channel for collecting case studies from which others can learn, within the wider context of NHS initiatives.
- Contributing to a broader understanding of equality and diversity ï across both the NHS and the wider public sector ï in the context of quality, innovation, productivity and disease prevention.

7. Case Study Examples

Below we outline some case studies examples which we feel showcase the activities undertaken by Trusts and on which the Intercultural Hospital Project Partners may like to reflect.

7.1 E-learning Resource

NHS England in partnership with the NHS and professional Bodies provides comprehensive knowledge of equality and Diversity in healthcare environments. This programme delivers an understanding of equality and diversity and helps learners apply that knowledge. A better understanding of the impact of decisions and actions on different people means healthcare staff can respond more

effectively, resulting in high quality care for everyone and leading to the more efficient use of resources.

The aim is to have a healthcare service that is delivered with dignity and respect by staff who are better informed and have a great awareness of the needs of individuals in a working environment that meets the needs of our diverse workforce. The programme is available to all healthcare staff through the Core Learning Unit and e-Learning for Healthcare platforms. It is also accessible through the National Learning Management System in the NHS.

7.2 BME Staff Networks

Many NHS organisations support Staff Networks. These can be either based on specific protected characteristics or combined across all (affinity groups) Staff networks are well recognised as a tool to promote the values of inclusion, diversity and equity and the assessment of local and individual needs. For individual members this is a forum they have to legitimately talk about the effects of discrimination on their personal and professional lives and to feel supported and listened to. The personal development offered by networks help individuals to enhance their skills in negotiating, mediation, managing conflict and listening. The resulting increase in self-confidence will bring about greater commitment to personal and professional fulfilment, which are the highest forms of motivation.

Having the support of a network is also known to be amongst one of the most important determinants for success in leadership roles. BME staff surveyed in a study identified õnetworkingò as having been instrumental in helping them to succeed. Networks also provide opportunities for BME staff to learn about and explore the implications of organisational policies and professional practice for them as a group and to thus play an active part in helping to further its strategic aims. NHS organisations benefit in that active and well supported BME staff networks are also important to a successful human resources strategy for recruiting, retaining and returning a diverse workforce.

7.3 The General Medical Council

The GMC has also been involved in the development of a training tool for clinical managers to help support individuals early on, to avoid reaching a stage where their fitness to practice might be questioned. The GMC was also considering the possibility of a web portal to serve as an information forum for internationally trained graduates.
The GMC is using ethnicity data to inform a research study examining suspected overrepresentation of minority ethnic doctors involved in disciplinary proceedings. Similarly the NMC was about to embark on a large scale data collection exercise to help identify trends in relation to the involvement of its members in fitness to practice procedures.

7.4 Breaking Through Programme

The Breaking Through Programme was part of the work of the NHS Institute for Innovation and Improvement. This work now forms part of the work of the NHS Leadership Academy to develop leaders from diverse backgrounds and champion inclusion. The programme also aims to identify, develop and support talented managers to move to the next level of their career. See Bibliography

7.5 Mary Seacole Award

The Mary Seacole Awards were created in honour of Mary Seacole, a Jamaican-Scottish nurse and business woman, was a celebrated Victorian heroine due to her bravery in nursing soldiers in the Crimean War (1853ï 6). They provide the opportunity for nurses, midwives or health visitors to undertake a specific health care project or other educational/development activity that benefits and improves the health outcomes of people from BME communities.

7.6 Staff Engagement

Civility in the Workplace, Royal Cornwall Hospitals NHS Trust

A theme common from the management review in early 2007 and feedback from the 2006 staff survey was that of how individuals treat one and other whilst at work. This prompted an innovative campaign making use of case studies, live improvised theatre performance, information on accessing advice and support as well as a thought provoking video. A series of roadshows on each of the Trust sites offered staff an opportunity to reflect on their own experiences and importantly on raising awareness of, and prevention of, inappropriate behaviour. The initiative was supported by funding from the Cornwall Acute Branch of UNISON (the Trade Union), which continued to support the programme of work through 2008-2009, encouraging members to participate in future awareness raising events.

7.7 Induction for overseas doctors new to clinical practice in the UK

The Northern Deanery held its second induction course for overseas doctors new to clinical practice in the United Kingdom. Eighteen doctors from seven NHS Trusts, from countries as far apart as India and the Netherlands, spent the day discussing a range of issues with local and national representatives of the wider NHS. Topics were as diverse as the audience, from advice on local secondary schools to the principles and values of the NHS. It was, according to one attendee, ñone of the most useful courses Iôve attendedò See bibliography.

7.8 Research to examine the experiences of UK, European and non- European medical graduates making the transition to the UK workplace

With funding from the General Medical Council, NHS North East and Newcastle University conducted a comparative study to explore issues faced by doctors entering the workplace and that might lead to later performance problems amongst particular ethnic groups. The study included cohorts of international medical graduates (European and non-European) and arose in response to a growing body of evidence highlighting performance problems occurring as a result of the transition process, from either one country to another or from one stage of training to another. The research involved conducting questionnaires and interviews with doctors as well as their educational supervisors in order to establish factors which help or hinder the transition to the UK workplace and differences in the performance of overseas and UK graduates during the transition into the first year of practice.

On the whole, the study found that overseas doctors arrived ready to start work with more self confidence in their ability to do the job than the UK doctors and were more prepared for NG tube, acute management and anatomy. UK doctors on the other hand were more confident in applying the principles of holistic care, and considering how social and psychological factors impinge on health. They were also more prepared for history taking and communication.

Factors that overseas doctors thought could hinder their transition included a long gap before starting work, lack of exposure to clinical practice in the UK and insufficient information about living and working in the UK. Since working here, overseas doctors had noted a number of cultural differences which they felt could affect their performance. These differences related to language and communication (particularly with nurses), working as part of a team, conducting practical procedures and the importance placed upon ethical and legal issues within the workplace.

The transition for overseas doctors had been helped by factors such as the Professional and Linguistic Board (PLAB) exam, clinical attachments, the induction programme and the review process. Shadowing was also highlighted as a useful way to clarify their role, familiarise themselves with the hospital system and ñnewô equipment, address gaps in clinical practice and improve communication with colleagues and nurses.
Additional factors that overseas doctors felt might help their transition included stronger support structures (mentoring, peer support and the availability of role models), regular feedback on their performance (including areas for improvement) and a buddy scheme put in place starting from the time of their induction. The study concluded that overseas doctors begin their working lives in the UK having been trained with different models of practice and a different ethical framework to influence practice which can cause problems when working in the UK.

7.9 Monitoring and analysis of disciplinary data

Bradford Teaching Hospitals NHS Foundation Trust employs just over 4,500 members of staff, has an annual budget of approximately £300 million and consists of two teaching hospitals. These hospitals serve a local population of approximately 500,000 made up of 75% white British, 20% Asian or Asian British and 5% other ethnic groups. Regular annual monitoring of the Trustôs disciplinary data alerted the Trust to the fact that BME staff were consistently overrepresented in their disciplinary proceedings. More detailed analysis showed that BME staff were twice as likely as white staff to be subjected to disciplinary action.

8. Questions for the Intercultural Hospital Project

Below we raise some key questions which the Intercultural Hospital Project may wish to factor in when considering the way forward.

1. What is Germanyôs approach to inward migration (Assimilation? Integration? Inclusion? And how will this hold up with an increase in migrant labour?

2. What are the predicted labour force requirements and how does Germany prepare the existing health system workforce generally for the inward migration? Training? Strategic Working Group? In order to avoid the potential pitfalls.

3. What countries will be involved and how can partnerships be forged at international, national and local levels.

4. What mechanisms will be put in place for community engagement in preparation for an increase in migrant workers?

5. What does the German legislation say about race equality?

6. What agencies will the healthcare system need to liaise with in order to have a holistic approach?

APPENDICES

Appendix 1

In-depth Discussion with Project Partners

Present
Richard Callicott- Chief Executive of Reddenhill Consulting Ltd.
Bruno Daniel
Maroline Lasebikan
Professor Carol Baxter
Lutz Eggeling
Ines Lieske
Simone Carl
Tino Winkelmann - Tino is the project leader.
Marco Bünger
Dr. Karsten Jäger

Presentation: an overview of the NHS supported by a youtube link

NHS has over a 100 million pounds sterling budget of which 60 million goes to commissioning groups made up of GPs and representatives from other professions, and public representatives. Within the new NHS their main role is to try to improve the health of their local population. They do this through commissioning (buying) services for their population from a range of different providers (NHS hospitals and NHS Community Services, Voluntary and Private sectors all of whom can bid for contracts), these commissioning groups are looking for value for money and quality of service provision. This has introduced competition with measurable delivery outcomes within a monitoring system. This process is overseen by regulators (Monitor and Health Care Commission) who oversee the quality and effectiveness of service provision.

Commissioning Groups have to take into account all the supporting infra structure needed to make sure that their local populations can access the service provisions. They are supported by organisations that provide the technical support to the commissioning groups called CCUôs. They are also supported by the clinical senate made up of a range of Medical Experts to advise and guide GPs on particular diseases.

NHS England looks at the NHS overall, it does specialist commissioning for conditions that affect relatively small numbers of people and make sure that there is access to these services across England. These services are commissioned either regionally or nationally.
NHE England also commissions GP services to ensure a separation of duties. This body has regional and national hubs.

Public health and their budget have moved to Local Government. Governed by another national body called Public Health England. Local Government also now have the role of establishing health and well being boards. These bring together the health and social care systems.

Under the new systems it was stated that part of all contracts there is a requirement for providers to demonstrate how they collect feedback from service users to inform service improvements.

Outcome indicators

It was reported that there are a number of general outcome indicators and specific outcome indicators that guide the commissioning and monitoring of service provision acute, community and public health. The idea of these indicators is to allow some comparison.

Question and Answer Session

Q How big a part does the measuring of outcomes have in the contracting process?

The new organisations like the Clinical Commissioning Units, which make use of a lot of the data, are in their infancy as new organisations in relation to workforce data. Therefore the use of data is an evolving process in the new NHS.

For example with regard to equality workforce data this can have gaps.

Q Who are the beneficiaries of the data?

The CQC measures the quality of care through monitoring standards of care. Where as Monitor is about the effective use of resources. Monitor focuses more on Foundation Trusts and their effectiveness. Foundation Trusts have more independence than other NHS Trusts.

The NHS is huge it has around 1.7 Million employees. The re-organisation is trying to improve the efficiency of the NHS. The NHS has always been an effective organisation delivering quality care and treatment.

Public health has done considerable work on ill health prevention and public health education. The new NHS focus on prevention through an independent body (Public Health England) working closely with Local Authorities was seen by project partners to be innovative and of real interest.

The economic drivers for a robust Public Health service were seen as important to delivering an NHS fit for the future.

Examples of how the voluntary sector works closely with local communities to prevent admissions such as the work of the Sickle Cell and Thalassaemia Centre, and the African Caribbean Community Initiative which prevent readmission to hospital for people with the related health problems. These are just a couple of examples.

What were the time and the reason for the New NHS?

The new NHS has been an incremental change. More evolutionary than revolutionary. It has been a long period of change with a recognition that the model that was developed in 1948 was fit for purpose then, but that public expectations have changed, technology has changed and the work place in terms of employment practices have changed and that the NHS needs to change with the societal changes.

The key driver being public expectations and designing a vision for the future. The changes are about trying to change the NHS for todayôs modern society with an eye on future expectations and challenges. The past 2 ï 3 years has seen the most impactful change.

The key changes in measurement are the measurement of the patient experience and staff experiences. The capturing of these experiences contributes a great deal to the picture of how effective the NHS is in meeting patients and staff requirements.

NHS Partner site project (headed up at the time by Professor Carol Baxter) and supported by Reddenhill Consulting Ltd is an example of how Trusts demonstrated their commitment to equality and diversity and linked well to the Equality Delivery System (the National Management tool for self reporting - measuring progress on integrating a consideration of equality and diversity into the NHS) which provides a set of criteria and indicators for managers to assess their progress on inclusion.

Appendix 2

Conference
'Look Back – Moving Forward' Black History Month Event

Published: 30/10/2014

Our Trust, in partnership with the Royal College of Nursing (RCN), co-hosted a conference as part of Black History Month celebrations, exploring the issues that particularly affect Black and Minority Ethnic (BME) patients, service users and health service staff.

Combining a host of expert presentations, thought-provoking drama performances and a panel discussion, the event attracted around 130 delegates from across the region.

Maxine Brookes, Practice Nurse, Sandwell and West Birmingham Hospitals NHS Trust and Beresford Dawkins, Community Engagement Manager, Birmingham and Solihull Mental Health NHS Foundation Trust opened the event by performing a song ó A Change Is Gonna Comeô by Sam Cooke, which poignantly introduced the underlying theme for the day.

Bruno Daniel, Senior Equality and Diversity Lead
Councillor Paulette Hamilton, Mental Health Champion for Birmingham City Council, referred to her own experiences as a nurse and talked about the gradual process of change and how the positive work we are doing, through addressing these issues, will ñhelp our children and our childrenôs children to create a legacy.ò

The theatrical interludes, by Hearth Drama Company and AFTA Thought Drama Company, evocatively told stories of some of the struggles faced by BME nursing staff, based on real-life stories from the NHS.

Paul Vaughan, Regional Director of RCN talked about the processes needed for change and highlighted the role of Cultural Ambassadors, a regional initiative that was introduced this year to local NHS trusts. Within our Trust they act as a staff support group, using their training to help raise awareness and tackle issues of equality and diversity across the workforce, something which this event was championing.

Judged by the success, we are hoping to hold the event again next year to demonstrate the commitment we have made as a Trust to value the diversity of our workforce and the communities we serve.

Appendix 3

Human Resources Meeting at Birmingham and Solihull Mental Health Foundation Trust

Present
Chris Berry Associate Director of HR
Satpal Gill Head of Recruitment
Bruno Daniel
Maroline Lasebikan
Carol Baxter
Lutz Eggeling
Ines Lieske
Simone Carl
Tino Winkelmann
Marco Bünger
Dr. Karsten Jäger

Joined us later
Stephanie Crowe Learning and Development
Annie Short Learning and Development

Introduction

The interpretation of migrant workers is used to describe Black and Ethnic Minority Groups. These are people who are in a minority in the country. This includes all the groups that are in a minority in this country it will include the migrant workers. So you may have more Black and Minority Ethnic people as migrant workers. But being a migrant worker is not necessarily about being black and minority ethnic.

Focus group questions around migrant workers

England (Trust) Introduction

Our recruitment tends to be from settled black and ethnic minority populations rather than going out to international recruitment. The Trust, because of the stability of these minority communities does not have to go out to international recruitment.

Four areas for the discussion

1. The organisation
2. Human Resources
3. Cooperation and collaboration with other agencies
4. Matching ï this is a process between the organisation and the people who come to the organisation ï One the one side you have diversity training of the staff and the people who come to the organisation and how they manage problems.

Overall we are looking at how we can integrate minorities into an existing system. What we have to do to make them feel comfortable, what we need to offer them, to keep them in the system?

Q Is there corporate mission statement that includes intercultural aspects?

The mission statement from the organisation was shared with the group. The mission statement says what the organisation is there to deliver. The values identify the behaviours expected of staff and users. The Trust is very pro-active in demonstrating and using the values when dealing with staff, patients and the public. The Trust is now considering value based recruitment.

That means that at interview people are questioned about their values related to their competency to deliver care to the population served.
The Trust also has a behavioral profile for staff and managers within which equality and diversity are integrated with an expectation right from the beginning of their employment journey that they will be inclusive in their behaviours.

The website provides information that demonstrates openness and transparency around equality, diversity and inclusion and treating people with dignity and respect.

We have found that BME people look to see that the organisation is committed to respect and dignity.

Q What do you do to ensure this is not a paper exercise?
This is a challenge, one of the actions that can be taken is around unconscious bias so that people begin to understand that although people can relate to the commitment intellectually, in practice the decisions they make and the behaviours they exhibit can sometime contradict the value. This is a growth area for personal development.

From the recruitment point of view the Trust has built on previous cultural bias work and all recruiting managers have training that specifically covers cultural bias. The Trust worked with a local organisation well recognised in this field to develop the recruitment training.

The Trust also used this organisation to help them develop their in-house training programmes. The Trust has policies that support this, for example, equal opportunities policies and harassment and bullying policies. Information about any cases is published so that lessons can be learned.

It is part of our culture as a Trust. We make it business as usual to treat people with dignity and respect. We have appraisal and performance management of our staff and part of that process is about the standards of the behaviours that we expect. If they do it well there is positive re-enforcement, not so well and we have a performance management system.

Q Do you have offers for patients and staff for example food things?
We provide a variety of meals that reflect the population we serve and this is something that is pretty well across the NHS.

We feel that leadership is the key element that supports success. In order to unblock say middle managers they need to lead the agenda at that level. The Chief Executives and the Directors also lead, monitor and promote action.

Middle managers are very busy and now have some management tools to help such as the Equality Delivery System.

The way the Trust is designed was described from corporate services (information technology, finance, Human Resources and Facilities).

In relation to workforce the Trust shared a breakdown of the ethnicity of staff within the Trust. Birmingham and Solihull MT F Trust has a white population of 58% the rest

of the workforce are what we call BME which can be broken down into a number of categories.

The Public Sector Equality Duty was presented as: To eliminate discrimination, promote equality and advancing equality.

One of the success factors for the NHS is measured by how well the workforce reflects the population served (locally). So within Birmingham and Solihull part of the recruitment strategy is to try to get to the stage where the Trust reflects the diversity of the population. In some areas the Trust is very good at this in other areas for example Chinese, Bangladeshi we are under-represented.
The second measure and another challenge is where within the workforce those individuals from BME groups are. So for example if all of your BME recruits are at the lower end of your pay scales it has to be challenged and action taken. Therefore the quality of the statistics gathered is very important as it guides the recruitment and retention strategy.

Our challenge is around attracting people into our organisation from certain groups. In particular younger people from both white and BME groups.

We have a legacy issue from the international recruitment that took place from for example the Caribbean where those early recruits are still in the NHS; their experiences were not always good so they do not appear to be encouraging their children to take up careers in the NHS.

Market forces also now provide alternative careers.

Other challenges for the NHS nationally are the gender make up of the Trusts, for example the top of NHS organisations was predominately male but is now improving greatly. Birmingham and Solihull Board is doing better than the national average.

We also have challenges around the disclosure of information around Gay, Lesbian and Transgender make up of the workforce.

England has had experience in the past which has informed the present system. In England we tend to look at targets rather than quotas. We aim to change the profile through taking action to ensure people get an equal opportunity. We may take positive action rather than quotas.

The US experience tells you that quotas can bring challenges, it does make things happen. One thing that you could learn from us is that quotas (never the law in England), can create a lot of problems. There will need to be steps in place to educate the whole organisation, and changes in organisational culture to recognise the reasons why change has to happen.

Q Can you explain the positive action?

Positive action is where the legislation in the UK allows for activities to develop people before they interview for a post. You can't give people a job because of their ethnicity, gender or any other equality characteristic. If you recognise that your organisation has an underrepresentation of a particular characteristic you can prepare them through training etc. Another example for a disabled person is the guaranteed interview system.

You can also use genuine occupational requirements, for example, a service requiring delivery in a certain language can recruit someone with those language skills if it can be demonstrated that it is a specific need.

To take positive action you need to demonstrate through statistical evidence the need.
Another example is of the Mary Seacole Awards which started out following a recognition that BME nurses where not getting senior positions. The award system has been going for over 10 years. It was challenged by the mainstream white community. The Commission for Racial Equality up held the Awards as being discriminatory. The reason this happened was because there was not sufficient data collected. This demonstrates the importance of data.

Birmingham and Solihull MHF T has a similar issue around recruiting male staff to some services. If any challenge comes forward the data is there to support the need.

Q Meeting the needs of different groups (religion or belief)

Religion or belief is one of the protected characteristics in England. Within the Trust there is a spiritual care team and within that team all the main religions are represented.

The spiritual care team also provide a clinical support role; they support patients as well as staff. For patients they support their recovery care plans. No matter what religion or belief they can be supported by the team. It should be noted that patient provide for their own religious needs.

The Trust is looking to set up a multi faith forum on the website.

All hospital sites across the city have a quiet room/ prayer room where people can go to pray or have a quiet moment to themselves.

Q Would you say that there is a welcoming culture in your organisation and involved authorities?

As a public sector organisation we have to set minimum standard against the Equality Duty. New members of the organisation go through an induction into the organisation; this includes an understanding of the organisations values and the expectations of behaviour. There are posters around the organisation about the values and what they stand for. All staff receive customer care training.
In reply to the question are we friendly, open and welcoming? We like to think we are. The staff survey tends to support this view. The second part of this question we believe to be are we inclusive. This comes back to what we are doing in terms of diversity and inclusion. From our point of view, a recruitment strategy point of view we think that is what we are trying to do.

Q If I started in your Trust do I have to confirm this?

There are a number of things in our contracts with staff. We require new starters to do the induction before they start employment with us. We insist that all the employment checks and some key parts of the induction have to be done before a new member of staff starts with us. In terms of them signing up to our values they do a great deal before they start. Part of the process insists that new started participate in the training (on values and other key elements). Then the contract clearly states that each employee needs to abide by our policies and procedures.

Within the contract there are clear statements around up holding the policies that are in place including a clear statement around equality and diversity and the expectations that the organisation has of them.

The contract clearly states these as rules of their engagement. These are re enforced though our intranet site. When new staff start they have a discussion with their line manager who goes through the local policies. We also have a staff handbook which talks about expected conduct.

Q Are there special training for migrant workers, language courses or projects?
For BME staff there is an expectation that they have to learn to speak and read English, because that is a health and safety issue.

Q In Germany we have different levels of language requirements.
We have ESOL which is English as a second language. Recently there has been national work looking at whether the minimum requirement should be higher for doctors.
In the recruitment process we look at whether their ability to communicate is adequate for the job they are applying for.

Q Do you have interpreter services for patients?
We have interpreting services so where there are communication barriers we can call on that service. What we are thinking of is making use of staff who have second languages but you come across lots of barriers like the level of competence in the second language. There are many issues around staff undertaking interpreter roles as well as competence, for example are staff required to do their own job and the additional interpreter role.

The area of interpreter services is a challenging one because of dialects and regional norms. As an organisation it is clear that the equality legislation requires us to provide such a service.
We don't normally allow staff to interpret because it puts our staff at risk. We go through the service that is competent to deliver this service.

For staff and patients with a disability we have an obligation to provide what we call reasonable adjustments. For example; information in large print, Braille or different colours.
Where there is a need we provide information in different languages. We monitor the languages within our patch so that we can make judgements about what is needed and in what languages. Particularly relevant to the marginalised populations within our area.

In relation to best practice some Trusts the staff go out and learn the local languages as a commitment.

In the Local Authority there are many life skill courses that staff and patients can utilise.

Q Are there special trainings, language courses or projects for migrants? How long are the courses, what is the action content and who finances them?

The length of the courses varies according to the need, the levels (depth) and the necessary content. It can be either a standalone course or it can be integrated into their personal professional development programmes.

We now have cultural ambassadors. They have had special focused training; they sit on all disciplinary meetings to ensure that the processes are fair.

There are also external courses that staff can access. Within England we have a body called Health Education England, which has regional hubs. We also have the National NHS Leadership Academy which provides development around inclusive leadership. They deliver a programme called the Inclusive Practitioner course.

Q Are there trainings with intercultural aspects for locals as well?
For staff generally there are. Most staff live locally. We are also looking at the community and voluntary sectors and because we rely on them for their contribution to services we aim to assist them with training. This is of mutually benefit.

In relation to staff we do e-learning and bespoke training designed specifically for their service/ department need.

In terms of EU a lot of hospitals are going to Spain and Europe to recruit nurses. We understand that they are providing training for example on local dialects.

The learning and development department provides the training that is post registration, induction training soft skills training, elements of first aid training. Mainly we provide the people focused organisational training. One of the new things we are doing is mapping the life career of staff within the organisation. Part of the induction is about getting people to do statutory and mandatory training in a virtual environment before they actually enter the organisation.

The induction training is service user and family orientated. It is having a good impact.

We have a suite of skills based learning solutions for bands (grades) of our lower level workforce for example soft skills, administration and others. We are looking at our leadership and management development programmes, we have two core programmes one is about first time leadership, during this they cover equality and diversity and inclusion. On our programmes there are links to the workplace and pre programme meetings to ensure the programmes meet the need of the delegate and their manager. They include peer support, work based projects and action learning sets. The other programme is about bringing the leadership skills of managers to the next level, enhancing them.

In terms at what is being developed we are looking at the matching to occupational competencies and career development.

Our vision for learning and development is that any employee can look at and identify a route/ path through the portfolio of learning opportunities.

There are particular initiatives around widening participation. This is focused on targeting underrepresented group to enter the organisation in different and creative ways. For example one of our underrepresented groups is our youth group (under 25 yrs) so we are targeting that group with programmes around work experience,

placements for schools, apprenticeships. We are actively recruiting for these programmes. We are looking to place approximately 30 young people across the Trust in the next few weeks.

We are also looking at secondments to expose existing staff to different opportunities.

We also have a volunteering programme. Working with local community to engage them with activities within the Trust. Talent management. We are in the early stages of launching our talent management strategy. The first part is about identifying what excellent looks like, what good looks like for our organisation. We are not only going to focus on our rising stars we are also looking at our core of excellent performers, to encourage life long careers with us. They may not be looking at hierarchical career paths but may have other ambitions. We are aligning this to the National NHS Leadership model.

We will also be doing some external benchmarking to get a sense of what leadership should look like. We then identify a fast tract of talent the first cohort will be focusing on our middle level managers.

We have a staff engagement programme called listening into Action. One of the Actions from this is about engaging with middle managers to provide them with the tools to deliver equality diversity and inclusion. It's about listening to them and getting them involved with the solutions.

Q Do you also make team building? With a background of diversity management?
Team building is a big thing. We have our internal organisational development team with whom we work closely to make sure that there is an equality element built into the programmes.

A lot of evidence is coming in now that in this country and the US diverse teams can deliver more creative outcomes. But there are conditions under which that happens, those conditions are around match, (University of Aston Study) if the population of the Trust, BME people over represented in comparison to the staff group then it can have a negative effect. If they are underrepresented it also can have a negative effect. It is the balance that is important. Matching as you talked about is important. There is evidence that diversity is positive under certain circumstances. Aston University Birmingham again also evidenced that those organisations which took team building seriously and developed people based on the important qualities of each team member which included diversity had better outcomes in terms of some really clear measures like patient readmission rates, coronary heart disease. So you were more likely to recover from a heart attack, less likely to be readmitted, less likely to have a hospital infection and mortality on the whole was better with team building taken seriously and including diversity perspective.

Q How do you recruit professionals?
We recruit professions mainly through the NHS Recruitment system.
The challenge for us is about how we compete. Our completion is sometimes from other local Trusts. The issue for us is how we differentiate ourselves from other organisations.

The NHS has a national pay system, so what we pay across the NHS is similar. Therefore, our values, including diversity is important to our brand and how we encourage people to want to work for us.
Our reputation around how we treat staff can be our selling point.
The recruiting part is straight forward and similar across the NHS it is our values and culture that are our selling point.
As a Trust we try to attend community events, family days to raise awareness of the Trust as a good place to work. We also work with local diverse radio stations to raise awareness.

Q Are there specific strategies for recruiting foreign experts/ professionals?
Not that we use at present. Nationally everyone uses NHS Jobs. This is for everyone from porters to all professionals. The site is open to all would be applicants. There are considerable numbers of overseas applicants. Therefore we do not have to encourage this talent pool at present.

We did some research with student nurses and found that social media was not thought highly of. They are told to keep away from social media.

Other Trusts needs might be different. For example, where they need a specialist in a particular field. The legislation in terms of international recruitment caters for this through the ósspecial occupational requirementsô

Q How important is the quality test in your hospital and how does it work? Relating to the quality to the patients. How do you relate quality to performance? How does this relate to the payment system? Or for organising and benchmarking companies?
Each NHS organisation has performance measures. That relate to quality and value for money. The performance management team collects information on the services the Trust delivers which are reported to the Trust Board.
There are also Clinical Commissioning Groups and their contract managers who check on the quality of care being delivering within the commissioned contract.

There are also bodies such as Monitor who look at the financial aspects.
In relation to service delivery quality the Care Quality Commission oversees the quality of services. They audit effectively, identifying where standards require action to improve. They have the power to end contracts.

The Trust can earn more money as an organisation by improving quality.

Whenever the Trust redesigns a services changing pathways and delivery, one of the first things that has to be done is a check on the impact on the patient experience and patient outcomes. Our medical and nursing directors are responsible for quality. They have to sign off any plans for redesign. Quality is the most important factor. We then have to find the balance between quality and cost.

In England there is a system of equality analysis, so when transforming a service the Trust has to undertake a consultation process with users to make sure that service changes do not impact negatively on any group of users (patients and workforce) with protected characteristics. This is based on data and information gathered about the services which inform the decision making process. These are public documents.

The Trust also has feedback from the patient experience and staff experience.
The public have access to quality information about the Trust.

The Commissioners put high value on the feedback from patients. The Trust also has the Friends and Family Test which is used to provide feedback to the Commissioners.

There is a lot of public information about all NHS Trusts.

Q Is there multi lingual information for employees and patients?
For patients yes. According to need.

What about in emergency?
The Trust uses Language Line which can be accessed immediately and covers all languages that are needed. This is a telephone service.

What about on the street. If they can't speak?
The ambulance service did develop a picture/ diagram handbook which ambulance paramedics can carried with them at all times.

Q Are there funding programmes by the federal regional government on matters of intercultural opening?
There have been and are a number of national programmes run by the NHS.
For example the Breaking Through programme, the Mary Seacole Awards, the NHS Leadership Academy which has programmes around inclusive leadership.

Q Communication do you have words which you use to describe situations for example gender communication?
We have equal opportunities and bullying and harassment policies and procedures. Within them we describe what bullying and harassment can look like, the steps to take. There is an appeals process. We also have bullying and harassment advisors that anyone can go and talk to independently of the process.

Our employee relations team regularly look at information about bullying and harassment to identify and find solutions for any emerging trends.

Some Trusts have a multi cultural guide. We have a glossary of some terms and practices, in particular to do with religion or belief, but we find it more useful to ensure our staff are culturally aware and sensitive.

Appendix 4

Pen Pictures of the Reddenhill Consulting Limited Team

Richard Callicott
Chief Executive of Reddenhill Consulting Ltd. Richard started out as a teacher of physical education, he ran a teachers centre, he then became vice principle of an Adult Education, Youth and Community Centre in Birmingham covering the whole of the inner city of Birmingham. Richardsôs passion has always been sport he became the coordinator for the Birmingham Olympic Bid. He then ran sport and leisure in the centre of Birmingham before becoming the Director of Sport at the Birmingham National Indoor Arena as well as Head of Sport for Birmingham. Richard then became the Chief Executive of UKSport the National Government Agency responsible for high performance sport in the UK.
Richard has also been the President of European Volleyball and President of volleyball in England. Richard is also a Director of the British Paralympics Association. Richard also sits on a number of other bodies to do with health, sport and disadvantage for example the Youth Charter for Sport.

Bruno Daniel
Bruno was born in St Lucia, in the Caribbean came to England in the early seventies served in the Royal Navy for twenty four years as a physical training instructor. Bruno left the Navy in 2000 and joined the Fire Service as their Equality and Diversity Advisor. Bruno then worked for a charity in a similar role. In 2007 Bruno joined the Health Service in a Primary Care Trust in Wolverhampton where he led equality and diversity for five and a half years. At this point he joined Reddenhill Consulting Limited; he now works for Birmingham and Solihull Mental Health Foundation Trust as the Head of Equality and Diversity.

Maroline Lasebikan
Maroline started her career as a Nurse and qualified as a registered nurse and an ophthalmic nurse. Maroline held positions of staff nurse, sister, nursing officer, and hospitals manager where she managed three satellite hospitals. Maroline then worked for the Department of Health as Director for the National Equality and Diversity programme for the NHS in England. Maroline has also worked for a Strategic Health Authority as an Associate Director responsible for leadership, equality and diversity, Information Management and Technology and Strategic Human Resources.

Maroline then joined Richard as the Managing Director of Reddenhill Consulting Limited. Reddenhill Consulting is an Institute of Leadership and Management Development Centre providing leadership development programmes from level 2 to level 5 for a variety of organisations. Maroline has a mastersô degree in quality in health care.

Professor Carol Baxter
Carol works part time as a professor at Imperial College London in the Department of Global Public Health. Prior to this Carol worked as Head of Equality, Diversity and Human Rights for NHS Employers. Providing guidance and support to NHS organisations.

Carols career began as a nurse, midwife and public health nurse. Carol has published widely.

Appendix 5

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Sports Division: International Sports Development, Major Events, Strategic Planning
Development Division: Leadership, Organisational Development, Equality & Diversity, Quality

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