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Inclusion: The DNA of Leadership and Change

A review of theory, evidence and practice on leadership, equality, diversity and inclusion in the National Health Service

Compiled for Building Leadership For Inclusion, NHS Leadership Academy by Richard Bolden, Addy Adelaine, Stella Warren, Anita Gulati, Hazel Conley & Carol Jarvis

Bristol Leadership and Change Centre, UWE Bristol

UWE Bristol
University of the West of England

AUTHORS

Richard Bolden is Professor of Leadership and Management and Director of the Bristol Leadership and Change Centre at UWE, Bristol. Richard's teaching and research explores the interface between individual and collective approaches to leadership. He has published widely on topics including distributed leadership, systems leadership, leadership in higher education, worldly leadership and leadership development evaluation.

Addy Adelaine is an international social worker and expert on action research and inclusive accountability. Working in the UK and internationally, her specialist areas of work include: organisational and youth-led action research; engaging hard-to-reach groups; collaborative knowledge creation and in ethical social research practices in challenging environments. Addy is a Research Associate on the UWE Bristol research team.

Stella Warren is a Research Associate at UWE, Bristol with a background in applied social research and supports a wide range of research project teams within Bristol Business School. Stella also teaches research methods at both undergraduate and postgraduate level. Her expertise includes social marketing and psychological pathways for behaviour change in health; gender and inequality in organisations; the gender pay gap; and women working in male-dominated industries. She is a founder member of Alta, a mentoring scheme for professional women in aviation and aerospace.

Anita Gulati is an Associate at Bristol Business School at UWE, Bristol and has a background in organisational psychology, applied social

research and evaluation to enable positive social change, all of which informs her work in leadership development. Anita is also an experienced coach. She is interested in bringing together the best of science and social science to help individuals, organisations, and society flourish.

Hazel Conley is Professor of Human Resource Management at UWE, Bristol. Much of Hazel's work has focused on the State as employer and legislator and most recently has centred on discrimination and inequality in the workplace, particularly in relation to the development and effectiveness of legal interventions. She has undertaken critical research on the concepts of multiple discrimination and intersectionality, focusing recently on the impact of economic crisis, austerity and 'Brexit'.

Carol Jarvis is Professor in Knowledge Exchange at UWE, Bristol and plays an active role in the design and delivery of leadership development and executive education programmes. Carol is also an experienced coach and facilitator. Particular areas of expertise include: organisational change and mobilisation; organisational effectiveness; entrepreneurial mindset; and leadership development. Her research interests include the leadership of innovation in the UK health sector; learning entrepreneurship; and coaching for transition.

ACKNOWLEDGEMENTS

We are grateful for the support of the NHS Leadership Academy in commissioning this work. Particular thanks go to Tracie Jolliff, Catherine Loftus, Morvia Gooden, Ian Mello, Anne-Marie Archard and Claire Price-Dowd from the inclusion team working on and leading BLFI, as well as the NHS Leadership Academy Managing Director, Stephen Hart, and

Deputy Managing Director, Caroline Chipperfield. We are also most grateful for the contributions and support of the BLFI facilitators at brap, Diversity Practice, People Opportunities and Tavistock Institute and everyone else who has engaged with as part of this research. For all who have shared their knowledge and expertise we sincerely hope that you will feel we have done them justice.

ISBN 9781860435485
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FOREWORD

In times of uncertainty we need to develop leaders that can operate effectively and in ways that truly reflect the aspirations and values of the NHS. Inclusion is core to the NHS Constitution and the NHS Long Term Plan, yet is still one of the biggest challenges that health systems face globally, nationally and locally.

Through leadership, the challenges of inclusion must be now be met. This is particularly relevant in the face of a growing body of evidence that demonstrates the critical role that inclusive leadership plays in ensuring that Health and Care systems operate effectively. The time has come to focus efforts on the development of compassionate and inclusive cultures that truly value the diverse health and care workforce, enabling them to deliver the best quality services to our increasingly diverse communities.

This literature review was commissioned in order to support the work of Building Leadership For Inclusion (BLFI), a core component of the Developing People - Improving Care framework. Its purpose is to begin to update and inform our thinking about how to progress the work of inclusive leadership development. This review is one component of a number of workstreams that will support the Academy's increasing understanding and development of leadership practice in this space, as we seek to model the thinking and behaviors that will bring about inclusion.

This literature review highlights the requirement for deeper and more creative approaches to leadership development in order to shift mindsets at all levels and to radically alter leadership expectations, plans, ideas,

and behaviours towards inclusion. This is essential work if those currently at the sharp end of discrimination are to experience inclusion as transformation – by which, we mean a fundamental change in how they experience relationships in the workplace across difference and an opening up of opportunities for all.

Inclusion, part of a global conversation

In this digital age many inclusion movements are springing up that seem to have begun from nowhere, or at least nowhere familiar. These are not started by the usual suspects and are not coming from a top down direction, with which many of us are well acquainted. Hashtags #MeToo #BlackLivesMatter #TimesUp, all started by women, are signalling a change in the global conversation on inclusion and, importantly, are asserting the voices of those who for so long, have been unheard, ignored, kept beyond the margins and excluded. These less familiar voices are initiating, participating in, and perpetuating new conversations and creating spaces to explore issues of lived experience, identity, power and privilege in different ways.

The pace and scale of these global conversations, as they relate to identity, diversity and inclusion, have, at times, rushed ahead of our collective abilities to contemplate their meaning - and yet, as leaders in health and care systems, we need to do just that. It is through hearing and developing our understanding of these and similar conversations in our organisations, and the diverse voices within them, that we will learn how to transform the health and care system towards inclusion and secure a sustainable future for it.

The NHS Leadership Academy ambition is to transform the ways in which leadership and leadership development is understood and

enacted, so that the leadership qualities that contribute towards inclusive cultures become the standard that is sought after and the benchmark against which ‘good leadership’ is measured. This can only come about through the conscious and purposeful work of leadership at all levels.

In offering up this literature review, we encourage the reader to engage with this material in several ways. Firstly, to consider this as an initial mapping of the conceptual and empirical landscape of leadership and inclusion, which highlights areas for future enquiry, exploration and learning. Secondly, to reflect critically on its contents, the extent to which it resonates with your own experience and the implications for your own leadership practice. Thirdly, to actively contribute to the ongoing conversations around leadership and inclusion and the work that follows as Building Leadership For Inclusion progresses into its second year.

The recommendations of this review emphasise a number of important areas of work for future leadership focus in the NHS and partner organisations. They highlight the complex nature of inclusion, the limitations of tick-box approaches that assume a straightforward link between cause and effect, and the pressing need for deep, honest and open discussions between people of differing backgrounds and identities. The work of BLFI emphasises the importance of listening to lived experience, of challenging power inequalities and of promoting principles of social justice. It is these principles that differentiate BLFI from other approaches to equality, diversity and inclusion, and which will become enablers of the transformative work of leadership development going forward.

Finally, remember that in reading this text you demonstrate your commitment to the challenging but essential work of inclusion and the role that you, as a leader, can play in bring this much needed change. As collaborators, partners and allies, let us learn together how to work boldly and collectively with and across difference, to turn this vision into our lived realities.

Tracie Jolliff
Director of Inclusion
NHS Leadership Academy

Caroline Chipperfield
Deputy Managing Director
NHS Leadership Academy

Executive Summary

1. This report, commissioned by the NHS Leadership Academy, sets out the evidence base for *Building Leadership For Inclusion* (BLFI) – an ambitious new programme of work that aims to (1) raise the level of ambition, (2) quicken the pace of change, and (3) ensure that NHS leadership is equipped to achieve and leave an ever-increasing and sustainable legacy in relation to equality, diversity and inclusion. The report has been written by a research team based at the University of the West of England and is informed by an extensive review of relevant literature, interviews with academic experts and preliminary action research with the BLFI team and partners.

2. Despite significant attempts in recent years to increase equality, diversity and inclusion in NHS leadership and management, progress has been exceedingly slow. Evidence suggests that the NHS is failing to fully engage its workforce and that there is a significant mismatch between the intention to 'provide a comprehensive service, available to all… [and] a wider social duty to promote equality through the services it provides' (NHS Constitution, 2015) and the ***lived experience*** of people from minority backgrounds. This report draws on a wide range of theory, evidence and practice to explore *why* such inequalities persist, *how* they are experienced and *what* needs to be done differently to make significant and lasting progress on these issues.

3. There is substantial evidence on the benefits of equality, diversity and inclusion (ED&I) in the workplace, including staff engagement, service improvement and innovation. Whilst the legal and business case for change in now widely accepted, real engagement with issues of

social justice is largely absent in mainstream approaches. Monitoring and compliance against targets, alongside the provision of development opportunities for people from marginalised groups, whilst important components of an ED&I strategy are insufficient to address the root causes of discrimination and exclusion in organisations as large and complex as the NHS.

4. Progression challenges for staff from minority backgrounds include a shortage of relevant role models, exposure to high-risk leadership positions, barriers to recruitment and promotion, limited career support, unequal appraisal and disciplinary processes, micro-aggressions, bullying and stigma. These do not arise from limitations in the expertise or abilities of the affected individuals, but from a complex range of social, cultural, political, economic and historical factors that give rise to, and sustain, discrimination, marginalisation and exclusion in the workplace. This report emphasises the need for an ***intersectional*** approach that recognises the ***complexity*** of these issues and the need to tackle the systemic factors underpinning inequality, in order to facilitate the emergence of inclusive and compassionate leadership for all.

5. Recent years have seen mounting challenges for the NHS in relation to both funding and performance. The Rose Report (2015), Dalton Review (2015) and Francis Inquiry (2013) all highlight the importance of leadership in mobilising, implementing and sustaining transformation and change. The NHS Five Year Forward View (2014b) and subsequent reports emphasise the need for closer integration of health and social care and more effective cross-agency partnership and collaboration. There remain significant practical and conceptual variations, however, in how leadership is recognised,

rewarded and developed across the NHS, and this report calls for a ***critical review of the assumptions*** underpinning current approaches, especially in the light of the changing nature and purpose of leadership in the NHS.

6. The NHS invests significant amounts of time and money in leadership and organisation development, yet evidence of impact is variable. Mainstream approaches often take a leader-centric approach that fails to address dominant power relationships and perpetuates the status quo. Programmes and interventions need to go beyond a focus on the skills and competencies of 'leaders' (as determined against predefined metrics) to cultivate collective capacity, networks and relationships that facilitate cooperation and collaboration across boundaries. We suggest that a more ***power aware*** approach is required that supports the creation of ***safe spaces*** where people can engage with issues of identity (of self and others), develop a stronger sense of shared purpose, and challenge oppressive practices.

7. In order to nurture ***inclusive leadership practice,*** we highlight the need for a pluralistic approach that recognises and gives value to the diverse expertise and experiences of NHS staff and those they engage with. Too many people with protected characteristics (female, BAME, LGBT+, disabled, etc) feel invisible, unheard or worse and are more likely to experience workplace harassment or dismissal than other staff. Focusing on ***lived experience*** can be a powerful way to rekindle understanding and compassion in the workforce, to grow trust, and to foster empathy and understanding. This report suggests that the NHS needs to do much more ***active listening*** across sectors of its workforce in order to enhance opportunities for collaborative

learning and the active engagement of individuals from marginalised groups in developing innovative solutions to service improvement.

8. This report argues that inclusion should be considered not as a problem to be addressed but as the fundamental ***DNA of leadership and change*** in the NHS - a central pillar of innovation, collaboration and service improvement. A number of key themes are identified that should inform the design and implementation of leadership and organisation development strategies. These include:

    a. **Identity**: a multi-faceted concept that incorporates both physical and non-physical attributes and the interactions between them. We encourage particular attention to issues of *intersectionality*, *social identity* and *identity work*.

    b. **Lived experience**: this refers to the diversity of experience that people may encounter as a consequence of their identity, and how they interpret these experiences. Valuing lived experience draws attention to the *plurality of perspectives* on different issues and encourages *giving voice* to those from marginalised groups.

    c. **Emotion**: interventions need to engage with the emotive nature of inequality, inclusion and change (both for those from marginalised and non-marginalised groups) and to create *safe spaces* for *challenging conversations/experiences* around race, gender, sexuality and other aspects of diversity.

    d. **Complexity**: in complex adaptive systems, leadership is not about command and control but requires fostering *systems thinking*, *facilitating emergence*, and *leveraging change*. Whilst a 'best practice' approach may be helpful in setting the parameters

of what is expected, it will be inadequate to mobilise lasting change on issues as complex and entrenched as equality, diversity and inclusion.

e. **Power**: a focus on compassionate leadership within the NHS calls for a more inclusive, distributed and participative approach, which encourages a shift from *power over* to *power with* and *power to*. The approaches described in this report emphasise the role of leadership and organisation development in exposing and critiquing dominant assumptions and developing a capacity for individual and collective *critical thinking and reflection*.

f. **Sensemaking**: in order to tackle intractable 'wicked' issues such as inclusion we need to draw on a wide range of expertise and knowledge and to engage people in individual and collective sensemaking around potential interpretations and responses. Within this process leadership is about *(re)framing* the question(s) and *convening* diverse groups of people to have challenging and honest conversations that encourage curiosity and learning. This involves developing empathy, understanding and a shared narrative around the nature of the problem and how it can be addressed.

g. **Ethics**: ED&I initiatives often focus on the legal and/or business case for change. The *moral case* for tackling inequality and promoting diversity could be made far more compellingly and requires people to think and see afresh in an honest way and commit to a shared set of *values* around fairness, compassion and inclusion. This calls for *large-scale culture change* throughout the entire organisation in order to tackle the

underlying causes of inequality rather than just surface-level metrics and indicators.

h. **Collaborative inquiry**: this review shows that you cannot command or order inclusion. By its very subjective and emotional nature, inclusion must be nurtured through collaboration. A negative tone does not inspire human learning and tolerance, yet an *appreciative approach* can be effective in focusing attention on what is working and how it could be broadened out. Given the need to contextualise and embed learning, an *action research* approach is likely to be effective in mobilising feedback and experiential learning for those directly involved in the work of change.

9. Clearly there is a need to ***shift mindsets*** in order to achieve lasting change in the NHS and, to do this, it is essential to understand what has failed in the past and think differently about what is done and why. This report provides a series of recommendations to inform the work of BLFI in achieving its strategic aims which include:

    a. creating genuine opportunities to engage with and share lived experience;

    b. engaging with those in positions of power and privilege;

    c. identifying, connecting and supporting key allies and sponsors;

    d. treating ED&I as a wicked/complex issue;

    e. focusing on culture and relationships;

    f. stimulating and encouraging people to engage with a compelling narrative;

g. taking a practice-based approach to trial and experimentation;

h. triangulating a range of data sources to inform interventions, strategy and evaluation;

i. building accountability, engagement and ownership of ED&I across the system; and

j. promoting collaboration and equal representation across all activities.

10. This is one of a number of outputs from the independent research and evaluation accompanying BLFI. It inevitably presents only a partial picture of such a complex landscape and additional publications and resources will explore particular issues in greater detail. We hope you will find it a useful resource and a timely provocation for reflection, debate, enquiry and action on this most pressing of issues.

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1 INTRODUCTION

> 'The NHS provides a comprehensive service, available to all… irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status... It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.' (NHS Constitution, 2015)

Over the 70 years since it was founded the National Health Service (NHS) has sought to be an exemplar of inclusive and compassionate health care, that understands and respects the needs of the communities it serves and which provides rewarding and worthwhile jobs for its staff. As the fifth largest employer in the world, with over 1.2 million employees (Nuffield Trust, 2017), the NHS has huge potential for promoting progressive leadership and management practice and mobilising lasting change well beyond its own boundaries.

The NHS, however, is not a single organisation but rather a complex and shifting network of commissioners, providers and regulators that work in partnership to deliver a diverse range of healthcare and related services, as shaped by government policy (King's Fund, 2017a, 2017b). Add into the equation the highly turbulent and uncertain environment of austerity, Brexit, marketisation of healthcare, demographic and social change, technology, labour disputes, and so on, and is it hardly surprising that many commentators are advocating the need for radical innovation and

new approaches to leading large-scale change (Sustainable Improvement Team and the Horizons Team, 2018).

In 2016 key organisations[1] with NHS responsibilities co-developed *Developing People, Improving Care* (National Improvement and Leadership Development Board, 2016), an ambitious framework to tackle the challenges of health and wellbeing, care and quality, and funding and efficiency identified in the NHS England *Five Year Forward View* (NHS England, 2014b). This document highlights the relationship between staff development and service delivery and identifies five conditions for quality health and care systems and three pledges, endorsed by partners, which underpin the development and implementation of these principles across the NHS in England (see Box 1.1).

The introduction of Sustainability and Transformation Partnerships (STPs), also in 2016, marked an attempt to move away from policies that encouraged competition towards more collaborative, cross-sector working across traditional organisational and sector boundaries (King's Fund, 2017c). The STPs are comprised of commissioning and provider NHS organisations, local councils, the private sector and charities working together in partnership and are supported by six national health and care bodies: NHS England; NHS Improvement; the Care Quality Commission (CQC); Health Education England (HEE); Public Health England (PHE) and the National Institute for Health and Care Excellence (NICE). Following publication of *Next Steps of the Five Year Forward*

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[1] Including Department of Health, NHS England, NHS Improvement, Health Education England, NHS Leadership Academy, Public Health England, National Institute for Health and Care Excellence, Care Quality Commission, Skills for Care, Local Government Association, NHS Providers, NHS Clinical Commissioners and NHS Confederation.

View (NHS England, 2017c) plans are now under ways to develop Integrated Care Systems to form even closer collaborations in which NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve (NHS England, 2018a).

Five conditions:	**Three pledges:**
• Leaders equipped to develop high quality local health and care systems in partnership. • Compassionate, inclusive and effective leaders at all levels. • Knowledge of improvement methods and how to use them at all levels. • Support systems for learning at local, regional and national levels. • Enabling, supportive and aligned regulation and oversight.	• We will model in all our dealings with the service and in our own organisations the inclusive, compassionate leadership and attention to people development that establish continuous improvement cultures. • We will support local decision-makers through collectively reshaping the regulatory and oversight environment. In particular we owe local organisations and systems time and space to establish continuous improvement cultures. • We will use the framework as a guide when we do anything at national level concerning leadership, improvement and talent management so we engage across the service with one voice.

Box 1.1 Developing People, Improving Care: 5 Conditions and 3 Pledges

(National Improvement and Leadership Development Board, 2016: 10-12)

Greater integration of services and closer engagement with local communities has the potential to significantly reduce health inequalities and have a positive impact on the needs of a range of equality groups (Public Health England, 2017). Collaborative partnerships such as this, however, are notoriously difficult to implement and sustain – requiring active engagement from a wide array of stakeholders, each of whom may have different priorities, agendas, areas of expertise and constituents. In such contexts hierarchical approaches to leadership, in particular command and control, are not only ineffective but counter-productive. Instead a more collective, inclusive and systemic approach is required that draws on leadership expertise and engagement at all levels (Crosby and Bryson, 2005, Crosby and Bryson, 2010, West *et al.*, 2014).

Such change, however, is situated against the backdrop of a 'crisis' in funding and performance, exacerbated by severe staff shortages. In March 2018, for example, the King's Fund's *Quarterly Monitoring Report* revealed 'around half of NHS trust finance directors [forecast] a deficit, broadly the same proportion that did so at the same time last year, a year when the trust deficit reached £791 million' (King's Fund, 2018). Performance against waiting times included 'the second highest ever month-on-month decline' in meeting A&E waiting targets (a standard not met since August 2014) and increasing difficulties meeting the 18-week referral-to-treatment times – which together, means the 'sickest wait longest' (*ibid*). As highlighted, risks to care quality, staff wellbeing, staff shortages (particularly in nursing) and decreasing staff motivation and engagement across the sector remain significant barriers to progress (Sizmur and Raleigh, 2018).

The ability of the NHS to tackle the challenges it faces will be dependent on its capacity to fully engage its entire workforce, regardless of

background or identity, to provide services that meet the changing needs of the communities it serves. Making a step change in equality, diversity and inclusion (ED&I) within the NHS is not only a moral and legal imperative but a fundamental driver of innovation and patient and employee engagement (West and Dawson, 2012, West *et al.*, 2017). At a time when the NHS is facing significant challenges to its survival there is no more compelling reason to tackle the underlying causes of discrimination, marginalisation and exclusion to create an NHS fit for the future. Key to achieving this will be mobilising and developing effective leadership that can create and sustain cultures of compassion and inclusion across the whole health and social care system.

This report, commissioned by the NHS Leadership Academy, sets out the evidence base for *Building Leadership For Inclusion (BLFI)* – a new and radical programme of work that aims to (1) raise the level of ambition, (2) quicken the pace of change, and (3) ensure that NHS leadership is equipped to achieve and leave an ever-increasing and sustainable legacy in relation to equality, diversity and inclusion (NHS Leadership Academy, 2018). The report draws on a wide range of theory, evidence and practice to explore *why* inequalities persist, *how* they are experienced and *what* needs to be done differently to make significant and lasting progress on diversity and inclusion. It begins with a review of the current state of ED&I in the NHS, followed by consideration of inclusion as a complex issue. We then consider the nature and challenges of leadership in today's NHS and the implications for leadership development. Finally, we consider key principles to inform BLFI and its approach to mobilising transformative change on inclusion. Our main conclusion is that in order to deliver a marked improvement in inclusion the NHS and partners should regard this as a critical

requirement for all aspects of its work, and the fundamental DNA[2] of effective leadership and change, rather than as a separate set of activities and indicators to complement current practice.

This is one of a number outputs from the independent research and evaluation accompanying BLFI and inevitably presents only a partial picture of such a complex landscape. The report has been written by a research team based at the University of the West of England, Bristol and is informed by an extensive review of relevant literature, interviews with academic experts and preliminary action research with the BLFI team and partners (see Appendix 1 for further details). In order to produce a report that is sufficiently broad yet detailed we have had to make choices about what to include and what to omit. Given the scale of interest in diversity and inequality in the NHS we have drawn on existing evidence where available and focused, in particular, on highlighting the links between the lived experience of leadership and inclusion and the implications for development and practice. We hope you will find it a useful resource and a timely provocation for reflection, debate, enquiry and action on this most pressing of issues.

[2] Deoxyribonucleic acid (DNA) carries the genetic instructions for all living organisms. It is passed on through reproduction, with genetic variations producing adaptation, change and the emergence of new species over time.

2 TACKLING INEQUALITY, BUILDING INCLUSION

> 'Building a more representative workforce is good both for hard working NHS staff and for the diverse patients and communities we serve. As the largest employer in Britain and one of the biggest in the world, the NHS has a particular duty to be fair and supportive for all our employees. Today's assessment shows important improvements for our BME[3] staff, but it's also a clear reminder of the hard work still ahead.'
> (Simon Stevens, Chief Executive of NHS England, response to the 2017 WRES Report)

Whilst 2018 marked the 70th anniversary of the NHS and gave cause to celebrate the significant contribution of diverse individuals throughout its history, it was also a year marred by manifestations of inequality that impacted upon the quality of service delivery and the confidence of the general public. Immigration issues, pertaining to what became known as the 'Windrush scandal' saw outrage as individuals were turned away or charged for health care services (Siddique and Stewart, 2018); the NHS' first *Gender Pay Report* denoted a 22% differential in pay highlighting persistent inequality between genders (NHS England, 2017a); and the *Learning Disabilities Mortality Review Annual Report 2017* demonstrated that individuals with learning disabilities still die, on average, 15-20 years earlier than the rest of the population, noting that a significant

[3] Please note that throughout this report we use the Black, Asian and Minority Ethic (BAME) category for race where possible as it is widely used across the NHS. In some instances, however, evidence is only available for Black and Minority Ethnic (BME) and/or other groupings and hence terminology may shift where this is the case.

demographic of our population is being left behind (NHS England, 2018b).

In many ways 2018 has been a landmark year with regards to attitudes towards inequality and discrimination as the full force of 'new power' (Heimans and Timms, 2014) became apparent through online campaigns such as *#MeToo* and *#NeverAgain*. Whilst such initiatives demonstrate the capacity for ordinary people to collectively mobilise against sexual, racial and other forms of discrimination, abuse and injustice they also highlight the complex and highly emotive nature of inclusion. In order to address such challenges we must take a systemic perspective that recognises the complex, contested and changing nature of the contexts we are working in.

2.1 What is Inclusion?

> 'Diversity is being invited to the party; inclusion is being asked to dance.' (Myers, 2015)

Despite significant and increasing focus on inclusion, it remains a rather ambiguous and elusive concept with varying conceptual underpinnings (Shore *et al.*, 2011). To better understand inclusion, and how it might be more effectively developed in the NHS, we will briefly introduce the concept and its relationship to equality and diversity.

Whilst acknowledging the breadth of this term, ***equality*** is often conceptualised in reference to legislative duties. In the UK, the *Equalities Act (2010)* and the *Public Sector Equality Duty (PSED)* outlined within it brought together a number of laws intended to prevent discrimination of persons based upon aspects of their identity. *The Equalities Act* also underpins the *Health and Social Care Act (2012),* which

set out a radical series of reforms for the NHS in England, and represents a significant attempt to reduce the day-to-day involvement that politicians, civil servants and managers will have in health care. It laid the foundations for the *NHS Equality and Diversity Council* (EDC), an advisory body that provides visible leadership on equality issues across the NHS, to support and improve on their equality performance (NHS England, 2017d).

As noted by Oswick and Noon (2014) in recent years ***diversity*** has been portrayed as distinct from equality. In a move that sought to shift the focus from legal compliance to embracing difference today diversity can be broadly considered as the difference between observable and non-observable personal characteristics with varying cultural significance (Cox, 1994), including physical difference or cognitive difference which might be immediately observable or hidden. Whilst diversity can, and arguably should, be utilised to embrace a huge range of difference, authors such as Kandola (2009) note that the term is frequently used in relation to the composition of workforces pertaining to equality groups; in particular, the 'big three' of race, gender and disability.

Frost (2014) highlights how in recent years there has been a noted shift of focus from diversity to ***inclusion***. Whilst the aim may be equality and an appreciation of diversity is essential, inclusion shifts the conversation into an understanding of culture, behaviours, resources, processes and structures, which either promote or inhibit the full and equal engagement of all individuals.

2.2 In/Equality in the NHS

Following the public inquiry into the murder of Stephen Lawrence, which highlighted institutionalised racism in the Metropolitan Police

(Macpherson, 1999), the NHS introduced an equalities framework, *The Vital Connection* (NHS Executive, 2000) to pave the way for the new public sector equalities legislation and as an introduction to the government's modernisation agenda for public services.

Four years later the NHS *Race Equality Action Plan* (Department of Health, 2004) was introduced. In 2014 Roger Kline assessed progress by means of a survey of leadership in London's NHS Trusts. His influential *Snowy White Peaks* (2014) report considered the diversity gap between the NHS Trust's governance and leadership, and the communities it served. The report found that, despite decades of government and institutional support for initiatives aimed at addressing barriers to progression for Black, Asian and Minority Ethic (BAME) individuals, very little progress had been made.

> 'Although black and minority ethnic people constitute approximately 45% of London's population and 41% of the London NHS workforce, just 7.9% of London NHS Trust Board members came from a BME background in 2013.' (Kline, 2014)

More recent data from the 2017 *NHS Staff Survey* (NHS Staff Survey Coordination Centre, 2018b) demonstrates that today's NHS workforce is extremely diverse in regard to ethnicity; BAME individuals comprise 13% of the overall population but 19% of the UK NHS workforce (NHS Employers, 2018). However, whilst the general representation of staff is diverse, data collated to assess the 2017 *Workforce Race Equality Standard (WRES)* highlights that for NHS trusts nationally, staff diversity is non-representative of the workforce when senior management and leadership roles are considered. Across the non-medical workforce (clinical and non-clinical), the proportion of BAME staff in Bands 8a-9

and ‘Very Senior Managers’ (VSM) was 10.4% compared with 16.3% in the workforce as a whole (NHS Equality and Diversity Council, 2017).

The lack of diversity in NHS senior leadership is mirrored within national statistics. A recent independent review conducted by Sir John Parker into the diversity of FTSE 100 boards found just 8% of directors were from BME backgrounds, out of a total 1,087 director positions. *The Parker Review* (2016), which studied the 500 largest charities in England and Wales, found over half had ‘all-white governance’ while as many as 113 charities (22.6%) had as few as 1% to 10% BME representation on their boards.

Evidence highlights that typical patterns and perceptions of leaders vary across different identity characteristics. Blanchet-Cohen (2006), for example, note how physically disabled adults have reported that nondisabled people treat them like children or fail to include them in social activities. Gündemir *et al.* (2014) found evidence for an implicit pro-white leadership bias in regard to who is conceived as a ‘leader’. These findings are echoed in a study by Business in the Community (BITC, 2012), which explored the experience of 130 women in private and public sector leadership positions. It noted that 70% of BAME women felt that their leadership style was being questioned in the eyes of others whom they believed held stereotypical and prejudiced views on how they perceived a BAME woman should lead.

Perceptions of leadership potential and ability appear to vary in relation to the identity and homogeneity of the group that is perceiving the ‘leader’. Morton (2017), for example, highlights that ‘current research demonstrates that people with different levels of homonegativity

evaluate heterosexual and gay male leaders differently' (Morton, 2017:167).

It has also been suggested that individuals with protected characteristics are placed in high-risk leadership positions. Ryan and Haslam (2005) refer to this as the ***glass cliff***, highlighting that in addition to receiving greater scrutiny and criticism than men, the positions that women occupy are likely to be less promising and more precarious than those of their male counterparts[4].

Collins (1991) highlights how black female community leaders commonly position themselves as 'the outsider-within', utilising their jobs to stimulate institutional transformation rather than trying to fit into the existing system. However, this process of trying to manoeuvre and create change from within an organisation where they are a minority places woman in personal jeopardy and professional risk.

It is beyond the scope of this report to discuss in depth the multitude of issues that have been highlighted in research on this subject. However, what is appreciated is that research has repeatedly evidenced that there is a relationship between observable or non-observable identity characteristics and factors that impede career progression. For example, Kepinski and Nielsen note how 'senior leaders knew less about the female talents than about the male talents in the senior executive pipeline' (2016:15). This lack of recognition or awareness of female talent impedes potential for promotion and career development support.

Marginalised individuals are also less likely to access career development support. The WRES 2017 noted that across England white

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[4] Further research has demonstrated similar trends for ethnic minorities (Cook and Glass, 2014, Kulich *et al.*, 2014).

staff were 1.22 times more likely to access non-mandatory training and career progression development (CPD) than BAME staff. This is higher than in 2016, when white staff were 1.11 times more likely to access non-mandatory training and CPD than BAME staff.

Identity also appears to bias appraisals and the rate at which individuals are referred into disciplinary action. It is noted that within the NHS BME staff are 1.37 times more likely to enter the formal disciplinary process in comparison to white staff (NHS Equality and Diversity Council, 2017).

Considering the known correlation between subjective evaluation criteria and identity, the importance of how we perceive emotions and engage in social interactions is significant. Psychological research has demonstrated that there is a relationship between race, perceptions of facial expressions, and the way in which aggression is perceived. Kang and Chasteen's (2009) study highlighted that this relationship becomes increasingly complex when multiple aspects of identity are studied. While 'participants perceived anger as lasting longer and appearing sooner on old compared to young White faces, this relationship was reversed for Black faces, with participants perceiving anger lasting longer and appearing sooner on young compared to old Black faces' (Kang and Chasteen, 2009:1281).

Whilst the *Equality Act* (2010) defined nine 'protected characteristics'[5] and introduced law to protect individuals from direct and indirect discrimination, many authors suggest that discrimination frequently

[5] Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

manifests through intended or unconscious ***microaggressions***[6], which are not protected in law.

Across the NHS individuals with protected characteristics report higher rates of bullying. A survey commissioned by Stonewall looking into LGBT+[7] issues in health and social care settings, for example, highlighted that from 3,001 health and social care staff a quarter (26%) say they have personally experienced bullying or poor treatment from colleagues in the last five years as a result of their sexual orientation (Somerville, 2015:6).

Essed (1991) utilises the term ***everyday racism*** to describe how systemic racism is reproduced through the day-to-day, taken-for-granted practices and procedures in everyday life that violate the rights, humanity and dignity of ethnic minorities. This includes ***'Aversive racism'*** (Dovidio and Gaertner, 1986; Kovel, 1970), whereby individuals who may well regard themselves as liberal and egalitarian consciously or unconsciously avoid interaction with people from other ethnic groups and behave differently on the basis of stereotypes. This everyday form of microaggression, which has a negative impact upon experience and psychological wellbeing, is not only associated with ethnicity. The Royal College of Nursing (RCN) commissioned a report into the experiences of internationally recruited nurses (IRNs) working in the UK. Whilst recognising variation, it draws attention to how some nurses felt stigmatised by the language difference and experienced a lack of

[6] 'Microaggressions are brief, everyday exchanges that send denigrating messages to people of colour because they belong to a racial minority group.' (Sue, *et al*., 2007: 273)

[7] LGBT+ refers to people who identify as lesbian, gay, bisexual or transsexual, as well as those who identify with other groups, such as asexual, intersex or queer.

willingness from others to try to understand them (Allan and Larsen, 2003).

In complex systems such as the NHS inequality and discrimination can manifest in a multitude of ways, a fact that is also recognised in the UK's approach to equality law. Whilst the NHS has a legal duty to protect individuals from direct and indirect forms of discrimination[8] inequality persists. For example, 'BME staff remain significantly more likely to experience discrimination at work from colleagues and their managers compared to white staff, at 14% and 6% respectively' (NHS Equality and Diversity Council, 2017:8).

UK law exists not only to react to incidents of discrimination, but also to proactively enhance inclusive practices. The 2010 *Equality Act* introduced the concept of ***reasonable adjustments*** and ***disability allowances*** to ensure that individuals were not restricted by their workplace environment. However, as is common with reactive legislation, there is a disjuncture between aspiration and implementation. One of many factors that inhibit actualisation of legislative rights pertains to a fear of claiming entitlements. It is noted, for example, that 'disabled employees may feel uncomfortable requesting accommodation for fear of appearing to want preferential treatment' (Cohen and Avanzino, 2010:275).

In addition to hostility (perceived or actual) when claiming legally entitled support, it is evident that individuals may have concerns about raising or

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[8] Direct discrimination occurs when an individual with protected characteristics is treated less favourably because of certain attributes of who they are. Indirect discrimination occurs when an organisation's practices, policies or procedures have the effect of disadvantaging people who share certain protected characteristics (ACAS, 2013).

reporting issues of discrimination. Oluo (2018) is one of several authors who highlights that when incidents of discrimination or harassment emerge, it is frequently those who have been discriminated against who feel the greatest responsibility to act and who encounter hostility and victimisation when they do so.

In a legal sense victimisation occurs where ‘a person is treated less favourably for bringing proceedings or giving evidence about discrimination on any ground, or for alleging that acts of discrimination have occurred’ (Kumra and Manfredi, 2012:33). In theory, individuals who raise issues of discrimination are protected from the detrimental effects this may have under UK law. However, it is likely that actual incidents of victimisation are under-reported as an individual who is treated in an adverse manner after reporting an incident of discrimination may be reluctant to trust the same systems and processes to report subsequent incidents of victimisation.

2.3 The Impact of Inclusion

Whilst the presence of staff and leaders with similar identities to those they represent may well create greater equality, research by King *et al.* (2011) across 142 non-specialist hospitals in the UK indicated that overall levels of ethnic diversity amongst hospital staff actually increased the probability of reports of incivility towards patients. More detailed analysis, however, reveals that the closer the ‘fit’ between the diversity of hospital staff and the communities they serve the more likely that patients would report being treated with civility, an indicator which in turn correlated positively to assessments of organisational performance by the Care Quality Commission (CQC).

In a review of evidence on workplace diversity Guillaume *et al.* (2014) used the 'Categorization-Elaboration Model' to explore the interplay between factors that inhibit and enhance the positive effects of diversity, concluding that leadership behaviours that inspire, support and participate have an important role to play in fostering collaboration and reducing conflict. With regards to organisational climate and culture two factors were found to be particularly significant – firstly that shared perceptions of trust, justice or psychological safety promote positive intergroup contact and well-being, and secondly that a shared commitment to information sharing and integration enhances information-elaboration and performance on complex tasks. Their research calls for a shift in thinking from ***diversity climate*** to ***diversity mindsets*** that clarify both the nature of diversity-related goals and how to achieve them.

In 2014 senior leaders from across health and social care signed the declaration on *Advancing Equality and Tackling Health Inequalities across Health and Social Care* (NHS England, 2014a). One of the key actions stated in this document is to 'raise ambition at every level of the health care system by campaigning to inspire strong leadership, removing barriers to change, and celebrating success' (NHS Equality and Health Inequalities Unit, 2017:19).

In their 2018 study, *The risks to care quality and staff wellbeing of an NHS system under pressure*, the King's Fund found that staff-reported experience was correlated with patient feedback in a number of areas, notably between staff perceptions of patient care and patient experience (Sizmur and Raleigh, 2018). In complex systems an impact in one part of the system can have a ripple effect in other parts of the system, often in unforeseeable ways.

The 2017 NHS staff survey, for example, highlighted that there were 55,535 staff who reported experiencing discrimination at work (NHS Staff Survey Coordination Centre, 2018c), a factor which has a direct relationship not only to staff wellbeing, but also to staff retention and absenteeism. The Care Quality Commission calculated the average cost to the trust for each staff member who leaves is £4,500 (CQC, 2017). Staff wellbeing is reported to be negatively impacted by an overstretched workforce, with a high proportion of temporary staff, and the staff experience associated with sickness absence rates, spend on agency staff and staffing levels (Sizmur and Raleigh, 2018). Ethnicity is consistently cited as the most commonly reported reason for discrimination across the NHS in the last five years (NHS Staff Survey Coordination Centre, 2018c), suggesting an indirect correlation between identity, discrimination and expenditure.

> 'Equality-related causes of absenteeism include work-related stress due to harassment and bullying. Inclusive cultures, free from discrimination also lead to higher employee engagement which is linked to lower absenteeism. NHS staff are absent from work, on average, 10.7 days each year. This loses the service a total of 10.3 million days and costs £1.75 billion.' (CQC, 2017)

Feminist scholars working to address gender inequality have long understood that 'the personal is political'[9]. Following this tradition, it is argued that issues of discrimination and inequality faced in the personal arena and work are inextricably linked to the political domain. In April 2018, for example, it was reported that NHS staff topped the list of those

[9] This was a rallying slogan of second-wave feminism in the 1960s and further popularised in the 1970s to highlight the relationship between personal and political issues.

applying for pay day loans (Booth, 2018). As we explore the significance and cost of absenteeism and stress upon the NHS it is important to recognise not only how these might be affected by political policies such austerity and pay freezes, but also how these issues may have a differential impact upon individuals of particular identities. As highlighted in a report by the Women's Budget Group and Runnymede Trust (Hall et al., 2017) BME women have faced disproportional impacts of austerity and subsequent debt which has resulted as a consequence of cuts.

The 'business case' is often used to convince senior management (which typically lacks diversity itself) of the value of diversity and inclusion at an organisational level. However, whilst the business case for diversity correlates a diverse workforce to a strong competitive business advantage, Noon (2007) highlights a fundamental weakness of such an approach and warns against replacing arguments for social justice with the business case rationale:

> 'The argument for the moral case based on the human rights of all employees and job seekers must not be abandoned for the current fashion of diversity and the business case.' (Noon, 2007: 781)

Critics of the business case refer to ***managing diversity*** policies, where the diversity of the workforce is valued 'as a direct contribution to the success of an organisation' (Greene and Kirton, 2004:9). For true diversity, organisations need to do more than acknowledge the value of a more heterogeneous workforce, it requires active engagement with policies and practices founded on principles of equal access to opportunities, social justice, fairness and human rights.

The moral case for embracing diversity and inclusion is simple – it is the right thing to do. Furthermore it is argued that treating people fairly and with respect helps to develop a more cohesive, tolerant and prosperous society (Cabinet Office, 2007). To mobilise sustainable large scale change on inclusion, however, the NHS needs to find effective ways of integrating practical and ideological arguments on diversity and inequality and linking them to current and emerging priorities, such as staff recruitment and retention, patient experience, collaborative partnership-working and addressing the long-term funding crisis.

2.4 APPRECIATING CONTEXT

Snowden and Boone (2007) propose the 'Cynefin' model (see Figure 2.1) as a framework to assist leaders in matching their leadership approach to the environment in which they are operating. A distinction is made between four domains - simple, complicated, complex and chaotic - suggesting that the former two are ordered systems amenable to processes of categorisation and analysis, whilst the latter two can only be understood through direct intervention and experimentation. This section proposes that addressing inclusion is not a simple or even complicated matter, rather it should be considered as a complex challenge that may, at times, tip into the chaotic.

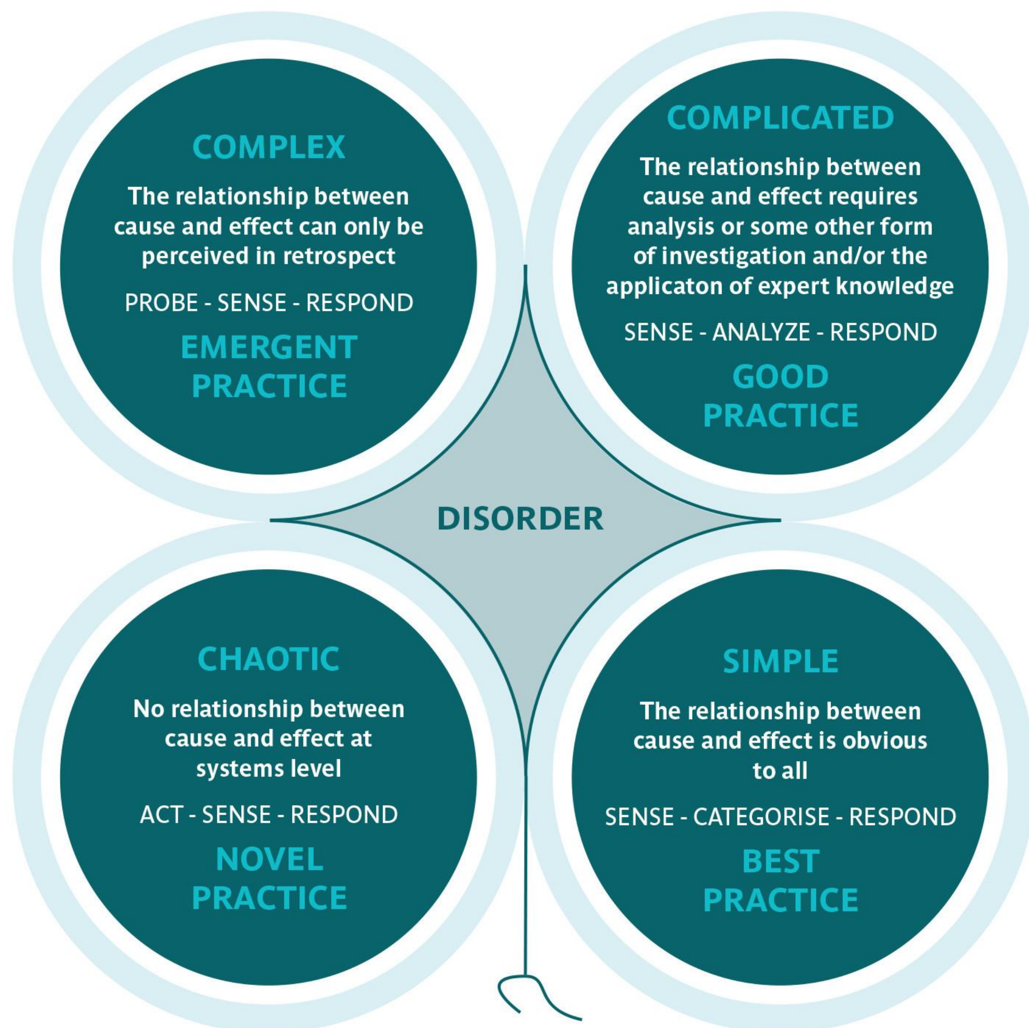

Figure 2.1 – The Cynefin Framework

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Simple contexts[10] are 'characterized by stability and clear cause-and-effect relationships' (Snowden and Boone, 2007:70). However, when dealing with issues of inclusion solutions are rarely simple. Take for example, the NHS 2017 *Gender Pay Gap snapshot report* which highlights a 21.2% difference between the average pay of men and women (NHS England, 2017a). On first inspection, this statistic may give rise to the proposal of a simple solution - men and women are not paid

[10] Note that since 2014 Snowden has referred to the 'simple' domain as 'obvious' (Berger and Johnson, 2015).

equally, so pay women more - however, the reality of the problem is less straightforward.

Whilst unequal pay between women and men for doing the same job would be a direct violation of the *Equality Act* (2010) the NHS' mean gender pay gap is calculated utilising the current UK government guidelines, whereby the difference is taken from the mid-point hourly salary for men and for women. This means that whilst pay is equal within the defined boundaries of the *Agenda for Change* (AfC) pay grades (which range from Band 2 to Band 9) there is something amiss with regard to how women progress through these bands and how female dominated professions (such as nursing and midwifery) are categorised within pay scales. The inequality becomes clearer as the data are probed further. Whilst 51% of the overall population of England are female, an above average 55% of female NHS England staff are in the highest quarter in terms of pay. This statistic, however, is less impressive when it is recognised that 77% of the NHS workforce are women or that 79.6% of employees in the lower quartile are female (NHS England, 2017a). These data suggest that women are not progressing at the same rate as their male counterparts or being rewarded for leadership positions at a rate that is representative of the wider workforce.

Analysis of the gender pay gap moves us from seeing inclusion as a simple problem and into the realm of the complicated. ***Complicated contexts,*** unlike simple ones, 'may contain multiple right answers, and though there is a clear relationship between cause and effect, not everyone can see it' (Snowden and Boone, 2007:71).

Positive examples have been demonstrated by initiatives such as unconscious bias training, mentoring and coaching. Whilst these interventions had some impact, substantive change has not emerged consistently and there is growing criticism for the lack of success of such schemes and potential unintended consequences (Dobbin and Kalev, 2016). This suggests that the issue is more than complicated, it is complex.

Complex contexts are characterised by path dependency and rich interdependence (Snowden and Boone, 2007; Uhl-Bien and Arena, 2017) in that what happens is influenced by preceding events and that any change will have knock on effects elsewhere in the system. Created in 1948 the NHS has been shaped by the input of staff with multiple ethnicities and nationalities, many of whom moved from British Commonwealth countries to the UK during the Second World War reconstruction period (Simpson, 2018). The NHS has always had a substantive international workforce yet the situation has been complicated by the UK's referendum to leave the European Union. The most recent figures from the Nursing and Midwifery Council indicate an 87% drop in registrations from the European Economic Area (EEA) between 2016/17 and 2017/18 and a 29% increase in the number of EEA nurses and midwives leaving the register, 47% of whom cited Brexit as one of the main factors influencing their decision (NMC, 2018). This contributes to an overall downturn in the number of nurses and midwives registered to work in the UK since 2016 (ibid). Recent policy shifts to retain the ability to recruit medically qualified staff from outside the UK demonstrates the NHS' continuing dependence on staff from a diverse range of nationalities and ethnicities (BBC News, 2018) and the extent of staff shortages and recruitment challenges in this sector.

Boulton *et al.* (2015) highlight that whilst complex contexts are path-dependent, that is to say that they are informed by historic events they cannot be predicted by them. In practice, issues that relate to complex contexts are '*emergent'*. They are shaped by unforeseeable patterns and interactions, such that cause and effect only become apparent with hindsight and may remain contested (Snowden and Boone, 2007). Treating a complex issue as if it were simple or complicated is likely to compound the problem and, as indicated by the raised lip at the bottom of the Cynefin model, may well tip the situation over into chaos. Instead, complex problems are best tackled by removing unnecessary layers of complication, whilst recognising the inherent uncertainty associated with them - as Einstein famously put it: 'things should be made as simple as possible, but not simpler'.

2.5 INTERSECTIONALITY

> 'Intersectionality is a way of understanding and analyzing complexity in the world, in people, and in human experiences. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are shaped by many factors in diverse and mutually influencing ways.' (Collins and Bilge, 2016:2)

The issue of ***intersectionality*** perhaps most powerfully illustrates the complexity of inclusion. Kimberlé Crenshaw (1991) coined the term to describe the social, economic and political ways in which identity-based systems of oppression and privilege connect, overlap and influence one another. Crenshaw drew from the work of notable feminist authors such as Beal (1969), Hooks (1982), Davis (2001) and Cheung (1999). Collins

and Bilge (2016), however, suggest that the popularisation of the concept since the early 1990s has led to misconceptions and oversimplifications. Whilst Crenshaw is frequently cited, there is often a lack of awareness of the full argument, or the history of its development. Describing the origins of the term, Davis (2016) states that intersectional perspectives have been developed to highlight the interrelationships between social inequality, power and politics. The aim is not to create a hierarchy of disadvantage, or ever more elaborate conceptual separation, rather it is a way of understanding how power and inequality interact across identities.

Appreciating the intersectional way in which power moves across and between identities requires an ability to see identity in the first place. Crenshaw suggests that whilst 'race, gender, and other identity categories are most often treated in mainstream liberal discourse as vestiges of bias or domination', for African Americans, other people of colour, gays and lesbians 'identity-based politics has been a source of strength, community, and intellectual development' (1991: 1242). Following this assertion she continues to propose that it is not recognition of identity, which is problematic, but rather the over-simplistic ways in which identity has been constructed and categorised. She states that the problem with identity politics is not that it fails to transcend difference, as some critics suggest, but rather the opposite - that it frequently conflates or ignores differences within groups.

> 'There's no such thing as having one identity or of there being one essential identity that fundamentally defines who we actually are.' (Cornel West, 1992)

In discussions of identity it is important to recognise that we all hold multiple identities simultaneously, some of which are more pervasive than others, some purposely hidden and some unconsciously adopted. Ospina and Foldy (2009), for example, note that research on race–ethnicity indicate that these aspects of identity seldom operate in isolation from other identities such as gender, class, sexual orientation, nationality and religion.

Within the NHS staff and patients hold multiple identities that interact in complex ways. As Davis highlights, historically those committed to creating social change have recognised this complexity. She states, there were those of us who 'recognized that we had to figure out a way to bring these issues together. They weren't separate in our bodies, but also they are not separate in terms of struggles' (Davis, 2016:19). Just as individuals cannot necessarily separate aspects of their identity, leaders do not have the luxury of being able to deal with problems in compartmentalised boxes, the reality is that organisations such as the NHS need to appreciate and develop strategies for addressing inclusion in more nuanced ways.

Rosette and Livingston (2012) explored Beal's (1969) concept of ***double-jeopardy*** to indicate how BME women are disproportionally affected by discrimination. With some similarities to Ryan and Haslam's (2005) 'glass cliff' phenomenon described earlier, they assert that black female leaders are disproportionately sanctioned for making mistakes on the job, particularly under conditions of organisational failure (Rosette and Livingston, 2012). At present, the evidence available in NHS and healthcare settings does not enable a detailed intersectional understanding of leadership and inclusion and may lead to over-

simplistic interventions that fail to engage with significant aspects of lived experience.

What is clear from the evidence, however, is that certain individuals face compounded discrimination in relation to the multiple and overlapping identities they hold. According to the 2017 NHS staff survey, for example, 12.3% of BAME staff cited that they had a long-standing illness, health problem or disability, yet only 68% of these felt that their employer made adequate adjustments to enable them to carry out their work, compared to 74.9% of white staff members.

3 Rethinking Leadership

> 'The level and pace of change in the NHS remains unsustainably high: this places significant, often competing demands on all levels of its leadership and management. The administrative, bureaucratic and regulatory burden is fast becoming insupportable.'
> (Rose, 2015:9)

In a review commissioned by the then Secretary of State for Health, Lord Rose (2015) highlighted three significant areas of concern regarding the capacity of the NHS to respond to the challenges it faces: (1) a lack of common vision and ethos, (2) insufficient leadership and management capability, and (3) inadequate career development pathways for leaders and managers across medical, administrative and nursing cadres. His recommendations, like those of the earlier *Dalton Review* (Dalton, 2015) and *Francis Inquiry* (Francis, 2013) emphasised the pivotal role of leadership in mobilising, implementing and sustaining transformation and change and set out a number of practical recommendations about what could be done to enhance leadership capacity in the NHS. Despite his best attempts, however, he could not find agreement on what people recognised as 'good' or 'best' leadership or even 'what does a good NHS look like, what would success be?' Whilst Rose took this as evidence of poor communication and the absence of a compelling NHS vision and ethos, it may well be indicative of the elusive and contested nature of leadership itself and its complex relationship to performance in a changing health and social care context.

3.1 The Nature and Purpose of Leadership in Times of Change

For decades leadership has been one of the most heavily researched topics in business and social science yet there remains remarkably little agreement on quite what it involves, where it resides and how it can be assessed. Writing on the topic, Ladkin (2010:2) suggests 'one thing that is clear about the leadership literature is that there is relatively little that is clear about leadership'. Unlike many authors, however, rather than arguing that this is a problem to be remedied through ever more elaborate research, she suggests that the very 'indefinability' of leadership offers important insights into what kind of phenomenon it is.

Within mainstream leadership theory and practice an 'entity' perspective dominates, whereby leadership is regarded as something with a discrete, tangible essence that can be objectively analysed and measured. This tends to be associated with a rather mechanistic and reductionist methodology, often supported through the statistical analysis of quantitative data, through which ***leadership*** is equated with the skills, qualities and/or behaviours of individual ***leaders***. This thinking pervades leadership theory and practice to such an extent that researchers at the Center for Creative Leadership (CCL) conclude that despite the apparent contradictions between theories and definitions they are virtually all underpinned by the assumption that leadership arises through the interaction of leaders, followers and a common goal (what Bennis (2007) refers to as the 'tripod'). As Drath *et al*. (2008:635) propose: 'this is not a definition of leadership but something much more fundamental: it is an expression of commitment to the entities (leaders, followers, common goals) that are essential and indispensable to leadership and about which any theory of leadership must therefore speak'.

Whilst the 'tripod' of leaders, followers and a common goal may be sufficient to explain how leadership occurs in certain contexts (for example when conducting clearly defined tasks in a relatively formalised, hierarchical structure) it is inadequate for understanding leadership in more complex, collaborative environments where the identification and distinction of 'leaders' *vis-à-vis* 'followers' may be inappropriate or where there may be no commonly agreed goal. Within a surgical operating theatre, for example, Klein *et al*. (2006) developed the concept of ***dynamic delegation*** to refer to the ways in which different professionals step in and out of a 'lead' role depending on the requirements of the task. When it comes to wide-scale social and organisational change the situation becomes even messier, where there are many examples of people mobilising collectively without a clear demarcation between 'leaders' and 'followers' or even a commonly agreed goal other than to bring about change[11].

To resolve this challenge CCL encourage a shift in focus from leadership ***inputs*** (leader, followers and common goal) to leadership ***outcomes*** (direction, alignment and commitment), providing the following definition of leadership across boundaries.

> 'We define boundary spanning leadership as the capability to establish direction, alignment, and commitment across boundaries in service of a higher vision or […] This capability resides within and across individuals, groups and teams, and larger organizations and systems.' (Yip et al., 2016:3)

[11] For a vivid illustration of this take a look at the King's Fund animation: *How does the NHS in England work? An alternative guide* - https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work

Such a shift allows for a more nuanced approach to recognising how leadership is acknowledged, and accomplished, including the extent to which it is 'socially constructed' through language and interaction. As Drath (2001) argues: 'leadership is not something out there in the world that we come to know because it impresses itself on our minds, it is something we create with our minds by agreeing with other people that these thoughts, words, and actions - and not some others - will be known as leadership.'

Grint (2005, 2008) draws upon the work of Rittel and Weber (1973) to provide a useful framework for thinking about the nature and purpose of leadership in complex settings such as healthcare by focusing on the kinds of problem that are being addressed, as illustrated in Figure 3.1. A ***tame problem*** is something that we've either seen before or can apply rational logic to resolve. Grint suggests that the best response to such problems is largely a case of organising a process to address the issue – effectively calling for 'management'. A ***wicked problem*** is complex and intractable, with no obvious solution. Such a situation, Grint suggests, calls for 'leadership' and is largely about asking questions and mobilising collective expertise to determine the real nature of the problem and weighing up the options. Such problems may appear 'messy' and solutions 'clumsy' (Grint, 2008) as people navigate their way through a complex and changing landscape. Finally, a ***critical problem*** is defined as urgent, requiring immediate and decisive intervention. In the face of a critical problem leaders and managers need to act fast and may not have time for wider consultation. Such situations call for a 'command' approach that provides clear direction, whether or not it is necessarily the most inclusive, informed or effective.

A key feature of Grint's framework that is often overlooked, however, is that problems are not necessarily 'critical', 'tame' or 'wicked' in of themselves but are framed and interpreted as such through a process of sensemaking. In presenting an issue as tame, wicked or critical leaders and managers legitimise different forms of response that shape both their relationship with 'followers' and the forms of power they can draw on[12]. Grint's typology highlights not only the varying nature of problems, but also the role of narrative and influence in determining an appropriate response. For leaders to be successful they need to be able to tell a convincing tale and, in an increasingly media savvy world, persuade others to tell stories on their behalf too. The success or failure of an idea lies not just in its accuracy or utility but in how it is communicated and interpreted.

[12] It is thus not uncommon for leaders with a preference for a command and control approach to present situations as 'critical' and in need of decisive intervention, dismissing those who call for a more collaborative approach as weak and indecisive. A command and control approach, however, won't resolve a wicked problem and is likely to place significant pressure on everyone involved if a way cannot be found to put in place management processes that produce some stability and to facilitate collective sensemaking around long-term complex challenges.

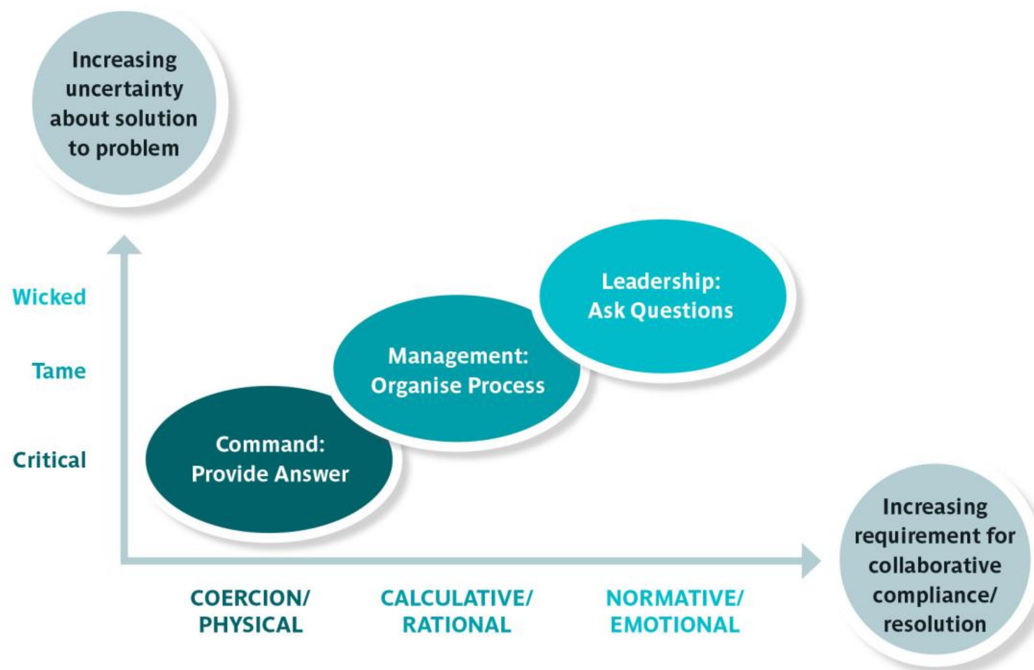

Figure 3.1 – A typology of problems and decision styles

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Ron Heifetz and colleagues at Harvard Business School and Boston Consulting Group make a similar distinction between 'technical' and 'adaptive' challenges and the different kinds of leadership and management needed to address them (Heifetz et al., 2009). ***Technical challenges***, they suggest, have proven approaches that can be applied to their solution. They often manifest themselves as crises, with a high degree of disequilibrium, and the work of leadership in this context is to manage the situation and regain stability. An example of a technical challenge in a healthcare context could be managing the appointments systems for a large hospital – whilst this is complicated, and may be prone to failure when, for example, there are staff absences, peaks in demand and/or problems with the IT system, it can usually be resolved through the application of logical, tried and tested, procedures. ***Adaptive challenges***, on the other hand, are issues for which there is no tried and tested solution, and which often present themselves as pressing but not

urgent. In this case the work of leadership is to raise awareness and to support people to remain in the ***productive zone of disequilibrium*** for long enough to collectively resolve the problem. An example of an adaptive challenge in a hospital setting would be preparing the organisation for a context of reduced public funding and unpredictable patterns of demand for services. Implementing such change will be disruptive, contested and may well be met by resistance – especially from those who have something to lose. Failing to respond appropriately, however, will compound problems over time and increase the likelihood of a catastrophic failure of services[13].

According to Heifetz *et al*. (2009), most organisational change comprises a combination of adaptive and technical challenges that must be distinguished through problem ‘diagnosis’ before they can be addressed. They suggest that, ‘the most common cause of leadership failure is produced by treating adaptive challenges as if they were technical problems’ (*ibid*: 19). Adaptive challenges, however, are difficult to address and may well be associated with a sense of loss as people transition from one state to another, needing to let go of things they had previously valued. In such a context leaders need to provide the psychological safety and emotional support that people require in order to deal with uncertainty, ambiguity and conflict.

For Heifetz and colleagues, nurturing and embracing diversity is a fundamental requirement for adaptive leadership as it brings the necessary variation required for adaptive change. Drawing an analogy to

[13] Note the similarities to Snowden and Boone’s (2007) Cynefin framework, as discussed in Chapter 2.

> 'The secret of evolution is variation, which in organizational terms could be called distributed or collective intelligence [...] For an organization adaptive leadership would build a culture that values diverse views and relies less on central planning and the genius of the few at the top, where the odds of adaptive success go down.' (Heifetz et al., 2009)

biological diversity and natural selection, they propose that similar dynamics operate in organisations.

As with several other perspectives described in this review, Heifetz suggests that managing a process of adaptive change requires leaders to engage in cycles of action and enquiry - moving between the 'dance floor' and the 'balcony', the nitty-gritty day-to-day concerns and the broader strategic picture. Such an approach has significant implications for leadership practice and the need to nurture an environment where calculated risk taking is accepted and collaboration and innovation rewarded.

3.2 Thinking and Working Systemically

Given the complex and interdependent nature of the NHS and associated bodies there are strong calls for a 'system' or 'systems' leadership approach that focus on leadership and influence across organisational and professional boundaries. As the NHS Confederation argue:

> ‘System leadership is about local leaders from across the health and care system sharing a cohesive approach to working together to improve the whole local health and care system […] System leaders have clear, shared priorities that are grounded in the needs of their communities and not in the interests of individuals or their organizations. […] System leadership is vital to delivering integrated care, transforming services to address the financial and demographic challenges facing health and social care, and tackling health inequalities.’ (NHS Confederation, 2014:7)

A review commissioned by the Virtual Staff College suggested that ***systems leadership*** has two main characteristics: (a) ‘it is a collective form of leadership…’ concerned with ‘the concerted effort of many people working together at different places in the system and at different levels’, and (b) it ‘crosses boundaries, both physical and virtual, existing simultaneously in multiple dimensions’ (Ghate and Lewis, 2013:6). Rather than taking an organisational focus, systems leadership shifts attention to the wider network of groups, organisations, communities and stakeholders – and the relationships between them – in effecting large-scale system-wide change.

The integrated leadership model (see Figure 3.2) arising from this work highlights how a systemic approach can improve outcomes for service users by helping leaders to navigate the volatile, uncertain, complex and ambiguous (VUCA) context in which they operate (Ghate and Lewis, 2013). The central ring of this diagram demonstrates that in order to nurture an innovative, distributed, participatory, inclusive and relational culture of ‘systems leadership’, leaders need to engage with ***ways of feeling***, ***perceiving***, ***thinking***, ***relating***, ***doing and being*** that are quite different from traditional command and control environments. This,

however, can be incredibly difficult to achieve given the constraints of existing systems and the time, effort and commitment required to develop these capabilities, and remains a significant challenge for the implementation and roll-out of a systems leadership approach across the NHS.

Figure 3.2 – Public service context, systems leadership and systems leaders - an integrated model *© Reproduced with permission of Deborah Ghate*

In a King's Fund report titled *Reforming the NHS from Within*, Ham (2014) identified evidence of three main approaches to NHS reform – targets and performance management, inspection and regulations, and competition and choice – concluding that whilst there is some evidence of impact for each approach, changes have been relatively small, incremental, and often associated with unintended consequences. He calls for an alternative approach, including national leadership and devolution, collaboration and competition, and innovation and standardisation, which, he argues, is more likely to deliver sustainable transformational change. Core pillars of this approach are an active engagement with clinical leadership (recognising the significant power and influence at this level), distributed/shared leadership (placing responsibility and autonomy at all levels) and a systems approach (that embraces principles of complexity and emergence).

> 'The art of systems thinking lies in seeing through complexity to the underlying structures generating change, it means organizing complexity into a coherent story that illuminates the causes of problems and how they can be remedied in enduring ways.' (Senge, 1990: 128)

This report echoes insights from the work mentioned earlier, which highlights that when tackling wicked or adaptive problems a collaborative approach is required that draws on the diversity of knowledge, expertise and experience across groups of people. In such a situation the role of 'leaders' is not to provide the answer but to convene and host a space for collective engagement and sensemaking[14] (Wheatley and Frieze,

[14] Uhl-Bien and Arena (2017) refer to the importance of *enabling leadership* in creating 'adaptive spaces' to bridge between *entrepreneurial leadership* and *operational leadership* in complex systems.

2010). Despite the rhetoric of inclusion and collaboration within the NHS, however, there is still a long way to go before such an approach becomes widespread, suggesting a lack of awareness of the genuinely complex, wicked nature of these issues.

3.3 CREATING A CULTURE OF COMPASSION AND INCLUSION

In recent years the NHS has rightly emphasised the importance of a compassionate and inclusive approach to leadership given the positive impact this can have on patient experience, staff engagement and organisational performance. These principles lie at the heart of the *Developing People, Improving Care* framework and the commitment of partner organisations to the pledges made within it (National Improvement and Leadership Development Board, 2016). These are complex concepts, however, open to varying interpretations and assessments.

The King's Fund report *Caring to Change* (West *et al*., 2017) draws on the work of Atkins and Parker (2012) to identify four key components of ***compassion***: attending, understanding, empathy and helping. These factors demonstrate the need for NHS staff to engage with others at a deep emotional level – acknowledging suffering, attempting to understand the cause(s) of distress, demonstrating a genuine empathic response, and taking thoughtful and appropriate action. The research identifies a strong link between compassionate leadership, innovation and performance and highlights how genuine compassion at individual and team level is dependent on an enabling environment at organisational and systems level, including (1) inspiring vision and strategy, (2) positive inclusion and participation, (3) enthusiastic team and cross-boundary working, and (4) support and autonomy.

For NHS employees to demonstrate compassion in their interactions with patients and staff they need to feel valued and supported. As West *et al*. argue:

> 'In order to nurture a culture of compassion, organisations require their leaders – as the carriers of culture – to embody compassion in their leadership.' (West et al., 2017:4)

Few people, if anyone, in the NHS intentionally set out to provide poor, uncompassionate care but nevertheless, through a combination of forces this may well be the outcome that is achieved (Iles, 2011). A common challenge is the ***blame culture*** that can arise when staff are required to meet externally allocated targets against demanding time deadlines with limited resources. The audit culture that has developed within the NHS in recent decades places significant demands on NHS employees and, whilst this may have achieved some service improvements, it has undoubtedly had a detrimental effect on the stress and morale of staff (Ballatt and Campling, 2011).

Research by West and Dawson (2012) on the relationship between ***employee engagement*** and NHS performance, identified four key success factors: (1) a compelling strategic narrative, (2) inclusive leadership and management, (3) staff in charge of service change, and (4) values and integrity. These closely mirror findings from their more recent work on compassionate leadership, further emphasising the case for a coherent and consistent strategic approach enacted at all levels of the organisation.

Such work clearly demonstrates the collective, cultural dimensions of compassionate leadership, yet many interventions and assessments are more frequently deployed at an individual level - a case in point being

the use of ***unconscious bias*** training. A recent report by the Chartered Management Institute (CMI) and British Academy of Management (BAM) indicated that 83% of FTSE100 companies surveyed provided unconscious bias training to their staff (Beech *et al.*, 2017). Whilst such interventions can be useful in raising awareness of issues around diversity and inclusion the impact on attitudes and behaviour is not always beneficial. Indeed, several studies suggest that by normalising unconscious processes leading to discrimination, requiring people to complete what can feel like a box-ticking exercise, or by blaming and shaming managers such training can increase rather than reduce discrimination (Dobbin and Kalev, 2016, West *et al.*, 2015). This kind of approach to change puts the onus on the individual to identify and manage their inherent biases rather than shining a light on the degree to which the broader organisational environment fosters openness, trust, learning and service improvement.

> ‘Executives favor a classic command-and-control approach to diversity because it boils expected behaviors down to dos and don’ts that are easy to understand and defend. Yet this approach also flies in the face of nearly everything we know about how to motivate people to make changes. Decades of social science research point to a simple truth: You won’t get managers on board by blaming and shaming them with rules and reeducation.’ (Dobbin and Kalev, 2016: 54)

A key challenge within any intervention aimed at mobilising culture change is to create a meaningful bridge between the individual and the collective – between lived experience and strategic priority. The CMI and BAM report on *Delivering Diversity* (Beech *et al.*, 2017) identified seven key findings and associated actions (Box 3.1). Together these findings

and recommendations highlight the importance of creating opportunities for different kinds of conversation, learning from good practice, using data to mobilise change, engaging with networks and advocates, building a talent pipeline, exploring perceptions around identity and ‘fit’, and drawing on evidence and examples from elsewhere to accelerate change.

Key findings:	**Actions for leaders:**
1. Let’s talk about race	1. Break the silence
2. Learn from the gender agenda	2. Change the story
3. Face the numbers	3. Measure it, manage it, report it
4. It ain’t what you know – it’s who knows you	4. Tap into the power of sponsorship
5. Wanted: role models and mentors at every level	5. Build diversity through ‘next up’ leadership
6. Fitting in?	6. Be inclusive and adaptive
7. Evidence based development	7. Benchmark and collaborate

Box 3.1 – Delivering Diversity: Key findings and actions
(Beech et al., 2017:7-8)

Central to this work is taking a proactive approach to promoting equality, diversity and inclusion, that demonstrates support and commitment at all levels and facilitates courageous and open debate about race and other forms of difference. In terms of leadership, this suggests the need to develop a ‘relational’ approach that recognises and explores the multiple

experiences and expectations of different staff groups. Crevani (2015) identifies key ***relational leadership practices*** as *framing* (being conscious of the perspective we use/have and be open for other perspectives), *positioning* (being aware of how we position ourselves in conversations and empower or marginalise others) and *bridging* (being mindful of interconnections and interdependencies). Giving people the incentive, opportunity and language with which to engage in discussions around ED&I is a fundamental step towards cultural, attitudinal and behavioural change (Kerr, 2017).

4 Rethinking Leadership and Organisation Development

The previous chapter highlights the limitations of traditional leadership approaches in contexts of complexity, uncertainty and change – which now characterise the NHS and wider public service - calling for a more collective, inclusive and systemic approach. In shifting attention from ***leaders*** to ***leadership*** we are alerted to a broader range of processes that lead to the achievement of outcomes such as direction, alignment and commitment (Drath *et al*., 2008). Such insights suggest a need to reconsider the nature and purpose(s) of leadership, management and organisation development.

4.1 Discourses of Leadership and Leadership Development

From an extensive review of the literature Day (2000) suggests that whilst the primary focus of ***management development*** is to build capacity to deal with current challenges, ***leadership development*** is concerned with preparing people and organisations for future challenges[15]. He also makes a distinction between ***leader*** and ***leadership*** development, whereby the former is focused on developing the 'human capital' of individuals in leadership roles, whilst the latter focuses on developing 'social capital' and collective capacity across the organisation.

[15] Mirroring Grint's (2005) suggestion that *management* is about the effective application of existing knowledge (*déja-vu*), whilst *leadership* involves preparing for unknown and unknowable challenges (*vu-jade*).

Leadership development has become a major global industry, with an estimated annual spend of 14 billion US dollars (Boatman and Wellins, 2011, cited in Ford, 2015). Despite this, and mirroring the debate about the nature and purpose(s) of leadership outlined earlier, a number of different schools of thought have emerged, each based on differing principles and assumptions.

Figure 4.1 summarises four main discourses within the leadership and leadership development literature (Mabey, 2013). The distinctions are helpful in highlighting the differing assumptions that underpin approaches – something rarely articulated or debated but which has a fundamental impact on how leadership is recognised, rewarded and developed.

> 'Every organisation has embedded unconscious assumptions about leadership. These assumptions have been termed the leadership concept (Probert and Turnbull James 2011): the set of schemata and assumptions about leaders and leadership that an organisation has embedded in its culture. These deep-rooted assumptions of organisational members about leadership are usually ignored in leadership development initiatives. As these assumptions shape the way organisational members perceive, act and evaluate leadership, Probert and Turnbull James suggest that renewing the organisation's leadership concept is the most important role of leadership development initiatives.' (Turnbull James, 2011, p 9-10.)

The ***functionalist discourse*** that dominates current thinking and practice (82% of the articles reviewed in Mabey's analysis) assumes consensus about the nature and purpose(s) of leadership and is

frequently associated with a competency/skills-based approach to the development of 'leaders'. Such an approach, however, largely neglects the significance of power relations in determining who and what are classified as leaders/leadership and may well perpetuate discriminatory practices that marginalise and/or silence particular groups to the advantage of others. This has been particularly well documented in relation to gender, whereby it is widely recognised that traditional notions of leadership are closely associated with 'masculine' traits such as decisiveness and desire for dominance (Stogdill, 1974).

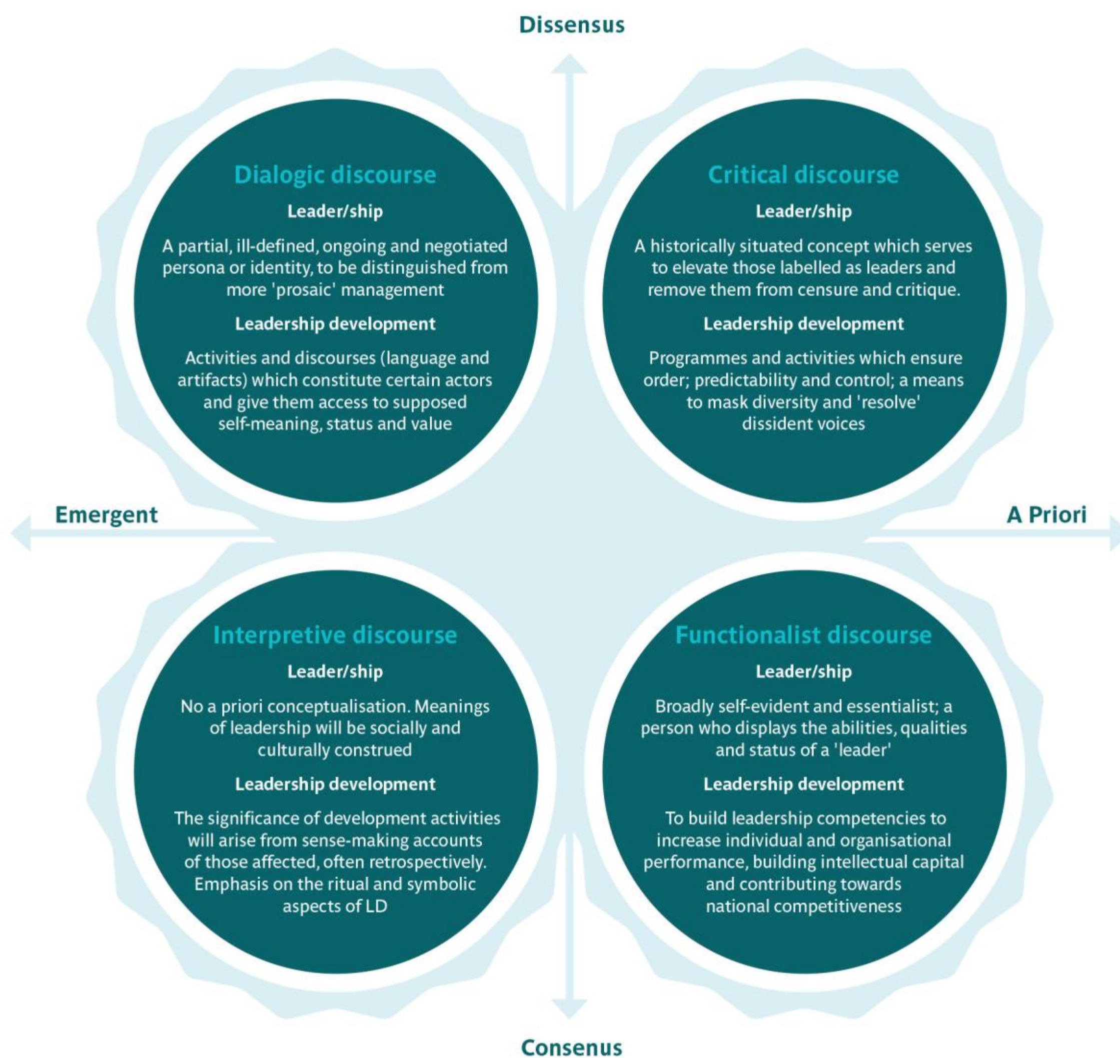

Figure 4.1 – Discourses of leadership and leadership development

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Amanda Sinclair, a Professor at Melbourne Business School, has been exploring the interface between leadership, gender and power for three decades. Her books, *Doing Leadership Differently* (2005b), *Leadership for the Disillusioned* (2007) and *Leading Mindfully* (2016) offer powerful insights into how gender, and other aspects of difference, impact upon leadership and provide useful guidance for leaders looking to adopt an inclusive approach. Sinclair's analyses of gender and leadership goes beyond identity to explore the 'embodied' nature of leadership practice, including the possibilities and limits afforded by the physical characteristics of the 'leader' (Sinclair, 2005a). Such work illustrates just how decontextualised and dehumanised most accounts of leadership have become – where gender, race and other physical characteristics go unreported, despite playing a key role in how leadership is enacted and experienced. More recent work has extended such ideas to transgender (Muhr and Sullivan, 2013), 'queer' (Chang and Bowring, 2015) and indigenous (Evans and Sinclair, 2016) leadership.

> 'Leadership should be aimed at helping to free people from oppressive structures, practices and habits encountered in societies and institutions, as well as within the shady recesses of ourselves.' (Sinclair, 2007: xv)

Despite a shift towards 'post-heroic' theories of leadership in recent years, that highlight the importance of collective and relational dimensions of leadership (Ospina, 2017, Uhl-Bien, 2006), the so-called ***female advantage*** has had only had limited impact on the number of women being appointed at senior levels (Eagly and Carli, 2003) and there appears to be a continuing preference for male leaders amongst people of either gender (Eagly, 2007). Fletcher (2002) highlights that systemic cultural bias means that there is a tendency for relational

aspects of leadership to 'disappear' when enacted by females, concluding that 'many women experience the so-called female advantage as a form of exploitation, where their behavior benefits the bottom line but does not mark them as leadership potential' (*ibid*: 3). Ibarra *et al.* (2013) highlight the effects of 'second generation gender bias', whereby gendered notions of leadership become so embedded in stereotypes and organisational practices that they become hard to detect yet nonetheless have a direct impact on the career aspirations and trajectories of female leaders.

Of the alternative discourses of leader/leadership development identified by Mabey (2013) the most common was ***interpretivist*** - evident in 11% of the articles reviewed, with just 4% as ***critical*** and 3% as ***dialogic***. Together these discourses offer the potential to unpick the assumptions embedded within current leadership and leadership development practice, facilitating a shift towards more inclusive approaches, as outlined in the following section.

4.2 ADDRESSING POWER AND PRIVILEGE

The functionalist paradigm that underpins much leadership practice and development ignores the ways in which power and privilege shape both the processes and outcomes of leadership in organisations and wider society. It is positioned as neutral, objective and evidence-based yet is based on a series of assumptions which have been extensively critiqued and which undoubtedly contribute towards continuing inequality and discrimination. Moving beyond this blinkered perspective, however, is essential if we are to facilitate the emergence of a truly inclusive and compassionate culture in the NHS that recognises and celebrates difference.

The notion of the ***hidden curriculum*** has been used in the field of education for many decades to refer to the ways in which, alongside the formal curriculum, educational programmes and environments convey implicit messages around cultural expectations and norms, cultural values and beliefs, the relative importance of different topics and pedagogies, institutional and social rules and structures, etc.

> 'Hidden curriculum refers to the unwritten, unofficial, and often unintended lessons, values, and perspectives that students learn in school. While the 'formal' curriculum consists of the courses, lessons, and learning activities students participate in, as well as the knowledge and skills educators intentionally teach to students, the hidden curriculum consists of the unspoken or implicit academic, social, and cultural messages that are communicated to students while they are in school.' (Glossary of Education Reform, 2015)

The enduring impact of the hidden curriculum is well documented by authors such as Giroux and Purpel (1983) and has been an issue of concern for educational reformists including John Dewey, Paulo Freire and Bell Hooks who highlighted how educational practices can perpetuate systems of oppression. Implicit messages and assumptions about what matters and what doesn't are conveyed in all forms of education, from schools to universities, companies to community groups. Within the field of Business and Management, Professor Martin Parker has called to '*Shut down the Business School*' (Parker, 2018) because of their continuing tendency 'to act as loudspeakers for neoliberal capitalism with all its injustices and planetary consequences' and 'have produced a generation of unreflective managers, primarily interested in their own personal rewards'.

Within leadership studies an emerging body of work seeks to encourage a more critical and reflexive approach to leadership practice and development. Collinson (2011:181) refers to this as ***Critical Leadership Studies*** (CLS): '[a] broad, diverse and heterogeneous [range of] perspectives that share a concern to critique the power relations and identity constructions through which leadership dynamics are often reproduced, frequently rationalized, sometimes resisted and occasionally transformed'. Whilst it is a relatively recent development within business/management studies, it draws on established thinking from areas including sociology and philosophy to unpack, explore and challenge the assumptions and practices embedded in mainstream leadership literature as outlined earlier.

> 'Rather than leadership being a straitjacket, it should seek to improve interactions between managers, clinicians, knowledge workers and all employees... [Leadership] learning should encourage participants to challenge the taken for granted, normative and hegemonic assumptions of leadership and introduce other ways of seeing, interpreting and understanding themselves, their colleagues and their work contexts. Embracing more critical approaches to leadership learning should encourage scholars, students and practitioners alike to be more eclectic, creative and heterogeneous in their approaches to thinking about, researching and practising leadership.' (Ford, 2015: 263)

Such an approach questions the ethics and effectiveness of top-down leadership and suggests the need to develop the capacity for critical thinking and reflection on the nature and purpose(s) of leadership in contemporary organisations and society. Rather than seeing leadership as something done *by* leaders *to* followers, CLS considers leadership

and followership as interdependent and mutually constitutive social processes shaped by context, discourse and identity. Given the focus on how leadership is constructed, communicated and accomplished through social interaction, CLS places a strong emphasis on language and discourse, and the ways in which they can perpetuate and/or transform leadership practice (Fairhurst, 2007, Tourish, 2014).

A framework commonly used to analyse power within organisations is Lukes' (1974, 2005) '***three faces of power***'. The first face, is the one most commonly used, and: 'involves a focus on *behaviour* in the making of decisions on *issues* over which there is an observable *conflict* of (subjective) *interests*, seen as express policy preferences, revealed by political participation' (Lukes, 2005: 19). From this perspective it is the individual who wins the argument/has greatest influence who is the most powerful. The second face: 'involves a *qualified critique* of the *behavioural focus* of the first view [and] allows for consideration of the ways in which *decisions* are prevented from being taken on *potential issues* over which there is an observable *conflict* of (subjective) *interests*, seen as embodied in express policy preferences and sub-political grievances' (*ibid*: 24-25). From this perspective power may be exerted behind closed doors through shaping the agenda – and hence what is discussed and what is not. The third face: 'involves a *thoroughgoing critique of the behavioural focus* of the first two views as too individualistic and allows for consideration of the many ways in which *potential issues* are kept out of politics, whether through the operation of social forces and institutional practices or through individuals' decisions' (*ibid*: 28). From this perspective power is seen to be culturally and structurally embedded in ways that masks the sources and

consequences of power and manipulates the beliefs and actions of those engaged.

In Holman's (2000) analysis of management and leadership education critical approaches (incorporating dialogic and interpretive approaches) are encouraged as ways to help individuals, groups and organisations develop capacity for future and unknown challenges where innovation and creativity are required. Such processes whilst necessary, however, can be deeply challenging and may well be met with resistance. The way this anxiety and resistance manifests has been illustrated by various authors such as Margaret Heffernan's (2011) discussion of 'wilful blindness' (see chapter 5) and Robin DiAngelo's (2011) description of 'white fragility'.

White fragility describes how ill equipped most white people are to confront racial tensions and defines a state where even a minimum amount of racial stress becomes intolerable (DiAngelo, 2011). Perversely, this situation seems to occur in conversations or situations designed to engage white participants in conversations about race, triggering a range of defensive emotions and behaviours, which are also described in Eddo-Lodge's (2017) book *Why I'm no longer talking to white people about race*.

Key to this and other approaches that take a complexity perspective is that 'there is nowhere outside of the complex (responsive) processes of organisational life for a leader or manager to stand; they too are caught up in the flux of stability and change as much as everyone else' (Flinn and Mowles, 2008:5). In attempting to be 'rational' and 'objective' leaders, managers and developers collude in marginalising particular

voices and perspectives. The developmental implications of such a position are outlined below:

> 'From the perspective of complex responsive processes of relating, leading leadership development involves encouraging radical doubt, enquiry and reflexivity as a way of developing the capacity of leaders to manage in circumstances of high uncertainty and ideological and political contestation. However, radical doubt does not mean throwing everything up in the air at once. It means learning how to navigate between the poles of absolute certainty and absolute doubt, while persisting in seeing the world as more complex than it is portrayed in the dominant discourse.' (Flinn and Mowles, 2014:19)

Such an approach, whilst challenging and potentially threatening to those in positions of authority is well suited to contexts of uncertainty and ambiguity where individuals and organisations face intractable wicked problems, such as addressing discrimination and moving to inclusion, that cannot be resolved through the application of proven management practices (Grint, 2005). From a complexity perspective Flinn (2018: 173) suggests that there are 'no recipes just rules of thumb'. Within leadership development, this involves recognising that any programme or intervention (no matter what the intent behind it) may be perceived or experienced as a form of coercive persuasion and hence those responsible for the design and delivery have a responsibility to expose participants to a plurality of perspectives, to encourage reflexive curiosity and to actively challenge their own agendas/biases throughout the process.

4.3 Working with Identity

Whilst it is not unusual for leadership development interventions to pay attention to identity alongside knowledge, skills, attitudes and behaviours this is often taken from a leader-centric perspective, with limited consideration of how identity processes are influenced by the social, cultural and relational context in which a person finds themselves.

Alvesson and Willmott (2002) conceptualise identity processes as an interplay between: (a) ***self-identity***, the individual's image of him or herself; (b) ***identity work***, the active construction of a self-identity; and (c) ***identity regulation***, which refers to the regulative effects of organisational and social processes. Self-identity here refers to subjective meaning and lived experience, and provides temporary answers to questions such as 'who am I, what do I stand for and how should I act?' (Sveningsson and Larsson, 2006). These are key concerns for anyone in a leadership role as they shape both how they engage with and are experienced by other people (including 'followers') and hence their capacity to exert influence.

Professor Herminia Ibarra's work demonstrates the significance of identity processes in leadership development, in particular 'the notion that "becoming a leader" is a process involving movement through the separation, transition and incorporation phases shared by all rites of passage' (Ibarra *et al.*, 2010). This process, she suggests, involves people experimenting with ***provisional selves*** in order to develop a credible and authentic sense of 'self as leader'. Such work draws attention to the relational and emotional nature of leadership and the role of leadership development in preparing and supporting people through transitions into and between leadership roles. Key factors impacting upon these processes include (1) the *developmental readiness* of participants, (2) *transitional time and space* in which people can work

through tensions, contradictions and challenges between aspects of their personal and professional identity, (3) *guides and reference groups* who can support, reinforce and provide feedback on identity transitions, and (4) *pre- and post- formal programme experience*, including how participants in formal programmes are prepared for and given the opportunity to enact their new identity as a 'leader'. Such processes are particularly significant in professionalised environments such as the NHS where people often transition into leadership roles from clinical and other forms of specialism. Giving people the opportunity to integrate and align potentially conflicting identities (for example, as clinical/organisational leader) is central to encouraging more people to take on leadership roles, managing the stress/anxiety experienced in such roles and increasing their effectiveness.

Coaching and mentoring can be particularly effective processes to support this kind of personal and professional development. However, Petriglieri (2011) suggests that formalised leadership development interventions can also be positioned as ***identity workspaces*** that offer the psychological safety and containment required for people to engage actively in identity transitions. With regards to leadership and inclusion such issues are likely to be highly significant in creating a willingness to engage in courageous conversations and to embrace disruptive change.

Identity is often treated as if it were a property of individuals however it is always negotiated in relation to others and shaped by historical and cultural factors as indicated in the following quote:

> '[Identity work] involves an exploration of not only how people categorize themselves and are categorized by others. It is also concerned with how the images and representations (physical, symbolic, verbal, textual and behavioural) become imbued with meaning and are taken as being part of one's identity.' (Beech, 2008:52)

Whilst self-identification and perceptions of identity can be difficult to deconstruct, there also needs to be recognition that leaders can and often do play an active role in the construction of what is termed 'social identity'. A ***social identity approach*** to leadership draws on insights from the field of social psychology to explain how perceived group membership affects an individual's sense of personal identity and influences their behaviour (Haslam, 2004). This perspective, developed from a combination of Self-Categorisation Theory (Turner, 1985) and Social Identity Theory (Tajfel and Turner, 1979), proposes that the extent to which a leader is accepted or chosen by a group depends on the degree to which they are perceived as a 'prototypical' group member (Haslam, 2004, van Knippenberg and Hogg, 2003, Haslam *et al.*, 2011).

Ruderman and Ernst (2004) state that leaders need to gain knowledge of their social identities by exploring their membership of certain social groups defined by categories such as gender, race, and religion and the implications of belonging to these groups. It is argued that when a shared social identity exists, 'individuals who can best represent that identity will have the most influence over the group's members and be the most effective leaders' (Reicher *et al.*, 2007: 26). Thus, when applied to the question of inclusive leadership, a social identity approach has important implications for how individuals who are perceived as primarily pertaining to marginal or majority identity groups can develop a sense of

credibility and legitimacy amongst those they are leading within diverse organisations.

Haslam *et al*. (2003, 2011) and others have argued that identification with a particular group is not simply a social nicety but a fundamental aspect of leadership. It is suggested that:

> '[…] for true leadership to emerge - that is, for leaders to motivate followers to contribute to the achievement of group goals - leaders and followers must define themselves in terms of a shared social identity.' (Haslam and Platow, 2001:1471)

Regardless of the skills, knowledge or abilities of the 'leader', in order to mobilise 'followers' s/he must be perceived by them as a credible and legitimate representative of the group (Haslam *et al*., 2011). Therefore, the affirmation of social identity is not just a case of articulating who 'we' are but also positioning 'us' *vis-à-vis* other social groups, and is considered an essential component of effective leadership practice. Leaders must be 'entrepreneurs of identity' in which 'leadership activity and leadership effectiveness largely revolves around the leader's ability to create identity definitions and to engage people in the process of turning those definitions into practical realities' (Reicher *et al*., 2005:556).

Within healthcare contexts such as the NHS, membership of professional and occupational groups also has a significant bearing on people's sense of social identity. There are numerous studies on clinical leadership and the tensions and contradictions experienced when leading across groups (for example, Lee, 2010). It is also well recognised that some professional groups (such as doctors) tend to be

given higher status than others (such as nurses) and that particular occupations are less inclusive than others[16].

Lowe and Gayle (2010) argue that professionality 'is based first on a theory of "difference", defined as the way in which social or professional groups distinguish themselves through their values, perspectives and vested interests; and second, on "agreement", which is defined as a process of accommodating and integrating these different perspectives to achieve organisational or professional goals in new ways' (Lowe and Gayle, 2010: 4). Effectively, ***professionalism*** describes a process by which different groups of staff sustain and develop their own professional values through developing new ways to respond to the conflicting and changing demands of the workplace and wider society.

Ham (2003) underlined the significance of clinical leadership in working at the front-line of service improvement. More recently, however, authors such as Simpson (2018) reveal how the elitism, identity and differentiation of doctors from the front-line, and particularly 'White' doctors fundamentally shaped the recruitment drive and uptake of posts in poor communities initially into hospitals and then general practice by Asian medics in particular. Thus, the NHS has been fundamentally shaped by a 'white' professional medical view of what it was to be a doctor with its associated status. The acculturation processes and progression routes for certain professional careers are therefore likely to pose particular challenges for promoting and embedding inclusion across the whole of the NHS and are important factors to consider in relation to intersectionality of identities (McGivern *et al.*, 2015).

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[16] For example, fewer than 5% of cardiothoracic surgeons are female (Westaby *et al.*, 2015).

4.4 Integrating Leadership, Management and Organisation Development

> 'To be fully effective, a development system must be integrated with the organization's other processes: management planning, performance management, job selection, reward and recognition systems, and even mistake systems. The confluence of these processes determines the relative effectiveness of any one development activity.'
> (McCauley et al., 1998:228-9)

Whilst leadership, management and organisation development are often treated as separate activities, informed by different theories and practices they are in fact 'all parts of the same process – namely enhancing the capacity of organisations and the people within them to better achieve their purpose' (Bolden, 2010:117).

Over recent years there has been a shift away from standardised leadership development programmes towards more tailored interventions, aligned to the needs and aspirations of individuals, groups and organisations. In a review of *Future Trends in Leadership Development* (Petrie, 2014) the Center for Creative Leadership identified a growing focus on the 'how' (as well as the 'what') of leadership, 'vertical' (as well as 'horizontal') development, learner-centred approaches (rather than those dictated by HR/training companies), and a focus on developing ***collective leadership capacity*** through networks (rather than just the skills/knowledge of individual leaders/managers). These developments reflect some of the ways in which the ideas outlined earlier in this chapter and the previous one are beginning to

inform leadership development practice however there is still a long way to go.

In an in-depth study of people management and performance Purcell *et al.* (2008) highlighted the central role of front-line managers, and the quality of their relationship with staff, in determining the effectiveness of HR (human resource) and other organisational interventions. Burgoyne *et al*., (2004) draw similar conclusions for leadership and management development, suggesting that it’s not so much a case of what you do, as how you do it, that matters. Building on these ideas, Burgoyne (2010) outlines the importance of considering the full ***leadership development bundle***, including the acquisition, development and utilisation of individual and collective talent and expertise across the organisation. Such work highlights the importance of a coherent, integrated, strategic approach to leadership, management and organisational development and practice (Day *et al*., 2012, Day *et al*., 2014).

There are significant challenges, however, about the extent to which such an approach is possible in an organisation as large and complex as the NHS. As outlined earlier, the NHS is a complex network of interdependent, (semi) autonomous units, each with their own leadership, management and governance structures and processes (King's Fund, 2017a). This means that the development and implementation of an overarching strategy for leadership and organisational development is unlikely and may even be counter-productive. Instead, a more emergent approach is required, drawing on insights from complexity science and ***social movement theory*** to rethink the processes through which large-scale cultural and behavioural change can be mobilised. A recent guide on *Leading Large Scale Change* (Sustainable Improvement Team and the Horizon’s Team,

2017) does just this, highlighting 10 key principles to inform practice (see Box 4.1).

1. Movement towards a new vision that is better and fundamentally different from the status quo.
2. Identification and communication of key themes that people can relate to and that will make a big difference.
3. Multiples of things ('lots of lots').
4. Framing the issues in ways that engage and mobilise the imagination, energy and will of a large number of diverse stakeholders in order to create a shift in the balance of power and distribute leadership.
5. Mutually reinforcing change across multiple processes/subsystems.
6. Continually refreshing the story and attracting new, active supporters.
7. Emergent planning and design, based on monitoring progress and adapting as you go.
8. Many people contribute to the leadership of change, beyond organisational boundaries.
9. Transforming mind-sets, leading to inherently sustainable change.
10. Maintaining and refreshing the leaders' energy over the long haul.

Box 4.1 – Ten Principles of Large-Scale Change

(Sustainable Improvement Team and the Horizon's Team, 2017: 14-18)

Drawing on insights from the field of open innovation this work calls for a shift in perspective from change programmes to ***change platforms*** (Hamel and Zanini, 2014) that embrace the benefits of diversity and divergent thinking.

> 'Shifting to a change platform means what Gary Hamel calls 'socially constructing' change – creating the opportunity for everyone in the organisation or system (including service users) to help tackle the most challenging issues. It means valuing diversity – seeking out hundreds of ideas and potential solutions through a divergent process, rather than converging thinking prematurely around a single solution. We know that large, diverse groups of non-experts consistently outperform small groups of experts when it comes to decision making.' (Sustainable Improvement Team and the Horizon's Team, 2017: 36)

Rather than focusing on the delivery of pre-determined outcomes, such an approach draws attention to the patterns of interaction, energy flows and leverage points within human systems. Building on his extensive experience of facilitating leadership and organisational development from a ***living systems*** perspective, Myron Rogers identified five 'maxims' to guide interventions in such contexts: '(1) People own what they create, (2) Real change takes place in real work, (3) The people who do the work do the change, (4) Start anywhere but follow it everywhere, (5) Keep connecting the system to more of itself' (Rogers, 2015: 23). These principles have been widely shared and

enthusiastically adopted within the NHS and UK public services in recent years.

Other important ideas informing the work of groups such as the *Systems Leadership Steering Group*[17] are Donella Meadows' work on ***leverage points*** (Meadows, 1999) and Marshall Ganz's work on leadership and change (Ganz, 2010) which demonstrate the importance of engaging with different mindsets and facilitating the development of a compelling ***public narrative*** when mobilising social change (see Chapter 6 and Atkinson *et al.*, 2015 for further details).

Integrated approaches to leadership, management and organisation development often take a ***place-based approach*** that focuses on the capacity of the wider system to collaborate and mobilise knowledge, expertise and resources to tackle systemic challenges that are beyond the capacity of any individual, group or organisation to address in isolation. Such approaches can be effective at building community ownership and engagement, and shifting entrenched imbalances of power and influence (Bolden et al., 2015, Hambleton, 2014, Vize, 2014, 2016).

[17] The Systems Leadership Steering Group is a multi-disciplinary network of professionals from across health and beyond with a shared commitment to mobilising public sector transformation through systems leadership.

> ‘In the era of globalisation, the one that we all now live in, placeless leaders – that is, people who are not expected to care about the consequences of their decisions for particular places and communities – have gained extraordinary power and influence. This power needs to be challenged, and people living in particular localities need to regain the authority to decide what happens to the quality of life in their area.’
> (Hambleton, 2015, p. 20)

Moving forward, far greater engagement is needed between leadership, HR and organisation development practitioners in the NHS to ensure greater alignment and coherence of approach, and to increase engagement and collaboration with communities and other key stakeholders in the locations where they operate.

5 TAKING A PLURALISTIC APPROACH TO LEADERSHIP AND INCLUSION

The discussion so far has demonstrated the inadequacy of reductionist approaches to leadership, leadership development and/or inclusion. Whilst a desire for simplicity is understandable, by attempting to separate aspects of identity and experience from the wider context in which they are embedded important aspects are marginalised or overlooked. In this chapter we consider a number of ways in which a more 'pluralistic' approach could be encouraged and facilitated.

5.1 LIVED EXPERIENCE

As Chapters 3 and 4 have illustrated, mainstream approaches to leadership and leadership development rarely consider or challenge embedded assumptions about power, privilege and the wider systemic factors that create and maintain inequality. Functionalist discourses and the hidden curriculum mean that certain perspectives dominate narratives of leadership and change, whilst others are marginalised, ignored or silenced.

The notion of ***Lived experience*** 'centres on attempts to develop a more contextualized and rich appreciation of how a person or group feel and react in relation to everyday life circumstances' (Stokes, 2011). Whilst conceptualised and explored for many generations, the concept remains under explored within leadership and management studies. Lived experience, however, not only presents an opportunity to understand issues of diversity, inclusion and inequality in a more nuanced way but, arguably, it also provides an opportunity for stimulating change. As Hall and Fine (2005) note 'contemporary research on marginal groups

disproportionately examines failures rather than successes; defeat rather than possibility' (Hall and Fine, 2005:186). Incorporating lived experience into leadership development and practice has the potential to stimulate innovative and effective levers for change and greater appreciation of positive outcomes and successes.

The idea of 'lived experience' is often associated with, and of particular relevance to, what is regarded as ***standpoint theory***. Cross-disciplinary expressions of standpoint theory have been offered in the fields of feminism (Smith, 1974, Hartsock, 1983, Harding, 2004), Black feminism (Collins, 1991), Cultural Studies, Social Work (Swigonski, 1993) and Disability Studies, to name but a few. The approach is informed by a critical approach, which questions the relationship between power and knowledge, alongside a fundamental belief that in-depth exploration of experience can be a powerful tool for empowerment and social change.

Whilst interpretations vary, the basic premise of standpoint theory is a belief that 'members of groups that are marginalized and oppressed in particular contexts can have significant and substantial insight into the way the world works' (Buzzanell, 2015:771). From this position it is recognised that marginalised individuals and groups encounter challenges that may not be immediately visible to people from more privileged positions within organisations and society.

> 'Life experience of subordination or exclusion can give people greater knowledge about certain realities that those in positions of relative power and privilege cannot easily know about in the same way because they lack that life experience.' (Tew et al., 2006:8)

Feminist Standpoint theories assert a belief that (1) knowledge is socially situated, (2) marginalized groups are socially situated in ways that make it more possible for them to be aware of things and ask questions than it is for the non-marginalized, and (3) research, particularly that focused on power relations, should begin with the lives of the marginalised (Bowell, undated).

Whilst many studies exist on the experience of 'leaders', there is a dearth of evidence on the specific experience of those from marginalised groups. Morton (2017) and Chang and Bowring (2015), for example, highlight how very few studies of leadership have focused upon the experience of leaders who are not heterosexual. Banks and Mona (2007) similarly highlight that the idea of viewing women with disabilities as leaders is still a novel idea, 'few disabled women are seen in leadership roles in mainstream society and of those we do see, they are typically in roles that focus on disability and/or the disability community' (Banks and Mona, 2007:335).

> Inclusive leadership means 'not just accepting, but actively seeking out diverse viewpoints and making sure everyone in your team feels their voice is heard.' (Morgan, 2017:12)

By broadening the range of voices on leadership and inclusion it becomes possible to present a richer, multifaceted picture of life in organisations and to offer a greater diversity of role models and examples to which people from minority groups can relate. ***Invisibility*** refers to 'the absence of positive or any representations of oppressed groups, particularly those whose voices are typically excluded from the dialogue about what is good or right' (Fryberg and Townsend, 2008). The invisibility of particular perspectives is not necessarily historic or

unconscious, rather it refers to the continual and active ‘writing out’ of the experiences and histories of specific individuals, which reflects and reinforces the status quo. Engaging with the concept of ‘lived experience’ marks an explicit attempt to take seriously the experiences (both positive and negative) of people with protected characteristics and to redress imbalances of power that perpetuate inequality and restrict progression opportunities for those with marginalised identities.

The notion of lived experience has been adopted and applied in numerous fields and was an important pillar of the educational philosophy of the Brazilian educator Paulo Freire whose seminal text ‘*Pedagogy of the Oppressed*’ (Freire, 1970) reveals the political, subversive, context and power-laden nature of education. Working with marginalised groups Freire highlighted how those who seek change can unintentionally perpetuate inequality by adopting the educational methods of the oppressor. Freire asserted the need for a transformative pedagogy, where all are able to engage in critical learning and where all participants (sponsors, facilitators and students) are viewed as equal. Each, it is argued, should be involved in the task of unveiling reality, and thereby coming to know it critically, but also in the process creating new knowledge.

5.2 Collaborative Learning

Jehn *et al.* (1999:743) argue that ‘the creation of knowledge and the discovery of insight by groups appears to depend on the presence of diverse viewpoints and perspectives about the task’. However, recognition of the importance of diversity does not typically seem to be embedded in how we create knowledge about leadership, or how we address the task of making leadership more inclusive.

The recent NHS guide to *Leading Large-Scale Change* (Sustainable Improvement Team and the Horizons Team, 2018) highlights how co-production and participation are enshrined in law as the *Health and Social Care Act 2012* places a duty on commissioners in relation to public involvement. So far, however, there is little evidence that staff and service users who are most adversely affected by issues of inclusion in the workplace are actively involved in the generation of solutions.

Kabeer (2010:105) is one of several authors to highlight that 'theories of change tend to reflect the worldviews of those who formulate interventions and their understanding of social reality'. Thus, in a world that is characterised by an unequal distribution of power, interventions are likely to be biased against those who do not exercise a great deal of voice or influence in either the formulation of these theories or their translation into practice. In other words they do not always promote, or even seek to promote, social justice.

The idea of collaborative and inclusive knowledge creation is not new. Dewey (1916a) and Mead (1913), for example, highlighted the importance and impact of diverse and collaborative groups in exploring issues and learning together. It is argued that by utilising lived experience in a collaborative, real-time, practical way, the depth of our understanding is increased whilst simultaneously developing relationships across bounds of identity. In more recent years, Fairman and Bevan (2016) have echoed this assertion, suggesting a need for the NHS to adopt a ***dialogic approach*** which reframes the role of diversity in the change process to include new and additional voices into change conversations for greater insight and innovation. They state:

> ‘Creating change is about changing the conversations that shape everyday thinking and actions. It is about bringing new, different and diverse voices into the change conversation and creating new perspectives, stories, texts, narratives and other socially constructed realities that impact on how people think and make sense of things.’ (Fairman and Bevan, 2016:10)

Based on a review of their own work and that of others, Hogan and Hogan (2002) note that when leaders fail it is often because they are unable to understand and respond to other people’s perspectives. The exploration of lived experience encourages leaders to better understand the perspectives of others and fosters hope of change, as individuals have the opportunity to be empowered through their own critical reflection on experience.

Kepinski and Nielsen (2016) demonstrate how real stories, told by company employees/leaders, of how small behaviours/practices contribute towards a sense of exclusion can trigger deep insight. In their own study they noted that many top leaders were shocked and surprised by the real-life examples of discrimination and by how these issues played out in their organisation.

> ‘Leadership development is the process through which individuals gain increasingly complex ways of understanding and engaging in leadership experiences.’ (Dugan et al., 2012: 176)

A collaborative learning approach can assist with the process of ***identity work*** (as outlined in Chapter 4) if exploration of the self in relation to the lived experience of others, becomes part of the inquiry. As highlighted by Sims (2005:54), identity work involves individuals engaging in a ‘combination of writing one’s own story, being written by others and of

seeking to write oneself into the stories of others'. This involves an exploration not only of how people categorise themselves, but also of how they are categorised by others. Collaborative and critical exploration of lived experience and consideration of how this relates to the self within the process of inquiry can create transformative impact.

Collaborative learning not only enables a greater potential to appreciate lived experience and different worldviews, but it can also stimulate learning across geographies and disciplines. The CMI and BAM report on *Delivering Diversity* (Beech *et al*., 2017), for example, suggests learning from good practice elsewhere, citing the gender equality movement as an example of where significant progress has been made.

Within the disability movement the slogan ***'nothing about us without us'*** been embraced to call for the active involvement of those people impacted by policies in the development and implementation of policy. This concept highlights the importance of collaboration and equal participation in the creation of knowledge; asserting that participation of those with lived experience of an issue is both practically and ethically essential. This approach has significant implications for leadership and inclusion by asserting the fundamental expectation that leaders and managers will actively engage disabled people (and those with other protected characteristics) in policy and practices that impact upon them and places responsibility for addressing inequality and exclusion on those in positions of authority and influence.

5.3 A Practice-Based Approach

Recognition of inclusion as a complex issue highlights the limitations of adopting an 'armchair approach'[18] to change. Speaking in regards to general management, Fendt and Kaminska-Labbé (2011:218) highlight that there is longstanding and intense awareness 'that the output of theory often fails to have an impact on what practitioners do'.

As outlined in Chapter 2, Snowden and Boone (2007) highlight that when issues are oversimplified, considered as simple or complicated rather than complex, experts can become overconfident in their own solutions or in the efficacy of past solutions. When addressing complex change, authors such as Flinn (2018) highlight that blueprints for change cannot be applied as there are too many variables to consider. Each situation must be regarded as unique in terms of the organisation, context, system, time, and individuals involved (each with their own unique lived experience, values and beliefs). Thus, when dealing with complex issues the only way to acquire workable useful knowledge is to engage in the context and to collaborate with those involved.

> 'Because outcomes are unpredictable in a complex context, leaders need to focus on creating an environment from which good things can emerge, rather than trying to bring about predetermined results and possibly missing opportunities that arise unexpectedly.' (Snowden and Boone, 2007:75)

[18] The notion of 'armchair speculation' was used by Dewey (1916b) to critique those who speculated about how to create 'utopian societies' without ever testing or creating approaches to change in the real-world.

A more nuanced understanding of leadership and inclusion demands attention to be paid to the reality of leadership practice. Beyond personal development Ryan (2006) highlights that inclusive leadership consists of distinct practices which include: advocating for equality, educating and supporting learning, nurturing dialogue, adopting inclusive decision and policy-making processes.

Raelin (2003, 2011, 2016) is one of a growing number of authors to assert that we need to move beyond regarding leadership as an individual property to considering it as a social practice. Adopting an approach referred to as ***Leadership-As-Practice*** (L-A-P) he brings into focus the moral, emotional, and relational aspects of leadership, asking where, when, how and why leadership work is being enacted.

> L-A-P focuses upon ‘how leadership emerges as a practice rather than residing in the traits, character or behaviours of individuals – in which traditional approaches to the study of leadership place emphasis.’ (Ford et al., 2016:223)

Whilst traditional leadership theory tends to focus on *who* leaders are and *what* distinguishes them from non-leaders a practice perspective explores the ‘*doing* [of] leadership as a practical activity in complex organizations’ (Denis *et al.*, 2010:67, original emphasis). Drawing parallels to the strategy-as-practice movement (Carroll *et al.*, 2008:364) suggest that ‘the time is ripe for a leadership-as-practice body of work that, for virtually identical reasons as strategy, aims at the demystification, deepening and appreciation of the “nitty-gritty details” […] of routine and practice’.

Social practice theory has also been effectively applied to analysis of behaviour change in complex systems through a focus on the

interactions and interdependencies between *materials* (including technologies, entities and physical matter), *competences* (including skill, knowledge and expertise) and *meanings* (including symbolic meaning, ideas and aspirations) (Shove *et al.*, 2012). Together with other critical and relational approaches these offer promising ways of mobilising large-scale change that goes beyond a person-centric perspective on how change is mobilised and sustained (Spotswood, 2016).

5.4 Using Data Wisely

Logan (2012) makes a distinction between ***data, information and knowledge*** to highlight the interpretive process through which 'facts' are converted into useable knowledge to inform decision-making, action and opinion. In this report, the term 'data' incorporates both qualitative ('soft') and quantitative ('hard') evidence from which information and knowledge are derived.

Given its scale, the NHS maintains and populates one of the world's largest data sources. This data, if transformed to knowledge, offers huge potential in relation to the core agenda of diversity and inclusion. In an age of 'Big Data' individuals and organisations are increasingly aware of both the opportunities and threats of living in an interconnected and data-informed world. Within health and social care data analytics offer huge potential for identifying subtle patterns, indicators and relationships that can have a huge impact on health outcomes (Wang *et al.*, 2018). Alongside these potential benefits we are witnessing the dark side of

‘datavores’[19] who use big data for political manipulation and the promotion of ‘fake news’.

The corporate world has always understood the value of customer and market data to business. However, there is rapidly increasing recognition that data alone is not enough to stay ahead and in order to connect more deeply with customers ***relationship marketing*** has become a mechanism for survival in a competitive world (Hennig-Thurau and Hansen, 2000). This approach - designed to foster customer loyalty, interaction and long-term relationships through carefully targeted communications - is mirrored by a digital shift in health care services. ‘An increasing array of digital tools enable us to be in almost constant contact with almost everyone in the world, at very little cost or effort’ (Sustainable Improvement Team and the Horizons Team, 2018). This increased connectivity brings with it further complexity as well as new possibilities for how data can be utilised.

McKinsey is one of several organisations to highlight inclusion and staff engagement as central to organisational success (Hunt *et al.*, 2015). The business imperative to grasp advantage from reaching a diverse customer base is the primary driver in this context. As Heffernan (2011) puts it ‘Diversity isn’t a form of political correctness, but an insurance policy against internally generated blindness that leaves institutions exposed and out of touch’.

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[19] Datavores is a term utilised originally by Nesta to describe data-elite organisations that devour data to inform organisational strategy and development (Bakhshi and Mateos-Garcia, 2012). A well-known example is the role played by the company Data Analytica in influencing outcomes of the 2016 US election.

The legal and moral imperative to ensure social justice against discrimination was a key pillar of the post war settlement that gave rise to the NHS (Simpson, 2018). The culture of public service, including the NHS, has transformed significantly over the last 20 years through the marketization of services and the drive for greater efficiency, leaving many services struggling to manage the tensions between values-led leadership and the bottom-line of budgets (Conley and Page, 2017). In his review of NHS leadership Lord Rose asserted that the absence of a consistent values-based approach has created a climate of fear and suspicion that has negative effective on service delivery:

> ‘There is a culture of fear; it’s all too difficult; there is an obsession with targets and it is impossible to operate in the current climate of suspicion and change.’ (Rose, 2015:20)

In relation to health outcomes in the wider population there is clear evidence of the link between inequality and poor health. Through the powerful use of data Marmot (2015) makes visible the systemic causal links between inequality and poor health, concluding ‘what good does it do to treat people and send them back to the conditions that made them?’ Marmot’s key point is that social conditions determine health outcomes and fundamentally drive demand for public services. Yet as Randle and Kippin (2014) note in a report for the RSA, the concept of ***managing demand*** is in its infancy at a time when public services are at breaking point. Indeed, the authors argue there is a fundamental need for public services to renew the social contract between service and citizen based on principles of equality in the service relationship, shared responsibilities, co-production and an understanding of factors that shape the need for services in the first place.

There is huge opportunity at this difficult juncture for the NHS to mine the rich resource of data at its fingertips to underpin the strategic development of the inclusion agenda, and to couple this with improvement of service and indeed its systemic work with crucial partners such as social care. There is evidence for example in local government, that where this is undertaken effectively, through a systemic lens, some of the most negative impact of austerity policies on society's most vulnerable citizens, such as those with disabilities, can be counteracted (Wood, 2011).

There is already recognition within the NHS of the relationship between a diverse and inclusive workforce and better patient care:

> 'We know that a diverse workforce and inclusive leadership is associated with more patient-centred care, greater innovation, higher staff morale, and access to a wider talent pool. Understanding data and the root causes of discrimination will be key steps in achieving these aspirations' (NHS Equality and Diversity Council, 2015:9)

However, the NHS is yet to make real embedded use of this insight across the board. NHS targets and metrics have typically formed the core toolkit of successive governments as they reach for levers for influence and seek to demonstrate service quality and value for money. Whilst these measures are intended to ensure political accountability they also fundamentally shape the culture of public service, which tends to be one of compliance rather than engagement, and this is certainly reflected in the ways in which the NHS and constituent agencies tend to make use of data (Chapman, 2004).

Whilst performance targets are in place for many areas of activity, data has not typically been used to assess progress on inclusion or the NHS' commitment to social justice and equality. In a significant move to address this shortcoming, the NHS Equality and Diversity Council (EDC) initiated the Workforce Race Equality Standard (WRES) in 2015 to monitor and assess race diversity across the organisation. The Council subsequently launched a Workforce Disability Equality Standard (WDES) in April 2018 that is mandated via the NHS Standard Contract in England.

These monitoring and evaluation processes represent a significant step forward for the inclusion agenda, although they do not yet facilitate an understanding of the rich interdependencies between different dimensions of diversity. For example, the Workforce Race Equality Standard (WRES) Strategic Advisory Group (2017) recognises that there is work to do in broadening its scope to include medical staff (a major current omission) and to deepen its work through embedding cultural change through leadership. The latter point reflects a significant recognition of the need to work well below the surface in addressing inequality and the importance of leadership in this respect.

> '… the evidence is clear that workforce race equality is critical to patient care, safety and outcomes and that it also leads to the efficient running of the NHS. The evidence is also clear that success in this area is dependent on demonstrable and committed leadership.' (NHS Confederation, 2017)

Whilst WRES, WDES and associated initiatives such as SOM (Sexual Orientation Monitoring Information Standard) are beginning to facilitate a different kind of data informed, discourse for the development of the

NHS workforce there is still a long way to go until evidence is systematically used to reveal underlying patterns of discrimination.

At present, equalities data only enables a partial picture, against specific protected characteristics. Nuanced data analysis that reveals different patterns in relation to intersectional analyses of staff data (workforce and talent pipeline) and in relation to community profiling will facilitate crucial insights into the relationship between equality and quality of service, thus forming a basis for a strategic and systemic approach to tackling embedded and hidden discrimination. The sub-analyses of the NHS Staff Survey by organisation and ethnicity[20], for example, provides an excellent opportunity for revealing the relationship between inclusion and staff engagement, as well as raising important issues with respect to equalities.

Whilst intersectional analyses are valuable, however, they can make data collection, analysis or representation difficult and may be dismissed as unnecessary 'red tape'. Furthermore, there is evidence to suggest that individuals with protected characteristics tend to under-report, posing challenges for data accuracy. For example, when Dawson (2018) explored links between NHS staff experience and patient satisfaction he was able to highlight that 'when a higher proportion of BME staff experienced discrimination, patient satisfaction was lower' (Dawson, 2018). However, these findings were accompanied with a recognition that in over 80% of Trusts there were fewer than 50 BME respondents in both years of the patient satisfaction survey which was used for the analysis. When exploring data from individuals with multiple protected characteristics this underreporting impacts upon the validity of the

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[20] These can be accessed at www.nhsstaffsurveys.com.

assertions that can be extrapolated from such data and underlines the importance of focusing on improving response rates (Fowler, 2013).

It is also clear that a legal imperative is not enough in its own right. A decade after the introduction of the *Race Relations Amendment Act* (2000), for example, Archibong and Darr (2010) noted that despite the statutory requirement to publish annual statistics relating to the number of staff involved in disciplinary action, broken down by ethnicity, only one-fifth (80) of all NHS trusts did so.

If combined with other data sources, NHS Boards could have a much more powerful strategic and enquiring discussion around the quality and improvement of provision, staff retention, talent pipeline and inclusion. Putting the pieces of a jigsaw together, rather than treating each piece of the jigsaw separately (or worse as something to put aside or quash) is the stuff of systems leadership that enables patterns to be detected and causation to be considered. A lack of curiosity in the mindset of compliance, or complacency that fails to join up the dots to facilitate seeing afresh or identifying the bigger pattern, is symptomatic of '***wilful blindness***' (Heffernan, 2011). Whilst 'wilful blindness is a legal concept which says that if there are things that you could know and should know and somehow manage not to know, the law holds you responsible' (Heffernan, 2014) it is the underlying psychological processes that merit consideration.

The notion of 'Wilful blindness' underlines the importance of using data to see and think afresh, of the importance of data, cultural practices and behaviours that support organisational learning from everyone, regardless of seniority of personal characteristics. Arguably data has an

important role to play not only in informing change, but in mobilising change and transforming services.

As highlighted in the Mid-Staffordshire Enquiry (2013) and the Mazars LLP (2015) report for Southern Health, not listening to front-line staff, poor and unequal service and poor performance are frequently linked with poor use of data. The Mid-Staffordshire NHS Foundation Trust Public Enquiry found: lack of collection of appropriate data, lack of joined up data, inability to detect overall pattern and synthesis and lack of reality testing, data as compliance rather than as source of learning and strategic leverage, and lack of analysis of the patient experience and voice (Mazars LLP, 2015).

> 'Despite the Trust having comprehensive data relating to deaths of its service users it has failed to use it effectively to understand mortality and issues relating to deaths of its Mental Health or Learning Disability service users.' (Mazars LLP, 2015:16)

The Mazars report on Southern Health showed how 'wilful blindness' with respect to data (and defensive staff behaviours) surrounding the deaths of vulnerable adults with learning disabilities led to the report's conclusion that failures by the Trust's board and senior executives meant that there was no effective management of responses to deaths, or effective focus by leadership. This report also showed how Southern Health failed to recognise any pattern in the deaths occurring because they were looking to defend, rather than explore the situation. Wilful blindness, if left unchecked, at best results in mediocrity (where systemic exclusion remains invisible) and can well lead to systemic failure and harm on a large scale. In the case of inclusion and inequality, NHS leaders are both responsible and accountable to 'call out' instances of

discrimination and to take action to eradicate factors that contribute towards the marginalisation of staff and/or patients. If the full picture is not understood, then leaders are ill-equipped to carry out their task, let alone position their organisations strategically to adapt to ongoing change.

Despite progress on how the NHS collates data since 2010, data is still typically reduced, simplified and generalised to offer 'bite-sized' knowledge, which eases digestion but masks the complexity of issues and their underlying causes. The reduction of complex issues to simple, tangible and measurable actions is an understandable and a natural reaction of psychological discomfort against ambiguity and complexity in a fast changing world (Kahneman, 2012, Konnikova, 2013). However, as we transition into new and more elaborate ways of engaging with data it is crucial to understand the intrinsic and nuanced relationship between equality, inequality and the configuration of NHS services. As corporate organisations are developing more advanced approaches to using data in light of an increasing awareness of the importance of diversity and inclusion, the NHS must question whether it is utilising one of the world's largest data sources to its full potential.

Data intelligence framed through an inclusion and complexity lens is one key among others to unearthing underlying problematic patterns such as racism, and other forms of discrimination and exclusion. It is also potentially a major key to facilitating a shift towards an ***asset-based approach*** to that makes the linkages between staff engagement, inclusion and talent management a reality.

6 The Reality of Change

This chapter gives recognition to the substantive work that has already been undertaken to shape inclusive environments in the NHS and beyond and draws on this learning to inform the distinctive approach of Building leadership for Inclusion in combining an understanding of inclusion with systems leadership. We explore the hard reality of creating change, with an appreciation of the huge range of approaches available (which cannot be fully synthesised in a report such as this). To be inclusive, we have purposely drawn on examples and approaches from a wide range of disciplines and authors. Our purpose at this stage is to raise awareness of issues and approaches that may be further explored in the strategic approach of BLFI to leverage lasting change.

6.1 Diversity Management and the Talent Pipeline

As outlined in Chapter 2, concepts of diversity and inclusion are distinct but inextricably linked. When considering leadership for inclusion it is important to consider (a) approaches for improving the diversity of leaders and (b) how all leaders can recognise and incorporate approaches to enhancing workforce diversity and supporting marginalised individuals in their day-to-day practice.

Talent Management is defined by Sweeney and Bothwick (2016) as an approach to considering the entire life-cycle of an employee 'that starts from the moment you are looking to attract individuals into the organisation and continues all the way through to their employment until they decide to leave you'. However, whilst the NHS expresses an explicit commitment to equality and diversity, the recruitment, human resource

management (HRM) and disciplinary procedures they adopt may not always be so inclusive in practice.

In recent years the concept of ***Diversity Management*** has been introduced to highlight the need for an inclusive approach to talent management, however, whilst the approach has grown in popularity, King *et al.* (2011:4) note that 'the literature on policies, procedures, and practices of diversity management in organizations is currently fragmented and often contradictory'. Diversity Management frequently focuses upon mechanisms to recruit a more diverse workforce without considering underlying systemic factors. Authors such as Bertrand and Mullainathan (2004) and Jacquemet and Yannelis (2012) note that discrimination can start from the point of writing your name on an application form.

In a study of the response to 990 fabricated and identical resumes, Jacquemet and Yannelis (2012) found that resumes with African-American and Foreign names receive one third fewer call-backs than resumes with Anglo-Saxon names. In order to address early stage discrimination several authors have noted that changes such as ***name-blind recruitment*** can have a positive impact upon unconscious bias, which may manifest in the selection process. Results from a study undertaken by Dechief and Oreopoulos (2012) suggest that employers should consider masking names on applications before making initial interview decisions.

However, whilst name-blind selection might improve access to interview, identity still may affect selection at the interview stage. Factors such as

'affinity bias' and the 'mere exposure effect'[21] are amongst a myriad of unconscious processes that may lead to discrimination at the interview stage. Whilst the McGregor-Smith Report (2017) highlights the importance of ***diverse interview panels***, the Chartered Institute of Personnel and Development (2015) emphasises that organisations must rigorously engage in constant and consistent evaluation of their own practices to address issues of inequality; asserting that there is no simple or immediate solution to addressing this complex issue.

The process of selection is not just an opportunity to enhance overall diversity of staff, but it is also an opportunity to recruit staff members who demonstrate a commitment to inclusive practice. The *Commission for Social Care Inspection* (CSCI, 2018:18) propose that 'staff recruitment processes should ensure that new staff have a positive commitment to a range of equality and diversity issues including sexual orientation and gender identity'.

As noted previously, however, the NHS does not have an issue in general staff diversity, rather there is an apparent distortion in relation to seniority and leadership roles - a ***glass-ceiling*** for those with minority characteristics. It has been suggested that the introduction of ***quotas or targets*** for higher level leadership or board positions may help level the playing field, leading to a gradual widening in the choice of candidates. In the UK private sector, Lord Davies (2015) stopped short of recommending enforced quotas in his gender equality report, allowing companies to take control of targets rather than have them imposed on them. Whilst this voluntary approach has been associated with a

[21] Affinity bias leads people to prefer those who are similar to them or someone they know; mere exposure effect causes individuals to be more appreciative of things they have had previous exposure to (CIPD, 2015).

doubling of the number of FTSE100 female board members, elsewhere mandatory regulation (along with penalties for noncompliance) has proved even more successful. Norway, for example, were the first country to adopt a quota system, increasing numbers of women on boards from 9% in 2003 to more than 40% by 2012 (Sealy *et al.*, 2016). An alternative approach to quotas is to implement maximum levels of homogeneity, whereby a specific identity group cannot occupy more than a certain proportion of senior leadership or board positions.

Whilst it is evident that quotas may have had a positive impact upon representation, this is only the beginning of the story of inclusion. For example, minority individuals who find themselves in leadership or high-level decision making positions can find themselves isolated and impacted by the lack of diversity they encounter at this level. Torchia *et al.'s* (2011) study on gender representation in boards highlights the importance of ***critical mass***, concluding that having 'at least three women directors makes boards more heterogeneous and allows majority-minority interactions and processes to take place thereby enabling the overall board to take high-quality decisions' (*ibid*:311).

We must also ask what kinds of position minority individuals are recruited in to. Defining what is referred to as the ***glass cliff***, Ryan and Haslam (2007) identified that two fifths of respondents believed that they had been placed in precarious leadership roles where there is a high risk of failure, with the situation even worse for those from BAME groups.

Arguably approaches to diversity management typically mirror the underlying assumptions of talent management. Rather than challenging and contesting normative frameworks many incorporate assumptions

that prove to be ineffectual for the career progression of marginalised individuals, as outlined below.

> '…many career development interventions are geared to traditional, and arguably male, conceptions of career as a linear and agentic climb up a hierarchy. This may work against people who have different definitions of career success, especially subjective experiential ones, which for many people take precedence.' (Barnard et al., 2016:71)

Literature suggests that HR policies alone are not a solution and highlights that beyond recruitment, individuals who are typically under-represented or marginalised in the workplace may benefit from on-going support and capacity building. In 2004, the Department of Health published their five-year *Race Equality Action Plan* which, amongst other positive actions, included those specifically aimed at developing and improving career opportunities and outcomes for BAME staff. These actions called for senior leaders to offer personal mentorship; expand training; development and career opportunities; and incorporate systematic processes for tracking the career progression of BAME staff in the NHS. Such initiatives are referred to as ***Positive Action*** programmes and focus on promoting leadership and management development opportunities for specifically targeted groups. Positive action requires a limited amount of lawful differential treatment, based on the rationale that such actions are required in order to level the playing field, rather than providing those groups with a unfair advantage (Johns, 2005).

Coaching and mentoring are also often deployed within Positive Action approaches. ***Coaching*** typically involves pairing individuals with an

experienced ‘coach’ to develop particular expertise and/or create safe spaces for learning and reflection. There is some excellent work (e.g. Cox et al, 2013) that highlights the need for coaching to be framed as a positive, whole organisational approach to improving performance and talent management. ***Peer coaching***, where two or more people (usually colleagues at a similar level) commit to supporting one another’s development in a confidential and reciprocal manner (Robbins, 1991), can be effective in developing a ***coaching culture*** across the organisation, particularly where it is linked to peer coaching ‘circles’, ‘groups’ or ‘networks’ (Brassard, 2016). However, whilst authors and practitioners generally recognise the value of diversity in teams, there tends to be limited consideration of how coaching could be used to foster inclusive leadership, particularly when offered to people *before* they enter into a more senior leadership role.

Mentoring typically involves a relationship between a senior/experienced ‘mentor’ and a more junior/less-experienced ‘mentee’. A trusted mentor or coach can be an invaluable support in problem solving and a ‘friendly ear’ with whom to share sensitive issues. Schein *et al.* (1996) argue that mentoring, while important for men, may be indispensable for women. It is asserted that mentoring enables women to overcome career obstacles, gain information and insight, seize power, understand organisational politics, obtain feedback and gain access to resources (Leck and Orser, 2013). Since Jack Welch (as CEO of General Electric) realised his senior executive team were struggling to take full advantage of the Internet back in 1999, many commercial organisations have embraced ***reverse mentoring***, harnessing the skills and knowledge of their younger members of staff to help senior colleagues with new technology (Murphy, 2012). This could

be a particularly significant intervention in relation to diversity and inclusion given the potential to share and learn from lived experience.

Sponsorship moves beyond concepts of coaching and mentoring to develop relationships that support and promote individuals[22]. The McGregor-Smith (2017) report highlights several case studies to demonstrate the potential benefits of sponsorship. Future Focused Finance's (2017) paper on Building a diverse and inclusive NHS Finance function also highlights the importance of sponsorship in the workplace.

> 'Sponsorship (which is different from mentoring) is a natural part of how organisations function and sponsorship relationships develop informally. […] the introduction of targeted sponsorship is not positive discrimination, it is about levelling the playing field and providing the support necessary for individuals from underrepresented groups to succeed.'(Future Focused Finance, 2017)

The CMI and BAM report on *Delivering Diversity* highlights the potential impact of sponsorship, noting that BAME managers reported the significant influence senior executive sponsorship has had on their career (Beech *et al.*, 2017). It is also important, however, to highlight the potential of collective action amongst peers. In the NHS numerous equality-based ***staff networks*** exist; such as the LGBT+ staff network or the British Association of Physicians of Indian Origins (BAPIO). It is argued that such networks are important for creating 'safe spaces' for discussion and promoting solidarity amongst those who experience

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[22] The NHS Leadership Academy is now also exploring the notion of 'allieship' to identify senior individuals and groups who can act as advocates and partners for change in diversity and inclusion.

discrimination. The collective power of groups affords greater potential for highlighting issues that are important to its members and for creating momentum around change.

> 'Staff networks can be effective mechanisms of workforce engagement. Acting as a collective discussing the different experiences of their members, staff networks can provide insight into unseen barriers and devise practical, creative and commercially workable solutions to help close the gap between white and black and minority ethnic staff treatment.' (NHS England, 2017c:6)

In her discussion of social identity Bernstein (2005) asserts a belief that shared collective identity can be deployed for political purpose. She argues that without ***collective agency*** and '***oppositional consciousness***' individuals are unlikely to be able to mobilise social change. However, whilst identity-focused groups and networks have been unquestionably successful in stimulating change it has also been argued that such groups can in themselves be exclusionary when intersectionality is not considered, membership is unexamined or when networks are not integrated in to wider organisational systems.

Finally, authors such as Unger (1998) note how some aspects of identity are regarded as more legitimate during some periods than others. She states that this 'contextual dimension is indispensable for understanding how much people reveal about the ways they construct their lives' (Unger, 1998:167). When considering identity-based network groups it is important to recognise how the relevance of such groups is shaped by historical events and societal norms; to ask which groups are

constructed, which are not, and how this relates to shifting understandings of diversity and priorities.

6.2 Mobilising Systems Change

Network approaches to change are increasingly being adopted across the NHS (Ferlie *et al.*, 2013) and offer the potential to span the divide between a focus upon the individual and a focus upon the system. In relation to inclusion, however, network approaches may be tokenistic where groups act in isolation, devoid of ability to influence wider systemic change. Particularly where networks are not supported by financial and time resources it has been argued that the expectation for marginalised individuals to participate within networks can be exploitative as membership is often unpaid and not considered as part of everyday work. Thus, those who are most marginalised are expected to do additional unpaid work to combat discrimination that was not caused by them.

Most of the approaches highlighted in the previous section focus upon stand-alone interventions that are framed as levers for change. However, when considering complex issues such as inclusion, 'we have to let go of the hope that outcomes have single causes or that there are single "levers" that can be pulled to create the change we want' (Boulton *et al.*, 2015:131). When addressing complex issues, it is argued that we need to consider whole systems and the inter-relationships between component parts:

> 'Organisational flows of information, energy, re-sources and learning are blocked by barriers between people, departments and subsystems that become detached from each other. To survive, internal complexity must match the external complexity of the environment; only variety can absorb variety.' (Attwood et al., 2003)

The concept of ***gender mainstreaming*** (GM) emerged and has gained currency since the *World Conference on Women* in 1995. At this time GM was championed as a 'strategy for infusing mainstream policy agendas with a gender perspective and transforming the institutions associated with them' (Eyben, 2010:159). It was envisioned as an approach that would lead to social transformation by embedding gender considerations into every role, process and function of an organisation. As discussed previously, systemic barriers such as lack of awareness, unwillingness to adopt change and unaligned bureaucratic process all conspire against change.

In part, mainstreaming approaches were introduced as a way of introducing ***identity-conscious practices*** into organisations. Roberson (2006:231) notes that whilst still contentious, 'research shows that identity-conscious practices are positively related to the employment status of protected groups in organizations'. Particularly, in the field of disability there has been widespread change achieved through recognising how identity affects workplace experience and how failures to appreciate different lived experiences in any part of organisational practice can result in discrimination.

The disability movement clearly highlights the way in which the physical environment can be viewed as a manifestation of discrimination. The

Social Model of Disability (Oliver, 1990) asserts that individuals are not rendered 'disabled' by impairments but by the disabling barriers they face in society. This model contrasts with the individual or medical model of disability, which views disability as a physical or psychological impairment, by focusing instead on how opportunities for 'disabled' individuals to actively engage in mainstream economic and social activities are restricted by the world around them. The social model of disability has had considerable influence on the ways in which disability is conceived and legislated for within UK society and offers significant potential for understanding and reframing the lived experience of other marginalised groups (Oliver and Barton, 2000). The social model radically reframes the way we view discrimination as it shifts attention away from a deficit model (which focuses on apparent weaknesses of those who are marginalised) towards the non-inclusive environments, processes and cultures themselves (which result in the discrimination of an individual who may not conform to perceived societal norms)[23].

Whilst UK legislation now recognises discrimination in the physical environment and enforces a requirement for introducing identity-conscious practices, inequality hidden in systems and processes is less commonly acknowledged. It is clear from the literature, however, that systems tend to work for those who design them and are usually designed and overseen by those with majority perspectives. Several authors have highlighted the significance of understanding administrative and bureaucratic processes and how these need to be

[23] The *Calibre Leadership Programme*, directed by Dr Ossie Stuart, is a good example of an integrated approach to developing and supporting leaders with disabilities. By addressing systemic barriers to inclusion, alongside personal and professional development, significant impact can be achieved. For further details see www.ossiesway.com/projects.

navigated with ***political astuteness*** and an awareness of how power operates within the system (Hartley *et al.*, 2013).

> ‘The women I worked with taught me where the real power lay; but they also taught me something about the limits of that power, and how a unit within the bureaucracy could facilitate a process of social change, drawing on the power of women within a political party.’ (Antrobus, 2000:53)

Whilst leaders are not expected to be architects or administrators, an awareness of how discrimination and exclusion manifests within systems and processes and what can be done to navigate these, is an important attribute of inclusive leadership practice.

When exploring mainstreaming and identity-conscious practices as tools for creating systemic change it is important to learn from previous experience. In the field of international development, for example, it is noted that whilst mainstreaming approaches garnered widespread praise and attention for some time, they quickly became adopted in a highly technical and bureaucratic tick-box way that did not reflect the original intention of this approach. Delivered by ‘experts’ and uninformed by lived experience, authors such Milward *et al.* (2015) note how critiques and reviews of mainstreaming approaches are almost universally negative. When considering the potential of mainstreaming, therefore, it is important to recognise the multitude of ways it has been applied and to appreciate the historic significance of an integrated approach to inclusion.

6.3 Inclusion, Governance and Accountability

Accountability can broadly be considered as 'how responsible action is ensured and demonstrated' (Adelaine, 2016). It is a term which embraces 'the means by which individuals and organizations report to a recognized authority (or authorities) and are held responsible for their actions' (Edwards and Hulme, 1996:967). However, 'the broadest view on accountability assumes that organisations are responsible and accountable to all those upon whom their actions have (or may have) an impact' (Unerman and O'Dwyer, 2006:357). ***Governance***, whilst having a symbiotic relationship to accountability, more specifically refers to decision-making processes and responsibility for the accountability process.

In discussions of inclusion it is important to reflect upon what the organisation and the leaders who act within it consider to be responsible action; who is accountable to whom; what are they accountable for and how we measure the impact of inclusion interventions. The *McGregor-Smith Report* (2017) asserted that diversity should be a Key Performance Indicator, stating that employers should ensure that all leaders have a clear diversity objective included in their annual appraisal to ensure that people throughout the organisation take positive action seriously. This highlights recognition of ***personal accountability***, whereby inclusion is viewed as an essential aspect of professional practice.

Anti-Oppressive Practice (AOP) refers to an approach widely used within the healthcare sector, which focuses attention, not upon diversity, but upon the systematic consideration of power and inequality, with a view to ensuring that professional practice is not discriminatory towards

a particular group or individual. It describes a way of working as opposed to a one-off intervention or initiative. Within professions such as nursing and social work a commitment to inclusive behaviour is frequently regarded as a key professional competency. Anti-Oppressive Practice is systematically taught in the professional development of UK based healthcare professionals and is frequently regarded as a core part of professional development or degree courses, indicating an approach whereby personal competency in relation to inclusion has been integrated in a systemic way not only into standards of professional practice but into staff development.

Moving beyond individual accountability there have been numerous attempts to enhance ***organisational accountability*** by introducing ***quality marks or standards***. However, the impact of these, largely voluntary quality marks or standards has been variable. Ryan *et al.*'s (2016) study on the employment experiences of disabled staff showed that equality standards did not indicate significantly better working environments, concluding that 'the Two Ticks award does not make a great deal of difference in terms of an organisation's awareness of disability issues or in its capacity to address any inequalities or inadequacies in practice' (*ibid:* 6).

> 'Studies from a range of contexts indicate that mandated policy interventions to promote diversity that have legal or funding consequences are associated with better outcomes than non-mandated polices.' (Priest et al., 2015)

With all forms of accountability, whether this be personal or organisational, a choice must be made between the right to hold individuals to account and the need for compliance to be enforced; with

the potential that compliance may have an inverse effect, potentially creating a hostile environment that is not conducive to inclusion. When considering accountability and responsible action it is important to remember that processes and interventions should be primarily held to account by those most affected by the issue at hand. Thus, when it comes to inclusion the NHS may need to consider ways in which it is held to account by the staff and service uses who encounter discrimination, against indicators that matter to them.

When considering accountability, it is important to note that leaders and managers are confronted with multiple, often competing, demands. Those in leadership positions may be held to account by multiple stakeholders with competing views and priorities ranging from patients, communities, staff members, action groups, senior leaders and politicians. Whilst leaders need to take action on inclusion and diversity and to be accountable for interventions (which have associated costs), they are also required to be financially accountable for reducing expenditure.

> 'A report by the NHS Confederation and Independent Healthcare Advisory Services (2009) found that NHS and independent sector health care providers were collectively subject to overview by some 35 regulatory, auditing, inspectorate and accreditation agencies.' (Ebrahim, 2010)

Excessive accountability systems are viewed as stifling action and preventing productivity. Ebrahim, for example, states that we must 'question the normative assumption that such regulatory accountability is necessarily good by asking whether there is a danger of too much accountability' (Ebrahim, 2003b:192). Arguably the true challenge of

inclusive leadership cannot be understood by looking independently at different forms of accountability. Rather we need to reflect upon which systems and paradigms are dominant, where power is and what the reality feels like of trying to juggle competing demands. In light of this, Ebrahim asserts that ‘what is missing from much of the debate on accountability is an integrated look at how organizations deal with multiple and sometimes competing accountability demands’ (Ebrahim, 2003a).

Holistic accountability approaches adopt a systemic view of accountability (Agyemang et al., 2009, O’Dwyer and Unerman, 2008). Rather than focusing upon one form of accountability an understanding of multiple stakeholders and competing priorities is developed. When viewing accountability in this way it is possible to identify who dominates the accountability process and where power lies.

6.4 Leadership for Inclusion

Whilst attention is often directed towards those who are most marginalised, an inclusive approach to leadership encompasses an understanding that all individuals, regardless of identity, should embrace and enhance their ability to behave in a manner which is conducive to creating an inclusive workplace.

In the fields of social work, nursing and medicine ***Reflexive Practice*** has been widely utilised to give individuals working in challenging and complex situations the space to critically reflect upon their practice in a manner that recognises the importance of identity. In their book *The Critically Reflective Practitioner* Sue and Neil Thompson (2018) highlight the importance of creating and maintaining space for critical reflection. Cunliffe (2009) takes a similar approach in management education,

calling for the development of 'the philosopher leader [who] thinks differently, asking: What is important? What if we think about organisations, leadership, and ethics in this way rather than that? Where will it take us?'

The significance of personal self-development and identity work is undeniable, however, it is also widely appreciated that is important for leaders to develop the practical and ***cultural competencies*** that will enable them to lead and stimulate an inclusive environment within a hugely diverse and complex organisation such as the NHS. Several authors assert that conflicts emerging from cultural difference may need to be responded to differently than one would in a homogenous environment. Connerly and Pedersen (2005), for example, propose that dominant methods of ***conflict resolution*** incorporate values and attitudes not necessarily shared by members of minority groups, but are instead based upon culturally bound assumptions of the dominant group. It is argued that by learning tried-and-tested techniques, such as Sunoo's (1990) guidelines for mediators of intercultural disputes, and applying them in context relevant ways leaders can develop their cultural competence in regard to inclusion. This is where the use of dialogic approaches to leadership and organisation development can be particularly effective (Bushe and Marshak, 2013).

As with other areas of leadership development, it is argued that ***psychometric profiling*** can also be useful for creating a baseline of understanding. The CoBRAS, for example, is a psychometric test that has been developed to measure 'colour-blindness' - a term utilised to describe the denial of the social significance regarding race and the existence of racism. From this perspective individuals, groups, and systems consciously or unconsciously use 'colour-blindness' to justify

the racial status quo or to conceptually minimise racial inequalities. Chao *et al.* (2011) note that typically, colour-blindness is negatively correlated with multicultural knowledge and awareness. As with all standardised instruments, however, it should be noted that psychometric tools often embed mainstream, functionalist assumptions that may accentuate rather than reduce inequality (Ladkin, 2005).

6.5 SHIFTING THE NARRATIVE

As noted by Nembhard and Edmondson (2006:943) 'creating understandable risk aversion that can inhibit willingness to engage in the chaos and uncertainty of team brainstorming and experimentation'. A lack of psychological safety inhibits learning, which can fundamentally affect the likelihood of mistakes, not to mention its effects on diversity and inclusion.

Working in the field of healthcare and organisational development, the *Learning Cultures Survey* developed by Garvin *et al.* (2008) is utilised to determine how organisations foster cultures of learning. By exploring approaches to knowledge sharing, idea development, learning from mistakes, and holistic thinking, this tool can be used to anticipate and prepare organisations for change. Whilst the tool is not explicitly linked to issues of diversity or inclusion it has the potential to ascertain the organisational receptiveness to learning (Gulati and Adelaine, 2017). There are other tools with similar aims, such as the *Culture Assessment Tool*, based on the work of Mike West and colleagues in NHS contexts.

In order to shift towards a learning culture, leaders can help by creating an environment that is conducive to and fosters a shared vision. Marshall Ganz, who worked extensively with Barack Obama prior to and

during his presidency, highlights the significance of crafting a compelling ***public narrative*** to inspire action and social change, as outlined below.

> ‘Social movement leaders tell new public stories: a story of self, a story of us, and a story of now. “A story of self” communicates the values that call one to action. “A story of us” communicates the values shared by those in action. “A story of now” communicates an urgent challenge to those values that demands action now. Participating in a social movement not only often involves a rearticulation of one’s story of self, us, and now, but marks an entry into a world of uncertainty so daunting that access to sources of hope is essential.’ (Ganz, 2010: 14-15)

Through stories of change leaders can tap into and influence the ***diversity climate***, something that has been referred to as ‘employees’ perceptions about the extent to which their organization values diversity as evident in the organization’s formal structure, informal values, and social integration of underrepresented employees’ (Dwertmann *et al.*, 2016:1137). Stories, especially those that connect lived experience to shared values/aims, can act as powerful ‘attractors’ around which to mobilise change. ‘Attractors are phenomena that arise when small stimuli and probes (whether from leaders or others) resonate with people. As attractors gain momentum, they provide structure and coherence’ (Snowden and Boone, 2007:6).

In his review of NHS leadership, Lord Rose suggested that ‘everyone should know what great leadership looks like […] Leadership qualities should be celebrated across all disciplines and job grades (Rose, 2015:6). Across the NHS and public sector, ***Diversity champions*** and ***Diversity awards*** have been utilised to shape positive diversity

climates. However, it is argued that if these awards are not perceived to be accompanied by a genuine commitment to change they may have an inverse effect (Davis, 2016, Oluo, 2018). L'Oréal, for example, has won a number of awards for its diversity and ethical approach to business (Danowitz *et al.*, 2012) yet, despite this it has come under intense criticism from the BAME and LGBT+ communities - most recently after the organisation dismissed Munroe Bergdorf, the new face of L'Oréal and first transgender campaign lead, following her statement urging white people to be aware of unconscious racism. This incident, alongside others such as the 2009 successful lawsuit for racial discrimination, has led many to question the validity of diversity awards where they are not clearly reflected by wider organisational culture and activities.

Whilst individual leaders, diversity champions and diversity awards can stimulate change, they may unintentionally reinforce an individualised approach to addressing inequality and recognising and rewarding success (see Chapter 3). A ***hero paradox*** emerges that reduces the complexity of leadership and inclusion to the actions and contributions of a small number of people in ways that neglects wider contextual and cultural factors (Allison and Cecilione, 2016).

Sinclair (2007) is amongst several authors who encourage us to move beyond myths and heroes to leading that liberates. Whilst the notable and significant contributions made by exemplary leaders cannot be understated it is also apparent that history distorts reality and creates individual heroes of change rather than recognising the collective contribution. For, example Angela Davis states that:

> 'Dr Martin Luther King, who was a great man, but in my opinion his greatness resided precisely in the fact that he learned from a collective movement. He transformed in his relationship with that movement. He did not see himself as a single individual who was going to bring freedom to the oppressed masses.' (Davis, 2016:118-119)

In recent years, through technological advancement and the increasing popularity of social media, the influence and significance of collective power has become ever more apparent. Heimans and Timms (2014) describe this phenomenon as ***New Power***. They state that this power operates differently from that seen previously, suggesting that: 'like a current. It is made by many. It is open, participatory, and peer-driven. It uploads, and it distributes. Like water or electricity, it's most forceful when it surges' (*ibid*:2).

Each of the approaches outlined in this and earlier chapters suggest the need for critical and collaborative engagement that builds on principles of complexity and systems thinking, and highlight the importance of narrative and debate in mobilising social change. In a pluralistic environment there will always be differences of opinion, informed by conflicting evidence and experience, and it is the role and responsibility of leaders to host safe spaces for people to engage with one another to increase mutual understanding and to mobilise a shared sense of direction, alignment and commitment (Drath *et al.,* 2008).

7 CONCLUSION

This document has explored a wide range of theory, evidence and practice in order to highlight key factors that impact on inclusive leadership and leadership development in the NHS. In this final chapter we identify key themes and recommendations to support the strategic aims of the NHS Leadership Academy's Building Leadership for Inclusion (BLFI) programme of work that seeks to (1) raise the level of ambition, (2) quicken the pace of change, and (3) ensure that NHS leadership is equipped to achieve and leave an ever-increasing and sustainable legacy in relation to equality, diversity and inclusion (NHS Leadership Academy, 2018).

7.1 INCLUSION: THE DNA OF LEADERSHIP AND CHANGE

This review has highlighted the complex and changing nature of the challenges facing the NHS. There is now widespread recognition of, and commitment to, the role of compassionate and inclusive leadership at all levels in developing innovative services, fostering improvement, minimising health inequalities and fully engaging staff, patients and communities that maximises the benefits of diversity.

The past two decades have seen a number of attempts to address the relative lack of diversity at senior leadership and management levels across the NHS. However, despite recognition of the potential benefits of diversity progress has been very slow – particularly in relation to race. There remain significant inequalities in relation to recruitment, promotion, and pay and experiences that need to be addressed. Recent equalities monitoring and assessment initiatives such as the Workforce Race Equality Standard (WRES), Gender Pay Gap Reporting (GPG),

Sexual Orientation Monitoring Information Standard (SOM) and Workforce Disability Equality Standard (WDES), introduced in 2016, 2017, 2017 and 2018 respectively, have placed equality, diversity and inclusion firmly on the agenda of NHS boards and put in place mechanisms for ongoing data collection and reporting. Compliance with such initiatives alone, however, will be insufficient to mobilise the large scale cultural change required for everyone (in particular those in positions of privilege) to become advocates for change and to recognise that tackling inequality is a duty and responsibility of everyone – not just those from minority groups or in diversity-related roles.

Whilst inclusion is often treated as if it were a problem to be solved what is less well understood is its generative capacity and its value as a key indicator for the wellbeing of groups and organisations. Until the NHS has removed systemic structural and cultural barriers to staff progression and patient access to services it will be unable to live up to its ambition of 'mak[ing] sure nobody is excluded, discriminated against or left behind' (NHS England, 2015). Furthermore, it will continue to waste essential skills, expertise, knowledge and experience as staff from marginalised groups are prevented from achieving their full potential.

Instead, inclusion should be regarded as the fundamental DNA that runs through everything. Good leadership is not simply a case of applying universal rules of behaviour, but rather understanding the group to be led, the types of actions it values and considers legitimate, and the nature of the context and challenges to be addressed. Far too much attention is given in both leadership theory and practice to the role of 'leaders' and not nearly enough to the nature of ***followership***. In contexts where people are expected to lead across boundaries to influence others over whom they have little or no formal authority the

nature of the relationship is key. Only where 'leaders' are perceived to be credible and legitimate in the eyes of those they are attempting to lead, and to have a valuable contribution to make, will they be effective. As Goffee and Jones (2006) famously said, if you can't convincingly answer the question 'why should anyone be led by you?' then you have no legitimacy as a leader. In their book of the same title they suggest that authentic leadership involves 'being yourself, in context, with skill'. What this looks like and how it is enacted, of course, will be unique to each person and situation.

> 'Leadership is not a person or a position. It is a complex moral relationship between people, based on trust, obligation, commitment, emotion, and a shared vision of the good.' (Ciulla, 1998:1)

The complex nature of leadership and inclusion means that they cannot be understood or developed by a reductionist approach that treats the parts separately. Instead it is essential to take a holistic approach that recognises the inter-relationships and dynamics within and beyond the immediate point of focus. Where attempts are made to tackle issues in isolation they result in unintended outcomes elsewhere in the system. In a recent Harvard Business Review paper titled *Why diversity programs fail and what works better*, for example, Dobbin and Kalev (2016) point to the unintended consequences of interventions designed to encourage compliance, suggesting that people may react against them in order to assert a desire for autonomy. Based on data from more than 800 US companies, they conclude that interventions such as targeted recruitment, mentoring programs, self-managed teams and task forces tend to be more effective as they encourage existing managers to play a part in addressing the problem, increase their contact with minority

groups and promote social accountability (a desire to appear 'fair-minded'). Such interventions are integrated into everyday leadership practice rather than treated as separate stand-alone activities.

Ron Heifetz and colleagues, as mentioned in Chapter 3, describe leadership as: 'the practice of mobilizing people to tackle tough challenges and thrive' (Heifetz *et al*., 2009: 14). Their notion of ***thriving*** is informed by evolutionary biology and identifies the following three key characteristics of successful adaptation: '(1) it preserves the DNA essential for the species' continued survival; (2) it discards (reregulates

> 'Honoring the reality that adaptive processes will be accompanied by distress means having compassion for the pain that comes with deep change. Distress may come with the territory of change, but from a strategic perspective, disturbing people is not the point or the purpose, but a consequence. The purpose is to make progress on a tough collective challenge.' (Heifetz et al., 2009: 29)

or rearranges) the DNA that no longer serves the species' current needs; and (3) it creates DNA arrangements that give the species' the ability to flourish in new ways and in more challenging environments' (*ibid*: 14). Such change, they observe, will inevitably be experienced as difficult and disruptive, yet is necessary in order to make genuine progress on adaptive challenges (wicked problems). Challenging long held beliefs, working practices and privilege requires leaders to be resilient, to support others coping with uncertainty and anxiety, and to hold them and the organisation to account for delivering change.

The evidence summarised in this report points to the close relationship between leadership and organisation development and the need to

develop collective capacity to collaborate and influence across boundaries. Inclusive leadership by definition should enable this to come about.

7.2 KEY THEMES

A number of themes emerge from this review that are of central significance when considering how to mobilise a step change in diversity and inclusion in the NHS yet are rarely explicitly considered in current interventions. These are summarised below and inform the recommendations in the next section.

1. **Identity** – this is a multi-faceted concept that incorporates both physical and non-physical attributes. Whilst equality and diversity initiatives typically focus on single characteristics (e.g. gender, race, sexuality, disability) evidence indicates that the ways in which different aspects of identity interact (a concept referred to as ***intersectionality***) has a significant impact on the extent to which particular individuals and/or groups are marginalised or excluded. Other important aspects of identity that are often overlooked include ***social identity*** (the extent to which someone regards themself and/or is regarded by others as a member of a particular social group) and ***identity work*** (whereby people work through and experiment with different aspects of identity, including that of 'leader').

2. **Lived experience** - this refers to the diversity of experience that people may encounter as a consequence of their identity, and how they interpret these experiences. Within an environment that advantages one group over another it is quite possible for those in positions of privilege to be unaware of the extent of discrimination,

oppression and/or abuse encountered by those from marginalised groups, or for them to rationalise these acts/experiences as something else. Valuing lived experience draws attention to the ***plurality of perspectives*** on different issues and encourages ***giving voice*** to those from marginalised groups.

3. **Emotion** – inequality and discrimination are highly emotive issues. Whilst attention may be given to supporting and building the resilience of those on the receiving end, far greater attention could be given to creating environments where those in non-marginalised positions can engage in challenging conversations/experiences around race, gender, sexuality and other aspects of diversity. This requires careful ***facilitation*** that provides the necessary ***psychological safety***, privacy and containment for people to engage at a sufficiently deep level to bring about enduring transformative change.

4. **Complexity** – the complex nature of both inclusion and leadership requires careful attention to the ***context*** in which they are embedded. The evidence from this review highlights the importance of taking a systemic approach that recognises the interconnections and interdependencies between aspects of the wider system and the likely knock on effects of any intervention. From a complexity perspective, leadership is not about command and control but of facilitating ***emergence***, triggering ***leverage points*** for change and fostering ***systems thinking***. Whilst a 'best practice' approach may be helpful in setting the parameters of what is expected, how this is achieved and manifested will vary significantly between contexts.

5. **Power** – whilst power is often considered to be an individual attribute, this review draws attention to the ways in which it is also embedded in organisational and social structures, processes and ways of thinking that advantage some people at the expense of others. It is rarely acknowledged that leadership is fundamentally about the exercise of power and that this can be done more or less responsibly. The focus on compassionate leadership within the NHS calls for a more inclusive, distributed and participative approach, which encourages a shift from ***power over*** to ***power with*** and ***power to***. The critical approaches described in this report emphasise the role of leadership and organisation development in exposing and critiquing dominant assumptions and developing a capacity for individual and collective ***critical thinking*** *and* ***reflection***. Considering the role of power, status and privilege can be particularly uncomfortable in a hierarchical and structured organisation such as the NHS, yet surfacing such tensions and assumptions is essential if we are to mobilise a more inclusive approach.

6. **Sensemaking** – across the NHS certain forms of evidence tend to be given precedence over others (for example, financial data takes precedence over equalities data, quantitative data takes precedence over qualitative stories of lived experience). In order to tackle ***wicked issues*** such as inclusion we need to synthesise multiple sources of data in order to build a rich picture and support fresh insight. In complex contexts the art of questioning is crucial in fostering different kinds of conversation, developing a shared sense of purpose and mobilising collective action. Within this process leadership is about ***(re)framing*** the question(s) and

convening appropriate groups of people to consider potential responses rather than about identifying and implementing a 'solution'. Such an approach is dependent on developing a ***compelling narrative*** and building commitment to a shared direction of travel.

7. **Ethics** – diversity and inclusion initiatives often focus on the legal and/or business case for change. Whilst these are not unimportant they are only ever likely to engender grudging compliance and/or weigh this up against other priorities. The ***moral case*** for tackling inequality and building inclusion is far more compelling and potentially inspiring, yet requires people to buy into a shared set of ***values***. This is a challenging objective and calls for wide scale ***culture change*** throughout the entire organisation rather than one-off stand-alone interventions. Our findings suggest there is a major opportunity for the NHS to review and re-establish its social contract in the light of inclusion and service improvement in order to deliver on its original promise of equal access and fair treatment for all.

8. **Collaborative Inquiry** – finally, this review demonstrates the importance of actively engaging those impacted by changes in developing and implementing the change process. Too many change initiatives are top down and seen as someone else's responsibility. An ***appreciative approach*** can be effective in focusing attention on what is working and how it could be broadened out, rather than focusing solely on areas of deficit. Given the need to contextualise and embed learning, an ***action research*** approach can be effective in mobilising feedback loops and experiential learning.

By highlighting these themes were are not denigrating the contribution of approaches based on other principles but drawing attention to the need to extend the reach and depth of inclusion initiatives to touch hearts as well as minds. It is unlikely that any single initiative will incorporate all of these aspects but by working systemically and in collaboration with others there is a greater chance of enduring positive change.

7.3 RECOMMENDATIONS

Whilst much of this report has addressed broader conceptual issues around leadership, leadership development and inclusion there are a number of practical recommendations that arise from this work. The following points highlight a number of key recommendations (in no particular order) for the NHS Leadership Academy to consider as it implements a strategic approach to Building Leadership for Inclusion.

1. **Create genuine opportunities to engage with and share lived experience** – this will involve creating facilitated spaces for challenging, honest conversations around race, gender, disability, LGBT+ and other protected characteristics. Whilst there is likely to be a need for some closed-group discussions around particular issues there also needs to be opportunity for exchange and interaction *across* different identity groups (including white, male, heterosexual, etc.) where issues of intersectionality, similarity and difference can be explored.

2. **Engage with those in positions of power and privilege** – whilst many diversity initiatives focus on marginalised individuals (such as the NHS LA positive action programmes *Stepping Up* and *Ready Now*) unless ways can be found to build the commitment of senior individuals and those without protected characteristics

engagement will be limited. Inclusion needs to be considered a mainstream issue, with active buy-in from leaders at all levels.

3. **Identify, connect and support key allies and sponsors** – active role modelling and senior-level endorsement is essential for initiatives such as this. We suggest that BLFI identifies influential allies, sponsors and champions from across and beyond the NHS who can champion the work on leadership and inclusion, act as role models and hold others to account where they fall short of expected standards. Through developing a network of key influencers they will be able to operate a support network for one another during times of adversity, as well as sharing good practice, resources and advice.

4. **Treat ED&I as a wicked/complex issue** – rather than taking a reductionist approach that separates equality, diversity and inclusion into component parts each with their own interventions, we suggest an integrated approach that recognises the complexity of these issues and the need to mobilise an emergent process to address them. In a complex system there is 'no blueprint, just rules of thumb' (Flinn, 2018) and a continuing need to adapt as situations evolve and change.

5. **Focus on culture and relationships** – individualistic approaches to leadership and inclusion pay insufficient attention to the quality of conversations, patterns of relationships, social capital and development of shared value. The majority of those who work in public service and particularly the NHS do so because they care about what they do and the services they provide – this is untapped energy and motivation that, according to the *NHS Family*

and Friends and Staff Satisfaction Survey, is currently being squandered. There is a real need to rebuild trust as the basis not just for inclusion, but for organisational learning. This is highly likely to create multiple advantageous synergies. On the basis of the evidence in this review we encourage the NHS to consider how it articulates and communicates its goals and objectives around equality, diversity and inclusion and the ways in which it captures and makes use of the value it creates.

6. **Stimulate and encourage people to engage with a compelling narrative** – in a context where NHS employees are continually assessed against multiple (and sometimes competing) metrics and priorities it is essential to articulate a clear and compelling narrative about where/how diversity, inclusion and leadership fit within this. Drawing on insights from Ganz's (2010) work on public narrative – the story of self, us and now – it is important that individuals and groups (from all backgrounds) are given opportunities to connect their own stories and aspirations to the wider narrative of change.

7. **Take a practice-based approach to trial and experimentation** – whilst many diversity and inclusion initiatives are based on the application of 'best practice' and/or the implementation of legal/regulatory frameworks BLFI is endeavouring to mobilise transformative change in attitudes towards and experiences of inequality and discrimination in ways that has not been done before. This would suggest that an action research approach, which incorporates opportunities for feedback, reflection and learning, would be well suited to work at all levels across the system. Collaborative inquiry, co-production and appreciative

inquiry will also be key elements in building the engagement and tapping into the knowledge, expertise and lived experience of those involved.

8. **Triangulate a range of data sources to inform interventions, strategy and evaluation** – there are a wide range of sources of data and evidence to inform ED&I interventions yet many of these are not integrated and frequently not used to inform interventions. We recommend that in planning and developing interventions in pilot sites (and beyond) BLFI reviews available data sources and how they can be triangulated to give a more nuanced understanding of diversity and intersectionality in specific local contexts. There is also considerable scope for NHS Boards, and for senior leaders to review the potential for data syntheses that will facilitate fresh insights into inclusion, quality, institutional performance and indeed systems leadership beyond the confines of the NHS.

9. **Build accountability, engagement and ownership of ED&I across the whole system** – BLFI does not operate in isolation and needs to find ways to effectively link with and complement other diversity, inclusion and leadership initiatives across the NHS and beyond. Drawing on Myron's Maxims (outlined in section 4.4) a key feature of systems change is to 'Keep connecting the system to more of itself' (Rogers, 2015) – in this way each initiative that seeks to create a more equal, diverse and inclusive NHS can be seen as part of a broader social movement.

10. **Promote collaboration and equal representation across all activities** – to genuinely model inclusive practice BLFI should

ensure diversity and equality of representation across all of its activities and to actively encourage partners to follow suit. It is not sufficient to have token representation from minority groups. BLFI should set minimum standards for recruitment, staffing and other areas of activity and to be prepared to make a stand where this is not met, in much the same way as Sarah-Jane Marsh, Chief Executive of Birmingham Women's & Children's NHS Trust, did when she recently announced that she would no longer sit on an interview panel that did not have BAME representation (Sky News, 2018). BLFI also has an important role to play in reviewing leadership development, OD and HR processes, systems, and structures and processes to ensure they embed and deliver on inclusion.

7.4 A Final Word

This report has drawn together a wide range of sources of evidence on leadership and inclusion in order to provide insights into how the NHS might facilitate a transformative shift in diversity at senior leadership levels and to embed inclusion across the entire health and social care system. What is included is simply the tip of the iceberg and we hope you will follow up the references and resources cited to find out more. Addressing inequality, transforming systems and mobilising culture change is challenging and tiring work. The barriers to achieving genuine equality, diversity and inclusion are deeply entrenched and, as those who attempt to implement change often find out, ‘hierarchical organisations can be resistant to change, and proficient at spitting out those who attempt to initiate it’ (Uhl-Bien and Arena, 2017:14). The NHS Leadership Academy’s *Building Leadership for Inclusion* programme of work is an ambitious response to the challenges of mobilising lasting

improvements in the experiences of its entire workforce and those it serves. This is no small undertaking, however as the poet, author and performer Salena Godden argues ‘pessimism is for lightweights’ (Godden, 2018) – optimism, hope and compassion are a powerful antidote to the apathy, alienation and oppression still experienced on a day-to-day basis by far too many people. We hope that this review will be a helpful companion for those embarking on the difficult path ahead and a powerful reminder of contribution everyone can make to ensuring the NHS fulfils its promise as ‘a comprehensive service, available to all’, with ‘a wider social duty to promote equality through the services it provides’ (NHS Constitution, 2015).

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APPENDIX 1: METHODOLOGY FOR THIS REVIEW

This review was conducted between April 2017-July 2018 by researchers at the University of the West of England (UWE). The team comprised of inter-disciplinary experts, with specialisms ranging from law, leadership and organisational development to data analysis, marketing, social work, gender studies and action research.

Following initial discussions between the Building Leadership for Inclusion (BLFI) team and the UWE research team, key themes and literature were identified. Members of the UWE team were interviewed to capture key insights from their academic and professional expertise, but also to ensure critical and transparent awareness of the inevitable gaps and biases that arise in any appreciation and curation of knowledge. Following an analysis of the UWE team's interviews a number of external experts were selected for interview based upon assessed blind spots and availability[24].

Interviews were transcribed and used to generate themes for further exploration. These themes informed the initial framework of the literature review, which was later developed into the synthesis report presented. Unfortunately, due to space limitations, not all themes are explored in depth within this report, but it is intended that others will be explored further within subsequent 'thought pieces' to support the work of BLFI moving forward.

[24] We acknowledge practical limitations of the scope of these interviews, which meant that despite inviting experts in race and ethnicity to contribute they were unavailable. We did, however, engage with this literature through the desk-review and engagement with the BLFI programme team and facilitators.

The preliminary stages of the review were carried out by reviewing academic, NHS and external literature on the topics of inclusion, diversity and leadership, with particular attention given to NHS focused literature and the external sources cited within it. Literature identified by experts and highlighted within key NHS publications was used to 'snowball' further readings.

The key terms of inclusion, inclusive leadership, diversity and leadership were used in combination to explore the online library at UWE, together with Internet searches, which drew on a combination of UK and international academic and practitioner sources on systems leadership and inclusion. In particular, we sought to locate current best practices in leadership and transformational change that promote equality and inclusion and address inequality.

The diversity of the UWE team and experts interviewed resulted in a cross-disciplinary population of literature from fields of leadership and organisation studies, human resource management, public administration, marketing, social work, social psychology, political economics and sociology, to name but a few. In order to broaden the scope and to encourage a holistic consideration of diverse perspectives particular effort was made to identify authors who used their 'lived experience' of inclusion and diversity to inform their writing. Furthermore, attempts were made to highlight the work of non-western authors, and authors of historic significance in the fields of race, gender, sexuality and disability.

Following the creation of the first draft of this literature review, the BLFI team and partner facilitators were invited to give feedback and these comments were into later versions. The UWE team also engaged closely

with the BLFI team and facilitators at a series of development sessions, through which additional sources that informed their professional practice were identified and included.

The scale of initial drafts reflected the breadth of thought and interest in this emotive and complex topic. Whilst the final synthesis of the literature remains substantive a large proportion of material, case studies and extracts from expert interviews has been removed in order to make it more focused. The challenge and complexity of drafting this literature review, which combined the thoughts and opinions of a wide array of individuals with diverse personal and professional lived experience, reflects the complexity of the subject and the emotive nature of this subject as a whole.

As highlighted within this review the field of leadership and management studies tends not to be particularly inclusive or diverse. Whilst considerable effort has been made to draw on a wide range of sources, it is likely that to some extent the content and authorship reflects existing biases within the field.

This review does not claim to be representative of all persons or disciplines but does, at least, aim to provide a broad overview of the field and important avenues for further enquiry. We greatly appreciate the suggestions and observations received from all parties throughout the period of compiling this literature review and believe they have considerably enhanced the final document.

UWE Bristol University of the West of England

Bristol Leadership and Change Centre
University of the West of England
ISBN 9781860435485