

# Releasing the potential within BME Networks



Royal College  
of Nursing  
London

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## About the authors

**Joan Saddler** is an independent consultant and trainer with a background in voluntary sector management and neighbourhood regeneration. Joan is also the Director of DDC, a research and development company specialising in equality and diversity. Joan brings her experience and management training together with her knowledge of whole systems health and social care interventions, to inform her NHS role as Chair of Waltham Forest Primary Care Trust in East London. She is currently a member of the NHS Confederation Council, and Chair of the NHS Confederation and the RCN BME Leadership Forum. Joan is an advisor on various Department of Health reference groups having also recently completed her role as a member of the external panel for the reconfiguration of health services in England.

**Community Investors Development Agency (CIDA)** is a strategic development agency working with local people to help provide the foundations necessary for the effective and sustained transformation of local communities. CIDA's research, publishing and information service aims to provide greater awareness of information as a valuable resource. CIDA provides policy briefings and papers for central government departments, such as the Department of Trade and Industry and the Department of Health. One such report focuses on Disseminating health research-based information among local voluntary and community organisations [www.cidagroup.org](http://www.cidagroup.org)

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## Preface

I believe it was important for RCN London, the London Equality Network (LEN) and partners to support a conference aimed at exploring the contribution of Black and Minority Ethnic (BME) people to the success of healthcare delivery in the UK, and to commission this report to ensure more people than those who attended the conference could learn from those experiences.

I have always been convinced that the key to un-locking the potential of BME networks lies in the ability of individuals to collectively act towards a common goal in a sustained and progressive way. I am therefore pleased to be able to endorse this report arising from the collective conference recommendations of dedicated individuals providing health and social care services both within and outside the NHS.

I have benefited personally from the existence of positive and focused BME networks, and I, along with many of my RCN colleagues, am convinced of the benefit of such networks to the health service.

The report is divided into two parts, with Part 2 detailing the strategic health service context within which equality and diversity strategy can be developed. Part 1 of the report documents key conference findings and recommendations. As such, the information presented will be of interest to a range of people such as:

- Practitioners – who may recognise some of the challenges outlined within the report and also benefit from the strategies for success
- Managers – planning to establish, develop or review BME networks that might gain useful tools for a range of equality and diversity network operations.
- Health and social care leaders and decision-makers – planning strategic equality and diversity interventions within the health and public sector, reform and policy context.

Our work does not end with this report, as my RCN colleagues and I will not only continue to demonstrate our commitment and ‘belief’ in the equality and diversity agenda, but we will continue to implement best practice and to advocate on behalf of our members towards this aim.

**Bernell Bussue**

*Director, RCN London*

## Forward

The contribution of BME communities to the delivery of healthcare within the UK has been wide-ranging and significant. BME networks have facilitated such contributions from BME staff working within the public, independent, private, community and voluntary sectors. The publication of this report appears within a constantly changing landscape for the Royal College of Nursing and the wider National Health Service.

If we are to maintain the gains that we have made in engaging and supporting BME staff to deliver the right healthcare, at the right time, in the right places, to the right people, then we must rigorously review and champion such gains in order to ensure future positive progress. BME networks have a positive role to play in specifically ensuring that leadership trainees and graduates from programmes such as the NHS Institute’s Breaking Through Programme and the various NHS Management Training Schemes can receive support and leadership opportunities.

The report addresses equality and diversity issues within the framework of the wider NHS and the future direction for health services. BME networks can specifically connect with diversity at a people level, an organisational level and in shaping the development of policy within a constantly changing healthcare environment.

It was my privilege to Chair the RCN BME Networks Conference from which a range of conference recommendations are noted here. I would like to thank the RCN for their foresight in facilitating the conference and in documenting the valuable lessons that we can learn and place within the agenda of supporting the NHS workforce to deliver qualitative healthcare services for all communities.

**John Batchelor**

*National Programme Lead for the Breaking Through Programme NHS Institute*

## Executive summary

With the opportunity for providing new pathways of care within a changing NHS, the benefit of framing equality and diversity issues to fit within strategic regional centres cannot be overemphasised. BME networks can make sense of the care and policy environment by translating policy into practice and vice versa.

Recognition of, and respect for, diversity among staff can better equip the NHS and its partners to improve health in partnership with, and provide appropriate and effective services to, a diverse public. The growth of BME networks involving nurses, managers and other staff are an important part of this. This becomes even more apparent with the need for NHS organisations to develop corporate boards with each member fully recognising their corporate responsibilities. BME non-executive members also have access to BME networks. They can add value by ensuring that equality and diversity areas are governed to high standards, particularly with regard to the necessary regulatory standards.

Visible, top-level commitment to nurturing equality and diversity is important, and can help the NHS and other employers in the health field to comply with legislation and public policy, improve their public image, and recruit and retain talented and motivated staff from different backgrounds.

Documenting, examining and sharing information on the experience of BME networks is important not only for their development but also more generally for promoting other forms of equality in the NHS, and among other health and social care commissioners and providers.

Both the commissioning agenda, and patient and public involvement guidelines linked to commissioning, can strengthen one of the central NHS targets of reducing health inequalities. For those engaged in developing and maintaining BME networks, building alliances within and beyond the health service can help to advance the agenda of greater equality, health and social care commissioning, planning and provision which are truly suited to the 21st century.

# Introduction

What is the contribution of Black and Minority Ethnic (BME) networks to the modernisation of the NHS? There is a need to evaluate the impact of such networks upon NHS organisations, the stated aims of which are given in the Improving Working Lives<sup>1</sup> BME Staff Networks Guidance. This report will present a number of key themes that include establishing developing and sustaining BME networks. Such networks can effectively network across health and social care organisations, contributing to the future delivery of NHS services.

In October 2005, the London Region of the Royal College of Nursing (RCN) organised a conference titled *Releasing the Potential within BME Networks*. Organised in response to a growing need as identified through soft and formal RCN member intelligence, the conference aimed to:

- Focus on realising and releasing the potential within BME networks
- Recognise BME networks as a conduit for enhancing the transfer of knowledge and the development of member skills
- Encourage the utilisation of BME networks with the primary goal of contributing to NHS service improvements for all.

A specific piece of work was also requested by the conference steering group from the NHS London Race Equality Group (LREG) in order to ascertain the number of active BME Networks within London NHS Trusts.

In successfully attracting high-level contributions from a range of nursing, clinical and managerial staff including NHS executives, non-executives and speakers from other sectors, conference recommendations focused on:

- Endorsing BME networks as critical change agents and innovation hubs
- Recognising the need to sustain and develop BME networks within the equality and diversity agendas
- Ensuring that a conference report was circulated, with a focus on disseminating good practice programmes and key conference messages within the wider NHS.

It is within this framework that the RCN London BME Networks Report is presented. The report is underpinned by conference findings as well as wider policy developments within the NHS. It is crucial that the context for the report clearly outlines both the background and the present NHS policy context within which equality and diversity issues sit.

Part 1 of the report is divided into four sections detailing:

- i. Background context
- ii. Key conference messages
- iii. Examples of best practice when establishing and sustaining BME networks
- iv. Findings from the London NHS BME networks survey

Part 2 of the report presents a broad overview and analysis of equality and diversity issues, and the consideration of such within key mainstream NHS policies. The report concludes with a number of recommendations for the future.

## Part one

# 1 Context

The contribution of BME networks to the development of health services within the UK has been somewhat understated, although in recent years this contribution has begun to be documented in a number of ways:

- RCN<sup>2</sup> archives
- The Mary Seacole Centre for Excellence<sup>3</sup>
- Department of Health (DH) Equality and Human Rights Department<sup>4</sup>
- The King's Fund<sup>5</sup>

BME networks have helped to shape past and current health service delivery across race and other diversities' areas. It is within this context that a focus on changes within the future health service policy environment is presented here with a view to first understanding mainstream service delivery and then placing BME networking opportunities and challenges within this context. References to key policy initiatives in this section are covered in detail in Part 2 of the report.

## 1.1 Delivering health services

“The NHS has to move away from being a set of Organisations and towards being a brand which funds comprehensive healthcare free at the point of need”

Sir Ian Carruthers, Health Service Journal (HSJ)<sup>6</sup> June 2005

### Systems change

It can be said that the NHS has undergone an unprecedented period of systems reform since the launch of the NHS Plan, a ten-year strategy for health service modernisation and change<sup>7</sup>. Key emerging themes emphasise:

- Strengthening commissioning with levers such as Payment by Results and Practice Based Commissioning
- Contestability and Choice effectively separating both the commissioning and provision of services, where in the past both services were essentially delivered by single organisations
- The integration of health services with social care and other public services as underpinned by overarching

public sector reform principles

- Whole systems planning and provision as facilitated through increased multi-agency partnerships and joint planning arrangements
- Holistic care as opposed to care in silos
- Putting the patient at the centre of care

### Delivery of care

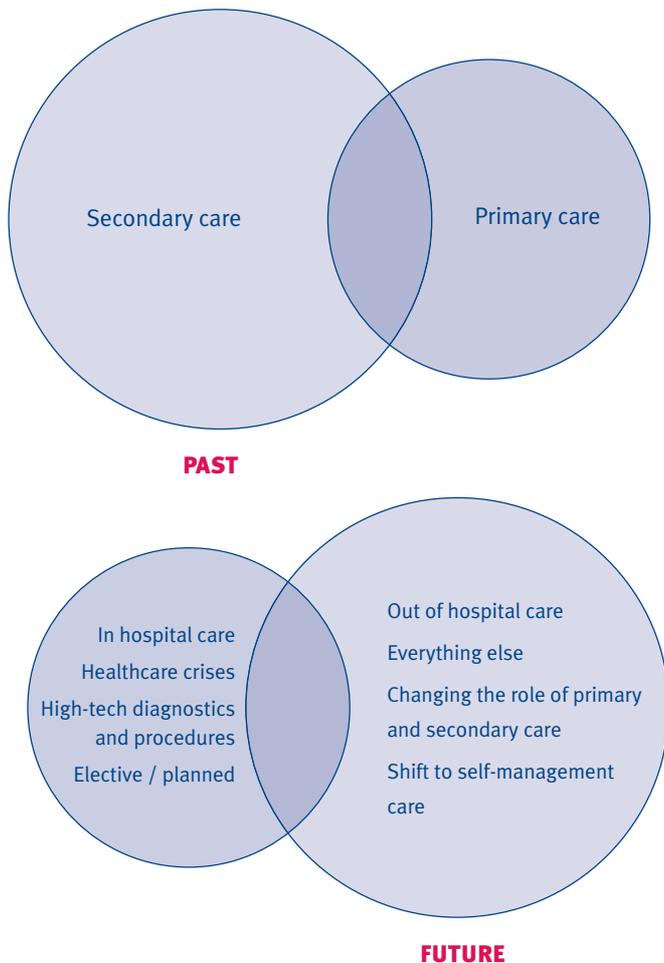
Additionally critical policy shifts have emerged in considering the way that care will be delivered for the future.

- Emergency care will continue to be delivered as a crisis service from a range of Trusts that are being encouraged to become Foundation Trusts
- Long-term conditions will have much more of a focus, with clinical staff increasingly working in multi-agency teams in order to offer holistic care to patients with complex and long-term needs
- Planned care will be managed more effectively across the system
- Independence and self care will be actively facilitated and supported
- A more proactive approach will be taken towards the prevention of ill health.

The Out of Hospital White Paper (2006) identified changes for both hospital and out of hospital care. The changing balance of health care is represented within the diagram on page 7.

Current NHS and public sector reforms emphasise efficiency and value for money. Health and social care regulatory frameworks seek to balance a range of qualitative benchmarks with the effective use of resources that should include finance as a part of such NHS resources requiring regulation. However financial management and regulation currently receive much more focus than other core operational areas. Additionally equality, diversity and human rights issues tend to sit somewhat outside of the reform agenda, despite the critical links to core areas such as public health, and patient and public involvement.

## CHANGING THE ROLE OF PRIMARY AND SECONDARY CARE



Not only is the NHS rapidly changing but also it is, and has been, the embodiment of constant organisational change. Unless the equality, diversity and human rights agenda is aligned to such long-term organisational and cultural change, there remains a key risk to considering the critical importance of this area within the mainstream. Networks help to form spaces within which to ‘knit’ both policy and the reality of practice together.

The next section outlines the way in which BME networks can effectively contribute to organisational change and the NHS as a whole.

## 2. Conference messages

### Releasing the potential within BME Networks

#### 2.1 Tapping into unconventional wisdom

Dr Nola Ishmael OBE offers an overview of the historical context within which NHS BME networks have evolved. She provides both a formal and informal cultural and policy perspective that has shaped the development of BME networks.

*‘The historical development of BME networks should be used as a basis for future planning’ (Ishmael 2006)*

*‘I was wary of joining a BME staff network due to the negative ways in which such networks can be viewed by colleagues. I had been struggling with my personal development plan and was not clear as to what to do next in my career. Getting involved with the network allowed me to hear from BME staff who had been able to identify training opportunities and who had shadowed other staff members. My manager also helped especially when our network was endorsed by the Board’*

##### *Health Visitor*

Various historical drivers have helped to shape the development of BME networks within the NHS and the public sector at large. They include the following:

Drivers that have helped to shape the development of BME networks

- The Old Boys network
- In-house volunteering
- Corporate networks
- Forums, Clubs, Groups and Inner Circles
- Common interests links
- Getting past ‘hello’ and making the first move – The Business Card
- Involvement by necessity.

Such drivers here have been largely exclusionary and they

## Part one

have helped to shape the response of BME Networks to such exclusionary practice. Within the primary development phase, BME Networks must focus on short-term and long-term aims within an equal opportunities framework. These include a specific focus on:

- Basic Equal Opportunities for ALL
- Further development of the equal opportunities framework
- An emerging focus on Difference that can flexibly respond to change
- Mainstreaming diversity in order to be a positive part of the mainstream NHS agenda

Some key issues for BME networks are listed below:

- The **recognition** of BME staff having given much to the NHS is as crucial as BME staff celebrating their pride in the NHS. BME Networks must ensure that they are a part of mainstream celebrations of the NHS.
- BME networks also have a critical role to play in **documenting information** at both a practical and strategic level. The commissioning and publication of primary and secondary research can be an important information resource for the NHS and the public sector.
- It is important to **recognise the voice of BME network members**, particularly those who have experienced negative and destructive experiences. However it is just as important to ensure that a clear programme of work is developed for the network that focuses on positive service changes for both staff and the public.
- The **historical development of BME networks** should be taken into account when considering the development of wider equality and diversity networks.

A number of key challenges also present themselves to BME networks. It is useful to be aware of them in order to prepare a positive way forward as a network, should such difficulties arise.

Network challenges and possible solutions

- Staff shortages may largely reduce the ability of BME staff and staff in general to attend network meetings or events
- Affirming available talent within the organisation and working in teams
- Shifting the balance of promotion in order for increased

numbers of BME staff into management positions to be secured

- Valuing the contributions of BME staff
- Rewarding competence and expertise in a transparent and open way for BME staff and staff in general.

In discussing the five main uses of a network, Ishmael specifically outlines the key challenge of focusing the work of the group. She states that “it is important to note that networks operate well where the member body is facilitated either individually or as a whole to influence practical change, or to influence strategic direction”

(See Appendix 1)

### The Blossoming of BME Networks in the NHS 2000-2005

Some key policy drivers have assisted the establishment of BME Networks (See Appendix 2)

One such policy, giving rise to an increased number of BME networks within the last four years, was the Improving Working Lives: BME Staff Networks Guidance/ 2001. The guidance required NHS Trusts to:

- Confirm organisational commitment to establishing BME networks
- Recognise the benefits of BME networks within the wider workforce and service delivery strategy of the Trust
- Recognise the ‘value-addedness’ of BME networks which could become organisational hubs that assist with decision making
- Networks could also become a source of creativity, information and direction
- Recognise staff empowerment as an important resource

As well as DH commitment to the development of BME networks in all NHS Trusts, such commitment was matched with financial resources and also DH guidance being issued at Trust Board level. Although not a large amount, the commitment to financial support and ‘top team’ commitment to the agenda became a force for change. These are outlined below:

- £1 million made available to pump into prime start-up costs for BME Networks
- Ministerial commitment to the initiative

- The requirement for Trusts to deliver BME networks as a part of the Improving Working Lives (IWL) Standard
- Workforce Development Confederations that spearheaded support to initiate BME networks
- Trust Board support and endorsement of BME networks
- The Race Relations Amendment Act 2000 where Race Equality Schemes were required from all Trusts and other public sector bodies
- The expectation and performance management functions of Strategic Health Authorities that all Trusts would deliver on this agenda
- A focus on Continuing Professional Development for all staff, which was closely linked with IWL
- Sir Nigel Crisp's *10-Point Plan for Race Equality*, where workforce and service delivery objectives were outlined (See Appendix 3)

BME staff have been made aware of the tangible benefits that can be gained from membership of, and contribution to, networks. Some staff have gained recognition and visibility as a consequence of their involvement with BME networks. For others, confidence has surged and soared. It is clear that BME staff can perform in a range of different settings when development and training are part of the package.

The blossoming of BME Networks in the NHS has uncovered a number of additional individual and organisational benefits:

- Developing a culture of helping others to experience learning, growth and an increasing influence
- Lessening feelings of frustration and failure
- Increasing visibility, audibility and fluency leading to a new reality – promotion and the ability to positively shape services
- Developing a culture of nurturing and reciprocal dignity
- Viewing networks as systems that can reduce resentment from BME staff.

#### Constraints and concerns

- Not everyone wants to be part of a BME Network. Some fear the identity a BME Network brings and this position should be respected
- Networks should not fall into the trap of avoidance – the art of doing nothing, choosing to excuse and exclude
- Neither should networks capitulate, surrender, give in or give up
- Networks should, sensitively and firmly, balance and facilitate the potentially vocal clarity that may be required on perspectives of disrespect and unfairness as well as perspectives of loss, threat and being passed over
- Networks should be prepared for the need to work with members with a range of perspectives
- Networks should consider a range of options and not be constrained with negative singular options

Finally Ishmael outlines the aims, goals & intentions of BME networks:

- To demonstrate commitment and leadership
- To bring about a sea change in organisations and attitudes where necessary
- To consider the meaning and impact of institutional racism
- To assist in ways to change negative deep seated corporate and societal mindsets

#### REMEMBER

- What you do for others is an *Investment* that will pay *Dividends* in the Future
- Nurture the perception of yourself as someone who can do things, someone who has access and someone who can get things done
- Tap into the Unconventional Wisdom that abounds in your Network

## Part one

### Key points

- Exclusionary practice has helped to shape the positive development of BME networks
- BME networks can develop a culture of inclusion whilst recognising and celebrating staff members
- BME networks have a crucial role to play in documenting information
- The historical development of BME networks should be taken into account when considering the development of wider equality and diversities' networks.
- Networks should be focused on influencing change
- Top team commitment is central to achieving change
- BME staff have been made aware of the tangible benefits that can be gained from membership of and contribution to Networks.

## 2.2 Learning from public sector BME Networks

### The National Black Police Association (NBPA)

David McFarlane is the National Coordinator for the NBPA. His unequivocal presentation about the damage that racism and disrespect for human rights can cause was presented at the conference. The presentation covered the development of BME network aims, objectives and governance issues outside of the NHS. David also outlined the steps taken by the association to ensure that the recommendations of the Stephen Lawrence report are implemented and that network members own and develop both national and local Black Police Association (BPA) networks.

'We must begin changing the way we approach training on Race and Diversity... A chain is only as strong as its weakest link. We must stop this idiotic approach to communicate with our community only when there is a crisis. To be perfectly brutal, we cannot solve crimes in the 21st century without a harmonised and good relationship with all sections of the community we serve'

### History of the NBPA

The first Black Officers in the UK joined up in the post-war

period during the 1950s and 60s. Those who had served in the war were the first recruits, and they were soon joined by the emergence of migrants from the Caribbean who had responded to the call from Britain for opportunities to work.

The experiences of BME officers were often rife with unmasked racism. Officers have described graphically the various monkey taunts and isolationist tactics used by fellow white officers both at that time, and up until more recent times. As there were few BME officers in the force, individuals suffered in silence or left the force.

### A personal journey

'I think the time has come for us to try and do something new to redress the issues concerning racism in the police service. Whilst I have to admit there has been some progress, it is not nearly enough to make the difference that some of us are yearning for. I have visited police forces, training centres and seminars and have felt the pain of my colleagues, in particular women of colour.

Let me ask you this simple question, what is 'Racism' and why do we find it so hard to eliminate it from the police service let alone from the human heart?... its legacy is still stifling the progression of some of us to improve the British police service.

I was introduced to a book (and I am very pleased to have met the author), entitled *The Isis Papers: The Keys to the Colours* written by Dr Frances Cress Welsing, an African-American sister who studied psychiatry in Washington, D.C., USA. She defined Racism as "the local and global power system structured and maintained by persons who classify themselves as white, whether consciously or subconsciously determined".

This definition has placed matters in perspective and gives some new leads to explore in order to begin the enormous task of deconstructing the mindset and the re-education of our understanding of what we are dealing with. My theory will no doubt cause some consternation. But if we are truly the peacemakers that we ought to be, then we have to be open-minded to find the answer to a complex issue that has de-skilled our staff and terrified sections of our communities for years. We must begin changing the way we approach training on Race and Diversity. The Commission for Racial Equality has alluded to this when its chairman referred to this as helping to get rid of the very people we are trying to recruit and to retain.

*David McFarlane*

An outline of the development and mission of the NBPA was then presented that included mapping a national network development period from 1990 to 1998 (See Appendix 4).

#### NBPA Cabinet

The governance structure of the NBPA is the cabinet, which comprises a full team of officers as follows:

President

Two vice-presidents

General Secretary

Deputy General Secretary

Treasurer/ Deputy Treasurer

Events Coordinator / Deputy Coordinator

Training and Development Coordinator

Sponsorship Coordinator

Metropolitan Police reserve position.

The NBPA ensures that it uses clear definitions for membership eligibility as well as explaining the different levels of membership.

The definition of 'black' is one that emphasises the common experience and determination of people of African, African-Caribbean, Middle Eastern, Asian or Asian sub-continent origin to oppose the effects of racism and victimisation. Members can join a local BPA, which then becomes a part of the NBPA network. Associate BPA members are also welcome from a range of services and representative bodies.

The objects of the National Black Police Association are to promote good race relations and equality of opportunity within the police services of the United Kingdom and the wider community. The NBPA plans to achieve its aims by:

- **Representing** the views of all representative members of constituted Black Police Associations (herein known as BPAs) who are affiliated to the NBPA.
- Providing a **support** to local BPAs.
- **Influencing** the direction of policies nationally in line with equality issues and anti-discrimination policies in the Police Service and wider Criminal Justice System.
- **Advising** and consulting on matters of racism and nationality.

- Working towards **improving relationships** between the Police and the minority ethnic communities of the United Kingdom.
- Working towards **improving recruitment**, retention and progression of staff members within the Police Service.
- Assisting the Police Service in the development of new and existing policies, where necessary.
- **Establishing relationships** and working with other groups and individuals whose aims are compatible with or supportive of the NBPA.

The aims and objectives of the NBPA are focused and realistic with clear expectations. The association aims to represent, influence, advise and improve internal and external relationships towards achieving their aims, Specifically they aim to *influence the direction of policies nationally in line with equality issues and anti-discrimination policies.*

#### Continuing the journey.....

It is crucial that you have community support. If there's a time when we need to re-establish community policing, that time must surely be now. It baffles the brain at times when, as law enforcers, we think we can tackle modern crime by the "good old Sweeney methods". This might seem all meaningless, but a serious implication has to be noted. It is this macho culture and sheer ignorance that has left our communities feeling that the police service is not part of them.

It took the government six long years to finally decide to implement Recommendation 61 of the Stephen Lawrence enquiry, the recording of stop and account. Then, I had the pleasure of visiting police stations around the country to hear directly from officers about their thoughts. Let us just say that the practical implementation was not met with joy and happiness. Here was an opportunity to interact positively with the community and again it is seen as political correctness gone mad.

A chain is only as strong as its weakest link. We must stop this idiotic approach to communicate with our community only when there is a crisis. To be perfectly brutal, we cannot solve crimes in the 21st century without a harmonised and good relationship with all sections of the community we serve.

*David McFarlane*

## Part one

### Key points

- BME networks outside the NHS have developed from a baseline of exclusion
- Some networks are governed with formal structures and well resourced teams
- Clear membership rules and focused and strategic objectives will assist the network and key organisational and external stakeholders
- The NBPA has a specific aim to ‘influence the direction of policies nationally in line with equality issues and anti-discrimination policies’.

‘As the head of the NHS in the UK, Sir Nigel Crisp’s commitment to the equality and diversity agenda was unequivocal. I hope that such commitment is kept at the top of the organisation in order to inform policy and practical service delivery from the top down. As a lead member of a BME network, I have been able to show how much I have to offer the NHS by commenting on key Trust policies and getting a secondment to another part of the organisation’

*Assistant Director*

## 2.3 The RCN’s Equality & Diversity Strategy

Wendy Irwin is the RCN Equality and Diversity Coordinator. She presented a brief overview of the RCN’s corporate diversity and equality strategy that provides clear and strategic priorities about equality and diversity as well as measuring specific outcomes and outputs. The RCN’s ‘belief’ in the strategy is clearly defined:

‘The RCN believes that championing the implementation of equality of opportunity and actively valuing diversity leads to stronger and more positive outcomes for nursing and nurses and ultimately for patient care’ (RCN Equality & Diversity Strategy 2005)

‘As a nurse I experienced difficulty in trying to have our collective voices heard. We would sometimes make suggestions to change services but these were never heard. If you had a problem with racism you were better off keeping it to yourself, as you would be targeted and moved as the troublemaker. I have seen BME networks make a difference, where together we are able to have dietary changes introduced to the Trust menu based on our experience and our collective voice’

Irwin began by outlining why the RCN needed an equality and diversity strategy:

“Overt or implicit discrimination violates one of the fundamental principles of human rights and often lies at the root of poor health status. Discrimination against ...marginalised groups in society both causes and magnifies poverty and ill-health.”

*World Health Organisation  
Health & Human Rights Publication Series  
Issue No 2. August 2001*

The RCN Strategic Plan 2003 – 2008 outlines the commitment ‘to supporting and protecting the value of nurses and nursing staff in all their diversity’. The organisation had previously identified the need for a strategy based on previous internal and external research findings as follows:

- The *Stepping Stones* programme showed that black and minority ethnic nurses were much less likely to feel that their current grade is appropriate to their role than white nurses.
- One in three BME nurses report experiencing racial harassment at work
- The Health & Safety at Work Executive (HSE) report identified the greater prevalence of stress and associated illnesses amongst BME nurses

As such, the equality and diversity strategy aims to address three dimensions of the RCN; as an employer; a trade union and professional body as well as a corporate citizen (RCN Equality & Diversity Strategy 2005)

### Equality and Diversity Vision

The RCN aims to deliver better results for members, RCN employees and ultimately improve patient care by placing valuing diversity and implementing equality of opportunity at the heart of the organisation. The strategy has six strategic themes where each theme is linked to the five key objectives of the RCN mission statement (to Represent, Influence, Support and Protect, Develop and Build – See Appendix 5)

The six themes of the RCN’s corporate strategy are prioritised and described as follows:

- Priority 1 – **Representation** – achieving a representative RCN for all
- Priority 2 – **Supporting and protecting** – Meeting our

legal and moral responsibilities for our members, our employees and our stakeholders

- Priority 3 – **Influence** – Leadership and influencing opportunities to be facilitated by the RCN for nurses to move into leadership positions on diversity and equality issues.
- Priority 4 – **Build** – effective service delivery by developing skills to carry out diversity impact assessments and also developing diversity champion roles
- Priority 5 – **Influence** – Connecting and communicating through internal and external forums and partnership structures
- Priority 6 – **Build** – performance and the journey to excellence through the creation of a diversity standard.

Measurable outcomes from the RCN strategy state that:

- By 2008 there will be no significant differences between or within groups based on their race, ethnicity, age, religion or belief, gender, sexuality or disability in terms of their satisfaction with the services provided by the RCN and in terms of their satisfaction with the RCN as an employer

Measurable outputs from the strategy confirm that:

- The RCN will build stronger partnerships with BME networks to get critical feedback on our effectiveness
- The RCN will implement a BME Nursing Strategy that addresses issues of institutional racism, discrimination and harassment.

The RCN has developed an equality and diversity work-plan that sets ambitions, measurable outcomes and outputs as underpinned by an equalities strategy placed within the mainstream organisational framework.

#### Key points

- Provide clear strategic priorities linked to the strategic business priorities of the organisation when developing an equality and diversity strategy
- Signal a belief in the value of diversity by placing it at the centre of the organisation
- Ensure that both outcomes and outputs are measurable

## 2.4 Supporting BME Networks

Terry Coode is the HR Director at Guys and St Thomas NHS Foundation Trust. Terry outlined the way in which the growth and support of the BME networks would assist the Trust in meeting strategic long-term objectives. High-level Trust commitment would also act as a lead in signalling support for additional diversity initiatives from the Trust as a model employer.

*'An active approach to Diversity (requires) top level commitment and scrutiny'*

*'I have had various clinical roles both within the NHS and within the private sector. I am now able to bring my experience to the Board as a NHS Non-Executive Director (NED). I support the Trust's equality and diversity strategy in the same way that I support other mainstream strategies. It's a part of the whole governance model and has to be taken as seriously as that'*

*NHS NED*

#### A snapshot of Guy's & St Thomas' NHS Trust

- We are a major London Teaching Hospital providing acute services to the multi-cultural communities of Lambeth and Southwark
- We are also one of the first wave NHS Foundation Trusts and it is important that our staff, governors and key stakeholders should have a high degree of affinity with the organisation
- We have 8,500 staff across the two hospital sites
- Nearly one-third, representing 31% of the overall workforce, is BME
- Some 130 languages are spoken in the two London Boroughs we serve
- The BME Network was established in 2003

The success of the network depends on there being clear terms of reference with Trust Board support for the work. The purpose of the network is to:

- Be a reference group on BME issues to the Trust
- Offer an environment for BME staff to learn and develop
- Provide advice on career development

## Part one

- Provide peer group support
- Provide BME role models
- Celebrate and promote success
- Discuss impact of issues affecting BME people
- Raise understanding of other cultures within the workforce

It is important that network actions are linked to the Trust's strategic plans with performance management set in place where possible. The Network is supported through:

- An active approach to Diversity
- Top level commitment and scrutiny
- Dedicating HR resources to diversity in employment
- Working collaboratively with staff-side representatives
- Monitoring the data (workforce, recruitment)
- Reviewing Policies and enforcing fairness
- Inducting and training our staff
- Raising awareness e.g. Mary Seacole celebrations
- Supporting mentoring schemes.

Supporting the BME Network structure includes:

- Regular meetings with the Network Chair
- Providing administrative support
- Facilitating supporting communications – e.g. intranet access
- Providing practical support for meetings & network development
- Pursuing joint working and staff engagement.

### **Why do we support and encourage BME Networks?**

- It demonstrates compliance with equal opportunities legislation
- It is morally correct and fair
- We wish to be a model employer
- It is positive for patient services
- It represents good business efficiency

- Supporting the BME Network helps us to develop our BME workforce and therefore to:

- Recruit from the multi-cultural communities we serve
- Employ a workforce with awareness of the many cultures represented by our patients
- Retain expertise and experience
- Develop our staff
- Engage and motivate a significant part of the workforce.

A range of workforce development initiatives can have a positive impact upon patient services as demonstrated through Trust support for BME networks. By synthesising the moral and business case for equity and diversity, Trusts can gain both internal organisational benefits as well as external benefits such as increased positive community perceptions of the Trust.

#### **Key points**

- An active approach to diversity is needed
- Trust board support is crucial for success
- It is important that network actions are linked to the Trust's strategic plans with performance management set in place where possible
- Trust's should adequately support and encourage BME networks

## **2.5 Black and Minority Ethnic Networks in North East London**

John Humphreys was Director of HR Strategy at North East London Strategic Health Authority until the organisation merged to form part of the new NHS London. John outlined the success of the SHA in supporting the development of BME staff networks across the region particularly in PCTs, Acute trusts and Mental Health trusts

*'Network members across North East London have specifically benefited from a range of regional and national development and leadership programmes'*

**An overview of North East London**

One third of the population of London belongs to an ethnic minority group. Additionally in Boroughs within North East London, BME communities range from 5% to 66% of the population with 48% of 5-19 year olds being from a BME community. 40% – 65% of the 30,000 staff in the sector are from BME communities and BME senior managers make up 31% of the senior managers across the sector.

The North East London Workforce Strategy places BME networks at the forefront by acknowledging that:

- Effective workforce planning and commissioning will lead to positive recruitment and staff retention of staff within innovative service delivery roles
- Pay modernisation linked to service modernisation can contribute to retaining staff teams who provide continuity of care
- Recruitment and retention that is focused on improving local opportunities can contribute to wider community benefits
- There are positive benefits to promoting a diverse workforce and developing new roles that can respond to wide ranging community needs
- Improving HR capacity and capability can assist BME and other staff networks in flexible ways

BME staff networks are acknowledged as an effective way of:

- Supporting the personal and career development of staff
- Sharing experiences and of ways to overcome actual or potential barriers to career progress
- Empowering staff by improving their knowledge and understanding of the NHS
- Prompting innovations and enhancing service and staff development.

Network members across North East London have specifically benefited from a range of regional and national development and leadership programmes as listed below:

- Supporting the “Advance” leadership programme for BME staff
- Having access to development opportunities such as

“Co-acting for Peak Performance”, mentoring placements and job shadowing

- Benefiting from a high number of placements on the National Breaking Through Leadership programme for BME staff in the NHS
- Celebrating success at a regional and local level with support from the SHA.

BME networks have also been viewed as a template for other equality and diversities areas. Future initiatives can build upon the success and lessons learned from network development. Further steps include:

- Developing and expanding networks
- Broadening ‘Diversity’ networks
- Widening Participation within networks
- Building knowledge and experience linked to the Skills Escalator and Knowledge and Skills Framework within the Agenda for Change programme
- Developing bespoke leadership programmes
- Facilitating staff to become integral partners in commissioning and providing services within a patient led NHS.

**Key points**

- BME networks can be placed within the centre of mainstream strategies
- Effective workforce planning and commissioning will lead to positive recruitment and retention of staff
- There are positive benefits to promoting a diverse workforce and developing new roles that can respond to wide ranging community needs
- Leadership and development programmes can be promoted effectively within BME networks.

*I did not think that I had either the organisational support or the confidence to go further in my organisation. My local network put me in contact with the Breaking Through Programme and my confidence improved a lot with the help of a coach who understood the blockages and problems I faced. Despite this I was pushed to succeed if I wanted to and it was worth it’*

*Commissioning Manager*

## 3. Sharing best practice – Conference workshops and recommendations

### Sharing best practice from conference workshops

Four workshops were repeated twice throughout the conference in order to generate thought provoking discussions about the main theme of the day ‘Releasing the potential of BME networks’. Each workshop addressed three key conference questions:

- How do we realise the potential within BME networks?
- How can we ensure that networks enhance the transfer of knowledge as well as enhancing skills and service improvements?
- How have BME networks made an impact upon and within NHS organisations?

Key workshop points are presented in the following three sections:

- Establishing and sustaining a network
- Sharing and Disseminating Best Practice
- Networks collaborating with networks

### Sharing best practice from BME networks in London

In preparing for the event, the conference steering group requested information from the NHS London Race Equality Group (LREG) detailing:

- The number of BME networks in London
- The breakdown of BME networks in the five London regions on a Trust by Trust basis
- The status of such networks in terms of being an active or not, partnership or autonomous network

Findings from the exercise will be presented in this section.

### 3.1 How to establish and sustain a BME network

Workshop facilitators detailed the principles necessary to

establish and sustain a network within a constantly changing environment. Bernie Collins chaired the event and Hazel Sawyers gave a presentation. Lynette Phillips submitted additional information for workshop participants.

*‘There should be clear reporting lines to the senior management team and accountability to the Board through formal structures’*

A BME Staff Network can offer a range of the following:

- Support
- Learning
- Celebration
- Empowerment
- Role models
- Career Progression
- Member advocates
- The development of strategies for inclusion

An outline was given detailing some of the necessary stages when establishing a network. BME Staff Networks exist to:

- Be a voice for BME staff
- Reduce racial inequality in employment
- Reduce racial inequality in service delivery
- Realise the benefit of an untapped resource to the Trust

It is important to establish a clear rationale for a BME network based on:

- The Business Case
- DH Guidance for BME Networks
- Identifying the need for a network that is based on staff views
- Policy and performance management frameworks

(Improving Working Lives and ‘Getting on against the Odds’)

Support for the network must also be gained from the appropriate sources such as:

- Meeting with the appropriate staff group
- Obtaining formal support from your Organisation
- Introducing the idea of the network to potential members by presenting a seminar or workshop
- Agreeing clear aims for the Network.

#### Make meaningful alliances

Part of making meaningful alliances includes being knowledgeable about the coalitions already existing in your work place. Make it your business to know ‘others’ issues and how their views coincide with yours.

Workshop facilitators also outlined various network development tools and the possible challenges and benefits that might arise in establishing the group. (See Appendix 6).

‘Active and well-supported BME staff networks are important to a successful human resources strategy for recruiting and retaining a diverse workforce’ (Department of Health – July 2001). Specific emphasis on the importance of the leadership role is also required to develop and sustain a network. Just as critical to sustaining BME Networks is the ability of the membership body to agree and develop a ‘can do’ culture (See Appendix 7 for suggested Leadership ground rules and for an example of agreed ways of working within BME Networks).

### 3.1.1 Workshop feedback

#### 1. How do we realise the potential within BME networks?

Workshops can be established to identify available skills

There should be opportunities to support career development

The key skills of network members should be identified

Networks should find and use the expertise of members and share good practice

Networks should be an organisational and individual resource

By facilitating alternative ways for members to positively contribute to the organisation.

#### 2. How can we ensure that BME networks enhance the transfer of knowledge as well as enhancing skills and service improvements?

*Ensure staff engagement with the Network*

*Ensure that the network is used positively in a consultative capacity*

*Ensure that the network can influence the Board of organisation*

Utilise the committees within the organisation

Ensure BME visibility

Value individual contributions

*Use BME networks to support and/or conduct organisational impact assessments*

*Use internal and external mentoring, coaching and shadowing*

*Use information technology effectively e.g. Set up group email*

Facilitate workshops and seminars

*Use BME networks as advocates for service users*

#### 3. How have BME networks made a positive impact upon and within NHS organisations?

*Networks reflect the wider community in terms of recruitment and retention*

*Networks contribute to the NHS aim to become a ‘model employer’ fostering good public relations*

Networks are a sounding board for individuals

Networks appeal to the ‘personal, feel good factor’

*Networks are organisational sounding boards offering excellent value for money*

Networks can contribute to reducing absenteeism

Networks sign-post people to opportunities

Networks can act as advocates for service users

Networks are ‘a voice for the voiceless’

## Part one

### 3.2 Sharing and Disseminating Best Practice

The workshop opened with a presentation about The Black Ethnic & Asian Minorities (BEAM) network. BEAM was described as a best practice model in terms of how to develop and maintain a BME network. Other presentations identified the critical aim of a network to lead and drive change. Sonia Harding chaired the workshop with presentations from Yvonne Coghill and Nasreen Iqbal.

*‘Get the CEO involved and show staff that they are fully engaged with the work of the network’*

#### BEAM

An established BME leader and a visible steering group of management and clinical staff at Newham University Hospital NHS Trust in East London, lead the BEAM Network. One of the key network aims is to:

*‘Help foster a level playing field on career development regardless of colour, creed or race’*

(See appendix 8 for BEAM structure, aims, and network projects)

The network has clear terms of reference and reports to the Director of HR who in turn reports to the management executive group (MEG). Formal approval was obtained from MEG in November 2002 and the network was launched in April 2003.

The prime purpose of the BEAM network is to:

- Provide a platform for sharing ideas and experiences of BME staff
- Explore ways of bringing the shared issues, problems or recommendations to the senior management of the Trust so that both can work in partnership (giving and receiving sources of information and guidance)
- Encourage links with other groups within the Trust as well as other BME networks
- Celebrate and promote success.

Following the launch of BEAM a series of workshops for BME staff was held for three months. These events not only helped to explore and identify issues relevant to BME staff but they set the direction for BEAM giving emphasis to practical skills development in line with Trust priorities. Consequently BEAM set up a self-help group offering a

range of development opportunities based on a skill-mix matrix (project management, IT skills, analytical skills, concise writing, etc.). The group also works closely with the Trust’s STAR Team (Service Transformation And Redesign) to identify and set up courses and development opportunities.

BEAM has an annual programme and also organises a yearly Trust wide event.

As a role model in the Trust, BEAM is modelling network development for other equality and diversity groups such as the Gay and Lesbian Network and the Young Mothers Network.

BEAM members would categorise the lessons learned from the experience of establishing and sustaining the network as:

- Hard work
- Having a total commitment to sustaining momentum
- Ensuring the involvement and support of senior management teams within the Trust

Nasreen Iqbal, BSc, Ph D / BEAM Chair

Facts

- 1.5 million staff in the NHS
- 195,000 BME people in the NHS
- 3 BME CEOs
- 8 BME Directors of Nursing

(Monitored within the Department of Health as of October 2005)

Networks should aim to impact upon key policy and performance levers in order to drive through service delivery changes and to help ensure that more BME staff are represented within NHS top teams.

Networks should aim to monitor delivery of the NHS Chief Executive’s 10-point Race Equality Action Plan. Networks and NHS Trusts should monitor implementation of the plan and should also utilise available DH support from the Equality and Human Rights directorate. The Breaking Through programme based at the NHS Institute of Innovation and Improvement is currently an invaluable resource for BME networks with a number of BME staff having already accessed training and development opportunities.

### 3.2.1 Workshop feedback

#### 1. How do we realise the potential of BME networks?

- Ensure that there are clear structures for staff to communicate with each other and the organisation.
- Ask staff what they expect from a network and also how they can contribute
- Make the network as inclusive as you can
- Get a champion for the network – meet regularly and have the champion at events
- Get the CEO involved, to show staff that they are fully engaged with the work of the network
- Support the development of staff in the network and the network leads
- Share data on good practice – use the links from this conference to start the sharing of information
- Produce a practical guide on the development of networks to support network development
- Get HR directors and directors of nursing engaged in this agenda
- Seek to develop the capacity of others to lead the group
- Engage both senior and grassroots staff in the work and core activities of the network

#### 2. How can we ensure that BME networks enhance the transfer of knowledge as well as enhancing skills and service improvements?

- Develop a Network plan of activities
- Seek funding to support development programmes
- Develop business cases for network activities
- Engage in development activities using the skills of network members and others in and outside the organisation. E.g. career surgeries, mock interviewing, CV preparation, presentation skills coaching.
- Seek to comment on activities which fall within the remit of the group
- Set up development sessions focusing on developing the leadership and management skills of junior staff

#### 3. How have BME networks made a positive impact upon and within NHS organisations?

- Supporting the achievement of IWL
- Sharing their wide cultural knowledge within the organisation
- They question activities and suggest solutions, for example poor recruitment practices, lack of appropriate food or access to appropriate food for patients and staff
- By linking into the mainstream of the organisation
- Demonstrating that staff can gain achievements with access to opportunities
- Improves the image of the organisation – great photo opportunities!

### 3.3 Networks connecting and collaborating with networks

Michael Parker and Joan Saddler Chair NHS Acute and Primary Care Trusts respectively, in London. Their presentation gave an overview of the range of networks and the ways in which BME networks can connect and work together towards effecting long-term change. Networks were presented as high-level intelligence sources through which the corporate sector in particular have supported them in order to gain business advantage. Not only do corporations promote the business model for diversity but also they promote BME staff into leadership training programmes. (Esmail 2005)

*'Networks are specific and complex intelligence systems that can positively contribute to micro and macro level business outcomes'*

#### What is a network?

'Systems, a set of connections, complex'

Contacts

Associations

Relational

Linkages

Interlocking

## Part one

NHS Trusts have benefited from the value of BME networks since the rigorous implementation of IWL and the pursuit of pledge, practice and practice plus status. With the commitment of the Trust Board and also with the necessary staff given the tools to succeed, BME Networks can positively influence the workforce and make a difference to service delivery.

BME networks also bring specific 'value' such as:

- Effective, high level networking opportunities
- Contextualising the power of relevant historical frameworks
- Facilitating the development of leadership skills
- Sharing information towards enhancing and developing the knowledge that networks have
- Facilitating the transfer of skills between individuals and groups of individuals
- Creating the space to develop ideas for the improvement of services

Three main reasons to collaborate with other networks were presented as follows:

- BME networks are an efficient marketing tool – promoting clear and relevant messages both to and from BME staff and communities that add value to the pursuit of core business targets
- BME networks can enhance BME recruitment and leadership campaigns through the provision of community intelligence, peer support and role modelling. Networks can organise development opportunities that address the needs of BME leaders based on past and current NHS and 'glass ceiling' data – DATA LINKS and information technology are important network tools
- Networks can effectively promote BME leadership particularly via multi-agency partnerships – they can implement an effective needs based work-plan that utilises member expertise and promotes network members to other parts of the NHS and other key stakeholder organisations.

NETWORKS connecting NETWORKS both maximise and fast-track potential, not only for the benefit of the individual, but also for the benefit of the organisation as a whole. BME networks contribute to the micro picture within the local health economy, and the macro 'Big

Picture' – the NHS Plan.

BME networks: -

- Are specific and complex intelligence systems that can positively contribute to micro and macro level business outcomes
- Are value based systems that can contribute to the attainment and promotion of core business objectives
- Are tools to develop, utilise and promote the skills and experience of BME staff

### 3.3.1 Workshop feedback

#### 1. How do we realise/release the potential within BME Networks?

By creating a BME Network of networks delivering the following:

- A resourced work programme that is realistically benchmarked in order to measure success
- Economies of scale so as not to re-invent the wheel
- Leadership mass
- Staff development
- The creation of knowledge networks
- Strategies for working effectively with other networks
- Effective communication on a variety of levels
- Power and influence
- Research and statistics
- Effective leadership of a corporate network body
- Celebrations of BME staff and cultures

#### 2. How can we ensure that BME networks enhance the transfer of knowledge as well as enhancing skills and service improvements?

- Facilitate specific training initiatives
- Cascade training
- Facilitate mentoring and coaching
- Create a learning culture
- Monitor and evaluate network feedback
- Facilitate understanding of the big picture within health and social care

### 3. How have BME networks made a positive impact upon and within NHS organisations?

- Motivated an empowered staff to stay engaged as a part of the solution
- Assisted recruitment and selection
- Facilitated diversity partnerships within and outside the NHS
- Contributed to consultation on race equality schemes
- Supported the Plain English policy campaign
- Supported the implementation of race impact assessments.

## 4. BME Networks within London NHS Trusts

SHA equalities leads were asked to submit information about the BME staff networks operating/or not, within their respective areas. The response period was from 1st Sept to “26th Sept 05. The RCN conference steering group requested this information from SHA’s through the London Race Equality Group

### Findings

- The understanding of the existence of BME networks and the overall provision is patchy with variations from almost 100% coverage in some areas to 50% coverage or unknown coverage in others
- It is imperative that SHA’s are fully advised as to the status of BME networks within performance-managed programmes such as IWL
- Some sectors within London were able to offer detailed information about BME networks on a Trust-by-Trust basis whilst others offered no information.
- With an increase in the regulatory regime for NHS Trusts particularly from the Healthcare Commission, there will be a need for effective information governance regimes within and across health and social care organisations
- Additionally the Race Relations Amendment Act (2000) specifically requires monitoring information in respect of the available support for BME staff within NHS Trusts. Such knowledge can also enhance the Annual Healthcare Declaration also required from each NHS Trust by the Healthcare Commission.

## Part one

### BME NETWORKS WITHIN LONDON NHS TRUSTS

LOCAL NHS TRUST	BME FORUM YES	BME FORUM NO	COMMENTS
<b>North Central</b>			
	Y		BME networks exist but detailed information not available in September 05' for 16 organisations
<b>North West</b>			
The Aspire network leads across the sector as a BME staff network	Most trusts have delivered staff events and celebrations around diversity		Do Trusts have their own networks – if not, does this have a negative or positive impact?
Kensington & Chelsea	Aspire – funded to run a mentoring programme		Has resourced this activity on a shared basis with other Trusts
NW London hospitals	As above		
Brent	As above		
<b>North East London</b>			
Barts & the London hospital	Y		
BHR hospital	Y		
NEL Mental health trust	Y		
Whipps cross hospital	Y		
Tower hamlets PCT	Y		
City & Hackney PCT	Y		
Newham PCT	Y		
Redbridge PCT	Y		
Newham Hospital	Y		
Homerton hospital	Y		
Waltham Forest PCT	Re-established		
Barking and Dagenham PCT	Have a joint Health & Social Care network – setting up an NHS only network		
Havering		N	
<b>South East London</b>			
7 organisations have established BME Networks	3 PCT's are considering a joint proposal		2 organisations no response No detail sent regarding which organisations do/do not have networks
<b>South West London</b>			
Mayday hospital	Not very active presently		(In September 05)
St Georges Hospital	Y		
Epsom & St Helier hospital	Y		Group organised by Unison and open to all BME staff
Royal Marsden hospital		N	Trying to set up a group
SW London Mental health Trust		N	
Croydon PCT		Looking into the feasibility	
Kingston PCT	Y		
Sutton & Merton PCT	Y		
Richmond & Twickenham PCT		N	Trying to set up a group
Wandsworth PCT	Y		
SWL SHA		N	
Kings College Hospital		N	

## 5. Equality and diversity in the NHS

The development of networks involving black and minority ethnic nurses, managers and other staff in the NHS is taking place in the context of major change. It is our understanding that this includes developments in the interconnected areas of:

- NHS policy, structures and services
- National policy and legislation on equality and diversity
- Workforce matters
- Public sector regulation.

The following section summarises key health and social care policies and other public sector initiatives that are linked to the above four areas. It is important to make the connection of equality and diversity strategies with central policy developments in order to make sense of and plan future healthcare strategy.

### 5.1 NHS policy, structures and services

In recent years in the UK, there has been a far-reaching programme of public sector reform seeking to apply the principles of:

- a national framework of standards and accountability
- devolving more local power to the frontline to deliver those high standards
- more flexible working to keep pace with constant change and better rewards and incentives
- more choice for customers and the ability, if provision is poor, to have an alternative provider.<sup>8</sup>

#### 5.1.1 The NHS Plan

A far-reaching NHS Plan was produced in 2000<sup>9</sup>. In future there was to be:

- Increased investment
- Greater autonomy for NHS organisations provided they met national standards
- A National Institute for Clinical Excellence (NICE), and Modernisation Agency to share good practice

- Making it possible for the NHS and social services to pool resources where required
- Modern contracts for doctors, and the opportunity for nurses and others to extend their role
- A greater say for patients, including surveys and forums
- A concordat with private providers of healthcare to enable greater use of their services
- Reduced waiting times
- Improvements in cancer screening, heart care, mental health and older people's services, and reduction in health inequalities.

Department of Health guidance in 2002 on Developing key roles for nurses and midwives – a guide for managers<sup>10</sup> highlighted the changing role of nurses and midwives and how local innovations could advance national priorities.

Major changes were made as part of the programme of modernisation. In 2004 the NHS Modernisation Agency produced 10 High Impact Changes for Service Improvement and Delivery: A guide for NHS leaders<sup>11</sup>. NHS bodies were to:

- Treat day surgery (rather than inpatient surgery) as the norm for elective surgery
- Improve patient flow across the whole NHS system by improving access to key diagnostic tests
- Manage variation in patient discharge thereby reducing length of stay
- Manage variation in the patient admission process
- Avoid unnecessary follow-ups for patients and provide necessary follow-ups in the right care setting
- Increase the reliability of performing therapeutic interventions through a Care Bundle approach
- Apply a systematic approach to care for people with long-term conditions
- Improve patient access by reducing the number of queues
- Optimise patient flow through service bottlenecks using process templates

## Part two

- Redesign and extend roles in line with efficient patient pathways to attract and retain an effective workforce.

The importance was highlighted of new roles and ways of working for nurses, often in multi-disciplinary teams focused on the patient journey, in facilitating better and more efficient care.

### 5.1.2 RCN Vision

Also in 2004, in *The future nurse: the RCN vision*<sup>12</sup>, the Royal College of Nursing set out a vision of how nursing – ‘The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death’ – might respond to developments in health and social care. The importance of holistic person-centred care was underlined.

It was suggested that action in three strategic areas should be undertaken in attempting to balance nurse workforce numbers with need and demand for health care:

- Increasing the registered nurse workforce
- Changing what registered nurses do
- Shaping demand and need for health care by focusing effort on public health and lifestyle education together with support for self-care and effective management of chronic and long-term illness.

The potential for nursing to improve health and deliver quality care could be maximised by:

- Nurturing an inclusive family of nursing, including establishment of clear working relations and mutual respect between registered nurses and others who provide nursing services, programmes to develop support networks, learning opportunities and managed care packages for patients, carers and communities, and investment in nurse expertise
- Developing person-centred care, not based on professional boundaries or demarcations in care settings, and encouraging patients and communities to become active participants in care and treatment
- Establishing integrated care across care settings, by teams organised around care pathways, and which will undertake a range of activities on their own initiative such as independent prescribing, admission, referral and discharge from/to care settings such as hospitals or treatment centres.

Investment in pre- and post-registration education would be needed to develop the capacity of those future nurses who would provide leadership to teams, acting as clinical co-ordinators of care.

### 5.1.3 Commissioning a Patient-Led NHS

*Commissioning a Patient-Led NHS*<sup>13</sup>, circulated in July 2005, took the modernisation programme further. It was proposed that:

- Primary Care Trusts (PCTs) be reconfigured, so that in most cases they would share boundaries with social services
- PCTs shift their focus to promoting health and commissioning services, securing more services from a range of providers
- Practice-based commissioning by GPs be rolled out
- Management and administrative costs be cut.

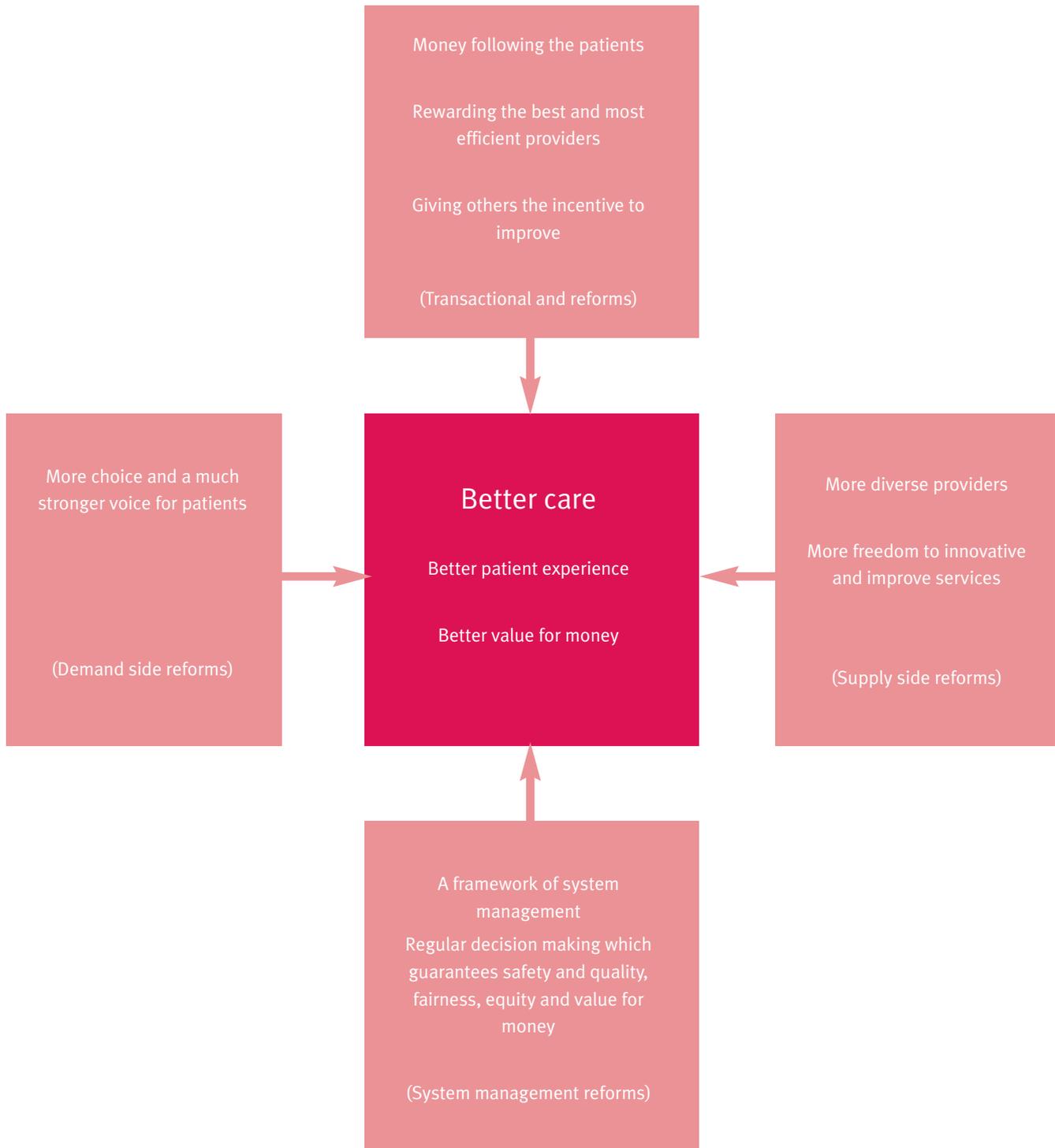
*Health reform in England: update and next steps*, published by the Department of Health in December 2005<sup>14</sup>, outlined future plans to develop an NHS which would ‘provide the highest possible quality of care, delivered in the most efficient way, led by the needs and wishes of patients and supported by staff.’ Four connected streams of work were identified:

- More choice and a much stronger voice for patients, involving patient choice among several healthcare providers, better information for the public and practice based commissioning
- More diverse providers, with more freedom to innovate and improve services, including NHS foundation trusts, private and voluntary sectors and NHS social enterprises; and workforce reform
- Money following the patients, involving payment by results, with a fixed fee for each type of medical treatment
- system management and decision making to support quality, safety, fairness, equity and value for money.

Expected benefits included more consistent quality, responsive services, convenient access, joined-up services and empowerment of patients.

(See reform diagram on page 25)

FRAMEWORK FOR THE REFORMS



## Part two

### 5.1.4 The White Paper

The White Paper *Our health, our care, our say: a new direction for community services*<sup>15</sup>, published in January 2006, set out four main goals:

- Better **prevention** services with earlier intervention, including personal health checks
- More **choice** and a louder voice, making it easier for patients to get information about and register with local GPs and get convenient appointments and extending and streamlining direct payments to people with long-term care needs
- More on **tackling inequalities** and improving access to community services, with more and better primary care in deprived areas and targeted services, for instance for young people, ethnic minorities and people with disabilities
- More **support for people with long-term needs**, supporting them in managing their conditions themselves, with greater investment in the Expert Patient Programme, more information for users and carers and greater integration of health and social care.

These improvements were to be achieved through:

- More PBC (practice based commissioning)
- Shifting resources into prevention
- More care undertaken outside hospitals and in the home
- Better joining up of services at the local level
- Encouraging innovation
- Allowing different providers to compete for services.

### 5.1.5 Commissioning Framework

Health reform in England: update and commissioning framework<sup>16</sup>, produced in July 2006, set out measures that aim to develop a patient-led NHS that uses available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest possible healthcare, against a background of rising expectations, increasing numbers of people with long-term conditions, major advances in medical technology and continuing variations in the safety and quality of care. This proposes various drivers for improving quality, patient experience and value for money.

- Greater patient choice, with competition among providers, voice and competition;

- Improved contracting by commissioners, contestability and service redesign; and
- National standards, targets, agencies and regulatory approaches.

Measures include:

- Indicative budgets held by GP practices for their patients
- Agreement by PCTs, practice-based commissioners and providers of protocols and care pathways for groups of patients, utilising improved information technology and drawing on clinical networks, local authorities and advice from others as appropriate, and development of more integrated services by forward-looking providers
- More effective commissioning in care and prevention, based on partnership across agencies and sectors where appropriate, making better use of information on population needs, and engaging patients and the public through feedback, petitions and local involvement networks (which would replace patient and public involvement forums)
- Further expansion of NHS Foundation Trusts and more opportunities for voluntary sector, social enterprise and private sector providers, though with the possibility of a continuing role for PCT direct provision
- A greater role for SHAs in staff training, support and advice, with an emphasis on competency-based training and support for interdisciplinary learning
- Oversight of PCTs by SHAs and reforms in regulation by Monitor (covering Foundation Trusts), the Healthcare Commission and other bodies.

### 5.1.6 RCN principles

Also in 2006, the Royal College of Nursing produced RCN principles: A framework for evaluating health and social care policy<sup>17</sup>. This is based on four main RCN principles – quality, accountability, equality and partnership – underpinned by various elements:

- Quality involves safety and dignity for patients and staff, clear, achievable and realistic standards, sustainability, staff competence and responsibility of providers to the public
- Accountability involves inspiring trust by commissioners and providers, leadership, meaningful public involvement and transparency
- Equality includes valuing and promoting diversity and

eradicating discrimination, enabling advocacy for black and minority ethnic and other communities of interest, universal and unhindered access which takes account of distribution of services and addresses race, ethnicity, faith, culture, sexuality, age, personal wealth, mobility and community cohesion, universality, with public funding through taxation, and equity

- Partnership involves consultation and negotiation with trade unions, professional associations and other stakeholders, acknowledgement of the legitimacy of representative bodies and individuals' human rights, representation and collaborative decision-making with the public and other stakeholders.

## 5.2 Equality and diversity

Discrimination on grounds of ethnicity has long been unlawful, though it has proved difficult to eradicate. Following the failure of the police adequately to investigate the murder of Stephen Lawrence, a report in 1999 by an inquiry led by Sir William Macpherson drew public attention to the ongoing problem of institutional racism.

Under the Race Relations (Amendment) Act 2000<sup>18</sup>, many public authorities were obliged to take a more active approach. In carrying out their functions, they were required to consider the need to eliminate unlawful discrimination and promote equality of opportunity and good race relations, and publish race equality schemes setting out how this would be done. NHS and other public bodies were expected to identify which of their functions were most relevant, assess how these affected race equality and make changes as necessary. The ethnic origin of staff and applicants for jobs, promotion and training was to be monitored.

### 5.2.1 Department of Health Equality Framework

In 2003, Department of Health Equality Framework: Priorities for Action<sup>19</sup> were published. These included:

- **Ensuring that equality was built into modernisation and systems reform**, with fairness and choice for all groups of patients
- **Undertaking equality impact assessments** of key national programmes, and developing and implementing action plans to make improvements where required
- **Maximising the benefits of investment in human**

**resources** by capitalising on the potential of all groups within society, with monitoring of progress on achieving a diverse workforce

- **Ensuring that the Department of Health could meet its statutory obligations and commitments in relation to equality both as an employer and in developing policies** with a robust and comprehensive evidence base, designed with the involvement of all groups and communities and communicated in a way which engages them on their own terms.

### 5.2.2 Promoting equality and human rights in the NHS

Promoting equality and human rights in the NHS – a guide for non-executive directors of NHS boards<sup>20</sup>, produced in 2005, highlighted:

- The principles – including equity of access and equity of treatment – and legislative framework underpinning equality and human rights
- The business case for promoting and delivering equality and human rights, including health improvement, meeting national and local targets, access to the best pool of talent in recruitment and avoiding under-use and demoralisation of the workforce
- Prompts for boards to take stock of how fairly their organisations treat their patients and workforce, including health equity audits, examining the impact of different options on different communities when undertaking business case analysis, meeting public health priorities and targets, arrangements for compliance with the Human Rights Act, and use of the SHA race equality guide and other guidance, fair procurement and commissioning
- The importance of outcomes.

Single equality schemes: a discussion paper for NHS organisations<sup>21</sup>, published by the Department of Health in 2006, drew attention to the implications of the Equality Act 2006, including creation of a Commission for Equality & Human Rights (CEHR) to replace the existing equality commissions, and strengthening of equality legislation in recent years. NHS organisations were asked to consider the possibility of developing a single equality scheme incorporating race, gender and disability, and maybe also religion or religious belief, age and sexual orientation, and making this effective. The use of equality impact assessments and monitoring was discussed, and the role of equality champions in some organisations.

## Part two

Also in 2006, NHS Employers drew attention in Equity in implementing organisational change<sup>22</sup> to the importance of making sure that organisational changes did not have a discriminatory effect on minority ethnic and other staff that might experience disadvantage. All staff responsible for managing change should be fully trained and up to date on all relevant legislation and have access to best practice guidance on equality and diversity, and the process should be monitored.

### 5.3 Workforce development

#### 5.3.1 The Vital Connection

In 2000, a health service circular from the Department of Health, Equalities Framework – The Vital Connection<sup>23</sup>, set out three strategic equality aims:

- To recruit, develop and retain a workforce able to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of different groups and individuals
- To ensure that the NHS is a fair employer achieving equality of opportunity and outcomes in the workplace
- To ensure the NHS uses its influence and resources as an employer to make a difference to the life opportunities and the health of its local community especially those who are shut out or disadvantaged.

Requirements included reduction of harassment, training in equality and diversity for boards, increasing ethnic minority and women's representation at executive level and producing an annual equality statement.

#### 5.3.2 Positively Diverse & Improving Working Lives

The NHS Positively Diverse programme had been in place for two years<sup>24</sup> before The Vital Connection. This sought to change the culture of the NHS to create an environment where differences among staff were welcomed, including gender, age, racial origin, sexual orientation and disability. Initial audits at pilot sites had revealed that most staff did not feel valued in their work, and had little confidence in voicing concerns; with minority ethnic staff feeling least confident, while equal opportunities and anti-harassment policies were not well known. It was pointed out that 'An organisation in which staff do not feel valued or able to voice concerns will have difficulty implementing the new agenda for the NHS'.

Improving Working Lives Standard<sup>25</sup>, produced by the Department of Health in 2000, set performance standards for NHS employers for 'improving working lives' (IWL) of employees in general, in line with the NHS Plan. NHS employers were to:

- Recognise that modern health services require modern employment services
- Understand that staff work best for patients when they can strike a healthy balance between work and other aspects of their life
- Accept joint responsibility with staff to develop a range of working arrangements that balance the needs of patients and services with the needs of staff
- Value and support staff according to the contribution they make to patient care and meeting service needs
- Provide personal and professional development and training opportunities that are accessible and open to all staff irrespective of their working patterns
- Have a range of policies and practices in place that enable staff to manage a healthy balance between work and their commitments outside work.

By April 2003 all NHS employers were expected to be accredited as putting into practice an IWL Standard, following a three-stage process: a pledge of commitment and putting in place of the policies and planning required; practice, in which the Standard would be met for most employees most of the time and there would be an action plan to address any gaps; and practice plus, involving consistently high performance.

Evidence of achievement would include an annual staff survey, with analysis of responses by staff group, ethnicity, gender, age and working patterns; examples of staff feeling supported and able to challenge harassment, bullying and discriminatory behaviour based on differences in language, culture, religion, sexuality, age, gender or employment status.

Diversity networks were among the measures put forward. Improving working lives: black and minority ethnic staff networks: guidance<sup>26</sup>, published in 2001, described some of the benefits for NHS organisations in setting up and developing BME staff networks:

- Staff feel a sense of belonging to the NHS and are encouraged to stay
- Staff are developed by improving their knowledge

- Positive investment in individuals leads to better motivated staff
- Developing networks shows the organisation's commitment to equality and valuing diversity.

This could promote the NHS as a positive career choice and help to fulfil the requirements of the Race Relations (Amendment) Act 2000.

### 5.3.3 Getting on against the odds

Getting on against the odds: how black and minority ethnic nurses can progress into leadership<sup>27</sup>, produced by the NHS Leadership Centre in 2001, suggested that:

- Representation at leadership level was inadequate
- Support from managers, mentoring, networking and clinical supervision could assist career development
- Sustained effort was required to convert commitments to equality and diversity into reality.

As experience in this field grew, some NHS organisations sought to examine how such networks had developed and evaluate what impact they had made. For instance in 2003 a report on BME (black and minority ethnic) networks in North East London discussed their contribution to staff learning and development.<sup>28</sup>

Valuing diversity could enhance staff motivation and performance and release potential, delivering improved services, according to a Royal College of Nursing diversity appraisal resource guide<sup>29</sup>, published in 2003. This offered practical guidance to employers, RCN officers and representatives on promoting diversity in the workplace. It urged that this be treated as a mainstream issue: all organisational processes and systems should include the positive management of diversity, and all business projects should be developed and audited to ensure that they did not discriminate and actively promoted diversity. Activities which could be incorporated in action plans included development of specific training programmes, mentorship schemes or employee support networks, tailored recruitment approaches and formation of links with community groups.

A national NHS Black and Minority Ethnic Leadership Forum was launched in 2003 by the NHS Confederation and the RCN<sup>30</sup>. This aimed to:

- Listen to and collate the views of members to inform and shape development programmes being developed nationally

- Listen, consult and inform views to influence policy
- Speak out on diversity issues and the wider policy agenda
- Provide a platform for national and peer networking to support members' development.

Also in 2003, the NHS Leadership Centre launched Breaking Through, the first national leadership development programme for BME staff in the NHS.<sup>31</sup>

In 2004 Improving Working Lives: Practice Plus National Audit Instrument<sup>32</sup> was produced, covering seven areas of good practice:

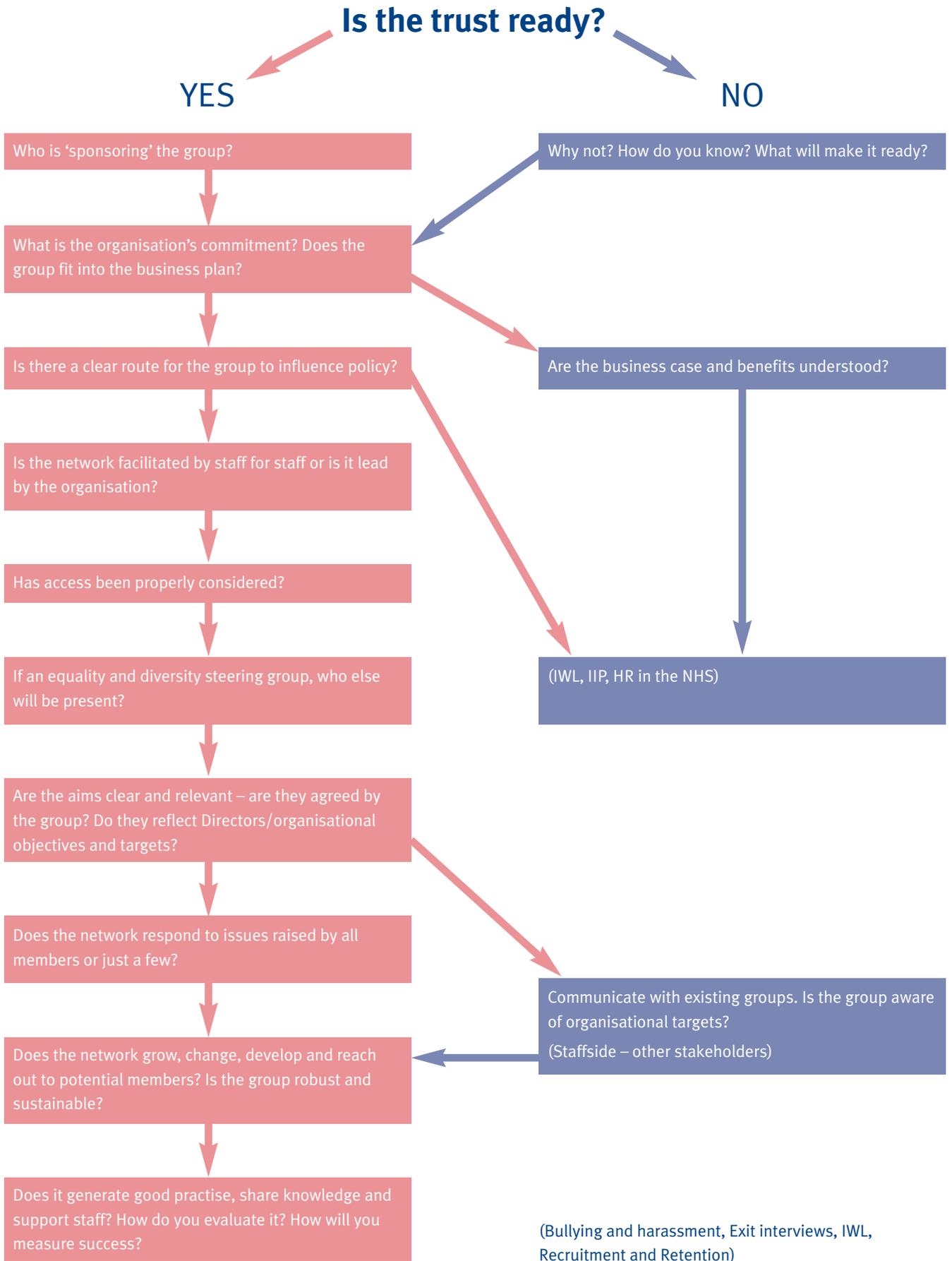
- Human resources strategy and management: at a strategic level the organisation should demonstrate an understanding of how good people management practices make a real contribution to service delivery
- Equality and diversity
- Staff involvement and communication
- Flexible working
- Healthy workplace
- Training and development
- Flexible retirement, childcare and support for carers.

By April 2006, most NHS organisations had achieved Practice Plus.<sup>33</sup>

It had become clear that diversity networks could play a useful part in improving working conditions and staff capacity. Materials developed for the Positively Diverse programme included *Staff support networks: a flowchart for success* (See diagram on page 30).<sup>34</sup>

## Part two

### FRAMEWORK FOR THE REFORMS



## 5.4 Public sector regulation

### 5.4.1 Reforming regulation

The public sector modernisation programme included reforming regulation – both legislation and structures for planning and delivery. Measures such as the Health Act 1999, Health and Social Care Act 2001 and NHS Reform and Health Care Professions Act 2002 have created new NHS and regulatory bodies, made it easier for the NHS to cooperate with social services to meet long-term care needs and introduced new duties around quality and patient involvement. Later reforms have sought to scale back arms-length bodies, freeing more resources for frontline services<sup>35</sup>, and avoid unnecessary measures, the costs of which might be greater than the benefits<sup>36</sup>.

Reports by regulatory bodies have sometimes shed light on the role of NHS staff in redesigning services to be more effective and efficient. Quicker Treatment Closer to Home: Primary Care Trust's success in redesigning care pathways<sup>37</sup>, published by the Audit Commission in 2004, drew attention to the need to involve more nurses and allied health professionals as practitioners with a special interest, and indicated that engagement with patients, clinicians and health economy partners was important to the spread and impact of new care pathways.

Regulation of healthcare professionals has also been updated to take account of the changing environment, including new roles and increased expectations of professionalism.<sup>38</sup>

### 5.4.2 The Healthcare Commission

The Healthcare Commission has undertaken a range of activities to promote equality, diversity and human rights. In 2005, a *Statement of Intent: Promoting human rights and reductions in inequalities in health and healthcare*<sup>39</sup> outlined how it would demonstrate its commitment:

- In developing criteria for assessment
- In targeting and carrying out its programme of work
- In dealings with patients and the public
- In the recruitment and development of its own staff.

Later a Race Equality Scheme<sup>40</sup> was developed, describing how this aspect would be taken forward.

NHS Staff Survey reports<sup>41</sup> have drawn attention to the experiences of racial discrimination experienced by some

black and minority ethnic staff. As advisory and regulatory bodies increasingly incorporate equality and diversity issues into their work, the NHS and partnerships to which it belongs will be under increasing pressure to demonstrate that they are taking practical measures to tackle discrimination.

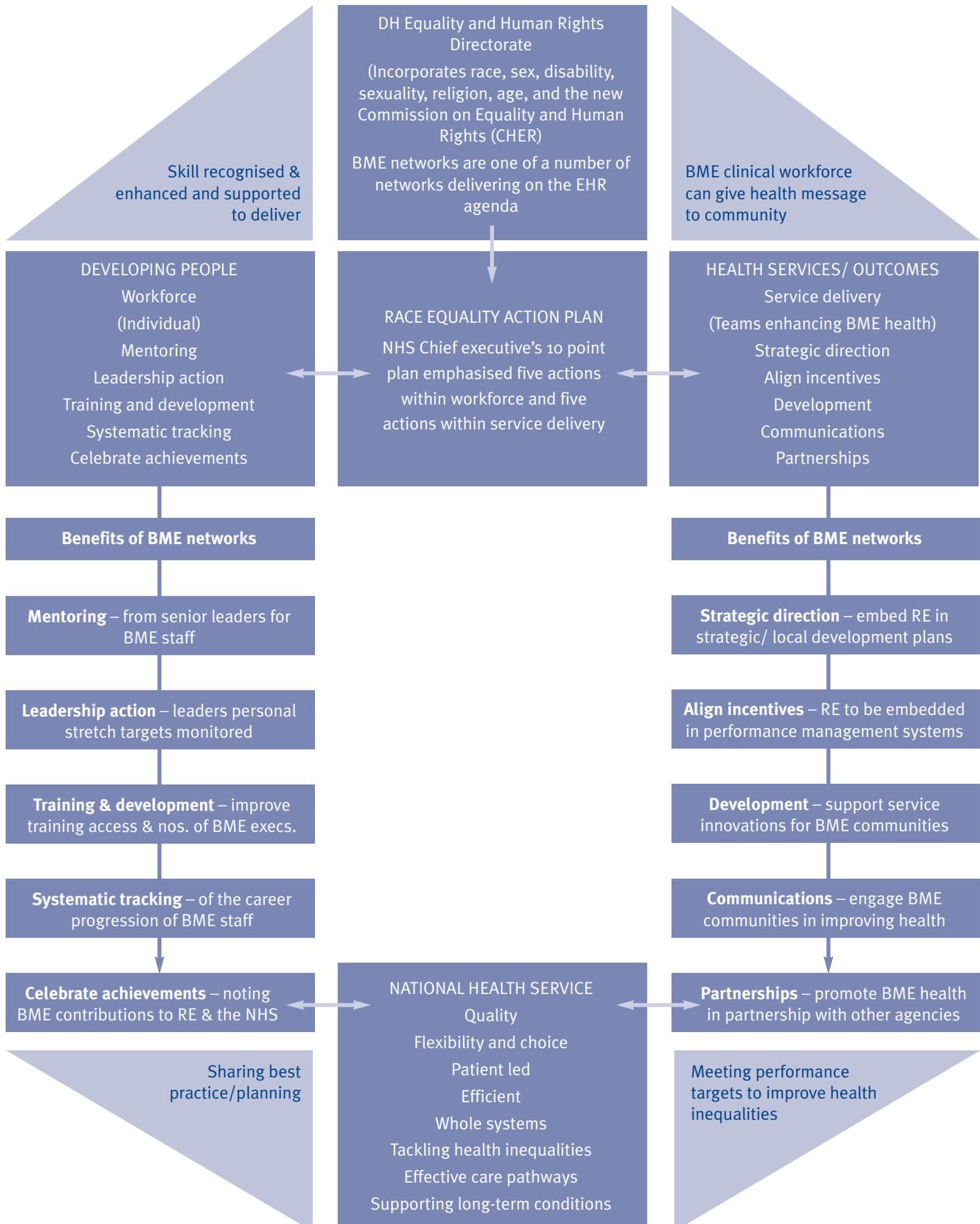
## 6. The future for BME networks

Both internal and external stakeholders may find it challenging to negotiate the complexity of the NHS in order to understand and develop the policy environment. For staff this can create a silo mentality where the culture of the organisation has been philanthropic (do your best for the better good of the organisation) and essentially hierarchical (this is the way we do things here and within this organisation).

Since the publication of the NHS Plan, the emphasis on escalating reform to redesign services and pathways of care within such complexity (that is further complicated by partnership working) can seem unreasonable to staff.

BME networks can make sense of the care and policy environment by translating policy into practice and vice versa. Additionally it would be useful to use the 10 point Race Equality Action Plan (See Appendix 4) template to organise and synthesise current policy and practice across equality and diversity areas. The plan focuses on service delivery and workforce as two key distinct areas for action. BME networks can help target the required actions and principles within the plan with such actions having the ability to be replicated across other equalities areas based on the need. (See diagram on page 33).

## BME Networks and future healthcare



## 7. Conclusions

With the opportunity for providing new pathways of care within a changing NHS, the benefit of *framing equality and diversity issues to fit within regional strategies* cannot be overemphasised. Both the commissioning agenda and patient and public involvement guidelines linked to commissioning can strengthen one of the central NHS targets of reducing health inequalities. Consequently from a provider and consumer point of view, BME networks can bring leverage to the NHS.

*Respect for diversity among staff* can better equip the NHS to improve health in partnership with local people and also provide appropriate and effective services to a diverse public. The growth of BME networks involving nurses, managers and other staff are an important part of this. The latter becoming even more apparent with the need for NHS organisations to develop corporate boards where each member fully recognises their corporate responsibilities. BME non-executive members also have access to BME networks. They can add value by ensuring that equality and diversity areas are governed to rigorous standards particularly with regards to the necessary regulatory standards.

*Visible top-level commitment to nurturing equality and diversity is important*, and can help the NHS and other employers in the health field to comply with the law and public policy, improve their public image and recruit and retain talented and motivated staff from different backgrounds.

*Documenting, examining and sharing information on the experience of BME networks* is important not only for their development but also more generally for promoting other forms of equality in the NHS, and among other health and social care commissioners and providers.

While nurses and others concerned with health will, and should, assess reforms in the NHS and wider public sector on the basis of core values, these offer both challenges and opportunities. *If the potential of the workforce is truly to be appreciated and developed*, and services designed around patient pathways, needs and views, diversity issues must be fully integrated in planning and delivery. And if the ways in which BME networks help to create a more effective, efficient, high quality and caring health service

are identified, these are more likely to be promoted and supported at high levels.

There is *diversity within BME communities, which should be recognised and celebrated* in staff networks, and different perspectives should be shared and creative thinking encouraged. Contact with other public services networks, and user, carer and community networks concerned with BME health, can be important in sharing good practice, learning together and sharing views and experiences.

For those engaged in developing and maintaining BME networks, *building alliances within and beyond the health service* can help to advance the agenda of greater equality, and health and social care commissioning, planning and provision which are truly suited to the twenty-first century.

## 8. Recommendations

### To the RCN

1. Continue to promote and support BME networks, and encourage partners to do so too.
2. Monitor and evaluate progress in implementing the equality and diversity strategy and work-plan, with particular reference to networks.
3. Assist in developing links between BME networks in health and other relevant networks, especially in public services, to share good practice and work together where appropriate for greater equality and diversity.

### To NHS and other health and social care commissioners and providers

4. Ensure senior managers and Board members are aware of the moral and business case for diversity, including motivation and development of the workforce, compliance with legislation and national policy, and improved public relations.
5. Ensure that the Board and senior managers have a good level of competence in equality and diversity issues, ensuring that this is performance managed in the same way as other high level organisational competencies.
6. Ensure that there are senior level champions of equality and diversity who can take the agenda forward at Trust, clinical network, Strategic Health Authority and/or partnership level.
7. Recognise that from a provider and consumer point of view, BME networks can bring leverage to the NHS.
8. Recognise the work still required to ensure that discrimination is effectively uprooted in health care, highlighting the importance of taking preventative action.
9. Take account of the diversity within the local and wider population, and the need to recruit and retain staff and nurture talent from as wide a pool as possible, in order to achieve the best results.
10. Recognise the value of, encourage and resource BME

networks, and seek their assistance and input in promoting best practice, including developing clear lines of communication.

### To BME networks

11. Continue to document, encourage research and reflection on, and learn from, experience so far in order to develop and flourish in future.
12. Examine possibilities of learning from, and making links with, BME and other relevant networks with an interest in public services.
13. Encourage initiatives to bring about greater recognition of and respect for diversity, and foster awareness that health and wellbeing are closely connected with equality and justice.
14. Keep informed about developments in public policy, structures and legislation, and consider their possible relevance to the role and activities of BME networks, including sharing knowledge and promoting good practice.
15. Promote patient and public involvement guidelines linked to commissioning in order to strengthen one of the central NHS targets of reducing health inequalities.
16. Promote discussion of how quality, accountability, equality and partnership might be promoted in a context of change, and creativity among nurses and others, including in prevention and care for people with long-term or complex conditions.
17. Consider the various roles which a network might undertake, including being a reference group on BME issues for the Trust or partnership, offering an environment for BME staff to learn, providing advice on career development, peer group support and role models, celebrating success, discussing issues affecting BME people and raising understanding of other cultures within the workforce, and periodically assess progress and reconsider priorities.
18. Seek to balance support for individuals dealing with negative experiences, and criticism of institutional racism, with constructive action to develop participants' knowledge and skills and improve the NHS.

## Part two

19. Encourage BME staff moving into leadership positions to bring with them awareness of, and commitment to, promoting equality and diversity.
20. Be aware of Trust or higher-level strategic plans, and seek to link network aims and activities with these.
21. Consider that BME non-executive members have access to BME networks and they can add value by ensuring that equality and diversity areas are governed to high standards particularly with regards to the necessary regulatory standards.
22. Make use of information and communication technology as well as opportunities for meetings, seminars, shadowing and mentoring.
23. Encourage diversity within the network, including willingness to listen to different points of view, and nurture and encourage emerging leaders.
24. Be aware of BME and other networks among users, carers and communities and possible linkages, especially in the context of a health service where the value of involvement and partnership is increasingly recognised.
25. Utilise links with organisations such as trade unions, user groups and other representative bodies for support and to get equality and diversity messages across.

## Appendix 1

### The five main uses of a network

It is important to note that networks operate well where the member body is facilitated either individually or as a whole to influence practical change and, or to influence strategic direction as demonstrated below:

- i. Exchanging Information, generating and sharing new ideas, identifying standards and benchmarks and developing views
- ii. Understand the organisation by talking to people from different sections
- iii. Making work more productive – enlisting support for innovative approaches
- iv. Developing skills and career opportunities, broadening horizons, getting noticed,
- v. Increasing personal and professional power and influence

## Appendix 2

Key policy drivers listed below are explained in more detail in part 2

- The Vital Connection
- Positively diverse
- Improving Working Lives
- Race Equality on the Agenda
- Making a Difference
- Getting on Against the Odds
- Breaking Through Programme
- DH Guides on Networking & Shadowing (1994) – guides for Nurses, Managers, Health Visitors & Allied Health Professionals

## Appendix

# Appendix 3

In February 2004 the NHS Chief executive announced his 10 point plan for race equality.

### **NHS Chief Executive Race Equality Action Plan**

## **Leadership and race equality in the NHS**

1. The NHS and Department of Health must give even greater prominence to race equality as part of our drive to improve health. We must:
  - pay greater attention to meeting the service needs of people from ethnic minorities. This will help us to meet the standards both for improved services and health outcomes in the long term and to hit our short term targets
  - make race an important dimension of our strategy for the next five years through more focus on helping people with chronic diseases – where morbidity is high amongst people from black and minority ethnic backgrounds – and on health inequalities – where ethnic minority communities are often disadvantaged
  - target recruitment and development opportunities at people from different ethnic groups whose skills are often underused. This will assist our drive to recruit more staff, increase our skill base and introduce new working patterns
2. We need to tackle this in a systematic and professional way. Equality and diversity need to be explicitly acknowledged and integral to all NHS corporate strategies.
3. I will lead this work personally given its importance. I will draw a strengthened team around me to monitor and support delivery of the ten actions on the accompanying page.
4. Success will be judged not on what we say but on what we do.
5. As well as my oversight, Ministers will take a keen interest in progress. Staff in black and minority ethnic networks from the service will be encouraged to express views and keep this plan under review. And, to make

sure we benchmark ourselves against the best, I have invited an independent expert panel to review our progress and report back to the September Chief Executive's conference this year.

6. This brings real focus. I hope by July that up to 500 senior NHS and DH leaders will be mentoring a member of staff from an ethnic minority. Some already do this and can help others who want to get started. The Leadership Centre will offer advice for those with little experience of cross cultural mentorship and will draw up a list of potential mentees for those who may find it hard to identify someone locally who would like this opportunity.
7. My hope is that staff from ethnic minority backgrounds who participate in this mentorship programme will provide NHS leaders with insights and inspiration to promote race equality in new ways. Equally I hope that they get the benefit of the experience and enthusiasm of our senior leaders.

**Sir Nigel Crisp**

*February 2004*

ACTION	RESPONSIBILITY
<b>1. HEALTH SERVICES AND OUTCOMES</b>	
STRATEGIC DIRECTION: Through the forthcoming planning guidance, embed race equality into future Local Delivery Plans to enable more personalised care, reduced chronic disease and health inequalities, increased capacity and community regeneration	DH and all NHS leaders with national and local partners
ALIGN INCENTIVES: Build race equality into the new standard and target setting regime, into local performance management systems and into the new inspection model	DH and all NHS leaders with national and local partners
DEVELOPMENT: Provide practical support to help NHS organisations make service improvements for people from ethnic minorities	NHS Top Team & NHS Modernisation Agency
COMMUNICATIONS: Encourage fresh approaches to communications to engage people from ethnic minorities more effectively in improving outcomes	All NHS organisations and DH
PARTNERSHIPS: Work with other national and local agencies to promote the health and well being of people from ethnic minority communities	DH and all NHS leaders in concert with national, regional and local partners
<b>2. DEVELOPING PEOPLE</b>	
MENTORING: Senior leaders to show their commitment by offering personal mentorship to a member of staff from an ethnic minority	All senior leaders in DH and NHS
LEADERSHIP ACTION: Senior leaders to include a personal 'stretch' target on race equality in their 2004/5 objectives	NHS Chairs and CEs; DH Board members
EXPAND TRAINING, DEVELOPMENT AND CAREER OPPORTUNITIES: Enhance training for all staff in race equality issues. Develop more entry points for people from ethnic minorities to join the NHS and take up training. Improve access for black and minority ethnic staff to the full range of development programmes, support networks and professional training. Encourage appropriately qualified leaders from ethnic minorities in health and other sectors to consider and apply for executive positions	Local WDCs and HR networks, NHS Leadership Centre, NHSU and other training providers
SYSTEMATIC TRACKING: Build systematic processes for tracking the career progression of staff from ethnic minorities including local and national versions of the NHS Leaders scheme	All senior leaders and NHS Leadership Centre
CELEBRATE ACHIEVEMENTS: Acknowledge the contributions of all staff in tackling race inequalities and promote opportunities for staff from ethnic minorities to celebrate their contribution to the NHS	DH and all NHS leaders

This action plan has been developed with the help of staff from ethnic minorities within the NHS, building on the advice from leaders in other sectors, and the Commission for Race Equality. It has the full backing of Ministers, the Department of Health's Management Board and the NHS 'Top Team'. (DH web site)

## Appendix

# Appendix 4

**History of the NBPA** as represented from the BPA website ([www.nationalbpa.com](http://www.nationalbpa.com))

‘Nationally the loss of Black staff from the service was at alarming levels. In 1990 a joint initiative between black staff within the Metropolitan Police Service (MPS) in London and a specialist support unit specialising in community and race relations training based in Turvey Bedfordshire raised concerns about staff wastage. This led to a meeting of black staff from the MPS. This meeting known as the Bristol Seminars led to the formation of a black support network.

The London Black Police association then formed following discussions between black staff and the MPS. The association, which formed in September 1994, was launched by the then MPS Commissioner Sir Paul Condon. From its inception it has sought to highlight issues facing Black staff in the Police Service, helping those in need of support by lending a listening ear and giving advice.

In October 1996 with interest having grown across the country in the work of the BPA, a National Communication Network was formed. This network consisted of Black staff members spanning the length and breadth of the country. It was quickly realised that the only way forward was to form a national association, speaking with "ONE VOICE, STRENGTH IN UNITY".

In early 1998 Paul Wilson, Leroy Logan MBE and Bevan Powell from the Metropolitan Police BPA and Ravi Chand from Bedfordshire Police BPA met with RT HON Jack Straw then Home Secretary to discuss the role of BPA's. The meeting resulted in tangible support with regular meetings between Home Office staff and the National Communication Network.

In November 1998 an interim executive was elected to launch the National Black Police Association. The executive committee was comprised of 14 executive members from 12 Constabularies.

The then Home Secretary, the Rt. Hon Jack Straw, gave full support to the NBPA voicing this in many public forum and was instrumental in negotiating the NBPA office situated within the Home Office building’.

### **NBPA mission statement**

The National Black Police Association seeks to improve the working environment of black staff members employed within the Police Service of the United Kingdom, with a view to enhancing racial harmony and the quality of service to the minority ethnic community of the United Kingdom.

## Appendix 5

RCN mission objectives aim to:

### Represent

- The interests of nurses and nursing and be their voice locally, nationally and internationally.

### Influence

- And lobby governments and others to develop and implement policy that improves the quality of patient care, and builds on the importance of nurses, health care assistants and nursing students to health outcomes.

### Support and protect

- The value of nurses and nursing staff in all their diversity
- Their terms and conditions of employment in all employment sectors
- The interests of nurses professionally

### Develop

- And educate nurses professionally and academically, building our resource of professional expertise and leadership
- The science and art of nursing and its professional practice

### Build

- A sustainable, member led, organisation with the capacity to deliver our mission effectively, efficiently and in accordance with our values
- The systems, attitudes and resources to offer the best possible support and development to our staff

### Mission statement

- The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

## Appendix 6

### Challenges to setting up a network

- A balance must be gained in ensuring that members are able to attend network meetings at mutually agreeable times for the majority of members and the organisation
- Non-BME staff can feel threatened by the network and good communication at a number of levels to all staff will be necessary
- Network membership can be seen as a clique. It is important to be as open and transparent and welcoming to members as to the organisation
- Sustaining the Network takes time and planning

### The process for developing a network

- Both a Chairperson and steering group should be appointed as soon as possible
- Development workshops can be organised around both organisational priorities and individual priorities as related to the key aims of the organisation
- Meetings must not be a talk shop
- The paramount purpose of the network is to influence policy and practice within the organisation (e.g. IWL issues, staff development)
- There should be clear reporting lines to the senior management team and accountability through to the Board through formal structures

### Potential Benefits of a BME Network:

- Offers Empowerment to members and staff within the organisation who may require support in other diversities areas
- Can assist with the management of change
- Facilitates learning and the development of BME staff
- Creates opportunities for support but not helplessness
- Offers flexible development through progress
- Contributes to the Quality Approach in effecting workforce and service change

## Appendix

# Appendix 7

### Network leadership and possible ground rules

A Leader must

- Establish trust as a Cornerstone
- Become an agent of Preparation
- Become an Agent of Options and Solutions
- Become an agent of Closure on outstanding issues
- Become an Agent of Change
- Be a Self-Educator
- Be aware of obsolescence and keep up-dated
- Some knowledge has a Shelf life – Embrace Continuous Learning
- Understand current Challenges and avoid being pigeon-holed

*Ishmael 2006*

### What to avoid in your network

- Bleary vision and lack of trust
- Inflexibility
- Poorly -conceived activities
- Poor quality Information
- Cronyism and poor decision making
- Out-dated thinking
- Knee-jerk reactions
- Learned helplessness
- Poor leadership and dereliction of duty
- Fear of daring
- Listening but not hearing

*Ishmael 2006*

### Network ground rules

- Avoid negative ‘frenzies’
- Take advantage of networking contacts
- Celebrate and learn from others
- Help others find success in failure
- Invest in the time to gain new skills
- Expand your sphere of influence
- Give others permission to disagree with you
- Stimulate creativity in others
- Show alert interest
- Promote mentoring
- Differentiate between personal and professional relationships and friendships
- Follow-through

## Appendix 8

### Sharing best practice – Black Ethnic & Asian Minorities (BEAM) Network

The BEAM network steering group draws on a range of clinical and managerial staff

- Senior Manager (Chair)
- Project Manager (Associate Chair)
- Specialist Nurse (Treasurer)
- Chair of JSCC (Joint committee)
- Junior Midwife
- Midwife Specialist
- Manager (Theatre)
- Analyst (Info. & Performance)
- HR Manager (BEL Project)
- Service Manager (Greenway Centre)
- Consultant (Urologist)
- (Consultant (Diabetologist))

### Aims of BEAM

- To raise awareness of BME staff and their different needs within the Trust
- Uplift and elevate black and ethnic minorities within the workplace (have representation at all levels of the Trust)
- Raise cultural awareness of BME staff within the Trust
- Set clear Terms of Reference
- Convey various issues being raised by BME staff to senior management so that they can work in partnership to deliver positive outcomes for all
- Provide a forum for discussion and identification of specific requirements for BME staff to aid in their career development
- Help foster a level playing field on career development regardless of colour, creed or race

### BEAM has a close working relationship with the Trust's Service Transformation and Redesign initiative (STAR) and facilitates a range of development opportunities.

- Organising 1-1 development sessions
- Access to the Trust intranet site
- Offers assistance with CV writing
- Organising role play and interview panels
- Coaching and confidence building
- Encouraging staff to move forward

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## Conference profiles

### John Batchelor

John Batchelor is the National Programme Lead for the Breaking Trough Programme (BTP) at the NHS Institute for Innovation and Improvement, which was launched in July 2005. The BTP aims to develop Black and Minority Ethnic staff into senior leadership roles.

John's key objective is to provide a range of national leadership development activities for up to 400 aspiring directors and senior BME managers and clinicians who wish to move into senior leadership roles. The programme also supports and has developed a template for more locally led development programmes for junior BME staff working in the NHS.

In addition, Breaking Through is the host for the national conference which tackles leadership and race equality in the NHS. The BTP also co-ordinates mentoring and coaching schemes with the 10 Strategic Health Authorities in England.

Prior to this appointment, John was the Programme Director at the Equality and Diversity Unit of the Ambulance Service Association. Sponsored by the Department of Health, this three-year programme sought to improve the representation of BME staff within the Ambulance Services in England, Scotland, Wales and Northern Ireland. During John's two-year stewardship, the numbers increased from 1.8% (548 BME staff) to 3.3% (1190 BME staff).

John has had an illustrious career in the NHS spanning 27 years. John has previously received the British Diversity Award for the most influential speaker of the year and more recently he was awarded an MBE for his services to the NHS.

### Yvonne Coghill, MSC, DMS, RGN, RMN, HV, CPT

Yvonne qualified as a staff nurse in 1980 and quickly progressed to complete her mental health and health visiting training. In 1986 Yvonne became a team leader for health visitors and later secured promotion to the post of Clinical Co-ordinator for Harrow and Hillingdon Community NHS Trust, where she managed the Harrow West locality.

Yvonne worked as a board nurse for Harrow PCG and then as Primary Care Development Manager for the PCG before moving on to the National Primary Care Development team as GP contract co-ordinator.

Prior to commencing a one-year secondment at the Department of Health as Sir Nigel Crisps Private Secretary Yvonne worked as a PCT/Local Medical Committee (LMC) Liaison Manager. Whilst working with Sir Nigel she completed an NHS waiting times project and also worked as the Project Director for MRSA and Cleaner Hospitals for 6 months. Yvonne currently works in the Department of Health for the Chief Nursing Officer as Nursing Officer for External Relations and Communication.

As an MBTI trainer and executive coach Yvonne has a particular interest in actively encouraging people to reach their full potential and is passionate about supporting colleagues to be the best that they can be in terms of personal and professional development.

### **Bernie Collins**

Bernie currently works at West London Mental Health NHS Trust as the Diversity Lead focusing on patient service provision. She has been supporting the Trust in developing and improving services for patients as well as staff and works collaboratively with her colleague who is the Diversity Lead for employees.

She was one of the founder members of the Ealing Black and Minority NHS staff Network and was involved in successfully launching the network in September 2002, which is a partnership of three local NHS Trusts.

Bernie has also been the Chair of the RCN London Equality Network (LEN) since its inception in 1999 and was re-appointed as Chair. As a member of the London Regional Board of the RCN she attended the European Parliament in November 2002.

Bernie is known for her commitment to the equality and diversity agenda and for ensuring a focus on motivating others towards achieving positive results.

### **Terry Coode**

Terry is a Fellow of the Chartered Institute of Personnel & Development. He originally completed his apprenticeship

in human personnel management and served in local government, with specialist and generalist roles in the former GLC, a Borough Council in Kent and Cambridgeshire County Council.

Terry joined the Building Society movement to obtain his first management role, and through subsequent mergers, he worked for the Woolwich Building Society ultimately as Group Personnel Manager. Further mergers saw Terry join Barclays Bank PLC where he was Head of Planning & Infrastructure in an Employee Relations and Reward function.

He joined Guy's & St Thomas' in September 2003 as Deputy Director of Personnel and was appointed HR Director in June 2004.

### **Sonia Harding**

As Equality and Diversity Development Manager for the North East London sector (formerly NELSHA), Sonia brings a varied and accomplished record of developing and sustaining equality and diversity initiatives, programmes and networks within the NHS.

Sonia is a nurse/health visitor who has worked in the health service for more than 25 years. Her interest and commitment to Equality and Diversity resulted in a significant job change five years ago and she now works in North East London with senior management teams in a range of acute, PCT and specialist Trusts to develop BME networks. Sonia also advises Trusts on the strategic development of Trust wide equality and diversity strategies as well as the implementation of race equality schemes.

### **John Humphreys**

John Humphreys is Director of Strategic Human Resources in the North East London sector, having worked at the Royal College of Nursing (RCN) since 1991 and as their Acting Director of Employment Relations from 2001.

Some of John's achievements to-date include successfully concluding the Agenda for Change pay negotiations in 2002 as the RCN lead negotiator on pay and conditions, for the NHS joint unions. Additionally in 1999 he represented the RCN on the NHS working party to provide HR guidelines for Primary Care Trusts.

## Profiles

John has extensive experience of leading and managing change in the working practices of the NHS workforce. He enjoys the challenge of being at the forefront of changes in developing the HR agenda across the wide range of NHS Trusts.

### **Dr Nola Ishmael OBE**

Dr Nola Ishmael OBE is a former Department of Health Nursing Officer now working as an Independent Health Care Consultant. She has extensive senior management experience exemplified by an impressive track record of leadership and achievement in the NHS at Director of Nursing level and through her ten years at the Department of Health working closely with Ministers and the Chief Nursing Officer.

She lectures extensively at local, national and international level and she continues to lead the Mary Seacole Leadership Award for the Department of Health.

Nola has a deep understanding of Diversity, Equality and Ethnic Minority issues. She is working currently with a number of NHS Trusts assisting in the development of BME Staff Networks. She sits on the Boards of a number of Charitable Organisations and is Vice Chair of Greenwich Community College.

She was awarded the OBE for her work in Nursing and at the Department of Health. In 2003 she was awarded an Honorary Doctorate by the University of Central England in Birmingham for her work in Policy Development in Nursing and with Ethnic Communities health care. In 2004 she won the Wainwright Trust Award for her work with BME staff in the NHS.

### **David McFarlane**

David McFarlane is the National Coordinator for the National Black Police Association, which is based in the Home Office in London and has held the post since the inception in 1998. He joined the Metropolitan Police Service in 1981 as a police officer, serving in various departments until his secondment to the NBPA.

As Coordinator, David is required to assist in establishing local associations around the country including Scotland and Northern Ireland and to act as an ambassador of the

national body. David also represents the association internationally in different forums. Because of his experience in supporting his colleagues, he is always called upon to assist in various cases across the country. He enjoys helping others and studying history, imparting the knowledge he gains to particularly redress the imbalance of racism.

### **Michael Parker**

In December 2002, Michael became the Chairman of King's College Hospital NHS Trust. He currently chairs the Finance Committee and is a member of the Performance, Information and Technology and the Equality and Diversity Committees.

In 1997 Michael was appointed a Non-Executive Director at Guy's and St. Thomas' NHS Trust and became their Vice Chairman in 2000. Michael chaired the Audit Committee and was a member of Risk Management Governance, Equality and Diversity and Information for Health Committees.

Michael is involved in many projects and organisations such as The Tropical Health and Education Trust (THET), and has held various managerial posts, including that of Chairman of a housing association and the Central London Fabian Society. Michael has always engaged in community politics and participated in supporting numerous community groups.

Michael worked as a part time healthcare assistant for his local hospital (a satellite of Kings College Hospital) whilst obtaining his first degree and also worked as the Coordinator of the Caribbean Teachers Association during his second degree. Michael qualified with Hogg Bullimore, which after a series of mergers became Alliotts. After working for some small firms Michael decided to enjoy the freedom of being self employed. This enabled him to lecture at the University of East London and Queen Mary, University of London on subjects such as Accounting, Methodology and Financial Strategy.

Michael leads on Diversity for the NHS Employers Organisation. He is a regional and national representative of the NHS Appointments Commission's BME Forum. He is also a Steering Group member of the NHS Confederation BME Leadership Forum.

**Lynette Phillips**

Lynette is a founder member of the Sutton & Merton PCT BME Staff Network launched in April 2004. Lynette utilises her various skills as a Registered Nurse, a Registered Midwife, the holder of a Diploma in Health Visiting and a Community Practice Teacher to add value to her many facilitative roles working with others. In addition to her nursing qualifications Lynette holds a Diploma in Management Studies and a Masters Degree in Business Administration.

For over 25 years Lynette has worked in the NHS and held a number of challenging positions both as a clinician and as a Senior Manager. These include the development of a Nursing Development Unit; working in Partnership with Mental Health to implement the Lone parent visiting, implementing Appraisal Systems and the development of Ancillary and Clerical Staff.

Lynette has worked as the Business /Quality Manager for Sutton and Merton PCT since January 2005.

Lynette has over time developed a wide range of skills in management in the NHS, writing policies; developing staff and as an assessor on the NHS Leadership Graduate Scheme In addition she has experience in running workshops for NVQ Care Management Programmes

Lynette is Chair of the London Black and Minority Network for NHS staff and Allied Profession and a member of the Chief Nursing Officers BME Advisory Group.

**Hazel Sawyers**

Hazel Sawyers is a founder member and current chair of ASPIRE, the BME Health Workers Network in North West London. Hazel has provided advice on setting-up and developing BME Networks to staff in the NHS and in other public sector organisations. She also has wide experience of working in the voluntary sector and in BME organisations. Hazel is a practicing Life Coach and she is currently the Head of Equality & Diversity at Kensington & Chelsea PCT.



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