

Resource Sheet 3:

Cultural Competence

This sheet summarises the meaning and application of cultural competence.

Cultural competence means being equitable and non-discriminatory in your practice and behaviour. It requires a balanced approach to others in which cultural identity and cultural context are taken into account. Like competence in general, cultural competence is the responsibility of both the individual and the organisation.

When talking about cultural competence, there are various groups of people who need to use and develop it:

- therapists needing to develop cultural competence for practice in a host country (see the case study provided)
- physiotherapy managers, who must ensure that the legal framework on diversity and the promotion of equal opportunities is implemented (see the case study provided)
- therapists who work in the country where they qualified, but have to manage a broad range of cultural backgrounds within their patient caseload. Help for this application of cultural competence is not provided in this pack but is available via http://wlmht.nhs.uk/docs/general/cultural_toolkit.pdf

Recruitment from abroad develops and enriches practice here, particularly as physiotherapists often work in increasingly diverse communities, but it can also give rise to challenges caused by language, cultural variations and different approaches to the management of conditions and clients. Every member of the healthcare workforce must therefore be able to understand, respect and work effectively with persons or groups from various cultural backgrounds, including different genders and ages.

There are, of course, strong professional and service reasons also for being culturally competent because you then practise effectively.

You and your practice must be:

- person-centred
- non-discriminatory
- accessible to all
- legally compliant.

Under the provisions of the Equality Act 2010 (see Resource Sheet 1) public sector bodies have a duty to consider the equality impact of everything they do. There is a requirement to consult with and involve the community and take steps to address any deficiencies identified. These new requirements are proving challenging for organisations and there are penalties for failing to comply.

There is a requirement on public sector employers to ensure staff receive equality and diversity training to enable them to play their part in fulfilling the general and specific duties outlined, and employers will be expected to monitor staff performance in this area. In this sense, therefore, there is a legal imperative for employers, but also for individuals as they can be separately named in addition to their employers in tribunal claims.

It is important to note in this context that Core Dimension 6 of the NHS Knowledge & Skills framework is about equality and diversity, which is described as 'a key aspect of all jobs and of everything that everybody does'. Core dimensions are a feature of all NHS jobs.

The KSF has two 'gateways', points at which postholders have to demonstrate competence against the KSF outline for the post, including core dimension 6, and progression up the pay scale will be dependent upon this. Demonstration of cultural competence is therefore a requirement to achieve career/pay progression for those working in the NHS.

Some further points about cultural competence:

- Culture is specific to the person, encompassing many facets that have contributed to their individuality, including ethnicity and family values
- Culture embraces diversity in its broadest sense and includes differences and similarities due to age, gender, ethnicity, religion and belief, sexual orientation and disability.
- Culture is not the same as 'ethnicity'. Ethnicity denotes origin and membership of a group of people linked for example by language or nationality. This may or may not correspond with a particular culture.
- Understanding your own culture and the underpinning values and beliefs that contribute to this is the starting point for acquiring cultural competence
- A culturally competent person recognises and responds to individual needs and adapts their practice accordingly
- Individuals and employers have a legal responsibility to be culturally competent.
- An individual's view of healthcare will be based on their culture and values, and they will interact and respond accordingly.

Ethnocentrism describes the opinion held by an individual that their view of the world is the universal standard by which every other culture is or should be judged. Failure to explore and respect the reasons behind someone's behaviour leads to inappropriate and ineffective practice and interactions.

Stereotyping operates when assumptions are made about someone based on their culture, ethnicity or other factors, ignoring variations that exist within and between cultures.

Trusts might not necessarily recruit from abroad in the current economic climate but might well receive applications from physiotherapists who qualified abroad.

More information is provided in the CSP's Equality and Diversity Toolkit, available from the CSP website at http://www.csp.org.uk/director/members/libraryandpublications/csppublications.cfm?item_id=04F93713F01DFA21A97DF4B3C6A3BACB

Other resource sheets in this pack provide advice and information about:

1. The legal framework
2. Performance improvement
3. Cultural competence
4. Disability
 - 4a Dyslexia
 - 4b Mental health
 - 4c Chronic Fatigue Syndrome (CFS).

Case study - International recruitment

Although opportunities to recruit from abroad are now limited by removal of physiotherapists from the Government's list of shortage occupations, trusts may still be recruiting EEA nationals or non-EEA nationals who have gained British citizenship or are married to British citizens. Also, applications from physiotherapists qualified abroad might still be received by employers. In the current work permit situation, the particulars of the issues that arise may differ but the approach/ strategies to address them are likely to be broadly similar.

In this case study, the implication of bias has been reduced by not naming a person or a country.

Mr X was interviewed over the telephone for a senior post in orthopaedics and elderly care in Greenhills NHS Trust, situated within a culturally diverse area of the UK. The staff profile was not ethnically diverse and they had never recruited from abroad before. He had never travelled outside his own country but wished to leave to gain more experience and a better life. The UK manager was under severe pressure to fill a post that had been vacant for some time.

During the phone interview, the manager asked Mr X a set of standard questions in accordance with the trust's HR policy: however these did not allow either party to glean adequate information. Standard questions are designed on the basis of assumptions about orientation to the NHS and UK practice, neither of which Mr X was familiar with. He had been provided with the job description and person specification for the post. He had not contacted the CSP for information prior to the

interview. In order not to lose face, especially when speaking to a female manager, he made a guess at questions relating to unfamiliar concepts and terminology concerning UK practice and NHS issues. The manager did not ask him about the context of practice in his own country, for example relating to a typical day, professional autonomy, evidence-based practice, CPD opportunities or quality issues.

Follow-up questions would have provoked a more in-depth discussion and this could have identified personal development needs and given an indication of the degree of support Mr X would have needed if offered the post. Consideration might also have been given to the most appropriate starting grade to reflect current skills and enhance future potential.

However, Mr X was the only candidate and was offered the post as a Band 7 on the basis that he had twelve years general experience as a physiotherapist in a hospital setting in his home country and had managed this service for seven years. His CV indicated that he had had specific experience in orthopaedics and was HPC registered.

His arrival in the UK was a cultural shock. No one met him at the airport as they would have done in his home country. At the hospital, temporary accommodation was provided. The therapy services manager introduced him to the staff and provided a two week programme of induction consisting of attention to personal needs (bank account, GP etc), periods of clinical observation with another Band 7 in his area of responsibility and study time. He was supervised by this Band 7 during the induction period, but soon felt their relationship was not conducive to learning. Mr X was unfamiliar with the assessment forms, the system of record keeping and working with so many other professionals in a multi-disciplinary team. He was also surprised at the number of 'older patients' over fifty. He had hoped his supervisor would help him but she did not seem to have the skills to create a learning environment. Neither did she, or anyone else, ever ask about his country and background. Mr X felt his cultural and professional identity

was undermined and he did not feel he was in a safe environment in which to ask questions.

After the two week period of induction, there was an expectation that Mr X would be competent to deal with the same volume of patients as his UK trained colleagues but this was not the case. He was finding it difficult to balance personal, professional and cultural pressures and asked the manager if there was someone from his own cultural background he could chat to informally. Some aspects of UK practice worried him. In his view, older people were not properly respected and patients were undressed unnecessarily. He felt very uncomfortable handling female patients.

He was provided with a 'buddy' who on the surface came from his own cultural background but with whom he found it difficult, for reasons of religion and gender, to relate to. He accepted the arrangement so as not to cause offence.

The relationship with the supervising senior deteriorated as Mr X did not seem to be able to provide her with the answers she was looking for. He did not feel safe to ask questions as he was afraid he was being judged as incompetent. This was particularly hard as he had been greatly valued in his own country. It was difficult to glean information in order to meet expectations as he wasn't sure what the priorities were and was not used to being told to 'just go and read'. He had a good level of English but found speed reading very difficult.

Staff and patients said they found his manner abrupt, that he did not give eye contact and rarely smiled. Mr X did not feel able to explain that direct eye contact in his culture was considered to be rude. Mr X began managing his own case load in week three but was deemed slow, incompetent and unsafe by the supervisor after a few days. She contacted the manager who arranged to speak to Mr X informally. Mr X was informed of the seriousness of the situation.

At the meeting, plans for a month of formal supervision and

assessment were instituted, based on the gaps in knowledge identified by the supervisor. She set the agenda and continued to supervise Mr X. Over the next month it was agreed that Mr X had shown improvement but the outcome was that he was still deemed to be unsafe to practise. At this point he went off sick.

The workplace steward was informed of the situation and was asked to support Mr X. In negotiation and agreement with the steward and Mr X, Greenhills Trust felt that a period of assessment in another workplace would help them objectively assess Mr X's competence. This was duly found and an up-grade programme implemented for Mr X. This Trust was very experienced in relating to staff from diverse backgrounds and Mr X felt he was in an environment where his cultural identity was valued, where he felt safe to ask questions and where there was a corporate commitment to equal opportunities.

He was assigned a supervisor of a higher grade than himself whom he was pleased to find was a clinical tutor. He completed his assessment successfully and found a job in a third Trust at Band 6 with the promise of promotion as soon as he reached Band 7 competencies. Mr X was very positive about this as he had time to develop the skills he would need to supervise juniors without undue pressure and could also demonstrate knowledge and skills from his own previous experience.

Lessons learnt by Greenhills Trust

As a result of this experience, the physiotherapy service manager instituted several changes to the departmental systems, to create:

- a more rigorous and equitable recruitment process when considering applicants from abroad, in line with DH guidance (Department of Health. Code of practice for the international recruitment of healthcare professionals London: Department of Health; 2004. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097730)
- tailored pre-interview material for non-UK graduates, including relevant CSP material
- interviews that are conducted in a way which

takes account of equal opportunities [see key issues below]

- induction policy and procedures based on Dept Health, organisational and departmental requirements, capable of adapting to individual needs and cultural diversity
- a realistic pacing of induction and early work that allows time for cultural orientation and a gradual build up of case load
- a culturally competent workforce, trained in diversity awareness, able to challenge discrimination – all staff are required to attend the Trust's diversity awareness day within the first three months of employment
- a climate of welcome and support for new staff, including meeting and greeting newcomers on arrival, which affirms personal identity and provides an open atmosphere in which they can ask questions and attain knowledge
- a starting grade that allows competence to develop without undue pressure, with the potential to fast-track to a more senior grade as soon as the requisite competencies are demonstrated
- the use of a professional mentor and/or a cultural buddy who can translate the organisational culture and help with general orientation: where this is not possible, help is sought through managers' networks, other trusts, iCSP or CSP networks.
- negotiated CPD programmes based on individual needs, which build competence
- an objective, fair and rigorous capability policy which is instituted in a timely manner, taking account of an appropriate timeframe for induction and orientation
- a formal capability assessment carried out by a staff member of a higher grade than the new employee, who has the appropriate skills
- effective liaison and collaboration with Trusts experienced in managing diversity.

Comment

Recruitment, induction and assessment protocols did not take account of diversity, promote equality of opportunity or follow relevant Department of Health Guidance. Poor practices had a high cost, both financially and in human terms.

Key issues to consider

Although the Greenhills therapy services manager had been under great pressure to recruit, reliance solely on a telephone interview when she had never recruited someone from abroad before, was ill advised and did not follow the DH Code of Practice.

There is a common misconception that all candidates have to be asked exactly the same questions as part of the selection process, but this is not necessarily the case. Good practice suggests that a well-designed set of initial interview questions should in most cases cover all the key competencies required for a job. However,

it is often necessary for a panel to ask follow-up questions to candidates, and these will differ from person to person depending on the answer provided to the initial question. There is nothing in equality legislation that prohibits different questions in certain circumstances, as long as the intention is not to discriminate, and the effect is not to put the candidate at a disadvantage.

Employment practice	Key questions
Preparation	<ul style="list-style-type: none"> • Have you referred to relevant guidance when preparing to recruit and select international staff? [e.g. The DH Code of Practice] • Have you sought advice from others in your organisation or elsewhere who have expertise in the area of international recruitment?
Recruitment	<ul style="list-style-type: none"> • Do your adverts and your recruitment process take account of the legislative framework on diversity and promote equal opportunities? • In addition to information about the job itself, have you provided the candidate with information relating to working in the UK? e.g. NHS organisation & the context of physiotherapy practice • Have you ensured that the interview process will assess their understanding of this in as far as it will impact on doing the job? • Does your planned interview process take account of different perspectives arising from cultural backgrounds whilst still testing the full range of skills and competencies the post requires? • Have you taken steps to research the context of physiotherapy practice in the country of origin [e.g. degree of autonomy of practice, access to CPD, approach to record keeping], so you can frame questions appropriately and avoid misunderstandings?
Induction	<ul style="list-style-type: none"> • In what ways does your induction take account of diversity? • How does it assist staff from a different background to understand the 'culture' of the organisation employing them? • Have you included an introduction/training on the context in which the individual will be working? • Have you allowed extra time for this process? • Where cultural adaptation is a factor, is the time frame realistic within which staff are expected to meet minimum standards? • Are other staff in the department aware of the cultural needs and perspectives of international recruits? • Have staff had diversity training?