The King's Fund>

Making the difference

Diversity and inclusion in the NHS

Authors

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Introduction

The culture of the National Health Service (NHS) should be sustained by the core values in the NHS Constitution including respect and dignity, compassion and inclusion. Given the diversity of the NHS workforce, these values have particular resonance.

Recent research demonstrates that very little progress has been made in the past 20 years to address discrimination against black and minority ethnic (BME) staff in the NHS. There is evidence too of discrimination experienced by many other groups including women, lesbian, gay, bisexual and transgender (LGBT) staff, people with disabilities and religious groups.

The King's Fund was commissioned by NHS England to assess the scale of this problem; the report used data from the 2014 NHS Staff Survey and drew on wider work on climates of inclusion to suggest strategies for lasting and pervasive change. The full report is available from: **www.england.nhs.uk/wp-content/uploads/2015/11/ making-the-difference.pdf**

The analysis sought to answer the following questions.

- What are the differences in reported levels of discrimination between NHS staff from different demographic and work backgrounds?

- Do these differences persist when controlling for other background variables?

The second question involved carrying out an in-depth analysis of the data. We wanted to explore levels of discrimination as reported by particular groups, once the effects of other defining factors were discounted. So, for example, are there still differences between ethnic groups once we control for the effects of gender or of being in a certain occupational group, and so on?

Key findings

- Overall, levels of reported discrimination in the NHS Staff Survey vary significantly by type of trust, location, gender, age, ethnicity, sexual orientation, religion and disability status.

- Reported levels of discrimination are highest in ambulance trusts.

- Overall, women are less likely to report experiencing discrimination than men (except in the case of ambulance trusts).

- Older staff are less likely to report experiencing discrimination than younger staff.

- Reported levels of discrimination are highest for black employees and lowest for white employees. All other non-white groups are far more likely to report experiencing discrimination than white employees.

- People from all religions report experiencing discrimination on the basis of their faith, but reporting is by far the highest among Muslims.

- Staff with disabilities report very high levels of discrimination; levels of reported discrimination are higher against people with disabilities than any other of the protected characteristics groups.

- Organisations can draw on well-evidenced approaches to inclusion to build positive cultures of care in order to reduce levels of discrimination.

Data and methodology

The 2014 NHS Staff Survey included responses from 255,150 individuals across 284 organisations (including 157 acute trusts, 57 mental health/learning disability trusts, 40 clinical commissioning groups (CCGs), 19 community trusts and 11 ambulance trusts). The data looked at discrimination within the NHS, between managers and staff, between colleagues, but also from patients and members of the public.

In order to answer the questions set out in the Introduction, the analysis used data from individuals rather than from organisations as a whole. In other words, we used individual responses from staff in organisations so that we could determine the demographic characteristics of respondents when they reported their experiences of discrimination. All the data is self-reported.

For our analysis, discrimination was assessed in relation to the nine key variables used in the survey:

- any experience of discrimination

- discrimination from patients, their relatives or other members of the public

- discrimination from managers, team leaders or other colleagues

- discrimination on the grounds of ethnic background

- discrimination on the grounds of gender

- discrimination on the grounds of religion

- discrimination on the grounds of sexual orientation

- discrimination on the grounds of disability

- discrimination on the grounds of age.

The data was analysed first by examining the straightforward prevalence of different types of discrimination among different groups of staff. We then carried out an analysis (logistic regression) of discrimination on groups, adjusting for type and region of trust, demographic characteristics (gender, age, ethnic group, sexual orientation, religion and disability) and background work factors (full-time or part-time, level of contact with patients, length of service with organisation, and occupational group). Figure A1 in the Appendix shows the breakdown of responses on the above variables.

The results are based on the prevalence of discrimination reported by staff members in the different groups (gender, ethnicity, disability status, religion, etc) in relation to each of the nine discrimination variables. Due to the very large sample size, almost all differences are statistically significant; the focus should therefore be on the magnitude of the differences rather than simply on whether such differences exist.

Detailed findings

Trust type

There is significant variation by trust type, with the highest levels of discrimination overall being reported in ambulance trusts (19.7 per cent) and the lowest in 'other' trust types such as CCGs (5.3 per cent).

Figure 1 Percentages of staff reporting discrimination by trust
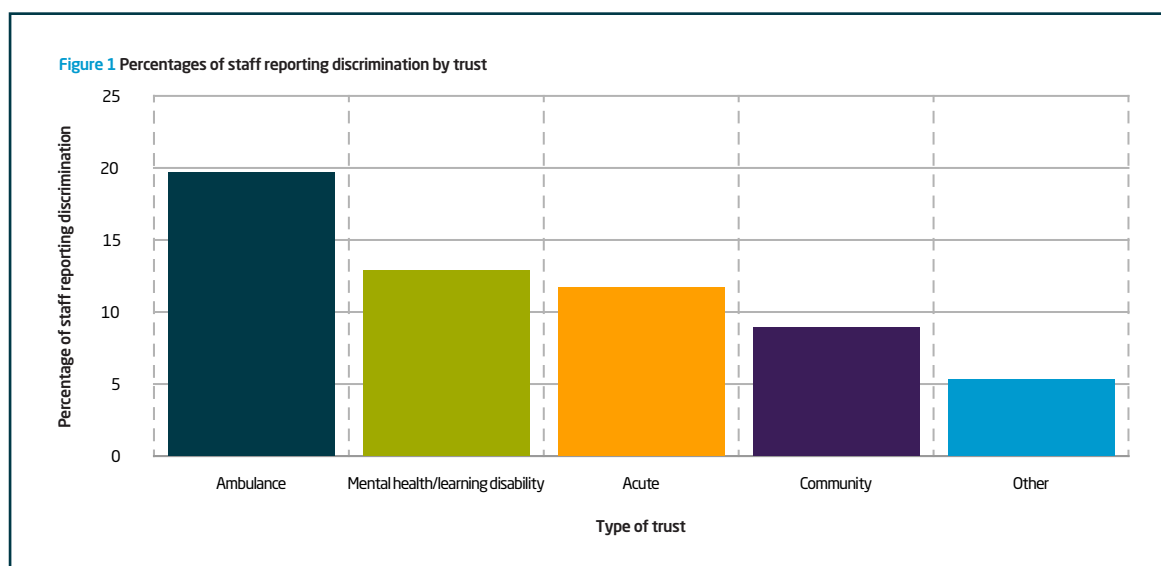
Discrimination on the basis of ethnicity was highest in acute (4.5 per cent) and mental health/learning disability trusts (4.8 per cent).

Region

Reported overall discrimination rates are higher in London than elsewhere – from all sources (patients, relatives, the public, managers, team leaders and other colleagues). Differences between London and elsewhere are, however, marginal for discrimination on the basis of sexual orientation, age, and disability. Few clear differences exist between the other regions. Generally staff in the South East and the East of England report slightly higher levels of discrimination overall, staff in the northern regions the lowest, but the differences are small.

Gender

More men than women report experiences of discrimination overall (14.6 per cent of men versus 10.8 per cent of women). Men are more likely than women to report experiencing discrimination on the basis of ethnicity and gender. Interestingly, the gap between men and women is slightly smaller for reports of discrimination on the basis of gender than it is for other forms of discrimination. The higher level of discrimination reported by men may reflect the fact that male staff are in the minority in the NHS workforce.

Staff in ambulance trusts are more than twice as likely as those in acute hospital settings to report discrimination on the basis of gender, with more women reporting discrimination than men. Again this may reflect the gender balance in the workforce as men constitute 56 per cent of the staff in ambulance trusts.

Age

The highest number of reports of discrimination on the basis of age came from staff in the youngest age groups (7.6 per cent of those aged 16 to 20 years, and 5.5 per cent aged 21 to 30 years).

Controlling for other factors (for example, occupational group, gender, ethnicity and so on), it is still the youngest age group (16 to 20) who are most likely to report experiences of discrimination.

Ethnicity

Discrimination is reported far more by people in non-white groups (25.6 per cent) than by white staff (9.5 per cent). The highest level of discrimination was reported by staff from black groups (30.9 per cent). The differences are particularly pronounced in relation to discrimination from patients, relatives and members of the public: 21.7 per cent for black staff, 16.6 per cent for non-white staff and 4.1 per cent for white staff.

Figure 2 Percentages of staff reporting discrimination by ethnicity
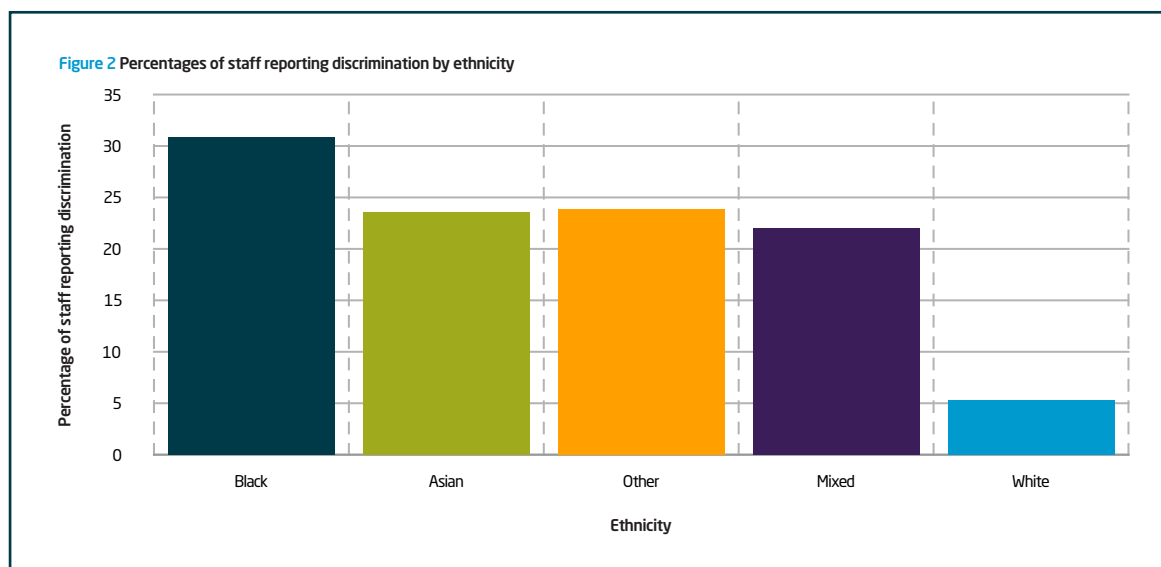
Unsurprisingly, most of these differences are explained by the discrimination experienced on the basis of ethnicity, which is highest among black staff (25.3 per cent) and Asian staff (18.1 per cent), compared with only 1.7 per cent for white staff.

Once other factors are controlled for (such as gender, age, occupational group and so on), non-white staff still report much more discrimination on the basis of ethnic background, with the rates for black staff 12 times higher than for white staff.

Controlling for the other factors produced some other notable results. Disabled staff report more discrimination on the basis of ethnic background than non-disabled staff. Nurses, midwives and nursing assistants are also far more likely than medical/dental staff to experience discrimination on the basis of ethnicity.

Sexual orientation

Reports of discrimination are considerably higher from non-heterosexual staff (20.9 per cent) than from heterosexual staff (11.3 per cent). This is mostly due to discrimination on the basis of sexual orientation (9.8 per cent of non-heterosexual staff compared with 0.2 per cent of heterosexual staff). However, non-heterosexual staff also have higher reported rates of discrimination on the basis of gender, disability and age.

Discrimination reported by non-heterosexual staff is 10 times higher among staff in ambulance trusts than among medical and dental staff.

Once other factors such as gender, age and ethnicity are controlled for, the odds of non-heterosexual staff experiencing discrimination on the basis of sexual orientation are 29 times higher than those of heterosexual staff.

Religion

Overall discrimination is reported most by Muslim (22.2 per cent) and Hindu (19.4 per cent) staff, compared with staff of no religion (10.0 per cent). Reported discrimination on the basis of religion is highest by far among Muslims (8 per cent), followed by those of other religions (all religions not including Christians, Muslims and Hindus) (1.9 per cent), Hindus (1.3 per cent), Christians (0.4 per cent) and staff of no religion (0.2 per cent). Muslims and Hindus also report a far higher rate of discrimination on the basis of ethnic background. This contributes to there being a less pronounced difference between Muslim and other staff when reporting discrimination of any type.

Figure 3 Percentages of staff reporting discrimination by religion
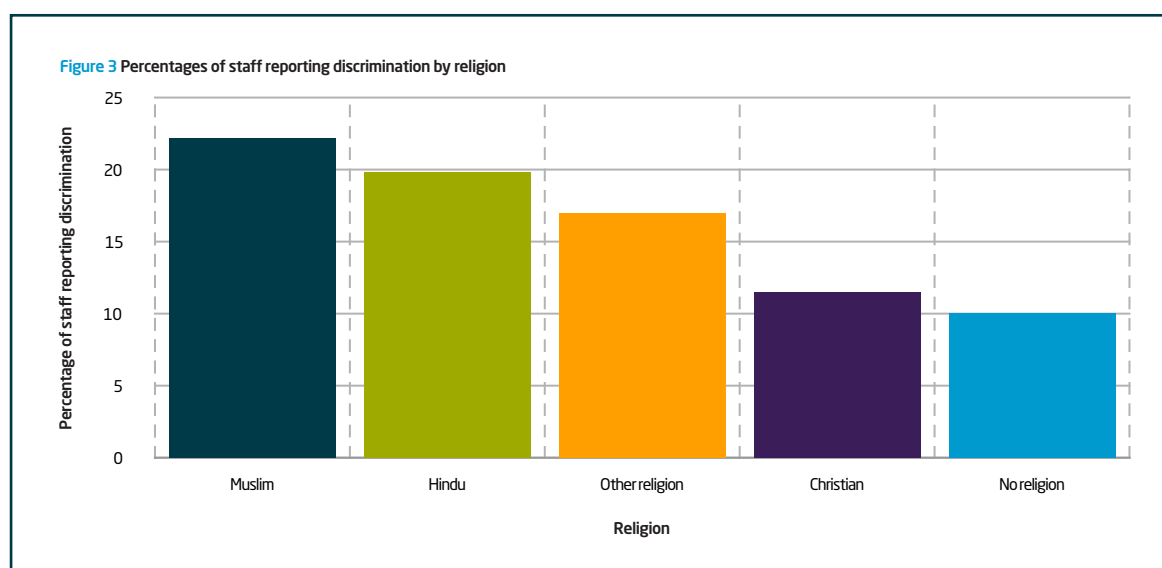
Disability

Staff are asked in the survey to report whether they have a longstanding illness, health problem or disability and are categorised as having a disability if they answer 'yes' to this question. Staff with a disability experience high levels of discrimination overall (18.4 per cent) compared with those without a disability (10.5 per cent) – and most of this is due to discrimination by colleagues.

Unsurprisingly, the largest difference between staff with a disability and those without is in relation to discrimination on the basis of disability (4.4 per cent compared with 0.1 per cent), but there are reported differences in relation to other factors too, notably age (3.6 per cent compared with 1.9 per cent).

The level of discrimination against disabled staff is remarkably high. Indeed, the odds of experiencing discrimination (compared with non-disabled staff) are higher for this category than for any other (gender, ethnicity, age, etc).

Staff groups

As reported in the data by trust type, overall discrimination is highest among ambulance staff (22.1 per cent). Reported levels of discrimination on the basis of gender and of age are particularly high among ambulance staff.

Across the full range of organisations, nursing assistants reported relatively high levels of discrimination (17.3 per cent), with ethnic background being the most significant factor in this. Medical and dental staff also experience relatively high levels of discrimination (13.5 per cent) along with nursing staff (14 per cent).

Source of discrimination

People from some ethnic backgrounds – particularly black and Asian – have far higher odds of experiencing discrimination from patients, their relatives or other members of the public, and these are very strong and consistent effects. The reported experience of discrimination from managers, team leaders or other colleagues is far less pronounced. However, there are differences between non-white and white groups, with the odds of black staff being discriminated against by their managers, team leaders and colleagues 2.64 times those of white staff.

Levels of discrimination from this source are similarly high for disabled staff, who are 2.5 times more likely to experience discrimination from managers, team leaders or other colleagues.

Controlling for other factors in the analysis produces little change to these effects, suggesting they are robust and unlikely to be caused by other factors.

Caveats

There are a number of limitations to this analysis. In particular, the analysis is based on more than 255,000 NHS staff who responded to the 2014 Staff Survey, which had a response rate of 42 per cent from the 624,000 staff invited to participate. Though this is a good response rate, there may be some response bias. We cannot know the extent to which the experiences of discrimination reported are truly representative of the whole of the NHS in England.

Furthermore, although we tried to control for some confounding factors, others were not measured (for instance, factors outside work, such as family, previous experience and education). In addition, some staff chose not to respond to some of the questions, particularly those relating to sexual orientation and religion.

Nevertheless, with a very large sample and a good response rate, we expect the results here to be a good (if not perfect) reflection of the reality in the NHS. Many of the findings are simply too large and compelling to dismiss as being due to methodological factors. The very large numbers of respondents to the staff survey mean that some problems may be masked. For example, we know that at the most senior levels of the NHS there are disproportionately few women and staff from black and other minority ethnic groups which may indicate discriminatory behaviour, not visible in these results

Recommendations

Our report addresses the question of how to make a difference to diversity and inclusion in the NHS at individual, team, organisational and national levels.

Individuals

Research suggests that conventional diversity training can boost individual knowledge and somewhat reduce levels of reported discrimination in organisations – but that it has little effect beyond that.

However, some strategies appear to be more successful in bringing about wider positive change.

- Evidence suggests that allies from non-disadvantaged or less discriminated-against groups can confront and have an impact on others' discriminatory behaviour more effectively than members of targeted groups alone.

- Messages communicated through diversity training interventions can have negative consequences. For example, asserting that most people exhibit unconscious race bias can legitimise that bias, making people feeling less motivated to discover their own prejudice and change their attitudes and behaviours.

- Training programmes in which participants agree a number of specific goals for their behaviour and attitudes (and review their progress) are more successful than interventions that focus on simply educating participants or encouraging discussion.

- A particularly successful intervention asks people to take the perspective of those in target groups – eg, 'If I spent a day in this organisation as a black person, I would probably experience…'.

- It is also important to educate people and leaders about the subtler aspects of discrimination. Although in society more generally there has been a move away from overt forms of discrimination (racist or sexist comments; consciously rejecting candidates because they have a mental health problem), more covert, subtle forms of discrimination continue – eg, negative humour, harassment and ridicule without overt discriminatory content – and these are harder to identify, assess and eradicate.

Teams

It is within teams that most discrimination occurs and where the opportunities to bring about change are most likely to be effective. The approaches likely to have the greatest benefit are those that encourage inclusion and value different perspectives.

Evidence suggests that teams are more inclusive when they are well-structured and have:

- a positive and motivating vision of the team's work

- five or six clear, agreed, challenging team objectives

- regular, useful feedback on performance in relation to the objectives

- clear roles and good mutual understanding of these roles

- shared team leadership where the hierarchical leader does not dominate but supports and facilitates

- a strong commitment to quality improvement and innovation

- a culture of valuing diversity

- a pattern of listening to and valuing all voices within the team

- an optimistic, cohesive climate characterised by a high level of team efficacy

- co-operative and supportive ways of working with other teams in the organisation

- regular 'time out' and 'after-action' reviews to reflect on and improve team performance

- a team leader who reinforces the value of a diversity of voices, views, skills, experiences and backgrounds as vital for creativity, innovation, good decision-making and team effectiveness.

Organisations

Effective diversity management policies, practices and procedures are vital. They can shape and reinforce equal employment via approaches to (among other things):

- recruitment and selection

- promotion policies

- coaching and mentoring of under-represented groups

- mobility policies and the use of quotas to influence promotion decisions

- job security including, for example, providing additional conditions for employees from protected classes

- appraisal processes, disciplinary procedures and rewards systems

- job design including workplace accessibility

- methods for encouraging staff participation in decision-making, information-sharing, dialogue and interaction throughout organisations.

Research suggests that it is particularly important to have visible and sustained top management support for positive diversity and inclusion policies and practices. But it is equally important that these are seen to be implemented effectively and are consistently reinforced by middle management and frontline supervisors.

Policies alone are not enough, however; organisations must take a strategic approach to creating cultures of inclusion. The key elements necessary for cultures of inclusion are also associated with high-quality health care. These elements include the following.

- **Vision and values.** A clear, compelling vision is important for encouraging staff to identify with their organisation and is likely to increase a sense of shared identity and to work against the development of 'in' and 'out' groups, which contribute to discrimination and exclusion. However, managers need to enact this shared vision and set of common values rather than merely espouse them.

- **Clarity of objectives and performance feedback.** A limited number of clear, agreed objectives, with regular, frequent feedback on performance for individuals and teams, creates clarity and accountability, minimising the ambiguity and confusion that feed stereotyping and discrimination.

- **People management, engagement and positivity.** All relationships – between staff and patients/service users, among staff members themselves, and between managers/leaders and staff – must be characterised by support, respect, care and compassion. Positivity reduces stereotyping and also the psychological distance that people perceive between themselves and others who are dissimilar.

- **Quality improvement, learning and innovation.** Where there is strong emphasis on quality improvement, learning and innovation in NHS organisations, there should also be strong emphasis on the value of a diverse workforce, on the importance of hearing everyone's voice and on the need to encourage constructive debate or controversy.

- **Team and team-based working.** The extent of team-based working in organisations will also affect diversity and inclusion. When most staff work in effective teams there is a culture of co-operation, support and inclusion that patients/service users and staff benefit from.

- **Collective leadership.** Collective leadership is characterised by all members of the organisation recognising that they play leadership roles at various points in their daily work and in their careers. It also reflects a collaborative approach where leaders work across boundaries in the interests of patient/service user care. Leadership styles that are supportive, respectful, warm and enabling are the norm.

Given the importance of culture in creating positive environments for diversity and inclusion, we recommend that every organisation should assess its culture at least every two years in relation to the six key elements described above.

National

There is evidence that national policies can bring about real change to tackle overt discrimination. To aid this, there should be clear guidance on how to develop climates for inclusion. The NHS should also exercise its power to set national standards around developing cultures of diversity and inclusion for all health and social care organisations
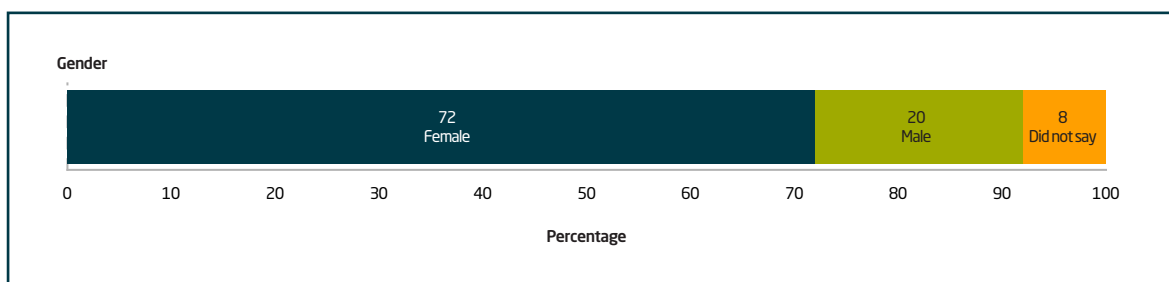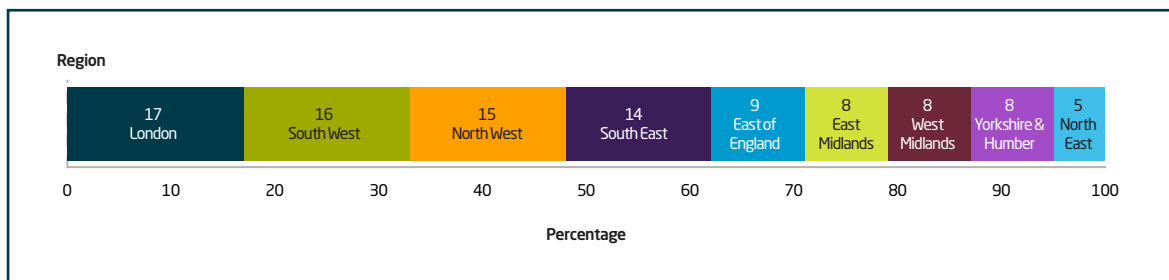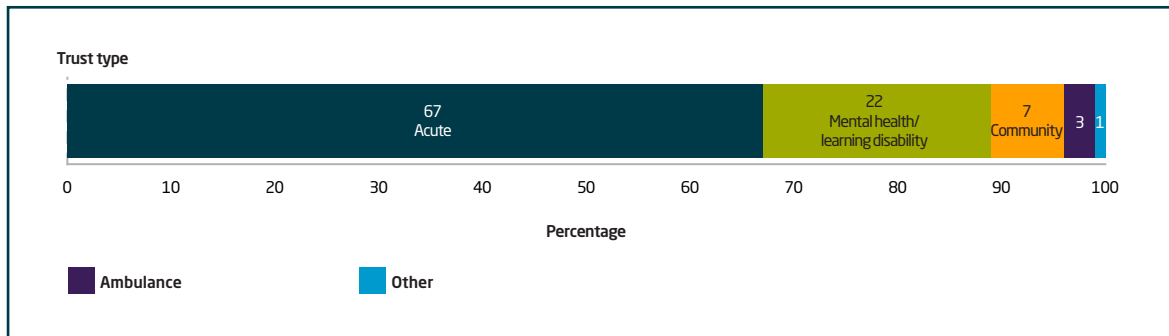
Conclusions

There is a clear and compelling need to cultivate a more diverse and effective NHS leadership that will nurture cultures of inclusion and high-quality care. The moral arguments against discrimination are clear. Experience of discrimination profoundly and pervasively damages the health, well-being and quality of work life of the many staff affected in the NHS. Research also shows that staff who are demoralised or demotivated for whatever reason will influence patients' experience of care. Furthermore, if staff experience discrimination as a result of their identity as gay, or Muslim, or disabled, or black, it is highly likely that patients who are members of these groups will experience similar discrimination.
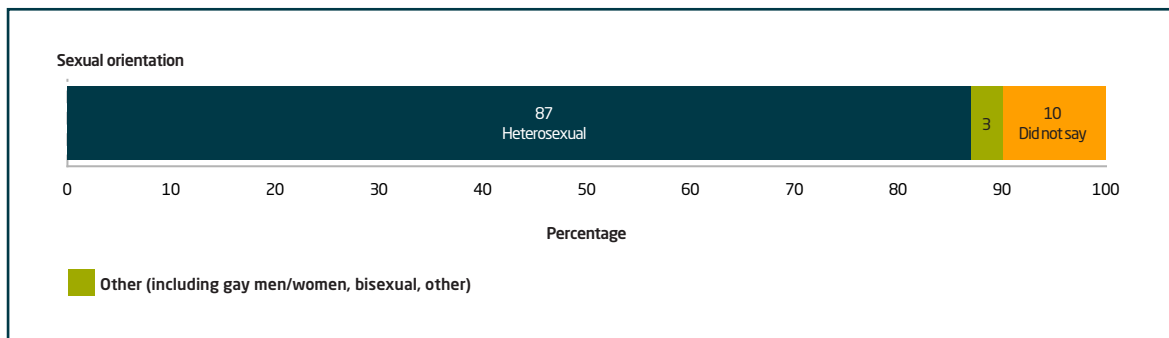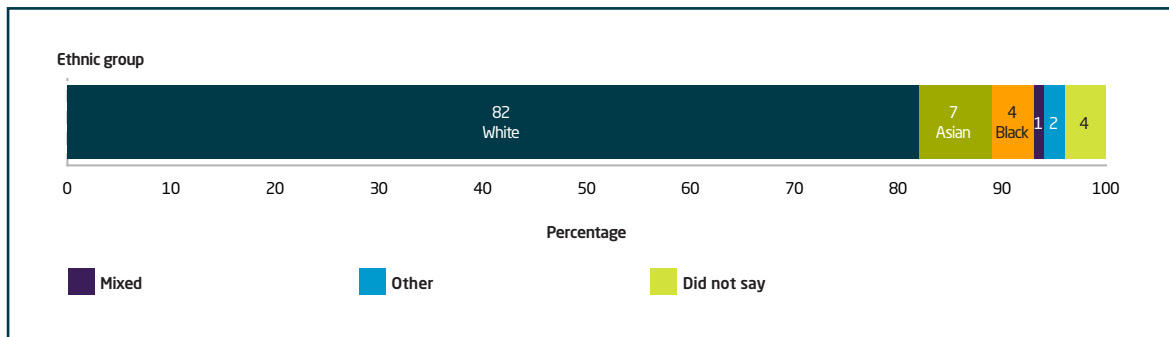
Many individuals, teams, organisations and national bodies in the NHS are now working hard to create climates of fairness, inclusion, compassion and equality. Every individual, team, leader, organisation and overseeing body must make comprehensive and sustained efforts to do the same.

The NHS is based on the principle of providing quality care for all and it is a source of great pride to the people of the United Kingdom. To safeguard its values, the whole system must take responsibility for solving the problem of discrimination. It will take concentration, vigour, courage and persistence to ensure that this change is effected and sustained over time. Now is the moment to begin.

Appendix: Distribution of respondents

Trust type

67 Acute	22 Mental health/ learning disability	7 Community	3 · 1

Percentage (0 10 20 30 40 50 60 70 80 90 100)

Ambulance   Other

Region

17 London	16 South West	15 North West	14 South East	9 East of England	8 East Midlands	8 West Midlands	8 Yorkshire & Humber	5 North East

Percentage (0 10 20 30 40 50 60 70 80 90 100)

Gender

72 Female	20 Male	8 Did not say

Percentage (0 10 20 30 40 50 60 70 80 90 100)

Age

1	13 21–30	19 31–40	26 41–50	33 51–65	4 Over 65	4

Percentage
(0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100)

■ 16–20   ■ Did not say

Ethnic group

82 White	7 Asian	4 Black	1	2	4

Percentage
(0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100)

■ Mixed   ■ Other   ■ Did not say

Sexual orientation

87 Heterosexual	3	10 Did not say

Percentage
(0, 10, 20, 30, 40, 50, 60, 70, 80, 90, 100)

■ Other (including gay men/women, bisexual, other)

Religious belief

Value	Label
55	Christian
2	
2	
3	
10	Did not say
28	Reported having no religion

Percentage

- Muslim
- Hindu
- Other

Disability

Value	Label
17	
78	Report not having a longstanding illness, health problem or disability
5	Did not say

Percentage

- Report a longstanding illness, health problem or disability

Occupational group

Value	Label
26	Nursing/midwifery
21	Admin and clerical/ central functions staff
20	Allied health professionals/ scientific and technical
7	
7	
4	
4	
2	
1	
3	
5	

Percentage

- Medical/dental
- Nursing assistants
- Managers
- Maintenance/ancillary staff
- Ambulance staff
- Social care staff
- Other
- Did not say

About the authors

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