MAKING THE DIFFERENCE:
DIVERSITY AND INCLUSION IN THE NHS
A summary of the King’s Fund report

This report for NHS England used data from the 2014 NHS staff survey, including responses from 255,150 individuals across 284 organisations, including all trust types and CCGs. The analysis used data from individuals, rather than organisations as a whole, to determine the demographic characteristics of respondents.

Discrimination was assessed in relation to the variables used in the survey: discrimination overall; discrimination from patients, families and the public; discrimination from managers, team leaders and colleagues; discrimination on the grounds of ethnicity, gender, religion, sexual orientation, disability and age.

HEADLINE FINDINGS

- Staff who are demoralised or demotivated influence patients’ experience of care. If staff suffer discrimination because of their disability or ethnic, religious or sexual identity, it is highly likely patients who are members of these groups will have a similar experience.
- Reported levels of discrimination are highest in ambulance trusts, but discrimination on the basis of ethnicity is highest in acute and mental health/learning disability trusts.
- Reported overall discrimination is higher in London than elsewhere, from all sources.
- At the most senior levels of the NHS there are disproportionately fewer women and staff from black and other minority ethnic groups, which due to the high numbers of respondents to the staff survey, is not reflected in the results of this analysis.

Levels of reported discrimination by protected characteristic groups

- Overall, women are less likely to report experiencing discrimination than men, except in ambulance trusts, where staff are twice as likely as those in acute hospitals to report discrimination on the basis of gender, with more women reporting this than men.
- Discrimination reported by non-heterosexual staff is ten times higher in ambulance trusts than among medical and dental staff.
- Younger people are more likely to report experiencing discrimination than older people.
- Reported levels of discrimination are highest for black employees (30.9 per cent), but are much higher for all non-white groups than for white employees. This is particularly pronounced in relation to discrimination from patients, relatives and the public.
- Nurses, midwives and nursing assistants are far more likely than medical staff to experience discrimination on the basis of ethnicity.
- People of all religions reported discrimination on the basis of faith, but this was by far the highest for Muslims.
- Levels of reported discrimination are higher for people with disabilities than for any other protected characteristic group, most of which is discrimination by colleagues.
RECOMMENDATIONS

• The whole system must take responsibility for solving discrimination. National policies can help tackle overt discrimination, and clear guidance on how to develop a climate of inclusion would be helpful.

• Research suggests that visible management support for positive diversity and inclusion policies and practices is important. These must be consistently reinforced by middle management and frontline supervisors.

• Areas where having effective diversity management policies and practices is vital include: recruitment; promotion; mentoring for under-represented groups; use of quotas; and appraisal and disciplinary procedures.

A strategic approach

A strategic approach to creating a culture of inclusion is key at an organisational level. Every organisation should assess its culture at least every two years in relation to six key elements:

1. Vision and values – a compelling vision can increase a sense of shared identity and work against ‘in’ and ‘out’ groups developing.
2. Clarity of objectives and performance feedback – a limited number of objectives and frequent feedback create clarity and accountability, minimising the ambiguity that can feed discrimination.
3. People management, engagement and positivity – support, respect, care and compassion reduce stereotyping and psychological distance between people who see themselves as dissimilar.
4. Quality improvement, learning and innovation – a culture of improvement and innovation fosters constructive debate and a listening culture.
5. Team-based working – when staff work in effective teams there is a culture of cooperation, support and inclusion that benefits patients and staff.
6. Collective leadership – all members of the organisation recognise that they play leadership roles at various points in their daily work and careers.

Working in teams

It is within teams that most discrimination occurs and where opportunities to bring about change are most likely to be effective. Evidence suggests teams that are more inclusive tend to have:

• Having five or six clear, agreed, challenging team objectives
• Regular, useful feedback on performance in relation to objectives
• Shared team leadership where the hierarchical leader support and facilitates rather than dominating
• A pattern of listening to and valuing all voices within the team
• Regular ‘time out’ and ‘after action’ reviews to reflect on and improve team performance

Successful strategies

Other strategies which appear to be successful in bringing about positive change include:

• Having allies from non-disadvantaged groups can increase the impact on others’ behaviour.
• Some messages about diversity can have negative consequences, for example, asserting that most people exhibit unconscious race bias may legitimise such bias.
• Training programmes where participants agree specific goals for their behaviour and attitudes are more successful than those that focus simply on education or discussion.
• A particularly successful intervention asks people to put themselves in the position of target groups.
• Educating people and leaders about the subtler aspects of discrimination such as negative humour, harassment and ridicule without overt discriminatory content – which are harder to identify and eradicate.