The King's Fund

Ideas that change health care

Making the difference: diversity and inclusion in the NHS

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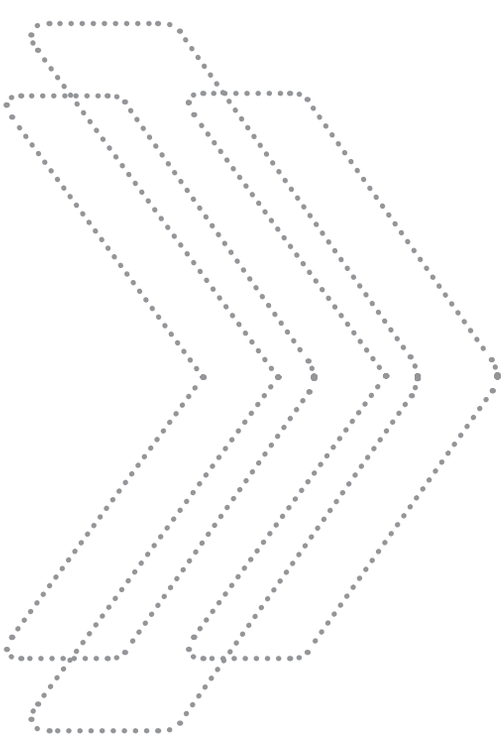

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Summary

National Health Service (NHS) culture is sustained by a set of core values including respect and dignity, compassion, and inclusion – the latter refers to a commitment to treat everyone with equal respect and significance. Given the diversity of the NHS workforce, these values have particular significance.

Recent research demonstrates that very little progress has been made in the past 20 years to address the issue of discrimination against black, minority and 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.

In this report we use data from the NHS Staff Survey to assess the scale of the problem before drawing on wider work on climates of inclusion to suggest comprehensive strategies to bring about lasting and pervasive change. The data is interrogated to answer the following questions.

- What are the differences in experienced discrimination between NHS staff from different demographic and work backgrounds (eg, ethnic group, gender, occupational group etc)?
- Do these differences persist when controlling for other background variables? (eg, are there still differences between ethnic groups when taking into account effects of gender, occupational group etc?).

The analysis was conducted on data from the 2014 NHS Staff Survey, which 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.

Key findings

- Overall, levels of reported discrimination 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 discrimination on the basis of their faith, but this is by far the highest among Muslims.
- Disabled staff report very high levels of discrimination; levels of reported discrimination are highest among all the protected characteristics groups.

There was also significant variation by organisation. In some organisations there was substantially more discrimination against non-White staff, whereas in others there was little or no difference between White and non-White staff. Staff in ambulance trusts generally reported higher levels of discrimination in comparison with staff in other trust types.

This report also addresses the question of how to make a difference at individual, team, organisational and national levels.

Individual

Research suggests that, at best, conventional diversity training can boost individual knowledge but has little effect beyond that. However, there are some strategies that appear more successful in bringing about positive change.

- Evidence suggests that allies from non-disadvantaged/discriminated groups can confront and have an impact on others' discriminatory behaviour more effectively than members of target groups.
- Evidence also suggests that messages communicated through diversity training interventions can have negative consequences. For example, asserting that most people exhibit unconscious race bias can legitimise that bias by labelling it as normative, with the result that people are less motivated to discover their own blind spots and change their attitudes and behaviours.
- Training programmes that include goal-setting by participants focused on changing their behaviours and attitudes, are more successful than interventions that focus on simply educating participants or encouraging discussion.
- It is also important to educate people and leaders about the subtler aspects of discrimination. Generally, there has been a change in our society away from overt to more covert forms of discrimination and this is a sign of progress. However, these more subtle forms of discrimination are harder to identify, assess and eradicate.
- A particularly successful intervention encourages perspective-taking.

Teams

Evidence suggests that teams are more inclusive when they are well-structured and have effective processes. These processes include:

- 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 role-understanding
- shared team leadership where the hierarchical leader does not dominate but supports and facilitates
- a strong commitment to quality improvement and innovation
- valuing diversity as a positive element of the team
- 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 to review team performance and how it can be improved
- a team leader who reinforces the value of diversity of voices, views, skills, experiences and backgrounds as vital for creativity, innovation, good decision-making and team effectiveness.

Organisations: HR policies, practices and procedures

It is vital that top management establish effective diversity management policies, practices and procedures. Such organisational HR shapes and reinforces 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, additional approvals for terminating 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 consistently and are reinforced by middle management and frontline supervisors.

The research literature suggests that HR policies alone are not a solution. Too often, the HR function reacts to discrimination problems and does not take a strategic approach to creating cultures of inclusion.

The culture of an organisation is critical for creating climates of inclusion or of discrimination and harassment. The key elements necessary for cultures of inclusion – respect and kindness – are also associated with high-quality health care. They include: vision and values; clarity of objectives and performance feedback; people management; quality improvement, learning and innovation; teamworking; and collective leadership.

- Vision and values. An inclusive superordinate identity alleviates the negative effects of employee dissimilarity on group identification and also promotes a stronger sense of belonging. However, managers need to enact this shared vision and set of common values rather than merely espouse them for the positive benefits.
- Objectives and performance feedback. Where staff feel clear about their roles, there is less ambiguity and confusion. Teams, from the executive team down, must have a limited number (no more than five or six) of clear, agreed objectives and regular and frequent feedback on performance. The same applies to individuals within the organisation. Where individuals at every level have clear goals and good feedback, the associated clarity and accountability ensure that the ambiguity and confusion that feed stereotyping and discrimination are minimised.
- People management, engagement and positivity. It is fundamental to nurturing such cultures that all relationships are characterised by support, respect, care and compassion – between staff and patients/service users, between staff members and between managers/leaders and staff. Where staff are overworked, stressed, marginalised by their leaders and blamed, engagement levels are likely to be low and discrimination and stereotyping high. Moreover, it is important to encourage positive emotional environments in NHS organisations, characterised by optimism, cohesiveness and efficacy. Positivity reduces stereotyping and reduces the psychological distance people perceive between themselves and others who are dissimilar.
- Quality improvement 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, the importance of hearing the voice of every individual and 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 day's work and in their careers. It also reflects shared leadership in teams; a collaborative style 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 to 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 in 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. The moral arguments against discrimination are clear. The human costs are huge. And the impact on patient care is clearly negative and substantial. If staff experience discrimination as a result of their identity as gay, or Muslim, or disabled, or Black African, there is no doubt 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 stands for valuing, caring, quality and compassion for all and it is a source of great pride to the people of the United Kingdom. It is necessary therefore that the whole of the system takes responsibility for solving the problem in order to continue to safeguard the founding values of the NHS. It will take concentration, vigour, courage and persistence to ensure this change is effected and sustained over time. Now is the moment to begin.

Introduction

English National Health Service (NHS) organisations represent the shared commitment of the people of the country to provide care and compassion for those in need, regardless of status, wealth, religion, ethnicity, sexual orientation or any other characteristic. The NHS culture is therefore sustained by a set of core values including respect and dignity, compassion and inclusion – the latter refers to a commitment to treat everyone with equal respect and significance.

To ensure that the aspirations implied by these values are fulfilled, NHS organisations must embody those values in all relationships, not only those with patients, service users and carers, but also in relationships between staff and between professional groups. Compassion, caring, respect, dignity and equality will be authentic and sustainable in organisations where these values are intrinsic to the culture rather than simply espoused but not enacted.

In this report we present analyses of data exploring the extent to which NHS provider organisations and a small number of clinical commissioning groups (CCGs) in England are characterised by these values. Not surprisingly, given levels of discrimination in UK society more generally, we demonstrate deficiencies. The report makes recommendations, based on international research into inclusion and discrimination in organisations, on how to achieve positive changes that will promote inclusion, respect and dignity for all working in the NHS in the future.

This report is structured into three main sections. First, the context is briefly described; then we present data drawn from the NHS Staff Survey describing staff perceptions of discrimination in the NHS. We then draw on international research to describe what is known about which organisational interventions are likely to be most effective in changing cultures to ensure that discrimination is reduced and that inclusiveness, respect and dignity for all are promoted.

The context

Many organisations now embrace diversity and consider it critical to organisational success and reputation in both the public and private sectors. Yet it is also clear that progress in creating genuinely inclusive

work environments has been very slow. Discrimination is still prevalent in organisations (McKay and Avery 2015; Kulik 2014; Guillaume et al 2013).

There are several strands of research in diversity management including relational demography (ie, individual level dissimilarity from peers), work group diversity and organisational diversity (Joshi et al 2011). This research has clarified the underlying mechanisms by which diversity facilitates performance, social integration and employee wellbeing. Relevant factors that have been identified include strategy, team/department characteristics, leadership, individual differences and climate/culture (Guillaume et al 2015; van Knippenberg et al 2013). Research in diversity management has focused on the consequences of demographic diversity or inclusion climate/cultures as well as diversity management strategies, policies and practices. We review this research briefly in the final section of this report.

It is clear however, that diversity in organisations can increase team and organisational effectiveness by enabling organisations to draw from a large pool of talent, increase capacity to innovate and make better decisions, and better satisfy patient/service user needs (Herring 2009; Richard et al 2004; Richard 2000; Cox 1993; Cox and Blake 1991). Researchers have therefore moved past the question of whether diversity affects outcomes and have instead begun to address the question of when and how diversity can facilitate positive outcomes (Joshi and Roh 2009). The case for diverse leadership is well-established. A recent study (Hunt et al 2014) found a significant relationship between more diverse leadership and organisational profitability. Similarly, in the NHS, there is evidence (King et al 2011) that where there is better ethnic representation among frontline staff then the quality of care and use of resources in NHS organisations is better.

But it can also lead to less favourable outcomes when not managed properly (Cox and Blake 1991). There is much evidence of longstanding discrimination in the NHS with previous research mainly focusing on the experience of staff from black and minority ethnic (BME) backgrounds (Kline 2014; Limb 2014; Stevenson and Rao 2014; Harris et al 2013; Kline 2013; Archibong and Darr 2010). However, recent research (Kline 2014) demonstrates that very little progress has been made in the past 20 years to address the issue of discrimination against BME staff in the NHS. Kline's report examined discrimination in governance and leadership in the NHS in London and the potential impact on patient care. The report found that the BME population is largely excluded from senior positions, both as NHS managers and as NHS trust board members and that this lack of representation was reflected also in national bodies: Monitor, the Care Quality Commission, NHS Trust Development Authority, NHS England, NHS Litigation Authority and Health Education England. There

were no BME board members on any board of the national bodies. The research revealed this picture of the NHS in London.

- Only one chair out of 40 was from a BME background.
- There were no BME chief executives in any London trust.
- The proportion of chief executives and chairs from a BME background has decreased from 5.3 per cent; it currently stands at 2.5 per cent.
- The proportion of (London NHS trust) board members from a BME background is 8 per cent, an even lower number than was found in 2006 (9.6 per cent).
- 17 out of 40 trusts had no BME board members, despite 45 per cent of the population and 41 per cent of the NHS workforce in London being from BME backgrounds.
- Two-fifths of trust boards in London had no BME members at all.
- There has been no significant change in the proportion of non-executive BME trust board appointments in recent years, continuing the pattern of under-representation compared to both the workforce and the local population.
- The likelihood of White staff becoming managers/senior managers was three times higher than that for BME staff.

Despite initiatives designed to improve the situation, representation of BME staff at leadership level has worsened over time.

A recent and, as yet, untested response to discrimination against BME staff is the introduction in April 2015 of a new mandatory workforce race equality standard (WRES), which requires trusts to self-assess against nine indicators of discrimination against ethnic minority staff. The nine standards include representation of BME staff on boards and extent of variation between ethnic groups in the experience of discrimination. It is hoped that a focus on race equality will lead to more robust efforts on all equality strands (though previous research suggests this is unlikely to be the case).

The problems of exclusion, discrimination and injustice are not confined to differences based on ethnicity. Studies suggest there are similar problems in relation to sexual orientation, disability, religion, age, gender and functional background (eg, doctors, nurses, health care assistants) and that even within the broad category of BME staff, there may be wide variations in the experience of discrimination, dependent on the particular sub-category of ethnicity that staff fall into (Disability Rights 2014; Hoel 2014; Newman 2014; Royal College of Physicians 2009).

In this report we use data from the NHS Staff Survey to assess the scale of the problem before drawing on our wider work on climates of inclusion

to suggest comprehensive strategies to bring about lasting and pervasive change.

2. Analysis of 2014 NHS Staff Survey data on discrimination

Introduction

The analysis aims to answer the following broad questions:

1. What are the differences in experienced discrimination between NHS staff from different demographic and work backgrounds (eg, ethnic group, gender, occupational group etc.)?
2. Do these differences persist when controlling for other background variables? (eg, are there still differences between ethnic groups when taking into account effects of gender, occupational group etc?)

Sample and variables

The analysis was conducted on data from the 2014 NHS Staff Survey, which included responses from 255,150 individuals across 284 organisations (including 157 acute trusts, 57 mental health/learning disability trusts, 40 CCGs, 19 community trusts and 11 ambulance trusts).

In order to answer the questions above, analysis involved using respondent-level data (that is data from individuals rather than from organisations as a whole). In other words, individual responses were used from staff in organisations so that we could determine the demographic characteristics of respondents when they reported on their experiences of discrimination. All the data is self-reported. It should be noted that sample sizes were lower in some analyses because of missing data.

The variables used for the analysis were as follows. First, the nine discrimination variables:

Variable	*Overall prevalence (%)*
1. Any experience of discrimination	11.9
2. Experience of any discrimination from patients, their relatives or other members of the public	5.9

3. Experience of any discrimination from managers, team leaders or other colleagues	8.0
4. Experience of discrimination on the grounds of ethnic background	4.3
5. Experience of discrimination on the grounds of gender	2.2
6. Experience of discrimination on the grounds of religion	0.6
7. Experience of discrimination on the grounds of sexual orientation	0.6
8. Experience of discrimination on the grounds of disability	0.9
9. Experience of discrimination on the grounds of age	2.2

Next, the background variables used (and the groupings, with percentages in each) were:

- Trust type:
  67% acute
  22% mental health/learning disability
  7% community
  3% ambulance
  1% other

- Gender:
  72% female
  20% male
  8% did not say

- Age:
  1% 16–20
  13% 21–30
  19% 31–40
  26% 41–50
  33% 51–65
  4% over 65
  4% did not say

- Ethnic group:
  82% White
  7% Asian
  4% Black
  1% Mixed

2% other
4% did not say

- Sexual orientation:
  87% heterosexual
  3% other [including gay men/women, bisexual, other]
  10% did not say

- Religious belief:
  55% Christian
  2% Muslim
  2% Hindu
  3% other
  10% did not say
  28% reported having no religion

- Occupational group:
  26% Nursing/midwifery
  21% Admin and clerical/Central functions staff
  20% Allied health professionals/scientific and technical
  7% Medical/dental
  7% Nursing assistants
  4% Managers
  4% Maintenance/ancillary staff
  2% Ambulance staff
  1% Social care staff
  3% other
  5% did not say

- Region
  17% London
  16% South West
  15% North West
  14% South East
  9% East of England
  8% East Midlands
  8% West Midlands
  8% Yorkshire and Humber
  5% North East

- Working hours:
  20% part-time
  77% full-time
  3% did not say

- Disability:
  17% report a longstanding illness, health problem or disability
  78% report not having a longstanding illness, health problem or disability
  5% did not say

- Patient contact:

66% have regular patient contact
15% have occasional patient contact
15% have no patient contact
4% did not say

- Length of service with organisation:
  8% less than a year
  11% 1–2 years
  15% 3–5 years
  21% 6–10 years
  17% 11–15 years
  24% more than 15 years
  4% did not say

Although the distribution of responses does not exactly mirror the distribution of groupings of staff found in the NHS in England, the size of the sample providing the data (more than a quarter of a million) gives confidence in the representativeness of the results.

Question 1: Differences by groups of staff

The tables on the following pages show prevalence scores of the nine discrimination variables for each breakdown by staff group (excluding 'did not say', which includes 'prefer not to say' where that option was presented). Due to the very large sample size, almost all differences are statistically significant; therefore the focus should be on the magnitude of the differences rather than focusing simply on whether such differences exist.

These were the key findings.

- Overall, levels of reported discrimination 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, though this is reversed in 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 the least; all other non-White groups are far more likely to report experiencing discrimination than White employees.
- People from all religions report discrimination on the basis of their faith, but this is by far the highest among Muslims.
- Disabled staff report very high levels of discrimination; levels of reported discrimination are highest among all the protected characteristics groups.

1.1 Differences by trust type

		Overall (%)	Acute (%)	Community (%)	MH/LD (%)	Ambulance (%)	Other (%)
	Any discrimination	**11.9**	11.7	8.9	12.9	19.7	5.3
Discrimination from…	…patients/relatives/public	**5.9**	5.6	3.7	7.1	10.9	1.5
	…manager/team leader/other colleagues	**8.0**	8.1	6.3	7.7	12.6	4.3
Discrimination on the basis of…	…ethnic background	**4.3**	4.5	2.3	4.8	3.0	0.8
	…gender	**2.2**	2.0	1.6	2.7	6.1	1.1
	…religion	**0.6**	0.6	0.3	0.7	0.8	0.1
	…sexual orientation	**0.6**	0.5	0.3	0.8	2.1	0.2
	…disability	**0.9**	0.8	0.9	1.1	1.4	0.6
	…age	**2.2**	2.1	1.5	2.5	5.4	1.2

MH/LD = Mental health/learning disability

This table reports differences in discrimination by trust type. It shows that the highest levels of discrimination are reported in ambulance trusts (19.7%) and the lowest levels are in 'other' trust types (5.3%) followed by community trusts (8.9%). Discrimination on the basis of ethnicity is reported by 4.5% and 4.8% of those in acute and Mental Health/Learning Disability trusts respectively. Staff in ambulance trusts face much more discrimination than staff in any other type of trust. This is the case not only for discrimination from patients/members of the public, but also for discrimination from colleagues. Discrimination on the basis of gender and age are particularly high in ambulance trusts (we examine this issue below). Staff in community trusts are generally less likely to face discrimination.

1.2 Differences by region

	London (%)	South East (%)	South West (%)	East of England (%)	East Midlands (%)	West Midlands (%)	Yorkshire and The Humber (%)	North West (%)	North East (%)
Any discrimination	16.9	12.5	10.7	12.7	11.5	11.1	9.6	9.9	8.7
From…									
…patients/relatives/public	9.3	6.6	5.2	6.2	5.3	5.4	4.2	4.5	3.4
…manager/team leader/other colleagues	10.9	8.2	7.2	8.6	7.7	7.3	6.7	6.8	6.4
On the basis of…									
…ethnic background	9.2	4.6	3.2	4.7	3.5	3.7	2.4	2.3	1.4
…gender	3.2	2.2	2.1	2.2	2.1	2.0	2.0	2.0	1.3
…religion	1.1	0.5	0.3	0.5	0.5	0.6	0.5	0.5	0.3
…sexual orientation	0.8	0.7	0.5	0.5	0.5	0.4	0.3	0.6	0.4
…disability	0.8	0.9	0.9	0.8	0.9	0.8	0.9	1.0	0.6

…age	2.6	2.4	2.2	2.5	2.0	2.2	1.9	2.0	1.8

This table shows levels of discrimination by region of the country. Reported discrimination rates are higher in London than elsewhere – this is true from whatever source (patients, relatives, the public, manager, team leader, other colleagues) although differences are marginal for sexual orientation and age, and are no higher for disability than elsewhere. Few clear differences exist between the other regions; generally the South East and the East of England have slightly higher levels than elsewhere, and discrimination is loweest in the northern regions, but the differences are small.

1.3 Differences by gender

		Female (%)	Male (%)
	Any discrimination	10.8	14.6
Discrimination from…	…patients/relatives/public	5.2	8.2
	…manager/team leader/other colleagues	7.2	9.2
Discrimination on the basis of…	…ethnic background	3.7	6.1
	…gender	2.0	3.0
	…religion	0.4	1.1
	…sexual orientation	0.3	1.5
	…disability	0.8	1.0
	…age	2.0	2.7

Men report experiencing more discrimination (14.6%) than women (10.8%), on all counts, although interestingly the difference is slightly smaller for discrimination on the basis of gender than it is for some other forms of discrimination. Males are more likely to experience discrimination on the basis of ethnicity (6.1%) than women (3.7%).

1.4 Differences by age group

		16–20 (%)	21–30 (%)	31–40 (%)	41–50 (%)	51–65 (%)	66+ (%)
	Any discrimination	11.2	13.6	13.2	12.5	10.4	8.8
Discrimination from…	…patients/relatives/public	6.0	8.3	7.2	6.3	4.3	3.4
	…manager/team leader/other colleagues	6.6	7.2	8.4	8.5	7.7	6.6
Discrimination on the basis of…	…ethnic background	2.0	4.3	5.6	5.2	3.2	2.1
	…gender	2.5	3.4	3.0	2.2	1.5	1.0
	…religion	0.9	0.8	0.7	0.6	0.4	0.3
	…sexual orientation	1.0	0.8	0.7	0.7	0.4	0.3
	…disability	0.4	0.6	0.8	0.9	1.0	0.9
	…age	7.6	5.5	1.5	1.0	2.3	2.7

Most of the patterns here suggest that discrimination is experienced more by people towards the middle of the age range - 13.6% and 13.2% of those in the 21-30 and 31-40 brackets report discrimination, compared with 11.2% of those in the 16-

20 bracket and 8.8% of those in the 66+ bracket. However, this is clearly different when considering discrimination on the basis of age, which is highest among the youngest age groups, with a slight rise towards the older end of the range as well. In addition, discrimination from patients/relatives/members of the public tends to be focused more towards younger staff in comparison with discrimination from colleagues.

1.5 Differences by ethnic group (broad categories)

		White (%)	Mixed (%)	Asian (%)	Black (%)	Other (%)	Non-White (aggregate) (%)
	Any discrimination	9.5	22.0	23.6	30.9	23.9	25.6
Discrimination from…	…patients/relatives/public	4.1	13.3	14.6	21.7	14.9	16.6
	…manager/team leader/other colleagues	6.7	13.1	14.7	16.8	15.1	15.2
Discrimination on the basis of…	…ethnic background	1.7	13.3	18.1	25.3	15.6	19.4
	…gender	2.1	4.3	2.5	3.2	3.3	3.0
	…religion	0.3	1.4	2.6	1.5	1.6	2.0
	…sexual orientation	0.6	1.0	0.3	0.4	0.8	0.5
	…disability	0.9	0.9	0.5	0.8	1.0	0.7
	…age	2.2	4.1	2.1	2.2	2.4	2.4

Overall, discrimination is reported most by staff from Black groups (30.9%), followed by other non-White groups; each of these groups reportedly experiences discrimination more than twice as much as White staff (9.5%). This difference is greatest in relation to discrimination from patients/relatives/members of the public, where reported discrimination levels for non-White groups (16.6%) are at least four times those for White staff (4.1%), and more than five times greater for Black staff (21.7%).

Unsurprisingly, these differences are almost completely explained by discrimination on the basis of ethnic background, which is highest for Black staff (25.3 per cent), followed by Asian staff (18.1 per cent), 'Other' (everything besides White, Black African/Caribbean, Indian/Pakistani/Bangladeshi/ other Asian and Mixed) (15.1 per cent), and Mixed (13.3 per cent) – all of which are several times greater than for White staff (1.7 per cent), a category which includes Irish and other non-British groups.

The following table shows the detailed breakdown of this, indicating clearly that although there is some reported discrimination on the basis of ethnic background among White British staff, the majority falls elsewhere. The highest level of discrimination on the basis of ethnic background, by some distance, is reported by Black African staff (27.9 per cent).

1.6 Differences by ethnic group (detailed breakdown)

	White British (%)	White Irish (%)	Other White (%)	White and Black Caribbean (%)	White and Black African (%)	White and Asian (%)	Any other mixed background (%)	Indian (%)
Any discrimination	8.8	14.7	21.1	24.4	24.0	15.9	24.1	20.8
From…								
…patients/relatives/public	3.6	8.0	12.5	15.1	15.5	8.9	14.6	11.8
…manager/team leader/other colleagues	6.3	9.0	12.9	14.4	12.7	9.7	14.9	13.5
On the basis of…								
…ethnic background	1.0	6.4	12.6	16.1	16.3	8.4	14.0	15.5
…gender	2.0	2.9	3.2	4.5	2.7	3.1	5.5	2.3
…religion	0.3	0.9	1.0	0.9	1.8	1.7	1.3	1.7
…sexual orientation	0.6	0.9	0.9	1.2	0.5	1.3	1.0	0.3
…disability	0.9	1.2	0.9	0.9	0.7	0.5	1.2	0.5

…age	2.2	2.7	2.6	4.9	3.4	2.4	5.2	1.9

	Pakistani (%)	Bangladeshi (%)	Other Asian (%)	Black Caribbean (%)	Black African (%)	Other Black (%)	Chinese (%)	Other (%)
Any discrimination	21.9	19.4	29.3	25.7	33.2	31.1	17.6	26.9
From…								
…patients/relatives/public	11.8	9.0	20.5	16.2	24.6	18.5	11.1	16.7
…manager/team leader/other colleagues	14.7	14.0	16.8	15.8	17.0	20.3	10.2	17.4
On the basis of…								
…ethnic background	15.4	12.2	23.8	19.8	27.9	24.5	13.1	16.8
…gender	2.2	2.7	2.8	3.1	3.2	4.7	2.9	3.5
…religion	7.3	7.1	1.8	1.1	1.6	2.2	0.6	2.1
…sexual orientation	0.3	0.4	0.5	0.7	0.3	0.2	0.6	0.9
…disability	0.6	0.7	0.4	1.3	0.6	1.7	0.3	1.3
…age	2.3	2.7	2.2	2.6	2.0	2.9	2.9	2.2

1.7 Differences by sexual orientation

		Heterosexual (%)	Other (%)
	Any discrimination	11.3	20.9
Discrimination from…	…patients/relatives/public	5.5	12.5
	…manager/team leader/other colleagues	7.5	12.8
Discrimination on the basis of…	…ethnic background	4.1	4.9
	…gender	2.1	4.7
	…religion	0.5	0.8
	…sexual orientation	0.2	9.8
	…disability	0.8	1.9
	…age	2.1	3.3

Discrimination is considerably higher for non-heterosexual groups (20.9%) than for heterosexual staff (12.3%). This is mostly due to discrimination on the basis of sexual orientation (9.1% compared with 0.2% for heterosexual staff), although there are also higher rates of discrimination on the basis of gender, disability and age, and slightly higher for other bases as well. This applies for both sources of discrimination (although the difference is slightly greater for discrimination from patients/relatives/members of the public).

1.8 Differences by religion

		Christian (%)	Muslim (%)	Hindu (%)	Other religion (%)	No religion (%)
	Any discrimination	11.5	22.2	19.4	17.0	10.0
Discrimination from…	…patients/relatives/public	5.8	12.7	10.6	8.6	4.7
	…manager/team leader/other colleagues	7.7	14.4	12.7	11.5	6.6
Discrimination on the basis of…	…ethnic background	4.5	15.3	13.6	6.9	1.9
	…gender	1.9	2.7	2.5	2.8	2.5
	…religion	0.4	8.0	1.3	1.9	0.2
	…sexual orientation	0.4	0.4	0.3	1.1	0.8
	…disability	0.8	0.6	0.6	1.4	0.8
	…age	2.0	2.4	2.1	2.9	2.4

Reported discrimination on the basis of religion is very much higher among Muslims than others (8.0 per cent), followed by other religions (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, which explains why the differences in experiencing any discrimination are less pronounced between Muslim and other staff, than the differences in experiencing discrimination based on religion (which are substantial).

1.9 Differences by disability status

		Not disabled (%)	Disabled* (%)
	Any discrimination	10.5	18.4
Discrimination from…	…patients/relatives/public	5.5	7.6
	…manager/team leader/other colleagues	6.7	13.9
Discrimination on the basis of…	…ethnic background	4.2	4.5
	…gender	2.0	3.1
	…religion	0.5	0.8
	…sexual orientation	0.5	1.0
	…disability	0.1	4.4
	…age	1.9	3.6

* 'Disabled' includes those with a longstanding illness or health problem

Disabled staff experience very high levels of discrimination (18.4%) and particularly when this is compared with those without a disability – and most of this difference is due to discrimination from colleagues. In terms of the attributed basis of discrimination, the largest difference is (unsurprisingly) 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).

1.10 Differences by working hours

		Part-time (%)	Full-time (%)
	Any discrimination	8.5	12.8
Discrimination from…	…patients/relatives/public	3.1	6.7
	…manager/team leader/other colleagues	6.6	8.3
Discrimination on the basis of…	…ethnic background	2.0	4.9
	…gender	1.4	2.4
	…religion	0.4	0.6
	…sexual orientation	0.2	0.7
	…disability	0.9	0.9
	…age	1.4	2.4

Full-time staff appear to experience discrimination more than part-time staff, which is likely to be due to the greater exposure to possible discrimination as a consequence of spending more time at work. It is noticeable that levels of

discrimination from patients are twice as high amongst full time (6.7%) as part time staff (3.1%), which supports the interpretation that more exposure to potential discrimination is one of the consequences of spending more hours at work.

1.11 Differences by contact with patients

		Regular contact (%)	Occasional contact (%)	No contact (%)
	Any discrimination	13.5	8.9	7.7
Discrimination from…	…patients/relatives/public	7.8	2.1	1.1
	…manager/team leader/other colleagues	8.1	7.8	7.2
Discrimination on the basis of…	…ethnic background	5.3	2.1	1.7
	…gender	2.6	1.5	1.3
	…religion	0.7	0.4	0.4
	…sexual orientation	0.7	0.4	0.3
	…disability	0.9	0.9	0.9
	…age	2.5	1.7	1.6

Consistent with the pattern of findings in the previous table, those staff who have contact with patients are far more likely to experience discrimination from patients/relatives/members of the public than those who do not (although 1.1 per cent of these still indicate that they have experienced discrimination – presumably from members of the public who are not patients). This is common across most categories, although the biggest differences are in reported discrimination on the basis of ethnic background (5.3% amongst those with regular patient contact compared with 1.7% among those with no patient contact), followed by gender and age.

1.12 Differences by organisational tenure

		Less than a year (%)	1–2 years (%)	3–5 years (%)	6–10 years (%)	11–15 years (%)	> 15 years (%)
	Any discrimination	9.7	12.5	13.6	13.2	12.9	9.5
Discrimination from…	…patients/relatives/public	5.8	7.2	7.2	6.5	6.2	3.9
	…manager/team leader/other colleagues	5.3	7.2	8.7	9.1	9.0	7.0
Discrimination on the basis of…	…ethnic background	4.3	5.0	5.5	5.0	4.9	2.2
	…gender	1.8	2.7	2.7	2.6	2.1	1.6
	…religion	0.6	0.7	0.7	0.7	0.5	0.3
	…sexual orientation	0.4	0.7	0.7	0.6	0.6	0.4
	…disability	0.4	0.6	0.8	1.0	1.1	0.9
	…age	2.2	3.1	2.8	2.1	1.7	2.0

The only significant finding to note here is that reported discrimination levels are somewhat higher among those who have worked for a moderate amount of time, and that these small differences are not much altered for particular sources or bases of discrimination. This U-shaped deterioration of working life experience mirrors that commonly found in organisations, with satisfaction highest early in organisational tenure and towards the end of working life.

1.13 Differences by occupational group

	Medical/ dental (%)	Nursing (registered) (%)	Nursing assistants (%)	AHP/ Scientific and technical (%)	Ambulance (%)	Managers (%)	Central functions (%)	Social care (%)	Ancillary (%)	Other (%)
Any discrimination	13.5	14.0	17.3	10.4	22.1	8.2	8.1	10.7	9.7	10.9
From…										
…patients/relatives/public	8.0	8.5	11.8	4.4	13.0	1.7	2.0	5.7	3.2	3.8
…manager/team leader/ colleagues	7.9	8.3	9.1	7.3	13.6	7.2	6.9	6.6	8.3	8.4
On the basis of…										
…ethnic background	7.1	6.5	7.7	2.9	3.4	1.9	1.7	3.0	2.8	2.8
…gender	3.6	2.2	2.9	2.3	6.9	1.7	1.3	2.2	1.3	1.8
…religion	0.9	0.5	0.9	0.6	0.9	0.4	0.3	0.3	0.5	0.7
…sexual orientation	0.3	0.6	1.1	0.5	2.4	0.6	0.3	0.6	0.6	0.6

…disability	0.5	0.8	1.0	0.8	1.5	0.5	0.9	1.4	0.8	1.2
…age	1.8	2.3	3.0	2.2	6.1	1.7	1.7	1.7	1.8	2.3

As demonstrated in the differences by trust type previously, reported discrimination against ambulance staff is clearly highest (22.1%) – and this is the same for either source (patients, etc, versus managers and colleagues). The difference is considerable with nearly one in four ambulance staff reporting discrimination. Reported discrimination on the basis of gender and age are particularly high among ambulance staff (the data suggests that women experience high levels of discrimination in ambulance trusts). Nursing assistants reported relatively high levels of discrimination (17.1%), with ethnic background being the most significant factor in this (there are similar patterns among registered nurses and for medical/dental staff). Medical and dental staff also experience relatively high levels of discrimination (13.5%) along with nursing staff (14%).

Question 2: Differences when controlling for other categorical factors

One particular difficulty was in ascertaining the extent to which these findings could be due to the multiple effects of factors simultaneously (being black, female and Muslim, for example). Data in relation to each of the nine discrimination variables was therefore analysed, examining all categorical factors (ethnicity, gender, occupational group, religion, disability etc) simultaneously. To enable this more sophisticated analysis, only the broad ethnic group background categories were used. The outcomes of this analysis would indicate that any differences (for example, on the basis of gender) that were still apparent after taking into account statistically the effects of all other categories would be above and beyond the influence of these other variables included in the analysis. Thus, for example, differences between men and women in reported levels of discrimination could not be attributed to differences in occupational groupings between the sexes.

The following tables show the results for each discrimination variable. The main figures shown are '*adjusted odds ratios'*: these can be interpreted to mean that the odds of experiencing discrimination in the category shown change by this factor compared with the reference category (reference categories are shown in italics), taking all the other factors into account. The analyses enable us to calculate (for example) what the odds are of experiencing discrimination if you work in an ambulance trust compared with working in an acute trust; or what the odds are of experiencing discrimination if you are from a BME background compared with from a White background. Thus, in the first table below, the odds of staff in ambulance trusts reporting discrimination are 1.5 times those of staff in acute trusts, whereas the odds of community trust staff are only 0.85 times those of acute trust staff (less likely in effect).

A 95 per cent confidence interval for these odds ratios is also shown, indicating how reliable these are. The greater the confidence interval, the less reliable the results are. We also show the unadjusted odds ratios – where no other variables are taken into account. The unadjusted odds ratio reflects the findings of the analysis reported in the series above and represent a less sophisticated type of analysis. We can thus compare how different the likelihood of reported discrimination is when we take into account the effects of all the categories together (adjusted odds ratios), versus the less rigorous approach of examining effects for each category (ethnicity, gender, sexual orientation etc one at a time) – the unadjusted odds ratios.

Key findings include:

- There are differences in overall levels of discrimination by all of the factors examined (ethnicity, religion etc), even when controlling for the effects of

the other factors (such as occupational group, trust type etc), although some of these differences are quite small once other factors have been taken into account in the statistical analysis.

- The levels of reported discrimination among those from a minority ethnic background are still very large, as is the effect for disabled staff, even taking into account other factors. That is, the odds of experiencing any discrimination among non-White staff, or disabled staff, are more than twice what they are for White or non-disabled staff respectively. Among Black staff, the odds of experiencing discrimination are more than three times higher than for White staff. A similar pattern emerges for discrimination on the basis of sexual orientation, which is much greater for non-heterosexual staff.
- The large differences by religion are often explained by other factors, including ethnic background. However, for discrimination on the basis of religion, Muslim staff experience a far higher rate of discrimination than any other religion, and all religions have a higher rate than those of no religion (after controlling for other factors).

Predictors of any discrimination

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
Trust size	.000	1.00 (1.00, 1.00)	1.00
Trust type [Acute]	.000		
Community	.000	0.85 (0.79, 0.91)	0.73
Mental Health/LD	.000	1.09 (1.05, 1.14)	1.11
Ambulance	.000	1.51 (1.26, 1.81)	1.84
CCG	.000	0.56 (0.44, 0.70)	0.42
Location [London]	.000		
South East	.129	0.96 (0.91, 1.01)	0.70
South West	.001	0.92 (0.87, 0.97)	0.59
East of England	.442	1.02 (0.96, 1.09)	0.71
East Midlands	.146	0.95 (0.89, 1.02)	0.64
West Midlands	.021	0.93 (0.87, 0.99)	0.61
Yorkshire & Humber	.000	0.84 (0.78, 0.90)	0.52
North West	.000	0.81 (0.77, 0.86)	0.54
North East	.000	0.77 (0.71, 0.84)	0.47
Sex [Male]			
Female	.000	0.85 (0.82, 0.88)	0.70
Age [16-20]	.000		
21–30	.296	0.90 (0.73, 1.10)	1.24
31–40	.000	0.69 (0.56, 0.85)	1.20
41–50	.000	0.64 (0.52, 0.78)	1.13

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
51–65	.000	0.58 (0.47, 0.71)	0.92
66+	.000	0.54 (0.43, 0.68)	0.76
Ethnic background [White]	.000		
Mixed	.000	2.46 (2.21, 2.73)	2.67
Asian	.000	3.05 (2.87, 3.25)	2.93
Black	.000	3.75 (3.53, 3.99)	4.23
Other	.000	2.68 (2.43, 2.96)	2.98
Sexual orientation [Heterosexual]			
Other	.000	1.76 (1.64, 1.89)	2.07
Religion [No religion]	.000		
Christian	.000	1.08 (1.05, 1.12)	1.17
Muslim	.665	1.02 (0.93, 1.13)	2.57
Hindu	.012	0.87 (0.79, 0.97)	2.16
Other	.000	1.20 (1.10, 1.30)	1.84
Disability status [Not disabled]			
Disabled	.000	2.15 (2.08, 2.23)	1.92
Working hours [Full time]			
Part time	.000	0.77 (0.74, 0.80)	0.63
Patient contact [None]	.000		
Regular contact	.000	1.66 (1.57, 1.76)	1.87
Occasional contact	.000	1.22 (1.14, 1.30)	1.17
Tenure [< 1 year]	.000		
1–2 years	.000	1.43 (1.34, 1.53)	1.32

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
3–5 years	.000	1.59 (1.49, 1.70)	1.46
6–10 years	.000	1.59 (1.49, 1.70)	1.41
11–15 years	.000	1.57 (1.47, 1.69)	1.38
> 15 years	.000	1.28 (1.19, 1.37)	0.98
Occupational group [Medical/dental]	.000		
Nursing/midwifery	.000	1.24 (1.16, 1.32)	1.05
Nursing assistants	.000	1.52 (1.41, 1.63)	1.35
AHP/Scientific & technical	.094	0.95 (0.89, 1.01)	0.75
Ambulance	.000	1.73 (1.42, 2.11)	1.83
Managers	.684	0.98 (0.87, 1.09)	0.58
Central functions	.002	0.89 (0.82, 0.96)	0.57
Social care	.699	0.96 (0.79, 1.17)	0.77
Ancillary	.310	1.05 (0.95, 1.16)	0.69
Other	.609	1.03 (0.93, 1.14)	0.78

This table shows that there are differences in overall levels of discrimination by all of the factors examined, even when controlling for the effects of the other factors. Some of these are quite small – the effect of trust size, for example, is minimal.

The most useful way to look at the results here is to ask two questions: (i) which factors have the largest differences, and (ii) are the effects of some factors partially or wholly explained by the inclusion of other variables – or even are they amplified once the effects of other variables are taken into account?

The largest effects are those where the adjusted odds ratio is greater than 2 or less than 0.5. Therefore the effects of being from a minority ethnic background are still very large (odds of Black people experiencing discrimination are 3.57 times those of Whites), as is the effect for disabled staff (whose odds are 2.15 times those of non-disabled staff). In effect, the odds of experiencing

discrimination for non-White staff, or disabled staff, are more than twice what they are for White or non-disabled staff respectively.

In many cases, controlling for the other factors reduces the effects of being from a particular group. For example, once other factors are taken into account, the odds of experiencing discrimination for female staff are 15 per cent lower (0.85) than for male staff (1.0), rather than 30 per cent lower (0.7) when other factors are not taken into account. Such a finding demands reflection about the experience of male staff, working in a sector where the majority of staff are female and how this impacts upon their experience of discrimination. However, it is important to note that the effect appears to be reversed in ambulance trusts. Controlling for other factors, it is the youngest age group (16–20) who are the most likely to experience discrimination. It is also notable how, once other factors (particularly ethnic background) are taken into account, the large differences by religion almost disappear (for the Muslim religion it is an odds ratio of 1.02 compared with an unadjusted odds ratio of 2.57).

But this is not always the case: the odds of experiencing discrimination for disabled staff are actually increased (from 1.92 to 2.15) once other factors are taken into account. The same is true for some occupational groups (notably nurses who experience slightly higher levels of discrimination than medical/dental staff). This means that the higher levels of discrimination for these staff cannot be explained by the other factors studied, but are much more likely to be due directly to the differentiating factors shown (disability status or occupational group, in this case).

Predictors of discrimination from patients, their relatives or members of the public

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
Trust size	.006	1.00 (1.00, 1.00)	1.00
Trust type [Acute]	.000		
Community	.000	0.82 (0.73, 0.91)	0.65
Mental Health/LD	.000	1.31 (1.24, 1.38)	1.29
Ambulance	.000	2.01 (1.44, 2.80)	2.05
CCG	.504	0.88 (0.59, 1.29)	0.25
Location [London]	.000		
South East	.348	1.04 (0.96, 1.11)	0.69
South West	.218	0.96 (0.89, 1.03)	0.53
East of England	.390	1.04 (0.95, 1.13)	0.65
East Midlands	.171	0.94 (0.86, 1.03)	0.55
West Midlands	.991	1.00 (0.92, 1.09)	0.56
Yorkshire & Humber	.000	0.82 (0.74, 0.90)	0.43
North West	.000	0.80 (0.74, 0.86)	0.46
North East	.000	0.72 (0.64, 0.82)	0.35
Sex [Male]			
Female	.000	0.73 (0.69, 0.76)	0.61
Age [16–20]	.000		
21–30	.661	0.94 (0.70, 1.25)	1.41
31–40	.001	0.60 (0.45, 0.81)	1.21
41–50	.000	0.52 (0.39, 0.70)	1.04

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
51–65	.000	0.44 (0.33, 0.59)	0.70
66+	.000	0.41 (0.29, 0.56)	0.55
Ethnic background [White]	.000		
Mixed	.000	3.20 (2.81, 3.65)	3.61
Asian	.000	4.05 (3.75, 4.37)	4.00
Black	.000	5.23 (4.85, 5.63)	6.53
Other	.000	3.44 (3.05, 3.88)	4.10
Sexual orientation [Heterosexual]			
Other	.000	1.93 (1.77, 2.11)	2.44
Religion [No religion]	.000		
Christian	.000	1.11 (1.05, 1.17)	1.25
Muslim	.402	0.95 (0.84, 1.07)	2.95
Hindu	.001	0.80 (0.70, 0.91)	2.41
Other	.019	1.15 (1.02, 1.28)	1.90
Disability status [Not disabled]			
Disabled	.000	1.66 (1.58, 1.75)	1.41
Working hours [Full time]			
Part time	.000	0.62 (0.58, 0.66)	0.45
Patient contact [None]	.000		
Regular contact	.000	6.96 (6.05, 8.01)	7.86
Occasional contact	.000	2.43 (2.08, 2.85)	1.95
Tenure [< 1 year]	.000		
1–2 years	.000	1.41 (1.29, 1.54)	1.26

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
3–5 years	.000	1.47 (1.35, 1.60)	1.25
6–10 years	.000	1.45 (1.33, 1.58)	1.12
11–15 years	.000	1.37 (1.25, 1.51)	1.07
> 15 years	.069	1.10 (0.99, 1.21)	0.66
Occupational group [Medical/dental]	*.000*		
Nursing/midwifery	.000	1.48 (1.36, 1.60)	1.06
Nursing assistants	.000	1.96 (1.79, 2.15)	1.54
AHP/Scientific & technical	.000	0.84 (0.77, 0.92)	0.54
Ambulance	.003	1.70 (1.20, 2.39)	1.73
Managers	.000	0.68 (0.55, 0.85)	0.20
Central functions	.000	0.77 (0.69, 0.87)	0.23
Social care	.697	0.95 (0.73, 1.24)	0.69
Ancillary	.118	0.89 (0.76, 1.03)	0.38
Other	.913	0.99 (0.85, 1.16)	0.46

The patterns for discrimination from patients, their relatives or members of the public are very similar to those for overall discrimination. The major exception, unsurprisingly, is that those who have regular patient contact are far more likely to experience this (the odds are nearly seven times greater).

The other notable effect here is that people from some ethnic backgrounds – particularly Black and Asian – have far higher odds of experiencing discrimination from this source (patients, their relatives or other members of the public) rather than overall, and that these are barely changed by the inclusion of other factors, suggesting very strong and consistent effects.

Predictors of discrimination from managers, team leaders or other colleagues

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
Trust size	.001	1.00 (1.00, 1.00)	1.00
Trust type [Acute]	.000		
Community	.000	0.86 (0.79, 0.94)	0.76
Mental Health/LD	.001	0.92 (0.87, 0.96)	0.94
Ambulance	.019	1.28 (1.04, 1.57)	1.63
CCG	.000	0.46 (0.35, 0.60)	0.50
Location [London]	.000		
South East	.075	0.94 (0.88, 1.01)	0.72
South West	.002	0.91 (0.85, 0.97)	0.63
East of England	.348	1.04 (0.96, 1.11)	0.77
East Midlands	.347	0.96 (0.89, 1.04)	0.68
West Midlands	.004	0.89 (0.83, 0.96)	0.64
Yorkshire & Humber	.000	0.85 (0.78, 0.92)	0.59
North West	.000	0.83 (0.78, 0.89)	0.59
North East	.000	0.81 (0.73, 0.89)	0.56
Sex [Male]			
Female	.002	0.93 (0.89, 0.97)	0.77
Age [16–20]	.000		
21–30	.136	0.82 (0.64, 1.06)	1.10
31–40	.057	0.78 (0.60, 1.01)	1.31
41–50	.036	0.76 (0.59, 0.98)	1.33

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
51–65	.009	0.71 (0.55, 0.92)	1.19
66+	.008	0.69 (0.52, 0.91)	1.01
Ethnic background [White]	.000		
Mixed	.000	1.93 (1.69, 2.21)	2.10
Asian	.000	2.46 (2.28, 2.66)	2.41
Black	.000	2.64 (2.45, 2.85)	2.82
Other	.000	2.31 (2.05, 2.60)	2.48
Sexual orientation [Heterosexual]			
Other	.000	1.64 (1.50, 1.78)	1.79
Religion [No religion]	.000		
Christian	.001	1.08 (1.03, 1.12)	1.17
Muslim	.014	1.16 (1.03, 1.30)	2.38
Hindu	.973	1.00 (0.88, 1.13)	2.06
Other	.000	1.25 (1.14, 1.39)	1.85
Disability status [Not disabled]			
Disabled	.000	2.42 (2.32, 2.52)	2.26
Working hours [Full time]			
Part time	.000	0.87 (0.83, 0.91)	0.77
Patient contact [None]	.022		
Regular contact	.040	1.07 (1.00, 1.14)	1.15
Occasional contact	.006	1.10 (1.03, 1.18)	1.10
Tenure [< 1 year]	.000		
1–2 years	.000	1.47 (1.34, 1.61)	1.38

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
3–5 years	.000	1.72 (1.58, 1.88)	1.71
6–10 years	.000	1.78 (1.64, 1.94)	1.80
11–15 years	.000	1.78 (1.63, 1.95)	1.78
> 15 years	.000	1.46 (1.34, 1.60)	1.34
Occupational group [Medical/dental]	.000		
Nursing/midwifery	.001	1.14 (1.06, 1.24)	1.05
Nursing assistants	.000	1.22 (1.11, 1.34)	1.17
AHP/Scientific & technical	.310	1.04 (0.96, 1.13)	0.91
Ambulance	.000	1.72 (1.37, 2.16)	1.84
Managers	.028	1.15 (1.02, 1.31)	0.91
Central functions	.588	0.98 (0.89, 1.07)	0.86
Social care	.886	1.02 (0.80, 1.29)	0.83
Ancillary	.000	1.24 (1.11, 1.39)	1.05
Other	.057	1.13 (1.00, 1.27)	1.07

The experience of discrimination from managers, team leaders or other colleagues is far less variable than that from patients etc. However, there are still some substantial effects: in particular, non-White groups are far more likely to experience discrimination than White staff. For Black staff the odds ratio is 2.64 – indicating that the odds of Black staff being discriminated against by their managers, team leaders and other colleagues are 2.64 times those of White staff. And levels of discrimination are similarly high for disabled staff who are far more likely (2.42 times greater odds) than non-disabled staff to experience discrimination from managers, team leaders or other colleagues. These effects are barely explained away by other factors controlled for in the analysis, suggesting they are robust and not open to the interpretation that they are due to these other factors. However, the general pattern of results is very similar to that for overall discrimination.

Predictors of discrimination on the basis of ethnic background

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
Trust size	.000	1.00 (1.00, 1.00)	1.00
Trust type [Acute]	.000		
Community	.000	0.75 (0.66, 0.86)	0.50
Mental Health/LD	.020	1.08 (1.01, 1.16)	1.06
Ambulance	.190	1.33 (0.87, 2.03)	0.65
CCG	.018	0.54 (0.32, 0.90)	0.18
Location [London]	.000		
South East	.047	0.92 (0.84, 1.00)	0.47
South West	.001	0.86 (0.79, 0.94)	0.32
East of England	.765	0.99 (0.90, 1.08)	0.48
East Midlands	.000	0.78 (0.70, 0.86)	0.36
West Midlands	.000	0.82 (0.74, 0.91)	0.37
Yorkshire & Humber	.000	0.65 (0.57, 0.73)	0.24
North West	.000	0.61 (0.55, 0.67)	0.24
North East	.000	0.44 (0.36, 0.54)	0.14
Sex [Male]			
Female	.000	0.73 (0.69, 0.78)	0.59
Age [16–20]	.000		
21–30	.135	1.46 (0.89, 2.41)	2.23
31–40	.279	1.32 (0.80, 2.17)	2.96
41–50	.275	1.32 (0.80, 2.18)	2.76

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
51–65	.589	1.15 (0.70, 1.90)	1.64
66+	.973	1.01 (0.59, 1.71)	1.06
Ethnic background [White]	.000		
Mixed	.000	7.44 (6.52, 8.49)	8.81
Asian	.000	10.35 (9.55, 11.21)	12.62
Black	.000	12.09 (11.18, 13.08)	19.39
Other	.000	7.69 (6.81, 8.68)	10.57
Sexual orientation [Heterosexual]			
Other	.851	1.01 (0.88, 1.16)	1.19
Religion [No religion]	.000		
Christian	.000	1.39 (1.29, 1.49)	2.44
Muslim	.001	1.24 (1.09, 1.40)	9.25
Hindu	.792	0.98 (0.86, 1.12)	8.07
Other	.014	1.19 (1.03, 1.36)	3.79
Disability status [Not disabled]			
Disabled	.000	1.34 (1.25, 1.43)	1.05
Working hours [Full time]			
Part time	.000	0.65 (0.59, 0.70)	0.40
Patient contact [None]	.000		
Regular contact	.000	2.32 (2.05, 2.61)	3.29
Occasional contact	.000	1.40 (1.22, 1.61)	1.27
Tenure [< 1 year]	.000		

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
1–2 years	.000	1.38 (1.24, 1.53)	1.18
3–5 years	.000	1.47 (1.32, 1.62)	1.29
6–10 years	.000	1.36 (1.23, 1.51)	1.19
11–15 years	.000	1.28 (1.15, 1.42)	1.16
> 15 years	.027	0.87 (0.78, 0.98)	0.52
Occupational group [Medical/dental]	.000		
Nursing/midwifery	.000	1.54 (1.41, 1.69)	0.91
Nursing assistants	.000	1.78 (1.60, 1.98)	1.09
AHP/Scientific & technical	.000	0.78 (0.71, 0.87)	0.38
Ambulance	.588	1.13 (0.72, 1.77)	0.46
Managers	.008	0.74 (0.60, 0.92)	0.25
Central functions	.000	0.68 (0.60, 0.77)	0.23
Social care	.154	0.77 (0.53, 1.10)	0.41
Ancillary	.901	0.99 (0.84, 1.17)	0.38
Other	.046	0.82 (0.68, 1.00)	0.38

The main focus here is on the difference between the ethnic groups. Unsurprisingly the extent of discrimination on the basis of ethnic background was far greater for non-White staff; the highest effect was for Black staff, for whom the odds of experiencing discrimination were 12 times (12.09) higher than they were for White staff. For Asian staff the odds are 10 times higher (10.35) and for other non-White staff, the odds are more than 7 times higher (7.69).

This is a smaller difference than the unadjusted odds ratios (of 19.39 for Black staff), suggesting that *some* of the raw differences between Black and White staff in experienced discrimination may be due to other factors such as patient contact, occupational group and location. However, the majority of the difference is still very much primarily explained by ethnic background.

Other notable results here are that disabled staff are more likely to experience discrimination on the basis of ethnic background than non-disabled staff (1.34 compared with 1.0), but this only comes to light once the other factors are controlled for. Similarly, nurses, midwives and nursing assistants are far more likely than medical/dental staff to experience such discrimination.

Predictors of discrimination on the basis of gender

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
Trust size	.004	1.00 (1.00, 1.00)	1.00
Trust type [Acute]	.000		
Community	.582	0.96 (0.82, 1.12)	0.80
Mental Health/LD	.000	1.33 (1.22, 1.44)	1.37
Ambulance	.000	2.07 (1.43, 2.99)	3.21
CCG	.315	0.79 (0.50, 1.25)	0.54
Location [London]	.000		
South East	.000	0.66 (0.59, 0.74)	0.67
South West	.000	0.70 (0.63, 0.78)	0.64
East of England	.000	0.76 (0.67, 0.86)	0.69
East Midlands	.000	0.74 (0.65, 0.84)	0.65
West Midlands	.000	0.72 (0.63, 0.83)	0.62
Yorkshire & Humber	.000	0.72 (0.63, 0.83)	0.61
North West	.000	0.65 (0.58, 0.73)	0.61
North East	.000	0.48 (0.40, 0.59)	0.40
Sex [Male]			
Female	.011	0.90 (0.84, 0.98)	0.67
Age [16–20]	.000		
21–30	.991	1.00 (0.65, 1.52)	1.35
31–40	.249	0.78 (0.51, 1.19)	1.20
41–50	.004	0.54 (0.35, 0.82)	0.86

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
51–65	.000	0.41 (0.27, 0.63)	0.59
66+	.000	0.29 (0.17, 0.47)	0.38
Ethnic background [White]	.000		
Mixed	.000	1.76 (1.43, 2.16)	2.09
Asian	.328	0.92 (0.78, 1.09)	1.19
Black	.000	1.37 (1.18, 1.59)	1.57
Other	.315	1.13 (0.89, 1.43)	1.60
Sexual orientation [Heterosexual]			
Other	.000	1.57 (1.37, 1.79)	2.30
Religion [No religion]	.013		
Christian	.015	0.92 (0.85, 0.98)	0.76
Muslim	.192	0.85 (0.67, 1.08)	1.11
Hindu	.909	0.98 (0.76, 1.28)	1.02
Other	.102	1.16 (0.97, 1.38)	1.12
Disability status [Not disabled]			
Disabled	.000	1.66 (1.54, 1.79)	1.53
Working hours [Full time]			
Part time	.000	0.65 (0.59, 0.72)	0.56
Patient contact [None]	.000		
Regular contact	.000	1.71 (1.50, 1.95)	2.09
Occasional contact	.002	1.26 (1.09, 1.46)	1.23
Tenure [< 1 year]	.000		
1–2 years	.000	1.60 (1.38, 1.84)	1.48

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
3–5 years	.000	1.77 (1.54, 2.03)	1.53
6–10 years	.000	1.92 (1.67, 2.21)	1.42
11–15 years	.000	1.75 (1.51, 2.04)	1.16
> 15 years	.000	1.64 (1.41, 1.92)	0.90
Occupational group [Medical/dental]	.000		
Nursing/midwifery	.000	0.60 (0.53, 0.67)	0.60
Nursing assistants	.001	0.78 (0.68, 0.91)	0.80
AHP/Scientific & technical	.000	0.61 (0.54, 0.69)	0.64
Ambulance	.669	1.09 (0.74, 1.61)	2.02
Managers	.000	0.57 (0.45, 0.72)	0.46
Central functions	.000	0.45 (0.39, 0.53)	0.35
Social care	.005	0.56 (0.38, 0.84)	0.61
Ancillary	.000	0.56 (0.45, 0.70)	0.37
Other	.000	0.54 (0.43, 0.68)	0.49

Once other factors are taken into account, men are still more likely than women to experience discrimination on the basis of gender, but this is a small difference (odds ratio of 0.90). Although there are still some differences between other groups, many of these are smaller once the difference between men and women is taken into account. Those in ambulance trusts are more than twice as likely as those in acute hospital settings to report discrimination on the basis of gender and there is some evidence that it is women who experience higher levels of discrimination in ambulance trusts rather than men.

Predictors of discrimination on the basis of sexual orientation

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
Trust size	.572	1.00 (1.00, 1.00)	1.00
Trust type [Acute]	.646		
Community	.903	0.98 (0.69, 1.38)	0.71
Mental Health/LD	.263	1.10 (0.93, 1.31)	1.65
Ambulance	.553	0.77 (0.33, 1.81)	4.59
CCG	.474	0.65 (0.20, 2.11)	0.47
Location [London]	.071		
South East	.239	0.87 (0.69, 1.10)	0.82
South West	.021	0.76 (0.60, 0.96)	0.58
East of England	.472	0.91 (0.69, 1.19)	0.66
East Midlands	.087	0.76 (0.56, 1.04)	0.58
West Midlands	.229	0.83 (0.61, 1.12)	0.53
Yorkshire & Humber	.081	0.75 (0.55, 1.04)	0.42
North West	.508	1.08 (0.86, 1.34)	0.80
North East	.155	0.75 (0.51, 1.11)	0.48
Sex [Male]			
Female	.000	0.34 (0.29, 0.39)	0.18
Age [16–20]	.000		
21–30	.890	1.06 (0.45, 2.53)	0.84
31–40	.796	0.89 (0.37, 2.13)	0.68
41–50	.775	0.88 (0.37, 2.11)	0.67

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
51–65	.291	0.62 (0.26, 1.50)	0.37
66+	.417	0.67 (0.25, 1.77)	0.29
Ethnic background [White]	.000		
Mixed	.841	1.05 (0.65, 1.69)	1.83
Asian	.000	0.40 (0.26, 0.61)	0.58
Black	.025	0.60 (0.38, 0.94)	0.73
Other	.283	0.75 (0.44, 1.27)	1.37
Sexual orientation [Heterosexual]			
Other	.000	29.41 (25.47, 33.95)	44.36
Religion [No religion]	.119		
Christian	.124	0.89 (0.77, 1.03)	0.49
Muslim	.165	1.53 (0.84, 2.79)	0.55
Hindu	.316	1.46 (0.70, 3.07)	0.32
Other	.386	1.14 (0.85, 1.54)	1.35
Disability status [Not disabled]			
Disabled	.000	1.76 (1.52, 2.04)	2.15
Working hours [Full time]			
Part time	.000	0.50 (0.38, 0.65)	0.29
Patient contact [None]	.000		
Regular contact	.000	2.37 (1.78, 3.14)	2.29
Occasional contact	.210	1.23 (0.89, 1.70)	1.29
Tenure [< 1 year]	.013		

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
1–2 years	.003	1.56 (1.16, 2.10)	1.65
3–5 years	.006	1.50 (1.13, 2.01)	1.53
6–10 years	.002	1.57 (1.17, 2.09)	1.39
11–15 years	.000	1.75 (1.29, 2.38)	1.37
> 15 years	.021	1.45 (1.06, 1.99)	0.90
Occupational group [Medical/dental]	.000		
Nursing/midwifery	.000	2.92 (2.08, 4.10)	1.99
Nursing assistants	.000	5.22 (3.62, 7.52)	3.82
AHP/Scientific and technical	.000	1.97 (1.39, 2.81)	1.54
Ambulance	.000	10.00 (4.03, 24.79)	8.30
Managers	.000	2.72 (1.66, 4.48)	1.88
Central functions	.000	2.10 (1.41, 3.13)	0.84
Social care	.462	1.40 (0.57, 3.40)	1.85
Ancillary	.000	3.53 (2.25, 5.53)	1.88
Other	.000	2.91 (1.79, 4.74)	1.90

Unsurprisingly, the biggest difference is between heterosexual and other staff. Although this effect is slightly smaller than the unadjusted effect, the odds ratio is still 29.41, indicating that the odds of non-heterosexual staff experiencing discrimination on the basis of sexual orientation are 29 times higher than those of heterosexual staff.

It is noteworthy that the effects for many occupational groups, especially nursing/midwifery staff, AHPs, ambulance staff, managers and ancillary staff, are greater once other factors are taken into account. The relative discrimination experienced by other staff in comparison with heterosexual staff is particularly high among ambulance workers in comparison with medical and dental staff (their odds of experiencing discrimination are 10 times higher, suggesting that

discrimination on the basis of sexual orientation is particularly problematic in ambulance trusts).

Predictors of discrimination on the basis of religion

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
Trust size	.000	1.00 (1.00, 1.00)	1.00
Trust type [Acute]	.003		
Community	.251	0.80 (0.54, 1.17)	0.48
Mental Health/LD	.003	1.30 (1.10, 1.54)	1.21
Ambulance	.290	1.66 (0.65, 4.22)	1.40
CCG	.117	0.20 (0.03, 1.49)	0.24
Location [London]	.013		
South East	.038	0.77 (0.61, 0.99)	0.42
South West	.001	0.66 (0.51, 0.85)	0.30
East of England	.314	0.87 (0.66, 1.14)	0.42
East Midlands	.108	0.80 (0.61, 1.05)	0.48
West Midlands	.687	1.05 (0.82, 1.35)	0.56
Yorkshire & Humber	.765	0.96 (0.73, 1.26)	0.45
North West	.120	0.84 (0.67, 1.05)	0.44
North East	.019	0.57 (0.36, 0.91)	0.26
Sex [Male]			
Female	.000	0.46 (0.39, 0.53)	0.35
Age [16–20]	.000		
21–30	.263	1.79 (0.65, 4.94)	0.93
31–40	.761	1.17 (0.42, 3.26)	0.78
41–50	.817	1.13 (0.41, 3.14)	0.66

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
51–65	.869	0.92 (0.33, 2.57)	0.44
66+	.599	0.74 (0.24, 2.30)	0.37
Ethnic background [White]	.000		
Mixed	.003	1.84 (1.23, 2.75)	4.52
Asian	.001	1.48 (1.17, 1.87)	8.29
Black	.000	1.73 (1.32, 2.27)	4.71
Other	.021	1.54 (1.07, 2.22)	5.21
Sexual orientation [Heterosexual]			
Other	.724	0.94 (0.66, 1.33)	1.42
Religion [No religion]	.000		
Christian	.000	1.66 (1.35, 2.05)	1.60
Muslim	.000	24.99 (18.82, 33.17)	39.31
Hindu	.000	4.36 (2.92, 6.51)	6.15
Other	.000	7.57 (5.71, 10.02)	8.66
Disability status [Not disabled]			
Disabled	.000	1.69 (1.44, 1.99)	1.46
Working hours [Full time]			
Part time	.046	0.81 (0.66, 1.00)	0.59
Patient contact [None]	.000		
Regular contact	.000	2.39 (1.81, 3.17)	1.76
Occasional contact	.006	1.56 (1.14, 2.13)	0.97
Tenure [< 1 year]	.013		

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
1–2 years	.081	1.27 (0.97, 1.66)	1.24
3–5 years	.072	1.27 (0.98, 1.64)	1.33
6–10 years	.006	1.44 (1.11, 1.87)	1.21
11–15 years	.502	1.11 (0.82, 1.48)	1.00
> 15 years	.866	1.03 (0.76, 1.40)	0.62
Occupational group [Medical/dental]	.000		
Nursing/midwifery	.000	1.76 (1.37, 2.27)	0.55
Nursing assistants	.000	2.60 (1.96, 3.45)	0.97
AHP/Scientific & technical	.001	1.52 (1.19, 1.96)	0.62
Ambulance	.100	2.28 (0.85, 6.11)	1.00
Managers	.121	1.47 (0.90, 2.40)	0.43
Central functions	.034	1.39 (1.03, 1.89)	0.37
Social care	.980	0.99 (0.35, 2.75)	0.33
Ancillary	.020	1.61 (1.08, 2.40)	0.53
Other	.028	1.60 (1.05, 2.43)	0.75

The large differences between ethnic backgrounds seen here is primarily explained by other factors – particularly religion, of course.

Compared with staff of no religion, there is a very large difference for Muslim staff, whose odds of experiencing discrimination on the basis of their religion are 25 times greater than those of no religion. There are also large effects for Hindu staff (4.36 times higher than for those of no religion) and those of other religions; Christian staff too report experiencing some discrimination (odds of 1.66) after other factors are taken into account.

Staff in ambulance trusts again have higher odds of experiencing discrimination on the basis of religion than other trust types. It is notable that the odds of ambulance staff reporting discrimination on the basis of religion are 2.28 times

those of medical and dental staff for example). The very different adjusted and unadjusted odds ratios for the different occupational groups, suggests that the religion of some groups may be more of a factor than the religion of other groups in predicting discrimination, notably among ambulance staff but also among nursing assistants.

Predictors of discrimination on the basis of disability

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
Trust size	.080	1.00 (1.00, 1.00)	1.00
Trust type [Acute]	.006		
Community	.547	1.07 (0.86, 1.34)	1.20
Mental Health/LD	.001	1.25 (1.10, 1.43)	1.51
Ambulance	.055	1.65 (0.99, 2.75)	1.91
CCG	.662	0.86 (0.43, 1.72)	0.82
Location [London]	.013		
South East	.152	1.16 (0.95, 1.42)	1.11
South West	.498	1.07 (0.88, 1.31)	1.03
East of England	.456	0.91 (0.72, 1.16)	0.98
East Midlands	.251	1.14 (0.91, 1.43)	1.12
West Midlands	.188	0.85 (0.66, 1.08)	0.93
Yorkshire & Humber	.901	1.02 (0.80, 1.29)	1.02
North West	.120	1.17 (0.96, 1.42)	1.17
North East	.063	0.74 (0.54, 1.02)	0.76
Sex [Male]			
Female	.033	0.86 (0.76, 0.99)	0.82
Age [16–20]	.070		
21–30	.405	1.64 (0.51, 5.22)	1.45
31–40	.445	1.57 (0.49, 5.01)	1.87
41–50	.520	1.46 (0.46, 4.66)	2.33

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
51–65	.681	1.28 (0.40, 4.06)	2.36
66+	.670	1.29 (0.40, 4.24)	2.35
Ethnic background [White]	.184		
Mixed	.359	0.79 (0.48, 1.31)	0.96
Asian	.020	0.63 (0.43, 0.93)	0.55
Black	.913	1.02 (0.76, 1.37)	0.95
Other	.957	0.99 (0.59, 1.65)	1.14
Sexual orientation [Heterosexual]			
Other	.001	1.45 (1.16, 1.83)	2.35
Religion [No religion]	.029		
Christian	.198	1.08 (0.96, 1.22)	1.01
Muslim	.461	1.21 (0.72, 2.04)	0.79
Hindu	.265	1.41 (0.77, 2.59)	0.73
Other	.001	1.54 (1.18, 2.00)	1.75
Disability status [Not disabled]			
Disabled	.000	43.33 (36.56, 51.35)	41.25
Working hours [Full time]			
Part time	.864	1.01 (0.89, 1.15)	0.99
Patient contact [None]	.694		0.00
Regular contact	.830	0.98 (0.82, 1.17)	1.00
Occasional contact	.429	0.93 (0.76, 1.12)	1.02
Tenure [< 1 year]	.000		

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
1–2 years	.095	1.29 (0.96, 1.75)	1.54
3–5 years	.007	1.48 (1.11, 1.95)	1.96
6–10 years	.000	1.72 (1.31, 2.26)	2.49
11–15 years	.001	1.58 (1.19, 2.10)	2.61
> 15 years	.053	1.32 (1.00, 1.76)	2.29
Occupational group [Medical/dental]	.231		
Nursing/midwifery	.754	1.04 (0.80, 1.37)	1.61
Nursing assistants	.778	1.05 (0.77, 1.43)	1.99
AHP/Scientific & technical	.888	1.02 (0.77, 1.35)	1.59
Ambulance	.913	1.03 (0.56, 1.90)	2.88
Managers	.101	0.69 (0.44, 1.08)	1.04
Central functions	.737	0.95 (0.71, 1.27)	1.68
Social care	.640	1.14 (0.65, 2.02)	2.61
Ancillary	.212	0.78 (0.53, 1.15)	1.49
Other	.198	1.26 (0.89, 1.80)	2.25

Disabled staff (including those with a longstanding illness or health problem) are very much more likely to experience discrimination (over 43 times the odds!) on the basis of disability, unsurprisingly. However, between many other groups the effects previously seen (without adjustment for other factors) disappear or reduce significantly, suggesting there is not a problem for any one particular characteristic, but that discrimination on the basis of disability is a problem across the board. And the level of discrimination against disabled staff is remarkably high. Indeed, the odds ratios of experiencing discrimination (compared with non-disabled staff) are higher than for any other group we have looked at in the analyses (Black staff, Muslims, gender etc.).

Predictors of discrimination on the basis of age

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
Trust size	.466	1.00 (1.00, 1.00)	1.00
Trust type [Acute]	.000		
Community	.011	0.81 (0.70, 0.95)	0.73
Mental Health/LD	.000	1.28 (1.18, 1.39)	1.19
Ambulance	.003	1.71 (1.21, 2.43)	2.69
CCG	.066	0.63 (0.39, 1.03)	0.59
Location [London]	.000		
South East	.016	0.87 (0.77, 0.97)	0.89
South West	.000	0.82 (0.73, 0.91)	0.81
East of England	.344	0.94 (0.83, 1.07)	0.93
East Midlands	.002	0.80 (0.69, 0.92)	0.75
West Midlands	.014	0.84 (0.74, 0.97)	0.81
Yorkshire & Humber	.000	0.74 (0.64, 0.86)	0.73
North West	.000	0.75 (0.66, 0.84)	0.74
North East	.000	0.72 (0.60, 0.86)	0.66
Sex [Male]			
Female	.000	0.80 (0.74, 0.87)	0.76
Age [16–20]	.000		
21–30	.000	0.50 (0.40, 0.64)	0.70
31–40	.000	0.12 (0.09, 0.15)	0.18
41–50	.000	0.07 (0.05, 0.09)	0.12

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
51–65	.000	0.16 (0.12, 0.21)	0.28
66+	.000	0.22 (0.17, 0.30)	0.33
Ethnic background [White]	.000		
Mixed	.000	1.66 (1.34, 2.06)	1.92
Asian	.917	1.01 (0.84, 1.21)	0.95
Black	.503	0.94 (0.78, 1.13)	1.01
Other	.615	1.07 (0.81, 1.42)	1.11
Sexual orientation [Heterosexual]			
Other	.091	1.14 (0.98, 1.34)	1.56
Religion [No religion]	.159		
Christian	.604	0.98 (0.91, 1.05)	0.83
Muslim	.565	0.93 (0.71, 1.20)	0.97
Hindu	.762	1.05 (0.78, 1.41)	0.84
Other	.031	1.22 (1.02, 1.47)	1.21
Disability status [Not disabled]			
Disabled	.000	2.02 (1.88, 2.17)	1.91
Working hours [Full time]			
Part time	.000	0.71 (0.65, 0.78)	0.59
Patient contact [None]	.000		
Regular contact	.000	1.65 (1.46, 1.87)	1.62
Occasional contact	.066	1.14 (0.99, 1.31)	1.10
Tenure [< 1 year]	.000		
1–2 years	.000	1.54 (1.35, 1.75)	1.41

Predictor	p	Adjusted OR (95% CI)	Unadjusted OR
3–5 years	.000	1.64 (1.44, 1.86)	1.25
6–10 years	.000	1.56 (1.37, 1.79)	0.93
11–15 years	.000	1.38 (1.18, 1.61)	0.74
> 15 years	.000	1.55 (1.34, 1.80)	0.89
Occupational group [Medical/dental]	.000		
Nursing/midwifery	.001	1.29 (1.11, 1.50)	1.24
Nursing assistants	.000	1.45 (1.22, 1.72)	1.65
AHP/Scientific & technical	.144	1.12 (0.96, 1.31)	1.24
Ambulance	.000	2.02 (1.38, 2.97)	3.49
Managers	.014	1.36 (1.07, 1.74)	0.95
Central functions	.761	1.03 (0.87, 1.22)	0.93
Social care	.553	0.87 (0.55, 1.38)	0.91
Ancillary	.278	1.13 (0.91, 1.41)	0.96
Other	.034	1.27 (1.02, 1.59)	1.29

The youngest staff (those in the 16–20 range) are by far the most likely to report discrimination on the basis of age, followed by those in the 21–30 group. Those in the 41–50 range are the least likely.

Staff from a mixed ethnic background are more likely than other ethnic groups to experience this discrimination. Some occupational groups are more likely to as well, although the effects of these group characteristics are reduced once other factors are taken into account: the one exception being managers, who are more likely to experience discrimination on the basis of age than most other groups. Ambulance staff are again the most likely to experience discrimination in comparison with all other occupational groups.

Conclusions and caveats

The analysis shows that there are clear differences in experiences of discrimination for staff of many types of different background – both demographic and work characteristics. Staff from non-White backgrounds were particularly likely to face discrimination from all sources; with disabled staff also experiencing high levels of discrimination. Non-heterosexual and Muslim staff were also particularly likely to experience discrimination on the basis of sexual orientation and religion respectively.

There was also significant variation by organisation: in some organisations there was substantially more discrimination against non-White staff, whereas in others there was little or no difference between White and non-White staff. Staff in ambulance trusts generally reported higher levels of discrimination in relation to most categories in comparison with staff in other trust types.

As always, there are a number of limitations to this analysis and therefore caveats have to be applied. In particular, the analysis is based on those NHS staff who responded to the 2014 staff survey which had a response rate of just over 50 per cent. Though this is a good response rate, a substantial proportion of people did not return a questionnaire, and therefore the sample providing the data for the analyses may be subject to some response bias. We cannot know to what extent the experiences of discrimination reported are truly representative of the whole NHS in England.

There are also some potential confounding factors that may partially explain some of the differences observed. Although we included as many as we could in answering question 2 to control for this possibility, there are some factors that are not measured (eg, factors outside work, such as family, and previous experience and education) that might also affect the results; 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 (more than a quarter of a million) and a good response rate, we expect the results here to be a good (if not perfect) reflection of the reality in the NHS, and many of the findings are simply too large and compelling to dismiss as being due to methodological factors.

The work life experiences of non-White, disabled, Muslim and non-heterosexual staff (among others) within the NHS are clearly much worse than their comparator groups and this experience of discrimination profoundly and pervasively damages the health, well-being and quality of work life of the many staff affected in the NHS. And this widespread discrimination is completely contrary to the stated values of the sector.

We now therefore turn to explore how these pervasive and disturbing problems of discrimination in the NHS can be overcome.

Making a difference

Diversity in organisations refers to the differences between employees on any attribute that evokes the perception that a co-worker is different to others. These can include demographic attributes such as gender, age, ethnicity, nationality, tenure, and functional or educational background (Cox 1993). Others include disability, sexual orientation, marital status, religion, skills, experience and values, attitudes and personality. There are two main approaches in organisations to deal with diversity and inclusion issues.

Human Resource Management (HRM) practitioners are mainly concerned with how diversity is managed at the organisational level in terms of recruitment, selection, promotion and disciplinary processes and with the application of equal opportunities training (Avery and McKay 2010). HRM practitioners are driven by equal opportunities legislation as well as by the moral arguments that discrimination profoundly damages health and wellbeing and is fundamentally unjust. They are also driven by the research evidence demonstrating that discrimination at work negatively affects organisational performance.

Academic researchers, particularly psychologists, have been more concerned with how and when diversity affects social integration, work group performance and innovation (van Knippenberg *et al* 2007). Work psychologists take two perspectives: first, a social categorisation perspective argues that diversity can undermine work group performance and social integration because it leads to more conflict and less trust, co-operation and commitment among group members. In contrast, the second perspective – information processing – proposes that diversity facilitates work group performance and innovation because it increases the pool of task-related knowledge, information and perspectives of the group (van Knippenberg and Schippers 2007). It is not so much the amount of skills, knowledge and abilities associated with diversity that facilitates performance but the elaboration of the available information and perspectives (Guillaume *et al* 2013).

It is clear from the research evidence that both social categorisation and information elaboration processes operate simultaneously. Which of these predominates will depend on employees' perspectives of the extent to which they see employers promoting integration and fairness – the organisational

climate for inclusion – and the behaviours of those in their immediate work group or team. The work group is a particularly important medium within which to seek to influence diversity management and inclusion because it is the most likely focus of employee attachment, and the most immediate domain of control. It is also the most powerful influence on employee motivation, innovation and effectiveness (Riketta and Van Dick 2005).

Diversity and how it is managed affects people's motivation to exchange and integrate information in groups and to discuss and elaborate this information leading to a thorough, rich and more accurate understanding of the group task (Guillaume *et al* 2013). The research evidence suggests that diversity climates can have a positive effect on work outcomes – such as performance, absenteeism, innovation, work group identification and work group functioning, as well as overall organisational performance and productivity (eg, King *et al* 2011).

Key to effective diversity management is creating a diversity climate that emphasises diversity as a valuable resource for the organisation. A diversity climate refers to both general perceptions of an employer's efforts to promote diversity and the prevailing attitudes towards the probable beneficiaries of these efforts within the team, unit or department in question (Guillaume *et al* 2013, 2015). A positive diversity climate will frame these efforts as benefiting all, including patients. Below we consider how to create such climates at individual, team and organisational levels, drawing on relevant research literatures, to justify the assertions. We also note that national cultures and attitudes towards diversity and inclusion are a key influence on what happens within organisations.

Individuals

The research suggests that, at best, conventional diversity training can boost individual knowledge but has little effect beyond that, although in organisations where there is such training there tend to be somewhat lower levels of discrimination. Evidence for its direct effects on attitudes and behaviours is limited and its impact is primarily on those who are already striving to be egalitarian (Kalinoski et al 2013; King et al 2012; King et al 2010; Kulik 2014; Kulik and Roberson 2008). However, there are some strategies that appear more successful in bringing about positive change (Bezrukova et al 2012). These include the following.

- There is evidence suggesting that allies from non-disadvantaged/discriminated groups can confront and thereby have an impact on others' discriminatory behaviour in ways that members of target groups cannot quite so effectively do. This is particularly important where there are invisible identities such as sexual orientation or religion. 'Ally training' can be powerful. This involves training those in the non-

target group (White people or men, for example) to speak up and confront perpetrators' discriminatory behaviours directed against target group members (eg, BME staff, women) (Lindsay et al 2013).

- It can be particularly helpful to focus interventions on hard-to-reach people and those with more entrenched discriminatory views, rather than adopting blanket equality training programmes in organisations (Madera et al 2013).
- Research evidence also suggests that the nature of messages communicated through diversity training interventions can have negative consequences. Asserting that most people exhibit (for example) unconscious race bias can legitimise that bias by describing it as normative, with the result that people are less motivated to discover their own blind spots and change their attitudes and behaviours. Saying that many people in this organisation are working to change their biases is likely to be more successful (Duguid and Thomas-Hunt 2015).
- Training programmes that include goal-setting by participants, focused on changing their behaviours and attitudes, is more successful than interventions that focus on simply educating participants or encouraging discussion only. Such goal-setting involves agreeing a limited number of specific, clear and challenging objectives and ideally finding a forum or a number of occasions to review progress of participants against these objectives subsequent to the training (Madera et al 2013).
- There is an emerging field of research that explores the extent to which interventions elicit socially engaging versus disengaging emotions and are more effective as a consequence. For example, training which encourages participants to feel shame about their tendency to treat (for example) Muslims or people with disabilities in discriminatory ways is likely to be relatively ineffective. However, training that encourages people to recognise, celebrate and value all colleagues and show them compassion when appropriate (paying attention and listening to them; being empathic; intelligently supporting them) may have more substantial effects on their long-term attitudes and behaviours (Lindsay et al, forthcoming).
- Interventions should also recognise that discrimination is perpetrated equally by gender, race etc. Black people or women are just as likely as White people and men to discriminate against people with a disability or on the basis of religion.
- It is also important to educate people and leaders about the subtler aspects of discrimination. There is generally a change in our society away from overt to more covert forms of discrimination and this is a sign of progress. However, these more subtle forms of discrimination are harder to identify, assess and eradicate. The consequences for people who are the targets of discrimination and for organisations can be more severe (Jones et al, forthcoming).
- One example that research has uncovered is in relation to gender differences in developmental work experiences, particularly concerning work challenges. With good support, work challenges lead to growth, learning and positive development. However, women report experiencing fewer challenging developmental opportunities than men despite wanting similar types of developmental experiences. The evidence shows that decision-makers who register high in benevolent sexism assign more challenging tasks to men than to women (King et al 2012) and benevolent racism is similarly manifested in more limited opportunities for BME staff to have challenging, empowering work opportunities.

- A particularly successful intervention encourages perspective-taking by asking participants to write about the daily life that they imagine would be experienced by members of groups subject to discrimination in the workplace – for example, 'if I spent a day in this organisation as a black person, I would probably experience …' (King et al 2010; Lindsay et al, forthcoming).
- Although, there is a need to recognise the limits of atomistic, focused, short duration interventions that only focus on changing individual attitudes and behaviours, there is nevertheless growing research evidence to show how such interventions can be designed to ensure a greater likelihood of changes in attitudes and behaviour (King et al 2010).

Teams

A team climate for diversity and inclusion integrates rather than merely values diverse individuals in work groups. Inclusion is the degree to which an employee perceives that he or she is an esteemed member of the work group, receives fair and equitable treatment and feels encouraged to contribute to the effectiveness of the work group. Developing climates for inclusion is therefore key to managing diversity effectively (Guillaume *et al* 2013, 2015).

The climate for inclusion at the team or work group level affects group members' perceptions of their organisation's diversity management policies and procedures. The extent to which those policies and procedures facilitate the integration of differences leads to equitable employment practices and promotes the inclusion of all employees in decision-making. Such a climate is most likely to emerge at the team or work group level because it is at this level where leadership implements and executes an organisation's diversity policies and procedures. A team climate for inclusion facilitates the integration of differences and assures all team members that they are treated in a fair and equitable way and empowers them to contribute to the effectiveness of their work groups (Groggins and Ryan 2013; Guillaume *et al* 2013, 2015).

Strong work group climates for inclusion enable team effectiveness, innovation and team member wellbeing. Dysfunctional teamwork and professional divisions in teams (such as professional groupings with associated conflict or competition) powerfully undermine climates for inclusion.

Diverse team members, and employees generally, are more willing to contribute when their identity concerns – the need to belong, reduction of uncertainty, positive self-image and distinctiveness – are addressed (Guillaume *et al* 2013).

- Employees need to feel they belong (are valued, cared for and supported) in their teams and organisations. Discrimination directly undermines that vital element of belonging in people's lives, damaging health, wellbeing and work team performance (such as the delivery of high-quality and

compassionate care). Supportiveness, kindness, respect, warmth, humour and positivity build a sense of belonging for all in teams.

- People strive for certainty in groups because it confers confidence in how they should behave as group members and what behaviours they can expect from others in their groups. Discrimination undermines such confidence because there is chronic inconsistency in how the same behaviours are rewarded or valued. Ensuring equal and consistent treatment of team members is fundamental to the sense of trust which is essential for effective teamworking. Another important strategy is addressing uncertainty concerns by assigning dissimilar group members well-structured roles that clarify task requirements, ensuring their contributions are thus distinctive and valued in the overall team performance.
- A positive group identity is important because it influences how people see themselves – and naturally people prefer a positive and distinct self-image. Building successful, functional and supportive teams, characterised by optimism, cohesion and efficacy leads to both good team performance and a positive self-image for all team members.
- Rather than being conceived of as problematic or challenging, diverse work groups which function effectively provide a fertile context for the development of distinctiveness – a work group identity that accommodates idiosyncratic self-views and engenders feelings of being known and valued as a unique group member.
- Assigning dissimilar group members equal status and distinct roles, and articulating an inclusive superordinate identity in the team reduces threats to distinctiveness, facilitates a sense of belonging and promotes a positive valued identity.

Health care teams and organisations that have a compelling narrative about their core, undiluted purpose of providing high-quality, continually improving and compassionate care encourage a strong sense of identity that transcends boundaries. Such an inclusive superordinate identity alleviates the negative effects of employee dissimilarity on group identification and also promotes a stronger sense of belonging. Considerable research evidence suggests that teams are more inclusive when they are well-structured and have effective processes. These include:

- having a positive and motivating vision of the team's work
- having no more than five or six clear, agreed, challenging team objectives
- regular, useful feedback on performance in relation to the objectives
- members having clear roles and good mutual role-understanding
- having high levels of information-sharing, influence over team decision-making and regular interaction
- having shared team leadership where the hierarchical leader does not dominate but supports and facilitates
- having a strong commitment to quality improvement and innovation
- having strong support for innovation in the team
- team members valuing diversity as a positive element of the team
- a pattern of listening to and valuing all voices within the team

- having an optimistic, cohesive climate characterised by a high level of team efficacy
- working co-operatively and supportively with other teams in the organisation
- regularly taking time out to review their performance as a team and how it can be improved
- a team leader who reinforces the value of diversity of voices, views, skills, experiences and backgrounds as vital for creativity, innovation, good decision-making and team effectiveness (West 2012).

Where such structures and processes are in place, team member wellbeing, inclusion, team positivity, cohesion and effectiveness are all high and discrimination is low. In the case of frontline health care teams, patient/service user care is likely to be of high quality, continually improving and compassionate. Some trusts have made considerable progress in developing effective team-based structures and processes (such as Mersey Care, Birmingham Children's Hospital) using initiatives based on a strong research evidence base. More effective team-based working provides the right context for creating climates of inclusion.

Organisations

People are more willing to contribute to the effectiveness of diverse organisations when they believe that their employers treat all employees in a fair and equitable way (Avery and McKay 2010). Indeed, trust, transparency and perceptions of fairness are key to creating organisational cultures of inclusion. This is very difficult to achieve in organisations characterised by excessive levels of hierarchy and professional and status divisions that undermine feelings of inclusion and trust.

The challenge is therefore not only to ensure interventions that focus on how to address diversity and issues of fairness but to change cultures more fundamentally and deeply. First we consider how to address discrimination and the management of diversity at the overt level in relation to policies and practices, for example, people management (or human resource management – HRM). Then we consider the vital elements of culture that must be nurtured to change the deeper, more covert aspects of NHS organisations that will influence progress towards compassionate, inclusive, high-quality and continually improving health care organisations.

HR policies, practices and procedures

First it is vital that top management establish effective diversity management policies, practices and procedures (Konrad and Linnehan 1995; Kossek et al

2006). Such organisational HR shapes and reinforces equal employment via the 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, additional approvals for terminating employees from protected classes
- appraisal processes
- disciplinary procedures
- rewards systems
- job design including workplace accessibility
- methods for encouraging staff participation in decision-making, information-sharing, dialogue and interaction from top to bottom and end to end of organisations.

The research suggests that it is particularly important that there is visible and sustained top management support for positive diversity and inclusion policies and practices (Bilimoria *et al* 2008; Joshi *et al* 2011; NHS Providers 2014). But it is equally important that these are seen to be implemented effectively and consistently and are reinforced by middle management and frontline supervisors (Avery and McKay 2010). Part of their accountability must therefore include effective execution and implementation of these policies and practices. This means having clear and useful goals, backed up by criteria against which their performance in this domain is assessed; a forum for those who fall significantly below standards to be held to account; and real consequences for those who fail to make and sustain progress, despite support and coaching.

However, the research literature suggests that HR policies alone are not a solution. Too often, the HR function is reactive to problems of discrimination and does not take a strategic approach to creating cultures of inclusion. Relying on more or less effectively implementing equal opportunities policies will not solve the longstanding problems of inequality and discrimination identified in this report. HR and organisational development practitioners must work together to change cultures along with the leadership of their organisations, at every level. The culture of an organisation is critical for creating climates for inclusion or for discrimination and harassment. Below we describe the key elements necessary for cultures of inclusion, respect and kindness, which also are associated with high-quality health care (Dixon-Woods et al 2014). There are six: vision and values; clarity of objectives and performance feedback; people management; quality improvement, learning and innovation; teamworking; and collective leadership (West et al 2014).

Cultures of inclusion

1. Vision and values. An inclusive superordinate identity alleviates the negative effects of employee dissimilarity on group identification and also promotes a stronger sense of belonging. A clear, compelling vision is important for encouraging staff identification with their organisation. Where there is such a compelling vision or strategic narrative, focused on the delivery of high-quality, continually improving and compassionate care, staff are likely to demonstrate high levels of commitment and identification with their organisations. Such shared identification will increase a sense of shared identity among all staff, working against the development of in-group out-group categorisations which contribute to discrimination and exclusion. However, such a shared vision and set of common values have to be enacted rather than merely espoused for the positive benefits to result. When leaders across the organisation, top-to-bottom and end-to-end, embody the values and the vision through their actions and interactions, a powerful sense of shared identity is likely to be sustained within the organisations.

2. Objectives and performance feedback. In the discussion on teams, we have already described the importance of role clarity and of agreeing team objectives. Similarly, to create an environment where staff feel clear about their roles, and ambiguity and confusion are minimised, teams from the executive team down, must have a limited number of clear, agreed objectives (no more than five or six), and have good information providing them with regular and frequent feedback on performance. The same applies to individuals within the organisation. Where there is clarity of purpose and learning about performance, aligned to the vision, services for patients are likely to be of high quality and continually improving. Moreover, the associated clarity and accountability ensure that the ambiguity and confusion that feed stereotyping and discrimination are minimised.

3. People management, engagement and positivity. Key to nurturing climates of inclusion is support and compassion within NHS organisations, whose very purpose is to provide support, care and compassion. It is fundamental to nurturing such cultures that all relationships are characterised by support, respect, care and compassion – between staff and patients/service users, between staff members, and between managers/leaders and staff. This means people paying attention to each other; carefully appraising the other's difficulties; experiencing and showing empathy; and then taking intelligent action to help. Such a culture is likely to dramatically reduce discrimination and increase inclusion. There is much evidence of the importance of staff engagement as a predictor of key outcomes for NHS organisations, such as patient satisfaction, quality of care, patient mortality and staff wellbeing. Creating conditions for staff engagement is vital for nurturing cultures of inclusion. Where staff are overworked, stressed, marginalised by their leaders and blamed, engagement levels are likely to be low and discrimination and

stereotyping high. Understanding the need for leadership that enables engagement is therefore fundamental to address the issues of diversity and inclusion in the NHS. Yet many boards continue to pay scant attention to the levels of staff engagement in their trusts. Moreover, it is important to encourage positive emotional environments in NHS organisations, characterised by optimism, cohesiveness and efficacy. Where staff feel relatively high levels of positive emotions at work, such as pride, belonging, optimism, humour and compassion, the evidence suggests the tendency to stereotype and feel different from others is reduced. Positivity reduces stereotyping and reduces the psychological distance that people perceive between themselves and others who are dissimilar.

4. Quality improvement 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, the importance of hearing the voices of all voices and the need to encourage constructive debate or controversy. The research examining creativity and innovation in workplaces has demonstrated how diverse work groups which function effectively (with clear objectives, high levels of participation and shared leadership, a commitment to quality and innovation) outperform other groups in terms of both productivity and innovation. Where there is a strong norm in organisations that values diversity for its own sake and for the difference it makes to the organisation's mission of delivering high-quality care, discrimination is low and inclusion is high. Moreover, such organisations outperform others in the delivery of high-quality, compassionate care to patients/service users.

5. Team and team-based working. The extent of team-based working in organisations will also affect the diversity and inclusion climate. When most staff work in effective teams (described above) there is a culture of co-operation, support and inclusion that ensures the benefits of diversity and inclusion are achieved for the benefit of patients/service users and staff. All teams must seek to ensure that climates of inclusion are continually nurtured and sustained because it is within teams that both the greatest benefits of diversity and inclusion are directly realised and it is within teams that the destructiveness of discrimination is most damaging to individuals and to performance.

6. Collective leadership. Key to achieving such cultures is leadership. Senior leadership must set direction and reinforce the values of the organisation. Leaders at every level must reject hierarchical, command-and-control styles that encourage division, stereotyping and exclusion. Instead, organisational cultures must be sustained by *collective leadership*. Collective leadership is characterised by all members of the organisation recognising that they play leadership roles at various points in their day's work and in their careers. It also reflects shared leadership in teams, where de facto leadership shifts imperceptibly depending on the task at hand and the expertise of individual team members, regardless of who is

> the hierarchically designated team leader. It also described a collaborative style where leaders work across boundaries in the interests of patient/service user care overall rather than leaders competing for success just for their own areas. Where such styles of supportive, respectful, warm and enabling leadership are common rather than exceptional across the organisation, cultural norms that value diversity and inclusion are likely to flourish (West *et al* 2014).

These key elements of cultures of inclusion are also key elements of cultures that deliver high-quality, continually improving and compassionate care. It is no coincidence that such cultures, creating the conditions for innovation and quality improvement, characterised by compassionate care for patients and service users, are also cultures within which all are more likely to feel included, valued and to thrive. How is this to be achieved? It requires all organisations to ensure they have leadership strategies in place that deliver the leadership needed to ensure these vital cultural elements are there. This includes the numbers of leaders, in all key leadership positions and a pipeline of leaders who can step into vacant or newly created roles. It includes leaders who represent appropriately all equality groups and offer the clinical leadership needed in organisations focused on quality of health care. It needs leaders with the knowledge, skills, attitudes and values that nurture the six elements described above. It needs organisational development, leadership development and human resource management policies that support the development and delivery of such strategies. The King's Fund, along with the Center for Creative Leadership and AstonOD, has developed a comprehensive programme to support trusts to deliver such leadership strategies and thereby, cultures of diversity, inclusion, high-quality care and compassion (Eckert *et al* 2014; West *et al* 2014).

The best way for change to occur is for holistic, systemic interventions targeted at every level of every NHS organisation (eg, Bilimoria et al 2008). That requires sustained focus, vision and a strategic narrative about inclusion, embodied, reinforced and sustained by leaders at every level – top to bottom and end to end. It requires objectives aligned to this strategy in every team and department in every organisation. It requires the involvement of all staff every month and every year in conversations about continually improving climates of inclusion and fairness in relation to all groups affected by discrimination and prejudice. It requires building truly effective teamwork where diversity is a source of productivity and innovation rather than conflict. Current estimates suggest that at least 50 per cent of teams in NHS organisations are dysfunctional and are therefore likely to be seedbeds for discrimination. There are many examples of organisations that are developing leadership strategies to make a difference (such as Lancashire Care); examples of organisations that are developing outstanding team-based working (such as Merseycare NHS Trust, Birmingham

Children's Hospital); and examples of organisations that are developing high levels of staff engagement, compassion and wellbeing (Wrightington, Wigan and Leigh, Northumbria Healthcare) from which other organisations can learn. There are few that have developed comprehensive and effective diversity and inclusion strategies but some trusts are making progress in reducing discrimination against BME staff such as North Middlesex University Hospital NHS Trust, Sandwell and West Birmingham Hospitals NHS Trust, King's College Hospital NHS Foundation Trust, Royal Brompton and Harefield NHS Foundation Trust and Great Ormond Street Hospital NHS Foundation Trust. All of these trusts have relatively high proportions of BME staff.

Given the importance of culture to creating positive environments for diversity and inclusion (Dwyer et al 2003), we recommend that every organisation should assess its culture at least every two years in relation to the six key elements described above. Such assessments should occur with the explicit intent to use the information gained to underpin comprehensive plans to nurture improved cultures. Such culture measures already exist including the Culture Assessment Tool which was designed and developed over a 15-year period to assess these aspects of culture (see www.kingsfund.org.uk/leadership/collective-leadership/how-we-can-work-you-develop-collective-leadership). Another is the Cultural Barometer, which focuses on cultures of compassion particularly (see www.england.nhs.uk/wp-content/uploads/2015/03/culture-care-barometer.pdf).

National

Nations are reputed to account for around half (49 per cent) of the variation in organisational practices, procedures and policies (Brodbeck et al 2004). So a country's culture, socio-economic variables, as well as the legal and political system, play an important role in shaping organisational policies and procedures in relation to how diversity is managed. According to the GLOBE studies of leadership around the world, countries with high performance orientation, high uncertainty avoidance, a high humane orientation and high gender egalitarianism are more likely to adopt sophisticated diversity policies (Brodbeck et al 2004). England is a country with relatively high performance orientation, relatively low uncertainty avoidance, a high humane orientation and high gender egalitarianism. Compared to other countries, it therefore has a favourable climate for adopting good diversity policies.

There is also some evidence that national policies can lead to real change in overt discrimination. When the National Institute for Health Research (NIHR) announced it would not fund university or NHS partnerships involving

departments that did not hold at least a silver level Athena Swan award (a gender equality policy standard) there was a subsequent sharp rise in women in leadership positions in these institutions and an increase in applications for the awards (Blandford et al 2011). Similar strategies have been shown to have effects on overt discrimination in a range of settings and countries (Priest et al 2015). A particularly striking example is the Rooney rule introduced in 2003 by the US National Football League requiring clubs to always interview one candidate from an ethnic minority background whenever a coach or manager post was being filled. This led to a significant increase in representation of ethnic minorities in these positions and, within three years, six division titles were won by teams with black coaches (Collins 2007). (Systematic analysis of corporate diversity policies of 708 US private sector organisations from 1971 to 2002 found legal establishment of leadership responsibility for representation of women and ethnic minorities in management positions had greater effects on managerial diversity than other strategies (Kalev et al 2006)). However, rhetoric that reinforces the idea that most NHS organisations are characterised by high levels of discrimination is likely to normalise discrimination (as we describe above) so it is important to emphasise that many organisations are seeking to create climates for inclusion (as indeed they are). To aid this, there should be clear guidance on how to develop climates for inclusion.

There are therefore good reasons for ensuring that the NHS exercises its power to set national standards around developing cultures of diversity and inclusion for all health and social care organisations. But there must also be accountability with organisations held to account in appropriate fora with clear consequences for falling below the acceptable standards.

Conclusion

Compassion, fairness, a culture of inclusion, psychological safety and leadership that models a positive attitude towards diversity are fundamental to addressing discrimination in the NHS (Singh et al 2013). There is a clear and compelling need to cultivate a more diverse and effective NHS leadership. Leadership is about creating the conditions to enable staff to deliver high-quality, continually improving and compassionate care. Extensive research evidence makes it clear that transforming cultures is at the heart of addressing issues around discrimination in order to improve the experience of all staff and patients. This includes creating a culture that emphasises diversity as a valuable resource for the organisation (for a review, see Avery and McKay 2010) and which is modelled in practice and communicated explicitly and repeatedly by all leaders.

The moral arguments against discrimination are clear. The human costs are huge. The impact on patient care is clearly negative and substantial. If staff experience discrimination as a result of their identity as gay, or Muslim, or disabled, or Black African, there is no doubt 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 stands for valuing, caring, quality and compassion for all and it is a source of great pride to the people of the United Kingdom. It is necessary therefore that the whole of the system takes responsibility for solving the problem in order to continue to safeguard the founding values of the NHS. It will take concentration, vigour, courage and persistence to ensure this change is effected and sustained over time. Now is the moment to begin.

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