October 2022

Talent South East
NHS England

Enabling our Disabled Talent

Research Report

Why look into disability and talent in the NHS?

NHS

It has long been known and accepted that senior leadership in the NHS and most other industries suffers from a lack of diversity. This has not happened by accident. It emerges through the choices made, and words selected and conversations between people over many generations. In progressing towards more inclusive and representative leadership of our services that can really improve decision making, care and health inequalities – we need more diverse leaders than we currently have.

The issue of diversity through our talent pipelines and leadership levels should be taken as seriously as an absence of effective leaders. Without deep insight into the causes of health inequalities, how can we ever hope to address them? Unless we address health inequalities how can we ever expect to improve health outcomes of our whole population.

Great steps have been made in the path toward equality and representation for staff from our constituent ethnicities and cultures. We are not finished by any means, but we have hardly begun in our work to address inequalities for Disabled staff. Our health services now face the biggest challenges in terms of access, need and resource. The pandemic has ravaged staff and our world and left us with the largest unmet need for services than we have seen in a generation.

Now we need to recognise the immense value and insight our Disabled staff bring. Their experiences give unique perspectives into what great care really means, of the impacts of siloed working on patient care along with compassion for staff struggling to deliver the best care they can. As the longer-term impacts of Covid show many for the first time how it really feels to have increased health needs, we must look to those who have lived this experience for much longer.

As our workforce ages and expectations for longer working lives increase, the NHS must adapt to better include talent with a range of different needs. Terms like Talent and Leader must actively include people with disabilities along with other underrepresented groups. We must help people expand their own definitions to include themselves. In doing so we will grow a more caring, compassionate and flexible service that will sustain a healthier population that is more affordable to taxpayers.

We thank Agnes for her great work assimilating a wide range of views to such clear direction to help us find our way forward. We are also grateful to the hundreds of people who took the time to share their experiences with us in hope and optimism for the next stage in our work for an inclusive talent approach in the South East and nationally.

Fiona Rodden, Head of Talent, South East NHS England

Dr Chris Rivers, Head of Workforce Disability Equality Standard, NHS England

Contents

Cover Image:
BSL sign for ‘Support’

Accessible formats of this document are available.
Please contact talent.southeast@england.nhs.uk

NHS

Executive Summary

The NHS needs to attract and retain a highly trained, values-led workforce and to manage in ways that optimise performance and well-being. Disabled people make up a large proportion of the existing NHS workforce. They represent a considerable asset, including in relation to the insights they bring to service delivery. Effective talent management for NHS Disabled employees is an imperative, from a performance and financial perspective, as well as from an equity and ethical perspective.

This research was commissioned by Talent South East, a part of NHS England and explored the experiences and opinions of Disabled NHS employees on barriers to and enablers of progression, and the value they bring.

The research was commissioned to inform planning for career development and progression. We wanted to get a better understand what helps Disabled people to progress and to develop their careers within the NHS – and what gets in the way. This information will be used to ensure our work is inclusive, that we target effectively and can help our partners to do the same.

Disability-related terms used in this encompass both an individual model (based on the definition of protected characteristics in the Equality Act 2010) and a social or barriers model, which emphasises that people are disabled by systems, culture, policy and practice rather than inherently by their conditions.

What research was done?

The research takes an intersectional lens, recognising people possess many characteristics impacting their career experience. There were 219 survey respondents complemented with a series of four focus groups with 15 participants and 12 individual interviews from January to May 2022. The survey invited respondents to share both their quantitative and qualitative information about their experience of disabilities in their work. The interviews explicitly explored dual or multiple barriers faced by minoritised employees, particularly in relation to ethnicity and LGBTQ+ identities.

What were the key findings?

First, we consider why Disabled staff face barriers at all. A hugely significant finding from the survey responses is that nearly 60% had experienced discrimination, bullying, harassment or victimisation in the previous five years[1]. Line managers and senior managers were responsible in the majority of cases (61.1% and 58.4% respectively), colleagues for some (43.45%) and patients/ the public rarely (7.1%, though it is noted a higher number of respondents were non-clinical). This weathering is likely to create a significant a 'chilling effect' on attendance, performance, retention, progression and ambition. It is not surprising then that 79% of those unsure whether they wanted to progress in their careers had experienced some form of discrimination. This may be a helpful flag for line managers offering support.

Introduction and purpose

Executive Summary

A 'deficit model of disability' as a cultural norm within their workplace and the NHS as a whole was cited by many, particularly in focus groups and interviews. Several mentioned that they did not believe that the "person-centred approach" explicitly offered to patients was being offered to employees. This impacted both openness with the organisation about needs and support accessed. Additionally, respondents felt that senior staff are still largely expected to conform to an heroic leadership model of extreme physical and mental resilience. They felt that this stereotype does not match the reality of many motivated, experienced employees who would add enormous value in different ways to leadership of the NHS workforce and to its services.

Who experiences barriers?

Respondents were particularly likely to experience barriers to progression if they:

- were also minoritised ethnically within the service;
- had multiple disabilities or conditions; and/or
- they had mental health conditions, were neurodiverse or had physical health conditions

Specific barriers to development and progression

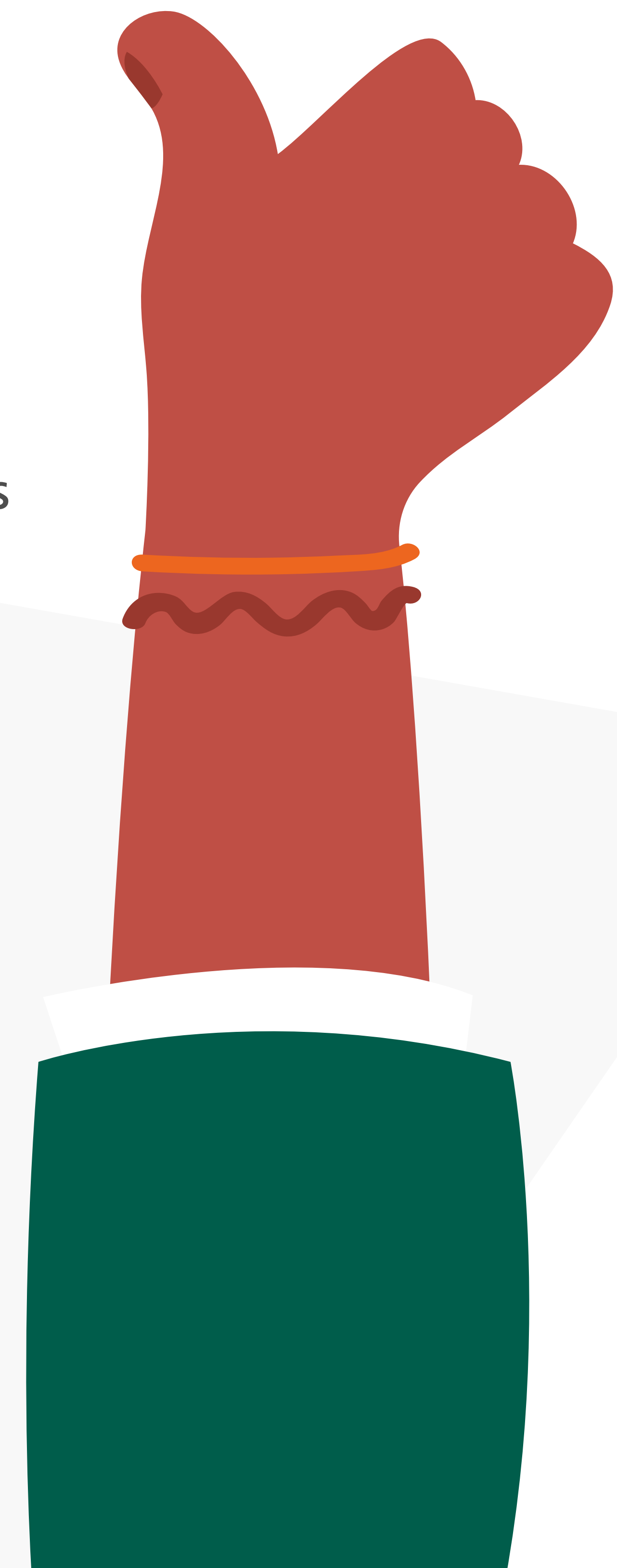
Identified here were often the same as those that inhibit performance for staff:

- A lack of flexibility in working practices and delays in identifying and implementing workplace adjustments.
- Lack of available development opportunities. This includes stretch opportunities and interim/acting up responsibilities not being offered to staff who are Disabled.
- Lack of accessibility of formal development programmes and training opportunities.

How can we enable Disabled staff in our organisations?

Key findings include:

- fair access to development opportunities and training;
- senior sponsors and mentors;
- fully inclusive and accessible training programmes, with a choice of generic programmes and disability-specific programmes;
- disability-specific programmes that support delegates explicitly to access senior sponsors and to develop a personal narrative that identifies the value of disability from a diversity perspective;
- role models; and
- a consistent experience of agile and responsive workplace adjustments.



Introduction and purpose

Executive Summary

NHS

How can we retain and motivate Disabled staff?

Respondents wanted:

- to feel safe and free from stigma and discrimination;
- supportive line managers who take a person-centred approach to their management and development;
- coaching, mentoring and senior level sponsorship;
- more knowledgeable managers and colleagues – with a more nuanced understanding of the individual impact of impairments, long-term health conditions and neurodivergence;
- an understanding of the systemic nature of disability and barriers to progression;
- an "affirmative model of disability" and recognition of the invaluable assets individually and collectively in Disabled employees.

The conclusions of this report are based on the number of research responses and the statistical significance of the data. This inevitably means limitations. For example, a large proportion (over 40%) of survey respondents did not disclose their pay band. This may imply a fear of being identified from such surveys and is consistent with underreporting of disability in other types of information gathering, notably the Electronic Staff Record (ESR).

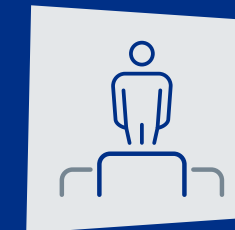
The recommendations – where to start?

The research does however identify a need to support staff in Bands 6 to 8 where there is significant frustrated ambition. Efforts should be focused to enable progression, promotion retention and support wellbeing. This does not preclude the need to work with more senior staff but reflects a higher demand for support at these levels. At the same time, there are some who are unsure about whether they want to progress or stay within the service because of negative experiences within the NHS workforce.

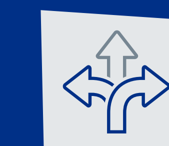
The report recommendations

Two overarching and three specific themes from our findings.

Accountability

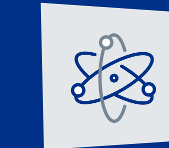


Accessibility



Role models

Safety for disclosure



Intersectionality

Increasing the number of Disabled leaders is an end in itself, to realise the benefits of diversity in our strategy and services. But it is also likely to create cultural change and may motivate others affected by disability to stay and continue to develop their careers within the NHS.

Introduction and purpose

Research purpose

The South East Talent Team launched this research early in 2022 to understand more about the career aspirations of Disabled NHS colleagues across the region. Some survey responses were received from outside of the South East region but do not alter the findings of the research. All focus group participants and interviewees worked within the South East region.

The research was commissioned to inform planning for career development and progression. The Talent Team wanted to better understand what helps Disabled people to progress and to develop their careers within the NHS – and what gets in the way.

The aims of the research were to:

- identify ways in which NHS England's South East talent team can contribute to narrowing employment equity gaps in access, outcome and experience between Disabled and non-Disabled staff within the NHS;
- learn from the lived experience of Disabled people;
- support NHS employers to improve recruitment, retention, development, progression, health and wellbeing for Disabled talent;
- explore barriers and enablers affecting aspiration, career development, progression, retention, engagement and wellbeing for people with lived experience of impairments, long-term health conditions and neurodivergence within the NHS; and
- provide evidence to influence national, regional and employer talent management for Disabled staff.

The Team commissioned an independent consultant, Agnes Fletcher, who is an expert in disability law, policy and practice and who has lived experience of disability. Agnes supported development of the survey questions, facilitated the focus groups, undertook one to one interviews and authored this research report, with support from members of the South East Talent Team.

Next...

About the research

Background, methodology and participants

NHS

Background and context

The current NHS leadership is acutely unrepresentative of the British population, the NHS workforce, and the approximately 70% of NHS patients that have impairments and/or long-term health conditions.

Workforce Disability Equality Scheme (WDES) 2021 data shows that just 3.7%2 of NHS staff in England record a disability on ESR. WDES data also shows that increasing seniority goes hand in hand with lower disability declaration levels: just 1.6% of senior level leaders at Band 8c3 and above declare a disability and 3.7% of Board members. 59% of trusts have five or fewer senior leaders who have declared a disability.

There are issues with actual representation but potentially also with trust, confidence and safety to declare. In the NHS Staff Survey, in which responses are anonymous, the percentage of Disabled staff declaring disability is 23%, or nearly a quarter of the workforce. This maps more accurately to the proportion of those in the British population with these experiences.4

Similarly, of the 3,883 responses to the disability status question within the latest anonymous NHS Leadership Survey, 21% indicated that they had a disability. However, specifically for the South East, ESR data at January 2022 shows those disclosing disability varied between NHS employers from 18.9% to just 4.3%.

WDES data shows that Disabled people are less likely to be recruited, more likely to be in capability processes, more likely to be bullied and less likely to progress. Disabled staff are less likely to inform managers that they are Disabled, have long-term health conditions and/or are neurodivergent, for fear of discrimination.

This has significant implications for their access to the flexibility and adjustments that would support their health and well-being and drive attendance, performance and progression. However, many respondents to this research also indicate difficulties with accessing the flexibility and adjustments that they need, even when they do declare.

If the ageing NHS workforce (and the link between age and disability) and the need to retain valuable, highly trained staff are factored in, the importance of effective talent management for Disabled employees is clear, from a business and financial perspective, as well as from an equity and moral perspective. Diversity of all kinds, including of background, experience and identity, is vital to the cognitive diversity required to ensure that the NHS works effectively for those it exists to serve.

Experience of disability, including living with an impairment, long-term health condition or neurodivergence, navigating policies, services and life challenges, is a vital asset to the NHS. Yet it is one that is unrealised because of the suppressing action of systemic, cultural and policy barriers to Disabled talent.

Previous reports from within and outside the NHS have consistently detailed barriers to and enablers of progression for Disabled talent.

About the research

Background and context

For example, in 2010 Radar (now Disability Rights UK) published 'Doing Seniority Differently', which found from a survey of "Disabled high-fliers" across sectors that:

- two types of support were significantly associated with career progression - having a mentor committed to your career and having senior staff support throughout your career – despite Disabled people being less likely to get these forms of support;
- those with the choice often do not reveal disability, particularly those with mental health conditions, because of a fear or experience of discrimination;
- many Disabled people with career aspirations lack confidence in equal access to progression and those who progress are majority of male[5]

In 2015, the Cabinet Office published 'Tackling Disability and Health-related Barriers to Progression within the Civil Service', based on extensive research, which found significant systemic and cultural barriers to progression. Many staff assumed leadership is out of reach for Disabled people. A large number of civil servants who are disabled[6] have reported discrimination, bullying, harassment and victimisation and a lack of trust and confidence in performance measurement. The report highlighted that the implementation of work adjustment and rigidity of job structure is a significant barrier to progression. Sustained follow-up after talent schemes and corporate investment is needed to ensure that individuals are able to navigate cultural and systemic barriers. Clear and strong commitment of senior level champions of diversity are essential and must be sufficiently incentivised and supported at a functional level. The report recommends assessing all managers' performance against strategically set diversity targets and the use of data to drive change.

Specific enablers to address barriers include:

- Compulsory line management training on disabilities with consistent diversity objectives for all managers
- De-biasing recruitment through reviewing job portals, job descriptions and person specifications
- Active promotion of flexible working, job shares
- Active recruitment of those with disability experience to main talent programmes plus a specific targeted acceleration programme for emerging Disabled leaders
- Access to coaching, mentoring and senior sponsors
- Speeding up and centralising adjustments and the use of Disability passports

This research broadly confirms these earlier studies on disability, seniority and progression. There are significant strategic issues for NHS leadership and management, relating to culture, systems, policies and practice.

Talent teams have a particular a role in identifying and supporting individuals who require career pathways actively cleared of barriers and in identifying and resourcing the specific levers of progression for Disabled people.

Methodology

This report analyses research about the experiences and opinions of disabled talent working principally in the NHS South East region.[7] The research consisted of:

- an online survey, open from 20th January 2022 to 5th April 2022 to any member of staff in England providing NHS funded health and care, with targeted communication to South East staff through disability networks;
- three focus groups of 15 disabled employees from different Trusts across the South East and from NHS England & Improvement; and
- twelve one-to-one interviews with individual disabled people from the South East region, with a focus on intersectional experiences to supplement the findings from the survey.

The purpose of the different research elements was to provide the independent researcher with quantitative and qualitative data about the experiences and opinions of Disabled people in relation to their career development and progression with the NHS South East region.

The survey communications allowed for a range of interpretations of the term disability. It set out the Equality Act definition of disability, emphasising that it covers people with impairments, long-term health conditions and neurodiversity. However, the introductory text acknowledged that some respondents would take an individual or medical model approach to their experiences and others would consider a barriers or affirmative model of difference more appropriate to their view of themselves and their experiences. Long Covid was intentionally included as a disability, despite it not yet having recognition legally as such, as it was felt the impacts of the pandemic should be captured.

This nuanced approach to interpretations and definitions of disability was continued within the focus groups and interviews, so that individual research participants were encouraged to define and describe their own lived experience.

The research aimed to take and takes an intersectional lens, recognising people possess many characteristics impacting their career experience. The survey invited respondents to share both quantitative and qualitative information about their experience of disabilities in their work. The 12 interviews explicitly explored dual or multiple barriers faced by minoritised employees, particularly in relation to ethnicity and LGBTQ+ identities.

About the research

About the survey respondents

About the survey respondents

One third of respondents (33.3%) were clinical and two-thirds (66.7%) were not. The majority of the clinical respondents were from nursing and midwifery.

A majority of respondents (52.5%) were from the South East, with 11.7% describing their location as 'national/ and 9.2% from London and 8.3% from East of England and 6.7% South West. There were very few respondents from other regions.

35% of respondents worked for an Arm's length body (e.g. NHS England or Blood and Transplant); 2% for acute trust, 19.2% in mental health and 10% working in commissioning.

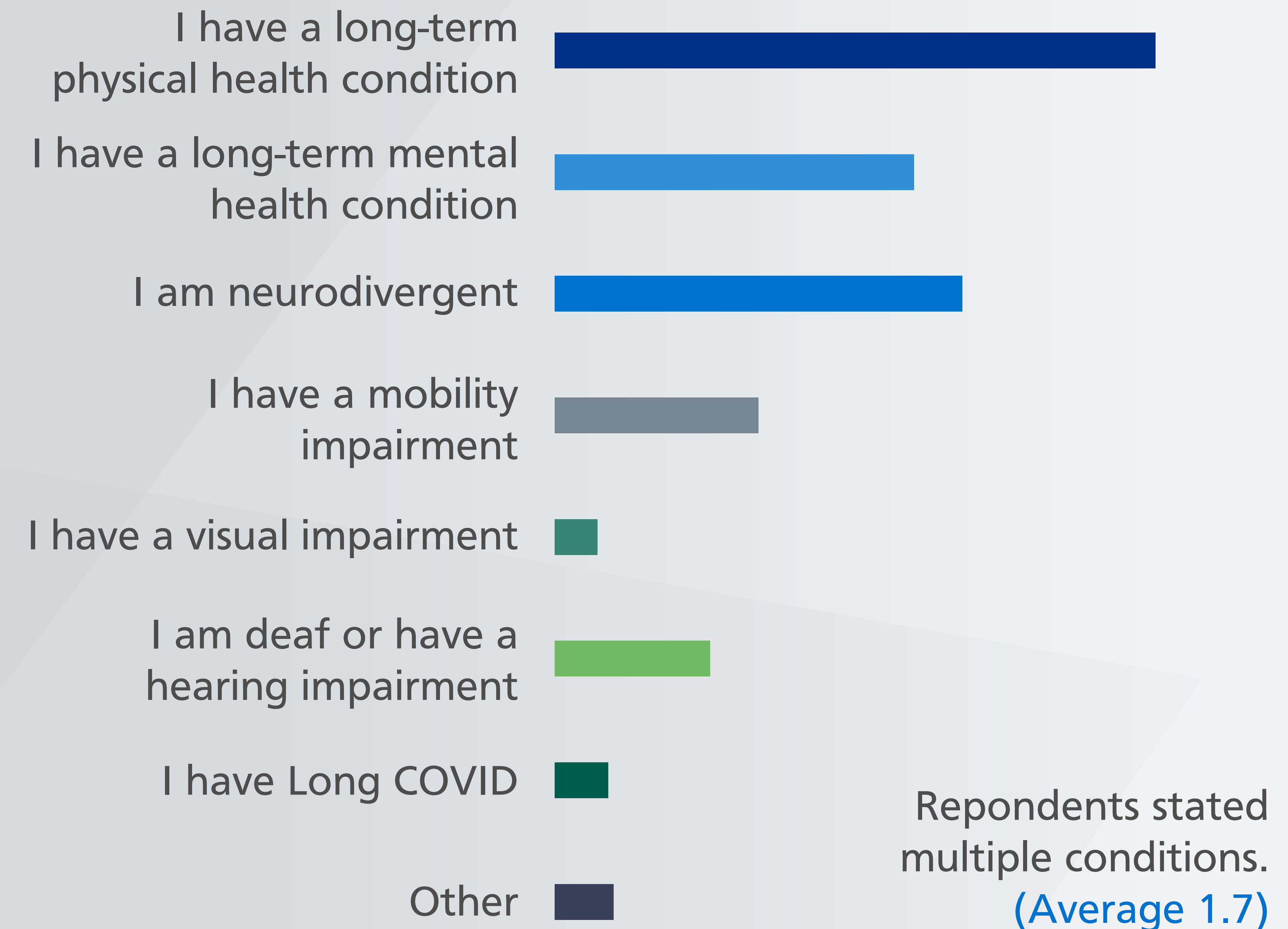
The vast majority of the 219 survey respondents (90.4%) had lived experience of disability. The views of those who answered "no" to this first survey question were not collected or analysed. All of those engaged via focus groups and interviews had lived experience of disability.

There was a broad representation of disability experience among survey respondents, with the highest percentage being those who were neurodivergent and/or had a mental health condition. This prevalence was mirrored in the focus groups and interviews.

Of those survey respondents with lived experience of disability, the vast majority had one or two impairments/disability experiences (52.4% had one and 28.6% had two). However, a sizeable minority (13.2%) had three impairments and a small percentage had four or more impairments.

The majority of respondents were female (85.3%), 12.2% male. Less than two percent identified as non-binary or trans and a non-identified gender. Although this is a relatively high rate of disclosure compared to other surveys, the small percentage makes it impossible to draw out any specific conclusions from the perspective of those who are transgender, non-binary or otherwise gender non-conforming.

Type of disability



About the research

About the survey respondents

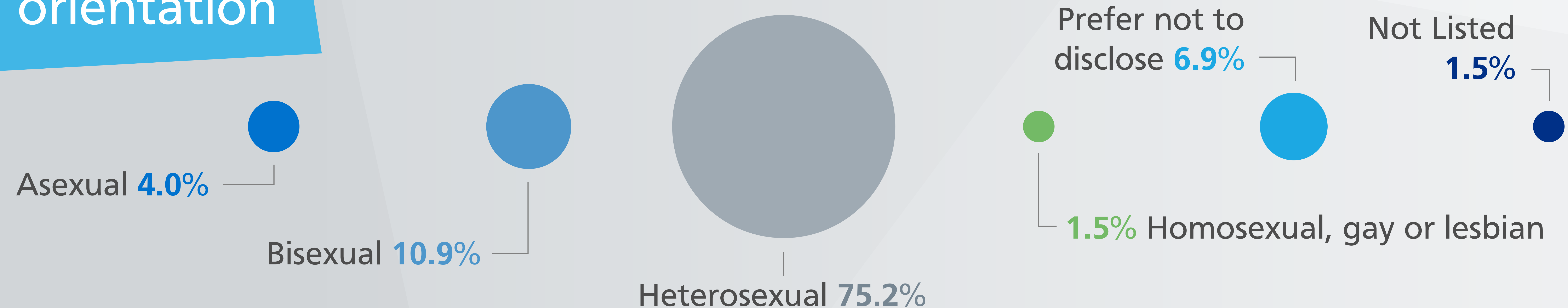
Respondents to the survey were less ethnically diverse than the NHS staff population in the South East, with 17.6% from ethnic minorities compared to 22.1% employed by NHS Trusts[8]. The constituent ethnicities of survey respondents reflected include: 3.6% described themselves as Black or Black British, 3.6% mixed ethnicities and 6.2% White non-British/English. 80.3% identified themselves as White British/English 2.6% of respondents chose not to disclose or said that their ethnicity was not listed.

All other groups comprised less than 2 per cent of responses each. As a result of the relatively low number of responses from minorities ethnicities, the researcher conducted additional one to one interviews with people with this characteristic.

A significant percentage of survey respondents (16.5%) declared that they had an LGBTQ+ identity. This is a higher rate than expected from overall staff survey data and much higher than recorded on ESR. Surveys in the past have also shown a higher representation of LGBTQ+ identifying staff with physical and mental health issues and disabilities[9]. For example, research on behalf of LGBTQ+ South East found that 40 percent of those LGBTQ+ NHS employees responding said that they had a disability.[10] These studies also reflect reluctance to declare formally through HR due to fears of discrimination and dissatisfaction with the language and categories for disclosure.

This intersectional finding could be for a variety of reasons, such as the impact of living/working within a heterosexist and/or racist culture on mental and physical health. Interviews found that several respondents identified their disability-related barriers as more significant to career progression than those relating to ethnic minority or being LGTBQ+.

Sexual orientation



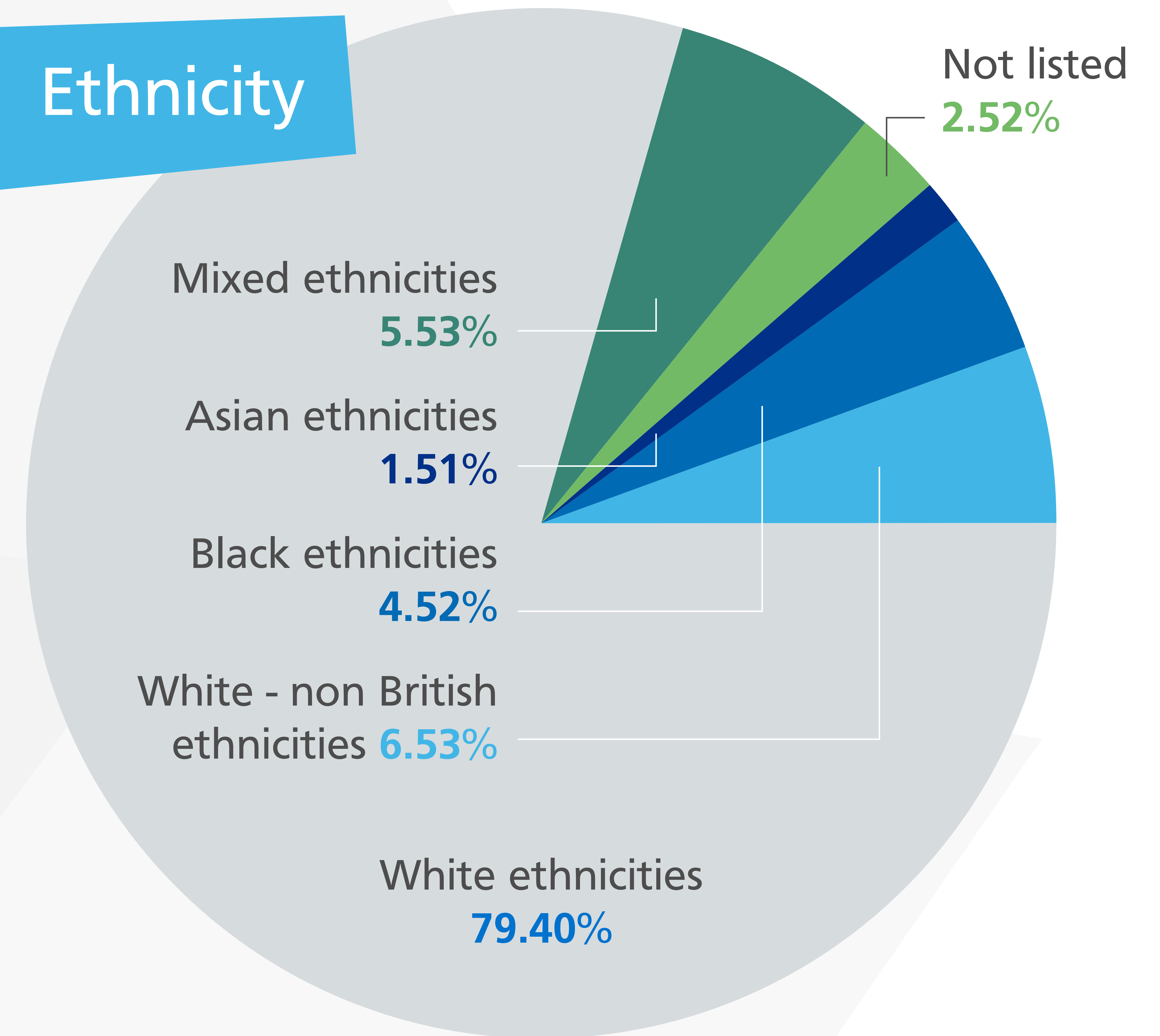
About the research

About the survey respondents

Among survey respondents, female respondents seemed to have a higher number of disability experiences (the mean was 1.71 vs 1.21 for males). Older people seemed to have slightly fewer impairments/disability experiences, which is counter-intuitive given the association of age and disability. This could possibly be explained by the high proportion of those identifying as neurodivergent and a perhaps increased likelihood of this being identified now during education and the early stages of working life for younger people.

Ethnic minority respondents had more types of disability experience than White British survey respondents. Those with a mobility impairment and those with mental health conditions were most likely to have more than one type of disability experience. Although Long Covid also featured, the sample size is small and has limited validity.

Of those who gave their age, 33.2% were aged 46-55, 19.9% were aged 36-45, 19.4% were aged 26-35, 16.1% were aged 56-65, 2.4% were under 25 and 1.9% were aged 66 or over.



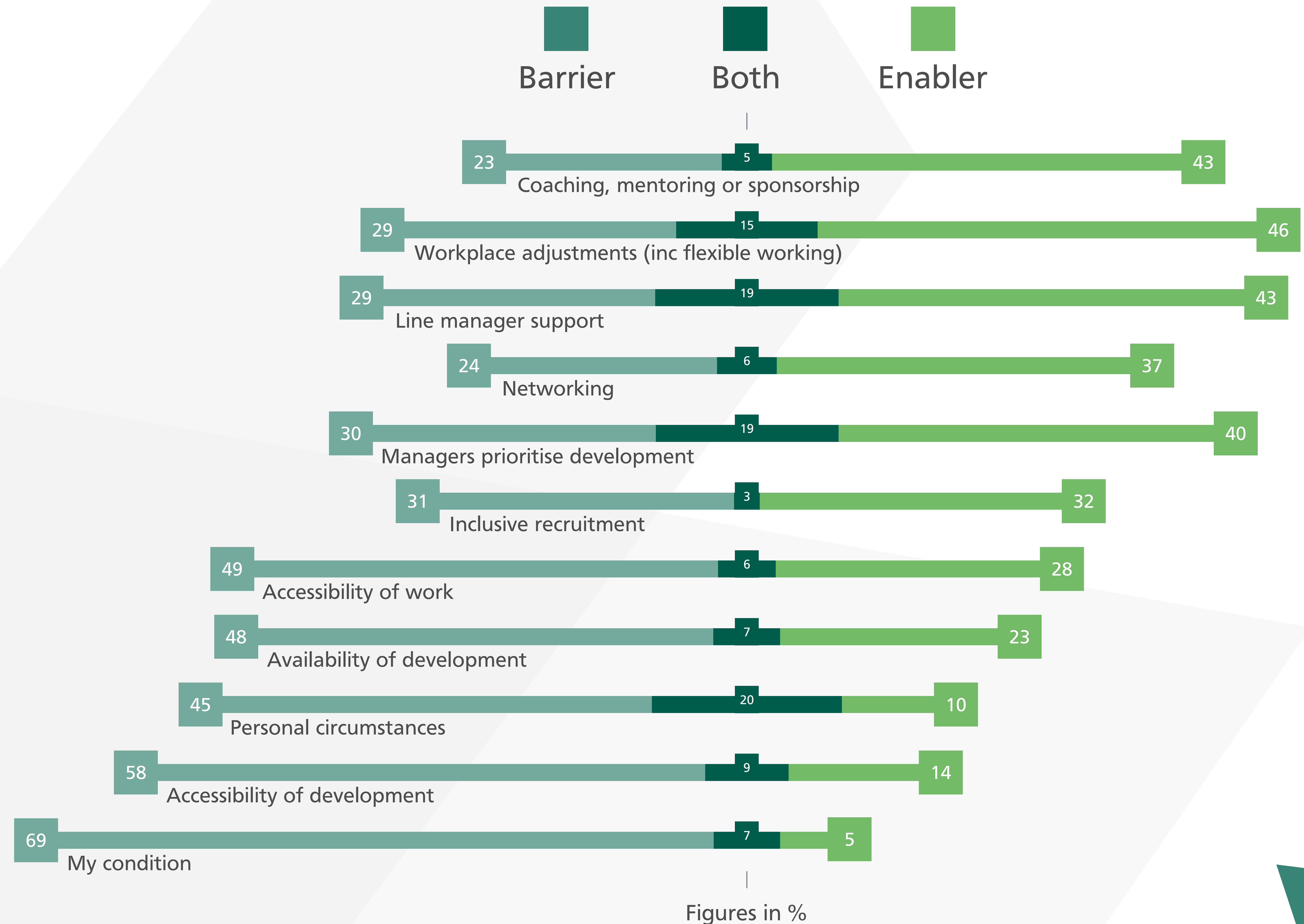
Next...

Key findings

Barriers and enablers, Access to training, Workplace adjustments, neurodivergence, openness at work, discrimination and formal management, aspirations, visibility

Career barriers and enablers

This research looked to find ways to narrow the gap in access, outcomes and experiences between Disabled and non-Disabled staff in the NHS. The survey gave us a guide for where to focus our group and individual conversations. The stories shared helped us understand in more depth, what the biggest barriers were and for whom; what has helped those who have had positive experiences; and what motivates people to stay in the NHS. Here we summarise the main barriers and enablers people shared and what has had the biggest impact on their careers, to help us find our way forward.



NHS

Career barriers

In question 18 of the survey, respondents were asked: "In the past, what have been the biggest barriers/enablers to progression?"[11] An impairment, health condition or neurodivergence itself and "personal circumstances" had the biggest response, potentially indicating internalised ableism. After that, the most frequently cited barriers were:

- inaccessibility of development initiatives;
- inaccessibility of work opportunities; and
- lack of inclusive recruitment practices.

Nearly two-thirds of survey respondents (64.5%) said that they had experienced a negative impact on their development or progression through disability-related absence, their impairment, health condition or neurodivergence itself, or related discrimination or bias (survey question 7). Those with a mental health condition are most likely to say that they have experienced a negative impact on development or progression (81.5%) and those who are Deaf or hard of hearing the least (55.2%).

Accessibility of development initiatives was a bigger barrier for those with visual impairment (100%) and Long Covid (80%) than for other disability-type groups. It was also a big barrier for those with a mobility impairment and those with a mental health condition (66.7% in each case). It was more of a barrier for female than for male respondents; more of a barrier for ethnic minority respondents than for White British respondents; and more of a barrier for those with LGBTQ+ identities than for heterosexual respondents.

Availability of development initiatives was a bigger barrier for those with visual impairment and Long Covid than those with other types of disability experience; those aged 36-55 compared to other age groups; female respondents (51% compared to 36% for men); for ethnic minority and higher band staff (54% of those on band 7 or higher compared to 45% of those up to and including band 6).

Accessibility of work opportunities as a barrier was greater for women than men (52% and 27.3% respectively saying this was a barrier). However, accessibility of work opportunities was less of a barrier for ethnic minority respondents than for White British; less for LGBTQ+ respondents than heterosexual respondents; and much more of a barrier for band 7 and above (59.3% for band 7 comparted to 42.3% of those up to an including band 6).

This was also a bigger barrier for those with a mental health condition (61.9%), those with a mobility impairment and those with Long Covid. It was also more of a barrier for older respondents (63.6% of those aged 56 or more compared with 44.4% of those aged up to 35).

Coaching/mentoring/sponsorship[12] was a bigger barrier for people with visual impairments (40%) than for those with other types of disability experience and for those aged 56 or older. It was slightly more of a barrier for ethnic minority respondents compared to White British respondents and more of a barrier for those on lower bands (26.9% against 18.5% for those on band 7 or above).

Key findings

Career barriers

The research overall confirms that barriers are cultural and systemic as well as practical and relating to traditional concepts of "access". Many research participants indicated that they feel there is an implicit cultural norm that employees who are disabled, have long-term health conditions or are neurodivergent will not progress to senior roles; that they are not able or not tough enough. This has previously been characterised as "benevolent paternalism".

In contrast, many individuals who participated in focus groups or who were interviewed felt that systems, policies and attitudes created unnecessary barriers to their performance and progression, to their health and well-being and to their opportunity to make a difference to the NHS as management and strategic levels. As one interviewee said:

"I don't want to be wrapped in cotton wool. I only want my contribution, my motivation, my talent and my ambition recognised and enabled."

The survey was not able to provide significant insight on intersectional experiences of systemic barriers, which is why interviews focussed on the experiences of ethnic minorities and those with LGBTQ+ identities.

One ethnic minority interviewee spoke about patients bypassing her to ask questions of more junior colleagues that she was managing who were White. She was disappointed that these colleagues appeared to condone this and did not direct patients to her for activities that were properly her responsibility. However, she said that while she could manage such situations, her neurodiversity had been a bigger barrier to her progression.

Another participant explained that she had been "stuck" at band 8c for more than 14 years because, as a disabled woman of colour, she did not fit the image of an NHS leader. She was working according to the demands and roles of a more senior grade but remained at 8c on paper and had been passed over frequently for promotion.

For some research participants, the impact of Covid and longer-term resourcing challenges have created substantial barriers and/or had an impact on health and well-being.

As one participant said:

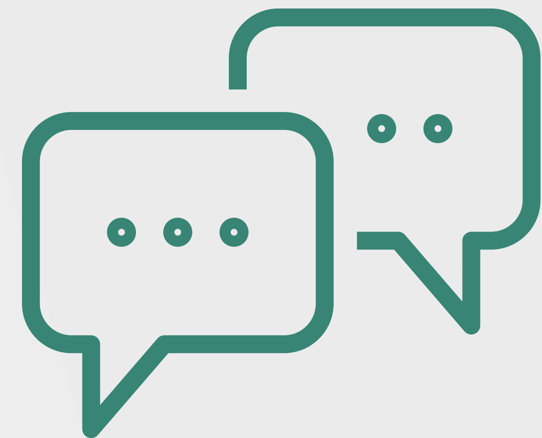
"I think the impact of understaffing and stress in the NHS is not taken seriously. Nor is the direct impact that it has on people's health. You're still under the same sickness monitoring and occupational health procedures, even if you work in a service that's been in crisis for years. In terms of barriers to attendance, performance – let alone progression – it just seems like the most obvious thing - the resourcing side of things. It affects the flexibility on offer, the adjustments people are given, probably people's management style, being under that sort of pressure."

The untapped potential of disabled employees and the capacity that is limited by poor provision of adjustments and lack of flexibility represents a huge, wasted resource for the NHS.

Career enablers

The biggest enablers of progression are identified as:

- workplace adjustments and flexible working;
- coaching, mentoring or sponsorship;
- Individual support from managers and;
- support from managers for training and development.[13]



Free text survey comments on enablers asked about enabling actions by NHS leaders:

"Develop an element of trust and not be so hell bent on doing everything at 130%. Some of us are not as quick to react, respond and like time to ponder or need time to consider things. Really listen and ask about me!"

Free text comments were also invited on what respondents' managers could do to ensure that disabled colleagues can progress and thrive. There were many contributions linking flexible working, agile adjustments and thoughtful stretch opportunities. For example:

"Allow minor workplace adjustments, agree to minor flexible working requests, listen and take recommendations from occupational health and specialist services seriously. My experience is that recommendations get ignored and any progress, even with basic equipment, such as DSE, takes so long. I've spent five years trying to get support!"

Key findings

Career enablers

"Acknowledge that I have more skills and experience in some areas than themselves and accordingly allocate the tasks that I can use these skills on and not ignore and put me aside making me feel unwanted and bored."

"Actually give me the opportunity to develop and not offer temporary promotions in the team to people outside the team."

"Allow education, time off to learn, time to be reflective and support you to excel and develop in your career. I feel there is a real lack of promotion and work done for those who would be excellent in higher management. Still an 'old boys' club' that mean a favoured few get all the support at the cost of many. Be fair, transparent and use the policies in the correct way, rather than bully and exclude staff or sack them or force them to leave or go sick with ill health."

"Approve my requests for training. Understand that I am marginalised in so many ways (gender, ethnicity, disability) so I need more support and more training on my CV to 'compete' against those who are not marginalised."

Survey question 19 asked about development opportunities undertaken and wanted.[14] 42.9% had completed professional, academic or clinical training and qualifications in the last five years, 18.8% were currently undertaking or due to start, and 29.5 were instead in undertaking training and/or qualifications. 22.3% had undertaken coaching, mentoring or sponsorship, 17.9% were currently undertaking or due to start, and 51.8% were interested in undertaking coaching, mentoring or sponsorship.

The opportunities with the biggest percentage who were "interested in undertaking" them were career development or leadership workshops (74.5%) followed by formal leadership and talent development scheme and programme (64.9%). Networking opportunities, bite-sized online development sessions and tools for self-directed learning on the job were all requested by around 60%. Other options had an interest rate at about 50% and professional, academic or clinical training and qualifications had the lowest level of interest, at 29.5%.

Focus groups and interviews focussed on changing cultural attitudes to disability/ neurodiversity and ensuring that adjustments were made quickly and handled in a neutral or positive way, underpinned by an understanding of adjustments as an investment in talent.

NHS

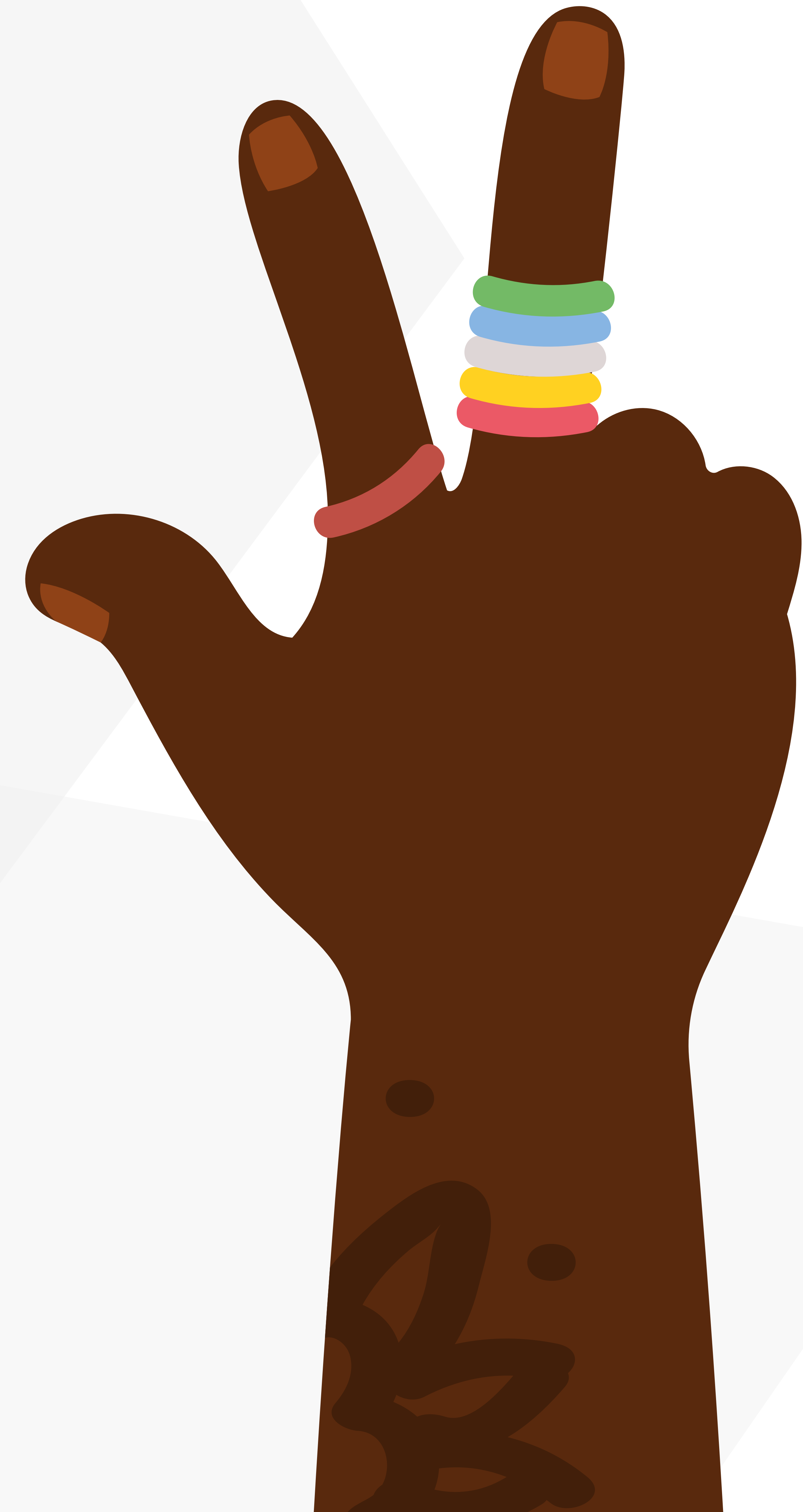
Access to training opportunities

Several focus group participants and interviewees identified issues with accessing the training necessary for professional development. This provided further insight to add to the survey findings about how prevalent a barrier this has been.

Courses have not been neuro-inclusive or otherwise accessible and sometimes respondents have been passed over the professional training opportunities. This has even felt like “a punishment” for having a long-term health condition or being neurodivergent. These experiences are deeply demotivating and can exacerbate mental and physical health conditions.

The pandemic has created huge challenges for some staff but also opportunities for others to deliver their roles effectively through home-based or hybrid working. This has helped some to achieve an optimal level of health, where they can balance work and management of a long-term health condition.

Hybrid or blended opportunities for learning could help leverage the benefits of inclusive online learning, be greener, reduce travel barriers, and reduce time away from delivery. Ideally, this would be alongside some/alternate opportunities for face to face interaction, which are preferred by others.



Workplace adjustments

In response to survey question 6 about whether respondents had adjustments or flexible working,[15] a quarter of those with a long-term physical or mobility impairment did not have adjustments or flexible working and only slightly fewer of those with a mental health condition or visual impairment or who were neurodivergent. Of those with Long Covid, 40% did not have an adjustment / flexibility and 47% of people who were Deaf or hearing impaired did not.

Older people reported being less likely to have adjustments or flexible working (55.9% of those aged 56 or older did not, compared to 25% of those aged up to 35); there was little difference on gender, LGBTQ+ identities, ethnicity or career band.[16]

Question 6 also provided an opportunity for free text comment. Many respondents indicated that they had been waiting for many months for adjustments to be put in place, even where this followed formal processes such as an Access to Work assessment. This was corroborated by participants in the focus groups and in the interviews. These adjustments were often for specific hardware or software. For example:

"I had an Access to Work assessment in October [2021] and they identified I would benefit from a laptop and some software. I am yet [at March 2022] to receive any of it. My manager has been chasing IT."

"I requested flexible working some time ago but have had nothing back from my manager despite reminding him."

"I've had to get my own software and use my own modifications."

"Access to Work grant but delay in implementation for over two years. Working part-time as a result and reduced hours."

One respondent underlined the researcher's experience of other sectors:

"[I have] minimal reasonable adjustments - far less than colleagues in the private sector."

NHS

Neurodivergence

Neurodivergence emerges as a key area for which to address workplace barriers, in terms of accommodating the diversity of learning and communication styles, equipment, software and environmental requirements that people may have. Neurodivergence was the second most common condition reported by respondents.

Focus groups and interviews discussed the need to move on from seeing this as a deficit towards an acknowledgement of the barriers in systems. These included policies and cultural norms that exclude those who are not neurotypical, limit their performance and potential, and undermine their confidence and well-being. Enablers that were described included recognition of skills and competencies and adapting roles to better fit them rather than a one-job fits all.

As one interviewee put it:

"I once met an incredibly successful conductor and he said to me: 'I've always been great at the core part of my career but catastrophically awful about the bits around the edges.' And I thought, yes, that's me. I am brilliant at what the essence of my job is about. But I'm not great at filling out my expenses forms or getting the tone right in an email.

"How many of us underperform or leave because we aren't supported, when we could make such a contribution if we had the right support. If you get the right individual in the right role with the right support, they can be brilliant. Everyone needs support with something. Assess my competencies and recognise me as an asset. Don't just regard me as a deficit."

This recognition that everyone needs support with something may contribute to a more compassionate leadership and service for all.

Trust and openness about disability

The survey asked "Are you open with HR, managers, colleagues, family and friends about your disability experience?" (Question 3).[17] The vast majority (91.1%) were open with family and friends; 83.3% were open with their manager; 71.4% were open with colleagues but just 59.4% were open with HR.

The latter response reflects the different declaration rates between anonymous staff surveys and ESR data. Low declaration rates hinder HR departments from planning or delivering effective strategies to address issues.

Those who were not open with anyone were more likely to experience bullying or harassment. This was echoed in the survey, respondents who declined to declare any of their characteristics were more likely to have experienced bullying, career barriers and negative experiences. Further research could be done to map experiences of those who prefer not to declare personal characteristics in all interventions. This has potential to be used as a measure for cultural safety around this characteristic.

In relation to being open with colleagues, there is considerable variation by disability type. Just half of those with Long Covid are open with colleagues, compared to 87.5% of those with a visual impairment and 90% of those with Long Covid are not open with HR. Those who are open with HR is relatively low for most disability experiences (58.5% for mental health conditions; 54.7% for neurodivergence; 54.3% for mobility impairments; and lowest at 50% for people with visual impairments). Being open with HR is relatively more likely for those with long-term physical health conditions (63.6%) and those who are Deaf or hard of hearing (65.5%).

Responses to survey question 3 did not surface significant differences in responses when analysed by age,[18] despite cultural assumptions about relative differences in attitude and openness between generations. For example, the percentage who are open with family and friends is 86.2% for those under 35, 87% for those aged 36 to 55 and 87.5% for those who are 56 or older.

There were some significant differences in relation to demographic groups and openness.[19] Women were somewhat more likely to be open with family and friends and management but much less likely than men to be open with colleagues or HR (75% of men said they were open with HR compared to 55.4% of women). However, it should be borne in mind that there were only 12.2% men in the sample reducing the reliability of gender comparison.

Ethnic minority respondents are much less likely to be open about disability with colleagues than white British respondents (60.6% compared to 72.9%), although the two groups were fairly similar in terms of being open with other groups (family and friends, management and HR). This could also contribute to the lower ethnic diversity of survey responses. Those with LGBTQ+ identities were less likely to be open with management and HR than those who identified as heterosexual/gender conforming.

Several research participants highlighted challenges with the central disability monitoring options within the employee record, particularly relating to neurodiversity, and would like to see this revised.

Key findings

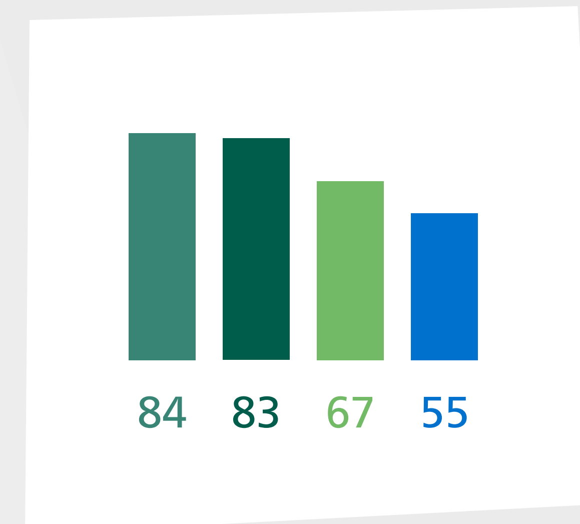
Trust and openness about disability

Declaration through formal HR channels enables organisations to provide support for staff. Survey respondents attributed lack of declaration to: a culture of ableism and fear of barriers to progress or work. Examples of how this is seen included bullying; the responsibility for ensuring adjustments on the employee rather than the employer; lack of knowledge or understanding on diverse abilities and adjustments available for both managers and staff; a lack of Disabled role models.

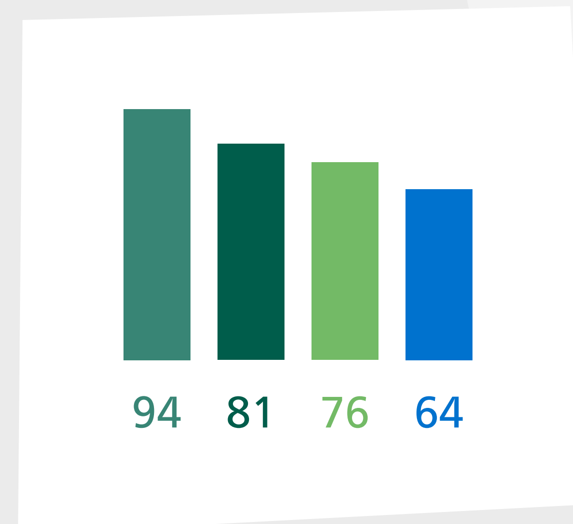
Focus groups and interviewees suggested a range of reasons for people not sharing disability information, including fear of discrimination or stigma, a feeling that it would be a net disbenefit to share information, and lack of knowledge/understanding of the 'disability' category.

I am open with...

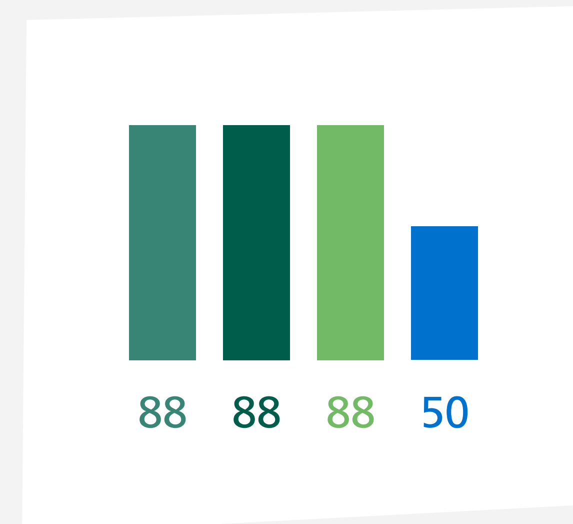
Friends and family | My Manager | Colleagues | HR



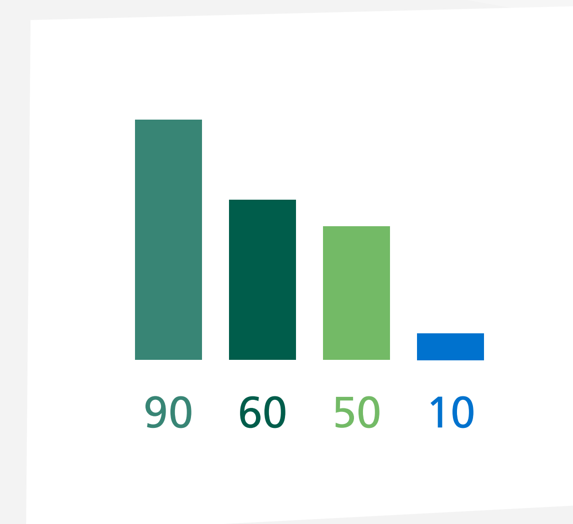
Neurodivergent



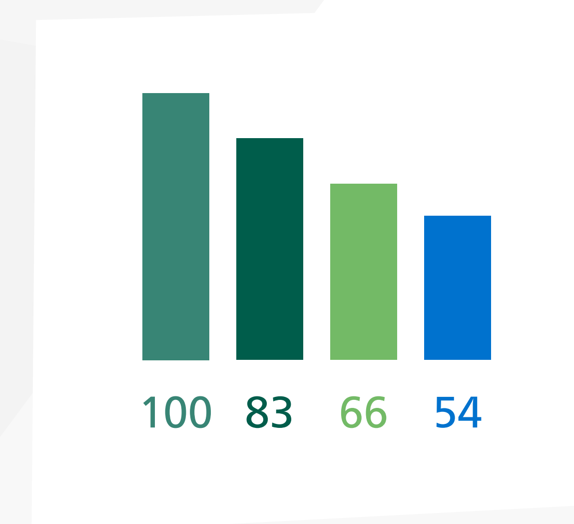
Long term physical



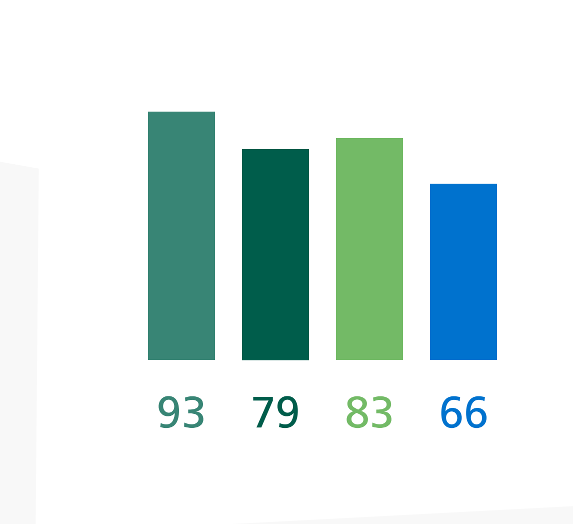
Visual impairment



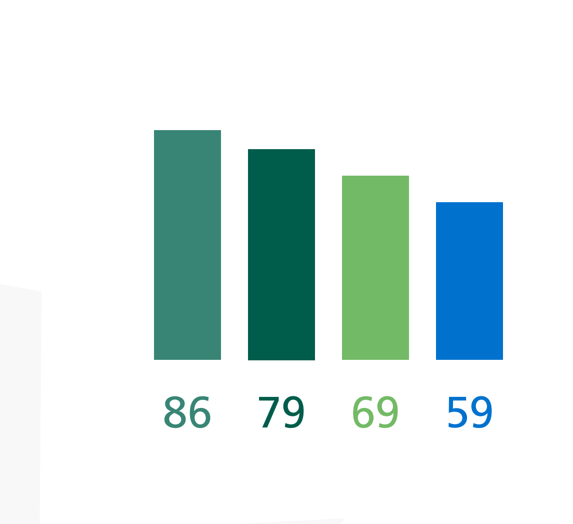
Long Covid



Mobility impairment



Deaf or Hearing impaired



Mental Health condition

This graph shows how open they are about their condition across the conditions reported.

NHS

Discrimination and formal management processes

Just under one third of respondents said that they had been put through a formal process to manage their performance (question 9). Those with a mental health condition (43.1%) and Long Covid (40%) are most likely to say that they have been put through a formal process to manage their performance.

The substantial majority (57.9%) said that they had experienced discrimination, bullying, harassment or victimisation at work in the past five years (question 10). A further 4.6% chose the “prefer not to say” option for this question. Those with mental health conditions (70.8%), those who are neurodivergent (69.3%), and those with visual impairment (62.5%) are most likely to say they have experienced discrimination.[20]

Those aged 56 or over were somewhat less likely to say that they had experienced discrimination. They were somewhat less likely to say they had been put through a formal process to manage their performance.

Women were much more likely to say that they had experienced a negative impact on development or progression. Women were less likely to have been put through a formal process to manage performance but more likely to say they had experienced discrimination.

Ethnic minority respondents were much more likely to say that they have experienced a negative impact on their progression and development (75.8% compared to 61.9% of White British respondents). The same patterns are apparent for formal processes (question 9) and for discrimination, bullying, harassment and victimisation (question 10).

Respondents identifying as LGBTQ+ are much more likely to have experienced a negative impact on their progression and development; much less likely to have experienced a formal process to manage performance; and much more likely to have experienced discrimination.

Key findings

Discrimination and formal management processes

Despite working at a higher level of seniority, respondents in higher bands were more likely to say that they have experienced a negative impact on development or progression. Respondents from higher bands are less likely to say they have been put through a formal process and a little more likely to say they have experienced discrimination, bullying, harassment or victimisation.

Three aspects: the relationship with managers; a lack of workplace adjustments/flexible working and an impairment; health condition and/or neurodivergence itself were each identified as being of similar importance as reasons for a negative impact on progression (question 8). Each of these were chosen by around 60% of respondents. Relationship with colleagues was much less likely to be identified as having a negative impact in development of progression (31%).[21]

Responses to question 11 about who was responsible for the discrimination, bullying harassment, or victimisation[22] indicated that line managers and senior managers were responsible in the majority of cases (61.1% and 58.4% respectively). Colleagues as the source of discrimination was mentioned in 43.45% of responses and patients/the public accounted for just 7.1% of responses.

Regarding the focus of discrimination (question 12),[23] the behaviours reported were overwhelmingly to do with the respondents' disability experience (93.9%). However, more than one in ten said that they had experienced discrimination on the basis of sex, ethnicity or age and 5% said that they had experienced discrimination the basis of sexual orientation.

Aspiration, motivation and retention

Survey question 16 asked: "Do you have aspirations for your career development and progression?"[24] More than half of respondents with all types of disability experience (53.9%) were looking to move to a new role, with 6.8% of respondents saying that they were looking to leave the NHS.

Only a relatively small minority said, "I am content where I am", with the highest contentment levels among those who were Deaf or hard of hearing (34.5%) and the least content those with a mental health condition (15.6%) and those with a visual impairment (12.5%).

Those aged 56 or older were most likely to say they were content in their current role (and hence least likely to be seeking a new role). Women seemed to be less content in their current role than men (21.1% and 33.3% respectively being content). LGBTQ+ people were less likely to be content. Ethnic minority respondents were less likely to be content than white British respondents.

Only 110 respondents indicated their career band and all of those chose either "Yes – I am looking to progress to a new role" or "Yes – I am seeking a change in career in health or care". There was little difference between bands – 88.8% of band 6 or lower were wanting to progress to a new role and 91.1% of band 7 or higher. Those most likely to be seeking a new role are young, female, gay or lesbian, and/or from an ethnic minority.

In terms of level of leadership that respondents aspire to,[25] there are only sufficient respondents to make a meaningful statement in relation to those who are neurodivergent and/or have long-term physical or mental health conditions. For other disability experiences, the numbers are too small to disaggregate as they are less than 20.

Nearly all respondents who are neurodivergent want to be on an executive board within two to four or five years, as do those with long-term physical health condition. The same is true for "leading and managing team, directorate or function", except that respondents aspire to reach such a role even sooner and a few are already at that level. The same holds true for and "leading and managing a team". People with mental health conditions are less likely to want to be on an executive board in two to four years but more likely to want to do in five or more years.

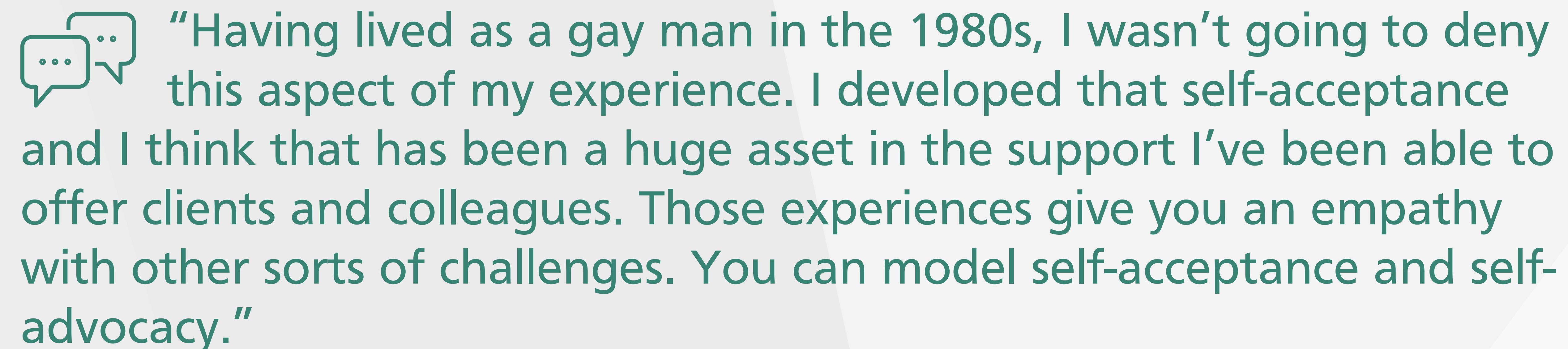
The most 'ambitious' group are 36-55 (around 87% want to be on an executive board either in two to four years or five years or more). Older people are understandably more likely to be currently leading/managing a team/directorate (28.6% of 36-55 year olds compared to 4.2% of those aged 35 or under).[26]

Visibility of Disabled leaders and the contribution of Disabled talent

Question 5 asked about disability as an asset: "What do/could you bring to the NHS through your experience of disability?"[27] The most frequently cited assets that respondents thought they could bring to the NHS were:

- compassion for patients and staff experiencing health and well-being issues (88.7%);
- peer support to enable those with similar experiences (85.6%); and
- being an advocate and ally for Disabled colleagues (77.9%).

Navigating disability-related barriers and working towards self-acceptance in the face of stigma is something that a number of research participants identified as being strengths that they bring to the NHS, including in relation to support for patients. One participant spoke about managing homophobia and dealing with a late diagnosis of ADHD:



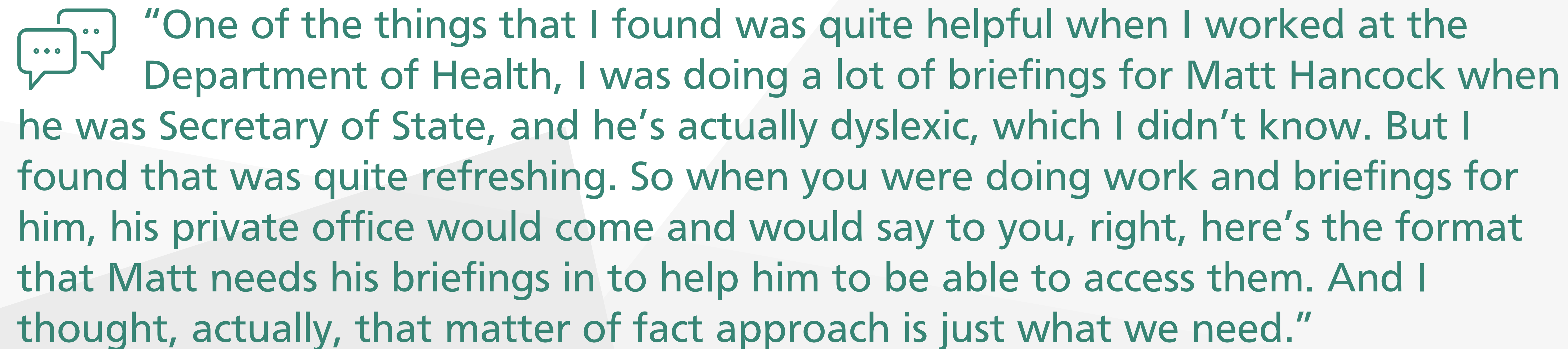
"Having lived as a gay man in the 1980s, I wasn't going to deny this aspect of my experience. I developed that self-acceptance and I think that has been a huge asset in the support I've been able to offer clients and colleagues. Those experiences give you an empathy with other sorts of challenges. You can model self-acceptance and self-advocacy."

Question 13 of the survey asked: "Are you aware of people in leadership roles with lived experience of disability?" Almost two-thirds of respondents (64.1%) said that they were not aware of people in leadership roles with lived experience of disability. The remaining third (33.6%) were aware of people in leadership roles with lived experience of disability.

One participant commented on the endemic leadership culture within the NHS was one of aggressive self-promotion; that it was individualistic rather than collaborative. Progression was based on an ability to achieve a broad range of leadership competencies, which led actually to a narrower 'type' of leader. Genuinely diverse leadership, which would enable cognitive diversity at systems level, required recognising that individuals can have significant strengths alongside areas of relative weakness but that they still might make a significant contribution to leadership.

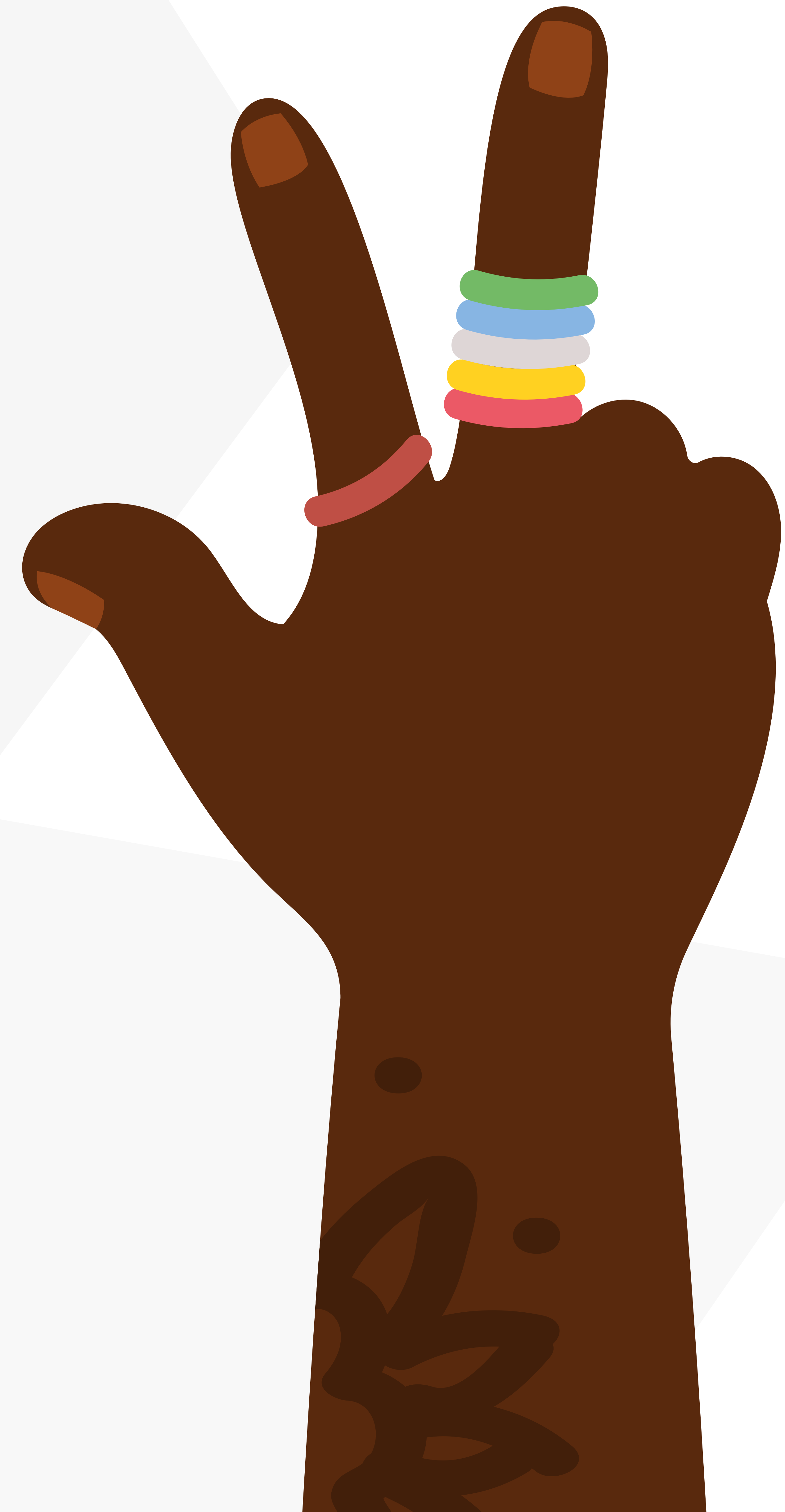
There was universal agreement about the benefits of visible Disabled leadership. One focus group participant explained how affirming it was to work with the Department of Health and be told in a neutral way about then Secretary of State Matt Hancock's dyslexia and that he needed briefings in a particular format. This adaptation or

compliance with inclusive principles was simply expected as what was necessary to ensure that he could do his job. By contract, other participants shared their experiences of having software or equipment approved as an adjustment but very lengthy delays in implementation.

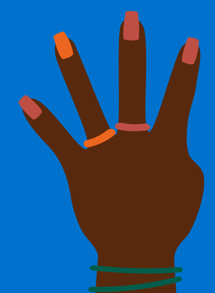


> "One of the things that I found was quite helpful when I worked at the Department of Health, I was doing a lot of briefings for Matt Hancock when he was Secretary of State, and he's actually dyslexic, which I didn't know. But I found that was quite refreshing. So when you were doing work and briefings for him, his private office would come and would say to you, right, here's the format that Matt needs his briefings in to help him to be able to access them. And I thought, actually, that matter of fact approach is just what we need."

Many participants in the focus groups and interviewees highlighted the valuable contribution of disability networks to the NHS. Some credited the peer support and influence on systems and policies. Several talked about the fact that active membership is not always recognised when assessing people's contribution to the NHS.



Next...



Conclusions

Conclusions

There are systemic, cultural and practical barriers, particularly in relation to identifying, delivering and managing general workplace adjustments, that impact health, well-being, performance, retention and the potential for career development and progression.

Additionally, specific career development and progression opportunities are inaccessible to many Disabled employees, because of apparent bias in the allocation of opportunities and because such opportunities are not always made inclusive and accessible.

This disabling effect on a significant proportion of the NHS workforce means that there is considerable unrealised capacity, contribution, insight and innovation from which the NHS and patients could benefit. The scale of this untapped, or restricted, potential is significant. Given the estimated one in five of the British population estimated to meet the current definition of being Disabled within the Equality Act 2010. An invest to save approach to Disabled talent could increase capacity and business efficiency for the NHS and employee engagement, discretionary effort and health and well-being.

Enabling Disabled talent requires addressing systemic, cultural, policy and process barriers and driving an increase in diversity at senior levels. These elements are intertwined – expertise from lived experience is needed to create the cultural change, inclusive-decision-making and 'pull' factor that will support retention and progression for Disabled talent. The current barriers that this research identifies prevent this progression, just as they bear down on the ability of Disabled employees to contribute to the service to their full potential in existing roles.

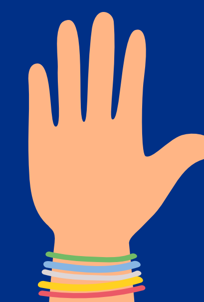
Contributors to this research identify the barriers to effective performance, career development and progression, confirmed by other research; the enablers; and the contribution, and potential contribution, of Disabled people to the NHS. While the barriers identified are common across sectors of the economy, progress has been faster in many sectors than in the NHS.

Talent Teams have an important role to play in supporting Disabled talent to secure the development and career opportunities that will demonstrate their potential to operate at more senior levels. Aiming for accessibility of mainstream programmes is crucial. This could helpfully be supplemented with bespoke initiatives for emerging Disabled leaders. Such initiatives could specifically support development of system-navigation skills and insights and confidence building - through peer action learning sets and access to senior mentors and coaches.

Given the ongoing impact of Covid, rising rates of mental ill health and an increasing understanding of neurodiversity, the NHS should invest in systemic solutions and in identifying and rapidly progressing diverse 'Disabled people' to enable the NHS to make the changes required to systems, culture, policy and process.

The NHS needs to ensure that its person-centred approach extends from patients to the people who shape its strategies and deliver its services.

Next...



Recommendations

Recommendations

In analysing the views shared in the survey, focus groups and individual conversations we have formed recommended actions across five cohesive themes.

Accountability and Accessibility are the most significant and urgent in helping not only improve lives for Disabled staff, but everyone.

Accountability

Accessibility

Role models

Safety for disclosure

Intersectionality

Accountability: A clear task enabling all managers and leaders

Senior leaders and all managers need to be proactive, monitored and incentivised in relation to a clear plan to drive diversity and inclusion throughout the NHS, with greater emphasis on managing progression of Disabled leaders.

All leadership and management competencies used by NHS employers should include insight into diversity (including from lived experience) and inclusive leadership practices.

Expectations and targets should be agreed for increasing the volume and timely delivery of workplace adjustments.

All managers should have at least one objective focused on diversity and inclusion. This might include recruitment, management and development of their team.

All managers should be having regular conversations with their staff around workplace adjustments with regard to health and wellbeing, irrespective of their declare disability status. Responsibility to initiate these should sit with line managers, rather than employees.

All line managers should be expected to support their direct reports in the development of ambitious and achievable career plans. There should be consequences for managers who consistently fail to improve diversity through their recruitment and/or development of teams.

All core curriculum and management standards and competency frameworks should include clear expectations for inclusivity and individual accessibility. All existing leadership programmes should be reviewed to determine how inclusive and accessible they are, and changes should be made as appropriate. These adaptations for accessibility should be published transparently and made accessible. Numbers of Disabled staff applying for and completing interventions should be monitored along with feedback and evaluation.

In order to enact and implement these changes line managers require upskilling. Line managers should undertake training on disability that takes an asset-based, affirmative approach to disability as an aspect of diversity. This should include specific knowledge transfer on the benefits of neurodiversity and practical methods for creating inclusion.

Line managers should be trained, supported and monitored to ensure regular career conversations with Disabled direct reports to encourage career planning and development. Line managers should assume around 20% of their team are disabled even if they do not declare and should seek out/support disclosure to help maximise team effectiveness through appropriate adjustments.

All NHS colleagues should demonstrate an asset-based approach to the contributions of disabled and neurodivergent talent. This means enabling contributions and helping people thrive - seeing strengths, not just needs.

NHS

Accessibility: Development for all and targeted for Disabled talent

Accessibility of all interventions must be improved: Equality impact assessments should be part of the development and delivery of all development interventions, and these should be transparent and accessible for all potential applicants. This should include all Leadership Development programmes, schemes and fellowships.

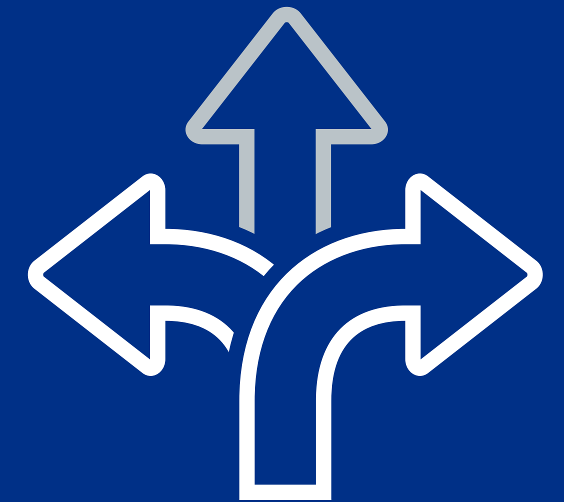
There should be an explicit requirement on all development providers and contractors to demonstrate that they are actively inclusive (including neuro-inclusive) and accessible, as recommended by the Deeds x Words report ‘Inclusive leadership and culture in the NHS’ (2020).[28]

Opportunities should be targeted for staff and talent with disabilities, particularly where they fall into multiple minority groups. These extend beyond leadership development interventions and include offers of flexible working and job-carving; stretch opportunities and secondments; job-share leadership training.

Positive action: There should be focused attention to facilitate progression of identified Disabled talent with a particular focus on bands 6-8, with increased accessibility and opportunities; the provision of a senior sponsor, mentor and/or coach and peer group support and/or action learning.

Beyond training: Access to a senior level sponsor or mentor, whether disabled or not, supports Disabled people with their career development and progression. This interaction would also bring significant benefits for senior leaders, whether as part of a formal reciprocal mentoring process or as a sponsor.

There should be the expectation of progression and monitoring of expected outcomes for alumni over a two-year period following completion of the programme. Targeted follow-up support should be planned and undertaken where alumni have not progressed within a pre-agreed timeframe of finishing a programme or intervention.



Recommendations

Role Models

We need to change attitudes about disability, including with those who are themselves Disabled.

People need to know someone at work who is disabled at the same or more senior level as themselves.[29]

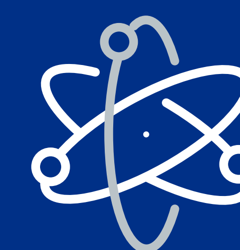
Increasing both the number and the visibility of senior role models (without pressurising individuals to declare) is crucial to cultural change toward de-stigmatisation and to realising the benefits of diversity.

We must celebrate and showcase success stories both individuals and organisations. We should encourage all leaders to discuss their career journeys, including challenges they have navigated and benefits accrued from those challenges. They should also identify and share good practice for managing Disabled staff – being role models as organisations.

Address disclosure safety concerns of staff

Explore whether a more effective communication of anonymity and confidentiality may support increased disclosure. Proper articulation of data protection and GDPR could reassure Disabled people that disclosure on ESR does not increase the likelihood of discrimination.

The introductory text and options for monitoring disability, health and neurodiversity within ESR should be reviewed with the input of experts with disability and other networks. Too many staff are not disclosing because the historic parameters do not fit them.



Intersectionality

While disability needs particular focus as a protected characteristic it is important that staff are not seen as a homogenous group and needs are individual. This study has shown varying career experiences not within Disabled staff groups but particularly where they fall into multiple minority groups.

This study reflects previous research showing significant overlap in LGBTQIA identifying and Disabled staff groups. Proportional representation is higher between these two groups and similar issues emerge with regard to non-disclosure, hidden needs, perspectives on flexible working policies, line manager relationship issues, increased issues for younger staff and minority ethnicities and the need for more visible role models.

Further intersectional research may be required that explores the experiences of Disabled employees from multiple minority groups – gender, ethnicity and LGBTQ+ groups should be undertaken to identify specific barriers or enablers.

Proper evaluation of interventions is required and should be monitored to gain qualitative insight into the effectiveness of initiatives and quantitative data about rates of progression for both Disabled and Intersectional groups.

References

1. See Table 11 in Appendix.

2. NHS England » Workforce Disability Equality Standard: 2021 data analysis report for NHS trusts and foundation trusts

3. Senior level leaders defined as: Clinical and non clinical staff at 8C and above, Medical Consultants and Members of the Board

4. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/datalist

5. The research did not analyse intersectional differences beyond sex/gender.

6. Disabled as a term included those with long term health conditions and are neurodivergent

7. Just over half (52.5%) of respondents were from the South East region; 47.4% were from other regions. 91 gave no reply.

8. NHS Workforce Race Equality Standard 2021: https://www.england.nhs.uk/wpcontent uploads/2022/04/Workforce-Race-Equality-Standard-report-2021-.pdf

9. Kneale, D. and Becares, L., 2020. The mental health and experiences of discrimination of LGBTQ+ people during the COVID-19 pandemic: Initial findings from the Queerantine Study.

10. https://se.leadershipacademy.nhs.uk/wp-content/uploads/sites/5/2021/12/SouthEast-LGBTQ-staffsurvey.pdf

11. Table 1 in the Appendix shows the top barriers in red and the top enablers in blue.

12. Coaching, mentoring and sponsorship definitions in brief??

13. See Table 1 in the Appendix (the top barriers are shown in red and the top enablers in blue).

14. See Table 15 in Appendix.

15. See Table 13 in Appendix.

16. See Table 14 in Appendix.

17. Table 4 in the Appendix shows percentage of are open with HR, manager, colleagues and family and friends, comparing different disabilities

18. Table 5 in Appendix shows openness by age.

19. Table 6 in Appendix shows openness by gender, ethnicity, sexual orientation and band.

20. Table 8 in the Appendix sets out differences in the behaviours of others by type of disability experience.

21. See Table 10 in Appendix.

22. See Table 11 in Appendix.

23. See Table 12 in Appendix.

24. See Table 17 in Appendix.

25. See Table 19 in Appendix.

26. See Table 20 in Appendix.

27. See Table 16 in Appendix.

28. https://www.deedsandwords.co.uk/work/projects/nhs-england

29. https://www.sjdr.se/articles/10.1080/15017419.2016.1222303/

Appendix tables available as a separate document

Talent South East, NHS England
September 2022

Authored by
Agnes Fletcher (Independent Researcher)

With contributions from Fiona Rodden,
Head of Talent South East and Helal Shahid, Inclusive Talent Programme Lead

Enabling our Disabled Talent

Research Report