A Fairer NHS Staff Survey March 2013

EXECUTIVE SUMMARY

'A Fairer NHS' Staff Survey was undertaken as part of the ongoing monitoring of NHSGGC's endeavours to meet the requirements of the Equality Act 2010; to mainstream change and deliver the Equality Outcomes. The survey was issued to all staff in February 2013 and 2607 members of staff completed the survey.

KEY FINDINGS

- There is broad support for specific NHSGGC action to tackle discrimination and for resources to be allocated to close the health gap.
- A high proportion of respondents indicate that they challenge discriminatory language and behaviour.
- There is a significant number of respondents whose answers to the questions, including the open questions, indicate that they strongly support the NHSGGC role in tackling inequalities
- Whilst there is support at a policy level and recognition that NHSGGC has made improvements in the last 3 years, there is less awareness of the actions that have been put in place to tackle inequalities. Staff in CHCPs are more aware than staff in the Acute Division.
- In terms of equality groups, respondents feel NHSGGC needs to do more for older people, people in poverty, disabled people and transgender people.
- 1 in 8 of the respondents have been involved in undertaking an Equality Impact Assessment (EQIA).
- Respondents with direct contact with patients indicate a high degree of compliance with procedures for communicating with patients who do not have English as a first language e.g. through use of interpreters. However a sizeable minority are not following agreed procedure e.g. using family members.

- Fewer respondents are following procedures for communicating with Deaf people. Nearly half are not following protocols and 10% are not providing Deaf people with any communication support.
- There is a considerable amount of activity aimed at improving access to care for people with learning disabilities, mental health issues or physical disabilities. However there is a lack of consistency in following all the available options for support.
- Consistent inquiry into patients' experience of inequality is very low. Respondents are most likely to ask routinely about employment status and money worries and least likely to ask about the experience of gender based violence and prejudice.
- Nearly half of the sample who work directly with patients have done nothing additionally to respond to the needs of marginalised groups who are vulnerable to additional discrimination. Respondents are most likely to respond to the needs of homeless people (40%) and least to the Roma population (9%).
- 65% of staff indicate that they would like more training on how to respond effectively to inequalities.
- A considerable proportion of respondents report that they have either experienced or witnessed discrimination. The two characteristics for which staff most frequently experience discrimination are age and sex. The two characteristics for which staff most frequently witness discrimination are race and age.
- There was a noticeably larger percentage of respondents who reported having some form of disability than has been identified through routine staff data collection (21.6% as opposed to 0.5%).

IMPROVEMENT CHALLENGES

The findings serve as a baseline for the next three years work aimed at meeting the requirements of equality legislation and internal policy.

Over the next three years we will;

a) Increase the number of staff who respond to the survey in 2016

b) Increase the numbers of staff using appropriate communication support and reduce inappropriate use of family members

c) Reduce the number of staff who experience discrimination or witness discrimination

d) Increase the number of respondents who routinely enquire about GBV, money worries, employment and discrimination

e) Increase staff awareness of actions taken by NHSGGC to tackle inequality

f) Modify practice to improve the response to access needs of people with physical impairments or mental health issues

g) Increase training opportunities for staff, for example reviewing the e-modules and integrating inequality into existing training programmes

h) Consider how we can support staff who demonstrate an in-depth knowledge of inequality to act as champions in their own part of the system.

The survey data can be used to find out more about individual parts of the system. If you would like more information to help you to improve responses to inequality in your local area please contact me for further discussion.

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A Fairer NHS Staff Survey

FULL REPORT

1. Introduction

The involvement and commitment of the NHSGGC workforce has been crucial to the development of an Inequalities Sensitive Health Service. A Fairer NHS Staff Survey was undertaken as part of the ongoing monitoring of improvement in meeting the requirements of the Public Sector Equality Duty associated with the Equality Act 2010, to mainstream change and deliver the Equality Outcomes. The survey aimed to identify: current attitudes to and knowledge of inequalities; progress in implementing key actions to tackle inequality; and patient and staff experience of discrimination.

The survey was issued by email to all staff during February and March 2013. A follow up survey will be carried out during February and March 2016 to show differences and the findings of the second survey will be used to inform the final monitoring report of the Equality Outcomes and Public Sector Equality Duty for the 2013 - 16 planning cycle.

An overview of the findings will be communicated to the workforce as part of the FTFT programme and also via the Equalities in Health website.

2. The survey form

The survey form which was extensively piloted, consisted of 29 questions in 3 sections;

- Your views on inequality
- Practical Action to Tackle Inequality
- and About You

Respondents were asked where they worked, what they worked as and for information about their personal characteristics. For the majority of questions, there was an opportunity for respondents to submit free text to augment their answers.

The survey was anonymous.

3. Results

2607 members of staff participated in the survey which comprises 6.8% of the workforce with an 88.7% completion rate. The full breakdown of responses by constituent part of the system and by job family is available at Appendix1. Respondents were also asked about their personal characteristics and this is available as Appendix 2. Whilst the diversity of the workforce largely mirrored what is already known through previous data collection, there was a noticeably larger percentage of respondents who reported having some form of disability than has been identified to date (21.6% or 861 respondents as opposed to 0.5% of staff equality monitoring data).

Analysis of the data has been carried out using SPSS and a range of cross tabulations have been carried out to identify variations between locations and staff groups. Themes from free text responses have been drawn out where they add value to the quantitative evidence and for illustrative purposes.

4. Findings

4.1 Staff views on inequality and discrimination

The aim of the first section of the survey was to determine whether or not staff support the position taken by the NHSGGC Tackling Inequalities Policy Framework. This seeks to tackle discrimination and to close the health gap by improving understanding, mainstreaming different approaches into core activity and using resources differently. The findings suggest that the staff who completed the survey support this approach and that they are also of the view that the causes of variations in health are structural as rather than as the result of personal failure. Staff views are summarised, as follows:

64% of the sample either strongly agree or agree that that NHSGGC could improve its health care if staff had a better understanding of discrimination with many of the individual comments highlighting importance for an organisation delivering person centred care. By contrast, many comments also highlight the efforts that have already been made to ensure there is no discrimination. The figure does however mask variations across the system by both location and job family. 89% of the

respondents from Health Improvement agreed with this view as compared with 52% of respondents from Surgery and Anaesthetics. For managers, the figure was 74.8%, for AHPs, 68.6%, for nurses, 66.2% and for medical staff, 58.1%.

The quotes below illustrate what the majority of staff who completed the free text option see as the relationship between holistic, inequalities sensitive approaches and improved quality of care.

> “a better understanding of the lived experience of people in GGC they meet would help staff think about access to services from a patient’s perspective and so impact on service design and delivery at all levels.”

> “by focusing on specific needs there are wider benefits in creating a patient centred organisation. Why people are ill and what that means to them can be as important - and some times more - as the illness itself”

> “a lack of understanding, or a suspicion, by staff of minority groups inhibits good communication and this impacts upon diagnosis, treatment and the feeling a patient / service user has of simply being cared for”

Another quote highlights that there is however still visible prejudice;

> “At the equality training sessions I attended, one of the nurses was muttering that he didn't mind if patients were black, just as long as they weren't gay. I was really shocked that he said that and it made me realise that there is still a long way to go before people are treated equally in NHSGGC.”

70% of the sample agrees that NHSGGC should be using its resources to narrow the health gap with a higher degree of consensus across staff groups and locations than for the question on the role that discrimination plays in poor health. The majority of respondents (55%) think that this health gap exists as the result of injustice in society (as compared with an inevitable part of modern life, because some people are unlucky or because some people are lazy and lack will power). This varies from 37% (Facilities) to

80% in specialist children services, homelessness, asylum and prison healthcare. 90% of therapeutic staff agree on injustice in society as compared with 58% of nursing staff.

> "Different patterns of seeking healthcare- poorer may delay health seeking until crisis-problem more entrenched- needs to be resourced differently."

4.2 Staff knowledge of action

The level of awareness of change over the past 3 years within NHSGGC and the nature of the activities that have been undertaken to promote equality and tackle inequalities is lower than the level of support for policy would suggest. 42% of the sample thinks that NHSGGC has got better at recognising and responding to the health effects of discrimination on patients. This is higher within CHCPs than within Acute Directorates and higher amongst managers than professional groups with only 27% of a subsample of 236 medical staff reporting 'yes.'

The reasons given for improvement focus included an increase in the availability of training, changes to policy, more general awareness and discussion, specific campaigns, raised profile of gender based violence and an increased willingness to discuss it with patients.

> "I have experienced a transgender patient who felt able to dress as the gender they wished during their stay in hospital and was not put under any pressure to conform to the sex on their birth certificate"

Some respondents did however highlight the mismatch between policy and practice;

> "I'd say it's more an issue that people are treated as individuals and their own needs should be understood full in order to treat them. I don't think a blanket policy that tries to categorise people is going to improve things that much in the longer term. Individuals often have many complex needs that cannot be simply addressed by ticking a box on a form".

Overall, 33% of respondents are aware of activity that NHSGGC has been doing differently over the past few years to close the health gap. Again this is higher in CHCPs (42%) than in the Acute Division (25%).

The activities or approaches that respondents mainly cite as contributing to closing the health gap are: targeted health improvement activity aimed at reducing smoking and alcohol use; early years work; reallocation of resources or development of targeted services in poorer areas; services with a different emphasis e.g. Special Needs in Pregnancy; more outreach; less stigmatisation of poor people; financial inclusion work; and partnership working with education and housing. Some respondents expressed concern that more affluent people were getting more and better health care.

> "There are still far too many resources sucked into affluent areas. Look at complaints for example".

> "Centralising services creates problems for low /no income service users. Outreach only access for some and seems to be decreasing".

> "Focused interventions for these groups should be delivered. Avoid the patronising routine health promotion messages but get to the roots of the problem by actively working with these groups".

Some felt that there was little that the health service could do and that other social determinants needed to be addressed by Government or people themselves had to make different choices.

4.3 Staff views of impact

The Public Sector Equality Duty requires organisations to tackle discrimination faced by people with protected characteristics. Staff were asked where NHSGGC had done well in removing prejudice and discrimination for each protected characteristic. For each characteristic there was a sizeable proportion of 'don't knows' but the characteristic for which the highest proportion of respondents who considered that NHSGGC had done well was black or

minority ethnic people (45%) The groups which the respondents prioritised as needing more done were:

- Older People (72%)
- People in Poverty (72%)
- Disabled People (60%)

50% of respondents who expressed a view about transgender patients also indicated that more could be done to support them but there was also a much higher proportion of ‘don’t knows’ in relation to this protected characteristic.

> “For those with mobility issues, more domiciliary visits/appointments could be offered”
>
> “Some incidents on the ward have led me to believe that all staff would benefit from training in the specific cultural needs and beliefs of different religions etc.”
>
> “Having worked with the transgender population, a recurring comment was that many are not aware of the services available to them, therefore, perhaps a need for more awareness raising”.
>
> “Widespread patronisation of older people (calling them "dear" for example) by nursing and medical staff. It remains routine practice for nursing staff to remove hearing aids and glasses before patient leaves ward for theatre”.
>
> “Very few staff know how to work correctly with an interpreter (language for "signer") in order to preserve patient's autonomy”.

4.4 Practical action taken by staff to tackle inequality

Inherent within the delivery of the Tackling Inequalities Policy are practical actions that staff are required to implement as part of their core practice. Section 2 of the survey focussed on determining the extent to which staff had undertaken key actions, as follows:

- Develop their service through equality impact assessment (EQIA)

- Improve communication by providing an interpreter for patients for whom English was not their first language
- Improve communication by providing a BSL interpreter or loop system for Deaf patients
- Improve access to services for people with learning disabilities, physical disabilities or mental health problem
- Inquire about life circumstances which have caused or impinged on medical presentations – gender based violence, money worries, employment/unemployment, direct discrimination e.g. racism
- Developed specific responses to groups who faced additional discrimination e.g. homeless people
-

4.4.1 EQIA

Equality Impact Assessment is a key tool to facilitate change in both services and policies to ensure that there are no risks of discrimination for specific groups and that equality is maximised. It is also now a requirement of the Scottish specific duties. A programme of EQIA has been undertaken across NHSGGC for the past six years. 17%, or 1 in 8, of respondents said they have been involved in EQIA with 11.9% of respondents in Acute reporting involvement as compared with 21% in CHCPs. This is however at odds with the number of known EQIAs completed in each sector.

When asked to comment on the impact of carrying out EQIA, respondents reported on a range of positive changes whilst some confirmed that they were already doing well. The quote below indicates that use of EQIA that there is still more to achieve.

> “Have led a few EQIAs and participated in others. It has helped identify where our service was discriminating without realising this, has improved our response to marginalised groups and given the organisation a better understanding of how services might indirectly discriminate. However I don't think front line staff and our patients have been involved enough and I think frontline staff being involved would help them understand their role and response in relation to inequalities. There has been some involvement of frontline staff and patents in this but it is very patchy across the system and especially in acute just seen as something they need to do in relation

to all the other targets and processes they need to meet rather than something that can support positive change".

4.4.2 Improving communication for patients for whom English is not their first language

Key to effective transactions between staff and patients is good communication. Respondents were asked about a range of practices in relation to communication with those for whom English is not their first language in line with NHSGGC policy. Whilst 74% of respondents who dealt with patients reported booking an interpreter for every clinical encounter which is the recommended course of action, 50% also report using family members which is counter to Board policy. Only 14% acknowledged using telephone interpreting which is a recommended practice in appropriate circumstances.

4.4.3 Improving communication for Deaf patients

Deaf people have consistently reported difficulties in securing communication support when attending for medical care and the survey findings indicate that good practice is not as widespread as for BME patients. 57.5% of the sample who deal with patients report booking a British Sign Language interpreter for each clinical encounter. 50% of the overall sample report using family members (58% Acute respondents). 10% reported that they provide no communication support at all for Deaf patients, with little variation between Acute and CHCPs.

4.4.4 Improving access to services for people with learning disabilities, physical disability or mental health problem

Access to health care for disabled patients has also been identified as being variable. Staff were asked about their use of a range of options known to facilitate greater access to health care. 89% of respondents who worked directly with patients reported that they had taken at least one of the options to support people with learning disabilities and 84% had taken one of the options for people with physical disabilities or mental health issues.

The most frequently cited option for people with learning disabilities was the use of family members (70% overall, 76% in Acute and 68% in CHCPs) which is not a system response to

need. The next most frequent option cited was extending the appointment time (52%) followed by the use of a communication aid (44%), working with an advocate (42%), and providing communication support (41%).11% of all respondents had developed a policy or strategy.

For people with physical disability or mental health issues, extending the appointment time was again relatively frequently used as an option (61%). 43% had worked with an advocate, 31% had followed up an appointment by phone, 25% had sought to improve physical access and 15% had been involved in developing policy or strategy.

4.4.5 Inquiring about life circumstances

Inequalities Sensitive Practice (ISP), enquiring about life circumstances, is a key part of NHSGGC's approach to tackling inequality. ISP recognises the significant interaction between experiences of inequality (such as poverty, gender based violence and racism) and medical presentations, access to health care and healthcare outcomes. It is a form of practice which requires practitioners to ask routinely about such experiences and to use the knowledge following disclosure as part of the management of the health problem in order to increase the chance of effective outcomes. Respondents were asked about the frequency of inquiry about employment status, money worries, experience of gender based violence and experience of discrimination which affected health, such as racism.

The life circumstance that staff indicated that they were mostly likely to enquire about was employment status (31.7% always and 28.6% often). Staff are least likely to enquire about discrimination such as racism affecting health – 17% always or often asking but 46% never enquiring. 24% of respondents reported always or often enquiring about gender based violence, 42% always or often enquired about money worries. These figures were higher for staff in CHCPs than in Acute.

> "I attended A & E as a patient and was asked if my injury was due to domestic abuse. If the answer was yes the nurse was able to provide support and information around this. If we don't ask we don't know".

4.4.6 Developing specific responses to groups who faced additional discrimination

In addition to potential discrimination as the result of protected characteristics, some groups face additional marginalisation. This can result directly in additional health problems or difficulties in accessing health care. 43% of respondents who dealt with patients indicated that they had done nothing specific to support such groups (54% in Acute, 36.5% in CHCPs). 40% respondents indicated that they had developed a specific response for homeless people, 37% for asylum seekers and refugees and 28% for ex offenders. Only 9% indicated that they had developed anything specific for the Roma population. Those staff who have developed specific responses appear from their comments to have been very focussed in providing person centred care.

> "Always treated them with the same respect as other clients. Provided adequate information on travelling expenses. Offered volunteer driver service. Ensured no language barrier".

> "Clothing toys, assistance to access health services, interpreting, monetary advice and assistance, access to CAB, school, nursery, housing".

> "Have been more tolerant of failed appointment attendance".

4.5 Support to improve personal effectiveness

Both the NHSGGC policy position and the legal requirement on public organisations is to make incremental improvements in the way that all its functions respond to inequalities and discrimination – this is called mainstreaming. Key to this approach is the ongoing development learning opportunities for staff and communicating information on inequality.

Staff were asked what they considered that NHSGGC as an employer could do most to increase confidence in working with people from Equality Groups. Respondents still regarded training (65% overall, 60% in Acute and 70% in CHCPs) and information

(60% overall, 62% in Acute, 58% in CHCPs) as the two most important contributions although some were critical of the online modules.

> “Avoid the useless on line modules. It allows management to think they are tackling the issue but most staff simply skip to the questionnaire at the end and keep ticking the boxes till they get the right answers”.

39% overall indicated that they wanted more support from managers and 37% more time for reflective practice but again there was variation between Acute and CHCPs with 37% of Acute staff requesting more support from managers as compared with 42% of CHCP staff. 32% of Acute staff required more time for reflective practice compared with 44% of CHCP staff.

Staff made a range of practical suggestions;

> “Audit of extra time taken with people from equality groups so that allowances can be made for staff to spend an appropriate time with them and not feel rushed. This leads to safer assessment and quality care”.

> “Encouragement to report examples of good practice through team meetings, and including them in clinical governance reports”.

> “Have better systematic approaches. Individuals should be educated and trained but good systems have to be in place to ensure every patient is supported appropriately at every encounter with the service”.

4.6 Personal experience of discrimination

As behaviour towards others can often be shaped by personal experience, staff were asked two different types of questions. Firstly, those people who considered themselves to have a condition or impairment that would class them as disabled under the terms of the legislation were asked if their manager knew of their condition. This question was included because other work within NHSGGC has indicated that there are low disclosure rates of disability (currently 0.5%). 52% of those for whom the question

was relevant (n=861), had disclosed to their manager but 28% had not and 20% preferred not to say.

Secondly, staff were asked whether they had either witnessed or personally experienced prejudice in relation to the protected characteristics including personal experience of prejudice in relation pregnancy and marriage and also including caring responsibilities. 53% of respondents (n=1425) acknowledged that they had either witnessed or experienced prejudice. There was a higher rate of witnessing prejudice than experiencing it, as follows

Characteristic	Witnessed (%)	Experienced (%)
Age	48	24
Disability	44	10
Race	52	14
Religion or belief	42	21
Sex	32	22
Sexual Orientation	36	7
Transgender	20	3

The figures for personal experience may reflect the composition of the workforce. Whilst 52% of this sub sample had witnessed prejudice with respect to race, only 14% acknowledged personal experience and some of this was by dint of being English. Many of the comments made as free text related to sectarianism.

> “Inappropriate accommodation for a wheelchair user”.
>
> “Racist remarks made by both staff and managers about gypsy travellers”.
> “Offensive remarks made by a colleague about a planned trip to Lourdes.”
>
> “Homosexual couple treated insensitively, rules being applied without consideration”.
>
> “I have witnessed patients being refused consideration for treatment due to both age and learning disability - specifically surgical procedures. These decisions should be based on the risk: benefit profile for the individual”.
>
> “Being told I wouldn't understand you're too old”.

> “Being passed over for a position and more or less told it was because I was female”.

19% of the sample that responded to the question about pregnancy, marriage or caring responsibilities reported experience of prejudice.

> “Employer very unhelpful as I am a Carer for very disabled sister. Only had on Carer day off in 29 years of service. Always made to feel you are "at it" if you ask for time relating to relative you care for. Feel colleagues feel they are "missing out" on something if I am off”.

> “I am divorced with 2 children and have had managers in the past who don’t seem to realise you can’t change AL or working hours at short notice when you are a single parent”.

5. Discussion

As with any survey of a large and varied workforce the findings only provide a snapshot of attitudes, behaviours and experiences. Many of these findings are very positive. For example, there is a the small but still substantial cohort of staff who appear to strongly believe in the aims of the Tackling Inequalities Policy and this group may require more support to maximise their contribution to the development of NHSGGC as an inequalities sensitive organisation.

There is also a view that permeates the open questions that equality involves treating everyone in the same way irrespective of differences in need or experience or that in responding to greater need it is somehow unfair for others. This view was countered by one respondent;

> “Many staff will believe that treating all people equally, irrespective of their specific characteristics, avoids inequality. This is not the case and training can facilitate staff to address the needs of patients with specific characteristics and avoid discrimination”.

APPENDIX 1: RESPONSE TO SURVEY – Fully completed

Total number of questionnaires returned: 2706

JOB FAMILY	**n**	**%**
Nurse/midwife	681	29%
Administrative/Clerical	505	21%
Allied Health Professions	368	16%
Medical	236	10%
Manager (Executive Grade, Senior Manager, Service Manager)	127	5%
Scientific and Technical	93	4%
Health Improvement	91	4%
Pharmacist	57	2%
Therapeutic (Physiology, Counselling)	50	2%
Ward Manager/Senior Charge Nurse	42	2%
Human Resources	41	2%
Dental	36	2%
Ancillary (Hotel Services, Facilities, Portering, Domestic,	21	1%
Maintenance/Estates	12	0.5%
TOTAL	**2360**	**100%**

LOCATION	**n**	**%**
Acute Surgery & Anaesthetics	196	8.3%
Acute Rehabilitation & Assessment	177	7.5%
Mental Health/Forensic/Learning Disabilities Services	176	7.5%
Acute Emergency Care and Medical Services	164	7.0%
Acute Diagnostics	163	6.9%
Glasgow CHP North East Sector	152	6.5%
Glasgow CHP South Sector	141	6.0%
Acute Women & Children's Services	130	5.5%
Acute Regional Services	129	5.5%
Glasgow CHP North West Sector	127	5.4%
Renfrewshire CHP	117	5.0%
Corporate Acute	90	3.8%
Acute Facilities	67	2.8%
Corporate HQ	67	2.8%
West Dunbartonshire CHCP	63	2.7%
Glasgow CHP	61	2.6%
Health Information & Technology	58	2.5%
Inverclyde CHCP	47	2.0%
East Dunbartonshire CHP	40	1.7%
Addictions Services	40	1.7%
Oral Health	29	1.2%
Public Health	29	1.2%
Sandyford Initiative	27	1.1%

East Renfrewshire CHCP	26	1.1%
Specialist Children Services	13	0.6%
Corporate Planning & Performance	10	0.4%
Homelessness, Asylum & Prison Healthcare	10	0.4%
Communications	4	0.2%
TOTAL	**2353**	**100**