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Research on the experience of staff with disabilities within the NHS Workforce:

A joint report between Middlesex University and the University of Bedfordshire

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Rev. December 2015

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Executive Summary

NHS England has commissioned a primarily quantitative research project, focusing on the experiences of staff with disabilities working within the NHS, drawing upon two national data sets:

- The 2014 NHS staff survey, completed by 255,000 staff, reporting their experiences of working in the NHS
- The Electronic Staff Record (ESR), comprising data on the entire NHS workforce, gathered for workforce planning, personnel and wage payment purposes.

The research tender required a focus on the following issues:

a. What is staff with disabilities' representation at all levels of the NHS and covering different types of disability?
b. Why is there a disparity between the proportion of staff who declare a disability on the Electronic Staff Record System and of those who declare a disability on the anonymous NHS staff survey?
c. How well are staff supported who become disabled during the course of their employment? Is there a process for recording this on the staff survey?
d. What are appraisal rates for staff with disabilities compared to non-disabled staff?
e. Do staff with disabilities have similar levels of access to training and development as non-disabled staff?
f. How well do NHS organisations make reasonable adjustments for staff with disabilities, from the recruitment process to the end of employment?
g. What difference does the 'two ticks' symbol make to recruitment and employment?
h. What are the numbers of staff with disabilities who are the subject of employment processes and procedures, for example disciplinary and capability processes?
i. What are the turn-over, retention and stability rates for staff with disabilities within the NHS?

Key findings are:

Staff with disabilities' representation at all levels of the NHS and covering different types of disability
Levels of reported disability are around 17% in the NHS Staff survey, and around 3% in the ESR. Neither data set allows for more specific analysis between different types or degrees of disability. The most likely reasons for the disparity between reported levels of disability are:

1. Differences in definition of disability used in the two data sets
2. Differing conditions for self-disclosure (NHS staff survey is anonymous)
3. Time of disclosure (ESR reports disability at the time of staff appointment, and is not reliably updated)

Differences in quality of support between staff with and without disabilities
There was not a specific survey question that addressed this issue, but it was possible to identify a number of questions that the report argues can be taken as acting as 'indicators': *What are the levels of bullying and harassment?; How far do staff feel 'Pressure to work when feeling unwell'?; Do staff feel their organisation acts fairly with regard to career progression?* Relative to non-disabled staff, staff with disabilities felt more bullied, in particular from their managers (12 percentage points more); more pressure to work when feeling unwell (11 percentage points more); and less confident that their organisation acts fairly with regard to career progression (8 points difference). The report concludes that, relative to non-disabled staff, staff with disabilities rate themselves as substantially less well supported.

Appraisal rates
Rates of appraisal between staff with and without disabilities were broadly comparable. However there were substantial differences in how the value of appraisal was rated. Staff with disabilities are less satisfied with the effects of their appraisal. 7 percentage points fewer felt that appraisals improved their performance. Moreover, 9 percentage points more disabled staff report that their appraisal left them feeling that their work is not valued by their organisation.

Experience of training
The NHS staff survey indicates that most staff had training within the last 12 months and only 5 - 25% staff received no training in each specified topic. There is very little disparity between disabled and non-disabled staff in the proportion not receiving training in any of the topics, or in their satisfaction with the training.

Reasonable adjustments
The NHS Staff survey asks if 'employer has made adequate adjustment(s) to enable you to carry on your work'. 40% respond 'Yes', 14% 'No' and 46% 'No adjustment required'. The proportion responding 'No' varies substantially depending on the Trust involved, from a low of 5% to a high of 41%. The proportion also varies by ethnicity, with white British staff with disabilities expressing the lowest rate of dissatisfaction with the adjustments their employer made, while all other ethnic categories have consistently higher rates. The relatively small groups of Bangladeshi and 'Other black background' staff have the highest rates of dissatisfaction.

Job satisfaction
Staff with disabilities rate themselves as more dissatisfied with the recognition, support, responsibility and opportunities they have in their jobs, even though there is no difference in the satisfaction they report in the quality of care they give to patients. Staff with disabilities felt less recognised for their good work undertaken (8 percentage points fewer); they felt less supported by their immediate managers (5 percentage points fewer); they felt less supported by their work colleagues (3 percentage points fewer); they were more dissatisfied with the levels of responsibility they had been given (4 percentage points fewer); they felt they had less opportunity to use their skills (5 percentage points fewer); and finally, they were substantially less satisfied with their level of remuneration, and they thought they were valued less highly by their organisation for the contribution they were making (both 9 percentage points fewer).

What difference does the 'two ticks' symbol make to recruitment and employment?
The evidence from previous studies suggests that the Two Ticks award does not make a great deal of difference in terms of an organisation's awareness of disability issues or in its capacity to address any inequalities or inadequacies in practice. We found in our study that the great majority of Trusts now have 'Two Tick' status. Using the NHS Jobs website, Trust websites and other evidence available online, as well as a DWP list, an estimate was made of the current 'Two Ticks' status of every Trust. 18 of 244 (7%) Trusts were found to not have the award. A comparison was made between Trusts with and without the 'Two Ticks' award of the extent to which staff who declare a disability report that their employer failed to make 'adequate adjustments' to enable them to carry out their work. Although in our study, there was a consistent finding that Trusts that have the 'Two Ticks' award have marginally higher average rates of 'adequate adjustments' reported by staff with disabilities, the difference is small, the number of 'No award' Trusts is small (just 1 in the case of Ambulance and Community Trusts) and the range among all Trusts is very large (from 5% to 41 %). Given also that the overall performance of Trusts was poor with respect to a variety of issues summarized above, such as levels of bullying and harassment, impact of appraisal etc., it would seem that 'Two Ticks' status achieves relatively little in terms of improved performance against these metrics.

Section 1: Introduction

In July 2014 Middlesex University submitted to NHS England its report entitled '*The Snowy White Peaks of the NHS'*, which looked at the representation and experiences of Black and Minority Ethnic trust board members within NHS Trusts in London. Partly as a result of this research, the Equality and Diversity Council has made two significant decisions: to make mandatory a Workforce Race Equality Standard as the first part of a Workforce Equality Standard; and to make the Equality Delivery System (EDS2) mandatory in the NHS contract.

NHS Employers has already commissioned some research from Disability Rights UK (DRUK), which has conducted a survey about the experience of staff with disabilities in the NHS.

NHS England decided to build upon DRUK's work by commissioning a further piece of research. This is primarily a quantitative piece of research, focusing upon staff with disabilities working within the NHS, and drawing primarily upon two national data sets:

- The 2014 NHS Staff Survey
- The Electronic Staff Survey (ESR) 2014

The NHS staff survey is conducted annually. The 2014 Staff Survey involved 287 NHS organisations in England. Over 624,000 NHS staff were invited to participate using a self-completion postal questionnaire survey, or electronically via email. Responses were received from 255,000 NHS staff, a response rate of 42% (49% in 2013). All full-time and part-time staff who were directly employed by an NHS organisation on September 1st 2014 were eligible, unless on long-term sick leave. Results are weighted by staff occupation only. The survey asks respondents to report factual information and attitudes about training and development, team working and culture, supervision and management, health and well-being, and clinical practice. Demographic information is collected about gender, age, hours of work, ethnicity, sexuality, religion, disability (including accommodations), years of service and occupation.

The ESR is a source of data on the NHS workforce, used for multiple purposes and held by the Health and Social Care Information Centre (HSCIC). The dataset contains records of 1,216,834 NHS staff, as of November 2014. It is partly based on the Electronic Staff Record (ESR), the HR record system that almost all NHS organisations use. The ESR is primarily a system for getting employees paid. Trust HR departments enter data into the system and there can be variation in the quality of data entry. ESR is 'real time' data that is collected on all staff. The ESR includes information on job role, employer, area of work, occupation, profession and qualifications, employment status, pay scale, absence duration and reasons, reasons for leaving, leaving destination, disability, ethnicity, and gender,

Through analysis of these two data sets, the research was intended to answer the following questions:

- What is staff with disabilities' representation at all levels of the NHS and covering different types of disability?
- Why is there a disparity between the staff who declare a disability on the Electronic Staff Record system and those who declare a disability on the anonymous NHS staff survey?
- How well supported are staff who become disabled during the course of their employment? Is there a process for recording this on the staff survey?
- What are appraisal rates for staff with disabilities compared to non-disabled staff?

- Do staff with disabilities have similar levels of access to training and development as non-disabled staff?
- How well do NHS organisations make reasonable adjustments for staff with disabilities, from the recruitment process to the end of employment?
- What difference does the ‘two ticks’ symbol make to recruitment and employment?
- What are the numbers of staff with disabilities who are the subject of employment processes and procedures, for example disciplinary and capability processes?
- What are the turn-over, retention and stability rates for staff with disabilities within the NHS?

Middlesex University, in collaboration with the University of Bedfordshire, was successful in bidding for the contract for this work, which commenced in late March 2015, and was submitted in June 2015.

Legal and policy context

A major legislative change in the UK with respect to disability came with the enactment of the Disability Discrimination Act (DDA) in 1995, which was intended to end discrimination against disabled people, by legislating for statutory safeguards, and to ensure the employer made ‘reasonable adjustments’:

> “A person who has a physical or mental impairment which has a substantial and long terms adverse effect on his ability to carry out normal day to day activities (s.1) are protected. Part 11 SA4A (1) includes requirements on employers where there is an obligation on employers to make reasonable adjustments. This obligation indicates an acknowledgement that among other issues, the built environment may not take account of people with impairments and will need alterations to allow access.”

The Disability Discrimination Act 1995 repealed Sections 6 to 8 of the 1944 Act which set up the register of disabled persons, and Sections 9 to 11 which placed obligations on employers to employ a quota of registered persons (Gooding, 1996). The DDA addressed discrimination at work, but also widened the definition by focusing on some of the social effects of having a disability such as discriminatory practice in the provision of, or access to goods, facilities, services, public buildings and transport.

Under section 6 of the DDA an employer is obliged to make reasonable adjustment to the physical workplace environment and or/to employment arrangements e.g. hours of work, allocation of duties to ensure the disabled person is not placed at substantial disadvantage. Amendments in the DDA aimed at strengthening its implementation came into force in October 2004, a consequence of the Disability Discrimination Act (Amendment) regulations 2003.

These were inspired by the by the European Union’s General Framework Directive for Equal Treatment Employment and Occupation of 2000, and affect the interpretation of the UK law, particularly the definition of disability discrimination.

In 2005, the DDA was amended to remove previous concessions that failure to provide reasonable adjustment may be justified. From 2006 onwards, employers in the public sector were required to be proactive in anticipating employment adjustments, including access and the work environment of potential and actual disabled employees and service users. In 2010 the Equality Act was introduced. This was a major piece of legislation, which aimed to unify a complex series of Acts and Regulations, which formed the basis of anti-discrimination law in the UK (see above for those most pertinent to disability). It proposed the following over-arching definition of disability:

> "Under the Equality Act 2010, the definition of a disability is a physical or mental impairment that has a **substantial** and long-term negative effect on someone's ability to do normal daily activities. Substantial is more than minor or trivial."

The Act provides for both direct and indirect discrimination. Direct discrimination occurs when an employer treats someone less favourably (section 13) on the ground of a 'protected characteristic'. A protected characteristic (age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, and sexual orientation) must be the reason for the different treatment, so that it is because of that characteristic that the less favourable treatment occurs.

With respect to bullying and harassment, in section 26 of the Act, a person harasses another if he or she engages in harmful or destructive behaviour linked to a 'protected characteristic' (viz disability in this instance) with the intended effect of physically or psychologically harming or abusing the individual concerned. Indirect discrimination "involves the application of a provision, criterion or practice to everyone, which has a disproportionate effect on some people and is not objectively justified."

Some initial issues

The two data sets used have major differences in how they define disability, resulting in widely differing rates of reported disability amongst essentially the same workforce. While both involve self-declaration of disability, the NHS Staff survey definition is broad in that it refers to a statement of: 'having a long-standing (meaning that it has lasted, or will last, at least 12 months) illness, health problem or disability'. This definition:

- Includes any illness or health problem, as well as disability
- Does not specify limitations
- Relates to the present time rather than at hiring
- Involves a self-declaration of disability that is anonymous

However, the ESR definition is narrower in focus and scope, referring to: 'A physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities'. This is the Equality Act definition. Its definition is 'narrow' in that:

- There must be an 'impairment'
- There must be 'substantial and long-term adverse effect …on normal day-to-day activities'.
- The self-declaration of disability is provided at the point of staff appointment, and may not be updated.
- The self-declaration is not anonymous, and individuals are therefore personally identifiable on the ESR as disabled.

In addition, the ESR has the categories under the disability question of 'Not disclosed' and Unknown', in addition to 'Disabled and 'Not disabled'. Because of all these differences, it should be expected that levels of identified disability in the survey and the ESR would be different, with the broader definition favoured in the survey leading to higher levels of reported disability in comparison to the narrower Equality Act definition used in the ESR.

Section 2: Research methods

Analysis of NHS Survey and ESR data

Survey data are first analysed by the difference in percentage points for the categories of response between staff who have declared a disability and those who have not. It may, however, be difficult to draw relevant conclusions on the basis of these percentage point differences, because they could reflect other differences between the groups such as age or gender. In addition, the scale of the difference needs to be seen in the context of the specific data involved (a one percentage point difference, for example, will be more notable if one group has 1% in a response category and the other has 2%, than if one has 30 and the other 31, even though the percentage point difference is the same).

Therefore, results that seem to show a relevant difference and are referred to in the main text, are tested by conducting a logistic regression analysis that controls for the demographic factors of age, gender, ethnicity and sexuality. The coefficients, significance levels and 'ExpB' values for the disability status variable are shown in Appendix 1, Table 2. If the significance level (p) is less than .05 (as it is in every case, due in part to the very large sample size) then it is reasonable to conclude that disability status does have at least some impact on the responses to the question. The 'ExpB' values show the magnitude of the impact. More specifically, the ExpB value represents how many times different are the odds of a particular outcome if a staff person has declared or not declared that they have a disability. For example, in relation to question 21b, the odds of a staff person who has not declared that they have a disability responding that they have experienced bullying, harassment or abuse by a manager or colleague are .564 less likely than the odds of one who has declared a disability.

The available ESR data are analysed by comparing the numbers and percentages of staff with disabilities to those without, and also comparing the large group who did not disclose and the group for whom disability status is unknown. Given that the dataset includes the whole population of NHS staff, significance tests are not needed, and the size of differences is discussed in the context of the specific topic.

Literature review

The main objective of the literature review was to collate, assess and synthesise the available research evidence on the experiences of staff with disabilities within the NHS workforce, and additionally for staff working in other sectors across the UK. Furthermore, we also include research evidence from studies illustrating the experience of "entry into workforce" as well as the perspectives of employers and their experiences in working with disabled individuals in the workplace. In this review, we define "experience" to include both entry into the workforce, and sustained work experience over time.

Search strategy

A comprehensive search of the academic literature was conducted systematically across a number of electronic academic databases for the health and social sciences, which included MEDLINE, PubMed, Academic Search Complete, PsycINFO, EBSCOhost, and Web of Science, among others. Additionally, searches were also conducted through Google Scholar, in order to further locate articles not abstracted in these databases, such as those published in open-source journals. Similarly, searches were also conducted on the websites of relevant organisations, such as the NHS and

Disability Rights UK, to locate "grey" sources of literature, such as official reports. The overall purpose of this comprehensive search was to locate all appropriate research studies available in the topic area.

The searches were guided by a number of keywords compiled by the research team. Initially, some of these keywords were searched in isolation as a way to firstly assess the range of available literature, and subsequently used in various combinations in more directed searches on the topic. These search terms included: "disabl*," "mental*," "discrimin*," "equality," "diversity," "work," "workplace," "workforce," "employ*," "manag*," "leadership," "NHS," "access*," "reasonable adjustment*," "experience," "reward," "recognition," "recruitment," "retention," "promotion," "representation," "training," "surveys," "personnel," "human resources," and kitemark schemes, such as "Two Ticks" and "Mindful Employer." As noted, a number of wildcards were used, such as the asterisk (*) in order to location sources containing variations of the same word (e.g. disability, disabled, etc.) and quotations ("") for purposes of searching for words placed together (e.g. "Two Ticks"), as opposed to separately. Additionally, a number of Boolean operators were used (e.g. AND, OR, and NOT) in order to further refine searches.

After each search was conducted, the titles and abstracts were scanned for the first several hundred results. Where possible, PDFs of the article were immediately downloaded, and in other cases citations were recorded to subsequently locate the full article by consulting other databases. In some cases, after a relevant source was found, a further "snowball" search was conducted, by following links for "related articles," or articles that have cited, or have been cited by, that particular source. Doing so helped to locate additional articles appropriate to this research. Keyword searches were systematically conducted across databases until "saturation" was reached, which is when no further new sources could be located. Once PDFs of all relevant articles were obtained, bibliographies of these articles were further snowballed as a way to locate further sources.

Inclusion and exclusion criteria

In keeping with the scope of the topic area as defined by the research tender, a number of inclusion and exclusion criteria were compiled by the research term. In order for a source to be included in this review, the following criteria were applied: (1) a research study published in a peer-reviewed journal or as a research report; (2) research conducted in the UK only; (3) research that concerns disability as defined under the Equality Act 2010 (i.e. a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on ability to do normal daily activities); (4) research focusing on working age adults (18-65 years); and (5) research published between the years of 1995 (when the Disability Discrimination Act was passed) until 2015.

Similarly, a number of exclusion criteria were also developed. These included: (1) commentary or conceptual articles that do not relate to or report research evidence; (2) non-UK research; (3) articles published in newspapers or magazines; (4) research that is not about working age adults (18-65); (5) research concerning conditions or illnesses that are not covered by the Equality Act 2010; and (6): research published before 1995. In some cases, however, sources such as these (e.g. articles in professional magazines) were briefly consulted to see if they had reported evidence of any research studies. If so, sources of these citations were obtained and checked against the inclusion criteria.

Data extraction, quality assessment, and data synthesis

Several researchers read all papers and recorded key information to a form created in order to streamline the extraction process. The following information was extracted: (1) publication details; (2) research design/method(s); (3) research aims and objectives; (4) sample size, technique and

research participants' details; (5) study location; (6) research context (e.g. NHS vs. non-NHS staff with disabilities research); (7) main key findings; and (8) strengths and limitations of the study.

During the extraction process, researchers also evaluated each study using the Critical Appraisal Skills Programme (CASP) checklist developed by the Social Care Institute for Excellence (2013). The purpose of this protocol is twofold: firstly, to critically assess the methodology employed by the study, and secondly, to determine the relevance of the study to this literature review. For the former, an overall grade of 1 to 3 (high-moderate-low) was given in consideration to a number of questions based on methodological aspects, and for the latter, an overall grade of A to C was given based on a series of questions to determine the relevancy of the study to this research. By doing so, this influenced how attention was given to various types of research evidence in this review.

The extraction of articles onto a pre-defined form ultimately culminated in providing a clear and detailed overview of all included research conducted on the topic. Essentially, this database took the form of a literature review table and thereby enabled researchers to easily observe various patterns, trends, themes and gaps across the empirical literature. This information was used to aid in the thematic analysis conducted for this literature review, which involved structuring and organising this review based on these observed themes and patterns across the literature.

Section 3: Results of the NHS 2014 staff survey and ESR quantitative analysis

The most notable information is presented in bar charts (Figure 3.1, 3.2, etc.), in the main text below. More comprehensive information is presented in tables (Table 3, 3.2 etc.) in Appendix 2.

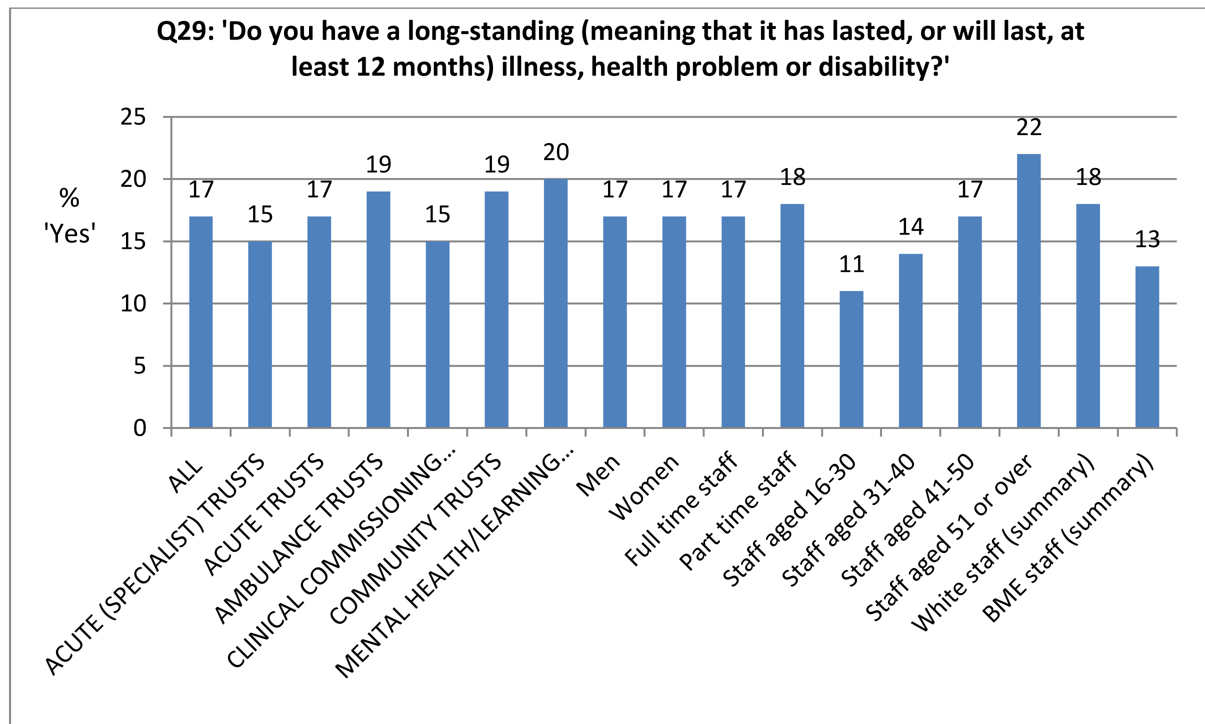
a) What is staff with disabilities' representation at all levels of the NHS and covering different types of disability?

NHS Staff survey:

It is not possible in the NHS staff survey to distinguish between different types of disability. It is possible to make a distinction between disabled or non-disabled staff within sub-groups, such as occupation, age or sex.

17% of staff responding to the survey report (Figure 3.1) that they 'have a long-standing (meaning that it has lasted, or will last, at least 12 months) illness, health problem or disability'. The survey results include information about the prevalence of self-reported disability within certain groups, but do not include information about what kinds or levels of disability exist within the workforce.

Figure 3.1: Disability by trust type, gender, full/part time, age and ethnicity (2014 staff survey)



Source: NHS Staff survey, 2014

- The prevalence of self-reported disability varies considerably between the different categories of Trusts, from a high of 20% in Mental Health/Learning Disability Trusts to a low of 15% in Acute (Specialist) Trusts
- There is no difference between men and women in the proportion reporting disability (both 17%).

- There is no substantial difference between full and part-time staff, but there were large reported differences (ranging from 11% to 25%) between the different occupational groups in the NHS workforce, with clinical and more senior staff having lower rates of self-disclosed disability.
- There were also differences, ranging from 9% - 27%. in reported disability with respect to ethnicity, sexuality, religion, length of service in the same Trust, and age
- With respect to ethnicity, a higher percentage of staff categorised as White (18%), compared to BME (13%), self-disclosed as disabled.
- Reported levels of disability increase with age, varying from 11% for staff aged 16 -30, to 22% for staff aged over 51.
- In summary, staff with disabilities on average are older, are more often white, have worked longer in same Trust, are in non-medical roles, and are less senior.

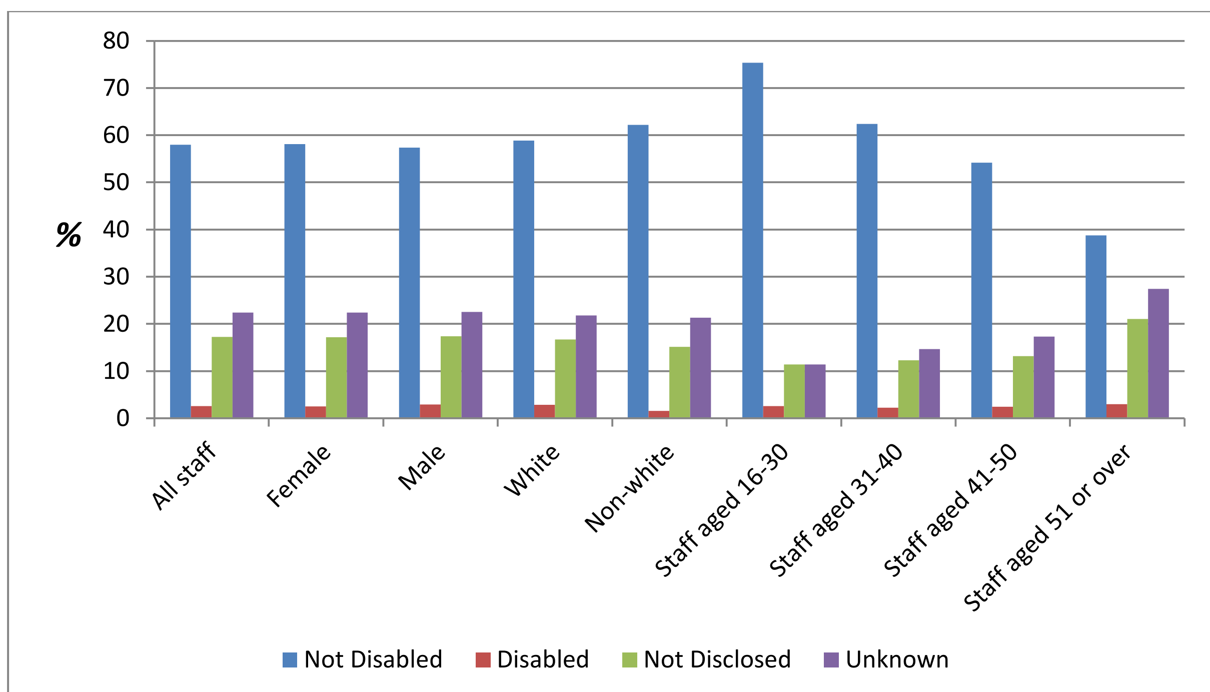
ESR:

As with the survey data, it is not possible in the ESR data to differentiate between different types or levels of disability.

2.58% of 1,213,433 staff are shown (Figure 3.2) in the ESR as having 'A physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities'. This is the Equality Act definition.

The available ESR data breaks these figures down by non-medical/medical staff (.92% of 113,214 medical staff [i.e., consultants, registrars, other doctors in training, other medical and dental staff] and 2.75% of 1,100,219 non-medical staff), by the area in which the Trust is located (Appendix 2, Table 3), by pay band and medical seniority (Appendix 2, Table 4), and by age categories (Appendix 2, Table 5). There are high levels of staff who do not disclose information about disability (11-25%), or for whom information is unknown (13-33%).

Figure 3.2: Disability by gender, ethnicity and age (ESR)



Source: Health and Social Care Information Centre, Provisional NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

Rates of disability range vary across Trusts from 2% to 4% for non-medical staff and 0% to 2% for medical staff (Appendix 2, Table 3). There was also variation across regions in non-disability (45% - 68% for non-medical staff; 45% - 70% for medical staff), non-disclosure (4% - 25% for non-medical staff; 6% - 31% for medical staff), and unknown (13% - 40% for non-medical staff; 12% - 43% for medical staff). As noted above (p.5), much of this variation may be due to differing data entry practices in Trust HR departments.

The high rates of ‘Unknown’ and ‘Non-disclosure’ in the ESR must be taken into consideration in interpreting any of the data concerning disabilities. While the ‘Unknown’ rate is decreasing each year (it was 47.6% in 2011/12, and 18.3% in 2014/15), it is still a large group for which there is not information about disability, and, of course, nothing is known about the disability status of the ‘Not disclosed’ group. As can be seen from Figure 3.2, the percentage declaring that they do not have a disability declines considerably among older age groups, while the percentage of ‘not disclosed’ and ‘unknown’ increases with age. These might indicate that older staff are reluctant to disclose disability, or that HR departments are over time becoming more assertive in obtaining a definitive answer to the question. It is also possible, of course, that disability as defined in the ESR does not increase with age among NHS staff, although this explanation is at odds with most of the literature on age and disability rates.

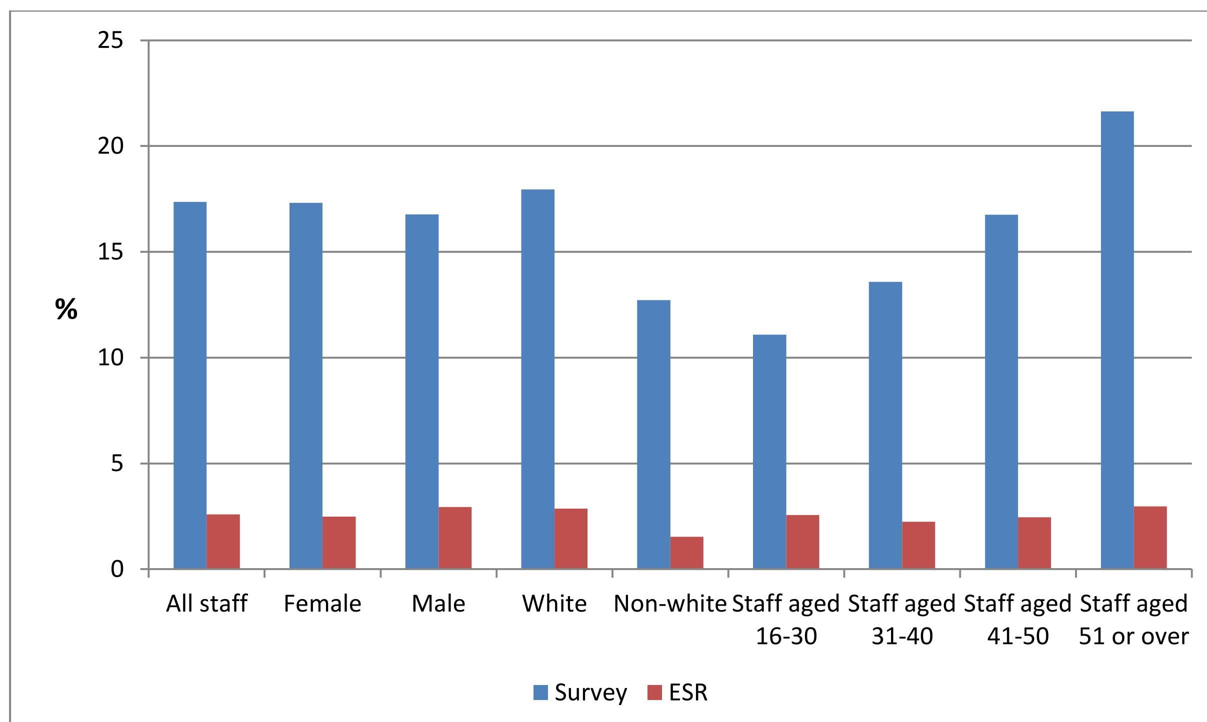
In terms of the distribution of disability across staff grade levels, the general trend was for staff with a lower disclosure rate to be located in the higher grade points (Appendix 2, Table 4). Disability rates are lower for higher bands, and for consultants and hospital practitioners. This is possibly due to higher non-disclosure and ‘unknown’ rates rather than actual disability. This in itself may be concerning, given the extra responsibility carried by these groups and their possible reluctance to acknowledge their potential limitations or need for accommodations.

There is no marked gender difference in disability rates within age groups (Appendix 2, Table 5). Both men and women have similar levels of staff for whom disability is not known or undisclosed. These rates are lower in the younger age groups for both men and women.

b) Why is there a disparity between the staff who declare a disability on the Electronic Staff Record System, and those who declare a disability on the anonymous staff survey?

The disability rates shown in the survey and the ESR are compared in Figure 3.3.

Figure 3.3: Comparative disability rates in the NHS Staff Survey and the ESR



Sources: NHS Staff Survey, 2014; Health and Social Care Information Centre, Provisional NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

The most striking difference between the ESR and the National NHS survey is the overall prevalence of reported disability. This was 3% in the ESR data and 17% in the national staff survey. The most likely reasons for this are:

1. The difference in definition of disability (see 1.2 above)
2. The conditions for self-disclosure
3. Time of disclosure

In the NHS staff survey, disclosure is anonymous, whereas this is not the case in the ESR. It may be easier to self-disclose as disabled in the anonymous circumstances of the NHS staff survey, compared to the ESR in which disability status is traceable. Furthermore, in the ESR data set, disability is disclosed at the point of staff appointment, and there is no reliable updating of the ESR to track disability that occurs during the course of employment.

The other clear difference between the survey and ESR data is that the disability rate across the age bands differs more in the survey data, with older staff showing higher levels of disability in the survey, which is not the case to nearly the same extent in the ESR. This is perhaps because the ESR is not generally updated after employment, or because of staff concerns about confidentiality, which are likely to be fewer in relation to the survey.

c) How well are staff supported who become disabled during the course of their employment? Is there a process for recording this on the staff survey?

It was not possible to generate an answer to this question directly through the data sets analysed. However, this is in our view an extremely important question, which we have attempted to answer through identifying a number of 'operational indicators' for which there is information available in the survey data analysed.

The following questions from the NHS staff survey have been selected to address the issue of how well staff with disabilities are supported:

- *Qs 21b & 23: What are the levels of bullying and harassment, and of discrimination?*
- *Q15b: How far do staff feel 'Pressure to work when feeling unwell'?*
- *Q22: How do staff perceive opportunities for career progression?*
- *Qs 8 & 9: What levels of job satisfaction do staff report?*

These questions involve issues for which all staff, whether disabled or not, should expect support and encouragement. Disproportionately negative responses by staff with disabilities to these questions are taken as an indication that staff with disabilities, including those who become disabled after joining the NHS workforce, are insufficiently supported.

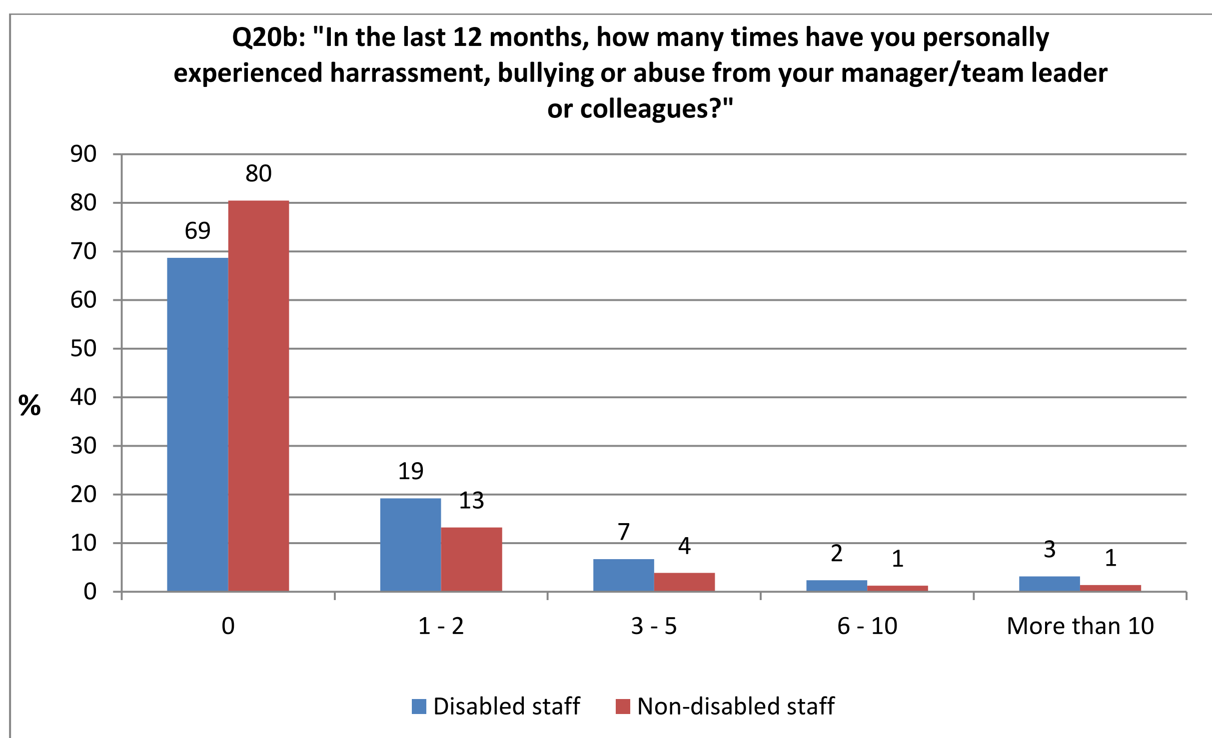
What are the levels of bullying and harassment, and discrimination?

The 'Violence, Bullying and Harassment' data (Figure 3.4 & Appendix 2, Table 6) indicate that, compared to non-disabled staff, staff with disabilities report:

- Substantially more bullying and harassment from managers, team leaders or colleagues (12 percentage points more)
- More discrimination at work from managers or team leaders (7 percentage points more)

As shown in Appendix 2, Table 6, these disparities between those with and without disabilities in their responses to these questions are much greater than those related to ethnicity or gender. Perhaps most noteworthy is the 12 percentage points difference in reported bullying by managers and colleagues, illustrated in Figure 3.4 below.

Figure 3.4: Staff with disabilities and non-disabled staff experience of bullying and harassment



Sources: NHS Staff Survey, 2014

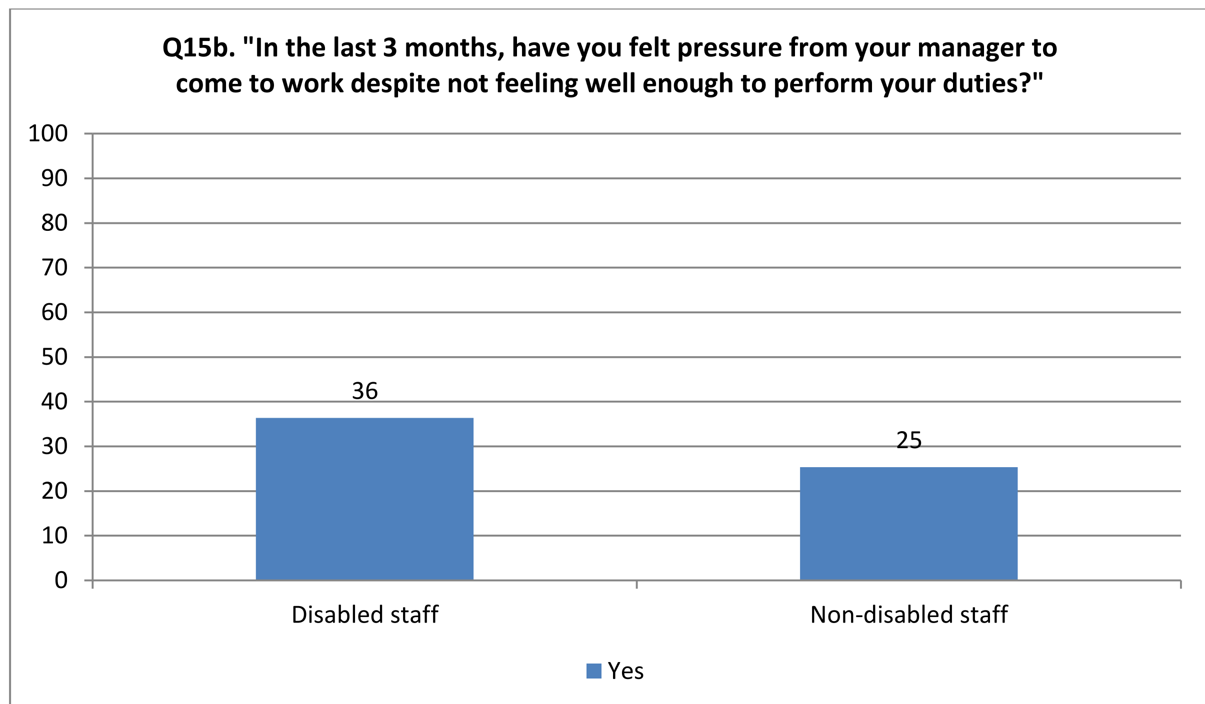
This disparity is much greater than those based on ethnicity or gender. Non-white staff responded that they experienced bullying and harassment by their managers 4 percentage points more than white staff, while women responded in this way 1 percentage point more than men (Appendix 2, Table 6).

The regression analysis (Appendix 1, Table 2) confirmed that disability explains more variation in responses to this question than any of the other available demographic variables. In other words disability was the most statistically significant predictor of all, in terms of likelihood of being subjected to bullying or harassment from managers, team leaders or colleagues.

'Pressure to work when feeling unwell'

The 'Pressure to work when feeling unwell' questions (Figure 3.5 and Appendix 2, Table 6) may give another indicator of the support that staff with disabilities experience. There is an 11 percentage point difference in the proportion of staff with disabilities who feel under pressure from their manager to attend when feeling not well enough to perform their duties, compared to those without disability.

Figure 3.5: Disabled and non-disabled staff: managerial pressure to attend work despite not feeling well

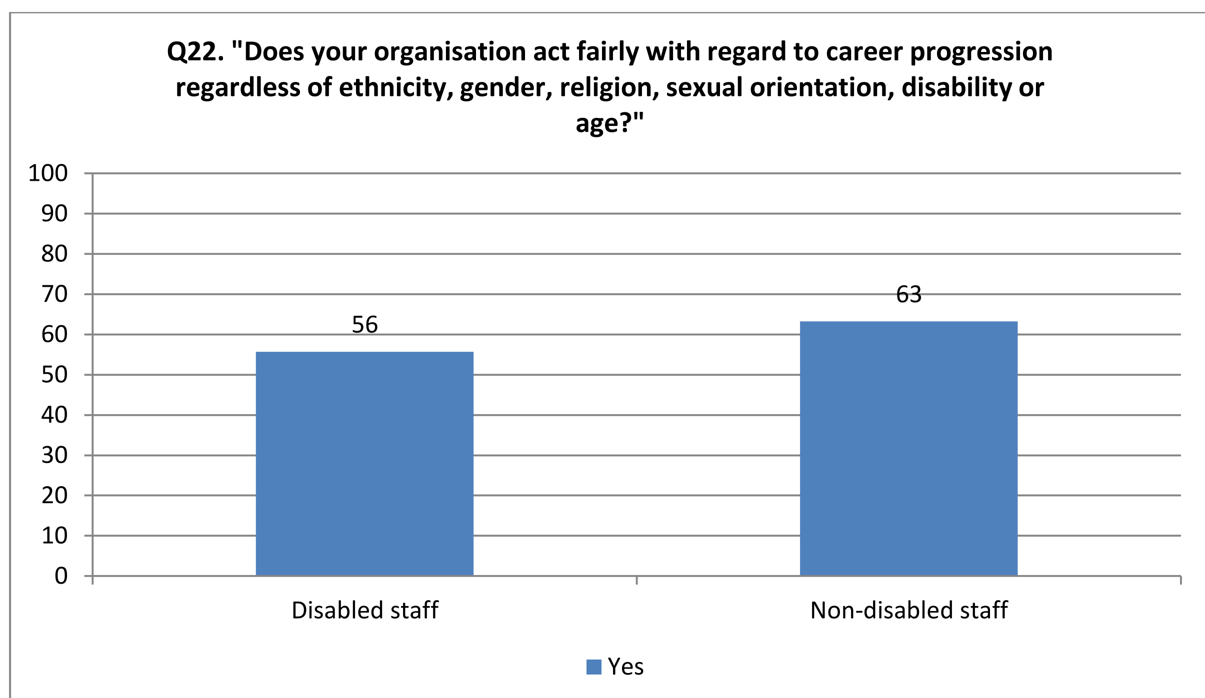


Source: NHS Staff Survey, 2014

Opportunities for career progression

More disabled staff report (8 points difference: Figure 3.6) that their organisation does not act fairly with respect to opportunities for career progression.

Figure 3.6: Fairness with respect to career progression



Source: NHS Staff Survey, 2014

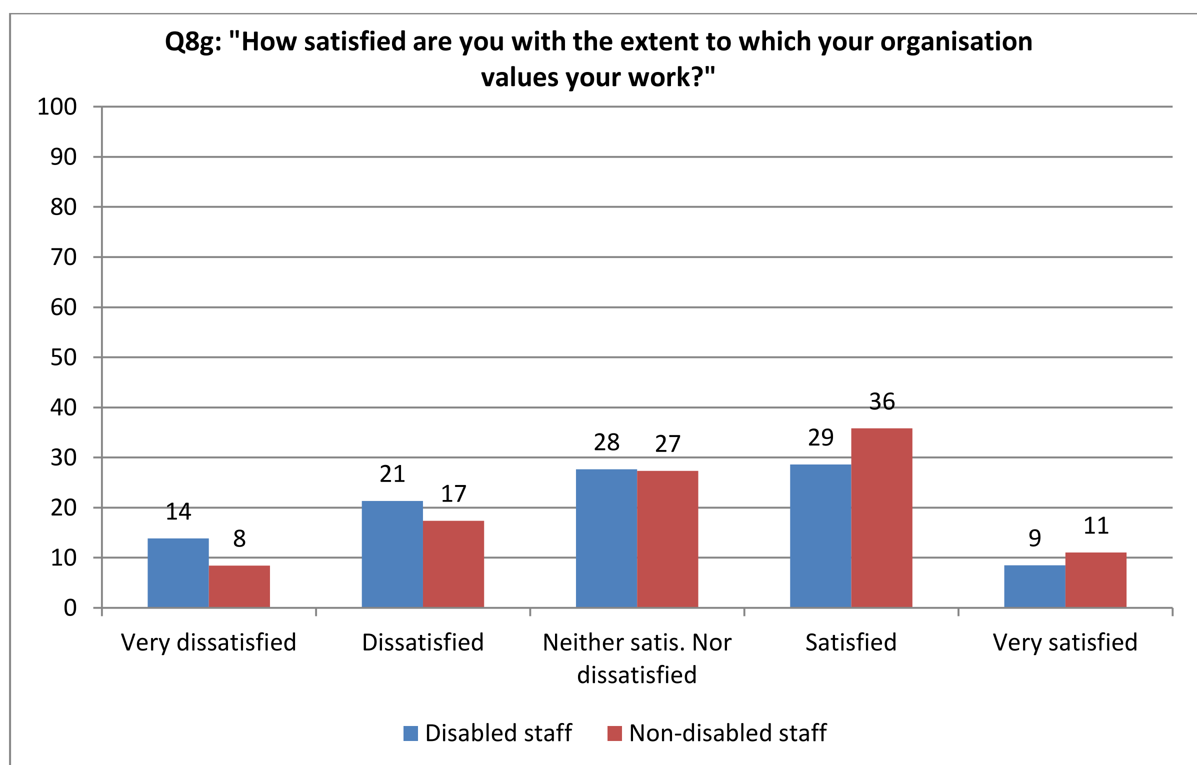
Do staff with disabilities report lower job satisfaction?

Another survey question that might give some indication of how disabled staff are supported is the question: 'How satisfied are you with each of the following aspects of your job?'

The responses to the various sub-sections of this question (see Appendix 2, Table 7) indicate that staff with disabilities are less satisfied with the recognition, support, responsibility and opportunities they have in their jobs, even though there is no difference in the satisfaction they report in the quality of care they give to patients. Disabled staff, in comparison with staff without disabilities, report less:

- Recognition for their good work undertaken (8 percentage points fewer)
- Support from their immediate managers (5 percentage points fewer).
- Support from their work colleagues (3 percentage points fewer).
- Satisfaction with the levels of responsibility they had been given (4 percentage points fewer).
- Opportunity to use their skills (5 percentage points fewer).
- Satisfaction with their level of remuneration (9 percentage points lower)
- Perception of being valued (Figure 3.7) by their organisation for their contribution (9 percentage points fewer).

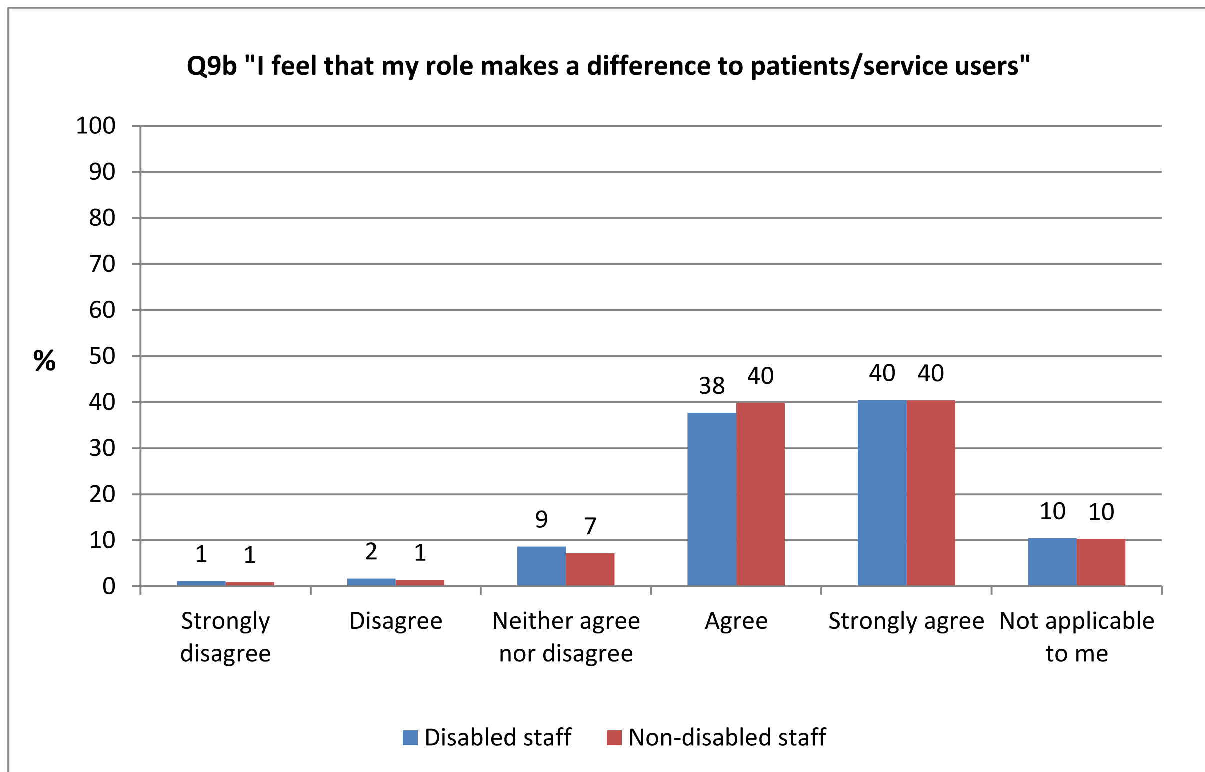
Figure 3.7: To what degree do you think your organisation values your work?



Sources: NHS Staff Survey, 2014

However, despite the lower job satisfaction expressed by staff with disabilities, they felt their role made a difference to patients and their ratings are very similar to those of non-disabled staff. (Figure 3.8)

Figure 3.8: Does my role make a difference to patients/service users?



Sources: NHS Staff Survey, 2014

In summary, in answer to the question: '*How well are staff supported who become disabled during the course of their employment?'*, we could not find one specific question which addressed this question but were able to identify a number of 'proxies' were identified that relate to *levels of bullying and harassment, 'Pressure to work when feeling unwell', opportunities for career progression, and levels of job satisfaction.*

Relative to non-disabled staff, staff with disabilities report more bullying, in particular from their managers; more pressure to work when feeling unwell; less confidence that their organisation acts fairly with regard to career progression; and lower levels of job-satisfaction, despite rating their impact on patient care broadly equivalent to the ratings of non-disabled staff.

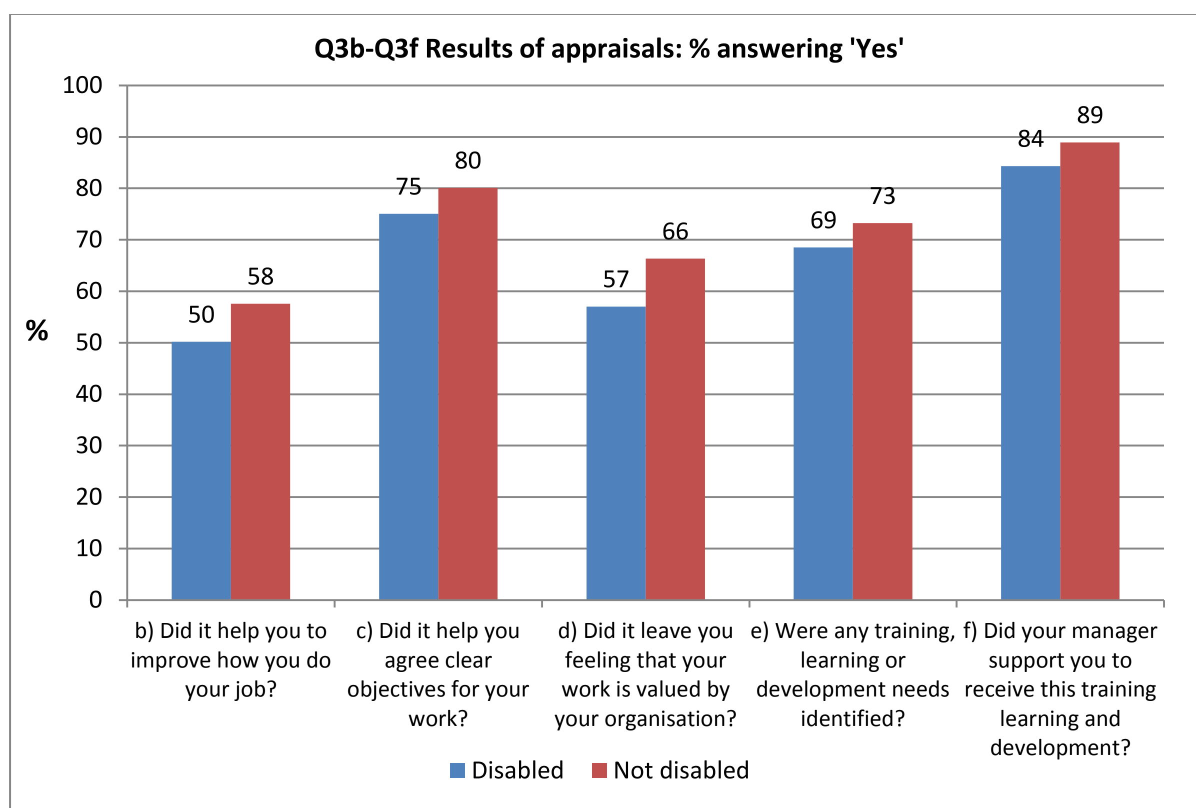
d) What are appraisal rates for disabled staff compared to non-disabled staff?

NHS Staff survey:

In the NHS Staff survey, while the range of appraisal rates between staff groups and types of Trust is great (28 – 100%), only one percentage point fewer disabled than non-disabled staff report having an appraisal, annual review, development review or KSF development review (Appendix 2, Table 8). This seems to be consistent across types of Trust (except for Ambulance Trusts which have an appraisal rate of 61% disabled vs 66% non-disabled).

However, disabled staff seems to be less satisfied with the effects of their appraisal. 7 percentage points fewer disabled staff report that appraisals improved their performance, 5 percentage points fewer that it helped to clarify their work objectives, 5 percentage points fewer that learning and development needs were identified, and 5 percentage points fewer that they have confidence that their manager would support them to receive the needed training. Moreover, 9 percentage points fewer disabled staff feel valued by their organisation for their work.

Figure 3.9: Results of appraisals, disabled versus non-disabled staff



Source: NHS Staff Survey, 2014

e) Do disabled staff have similar levels of access to training and development as non-disabled staff?

NHS Staff survey:

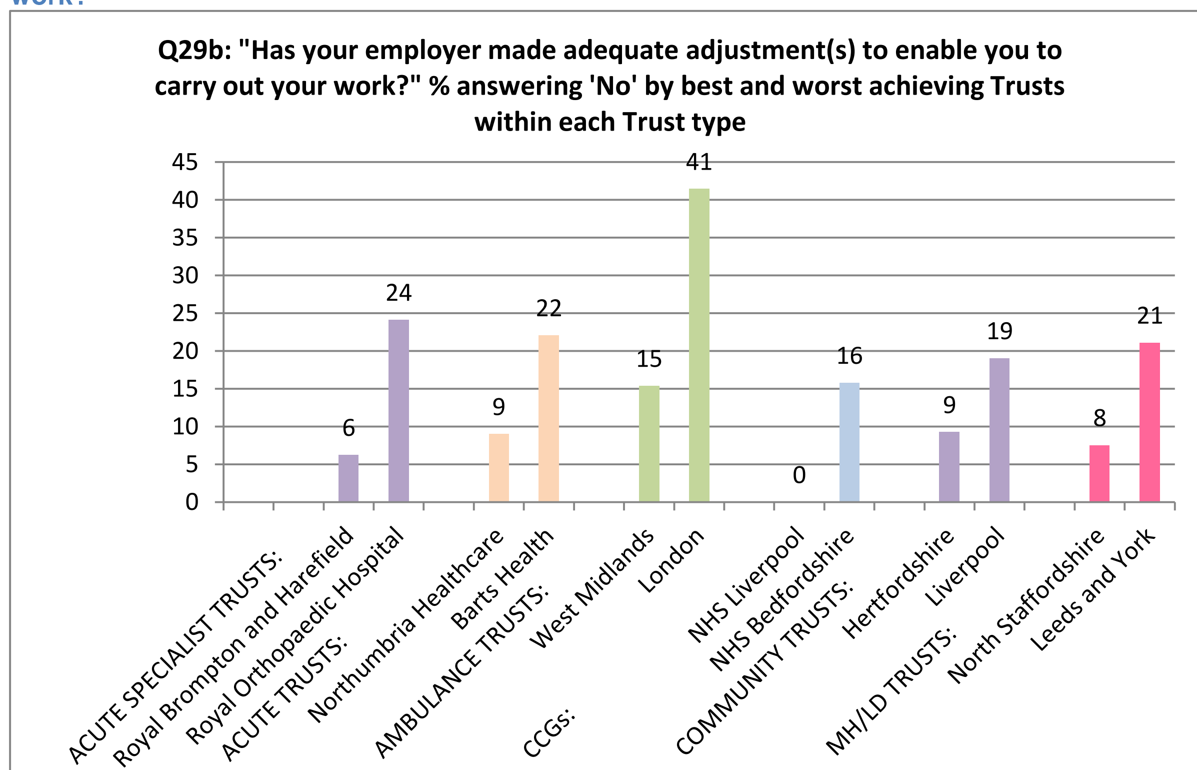
The survey results indicate that most staff had training within the last 12 months in the various topics given in Table 9, and only 5 - 25% staff have received no training in each topic. There is very little disparity between disabled and non-disabled staff in the proportion not receiving training in any of the topics, or in their satisfaction with the training. The relevant survey question (Q1) specifies six training topics that are likely to be mandatory in many trusts (e.g., health and safety, infection control), and a seventh topic of 'Any other job-relevant training, learning or development', which may represent non-mandatory training in most trusts. The same level of training is reported by staff with and without disabilities in non-mandatory training as in training that is likely to be mandatory.

f) How well do NHS organisations make reasonable adjustments for disabled staff, from the recruitment process to the end of employment?

NHS Staff survey**:**

The survey (Q29b) asks respondents who have declared a disability 'Has your employer has made adequate adjustment(s) to enable you to carry on your work'. 40% respond 'Yes', 14% 'No' and 46% 'No adjustment required 'There is little disparity between types of Trust (apart from Ambulance Trusts), but, as can be seen from Figure 3.10 below, within types of Trusts the extent to which people with disabilities report that their employer has made adequate adjustments varies greatly. A substantial minority of respondents varying from a low of 0% to a high of 41% report that their Trust has not made an adequate adjustment in their place of work to their reported disability. This perhaps indicates that Trusts could learn from each other about how to make adjustments.

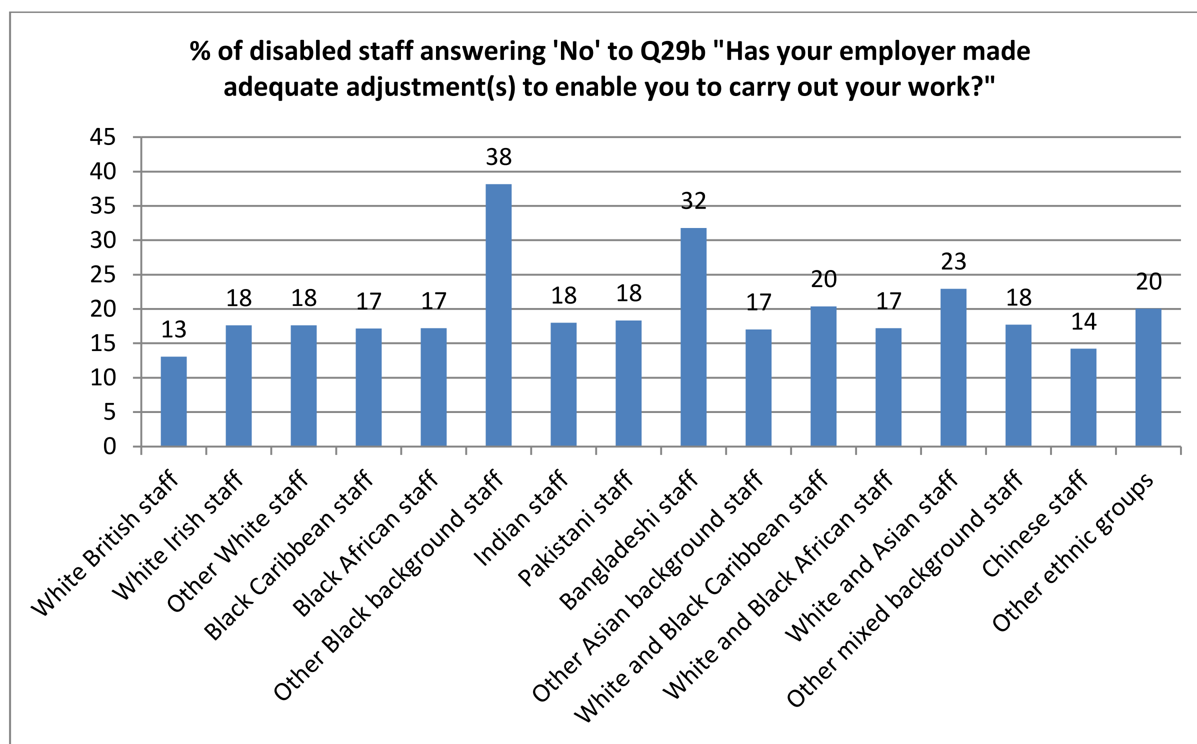
Figure 3.10: Has your employer made adequate adjustments to enable you to carry out your work?



Source: NHS Staff Survey, 2014

There is also significant disparity in the reporting of 'adequate adjustments' within the group of disabled staff depending on their ethnic background, as shown in Appendix 2, Table 10, and Figure 3.11 below.

Figure 3.11: 'Adequate adjustments' and ethnic background



Source: NHS Staff Survey, 2014

White British staff with disabilities report the highest rate of adequate adjustments made by their employer. While other ethnic categories have consistently lower rates than white British, the relatively small groups of Bangladeshi and 'Other black background' staff report much lower rates.

g) What difference does the 'two ticks' symbol make to recruitment and employment?

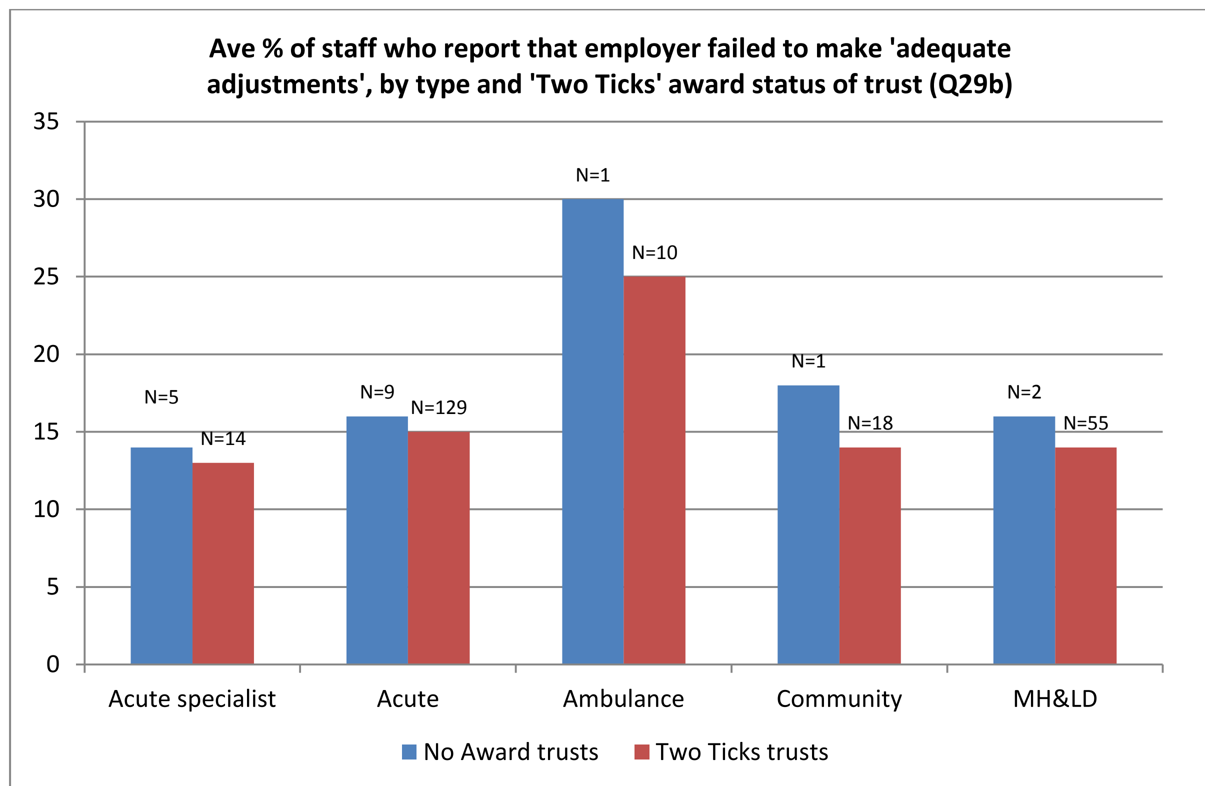
The Department of Work and Pensions (DWP) 'Two Ticks' award is made to organisations that commit to the following five practices:

- To interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities
- To discuss with disabled employees, at any time but at least once a year, what both employer and employees can do to make sure they can develop and use their abilities
- To make every effort when employees become disabled to make sure they stay in employment
- To take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work
- To review these commitments every year and assess what has been achieved, plan ways to improve on them and let employees and Jobcentre Plus know about progress and future plans

The DWP has list of 'Two Ticks' organisations as of May 2013. However, the list appears to have many inaccuracies and was compiled one year before the relevant staff survey was undertaken. Using the NHS Jobs website, Trust websites and other evidence available online, as well as the DWP

list, an estimate was made of the current ‘Two Ticks’ status of every Trust. 18 of 244 (7%) Trusts were found to not have the award. A comparison was made between Trusts with and without the ‘Two Ticks’ award of the extent to which staff who declare a disability report that their employer failed to make ‘adequate adjustments’ to enable them to carry out their work. The results are shown in Figure 3.12.

Figure 3.12: Percentage of staff with a disability who report that their employer has failed to make adequate adjustments to enable them to carry out their work, by type of trust and by ‘Two Ticks’ status.



Source: NHS Staff Survey, 2014

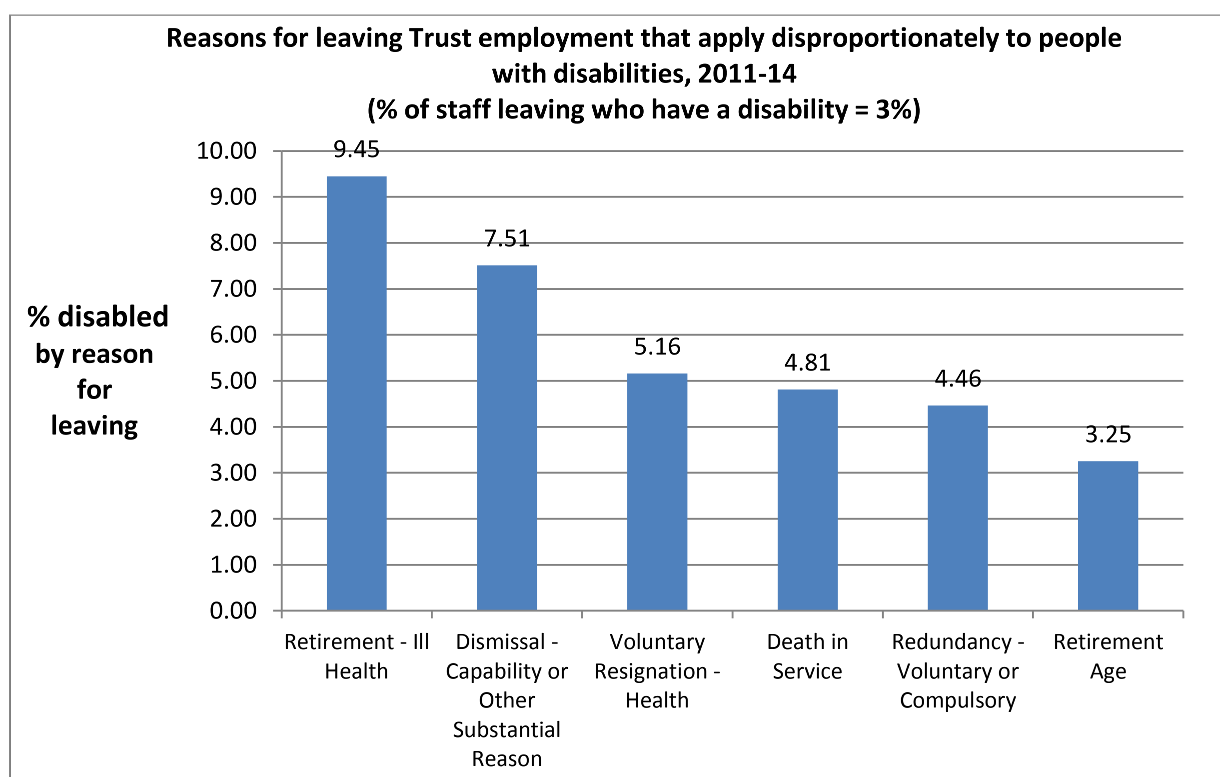
Although there is a consistent finding that Trusts that have the ‘Two Ticks’ award have marginally higher average rates of ‘adequate adjustments’ reported by staff with disabilities, the difference is small, the number of ‘No award’ Trusts is small (just 1 in the case of ambulance and Community Trusts, as shown in figure 3.12) and the range among all Trusts is very large (from 5% to 41 %).

h) What are the numbers of disabled staff who are the subject of employment processes and procedures, for example disciplinary and capability processes?

We could not find definitive data concerning the specific prevalence of employment procedures for staff with disabilities such as frequency of disciplinary or capability proceedings. However, there are data about reasons for leaving the NHS that provide an indication of whether staff with disabilities are disproportionately represented among those dismissed as a result of disciplinary or capability issues. Table 11 in Appendix 2 shows the numbers of staff leaving as recorded in the ESR during Q3 of 14-15, broken down by reason for leaving, and the percentage within each reason for leaving who had a disability.

The overall percentage of leaving staff who had declared a disability in the ESR record was 3%. The number of staff leaving because they were dismissed due to capability was 8.7% (of 705), due to other substantial reason was 4.5% (of 334) and due to conduct was 4.2% (of 403). The only dismissal category in which staff with disabilities were 'under-represented' (i.e., <3%) was within a small group of 38, dismissed due to 'statutory reasons', of whom 2.6% had a disability. While these figures strongly suggest that staff with disabilities are more subject to disciplinary and capability processes, it is still possible that staff with disabilities are subject to disciplinary proceedings that do not result in dismissal at a rate that is proportional to their representation of 3% in the staff group as a whole.

Figure 3.13: Reasons for leaving for staff with disabilities



Source: Health and Social Care Information Centre, Provisional NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

i) What are the turnover, retention and stability rates for staff with disabilities within the NHS?

No reliable information is available on turnover, retention or stability rates.

However, as noted in the last section, there is information available concerning reasons for leaving employment (see Figure 3.13 above, and Appendix 2, Table 11).

Compared to staff without a declared disability, staff with a declared disability left employment more for the following reasons:

- Flexi-retirement
- Retirement for health reasons
- Dismissal related to capability, conduct or other reason
- Voluntary and compulsory redundancy
- Voluntary resignation for health reasons or incompatible working relationships.

They were less likely than staff without a declared disability to leave for the following reasons:

- End of fixed term contract
- Voluntary resignation for promotion, education
- Care of adult dependents
- Lack of opportunities.

Section 4: Literature review

Introduction

It is conventional to place the literature review at the start of a research report, before reported data. In this instance the view was taken by the team undertaking the research that the literature review did cover an extensive area of additional findings, both within the context of the NHS and outside of it. In this sense it can be seen as constituting an additional data source, within which the specific findings of this report with respect to the NHS Staff Survey and ESR analysis can be seen in a broader context.

The literature identified from the search protocol has been considered in different ways so as to appraise the quality, type and extent of existing empirical evidence which might inform the key themes underpinning this research study. The main component of the review (4.4) therefore groups the evidence under the research question headings outlined in section 1 of this report. Before that, sub-section 4.1 lists relevant studies that include NHS staff. Sub-section 4.2 highlights some of the overarching theoretical approaches from the diverse range of studies we examined, given that there are cross-disciplinary academic and professional interests in disability and employment in the UK context . Sub-section4.3 provides a broad overview of studies across various employment sectors on disability and employment. Finally, sub-section 4.4 highlights and discusses selected relevant key themes across all of the sources examined and which speak to the specific research questions stated in section 1.

4.1 Abstracts of relevant research studies that include NHS staff

Bogg, J. & Hussain, Z. (2010). Equality, diversity and career progression: Perceptions of radiographers working in the National Health Service. *Radiography*, 16 (4): 262-267.

This study evaluated radiographers' perceptions of equality, diversity and career progression in the National Health Service (NHS) by means of a quantitative national survey in which 120 radiographers responded. The findings were assessed in relation to the participants' own beliefs about equality and diversity. Key findings included that despite the fact that the NHS is actively attempting to address equality and diversity issues, radiographers working within the NHS still perceive that problems exist. This is apparent from the findings that 55% of participants thought that women generally experience some barriers to career progression. Sixty-seven percent perceived that people with disabilities experienced barriers to career progression and 49% felt that the profession did not reflect the community that it served. Reassuringly, policy and procedures are felt to be making a difference and worthwhile. In the light of the introduction of the Single Equality Scheme and Equality Impact Assessments, it is important that radiographer perceptions of equality and diversity are evaluated and that incorrect beliefs are challenged.

Bogg, J., Pontin, E., Gibbons, C. & Sartain, S. (2007). Physiotherapists' perceptions of equity and career progression in the NHS. *Physiotherapy*, 93 (2): 137-143.

Objective: To evaluate physiotherapists' personal perceptions of equality and diversity both in the NHS and within their profession. In order for policy to make a difference and change to occur in actual practice, personal beliefs of frontline staff must be evaluated and incorrect beliefs challenged. **Design:** National Survey. **Setting:** The UK. **Respondents:** Four hundred and twenty physiotherapists. **Results:** The findings were assessed in relation to respondents' own beliefs in relation to equality and diversity. Key findings included that 88% of respondents agree that diversity is important in the NHS and that equality and diversity policies make a difference. However, 24% think the NHS is not working hard enough to promote equality and diversity. Fifty-five percent of

respondents agreed that women experience barriers to career progression. Sixty-three percent of respondents think that black and minority ethnic (BME) groups are not well represented at senior levels in the NHS, 65% of respondents think that BME groups are not well represented at senior levels in physiotherapy. Overall, 19% of all respondents reported being treated differently in the workplace, yet 36% of non-white respondents reported being treated differently in the workplace. **Conclusions:** Policy and procedures are making a difference in the NHS. However, as advocated, the CARE framework (**http://www.liverpool.ac.uk.clinpsy.breakingbarriers**) would be beneficial in facilitating change. Further efforts are required by NHS and physiotherapy leaders to promote equality in the workplace and diversity within the workforce.

Forster, D. (2007). Legal obligation or personal lottery? Employee experiences of disability and the negotiation of adjustments in the public sector workplace. *Work, Employment and Society*, 21 (1): 67-84.

This article 'gives voice' to disabled employees by documenting their experiences of negotiating workplace adjustments under the terms of the UK's Disability Discrimination Act, 1995.This ad hoc process of 'negotiation' is explored through in-depth interviews that reveal persistent problems with the character of legislation and its implementation in public sector organisations. Negotiations on adjustments were characteristically highly individualized and outcomes almost entirely contingent upon the knowledge, attitudes and goodwill of poorly trained line managers. The adjustment process itself often led to instances of bullying by managers, resulting in stress and ill health among employees. An analysis of managers' behaviour in the context of wider debates on power and organisational decision-making concludes that, even where outcomes are positive for employees, managers still choose to abdicate responsibility in this area. Such behaviour represents a form of non-decision-making that is essentially political in character and has wider implications for equality agendas.

Foster, D. & Fosh, P. (2009). Negotiating 'difference' Representing disabled employees in the British workplace. *British Journal of Industrial Relations*, 48 (3): 560-582.

Drawing on qualitative interviews with disabled employees, union officers and disability-related organisations, this article examines employee attempts to negotiate workplace adjustments and associated issues of workplace representation. UK employment law utilizes an individual medical model of disability, which conflicts with traditional collective approaches favoured by trade unions, which has implications for disabled employees and union representation. The authors explore the different strategies available to unions and conclude that, despite the role played by disability-related organization in supporting employees, unions are the only workplace actors who are capable of reconfiguring the 'personal as political' and integrating disability concerns into wider organisational agendas.

Grunfeld, E. A., Drudge-Coastes, L., Eaton, E. & Cooper, A. F. (2013). "The only way I know how to live is to work:" A qualitative study to work following treatment for prostate cancer. *Health Psychology*, 32 (1): 75-82.

Objective: For many survivors of prostate cancer, returning to work post-treatment is a realistic goal. However, little research to date has explored work among prostate cancer survivors. The focus of this study was to explore the meaning of work among prostate cancer survivors and to describe the linkages between masculinity and work following prostate cancer treatment. **Method**: Fifty prostate cancer survivors who were in paid employment prior to their diagnosis completed a semi-structured interview following completion of their treatment and of these, 41 also completed a 12-month follow-up interview. Framework analysis of the 91 transcripts was undertaken. **Results**: The majority of the men had returned to work at the 12-month interview. Four themes were identified, and these were labeled "Work and self-identity," "Work-related implications of treatment side effects," "Disclosure of cancer," and "Perceptions of future as a cancer survivor." A degree of embarrassment and concern about residual side effects and whether these would present a

challenge within the workplace was apparent among the sample and was compounded by a reluctance to disclose these. **Conclusions**: The descriptions provided by the men in this study reveal that the experience of prostate cancer can lead to challenges for both social and work-related roles. The influence of prostate cancer on men's reports of masculinity was variable, and recognition of these differences is required. In addition, some survivors of prostate cancer may require specific interventions aimed at helping them to manage disclosure of their illness, particularly within a work environment.

Kennedy, F., Haslam, C., Munir, F. & Pryce, J. (2007). Returning to work following cancer: A qualitative exploratory study into the experience of returning to work following cancer. *European Journal of Cancer Care*, 16 (1): 17-25.

The experience of returning to work following cancer is a largely unknown area of cancer research. This preliminary study aimed to explore the factors that influence decisions about return to work either during or after cancer treatment and to identify the important aspects of returning to work. Qualitative data were collected using individual interviews (n = 19) and two focus groups (n = 4, n = 6), predominantly with breast cancer survivors. Patterns of returning to work were diverse and a variety of reasons influenced work decisions, including financial concerns and regaining normality. Participants also discussed their ability to work, health professionals' advice, side effects, support and adjustments, and attitudes towards work. Although the majority adapted well, a few encountered difficulties on their return. It is evident that more advice is required from health professionals about returning to work, along with reasonable support and adjustments from employers to ensure that cancer survivors are able to successfully reintegrate back into the workforce.

Moloney, R., Hayward, R. & Chambers, R. (2000). A pilot study of primary care workers with a disability. *British Journal of General Practice*, 50 (461): 984-985.

Eighty practice managers identified 55 colleagues with disabilities in a postal survey. Most of the 15 people with disabilities who were subsequently interviewed described colleagues having helpful attitudes but changes had not been made to practice workplaces or systems to retain them at work. Proactive support for disabled workers might improve retention in the National Health Service workforce.

Morris, D. & Turnbull, P. (2007). A survey-based exploration of the impact of dyslexia on career progression of UK registered nurses. *Journal of Nursing Management*, 15 (1): 97-106.

Aim: To explore the effects of dyslexia on the practice and career progression of UK registered nurses (RN). **Background**: Literature suggests dyslexia can have a negative impact in the workplace and may pose particular difficulties for nurses, where accuracy in information processing activities is essential for practice. **Methods:** A questionnaire was used to survey RNs with dyslexia (n = 116) and results analysed using content analysis. **Findings:** Dyslexia provided a challenge to the everyday work of RNs, which was often met successfully using a range of individualized strategies. Career progression was achievable but compared with peers, was perceived to take longer. Disclosure of dyslexia to work-colleagues was selective and dependent on the perceived benefits. Informal support mechanisms were commonly utilized with formal management support less well defined. **Conclusion:** Dyslexia appears to have a negative impact on working practices and career progression, but remains a poorly understood and often hidden disability.

Stanley, N., Ridley, J., Harris, J. & Manthorpe, J. (2011). Disclosing disability in the context of professional regulation: A qualitative UK study. *Disability and Society*, 26 (1): 19-32.

In the UK, the ‘fitness to practice’ criteria that allow regulatory bodies to use health standards to restrict entry to the human professions have resulted in some disabled people being excluded from this workforce. Disclosure of disability is therefore a risky process for those aiming to practice or train in nursing, social work and teaching. This research, commissioned to inform the Disability

Rights Commission's Formal Investigation into fitness standards in the professions, was undertaken in 2006–07 and explored experiences of disability disclosure amongst professionals. Interviews with 60 practitioners and students, most of whom had unseen disabilities, revealed considerable variations in the extent of disclosure. Disclosure was perceived as having the potential to exclude participants from their chosen profession. Two overlapping models of disability disclosure emerged from data analysis. The study concludes that abolishing health standards for the professions would increase disability disclosure and decrease the stigma associated with disability.

Wray, J., Aspland, J., Gibson, H., Stimpson, A. & Watson, R. (2007). Employment experiences of older nurses and midwives in the NHS. *Nursing Standard*, 22 (9): 35-40.

Aim: To examine the employment experiences of older nurses and midwives working in the NHS. **Method:** A total of 27 semi-structured telephone interviews were conducted with nurses and midwives to identify positive and negative aspects of their working lives in the NHS. The interviewees were selected from a potential pool of 87 nurses and midwives who had consented to be involved in an earlier part of the study. Data were analysed using QSR NVivo 7.0. **Findings:** Positive and negative issues were identified as having an impact on the quality of working life. These included: access to training, change and *Agenda for Change (AfC),* quality of management, work demands, patient/colleague contact and nursing and midwifery as a career. **Conclusion:** This study highlighted a number of issues relevant to older nurses and midwives that warrant further study and attention. These include access to training and continuing professional development, issues relating to change and *AfC*, and general work demands including workload, resources and morale. The ability of staff to remain healthy, committed and able to deliver quality care can be compromised in cases where the staff experience is negative.

Wray, J., Apsland, J., Gibson, H., Stimpson, A. & Watson, R. (2009). "A wealth of knowledge:" A survey of the employment experiences of older nurses and midwives in the NHS. *International Journal of Nursing Studies*, 46 (7): 977-985.

Background: The United Kingdom's National Health Service workforce is ageing, and the specific needs of this sector of its workforce need to be addressed. Nursing, and midwifery shortage is a worldwide issue, and with increasing demands for care the retention of older nurses and midwives is crucial. **Objectives**: To report on the employment experiences of nurses and midwives with particular focus on issues relating to age, ethnicity, ill-health and disability. **Design**: The postal survey was developed following a literature review and analysis of National Health Service and Government policy documents. **Settings**: This was a UK-wide Survey of nurses and midwives working in National Health Service Trusts and Primary Care Trusts. **Participants/methods**: A postal Survey of nurses and midwives was undertaken between May and December 2005. National Health Service Trusts and Primary Care Trusts (n = 44) identified as having policies relevant to the Study were contacted regarding the procedure for seeking research governance approval. Thirteen National Health Service Trusts and Primary Care Trusts participated, with 2610 questionnaires distributed; 510 were returned (20% response rate). **Results**: Nurses and midwives aged 50 years and over had undertaken fewer Continuing Professional Development activities than nurses and midwives Under 50. Whilst not related to age, the study also found that 20% of the survey sample reported experiencing some form of discrimination. Nurses and midwives did not differ on either quality of life or psychological health using standard instruments. Having a disability did not lead to greater psychological morbidity but did have a negative effect on quality of life. Having a work-related illness had a negative impact on both quality of life and psychological morbidity. In relation to ethnicity, black nurses and midwives reported lower psychological morbidity than other ethnic groups; that is, they enjoyed a higher level of mental well-being. **Conclusion**: The nursing and midwifery workforce is ageing worldwide with a significant proportion now approaching, or having already reached, potential retirement age. With the recent introduction of age-related legislation, the working lives of older nurses and midwives in the National Health Service have never been more relevant. Whilst access to Continuing Professional Development is pertinent to the retention of

nurses and midwives of all ages, in this study, older nurses reported less access that younger nurses.

4.2 Theoretical context

Overall, we found a plurality of theoretical approaches to researching this field which framed researchers' views about how society and its institutions think about and designate 'Disability' (Shakespeare, 2006). The social model of disability has been politically significant in providing a framework for examining how 'Disability' has been researched and analysed in relation to employment in different settings (Shakepeare, 2002; Foster, 2007, 2012; Barnes et al, 2010). This helps to illustrate the subsequent tensions of designating 'Disability' as a status in the context of our capitalist economy and social organisation as well as in providing insights about what is driving those involved in this area of empirical enquiry.

A further evolving and developing area of research activity aimed at revising and extending the social model has contributed to the conceptualisation of a relational-cultural model of Disability which focuses on the interaction between 'impairment' and the environment and on the person and others (Campbell, 2014). The themes highlighted in this area of research activity reveal how disability is often conceptualised as a problem by individualising experience as opposed to uncovering the process of abledness that sustains the idea that disability is an operational difference (Campbell, 2011). The emergence of the theory of 'Ableism' is a form of prejudice that indicates a preferential treatment that devalues and differentiates disability through the valuing of able-bodiedness which is seen as the norm (Ho, 2008). A critical feature of ableism is the belief that impairment or disability is inherently negative or a deficit position in need of action which seeks to minimise its effects but which shapes the identity of the disabled people. This concept is useful in interrogating equality practice so as to negotiate how the integration and engagement of disabled people might be achieved and to identify opportunities to develop learning relationships between the disabled and their organisations.

Ableism within the organisational context asserts that the issue of providing resources to accommodate people is based on a perception that there is a financial *burden* inherent in reasonable adjustment measures for the 'other' to make them like 'abled' people. A number of qualitative studies we examined, particularly those coming from the critical disability field, also supported the notion that attitudes towards long term illness and disability are socially constructed giving rise to a culture where employees are viewed in terms of what they can't do, rather than on their strengths. This source of discrimination and prejudice is not always so explicit or recognised (Barnes, 2010; Campbell, 2014) but causes dissonance between what a person is able to do and their realities given that it is based their disability alone. For example a small narrative inquiry of 12 Chartered Accountants (Duff and Ferguson, 2011) highlighted how negative perceptions regarding their professional abilities found that their associated technical ability was often overlooked. Disabled accountants were often put in non-client facing positions because of over attention to bodily identity and this highlights how disabled people may not being seen to fit with the image of the organisation (Adams and Oldfield, 2011).

Further, an overarching theme that has arisen from our review of the literature on Disability and employment, concerns the need to engage with intersectionality. Intersectionality is a concept often used in critical theories to describe the ways in which a range of discriminatory issues (racism, sexism, homophobia, transphobia, ableism, xenophobia, classism, etc.) are interconnected and cannot be examined separately from one another (Cocker and Hafford-Letchfield, 2014). Intersectionality highlights the complexity of how we support and respond to people experiencing discrimination and the need to critique procedural approaches to anti-discriminatory practice that appear to become absorbed into the way care organisations managerialist bureaucratic processes (Carr, 2014). Finkelstein (1991) has referred to this as administrative reductionism – a technical way

of categorising and dealing with disabled people without giving adequate consideration to their multiple individual identities.

Finally, the voices of disabled people have come through clearly within this review of the literature not only on the ongoing discrimination and inequality that they continue to experience in the workplace and the clear identification of what can make this better from their own perspectives, but also with very strong messages about their underused and unrecognised capabilities at work, their contribution and leadership within workplace cultures. These findings demonstrate a high degree of resilience and achievement (RADAR, 2010). Disabled employees voices are mostly portrayed as research participants, i.e. the subjects of research. However, there is a substantial body of literature which is user-led and strengths-based from the Disability movement which demonstrates the value and significance of a co-productive approach to providing positive environments at work in partnership with disabled people and their advocates (Oliver and Barnes, 2008: Needham and Carr, 2008; Boyle and Harris, 2009) and from leading disabled researchers in this area using participatory methods; see Centre for Disability Studies http://disability-studies.leeds.ac.uk/about/ as an example. Public services such as the NHS face an unprecedented set of challenges, increasing demand, rising expectations and reduced budgets which cannot be confronted through policy and reform alone but require radical innovation through co-production (SCIE, 2013). Co-production in Disability employment – making changes based on the experiences of disabled professionals and employees and developing an equal partnership to develop a more positive environment through the design and delivery of change and support, can break this cycle of disadvantage in employment and make their contribution more cost-effective and sustainable in the longer term. The literature that grapples with a co-productive approach emphasises that a systems approach is essential to having a stronger impact on the delivery of quality services to end users in the NHS and its partners (Leatherman and Sutherland, 2007: Boyle and Harris, 2009; Hafford-Letchfield et al, 2014). In broader terms, maximising and supporting employment for disabled people provides a route to social inclusion (Gosling and Cotterill, 2000; Hirst et al, 2004; Pearson et al, 2013) given the wealth of evidence about the economic, social, psychological benefits and the strong value attached to work by disabled people (Adams and Oldfield, 2011) not to mention the social capital generated (Schuller and Watson, 2009).

4.3 A broad overview of the literature on disability and employment

A reasonably substantial body of work has been undertaken across service and manual industries for example in accountancy (Duff and Ferguson, 2011); construction (Clarke et al, 2009; Ormerod and Newton, 2013) and education (Skellern and Astbury, 2012; Hargreaves et al, 2014). Table LR1 has summarised some of the more significant review studies engaging with quantitative approaches mostly deploying secondary data analysis for example using the Labour Force Survey: the largest household survey in the UK which provides official measures of employment and unemployment (ons.gov.uk). There is also a good range of qualitative research exploring the experiences of key stakeholders particularly disabled people themselves, employers, support organisations, trade unions including the use of mixed methods in summarising the complexity of issues in the field. For example Kidd et al (2000) aimed to examine the relative labour market outcomes of disabled vis-a-vis non-disabled using an econometric model on data from the 1996 Labour Force Survey. They stressed the importance of using multiple measures of Disabilities and explored the challenges of controlling for the impact of disability on productivity.

The adverse employment effects that attach to disability are empirically well-established, significant, enduring and persistent:

- There are 5.7 million disabled people in Great Britain of working age (Office of Disability Issues, 2014). Trends note that around 30% of the working-age population report a

long-standing illness or disability of which 56% report a limitation to their activities of day-to-day living or their ability to work (Labour Force Survey, 2011, Qtr2).

- Trends in the prevalence of reported impairment and disability have steadily risen over the last 30 years across developed countries seemingly independent of reported improvements in health and advance in medicine and rehabilitation (OECD, 2007) creating a shared paradox.
- Disabled people are around 3 times as likely not to hold any qualifications compared to non-disabled people and around half as likely to hold a degree-level qualification (Office of Disability Issues, 2014).
- There is a 30% gap between the number of disabled people of a working age in employment (46.3%) and non-disabled people of a working age in employment (76.4%); this represents over 2 million people (Office of Disability Issues, 2014).
- 44.3% of working age-disabled people are economically inactive. This figure is nearly four times higher than non-disabled people (11.5%) (Office of Disability Issues).
- There has been an increase in the employment rate gap between those who report disability and those who do not (Berthoud, 2011). This is a second paradox since the employment rate for those reporting disability might be expected to rise as those at the margin of the classification are included.
- Disabled people are more likely to be underemployed or work part-time and have lower earnings as compared to their counterparts who are not disabled (Houtenville and Ruiz, 2011).
- Disabled people tend to experience less career success than their counterparts who are not disabled, particularly in the downturn and so their talent and skill remains underutilised (Gore and Parckar, 2009). Lack of career progression is also related to wider inequalities for Disabled people including health (Marmot, 2010). There is a cumulative effect of combined and intersecting disadvantage (for example people with financial or caring responsibilities), which hinders disabled people's career progression. The employment position of disabled people is significantly poorer than that of non-disabled people with the same qualifications at every level, including those with degree/higher degrees (Hills, 2010).
- Whilst some of the figures have been contested (Hones and Wass, 2000), there is indisputable evidence that the disability-induced employment gap (44% in 2010) is the largest and most enduring amongst all disadvantaged groups (Foster and Wass, 2012)
- There is a particular precariousness experienced by disabled people in leadership positions in relation to the nature of the positions they hold and the difficulties they encounter as they attempt to advance their careers (Wilson et al, 2008). Some national research is emerging however on the organisational factors which enable senior disabled talent to fly high (Radar, 2010)
- There is a pay gap between disabled and non-disabled people, which varies between men and women (20-12% respectively) (Hills, 2010).
- Disabled people are significantly more likely to experience unfair treatment at work than non-disabled people (Papworth Trust, 2013).
- The 2004 Workplace Employment Relations Survey found that only 23% of workplaces monitored recruitment and selection; 9% monitored promotions by disability, while only 19% reviewed recruitment and selection procedures, 10% reviewed promotion procedures and 4% reviewed relative pay rates by disability (Kersley et al., 2006; Hoque et al, 2014).

A number of researchers have stressed the need to focus on the demand side of labour or on the social organisation of work and on human and social rights to be employed and supported in employment rather than on the individual needs which tackle features of the disabling society (Barnes, 1992; Evans, 2007); and to acknowledge the levels of persistence and resilience from

disabled people and the link of employment issues to broader concerns of social exclusion (Kenway and Palmer, 2006).

4.4 The research questions addressed in this report

Disparities between staff who declare a disability on the Electronic Staff Record System and those who declare a disability on the anonymous NHS staff survey

We identified a range of studies that explored the issue of ‘disclosure’ by disabled employees. This was by far the most prominent theme within the literature on Disability and employment, not only as a specific research topic but as a theme in studies focusing on other issues. Estimating the number of disabled individuals entering, currently in and exiting the workforce poses enormous challenges related to definition and disclosure, as well as deception, which can arise where stigmatising conditions are involved (Rooke-Matthews and Lindow, 1998). For the disabled individual, the personal consequences of disclosure may have negative consequences for relationships at work; ability to keep in work and career prospects and lack of sympathy for sickness absence or time off for medical appointments (Atrill et al., 2001). This is a significant issue given that disclosure of some details of the nature of an impairment or health condition is key to accessing ‘reasonable adjustments’ – either through invoking legislative rights or on a more informal basis (Adams and Oldfield, 2011).

Muniri et al (2005) explored the role of self-management of chronic illness at work in a higher education setting, as a predictor for self-disclosure. Their sample of 610 disabled people completing a tailored questionnaire found that chronically ill employees adopt a disclosure strategy specifically related to different self-management needs of chronic illness at work. For example, for partial disclosure, a greater reported experience of chronic illness by employees was positively associated with self-disclosure. For full-disclosure, employees were more likely to report disclosure to line managers if they had already disclosed to colleagues and if they perceived receiving support from their line managers in relation to their chronic illness as important. Academics were least likely to disclose amongst the occupational groups. Some studies documented the impact of previous experiences of discrimination on disclosure (Adams and Oldfield, 2011; Fevre et al, 2013).

Allan and Carlson, (2003) interviewed participants to gain insight into the disability-to-employment transition experience regardless of their diagnosis. Of the 11 psychosocial themes that emerged from the data, concealment was one that was frequently and spontaneously identified by participants. The theme of concealment in the disability-to-employment transition was explored in detail. RADAR (2010) found that people with mental health conditions were nearly four times more likely than other disabled people to be open to ‘no one’ about their impairment; and less than half as likely to be open to everyone. Other groups that disclosed potentially hidden impairments – long-term health conditions or learning difficulties – were more likely than other disabled people to be open to everyone (RADAR, 2010; Richards 2012). There is some evidence that asking for extra support can be experienced as demeaning and finding colleagues and managers overprotective (Royal et al, 2009) or be embarrassed as in the case of following treatment for gynaecological cancer (Grunfield and Cooper, 2012) or prostate cancer (Coates et al, 2013). The latter research included a case study of an NHS worker who took the decision not to disclose his diagnosis to work colleagues until his return to work. He suggested that his reasoning was driven by a desire not to receive ‘solicitous gestures’ of sympathy.

People with mental health conditions were nearly four times more likely than other disabled people to be open to ‘no one’ about their impairment; and less than half as likely to be open to everyone (Stanley et al, 2007; Sallis and Birkin, 2013) and two thirds of employees in one study said that they wouldn’t tell potential employers about their mental health problems because they feared discrimination (Marwaha and Johnson, 2005). Biggs et al (2010) cited a high level of employers

concern around employing people with mental illness reporting issues of trust, needing supervision, inability to use initiative, and their perception that employees would not be able to deal with the public including both those with either existing or previous mental health needs. Stanley et al (2007) explored the dual identity of social workers experiencing depression in the workplace as both professionals and mental health service users which focuses attention on the barriers which the profession constructs between those who use and those who deliver services. This is not a consistent picture as a national survey of social work practitioners and managers describing the workplace response to depression in the workplace (Manthorpe et al, 2002) reported only a small proportion of their colleagues – 6% in a survey of 499 – were experienced as critical or hostile although where this did occur, it was more likely to be their managers acting negatively. There is evidence that active support for people with enduring mental health conditions such as schizophrenia, bi-polar and depression (Scheider et al, 2009) can do well with targeted support. The views of 15 individuals with psychosis (Marwaha and Johnson, 2005) revealed a universal strong belief by them that employers would prefer not to employ people with mental health problems. Other groups that disclosed potentially hidden impairments – long-term health conditions or learning difficulties – were more likely than other disabled people to be open to everyone (RADAR, 2010). People with Asperger syndrome who may typically have social and emotional difficulties and problems with processing verbalised information, as well as difficulties with imagination in an employment situation, can experience difficulties with team working, coping with office "banter" and adapting to change. However, evidence has suggested that, given the right support and encouragement, adults with Asperger syndrome are capable of negotiating key employment-related social situations, such as job interviews, team working and the broader social conventions of work organisations (Attwood, 2007:Richards, 2012). Further, jobs that are administrative, professional or technical in nature, can be well suited to the educational and intellectual capabilities of the individuals involved (Howlin et al, 2005).

There were a number of issues about expectations of disabled employees working to full 'capacity'; getting sufficient time off for medical appointments and periods when employees are unable to work to their full ability (Atrill et al., 2001; Brown, 1998; Rooke-Matthews and Lindow, 1998; Lock et al, 2005). Biggs et al (2010) which explored employers' attitude towards employees with mental illness demonstrated that they were willing to allow flexible working hours, job sharing and temporary assignment of duties to other colleagues to accommodate sick leave. Some studies have documented the impact of previous experiences of discrimination on disclosure. Allan and Carlson, (2003) interviewed participants to gain insight into the disability-to-employment transition experience regardless of their diagnosis. Of the 11 psychosocial themes that emerged from the data, concealment was one that was frequently and spontaneously identified by participants. The theme of concealment in the disability-to-employment transition was explored in detail. Relevant implications are identified for vocational rehabilitation professionals.

How well do NHS organisations make reasonable adjustments for staff with disabilities, from the recruitment process to the end of employment?

One of the issues for the NHS posed by the literature is, if a profession cannot offer its members the support and structures that they require to manage the demands of the work within the workplace, the outcomes may be further insulation from the communities they service and a reputation for poor mental health. The majority of research we found here engages with the narratives of disabled people either entering, in or leaving employment. Coole et al (2010) found that managers appear to have limited expertise in modifying work for employees with low back pain, so that employees have to make their own modifications or arrange these informally with line managers and/or colleagues in order to remain in work. Their study of 25 patients from a range of professional, skilled and manual occupations, aged between 44-67yrs and with a history of back pain prior to attending a rehabilitation programme, found that getting help was very dependent on the individual manager. People with back pain were able to easily modify their workload if they had control but found that some managers could

also be overcautious which led to restrictions. The need for a more seamless approach between rehabilitation programmes and return to employment is also noted (Lock et al, 2005). Marwaha and Johnson (2005) documented the views of employees with psychosis working in North London that they were discriminated against when they became ill, and also on their return to work, or even bullied by managers about their disability (Foster, 2007). It appeared that this was often disguised; for example being asked to move to an area, where it was not so easy to commute or being asked to take a demotion. Out of the 15 participants, 6 wished to work only part-time as they felt they could not cope with starting full time directly from unemployment. Problems associated with adjustments are consistently related to immediate line managers or heads of department (Foster, 2007; Lock et al, 2005) including sick leave arrangements and timely provision of equipment supporting evidence that employers do not understand their legal obligations (Lock et al, 2005).

Other disabled employees (Foster and Fosh, 2010) reported that the very act of requesting workplace disability adjustments was itself interpreted by employers and confrontational. They referred to instances at work where disability related decisions were made about them with little or no consultation and some cited situations where the legitimacy of their requests for adjustments was questions, as well as struggling to secure basic, but essential, alterations to their working arrangements and environment. This appeared less so in the studies of employees returning to work after a cancer diagnosis (Amir et al, 2007; Grunfield et al, 2010). There were also differences in perception between people returning following cancer and myocardial infarction (Grunfield et al, 2010) where human resource personnel were less likely to report that an employee with cancer would have control over their cancer at work. In the case of 55 GP practices in North England, colleagues were described as having helpful attitudes but changes had not been made to the practice workplaces or systems to retain GPs and staff at work. This is significant given current issues on retention of GPs in the workforce (Purvis, 2014). For example only 76% of 100 practices provided access to a disabled toilet.

Some disturbing findings (Foster, 2007) allude to the stress and ill-health that can be consequential to failure of the workplace adjustment process often related to the absence of formal organisational procedures for implementing adjustments and the need for further education and training among line managers. The stress of returning to work can be particularly damaging in the context of particular conditions such as stroke, where it may have been a contributory factor in the first place. Some disabled employees can be cautious of returning to former stressful work settings even where this was a valuable stage in their road to recovery (Alaszewski et al, 2007; Grunfield and Cooper, 2012). In addition, women in a study on recovery from gynaecological cancer spoke of reduced confidence regarding their ability to perform in the workplace (Grunfield and Cooper, 2012) which perpetuated anxiety and stigma. Managers themselves are less likely to be offered workload support or reduction and flexible hours, particularly in relation to depression (Manthorpe et al, 2002). This latter study suggested that when asked what support people experiencing depression would like, the largest group of suggestions concerned the need for more understanding and support from the workplace.

Appraisal rates for staff with disabilities compared to non-disabled staff: Do staff with disabilities have similar levels of access to training and development as non- disabled staff?

Both of these research questions are supported by the literature relating to career progression of disabled people. There are two competing discourses arising from those studies using narrative inquiry (Wilson et al, 2008) which suggest that the treatment of disabled professionals is paradoxical. On the one hand there is a story of success, encouragement, support and professional development where disabled people had broken through the metaphorical glass ceiling (Haslam and Ryan, 2008). On the other, evidence of rigid equal opportunities policies, ineffectual human resource departments and a lack of organisational knowledge in relation to disability combined with paternalism and lack of

accommodation to specific needs. The literature in relation to career progression and job satisfaction illustrates a strong connection between several contributory factors.

Wray et al (2009) found that older nurses experienced less access to Continuing Professional Development than younger nurses and that ill-health/work related illness may be a particular risk factor for older nurses. This older group of nurses are likely to experience key areas of inequality and demonstrates that people facing discrimination and also face barriers when accessing Continuing Professional Development.

The picture is not always a negative one however as there is some literature emerging which documents the achievements of disabled people particularly in leadership and senior positions. RADAR, (2010) undertook the first ever national survey of senior directors, directors, non-executives and more of their experiences and found a significant senior disabled talent pool: people living with ill-health, injury or disability who are 'flying high'. A survey of 1461 people (911 disabled and 550 non-disabled people), followed by 50 structured interviews with disabled high fliers and employment professionals (in leadership, occupational health, human resources and recruitment) and found that based on their experience identified nine recommendations for individuals and organisations so that more people can follow and build. Some of the recommendations for Employer leadership included:

- Set a culture of respect and high expectations of what disabled people can achieve
- Model open conversation about disability, mental health (and other differences)
- Adopt a proportionate approach to risk, ensuring disability and health conditions are not viewed - explicitly or implicitly - as grounds for screening people out of employment or promotion
- Benchmark and review cultural change and employee confidence
- Make available senior support, mentoring and development for staff with disabilities
- Commit to spotting, supporting and developing talent
- Take action to enable managers to develop and get the best out of diverse teams
- Measure and report on change: rates of recruitment, promotion, time in grade and take-up of development opportunities – by disability

Within the wider career literature, careers of disabled academics have been rarely studied (Lucas, 2008). Williams and Mavin (2015) examined some of the micro practices of the academy which contribute to the career boundaries experienced by disabled academics. Networking is central to, and characterizes, academic careers, and formal and informal knowledge sharing opportunities, such as those afforded through conferences for example, are an important mechanism to facilitate such networking. Their study of 8 women disabled academics found that they made career shaping decisions which include a consideration of their own or other organisational members' willingness to support or constrain ways of working with impairment effects. The notion of academia as a 'greedy institution' (Acker 1983, 192) which requires 'continual commitment' meant that disabled academics who extend the 'flexibility' of academic work to accommodate impairment effects rather than challenge normative expectations may also experience career limitations. Disabled academics who are unable to commit the personal time or achieve productivity levels (in research outputs for example) usually expected to develop an academic career, will therefore be at a disadvantage. Williams and Mavin (2015) research suggests that reduced networking opportunities through conference attendance, restricted to 'physically manageable' conferences, can limit career prospects through constrained knowledge sharing opportunities and these findings call for the use of increased technologies and affirms the insight that disabled academics strategize and negotiate organizing contexts other to achieve, or negate, impairment effects related requirements in order to do well. Overall we found that the literature in relation to appraisal was relatively weak in terms of research.

A number studies documented weakness in some professional bodies handling of disability issues where there is 'Disability blindness' and an absence of policy recommendations, monitoring procedures and proactive training and guidelines such as in the accounting industry (Duff and Ferguson, 2011). Disabled participants have referred to the need for networks across professional bodies so that disabled members can share advice and benefit from each other's experiences (Duff and Ferguson, 2011; Williams and Mavin, 2015). Foster and Wass (2012) through their documentary analysis of employment tribunal transcripts explored the reasons why employers are not flexible enough. They found that the complex design of many modern jobs and largely unchallenged assumptions of what constitutes a typical or ideal worker are deeply embedded in the practices, policies and culture of organisational life. Legislative provision of making reasonable adjustments relies on a medical model of disability, yet medical opinion is marginalised in organisational decision making. They found that managers who were wedded to the concept of a 'standard worker' will view an adjustment as disruptive or unworkable, and costly in terms of time and resources. As decision makers, managers may prevent the revolution in attitudes, values and social prejudices in the operational contexts. For example, the effects of reorganisation often increases the number and variety of tasks included in a job description and results in tighter more inflexible jobs that can exclude or highlight the impairments of disabled workers. The effect of team based performance targets adds a further layer of inflexibility.

Black (2008) recommends an enhanced role for occupational health specialists who tend to be marginalised and regarded as advisory, rather than educational by inflexible managers. In their analysis of the issues presented at employment tribunals, Foster and Wass (2012) they recommended that employers address ill-treatment in the workplace either as a formal part of the internal grievance process or as part of an investigation that precedes this. They recommend that before a case reaches court employers should be obliged to demonstrate that they have engaged with advisory bodies in a meaningful way and have sought to resolve disability-related disputes using valuable independent expertise. This was echoed in Coole et al (2010), who reviewed modifications for employees with back pain. Consultations with clinicians to whom employed people with back pain had been referred for multi-disciplinary rehabilitation, found that the advice received as a result of the consultation varied in its adherence to occupational guidelines. It appeared rare for occupational health personnel to meet with anyone other than the patient with the patient having to act as a conduit between occupational health, their employer and their GP. Whilst based on a small convenience sample of 25 qualitative employees with back pain, this study provided some valuable insights into the inconsistencies of how reasonable adjustments are made, and how these depend on personal relationships rather than the disabled person's rights.

In 2005, a UK wide postal survey of NHS and Primary Care Trust nurses and midwives was developed following a literature review and analysis of National Health Service and Government policy documents (Wray et al (2009).The forty four Trusts identified as having policies relevant to the study were contacted regarding the procedure for seeking research governance approval. Thirteen National Health Service Trusts and Primary Care Trusts participated, with 2610 questionnaires distributed; 510 were returned (20% response rate). Having a work-related illness had a negative impact on both quality of life and psychological morbidity. In relation to ethnicity, black nurses and midwives reported lower psychological morbidity than other ethnic groups; that is, they enjoyed a higher level of mental well-being.

How well are staff supported who become disabled during the course of their employment? Is there a process for recording this on the staff survey?

According to the research identified, the lived experience of discrimination, stigmatisation and marginalisation is broadly similar regardless of whether an individual's disability is acquired or been lifelong. Within a stratified sample of 20131 management, field, residential and home care workers

across five social services departments in England, McLean (2005) estimated the proportion of workers in statutory social services employees in the UK with long term illness or disabilities as being over a fifth with 8% affecting daily life. She examined the distribution and nature of these through the effects of gender, age, occupational categories and work experience such as job satisfaction, stress and sick level. What employers do to help people adjust seems to be important in the studies examined. There is limited evidence in the UK on the impact of acquired disability during paid employment. Looking specifically at the impact of a diagnosis of cancer and their experiences of returning to work, Amir et al (2007) reported on the outcomes of multivariable logistic regression analysis and work life measures based on a questionnaire with 267 eligible patients with a median age of 48yrs and their GPs. Statistically significant differences in return to work rates were found by the length of sick leave taken, with more than 90% of those with sick leave duration of less than 12 months returning to work, compared with 62% with sick leave of 12 months or more. Out of those with less than 6 months leave taken, 94.5% returned to the same employer; whilst those with longer sick leave (more than 18 months), only 71.4% returned to the same employer.

Luker et al (2013) found that 73% employers and line managers did not ask the respondent to set an exact date for returning to work after a diagnosis of cancer and 73% stayed in touch while respondents were absent having treatment. Having not anticipated the time needed to recover and dealing with expectations of their employer or colleagues once they returned can also be related to whether the individual looks well or not (Kennedy et al, 2007). Women returning after breast cancer for example felt apprehensive that if they were looking well, this might mislead employers into thinking that they had completely recovered and they found managing these expectations difficult (Kennedy et al, 2007). Amir et al (2007) said that one fifth of those who returned reported deterioration in their job satisfaction and career prospects which was highest in those who took longer periods of sick leave. Overall, 82% of cancer patients who were judged by their GPs as having reasonable chances of returning to work did so.

On the other hand, a much rarer condition such as Guillain-Barre syndrome with a smaller in-depth sample of 5 to explore returning to work experiences (Royal et al, 2009) found that participants were very oversensitive to the reactions of others at work. Most of them dealt with potential loss of self by trying to conceal their impairments or by avoiding discussion, and were ambivalent about accepting support and making other adaptations. This was despite having been prepared through education and inpatient rehabilitation. Building enablers for supporting continuing employment into the rehabilitation process was a recurring issue for example for people surviving stroke (Lock et al (2005). Flexibility in the workplace was also found to be short-term.

What are the numbers of staff with disabilities who are the subject of employment processes and procedures, for example disciplinary and capability processes?

This was an area in which we did not find any significant studies. Much of the workplace research that explores the relationship between disability and performance is designed based on social models where researchers attempt to show that differences in performance evaluations are based primarily on negative stereotyping. Reilly et al (1998: 40) found that the performance of a teacher portrayed as learning disabled was rated more harshly than the performances of teachers portrayed as physically disabled or non-disabled. Though knowledge regarding the disability–performance interface is expanding, the literature is not particularly robust. First, the majority of studies from the social paradigm assume or portray disabled and non-disabled employees as having equal ability. While this often is a deliberate manipulation done to elicit stereotypes, this equality condition does not allow for the possibility that a disabled employee's performance may not be equal to that of his or her peers. For example, conditions such as depression or chronic pain are rarely static (Zola 2005), so the employee's abilities may fluctuate. In addition, this may be made difficult if employees are being returned to the workplace too early following a disabling incident and before the full extent of their

capabilities is understood (Krause et al. 1998). In a return-to-work scenario, a disabled employee with a significant history with the employer may influence the expectations of supervisors and co-workers. While past performance has been recognized as a factor affecting employer efforts to accommodate (Florey and Harrison 2000: 230), very little research has featured the interface between disability and work history. Disabled employees are not necessarily capable of performing the tasks they have been assigned, thus capturing the variability and uncertainty of many health conditions.

A Canadian study (Williams-Whitt and Taras, 2010) tried to captures the physical and social experience of disability by analysing the practical performance problems that arise when an ill or injured employee returns to work, and documenting how those problems are interpreted. They used a grounded theory approach to suggest an alternative to the traditional biomedical or social perspectives on disability. Their field research revealed four themes: attendance, disciplinary history, peer interaction and task function. Managerial and co-worker perceptions were significantly affected by interactions that occurred before any disability was known to exist.

What are the turn-over, retention and stability rates for staff with disabilities within the NHS?

Jahoda et al (2009) found that a quarter of people in a sample of 35 individuals interviewed with intellectual disabilities in supported employment had lost their original jobs at a follow up 9-12 months after starting. The literature points strongly to the importance of developing and keeping under review the impact of employment support initiatives as well as training and support of employers to ensure that they meet their legal obligations and acquire the soft skills and leadership to ensure workforce development. The second area of importance is the interface between the HRM functions/systems and organisational disability-management policies (Cunningham et al, 2004). The effectiveness or ineffectiveness of these impact directly on relationships and effective communication between HR, Occupational Health, Trade Union and management personnel with the disabled employee supported by clear policies, procedures, training and guidelines to enable support to be identified, implemented and reviewed.

Schneider and Dutton (2010) used Delphi methods to draw on the expertise of a national sample of 100 employers of disabled people, and a similar number of Disability Employment Advisors (DEAs). They analysed their existing attitudes towards disabled employees before analysing the effect of the National Minimum Wage on these views. Differences between employers and DEAs were found in relation to the perceived costs and obstacles to employers of taking or retaining staff with disabilities, the problems presented by specific disabilities and the motivation shown by staff with disabilities. There was general agreement that the National Minimum Wage has benefited disabled people by making low paid jobs better paid. A minority of respondents thought it had created additional obstacles to employment for disabled people. Some disabled employees appear to have been adversely affected by the interaction of the National Minimum Wage with the Supported Placement Scheme (now known as ‘Workstep’) and the benefits system. They concluded that understanding employers’ perspectives may facilitate the promotion of work opportunities for disabled people.

Lewis et al (2013) looked closer at the national supported employment programme WORKSTEP from the perspective of 98 participants’ qualitative experiences from a sample of 11 providers which were overwhelmingly positive. This finding is valuable for considering in the light of ongoing welfare reform as well as recessionary pressures on labour markets and employment services. Some critique that these are emphasising individual solutions to employment problems and may overlook the need for more broad-based, social interventions (Barnes, 1992; Evans, 2007). Lewis et al suggest that the government programme of welfare reform (DWP, 2010) is premised on the belief that some unemployed people are choosing not to find employment with increased conditionality and sanctions (Patrick 2011) and narrower eligibility to benefits for example for the new Personal Independence Payments (Disability Rights UK 2013) and the introduction of a time limit of 1 year for eligibility for

Employment and Support Allowance (Welfare Reform Act 2012). Empirical evaluations have demonstrated however that the 'in-work' policies which help people retain employment have been more effective, although they have been reliant on employers adopting good practices and implementing cultural changes. Interventions with that not in work have been less effective.
There has been extensive debate over whether interventions should be focused on the individual disabled worker or job-seeker, rather than on the workplace (Smith 2010).

Grover and Piggott (2010) suggest that initiatives focused on improving disabled people's skills, training, and qualifications, and on practical equipment and gadgets, rather than on employers' or colleagues' discriminatory attitudes and institutional arrangements tend to draw on a 'a medicalised model of sickness and impairment' that aims to fit the 'sick' disabled person into the workplace rather than adjusting the workplace (p. 272). This also overlooks the role that work plays in wellbeing, personal development rather than financial reward. Overall the flexibility of support should incorporate adaptation of the workplace alongside changes to working conditions and cultures and to how staff relate to each other. Findings emphasise how disabled people particularly valued working in environments where colleagues, peers and managers were supportive.

A study of 67 disabled graduates making the transition from higher education to employment (Williams, 2013) indicates that whilst they share many of the same experiences as non-disabled graduates, the recruitment process hindered how disabled graduates manage and navigate the UK labour market. Obtaining the reasonable adjustments needed for participating in assessment centres were problematic although assessment centres were considered to be fairer than other selection techniques to minority groups where competency based HR practices were used. Williams found that disabled graduates were active agents in executing coping strategies to deal with any negative situation they found themselves in, and the use of agency and synergy between LGBT and disabled graduates in developing coping strategies as a student came into play. Support in the form of job trials to illustrate the adjustments needed and having access to a network, a form of social capital including professionals, families and friends were an important source of locating skilled employment. The experience of gaining employment from the perspectives of students with learning disabilities again using qualitative interview data (Skeller and Astbury, 2012) revealed some interesting insights into the different roles that people take up that impact on gaining meaningful employment. These were the 'protector' referring to the required attention and prolonged involvement of parents; the 'rescuer' providing guidance and encouragement for students to become more accustomed to self-management and independence and 'worker' where all students who participated in the interview expressed their enjoyment of time spent at collaborating organisations and appreciated the work based placements and/or employment opportunities.

For people with intellectual disabilities in supported employment, Jahoda et all (2009) examined the social and emotional experiences of 35 people in relation to their levels of satisfaction when they began supported employment and how these changed as they became more established in the workplace. Most of the reported experiences of moving into work were very positive in bringing a greater sense of purpose and self-confidence, a feeling of autonomy and financial control, and an enjoyment of meeting people in the workplace. Continuing fears were also expressed about having a tenuous position in the workplace and a quarter of the sample had lost their original jobs at follow-up. This finding is particularly striking, given the fact that this was a relatively able group of individuals. Many participants appreciated that consideration was given to their difficulties and that they were not subject to the same demands as other workers, although others felt at follow-up that greater accommodation should have been made for their particular needs. A related study (Schneider et al, 2009) investigating how people with severe mental health problems fared in existing supported employment through a sample of 6 agencies in England placing them, was able to identify factors associated with successful placement in work and to test the impact of working on the psychological well-being in this group. They used a large detailed sampling method, demographic information and a

range of statistical data tests on questionnaire data including baseline and follow up interviews with people with mental health. Findings revealed that the support agencies helped 25% of unemployed clients into work, a statistically significant increase in the proportion of clients in employment. Gaining employment again was associated with improvements in financial satisfaction and self-esteem and there was a trend towards working half time. People who had been out of work longer were less likely to secure employment. There were no significant associations however between getting a job and personal characteristics, the quality of employment support given, nor the recipient's rating of the support offered. Given that partners in the study included four leading third-sector providers, the DWP and one mental health trust, this study offers a lot of evidence for the social inclusion of employment support for adults with mental illness. Biggs et al (2010) found that employing managers in small businesses Western England were unified in stating that they would think twice about hiring someone with a mental illness and had a range of negative beliefs and concerns about clinical factors such as frequency of episodes and relapse, control and severity of the illness, more so than the recruitment agencies who promoted them.

Kate Nash Associates (2014) used a questionnaire about challenges and current practice with regard to monitoring. The initial findings of the survey were shared with 41 employer partners during five focus groups to discuss the early findings and record their reactions. They found that while employers acknowledged that a monitoring exercise might be seen as transactional for the employer, it is often personal and emotional for the employee. Employers acknowledge that this is the case in both formal monitoring exercises and at other times when colleagues share information about their disability. This is a key challenge for employers. The employers surveyed expressed their need to improve their data capture but want to do this by better reflecting that they understand this key dynamic. Many feel constrained by structural and procedural systems that do not allow for imaginative and 'human' communication methods. One or two employers expressed disappointment in their legal teams; having to balance a strategic imperative to communicate that the business wants to do well by its people with the risk of non-compliance in delivering workplace adjustments

The employers surveyed recognised that language can often get in the way of building an accurate picture about their workforce. The vast majority are keen to find new approaches to make it easier for people to share information about their disability and to respond in appropriate ways. Employers suggested that there are two key reasons why they want better data. Firstly, to create better plans in order to reduce barriers for groups of people at a business (macro) level and secondly, to create better processes to make specific adjustments at the individual (micro) level. Employers recognise the need to be clearer about specifying the limits to which they will use/pass on information that is given in monitoring processes and to specify why they asking for information and in what context. Most of the employers also suggested that they need to get better at signposting individuals to information about what adjustments they can get, and how to do so. 75% of the employers expressed concern about whether their processes (to data capture) were 'joined up' or consistent.

Employers repeatedly stated their wish to convey the message that disability and ill-health are normal life events. Employers wished to start with the principle that they are likely to be able to make an adjustment (which both parties will want to be reasonable – or which 'feels fair'). Of those surveyed, 38% had a centralised budget for workplace adjustments.

A consistent finding from UK research is that line managers are not provided with the necessary skills to perform the HR aspects of their jobs effectively. Cunningham et al (2004) echo recent research that indicates how line managers in the face of other business pressures are not equipped to provide support to facilitate the return to work and continued employment of people who become disabled. Only a minority of workplaces have access to functional specialists such as occupational health professionals, ergonomists, health and safety practitioners, or even a general medical practitioner (Pilkington et al., 2002). They cite other studies (Industrial Relations Services, 2001; Labour

Research, 2002), that further highlight the possibility of tensions between the goal of offering supportive and sympathetic treatment and the requirements of disciplinary policies. Cunningham et al (2004) reveal how these tensions are largely played out at the level of the line manager who has to resolve the contradictory requirements of these policies which they refer to as “ad hoc, fragmented and ‘hard’ nature of many approaches to HRM adopted by UK employers” (p289).

What difference does the ‘two ticks’ symbol make to recruitment and employment?

Launched in 1990, the ‘Positive about disabled people, two tick’ symbol has been one initiative to meet responsibilities on public sector organisations to promote disability equality by encouraging employers to sign up to voluntary standards and make commitments to introduce changes to promote greater equality. Employers displaying the symbol have been expected to adhere to five commitments:

1. To interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities
2. To discuss with disabled employees, at any time but at least once a year, what both parties can do to make sure disabled employees can develop and use their abilities
3. To make every effort when employees become disabled to make sure they stay in employment
4. To take action to ensure that all employees develop the appropriate level of disability awareness
5. To review the commitments each year and assess what has been achieved, plan ways to improve on them and let employees and Job Centre Plus know about progress and future plans.

The Two Ticks symbol has been awarded to 8,387 organisations since its launch in 1990, and is used by nearly half of the top 200 FTSE companies (Hoque, 2014).

There is little independent monitoring or governance arrangement to review how employers meet the five commitments they are expected to uphold (Trades Union Congress, 2009). It is Job Centre Plus policy to audit employers’ adherence to the commitments annually, but it does not keep data on how many reviews have been undertaken and how many of these reviews have resulted in the symbol being withdrawn (DWP, 2012). The little research undertaken on the impact of the ‘Two Ticks’ symbol on employer disability practices has not provided evidence of its efficacy. Hoque et al (2014) analysed the adherence to the five criteria between ‘Two Tick’ and ‘non-Ttwo Tick’ employers. They also explored the levels of support for disability champions in two tick employer contexts, for both the private and the public sector. They found only limited adherence to the five criteria in ‘Two Tick’ employer locations, and no evidence that it was any better than with ‘non-Two Tick employers. Also there was little evidence of support for disability champions in the two tick workplace locations studied. Hoque et all found that only 15 per cent of organisations awarded the Two Ticks symbol kept to all five of its commitments, with 18 per cent of those signed up not fulfilling any of them; nearly two-fifths – 38 per cent – only kept one of the promises. Hoque concludes: “ there was no difference in the support and commitment to disabled workers between companies who had the Two Ticks symbol and those who did not have it. It suggests that the symbol may often comprise little more than an ’empty shell’, where employers display the symbol for impression management purposes to take advantage of its potential reputational benefits rather than because of a genuine concern for disability issues.”

Drawing on data from a survey of trade union Disability Champions and using multivariate analysis, Hoque et al (2014) concluded that:

- There was little evidence that the commitments were more widely adhered to, or that support for and dialogue with Disability Champions was any greater in the Two Ticks than in the non-Two Ticks workplaces.
- There was no consistent evidence of a stronger Two Ticks effect in the public than in the private sector, suggesting that in both sectors the symbol may often comprise little more than rhetoric.
- The five commitments employers are expected to uphold is dependent on employer goodwill, and compulsion is seen as neither necessary nor desirable. Hence, there is significant scope for employers who do not perceive a business case for adhering to the five commitments to display the symbol for impression management purposes or to take advantage of its potential reputational benefits rather than because of a genuine concern for disability issues.
- The Two Ticks symbol will continue to lack substance unless it moves away from its neo-liberal underpinnings, and a degree of regulation, possibly in the form of an independent awarding and monitoring body as called for by the Trades Union Congress (2009), is introduced to ensure compliance with the five commitments.

Hoque et al (2014) suggested that their findings have implications for the public sector Disability Equality Duty and the provision of support and increased dialogue with Disability Champions could be viewed as ways in which public sector managers might demonstrate adherence to the duty.

Section 5: Discussion of results

The purpose of this section of the report is to discuss in a more reflective and integrated way the major findings of this study. For this reason, some of the major headings from the results section will be followed. In addition, some of the key findings from the literature review section will be used to locate the findings from this study in a broader policy and practice context.

Representation of staff with disabilities at all levels of the NHS and covering different types of disability

It is remarkably difficult to arrive at a clear-cut figure as to the overall numbers of staff with disabilities in the NHS. At the most fundamental level, there is no data concerning kinds or degrees of disability. Disability is not a uniform state or condition, and has numerous physiological, psychological and social consequences, which are specific to particular conditions. Furthermore, there is the enormous difference in reported disability prevalence between the ESR (1% medical staff; 3% non-medical), and the NHS staff survey (17%). Based on information from both data sets, there is considerable variation both within and between different categories of Trust, and between geographical regions. Both data sets need also to be discussed in terms of the problem of disclosure (see below for a discussion of required versus anonymous self-disclosure).

However, for a substantial proportion of staff recorded in the ESR, no clear information is available at all, given the high rates of ‘Unknown’ (22%) and ‘Non-disclosure’ (17%) in the record. It is highly probable that both these categories contain staff with disabilities, but it is not possible to estimate what that figure might be. Ambiguity over the numbers of staff with disabilities also extends in a number of other directions. There are large differences in the different professional and occupational groups with respect to disability, varying from 11% -25%, but the rates of ‘Unknown’ and ‘Non-disclosure’ are higher for some groups than others, making firm conclusions about occupational differences less possible.

It is worth noting that other large data sets such as the Labour Force Survey (e.g. LFS, 2011, Qtr2) have reported higher overall levels of disability in the workforce. The LFS records a level of around 30% of the working-age population who self-disclose a long-standing illness or disability, of which 56% report a limitation to their activities of day-to-day living or their ability to work. Working with a more restricted workforce focus, social service departments, McLean (2005) estimated the proportion of workers in statutory social services in the UK with long term illness or disabilities as being over a fifth. Eight per cent said that these conditions affected their daily life and McLean further examined the distribution and nature of these through the effects of gender, age, occupational categories and work experience such as job satisfaction, stress and sick leave.

An important finding in our data is that relatively more staff with disabilities were in administrative roles, and that proportionately fewer staff with disabilities were represented at the higher echelons of management. This finding has received confirmation from other sources. Wray et al (2009) found that older nurses experienced less access to Continuing Professional Development than younger nurses and identified that ill-health and work related illness may lead to particular disadvantages in the workforce. Bogg and Hussain (2010) conducted a quantitative evaluation of data relating to 120 radiographers’ perceptions of equality, diversity and career progression in the NHS, drawing on data from a larger study on 1496 allied health professionals. Disabilities were seen as one of the biggest barriers to career progression (67%), which was more than the barriers for women (55%).

In summary, it is difficult to come to any firm conclusions about the overall prevalence of disability in the NHS workforce. A ‘best guess’ might indicate that overall prevalence levels lie between 3%-17%,

although this assumes that the NHS annual survey is a ‘top of the range’ figure, not influenced by additional factors such as inhibitions on disclosure. However, such a ‘guestimate’ is made more complex by the different definitions used by the ESR and the NHS staff survey. Added to this, disclosure is at point of entry and not reliably updated in the ESR all of which makes the ESR reported rates of disability likely to be a substantial underestimate. In addition, the large proportion of staff in the ESR (around 39% in the 2014 survey) for which information is either unknown or not disclosed, makes any general conclusion problematic.

Our analysis of the available data as it stands does suggest that staff with disabilities tend to be older, and to have worked longer in same Trust; in addition, they are more likely to be in administrative roles, and are less well represented at more senior management levels, including at the consultant level.

The problem of definition

The NHS Staff survey definition is broad and inclusive in that it refers to a statement of: ‘having a long-standing (meaning that it has lasted, or will last, at least 12 months) illness, health problem or disability’. There is no independent medical confirmation of the particular illness or impairment concerned, and the definition also seems to assume a necessarily permanent and static rather than episodic, fluctuating or degenerative long-term condition. As has previously been discussed, the ESR definition is narrower in focus and scope, referring to: ‘A physical or mental impairment which has a substantial and long-term adverse effect on a person’s ability to carry out normal day-to-day activities. Substantial is more than minor or trivial’. This is the definition underpinning the 2010 Equality Act. Like the survey definition, it relies on self-reporting and seems to assume that disability once recognised, is permanent, and does not fluctuate, degenerate or improve. Furthermore, both data sets do not allow for any more specific analysis between different disability types. In conclusion, the fact that there are two different definitions, with common potential problems in interpretation, being used by the two surveys is not helpful, and does not make comparison between the two data sets easy.

The issue of required versus anonymous self disclosure

Estimating the number of disabled individuals either entering, currently in and exiting the workforce poses enormous challenges for definition, disclosure as well as deception which can arise where stigmatising conditions are involved (Rooke-Matthews and Lindow, 1998). For the disabled individual, the personal impact of disclosure may have negative consequences for relationships at work, the ability to stay in work, career prospects and sympathy for sickness absence or time off for medical appointments (Atrill et al., 2001).

As previously discussed, in the NHS staff survey, self-declaration is anonymous, which gives the individual the freedom to self-declare – or not – as disabled, within the definition provided. It is arguably too loose and ambiguous a definition to enable any great clarity as to what is included or excluded. On the other hand, the freedom it gives the individual to define their ‘disability’ on their own terms is a great advantage of the NHS staff survey approach.

The survey evidence suggests that reported levels of disability increase with age, varying from 11% for staff aged 16 -30, to 22% for staff aged over 51. This implies that the discrepancy between the ESR and the staff survey is likely to be greater with older staff members. It is a severe limitation of the ESR that disability is recorded at point of entry to the workforce, but does not have a reliable method for updating the information and therefore for identifying staff who develop a disability after their career within the NHS commences.

There were in the ESR fairly high levels of staff who did not disclose information about disability (4 – 30%), or for whom information was unknown (11-43%). The variation is occurs within regions and within occupational categories. There may be many reasons why staff are unwilling to declare a disability. These include:

- Fear of prejudicing an appointment during the initial job interview
- Fear of harming promotion prospects
- Fear of facing discrimination, stigma and harassment

Munir et al (2005) found that employees in a higher education organisational context with long term disability adopt a disclosure strategy specifically related to how they feel they need to manage their disability to their colleagues and managers. For full-disclosure, employees were more likely to report disclosure to their line managers if they had already disclosed their disability to colleagues and if they perceived receiving support from their line managers in relation to their chronic illness as important.

The complicating factor in generalizing these findings to the NHS context is the 12 percentage points higher levels of bullying and harassment experienced by staff with disabilities in the NHS from managers, relative to non-disabled staff. In other words, a disabled NHS staff member is less likely to fully disclose to their manager, if the manager concerned is perceived as bullying them. This in turn reflects a broader issue of managerial trust amongst staff with disabilities. This is unlikely to be present when risk of managerial bullying and harassment is high.

How well supported are staff who become disabled during the course of their employment?

It is difficult to find data in the NHS staff survey or the ESR which addresses the question of staff support directly. However, 'proxy' indicators are available in the staff survey on appraisal, bullying and harassment, pressure to work when feeling unwell, perception of opportunities for career progression, and levels of job satisfaction that staff report.

Across all NHS staff, the 2014 staff survey reported that 28% of all staff rated themselves as having experienced harassment, bullying or abuse from patients, their relatives or the public. Although slightly reduced (by 1%) from 2013 figures, this still represents a very large level of perceived bullying and harassment. Almost a quarter (24 percent) of staff said that they experienced harassment, bullying or abuse from their manager or other colleagues. It is significant to note that, relative to staff without disabilities, staff with disabilities reported substantially more bullying and harassment across the board, from patients, and also from colleagues and their managers. With respect to patients and their relatives they experienced seven percentage points more. This increased still further with respect to perceived bullying and harassment from managers, team leaders or colleagues (12 percentage points more).

This is an alarming finding. Bullying and harassment by managers and/or colleagues is reported by over one fifth of staff without disabilities (22%). Levels of reported bullying and harassment by management and/or colleagues for staff with disabilities are 12 percentage points higher than this,. Clearly, for very large numbers of disabled staff, far from being supported by their managers, managers are themselves a significantly greater source of bullying and harassment than they are for non-disabled staff. Another very telling finding in this respect is that large numbers of staff with disabilities reported feeling under pressure in the last three months from managers to attend work whilst feeling unwell (11 percentage points more than non-disabled staff). The indications here are that ethnic minority staff with disabilities are particularly prone to feeling pressured to work whilst unwell.

In order to double check the validity of these findings with respect to bullying and harassment, an additional multiple regression analysis was carried out (see Appendix 1), to control for variance that might accrue from age, gender, ethnic background or sexual preference. The results confirmed that disability explains more variation in responses to this question than any of the other available demographic variables. In other words disability was the most statistically significant predictor of all, in terms of likelihood of being subjected to bullying or harassment from managers or colleagues. Disabled staff also felt less supported by their managers in terms of encouraging them in their career progression.

Unsurprisingly, perhaps, they also reported substantially lower overall job satisfaction. Staff with disabilities were more dissatisfied with the recognition, support, responsibility and opportunities they had in their jobs. They felt less recognised for their good work undertaken (eight percentage points fewer), and less supported by their immediate managers (five percentage points fewer) and their immediate work colleagues (three percentage points fewer). At the same time, they were less satisfied with their levels of responsibility (four percentage points less), and felt they had fewer opportunities to use their skills (five percentage points fewer). Perhaps most noteworthy of all they were substantially less satisfied with their level of remuneration (nine percentage points lower), and less valued in overall terms by their employer for the contribution they were making (9 percentage points fewer). These are not unusual findings.

Marmot's (1999) Whitehall 2 study lends a broad basis of support to this conclusion. In a careful piece of empirical research, Marmot found that 'effort-reward imbalance' is an important predictor of negative health outcomes such as increased risk of alcohol dependence, increased mental health symptoms, long spells of sickness absence and poor general physical health functioning. Given that many staff with disabilities are likely to experience substantially poor job satisfaction, there must be concern over the additional effects this may have upon their overall health

There is no doubt that disabled staff rate themselves as substantially less well supported than non-disabled staff, as highlighted in the 'proxy' indicators used. In this sense they are doubly if not triply disadvantaged. They have to contend with the impact upon themselves and their work performance of their disability per se. They are in an additionally vulnerable position since their sources of managerial support are far more likely themselves to be a cause of bullying and harassment compared to non-disabled staff. This is likely to have knock on effects with respect to a number of additional factors such as their overall job satisfaction, stress-related ill-health, their overall sense of being valued in the workplace, and their overall career trajectory.

The impact and efficacy of appraisal for staff with disabilities

Whilst the frequency of receiving appraisal seems to be more or less equivalent for disabled and non-disabled staff, the impact of appraisal was perceived in considerably more negative terms. Staff with disabilities felt much less positive that appraisal had helped their job performance (a difference of seven percentage points). Related to this was the fact that they felt it had not helped to clarify job targets or the overall aims of their job (a difference of five percentage points). Moreover, fewer staff with disabilities (five percentage points less) thought that training or job development needs had been identified by their managers through the appraisal, and fewer felt supported by their managers to pursue additional training (five percentage points difference).

Appraisal can also serve as a lever or facilitator for promotion or career progression – but this was far less likely to be the case for staff with disabilities. It is significant in this respect that more staff with disabilities felt (eight percentage points difference) unfairly treated with respect to opportunities for career progression. This perception of being disadvantaged was especially pronounced amongst ethnic minority staff who disclosed as disabled (thirteen percentage points difference).

Reasonable Adjustment?

It is a requirement under the 2010 Equality Act for an employer to make 'reasonable adjustments' to avoid a disabled person being put at a disadvantage compared to non-disabled people in the workplace. This may for example require flexible working hours or providing a special piece of equipment to help the disabled person carry out their allocated tasks. Foster and Wass (2012) undertook a documentary analysis of employment tribunal transcripts and explored some of the reasons for employer inflexibility when issues arise in the workplace in relating to disability. They found that the complex design of many modern jobs and largely unchallenged assumptions of what constitutes a 'typical' or 'ideal worker' are deeply embedded in the practices, policies and culture of organisational life. They found that managers who were wedded to the concept of a 'standard worker' will view an adjustment as disruptive, unworkable and costly in terms of time and resources needed. For example, reorganisations often increase the number and variety of tasks included in a job description and result in tighter, more inflexible jobs that can exclude, or highlight the impairments of, disabled workers. The authors call for equality impact assessments during these periods. Further, the effect of team based performance targets can add a further layer of inflexibility.

In terms of our study, in response to the question 'Has your employer made adequate adjustment(s) to enable you to carry out your work?", 40% of staff with disabilities responded in the affirmative, and an additional 46% thought that no adjustment was required. However, this did leave 14% who thought that no reasonable adjustment had been made. Given that making reasonable adjustment is a statutory requirement under the 2010 Equality Act, this would suggest that a substantial minority of Trusts are in breach of the requirements of this legislation.

A study by Newton et al (2007) undertook narrative interviews with 38 disabled people in the public and private sector. Their participants emphasized tackling discrimination at the point of recruitment, and establishing cost effective mechanisms to support disabled people in tackling grievances including support for those who find the built environment continues to be a barrier. These findings support other studies (Roulstone et al, 2003 and Goodley, 2005) that find that organisations which are run by disabled people are far more inclusive. The point here is that if people with lived experience of disablement are in senior management positions (quite rare in the NHS) appropriate reasonable adjustments are more likely to be made. In an important national study the disabled people interviewed referred to the need to establish support networks across professional bodies so that disabled members can share advice and benefit from each other's experiences (Duff and Ferguson, 2011).

Foster and Wass (2012) recommended that employers address ill-treatment in the workplace either as a formal part of the internal grievance process or as part of an investigation that precedes this. They recommend that before a case reaches court employers should be obliged to demonstrate that they have engaged with advisory bodies in a meaningful way and have sought to resolve disability-related disputes using valuable independent expertise.

Reasonable Remuneration?

Nine percentage points fewer staff with disabilities were satisfied with their level of remuneration. It has to be remembered that all these findings are based on self-assessment and have not been independently validated. However, it does raise an important substantive issue as to whether staff with disabilities are in fact underpaid in comparison to non-disabled staff, and requires further investigation.

What difference does the 'Two Ticks' symbol make to recruitment and employment?

The evidence from previous studies suggests that the Two Ticks symbol does not make a great deal of difference in terms of a Trust's awareness of disability issues or in its capacity to address any inequalities or inadequacies in practice. For example, Hoque et al (2014) found only limited adherence to the five criteria in Two Tick employer locations, and no evidence that it was any better than with non-Two Tick employers. Also there was little evidence of support for disability champions in the Two Tick workplace locations studied.

- There was little evidence that the commitments were more widely adhered to, or that support for and dialogue with Disability Champions was any greater in the Two Ticks than in the non-Two Ticks workplaces.
- There was no consistent evidence of a stronger Two Ticks effect in the public than in the private sector, suggesting that in both sectors the symbol may often comprise little more than rhetoric.
- The five commitments employers are expected to uphold is dependent on employer goodwill, and compulsion is seen as neither necessary nor desirable. Hence, there is significant scope for employers who do not perceive a business case for adhering to the five commitments to display the symbol for impression management purposes or to take advantage of its potential reputational benefits rather than because of a genuine concern for disability issues.
- The Two Ticks symbol will continue to lack substance unless it moves away from its neo-liberal underpinnings, and a degree of regulation, possibly in the form of an independent awarding and monitoring body as called for by the Trades Union Congress (2009), is introduced to ensure compliance with the five commitments.

Because we found in our study that the total number of Trusts with the 'Two Ticks' award was so large compared to those without the award, it is difficult to draw definitive conclusions. Although there is a consistent finding that Trusts that have the 'Two Ticks' award have marginally higher average rates of 'adequate adjustments' reported by staff with disabilities, the difference is small, the number of 'No award' Trusts is small (just 1 in the case of ambulance and Community Trusts, as shown in Figure 3.12) and the range among all Trusts is very large (from 5% to 41 %). Bearing in mind these differences in sub-sample sizes, it would seem that the trend was for 'Two Ticks' status to make a modest difference in terms of how Trusts performed in making 'reasonable adjustments'. Given the marginal levels of improvements, and that the overall performance of Trusts in all Trust sectors was poor, with respect to a variety of issues such as levels of bullying and harassment, impact of appraisal etc., it would seem that 'Two Ticks' status achieves relatively little in terms of improved performance against these metrics.

Reasons for leaving the NHS

In our study, staff without a declared disability tended more frequently to leave either simply because of the completion of a fixed term contract, or sometimes resignations were voluntary due to promotion, to pursue opportunities in further education including additional professional qualification. Another major reason was to care for adult dependents; some left due to a lack of further opportunities. None of these reasons seem related to problems of health or significant problems with the employer.

Staff with disabilities tended to leave for markedly different sets of reasons. Mostly, these reasons for leaving seem either health related, or linked to a problem with the employer. Some staff with disabilities took early retirement for health reasons, voluntary resignation for health reasons or took flexi-retirement, possibly with a view to assisting them in managing their disability. Some left due to

incompatible working relationships. Some reasons were more negative still, and were formal dismissals related to capability, or (mis)conduct. Finally, many were made redundant, either voluntary or compulsory. It is clear that substantial numbers of people with disability do face dismissal processes of various kinds. It is worth enquiring whether more proactive support measures earlier on in such a scenario might result in retaining more people with disabilities in employment.

Conclusions

A key question this research was asked to explore was: “How well supported are staff who become disabled during the course of their employment?” There are clearly many staff with disabilities who would say that they are well supported by their employer, as indicated for example by the 40% who thought that a reasonable adjustment to their disability had been made, or the 46% who thought that no adjustment was necessary. However, there is a subtext running through this research which must give cause for concern. Substantially greater staff with a declared disability felt poorly served by the appraisal system, and in this respect, and at the same time, larger numbers relative to non-disabled staff felt bullied or harassed by their managers. Substantially fewer felt valued and supported by their organisation, or that their skills were properly valued or utilised. Perhaps linked to that, substantially fewer felt appropriately remunerated for their work. Finally, reasons for leaving the NHS were more frequently related to compulsory or voluntary redundancy, and to formal dismissals for capability or misconduct. Are staff with disabilities being appropriately supported by the NHS throughout their career? For many staff with disabilities, there are worrying signs that this may not be the case.

Section 6: Recommendations for Best Practice Organisations

Issue	Evidence (NHS Staff Survey/ESR)	Recommendation
Staff with disabilities representation at all levels of the NHS and covering different types of disability	Levels of disability were around 17% in the NHS Staff survey, and around 3% in the ESR There is an 11 percentage point difference in the proportion of staff with disabilities who feel under pressure from their manager to attend when feeling not well enough to perform their duties, compared to those without disability. More staff with disabilities felt (8 points difference; Q22) unfairly treated with respect to opportunities for career progression. This perception of being disadvantaged was especially pronounced amongst BME staff that were disabled (13 points difference). Staff with disabilities were substantially less satisfied with their level of remuneration (9 percentage points lower)	Develop an explicit, values-based, proactive rights- and strengths-based approach to disability in the work place. Allocate sufficient resources to ensure staff at all levels have access to Disability Equality Training delivered by disabled people and their organisations. Use the legal framework of the Equality Act 2010 to underpin strategies and ensure that leaders, managers, staff, patients and carers understand their obligations and implications under the Act (especially with regard to 'reasonable adjustments', bullying and harassment, discrimination, and the concerns expressed by staff with disabilities with respect to levels of pay for equivalent work). Establish jointly with NHS Employers a series of joint action learning sets exploring with disabled people and their organisations the development of an inclusive culture where staff feels supported and safe to disclose disability, focusing on the implementation of jointly agreed key issues arising from the DRUK and NHS England research report. Ensure that each Trust appoints and resources a designated senior manager with responsibility for disability and a disability champion
Different categories of reported disability	Neither the ESR or the NHS Staff survey distinguish between different types or category of disability	Revise and refine NHS Staff survey and ESR data collection process to include the broad variety and categories of disability
Issues of Disclosure: Disparity between ESR and NHS staff survey in terms of reported disability	Much broader and more inclusive definition of disability in the NHS staff survey NHS staff survey is anonymous ESR declaration of disability is at appointment but not updateable	Through consultation with the relevant organisations, to include a common definition of disability in the ESR and the NHS staff survey., This should be the definition used by the 2010 Equality Act, which is already the case in the ESR, and could perhaps be adopted in the survey in addition to the current wider definition for a limited period, so that there can be continuity in the understanding of data related to disability . Through further consultation with Trusts and HSCIC, to develop ways in which ESR data entry can be anonymized Positively address through engagement with Trust HR departments, any concerns about disclosure and fear of discrimination. Develop a responsive ESR system so that

		changes in disability status can be recorded as part of HR and appraisal processes. Identify and respond to the implications for staff who have less visible disabilities (particularly with reference to mental health issues) in relation to disclosure and protection under the Equality Act 2010.
Levels of bullying and harassment	Seven percentage points more bullying and harassment from patients and their relatives Twelve percentage points more bullying and harassment from managers, team leaders or colleagues Seven percentage points more discrimination at work from patients, their families or their managers or team leaders Eleven percentage points more feeling under pressure in the last three months from managers to attend work whilst feeling unwell	At the national level, ensure that an anti-bullying and harassment programme is in place which is disability-sensitive At the regional level, led by Disability Champions and senior executive managers, to implement a disability-sensitive anti-bullying and harassment training programme Ensure roll out of the above at the local level Monitor, review and evaluate management and leadership performance with regard to the implementing of equality and diversity policies and procedures, including specific disability related policies and procedures e.g. recruitment, accessibility, etc. Ensure a consistent and robust response to bullying and harassment, with access to independent support if manager/s is implicated. Develop and Implement a coherent, fair Disability Absence policy nationally Ensure that there is a transparent, disability-sensitive national and local mediation policy for absence disputes Consider the inclusion of disability support and management in manager and leader performance appraisals.
Experience of appraisal	Rates of appraisal broadly similar Seven percentage points ewer staff with disabilities felt that appraisals improved their performance. Nine percentage points fewer staff with disabilities felt valued by their organisation for their work. They were substantially less satisfied with their level of remuneration (nine percentage points fewer) They were more unsatisfied with their levels of	Review managerial training with respect to appraisal to ensure that it provides supportive, responsive practice to enable high performance and job satisfaction, so that disabled staff are not disadvantaged and their concerns are addressed. Mandatory managerial appraisal training which is developed and implemented from an explicit, proactive rights-based and strengths-based approach to disability in the work place. Include review of reasonable adjustments in appraisals of staff with disabilities. Include disability support and management in manager and leader performance appraisals Collate a national overview of issues arising from appraisal from a disability perspective and identify and disseminate best practice in this respect

	responsibility they had been given (4 percentage points fewer). They felt they had less opportunity to use their skills (5 percentage points fewer).	Ensure that appraisal systems explore opportunities for raising levels of responsibility for staff with disabilities Ensure that appraisal systems explore the optimising of skill development and skill deployment for staff with disabilities
Training and staff development	Very little disparity between disabled and non-disabled staff in the proportion not receiving training or in their satisfaction with the training.	-
Management of reasonable adjustment	An average of 14% of staff with disabilities varying from 0% to 41% report that their Trust has not made a reasonable adjustment in their place of work to their disability	Monitor, review and evaluate management and leadership performance with regard to implementing an effective reasonable adjustment policy. Include review of reasonable adjustments in appraisals of staff with disabilities. Develop links with local Job Centre Plus re Access to Work funding to assist and support reasonable adjustment measures for disabled employees. Enhance the profile of the NHS as a 'disability smart' organisation by developing a national updateable data base and resource bank on reasonable adjustment across all disabilities Update the NHS Agenda for Change Handbook on reasonable adjustment but reframing the language Access and synthesise external resources such as Lloyds Bank 'disability smart' approach,
Does the 'Two Ticks' symbol make a difference?	-	Build in a robust monitoring and evaluation procedure for the 'Two Ticks' system to ensure systematic review and action planning.
Experience of disciplinary and capability processes	-	Develop a disability-sensitive values-based approach to recruitment and retention ensuring that disciplinary and capability process are integrated.
Turn-over, retention and stability	-	
Job satisfaction and career development	Staff with disabilities felt less recognised for their good work undertaken (8 percentage points fewer). They felt less supported by their immediate managers (5 percentage points fewer). They felt less supported by their work colleagues (3 percentage points fewer).	Utilise NHS Standards to integrate disability issues and mount a positive promotion anti-stigma campaign on disability both within the NHS and in the public arena See above

Section 7: Towards a draft Disability Equality Standard

The NHS Equality and Diversity Council announced in July 2014 that it had agreed to implement a standard of Workforce Race Equality (WRES), with a view to ensuring that people from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This would be benchmarked on an annual basis across a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.

The initiative to establish this was closely linked to the publication of an influential report, The Snowy White Peaks of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England (Klein, 2014). This report found that there were major discrepancies in the number of BME people in senior leadership positions across the NHS, as well as lower levels of wellbeing amongst the BME population. This led to the development of an ambitious national level change management strategy, designed to ensure that a national Race Equality Standard could be effectively implemented and monitored, and which would come into force in April 2014.

In undertaking this study, the researchers were asked to consider possible responses to the findings. An option that is being considered as an offshoot of this current research is the development of a broadly equivalent standard for disability equality. A significant component of this would be to explore ways in which such a standard could be supported by appropriate metrics. Accordingly, this report has developed a draft Disability Equality Standard, including appropriate metrics (see Appendix 4 of this report). To ensure continuity with the work undertaken for the Race Equality Standard, a similar template and format has been utilised. The metrics underpinning this draft Disability Standard are summarised in Table 1.

Table 1: Metrics for the Disability Equality Standard

Metrics for the Disability Standard (Where a 'Q' number is identified below, this refers to the number of a question in the most recent staff survey)	
1 Percentage of disabled staff in Bands 8-9, VSM (including executive board members and senior medical staff) compared to the percentage of disabled staff in the overall workforce	Non-disabled
	Disabled
2 Q20b: In the last 12 months, how many times have you personally experienced harassment, bullying or abuse from your manager/team leader or colleagues?	Non-disabled
	Disabled
3 Q15b: In the last 3 months, have you felt pressure from your manager to come to work despite not feeling well enough to perform your duties?	Non-disabled
	Disabled
4 Q22: Does your organisation act fairly with regard to career progression regardless of ethnicity, gender, religion, sexual orientation, disability or age?	Non-disabled
	Disabled
5 Q8g: How satisfied are you with the extent to which your organisation values your work?	Non-disabled
	Disabled

6 Q3e (Appraisal): Were any training, learning or development needs identified?	Non-disabled
	Disabled
7 Q3f (Appraisal): Did your manager support you to receive this learning and development?	Non-disabled
	Disabled
We need8 Q29b (Reasonable adjustment): Has your employer made adequate adjustments to enable you to carry out your work? (For reporting year)	% yes
9 Does the board meet the requirement on Board membership (referred to in the Race Equality Standard) that '*Boards are expected to be broadly representative of the staff and population they serve'?*	

The rationale for this is the same as that for the Race Equality Standard. Evidence previously presented in this report demonstrates clearly that staff with disabilities perceived themselves as at a clear disadvantage compared to non-disabled staff with respect to harassment, supervision, career progression, appraisal and reasonable adjustments

Accordingly, the metrics supporting the draft Disability Equality Standard are those referred to in the report which evidence perceived differentials as to how these issues are affecting staff with and without disabilities in the NHS workforce. To briefly summarise, the report found that:

- Relative to non-disabled staff, staff with disabilities felt more bullied, in particular from their managers (12 percentage points more); more pressure to work when feeling unwell (11 percentage points more); and less confident that their organisation acts fairly with regard to career progression (8 points difference).
- With respect to appraisal, 7 percentage point fewer felt that appraisals improved their performance. Moreover, 9 percentage point fewer report that their appraisal left them feeling that their work is not valued by their organisation.
- Staff with disabilities rate themselves as more dissatisfied with the recognition, support, responsibility and opportunities they have in their jobs, even though there is no difference in the satisfaction they report in the quality of care they give to patients. Staff with disabilities felt less recognised for their good work undertaken (8 percentage points fewer); they felt less supported by their immediate managers (5 percentage points fewer); they felt less supported by their work colleagues (3 percentage points fewer); they were more dissatisfied with the levels of responsibility they had been given (4 percentage points fewer).

In addition, metrics are proposed with respect to how staff with disabilities rate the 'reasonable adjustments' made with respect to their needs, and whether Trust Boards are sufficiently representative of their workforce with respect to staff with disabilities.

Consideration needs to be given to the desirability and feasibility of developing the data collected in both the ESR and the staff survey, including collecting data on type of disability and increasing the response rate for specific items,

It is important to note that this proposed Disability Equality Standard would need to sit alongside the EDS2, after it has been reviewed to ensure it is fit for purpose with respect to the equal treatment of staff with disabilities.

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Appendix 1

Table 2: B, p and ExpB values for disability status in regression models that also include gender, age, sexuality, and ethnicity

	Dependent Variable	*Independent Variables*	*B for 'No disability'*	*p value*	*ExpB for 'No Disability'*
Q3					
a) In the last 12 months, have you had any form of appraisal? Yes vs. No or Can't remember	Yes=0; No/Cnt rmbr=1	Male, <51, white, hetero, no dis = 1 Other=0	-.146	.000	0.865
b) Did it help you to improve how you do your job? Yes /No	Yes=0; No=1	Male, <51, white, hetero, no dis = 1 Other=0	-.263	.000	0.769
c) Did it help you agree clear objectives for your work? Yes /No	Yes=0; No=1	Male, <51, white, hetero, no dis = 1 Other=0	-.260	.000	0.771
d) Did it leave you feeling that your work is valued by your organisation? Yes /No	Yes=0; No=1	Male, <51, white, hetero, no dis = 1 Other=0	-.359	.000	0.699
e) Were any training, learning or development needs identified? Yes /No	Yes=0; No=1	Male, <51, white, hetero, no dis = 1 Other=0	-.164	.000	0.849
f) Did your manager support you to receive this training, learning and development? Yes /No	Yes=0; No=1	Male, <51, white, hetero, no dis = 1 Other=0	-.388	.000	0.678
Q8 *How satisfied are you with each of the following aspects of your job?*					
a) The recognition I get for good work Very dissatisfied or dissatisfied vs Any other category	V. dssatsfd or dssatsfd=1 other=2	Male, <51, white, hetero, no dis = 1 Other=0	.428	.000	1.534
b) The support I get from my immediate manager Very dissatisfied or dissatisfied vs Any other category	V. dssatsfd or dssatsfd=1 other=2	Male, <51, white, hetero, no dis = 1 Other=0	.385	.000	1.469
c) The freedom I have to choose my own method of working Very dissatisfied or dissatisfied vs Any other category	V. dssatsfd or dssatsfd=1 other=2	Male, <51, white, hetero, no dis = 1 Other=0	.419	.000	1.521
d) The support I get from my work colleagues Very dissatisfied or dissatisfied vs Any other category	V. dssatsfd or dssatsfd=1 other=2	Male, <51, white, hetero, no dis = 1 Other=0	.507	.000	1.66

e) The amount of responsibility I am given Very dissatisfied or dissatisfied vs Any other category	V. dssatsfd or dssatsfd=1 other=2	Male, <51, white, hetero, no dis = 1 Other=0	.439	.000	1.551
f) The opportunities I have to use my skills Very dissatisfied or dissatisfied vs Any other category	V. dssatsfd or dssatsfd=1 other=2	Male, <51, white, hetero, no dis = 1 Other=0	.468	.000	1.596
g) The extent to which my organisation values my work Very dissatisfied or dissatisfied vs Any other category	V. dssatsfd or dssatsfd=1 other=2	Male, <51, white, hetero, no dis = 1 Other=0	.443	.000	1.557
h) My level of pay Very dissatisfied or dissatisfied vs Any other category	V. dssatsfd or dssatsfd=1 other=2	Male, <51, white, hetero, no dis = 1 Other=0	.376	.000	1.457
Q15b *In the last three months, have you felt pressure from your manager to come to work despite not feeling well enough to perform your duties? Yes/No*	Yes=0; No=1	Male, <51, white, hetero, no dis = 1 Other=0	.513	.000	1.67
Q21b *In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from... manager / team leader or other colleagues? Never vs Any other category*	Never=0; Other=1	Male, <51, white, hetero, no dis = 1 Other=0	.640	.000	0.527
Q22 *Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? Yes/No (omit 'Don't know' cases)*	Yes=0; No=1	Male, <51, white, hetero, no dis = 1 Other=0	-.673	.000	0.51
Q23b *In the last 12 months have you personally experienced discrimination at work from … manager / team leader or other colleagues? Yes/No*	Yes=0; No=1	Male, <51, white, hetero, no dis = 1 Other=0	.897	.000	2.451

Appendix 2

Table 3: Disability by medical/non-medical staff and by region

	Total Headcount of staff	Disabled	Not Disabled	Not Disclosed	Unknown
Non-medical staff	1,100,219	3%	57%	17%	23%
East Midlands	83,365	3%	61%	14%	21%
East of England	97,224	2%	45%	16%	37%
Yorkshire and the Humber	117,737	3%	62%	19%	16%
Wessex	51,091	3%	53%	13%	30%
Thames Valley	34,540	3%	63%	19%	15%
North West London	46,313	2%	54%	4%	40%
South London	53,347	2%	68%	17%	13%
North Central and East London	61,043	2%	59%	12%	27%
Kent, Surrey and Sussex	78,608	4%	57%	17%	22%
North East	66,387	3%	49%	15%	33%
North West	167,959	3%	58%	25%	15%
West Midlands	118,207	2%	50%	24%	24%
South West	89,942	3%	68%	11%	19%
Special Health Authority	34,217	4%	66%	11%	19%
Medical staff	113,214	1%	60%	19%	21%
East Midlands	7,663	1%	65%	16%	18%
East of England	10,678	1%	53%	10%	37%
Yorkshire and the Humber	10,817	1%	68%	17%	13%
Wessex	5,347	1%	61%	16%	22%
Thames Valley	3,822	1%	59%	28%	12%
North West London	6,167	1%	60%	6%	34%
South London	8,511	1%	70%	15%	15%
North Central and East London	9,726	1%	62%	12%	26%
Kent, Surrey and Sussex	8,520	1%	62%	23%	14%
North East	6,331	1%	45%	12%	43%
North West	15,273	1%	56%	31%	12%
West Midlands	11,253	0%	53%	30%	17%
South West	8,736	1%	69%	13%	18%
Special Health Authority	338	2%	52%	20%	27%

Source: Health and Social Care Information Centre, Provisional NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

Table 4: Agenda for Change band and grade by disability status, November 2014

	All staff	Not Disabled	Disabled	Not Disclosed	Unknown
All staff	*100*	*58*	*3*	*17*	*22*
Band 1	*100*	*54*	*3*	*21*	*23*
Band 2	*100*	*58*	*3*	*18*	*21*
Band 3	*100*	*59*	*3*	*18*	*21*
Band 4	*100*	*57*	*3*	*17*	*23*
Band 5	*100*	*61*	*3*	*16*	*21*
Band 6	*100*	*56*	*3*	*17*	*24*
Band 7	*100*	*55*	*2*	*18*	*25*
Band 8a	*100*	*57*	*2*	*16*	*24*
Band 8b	*100*	*56*	*3*	*16*	*26*
Band 8c	*100*	*58*	*2*	*15*	*25*
Band 8d	*100*	*59*	*2*	*14*	*24*
Band 9	*100*	*59*	*2*	*13*	*26*
Consultants (including Directors of public health)	*100*	*49*	*1*	*22*	*28*
Registrars	*100*	*72*	*1*	*15*	*13*
Other doctors in training	*100*	*74*	*2*	*14*	*11*
Hospital practitioners & clinical assistants	*100*	*42*	*1*	*25*	*32*
Other medical and dental staff	*100*	*50*	*1*	*24*	*25*
Unknown	*100*	*50*	*2*	*12*	*37*

Source: Health and Social Care Information Centre, Provisional NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

Table 5: Age categories by gender and disability, November 2014

	Female					Male				
	All Female staff	Not Disabled	Disabled	Not Disclosed	Unknown	All Male staff	Not Disabled	Disabled	Not Disclosed	Unknown
All staff	78	45	2	13	17	22	13	1	4	5
< 25	79	63	2	7	7	21	16	1	2	2
25 to 29	77	57	2	9	9	23	16	1	3	3
30 to 34	77	50	2	11	14	23	15	1	3	4
35 to 39	75	44	2	12	17	25	15	1	4	5
40 to 44	76	42	2	13	19	24	13	1	4	6
45 to 49	78	42	2	15	20	22	11	1	4	6
50 to 54	80	40	2	16	21	20	10	1	4	6
55 to 59	80	39	2	17	22	20	10	1	4	6
60 to 64	76	36	2	18	21	24	11	1	5	6
65 to 69	74	32	2	18	22	26	12	1	6	7
>70	74	30	2	20	22	26	13	1	6	7

Source: Health and Social Care Information Centre, Provisional NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

Table 6: Disparities in NHS survey responses of disabled/non-disabled, non-white/white and women/men

	Disparities as measured by percentage point difference		
	Disabled vs Non-disabled	*Non-white vs white staff*	*Women vs men*
In the last 12 months have you personally experienced physical violence at work from...? (Q20)	Disparity in the % answering 'Never'	Disparity in the % answering 'Never'	Disparity in the % answering 'Never'
a) Patients / service users, their relatives or other members of the public	-2	-3	1
b) Managers / team leader or other colleagues	-1	-2	0
c) The last time you experienced physical violence at work; did you or a colleague report it?	0	-4	-2
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? (Q21)	Disparity in the % answering 'Never'	Disparity in the % answering 'Never'	Disparity in the % answering 'Never'
a) Patients / service users, their relatives or other members of the public	-7	-1	-3
b) Managers / team leader or other colleagues	-12	-4	-1

c) The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	2	2	7
	Disparity in the % answering 'Yes'	Disparity in the % answering 'Yes'	Disparity in the % answering 'Yes'
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? (Q22)	-8	-13	3
In the last 12 months have you personally experienced discrimination at work from any of the following? (Q23)			
a) Patients / service users, their relatives or other members of the public	2	11	-2
b) Manager / team leader or other colleagues	7	8	-1
c) How many times have you experienced discrimination on grounds other than disability?	6	20	-4
Have you felt pressure in last 3 months from manager to attend work despite not feeling well enough to perform their duties? (Q15b)	11	-1	3

Source: NHS Staff Survey, 2014

Table 7: Responses to job satisfaction survey questions by disabled/non-disabled, non-white/white and 16-30/51+ staff

Job satisfaction questions from 2014 NHS staff survey	***Percentage point disparity between levels of dissatisfaction ****		
	Disabled vs non-staff with disabilities	*Non-white staff vs white*	*Staff age 16-30 vs 51 & over*
How satisfied are you with each of the following aspects of your job? (Q8)			
a) The recognition I get for good work	-8	3	-2
b) The support I get from my immediate manager	-5	2	1
c) The freedom I have to choose my own method of working	-4	-2	0
d) The support I get from my work colleagues	-3	-1	0

e) The amount of responsibility I am given	-4	-2	-2
f) The opportunities I have to use my skills	-5	0	-2
g) The extent to which my organisation values my work	-9	7	2
h) My level of pay	-9	0	-2
Total disparity:	**-49**	**8**	**-6**
Do the following statements apply to you and your job? (Q9)			
a) I am satisfied with the quality of care I give to patients / service users	-1	2	1
b) I feel that my role makes a difference to patients / service users	0	0	-1
c) I am able to deliver the patient care I aspire to	-2	5	0
Total disparity:	**-4**	**7**	**0**

* Minus score means that the 1st group (disabled, non-white, staff 16-30) more dissatisfied
Source: NHS Staff Survey, 2014

Table 8: Appraisal rates and attitudes to appraisals by 3 staff groups and by Trust type

	All Trusts			*Type of Trust*				
	Disabled Vs Non	*Non-white Vs White*	*Women Vs Men*	*Acute*	*Ambulance*	*CCGs*	*Community*	*Mental health*
Q3				*Disabled Vs Non*				
a) In the last 12 months, have you had any form of appraisal?	-1	1	0	-1	-5	1	-4	-1
b) Did it help you to improve how you do your job?	-7	20	-5	-8	-8	-3	-8	-6
c) Did it help you agree clear objectives for your work?	-5	6	1	-6	-9	-1	-6	-5
d) Did it leave you feeling that your work is valued by your organisation?	-9	9	1	-9	-8	-10	-8	-9
e) Were any training, learning or development needs identified?	-5	5	-4	-5	-5	-5	-5	-3
f) Did your manager support you to receive this training learning and development?	-5	2	-1	-5	-10	-2	-6	-3
Total disparity:	-32	43	-9	-35	-44	-20	-37	-28

Source: NHS Staff Survey, 2014

Table 9: Training received and satisfaction with training of disabled vs non-disabled staff

Q1: Have you had any training, learning or development (paid for or provided by your organisation) in the following areas?	*Disparity between % points of disabled and non-disabled answering 'No' (+'ve value = more disabled reply 'No')*
a) Health and safety training	1
b) Equality and diversity training	1

c) How to prevent or handle violence and aggression to staff, patients / service users.	2
d) Infection control (e.g. Guidance on hand washing, MRSA, waste management, disposal of sharps/needles)	1
e) How to handle confidential information about patients / service users.	1
f) How to deliver a good patient / service user experience	2
g) Any other job-relevant training, learning or development	2
Q2: To what extent do you agree or disagree with the following statements? My training, learning and development has helped me to....	Disparity between % points of disabled and non-disabled disagreeing with the statement (-'ve value = more disabled disagree)
a)...do my job more effectively	-1
b)...stay up-to-date with professional requirements	-1
c)...deliver a better patient / service user experience	-2

Source: NHS Staff Survey, 2014

Table 10: Staff with disabilities' experience of 'adjustments' made by Trusts

Responses to question29b: 'Has your employer made adequate adjustment(s) to enable you to carry out your work?' (Question asked only of respondents who declare that they 'have a long-standing illness, health problem or disability')	*Yes %*	*No %*	*No adjustment required %*	*n*
All	**40**	**14**	**46**	**45,921**
Acute (Specialist) Trusts	**37**	**13**	**50**	**1,914**
Royal Brompton and Harefield NHS Foundation Trust	44	6	50	32
The Royal Orthopaedic Hospital NHS Foundation Trust	34	24	41	37
Acute Trusts	**39**	**15**	**45**	**27,094**
Northumbria Healthcare NHS Foundation Trust	48	9	43	131
Barts Health NHS Trust	31	22	47	548
Ambulance Trusts	**34**	**24**	**43**	**1,446**
West Midlands Ambulance Service NHS Trust	33	15	51	43
London Ambulance Service NHS Trust	15	41	44	49
Clinical Commissioning Groups	**46**	**6**	**48**	**394**
NHS Liverpool CCG	36	0	64	14
NHS Bedfordshire CCG	16	16	68	19
Community Trusts	**40**	**14**	**46**	**3,363**
Hertfordshire Community NHS Trust	38	9	52	162
Liverpool Community Health NHS Trust	37	19	44	247
Mental Health/learning Disability Trusts	**40**	**14**	**45**	**11,507**
North Staffordshire Combined Healthcare NHS Trust	39	8	54	114
Leeds and York Partnership NHS Foundation Trust	42	21	37	102
White staff (summary)	40	13	47	40,175

BME staff (summary)	35	21	45	5,089
- Black Caribbean staff	45	17	37	745
- Black African staff	36	17	47	906
- Other Black background staff	32	38	30	128
- Indian staff	37	18	44	1,080
- Pakistani staff	35	18	47	314
- Bangladeshi staff	29	32	40	77
- Other Asian background staff	35	17	48	693
- White and Black Caribbean staff	33	20	46	158
- White and Black African staff	46	17	37	82
- White and Asian staff	36	23	41	152
- Other mixed background staff	37	18	45	241
Chinese staff	28	14	58	109
Other ethnic groups	38	20	42	404

Source: NHS Staff Survey, 2014

Table 11: Reasons for leaving and staff movements by disability status in 2014-15 Q3. (Overall % w a declared disability who left in this quarter=3 %.)

Reason for leaving	*Number leaving in 14-15 Q3*	*% leaving for specified reason who have declared a disability*
Retirement - Ill Health	320	*11.9*
Mutually Agreed Resignation - Local Scheme without Repayment	41	*9.8*
Dismissal - Capability	705	*8.7*
Redundancy - Voluntary	159	*7.5*
Mutually Agreed Resignation - National Scheme with Repayment	71	*5.6*
Voluntary Resignation - Health	779	*5.3*
Redundancy - Compulsory	493	*5.1*
Voluntary Resignation - Incompatible Working Relationships	373	*4.8*
Dismissal - Some Other Substantial Reason	334	*4.5*
Flexi Retirement	856	*4.3*
Dismissal - Conduct	403	*4.2*
Has Not Worked	80	*3.8*
Retirement Age	4,793	*3.7*
End of Fixed Term Contract - End of Work Requirement	235	*3.4*
Mutually Agreed Resignation - Local Scheme with Repayment	184	*3.3*
Voluntary Resignation - Relocation	4,757	*3.0*
Voluntary Resignation - Lack of Opportunities	719	*2.9*
End of Fixed Term Contract - Other	347	*2.9*
Voluntary Early Retirement - with Actuarial Reduction	458	*2.8*
Voluntary Resignation - Other/Not Known	9,232	*2.7*
Voluntary Resignation - Adult Dependents	225	*2.7*
Dismissal - Statutory Reason	38	*2.6*
Voluntary Resignation - Better Reward Package	1,232	*2.6*

Voluntary Resignation - Work Life Balance	3,737	2.6
Voluntary Resignation - Promotion	3,174	2.5
Voluntary Resignation - To undertake further education or training	516	2.3
Employee Transfer	4,406	2.3
Voluntary Early Retirement - no Actuarial Reduction	375	2.1
End of Fixed Term Contract	2,128	2.1
End of Fixed Term Contract - Completion of Training Scheme	346	1.7
Voluntary Resignation - Child Dependents	635	1.7
Death in Service	219	1.4
End of Fixed Term Contract - External Rotation	609	1.0
Bank Staff not fulfilled minimum work requirement	15	-
Initial Pension Ended	8	-
Merged Organisation - Duplicate Record	89	-
Not Set in Legacy at Migration	14	-
Pregnancy	24	-
Unknown	363	-

Source: Health and Social Care Information Centre, Provisional NHS Hospital & Community Health Service (HCHS) monthly workforce statistics

Appendix 3

Summary of significant studies engaging with quantitative approaches

Citation of source	*Research aims, method and sample*	*Key findings*	*Evaluation*
Meager, N., Bates, P., Dench, S., Honey, S. & Williams, M. (1998). *Employment of Disabled People: Assessing the Extent of Participation.* Research Brief # 69. Brighton, UK: Institute for Employment Studies. ISBN: 0855228113	• National survey of 2000 disabled people of working age (16 – 59, women; 16 – 64 men). • Definition of disability according to the DDA 1995. • Screening interviews with a random sample of 26,000 households to obtain a representative sample of disabled people. Main survey took place July-October 1996. Interviewed 2015 people of whom 1,440 were economically active.	• 92% of those surveyed have a current disability. • 64% of those who were unemployed agreed strongly that getting a job was important and they would continue to look for a job. • One in 6 (16%) of those who are/have been economically active say they have received unfair treatment or discrimination in a work-related context e.g. job interview that focused on their disability. • Over a quarter that left their job due to disability said adaptations would have enabled them to stay in work; less than one in five were offered this. • 47% of those currently economically inactive would like a paid job. • Disabled people in employment more likely to be in manual/lower skilled occupations. • However a majority of those in work were broadly content with their current/ recent job(s) and the way they are treated. • Those from ethnic minorities more likely to be unemployed than white counterparts • Disabled received on average lower take home pay than non-disabled. • Only 25% of disabled people working part time said they did so due to their disability. • Disabled people had overall lower levels of qualification than non-disabled counterparts e.g. 16% had A levels compared to 27% of non-disabled.	• Nationally representative sample. • Clear focus on people with disabilities and on employment issues. • Does not distinguish different types of disability. • Does not distinguish between different types of employer. • Relatively old study (research carried out in 1996).
Newton, R. A. & Ormerod, M. (2005). Do disabled people have a place in the UK construction	• Aimed to survey construction industry employers to explore the contractors' practices in the employment of disabled people and in the adaptation of workplace environments.	• Contractors are more likely to make 'reasonable adjustments' for staff that become disabled if these are reasonably inexpensive. • Minimal adjustments are required to adapt workplaces so they provide an inclusive approach to the employment of disabled people. • Most employers worked hard to ensure that if an employee	

industry? *Construction and Management Economics*, 23 (10): 1071 - 1081	• Survey of 100 top contractors in the construction industry.	becomes disabled they are appropriately supported. • A small number of employers believed that 'disabled people do not have a place in the UK construction industry.	
Banks, P. & Lawrence, M. (2006). The Disability Discrimination Act, a necessary, but not sufficient safeguard for people with progressive conditions in the workplace? The experiences of younger people with Parkinson's disease. *Disability and Rehabilitation*, 28 (1): 13-24.	• Aims to explore the impact of PD on employment form the perspective of affected individuals (especially what may affect the duration of employment after onset/diagnosis). • Postal survey facilitated by the PD society. • Survey n = 339 (women = 175, men = 164) who were of working age (f = up to 59, m = up to 64) or in paid employment. • One to one interviews arranged with volunteers who had completed the survey questionnaire (n = 24).	• Most people (3 quarters) had received a diagnosis of PD within 2 years of experiencing symptoms. • 51 men and 52 women in sample were in paid employment at time of the study. • 4 out of 5 participants reported that PD had made work difficult for them. • Only 15.3% of respondents had worked for more than 5 years following diagnosis. • Factors associated with maintaining employment-included age at diagnosis, support received from employers and manipulation of drug therapy. • Factors associated with leaving employment included severity of symptoms, lack of support in the workplace and opportunities for 'early retirement'. • Several people experienced considerable stress prior to leaving work. • DDA and social justice agenda may fail to take into account individual circumstances of those with a degenerative condition like PD over time. • Do younger people with PD have sufficient information to enable them to make an informed choice about maintaining or giving up employment? (Recommendation from this study)	• Useful for its focus on younger people with chronic progressive condition and in relation to employment. • Fairly large UK based study done with PD society as partner. • Distribution of questionnaires by the PD society resulted in the survey response rate not being available. • No detailed information about employers or type of work involved e.g. in NHS.
Bogg, J. & Hussain, Z. (2010). Equality, diversity and career progression: Perceptions of radiographers working in the National Health Service.	• This study evaluated radiographers' perceptions of equality, diversity and career progression in the National Health Service (NHS) by means of a quantitative national survey in which 120 radiographers responded (111 female and 9 male). • The full sample set for allied health professionals was 1496;	• 55% of participants thought that women generally experience some barriers to career progression. • 67% perceived that people with disabilities experienced barriers to career progression • 49% felt that the profession did not reflect the community that it served. • Only 2% of participants were from black or minority ethnic backgrounds and so not representative of the workforce employed in radiography. However, 53% of all participants thought that minority groups experienced barriers to career progression. • 'Participants were asked if they thought that those who are capable	• Useful as a study of one NHS professions' views of equality etc. covering disability (but does not distinguish types) • UK based and recent study. • Relatively small sample given numbers of radiographers employed in the NHS.*[Qualified

Radiography, 16 (4): 262-267.	the results presented in this paper are the extraction of the 120 radiographers. • The data reported in this paper are part of a complex and large-scale mixed methods study Breaking Barriers, funded by the European Social Fund.	of doing their job but were disabled, experience barriers to career progression. Sixty-seven per cent of participants agreed that disabled people experience some barriers to career progression. Of the 24 participants with a disability or health problem, 10 thought this would be a barrier to future career progression' (p. 265).	diagnostic radiography staff employed in NHS = 12,934 • Qualified therapeutic radiographers employed = 2,132- figures up to 2007, data accessed 2009).
Morris, D. & Turnbull, P. (2007). A survey-based exploration of the impact of dyslexia on career progression of UK registered nurses. *Journal of Nursing Management*, 15 (1): 97-106.	• To explore the effects of dyslexia on the practice and career progression of UK registered nurses (RN). • Background Literature suggests dyslexia can have a negative impact in the workplace and may pose particular difficulties for nurses, where accuracy in information processing activities is essential for practice. • A questionnaire was used to survey RNs with dyslexia (n = 116) and results analysed using content analysis.	• Dyslexia provided a challenge to the everyday work of RNs, which was often met successfully using a range of individualized strategies. • Career progression was achievable but compared with peers, was perceived to take longer. • Disclosure of dyslexia to work-colleagues was selective and dependent on the perceived benefits. Informal support mechanisms were commonly utilized with formal management support less well defined. • Dyslexia appears to have a negative impact on working practices and career progression, but remains a poorly understood and often hidden disability.	
Robinson, J. E. (2000). Accessing to employment for people with disabilities: Findings of a consumer-led project. *Disability and Rehabilitation*, 22 (5): 246-253.	• A consumer led initiative which aimed to gather information from local employers and disabled people which might inform future action to improve work opportunities for disabled people. • A survey of 500 companies with more than 20 employees randomly sampled from 4 locations across Suffolk was undertaken. The survey generated both numerical and verbal data. • Response rate was low (25%)	• On all key employment measures examined in this study, disabled people of working age in Great Britain are at a disadvantage compared with non-disabled people. They are less likely to be in work (47 per cent compared with 77 per cent); less likely to be economically active (47 percent are economically inactive compared with 16 per cent of non-disabled people). • Those who are economically active are more likely to be unemployed (12 per cent compared with eight per cent) and unemployed for longer (47 per cent of unemployed disabled people have been unemployed for a year or more, compared with 31 per cent of unemployed non-disabled people). • In terms of type of work, disabled people are more likely than non-disabled people to work part-time (33 per cent compared with 25 per cent) and to do lower skilled jobs; around one third (31 per cent) are in semi-routine or routine occupations compared with only	

	but achieved a reasonable spread of organization in terms of size, type of industry and geographical location. • Semi-structured interviews were carried out with nine disabled people. Open-ended questions were used to elicit information about the nature of their disability, experiences of education and experiences of seeking and} or maintaining work.	a quarter (25 per cent) of non-disabled people, and 34 per cent compared with 43 per cent are in managerial or professional roles. • The transition from full-time education to work is difficult for all young people, but more so for disabled people and especially disabled young men: the employment rate gap for young women aged 16 to 24 is much smaller than that for young men (11 percentage points compared with 27). • The percentage that is economically inactive does not differ much between disabled men and disabled women. However, between the ages of 25 and 54, disability is by far the main reason for economic inactivity among men - over one third of disabled men of this age are economically inactive, compared with just three per cent of non-disabled men. • People with mental health conditions and learning disabilities are considerably more disadvantaged than other impairment groups, in terms of employment rate, type of work and level of unemployment.	
Coleman, N., Sykes, W. & Groom, C. (2013). *Barriers to Employment and Unfair Treatment at Work: A Quantitative Analysis of Disabled People's Experiences*. Research report # 88. Manchester, UK: Equality and Human Rights Commission.	• Detailed, statistical picture of social and environmental factors in the workplace, including unfair treatment that can affect disabled people's chances of getting work, staying in work and making progress at work • Secondary analysis of quantitative findings already been published existing survey and other data carried out to add further detail, especially in terms of differences between groups of disabled people.	• Analysis showed that one in six people of working age living in the UK are disabled. Although some are not able to do paid work because of the factors related to their impairment or the barriers experienced, for others the opportunity and right to work is of paramount importance.	Recommends qualitative research on unfair treatment and discrimination, and how this relates to the broader issues of labour market activity and barriers to work with both employers and disabled people to unpack the complexity of the issues and help to understand how and why unfair treatment occurs.
Schneider, J., Slade, J., Secker, J., Rinaldi, M., Boyce, M., Johnson, R., Floyd, M. &	• "This study investigated how people with severe mental health problems fare in existing supported employment agencies [and] the aim of the study was to identify factors	• "82% of those working at baseline were still in work a year later. The support agencies helped 25% • Of unemployed clients into work, a statistically significant increase in the proportion of clients in employment. • Gaining employment was associated with improvements in financial satisfaction and self-esteem.	• Very detailed sampling process and demographics information. • Very generalizable due to large sample.

Grove, B. (2009). SESAMI* study of employment support for people with severe mental health problems: 12-month outcomes. *Health and Social Care in the Community*, 17 (2): 151-158.	associated with successful placement in work and to test the impact of working on psychological well-being in this group." • The study was a questionnaire of four measures of other standardised instruments. • Baseline interviews were carried out between September 2004 and March 2005. Follow-up interviews were conducted 12 months later." • Of 888 people contacted, sample eventually consisted of 182, due to various processes of elimination.	• There was a trend towards working half time. • People who had been out of work longer were less likely to secure employment. • No significant associations were found between getting a job and personal characteristics, the quantity of employment support given, nor the recipient's rating of the support offered. " • "If participants had visited a job centre in the 3 months preceding the baseline interview, they were more likely to move into work in the course of the study." • "Whole study sample increased on average in self-esteem, including the six people who left paid work."	• Strong discussion of findings in connection with other research evidence. • Used quite a range of statistical data analysis tests, including t-test. • Low response rate and many processes of elimination ultimately resulted in a much smaller sample.
Amir, Z., Moran, T., Walsh, L., Iddenden, R., Luker, K. (2007). Return to paid work after cancer: A British experience. *Journal of Cancer Survivorship*, 1 (2): 129-136.	• Given the limited research from the United Kingdom on return to work in cancer survivors, the aim of this study was to explore the rate and factors associated with return to paid employment within 18 months after a diagnosis of cancer in one English region." • "A postal survey of all cancer patients registered in North West England from June 2002 through December 2002. Participants were between the ages 18–55 with a primary diagnosis of cancer, in paid employment at the time of diagnosis and being judged by their General Practitioners as suitable for return to work." • Sampling – recruited from North	• "Statistically significant differences in return to work rates were also found by the length of sick leave taken, with more than 90% of those with sick leave duration of less than 12 months returning to work, compared with 62% with sick leave duration of 12 months or more." • "Out of those with less than 6 months sick leave 94.5% returned to the same employer while of those with more than 18 months sick leave 71.4% only returned to the same employer." • "Over eighty percent (83.3%) of those who did not return to work reported that their overall working life had deteriorated as a result of their cancer, compared to only 19.4% of those who did return to work." • "One fifth of those who returned to work and stayed in the same employment reported deterioration in their job satisfaction and career prospects, highest in those who took longer period of sick leave." • "In the present study, overall 82% of cancer patients, who were judged by their GPs as having reasonable chances of returning to work, did so."	• Sampling method and process quite detailed with various stages of elimination. • Sample quite unrepresentative – only a quarter males compared to ¾ females; many respondents were from white-collar occupations. • "Limited in recruitment of participants through their GP who had the flexibility to exclude patients who were too ill. • Reliant on the judgment of patients' GPs as to whether or not potential participants were

	Western Cancer Intelligence Service in Manchester, needed a diagnosis of any cancer from June 2002 to December 2002; aged 18-55; in paid work at diagnosis; have reasonable chance to return to work.		suitable for the study and the resulting loss of patients to the study was considerable."
Maloney, R., Hayward, R. & Chambers, R. (2000). A pilot study of primary care workers with a disability. *British Journal of General Practice*, 50 (461): 984-985.	• We explored the extent to which measures are being taken to retain general practitioners (GPs) and employed staff with disabilities at work in general practice." • Postal survey to practice managers of 100 general practices in North Staffordshire in 1999. • 80% response rate. • 80 practice managers identified 55 colleagues with disabilities in a postal survey – many of these had back problems, hearing problems, and difficulty with mobility. • Interviewed followed with 15 people with disabilities.	• "Most of the 15 people with disabilities who were subsequently interviewed described colleagues having helpful attitudes but changes had not been made to practice workplaces or systems to retain them at work." • "No responders reported that changes had been made to the practice workplaces or systems to help those with 'chronic ill health or disability' remain at work." • (40%) believed that their practice 'completely' adhered to DDA, six 'sometimes' or 'rarely', and 31 (39%) did not know; there were 11 non-responders. • (76%) practices provided access to a disabled toilet and half (40) of practices provided access to every part of their premises for a wheelchair-bound member of staff. • Interview findings - 11 had found work colleagues helpful in minimising the effects of their health problems; 3 reported indifference; 1 reported active unhelpfulness; 1 thought that it would be useful to consult an occupational physician. • "There was little proactive or reactive help from employers, contrary to the responsibilities laid out in the Act."	• Very relevant to this NHS research • Article was quite brief and therefore analysis was limited in detail. • Lack of methodological discussion, other than to simply acknowledge which methods were used. • Statistical analysis seemed to be based only using descriptive statistics, so doesn't control from any other variables. • Adequate sample size for generalizability, however limited attention given to participant's demographics, may not be as generalizable.
Manthorpe, J., Stanley, N. & Caan, W. (2002). Managers' and practitioners' experiences of depression? A unifying	• "This article reports on a national survey of practitioners and managers in social work, describing their experience of depression in the workplace, and the workplace response." • "The survey sought to identify the extent to which work	• "Just over half of both groups reported that their colleagues had known of their depression, and there were no significant differences in how the two groups of respondents described reactions to their depression. Only a small proportion (approx. 6%) of practitioners and managers described colleagues' responses as critical or hostile; the majority of those whose colleagues were aware of their depression found them supportive or tolerant." • "Both groups were more likely to report managers as critical or	• Recruitment of participants was by advertisement through this journal, so could be a biased sample. • "Respondents were self-selected, and cannot be seen as

phenomenon? *Journal of Integrated Care*, 10 (4): 27-30.	contributed to the experience of depression and the ways in which the respondents managed their depression in the workplace. It also examined how depression affected work." • Used questionnaire online – 499 responses were received, of which 72% came from practitioners and the remainder from managers.	hostile, just over a quarter of respondents in both groups describing their managers in this way. Managers and practitioners therefore appeared equally likely to experience lack of sympathy from the hierarchy above them." • "Managers were more likely than practitioners to describe receiving no support from the workplace and they were less likely to be offered workload support or reduction and flexible hours." • "When asked what support they would have liked, respondents came up with a range of proposals. The largest group of suggestions concerned the need for more understanding and support from the workplace."	representative of the workforce as a whole." • No information provided on participants in terms of demographics, other than their roles, so don't know how generalizable. • Lack of methodological discussion, other than to simply acknowledge which methods were used. • No clear method of analysis mentioned, though appears to have been descriptive statistics.
Luker, K., Campbell, M., Amir, Z. & Davies, L. (2013). A UK survey of the impairment of cancer on employment. *Occupational Medicine*, 63 (7): 494-500.	• "To examine the impact of cancer on work activities, sources of advice and support for return-to-work decisions and the role of employers in supporting employees with cancer." • "A cross-sectional survey of a randomly selected sample of people from two cancer registries was conducted in England, completed online or by telephone." • Were aged 21–60, diagnosed • 2–3 years previously with cancers having a >50% 5-year survival rate. • A total of 382 people completed the survey, 27% of those invited to participate.	• "The majority of respondents perceived their employer or manager as having been supportive during their treatment." • "Employers' or line managers' reaction to their diagnosis: Most of the participants reported a positive reaction. Most employers/managers did not ask the respondent to set an exact date for returning to work (73%), did not believe an employee with cancer was less able to perform their duties (52%) or did not think it was impossible to manage an employee with cancer (70%). • Around three-quarters were perceived to be very supportive throughout respondents' illness (76%), were happy for respondents to continue work before starting treatment (74%), made reasonable adjustments to respondents' normal duties (73%) and stayed in touch while respondents were absent having treatment (72%)."	• Sample was mainly of 41+ plus age, and mainly White British, so not as representative of other BMEs. • Potential recall bias due to asking participants to ask on past events

Grunfield, E. A., Low, E. & Cooper, A. F. (2010). Cancer survivors' and employers' perceptions of working following cancer treatment. *Occupational Medicine*, 60 (8): 611-617.	• To determine patient and employers' beliefs about the impact of cancer on returning to work and to Identify differences in the beliefs held by patients and employers." • 1974 four patients (response rate of 82%) and 252 employers (response rate 31%) completed the questionnaire. • "Patients were approached on average 1.6 weeks post treatment." • "Survivors of head and neck, gynaecological, urological or breast cancer were eligible for inclusion providing they were aged under 60 years."	• "The organisational respondents reported more negative beliefs about the impact of cancer on work than the patient respondents." • "Employers of patients who have had myocardial infarction have also reported negative perceptions regarding their return to work due to the extra support required to facilitate the return and a perceived reduction in occupational functioning." • "Organisational respondents were more likely to report that an employee with cancer would experience symptoms at work (P, 0.001) and that cancer treatment would impair ability to work (P, 0.001)." • "Organisational respondents who worked in human resources departments were less likely to report that an employee with cancer would have control over their cancer at work (P, 0.01) and were less likely to think that that effects of cancer and its impact would be understood by co-workers (P, 0.05)."	• Questionnaire consisted of a standardised tool - Brief Illness Perceptions Questionnaire (IPQ) • "The cancer survivor sample was overrepresented by participants who had undergone higher education and who worked in white collar occupations compared to the population of the UK as a whole"

Appendix 4

WORKFORCE DISABILITY EQUALITY STANDARD REPORTING TEMPLATE		
Name and title of Provider Organisation	**Month**	**Year**
Name and Title of Board Lead for Workforce Disability Standard		
Name and contact details of co-ordinating commissioner compiling this report		
Names of Commissioners this report has been sent to		
Unique Url link on which this report can be found		
This report has been signed off by on behalf of the Board on		
1 Background Narrative : issues of completeness /reliability		
2 Total Numbers of staff employed within this organisation at date of report		
Proportion of disabled staff employed within this organisation at date of report		
3 Self Reporting		
a) The proportion of total staff who have self-reported disability		
b) Have any steps been taken in the last reporting period to improve the level of self-reporting of disability		
c) Have any steps been taken in the current reporting period to improve the level of self-reporting of disability		
4 Workforce data: What period does the organisation's workforce data apply to?		

5 Workforce Disability Equality Indicators				
For each of these seven staff survey workforce indicators, the standard compares the metrics for disabled and non-disabled staff	Data for reporting year	Data for previous year	Narrative: the implications of the data	Action taken and planned (and what was the impact of this (improvement, worse, no difference)?
1 Percentage of disabled staff in Bands 8-9, VSM (including executive board members and senior medical staff) compared to the percentage of disabled staff in the overall workforce	Non-disabled	Non-disabled		
	Disabled	Disabled		
2 Q20b: "In the last 12 months, how many times have you personally experienced harrassment, bullying or abuse from you manager/team leader or colleagues?"	Non-disabled	Non-disabled		
	Disabled	Disabled		
3 Q15b. In the last 3 months, have you felt pressure from your manager to come to work despite not feeling well enough to perform your duties?	Non-disabled	Non-disabled		
	Disabled	Disabled		
4 Q22. Does your organisation act fairly with regard to career progression regardless of ethnicity, gender, religion, sexual orientation, disability or age?	Non-disabled	Non-disabled		
	Disabled	Disabled		
5 Q8g: How satisfied are you with the extent to which your organisation values your work?	Non-disabled	Non-disabled		
	Disabled	Disabled		
6Q3e (Appraisal): Were any training, learning or development needs identified?	Non-disabled	Non-disabled		
	Disabled	Disabled		
7 Q3f (Appraisal): did your manager support you to receive this learning and development?	Non-disabled	Non-disabled		
6 Reasonable Adjustment (current and previous reporting year)				

<table>
<tr><td>Q29b Reasonable adjustment: Has your employer made adequate adjustments to enable you to carry out your work? (For reporting year)</td><td>% yes</td><td>% No</td><td>% No adjustment needed</td><td></td><td></td></tr>
<tr><td>Q29b Reasonable adjustment: Has your employer made adequate adjustments to enable you to carry out your work? (For previous year)</td><td>% yes</td><td>% No</td><td>% No adjustment needed</td><td></td><td></td></tr>
<tr><td>7 Disability representation at board level

Does the board meet the requirement on Board membership as in 7 below?</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>7 Boards are expected to be broadly representative of the staff and population they serve</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">8 Are there any other factors or data which should be taken into consideration in assessing progress? Please bear in mind any information, action taken and planned maybe subject to scrutiny by the Co-ordinating Commissioner or by regulators when inspecting against the ‘well led domain’</td></tr>
<tr><td colspan="6">9 If the organisation has a more detailed plan agreed by its Board for addressing these and related issues you are asked to attach it or provide a link to it. Such a plan would normally elaborate on the steps summarised in section 5 above, setting out the next steps with milestones for expected progress against the metrics. It may also identify the links with other workstreams agreed at board level such as….</td></tr>
</table>