Intensive Care Society

Towards an Inclusive Future

A look inside our community

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Equality, Diversity and Inclusion

Foreword

The Intensive Care Society's Equality, Diversity and Inclusion Work Group (EDI) was launched in 2021 to support the Society's workforce agenda and need to better understand the breadth of diversity within the intensive care community. In order to achieve this, an EDI Census was conducted in 2022 comprising all the elements outlined within this report. The survey was designed to be anonymous in order to provide a space where people felt safe to share their experiences, and all questions were optional to ensure that respondents only provided information that they felt comfortable sharing. This is reflected in the baseline numbers outlined below, with some areas having greater response rates than others.

This report draws on real life experiences of people working within intensive care. The data in this document represents a small proportion of our community (n = 352) but it is with thanks to these individuals that we have been able to find a starting point for us to begin working on providing more education, better awareness and help influence sustainable change to encourage a better workforce of tomorrow.

The key recommendations for the Society's next steps rely on the real-life experiences of the people outlined in this report and it is essential to understand these in the first instance to recognise why we are embarking on this journey. We encourage you to read this document in its entirety to acknowledge that it may not represent the experiences of everyone but for some, this is very much their reality.

If you would like to speak to us about our EDI work or would like to be a support any/all of the areas of work outlined in this report, please contact **edi@ics.ac.uk** and mark your email for the attention of the Chair.

Alex Day
Head of Communications,
Intensive Care Society

The key recommendations for the Society's next steps rely on the real-life experiences of the people outlined in this report

A Message from our President and Chief Executive

We would like to thank Aoife Abbey and the whole of the Equality, Diversity and Inclusion (EDI) Working Group and members of our staff team for their extensive work in synthesising the results of the EDI census into this landmark report.

This report is based on the lived experiences of hundreds of clinicians from the breadth of the critical care community and highlights some of their real-life stories and negative experiences. These stories will enable us to establish real and lasting change to ensure that every intensive care professional is treated equally and without bias to encourage a better working environment tomorrow.

This year we launched our Your Society – Our Strategy 2023 – 2027 roadmap for the next five years. One of our two critical enablers to underpin the delivery of the strategy is Equality, Diversity and Inclusion. Our critical enablers are built into the bedrock of our strategy and applied to all aspects of our work.

Intensive care's flat hierarchical approach is something other specialities aspire to. We have always understood that the unique and blended skills needed at the bedside are integral to our patient's survivorship, and it is only by working as one team that we can strive for better patient outcomes.

Fundamentally, multi-professional input sits at the very heart of our service and not one person in intensive care can do their job without the others.

We know first-hand the challenges faced by the intensive care community and as a result we work hard to influence the delivery of the core conditions to thrive through work at governmental and national level as well as on a 1:1 to basis with our members.

We cannot emphasise enough that to us, retention is more important than recruitment. The years of experience our members have is fundamental to training and growing the future workforce.

To achieve this, we need to understand the lived experiences of colleagues, friends and peers. They have the information we need to develop and implement resources, education and projects that make intensive care fit for the future. We take this report as a positive first step in helping us to begin this work.

Our workforce is built on diversity, uniting professionals from all walks of life, and it is by better understanding one another that we are able to build better relationships. Furthermore, it also enables us to apply this knowledge and respect to our patients who are members of the communities outlined in this report.

We would like to thank everyone who provided their experiences to this report, we understand that it would not have been easy, and we admire your bravery. We commend this report to all those working in the NHS.

Steve Mathieu
President

Sandy Mather
Chief Executive

Introduction

It has been fifty-three years since the Intensive Care Society (Society) was founded and held its first council meeting. In the great scheme of healthcare, intensive care is somewhat of a start-up. Those born the very same year as the first UK intensive care unit, established at St Thomas' Hospital in London in the late 1960s, have yet to reach what seems like an ever-shifting retirement age.

Nevertheless, The Society is an organisation that has been around since the very birth of intensive care in the UK, and we are proud of this longevity. We are even prouder of how far we have come in that time. Since 1970, we have worked hard to ensure that we are a fluid organisation that moves with the tide rather than against it - we are not scared to ask the difficult questions or defy the status quo.

How did we evolve to where we are now?

A landmark change to the Articles of Association, which govern how the Society is constituted took us from a doctor founded organisation, to being the largest multi-professional intensive care membership organisation in the world.

We now proudly welcome doctors, nurses, psychologists, physiotherapists, speech and language therapists, pharmacists, occupational therapists, advanced critical care practitioners and all other allied health professionals working in critical care.

With further change to our Articles in 2020, we established full democratic legitimacy by enacting a provision to elect up to 10 members to each of our new Professional Advisory Groups (PAGs) representing; advanced practitioners, allied health professionals, nurses, pharmacists, physiotherapists, specialty doctors (SAS) and trainees (post-graduate doctors in training) to sit alongside our Council, providing everyone with a voice to inspire change.

Having laid these strong foundations, I believe that now is the right time to challenge ourselves to look deeper. We must consider and better understand the diversity within our teams and membership, not just with respect to their profession and the skills they provide, but also who they are and what makes them individuals. It is to the detriment of great things that the reality that 'diversity' by itself is rarely a valuable end point for anything - is ignored.

Two of our four organisational values, **freedom of expression** and **accept and respect,** contribute to a culture where the diverse views and experiences of every individual are accepted, where we treat everyone with dignity and respect and celebrate our differences. We recognise that it takes both time and deliberate action to embed the organisational values capable of facilitating inclusivity and that it is **inclusivity** which is ultimately the goal.

Strong teams are not just diverse, they are diverse and inclusive.

In 2021, from our desire to embed this push the EDI working group was established. Subsequently the agenda for EDI became one of two critical enablers linked to the Society's 2023 - 2027 strategy.

Intensive Care Society

Intensive Care Society

Equality, Diversity and Inclusion

When our working group first met, we were mindful that **'deeds not words'** was what we wanted to be recognised for. With such a broad range of issues needing our attention and no data to support our work, finding that starting line and figuring out where we could and should make a difference was a daunting task. We knew that we needed to understand more about our community to frame a roadmap, so our 'EDI workforce census' was born.

When it comes to cultivating inclusion there can be no end to the work, but there must be a beginning, and this exercise made that start. What you will read comprises conclusions from the personal experiences of **352** members of critical care teams.

These testimonies are just a fraction of our immense workforce, and yet this work still represents the largest and most expansive project of its kind carried out in our multi-professional community to date. More importantly, irrespective of the denominator, we believe each of the voices and therefore their experiences shared not only 'count', but also represent a learning opportunity for both the Society and the teams we work with each day.

Some of the sections that follow will include points for action and a way forward. For the most part these are relatively straight forward actions which can create momentum now. The findings from this survey are complex and so targeting our work will require careful consideration. For the EDI group, our next step will be to formulate a strategy, involving our colleagues in Council as well as individual workstreams across the breadth of the Society.

The future of Intensive Care in the UK is bright, but if we accept our failings, really listen, and take responsibility for being better, it can be dazzling.

The Intensive Care Society intends to cultivate teams that dazzle.

Aoife Abbey
EDI Working Group

Aoife Abbey
Alex Day (he/him)
Segun Olusanya
Sekina Bakare
Jen Warren
Luke Flower
Stuart Connal
Alice Carter
Ashton Burden-Selvaraj
Shoneen Abbas
Daro Iizuka Bjayou

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Acknowledgements

The Society would like to thank Enventure Research who assisted in keeping our data non-identifiable by creating preliminary reports from experiences and data collected in this survey. We would also like to thank our colleagues in the intensive care community for allowing us to hear their experiences.

We would also like to thank the Society's Head of Standard and Policy, Asha Abdillahi, for their substantial amount of support provided throughout the project.

Our Census

Data for this work was collected for six months, between February and August 2022. During this time, 352 responses were received.

To allow as much freedom of expression and personal testimony as possible, the main body of 'data' was collected through open-ended, free text questions and for most questions, respondents could give more than one answer. No respondent was forced to answer any question. Although this form of response collection created a challenge for analysis, our group chose to prioritise a form of data that would be as receptive as possible to self-description and intersectionality.

Meet the Team

Aoife Abbey
EDI Chair
and Consultant
Intensivist

Alex Day (he/him)
Head of
Communications,
Intensive Care Society

Alice Carter
Consultant
Intensivist

Ashton Burden-Selvaraj
Advanced Critical
Care Practitioner

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Segun Olusanya
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Sekina Bakare
Intensive Care
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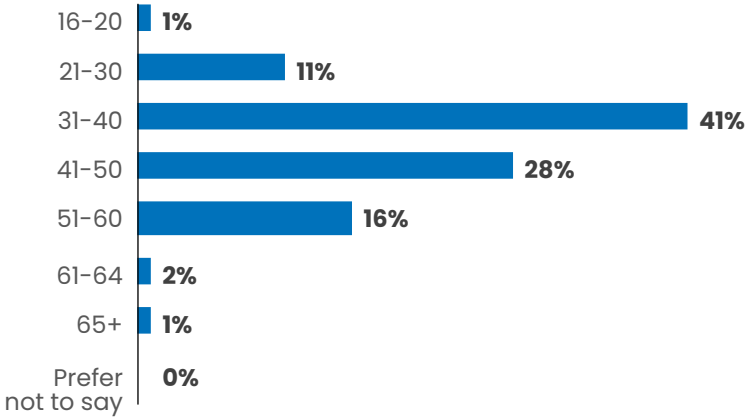
Trainee

Shoneen Abbas
Consultant
Intensivist and
Acute Medicine

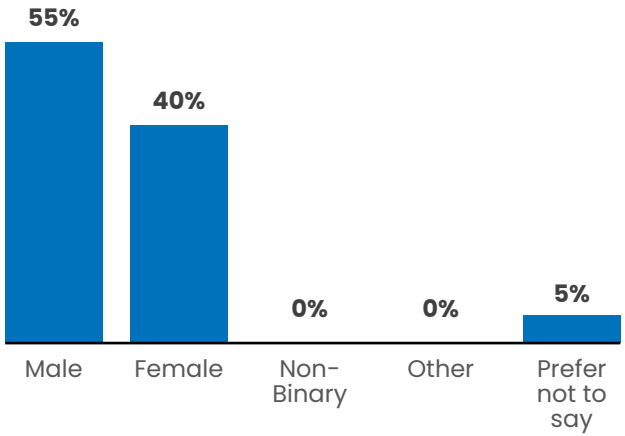
Stuart Connal
Anaesthetic
Registrar

Respondent Profiles

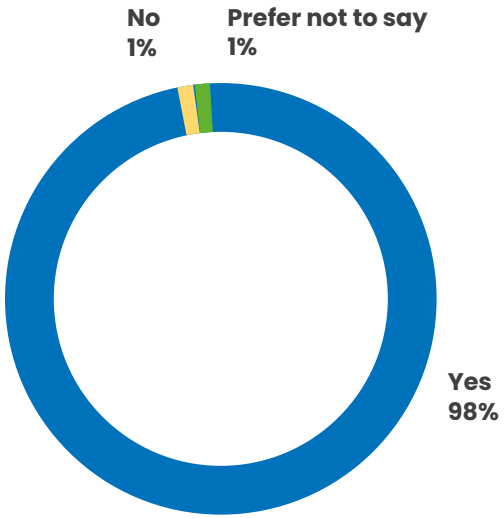
Age (base: 352)



Gender (base: 352)



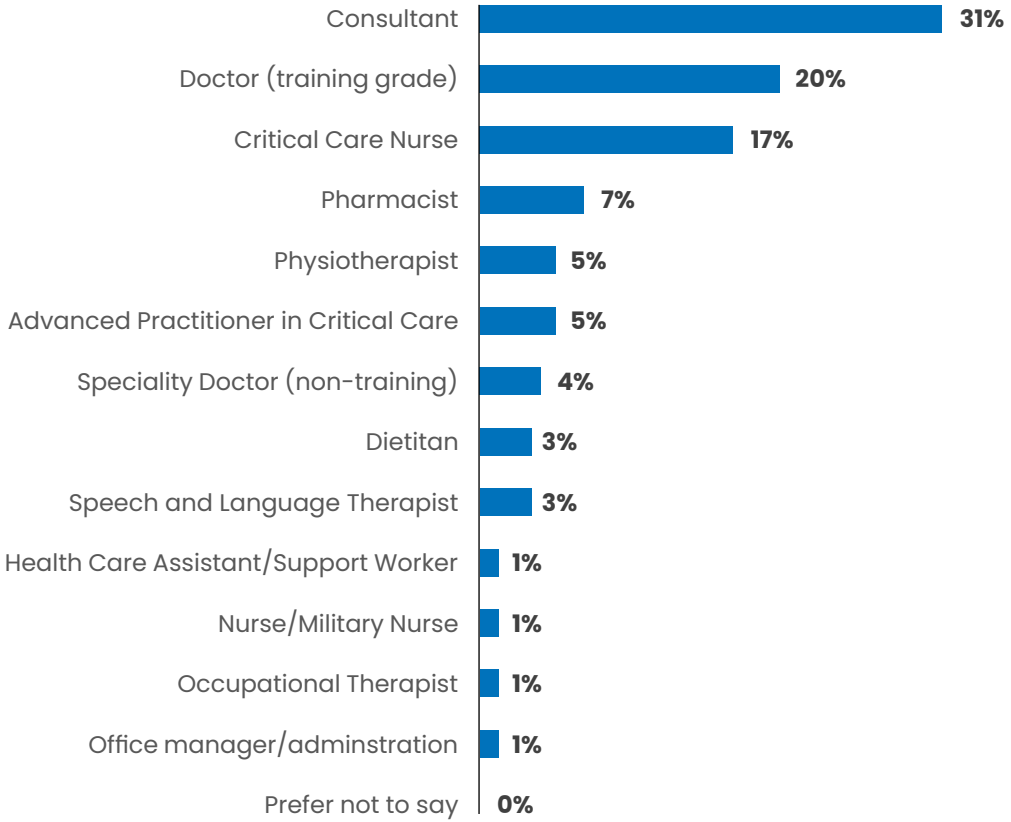
Is your gender identity the same as the sex you were assigned at birth? (base: 352)



41% are aged between 31-40, followed by **28%** 41-50 and **16%** 51-60

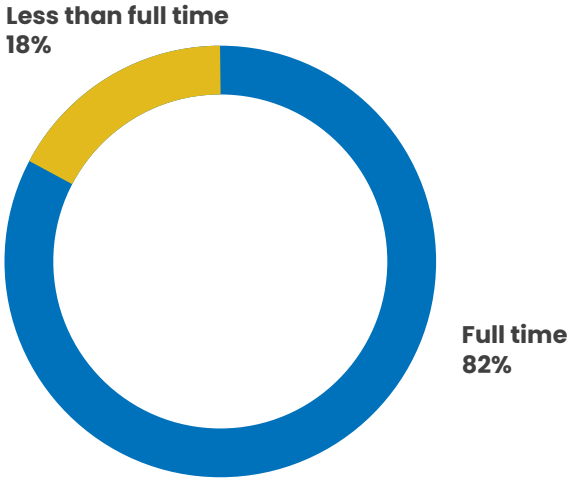
Almost a **third** of respondents were consultants, followed by **20%** who were training grade doctors and **17%** who were critical care nurses.

What is your role in the critical care team? (base: 351)

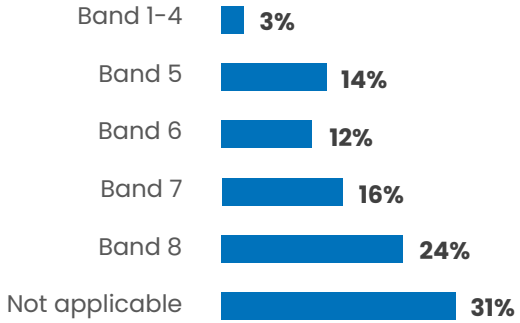


Other roles provided by less than 1% of respondents included pharmacy technician, psychologist, psychology assistant, researcher, retired, specialist nurse organ donation, and student.

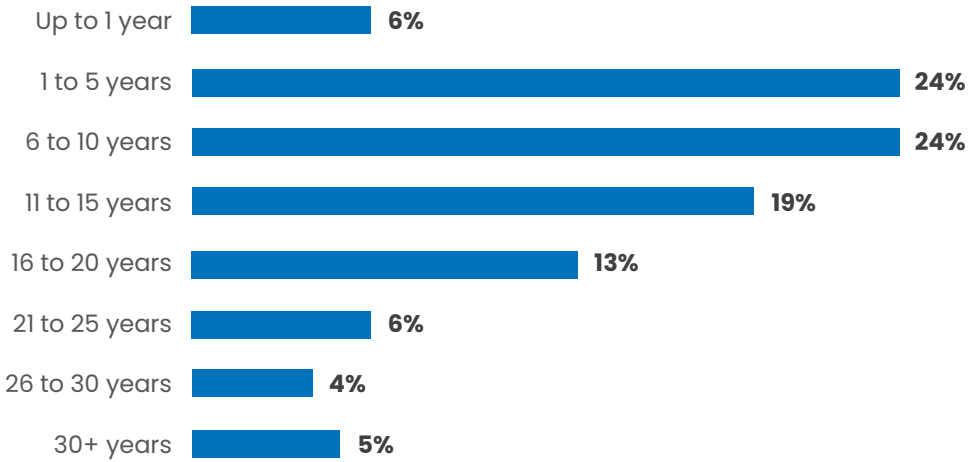
Do you consider yourself to work full time or less than full time? (base: 341)



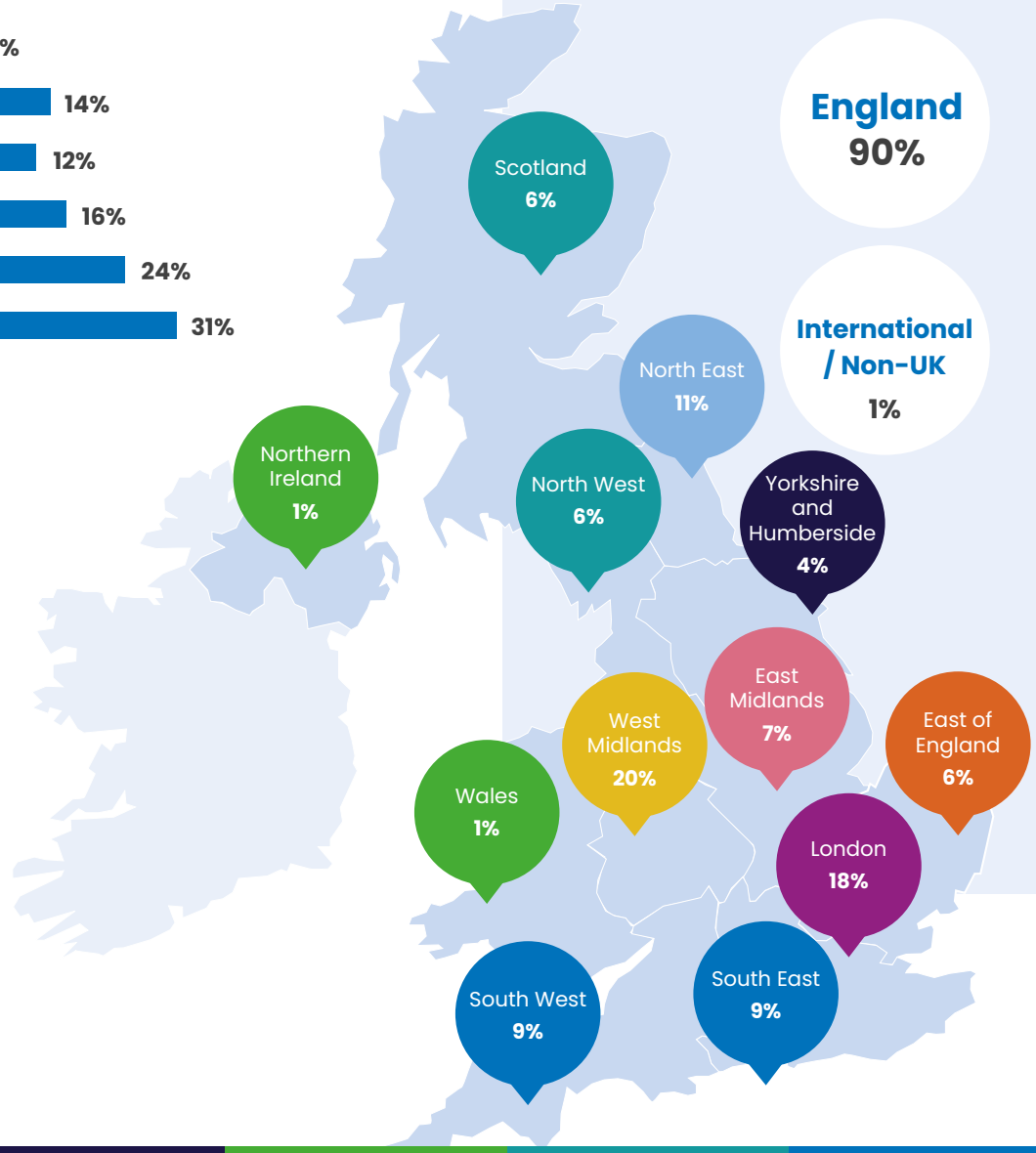
If you are on the Agenda for Change banding, what band are you? (base: 219)



How long have you worked in a role within the critical care multi-professional team? (base: 338)



Which geographical location best describes where you work?



Section 1:
Working in Critical Care

Section 1: Working in Critical Care

This section comprises information about attitudes towards working in critical care. In the words of the late MP Jo Cox '*we are far more united and have far more in common than that which divides us.*'

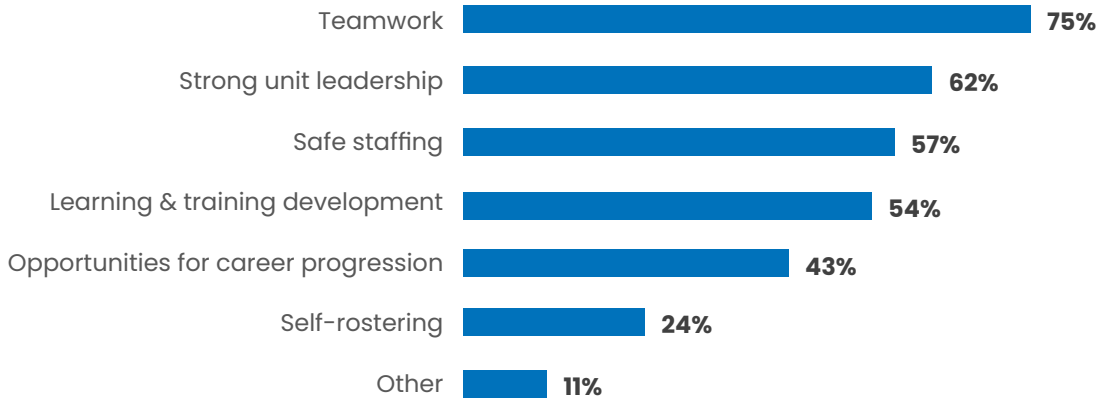
We have chosen to open with this section in the hope that you might recognise some of your own experiences and use that sense of commonality to listen to and understand the range of experiences that follow in subsequent themed sections.

How do we feel about critical care?

Respondents were asked to use up to three words to describe how they felt about their work in the past month. The most used words related to being tired/exhausted/fatigued. The next most frequent category of feeling related to work being 'challenging/demanding' but this was met with a similar proportion of words related to work being 'rewarding/fulfilling'.

What contributes to our experiences of job satisfaction in critical care?

The top three priorities described were teamwork, strong unit leadership and safe staffing. It is reassuring that these three things align substantially with our priorities at the Society. Those over the age of 51 years were most likely to align teamwork to job satisfaction. They were also more likely than other age groups to describe as important, something related to training, learning and development.



Section 2:
Ethnicity

Section 2: Ethnicity

A common theme running through our survey is that members of the intensive care community from ethnic minority backgrounds are more likely to have negative experiences in the workplace compared to members of white ethnicity.

Numerous recent reports have highlighted the relationship between ethnicity and poorer career outcomes in medicine for minority ethnic groups.[2,3] Whilst the reasons are multifactorial, tackling discrimination and differential attainment is paramount in addressing these disparities, and improving the wellbeing of members of the intensive care community and ultimately patient care.

The experiences shared in this survey, provide the Society with a mandate for a holistic strategy to continue to promote equality, diversity, and inclusion in the intensive care community. Asking the questions, no matter how difficult, and actively listening to move from policy to practice.

What you told us

Ethnicity

Most respondents described themselves as White (76%). 13% described themselves as Asian, 3% Black, 3% Mixed, 3% Other and 1% preferred not to say.

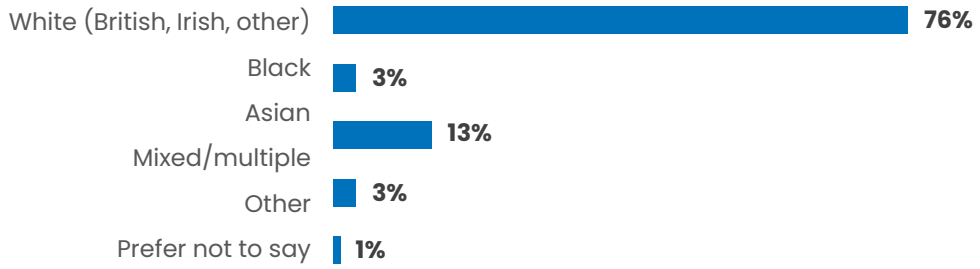
In total, 22% of respondents came from ethnic minority groups.

Respondents who described themselves as Black or Black British: Caribbean are underrepresented (1, <1%) compared to Black or Black British: African (8, 2%).

How would you describe your ethnicity?

Ethnicity (base: 341)	Percentage
White - English/Welsh/Scottish/Northern Irish/British	33%
Irish/White Irish	2%
White - Any other White background	4%
Black or Black British - Caribbean	0%
Black or Black British - African	2%
Asian or Asian British - Indian	6%
Asian or Asian British - Pakistani	1%
Asian or Asian British - Chinese	1%
Asian or Asian British - Tamil	1%
Asian or Asian British - Any other Asian background	1%
Mixed/Multiple ethnic group - Black Caribbean & White	1%
Mixed/Multiple ethnic group - Asian & White	1%
Mixed/Multiple ethnic group - Any other	1%
Arab	1%
Any other ethnic group	1%
British/English (not specified further)	3%
European (not specified further)	2%
White (not specified further)	34%
Black/Black British (not specified further)	1%
Mixed (not specified further)	1%
Asian/Asian British (not specified further)	3%
Prefer not to say	1%

Ethnicity – grouped



Nationality

Most respondents described their nationality as British (84%), which also included English, Welsh, Scottish, Northern Irish, and Cornish. Only 3% described themselves as having a Dual Nationality.

The NHS staff survey (June 2022) similarly reported 83.5% of NHS staff described themselves as British.[1] The remaining cohort, as per NHS staff survey data, represent >200 nationalities, with 7.2% of these described as Asian nationalities. In the wider NHS, the most common nationalities other than British are Indian, Filipino, Nigerian and Irish.

The spread of nationalities across respondents from this survey are represented in figure 7. This shows that although the proportion of British nationals is similar to the NHS survey, the next largest group were dual nationality holders (British/other). *The voice of non-British nationals, even for those groups which we know make up larger proportions of the NHS workforce, have been under-represented in this survey.*

Most respondents described their nationality as British (84%), which also included English, Welsh, Scottish, Northern Irish, and Cornish

Nationality (base: 348)	Percentage
British/English/Welsh/Scottish/Northern Irish/Cornish	**84%**
Dual nationality (British/other)	**3%**
Irish	**2%**
Indian	**1%**
Filipino	**1%**
Egyptian	**1%**
Dual nationality (non-British)	**1%**
Australian	**1%**
Greek	**1%**
Italian	**1%**
Nigerian	**1%**
Dutch	**1%**
German	**0%**
Maltese	**0%**
Portuguese	**0%**
Romanian	**0%**
South African	**0%**
Spanish	**0%**
Turkish	**0%**
European	**0%**
Prefer not to say	**0%**

Where you gained your professional qualification

90% of 344 respondents received their professional qualification in the United Kingdom. The only other country featuring at >1% was India (3%). Indian is also the second most common nationality in the wider NHS.[1]

It is likely that our survey has also under-represented the views of those with international professional qualifications.

How do you feel about the term Black Asian and Minority Ethnic (BAME)

Combined, a greater proportion of respondents were critical of the term BAME (37%). Importantly, a negative relationship with the term was more apparent from respondents who described themselves as being of an ethnic minority (59%).

Themes from responses:

- It groups all non-white or diverse groups together.
- They disliked the term and that it should be avoided.
- It is too broad and can over-generalise.
- Outdated, Offensive, Divisive, Controversial.
- Several respondents indicated that the Society should ask the question to those who the term will be used to describe, or that they did not feel qualified to have an opinion as they were not from a minority ethnic group.

I think this term (BAME) is very reductive, it groups together a very broad range of people who have different experiences and needs. The term also emphasises certain ethnic groups to the exclusion of others
Asian/Asian British respondent

It is good to show support for minority ethnicities but I believe this term is mainly used to describe non-white people. There are white people in the UK who are in the minority – would they fall into the BAME category?
Mixed ethnicity respondent

BAME covers every ethnic minority which is basically not British Caucasian & white. It lumps a diverse group of people into one category, which implies that they all have the same identity, needs and problems. This is clearly not true
Black/Black British respondent

My voice is not the voice you need to listen to on this
White British respondent

90% of respondents received their professional qualification in the United Kingdom

What would be a better term?

- Most respondents could not suggest an alternative term or had no preference.
- Several respondents also said they did not feel qualified to suggest a term.
- Some respondents suggested that no term was needed and that groups should be referred to individually.
- Some alternative terms suggested by small numbers of respondents included ethnic minorities/minority ethnicities and minorities/minority individuals.

Ethnicity also has a clear relationship with experiences of inappropriate behaviour, lack of inclusivity and poor career progression in critical care.

Respondents from ethnic minority groups were more likely to indicate that they had personally experienced discrimination and harassment when compared with those of White ethnicity. This will be followed up in section six.

Respondents from ethnic minority groups were more likely to think that their ethnicity or nationality has limited their career progression or leadership opportunities when compared with those of White ethnicity. This will be followed up in section seven.

Being a BAME member of staff, we needed to work twice as hard to gain recognition to our hard work
Critical care nurse, Asian/Asian British

There are so few black consultants in critical care it feels like there is a glass ceiling that can't be broken through
Training grade doctor, Black/Black British

Don't see career progression after so many years of work experience
Speciality doctor, male, Asian/Asian British

No progression or slow progression as ethnic minority even though well experienced for the job
Critical care nurse, Black/Black British

Respondents from ethnic minority groups were more likely to indicate that they had personally experienced discrimination and harassment when compared with those of White ethnicity

What the Society will do

We have named Equality Diversity and Inclusion (EDI) as one of two critical enablers in our 2023-2027 organisational strategy. Our EDI workstream is based within our professional affairs division which drives our workforce priorities, it is also a cross-cutting theme designed to ensure the Society considers EDI in all of our activities.

We will continue to positively Influence the intensive care community by taking the lead through listening and learning what can be done to understand and support EDI.

Our EDI working group through educational, membership and external engagement activities continues to ensure the Society is an inclusive organisation championing diversity. We have created and will continue to create events aimed at increasing awareness, recognising challenges, and driving change to improve visibility and representation of minority ethnic groups and celebrate diversity.

You can check out our 2022 Black History Month Podcast here. This conversation includes some important insights into the needs of and challenges experienced by black people in intensive care.

Inclusive Leadership

Our bespoke leadership programmes (LeaP) have been created to champion the compassionate, transformative leadership that we call for in our Workforce Wellbeing best practice framework.[5]

What the Society would like to do next

The term BAME or BME will not be used in any of our communications going forward. This is in line with the UK Commission on Race and Ethnic Disparities recommendation in March 2021.

- Pending resolution, we will use the specific ethnic classifications of the UK 2021 Census. This aligns with one of the final recommendations in the final report on COVID-19 disparities, to refer to ethnic minority groups individually, rather than as a single group. If it is necessary in the interim, to group people from different ethnic minority backgrounds, we will use the terms 'ethnic minorities' or 'people from ethnic minority backgrounds'.

We seek to champion clear Practical National Guidelines to support critical care units to promote a diverse and inclusive environment, with the recommendation that each department have an EDI Lead. We expect much of this influence to come through advocacy opportunities created by our role in co-designing GPICS (Guideline for the Provision of Intensive Care Standards) version three.

We will champion clear Practical National Guidelines to support critical units to promote a diverse and inclusive environment

We will create resources for leaders and their teams to support minority ethnic team members. To action this change we will:

- Promote role models and develop peer support networks that further the agenda for inclusion in our teams.
- Explore a cross organisational working group to pull together resources, focusing on listening to the voices and experiences of minority groups.
- With respect to our own projects, we will collect good quality evidence about which interventions make a real and sustained difference by monitoring the impact of their actions and then share findings with the wider community to scale up potential solutions and increase the pace of change.[2]

We will promote role models and develop peer support networks that further the agenda for inclusion in our teams

References

1. NHS Staff Survey (2022), https://commonslibrary.parliament.uk/research-briefings/cbp-7783/ (Accessed 08/06/2023)

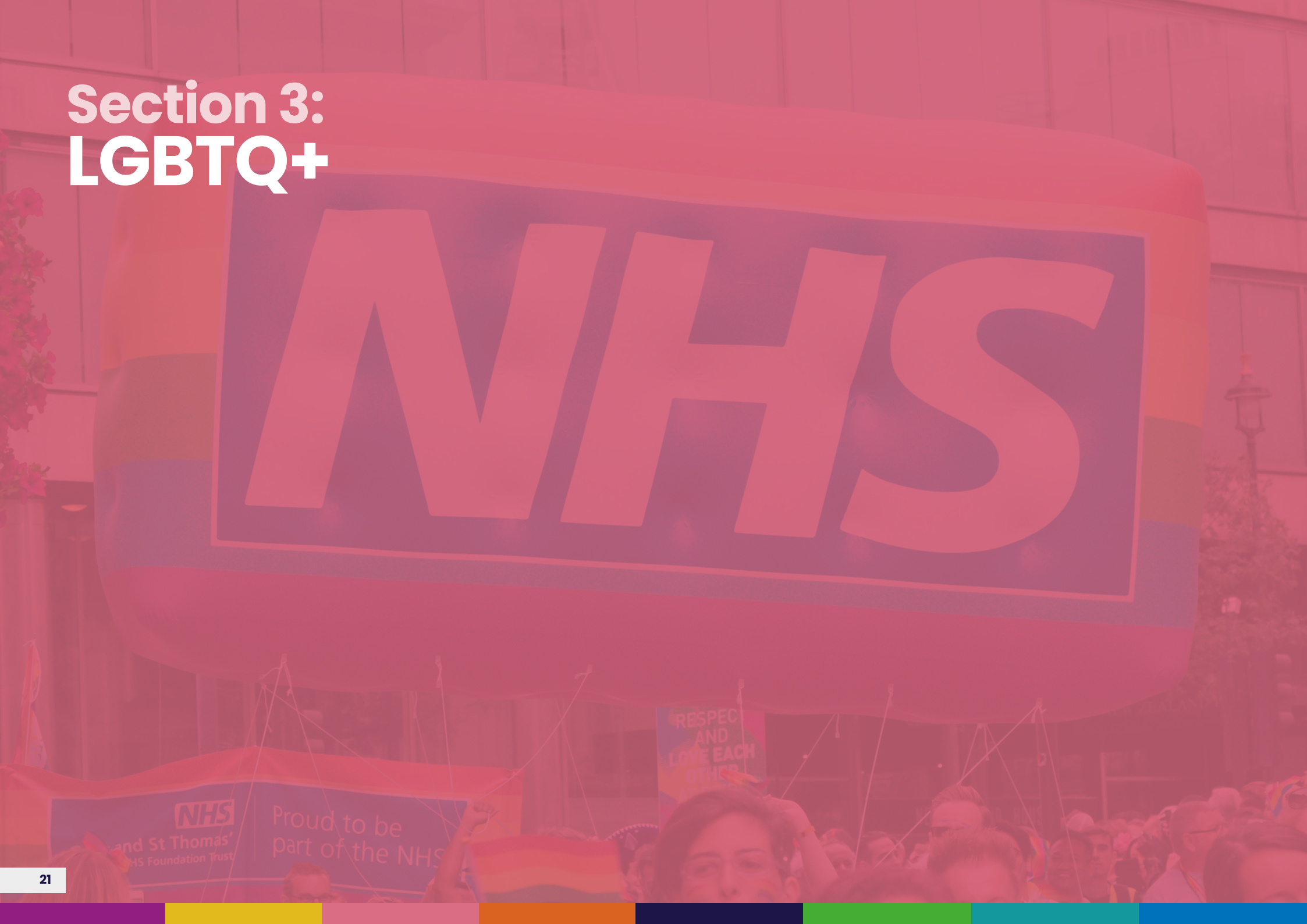
2. The Royal College of Surgeons of Edinburgh Black Surgeons in the UK, 2022 https://www.rcsed.ac.uk/media/684310/rcsed-black-surgeons-in-the-uk-report.pdf (Accessed 01/06/2023).

3. General Medical Council. Tackling disadvantage in medical education, 2022 https://www.gmc-uk.org/-/media/documents/96887270_tackling-disadvantage-in-medical-education-020323.pdf (accessed 01/06/2023).

4. Racial Disparity Unit Why we no longer use the term BAME in government, 2022 https://equalities.blog.gov.uk/2022/04/07/why-we-no-longer-use-the-term-bame-in-government/ (accessed 01/06/2023).

5. Intensive Care Society. Workforce Wellbeing Best Practice Framework, 2021 https://ics.ac.uk/resource/wellbeing-framework.html (accessed 08/06/2023)

Section 3:
LGBTQ+



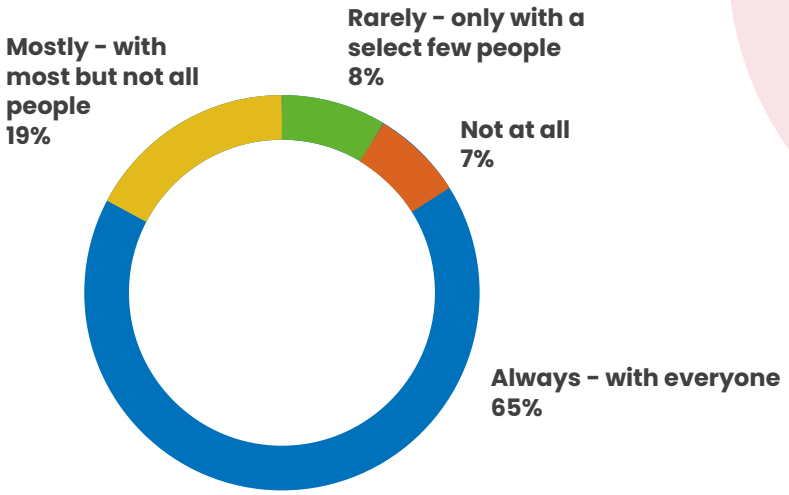
Section 3: LGBTQ+

The experiences of LGTBQ+ staff and patients in critical care remains different to others. Our data shows that persistent perceived and actual discrimination based on sexuality and gender identity is still apparent. This results in staff not feeling comfortable being open about their sexuality and/or gender in the workplace. In turn this has adverse consequences for experiences and wellbeing and impacts perceived and actual opportunities for career development and leadership.

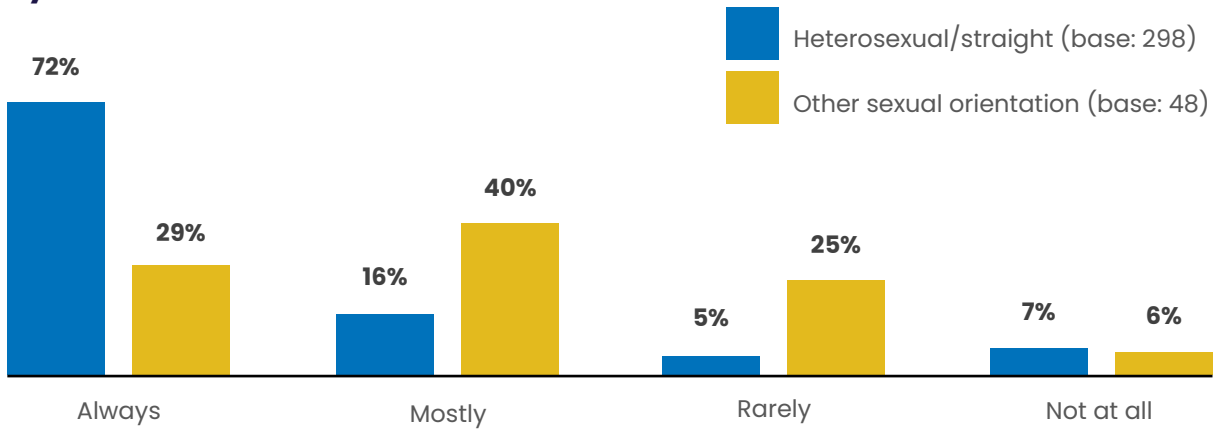
What you told us

- 15% of 352 respondents reported being gay/ lesbian/ asexual/pansexual/queer. This is higher than the reported general population but there may be an element of self-selection bias present.
- Only 29% of non-heterosexual respondents reported being comfortable being open to everyone about their sexuality at work (compared to 72% of heterosexual respondents), with 40% reporting being comfortable with most people, 25% rarely and 7% not at all.
- Almost one in five participants who identified as gay or lesbian in this census reported that their career progression had been negatively impacted by their sexuality. Transgender respondents were also likely to feel that this negatively impacted their career and leadership opportunities (see section seven).

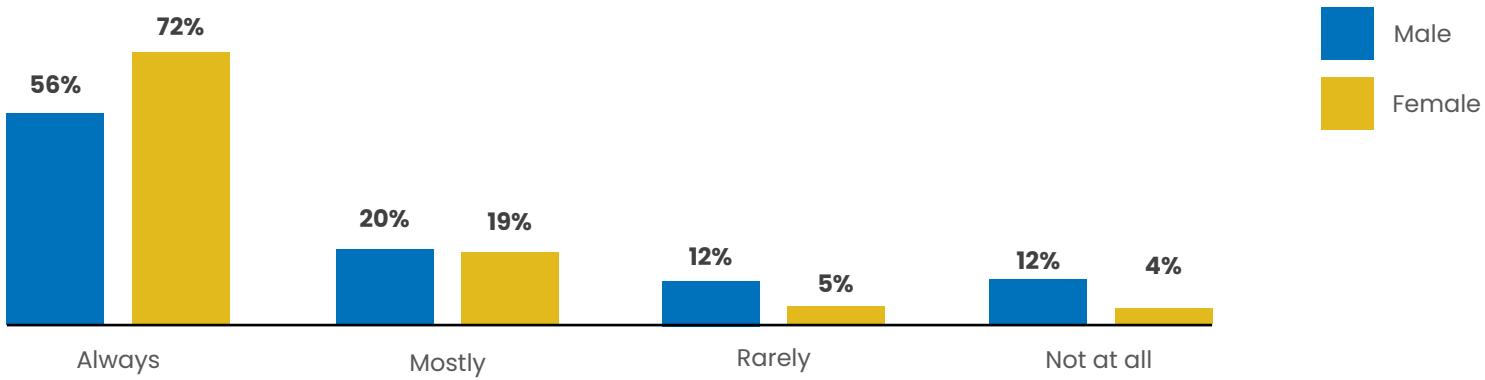
Do you feel comfortable being open about your sexuality at work in critical care?



Feeling comfortable being open about sexuality at work in critical care by sexual orientation



Feeling comfortable being open about sexuality at work in critical care by gender



- Female respondents were more likely to feel comfortable being open about their sexuality with everyone compared to males (72% vs 56%).
- 1% (n=4) of respondents identified as transgender/gender diverse.
- Only one of these respondents were comfortable with being open with everyone about their gender identity at work, with 50% reporting being rarely comfortable and 25% not comfortable at all.

The data presented here should be understood in context of other important work in this field. In 2022, the British Medical Association (BMA) and the Association of LGBTQ+ Doctors and Dentists (GLADD) undertook a survey about sexual orientation and gender identify in the medical profession, which built on previous work exploring the experiences of lesbian, gay and bisexual doctors in 2016.[1] The survey was open to all doctors and medical students, and to people of all sexual orientations and gender identities or none. The survey received 2490 responses: 43% of lesbian, gay, bisexual and queer respondents had directly experienced homophobia or biphobia; and 49% of trans respondents had experienced transphobia in the past two years. This echoes findings from the NHS workforce survey, which in 2020 reported 11.8% of gay or lesbian staff reporting discrimination from their colleagues.

Micro aggressions re sexuality are extremely common and hard to call out… I've been on ward rounds with consultants who have used derogatory terms for gay people…

My career was undoubtedly held back because I held back from fully engaging in case colleagues found out I was gay. I always kept under the radar… avoided social situations so as not to have discuss partner/home life

Consultant

Female respondents were more likely to feel comfortable being open about their sexuality with everyone compared to males

There was some talk about trans-inclusivity going 'too far' and 'them' trying to push things too far too fast. I felt uncomfortable because the staff member in question was obviously upset about this and could not tell me exactly who 'they' were. I didn't feel the need to report the staff member, because I felt she was only expressing her frustration to me because she is comfortable with me and did not consider that I might have a somewhat personal stake in what she was saying
Non-Binary Respondent

Micro-aggressions re sexuality are extremely common and hard to call out - people will usually state they were only joking, or will even get angry about being challenged...I've been on ward rounds with consultants who have used derogatory terms for gay people, albeit not directed at me. I've never faced overt discrimination at work for my sexuality, but in a way, that'd be easier to deal with - it would be illegal discrimination on the basis of a protected characteristic and lead to disciplinary action
Gay/Lesbian respondent

Being trans in a transphobic society takes up a lot of energy that I could otherwise be spending on passing exams, CPD etc
Doctor

What this means

We need to better understand our LGBTQ+ workforce's needs and experiences. To advocate for and improve the experience of staff working in critical care, we must first gain a clearer image of their experiences.

We must understand and address the barriers currently experienced by trans gender/gender diverse members of staff. The majority of non-cisgender respondents reported not feeling comfortable being open about their gender identity at work. It is important we ascertain the reasons for this so they can be addressed.

We must understand and address the barriers currently experienced by non-heterosexual members of staff. The majority of gay/lesbian/bisexual/pansexual/asexual/queer staff are not comfortable being open about their sexuality at work, with microaggressions commented on by respondents.

What the Society is doing

We have expanded our educational content to include collaborations with other stakeholders about caring for transgender patients in critical care: check out our recent blog post, podcast, journal article & editorials here.

We have increased visibility of the Society as an inclusive organisation which recognises the challenges faced and contributions of LGBTQ+ team members working in intensive care.

We have incorporated the experiences of LGBTQ+ respondents into our EDI workstreams and platformed related themes at our flagship national Congress, State of the Art.

We have increased visibility of the Society as an inclusive organisation which recognises the challenges faced and contributions of LGBTQ+ team members working in intensive care

Next steps

Our next steps in this area will focus on further evaluating the experience of LGBTQ+ staff to understand the barriers experienced by this group. Our focus group within the EDI group will also now consider how the Society can collaborate with stakeholder organisations to promote a culture of effective allyship in our community.

Terminology

- **LGBTQ+** – This term incorporates lesbian (L), gay (G), bisexual (B), those whose gender identity is not the same as their sex assigned at birth (T), queer (Q) and sexual orientations and those with other non-heterosexual orientations such as asexual and pansexual and those who prefer to self-describe (+).
- **Queer** – is an adjective used by some people, particularly younger people, whose sexual orientation is not exclusively heterosexual. Once considered a derogatory term (and still considered so by some), queer has been reclaimed by some LGBTQ+ people to describe themselves.
- **Gay man** – is a male who has a romantic and/or sexual orientation towards men.
- **Lesbian** – is a female who has a romantic and/or sexual orientation towards women.
- **Bisexual** – is an individual who has a romantic/or sexual orientation to both men and women.
- **Transgender man** – is an individual who was assigned female at birth but identifies and lives as a man. This may be shortened to trans man.
- **Transgender woman** – is an individual who was assigned male at birth but identifies and lives as a woman. This may be shortened to trans woman.
- **Cisgender** - is often described as someone whose gender identity is the same as assigned at birth.
- **Non-Binary** – is an individual who experiences their gender identity and/or gender expression as falling outside the binary categories of "man" and "woman." Many non-binary people also call themselves trans and consider themselves part of the trans community. Others do not.
- **Pansexual** – is an individual that has sexual, romantic, or emotional attraction towards people of all genders, or regardless of their sex or gender identity. Pansexual people might refer to themselves as gender-blind, asserting that gender and sex are not determining factors in their romantic or sexual attraction to others.
- **Asexual** – is an individual who experiences no sexual feelings or desires; not feeling sexual attraction to anyone.
- **Homophobia** - is the fear, hatred, discomfort with, or mistrust of people who are lesbian, gay, or bisexual.
- **Biphobia** - is fear, hatred, discomfort, or mistrust, specifically of people who are bisexual.
- **Transphobia** - is fear, hatred, discomfort with, or mistrust of people who are transgender, genderqueer, or don't follow traditional gender norms.

Our next steps in this area will focus on further evaluating the experience of LGBTQ+ staff to understand the barriers experienced by this group

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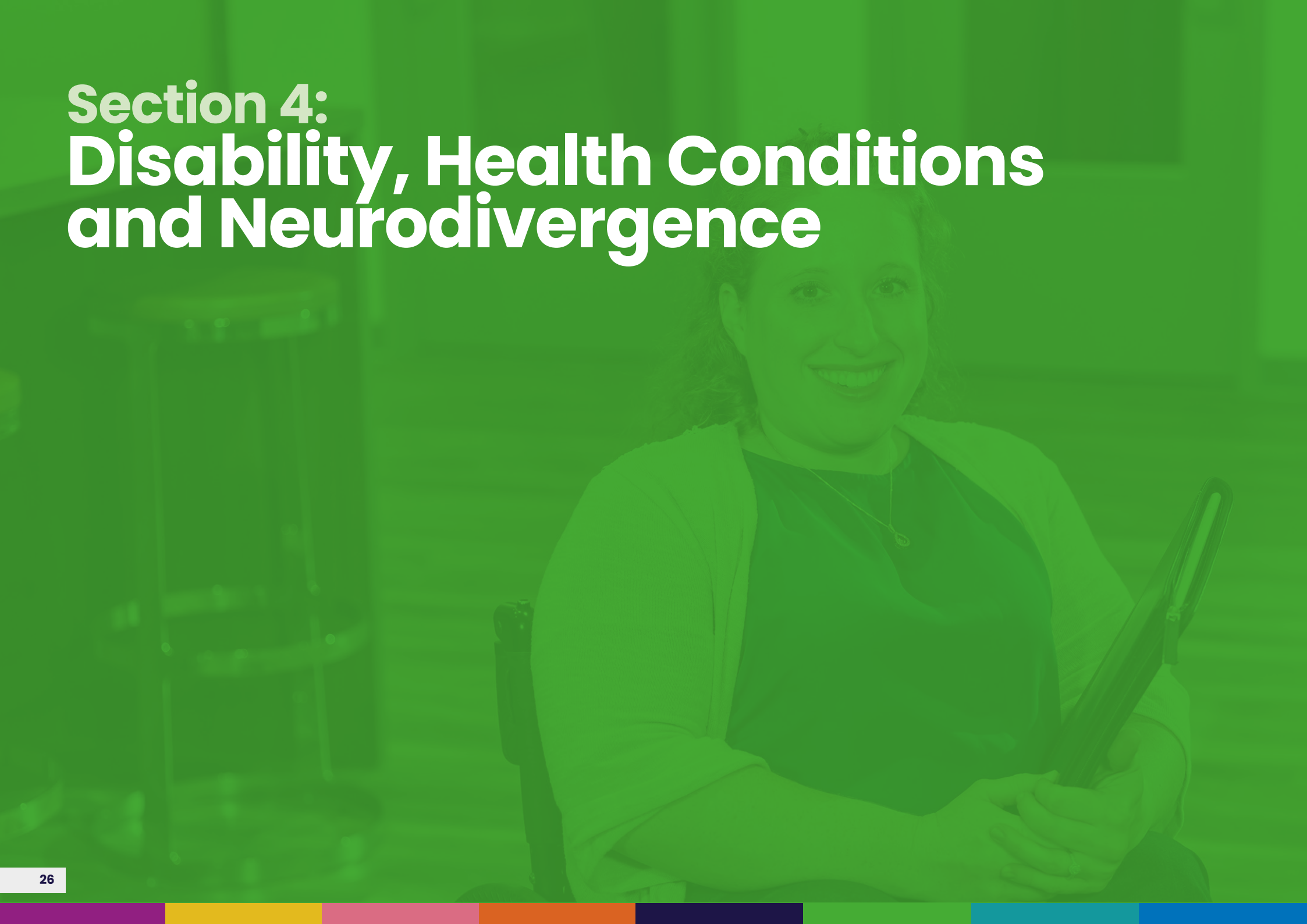
1. Sexual orientation and gender identity in the medical profession, British Medical Association (2022) https://www.bma.org.uk/media/6340/bma-sogi-report-2-nov-2022.pdf, accessed 10/06/2023

Section 4:
Disability, Health Conditions and Neurodivergence



Section 4 : Disability, Health Conditions and Neurodivergence

What you told us

The numbers of healthcare professionals working with a disability, health condition or neurodiversity who responded to this survey are low. This alone is a significant finding given the relatively high profile of disability, health conditions and neurodivergence amongst the population we treat. Although a low response rate from people with a disability, health condition or neurodivergence means we should be cautious in how we interpret our findings, it is important that the experiences of those working in our teams with disability, health conditions or neurodivergence are not marginalised or forgotten.

10% of 350 respondents reported a disability, health or neurodivergent condition. The majority of healthcare professionals working reported their disability, health condition or neurodivergence was invisible with less than 1% reporting a visible condition. The UK general population report 70-80%[1] of people with a disability report invisible conditions so our survey findings suggest we have not only low levels of self-reported disability, health conditions and neurodivergence but also have comparably much lower levels of those with a visible health condition or disability.

It's important to note that 76% of respondents were white. In a recent GMC report[2] into tackling disadvantage in medical education, the self-reporting of disability amongst doctors varied widely across ethnicity and location of primary medical qualification. In the GMC data, 10% of white UK trained graduates self-reported disability but that dropped to 2% of international medical graduates in Asian and Black ethnic groups. Our survey findings align with those reported by the GMC as 10% of respondents self-reported a disability health or neurodivergent condition, although our survey population included a much broader group of healthcare professionals. The combination of low rates of self-reported conditions and the wider context of our survey under-representing those from minority ethnic groups and whose primary medical qualification is outside the UK means the experience of those at the intersection of these groups has been missed.

Impact on work, work-life and adjustments

Of the 10% of responders who work with a disability, health or neurodivergent condition in our intensive care community, around half report that their condition impacts their day-to-day work. It is interesting however that only 30% of respondents reported that reasonable adjustments were in place and our survey data suggests that around 20% are trying to manage without them. The results beg the question, why as healthcare professionals are we not *as* caring inside our teams and organisations, as we are to our patients and loved ones?

37 respondents told us about the benefit a disability, neurodiversity or a health condition brought to a their role in intensive care. Empathy/understanding were most commonly cited (46%) but other benefits included attention to detail, different perspectives and approach to problem solving. **Free text coding of all 37 responses returned nine different benefits**, demonstrating the value in diversity. A minority (25%) reported their condition did not bring any benefits to their work.

10% of survey respondents reported a disability, health or neurodivergent condition

What benefits does your neurodiversity, disability, or health condition bring to your role within critical care?

Response (base: 37)	**Percentage**
Empathy/understanding	46%
Attention to detail	16%
Different perspective/way of thinking	16%
Critical thinking/ability to question	11%
Ability to advocate/champion causes	8%
Strong focus	5%
Better care for patients	5%
Good decision making	5%
Ability to multitask	3%
None	24%

Lived experience allows rapport building and empathy with patients and families and ensures patient centered care is at the forefront
Respondent with invisible disability, health condition, neurodivergent diagnosis

Meticulous, different perspective, algorithm or policy recall, quick learner, empathy for patients, advocate for patients, focused
Respondent with both visible and invisible disability, health condition, neurodivergent diagnosis

I see things from a different perspective, think outside the box, am not influenced by group think, can collate information well, am an original thinker
Respondent with invisible disability, health condition, neurodivergent diagnosis

Neurodiversity (ADD) occasionally means I notice small changes before others and am perceived to "overreact" to certain situations before they become critical
Respondent with invisible disability, health condition, neurodivergent diagnosis

Just under half of 36 respondents (42%) reported their disability, health or neurodivergent condition did not cause any activity limitations and the same proportion said it did not restrict participation. The most commonly reported activity limitations were tasks taking longer, physical difficulties and fatigue. Anxiety and stress were the main barriers to participation reported. In terms of how this affected work on a day-to-day basis, just over half reported no problems but for those reporting limitations, the same themes persisted.

Neurodiversity (ADD) occasionally means I notice small changes before others and am perceived to "overreact" to certain situations before they become critical

Does your neurodiversity, disability, or health condition cause you any activity (execution of a task) limitations?

Response (base: 36)	**Percentage**
No	42%
Work more slowly/things take longer	14%
Physical difficulties (standing, reaching, stairs etc.)	11%
Unable/difficult to complete some tasks/procedures	11%
Yes - unspecified	8%
Easily tired/fatigued	6%
Easily overwhelmed/frustrated/stressed	6%
Time out of work/sick leave	6%
Lack of support/reasonable adjustments	6%
Have learned to adapt/use coping mechanisms	6%
Difficult to pass exams	3%
Hearing difficulty	3%
Mixed experience in different workplaces	3%

Just under half of respondents (42%) reported their disability, health or neurodivergent condition did not cause any activity limitations and the same proportion said it did not restrict participation

Does your neurodiversity, disability, or health condition restrict your participation (involvement/joining in)?

Response (base: 36)	**Percentage**
Avoid/find social situations stressful	14%
Sometimes/potentially	11%
Yes - unspecified	11%
Take own steps/ask for support if needed	8%
Some tasks take longer	6%
Can feel anxious	6%
Less likely to participate in some activities	6%
Physical difficulties	6%
Sometimes feel misunderstood	3%
No	42%

Anxiety and stress were the main barriers to participation reported

Yes, to a degree. I avoid prolonged periods with a large number of other people, and find coffee breaks and social situations stressful and unpleasant, trying to understand what other people are talking about. I also avoid social activities out of hours
Respondent with invisible disability, health condition, neurodiveregent diagnosis

Sometimes, I don't feel like engaging with others and feel the need to isolate myself until I feel better with myself. I want to engage with others but it's hard for me
Respondent with invisible disability, health condition, neurodivergent diagnosis

Although I am completely literate – I can obviously read and write – but it does take me longer to read big paragraphs of text e.g. in patient notes (due to my dyslexia) and similarly It takes me a long time to document in patient notes
Respondent with invisible disability, health condition, neurodivergent diagnosis

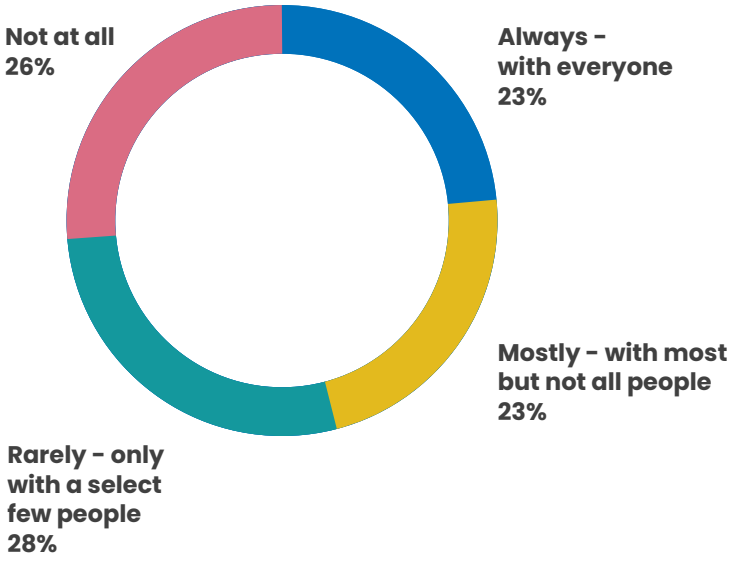
Not significantly day to day but it has an impact beyond that – as previously struggle to fit in all the additional self-motivated low reward stuff
Respondent with invisible disability, health condition, neurodivergent diagnosis

My near vision eyesight is deteriorating so I struggle sometimes to read computer screens or very small print even with glasses
Respondent with unspecified disability, health condition, neurodivergent diagnosis

We asked respondents if they felt comfortable talking to work colleagues about their condition. Just 23% agreed that they were, with everyone. More than 50% of people were rarely or never comfortable.

Do you feel comfortable talking to your work colleagues about your condition?

(base: 39)



Just 23% agreed that they were comfortable, with everyone

Chronic understaffing makes reasonable adjustments difficult to achieve
Respondent with invisible disability or health condition, or diagnosis related to neurodiversity

My desk computer allows me to increase font size but this isn't possible on many of the mobile computers I use in the ICU or on the anaesthesia e-charting, so I struggle sometimes
Respondent with invisible disability, health condition, neurodiversity diagnosis

I would love to go LTFT it would help me hugely, but it would seriously extend my training and I think be viewed unfavourably
Respondent with unspecified disability, health condition, neurodiversity diagnosis

What this means in context

That the majority of respondents sharing experiences here either never or rarely felt comfortable even discussing their condition or challenges, is a stark finding and we may ask ourselves, how would we react if a survey of our patient community reported the same findings?

Andrew Powell in his 2020 briefing paper to the House of Commons reports that 20% of the working age population report a disability. We do not yet represent the population we serve and as a community we need to strive to understand our knowledge gaps and both conscious and unconscious bias to ensure we treat every patient and colleague fairly. Reflecting on the tiny numbers of those with visible disabilities and health conditions in our teams, when compared with the general population, we need to consider if this is purely down to the working environment or has roots in a negative culture towards disability. To move forward, we need to appreciate that the current standpoint is that disability is a 'negative' and once we do this, take steps to create a more inclusive community.

This is not just important for workplace relationships, but also to inform the interactions we have with patients and their loved ones. In the context of critical care, where stakes are high and 'best interest' decision making is part of everyday practice, attitudes fuelled by ableism, a form of disability discrimination that views someone with a disability as of lower importance, must be consciously controlled and dismissed.

Our community needs to acknowledge our failings in this area and take active steps to address this in training and workshops. A 2021 study aimed and understanding inequalities in COVID-19 outcomes following hospital admission for people with intellectual disabilties[4] demonstrated that adjusted for age, sex, severity of illness, comorbidities, and Down's syndrome those with intellectual disability were 50% less likely to be admitted to critical care, 40% less likely to receive intubation and 37% less likely to receive non-invasive ventilation. They were also deemed to have lower performance status and given higher scores on clinical frailty scale, which was deemed to reflect a misinterpretation of the degree of frailty in the context of long term but stable cognitive impairment. Ableism must be actively countered.

We need to acknowledge our failings in this area and take active steps to address this in training and workshops

A measure of future success would be a survey where most respondents felt comfortable talking about their neurodiversity, disability or health condition with a colleague.

What the Society will do

The Society cannot change the structure or physical aspects of the workplace but given most of the ways in which respondents reported problems with activities or participation was anxiety and stress, increased awareness, education and a positive workplace culture will have an important role to play. We will use our values (collaboration, accept and respect and freedom of expression) to engage our internal processes and wider membership in this work.

Our EDI workstream will now consider the challenges presented by the experiences shared with us and use them to inform our strategy for change going forward.

In the short term we will work with our education team, to understand and improve how our learning portfolio, both in terms of static online and in-person events, can be improved with inclusivity in mind. We also accept that when it comes to parity of access to in person events, we have not always provided the best experience and going forward, this will be corrected. We have also understood the value of hybrid Congress and are pleased to be able to say that after the success of previous hybrid formats for State of the Art, this will be factored into future events and the EDI group will advocate for a hybrid annual Congress, for as long as this format can be supported.

It would be really, really helpful to have meeting/ Congress transcribed notes or one pagers to summarise talks/other things and to make sure as many things are recorded to be replayed as possible
Respondent with invisible disability, health condition, neurodivergent diagnosis

I feel very lonely at Congress, often the wheelchair space in a Congress hall is on its own so I can't sit with anyone. I found the last SOA in Birmingham particularly difficult as the lifts/floors were incredibly difficult to navigate
Respondent with both visible and invisible disability, health condition, neurodivergent diagnosis

As someone who is clinically extremely vulnerable, I would rather attend (SOA) online this year. I would appreciate a hybrid format (and I'm sure many others would for other reasons)
Respondent with invisible disability, health condition, neurodivergent diagnosis

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1. Kelly, R Mutebi Invisible Disabilities in Education and Employment UK Parliament POSTnote Jan 2023 https://post.parliament.uk/research-briefings/post-pn-0689/

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3. Powell A, Disabled people in employment. House of commons briefing paper 7540 May 2021 https://researchbriefings.files.parliament.uk/documents/CBP-7540/CBP-7540.pdf

4. Baksh RA, Pape SE, Smith J et al. Understanding inequalities in COVID-19 outcomes following hospital admission for people with intellectual disability compared to the general population: a matched cohort study in the UK https://bmjopen.bmj.com/content/11/10/e052482

Section 5:
Menstruation, Menopause, Fertility and Pregnancy

Section 5: Menstruation, Menopause, Fertility and Pregnancy

Menstruation

What you told us

185 respondents provided their experiences here and only 35% indicated that menstruation had never had a negative impact on their work life. The most commonly described negative experiences were in relation to pain, but similar amounts of people reflected on concerns around difficulty taking sufficient breaks and access to toilets. Other comments included negative experiences while wearing PPE and having to use facilities without access to sanitary bins or single stall toilets.

Indescribable period pain that you just put up with to get on with your work
Respondent age 41 to 50

Menstrual cramps during working hours and sometimes feel unable to take a break as do not want to be seen as lazy or not pulling my weight
Respondent age 21-30

Pain and discomfort while working. Being in the middle of doing something at work and feeling that ideally, I would leave to go to the toilet due to menstrual needs but not always having the opportunity to, or feeling comfortable to say why
Respondent age 31-40

If you menstruate, has this ever had a negative impact on your work life?

Response (base: 185)	Percentage
No effect/no problems	35%
Feeling unwell/pain/cramping	21%
Yes	19%
Difficult to take breaks/access toilets	16%
Heavy flow/concern about flooding	14%
Sometimes/occasionally	5%
Tiredness	4%
Lack of sanitary bins/single stall toilets	4%
Reduced concentration/distraction	4%
Difficult when wearing PPE	4%
Causes delay/disruption/reduced effectiveness	4%
Discomfort	3%
Don't expect/need support	3%
Take painkillers	3%
Low mood	2%
Headaches/migraine	2%

There aren't facilities for disposal of menstrual products outside of the ladies, which is a significant problem if you're a trans man or non-binary person who menstruates
Respondent age 31-40

35% indicated that menstruation had never had a negative impact on their work life

The same respondents were asked if they feel supported with this in the workplace and how they could be better supported. The most common answer was in relation to accessible or free sanitary products, followed by a call for more openness, understanding or recognition of the challenges faced by people menstruating. Other suggestions included ability to take regular breaks, access to better toilet facilities and sanitary bins, flexible working, more practical uniforms, lockers to store sanitary products and access to pain relief.

Freely available sanitary wear should be as common as loo roll, since menstruation is as natural as defecation
Respondent age 41-50

Darker coloured scrubs (or at last the option)
Respondent age 31-40

Change the culture to be able to openly discuss that it is ok to be menstruating and that it is normal thing that happens to 50% of our population, no need to hide in shame
Respondent age 41-50

It isn't addressed despite affecting such a large population of the workforce. I wouldn't feel able to call in sick citing period pain
Respondent age 31-40

There's a complete lock of toilets in some departments, lack of lockers where sanitary items can be stored and scrubs which aren't discreet for storying sanitary items either
Respondent aged 31-40

What the Society will do

A person who menstruates has on average 456 periods over the course of thirty-eight years.[1] We also know that more than 70% of the NHS workforce are women and given our business is 'healthcare', the evident lack of support, openness and understanding with respect to menstruation in our workforce is both ridiculous and unacceptable. With respect to critical care teams specifically, we also know that the impact of long and alternating shift work as well as the 'normality' of emergency and unpredictable clinical demand has the potential to amplify any deficiencies in support. Respondents in our survey are calling for an open culture with respect to discourse around this topic, as well as access to what can only be described as basic provision and facilities. This objective should not be unmanageable.

- We will provide access to sanitary wear in all toilets at our Congress and events.
- We will amplify to support the success of the #BMAPeriods campaign, which succeeded in getting agreement that period products should be in all staff toilets in NHS sites across the UK by creating our own template 'period policy'. This policy will cover both attitudes/openness, as well as practical support and will be shared with our networks to encourage implementation locally and advocacy for support at trust level. Engagement and uptake will be recorded.

We will amplify to support the the success of the #BMAPeriods campaign, which succeeded in getting agreement that period products should be in all staff toilets in NHS sites across the UK

- Menstruation Hygiene Day is held annually on 28 May. We will add this event to our list of regularly supported awareness days. We will launch our template 'period policy' on or before Menstrual Hygiene Day 2024.

Menopause

What you told us

53 respondents who had experience of or were currently experiencing menopause were asked how this had impacted their work life. 75% of respondents recalled a negative or challenging impact.

Free-text coded responses most frequently related to tiredness/fatigue/aching (32%), hot flushes/sweating (28%) and brain fog/poor concentration/memory issues (28%). The wider list of challenges experienced by the workforce however was broad and included disturbed sleep (8%), reduced confidence (8%), low mood (8%), embarrassment (8%), symptoms exacerbated by PPE and face masks (8%), headaches (6%), anxiety (6%), feeling short tempered (4%), dizzy spells (2%), fear (2%) and a need to take more breaks (2%)

Brain fog, memory issues, word finding issues, self-confidence issues, disturbed sleep. All of these affect confidence in workplace
Respondent aged 51-60

Higher stress and emotional rollercoaster levels. Supportive team at work but don't talk about it
Respondent aged 51-60

The unit is very warm all the time, this does not assist with hot flushes....and the water fountain is off the unit
Respondent age 41-50

Brain fog is frightening and embarrassing. Hot flushes a nightmare particularly when wearing PPE and poor availability of something like an air con. Aching bones, fatigue
Respondent age 51-60

When asked if menopause was something they felt supported with in their workplace, only 11% of gave a response in the affirmative. *This is despite only 9% indicating that they did not need support.* Respondents most frequently indicated that they did not feel supported or it was not discussed. Other specific experiences recalled in several responses (5%) highlighted that most of their colleague were men. Suggestions for support included better general understanding and awareness, a culture of openness and communication, ability to take more frequent breaks, more appropriate and thinner

uniforms, better resources, counselling, better ventilation in hospitals and good/usable access to water fountains.

I feel ashamed to discuss my health problems with my colleagues as most of them are male
Respondent aged 41-50

More openness would be welcomed. It's ok to say 'I'm unwell' Or I have high blood pressure' but misogynistic colleagues would laugh if I said I'm menopausal in seriousness, they'd think I was joking and making fun
Respondent aged 51-60

We have to wear thick synthetic uniforms, there are scrubs for doctors but we are not allowed to wear them. There are also thinner 'formal' uniforms available, but you have to buy them yourself
Respondent age 51-60

I think that generally there needs to be an increased awareness of the impact that perimenopause, menopause and post menopause has on individuals and the vast array of symptoms and how it impacts everyday life
Respondent aged 51-60

Ability to drink and take more regular breaks
Respondent age 41-50

What this means

The results of our survey demonstrate that the challenges presented by menopause are not just a result of psychological and physiological symptoms, they are compounded by an ongoing lack of support or perceived support. Even more disappointing is that this lack of support is perceived not only at an organisational level, but even at that very basic level where colleagues interact with each other. These results align with other similar investigations, including the BMA report 'Challenging the culture on Menopause'.[3]

As the majority of our NHS workforce now have a retirement age between 65 and 68 years, and more than 70% of that workforce are women, ensuring a culture of responsiveness, openness and understanding around how menopause impacts the people in our teams is pivotal.

What the Society will do

We will explore collaboration opportunities with a view to considering educational events on how menopause impacts the people in our teams. We will aim to equip our community not just to ask for and receive what they need but also target materials at all members, aiming to increase 'menopause literacy' of the whole team.

We will review the NHS menopause policy[2] to examine if it is applicable and useful within the context of how our teams work in critical care. If required, we will advocate on this basis.

We will explore collaboration opportunities with a view to exploring educational events on how menopause impacts the people in our teams

Pregnancy, baby loss & infertility

What you told us

Respondents who had ever been pregnant were asked whether they felt supported regarding any impact their pregnancy may have had on their day-to-day work, and if they did not feel supported, why this was the case. 86 respondents answered this question.

52% indicated that they had felt supported and although this was the most common response, the goal here is of course that 100% of respondents would feel supported during a pregnancy. 13% indicated they were not supported and a further 9% indicated that they had received no flexibility or adjustments. A further 12% indicated they had a mixed or inconsistent experience.

Important challenges expressed include feelings of guilt or being a burden (5%), forced early maternity leave (1%), perceived negative impact on training and career (3%) and a lack of support after maternity leave (3%).

Deeply scared to tell anyone at work that I'm pregnant. I've seen many trainees who are pregnant and LTFT be discriminated against. I've seen their careers completely ruined by people that don't want pregnant or less than full trainee colleagues
Respondent aged 31-40

High expectations on just carrying on as "normal"
Respondent aged 41-50

Just expected to put up with terrible morning sickness and get on with it. Good support with regard to manual handling
Respondent aged 41-50

...concern for contact with infection patients wasn't taken seriously enough'
Respondent 31-40

I had adjustments to my rota and was never questioned about time off for midwife appointments or scans
Respondent aged 31-40

60 respondents answered a question about the experience of miscarriage or baby loss. This question was open to those who had experience of this either through carrying a pregnancy or as a partner. 44% of respondents either did not discuss this life event with their workplace or did not receive any support. 3% indicated it was their preference not to discuss this with their workplace and a further 3% indicated that they felt their workplace would not be supportive.

Just 13% indicated that 'good' support was received. Positive experiences recalled include having access to a counsellor (2%), good support during IVF (3%) and being allowed compassionate leave (12%)

I was given compassionate leave and my boss at the time was very supportive
Female respondent

52% indicated that they had felt supported and although this was the most common response, the goal here is of course that 100% of respondents would feel supported during a pregnancy

Other comments where workplaces were aware included 'nobody talked about it' (7%) and pressure or expectation to return to work quickly (5%).

I did not share the experience with work and only took a single day off
Female respondent

No, I was expected to continue with my clinical commitments
Male respondent

Didn't tell work as I wouldn't have expected much in the way of sympathy, and definitely not time off
Male respondent

Some staff felt their loss was minimised when they did report it to team members:

Was told by a woman Consultant that "miscarriages happen to everyone" so I should just "get over it" and was not given time off work
Female respondent

Experienced a missed miscarriage, had to wait 2 weeks to confirm if I had miscarried or not. I was continually phoned at home by my line manager and asked if I could come in and do admin work or 'light duties'
Female respondent

Importantly 6% of respondents highlighted that alongside the clear void of support for people in the critical care community experiencing baby loss or miscarriage, support needs to be extended to include staff undergoing fertility treatment and infertility.

What this means

Pregnancy, fertility and the loss of a baby are life events for which those impacted require and deserve effective workplace support. This is particularly the case where members of team are navigating the trauma of miscarriage, baby loss and fertility treatment. Some of the comments highlighted above also demonstrate a need to consider the impact of pregnancy and its loss on both parties involved. What is most apparent from the comments received, is that access to the right support appears to be too patchy and too variable.

What the Society will do

We will encourage conversation amongst out community by creating a podcast or webinar to discuss the impact of miscarriage and fertility treatment and how this can be navigated in the workplace, both by individuals concerned and those who lead them.

We will signpost our membership to useful workplace actions including signing up to the miscarriage association baby loss pledge.

We will add baby loss awareness week to the list of our annually supported events.

We will explore opportunities to collaborate with other professional bodies to promote an openness in attitude to discussing issues relating to pregnancy, baby loss and miscarriage and to enhance our community's understanding of what support they should expect in those circumstances.

References

1. Regional Health– Americas, T.L. (2022). Menstrual health: a neglected public health problem. *The Lancet Regional Health - Americas*, 15, p.100399. doi:https://doi.org/10.1016/j.lana.2022.100399.

2. Supporting our NHS people through menopause: guidance for lien managers and colleagues, NHS England, 2022 https://www.england.nhs.uk/long-read/supporting-our-nhs-people-through-menopause-guidance-for-line-managers-and-colleagues/ (accessed 10/06/2023)

3. British Medical Association. Challenging the culture on menopause for working doctors. 2020. https://www.bma.org.uk/media/2913/bma-challenging-the-culture-on-menopause-for-working-doctors-report-aug-2020.pdf (accessed 10/6/23)

Section 6:

Experiences of Inappropriate Behaviour in Critical Care

Section 6: Experiences of Inappropriate Behaviour in Critical Care

There are still consultants who consider belittling and microaggressions an educational tool, and that's not acceptable
Anonymous consultant

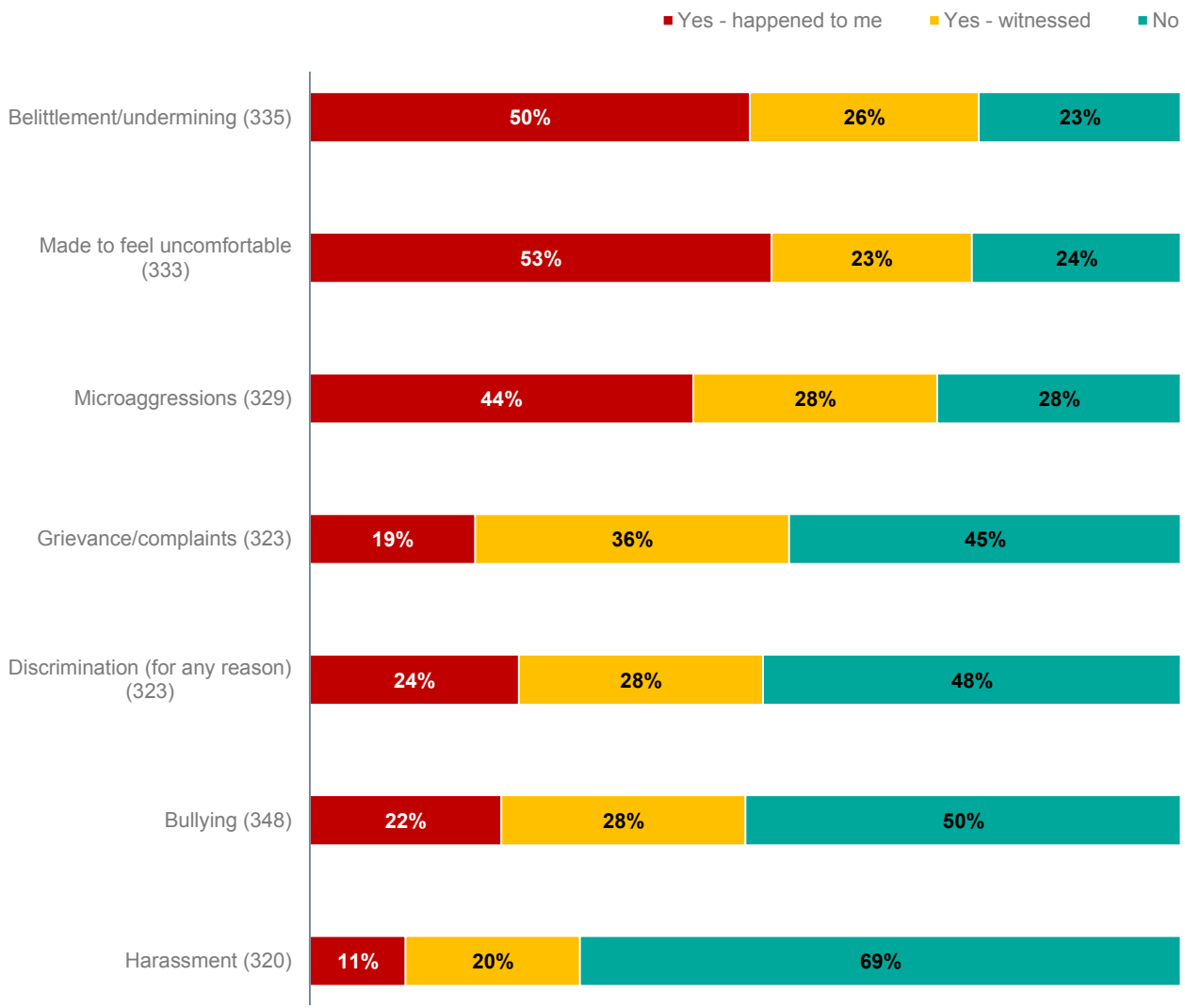
One of the most powerful sections included in the survey looked at individual experiences of inappropriate behaviour. Regrettably, over half of respondents have either experienced or witnessed some form of inappropriate behaviour. When broken down into different behaviours - belittling or undermining, being made to feel uncomfortable, microaggressions, complaints, discrimination, bullying and harassment - these testimonies create a compelling case for change.

What you told us

When separated by ethnicity, gender and age, there were clear differences in experiences recalled by different groups.

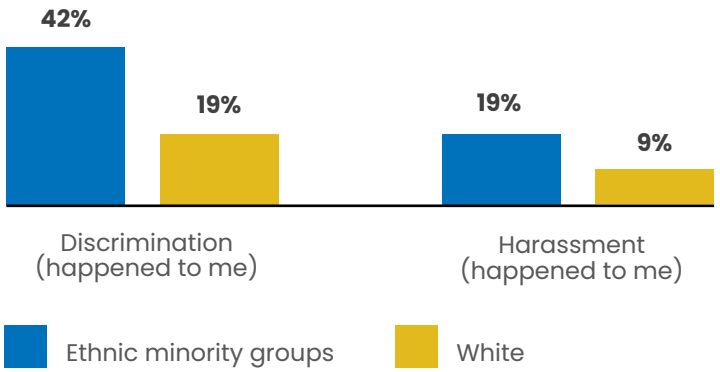
As described in section four, minority groups reported far greater experiences of discrimination and harassment, while those of white ethnicity were more likely to witness these behaviours.

Have you experienced or witnessed any of the following working in critical care? (base shown individually in chart)



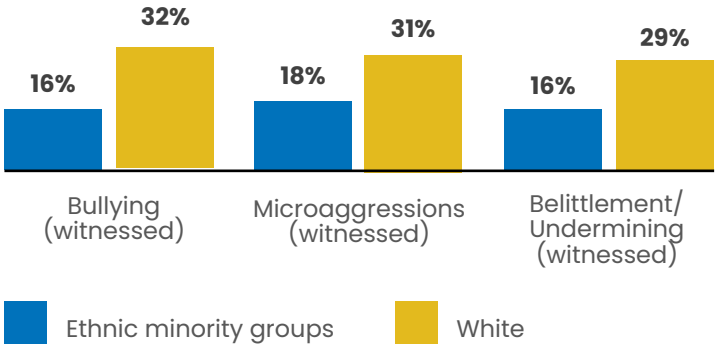
Experiences of discrimination and harassment by ethnicity

(base: Ethnic minority groups 69, 67; white 248, 247)



Experiences of bullying, microaggressions, and belittlement/undermining by ethnicity

(base: ethnic minority groups 77/74/75; white 263, 248, 255)



More women reported personal experiences of being made to feel uncomfortable, while more men experienced complaints. Those under fifty years of age reported more experiences of being made to feel uncomfortable (56% vs 38% of those over 50)

For those who elaborated, the following themes were most frequently represented:

Belittlement/bullying by consultants/senior staff
27%

Gender related discrimination/micro-aggressions
11%

Ethnicity related/racism/stereotyping
10%

Poorly managed/no action taken/lack of support
10%

Belittlement/undermining by a colleague/peer
10%

A senior member of staff asking personal and uncomfortable questions about my sexuality in an inappropriate manner
Female respondent

Muslim female colleague in hijab not spoken to in same way I was by surgical colleague; she was belittled in my opinion
Respondent from other white background

More women reported personal experiences of being made to feel uncomfortable, while more men experienced complaints

I've witnessed consultants belittling junior doctors or getting impatient with them if they asked questions that the consultant thought to be silly
Pharmacist

I have had multiple problems with male peers undermining me – just because they say something confidentially, it doesn't mean they are right
Training grade doctor

Bullying and undermining – doctors to nurses all the time
Critical care nurse

Sexually inappropriate verbal advances, more as a trainee than now
Female consultant

It is common to witness microaggressions and undermining from white nurses to non-white, especially black nurses
Asian/Asian-British respondent

It's almost impossible to call out someone for micro-aggressive behaviour as they will act ignorant and make you out to be paranoid or aggressive and rude
Black/Black-British respondent

There appears to be an acceptance of bullying and harassment from white managers and colleagues. Microaggressions are commonplace and generally go unchallenged
Black/Black-British respondent

Increased anger and aggression towards staff from relatives and patients since the pandemic. Increase in number of complaints. Multiple nuisance calls to my ICU calling us murderers
Consultant

Gender discrimination common – often unintentional, but I feel that male peers are generally better trusted/thought of as competent and offered opportunities.
Female respondent

I have regularly witnessed female junior doctors being treated differently (in a negative way) compared to male junior doctors (myself) by senior nursing staff
Male training grade doctor

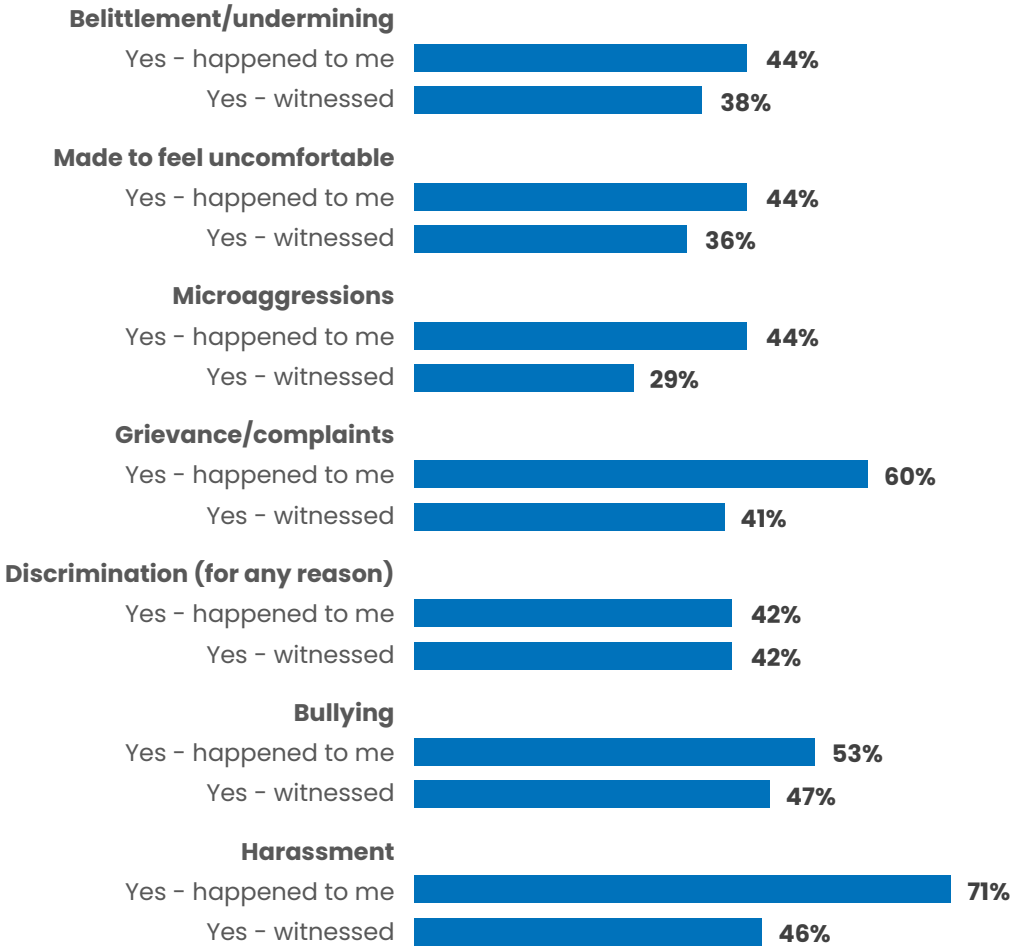
Racial discrimination as an example of limiting my opportunity to step up to a band seven role...when I interviewed for the same role, with a diverse panel, I got the job
Black/black British respondent

As a trainee I worked on an ICU where a senior consultant colleague clearly had a problem with people coming to critical care from backgrounds other than anaesthesia and would make such individuals a target...there was strong message of 'don't make a fuss, she is going to retire in the next couple of years' from other consultants
Consultant

Racial discrimination as an example of limiting my opportunity to step up to a band seven role

We asked follow up questions about how the issue was handled by the individual and their organisation. The majority of persons experiencing belittlement/ undermining, being made to feel uncomfortable or discrimination didn't report these things up the chain to their employer. Just over 53% reported their experiences of bullying. Harassment was most likely to be reported. With the exception of discrimination, all inappropriate behaviours were more likely to be reported by the person experiencing them, than by a witness.

Did you inform your employer?



Just over 53% reported their experiences of bullying

Regarding workplace response, the largest proportion of respondents (n = 159) said they were dissatisfied with the response from their employer. Just 17% submitted comments indicating they were 'satisfied' with the response.

Positive experiences reporting:

Reported the bullying, there was quite a formal process and high levels of clinical management involvement
Consultant

Have received apologies after the event once person realised the impact of the actions
Dietitan

Supported by other colleagues and changed thinking of some others through discussing it
Consultant

Negative experiences reporting:

It never gets taken any further because nobody makes a formal complaint, they usually just leave to work in other hospitals or departments
Consultant

I was told by a senior member of management that we are not out to ruin someone's career (my life has been completely ruined and changed). I have left my dream job and moved to another trust and down two pay bands
Critical care nurse

*Significant sexual harassment from a male colleague... Although this was reported by myself and many other colleagues, the response was always 'it's just *person's name*'*
Anonymous Critical care nurse

They said it was just banter
Training grade doctor

These results are both alarming and have a potential direct relationship with patient care. A systematic review on unacceptable behaviours in ICU has demonstrated an association between said behaviours and a worsening of both clinical performance and patient outcomes.[1]

The Society will always advocate that teams should take a clear stance against unacceptable behaviours. They have no place within our teams or around the bed of the critically unwell patient.

What the Society will do

We will actively role model a strong stance against unacceptable behaviour.

We will continue to use our platform to provide educational resources highlighting how to recognise and approach unacceptable behaviours, including at our flagship Congress State of the Art.

We continue to promote and prioritise the compassionate transformative leadership called for in our Workforce Wellbeing Best Practice Framework through numerous educational resources and

We take a strong stance against unacceptable behaviour within the Intensive Care Society

programmes including our bespoke leadership course LeaP. You can find out more here: ics.ac.uk/thriving

What the next steps are

The Society would like to explore potential for an active campaign against unacceptable behaviours in our community and to champion all the facets of our 'Thrive at Work' project outputs with a view to reaching those most impacted by these behaviours - particularly ethnic minorities and women. You can find more information here: ics.ac.uk/thriving

References

1. Guo L, Ryan B, Leditschke IA, Haines KJ, Cook K, Eriksson L, Olusanya O, Selak T, Shekar K, Ramanan M. Impact of unacceptable behaviour between healthcare workers on clinical performance and patient outcomes: a systematic review. BMJ Qual Saf. 2022 Sep;31(9):679-687. doi: 10.1136/bmjqs-2021-013955. Epub 2022 Jan 19. PMID: 35046101

2. Orthopaedic trainees launch anti-bullying campaign. *BMJ* 2017;356:j398

3. Royal College of Surgeons of Edinburgh. https://www.rcsed.ac.uk/professional-support-development-resources/anti-bullying-and-undermining-campaign (Checked 30 May 2023)

We would like to explore potential for an active campaign against unacceptable behaviours in our community

Section 7:
Career Progression

Section 7: Career Progression

It is easier to be a white man at work than pretty much anyone else
Training grade doctor, male, White British

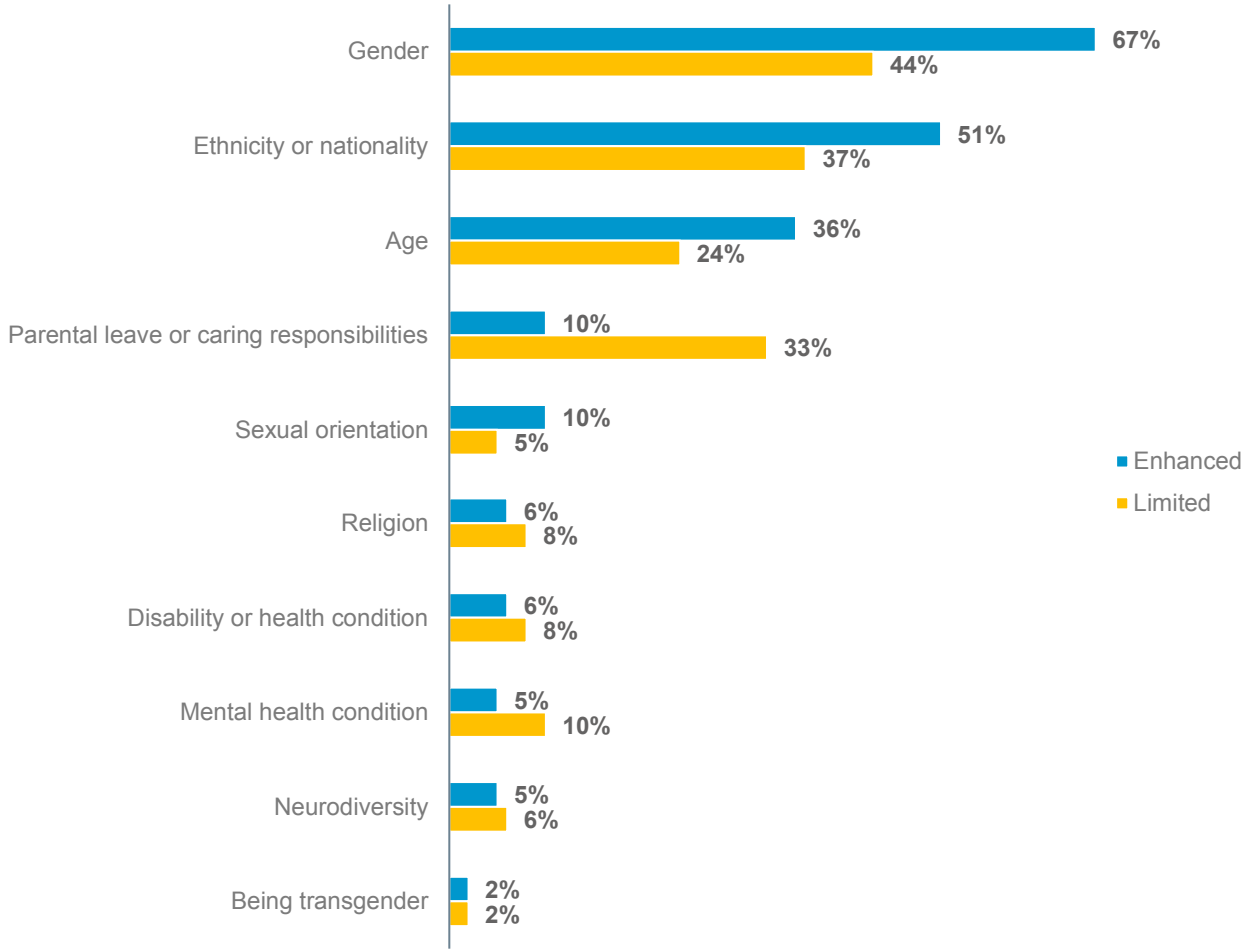
Career progression can be defined in many ways; 'climbing the ladder' or getting promoted, taking on new opportunities and responsibilities and/or achieving career aspirations. Achieving this progression is a several step process of self- knowledge, exploration, decision-making and action. Career progression is vital to retain our workforce; individuals that feel valued and investment made into their development are more likely to be more productive, happy and stay.

Within critical care, it is clear there are many perceived barriers to career progression, some describe this as a glass ceiling. Identifying these barriers is the first step to removing them.

What you told us

Survey respondents were able to specify whether they thought their career progression or leadership opportunities had been either enhanced or limited due to different personal attributes. 115 respondents provided attributes under 'enhancements'. 144 answered the question with respect to 'limitations'. Choosing more than one attribute was possible. The perceived interaction between characteristic and impact on career progression is represented opposite .

Do you feel that your career progression or leadership opportunities have been enhanced or limited because of any of the following?



Parental leave and caring responsibilities

Of all the factors where a relationship was chosen, parental leave or caring responsibilities were more likely to be perceived in the negative.

43% of women and 16% of men felt parental leave or caring responsibilities had negatively impacted their progression or opportunities.

Struggle to make meetings/education on my days with my children
Training grade doctor, female, primary carer responsibility

Having a total of 22 months off work for maternity leave has definitely limited my progression
Pharmacist, female

Having family commitments both child and elderly mean that I was geographically limited in what I could do and made choices about jobs as a result
Consultant, female, primary carer responsibility

When I had kids I went part time. I was still as motivated and enthusiastic about my work. I lost out on the opportunity to get a temporary promotion purely because I worked part time. This was the reason given to me when I questioned things
Critical care nurse, female

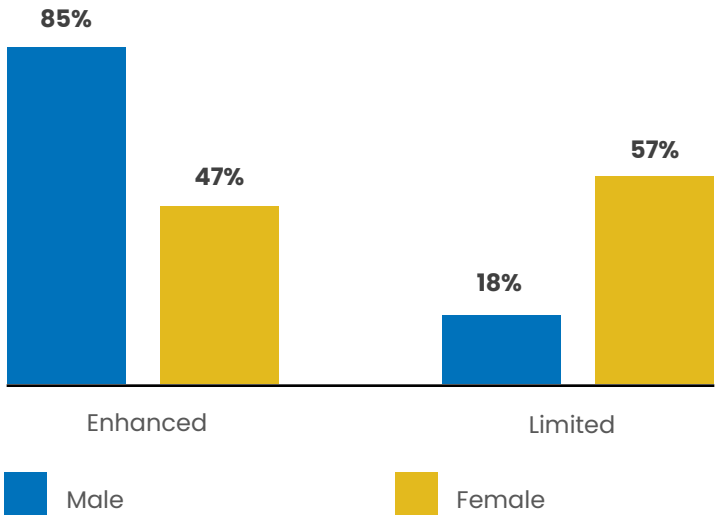
Gender

Male respondents were more likely to think that their gender has enhanced their career progression and leadership opportunities, whereas females were more likely to choose a limiting relationship.

Where a respondent indicated a transgender identity half of those respondents said their transgender identity had limited their opportunities or progression.

Impact of gender on career progression/ leadership opportunities by gender

(base: male 60/49; female 53/94)



43% of women and 16% of men felt parental leave or caring responsibilities had negatively impacted their progression or opportunities

Indirectly. I think that being a man has at times made it easier for me to commit to career aspects of my life, which many women are unable to because of family commitments
Training grade doctor, male

I think people still worry about women going off to get pregnant
Training grade doctor, female

There are definite advantages to being a man in terms of being given opportunities for learning, leading and management
Training grade doctor, male

My male colleagues seem to "climb the ladder" quicker than females
Critical care nurse, female

Being young & female, especially when of childbearing age in a patriarchal society has lead to inappropriate questions during recruitment processes, belittlement & discrimination within the workplace, being overlooked for career progression and objectification
ACCP/ACP/ACN, female

Male dieticians seem to progress faster and I have been overlooked by management in the past in favour of a male dietician with less experience and skills. He is now a band above me
Dietician, female

I think there is such a strong swing at times, I am penalised for being male
Consultant, male

Being trans in a transphobic society takes up a lot of energy that I could otherwise be spending on passing exams, CPD etc.
Training grade doctor, male

Being younger and of childbearing age I have received comments on perceived career progression relating to when I might have children
ACCP/ACP/ANP, female, aged 21-30

Sexuality

The proportion of gay or lesbian responders answering this survey, who also felt their sexuality had negatively impacted career progression or leadership opportunities was 18.5%

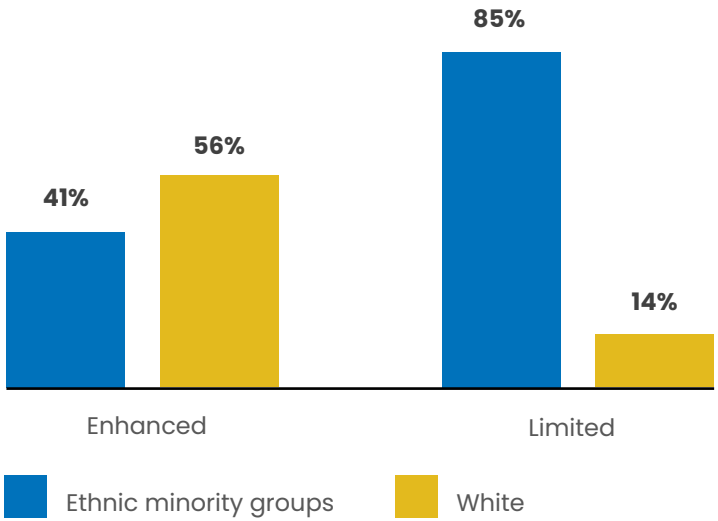
My career was undoubtedly held back because I held back from fully engaging in case someone found out I was gay. I always kept under the radar/low profile. Avoided social situations so as not to have to discuss partner/home life
Consultant

White, male, straight – I realise that these things are 'safe' and 'normal' in the minds of those who were responsible for making decisions about me in my career
Consultant, male, White British

Ethnicity

Respondents from minority ethnic groups were more likely to think that their ethnicity or nationality has limited their career progression or leadership opportunities when compared with those of white ethnicity.

Impact of ethnicity or nationality on career progression/leadership opportunities by ethnicity (base ethnic minority groups 32/46; white 81/97)



Don't see career progression after so many years of work experience
Speciality doctor, male, Asian/Asian British

No progression or slow progression as ethnic minority even though well experienced for the job
Critical care nurse, Black/Black British

There are so few black consultants in critical care it feels like there is a glass ceiling that can't be broken through
Training grade doctor, Black/Black British

Being a BAME member of staff, we needed to work twice as hard to gain recognition to our hard work
Critical care nurse, Asian/Asian British

Being a tall white middle aged man makes it more likely that my competence is accepted
Consultant, male, White British

It's clearly easier being a white British trainee with English as a first language – even though I probably have less knowledge than many overseas trained counterparts
Training grade doctor, female, White British

None of the above I like to think my progression has been through my own hard work and determination
Critical care nurse, female, White British

No progression or slow progression as ethnic minority even though well experienced for the job
Critical care nurse, Black/Black British

Being a tall white middle aged man makes it more likely that my competence is accepted

Disability, health condition or neurodivergence

The numbers of persons reporting any of these factors in our survey overall was low and reporting is indicative only. Respondents reporting one of these conditions were more likely to report that it had limited their progression or opportunities.

I feel my career has been hampered by having epilepsy. I have had to go part time to stay well following an increase in seizures
Physiotherapist

Current health issues – not deemed reasonable to work in ICU without doing on calls at night – will mean leaving medicine earlier than otherwise would
Consultant

When I've struggled with mental health problems it's definitely been interpreted as 'not being committed to the cause' or 'not wanting it enough'
Training grade doctor

What this means

The relationship between personal factors and career progression is complicated and this survey has indicated that we need to better understand both experiences and barriers at play. The discrimination indicated by comments shared with us demonstrate just how much work there is to do.

What the Society will do

Following release of this report, we will take the learning from this specific section and start the process of understanding how we can use our current leadership programmes to target those who are likely to be experiencing differential attainment or discriminatory barriers to career progression. We will continue to use our platform to promote positive role-models with examples of diverse clinical leaders and think about how we can use our voice and learning portfolio to enhance our community's understanding of and competence in allyship. This will work alongside our organisational strategy (2023-2027).

We will continue to use our platform to promote positive role-models with examples of diverse clinical leaders

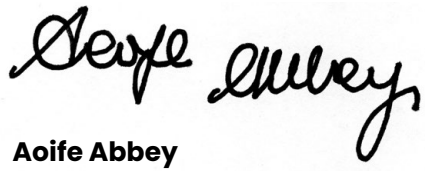
Closing Remarks

The experiences shared with us have demonstrated that when it comes to inclusivity, there is work to do. We recognise that none of the action points described in this report will move mountains or work miracles, but as a member of the critical care multi-professional team, you will already know that the work we do isn't about moving mountains or conjuring miracles. Intensive care is mostly about a series of small steps in the right direction. Often, when stood at the foot of a bed, beside a patient with complex and far-reaching needs, whose journey has not yet been defined, I find myself actively centring my mind and asking out loud "what will progression look like **today**?"

This exercise was about finding tangible progress that our EDI group could take ownership of today and much of the work needed to deconstruct action points from more complex sections is still to come.

Aside from that, I hope this report has provided you not just with the sense of community that comes from realising so many of our adversities are shared, in some form, with others. But also, that you might have gained insight into some experiences that exist outside of your own. Perhaps you may even use these insights to recognise the challenges faced by others around you and ask yourself how you can be a better leader or a more inclusive team-player.

Our survey has not reached important voices, we have failed to capture the voice of some members of our community, and this is particularly notable with respect the proportion of non-British nationals, people from minority ethnic groups, those with international professional qualifications and those with disabilities or health conditions. With that in mind, if you have any ideas or feedback on what you have read today, the EDI team would love to hear them. If you would like to voice an experience or have done work in your own teams, which you would like to share with us and the wider community we would also love to hear about that too.



Aoife Abbey
EDI Working Group

You can contact us by marking your email for attention of the EDI Chair and sending to EDI@ics.ac.uk.

Useful Links, Support Lines and Advice

Ethnicity

- Mental Health UK - https://mentalhealth-uk.org/black-asian-or-minority-ethnic-bame-mental-health-support-services/
- Healthcare Communication Matters - https://healthcarecommunicationmatters.co.uk/bame/support-bame-healthcare-professionals/
- BMA (Forum for Racial and Ethnic Equality) - https://www.bma.org.uk/about-us/equality-diversity-and-inclusion/edi/bma-free

Disability, Health Conditions and Neurodivergence

- Scope - https://www.scope.org.uk/advice-and-support/
- Disability rights - https://www.disabilityrightsuk.org/
- National Autistic Society - https://www.autism.org.uk/
- NHS Employers Neurodivergent Support - https://www.nhsemployers.org/articles/supporting-neurodivergent-colleagues-nhs
- Disabled Doctors Network - https://www.disableddoctorsnetwork.com/

LGBTQ+

- NHS support - https://www.nhs.uk/mental-health/advice-for-life-situations-and-events/mental-health-support-if-you-are-gay-lesbian-bi-sexual-lgbtq/
- LGBT Foundation - https://lgbt.foundation/helpline
- Mind LGBT - https://www.mind.org.uk/information-support/tips-for-everyday-living/lgbtqia-mental-health/useful-contacts/
- IMANN https://imaanlondon.wordpress.com/ (dedicated charity that supports LGBT+ Muslims)
- https://mindout.org.uk/
- Association of LGBTQ+ Doctors and Dentists - https://gladd.co.uk/
- LGBT Ireland - https://lgbt.ie/

Menstruation, Menopause, Fertility and Pregnancy

- NHS England Support Guidance - https://www.england.nhs.uk/long-read/supporting-our-nhs-people-through-menopause-guidance-for-line-managers-and-colleagues/
- Menopause and Me - https://www.menopauseandme.co.uk/
- The Menopause Charity - https://www.themenopausecharity.org/
- Tommy's - https://www.tommys.org/baby-loss-support

Inappropriate Behaviour

- Speak to your line manager, senior member of the team or through your hospital HR team
- Intensive Care Society, Thriving at Work support - https://ics.ac.uk/thriving.html
- Royal College of Nursing Counselling support - https://www.rcn.org.uk/Get-Help/Member-support-services/Counselling-Service
- BMA Counselling and Peer Support - https://www.bma.org.uk/advice-and-support/your-wellbeing/wellbeing-support-services/counselling-and-peer-support-services
- NHS England SARCs support https://www.nhs.uk/live-well/sexual-health/help-after-rape-and-sexual-assault/

General and Other Useful Links

- Intensive Care Society – https://ics.ac.uk/membership/equality-diversity-and-inclusion.html
- Royal College of Nursing - https://www.rcn.org.uk/About-us/Diversity-and-inclusion
- Faculty of Intensive Care Medicine - https://staging.ficm.ac.uk/sites/ficm/files/documents/2021-10/ficm_equality_diversity_and_inclusion_form_2021.pdf
- Chartered Society of Physiotherapy - https://www.csp.org.uk/about-csp/equity-diversity-belonging
- The British Dietetics Association - https://www.bda.uk.com/practice-and-education/education/dietetic-education-training/equality-diversity-inclusion.html
- Royal College of Occupational Therapy - https://www.rcot.co.uk/equity-diversity-and-belonging
- Royal Pharmaceutical Society - https://www.rpharms.com/recognition/inclusion-diversity
- Royal College of Speech and Language Therapy - https://www.rcslt.org/learning/diversity-inclusion-and-anti-racism/external-resources/
- NHS England Support - https://www.england.nhs.uk/supporting-our-nhs-people/support-now/
- Mind - https://www.mind.org.uk/
- Samaritans - https://www.samaritans.org/
- Anxiety UK – https://www.anxietyuk.org.uk/
- Centre for Mental Health - https://www.centreformentalhealth.org.uk/
- National Guardian – Freedom to Speak Up- https://nationalguardian.org.uk/about-us/
- Protect advice (whistleblowing) https://protect-advice.org.uk/

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