Ethnic Inclusion in the NHS's workforce

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Briefing Note:

The briefing section of our report will discuss four key ideas:

Overview:

- Although some parts of the NHS workforce are very diverse, ethnic minorities remain underrepresented in senior management roles as well as in medical academia.
- Ethnic minority NHS staff experience discrimination from staff and patients alike, ranging from overt harassment and abuse to more covert forms of racism such as scepticism regarding the competence of minority staff.
- Ethnic minority patients tend to have worse experiences with the NHS, both in terms of perceived quality of care and actual health outcomes.
- The NHS has implemented numerous initiatives in an attempt to increase diversity and reduce discrimination, with some successes (particularly on a local level). However, inadequate action plans and monitoring procedures have hindered progress.

Staff Diversity:

The NHS is one of the largest employers of people from BME backgrounds in the country.

- A report commissioned by the NHS, the Medical Workforce Race Equality Standard (MWRES), details the ethnic diversity of the NHS and the experiences of its workforce who come from minority ethnic backgrounds through various indicators.[1]

- The WRES found 22.4% of NHS trust staff, or 309,532 employees, are from a BME (Black and Minority Ethnic) background whilst this figure makes up 42% of medical doctors employed by the NHS. These figures have increased year on year to result in the highest recorded employment of those from ethnic minorities.[2]

- This is compared to the estimated figure of around 14% of the UK's population being from a BAME background. It's worth noting that the 2021 Census aims to look beyond the "BME" label and found that 18.3% of the UK population identify as a minority ethnicity, with that including the "Asian", "Black", "mixed" and "other" ethnic groups.[3]

Despite this strong diversity in the workforce, ethnic minorities are consistently underrepresented in senior medical positions.

- In 2021, only 10% of staff employed at a senior level akin to head of department, consultant paramedic or clinician (band 8c pay grade) were from a BME background. Those from ethnic minorities were most likely to be employed in band 5, which includes staff nurses and newly qualified clinicians, or lower.[4]

- The proportion of board members that come from ethnic minorities (12.6%) has always been significantly lower than the general workforce, having strong effects on the management of NHS trusts.[5] The Board is the leading decision-making structure that coordinates strategy and delivery of service across the NHS trusts, whilst also determining the "culture and values of the organisation".[6]

There are also issues with other forms of representation within medicine, such as academia positions and admissions.

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[1] Ibid.
[2] NHS England, 2022, NHS Workforce Race Equality Standard
[3] ONS, 2022, Population of England and Wales - GOV.UK Ethnicity facts and figures
[4] NHS England, 2022, NHS Workforce Race Equality Standard
[5] Ibid.
[6] NHS England, n.d., NHS England board

- People of ethnic minorities were also found to be underrepresented in academic positions with 16.1% of Clinical Professors coming from a BME background.[7]
- Despite the increased rates of ethnic minorities applying and graduating from medical schools, BME students are less likely to attain a place in medical schools than white students.[8] This raises issues that lie perhaps within the medical schools and royal colleges in making healthcare a more inclusive workforce.
- Another example of the lack of representation at senior levels includes membership of Royal College's elected council having just 13% of their members from a BME background.[9] The Royal College of Physicians is a professional membership group that represents doctors and clinicians across Britain; improving the diversity of the governing body results in ethnic minorities being represented in both a professional and clinical capacity, affecting health outcomes.[10]

[7] NHS England, 2021, Medical Workforce Race Equality Standard (MWRES)
[8] NHS England, 2021, NHS workforce more diverse than any point in its history, as health service commits to more action on representation
[9] Ibid.
[10] Royal College of Physicians, n.d., Our role

Staff Experience:

Ethnic minorities are particularly vulnerable to harassment or abuse, from both patients and other staff.

- According to the NHS staff survey, 28.9% of BME staff experienced harassment or abuse from the public, and 28.8% from other staff in the last year: for white staff, the figures were 25.9% and 23.3%, respectively (n=648,594).[11]
- Further, this may be an underestimate given staff may be reluctant to criticise the NHS in its own surveys. According to a BMA survey, 37% of Black and Asian staff and 22% of mixed staff, versus just 5% of white staff, had experienced bullying in their workplace (n=1047).[12]
- However, vulnerability to abuse varies significantly based on ethnicity: Chinese and African staff are more vulnerable than average to abuse from the public, whereas South Asian staff are more vulnerable to abuse from other staff. Traveller staff, although white, are also disproportionately likely to suffer abuse (n=648,594).[13]
- Negative experiences are compounded by an institutional culture which often fails to support whistleblowing: one black intensive care nurse raised concerns of 'microaggressions' and 'false accusations' but was 'bullied'; 'other staff warned her to stop speaking out'.[14]

Ethnic minority staff also suffer more covert forms of discrimination, in particular the application of prejudiced stereotypes.

- One such stereotype is that minorities are less competent and professional: 54% of Black staff, 46% of Asian staff, and 37% of Mixed staff versus just 6% White British staff have had their clinical or professional ability doubted (n=857).[15]
- Subsequently, minority staff are subjected to unfairly harsh scrutiny compared to white staff, with 48% of Black staff, 44% of Asian staff and 35% of Mixed staff feeling their work is overly scrutinised, versus just 4% of White British Staff (n=857).[16]

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[11] NHS England, 2021, NHS Workforce Race Equality Standard (p. 5)
[12] BMA, 2022, Racism in medicine (p. 18)
[13] Ibid. (pp. 18-25)
[14] White, N., and Thomas, R., 2022, NHS racism shame: One in three minority ethnic staff face discrimination or bullying
[15] BMA, 2022, Racism in medicine (p. 11)
[16] Ibid (p. 12)

- Patients, too, are guilty of such prejudices, with staff experiencing instances of mistrustful patients refusing care from minority staff members (even if this meant they had to wait longer for treatment). Although large-n survey data on this issue is limited, the president of the British Association of Physicians of Indian Origin claims to receive reports of such incidents from NHS staff all too frequently.[17]

- The consequence of these stereotypes is that minority staff feel they must strive for higher standards to counter negative assumptions and justify their position: according to one minority staff member, 'you feel like you are treading on shards of glass'.[18]

The discretionary nature of access to opportunities for career progression introduces the risk of racial discrimination with respect to achieving promotions.

- Career progression is dependent on being permitted or supported to career-enhancing training. Management staff often have discretionary power to withhold or provide this permission.[19]

- Just 69.2% of BME staff, versus 87.3% of white staff, believe their trust provides equal opportunities for career progression or promotion, with Black staff being particularly cynical (n=648,594).[20]

- Indeed, white staff are 1.14 times more likely to access training or professional development which could help them advance their career (n=648,594).[21]

- The factors contributing to this inequality are likely manifold, but minorities may be blamed for their own unequal progression - which only serves to contribute to their career stagnation. In an interview, a London-based white British nurse is quoted as claiming that 'there's an element of self-choice' with respect to the failure of ethnic minorities to achieve career progression.[22]

Minority staff members seem to be disproportionately subjected to disciplinary measures, although data on the causes of this are limited.

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[17] Choudhury, B., 2021, EXCLUSIVE: White patients refuse care from Asian doctors

[18] King's Fund, 2020, 'A long way to go': ethnic minority NHS staff share their stories

[19] Woodhead et al., 2021, "They created a team of almost entirely the people who work and are like them": A qualitative study of organisational culture and racialised inequalities among healthcare staff (p. 278)

[20] NHS England, 2021, NHS Workforce Race Equality Standard (pp. 5-25)

[21] NHS England, 2021, NHS Workforce Race Equality Standard (p. 5)

[22] Woodhead et al., 2021, "They created a team of almost entirely the people who work and are like them": A qualitative study of organisational culture and racialised inequalities among healthcare staff (p. 278)

- BME staff are 1.14 times more likely to enter the formal disciplinary process than white staff. Admittedly, this ratio has improved somewhat in recent years: it was 1.57 in 2016 (n=648,594).[23]

- The Fair to Refer report, commissioned for the GMC, found that doctors from ethnic minority backgrounds are twice as likely to be referred to fitness to practise proceedings by their employer and that IMG doctors are two and a half times as likely to be referred to fitness to practise proceedings by their employer. A key contributing factor identified in this report was that organisations often have a 'blame culture' rather than learning from mistakes.[24]

- A study of referrals to the Nursing and Midwifery Council Fitness to Practice process in 2012-2014 found that ethnic minorities are particularly likely to be referred by their own employers - whereas white people are disproportionately likely to be referred by members of the public (n=5811).[25]

- Of the above fitness-to-practice cases which progressed to the final 'adjudication stage', white nurses were more likely to be barred from working than Black or Asian nurses, implying that the scrutiny imposed on Black or Asian nurses is less justifiable.[26]

The health of ethnic minority staff members was particularly severely impacted during the Covid-19 pandemic, potentially in part due to discrimination in the protection of staff safety.

- By April 2020, BAME medical staff were dying of Covid-19 at between two and three times the proportion of their NHS population.[27]

- Around this time, a survey found 64% of frontline BAME doctors felt pressured to work in settings where aerosol-generating procedures expose them to risk of infection, despite inadequate PPE, versus 33% of white doctors (n=500).[28]

- The same survey found just four in ten BAME doctors in general practice felt they had sufficient PPE for safe contact with patients, versus seven in ten white doctors (n=1000).[29]

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[23] NHS England, 2021, NHS Workforce Race Equality Standard (p. 5)
[24] BMA, 2022, Delivering racial equality in medicine
[25] West et al., 2017, The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process (p. 2)
[26] Ibid. (p. 2)
[27] Cook, T., Kursimovik, E., and Lennane, S., 2020, Exclusive: deaths of NHS staff from covid-19 analysed | Comment | Health Service Journal
[28] Cooper, K., 2020, BAME doctors hit worse by lack of PPE
[29] Ibid.

Patient Experience:

Those from ethnic minorities perceive the level of care they receive from the NHS to be of lower quality.

- A shocking Parliamentary report found that two-thirds of black Britons believe that the NHS does less to protect their health than that of white people, suggesting differences in the care received.[30]
- This was exacerbated when considering gender: these sentiments of neglect are more strongly held by black women as 78% think that the NHS does less to help than white peers, whilst this view was shared by 47% of black men.[31]
- Those from other ethnic minorities also experience issues in perhaps different ways as many report poor experiences at their GP surgery, especially those from Asian groups.[32]
- However, other studies suggest that there are not any significant differences in public satisfaction across ethnic groups, yet they are all reporting low levels of satisfaction of around 35% population satisfaction.[33]

These feelings of dissatisfaction are more clearly reflected in the relatively poorer health outcomes of minority ethnic groups.

- Recently, significant research found that black mothers were five times more likely to die from childbirth than white mothers, with Asian women being twice as likely.[34] This is merely a subsection in the several health outcomes that are worse for those from ethnic minorities.
- There are many health issues that fall disproportionately on some ethnic minorities in the UK such as the increased risk of obesity, cardiovascular disease and diabetes. It is argued that this is not only due to genetics with the Royal College of Nursing calling this factor a “distraction”.[35]
- Covid-19 has brought the issue of health inequalities to the fore. During the first wave of the pandemic, people from all ethnic minority groups (except for women in the Chinese or "White Other" ethnic groups) had higher Covid-19 death rates

[30] Joint Committee on Human Rights, 2020, Black people, racism and human rights
[31] Ibid.
[32] Watkinson, R. E., Sutton, M. and Turner, A. J., 2021, Ethnic inequalities in health-related quality of life among older adults in England: secondary analysis of a national cross-sectional survey
[33] Wellings et al., 2022, Public satisfaction with the NHS and social care in 2021
[34] Knight et al, 2019, Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal: Deaths and Morbidity 2015-17.
[35] Lawrence et al., 2020, An Avoidable Crisis - Time to tackle health inequalities

than White British people - in particular, Black African men were 3.7 times more likely to die than White British men.[36]

- However, adjusting for measures of socioeconomic disadvantage explained a large proportion of this disparity (albeit not all of it), showing how socioeconomic factors interact with health inequalities to lead to disparate outcomes.[37]

Certain ethnic groups experience different forms of medical racism due to the different stereotypes they face, causing real harm to their health.

- Misperceptions about medical differences between ethnic groups appear worryingly common: one study (albeit conducted in the US) found that up to half of white medical students endorse at least one false belief about Black patients, for instance, that Black patients have less sensitive nervous systems, stronger immune systems, or thicker skin than white patients (n = 222).[38]

- These misperceptions have tangible results for healthcare provision. One example is the dismissal of Black complaints of pain and the use of higher standards of pain reporting before pain relief is provided. This inequality extends even to paediatric care: a US study of childhood appendicitis found that Black children reporting severe pain were less than half as likely as white children to be prescribed opioids (the most appropriate form of pain relief for such severe pain). Similarly, Black children in moderate pain were less likely to be prescribed any analgesics at all, suggesting Black patients must reach a higher threshold of pain before being given pain relief (n = 1,000,000).[39]

- A similarly problematic phenomenon is the stereotyping of South Asian women as hypochondriacal. This stereotype is well-established enough to have its own epithet: ‘Mrs Bibi Syndrome’, or ‘Begum syndrome’. Not only does applying such a term demean South Asian patients, but it also puts them at risk by leading doctors to neglect their real health complaints.[40]

- This “medical racism” can make patients reluctant to open up to doctors and lead to neglect of health conditions, putting them more at risk from coronavirus.

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[36] ONS, 2021, Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021
[37] Ibid.
[38] Hoffman et al, 2016, Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites
[39] Goyal et al, 2015, Racial Disparities in Pain Management of Children With Appendicitis in Emergency Departments
[40] Chao-Fong, L., 2020, 'Medical Racism' Could Be Putting South Asian People At Greater Risk Of Coronavirus, Say Doctors

Existing Initiatives:

There is no shortage of NHS plans to improve workforce diversity and inclusion.

- The NHS Constitution, introduced in 2009, acknowledges staff's legal right to be treated 'fairly, equally, and free from discrimination'.[41]
- The NHS is bound by the UK's body of equalities law, such as the 2010 Equality Act, which imposes a 'duty' on all public sector organisations to consciously consider how to eliminate unlawful discrimination and advance equality of opportunity.[42]
- Various quantifiable targets for diversity in management have been set - for instance, the NHS Chief Executive's pledge in 2008 that 30% of top tier roles would be staffed by ethnic minorities,[43] or the 2018 Health Minister's goal that senior management would match the NHS's overall diversity by 2028.[44]

However, the extent to which these pledges have been realised is questionable.

- The NHS Constitution has not appeared particularly impactful: though just 4% of NHS staff oppose it in principle (n=466), only 40% had used it in the past year (n=199) and just 20% think it has made a positive difference since 2009 (n=466).[45]
- With respect to representation, a 2014 report on the progress of the Race Equality Action Plan claimed that it's initiatives have 'withered on the vine' - for instance, the proportion of annual appointments to NHS trust boards who are BME had actually fallen since the Plan (8.7% in 2006 versus 5.8% in 2013).[46]
- WIth respect to discrimination and abuse, the Workforce Racial Equality Standard's annual evaluations indicate that the disproportionate vulnerability of minority staff to harassment and discrimination from public, colleagues, and managers has stagnated, if not actually worsened, since 2016.[47]

Implementation of these goals has been hindered by inadequacies in the strategies for how they will be implemented.

- The NHS seems to lack clear chains of accountability for initiatives: according to a 2014 study using Freedom of Information requests to NHS England, "there [is]

[41] UK Government, 2021, The NHS Constitution for England
[42] Citizens Advice, n.d., Public Sector Equality Duty
[43] Kline, R., 2014, Snowy White Peaks (p. 5)
[44] UK Government, 2018, NHS pledges action to eliminate ethnicity pay gap
[45] UK Government, 2022, Fourth report on the effect of the NHS Constitution (pp. 15-17)
[46] Kline, R., 2014, Snowy White Peaks, (p. 60)
[47] NHS England, 2021, NHS Workforce Race Equality Standard (p. 5)

deep confusion at the heart of the NHS about who was responsible for helping ensure workforce race equality was taken seriously".[48]

- Monitoring of target progress also appears inadequate. For instance, the 2004 Race Equality Action Plan introduced plans for senior leaders to mentor minority staff members, and to introduce 'stretch' targets on race equality in their organisation's annual objectives - but, ten years on, there is no data on how many staff are receiving mentoring, or how many trusts are producing such targets.[49]

- The NHS (along with many other organisations) has been criticised for focusing on the 'wrong' initiatives. For instance, concerns have arisen that unconscious bias training sessions, which 'commonly' features in NHS strategies,[50] may actually backfire by 'activating' problematic stereotypes, or rendering staff complacent that the process of eliminating inequality has now been completed.[51]

- The NHS is caught between public criticism over spending too much on 'woke' initiatives (for instance, a Daily Mail article calling for replacing the NHS's 800 'diversity officers' with 1200 nurses)[52] and concerns that current funding for diversity and inclusion is inadequate, with one trust claiming to have just £500 per year to implement and evaluate diversity initiatives.[53]

That said, some progress has been made with respect to both commitment and outcome.

- As a response to criticism, the NHS has recently implemented more effective monitoring procedures to evaluate progress, such as the Workforce Race Equality Standard, which measures NHS organisations annually against nine equality indicators.

- Progress on equality goals can be seen within certain regions or trusts - for instance, in the East of England, the likelihood of minority staff being referred to the disciplinary process relative to white staff had fallen from 1.43 times in 2012 to near-parity in 2017 after 'concerted action' by the trust.[54]

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[48] Kline, R., 2014, Snowy White Peaks, (p. 64)
[49] Ibid.
[50] Hemmings et al., Attracting, supporting and retaining a diverse NHS workforce (p. 50)
[51] Behavioural Insights Team, 2020, Unconscious bias and diversity training – what the evidence says, pp. 3-4)
[52] Haigh, E., 2022, NHS spends £40m a year on 800 'diversity officers' as campaigners say it could fund 1,200 nurses
[53] Hemmings et al., Attracting, supporting and retaining a diverse NHS workforce (p. 64)
[54] NHS England, 2021, NHS Workforce Race Equality Standard (p. 36)

Insight:

Overview:

This section will delve into one major reason why a lack of diversity and inclusion in the NHS's workforce is so problematic - because of its impact on patient outcomes. The causes of racism and underrepresentation within the workforce are complex and numerous: this insight will focus on the the actions of NHS management as a factor, looking both at how mid-level management treat their minority staff subordinates and at how top-level management is failing to drive top-down change because of an apparent lack of adequate concern or commitment.

Patients from ethnic minorities seem to receive worse treatment from the NHS, in part due to cultural barriers and the application of racial stereotypes.

Our briefing demonstrated that patients from an ethnic minority background experience worse-quality healthcare. Minority patients' perceptions that the NHS does less to protect their health is reflected in tangible outcomes - for instance, the higher mortality rates of ethnic minorities with Covid-19 and of black women in childbirth. The causes of health inequalities are manifold, and include factors outside of the NHS such as socioeconomic inequality (since deprivation is associated with worse health). However, injustices within healthcare are also key.

Minority patients are subjected to stereotypes which cause doctors to make incorrect diagnoses and prescriptions, jeopardising patients' health. For instance, our briefing identifies the "pain bias" - the dismissal of pain complaints by black patients, which means that diagnosis and prescription is treated with an unjust lack of urgency.[55]

Similarly, the complaints of South Asian women may be dismissed as "Mrs Bibi/Begum syndrome" - the stereotype that South Asian women are hypochondriac.[56] This stereotype likely played a factor in the death of Shahida Begum in 2019 after doctors dismissed her complaints of sepsis symptoms as mere muscle sprain.[57]

Such stereotypes arise when doctors are either ignorant of or misinformed about the specific medical circumstances of certain ethnic groups and so during diagnosis (a process which relies significantly on discretion and intuition) they rely not on medical fact but on these heuristic assumptions instead.

A second reason a lack of understanding about the cultural and medical circumstances of ethnic groups leads to healthcare inequalities is the barriers it poses to tailoring treatments to suit patients' individual circumstances - in particular, cultural conditions which may affect how successfully patients adhere to treatment programmes. For example, US studies have found that patients from certain ethnic minorities are more likely to use 'complementary and alternative medicines' (traditional, or folk, medicines)

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[55] Hoffman et al, 2016, Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

[56] Chao-Fong, L., 2020, 'Medical Racism' Could Be Putting South Asian People At Greater Risk Of Coronavirus, Say Doctors

[57] Nikolik, I., 2019, Mother-of-two, 39, died from sepsis after she was misdiagnosed and twice sent home by a GP

instead of the clinical medicines they have been prescribed.[58] Prescription adherence is influenced by a complex set of socioeconomic and cultural factors which makes it difficult to draw generalisations about any single ethnic group – indeed, to do so may merely generate new stereotypes. But a lack of awareness among doctors as to the possible existence of these factors may mean they go unexplored altogether, so that, unbeknownst to their doctors, patients fail to adhere to their treatment programmes - to the detriment of their own health.

Studies suggest that patients experience better outcomes when treated by staff of the same ethnic background as them.[59] However, arguably the crucial factor is not the ethnic background itself, but rather the cultural understanding and capacity to avoid stereotypes which this shared background fosters, since this insight has shown how harmful a lack of cultural understanding can be. Thus cross-cultural education and immersion is crucial to improving the outcomes of ethnic minority patients.

[58] Nguyen et al, 2014, Complementary and alternative medicine (CAM) use among non-Hispanic white, Mexican American, and Vietnamese American patients with type 2 diabetes

[59] King, E.B., and Dawson, J.F., 2011, Why organizational and community diversity matter: representativeness and the emergence of incivility and organizational perform

The Management of the NHS is failing in securing a diverse, inclusive and safe workforce environment for those from ethnic minority backgrounds.

Trigger warning: this insight includes direct quotes of racist abuse yet, it is kept to a minimum

In our briefing we outlined the issues in the NHS felt by both staff and patients from ethnic backgrounds, in particular there has been an increased reporting of staff facing a toxic work environment, brought forward by the crisis of labour supply and strikes in the NHS. Most recently, a senior nurse in the NHS, Michelle Cox, won a landmark discrimination against her manager in the NHS for excluding her "at every opportunity" whilst also creating an "intimidating and hostile" environment for her.[60] This raises issues of discrimination against staff from ethnic minorities throughout the workforce structure of the NHS, specifically from the management. The main ways this manifested was the trivialisation of issues of racism *when raised* but also racist *attitudes* of management that affects the progression and workplace environment of ethnic minority staff.

The case of Michelle Cox brings to light issues that Black staff face within the NHS; they are sometimes treated with contempt and ridicule when attempting to progress in their job despite this being a natural desire for most. This is not an isolated incident; another Black senior nurse of the NHS, Neomi Bennett, exposed the targeting of Black nurses with false allegations to prevent them rising in pay bands and receiving more pay.[61] This recurring exposure of working conditions in the NHS, in spite of initiatives to promote racial equality, prompts us to investigate how deep-rooted issues are across the management of the organisation.

Disciplinary processes on ethnic minority staff is one issue in a heap of racial discrimination; the NHS WRES 2021 reported that those from BME background are 1.14 times (or 14%) more likely to enter into the process than their white counterparts. However, the General Medical Council (GMC) commissioned a report in 2019 that found that doctors from ethnic minority backgrounds are twice as likely to be referred to fitness-to-practice proceedings by their employer.[62] They are also more likely to be dismissed due to these processes, creating a constant fear in the minds of ethnic minority staff,

[60] Hull, L., 2023, NHS accused of 'institutional racism' by 'sidelined' black nurse
[61] TMclean, 2023, Black nurses 'targeted' to deny them promotion
[62] BMA,, 2022, Delivering racial equality in medicine

specifically Black staff, over the security and stability of their job.[63] Neomi Bennett remarks that a number of these cases involved 'confidence nurses' who had never previously had a complaint against them yet were often due a pay rise.[64] This highlights serious issues in racial equality for those working the same job in the NHS with racial harassment from both patients and other staff being another main pillar of the problem.

It is possible that the statistics for racial harassment in the NHS are actually underestimated as, in one BMA survey, 71% of respondents who had personally experienced racism chose not to report this to anyone. Whilst this racism could be from both patients or staff, it was the trivialisation and perpetuation of racism that meant 56% of these respondents had "no confidence that the incident would be addressed".[65] This is reflected in shocking incidents of racial harassment but the neglect in recognising them with a Black nurse, Adelaide Kweyama, reporting constant and harrowing racist abuse from patients in a detention centre, and when she complained to a superior, she was told "You need to get a pool of bleach your skin so that… the patient will be nice to you".[66] It must be noted that this issue is not just limited to Black staff in the NHS. This being said, these cases *are* the most shocking and have resulted in court rulings, whilst those from South and East Asian backgrounds are reported to have similar experiences of harassment in the 2022 BMA Racism in Medicine report.[67] These are just a few instances in a pattern of racial harassment which often remains unreported due to the negligence and lack of care from largely white managing staff.

This negligence and lack of concern for the staff experiencing racial harassment and abuse has a significant effect on the victims' mental health and working conditions in the NHS. A BMA report published last year found the NHS risks losing one third of ethnic minority doctors due to racism.[68] In the case of Kweyama, she experienced feelings of depression due to the psychological and emotional impact of the harassment yet, the NHS Trust did "nothing to support her". This emotional trauma is not unusual across ethnic minority staff; a Pakistani junior doctor reported PTSD from racial abuse from a consultant yet was told to "avoid making a formal complaint".[69] A BMA report also found

[63] Sprinks, J., 2012, BME nurses more likely to be referred to NMC by employer – but white staff more likely to be struck off
[64] Mclean, 2023, BMA outrage over racism against Black nurses
[65] BMA, 2022, Racism in medicine
[66] Sigodo, M., 2022, Black nurse told to 'go and bleach her skin' by boss so patients would be 'nice to her'
[67] BMA, 2022, Racism in medicine
[68] BMA, 2022, NHS risks losing one third of ethnic minority doctors due to racism, finds BMA report
[69] BMA, 2022, Racism in medicine

that from those who experience racism at work, 60% say that it has affected mental health, supporting personal stories told.[70]

In the context of a collapsing NHS system that is failing to meet the higher demands and pressures on its services since Brexit and now the cost of living crisis, a mental health crisis, as warned by the BMA chairman Dr Chaad Nagpaul, could have disastrous effects on the quality of care provided by these doctors as well the proportion of doctors that choose to leave the profession and/or the NHS.[71] These issues have been exacerbated in the midst of the Covid-19 pandemic which put strenuous pressures on NHS staff as a whole. There was a disproportionately higher number of deaths in BAME NHS staff than white staff, with 50% of surveyed respondents believing discriminatory behaviour was a factor.[72]

These issues of racial harassment, abuse and discriminatory behaviour in the NHS against staff from ethnic minorities have severe risks for both their mental and physical health, as well as their capacity to provide the best possible care. As remarked by Dr Chaand Nagpaul, “the status of being a BAME doctor puts you at risk”.[73]

[70] Nagesh, A., 2022, NHS racism making doctors 'anxious and depressed' - BBC News
[71] Ibid.
[72] ITV, 2020, ‘Discrimination’ on frontline of coronavirus outbreak may be factor in disproportionate BAME deaths among NHS staff
[73] Ibid.

The lack of significant progress achieved by equality initiatives is in part due to a lack of true commitment in the highest levels of government leadership.

Our briefing juxtaposed the government's pledges to eliminate racism in the NHS and public sector in general, such as those of the NHS constitution,[74] with evidence of continued racism against and underrepresentation of ethnic minorities in the NHS workforce. The implication is clear: NHS pledges and initiatives to resolve racism have not been successful. Indeed, the NHS itself has admitted that 'despite years of trying to address issues of racism in the NHS, there has only been a limited amount of success'.[75] This insight argues that the failure of these initiatives is, in part, due to failings at the very top of the NHS hierarchy and central government.

One key failing is the reluctance, at every level of NHS leadership, to integrate issues of inclusivity into every aspect of the NHS.[76] Interviews with key stakeholders in government and NHS suggest a prevalent mind-set that diversity and inclusion work is 'on top' of other goals, rather than being 'incorporat[d]' into 'what we already do'. For instance, efforts to achieve quality goals like the Indicators for Quality Improvement are undertaken entirely separately from efforts to achieve equality goals like those of the Equality Delivery Standard. The siloing of equality issues arguably implies how they are viewed as an afterthought - with unsurprising negative consequences for progress.

A second failing is the reluctance to assign or take on responsibility for the success of initiatives: Freedom of Information requests suggest "deep confusion" as to who is responsible for improving race equality; higher levels of leadership pass the buck to "individual employers" or less senior staff.[77] This undermines the incentive of leaders to work to ensure the success of equality policies: it is unclear who should receive praise or blame for the success or failure of initiatives.

Senior NHS leaders have repeatedly asserted their desire for equality in theory, so it must be questioned why their actions indicate a lack of commitment in practice. We argue that it is indicative of a culture of denial of the full extent of racism in the NHS and beyond, as exemplified by the Sewell Report of 2021, a major government inquiry into race inequalities in the UK, which claimed that "racism and discrimination is not widespread in

[74] UK Government, 2021, The NHS Constitution for England
[75] NHS England, n.d., Tackling racism and other types of discrimination
[76] Salway et al,. 2013, High quality healthcare commissioning: why race equality must be at its heart
[77] Kline, R, 2014, Snowy White Peaks, p.64

the health system"[78] (a claim "firmly refut[ed]" by the main trade union for UK doctors).[79] Denial has been legitimated by a lack of data on racism in the NHS: the Workforce Race Equality Standard (the main way the NHS measures progress on a range of equality indicators) was only introduced in 2015, and is still limited by failing to disaggregate data for different ethnic groups rather than merely "BME". Where data *has* been collected, it has been described by NHS staff as having "opened the eyes" of leadership and forced them to face up to problems, suggesting how a lack of data has allowed leaders to become complacent about NHS racism.[80]

However, even when data is available, NHS trust leaders have been criticised for failing to adequately respond to it, suggesting a deeper problem in government culture. The causes are likely manifold, but one key factor may be politicians' fear of a backlash if they appear to be committing too many resources to inclusivity in the context of an under-funded, overburdened NHS.[81] A recent article by the Daily Mail criticising the NHS for hiring diversity officers entitled "money could be spent on extra 1,200 nurses" exemplifies this concern. This suggests a lack of appreciation among sectors of the public and government itself of the benefits, outlined briefly previously in the insight, that tackling issues of discrimination can have for NHS efficiency and spending.[82]

[78] Commission on Race and Ethnic Disparities, 2021, Commission on Race and Ethnic Disparities: The Report

[79] BMA, 2021, A missed opportunity BMA response to the Race Report

[80] Dawson et al, 2019, Evaluation of the NHS Workforce Race Equality Standard (WRES)

[81] NHS Confederation, 2021, NHS leaders facing real-terms cut in funding and 'impossible choices' over which areas of patient care to cut back

[82] Rhead et al, 2021, Impact of workplace discrimination and harassment among National Health Service staff working in London trusts

Conclusion:

- Patient outcomes (particularly those of ethnic minorities') are tangibly affected by the diversity of the NHS's workforce - in particular, the exposure of staff to cross-cultural experiences.
- Ethnic minority staff in the NHS are vulnerable to multiple forms of discrimination; too often, senior/managerial staff often participate in or fail to tackle this discrimination.
- The failings of NHS leadership seem to extend beyond those of mid-level management to a failure at the very top of NHS and government hierarchies to fully commit to anti-racist policies, perhaps because of a culture which does not acknowledge the urgent need for these policies, instead fearing backlash for being excessively "woke".

Policy Recommendations:

Overview:

In this section, we will outline three policy recommendations to improve how both ethnic minority staff and patients are treated by the NHS. We acknowledge the initiatives which are already in place to further this goal, and propose measures which could increase their effectiveness - key to our policy recommendations are ensuring that minorities are represented in paradigms of medical knowledge as well as leadership, and increasing accountability for efforts to improve inclusion. Our recommendations are as follows:

- **Action 1:** Diversifying medical curricula by addressing gaps in medical knowledge and improving cultural competence training.
- **Action 2:** Forming an external independent review procedure for reporting and investigating instances of harassment and racism in the NHS workforce
- **Action 3:** Accelerating efforts to increase minority representation in management.

Action 1: Diversifying medical curricula by addressing gaps in medical knowledge and improving cultural competence training.

We have seen how the quality of doctors' knowledge on the specific medical and cultural circumstances of ethnic minorities impacts treatment and thus patient outcomes. If inadequately informed about how illness symptoms manifest in different ethnic groups, there is a risk that doctors will instead rely on stereotypes and racialised assumptions, even dismissing patients' complaints altogether. Further, without understanding how cultural circumstances affect patient behaviour, doctors cannot guarantee that patients will follow their prescriptions effectively. Therefore, this insight calls for the UK to address the gaps in its doctors' knowledge at their root: during medical school. This reform has two elements: "fixing the knowledge", and "fixing the numbers".[83]

First, the need for "fixing the knowledge" - that is, more comprehensive curriculum coverage of racial difference - is clear: one study of medical students found that almost half affirmed at least one false claim about racial difference (for instance, that black people have stronger immune systems), and that, unsurprisingly, these misperceptions were linked to less accurate treatment recommendations.[84] The first step in this process is identifying where gaps lie in the curriculum through 'curriculum mapping', carried out either independently by the General Medical Council as part of its quality assessments of medical schools, or by institutions themselves - drawing for instance on Mbaki et al's "toolbox" of questions to self-assess their curricula.[85]

Also crucial will be the development and use of more diverse reading materials for students, given the underrepresentation of ethnic minorities in clinical images and case presentations in textbooks.[86] Publishers should commit to ensuring that, where symptoms manifest differently between ethnic groups, newly published textbooks explicitly discuss these differences. During this process of textbook updating, more medical schools could add resources such as the Mind the Gap Handbook (a bank of images of symptom manifestation in ethnic minorities) to their curricula.

This insight also calls for medical schools to improve cultural competence training to ensure that graduates are able to integrate an understanding of how patients' cultural context may affect their behaviour into their prescriptions. The General Medical Council has advocated for the inclusion of cultural diversity in curricula since 1993, but although an increasing number of schools are integrating cultural education into their curricula, the consistency and comprehensiveness of this education is unclear. However, some medical

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[83] Muntinga et al, 2016, Toward diversity-responsive medical education: taking an intersectionality-based approach to a curriculum evaluation

[84] Hoffman et al, 2016, Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

[85] Mbaki,Y., Todorova, E. and Hagan, P.,, 2021, Diversifying the medical curriculum as part of the wider decolonising effort: A proposed framework and self-assessment resource toolbox

[86] BMJ, 2020, Diversifying medical school education to represent BAME backgrounds

schools have demonstrated good practice which could be utilised by others, such as appointing an academic lead on cultural competence to ensure clear chains of responsibility and accountability for the effectiveness of this training.[87]

Secondly, “fixing the numbers” - that is, seeking representation of ethnic minorities in the faculty and leadership of medical education institutions - is also crucial: it is difficult to ensure teaching is diverse and representative if teachers (and other staff) are not. Therefore we advocate for the explicit setting of targets for representation in the staffing and leadership of medical education institutions - perhaps drawing inspiration from the Workforce Race Equality Standards, which measures NHS trusts’ progress on BME representation among all staff and on leadership boards.[88] Medical schools should be held to similar standards, since diversity in medical schools is just as important as diversity in the NHS as a whole for resolving issues of racism in healthcare at their source.

[87] Liu, J., Miles, K. and Li, S., 2022, Cultural competence education for undergraduate medical students: An ethnographic study

[88] NHS England, 2022, NHS Workforce Race Equality Standard 2022

Action 2: Forming an external independent review procedure for reporting and investigating instances of harassment and racism in the NHS workforce.

From our research into actions taken by the NHS for racial equality, it is unclear which of the initiatives have successfully tackled racist harassment and discrimination. Workers from ethnic minority backgrounds have consistently reported higher levels of bullying and harassment from public, colleagues and managers than their white counterparts, with the WRES evaluations even suggesting that these levels had worsened since 2016.[89] More recently, there has been an exposing of the racist and malignant practices of management in processing reports of harassment as well as in the lack of progression of staff from ethnic minority backgrounds, as detailed especially in our 2nd insight. To tackle this, we propose an independent review board that works to provide proper procedure in reporting and investigating instances of harassment and discrimination in the NHS workforce.

This arm-length body could be repurposed from the roles of diversity officers or rather recruited externally to the NHS to provide a safe forum for staff to report the harassment they face from both patients and colleagues. As for instances of reported discrimination, especially in the decision of promotions, the review board can examine the workplace dynamics and the reasons that many staff of ethnic minority backgrounds are refused such promotions. These instances may well flow into our other recommendations of unconscious bias training and greater diversity within managerial roles yet, it would be the personalised recommendations of the independent review board to make actionable change within the Trust structures they are working in.

Currently, staff are told to report issues of harassment and such to their managers and senior colleagues, yet consistent complacency has been observed across management. This has meant that staff are unlikely to report these instances as 71% of respondents in a BMA survey say they have experienced racism at work but chose not to report it.[90] The NHS Staff Council's Health, Safety and Wellbeing Partnership Group cites that toxic behaviour costs the NHS more than £2 billion a year.[91] Creating a few roles within each trust would be a significant saving from this and could work to improve the quality of working conditions for staff from all backgrounds but especially those from ethnic minorities.

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[89] NHS England, 2021, NHS Workforce Race Equality Standard (p. 5)
[90] BMA, 2022, Racism in medicine
[91] NHS Employers, 2022, Tackling bullying in the NHS infographic

To expand on the scale of this recommendation further, this board would work across NHS trusts, with each role assigned to a trust integrating to the systems of working in the trust whilst maintaining a sense of standardisation across the board. It is important that these roles are attuned to the hierarchy dynamics present in each trust but enforce a strong sense of justice and integrity throughout. Despite these being an external board, integration into the Trusts are key so that there is not a misalignment of values and therefore possibility that these roles could be rejected by staff and management.

This independent taskforce provides a short-term solution to issues that many staff face at first, experiencing harassment and discrimination, but then also not having anywhere to report it. Whilst recommendations such as increasing minority representation in management and creating a more inclusive culture in medicine work to effectively eradicate racism in medicine, they can often take much longer to show results. This recommendation allows staff to report safely without fear of risking their job, without adding to the workload of colleagues and avoiding the outburst of discrimination cases the NHS Trust have to deal with. The independent review board acts as a convenor of instances of harassment and discrimination before it gets to court-level by supporting the staff appropriately and intervening with corrective measures that suit the situation.

Action 3: accelerate efforts to increase minority representation in management.

As discussed in our insight, a key barrier to the success of efforts to improve equality is the reluctance of senior leadership to truly commit to these efforts. Consequently, a primary priority must be increasing the representation of ethnic minorities in senior leadership, since non-diverse management teams are at risk of complacency and groupthink, leading to stagnation in efforts to improve inclusion elsewhere.

A wide range of initiatives have been introduced to attempt to improve representation in senior leadership, with some success: according to the WRES, 12.6% of members of NHS organisation boards are now ethnic minorities,[92] up from 7.1% in 2016.[93] However, this is still seriously unrepresentative of the NHS or population as a whole: there is clearly scope for existing initiatives to be accelerated.

Existing interventions have tended to be focussed on increasing the hiring desirability of ethnic minority candidates: for instance, mentoring and skills development programmes which give ethnic minority staff experience and confidence.[94] These interventions seem to have been beneficial given the resulting improvements in representation identified by the WRES. Indeed, they should be extended - for example, the NExT Director scheme which offers ethnic minority staff opportunities for work placements to gain experience of the work of board members should be expanded to benefit potential applicants for executive director roles as well as non-executive roles.

However, such applicant-focussed initiatives risk over-emphasizing the responsibility of ethnic minorities to make themselves more employable, rather than reforming the hiring practices which cause ethnic minorities to be viewed as less suitable for board positions. With respect to hiring practices, there is much more to be done. A key issue is the lack of standardisation across NHS organisations' appointment processes. Decisions are made on the discretion of existing boards and recruiters, which makes the process vulnerable to unconscious bias – for instance, rejecting candidates because they are a poor 'fit' for the board (which, given the current paucity of ethnic minority staff on boards, negatively affects ethnic minority applicants). Therefore, this policy recommendation calls for making the board appointment process more systemic, standardised, and transparent.

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[92] Ibid.
[93] NHS England, 2016, NHS Workforce Race Equality Standard 2016
[94] BMA, 2022, Summary of key evidence on barriers to and initiatives to support career progression for ethnic minority doctors

One way in which hiring processes can be made more transparent is the expansion of data collection about various aspects of the process. At present, the WRES measures ethnic minority representation on boards, and the likelihood of white candidates being hired from shortlists relative to ethnic minority candidates. While this is a positive start, it should also consider other aspects of the hiring process such as the relative likelihood of different ethnicities being shortlisted in the first place. It should also disaggregate data by ethnic minority, as the catch-all term "BME" risks masking differences between ethnic groups. We also propose that data be made more easily available for individual trusts rather than being aggregated across the NHS as a whole, as the WRES does at present. Such improved transparency as to the equality of hiring processes will better allow trusts to be held accountable - by the public as well as by central NHS government - for failures in their hiring processes. It has been shown that awareness of accountability helps preemptively prevent the introduction of bias into hiring processes before it even occurs.[95]

Finally, although this policy recommendation focusses on representation at board level, it also calls for its proposals to be applied to the hiring process at every level of NHS seniority. Since applicants for board-level roles must often demonstrate institutional experience, they tend to be hired from the top few rungs of NHS management - if these rungs are undiverse (and, in turn, the rungs below them), then at every stage the pool of minority talent available will be limited.[96] The WRES' findings that white people are 1.61 times more likely to be hired after shortlisting imply that, if candidates are promoted one seniority "band" at a time, the cumulative effect of discrimination endows white people with a 28-fold greater chance of progression from "Band 6" to the very senior "Band 9".[97]

The case for more representative management has been made repeatedly - not only can it improve commitment to equality across the rest of the NHS, but leadership diversity has been shown to render organisations more efficient and effective.[98] Thus, we emphasise the urgency of expanding existing initiatives and improving transparency and accountability in hiring procedures for senior roles in the NHS.

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[95] Kline, R., 2021, No more tick boxes: a review on the evidence on how to make recruitment and career progression fairer

[96] Warmington, J., 2018, NHS workforce race equality: a case for diverse boards

[97] Kline, R., 2021, No more tick boxes: a review on the evidence on how to make recruitment and career progression fairer

[98] Warmington, J., 2018, NHS workforce race equality: a case for diverse boards

Conclusion:

In the context of NHS staff shortages only exacerbated by strikes, the treatment of NHS staff is a serious cause for concern. It is clear that, despite the NHS's reputation as one of the UK's most diverse employers, issues of unrepresentative management and discrimination remain, adversely impacting ethnic minority staff and, subsequently, patients. This report has acknowledged the efforts and progress which have already been made to tackle this issue - however, it calls for reforms to be taken further. With respect to existing initiatives, transparency (in terms of data collection) and accountability will be key to stimulating commitment to inclusion. We also advocate for reform at the roots of healthcare - in medical schools - to ensure staff are competent to treat a diverse patient base. Diversity and inclusion in the NHS's workforce is not a "woke"[99] waste of resources, but rather crucial for improving and equalising the health of the UK's population.

[99] Thorburn, J., 2021, White NHS members of staff given five new pieces of anti-racism advice in official NHS blog post.