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"To tell you the truth I'm tired": a qualitative exploration of the experiences of ethnically diverse NHS staff

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ABSTRACT

Objectives The aim of this paper was to explore the experiences and support needs of ethnically diverse healthcare staff and how they were affected by the COVID-19 pandemic.

Design A qualitative study using focus groups conducted remotely on Microsoft Teams.

Setting The study took place across 10 National Health Service Trusts in England; 5 were Acute Hospitals Trusts and 5 were Community and Mental Health Trusts.

Participants 55 participants across 16 focus groups took part in the study. Participants were all healthcare staff members from ethnically diverse backgrounds.

Results Seven themes were generated which highlighted issues of negative experiences of discrimination at work, particularly during the COVID-19 pandemic, including participants often finding line managers unsupportive, appearing to lack care and compassion, and not understanding ethnic diversity issues. Participants identified many reasons for finding it difficult to speak up when faced with such experiences, such as feeling unsafe to do so, or feeling too exhausted to keep speaking up. Other staff had more positive experiences and described supportive interventions, and despite workplace difficulties, many participants discussed remaining motivated to work in the National Health Service.

Conclusions Negative day-to-day experiences of ethnically diverse healthcare staff, and the difficulty of speaking up about these align with other, international literature on this topic. Progress in the area of staff equality is vital if healthcare organisations are to continue to provide high-quality patient care and retain skilled, compassionate staff who value their place of work. Recent literature suggests that many initiatives to reduce inequalities have not been successful, and there is a call for fundamental, cultural-level change. Future research is needed to understand how best to implement these organisational-level changes and to evaluate their effectiveness.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study adds to a growing body of qualitative investigations into the experiences of ethnically diverse National Health Service staff in the UK and was designed to enhance an already well-developed body of quantitative research in this area.
⇒ Of the six research team members, three were from ethnically diverse backgrounds and three were of white British ethnicity. This gave an opportunity for a broad range of researcher views and cultural perspectives.
⇒ The participants were from a broad range of religious affiliations, ethnicities, ages, professions and seniority levels.
⇒ A study limitation is that only people who could access computers and online working were able to participate. This is likely to have excluded among others; porters, cleaners and staff needed intensively on hospital wards.
⇒ The use of remote focus groups appeared to moderately limit natural conversational flow and may thus have slightly inhibited direct participant-to-participant interaction.

INTRODUCTION

The UK National Health Service (NHS), founded 75 years ago, is the UK's largest employer and is one of the biggest employers globally.[1] The NHS also has one of the most ethnically diverse workforces in the UK public sector,[2] with an estimated 20% of NHS staff identifying as belonging to an ethnic minority group.[3] Approximately 14% of NHS staff are from overseas, with Indian, Filipino and Irish migrant groups commonly represented, particularly among nurses.[4]

The NHS Staff Survey in England 2021[5] showed that people from ethnically diverse groups report higher levels of discrimination, bullying, harassment or abuse from colleagues or managers compared with white staff and were also subjected to racism by patients and other members of the public during their work. The Workforce Race Equality Standard (WRES) report from 2021 found that ethnically diverse staff are more likely to experience bullying, harassment and abuse from

patients and colleagues, are more likely to enter into formal disciplinary processes and have more obstacles to progressing in their careers.[6] Ethnically diverse staff in the NHS are also less well represented at senior levels.[6]

The racial inequalities that are often experienced by NHS staff have been brought into sharp focus by the COVID-19 pandemic; ethnically diverse staff have experienced more deaths than white ethnic staff,[7] and recent data suggests that ethnically diverse staff have been coerced into working longer hours, were disproportionately represented in frontline, high-risk roles[8] and disproportionately harmed by chronic shortages of personal protective equipment across the NHS.[9]

It is critical that the NHS and other healthcare organisations at an international level address these workplace inequalities; research confirms that the extent to which an organisation values its minority staff is a good barometer of how well patients are likely to feel cared for.[10] Moreover, the NHS is facing a workforce recruitment and retention crisis and improving its performance on diversity and inclusion will play an important role in addressing this.[11]

A growing body of quantitative data makes a compelling case for addressing workplace inequalities; however, it is limited in its ability to describe the detail and complexity of people's lived experiences. Previous qualitative studies have highlighted individual experiences of racism, institutional discrimination and lack of equal opportunities in the Caribbean, Asian and black African nursing population.[12–14]

The 2020 WRES report highlighted that much racial discrimination experienced by ethnically diverse staff is through subtle processes and behaviours[15 16] that are often undetected by others.[17] This indicates that white ethnic observers may not notice the institutional racism and may be unaware of its extent; they may also lack understanding about the precise nature of discriminatory experiences at work and narratives of people's lived experience. This is likely partly a reflection of Ray's Theory of Racialised Organisations[18] and Moore's Theory of 'White Institutional Space',[19] which suggest that whiteness shapes institutional and organisational processes and thus whiteness is seen as normative and neutral.[20] This highlights a clear need for institutional change; however, for people seeking to be 'white allies' and who have the desire to learn, the narratives of qualitative data may resonate.

At the time of conducting this study, there was limited qualitative research exploring the experiences of a range of ethnically diverse staff in different types of NHS organisations, so it is hoped that this qualitative data can add a fuller dimension to a growing body of quantitative data in this area and highlight complex and often little-understood processes. This study aimed to explore the experiences and support needs of ethnically diverse staff in the NHS, and how they were affected by the COVID-19 pandemic. We have discussed themes relating to psychospirituality elsewhere[21]; the focus of this paper captures the unique accounts of being an NHS employee and belonging to an ethnically diverse community both generally and during the COVID-19 pandemic.

METHODS

Study context

The data for this study was collected as part of the 'Listen, Share, Hold, Respond' project which was commissioned by NHS England. The project aimed to explore the experiences and support needs of ethnically diverse healthcare staff and how they were affected by the COVID-19 pandemic.

Design

A qualitative study using focus groups conducted remotely on Microsoft Teams.

Patient and public involvement

None.

Setting

The study took place across 10 NHS Trusts in England; 5 were Acute Hospitals Trusts and 5 were Community and Mental Health Trusts.

Participants and recruitment

Focus groups were conducted with English-speaking NHS staff (any pay band/grade, profession, gender or religion) from an ethnically diverse background. In this paper, we use the term 'ethnically diverse' to describe non-white British people, acknowledging current difficulties with terminology.[22] A total of 10 trusts were approached, and within each participating trust a 'gatekeeper' was identified who assisted with recruitment. Gatekeepers were typically the Equality, Diversity and Inclusion (EDI) officer or black, Asian and minority ethnic (BAME) network coordinator. To further support recruitment, we also advertised the study in local trust-wide intranet communications and BAME network communications, including via researcher attendance at online BAME network meetings (HKG, JC and GH). Volunteer participants then contacted the research team and were assigned to a focus group with other members of their participating NHS Trust. Snowballing sampling methods were also applied to support recruitment into the study. Members of the public were not involved in the design or conduct of the research.

Data collection

Two experienced facilitators (RP, BN, JC, HKG), at least one of whom was from an ethnically diverse background, ran the focus groups which took place between June and October 2021. The average group size was 3–4 participants, and the focus groups lasted approximately 90 min. The focus groups took place predominantly during working hours, were held online and followed a topic guide (Box 1) to facilitate discussions around participants' experiences as healthcare workers generally and how they were affected by the COVID-19 pandemic. All

Box 1 Topic guide

Could you tell us about your experiences of working in the NHS as an ethnically diverse member of staff?
Have these experiences changed during the COVID-19 pandemic? How and in what ways?
What would you say was the impact of COVID-19 on you at work?
Could you tell us about your experiences of the COVID-19 pandemic when you were out of your professional role (what was it like in your own social or spiritual world in lockdown)?
What would you say was the impact of the COVID-19 pandemic on you as a social/spiritual human being outside work?
If you have had a challenging experience, what strategies have you used to help you cope?

focus groups were asked some of these questions. (The full topic guide including questions on psychospiritual topics is reported elsewhere[21].)

Many participants appeared to speak openly and passionately about topics that were sometimes sensitive and painful for them. Facilitators were able to offer practical and emotional support during the sessions and afterwards should participants show any distress, for example, by signposting to relevant support services. A number of participants expressed how helpful it was to be able to discuss such topics openly in this format and safe space. Sessions were audio recorded and transcribed by a transcription company with the relevant confidentiality agreements in place. All transcripts were anonymised at the point of transcription.

Data analysis

Data was analysed using thematic analysis[23] of recorded material using the framework approach.[24] The data were generated into codes and categories and entered into the framework matrix via a Microsoft Excel spreadsheet. Narrative summaries were written to detail the findings relating to the individual categories and themes were generated relating to the codes and categories that were summarised. The research team held regular meetings to discuss the themes that were emerging and at this point, the themes were further refined, adapted and modified to reflect the interpretations generated from these meetings.

FINDINGS

55 participants across 10 NHS Trusts in England were recruited into the study. A total of 16 focus groups were conducted at which point data saturation was reached.[25] See table 1 for demographic characteristics.

Thematic analysis identified seven themes relating to the experiences and needs of ethnically diverse NHS staff: (1) experiences of discrimination through being an ethnically diverse member of staff; (2) experiences with line managers and senior leaders; (3) intersectionality of ethnicity and experiences as a healthcare worker during the COVID-19 pandemic; (4) difficulty of speaking up;

Table 1 Demographic characteristics of participants

Domain	n=55
Gender	
Female	41
Male	14
Age group (years)	
18–29	7
30–39	12
40–49	17
50–60	16
Over 60	6
Ethnicity	
Asian or Asian British—Indian	14
Asian or Asian British—Pakistani	8
Asian or Asian British—any other Asian background	5
Black or Black British—African	17
Mixed—white and black African	2
Black or black British—Caribbean	5
Mixed—white and black Caribbean	1
Other (including different combinations of Russian, Somali, British, Tunisian and Dutch to maintain anonymity)	3
Religious affiliation	
Buddhist	1
Christian	22
Hindu	5
Muslim	16
Not religious	4
Sikh	5
Spiritual	2
Paybands	
B2	0
B3	2
B4	5
B5	7
B6	10
B7	10
B8a	6
B8b	5
B8c	1
B9	0
Unsure	6
Doctor pay scales	3
Years working in job role	
<1 year	8
1–5 years	15
6–10 years	12

Continued

Table 1 Continued

Domain	n=55
11–15 years	4
>15 years	16
Profession	
Administration	5
Chaplaincy	3
Medical (doctor)	4
Freedom to speak up guardian	1
Healthcare assistant	1
Human resources	2
Information technology	2
Management	5
Nursing	18
Pharmacy	5
Physiotherapy	1
Psychology	1
Research	3
Social work	3
Volunteer	1

(5) positive experiences of being ethnically diverse in the NHS; (6) motivation for continuing to work in the NHS; (7) supportive interventions for ethnically diverse NHS staff. The themes begin with the challenging experiences described by the participants and how difficult it can be to speak up about these, followed by an exploration of some of the positive experiences and motivations for working in the NHS, and finishing with participants' suggestions for improvement. The themes are presented below with supportive illustrative quotes.

Experiences of discrimination through being an ethnically diverse member of staff

This theme addresses participants' everyday experiences perceived to be a result of racist and discriminatory practices. Participants described many negative experiences of discrimination within the NHS, particularly with regard to having their qualifications and professional experience underestimated, and being denied promotion for a long time:

> In the last three years, I've applied for 110 jobs within the NHS, a lot of them the same level and some higher up, and it's taken me until the end of those three years to secure a promotion…All of that can't be me. Some of that has got to be the culture of the organisation (Asian British Pakistani, 50 – 60).

Some described being treated differently when their professionalism was called into question:

> I was actually admitted to the hospital twice and had surgery under general anaesthetic, but I still had to have meetings face-to-face to explain my absences […] which was really intimidating and almost humiliating […] I know that the British consultant who was off, I'm not saying she wasn't off without reason, she was off for a medical reason, but she didn't have such a meeting (Black British African, 60+years).

Some participants talked about they felt 'under the spotlight' as conversations about race intensified following the murder of George Floyd in the USA:

> As a person from a minority background, you feel drained at some point because you can't escape the debate. […] Even when you say 'I don't want to discuss this, I'm done, can we talk about something else?' You get home, my daughter coming home, she'd been racially bullied at school. You can't escape it and you have to deal with all of that. So [I feel] quite alone (Black British African, 30 – 39).

Experiences with line managers and senior leaders

This theme considers experiences of and suggestions for managers and leaders. Participants talked about wishing to see greater diversity of colleagues in senior leadership roles hoping this would lead to greater insight into, and commitment to tackle the range of discriminative obstacles facing ethnically diverse staff:

> We have somebody really strong in our People Director at the moment. She's a Black woman. And that has made a huge difference (Black British African, 40 – 49).

Participants also talked about their experiences with their immediate line managers, with some white managers described as having poor communication skills:

> It's usually just textbook-based from the White manager and then the Black manager is more personal. My [Black] manager will ask me 'how is everything at home, is everything okay?' But that question I've never received really from my [White] modern matron (Mixed White and Black African, 30 – 39).

Participants reported wanting caring and compassionate leadership, and for line managers to talk to them as a whole person, rather than in a procedural way:

> I think [compassionate leadership is] a different type of leadership style that we're not taught. We're taught to be very dictatorial, we're taught to be very hierarchical, and that's how the NHS has been (Asian British Indian, 40 – 49).

There was a strong view that managers and leaders often hesitate to have open conversations about ethnicity or other sensitive issues for fear of 'saying the wrong thing':

> We now live in a world that's so politically correct that I think nine times out of ten even when somebody wants to ask a question or talk to you about this, they don't know how to, so they just won't. Because they

don't want to offend you or they don't want to say something that will be misinterpreted (Mixed White and Asian, 30 – 39).

There was often sympathy expressed for this position, but managers were urged nonetheless to overcome this and 'have the difficult conversations':

The compassionate side of me is […] thinking 'well, whatever manager is in place, how difficult that might be because they might not understand certain things themselves or feel as if they can be open and honest without feeling their actions might be questioned.' It's a very difficult balance (Mixed White and Black African, 30 – 39).

Intersectionality of ethnicity and experiences as a healthcare worker during the COVID-19 pandemic

This theme considers how the challenges that were felt by all healthcare workers during the pandemic were affected by also being from an ethnically diverse background. Some participants shared positive experiences of feeling well supported during the pandemic:

I've always felt valued by my team. And my manager, who was White, didn't treat me any different [worse]…He took my health very seriously and made sure that I had the resources when I was moved away from the ward because of my risk identified by my GP. So, I can't say that I was treated any… I was actually treated really well (Asian British Pakistani, 30 – 39).

However, other participants described a range of difficulties that were harder due to their ethnic diversity. For example, when setting up COVID-19 risk assessments, some white line managers reportedly did not consider that many ethnically diverse NHS staff had family living in other parts of the world and that this might impact their well-being:

A lot of us from the diaspora of different communities actually have family abroad…We were trying to support family back at home, as well as support family here, but actually we couldn't. And we knew that some of our family were going to die. How on earth, how do you share that to somebody? How do you say that this is on our heads? […] So the action of providing a risk assessment is useful, but actually following it through in a meaningful and sustainable way, I think is where we've probably not been able to do that, if I'm honest and open about it (Asian British, 40 – 49).

Some participants described how inequalities at work magnified and became unavoidable during the pandemic. Participants talked about working longer hours despite initially being at greater risk of death than white NHS staff:

I don't want to say it's a cultural thing, I'm not sure, but in our team, the ethnic minority in our team, we will work and work. We have families that are back home that we supply, sending money back home […] For our White counterparts, it was much easier for them to call in sick (Mixed Asian and White, 30 – 39).

Some participants felt that senior management teams were slow to react to the initially higher death rates of ethnically diverse NHS staff:

The BAME network came about on June 20. And it was only once that came about that I started to feel really bad about the PPE conversations that weren't landing properly, about our BAME colleagues […] dying. And I was thinking, 'Gosh, if this was happening to White people and White people were dying with the numbers that BAME people were dying, there'd be a different response' (Asian British Indian, 40 – 49).

Another participant reported that the treatment of ethnically diverse NHS staff raised questions about fairness and equity:

The proportion of testimonies that we had of staff who were sent to the frontline without appropriate PPE – because you remember we struggled […] with getting aprons, masks and so on – is just ridiculous. And there were people who were more likely to send BAME staff out there without appropriate masks, aprons, gloves, etc. than they were to send their White counterparts. So, there was a lot that also transpired around institutional racism during COVID, and BAME staff being treated unfairly. So, yes, it created a lot of commotion… around identity, how we're perceived, how we're treated at work, and fairness and equity (Black British African, 40 – 49).

Difficulty of speaking up

This theme highlights that despite painful experiences of discrimination, many participants spoke of finding it difficult to raise their voices and discuss uncomfortable topics at work. Reasons given for this were varied and complex. One reason given was previous traumatic or unsafe experiences relating to having spoken up:

[My managers] actually approached me with so much anger. About nothing really. And it was a point where they were looking to see if they could, really get me sacked. Because at the end of the day, I was speaking up, and they didn't like that. That someone with such a low banding, was speaking up for themselves (Black British Caribbean, 50 – 60).

Another reason was having their ideas and concerns previously dismissed:

I'm a head of department and got moved a couple of years ago…Even as a senior leader, one is not heard… And then you give up, don't you? Well, I gave up, because I was like, 'I can say it, I'm really experienced at what I do, I've done it for 20 years. I can give you an opinion, but actually you're not listening, or you're choosing not to listen' (Asian British Indian, 40 – 49).

Participants expressed the fear of being labelled a bad or difficult coworker if they spoke up; they thus put up with the existing working conditions:

> I'm already an ethnic minority, if I'm also going to demand for more I'm going to be perceived as not a good worker. I don't know, it's that mind-set that I noticed that loads of workers do have. Hence why they're working so many hours…But I think it's also really important to understand that they feel that they don't have the voice to speak up in a lot of cases (Mixed White and Black African, 30 – 39).

Participants felt that it was necessary to keep silent and conform in order to have any opportunity of being promoted:

> I've met a number of people who […] have managed to climb up the ladder somehow…You've gotten to the top. You're an associate director […] But you're then thinking, 'Did you recognise that you've probably ignored bits of racism to get where you are because people have to just assimilate in workplaces?' You have to almost accept it sometimes to get where you need to get to…I don't accept any of it. So I will always stay on the bottom bandings (Asian British Indian, 40 – 49).

Some participants stated that they were simply tired of not being understood and having to constantly explain what equality should look like to their white ethnic coworkers:

> I think sometimes there is an onus where people think, as visible people of colour, as visible people of faith, that we are the ones who [should] explain to them about what equality should look like…To tell you the truth, I'm tired. Sometimes you get exhausted from explaining to people what equality should look like because they can't understand it. It doesn't fit into their narrative (Asian British Indian, 40 – 49).

A few participants in senior positions used their platform to speak on behalf of other ethnically diverse members of staff. This was perceived to be empowering to them and others around them:

> [Being senior and speaking up] definitely has made [my work] feel different for me. [My managers] look at me in a different kind of way. […] My colleagues also feel empowered, as well. […] And they have approached me and said, 'I'm so glad that you are doing what you're doing' (Black British Caribbean, 50 – 60).

Positive experiences of being ethnically diverse in the NHS

This theme describes how many participants spoke of their positive experiences as healthcare staff, such as describing warm and supportive relationships with their white ethnic colleagues:

> I remember when I came, and I was new, my line manager […] said 'if you want, on Friday, you can go to the mosque. It's your right.' So, I was grateful, and I said 'no, I don't need it, but thank you.' (Other, 40 – 49).

Participants who were from second-generation or third-generation immigrant families described how they were not constantly aware of their skin colour or ethnic backgrounds and felt generally less subject to ethnic discrimination. Some participants described how they had been given opportunities for development, and with the support of mentors, managers and 'white allies', had risen in the NHS ranks:

> I always have a positive [outlook] about how I've grown in the department and how, in the organisation, people really took some time out to invest in me. So, I've been in quite a fortunate position compared to some of my colleagues. I was also successful in doing what we call the 'BAME Leadership Academy' programme which was paid for by the Trust […] I've been quite lucky. (Asian British Indian, 30 – 39).

Participants reported that many things had changed for the better in recent years, such as ethnically diverse NHS staff and women being better represented in senior leadership positions:

> Slowly, I think we're getting there. We do see some change, even within my speciality of not just even changes in people of different ethnicities coming into high positions, but even more women of ethnicities coming in, which is really nice to see, I think. I didn't see that 20-25 years ago (Asian British, 40 – 49).

Motivation for continuing to work in the NHS

This theme addresses participants' motivation for working in the NHS despite the perceived challenges. Overall, participants found their roles to be rewarding and vocalised a strong dedication for their profession:

> No one can destroy my passion about my job. It's not like my job, it's my passion, and I will not let anybody come and destroy my love […] So, it doesn't matter I'm going through a challenging time, doesn't matter somebody throwing so many stones, I will make bricks with those stones (Asian British Indian, 40 – 49).

Participants felt that working in the NHS was a privilege, particularly when drawing comparisons between themselves and their parents:

> I put up with the crap, to be honest, because […] I know I've got a very privileged position. I'm doing a job I love with people I like working with, and I work less hard than my parents did. I'm quite lucky really (Asian British Indian, 40 – 49).

Some participants stated that positive feedback from patients/service users motivated them. Other participants

stated that it was rewarding to face challenges at work and in the process change things for the better for future generations.

Most participants reported their spirituality as being a source of personal motivation. Their work in the NHS was perceived as providing an avenue for putting spirituality/religion into practice:

> I have to come to work and help humanity, that's a part of my spirituality. And that's what I look at regardless of every pain, distraction and anxiety. Because I know this is the only way I can practise my religion, my spirituality, by giving that helping and supportive hand (Black British African, 40 – 49).

Supportive interventions for ethnically diverse NHS staff

This theme provides examples of supportive interventions that were in place in some of the NHS Trusts where the participants worked, such as mentoring, webinars and drop-ins. There was a good deal of enthusiasm for Trust BAME networks which were described as a great space for people to share their experiences, connect with fellow staff from ethnically diverse backgrounds and discuss ongoing concerns:

> I was part of the BAME network from the beginning… We have a WhatsApp group and we share our things openly. About, mainly if we've had not a really great day…I attend the meetings where they raise issues that I've thought may be happening within my area. And or, the wider picture of what's happening to BAME across the whole hospital sites. (Black British African, 60+years).

However, one of the participants who was involved in the BAME network within her trust reported that it was a tough undertaking as it came on top of her normal day-to-day work in the NHS:

> It's very challenging because obviously we've got a full-time job. And then we take on this role in the committee (Black British African, 30 – 39).

A strong view was that ethnically diverse NHS staff needed a safe space where they could discuss their problems, feel heard and cared for and create a safe space for dialogue:

> There needs to be a protective space where we should be able to talk about these things and find some kind of solution to it (Asian British Pakistani, 30 – 39).

DISCUSSION

Summary of findings

The study provides an in-depth insight into the difficulties experienced by ethnically diverse staff within the NHS, particularly during the COVID-19 pandemic. Participants shared experiences of indifferent treatment from senior team members, and how there was limited sensitivity towards and knowledge of their cultural differences. Specifically, during the pandemic, ongoing conversations around racism and discrimination left participants feeling trapped and unable to escape these conversations. Participants also discussed the difficulties they had in speaking up against discriminatory behaviours as they recalled previous negative experiences, which further deterred them from saying anything. Participants voiced a strong passion for their jobs and how this superseded their negative experiences as well as drawing on their spirituality to cope. While many negative experiences were highlighted, participants also described positive experiences with colleagues, as well as beginning to see more representation of ethnically diverse leadership. Participants described how through the establishment of Trust BAME networks staff were able to connect and create safe spaces to talk to one another about problems. Staff reiterated the need for diverse leadership, but also compassionate leadership where senior staff are comfortable with having difficult conversations around racism and discrimination. There was a genuine need for a protective space, as well as support to speak up and feel heard, highlighting that the NHS still has much work to do in order to support its ethnically diverse staff.

Consistency of findings with the wider literature

There have been a large number of qualitative studies published since 2021 describing healthcare workers' experience during the COVID-19 pandemic, including studies from India,[26] Malawi,[27] South Africa,[28] Puerto Rico,[29] the USA,[30] the UK,[31] Canada[32] and Singapore.[33] Most of these studies describe high levels of stress and trauma among healthcare workers, which was exacerbated if there was a perceived lack of resources and operational efficiency within their respective healthcare organisations. This study focuses on the experiences of ethnically diverse healthcare workers in a predominantly white British healthcare system and society, which arguably have usually been harder. The often negative experiences described by participants reflects other qualitative literature on pandemic-related experiences of ethnically diverse healthcare staff, with one UK study highlighting how participants did not feel adequately supported by their employer and their manager during the pandemic, feeling particularly unsupported when their supervisor was from a white British background.[34] The same study indicated how some staff members felt risk assessment exercises had not been treated seriously by their managers and organisations.[34] Another qualitative UK study highlighted four key areas of racialised discrimination that put the lives of ethnically diverse staff more at risk of serious injury and death: work allocation, PPE provision, risk assessment provision and a culture of neglect.[35] This same study noted that 'these experiences should be seen as a continuation of prepandemic experiences resulting from a systemic culture of racism'.[35]

The wider international literature identifies similar themes: in the USA, there is limited ethnic diversity

among nursing staff[36] and qualitative exploration of the experiences of black nurses working within hospitals highlights feeling a need to work harder than their white counterparts to earn the same recognition, and feeling despondent when failing to see people in leadership positions that 'looked like them'.[37]

In medicine, quantitative evidence from a recent UK cross-sectional study involving 2030 respondents (doctors and medical students) identified that over three-quarters (75.6%) of respondents had experienced racism at least once in the past 2 years, and 17.4% experienced racism regularly. More than 70% of doctors who had experienced racism at work did not report it because they had no confidence that the incident would be dealt with, or they feared that they would be labelled a troublemaker.[38] A UK qualitative study reported respondents describing difficulties in challenging or reporting adverse experiences due to concerns about the impact on their career progression, fears of upsetting team dynamics, 'rocking the boat', and of being labelled a 'snitch' or 'troublemaker'.[20] This further supports the credibility of our findings regarding barriers to speaking up.

The findings of our study can be further understood through a lens of critical race theory (CRT): CRT argues how societal racism operates in favour of the dominant racial group in power; such perceptions were expressed by participants within our study. When describing being overlooked for promotions, or meeting backlash when speaking up, this supports the tenet that describes the permanence of racism, in this case how structural racism can promote silencing and fear of speaking up so to not be seen as disruptive. This can further exhaust ethnically diverse individuals and cause them to feel racism will not be eradicated. When considering solutions, there needs to be promotion of systems change with senior-level buy-in and accountability to deliver.[39 40] However, the risk of retraumatisation when involving ethnic minority groups to codesign strategies requires serious consideration. As shown across our data, participants, in particular following the killing of George Floyd, expressed significant exhaustion when having to recount or defend the existence of racism and the impact of their lived experience. This aligns with the colour blindness tenet of CRT that has been observed in other studies[20 41] adding credibility to our findings.

The findings call for greater diversity in healthcare leadership which is a well-known issue within the NHS,[42 43] highlighted by the 2014 'Snowy White Peaks of the NHS' report.[44] This further reflects an international issue where a lack of diversity in healthcare leadership is dramatic, for example, in the USA 98% of senior management in healthcare organisations are white.[45] Similarly, across Canada, individuals from non-white backgrounds occupied only 7 out of 118 highest-level hospital roles.[46] This same paper argues that racial diversity in healthcare services leadership needs to increase, as racially diverse leaders are more likely to promote culturally sensitive care, address discriminatory policies, create inclusive spaces and use their own insights to improve staff experiences.[46] However, it has also been highlighted that although increasing diverse representation in management positions is a critical step, this alone cannot eradicate the culture of racism: black managers have highlighted how they are not always fully involved in decision-making processes or are isolated, leading to the reproduction of discrimination and the failure to address racism even by racialised minorities in management.[35] It can be argued that until the inherent institutional structures that prop-up racism and white privilege[47] are dismantled, most of these efforts become tokenistic without real change in clinical practice. Inequalities will continue and arguably at the benefit of the dominant group in the organisation.

For ethnically white line managers, the study findings provide some suggestions as to the most effective ways for them to support ethnically diverse team members. Many white line managers may have good intentions but little understanding of cultural sensitivities and may therefore treat all ethnically diverse colleagues 'the same' as white staff members, or the same as each other, overlooking difference or individuality. One reason for this limited understanding may be that people are reluctant to discuss such topics, finding them uncomfortable; this is something that was highlighted in our findings.

It is crucially important that healthcare organisations take steps to become more culturally aware and sensitive to the needs of the individuals within their organisations. However, care must be taken to ensure that the need to respect each other's cultural and ethnic viewpoints does not stymie discussion and close down any open questioning relating to these issues. The current EDI agenda that is increasingly prominent across healthcare organisations sets out to ensure that staff are treated fairly in relation to this premise. However, it is important that the differences that set people apart are not silenced in the drive for equality, as this may serve to create more tensions and divisions than it solves, as mutual understanding and shared support mechanisms are eroded. There is therefore an urging to 'have the awkward conversations' and improve understanding and hence staff well-being. Much evidence shows that supportive managers are strongly linked to improved mental health at work[48 49] and changes in awareness and communication techniques could have widespread implications for the well-being, recruitment and retention of staff.

Not all participants' experiences in our study were negative and evidence from another qualitative study suggests that participants who felt they had organisational support experienced improvements to their well-being, which may have mitigated against the effects of any racial injustices they were increasingly aware of and subjected to during the pandemic.[34]

While many of the studies highlighting the negative experiences of ethnically diverse staff indicate how staff are leaving or considering leaving their roles,[50] the participants in this study mostly indicated that despite the challenges and experiences of discrimination, working for

the NHS was part of a larger purpose made clear to them through their spirituality. Participants also expressed how their passion for their work provided them with a drive to continue in their roles.

The value of BAME networks to support ethnically diverse staff, and psychologically safe routes for raising concerns was highlighted by our findings. These ideas link to some extent with suggestions in the Kings Fund (2020) report '*Workforce Race Inequalities and Inclusion in NHS Providers*'.[1] There are also practical ideas for tackling racism at work in recent guidance around combatting racial discrimination against minority ethnic nurses, midwives and nursing associates[51] and the '*Anti-Racist Health Service Manifesto for Change*' published by the Anti-Racism Research Group at the Centre for Culture Media and Society at Sheffield Hallam University.[35]

However, in the UK, despite the implementation in recent years of measures to tackle racialised inequities in the health services such as the NHS WRES,[6] little progress has been made[20 35] and in fact, in some areas discrimination and harassment has increased.[52] Interventions tackling discrimination among healthcare staff have been reviewed,[40 53] finding little evidence that initiatives such as cultural competency and unconscious bias training are effective in reducing discrimination. It is therefore suggested that 'a radical shift in the institutional approach is needed to change the underlying narratives and to help dismantle the racialised structures that create an environment and tolerance for racialised inequalities which cause both physical and psychological harm'.[35]

One study, drawing on qualitative interviews with 48 healthcare staff in London (UK), identified how microlevel bullying, prejudice, discrimination and harassment behaviours, independently and in combination, exploited and maintained organisational-level racialised hierarchies.[20] As a result, there was a call to reduce disparities via structural and systemic-level shifts in organisational culture, via instilling a promotion of work/life balance, proactively fostering inclusion by equitably valuing and esteeming differences in roles, attributes, knowledge and perspectives; and proactively levelling-up opportunities for career progression. It was stated that these actions were structurally key for staff retention and improved health outcomes for staff (and ultimately patients).[20] Future research is needed to test implementation of these wider structural actions and their effectiveness.

Strengths and limitations

This was a qualitative study exploring the experiences of ethnically diverse NHS staff, to provide a rich, narrative dimension to complement the many quantitative studies in this area. This qualitative perspective can highlight subtle processes and experiences that may otherwise go undetected by outside observers.

Of the six research team members, three were from ethnically diverse backgrounds and three were of white British ethnicity. The research team had regular meetings to discuss the data analysis and identify themes, giving a broad range of views and perspectives, personal lived experiences and academic understanding to the topic.

The participants were a diverse sample from a broad range of religious affiliations, ethnicities, ages, professions and seniority levels.

A study limitation is that only people with ready access to computers and online working were able to participate. This is likely to have excluded staff such as porters, cleaners and staff needed intensively on hospital wards. This is a possible gap in the findings as it may be that general medical hospital staff, such as those working on COVID-19 wards, in intensive care units or in emergency departments experienced the highest levels of post-traumatic stress; the current literature suggests that although levels of trauma were high in all healthcare workers during the pandemic, most studies do not draw a distinction between different healthcare professions or specialties.[54] There is very little literature about the role of cleaners (and seemingly none about porters) to the point that they are 'an invisible workforce',[55] and yet they have often been exposed to high levels of risk from COVID-19 and are instrumental in infection control measures.[55 56] They are also likely to be from ethnically diverse groups, although precise figures on this are difficult to obtain.

Another limitation is that the use of remote focus groups appeared to make discussions slightly less fluid than if they had been face to face, with participants waiting their turn to speak, which may have limited natural conversational flow and meant there was less direct interaction between the participants and few opportunities to observe participants concurring with or challenging each other. Although it was felt that most participants appeared to speak openly and passionately, this may have moderately limited the richness of some of the data. Some participants expressed reservations about being funded by NHS England, but we assured them that all discussion would remain anonymous, and NHS England, although reviewing and approving the final draft of the paper, would not be permitted to compromise the ethical and scientific integrity of the study.

There was no formal patient and public involvement (PPI), although we did present several webinars where some of the themes from the focus groups were discussed, which can be accessed online.[57] Using a formal PPI process may have improved the design of the study and its relevance to participants.

CONCLUSION

Progress in the area of staff equality is vital if healthcare organisations are to continue to provide high-quality patient care and retain highly skilled, compassionate staff who value their place of work. With its diverse and large workforce, the NHS has the potential to pave the way for other healthcare organisations internationally that wish to promote a value-driven culture that is inclusive of staff and patients alike, increasing productivity, staff retention and recruitment as a result.

Our findings, when linked with the wider literature, suggest that many initiatives implemented to date have not been successful at reducing discrimination and that increasing ethnic diversity of leadership teams is not enough; instead, there needs to be systemic acceptance of such leaders at an organisational level, and fundamental structural changes need to be made in healthcare organisations. Future research is needed to understand how best to implement these organisational-level changes and their effectiveness.

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Contributors All authors made substantial contributions to the conception or design of the work; or the acquisition, analysis or interpretation of data for the work and were involved in drafting the work or revising it critically for important intellectual content. All authors gave final approval of the version to be published and have agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. JC was involved in the data collection, data analysis process and the overall coordination and management of the study. She was also responsible for co-collating the first draft of the paper. HKG was involved in the data collection, led on the data analysis process and co-collated the first draft of the paper. BN and RP contributed to the study design and development, were involved in data collection and the analysis and/or interpretation of the study data. GH and CH were responsible for the original study design and conception and were involved in the analysis and/or interpretation of the study data. CH, as guarantor, is responsible for the overall content. All contributed to either the drafting or critically reviewing the manuscript.

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