THE SEACOLE GROUP
The Network for Black, Asian & Minority Ethnic NEDs in the NHS Health System

NOT AN OPTIONAL EXTRA

THE PRICE OF NOT TACKLING RACE DISCRIMINATION IN THE NHS

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Not an "optional extra"

The price of not tackling race discrimination in the NHS

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Foreword

Those who work in the healthcare system endeavor to provide continuous, inspirational and unconditional care to the people of our nation. A huge proportion of these staff come from an ethnic minority background.

The key founding principle of the NHS is the provision of a comprehensive service available to **everyone** and underpinned by **anti-discrimination** provisions and a wider social duty to **promote equality** through the services it provides.

But for too long, both the experience of the service from those citizens from underrepresented populations and the work experience of our staff from Black, Asian or minority ethnic backgrounds, have been poor and is continuing to be poor ~~worsen~~ in comparison to that of their white colleagues.

To further exacerbate the imbalance, representation of members from ethnically diverse racial groups at Board level has seen insufficient improvement and their voices in the wider equity, diversity and Inclusion (EDI) debate are not sufficiently heeded. The time has come to reframe and strengthen the discourse around diversity and inclusion and to press the case for improvement.

This report has been commissioned by the Seacole Group against a backdrop of hostile rhetoric and action from Governments abroad, public hostility in the UK around immigration and at a time of significant upheaval and financial pressure in the NHS. As NHS leadership capacity is increasingly absorbed by these ever-present challenges, it is vital that the discussion and action to reduce health inequity through the best treatment of our NHS Black, Asian and ethnic staff remains the highest of priorities.

The information in this concise and compelling report provides further evidence that supports the case for tackling discrimination in our NHS workforce, the cost and damage to productivity of not doing so and even more importantly, the opportunities that facing into our EDI challenges can bring.

We want this report to become a practical guide for our Seacole Members, NHS leaders and other Board Members alike, to reference the evidence within it and to hold to account those responsible in their organisations for delivering improvements in tackling race discrimination. We have the evidence, now we need the focused action, determination and courage to deliver race equity.

Sim Scavazza,
Chair, The Seacole Group
May 2025

Introduction

14 years of austerity, at a time of rising health needs, exacerbated by Covid, has left the NHS with immense challenges. The NHS faces a perfect storm as the Darzi report (2024) demonstrated. https://tinyurl.com/4vwv7c8x

Despite this, the NHS had, almost until Covid, improved its productivity faster than the UK economy, with a raft of improvements and innovations thanks to the dedication of its workforce. Nevertheless, rising health needs and financial pressures mean further radical improvements are essential alongside much greater emphasis on prevention, community services and health inequalities.

Staff costs are two thirds of NHS expenditure. Staff are both the most expensive, and the most valuable, NHS asset. Research over the last three decades has established conclusively that how staff are treated in their working lives makes a radical difference to the safety, quality and productivity of the NHS. Research is clear that:

- Teams where staff are treated respectfully, and where mistakes lead to learning not blame, are more likely to be innovative and effective, placing a premium on collaborating within the team and with other teams;
- Innovation is best developed in teams where staff feel it is safe to raise concerns, admit mistakes, and promote new insights. Such teams must be underpinned by inclusion and psychological safety, whilst research is clear that this is best done by cognitively-diverse and identity-diverse teams because the latter improves the former;
- Attracting, promoting and supporting staff fairly at every level is essential if those teams are to have staff with the best possible mix of talent and potential. For individual staff, being supported and treated equitably is also crucial to their discretionary effort and retention;
- A cornerstone of such teams will be an understanding of, and challenge to, the damage discrimination does to staff health and well-being, organisational effectiveness and patient care and safety.

All forms of discrimination undermine effective healthcare. The NHS has especially struggled to tackle discrimination especially race discrimination. Workforce and staff survey data show that any improvement has been painfully slow, despite the growing evidence of the damage racism causes. The damage to staff from actual or anticipated racism is immense. The Messenger Report (2022) https://tinyurl.com/4b8ss3kd found:

> "EDI should become a universal indicator of how the system respects and values its workforce, and the provision of an inclusive and fair culture should become a

key metric by which leadership at all levels is judged…..Although good practice is by no means rare, there is widespread evidence of considerable inequity in experience and opportunity for those with protected characteristics, of which we would call out race and disability as the most starkly disadvantaged**."**

Ministers have acknowledged aspects of this culture that can impede improvement:

Warning that those who are racist to NHS staff 'can be turned away'. https://tinyurl.com/4yrnd5bv

- NHS managers who silence whistleblowers could be barred from working in the NHS. https://tinyurl.com/58z3bsnp

This report builds on those statements. Parts of the NHS responded immediately to the racist riots of 2024 but underlying race discrimination remains. Addressing how staff are treated, and specifically discrimination, is **not** an alternative to focussing on specific goals such as reducing waiting lists or shifting resources towards community services and prevention. Rather, it is a precondition of achieving those goals in a sustainable way.

Such work builds on the moral obligation we have to treat our fellow human beings – whether as staff or as patients – with humanity and equitably.

The latest NHS planning guidance https://tinyurl.com/3jn7ds33 seeks sharp productivity increases. But sustainable productivity does not mean staff working harder. In many parts of the NHS staff are working at an intensity well beyond what is safe to them or to patients, as NHS staff survey data shows. **Sustainable productivity** requires:

- clarity that the NHS seeks improved effectiveness, not just more efficiency, because increasing "output" is only worthwhile if achieved in a safe manner that doesn't compromise care quality and staff health;
- recognising that working more effectively requires complex inter-professional interventions and teams (e.g. service redesign, new pathways, community engagement etc) dealing with ambiguity and uncertainty;
- understanding that if patients can be supported to contribute to their health care, they may make a significant improvement to NHS productivity as well as their own health; https://www.annfammed.org/content/8/5/410.short ;
- clarity that treating staff fairly, inclusively, respectfully and compassionately, challenging bullying and discrimination, and ensuring concerns can be raised safely and effectively, is a prerequisite of sustainable improvement.

Dixon-Woods et al (2013) found six key elements were necessary for sustaining cultures of high-quality compassionate care for patients:

- inspiring visions operationalised at every level by leaders;
- leaders ensuring clear aligned objectives for all teams, departments and individual staff; supportive and enabling people management;
- high levels of staff engagement;
- leaders focused on ensuring learning, innovation and quality improvement in the practice of all staff and effective team working;
- inclusive leaders who help achieve such cultures by providing a limited number of challenging but manageable priorities. https://tinyurl.com/mtjsjnap f

Despite the immense pressures on resources – staffing, equipment, buildings and maintenance - which have been (and still are) a serious challenge to those essential elements, the NHS is increasingly aware of the crucial importance of such leadership and team behaviours and the multiple ways in which tackling discrimination and promoting equity can assist the NHS in sustainable improvement. Ministers and NHS Boards have always had to balance what is needed against what is possible. Central to this report is that Boards must not abandon the raft of research evidence that culture is crucial to effective healthcare and service improvement. As the Messenger Report put it:

> "spending time and resource on looking after the workforce will quickly repay the investment through improved support to patient and service users."

A very helpful resource on racism and health inequalities

This report might be usefully read alongside the excellent research published by the NHS Race and Health Observatory https://www.nhsrho.org/our-research/ which has commissioned a range of work across numerous aspects of healthcare provision which demonstrates how race discrimination undermines effective, safe healthcare. They have also explored the cost of racism in healthcare provision.

Note 1. This report uses the term "equity" throughout rather than "equality. " Equality means each individual or group is given the same resources or opportunities whereas equity recognizes that each person or group has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.

Note 2. The category "Black and Minority Ethnic" staff is used throughout, abbreviated to BME. It fails to capture the complexity of ethnicity but it is widely used (including within Workforce Race Equality data) to capture data. It does not mean the term is regarded as superior to other categorisations

Part 1. The opportunities arising from tackling race discrimination: some examples.

Promoting equity, diversity and inclusion in healthcare should be seen as a key element of improvement, not just a matter of statutory compliance. In an NHS where 27% of staff are of BME heritage and one in five of the population we serve are too, racism is a serious impediment to the respect, compassion, psychological safety, inclusion, speaking up, and effective teams that are essential to a culture capable of driving innovation, collaboration and productivity. Racism is also a serious obstacle to co-production with communities in tackling health inequalities.

The extensive evidence of the toxic impact of racism in healthcare (summarised in Part 2 of this report) exists alongside the opportunities arising from tackling it in a relentless and courageous manner. Doing so will also benefit the shift to prevention and tackling health inequalities that is needed. It will benefit staff health and wellbeing and it will very significantly contribute to organisational effectiveness and productivity.

1.1. Drawing on a greater pool of talent and potential

Discrimination, including race discrimination, undermines the benefits that can accrue from equity in recruitment and career progression. Embedding equity into recruitment and career progression, and then ensuring the teams that staff join are inclusive, can:

- Ensure there will be a greater pool of talent to draw on (and retain) – and this will help ensure all staff can reach their potential;
- Improve the effectiveness of teams since diversity in teams where cognitive diversity is strengthened by identity diversity are (as Page (2017)) and others have shown, especially effective for the non-routine cognitive activities huge numbers of NHS staff are required to engage in;
- Help create a diverse workforce that is representative of the communities it serves, since that is critical to addressing the population health inequalities in those communities.

1.2. Building effective teams

Effective teams are the backbone of safe, high-quality care. Page (2017) demonstrates that people from different identity groups bring different knowledge, experiences and mental models to teams and therefore, he shows, better outcomes (predictions, creativity, decision making, problem solving and so on). https://tinyurl.com/28k63cjt

He showed that the various types of cognitive diversity—differences in how people perceive, encode, analyse, and organize the same information and experiences—are linked to better outcomes and that these cognitive differences are influenced by other kinds of diversity, including racial and gender differences- in other words, identity diversity. He showed that such teams (if inclusive) engaged in non-routine cognitive work (as many NHS teams are) are more effective, innovative, creative, are better problem solvers and decision makes o long as they are inclusive.

Tackling racism is a pre-requisite of such teams. Page's findings complement those of Turner and Pratkanis (1998) https://tinyurl.com/32jmhkn5 , Bersin and Bourke (2018) https://tinyurl.com/mr4as5yd and Phillips et al (2019) https://tinyurl.com/k3w5hees

1.3. Innovation and teams

Innovation is not just the eureka moments that happen in the lab but the continuous drive to problem-solve in different ways and for greater impact. Organisations thrive and are more resilient where innovation and problem solving is embedded in their leadership and organisation culture. Cognitively diverse teams bring a multi-lens approach to problem solving and creating different and more innovative solutions since they see the answer to the problem presented from completely different perspectives.

Innovation is best developed in teams where staff feel it is safe to raise concerns, admit mistakes, and promote new insights and research is now clear that this is best done by cognitively-diverse and identity-diverse teams because the latter improves the former.

Neurological research shows that our most productive, innovative, and collaborative times at work happen when we feel like we are a part of the team. When we feel included and respected, our bodies create hormones and healthy energy that raises our performance at work. https://tinyurl.com/msk7r9wp

Google (2016) researched why some of their teams were much more productive, innovative, and with better retention than others. They found:

- capabilities of the individual team members mattered less for team performance than group processes (how team members shared information and collaborated);
- when individual members attached low interpersonal risk to voicing their ideas or making mistakes, they were more likely to share novel information or challenge the status quo. The group was then able to access and integrate a greater; diversity of thought to drive innovation, improve judgment and decision-making;

- employees in psychologically safe teams were also less likely to want to leave, brought in more revenue and were rated as effective twice as often by executives. https://tinyurl.com/pak8nsyz

Edmondson (2018) shows how closely psychological safety and inclusion overlap https://tinyurl.com/ybdka57s and as Guillaume et al. (2017) and others have found, diversity without inclusion in workforces is unlikely to leverage its potential advantages but may compromise organizational outcomes. https://tinyurl.com/29zhdcdr Racism, for example, will disrupt diverse teams.

Much of the innovative capacity of an organization is realized at the unit level in working teams. Jones (2020) found cultural diversity had an especially significant impact on innovation and team performance and highlights the need for the optimal team operating principles to derive maximum benefit. https://tinyurl.com/2pjnecx9

Brimhall and E. Mor Barak (2018) found significant relationships between inclusion and quality of care through increased innovation and job satisfaction - and that to improve quality of care, leaders must strive to promote a climate of inclusion in human service organizations. https://www.tandfonline.com/doi/abs/10.1080/23303131.2018.1526151

1.4. Speaking Up

Teams and organisations in which concerns can be raised and mistakes admitted are a prerequisite of patient safety, good care and innovation. Raising concerns should be seen as an integral part of service improvement to be addressed in a timely and effective manner with the assurance that leaders will make doing so safe. Problem sensing, not comfort seeking, must become the norm of staff at every level.
https://tinyurl.com/3rn3y7jc

These benefits arise crucially where leaders model such behaviours, are curious and problem sensing, then listen and act in a timely and effective manner when concerns are raised. Where that does not happen, the costs are considerable both to patient care and staff wellbeing – not to mention the costs of inquiries. The Thirlwell inquiry, for example, is estimated to cost £39m. https://tinyurl.com/mr33hd7z

Research (see section 2.5) consistently shows substantial differences in whether White and BME staff are listened to (and their concerns acted upon) when raising concerns and whether they risk detriment when they do so. Just eliminating that gap would be immensely beneficial to the NHS. The Ministerial intention to act decisively against those who prevent staff raising concerns is therefore very helpful.

1.5. Promoting heath equality and prevention

In his opening letter to NHS leaders, Jim Mackey, Interim NHS CEO said the intention was, as soon as possible, to:

> "shift away from focusing so much of our leadership energy on deficit reduction and create the bandwidth to do much more on quality (including wider population health), access and leading our organisations and local systems. https://tinyurl.com/3kphjfuy

Doing so can build on existing examples of leadership by individuals and partnership working – for example see Sansum and Tucker (2025). https://tinyurl.com/33het5up To do so requires teams and leaders:

- who are representative of the communities they work with, and value both difference and collaboration;
- working in teams that are comfortable engaging with communities where they can engender trust and engagement with those communities, listening with attention and welcoming challenge;
- where staff are trusted, respected and culturally competent - better enabling the co-production of care with service users and communities.

The ability to prompt such improvement will depend on whether health teams are sensitive to a range of communities and patients and are able to diagnose problems and design solutions sensitive to difference community needs. Values-based leadership practices, led by patients, carers, staff and communities, are indispensable in such work.

As working with communities to challenge inequality and encourage prevention during Covid showed, such work depends on staff and managers who themselves are respected and motivated to undertake work whose progress may be slow, and uneven, though ultimately rewarding.

That work must have cultural competence embedded - the ability to participate ethically and effectively in personal and professional intercultural settings. This requires staff whose behaviours and knowledge, and ability to reflect on their own cultural values and world view, can empower patients and carers to co-develop individual and community health plans. https://www.annfammed.org/content/8/5/410.short

A financial balance sheet on tackling racism

Many consequences of race discrimination in healthcare have substantial financial costs, over and above the immense waste and harm caused. It is not currently possible to estimate many of these costs as key data is not available. We can, however, signpost a small proportion of the financial benefits if racism were tackled more effectively that it is at present.

If the level of **bullying harassment and abuse by staff and colleagues** of NHS BME staff was reduced to the same level as that reported by White NHS staff, the estimated saving for the NHS would be **£46.7 million annually**.

If the level of **bullying, harassment, abuse by patients, relatives and the public of BME staff** was reduced to the same level as reported by White NHS staff, the estimated NHS saving would **be a similar figure.**

The costs to the NHS of violence towards staff in England in 2021/ was estimated at £**1.368 million.** If levels of violence towards BME staff were reduced even to the shocking levels towards White staff, the financial savings would be **very** substantial.

The estimated saving in 2023-24, primarily arising from efforts to reduce disproportionate numbers of BME NHS staff entering the **disciplinary** process compared to 2O17, is conservatively estimated at between **£99,05m per annum and £208.01m per annum overall – and £23.7m and £49.8m for BME staff alone**

If the **sickness absenteeism of BME staff** due to racism at work could be reliably estimated and reduced there are likely to significant financial savings to the NHS.

If staff **speaking up** to raise concerns were listened to (about patient care or staff behaviours) and acted on, there are likely to be **significant financial savings** to the NHS, even before counting the **cost to patient care**. **BME staff** are listened to less and victimised more when speaking up, so even if BME staff were simply treated the same as White staff raising concerns there are likely be significant savings.

Research suggests other direct financial benefits from tackling racism including:

- It is likely to reduce **turnover;**
- It is likely to improve NHS **recruitment,**

NOTE. The calculations on which these estimates are based can be found

Part 2. The risks and damage caused by race discrimination.

2.1. Overall.

We know that in hospital settings, managing staff with respect and compassion correlates with improved patient satisfaction, infection and mortality rates, Care Quality Commission (CQC) ratings and financial performance4 as well as lower turnover and absenteeism. https://tinyurl.com/mtjsjnap

Edmondson (1999) defined psychological safety as a shared belief that the team is safe for interpersonal risk taking and she demonstrates that psychological safety allows employees "to feel safe at work in order to grow, learn, contribute, and perform effectively in a rapidly changing world" https://psycnet.apa.org/record/1999-03028-001 Edmondson (2018) also explains why psychologically safe work environments, where people feel they are treated with dignity and respect, achieve more effective, safer patient care. https://tinyurl.com/ybdka57s

Psychological safety and inclusion overlap and complement each other. Leaders who care about diversity must care about psychological safety, just as those who care about psychological safety must also care about diversity, inclusion, and belonging. https://www.hbs.edu/faculty/Pages/item.aspx?num=54851

Compassion means paying attention, understanding, responding empathetically to others' feelings, and acting upon what you have heard and learnt. West (2021) showed how inclusive and compassionate leadership helps create a psychologically safe workplace where staff are more likely to listen and support each other resulting in fewer errors, fewer staff injuries, less bullying of staff, reduced absenteeism and (in hospitals) reduced patient mortality. https://tinyurl.com/536j4h3w

West and Dawson (2012) found NHS providers with high levels of staff engagement (as measured in the annual NHS Staff Survey) tend to have lower levels of patient mortality, make better use of resources and deliver stronger financial performance, https://tinyurl.com/3usz3y7w whilst Tambunan et al (2024) noted that a decline in employee engagement in an organization often originates with toxic work environments affecting overall performance and productivity. https://tinyurl.com/h7wvh3yt

A meta-analysis of Employee Wellbeing, Productivity, and Firm Performance, by Krakel et al (2019) estimated a positive correlation between employee well-being and productivity, and noted an evidence base documenting this being a causal effect. They referenced

experimental evidence suggesting that a meaningful increase in well-being yields, on average, a productivity increase of about 10%. https://tinyurl.com/4z4tfat3

Dawson (2018) found the extent to which an organisation values its minority staff is a good barometer of how well patients are likely to feel cared for. https://tinyurl.com/pzkhv3c8 West et al (2018) found that the percentage of staff believing trusts provides equal opportunities for career progression or promotion was an important predictor of patient satisfaction in all three analyses (2014, 2015 and across the years). The more staff believe this to be the case, the more satisfied patients will be on average. https://tinyurl.com/pzkhv3c8

2.2. Racism makes you ill: staff health and well-being

Two landmark studies explored the extent and nature of race discrimination in the UK. Karlsson and Nazroo (2002) https://doi.org/10.1111/1467-9566.00001 and Becares et all (2024) https://tinyurl.com/mww46uz2 reported between them that:

- both the experience of racial harassment and perceptions of racial discrimination make an independent contribution to health. For example, those who had been verbally harassed had a 50% greater odds of reporting fair or poor health compared with those who reported no harassment, Moreover, discrimination, like other stressors, can affect health through both actual exposure and the threat of exposure;
- those reporting any experience of racial harassment had between 55% and 125% greater risk of reporting fair or poor health compared with those who had not. Those who perceived the persistence of racist attitudes in over half of British employers had almost a 70% increased risk of fair or poor health. Racism impacts BME staff not only through the experience of racism but through the impact of the awareness of the constant risk of race discrimination;
- Race discrimination is positively associated with an extensive range of adverse conditions including coronary artery calcification, high blood pressure, lower birth weight, cognitive impairment, and mortality.

Those findings overlap with Triana et al (1988) whose meta-analysis on found that perceived racial discrimination at work is negatively related to job attitudes, physical and psychological health. file:///C:/Users/roger/Downloads/ssrn-2627785.pdf Other research found that perceived racial discrimination increases turnover intent https://psycnet.apa.org/record/2010-04488-002 . Another meta-analysis (Dhanani

2018) showed the negative effects of subtle forms of discrimination on a range of work-related outcomes can be worse than overt discrimination. https://tinyurl.com/23ns5maz

2.3. Bullying, harassment, abuse, incivility and violence

Bullying and harassment

Bullying, harassment, abuse and incivility are a common feature in almost every single independent review of systemic patient harm from Bristol (2001) to Francis (2013) to Ockenden (2022). Evidence commissioned by Lord Darzi (2008) for the Francis (2013) report concluded "the NHS has developed a widespread culture more of fear and compliance, than of learning, innovation and enthusiastic participation in improvement." https://www.ajustnhs.com/wp-content/uploads/2012/09/JCI-Report.pdf

Reported rates (NHS staff survey 2024) of bullying and harassment from both NHS staff and managers, and from patients, relatives and the public, are astonishingly high for all staff and are significantly worse for BME staff. 23.8% of BME staff (20.2% White) report such treatment from patients, relatives and the public and 28.6% report (24.3%) such behaviours from managers and colleagues.

The adverse impact of bullying and harassment on staff health is well evidenced. It impacts on performance, career progression, engagement, retention and team effectiveness, as well as harming the safety and physical and mental well-being of staff. Lever et al (2020) found that perceived bullying was associated with mental health problems including psychological distress, depression and burnout, as well as physical health problems including insomnia and headaches. Bullied staff took more sick leave. https://tinyurl.com/mn4r3bv9

Lucien Leape (2012) found that a culture of disrespect in medicine is a threat to patient safety because 'it inhibits collegiality and cooperation essential to teamwork, cuts off communication, undermines morale and inhibits compliance with and implementation of new practices'. https://tinyurl.com/muvp3tst

Maben et al (2025) found that unprofessional behaviours, including bullying, incivility, and harassment, are linked to significant negative impacts on staff well-being, team dynamics, and patient safety – and discrimination:

- Unprofessional behaviours disproportionately affect minoritized staff, exacerbating workforce inequities and potentially contributing to health disparities, as seen in worse outcomes for patients from minoritised backgrounds in diverse healthcare settings;

- Ethnically minoritised healthcare professionals, as well as staff of diverse gender, or who have disabilities, more frequently encounter higher levels of unprofessional behaviour, including microaggressions, racism, discrimination, and exclusion from critical communications and decision-making processes. https://tinyurl.com/35jr7bk8

Incivility

Incivility manifests itself as subtle, disrespectful, behaviour. Research finds incivility can adversely impact targets and witnesses, resulting in poorer mental health, reduced job satisfaction, diminished performance and compromised patient care and repeatedly found that incivility erodes self-esteem, damages relationships, increases stress, contaminates the work environment, and may escalate into violence. https://www.medscape.com/viewarticle/739328_2?form=fpf

A recent global scoping review systematically analysed existing research exploring the ways incivility manifests and impacts racially minoritised hospital workers. It highlighted detrimental consequences such as withdrawal and reduced support-seeking behaviours. Racialisation and racial dynamics are a significant factor for hospital-based incivility. https://pubmed.ncbi.nlm.nih.gov/38509641/

Violence towards staff

A recent survey found around one in six (17%) nurses and midwives said they had experienced violence in the previous week. More than six in ten (63%) had been attacked within the preceding 12 months. https://tinyurl.com/52zdpbsa

One quarter of Bank-only NHS staff experienced at least one incidence of physical violence in the last 12 months from patients/service users, their relatives or other members of the public. For BME women the incidence was 2.2% higher and for BME men it was 6.9% higher than for their White counterparts. It is reasonable to assume that the incidence of violence against BME staff was higher for substantive employees too given the data on bullying, harassment and abuse is higher. https://tinyurl.com/mu4r9ern

The Secretary of State's decision to reverse the 2016 decision to stop collecting data on violence against staff should enable a more targeted approach to this problem https://tinyurl.com/3y4yfu2h and is reflected in welcome new NHS England resources. https://tinyurl.com/4prxtd62

The cost of violence against staff

Jones, L., Quigg, Z. (2024) estimated the costs of violence to the NHS in England in 2021/22 (excluding primary care) at £**1.368 billion.** https://tinyurl.com/24kd2zc9 They note that in additional to physical impact, staff may experience stress, anxiety, and depression as a result. A range of data strongly suggests violence towards BME staff is even greater than towards White staff so even reducing the level of violence experienced by BME staff to the level of violence experienced by white staff would make a **very** substantial financial saving to the NHS. Now monitoring requirements will make the impact on BME staff very clear. https://tinyurl.com/2u2dr9ja

2.4. Disciplinary action

Whilst disciplinary action will sometimes be appropriate, too often the response to "incidents" and "behaviours" is a focus on blame not learning.

When NHS disciplinary data was first collated nationally it showed (2016) BME staff were 1.54 times more likely to enter the disciplinary process than White staff were. The introduction of a "bias interrupter" at the point of incident has inserted accountability into decision making to address disproportionately against BME staff. It reduced the relative likelihood of BME staff and White staff entering the disciplinary process to 1.03 (2023) but it **also**, by inserting accountability into decision making, helped to more than halve the **overall** numbers of staff (both BME and White) entering the disciplinary process from 17,702 to 7,797. That reduction is estimated to have saved the NHS between £99,05m per annum and £208.01m per annum.

That improvement was aided by the Just and Learning culture pioneered in Mersey Care NHS Trust from 2016. The total economic benefit of the culture change was £2.5m per annum or 1% of total costs and 2% of labour costs. Though no data was published on any differential impact on White and BME staff, this strategy is a good example of applying research on culture to employment relations. https://tinyurl.com/3s8xus3y When behaviours cross expected standards, a focus on learning not blame is (wherever possible) beneficial not only to staff (especially BME staff) but to patient care and safety.

2.5. Racism damages staff health and well-being

Dame Carol Black (2008) https://tinyurl.com/5exnzcev estimated the annual economic costs of UK sickness absence and worklessness to be over £100 billion. The Health and Safety Executive estimate that the health and social work sector had the highest proportion of

sickness absence for stress. NHS England based their 2015 workforce health strategy on an estimate by Public Health England that the cost of absenteeism to the NHS because of poor health was estimated at £2.4 billion per. The cost is likely to have increased very significantly since.

Anxiety/stress/depression/other psychiatric illness was the most reported reason for NHS sickness absence, accounting for 25.7% of all NHS sickness absence in October 2024. https://tinyurl.com/4ns388tb The latest (2024) National NHS staff survey data suggests that of the 1.5 million people who work in the NHS in England, almost 55% have gone into work in the last three months despite not feeling well enough to perform their duties. https://tinyurl.com/4cf38pyf Boorman (2009) found that staff ill-health and related absence is linked to an increased risk of unsafe care, worse experiences of care for patients and poorer outcomes. https://tinyurl.com/3568prb2

Rhead et al (202) reported that NHS staff, particularly those working in London trusts, are exposed to unprecedented levels of discrimination and harassment from their colleagues (and) both witnessing and experiencing these factors were associated with low job satisfaction and long periods of sickness absence. https://tinyurl.com/ytnek63f

It is not possible to calculate from published NHS Digital data whether there is any overall difference in sickness absence rates (or length of sickness absence) by ethnicity but given that research shows race discrimination on health contributes to ill health amongst BME staff, it is likely that tackling racism would reduce sickness absence and presenteeism amongst BME staff.

Covid: the cumulative impact of racism at work

The cumulative impact of race discrimination on staff welfare was highlighted during the COVID-19 pandemic when BME staff, who worked disproportionately in lower-graded patient facing roles, had poorer access to appropriate PPE with the correct fit, were more reluctant to raise concerns and were disproportionately redeployed to riskier areas. The resultant impact on staff health and safety in turn impacted staff sickness, staff long-Covid levels, staff morale and probably turnover, risking patient safety and the quality of care, not just staff welfare. https://tinyurl.com/y29995nm

Presenteeism

Presenteeism is the lost productivity when staff come to work while unwell (such as because of stress) and are not fully functioning. It impacts upon productivity by impairing performance, and prompting errors and mistakes . https://tinyurl.com/yzyjm9md Cooper

and Dewe (2008) estimated that the impact of presenteeism is double that of absenteeism. https://tinyurl.com/mp63pnfx

White-Means et al (2022) observed statistically significant racial differences in presenteeism amongst nurses and respiratory therapists AHPs, and in the ways presenteeism impacted health. While presenteeism among White workers occurred primarily with impacts on emotional health, for Black workers it impacted both their physical and emotional health conditions. Additionally, Black participants exhibited significantly greater reductions in productivity. https://tinyurl.com/3e4m9z4x

2.6. Speaking up about patient safety and staff well being

Despite repeated exhortations, policies and procedures over two decades, the 2023 National Guardian's Office Annual Report was entitled Fear and Futility and concluded:

> "there is a growing feeling that speaking up in the NHS is futile – that nothing changes as a result… They fear experiencing negative consequences if they do… ……There is a disconnect between the encouragement which workers feel in reporting (very high) and the perception of how fairly those involved are treated.". file:///C:/Users/roger/Downloads/National-Results-Briefing-2023.pdf

All research on raising NHS concerns suggests detrimental impact when speaking up about both staff behaviours and about patient care and safety. In virtually every NHS scandal of recent years, the failure of staff to raise concerns or of leaders to be problem sensing and curious, listening to, and acting upon, such concerns, has been a factor. There is a substantial cost in staff health and well-being when concerns are ignored and a huge cost in patient care.

For BME staff, raising concerns and admitting mistakes is doubly problematic. Like other staff these staff hesitate to raise concerns because they lack confidence it will be effective and worry it will make things worse for them. In his 2015 Speaking Up Report Robert Francis found that, when surveyed, that:

- BME staff compared to White respondents (n=19,764) were significantly less likely to be listened to; and
- more likely to be victimised than White staff were. https://tinyurl.com/5n6p8tc5

In Too Hot to Handle Kline and Warmington (2024) similarly reported that of those BME staff who raised concerns (n=1300), only 5.4% said they were taken seriously and that their problem was dealt with satisfactorily. BME staff largely said they believed raising

concerns was unlikely to be effective, would take a long time to be investigated, and that they ran a risk of retaliation of they did raise concerns. https://tinyurl.com/34rdzxzz

They noted particular challenges for internationally recruited staff, evidence confirmed by the National Guardian's Office (2025) who found "Speaking up was hindered by fears of retaliation, including potential dismissal and jeopardising career progression, exacerbated by the link between visas and employment." https://tinyurl.com/2bx2hvvv

There are parallels between the findings of research on whether those subjected to sexual harassment feel safe speaking up and whether BME staff subjected to bullying and harassment are (there of course will be some overlap between those subjected to both detriments). Similar impacts were reported by both Surviving in Scrubs (2023) https://tinyurl.com/3vsy3xtz and Begeny et al (2023).

https://tinyurl.com/ha2j375t

2.7. Race discrimination, patient access and treatment

Discrimination in healthcare provision is not new as the recent UK evidence that mortality rates remain exceptionally high for babies of Black and Black British ethnicity showed, with stillbirth rates over twice those for white babies and neonatal mortality rates 43% higher. For babies of Asian and Asian British ethnicity, stillbirth and neonatal mortality rates are both around 60% higher than for white babies. https://tinyurl.com/f5zn9em5

A recent Rapid Evidence Review of ethnic inequalities in healthcare (Kapadia et al (2022)) https://tinyurl.com/muba8zfn concluded that:

> "Ethnic inequalities in access to, experiences of, and outcomes of healthcare are longstanding problem s in the NHS, and are rooted in experiences of structural, institutional and interpersonal racism. For too many years, the health of ethnic minority people has been negatively impacted by: lack of appropriate treatment for health problems by the NHS; poor quality or discriminatory treatment from healthcare staff; a lack of high quality ethnic monitoring data recorded in NHS systems; lack of appropriate interpreting services for people who do not speak English confidently and delays in, or avoidance of, seeking help for health problems due to fear of racist treatment from NHS healthcare professionals.

Mental health and racism

The mental health Bill highlights the need for patient voice and greater accountability for clinicians. It needs to address access and support for BME patients ensuring the risk of race discrimination is explicitly addressed. Kapadia (2022) noted a number of reports highlighting the likely financial cost of health inequalities such as 2006 study by the Salisbury Centre for Mental Health comparing the costs of mental health care pathways for Black and White service users in London which found that the average annual cost per Black service user was £6,539, compared to £4,132 for White service users. This disparity was primarily due to Black individuals accessing services later and in more acute states, resulting in higher-intensity and costlier interventions. The study estimated that more equitable care could save approximately £100 million.

Hoffman (2016) detailed how racism directly impacts on healthcare. Stereotyping negatively influences diagnosis and treatment options made by clinicians, including pain management reduces the level of healthcare people receive, either through direct care or from communication gaps in which crucial medical history details are missed or not shared https://tinyurl.com/24v7hwyt . This in turn creates a cycle where "Black and Brown people avoid interactions with healthcare professionals through fear of potential prejudice and discrimination." https://tinyurl.com/yx67zfxw This can then contribute to widening health disparities, as having diverse staff available to care for patients improves communication, increases patient-to-staff trust, and improves adherence to medical advice, all of which are essential for safer care and better health outcomes. https://pubmed.ncbi.nlm.nih.gov/11802641/

Maternity care: a case study in avoidance and denial

Despite the wealth of evidence, national NHS programmes have failed to adequately address the issue of racism in health provision. When Martin G et al (2024) reviewed *large-scale improvement programmes in maternity 2010–2023* they found:

"Despite repeated policy commitments to improve equity, we found no examples of improvement programmes included in our quality assessment that identified the reduction of health and care inequalities as an explicit goal. Indeed, there was some evidence of programme design having potential to contribute to widening inequalities between high-performing and low-performing services, which is likely to impede efforts aimed at improving equity" *https://qualitysafety.bmj.com/content/33/11/704*

2.8. Recruitment, career progression and effective teams.

27% of NHS staff are of BME heritage. The NHS Workforce Race Equality Standard has highlighted systemic patterns of disadvantage at every stage of recruitment and career progression for staff of BME heritage. https://tinyurl.com/29f5j9nz

There has been some increase in ethnic diversity at more senior levels, but despite the large-scale recruitment of overseas-trained staff, the WRES Metric 2 (the relative likelihood of BME staff compared to White staff being appointed from shortlisting) is unchanged over the last 8 years at 1.59 worse. The cumulative effect of that disparity in outcome applied to each step in the promotion ladder from Band 5 to Band 9 is that it is currently 25 times more likely on average that a white band 5 recruit will reach Band 9 compared to a BME Band 5 recruit.

Table 1. The cumulative impact of appointment decisions

Current pay band	Pay band promotion sought		Cumulative effect
Band 5	Band 6		1.59
Band 6	Band 7		2.53
Band 7	Band 8a		4.02
Band 8a	Band 8b		6.39
Band 8b	Band 8c		10.16
Band 8c	Band 8d		16.16
Band 8d	Band 9		**25.69**

Developed from Kline (2022) https://tinyurl.com/3268dufd

Case study. The experience of senior NHS BME leaders

Even when BME staff do reach more senior positions, the NHS Confederation's Shattered Hopes report (2022) found that more than half of the black, Asian and minority ethnic NHS leaders who were surveyed for the report considered leaving the NHS in the last three years because of their experience of racist treatment while performing their role as an NHS leader. https://tinyurl.com/ykzh548s

Effective teams are the backbone of the NHS. As summarised in section 1.2. above. Page (2017) showed that various types of cognitive diversity differences in how people perceive,

encode, analyse, and organize the same information and experiences are linked to better outcomes. He shows how these cognitive differences are influenced by other kinds of diversity, including racial and gender differences- identity diversity. He showed that such teams, when engaged in non-routine cognitive work (as huge numbers of NHS teams are). are more effective, innovative, creative, good at decision making and at problem solving so long as they are inclusive. https://tinyurl.com/28k63cjt

Moreover, at a time when Government strategy is to shift resources into prevention, and community services, a diverse workforce that is representative of the communities it serves is critical to addressing the population health inequalities in those communities. https://tinyurl.com/536j4h3w

Managers

Managers play a key role in creating workforce culture. It is line managers who have the strongest influence on workers' psychological and physical environment. https://tinyurl.com/4t36rfvn They do most recruitment, make most disciplinary decisions, conduct appraisals, are key to stretch opportunities, and set the tone within their teams. Messenger (2022) reported however an "opportunistic approach to succession planning" (which) lacks equity and does not guarantee that the most deserving leaders reach the top." https://tinyurl.com/3h45hc9k

The NHS has too few managers, who often face, as Messenger noted, inequitable career progression. Restructures and redundancies, as the NHS is now experiencing, risk exacerbating such inequity (as happened with the abolition of Primary Care Trusts) unless close attention is paid to this risk. https://tinyurl.com/2k752vnv

2.9. NHS Leadership and racism

In Too Hot to Handle, Warmington and Kline (2024) noted that:

> Time and time again people have said that they fear discussing race. They fear offending someone and saying the wrong thing. There is a lack of competence (in understanding racism, how it plays out, and how it is maintained) which means we don't believe we can confront it unless it is staring us in the face – until we are 'forced' to confront it.
>
> Being able to talk about 'race' and in particular covert racism ('everyday racism') helps people get past the belief that racism is an unusual occurrence. It works the

muscle of understanding, lessens the fear of discussing it, and helps create conditions where racism is spotted, believed, and referred to more routinely.

Once organisations adopt a culture where racism is spoken about routinely and understood as being maintained by organisational culture, they can create an early reporting system that can flag up opportunities for intervention. We already know that data on attrition, complaints, disciplinary, and absenteeism and presentism rates are indicators that there is something that is amiss with culture: the crucial step is acting on what this data is saying.

Research is clear that what leaders do (and do not do) in respect of equity, diversity and inclusion is decisive:

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- Leaders tasked with accomplishing diversity goals are more likely to be effective when clear accountability existed; https://tinyurl.com/2vezxyre
- Support from top management is a key factor in determining the success of diversity programmes; https://tinyurl.com/4w9a4pfp
- Where diversity interventions lack the involvement of top managers and fail to address overall work processes, their long-term effectiveness in transforming organizational culture is likely to be limited. https://tinyurl.com/4yd6ctpd

Leaders who wish to lead effectively will want to understand and act on this evidence, modelling the behaviours they expect of others and acting proactively and preventatively to tackle the damage that race discrimination causes to staff and services.

They will be aware that too many NHS strategies on tackling race discrimination are driven by good intentions, but not guided by research – one reason why progress has been so painfully slow in tackling NHS race discrimination. https://tinyurl.com/2hev7tf6
There is no shortage of good intentions and detailed plans to address these issues in many parts of the NHS but much more attention is needed to what research evidence signposts to interventions that have a reasonable likelihood of working. Clinical leaders are expected to pay careful attention to research and evidence when tackling concerns. Those leading on equity, diversity and inclusion must do the same.

For Boards (both Executives and Non-Executives) good governance requires constant scrutiny, challenge and support of those charged with tacking race discrimination. Tackling race discrimination will never be an easy fix but leadership means adopting and sharing evidenced approaches to tackling racism

always asking this question: "what confidence do we have that what we propose to do has a reasonable likelihood of achieving its goal – and why?"

Challenging overt racism

Sustained attention to race discrimination will also face difficult challenges. Covid was one example. The August 2024 race riots were another. Another challenge is explicit racism from patients, relatives or the public. Boards will be judged by how they respond. The late Andrew Foster CEO gave an example. https://tinyurl.com/4yrbcyhk

Wes Streeting, Secretary of State stated "People who are abusing NHS staff can be turned away, and should be turned away, if that is the way that they are treating our staff" https://tinyurl.com/3m2s2exy NHS guidance similarly reminded employers that "In general terms, it is lawful for providers of NHS services to refuse to provide treatment where a patient's behaviour constitutes discrimination or harassment towards staff; but this must be reasonable, and the approach tailored to specific cases." https://www.england.nhs.uk/long-read/nhs-response-to-2024-riots/

Such overt acts of racism impact staff health and well-being. Challenging then, of course, must be done alongside the ongoing work to challenge the multiple subtle ways in which racism undermines BME staff and patient care. https://tinyurl.com/ywa2cus8

A footnote on methodology

This report is a summary of a much longer rapid review of relevant literature. Identifying who is impacted and how when race discrimination occurs is not straightforward. Much race discrimination is subtle or covert. It may not be intended and allegations of race discrimination often meet a very defensive response. Multiple factors may be at play.

When considering the impact of race discrimination, it is difficult to prove causality rather than correlation, other than through experiments. https://tinyurl.com/2h3959nd This report draws on a range of evidence. Whilst randomised controlled studies and controlled longitudinal studies would be the most reliable evidence, in this field we have to rely on meta-analyses, systematic reviews, cross sectional studies, case studies – and "grey" literature. Some of the published research is problematic, so we have not, for example, relied on the widely quoted high profile research on causality between company profits and board diversity.

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