Minority ethnic NHS staff more likely to face workplace discrimination during pandemic than White colleagues

Urgent action needed to redress ongoing health service race inequalities, insist researchers

Minority ethnic NHS staff were more likely to face workplace harassment, discrimination, and unavailability of personal protective equipment (PPE) than their White British colleagues during the pandemic, reveals research published online in the journal ***Occupational & Environmental Medicine.***

Urgent action is needed to redress ongoing race inequalities in the health service, insist the researchers, who call for the inclusion of diversity and inclusion training in professional development, and the expansion of the NHS Workforce Race Equality Standard.

Staff from minority ethnic groups make up nearly a quarter of the NHS workforce in England—half in London—but continue to be underrepresented in leadership roles and are more likely to face disciplinary action, note the researchers.

And evidence suggests that pressurised working environments with high workload and staff shortages can worsen bullying and discrimination. The pandemic created extreme and unprecedented pressures for all NHS staff, they point out.

To explore this further, the researchers drew on the responses of 4622 NHS staff from 18 trusts to the TIDES Inequalities Survey. This is a partnership between the Tackling Inequalities and Discrimination Experiences in Health Services (TIDES) and NHS CHECK, which sought to capture the psychosocial impact of the pandemic on NHS staff.

They analysed the survey responses to estimate the prevalence of negative workplace experiences during the pandemic among minority ethnic groups and to find out whether these experiences were associated with mental and physical health issues.

Of the total, 3741 staff identified as White British; 392 as White Other; 136 as Black; 220 as Asian; and 133 as Mixed Race. The over 50s made up the highest proportion of staff in all racial groups, bar Asian and Mixed.

Most of the sample were women (75%), born in the UK (84%), worked in clinical roles (68%) and had a permanent employment contract (90%). Almost half of the staff identifying as Black worked in non-clinical roles compared with a third of those identifying as White British.

On the other hand, staff identifying as Asian were predominantly employed in clinical roles and had the highest proportion of doctors (20%). Staff identifying as Mixed/Other had the highest proportion of nurses (33%).

Nearly 1 in 4 (23%) staff indicated probable depression; nearly 1 in 5 (18%) indicated probable anxiety; and nearly 1 in 4 (23%) reported medium/severe somatic symptoms.

The difference in the likelihood of experiencing probable depression among those who faced bullying, harassment and discrimination varied by ethnicity.

Staff who identified as Mixed/Other had a higher prevalence of probable depression (36%), anxiety (28%), and somatic symptoms (33%) than all the other ethnic groups.

A third of all the respondents reported experiences of workplace bullying, harassment, and abuse, and 1 in 5 reported facing discrimination from other members of staff.

Staff identifying as Black and Mixed/Other were more than twice as likely to experience bullying, harassment, and abuse as their White British colleagues, and they were around 4 times as likely to face discrimination from other staff.

While Black staff were 4 times as likely to be risk assessed during the pandemic as White British staff, they were also twice as likely to report a lack of available PPE. Asian staff, however, were 52% less likely to report PPE unavailability compared with White British Staff.

Lack of available PPE was associated with an approximate doubling in the reporting of probable depression, probable anxiety, and moderate/severe somatic symptoms. Bullying, harassment, and abuse were associated with a tripling in each of these health outcomes.

Just over a third of respondents (35%;1123) said they were redeployed during the pandemic. Of these, Black staff were less likely to feel able to challenge their redeployment, while staff identifying as Mixed/Other were less likely to be forewarned about the plans.

Staff identifying as Asian were 3 times as likely as White British staff to feel they could challenge their redeployment decision. And regardless of whether they were redeployed, Black staff were less likely to understand their redeployment rights than their White British colleagues.

But among those who were redeployed, involvement in redeployment decisions– including feeling able to challenge them—understanding their rights, and being given a heads up about the move were associated with lower odds of probable depression and moderate/severe somatic symptoms.

The researchers acknowledge the relatively low participation rate of staff from non-White ethnicities, but emphasise that their findings are in line with those of previous studies and staff surveys.

“Our study found alarmingly high exposure to negative workplace experiences related to harassment and discrimination among ethnically minoritised NHS staff during the pandemic.

“The short-term and long-term impacts of such experiences are likely to take a toll on the mental and physical health of employees, as well as their dependents and social networks, with implications for career progression, intention to remain at the NHS and salary,” they write.

“It is crucial to prioritise racial discrimination as a public health issue, not just an ethical imperative, and ensure that decision-makers from ethically minoritised groups are involved in processes that affect their health and wellbeing,” they insist.

“These approaches are urgently required to address racism and inequalities in the UK healthcare system, which have long been recognised as both ‘avoidable and unjust’,” they conclude.