BME Leadership Network
NHS Confederation

Shattered hopes

Black and minority ethnic leaders' experiences of breaking the glass ceiling in the NHS

June 2022

About the report and the NHS Confederation

This report spotlights the findings from a recent survey and engagement on the experience of senior black and minority ethnic leaders in the NHS.

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

The BME Leadership Network, which is part of the NHS Confederation, exists to strengthen the voice of NHS black and minority ethnic (BME) leaders and to support NHS organisations to meet the needs of all communities.

We meet quarterly and we aim to:

- improve understanding of equality, diversity and inclusion and publish the benefits to help deliver better care for all
- improve and sustain the number of BME leaders working in the NHS
- profile the diverse range of BME leaders delivering solutions across the health and care system.

The network is supported by the AHSN Network, NHS Leadership Academy and the Royal College of Nursing.

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Key points

- Racism and inclusion have become key areas of focus for the NHS in the wake of the Black Lives Matter movement and the disproportionate impact of COVID-19 on black and minority ethnic staff and patients. With diverse leadership a key plank of the NHS's strategy to achieve equality, improving the working life for senior black and minority ethnic staff should be a critical priority for the health service.

- We were encouraged that the Messenger Review into health and social care leadership advanced this cause, placing the need for more diverse senior leadership at the top of the NHS agenda. But we remain convinced that a greater commitment to act is needed. In spring 2022, the BME Leadership Network conducted an online survey and hosted a series of roundtables to understand the experiences of BME leaders, and to explore the challenges they faced in relation to racism and discrimination as they moved through their careers. This report captures what we found and puts forward recommendations to improve the working conditions of BME leaders.

- More than half of surveyed BME NHS leaders considered leaving the health service in the last three years because of their experience of racist treatment while performing their role as an NHS leader. A majority said they had experienced verbal abuse or abusive behaviour targeting racial, national or cultural heritage at least once in the past three years, with more than 20 per cent saying this had happened five times or more.

- Colleagues, leaders and managers seemed to be a particular source of racist treatment, more so than members of the public. This is concerning, given that the NHS has been prioritising equality, diversity and inclusion activities in recent

years. This suggests that more focused efforts are required at every level to reduce the incidence of racist behaviour and to improve awareness among all staff of the impact of this type of discrimination.

- Only 10 per cent were confident that the NHS is delivering its commitment to combat institutional racism and reduce health inequalities and fewer than 1 in 4 were confident that their organisation has a robust talent management process that is enabling the development of a pipeline of diverse talent.

- Senior BME staff reported low levels of confidence in their own organisations' abilities to manage and support a pipeline of diverse talent and in the ability of the system to achieve this at a national level. Moreover, only a minority were confident they could rely on the support of colleagues to challenge racial discrimination, and a smaller minority believed they would be supported by NHS England and NHS Improvement if challenging prejudice or discrimination locally.

- Leaders described how structural and cultural issues within the NHS led to a situation where BME leaders were not present in sufficient numbers to generate a climate of inclusivity and were sometimes siloed in particular types of role. This helped to create a situation where career progression was felt to be unduly challenging and where neither succession planning nor talent development were occurring at sufficient scale to support the next generation of diverse leaders.

- Being able to be authentic in the workplace was an issue that emerged powerfully. Some leaders reported policing their own behaviour in the workplace and compromising their values in order to fit in. Being able to represent their own cultures and be themselves at work was a critically important goal for many. For BME leaders, feeling secure that they will be treated equally, regardless of background, was seen to be the ultimate success measure of equality.

- It is essential that BME leaders are able to see effective development programmes to support diverse talent, and that they are provided with sufficient support, both locally and nationally, to feel secure in calling out unacceptable behaviour when this occurs.

- At such a critical juncture for the NHS, action must be taken to end cultures of discriminatory behaviour, to provide personal support to current and aspiring leaders, and to develop succession planning and talent development schemes.

Background

Racism and inclusion have become key areas of focus for the NHS in the wake of the Black Lives Matter movement and the disproportionate impact of COVID-19 on black and minority ethnic staff and patients. As the national network for BME leaders in the NHS, we have been supporting members through the difficulties of the pandemic and lobbying for change on their behalf.

In our engagement with members, we have heard that staff from minority ethnic backgrounds find conversations about racism in the NHS difficult. This is compounded by the lack of diversity in leadership, which leads to staff finding it difficult to feel safe when voicing concerns about racism.

Leaders have felt that the NHS needs to do more to translate words into action. This could be by doing more to recognise and celebrate the contribution of migrant workers to the NHS, for example, and by ensuring that the NHS's public-facing position on equality, diversity and inclusion is also deployed fully within the health service.

We were encouraged that the Messenger Review into health and social care leadership advanced this cause, placing the need for more diverse senior leadership at the top of the NHS agenda.[1] But we remain convinced that a greater commitment to act is needed. That is the task ahead and equality, diversity and inclusion leaders will be integral to achieving this mission. With diversifying leadership a core plank of the NHS's strategy to advance equality, improving working life for senior BME staff should be a critical priority for the health service.

That's why in spring 2022 we engaged our members to delve into the experiences of black and minority ethnic leaders, and

to explore the challenges they faced concerning racism and discrimination as they moved through their careers. This report captures what we found and puts forward a set of actions to develop an inclusive environment that improves working conditions for BME leaders.

What follows will make for sobering reading and should provide much food for thought for leaders at every level and of every ethnicity within the NHS, both locally and nationally. It is based on a survey of more than 120 senior BME leaders in the NHS, and a series of roundtable discussions.

In this report, we have used the following definitions:

- **Abuse**: threatening, abusive or insulting words or behaviours likely to cause fear, harassment, alarm or distress by targeting someone's racial, national or cultural heritage

- **Harassment**: an incident or a series of incidents intended or likely to intimidate, offend or harm an individual or group because of their ethnic origin, colour, race, religion or nationality

- **Bullying**: the experience of being unjustifiably targeted or picked on

- **Covert discrimination**: the experience of being subtly excluded or ridiculed, which you may have only realised with hindsight was due to racism

- **Overt discrimination**: the experience of being openly or obviously excluded or ridiculed

The BME Leadership Network, part of the NHS Confederation, exists to strengthen the voice of NHS black and minority ethnic leaders and to support NHS organisations to meet the needs of all communities.

Our members are drawn from all racialised communities living in England. They share common experiences of racialisation and support each other to develop collective solutions to address institutional racism in the NHS.

This report upholds the principle of the right and choice to self-identification by equalities groups, including people from black and minority ethnic communities.

Four main types of race discrimination

The Equality and Human Rights Commission describes four main types of race discrimination: direct discrimination, indirect discrimination, harassment and victimisation.[2]

Direct discrimination happens when someone is treated worse than another person in a similar situation because of their race.

Indirect discrimination happens when an organisation has a particular policy or way of working that puts people of a particular racial group at a disadvantage.

Harassment occurs when someone is made to feel humiliated, offended or degraded.

Victimisation is when a person is treated badly because they have made a complaint of race-related discrimination under the Equality Act. It can also occur if a person is supporting someone who has made a complaint of race-related discrimination.

Methodology

Between April and May 2022, we carried out an online survey of network members and held three roundtables with senior black and minority ethnic NHS leaders to understand their experiences and explore the challenges they faced in relation to racism and discrimination as they moved through their careers.

Survey responses were received from 123 members:

- 42 per cent of respondents were in Agenda for Change band 9 roles
- 46 per cent were very senior managers
- 12 per cent were in chair or non-executive director positions.

Twenty participants took part in our roundtable discussions. The discussions took place in three groups:

- executive directors (including chief executive and board-level director roles)
- clinical leaders (directors with a clinical background)
- primary care leaders (directors with a background in primary care).

Leaders were invited to participate to challenge the assumption that once a person has achieved a top-level role, they are no longer exposed to discrimination. Following each roundtable, a note of the main points of the discussion was produced. These set of notes were then reviewed to understand which themes arose from each of the discussions and where common themes emerged.

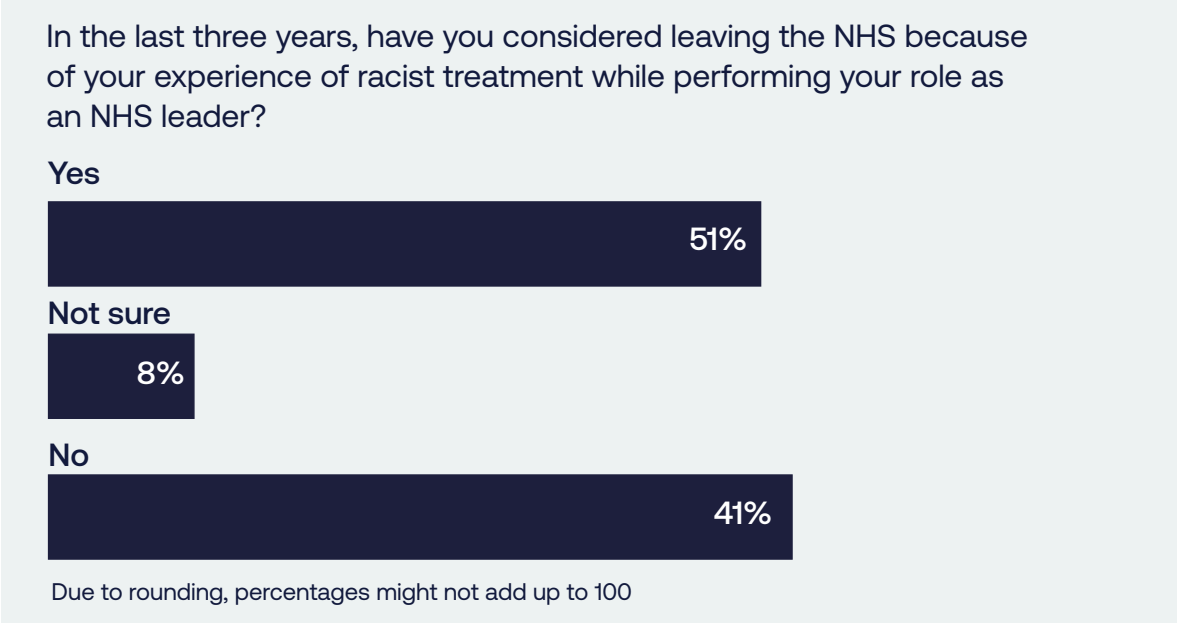
The lived experience of senior BME leaders

Several common themes emerged from the roundtables and survey, which reveal four key issues: NHS culture and management; career progression; the ability to be true to oneself; and feeling safe. This chapter explores each theme in detail.

NHS culture and management

More than half of those participating in the survey (51 per cent) said they had considered leaving the NHS in the past three years because of their experience of racist treatment while performing their role as an NHS leader.

Of those answering that they had considered leaving, only 10 per cent said they had decided to stay because the issue had been resolved to their satisfaction. Most were still considering their position, with nearly three-quarters saying they had felt it essential to stay and fight to make things better for others.



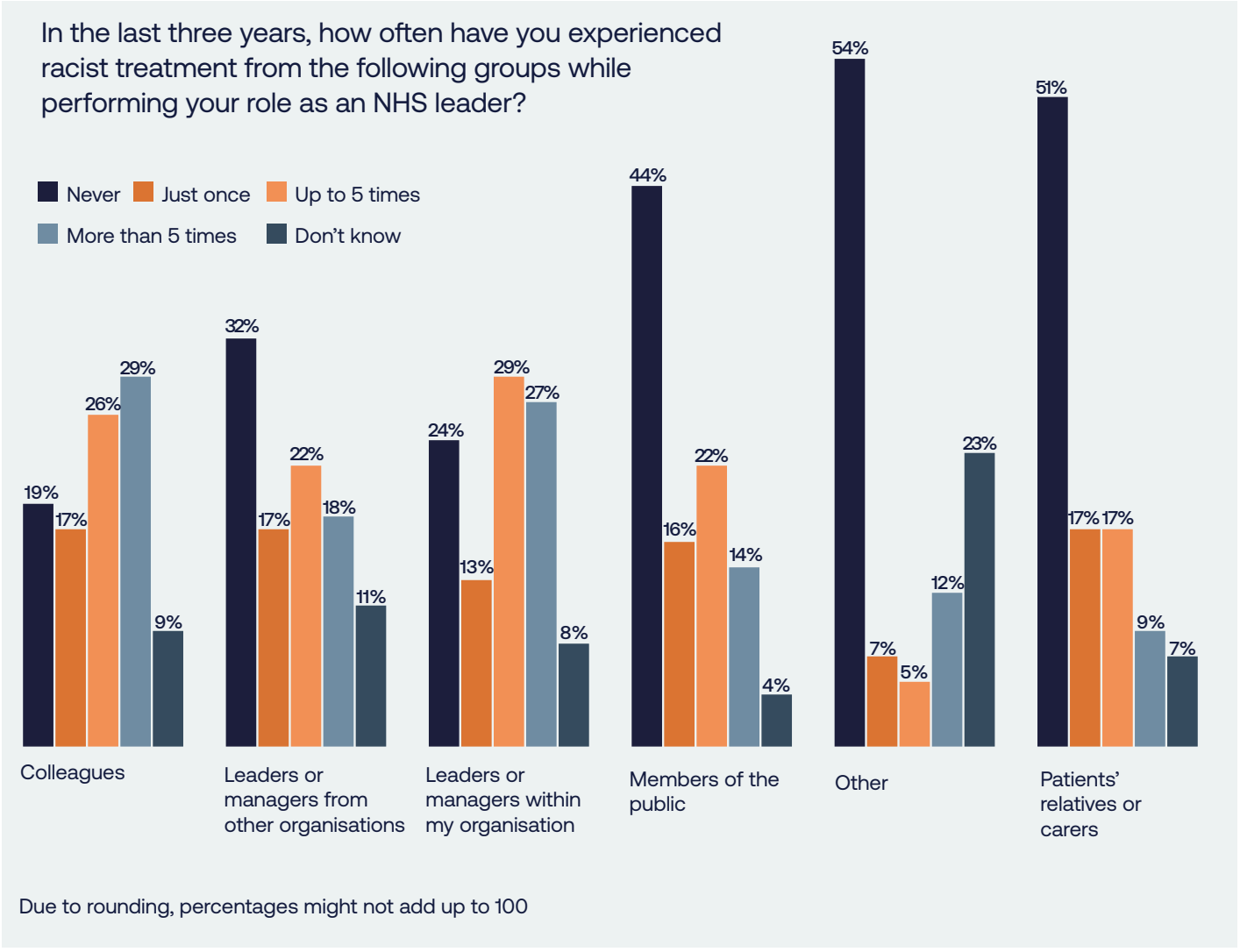
If you have considered leaving the NHS in the last 3 years because of your experience of racist treatment while performing your role as an NHS leader, what were the main reasons why you decided to stay?

Due to rounding, percentages might not add up to 100

Colleagues, leaders and managers seemed to be a particular source of racist treatment, more so than members of the public, with 72 per cent stating they had experienced this at least once in the previous three years. Sixty-nine per cent had experienced this behaviour from leaders or managers within their organisation at least once in the last three years, and 57 per cent had experienced it from leaders or managers in another organisation at least once over the same period.

This is concerning, given that the NHS has been prioritising equality, diversity and inclusion activities in recent years. This suggests that more focused efforts are required at every level to reduce the incidence of racist behaviour and to improve awareness among all staff of the impact of this type of discrimination.

Participants were less likely to have experienced racist treatment from members of the public over the previous three years. However more than half had still experienced this (52 per cent) at least once, with patients' relatives and carers being the least likely sources of racist treatment.



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Three-quarters of respondents (74 per cent) said their working environment had changed significantly as a result of the COVID-19 pandemic, and 58 per cent said this had an impact on their experience of or exposure to racism in the workplace.

Participants at the executive leaders' roundtable observed that despite well-evidenced progress detailed through the Workforce Race Equality Standard, statistics about how well local NHS leadership reflects the diversity of the local population and NHS Staff Survey data do not seem to change, leading them to feel cynical about progress towards greater representation of BME staff in leadership roles.

It was suggested that the Black Lives Matter movement had at least led to a higher quality discussion about equality and racism, but that this had not yet filtered through into changes in the profile of the people recruited to senior roles. Where BME staff did attain senior positions, it was felt that these tended to be in roles relating to equality, diversity and inclusion (EDI) and inequalities, and that there was sometimes a perception that these roles were about race rather than issues such as population health. There was a suggestion that even when in high-ranking roles, some felt excluded from senior-level strategy discussions, yet they also spent a lot of time explaining the needs of local populations to their peers in leadership roles.

> Recruitment processes were a particular area where problems arose, with both clinical and executive leaders describing feeling that they were involved to demonstrate diversity

Clinical leader participants felt that having a few BME people in senior leadership roles was not sufficient to make an organisation truly inclusive. All leaders needed to recognise better the benefits of a diverse leadership, because in the absence of this understanding, forcing the issue could create animosity. A good values-led chief executive would strive to ensure diversity and inclusion because this is what staff and communities need, and leadership that reflects the workforce and the communities served results in stronger organisations.

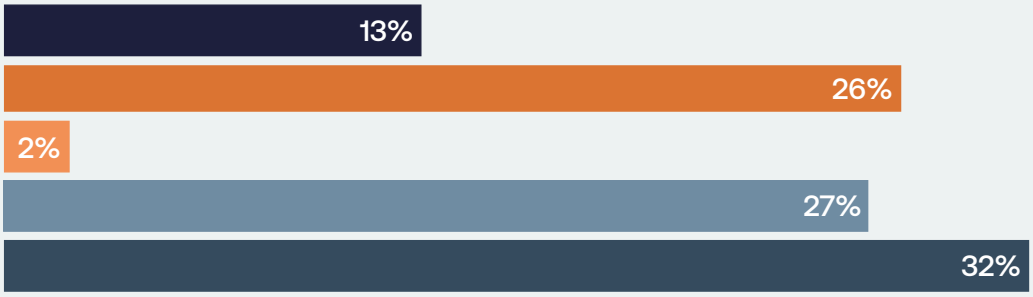
Recruitment processes were a particular area where problems arose, with both clinical and executive leaders describing feeling that they were involved to demonstrate 'diversity', while the same culture continued. In the primary care leaders' discussion, there was a comment that recruitment processes inherently discourage diversity in leadership. In this latter group, the issue of discrimination against people whose first language was not English arose. It was felt that no account was taken of the extra cognitive processing required to compete for a job in a second language.

Career progression

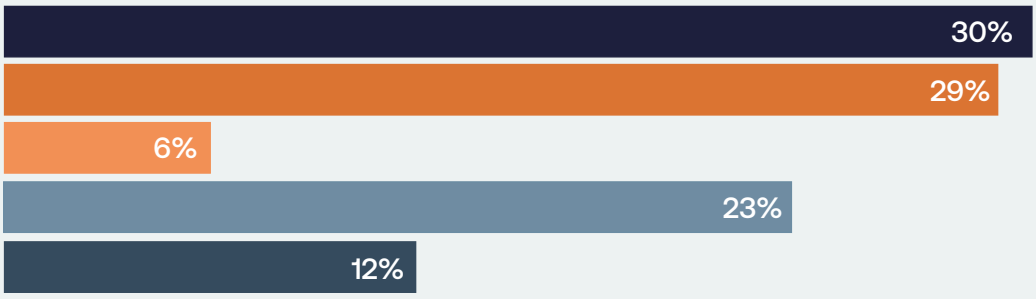
Fewer than 1 in 4 (23 per cent) agreed or strongly agreed that they were confident that their organisation has a robust talent management process that is enabling the development of a pipeline of diverse talent. Fewer still (14 per cent) were confident that the NHS People Plan would successfully reduce barriers to career progression of BME colleagues in the NHS. And only 10 per cent agreed or strongly agreed that they were confident that the NHS is delivering its commitment to combat institutional racism and reduce health inequalities.

As a senior NHS leader how far do you agree or disagree with the following statements?

I am confident that I am able to be my authentic self in my role, without having to compromise my values to achieve or retain my position



I am confident that I have the personal skills and capacity to successfully challenge overt or covert racial prejudice or discrimination I may confront in my role



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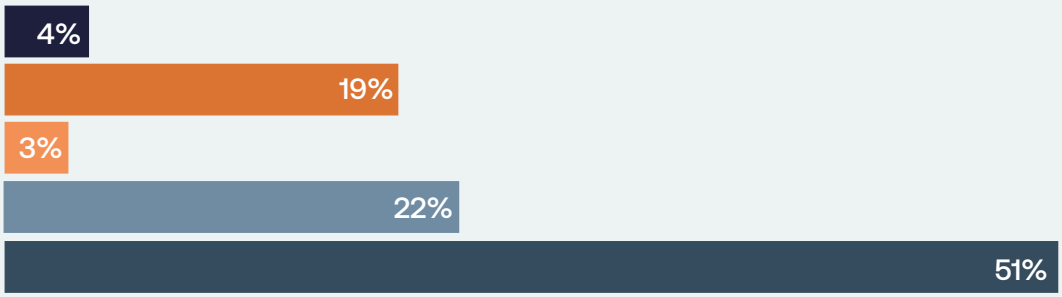
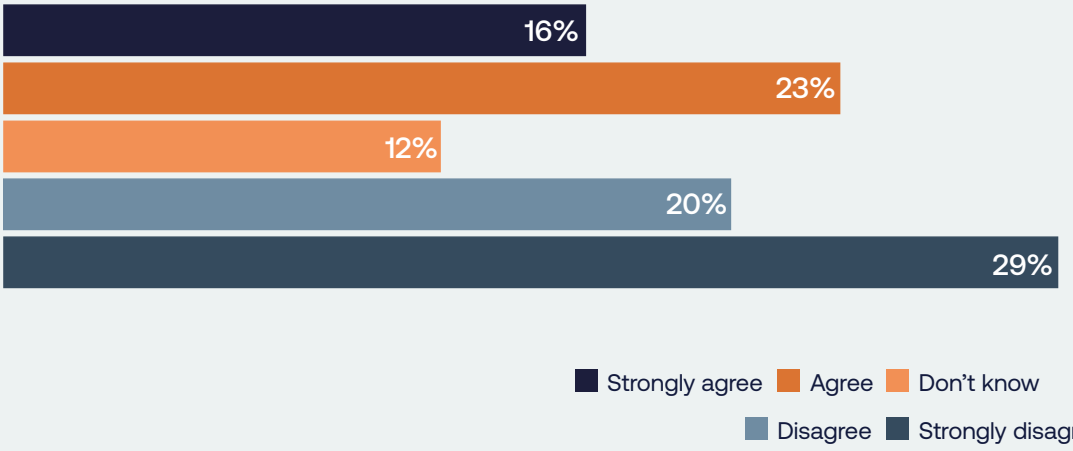
I am confident that my organisation has a robust talent management process that is enabling the development of a pipeline of diverse talent



I am confident that the NHS People Plan will successfully reduce barriers to career progression of BME colleagues in the NHS

I am confident that I would have the support of my colleagues if I needed to challenge racial prejudice or discrimination in my organisation



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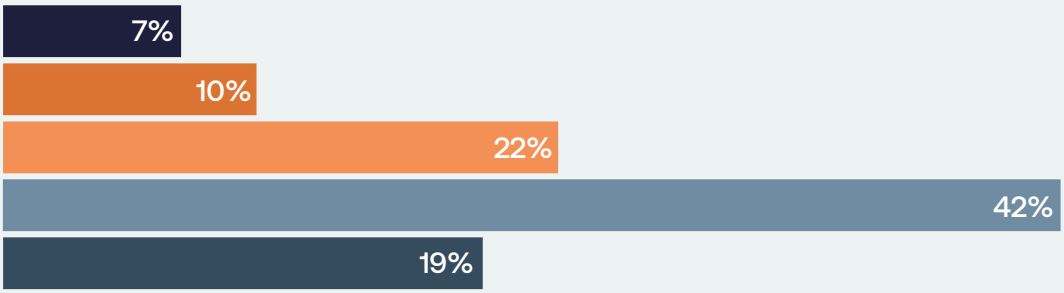
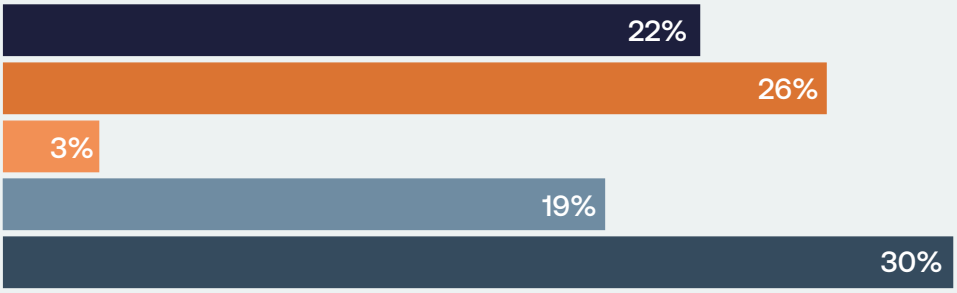
I am confident that I would have the support of NHS England and NHS Improvement, if I needed to challenge racial prejudice or discrimination in my organisation, ICS or ICP



I am confident that I am as able to influence decision making within my work environment as any of my colleagues from the majority community



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Executive leader roundtable participants felt that a lack of succession planning meant that BME staff were locked out of senior positions. One participant said they expected to look outside their organisation and perhaps even the NHS for their next career move because there might be better opportunities to gain new skills, though they were not hopeful of finding a better culture elsewhere.

Leaders participating in the roundtable discussions described how structural and cultural issues within the NHS led to a situation

where BME leaders were not present in sufficient numbers to generate a climate of inclusivity and were sometimes siloed in particular types of role. This helped to create a situation where career progression was felt to be unduly challenging and where neither succession planning nor talent development was occurring at sufficient scale to support the next generation of diverse leaders.

Participants in the clinical leaders' discussion felt that talent residing within BME staff was not nurtured in the same way that it was for white colleagues, and that this was a barrier to career progression.

It is essential that BME leaders are able to see effective development programmes to support diverse talent, and that they are provided with sufficient support, both locally and nationally, to feel secure in calling out unacceptable behaviour when this occurs.

> A lack of BME role models at higher levels makes it harder for aspiring leaders to find development opportunities such as clinical shadowing

Where people spoke with a different accent, it was felt within the clinical leaders' group that discrimination was more overt, and that assumptions were often made about the person's understanding of British culture or societal norms. This was perceived to be a particular issue in the handling of complaints, and was linked to staff members experiencing this avoiding being blunt in order to be heard at all.

Primary care leaders spoke in their roundtable about how BME leaders often had skills at higher levels than white peers and had to work twice as hard to get the same recognition, rewards and career progression. Female leaders highlighted that some male BME colleagues could be equally misogynistic as white colleagues. Mentors were viewed as a good solution to these problems as they

were able to champion aspiring leaders and create space for them to demonstrate their ability.

A further message from this group was that a lack of BME role models at higher levels makes it harder for aspiring leaders to find development opportunities such as clinical shadowing, which perpetuates existing barriers to career progression.

However, achieving these supportive relationships was not always felt to be straight forward. A female participant in the primary care leaders' group described emotional and verbal bullying from a BME woman within her own professional cohort, which was so serious that she felt unable to progress to a senior role she had been asked to apply for. No peers offered support and when this participant asked for support, she was advised to submit a grievance. She was concerned that doing so would have led to further career repercussions.

Her experience was echoed by a leader in the executive leaders' group who suggested some discrimination could occur within BME communities. A further point made by a clinical leader was that some leaders felt uncomfortable being openly supportive of BME colleagues for fear of being seen as only helping colleagues from these groups.

Being true to oneself

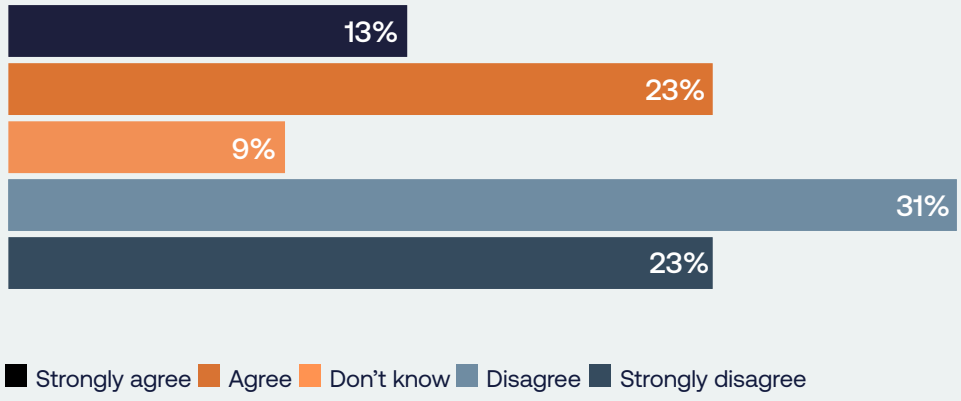
Being able to be authentic in the workplace was an issue that emerged powerfully from the discussion groups. Some leaders reported policing their own behaviour in the workplace and compromising their values to fit in. Being able to represent their own cultures and be themselves at work was a critically important goal for many.

Fewer than 4 in 10 (39 per cent) agreed or strongly agreed that they were confident that they were able to be their authentic

self in their role, without having to compromise their values to achieve or retain their position. One younger participant in the executive leaders' group said he was careful never to behave in a way that could be twisted to make him fit the 'angry Black man' trope, choosing his language carefully to avoid being seen as antagonistic.

Only 37 per cent agreed or strongly agreed that they would have no reservations recommending a role as a senior NHS leader to members of their community. The proportion of senior leaders strongly agreeing with this statement was only 13 per cent.

I would have no reservations recommending a role as a senior NHS leader to members of my community



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Another young leader in the same group said they refused to join staff BAME networks, because they wanted to be seen as equal, not different. They described working in a previous role in a smaller organisation where the executive leadership team was representative of the diverse population and where they felt they had been recruited for their ability to do the job, rather than to 'tick a box'. Since moving into a new role in a larger organisation, they were noticing a difference, but feared being labelled an 'activist' if they spoke out.

A further leader in this group referenced the tendency for women in the 1980s to dress and behave like men in order to 'become

equal', suggesting there was a similar expectation for BME staff to 'behave like white people' to fit in and progress to senior leadership roles. They viewed the problem as structural racism and pointed to accountability and activism as the solution, adding that black and minority ethnic people shouldn't be scared to show who they are.

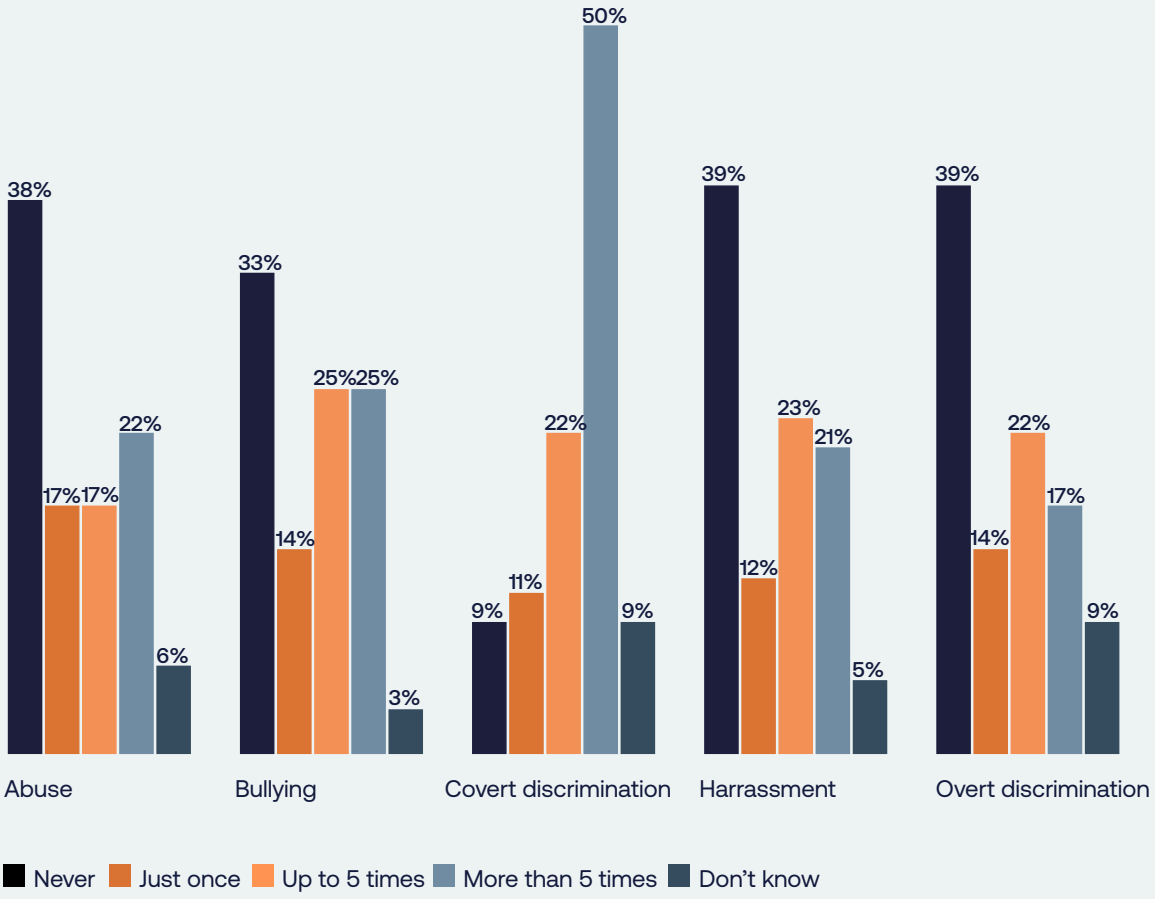
A member of the clinical leaders' group felt that people retained their positions by compromising their values, tolerating hurtful experiences and accepting racism instead of speaking out. Because of the environment in which leaders operate, there was felt to be a required degree of conformity in order to progress. Diversity should lead to belonging without individuals having to change who they are or want to be included. A primary care leader also said a recognition of different cultures and how these might have an impact on willingness to speak up was needed to get those from different cultures' voices heard.

Feeling safe

More than half of respondents (57 per cent) said they had experienced verbal abuse or abusive behaviour targeting racial, national or cultural heritage at least once in the past three years, with 22 per cent saying this had happened five times or more. Almost the same proportion (56 per cent) had experienced harassment because of their ethnic origin, colour, race, religion or nationality over the same period.

Nearly two-thirds reported having been bullied and more than 4 in 5 said they had experienced covert discrimination (being subtly excluded or ridiculed) due to racism. More than half reported having experienced overt discrimination (the experience of being openly or obviously excluded or ridiculed) over a three-year period.

In the last three years have you experienced racist treatment while performing your role as an NHS leader?



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When asked to indicate which characteristics they had experienced unfair treatment because of in the last 12 months while performing their role, 41 per cent highlighted their ethnicity, 19 per cent their gender, 14 per cent their age, 6 per cent their religious beliefs, 6 per cent their class, and 4 per cent because of a health condition or a disability. One person reported experiencing unfair treatment because of their sexuality – it is well-evidenced that LGBTQ+ leaders experience variable levels of safety in disclosing such information.[3]

When asked about their experiences of working in a senior role in the NHS, although a majority of respondents (59 per cent) either agreed or strongly agreed that they were confident they

had the personal skills and capacity to successfully challenge overt or covert racial prejudice or discrimination in their role, only 39 per cent agreed or strongly agreed that they were confident they would have the support of their colleagues in doing so. Even fewer (17 per cent) agreed or strongly agreed that they were confident they would have the support of NHS England and NHS Improvement, if they needed to challenge racial prejudice or discrimination in their organisation, integrated care system or integrated care partnership.

On several occasions in the executive leaders' group, the issue of feeling safe came up. One participant described this as "knowing I will be treated the same regardless of who's around me and whether they're from the same community or not". This was seen to be the ultimate success measure of equality. Another leader in this group highlighted the importance of holding onto the truth. They viewed it as the responsibility of more experienced senior leaders to help less experienced staff navigate institutional racism, but this posed a problem for the senior staff, who needed to be able to use their knowledge without becoming demotivated.

Advice for the next generation of BME leaders

Roundtable participants were asked what advice they would offer to a junior BME colleague who has ambitions to achieve a very senior leadership role in the NHS. A selection of responses are provided below:

"Get a mentor, stay true to self and be aware of the institutionalised discrimination so you can manage yourself in the role. Change takes time and the appetite is there to challenge bad behaviours and values."

"Seek an effective mentor, continue to be ambitious, but be realistic. Remain authentic."

"Be tough as nails. Know your rights. Don't be afraid to challenge/confront. But try not to see discrimination everywhere. Most people are decent and many times don't realise if they are behaving with implicit bias."

"They have to work double as hard as white colleagues. Tolerance for your mistakes will be less. You have to be ready for that."

"Don't compromise your integrity; be a compassionate leader by leading by example. Be honest and fair in your decision making."

"Establish a support network with psychological safety. Have a core purpose in mind and be prepared for challenge that will be more about who you are and represent rather than what you know."

"Don't be put off by your experience from applying for senior roles as this is the only way that data can be analysed to demonstrate discrimination."

"I feel that there are structural barriers to progressing, then once a senior role is achieved, this is blocked. However, I encourage others to progress and one day I hope it will change."

"I absolutely still believe it's a privilege to lead in the NHS and ensure our communities are well-served by a diverse leadership. But the flip side is feeling like you are being driven out of something you love because you represent difference. For anyone joining, I strongly recommend they have a strong network, a coach and a mentor."

"Ensure you are aware of your strengths, harness and verbalise them and ensure you build your networks so you are not isolated."

"Do not forget your roots. Try and have a White ally earlier in your career. Seek out coaching early in your senior leadership journey. You will need bucketloads of resilience. Challenge microaggressions and talk to someone about it."

"Keep rooted in the purpose: better patient care. Look for BME and white allies – create networks. Have your red lines and know what you will do if they are breached."

Viewpoint and recommendations

It is well understood that the most senior roles in NHS leadership are highly pressurised jobs where a great deal of personal and professional resilience are required to succeed. Nevertheless, our research makes sobering reading for the NHS. The findings should provide food for thought for leaders at every level and of every ethnicity within the NHS, both locally and nationally.

When leaders are not representative of the communities they serve, service users suffer. Similarly, when senior staff are unhappy and turnover is high, organisational stability can be affected. The NHS says a key part of its strategy to achieve equality is creating a diverse leadership. Improving working life for senior BME staff should therefore be a critical priority for the health service.

There are some steps the NHS can take urgently to address these concerns and improve working conditions for BME leaders.

Putting better processes in place to support future and current BME leaders

Personal support

BME leaders require more tailored and intensive support as they overcome the challenges they face in accessing and retaining the most senior jobs in the NHS. Mentoring schemes involving both top-level NHS leaders and leaders from outside the health service are likely to be beneficial, but should be designed in collaboration

with existing BME leaders, to ensure that they address the right areas of need. We are developing a mentoring programme, co-produced by our members, and **the NHS should encourage its staff networks to use this model and consider embedding it within its organisations**.

Recruitment and retention

Structural change is also needed: the NHS is losing committed, highly skilled and motivated talent to institutional discrimination. **Specific succession planning and talent development schemes are necessary to enable BME leaders to move their careers forward. NHS recruitment should be reformed, with required skills, roles and experiences described in more inclusive ways, along with better community engagement to encourage a more diverse pool of applicants for senior roles**.

As we can see from this report, however, the appointment of diverse leaders to senior positions does not remove the challenges they have faced throughout their career. NHS organisations need to show that they are cognisant of these continuing challenges and mitigate against them by ensuring robust support that does not end with the induction process.

Ending cultures of discriminatory behaviour and supporting leaders to feel safe

Despite the NHS's recent focus on equality, diversity and inclusion, we know that BME leaders at all levels still experience significant levels of discrimination, both from members of the public and, unforgivably, from fellow NHS staff. Working towards ending discriminatory behaviour should remain an important priority for all NHS organisations, ensuring that all staff have a better understanding of their own responsibilities in relation to respecting others.

Since leaders report that there is no point within the NHS hierarchy where they feel safe from discrimination, abuse and harassment, such treatment can negatively impact their ability to provide leadership around the EDI agenda. **The NHS must prioritise supporting BME leaders to feel safe from discrimination in the workplace** so they can drive change forward or risk failing to achieve the ambition to improve equality by increasing leadership diversity.

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