Nursing Narratives: Racism and the Pandemic

Report of Key Findings

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Summary

"What starts off as a germ, a little tiny piece of behaviour, or maybe a big aggressive piece of behaviour, left unchecked, it spreads…like a virus"

[Estephanie Dunn, Regional Director of RCN]

Black, Brown and migrant health workers make a critical contribution to the NHS and social care. The current coronavirus outbreak has laid bare structural inequalities and disproportionately affected racialised minorities, including health care workers.[1] In the first month of the UK lockdown, 72% of the NHS and social care staff who died were from Black and Brown backgrounds.[2] In February 2021, a Public Accounts Committee (PAC) recognised that the government 'does not know enough about the experience of frontline staff, particularly BAME staff'. It asked the government to consider the 'extent to which (and reasons why) BAME staff were less likely to report having access to PPE and being tested for PPE and more likely to report feeling pressured to work without adequate PPE'. [3] The October 2021 Lessons Learned report recognises that 'the higher incidence … may have resulted from higher exposure to the virus', [4] but there is no address to racism.

Our study collected stories of the working lives of Black and Brown staff and asked them to reflect on their experiences and advocate the changes they would like to see. It confirms previous studies that identify the entrenched nature of racism in health care systems, structures, processes[5 6 7 8] and the writing of history. [10] It depicts a bleak picture indicating it is damaging for staff, patients, and society with worsening incidences of harassment.[11] The study highlights how systemic cultures of racism contributed to the disproportionate impact of COVID-19 on racialised minority health workers.

Nineteen participants have spoken out on film, and their stories will form part of a ground-breaking resource of nineteen extended documentary testimonies and a collective documentary film. This storytelling approach demands that we look at the histories of racialised experiences that many staff have faced and continue to face. It highlights racism as a pandemic that must be confronted.

Our participants have written a joint manifesto to demand an actively anti-racist health service as a fundamental principle for the treatment of all staff with respect. It is being supported by several grassroots nursing and midwifery organisations.

[a] We have adopted the terms Black and Brown to recognize the continued impact of colour-based racisms despite the intersection of discriminations based on other markers of ethnicity.

Aims and Objectives

- To use storytelling as a methodology to develop our understanding of the impact of racism and discrimination on Black and Brown nurses and healthcare workers during the COVID-19 pandemic and historically.

- To use intersectionality and critical race theory to examine interconnections and interdependencies between various social categories and systems, which shape the racialised experiences of people of colour.

- To document the experiences of nurses, midwives and other health workers through an interdisciplinary framework by employing both social science and arts based methodologies.

- To produce insights to support systemic change through a participatory framework.

Methodology

Nursing Narratives: Racism and the Pandemic has taken a grassroots approach to understanding and documenting the experiences of Black and Brown health care staff during the pandemic. The mixed-method approach incorporated an online survey conducted during January – May 2021 (n=308 respondents) [Table 1] and narrative interviews on film and audio (n=45 participants) [Table 2]. In total, 353 Black and Brown nurses, midwives, allied health professional and other healthcare staff participated.

As an arts and humanities research project, we recognise the value of history and human experience. We chose a storytelling approach in order to excavate the cumulative nature of racism on individuals and the health service as a whole. The testimony films form a collective memory that will be a resource for future generations. The participatory filmmaking approach was an integral part of our work and a crucial way to present our findings.[12] It allowed us to place Black and Brown nurses, midwives and health care workers centre stage and focus on emotions and feelings as part of the evidence to understand experiences of racism, its cumulative impact and the devastating experiences of the pandemic. [13 14]

We brought nurses, midwives and other health care workers together from across the country to share and recognise their expertise. Our aim has not been to ask nurses simply what happened to them, but to ask them what they want to happen now. Asking nurses and midwives their ideas for a better future was fundamental to the research. Time and again, nurses and health care workers argued that they had seen many reports being written, and they did not simply want another report. They were clear that they were telling their stories in order to work together to push forward for change.

We started with the following premises:

- **Racism is a socially constructed entity, not a biological reality. Its pervasive nature means it is the ordinary experience of most people of colour. Its influence lies not just in the acts of race hatred but in the 'more subtle and hidden operations of power that have the effect of disadvantaging one or more minority ethnic groups'.** [15] [16] [17]

- **The pandemic is a portal through which we can build a new society**[18]

- **Giving health care workers 'permission to narrate' would yield a new way of understanding**[19]

Black Lives Matter (BLM) provided courage to many of our participants to speak out. Nineteen have been brave enough to speak out on film. Due to various circumstances, including fear of reprisals from employers, some of our audio participants were too vulnerable to do this. Their stories have been critical in understanding the migrant experience.

Key Findings

The Pandemic - The Perfect Storm

The experiences of health care workers during the pandemic highlights four key areas of racialised discrimination that put the lives of Black and Brown staff more at risk of serious injury and death: Work allocation, PPE provision, risk assessment provision and a culture of neglect. These experiences should be seen as a continuation of pre-pandemic experiences resulting from a systemic culture of racism.

The treatment of staff regarding delegation to COVID-19 positive environments, access to appropriate PPE and risk assessments should be understood in the context of a culture that has historically expected Black and Brown workers to work harder, accept more significant risks and give them less overall support at work. All the forms of structural and institutional racism that existed before the pandemic compounded the vulnerability of Black and Brown staff. It created the perfect storm.

• 52.6% of Black and Brown staff experienced unfair treatment in the pandemic concerning either deployment to COVID-19 positive environments, PPE or risk assessment provision.

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1. Work allocation

'We were chosen to be exposed' **[Filipino nurse]**

Black and Brown staff's frequent allocation to more risky spaces impacted them massively during the pandemic. For example, in one hospital, nearly all the Filipino nurses caught COVID-19 even before the process of redeployment was organised, highlighting the endemic practice of allocating risky work to Black and minority ethnic health care workers.

All the Filipino nurses we spoke to had personally experienced discrimination regarding work allocation during the pandemic. There were numerous testimonies of Black and Brown nurses, managers and health care assistants (HCAs) being the only ones from their units to be redeployed to COVID-19 wards. Agency workers experienced similar practices in many hospitals. Roseline, a Black African agency nurse, spoke of how 'all the black nurses were always allocated in the red area' (the high risk area) in A&E. Participants described the discriminatory practice as cultural and endemic.

Discrimination in allocation to high-risk environments must be understood as conscious decision-making and not an oversight. There were examples of pressure, threats and coercion. This was experienced particularly by migrant workers who were threatened with losing their employment visas. Staff were repeatedly informed that they were contracted by the hospital and not by a unit and were expected to move. When these delegations were queried, staff were sometimes informed that they were being placed on rotation to high-risk areas, yet six to twelve months later, the same staff were still in those areas.

Some staff did raise concerns collectively with success. However, it is clear that even after questions about risks to Black and Brown staff were raised publicly, they were still often placed in areas of high risk.

• 27% of respondents said they had been unfairly delegated to COVID-19 positive areas.

Worst affected groups:
• 44% Filipino
• 33% Black African
• 32% Pakistani and Bangladeshi

2. Personal Protective Equipment (PPE)

The lived experience of nurses working during the early months of the pandemic highlighted several challenges that Black and Brown nurses were faced with concerning PPE allocation.

The night shift

Historically, Black staff have often worked nights to reflect patterns of home life, often juggling more than one job or running a home as a single parent with children. However, some are automatically placed on regular nights, limiting opportunities for career development. Participants highlighted how the longer shifts that night staff work increased their vulnerability.
The night shift was acutely described as being left exposed to danger due to the absence of PPE. There was evidence that PPE sometimes ran out at night. Evidence showed that PPE was locked away at night in some units, leaving night staff, often Black, particularly vulnerable. Some Black and Brown staff felt they had to bring in their own PPE to keep safe.

• 19.5% of respondents felt they were either discriminated against regarding access to PPE or its suitability.

Discrimination in access

Nurses spoke of PPE being hidden by managers and handed out to individuals through preference, the preferred nurses usually being white.

'Some people sometimes hoarded it, especially the FFP3 masks and the N95. It was the whites who were close to the managers and storekeepers'. **[Filipino nurse]**

Even when Black and Brown staff were allocated to COVID-19 wards, there is evidence that many were denied appropriate PPE, and allocated only surgical masks. For example, Neomi Bennett, a Black agency nurse, described,

'I was allocated to a COVID ward, and I was not given protection.... I'd asked for... like a proper filtered mask, and I was told I can't have it because I will scare people'. **[Neomi]**

When Karen, a Black agency nurse, questioned procedures, she found herself removed from the role of looking after PPE, with her contract terminated.

Falsified protection - Racism in medical equipment

Participants spoke about fit tests and their suspicions about the PPE not fitting them correctly. This caused staff some anxiety, especially as many of the participants were allocated to work in COVID-19 areas. Sometimes there would only be one type of mask that fitted due to anthropometric bias, yet staff told us how they were denied access to these and were only given surgical masks. Others spoke about the lack of accommodation for the hijab or the lack of proper head protection. Neomi describes herself and other black nurses as forced to use bin bags to cover hair or braids. There was a feeling that,

'...nobody cared that this equipment wasn't suitable for us. Even knowing that our risk of developing COVID was so high, nobody seemed to be talking about it' **[Black British nurse]**

Nurses did try to challenge the failure to protect them and spoke of how they encouraged others to speak out regarding both the lack of PPE and the expectation that they should reuse PPE.

3. Risk assessments

• 32.7% of respondents had difficulty accessing a risk assessment or receiving reasonable adjustment following a risk assessment or both.

Timing of Risk Assessments

The failure to assess staff put many Black and Brown staff at undue risk. There were many examples of staff who failed to get timely risk assessments despite severe underlying conditions. Some of these staff caught COVID-19, putting them at risk of serious harm, which could have been avoided.

Olanike, a union representative, noted how staff were denied risk assessments which had to be fought for. There were staff who were given delayed responses after carrying out risk assessments. There was resistance to understanding individual circumstances with responses such as 'we're all scared.' The risk assessments were described by many as happening too late.

Some nurses highlighted how white staff appeared to be able to get shielding letters more easily than Black and Brown staff. Migrant staff who had not registered their risks with a GP describe not being adequately assessed. There was no provision made in the usual procedures.

A tick box exercise

Nafiza described the risk assessments as 'a tick box exercise'. Often, recommendations were felt to be arbitrary and did not always seem to assess underlying conditions. June, a senior nurse, highlighted how she was excluded from meetings about risk assessments, even though she was the only Black member of a leadership team.

There was a feeling amongst some that the exercise was a waste of time because vulnerable Black and Brown staff were still allocated to risky areas. There were stories of Black and Brown nurses who were told to shield while still being asked to come to work. Their risks were essentially ignored. Some staff, who were risk assessed as not to work with COVID-19 patients had to assert this fact on their wards continually. There was no system in place beyond informal requests.

The arbitrary nature of the risk assessment was borne out by one nurse whose colleague worked through the first and second waves after completing a risk assessment. After the second wave at a subsequent risk assessment, she was informed that she should be shielded. Fatimah, a midwife described the risk assessment process as 'a joke'. She was told to shield after many months of being put at risk.

Cultures of racism also played out within ward cultures; one midwife described white colleagues as goading her to accept that being from an ethnic minority should not be a criterion of risk despite the number of Black and Brown health care workers who had died.

4. A culture of neglect

From Band 2 to Band 8B, nurses articulated the lack of care or value attributed to Black and Brown lives:

'***they would just tell you; you are hired to work here. Just work, I don't care if you die or not, I don't care if you are sick or not, just work'.*** [Filipino nurse]

'The way we've been treated like we're nothing, not caring enough about us to give us the proper PPE, knowing that we are more at risk. They don't care. They don't care about us. No compassion, no understanding, no nothing. Just cold as ice or colder than ice' [Black British HCA]

Neglect induced fear amongst many participants. Many expressed their fear of arriving on COVID-19 wards, not having been fitted correctly for PPE. One nurse manager expressed anger and despair. Rather than managers thinking about protecting the lives of their staff, the mantra of following PHE guidance was frequently rolled out, and there was a feeling that racism played a role in the lack of care:

'I sat with my manager in a corporate, … and she just said, well, they're just following PHE guidance… "we can't do anything", but we didn't see any of them on the floor… because I worked in a very ethnic minority heavy area, I felt a lot more angry because I felt like you were just letting them die. It doesn't matter because obviously, they're all ethnic minorities, you know'. **[Indian nurse manager]**

The lack of care and neglect of Black and Brown workers led to some being refused swab tests in the first wave, although white staff from the same hospital had received tests. One described using the public testing facility to have her positive status confirmed. Lack of care also manifested in what some nurses felt was harassment with phone calls every day while they were ill, to find out when they were returning to work. Many felt they were treated as second class. Riel, a Filipino nurse who has left the NHS, described how charitable donations from the public were first given to those close to the nurse managers, with migrants only getting what was leftover.

5. Migrant Nurses

• 52% of migrant nurses felt that work visas had made them more vulnerable to racism and exploitation

Migrant nurses, in particular, felt they were treated as disposable:

'at the end of the day, I'm just a number. I'm just a number. Because if anything happens to me or happens to my family, it's not going to be so long before you take someone else to replace me… And that was what happened to these ones that died. It was very disturbing' [Olanike]

This feeling of disposability was strongest amongst migrant nurses whose vulnerability was increased through discriminatory immigration legislation:

'they look at overseas workers as commodities, whom they buy through recruitment from other countries to get to their land to work as their slaves. We are nothing but a disposable commodity'. **[Filipino nurse who has left the UK]**

Migrant staff expressed vulnerability to victimisation and exploitation through work visas that tied their right to work to particular trusts making it difficult for them to remove themselves from toxic work environments. There was evidence that migrant workers were threatened with losing their jobs and visas if they did not accept redeployment to COVID-19 positive environments. Immigration legislation places migrant workers at risk of poverty through high visa fees. The fees for indefinite leave to remain were described by some healthworkers as prohibitively expensive to families for years.

6. The impact of racism

• 59% had experienced racism during their working lives that had made it difficult for them to do their job

• 53% said racism had impacted their mental health

• 36% had left a job as a result of racism during their working lives

• 33.4% had been forced to take sick leave as a result of racism

The impact of racism not only killed Black and Brown staff, but has traumatised many, both before and during the pandemic. The culture of delegating riskier work and 'heavier' work to Black and Brown staff led to staff being placed in impossible situations in the pandemic, such as looking after four patients that should have had one to one care. The deaths of patients in these circumstances haunt staff.

I did not see my nurse; he just came in to do the medication and came out.… The one with the CPAP died when I got up to attend to the one with the hourly urine, and that really, that really got me. I couldn't eat, I couldn't sleep, I couldn't drink. And I thought to myself, what if I didn't give the gentleman that blanket? He will still be alive today. [Black British HCA]

Previous experiences of racialised victimisation led to fear from the above HCA that she would be blamed for the death, compounding stress and anxiety levels that were already high due to trauma, impacting mental and physical health.

Many also saw their experiences of racism as worse than the pandemic:

'The pandemic hasn't affected me as much, really, but this bullying culture in our unit has persisted, and it's difficult to uproot. That's why I'm going to uproot myself' **[Filipino nurse]**

An Indian nurse who was victimised before the pandemic and had to move roles, as a result, argued that the victimisation she experienced 'was even more horrible than the pandemic'. This was despite her delegation to ICU, supporting Covid patients through the first wave, an experience she described as traumatic.

Cultures of racism have sustained nineteenth-century colonial attitudes. Black and Brown staff repeatedly spoke about trying to prove that they weren't lazy. This led to shielding staff, describing 'overcompensating' when working from home to 'prove' they were working. An HCA reflected, 'they rarely trust that Black people can do things as well as white people'. Such perceptions have led to over scrutiny and victimisation, severely impacting mental and physical health. It has led to resignations, electing to work as agency nurses, leaving the NHS and, in one instance, leaving healthcare altogether.

7. Speaking out and challenging discrimination

Many of our study participants believed that they were speaking out for others as they wanted to share their stories and experiences to make a difference to ensure that what happened to them should not happen to others. Despite their experiences, dozens of interviewees were determined to challenge racism.

'Even when you feel you have lost hope, you will always find a person of colour who will be willing to fight, and you think…I can't' give up'. [Esther, Black British nurse]

During the pandemic, Black and Brown nurses have found solidarity and support through self-organised nursing organisations and WhatsApp groups to counter the feelings of isolation and find 'acknowledgement and validation' of their experiences.

'The rise of Black Lives Matter gave many a chance 'to speak out'. I wanted my colleagues to know that Fatima, their colleague, had also experienced racism. It's not just something that they heard on the TV… it's next to them'. **[African midwife]**

Several grassroots organisations were developed to enable nurses and midwives to organise collectively. The Film **EXPOSED** and the nineteen individual testimony films produced as part of the Nursing Narratives project are a collective effort to highlight injustice and call for change.

The historical context

1. Cultures of racism

The study findings highlight that racism is often unreported. Most participants highlighted experiences of racism both before and during the pandemic. It was a culture that permeated daily practice. Many participants reported that they initially thought incidents of racism were individual and isolated, but gradually they realised a pattern.

'When you put it [racialised incidents] altogether, it's like more than just a little bit. It's a culture' **[Black British nurse].**

The culture of racism permits attitudes that undermine Black and Brown health care workers. When Gemma, a Black British nurse, mentioned that she was tired or seemed to have more patients than her colleague, she received retorts such as 'it beats being a slave'.

2. Exclusion and neglect

Exclusion and neglect were among the most widely recounted experiences. Participants reported being ignored when they walked into a room, conversations stopping, being excluded from meetings, and their contribution to discussions ignored: 'I was invisible' [Indian nurse]. This was an experience highlighted from student nurses to Band 8s. A Black African Equality Diversity and Inclusion (EDI) lead described 'people on the phone in tears because they've just been so pushed out'. Experiences of racism started in training. Race and class intersected, with some participants describing how Black and Brown students and staff on lower bands received the worst treatment. Others indicated that white HCAs were listened to more than Black and Brown nurses.[20] Nurses and midwives also described not being supported when they needed help, making it next to impossible for them always to do their jobs safely, leading to fear of reprisals.

• 77.3% of respondents who complained about racism said they were not treated fairly.

The greatest impact on our participants was not racial abuse from patients or colleagues 'but then not getting support from your team and your colleagues' [Black British nurse]. This must be understood as a systemic form of neglect.

3. Victimisation

• 42.8% had suffered excessive scrutiny and punishment during their working lives prior to the pandemic

• 28.2% had experienced excessive scrutiny and punishment in the first year of the pandemic.

Participants describe victimisation through exclusion as well as active bullying. The opinions of Black and Brown staff were invariably less valued and not trusted when challenging their situation. One Black British student nurse described having to get evidence of victimisation from a white student despite the fact a Black student had already given evidence of her experience. There were reports of gaslighting and experiences of racism being dismissed as 'a perception' or as a result of being overly emotional. It was clear that racism also intersected with other forms of oppression, such as Islamaphobia and homophobia. There were examples of speaking out being described as rudeness with threats of referral to the matron. There were also instances of staff being referred to both the Nursing and Midwifery Council (NMC) and the police without substantive evidence. [21] There were incidences of bullying that led to compromises in patient safety.

4. Training and progression

• 60.3% of Black and Brown respondents said that they had been prevented from progressing in their working lives prior to the pandemic.

• 28.2% had been prevented from progressing during the first year of the pandemic.

Nearly every interview participant described their difficulties with progression. Some health workers were told to pay for their own training when they requested support. Others were told to wait, repeatedly. There were instances of individuals who had to work on short term contracts absorbing the work of vacant posts, only to be given progression when there was legally no choice. Ambition was crushed with suggestions that they were 'thinking too big'. Nurses and midwives who trained white students repeatedly saw their students' progress before them. Some highlighted their disinterest in progressing because they had seen how Black and Brown colleagues in management had been treated. There were experiences of potential midwives being directed away from midwifery at the point of entry and into nursing in training institutions because of their ethnic background.

5. Workload allocation

The practice of allocating Black and Brown health care staff to riskier settings or allocating them 'heavier' work was highlighted by staff who had just begun their careers as well as those who had worked for decades in the health service. Nurses described being delegated to more labour-intensive work or being allocated more complex or riskier patients to manage. This was widespread amongst health care assistants, nurses and midwives.

'You're more likely to be allocated... more complicated service users to care for if you are on shift, or you're expected to have a heavier, larger workload'. **[Benash, South Asian midwife]**

'even though they treated me as newly qualified and told me that I wasn't supposed to have Level 2 or 3 patients, I would often get patients that were combative and delirious.' **[Riel, Filipino nurse]**

Despite higher workloads, some participants describe colleagues seeing them as lazy. There were repeated testimonies of not getting breaks, having to wait for hours for their breaks or being asked to return before they had even been able to eat. Migrant nurses also highlighted the failure of management to inform them of break policies. Such patterns of racism can be understood more clearly when we reflect on racialised attitudes toward Black and Brown bodies as 'born to labour' dating back to the era of slavery and British colonialism. [22] [23] [24] [25]

Conclusion

Our research underscores that the endemic culture of racism led Black and Brown workers to be placed at higher risk of the virus. They were more exposed. [26] [27] This manifested both through their patient-facing roles and discrimination in work allocation, shift patterns, insufficient PPE, and lack of adequate risk assessments. Black and Brown staff are aware of the discrimination they face. They view health organisations as uncaring and not valuing their lives. They describe being viewed as commodities rather than human beings, and this perception was particularly pronounced amongst migrant workers.

The mixed-methods data we collected highlights the patterns of racism known to exist within health care in the UK. When a repeated action, behaviour, or practice goes unchallenged, it becomes the norm, legitimising such behaviours. Cultures of racism must be recognised and called out. This must include being transparent about what happened in the pandemic, including the release of figures that indicate the deaths of health care workers by ethnicity. The Nursing Narratives: Racism and the Pandemic team submitted a Freedom of Information request to NHS Digital regarding the number of health care workers who had died of COVID-19 by ethnicity, but the request has never been answered.

When staff challenged racism, a dominant impetus from management was to push it aside as though by ignoring it, it would disappear. [28] Such colour-blind approaches were seen to impact initiatives to challenge disproportionate health outcomes. At other times the staff were victimised. The glaring disproportionate impact of the pandemic on Black and Brown staff has led many to get organised. They say the need to organise for change is 'not just about us, it's also about our patients and ensuring that we get justice for our patients' [Black British nurse].

While addressing the lack of Black and Brown staff in management is a critical step, this alone cannot eradicate the culture of racism. Black managers have highlighted how they are not always fully involved in decision-making processes or are isolated, leading to the reproduction of discrimination and the failure to address racism even by racialised minorities in management. This study clearly shows despite the series of initiatives to address inequalities, the culture of the NHS fundamentally remains systemically racist. This put Black and Brown staff at greater risk during the Pandemic leading to disproportionate impact and loss of life. Therefore, a radical shift in the institutional approach is needed to change the underlying narratives and dismantle the racialised structures that create an environment and tolerance for racialised inequalities which cause harm.

The Manifesto for Change

As the study developed, we engaged in discussions with participants about how the report could have a concrete action that would exist beyond the life of the study. We were all aware of numerous reports published on racism in the NHS and needed a tool that would take the findings of our study and place them in the real world. The idea of creating a manifesto developed with the participants. A statement of shared aims would act as a call to arms for all interested parties.

The manifesto was put together following reflection by our participants on the following questions:

1. What is the most significant change that can be made to tackle discrimination?

2. What would you like the future of the NHS to be?

Reflections related to both the pandemic experience and the overall experience of working in health care in the UK. The reflections were collated and refined through a series of iterations that were shared with the participants. We also took into consideration the overall experiences and concerns of nurses, such as those in education and training. The most fundamental concern was the endemic nature of racism and the lack of meaningful address to it. Many felt that the existing policies to prevent racism were not implemented. Rather than approaching the policies in the spirit intended, there was often an attempt to work around them to continue discriminatory practices. It was felt that racism was constantly brushed under the carpet. Due to the longstanding and systemic nature of racism, the nurses saw it as an issue to be enforced through regulatory systems. If racism is understood as embedded in the structure of an institution, it cannot be addressed by simply encouraging personal transformations.

While the manifesto focuses primarily on the concerns of nurses and midwives, there was care taken to broaden the meaning of the manifesto through minimal reference to specific regulatory bodies in order to create a manifesto that would include the concerns of other groups such as allied health professionals.

The impact of racism should be recognised as a moral injury that Black and Brown health care staff have suffered over decades, an injury that was exacerbated in the pandemic with devastating consequences. Given both the levels of moral harm and actual harm that Black and Brown nurses, midwives and other health care workers have suffered through the pandemic, it is essential that their ideas for change are actively engaged with and adopted to create a health service that works in the best interests of staff, patients and society.

An Anti-Racist Health Service
A Manifesto for Change

Due to the history of racist practices towards Black and Brown health workers that have been further exposed by our experience of the pandemic, we demand a health service that is actively anti-racist:

We call upon the NHS to:
1. Implement a Zero tolerance to racism policy and practice.
2. Stop putting Black and Brown staff in danger of death and psychological harm.
3. Build a more compassionate NHS with respect and equity for Black and Brown workers.
4. Remove whiteness as the benchmark in training and organisational culture
5. Build an NHS with equality at the core of health provision for all ethnicities.
6. Create clear and real consequences for racist actions, including dismissal, legal action and referral to regulatory bodies.
7. Create a fair and transparent recruitment process, including all internal opportunities.
8. End the exploitation of Black and Brown workers - delegate work equitably.

We call upon Universities and Practice learning partners to:
9. Be accountable for providing equitable access to learning opportunities that enable all student nurses and midwives to meet the NMC competencies for registration.

We call upon the government and regulators to:
10. Create accountability and penalties for trusts for failure to address racism through the Health and Safety Executive
11. Recognise the experience and training of overseas nurses and midwives. Don't treat them automatically as unqualified.
12. Evaluate and reflect on Black and Brown staff experiences of discrimination in CQC ratings.
13. Investigate and challenge referrals of Black and Brown nurses and midwives to regulatory bodies with no evidence and no case to answer
14. Change the immigration system for international health care workers to end exploitative visa fees, the denial of recourse to public funds and give automatic indefinite leave to remain.
15. Reinstate third party discrimination into legislation.

We call on all Black and Brown staff to build a collective voice, which will also be supported by all allies to build a just health service.

Strength in Unity

Endorsed by: Equality for Black Nurses; Nurses of Colour Network, Association of South Asian Midwives, Kanlungan Filipino Consortium, Caribbean African Health Network, Filipino Nurses Association, Nigeria Nurses Charitable Association UK, Malawian-UK Nurses Association, Uganda Nurses and Midwives Association UK, Caribbean Nurses and Midwives Association (UK), Society of African and Caribbean Midwives, Nurses Association of Jamaica, Zimbabwean Midwifery and Nurses Association, Philipine Nurses Association, British Indian Nurses Association, Ghana Nurses Association, Kenyan Nurses and Midwives Association UK, Cameroon Nurses, Association of South African Nurses in the United Kingdom, Gambia Healthcare Matters, Ivorian Association for Health Promotion UK, British Pakistani Nurses and Midwives Association, Migrant Media

Table 1: Distribution of Respondents to survey by Demographics, Care Settings & Job Role by NHS/Non-NHS Organisation

Profile	Sub-group	NHS		NON-NHS		All	
		Count	Col%	Count	Col%	Count	Col%
All		267	100	41	100	308	100
Gender	Male	59	22.10	12	29.27	71	23.05
	Female	203	76.03	28	68.29	231	75.00
	Other/ NR	5	1.87	1	2.44	6	1.95
Age	18-30	20	7.49	6	14.63	26	8.44
	31-44	135	50.56	13	31.71	148	48.05
	45-54	80	29.96	12	29.27	92	29.87
	55 & above	32	11.99	10	24.39	42	13.64
Ethnicity	Black African	69	25.84	13	31.71	82	26.62
	Black Caribbean	33	12.36	7	17.07	40	12.99
	Black British	18	6.74	5	12.20	23	7.47
	Black mixed heritage	19	7.12	1	2.44	20	6.49
	Asian Indian	44	16.48	1	2.44	45	14.61
	Asian Pakistani	30	11.24	9	21.95	39	12.66
	Asian Bangladeshi	5	1.87	0	0.00	5	1.62
	Asian Filipino	31	11.61	3	7.32	34	11.04
	Asian Other	11	4.12	1	2.44	12	3.90
	Asian mixed heritage	2	0.75	0	0.00	2	0.65
	Arab	5	1.87	1	2.44	6	1.95
Job Role	Nurse/ Nursing Associate	166	62.17	24	58.54	190	61.69
	Midwife	16	5.99	0	0.00	16	5.19
	Medical staff	18	6.74	2	4.88	20	6.49
	Clinical Support Worker	21	7.87	3	7.32	24	7.79
	Allied Health Professional	37	13.86	7	17.07	44	14.29
	Social Care Worker	2	0.75	4	9.76	6	1.95
	Ancillary Staff	7	2.62	1	2.44	8	2.60
Settings	Hospital	188	70.41	12	29.27	200	69.94
	Community	58	21.72	13	31.71	71	23.05
	Primary Care	9	3.37	2	4.88	11	3.57
	Nursing home/ residential	2	0.75	14	34.15	16	5.19
	Intermediate care	10	3.75	0	0.00	10	3.25
Work Permit	Not Required	147	55.06	21	51.22	168	54.55
	Immigrant vulnerable to Racism	65	24.34	10	24.39	75	24.35
	Immigrant not vulnerable	55	20.60	10	24.39	65	21.10

Table 2: The film and audio interview participants

No	Job Role	Ethnicity	Gender	Age
1	Midwife	Pakistani	Female	26
2	Nurse	Pakistani	Male	38
3	Nurse	Pakistani	Male	40
4	Midwife	Pakistani	Female	34
5	Nurse	Pakistani	Female	53
6	Nurse	Filipino	Female	44
7	Nurse	Filipino	Male	NA
8	Nurse	Black Caribbean	Female	34
9	Nurse	Filipino	Female	34
10	Nurse	Indian	Female	41
11	Allied health professional	Indian	Male	43
12	Nurse	Filipino	Male	31
13	Nurse	Bangladeshi	Female	31
14	Allied health professional	Mauritius	Female	39
15	Nurse	Black African	Female	43
16	Nurse	Black Caribbean	Female	53
17	Nurse	Zimbabwean	Female	51
18	Nurse	Black African	Female	31
19	Nurse	Black African Portuguese	Female	34
20	Support worker	Mauritian	Female	46
21	Nursing associate	Black African	Female	33
22	Nurse	Dual heritage Asian/ white	Female	35
23	Health care assistant	Black British	Female	58
24	Nurse	Pakistani	Male	44
25	Nurse	Filipino	Female	31
26	Nurse	Black British	Female	32
27	Nurse	Dual heritage Black Caribbean/ white	Female	
28	Nurse	Filipino	Female	45
29	Midwife	Pakistani	Female	31
30	Midwife	British Bangladeshi	Female	56
31	Allied health professional	Indian	Male	43
32	Midwife	Arab	Female	32
33	Nurse	Black British	Female	61
34	Nurse	Black African	Female	54
35	Nurse	Black Caribbean	Female	66
36	Midwife	Arab/ Bengali	Female	33
37	Nurse	Indian	Female	47
38	Lab worker	Indian	Male	49
39	Student Nurse	Mixed Black British	Female	34
40	Nurse	Black Caribbean	Female	57
41	Nurse	Black British	Female	47
42	Community worker	Filipino	Female	NA
43	Nurse	Dual heritage Black Caribbean/ white	Female	NA
44	Nurse	Black British	Female	53
45	Nurse	Black African	Female	38

Chi-square values were found significant for age groups, job roles, and settings; thus, suggesting their significant association with a type of organisation (NHS/Non-NHS).

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