Challenging the cultures of racism at work in the UK's healthcare sector

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Abstract

Background
In UK's health care sector, racism is rampant. It impacts Black and Brown staff working in NHS at all levels. We aimed to explore and understand the stories and experiences of Black and Brown health care staff during the pandemic and previously in their working lives.

Methods
We conducted a questionnaire survey and qualitative interviews with Black and Brown nurses, midwives and other healthcare staff. 308 respondents completed an online survey, and 45 people participated in the narrative interviews. Interviewees were contacted through meetings organised with several BME health and social care professional networks and the survey. In total, 353 Black and Brown staff members participated. The Critical Race Theory informed the data collection and analysis of the study.

Findings
The study findings report that racism is prevalent in the health and social care sector, and it is usually unreported. Most participants worked during the pandemic and reported experiences of racism before and during it. Our survey findings revealed that 52.6% of the Black and Brown staff experienced unfair treatment in the pandemic concerning Covid deployment, PPE or risk assessment provision. Similarly, 59% had experienced racism during their working lives, making it difficult to do their job; thus, 36% had left a job. Most participants reported that exclusion and neglect as a form of bullying were among the most widely recounted experiences that took a toll on their lives; for example, 53% said racism had impacted their mental health.

Interpretation
Our research underscores that the endemic culture of racism is a fundamental factor that must be recognised and called out. Colourblindness exacerbates racist practices. We argue that only implementing an active zero tolerance to racism policy with penalties for organisations that do not comply can change the status quo.

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Introduction

Despite legislation against racial discrimination, racism in the NHS is widespread and impacts staff at all levels[1]. Racialised negative experiences of Black and ethnic minority doctors at the workplace are well documented[2]. However, evidence about the experiences of Black and Brown nurses, midwives, and other health care workers is scarce but emerging.

Most of the existing studies discussing racial inequalities do not explicitly talk about structural racism or racist cultures in health care; however, they refer to the policies and practices within and across institutions that, consciously or unconsciously, produce outcomes that persistently favour or put a racial or ethnic group at a disadvantage.[3,4] The Workforce Race Equality Survey (WRES) provides annual statistical evidence that indicates increased bullying and harassment despite changes in senior management that include more Black and Brown staff.[5] A typical example of institutional racism can be found in NHS Disciplinary Proceedings which found that racially minoritised staff were almost twice as likely to be disciplined. Black and ethnic minority staff are punished at higher rates than their white counterparts, and recruitment, retention, and promotion practices have significantly disadvantaged racially minoritised health care staff.[6] Most papers avoid calling out this practice as institutional racism. Instead, such issues are discussed as 'racial diversity management' and justified due to communication gaps, lack of cultural competency, and insufficiently trained managers to manage staff from diverse backgrounds.[7]

Some studies have investigated racial microaggressions. The NHS Staff Survey in England reports that staff from Black, Asian and ethnic minority communities experience continued discrimination and higher levels of bullying, harassment or abuse from other staff.[8] Qualitative investigations highlight the kinds of experiences encountered. An investigation into the experiences of overseas nurses working as support workers in the UK described how most reported being shouted at, laughed at for their accent, and often not trusted by white

colleagues, patients, and families.[9] Another explored the experiences of racial microaggression, in which 11 migrant nurses maintained a reflective diary for six weeks to record their living and working experiences in the UK and found that most of the study participants believed they were blamed for "stealing" local jobs.[10]

A qualitative study with 30 nurses and ten managers from four NHS trusts in the northeast of England reported that Black and ethnic minority nurses experience discrimination in their promotion, equal opportunities, and professional development in the NHS despite the Equality Act. However, the managers ruled out institutional or systemic discrimination against Black and Asian staff, attributing discrimination to individuals, i.e., colleagues, patients, and relatives.[11]

The denial of racism's existence is ineffective and counterproductive.[12] The Covid 19 pandemic has disproportionally affected racialised minorities, including health care workers.[13] The pandemic has highlighted the structural disadvantage experienced by people from these groups. They have been at greater risk of contracting the disease and its severity, hospitalisation, and death from Covid-19. A study drawing on weekly zoom discussions and data from an online survey with 103 Zimbabwean healthcare workers in the UK reports that most healthcare staff who participated experienced discrimination in equipment allocation, workload, moral injury, and trauma that could lead to long-term mental health during the pandemic issues.[14] Similarly, a cross-sectional survey with 1119 healthcare professionals in the UK, 71% of whom were black, Asian and from other ethnic minorities, revealed that the majority of ethnic minority healthcare professionals considered themselves at increased risk due to their allocation to high-risk areas, and inadequate personal protective equipment (PPE).[15]

Our study collected stories of the working lives of Black and Brown staff[1] and asked them to reflect on their experiences and advocate the changes they would like to see. It depicts a bleak picture of the pervasive nature of racism within health care. It highlights that it is entrenched in health care systems, structures, and processes. It is the culture of racism that is systemic and damaging for staff, patients and society and has contributed to the disproportionate impact of Covid19 on racialised minority health workers.

Methodology and data collection

The paper draws on a survey and qualitative data from the *Nursing Narratives: Racism and the Pandemic* study that adopted a bottom-up approach to understanding the experiences of Black and Brown staff during the pandemic and previously in their working lives. The mixed-method approach incorporated a survey (n=308 respondents) and narrative interviews (n=45 participants) with Black and Brown health care staff. Interviewees were contacted through meetings organised with several BME networks and the survey. In total, 353 Black and Brown staff members participated. Nineteen have spoken out on film, and their stories will form part of a resource of extended documentary testimonies and a collective documentary film. Ethics approval was obtained by Sheffield Hallam University Research Ethics Committee

Theoretical framework

The study adopts a Critical Race Theory (CRT) approach, which recognises that the legal and institutional frameworks of society primarily act to legitimise the status quo and, as such, serve the interests of dominant groups and intersect with other forms of oppression.[16] CRT scholars argue that only colour-conscious efforts can challenge the dominant system.

It is often the case in positivist research that power dynamics are unrecognised, resulting in silencing marginalised groups.[17] CRT scholars argue that people of colour's experiential knowledge through storytelling is essential to challenge the status quo.[18] CRT's analytical framework employs a constructivist approach that enables resistance to claims of 'objectivity' in research favouring co-constructing knowledge with participants[19], highlighting voices that remain invalidated and distorted in social science research.[20]

The study has also drawn on artistic practices such as a/r/tography as an arts-based form of enquiry to disrupt standardised research criteria to evoke alternative possibilities of understanding. Through this, we have centred human emotion in the articulation of experience.[21]

[1] 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.

Table 1: The study participants

NO	Pseudonymn	Job role	Band	Ethnicity	Gender	Age
1	Humera	Midwife	6	Pakistani	Female	26
2	Mustafa	Nurse	5	Pakistani	Male	38
3	Mushtaq	Nurse	5	Pakistani	Male	40
4	Saima	Midwife	6	Pakistani	Female	34
5	Feroza	Nurse	5	Pakistani	Female	53
6	Luna	Nurse	5	Filipino	Female	44
7	Alon	Nurse	5	Filipino	Male	NA
8	Adelaide	Nurse	7	Black Caribbean	Female	34
9	Sam	Nurse	5	Filipino	Female	34
10	Abby	Nurse	8b	Indian	Female	41
11	Riaz	Allied Health Professional	6	Indian	Male	43
12	Abel	Nurse	5	Filipino	Male	31
13	Usma	Nurse	6	Bangladeshi	Female	31
14	Divya	Allied Health Professional	7	Mauritius	Female	39
15	Maria	Nurse	6 & 8a	Black African	Female	43
16	Cynthia	Nurse	8a	Black Caribbean	Female	53
17	Precious	Nurse	6	Zimbabwean	Female	51
18	Tina	Nurse	6	Black African	Female	31
19	Anita	Nurse	6	Black African Portugese	Female	34
20	Rani	Support worker	2	Mauritian	Female	46
21	Aamina	Nursing Associate	4	Black African	Female	33
22	Layla	Nurse	6	Dual heritage Asian and white	Female	35
23	Joan	Health Care Assistant	2	Black British	Female	58
24	Deedar	Nurse	5	Pakistani	Male	44
25	Iris	Nurse	5	Filipino	Female	31
26	Esther	Nurse	6	Black British	Female	32
27	Rachel	Nurse		Dual heritage Black Caribbean/white	Female	
28	Rona	Nurse	6	Filipino	Female	45
29	Shahnaaz	Midwife	7	Pakistani	Female	31
30	Rafia	Midwife	8a	British Bangladeshi	Female	56
31	Bhano	Allied Health Professional	7	Indian	Male	43
32	Razia	Midwife	7	Arab	Female	32
33	May	Nurse	7	Black British	Female	61
34	Ayotunde	Nurse	6	Black African	Female	54
35	Bella	Nurse	Senior	Black Carribean	Female	66
36	Tahira	Midwife	5	Egyptian Bengali	Female	33

37	Lily	Nurse	6	Indian	Female	47
38	Aaju	Lab Worker	3	Indian	Male	49
39	Zoe	Student Nurse	-	Mixed Black British	Female	34
40	Grace	Nurse	-	Black Caribbean	Female	57
41	Neomi	Nurse	Agency	Black British	Female	47
42	Susan	Community worker	-	Filipino	Female	NA
43	Tina	Nurse	5	Dual heritage Black Caribbean/white	Female	NA
44	Leticia	Nurse	8d	Black British	Female	53
45	Patricia	Nurse	6	Black African	Female	38

Findings

Cultures of Racism

The study findings highlight that racism is usually unreported. Most participants reported experiences of racism both before and during the pandemic. It was a culture that permeated daily practice:

> "I'm sorry to say, but racism exists…you will *feel it and see it* [emphasis added]. I mean, it's not written on the piece of paper, but the way they're talking to you, even a blind person can see, can feel' [Mushtaq].

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" [Irene].

As Estephanie, a senior nurse, emphasised: 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'. As a result of racism, trauma was presented by many of the interviewees. The documentary process was the first opportunity for many to release emotions that they had internalised. The process allowed the release of a depth memory.[22]

Exclusion and neglect as a form of bullying 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' [Abby]. This was an experience highlighted from student nurses to Band 8s. EDI lead Maria described 'people on the phone in tears because they've just been so pushed out.' During the pandemic, those closer to the managers even had more access to public donations in some wards.

What had the most impact on our participants was not racial abuse from patients or colleagues 'but then not getting support from your team and your colleagues.' Nurses and midwives sometimes repeated their names and positions when they challenged discriminatory actions and behaviours in order to be heard. One participant described how even black HR members pushed them to drop discrimination cases to avoid tension in the team. Experiences of racism started in training. Race and class intersected, describing how Black and Brown students and staff on lower bands received the worst treatment. Others indicated that white HCAs listened to more than Black and Brown nurses.

In our survey,

- 52.6% of the Black and Brown staff experienced unfair treatment in the pandemic concerning either Covid deployment, PPE or risk assessment provision.
- 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.

Colonial attitudes that projected racialised bodies were born to labour permeated working practice.[23-26] When Tina questioned why she had been given more patients than a colleague, a fellow nurse retorted: 'it's better than being a slave'. Shahnaz, a midwife, reflected:

> 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.

During the pandemic, this manifested in the unfair delegation of Black and Brown staff to Covid wards or patients with Covid infections.

> 'coloured ones are the only ones that have been deployed. … even the Filipino managers got transferred to the COVID wards [Luna].

> ‘All the black nurses were always allocated in the red area [Patricia].

Joan noted

> 'At that time, there were no white Health Care Assistants on that ward. … all the black people get assigned to the COVID patients… the nurse in charge. She didn't give a damn, basically. She didn't care. She's white. If I wanted something, she just stood outside. …She will not come in for anything.

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 staff that were shielding describing 'overcompensating' when working from home to 'prove' they were working. Tina 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. Sam's story highlights the trajectory:

> "at first, I thought it was part of toughening up newbies... I thought it's fine because it's part of the culture, but it's not [fine]. It really affected me so much. And it's too much. … I got sick".

Sam returned to the Philippines after sustained bullying, including victimisation and exclusion. She caught Covid after being delegated to work with Covid + patients without protection despite having serious health conditions. The bullying almost led to risk to a patient. It led to a mental health crisis.

Colonial perceptions and hierarchies have sustained the NHS's 'snowy white peaks'.[4] Maria described how she was told she was 'thinking too big' when discussing training. Nurse manager Abby described being “aware of the impossibility to progress” due to the culture. Others had to work on short term contracts absorbing the work of vacant posts only to be given progression when there was legally no choice.

All the forms of structural and institutional racism that existed before the pandemic compounded the vulnerability of Black and Brown staff. From Band 2 to Band 8B, nurses articulated the lack of care or value attributed to Black and Brown lives:

> 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 [Joan].

> 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 are just letting them die, it doesn't matter, because obviously, they're all ethnic minorities, you know [Abby].

Black and Brown nurses felt treated like 'a commodity' [Sam]. Having fought to be redeployed to protect a very vulnerable family member, Olanike reflected:

> '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.

This feeling of disposability was strongest amongst migrant nurses whose vulnerability is increased through discriminatory immigration legislation that places them at risk of poverty through high visa fees required to maintain the right to work with fees for indefinite leave to remain sometimes prohibitive to families for years. Migrant staff expressed vulnerability to victimisation and exploitation through work visas that tied their right to work to a particular trust making it difficult for them to remove themselves from toxic work environments. 52% of migrant nurses who answered the survey felt that work visas had made them more vulnerable to racism and exploitation.

The impact of racism not only killed Black and Brown staff, many 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" [Abel].

Lily, who was victimised before the pandemic and had to move roles, as a result, argued that 'the victimisation was even more horrible than the pandemic' even though she worked in ICU supporting Covid patients through the first wave she described as traumatic.

Resistance to racism

In our survey, 73.1% (225 of 308) respondents complained about racism at the workplace. Out of 225 who complained, 174 (77.3%) were not treated fairly. Rona tried to raise the plight of her fellow Filipino workers on precarious visas: “I was raising issues about our unit, about how understaffed we are, how bullying and harassment are rampant in our unit”. She was victimised. Interviewees spoke of management processes dealing with racism as “a tick-box exercise” [Rafia].

When nurses raised issues of racism, they were frequently dismissed. Fatimah noticed that white student midwives were allocated to the birthing centre while black student midwives were allocated to more risky work on the wards at night. She tried to raise the issue of white privilege. It was dismissed as 'a perception' [Tahira].

Even after the murder of George Floyd, there was a concerted effort in some workplaces to deny the reality of racism. Humera describes how a project offers continuity for Black and Brown women in maternity due to disproportionate deaths[27] received 'horrendous' racism. 'I was approached pretty much every day about that;... “do you agree with this? Do you think BAME women should be special? I think it's offensive. Don't you think that's offensive?”

Some were labelled as oversensitive or as poor communicators. When Riel wrote an emotional letter about bullying, resulting from both his ethnicity and his sexuality, his matron's response was to ask him to stop feeling:

> 'your complaint always starts with; I feel, … I feel not appreciated. I feel I was bullied. Riel, let me give you advice. I want you to stop feeling you need to go there and get back to work, be confident and do your work. You need to stop feeling.'

Yet as Riel pointed out, 'I thought my work is actually about feeling, about feeling the needs of my patients' [Alon].

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].

Some nurses did challenge racism successfully with positive outcomes. When a manager sidelined Patricia, she stood up for herself. It enabled her to get her dream job as a theatre nurse. Such an outcome was rare, but microaggressions were often met with microdefences.

However, the most common experience of those who raised complaints of racism was victimisation. As Tina noted:

> 'when you file a complaint against a racist incident, it comes back to you harshly …they come with more worse practices against you because you complained against one of them, then there is like a system in which all go against you."

In Tina’s case, she was removed from her substantive role until the perpetrator retired. Only then did the trust acknowledge the racism that she had suffered.

Black and Brown nurses have found solidarity and support through self-organised WhatsApp groups to counter the feelings of isolation and find 'acknowledgement and validation’ of their experiences [Layla]. There was a feeling of more support 'on the outside' during the pandemic through the distribution of, for example, free meals. For nurses fasting in Ramadan, the moments when colleagues shared iftar were recalled as important moments of solidarity, especially when isolated in hotels away from family.

The rise of Black Lives Matter gave many a chance 'to speak out'.

> 'It allowed me to have conversations, which I never thought I would have with my white colleagues' [Neomi].

> "I wanted my colleges to know that Fatima, their college, had also experienced racism. It's not just something that they heard on the TV, … it's next to them" [Razia]

Several grassroots organisations were also developed to enable nurses and midwives to be 'allowed a voice together" [Neomi]. The nurses, midwives and health care workers who participated in our project have reflected on their experience to produce a 'Manifesto for Change'. [Appendix 1] The response was stark from a nurse with 33 years in healthcare 'what I'd really say, but I'm not going to say, is stop killing black people' when asked about their demands.

Sam highlighted:

> I did this interview because I don't want newbies like me from overseas, whatever their race is, to suffer… We are also humans.

Discussion

When a repeated action, behaviour, or practice goes unchallenged, it becomes the norm, legitimising such behaviours. When staff challenged racism, the dominant impetus from management was to push it aside as though by ignoring it, it would disappear.[28] Such colour-blind approaches have even impacted the initiatives to challenge disproportionate health outcomes.

There were repeated examples of 'gaslighting' (blaming the victim) when they raised racist behaviours.[29] This manifested in arguing that staff were not confident, too emotional, or incompetent.

Patterns of racism can be understood more clearly when we reflect on racialised attitudes that have existed about labourers dating back to the era of slavery and at the height of British colonialism.[24-26] While addressing the lack of Black and Brown staff in management is an important step; this alone cannot eradicate the culture of racism as 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. [29,30]

The culture of neglect for Black and Brown health care workers who have experienced racism led them to be placed at higher risk of the virus. They were more exposed.[14,15] This manifested both through their patient fronting roles and discrimination in work allocation, shift patterns, insufficient PPE, and lack of effective 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.

Black and Brown health care professionals have often not been able to challenge racism effectively due to victimisation. The glaring disproportionate impact of the pandemic on Black and Brown staff has led many to get organised. The need to organise for change is 'not just about us, its also about our patients and ensuring that... we get justice for our patients' [Neomi].

It has been recognised that the higher incidence of Covid19 in Black and Brown communities 'may have resulted from higher exposure to the virus'.[31] We argue that cultures of racism contributed to this vulnerability making it imperative to enable all service users and healthcare workers to be treated equally.

Conclusion

The mixed-methods data we collected highlights the patterns of racism known to exist within health care in the UK. Our research underscores that the endemic culture of racism is a fundamental factor that must be recognised and called out. Colourblindness exacerbates racist practices. Our nurses, midwives and health care workers argue that it is only the implementation of an active zero tolerance to racism policy with penalties for

organisations that do not comply that can change the status quo. Current immigration legislation makes international nurses especially vulnerable, which should also be addressed.

References

1. Ross S, Jabbal J, Chauhan K, Maguire D, Randhawa M, Dahir S. Workforce race inequalities and inclusion in NHS providers. King's Fund; 2020 7 July. https://www.nhsbmenetwork.org.uk/wp-content/uploads/2021/06/workforce-race-inequalities-inclusion-nhs-providers-july2020.pdf. Date accessed: 10 January 2022.

2. British Medical Association. A missed opportunity BMA response to the Race Report. London: BMA, 2021: 1-14. https://www.bma.org.uk/media/4276/bma-analysis-of-the-race-report-from-the-commission-on-race-and-ethnic-disparities-june-2021.pdf. Date accessed: 10 January 2022.

3. Parekh BC. The future of multi-ethnic Britain: Report of the commission on the future of multi-ethnic Britain. Profile Books; 2000.

4. Kline R. Beyond the snowy white peaks of the NHS. Race Equality Foundation. 2015. http://raceequalityfoundation.org.uk/wp-content/uploads/2018/02/Health-Briefing-39-_Final.pdf. Date accessed: 10 December 2021.

5. Nursing and Midwifery Council. Workforce Race Equality Standard (WRES) Survey 2021. https://www.nmc.org.uk/globalassets/sitedocuments/data-reports/edi-reports/wres-2021.pdf. Date accessed: 12 January 2022.

6. Archibong U, Kline R, Eshareturi C, McIntosh B. Disproportionality in NHS disciplinary proceedings. *British Journal of Healthcare Management*. 2019 1 April;25(4):1-7. https://doi.org/10.12968/bjhc.2018.0062

7. Gay W, Bamford D. A case study into the management of racial diversity within an NHS teaching hospital. *International Journal of Public Sector Management*. 2007; 20(4): 257-271.

8. NHS England. NHS Staff Survey 2019: National results briefing. NHS; 2020. https://www.nhsstaffsurveys.com/Page/1085/Latest-Results/NHS-Staff-Survey-Results/. Date accessed: 29 January 2022.

9. Stuart P. Overseas nurses' experience as support workers in the UK. *Nursing & Residential Care*. 2012; 14(12): 660-3. https://doi.org/10.12968/nrec.2012.14.12.660

10. Estacio EV, Saidy-Khan S. Experiences of racial microaggression among migrant nurses in the United Kingdom. *Global Qualitative Nursing Research*. 2014; 8(1): 1-7. https://doi.org/10.1177/2333393614532618.

11. Likupe G. Experiences of African nurses and the perception of their managers in the NHS. *Journal of nursing management*. 2015 Mar;23(2): 231-41. https://doi-org.hallam.idm.oclc.org/10.1111/jonm.12119.

12. Sewell T, Aderin-Pocock M, Chughtai A, Fraser K, Khalid N, Moyo D, Muroki M, Oliver M, Shah S. Commission on race and ethnic disparities: The report. London, UK: Commission on Race and Ethnic Disparities. 2021. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf. Date accessed: 10 January 2022.

13. Public Health England. COVID-19: review of disparities in risks and outcomes. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf. Date accessed: 21 January 2022.

14. Mbiba B, Chireka B, Kunonga E, Gezi K, Matsvai P, Manatse Z. At the deep end: COVID-19 experiences of Zimbabwean health and care workers in the United Kingdom. *Journal of Migration and Health*. 2020;1(2): 100024. https://doi.org/10.1016/j.jmh.2020.100024.

15. Ali P, Adam Z, West J, Pareek M, Raza M, Iqbal J. Perceptions of COVID-19-related risk and mortality among ethnically diverse healthcare professionals in the UK. *Ethnicity & Health*. 2021;26(1): 1-10. https://doi-org.hallam.idm.oclc.org/10.1080/13557858.2020.1849568

16. Crenshaw K. Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*. 1989; 1(8): 139 -167. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8.

17. Serrant L. Silenced Knowing: An Intersectional Framework for Exploring Black Women's Health and Diasporic Identities. *Frontiers in Sociology*. 2020; 7(5):1. https://doi.org/10.3389/fsoc.2020.00001.

18. Delgado R, Stefancic J. Critical race theory. New York University Press; 2017.

19. Rose G, Jasmine B., Toward a Critical Race Theory of Evidence. Minnesota Law Review. 2007; 176. https://scholarship.law.umn.edu/mlr/176.

20. Smith LT. Decolonising methodologies: Research and indigenous peoples. Zed Books Ltd.; 2021.

21. Springgay S, Irwin RL, Kind SW. A/r/tography as living inquiry through art and text. *Qualitative inquiry*. 2005;11(6): 897-912. https://doi-org.hallam.idm.oclc.org/10.1177/1077800405280696

22. Ken F. Obstinate memory: Documentary as trauma in disrupting state narratives on racial violence. *Viewfinder Magazine*. 2021. https://learningonscreen.ac.uk/viewfinder/articles/obstinate-memory-documentary-as-trauma-in-disrupting-state-narratives-on-racial-violence/. Date accessed: 28 January 2022.

23. Wilson K. Race, racism and development: Interrogating history, discourse and practice. Zed Books Ltd.; 2013.

24. Ramamurthy A. Imperial persuaders: Images of Africa and Asia in British advertising. Manchester University Press; 2003.

25. Buck-Morss, S. Hegel and Haiti. Critical Inquiry. 2000; 26(4): 821–65. http://www.jstor.org/stable/1344332.

26. Miles R. Racism. Routledge; 2004.

27. Kulakiewicz A, Gheera M, Harker R, Foley N. Black maternal healthcare and mortality. House of Commons Library. 2021, 14 April. https://researchbriefings.files.parliament.uk/documents/CDP-2021-0055/CDP-2021-0055.pdf. Date Accessed: 22 January 2022.

28. Apfelbaum EP, Norton MI, Sommers SR. Racial colour blindness: Emergence, practice, and implications. *Current directions in psychological science*. 2012 Jun;21(3):205-9. https://doi.org/10.1177/0963721411434980.

29. Shore LM, Cleveland JN, Sanchez D. Inclusive workplaces: A review and model. *Human Resource Management Review*. 2018 1 June;28(2):176-89. https://doi.org/10.1016/j.hrmr.2017.07.003.

30. Yuan K. Working While Black: Stories from black corporate America. Fortune; 2020, 16 June. https://fortune.com/longform/working-while-black-in-corporate-america-racism-microaggressions-stories/. Date Accessed: 31 January 2022.

31. NHS Confederation. The impact of COVID-19 on BME communities and health and care staff; 2020. https://www.nhsconfed.org/sites/default/files/media/BRIEFING_Impact20of20COVID-1920BME_communities20and20staff_FNL_0.pdf. Date Accessed: 31 January 2022.

Appendix 1

AN ANTI-RACIST HEALTH SERVICE
OUR 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 in 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 and legal action
7. Create a fair and transparent recruitment process, including for internal vacancies.
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. Don't treat them automatically as unqualified.
12. Evaluate and reflect 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