NHS England and NHS Improvement

NHS
Health Education England

Experiences of Racial Discrimination and Harassment in London Primary Care

Skyline by Michael Tompsett

First ever pan-London survey of the primary care workforce

March 2022

Forewords

Lizzie Smith
Regional Director, London
National HEE Equality, Diversity and Inclusion Lead
NHS London Anchor programme SRO
Health Education England, London

Gathering information on Primary Care is a longstanding challenge in the NHS, and one that means we do not serve the workforce well when it comes to understanding the realities and experiences of the people delivering and supporting these critical services. 90% of NHS consultations happen in a Primary Care setting, yet a small proportion of our intelligence and analytic resource is invested here; something we are working to address but have a long way to go to resolve.

I welcome this survey and all it tells us. I commend the team who made it happen and those who took time to respond at the most pressurised time the NHS has experienced. People have shared difficult, painful experiences. It now rests with us all to act on what we have learned. We need to show our Primary Care colleagues that we value them and stand alongside them; we need to confront these issues together.

I was struck by a number of things in the report. Most obviously that half of the respondents had personally experienced discrimination. That for many, the abuse was not overt, but subtle and underhand; frequent microaggressions culminating in a hostile work environment. We know that most of these experiences go unreported, but only 1 in 10 of those who had raised a concern felt that it was dealt with well. We must do better.

The examples in the report of the initiatives underway to address racial discrimination and harassment in Primary Care are impressive and heartening. We will continue to invest in this work in HEE but recognise for the work to succeed there will need to be a huge amount of engagement with a broad range of stakeholders.

We are working to address health inequalities for patients and create services that are free from discrimination, yet we continue to tolerate a working environment where many regularly endure the effects of racism. We ask ourselves why attrition from the workforce is high. We invest heavily in training and recruiting continually to maintain staffing levels. We need to get smarter about what is causing people to leave a job they love and focus on supporting systems to change for the better. It's through reports like this that we can uncover the facts and drive the improvement required to create a fair and just working culture for all.

Professor Simon Gregory MBE DL
Deputy Medical Director, Primary and Integrated Care
Freedom to Speak up Guardian.

The BMJ cover showing colleagues that had died in the first wave of COVID remains an incredible reminder of systemic differentials in our society that are only explained by the impact of systemic racism. There is considerable evidence that the UK is systemically racist, and that the NHS is a systemically racist workplace. The relative lack of evidence in Primary Care is just that, not evidence of lack. The awful and painful narratives of so many colleagues over so many years cannot be ignored but thanks to London's Primary Care educational leaders we now have firm evidence. Evidence that cannot be ignored! This report is part of their and our firm commitment to address the absence of a Workforce Race Equality Standard (WRES) for Primary Care and to implement a WRES for London Primary Care.

I do not want this forward to steal the thunder of the report. Though I am not sure that would be possible given the impact of the words and numbers contained herein. This report is shocking evidence of terrible, indeed appalling, levels of discrimination across protected characteristics and with much intersectionality, but especially shocking levels of racial discrimination. This in one of our most cosmopolitan cities with a fabulously diverse health and care workforce. This report provides evidence of discrimination by patients, colleagues, and managers across London Primary Care (and I have no doubt this would be replicated in a similar survey in any area of England). It tells us of discrimination and abuse with heart rendering personal narratives of the same, of a hostile environment that limits reporting, of colleagues standing silently by and of only one in ten colleagues feeling that complaints are adequately dealt with. To which I also add the continued 'snowy white peaks' with many colleagues of colour in lower paid roles but far fewer in top leadership positions.

This clear and present racism impacts on individuals, the whole workforce, recruitment, retention, on wellbeing and impedes safety and quality of care. Colleagues and patients are harmed by the impact of this discrimination.

I understand I write this foreword from a position of privilege as a middle aged, straight, cis-, white male and that I have much to learn and in aspiring to be a good ally much more to do. Health Education England is committed to being an anti-racist organisation and together we commit to changing the unacceptable state of primary care that is evidenced by this report. I thank the authors and sponsors for their leadership and the respondents for their courage and openness. I commend this report to you. I defy you not to be heartbroken by its content and ask you to turn that into a commitment for change and to change.

Introduction

Early in my career as an educator, I worked with 'doctors in difficulty' many of whom had trained abroad. These were, in the main, Black and Asian inner-city GPs, working in under-doctored, deprived areas, and their difficulties stemmed largely from professional isolation. Since then, evidence has confirmed that the differential outcomes for healthcare professionals have been driven by race, ethnicity, or migrant status, not by motivation, ability or effort. Disenfranchised from senior leadership roles by structural factors it has been their patients who, lacking representation, are the real victims of health inequalities, as vividly played out during the Covid-19 pandemic.

The NHS was established on the principles of social justice and equity but the treatment of our colleagues from minority groups often falls short, as evidenced by this first pan-London primary care survey. The NHS Workforce Race Equality Standard (WRES) has led to progress across several areas in secondary care but to date primary care has been excluded. I applaud the London Primary Care School for making one of its key priorities a primary care strategy to ensure that equality and diversity are supported in London's education and workforce development.

I am proud to be leading on the strategy's implementation. Within this we will, of course, support our internationally trained doctors and other health professionals in rising to the significant challenges they face as new to the NHS and life in the UK. But we will go further to ensure cultural transformation that ensures respect, job satisfaction and autonomy are fundamental to the experience of all in our primary care workforce regardless of age, race, gender, sexual orientation, ethnicity, disability, socio-economic deprivation or migrant status.

There is strong evidence that diversity and inclusion lead to improved health and greater staff and patient experiences of the NHS. Working in inner-city general practice for over 20 years has made me passionate about health inequalities. It is essential that primary care is part of this journey if the NHS is to achieve the excellence in healthcare that is needed to close the gap on the health inequalities that are undermining population health.

Dr Naureen Bhatti,
HEE London Workforce Race Strategy Primary Care Strategic Lead

Background

Everyone in the NHS deserves to work in an environment that is safe, welcoming, and free of discrimination. 90% of NHS consultations take place in primary care[1], and, post pandemic, the workforce is under more pressure than ever before. It is essential that we support the workforce because a motivated and valued workforce helps deliver higher quality patient care and more sustainable services[2]. Part of feeling valued is working in a supportive environment free from discrimination and harassment.

From 2011, commissioners and healthcare providers have been implementing the Equality Delivery System (EDS) to provide better working environments and reduce discrimination for those who work in the NHS, including those with protected characteristics under the Equality Act 2010[3]. Although NHS Trusts and arm's length bodies have been reporting on the extent to which they are ensuring that people from Black and minority ethnic backgrounds are fairly treated in the workplace, as part of the Workforce Race Equality Standard (WRES)[4], no such information exists for primary care. The only information available comes from small local surveys[5,6,7].

The London Primary Care School Workforce Priorities (2020)[8] have been jointly agreed between Health Education England (HEE), NHS England and Improvement (NHSEI) and the partners of the Primary Care School Board. A key priority is to ensure equality and diversity is fully supported in education and workforce development and to implement the London Workforce Race Equality Standard[9] in primary care; this will be instrumental in providing a better working environment and reducing discrimination for people working in the NHS and have a positive impact on retention, staff wellbeing and patient care.

To begin to address gaps in knowledge and act as a catalyst for finalising London's primary care Workforce Race and Equality Strategy, HEE and NHSEI undertook the first ever London-wide survey of experiences of discrimination and harassment in primary care. In November / December 2021, HEE and NHSEI invited people working in London primary care to share their experiences over the past 12 months. The anonymous online survey aimed to understand who is affected and their views on making primary care a better place to work.

The survey was advertised by email, social media, at meetings and in newsletters directly to staff, committees, employers, unions, training hubs, educators, and other stakeholders. It was undertaken at a particularly busy time in primary care, in the context of the COVID-19 pandemic and vaccination programmes in addition to winter pressures.

1,025 people shared their experiences, including people working in general practice, community pharmacy, dentistry, and optometry. Whilst this is only approximately 3% of London's total primary care workforce the respondents were broadly representative of the age, gender, ethnicity, and roles of the wider workforce, particularly for general practice.

[1] Primary care - NHS Digital
[2] https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf
[3] https://www.england.nhs.uk/about/equality/equality-hub/eds/
[4] https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
[5] Br J Gen Pract 2020 Jun; 70 (suppl 1): bjgp20X711125.
[6] https://www.humbersidelmc.org.uk/newreportcallsforactionondiscrimination
[7] NEL Inequality and Inequity in Primary Care' survey, NEL Collaborative, 2020
[8] NHS England and NHS Improvement and Health Education England Primary Care Workforce Priorities for London, HEE Primary Care School Board for London, 2020
[9] London Workforce Race Equality Standards, NHS England and NHS Improvement, 2020, LWRS.pdf (mcusercontent.com)

Findings

Annex 1 summarises survey methods and findings in detail.

Experience of discrimination

- **Half of those taking part said that, in the past year, they had been harassed or discriminated against at work based on their personal characteristics** (49%). We cannot generalise because those who took part may have been more likely to have something to report. However, the survey indicates that this is a sizable issue.

- **4 out of 10 people said they had been harassed or discriminated against by patients** in the past year (39%).

- **3 out of 10 said that colleagues or managers had harassed or discriminated** against them due to their personal characteristics (29%)

Racial discrimination and harassment

- Ethnicity was the most common characteristic associated with harassment and discrimination in primary care, above gender, age, religion, and disability. **1 in 3 of those surveyed reported racial discrimination or harassment from patients in the past 12 months (30%) and about 1 in 5 from staff they worked with (18%)**. The proportions were similar amongst GP partners and salaried GPs, nursing, and administrative staff.

- People from Black ethnic backgrounds were most likely to say they had experienced racial discrimination or harassment from patients and from colleagues. People from Asian backgrounds also commonly reported discrimination or harassment from patients.

- Two thirds of recent incidences of racial discrimination or harassment involved subtle or underhand comments or actions, rather than overt or confrontational behaviour. This may make it more difficult for people to question, address or complain about. This led some to feel that they were working in a 'hostile environment' or unsupportive culture, where negative attitudes were part of 'business as usual' and often not openly challenged.

- Racial discrimination and harassment may affect retention and productivity as well as negatively affecting individuals. Impacts reported included people losing confidence, feeling upset or anxious, taking sick leave, changing roles and in a small number of cases, significantly affecting their mental health. A small number reported what they believed was institutional or systemic racism towards practices or teams from minority ethnic groups.

- **12% left or considered leaving their role last year due to racial discrimination or harassment.** Amongst people from Black backgrounds, the figure was 1 in 4 (27%), and 1 in 7 people from Asian backgrounds (15%).

Addressing discrimination and harassment

- 1 in 3 people who said they had experienced racial discrimination or harassment in the past year said they had reported it. Of these only 1 in 10 said it had been dealt with well from their perspective.

- **Around half of people from minority ethnic groups did not know where to get help or feel confident that something would be done if they reported an issue.**

  Regardless of whether people had experienced discrimination or harassment of any type, most people who responded to the survey felt that **the culture and processes in primary care needed to change to provide a safer and more supportive environment** for London's diverse workforce. Participants called for diversity and inclusion training for everyone working in primary care to help raise the profile of the issues, understand each other better and build solutions together. They also suggested recruiting more diverse leadership and having an independent mechanism to provide advice and help investigate potential racial discrimination and harassment in primary care.

Next Steps: The London Primary Care in Workforce Race Strategy

This first ever London-wide survey of discrimination and harassment in primary care provided quantitative evidence of staff experiences and gave the respondents an opportunity to put these experiences into their own, powerful words. Respondents were also asked for their suggestions for changes that they felt would make a difference in primary care.

Key learning included:

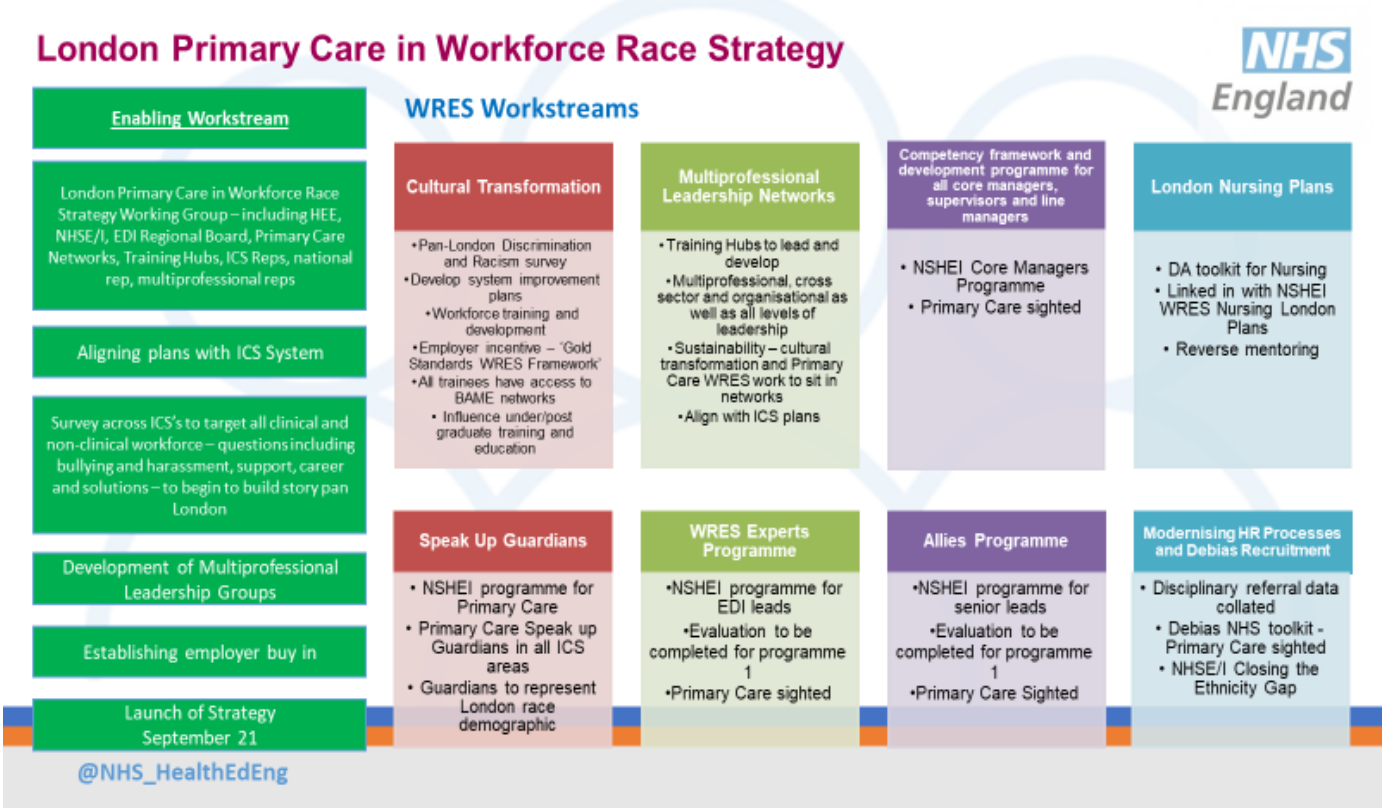
- racial discrimination and harassment are likely to be widespread in primary care workplaces.
- racial discrimination and harassment can have significant impact individuals, on workforce retention, and on the sustainability and quality of services.
- there is no easy solution, and mitigations will be needed at many levels.
- it is essential that the impact of interventions is monitored - implementing the Workforce Race and Equality Standard in primary care is key to this.

Findings from the survey work feed into the work of the London Primary Care in Workforce Race Strategy Working Group, established in March 2021. Working with regional primary care leaders and stakeholders, the group agreed 8 workstreams from the London Workforce Race Strategy Standards (2020) to implement in Primary Care. These form the basis of the **London Primary Care in Workforce Race Strategy** (table 1).

We have reviewed these existing priorities and workstreams in the light of the survey findings to ensure that they remain pertinent and to incorporate suggested changes as appropriate (table 2).

We will continue working in partnership with stakeholders and providers in primary and community care, applying the principles of the London workforce race equality strategy, to build a valued and inclusive primary care workforce in London.

Table 1:



Source: London Primary Care in Workforce Race Strategy, London Primary Care in Workforce Race Strategy Working Group, 2021

Table 2:

Review of how the agreed strategy addresses the survey findings

Common Survey Suggestions	WRES priority activities	Description of initiatives
Training on diversity and unconscious bias **Enabling confidence** to raise and deal with issues	Cultural transformation programmes for London. Competency framework and development programme for managers and supervisors	Stakeholders took part in a workshop in March 2022 to review suggestions from the survey and consider appropriate training for Primary Care colleagues.
An **independent body**, task force or group to investigate concerns raised and support workers to speak up	Freedom to Speak Up Guardians (FTSUGs) WRES Multi-professional Leadership Networks (WMPLN)	Primary care FTSUGs and WMPLNs to be developed in all ICSs, to serve as independent bodies where primary care employees can seek advice and support if they have concerns relating to discrimination or harassment of any type.
A **zero-tolerance campaign and policies**	Cultural transformation programmes for London	Development of a 'Gold Standards Workforce Race Equality Strategy Framework'. – a recruitment and retention tool for practices. Practices

		will be asked to pledge to promote race equality, and be supported to meet the criteria and receive a 'Gold Standards WRES Framework Stamp' Zero tolerance policies will be a significant part of the framework.
Safe spaces	WRES Multi-professional Leadership Networks in Primary Care	WMPLNs will serve as safe spaces to discuss and report discrimination and harassment. Formation of staff and trainee networks
A primary care leadership and workforce that reflects the diversity of local communities	Modernise HR processes and de-bias recruitment Implement the key recommendations from the London Nursing Plans London-specific WRES Experts and White Allies Programmes to be extended to primary care to build London's capacity and capability	The NHS Debias Toolkit will be adapted for Primary Care *'to ensure all those involved in recruitment … are aware of how bias exists …and what actions they can take to ensure the process is equitable'.*[10] The London NHS Region is committed to developing nursing, midwifery and allied health professionals that reflect the multicultural, multi-ethnic patients/communities served in the London region. And to see diversity in senior roles driving change in Primary Care. The WRES Experts Programme supports *'participants to develop as leaders… able to influence the shift and cultural changes necessary to bring about race equality in organisations'*[11] The White Allies Programme to support leaders to *'take up the responsibility for change so that we can look towards a better future with a much more diverse leadership group'*[12] Primary Care will be included in cohorts moving forward.
Standardised policies and protocols	Cultural transformation programmes for London Establish WRES Multi-professional Leadership Networks in Primary Care	Development of 'Gold Standards Workforce Race Equality Strategy Framework' to engage all PCNs and practices to standardise policies and protocols responding to discrimination and harassment. WMPLNs developed in all ICSs, will be responsible for signposting as well as promoting and simplifying processes for colleagues in need of support.

[10] DeBias Recruitment Interactive Final.pdf
[11] WRES-Cohort-3-bios-booklet.pdf (england.nhs.uk)
[12] LWRS.pdf (mcusercontent.com)

Enabling meaningful cultural change is challenging, takes time and requires collaboration across system partners and support of local employers. The London Primary Care Workforce Race Strategy Working Group will continue to work closely with the EDI Sub-Group (Delivery Board), EDI Reference Group and the ICSs, as well as national partners, to ensure plans are aligned, and support is provided where needed to ensure maximum impact as well as sustainability of interventions. A post survey pan-London workshop took place in March 2022 to provide system partners the opportunity to respond to the survey and discuss ways to address the suggestions made in it.

Going forward:

- The London Primary Care in Workforce Race Strategy Working Group will continue to support Training Hubs in the development of the Primary Care WRES Multi-Professional Leadership Networks.
- Primary Care colleagues will have access to Speak up Guardians and staff networks in all ICS areas.
- All primary care colleagues have access to EDI training in all ICS areas.
- A regional task and finish group will be established to develop the 'Primary Care WRES Gold Standards Framework'.
- The London Primary Care in Workforce Race Strategy Working Group will continue to work collaboratively with the Equality and Inclusion Workforce NHS England and NHS Improvement team providing support where needed in relation to the Core Managers Programme, White Allies Programme, WRES Experts Programme, NHS Debias and Selections toolkit as well as programmes to help close the ethnicity gap in relation to disciplinary procedures.
- The London Primary Care in Workforce Race Strategy Working Group will continue to connect with the London Workforce Race Strategy (LWRS) - Nursing and Midwifery Steering Group providing support in development and training opportunities for nurses and AHPs in Primary Care.
- The London Primary Care in Workforce Race Strategy Working Group will work closely with HEIs to establish current provision of education and training in undergraduate and postgraduate courses.

"The main issue is to listen and support our colleagues as the hurt and offence that we all experience can only be healed by the support we receive from our peers."

The impact of interventions will be carefully evaluated, and progress will be monitored by the planned national primary care workforce survey which, like the NHS staff survey used by NHS Trusts, contains questions that will allow us to monitor changes in the experience of discrimination and harassment in the primary care workforce. Our survey is a good starting point to help us have conversations and move towards the ambition of making sure that everyone in the NHS can work in an environment that is safe, welcoming, and free of discrimination and harassment.

Dr Naureen Bhatti, Primary Care Strategic Lead for WRES and DA, HEE London
Jonathan Sampson, Senior Programme Manager, Workforce, Healthy London Partnership
Dr Debra de Silva, Head of Evaluation, The Evidence Centre
Sarah Swinfin, Primary Care School Programme Manager, HEE London
Carrianne Green, Project Support Officer, Primary Care School, HEE London
Dr Rachel Roberts Primary Care Dean and Primary School Board Chair, HEE London

Annex 1
Pan-London survey of the primary care workforce – methodology and findings

All NHS staff deserve to work in an environment that is safe, welcoming, and free of discrimination.

90% of all patient consultations take place in primary care. Yet despite over 5 years of NHS WRES data, we don't know what our staff in primary care experience because we have not asked them"

Dr Navina Evans CBE
Chief Executive, HEE

Acknowledgements

Many thanks to the independent team from The Evidence Centre, led by Professor Debra de Silva - Head of Evaluation.

Health Education England and NHS England and NHS Improvement would like to thank everyone who took part in the survey and everyone who contributed to promoting it.

The content of this report reflects the views of the individuals that provided feedback, not necessarily the views of Health Education England, NHS England and NHS Improvement or any other organisation.

What did we do?

Aim

The aim of London's primary care discrimination and harassment survey was to:

- give members of the primary care workforce an opportunity to share their experiences
- begin to quantify the extent to which people are experiencing discrimination and harassment in the workplace, and the types of discrimination experienced
- collect information that can be used as a baseline, to help track changes over time
- Provide evidence to support London's Workforce Race Equality Strategy in Primary Care,

How did we invite people to share?

We undertook an anonymous online survey with people working in primary care, including general practice, community pharmacy, optometry and dentistry.

A short online survey was developed with the support of an independent team[13]. We based the questions on our key aims and drew on questions and topics used in other surveys such as the NHS staff survey and discrimination surveys used in other parts of the country. We pilot tested the questions with over 60 people working in primary care, so the wording and format was easy to understand and use and was coproduced based on what was important to the workforce.

Over a 7-week period in November/December 2021, we promoted the survey across the workforce, including through:

- newsletters and bulletins
- social media
- meetings and forums
- Primary Care School contact lists, including trainers, trainees, deans, practice managers, clinical directors
- Local Medical Committees, Local Pharmacy Committees and Local Dental Committees
- Integrated Care Systems, GP Federations, Training Hubs and Primary Care Networks
- Equality, Diversity and Inclusion leads, boards, and reference groups
- mailing lists for pharmacy, dentistry, optometry, and GP locums

We sent four reminders to each group, approximately every two weeks, and included information on social media and in bulletins weekly.

[13] Professor Debra de Silva, Head of Evaluation, The Evidence Centre

Interpreting the findings: things to bear in mind

London's first ever primary care discrimination and harassment survey is part of a journey to support the workforce, create better working environments and develop a London Workforce Race and Equality Strategy. It is one component of understanding where we are now and to help us plan practical next steps. We are aware that there are limitations with the approach we used. We need to bear these in mind when interpreting the results. They include:

- Discrimination and harassment are complex and multifaceted. A short survey is not the best tool for gaining a detailed understanding of people's experiences. We chose a survey in order to hear from a large number of people working in wide range of roles in primary care quickly and because one of our goals was to quantify the proportion of people experiencing discrimination and harassment.

  We surveyed people in November/December 2021, which was an exceptionally busy time for primary care. In addition to winter pressures, primary care was coping with the emergence of the Omicron COVID-19 variant and implementation of the Covid-19 vaccination programme.
- Our survey tells us about the perceptions and experience of people who chose to respond. It does not give us 'factual' accounts or explore the 'accuracy' of people's perceptions as we were interested in lived experience.

- We cannot use the survey to generalise to the whole workforce. We promoted the survey widely, but some people may have been more likely to hear about it, want to respond and feel comfortable responding. This includes people who have access to email and the internet and the ability to respond privately; those who are interested in the topic and those who feel confident that there will be few negative consequences from sharing their stories. People who experienced discrimination may have been more likely to respond, but our invitations asked people to tell us whether they had experienced discrimination, rather than targeting mainly those who had something to report. We also aimed to gain feedback from at least 1,000 people to get insights from people with different roles, from across London and with various personal characteristics. This gives us more confidence that we are hearing a range of experiences, but we do not seek to extrapolate or assume that those who did not respond have similar experiences.

- Those from community pharmacy, dentistry and optometry were not well represented and this is a gap to build on.

- It can be tempting to focus on numbers in the findings. However, it is important that we look at the broad trends - the important point is whether a significant proportion of people felt they experienced discrimination or harassment, not the exact proportion.

Despite these issues, the survey provides a good starting point to help reflect and plan next steps.

Who took part?

1,025 people shared their views:

- 176 working in North Central London
- 286 working in Northeast London
- 134 working in Northwest London
- 244 working in Southeast London
- 181 working in Southwest London

This represents about 3% of the total primary care workforce in London or 4% of the general practice workforce (Table 1). The workforce outside general practice was not well represented.

Table 1: Number of people taking part in survey compared to total primary care workforce

Group	Number taking part in survey	Total in London	% of total surveyed
Community pharmacy	38	4,518	Under 1%
Community dentistry	6	4,179	Under 1%
General practice	926	25,210	4%
Community optometry	55	2,500	2%
Total	**1,025**	**36,407**	**3%**

Note: The 'Total in London' is based on latest available figures, including the 2021 pharmacy survey (released January 2022), October 2021 figures from NHS Digital for general practice and estimates from sector colleagues. The number of clinical support roles and administrative roles are not known outside general practice, so these numbers likely underestimate the workforce outside general practice.

Figure 1 shows the characteristics of people who took part. Two thirds of participants were from ethnic minorities (66%). We know that 44.9% of London NHS staff are from ethnic minority backgrounds[14], but we do not have data for primary care staff. Three quarters of people responding were female and 80% of the total general practice workforce in London is female.[15]

The age profile of those surveyed was similar to the total general practice workforce. 41% of those taking part in the survey were 51 or older, which is comparable to 41% in the general practice workforce who are aged 50+[15].

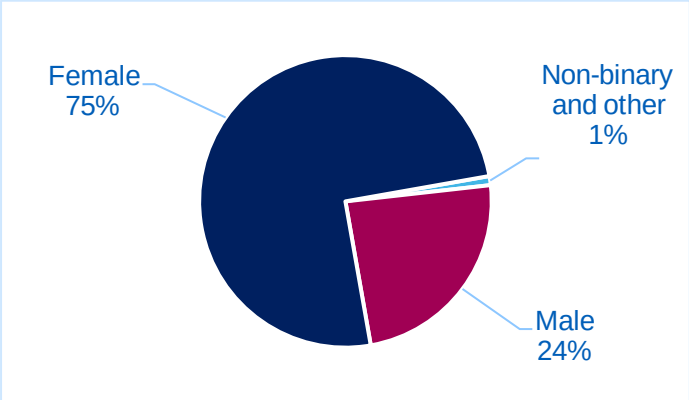
A slightly higher proportion of GPs completed the survey compared to the total in the general practice workforce (37% in the survey compared to 30% of the total workforce), but the proportion of those in administrative, nursing and other direct patient-facing roles surveyed was broadly similar to the total workforce.

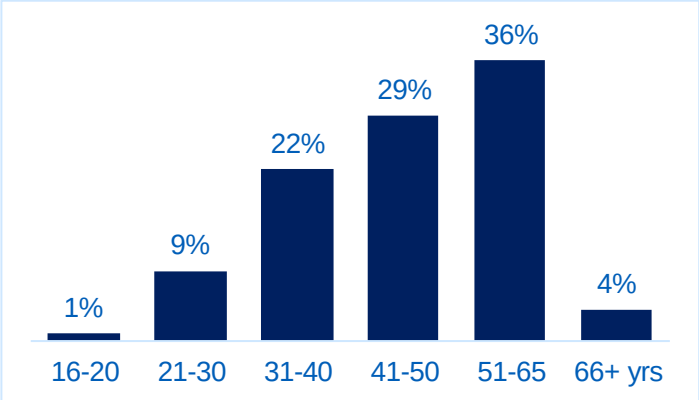
Thus, **although the overall proportion of the workforce responding to the survey was small, those surveyed had similar demographic characteristics to London's general practice workforce as a whole**. This provides more confidence in the feedback, as people from a relatively representative range of ages, genders, ethnicities, and roles took part.

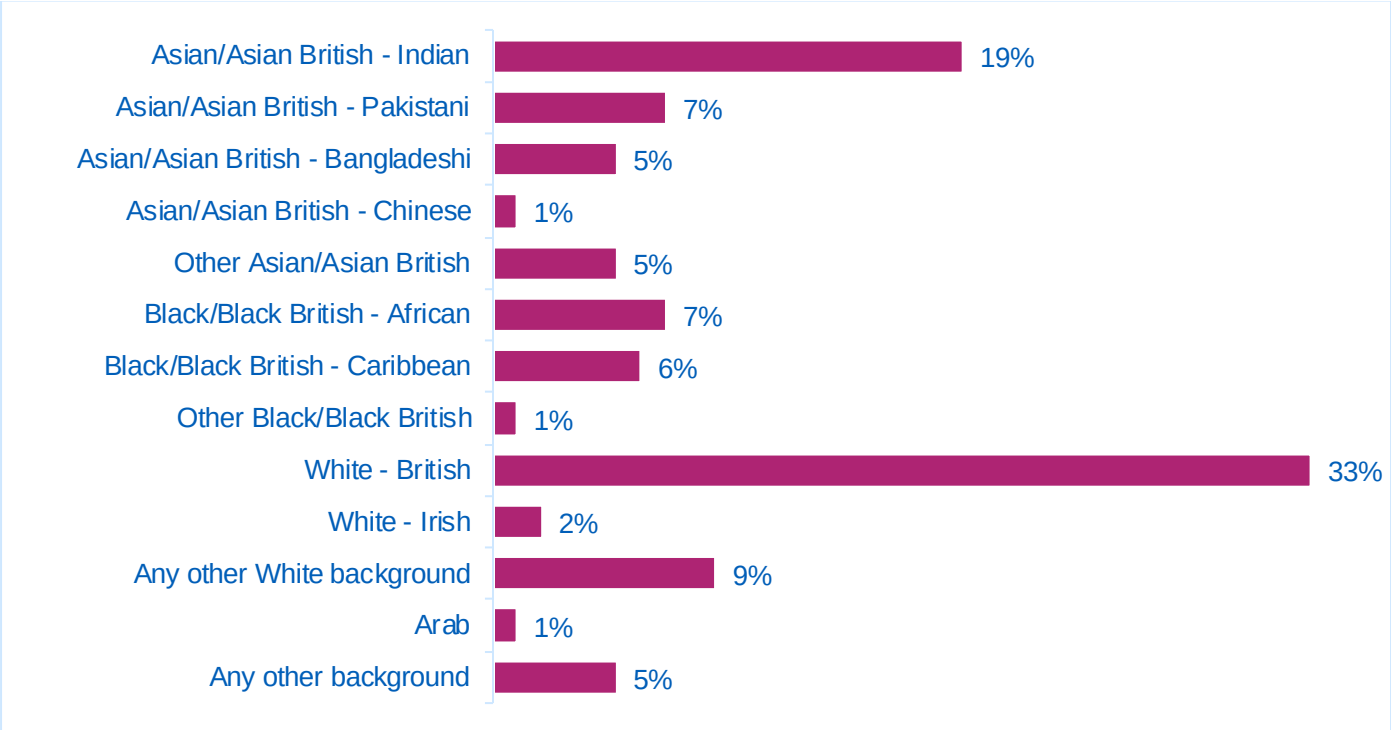
[14] LWRS.pdf (mcusercontent.com)

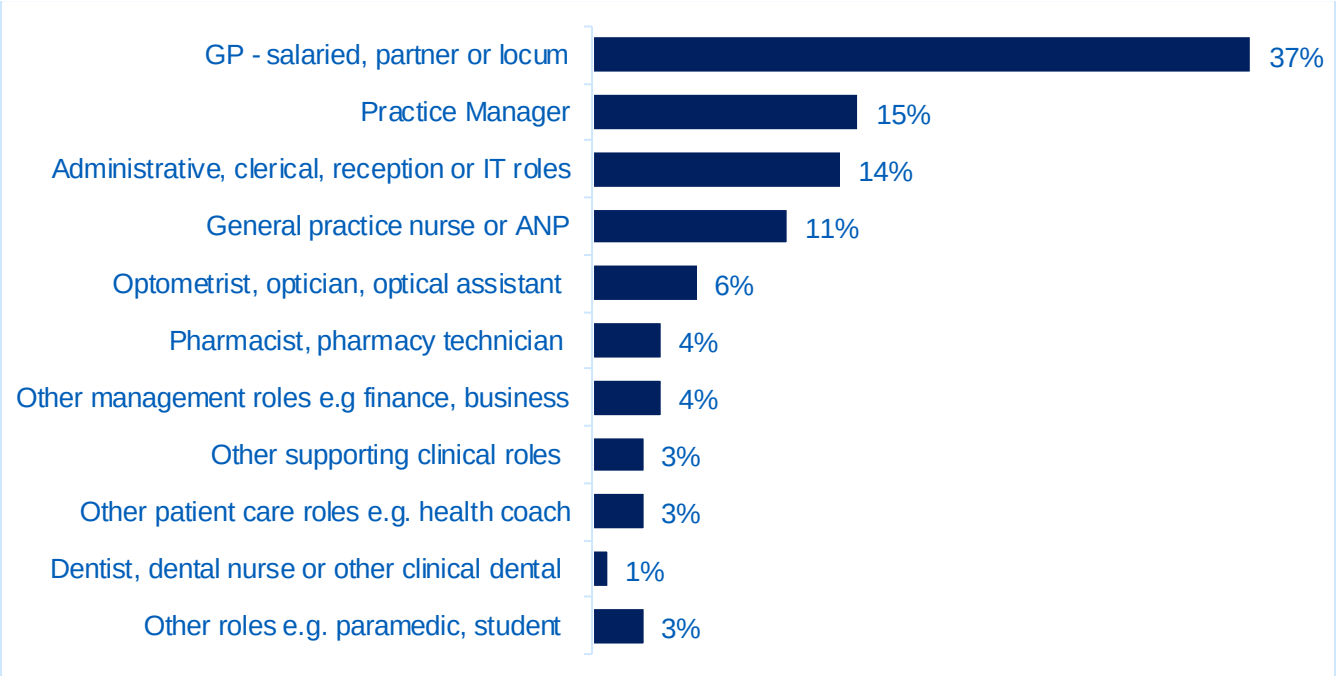
15 Comparative proportions are based on October 2021 figures from NHS Digital. They use numbers for the general practice workforce in London, as numbers for other types of primary care were not readily available. The proportion of people from different ethnic groups in London primary care was not readily available to compare with.

Figure 1: Characteristics of people taking part in the survey









What did we find?

This section describes how many people said they experienced discrimination or harassment in their primary care work in 2021 and the impact it had on them.

Extent of discrimination and harassment

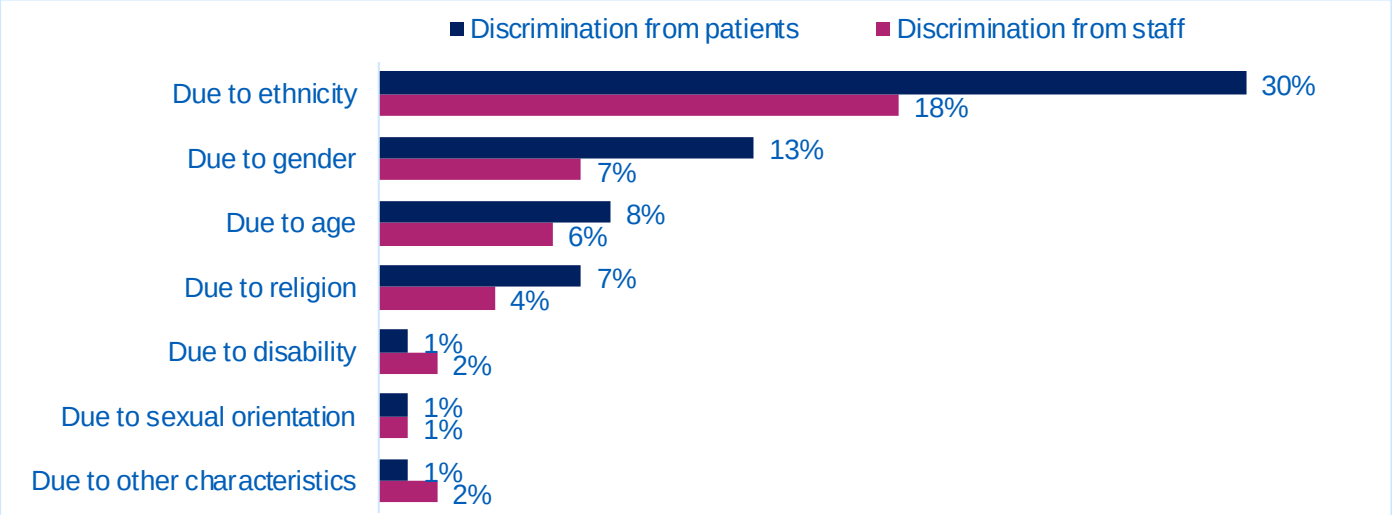
Half of those taking part in the survey said they had experienced one or more types of discrimination or harassment during their primary care work in the past 12 months (49%).

We defined the words 'discrimination or harassment' in the survey to mean any bullying, abuse or being treated differently due to people's personal characteristics. Apart from this we did not seek to define the terms or differentiate between them because we were interested in people's perceptions of being treated differently, defined in whatever way was meaningful for them. Throughout this report we often use the term 'discrimination' to cover all elements. These figures reflect people's perceptions, rather than attempting to quantify the 'accuracy' of those perceptions.

4 out of 10 people said they had been discriminated against or harassed by patients (39%). 3 out of 10 felt that their primary care colleagues or managers had discriminated against or harassed them in the past year based on personal characteristics (29%). (Figure 2)

Discrimination or harassment due to ethnicity was the most frequently perceived, followed by discrimination or harassment based on gender and age. The trends were broadly similar across different role types, where numbers were sufficient to compare (Table 2).

Figure 2: Proportion who experienced discrimination based on personal characteristics



Note: The survey asked 'In the past 12 months have you personally experienced any discrimination or harassment in your primary care work from patients, their relatives or members of the public due to your personal characteristics? Choose as many as apply.' Another question asked about colleagues or managers. Characteristics were listed and people were invited to describe any other characteristics. 'Other' characteristics mentioned were appearance (size, weight, scars, tattoos), pregnancy, whether or not people had children and 'class' based on education or accent.

We recognise that people are multifaceted, and there is intersectionality in people's identity and experience so it may be difficult to attribute the reasons for discrimination to a single characteristic. In line with this, as well as being more likely to experience racial discrimination, there was a trend towards those from minority ethnic groups being more likely to say they had experienced discrimination based on age, gender and religion than those from White British or Irish groups (Table 3).

The appendix contains more detailed breakdowns of the proportion of people from various ethnic groups and roles reporting discrimination or harassment based on their personal characteristics.

Table 2: % of different roles who said they experienced discrimination in past 12 months

	% stated discrimination by patients due to …						% stated discrimination by staff due to …					
Role	age	disability	ethnicity	gender	religion	sexual orientation	age	disability	ethnicity	gender	religion	sexual orientation
Nursing	8	3	30	9	5	1	5	3	19	4	3	0
GP	7	1	32	18	7	1	6	2	18	8	6	1
Other practice direct care roles	7	0	22	10	3	3	3	3	15	4	0	3
Administrative and managerial	8	1	27	9	6	1	7	1	16	5	2	1
Dental roles	0	0	50	50	17	0	0	0	17	0	17	0
Optometry roles	7	0	33	7	9	2	4	0	13	6	2	0
Pharmacy roles	13	0	40	13	21	0	21	0	37	16	11	0
Other roles	22	0	19	22	4	4	7	7	19	11	0	0

Note: Based on 109 people in nursing roles, 365 GPs, 68 other direct care roles in general practice, 332 administrative, clerical and managerial roles in any part of primary care, 6 dental direct care roles, 55 optometry roles, 38 direct pharmacy roles and 27 other roles. The number of people in roles outside general practice are too small to draw conclusions from. The question wording is provided underneath Figure 2.

Table 3: % of different ethnic groups who said they experienced discrimination

	% discrimination by patients due to …						% discrimination by staff due to …					
Ethnicity	age	disability	ethnicity	gender	religion	sexual orientation	age	disability	ethnicity	gender	Religion	sexual orientation
Asian or Asian British	10	1	45	16	13	1	8	1	23	10	6	1
Black or Black British	12	2	53	13	2	1	13	4	42	7	2	0
White British or Irish	6	1	7	10	1	2	3	2	4	5	1	1
Other White background	7	1	19	12	3	0	4	0	10	1	3	0
Other background	11	0	39	15	18	2	8	3	27	7	11	2

Note: Based on 365 people from Asian backgrounds, 136 Black, 353 White British or Irish, 90 other White backgrounds and 62 from other backgrounds. People could choose more than one ethnic background. The appendix contains data for more specific ethnic background categories. The question wording is provided underneath Figure 2.

Racial discrimination and harassment

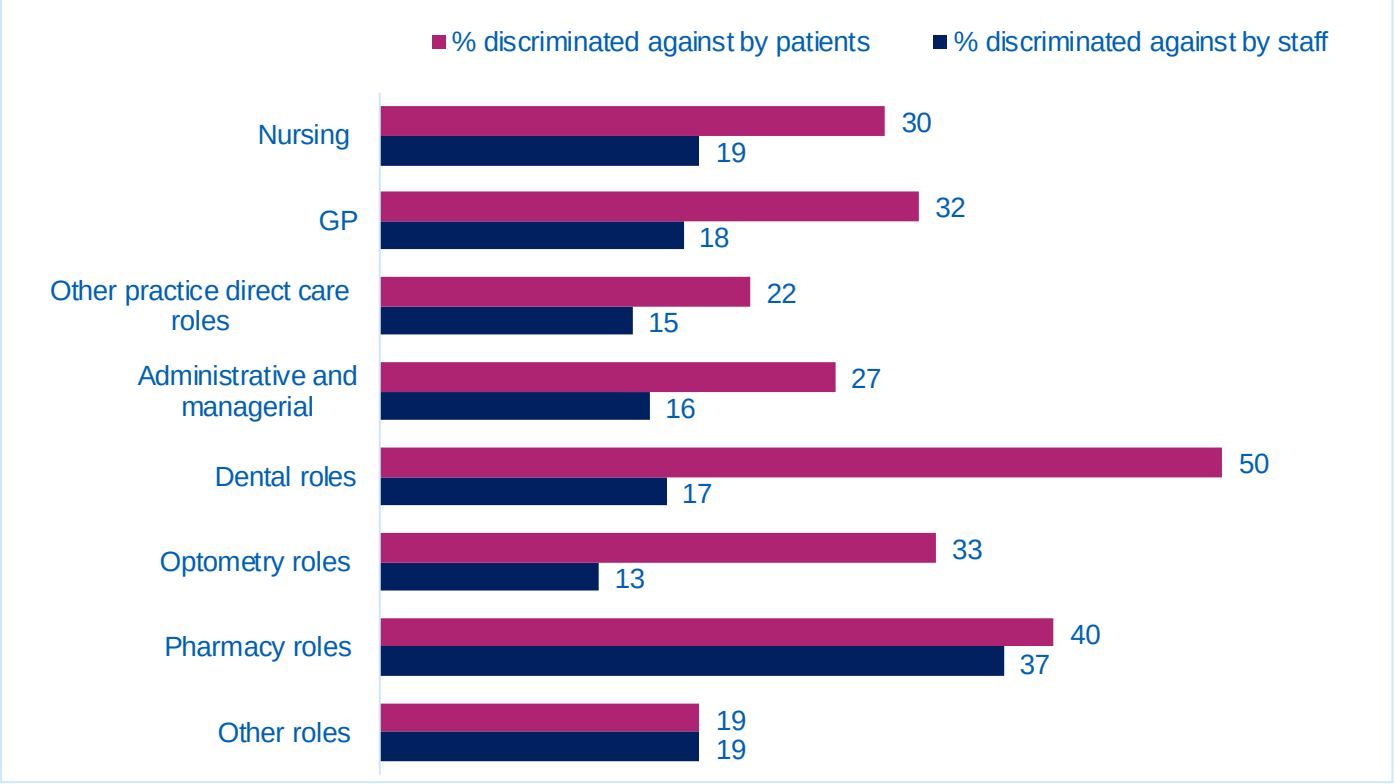
How many people experienced racial discrimination or harassment?

About 1 in 3 people surveyed said that they had felt racially discriminated against or harassed by patients in the past 12 months (30%) and 1 in 5 by staff (18%).

This trend was replicated in nurses, GPs and administrative and managerial staff (Figure 3). GP Partners were just as likely to say they had experienced racial discrimination or harassment as salaried GPs. There was a trend towards GP locums being even more likely to say they experienced racial discrimination or harassment from patients and from colleagues in primary care, though the small number of locums responding to the survey makes it difficult to know whether this occurred by chance (see appendix).

Slightly fewer of those in other patient-facing roles in general practice said they experienced racial discrimination or harassment and slightly more in dental and pharmacy roles, although the numbers responding to the survey from these groups were too small to make valid comparisons.

Figure 3: % of roles who said they experienced racial discrimination in past 12 months



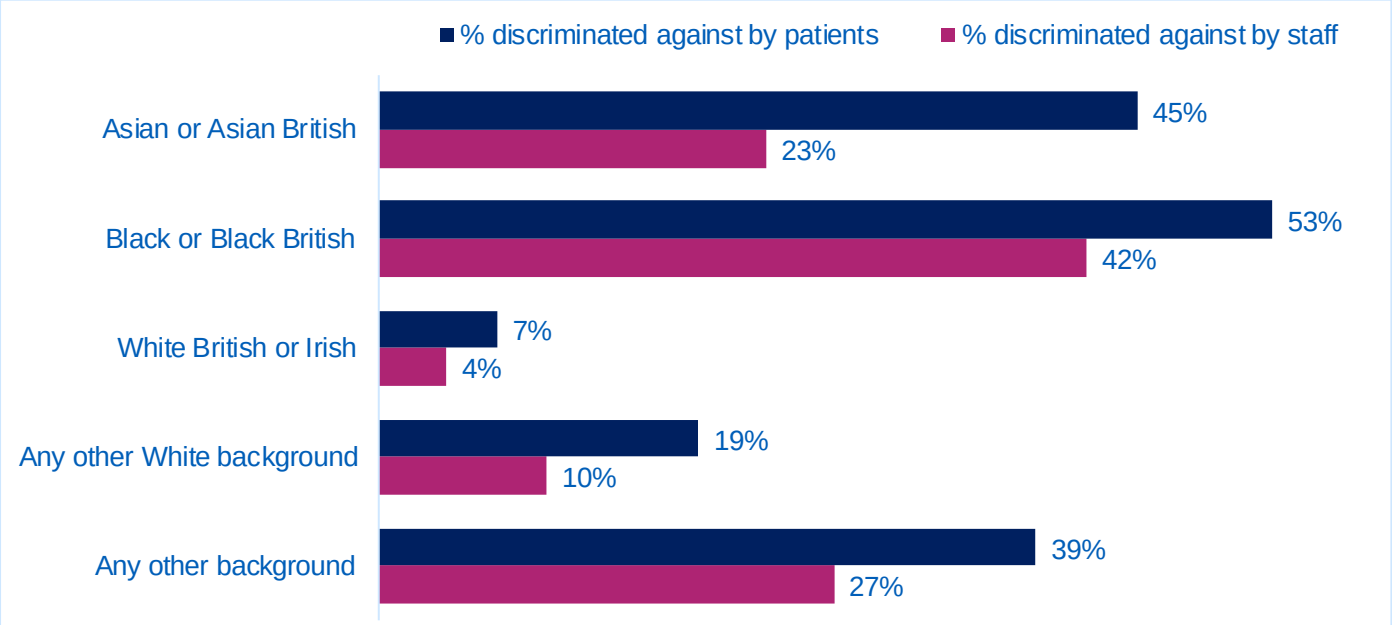
Note: Based on 109 people in nursing roles, 365 GPs, 68 other direct care roles in general practice, 332 administrative, clerical and managerial roles in any part of primary care, 6 dental direct care roles, 55 optometry roles, 38 direct pharmacy roles and 27 other roles. The question wording is provided underneath Figure 2.

People from Black and Asian backgrounds were more likely than others to say they had experienced racial discrimination or harassment in the workplace in the past year (Figure 4). Half of all people from Black ethnic backgrounds (53%) and 4 out 10 people from Asian backgrounds felt they had been racially discriminated against or harassed by patients (45%). **The difference was even greater regarding perceived racial discrimination and harassment by colleagues or managers, with 4 out of 10 Black people describing this (42%) compared to 2 in 10 of those surveyed overall** (18%).

It is important to note that racial discrimination or harassment did not refer solely to 'majority' groups discriminating against 'minority' groups. A number from an ethnic minority reported perceived discrimination or harassment by someone from another minority ethnic group.

A small number of people from White British or White Irish backgrounds said they felt discriminated against or harassed by other ethnic groups (1 in 20), such as feeling they were not as favoured for promotion or other opportunities.

Figure 4: Proportion of different ethnicities who said they experienced racial discrimination



Note: Based on 365 people from Asian backgrounds, 136 Black, 353 White British or Irish, 90 other White backgrounds and 62 from other backgrounds. People could choose more than one ethnic background. The question wording is provided underneath Figure 2.

What type of racial discrimination did people experience?

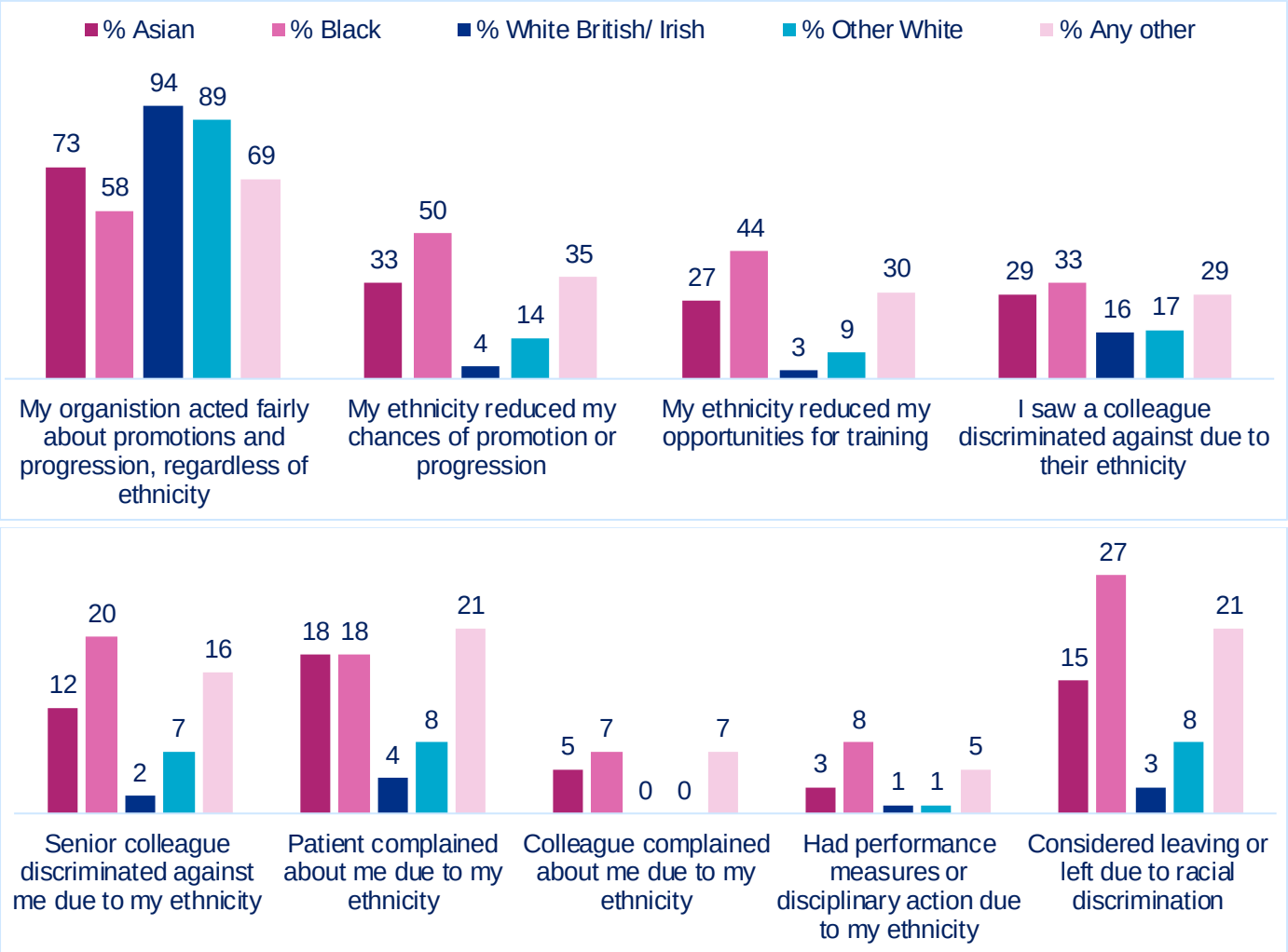
Perceived racial discrimination or harassment took many forms, including direct or subtle comments or behaviours, feeling overlooked or less favoured for opportunities and more systemic and structural manifestations.

A **significant proportion of people from ethnic minorities believed that their ethnicity had impacted their work opportunities over the past year**. People from White ethnic backgrounds were more likely than others to feel that their organisation had acted fairly regarding promotions and progression over the past 12 months, regardless of people's ethnicity. Whereas people from Black and Asian backgrounds were more likely to believe that their ethnicity had reduced their opportunities for promotion and training over the past 12 months (Figure 5).

People from Black and Asian backgrounds were also more likely to say that a patient had complained about them based on racial grounds. About 1 in 5 Asian and Black people perceived this.

The appendix contains more detailed breakdowns by role, ethnicity and geographic area.

Figure 5: Views about impact of ethnicity on opportunities and behaviours in past year

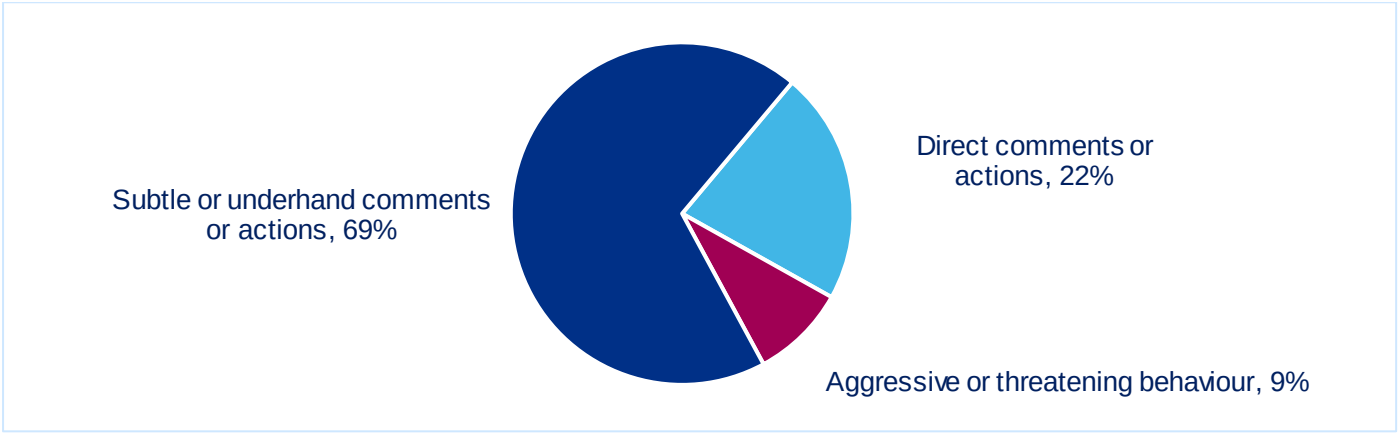


Note: All of the questions above asked people to reflect on the past 12 months. The numbers upon which the percentages are based are listed underneath Figure 4. The questions about promotion and training invited people to agree or disagree. All other data are from the question 'In the last 12 months, did you experience any of the following? Choose as many as apply or leave blank if nothing applies to you.'

388 people shared details of perceived racial discrimination or harassment based on their ethnic background. Thinking about the most recent instance of racial discrimination or harassment in the past 12 months:

- 7 out of 10 people said this involved subtle comments or actions (69%)
- 2 in 10 described explicit comments or actions (22%)
- 1 in 10 said they had experienced aggressive or threatening behaviour, mostly from patients (9%)

Figure 6: Types of recent racial discrimination at work in past 12 months



Note: Based on 388 people who described their most recent experience in the past 12 months. The question asked 'For anyone who experienced any discrimination or harassment based on your ethnic background, was the discrimination or harassment you experienced mainly…' People then chose from the 3 categories above.

People described a wide range of examples of perceived racial discrimination and harassment, including:

- racial slurs / stereotyping (25% of examples)
- being undermined or put down (18%)
- not being listened to, treated with respect, promoted or prioritised (18%)
- patients expressing a lack of confidence or saying they wanted to see someone else (13%)
- perceived differences in processes or the way things are done based on ethnicity, such as more scrutiny and oversight for some groups or being asked to do tasks others did not want (11%)
- being paid less, receiving fewer employment benefits or having an unfair work rota or leave allocation (9%)
- bullying (7%)
- being called a 'racist' or assumed to be treating people differently based on race (usually amongst White people who felt they were assumed to be doing or saying something based on race) (7%)
- performance measures or complaints that appeared to be based on ethnic background or had 'no justification' (6%)
- feeling excluded from activities (3%)

We did not separate 'discrimination' versus 'harassment' because examples often contained instances of both. We provide some examples in people's own words below. Quotes were selected as representations of what many people said. **These examples are provided as illustrations of people's feedback about their experiences, not to be inflammatory, nor to suggest they are 'factual'. They give a flavour of the variety of experiences people described, as well as their strength of feeling about their lived experience.**

Many of the examples' people provided were descriptions of upsetting and inappropriate comments.

> *"My employers bullied me and made sexist and racist comments to me and other members of staff from the same mixed background as myself. They commented on my religion and would say I'm going to hell because I don't believe what they believe. They failed my probation with no valid reason."*

Other examples included people feeling excluded from workplace activities, discussions or opportunities. Or perceiving colleagues to not be as inclusive as they could be, perhaps inadvertently, such as having social activities based around alcohol or on dates that clashed with religious festivals. Sometimes this was perceived to be intentional, such as not being favoured for leave, training or promotion or not being encouraged to ask for help.

> *"New non-ethnic members of staff hired after me doing the same job on better pay when I have been asking for a pay raise for the last six years. Non-ethnic members of staff receiving training even though I have been asking for extra training each year in my appraisal."*

> *"Hardly any BAME staff in certain roles and at higher levels despite people trying… I am constantly in fear that I will be let go because they will find someone better. I feel unsupported and cannot ask for help for fear of being seen as useless."*

> *"Appointments were shifted from White colleagues to my list. On-screen messages sent only to myself to deal with a task. Declining annual leave even though the request had been put in 4-6 months before, whilst White colleagues got the annual leave dates after my request. Asking me to discuss issues with admin staff when White colleagues have not been asked to do this."*

A number from an ethnic minority reported perceived discrimination or harassment by someone from another minority ethnic group.

> *"Racism can come from minority groups. The (ethnic minority) Practice Manager paid the Black admin staff significantly less than the White staff, and often less than minimum wage. She waged a systematic campaign against me. This eventually triggered an episode of major depression. I took sick leave and left the practice."*

A smaller number of examples focused on more structural, systemic or institutional issues, whereby people felt that systems and processes prioritised some groups of people over others. These types of comments were more commonly from people in more senior roles.

> *"Unconscious bias is sewn into the fabric of the NHS. Very junior inexperienced White colleagues invited to senior positions in the CCG, GP Federation and Primary Care Network. Relevant experience with additional qualifications is discarded if you are non-White. It's so*

overt. Culture is so biased against race, religion and gender. Ethnic minorities are there to do the coal face work whilst White colleagues get promoted to managerial and strategic roles."

"Federation RAG-rated practices. Poorly performing were all small Asian-run practices. All-White members of the Federation unable to explain criteria and no support provided to member practices who were deemed 'inadequate' despite these practices being rated good by CQC."

Linked to broader structural issues, some people provided examples of a perceived culture of acceptance of discrimination or a lack of challenge or support from leadership. People often commented that this 'standing by' was more hurtful and harmful than the initial instance of discrimination or harassment. This led some to feel that they were working in a 'hostile environment' where negative attitudes were often not openly challenged.

*"One of our receptionists was called a n**ger by a patient and I witnessed this patient assault other receptionists by throwing something at them and shouting. I was distressed by this incident but more deeply distressed by what I perceived as a lack of leadership and action taken by my practice. The junior practice manager arranged removal of the patient, however not a single partner spoke to myself or any of the receptionists involved."*

"I am regularly told by patients that there are too many Indians in the NHS, other people don't have a job since 'your lot' arrived and all opticians are 'Pakis' now. Colleagues stand by and say nothing."

How did racial discrimination affect people?

People passionately described the impact of racial discrimination and harassment. In many cases, they reported that recent incidences were part of a long history of discrimination or harassment, both in the workplace and in wider society.

"As a minority group nurse and a woman, I have experienced discrimination and harassment throughout my career. I had moments when I had to call a colleague to chaperone while I was carrying out care as I was scared of being with the patient on my own. These experiences have definitively impacted me. It has reduced my confidence, my willingness to help others and made me question my career as a nurse. I am studying for a different career now."

People said the impacts of their experiences of racial discrimination in the workplace included:

- feeling undervalued, unsupported, hurt and demoralised in their role (1 in 5 people who provided examples of racial discrimination)
- leaving their job or going on sick leave (1 in 10)
- serious depression, suicidal thoughts or other significant mental ill health (1 in 20)
- withdrawal from colleagues and feeling isolated (1 in 20)
- reduced performance at work (1 in 20)
- feeling unsafe at work (particularly related to aggression from patients) (1 in 20)

People talked about how their experiences left them feeling unvalued and demotivated.

"Worked through the whole COVID crisis, only to be called for disciplinary action for breach of COVID rules 3 months after the event. Just used me to keep offering services. I won my case

but I have never felt so demoralised and unappreciated in my life. I would rather go drive an HGV than do this job right now."

"Seeing that I was being treated differently compared to my colleagues made me feel as if my feelings and opinions were not worthy. Discrimination makes me feel worthless and sad that I have given so much yet not appreciated. White bureaucrats discriminate and they harass you into feeling that you are not doing a good job."

Some people spoke about feeling 'ground down' by what they perceived to be constant racial harassment and discrimination. Rather than seeking to differentiate the causes and individual circumstances of people's stories, the important thing is to acknowledge that people felt their experiences were racially motivated – and that some people said that they had suffered significantly as a result of their experiences.

"Malicious and vexatious complaints that had no basis. Investigated, had performance measurements put in place with no evidence provided as to why. Obvious it was discrimination. Felt suicidal and severely affected my mental health."

"People from ethnic minority backgrounds are treated less favourably. My stress level increased, had to seek help from 'Looking After You' team for managing my anxiety and find a way to deal with difficulties at work."

"Two senior managers harassed, bullied, constantly scrutinised and undermined my work, found fault in everything I did. This largely dented my confidence and resulted in my doctor signing me off with stress."

As well as affecting individuals significantly, people said that racial discrimination and harassment also has the potential to negatively affect workplace morale, productivity, and retention.

"Colleagues say things and act towards you in a discriminative way. You do not feel like interacting with that person anymore or even speaking to them. This does not help team morale nor does it lighten the atmosphere to make the work an enjoyable experience."

12% said that they had considered leaving or had left their role in primary care over the past 12 months as a result of racial discrimination or harassment.

"My boss treated me badly and got rid of me and replaced me with newly qualified nurses due to my religious and ethnic background. I approached the lead nurse but did not allow me to discuss. Treated me differently. So I changed my role and left the job. Boss is the king and has no one to challenge him about his work and attitude."

About **one quarter of people from Black backgrounds (27%) and 1 in 7 people from Asian backgrounds (15%) said that they had considered leaving or had left their role in the past year due to racial discrimination** or harassment (Figure 5).

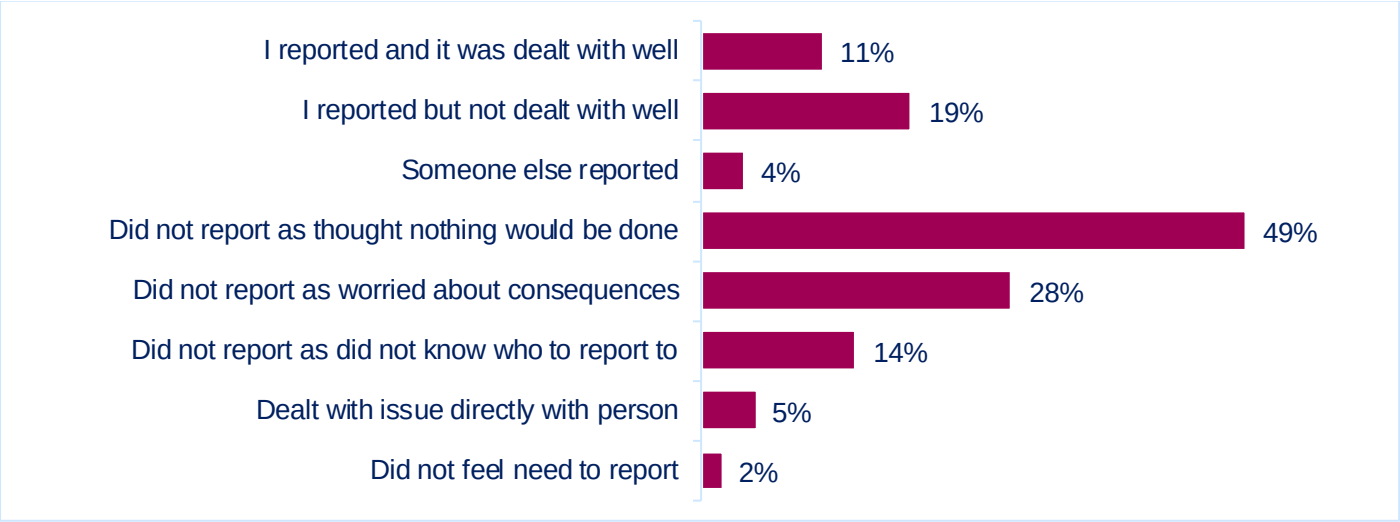
Ethnic background was a greater predictor of whether people said they considered leaving due to racial discrimination than people's role, age, gender or religion. 15% of nursing staff, 11% of GPs and 13% of administrative and managerial staff said they had considered leaving or had left their role in the past year due to racial discrimination, so these proportions were relatively similar across roles.

Addressing (racial) discrimination and harassment

Is racial discrimination dealt with appropriately?

Of the 388 people who said they had experienced racial discrimination or harassment in the past year, **1 in 3 said they or someone else reported it** (Figure 7). **Only 1 in 10 said they reported it and it was dealt with well** (meaning that they were satisfied with the way it was handled and/or the outcome).

Figure 7: % that reported or did not report racial discrimination at work in past 12 months



Note: The survey asked 'Did you report the harassment or discrimination? Choose as many as apply.' Percentages add to more than 100% as people could provide more than one reason for not reporting. Percentages are based on the 388 people who said they had experienced racial discrimination or harassment in the past year.

Table 4: % of different roles and ethnicities who reported the racial discrimination

	Number who experienced racial discrimination	% reported and dealt with well	% reported but not dealt with well	% someone else reported	% did not know who to report to	% did not report as nothing would be done	% did not report as worried about consequences
Asian or Asian British	202	10	16	4	15	**53**	27
Black or Black British	90	7	**29**	2	12	43	32
White British or Irish	35	**29**	20	9	11	37	11
Other White background	23	**22**	17	0	17	39	22
Other background	32	6	9	6	16	**59**	41
Nursing	36	6	42	8	11	39	25
GP	151	11	13	2	17	50	32
Other direct care roles	20	5	20	0	0	65	25
Administrative and managerial	116	15	23	8	11	45	28
Dental roles	5	40	0	0	60	20	20
Optometry roles	21	19	10	0	14	67	10
Pharmacy roles	17	0	29	0	6	53	18
Other roles	11	0	9	0	27	45	9

Note: The question wording is in Figure 7. The percentages are based on the 'number' column in the table above. Many of the numbers are too small to make meaningful comparisons.

People from White backgrounds were more likely than those from Black, Asian and other backgrounds to say that they had reported discrimination or harassment against themselves, and it had been dealt with well, though this was based on small numbers.

Although one third of Black people who experienced racial discrimination or harassment said they had reported it, most did not feel that the issue had been dealt with well.

People from Asian and other ethnic minority backgrounds were less likely to have reported the racial discrimination or harassment, most commonly because they said they did not think anything would be done.

People in nursing roles were more likely than other roles to say they had reported racial discrimination or harassment, but they usually did not feel that the issue had been dealt with well. GPs were less likely than many other roles to say they had reported racial discrimination or harassment, often because they said they did not think anything would be done.

Support with any type of harassment or discrimination

Regardless of whether they experienced any discrimination or harassment, we asked if people knew where to get support with any harassment or discrimination at work (not solely related to racial discrimination). Overall:

- 74% of people said that they knew where to go for help with any harassment or discrimination
- 68% said they would feel secure raising concerns about any harassment or discrimination at their place of work
- 68% said they were confident that their workplace would address any such concerns they raised

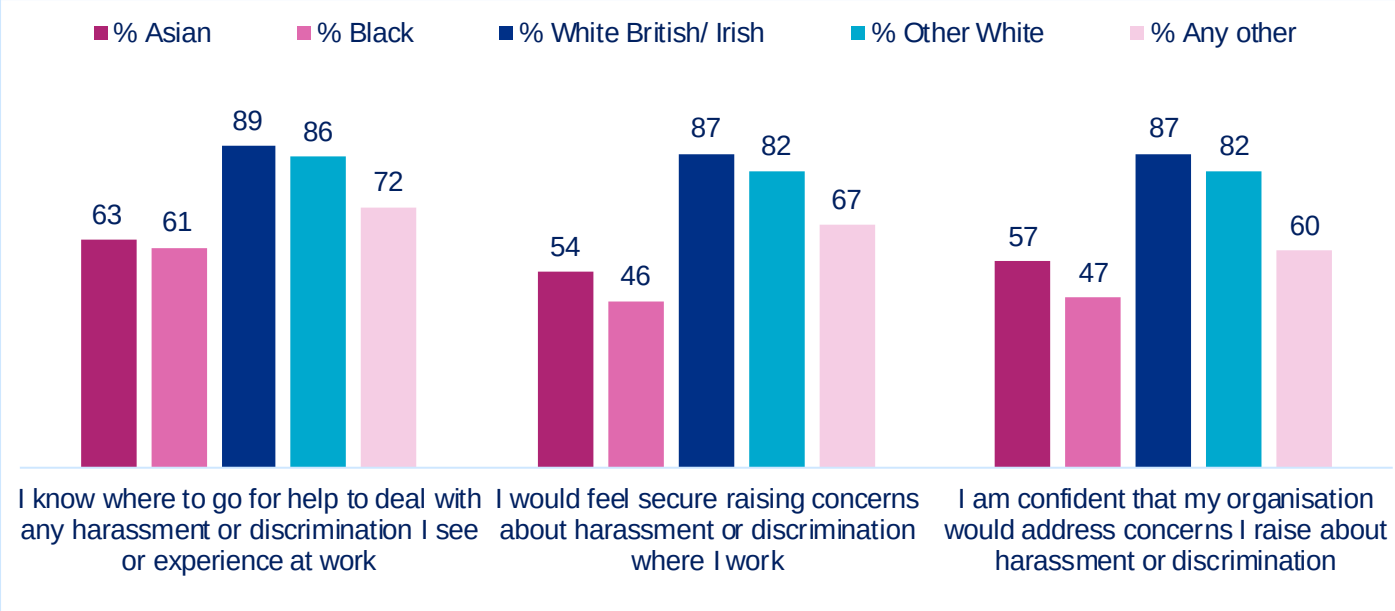
However, there were significant differences based on people's ethnicity and role. People from White backgrounds were more likely than Black or Asian people to say that they knew where to go for help, felt secure to raise issues and believed they would be dealt with. People from Black ethnic groups were least likely to say that they felt secure raising issues and least confident that concerns would be addressed (Figure 8).

Interestingly, GPs were less likely than nursing, other direct care roles and administrative / managerial roles to say that they knew where to go for help (64%), that they would feel secure raising concerns (59%), or that their organisation would address the issue (64%).
GP partners were more likely than salaried GPs or locum GPs to say they knew where to find support (see appendix). Only one third of GP locums said they would feel secure raising discrimination or harassment with a practice where they were working (34%)

Those who said they had experienced discrimination or harassment of any type and those who had experienced racial discrimination or harassment in the past year were less likely to say they knew where to get help, would feel secure raising issues or would feel confident that issues would be addressed. People who said they had experienced racial or other discrimination or harassment from colleagues or managers were least likely to say they would feel secure raising issues or were confident they would be addressed, with less than 1 in 3 believing this (Table 5).

The overall picture was that those from White backgrounds, in the most senior roles and who had not experienced discrimination or harassment, felt most knowledgeable and confident about sources of support, whereas those from minority ethnic groups, in less senior roles and those who had experienced discrimination, were least likely to know where to seek help or to feel that they would be supported.

Figure 8: % that knew where to get help or felt confident raising issues



Note: The survey asked, 'Do you agree or disagree with the following?' Percentages are based on the numbers listed underneath Figure 4. The appendix contains more specific ethnic breakdowns.

Table 5: % of those who experienced discrimination who knew where to get support

	% who experienced racial discrimination from patients in the last 12 months	% who experienced racial discrimination from staff in the last 12 months	% who experienced any discrimination from patients in the last 12 months	% who experienced any discrimination from staff in the last 12 months
Know where to go for help to deal with any harassment or discrimination see or experience at work	55	44	58	47
Would feel secure raising concerns about harassment or discrimination at workplace	43	22	46	27
Confident that organisation would address concerns raised about harassment or discrimination	44	20	48	28

Note: The survey wording is underneath Figure 8. In comparison to the percentages above for people who had experienced discrimination, 74% of all respondents said that they know where to go for help with any harassment or discrimination, 68% said they would feel secure raising concerns and 68% said they were confident that their workplace would address any such concerns they raised.

Steps towards addressing discrimination and harassment

Whether or not they had experienced any type of discrimination or harassment, people surveyed often expressed a desire to see change in primary care, but not knowing how to achieve it.

> *"I regularly see discrimination by patients towards my Black colleagues. My practice is good at dealing with it if it is aggressive and blatant, however some people are subtly racist towards our Black healthcare assistant, not wanting to see her or not trusting her opinion, but not being rude. This is much more difficult to deal with."*

Recognising that there is not a simple or single way to tackle discrimination and harassment in primary care, in open-ended comments, 274 people suggested practical things that they believed would help (regardless of whether they had experienced discrimination or harassment).

Suggestions included:

- **training** about diversity and unconscious bias for everyone working in primary care (33% of suggestions) and helping people feel confident to raise and deal with issues (9%)
- an **independent body**, task force or group to investigate and support, perhaps including an advice helpline and anonymous reporting (21%)
- a **zero-tolerance campaign and policies**, informing patients about what is unacceptable and making it easier to remove patients from practice lists if they behave unacceptably (21%)
- **safe spaces** to discuss and report discrimination and harassment, including meetings, website forums and regular surveys (19%)
- making sure that primary care leadership and the workforce reflects the diversity of local communities, including **recruiting** diverse people to (senior) roles and setting diversity targets (18%)
- **standardised policies and protocols** for responding to discrimination and harassment (6%) and more promotion of processes for reporting and gaining support (6%).

One third of suggestions were about further training and opportunities to discuss discrimination and harassment, learn about other people's backgrounds and beliefs and share experiences. People said that this may help to break down barriers, co-produce solutions and help people understand the impact of discrimination and harassment. Some believed that this type of interaction and training should be mandatory for everyone working in primary care and be repeated regularly. The focus was not necessarily on learning 'facts' or strategies, but rather on opportunities to engage in difficult conversations and build trust amongst team members.

> *"People need to receive updated training. Many people hold archaic views and do not understand the concept of privilege. They don't mean any harmful intent. Their views are offensive, and they don't realise it. Please can we have intensive, thought provoking and expertly delivered training."*

There needs to be unconscious bias training. Ethnic colleagues with decades of experience passed over for promotion in the wider NHS management vs newly qualified White locums promoted instantly to leadership positions."

Linked to this, others suggested providing safe spaces to share stories and experiences. For some this was about having an opportunity to report discrimination or harassment, but for others this was also related to raising awareness about the variety of different types of discrimination and changing attitudes and behaviours across teams. Other people emphasised the importance of funding equality, diversity and inclusion networks and posts.

"Raise awareness it is not just people of colour who experience racism. Being White non-British is like having a hidden disability. No one is willing to acknowledge the racism that occurs."

"More open dialogue that it isn't just between BAME 'vs' non BAME: most discrimination I've faced has been within BAME community. Training/other measures don't directly focus on that. Also occurs within BAME communities between doctor and patient, such as BAME patients expecting different things from BAME health care professionals which can feel doubly oppressive."

Other suggestions focused on strengthening the diversity and inclusiveness of the workforce through recruitment and retention. Whilst a number of people talked about recruiting people from minority group backgrounds to leadership positions, these people were not suggesting that recruitment should be based on 'tick boxes' to achieve diversity, but rather that it was important to make a concerted effort to help everyone have opportunities, regardless of personal characteristics. They also emphasised the importance of having people from various groups in senior posts in primary care as role models who had the potential to change conversations, understanding and expectations.

"Having senior persons who are all Caucasian in a position to make decisions relating to racist incidents/behaviour is not fair. There is a blatant lack of knowledge about what equates to racism and how it affects an individual. This consequently affects how the whole situation is resolved. Situations like this should be presented to a more ethnically diverse group, making it fairer."

Another strong theme was giving those working in primary care access to independent support and advice.

"Having an independent source of help/support, an organisation with 'teeth', where one could take concerns to (outside the practice)."

"Having an external support officer to talk to, as it could be difficult reporting on those in authority, particularly if they the ones to whom you are supposed to talk about discrimination with. It can also be difficult to get an objective perspective if you are required to speak to somebody within the team who is already involved in the dynamic."

People felt that this may be particularly important in primary care given that organisations are relatively small 'standalone' businesses, perhaps with less consistent policies and practices than other healthcare organisations due to ownership and management models. Many raised concerns

about who was holding the leadership of practices and other small primary care organisations to account.

"At GP practices there is no transparency on how staff are treated and why they leave. The GP partners have ultimate control and as such the culture becomes very tight knit. They will not address behaviours from individual partners even when this is quite clearly discriminatory. We need independent help."

"People need to be held accountable for their actions. People want to report the behaviour of senior staff but are too scared to do so out of fear we will lose our job. There is a very strong racial bias and racist undertone especially in senior management. It is very alarming and concerning. There needs to be more support."

As much of the discrimination and harassment that people described came from patients, participants also believed that more could be done to support organisations to address inappropriate comments and behaviours from patients. One in five suggestions related to enforcing zero tolerance policies, communication campaigns for patients and making it easier to remove patients from practice lists.

"Practices should have a zero-tolerance policy to racism to any member of staff. If a patient is abusive, it should be addressed and dealt with promptly and appropriately."

Summary

The survey succeeded in its goal of gaining feedback from at least 1,000 members of the workforce and starting to develop a picture of the impact of people's experiences on individuals, and at organisational and system level. This will inform both the implementation of London's Workforce Race and Equality Strategy in primary care and the extension of the Workforce Race and Equality Standard into primary care.

In interpreting the findings, we need to be cognisant of the context. The survey was undertaken at an exceptionally busy time in primary care and gained feedback from a small (although demographically representative) proportion of the total primary care workforce.

The survey does not give the 'whole picture' in terms of the scope and impact of people's experiences, but it does provide a compelling narrative on the potential scale of racial and other discrimination and harassment in primary care. It is significant as up until now primary care has not been included in the NHS Workforce Race and Equality Standard. The trends mirror previous smaller surveys, both in London and other parts of the country. This gives confidence in the picture being built, and some of the overarching lessons that we can take from our survey:

1. Racial discrimination is likely to be widespread in primary care workplaces.

- In a survey of just 3% of the primary care workforce, over 500 people reported some type of discrimination or harassment based on their personal characteristics in the past year. This demonstrates that the scale of perceived discrimination and harassment is immense.
- Discrimination and harassment based on ethnicity is likely to be the most common type of discrimination experienced by the primary care workforce.
- Whilst racial discrimination and harassment from patients is the most common a 1 in 5 reported racial discrimination and harassment from colleagues too.
- Much racial discrimination and harassment may be subtle, perhaps making it difficult to pinpoint, challenge and 'prove'.
- Discrimination and harassment take many forms and we need to be careful to avoid the assumption that it always involves an ethnic majority discriminating against a minority.

2. Racial discrimination and harassment can have significant impacts.

- People shared powerful accounts of how racial discrimination and harassment had impacted on their wellbeing, career and morale over the past year. The fact that **12% said that they left or considered leaving their role due to racial discrimination or harassment last year** has significant implications for retention and the workforce crisis in primary care.
- The impact of racial discrimination and harassment are not felt equally. People from Black ethnic backgrounds were more likely than all other groups to say they had experienced racial discrimination and that they considered leaving their role as a result.
- People in what may traditionally be thought of as 'powerful' roles, such as GP partners, were just as likely as those in other roles to say they experienced racial discrimination and harassment from patients and colleagues. Locums may also be particularly affected.

3. There is no easy solution, and mitigations are needed at many levels

- Despite the prevalence of racial discrimination and harassment, the survey suggests that many people and teams do not feel supported and empowered to address it. People often did not know from whom to seek help and/or were not confident that anything would be done as a result. This may be a particular issue in primary care, as practices, pharmacies and dental and optometry services are often small independent businesses, without standardised policies and practices and where owners and managers may be perceived as 'part of the problem rather than part of the solution'. This is perhaps why there were strong calls for independent advice and support from outside of people's place of work to help investigate and address reports of discrimination.
- In our survey, people working in primary care suggested that some solutions needed to be at the level of individual staff (such as mandatory diversity and inclusion training for all team members); at the level of organisations and teams (such as having an independent group to provide advice and investigate); and at the level of wider culture, education (such as having a zero tolerance campaign with patients and government) and at system level (representative senior NHS leadership and role modelling to help build a more inclusive and supportive wider society).

There is a danger that readers may focus on the 'representativeness' of the survey feedback or the 'accuracy' of people's perceptions. However, to do so would overlook the key purpose of the survey; to understand the lived experience of discrimination and harassment, particularly racial, of staff in London primary care and its significant impact on individuals and on workforce retention and the sustainability and quality of services.

We have taken an important step forward to begin listening, learning, and quantifying the primary care workforce's lived experience of racial and other discrimination and harassment in the workplace, but there is much left to do. It is essential that the impact of interventions is monitored through further surveys and the implementation of the Workforce Race and Equality Standard in primary care is key to this.[16]

This survey suggests that discrimination and harassment, particularly based on race and ethnicity, is equally an issue outside general practice. Moving forward, we need to understand whether community pharmacy, dentistry and optometry have the same trends and future surveys must target these workplaces help inform system wide transformational change.

However, surveys are only part of the story. They do not always expose the complex and nuanced details needed to understand sensitivities or to engage people in the journey. Therefore, this is just one of a number of approaches we will use to give people an opportunity to share their experiences and help to plan next steps.

> *"Surveys like this help, but there needs to be a much bigger focus from the NHS so organisations are assessed and required to report on this as with other matters. The impact on wellbeing is devastating, debilitating, insidious and completely unacceptable for those at the receiving end! Action is paramount now."*

[16] A national primary care workforce survey is planned, along the lines of the NHS staff survey used by NHS Trusts.

Appendix 1

Too few people responded from each detailed role breakdown, ethnic group or Integrated Care System to make meaningful comparisons, but the data are included here for completeness. Differences should be treated with caution as most are not statistically significant.

Feedback from people from different ethnic groups

Ethnicity	Number	% discrimination by patients						% discrimination by staff					
		age	disability	ethnicity	gender	religion	sexual orientation	age	disability	ethnicity	gender	religion	sexual orientation
Asian or Asian British – Indian	189	9	1	47	14	7	2	7	2	23	11	3	1
Asian or Asian British – Pakistani	67	13	0	45	21	31	2	12	0	27	13	13	2
Asian or Asian British – Bangladeshi	49	6	0	45	16	18	2	6	0	31	6	8	0
Asian or Asian British – Chinese	13	15	0	46	8	0	0	0	0	8	0	0	0
Asian or Asian British – Any other Asian	47	9	0	36	19	13	0	9	0	15	4	8	0
Black or Black British – African	72	18	3	64	17	3	0	14	3	46	4	0	0
Black or Black British – Caribbean	56	5	0	41	11	2	2	14	5	36	11	4	0
Black or Black British – Any other Black	8	0	0	38	0	0	0	0	0	50	0	0	0
White –British	333	6	1	7	10	1	2	2	2	4	5	1	1
White – Irish	20	5	0	5	15	0	0	10	0	5	10	0	0
White – Any other White background	90	7	1	19	12	3	0	4	0	10	1	3	0
Other – Arab	8	0	0	38	25	25	0	0	0	25	0	0	0
Other – Any other background	54	13	0	39	13	17	2	9	4	28	7	13	2

Note: the table shows the proportion of people from each ethnic group who reported discrimination or harassment in the past year based on various personal characteristics, from either patients and/or staff. People could select more than one ethnic group. The 'number' column provides the number of people from each ethnic group who responded to these questions.

Ethnicity	Number	% Org acts fairly about promotions and career progression, regardless of ethnicity	% My ethnicity reduced my chances of promotion or progression	% My ethnicity reduced my opportunities for training	% I saw a colleague discriminated against due to their ethnicity	% Senior colleague discriminated against me due to my ethnicity	% Patient complained about me due to my ethnicity	% Colleague complained about me due to my ethnicity	% Had performance measures or disciplinary action due to my ethnicity	% Considered leaving or left due to racial discrimination
Asian or Asian British – Indian	189	72	32	27	28	13	19	5	4	14
Asian or Asian British – Pakistani	67	64	36	31	34	15	25	8	3	21
Asian or Asian British – Bangladeshi	49	71	41	33	33	13	18	4	0	16
Asian or Asian British – Chinese	13	92	15	0	23	0	8	0	0	8
Asian or Asian British – Any other Asian background	47	79	28	19	28	2	4	4	0	13
Black or Black British – African	72	51	47	43	31	19	19	10	10	24
Black or Black British – Caribbean	56	59	48	39	34	18	18	4	5	27
Black or Black British – Any other Black background	8	50	50	50	50	38	0	0	13	63
White – British	333	92	3	3	15	2	4	0	0	3
White – Irish	20	95	10	5	30	0	5	0	5	5
White – Any other White background	90	88	13	9	17	7	8	0	1	8
Other – Arab	8	88	13	13	13	0	0	0	0	25
Other – Any other background	54	63	37	32	32	19	24	7	6	20

Of those who experienced harassment or discrimination based on ethnicity:

Ethnicity	Number	% Reported it and it was dealt with well	% Reported it but it was not dealt with well	% Someone else reported it	% Did not report because did not know who to report it to	% Did not report because did not think anything would be done	% Did not report because was worried about negative consequences	% Dealt with directly or did not think needed reporting
Asian or Asian British – Indian	100	10	16	4	20	59	21	6
Asian or Asian British – Pakistani	43	12	19	0	14	44	30	5
Asian or Asian British – Bangladeshi	29	3	14	7	10	62	48	3
Asian or Asian British – Chinese	6	17	0	0	0	50	0	17
Asian or Asian British – Any other Asian background	24	13	21	8	8	38	29	8
Black or Black British – African	50	4	26	0	14	48	36	4
Black or Black British – Caribbean	34	9	26	6	12	44	26	3
Black or Black British – Any other Black background	6	17	67	0	0	0	33	0
White – British	34	29	15	9	12	35	12	24
White – Irish	1	0	200	0	0	100	0	0
White – Any other White background	23	22	17	0	17	39	22	13
Other – Arab	4	25	0	0	0	50	25	0
Other – Any other background	28	4	11	7	18	61	43	14

Note: The 'number' column is the number who reported some type of harassment or discrimination based on ethnicity in the past year. The proportions add to more than 100% because people could give more than one reason for not reporting.

Ethnicity	Number	% Know where to go for help to deal with any harassment or discrimination see or experience at work	% Would feel secure raising concerns about harassment or discrimination at work	% Confident that organisation would address concerns raised about harassment or discrimination
Asian or Asian British – Indian	189	63	52	57
Asian or Asian British – Pakistani	67	65	49	55
Asian or Asian British – Bangladeshi	49	58	57	54
Asian or Asian British – Chinese	13	62	77	62
Asian or Asian British – Any other Asian background	47	64	62	63
Black or Black British – African	72	53	41	44
Black or Black British – Caribbean	56	72	52	50
Black or Black British – Any other Black background	8	50	38	50
White – British	333	89	87	87
White – Irish	20	95	84	90
White – Any other White background	90	86	82	82
Other – Arab	8	75	88	63
Other – Any other background	54	71	64	60

Feedback from people in different roles

Role	Number	% discrimination by patients						% discrimination by staff					
		age	disability	ethnicity	gender	religion	sexual orientation	age	disability	ethnicity	gender	religion	sexual orientation
Advanced Nurse Practitioner	28	4	4	36	7	4	0	4	0	25	7	4	0
Dentist, hygienist, dental nurse etc	6	0	0	50	50	17	0	0	0	17	0	17	0
General Practice Nurse	81	10	3	28	10	5	1	5	4	17	3	3	0
GP – Locum	39	21	0	36	28	3	5	21	5	23	21	5	0
GP – Salaried	137	10	1	26	24	10	2	5	2	13	8	6	0
GP Partner	189	3	1	29	11	6	1	4	1	21	5	5	2
Health Care Assistant	25	12	0	20	4	0	0	8	0	20	0	0	0
Nurse Associate	3	33	0	33	33	33	0	0	0	0	0	0	0
Optometrist, dispensing optician, optical assistant etc	55	7	0	33	7	9	2	4	0	13	6	2	0
Paramedic	2	0	0	0	0	0	0	0	0	50	0	0	0
Pharmacist, pharmacy technician etc	38	13	0	40	13	21	0	21	0	37	16	11	0
Physician Associate	6	17	0	33	17	0	17	0	0	33	0	0	17
Practice Manager	157	6	1	27	8	6	1	1	1	10	5	2	1
Business Manager or other management	38	8	0	21	8	0	0	16	3	34	16	0	0
Administrative, clerical, reception or IT	137	10	1	27	11	7	1	11	1	17	2	4	1
Social Prescriber, wellbeing coach, care coordinator	16	0	0	6	19	0	6	0	0	0	0	0	0
Trainee or student of any type	23	26	0	22	22	4	4	9	9	17	13	0	0
Social work or mental wellbeing role	18	0	0	33	6	6	0	0	11	17	17	0	6
Other roles	2	0	0	0	50	0	0	0	0	0	0	0	0

Note: the table shows the proportion of people from each role who reported discrimination or harassment in the past year based on various personal characteristics, from either patients and/or staff. The ‘number’ column provides the number of people from each role taking part. Some participants did not specify their role and are not included here.

Role	Number	% Org acts fairly about promotions and career progression, regardless of ethnicity	% My ethnicity reduced my chances of promotion or progression	% My ethnicity reduced my opportunities for training	% I saw a colleague discriminated against due to their ethnicity	% Senior colleague discriminated against me due to my ethnicity	% Patient complained about me due to my ethnicity	% Colleague complained about me due to my ethnicity	% Had performance measures or disciplinary action due to my ethnicity	% Considered leaving or left due to racial discrimination
Advanced Nurse Practitioner	28	61	29	29	32	11	11	4	0	18
Dentist, hygienist, dental nurse etc	6	67	33	33	33	0	33	0	0	17
General Practice Nurse	81	83	25	21	15	10	11	4	6	14
GP – Locum	39	62	41	41	31	18	26	0	0	10
GP – Salaried	137	74	24	18	29	10	12	4	1	10
GP Partner	189	80	25	21	30	10	12	6	4	11
Health Care Assistant	25	80	8	4	4	8	0	4	4	12
Nurse Associate	3	100	0	0	33	0	33	0	0	0
Optometrist, dispensing optician, optical assistant etc	55	86	16	13	16	7	11	0	2	6
Paramedic	2	50	50	50	50	0	0	0	0	50
Pharmacist, pharmacy technician etc	38	71	26	26	5	11	8	3	11	21
Physician Associate	6	67	33	33	17	33	33	0	17	33
Practice Manager	157	87	17	12	17	5	13	3	0	10
Business Manager or other management	38	63	34	24	34	16	13	3	11	26
Administrative, clerical, reception or IT	137	80	19	18	27	9	12	2	2	14
Social Prescriber, wellbeing coach, care coordinator	16	81	6	6	13	0	0	0	0	0
Trainee or student of any type	23	91	26	22	26	4	9	0	0	0
Social work or mental wellbeing role	18	61	28	6	44	6	11	0	0	6
Other roles	2	100	0	0	50	0	0	0	0	0

Of those who experienced harassment or discrimination based on ethnicity:

Role	Number	% Reported it and it was dealt with well	% Reported it but it was not dealt with well	% Someone else reported it	% Did not report because did not know who to report it to	% Did not report because did not think anything would be done	% Did not report because was worried about consequences	% Dealt with directly or did not think needed reporting
Advanced Nurse Practitioner	12	0	17	8	8	42	42	17
Dentist, hygienist, dental nurse etc	5	40	0	0	60	20	20	0
General Practice Nurse	24	8	54	8	13	38	17	8
GP – Locum	19	5	11	0	21	47	42	21
GP – Salaried	61	16	15	0	13	56	25	5
GP Partner	71	8	13	4	18	45	37	7
Health Care Assistant	6	17	50	0	0	17	17	17
Nurse Associate	1	0	0	0	0	100	0	0
Optometrist, dispensing optician, optical assistant etc	21	19	10	0	14	67	10	0
Paramedic	2	0	50	0	0	0	0	0
Pharmacist, pharmacy technician etc	17	0	29	0	6	53	18	12
Physician Associate	2	0	50	0	0	50	0	0
Practice Manager	50	18	28	6	14	42	22	4
Business Manager or other management	19	5	26	5	0	47	21	21
Administrative, clerical, reception or IT	47	15	17	11	13	47	38	4
Social Prescriber, wellbeing coach, care coordinator	3	0	0	0	0	67	33	67
Trainee or student of any type	8	0	0	0	25	63	13	13
Social work or mental wellbeing role	8	0	0	0	0	100	38	0
Other roles	1	0	0	0	100	0	0	0

Note: The ‘number’ column is the number who reported some type of harassment or discrimination based on ethnicity in the past year. The proportions add to more than 100% because people could give more than one reason for not reporting.

Role	Number	% Know where to go for help to deal with any harassment or discrimination see or experience at work	% Would feel secure raising concerns about harassment or discrimination at work	% Confident that organisation would address concerns raised about harassment or discrimination
Advanced Nurse Practitioner	28	82	67	65
Dentist, hygienist, dental nurse etc	6	50	67	50
General Practice Nurse	81	82	72	71
GP – Locum	39	49	34	67
GP – Salaried	137	56	53	62
GP Partner	189	72	69	71
Health Care Assistant	25	96	92	83
Nurse Associate	3	100	100	100
Optometrist, dispensing optician, optical assistant etc	55	76	72	74
Paramedic	2	50	50	0
Pharmacist, pharmacy technician etc	38	47	45	50
Physician Associate	6	33	33	50
Practice Manager	157	86	84	82
Business Manager or other management	38	81	60	62
Administrative, clerical, reception or IT	137	87	78	74
Social Prescriber, wellbeing coach, care coordinator	16	94	94	94
Trainee or student of any type	23	74	52	61
Social work or mental wellbeing role	18	59	41	50
Other roles	2	100	50	100

Feedback from people in different Integrated Care Systems

Integrated Care System	Number	% discrimination by patients						% discrimination by staff					
		age	disability	ethnicity	gender	religion	sexual orientation	age	disability	ethnicity	gender	religion	sexual orientation
North Central	176	13	1	27	14	5	2	8	2	18	7	2	1
North East	286	9	1	32	14	10	1	9	2	19	9	6	1
North West	134	9	1	30	16	9	1	3	2	18	8	8	0
South East	244	6	2	22	13	4	1	5	1	18	4	3	1
South West	181	6	0	25	10	5	2	4	1	16	4	2	1

ICS	Number	% Org acts fairly about promotions and career progression, regardless of ethnicity	% My ethnicity reduced my chances of promotion or progression	% My ethnicity reduced my opportunities for training	% I saw a colleague discriminated against due to their ethnicity	% Senior colleague discriminated against me due to my ethnicity	% Patient complained about me due to my ethnicity	% Colleague complained about me due to my ethnicity	% Had performance measures or disciplinary action due to my ethnicity	% Considered leaving or left due to racial discrimination
North Central	176	80	22	13	27	7	10	2	2	9
North East	286	76	26	21	26	10	15	5	2	14
North West	134	75	31	15	22	8	12	4	3	12
South East	244	80	18	21	22	10	14	4	4	12
South West	181	79	19	24	20	11	8	1	2	11

Of those who experienced harassment or discrimination based on ethnicity:

ICS	Number	% Reported it and it was dealt with well	% Reported it but it was not dealt with well	% Someone else reported it	% Did not report because did not know who to report it to	% Did not report because did not think anything would be done	% Did not report because was worried about negative consequences	% Dealt with directly or did not think needed reporting
North Central	60	12	22	8	15	43	18	7
North East	127	6	15	3	13	56	35	7
North West	54	13	20	2	13	46	26	2
South East	91	15	22	4	19	47	29	9
South West	55	13	22	2	11	47	27	15

ICS	Number	% Know where to go for help to deal with any harassment or discrimination see or experience at work	% Would feel secure raising concerns about harassment or discrimination at work	% Confident that organisation would address concerns raised about harassment or discrimination
North Central	176	69	67	68
North East	286	72	64	69
North West	134	68	60	61
South East	244	81	77	73
South West	181	78	69	70