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Middle managers as barriers or enablers in tackling racial discrimination in the NHS: a qualitative research study

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ABSTRACT

Objective To explore the role of senior and mid-level managers as barriers or enablers to change in tackling the discriminatory challenges experienced by Black and Minority Ethnic (BME) employees working in the National Health Service (NHS).

Design A multi-level, multi-sourced qualitative study of five NHS Trusts in England.

Setting and participants 26 qualitative interviews with senior leaders and BME network chairs (27 participants) and five focus groups (37 participants) with BME employees, across five NHS Trusts in England.

Results Our findings revealed that discrimination, racial harassment, incivilities, lack of progression and exclusion experienced by BME employees appear to be deeply ingrained in the culture of the NHS. Despite numerous national and local initiatives aimed at promoting inclusivity and addressing discriminatory behaviours, our findings also revealed a notable disparity between what senior leaders thought was effective in addressing discriminatory behaviours and the actual lived experiences of BME employees. Finally, a key finding was the pivotal role middle managers played in setting the tone for whether discriminatory behaviours are challenged or allowed to persist, which directly impacts on the overall experiences of BME employees within the NHS.

Conclusions Our results provide evidence that not only does racial discrimination continue to be experienced by NHS BME employees, but that middle managers are key to addressing and improving this situation. Despite there being national policies and initiatives addressing racial discrimination, our study found that positive change, whether at an individual or organisational level, is dependent on the actions and commitment of middle managers.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Multi-sourced data from both senior leaders and Black and Minority Ethnic (BME) staff.
⇒ BME staff in a variety of roles and grades.
⇒ Mixed qualitative method using interviews and focus groups.
⇒ Self-selected focus group participants may not be representative.
⇒ Participating Trusts actively motivated to address issues regarding inequality—again, less representative.

INTRODUCTION

The National Health Service (NHS) is the largest healthcare provider in the UK and one of the largest employers in the world,[1] with employees represented from diverse backgrounds.[2] Despite this diversity and the large numbers of Black and Minority Ethnic (BME) staff within the NHS workforce,[3] these staff continue to experience discrimination, racial harassment, abuse, incivilities and exclusion.[4 5] Specifically, studies have shown that BME employees are more likely to have negative work experiences, including being subject to stereotypes, biases and discrimination, with these impacting differentially depending on a variety of factors including migrant status and job role.[4 6 7] Similarly, the NHS Workforce Race Equality Standards (WRES) metrics demonstrate widespread race inequalities within NHS organisations, with a lack of inclusive cultures and predominantly white leadership, which does not represent the increasing racial diversity of the workforce.[8]

Pockets of research have created an awareness of these issues,[4 9] with some providing suggested actions.[10] NHS England, the governing body of the NHS in England, is also aware of the ongoing issues, with many NHS organisations reporting a worsening trend.[3] As a response to these issues, the NHS has committed to tackling racial inequality at work and in healthcare through ongoing and established initiatives such as the WRES, the NHS Race and Health Observatory and the NHS People Plan.[11] Reports from these initiatives have shown minimal progress and continue to call for more research into how we can create a fairer and more equitable workforce.[3 12] Therefore, urgent action and research are required to create in-depth understanding of the challenges and to identify solutions.

The role of middle managers in tackling race discrimination in the workplace continues to be unclear.[13] Our research aims to explore how leaders (senior and mid-level) are key to fostering or hindering progress made towards mitigating the negative persistent experiences of racial discrimination experienced by BME employees working in the NHS. We adopted a multi-perspective (ie, BME staff and senior leaders) approach and sought to address the following research questions:

1. What are the key experiences (and resulting impact) of discrimination by BME employees in the NHS?
2. To what extent do leaders act as barriers or enablers to addressing these persistent race discrimination experiences at work?

METHODS

Theoretical framework

We explore these research questions through the lens of 'institutional theory'. Institutional theory provides a rich theoretical foundation for examining such critical issues such as race inequality within the UK healthcare sector. Underpinned by the notion of 'institutions', that is, the 'regulative, normative, and cognitive structures and activities that provide stability and meaning for social behaviour',[14, p33] we use institutional theory as a lens to examine how institutional structures, policies and practices systematically disadvantage certain racial groups (ie, institutional racism). According to Jones,[15] the effects of institutional racism 'are suffused throughout the culture via institutional structures, ideological beliefs and personal everyday actions of people in the culture.'[15, p472] There are three levels within the organisation whereby institutional racism operates: the extra-organisational (ie, between organisations and externals); the intra-organisational (ie, the internal organisations climate, policies and procedures) and the individual (ie, through employees' attitudes, beliefs and behaviours).[16]

Setting

The data for this study were originally collected as part of a baseline analysis for a cultural change programme that the NHS England WRES team had planned to implement in 2020 but was subsequently cancelled due to the COVID-19 pandemic. Five NHS Trusts were identified and asked by the WRES team to participate based on their WRES indicators which highlighted areas for improvement in workplace culture for BME employees. The selection also aimed to ensure a diverse range of healthcare settings and geographical locations.

Sampling, recruitment and data collection

Once agreement had been obtained from the five NHS Trusts, the national WRES team gave a presentation to senior staff to raise awareness and encourage participation. The project lead attended these meetings and liaised with relevant staff to identify and obtain contact details for key informants for interview. These included the Chair of the Board, the CEO, one or more people with responsibility for HR and/or Equality, Diversity and Inclusion (EDI) and/or the WRES agenda and the chair of the BME staff network. Key informants were then emailed by one of the two researchers (JL or FCS) and sent an information sheet and consent form. Once the consent form had been returned, interviews were arranged.

Interviews were conducted by one of two members of the research team (FCS or JL) and were undertaken predominantly via MS Teams (20), with a few (6) being conducted by phone. This was due to the COVID-19 pandemic restrictions at the time. A topic guide was developed based on the stated objectives of the initiative and used to guide the interviews (online supplemental file 1). Interviews lasted approximately 30–45 min and were recorded and transcribed, with the researchers also writing summary notes.

During the interviews with BME network chairs, an appropriate process for recruitment of BME staff to the focus groups was agreed. This varied between Trusts depending on staffing structures and access to contact information. Approaches included specific staff being directly approached by the BME chair; all staff in the BME network being emailed an invitation by the chair; and all BME staff being contacted via a list provided by HR. Potential participants were sent information and consent forms, which they returned to the research team who then arranged a convenient date and time for the focus group.

One online focus group for BME staff was held using MS Teams in each Trust. Groups were facilitated by two or three researchers (FCS, JL and LO-E). A topic guide (online supplemental file 2) was used to ensure key themes were explored, although this was used flexibly to allow participants to speak as freely as possible. Some people contributed via the chat function and in one case via a phone link due to connectivity difficulties. Focus groups generally lasted 2 hours and were video recorded and transcribed verbatim. The researchers also took notes and held brief reflective meetings afterwards to identify key issues.

Analysis

We analysed the data, including transcripts and chat comments, using an approach informed by aspects of thematic analysis,[17] but with some key differences. We used an inductive approach, seeking to identify key themes from the data and focused on the explicit or semantic level rather than exploring more interpretive meanings.

Most of the analysis was undertaken by one researcher, with emerging themes being checked with other members of the research team who had taken part in the interviews and focus groups as it progressed. The process of analysis had a number of stages. First, the transcripts for the senior leadership interviews were read and summary notes made of the issues discussed. These notes were then used to produce a summary of key themes among the senior leadership for each Trust, followed by a single

Table 1 Interview participants

Trust ID	Total participants	Role of participants (and number interviewed)				
		CEO	Chair of board	BME network chair	HR/workforce/organisation development lead	EDI lead
A*	5	1	1	1	2	1
B	5	1	1	1	1	1
C	5	1	1	1	2	–
D	5	1	1	1	1	1
E	7	1	1	2	2	1

*One participant in this Trust had a dual role so total number adds up to more than 5.
BME, Black and Minority Ethnic; CEO, Chief Executive Officer; EDI, Equality, Diversity and Inclusion; HR, Human Resources.

summary across all five Trusts. A similar process was used to identify key themes in each Trust focus group, with data from the interview with the BME chair interview being integrated into the summary. A summary of key themes in BME staff experience across the five Trusts was then created. The two sets of summary findings were reviewed to identify areas of similarity and difference in perspective and understanding between senior leaders and BME staff. Further discussion within the team led to the development of the final themes identified in this paper. At this stage, we focused our attention on BME staff experiences of discrimination and the organisational structures, strategies and processes which they considered helped to address these challenges, in particular the role of the middle manager, which emerged as a key theme. Transcripts were then reviewed to identify illustrative quotes.

Positionality of researchers

FCS and JL are both health service researchers and identify as white and female. LO-E identifies as a black female with expertise in health service research. While none of the researchers have been employed within the NHS, their previous health services research experience provided insight into navigating recruitment and data collection challenges and of health services' staff experience in other contexts. FCS and JD had also both undertaken previous research relating to the WRESs. These prior experiences may have created prior assumptions about the experiences of BME staff participating in this study.

Patient and public involvement

None.

RESULTS

We undertook a total of 26 interviews, 21 with senior staff and five with BME network chairs, a total of 27 participants (one interview had two participants) (table 1). We did not formally collect demographic data, but participants were approximately evenly split between men and women, and apart from the BME network chairs, were predominantly white.

We also undertook five focus groups with a total of 37 participants (6–9 per group) (table 2). Gender balance was approximately three quarters female. Not all participants provided data regarding ethnicity, but those that did described a range of backgrounds, with most describing Asian or British Asian, Black Caribbean or British Caribbean and Black African, and a smaller number reporting mixed heritage. Participants were spread across a wide range of bands from 2 to 8 days, plus one bank worker, with band 7 and above most strongly represented. A wide variety of roles were represented, including both clinical and support staff.

We identified three key themes within the data, each with a number of sub-themes, which were present across all Trusts despite their diverse contexts: experiences of discrimination at both an individual and structural level, and the impact on BME employees; the role of senior leadership in changing BME staff experience; and the pivotal role of middle managers as barriers to or enablers of change. Each theme is illustrated with quotes where the code letter indicates the specific Trust and the number the individual participant.

Experiences of discrimination at individual and structural level and their impact on BME employees

Almost all BME staff described experiences of discrimination and disadvantage, both in terms of interactions with individuals and at a systemic or organisational level, and the cumulative impact that these had on them.

Table 2 Focus group participants and facilitators

Focus group number	Trust ID	Number of participants	Researchers facilitating
1	A	9	FCS, JL
2	B	8	FCS, JL
3	C	6	FCS, JL, LO-E
4	D	8	FCS, JL, LO-E
5	E	6	FCS, JL, LO-E

Negative interactions with individual colleagues

Participants described greater levels of bullying and harassment than their white colleagues, an issue also identified by senior staff from staff surveys. While this sometimes took the form of overt racist and/or inappropriate comments, particularly in areas with a less ethnically diverse population, other more subtle forms of discrimination were also highlighted. Many described 'micro-aggressions', which left them feeling 'unable to be their authentic self' in the workplace. When these were challenged, however, this could lead to negative reactions from colleagues, including blaming BME staff for taking things too seriously or being too sensitive, that is, gaslighting. Additionally, lack of diversity in some teams could leave BME staff feeling isolated and over time this could undermine confidence and lead to self-doubt.

> …some black staff, female black staff still feel that […] if they were to bring criticism or they were to voice unhappiness or something, they are perceived as the angry black woman. […] I've had Asian staff talk about when they've brought their lunch in and it's been curry, for example, and the comments sometimes they get from non BME colleagues. […] being able to be your authentic self in the workplace has been difficult for some. Trust B – BME chair

While these experiences were actively discriminatory, participants also described a lack of support, engagement and/or recognition for the challenges they faced. This could include not challenging racist comments or behaviour from colleagues or service users, unwillingness to discuss issues relating to race and expressing concerns about the fairness of initiatives to improve BME staff experience.

> You just get pushed aside with those responses, "it's the race card" oh, you know, it's, you just become weary. FGB/P8

> I've heard, you know, staff talking about "oh, you know, [P3]'s been to a BAME meeting again. FGB/P3

Experiences of systemic discrimination

In addition to difficult interpersonal interactions, BME staff highlighted concerns regarding structural/systemic discrimination. One of the most frequently discussed issues was experiences of barriers to career progression. Many staff described their own personal struggles to progress, contrasting this with seeing their white colleagues advance more rapidly, despite having lesser skills, experience or qualifications. This impacted significantly on their confidence, making them less likely to apply for opportunities, and there were concerns that this could then be interpreted as a lack of motivation to progress.

> …I have been that person in the last ten years, who've always been good enough to act but never actually get the role, and you actually always have your white colleagues getting the role but with less experience. FGA P6

> I self-funded myself to get a master degree from [name of university] but still band 5 after working for over 17 years in the NHS. Same with all my BME colleagues. FGC P4 (chat comment)

Many described repeatedly missing out on receiving information regarding development opportunities and, when managers were challenged, this being brushed off as 'a mistake'. Others were excluded due to being in roles where they lacked access to computers. This applied particularly to staff in inpatient settings or domestic/portering roles, which are disproportionately filled by BME staff.

> When you try to progress, everything you do has to go through online, but you know, some of us don't have access to computer, we don't work with computers, we work on the floor all the time. FGA P9

Other instances of discrimination included having applications for non-mandatory training repeatedly turned down, with a lack of transparency in decision-making processes. Concern was also raised about the lack of access to informal coaching and information-sharing opportunities; these were linked to social networks which BME staff were not part of, and the need for formal processes to overcome this disadvantage was highlighted.

Even when successful in progressing, BME staff described experiencing suspicion from colleagues, with suggestions of positive discrimination and being a 'token black' rather than being appointed on merit. Others described occasional promotions as 'tick box' exercises to improve metrics, with a lack of support once in the role, and being judged more harshly for errors than white colleagues.

> if you are promoted you're either seen as the token black person and they've ticked a box. And then, to your peers, it's 'oh yeah you, you are that token black person, they've picked one and they've picked you. FGB P5

The impact on BME staff

BME staff described feeling reluctant to come forward to raise concerns due to being labelled a troublemaker and the potential impact on their career. They expressed frustration and distress at the lack of response to sharing their experiences, raising concerns or making suggestions, often at personal cost to themselves, and reflected how this led many people to stop engaging in consultations.

> …some of my BME colleagues are fed up of even speaking up, because nothing changes even if people speak up. FGC P5

> Most of my colleagues here were really anxious to a point that some of the people were not willing to

even take part [in the focus group], because they didn't want to then be identified as the people who have, you know, let the cat out of the bag. Trust E BME Chair

The role of senior leadership in changing BME staff experience

Perceptions of the effectiveness of senior leaders as change catalysts

Senior staff described a range of initiatives to improve BME staff outcomes and experience, including reverse mentoring, inclusion of BME staff on interview panels and talent management schemes. While these were welcomed, many considered that they did not go far enough to address the underlying issues and achieve meaningful change, often only reaching those who were already engaged. Appointment of EDI posts at low grades in some instances also reinforced the sense that the issues were not being taken seriously.

While senior staff described being aware of the issues highlighted by BME employees, focus group participants in many instances did not believe there was an understanding of the degree to which discrimination was experienced across the organisation. They also frequently described lacking confidence in the leadership's commitment to actively address the problems they faced.

…we may have all the flowery language and very good policies […] when it comes to crux of the matter, it's the implementation FGD P4

although you can speak freely and say your view and your point, it doesn't always filter down. It's almost as if some of the execs walk around with their eyes closed. FGA P7

There is no accountability. Ultimately what it comes down to is, there is no sufficient sanctions or accountability for managers' actions. FGB P1

Greater recognition for BME staff networks

One positive recent change identified in most Trusts was greater support and engagement from senior leadership with the BME staff networks, including closer involvement in key decisions. Both the COVID pandemic and the Black Lives Matter campaign were seen as having catalysed this dialogue. The tangible outcomes from it were leading to improved staff confidence and engagement with BME networks in most NHS Trusts, although the opposite was reported in one Trust.

Black Lives Matter has put us in a position whereby we're able to have these conversations with our management. (…) for the first time in my life I had a corridor conversation with my manager about Black Lives Matter, and that's when I got the confidence that oh is that a topic we can talk about now? FGA/P6

Many participants, however, highlighted the need for more resources to support the work of the BME networks, which frequently depends on participants' and their managers' goodwill. The need for more tangible commitment such as paid time or backfill of posts was seen as key to enabling more progress to be made.

The pivotal role of middle managers as barriers to or enablers of change

Reflecting on issues discussed in the previous themes, participants highlighted the significant impact their immediate line managers had on their workplace experience. Middle managers were perceived as pivotal in either addressing race discrimination by actively implementing policies and providing direct support or failing to do so by being insensitive and dismissive of BME staff experiences. In either case, managers were identified as setting the tone for whether discriminatory behaviours and processes were challenged or allowed to persist.

Translating organisational policy into practice

While participants identified some progress at senior levels, a particular area of concern highlighted by many was the limited degree to which policies were translated into action 'on the ground', and particularly a frequent lack of engagement by middle managers to implement the policies.

There does feel like there's the beginnings of a sense of change within the kind of executive leadership team within the Trust. So there seems to be a sense of commitment to wanting to create change, but (…) the layer that's above me, so kind of my clinical leads, my service leads, the family service managers, are nowhere near that level of change. FGD P5

…there's a lot of sort of middle managers who don't believe there is an issue, they don't seem to, even with all the data there now. FGB P3

The willingness to change isn't there with some of middle management. Some believe there isn't an issue despite all the data out there. FGB P6

The role of line managers in BME staff experience

Participants emphasised the significance of their immediate line managers to their workplace experience, highlighting the key role they played in a variety of ways including providing direct support, challenging discriminatory behaviour and practice and validating BME staff experiences. While some described supportive relationships, negative experiences were more frequently described. These ranged from instances where managers failed to 'go the extra mile' to counteract existing inequalities—thereby reinforcing and compounding the situation—to behaving in discriminatory or dismissive ways which further undermined BME staff confidence.

I've worked under managers that have [a caring, nurturing, developing style], and it's absolutely fantastic, I can tell you now. I don't know if anyone else has, but it is really great, cause they'll say well what do you want to be? I'm gonna help you – I'm gonna help you to get there. FGC P4

…my line managers are very, very supportive, I will say that. FGC P6

The worst one I would say was. when somebody had used the 'N' word in a meeting whilst I was at the toilet. Now, and I never, and my manager was in that meeting… I approached my manager and she'd not done anything about it. FGB P8

…stop calling me by somebody else's name because they're the only black person at the level, yeah? You know?! That's not good. You know, you are my line manager, please get my name right… FGA P1

…there's too many times I've seen domestic and housekeeping staff being spoken to so disrespectfully, and a lot of managers think they can get away with it, you know, and it's just, it's just not right. FGA P7

Many participants spoke of working harder to prove themselves and overcome discrimination and feeling this was not recognised by their managers. Participants reflected that many managers appeared unwilling, lacked insight or lacked the skills to discuss issues relating to race or to be challenged, with a fear of being seen as racist. They also reported not being understood or offered support when they raised concerns about unfair treatment or discrimination or that no action was taken despite 'saying the right things'. In other instances, participants reported not being taken seriously, even with suggestions that they were exaggerating their experiences. Some described feeling blamed and labelled a 'troublemaker' and further discriminated against. These experiences unsurprisingly left BME staff unwilling to bring concerns to their managers.

…you always feel like you are a troublemaker… FGE P1

…as well, you know, that the managers that say oh, I think there is an impression that we kind of overplay what we face on a day-to-day basis.' FGB P2

If they think it's ok to actually verbalise 'oh, well I think it's gone too far the other way now' then, you know, how can they then help anybody progress or how can anybody go to them if they then think they've got an issue? FGB P8

Due to disproportionately being at lower bands, BME staff often had white line managers, who in some instances did not appear to be comfortable or competent in building individual relationships with them. These and other experiences contributed to a lack of confidence to raise concerns. Recommendations of additional training to address complex issues such as discrimination were regularly raised.

…there seems to be a fear with some managers of speaking to BME staff, 'cause they don't know how to approach us. Even though we all like food, we like sport. FGB P3

Staff experience goes probably unheard because your manager does not look like you, and you don't feel you can necessarily trust them to share your real experience of the Trust. FGA P3

'…what we need to try then is to try to change the attitudes and mindsets of managers so that they're not just a manager for business, but they're a manager for people to develop skills. FGC P3

DISCUSSION

We argue that the configuration of the UK health sector, that is, the NHS, provides a unique institutional framing heavily influenced by external regulatory bodies and a hierarchical management structure that directly impacts on the norms that are embedded into the organisations' culture/system and in turn individual attitudes and behaviours.

Our study offers one of the first qualitative multi-sourced studies exploring not just the persistent experiences of discrimination by BME staff in the NHS but goes further to reveal how and in what ways managers (particularly middle managers) act as enablers or barriers to addressing race discrimination issues at work. By addressing these research questions, we highlight how managerial actions impact BME staff experiences and the effectiveness of workplace initiatives.

Across all participants in our study, there was the recognition that BME staff experience needed to be significantly improved, both in relation to individual interactions with colleagues and through institutional level policies. Senior staff highlighted initiatives that were in place or being introduced to address these concerns, although there was variation in their extent and progression. Differing levels of understanding among senior staff of the issues relating to cultural change were also highlighted. In contrast, BME staff views were much more consistent across all organisations. While initiatives to bring about change were recognised, there was widespread frustration at the lack of progress. In particular, they frequently expressed concern about the 'gap' between the commitment being expressed at Exec/Board level and its implementation on the ground. The attitudes and behaviour of many middle managers were highlighted as a key barrier or enabler to change, and BME staff expressed varying levels of confidence in senior staff's awareness of this, and their willingness to take action to address where barriers occurred. There was also widespread frustration that change was

still being driven more by BME staff than the organisations that they worked for.

Whereas the importance of top-level or senior level managers' roles in tackling race discrimination has been widely substantiated within literature,[13 18] the role of middle managers remains an ambiguous topic.[13] This ambiguity has been suggested to be due to the challenges of having a dual role—one that is required to align with senior leaders as well as build trust within their teams.[19–21] This dual purpose creates potential conflicts, as middle managers must navigate pressures from above and below, making it difficult to balance the requirements placed on them. It is the role of middle managers to embed organisational policies and strategies into operational priorities; however, studies have shown that they may purposefully hinder organisational change.[22 23] This suggests that their role in implementing policies, including those addressing discriminatory behaviours, is not only complex, but may also involve resistance. This has been shown to be due to either a personal disagreement with the policy or the inability to manage the tensions it may create within their teams.[22]

This study built on those that have looked at similar issues previously[4 24] by involving both senior leaders and BME staff in a series of interviews and focus groups across five organisations. In this way, we were able to identify the disconnect between the usually well-intentioned practices of senior managers, who were generally aware of issues and spoke of wanting to put them right, and the experience of staff at lower levels, where there was often little evidence of practices and policies making a difference to their working lives. In particular, the pivotal role of middle managers as the conduit for delivering better experience came through strongly.

A clear implication of this research is that senior managers need to ensure their actions are implemented at all levels, rather than assuming that policy changes at the top will necessarily impact the lives of those throughout organisations. Listening directly to those working in different roles, especially from BME backgrounds, can play a crucial role in that process. Likewise, it is important that middle managers are trained and supported to provide appropriate leadership and management which recognises and addresses the challenges faced by BME staff.

It is important to recognise that researcher positionality can shape both the dynamics of the conversations and the data collected, and a limitation of this study is the potential impact of the researcher' racial identities on participants' responses. We tried to address this in a number of ways. Within the interviews and focus groups, we clarified the purpose of the research and how confidentiality would be upheld, and used a broad topic guide to ensure everyone was asked similar questions. At the beginning of each focus group, particularly those facilitated only by two white researchers, we acknowledged our racial identities, how this reflected the lack of representation within our own research team and wider organisation and the potential impact of this on what participants might feel comfortable sharing. We also established clear ground rules to encourage equal participation and respect for different viewpoints.

A further limitation is that the study included only five self-selecting organisations, which therefore might be those that are more aware of issues affecting BME employees. Future research may focus on a wider range of organisations, including those where senior managers are less alert to such problems. Finally, our study did not have sufficient sample size to explore variations within BME staff experience (eg, by migrant status), and this is another important area for further research.

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