THE BOTTOM LINE

Partha Kar: It’s time for accountability and discomfort about the NHS’s workforce inequalities

Partha Kar: consultant in diabetes and endocrinology

In debates about the challenges facing the NHS, financial difficulties are always front and centre. Now there’s a realisation that workforce issues also pose a real danger. And yet it’s striking that one of the biggest employers on the planet continues to rely on the stopgap measure of asking people from other countries to come and fill the holes in the workforce.

The problem with this is its unsustainability in the long term. And as the cohort of “non-local” healthcare workers grows, so do the voices showcasing the unfairness that these workers experience. How do you shut down a huge group talking about how they’re treated worse because of where they trained or their ethnicity? How do you defend the narrative that their training is good enough for lower grade roles—the ward duties no one else does—but not for higher bands and posts?

How do you square that circle when datasets in the public domain, such as the Workforce Race Equality Standard (WRES) and the Medical Workforce Race Equality Standard (MWRES), not only confirm what people have been saying but tell you even more about inequalities in the health workforce? And what do you do when an unhappy workforce contributes further to gaps, and many HR departments end up having to rely on people’s goodwill to fill gaps in rotas?

The recent suspension of Manjula Arora led to a groundswell of support for UK doctors who trained in other countries, and work by the British Association of Physicians of Indian Origin, the Doctors’ Association UK, and others have shown the appetite for coordinated effort in this area. On a personal front, it’s heartening to see engagement from the General Medical Council, willingness to open a review, and acceptance of mistakes made. Hopefully this is the start of a fairer and kinder health system.

How, then, can we map out the next steps for tackling racial inequalities in the NHS workforce? It’s time to move beyond reconfirming the same narrative. Data should track progress, or the lack of it, and bring accountability. If, as a trust or system, you’re serious about this, show me the data to justify your hashtags and posters. Or let the data be part of your assessment of whether or not you’re a failure on this. There’s no point in having job titles or departments dedicated to equality if the data show no such dedication.

Consider the WRES work led by Anton Emmanuel. The next steps are ambitious. They start with disaggregation of data so that there’s no more lumping everyone together and labelling them “BAME”—having a couple of South Asian people to tick a box does nothing to improve representation from the black community. The data will also help with setting targets and drilling into the performance of individual trusts, systems, and regions—and they need to be made public. Holding areas to account, and involving the Care Quality Commission in using them for assessments, is all part of the data driven approach to improve outcomes, as is offering support when data show a lack of progress.

The future of the medical workforce

Which brings us to medicine, and the MWRES role I hold now. The plan is mapped out, as I’ve outlined here previously. We’re on the cusp of agreement from all stakeholders in the system—the GMC, NHS Employers, NHS Resolution, the Academy of Medical Royal Colleges, and the BMA. Once we have that, the work starts. The key is having data in the public domain and having accountability. We need to be able to challenge trusts and systems, openly and transparently, not hidden in emails or board meetings where compromises are struck.

A firm focus on GMC referrals will remain, tracked by data and with robust challenges around inappropriate referrals and the systems that facilitate them. We need to see what these systems are doing to improve representation in leadership roles, with the disaggregated data mentioned above, as well as induction programmes for international medical graduates and, importantly, progress of SAS doctors (specialty doctors and associate specialists) into relevant senior roles. We’ve shown that we can improve diabetes care using processes such as Getting It Right First Time, so why can’t we do it for a workforce struggling with racial discrimination? If a trust’s WRES/MWRES data continue to be poor, this should form part of a CQC finding of “poor” or “inadequate.” Workforce wellbeing is everyone’s business and, in 2022, you can’t be an “outstanding” trust if you can’t look after your whole workforce.

That at least is the ambition, and the trillion dollar question is whether NHS England has the stomach or dedication to achieve it. Will those plans and ambitions survive the ongoing upheaval, restructuring, and crisis? Not if plans are diluted. That would show that, as a system, we fail to understand the basic tenets of the workforce issue, continuing to pay lip service to this vital issue when 40% of the medical workforce in the NHS is non-white. Every protected characteristic is important, and prejudice must be tackled at all levels—yet NHS surveys still show that ethnic
minority staff have a more a negative experience of working in the NHS.\(^8\)\(^9\)

After years of talk, presentations, and hashtags, the time to challenge and bring accountability is now, without fear of causing discomfort to others or oneself. Anton and I have a clear vision and strategy for the next steps, and I hope you can join us in this journey.

Competing interests: www.bmj.com/about-bmj/freelance-contributors. Partha Kar is director of equality, medical workforce in the NHS, leading the Medical Workforce Race Equality Standard. He is also co-lead of the Getting it Right First Time (GIRFT) national programme for diabetes.

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