Nottingham and Nottinghamshire Primary Care Racial Equity and Diversity Working Group Racism and Discrimination Survey Report 2022

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Introduction

In March 2021, two Co-Leads were appointed to support and take forward the work of the Primary Care Racial Equity and Diversity Working Group with support from a coordinator. The vision the team have been working with is: 'To create a safe space and advocate for Black, Asian and Minority Ethnic Primary Care workforce, increase representation, and champion a racially equitable and diverse workforce and inclusive leadership. To ensure justice and belonging.'

As part of this role, it was critical that as, Primary Care and the wider system, we understood the challenges faced by colleagues who have experienced discrimination and to provide an appropriate intervention.

This report sets out key findings from a racism and discrimination survey undertaken in the Winter of 2021/2022, which aimed at identifying racial, ethnic, and religious discrimination faced by our Primary Care staff from patients, colleagues, patients' carers, and relatives. It also surveyed staff regarding the impact of this discrimination and barriers to career development in Primary Care.

The increasing number of additional roles in Primary Care meant that dissemination of the survey to all Primary Care and community colleagues was necessary to ensure that the survey captured the voices and experiences of as many colleagues as part of our Primary Care.

Background

There is long-standing and a substantial body of evidence to support that structural racism in the NHS exists. The cost of this behaviour to the NHS in terms of treating a large section of its workforce as non-mainstream is burdensome and often means talent within the Primary Care workforce is not always fully optimised, which can translate as a negative impact on patient outcomes. This not only translates as a negative impact on patient outcomes but also demoralises the workforce whose lived experiences and hardships faced within the NHS are not tackled and whose talents are overlooked. [1]

The impact of the COVID -19 pandemic on Black, Asian, and Minority Ethnic (BAME) groups and those at the frontline, highlighting the barriers and racial prejudice faced, has highlighted this area of work. Furthermore, the Black Lives Matter Movement and increased social awareness have garnered momentum and support in the NHS to ensure action is taken to impact the NHS staff experiences positively.

The previous NHS Chief People Officer, Prerana Issar, set a challenge for every NHS organisation to have a Black, Asian, and Minority Ethnic staff network in place and for every network to be driving, thriving, and influencing – with the help of real support from their organisation, in this case, Primary Care colleagues through helping each other to address structural racism.[1,2]

Although there have been reports from the Government regarding institutional racism not existing, many subsequent reports and long-standing evidence suggest otherwise. Some of these include The Messenger Review on leadership in health and social care, the ongoing work conducted by Roger Kline around workforce race discrimination in the NHS and the most recent medical workforce race equality standard (WRES) report. Those mentioned above all further supporting the need to address the structural racism that exists.[3]

Meaningful and sustained engagement with Primary Care colleagues are crucial drivers in ensuring that steps are taken to start and make consistent, tangible improvements in the workforce race equality strategies. [4]
As a result of this 'Call to Action,' Nottingham & Nottinghamshire ICS supported the formation of a Primary Care Racial Equity & Diversity Working Group. Initially, the working group aimed to include General Practice as individual organisations but was expanded to include Primary Care Networks and Federations and is working towards the wider Primary Care workforce.

As a working group, we believe that Equality, Diversity, and Inclusion are not optional extras but are crucial in ensuring the best environment to deliver patient care, better clinical outcomes and promote staff retention [4]

We must root out the racial inequities experienced by our NHS workforce. We must create a positive workplace culture and an environment where all can belong, develop, and progress. If we earnestly tackle racial equity and diversity with tangible actions and achieve positive outcomes, then we can collectively address all Equality, Diversity, and Inclusion.

Advice to readers of this report: This report contains language and viewpoints which may offend. Whilst these comments are few, we have kept statements in full as written by the respondents for transparency and openness

We understand that reading this report and colleagues lived experiences may be difficult; if you require support or if you would like to talk to someone confidentially you can contact:

Racial Equity and Diversity team on info@nottsredgroup.co.uk

Nottinghamshire Staff Support 0808 196 8886 (Monday to Friday 9am-5pm)

Email: notts.staffsupport@nhs.net

Website: www.nottinghamshirestaffsupport.nhs.uk

Foreword

I'm really pleased to have been asked to contribute this foreword, and I intend to keep it short because this is not about me. It's about me, and you, and about us all. It is above all about our colleagues who work in our health and care system, and those who aspire to in the future, who should be described and revered for their compassion, grace, commitment, and soul. This report reminds us that commonly they are not.

It's uncomfortable read and so it should be. From beginning to end, this report describes the challenges we still face and the responses we need. It shows us how we need to think about the future, what we need to do and who we need to be.

The report speaks powerfully for itself but a challenge I'm often reminded of is completely appropriate here: "Knowing is not enough we must apply. Willing is not enough; we must do".

So, I would really encourage us not to be docile. Not to succumb to that "tranquilising drug of gradualism"; to find the antidote to passivity. We should, no we will, work collectively and continuously to think and decide about a more just future. Everyone needs to create the outcomes we want together, that we can't do alone, and create the future we want and can believe in together. I'm also convinced that "Action has magic and power in it".

We must all thank Aiysha and Ojali for this urgent report and commit to ensuring that in developing our primary care system, and our integrated care system, we will not accept as ineradicable but aim to eliminate the experience of discrimination and bias, unequal relationships, and every day and institutional and systemic racism.

Dr Stephen Shortt
GP Clinical Lead – Nottingham and Nottinghamshire ICB

This survey offers and insight into the reality of Primary Care in our system and reminds us that discrimination against Black, Asian and minority ethnic people continues, despite the best efforts of some committed people in our system to address this. This discrimination is multi-layered and complex but has a significant impact on people across Primary Care.

Black History Month 2022 theme was "Time for Change: Action Not Words', and we too now need to use this insightful work to generate action and change within Primary Care and across our whole system. I am personally committed to ensuring that across our system we work as active partners to tackle discrimination in all forms.

Kathy McLean
Nottingham and Nottinghamshire ICS Independent Chair

Our Primary Care workforce plays a vital role in supporting our communities and in delivering care. Everyone should feel comfortable bringing their true selves into the workplace, without fear of discrimination or negative overtones. We have a rich diversity of ethnicities, religions, and heritage in our communities, which should be reflected in our workforce and celebrated. This report is ground-breaking in raising awareness of how it feels to work in Primary Care in Nottingham and Nottinghamshire. It will also inform how we should work together differently and inclusively in the future. I fully support the report and pledge that the ICB will play our part in reducing disparities that should not exist.

Amanda Sullivan
Nottingham and Nottinghamshire ICS Chief Executive

Comments of support – Nottingham and Nottinghamshire Integrated Care System

"The findings of the survey into racism in Primary Care fill me with great hope that working together we can create a different future for our front-line workforce, enabling them to deliver their best care. It is clear that our people are willing to speak, and they therefore must be heard. These insights come at a seminal moment in the future of the NHS, that depends entirely on the collective strength of our people. We know that our people are our greatest asset so we must act differently to truly value everyone equally and individually. As Primary Care is the setting in which the majority of patient contacts happen, we must promote an inclusive and tolerant culture for our workforce and our citizens to ensure best outcomes from services."

Lucy Dadge
Nottingham and Nottinghamshire ICB Director for Integration

"I'm delighted to welcome this first Primary Care Racial Equity and Diversity Racism and Discrimination Survey Report. That the NHS has racism and equality issues is widely understood and nationally acknowledged, and this clearly applies to Primary Care as other areas of the NHS. Highlighting the local Primary Care picture gives us the opportunity to further develop conversations that are already happening and explore how together we address systemic aspects that entrench these issues. Its sits alongside the work the City Place Based Partnership is doing on Race health inequalities, and which is a key enabling programme of the newly agreed City Health and Wellbeing Strategy, so we look forward to working with Primary Care colleagues and beyond to move the dial towards a fairer Primary Care workplace, a fairer NHS and a fairer City"

Dr Hugh Porter
Clinical Director – Nottingham City Place Based Partnership

'While we have made great strides in addressing racial inequity and discrimination in our society and particularly within the NHS, this in-depth reports highlights individual's lived experiences have been very variable, and a lot more needs to be done working together to address challenges faced. Tackling discrimination in any form is everybody's responsibility and diversity of our staff is what has made NHS the success it is.'

Dr Thilan Bartholomeuz
Clinical Director – Mid-Nottinghamshire Place Based Partnership

'The pandemic has sadly exacerbated many of the existing inequalities that affected minority communities. In Nottinghamshire we are proud to have a diverse workforce which serves a community comprising of many cultures and ethnicities but unfortunately, the flip side of this diversity is that it has been disproportionately impacted by the pandemic. We as an LMC are at the forefront of addressing these disparities via our EDI forum. We have been working with the Racial Equality and Diversity Working Group who are also are doing excellent work in identifying and challenging the inequalities that are experienced by traditionally marginalised and minority group. We hope to continue working collaboratively to achieve our collective goals.'

Dr Carter Singh MBE
Chair - Nottingham and Nottinghamshire Local Medical Committee
National Council Member - Royal College of General Practitioners

Executive Summary

In response to the challenge set by the previous Chief People office Prerana Issar in the NHS People Plan [1], as a working group, we believed that it was important to understand the lived experience of our Primary Care workforce on the issues of racism and discrimination. We therefore created and disseminated a survey based on the Workforce Race Equality Standards survey indicators to aid us in capturing Primary Care workforce experience of racial discrimination and racism in Nottingham and Nottinghamshire to better understand our system and to provide recommendations on how we can work towards an inclusive and equitable Primary Care culture.

We must root out the racial inequities experienced by our NHS workforce. We must create a positive workplace culture and an environment where all can belong, develop, and progress. If we earnestly tackle racial equity and diversity with tangible actions and achieve positive outcomes, then we can collectively address all Equality, Diversity, and Inclusion.

As a working group we believe that Equality, Diversity, and Inclusion are not optional extras but are crucial in ensuring the best environment to deliver patient care, better clinical outcomes and promote staff retention [4]

Key survey results:

- 33% of respondents had witnessed a colleague be the subject of racism
- 8% of respondents stated that they believed they faced a barrier to actively practice their religion or belief.
- 22% of Black. Asian and Minority ethnic respondents reported that their education or professional development was affected by racism or discrimination
- 24% of Black. Asian and Minority ethnic respondents reported they received complaints from colleagues due to racism or discrimination.
- 33% of respondents from an ethnic minority background felt that racism and discrimination had impacted the outcome of their job application. 5% of Black African and Caribbean respondents found that their ethnicity negatively affected the outcome of a job application.
- 25% of respondents stated that they did not feel empowered to speak up when they witnessed or experienced racism.
- 68% of respondents stated they were not aware of who their local freedom to speak up guardians are.

Key recommendations:

Supporting and Empowering our Workforce

- ICS OD and People and Culture Board to support Place Based Partnerships to develop Black, Asian and Minority Ethnic Network for staff support and discussion.
- ICS OD and People and Culture Board to support employing organisations in Place Based Partnerships to review recruitment practices, complaints procedures and equality diversity and inclusion policies in line with Regional and National guidance.
- Tailored Wellbeing offer for Primary Care workforce
- ICS to support Primary Care development and support for Freedom to Speak Up Guardians across Nottingham and Nottinghamshire and remove barriers that prevent staff from speaking up.

- Committed and transparent communication between ICB, ICS Organisational Development, People and Culture Board with Primary Care in ensuring tangible actions and outcomes in supporting and empowering our workforce
- Use of agreed ICS Maturity Matrix use to meaningfully assess and track progress in tackling workforce racial inequalities.

Inclusive, Compassionate and Representative Leadership

- Developing Inclusive, Compassionate and Representative Primary Care leadership and talent within the ICS that is reflective of Primary Care workforce.
- ICS commitment to provide investment and support for training of Primary Care WRES Experts to support system delivery
- ICB commitment to engage with Sponsorship/Reverse Mentoring Programmes for Primary Care Workforce and system leadership
- ICS HR/OD Support and Standardisation of education, training and HR across ICS through provision and support at place level
- ICS OD and People and Culture Board accountability on tackling racial inequities in Primary Care and commitment to investment to support roles tackling racial inequalities and for further Equality, Diversity, and Inclusion programme of work across Nottingham and Nottinghamshire
- Executive sponsor for tackling Racial Inequality at Place Level
- Use of agreed ICS Maturity Matrix to meaningfully assess and track progress in tackling workforce racial inequalities
- ICS and Primary Care commitment to reviewing of job descriptions and interview panel training through support from system Workforce Race Equality Standard (WRES) expert or Equality Diversity and Inclusion lead, to ensure equity and parity throughout recruitment process.

Embedding Cultural Change

- ICS commitment to investment in Education and embedding of cultural change for Primary Care Workforce – cultural safety, bias, bystander training, antiracism education workshops
- ICS OD and People and Culture Board accountability in standardisation of Antiracism and Bystander training across Primary Care workforce
- Embedding Race Equity and Equality, Diversity, and Inclusion in Primary Care and across ICS

Methodology

The aim was to conduct the survey with all Primary and Community care colleagues working within Nottingham and Nottinghamshire from 17th January 2022 to 13th March 2022. The survey was electronically distributed to approximately 3,835 Primary Care colleagues (data as of September 2021 and prior to inclusion of Dentistry, Optometry, Community Pharmacy and Bassetlaw Primary Care workforce as part of Nottingham and Nottinghamshire Primary Care Workforce). [5]

This survey was based on the Workforce Race Equality Standard indicators [3] which are already established in secondary care, this data and background can be found at **https://www.england.nhs.uk/wp-content/uploads/2017/03/wres-technical-guidance-2019-v2.pdf**

This consisted of a total of 39 questions; 39 tick box questions in addition to 27 opportunities for additional free text comments to be included.

Survey participants were advised that the survey would take 15-20 mins to complete anonymously, and 367 colleagues responded. Because not all survey's respondents were from Nottingham and Nottinghamshire these results were removed, leaving 361 survey results which were included in the analysis. This equated to a response rate of 9.4% from Primary Care colleagues.

Survey Monkey was used to create and disseminate the survey across the Nottingham and Nottinghamshire ICS. The results are stored anonymously and securely on the Survey Monkey software hosted by the Nottinghamshire Alliance Training Hub (NATH).

Before analysis the gathered data and the dataset was checked for missing data. The data was then used to create graphs, charts, word clouds. Free text responses were at times categorised into emerging themes to pull together an understanding of colleague experiences. At each point where a free text response was requested, participants were asked for consent to share the text anonymously. Where it has not been possible to share the full text (as consent was not given), emerging themes have been derived from these responses to add to further understanding of the discriminatory experiences faced by our Primary Care colleagues.

The free text responses were reviewed and grouped into key themes and to help identify patterns. to gain a deeper understanding of participants' perceptions and described experiences.

This survey was designed as a method of capturing staff experience of racial discrimination and racism in Nottingham and Nottinghamshire to better understand our system and to provide recommendations on how we can have an inclusive and equitable Primary Care culture.

This survey was not designed as quantitative and qualitative research; we are not presenting statistics we are presenting colleagues quotes and lived experiences so that we can continue the conversation and implement strategies and solutions to tackle racial inequalities.

Acknowledgements

We are grateful to all colleagues who have completed this survey and to colleagues who have shared their lived experiences.

We would also like to thank the Racial Equity and Diversity working group members and all who have supported this survey and given their time, perspectives, and support to this work.

Key Findings

Key Findings Section 1: Demographics

1.1 Locality of respondents

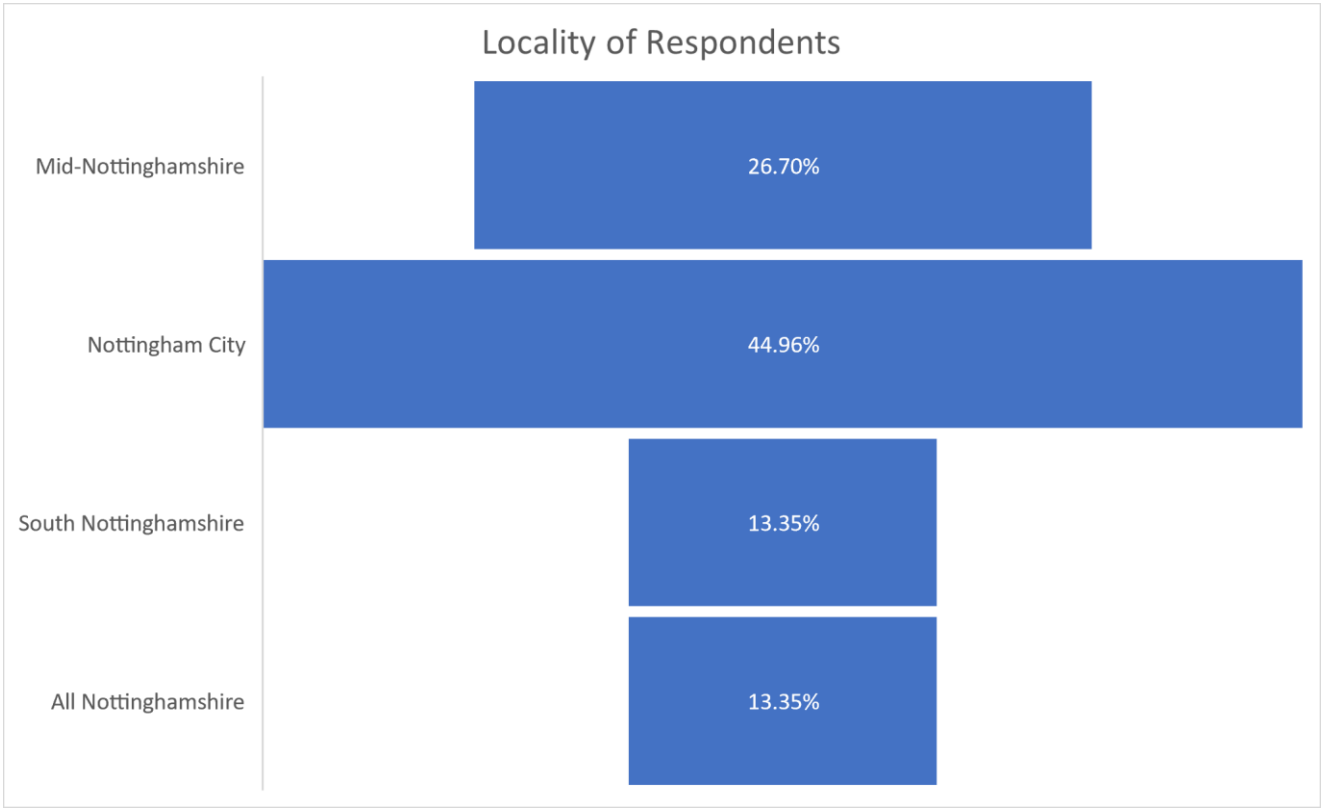

Figure 1 Locality of survey respondents

This survey was disseminated across all networks in Nottingham and Nottinghamshire with support from colleagues such as Place Based Partnership Locality Directors, Primary Care Network (PCN) Federations, PCN Clinical directors.

We received a total of 361 Responses. 52% of respondents stated that they worked in urban Nottinghamshire settings and ~40% of respondents stated that they either worked in suburban or rural Primary Care settings.

Approximately 45% of responses from Primary Care colleagues worked in Nottingham city, followed by ~27% of responses from Mid Nottinghamshire. Approximately 13.4% of Primary Care colleagues worked in South Nottinghamshire and 13.4% worked in roles which covered the whole of Nottinghamshire.

This survey was released prior to the merger of Nottingham, Nottinghamshire, and Bassetlaw and as such there are no responses from our Primary Care colleagues in Bassetlaw place.

1.2 Age of respondents

There is an approximately even split in the Primary Care age breakdown with 45% of respondents aged 26-45 and 46% of respondents aged 46-65.

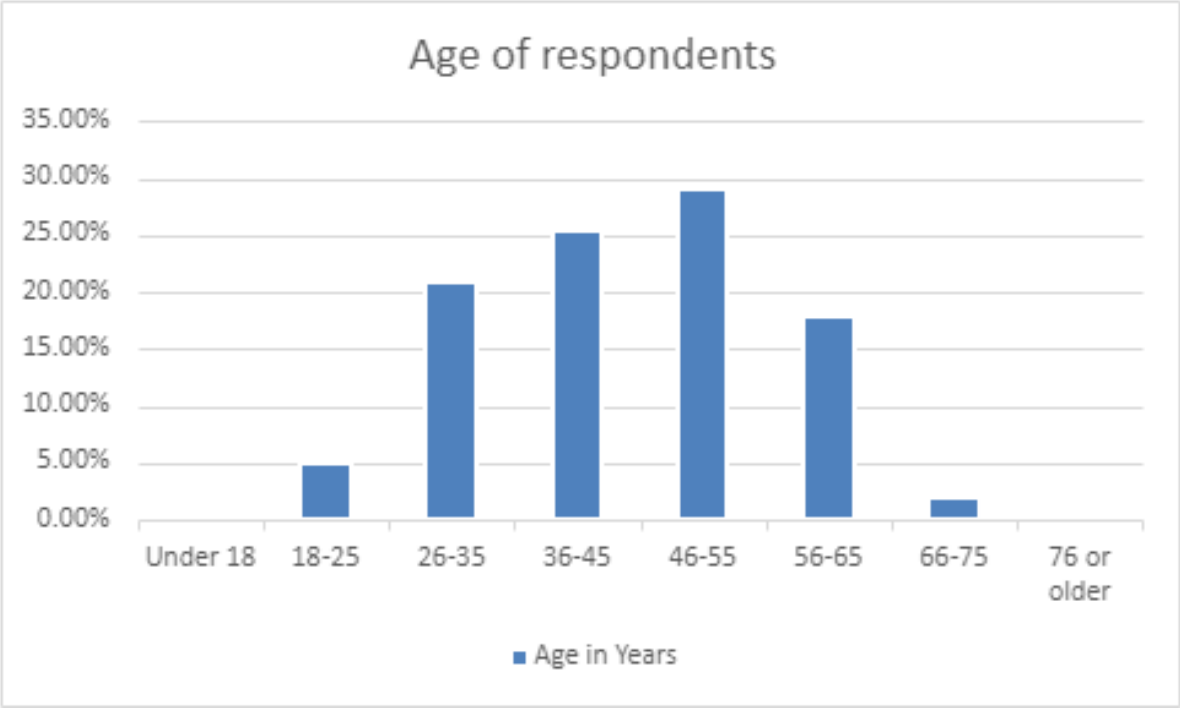

Figure 2 Age of survey respondents

Ethnicity of respondents– see appendix 2 for graphical display of data

Table 1 Ethnicity of survey respondents

Arab	0.63%
Asian/Asian British – Indian	12.81%
Asian/Asian British – Pakistani	5.00%
Asian/Asian British – Bangladeshi	0.00%
Asian/Asian British – Chinese	1.56%
Any other Asian background, (please describe)	1.56%
Black/African/Caribbean/Black British – African	4.06%
Black/African/Caribbean/Black British – Caribbean	3.13%
Any other Black/African/Caribbean background, (please describe)	0.00%
Mixed/Multiple ethnic group - White and Black Caribbean	2.81%
Mixed/Multiple ethnic group - White and Black African	0.63%
Mixed/Multiple ethnic group - White and Asian	1.25%
Any other Mixed/Multiple ethnic background, (please describe below)	0.31%
White - English/Welsh/Scottish/Northern Irish/British	62.19%
White – Irish	1.25%
White - Gypsy or Irish Traveller	0.00%
Any other White background, (please describe below)	2.19%
Any other ethnic group, **- please see appendix 3 for further information**	0.63%

There is noticeable diversity in ethnicity of the Nottingham and Nottinghamshire Primary Care workforce. Approximately 62% respondents are from a White British heritage, 38% of respondents are from Black, Asian, and Minority Ethnic communities.

1.3 Profession and country of Training

Figure 3 Country of training

9% of respondents are internationally trained healthcare professionals from nursing to advanced practitioners and medical colleagues. Unfortunately, this survey did not capture much data from healthcare professional trainees (i.e., GP trainees). We are, however, aware that Nottingham and the East Midlands has a significant number of international medical graduates who reside and train in Nottingham and Nottinghamshire and therefore believe that greater focus should be made to encourage submission of responses from medical and non -medical trainee colleagues when disseminating this survey in the future.

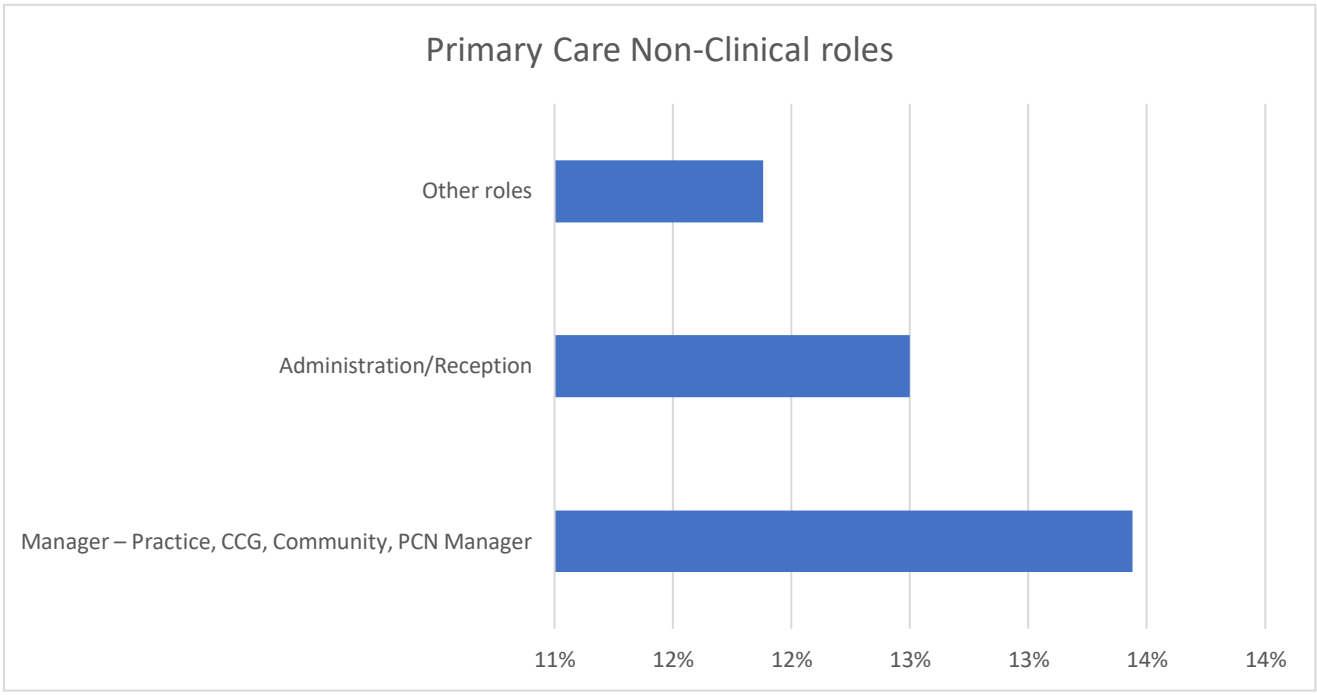

Figure 4 non-clinical roles in Primary Care

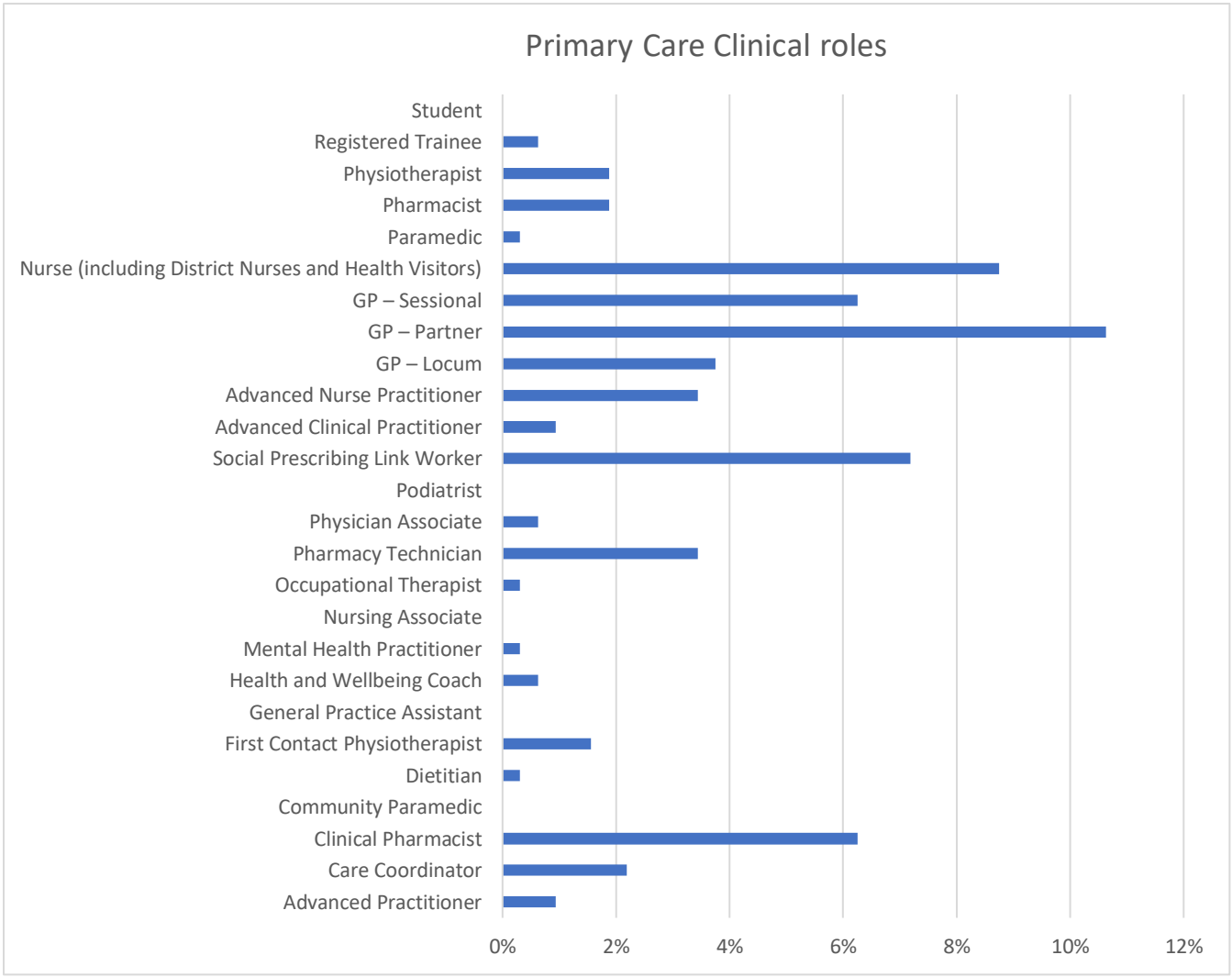

Figure 5 Clinical roles in Primary Care

Approximately 3835 colleagues make up Primary Care workforce in Nottingham and Nottinghamshire (Data as of September 2021 and presented to ICB in March 2022) [5].

It is important to note that over the past two years Primary Care workforce has rapidly grown with the inclusion of the Primary Care Network Additional Roles Reimbursement Scheme which sees the wider inclusion of healthcare professionals such as Clinical Pharmacists, First contact physiotherapists, Wellbeing coaches, Mental Health practitioners, Physicians Associates.

Nationally work has been undertaken to access the impact of racial inequalities facing NHS staff in both the Primary and Secondary care setting, however most of this work has focused on the experiences of doctors and nurses.

We would like to encourage Nottingham and Nottinghamshire system leaders to seek to understand the experiences of colleagues all professional groups within its system so that the system is fully informed and implements strategies which support the whole Primary Care workforce and is not selective in its scale and impact.

We would also encourage that in the future there is greater engagement and dissemination to healthcare professional trainees within the system to ensure that their experiences are included in our understanding of the Nottingham and Nottinghamshire ICS.

1.4 Religion and barriers faced

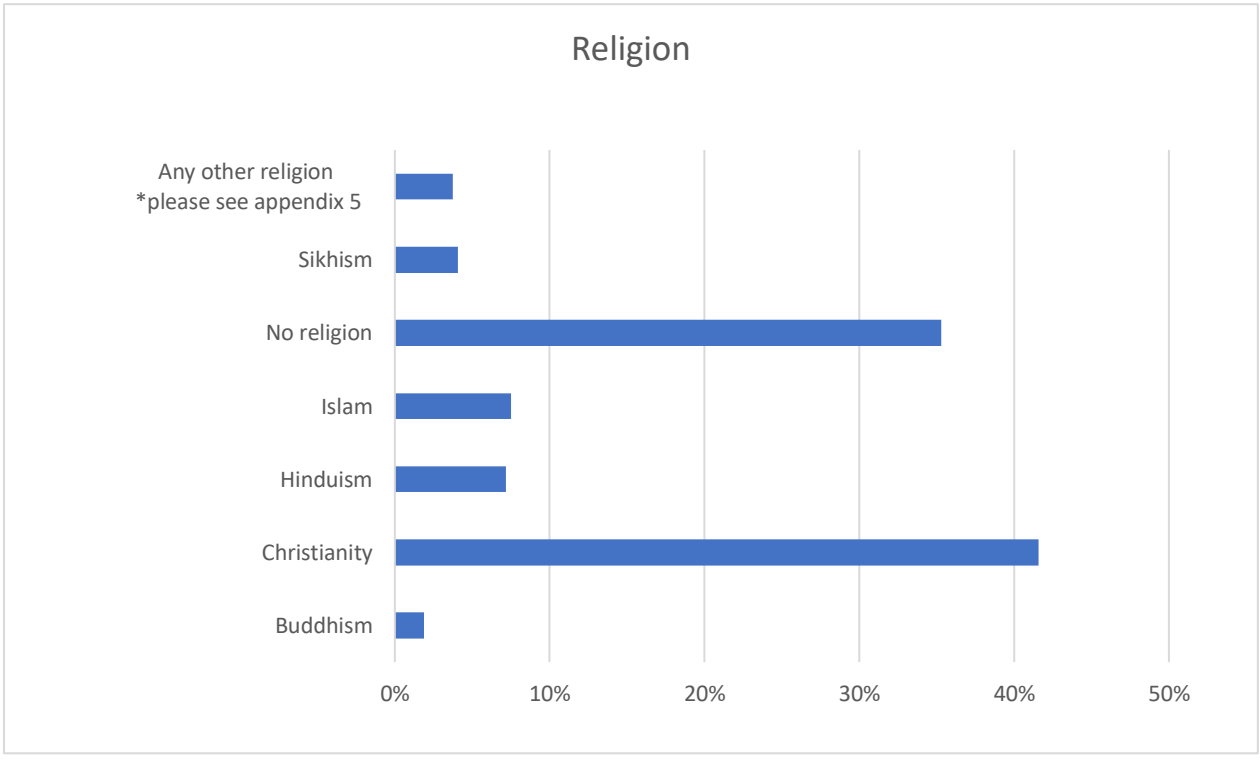

Figure 6 Religion

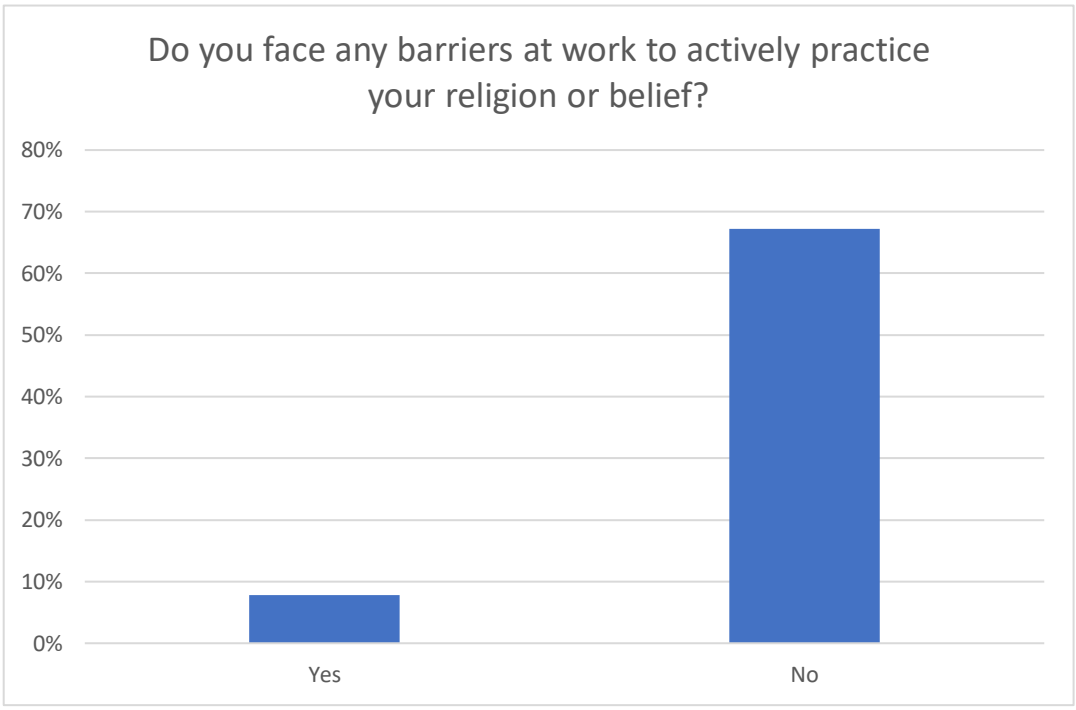

Figure 7 Barriers at work to actively practice religion or belief.

Over 64.7% of respondent identified as having a religious belief and of these, approximately 8% of respondents stated that they believed they faced a barrier to actively practice their religion or belief.

These gathered themes highlight examples as to the reasons why colleagues view that there is a barrier to express or be open about their religious beliefs. The themes are listed below:

- Lack of organisational leadership viewing issues with intersectional lens
- Issues around time off for religious or cultural celebrations
- Lack of facilities (i.e., prayer room)
- Stereotyping of religious group impacting equity in workplace
- Emotional conflict in expressing religious belief in the workplace
- Keeping work and religion separate
- Desire to fit in and not wanting to come across as overly religious or difficult
- Lack of understanding of experiences of diverse ethnicities
- Lack of safety in organisational culture
- Denial of lived experience

Some colleagues also stated that they did not practice their religion.

1.4 Gender Identity and Sexual Orientation

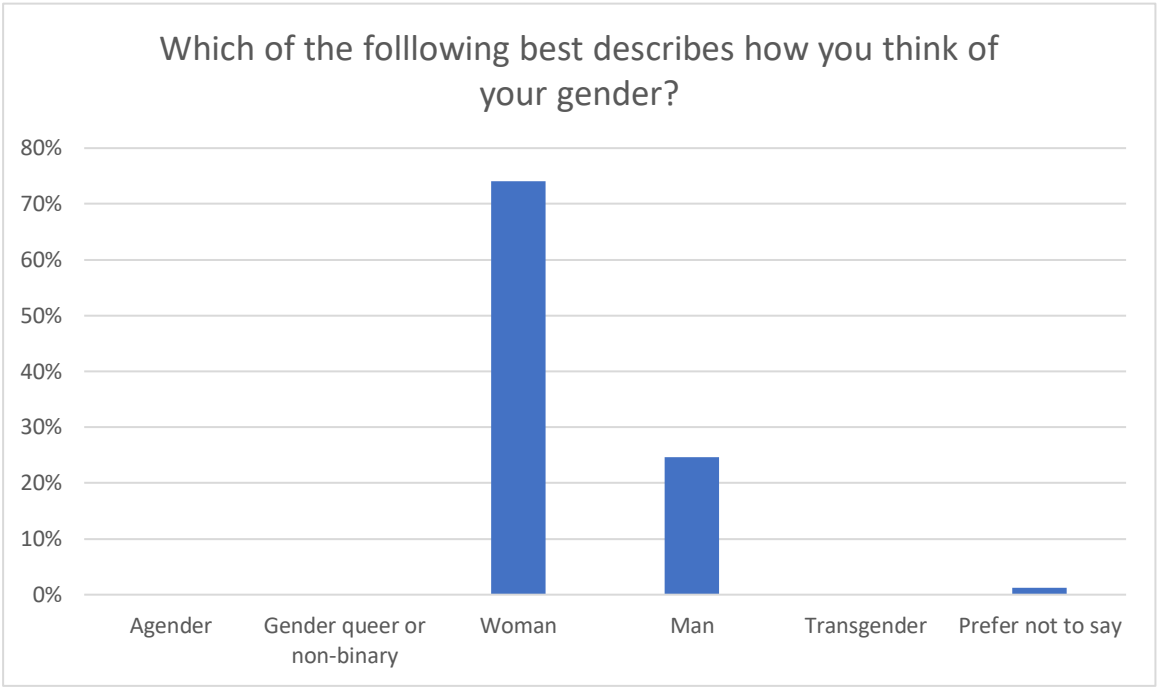

Figure 8 Gender identity and sexual orientation

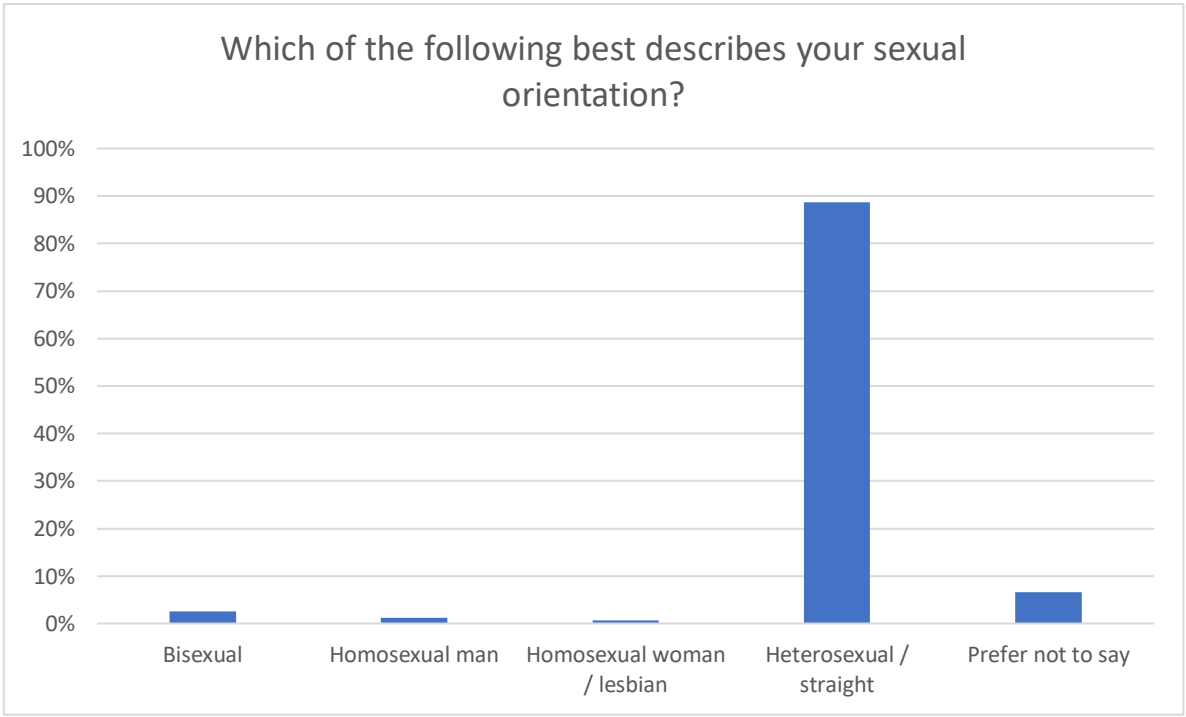

Figure 9 Sexual orientation

74% of respondents identified as women which slightly less than national 2018 NHS workforce data which is 77%[6]

Almost 90% of respondents identified as heterosexual, however it is important to note that % of respondent identified as bisexual or homosexual with appropriately 8% of respondent indicating that they would prefer not to say.

Section 1 recommended action points:

ICS Leadership recommendations

- Repeat survey to gauge the views of all Primary Care (including dental, optometry and community pharmacy) and across all localities which now make up the Nottingham and Nottinghamshire Integrated Care System.

- Further assessment of diversity of ethnicity across leadership and management levels in the system. Assess to see if representative of Primary Care work force across the ICS and of ICS population.

- Important that as ICS Race equality strategies are developed colleagues in optometry, dental and community pharmacy are engaged with and consulted.

- Important to acknowledge the diversity of ethnicities, heritage and lived experiences of health and social care workforce in Nottingham and Nottinghamshire this could be through holding awareness events/educational sessions, ICS celebration events, encouraging employers to understand workforce diversity and to advocate celebration and assets of diverse workforce to work environment and patient care.

- Public ICS/ICB System statement and commitment to tackling racial discrimination in all forms (from individual to systemic and institutional)

- ICS led development and dissemination of training on developing organisational cultural safety

- ICS and Primary Care leadership education and support to better understand lived experiences of colleagues from ethnic minority backgrounds this can be through sponsorship, reverse mentoring programmes

- ICS Primary Care assessment using an agreed maturity matrix to monitor progress in tackling racial inequalities

- ICS to commission resources to assess the intersections of gender, pay and career progression and seniority.

Primary Care Recommendations

- Resources and materials developed on the topic of Equality, Diversity, and Inclusion (EDI) should be tailored to all roles within Primary Care. Whilst it is helpful to note and review EDI material for NHS provider organisations, the needs and infrastructure of Primary Care mean that optimised material is designed to meet workforce needs and requirements.

- Understand what support and infrastructure is in place when international healthcare professionals move to Nottingham and Nottinghamshire ICS and work as part of our Primary Care workforce force. We understand that work will be undertaken to review this for the Primary Care medical workforce, however we believe that it would be necessary for this work to also be undertaken for other professional groups (i.e., Nursing colleagues). Develop a package of

resources which can be distributed to internationally trained colleagues as part of induction process.

- Important to acknowledge the diversity of ethnicities, heritage and lived experiences of Primary Care workforce in Nottingham and Nottinghamshire. This could be through holding awareness events/educational sessions, ICS celebration events, encouraging Primary Care employers to understand workforce diversity and to advocate celebration and assets of diverse workforce to work environment and patient care. This should also be implemented for all protected characteristics.

- Review social, legal and immigration assistance mechanisms currently in place for Primary Care colleagues in Nottingham and Nottinghamshire ICS to ensure sufficient support is in place to deliver effective workforce wellbeing and to drive workforce retention.

- ICS and Primary Care leadership training and support to better understand lived experiences of colleagues from ethnic minority backgrounds; this can be through sponsorship, reverse mentoring programmes.

- Use and assessment of an agreed maturity matrix to access development and progress of Primary Care in tackling racial inequalities.

Key Findings Section 2: Discrimination from colleagues/profession/ employer

This section focused on respondents' experiences with discrimination from their peers, colleagues, and the wider Primary Care teams. Respondents training and career choices were also looked at in this section to understand the impact of discrimination with an intersectional lens, ethnicity, religion, culture, and racism.

The definition of discrimination for the purposes of the survey and report is 'the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, ethnicity or religion.'

2.1 Impact on career

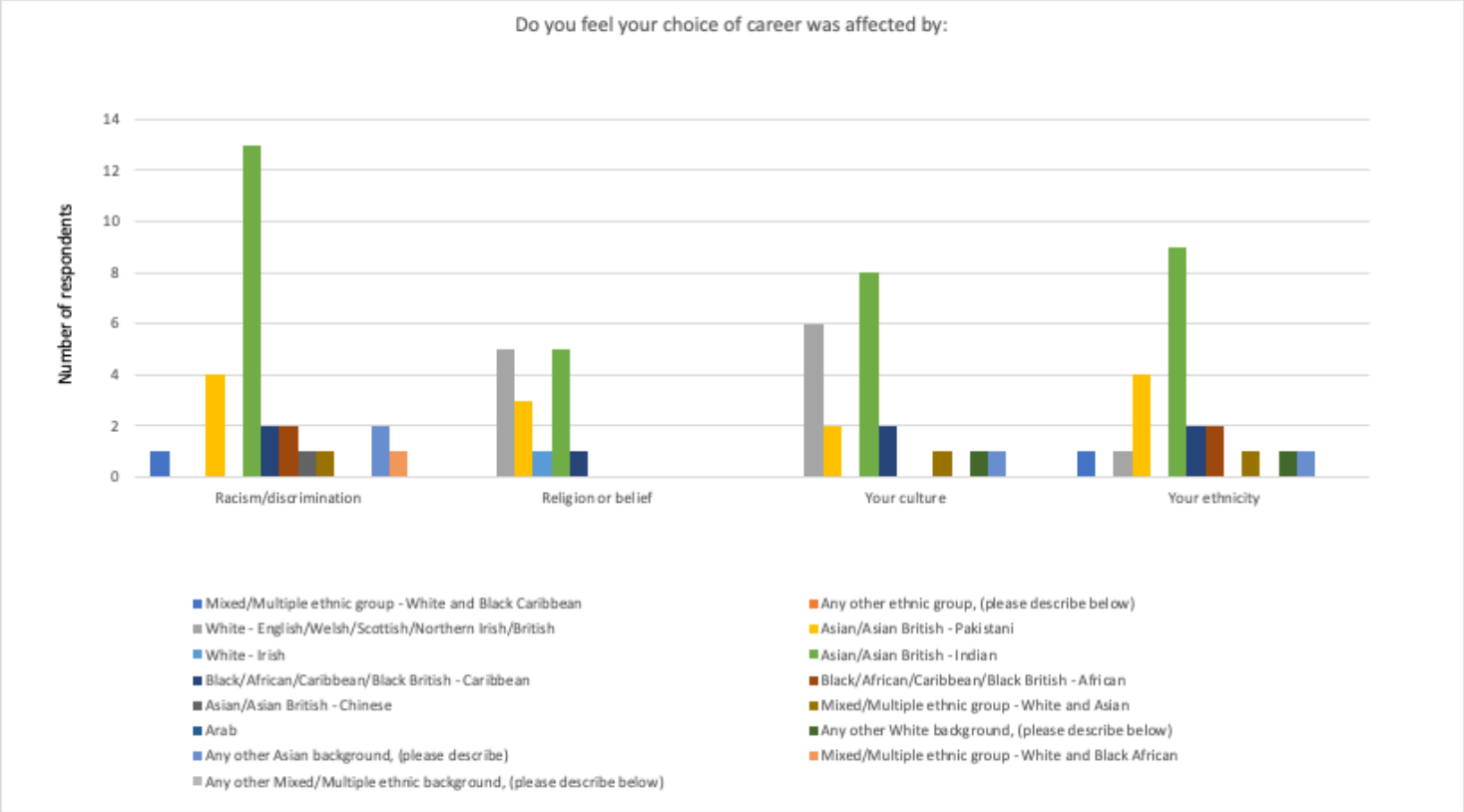

Figure 10 Impact on career

13% of Asian/Asian British Indian respondents felt their career was impacted by racism and or discrimination, the second largest impact being their ethnicity (9%). Whilst those from a Black Caribbean and Black African ethnicity found racism, discrimination and ethnicity equally impacted their career choice (2%).

Those from a White English background were the second largest responder in accounting culture as impacting their career choices (6%)

2.2. Training, Education and Development

There were a total of 143 responses to this question, 40% of those who undertook the survey. Most respondents from an ethnic minority background found their training experience was affected by racial discrimination, closely followed by their ethnicity.

Figure 11 Impact of discrimination/racism, religion, culture and ethnicity on training pathway or training

Common reasons shared by respondents covered concerns around passive and unconscious discrimination and racism, with the reoccurring concerns about these forms of discrimination not only being historical but also present. Some comments included:

'The availability and access to training and additional development appears to have been not transparent for some time'

'Looking back having spent 34 years in NHS there were times when I had to be twice as good or work twice as hard than the local Caucasian colleague to get where I needed to professionally'

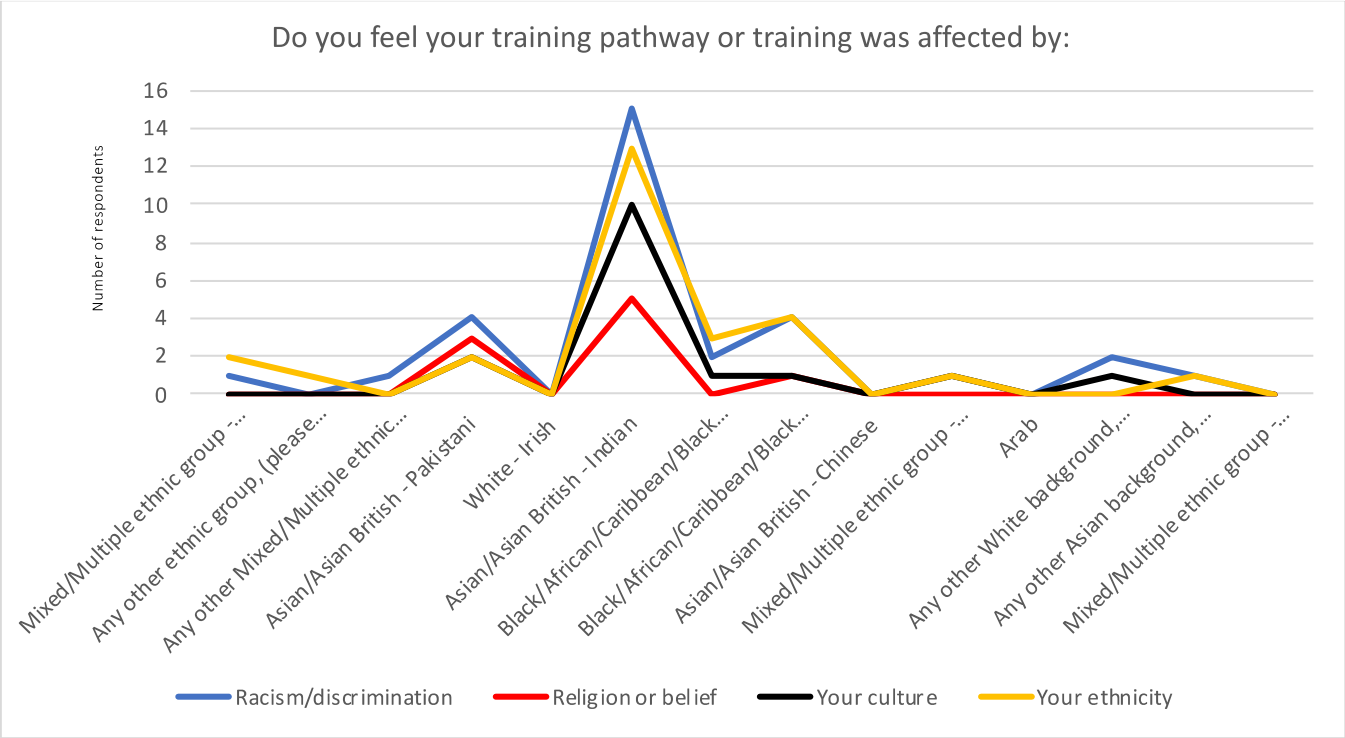

Figure 12 Impact of discrimination/racism, religion, culture and ethnicity on training pathway or training breakdown by ethnicity

Breakdown by ethnicity highlights that, the most common factor respondents felt impacted their training pathway across all ethnicities was racism and/or discrimination. With those respondents from an Indian, Pakistani, Black African, and Caribbean ethnicity impacted the greatest.

2.3 Job applications

33% of respondents from an ethnic minority background felt that racism and discrimination had impacted the outcome of their job application. With 5% of Black African and Caribbean respondents found that their ethnicity affected the outcome of a job application in a negative manner.

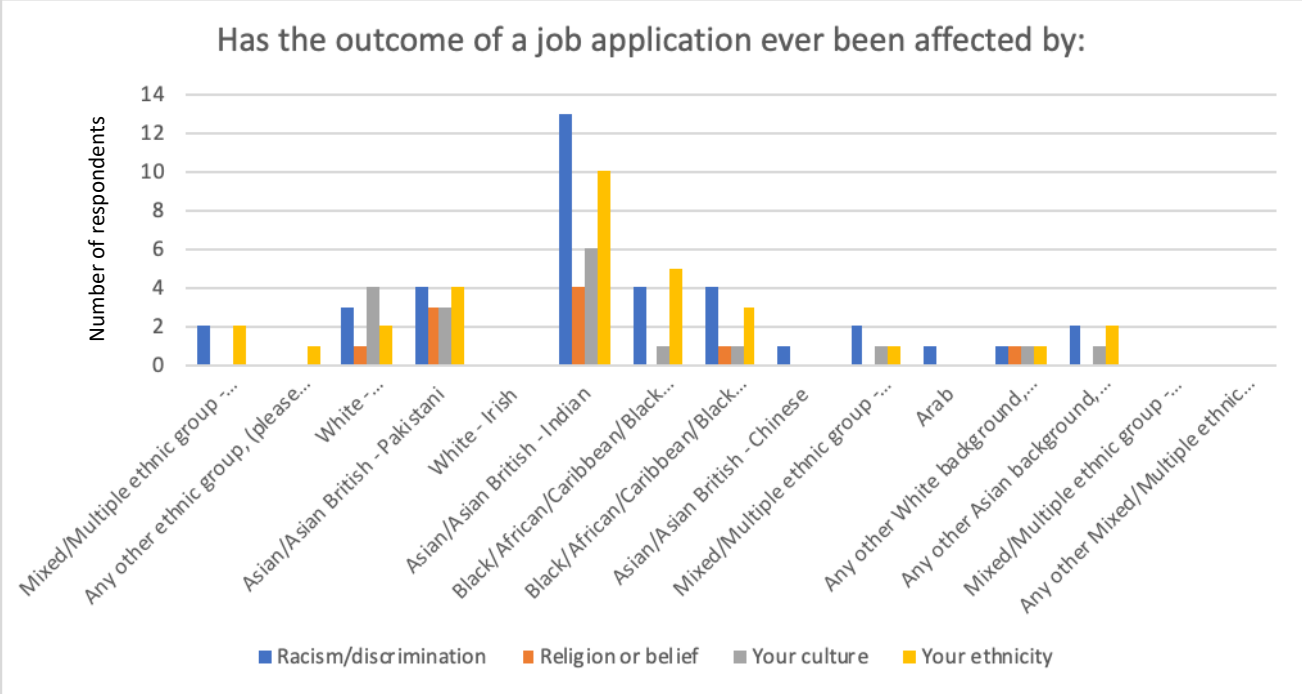

Figure 13 Impact of discrimination/racism, religion, culture and ethnicity on training pathway or training on job applications

Reoccurring themes amongst respondents included both direct and indirect discrimination, where it was apparent to respondents that the situation they were in, that the outcome of the job was impacted due to their race, name and as well as accents.

A respondent shared that they received the following feedback post an application:

'you got to speak like an English man… go for a interview course, learn to speak like local candidate'

2.4 Working pattern

This question focused on respondents working patterns being affected by one of the four parameters. Overall respondents from an ethnic minority background felt all four parameters measured impacted their working patterns, with more than 20% of respondents belonging to an 'other group' reporting racial discrimination to have affected working patterns.

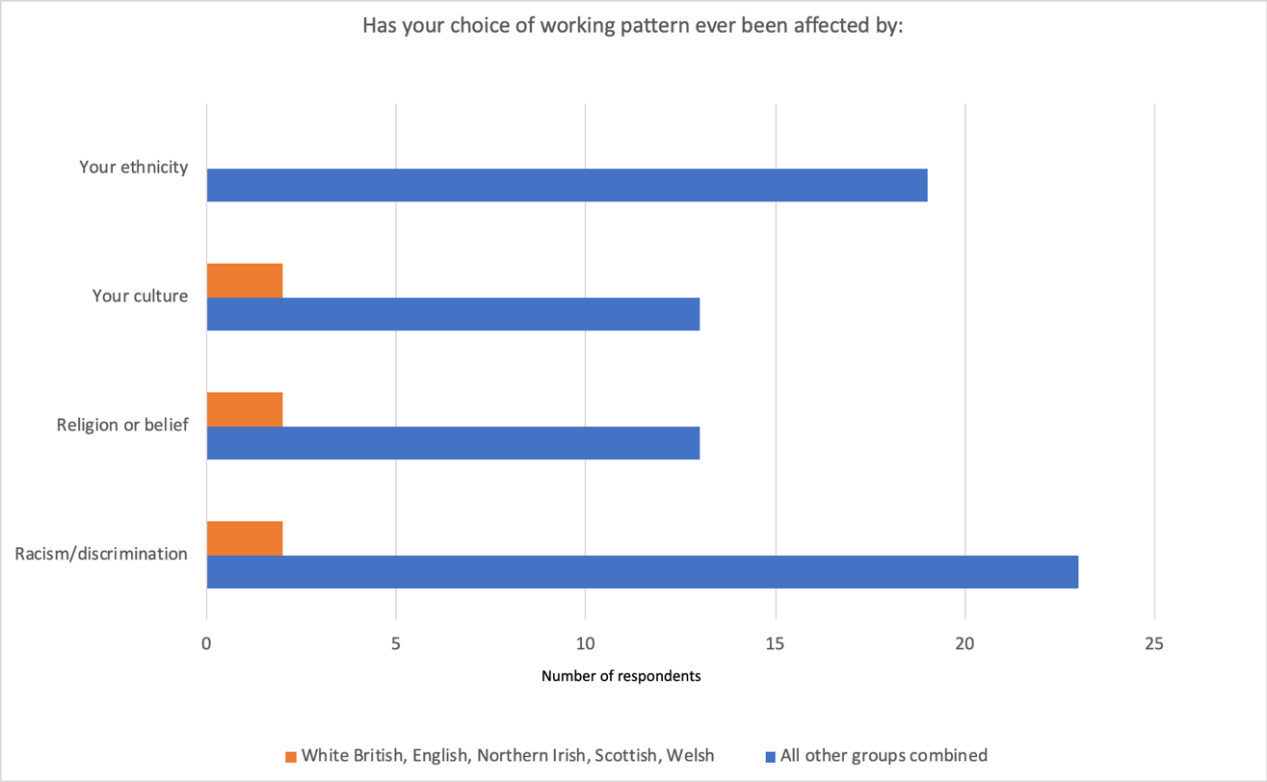

Figure 14Impact of discrimination/racism, religion, culture and ethnicity on training pathway or training on working patterns

A key observation was that culture, religion/belief and racism/discrimination was accounted amongst most responded regardless of ethnicity. This highlights an overall concern regarding working choice pattern and the need for better understanding in preventing bias or discrimination in the areas of culture, ethnicity, religion, beliefs, racism, and discrimination.

2.5 Education and professional development

Impact on respondents' access to education and professional development revealed across the different measures, with racism, discrimination and ethnicity all being key contributors.

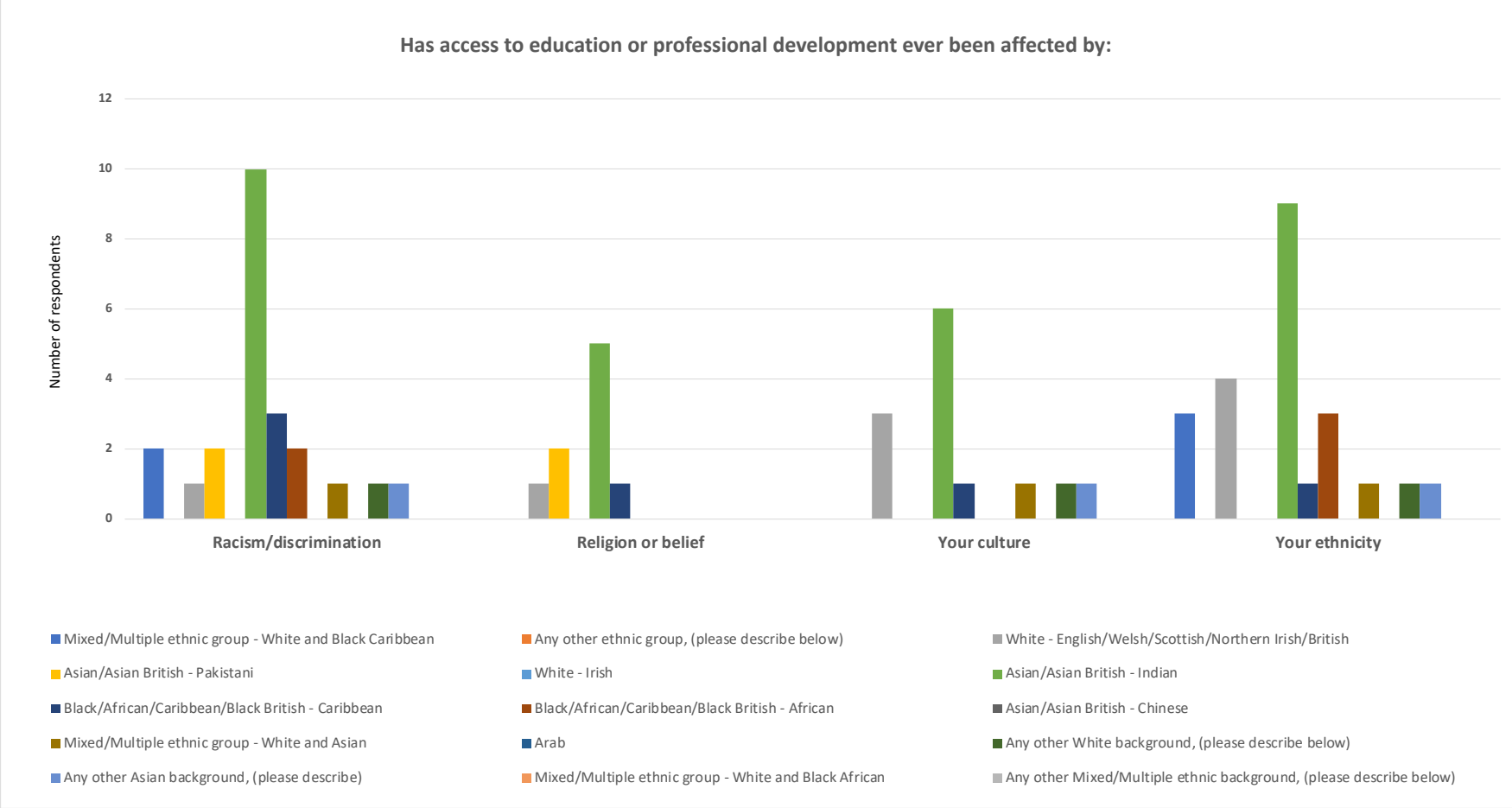

Figure 15 Impact of discrimination/racism, religion, culture and ethnicity on training pathway or training on education and professional development, breakdown by ethnicity

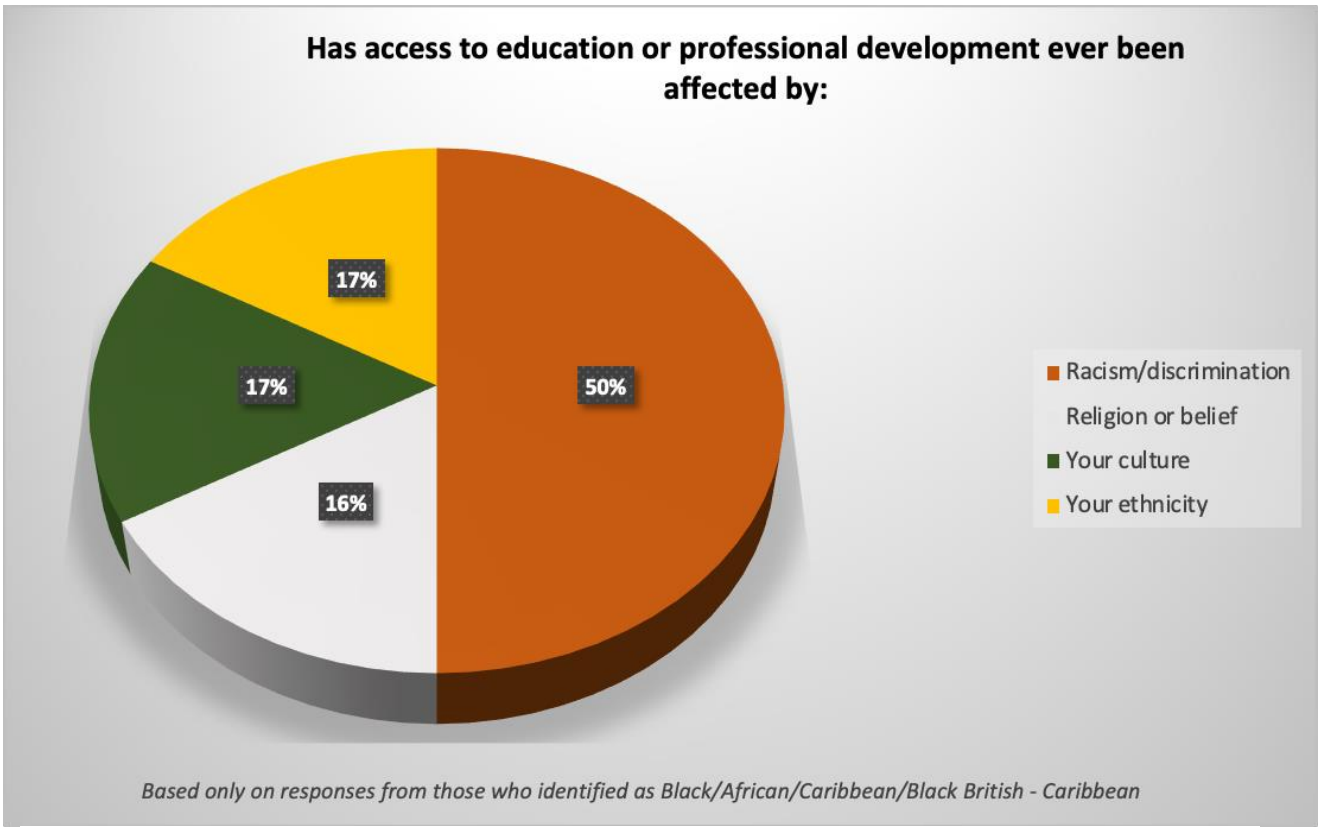

Figure 16 Impact of discrimination/racism, religion, culture and ethnicity on training pathway or training on education and professional development

Respondents who identified as Black Caribbean were impacted by all four categories affecting their education or professional development and 22% of respondents from all ethnic minority backgrounds finding racism and discrimination as being the greatest factor.

2.6 Complaints, disciplinary and performance management

Complaints were broken down within the survey to understand the impact respondents have found in their day to day working life from the public (patients) and colleagues.

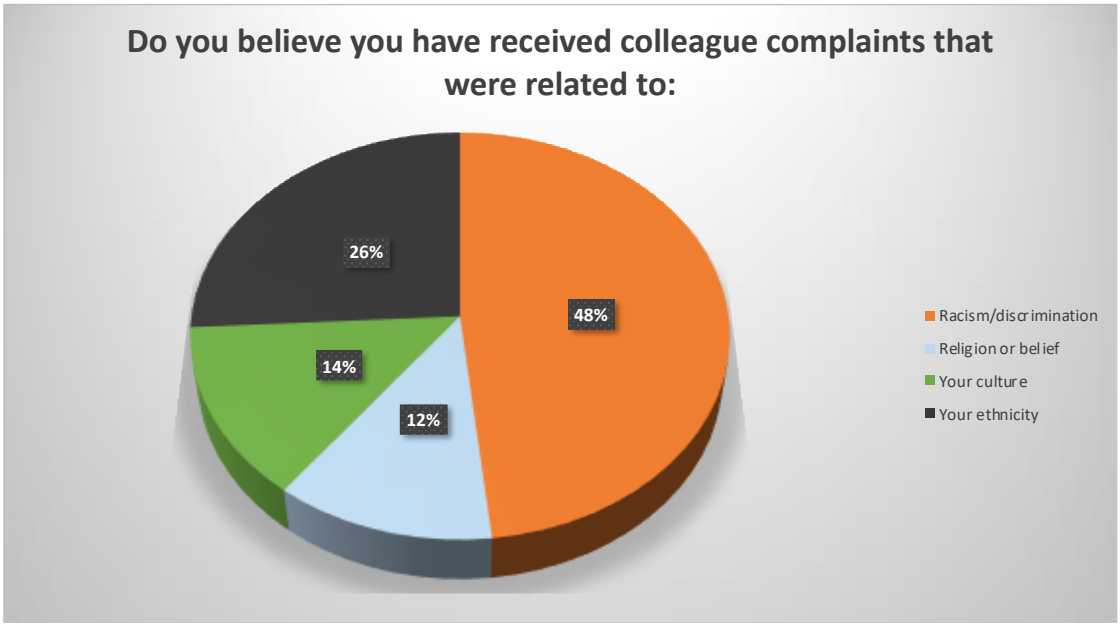

Figure 17 Impact of discrimination/racism, religion, culture and ethnicity on training pathway or training on complaints.

The responses for this part of the survey identified that the complaints received were spread across staff working in all three localities and ethnicities. 24% of respondents, from all ethnic minority groups, believed they received complaints from colleagues due to racism or discrimination.

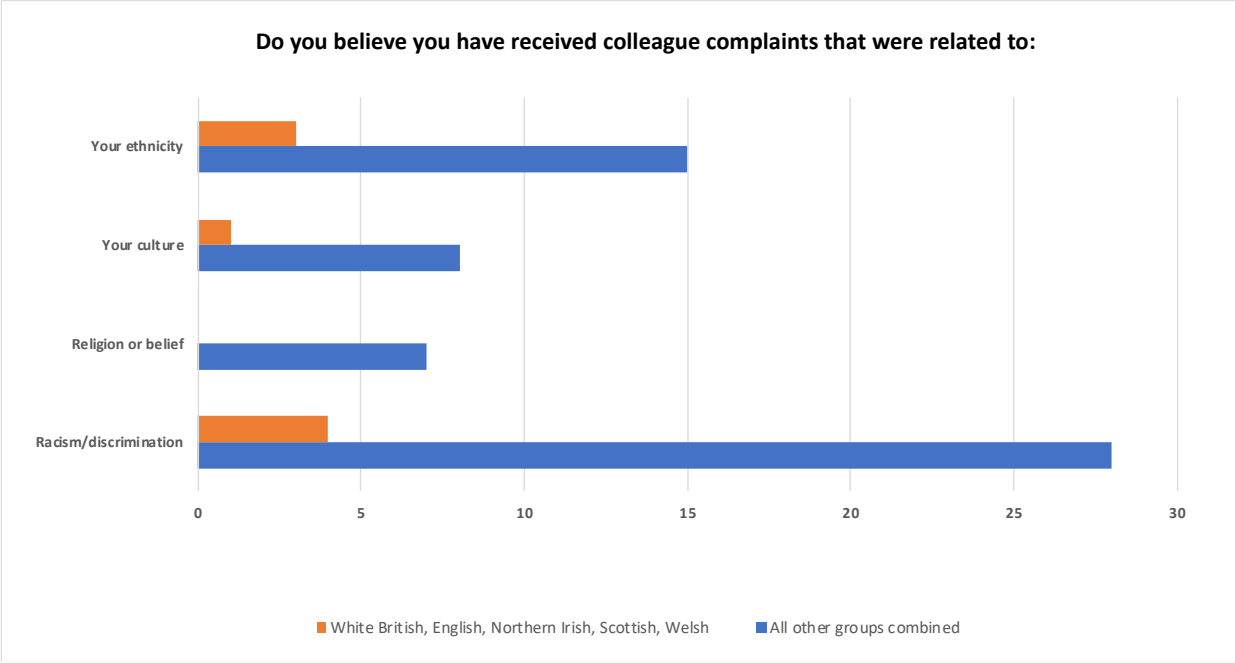

Figure 18 Impact of discrimination/racism, religion, culture and ethnicity on training pathway or training on complaints, breakdown by ethnicity.

Lived experiences were shared via respondents' comments highlighted training needs required around discrimination, bias and need for increased diversity within leadership.

'staff member found it difficult being managed by a black manager.'

The mental health impact on those from a Black, Asian, and Minority Ethnic background who are encountering this bias and discrimination is another reoccurring theme as is increased micromanaging of staff from a from a Black, Asian, and Minority Ethnic background.

'Constantly covering your back. It becomes wearing mentally.'

With this question of the survey highlighting the negative working environments faced by respondents due to behaviour and environments created by colleagues in what is expected to be a safe environment.

Similar themes were found in the responses around respondents undergoing disciplinary or performance management that was related or felt to be related to racism, discrimination, religion, belief, culture, or ethnicity.

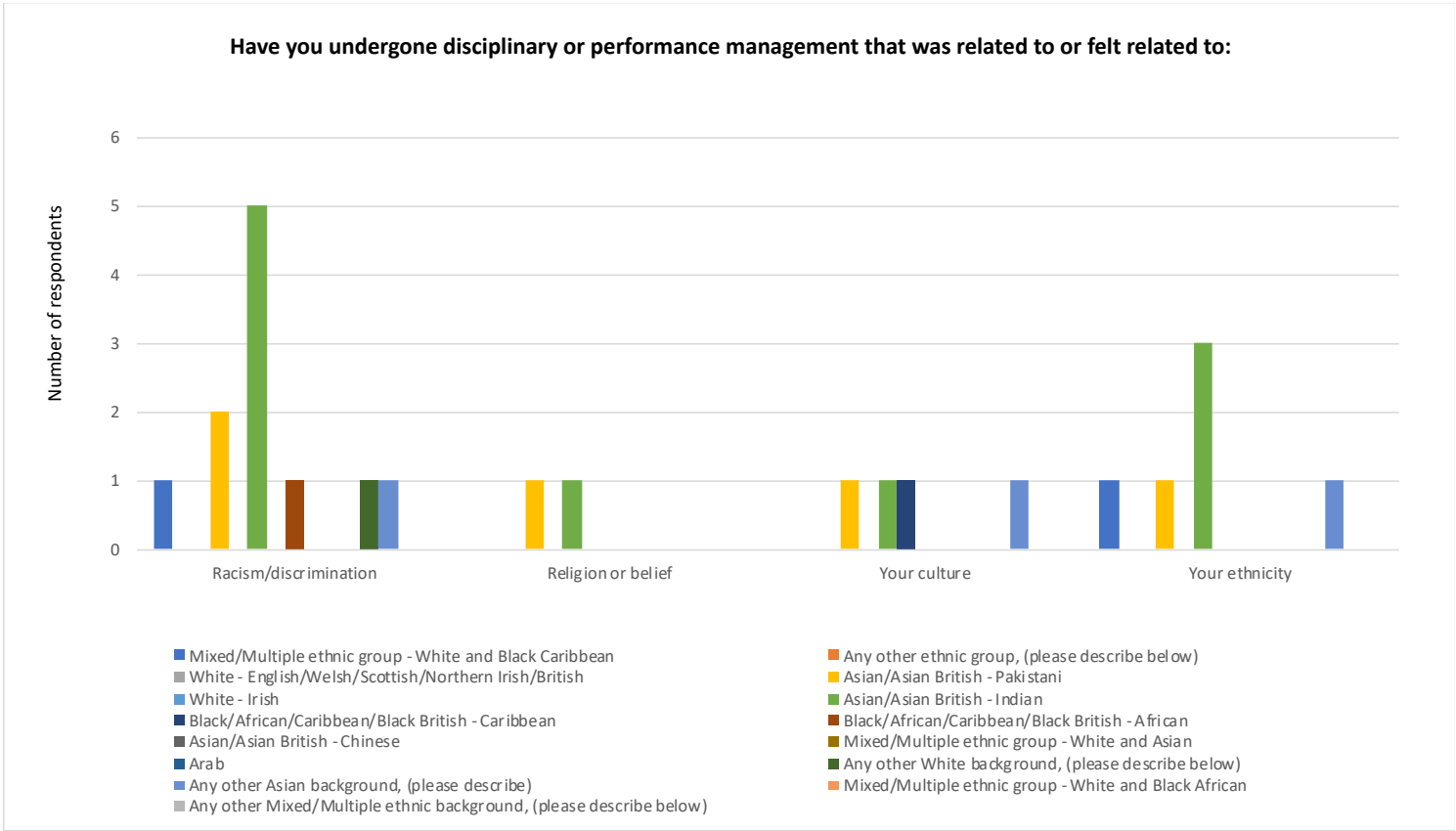

Figure 19 Impact of discrimination/racism, religion, culture and ethnicity on training pathway or training on disciplinary and performance management, breakdown by ethnicity

Respondents across the below Asian ethnicities were found to have been impacted by more than one of these factors at some point within their time in Primary Care.

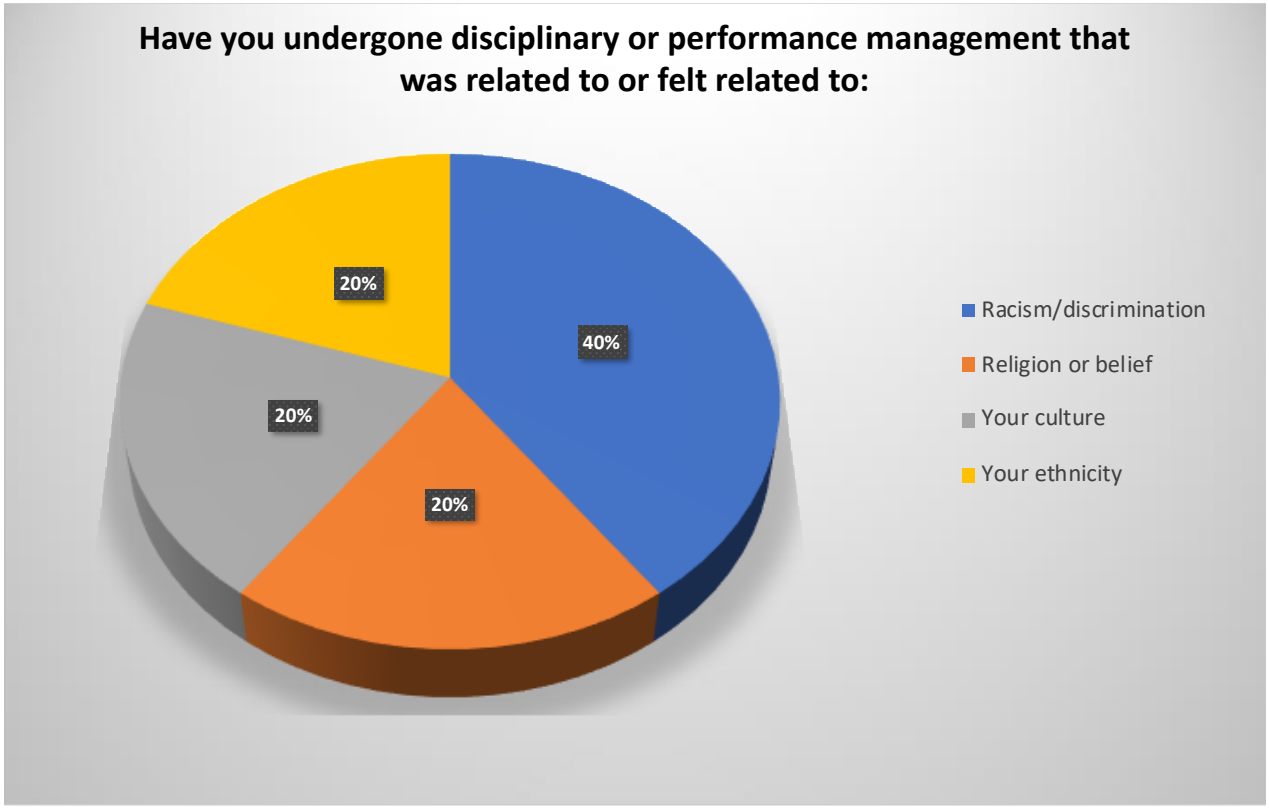

Figure 20 Impact of discrimination/racism, religion, culture and ethnicity on training pathway or training on disciplinary and performance management.

With respondents finding no support from workplaces and being left to intervene to defend themselves or leaving their employment due to the impact on mental health.

2.7 Ethnicity related comments

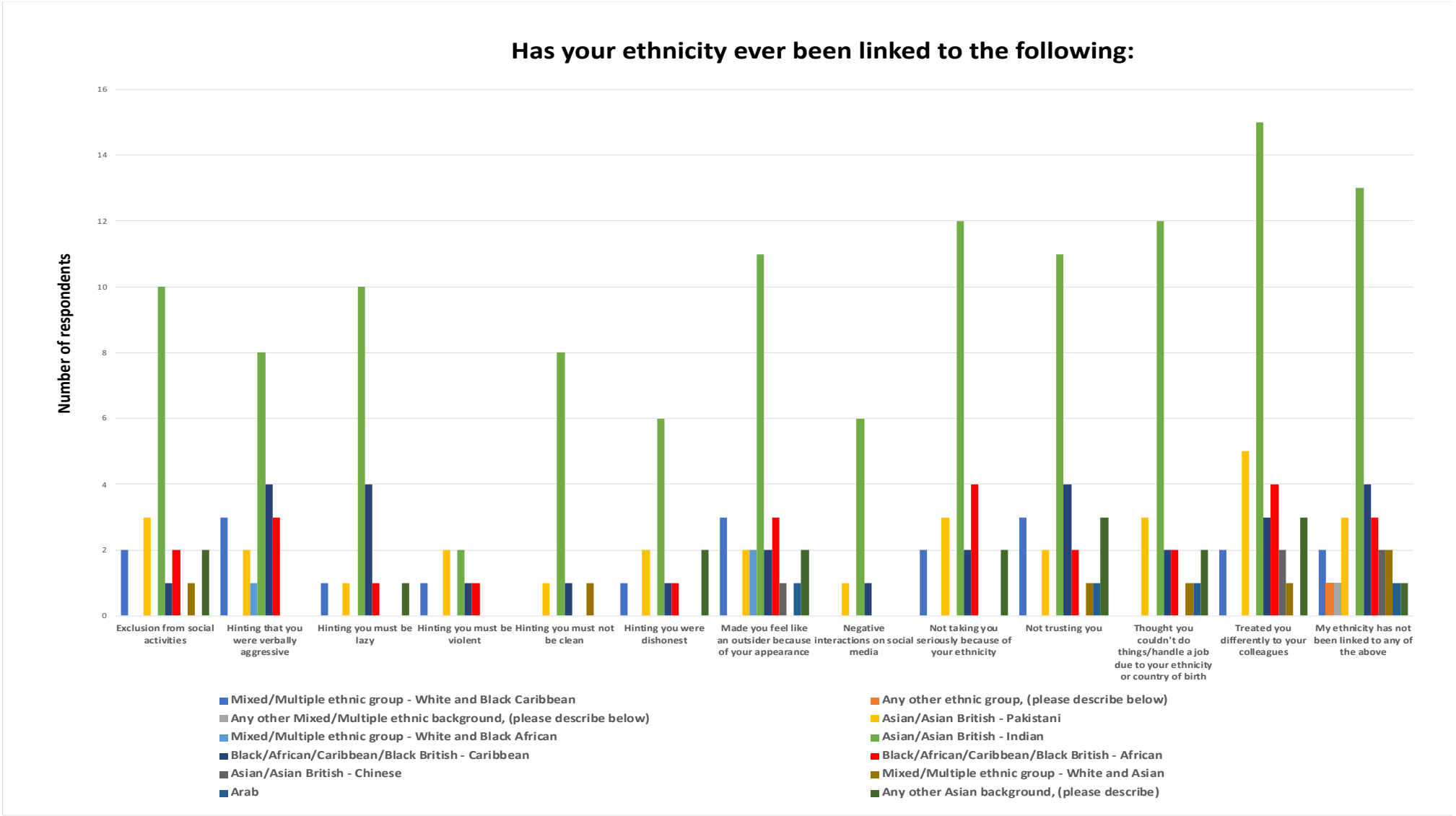

Figure 21 Ethnicity and associations

The following is a focused breakdown on only those respondents whose ethnicity was impacted by the specific comments. Those from an Asian or Asian British Indian background were impacted the most, with 39% finding their ethnicity was linked to them not being taken seriously.

Followed by Black or African Caribbean British respondents (13%) and White British or Asian British Pakistani (10%)

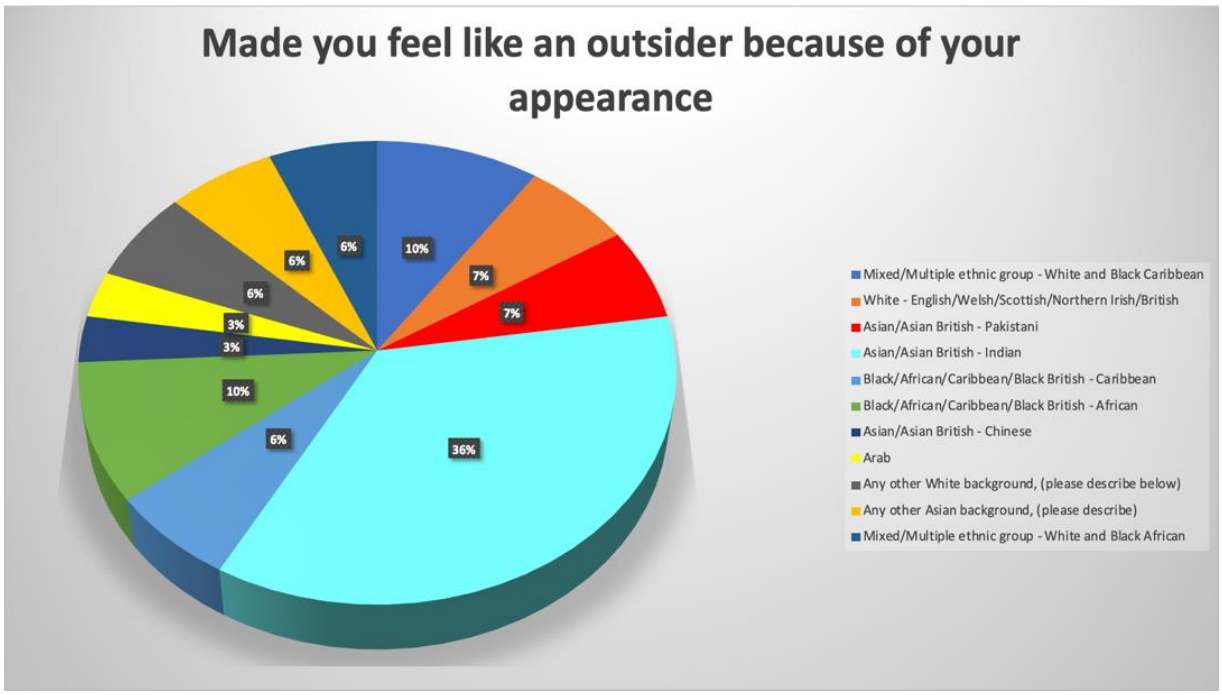

Figure 23 Ethnicity linked to being made to feel like an outsider

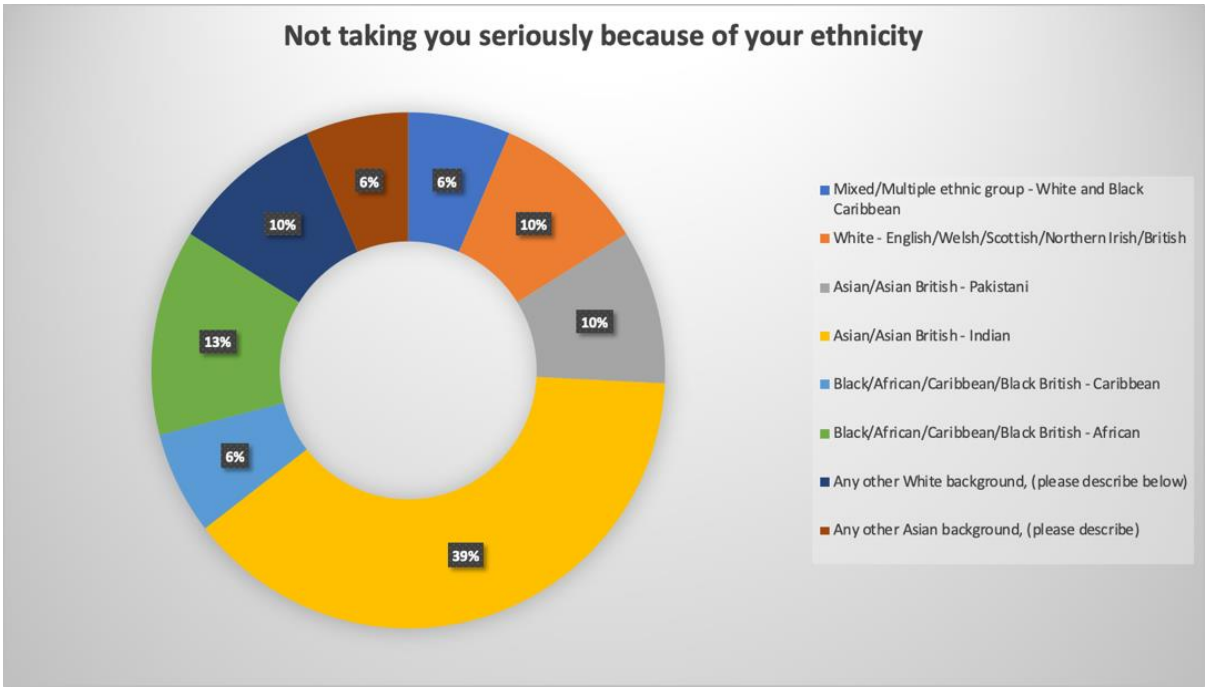

Figure 22 Ethnicity linked to not being taken seriously

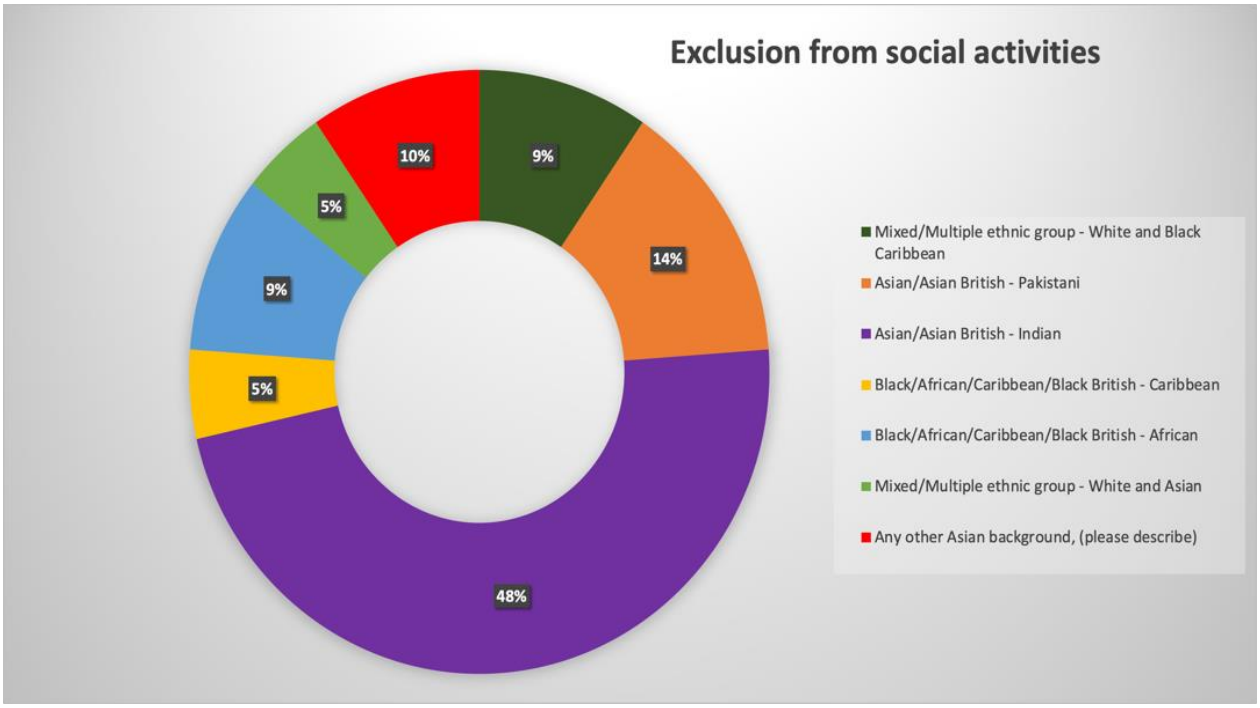

Figure 24 Ethnicity linked to exclusion from social activities

2.8 Racism Experiences

From discussions with stakeholders, we were aware of the need and importance to clarify if respondents were basing experiences on only historical racial experiences or if these were current ones. IT was also found to be important to understand when respondents qualified, for non-clinicians this refers to when they joined Primary Care.

We, therefore, queried if respondents had been the subject of racism in the last 24 months and what year they qualified.

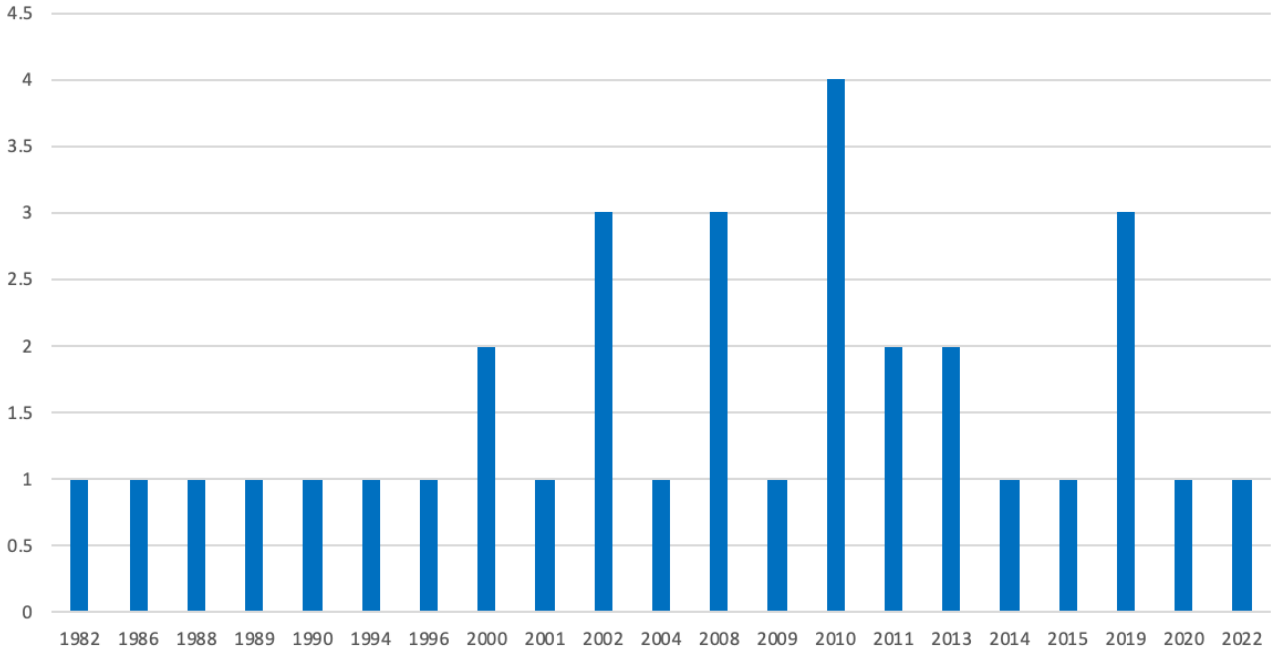

Figure 25 Year of professional qualification

Additional comments shone light on the lack of support and follow up around these incidents by management and colleagues. Where those from an ethnic minority are managing to raise concerns repeated concerns around conflict and poor outcomes have been mentioned.

Where respondents have tried to resolve and discuss the incidents, they have had concerns ignored or have been called out for raising the racist encounters.

''Colleague accused me of going on a witch hunt after her'

Those who were able to raise concerns directly with line management, around physical and verbal racism, found their concerns ***'felt dismissed'*** and no further action or investigations were recorded or noted by respondents.

Not all racism experiences were as obvious, with some more subtle and perceived as passive. With issues raised throughout the Primary Care system around repeated mispronunciation of names and misspellings on repeated episodes.

2.9 Colleague experiencing racism

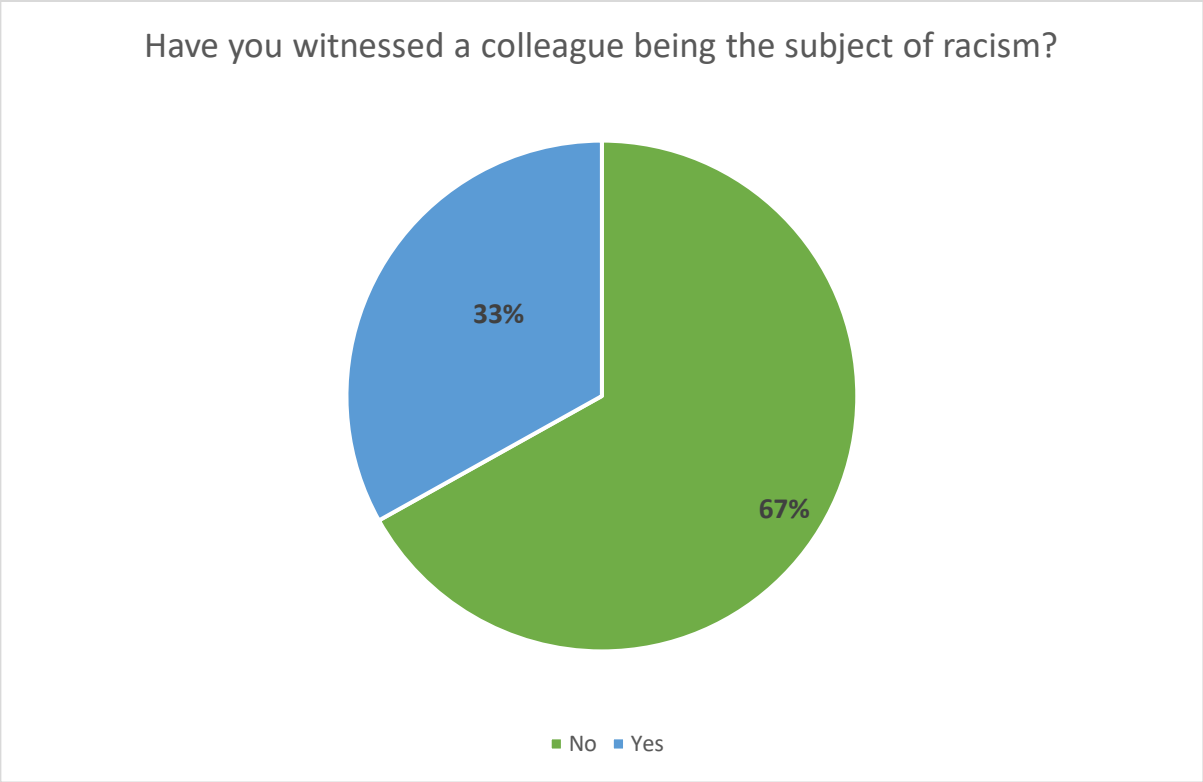

Figure 26 Colleague experiencing racism

Whilst 67% of colleagues stated that they had not witnessed a colleague being the subject of racism, 33% of colleagues had witnessed this and gave examples of when this had occurred. Of those who replied 'yes' to having witnessed a colleague being the subject of racism, 47% were from an ethnic minority background whilst 53% were from a White - English/ Welsh/Scottish/ Northern Irish/ British background.

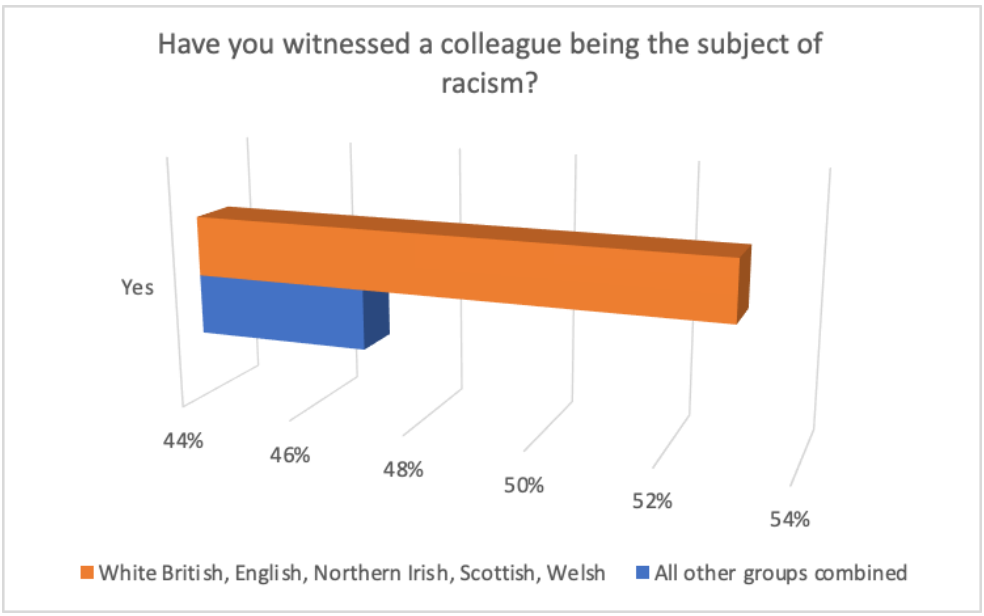

Figure 27 Colleagues experiencing racism, by ethnicity

'Sometimes I have seen a colleague talking to another colleague and joke that she looks like someone selling "The Big Issue", using an accented voice when saying this (and laughing).'

'White and southeast Asian staff get racism on a daily basis from black and Muslim colleagues & patients.'

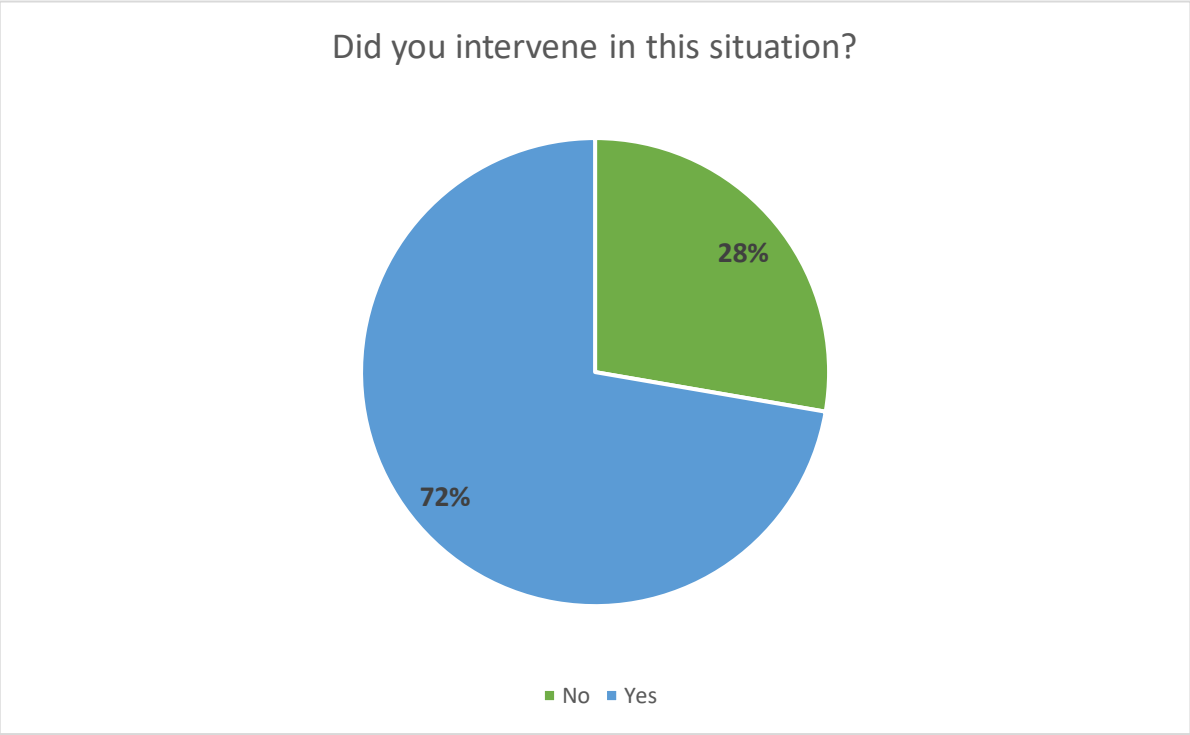

Figure 28 Intervening when witnessing colleague experiencing racism

72% of colleagues stated that they had intervened when they had witnessed a colleague being the subject of racism, 28% of colleagues responded that they did not intervene.

'I arranged to see patient for their next appointment and explained that I trained and observed my colleague and was confident in her abilities. I felt that their complaint/comments had been inappropriate and based on her skin colour and mode of dress. While patient did not comment further, he continued to see my colleague and appeared happy to do so.'

'Lengthy drawn-out investigations into who said what. Foreign staff member accused of saying things that she claimed she hadn't said. Patient accusing staff member of being aggressive. I have called for all telephone calls to be recorded.'

'Gentle explanation that offensive & reminded that those who speak several languages be e.g., Trained elsewhere often have far more skills than those without'

'it was raised with and dealt by the management team.'

Some respondents who stated no gave the following examples/reasons:

'It was reported as discrimination, but nothing was done, or training offered'

It was a manager and she thought it was funny and I did not speak up that I thought it could be construed as inappropriate. I guess I didn't want to feel judged by voicing thoughts such as these.

I intervene but never get support because the Diversity departments are promoting anti-white racism, misandry, heterophobia, and Christophobia. Other senior staff are too scared to intervene because of Wokeness & cancel culture.

What can a lone voice do?

Emerging themes from respondents who did not give their consent to share their statements included:

- Fear of reprisal if intervened
- Fear of being singled out

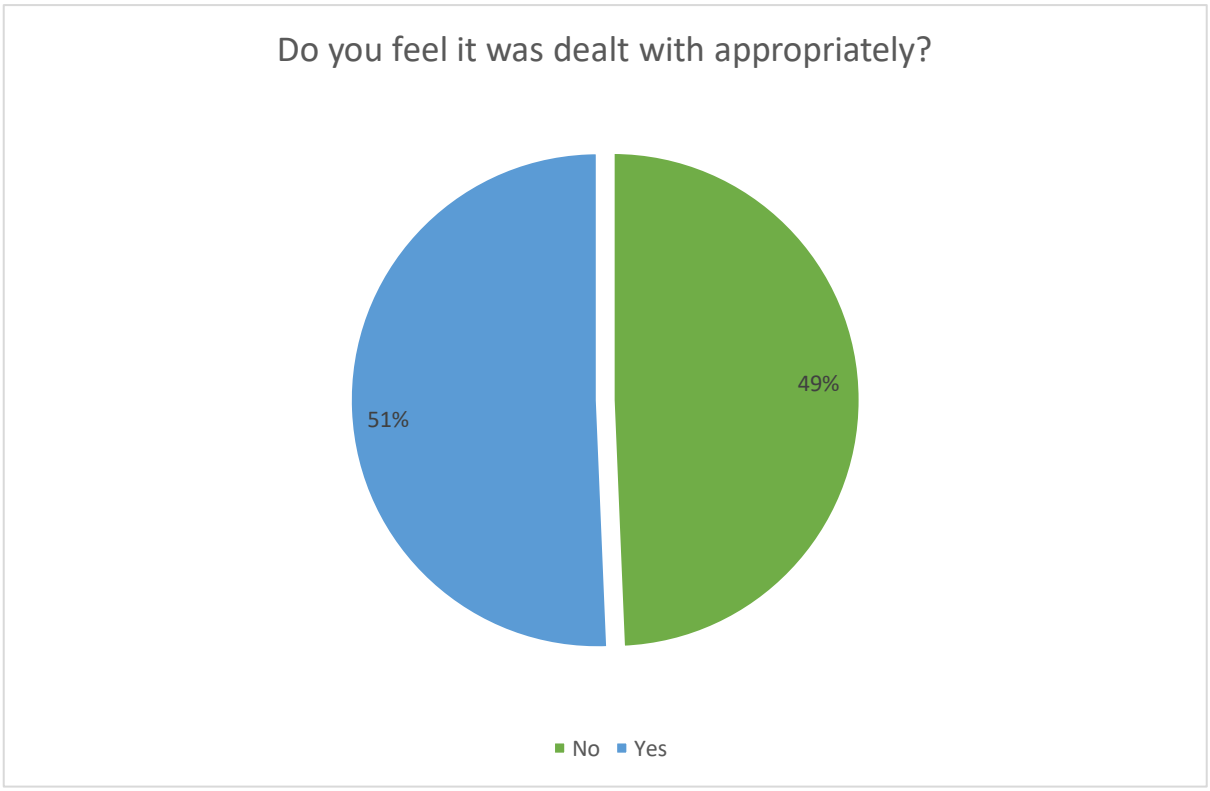

Figure 29 Racism experienced by colleague dealt with appropriately

Whilst 51% of respondents to this question stated that the situation they had witnessed was dealt with appropriately, 49% did not and two examples were by respondents who felt it had not been dealt with appropriately

'The whole team should have been sent on cultural awareness training, instead it became an elephant in the room'

'The Diversity fascism is driving anti-white racism, misandry, heterophobia, and Christophobia. They are not remotely interested in victims if they are white and/or straight, and/or male, and/or Christian.'

Other emerging themes from respondent who stated no include:

- Patient's wishes being adhered to
- Lack of consistent reporting processes and mechanisms

75% of those who responded to the survey said they felt empowered to speak up when they witnessed or experienced racism.
The breakdown of this question, below, suggests that colleagues from White British, English, Northern Irish, Scottish and Welsh backgrounds felt more empowered than colleagues from all other ethnic backgrounds.

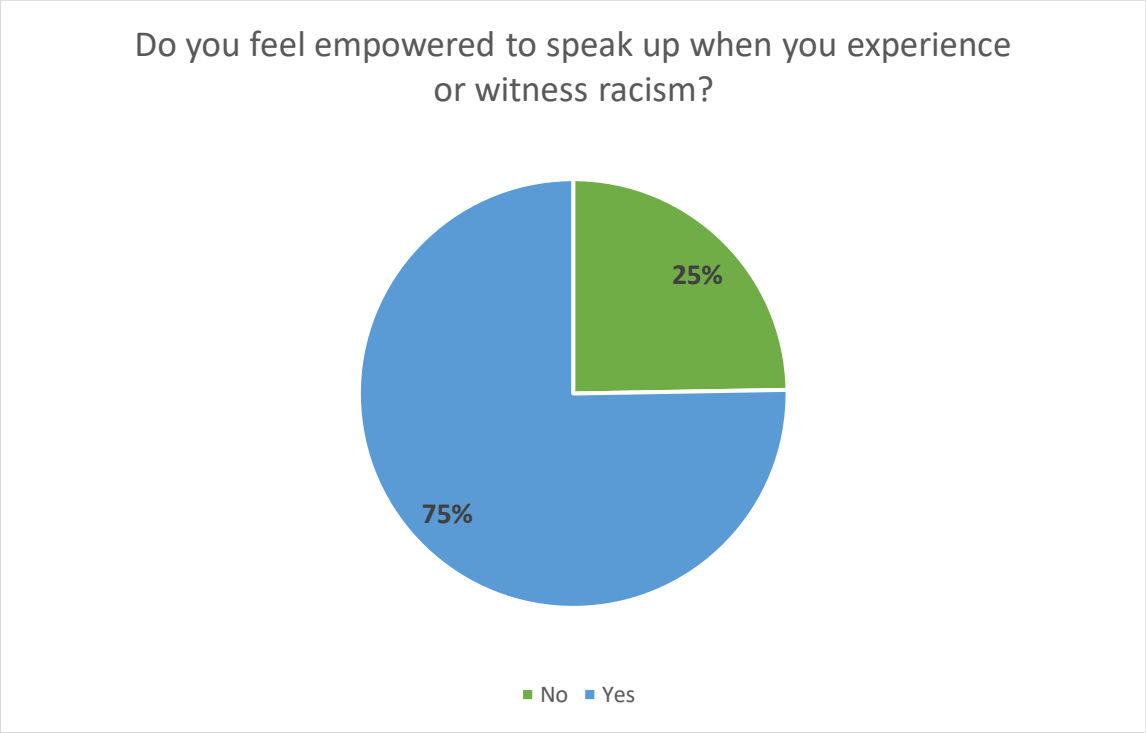

Figure 30 Empowered to speak up when racism experienced or witnessed

Some respondents gave examples of intervening when they witnessed or dealt with a particular situation:

'If ever I feel racism - perceived - vague - I make a point of being very straight and not giving any air to that. No room for it.'

Other respondents highlighted the restrictions or barriers they encountered when faced with such situations:

'To an extent'

'No. After it was dealt with poorly I realised nobody really cares and its just lip service.'

'But only if it is anti-black racism or, so called, islamophobia.'

'I'm sad to say that I don't feel empowered. I feel there would be a negative repercussion towards me if I spoke up.'

'As I said above, I now feel able to speak up but I still find it very difficult even though I have a lot of experience and am a confident person when it comes to saying what I think'

Some colleagues stated that they now felt comfortable after attending events hosted by a Nottingham and Nottinghamshire organisation:

'At the moment since attending the BAME programmes with city care'

One respondent commented on the support for colleagues from Black, Asia and Minority Ethnic communities which they were pleased to see, however highlighted the issues of accent and country of origin bias faced by colleagues who identify as being of White ethnicity.

'We are currently supporting colleagues from BAME communities, and this is an absolutely great move, which makes me very happy, especially that some of my loved ones are of Jamaican origin. Unfortunately, we tend to go for all or nothing. by this I mean, we should not forget about colleagues who might be facing problems due to their accent or country of origin just because they are white.'

Whilst over three quarters of respondents stated that they did feel empowered to speak up, there were numerous examples mostly from colleagues who identified as being from an ethnic minority ethnicity who shared experiences which were categorised into the themes below as we did not have permission to quote the comments verbatim:

- Repercussions experienced by the person who speaks up
- Confidence to speak up when witnessing other experience racism but not for own self
- Lack of appropriate action when issues raised
- Feeling like no change will occur from speaking out
- Adding to race-based trauma
- Positive examples of standing up to and speaking out against racism witnessed
- Some respondents expressed feeling somewhat empowered to speak up
- Some respondents did not feel empowered to speak up
- Impact on job taken into consideration before speaking out

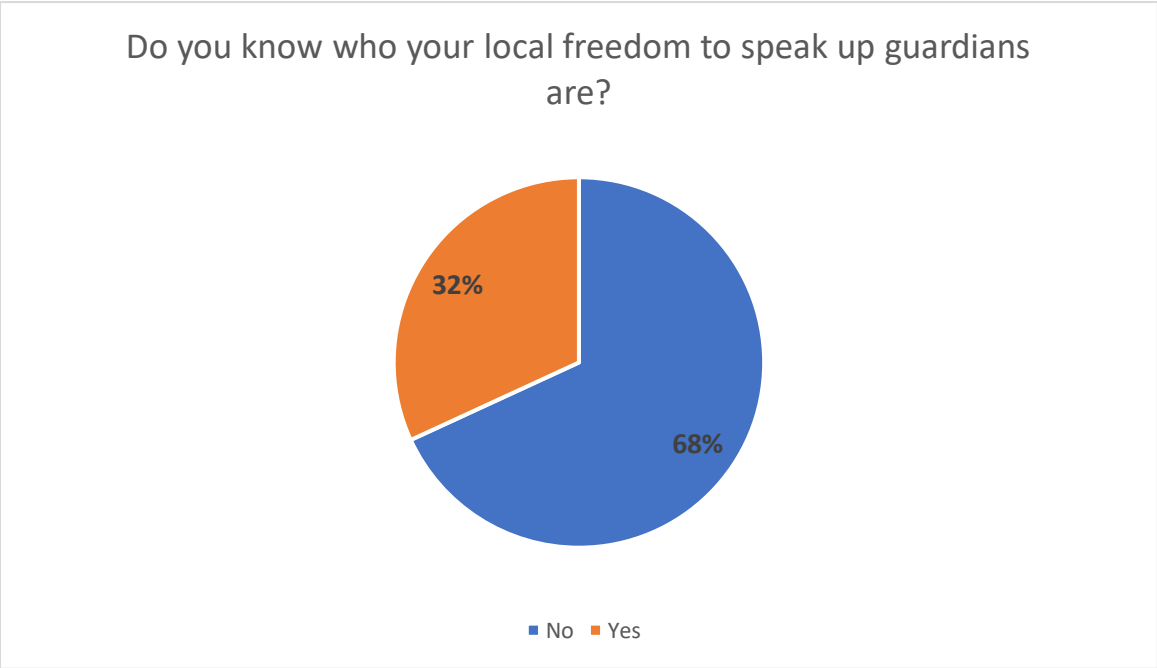

Figure 32 Awareness of local Freedom to Speak Up Guardian

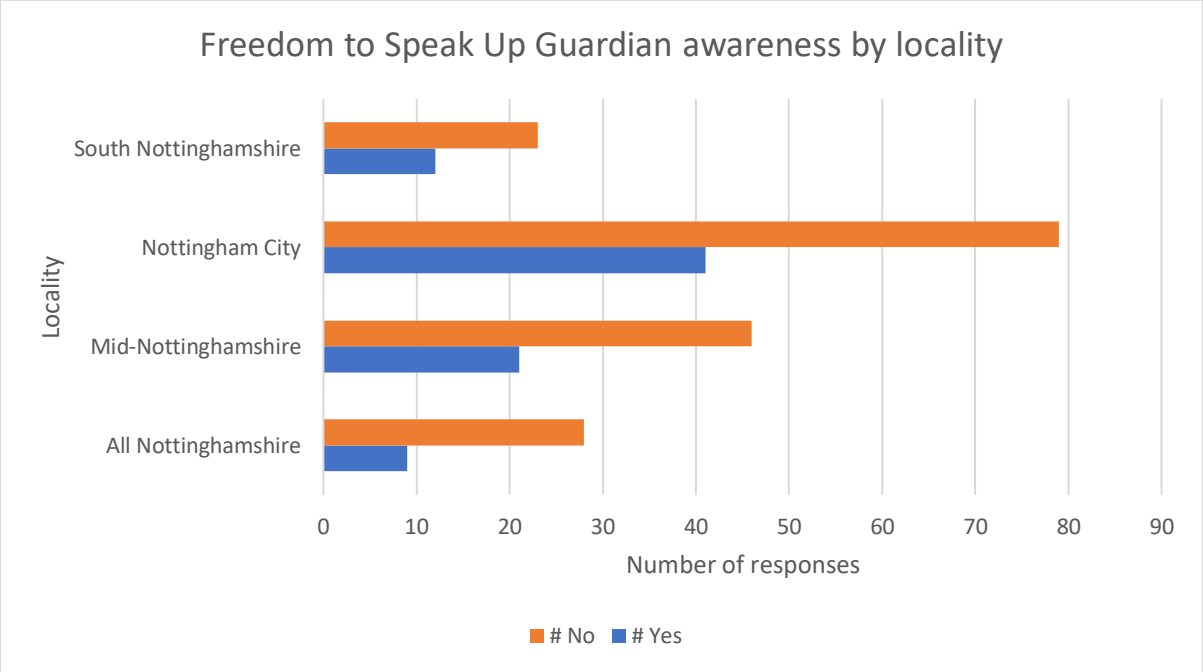

Figure 31 Freedom to Speak Up Guardian, breakdown by locality

68% of those who responded to the survey said they were not aware of who their local freedom to speak up guardians are. This can be seen across the 3 place locations across Nottingham and Nottinghamshire with the highest number of respondents (79) working in Nottingham city.

This presents a good opportunity for the ICB, Local professional committees and Federations to consider place based and co-ordinated access to Freedom to Speak Up Guardians.

2.10 Strategy development and Implementation

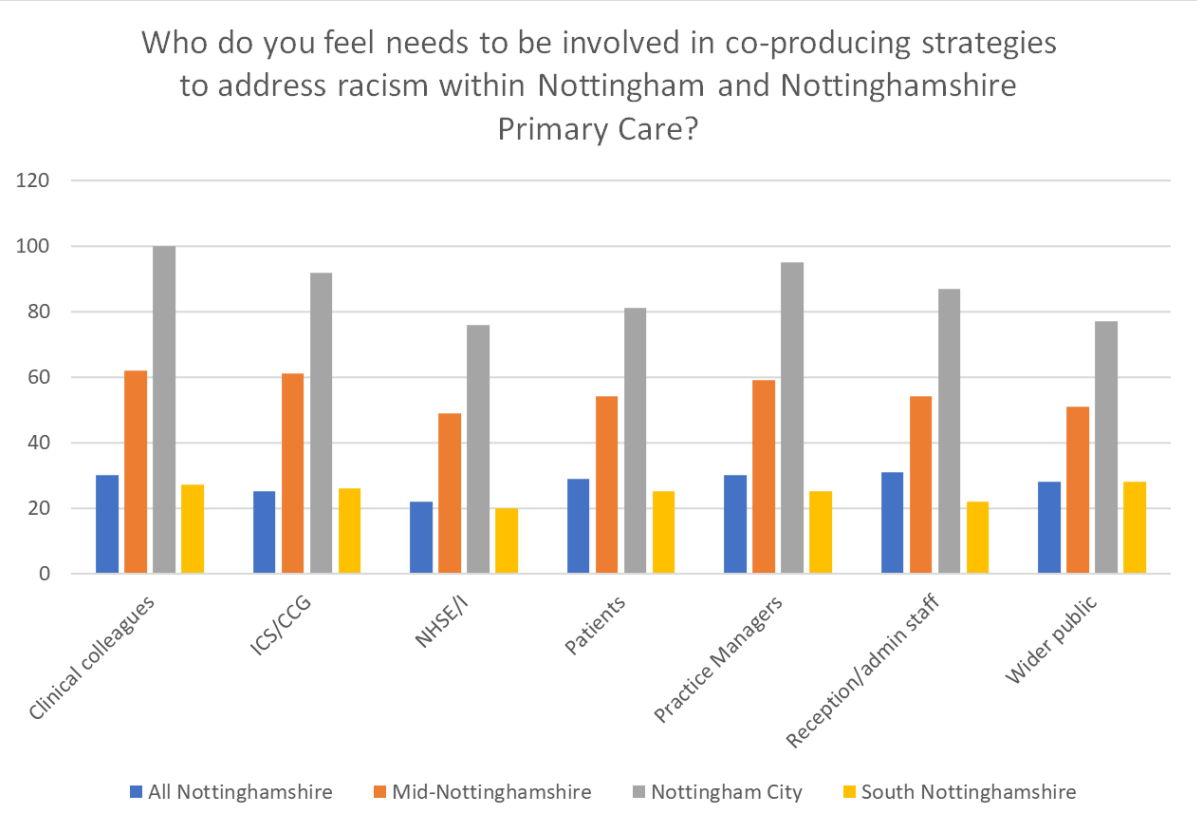

Figure 33 Involvement in co-producing strategies to address racism

Some respondents stated that they believed that everyone across the system including patients and the wider public need to be in co-producing and developing strategies:

'Needs input from everyone'

'Everyone has to play their part'

'This subject is one that effects all of us who are human, so needs to involve everyone. Racism and xenophobia are deeply engrained in the population (and I mean people of colour too- I have witnessed racist statements from Asian people about Black people for eg)'

'Everyone needs to be involved, especially bottom up'
'It needs to be addressed by all members of our population to get a true reflection of issues and address them effectively'

'Bring in people of colour specifically from these options provided AND bring in, intentionally and strategically, external consultants who are Black and people of colour who are NOT institutionalised, have non-NHS and cross-sector experience, including international experience, and have wider exposure to life and best practices beyond the region so that they can bring strong learning and expertise into Nottingham and the midlands region. Believe in their solutions and demonstrate trust. Decolonise the

space - initiatives across ICS/ organisations etc are predominantly led and in the power to influence of White leaders and there is no counter-balance.'

'Where Black and People of Colour are in positions to lead, they are not supported and innovative solutions are neither understood nor supported for implementation, facing several barriers and excessive pressure put on minoritised groups and people of colour to perform to higher standards of delivery and expectations. This region's practices and knowledge (within ICS/ CCG, clinical and practice colleagues lag behind not just the South East/ London but internationally and are at least 20 years behind the rest of the world in terms of intentional inclusive process design, digital transformation and solutions, data-driven business intelligence practices and systemic-root cause resolution-based solutions design and working.'

Some respondents were either unsure about who should be involved and another stated that discussion and development of strategies would add to and cause further workplace divisions:

'Unsure'

'Wokeness, cultural Marxism, and the Diversity monster, will ensure that anti-white racism, misandry, heterophobia, and Christophobia, are never addressed. It will lead (has led) to exceedingly low standards in the NHS, and complete division in the workplace and society.'

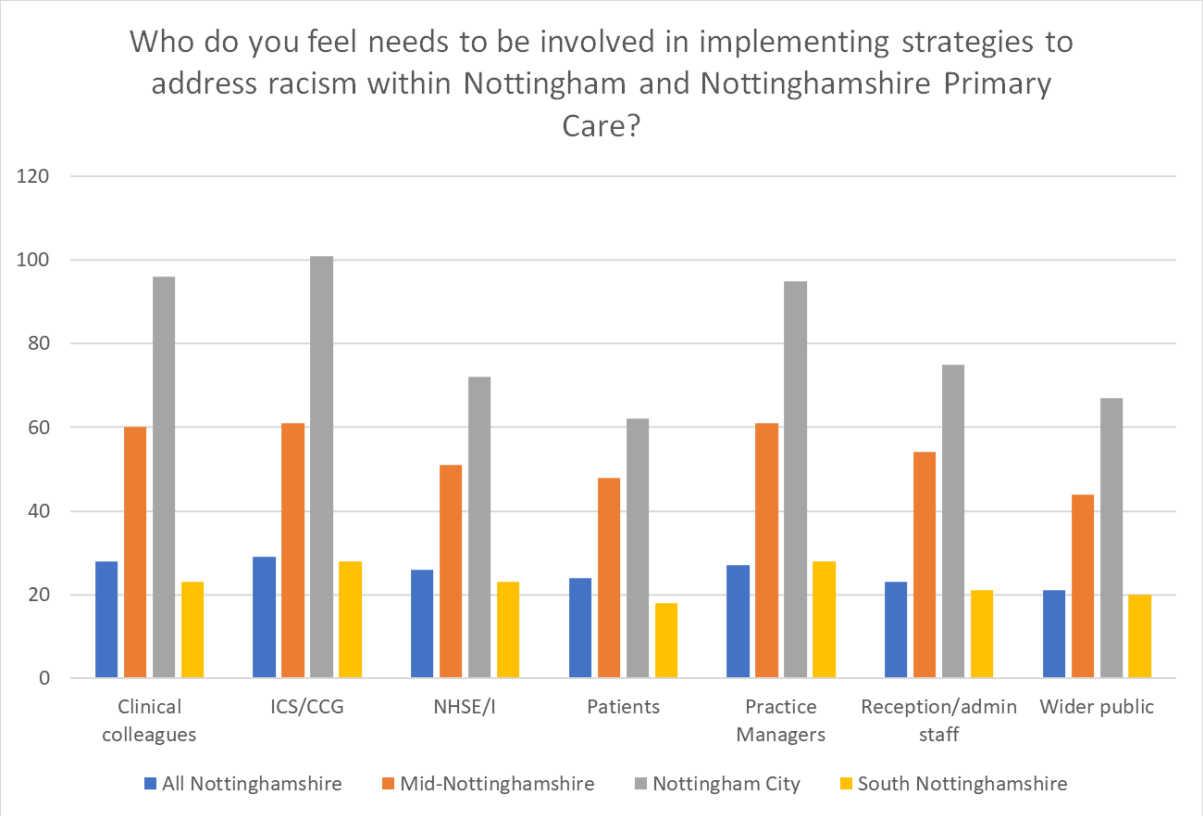

Figure 34 Involvement in implementing strategies to address racism

The last two questions in this survey asked respondents to indicate who they felt they wanted to be particularly involved in developing and implementing anti-racism in Primary Care locally.

'*Everyone's responsibility*'

'Almost all racism is anti-white, but nothing will ever be done about this. Black and Muslim colleagues are never held to the same standards as white & southeast Asian staff.'

Section 2 recommended action points:

- Anti-racism education and campaign for Primary Care - for patients and colleagues. working toward eliminating discrimination and racism and creating positive cultural change in our workplace.

- ICS wide Bystander training to empower Primary Care colleagues with tools and actionable recommendations in how to raise or intervene when faced with or witnessing discrimination in the workplace.

- ICS OD and HR investment and commitment to support equitable access to Freedom to Speak Up Guardians across Primary Care.

- ICS assessment using an agreed maturity matrix to assess development and progress of Primary Care in tackling racial inequalities

Key Findings Section 3: Discrimination from patients

The following section is about experiences with patients / service users / their relatives or other members of the public.

The definition of discrimination for the purposes of this this survey is 'the unjust or prejudicial treatment of different categories of people, especially on the grounds of ***race***, ***ethnicity*** or ***religion***.'

3.1 Racism from patients

The survey covered experiences with both patients and Primary Care colleagues and workforce, various forms of racism was encountered by respondents both overt and direct. These are across the three localities with encounters occurring not only in work settings around colleagues but also faced by clinicians when undertaking home visits in secluded settings.

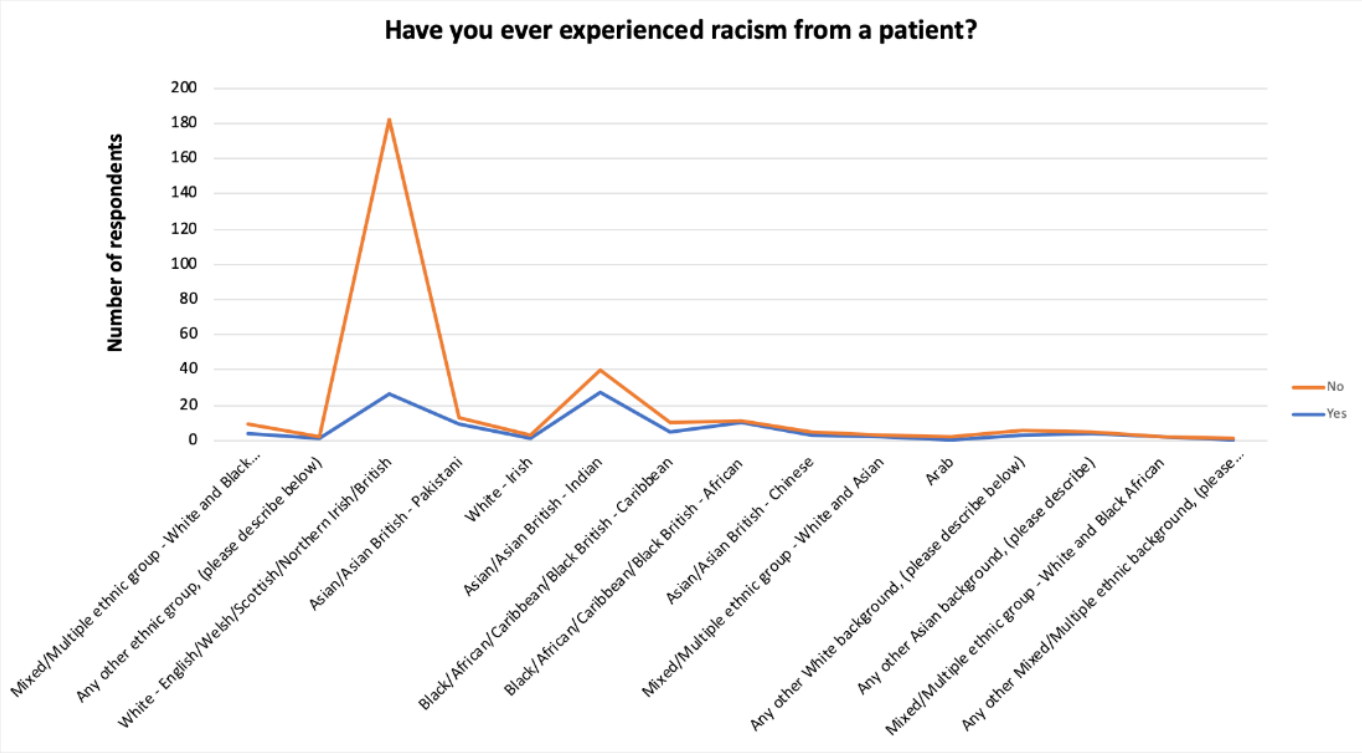

Figure 35 Experience of racism from patients, breakdown by ethnicity

Out of the survey respondents who replied to this question, 19.7 % of respondents from an ethnic minority background had encountered a racist experience from a patient. With 7.4% of these experiences accounting for those who identify as coming from a mixed ethnic background.

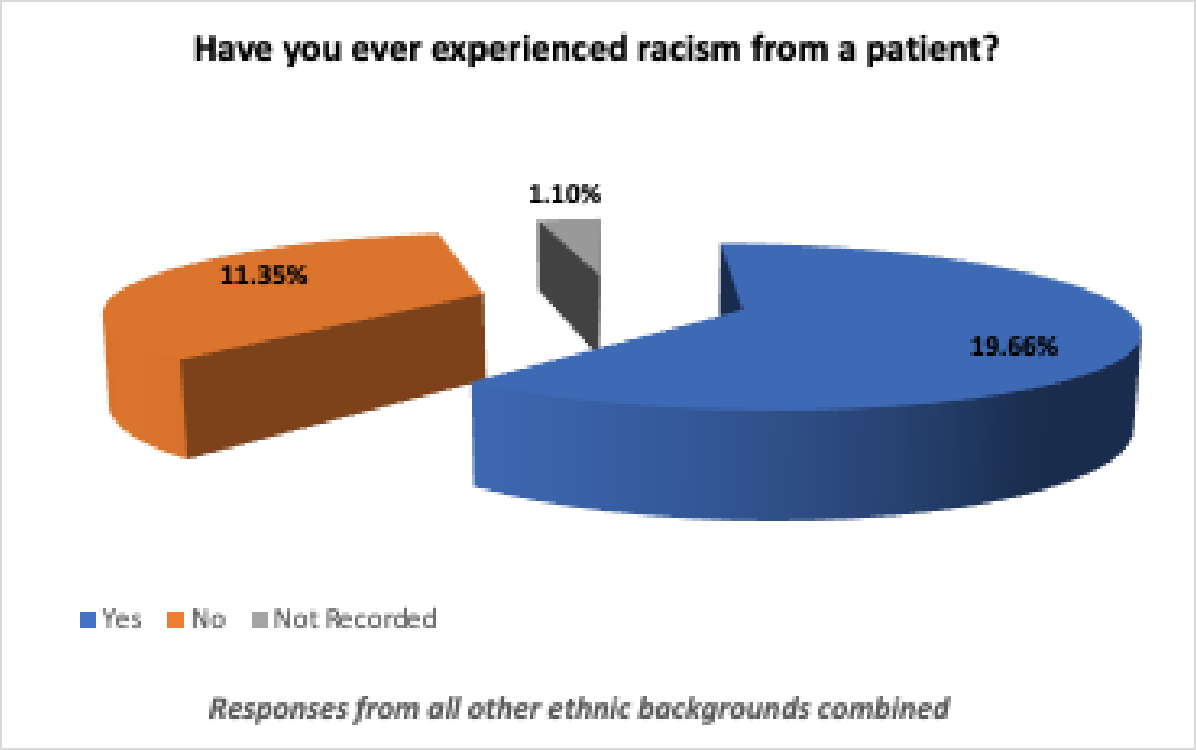

Figure 36 Ethnic minority background colleagues experience of racism from patients

Responses covered a clear need for education around racism for both the workforce, patients and how racist encounters are managed, with responses highlighting the need for a zero-tolerance approach to racism needed to be reviewed.

Experiences of racism came from both colleagues and patients, with offensive and derogatory comments cited as being common:

'I visited a patient at home who we visited daily. On a routine visit I noted he had a new black cat and when I asked it's name he informed me 'nigger'

'I was asked for a cigarette lighter in the car park outside the practice. I advised the patient that I did not smoke or have a lighter- I was told Fuck off then you Paki'

'yes once in 18 years in partnership... verbal abuse from an older patient to receptionist saying he did not want to see a particular doctor due to racial reason.... I wanted to strike him off our patient list but my colleague felt his opinions were related to his demographic'

'Patients will sometimes refer to BAME colleagues identifying them by their ethnicity. It's rare for this to be overtly linked to mistrusting their performance, but it happens.'

Those who had witnessed patients making such comments or were on the receiving end of such comments, found when raised their experience was brushed over and very little active interventions made or justifications for the behaviour was given, an example being;

'verbal abuse from an older patient to receptionist saying he did not want to see a particular doctor due to racial reason.... I wanted to strike him off our patient list but my colleague felt his opinions were related to his demographic'

There is also a theme around competency and judgement on clinician's abilities within responses, With patients questioning competence if the clinician is from an ethnic minority background, with patients openly voicing their views to white staff at practices;

'I have had encounters with patients where they have felt the right to express the fact they did not wish to be seen or treated by colleagues of certain ethnic backgrounds.'

From the experiences shared, complaints and aggression resulted in comments on appearances associated with discrimination around religion, ethnicity and/or culture:

'Patient stated didn't want to see the doctor with a beard. On asked by reception team why that mattered, patient stated as he not from around here (born and raised in Nottingham)'

'*Patients asking not to see Colleague because couldn't understand accent or used offensive name'*

'Is there no white doctors around'

'Patients complaining that my colleague (of Asian ethnicity) was not competent to do her work. As I trained her and often witnessed her working, I felt the complaints were racist.'

'I can't believe I am being refused medication in my own country from a foreigner who is not even from here'

With incidents not only shared by people of colour, White British respondents shared incidents they had observed of racist encounters their peers or colleagues have faced but little around support, interventions or allyship.

'I have been with colleagues when patients are very racist about my colleagues'

3.2 Patient complaints

As well as asking about incidents of racism from patients, we asked about complaints received from patients that were evidently related or explicitly being due to religion, discrimination, religion, belief, culture and or ethnicity.

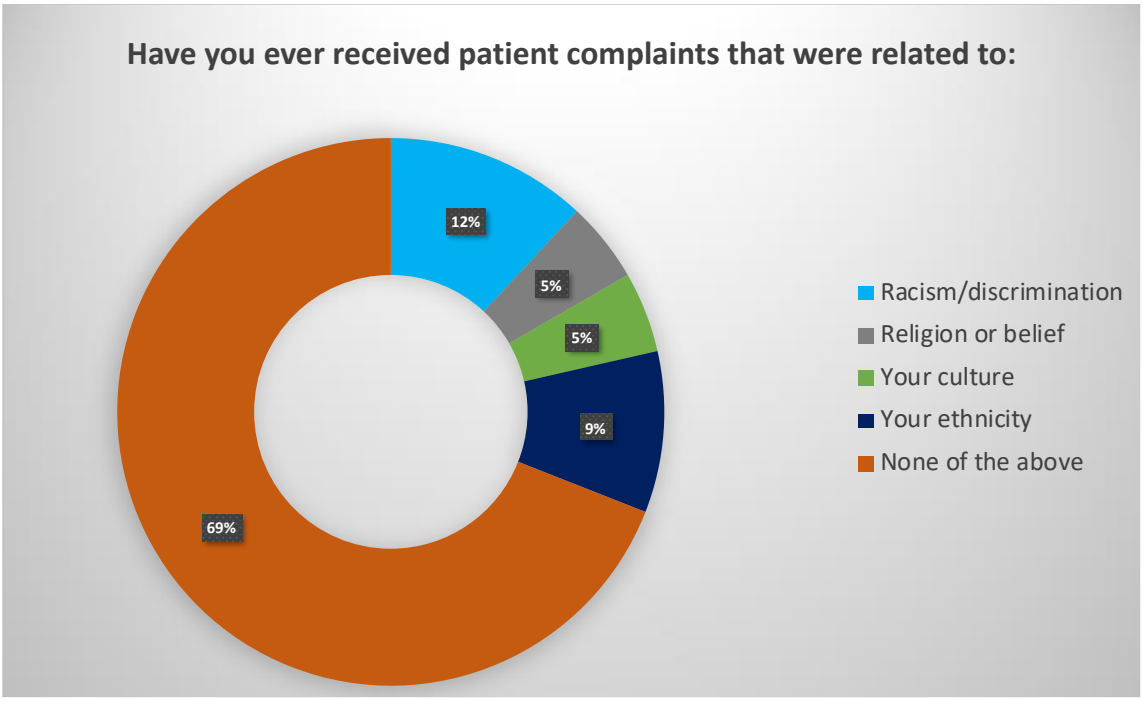

Figure 37 Patient complaints due to racism/discrimination, religion or belief, culture, ethnicity

Respondents from an ethnic minority background experienced the most complaints due to racism and discrimination, 4.16%, with 12 respondents citing their ethnicity as being a cause for complaint from patients.

A respondent who had selected that they received complaints related to all the above, also shared the context and comments around complaints.

'Being called 'your lot,' 'paki,' 'coloured' derogatory comments made about culture and beliefs'

This question also captured complaints that were received from patients where they were on the receiving end of the discrimination.

'Indian patient complained about ... her diet needed looking at as very sugar based e.g., Indian sweetmeats'

This shared example is a clear example of the type of comments made to patients based on their ethnicity and culture, with this response having come from a GP. This is also not a one-off incident, with similar responses picked up in other sections of this survey, from both patients and staff patients with various comments around inflammatory remarks around or tied to their religion, culture, or ethnicity.

3.3a. Witnessing racism; Patients

Those respondents from a White background were least likely to witness a racist encounter, whilst out of only those who responded 'yes', 61% were from an ethnic minority background.

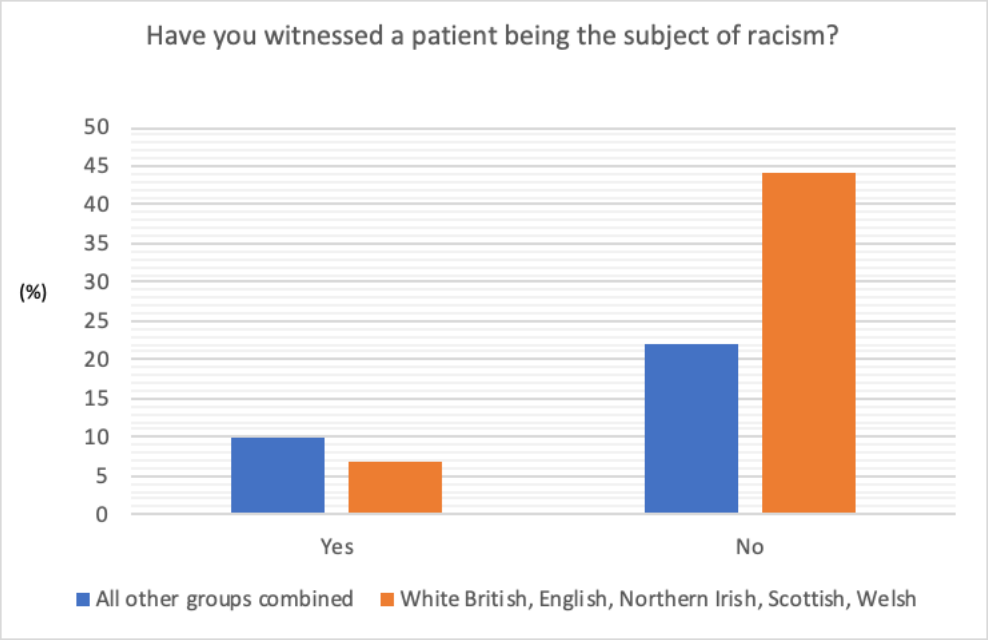

Figure 38 Patients being the subject of racism

The examples shared included both racist encounters from patients to other patients but also mentions of respondents witnessing those within the workforce directing racist behaviour or comments towards patients.

'We have had an incident where we had to remove a patient from the waiting room who was making loud and offensive remarks aimed at the non-white patients in the waiting area'

'Receptionist talking in a derogatory way about a patient of Chinese background (not in front of the patient).'

Patients whose first language may not have been English were not provided support and not only encountered challenges but were also faced with poor quality of care and engagement. As well as a lack of understanding around culture and religion and poor accommodation and awareness of this.

'Patient of colour who spoke English as a second/ third language was dealt with impatiently, rudely and with lower standards of patient engagement'
'do not feel as if we appreciate cultural differences of some patients in the organisation. As in ways they wash, ways of addressing them, foods they eat'

3.3b. Did you intervene in this situation?

'I translated as I knew the language and on another, I said we do have access to translators'

'If a colleague makes a comment about certain parts of the city....I have heard remarks about Snienton Oh be careful its like a mini Beirut'

'At the beginning of my career I didn't use to challenge patients when they made racist comments, but I now do as I now feel I have the maturity to call out patients without affecting the doctor-patient relationship with me'

3c. Do you feel it was dealt with appropriately?

Figure 39 Word cloud of quotes from survey respondents on if patient being subject of racism was dealt with appropriately

Closing statement

This survey was designed to capture a snapshot of experiences of Primary Care colleagues on the issue of racism and discrimination which colleagues may have witnessed or experienced in the Nottingham and Nottinghamshire ICS with a purpose of starting the conversation and as a system tackle the racial inequalities faced and experienced by colleagues within our ICS and hopefully start the wider conversation on how we embed equality, diversity and inclusion within all aspects of our system for the benefit of all the Primary Care workforce and our patients.

As mentioned at the start of this report, this survey was not designed as research project therefore there are methodological limitations. which include factors such as sample size, representation of all ethnicities, and response rates.

We understand that reading this report and colleagues lived experiences may be difficult; if you require support or if you would like to talk to someone confidentially you can contact:

Racial Equity and Diversity team on info@nottsredgroup.co.uk

Nottinghamshire Staff Support 0808 196 8886 (Monday to Friday 9am-5pm)

Email: notts.staffsupport@nhs.net

Website: www.nottinghamshirestaffsupport.nhs.uk

Nottingham and Nottinghamshire Racial Equity & Diversity Working Group Co-Lead Associates:

Aiysha Raoof and Ojali Yusuff at info@nottsREDgroup.co.uk

Glossary of Terms

Racism[7]	Racism is often wrongly understood as mistreating someone or holding prejudiced views. Prejudice views and unfair treatment can occur between any racial groups. However, there is a much more fundamental issue. Systemic racism is power and privilege that can offer intrinsic advantages to White people over people from a BME background.
Institutional Racism [7]	The Macpherson report's definition of institutional racism is "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people."
Structural racism [7]	Structural racism is inequality rooted across the operation of a system or society that excludes or has a significant negative impact on large numbers of a particular racial group and their ability to participate.
Discrimination [7]	Discrimination happens when someone is treated unfairly or less favourably due to an actual or perceived protected characteristic and is unlawful under the Equality Act 2010. There are four types of discrimination.
Direct discrimination [7]	Treating someone worse than someone else, for example, not inviting someone for an interview because you believe them to be from a particular racial background.
Indirect discrimination [7]	Rules, policies, or ways of doing things that negatively impact someone with a particular characteristic than someone from another group, such as Friday team meetings in a pub.
Harassment [7]	Violating someone's dignity; creating a hostile, humiliating, degrading or offensive environment, for example, making fun of someone's name or how it is pronounced.
Victimisation [7]	This is treating someone unfairly if they act under the Equality Act or support someone else who is doing so. For example, a white ally could be victimised if they support a BME colleague with a harassment claim.
White Privilege[7]	Originally coined by the black civil rights activist William Du Bois in the 1930's and coming to prominence in Peggy McIntosh's 1988 ground-breaking paper White Privilege: Unpacking the Invisible Knapsack. The term white privilege describes how having white skin gives an individual an advantage in life. White privilege does not mean white people have never struggled, but white people do not experience racial discrimination on an institutional or societal basis in Britain. Having white privilege and recognising it is not racist. But white privilege exists because of historic, enduring racism and biases and is the "power of accumulated power".

Religion [8]	A personal set or institutionalized system of religious attitudes, beliefs, and practices
Culture [9]	The set of shared attitudes, values, goals, and practices that characterizes an institution or organization a corporate *culture* focused on the bottom line **OR** the set of values, conventions, or social practices associated with a particular field, activity, or societal characteristic

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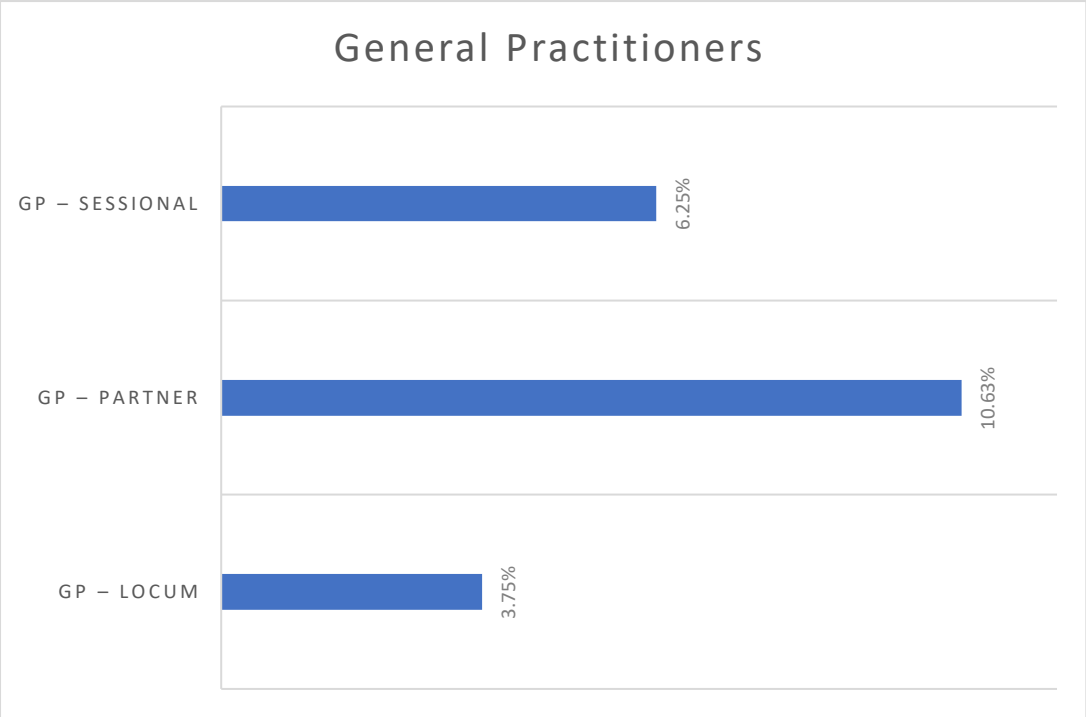
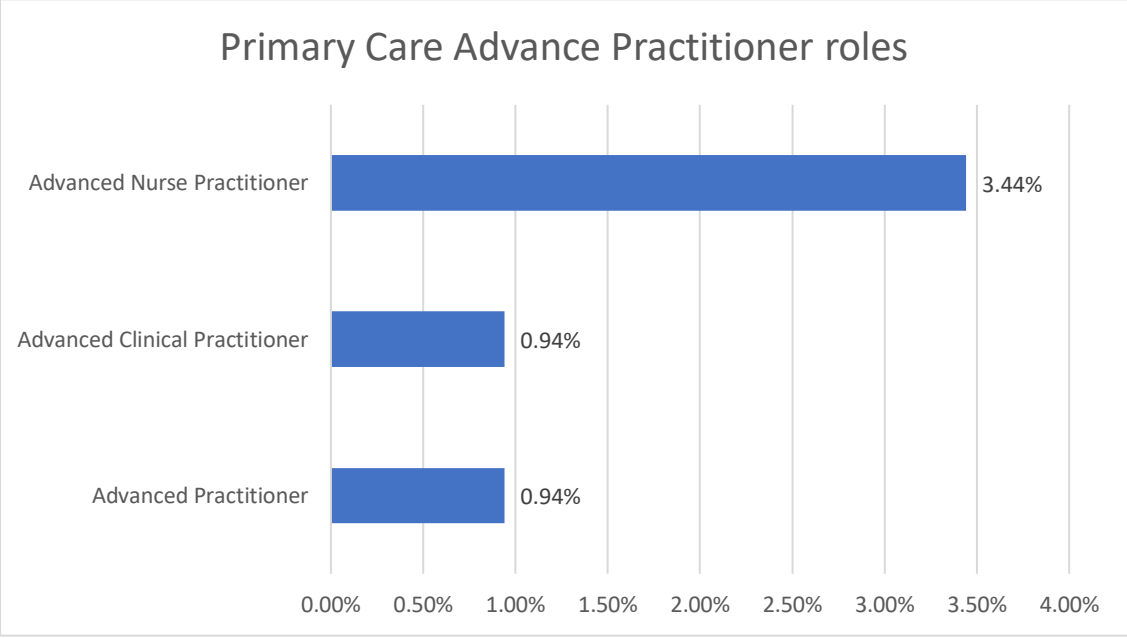
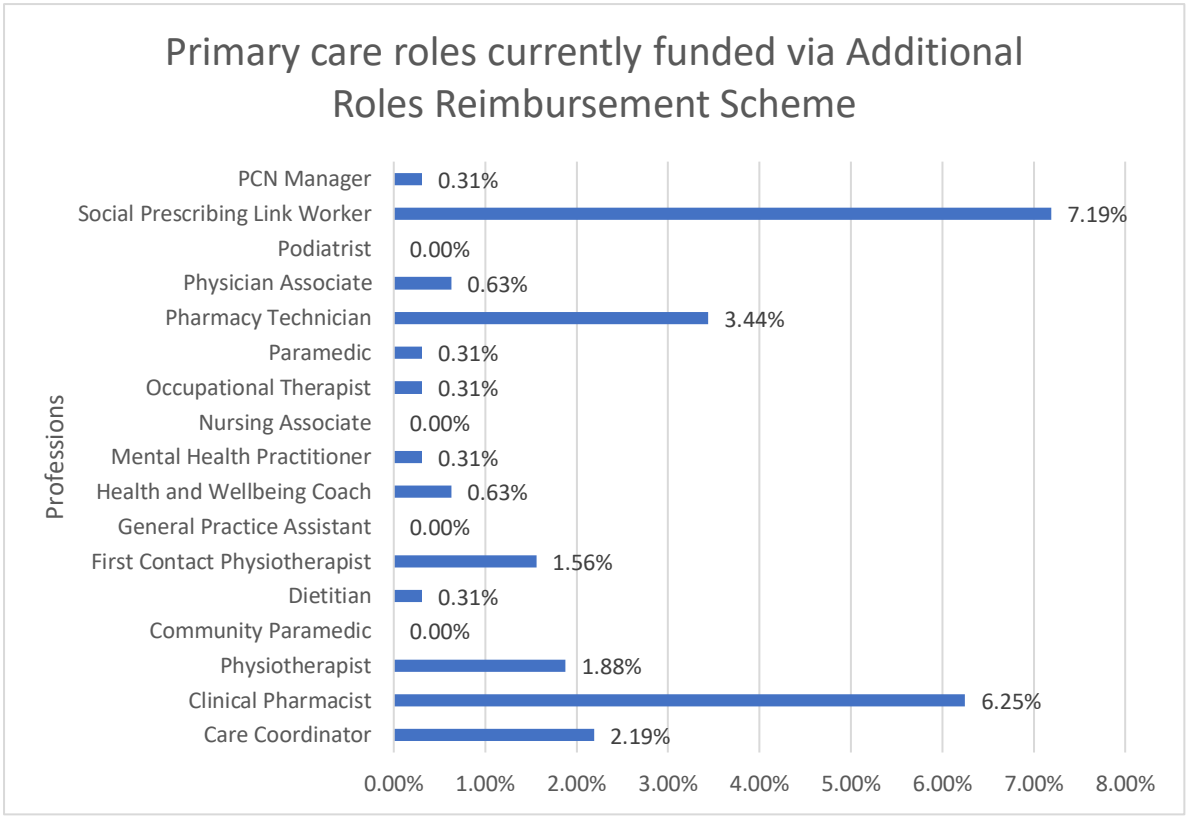
7. NHS England. Midlands Workforce, Race, Equality, and Inclusion strategy. Glossary and key concept. Available at: https://www.england.nhs.uk/midlands/wrei/glossary-and-key-concepts/
8. 'Religion. *Merriam-Webster.com.* Merriam-Webster, 2022 Webpage October 2022
9. 'Culture'. *Merriam-Webster.com.* Merriam-Webster, 2022 Webpage October 2022

Appendices

Appendix 1



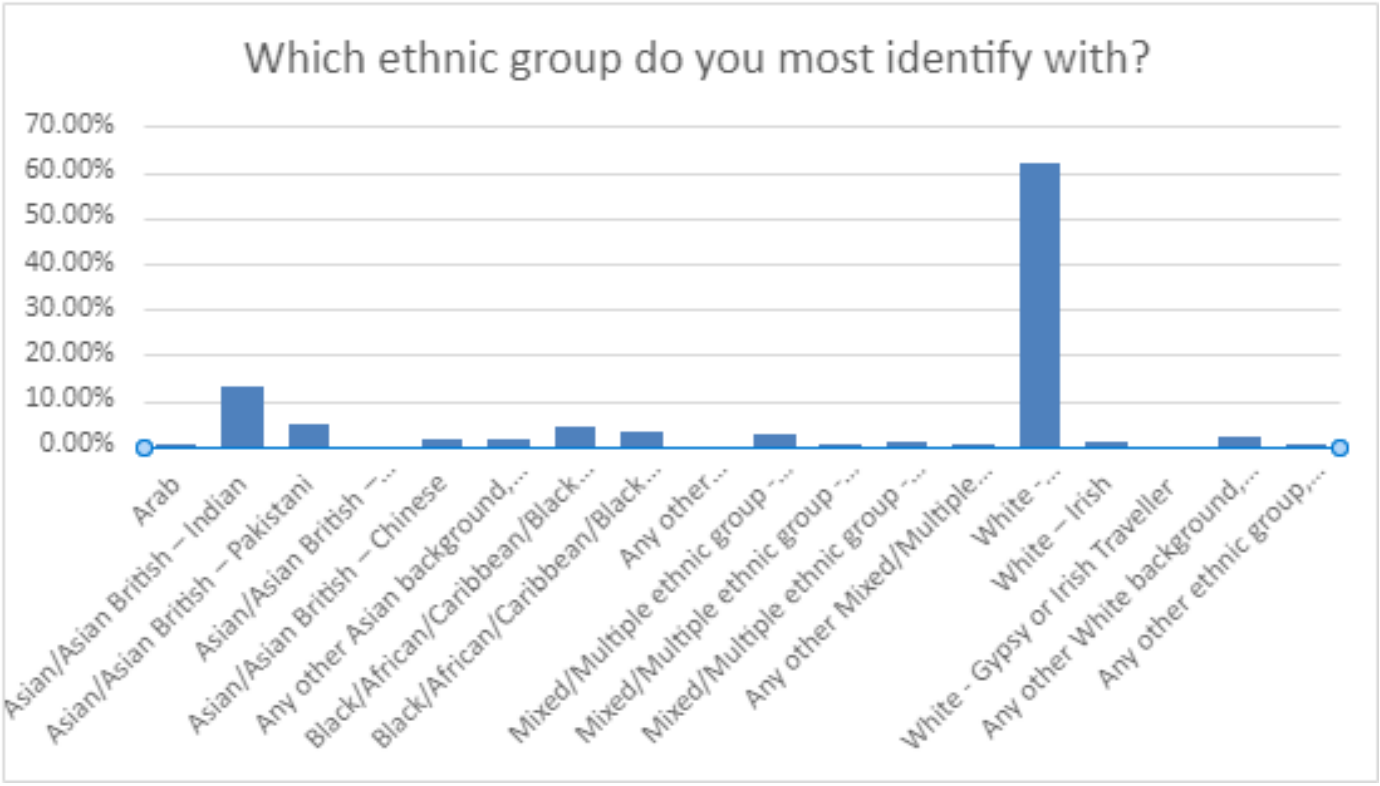



Primary care roles currently funded via Additional Roles Reimbursement Scheme
Professions
PCN Manager
Social Prescribing Link Worker
Podiatrist
Physician Associate
Pharmacy Technician
Paramedic
Occupational Therapist
Nursing Associate
Mental Health Practitioner
Health and Wellbeing Coach
General Practice Assistant
First Contact Physiotherapist
Dietitian
Community Paramedic
Physiotherapist
Clinical Pharmacist
Care Coordinator
0.31%
7.19%
0.00%
0.63%
3.44%
0.31%
0.31%
0.00%
0.31%
0.63%
0.00%
1.56%
0.31%
0.00%
1.88%
6.25%
2.19%
0.00% 1.00% 2.00% 3.00% 4.00% 5.00% 6.00% 7.00% 8.00%

Breakdown of Primary Care roles listed as other

Support Worker
Assistant Practitioner
HCA
Data
Notes Summariser Data entry
Assistant HR Officer
Head of programme
Human Resources - Strategic Leadership
Community nursery nurse
Infection Prevention & Control Nurse
Digital Marketing and Communications
Practice Nurse
Clinical Nurse Specialist Palliative Care
phlebotomist
Reception
Marketing Communications Manager - City ICP
Cleaning supervisor
Digital Marketing and Communications
Not prepared to say
Allied HP
Practice Nurse
GP working non clinically for NCGPA on SMD
Not prepared to disclose x 2
Service support officer
Clinician
GP Practice Support
Quality and Governance
Domestic
Care Navigator
PICS manager
Nurse - Non-Clinical role
HCA/training nurse associate
Health care assistant
HR
Office worker
HCA

Appendix 2


Which ethnic group do you most identify with?
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Arab
Asian/Asian British – Indian
Asian/Asian British – Pakistani
Asian/Asian British –...
Asian/Asian British – Chinese
Any other Asian background,...
Black/African/Caribbean/Black...
Black/African/Caribbean/Black...
Any other...
Mixed/Multiple ethnic group -...
Mixed/Multiple ethnic group -...
Mixed/Multiple ethnic group -...
Any other Mixed/Multiple...
White -...
White – Irish
White - Gypsy or Irish Traveller
Any other White background,...
Any other ethnic group,...

Appendix 3

Asian/ Asian British - Other
European
Sri Lankan
Prefer not to say
Canadian
Filipino
White British
White- other born and brought up in India
European
Polish
Romanian
White/South East Asian
Malay
Hungarian/English

Appendix 4

Atheism x 3
do not wish to disclose
By
Prefer not to say x 2
unitarian
(Sikhi- not Sikhism)
Pagan
Spiritual Atheist
Bkb