10 Year Workforce Plan - call for evidence document

A response from the Race Equality Foundation

Introduction

This briefing responds to the NHS 10-Year Workforce Plan consultation, focusing on two areas where the Race Equality Foundation can add most value: workforce modelling assumptions and culture and values.

While the NHS workforce is increasingly diverse, with staff from Black, Asian and minoritised ethnic backgrounds forming a growing share of the total, persistent racial inequalities remain in pay, progression, disciplinary action and workplace experience. Tackling these inequalities is not only a matter of fairness but a prerequisite for improving the quality of care, staff wellbeing and overall productivity across the NHS.

About the Race Equality Foundation

The Foundation works to promote race equality in health and social care through evidence, lived experience and co-production. As a member of the Health and Wellbeing Alliance, the Foundation brings together research, policy and practice to develop solutions that tackle structural racism and improve outcomes for Black, Asian and minoritised communities. All of its work is grounded in partnership with those most affected by inequality—co-producing evidence, shaping policy recommendations, and supporting organisations to turn commitment into measurable change. Through initiatives such as the Race Equity Maturity Index (REMI) and collaborations with VCSE organisations as well national organisations such as the NHS Race and Health Observatory and others, the Foundation helps build systems and workforces that are fairer, more inclusive and better able to deliver high-quality care for all.

NHS workforce and race equality: key context

The National Health Service (NHS) is the largest employer in the United Kingdom, with around 1.5 million staff employed across NHS trusts in England (NHS England, 2024a). It is also the largest single employer of Black, Asian and minoritised ethnic staff in the UK—and one of the largest in Western Europe. According to the Workforce Race Equality Standard (WRES) 2024 Data Analysis Report, staff from Black, Asian and minoritised ethnic backgrounds now make up 434,077 of the NHS trust workforce, representing 28.6 per cent of all staff (NHS England, 2024a:7). This proportion has grown markedly over the past six years, increasing from 19.1 per cent in 2018 to 28.6 per cent in 2024, an 84.4 per cent rise (NHS England, 2024a:7). In London,

staff from these backgrounds now form a majority of the NHS workforce (53.9 per cent), highlighting the scale of demographic change (NHS England, 2024a:8).

The NHS has taken a number of ground-breaking steps to address workforce race inequality. Chief among these was the introduction of the Workforce Race Equality Standard (WRES) into the NHS Standard Contract in 2015/16, requiring all NHS providers to collect, publish, and act upon workforce data disaggregated by ethnicity (NHS England, 2021). The annual WRES data collection is now embedded in the regulatory landscape, informing inspection and improvement work by the Care Quality Commission (CQC) and shaping the oversight of leadership and culture across NHS trusts (CQC, 2024; NHS England, 2024a). This systematic approach to data has created one of the most comprehensive race-equality monitoring frameworks in any European public-sector employer.

While persistent inequities remain, recent evidence suggests that the NHS continues to attract and retain large numbers of staff from Black, Asian and minoritised ethnic backgrounds. The Nuffield Trust's report on clinical support workers found that these groups are over-represented in some occupations, particularly in mental-health support roles, where Black or Black British staff account for around 14 per cent of the workforce, roughly twice their proportion in non-mental-health support roles and in the NHS workforce as a whole (Nuffield Trust, 2024:22). In medical professions, staff from Black, Asian and minoritised ethnic backgrounds now constitute 48.7 per cent of all doctors, including 64.3 per cent of non-consultant specialist grades, 51.0 per cent of trainees, and 41.0 per cent of consultants (NHS England, 2024a:9). In other words, while representation remains uneven, in several key professional groups, staff from these backgrounds are not a minority.

The combination of a large, ethnically diverse workforce and a structured equality-monitoring framework means the NHS provides an exceptionally rich base of evidence for understanding how workforce modelling and organisational culture affect equality outcomes. The WRES dataset, now collected and analysed annually for almost a decade, is central to understanding the relationship between representation, progression, and experience and therefore provides a crucial foundation for both the "modelling" and "culture and values" sections of the current 10-Year Workforce Plan consultation.

The NHS workforce and wider demographic change

The ethnic composition of the United Kingdom is undergoing sustained transformation, and these shifts are reshaping the future labour supply available to the NHS. According to the 2021 Census for England and Wales, people from Black, Asian, Mixed and other minority ethnic backgrounds made up 18.3 per cent of the population, up from 14 per cent in 2011 (Office for National Statistics [ONS], 2022). In large urban areas, and especially in regions with major NHS providers, diversity is significantly higher: London's population is now over 46 per cent Black, Asian or minoritised ethnic, while Birmingham and several other metropolitan areas already have majority-minority youth cohorts (ONS, 2022). These patterns are mirrored in Scotland and Northern Ireland, though at different scales.

Demographic evidence also shows that Black, Asian and minoritised ethnic populations are considerably younger on average than the White British population. The median age for White British people in England and Wales is 43 years, compared with 30 years for Pakistani, 27 years for Bangladeshi, and 31 years for Black African populations (ONS, 2022). As a result, these communities form a disproportionate share of the working-age and early-career population and are therefore a crucial recruitment base for the health and care workforce over the coming decade.

Taken together, this evidence suggests that the future NHS workforce will increasingly be drawn from Black, Asian and minoritised ethnic communities. Population ageing among the White British majority, combined with the youth and growth of minority populations, makes it statistically unavoidable that a rising share of entrants to the health and care professions will come from these groups. This has profound implications for workforce modelling: without explicit attention to equitable access, progression and retention, national models risk mis-specifying future supply. At the same time, the sustainability and quality of patient care depend on creating an organisational culture in which this increasingly diverse workforce can thrive.

Diversity and persistent racial inequality in the NHS workforce

While the NHS is increasingly diverse, the persistence of racial inequality across the system is both striking and well-documented. The Workforce Race Equality Standard (WRES) reports have, since their inception, shown that staff from Black, Asian and minoritised ethnic backgrounds experience systematic disadvantage in recruitment, promotion, disciplinary action and workplace treatment. The 2015 baseline analysis found that Black and minority ethnic staff were less likely than White staff to believe their trust provided equal opportunities for career progression, more likely to experience bullying, harassment or discrimination from colleagues and managers, and more likely to be involved in formal disciplinary procedures (NHS England, 2016). Nine years later, these inequalities persist. The WRES 2024 Data Analysis Report shows that BME staff remain twice as likely as White staff to enter the disciplinary process and less likely to be appointed from shortlisting despite equal qualification levels (NHS England, 2024a). Such patterns suggest enduring structural barriers rather than isolated instances of bias.

The COVID-19 pandemic exposed and deepened these inequalities. Black, Asian and minoritised ethnic staff were disproportionately represented in patient-facing and lower-paid roles, often with limited access to adequate personal protective equipment, limited ability to work remotely, and lack of risk assessment (Oskrochi et al., 2023). Analyses from the *Virus Watch* study of the wider population showed that the higher rates of infection, hospitalisation and death among ethnic minority workers were driven by structural and occupational factors, not biology: greater exposure through frontline roles, crowded housing, and financial insecurity increased risk, while institutional failures to conduct proper risk assessments compounded it.

Evidence also shows that Black, Asian and minoritised ethnic staff are disproportionately referred for disciplinary proceedings, often for comparable or lesser infractions than their White colleagues (NHS England, 2024a). This pattern of disproportionate scrutiny is

accompanied by a recurring tendency for individuals from these groups to be blamed when wider systems fail. The case of Dr Hadiza Bawa-Garba, whose initial erasure from the medical register followed a catalogue of systemic failings at her employing trust, became emblematic of how professional regulation can reproduce structural racism (The Guardian, 2018). The subsequent appeal judgment, which reinstated her registration, underscored that culpability had been misattributed to an individual rather than the system.

Worryingly, the recent Independent Culture Review of the Nursing and Midwifery Council (NMC) revealed that the regulator itself suffers from entrenched problems of bullying, discrimination and racial bias (Afzal, 2024). These findings suggest that the institutions charged with maintaining professional standards are not immune from the very inequities they are expected to challenge. The result is a compounding effect: racially minoritised practitioners face disproportionate disciplinary exposure within their workplaces and then encounter further disadvantage within regulatory processes, reinforcing patterns of mistrust and fear that damage both workforce confidence and patient safety.

At the same time, ethnic inequalities in patient experience and outcomes persist. The Care Quality Commission's State of Care reports have consistently found that people from Black, Asian and minority ethnic backgrounds receive poorer care and have worse outcomes, particularly in maternity services and among those with long-term conditions (CQC, 2022; 2024). The 2023/24 report reiterates that women from ethnic minority backgrounds "continue to be more at risk of experiencing poor maternity care and outcomes," and that people from Black ethnic groups are over three times more likely to be detained under the Mental Health Act than White people (CQC, 2024).

Crucially, the evidence also demonstrates that addressing racial inequality improves care for all. Research by West and Dawson (2012) found that NHS trusts with higher levels of staff engagement, fairness and inclusion have better patient satisfaction, lower mortality and fewer safety incidents. In other words, equity and quality are interdependent: where the workforce experiences discrimination, patient care suffers; where equality and respect are embedded, care outcomes improve.

Modelling assumptions: embedding equity in workforce planning

The NHS Long Term Workforce Plan sets out to align workforce supply with future service needs across the next decade. Yet, as current data reveal, the assumptions underpinning workforce modelling are often demographically neutral treating the labour force as homogeneous and overlooking the structural inequalities that shape who joins, who progresses, and who leaves. Without incorporating equity variables, such models risk systematically mis-specifying supply and demand, underestimating attrition, and overestimating the capacity of the system to deliver reform.

Recognising diversity as a structural condition, not a variable

The NHS workforce is already one of the most ethnically diverse in Europe, with nearly 29 per cent of staff identifying as Black, Asian or minoritised ethnic (NHS England, 2024a). As earlier

sections have shown, this share is projected to increase, reflecting demographic change in the wider population (ONS, 2022; Race Equality Foundation, forthcoming). Workforce planning therefore cannot treat diversity as a marginal feature: it is a structural condition of future supply. Modelling must integrate the ethnic composition of the working-age population and recruitment pipelines, recognising that these groups now constitute the core of the future NHS labour market, not its periphery.

Accounting for inequality in progression and retention

Current workforce models often rely on average rates of retention, progression and exit. However, WRES data show consistent ethnic differentials in these outcomes: racially minoritised staff are less likely to be appointed from shortlisting, more likely to enter disciplinary procedures, and less likely to report equal access to training or career development (NHS England, 2024a). When these disparities are unaccounted for, modelled supply appears artificially stable. In reality, unequal progression and higher attrition among minoritised staff constitute hidden drains on workforce capacity. Equity-sensitive modelling would therefore include parameters for differential retention and advancement by ethnicity and intersectional identity, allowing planners to estimate the productivity and cost benefits of closing those gaps.

Structural determinants of workforce participation

The Virus Watch and other studies highlight how employment conditions, economic insecurity and occupational segregation drive differential exposure to ill-health and constrain career continuity (Oskrochi et al., 2023; Race Equality Foundation, forthcoming). These structural factors shape both entry into and exit from the NHS workforce. Modelling that ignores them cannot accurately project workforce availability. Variables such as occupational sick-pay coverage, contract type (permanent, agency, or bank), and exposure to discrimination or bullying should be recognised as determinants of effective labour supply. Modelling should also anticipate how reforms to immigration policy, cost-of-living pressures, and international recruitment practices intersect with race and migration status.

Linking equity to productivity and reform delivery

The Government's consultation explicitly seeks evidence on productivity gains and reform implementation. Evidence from West and Dawson (2012) demonstrates that trusts with higher staff engagement, fairness and inclusion have better patient outcomes, lower absenteeism and greater efficiency. Addressing racial inequity is therefore not simply a moral imperative but a productivity intervention. Modelling scenarios that include improvements in WRES indicators, such as halving the disciplinary gap or increasing perceptions of equal opportunity, would quantify the retention and efficiency dividends of equity. In economic terms, reducing turnover among racially minoritised staff yields measurable savings in recruitment, agency costs and lost productivity.

Integrating data sources and accountability

Finally, effective modelling requires the integration of WRES datasets, NHS Staff Survey data, and regional population projections into the modelling architecture used by NHS England and

DHSC. These sources can support the development of equity-adjusted workforce scenarios at national and Integrated Care System levels. Transparency in assumptions, particularly those related to progression, disciplinary rates, and attrition by ethnicity, should become a requirement of the modelling process, enabling external scrutiny and continuous improvement. Equity must therefore be embedded not only in workforce targets but in the modelling methodology itself.

Culture and values: from compliance to belonging

Culture and values are at the heart of the NHS's ability to deliver safe, high-quality and compassionate care. As the Workforce Race Equality Standard (WRES) and the Care Quality Commission (CQC) State of Care reports repeatedly demonstrate, inequalities in staff experience are not incidental but systemic. They are also consequential: workplaces that tolerate discrimination or inequity see poorer staff morale, higher turnover, and worse patient outcomes (West and Dawson, 2012; CQC, 2024). The evidence therefore demands a shift in focus—from *compliance* with equality obligations to the *active creation of belonging, trust and fairness* as core organisational values.

The persistence of unequal cultures

The WRES 2024 data show that nearly one in three (30%) staff from Black, Asian and minoritised ethnic backgrounds report experiencing bullying, harassment or abuse from colleagues, compared with around one in four (24%) of White staff (NHS England, 2024a). Only 48.8% of minoritised staff believe that their organisation provides equal opportunities for career progression, compared with 59.4% of White staff. Evidence further suggests that *Black and Asian women experience the highest rates of discrimination and least access to development opportunities* (NHS England, 2024a). Occupational segregation compounds this: women from these groups are more likely to work in shift-based, lower-paid, and high-risk frontline roles, which carry greater exposure to patient aggression and workplace stress but fewer progression pathways. Despite nine years of monitoring, these gaps have narrowed only marginally.

The *Nuffield Trust* review similarly finds discrimination "at every stage of the career pipeline", whilst also noting women from minoritised backgrounds are overrepresented in the lowest pay bands, especially in clinical support and social care roles, while being underrepresented in senior leadership. These findings point to a persistent disconnect between national commitments to inclusion and the lived experience of staff.

Institutional and regulatory culture

Recent reviews show that problems of culture are not confined to frontline workplaces. The Independent Culture Review of the Nursing and Midwifery Council (NMC) (Afzal, 2024) found systemic racism, bullying and fear within the regulator itself, with staff of colour describing "psychological harm" and a lack of trust in senior leadership. When the bodies responsible for professional oversight reproduce inequity, it undermines confidence that fairness exists anywhere in the system. The same dynamics are visible in disciplinary referrals: as noted above, Black and minoritised staff are disproportionately referred for investigation (NHS

England, 2024a). These institutional patterns create an environment of chronic hyper-vigilance and erode psychological safety across the workforce.

Patient outcomes and organisational safety

The CQC's *State of Care 2023/24* report reinforces the link between workforce culture and quality of care. It highlights that women from Black and minority ethnic backgrounds "continue to be more at risk of experiencing poor maternity care and outcomes," and that variation in the use of ethnicity data limits providers' ability to address these disparities (CQC, 2024: 100). Similar patterns appear in mental health and long-term conditions. In each case, inequities in staff culture—manifested in lack of trust, communication failures and leadership complacency—mirror inequities in patient outcomes. A culture that marginalises staff inevitably produces care that marginalises patients.

What works: leadership, engagement and accountability

Research evidence is clear that *inclusive leadership and high staff engagement* are the most powerful predictors of safe and effective care (West and Dawson, 2012). Trusts with more engaged staff have lower patient mortality, higher patient satisfaction, and fewer safety incidents. Conversely, discrimination and burnout correlate strongly with absenteeism, turnover and adverse clinical outcomes. Changing culture therefore requires more than training or policy statements: it demands sustained, visible leadership commitment. Senior leaders must be held accountable for measurable improvements in equality metrics—especially WRES indicators—and for creating psychologically safe workplaces in which staff feel heard and valued.

Embedding equity as a core organisational value

The next decade of workforce reform offers an opportunity to re-conceptualise culture as an operational priority, not an adjunct to performance. Equity should be built into every dimension of the workforce lifecycle: recruitment, development, supervision, appraisal and reward. Metrics on race equality should form part of Integrated Care System (ICS) performance frameworks and CQC well-led assessments, ensuring that leadership cultures are judged by their ability to foster belonging and fairness. Investment in staff networks, peer mentoring and restorative approaches to conflict resolution has been shown to strengthen engagement and trust, while also improving retention. Above all, a values-based culture must recognise that racial equity and compassion are mutually reinforcing—neither can thrive without the other.

Race Equality Foundation
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