

Structures to support ‘resilience’; ethnic minorities, migrants and the NHS.

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Abstract.

The notion of resilience at work has gained considerable attention in recent years, as workplaces face constant change, uncertainty, and stress. Resilience is typically understood as the ability to bounce back from adversity, adapt to change, and maintain performance under pressure. However, the concept of resilience at work is complex and the contextual factors that shape its effectiveness are multileveled. Recent criticism argues that resilience is over-conceptualised as an individualised construct and the emphasis should, instead, be on structural aspects that enhance sustainability.

The National Health Service (NHS) in the United Kingdom (UK), is one of the largest employers globally, and is composed of a highly diverse workforce with 24% of staff from ethnic minority groups, compared to 18% of the UK population as a whole (NHS Improvement, 2019). 19.5 percent of healthcare workers are migrants from overseas (Baker, 2023). This paper analyses data from an NIHR sponsored project using administrative data from the whole NHS workforce and finds, as a starting point, evidence to counter to media reports of high departure rates (The Express, Dec 29th, 2024; Russell, 2023; Sky News, Feb 21st 2023). Following periods of workforce instability affected by Brexit, COVID, and the cost-of-living crisis, rates of leaving the NHS are reducing. Notable here, are patterns amongst ethnic minorities and migrant workers. Whilst existing evidence suggests that this group in particular face high levels of discrimination (Shields, 2000), disproportionate disciplinary action, poor line management and are more likely to signal a higher intention to leave, pockets of good organisation practice might be encouraging actual retention.

We might wish to frame this as positive in workforce management and evidence of individual resilience, however it can also be the case that fewer labour market options are available to ethnic minorities, given the labour market discrimination they face. This creates a workforce that, superficially might be termed ‘resilient’, but might be demotivated and lacking productivity.

This working paper sets out early findings make a case for a fuller follow-on investigation that will inform theoretical debates of leaving and staying in the workplace. We adopt a structuralist perspective on ‘resilience’ to evaluate workplace mechanisms that might be encouraging retention, whilst also looking for the effects of disengagement, discrimination and fatigue.

Background literature

Since the pandemic, the phenomenon known as ‘the Great Resignation’ has significantly impacted various industries, with the healthcare sector being one of the hardest hit. For instance, Gordon (2022) notes that in the United States, around 20% of the healthcare workforce has resigned, including 30% of nurses. This represents nearly 3% of the healthcare workforce leaving every month, according to data from the US Bureau of Labor Statistics.

The NHS suffers similar outcomes. Staff satisfaction remains low. A recent report (NHS Providers, 2024) states that under a third (32.4%) of staff think their organisation has enough staff for them to do their job properly, and only 26.3% say they never or rarely experience unrealistic time pressures. Despite slight positive recent improvements, all measures relating to burnout have remained persistently high. Four in ten (42.7%) staff often or always feel worn out at the end of their shift and three in ten (30.4%) staff feel burnt out because of their work. The measure related to burnout increases to four in ten (41.7%) for staff working in ambulance trusts. Instances of staff experiencing discrimination at work are at their highest levels since 2019 (NHS Providers, 2024). A new University of Bath Institute for Policy Research (IPR) report into NHS workforce retention indicates that more frontline workers are actively trying to leave the NHS now than at the height of the Covid-19 pandemic in winter 2020/21. The report, ‘Should I stay, or should I go? NHS staff retention in the post Covid-19 world’, (Weyman, 2023) highlights a rising trend in numbers of NHS staff applying for non-NHS jobs since the emergence of the Covid-19 pandemic.

There are two primary motivations driving an analysis of ethnic minority and migrant groups in these circumstances.

- First, it is important that an up-to-date analysis is presented of leaving rates in the NHS. The COVID period represented a major disruption to career and labour force patterns. It might be that in line with general labour market trends on the availability of jobs, departure patterns are regularising. So, it important that we update information on leaving a job from the NHS (see Gordon, 2022).
- Second, actual departure may not correlate well with ‘intention to quit’ even in circumstances of poor management practice including discrimination. In labour market studies, scholars have found empirical support for the argument that ethnic minority workers voluntarily quit their jobs less than White workers (BITC, 2022; Fryer, Pager and Spenkuch, 2013), potentially due to discrimination in the wider labour market (e.g., Kirschenman & Neckerman, 1991; Bertrand & Mullainathan, 2004; Pager et al., 2009) despite facing precarious work conditions (Living Wage Foundation, 2022).

Our early analysis can shed more light on these issues.

Data and data analysis.

Our analysis for this paper is drawn from the electronic staff record (ESR) workforce, absence and leavers’ data for Sept 2009 to May 2024 in England provided by NHS England. The ESR is the administrative database for all staff integrating human resources and payroll information for

individual employees. Ninety-nine percent of NHS trusts upload their data to it and update monthly. It contains rich information on hospital staff job and personal characteristics. Variables include earnings and overtime payments, job title and grade, occupation, migrant/nationality status, total hours worked, full or part-time contract, incidence of maternity/paternity leave, age, gender, ethnicity, nationality, time spent on sick leave, and type and size of hospital trust.

Measures.

We define leaving as being removed from the ESR – in other words leaving the NHS, rather than moving between trusts. We define leaving as a voluntary action, in other words not for reasons of ill health, retirement or dismissal. Early retirement is read as a voluntary decision. Staff frequently return to NHS employment, so we define ‘leaving’ as departing for a minimum of 6 months, excluding for reasons of maternity.

The full ESR lists 41 ethnic categories. We aggregated observations into five ethnic distinctions: White British; White Other; Black; Asian; Other/Unknown

Migrant status. Migrant status is not formally recorded for most occupational groups (only nurses and doctors). Given the overall project aims, and the importance of migrant status to the overall NIHR funded project, we proxied migrant status using the first Nationality recorded in the dataset. Where migrant status is formally recorded (e.g. nurses and doctors) we calculated the correlation between our use of first recorded nationality and migrant status and realised a coefficient of 0.87. This gave us the reassurance of validity. Groups were classified into British (Non-Migrant); Not British (Migrant); Other/Unknown on the basis of first recorded nationality.

Initial findings.

Our longitudinal analysis of leavers from the NHS over a 13/ 14-year period (Fig 1) shows that, following a dip in leaving during the COVID period and an extraordinary increase in leaver rates following COVID, the leaving rate has reduced. Worthy of further investigation is the drop in leaving rate following the Brexit vote. It is possible that fewer posts may have been taken up by White (other) Europeans – who have the highest leaving rate (see Fig 2). When we split the overall trend by ethnicity, we can see that figures of leaving may not correlate well with ‘intention to quit’ data. The highest incidence of leaving is consistently from the White (Other category), especially in the lead up to the Brexit vote, and falling afterwards. Asian staff are the least likely to leave for the last decade. Figure 3 shows, perhaps not unexpectedly, given changes to visa rules post-Brexit that have made it significantly more difficult for staff to change employers in the UK, the leaving rate of non-British (migrant) staff has significantly dropped in the past 5 or 6 years.

Discussion and plans for further analysis.

Taken at face value, this analysis is informative and counters the popular narrative of increasing departures from the NHS. It is limited because our measure is taken at individual level and therefore refers to head count, not overall capacity including FTE, nor whether supply meets ever-increasing demand. We also cannot assume that staff, especially ethnic minority migrant staff are demonstrating positive resilience. Resilience at work is often presented as a positive individualistic trait, emphasizing personal strength and coping mechanisms (Winwood, Colon and McEwen, 2013; Jackson, Firtko, & Edenborough, 2007), but this view overlooks the social and structural factors that contribute to stress and adversity, such as poor leadership,

organizational culture, or workload issues. As a result, organizations focus on encouraging employees to be more resilient without addressing the root causes of stress or adversity in the workplace. This can lead to a blame-the-victim mentality, expecting employees to cope with excessive workloads, or toxic work environments rather than confronting the systemic issues that contribute to these challenges.

Based on this perspective, our findings lead us to explore a number of other research directions. we will look for evidence that resilience may be collectively experienced and structural (King, Newman and Luthans, 2016). Given our access to informative data for the whole NHS workforce, and our interest in evaluating measures of structural resilience there are a number of dimensions that warrant further consideration. Taking measures influenced by job embeddedness theory, from our ESR combined with NSS and WRES data, we consider whether the decision to leave the NHS is influenced by factors of structural resilience.

These can include, but are not limited to:

- Stability in occupational group/ subgroup by trust. Increased workload caused by excessive resignations that may create mutually reinforcing downward spirals of staff losses.
- Stability in ethnic / and migrant group in occupational group/ subgroup by trust
- Cultural resilience: Indicated via a score for each trust on engagement and morale.
- Organisation scores for discrimination and the ratio of ethnic minority: White staff entering the formal disciplinary process.
- Size and type of trust.

To address these questions, we will supplement our administrative data with:

1. NHS Staff survey annual data for 2009 to 2023. Annually this receives 600,000 responses. We refer to five years of data NHS Staff Survey data from 2019 to 2024 aggregated at trust level to provide a nested indicator of trust climate and culture including staff morale, staff engagement and
2. Workforce Race Equality Standard data is WRES data (2016 – 2022) is collected through individual NHS trust submissions via the Data Collection Framework (DCF). A return rate of 100% for trusts is typically achieved. Of the nine indicator topics that are analysed as part of Race Equality Standard, we only refer to Indicator 3 (staff entering the formal disciplinary process): expressed as a ratio of ethnic minority staff: White staff.

We have selected, appended and merged all of the data sources into one large data file comprising over 220 million monthly records, and representing over 2.7 million NHS staff. We have undertaken data cleaning, recategorization and recoding of variables to prepare for analysis of structures that support collective resilience.

Conclusion.

Many authors argue that resilience has become a buzzword in organisational development, used to promote employee engagement programmes or training initiatives that promise to make workers more adaptable or productive in the face of stress. On the face of it, our findings might be taken as the demonstration of ‘resilience’ from ethnic groups during and following COVID in the NHS. However, the concept needs to be critically analysed, and further testing undertaken prior to assumptions being made. Resilience may be embedded in workplace structures and practices that support ethnic minority groups. Collective resilience may be synergistic with

group values of collectivism or communal support. In such cases, promoting individual resilience may overlook the importance of team-based coping strategies or collective efforts to overcome adversity. Resilience models that fail to account for cultural or contextual differences may inadvertently exclude certain groups or fail to address broader societal or organizational inequalities. Longitudinal analysis using our broader range of indicators will assist our understanding.

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Figures

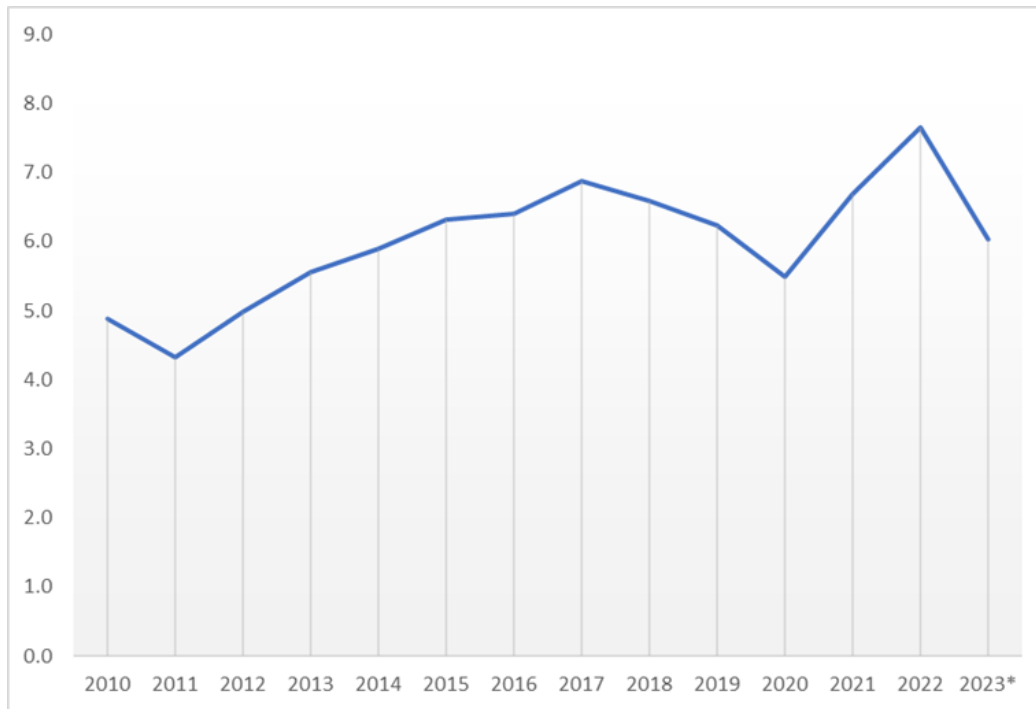


Figure 1: Annual leaving rate over time (%)

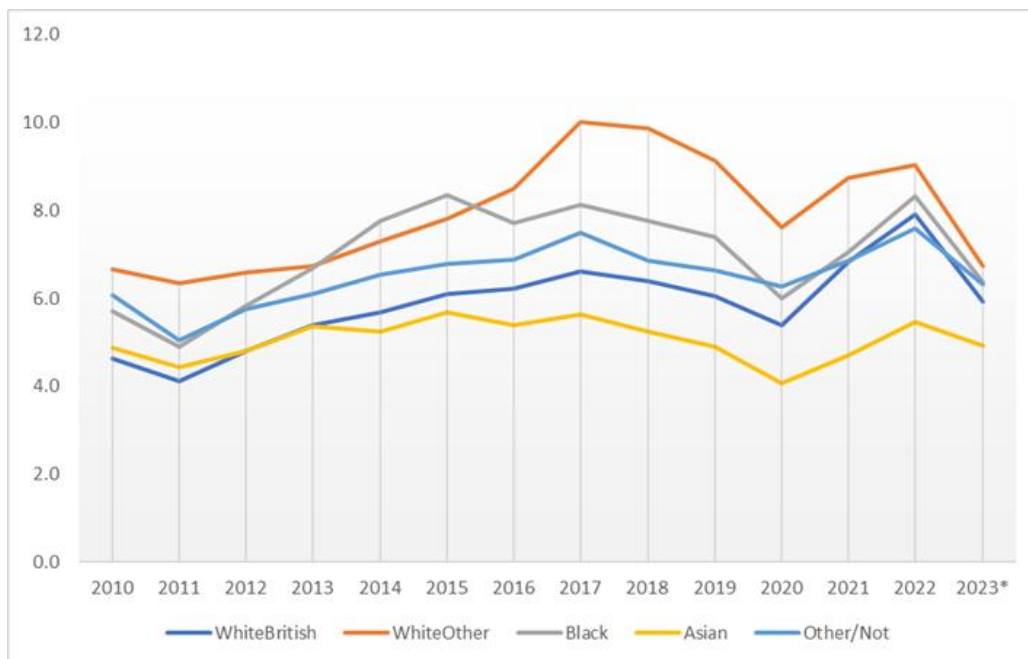


Figure 2: Annual leaving rate by ethnicity (%)

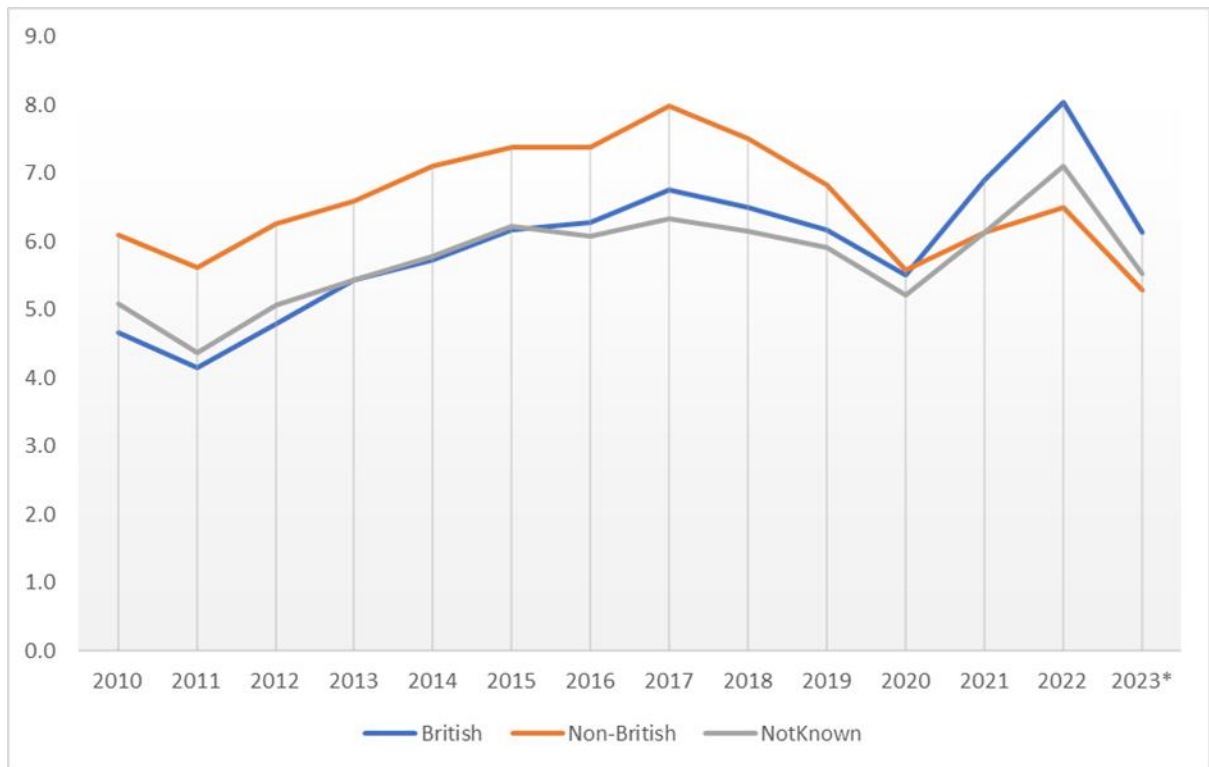


Figure 3: Leaving rate by nationality/ migrant status (%)