REPORT TO:	NHS SOMERSET INTEGRATED CARE BOARD ICB Board Part A	ENCLOSURE: I
DATE OF MEETING:	28 March 2024	
REPORT TITLE:	Anti-Racism Report	
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EXECUTIVE SPONSOR:	Victoria Downing-Burn	
PRESENTED BY:	Victoria Downing-Burn/Emma Symonds	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☐
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☒
Discuss	To discuss, in depth, a report noting its implications	☒
Note	To note, without the need for discussion	☐
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

PREVIOUS CONSIDERATION/ENGAGEMENT
The Previous Anti-Racism work was originally developed by the Equality Steering Group, pre-Covid, and was agreed by the Directors.

Executive summary and reason for presentation to Committee/Board	This report is to inform and highlight the work that has been happening within NHS Somerset to address racial discrimination felt by the workforce and to establish pathways and initiatives that will influence authentic change. It also highlights the current work, both within the system and alongside national programs that respond to inequalities for the population, and how collaborative agendas support the anti-racism agenda. The purpose of this report is not only to showcase and inform, but also to seek commitment from the board to adopt and role model good practices across the system, promoting NHS Somerset as a role model for authentic Anti-Racism practices, whilst meeting our statutory duties.
Recommendation and next steps	We are asking the committee to consider a robust, direct response to Anti-Racism practices, policies and processes within NHS Somerset to help address inequalities and health inequalities experienced by Black and Ethnic minority people working and living in Somerset. We present recommendations which address institutional racism, unconscious bias and limited lived experiences and influence systemic change to improve the negative experiences felt. This will be an ongoing program of change and will require review.

Links to Strategic Objectives (Please select any which are impacted on / relevant to this paper)
☐ Objective 1: Improve the health and wellbeing of the population
☒ Objective 2: Reduce inequalities
☐ Objective 3: Provide the best care and support to children and adults
☐ Objective 4: Strengthen care and support in local communities
☐ Objective 5: Respond well to complex needs
☐ Objective 6: Enable broader social and economic development
☐ Objective 7: Enhance productivity and value for money

Impact Assessments – key issues identified (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	Health inequalities will be reduced as better experiences in the workplace lead to a more engaged and positive workplace. Black and Ethnic minority people often experience a poorer level of care when accessing healthcare which can lead to long-term impacts on their health and wellbeing. Inequalities will also be positively impacted as racism and discrimination will be less prevalent, due to a systemic approach to addressing the negative experiences of the workforce.
Quality	Improved experiences for Black and ethnic minority people lead to a more productive and efficient work environment and better health outcomes for the population.
Safeguarding	Safeguarding has been considered when responding to Anti Racism. Freedom to speak up is an essential element of supporting an open culture of Speaking up and psychological safety for all those experiencing Racism.
Financial/Resource/ Value for Money	Racism hurts recruitment and retention costs, potential tribunals, and Colleague well-being support, including long-term sickness. These recommendations offer long-term cost-cutting solutions that lessen the burden on the Healthcare system.
Sustainability	N/A
Governance/Legal/ Privacy	NHS Somerset has a statutory duty to respond to the Public Sector Equality Duty, ensuring we foster good relations, eliminate discrimination, harassment, and victimisation, and advance opportunities for individuals who share a protected characteristic, in this case, race, ethnicity, and nationality.
Confidentiality	N/A
Risk Description	The risks of not responding to the substantial impact of racism will lead to a growth of negative experiences, low diversity within the workforce, possible high tribunal costs, poor organisational reputation and poor patient care.

Please keep these front pages to a maximum of three

ANTI- RACISM REPORT

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ANTI-RACISM REPORT

1 INTRODUCTION

1.1 This report supports NHS Somerset ICB's statutory duties under the Public Sector Equality Duty. These duties include:

(a) eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the Equality Act 2010.

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

1.2 This Anti-Racism report demonstrates the work happening within NHS Somerset ICB to combat racism and discriminatory behaviour towards Colleagues and the Somerset Population. It highlights the collaborative work and initiatives that have supported this key agenda, whilst ensuring we are responsive to Regional and National reports such as the People Plan and the NHSE Equality, Diversity & Inclusion Plan (June 2023).

Please note we will not be using BAME (Black, Asian, and ethnic minority) through this report as it does little to recognise or respond to individuals' lived experiences. Instead, we will be using Black and Ethnic minority when referring to Non-White British people, unless specifically referring to a particular race, ethnicity or nationality.

2 WHY IS IT IMPORTANT TO BE ANTI-RACIST

2.1 **Staff Experience**: Black and ethnic minority staff can face racism and discrimination from both colleagues and the population (patients, family, and visitors) which can affect their morale, job satisfaction, mental well-being, and ultimately patient care.

An Anti-Racist workplace fosters a culture of Inclusion and respect leading to a happier and more productive workforce. NHS Providers Anti-Racism Action Plan (2020) states that they actively tackle racism, providing five commitments that support that work and actively promote NHS Organisations to develop a robust plan.

2.2 **Diverse Workforce**: A diverse workforce with a range of different perspectives and experiences is a stronger workforce. Being Anti-Racist helps attract and retain top talent from a wide range of back grounds, leading to better, more rounded decisions and innovations.

2.3 **Addressing Inequality:** Racism is a major factor behind inequalities and health inequalities. Black and ethnic minority communities often experience worth health outcomes due to social determinants like poverty, housing, lack of good education, and access to healthy food. An Anti- Racism Commitment will actively respond to these issues and create a more equitable healthcare system.

2.4 **Better Health Outcomes:** Racism, both unconscious and implicit, can negatively impact the mental well-being and health of Black and ethnic minority patients. It can lead to misdiagnosis, poorer communication, hesitancy to help, and inappropriate dangerous responses that can lead to negative outcomes. An Anti -Racism commitment works to dismantle these barriers and ensures everyone receives the best care possible.

If we recognise that our workforce, is also our population (patient) we can reason that racism and discrimination can eventually lead to the need to access healthcare, which adds additional pressure on an already pressured environment.

3 ICB Past Work

3.1 **Black Lives Matter Pledge**: The Black Lives Matter pledge (Appendix 1) was developed following the murder of George Floyd in 2020. The then CCG and Yeovil District Hospital responded to this moment in time by acknowledging the effect the event had on our collective colleagues. This Pledge aims to show that:

We commit to:

- celebrating the diversity of our Black and ethnic minority colleagues, patients and carers.
- supporting our Black and ethnic minority staff to ensure they have equal opportunities in respect of access to employment, progression and personal development.
- developing a culture of inclusion to ensure that all of our colleagues feel welcomed, valued and treated with respect and dignity.
- commissioning services in a way that is mindful of the different needs of people to improve both access to healthcare and health outcomes.
- working together with our system colleagues and communities to break down barriers to health care in all settings.

Following the initial conversations, the then Somerset County Council also signed up to this pledge and it became a significant joint piece of work to help stamp out Racism at a time of substantial unrest.

3.2 **Referencing Race Document**: To support the Anti-racism work, a Referencing Race document was developed (Appendix 2). The aim of this document is to support colleagues when writing about ethnicity. It became apparent when engaging with teams and line managers that language and terminology were causing anxiety, which in turn led to people offending or, even worse, not approaching the issue at all.

This document was to be used when writing about Race and Ethnicity, as well as supporting Equality Impact assessment, future policies, processes, and when developing services.

3.3 Alongside the above, there has been extensive engagement work such as lunch & learn online sessions, colleague educational pieces in organisational communication, and system engagement with commissioned and community organisations, to address not only racism but also intersectional impacts felt by those who are deemed as “different”.

4 Current Anti-Racism Work

4.1 **South West Ethnic Minority Action Plan** (EMAP): The EMAP was established in the Summer of 2023 with an accountability framework and a close working relationship with the CNO CMidO BME Strategic Advisory Group. The current priorities for the EMAP are being mapped against the National EDI Improvement Plan, and include more collaboration between Nursing and Midwifery leaders, by working closer with their people and Teams.

NHS Somerset works closely with system partners as well as holding up an internal mirror to evaluate our own Anti-Racism work. This includes:

- Delivery of Building Inclusion for Leadership program in NHS Somerset, aimed at Executives and NEDs to help create an understanding of Peoples's experiences to deliver dynamic and inclusive programs for people and the workforce.

- The What, Why & How of Civility & Inclusion course is available to all colleagues and has been embedded within the core standards box set for nursing colleagues.

- In November 2023, the first holistic diversity data report was shared with the Board. This pulled together data relating to all protected characteristics, covered reporting requirements for the WRES, WDES and gender pay gap reporting, and formed the basis of a new inclusion workforce plan. This aided the development of the People Strategy.

- The ICS Workforce Team now has a dedicated Inclusion Manager for ICB & ICS, allowing for a focused view on both the workforce and People.

4.2 **Primary Care EDI Fellow**: Funding was secured by the Training Hub to support the growing understanding that our Internationally training GPs were facing challenges that impacted their experiences during the standard national qualification period.

It became apparent that the extended qualification period was affecting their morale, impacting the shortage of GPs, and adding a financial burden to the system. A Somerset Staff survey was also carried out in 2023, focusing on Primary care and it highlighted that discrimination and racism were areas of improvement.

This role was developed and promoted to Qualified GPs to work within Primary care to support, influence, and advocate for change. The ICB/ICS Inclusion manager acts as a mentor for this individual, ensuring that legal and statutory duties are adhered to but also encouraging and supporting system engagement and collaborative working.

4.3 **Primary Care Allyship Training Sessions:** The Inclusion leads within NHS Somerset have been working closely with The Training Hub and individual practices to advocate and educate the workforce on Racial Allyship.

These bespoke sessions inform practice staff on areas of Unconscious and implicit bias, stereotyping, and types of allyship and offer the opportunity to explore situations and challenging experiences in a safe environment. Following each session an action plan is put in place with the practice manager and feedback is sought to help develop future sessions.

4.4 **BRAP - Too Hot to Handle Report**: This is a report written by Roger Kline and Joy Warmington, CEO of BRAP that sheds light on race discrimination and employment tribunals in the NHS. (Appendix 4, Appendix 5)

The report was developed by a combination of reviewing several race discrimination tribunals, a review of literature, and an online survey of NHS Black & ethnic minority staff. The intention was not to prove that racism exists as there is a mountain of evidence to show that it does, but to understand the NHS response to racism, what trusts, and healthcare organisations do about it, and how effective they are at addressing it. There were over 1300 responses to the survey.

Currently, this report is being mapped against the EDI Improvement plan and Anti Racism work, with recommendations for transformational and transactional approaches when addressing racism. It calls on HR, OD, and EDI leaders to not simply manage risks as they arise but to seek to improve culture to prevent discrimination and promote equity, diversity,

and inclusion. It support the organisation with addressing specifics around:

- Talking about race
- Setting Standards
- Getting comfortable with staff speaking up
- Adopting a coherent anti racist strategy
- Being proactive
- Commissioning the right development

This is a key report in capturing the experiences of our Black and Ethnic minority staff, from an external source, highlighting a need for our leaders to role model and advocate for a strong anti-racist agenda.

Freedom To Speak Up (FTSU)

The Freedom To Speak Up framework is a program supporting colleagues to speak up when things are going wrong. When the issue is related to Racism and/or discrimination the FTSU Guardian and Champions offer a robust and neutral service where ICB colleagues can share and discuss their concerns and be supported to find a positive outcome, and where possible avoid formal Human Resources processes. This service is invaluable to individuals who have negative experiences at work, due to the long-term detrimental impacts as well as the potential for poor organisational reputation.

5 CONCLUSION

5.1 Racism within the NHS has a demonstrably negative impact on both patients and staff. By actively combating racism and promoting inclusivity, NHS Somerset can ensure everyone receives the best possible care.

5.2 Eradicating racism within the NHS Somerset is not just a moral imperative, but also essential for delivering equitable and effective healthcare. By adopting and implementing the below recommendations NHS Somerset will be taking a substantial step forward in becoming a role model in the Somerset system, acting as change agents in an environment that has significant detriment to individuals and patient care.

6 RECOMMENDATION

6.1 The Board/Committee is asked to:

Acknowledge that Racism plays a role in the experiences of the population and recognise that authentic change starts with strong leadership.

- Promote the Anti Racism commitment as part of the Recruitment & Retention agenda, ensuring we acknowledge the challenges of Black

& ethnic minority people face when applying for roles. This would include publicly promoting the Anti Racism commitment and promotion of an EDI Commitment statement (Appendix 5).

- Implementation and delivery of the Inclusion for leadership Development Program. This program empowers Leadership to understand the impact of decisions made and help influence authentic change.

- Endorsement and support for a Reverse/Reciprocal mentorship program for Black and ethnic minority Colleagues, ensuring that each participant has an opportunity to learn from the other. A key element of this relationship is to empower the Black and ethnic minority individuals to share their lived experiences with a White British senior leader in a way that enables the leader to critically review their personal and professional practices.

- Implementation of clear Anti-Racism policies and training for all staff, including promotional pieces for our Healthcare professionals across the system. There also needs to be strong messaging available to the population informing them of the stand the ICB takes on Anti-Racism and the opportunities for allyship. We must be brave and lean into the word RACISM to dismantle the negative experiences and impacts and create a fairer and more effective healthcare system.

- Embed a robust, time-managed Freedom To Speak Up Framework that encourages all ICB colleagues to raise concerns and issues in a safe and psychologically safe space, with the knowledge that Senior Leadership fully embraces and understands the importance. Consider a dedicated position specifically focused on all activities related to Speaking Up, including management of Freedom to Speak Up Champions, Leadership development, training analysis, and system development. A Freedom to Speak Up Reflective Toolkit Guide will be presented to the Board to discuss this in finer detail.

- Review and implementation of the “Too Hot to Handle Report”, mapping the recommendations alongside the NHS Somerset Equity and Equality Improvement plan, including mapping the recommendations to ensure the Building for Inclusive Leadership program is responsive, Cultural commissioning is considered and proactive and coherent Anti-Racism strategies are embedded in various EDI Requirements, including WRES and EDS. (Appendix 3)

ANTI-RACISM REPORT

APPENDICES

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APPENDIX 4: TOO HOT TO HANDLE MAPPING

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APPENDIX 1

NHS Somerset

OUR BLACK LIVES MATTER PLEDGE

The Black Lives Matter movement has shone a light on the racism that our Black, and Ethnic Minority colleagues, patients and carers continue to face throughout the world.

As an NHS commissioner, we recognise our role in supporting a culture of inclusion and equity both for staff and for those patients whom we serve.

We commit to:

- celebrating the diversity of our Black & ethnic minority staff to ensure they have equal opportunities in respect of access to employment, progression and personal development.
- developing a culture of inclusion to ensure that all of our colleagues feel welcomed, valued and treated with respect and dignity.
- commissioning services in a way that is mindful of the different needs of people to improve both access to healthcare and health outcomes.
- working together with our system colleagues and communities to break down barriers to health care in all settings.

We do not tolerate racism or discrimination in any form, and we will continue to listen to our colleagues, patients and carers as we work to tackle health inequalities and discrimination wherever these occur.

APPENDIX 2

NHS Somerset

Referencing Race and Ethnicity

This short guide has been written to support you in making appropriate references to the various races and ethnicities of our patients and colleagues.

A report[1] published by the government's Commission on Race and Ethnic Disparities makes a number of recommendations, including addressing the use of overarching terms such as "Black, Asian and Minority Ethnic", "BAME", and "Ethnic Minorities" where this is seen to be masking a particular issue or being used to present a more favourable picture which isn't true of all ethnicities.

The recommendation (#24) calls for the disaggregation of the acronym BAME and to better focus on understanding disparities and outcomes for specific ethnic groups.

So what does this actually mean?

Using terms such as BAME can often mask underlying issues. Here are some fictitious examples:

5% of Board Members within the ICB are from a BAME background.

In Somerset, this would, on the surface, look to be a positive statement, however this doesn't reflect the fact that all of these Board Members might be from an Asian or Asian British background. Therefore, this is masking the fact that there is no representation at Board level of any other ethnicity suggesting that, with the exception of Asian or Asian British, all other ethnicities do not fare as well at this level. Furthermore, if "BAME" were to be replaced with "Asian or Asian British", this too would be misleading as Asia covers a whole myriad of ethnicities and national identities such as Indian, Pakistani, Chinese, some areas of Russia, and so on.

Another example might be:

60% of BAME people reported a poor experience of Mental Health Services

This could also be masking the fact that the majority of the 60% are from a particular ethnic group, such as "Black – African" suggesting that other ethnicities are reporting better experiences.

[1] Commission on Race and Ethnic Disparities: Report

Therefore, in order to fully understand where our efforts are best placed to improve services, we need to delve much deeper. BAME, and similar terms, have become a short-hand for “non-White” which is, in many cases, unhelpful and in some cases, misleading.

Although this isn’t explicit in the recommendation, the report does set out similar issues when referring to White people as a homogenous group. If 50% of White people reported difficulty in accessing Primary Care services, this doesn’t tell us if they are all “White – British”, “White – Polish”, “Irish Travellers”, etc.

What can you do differently?

We have pulled together some tips below to help you when drafting reports or making references to particular ethnicities.

- **Be specific** – If you are referencing a particular ethnicity or nationality, be specific. If the issue you are raising relates specifically to people from Bangladeshi backgrounds, use the term Bangladeshi. If the issue relates to something that is shared by all people from South Asian backgrounds, including Bangladesh, use South Asian.

- **Explain your use of generic terms** – Where it is necessary to use an overarching term, explain your reason for doing so. There might be issues around making people identifiable by using a more granular reference in which case it may be appropriate to aggregate numbers and percentages through the use of a wider reaching term. One key point to make is that BAME should not be used any longer.

- **Avoid generalisations** – If you are stating that the majority of people from all ethnic minority backgrounds have difficulty engaging with digital services, this could be for a variety of different reasons that are specific to different backgrounds. For example, one ethnicity might report that there are barriers around language, where as another may report barriers around digital access. These need to be dealt with separately rather than an overarching statement around all ethnic minorities.

And finally…

Race and ethnicity is not simply a person’s skin tone, appearance, nationality or geographical origin. It is a combination of these, along with cultural roots, language, values, and how all of these interlink with other characteristics.

TOO HOT TO HANDLE?

WHY CONCERNS ABOUT RACISM ARE NOT HEARD... OR ACTED ON

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AND
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brap

January 2024

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The authors would also like to acknowledge the contributions of Rebecca Pillière.

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FOREWORD

I welcome this report which, for the first time, sheds a clear light on race discrimination and employment tribunals in the NHS.

Through extensive research, analysis, and consultation with Black and minoritised ethnic staff, a bold and comprehensive overview is presented to the reader of the challenges faced by NHS staff. From hindrances to career progression through to both subtle and overt forms of discrimination that ultimately cause psychological harm when unaddressed or not understood by those in positions of power, it's clear there remains a very long way to go to. The business case of why discrimination is harmful to individuals, teams, and organisations has been established for decades now, but NHS staff continue to experience race discrimination at an all-time high.

Central to this report is a review of a number of race discrimination employment tribunal cases, including my own. Some of the lessons of this are discussed in section 5.

What is apparent are the recurring themes: from poor investigations to high levels of defensiveness where NHS organisations repeatedly dispute allegations of discrimination despite the evidence. Organisations need to be open and curious so that Black and minoritised ethnic staff can feel valued, respected, and included in their roles without the need for drawn-out and poorly conducted investigations and grievances that progress to employment tribunals.

My respect goes to the authors for their time, skill, and expertise in the collation of this report. I hope it contributes to principles of equity, justice, and the freedom to speak up without recrimination, provide a nurturing and safe environment for all.

Michelle Cox

EXECUTIVE SUMMARY

A number of Bermuda triangle moments served as a catalyst for this report. Firstly, the ongoing collaboration between Roger Kline and brap (a collaboration which has included mutual criticism, challenge, and downright arguments, but which is sustained through commitment to addressing racism and its persistence).

Secondly, a number of high-profile tribunal cases within the NHS that made us reflect on just how significant they were, and ask whether there was a correlation between these cases and the way in which the NHS responds to allegations of racism. Despite the efforts of many, talking about racism still causes fear and concern and addressing racism appears to frequently be a performative response by the system.

What this report is **not** is a report which tries to prove racism is widespread in the NHS. We are more than convinced it is and you should be too. Our intention is to support the NHS and others to respond more fearlessly to these types of allegations.

This report brings together key learning from a number of significant tribunal cases and responses from 1,327 people who answered our survey, relaying their experiences of raising allegations of racism within their respective organisations.

Survey findings showed:

- UK trained staff are much more likely than internationally trained staff to raise concerns. 71.0% of UK trained staff have highlighted race discrimination as an issue, compared with 53.1% of internationally trained staff
- the most common reason for not raising a concern of race discrimination was not believing anything would change (75.7%). 63.5% of people who didn't raise their concerns were worried about being seen as a troublemaker
- of those staff who have raised concerns, only 5.4% said they were taken seriously and that their problem was dealt with satisfactorily
- the most common outcome to a race discrimination concern was nothing happening (the outcome in 42.7% of cases). In one in five (19.1%) instances, claims of race discrimination were treated the same as any other workplace dispute and referred to mediation. In 5.0% of cases, the individual raising the concern were themselves disciplined
- 41.8% of respondents left their jobs as a result of their treatment

Survey findings also show racially minoritised staff face common responses when raising concerns about race equality. These include:

- **denial**: in many of the cases outlined above, staff were subjected to 'poor behaviours' but neither managers nor subsequent investigations felt they could name the race discrimination that lay behind these behaviours

- **reluctance or refusal to acknowledge race as an issue**: connected with the above, employers tend to resist acknowledging poor treatment as race discrimination often, it seems, because of the stigma attached
- **minimising of harm**: organisations go to great lengths to downplay the impact of racist behaviours
- **a lack of empathy**: racially minoritised staff do not always receive compassion and understanding when raising concerns. Indeed, it is more common they are met with frustration, defensiveness, and exasperation

In addition to the above responses, there are some very common features of race-related investigations:

- many employers set an unnecessarily high bar requiring staff to prove any allegation of race discrimination was 'racially motivated'
- tackling racism is seen as too difficult and so is avoided
- the process of raising a concern and the time an investigation takes deters staff from raising a concern
- staff lack confidence investigatory processes and other responses will be fair

As part of our response to these findings we critique our existing approaches to addressing racism and consider why racism is not better understood (see section 6.2). We also consider what organisations could do if they were serious in their intentions to respond more effectively to both overt and covert forms of racism (section 6.3).

In this respect, we have thought critically about how the NHS creates a culture freer from race discrimination. Among our recommendations we include a call for organisations to develop an appetite for 'race talk' and set standards of behaviour that challenge 'everyday' racism. In addition, organisations need to develop greater levels of comfort in staff speaking out about racism and in acting on the early warning signs of racism by tackling racism more informally and being proactive when evidence would suggest that there might be a problem. There is also a clear need to impart the skills that all staff need to get closer to genuine anti-racist practice, with particular development needed for boards, leaders, and professionals whose roles directly uphold the values of their organisations.

Racism and its impact don't have to be enduring. We have the means to address it. We can go beyond the reporting of statistics, the constant 'listening' to the views of racially minoritised staff, and the belief that representation will fix everything. Essentially, if white staff feel more confident talking about race, are able to recognise and call out racism, and our organisations get better at responding to the reality of racial discrimination, then we would really be getting somewhere.

1. INTRODUCTION

1.1 ABOUT THIS REPORT

The very serious function of racism is distraction. It keeps you from doing your work.
Toni Morrison

This survey differs from other reports about racism you may have come across. For one thing, it was never our intention to prove that racism exists. We know it exists; there is a mountain of evidence showing it does. Instead, this report – and the unique survey it emerges from – aims to understand the NHS response to racism, what trusts and healthcare organisations do about it, and how effective they are at addressing it.

The importance of tackling racism in healthcare should be self-evident. In an NHS workforce where 25% of staff are now of Black or minoritised ethnic (BME) backgrounds and a significant and growing proportion of the population served by healthcare organisations are too, this is not remotely a marginal issue. Nor is it a new one, especially as we already have a wealth of evidence as to the damage done to staff and to patient care by racism.

Many people contributed to the survey at the heart of this report – we had over 1,300 responses – and we are grateful for their involvement. In conveying their experiences, participants have overwhelmingly demonstrated that the NHS is not addressing racism effectively, and that it actually expends a lot of energy defending and burying allegations of racism as a reactive measure. In doing so, many organisations have created environments where it is unsafe to speak out about racism, and this means many staff must endure their experiences of racial discrimination over a prolonged period.

Why – after years of initiatives, programmes, plans, and policies – is this still the case?

As the responses to our survey show, there is still a paralyzing reluctance within organisations to talk about race. Some minimize racism when it occurs, others demand evidence it exists, others still simply ignore the issue, hoping the person experiencing it will shut up or move on (you can see exactly how common this is in the following pages).

For many organisations, racism is just too scary to address. The complexity of the issue facing them seems so daunting they plump for short-term, piecemeal approaches that show they are doing *something* (even if it's not the stuff change is made of). In doing so, the roots of the issue go untouched. As a result, nothing changes and the belief that racial discrimination is intractable is reinforced. The NHS, for all its noble intentions, is entangled in a system of 'doing': of addressing the symptoms of racism, rather than addressing its causes. It is stuck in a dance routine, but not one with the right moves.

But while racism may be big and complex, it does not have to be enduring. There is a growing evidence base around what works in confronting it. And more importantly, we can always improve our understanding of how racism is reproduced and maintained. A lot of the time, what stops us

from doing anything about racism is that awkward conversation we would rather avoid. We produce toolkits that are of limited use because what is still required is the *practice* of having the conversation. Our learning about 'race' remains limited to stereotypes about ethnicity, religion, and culture. It does little to address our personal and organisational belief systems.

The NHS, like many organisations is a mirror of our society spending little or no time on this stuff, and because there isn't investment in learning, reflection, and practice, the system doesn't really get any better at understanding the issue. It is a deliberate blind spot; an unspoken reluctance to confront racism built on the acceptance of data which continually shows inequities of experience and outcome. All of which means racism remains shrouded in silence – or mediated through employer networks or the routine of Black History Month. Until, that is, the issue erupts in the workplace in ways which cannot be hushed-up or ignored.

But this report is not about pointing fingers; it's about unravelling the mystery behind the cover-up. By talking about this systemic blind spot and how it affects NHS staff, we hope to encourage more open environments where conversations about racism are seen as necessary to systems change, environments where cultivating our personal and shared understanding of racism becomes part of an overall improvement culture. Moreover, we hope that by challenging the belief that racism is something that 'just needs to be accepted' we will pave the way for lasting change and true equity within our healthcare system.

We believe that it is possible to end racism.

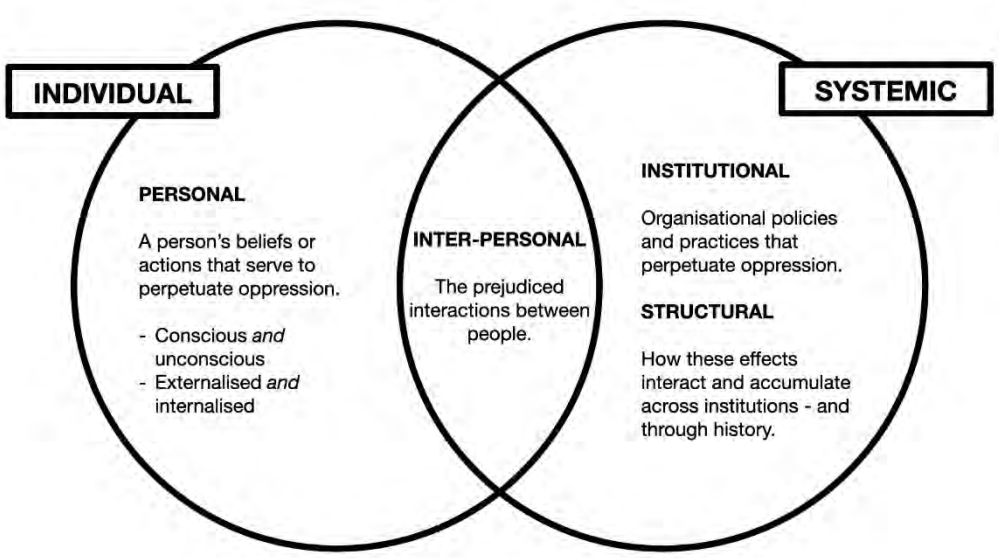
1.2 WHAT IS RACISM?

There is still a heated discussion about what really qualifies as racism and the various ways it can show up in the workplace (see, for example, Roberson, 2023). Many still believe racism is upfront, hostile verbal (or physical) abuse (Braveman, 2022). However, there's increasing recognition that racism is becoming more subtle and ambiguous (Levy, 2017). Indeed, despite some recent high-profile incidents of overt racism, a growing number of healthcare organisations are increasingly trying to understand racism as a systemic issue.

Understanding racism as systemic means understanding how it operates through formal and informal habits and norms that subtly and consistently disparage, limit, and dehumanise individuals who are racialised as non-White. Tackling systemic racism requires us to identify and address the drivers of this way of thinking, not just deal with the symptoms. This means looking at uncovering the ideas that are held consciously and unconsciously by all of us socialised into a racially unequal society. For organisations, it also means looking at patterns in our cultural practices that support the status quo.

Racism is complex. Our unwillingness to engage in this complexity can mean that we don't really give ourselves an opportunity to recognise racism and how it is perpetuated. A somewhat more accessible way of thinking about this is illustrated in figure 1, below. It shows four mutually reinforcing fields through which racism operates: personal, inter-personal, institutional, and structural. The individual and systemic sides of the diagram act a little like a call-and-response. Racialised social structures shape our sense of agency and the choices we make, and the choices we make and the action we take in turn remakes (or disrupts) these social structures.

Fig 1: The four fields of racism



Taken from: https://newwestschools.ca/deia-parent-toolkit/introduction/the-4-levels-of-racism

1.3 WHAT DO WE KNOW ABOUT RAISING CONCERNS IN THE NHS?

Raising concerns in the NHS can still prompt a defensiveness Robert Francis (2015) first noted a decade ago:

> *there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism and an institutional culture which ascribe[s] more weight to positive information about the service than to information capable of implying cause for concern.*

As many staff have found out, this is especially true when raising concerns about race discrimination, despite the supposed contractual protection of the national *NHS Staff Contract* and the exhortations of the 2020-2021 NHS People Plan:

> *We all need to feel safe and confident when expressing our views. If something concerns us, we should feel able to speak up… Many staff have felt unable to speak up, or they have been ignored. This is another area in which BAME staff have been particularly affected. We need to look beyond the data and listen to the lived experience of our colleagues. NHS England.*

NHS England (2022) recently revised its *Guidance on Freedom to Speak Up for NHS leaders* but, as the House of Commons Health Select Committee noted (2013), whistleblowing is:

> *only necessary because of the absence of systems and a culture accepted by all staff which positively welcomes internal reporting of concerns.*

Recent research argues that while improving clarity, fairness, quality, and transparency of policy, process, and procedure is important the addition of further layers of formal policy may provide a

veneer of order without enhancing understanding (Wu et al, 2021). Other research (Reitz and Higgins, 2020) agrees and highlights the…

> *power imbalance in organisational roles (as) perhaps the most important factor that makes employee silence such a common experience*

and goes on to argue that leaders should not focus

> *their attention and efforts predominantly on those who feel silenced, urging them to 'be brave', 'speak up' and have the 'courageous conversations' that are required… [Instead] we need to stop trying to 'fix the silenced' and rather 'fix the system'.*

Reitz and Higgins conclude that:

> *instigating whistleblowing lines and training employees to be braver or insisting that they speak up out of duty will achieve little therefore without leaders owning their status and hierarchy, stepping out of their internal monologue and engaging with the reality of others.*

In summary, a reliance on policies, procedures, and training 'will not, in isolation, reduce bullying, improve the effectiveness or safety of whistleblowing, (or) create a disciplinary environment focused on learning' (Kline, 2023).

A decade ago, Public Concern at Work, the independent whistleblowing charity which ran the NHS whistleblowing helpline until 2012, commissioned research on the experiences of 1,000 whistle blowers in a cross-sectorial analysis and concluded that the NHS is at least as unsafe an environment to raise concerns as other sectors (Wim, 2013).

The National Guardian Office (NGO) *Freedom to Speak Up Index* 2021 found very substantial differences between organisations on whether staff reported significant barriers to speaking up and whether managers were a source of detriment when staff did try to speak up with almost half of Freedom to Speak Up Guardians (48%) reporting that line managers were a source of detriment in most cases.

In their recent aptly named report *Fear and Futility,* published 2023, the NGO concluded:

> *there is a growing feeling that speaking up in the NHS is futile – that nothing changes as a result… They fear experiencing negative consequences if they do… When they speak up about matters including the impact of understaffing, their leaders themselves may struggle to be heard when trying to address these concerns.*
>
> *Of concern are the responses to the questions about whether workers have witnessed an incident which could harm patients or colleagues and whether they feel they will be treated fairly or that preventative action would be taken if they do report it. There is a disconnect between the encouragement which workers feel in reporting (very high) and the perception of how fairly those involved are treated*.

In summary, NHS England's approach to staff who have concerns has not achieved its stated goals and has left it unsafe and/or ineffective for individuals in many organisations to raise concerns despite the Francis Freedom to Speak Up Review (Francis, 2015).

New guidance in the Freedom to Speak Up guide for leaders in the NHS and organisations delivering NHS services (NHS England, 2022) states leaders should:

> *work hard to understand the barriers that colleague from minority ethnic communities or people who have been recruited from abroad might face.*

Section 3.3 of the Francis *Freedom to Speak Up Report* (2015) considered the experience of workers from a BME background. At the time, one author of this report was told by DHSC that they had initially not requested analysis of data by ethnicity as 'they had no evidence that this was an issue'. In fact, Francis found that, compared to White respondents:

- a higher proportion of BME respondents reported fear of victimisation as a reason for not raising a concern
- BME staff were more likely to have reported concerns about harassment and appeared less satisfied with the response to their concerns

After raising a concern, BME staff were:

- more likely to report being victimised, or ignored by management than worker from a white background
- slightly more likely to report being victimised by co-workers than workers from a white background
- less likely to report being praised by management than workers from a white background

In addition, after supporting a colleague who had raised a concern, BME workers were:

- more likely to report having suffered detriment
- more likely to report having been victimised by management
- less likely to raise a concern again if they suspected wrongdoing than white workers did

The *NHS National Staff Survey 2020* reported a significant difference between White and BME workers views on raising concerns. It found that staff with long-lasting health conditions or illnesses and staff from BME backgrounds were less likely to feel safe to speak up about any concerns they have, compared to White staff (NHS Staff Survey, 2023).

The COVID-19 pandemic highlighted the role played by BME staff in frontline services and the factors which contributed to their disproportionate mortality. There was extensive media coverage with additional issues affecting overseas recruited staff. For example, *Nursing Standard* reported (2020):

> *Filipino nurses and their families have raised concerns that social and cultural factors might be putting healthcare workers in their community at heightened risk from COVID-19. They fear that marginalisation and a possible tendency to 'keep quiet and be extremely hardworking' may, in part, account for what looks like a disproportionate tally of deaths among Filipino nurses in the UK.*

Kline and Somra (2021) asked staff surveyed if an issue they had raised as a concern involved people – workers or patients – being treated differently because of their race, nationality, or ethnicity. BME respondents were far more likely to say their concern involved some element of race-based inequality. They found some Freedom to Speak Up Guardians (FTSUs) reported particular issues with overseas-trained staff who can be anxious about raising concerns due to fear of the consequences (especially if they felt their visas would be jeopardized) or if they had previously worked in a culture in which concerns were not raised.

Confirmation of the specific challenges facing BME staff racing concerns came from both BME and White FTSU Guardians interviewed:

> *"It became clear that being a BME Guardian appeared to give staff more confidence to raise issues – 'you'll understand what I am saying to you." BME Freedom to Speak Up Guardian.*
>
> *"In our trust, there was certainly an issue about overseas staff not speaking up, and the culture of the Trust was generally not conducive. That might be made worse if staff had concerns that raising a concern might have implications for their visas or if there was a culture of not raising concerns as highlighted in COVID." White Freedom to Speak Up Guardian.*
>
> *"I thought I was doing well although I could tell from individual cases that there were specific issues with BME staff raising concerns. When evidence of more serious problems within the trust was provided I realised I had not sufficiently understood the perceptions or experiences of BME staff." White Freedom to Speak Up Guardian.*

Kline and Somra also found:

> *Respondents referred to workplace discrimination being subtle and hard-to-define, and therefore difficult to explain to someone who had not experienced it first-hand. Given this, a respondent said they would prefer to speak to someone who was 'more likely to understand the nuances of working dynamics'*

We know that (NHS England, 2023) in addition to facing additional obstacles to raising concerns BME staff are:

- more likely than their White colleagues to be bullied by their managers and colleagues
- more likely that their White colleagues to enter the formal disciplinary process
- much more likely to experience discrimination from managers and colleagues

Sir Robert Francis' *Freedom to Speak Up Review* (2015) found NHS staff in general may be reluctant to speak up because of fear of being:

- blamed or scapegoated
- discriminated against
- disbelieved
- seen as disloyal
- seen as disrespectful in a hierarchical system
- bullied
- and the wider consequences for their career

These conclusions were similar to the academic literature that preceded it (see, for example, Carter, 2013).

Empirical research consistently shows that the two main reasons why people do not report perceived wrongdoing are fear of retaliation and a belief that even if they do the matter would not be rectified (Lewis, 2013).

The National Guardian Office *Freedom to Speak Up Index* (2021) found that less than half (48%) of the respondents said people in their organisation did not suffer detriment for speaking up. However, almost a fifth of respondents (19%) felt individuals did suffer detriment for speaking up in their organisation.

When staff raise concerns of any kind there is always a risk that retaliatory steps may be taken by colleagues or managers, as was recognised by Francis in his *Freedom to Speak Up* report. If concerns about performance or behaviour that had not been mentioned previously suddenly surface when discrimination is an issue, alarm bells should ring. The issues arise repeatedly in Employment Tribunals when BME staff have raised concerns about their treatment.

1.4 LANGUAGE AND TERMINOLOGY

Please note that this report does not censor the verbal racist abuse some staff have been subject to.

We use the term ‘BME’ to refer to people who identify as Black or as part of a minoritised ethnicity, community, or group. We recognise that this is a contested term and not everyone will identify with it. We also recognise that because it is a broad term, it may not accurately express the views of those who experience discrimination on the basis of skin colour. However, for the purposes of analysis, we have used the term so that we can draw comparisons between people from White British and BME backgrounds.

2. FINDING YOUR WAY ROUND THIS REPORT

2.1 OUR APPROACH

The mixed-method approach was undertaken in six distinct phases.

Phase 1 Jump to section1.3	We undertook a brief review of relevant literature related to the experience of NHS staff in raising concerns in general, and of Black and minoritised (BME) ethnic staff raising concerns in healthcare environments. It is worth noting that there is considerable literature on the former, and very little on the latter.
Phase 2 Jump to section 5	We identified a number of employment tribunal cases taken by NHS staff as litigants against NHS employers. We selected three 'landmark cases' between 2011 and 2016 and then the five most prominent cases in 2023. We are confident they are reasonably representative (rather than comprehensive) of the shortcomings tribunals have identified, not least because the authors are familiar with other cases where similar themes are identified. We are thankful for the expertise of Shazia Khan, Founding Partner at Cole Khan, who is an experienced lawyer very familiar with race discrimination cases across most sectors, including in the NHS and healthcare.
Phase 3 Jump to section 4	Between May and July 2023, an online survey was sent to NHS staff. A link was circulated to the report authors 'contacts and disseminated through social media. NHS staff were encouraged to share the link with their colleagues. The survey was designed to be completed by BME staff. Participants were told the purpose of the survey was to: • draw a picture of the lived experiences of BME staff in the NHS and • signpost what the NHS could (and should) be doing to recognise and address racist/discriminatory experiences We allowed individual respondents to answer questions with their own definition and interpretation of racism, on the understanding that it may differ from our own. This was to ensure we captured the range of experiences affecting staff which *they* deem to be racist. It is worth re-emphasising that the purpose of this survey was **not** to establish the existence of racism in the NHS: numerous reports have already demonstrated its presence. Rather, our objective was to concentrate on understanding both personal experiences of racism and the institutional responses that followed when allegations of racism are raised. In total, 1,327 people responded. A breakdown of survey respondents is outlined in Appendix A.

Phase 4	Following the survey responses, we conducted a review of the literature on bias (and specifically racial bias) in investigations, and the challenges staff face in raising concerns about racism. It seemed important to understand more about the reasons why so many allegations of racism within the NHS are deemed to be flawed, or don't even get off the starting block. The findings from the review are summarised in the report, but an expanded version will be published as a separate guide on' Avoiding Racial Bias in Investigations'.
Phase 5	We hypothesised that there was a correlation between the themes identified through our analysis of the employment tribunal cases, and the experiences of staff described by the staff survey. We then interrogated that data to explore and expand our hypothesis and understanding of the issues.
Phase 6 Jump to section 6	Finally, drawing on our findings and the wider literature we then set out our recommendations for NHS employers – and specifically its Human Resources community – on how to enable better challenge and mitigation of race discrimination within the NHS.

2.2 LIMITATIONS

The reader should keep the following in mind when engaging with the findings and analysis presented in this report:

- We did not set out to demonstrate the NHS is institutionally racist. Our assumption that it is, is well-founded and based on a wealth of available data and research, much of it espoused by the NHS itself.
- The employment tribunal cases we present are limited in number and therefore not comprehensive. However, we are confident our findings are representative, based in part on our knowledge of other NHS cases, and in part on the expert input of Shazia Khan (who has 20 years' experience working on these cases and issues). In addition, a significant number of claims will have been settled subject to confidential terms being agreed, and so would not form part of the available data.
- The survey itself has one important limitation – we are unable to demonstrate the survey respondents are representative of NHS staff as a whole, or of those who have raised concerns. However, their reported experiences do match those outlined in NHS survey data, peer-reviewed, and grey literature. Moreover, the size of the sample gives some assurance of sufficient representation and reliability.
- There is one other inherent limitation, and that is the collective denial of the existence and proliferation of racism, both within our society and in institutions like the NHS. Consequently, we believe there will always be a challenge to any data intended to confront racism. We offer this not as an excuse or substitute for robustness, but to illuminate another pattern of systemic racism – that of always asking for more data and more evidence of its existence prior to any action addressing it.

3. EXPERIENCES OF RACISM

This section outlines some of the different forms of racism survey respondents experienced. As stated above, this report does not aim to show that racism exists in the NHS. However, before moving on to look at how organisations respond to claims of racism, it is important to illustrate the different behaviours and actions staff are subject to.

Participants in the survey were asked if they had experienced racism and what form it took. Figure 2 (below) shows the most common responses.

Fig 2: If you have experienced racism, what form did it take?

My performance or behaviour is subjected to greater scrutiny than White colleagues	63.4%
I have heard someone make an assumption about another person based on their race or nationality	53.2%
I have not been offered development opportunities	52.5%
I suggest ideas, but they don't appear to be heard or taken up	51.1%
I have heard someone make a generalisation about a particular race	51.0%
I don't get the same information as everyone else	49.3%
I have been denied promotion opportunities	49.0%
I have heard someone make a race-based joke [not necessarily about your race]	38.2%
As a manager my staff question my authority and/or competence in ways they are unlikely to challenge a White manager	33.9%
Colleagues speak to me rudely/in a different tone compared to how they speak to other people	33.8%
My manager speaks to me rudely/in a different tone compared to how they speak to other people	30.6%
People call me another version of my name because they feel my name is too difficult to pronounce/learn	26.6%
I don't get the opportunity to choose my work areas or shift as other staff are	23.3%
I was unsupported when a patient was racist towards me	23.2%
I'm often allocated to work with people who look like me	15.4%
Other	22.2%

Scrutiny

63.4% of BME staff feel their performance or behaviour is subject to greater scrutiny than their White colleagues. This is particularly true for BME staff in bands 8 and above: 71.3% report this as an issue (see figure 3).

Race as a factor in regulator referrals has been explored for both the NMC and the GMC (see Atewologun and Kline 2019; West et al 2017). A small number of respondents reported being referred to their regulatory body (such as the GMC or NMC) for minor issues or concerns the significance of which have been exaggerated. The punitive natures of these referrals is evidenced by the regulator's rejection of them. Other respondents discussed how managers punitively used performance management procedures, often despite evidence such measures were having a detrimental impact on employee wellbeing:

> *"My line manager put me on a performance management process. I was diagnosed with depression, [and] started taking medication. I told my manager [that] the performance management process was adversely impacting on my mental health, but she was insistent [that] I follow through. She treated me like a child…she was unforgiving... White colleagues experience[d] a leniency and compassion which wasn't extended to me. My every error was pointed out, in an unconstructive, quite punishing way. I was exhausted by it. I worked late into the night, doing things twice, sometimes three times over, to ensure my work was accurate… [I] left the team in the end - but have bought that bad experience with me. It impacts on my relationships and how I see myself. Sometimes, I don't feel I deserve my seat at the table. She made me feel like an imposter."*
>
> **(Asian/Asian British, Band 8b)**

Some respondents discussed how accounts of BME staff's ability by white colleagues hold greater credibility to concerns raised by BME staff themselves:

> *"Punishment is more severe than white colleagues. Complaints from white colleagues and juniors are taken as true but never verified before punishment! Whereas BME complaints are brushed aside by line managers, directors and even the CEO."*
>
> **(Black/Black British, Band 8a)**

Assumptions and generalisations

Over half of BME staff (53.2%) have heard a colleague or patient make an assumption about someone based on their race/nationality, with another 51.0% hearing someone make generalisations about racial groups. Assumptions and generalisations can cover a range of issues, such as presumptions about where someone went to school, the type of food they like, or, more seriously, their competence (often connected to assumptions about their communication skills or language proficiency). Survey respondents also talked more generally about assumptions made about who they are 'as a person'. For example:

> *"A colleague made assumptions that I was a patient who lived in a black neighbourhood. We had never had a conversation to this effect so the assumption could only have been based on 'who' they saw standing in front of them."*
>
> **(Black/Black British, Band 8a)**

Fig 3: If you have experienced racism, what form did it take? (by band grouping)

Lack of development opportunities

A lack of access to development opportunities is the third most common form of discrimination, experienced by 57.7% of staff in bands 6-7 and 56.0% of staff in band 8 or over. Many participants argued that opportunities for growth and advancement are distributed unfairly and inconsistently. This means that individuals, despite their qualifications, experience unequal access to developmental resources and support both institutionally and from management.

> *"[I am a] Black male [who was] denied promotion. [I saw] students less than 2 years after qualifying getting positions higher than myself who mentored them… No one will tell you 'you are [a] Black man and you are not welcome'. They tell [you] when you apply for 20+ senior positions after nearly 30 years [of experience] … I have 3 degrees and [a] diploma [but] I am still at the same band I was on [in] 1995. I have attended a major NHS leadership course, and inequalities still unfold before me 39 years later. The same issues, the same subjects, and the same agenda".*

(Black/Black British, Band 5)

Often this form of racism manifests as white colleagues, sometimes with significantly less experience or qualifications, advancing at a faster rate, receiving more opportunities, and enjoying greater support (even when things go wrong). For example:

> *"A white colleague who has no governance or managerial experience whatsoever was given the manager role in the governance team. I am ethnic and have been in my role in governance for over eight years but was not even given the opportunity to apply for the role as manager. The role was not even recruited too, it was handed to the white colleague. I also found out that when this colleague was Business Manager they were on a band 7. I have the same title but am on a band 6."*
>
> **(Asian/Asian British, Band 6)**

Those affected often find themselves excluded from the same career-enhancing opportunities and promotions, despite possessing the necessary expertise and skill.

Survey respondents also witnessed and experienced the unequal distribution of development opportunities, regardless of funding status; unequal access to or exposure to opportunities that may lead to promotion; and having their expertise and experience disregarded, belittled, and undermined. Less qualified white colleagues are prioritised when it comes to opportunities that may lead to progression – even when they have demonstrated incompetence in their role:

> *"Wanting to change job from being a nurse (Band 7) to service delivery manager (Band 7) in the same trust. Applied for 21 jobs within a year and had seven interviews but was told that I had no experience as a service delivery manager. I have an MSc and PRINCE 2 qualification. A white nurse who completed [redacted] programme was given a similar role and now she is a General Manager in the same trust. She told the nurse who was seconded to her post while she was on [the programme] that she was not coming back because she already has a job waiting for her."*
>
> **(Black/Black British, Band 7)**

‣ Interpersonal relationships with colleagues and managers

BME staff often encounter pervasive bias, discrimination and racism originating from both colleagues and managers. Discriminatory behaviour, ranging from covert to overt racism targeting lower-band employees, can lead to bullying, harassment, and micro/macro-aggressions, creating routine distress. Some staff talked about how their health and wellbeing is valued less than their White colleagues':

> *"When I call in sick (which I very rarely do) my managers doubt that I'm really sick and tell other team members I just wanted a day off. When I am struggling with mental health, managers tell me I'm being over sensitive and I need to be productive (even though I still am) but white members of staff are signposted to well-being teams."*
>
> **(Multiple heritage, Band 5)**

An equally common complaint was white staff receiving greater support around professional development.

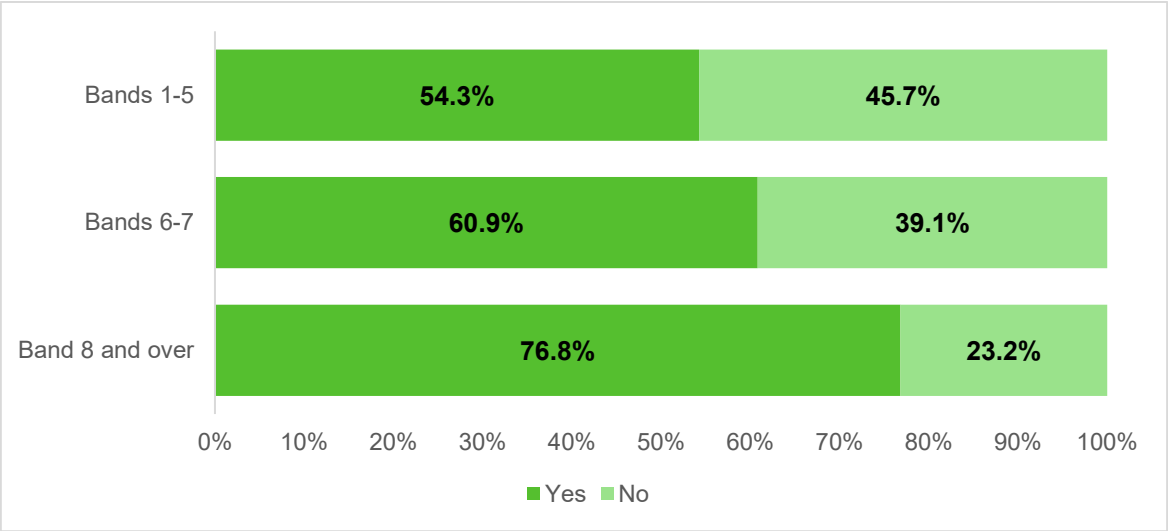
> *"I was bypassed for promotion. I was a band 7 specialist nurse and worked in the capacity of lead nurse. My manager advertised a band 8b post without informing me about it. Other colleagues saw the advert and encouraged me to apply for it as they explained that I was already working in a band 7 capacity anyway. I approached my manager to have an informal discussion about the post, but they avoided me several times. When I finally got to meet her she asked me if I thought I met the essential requirements. She was quite dismissive and suggested I lacked particular skills. I applied anyway, but was not shortlisted. I later approached her for feedback about how I could improve my chances of being shortlisted in the future but she never responded to my requests verbally and in writing by email. She then directed me after several months when I persisted to another manager from a different organisation who she said was responsible for shortlisting. This person never responded to my requests. I contacted the chief nurse who also did not respond to me."*
>
> **(Black/Black British, Band 7)**

4. RAISING CONCERNS

4.1 PROPENSITY TO RAISE CONCERNS

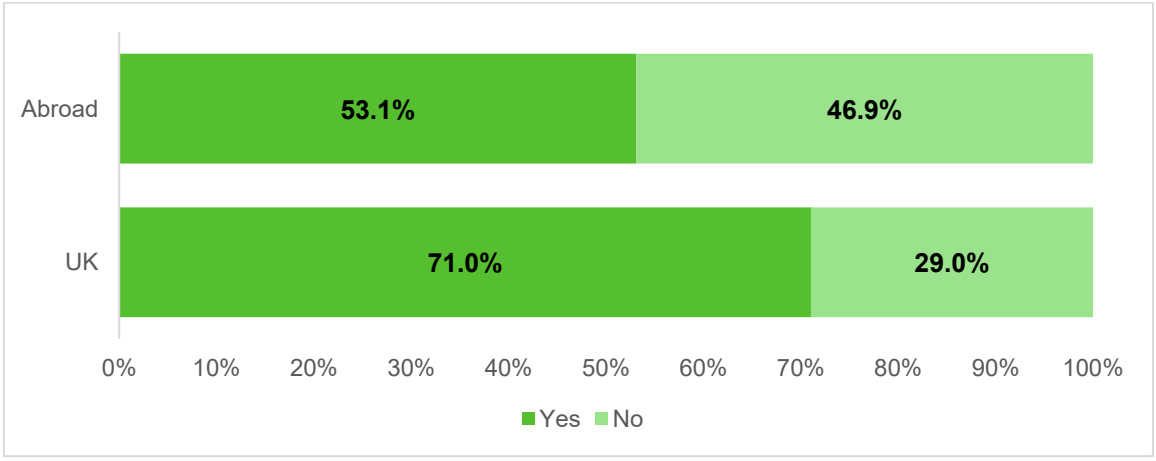
67.2% of respondents have highlighted concerns of race discrimination to their organisation. Figure 4 shows the proportion of staff who have raised concerns by band. 76.8% of staff in bands 8 and over have raised a concern, compared with only 54.3% in bands 1-5.

Fig 4: Have you ever highlighted race discrimination as an issue? (by band grouping)



UK trained staff are much more likely than internationally trained staff to raise concerns. 71.0% of UK trained staff have highlighted race discrimination as an issue, compared with 53.1% of internationally trained staff (see Figure 5, below).

Fig 5: Have you ever highlighted race discrimination as an issue? (by training location)



4.2 BARRIERS TO RAISING CONCERNS

The most common reason for not raising a concern of race discrimination was not believing anything would change (fig 6). 63.5% of people who didn't raise their concerns were worried about being seen as a troublemaker, while 57.3% were worried about repercussions from their line manager or other organisational leaders.

Fig 6: Reasons for not highlighting race discrimination despite experiencing/witnessing it

I didn't believe anything would change	75.7%
I didn't want to be seen as a troublemaker	63.5%
I was worried about repercussions from my line manager/other leaders	57.3%
I didn't think my trust would take my concerns seriously	54.5%
I was worried about repercussions from my colleagues	38.2%
I didn't think my trust would understand my concerns	27.8%
I felt pressured not to make a fuss	25.4%

4.3 ORGANISATIONAL RESPONSES TO RACE DISCRIMINATION CONCERNS

Of those who raised concerns, only 5.4% said they were taken seriously and that their problem was dealt with satisfactorily (see fig 7, below).

The most common outcome to a race discrimination concern was nothing happening (the outcome in 42.7% of cases). In one in five (19.1%) instances, claims of race discrimination were treated the same as any other workplace dispute and referred to mediation. In 5.0% of cases, the individual raising the concern were themselves disciplined.

Fig 7: Outcome when raising concerns

Nothing happened	42.7%
Seen simply as a disagreement – and referred to mediation	19.1%
My concern was taken seriously and the problem satisfactorily dealt with	5.4%
I was disciplined unfairly	5.0%
I was told it was my problem	4.9%
I was dismissed	2.2%
Other (please specify)	19.8%

41.8% of respondents left their jobs as a result of their treatment, and the survey highlighted a number of specific issues in relation to raising concerns.

Retaliatory investigations

Staff report that they have an elevated risk of experiencing racism and discrimination when they raise concerns related to racism.

> *"I was told that there has been a 'breakdown in communication', [and] asked to work elsewhere. [I was] investigated for my behaviour towards colleagues making it unsafe for patients."*
>
> **(Black/Black British, Band 4)**

> *"I was told that I had misunderstood the situation, and I was accused of being the reason for the way the other party had behaved. I was told that my tone and language was aggressive, and my concerns were dismissed…even after my complaint was upheld. None of my suggestions [were] implemented, and I am still sitting next to [a] person who continues to interfere in my work."*
>
> **(Multiple heritage, Band 8a)**

A number of survey respondents discussed how the standard of evidence required by grievance investigations allowed perpetrators of discrimination to escape censure:

> *"I was basically ignored, not taken seriously, asked to move to another ward, judged and looked upon as a challenging harasser. I should be seen and not heard and even told at one point to stop talking."*
>
> **(Black/Black British, Band 2)**

> *"My manager… denied everything in my submitted report. He then tried to prove that I was not competent in my job and made my life so difficult, that I would leave. I was told to change my behaviour and put on a disciplinary process."*
>
> **(Asian/Asian British, Band 7)**

> *"When I finally decided to say in a meeting with [a] manager that I feel I am being treated differently due to the nit-picking. I was told, 'If you are going to play the race card, I will shut this meeting down'. That statement was then ignored in feedback info and stated as not being said!"*
>
> **(Black/Black British, Band unknown)**

Epistemic injustice

'Epistemic injustice' refers to how an individual's testimony regarding their experience can be dismissed (see Fricker, 2007). The term references beliefs about what constitutes knowledge and opinions. For example, attempts to discuss racism within a belief system that presupposes it does not exist won't get off the ground. And, indeed, this was a common theme amongst survey respondents: poor and discriminatory behaviour is routinely excused, explained away, distorted and/or overlooked. Often, attempts are made by management to disregard and obscure complaints against repeat offenders; they are consistently protected and face little sanction or accountability:

“I was victimised. My work and job plan [were] suddenly scrutinized, although I had a perfect record. My complaint was never investigated. The manager moved and was promoted elsewhere at another Trust. HR are often supporting the racist behaviour by managers and supportive in the victimisation... It’s as if HR see it as their role to cover up racist behaviours within trusts.”

(Asian/Asian British, VSM)

“I was told that I take this personal. Yes, I do because I am a person. Then told, ‘We know how this person is’. That is just how he is. He gets away with name-calling, despising anyone who is not English, and constantly says [that] if we are not happy, to go back where we came from. Some people seemingly laugh but afterwards talk [about] how uncomfortable they are and what can they do or say since he openly says racist remarks in front of managers, senior colleagues, and even consultants and no one says anything about it.”

(Black/Black British, Band 6)

Some participants suggested trusts do not have a sufficiently developed understanding of the different forms racism can take. This can lead to them minimizing complaints raised by BME staff:

“I was made to feel like the perpetrator, the actual perpetrator who has had a number of grievances, has been let off, I am told I need to make more of an effort, it's my problem, they refuse to acknowledge the power differences.”

(Asian/Asian British, Band 8a)

“[I] highlighted [an] Islamophobic colleague, and [was] told he is ‘old fashioned’ rather than racist."

(Asian/Asian British, band unknown)

"My supervisor was bullying me, she turned everyone against me, including the manager of the service and put a complaint against me. There were two job interviews where I was interviewed by the manager involved in the complaint. This was unfair, I had less training than every other therapist and less opportunities, too. I was victimised. It was awful. The complaint procedure lasted one year. I feel the trust swept it under the carpet and wanted the issue to disappear. I had to leave.”

(Asian/Asian British, Band 7)

“Nothing happened as some managers were racist themselves and would cover up such cases and concerns.”

(Black/Black British, Band 3)

“[there was a] very openly biase[d] investigation and appeal process. Support [was] given to the perpetrator. I have [had] no legal help to do my witness statement, and when I submitted

[it], they objected, saying it [was] inflammatory to the perpetrators and [much] of my testimony was [struck] out…I tried to settle so I can move on and rebuild...I [now] have to go on benefits."

(Black/Black British, Band 5)

‣ The fear and reality of repercussions as a result of making a complaint

Staff expressed their apprehension regarding raising concerns, as they fear and experience reprisal, retaliation, and victimisation. This inevitably has an adverse impact on their well-being and mental health. These concerns are further exacerbated as staff are treated as disloyal as well as being subjected to bullying, scapegoating, and harassment. Staff who raise concerns about racism are often met with indifference, skepticism, or outright dismissal.

"I escalated this; the managers did nothing. I was then bullied out [of] the company."

(Black/Black British, Band 5)

"[I was] gaslighted, victimised and excluded, given worst cases, information withheld, scrutinised and referred to the regulator."

(Asian/Asian British, band unknown)

"[I was] gaslit, ostracise[d], [and experienced] shifting blame and [the] formation of cliques. [There was a] defensive response placing barriers to constructive resolution and [a] delay in keeping me safe in the workplace. Resulting in [the] escalation of my poor experiences, impacting on my wellbeing, mental health, and all aspects of my life."

(Asian/Asian British, Band 6)

***"**[I was] told not to get involved; it wasn't my job. Questioned if what I reported really was racist or just a 'misunderstanding'. [I was] made to feel [like] I was being disloyal to the organisation as I wanted to pursue it further."*

(Multiple heritage, Band 9)

"[The] given grievance policy went against the Respect in Workplace policy…the complaint was not upheld then lost at appeal. No one would talk to me, and I was ostracised in the workplace. [The] gossip mill went into overdrive. Staff in CCGs also knew of my grievance and started ignoring my emails, too. I became aware that my position was untenable."

(Multiple heritage, Band 8a)

"I've been made to feel that because I spoke up…I am the bad person. I have even had people say to me, 'Why are you doing this to yourself?', like the situation I am in is my entire fault. My therapist and GP have suggested I have contracted PTSD as a result of the trust failing to deal with the psychological impact [of] the mishandling of my case…I have tried reaching out to management on numerous occasions in the hope of getting some support with each of these things, only to be left with feeling gaslighted and questioning my sanity. I

go into this cycle of mental health deterioration, and then in the end, it becomes a disaster, and I reach a crisis point…I am actually at the point where I feel like I am being bullied out of my job."

(Black/Black British, Band 6)

‣ A lack of confidence in the complaints and investigations process

Doubts about fairness, the limited impact of policies and procedures, and a seemingly rigged investigation process all collectively hinder confidence in the NHS complaints and investigations process:

"The Trust conducted biased investigations using their own legal team and called this independent. They covered up and whitewashed the facts. They even promoted the perpetrators to silence the victims."

(Multiple heritage, Band 6)

"I was targeted and victimised further. False allegations were created. I was set up to fail. The Trust called in their own legal team to investigate, who whitewashed and covered up the racism. Went to tribunal and won."

(Black/Black British, Band 7)

"I raised a complaint to the CEO and Medical Director, there was an external investigation which took a year… and [the] investigation whitewashed all the race harassment events as 'personal issues'. They advised some policy review advice, no acknowledgement, no duty of candour, [and] no apology. I was harassed and gaslighted to a point where I had to be moved out of the service."

(Asian/Asian British, Band 8a)

‣ A poor or absent institutional response to racism and discrimination

Many participants suggested institutional responses to racism are poor, with organisations often preferring to avoid the issue. This undermines staff's confidence in their managers 'ability to handle race discrimination complaints:

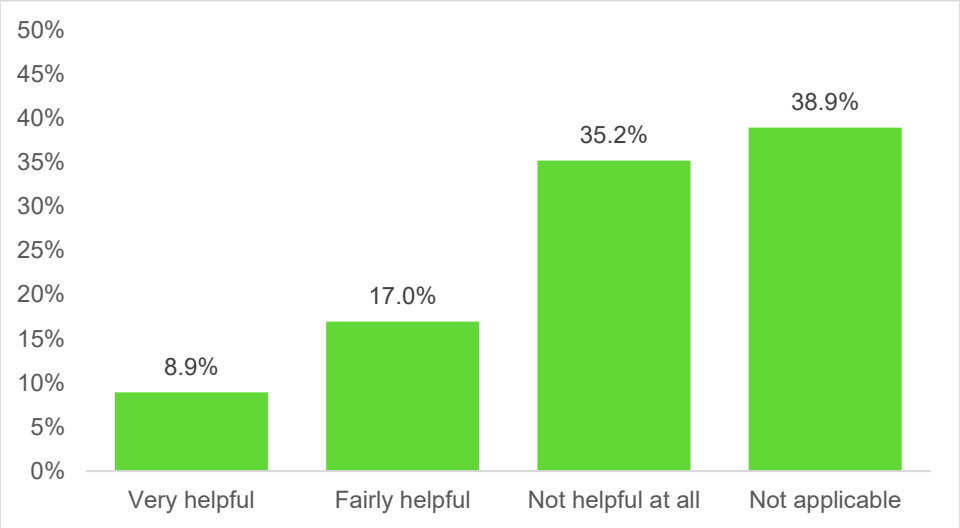
"I reported racism experienced by myself and another colleague; [my manager] heard [it], but no action [was] taken. In fact, I was told that there were many others who left the organisation as they didn't feel racism was handled or dealt with appropriately, so [the] only option was to leave. There was no trust in the system or with senior leadership and management to act on it."

(Asian/Asian British, Band 8b)

4.4 SUPPORT FROM UNIONS, HR, GUARDIANS, ETC

Participants were asked, if they were a member of a trade union, how helpful the advice they were provided was (figure 8). A third of respondents (35.2%) said it was not helpful at all; 25.9% said it was 'helpful 'or 'very helpful'.

Fig 8: If you are a member of a trade union how helpful did you find their advice?



NHS staff have experienced a number of issues raising race discrimination claims with HR colleagues, unions, and, to a lesser extent, Freedom to Speak Up Guardians. Most common is a lack of understanding regarding what racism is and how it manifests in the workplace:

> *"I am quite vocal about issues to do with race and will call out poor/racist behaviour. One of the Union reps in a meeting I chaired was particularly rude asking why do we need to focus on race - in a very derogatory manner. He subsequently gathered his mates including the CPO and got another Union rep to raise a grievance against me."*
>
> **(Black/Black British, Band unknown)**

> *"I really had to push for HR to potentially take staff survey results data back to the execs as a systemic problem not just of race but also on behalf of all the protected characteristics. We are equally failing across the board in the same areas. When previously talking about racism experience it is just shrugged off (in a friendly way) but no material action."*
>
> **(Asian/Asian British, Band 7)**

Some participants noted their trust's HR team was not immune from the systemic racism that pervaded other parts of the organisation. This meant they were unable to spot and respond adequately to common indications of racism:

> *"The HR Director had several complaints from others but made us feel like we were the problem especially when he got 'white women's tears 'so basically told me I needed to understand my boss more and be less sensitive. I chose instead to leave the NHS*

alongside my other three colleagues who complained. It's sad as I loved my job but couldn't continue being treated in this way, it was impacting on my mental health. HR let us down and most times HR are racist themselves."

(Black/Black British, Band 8b)

Other participants suggested their unions were themselves institutionally racist. As a consequence, they are particularly ill-equipped to identify, and campaign on, organisation-wide inequalities:

"They are worse as they cover up more. They seem to ignore WRES data even though this is poor. There seem to be no repercussions of bad WRES data. Medical Unions take no action and like all institutions seem to be institutionally racist. I know of around 10 female BAME doctors who have left the NHS and the unions as they feel unsupported when they report racism in the workplace."

(Asian/Asian British, VSM)

Some participants claimed their union advised them not to pursue race discrimination claims because of the potential negative consequences:

"I was advised by trade union not to pursue my complaint as it would damage my reputation."

(Asian/Asian British, VSM)

A small group of participants relayed feeling concerned by how close their union representatives appeared to be with their organisation's HR and management staff:

"Colleagues complained about my work unfairly, I expressed my frustration and hurt, it was turned into me raising that I am having issues with my work (which I didn't). This was bullying as the whole senior team ganged up on me. I couldn't bring myself to ask my union rep for support as they all seemed to be in a clique. I didn't want to risk making the situation worse."

(Black/Black British, Band 7)

Finally, a number of survey respondents questioned the power union representatives, Guardians, and equality leads have to effect change within organisations that are committed to downplaying race equality claims. One Guardian responded to the survey outlining the frustrations s/he experienced when trying to get their organisation to see a pattern of racism in the complaints raised by staff:

"I worked as a guardian at a large trust which claimed it was working hard to address racism. It wasn't. When I highlighted cases where I perceived race to be the issue, these were downplayed, I was told I was wrong and seeing things that weren't there. I'm white, but could clearly see the distress and futility for staff of raising this with me. I was lucky that they trusted me but clearly I and the trust let them down. One HR manager sat in a meeting and said he's 'playing the race card'. I openly challenged them on this and raised with CPO who said she would look in to it. I don't believe she really did do anything."

(White/White British, banding withheld)

5. LEARNING POINTS FROM KEY TRIBUNAL CASES

The denial of racism and minimization of its impact often positions organisations into a non-negotiable position, where defending any allegation becomes the right thing to do. There is a thin line between recognising racism as an overt practice/behaviour and being cognizant of its impact. Belief that racism is often over-stated (and used as an excuse for poor behaviours and non-performance) sustains the frequent efforts to defend, minimize, or otherwise explain away allegations of racism, at all cost. Furthermore, staff are too quickly caught up in this system to deny racism – despite impact or evidence.

Winning often does nothing to support our understanding of racism, but it does help organisations to recognise that there are some legal precedents which should guide our treatment of individuals and offer them better experiences, should they wish to come forward with these types of allegations.

This section summarises the common themes found in eight recent NHS employment tribunal decisions.

5.1 TRIBUNALS

Many Employment Tribunal cases are settled or withdrawn. Notwithstanding these cases, the number of race discrimination cases dealt with by Employment Tribunals in England in the last year for which data is available (2020-21) was 2,565. Despite the high profile of some NHS cases, across all sectors just 3% of cases were successful at hearings (this the average for the last 14 years). The median award was just £14,120.

Cases that NHS employers defend at Tribunal are those which they judge the employee will lose – often because they are litigants in person or because of poor legal advice to the employer, or due to reputational defensiveness by employers. Moreover, cases that might have a better chance of success are often settled, albeit because litigants cannot face the pressures of extended cases. The cases employers judge litigants are more likely to win are often settled, albeit with little organisational learning.

Despite this miserable record, the outcomes of successful cases are important for three reasons. Firstly, for a small number of people, the success of their claims is personal vindication after a personal injustice. Second, they help establish the legal framework within which employers are expected to conduct their employment relations, in particular in respect of race discrimination. Thirdly, they may act as a salutary reminder to individual employers – and, in the case of the NHS, the entire healthcare sector – of the damage to management reputation and staff morale of such cases.

The successful claims by NHS staff considered here are therefore of importance, especially in a sector where almost one in four staff are of BME and where every employer protests their commitment to tackling race discrimination.

We identified a number of Employment Tribunal cases taken by NHS staff as litigants against NHS employers. We selected three 'landmark' cases between 2011 and 2016 and then five of the most prominent cases in 2023. We are confident they are reasonably representative of the employer shortcomings tribunals have identified, not least because we, as authors, are familiar with other cases where similar findings have been identified. We don't claim they are comprehensive but do believe they are sufficiently representative to identify common themes.

5.2 THE CASES

The themes in this section are drawn, in the main, from the following cases. For references, see Appendix C.

- **Eva Michalak (2011)** was a hospital consultant in Mid-Yorkshire Hospitals NHS Trust who was hounded out of her job after deciding to have a baby. She was awarded £4.5 million compensation for the race and sex discrimination she suffered which ended her career. Remedy decision – finding is not online.[1]

- **Eliot Browne (2012)** was a very senior scientist at Central Manchester University NHS Foundation Trust who was awarded £1 million after an Employment Tribunal ruled he faced "persistent discrimination" and "an intimidating environment" before the Trust suspended him when he complained and then ended his 34-year NHS career. The Trust appealed and lost at the Employment Appeal Tribunal.[2]

- **Richard Hastings (2016)** was an IT manager at King's College NHS Trust who was awarded a £1million pay-out after an Employment Tribunal found the Trust guilty of racial discrimination and unfair dismissal. He had been (falsely) accused of assault in an incident involving a delivery driver and a contractor and was dismissed for gross misconduct in October 2015, despite an exemplary work record.[3]

- **Michelle Cox (2023)** was a senior nurse working for NHS England who (unanimously) won her claims of discrimination, harassment and victimisation in a case that exposed shoddy procedures within NHS England and prompted scathing comments from the judge about her managers.[4]

- **Adelaide Kweyama (2023)** was an agency nurse racially abused by patients whose manager told her to "bleach her skin" and then she would get less racist abuse. She won a race-related harassment case against Central and North West London NHS Foundation Trust.[5]

- **Olukemi Akinmeji (2023)** was a midwife at William Harvey Hospital in Ashford, Kent who successfully sued East Kent Hospitals University NHS Trust for discrimination and victimisation. She faced a 'toxic 'work environment in which her colleagues "ganged up" on her.[6]

- **Princess Mntonintshi and Ubah Jama (2023)** were scientists at Barking, Havering and Redbridge University Hospitals NHS Trust. They won their race discrimination claim after an Employment Tribunal found they faced multiple incidents of discrimination over a period of two years.[7]

- **Samira Shaikh (2023)** was an Ophthalmic Technician at Moorfields Eye Hospital NHS Foundation Trust. She successfully claimed she had been subjected to direct race discrimination, harassment related to race, victimisation, and constructive dismissal.[8]

5.3 KEY TRIBUNAL LEARNING

1. It is very unusual for individual (or collective) allegations of discrimination to be upheld by employers or courts.

   As Lord Justice Mummery explained this is because:

   > *The legal and evidential difficulties are increased by the emotional content of the cases. Feelings run high. The complainant alleges that he has been unfairly and unlawfully treated in an important respect affecting his employment, his livelihood, his integrity as a person. The person against whom an accusation of discrimination is made feels that his acts and decisions have been misunderstood, that he has been unfairly, even falsely, accused of serious wrongdoing.*
   >
   > **Qureshi vs Victoria University of Manchester & Anor [2001] ICR 863.**

2. Discrimination is rarely admitted and thus the function of an internal appeal is to see what inferences could be drawn.

   In Cox (a similar point was made in a number of other cases), the Employment Tribunal emphasised that:

   > *Under cross-examination, (the NHS England appeal hearing chair) accepted that discrimination is rarely admitted and thus the function of the appeal was to see what inferences could be drawn. The Tribunal found that the appeal identified a number of instances of what it variously described as "poor" behaviour towards the claimant yet failed to address why this poor behaviour had taken place nor was the respondent able to explain why this was somehow unimportant. (Para 59).*

3. NHS staff – including senior staff – struggle to talk about race, without becoming defensive and falling back on stereotypes.

   In Shaikh, the Employment Tribunal found:

   > *The evidence generally points strongly towards Mr Holm stereotyping the claimant as a 'loud ethnic female', in particular the email sent to Ms Tinkler on 24 September 2020, the*

fact that Mr Holm indicated the move was to allow for a 'cooling off period' and Mr Holm's evidence in cross examination that the move was because of the perceived 'outburst'. This conclusion is also supported by the subsequent references made by Mr Holm to the claimant being 'aggressive' when she was not in fact displaying any aggressive behaviour, coupled with the false allegation that the claimant was audible to patients after the meeting. We also take into account that the reason for the move was that a complaint about discrimination had been made, and only the claimant and Ms Chekar were moved (Para 95).

We find that Mr Holm did not take well to allegations of discrimination being raised and from that point on perpetuated a stereotype of the claimant as a 'loud ethnic female." (Para 106).

4. Very little direct discrimination is overt or even deliberate. Discrimination factors will, in general, emerge not from the act in question but from the workplace environment (including workforce and staff survey data) and previous history.

If it is established that there is an instance of negative conduct which could be assigned to race discrimination, and the employer cannot provide a reasonable and adequate explanation that this was *not* due to discrimination, then the tribunal can draw an inference that the negative conduct was caused by discrimination (s.136 Equality Act 2010), as in the case of Cox:

Very little direct discrimination is overt or even deliberate. In Anya v University of Oxford [2001] IRLR 377 CA guidance was given that Tribunals shall look for indicators from a time before or after the particular act which may demonstrate that an ostensibly fair-minded decision was or was not tainted by bias, in Anya racial bias. Discriminatory factors will, in general, emerge not from the act in question but from the surrounding circumstances and the previous history. (Para 72).

In Cox (Para 114) Browne, and Hastings (Para 369) workforce data was important context for the Tribunal but something the employer failed to acknowledge.

5. Employers generally look at events individually but should consider whether there are cumulative patterns or behaviours which required examination.

An accumulation of apparently small acts of detriment – such as microaggressions – can have a catastrophic impact on staff which damages their health and may constitute discrimination. Failure to consider whether such acts might cumulatively constitute race discrimination and to then fail to investigate what might be the underlying causes, whether in an investigation or during a hearing, might itself constitute an act of discrimination and harassment. As the Tribunal concluded in Cox:

This approach to the claimant's grievance continued in the grievance appeal process where the Tribunal found that the appeal outcome failed to uphold the Claimant's grievance despite the underlying findings made. The problem arose because the appeal looked at events individually and did not consider cumulatively whether there was a pattern of

behaviour which required examination. It did not consider the issue of discrimination and or whether there might be an underlying reason for the matters complained of if those matters were taken together. It did not ask why things happened, nor did it question or probe what it was told. (Para 109).

6. Employers often set a high bar of needing to see 'deliberate' discrimination, thus failing to consider the possibility of subconscious discrimination.

Employers often seek to show that although there were aspects of the treatment of staff which may have led the worker to be believe they were being racially discriminated against, there was no discriminatory intention. This is a misunderstanding of the law. Courts have made it very clear that it is not necessary to show that the person(s) alleged to have discriminated did so consciously since 'unconscious' discrimination is also prohibited.

Lord Browne-Wilkinson noted that claims under discrimination legislation present special problems of proof as those who discriminate…

…do not in general advertise their prejudices: indeed, they may not even be aware of them.

Glasgow City Council v Zatar 1998 ICR 120, HL

In another significant case, the House of Lords similarly stated:

Many people are unable, or unwilling, to admit even to themselves that actions of theirs may be racially motivated.

Nagarajan v London Regional Transport and others [1999] IRLR 572 (HL)

A tribunal will not assume that a person's actions are free of subconscious bias even if the person is an honest and reliable witness, and one who genuinely believed they were acting for non-discriminatory reasons. In Cox, NHS England failed to act accordingly:

Despite the claimant's grievance about (her line manager's) conduct, the Tribunal considered that the respondent's grievance outcome and appeal outcome avoided addressing the reasons for (her) behaviour towards the claimant. They did not draw inferences from the evidence gathered despite, as the Tribunal found there, were many aspects from which inferences could be drawn. In addition, by setting a high bar of needing to see 'deliberate 'discrimination, the respondent failed to consider the possibility of subconscious discrimination at all. (Para 117).

When presented with such a pattern of events, HR are expected to be curious and understand what might lie behind them and to consider the possibility that they might constitute direct discrimination. They should never try to deter staff raising concerns by claiming that to be successful they must first prove that those responsible were motivated by racism (or sexism, homophobia, etc.).

7. Employers repeatedly seem insufficiently aware of the legal framework of burden of proof in discrimination cases.

Once it has been established that a claimant has been treated less favourably, the burden of proof shifts to the respondent to disprove that this was on the grounds of race. In Hastings, the Court summarised this as follows:

> *We conclude that the Claimant has shown sufficient facts from which the Tribunal could conclude that he has been treated less favourably because of race. The burden of proof shifts to the Respondent to show that the treatment was in no sense whatsoever on the grounds of race. Ms Casseatari (Appeal panel chair) has provided no credible reason for failing to comply with policies, failing to investigate the Claimant's evidence of race discrimination and failing to conduct a fair and non-discriminatory process. The claim for race discrimination by summarily dismissing him is well founded. (Para 385).*

In their internal processes NHS organisations often appear to not recognise this approach. The onus is on employers, and indeed, the HR professionals within large NHS organisations, to be alive to the fact that once it has been established that the claimant has been treated less favourably, it is for the respondent to disprove that this was on the grounds of their race. Educating employers and being aware of the nuances of this area is vital if they are to properly support an employee who raises concerns about race discrimination.

8. Discrimination (including race discrimination) need not be the main reason for an act or omission to have been discriminatory.

Case law (referred to in a number of these cases) has determined discrimination simply needs to have a 'significant influence'. Thus:

> *the discriminatory reason for the conduct need not be the sole or even the principal reason of the discrimination; it is enough that it is a contributing cause in the sense of a 'significant influence'.*
>
> **Law Society v Bahl [2003] IRLR 640, at 83**

9. Employers should ensure that they are signposting staff to the appropriate policies. Not to do so can derail an investigation.

In Cox, the Tribunal noted:

> *The claimant emailed (the appeal hearing chair and the senior HR adviser) with additional information, pointing out the fact that her grievance was about discrimination and that she had asked for the respondent's Equality Diversity and Inclusion in the Workplace policy to be used, whereas the respondent had decided to investigate it under the Respect at Work policy despite that the claimant had been clear that race discrimination was a factor in her complaint. (Para 57).*

Anecdotally, this is a common shortcoming, and one which can easily derail an investigation.

10. Employers (and external consultants) may be reluctant to conclude that race discrimination has occurred even when it is clear it has.

Employers, and those resisting allegations, may confuse being a racist with the existence of race discrimination. Thus, when a selection or disciplinary process results in an outcome that is discriminatory, employers will generally resist reaching such a conclusion because of the stigma attached to a finding of race discrimination. The lack of accountability for systemic or institutional racism enables individuals to be scapegoated.

The Macpherson Inquiry definition of institutional racism is regularly referenced in employment tribunals and captures much of the experience of race discrimination in the NHS:

> *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 racial stereotyping.*

All manner of euphemisms are used to avoid naming racism in many of the cases considered, notably in Kweyama (Para 382), Akinmeji (Para 143), Shaikh (Para 77), and Browne. In Cox, NHS England agreed that Michelle Cox was subjected to 'poor behaviours' but the appeal hearing could not bring itself to name these as race discrimination:

> *The grievance conclusions recorded that it was "evident that the relationship between Gill Paxton and the claimant had broken down significantly" and that the claimant "feels greatly impacted by this and she does feel undermined, excluded, unappreciated and disenfranchised" whilst finding that it was reasonable for the claimant to feel like that in the circumstances. Nevertheless, it was not prepared to examine the conduct in terms of possible discrimination nor to even state in clear terms that the grievance appeal had been upheld in part. In those circumstances, the Tribunal considered that the outcome served as a way of placating the claimant whilst failing to deal with the issue of discrimination. (Para 133).*

In Browne, the Trust did not deny that Mr Browne had been wrongfully dismissed but disputed the claims of race discrimination and victimisation arising from his claims of race discrimination. The Employment Appeal Tribunal dismissed the appeal.

11. Simply because race discrimination has not been alleged does not mean it has not taken place.

Many organisations in the NHS have parts of their workplaces where racism is normalised and not challenged and where staff fear challenging it because they believe it is either pointless or will make things worse. Racism will go unchallenged without a continual proactive process of review of employer data on patterns of treatment (such as disproportionately poor outcomes in recruitment, or disciplinary cases, or turnover by BME staff) as well as staff survey data, analyzed by ethnicity, and of lived experience, accompanied by challenge and improvement. And most importantly, organisations having the moral courage to name racism as the cause.

In Mntonintshi the Tribunal notes:

> *Although we have found (para 176 onwards) that Ms Mntonintshi did not mention race discrimination, either in this email or orally, we have found (para 186) that Ms Valera-Larios believed that Ms Mntonintshi was complaining about race discrimination and supporting Ms Jama's complaints of race discrimination. (Para 459).*

In Akinmeji:

> *Finally we note the following. This was an unusual case, with the claimant relying on matters which she did not believe were race discrimination at the time, but only with hindsight. The evidence we heard reflected a toxic and difficult working environment generally where the claimant and colleagues were shouted and sworn at over differences of professional opinion. There was some evidence before us that there were wider issues beyond the specific allegations before us and which were possibly related to race. There were references to further issues related to the claimant's reasons for leaving. (Para 148 and 149).*

12. Investigations in general are prone to bias but, where race may be a factor, they are notoriously poor in quality and especially prone to bias.

In Hastings, the Tribunal was scathing, concluding that one of the respondent's "evidence was not credible on a number of occasions" (para 365). It went on to say:

> *Turning to the next issue of whether the investigation conducted and the conclusions reached by Mr Yousuf were less favourable treatment because of race, we conclude that they were. Mr Yousuf impressed upon the Tribunal his 17 years 'experience as a police officer in conducting investigations and with evidence handling but the conduct of the investigation showed unconscious bias. There were a number of examples that the Tribunal refer to in support of this conclusion, the first being that he referred to the white complainants as victims. (Para 373).*
>
> *He (the Trust's investigator) professed to be sceptical about the Claimant's evidence that he was subjected to race discrimination and did not investigate. His failure to investigate was in breach of the Respondent's policies as referred to above and in breach of the EHRC Code of Practice. There has been no explanation from any of the Respondent's witnesses as to why they failed to comply with their policies despite three HR managers having involvement throughout. (Para 374).*

13. That the commissioning manager, investigator, panel members, or their HR advisers are themselves BME is no assurance that investigations in such matters will be robust and unbiased.

Investigators, advisers and panel members who are of BME heritage may indeed have additional insights, but unless they are effectively trained, held to account, are expected to speak truth to

power, and feel safe in doing so, there can be no assurance that their involvement necessarily mitigates the likelihood of bias. In Hastings, (Para 378) it was a former BME police officer who carried out the investigation so heavily criticised by the Tribunal. In Cox, the initial investigator was a BME senior manager, whilst the senior HR adviser to the panel (which concluded racism was not proved) was of BME heritage.

In Kweyama, the Trust's claim that the ethnicity of the manager would mitigate any bias was not accepted by the Tribunal:

> *It is argued by the respondent that since KM's husband is West Indian, she is more likely than most to be well acquainted with the effect of racial abuse in the workplace and in wider society. However, this was not the evidence she gave about the relevance she attaches to her family circumstances. She did not say that she went to see the claimant because she had an understanding about what the claimant had gone through.* (P*ara 105)*

14. Employers should be proactive and preventative when seeking to address race discrimination rather than waiting for individuals to raise concerns formally.

The primary reliance on policies, procedures, and training in employment relations frequently gives employers false assurance of fairness when handling cases of race discrimination. An employer who relies on individual staff raising concerns about race discrimination, rather than using data and soft intelligence to be proactive and preventative, will inevitably be faced with staff who leave, keep their heads down, or eventually raise concerns but only after relations have become embittered and formalised.

Employment Tribunals expect employers to be curious and apply the Equality Act 2010 which requires that public bodies have due regard to the need to:

- eliminate discrimination
- advance equality of opportunity
- foster good relations between different people when carrying out their activities

In Shaikh, not only had management failed to address concerns raised by staff but the Employment Tribunal concluded that:

> *We find that the respondent did not take action or make any real attempt to understand what the issues were. Management was by this point so sensitive about allegations that discrimination had occurred that rather than dealing with such allegations head on they did not touch on the issues at all. (Para 114).*

15. Tribunals regularly criticise Human Resources staff for falling short of the expected standard in race discrimination cases and that may itself be an act of discrimination.

The judgements in Browne (2012) and Hastings (2016) should have been a core part of subsequent HR training across the NHS but clearly have not been – many of the shortcomings identified there were repeated in subsequent cases, including that of Michelle Cox. Repeatedly, there appears to be

no HR oversight of the credibility of the case being defended. In Hastings, for example, the Tribunal found a number of shortcomings with the HR responses:

> *None of the Respondent's witnesses made reference to their own Dignity at Work Policy and Equal Opportunities Policy which was not produced until the fourth day of the hearing after the Tribunal had requested sight of it. (Para 365).*
>
> *It appears to be an unfortunate coincidence that all the minutes of the hearing and appeal are missing and neither manager chairing the hearings took minutes during the hearing, we raise an adverse inference from this. (Para 367).*
>
> *The Respondent failed to carry out any investigation into the Claimant's complaints of racist abuse, despite this being a breach of their own policies and procedures. (Para 368).*

16. Tribunals regularly find that key management witnesses, including investigators and panel members, are not credible. Yet there do not appear to be any consequences for those responsible even when it is clear they lied or were complicit in a coverup.

In every single one of these eight cases we are exploring, key management witnesses were simply not believed by the Tribunal. That raises the question as to what level of prior scrutiny existed within each organisation which allowed key witnesses' lies to go undetected. Thus, in Cox, the main employer witness was described thus:

> *The Tribunal found that the evidence of the claimant's line manager, Ms Paxton, was less than credible. Her responses to cross-examination were often unhelpful, evasive or defensive. At times, she sought to avoid answering questions from Counsel for the claimant, or did not explain her evidence despite it being probed. A number of explanations were given with the benefit of hindsight and differed from contemporaneous evidence or conflicted with it. The Tribunal considered that Ms Paxton's continued evasion when challenged, and her failure to explain her conduct at the material time, on occasion providing new excuses not mentioned before or to the grievance appeal, led the Tribunal to view her as an unreliable witness. (Para 97).*

The evidence from these tribunals (with one exception, Michalak) is that those who lied and thereby contributed to the injustice were not held to account by their employer. Indeed, where career paths after the acts of race discrimination are known, they generally show that key witnesses were promoted.

17. Tribunals may make a damaging note of events even when they are not upheld or were only part of a claim.

In Akinmeji, for example, the Tribunal noted there was evidence of race discrimination even though the claim was ruled out as being made out of time, e.g.:

- a colleague asking the claimant not to go near her patients
- a colleague saying to the claimant: "nobody likes you or wants you here" and "go back to where you came from"
- a colleague telling the claimant that her help was not needed when they worked together

Though the majority of complaints were not upheld, the Tribunal found, compounded by the multiple documented failings of the senior HR person involved, that the evidence:

> *reflected a toxic and difficult working environment generally where the claimant and colleagues were shouted and sworn at over differences of professional opinion. (Para 148).*

18. Administrative and policy incompetence and delayed timescales may contribute to the finding that discrimination occurred.

Incompetence and delay appear normal in the cases examined but, of course, are no defence for an employer. In Hastings, the Tribunal said:

> *Although unreasonable and incompetent handling of a process cannot be equated to discrimination, the catalogue of failings in the disciplinary process showed a correlation between the less favourable treatment of the evidence provided by the white complainants as compared to the disbelief and the distrust shown by Ms Cassetari (appeal hearing chair) when considering the Claimant's evidence. (Para 385).*

19. HR do not always acknowledge the possibility that complaints about staff subjected to discrimination may be manufactured either to justify discrimination or as acts of retaliation.

When staff raise concerns of any kind there is always a risk that retaliatory steps may be taken by colleagues or managers. This was recognised by Robert Francis's Freedom to Speak Up report. If concerns about performance or behaviour that had not been mentioned previously suddenly surface when discrimination is an issue, alarm bells should ring – it was a feature in every one of the cases we're exploring here.

In Michalak, where sex and race discrimination were found proved, senior doctors conspired to make complaints about her based on her having trained in Poland, after she became pregnant. She was subjected to a "lengthy and wholly unauthorised period of suspension" and then dismissed following complaints and criticism which were without foundation. The Employment Tribunal described the Trust's disciplinary process as "bogus". In other cases, the tribunals identified retaliation such as:

- in Shaikh, "the Respondent moved the Claimant out of the adult department and into paediatrics following her querying management's plan of action following discrimination claims from four other members of staff"
- in Mntonintshi, extending probation was "a cynical act of victimisation"
- in Browne the Tribunal found that "Once the race discrimination grievance was put in […] the Trust closed ranks around [the deputy CEO] and commenced disciplinary action against the claimant to secure his removal from office"

20. The NHS employer should not assume that it has no responsibility for the behaviour of contract staff.

In Kweyama, the claimant had been regularly carrying out shifts as an agency nurse at band 5 and the Tribunal noted that:

> *it is equally absolutely clear that the Dignity at Work policy does apply to agency workers since they would fall within the category "employees of other organisations who are on site" within the scope definition on page 250. (Para 45).*

In Hastings, the racist abuse came from two contract workers. The Tribunal had no hesitation in holding the Trust responsible for what happened.

21. Tribunals have repeatedly found that NHS employers fail to action their own internal decisions, to the detriment of the employee concerned.

In Akinmeji, in the Tribunal noted:

> *[A] was given a false explanation of what the respondent had done in consequence of her complaint. She was told [KC] had done unconscious bias training and reflected on her actions and had been warned about the possibility of disciplinary action if she repeated such conduct. The only unconscious bias training organised had been in response to an earlier grievance by another colleague. [KC] had not even attended it. She was not warned about any possible disciplinary action. She had been spoken to in order to get her account and that was all*. (Para 142.5).

22. Employers tend to disproportionately focus on the distress of those who may be causing discrimination rather than that of those experiencing it.

In Shaikh, for example, a manager wrote of the claimant's line manager:

> *The increased levels of stress and aggression she is having to endure since the first Medical Imaging meeting from Samira Shaikh have had some very distressing consequences to her physical and mental health… Following a meeting with Katie this morning with her blessing as from today I wish Katie to be removed from any further telephone/email or video conference interaction with Samira Shaikh*.

Perpetrators, and alleged perpetrators of race discrimination, may be distressed when challenged. But their distress is nothing compared to the distress experienced by BME staff who have often experienced racism for a very long time and only challenged it when a last straw triggered their raising a concern. BME staff distress may be increased by the process they experience when raising their concern.

23. NHS employers frequently allow cases to reach the courts, despite the evidence appearing to straight forwardly benefit the litigant.

In all the cases considered, it is difficult to understand why early decisive action was not taken to address the concerns raised. The corporate decision to fight each case – sometimes using barristers who behaved brutally towards already traumatised staff – raises serious issues of governance and a shoddy corporate attitude towards race discrimination. It is unclear what scrutiny or peer review took place to check why the employer was defending each case at tribunal with the risk of substantial financial cost, reputational damage, and undermining of relations with BME staff.

In Kweyama, for example, the Tribunal found:

> *The respondent subjected the claimant to race-related harassment by the following unwanted conduct:*
>
> - *On 9 February 2019 by a nurse saying to the claimant. "You need to get a pool of bleach and bleach your skin so that you come back tomorrow white and the patients will be nice to you";*
> - *On 10 February 2019 by the same nurse who was overheard saying "I do not care let her go into bleach her skin, I am sick and tired of people coming to work and said they are not well";*
> - *On 22 February 2019 by the deputy lead nurse for offender care saying that she was concerned about the claimant's mental health because some of the words used in her statement to complain of the above race related harassment were worrying*

The same Tribunal was presented with evidence that:

> *they (the detainees) "started calling me nigger, monkey, and started making monkey noises and dog noises, demanding to come in at the same time." (Para 36).*

We have been told by some employers that they did try to settle cases before a tribunal, but a serious obstacle was the refusal of the DHSC/Treasury to contemplate settlement in many cases. That ought to act as an incentive to avoid ever being in a position when a Trust wants to settle but cannot because of the Treasury.

Moreover, given that the average award for race discrimination cases currently stands at around £6,000, the claimant's legal costs, should they be represented, will often far outweigh their award for damages. In turn, this essentially nullifies the award to the claimant beyond the personal vindication they may receive for winning all or part of their claim.

Finally, and crucially, when cases are settled without the need for legal proceedings it is absolutely crucial that what emerges is not covered up by a Compromise Agreement whose prime aim in general is to protect the employer's reputation, not ensure learning from the distress caused to the person with whom the employer is settling.

6. WHAT DOES ALL THIS MEAN?

6.1 WHAT WE HAVE HEARD

As sections 4 and 5 show, racially minoritised staff face common responses when raising concerns about race equality. These include:

- **denial**: in many of the cases outlined above, staff were subjected to 'poor behaviours' but neither managers nor subsequent investigations felt they could name the race discrimination that lay behind these behaviours
- **reluctance or refusal to acknowledge race as an issue**: connected with the above, when a process or series of behaviours cause distress to a BME member of staff, employers tend to resist acknowledging such treatment as race discrimination often, it seems, because of the stigma attached. Employers, and those resisting allegations, may further confuse being a racist with the existence of race discrimination
- **minimising of harm**: organisations go to great lengths to downplay the impact of racist behaviours. As we note in section 5, the accumulation of apparently small acts of detriment – such as microaggressions – can have a devasting impact on staff wellbeing. Yet many organisations seem intent on viewing, and responding to, specific incidents as individual allegations rather than a potential pattern of exclusion and discrimination
- **a lack of empathy**: an outcome of the above responses is that minoritised staff do not always receive compassion and understanding when raising concerns. Indeed, it is more common they are met with frustration, defensiveness, and exasperation (particularly, it seems, that they are playing the race card 'again'). Common to these responses is the focus on how the managers feel at having to respond to race concerns, rather than a consideration of the emotions the complainant may be experiencing

In addition to the above responses, there are some very common features of race-related investigations:

- **many employers set an unnecessarily high bar requiring staff to prove any allegation of race discrimination was 'racially motivated'**: employers may accept there were aspects of the treatment of staff which may have led the worker to be believe they were being racially discriminated against, but then proceed to reject the claim because the complainant cannot prove there was racially discriminatory intention
- **tackling racism is seen as too difficult and so is avoided**: White managers may be less comfortable speaking with, or listening to, an individual of a different 'race' or background. This can lead to a lack of rapport that, in turn, may impede the ability of investigators to obtain information
- **the process of raising a concern and the time an investigation takes deters staff from raising a concern**: concerns about the length of the process prompted by staff raising a race discrimination concern is a common theme arising from the survey results in section 4 and the review of tribunal cases in section 5. There is a widespread belief amongst staff raising

concerns about racism that such delays may often be deliberate, sometimes to 'time out' tribunal claims and sometimes to simply wear staff down

- **staff lack confidence investigatory processes and other responses will be fair**: this may be prompted by a view that HR are not independent upholders of NHS values but are an arm of management, that investigations are likely to be biased, and that senior managers who sit on panel hearings (and appeals) may themselves be biased

As section 1.3 suggests, some of the above analysis is already known to the sector. As such, in the next section we want to address a connected, but harder-to-answer, question: why do these behaviours persist? What follows is an atypical form of analysis but one that we hope will stimulate the curiosity of leaders in the NHS.

6.2 WHY DOES RACISM PERSIST?

An uncomfortable truth

It's still common for people today to define racism exclusively as a deliberate act of discrimination motivated by prejudice. This is misguided. Racism (also) operates through formal and informal habits and norms that subtly and consistently disparage, limit, and dehumanise individuals who are racialised as 'not white'. In other words, racism is systemic. It operates as a system of marginalisation and discrimination. Its effects can be seen in differential employment rates, ethnic disparities in stop and search statistics, housing inequalities, and a range of other fields.

Central to the maintenance of racism as a system of marginalisation is the way particular people (and their experiences) are racialised. Because white people are positioned outside of race (that is, they very rarely have to think about their race), their experiences and outlooks are considered the default. Mention of someone being white or of 'whiteness' as a concept is often seen as 'woke' or politically incorrect, which tends to curtail the discussion. Other cultural norms, beliefs, and ways of being are considered 'different', and an expectation is made that these individuals will adapt to a system that privileges the status quo.

If this concept seems odd to you, consider whether you have ever heard of a white person having 'lived experience', or if colleagues have ever discussed the need to recruit a white person to a board for the 'unique' perspective they might bring. Even in circumstances where a White British person may be in a minority, there is rarely a need to find a White community representative because a presumption of whiteness is built into the system.

Understanding the structural nature of racism allows us to move beyond simplistic notions, such as the idea only 'bad' people can be racist or that racism is conscious dislike. But this does not make dealing with allegations of racism any more palatable. Engaging with racism can invoke a range of emotions – anger, resentment, fear, shame, sadness – which, together, can help explain why concerns about race equality are evaded more often that they are confronted:

- **exposing views of normality**: we have a very narrowly defined view of who is normal. Issues such as class, religion, disability, gender, and sexual orientation can all have an impact on who fits in and who belongs. When we think of this in racial terms, not being seen as white often means people are classified as 'different' or the 'other'. This means it can be challenging for

majority white groups to understand the impact of racism or even 'see' racist behaviours. Because racism is outside of the experience of these groups, allegations of racism can feel like a personal attack when, in reality, they are actually a statement of how the system operates. Often, responses from the system defend the hurt that people feel and seek to explain away behaviours which they are uncomfortable with

- **assumption of system fairness**: not being able to see how bias operates is muddied by a strong belief that the existing system is fair. When considering our success, we tend to focus on the things we had control over (such as hard work and long hours of study) and assume this experience is the same for other people. As a result, when managers are confronted with concerns that, for example, a particular individual is not progressing at the same rate as their colleagues, a natural response is to question the individual's competence rather than face the possibility the playing field is not fair. Acknowledging there are other factors that contribute to success (a pushy mentor, access to secondments, supportive managers) and that the allocation of these goods is not always equitable can be disorientating to those who have received those benefits in the past
- **operationalisation of stereotypes**: challenging prevailing assumptions about BME staff requires a shift in mindset. Note that the assumptions in question do not necessarily relate to cultural or ethnic practices (although this can still be the case). Rather, they relate to the expectations leaders have of BME staff. For example, it is not uncommon for BME senior leaders to be undermined, unsupported, and over-scrutinized. Trusts' lack of response to these pressures can stem from assumptions that BME people are not a good fit for leadership: as BME leaders' pleas that they are being undermined and unsupported are dismissed as incompetence, the assumption becomes a self-fulfilling prophecy. Many of the respondents to this survey are BME leaders in bands 8 and above, and it is striking how many feel undermined in their role
- **fear of talking about race**: people are still reluctant to talk about racism. Not only are leaders within the health system fearful of saying the 'wrong' thing, they are, quite naturally, keen to avoid the emotions discussion of racism generates: uncertainty, guilt, defensiveness, cognitive dissonance. Holding on to this fear avoids discussion about our role in maintaining the status quo and colludes with our feelings of incompetence. This silence hinders the early identification of problems and inhibits collective efforts toward change

Outlining the aspects of people's thinking that maintains structural racism is crucial to understanding why it persists. This thinking has become part of our response mechanism. It also helps us understand some of the limitations of past approaches to promoting race equality. Toolkits and policies can only go so far. As this section hopefully shows, what is required is more concerted effort on challenging mindsets and ways of thinking. What would such an approach look like? Well, first of all, let us consider the story of the emperor's new clothes…

The emperor's new clothes

Some of us will know the story of the emperor's new clothes. A couple of conmen are presented before an emperor who has a taste for magnificent clothes. In an attempt to convince the emperor that he will be purchasing the most magnificent set of clothes, the conmen convince him that they will create an invisible suit that only those who are wise will be able to see. The emperor sets off in his new invisible clothes in a procession through the city. Those who see the emperor go along with the pretense because he is in power and because they do not want to appear to be inept or stupid.

It is only when child blurts out that the emperor is wearing nothing at all that the emperor realises he has been fooled and others begin to laugh.

What is the relationship between this story and work on race equality? Well, we are unfortunately tied into a system which convinces itself and us that it is doing exactly what needs to be done on issues of racism and that we can be satisfied that there is progress. Because we haven't developed enough understanding of the causes of racism and are not good at using evidence in our solutions to address it, we are tied into a process that rewards our efforts that we enjoy and silences the voices of those who counter these views.

Our interventions to address racism are often transactional in their nature; that is, their impact is limited to surface-level change. The underlying causes of race discrimination – the unthinking norms and assumptions by which we categorise people – remain untouched. Transactional activities are interventions like celebrating Black History Month, hosting award ceremonies for diversity initiatives, or providing mentoring programmes for BME staff. Many reasons are given for pursuing transactional approaches, including a lack of time and resources. Most often, however, this approach is tied into existing belief systems, and a tendency to rehearse the activities and interventions which provide comfort by not upsetting the status quo. Activities such as these may have individual benefit, but tend not to move the dial on the experience of BME staff as a whole. And even if they provide an individual staff member with an initial boost, this tends to be short-lived. The minoritised member of staff still has to navigate a system that is unchanged in its unfairness. In the face of this, the sheen of the support that has been offered soon wears off.

Opposed to transactional activities is transformational work. Transformational activities aim to change the culture of organisations by focusing on the way people interact with others. Fundamental to this is engaging leaders so they are better able to identify and address systemic racism within their organisation and leadership practice. But transformational change doesn't stop with leadership: the whole organisation becomes responsible for engaging in change. Transformational practices deliberatively intend to engage white staff in exploring their beliefs and behaviours. Crucially, the job of creating a more inclusive culture is not left solely to those who experience racism.

Figure 9 over the page shows some of the differences between transactional and transformational approaches. In the next section, we consider what this means in terms of organisations' responses to race equality claims.

6.3 SOME THOUGHTS ON WHAT ORGANISATIONS SHOULD DO NEXT

Organisations employ a range a techniques and tools to influence their culture (the behaviours and ideology of 'just' cultures, for example, or values-based work, strategies on kindness, and inclusive management). What is often not thought through, however, is how organisations should reinforce adherence to the behaviours these initiatives are designed to promote. This is particularly important given these strategies are often the primary means by which organisations choose to foster inclusion (despite the equalities monitoring data they then receive).

Fig 9: Transactional vs transformational approaches

Transactional activities	Limitations of this approach	What success looks like for transactional activities
▪ collecting data ▪ increasing representation ▪ revamping policies and procedures ▪ increasing diverse representation in publications ▪ diverse representatives on panels or in advisory roles ▪ changing menus, celebrating diverse events ▪ information giving and outreach ▪ establishing support processes (e.g. staff networks/mentoring) ▪ putting in place board champions	▪ not intended to affect organisational culture ▪ not intended to change behaviours or relationships between majority/minority experiences. ▪ responsibility for engagement lies mostly with groups who are racialised or those who already have power within the organisation	▪ increased representation of racialised individuals ▪ the progress of particular racialised individuals ▪ assigning resources based on background/identity to fulfil particular gaps and needs ▪ celebratory events ▪ awards/public recognition
Transformational activities	**Limitations of this approach**	**What success looks like for transformational activities**
▪ acknowledgement of systemic racism within the system and organisation and willingness to address it ▪ leadership engagement so that leaders are better able to sponsor and support this way of working ▪ learning and self-reflection and assertive interrogation – especially by those who are not racialised – 'white' people ▪ understanding and responding to the various forms racism, prejudices and biases ▪ moving away from stereotypes ▪ relationship building ▪ support to form new alliances and to have challenging conversations ▪ support to work on hierarchies, behavioural norms and cultural practices which stifle authentic/ diverse contributions ▪ reflection on leadership behaviours/ style and the consequences of these	▪ more disruptive and challenging to the status quo ▪ 'white' people can feel attacked or made to feel more responsible ▪ interventions can be criticised as promoting one group over another ▪ it requires viewing success as learning, development, and behavioural change – and not just how an organisation looks ▪ it can take different types of skills and resources ▪ it is a longer term strategy and requires commitment from leadership	▪ how people experience work and feel about coming to work ▪ increases people's understanding of the root causes of racism and their ability to face into systemic challenges. ▪ less 'fear' and improved confidence about how we work with difference ▪ can break down barriers and cliques within organisations ▪ reduction in discriminatory behaviours and biases ▪ more likely to bring about sustainable change

As this survey has shown, everyday racism is too often accepted within NHS organisations. Organisations will minimize, explain away, or outright deny the existence of behaviours that exclude people. This means BME staff have to accept poor treatment for much longer than necessary and action is only taken when the situation escalates. In these cases, the effectiveness of a behavioural standard is constrained by an organisation's unwillingness to uphold it. This is not to say that regulating behaviour is easy, of course. Below, we offer some thoughts on how to go about this tricky task.

6.3.1 ALL ABOUT CULTURE

‣ Talking about race

Time and time again people have said that they fear discussing race. They fear offending someone and saying the wrong thing. There is a lack of competence (in understanding racism, how it plays out, and how it is maintained) that which means we don't believe we can confront it unless it is staring us in the face – until we are 'forced' to confront it. Being able to talk about 'race' and in particular covert racism ('everyday racism') helps people get past the belief that racism is an unusual occurrence. It works the muscle of understanding, lessens the fear of discussing it, and helps create conditions where racism is spotted, believed, and referred to more routinely.

Once organisations adopt a culture where racism is spoken about routinely and understood as being maintained by organisational culture, they can create an early reporting system that can flag-up opportunities for intervention. We already know that data on attrition, complaints, disciplinary, and absenteeism and presentism rates are indicators that there is something that is amiss with culture: the crucial step is acting on what this data is saying.

‣ Setting standards

NHS organisations are increasingly developing behavioural standards. These are not primarily focused on racism but will include standards relevant to how we treat one another. As such, there is an opportunity for behavioural standards to establish expectations of behaviours with regards to 'race 'and the consequences of breaching them. Depending on the nature of the behaviour, interventions should be improvement-focused, taking for example, the form of coaching for individuals so they understand more about the impact of their behaviours or the use of nudge theory as a means of improving performance and recognising how non-inclusive behaviours are experienced. However, compliance-focused measures will be essential when responding to:

- overt racism whether by staff, contractors, visitors and patients
- discriminatory practices where there is a refusal to learn and change behaviours
- any action intended to victimise a staff member for raising concerns about racism

‣ Getting comfortable with staff speaking up

Employers, despite ongoing evidence to the contrary, must recognise organisations are experienced very differently depending an individual's role, position, and identity. The result of this is that staff hesitate to make allegations of racial discrimination because there is good evidence that

they won't be believed, and raising a complaint will make things worse or will be a waste of their time. As such:

- Employers should appreciate that individual efforts to raise race discrimination are often costly (psychologically, relationally, financially, and timewise) and therefore should be keen to employ preventative measures, rather than waiting for individual members of staff to raise concerns formally. (There is a particular irony in employers assuming raising complaints about racism is easily done when the fear of talking about racism is so abundant.)
- When allegations of race discrimination are made, it prompts an intense level of defensiveness:
  - complaints are often not taken seriously. The concern may be dismissed as a 'communication problem' or a 'misunderstanding' or the complainant is told the person who they believe is responsible 'didn't mean it 'or it was 'completely out of character'. Worse still, they themselves may be regarded as 'playing the race card, raising racism as a defence
  - even when detriment is shown to have taken place there is a great reluctance to accept race discrimination has occurred and instead it is often categorised as 'poor behaviour' or 'poor management practice'

‣ Adopting a coherent anti-racist strategy

Anti-racism is about proactively intervening in the system of racism, which means boards and senior leadership teams need to acquire an understanding of systemic discrimination and racism. This will enable them be more curious about the organisations they lead and the impact of systemic racism on staff and patients. Anti-racist practice is deliberate in its involvement of *all* people whatever their ethnic background. It will also enable the board to understand how organisational culture can help maintain discriminatory practices (and allow white people to opt out) and why BME staff may be reluctant to raise concerns.

- The board should be able to model discussions on race discrimination and openly acknowledge and discuss their collective and personal responsibilities to tackle race discrimination.
- Leaders at all levels must recognise how their behaviours may contribute to creating a culture where race discrimination is minimised or dismissed and where their own lack of understanding about racism can lead them to be overly defensive.
- Boards should above all create environments that support an anti-racist approach by both stressing its benefits and also the consequences of discriminatory behaviours.

In addition, boards, in their role in establishing a culture freer from racism, must ensure there is learning from all cases including:

- noticing whether there is a greater level of ease in discussing race and racism
- reviewing all investigations and hearings for learning – including recognising whether issues could have been addressed more informally
- reviewing investigations to ensure they are in line with an anti-racism policy
- gaining feedback on the process from the staff who raised concerns
- sharing learning from the case reviews across the whole organisation, but in particular HR staff and managers

‣ Being proactive

Employers should think more critically about the environment they create and foster – including their own inability to speak confidently and directly about racism within their culture. As part of their adherence to the Equality Act 2010, organisations should also take seriously their obligation to prevent discrimination from happening in the first place.

Leaders should be supported to proactively address race discrimination. This means more than reviewing data and listening to the 'lived experience' of staff: It also means understanding how their organisation's normative culture can make it unsafe for minoritised staff (and patients) to speak up. The board and senior leaders need to be to be seen to praise anti-racist behaviour and reward standers (allies) who intervene and stand up for others.

- Organisations must use evidence to inform the strategies they devise to tackle disparities in disciplinary, appraisal, recruitment, complaint, and bullying rates. If an organisation doesn't know why what it plans to do has a reasonable likelihood of achieving what it wants, it should ask itself why it is adopting that particular course of action. This is, after all, what we would do in other aspects of healthcare.
- Organisations should use hard and soft intelligence to address concerns at the earliest possible stage (rather than wait until a beleaguered member of staff plucks up the courage to raise a concern)
- All staff, especially leaders, should be encouraged to intervene early so that when issues arise, they are taken seriously, acted upon promptly, and in a way that builds confidence that racism is seen as a serious issue. Organisations should recognise that toolkits have limited value here and that staff need practical support /modelling to effectively intervene.
- HR and managers must be immersed in development opportunities which help them hold conversations about recognising and responding to racism – recognising that trust is a precondition of effective conversations.

‣ Commissioning the right development

Training may help understand bias and discrimination but in isolation won't prevent discrimination or flawed responses to discrimination concerns. Bias is often positioned as a term to disguise racism and racist behaviours, and can normalise and minimise its impact. An understanding of racism and how it impacts our beliefs and behaviours is essential to sustainable progress. But whilst good development can improve cognitive understanding and create a willingness and determination to act, accountability and debiasing of processes will also then be essential to ensure leaders can act on their understanding.

Employers need to think about commissioning 'development' and not 'training' (and be clear about the distinction and about what they have commissioned). Common flaws with training opportunities are: they are often not lengthy enough; they are not engaging; and they do not support staff to gain a more critical understanding of race and racism. Organisations should be prepared for staff to feel disrupted as a consequence of any development. Simply having training that endorses beliefs about those who are 'different' and peculiarising their behaviours will not create the conditions that enable staff to challenge systemic racism, especially within themselves. Even when good quality

development is commissioned, employers must be aware that there is a limit to what can be achieved through programmes of this type.

Cultures that don't permit racism to be discussed and challenged often limit the ability of individuals to put in place what they have learnt. With this in mind we recommend:

- Development should help participants understand what types of behaviour are discriminatory and by implication the types of behaviours which are not.
- Organisations should encourage staff to put in practice what they have learnt.
- The most effective development opportunities will be tailored to specific roles (e.g. for boards, leadership, HR, investigators, panel members); designed to develop skill and confidence; and, most importantly, able to provide clarity about what racist behaviours are and how they are maintained.
- Organisations should have a range of measures in place to sanction staff who exhibit racist behaviours. If not, development opportunities to identify and call out racism will be wasted.
- Organisations should be clear about what racist behaviours are – and not confuse intent with impact. An act or omission can be an act of race discrimination whether or not it was intended to be.

6.3.2 HR RESPONSIBILITY

HR teams have specific responsibilities to prevent race discrimination and address specific concerns raised. The role of HR, OD, and EDI staff should not simply be to manage risks as they arise but to seek to improve culture to prevent discrimination and promote equity, diversity, and inclusion. Here are as several key recommendations for the HR community.

‣ Developing the right individual and collective capabilities

HR, OD, and EDI staff must be enabled to develop a professionally based expertise, which draws on an understanding of the evidence-base of EDI initiatives and specifically on race discrimination. That expertise must include an understanding of institutional racism and how it is maintained, the dynamics of power, what is normalised and 'othered', how biases are enacted and the role of racism in institutional decision making. They should also recognise not only 'what works', but also how when positioning interventions, the burden of change is often placed onto those who experience discrimination in the first place.

All managers, but especially HR colleagues, must become problem-sensing and not comfort-seeking. This means being curious about what lies behind patterns of detriment even where individual detriments may not be obviously driven by race discrimination.

- Every HR, OD and EDI staff member should be expected to flag potential concerns about racism without waiting for individual staff to do so.
- There should be peer review of race cases before, during, and after informal and formal processes with HR staff involved. If possible, reviews should include staff who have investigation training and/or training on racism and anti-racism. This should be consistently applied, whatever the ethnicity of the individuals involved.

- Ensure that case investigators are appropriately competent to undertake any investigation concerning race (competence is not automatically linked with the background of the investigator!).

‣ Consider carefully the motivation for complaints

HR do not always acknowledge the possibility that complaints about staff subjected to discrimination may be manufactured either to justify discrimination or as acts of retaliation. Unfortunately, NHS staff raising concerns of race discrimination are commonly subjected to detriment as a result of doing so.

HR staff and senior managers should assume that detriment is a possibility, take it seriously, and make it clear to all those who might be responsible that causing such detriment will be grounds for gross misconduct proceedings.

‣ Better use of Freedom to Speak Up Guardians

Organisations should recognise that complaints raised through a Guardian are a reflection of the (lack of) trust in, and the credibility of, other existing arrangements. As such boards should actively discuss how information from Freedom to Speak Up Guardians, in combination with other information the trust collects, tells a story about its culture and is acted on in a timely and effective manner.

Relying on a network of Freedom to Speak Up Guardians will not, in itself, be an effective means of encouraging staff to raise concerns: Trusts must ensure Guardians are supported and have credibility with staff on issues of equality, especially on race.

- Guardians should have training in understanding systemic racism and in noticing how patterns of discrimination are often overlooked and reproduced. This might not just be helpful in cases of ‘race’, but also in recognising how power is distributed and maintained and its impact on those who voices are marginalised within cultural practices.
- The Guardian could be an active part of the organisation’s strategy to win the trust of BME staff.
- The Board must make it clear that managers who seek to dissuade staff from raising concerns about race or impede Guardians from doing so, or who seek to victimise staff as a result of raising concerns will face gross misconduct proceedings.

‣ Assuring policies and procedures

Every employer has a range of policies that are relevant to considerations of race discrimination. Most will have been equality impact assessed, but these assessments have frequently been tick-box exercises.

Employers should ensure relevant policies, procedures and reporting structures have been reviewed to understand how they are used and whether they can be triangulated to deliver

assurance. In many cases, there is little evidence that policies offer this level of assurance. Expertise in this area should be sought.

‣ Take notice of the warning signs

We have proposed that organisations should be proactive in their promotion of interventions that support dialogue and increase understanding of race and racism. There is a growing evidence based to suggest that more fluency will create less fear and that improving understanding and recognition of racism will create competence in being able to deal with racist behaviours more informally. What does this look like in practice?

Even if there is an organisational determination to tackle racism, there can still be a tension between staff and organisations on the most appropriate approach. Informal approaches may seem more attractive but may be ineffective and undermine taking matters further. Formal approaches may be necessary but can become entrenched, lengthy, and ineffective. In light of this, employers should explore how they can intervene without waiting for an individual to raise a concern, perhaps by asking whether there is sufficient evidence that there is a problem that needs to be addressed. This is how organisations approach patient safety concerns.

Responding informally may often (but not always) be best. Mediation can be useful, but only if parties are willing – and it is important to note that the outcomes of mediation do not always require individuals to acknowledge racist behaviours that may have been at play. In fact, the result can sometimes create conditions where racist behaviours are masked as ‘misunderstandings’; giving the impression that there was smoke without fire. In addition, mediation can often be ineffective when there is a power imbalance between the parties involved. For these reasons, mediation should not be mandated in policy and should be considered carefully as a response to race discrimination claims, and if it is used the meditators deployed should have skill and experience of dealing with this issue.

If informal approaches are to be utilized organisations will need:

- people who have an excellent understanding of racism especially in its covert form
- people who are supportive, but are also good at handling challenging conversations – about ‘race’
- clear anti-racist commitments in place which specify behaviours required of their staff (including recognition of covert behaviours/microaggressions) in line with the explicit values of anti-racism

Organisations that are clear about the existence of systemic racism and their commitment to tackling it won’t be taken by surprise when it crops up in the workplace. They can begin to hold themselves and their staff accountable for behaviours which contravene their expectations. And they will be more willing to explore a lack of reluctance in naming racism as a cause for poor behaviours.

Based on the above, organisations should consider:

- Informal approaches may work but only if they are used at an early stage and within an organisation that makes absolutely clear its commitment to anti-racism. (a commitment to anti-racism means that we recognise that racism is inculcated into our society).

- Informal approaches mean coaching staff in behaviours which are in line with anti-racist commitments – not waiting for infringes to occur.
- Informal approaches require therefore, staff who understand their own positionality, are skilled in their communication and understand of racism, and are serious about tackling racism.
- Staff may lack confidence in informal processes, if difficult issues are not discussed and addressed. They should not be expected to engage in mediation any more than we would expect someone to sit down with a sexual harasser for mediation. Staff may also be reluctant to raise matters formally for fear the process will drag on, will not be effective, and may make things worse. They may also fear that an informal 'resolution' may be a fudge that does not addressed the underlying issues and prevent recurrence.
- On the other hand, staff may well be reluctant to lodge formal complaints since their experience will be that such process are frequently drawn out, and may make matters worse (as this survey has shown, the risk of retaliation is real). However, staff who wish to keep open the possibility of recourse to Tribunals will need to lodge their concerns more formally or risk being unable to access legal recourse.
- Staff could be offered the option of placing their concerns formally on the record as a prompt to management action without being expected to necessarily lodge a formal grievance. The organisation could then use the available evidence to intervene e.g. to prevent discriminatory job appointments and development opportunities, or intervening whether there is evidence of sustained micro-aggressions.
- Organisations should always start by assuming concerns about racism are raised in good faith and then decide (after discussion) how to address them.
- Beware the temptation to reclassify such concerns under other headings (e.g., bullying) as an alternative.
- If the complainant is a contract worker of any kind, or is leaving employment, they are entitled to have their complaint addressed.
- Make clear to relevant managers and staff that any attempt to impede or victimise a complainant will be regarded as potential gross misconduct.
- Staff considering raising concerns will be hesitant as they fear victimisation, ostracism, or are skeptical of being heard fairly and effectively. The employer should have a dedicated trained member of staff to offer support to complainants.

There is a wider challenge for the NHS. There is no national framework for addressing these issues, where an individual trust is self-evidently not capable of addressing racism. Though ICBs for example, have been alerted to the EHRC inspecting them, and though the CQC have improved their framework for inspecting on discrimination, and though NHS England has a series of standards on equality, there remains no coherent framework of accountability that enables or requires ICBs, the CQC or NHJS England to intervene.

Where this does currently happen (and it does sometimes) it relies heavily on senior individuals being prepared to intervene. When that happens that are few options for effective specialist support available, nor is there any coherent system for sharing evidenced good practice in this field. Both shortcomings need to be addressed.

‣ Improving the case management and administration of concerns

Both employment tribunals and this survey have identified sustained shortcomings in the administration and management of concerns raised about race discrimination. The administrative and managerial shortcomings identified in race discrimination cases are likely to apply to other employment issues, notably whistleblowing and other discrimination cases, and so some recommended actions include:

- HR need to review the administrative staff and IT/case management systems to give confidence that administrative mistakes are minimised including whether outcomes from investigations or hearings are acted on in a timely manner.
- When local management deny allegations of racism, the triangulation of available evidence should enable an organisation to determine whether to consider taking take the matter further This would include granular data from staff surveys, WRES data and other relevant data analyzed by ethnicity e.g. turnover, sickness, exit interviews.
- HR should beware of allocating race cases to BME staff in the belief that this will impress tribunals or in the belief that such staff are necessarily the appropriate person – whether as adviser, investigator or panel member unless those staff have the appropriate level of competence.
- When BME HR staff are allocated to race cases, peer support may be necessary to ensure there is psychological safety for that HR staff member to reach the appropriate decisions.
- HR teams should ensure they model the behaviours on racial equity they expect of other teams

‣ Understanding what the case law says

Employment tribunals have repeatedly identified misunderstandings of race discrimination case law by NHS employers, so a key and self-evident recommendation points to organisations understanding these lessons.

- Employers and staff need to be confident that HR staff understand the key principles of case law in discrimination with specific reference to race discrimination and how to apply them.
- HR staff must be competent and confident is sharing their knowledge with managers they advise including with managers at an equivalent or higher grade who may disagree with the advice being given and may seek to pull rank. HR staff should receive explicit senior management support if line managers seek to ignore their advice and should be equipped and supported to deal with any detriment that arise as a result of escalating their concern.
- Those who respond initially (formally or informally) at an early stage to allegations of race discrimination must be trained to identify relevant contextual factors and/or be required to access advice from those who are. This should be incorporated into all management training.
- Systematic analysis of internal processes should be initiated to identify possible triggers for racial bias (e.g., in recruitment, career progression, appraisal, disciplinary processes, and so on)

‣ Fulfilling your duty of care

Staff subject to any form of race discrimination are likely to be distressed. Their employer has a duty of care to both offer support and ensure the processes do not unduly impact their health and wellbeing. That should include offering wellbeing support.

Staff alleged to be responsible in some way for alleged racism may be very upset. An employer also has a duty of care to these staff but should not disproportionately focus on the distress of those who may be causing discrimination rather than that of those experiencing it. Some specific recommendations here include:

- Staff alleged to have been party to direct or indirect discrimination or victimisation may be distressed when this is called out. Any support offered, wherever possible, should be focused on them owning responsibility for their acts and omissions.
- Staff making allegations should be cautioned about confusing direct racism with covert (indirect) racism. These distinctions are important and can help to clarify the process going forward.
- Research shows conclusively that staff subjected to race discrimination – whether direct or indirect – experience significant adverse health impact, both physically and mentally. They should be offered support both in respect of such health impact arising from the original alleged detriment and support during whatever process follows.

‣ Don’t litigate when the evidence is clear

It is difficult to understand why an NHS employer would ever allow cases in which the evidence seems so straightforwardly to the benefit of the litigant to reach the Courts. Wherever possible race discrimination should be dealt with as early as possibly, proactively and with clear outcomes to tackle root causes and present repetition.

Employer decision-making where litigation is considered should consider the following questions:

- do you understand racism?
- have the correct tests/understanding of racism applied in reaching a decision?
- in whose interest is it to proceed to an employment tribunal hearing?
- if there is a need for further evidence – including recalling witnesses – has that been done?
- does the panel outcome not only address any discrimination that occurred but how to prevent any recurrence of the specific issue?
- are there clear criteria for checking the process and outcomes at each stage (pre-investigation (if one needed), investigation, initial hearing, appeal, decisions post appeal)?

For staff, a failure to seriously resolve the issues raised, to address possible repetition and prevent retaliation will be crucial. Fudged settlements are not acceptable.

‣ Accountability

Employers need to have more in the tank than believing that transactional measures demonstrate an understanding of racism. Measures of numbers of BME staff on boards and at ‘higher levels’ in the organisation can be false positives.

Engaging external consultants

NHS employers should not employ external consultants to undertake reviews of culture or carry out investigations unless they have a proven track record of understanding race discrimination and how to challenge it. Our recommendations here include:

- Be especially cautious about using lawyers who may understand the law but have little understanding of the culture – and focus on individual cases at the expense of wider contextual and cultural considerations.
- There will be a temptation to expect external consultants of any kind to 'find' what an employer wanted them to find and that may be both picked up by and influence how some external consultants and lawyers work.
- Wherever possible employers should develop internal expertise and capacity and possibly partner with other organisations to "loan" independent investigators where possible.
- Where external support is required insist on scrutiny of the consultants track record and knowledge of race discrimination and how to tackle it.

6.4 A FINAL WORD

In producing this report, we hope to have created a persuasive argument for organisations and leaders to think critically and act in line with the evidence of what will create more impact in addressing racial discrimination. The confusion about what to do and how progress is judged and supported remains real, with many organisations treading water in relation to their progress.

The NHS is a microcosm of our society – and a really important one. If we can create the conditions of change within this beloved institution, we can possibly lead a way through the quagmire of approaches that exist to manage our emotional response to racism but which do very little to address the racist experiences of staff and patients.

APPENDIX A: SURVEY RESPONDENT PROFILE

In total, 1,327 people responded to the to the survey between May and July 2023.

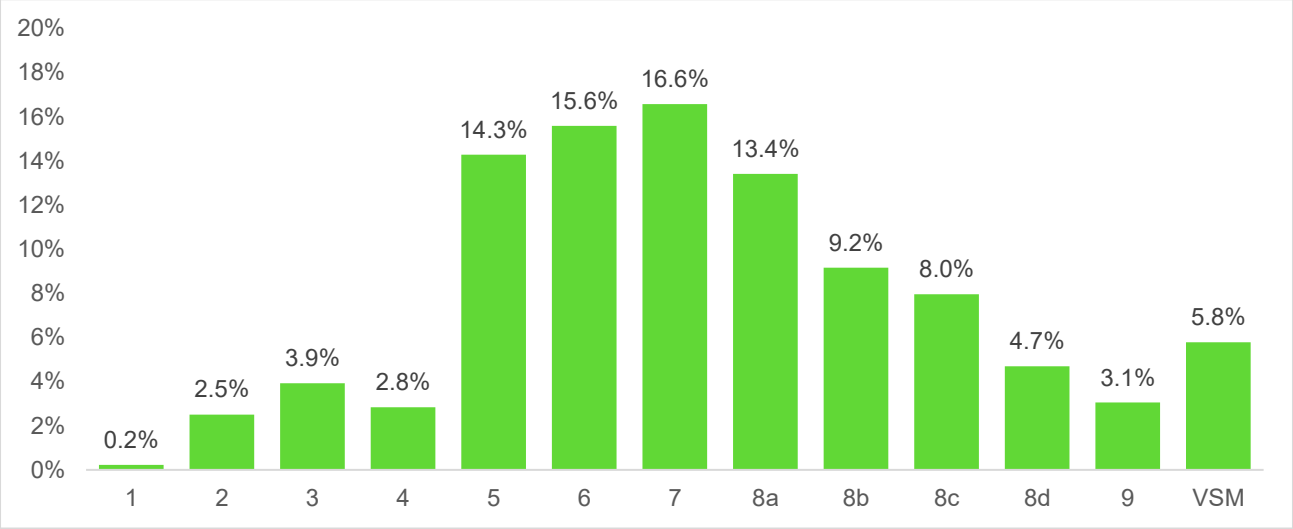
Employment status

93.3% of respondents are employed by the NHS. 3.4% are contract workers, and the remaining 3.3% work as bank or agency workers.

Agenda for Change Banding

23.8% of respondents work in bands 5 and below. 44.1% are in bands 8a and above. 15.6% are in band 6, with a further 16.6% in band 7 (figure 10).

Fig 10: Survey respondents by AfC band



Training location

70.4% of respondents received their training in the UK; 25.4% abroad. (For 4.3% of respondents the question was not a binary choice, either because they had not received training or were trained in multiple locations)

Occupational group

A quarter (25.6%) of respondents are nurses or midwives. 20.6% are AHPs/Healthcare Scientists; 15.6% in general management; and 12.5% nursing or healthcare assistants (figure 11).

Fig 11: Survey respondents by occupational grouping

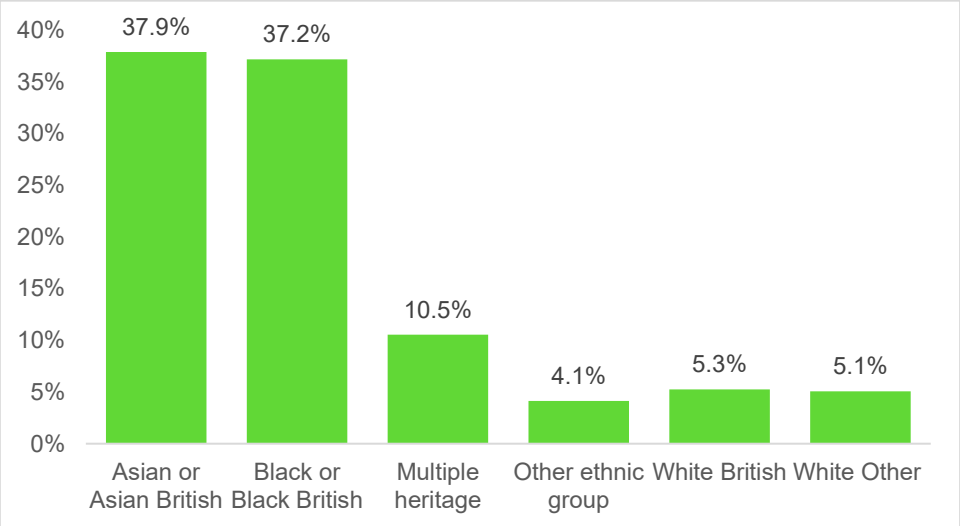
Registered Nurses and Midwives	25.6%
Allied Health Professionals/ Healthcare Scientists/ Scientific and Technical	20.6%
General Management	15.6%
Nursing or Healthcare Assistants	12.5%
Other	11.9%
Medical and Dental	11.5%
Commissioning	2.7%
Public Health	1.7%
Wider Healthcare Team	1.2%
Social Care	0.8%

Ethnicity

In our analysis, we have organised data in broad ethnic categories based on commonly used ethnic categorisations found in, for example, the 2021 Census and the Workforce Race Equality Standard (WRES). We acknowledge that these categories have limitations and do not fully capture individual experiences. However, they provide a means of comparison with existing data.

Over a third (37.9%) of respondents are from Asian/Asian British backgrounds. 37.2% are from Black/Black British backgrounds (fig 12).

Fig 12: Survey respondents by ethnic category (broad)



APPENDIX B: LESSONS FOR TRADE UNIONS

This report has been written to support NHS organisations to better understand and respond to instances of race discrimination. However, there are also important lessons for trade unions.

Some trade union officials and local representatives are exemplary in their understanding, advice, and representation of BME staff who raise allegations of racism. However, as responses to this survey show, it is important not to assume someone raising concerns is receiving good advice from their trade union representative. It was clear from our survey that many staff lack confidence in trade unions when tackling racism. Common failings included:

- misunderstanding the law – especially in respect of whether it was necessary to show the person discriminating was 'motivated' by racism
- failing to consider methodically the context in which the alleged racism took place, including the extent to which other members might have similar concerns
- advising members to reach a compromise that fails to address the causes of what is alleged to have occurred
- poor preparation, a lack of attention to detail, and a lack of preparation for any meeting or hearing – often (but certainly not always) driven by a heavy workload
- referring a member to a member of the BME network rather than a local representative initially
- seeking to address a potentially complex issue via a volunteer local representative rather than a paid official
- possibly most crucially, failing to be curious about the root causes behind an individual case and whether it is the tip of a much wider problem

Whilst in some cases (Michalek and Browne, for example) representation was clear and effective, in other instances the advice given was clearly wrong (including initially on Cox).

One concern is the application of what trade unions call the 51% rule applied by almost all unions to any case before it can be supported in legal proceedings. This is based upon a judgement as to whether the member has a 51% chance or better of succeeding in court. This criterion is open to subjective judgements and may be influenced by the poor preparation and representation at employer level.

Our recommendations for trade unions include:

- Trade unions should consider how they can be more effective in tackling racism at source rather than primarily responding to individual cases, where possible working with HR, OD, and EDI staff. They need to become more preventative and proactive beyond media campaigns.
- Trade union-employed officials need to ensure they have at least the same level of legal and cultural knowledge as the HR staff they are dealing with. Trade unions should work jointly with

employers to encourage informal resolution of allegations but not at the expense of cases where the allegations are exceptionally serious, where there is a pattern of discrimination, or where there is a refusal by those responsible to accept responsibly and work to improve the culture.

- Trade unions should ensure they engage properly with BME staff within their local branches or networks.
- Trade unions might consider whether a better test than the standard 51% test might be whether the member has demonstrated there is a case to answer. If so, the member can reasonably expect representation where needed.

APPENDIX C: LIST OF EMPLOYMENT TRIBUNAL CASES REFERENCED

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APPENDIX 4

Too Hot to Handle and Other EDI Requirements

There are many links to a range of NHS EDI requirements. Work is needed to explore these further to inform regional priorities, and how we work together to deliver in the new operating model. There are many areas of overlap, the table below highlights some of them. The challenge for all is to move from transactional to transformational

Requirement	Mapping to Too Hot to Handle
HIA	HIA 1 re board responsibility maps to accountability and setting standards HIA 2 re recruitment and talent management maps to development HIA 3 re pay gaps maps to HR responsibility HIA 4 re health inequalities maps to a clear strategy on race and being proactive HIA 5 re induction, onboarding and development links to development HIA 6 re eliminating bullying and harassment links to talking about race, speaking up and HR responsibilities
WRES	WRES is more focused on the measures to assess progress, rather than specific actions to shift the culture in organisations. The measures cover the role of HR at a superficial level and some of the cultural elements but are rather transactional
EDS	EDS is a mixture of actions and measures, all of which are transactional in nature. All could be developed further to become transformational and link to the issues highlighted in too hot to handle

APPENDIX 5

ICB Statement of Inclusion Commitment

Inclusion Commitment

NHS Somerset ICB is committed to creating an inclusive, welcoming environment that supports applicants and colleagues to embrace their diversity, take advantage of learning opportunities and develop their careers.

We aim to eliminate any disadvantage based on age, disability, marriage, civil partnership, race, culture, religion or belief, lack of religion or belief, sex, gender identity, sexual orientation, pregnancy, maternity, or any other characteristics.