An Anti-Racist National Health Service & The Future of EDI roles

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Abstract

It is beginning to be recognised beyond a cohort of social research scholars that to achieve fairness and justice in society; it is no longer enough to make noises about bias and discrimination but to take a bold anti-racist stance. The brave among scholars and influencers are urging those in power to move from window-dressing to being active anti-racists. This can have dire consequences for those making their views known. Society, including large behemoth organisations such as the UK National Health Service (NHS), does not have a legacy of protecting whistle-blowers or providing a psychologically safe space for honest discourse. Such opinion leaders are likelier to be seen as troublemakers and moved to the fringes.

With another reorganisation of NHS England, and also in the name of cost efficiency, a rationale is being presented to scrap the role of equality, diversity and inclusion (EDI) champions from the organisation. In a civic society, such moves are usually dressed up as progression or as an improvement. One such argument is that the organisation is now mature enough for the role of EDI to become 'business as usual', thus incorporated in the skillset of every leader. Is there any truth in such a belief? Is it safe to presume that organisations (i.e. NHS) and society are now mature enough from a social justice perspective that EDI is now a core business? This article will review the evidence and explore both sides of the hypothesis.

Key words
Anti-racist, NHS, EDI roles, Nepotism

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Background

Racism towards Black and minority ethnic people (BME), prevalent in broader society, also continues in the healthcare system. Although the term was defined by the social construct of 'race' and considered synonymous with the bias against those identifying as 'Black' (i.e. those originally from an African or Afro-Caribbean origin), it is primarily taken in a much border context in modern society to include all whose colour or ethnicity leads to discrimination, bias, oppression and marginalisation. The European Network Against Racism (ENAR) identifies five main groups particularly affected: (i) Roma and travellers, (ii) People of African descent and black Europeans, (iii) Muslims, (iv) Jews, (v) Migrants. In addition to these groups, racism against Asians and people of Asian descent and racism against indigenous people are also included.[1] The need to foster understanding and acknowledgement of the causes of racism is essential. Acknowledging the legacy of Europe's role in colonialism and imperialism, followed by its need to welcome a workforce after the Second World War, and the perpetuating structural inequalities it created, is an important step. Since the late 20th century, biological race has been recognised as a cultural invention without a scientific basis.[2]

The bias due to racism also mirrors the inherent structural discrimination against those with protected characteristics defined by the Equality Act 2010 and those from multiple deprivation backgrounds. Systemic discrimination perpetuates health and quality of life inequalities. It causes profound harm to people who use health services or work within these settings. [3]

The issue of discrimination and racism prevalent within the NHS, especially for patients and staff, has been a part of public discourse during the #Blacklivesmatter protests and the COVID-19 pandemic. The NHS decided that something had to be done, [4] and hospital Trusts started appointing dedicated officers who would "look after" equality, diversity and inclusivity (EDI) within these organisations.[5] Lately, this has been queried, and health service chiefs have decided that appointing these officials should stop. So what is right?

While 'race' and racism have been subjected to many deep and often divisive analyses, anti-racism has often been considered as either the opposite of racism or as a theme for polemics by those concerned with the persistence of racist discrimination. [6] Racism and, therefore, anti-racism is central to how modern politics, citizenship, and immigration is viewed and discussed in society and thus has an impact on organisations and its people. Given how embedded racism is in institutions such as healthcare, a significant shift in the system's policies, practices, and procedures is required to address institutional racism and create organisational and institutional change. Much of the healthcare literature has focused on identifying and illustrating racial and ethnic disparities, often without naming the causes of those disparities. There is also a counter-argument which vehemently discredits the so-called absurdities of anti-racist orthodoxy[7] by those on the right of the political ideology, and the intellectual argument to support anti-racist theory has been hard to find. [8]

An Ant-Racist NHS

Most national policy frameworks almost entirely overlook the existence of structural inequalities. Their focus is mainly on individual forms of racial discrimination and hatred, ignoring the other dimensions of racism that are structural, institutional and historical. Individualising of responsibility to respond to what more extensive evidence shows is structural inequalities can perpetuate damaging narratives and lead to ineffective interventions.[9] Being anti-racist means actively dismantling systemic racism and discrimination within society.

The National Health Service (NHS) in the United Kingdom is one of the world's largest organised healthcare systems. As a public service that provides healthcare to everyone, regardless of their background, the NHS is

responsible for ensuring that it is anti-racist in all aspects of its operations. For the NHS, this means actively targeting, challenging and removing systemic barriers that enable racism, recognising this as a corporate responsibility.[10] One of the ways to become an anti-racist institution is by acknowledging and addressing the historical legacy of racism within healthcare. For example, in the past, BME individuals were often used as test subjects for medical experiments without their consent or knowledge.[11] This has led to mistrust and fear of the healthcare system among some BME communities. By acknowledging and addressing this history, organisations can work to rebuild trust and create a more equitable and inclusive healthcare system.

Another important aspect of being anti-racist in the NHS is ensuring that the workforce is representative of the communities it serves. [12] The NHS has set targets for increasing the number of BME staff in leadership positions and has committed to reducing the ethnic pay gap.[13] This is important because having a diverse workforce can help to identify and address racial disparities in healthcare.

The NHS has also developed a range of initiatives to address racial disparities in health outcomes. For example, the NHS Long Term Plan[14] is committed to reducing the gap in infant mortality rates and improving mental health services for BME communities, who are often less likely to seek help for mental health issues.

In addition to these initiatives, the NHS is also working to improve patient care by addressing unconscious bias and ensuring that staff receive training on cultural competency.[15]

Structural Racism

Structural racism refers to how policies, practices, and social norms are built to disadvantage certain racial or ethnic groups. This can result in a wide range of disparities, including differences in health outcomes, education, employment opportunities, and access to resources. It impacts health directly and through persistent inequities in socioeconomic status. In the context of the NHS, structural racism can manifest in many ways, such as disparities in health outcomes for different racial or ethnic groups, biases in healthcare delivery, and a lack of diversity in the healthcare workforce.

In addition to these strategies, there is a need for structural changes within the NHS to ensure that healthcare is provided fairly and equitably. This can include developing policies and protocols that address racial disparities in health outcomes and creating systems for monitoring and reporting on progress towards reducing these disparities. It is important to note that tackling structural racism within the NHS is an ongoing process that requires sustained effort and resources. It requires a commitment to addressing the root causes of disparities and creating a more equitable and inclusive healthcare system for all.[16]

Anti-Racist Actions

Critical Race Theory positions race as a social construct and outlines the interplay between race and racism, the means of power and domination. Structural determinism, a vital tenet of the Critical Race Theory, proposes that macro-level forces have a crucial role in creating and maintaining inequities and that racism and intersecting systems of power function to preserve the dominant group's power. Due to the complex and pervasive nature of structural racism, interventions at the structural level rather than the individual level are necessary to improve racial health equity. The principles to help organisations develop a robust anti-racism strategy stems from discussions with internal stakeholders and external groups.

- **Clarify** the organisation’s stance and values: Set clear expectations of what the organisation stands for and maintain zero tolerance for racism.
- **Co-create** a systemic approach for practical action by working across the organisation: Scrutinise all operational processes, working methods, and people management policies.
- **Commit** to sustained action through visible leadership and a willingness to change: Sustained effort needs a long-term plan led by a firm commitment from the top.

- **Critically** appraise the people management approach from end to end.
- **Connect** to people by creating safe spaces, systems and times to talk, share experiences and learn from each other: Ensure plans are informed by employee voice and experts where necessary.
- **Communicate** messages consistently and ensure two-way conversation: Leave the workforce and broader stakeholders in doubt about critical messages. Ensure they are reflected in people's behaviour, the organisation's operations, and stakeholder interactions.[17]

A systematic review in 2021 recommended that anti-racism actions should incorporate leadership buy-in and commitment with dedicated resources, support and funding; a multi-level approach beginning with policy and organisational interventions; transparent accountability mechanisms for sustainable change; long-term, meaningful partnerships with BME communities; and ongoing, mandatory, tailored staff education and training. Decision-makers and healthcare staff are responsible for taking anti-racism action effectively and sustainably. NHS England set up the EDI framework and appointed not only to the national roles but also mandated every organisation within its jurisdiction to do so. The NHS People Plan and strategic actions professed to create an anti-racist, compassionate, and inclusive working culture by 2021.[18]

Progress in Tackling Structural Racism

While the NHS has made some progress in addressing racism, many challenges still prevent it from comprehensively tackling structural racism, which includes:

- Systemic nature of racism: Addressing racism in the NHS requires a fundamental shift in the organisation's policies, practices, and cultural norms. This requires a significant amount of time, resources, and sustained effort.
- Lack of diversity in leadership: Although the NHS has made some progress in increasing the diversity of its workforce, there still needs to be more representation of BME individuals in leadership positions. This can make it challenging to address the root causes of structural racism and ensure that policies and practices are developed with the needs of all communities in mind.
- Limited resources: The NHS operates within a complex and challenging environment, with limited resources and competing priorities. Addressing structural racism requires significant investment and resources, including funding for research, training, and outreach programs.
- Resistance to change: Addressing structural racism often requires challenging deeply held beliefs and attitudes, which can be difficult to shift. Some staff members may resist change or not fully understand the impact of structural racism on healthcare outcomes.
- Lack of accountability: There is no central accountability framework to monitor and report progress in addressing structural racism within the NHS. This can make it challenging to identify areas for improvement and measure the impact of policies and practices.

FTSU

A parallel can be drawn with the appointment of the "Freedom to speak up Guardian" (FTSU). While it was meant well, it didn't work out because it was a tick-box exercise. A national survey of guardians painted a mixed picture of speaking up - positively, many guardians thought that the "speaking up" culture had improved in the healthcare sector. Yet, there has been a fall in the proportion of respondents who said their organisation had a positive culture of speaking up. Freedom to Speak Up Guardians[19] do not work in isolation. Although well-meaning people were appointed to the position, they spent much time gathering data. Still, effective action was stalled due to institutional barriers and a lack of commitment or accountability at the leadership level. Leaders set the tone for fostering a healthy speak up, listen up, follow up culture. Also of

concern was that senior leaders did not understand the Freedom to Speak Up Guardian role and were ineffective role models for speaking up.

A similar picture unfolds for the effectiveness of officers appointed as EDI champions, what has happened as a tick box exercise. The national Workforce Race Equality Standards (WRES)[20] data over the last seven years has changed very little, suggesting that these EDI champion posts have not been effective. They have helped point out that systemic and cultural changes take time to happen in organisations, and that is because the will of the people (i.e. leaders) in positions of power and influence is missing; there is accountability. The barriers include the fear of retaliation and the concern that nothing will be done about the matter raised.

Nepotism

There are multiple examples of cronyism in public (including healthcare) appointments and a lack of transparency and governance.[21] Unfairness in appointing managers or leaders in organisations is perceived as one of the main areas where favouritism is demonstrated in the healthcare sector, which damages the sense of fairness and justice.[22] The World Health Organisation report on strengthening health system governance presents a detailed framework for analysis and reform called TAPIC – Transparency, Accountability, Participation, Integrity and Capacity.[23] Cronyism often excludes people with lived experience, and thus organisations fail to benefit from the diversity of culture, thought and motivation to make a change. The UK government's response to COVID-19 has been controversial, not only because of an extraordinarily high death rate but also because of allegations of cronyism around granting government contracts and bailouts.[24]

Systemic racism

Since the publication of the WRES data demonstrating the prevalence of systemic racism within the NHS, there have been acknowledgements and subsequent declarations of intent to implement equity and justice. However, there is a general critique of the mode of declaration, in which mere 'admissions' of 'bad practice' are taken up as signs of 'good practice', and how institutions consolidate their defences through such fantasy of transcendence. [25] However, it is proven that declarations of noble intent, the appointment of EDI champions and such measures have done little to bring about equity and justice.
Following the pandemic, the NHS Race & Health Observatory explored the impact of racism on patients' experiences. Notably, the report on maternity outcomes proved that racism costs innocent lives. Long-term work is needed to achieve and sustain progress in these areas. Engaging patients from racial minorities and independent assessments of the impact of these endeavours is vital.[26]

Most things have stayed the same following the Baroness Kennedy report and the Royal College of Surgeons pledging to tackle the lack of diversity, among other professional challenges. [27] It is only if the nation, society and the organisation are committed to change then will happen. The 'ring' of power firmly holds our community and won't change easily.

Becoming an anti-racist NHS requires a comprehensive and sustained effort to address the root causes of structural racism within the organisation. Here are some critical steps that can be taken to move towards an anti-racist NHS:

1. Acknowledge the problem: The first step towards becoming an anti-racist NHS is to acknowledge the existence of structural racism and its impact on healthcare outcomes. This requires listening to the experiences of BAME staff and patients and taking their concerns seriously.
2. Increase diversity: The NHS should actively seek to increase the diversity of its workforce, including in leadership positions. This requires a commitment to recruiting and retaining BAME staff, creating development and training opportunities, and ensuring that policies and practices are inclusive and equitable.
3. Cultural competence training: Cultural competence training can help

healthcare professionals better understand the unique needs of different communities and improve communication with patients. This can help to reduce disparities in healthcare outcomes and improve patient satisfaction.

4. Community engagement: The NHS should actively engage with communities to better understand their needs and concerns. This can involve developing partnerships with community organisations, creating patient feedback mechanisms, and involving patients and community members in developing policies and practices.
5. Monitoring and evaluation: The NHS should develop an accountability framework to monitor progress in addressing structural racism and reducing disparities in healthcare outcomes. This requires collecting and analysing data on health outcomes for different racial and ethnic groups and using this information to inform policy and practice.
6. Zero tolerance for racism: The NHS should have a zero-tolerance policy for racism, including discrimination and microaggressions. This requires creating safe spaces for staff and patients to report incidents of racism and providing support and resources to those affected.

Impact of EDI Roles

In conclusion, becoming an anti-racist NHS requires a sustained commitment to change and a willingness to challenge the systemic barriers contributing to structural racism. By taking these steps, the NHS can work towards creating a more equitable and inclusive healthcare system for all.

Equality and diversity officers in the NHS promote equality, diversity, and inclusion within the organisation. Their responsibilities typically include developing and implementing policies and procedures that ensure fair treatment of all staff and patients, providing training and support to staff, and monitoring and reporting on progress towards improving diversity and reducing discrimination.

The impact of equality and diversity officers in the NHS can be significant. Here are some key ways they can make a difference: 1. Improving staff morale and well-being: By promoting an inclusive and supportive working environment, equality and diversity, officers can help improve staff morale and well-being. This can lead to higher staff engagement, lower absenteeism, and increased job satisfaction.

1. Reducing discrimination: Equality and diversity officers work to identify and address discrimination within the NHS. By implementing policies and procedures that prevent discrimination and providing training and support to staff, they can help to reduce incidents of discrimination and improve the experience of staff and patients.
2. Increasing diversity: By working to improve diversity within the NHS workforce, equality and diversity officers can help to ensure that the organisation is better equipped to meet the needs of a diverse patient population. This can also help to reduce disparities in healthcare outcomes for different racial and ethnic groups.
3. Enhancing patient experience: By promoting an inclusive and culturally sensitive healthcare environment, equality and diversity officers can help to enhance the patient experience. This can lead to higher levels of patient satisfaction, increased trust in healthcare providers, and improved healthcare outcomes.
4. Meeting legal and regulatory requirements: Equality and diversity officers are crucial in ensuring that the NHS meets legal and regulatory requirements around equality and diversity. This can help to protect the organisation from legal action and reputational damage.

An example of an institutional commitment to accountability is the 'Widening Participation and the 10-point plan [28], which has been actioned by the British Association of Urological Surgeons, where green shoots of change appear. Therefore transparency of data, appointing and empowering people with the remit, authority and resources to implement change and investment in research into the effectiveness of interventions are crucial to making a difference. While we agree with NHSE's self-assessment that investment in EDI champions and declaration of intent to tackle the scourge of racism has been largely ineffective and probably a waste of limited resources, the proposal for disbanding the role and assuming that NHS leaders will be responsible for implementing effective interventions to tackle racism for its 1.3 million diverse workforces and the 67 million people they serve is foolhardy. The solution is to invest in research for results, publish data, hold leaders accountable, and empower EDI champions. The Athena Swan model for gender equality for higher educational institutions has demonstrated that incentives and self-assessments effectively make organisations shift. [29] NHS England needs to listen, learn and lead the change it wishes to see.

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