2024

Racist Riots and the NHS

What next?

Race Equality Foundation

Racist riots and the NHS: what next?

Almost four months ago, racist riots broke out in several UK cities and reverberated across the UK. During the riots, NHS staff faced targeted racist attacks both physically and on social media channels. Roger Kline considers the NHS response and what still needs to be done.

Racist riots have a history in the UK going back at least as far as the Liverpool riots of 1919 when a black soldier was stoned to death in a canal by a crowd with the police standing by.

Racism is well embedded in many aspects of British society. In the NHS, the UK's largest employer and now our largest employer of Black and Minority Ethnic (BME) staff, racism has impacted, amongst others, Jewish staff and Irish staff, and from its foundation, BME staff. In the wake of the Macpherson Inquiry the NHS made belated moves to address its "snowy white peaks" but with little impact and determination. Since the introduction of the Workforce Race Equality Standard (WRES), aspects of race discrimination have been in plain sight to leaders. But progress on tackling racism has been glacial despite an abundance of "action plans".

The Black Lives Matter movement jolted some leaders who acknowledged the institutional racism in their organisation and pledged greater progress but, despite the disproportionate impact of Covid on both BME staff and patients, the national NHS response was characterised by caution and a fear of upsetting Secretaries of State who had a particular problem with equality, diversity and inclusion in general and tackling racism in particular.
https://www.linkedin.com/posts/roger-kline-3a41941b_an-open-letter-to-stephen-barclay-on-diversity-activity-7211066239027134465-TTlp/

'*Too Hot to Handle*' (2024) was a report in response to the failure of the NHS at every level to listen to BME staff and act on their concerns as demonstrated by workforce data, Employment Tribunal decisions and a specific survey on the topic conducted by the authors.

The August 2024 race riots gave another jolt to the system. Almost universally, BME staff in the NHS felt unsafe at home, travelling to work, whilst shopping and were left wondering what their colleagues at work really thought about them.

26% of NHS staff are of BME heritage and the fear triggered by the racist riots was profound. The initial response from Amanda Pritchard was widely met with disbelief, not only by BME staff but by many white staff and leaders, since it contained no robust steps NHS employers should take.

Finally, some leadership

The second letter (not signed by Amanda Pritchard but by several other NHSE leaders) was much better. It said employers should ensure that

- *"mechanisms exist to undertake a local risk assessment and put appropriate mitigating actions in place, such as consideration of temporary remote working arrangements and/or safety measures for lone workers"*

Some Trusts went further and implemented proactive discussions by line managers as the guidance advised, rather than waiting for staff to raise concerns – recognising that all BME staff were impacted and that many might be reluctant to raise concerns unless prompted to. The guidance also said staff networks and trade unions should be engaged to advise on employer responses.

The letter helpfully clarified one crucial issue: how to respond when patients act in a racist or discriminatory manner. Wes Streeting, Secretary of State stated

- "*People who are abusing NHS staff can be turned away, and should be turned away, if that is the way that they are treating our staff*"

The second NHS guidance reflected that approach, the section is worth reprinting in full as it has relevance well beyond the NHS:

- *"In general terms, it is lawful for providers of NHS services to refuse to provide treatment where a patient's behaviour constitutes discrimination or harassment towards staff; but this must be reasonable, and the approach tailored to specific cases.*

The NHS Constitution, to which all NHS bodies and all providers of NHS care (including primary care providers and subcontractors) have a statutory duty to have regard, is clear that access to NHS treatment is contingent on patients and the public acting in a respectful way.

This is reinforced by the NHS Standard Contract 7.2.3, which confirms that a provider is not required to provide or continue to provide a service to a patient "…who displays abusive, violent or threatening behaviour unacceptable to the Provider, or behaviour which the Provider determines constitutes discrimination or harassment towards any Staff or other Service User", with the provider "in each case acting reasonably and taking into account that Service User's mental health and clinical presentation and any other health conditions which may influence their behaviour".

Similar but different provisions exist in general practice, dental services, pharmacy and optometry under the relevant regulations.

All healthcare settings should have policies relating to abuse, violence and racism against their staff (including trainees) by patients and or their accompanying relatives, that put processes in place to trigger a refusal of treatment, with appropriate safeguards and that are in keeping with the regulations and rules the service is delivered under."

The letter drew attention to guidance from the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) professional regulators and the Royal College of Nursing's (RCN) on refusal to treat. It also reminded employers that

- *"It should also be noted that some types of behaviour potentially constitute criminal acts. Where this is suspected, and particularly where the safety of colleagues or other members of the public is threatened or compromised, it should be reported to the police immediately, or as soon as practicable afterwards.*

While respecting the wishes of individual staff in this regard, we support organisations pursuing criminal charges and convictions in all applicable cases."

The letter addressed the issue of social media, and the position of staff involved in civil unrest, or other racism-related activities outside of the workplace. It stated that

- *"Some comments made on social media may contravene the law. Where this is suspected, organisations should report them to the Police for investigation*.

  We support a robust and proactive approach to applying local disciplinary policies where staff are allegedly involved in discriminatory behaviour, inside or outside of work.

  This may include a risk-based approach to concluding the investigation, hearing the evidence, and appropriate sanction applied, in advance of the police concluding their procedures.

  Additionally, there may be cases where there has been no police involvement to date, but where internal investigations suggest criminal acts may have taken place; in these cases, employers should report their concerns to the police."

It also links this to advice from NHS Employers and rightly acknowledges that:

- *"The concerns of staff about the discrimination they experience working in the NHS are not new; nor do they manifest solely in the ways we have seen over the last fortnight.*

  We all have a duty to staff, patients and the public to root out discrimination in all forms in the NHS. We can do this by taking forward the 6 high-impact EDI actions set out in the NHS EDI improvement plan, through a plan of tangible actions against which performance can be assessed internally by leaders, in a transparent way.
  In doing so, it is important to pay attention to the experience of students/learners, bank workers, international recruited and

subcontracted staff, to ensure they are included in our support and their experiences shape our wider work."

This guidance is a significant step forward. Wes Streeting's guidance and the decision to refuse treatment clearly establishes that the NHS treatment depends on the well being of workers and patients respect for staff. Racist violence toward NHS staff therefore undermines both the core of the NHS, and its workforce. Similarly, the RCN acknowledged that racism is a criminal act - contrasting with Pritchard's statement, riots would leave workers 'afraid', downplaying the severity of the targeted racist hatred displayed.

But there is much more to do

Firstly, those who lead the NHS at national and local level need to "own" the issue of racism. They need to understand the uncomfortable truth that racism is deep rooted, resilient, and that NHS leaders have largely looked the other way. NHS leaders have failed to move the dial significantly on the everyday racism staff face. Many leaders are still, after all these years, not comfortable in talking about racism or acting on what their own staff experience. The 2022 report *'Shattered hopes'* by the NHS Confederation, reported that over half the Black, Asian and Minority Ethnic NHS leaders surveyed had considered leaving the NHS in the last three years because of their experience of racist treatment while performing their role as an NHS leader.

The WRES data makes clear the NHS record on race discrimination organisations remains dreadful. As one leading Black CEO put it

- *"Can the NHS really root out racism from the service if it cannot confront the institutional racism that persists within it?"*

Second, the NHS has to stop primarily responding to individual staff raising concerns and be proactive and preventative. Racism's impact is universal and we need to address its root cases with the same data driven accountability we would use for any other challenge. Racism has a long history of institutionalisation in the NHS and occurs daily. The immediate response by Wes Streeting is welcome, but is not enough. It risks being a reactive, short term solution unless it prompts a profound, sustained, preventative approach to the everyday racism

staff experience.

Thirdly, HR needs to step up. The repeated criticism of the capacity and competence of HR by Employment Tribunals and by staff reported in '*Too Hot To Handle'* galvanised some Chief People Officers, but certainly not all. The recent racist riots have galvanised others. But there is much to do in terms of HR staff being able to recognise racism, understand the standard of proof needed, refuse to accept the ways in which managers tend to "skirt around the topic" and improve how investigations are conducted.

The recent NHS Employment Tribunal in which dismissal of a racist was held to be justified should give some confidence to employers to take decisive action against NHS staff who are racist. The crystal clear judgement in Michelle Cox's case set out learning for every single manager (and HR member) when faced with potential racism – a radical challenge to existing practice in many organisations. Racism in the NHS is generally covert, not overt, but is no less unlawful or damaging for that.

Fourthly, retaliation against those raising concerns about race must end. The new Secretary of State for Health and Social Care has recently stated

- *"I'm deadly serious when I say NHS managers who silence whistleblowers will be out and will never work in the NHS again. It is the number one priority for the system"*

This ambition confronts an embedded culture where raising concerns about racism is seen as largely ineffective and personally unsafe as recent events at the largest professional regulator, the NMC have demonstrated. Other regulators such as the Care Quality Commission and NHS England both have poor internal race discrimination data and recently lost embarrassing Employment Tribunals on race discrimination.

Fifthly, the response to patients and relatives who insist on having a white doctor and nurse needs to be absolutely clear. Many Trusts have policies on this, but many staff are unaware of them and I hear of numerous cases where the issue is avoided.

There is no good clinical reason for choosing a white doctor rather than a doctor from an ethnic minority (or the reverse). Since there is no evidence that minority ethnic doctors as a whole provide inferior care compared to white doctors, it is difficult to imagine any motive other than a discriminatory one. Doctors in the UK and elsewhere have described how extraordinarily distressing such demands are. Moreover, conceding such a request might leave an employer open to a race discrimination claim. As one trust put it

- "*They will still receive emergency treatment at A&E if needed, but for anything else they will have to go elsewhere"*. That should be the default principle, recognising there may be some instances where an underlying pathology (e.g. mental health) might require a nuanced response."

A test for leaders

Finally, there have to be consequences for NHS leaders who fail to address racism. This is not a minor issue. Over a quarter of NHS staff and approaching a firth of patients are directly impacted by racism. Those leaders who collude or look the other way when faced with racism, and refuse to learn, cannot possibly be regarded as 'Fit and Proper Persons' to lead NHS organisations. That includes not just responding to exceptional crises, but tackling the everyday racism staff face. Those few leaders who have recently had to step down on such grounds have done so as a result of external pressure not through any formal process. That has to change.

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