

**Black Workers and BME Networks  
Organising Against Racism in the NHS  
Workplace**

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# **Abstract**

This research, conducted against the backdrop of neoliberal NHS austerity cuts and the Health and Social Care Act 2012 accelerating privatisation and outsourcing of NHS services, investigates the political differences and similarities of two forms of Black and minority ethnic self-organisation challenging racism in the NHS workplace. Based on case studies of two organisations – a local NHS BME Network and a local UNISON Black Self-Organised Group – the research explores the hypothesis that BME Diversity Networks may be seen as more effective ‘collective voices’ than trade union Black Self-Organised Groups for promoting race equality in the NHS workplace. The research documents the local NHS BME Network’s affiliation to the independent NHS BME Network, capturing a moment in time – 2012 -2018 – when the activism and lobbying of NHS Black workers led to the implementation in 2015 of the NHS Workforce Race Equality Standard. As an empirical qualitative study of a relatively under-researched group of BME NHS support workers and Allied Health Professionals, along with BME nurses, the thesis makes a contribution to knowledge by foregrounding the voices, agency, and everyday lived experience of BME workers challenging racism in the NHS workplace. The research uses a Black Radical Tradition theoretical framework drawing on scholars applying Marxism to conceptualise modes of ‘resistance and accommodation’ in anti-racist Black politics. The concept ‘racial capitalism’ is also linked to race and class theories of Black self-organised resistance to racism in the UK context. The research makes a theoretical contribution by applying the concept of ‘common sense neoliberalism’ alongside the concept of ‘racial capitalism’ to consider the implications of forms of race equality which, in aligning with neoliberal corporate diversity management agendas, operate to privilege Black professional middle class identities whilst marginalising Black working class perspectives.

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# Abbreviations

BAME	Black, Asian and minority ethnic
BAPIO	British Association of Physicians of Indian Origin
BARAC	Black Activists Rising Against the Cuts
BME	Black and minority ethnic
BPA	Black People's Alliance
BPA	Black Police Association
Brexit	Britain's planned exit from the European Union
CARD	Campaign Against Racial Discrimination
CCCS	Centre for Contemporary Cultural Studies
CE	Chief Executive
CEO	Chief Executive Officer
CMO	Chief Medical Officer
CQC	Care Quality Commission
CRC	Combahee River Collective
CRE	Commission for Racial Equality
CTA	Caribbean Teachers' Association
DH	Department of Health
EDS2	Equality Delivery System 2 of the NHS
EHRC	Equality and Human Rights Commission

EU	European Union
GMB	General, Municipal and Boilermakers' Union
GMC	General Medical Council
GP	General Practitioner
HR	Human resources
IWGB	Independent Workers Union of Great Britain
LGBT	Lesbian, gay, bisexual and transgender
LGBTQ	Lesbian, gay, bisexual, transgender and queer
NALGO	National Association of Local Government Officers
NAME	National Association for Multi-Racial Education
NHS	National Health Service
NUT	National Union of Teachers
OWAAD	Organisation of Women of African and Asian Descent
RCN	Royal College of Nursing
RRA	Race Relations Amendment Act 2000
SEN	State Enrolled Nurse
SERTUC	South East Regional Trades Union Council
SOG	Self-Organised Group
SRN	State Registered Nurse
TELCO	The East London Citizens' Organisation



TUC	Trades Union Congress
UK	United Kingdom
US	United States
VCS	Voluntary and Community Sector
WRES	NHS Workforce Race Equality Standard

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# Chapter 1 Introduction

## Research issue

This thesis critically explores why and how Black workers are organising against racism in the NHS workplace through an investigation and analysis of contemporary Black and minority ethnic (BME) self-organisation and collective mobilisation as represented by a local UNISON Black Self-Organised Group (SOG) embedded within the UK's largest public sector trade union, UNISON's Black/Equalities Self-Organised Group structures and a NHS (National Health Service) BME Staff Network affiliated to an independent national NHS BME Network. The thesis foregrounds the agency, every day lived experience and voices of Black workers challenging racism in the workplace, and utilises a case study approach to consider, and assesses the respective strengths, weaknesses, and effectiveness of the local UNISON Black SOG vis a vis the local NHS Trust BME Staff Network as anti-racist vehicles deployed to collectively mobilise Black workers against racial discrimination within the NHS.

Making reference to the recently re-published archival documentation of workplace and community Black self-organised anti-racist struggle – contained within the classic texts – 'Black Women and Nursing: A Job Like Any Other' ('Black Women and Nursing', 2019), 'The Heart of the Race' (Bryan et al, 2018), 'The Making of the Black British Working Class' by Ron Ramdin (2017), the thesis is cognisant throughout that the systemic racism of the present is structured by the racism of the past. In this regard the thesis pays attention to the status of the NHS as the largest employer in the UK of Black workers built as an 'ethnically segregated organisation' (Bloch et al, 2013) with the occupational setting and institutional discourses and practices of the NHS existing as key sites for investigating the impact of racism on Black workers and communities within contemporary Britain.

The thesis therefore, critically examines the strategies the local NHS BME Network and Local UNISON Black SOG have adopted to challenge forms of racism being experienced by their members and activists within the institutional settings of the 21<sup>st</sup> century NHS.

In symbolic terms the NHS, like no other public body, has come to encapsulate the emergence of Britain as a diverse multi-ethnic nation, as was represented in the 2012 London Olympics opening ceremony (Baker, 2012). Similarly, the arrival of the SS Empire Windrush from the Caribbean in 1948 – the same year the NHS was launched – has come to symbolise the development of Britain as a multicultural society (Lowe, 2018; Phillips and Phillips, 1998). And therefore in relation to historical context given the past and current dependence of the NHS and British Welfare State on racialized migrant workers (Kyriakides and Virdee, 2003; Harris, 1993; Carter et al., 1993), the thesis is aligned to current approaches to ‘reframe racism’ (The Runnymede Trust et al., 2017), by putting ‘history to the forefront’ (Snow and Jones, 2011) and by ‘writing migrants back into history’ (Simpson et al, 2010; Fryer, 1988, 1999, 2000; Ramdin, 1987, 1999, 2017; Visram, 2002; Davis, 2009; Hall, 2005; Phillips and Phillips, 1998; Kyriakides and Virdee, 2003; Panayi, 2010; The Runnymede Trust, 2000).

In regards to investigating Black workers every day lived experiences of racism in the present moment this thesis explores the collective mobilisation of Black workers within the NHS in relation to the plethora of official inquiries, policy reviews and reports evaluating the nature, scale and impact of systemic and structural racism on Black workers and Black communities in the here and now. These official reports include ‘Healing a Divided Britain’, the Equality and Human Rights Commission Report calling for a comprehensive race equality strategy (EHRC, 2016), the Theresa May government’s Race Disparity Audit (Cabinet Office, 2018) and ‘Race in the workplace: The McGregor–Smith Review’ which calls for ethnic pay gap reporting (McGregor-Smith, 2017) – see Thesis appendix 1 for a brief outline of these and other recent reports highlighting race inequality in the UK.

Thus in terms of the NHS as employer - and the occupational setting of the NHS, this research highlights the continued importance of the concept of institutional racism for Black NHS workers collectively organising in a workplace context in which ‘the language of diversity’ (Ahmed, 2012) and forms of corporate diversity management discourse (Newkirk, 2019; Berrey, 2015, 2014; Wrench, 2005) have increasingly supplanted or de-prioritised the moral and social justice imperative for promoting race equality and addressing institutional racism in the workplace which had been prompted by the Stephen Lawrence Inquiry and Macpherson Report (Macpherson, 1999) outcome of the Race Relations Amendment Act 2000. The current trend for and popularity of ‘business case’ narratives and discourses captured within ‘The Business Case for Equality and Diversity: a survey of the academic literature’ (Department for Business Innovation and Skills, 2013) which seek to incorporate race equality within organisational diversity and inclusion agendas (McGregor-Smith, 2017; Williams and Yarker, 2017; Berrey, 2015; Hunt et al, 2015; Inko-Tariah, 2015; Esmail et al, 2005) – especially promotion of the idea that developing more diverse senior leadership boosts business performance and corporate outcomes has been summarized by Naqvi, who states:

“More recently, organisations have increasingly begun to regard diversity...in the workplace as a source of competitive advantage, and specifically as a key enabler of efficiency and growth...” (Naqvi, 2019:8)

Naqvi adds that organisations that have more ethnically and culturally diverse senior leadership teams:

“...are 33 per cent more likely to have outperform their peers on profitability...Whilst in the public sector the focus may be less upon profitability and competition, and perhaps more upon the ability of responding to increasingly diverse client groups and populations.” (Naqvi, 2019:8).

In this context, this research examines how Black workers organising collectively to challenge racism in the NHS workplace on the basis of the Macpherson definition of institutional racism enshrined within the RRA 2000 are conducting their efforts within a

policy landscape and period in which tackling institutional racism has become subsidiary to promoting ‘diversity and inclusion’ (Berrey, 2015; Ahmed, 2012, 2007, Wrench, 2005). In terms of research agendas this thesis as an empirical qualitative analysis of Black workers organising in the NHS workplace, has in part been prompted by and seeks to contribute to the research literature by responding to the research call to action made by John Solomos in relation to the Stephen Lawrence Inquiry and Macpherson Report definition of institutional racism, asking for: “more research on how minorities experience their treatment in key institutions...it is important to find out more about the processes of social regulation and identity formation that work within key institutions.” (Solomos, 1999).

In this context, this research is framed by the fact that it was at the beginning of the millennium coinciding with the new Race Relations Amendment Act 2000 legislation that the Commission for the Future of Multi-Ethnic Britain (also known as the Parekh Report, 2000) identified some of the key reasons why Black workers are organising against racism in the 21<sup>st</sup> century NHS. A key component of the Parekh Report was its call for a more inclusive, ‘re-imagined’ idea of British history because exclusion of Britain’s ethnic minorities as stereotyped and racialized ‘other’ (Virdee, 2014) is predicated on residual notions that see the white British as a ‘superior race’ (Parekh, 2000:24-25). Thus the symbolic representational and material importance of campaigns and initiatives led and supported by Black NHS workers such as the Mary Seacole Memorial Statue Campaign resulting in the first statue dedicated to a named Black woman placed in St Thomas Hospital, London in 2016 (Hammond Perry, 2019:70) and Black History Month (discussed in thesis chapters 4 and 5) were presciently outlined by Parekh Report commissioner Stuart Hall, who stated:

“The binding function of national identity only works if individuals can somehow see themselves as reflected in the culture. Otherwise, they may feel British, but will not be publically recognised to be so.” (Hall, 2000).

Thus the Parekh Report predicted the deleterious consequences on British society and institutional life if a willingness to deal constructively with the legacies of Empire and relinquish ‘postcolonial melancholia’ (Gilroy, 2004) was not quickly found and fully engaged:

“There has been no collective working through of this imperial experience. The absence from the national curriculum of a rewritten history of Britain as an imperial force, involving dominance in Ireland as well as in Africa, the Caribbean and Asia is proving from this perspective to be an unmitigated disaster.” (Parekh, 2000:25).

Against this backdrop of – ‘rethinking the national story and national identity’ the Parekh Report also identified the key issues galvanising Black workers to organise and challenge racism in the NHS workplace referring first and foremost to the majority of Black, Asian, and minority ethnic workers being situated in the lower grades and under-represented at a senior level (Parekh, 2000:188-189). The Report states, “Racism damages students applying to medical schools”, and, making reference to the initiative ‘Tackling Racial Harassment in the NHS’, comments, “it is important that the programme is properly audited so that success (or lack of it) may be accurately assessed.” (Parekh, 2000: 189-191). It is in this historical context that this thesis has considered the persistent and systemic nature of racism within the NHS as evidenced by the British Medical Association’s more recent criticisms of the disproportionate numbers of Black, Asian and ethnic minority medical students subject to ‘institutional racial bias,’ in occupational spaces where they feel too intimidated and afraid to speak out (Batty, 2020). This fear resulted in the launch of the BMA’s ‘A charter for medical schools to prevent and address racial harassment.’ (2020). In this regard, the corrosive effects of racial discrimination on Black and minority ethnic medical staff’s career trajectories and wellbeing linked to racialized exclusion from patronage networks and lack of career progression is seen as an important contributory factor to the persistent levels of under-representation of NHS Black workers at senior levels (Henry, 2007; Esmail et al, 2005).

Thus longstanding calls for the NHS as employer to address racial discrimination via implementation of policies and procedures which include - “monitoring and reporting arrangements in order to assess progress” (Parekh, 2000: 191) as noted by the Parekh Report, forms the kernel of the approach set out in Roger Kline’s influential report ‘The Snowy White Peaks of the NHS:’ (2014) which in arguing that greater inclusion of ethnic diversity in senior leadership increases staff morale and produces better patient care, provides the policy framework of business rationale fused with moral-ethical case underlying NHS England’s introduction and implementation in 2015 of its new NHS Workforce Race Equality Standard.

Within this policy context BME Diversity / Staff Networks located in the NHS are often positioned as ‘critical friends’ to the institutional employer in a manner similar to the Black Police Association and Black Probation Officers Association which emerged in the 1990’s as collective support structures for ethnic minority staff challenging racial discrimination in the workplace (Holdaway, 2010; Phillips, 2005, 2007). In this vein this research study is mindful of scholarly debates which highlight the tensions inherent within the critical friend’ approach adopted by Black Professional Associations and BME Diversity Networks where a level of dependence on the institutional employer for funding and resources can facilitate a ‘politics of compromise’ (Richardson, 2013; Shukra et al, 2004, Shukra, 1998).

### **Research Rationale and Key Research Questions**

Against this backdrop, to explore how black workers are collectively challenging racism in the NHS workplace, this research critically investigates the hypothesis of whether the growing prevalence of BME Staff/Diversity Networks – such as the Local and National NHS BME Networks featured in this research study, in relation to ideas of a relative decline of the ‘traditional’ employee voice – trade unions – signal that BME Networks are



increasingly seen by Black workers and BME professionals as being more effective collective voices for promoting race equality in the workplace.

This ‘power of staff networks’ perspective drawing on the research of Colgan and Mckearney (2012) into Lesbian, gay, bisexual and transgendered employee networks is articulated by Cherron Inko Tarriah, a vice-chair of the Seacole Group (Network of BAME NEDs in the NHS) who argues for staff networks to move beyond their traditional diversity and inclusion remit by ensuring greater alignment of diversity goals with organisational business outcomes (Inko-Tarriah, 2015). And this ‘power of staff networks’ discourse, partly premised around ongoing perceptions of racial discrimination within trade unions (Andrews, 2018), is similarly presented by Nina Williams and Joanna Yarker, who state:

“...it is evident that public and private organisations as well as leading charities and opinion makers perceive staff networks as having multiple positive business relevant outcomes. Baroness McGregor-Smith made the setting up of professional staff networks a key recommendation to government in order to improve diversity...Some authors have suggested that staff networks provide a new form of employee voice in the workplace...if other avenues of employee voice like trade unions are not available or adequately representing certain minority groups effectively, then staff networks have an opportunity to step in and fill this chasm.” (Williams and Yarker, 2017: 11-12).

However, contestation of the rising ‘power of staff networks’ perspective linked to ideas of a corresponding demise and perceived diminishing relevance for Black workers of trade unions can be detected within the key findings of Ashe and Nazroo’s (2016) research, ‘Equality, Diversity and Racism in the Workplace: A Qualitative Analysis of the 2015 Race at Work Survey’, which highlights the continuing significance of trade unions and trade union representatives for supporting Black and minority ethnic workers to challenge racism in the workplace. This research thesis, then, critically explores this area of contestation and investigates the hypothesis articulated above within a qualitative research analysis framed by the following key research questions:

1. How are the NHS BME Network and UNISON Black Self-Organised Group challenging racism in the NHS workplace?
2. What are the political differences and similarities between the NHS BME Network and UNISON Black Self-Organised Group in their approach to promoting race equality in the NHS?
3. How does class intersect with race, gender and ethnicity within the NHS BME Network and UNISON Black Self-Organised Group?

### **Viewing contemporary forms of systemic and institutional racism through the theoretical concept of racial capitalism and the theoretical lens of the Black Radical Tradition**

This thesis whilst aware of the current pervasive corporate diversity management trend for addressing racism within organisational cultures via the concept of ‘unconscious’ or ‘implicit’ bias prefers to foreground the historically patterned structural forces and power relationships which undergird racial discrimination (Wrench, 2005). In this regard the thesis is aligned with Jonathan Kahn’s critique which argues for contestation with ideas of ‘unconscious’ and ‘implicit’ bias (Kandola, 2018) that have become ‘common sense’ notions of racism (Kahn, 2018). This thesis therefore pays attention to the deliberate setting the scene opening statement in ‘Race in the Workplace’, which comments:

“We need to stop hiding behind the mantle of unconscious bias. Much of the bias is structural and a result of a system that benefits a certain group of people.”  
McGregor Smith, 2017:1).

Thus, this thesis explores Black workers organising against racism in the NHS workplace within the context of the structural discrimination and migrant division of labour (Wills et al, 2010). Black and minority ethnic workers encounter in the ethnically segmented labour market (Moore, 2011), education and wider society as noted by Ainsley in her analysis of the UK’s new multi-ethnic working class (Ainsley, 2018). And, for a deeper understanding

of what Satnam Virdee refers to as the ‘Continuing significance of ‘Race’, Racism’ (Virdee, 2010) this thesis theoretically foregrounds the approach of Black Radical Tradition aligned scholars applying Marxism to analyse intersections of race, class and gender (Rodney, 1981a, 1981b; Robinson, 2000; Davis, 2017; Marable, 2009, 1983). Within this thesis the concept of ‘racial capitalism’ (Robinson, 2000; Bhattacharyya, 2018) – “Capitalism and racism were historical concomitants” (Robinson in Quan 2019:79) – is deployed as a key theoretical concept to critically explore and gain a more incisive and expansive understanding of the entrenched and persistent nature of systemic racism and racial inequality as a historically developed “racialized social structure emerging from capitalism.” (Osuna, 2017:25). In this vein, this thesis seeks to heed Osuna’s call to consider:

“how the material realities of the political economy exacerbate racialized inequality, thus demonstrating the continued significance of race under capitalism as racism produces a consistent disadvantage for racially oppressed communities. The exploitation wrought by capitalism is racialized.” (Osuna, 2017:26).

This research study therefore links and maps the Black Radical Tradition theoretical concepts of ‘racial capitalism’ and ‘resistance’ to slavery, colonialism, capitalism and imperialism (Robinson, 2000; James, 2001; Marable, 1983, 1987) to race and class ‘Black Self-Organisation’ within the UK labour movement (Virdee, 2014; Moore, 2011; Davis et al., 2006; Virdee and Grint, 1994) with racialized ethnic minority workers, particularly in the 1970’s and 1980’s, mobilizing behind a ‘Black’ – race and class – political identity to resist racism in the workplace and in communities resulting in the opening up of employment opportunities for Black workers in the public sector (Sivanandan, 2019; Narayan, 2019; Bryan et al, 2018; Ramdin, 2017; Virdee, 2014, 2010; Ramamurthy, 2013; Davis et al., 2006; Brah, 1996).

This thesis purposely retrieves the theoretical insights provided by Marxist scholars of racial capitalism such as Walter Rodney, Angela Davis and Manning Marable, who in their

analyses of multi-ethnic political alliances and coalitions based on intersections of race-ethnicity and gender, also foreground class and the implications of class stratification and socio-economic differentiation alongside highlighting the relationship between ‘resistance and accommodation’ within Black politics:

“Each day in the life of a member of the working population was a day on which there was both struggle and accommodation” (Rodney, 1981b:151).

Similarly Manning Marable in his race and class analysis of racial capitalism in stating – “Black American history’s central axis is the tension between accommodation and struggle.” (Marable, 1983:186), also highlights the ideological preference for individualised solutions to social problems associated with accommodationist discourses: “Black accommodationists...acknowledge the centrality of individualism within their political practice.” (Marable, 1983:192). In this context this thesis by applying the concept of racial capitalism makes a potential contribution to knowledge by engaging theoretically with scholars who in their critiques of racial capitalism, like Manning Marable, affirm the need to go beyond ‘racial –ethnic identity politics’ and the politics of ‘black faces in high places’ (Narayan, 2019, Haider, 2018; Taylor, 2016).

With many Black and ethnic minority workers “segregated” into lower paid occupational roles (Ainsley, 2018) under-representation of Black workers in senior executives roles is recognised as a perennial feature of persistent race inequality in the workplace.

Increasingly BME talent management strategies coalescing with promotion of BME Diversity Networks (e.g. the NHS Confederation’s BME Leadership Network, NHS England’s BME Network) which call for organisations to develop ‘inspiring BME leaders’ (independent NHS BME Network Operating Framework 2010/11 (NHS BME Network, 2010)) are presented within corporate diversity management discourse and strategies as leadership interventions designed to address under-representation at senior executive and management levels – the ‘Snowy White Peaks of the NHS’ (Kline, 2014) and progress

diversity, inclusion and race equality in the workplace ('Improving through inclusion: Supporting staff networks for black and minority ethnic staff in the NHS' (NHS England, 2017); McGregor-Smith, 2017; Powell et al, 2013; Esmail et al, 2005). However, this thesis notes Ellen Berrey's critique of the culture and class bias of neoliberal aligned diversity management approaches to racial justice which 'valorise model minorities' and is 'selectively inclusive' (Berrey, 2015, 2014). This research study therefore applies Marable's theoretical insights around moving 'beyond racial identity politics' in which the problem of "symbolic representation" – 'black faces in high places' (Narayan, 2019; Haider, 2018; Taylor, 2016, Davis, quoted in Younge 2011: 167) can "minimize greatly any awareness or analysis of class stratification and concentrations of poverty or affluence among the members of the defined racial minority group." (Marable, 2009:190). This research study has therefore incorporated a theoretical awareness of how ideas around diversity and inclusion can be discursively deployed to promote forms of neoliberal governance alongside the politics of neoliberal austerity as favoured by politicians such as Kwasi Kwarteng and Sajid Javid, proclaimed by the Tory press as members of "the most ethnically diverse cabinet in history" (Kirk and Mendick, 2019), reflecting a trend described by Paul Warmington as "the emergence of Black British social conservatism" (Warmington, 2014).

In this context, this research study makes a contribution to knowledge by highlighting the importance of "naming neoliberalism" (Hall, 2017:318) within anti-racist politics, placing Black workers collective struggles for race equality in the NHS within the context of a 'neoliberal revolution' (Hall, 2017) which has subjected the NHS to efficiency savings, privatisation and outsourcing of services. And as a result of the 'neoliberal revolution' Black workers have been disproportionately affected by the increase in casualization and precarious-insecure work linked to privatization and outsourcing alongside the steep decline in living standards and intersecting inequalities arising from neoliberal austerity

(Women's Budget Group et al., 2017). It is against the backdrop of neoliberal austerity that this thesis theoretically considers the implications of the 'neoliberal turn in Black politics' (Spence, 2016; Osuna, 2017; Gilroy, 2016) for Black workers collectively organising against racism in the NHS workplace, where instead of ensuring a real living wage and maintaining accessible public services, as Osuna notes:

“the neoliberal turn has exacerbated the inequalities produced by racial capitalism...encouraged government dismantling of ...resources and opened them up to market and entrepreneurial forces” (Osuna, 2017:26).

The neoliberal turn in black politics includes mobilisation of “entrepreneurial identities”: “under the neoliberal turn cities and individuals alike are forced to become more and more entrepreneurial” (Spence, 2016:38). Thus Lord Victor Adebawale the recently announced new Chair of the NHS Confederation as Chair of Social Enterprise UK prescribing an entrepreneurial remedy for the current time of uncertainty and crisis, in calling for more input from financial markets to promote social enterprises as the future of business linked to the harnessing of ‘social’ and ‘cultural capital’, made the interesting observation that – “some 20 percent of the UK’s social enterprises ...are based in our most deprived areas. One in eight are led by BAME chief executives and directors, compared to one in 20 SME’s” (Adebawale, 2020). This thesis, therefore, is also, mindful of Hardt and Negri’s theoretical discussion of discourses of ‘entrepreneurship’ in the 21<sup>st</sup> century being a - “common sense way of navigating...global capitalism” (2017:139). In relation to forms of neoliberal aligned diversity discourses this thesis draws theoretically on Spence’s insight that the incorporation and reproduction of neoliberal ideas within Black politics is akin to a ‘remobilization project’:

“This remobilization project posits that there are two types of black people- black people who have the potential to be successful if they take advantage of their human capital, and black people who have no such potential.” (Spence, 2016: 25).

The research study therefore critically appraises NHS BME Diversity Networks adoption of neoliberal aligned diversity management strategies such as individualised coaching

seminars delivered by management consultants, noting how BME Staff Networks can also be enlisted to facilitate neoliberal-austerity aligned efficiency savings and business outcomes associated with the mantra of “doing more with less”, alongside promoting “frugal innovation” (NHS England, 2017:19). Thus, this research study references the theoretical insights contained within Paul Gilroy’s critique of forms of ethnic minority entrepreneurship and corporate diversity management within UK Black politics which he argues have become a kind of common sense ‘Black Vernacular Neoliberalism.’ (Gilroy, 2016: 37).

Similarly, this research has noted Cox and Gunvald Nilsen’s discussion of the struggle between social movements from below in opposition to neoliberalism as a social movement from above (Cox and Nilsen, 2014:20) as well as their use of Marxism as a theoretical resource to not only – “go beyond everyday ‘common sense’ and ideological justifications of why things are as they are...” (Cox and Nilsen, 2014:5) but also encourage “certain kinds of activist good sense” (Cox and Nilsen, 2014: 19). It is in this vein that this thesis seeks to make a contribution to knowledge by applying the theoretical concept of “common sense neoliberalism” articulated by Stuart Hall and Alan O’Shea (2013), linked to the discussion of the ‘good sense’ component of ‘common sense’ as originally set out by Antonio Gramsci who stated: “Critical understanding of self takes place...through a struggle of political hegemonies.” (Gramsci, 1971:333).

In ‘Common sense neoliberalism’, Hall and O’Shea argue for renewed ideological struggle which links to the - “widespread good sense of the anger towards the banks...and... the growing support for the living wage.” (Hall and O’Shea, 2013:23). In this regard the theoretical approach of this thesis has also been mindful of Antonio Gramsci’s delineation of ‘a philosophy of praxis’ which – “must be a criticism of common sense, basing itself initially, however, on common sense...renovating and making critical an already existing activity” (Gramsci, 1971:330-331). And in relation to anti-racist politics and Black

workers in the UK challenging racism in the workplace this thesis is underpinned by a theoretical consideration of the challenge set out above by Stuart Hall and Alan O'Shea which resonates with Keenga-Yamahtta Taylor's analysis of the struggle for 'Black Liberation' where she states: "Profit comes at the expense of the living wage" (Taylor, 2016:194). Similarly this thesis resonates with Manning Marable's arguments around 'rethinking Black liberation' in which he advocates living wage campaigns as important models of "practical class politics" given the increasing neoliberal induced precarious and insecure work conditions experienced by many Black and minority ethnic workers which make it imperative for – "Black and progressive politics...to focus specifically on the issues of employment and a living wage..." (Marable, 1997:9). Thus highlighting the importance of the living wage linked to colonialism, imperialism and the historical formation of racial capitalism, Rodney commenting on capital and African wage labour notes that in relative terms, where for workers in Europe "...to some extent the employer was responsible for ensuring the physical survival of the worker by giving him a 'living wage'. In Africa, this was not the case. Europeans offered the lowest possible wages and relied on legislation backed by force to do the rest." (Rodney, 1981a:149-150). Thus in our current political context we find the TUC as a body representing the interests of workers contributing to the drawing up of the Sustainable Development Goals advocating implementation of a living wage, linked to the Global Living Wage Coalition promoting "the principles of a global living wage" (UK Living Wage Foundation, 2019), to alleviate the poverty and inequality experienced by the 'Global working class' situated in the 'poorer nations' of the 'Global South' (Ness, 2016; Prashad, 2014).

In this context, this research study documents that it is Black workers active within the UNISON Black SOG local-regional and national structures that have campaigned consistently for the 'good sense' of workers enjoying a living wage as argued by Stuart Hall and Alan O'Shea (2013) and advocated by Manning Marable (1997), Walter Rodney



(1981a) and Keeanga Yamahatta Taylor (2016) in their critiques of racial capitalism. And, in investigating the hypothesis that BME Diversity/Staff Networks are more effective collective vehicles than UNISON Black SOGs for promoting race equality in the workplace this research study has found that, in particular, it is the local UNISON Black SOG's collective bargaining approach to tackling racism in the workplace, linked to the active participation of Black workers within UNISON's local, regional and national Black members structures, that provides a more effective voice. This is in contrast to BME Diversity Staff Networks whose efficacy around challenging racism in the NHS workplace is compromised by the exclusion of lower paid and lower band NHS ancillary support workers such as porters and cleaners within their collective structures mirroring the occupational hierarchy of the NHS, and thereby, reproducing it's 'inequality regimes' and hierarchal exclusions (Acker, 2006; Healy et al, 2011; Berrey, 2014). This pattern of class and racialized exclusion is linked to ideas of 'upward mobility' and 'breaking glass ceilings' focused strategies which favour individualised neoliberal aligned diversity management discourses, and processes orientated towards reaching the 'snowy white peaks' (Kline, 2014) of the elite-class structured summit of the NHS. As an investigation of Black workers and BME Networks collectively organising against racism in the multi-ethnic NHS workplace this thesis has been researched and developed with an awareness of Manning Marable and Leith Mullings' 'race and class', 'social movements from below' orientated observation that:

“The new progressive paradigm must grasp the common sense of our people, their recognition of the inequalities of daily life which exist under a racist and capitalist social order, creating the possibilities for new resistance movements.” (Marable and Mullings, 1994:71).

This thesis as an empirical study of a relatively under-researched group of workers in the NHS – Ancillary support staff and Allied Health Professionals (porters, administrators, health advocates, commissioning managers, and equality and diversity officers) - makes a

potential contribution to the research literature by foregrounding the voices, everyday lived experience, and agency of Black workers within trade union Black Self-organised groups and BME Networks collectively organising against racism in the contemporary NHS workplace.

## **Methods**

The research methods for this thesis are based on a qualitative analytical approach, including case studies of the local NHS BME Network (which is affiliated to the national NHS BME Network) and the local UNISON Black SOG within a local UNISON Health Branch. Qualitative semi-structured interviews were conducted with 23 research participants, three of whom were key informant interviewees. The research case studies also included collation of secondary data including official conference reports and briefing documents, Thematic analysis was applied to the fully transcribed data to attain understanding and depth of meaning from the multiple perspectives of the diverse, multi-ethnic research participants, whose social identities encompassed race, ethnicity, gender and class as ‘categories of analysis and connection’ (Hill Collins, 2013).

## **Brief Summary of the key findings**

The key findings of this qualitative case study research in summary highlight that the activists within the local NHS BME Network and UNISON Black SOG described racism in the NHS as systemic and experienced by them in their everyday working lives as ‘subtle’ and embedded within NHS workplace cultures, processes and systems (e.g. interviews, lack of promotion, exclusion from NHS Leadership programmes, higher rates of disciplinary procedures). The research found that for racialized BME workers in the NHS, both the local NHS BME Network and local UNISON Black SOG provided vital support mechanisms and empowering environments where BME workers can find empathy, a sense of belonging, advocacy and advice around navigating toxic workplace cultures based on a shared experience of racism in the NHS workplace.

A key finding in the research is identification of the prominent role of Black women within both the local (and national) NHS BME Network and local UNISON Black SOG both as active members and as leaders, with Black women being leaders of the local (and national) NHS BME Network and local (and Regional Black Members Group) UNISON Black SOG. In this regard the voices of Black women workers challenging racism in the NHS documented in this research takes on added significance given the entrenched nature and persistence of under-representation of Black women in senior leadership roles in the NHS. Importantly, the research through its application of the case study approach documents that whilst there is a degree of similarity between the local NHS BME Network and UNISON Black SOG distinct political differences and divergence also existed between the two forms of collective organisation challenging racism in the NHS workplace. In particular in exploring the research hypothesis that diversity networks like the NHS BME Network aligned to corporate diversity and inclusion management agendas are supplanting trade unions and increasingly being seen as more effective collective voices for promoting race equality in the workplace, this study found that the local UNISON Black SOG was deemed to have a more comprehensive and consistent track record for delivering results in its representation of Black workers. And in this context, an important key finding within this research was the identification of exclusion from active participation within the local NHS BME Network of BME and migrant workers on lower NHS Bands, particularly BME workers employed in outsourced NHS services managed by private contractors. The case studies deployed in this research also revealed that the UNISON Black SOG structure facilitating Black workers access to stewards and reps training courses and activities enabled participation across a wider range of NHS bands and pay scales, creating branch activists and union reps who were resourced, equipped and supported to act in a wide range of union initiatives.

In this context the research identified the more demonstrated ability and effectiveness of the local UNISON Black SOG to make the local branch and wider union more diverse and properly representative of the workforce it defends. An associated issue, identified in the research, is the problematic nature of corporate diversity management approaches orientated to breaking glass ceilings as favoured by the local and (national) NHS BME Network in this research. This research documents that the local NHS BME Network's individualised strategies for Black workers empowerment namely career development seminars and workshops, coaching, mentoring and leadership programmes, in privileging upper strata managerial and professional middle class identities excluded Black workers employed on lower NHS bands particularly outsourced BME migrant workers. This research therefore contests narratives which ignore class stratification and race and class dynamics but which foreground 'symbolic representation' – the idea that having more Black people in senior roles – will, in and of itself – create improvements further down the occupational hierarchy. On this issue, the case studies in this research revealed that this kind of narrative somehow loses its force when the management grade group leading that fight within the local NHS BME Network seemed to have forgotten about (or failed to engage) with those Black workers employed on lower occupational NHS bands.

And in this context, this research thesis teases out and highlights the underlying political differences and divergence between the local NHS BME Network's incorporation of neoliberal aligned diversity management approaches to promoting race equality prioritising 'breaking glass ceilings', which in effect reproduce rather than transform institutional inequality regimes, vis a vis the local UNISON Black SOG asserting a collective bargaining approach to challenging racism in the NHS workplace.

## **Structure**

The structure of this research begins with a chapter providing the background context with historical perspective for the research topic, this is followed by a conceptual/theoretical

framework chapter assisting exploration of the research hypothesis. The next chapter outlines the research methods used, along with the case studies of the Local NHS BME Network and Local UNISON Black SOG. The next chapter highlights the voices and agency of Black workers challenging racism in the NHS workplace via their respective collective structures. A concluding chapter summarises the thesis.

***Chapter 2: Background/Context*** – to help situate the research topic, this chapter provides the background and context of the research including the historic dependence of the NHS on racialised migrant workers. Current issues around systemic racism linked to disproportionate rates of BME workers subject to disciplinary action and lack of visible BME representation at Board/senior leadership levels in the NHS are discussed.

***Chapter 3: Conceptual / theoretical framework*** – linked to the key research questions, this chapter provides an overview of the conceptual and theoretical framework drawn from the scholarly literature which has been used to explore and investigate the research hypothesis. In particular this chapter engages with the concept of ‘racial capitalism’ – the historically intertwined relationship between racism and capitalism - as a means to understand the persistent and deeply entrenched structural racism experienced by racialized Black and BME migrant workers within the labour market and wider society. The Black Radical Tradition’s theoretical approach to forms of resistance (and accommodation) to racial capitalism, colonialism and imperialism (Walter Rodney, Manning Marable, Cedric Robinson) are linked to the race and class driven Black self-organisation in the UK which enabled racialized ethnic minority workers to open up employment within the public sector. The chapter considers the implications of the ‘neoliberal turn in Black politics’ and uses the concept of ‘common sense neoliberalism’ to interrogate neoliberal aligned diversity management approaches to race equality which are ‘selectively inclusive’.

***Chapter 4: Methodology*** – provides an outline of the social constructionist qualitative research methods used in this thesis, including details of semi-structured interviews, a brief

discussion of the case study approach, discussion of the use of primary and secondary data, use of thematic analysis, and the case studies of the two organisations.

***Chapter 5: Voices of Black NHS Workers challenging racism in the NHS workplace -***

this chapter presents a selection of excerpts from the 23 research interviews highlighting some of the key themes emerging from the larger group. The chapter highlights the agency of BME workers challenging racism in the NHS workplace. Relevant to the key research questions, the participants talk about the importance of identities and differentials such as Black, BME, banding, profession, class background, education, and how these affect their working lives and need to organise. The research participants discuss their involvement in the local NHS BME Network and local UNISON Black SOG illustrating different organising tactics, barriers and routes into active involvement (particularly for lower band workers). The relative merits of the two different organisations including their levels of effectiveness and potency in delivering results are also presented by the research participants.

***Chapter 6: Conclusion*** – provides a summary and conclusion of the thesis.

## **Chapter 2 Background / context for this research**

### **Race equality in the NHS: from ‘hostile environment’ to celebrations of Windrush and diversity**

Recent events and programmes designed to showcase equality and diversity within the NHS, the biggest employer of BME workers in the UK with more than 200,000 BME staff, (NHS Digital, 2018), reveal aspects of the cultural politics informing the collective mobilisation of members of UNISON Black SOGs and the NHS BME Network to challenge the racism BME workers encounter within the NHS. It is currently estimated that approximately a third of doctors and a fifth of nurses and midwives have BME backgrounds, whilst a third of NHS doctors are trained overseas (Chand, 2018). Thus, in their essay ‘Writing migrants back into NHS history’, Simpson et al state: “There is a basic need to document and recognise the scale of the dependency of the NHS on immigration” (Simpson et al, 2010). The British Nationality Act 1948 recognised British citizenship for people born in the Empire / Commonwealth Countries, and the arrival of the SS Windrush from the Caribbean in 1948 marked the gradual flow of migrant labour from Britain’s former colonies. An estimated Black population of one million mainly African-Caribbean and Asian immigrants had settled in Britain by 1969, growing to 2.4 million by 1985 (McIvor, 2013). The 1962 Commonwealth Act became the first in a steady succession of racialised immigration laws – policies of state racism – restricting entry of Black immigrants to the UK (Hammond Perry, 2015; Solomos, 2003; Sivanandan, 2008; James and Harris, 1993), whose combined and cumulative effect in relation to determining individual legal citizenship has created the “fuzziness of post-imperial British national identity” (Cohen, 1994, cited in Goulbourne, 2002:64). The recent ‘hostile environment’, 2014 Immigration Act induced ‘Windrush Scandal’ coinciding with the 70<sup>th</sup> anniversary of the Windrush arrival and the birth of the NHS in 1948, offers a useful vantage point from which to reflect on how in 2015 NHS England hosted its first ever event celebrating the

arrival of the SS Empire Windrush and the contribution of the Windrush Generation to the NHS Workforce (NHS England, 2015b). The politics of race and immigration (Hammond Perry, 2015) or the ‘Politics of Windrush’ (Fryer, 1999) inscribed in this event were delineated by the presence of guest of honour Sam King, an RAF serviceman during the war, arriving from Jamaica on the SS Windrush in 1948, who also became a circulation manager for Claudia Jones’ ‘West Indian Gazette and Afro-Asian Opinion’, co-founder of the Windrush Foundation, and the first Black Mayor of the London Borough of Southwark (King, 1998). In his autobiography, Sam King notes the New Commonwealth immigrants settling in Britain being visible by virtue of their skin colour, led to “...being treated with suspicion and hostility. This provided the basis for exclusion from jobs, clubs and housing” (King, 1998:266). NHS England Chief Executive Simon Stevens and Chief Nursing Officer Jane Cummings reflected on how several decades after the arrival of the Windrush and the emergence of a multicultural Britain, BME workers were still under-represented at senior and leadership levels in the NHS workforce. Thus for Simon Stevens and NHS England, honouring Sam King and the Windrush Generation was also the optimum moment to promote the introduction of the new NHS Workforce Race Equality Standard (WRES). As a positive action race equality policy, the WRES is meant to signal NHS leaders’ renewed commitment to address the particular racial disparities experienced by BME staff alongside promoting equality and diversity in general.

A year later in June 2016 a symbolic narrative around Black workers challenging race and racism from the days of Empire into the present was encoded within the unveiling of the new statue of the pioneering Jamaican-Scottish Crimean War nurse Mary Seacole (Rodrigues, 2016). Given that both UNISON Black SOGs and the NHS BME Network were active donors funding and supporting the Mary Seacole Memorial Statue Appeal, it is useful to bear in mind the important historical legacy that the life of Mary Seacole, encapsulates as a “precursor” (Ramdin, 1987:35) and role model (Anionwu, 2005) for



today's racialised BME workers, particularly BME women in the NHS. Thus the symbolic Black history and legacies of resistance to racism conveyed by the life of Mary Seacole (Samuels, 1998; Fryer, 2000) has been incorporated and co-opted by the NHS for the purpose of 'raising the national profile of equality and diversity' via the NHS Mary Seacole Awards, introduced by the Department of Health, by no coincidence in 2004, the same year the 'charismatic Black Nurse' Mary Seacole was voted 'the greatest Black Briton in History' (Robinson, 2005).

In discussing future research agendas around race and racism in the UK, linked to the implementation of the Race Relations Amendment Act 2000, public sector policy recommendations and definitions of institutional racism conferred by the Stephen Lawrence Inquiry and Macpherson Report, John Solomos called for empirical research that investigates the effects within institutions of policy implementation flowing out of the landmark legislation of the Race Relations Amendment Act (RRA) (2000) Solomos (1999, 2003). In this regard, this thesis places initiatives like the Mary Seacole Awards within the wider context of a public sector race equality landscape driven by the RRA (2000) statutory duty for public authorities to promote race equality within their processes and functions, with race equality action plans being an officially mandated mechanism for registering and auditing the organisations' race equality commitments (Ahmed, 2007b).

Thus in 2004, the same year as the launch of the Mary Seacole Memorial Awards, the NHS and Department of Health announced in its Race Equality Action Plan that:

"The NHS and Department of Health must give even greater prominence to race equality... We must... target recruitment and development opportunities at people from different ethnic groups... We need to tackle this in a systematic and professional way. Equality and diversity need to be explicitly acknowledged and integral to all NHS corporate strategies." (Crisp, 2004:1)

This race equality and equality and diversity legislative framework is, then, the institutional landscape within which UNISON Black SOGs and the NHS BME Network

have been representing BME workers and collectively mobilising to challenge racism in the NHS workplace. This institutional context is outlined in the stated aims of the independent NHS BME Network:

“The aim of the NHS BME Network is to be an independent and effective voice for BME staff, BME patients, BME carers and BME service users to ensure the NHS delivers on its statutory duties regarding race equality.” (NHS BME Network, 2012:3)

A key research question in this thesis asks how are the local NHS BME Network (affiliated to the independent NHS BME Network) and local UNISON Black SOG challenging racism in the NHS workplace? And, in this respect, to help explore the persistence and reproduction of racisms impacting on BME NHS workers this thesis critically engages Black Radical Tradition aligned theories of racial capitalism that consider the intertwined relationship between racism and capitalism (Rodney, 1978a; Rodney, 1981b; Robinson, 2000; Marable, 1983; Marable, 2009; Davis, 2019; Davis, 2016; Bhattacharyya, 2018; Virdee, 2014) alongside those scholars who engage with the ‘neoliberal turn in Black politics’ by foregrounding class stratification and race and class dynamics (Narayan, 2019; Haider, 2018; Osuna, 2017; Gilroy, 2016; Taylor, 2016; Spence, 2016; Berrey, 2015). In this context as the systemic racism of the present is rooted in the structural racism of the past this thesis notes the UK government’s recent Race Disparity Audit (Cabinet Office, 2018), highlighting issues of an endemic racialised disparity and exclusion within key UK institutions and across society in general.

### **The political economy of racialised migrant labour in the NHS**

This thesis pays attention to how collectively organised resistance to forms of racism in the present are layered by collective experiences and legacies of resistance to racism in the past and, as alluded to above for activists within the NHS BME Network and UNISON Black SOGs, the Mary Seacole Awards and Mary Seacole Statue are symbolic reminders of patterns of racialised exclusion experienced by previous generations of BME workers in

the NHS. From its birth in 1948, the NHS has been marked by regular recruitment drives encouraging migrant labour to work as doctors, nurses and non-medical staff. Whilst acting as Minister of Health, Enoch Powell, prior to his 1968 anti-immigration ‘rivers of blood’ speech, encouraged recruitment drives inviting BME workers from the English speaking Caribbean, India and Pakistan to come to the ‘Mother Country’ and help staff an NHS that was short of workers (Kyriakides and Virdee, 2003; Snow and Jones, 2011; Ward, 1993).

In this perspective, racialised migrant labour is seen within the context of the historical formation of a capitalist world economy which included the ‘historic compromise’, in class terms, of the development of the British Welfare State, linked to the decline of Empire and subsequent ‘postcolonial melancholia’ (Gilroy, 2004). In applying a Marxist interpretation of political economy, inserting class relations alongside intersections of race, gender, ethnicity and nationality, the analysis of Kyriakides and Virdee (2003), resonates with Lewis (1993) and Carter et al.’s (1993) key argument in relation to the ‘racialisation of Black post-war immigration’ of “the need to recover the state’s central role in the construction of post-war British racism” (Carter et al, 1993:70).

### **BME nurses and doctors facing racism in the NHS**

Discussing the vital role played by immigration in developing and sustaining the NHS, Snow and Jones (2011) highlight that by 1965 approximately 3000-5000 Jamaican nurses were employed in the NHS, and that by the late 1970’s, of the total overseas recruits making up 12 percent of the trainee nurse and midwife sector of the NHS, around 66% were from the Caribbean. Irish migrant nurses have also historically comprised a large part of the NHS workforce with 12% of nurses in the early 1970’s being Irish born (Laud, 2015). And Laud notes that in the contemporary NHS workforce Ireland provides the fourth highest number of migrant staff to the NHS, following India and the Philippines, but ahead of Poland, Nigeria, and Zimbabwe (Laud, 2015:37), highlighting the continued dependence on migration and migrant labour which has historically ‘underpinned’ the

NHS (Simpson et al, 2010). However, migrant nurses from the above countries can also be found doing care work in nursing homes, for which they are over-qualified (Batnitzky and McDowell, 2011).

Historical accounts documenting the racialised experiences of these early waves of BME workers employed in the NHS (Simpson et al, 2010; Snow and Jones, 2011) highlight intersections of race, ethnicity, gender, and class with one third of BME workers shunted into lower status auxiliary nursing roles and the less favoured sectors of psychiatric and geriatric nursing (Ward, 1993:170; Harris, 1993, Bryan et al, 1985).

Thus the racialised experiences of BME workers in today's NHS can be traced in part to the early patterns of discrimination faced by the first generation of BME NHS workers, which took the form of unequal access to training and career opportunities. Thus, Snow and Jones (2011) state, this "has had negative consequences for recruitment" for succeeding ranks of BME female workers. Noting processes of exclusion and segmentation embodied within the differential and hierarchical status relationships between the State Enrolled Nurse (SEN) and more prestigious State Registered Nurse (SRN) qualification, and embedded within the industrial relations fabric of the NHS and British economy, Harris discussing 'Black Labour in the NHS' comments that the majority of BME nurses were:

"encouraged to qualify as State Enrolled Nurses (SEN) rather than State Registered Nurses (SRN). Not only did this limit the avenues for promotion but it posed special problems for nurses from countries such as the Philippines and Singapore where the SEN qualification is not recognised...many therefore remained in the lower-paid positions of the NHS." (James and Harris, 1993: 39)

Discussing the 'patterns of Black Women's Employment' in the post war British economy, Lewis asserts that the ideology of racism intersected with the ideology of sexism to help structure "the industrial and occupational location of black women workers" with Black women "concentrated in the lowest paid, least skilled jobs with bad conditions of work"

(Lewis, 1993:74-75). In addition, many Asian doctors recruited from India, Pakistan, Bangladesh and Sri Lanka during the 1960's also experienced confinement to specialties regarded as less favourable by many white clinicians, such as mental health, geriatrics and running single GP (General Practitioner) surgeries in poorer urban settings (Simpson, 2018). By 1960 up to 40 percent of the total number of junior doctors in the NHS were from the Indian subcontinent (Snow and Jones, 2011; Simpson, 2018; Donaldson, 2007). The situation encountered by many highly skilled Asian doctors employed in the NHS has been researched and documented as evidence of processes of 'ethnic clustering' (Raghuram et al, 2009). In this regard Kyriakides and Virdee (2003) also highlight processes of exclusion circumscribing the career progression and 'racially stratified' position of migrant doctors in the NHS. They articulate this exclusion as being inextricably connected to forms of discrimination which are shaped by intertwined ideologies of racism, nationalism and state enforcement and regulation of immigration controls. Thus the Merrion Report (1975) 'On the Regulation of the Medical Profession', through an "interplay of nationalist and racist ideologies" (Kyriakides and Virdee, 2003:294) framed its findings in a way that unfavourably compared the professional expertise and competence of overseas BME doctors to white British doctors, citing a supposed lower standard of medical education and training in their 'places of origin'. However, Ward informs that during the 1980's, research investigating discrimination on the basis of race, ethnicity and colour of BME doctors in the NHS revealed the deeply entrenched nature of racism within the NHS, highlighting: "race rather than one's place of qualification, was the real reason why black doctors were employed and deployed in the way they were" (Ward, 1993, 175). Further research conducted in the early and late 1990's examining recruitment and selection processes of doctors in the NHS by Esmail and Everington provided yet more evidence of the systemic and embedded nature of racial discrimination within institutional practices and processes. Their research indicated that BME applicants with better A-level

grades were still less likely to be offered a place to study at medical school than white applicants with lower A-level grades. Revealing racially discriminatory barriers erected for applicants with Asian names – 36% – compared to English names – 52% – for junior doctor positions in the NHS, Esmail and Everington concluded that:

“Discrimination against ethnic minority candidates is still prevalent five years after we first highlighted the problem and despite numerous public commitments by the professions leaders and employers to deal with it. The discrimination is being practised by consultants, who are responsible for short-listing junior posts.” (Esmail and Everington, 1997: 1619)

By 2007, ten years after Esmail and Everington’s 1997 research, the Chief Medical Officer’s Annual report included a section titled ‘On Equal Terms – Achieving Racial Equality in Medicine’ which argued that racism was experienced diffusely and more in the form of ‘subtle’ and covert “pockets” of racism” rather than the intentional and overt racism experienced by BME doctors in the 1960’s and 70’s. (Donaldson, 2007:58). Thus, according to the report, issues that still need addressing in the 21<sup>st</sup> century around promoting race equality in medicine included tackling the disparity in rates for BME students making successful applications to medical school compared to white applicants. Intersections of race, class and gender are indicated by the report’s reference to under-representation of lower socio-economic groups in medical schools and under-representation of female BME consultants compared to male white and BME consultants, with the more prestigious consultant workforce still being “predominantly white” (Donaldson, 2007:60). Segmentation and ethnic clustering of the BME medical workforce is also linked to racial disparities in the report, which notes that BME doctors are concentrated in the “less prestigious” non-consultant staff grade jobs, with concerns still lingering that BME consultants are confined in their consultant options to less favoured specialties (Donaldson, 2007:60-61). The CMO (Chief Medical Officer) Annual Report frames the aspiration to achieve racial equality in medicine as a need to address cultural and behavioural change rather than directing too much attention to tackling institutional

barriers. Racism is referred to as ‘subtle’ or covert (Holdaway, 2010; Coates, 2012) in the report, which makes no mention of ‘institutional racism’. Reflecting institutional approaches to racism in a ‘post-Macpherson’ age (Phillips, 2007), the CMO report highlights issues around different understandings, definitions and conceptualisations of racism. This is of relevance in relation to the NHS BME Network’s reference to the Macpherson report’s definition of institutional racism, which it presents as legitimising its independent ‘critical friend’ approach to ensuring the NHS meets its statutory duties on promoting race equality, and is a central factor in its approach to collectively organising racialized BME workers.

### **South Coast BME Network highlights systemic racism in the NHS**

Two very influential reports have galvanised the efforts of BME workers in the NHS to organise collectively against racism in the workplace. The first of these influential reports was the ‘Race Equality Service Review’ produced by the South East Coast BME Network in 2008. The Review highlighted that BME staff, who made up 15% of the South East Coast region workforce, represented more than half of the bullying and harassment cases and 25 percent of disciplinary cases in the region’s NHS Trusts. The Race Equality Service Review also revealed that in a region with a 10.5 percent BME population, no more than 3 percent of the region’s 193 Executive Directors and 2.5 per cent of the 160 Non-Executive Directors were from BME backgrounds (Lyfar-Cisse, 2008; Santry 2008a, 2008b, 2009). It was the South East Coast BME Network Race Equality Service Review which provided the mandate, springboard and platform for the launch of the national independent NHS BME Network in 2010.

In 2014, health and social care policy researcher Roger Kline, borrowing Reid and Phillip’s (2004) ‘snow-capped’ NHS metaphor, published ‘The Snowy White Peaks of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England’ (Kline, 2014). Incorporating earlier research dealing

with racial discrimination in the NHS, linked to recruitment and career progression processes, such as Oikelome (2007); Esmail et al (2005), Beishon et al (1995) and Coker (2001), Kline's 'Snowy White Peaks' (2014) and 2013 report 'Discrimination by Appointment' (2013b) provides the evidence base and rationale for combining the business case with moral and legal imperatives, which underpin the NHS positive action Workforce Race Equality Standard, which was launched in 2015. The welter of initiatives designed to tackle racism in the NHS, from the 2004 NHS Race Equality Action Plan, are systematically recorded by Kline. It is worth adding here that Ward in his analysis of 'race equality and employment in the NHS' notes as far back as 1978 the first Department of Health Circular outlining the requirements of the Race Relations Act:

“The document is quite comprehensive...it shows that a policy framework was in place as early as 1978 to begin to seek to eliminate discrimination from the NHS.” (Ward, 1993:177)

It is perhaps in this context that we can note how the incoming NHS CEO (Chief Executive Officer), Simon Stevens, in his 2014 Kings Fund annual leadership summit speech linking diversity in leadership with better patient care, asked why there had been so little positive change a decade after the launch of the 2004 NHS Race Equality Action Plan:

“...while 41 per cent of NHS staff in London are from Black and minority ethnic backgrounds (similar in proportion to the Londoners they serve) only 8 per cent of Trust board directors are, with two fifths of London trust boards having no BME directors at all. Similar patterns apply elsewhere and have actually been going backwards.” (Stevens, 2014).

The narrative presented by Simon Stevens reflects a range of interlocking themes and issues around discrimination in the racial and ethnically segmented British labour market, described as an 'ethnic penalty' by Heath and Cheung (2006). And as with the public sector, an ethnic- penalty-related under-representation of BME people in leadership roles persists in the private and business sector:

“Race at the Top, a comprehensive study by Race for Opportunity on black, Asian and minority ethnic representation in leadership in UK businesses, concluded that



there had been virtually no ethnicity change in top management positions in British business in the five years between 2007 and 2012.” (Sarpong, 2017:38)

An important shift is noted by Kline in the legislative requirements placed upon the NHS, linked to the replacement of the Race Relations Amendment Act (2000) with a single public sector equality duty set out in the Equality Act 2010, covering the nine ‘protected characteristics’ of race, disability, gender, age, sex and sexual orientation, gender–reassignment, pregnancy and maternity, marriage and civil partnership, and religion and belief. He tracks and highlights an issue concerning activists within both the NHS BME Network and UNISON Black SOGs: dilution of institutional action promoting race equality, exacerbated by the coalition government’s “Red Tape Challenge”:

“The weakening of the specific requirements for collecting and analysing data on ethnicity set out in the Race Relations (Amendment) Act 2000 has anecdotally, already led to less information on race discrimination being placed in the public domain. Our research suggests that the need to collate employment data analysed by ethnicity remains as important as ever. Any further weakening would undermine both the understanding of race discrimination and remedying it.” (Kline, 2013:13)

Thus the issues of BME under-representation at senior Board and leadership levels within the NHS, alongside disproportionate rates of BME staff experiencing bullying and harassment and disciplinary action identified by the BME South East Coast Network Race Equality Service Review, and evidenced by Kline (2014), were comprehensively investigated in relation to the vexing issue of BME over-representation in disciplinary cases in the NHS.

### **NHS BME staff disciplinaries and the wider public sector**

In their study of BME staff subject to disciplinary proceedings in the NHS, Archibong and Darr, linked the high disciplinary rates of BME staff in the NHS to similar patterns in the police and local government, stating:

“Reasons for the disproportionate representation of BME staff in these sectors appear to ...relate to a tendency amongst managers to formalise the disciplinary process too quickly, the presence of discriminatory attitudes.” (Archibong and Darr, 2010:8)

The findings of Archibong and Darr, were reinforced by the results of freedom of information requests conducted by the Royal College of Midwives (RCM) between 2010 and 2015. The RCM report, which was presented at the 2016 TUC Black Workers' Conference, showed that of the 38 midwives dismissed during the five year period 37 were from a BME background, 32 being Black or Black British, whilst 44.1% of the midwives employed in London were from a BME background compared with 66.4% of the midwives subject to disciplinary measures having a BME background. Thus the report stated that the continued discriminatory experience of BME staff in the NHS is "why the Workforce Race Equality Standard was introduced" (The Royal College of Midwives, 2016:15).

Despite their position of relative privilege within the occupational hierarchy of the NHS, the status of BME GPs within the summit of the medical profession is compromised and unstable as witnessed in the disproportionate numbers of BME GPs subject to fitness to practice investigations and complaints from patients. The recent case of a Nigerian heritage GP, Dr Hadiza Bawa Garba, whom many medical colleagues argued was unfairly struck off from the medical profession for gross negligence manslaughter by the General Medical Council has served to highlight key underlying issues faced by racialised BME GPs in the NHS. In this context the General Medical Council (GMC) in April 2018 announced the launch of its own commissioned review to investigate the reasons underlying the disproportionate rates of BME doctors facing complaints from NHS employers. Whilst the most recent GMC report on medical education and practice records BME GPs are 20% more likely to face a patient complaint and 30% more likely to be investigated by the GMC. The GMC Review will be led by Roger Kline, author of the "Snowy White Peaks of the NHS" (2014) report and will focus on the role of conscious and 'unconscious bias' within workplace cultures. Thus for BMA Chair, Dr Chaand Nagpaul, discussing the remit of the GMC Review, the underlying issues to be addressed were those already highlighted in Kline's (2014) report and Esmail et al.'s preceding 2005 report: higher rates of referral for disciplinary and performance issues, higher reported cases of being subject to bullying and harassment, and lack of career progression. In this light, Dr Ramesh Mehta, president of the British Association of Physicians of Indian Origin (BAPIO), commenting on the upcoming review stated: "The GMC has had several reviews and research projects on the issue in the past with no useful outcome" (Wickware, 2018).

## **Inclusive or exclusive: are the snowy white peaks in the NHS too high to climb?**

In their research on Talent Management Discourses in the NHS, Powell et al referred to NHS workers' concerns around approaches that focus too much on progression into senior leadership roles, facilitating an "exclusive rather than inclusive perspective" (Powell et al, 2013: 307). The dangers of diversity management approaches that focus on breaking glass ceilings for select individuals at the expense of the whole workforce are highlighted by Berrey (2015, 2014); Acker (2009); Healy et al (2011); Bradley (2016); and Wrench (2005). Where delivering race equality is framed as an issue of enabling BME talent to progress into the organisational 'snowy white peaks', collective bargaining approaches to challenging systemic racism can be marginalised. Thus in its workforce development guide, the Department of Health Initiative 'Race for Health' recommended special coaching and mentoring programmes as a means to advance career progression for BME workers into the top tier of NHS leadership, with a focus on "nurturing individual talent and skills rather than on race equality" (The Royal College of Midwives, 2007). A similar individualised approach was also endorsed by the CMO Annual Report (Donaldson, 2007), which prioritised attitudinal, behavioural, and cultural change over addressing institutional barriers. In 2016 a debate, perhaps challenging some of the individualising talent management premises underlying the above approaches, was convened at TUC Congress House by the Royal College of Midwives posing the question "Are the snowy white peaks in the NHS too high to climb?"

In approaching the key research questions:

1. How are the NHS BME Network and UNISON Black SOG challenging racism in the NHS workplace?
2. What are the political differences and similarities between the NHS BME Network and UNISON Black SOG in their approach to promoting race equality in the NHS?
3. How does class intersect with race, gender and ethnicity within the NHS BME Network and UNISON Black SOG?

this thesis notes Kyriakides and Virdee's (2003) reference to the urgent need to document and investigate the history of campaigns and experiences of anti-racist collective action of BME workers in the NHS, as represented in the past by BME associations such as the Overseas Doctors Association, the Overseas Doctors Federation, and the National Association for Ethnic Minority Doctors. Similarly, Simpson et al (2010) encourage investigation of "How have migrants organized themselves in the past to develop networks

that provide social and professional support?” Noting the importance of this legacy of BME collective organisation to challenge racism in the NHS workplace, in relation to the contemporary activities of the NHS BME Network and UNISON Black SOGs, this thesis is critically aware of the implications and lessons that can be drawn from Ward’s analysis of ‘race equality and employment in the NHS’ during the period of the ‘equal opportunities revolution’ (Heartfield, 2017), where he states:

“When black workers organized themselves it was mainly for reasons of self-advancement, as with the Overseas Doctors Association, and only indirectly as a challenge to discrimination against black staff in the system as a whole. Mainstream health service unions have never given equal opportunities policies a priority.” (Ward, 1993: 179)

This chapter has highlighted how the history of NHS dependence on the first wave of ‘Windrush Generation’ racialised BME NHS migrant workers facing racism in the workplace whilst settling into the ‘hostile environment’ of post war Britain (King, 1998; Carter, 1986; Hammond Perry, 2015; James and Harris, 1993; Brah, 1996) underscores the reproduction of racial discrimination faced by BME and migrant workers within the institutional and occupational hierarchies of the NHS today. The chapter discussed how whilst the elite white, mainly male, leadership of a 21<sup>st</sup> century multi-ethnic NHS seeks to promote equality and celebrate diversity, continuing evidence of systemic racism as documented in the South Coast BME Network Race Review (Lyfar-Cisee, 2008) has spurred the collective organisation of BME workers, leading to the launch of the national NHS BME Network in 2010. The local NHS BME Network (mirroring its parent organisation - the independent NHS BME Network) unlike predecessors such as the Overseas Doctors Association is made up predominantly of BME Allied Health Professionals, including NHS managers, commissioners, administrators, and equality and diversity Officers. The next chapter explores the conceptual/theoretical framework used to investigate the research hypothesis.

# Chapter 3 Conceptual/theoretical framework

## Introduction

This chapter sets out the theoretical framework that has been used to explore the research hypothesis which reflects current corporate diversity management discourses, contending that a relative decline in the traditional employee voice – trade unions – signals that BME Diversity networks may be seen as being more effective ‘collective voices’ for promoting race equality in the workplace by Black workers.

The key research questions linked to the hypothesis are:

1. How are the local NHS BME Network and local UNISON Black Self-Organised Group challenging racism in the NHS workplace?
2. What are the political differences and similarities between the NHS BME Network and UNISON Black Self-Organised Group in their approach to promoting race equality in the NHS?
3. How does class intersect with race, gender and ethnicity within the local NHS BME Network and local UNISON Black SOG?

The chapter foregrounds a theoretical framework that engages with the Black Radical Tradition application of Marxism (Rodney, 1969; Robinson, 2000; Davis, 2017; Marable, 1983) to gain an understanding of the intertwined relationship between racism and capitalism and an historical perspective on the role ideologies of racism play in racializing migrant labour as ‘outsiders’ (Virdee, 2014), thereby conferring ‘inferior’ and subordinate positions to racialized groups within the UK labour market. In this context the theoretical concept of ‘racial capitalism’ (Robinson, 2000; Bhattacharyya, 2018) is introduced and is linked to the Black Radical Tradition’s approach to theorizing forms of collective ‘resistance’ to slavery, colonialism, capitalism and imperialism. The chapter then theoretically maps the Black Radical Tradition of resistance to racism to race and class

Black Self-Organisation within the UK labour movement which, under a Black (race and class) political identity, opened up employment opportunities for Black workers within the public sector. Here the chapter notes Satnam Virdee's (2010) critique of an 'over-emphasis' on 'upward social mobility' in a period where Black workers inscribed by 'migrant divisions of labour' (Wills, 2009) have been disproportionately experiencing the adverse impacts of neoliberal economic restructuring. Hence the theoretical framework embraces the argument of "naming neoliberalism" (Hall, 2017) as a key theoretical concept to investigate the research hypothesis against the backdrop of the 'neoliberal revolution' (Hall, 2017). The chapter's theoretical framework therefore engages with areas of contestation linked to the hypothesis that BME Diversity Networks can be seen as more effective collective voices for Black workers than Black Self-Organised Groups within trade unions, via a consideration of the implications for anti-racism of current forms of BME racial identity politics associated with a 'neoliberal turn in black politics' (Spence, 2016; Osuna, 2017; Haider, 2018), which erases class stratification. Similarly, the consequences for anti-racist politics of a rise in forms of 'black vernacular neoliberalism' (Gilroy, 2016) aligned to corporate diversity management is discussed within the theoretical framework.

### **Racialized Black migrant workers in the British labour market**

This research charts the development of a Local NHS BME Network, based at a Local NHS Trust, and its political relationship to and contestations with a local UNISON Health Branch Black SOG during the period 2012 – 2018. The emergence of the local NHS BME Network, officially launched in 2012 as a BME Equality and Diversity Staff Network in the context of NHS Equality, Diversity and Inclusion policies, reflects the increasing proliferation and ubiquity of BME/other Diversity Staff Networks across the UK public and private sectors. As the largest employer of Black and minority ethnic workers in the UK (almost one in five NHS staff members are BME) – linked to an historic dependence

on Black migrant labour – the NHS is a key site and institution within which to explore and investigate some of the main factors propelling the mushrooming of BME Staff /Diversity Networks in the 21st century workplace. In this regard, a key focus and rationale for this research is to enquire into and seek greater understanding of how Black workers are, from an anti-racist perspective, collectively responding to their experiences of racism in the workplace. Thus the starting point for this inquiry is recognition of the disadvantaged position and intersecting inequalities faced by Black workers in the British labour market (TUC, 2012; TUC, 2015a; Women’s Budget Group et al, 2017; Cabinet Office, 2018). The racial discrimination faced by Black workers in the wider labour market translates into and manifests within particular occupational settings. Within the NHS workplace Black workers experience racism in the form of being subject to disproportionate rates of disciplinary and grievance procedures; bullying and harassment; lack of recruitment, retention and career progression; and under-representation at board, Non-exec, and senior management level (Esmail et al, 2005; Kline, 2013; Kline, 2014). In response to this persistent issue, in 2004 the NHS launched its Race Equality Action Plan (Crisp, 2004), and the NHS Breaking Through Programme: “the first national development programme for BME NHS staff”. In 2005, Esmail et al (2005) recommended development of BME Staff Networks within the NHS as a ‘leadership intervention’ aimed at BME workers traditionally excluded from the informal ‘patronage networks’ which can influence professional career paths and access to particular roles. Adding to the growing drumbeat proclaiming the benefits BME Networks can bring for organisations seeking to improve diversity, the report ‘Releasing the potential within BME Networks’, states:

“BME Networks have a positive role to play in specifically ensuring that leadership trainees and graduates from programmes such as the NHS Breaking Through Programme and the various NHS Management Training Schemes can receive support and leadership opportunities.” (Saddler, 2006:3)

And the report recommends, “Networks should aim to monitor delivery of the NHS Chief Executives 10 Point Race Equality Action Plan...” (Saddler, 2006:19).

On this basis support for the development of BME Networks within the NHS has increasingly been couched in terms of asserting the business case for promoting diversity, with recent NHS England Guidance on supporting BME Networks stating:

“...they have slowly developed from providing informal networking opportunities to becoming business partners in support of the business mission.” (NHS England, 2017:7)

Invoking the NHS austerity (‘Nicholson Challenge’) efficiency savings mantra of ‘doing more with less’, the NHS England Guidance, incorporates BME Diversity Networks into an austerity driven ‘frugal innovation’ narrative, declaring:

“Staff networks are well placed to demonstrate frugal innovation... Staff networks identify ways to do better with less. They can embrace a business enthusiasm using their skills and passion...” (NHS England, 2017:30)

In 2015 the NHS launched its Workforce Race Equality Standard (WRES) as a mandated policy for NHS Trusts and organisations to monitor improvement in the systemic issues of racism highlighted in Roger Kline’s ‘Snowy White Peaks’ Report (2014). Thus NHS England’s implementation policy recommends:

“For many NHS organisations across England the, introduction and effective running of a BME staff network is an important part of putting into practice the Workforce Race Equality Standard...” (NHS England, 2017:3).

Within this institutional landscape the Local NHS BME Network featured in this research was launched in 2012 as a BME self-organised rather than HR initiated staff network. In this regard the Local NHS BME Network took its inspiration from an independent National NHS BME Network, which was launched in 2010. The Local NHS BME Network was affiliated to the National NHS BME Network adapting the National Network’s organisational approach to its own local NHS Trust setting. The Macpherson Report definition of institutional racism following the inquiry into the death of Stephen



Lawrence underpinned the National NHS BME Network's race equality campaign which began in 2008 in the form of the South East Coast BME Network Race Equality Review which preceded Kline's 2014 'Snowy white Peaks' revealed the systemic racism BME staff were experiencing in the NHS workplace. And the South East Coast BME Network Race Equality Review provided the mandate for the launch of the national independent NHS BME Network in 2010, in turn inspiring the launch of the local NHS BME Network in 2012. During the period of the launch of both the National and Local NHS BME Networks, Black anti-racist politics in the UK was influenced by two key moments - the emergence of Barack Obama's as the US's first Black President, and the 2008-9 financial crash and the resulting impact of neoliberal austerity on Black communities and Black politics. Both of these key moments feature in the discussion which follows.

With the ascendancy of BME Diversity Networks aligned to corporate diversity management discourse in the contemporary workplace, alongside perceptions of the decline of the traditional workers' voice – trade unions – this research seeks to investigate the hypothesis that Diversity Networks such as the local NHS BME Network are increasingly being seen by Black workers and BME Professionals as more effective collective voices for promoting race equality in the NHS workplace. As noted earlier, a clear articulation of the hypothesis proclaiming “the benefits of staff networks”, via a business inflected narrative vis a vis trade unions is presented, thus:

“Some authors have suggested that staff networks provide a new form of employee voice in the workplace. This has coincided with the decline of the traditional employee voice – trade unions – which has created a void for new employee relations actors to come to the fore. ...if other avenues of employee voice like trade unions are not available or adequately representing certain minority groups effectively, then staff networks have an opportunity to step in and fill this chasm.” (Williams and Yarker, 2017:12)

Racial discrimination in the UK labour market, where Black workers are concentrated in low paid work, get paid less and experience an ethnic pay gap, are disproportionately employed in insecure-precarious work, and where Black graduates are over-qualified for

their work role, is both a contributory factor to and a consequence of the persistence of state racism and structural racism within wider society in 21<sup>st</sup> Britain, as highlighted recently by the UK government's own Race Disparity Audit (Cabinet Office, 2018). Similarly, evidence of the adverse impact of neoliberal inflected austerity in terms of race equality and social equality for Black workers in the NHS and wider labour market has been recently highlighted in a range of reports including the findings of the Women's Budget Group et al. Report 'Intersecting Inequalities' (2017) which assessing the disproportionate impact of austerity cuts to public services, benefits and tax credits since 2010, revealed:

“Black families in the poorest fifth of households will see their living standards fall by over £8,400 a year on average from cuts to benefits and services.” (Women's Budget Group et al., 2017: 1)

And, in her discussion of an 'emerging' 'New Working Class' in the UK which is 'multi-ethnic' (Ainsley, 2018; Virdee, 2014), Claire Ainsley, notes:

“Black, Asian and minority ethnic workers face persistent disadvantages in employment. Some minority ethnic groups are segregated into certain low-skilled occupation types, compared to a relatively even distribution of White British workers, with significant differences between and within minority ethnic groups... The typical Bangladeshi household income is 35 per cent (8,900 a year) lower than the White British median, for example, and Bangladeshi Women have just a 31 per cent rate of employment compared to 72 per cent of White British women. Poverty is up to twice as likely among some minority ethnic groups as it is for White people. The backdrop to this disadvantage in the labour market is persistent discrimination faced by black, Asian and minority ethnic people, which restricts racial equality in work, education and wider society.” (Ainsley, 2018:18)

It is also in this context that in their own race and class analysis of Britain's multi-ethnic 'New Working Class' – Dhelia Snoussi and Laurie Mompelat recommend the introduction of the socioeconomic duty: “making class an 'equality ground', this will allow for positive action measures to be taken on grounds of class as well as race.” (Snoussi and Mompelat, 2019:7) (See also EHRC, 'Healing a Divided Britain', 2016; Women's Budget group et al., 2017; The Runnymede Trust, TUC and JRF, 2017).

## **Racial capitalism**

In this regard, the argument being set out here is that any meaningful attempt to understand the continuing significance of race and deep-rooted racism on the life chances and experiences of Black people in the UK, including within the British labour market, requires an historical and contextual consideration of the relationship between racism and capitalism. And, in this context, the analysis which follows draws on and affirms ‘The Black Radical Tradition’s critique, as mapped by Cedric Robinson, of the inter-twined relationship of capitalism, slavery, racism, nationalism, colonialism and imperialism:

“The tendency of European civilization through capitalism was thus not to homogenize but to differentiate - to exaggerate regional, subcultural, and dialectical differences into racial ones....so at the systemic interlocking of capitalism in the sixteenth century, the peoples of the Third World began to fill this expanding category of a civilization reproduced by capitalism” (Robinson, 2000:26)

The concept of ‘racial capitalism’ – “Racial capitalism is a way of understanding the role of racism in enabling key moments of capitalist development” (Bhattacharyya, 2018: x) as articulated by Cedric Robinson through his engagement with Black historians of ‘capitalism and slavery’ – WEB DuBois, CLR James, Oliver C Cox, Eric Williams – explicitly links the ‘African slave trade, ‘African labour’ and forms of ‘migrant labour’ in the ‘ledger’ of modern civilization to the “column marked British Capitalism” (Robinson, 2000:116). The role of slavery, colonialism, Empire and the ideology of racism in the formation of British Capitalism has also been debated by Walter Rodney in ‘How Europe Underdeveloped Africa’ (1981a) (see also Tharoor, 2016; Beckles, 2013).

At this point Robinson’s analysis of migrant labour as an essential component of capitalism dovetails with Kyriakides and Virdee’s (2003) discussion of the role of migration in relation to the development of capitalism, and in the context of an NHS constructed against the ideological backdrop of racism and ‘After Empire’ (Gilroy, 2004) postcolonial melancholia: “drawing heavily on the skilled labour of the inferior races in the postcolonial era” (Kyriakides and Virdee, 2003: 287). In their analysis of ‘Migrant Labour,

Racism and the NHS' Kyriakides and Virdee took account of the marginalisation (in the African-American context Marable (2009b) refers to the tension between marginalisation and inclusion) of “a relatively middle class migrant group” of doctors vis a vis white British doctors (Kyriakides and Virdee, 2003:288). Whilst Navarro, discussing the class structure of the NHS, refers to its working class predominantly found in ancillary support services includes an “over representation of foreign workers (the blacks of Britain)” (Navarro, 1978: 75; see also Bryan et al, 1985).

Thus in relation to racialized class stratification and differential privileges within capitalism, it is interesting to note Gargi Bhattacharyya's ‘Ten Theses on Racial Capitalism’, where she states:

“Racial capitalism helps us to understand how people become divided from each other in the name of economic survival or in the name of economic well-being. One aspect of its techniques encompass the processes that appear to grant differential privileges to workers and almost workers and non-workers and the social relations that flow from these differentiations.” (Bhattacharyya, 2018: x)

Alongside theorising ‘racial capitalism’ linked to the development of British capitalism, Cedric Robinson identified the ‘Black Radical Tradition’ as a current of self-organised resistance, referring to:

“...the dialectic of imperialism and liberation, the contradiction that compelled the appearance of resistance and revolution out of the condition of oppression...” (Robinson, 2000:166)

In this regard the ‘Black Radical Tradition’ is an anti-racist ideology of resistance and liberation:

“The resoluteness of the Black radical tradition advances as each generation assembles the data of its experience to an ideology of liberation.” (Robinson, 2000:317)

### **The Black Radical Tradition and Black self –organisation in Britain**

Here then are the historical and theoretical contours of a particular form of ‘Black Self–Organisation’ aligned to the Black Radical Tradition, which emerged in 20<sup>th</sup> century

Britain as a current of resistance to racism, colonialism and imperialism, on the part of migrant workers from Britain's former colonies in Africa, Asia and the Caribbean, now settling in the UK:

“The self-organisation of black people thus has a long pedigree born of the hostility or indifference of white society. The organisations so formed had a dual function. They attempted to give some support to black Britons at the sharp end of racial prejudice and in addition were at the forefront of the anti-colonial struggle.” (Davis, 2009:253)

Thus ‘Black Self-Organisation’ as an anti-racist political ideology informed by the ‘Black Radical Tradition’ was developed in Britain by Black migrant workers racialized as ‘outsiders’ (Virdee, 2014). Black and Asian workers struggling against racism in the workplace, their trade unions and within wider society, built organisations like the Indian Workers Association, and Claudia Jones’ West-Indian Gazette, alongside fighting militant race and class battles such as the Bristol Bus Boycott, and Grunwick Strike which helped push the British trade union movement more firmly in the direction of anti-racism (Virdee, 2014; Carter, 1986).

At this point, then, it is useful to revisit the Black Radical Tradition aligned anti-racist ideology of ‘Black as a Political Colour’, which forged unity and solidarity amongst Black and Asian activists in the UK based on an experience and common understanding of liberation struggles against colonialism and imperialism (Brah, 1996; Sivanandan, 2019; Ramamurthy, 2013) during the period of ‘Black Power’, as exemplified by the Black Panther Party in the US (Bloom and Martin JR, 2013). Importantly, the necessity of grappling with the interplay of race and class is a key aspect of the Black Radical Tradition orientation of ‘Black’ as a political colour, which continues to underpin the organising principles of Black Self-Organisation within British trade unions (Carter, 1986; Virdee, 2014). Discussing ‘British Black Power’ and the anti-imperialism of political blackness, which he situates historically between “the fall of British social democracy and the rise of

British Neoliberalism” (Narayan, 2019: 948), John Narayan, referring to the authors of

‘Policing the Crisis’, makes the observation:

“BBP’s theorization of race and class prefigured that of Hall, Critcher, Jefferson, Clarke and Roberts, that race is the modality in which class is lived and the medium in which class relations are experienced” (Narayan, 2019:394).

Narayan also makes reference to Robbie Shilliam’s maxim ‘class is race’, presented in his recent analysis of how in post-war Britain ‘Commonwealth’ migrant workers, based on a ‘racialized division of labour, have been cast as both foreign ‘Other’ and as an ‘undeserving poor’ (Narayan, 2019; Shilliam, 2018). Thus Narayan adds:

“New Commonwealth citizens often occupied the bottom rung of the labour market, regardless of their previous class trajectory...” (Narayan, 2019:948)

In accord with Avtar Brah, who notes how “the sign black was mobilised also as a displacement for the categories immigrant and ethnic minority” (Brah, 1996:98), Narayan, comments:

“British Black Power’s political blackness was a thus a response to the state’s racialization of New Commonwealth communities as coloured people.” (Narayan, 2019:949)

Arguing that whilst some may wish to ditch the idea of political blackness on grounds of displacement and marginalisation of different ethnic identities, (see also Sivanandan and Kundnani’s critiques of ‘ethnicism’) and being ‘outdated’, Narayan comments:

“We would do well to recover its interlinking of domestic forms of race, class and gender discrimination...and the formation of domestic and international forms of solidarity with the ‘Global South’ in resistance to oppressive forms of globalised capitalism.” (Narayan, 2019:960)

For Narayan, then a key political legacy of ‘British Black Power’ is the idea that

“Neoliberalism must be read through the lens of racial capitalism” (Narayan, 2019:960).

And therefore, a key political lesson for the anti-racist struggle today, is:

“The new anti-racism much like the old, should not seek to merely put brown and black faces in high places in dealing with the problem of ethnic inequality.” (Narayan, 2019:962)

However, in this regard, the orientation of many BME Diversity Networks linked to forms of racial identity politics fused with corporate diversity management discourse has resulted in an exclusive focus on ‘breaking glass ceilings’ and ‘identifying talent’ for senior leadership positions (e.g. see NHS BME Network 2010 Operational Framework).

Highlighting the implications of this breaking glass ceilings orientation, Manning Marable in his essay ‘Beyond Racial Identity Politics: Towards a Liberation Theory for Multicultural Democracy’, critiques the brown and black faces in high places form of “symbolic representation”, associated with racial identity politics and corporate diversity management, stating:

“Racial-identity politics ...tends to minimize greatly any awareness or analysis of class stratification and concentrations of poverty or affluence among the members of the defined racial minority groups.” (Marable, 2009:190)

Similarly Berrey, noting the consequences of neoliberal aligned diversity management discourse, which does not recognise class, discussing the “symbolic politics of racial progress” in neoliberal America, states:

“...the organizational drive for diversity complements neoliberalism in that it is primarily a drive for minorities who are high status or otherwise desirable for those in the majority. It is selectively inclusive” (Berrey, 2015:258)

In its 2010/11 National Operating Framework (NHS BME Network 2010), the NHS BME Network linked its ‘Hope, Change and Bottom Up’ organising vision and programme for “Developing Talent and Inspiring BME Leaders” to the hope inspired by Barack Obama becoming the first US Black President in 2009. In a similar vein, June Sarpong in her study ‘Diversify’, stated: “The Obama presidency has been the modern defining event for aspiring black males...” (Sarpong, 2017:40). However, for Paul Gilroy, “the Age of Obama” (Gilroy, 2016:34) runs in parallel to a neoliberal corporate diversity management

discourse in which “the myth of meritocracy” and what Cedric Robinson referred to as “the seductiveness of the bourgeois myth of social mobility” (Robinson, 2000:314) is encoded. Thus amongst those scholars critical of the ‘symbolic representation’ approach of racial identity politics that erases class, Berrey reminds that Barack Obama “side stepped issues of concern for people of colour” (Berrey, 2014: 268). And, Yamahtta Taylor links the ‘Age of Obama’ to the biggest change in Black American politics in the post-civil rights era - the rise of a ‘Black elite’ which was complicit in implementing cuts to public services and neoliberal privatization. Thus Yamahtta Taylor notes the race and class contradiction of a social movement asserting Black Lives Matter emerging “under the nation’s first black president” (Taylor, 2016:17).

In this context, the implications of the National NHS BME Network’s ‘symbolic representation’ - Barack Obama as ‘uber’ role model approach, which corresponds to corporate diversity management narratives’ focusing on nurturing senior leaders through ‘selective inclusion’ and ‘breaking glass ceilings’, is highlighted by Angela Davis, who like Berrey and Yamahtta Taylor reminds that Obama’s presidency did not enact any policies that significantly addressed racism in US society:

“He’s become the model of diversity in this period...but when the inclusion of black people into the machine of oppression is designed to make that machine work more efficiently, then it does not represent progress at all. We have more black people in more visible and powerful positions. But then we have far more black people who have been pushed down to the bottom of the ladder. When people call for diversity and link it to justice and equality, that’s fine. But there’s a model of diversity as the difference that makes no difference, the change that brings about no change.” (Angela Davis, quoted in Younge, 2011:167)

### **Anti-racism as social justice requires a race and class perspective**

Drawing attention in the UK context to the intersection of race and class, Colin Prescod, film maker (The Struggles for Black Community, 2008) and Chair of the Institute for Race Relations, as the key note speaker at the 2011 National NHS BME Network Conference held at London Hilton, Park Lane, W1, made a powerful intervention placing the NHS



BME Network's present campaign for race equality in the NHS within a past and present context of a Black Radical Tradition aligned Black Self-Organised activism in the UK:

“Eventually...we forged the remarkable idea of ‘Black’ not as a mere label for skin colour, but as a political colour – as the colour of resistance to all race and class injustices. Note, not Black and minority ethnic, but just plain Black – all inclusive.” (Colin Prescod, 2011)

At this stage the National NHS BME Network was holding its first national conference at the Park Lane Hilton Hotel just as the Coalition government was unleashing its austerity programme – a kind of domestic structural adjustment programme (Kundnani, 2007: 29) – including public sector cuts. Health Minister Andrew Lansley was also ‘liberating’ the NHS with the ‘Lansley Reforms’ of 2011 – that is gradually ‘denationalising the NHS’ (Sivanandan, 2013:7). Based on the programme drawn up by the Global Management firm McKinsey, Lansley’s ‘reforms’ imposed “...the most far reaching, top down NHS reorganisation” (Hall, 2017:333), geared towards accelerating privatisation of NHS services and ‘doing more with less’ efficiency savings: “You cannot make £20 billion savings in the NHS without affecting front-line, clinical and nursing services...” (Hall, 2017:332).

Importantly, Colin Prescod’s speech drew attention to Stuart Hall’s ‘The march of the neoliberals’ critique (Hall, 2017), in the same month as the NHS BME Network Conference (16<sup>th</sup> September 2011), of the impact of neoliberal austerity on public services and the Welfare State:

“For the public sector there will be massive redundancies, a wage freeze, pay running well behind the rate of inflation, pensions which will not survive in their present form, rising retirement ages.” (Hall, 2017:332)

In this regard, Colin Prescod, after querying whether a narrow focus on race could encompass the wider political complexity of the current neoliberal period, stated:

“I want you to be as concerned about ‘public health’ in capitalist culture...‘public health’ which involves a broader concept of what constitutes our national health.

Given this context, you may want to look again at the challenges of pursuing ‘race equality’ as against ‘social equality’ demands in this time...” (Prescod, 2011)

It was then in this period that a ‘Black activist’ race and class social justice approach to anti-racism, aligned to the ‘Black Radical Tradition’ as advocated by Colin Prescod, was the basis for the organising and campaigning activities of UNISON Black SOG, UNISON National Black Members Conference and the TUC Black Workers Conference structures. Thus the trade unions’ Black Self-Organised Group Campaigns included: campaigning against the disproportionate impact of austerity on Black workers and working class communities; campaigning against the State racism of the ‘hostile environment’ 2014 Immigration Act; fighting against the NHS privatisation linked to fragmentation and outsourcing of NHS services; campaigning against the austerity driven pay freeze, and reduction in pensions, and provision of a living wage. In this regard, UNISON and TUC Black Workers Self-Organisation in the UK, continue to champion an inclusive political black identity to enable the type of multi-ethnic collective solidarity and coalition building described by Manning Marable in his call to –rethink Black liberation by going beyond racial identity politics. Urging that anti-racist politics link categories of race, class and gender in a neoliberal era of increasing insecure and precarious forms of employment, Marable states:

“Black and progressive politics need to focus specifically on the issues of employment and a living wage, initiating a public conversation about the importance of work for all people. The Association of Community Organisations for Reform Now (ACORN) recently initiated a ‘Jobs and Living Wage Campaign’, for example which represents an excellent model of practical class politics.” (Marable, 1997:9)

Thus anti-racist Black Self-Organised activists within the trade unions are at the forefront of the fight to secure a living wage for the UK’s racialized multi-ethnic working class and migrant workers who constitute a ‘migrant division of labour’ in the UK labour market (Wills et al, 2010; Wills, 2009; Hearn and Bergos, 2011; Alberti et al, 2013), as per UNISON and the East London Communities Organisations (TELCO’s) 2002 campaign

citing that less favourable pay, terms and conditions of mainly outsourced black and minority ethnic women contravened the Local Health Authorities' duties under the Race Relations Amendment Act 2000 (Lethbridge, 2009:115).

Here it is important to note that UNISON's 'Challenging Racism in the Workplace' resources and training incorporates 'community organising' as a key element of anti-racism, thereby building on Black self-organisation in the UK's long established tradition of organising against racism simultaneously in the workplace and within Black communities (Davis et al., 2006). And it is this community organising approach that is considered the bedrock of UK trade unions' current strategies for applying forms of 'community unionism' and 'social movement unionism' to facilitate trade union renewal (Simms et al., 2013; Holgate et al., 2008; Moore, 2011; Lethbridge, 2009). It is, then, in this context that UNISON officially launched its African Migrant Workers Network at the UNISON National Black Members Conference in 2014 (thus joining UNISON's Filipino Migrant Workers Network and East European Migrant Workers Network). This was the same year in which UNISON Members working in the NHS joined the first national NHS strike since the 1982 NHS strike against Thatcher's attack on NHS workers. In 2018 UNISON, alongside other trade unions, negotiated an English NHS Pay Deal increasing the salary for NHS Band 1 staff to Living Wage rates.

### **'Naming neoliberalism'**

As alluded to above, it is crucial to recognise and acknowledge that anti-racist activism and Black politics in the UK have not been immune from or somehow miraculously escaped the influence and effects of neoliberalism. A key aspect then of the theoretical framework being set out here is the necessity in the current period to investigate anti-racist activism and Black politics in Britain within the context of neoliberalism (Harvey, 2007). Hence the theoretical framework elucidated in this thesis invokes the approach outlined by Stuart Hall

who, discussing his use of ‘neoliberalism’ as a “provisional conceptual identity” (Hall, 2017:318), states:

“I would also argue that naming neoliberalism is *politically* necessary, to give resistance content, focus and a cutting edge.” (Hall, 2017: 318)

Thus, Black workers within the NHS BME Network and Unison Black Self-Organised Groups have been organising in a NHS workplace that has undergone intense change and restructuring linked to the pervasive effects of neoliberalism on British society since the 1980’s. The drive to privatise an ‘inefficient’ public sector unleashed by Thatcherism, followed by New Labour’s embrace of “Managerial Marketisation” (Hall, 2017:327) “New Labour orthodoxy is that only the private sector is efficient” (Hall, 2017:306) – has been facilitated ideologically through what Stuart Hall terms “the practices of management”, and, following Du Gay, “entrepreneurial governance”. For Hall, a key example of the incursion of different forms of neoliberal governance aligned to New Labour’s ‘gospel’ of ‘market fundamentalism’ can be mapped by tracing the impact of private finance initiatives and outsourcing designed to facilitate “the corporate penetration of, parts of the public sector (the prison service, schools, the NHS)” (Hall, 2017:305). Importantly for Stuart Hall:

“The New Managerialism is really the vehicle by means of which neoliberal ideas actually inform institutional practices...This involves the marketisation of the state’s governing and administrative practices, the transformation of public service individuals into entrepreneurial subject...”(Hall, 2017:307)

In this regard the ideological influence and incorporation of ‘New Managerialism’ into forms of anti-racism and Black politics in the UK has been detected by scholar Coretta Phillips who in her study of ‘minority professional associations in the criminal justice field in the post-Macpherson era’ (2007) notes a political landscape in which the term ‘institutional racism’, linked to the Stephen Lawrence Inquiry and Macpherson Report (Macpherson, 1999) injunction to tackle the institutional racism endemic within British society, has all but disappeared from New Labour policy statements, supplanted by forms

of corporate diversity management with an “explicit managerialist focus” to “promoting race equality and embracing diversity,” (Phillips, 2007:2). And, in this regard we can note the reflection of Doreen Lawrence, the mother of Stephen Lawrence, that: “As time moved on, it’s as though they changed the word from racism to diversity” (Quoted in Philo et al., 2019:153).

And, in relation to the anti-racist Stephen Lawrence Family Campaign for Justice, which led to the introduction of the Race Relations Amendment Act 2000 and the Macpherson Report definition of institutional racism, it is important to note the positive role and sustained support of Black trade union activists and the trade union movement as a whole within the campaign:

”NALGO member Jackie Burnett told the conference about the murder of her 18 year old cousin, Stephen Lawrence, by racist youths in south London three weeks earlier.. NALGO (and then UNISON) and the TUC gave long term support to the Lawrence family in their quest to bring the killers to justice.” (Ironsides and Seifert, 2000:357)

Whilst, in relation to Doreen Lawrence’s criticism of the term racism being replaced by diversity, Sara Ahmed (2007a) has highlighted how the “language of diversity” works to remove any meaningful focus on tackling racism in institutional life, with business case rationales linked to deregulated market driven environments supplanting moral-social justice imperatives (Ozbilgin, 2011; Wrench, 2005).

### **Race and class and the ‘Black managerial turn’**

Twenty first century BME Diversity/ Staff Networks, such as the National NHS BME Network, which have emerged within organisational environments shaped by corporate diversity management discourse (for example, see Hunt et al., 2015; Page, 2017; Williams and Yarker, 2017, Ozbilgin, 2011), functioning as collective voices for BME professionals are closely related to and have emerged from Black and Asian Professional Associations, which themselves emerged out of the expansion of Black workers in professional roles

within the public sector during the 1970's and 1980's, linked to Black workers forming anti-racist 'semi-autonomous groups' in unions like NALGO during this period (Davis et al., 2006; Virdee and Grint, 1994; Virdee, 2010, Virdee, 2014; Shukra, 1998). So by the 1990's "The TUC black workers conference called for self-organization within unions, support for the Anti-Racist Alliance (ARA) and more union help for black workers" (Ironside and Seifert, 2000:357). Black self-organisation within trade unions and Black Professional Associations are also linked to the emergence and influence of Black Sections in the Labour Party: "...Dianne Abbott acknowledged in a round-table discussion on LPBS [Labour Party Black Sections] that 'black sections must be seen in the context of the emergence of parallel demands for black sections in the unions'" (Shukra, 1998: 71). And scholar-activist Gus John (2018) refers to Black Professional Associations as the public sector equivalent of Black Sections in the Labour Party.

The emergence, following the 1980's riots in the UK, of a younger generation of Black activists and workers associated with the Labour Party Black Sections making greater inroads into local government and professional public sector roles (Shukra, 1998; Virdee and Grint, 1994; Virdee 2010, Virdee, 2014) began to prompt debates about emerging class differentiation within Britain's Black communities amongst an earlier generation of Black Radical Activists contesting what they perceived as a growing professionalization, incorporation and compromise to the British State within Black UK politics (Sivanandan, 2008; see also Shukra et al., 2004; Garbaye, 2005; Richardson, 2013). Thus John La Rose, contrasting the mainly low paid Black working class of the first generation of post-war 'New Commonwealth' settlers who fought the 'colour bar as racism' (Fryer, 2000; Ramdin, 1987) with an embryonic 'New Black Middle Class', in a *Race Today* article of 1987 states:

"As they worked in low-paid jobs these new black workers confronted the latent racism of their fellow workers...This was my own experience when I worked as a brickie's labourer and was elected by white workers as their shop steward...That is

how the new black working class built their independent organisations, their churches, their associations, their domino and cricket clubs... There is a difference in the way the new black middle classes have asserted their interests especially in the black sections controversy and in local councils. Most of them had not fought in the earlier battles of the low paid black working class though they might have heard about them or witnessed them... It should be clear by now that a new period in the history, politics and perspective of this new black social grouping within the general middle classes in British society has begun.” (La Rose, 2014:42-43)

In this context then, discussing the route from the initial Black Caucus model of Black self-organisation in trade unions (Carter, 1986; Virdee and Grint, 1994) to the Black professional associations and networks which now proliferate in the public sector, Shukra et al make an observation which brings to mind Grint and Virdee’s (1994) observations on the role of Black managers in their research on forms of semi-autonomous Black self-organisation linked to the workplace and trade unions:

“...black caucuses are accepted as a way of creating channels through which black perspectives on issues might be channelled. Hence the growing numbers of black staff groups and professional associations. Sometimes they are demanded by black workers but, increasingly, they are becoming institutional initiatives led by managers, employers or service providers as in the Black Staff Forums run by the London Borough of Lewisham.” (Shukra et al, 2004: 42)

And Shukra et al make reference to an “increasing professionalization of social movement actors... in the twenty-first century and their incorporation into mainstream political institutions” (Shukra et al 2004:43).

21<sup>st</sup> century Diversity Networks are often orientated towards managerial identities in a way that excludes non-managerial workers (Colgan and Mckearney, 2012; Williams and Yarker, 2017): in this regard BME Diversity/ Staff Networks where the membership profile asserts Black middle class professional identities, can perhaps be considered as part of an ensemble of collective organising ‘strategies’ for an emergent Black middle class in the UK (for example, see, Rollock et al, 2015). Rollock et al invoke Barack Obama’s presidency in their analysis of how the Black middle classes in a UK setting deploy specific ‘survival strategies’ to navigate and negotiate their ‘public identities’ within ‘public spaces’. Rollock et al, however, do not as per Stuart Hall (2017), in any way

‘name’ neoliberalism, relying instead on the idea of an aspiring Black middle class, referencing Bourdieu’s concept of ‘different forms of capital’ to account for transitions from a Black working class to middle class identity and status (Rollock et al, 2011).

In this regard, a ‘racial identity’ approach to Black politics, devoid of contending with the malign influence of neoliberalism on Black politics (Spence, 2016), as delivered by Rollock et al (2011), can be contested by reference to Yamahtta Taylor who, discussing “The Future of Black Politics’ in the African-American context states:

“The most significant transformation in all of Black life over the last fifty years has been the emergence of a Black elite...that has been responsible for administering cuts and managing meagre budgets on the backs of Black constituents. Today a layer of Black ‘civil rights entrepreneurs’ have become prominent boosters and overseers of the forces of privatization, claiming that the private sector is better suited to distribute public services than the public sector.” (Taylor, 2016: 15)

Similarly, Cornel West is explicit in his condemnation of the endorsement of neoliberal policies by Barack Obama and many in the US’s Black professional middle classes:

“So, just as precious Black poor people were crushed by predatory capitalism, our Black professional class has shifted from a discourse on poverty to one of diversity. Just as Black working people are pushed out of jobs and neighbourhoods, our Black politicians shift from talk about jobs with a living wage to talk of urban zones of gentrification and upward mobility.” (West, 2017: xxi)

Detecting similar neoliberal ideological trends within Black politics in the UK, Paul Gilroy castigates the group of Black activists who, rather than fighting for progressive political alternatives and against the ‘neoliberal turn in Black politics’ (Spence, 2016), have enlisted in facilitating the ‘neoliberal revolution’ via their promotion of race equality within the parameters of corporate diversity management:

“Neoliberal techniques of power, management and communication...They are deployed as part of a battle to control work processes and fatally to diminish the autonomy of working people. This position cuts against the achievements of a whole political generation of black community activists who have, with varying degrees of enthusiasm, accepted the privatisation of the struggle against racial inequality and hierarchy and begun to sell their expertise and insight in the form of consultancy services”. (Gilroy, 2016:50)



## **Black middle class or ‘state working class’?**

Discussing class differentiation in the context of the neoliberal restructuring of the British economy and society, Satnam Virdee makes a crucial intervention discussing the ‘professionalization’ of some racialized black and ethnic minority workers within the context of anti-racist and multi-ethnic working class struggle. Highlighting the major role black workers utilising semi-autonomous Black self-organisation within trade unions such as NALGO (now UNISON), in alliance with white trade unionists, black community activists and left wing councillors, have played in fighting for employment opportunities within the public sector and wider labour market, Virdee, states:

“Significantly, this process of self-organisation in trade unions around a racialized black identity was replicated across much of the public sector such that by the mid-1980’s other large public sector employers such as the Civil Service and the National Health Service (NHS) had followed suit and introduced equal opportunity and anti-discriminatory policies designed to encourage the recruitment and selection of racialized workers for administrative and clerical work.”

Thus for Virdee:

“...It was political struggle first outside the workplace, then within the workplace, especially within sympathetic trade unions and left-leaning Labour councils – that enabled racialized minority workers to penetrate and ultimately consolidate their position in non-manual state work and alter the long term position of some racialized groups in the employment structure in England.” (Virdee, 2010:84)

Similarly, Immanuel Ness, considering aspects of trade union decline linked to poverty and inequality, refers to higher numbers of people in trade unions in the public sector than the private sector, with a growing number of trade union members employed in managerial, professional or associate professional occupations (Ness, 2016: 51). It is then in this context that we are better able to understand the impetus behind the collective mobilisation of Diversity Networks within the public sector, such as the national and local NHS BME Networks with their membership and organisational programme focussed on progressing the race equality interests of predominantly ‘Allied Health Professionals’ – junior and senior managers and clinical staff at NHS Pay bands 5 - 7. Importantly, Virdee, notes the

continuing significance of structural racism upon these Black workers racialized as ‘outsiders’ (Virdee, 2014) within a capitalist labour market currently undergoing intense neoliberal restructuring. In this regard, Virdee provides a useful framework for understanding the relatively unstable position of an ‘emergent’ Black middle class (Savage, 2015; Rollock et al, 2011; Andrews, 2018), linked to the increase in and disproportionate numbers of Black workers subject to precarious and insecure forms of work alongside higher levels of unemployment in the UK labour market. In this regard, contesting narratives that over-emphasise ‘upward social mobility’, Virdee states:

“Even much of the racialized minority shift into non-manual or white collar work driven by the power of anti-racist politics built around a ‘black’ identity occurred in the context of the growing deskilling, routinisation, and therefore proletarianisation of such work such that it becomes more appropriate to speak of their growing representation in the state working class. Consequently, it would be a mistake to equate such social change with a change in their objective position in class relations. Instead the vast majority remain working class, albeit members of a very different working class to that of the 1960’s, with a small minority entering the petty-bourgeoisie and bourgeoisie.” (Virdee, 2010:88)

Another important issue then linked to Virdee’s analysis is the relatively recent decrease of Black membership within trade unions, linked to the disproportionate numbers of Black workers impacted by casualization, outsourcing, and increase in insecure and precarious employment. In their theoretical analysis of ‘Workplace Equality in Europe’ Anna Paraskevopoulou and Sonia McKay link “the decreasing membership in trade union density across Europe” to “the introduction of neoliberal policies” (Paraskevopoulou and McKay, 2015: 19). In the UK trade union density amongst Black workers has traditionally been relatively high, thus in 2018 the percentage of employees who were trade union members was highest in the Black or Black British ethnic group (27.1%) followed by the mixed ethnic group (24.3%) and the White ethnic group (23.8%) (Trade Union Membership Statistical Bulletin, 30 May 2019, Department for Business, Energy and Industrial Strategy). However, a conflicting and less upbeat picture reflecting the impact on Black workers of neoliberal aligned austerity, privatisation and outsourcing, which has

dovetailed with a surge in precarious and insecure forms of employment, is presented in the TUC's 2018 Equality Audit. In its section on 'Labour market diversity and trade union membership' the TUC's Equality Audit states:

“Density among Black or Black British employees has fallen substantially (to 24.1 per cent compared with 29.3 per cent...As the recent government Race Disparity Audit showed, employment rates are higher for white workers than for Black workers. TUC analysis has shown that Black workers are far more likely than white counterparts to be in insecure jobs, with those in temporary work less likely to be in unions.” (TUC, 2018)

Thus, the 2008 – 2018 period in which the National NHS BME Network emerged and in which activists within the Local NHS BME Network (launched in 2012) and UNISON Black Self Organised Groups have been organising to challenge racism in the NHS workplace corresponds with the period in which the TUC has recorded Black workers being disproportionately affected by casualization in the work place. Part of the fall-out from the 2008 recession has been the rise in insecure, precarious and casual working patterns, linked to temporary work, zero hour contracts and agency work. All of which feature in a NHS workplace marked by outsourced related divisions of a segmented two and three tier workforce, inscribed with BME and migrant divisions of labour (Wills et al, 2010). The TUC notes that while just 11 per cent of UK employees are from BME backgrounds, they hold 17 percent of temporary jobs and 21 per cent of agency jobs. And the TUC highlight that young Black workers are disproportionately affected by precarious work with 15.2 per cent of young BME workers in non-permanent jobs compared to 8.4 percent amongst young white workers (TUC, 2015a).

By 2019 the cumulative impact of austerity policies, privatisation, outsourcing and restructuring of the Labour market, resulting in Black workers being “far more likely to be trapped in insecure work”, was again highlighted by TUC analysis of ONS Labour Force Survey, which revealed that of the 3.9 million BME workers in the UK, they are:

“More than twice as likely to be stuck on agency contracts than white workers.”

“More likely to be on zero hours contracts - 1 in 24 BME workers are on zero hours contracts compared to 1 in 42 white workers.”

“1 in 13 BME workers (264,000) are in temporary work, compared to 1 in 19 white workers.”

“Many Black workers are working in temporary and zero-hours jobs where pay is typically a third less an hour than for those on permanent contracts.”

(TUC, 2019)

Thus it is against this backdrop of Black workers’ subject to systemic discrimination in the UK labour market that UNISON Black SOG and TUC Black Workers activists are attempting to increase recruitment of Black workers into trade unions, including via community organising approaches that engage with Black and migrant workers employed in outsourced services subject to precarious and insecure work and less favourable terms and conditions.

### **‘Groundings with my sisters and brothers’ – race, gender and class**

In its 2010/11 Operating Framework the national NHS BME Network invoked Barack Obama in its organising slogan of ‘Hope, Change and Bottom Up’ as its approach for delivering race equality in the NHS workplace, (NHS BME Network, 2010), in this regard, Horace Campbell informs us that:

“Barack Obama...has been hailed as the first community organizer who brought the skills of bottom-up political organizing to the national stage in order to win power in electoral politics” (Campbell, 2010:1)

From its launch in 2010 to 2018, when the activities of the national NHS BME Network appeared to cease, the NHS BME Network’s Chair and leader was a Black professional woman, employed in a senior management position within her own local NHS Trust, who had spearheaded the BME South Coast Network Race Equality Review. In this regard, as an independent national BME Diversity Network campaigning for race equality in the NHS, the NHS BME Network set out its ambition to support the development of affiliated local NHS Networks, thus:

“We will continue our groundings with our sisters and brothers to maintain their respect and stay grounded in their reality. This is the source of our legitimacy and the driving force for all our efforts.” (NHS BME Network 2010:9)

In this context ‘a bottom-up’ approach is more of a reference to an instrumental spatial-geographical relationship between the national NHS BME Network and the local regions than to a grass-roots, frontline or outreach connection with those workers employed, increasingly in fragmented-outsourced services on the lowest NHS pay bands at the bottom of the NHS occupational hierarchy.

Ironically, by referring to “groundings with our sisters and brothers” the NHS BME Network is invoking the legacy of Guyanese Marxist Historian Walter Rodney, whose key texts ‘Groundings with My Brothers’ (1969); ‘How Europe Underdeveloped Africa’ (Rodney, 1981a); and ‘A History of the Guyanese Working People’ (1981) are classic works within the ‘Black Radical Tradition’. Hence, Manning Marable’s ‘How Capitalism Underdeveloped Black America’, written in the tradition of Walter Rodney, has its third chapter entitled “Groundings with my Sisters: Patriarchy and the exploitation of “Women”” (Marable, 1983:69). In addition, it must be asserted here that, drawing on Black radical feminist critiques (Davis, 2016; Combahee River Collective, 2017) Marable’s own ‘groundings’, unlike the NHS BME Network’s single-axis race equality ‘organising principle’, asserts the intersection of race, class and gender as developed in his chapter entitled ‘Groundings With My Sisters: Patriarchy And The Exploitation of Women’ to counter “capitalist patriarchy’s ideological hegemony over the future struggles of all Black working people” (Marable, 1983:70).

In this context, rather than signalling alignment with Walter Rodney and Manning Marable’s Black working class orientation, the NHS BME Network’s ‘groundings with our sisters and brothers’ reference can be linked to Rollock et al.’s investigation of constructions of Black middle class identities and strategies deployed in public spaces by relatively privileged but still racialized Black professionals in the UK, where they state:

“Middle-class Black people also carry out what we think of as *authenticity-signalling work* to let other Black people know that, even though they are sending one set of messages to Whiteworld (to gain acceptance and inclusion and to indicate their difference from working-class Blacks)... They have not been entirely subsumed by this dominant ideology (and their enactments of it) and hence forgotten their Black roots and identity.” (Rollock et al, 2015:150)

And in this respect, BME Diversity Networks’ links to forms of racial identity politics which erase class stratification (Marable, 1983; Marable, 2009; Haider, 2018; Taylor, 2016; West, 2017) even whilst deploying the rhetoric of a ‘bottom-up’ approach to eliminating racial discrimination in the NHS, can be problematized when viewed through a race, class and gender lens of analysis, as applied by the aforementioned scholars within the Black Radical Tradition (Davis, 2016; Combahee River Collective, 2017; Taylor, 2016; Rodney, 1969; Robinson, 2000; Marable, 1983), by examining the extent to which claims of ‘bottom up’ ‘groundings with our sisters and brothers’ in reality embrace and are inclusive of those workers based at ground floor level of the NHS occupational hierarchy. In this regard it is argued here that BME Diversity Networks, whether independent and self-organised like the NHS BME Network, or employer/HR organised, where they are aligned to a corporate diversity management discourse which focuses on selective ‘talent management’ for senior leadership and ‘breaking glass ceilings’, can only make claims to a provisional, selective and instrumental form of ‘bottom-up’ organising. These functional relationships are encapsulated within forms of workplace mobilisation which privilege ‘professional managerial identities’ and ‘professional status’, expressed in terms of increasing ‘diversity in BME senior leadership roles’, e.g. ‘The NHS Breaking Through Programme’, and whilst this approach does provide a degree of political leverage in the fight against under-representation of Black workers in senior positions within institutions like the NHS, by focusing exclusively on ‘glass ceilings’ and ‘snowy white peaks’ it can also relegate, side-line, and even ignore the urgent need for race equality for the already marginalised lower band, lower paid Black working class and BME migrant workers, often working in privatised and outsourced areas of the NHS subject to insecure and precarious

employment with worst terms and conditions, including lack of access to promotion and training opportunities, and often subject to the worst forms of bullying and harassment in the workplace (Berrey, 2014; Acker, 2009; Arruzza et al., 2019).

In this regard the critique of the ‘professional–managerial stratum’ presented by the authors of ‘Feminism for the 99%: A Manifesto’ is also relevant here, for race, class, and gender considerations of social justice which seek resistance to, rather than accommodation within, the prevailing system of capitalism that gives rise to structural racism:

“Dedicated to enabling a smattering of privileged women to climb the corporate ladder...it propounds a market-centred view of equality that dovetails perfectly with the prevailing corporate enthusiasm for ‘diversity’. Although it condemns ‘discrimination’, liberal feminism steadfastly refuses to address the socioeconomic constraints that make freedom and empowerment impossible for the majority of women. Its real aim is not equality but meritocracy. Rather than seeking to abolish social hierarchy, it aims to ‘diversify’ it, empowering ‘talented’ women to rise to the top. In treating women simply as an ‘under-represented group’ its proponents seek to ensure that a few privileged souls can attain positions and pay on a par with the men of their own class...Everyone else remains stuck in the basement.”  
(Arruzza, et al., 2019:11)

### **Mary Seacole and Black women’s activism in the NHS.**

In 2016 the BBC film documentary ‘Black Nurses: The Women Who Saved the NHS’ (2016), in its depiction of the contributions of Caribbean and African migrant nurses to the building of the NHS since its inception in 1948, via archive film footage and personal narrative, concluded with the 2016 unveiling of the Mary Seacole Memorial Statue in the grounds of St Thomas Hospital, London. The first memorial statue of a named Black woman in the UK, the statue of the 19<sup>th</sup> century Jamaican nurse who came from ‘the colonial periphery to the metropolitan centre’ (Ramdin, 1987) to care for wounded British soldiers during the Crimean war, the significance of the 12-year campaign to erect the statue is encapsulated in Ramdin’s comment in ‘The Making of the Black Working Class in Britain, that:

“While her struggle reflected the oppression of women generally in the nineteenth century. She was the precursor of an exodus of...black nurses who came to serve Britain in the twentieth century only to realize the harsh reality of race and colour prejudice.” (Ramdin, 1987:35)

In this regard, Black women activists within UNISON (and to a lesser extent the RCN, and RCM) were instrumental in raising awareness of the Memorial Statue Appeal via UNISON National Black Members Conferences, Regional Black Members Groups, alongside organising donations from local UNISON Branches. Similarly, it was a Black woman UNISON activist who initiated the successful Operation Black Vote online petition signed by over 36,000 people in 2013 to have Mary Seacole restored to the National Curriculum, forcing Tory Education minister Michael Gove to backtrack on previous plans for her (and Olaudah Equiano’s) removal from a curriculum already devoid of Black history (OBV, 2013). It is in this context that scholar Kenetta Hammond Perry (author of ‘London is the Place for Me: Black Britons, Citizenship and the Politics of Race’, 2015), makes reference to the honouring of Mary Seacole with a statue in her ‘Sex, Race and Class’ discussion of the archive resource that is the recently published Race Today Anthology, which documents:

“...how Black women have made sense of the ways in which the gendered processes of racialisation have shaped dynamics within the working classes.” (Hammond Perry, 2019:70)

In this regard, in documenting the first and second generations of Black and Asian women’s employment in the NHS, largely as auxiliaries or State Enrolled Nurses – “a qualification which cannot lead to promotion” (Hammond Perry, 2019:74) – rather than the higher status State Registered Nurse, the Race Today article ‘Black Women and Nursing: A Job Like Any Other’ (‘Black Women and Nursing’, 1974) highlights the NHS’ historic dependence on recruiting “Overseas nurses as cheap labour”: “The number of overseas student nurses coming into the British health service increases rapidly each year” (Hammond Perry, 2019:73). Similarly, another archival resource also recently republished:



‘The Heart of the Race: Black Women’s Lives in Britain’, refers to the ‘Triple Oppression’ of Black women workers and their location within NHS hospitals and employment “at the base of the pyramid” (Bryan et al, 1985:45). Thus the contemporary features of today’s multi-ethnic and ‘super-diverse’ NHS workforce – approximately 153,000 out of 1.2 million staff, 13.1% are non-British (Baker, 2019) – is overlaid on previous patterns of occupational hierarchies, segmented workforces and migrant divisions of labour, linked to race, class and gender:

“Labour in the hospital is organised according to sex, race and age. Different jobs are done by people in different uniforms, getting different wages, and having different degrees of power. Those who work the hardest have the least status and the least wages. These divisions are reinforced by the division between those who are ‘professionals’ and those who are not.” (Hammond Perry, 2019:73-74)

## **Eleanor Smith**

In 2011, Eleanor Smith, a Black working class nurse with over 40 years’ service and a trade union activist, was voted the first Black president of UNISON. Discussing the relevance of the Stephen Lawrence Inquiry for subsequent policies to tackle racism in the NHS, in an interview with the Health Service Journal, Eleanor Smith stated:

“The Stephen Lawrence case and institutional racism was a wake-up call to everyone...the equality agenda was then put on the table and they introduced these leadership schools...” (Gbadamosi, 2014)

However, for Eleanor Smith based on her everyday lived experience as a senior Black nurse of ‘unfair grading systems’ which consign NHS BME and migrant workers to the lower end of the pay scale, corporate diversity management leadership programmes and courses have not proved effective for delivering race equality in the NHS workplace (Smith,2014), but are instead implicated in reproduction of ‘ethnic hierarchies’ and ‘inequality regimes’ (Acker, 2006) within the occupational systems and processes of the diverse and multi-ethnic 21<sup>st</sup> century NHS.

In 2017 Eleanor Smith was voted Labour MP for Wolverhampton South, the seat once held by Enoch Powell, whose ‘Rivers of Blood’ speech Eleanor Smith remembers prompted her parents to recall how the politician calling for repatriation of Black workers had led the early recruitment drive for ‘Windrush Generation’ Black workers to join the NHS (UNSON, 2017). In 2018 Eleanor Smith rose to the race and class challenge of linking race equality to social justice as advocated by Colin Prescod in his keynote conference speech to the national NHS BME Network in 2011, in which applying Stuart Hall’s analysis of the ‘Neoliberal Revolution’ to the impact of austerity on the NHS, Prescod highlighted the need to be - “concerned about ‘public health’ in capitalist culture... ‘public health’ which involves a broader concept of what constitutes our national health.” (Prescod, 2011).

Highlighting that for her the ‘political will’ to effectively challenge racism in the workplace and wider society requires a race and class approach to achieving social justice, Eleanor Smith presented the NHS (Reinstatement) Bill (Parliament, House of Commons, 2018) in the House of Commons in July 2018. The bill sought to restore proper funding for the NHS, with a return to its ‘public service ethos’, and an end to privatization, outsourcing and Private Finance Initiatives. It was only three years earlier in 2015 that Sam King, (the co-founder of the Windrush Foundation) who had arrived from Jamaica on The Empire Windrush in 1948) had joined NHS England Chief Executive Simon Stevens to launch the NHS Workforce Race Equality Standard. Yet, by 2018, the state racism of the 2014 immigration Act and its ‘hostile environment’ policies entered public awareness in the form of the ‘Windrush Scandal’, which had led to ‘Windrush Generation’ Black British citizens, being denied access to NHS services (in which they had previously been employed) resulting in loss of jobs, income and housing; deportation; and in some cases loss of life. The state racism of the ‘hostile environment’ resulted in “signs in hospital waiting rooms declaring the ‘NHS is not free for everyone’ highlighting limited access to ‘universal healthcare for some migrants.” Jones et al, 2017:13). It is in this context, that Eleanor

Smith's NHS Reinstatement Bill called for the removal of imposed charges on migrants to access the NHS. In its opposition to neoliberal ideologies, the NHS Reinstatement Bill is an example of a type of social justice politics that seeks to 'reverse' forms of 'common sense neoliberalism' unleashed since the period of Thatcherism in which: "Thatcherism aimed for a reversal in ordinary common sense" (Hall, 1998:164).

### **'Black vernacular neoliberalism' as 'common sense'**

In exploring the hypothesis that BME Diversity/Staff Networks can be seen as more effective collective voices for promoting race equality in the workplace for Black workers and BME professionals, the key thread throughout this theoretical enquiry has been a sharp scepticism towards the notion that racial identity politics informed approaches that erase class stratification whilst privileging professional middle class identities can effectively challenge the structural discrimination and inequalities that are reproduced within racial capitalism. Where BME Diversity/Staff Networks adhere to corporate diversity management discourses promoting the business case for equality and diversity, this theoretical enquiry argues that in their accommodation of and alignment with rather than resistance to neoliberal ideologies, BME Diversity/Staff Networks help to perpetuate forms of 'common sense neoliberalism'. Noting this corporate diversity management influenced conformity to the 'neoliberal revolution via forms of what he calls "Black vernacular neoliberalism"', Paul Gilroy states:

"It is not possible to disassociate these historic developments from the entrenchment of the neoliberal habits and styles of thought that operate spontaneously as a kind of common sense and institutionally as a mode of governmentality." (Gilroy, 2016:35)

It is then in this context that this theoretical enquiry states its preference for a Black Radical Tradition aligned approach to advancing race equality via engagement with a race, class and gender accented resistance to rather than accommodation of neoliberal capitalism, as set out by Manning Marable:

“We should assume, what Antonio Gramsci often called the ‘long view’ of socialist transformation.... socialism... must ...become the commonsense of the working class, the brown and black populations and critical elements of the petty bourgeoisie” (Marable, 1983: 16)

Thus for Stuart Hall and Alan O’Shea making ‘good sense’ social justice arguments for policies like the living wage as part of waging ideological struggle with what they term “common sense neoliberalism” is imperative (Hall and O’Shea, 2013:23).

It is then in this context that this theoretical enquiry contends that ideologically challenging the ‘common sense neoliberalism’ of corporate diversity management approaches to delivering race equality in the workplace, from a race and class perspective aligned to a Black Radical Tradition critique of racial capitalism, is a pre-requisite for progressive anti-racism in the 21<sup>st</sup> century. In this regard, Stuart Hall, like Manning Marable highlights the relevance of Gramsci’s application of Marxist theory for challenging racism in the contemporary workplace and wider society:

“He thus helps us to understand one of the most common, least explained features of ‘racism’: the subjection of the victims of racism to the mystifications of the very racist ideologies which imprison and define them. He shows how different, often contradictory elements can be woven into and integrated within different ideological discourses; but also, the nature and value of ideological struggle which seeks to transform popular ideas and the ‘common sense’ of the masses. All this has the most profound importance for the analysis of racist ideologies and for the centrality, within that of ideological struggle.” (Hall, 1996: 440)

## **Conclusion**

This chapter has engaged with a Black Radical Tradition theoretical analysis to investigate the research hypothesis. The theoretical concept ‘racial capitalism’ was linked to Black Self-Organised resistance to racism, colonialism and imperialism in Britain. The chapter considered promotion of race equality in the workplace and anti-racist activism within the context of the ‘neoliberal revolution’ which has inflicted severe austerity cuts on public sector services and impacted disproportionately on Black workers. It is in this context that in investigating the research hypothesis the chapter applied the concepts of ‘common sense neoliberalism’ (Hall and O’Shea, 2013) linked to ‘Black vernacular neoliberalism’ (Gilroy,

2016) and the ‘neoliberal turn in black politics’ (Spence, 2016) as a means to theoretically contest promotion of race equality in the form of neoliberal aligned diversity management discourses which privilege professional-middle class identities and erases class stratification.

## **Chapter 4 Methodology**

This chapter outlines the qualitative analytical approach and research methods deployed in this thesis, based on a social constructionist approach which incorporates Marxist perspectives drawn from the Black Radical Tradition critiques of racial capitalism.

Recognising the importance of critically engaging with issues of class stratification within anti-racist politics in a period marked by a neoliberal turn in Black politics, the research philosophy draws on the Black Radical Tradition's analytical approach to investigating forms of collective 'resistance and accommodation' to racism that are imbued with intersections of race, ethnicity, gender, and class.

This chapter provides details of the research strategy use of case studies of the local UNISON Black SOG and the local NHS BME Network, sampling design and use of qualitative semi-structured interviews. The use of thematic analysis for data interpretation has also been explained along with ethical issues including researcher positionality.

The second part of the chapter sets out the case studies of the two organisations collectively organising to challenge racism in the NHS workplace. Located within the institutional setting of a local NHS Trust, the two case study organisations were chosen on the basis of the high level of activism around promoting race equality in the workplace via their respective structures and membership. Using the case study approach for both organisations assists in investigating the hypothesis that BME Diversity Networks may be seen by BME workers as being more effective collective voices than UNISON Black SOGs for promoting race equality in the workplace.

### **Research philosophy and approach**

A social constructionist approach, which is geared towards gaining understanding and meaning around the subjective experience and the lived reality of BME workers collectively mobilising and challenging racism within the institutional setting of the NHS,

underpins the research philosophy of this thesis. Application of an interpretative approach that can facilitate enquiries into “culturally derived and historically situated interpretations” of social relations (Crotty, 2010:67) to Black self-organisation within trade unions and BME professional associations and networks which emerged historically in the UK during the 1980’s is also central to the research philosophy of this thesis. In this regard an interpretive approach can facilitate description of variation, capture individual experiences, highlight relationships and outline group norms (Berg, 2007).

### **Race as a social construct, racisms and racialisation**

Race as a category or idea is approached in this thesis as a social construction, rather than natural or biological fact, which has social and economic, material, structural and symbolic effects, with race as a category being embedded within social institutions, discourses and practices (Patel, 2017; Garner, 2010; Quraishi and Philburn, 2015; Brah, 1996).

Deployment of the socially constructed idea of race can be linked historically, politically and economically to the concept of racism defined by Garner as a “social relationship” “where there is an imbalance of power” (Garner, 2010:5). Racism is also linked to notions of superiority and inferiority based on apparent racial characteristics, including skin colour, between different groups of people, by which “negative and detrimental constructions about particular people are created and maintained” (Quraishi and Philburn, 2015:13). In this regard the concept of racialisation is used by scholars such as Miles (1993) to investigate social, economic, cultural and ideological processes which “construct differentiated social collectivities as races” (Miles, 1989:79, quoted in Meer, 2014:126). As racialised BME workers, participants within the UNISON Black SOGs and the NHS BME Network relate to each other in terms of their racialisation providing the basis for anti-racist ‘group solidarity’ (Garner, 2010:22). In this regard, Virdee has highlighted historically in the British context how, in relation to dynamics of race and class, racialised minorities through anti-racist politics and black self-organisation during the 1980’s

effected a real transformation for BME workers within public sector employment and inside the British Trade Union movement (Virdee, 2014:155). Given this thesis' interest in the use of history to 'reframe' narratives around racism, the research approach used is aligned with Denzin and Lincoln's (2000) advice to situate qualitative research in its complex historical field.

Similarly, as a key aim of this research was to gain insight into the perceptions and subjective everyday lived experience of members of the NHS BME Networks and UNISON Black Self-Organised Groups in relation to processes of racialisation, qualitative research methods were deployed to enable access to a "plurality of perspectives", and "multiple truths" as described by Quraishi and Philburn in relation to researching issues of race, racism and racialisation (Quraishi and Philburn, 2015: 65).

## **Research strategy**

The purpose of this research is to explore how BME workers are resisting racial discrimination and pursuing race equality in the workplace through their collective mobilisation within UNISON Black SOGs and within a local NHS BME Network affiliated to an independent national NHS BME Network. This research also sought to explore how people with different social identities attach meaning to and understand ideas of race equality, anti-racism and social justice. In this context the research has utilised case studies of UNISON Black SOG members participating in a local UNISON Health branch SOG. These research participants were also active in their local UNISON Regional Black Members Group and National Black Members Conference. A case study of BME members active in their local NHS BME Network affiliated to the national NHS BME Network was also conducted. Research participants in both case studies were interviewed in two phases: from 2012-2015, reflecting the period of the Lansley 'Reforms of the NHS' and shift to the 2010 'Single Equality Act', mirrored by the policy implementation of the NHS Equality Delivery System 2; and a second 2015-2016 phase when the NHS WRES policy was first



implemented. In relation to the purpose of this research, a case study approach was identified as useful and appropriate for gaining understanding of “the complex relationship between factors as they operate within a particular social setting” (Denscombe, 2010:5).

## **Research design**

### **Qualitative research**

An interpretive approach to exploring social action can be facilitated through applying qualitative methods engaging with verbal accounts, and an inductive approach with data collection informing the development of theory and concepts. Qualitative methods and interpretive forms of enquiry such as qualitative interviews and engaging with documentary records are useful for drawing attention to meaning in relation to contexts and settings, with events presented from the viewpoints of those involved (Robson, 2011:19), highlighting participants’ own meaning and understanding of issues. Making use of semi-structured interviews where, alongside specific questions, the interviewer has the flexibility to probe past the response and engage in dialogue with the interviewee, who can expand on points of interest, can assist understanding of how interviewees construct and attach meaning to social action (May, 2011:134-135). Comparison is facilitated by engaging with a number of semi-structured interviews, providing multiple perspectives and multiple factors that can furnish, in regards to researching race and racism, more depth and a richer understanding of intersecting categories of race, ethnicity, gender and class in relationship to subjectivity and everyday lived experience (Quraishi and Philburn, 2015:60). In particular, and a key factor for this thesis, semi-structured interviews “bring human agency to the centre of ...analysis, and they generate representations that embody the subjects’ voices” (Blee and Taylor, 2002:96).

Documentary sources of data such as publications by trade unions, race equality organisations, government reports, official statistics and documents from websites are also useful in qualitative research, and have been utilised as secondary sources of information

and data in this thesis. An advantage of utilising secondary-documentary sources is the ability to access large amounts of data fairly easily. Overall, qualitative research methods are useful for acquiring rich data which encompasses depth and accommodates nuance, contradiction, ambiguity and the complexity of social interaction within real life situations and specific settings. In terms of the disadvantages of qualitative research, factors to consider in relation to this thesis include issues around representativeness and the degree to which findings can be generalised in the same manner as statistical generalisability provided by quantitative methods' use of numerical data, as in questionnaire surveys. In this regard the qualitative research method used in this thesis has engaged with multiple viewpoints within a context –specific reality.

In terms of a qualitative research approach, an acute awareness has been exercised in relation to the role and identity of the researcher linked to the construction and interpretation of data, often warrants more consideration than with forms of quantitative research. A disciplined exercising of this awareness can help to facilitate more objectivity and distance between the researcher and research participants (Robson, 2011:19). In addition, an awareness has been cultivated for the purposes of this qualitative research of the ways in which the identity of the researcher risks inadvertently changing the context of meaning in the course of coding and categorising data, and oversimplifying explanation by avoiding ambiguity and alternative explanations (Denscombe, 2010:305). In the context of this thesis, qualitative semi-structured interviews, were particularly deemed useful in relation to research on race and racism for facilitating access to a “plurality of perspectives” linked to the idea of “multiple truths operating around race and racism” (Quraishi and Philburn, 2015:65). And, in this regard it is useful to note Essed's research/methodological approach to her concept of ‘everyday racism’ which required listening “first to what ethnic minorities had to say, to explore through probing and questioning what life felt like in a white-dominated society” (Essed, 2004:125). In this

context a qualitative approach can assist in foregrounding the agency of BME workers collectively organising to resist racism experienced within institutional settings and via everyday discourses and practices.

### **Case study as research strategy**

The research strategy utilised multiple sources of evidence, including qualitative semi-structured interviews with 23 research participants, three of whom were key informant interviewees. Collation of archival documents and conference reports were also used as secondary documentary sources of information. According to Yin (2009), such use of multiple sources of evidence enables the potential for more detailed and in depth understandings and meanings of subjective experience, which can be aided by the preparatory use of theoretical propositions to steer data collection and analysis. The research strategy utilised here bore in mind Yin's suggestion that that a "two-case" case study may make for stronger research (Yin, 2009: 60-62). Recognising the NHS BME Network and UNISON Black Self-Organised Groups as complex and diverse entities, the boundaries of the two case studies were: a study of UNISON Black SOG members participating in a local UNISON Health branch SOG – these research participants were also active in their local UNISON Regional Black Members Group and National Black Members Conference; and a case study of BME members active in their local NHS BME Network affiliated to the national independent NHS BME Network.

### **"Two-case" case study**

As a "two-case" case study (Yin, 2009), the research was conducted to gain a particular view and in-depth analysis of the relationships, anti-racist strategies adopted, and processes at play within the local NHS BME Network and local UNISON Black Self-Organised Groups, in accord with Flyvbjerg's view that development of knowledge can occur without formal generalisation or notions of representativeness (Flyvbjerg, 2006:227). By comparing and analysing members' perceptions and perspectives on NHS equality,

diversity, and inclusion policies and processes, utilising the case study approach, this research has been able to gain insights from the similarities and differences within and between both forms of collective BME mobilisation seeking to promote race equality and challenge racism within the embedded institutional setting of a local NHS Trust. The approach adopted in this thesis accords with Yin's preference for "two case" or multiple case designs over a single case on grounds of the potential to increase the research's theoretical and analytical benefits (Yin, 2009). In addition, adoption of a "two-case" or multiple case study approach also facilitated comparison as a means to highlight difference rather than attempt to produce representativeness (Perry, 2011). The case study approach is recognised, for its usefulness in facilitating in-depth "understandings of cases as cultural systems of action" encompassing nuance within complex social situations (Snow and Trom, 2002:163). However, the disadvantage of not being able to generalise from case study findings as with quantitative approaches, alongside potential subjective-researcher bias encouraging verification, are long standing criticisms that require attention. In this regard, the case study approach utilised for this thesis has been mindful of the approach to establishing rigour in case studies outlined by Flyvbjerg, who highlights that diligent case study practice and learning within real life situations often results in "a greater bias towards falsification of preconceived notions than towards verification" (Flyvbjerg, 2006:21). And in this vein, in applying a case study approach for this thesis, awareness in the context of research on race equality and anti-racism has been exercised around the analytic potential for "theoretical generalization – extension and refinement" (Snow and Trom, 2002:164-165).

### **Sampling design**

A non-probability sampling approach was used for this research, combining judgemental-purposive sampling and snowball sampling methods. Purposive sampling was the main sampling approach used to facilitate access to participants according to their experience,

knowledge and potential to provide insights and understanding on the research topic. In this context sampling for this thesis was directed by “theoretical considerations...Sampling choices reflect the underlying questions and theories guiding the research and the emergent understandings garnered in the study” (Blee and Taylor, 2002:100). Attention was paid, in relation to selection of potential research participants, to the idea of ‘similarity’ and ‘dissimilarity’: “to see how the interpretations or accounts of similarly situated respondents compare” (Blee and Taylor, 2002:100). A supplementary snowball sampling approach of participants referring to other potential participants with particular characteristics of ethnicity, gender, age, and occupation, complements purposive sampling (Denscombe, 2010) and is also applicable to networks of people (Kumar, 2011; Gilbert, 2008) and thus known contacts within the NHS BME Network and UNISON Black Self Organised Group were approached to commence the snowball sampling process. The sample size of 23 research interviewees was based on the qualitative research principle that the sample size should “be large enough to gather the data that you require” (May, 2011:102).

### **Semi structured interviews**

A total of 23 semi-structured face to face qualitative interviews lasting approximately 45 – 60 minutes were conducted on the basis of diverse categories of age, gender, ethnicity, occupation and NHS band/grade. In terms of occupation, the participants interviewed, alongside BME Nurses, were ancillary support workers and allied health professionals and non-medical staff with different roles and NHS occupational grades including hospital porters, administrators, senior managers, Equality and Diversity Leads, Equality and Diversity Officers and Health Advocates working with diverse patient groups and communities. Three key research informants were also interviewed, including a senior retired BME nurse/health academic and two senior BME trade union representatives. The research participants were interviewed in a space designated as safe, comfortable and relaxing by them, and the interviews were tape-recorded and fully transcribed.

## **Data analysis - thematic analysis**

As part of a qualitative analytical approach linked to a social constructionist epistemology, the data analysis for this thesis was conducted via thematic analysis, which provides a flexible and clear, step by step approach to finding patterns and themes across a complex data set (Braun and Clarke, 2006). For this thesis the first step of thematic analysis involved immersion in the data through reading and re-reading the data several times, accompanied by keeping memos and notes of ideas on significant terms and phrases encountered in the data to clarify thoughts in the research process and plan further research actions.

### **Thematic coding**

An inductive coding method was used as part of an iterative ‘zig-zag’ approach to data gathering and analysis, with initial thematic coding informing further data gathering and feeding in of new themes, in turn assisting the refining of thematic coding. Manual hand coding was applied for the initial thematic coding, supplemented by use of NVivo software to facilitate data management and collation of codes into categories and themes. The long list of codes acquired through this process were then grouped and developed into analytic categories with constant comparison of data within each category and across all categories. In this regard Rivas notes: “Constant comparison of a gradual trickle of data ensures that your interpretations remain grounded in the data” (Rivas, 2012:376). Techniques used to identify themes from categories included looking for ‘similarities’ and ‘differences’, repetition of topics, ‘indigenous categories’ used by the research participants in contrast with the categories used by the researcher, and theoretical issues and concepts underlying the research questions (Robson, 2011:482) were reflected on as prompts for possible themes, e.g. applying the theoretical concept of racial capitalism to interpreting issues around structural and systemic racism and being mindful of intersectional approaches to race, class, ethnicity and gender as mutually constitutive categories of analysis and

connection, privilege and subordination within interlocking systems of power (Hill Collins, 2013:213-230).

### **Key Thematic categories**

By applying a thematic analysis process that followed a step by step, six stage process, as outlined by Braun and Clarke (2006), with the review and defining of key themes linked to sub themes the development of thematic maps helped compare and establish the links and patterns between themes. This process was then continued to obtain more precise definition of main themes in relation to the data. Fourteen recurring themes were transposed to an initial thematic map of seven main themes with related sub-themes. This was then refined to a thematic map containing four main themes with corresponding sub themes (see Appendix 9). The four key themes developed through this thematic analysis and thematic coding process are:

- A. Diversity
- B. Racism
- C. Inclusion
- D. Exclusion

### **Rigour**

An ‘audit trail’ (Robson, 2011:59) and “chain of evidence” (Yin, 2009:122) for this research includes interview transcripts, field and case study notes, data records, memos and documentary evidence. Key criteria for establishing and assessing rigour, reliability and validity for qualitative case study research, (Creswell, 2009; Denzin and Lincoln, 2011; Stake, 1995) were adopted, including: triangulation; member checking; rich, thick description; noting researcher bias, and inclusion of contradictory evidence. In this context the research strategy noted Macdonald’s (2008) viewpoint that triangulation of research strategies is central to achieving both internal and external validity in the whole research process. In this context, data triangulation included evaluation of NHS England

quantitative data on BME workers in the NHS, including NHS England Workforce Race Equality Standard quantitative data. In relation to the criteria established by Guba and Lincoln (1994) for assessing validity and reliability in qualitative research, ‘credibility’ from the viewpoint of the research participants can be ascertained to some extent by sharing the findings with the participants to gauge the degree of validation and confirmation. An audit trail, as noted above, linked to a record of key steps taken and decisions made during the course of the research process can enable ‘dependability’ and help establish ‘confirmability’ or corroboration by other researchers.

### **Research ethics**

Full University ethics approval for this research was received from London Metropolitan University’s Ethics Review Committee in 2012. Following University ethics approval, correspondence explaining the purpose of the study and research aims was sent to the chairperson of the local NHS BME Network and the local UNISON Black SOG Officer, along with the Chair and Branch Secretary of the local UNISON Health Branch to which the local Black SOG belonged. Following agreement on contacting members, potential research participants were contacted and provided with relevant information about the research study. In addition, local NHS Trust and NHS Commissioning Managers were also informed of the research study purpose with the nature of consent and participation explained.

### **Confidentiality and anonymity**

A summary of the research aims and objectives, description of the approximate length and nature of semi-structured interviews, to be conducted at a time convenient to and in a safe and comfortable place of the research participants’ choosing, was provided in the information given to the research participants. In addition, information about assuring confidentiality was included, which explained that confidentiality will be respected, and personal data will be anonymised, thus the names of the research participants quoted in this



thesis have been changed and their workplace location unstated. The protection of personal data included password access to files to prevent unauthorised access, with personal data stored on a stand-alone PC and not connected to a network or internet. Information was also provided about data storage in adherence with the requirements of the 1998 Data Protection Act, with contact detail sheets and personal data stored in a locked cabinet. Assurance that disposal of anonymous data will take place after a suitable time period as stipulated by the Data Protection Act 1998 was also provided (the General Data Protection Regulation was implemented in 2018, after the data collection phase – the arrangements already in place are compliant with this new Regulation). Thus, in relation to research ethics, Ali and Kelly note that “informed consent is considered the ideal in terms of respecting the autonomy of the potential research participant” (Ali and Kelly, 2012:67). In this context, informed consent was sought in writing from the research participants, with assurance set out that people could stop participating at any time if they so wish. Information was also provided on how any research findings are to be disseminated, with research participants offered a summary of the research findings and the main findings of the research study presented via a project seminar.

### **Ethical guidelines: insider-researcher approach**

A key ethical consideration throughout the course of conducting this study was researcher responsibility to ensure research participants were not adversely harmed or affected in any way by their involvement in the research. In particular, as an activist member of UNISON Black SOG structures, and a BME NHS worker interacting with members of the NHS BME Network, I was sensitive, in relation to researching issues around race and racism, of having to consider and think through “the possibility that the research experience may be a disturbing one” (Quraishi and Philburn, 2015:129), depending on a range of factors including power dynamics linked to occupational status and hierarchies within particular organisational settings and professional contexts. Furthermore, in relation to questions of

‘power’, ‘politics’ and ‘privilege’ linked to the motives and purpose of the researcher, and underlying the research, ethical consideration of the issue highlighted by Costley et al was a constant feature of the research process:

“researchers must look inward to see what they are personally trying to gain from the research and how are they using the subjects to achieve this” (Costley et al 2010:39)

In addition, awareness of the “key power dynamics and forms of relationship” within the research interview process were noted from an ethical standpoint, including how as a form of instrumental dialogue “the interview is an instrument for providing the narratives and texts needed for research goals and interests” (Costley et al, 2010:42).

## **Challenges**

A key challenge throughout the course of this research as an insider-researcher in relation to knowing colleagues within the local NHS BME Network and being known as an activist within the local and regional UNISON Black SOGs was handling the tensions and sense of being within and moving between two camps. Part of the tension in this regard stemmed from my own sense embeddedness within UNISON, whose local and national leaderships at the time of this research I believed viewed the emergence and existence of BME staff networks in the NHS as a situation undermining of the workplace joint committees of unions and management, linked to collective bargaining processes. In this context, being sensitive to some UNISON Black SOG members’ ideas that BME Staff Networks were an employer-led concept, with networks outside of UNISON’s own Black self-organised tradition not worthy of consideration, was necessary. The flip-side of this was hearing and being aware of criticisms levelled at trade unions by leaders of the national NHS BME Network, who asserted the ‘racism of trade unions’ was part of the rationale for developing the national NHS BME Network. Given these and other organisational contestations and differences of members’ political perspectives and outlooks within both ‘camps’, it took a while for me to feel comfortable with my

researcher role, shuttling in and out and back and forth between the two organisations and endeavouring to be even handed in my own communications and interaction.

Another level of challenge encountered in the course of this research was working with and thinking through the relationship and differences between the categories ‘BME worker’ and ‘migrant worker’ as constituted within the membership of the NHS BME Network and UNISON Black SOGs. In this context, a key challenge in terms of the scope of this research – Black Self-Organisation and BME Networks – was maintaining a distinct focus on Black, Asian and non-white minority ethnic and migrant workers in workplace, trade union, and community settings, in a wider background context where white EU migrants, from Poland in particular, were becoming a major presence. Hence this challenge was considered via Bloch et al.’s advice to approach issues of race and multiculturalism by recognising the “diversity that characterises both traditional BME and new migrant populations” (2013:4). Similarly Brah’s concept of differential racialisation – “how different racialized groups are positioned differentially vis a vis one another” (Brah, 1996:15), has informed the approach in this thesis to thinking through issues of racism and racialisation confronting BME and migrant workers. In this context, this research also notes the existence of UNISON’s Filipino Migrant Network, joined by UNISON’s more recently formed African Migrant Workers Network and Polish Migrant Workers Network (organised by the UNISON national organising team) as a response to the call to organise migrants as ‘migrant workers’ (Alberti et al 2013).

## **Limitations**

An identified limitation in this study, linked partly to the social identity of the researcher and the sampling design, is the ‘absence’ of sexuality as a category, and lack of engagement with research participants who self-defined as LGBT and /or disabled (one research participant self-defined as BME and disabled) during the data collection phase of this thesis. In this regard, this thesis is mindful of research highlighting equalities

‘hierarchies’ (Colgan et al, 2007:75-76) and intersectional issues in the context of UK local government and the public sector around the marginalisation of sexuality and LGBT equalities in relation to race and gender equality in particular (Munro and Richardson, 2011).

Whilst at the time of data collection for this research there was no active local UNISON LGBT SOG and Disabled SOG (and no active local LGBT NHS or local government LGBT network), the blind spot in relation to social identities linked to sexuality and disability may have been addressed at an earlier stage in the research design by approaching, in the case of UNISON, Black LGBT and Black Disabled members participating in UNISON’s National LGBT Committee, Disabled Committee and National Black Members Committee. In this regard, future research to address this ‘absence’ in relation to sexuality, could also for instance, approach UK Black Pride, which was founded by a Black trade unionist and receives much of its financial support from the trade unions. And, in the context of this research’s exploration of how UNISON Black SOGs and the NHS BME Network relate to each other, it is instructive to note that UK Black Pride also works in alliance with and fits Shukra et al.’s (2004) description of organisations like Operation Black Vote which operate in the transitional public sphere:

“UKBP has had excellent coverage in the black community paper *The Voice*, and works with groups like Operation Black Vote and the Runnymede Trust” (Purton, 2017:169)

In the context of intersectional Black feminist approaches within Black self-organisation, with LGBT participation being at the forefront of new waves of community organising against racism such as in the Black Lives Matter Movement, foregrounding the perspectives of Black LGBT members (and other social identities such as Disability) within UNISON, the trade unions in general and BME networks / professional associations is an important area for ongoing and future research.

## **Research instrument: interview schedule**

Informal discussions with NHS Equality and Diversity Leads, and BME trade union activists and officers helped to inform the research design, key questions and conceptual framework. This preparatory phase also assisted the design of the interview schedule as the key research instrument facilitating the interview process. The interview schedule was constructed based on initial ideas coming out of the informal preparatory phase discussions, and themes and categories identified within the research literature review. These themes and categories underpin the main questions, supplemented by probes as sub-questions (Fielding and Thomas, 2008). Following informed consent the interview schedule was piloted with a female African-Caribbean member and male South Asian member of the local UNISON Black SOG and local NHS BME Network to help clarify and concentrate the area of enquiry (Gillham, 2009), and gauge whether participants could understand the interview schedule questions. The pilot interviews enabled reflection on issues related to interviewer effects, and the research strategy was mindful of issues linked to the researcher's own "embodied identity", and "insider-outsider status" alongside "racialisation and ethnicisation processes" which can influence levels of rapport with respondents as discussed by Quraishi and Philburn (2015: 46-53), and Costley et al (2010) in relation to insider-research.

## **Case studies of the two organisations**

This section of the methodology chapter sets out the case studies of the two organisations collectively organising to challenge racism in the NHS workplace. Situated within the institutional setting of a local NHS Trust, the two case study organisations were chosen on the basis of the high level of activism around promoting race equality in the workplace via their respective structures and membership. UNISON had the biggest number of diverse BME members within the local NHS Trust, with the local UNISON Black SOG having a very visible presence within the Trust. As a new autonomously organised rather than HR-

initiated BME Network, the local NHS BME Network was attracting membership from some Black workers due to its affiliation to the national independent NHS BME Network. In this context, using the case study approach for both organisations assists in exploring the hypothesis that BME Diversity Networks may be seen by Black workers as being more effective collective voices for promoting race equality in the workplace.

The sampling rationale for respondents within each group is outlined, linked to national NHS workforce statistics. This case study section of the chapter looks at the NHS context within which the two groups operate, both at the local level within the Trust and at national level. The formation and history of each group is discussed and timescales mapped in an accompanying diagram. These accounts include an overview of the positioning of each group within a broader history of anti-racist activism in Britain. The structure of each case study organisation is outlined, along with the relationship between the groups and their parent organisations: national UNISON and the national NHS BME Network. This case study section includes reference to national equality and diversity policy and NHS workforce race equality initiatives that have a bearing on both case study organisations' anti-racist activism.

For each case study organisation, key points are explored around their stated purpose, priorities and strategies – linked to social identities being represented – as well as observations on their activities in practice. These areas of investigation aim to inform the key research questions of how the local NHS BME Network and UNISON Black SOG are challenging racism in the workplace; and what their political differences and similarities are in their approach to promoting race equality. Areas of thematic focus include: attitudes towards definitions of groups (BME, political black identity); comparative conceptions of 'race'; representations of class; and different approaches to training and development of members.

The two figures below show key dates in the development of the two groups, and related NHS and contextual dates.

**Table 1: Qualitative interview schedule**

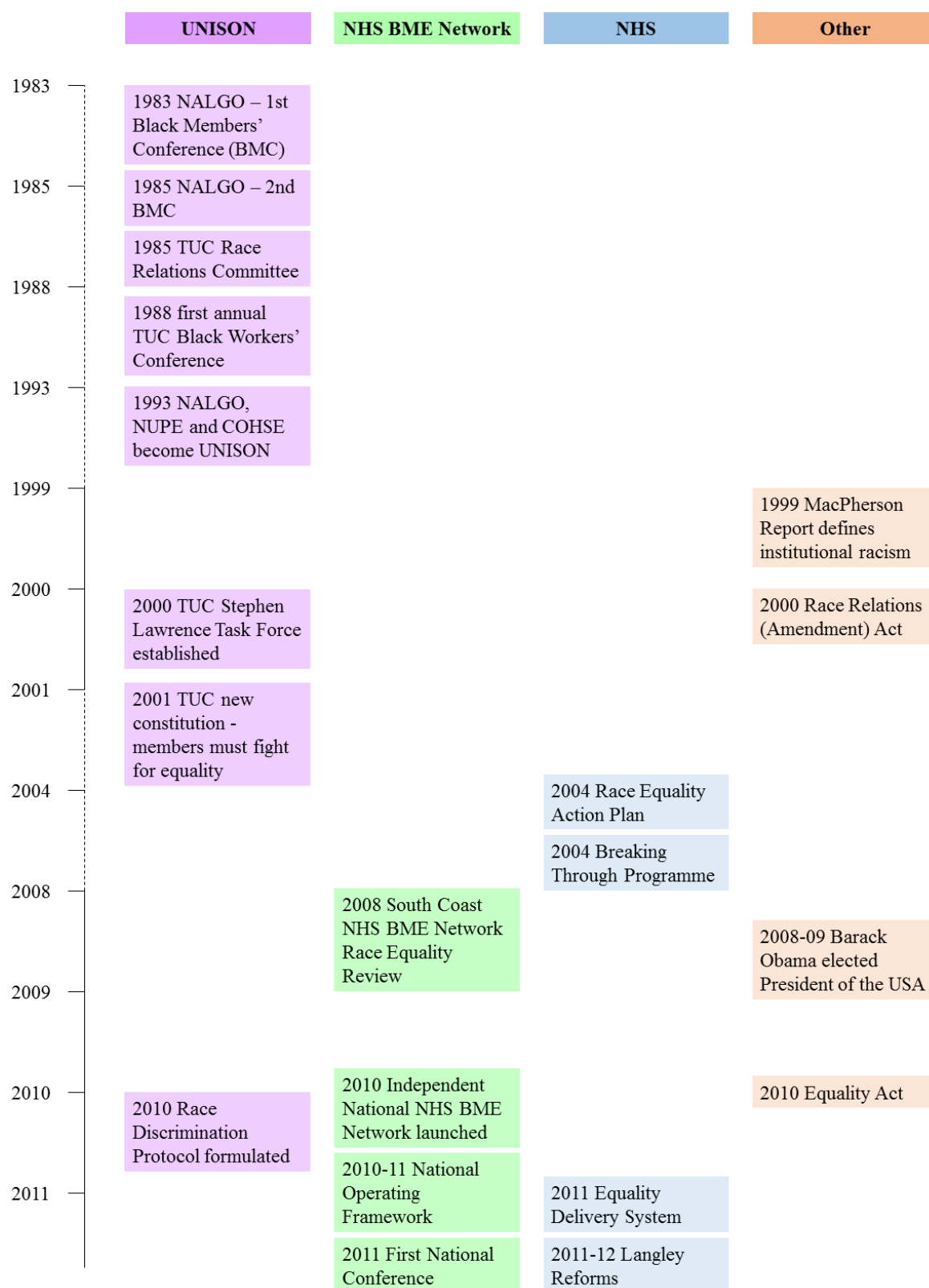
Q: Which do you prefer Black or Black and Minority Ethnic (BME) please explain why?
<p>Prompts:</p> <ul style="list-style-type: none"> <li>• How do some ethnic minority groups' e.g. South Asian, Filipino, Chinese, Arabic, dual heritage, relate to a 'Black' or 'BME' definition?</li> <li>• 'Black' – politically black</li> <li>• 'Black' – African diaspora</li> <li>• 'Brown'</li> <li>• 'Muslim'</li> <li>• 'People of colour' – 'visible minorities'</li> <li>• Does use of 'BME' reflect – new and emerging migrant communities, equality, diversity and inclusion in the workplace?</li> <li>• Majority vs 'ethnic minorities'</li> </ul>
Q: How do NHS BME Staff Networks support BME Workers?
<p>Prompts:</p> <ul style="list-style-type: none"> <li>• Group support</li> <li>• Membership</li> <li>• Courses – training</li> <li>• Participation in local and national NHS BME Network activities and events</li> </ul>

<ul style="list-style-type: none"> <li>• Representations and negotiations with managers/organisational leaders</li> </ul>
Q: How do UNISON Black Self Organised Groups support BME Workers?
<p>Prompts:</p> <ul style="list-style-type: none"> <li>• Group support</li> <li>• Representation – case work</li> <li>• Courses – access to training and learning opportunities</li> <li>• Participation in local and regional Black Self Organised Group</li> <li>• Participation in UNISON National Black Members Conference</li> <li>• Community organising activities</li> </ul>
Q: How do you understand race equality?
<p>Prompts:</p> <ul style="list-style-type: none"> <li>• Stephen Lawrence Inquiry</li> <li>• Macpherson Report / institutional racism</li> <li>• Positive duty to promote race equality</li> </ul>
Q: How do you think the Equality Act can be used to challenge racism in the workplace?
<p>Prompts:</p> <ul style="list-style-type: none"> <li>• Public sector equality duty</li> <li>• Nine ‘protected characteristics’</li> <li>• Equality Impact Assessments</li> </ul>

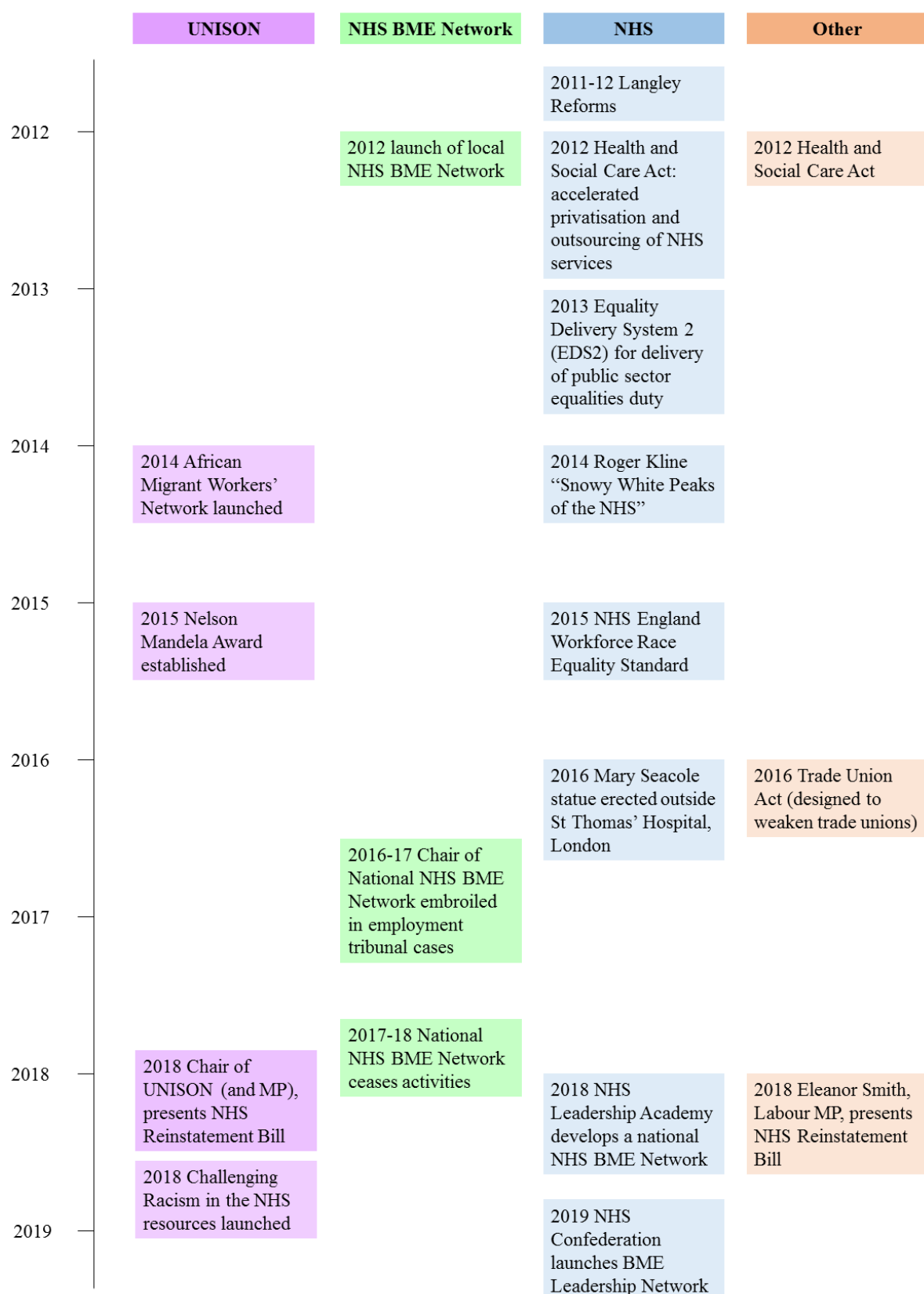


Q: How are identities of race, class, gender, and ethnicity, important to you in the workplace?
<p>Prompts</p> <ul style="list-style-type: none"> <li>• Individual and collective</li> <li>• Multiple identities</li> <li>• Other identities - occupation/expertise, religion, sexuality, disability</li> </ul>
<b>Key Research Informant Interviewee Questions</b>
Q: How has Black self-organisation changed and evolved in the last ten years?
Q: What do you think are the differences and similarities between trade union Black self-organisation and BME Staff Networks?
<p>Q: How do you think the change from the CRE to the EHRC and 2010 Equality Act has impacted on BME workers?</p> <p>How have neoliberalism and austerity politics impacted on Black workers and communities?</p>

**Figure 1: Timeline 1983 - 2011**



**Figure 2: Timeline 2012 - 2019**



## **Case studies sample**

The NHS workforce is predominantly female (77% of the whole workforce), however women remain in the minority in senior roles (37% of senior roles), 89% of women are nurses, whilst women make up 74% of the most junior and lowest paid band 1 grade in the NHS, and outnumber men four to one in bands 1-7. Black and minority ethnic staff make up approximately 18% of the total NHS workforce, with 7% holding senior manager roles. Approximately 97,000 overseas women are employed in the NHS, with around 51,000 coming from outside of the EU. Within the medical workforce BME doctors are more under-represented at senior doctor level, with a higher number of junior BME doctors. Within the non-medical workforce BME staff are over-represented in junior grade and bands and under-represented in senior manager roles and higher bands.

### **Percentage of NHS non-medical staff by ethnicity and grade**

Very Senior Manager:

Asian - 4.6%

Black - 1.2%

Chinese – 0.2%

Mixed – 0.8%

Senior (Bands 8a-9)

Asian – 6.1%

Black – 3.5%

Chinese – 0.6%

Mixed - 1.4%

White – 87.5 %

Other – 0.9%

Middle (Bands 5-7)

Asian – 8.9%

Black – 6.7%

Chinese – 0.4%

Mixed – 1.6%

White – 79.8%

Other – 2.6%

Support (Bands 1-4)

Asian - 7.3%

Black – 6.2 %

Chinese – 0.2%

White – 82.9%

Other - 1.6%

(Source: NHS Workforce 6<sup>th</sup> January 2020).

**Table 2: List of interviewees**

<b>Organisation</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Occupation</b>	<b>Pay Band</b>
1. UNISON	Female	African-Caribbean	Administrator	Band 2
2. UNISON	Female	Mixed Race - Dual Heritage	Health Advocate	Band 3
3. UNISON UNISON Filipino Migrant Network	Female	Filipino	Nurse	Band 5
4. UNISON	Female	African	Catering	Band 1
5. UNISON	Female	African-Caribbean	Equality and Diversity Practitioner	Band 5
6. UNISON	Female	African Caribbean	Administrator	Band 3
7. UNISON	Female	South Asian	Equality and Diversity Practitioner	Band 5
8. UNISON	Male	South Asian	Porter	Band 1
9. UNISON	Male	Filipino	Porter	Band 1
10. UNISON	Male	African-Caribbean	Porter	Band 2
11. UNISON	Male	African-Caribbean	Nurse	Band 5

<b>Organisation</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Occupation</b>	<b>Pay Band</b>
12. NHS BME Network	Female	African-Caribbean	Matron	Band 8
13. NHS BME Network	Female	Mixed Race – Dual Heritage	Manager	Band 7
14. NHS BME Network	Female	South Asian	Equality and Diversity Manager	Band 7
15. NHS BME Network	Female	South Asian	Equality and Diversity Officer	Band 6
16. NHS BME Network	Female	African	Senior Manager	Band 7
17. NHS BME Network	Male	Filipino	Professional Clinical Manager	Band 8b
18. NHS BME Network	Male	African	Community Development Worker	Band 6
19. NHS BME Network	Male	South Asian	Equality and Diversity Lead	Band 7
20. NHS BME Network	Male	African-Caribbean	Equality and Diversity Lead	Band 8
21. <b>Key Informant</b> NHS	Female	Mixed –Race / Dual Heritage	Former Senior Nurse – Health Academic	
22. <b>Key Informant</b> Trade Unions	Male	African-Caribbean	Senior trade union representative	
23. <b>Key Informant</b> Trade Unions	Male	African-Caribbean	Senior trade union representative	

The case studies sample within this research reflects a cross-section of Black workers employed by the local NHS Trust who were active within the local UNISON Black SOG and the Local NHS BME Network, which was affiliated to the National independent NHS BME Network. Within the institutional setting of the local NHS Trust, challenging racism in the workplace for the activists within both the Local UNISON Black SOG and the Local NHS BME Network was focussed on:

1. tackling disproportionate rates of bullying and harassment faced by Black workers;

2. the grievances of Black workers around recruitment, retention and career progression; and
3. The under-representation of Black workers in senior roles, the latter issue reflected by the fact that the local NHS Trust had no BME board members or Non-Executive directors during the period this research was conducted (2012-2018).

The chairs of both case study organisations, who were both Black Caribbean women, were approached to be interviewed in their own right and to also facilitate access to leading activists and members. The chair of the Local NHS BME Network, employed as a Senior Matron, was one of a tiny number of Black workers working in the NHS Senior Band 8 category. Alongside the chair, key members of the Local NHS BME Network Steering group also formed part of the case study organisation sample, including two male senior Band 8 managers. There were no Very Senior Manager grades or medical doctors (senior or junior grade) active within the Local NHS BME Network, and the case study sample of Black workers at Band 6, 7 and 8 is reflective of both the steering group and wider membership, consisting of members working as non-medical staff from bands 6-8. In this context, an important aspect of the case study sample was the larger presence of these Allied Health Professionals, straddling the NHS middle bands 5-7, alongside senior nursing managers (Bands 8a -9), within the sample as the main activist constituency within both the local NHS BME Network and the National NHS BME Network. Where BME Doctors and Nurses have hitherto been the primary focus of research investigating Black workers' experiences of racism in the NHS (Esmail and Everington, 1997; Simpson, 2018; Dhaliwal and McKay, 2008; Smith et al., 2006;), the significant presence within the NHS of Black Allied Health Professionals, many clustered at middle bands 5-7, and their collective voice and movement interests as promoted within the Local NHS BME Network and UNISON Black SOGs are at present under-researched.

In this regard, the Local NHS BME Network case study sample reflects the wider constellation of Black NHS workers, many being Allied Health Professionals clustered in the intermediate grades of bands 5, 6, 7 who, demoralised by their exclusion from progression into more senior roles, have been pushing and lobbying for an end to racism in the NHS (Lyfar-Cisse, 2008; National NHS BME Network 2015 Conference Report). In 2014, Roger Kline's 'Snowy White Peaks' report provided the policy framework for the 2015 launch and implementation of the NHS Workforce Race Equality Standard, by which the NHS would seek to address Black workers' experiences of racial discrimination in the NHS. Hence signalling the arrival of the NHS WRES, NHS Chief Executive Simon Stevens, referring to the NHS' senior leadership to reflect the UK's diverse multi-ethnic population, stated:

“It can't be right for example – as Roger Kline's recent research has pinpointed – that ten years after the launch of the NHS race equality plan, while 41% of NHS staff in London are from black and minority ethnic backgrounds (similar in proportion to the Londoners they serve) only 8% of trust board directors are, with two-fifths of London trust boards having no BME directors at all. Similar patterns apply elsewhere, and have actually been going backwards.” (NHS England, 2014)

The ethnic diversity of the activists within both case study organisations features in the research sample, with research interviewees of South Asian, Black African, Black Caribbean, Filipino, and Mixed-Heritage being predominant within the activist base of the Local NHS BME Network and Local UNISON Black SOG. Black workers have historically been situated at the base of the NHS hierarchy and continue to be over-represented in the NHS 'non graduate entry grades' bands 1-4. The Local UNISON Black SOG case study sample sought to capture the active participation and representation of NHS Black workers on bands 1-4, including Black workers and UNISON activists managed by private contractor Carillion. The Black female and male activists within the UNISON Black SOG were also active within the local UNISON Health Branch (as Equality officer, Recruitment Officer, Social Secretary), acting as stewards and workplace



reps supporting UNISON members in casework. A key focus around challenging racism in the workplace for these Local Black SOG members was representing the disproportionate number of Black workers, particularly in the support bands 1-4 (many managed by private contractors), experiencing bullying and harassment from managers. As one of the key indicators of the NHS WRES, five years after the launch of the WRES in 2015, commentators denounced the NHS's "tick box approach" to tackling racism as the latest WRES workforce data, showed that "29% of BME staff reported being bullied or abused by other NHS workers" (Lintern, 2020).

In this context, representations of class intertwined with race, ethnicity and gender become apparent and feature within the case study organisations with the local NHS BME Network (in concert with the National NHS BME Network), projecting a corporate diversity aligned Black professional middle class aspirational outlook. Black NHS Band 1-4 workers were a non-existent presence within the Local NHS BME Network, but in contrast were highly visible, very active and well integrated within the local UNISON Black SOG structures (including the Regional Black Members Group and National Black Members Conference). Their efforts to challenge racism in the workplace were linked to their fight for a living wage to end low pay and worsening terms and conditions precipitated by privatisation, fragmentation and NHS austerity.

## **History and nature of each organisation**

The research respondents within the case study organisation of the local UNISON Black SOG were all Black NHS workers employed within a local NHS Trust including Black NHS outsourced workers managed by private contractor Carillion.

UNISON's estimated 1.3 million membership makes it one of the largest public sector unions in the UK and Europe: it was formed in 1993 through the merger of the unions NALGO, NUPE and COHSE (Humphrey, 2002). Ironside and Seifert note Alan Jinkinson's endorsement of the UNISON merger:

“Never before has it been so necessary for public sector workers to speak with one voice and to demonstrate the fundamental trade union value of unity, which the name UNISON implies. We must not allow employers to drive a wedge between the manual and white-collar workers. Nor can we allow a hostile government, intent on running down and privatising the NHS to benefit from wasteful multiunionism” (Ironsides and Siefert, 2000:356-357)

It is in this context that today UNISON’s national membership profile consists of manual workers alongside managerial / professional and administrative workers employed across public, private and outsourced sectors. This membership / employee profile was also reflected in the make-up of the local UNISON branch and its Black Self-Organised Group, with nurses, administrators, health care assistants, porters, cleaners, catering staff and managers working as ‘core’ staff within the local NHS Trust as well as the local Trust’s NHS staff employed by private contractors participating within the local UNISON Health Branch and UNISON Black SOG.

### **UNISON’s Equality and Diversity Structures**

Promoting equality and tackling discrimination in the workplace are key organising, campaigning and negotiating priorities for UNISON across its national, regional and local branch structures. The local branch case study organisation in this research was based in one of UNISON’s 12 geographic regions – which include Cymru / Wales, Northern Ireland, Scotland, East Midlands region, etc. Each Region has a Regional Black Members Committee, which is tasked with nurturing the development of activists within local Black SOGs, encouraging members to access training courses and become more active within UNISON’s Black SOG structures and the wider union. The Regional Black Members Committees also meet on a regular basis, often hosting training events and inviting a range of speakers with a variety of race equality, trade union and anti-racist experience, linked to a range of workplace and community-based anti-racist initiatives and campaigns.

UNISON has a National Race Equality Officer based at the UNISON London Central Office who, as well as supporting the Regional Black Members Committee structure, also

works alongside UNISON's National Black Members Committee.. The Race Equality Officer assists the coordination and helps convene UNISON's annual National Black Members Conference – the key forum in which local Black SOG members, along with the Regional Black Members Committees, come together to discuss and vote on a plethora of race equality workplace and anti-racist community and international solidarity campaigns, which will set UNISON's race equality agenda for the coming year and beyond. The UNISON Black SOG members participating in this research were also active within their local Black SOG Regional Black Members Committee, as well as attending UNISON's annual National Black Members Conference. One of the research participants was also the Chair of the Regional Black Members Committee.

### **From NALGO to UNISON Black Self-Organised Groups**

To fight discrimination and promote equality and diversity in the workplace and within its own structures, UNISON has a long established structure of self-organised groups, which also seek to facilitate greater democratic inclusion and participation of its diverse membership at all levels within the union. Black Self Organised Groups, as an integral part of UNISON's Equality Groups structure, are a political feature developed in the days of NALGO in the 1980's, with NALGO's self-organised groups for Women, Lesbian and Gay (now called the LGBT + Group), Disabled and Black Workers becoming enshrined within the 1993 newly merged union UNISON's constitution and rule book (Ironsides and Seifert, 2000:60; Humphrey, 2002). UNISON's Equality Groups structure also includes a Young Members Group and a Retired Members Group. This Equality Group structure straddles UNISON's seven service groups (Health – includes, nurses, midwives, paramedics and cleaners; Local Government; Higher Education; Police and Justice; Community; Water-Environment-Transport; and Energy) and also links members' workplace issues into the union's annual conferences and committees (Ironsides and Seifert, 2000:60). Their embeddedness within UNISON's democratic structures at a local, regional

and national level means the self-organised groups are “able to create and influence” (Simms et al, 2013:24) policy and decision making within the trade union.

UNISON’s Black Self-Organised Groups are rooted in the longstanding history and tradition of Black self-organisation in Britain, exemplified by organisations like the Coloured Seamen’s Union, the Indian Workers Association, the Black People’s Alliance (formed by Black and Asian communities in 1968 in response to Enoch Powell’s ‘Rivers of Blood’ speech), and the Organisation of Women of Asian and African Descent (OWAAD. Making reference to the principle of Black self-organisation, Black Radical Tradition aligned communist activist and political organiser Claudia Jones, stated:

“In common with other workers, the West Indians take part in the struggle for defense of their working and living standards. But the growing intensity of racialism forces them, as it does other Afro-Asians to join and found their own organisations.” (Jones, 2011:178)

Describing the struggle to embed the principle of Black self-organisation within the trade union movement as “historical confrontation between race and class,” Trevor Carter (1986:140) highlights that the formation of Black Caucuses within trade unions like NALGO in the 1980’s (Virdee and Grint, 1994; Humphrey, 2002; Ironside and Seifert, 2000), was advanced not as a separatist agenda but rather to assert Black participation and increase democracy within the trade union (Virdee, 2014) as part of the fight against institutionalised racism within the labour movement and wider society: “A black caucus simply aims to ensure that the wider body is more fully informed by and answerable to its whole membership” (Carter, 1986:141). Similarly, Ron Ramdin, documenting how militant Black workers in this period were linking workplace struggles against racism to resistance against racism in their communities, states: “Thus they have clearly stated their intention to organise and work within the trade union movement” (Ramdin, 1987:368).

And in relation to UNISON’s forerunner, NALGO, Virdee also states: “By the mid 1980’s then, one of the largest trade unions in Britain had officially committed itself to the

principle of black self-organization allowing Black and Asian workers to collectively determine and formulate the most appropriate strategy to combat racism.” (Virdee, 2014:159).

Further contextualizing the historic race and class basis upon which Black self-organised groups within public sector trade unions like UNISON exist, Virdee notes how the influx of Black and Asian workers into local government employment, particularly those racialized workers radicalized by the urban unrest in the 1980’s, converged with and facilitated an alliance between municipal anti-racism in Labour run authorities – influenced by the politics of the GLC – and Black self-organisation within trade unions which, by pushing for and implementing positive action approaches and equal opportunity measures to combat racial discrimination in recruitment and employment procedures, was able to consolidate the presence of Black workers across the public sector:

“...the National Health Service as well as many government quangos, was forced to follow suit and introduce a raft of measures under the rubric of equal opportunities that attempted to create a more level playing field when it came to questions of recruitment and selection. Of course, employers like the NHS had long employed Doctors and nurses of Caribbean and Asian descent, but most had been confined to the least desirable parts of their professions – the intention now became to challenge the representations and procedures that sustained such structural racialized inequalities.” (Virdee, 2014:159).

It is then in this context that the local Branch Black SOG in this study collectively mobilises Black workers, ensuring race equality issues are fed into the branch and the local branch plan, with recruitment of activists who are supported to take up leadership positions within the branch and receive training as union/workplace representatives involved in casework with individual members. And it is in this context that a number of the Black Self-Organised Group participants in this research were active on a daily basis providing volunteer workplace representation for UNISON as elected workplace stewards, and a Black Self-Organised Group member participating in this research was also fulfilling the role of Equality Rep on the local UNISON Health Branch’s committee, illustrating the

potential for the Equality Rep role to “provide new routes to activism for UNISON” (Moore, 2011:104).

### **Challenging Racism in the Workplace**

The Black SOG members in this research also played a key role in supporting their Health Branch’s efforts to scrutinise the local NHS Trust’s adherence to its legal statutory duties in relation to promoting race equality, as set out originally in the Race Relations Amendment Act 2000 and subsequently incorporated into the Equality Act 2010 and its accompanying Public Sector Equality Duty. UNISON’s ‘Challenging Racism in the Workplace’ training programme and guidance resources, developed following the Stephen Lawrence Inquiry and Macpherson Report (Macpherson, 1999), provided the main framework within which the Black SOG members in this research were conducting their fight against racism in the workplace. The training encourages local UNISON branches to ensure promotion of race equality is a core element of the branches’ local bargaining and campaigning activities, by incorporating race equality measures into the branch action plan and branch assessment process. Thus the Challenging Racism in the NHS (UNISON, 2019) framework enables Black SOG members and other UNISON activists to apply a collective bargaining approach, and is therefore designed to encourage a shift away from dealing with racism on an individual basis. In this context, the Black SOG members in this research were providing race equality information and evidence for the branch in relation to Black members’ actual lived experience of recruitment, retention and access to training opportunities within the NHS Trust, sharing information on the disproportionate numbers of Black UNISON members and Black NHS staff facing disciplinary cases and grievance procedures, as well as the impact of cuts and redundancies on Black staff. In this regard, the Black SOG members, through applying the Challenging Racism in the Workplace framework, were playing an important role in assisting the local branch to apply trade union negotiating pressure on the local NHS Trust to implement its Equality Delivery

System and more effectively monitor and evaluate the impacts on race equality of its policies and procedures.

### **UNISON's Migrant Worker Networks**

In 2018 approximately 17% of the UK labour force were born abroad (Fernández-Reino and Rienzo, 2019). In this context the NHS' historic dependence on migrant labour from Britain's former colonies in the Caribbean and Indian subcontinent, with recruitment of doctors, nurses and other health workers (Kyriakides and Virdee, 2003; Snow et al, 2011; Simpson et al; 2010) has continued and, increasingly since the 1990's, also been supplemented by the arrival of new migrant workers from across the globe including Africa, India, the Philippines, and the East European countries which joined the EU in 2004 (Snow and Jones, 2011; Simpson et al, 2010; Pero, 2013; Kundnani, 2007). Around 153,000 out of 1.2 million staff (13.1% of all staff) are registered as having a non-British nationality, with approximately 65,000 (5.5%) being nationals of other EU countries (Baker, 2019). For Kundnani, an important factor in New Labour's 'market state', 'managed migration' approach was the regulation of the supply of workers "according to the demands of low wages and disposability" (Kundnani, 2007:144). Similarly, Wills et al (2010) have highlighted how the 'new migrant division of labour', with migrant workers often employed in cleaning, care work, construction, and hospitality subject to low pay and insecure –precarious terms and conditions, is linked to the neoliberal aligned deregulation of markets in which dual processes of outsourcing and subcontracting combined with international migration are embedded (see also Pero, 2013; Anderson, 2013).

It is in this context that UNISON's organising work with migrant workers is situated; thus Sian Moore (2011:125), highlighting the structural barriers to greater migrant worker recruitment and activism within trade unions that initiatives such as UNISON's Migrant Worker Participation Project are seeking to address, comments:

“The privatisation of services, often based upon an ethnic division of labour underpinned by state immigration policies, limits the development of structures of engagement for migrant workers.”

There is then overlap and interconnection between UNISON’s Black Self-Organised Group structures and UNISON’s development of a Filipino Migrant Workers Network and EU Migrant Workers Network, which strive to support and recruit migrant workers often employed in areas of the public sector that have been outsourced and privatised, creating two and even three tier workforces, with migrant workers facing more isolated working environments on worse terms and conditions than colleagues linked to the main employer, who have more favourable union-negotiated terms of employment.

In 2014, UNISON’s National Black Members Conference formally announced the development of UNISON’s African Migrant Workers Network:

“Migrant workers make up a large and growing part of the public sector workforce, particularly the health service and many of the outsourced areas of work, such as catering and cleaning...In some key growth areas such as social care they account for nearly 20% of the workforce. UNISON has sought to recruit migrant workers into membership over many years. Amongst the Black UNISON membership, Black African workers have continued to have the highest joiner rates. In identifying the different needs of groups within Black membership, an African Migrant Workers Network is being developed. This network is for workers who may be isolated in the workplaces and face common issues. The network will support them to access the services of the wider union and have a collective voice through Black members’ structures.” (UNISON, 2014)

### **UNISON Definition of Black**

As noted earlier, UNISON’s Black Self-Organised Groups are structures that, whilst closely linked to Black self-organisation within communities, have evolved within the UK labour movement context as collective vehicles developed by Black workers to tackle racism in the workplace and historically within trade unions themselves (Davis et al., 2006; Virdee, 2014). Thus the activities of the local UNISON Branch Black SOG members in this research were modelled on ideas of Black self-organisation within trade unions, identified by Virdee and Grint (1994, 202): “...a strategy of relative autonomy rather than separatism or submersion within a race blind union.”



Importantly Virdee argues that it was the convergence of municipal anti-racism, linked to socialist activists in the labour movement in alliance with Black worker groups that “ensured the principle of black self-organization was ratified” within UNISON’s forerunner NALGO (Virdee, 2014:158). It is crucial to reprise these points to gain a deeper ideological understanding of UNISON’s Black SOG structures’ continued commitment to and use of an inclusive race and class Political Black identity to collectively organise Black Workers to challenge racism in the 21<sup>st</sup> century workplace. As discussed by Virdee, the unity of Black and Asian workers, based on the principle of Black self-organisation during the NALGO 1979-1990’s period of ‘Facing up to Thatcherism’ (Ironside and Seifert, 2000) acted as:

“a kind of catalytic agent that collectively brought its weight to bear on their unions, and through them forced employers to further democratize the recruitment and selection process, contributing eventually to the significantly increased levels of black and Asian employment in these sectors during the 1980’s and 1990’s” (Virdee, 2014: 159-160)

Thus in his speech at the NHS BME Network Conference in 2011, Colin Prescod made a point of highlighting the activist component and legacy of ‘Black as a political colour’ linked to the racialized New Commonwealth settlers designated as ‘coloured’ by the British state. The racialized outsider status (Virdee, 2014) and daily experiences of ‘racism as colour bar’ (Fryer, 2000) enforcing conditions of low pay and less favourable roles in relation to employment and exclusion in relation to access to housing and other mainstream goods and services, were highlighted by Prescod (see also: Narayan, 2019; Bourne, 2016; Virdee, 2014; Ramamurthy, 2013; Sivanandan, 2008; Kundnani, 2007; Brah, 1996):

“The Black in your BME concept has a very particular history of emergence.... Eventually, as migrants began to put down roots in the UK, there was a turn to ‘here to stay, here to fight’ struggles. Alongside other migrant settlers with colonial pasts, from the Indian subcontinent, and from continental Africa...for maybe a decade and a half we forged the remarkable idea of ‘Black’ not as a mere label for skin colour, but as a political colour – as the colour of resistance to all race and

class injustices. Note, not Black and minority ethnic, but just plain Black – all inclusive.” (Prescod, 2011)

It is then in the context above that, just as Colin Prescod saw fit to foreground the ‘Black as political colour’ activist legacy within the NHS Network’s ‘BME’ construct, so too UNISON Black SOG structures have been defining Black:

“In UNISON, ‘Black’ – with a capital B – is used to indicate people with a shared history. ‘Black’ is used in a broad political and inclusive sense to describe people in the UK who have suffered from colonialism and enslavement in the past and continue to experience racism and diminished opportunities in today’s society... Using ‘Black’ is about creating unity in the fight against deep-rooted racism that sees Black people disadvantaged in housing, education, employment and the criminal justice and health systems.” (UNISON, 2013)

Both UNISON Black SOG and the TUC Black Workers Conference have seen fit to reassert ‘Black’ as an inclusive self-organised position that fosters anti-racist unity, rather than using government terminology and other forms of discourse which refer to BME or BAME individuals and groups:

“Conference understands that UNISON has always used the term ‘Black’ as an inclusive and political term. However, it is also clear that many members do not understand why it is used – particularly when their employer and public bodies may use the term BME. Conference calls on the NBMC to agree a concise definition and explanation of the term ‘Black’ and suggests that it is used consistently throughout our Self Organised Group.” (UNISON, 2013)

### **Race discrimination protocol**

UNISON’s Black SOG members and structures have been instrumental in applying pressure on the union to develop a tool that is designed to help branch officers and stewards representing Black workers to make more effective decisions around supporting UNISON’s Black members involved in race discrimination cases. In its application the Race Discrimination Protocol tool (UNISON, 2016) requires local branches to systematically use the tool, which functions as a formal checklist procedure when any UNISON member reports and seeks representation from the union on the basis of racial discrimination in the workplace. The numbers of cases where the Race Discrimination

Protocol is used and submitted by stewards is recorded by local branches and reported into the union's regional and national structures. In this regards the Black SOG members participating in this research were active in ensuring their local branch officers understood and integrated the Race Discrimination Protocol into the local branch systems, with Black SOG members facilitating Race Discrimination Protocol Briefings at their local branch stewards training day events. The Black SOG members in this research participating in their Regional Black Members Group also received statistical reports on the outcome of race discrimination cases referred to UNISON's legal firm Thompson's Solicitors. Implementation of the Race Discrimination Protocol and the robust level of accountability to Black SOGs and Black members on the number and nature of race discrimination cases taken up by the union is deemed a vital necessity by UNISON's Black members, in a context where the union is mindful of criticism that Black members, particularly in the past, have been poorly served by trade unions in relation to representing individuals pursuing race discrimination cases with their employers. And this legal area of employment rights is one of the key issues by which some emerging BME Staff Networks like the NHS BME Network seek to claim legitimacy amongst Black workers, based on negative perceptions as highlighted by Davis et al:

“The intersection of cautious trade union practice with black members' expectations has resulted in a negative view within black communities of the relevance of trade unions to the working lives of black people.” (Davis et al., 2006:7)

The increased accountability of UNISON to its Black members, that the Race Discrimination Protocol facilitates, and the monitoring system that has been built around its implementation at branch, regional and national level has also served to improve the dialogue and understanding between the union and its Black members around holding more realistic expectations in relation to the levels of success and positive outcomes that can actually be achieved for race discrimination cases through pursuing individual

employment tribunal processes. Thus the embedding and use of the Race Discrimination Protocol within a collective bargaining approach to race discrimination was the preferred orientation of the Black SOG members in this local branch Black SOG case study, linked to their awareness of “...the very individualized, uncertain and personally risky strategy of legal action” (Ouali and Jefferys, 2015: 103).

And here it is important to note that whilst in its 2010/11 National Operating Framework (NHS BME Network, 2010) the NHS BME Network’s bold rhetoric stated aggressive pursuit of employment tribunals in the event of its members facing race discrimination in their workplaces, in actual practical and far-reaching terms it was UNISON’s landmark four year legal battle and eventual win over the government in the Supreme Court in 2017, *UNISON v Lord Chancellor* [2017], that highlighted the effectiveness of trade unions’ collective bargaining approaches to fighting for equality and challenging discrimination in the workplace. UNISON argued that the introduction of employment tribunal fees – administered as part of the government’s public-sector-wide neoliberal austerity cuts – would deny workers access to justice, and due to the difficulties of pursuing specific types of workplace discrimination cases, have an adverse impact in particular on women and other marginalised groups with protected characteristics (Disability and Race) (Women’s Budget Group et al, 2017). The union bolstered its arguments with official data that revealed that from October 2013 to December 2013 there had been a huge 79% drop in claims compared to the same months in 2012. UNISON’s successful pursuit of this lengthy legal battle with the Supreme Court, reaching a judgement that benefits all workers, not just trade union members, is an important example and reminder of the continuing role of trade unions as the ‘authentic voice’ of workers (Davis et al., 2006).

## **The NHS Trust**

During the period in which this research was conducted, the local NHS Hospital Foundation Trust within which the UNISON Black SOG participants and NHS BME

Network participants were employed and collectively active was, like the NHS as a whole, subject to huge financial pressures and massive top down Conservative inspired and Coalition government enforced reorganisation and restructuring, linked to the austerity measures implemented in the wake of the 2008-9 financial crash. Under New Labour the NHS witnessed an increase in budgets and professional salaries, which was abruptly halted with the advent of the Coalition government in 2010. Whilst New Labour's increase in budgets led temporarily to growth in staff numbers and new programmes like the NHS Delivering Race Equality in Mental Health Programme recruitment of 500 Community Development Workers deployed from 2005 – 2010, New Labour also presided over further opening up of the NHS to privatisation and outsourcing, originally initiated under Margaret Thatcher's outsourcing of cleaning, catering, laundry and other support services and the creation of the NHS 'internal market' fostered by her Conservative government's 'purchaser- provider split' in the NHS:

“The cost reductions achieved by outsourcing, and the profits made by the outsourcing companies, were made largely by paying workers less.” (Leys and Player, 2011:27)

And in this context, the UNISON Black SOG participants in this research, working at the NHS Trust as porters on NHS terms and conditions but managed by private contractor Carillion, explained how the process of privatisation unleashed by Thatcher and continued by New Labour had resulted in a two tier workforce, as whilst they, through union UNISON, had been able to negotiate staying on NHS terms and conditions when their portering functions were transferred by their NHS Trust to the management of private contractor Carillion, agency workers doing the same job were being hired by Carillion on less pay and worse annual-leave/holiday, pension, training and sick pay entitlements. Hence Leys and Player's observation on NHS outsourcing of some support services:

“The unions did their best to defend them, as well as those who were later affected by the transfer of portering and maintenance work to the private owners of PFI hospitals from the late 1990's onwards. TUPE (Transfer of Undertakings Protection

of Employment) regulations gave them some protection against being replaced by new workers employed on worse terms, but they had no choice about transferring.” (Leys and Player, 2011:28)

Black and minority ethnic NHS workers and migrant workers are concentrated in NHS outsourced areas of employment like portering, cleaning and catering, in which private contractors like Carillion and G4S have contributed to an increase in precarious and insecure work, including use of zero hours contracts which create a ‘two tier workforce’.

It is in this context that discussing trade union resistance to neoliberal ‘healthcare commodification’ Jane Lethbridge highlights the links between race equality and social justice campaigns for a living wage (and in this regard linking race equality to a social justice campaign for a living wage was put forward as a motion at UNISON’s 2014 National Black Members Conference):

“...the East London Communities Organisation (TELCO), has campaigned against low pay in the National Health Service in partnership with UNISON...the low pay was a direct result of the contracting out of catering and cleaning services. ...TELCO pointed out that low rates of pay impacted on ‘Household poverty, the health of staff, the quality of services delivered to the public, the turnover and management of ancillary services. It also observed that the majority of contracted out staff in East London are women from black and minority ethnic groups. Their second class pay and conditions are inconsistent with the obligation on public bodies to actively promote racial equality under the Race Relations Amendment Act.” (Lethbridge, 2009:114-115)

At the time this research was conducted approximately 30% of the Local NHS Trust’s hospital sites in which the UNISON Black SOG and NHS BME Network members were based were funded through the Private Finance Initiative, whilst the Trust’s NHS Foundation status further incentivised its provision of private health care services across its hospital sites, as the NHS Foundation Trust commercial contracting orientated policy initiated by New Labour Health secretary Alan Milburn in 2002 was further accelerated by the Coalition government’s Health and Social Care Act 2012:

“The cap on ‘Foundation Trusts’ generation of income from private care is raised, allowing them to earn almost half their income from non-NHS patients, thereby blurring boundaries between what is NHS funded care and what is private...Now

Trusts will be in a race to generate income from private paying patients and the principle of equity will be disrupted further.” (Pollock and Price, 2013a:20)

In 2000 Britain’s private healthcare industry negotiated a ‘concordat’ with New Labour enabling private providers to treat NHS patients:

“By 2009, 149 private hospitals, treatment centres and clinics were treating NHS patients on the NHS, and using the NHS logo.” (Leys and Player, 2011:1)

### **‘Doing More with Less’ – The Nicholson Challenge**

In the same 2010/11 period that the NHS BME Network published its National Operating Framework, NHS Chief Executive, Finance Directors and Senior managers were all repeating the mantra of “doing more with less” as dictated by the directive announced by the then NHS Chief Executive Sir David Nicholson (2006-2012) for the whole of the NHS to deliver £20 billion in “efficiency savings” by 2015. This directive dubbed “The Nicholson Challenge” was imposed against a backdrop of a rapid reversal in growth of NHS funding, linked to a UK economy seriously affected by the 2008-9 financial crash. Here it is useful to note that the Nicholson Challenge was based on a 2009 Report ‘Achieving World Class Productivity in the NHS 2009/10 – 2013/14: Detailing the Size of the Opportunity’ drawn up by management consultancy McKinsey and Co, which “called for ‘efficiencies’ in the shape of fewer staff doing the same or more work” (Leys and Player, 2011:125).

Frontline clinical services alongside managerial-administrative and support services were to bear the brunt of the NHS austerity drive, with hospitals urged to “consider radical solutions such as closing beds, reducing staff numbers....” because “the evidence suggests efficiency gains will not be made unless beds and services are closed” (Hurst and Williams, 2012:17).

However, the impact of this ‘doing more with less’ approach, linked to increased marketization, deregulation and efficiency savings within the NHS, has contributed to a

marked deterioration in the quality of patient care across the NHS system as a whole, as evidenced by a catalogue of patient care scandals:

“NHS staffing levels are emerging as a key concern of the Francis Inquiry into substandard care at Mid Staffordshire Hospital where finances were put before patient care and staff numbers cuts to save money. Inappropriate and low levels of staffing have previously come to light in the corporate nursing home and residential care sector through scandals like Winterbourne.” (Pollock and Price, 2013a:24).

In this regard the Private Finance Initiative (PFI) policy endorsed by New Labour and successive governments for the construction of hospitals and contracting out of support services is a key element in the decline in the quality of patient care linked to staff cuts. Highlighting the role of PFI in NHS austerity, authors Pollock, Price and Liebe (Pollock et al., 2011) highlight how rising interest rates since the financial crisis of 2008 have exacerbated the financial pressures faced by PFI hospitals, and Pollock and Price state:

“PFI costs drive service closures, bed and staff reductions due to the high cost of debt servicing and enormous transfers of resources from patient care to bankers, shareholder and financiers.” (Pollock and Price, 2013b:1)

And it is in this context that the National Audit Office calculated that because PFI involves contracts between the public and private sector that can run for 30- 60 years, the public will have to pay £199 billion for PFI until the 2040's, with annual charges estimated at £10.3 billion in 2016-17 (HM Treasury, 2018).

UNISON Black SOG activists working as porters who participated in this research were able to draw on their own lived experience of the impact on their working lives of private contractors managing outsourced services via PFI schemes, and ultimately the unsustainable nature of the PFI relationship when the outsourcing private contractor Carillion – which managed them and ran NHS Private Finance Initiative schemes at their local NHS Trust along with PFI initiatives at other NHS hospitals in England and Scotland – financially collapsed in 2018 (Blackburn, 2018; Qamar and Collinson, 2018).



In 2012, Andrew Lansley the Health Secretary in the Coalition Government managed to get the Health and Social Care Act passed, enforcing massive top-down restructuring of an NHS already destabilised by austerity cuts hitting the whole of the public sector. NHS austerity meant the workforce were facing increasing workloads, and working longer hours with the Coalition government's pay freeze on public sector workers, whilst the cost of living was constantly rising, contributing to increasing rates of in-work poverty. Nevertheless, the role of global management consultancy McKinsey, who between 2006 and 2010 received £30 million from New Labour for devising approaches to open up the NHS to further marketization, alongside their input in framing the 'Nicholson Challenge' NHS "efficiency savings", was continued under Lansley:

“...McKinsey's influence with politicians ran so deep that many of the firm's proposals for Andrew Lansley's controversial Health and Social Care Bill were included in the legislation wholesale...The bill would ultimately make most of the NHS' sizeable budget available to the private sector, with many valuable contracts likely to be won by clients of McKinsey.” (McDonald, 2015:286; see also Pollock and Price, (2013b); Leys and Player, 2011)

In 2014 the local UNISON Black SOG activists participating in this research joined other NHS nurses, porters and healthcare assistants in a strike over pay, supported by other unions including Unite, GMB, and the Royal College of Midwives – the first NHS national strike since 1982. In 2018 UNISON, alongside other trade unions, negotiated an NHS pay deal increasing the minimum basic rate by 10% to £8.92 per hour, with all jobs in Band 1 moving towards a living wage rate and being changed to Band 2 by March 2021. In 2016 UNISON, alongside other health unions, released a joint statement denouncing the upsurge in private sector involvement in the NHS, which was costing £18 million a day, facilitated by the Health and Social Care Act 2012:

“Resources are scarce and this surge in privatisation is a huge waste of public money. The billions spent creating the internal market, in which private firms are thriving could have gone on patient care...we urge the government to call time on its failed privatisation experiment.” (Prentis et al., 2016)

As a national trade union, UNISON had fought determinedly against the Health and Social Care Bill, and this is the wider institutional context in which the local Black SOG activists participating in this research were collectively organising within their NHS workplace and within the Black SOG Regional and National Black Members structures, as part of UNISON's "wider activist approach to defending the NHS" (UNISON, 2012).

Whilst commending the contribution of UNISON to challenging marketization in the NHS, Leys and Player (2011) also note the dissenting voice of Professor Allyson Pollock, who has determinedly and consistently highlighted the corrosive effects of increased marketization on the NHS' founding principle of universal healthcare. In their exposé of the implications of the Health and Social Care Act 2012, Pollock and Price state:

"The effect was to transform the English NHS from a nationally-mandated public service required of the government under primary legislation, into a service based on commercial contracting...exacerbated by non-accountability to Parliament of commissioners and providers. Abolition of the duty of the Secretary of State to provide or secure provision of health services was the second change that brought that transformation about." (Pollock and Price, 2013a)

It is this analysis which informs Allyson Pollock's call for a 'NHS Reinstatement Bill' which will protect "...more than a century of activism and commitment to universal public health care" (Pollock and Price, 2013a:32).

And, in this regard it was UNISON's first Black President, a practising NHS nurse for 40 years and UNISON Black SOG activist who, as the elected Labour MP for Wolverhampton South West (former Conservative Health Minister Enoch Powell's constituency), presented the NHS Reinstatement Bill in the Houses of Parliament on 11<sup>th</sup> July 2018. Combining the fight for race equality with social equality to defend the principle of the NHS as a universal Public Health Service, as advocated by Colin Prescod in his 'provocation' to the 2011 NHS BME Network Conference delegates assembled at the Park Lane Hilton in London. Thus in 2018, to coincide with the 70<sup>th</sup> anniversary of the NHS, UNISON launched and promoted its 'Race for Equality: Challenging Racism in the

NHS' (UNISON, 2018) political and workplace campaigning resources throughout its national, regional and local branch Black SOG structures.

### **The NHS BME Network**

The Local NHS Black and Minority Ethnic Network featured in this research was based at the same local NHS Hospital Trust as the local UNISON Black SOG. It was launched in 2012 – the same year as the Health and Social Care Act – by Black and minority ethnic NHS workers, who were motivated and inspired to set up a local staff network by the launch in 2010 of a National Independent NHS BME Network, which quickly assembled a constellation of affiliated local NHS BME Networks. In this regard the local affiliated NHS BME Network featured in this research was like the national NHS BME Network on which it was modelled: a self-organised collective body of BME NHS workers, rather than an employer- or HR-initiated staff network. However, whilst both the National NHS BME Network and the local NHS BME Network positioned themselves as 'critical friends', lobbying and maintaining a 'critical voice' in a manner similar to the Black and Asian Professional Associations in the criminal justice system discussed by Phillips (2007), their dependence on funding and resources from NHS employers and management meant their level of independence was always relative. In this regard the National NHS BME Network, in its 2010 Operating Framework, called on the NHS to resource the development of local BME Networks. Thus, the local NHS BME Network in this research did not receive direct funding from the local NHS Hospital Trust. The local NHS BME Network steering group's members were given time by the Local NHS Trust to attend Network meetings, which ran for two hours on a bi-monthly basis, but the steering group was not officially allocated additional time to conduct Network business. However, event sponsorship and funding would be made available by the local NHS Trust for big strategic events like the annual local NHS BME Network Conference events and October Black History Month events, which as well as Trust staff were attended by patient and service user groups, local

community groups and the wider public. In this sense the local NHS Trust's 'strategic' financial support of the local NHS BME Network enabled both 'inward' and 'outward' promotion of its institutional (Ahmed, 2012) commitment to equality and diversity.

### **BME Diversity Networks as leadership interventions**

In a similar vein the National NHS Network, which held its annual conference event at the Hilton Park Lane, London, would be attended by NHS Chief Executives – again keen to demonstrate their commitment to advancing race equality and promoting diversity in the NHS.

NHS institutional support at a local and national level for BME staff and other diversity networks flows from NHS policy guidance on developing a more diverse leadership, linked to business case rationales for greater equality and diversity within organisations, such as McKinsey and Company's 'Diversity Matters' (Hunt et al., 2015); and 'The Business Case for Equality and Diversity: A Survey of the Academic Literature' (Department for Business Innovation and Skills, 2013). And in this regard it would appear that the primary focus and function of the local NHS BME Network and the national NHS BME Network was to increase the pressure on the NHS to implement "leadership interventions" aimed at BME staff, with BME Networks being an important strategy "for increasing the diversity of the workforce at senior levels in the NHS, in order to deal with the problems of...staff disaffection" (Esmail et al, 2005:3).

"Networks have been used quite widely as a management tool to encourage black and minority ethnic staff to overcome the informal networks and the sponsorship and patronage that may exist amongst work based groups of senior executives and directors...the networks provide social support, professional development and access to mentors and role models of the same race/ethnicity or gender. Although aimed primarily at individuals, they also allow members to act in concert, reducing the risk for individuals, when they identify deficiencies in the system leading to discrimination or when they make suggestions for changing aspects of the organisational culture." (Esmail et al, 2005:29)

The deeply entrenched patterns of racial discrimination documented within the NHS have been highlighted by Esmail et al (2005), with Kline's influential 'The Snowy White Peaks of the NHS: a survey of discrimination in governance and leadership' (2014) argument that racial discrimination in the form of lack of BME representation at Board, Chief Executive and senior management levels would also have a detrimental effect on patient care, which would be damaging to the fundamental NHS principle of equality, essentially reasserting Esmail et al.'s (2005) stance that the UK's 21<sup>st</sup> century diverse and multi-ethnic population needed to be reflected at all levels of the organisation:

“The business case for diversity in the top management of the NHS recognizes that in order to improve the quality of services delivered to BME patients; the organisations that constitute the NHS need to embrace diversity as a central facet of their business plans.... The business case for developing a coherent strategy for diversity management works alongside the legal framework that ensures equal opportunities and a moral argument for social justice.” (Esmail et al, 2005:4)

It is in this context that in 2008 the South East Coast BME Network (the forerunner to the national NHS BME Network) published its 'Race Equality Review' (Lyfar-Cisse, 2008), a report whose evidence was highly damaging to the reputation of the NHS, attracting the attention of the Health Service Journal (HSJ), which followed up the 'Race Equality Review' with its own damning survey. Where Esmail et al had noted that: “Nearly two thirds of cases in the Employment Tribunals are from the NHS and nearly 80% of these are related to allegations of racial discrimination” (Esmail et al, 2005:3). Similarly, the South Coast BME Network 'Race Equality Review' highlighted the disproportionate rates of BME staff facing disciplinary procedures, subject to bullying and harassment, taking out grievances and experiencing low rates of recruitment, retention and progression within the South Coast NHS region. Thus publication of the South Coast BME Network 'The Race Equality Review', confirming evidence provided in previous studies of the systemic racial discrimination experienced by Black workers in the NHS workplace, provided the mandate and impetus for the cohort of Black NHS workers who had produced the 'Race Equality

Review’ to launch the national NHS BME Network in 2010, spurring the development of affiliated local BME NHS Networks in England, including the one featured in this case study.

### **Structure of the Local NHS BME Network**

Mirroring the National NHS BME Network, which asserted its ‘independent’ status, the local NHS BME Network, based in a local NHS Hospital Trust in an England region of the NHS, was formed autonomously by BME workers in 2012, and was not an employer led or HR initiated staff network. A steering group comprised of eight BME NHS professionals were the core activists that developed a constitution and terms of reference (modelled on the National NHS BME Network constitution), thereby receiving recognition from the local NHS Hospital Trust. Formal recognition from the local NHS Hospital Trust was solidified by the local NHS BME Network sending representatives to the Trust’s Equality and Diversity Committee Meetings, which met on a monthly basis and had a scrutiny responsibility overseeing the Trust’s compliance around its Equality and Diversity commitments in relation to patients and staff.

Whilst the local UNISON branch’s Equality rep (also a local UNISON Black SOG member interviewed for this research) attended the Local Trust Equality and Diversity Committee Meetings, the Local NHS BME Network steering group were not part of the Local Trust’s Joint Consultation Negotiation Committee, made up of representatives from the recognised trade unions and nominated staff representatives. As this was the major staff and management forum in which major issues affecting the Trust workforce could be raised via a collective bargaining approach, the local NHS BME Network’s non-participation in this forum may have blind-sided the Network to some of the issues being raised collectively by the union reps on behalf of their members, particularly around low pay for outsourced and subcontracted ancillary workers – porters, cleaners, caterers, and domestics – linked to the injustice of the Trust’s three tier pay system (agency, Carillion,

Trust). Similarly, the Trust providing more support for workers whose first language was not English and frustration at high numbers of Black and minority ethnic and migrant workers reporting bullying and harassment and receiving case work representation from UNISON stewards around disciplinaries and grievance procedures were issues being raised by UNISON reps, who were Black SOG members within the Joint Consultation Negotiation Committee, whilst the local NHS BME Network was unable to engage with these major issues via a collective bargaining approach by dint of not having representation within the Joint Consultation Negotiation Committee. Thus in the period where interviews for this research were conducted with local NHS BME Network members, the research interviewees informed that whilst the local Network steering group had made a request for workforce data around race and ethnicity, there was as yet no process agreed around the Trust providing key equality and diversity indicator data such as BME staff subject to disciplinaries and grievances to the steering group (until the introduction of the WRES in 2015).

### **Facility Time - NHS Guidance to support BME Networks**

Whilst the Local Hospital Trust had clearly defined Trade Union facility time agreements with UNISON and the other recognised trade unions, management restrictions and reservations around levels of formally agreed facility time may have been a factor around the local NHS BME Network members not attending the Joint Staff Negotiating Committee, in a context where Trust managers were reluctant to release staff for BME Network meetings they considered ‘non-essential’ and not part of the Trust ‘core business’. Thus the local NHS BME Network members felt they were conducting their organisational activities on a kind of semi-officially recognised, ad hoc basis, with some steering group members fully at ease in their attendance of local NHS BME Network meetings having received consent from their line managers, whilst other members were anxious and felt constrained because of lack of support and approval from their managers for their

attendance. So whilst the local NHS BME Network steering group met formally for two-hour meetings on a bi-monthly basis, informal lunch time meetings were also held to accommodate BME steering group members who found it more difficult to be released for Network meetings by their managers. Since the launch of the local NHS BME Network featured in this research, NHS England have recently produced guidance for NHS organisations around supporting black and minority ethnic staff networks which in its recommendations, states:

“All black and minority ethnic staff network chairs and vice/deputy chairs and executive committee members are allocated an average of half a day a week (as a minimum) facility time to conduct activities aimed at running the network and delivery of their business plans.” (NHS England, 2017:34)

### **Local NHS BME Network Activities for Challenging Racism in the Workplace**

Developed autonomously and officially launched by a core group of BME workers at their NHS Hospital Trust in 2012, the local NHS BME Network programme of activities for challenging racism in the workplace was very much influenced by the national NHS BME Network, which had launched in London in 2010. The local NHS BME Network was affiliated to the National NHS BME Network; one of the local Network’s steering group members (interviewed in this research) was on the executive committee of the National NHS BME Network; the local steering group members attended the National NHS BME Network annual conference; and the Black female chair of the National NHS BME Network was the keynote guest speaker at one of the local NHS BME Network’s first annual conferences, held at the local NHS Hospital Trust.

In this context, the local NHS BME Network’s programme of activities aimed at challenging racism in the workplace drew on the national NHS BME Network’s 2010/11 Framework, which asserted that holding the NHS to account on meeting its statutory duties around eliminating racial discrimination was its primary objective:



“The regions recognise the importance of equal opportunities and support the pursuit of equality for all. But whilst gender, disability, sexuality, religion and age affect all people, race discrimination is particularly damaging to our situation in the NHS and will therefore be the overriding concern for the NHS BME Network – Race Equality is the overarching principle of the NHS BME Network.” (NHS BME Network, 2010)

Assertion of race equality as the overarching principle by the National NHS BME Network was linked to its alignment to the Race Relations Amendment Act 2000 placing of a legal statutory duty on NHS organisations to promote race equality. In this regard, the National NHS BME Network shared an intention similar to UNISON’s Black SOG structures to ensure the legislative legacy of the Stephen Lawrence Inquiry, Macpherson Report and Race Relations Amendment Act 2000 continued to be implemented in the workplace. However where UNISON, through the collective trade union efforts of its Black SOG members, had from the late 1990’s been able, through its experience of supporting the Stephen Lawrence Family Campaign for Justice, to turn intention into tangible action by developing its Challenging Racism in the Workplace toolkit of resources, guidance and training courses, both the national NHS BME Network and the local NHS BME Network had no such similar independently and collectively developed suite of anti-racist training resources to draw on.

Whilst the national NHS BME Network’s 2010/11 Operational Framework invoked the Race Relations Amendment Act 2000 to assert race equality by 2010, the equality legislative framework had changed with the introduction of the Single Equality Act. Thus by 2011 the NHS Equality and Diversity Council (formed in 2009 with UNISON represented as a key member: during this research the National NHS BME Network was not represented on this influential body) had developed the Equality Delivery System (EDS) (upgraded in 2014 to EDS2) as a system enabling NHS organisations to adhere to statutory requirements set out in the Equality Act 2010 and the Public Sector Equality Duty, including ensuring better outcomes and equality of service delivery for patients and

service users and ensuring better work environments which are free of discrimination in relation to the 2010 Equality Act's nine 'protected characteristics'. In this context, much of the local NHS BME Network's energy and focus was placed on participating in the local NHS Trust's EDS patient and staff-side consultation and scoring process. And on this point the Local NHS BME Network steering group interviewees participating in this research informed that they had registered the Local Network's view that the Trust had scored itself too highly in regards to its EDS scores on race equality, and that the Network was in a process of negotiation with the Trust's Equality and Diversity Committee around release of relevant race and ethnicity workforce data. This was an approach similar to that already conducted by the local UNISON Black SOG, which applied UNISON's 'Challenging Racism in the Workplace' guidance around monitoring employment processes by ethnicity in relation to recruitment, promotion and rates of grievance and disciplinary procedures experienced by Black workers.

As noted earlier, the local Black SOG members were able to request that UNISON stewards and convenors participating in the local Trust's Joint Staff Negotiation Committee receive relevant ethnic monitoring data on a quarterly basis. And in this regard, some members of the Local NHS BME Network were mindful of and shared the National NHS BME Network's call in its 2010/11 Operational Framework (NHS BME Network, 2010) to pressure NHS organisations and regulatory bodies: "... to bring forward a fit-for-purpose common race equality performance standard."

Thus as a result of this activist pressure, in the course of this research, in 2015 NHS England introduced a mandatory workforce race equality standard (based on the leadership interventions approach aimed at black and minority groups recommended by Esmail et al (2005), and the 'Snowy White Peaks' related research of Roger Kline (2013, 2014)). NHS organisations were tasked with collecting information on nine workforce indicators or metrics, comparing experiences of white and BME staff. The WRES metrics included:

“Percentage of BME staff in bands 8-9 (very senior managers, including executive board members and senior medical staff) compared with the percentage of BME staff in the overall workforce”

“Relative likelihood of BME staff entering the formal disciplinary process, compared with that of white staff entering the formal disciplinary process...” (NHS England, 2015a)

Supporting the NHS implementation of the WRES, based on arguments highlighting ‘mandatory standards’ as ‘effective strategies’ for improving ‘workplace diversity’, Priest et al in the BMJ stated:

“Studies from a range of contexts indicate that mandated policy interventions to promote diversity that have legal or funding consequences are associated with better outcomes than non-mandated policies... [an] approach that has had striking results in the US is the Rooney rule... Implemented in 2003 by the National Football League... Within three years, the number of black coaches recruited increased substantially...” (Priest et al, 2015)

This was the policy context in which the local NHS BME Network sought to act as a ‘critical friend’ by supporting the Local Trust’s WRES monitoring and reporting mechanisms. This is an approach advocated by NHS England in its diversity management inflected business case guidance for NHS organisations to support and resource development of local NHS BME Networks:

“For many NHS organisations across England, the introduction and effective running of a BME staff network is an important part of putting into practice the Workforce Race Equality Standard (WRES) and associated action plans...” (NHS England, 2017)

It is an approach that has stripped out the confrontational stance and tone of the independent National NHS BME Network, which in its own call for a ‘minimum performance standard’ for delivering race equality stated in its 2010/11 National Operational Framework argued for the application of “deterrent sanctions” for NHS organisations non-compliance with their race equality duties.

## **Training**

As part of its Equality Delivery System requirements, the local NHS Trust was required to ensure all its staff received mandatory equality and diversity training, which at the time of this research was accessed by the Trust's NHS staff once a year online. The Trust's three tier contract system of staff (Agency, Carillion, NHS Trust) as relevance here, as UNISON Black SOG research participants working as porters who were managed by private contractor Carillion informed that they hadn't received equality and diversity training from Carillion or the Trust in years, and they explained that equality and diversity training was not a consideration by management for agency staff they worked alongside.

In this context the UNISON Black SOG members interviewed in this research referred to the high value placed on the range of free training courses they were able to access via UNISON, including equalities training, 'new stewards training on employment rights, and 'Challenging Racism in the Workplace' training. This comprehensive training activity was geared towards recruiting more members into the union and branch as workplace reps, stewards and activists. The training equipped the members to conduct the Union's organising and campaigning work around improving members' terms and conditions through collective bargaining with a focus on protecting public services from privatisation and austerity cuts which were disproportionately impacting on Black and migrant workers.

In contrast, the Local NHS BME Network's approach to facilitating training for its members was orientated towards individualised leadership programmes, ostensibly designed to provide BME staff with the necessary equipment to break through the NHS glass ceiling. In this sense the local NHS BME Network reflected Esmail et al.'s (2005) recommendation that the NHS support BME Staff Networks as a leadership intervention for ethnic minority staff to "overcome the informal network and the sponsorship and patronage that may exist amongst work based groups of senior executives and directors..." (Esmail et al, 2005:29).

Members of the local NHS BME Network steering group interviewed in this research informed that they had been on the NHS positive action ‘NHS Breaking Through Programme’ (which ran from 2004-2008), and this diversity ‘talent management’ approach was displayed in the local network’s provision of professional development workshops and coaching seminars resourced by the local NHS Trust and facilitated by management consultants linked to the national NHS BME Network. The Local NHS BME Network also liaised with the NHS Leadership Academy to encourage more diverse BME staff representation in NHS Leadership Academy initiatives and events. The Local and the National NHS BME Networks’ approach to offering training for its members conformed to NHS England’s corporate business approach to diversity management, in which BME NHS workers participate in a kind of trade-off, where the promise of access to leadership roles requires acceptance of neoliberal- austerity aligned business ideologies. This orientation is articulated in ‘Improving through Inclusion: Supporting Staff Networks for black and minority ethnic staff in the NHS’, which states:

“Continued financial limits mean that the NHS will need to identify ways to work with less money to deliver services...diversity unlocks innovation and staff networks are well placed to demonstrate frugal innovation. Having to deliver their goals using limited resources and time, staff networks identify ways to do better with less. They can embrace a business enthusiasm...” (NHS England, 2017:30)

## **Black History Month**

Both the Local NHS BME Network and UNISON Black SOG held annual events and conferences at the local NHS Trust. In this regard the main events in the annual calendar for the local Black SOG and the local NHS BME Network for the purpose of celebrating Black success via inviting motivating and inspiring speakers to address aspects of Black History were October Black History Month events. During the course of this research the Local NHS BME Network held annual Black History Month events, which were supported by the UNISON Black SOG, and these Black History Month events provided organising and recruitment opportunities for both the local NHS BME Network and UNISON Black

SOG. The Local NHS Trust, as with most public sector organisations that have incorporated Black History Month into their calendar of workplace diversity activities, provided the local NHS BME Network with funding for these events. Because the Local NHS BME Network and UNISON Black SOGs invited diverse BME service users and BME community groups to these gatherings, the local NHS Trust recognised that its support of the Black History Month events was a means of demonstrating institutional commitment to diversity (Ahmed, 2012), alongside fulfilling its EDS obligations. This diversity management institutional incorporation of Black History Month is obviously in tension with the ‘Black Radical Tradition’ of Black History Month described below by Angela Davis:

“When we celebrate Black History it is not primarily for the purpose of representing individual Black people in the numerous roles as first to break down barriers in the many fields that have been historically closed to people of colour, although it is extremely important to acknowledge these firsts. But rather, we celebrate Black history, I believe, because it is a centuries old struggle to achieve and expand freedom for us all.” (Davis, 2016:112)

### **BME definition**

Reflecting the shift in terminology influenced by diversity management (Ahmed, 2012) towards a ‘BME construct’, BME Network was the title assumed by the local NHS BME Network affiliated to the National NHS BME Network. In this regard the UK public and private sectors abound with diversity staff networks that use the seemingly ubiquitous acronyms BME or BAME, e.g.:

“BAMEed Network is a movement initiated in response to the continual call for intersectionality and diversity in the education sector...BAMEed...enables and showcase the talent of diverse educators...” (BAMEed Network)

As discussed earlier, Colin Prescod, in his speech to delegates at the national NHS BME Network in 2011, referred to the ‘Black’ activist history in the ‘BME concept’. Similarly, UNISON’s Black SOG structures passed a motion, ‘Defining Black’, at the 2013 National Black Members Conference because:

“UNISON has always used the term ‘Black’ as an inclusive and political term. However, it is also clear that many members do not understand why it is used – particularly when their employer and public bodies may use the term BME.” (UNISON, 2013)

In contrast, the national NHS BME Network provided the following “BME Definition” on its membership form:

“Any person whose ancestral origins are African, Asian, Caribbean, Chinese, Irish, Japanese, Middle Eastern, North African, Romany. The indigenous peoples of the South Pacific Islands, the Americas, Australia and New Zealand. People from mainland Europe and any persons visiting from overseas.” (National NHS BME Network, n.d.)

In reality, very similar to the ethnic composition of the local UNISON Black SOG, most of the members of the local NHS BME Network were from Black African, Black Caribbean, Filipino and South Asian heritage. And whilst debates on the contemporary ‘fragmented’ nature of ‘political Blackness’ are longstanding (Alexander, 2018; Hall, 2005; Modood, 1994; Anthias and Yuval Davis, 1993; Brah, 1996) the terms BME and BAME favoured by many diversity networks are also subject to contestation, as highlighted by Zamila Bunglawala, Deputy Head of the government’s ‘Race Disparity Unit’, who in arguing for diversity networks to stop using the acronyms BME and BAME, and instead use the term ethnic minority, stated:

“The acronym BAME and initialism BME...are widely used by government departments, public bodies, the media and others when referring to ethnic minority groups. Yet during research we carried out with nearly 300 people across the UK, we found that only a couple recognised the acronyms and only one knew vaguely what they actually stood for.” (Bunglawala, 2019)

In this regard we note Avtar Brah’s reflection that: “...the replacement of ‘black’ by some other politically neutral descriptor will not secure more equitable distribution of resources.” (Brah, 1996:100).

Hence a key political difference in approach to race equality and anti-racism between UNISON’s Black Self-Organised approach and the NHS BME Network was indirectly

signalled by Colin Prescod in his key note speech to the national NHS BME Network

Conference in 2010, where he stated:

“The ‘Black’ in your BME concept has a very particular history of emergence...there is much point to looking at the activist meaning of ‘Black’, then, as compared to the activist meaning of ‘Black’ now.” (Prescod, 2011).

And, highlighting the crucial relationship between race and class in the context of post-war settlement of racialized African-Caribbean and Asian migrants, whose anti-racist politics were based on shared understandings of anti-colonial and anti-imperialist struggles,

Prescod informed the NHS BME Network Conference delegates, that:

“...for...maybe a decade and half, we forged the remarkable idea of ‘Black’ not as a mere label for skin colour, but as a political colour – as the colour of resistance to all race and class injustices. Note, not Black and minority ethnic, but just plain Black – all inclusive.” (Prescod, 2011).

In the last few years new editions of classic texts originally written in the period ‘When Black was a political colour’ (Bourne, 2016) have been published with new introductions and forewords contextualising anti-racist activism ‘then’ in relation to anti-racist activism ‘now’ for a new generation influenced by forms of contemporary identity politics, including “the politics of ethnic difference” (Kundnani, 2007:180), but unfamiliar with the shared ‘Third World’ anti-colonial and anti-imperialist ideological stance that formed the basis for the race and class solidarity forged in the UK under the unifying banner of ‘Black as the colour of our politics not the colour of our skin’ (Brah, 1996; Kundnani, 2007; Ramamurthy, 2013; Ramdin, 1999; Bryan et al, 1985; Sivanandan, 2008; Bourne, 2016).

In this context, Avtar Brah, who in an earlier period stated: “Class was an important constitutive element in the emergence of black as a political colour” (Brah, 1996:97), reflecting on the relative fragmentation of political solidarity in and between Asian, African and African-Caribbean communities, in the recent publication ‘Coming of Age: 1976 and the Road to Anti-Racism,’ (Brah, 2017) refers to the current implications of class



differentiation linked to the less radical politics of many ethnic minority business and professional elites:

“And identity politics is part of this. Nowadays you can’t talk about the ‘Asian’ as a palpable category: it’s Muslims or Hindus or Sikhs or Christians. Over the last twenty to thirty years, the ‘Asian’ category is fractured along religious lines. The category Black as a common referent for people of colour has also disappeared. Southall Black Sisters still call themselves Black Sisters, but black as a common symbol to refer to Asians and African-Caribbeans in our communities is gone now.” (Brah, 2017:131)

However, as noted earlier, UNISON’s definition of and continued use of ‘Black’ (passed at the 2013 National Black Members Conference) illustrates this ‘common symbol’s continued vitality and existence within trade union Black Self-Organisation in the UK. And whilst unrecognised in most mainstream political circles, it is still the case that every year, two of the biggest annual gatherings of anti-racist trade union activists in the UK and Europe are brought together under the banner of UNISON’s National Black Members Conference and the TUC’s Black Workers Conference.

## **Conclusion**

The above case studies section of the chapter presented the case study framework and discussed the case studies sample which contains a cross section of people active in each group. The local NHS BME Network sample spanned NHS bands 6-8, which reflected the Network membership of NHS nurses and allied health professionals including NHS managers and equality and diversity officers. Allied Health Professionals formed the bulk of the Network sample, and were equally present within the UNISON case sample. The samples for each case study reflect the diversity of activists in each group. Black workers are over-represented in NHS non-graduate entry grades Bands 1-4. The UNISON Black SOG sample included Black workers on NHS Bands 1-4 alongside Black workers managed by private contractor Carillion. The Black SOG activists featured in the case study were also fully active in the local UNISON Branch. Intersections of race, class, ethnicity and gender are apparent within the case study samples with Black workers on

Band 1-4 seemingly absent from the steering group and wider membership of the local NHS BME Network, in part reflective of a professional middle class aspirational outlook invested in ‘breaking the glass ceiling’.

The UNISON Black SOG case study organisation profiled in this chapter highlights the continued relevance and effectiveness of trade union Black self-organisation which can act as a mechanism for increasing Black workers’ involvement in UNISON activism, creating union reps and activists who can act in a wide range of union initiatives. This has the potential to make the union more diverse and properly representative of the workforce it defends. Black and migrant workers on bands 1-4 featured in the UNISON case study sample were well integrated into UNISON’s local, regional and national structures participating in activities linked to struggles against poor terms and conditions in the context of neoliberal austerity and privatisation.

# **Chapter 5 Voices of Black NHS workers challenging racism in the workplace**

## **Introduction**

This chapter presents a selection of excerpts from the 23 research interviews, representing some of the key themes emerging from the larger group. The narrative voices illustrate the high level of activism, leadership roles, and the perspectives of diverse women, within both case study organisations, on how they are challenging racism in the NHS workplace. The chapter also highlights some of the key political differences and similarities in approach to promoting race equality, through the medium of the research interviewees' discussions of the importance of identities, and how differentials of grade-banding, profession, class background and education affect their working lives and need to organise. The manner in which class intersects with race, gender and ethnicity is teased out through the research interviewees' discussions of labels and discrimination around race, education, accent, pay band and profession. The research interviewees relay their involvement in the local NHS BME Network and local UNISON Black SOG, highlighting different organising tactics, barriers and routes into active involvement (particularly for workers on a lower band). Assessments of the relative merits of the two case study organisations are presented by the activists within both case study organisations, linked to discussions around which groups of workers they appeal to, which issues they prioritise, and their levels of effectiveness in delivering results. The chapter also documents the research respondents' views on the relationship between the local NHS Trust and the two case study organisations, and the effects this may have on independence, credibility and ability to influence and act.

## **Black women leaders**

Black Women have long been at the forefront of Black self-organised trade union anti-racist activism and promotion of race equality in the NHS workplace and wider society (Anitha et al., 2018; Williams, 1993; Bryan et al, 1985; Parmar, 1994). And Black women

are in the forefront of current campaigns addressing racism in the workplace, including: the call for mandatory ethnicity pay gap reporting to accompany gender pay gap reporting; addressing the under-representation of Black workers at board, executive and senior leadership positions; and tackling the on-going scourge of Black workers being subject to disproportionate rates of disciplinarys in the workplace (Archibong and Darr, 2010)

Within UNISON, this activist tradition is exemplified by anti-racist campaigners such as Eleanor Smith, a Black NHS nurse who was elected president of UNISON in 2011, and who as the Labour MP for Wolverhampton South West (2017-2019) presented the NHS Reinstatement Bill to parliament in July 2018 (Parliament, House of Commons, 2018). Similarly, UNISON's National Secretary for Equalities, Gloria Mills, was elected President of the European Trade Union Confederation Women's Committee in 2015. During the period this research study was conducted, the local UNISON Black SOG representative on the local Health Branch committee was a Black woman: this woman (Rachel, interviewed in this research) was also the chair of the UNISON Regional Black Members Group; and the Local UNISON Health Branch committee's Equalities Rep (Carol, also interviewed for this research) was a Black woman active in the Branch's Black SOG. Black women are also leaders at the forefront of the development of many BME Diversity/Staff Networks in the public and private sector. The chair and vice chair of the local NHS BME Network (Annette and Jean, interviewed in this research) were Black women, and in the period this research was conducted the chair of the national independent NHS BME Network was a Black Caribbean woman.

As noted earlier, BME Networks are recommended as a strategic intervention within diversity management to tackle under-representation of ethnic minorities in senior leadership positions within public and private sector organisations (Esmail et al, 2005; McGregor-Smith, 2017; Williams and Yarker, 2017). In this context, research interviewee Annette, a Black Caribbean woman – one of a very few BME women working as a

Matron, at a senior nursing Band 8 grade in the NHS Trust – linked her activism helping to develop the local NHS BME Network to her lived experience as a Black Trinidadian heritage woman racialized as an ‘outsider’ (Virdee, 2014) and categorised as a ‘minority’ migrant worker within the NHS workplace. Noting official use of ‘BME’ in the workplace, but asserting a ‘majority world’ rejection of the notion of minority, for reasons similar to UNISON’s approach to ‘Defining Black’, research interviewee Annette, stated:

“Minority, if you think about it and break it down, Black yes, other ethnic groups yes, but why minority, you know, because where I come from in Trinidad...we have loads of ethnic groups...it’s one nation if you like there isn’t this concept of minority at all. That’s not to say that there isn’t difference amongst the races, there is, but there’s not this notion of minority people.”

And, emphasising her dislike of being categorised as a ‘minority’ in the workplace, research interviewee Annette, added:

“To say like, minority, is not so really, because you have large continents, you have Africa, you have Asia, you have all of these large continents which are non-white so why is it that non-white becomes a minority? That’s how I see it, why should it be minority, that’s my issue.”

In this regard, Avtar Brah highlighting the importance of the political solidarity of African-Caribbean and South Asian activists forged under the anti-colonial - anti-imperialist and therefore anti-racist political colour of ‘Black’ reminds us of the underlying ideological function that official terminology can play, and the role of anti-racist resistance in rejecting this coded form of racialization:

“...the sign ‘black’ was mobilised also as a displacement for the categories ‘immigrant’ and ‘ethnic minority’ which, throughout the 1960’s and 1970’s, had come to denote racialized re-definitions of belonging and subjecthood” (Brah, 1996:98)

In this context, for research interviewee Annette, BME and migrant NHS workers’ experiences of racial discrimination legitimised the development of a collective voice to more effectively promote race equality and represent the interests of those workers categorised as racial and ethnic minorities in the NHS workplace:

“In my experience, because you have this whole question of minority, the whole idea of the network is bringing that kind of minority together to give them a voice because as minorities they don’t have, they don’t have a voice, you know what I mean. So it’s kind of starting in a back position, you’re starting on a back foot anyway because you are considered minority. So that’s where the networks come in to give these people a bigger voice, to support them to have their opinions and their voice heard.”

The Local NHS BME Network set up autonomously by BME workers and launched in 2012 was in part inspired by and in due course affiliated to the independent national NHS BME Network, which was set up in 2010 (this independent BME NHS Network which appeared to cease functioning in 2017/18 is not to be confused with NHS England’s recently launched corporate NHS BME Network or the NHS Confederation’s BME Leaders Network launched in 2019). The national NHS BME Network in its 2010/11 Operational Framework refers to one of its key principles being ‘a bottom-up approach’ – meaning having close links with affiliated local BME Networks: “We will continue our groundings with our sisters and brothers to maintain the respect and stay grounded in their reality. This is the source of our legitimacy.” (NHS BME Network 2010:9).

Thus the chair of the national NHS BME Network was the key guest speaker at the local NHS BME Network’s first annual conference events held at the local NHS Trust, reinforcing the links between the local NHS BME Network and the national NHS BME Network. In this context, outlining how she thought the relationship between the local and national NHS BME Networks might develop, interviewee Annette stated:

“Well I think that it should be that the local group is quite tied into the national group and is able to influence. So let’s say you know you have a bit of legislation that’s going to be national legislation. I think the local group will say how does this work for us, how will this affect our local region and then the purpose of the national group will be to gather all of the information from the local Network and come up with one kind of national position or whatever it is so that you get that kind of from the ground-up – joined up position as to how this affects us.”

In the South East Coast BME Network Race Equality Review (Lyfar-Cisse, 2008) which spurred the development of the national NHS BME Network (launched in 2010), the Review highlighted the extent to which BME staff were disproportionately represented on

HR disciplinary procedures. For research interviewee Annette, as chair of the local NHS BME Network, lack of confidence in the local NHS Trust's HR department, which she linked to a lack of ethnic diversity within the HR staff make-up, was for her a major reason why the local NHS BME Network should exist. Annette voiced her concerns about the lack of race equality awareness and cultural competence within the local Trust's systems and processes, in a context where the NHS own Equality and Delivery System / EDS2 framework calls for managers to be able to work in a 'culturally competent' manner. In this regard, research interviewee Annette, shared her perspective that the systemic NHS racism, evidenced by the on-going disproportionate numbers of BME NHS staff subject to disciplinaries and grievance procedures, was linked to low levels of cultural awareness and cultural competence amongst some white managers and HR officers:

"The idea of race equality is about ensuring that people have what they need – as a manager I manage people from all the ethnic backgrounds and know for instance that I need to take a different approach to the Indian nurses, than I would to the African nurses, and again to the Filipino nurses. You have to tailor your approach to meet the needs of these diverse workers. There was a staff member who was coming back to work from leave, he was flying from Zimbabwe and his flight got delayed. His line manager wanted to reprimand him because of the delayed flight. Now I was able to appreciate it – he wasn't coming back on British Airways – but by the time I got involved he felt he'd been under so much pressure that he's handed in his resignation. But you know, I think that is where your cultural competence comes in, because if I had spoken to him first I would know that delayed flight was quite credible, you know that would be very credible, and so I would have been able to make allowance for that and then my first kind of interaction with him would be to negotiate how he makes the time back, and not make him feel pressured enough that he resigns. Cultural sensitivity is a real practical thing because if that ward manager had known what I know about Zimbabwe it might have made a difference between whether he was going to continue working or not."

Thus research interviewee Annette, added:

"I think that's where the Network can help people to be alive to what is politically correct in terms of equality and diversity. And it shouldn't have to be so, because actually it's the Trust's responsibility, but in reality that's where the Network can come in and really help people to understand, giving people the confidence to challenge. I know where I can get the support to do that because that's what people need really."

With BME Networks increasingly being positioned within diversity management discourse as important strategic vehicles for increasing ethnic diversity in senior leadership roles within public and private sector organisations (and by implication improving the ‘social mobility’ prospects of ethnic minorities in the UK) one of the key areas of focus of many BME Networks in this regard is the area of ‘Talent Management’ for senior leadership, (e.g. see Powell et al, 2013 ‘Has the British National Health Service (NHS) got talent? A process evaluation of the NHS talent management strategy’). Thus the national NHS BME Network outlining its aim for ‘Developing Talent and Inspiring BME Leaders’ states:

“The NHS BME Network will promote positive action programmes to increase the number of BME staff in senior management positions in the NHS.” (NHS BME Network, 2010).

Similarly, a major aspect of the local NHS BME Network’s approach to challenging racism in the workplace was inviting powerful role models to speak at annual conferences, and Black History Month events, alongside the facilitation of career development coaching and workshops, often delivered by BME business and management consultants offering coaching strategies designed to empower individual BME NHS workers to progress into senior leadership roles. In this sense corporate aligned BME Diversity Network’s harnessing Talent Management strategies might also be associated with the aspirational occupational status of the UK’s Black professional middle class, situated in the public and private sector, intertwined with the layer of BME ‘emerging service workers’ identified by Savage (2015) in the Great British Class Survey. In relation to the NHS a major issue prompting the launch of the Workforce Race Equality Standard is the large number of BME allied health professionals clustered in the intermediate NHS Bands 5-7 frustrated by lack of progression into senior management roles.

In this context, an interesting insight into the value and benefits attached by some Black professionals in the type of positive action mentoring and coaching workshops and programmes developed in recent years to assist BME workers to break through



organisational glass ceilings is given below by the chair of the local NHS BME Network, research interviewee Annette who, commenting on her sense of responsibility of being a positive BME role model in the NHS workplace challenging negative stereotypes around the intellect and professional competence of Black workers (as discussed in the TUC ‘Let’s Talk About Racism’, 2017; and the McGregor Smith Review, 2017), stated:

“The fact that I have been able to show people that really Black people can get to a Senior Matron Post, you know that it’s not impossible. I think it has been important for me and because I’ve worked really hard in terms of academically to achieve and all the way I’ve kind of said to people there’s nothing stopping you from doing what I’ve done, you are able to do that.”

And in an institutional context where Black women are largely absent from and under-represented in senior leadership positions within the NHS despite the huge contributions of Black women to the building and sustaining of the NHS since its inception (Black Nurses: The Women Who Saved the NHS, 2016; Kyriakide and Virdee, 2003; Bryan et al, 1985), research interviewee Annette, noted:

“The importance as a Black woman of showing others what’s possible, it’s very important. From my experience here at the Trust for instance, when I went on to the Breaking Through Programme. I was really energised, and I was thinking yes, because I had made contact with you know women, and it was all women and there was 30 something of us and we spent a week together and it was really, real powerful dynamic women. We spent this week together all NHS, all BME from Manchester, Leeds, London, really powerful women that had achieved and I went back to work really energised, it was like yes we can do this.”

“And I remember another nurse saying to me she hadn’t done the training, and she said how did you do that, and I said I applied, I said have you ever applied to do it? And she said I won’t get it anyway, and I said but you haven’t applied so you don’t know until you’ve applied, you know what I mean. And that’s why it’s important for me, you can apply to do it you have as much right to apply as the other person and then you have the ability you know – we’re not stupid because we’re Black or lack intellect. So, yes that for me was the greatest impact.”

And equating the potential for the local NHS BME Network to have as much impact as she felt from participating in the NHS Breaking Through Programme, research interviewee Annette stated:

“Thirty women, it was like a network. A few of us still kind of make contact and stay in touch. It was the first ever Black and Minority Ethnic Strategies for Success for Women’s Programme, and it was kind of a catalyst for me realising that actually because I’d been in my previous role for ten years and I’d reached the glass ceiling, I wasn’t progressing and this programme came up and I think it was the Equality and Diversity lead at the time who sent it to me, she was Black. And I went on that programme. It was a residential programme you went away for the week. So you worked and lived together and it was really fantastic! It really was inspiring. Certainly for me and I know the other women it was life changing it really was. And if the networks could support anything like that where you get the Black woman’s company that was brought in to deliver the programme, it was really fantastic.”

### **Lack of BME trade union reps equals alternative BME networks**

Research interviewee Annette, discussing her professional position as a Matron and senior manager, as one of a very few BME nursing members of staff at such a senior grade in the local Trust, also linked her individualised approach and on-and-off engagement with trade unions – specifically the RCN and UNISON – to a lack of BME trade union representatives active within local NHS Trusts.

Beginning with the local Trust’s HR department, research interviewee Annette, stated:

“So most of the human resources from my knowledge, our human resources here there’s only one minority ethnic – if you want to call them that – person as a human resource consultant, HR and the whole recruitment here is white. They’re not going to be able to accurately reflect the experience, because they can’t understand it they haven’t felt it, not accurately anyway. They’re never going to know how it feels.”

Similarly, discussing her perspective on trade unions’ ability to represent BME workers, research interviewee Annette, who at the time of interview was a member of the RCN commented:

“My interaction with unions as always been as a manager you know, and seeing RCN people supporting people, UNISON supports people, RCN doesn’t. They [RCN] do have a regional equality and diversity lead but she’s white and again, there’s this whole thing about who feels it knows it.”

And putting forward an individual servicing model rather than collective organising approach to trade union participation, which also informed how she positioned and viewed the role of the local NHS BME Network, research interviewee Annette, added:

“I’m a member of a union mostly because of my profession as opposed to anything else. As a nurse I know that it is important that I have a union because if it comes to any issues around professional practice I will need a union. I could make use of their services but I do not use it for any other purpose and I don’t get involved in any of the other activities.”

The observation that “UNISON supports people, RCN doesn’t”, can be better understood in the context that within the research interviewee’s local NHS Trust there was a strong visible presence of Black UNISON stewards, reps, branch officers, and an active Black SOG reflecting and representing members on lower as well as middle and higher NHS bands. In this regard, highlighting the need for active and visible BME representation within NHS and trade union organisational structures, research interviewee Annette, stated:

“They have to get the representation of the people who they serve, so you know, you have a Trust this size with 2,000 or more members of staff, you have two or three RCN people around and they are all white, you know band 5 and above. Everybody knows anything below band 6 is probably Black and minority ethnic, there isn’t one non-white representative that they can go to and that’s where my conflict has come in.”

Thus presenting the local NHS BME Network as an alternative forum to trade unions where BME workers can connect and get support from colleagues with a shared experience of racial discrimination in the workplace (Phillips, 2005; Phillips 2007; Holdaway, 2010), research interviewee Annette stated:

“I can give advice from my own experience and what I know of the organisation and the policies, you know what you’re entitled to what your rights are in the situation and I think people don’t trust the union representatives to do that.”

### **UNISON supports BME workers in the lower grades**

Jean, the Vice Chair of the local NHS BME Network, was a dual-heritage band 7 senior manager. For Jean, her task via the collective voice of the NHS BME Network was to assert ideas of diversity and inclusion in the NHS workplace:

“That’s what we need to look at as a group – dispel the myth that this is an uprising of Black people in the Trust – that’s not what the group is about – that’s not what I want to be about – it’s about support, enabling, encouraging, empowering – that’s my view on my role within the BME group.”

However, alongside promoting greater diversity, Jean informed that her experience of systemic racism from nurse trainee, to fully qualified nurse, and now manager, at different career levels and organisational settings within the NHS was also a key reason for her participation in the NHS BME Network. In this regard, Jean recalled getting a place as a trainee cadet nurse in her local hospital at 16 but having to fight for her place as a SRN. This was recounted in relation, as a BME worker, to her current membership of the RCN (which she contrasted with UNISON), and Jean's reference to 'elitism' around occupational status, indicated the reproduction of racial hierarchies and ethnic enclaves within the field of nursing:

"I don't think the take up is as great as in UNISON – probably because there are more BME workers in the lower grades – they are seen as a bit elitist – it's for qualified nurses, but in my day in the wards, the Black nurses were the auxiliary nurses, or the enrolled nurses as it was – I had to fight for my place in the SRN, because normally you were put into the SEN."

Similar to Annette's testimony above, Jean argued that her body the RCN should work more closely with the local and the national NHS BME Network because of the patchy and inconsistent level of representation available to BME nurses seeking support around race equality issues:

"BME workers are probably more of a minority in the RCN than they would be in UNISON or Unite."

And in this regard, Jean informed that a strategy being adopted by some BME nurses, who because of professional standards would join the RCN, was to also join another union like UNISON or Unite in case an issue or difficulty around race discrimination arose. Thus at the local NHS BME Network Conference event, which Jean was involved in organising, she recalled a Filipino senior female nurse telling her she had joined UNISON:

"I said, but you're in the RCN – she said 'I'm going to have both – if I can't do it with one, I'll do it with the other'"

Here Jean's testimony highlights why the NHS BME Network and UNISON are still organising on the basis of race equality, and demonstrates how the UNISON Black SOG and NHS BME Network relate to each other in terms of members informally sharing information and best practice through networking across multi-ethnic coalitional alliances in the context of a transitional public sphere (Shukra et al, 2004).

**'People in a higher band don't know the issues of people on a lower band'**

The UNISON Black SOG members interviewed in this research did not share the positive hopes expressed above by the chair of the local NHS BME Network, that this network had the potential to effectively represent Black NHS workers, and this negative view was in part prompted by previous attempts to establish BME Staff Networks at the local NHS Trust. In this regard research interviewee Rachel, a Black Caribbean woman and a band 5 Equality Officer within the local Trust, who was the Black SOG Rep on the local UNISON Branch Committee and Chair of the UNISON Regional Black Members Group, expressed her view that the local and national NHS BME Networks' primary focus on the higher bands in the NHS ignored and ruled out any chance of effective representation of workers on a lower band within the NHS occupational hierarchy. In this regard, it is worth noting Berrey's (2014) investigation of a neoliberal aligned corporate diversity management fixation on 'model' minorities 'breaking the glass ceiling' whilst 'ignoring dirty floors'. Thus, referring to the local NHS BME Network, research interviewee Rachel, stated:

"I don't think people have a got a lot of faith in that NHS Network, because of what's gone on before. Most of the Black workers are lower paid so most of the people have not got a lot of faith in that network. There's a gap somewhere there because people in a higher band don't know the issues of people on a lower band. So people on a lower band don't have much faith in these people from higher bands who are setting these networks up."

For research interviewee Rachel, UNISON was in a far better position to represent workers on a lower NHS band alongside other NHS bands:

“People on a lower band, where do they turn? A person on a lower band said to me her manager won’t put me on a training course, and where does she go to for support? I think people have more faith in the union, because the union is consisting of a wide range of bandings and BME people rather than just people at a higher banding, it’s a different set up all together.”

Again, against a backdrop of austerity cuts impacting on BME workers subject to disproportionate rates of redundancy and casualization within the NHS and wider public sector, research interviewee Rachel put forward her view of why more Black workers needed to receive UNISON’s ‘challenging racism in the workplace’ training:

“More black people are losing their jobs, all the people at the top are White British. So we’ve got to make sure that we stick to race equality, and that comes with UNISON’s training, making sure that people in the union understand the Equality Act.”

And, stating why she felt UNISON was more effective than the local NHS BME Network at representing Black workers because of its collective bargaining rather than individualised approach to challenging racism in the workplace, research interviewee Rachel, commented:

“UNISON is better because it supports members’ terms and conditions, so people on a lower banding get better support because collectively the union is made up of more than just bands 6-7 – UNISON is made up of a wide range of bands rather than people just looking to make the NHS look good.”

Noting the ‘performance’ of race equality and diversity management initiatives in institutional life, Sara Ahmed (2007b) refers to the operation of ‘tick box exercises’ incorporated within diversity management discourse and ‘the language of diversity’. In this regard, research participant Rachel expressed her rejection of any notion of the local NHS BME Network acting as a ‘critical friend’ to the NHS Trust on the grounds that it was too dependent on and part of an HR driven process:

“The NHS Staff Network is just a tick box. My personal view is that the union will support me more than the NHS Network will because of the tick box exercise, the BME Network is just a cosmetic exercise. Unions have a track record of delivering, but to be honest I don’t know what the national Network has done, and for the local Network, people want to see things that have been done, before they will join and participate”.

And research participant Rachel, piercing the rhetoric of BME Staff Networks acting as an ‘alternative voice’ and offering more effective representation of ethnic minority workers in the workplace than trade unions (Williams and Yarker, 2017), contrasted the local NHS BME Network’s lack of a track record and delivery of tangible benefits compared to UNISON’s Black SOG alongside the quality and range of resources available to UNISON members challenging racism in the NHS workplace. Thus, articulating a viewpoint that anticipated NHS England’s own recent guidance on the need for local NHS Trusts to provide sufficient facility time and resource investment to enable the sustainable development of local NHS BME Staff Networks (NHS England, 2017), research interviewee Rachel stated:

“Nothing’s been seen, nothing’s been done. It’s been tried before... We just sat around the table and twiddled our fingers. HR departments don’t want to invest in BME staff. I haven’t seen resources like conferences, training, which we have with UNISON, if you’re going to have BME staff progress you have to invest in them. The Network should be speaking to the management – we want to do this, this and this, are you going to invest in us and provide training courses, put the resources in – but I haven’t seen that happening so far – so that’s why I haven’t got the faith in this network.”

And, research interviewee Rachel added:

“UNISON has a wider range of banding, UNISON invests in its members, people want to see things happening, people want to be able to have faith in something.”

Working as a band 2 administrator in the local Trust, research interviewee Carol, a black Caribbean female member of the local UNISON Black SOG, expressed similar reservations around the local NHS BME Network’s ability to provide tangible benefits for BME workers, linked to issues around a lack of consistency, follow-up, investment in resources and provision of facility time for frontline Black workers to attend Network meetings. Her views were prompted by a previous experiment to launch a NHS BME Network initiated by the local NHS Trust’s HR managers:

“To be quite honest, with the local Network, I was quite enthusiastic in helping, you know, BME staff members, but we were just, how can I say, they just put a

carrot in front of us and we were thinking of pursuing this, having to go to meetings, having to do what they said with terms of reference, but then we were told that there was no resources, there was no financial aid, so how can that be a network? A support network with nothing to offer the BME staff, the staff locally, towards their training or having meetings or even socials. So I felt a bit let down by that.”

Highlighting the dangers and potential pitfalls for BME Networks, whether HR initiated or semi-autonomously led by Black workers, which are dependent on the arbitrary decision making of NHS managers to provide financial resources and free up staff time so people can participate, Carol added:

“I think it was a tick boxing exercise, just to have our faces there to promote the Trust. I mean we had meetings, we arranged meetings, we even organised all the officers in charge, like the secretary and the chair, I was excited at the beginning. But we just came to a wall, and that was it we just disbanded. Nothing. We were left high and dry, we had the programme, a BME Support Network, and there wasn’t support, where were we going to get the support from?”

Placing this issue in the context of her every day experience of the local NHS Trust staff-teams being understaffed and under-paid, under-resourced and facing cuts to services, Carol commented:

“There is a lot of pressure. I mean look at us, you’ve got staff cuts, you’ve got people who are on low pay, and they’re getting pressure in my experience from their managers to do work, I mean covering sicknesses, and others on holidays, and staff are leaving. I mean it takes a while for the workforce to advertise jobs, so in the meantime they are stretched, they haven’t got time to come out to meetings. As for me I know I’m stretched at the moment, there’s only so much you can do.”

## **UNISON provides material support**

Having faith in UNISON’s ability to provide real material support was expressed by Filipino band 5 nurse, research interviewee Angela who, as a member of the local Branch Black SOG and UNISON Filipino Migrant Worker Network, discussed the support available within UNISON for the Black SOG and BME members engaged in collective struggle against NHS austerity including a pay freeze, cuts and redundancies, which was visiting real hardship upon BME NHS workers:



“Well number one financially we do get a budget, well that’s the most important thing, every time we ask about a budget, they don’t say no to us, they always say yes alright. So from there they are quite supportive actually.”

And research interviewee Angela, noted:

“There is quite a few Filipinos who are in RCN, but mostly I think it’s UNISON because you know UNISON is much more visible actually. And I think it’s because you know UNISON is much more involved in dealing with Agenda for Change, pensions, cuts, and all those just like we did last time with the strike. So UNISON is our only guarantee, you know they are going to fight for us, and we need to have that because of what I’ve said it’s not all a bed of roses every time I go to my shift. My patient might be complaining, my colleague, my manager, or the management, so at least there is somebody in there, there is a union in there who we can turn to if there is trouble. That is the number one thing I think because I’ve recruited a lot of especially Filipino NHS nurses who the reason that they have joined UNISON is because of that, if they’ve got trouble there is a union who is going to support them.”

And highlighting the depth of resources such as welfare hardship funds – real, practical benefits- available to UNISON Black SOG members, who in the period of this research were gripped by falling living standards induced by the NHS austerity pay freeze, (see Women’s Budget Group et al, 2017, ‘Intersecting Inequalities’), research interviewee Angela, expressed her faith in the ability of UNISON to effectively represent its BME members in the following manner:

“And you know when I joined UNISON, I didn’t realise we’ve got a UNISON Welfare, I didn’t realise that until I became a UNISON officer [Branch Recruitment Officer], so I’ve learned that wow UNISON is really great because not only are they going to stand for you if you’ve just got a meeting with your manager, not only are they going to go with you and defend you. But then if you have got a personal crisis, a financial crisis, the union is going to support us. Wow, where can you find a union like that. I was so amazed, my God. They have done a lot of good things for me first and I feel that right now it’s time for me to return the favour to them as well, so I feel like I owe something to UNISON so that’s why I support UNISON.”

The favours that research interviewee Angela referred to above include access to training, which is a massively underestimated resource provided by UNISON on an ongoing basis. Access to UNISON’s training courses, which instilled confidence in members’ ability to represent fellow workers in case work and workplace collective bargaining, alongside

furnishing a better understanding of equalities legislation, was the key resource cited by the UNISON Black SOG research participants that enabled them to more effectively challenge racism in the NHS workplace. Thus research interviewee Angela stated:

“UNISON sent me to college for stewards’ training, I’m a qualified steward, and then as well they have sent me on Health and Safety reps training, I’ve been to training also for the RMS system, I did that as well.”

In this regard, access to ongoing UNISON training for BME workers on a lower banding took on an added dimension. In an institutional context inscribed with privilege and marginalisation linked to race, class and gender differences, (Kyriakides and Virdee, 2003; Smith et al., 2006), with research interviewee Angela, noting the situation of “those who are in the upper class”:

“But what I’m saying is all these higher ups they didn’t start from the bottom end because when they applied for work I think they are well equipped with all this training and knowledge, and you know they’ve all got their diplomas from a prestigious university and that explains why I think they didn’t start from the bottom end. So I don’t think everybody has equality, and equal opportunity.”

### **We still have a great big fight on our hands**

Similarly, appreciation of her access, as a low paid worker, to UNISON’s training courses, which enabled her to “reach out and network” with other black workers from across her region, was presented by research interviewee Carol who, discussing her experience of attending UNISON’s ‘Challenging Racism in the Workplace’ training delivered at a Regional Black Members Seminar, stated:

“If you are BME we are the lowest paid, and we are more prone to get disciplined and stuff, so if we want to speak out or whatever, we are discriminated against. So, for me UNISON has helped build my confidence a lot with the courses that you can go on to build up – better than the Trust – it gives people some sort of direction and you know hope that there is something, that you know that there is people out there and that we can reach out and network with. That is what I feel, that the Unions have done more for me than the Trust, because there, you are just left, you are just left on your own unchallenged.”

And, so, highlighting the opportunity for the building of Black workers’ networks afforded by UNISON’s ‘Challenging Racism in the Workplace’ training events, Carol added:

“Well there is good networking because you meet different people from all over. We know our regional chairs from the National Black Member’s Conference and they do keep in touch with emails and stuff. And I find the Regional Black Members Group training useful, and scary. I did things that I think I didn’t have in me. You’re out of your comfort zone and you meet all these people, and you’ve got to do all these role plays, and I hate doing role plays, but your confidence again, it’s about confidence and it has really built up my confidence, it has really taught me a lot, and showed me how other Black workers overcome their bad experiences. The training gives you ideas and you’ve got to think. So, I really enjoy my regional training, and I really hope the Trust will be able to look at UNISON and see how they can go on to provide courses around different issues and topics that are important to BME staff.”

And Carol highlighted that UNISON’s training to tackle racism in the workplace, and to pressure the local NHS Trust to adhere to its own race equality policies and equalities duties was necessary for UNISON members like her doing casework with BME migrant workers managed by private contractors like Carillion and employed in private nursing homes:

“In the private sector there’s a lot of race issues going on, people being victimised and bullied, their passports taken, their work permits being taken away from them. They’re just not valued, they’re not being paid the right money, and if they say anything they get put on a disciplinary or face dismissal. They are exploited, and they are afraid to come to the union because the managers will either dismiss them or say that they are trouble makers and send them back home, so yes we’ve got a lot of members out in the nursing homes that don’t want to get involved because they think it’s more than their job’s worth.”

So delivering race equality for lower band NHS workers and outsourced migrant workers managed by private contractors was an organising and collective bargaining priority for Carol, who stated:

“The race thing is about management: they just disregard it. Because they don’t see racism, do they at the top, they think their firm is wonderful and there is no race thing happening there, but it does happen. I don’t know if they just turn a blind eye or they just don’t want to acknowledge that there is a problem. So we still have a great big fight on our hands.”

Iqbal, a South Asian heritage UNISON Black SOG member and steward, working as a porter at the local NHS Trust (the porters were managed by private contractor Carillion),

discussed how in the role of the local Branch's Disability Officer he was able to represent members by challenging the Trust's non-compliance with its statutory equality duties:

"The Trust and Carillion didn't have a good policy on disability, and as result they were issuing too many sickness and absence warnings. Management weren't properly aware we should be making a reasonable adjustment wherever appropriate for staff with disabilities. And in one case I represented a member, and he hadn't been referred to occupational health. So in the hearing the case was dismissed, there was no case against this person. So it's ridiculous, the Trust does not have a proper policy on these sort of things, disability and racism."

Noting the emergence of the local NHS BME Network at his Trust, Iqbal commented on a barrier he thought prevented the participation and inclusion of his colleagues working as porters in the activities of the local NHS BME Network:

"They haven't got access, for instance none of the Carillion staff have got regular access to the computers, the only people who have is the management and supervisors. So they need to put a couple of posters around and let people know this is including Carillion staff, and maybe write to management and say look it would be nice for maybe the porters, domestics, catering staff to be able to attend the BME Network and get people involved, that might be a good idea."

Referring to the joint union agreed facility time mechanism with the local NHS Trust, which meant private contractor Carillion had to adhere to the negotiated release time for UNISON stewards and workplace reps, Iqbal commented:

"If it's been agreed by the joint staff side like it is with UNISON then Carillion will start thinking about sending staff."

Another barrier preventing lower band BME NHS workers participating in the local NHS BME Network was articulated by research interviewee Steve, a Black-Caribbean male and member of the local Black SOG, who worked as a porter. Making reference to occupational hierarchies linked to class, professional status, and lack of inclusion of workers on a lower band at the local NHS Trust, Steve commented:

"I haven't been to a Network meeting yet, but if it's run like the UNISON Self Organised Group, it should be very effective. But I don't think it will be like the UNISON one, because it will be more like doctors, nurses, technicians, who don't really have anything in common. When you go to a Black Self-Organised Group it's all UNISON. If I go to a group and it's just technicians, doctors, the intellect is

different. I won't feel as comfortable, it's the body language, everything is different from a porter to somebody that is well educated. There's still a lot of walls that need to come down. With a high professional, I always feel that they are not talking to me but talking down at me. So I'm comfortable in a UNISON group where we are all peers."

In this regard the local NHS BME Network, in its conference events inviting Black Chief Executives as key speakers and coaching seminars delivered by BME management consultants, projected a Black professional middle class status, and this was even more so the case with the national NHS BME Network, whose promotional material reflected a corporate professional image bolstered by the Network's annual conferences held each year at the London Hilton, Park Lane, complete with 'black tie dress code' for the conference dinner. This upper echelon orientation therefore perpetuates and reproduces forms of exclusion highlighted by Colgan et al. (2007), who noted the absence of frontline workers, who were either put off from participating in Diversity network events because of the managerial focus and/or were unable to get time off from 'front-line' work.

In this context, as a band 6 NHS Community Worker, research interviewee James, a Black African member of the local NHS BME Network and executive member of the national NHS BME Network, noted the need for the local NHS BME Network to facilitate inclusion of BME workers on a lower NHS band, but didn't have any specific action plan or programme to enable this inclusion:

"So you have buy-in at the top level, but also for those at band 1 and 2, from band 1 upwards if you want any level of equity for how people are treated you need to have a forum for those people who are at floor one on the rung of the employment ladder, so the local network has a bit of work to engage with those people, but I don't know really how much that happens with that group of people from those bands."

However, for research interviewee Steve, based on his casework experience as a UNISON steward representing many lower band BME and migrant workers within the local NHS Trust's three tier contract structure (NHS terms and conditions, Carillion and Agency), the local UNISON Black SOG and UNISON Branch structures provided the most welcoming

and conducive participatory environment for lower banded workers, as opposed to the local NHS BME Network, which he considered too closely aligned to the NHS Trust:

“I would rather go to UNISON because there’s more of me there, than if it’s the Trust where it will be those of a more professional standing.”

### **We need to involve the rank and file staff more**

From his own perspective, senior band 8b NHS manager, Filipino male research interviewee Anthony, as part of the local NHS BME Network’s steering group, alluded to the exclusion of BME workers on a lower band from involvement in the local NHS BME Network, discussing in aspirational terms his desire for the local NHS BME Network to develop a clear structure or mechanism that would facilitate the inclusion of BME and migrant workers on a lower band in the local NHS BME Network’s activities:

“Well as I keep saying these initiatives need to be felt and seen by the people on the ground. People on the floor, the nurses, the gardeners, the administrators, you know for those people, the accessibility and the visibility needs to be there.”

And research interviewee Anthony suggested the local NHS BME Network might play a positive role by facilitating provision of a sustainable suite of training resources for BME workers on a lower band:

“There should be an ongoing - not one off - an ongoing structure of events and programmes, not only once a year or something, but for example, training for interview skills, it should be ongoing, and for example training on resilience, training on harassment and bullying, we need to do more, to reach out. But you know nobody really has time to listen to these workers who are on the lower bands, so they feel like they are forgotten maybe, or that nobody cares for them.”

Thus for research interviewee Anthony, the role of the local NHS BME Network was to work more closely with the local NHS Trust in relation to promoting race equality across the workforce as a means to help the local NHS Trust improve its performance around recruitment, retention and progression of BME workers, particularly BME workers on a lower band balancing child care and family responsibilities with their working lives:

“For those people who are on the lower bands, I think we need to involve the rank and file staff more. We need to understand what their needs are in terms of learning needs and what is a perfect world for them. The common problem is work life balance, flexibility, people who are working in the Trust who have children for example, care is an issue so we as a Trust we have our flexible working policy, but whether the managers are implementing that with compassion, or based on our service needs or we are just implementing it the way we want to implement it. I don’t know, but what I am saying is we need to be more accommodating, we need to be more flexible because the fact is we are losing these staff, they go away because they can’t maintain work-life balance because of child care. What happens to them? They work agency, it’s more flexible, and then some of them work in the nursing home, it’s more flexible, so I think we need to look at these issues alongside the Trust. And we need to be more accommodating and flexible of the needs of our staff.”

Because of the very high numbers of BME staff reporting bullying and harassment at the local NHS Trust, research interviewee Anthony, expressed his desire for the local NHS BME Network to be more assertive around monitoring the local Trust’s NHS WRES performance, arguing that the local NHS BME Network needed to be more proactive around supporting ‘rank and file’ BME NHS workers to have a better understanding of the Equality Act to help achieve the goal of effective scrutiny and challenge of the NHS Trusts annual WRES performance:

“Many of them don’t know and I don’t know if they were involved or consulted. So this is why understanding the Equality Act can really help the staff. The question is, are the staff aware of it? Second, are the staff using it? Third are the staff empowered enough to challenge the culture? Because people fear retaliation, people don’t complain because they feel, oh you will never be promoted, because if you have an argument or you have a case against your manager, then you are kind of branded to be a troublemaker. And I think we need to break that culture, we need to empower those staff more. Yes, we have the ammunition, we have that Equality Act, the question is, are we using it, and if not why not, and that is the thing for me, we need to understand why people are scared to challenge bad behaviour, bad culture, in the workplace.”

Interestingly, research interviewee Anthony, discussing his community group role as president of the local Filipino community organisation, revealed that rather than the local NHS BME Network intervening in relation to Black workers’ disproportionate experiences of bullying and harassment in the workplace, it was UNISON Black Self-Organised Group members and UNISON stewards, reps and case-workers who were representing individual

Filipino nurses involved in disciplinary and grievance procedures at the local NHS Trust, thus playing a role similar to UNISON's work with Filipino migrant workers discussed by Alberti et al (2013). And, in this regard, the benefits of UNISON's 'Challenging Racism in the Workplace' training and resources, whose collective approach to tackling racism in the workplace and communities includes incorporating community organising as a key element of UNISON's local Black SOG and branches campaigning work, became evident:

"In terms of the Filipino community organisation, UNISON's Black SOG always supports us in terms of financial support, every year they sponsor us, they also increase our awareness in terms of the individual members of our Filipino community organisation where I am the president. I am aware that many of them have contacted UNISON and its representatives in times of difficulties with the Trust when they need a representative to come with them during a hearing, during a meeting with managers, and that by itself is an extremely big help for us. Because this is the reason why we established the Filipino community organisation as a support mechanism, if you are new to the area, you don't know your rights, you don't know who to ask for help, you don't know what to do. So instead of getting depressed and lonely and you know suffering in silence, we established this community. So we are the first contact if you like of our members. But obviously most of our members, and as I said there are more than 3,000 of us Filipinos here, the majority of them are members of UNISON. And I am aware that they have contacted UNISON many times in times of difficulty."

Because of the NHS's stratification and segmentation by class, gender, race and ethnicity, research interviewee Lubna a young, female, South Asian, Oxbridge educated NHS management graduate saw the role of the local NHS BME Network as being a strategic vehicle to leverage influence for BME staff who were locked out of particular 'patronage networks' (Esmail et al, 2005) and lacked forms of 'social capital' and 'cultural capital' imbued in the white upper and middle class demographic who dominate the 'Snowy White Peaks of the NHS' (Kline, 2014):

"The main problem for the BME staff is they don't see leaders who look like them, who speak like them, who dress like them. And if they don't see it, they don't believe it can happen. And I think what the BME Network is capable of doing, which local people are not capable of doing is breaking down those barriers, and engaging with those people who we as BME people don't normally have access to."



In this context, we can note that the above approach outlined by research interviewee Lubna, is again evident in the recently launched NHS BME Leaders Network (launched in 2019 and supported by the NHS Confederation). For research interviewee Lubna, these type of BME leadership interventions (Esmail et al, 2005) are necessary because of how class interacting with race within the NHS bestows forms of cultural capital (Savage, 2015; Appiah, 2018; Rollock et al, 2015) to groups in receipt of a public school and private school education, which are then harnessed to maintain and reproduce privilege, with the most esteemed and respected positions in the NHS such as medical consultants being dominated by white upper and middle class men:

“it’s about helping the BME people to understand, look there will always be you know public school and private school differences, so it’s about helping us to re-think these differences and stabilise the situation, and that’s what I think the BME Network could easily do.”

Employing the coded term ‘soft skills’, which she reserved for white members of staff in senior management, research interviewee Lubna also commented on why she thought the trade unions, because of race and class differences in the workplace, had even more of a duty to represent BME workers:

“That’s the whole idea, supporting the vulnerable, supporting those in need, supporting people who generally do not come from the upper class, so trade unions have a major responsibility and I think they need to carry it out. I think sometimes what happens is because of the history of what BME people go through and have gone through, there is sometimes this element of soft skills that they lack. And that is absolutely the advantage that the white staff have, that they do have better awareness of soft skills, not many BME people go to public school or go to summer holidays in France. There will always be a few, who break the rules and go to Oxbridge and study, but the majority will not. They will always be competing very hard, but because they lack this sort of soft skills expertise, I mean that’s where they get beaten.”

Thus in relation to the NHS workforce, research interviewee Lubna, highlighted power dynamics linked to the interaction of race and class underlying Black workers’ experiences of racism in the NHS:

“if you look at the NHS work staff, where BME staff are and the sort of feedback BME staff get in relation to patient experience, so why there’s such a lot of racial abuse and racial incident when patients interact with staff, where does it happen? It doesn’t happen at the consultant level, why, because the consultant is somebody you look up to, the consultant is highly educated, you misbehave you don’t get an appointment again until next year and you’re desperate. It happens a lot at the nursing level, there are lots of them, they can be replaced. It happens a lot more at the carer level? Why, again look at the ethnicity. So when you break it down to the level of responsibility, and the amount of money the member earns and the reactions they get it’s quite easy. And if you look at the WRES (Workforce Race Equality Standard) in most organisations, there are a higher number of BME staff who get into disciplinary action than white staff.”

And, drawing on her own relatively privileged background, research interviewee Lubna, added:

“I’m speaking to you from a very empowered sort of background, well educated, been to a good university, but the lesson I learned the hard way, when I graduated and I came to work for the NHS, I realised that I had most things that an employer would look at but I didn’t have a public school accent, so for me it’s a huge difference, especially from a migrant point of view. But once I tell them the university that I went to, they change, they really change, I have seen that. And it could be nothing but class, so even if it’s not me who thinks it’s the most important, it’s definitely very important, very relevant in England. I say this and I can stand by it, and everything else works around it.”

## **Challenging the NHS Leadership Academy**

Illustrating how the local NHS BME Network focussed primarily on ‘breaking the glass ceiling’ type leadership interventions, and lobbying linked to narratives around developing ‘BME Talent’, as a means to challenge racism in the NHS, research interviewee Lawrence, a Black-Caribbean heritage band 8 senior NHS manager, informed:

“I ended up in London because we were challenging the Leadership Academy (NHS Leadership Academy). Their role is to produce leaders of the future for the NHS, and when I went to their recognition awards ceremony there was 200 odd people there, and there was only four visible minority there, and none of them were successful. And if you think about the whole concept of a Leadership Academy, built into that whole process and recognition awards system is the notion of inspiring people. And if I as a BME person thinks one day I want to acquire that level of seniority, where do I look for the inspiration, where do I see people who inspire me, there aren’t any. Or very, very few. And so at the core of it we are talking about systemic problems, we can see that even at the Leadership Academy, who are supposedly tasked with turning out future leaders. Their systems exclude Black people. Absolutely they do and I make the point of saying Black people and not BME because that’s the discussion we are having here. Where’s the evidence of Black people progressing if we tie that in with the ‘Snowy White Peaks’ and say

that's what it says on the tin, where's the evidence of progression. It is about Black people and the discrimination that they face. That's the goal, that's the key to it. If we want to see senior Black people in the organisation, then that's what we need to focus on."

Here in contrast we can note UNISON Black SOG structures' approach to inspiring and nurturing leaders amongst its activist base – in particular, via the launch in 2016 of the Nelson Mandela Award presented annually at UNISON's National Black Members Conference to an activist nominated by members for their outstanding contribution to trade union anti-racist activism:

"Amongst our Black membership we recognise that there is an abundance of talent and that there are many people who tirelessly contribute to the fight for racial equality. The award will be presented to a Black member who has supported and gone above and beyond to represent Black members' celebrating their achievements, courage and determination within the union and more widely in our society." (UNISON, 2015)

Interestingly, research interviewee Lawrence, perhaps alluding to the trade union's strength garnered via collective bargaining and their role in joint consultative negotiation committees, and also being cognisant of UNISON's presence on the national NHS Equality and Diversity Council, signalled a limitation of the local and national BME Networks, by stating:

"So if you think about workforce, because the BME Networks are by definition there to support workforce, where is the step up to the influential platform so that they can make those impacts, where is it? Because all that happens is they meet and they sit together and they have their discussions, they feed back into an arms-length body and maybe an E&D committee and all of that. But they don't have any power or influence. So the question would be, why wouldn't an organisation, if it was genuinely committed to the agenda, share or give that group an opportunity to influence decisions? It touches back on what I said earlier about the NHS Constitution and the idea that there's no decision about me without me. Well the workforce should have the same kind of role in terms of, you're going to be making decisions about me so why can't I be part of that decision making process? And it's weird, the unions I see would be a good example of that, so if BME Networks had the approach that the unions have then we might be able to say yes. Let us share the decision making, let's have that discussion, allow us to tell you the things that impact us".

In this context, sharing his perspective on the importance of campaigning to see greater Black representation at senior decision making levels in the workplace and wider society, research interviewee Lawrence highlighted why he thought it was important for Black workers to monitor the implementation of the WRES as a means to challenge racism in the workplace, with a call for the trade unions to be more proactive in this area:

“Actually, the one thing I haven’t seen is any public statement about the support for it. I haven’t seen it. So at the moment the WRES is driven by the Implementation Team, the Implementation Team has only two years of funding, if we are not careful the WRES will disappear into the ether. And yet we should be seeing the unions sort of flying the flag and making it actually almost a mainstream consciousness. Firstly, they should be publically acknowledging the under-representation of BME people, I’ve never seen that, and not having the discussions of saying look this is terrible we have to do something about it. So there ought to be that, and then they should embrace it and help to support the achievement of it.”

Thus, for research interviewee Lawrence, the strength trade unions can bring through their collective solidarity was vital, because:

“If you think about how it works, for the most part, most Black people don’t raise their heads above the parapet because it will get knocked off. I’ve got my family to feed and I’ve got my mortgage to pay so I’m going to keep my head down and get on with life. So that’s what happens, it almost needs a stronger leadership. People with more commitment to stand there and be the torch bearers for those people who are less willing or less able to stand up. And I’ve heard it said, oh BME people, Black people, well they don’t complain they must be alright. Well they are not alright, it’s just that I remember, I remember in the early days, I’m fortunate, I’m in a position where I can say up yours, but in the early days in my career, there were times when I put up with some horrible things. I’ve gone through huge amounts of experience where I acknowledge now why the hell did I put up with that? And I know why I did it, it was survival, I have to pay my bills, so I keep my head down, it’s sad but it’s still happening in 2016, people are still not willing to challenge, unless someone challenges on their behalf. And so it needs more of that and I think the unions are a good starting point for doing that.”

In 2015 two motions on the NHS Workforce Race Equality Standard were carried at the TUC Black Workers Conference welcoming the introduction of the WRES, advising that: “...union reps engage in local consultative machinery to find out what employers are doing to comply with the Standard and to analyse progress against the indicators.” (TUC 2015b: Report of TUC Black Workers Conference 2015. Motion 17: ‘NHS Workforce Race Equality Standard’. Motion 18: ‘Turning Words into Action for Race Equality in the

NHS’). And a similar motion was passed at UNISON’s 2020 National Black Members Conference. Thus in 2019, as argued for above by research interviewee Lawrence, UNISON launched its ‘Race for Equality: Challenging Racism in the NHS’ Campaign: “Our Race for Equality Campaign is equipping UNISON branches to get active and tackle racism in the workplace” (UNISON, 2019). Highlighting ‘Racism in Numbers’ based on the statistics from the NHS Workforce Race Equality Standard, UNISON echoed Lawrence’s call for the discussion to be politically Black (Narayan, 2019; Virdee, 2014, 2010):

“The WRES Data uses Black and Minority Ethnic (BME). UNISON uses the more political and inclusive term Black.” (UNISON, 2019)

## **Conclusion**

The Black workers’ voices documented in this chapter revealed that racism in the NHS workplace is experienced differently by different groups, particularly based on relative seniority within the pay band and professional hierarchy. Commonalities between groups included experiences of bullying and harassment, lack of access to progression and training opportunities, and grievance and disciplinary disparities. However, specific groups were disproportionately affected (e.g. workers on lower pay bands – outsourced BME porters and migrant workers based in private care/nursing homes). Differences in approach and interests represented between the local NHS BME Network and local UNISON SOG were indicated by some workers on lower bands’ complaints that those on upper bands (particularly with reference to the BME Network) don’t understand their problems. Some of the higher band participants within the BME Network did make reference to the problems faced by people on lower bands, some had ideas of how to address these issues, but there was also some vagueness around what was already being done, and how these workers could be engaged and supported.

Both the UNISON Black SOG and the local NHS BME Network included elements of individual servicing and collective support. The local NHS BME Network's collective approach was mainly funnelled into monitoring and audits of the local NHS Trust's EDS performance and WRES statistics, seeking to hold the Trust to account in relation to its equalities duties. The NHS BME Network also had a greater focus on individual career development, linked to the lack of BME representation in senior roles. Sharp political differences between the two case study organisations' approaches and effectiveness in challenging racism begin to be revealed as the chapter records the research participants' views that the UNISON Black SOG had been established for longer and had a clear track record of delivering results through collective bargaining. The more recent BME Network had less credibility in this respect, as it didn't have a track record for results, and a previous HR initiated incarnation had folded prematurely after it 'hit a wall', having been unable to resource meaningful activities. An important difference between the two case study organisations was that the UNISON Black SOG was both completely independent of the local NHS Trust, and the Black SOG members benefited from the Union's negotiated facility time agreement, which enabled participation in activities. In addition, the Black SOG had access to an ongoing budget for its activities delivered by the collection of member subscriptions. By contrast, the self-organised local NHS BME Network, whilst nominally independent, was dependent on the Trust for resources. It did not have an agreement for facility time, which restricted staff involvement, particularly NHS band 1-4 support workers, and it lacked representation at joint consultative decision making meetings.

Differences in approach to promoting race equality in the workplace were also articulated in relation to training and perspectives on leadership. Several members of the local NHS BME Network referred to the need for more role models in senior positions, who would provide inspiration to other members of the BME workforce, increasing their confidence to

pursue more satisfying careers and move up through the bands. Interviewees from the local UNISON Black SOG talked about the union investing in the training and development of rank and file workers, and putting them into representative and leadership positions. Some of the BME Network members spoke about supporting workers in lower bands by giving advice from their position of experience, and BME Network members commented that the unions have a duty to support vulnerable groups – but there seems to be a difference between saying this and saying that the unions include vulnerable groups who are acting for themselves. In this sense there appeared to be tension between this ‘top down’ approach to helping staff on lower bands, and the comments made by people working in those bands, who talked about those in higher grades talking down to them and not fully understanding their problems. Differences of professional identity, power and class were creating a divergence around preferences in how leadership is delivered. Respondents from both the local Black SOG and local BME Network had a focus on identification with leadership, but for workers on lower bands, trust and effectiveness was not built solely on BME identity, but also required identification on the basis of class or social position. Within the BME Network, perspectives on leadership seemed to parallel the hierarchy of the local NHS Trust, with people in more senior positions providing better role models and therefore more highly valued leadership. By contrast, the UNISON leadership structure diverged from the Trust’s professional hierarchy, by giving workers on lower bands an opportunity to develop into leadership roles, valuing their skills as activists and advocates for their peers, rather than prioritising conventional academic and professional achievement. This independent structure was a source of credibility with workers on a lower band.

Another key difference delineated between the two case study organisations in their relationship with the local NHS Trust, which was mentioned in several places, was the UNISON Black SOG members’ criticisms of the local BME Network, based on the idea

that the Network is fulfilling a need for the Trust – that is a cosmetic ‘tick box’ exercise that makes the Trust look good without really requiring it to allocate resources or make serious changes. A sense was conveyed that the Network was sacrificing true independence, and yet somehow coming out of it with less influence than the unions – less access to decision-making meetings, less facility time to support their activities, and restricted access to resources.

In relation to collective approaches to promoting race equality in the workplace, this chapter also highlighted the difference in recruitment and participation strategies of the two case study organisations. One of the research respondents was the local UNISON branch Recruitment Officer tasked with bringing new members on board, partly through face to face interaction. By contrast, one of the UNISON Black SOG respondents commented that the BME Network should put up posters in order to reach lower band staff with limited computer access – this suggested that the local NHS BME Network had been publicised through electronic means, perhaps through the staff email or intranet system. This difference in recruitment methods may also link to perceptions of the relative autonomy of the two case study organisations. Because the local NHS BME Network is operating through Trust systems, it is reproducing barriers that already exist for front-line workers on a lower band, such as lack of access to computer-based information, and less access to training opportunities. It seems that the local NHS BME Network cannot begin to understand these questions of access unless it first engages with some of the relevant staff members by non-electronic means. Some of the BME Network respondents on a higher band expressed a need for the Network to engage with lower bands, but were vague about how to achieve this, this suggested that no consultation or effective engagement with staff on lower NHS bands had yet taken place.



# Chapter 6 Conclusion

## Key research questions

- 1) How are the NHS BME Network and UNISON Black Self-Organised Group challenging racism in the NHS workplace?
- 2) What are the political differences and similarities between the NHS BME Network and UNISON Black Self-Organised Group in their approach to promoting race equality in the NHS?
- 3) How does class intersect with race, gender and ethnicity within the NHS BME Network and UNISON Black Self-Organised Group?

## Conclusion

This qualitative study has sought to explore and investigate the research hypothesis of whether the prevalence of BME Diversity Networks, linked to diversity management agendas alongside a relative decline of the traditional employee voice – trade unions – signals that BME Networks are increasingly seen as being more effective ‘collective voices’ for promoting race equality in the workplace than trade union Black Self-Organised Groups by Black workers and BME professionals. The research explored this hypothesis via the key research questions above which focused on the institutional setting of the NHS, the largest employer of Black and minority ethnic workers in the UK.

Utilising case studies of two organisations collectively organising BME workers within a local NHS Trust in the period 2012 – 2018, the research, via 23 semi-structured interviews and use of secondary sources of data, investigated how the local NHS BME Network and the local UNISON Black SOG linked to their own parent organisations and national structures (the national independent NHS BME Network and UNISON Regional and National Black members structures) were mobilising to challenge racism. As with many BME workers challenging racism within the UK’s public and private sectors, the foci for activism were: addressing disproportionate rates of disciplinary and grievance procedures;

tackling bullying and harassment; improving recruitment, retention, and career progression; and addressing under-representation of Black people in senior management roles. In this regard, Black NHS workers' collective efforts to tackle racism in the workplace were occurring within a local and national NHS policy context foregrounding business case approaches to improving equality and diversity in the NHS (Esmail, 2005; Kline, 2014).

Exploring the aforementioned hypothesis requires a theoretical understanding and engagement with the role the ideology of racism plays in the continued structural disadvantage and inequalities faced by Black workers in the labour market (Ainsley, 2018; Cabinet office, 2018; Virdee, 2010). Hence this research has drawn on the theoretical framework of Black Radical Tradition aligned scholars Walter Rodney and Manning Marable, both of whom apply Marxism to interrogate in historical perspective the intertwined relationship between racism and capitalism, in particular highlighting how these dual structures shape "the underdevelopment of black people" within contemporary society (Marable, 1983:1; see also Rodney; 1981a). Similarly, the theoretical framework advanced in this research has also drawn on the concept of 'racial capitalism' articulated by Cedric Robinson in his *Black Marxism: The Making of the Black Radical Tradition* as a means to get to grips with racism's deep embeddedness within capitalism, which inscribes racialized 'migrant labour' with an inferior position and status:

"The tendency of ...capitalism was thus not to homogenize but to differentiate – to exaggerate regional, subcultural and dialectical differences into racial ones."  
(Robinson, 2000: 26)

In this context, adopting a conceptual approach of 'rethinking racial capitalism' (Bhattacharyya, 2018) enables a richer understanding of how within capitalism racial and ethnic hierarchies function to structure ethnic inequalities in the labour market and reproduce workplace divisions and 'differential privileges' (Bhattacharyya, 2018: x), and this is the theoretical vantage point from which the research has considered the continued

21<sup>st</sup> century dependence of the ‘multi-ethnic’, ‘super-diverse’ NHS on racialized ‘migrant labour’ (Kyriakides and Virdee, 2003; Virdee, 2014).

In addition, applying a theoretical framework grounded in the Black Radical Tradition understanding of resistance to slavery, capitalism, colonialism, and imperialism elicits consideration of the historic relationship between ‘resistance and accommodation’ within contemporary forms of Black anti-racist politics (Marable, 1983; Sivanandan, 2019). Here the research theoretically linked the concept of racial capitalism – understanding the deeply embedded and intertwined nature of racism and racist ideologies within capitalism – to Satnam Virdee’s race and class informed theoretical perspective on how in the UK context ‘racialized outsiders’ were, via Black Self-Organisation, able to mobilise under a political Black identity to open up employment opportunities in the NHS and the wider public sector. In this way the research was able to theoretically contextualise the emergence of BME Professional Associations and Diversity Networks in relation to the dynamic interplay and intersections of race, class and gender, including class differentiation and the mobilisation and privileging of Black professional middle class identities against a backdrop of continuing racism within the UK labour market during a period of neoliberal economic restructuring (Virdee, 2010).

It is in this context that Colin Prescod, as noted in the research, highlighted the ‘race and class’ ‘activist’ history of the use of ‘Black’ in his speech at the 2011 NHS BME Network Conference. And this ‘race and class’ Black ‘activist’ perspective, is the Black Radical Tradition aligned theoretical standpoint upon which UNISON’s reassertion of a ‘Black’ political identity, signifying anti-racist unity and solidarity for those whose racialized experiences in the present are linked to histories of resistance to colonialism and imperialism, is based. The research also linked current critiques of racial identity politics (West, 2017; Taylor, 2016; Spence, 2016; Younge, 2011; Marable, 2009; Marable, 1997) to the organisational strategies of Black professionals privileging middle class identities, as

manifested within the local and national NHS BME Networks, that erase class, class stratification and Black working class perspectives. This research then, theoretically foregrounds the intersection of race with class – approached conceptually via the tradition of Black British working class resistance to racism, encapsulated in the tradition of Black self-organisation developed within trade unions (Narayan, 2019; Virdee, 2014, Virdee and Grint, 1994).

‘Naming neoliberalism’ (Hall, 2017) as a key concept for investigating the research hypothesis, linked to periodising the research enquiry within the theoretical context of the ‘neoliberal revolution’ (Hall, 2017) has been central to engaging the key research questions. The research was conducted in a period where the fall-out from the 2008 financial crash led to the imposition of the ‘Doing More With Less’ – ‘Nicholson Challenge’, mantra seeking to deliver ‘efficiency savings’: that is, neoliberal austerity, which has impacted severely on the NHS workforce as well as on the quality of patient care. In addition, the increase in work, longer hours, and reduction in living standards from a public sector pay freeze was compounded by the top down restructuring of the 2012 Health and Social Care Act, which accelerated privatisation, fragmentation and outsourcing of NHS services. In this regard, Black workers collectively challenging racism in the NHS workplace were faced with the reality of contending with the disproportionate impact of neoliberal austerity measures on Black workers and communities – including in the form of redundancies and an increase in insecure-precarious employment linked to casualization and outsourcing. It is then against the conceptual backdrop of the ‘neoliberal revolution’ linked to a theoretical consideration of the ‘neoliberal turn in black politics’ (Spence, 2016; Gilroy, 2016) that this research has investigated the hypothesis that BME Diversity Networks are seen as being more effective for promoting race equality in the workplace by black workers.

### **Challenging Racism in the Workplace – audit cultures**

In this regard, a key research question asked how the NHS BME Network and UNISON Black SOGs were challenging racism in the NHS workplace. The local NHS BME Network initially sought to apply the national NHS BME Network's operational framework, aimed at ensuring the NHS upheld its statutory duties under the Race Relations Amendment Act 2000. With the NHS introduction of its Equality Delivery System, designed to support the NHS to operate equitably in relation to the nine protected characteristics of the 2010 Equality Act, the local NHS BME Network participated in monitoring the local Trust's progress against the EDS, contesting the Trust's scoring against race equality. Here the research respondents from the Local NHS BME Network shared the national NHS BME Network's call for the NHS to implement a common race equality performance standard, incorporating deterrent sanctions. A partial success was thus registered by the local NHS BME Network in its affiliation to the national NHS BME Network, with the NHS succumbing to the activism and lobbying pressure of BME workers against systemic racism by implementing the NHS Workforce Race Equality Standard (WRES) in 2015. Here the local NHS BME Network focused on monitoring the WRES as a 'critical friend', in line with NHS guidance on the role of BME Networks, and in this respect its approach was less confrontational than the national NHS BME Network, which criticised the lack of any effective "deterrent sanctions" being incorporated within the NHS WRES. Within the UNISON Black SOG case study, more focus was placed on use of UNISON's Race Discrimination Protocol for monitoring and reporting processes around discrimination, which was fed into the local branch via case work representation and stewards' training days.

### **Challenging Racism in the Workplace – legal approaches**

Outside of the EDS and WRES audit process, the local NHS BME Network had no resource-toolkit or mechanism like UNISON's Race Discrimination Protocol to engage

BME workers subject to race discrimination in the workplace. Use of the Race Discrimination Protocol with regular branch and regional feedback on case results potentially afforded the local UNISON Black SOG members with a more nuanced understanding of the risks of legal action for race discrimination cases. The national NHS BME Network in its 2010/11 Operational Framework asserted swift recourse to employment tribunals on behalf of its members subject to racism in the workplace. Use of employment tribunals did not register in the local NHS BME Network, but during the course of this research UNISON won an important legal battle over the government's introduction of prohibitive employment tribunal fees, which had led to a massive decrease in cases of sex and race discrimination being brought to tribunal. In contrast, the national NHS BME Network's over-emphasis on seeking recourse for racism via individual legal means contributed to the effective end of the Network's activities between 2017/18, when the Chair of the network became embroiled in a race discrimination employment tribunal case against her local NHS Trust. In the vacuum left by the suspension in activities of the independent NHS BME Network, NHS England established its own NHS corporate diversity management and NHS Leadership Academy aligned NHS BME Network, swiftly followed by the NHS Confederation sponsored BME Leaders Network in 2019.

### **Structural barriers to inclusion and participation**

And, in this context the research highlighted a key and fundamental issue linked to the hypothesis that BME Diversity Networks are more effective collective voices for promoting race equality in the workplace than Black Self-Organisation within trade unions – namely the relative dependence of the local NHS BME Network upon the local NHS Trust for investment in a budget and resources to conduct organising activities within the Trust. This research noted that the advantages of being self-organised by BME workers rather than initiated by the HR department or employer dissipated as 'independence' was only nominal, with the Local NHS BME Network depending on receiving funding from

the Local NHS Trust – which was provided on a sporadic and arbitrary basis – for events such as its annual conference, Black History Month events and career coaching seminars. The Local NHS Trust funding for these specific activities enabled it to demonstrate its institutional commitment to diversity via a ‘tick box approach (Ahmed, 2012). The national independent NHS BME Network in its 2010/11 Operational Framework (NHS BME Network, 2010) called on the NHS to fund and resource the development of local NHS BME Networks, and NHS England’s own recent guidance on developing BME Networks calls on NHS Trusts to provide structured funding and facility time for BME Networks. In this respect, the UNISON case study revealed that because the UNISON Black SOG structure had been established for far longer, this conferred a clear track record of delivering results through collective action and collective bargaining processes. The more recent local NHS BME Network had less credibility in this respect, as it didn’t have a track record for results. Black workers’ perceptions of the local NHS BME Network being too close to the Trust led to it being associated with a previous HR led incarnation, which had folded prematurely after it ‘hit a wall’, having been unable to resource meaningful activities. There was a clear difference here with the UNISON Black SOG status within UNISON structures, which enabled the Black SOG to be Black member led and fully resourced and financed. Rather than reported obstacles, the case study revealed high levels of participation of Black workers within the Black SOG structures at local, regional and national level, and within the local branch activities. In addition, in a period of neoliberal austerity in which a public sector pay freeze was impacting severely on low paid NHS workers, within the local collective branch structure Black SOG members could also access UNISON benefits for individuals experiencing work difficulties, including access to a welfare hardship fund.

Another fundamental issue highlighted via investigating the hypothesis that BME Networks can be seen as more effective collective voices for promoting race equality than

Trade Union Black Self Organised Groups was the structural barrier to BME workers' participation, particularly for those workers on a lower band, linked to the lack of a formalised facility time agreement between the local NHS BME Network and the local NHS Trust. This restricted staff involvement, with BME NHS Network members relying on the ad hoc consent of their line managers to attend Network meetings. In contrast, the local UNISON Black SOG respondents in this research understood the facility time agreements the union had agreed with the Trust via the JSNC and linked to their roles as branch stewards, reps and caseworkers.

### **Challenging Racism in the Workplace - individualised and collective approaches**

In discussing how both the local NHS BME Network and the local UNISON Black SOG provide training activities as a means to challenge racism in the NHS Workplace, the research highlighted a key difference in approach linked to the BME Network's individualised career development ideas of training and leadership progression, and the UNISON Black SOG's activist, collective-bargaining, steward, workplace representation and campaigning form of training. In this regard, the local NHS BME Network focussed on occasional coaching seminars funded by the local NHS Trust and delivered by BME management consultants, which focused on individual career development and progression. This offer was aligned to a corporate diversity approach around 'breaking glass ceilings', senior leadership, and NHS 'talent management' narratives which, whilst geared to increasing BME staff numbers in senior management, also legitimised conformity to and uncritical acceptance of neoliberal austerity aligned narratives around 'doing more with less' and 'frugal innovation'. In addition, the individual career orientation of the NHS BME Network's coaching seminars meant this offer could reach only a much narrower number of staff, with fewer options for movement building (e.g. as facilitated by the UNISON Black SOG members through case work) and benefits to other staff not receiving the training.



In contrast, the experiences of training highlighted by the UNISON Black SOG research interviewees revealed a focus on the improvement of case work and campaigning effectiveness alongside member development to enable more effective collective bargaining in the fight for better working lives. In this regard the UNISON Challenging Racism in the Workplace training, alongside other courses, whilst also helping to plug some gaps which were missing in the local NHS Trust's mandatory equality and diversity training, which excluded lower band outsourced workers, was extremely beneficial in supporting Black members to take up roles within the local branch and in representing members via casework by increasing their skills and confidence. In this respect the UNISON Black SOG research interviewees highlighted the distinctive collective bargaining difference delivered by UNISON's Challenging Racism in the Workplace training, with Black SOG members furnishing information to the local branch based on Black members' every day experiences of racism in recruitment, retention, training, disciplinary action, cuts and redundancies. This approach enabled the local branch to put pressure on the Trust via the Joint Steward Negotiating Committee to more effectively implement its Equality Delivery System.

### **Different organising structures – different conceptions of leadership**

In this context, the UNISON case study highlighted how the Black SOG structure and activities acted as a mechanism for increasing involvement in UNISON, providing different routes into activism via creating union reps who could act in a wide range of union initiatives. This enabled the union overall to be more diverse and more representative of the workforce it sought to defend. Thus for example, research interviewees in the UNISON Black SOG included workplace stewards, a Branch Recruitment Officer and a Black SOG member who was also the local Branch's Disability Officer, with active involvement in branch leadership roles for BME workers on a lower

NHS bands. And, here UNISON was also compared favourably with the nursing union RCN in terms of BME representation and representation of staff on lower bands.

The local NHS BME Network structure did not offer equivalent opportunities for membership participation. And the two case study organisations' different recruitment and participation strategies could be contrasted via the example of the UNISON Black SOG member who was also the local Branch Recruitment Officer tasked with bringing new members on board through face to face interaction. By contrast, another UNISON Black SOG member commented that the BME NHS Network should put up posters in order to reach the outsourced Carillion-managed NHS staff working alongside him as porters, who had limited computer access – suggesting that the local NHS BME Network had been publicised through electronic means, perhaps through the staff email or intranet system. This difference in recruitment methods may also link to the relative positions of the two groups. Because the BME Network is operating through Trust systems, it is reproducing barriers that already exist for lower band workers such as lack of access to computer information, and reduced access to training opportunities (lack of access to the Trust's mandatory equality and diversity training was cited by a UNISON Black SOG member managed by private contractor Carillion).

The research indicated that the local NHS BME Network was unable to understand these questions of access as it needed to engage with the relevant staff members by non-electronic means. In addition, there were also barriers to participation in terms of frontline lower band staff not being in a position to take time off to attend local NHS BME Network meetings. Where some of the higher band local NHS BME Network research respondents expressed a need for the Network to engage with BME NHS colleagues on a lower band, the vagueness around how to achieve this suggested that no consultation or effective engagement with staff from these bands had taken place. Thus, where the UNISON Black SOG had a greater focus on collective bargaining, and had more developed resources for

training Black workers from a wider range of NHS bands and occupations, with skills for resilience in the workplace and union activism, this was also fused with wider engagement via a community organising and community solidarity approach, illustrated by the funding of the local Filipino community organisation. The NHS BME Network had no structured mechanism for engaging with outsourced NHS BME and migrant workers, whereas research respondents in the UNISON case study noted the need to bring ‘race equality into the private sector’, in which many African, Asian and East European migrant workers were facing exploitation and high rates of bullying and harassment. In 2014 during the course of this research UNISON’s African Migrant Workers Network was officially launched at the 2014 National Black Members Conference.

### **Black History Month**

An area of similarity and shared political purpose between the two case study organisations was the importance given by both groups to Black History Month for the purposes of promoting race equality in the workplace and facilitating the organising and recruitment of Black workers, alongside engagement with BME community groups. This research found collaboration between the local NHS BME Network and the local UNISON Black SOG in jointly organising annual Black History Month events held under the institutional auspices of the Local NHS Trust, which funded the events, with the local UNISON Branch also providing a donation to support the event. Whilst successful BME role models active within the public sector were invited as key note speakers to these events, the UNISON Black SOG also held its own activist-orientated community based Black History Month events alongside Black community organisations.

### **Representations of race, class and gender**

In seeking to address the ‘snow capped’ (Reid and Phillips, 2004) “Snowy White Peaks of the NHS” (Kline, 2014), The local NHS BME Network, in concert with the national independent NHS BME Network, projected a Black professional middle class identity

linked to discourses around ‘breaking glass ceilings’ and narratives focusing on the need for more ‘role models’ in senior management positions who would provide inspiration to other BME members of the workforce. In this respect both the local NHS BME Network and the national NHS BME Network, with its high profile-self-esteem boosting annual conferences being held at the Hilton, Park Lane, London, with after conference dinner black tie events, whilst mobilising BME professionals clustered in NHS Bands 6-8, seemed unable to attract BME NHS ancillary workers in NHS support roles graded Band 1-4. Given the concentration of marginalised NHS Band 1-4 BME and migrant workers, their exclusion from and non-participation in the local and national NHS BME Network events and activities problematizes and signals contestation around the hypothesis that BME Diversity Networks are seen as being more effective collective voices for promoting race equality in the workplace. Whilst some of the local NHS BME Network research interviewees were aware of the exclusion of lower band BME and migrant workers, they were unable to articulate a strategy or programme for overcoming this exclusion. Interestingly UNISON Black SOG research participants on lower NHS bands made reference to class differences and professional hierarchies as the key source of this marginalisation and exclusion. Interviewees in both case studies presented viewpoints on how they perceived class interacting with race to bestow power and reproduce privilege in the workplace. This interplay of class with race was expressed in relation to forms of ‘cultural capital’ (Savage, 2017; Savage 2015; Rollock et al., 2015) with ‘upper class education’ and ‘soft skills’ linked to those in senior roles having more power and being subject to less abuse, as “the nurses get more; the carers get much more.”

### **Black women leaders as anti-racist activists**

The prominent role of Black women as leaders and activists within both the local NHS BME Network and the UNISON Black SOG reflects the longstanding part racialized Black women’s labour has played in the construction of the NHS (Race Today Anthology, 2019;

Bryan et al., 1985, Bryan et al., 2018), alongside their struggle and resistance to the racism that placed them at the base of the NHS occupational hierarchy. The case studies revealed that anti-racism was approached differently by the respective leaders of the local NHS BME Network and the local UNISON Black SOG. The leader of the local NHS BME Network who, having progressed to become a senior band 8 manager was seen by her peers as an admirable role model, appreciated the motivational benefits she'd gained from participating in the NHS 'Breaking Through Programme'. However, she also highlighted that it was UNISON who were representing the majority of lower bands in her workplace. This observation contradicted a key rationale she put forward for the local NHS BME Network being an alternative to unions for Black NHS workers, based on her experience of the lack of BME representatives within the HR department and unions like the RCN. Here was the crux of the matter for the leader of the local UNISON Black SOG: the Black SOG structures facilitated Black workers' participation within the wider union, and because UNISON covers a wider range of NHS pay bands and BME identities and has a clear and longer track record of delivering, "people have more faith in the union."

In exploring the hypothesis that BME Networks may be seen as more effective 'collective voices' (Williams and Yarker, 2017) than trade union Black Self-Organised Groups, for promoting race equality in the NHS workplace, the evidence from this empirical study based on the qualitative testimony of Black activists, highlights some of the contradictions and key areas of contestation associated with the above hypothesis. This study engaged with a relatively under-researched group of Black workers in the NHS – ancillary NHS support workers and Allied Health Professionals – alongside BME nurses. Where much research on Black workers in the NHS has focused on the racialized experiences of Black doctors and nurses, a potential contribution to knowledge is presented in the form of this research's exploration of the collective strategies deployed by Black ancillary NHS support workers and Allied Health Professionals inscribed by categories of race, class and gender

to challenge systemic racism within the NHS workplace. The research documents the relationship between the now lapsed independent national NHS BME Network and a local affiliated NHS BME Network capturing a moment in time – 2012 -2018 – when the activism and lobbying of NHS Black workers led to the implementation of the NHS Workforce Race Equality Standard. This research mapped a Black Radical Tradition theoretical understanding of ‘resistance and accommodation’ to racial capitalism, linked to the Marxist scholarship of Walter Rodney, Manning Marable and Cedric Robinson, alongside race and class theories of resistance to racism in the UK context (Narayan, 2019; Virdee, 2014; Virdee, 2010). The research makes a potential theoretical contribution by applying the concept of ‘common sense neoliberalism’ (Hall and O’Shea, 2013; Gilroy, 2016) to consider the implications of forms of race equality which, in aligning with neoliberal corporate diversity management, privilege Black professional middle class identities and marginalise Black working class perspectives (West, 2017; Berrey, 2015; Marable, 2009). In this context this research by foregrounding the voices and agency of Black NHS workers collectively challenging racism in the workplace reaffirms the Black Radical Tradition’s critique of ‘racial capitalism’ alongside highlighting the importance of race and class inspired activism which is able to critically contest ‘common sense neoliberalism’ (Hall and O’Shea, 2013; Gilroy, 2016) and the ‘neoliberal turn in black politics’ (Spence, 2016, Gilroy, 2016; Narayan,2019) by moving beyond ‘identity politics’ (Marable,2009;Taylor,2016;Haider, 2018) to incorporate broader conceptions of social justice.

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## **Legal Cases**

*UNISON v Lord Chancellor* [2017] UKSC51 (Supreme Court)

## **Legislation**

Equality Act 2010

Health and Social Care Act 2012

Race Relations Amendment Act 2000

## **Appendix 1 Recent reports highlighting race inequality in the UK**

A key research question asks why UNISON Black SOGs and the NHS BME Network are organising on the basis of race equality at a time of the ‘single’ Equality Act?

A series of recent reports highlight the extent and depth of structural racism, institutional racism and intersecting inequalities in the UK workplace and wider society.

### **The Race Disparity Audit**

In August 2016 incoming Prime Minister Theresa May announced the launch of the government’s Race Disparity Audit. In a speech to key stakeholders on 10th October 2017 at an event presenting the Audit’s findings, Theresa May, in words evocative of the 2000 ‘Future of Multi-Ethnic Britain’ (Parekh Report), stated:

“We know that Britain today in the 21st century is a diverse multi-ethnic democracy. Diversity is a source of strength and pride for us. But when one person...experiences a worse outcome solely on grounds of their ethnicity, then this is a problem that I believe we have to confront....”

The Race Disparity Audit collates data across government and public sector areas including health, education, welfare and the criminal justice system, with a view to being regularly updated. And Theresa May added:

“I think the data we’re releasing today and the online platform that presents it should quickly become to be regarded as the central resource in the battle to defeat ethnic injustice.”

The approach is similar to the use of data applied in ‘Black Stats: African-Americans by the Numbers in the Twenty-First Century’, where Morris states:

“Race, as a social construct, continues to play an important role in shaping the life outcomes of individuals in the United States... the use of data is a powerful tool for understanding how... conditions may have changed or where they have remained the same...Because data are able to highlight both equality and disparity, they remain an essential component in evaluating progress on racial equity.” (Morris, 2014: preface)

Whilst Theresa May and her government have titled their audit ‘The Race Disparity Audit’, in its tracking and audit of differences within and between different ethnic groups it reflects the statistical ‘dynamics of diversity’ as discussed by Jivraj and Simpson in their recent study of ‘Ethnic identity and inequalities in Britain’ (2015).

**Race Disparity Audit (2017), key findings:**

**The public sector workforce: “snow-capped” and “snowy white peaks”**

The public sector is a big employer of ethnic minorities, however ethnic minority workers are found mainly in the lower grades of the public sector workforce.

In 2016, 18% of the non-medical NHS workforce (excluding white minorities) were from an ethnic minority group. Only 7% of very senior managers and 11% of senior managers were of an ethnic minority background. The Executive Boards of many NHS trusts do not reflect the diversity of the NHS workforce: 93% of NHS Board members in England are white (which includes white ethnic minority backgrounds). Judges and the judicial system are overwhelmingly white. In spite of the Stephen Lawrence Inquiry and Macpherson Report, there has been no significant change over the past decade in the police service, which is predominantly white.

**Employment**

Differences in Labour market participation include: one in ten adults from a Black, Pakistani, Bangladeshi or Mixed background were unemployed in contrast to 1 in 25 White British people. Pakistani and Bangladeshi women were the least likely to be employed. Individuals of Pakistani and Bangladeshi heritage were found to be more likely to be in low skilled, low paying occupations than other ethnicities. Having higher rates of self-employment, Pakistani and Bangladeshi workers received the lowest average hourly pay – less than Indian workers, who received the highest average hourly pay.

## **Poverty and living standards**

Asian, Black and the Other ethnic group households are more likely to be poor and found in persistent poverty. Bangladeshi, Pakistani, Black, Mixed and Other households were more likely to receive income related benefits than other ethnic groups. People from Black, Pakistani and Bangladeshi households were more likely to live in areas of deprivation.

## **Health**

Many Asian groups experience less satisfaction and have less positive experiences of NHS General Practice services than other ethnic groups. Black men are the most likely to have experienced a psychotic disorder in the past year. Black adults were more likely than adults from other ethnicities to have been sectioned under the Mental Health Act.

## **Education**

The best attainment levels in school through to university entry were from Chinese and Indian pupils. In contrast, pupils from Gypsy, Roma and Irish Traveller backgrounds (which are not included in the White British category) had the lowest attainment rates. Black Caribbean pupils experience poor overall attainment rates. White pupils from state schools experienced the lowest university entry rates of any ethnicity in 2016.

## **Housing**

Ethnic minorities in general and Pakistani households in particular experience poorer standards of housing. Ethnic minorities in general and Bangladeshi households in particular experience higher rates of overcrowding. In the past two decades, officially recorded homelessness as increased amongst ethnic minority households.

## **Communities**

The UK is becoming increasingly more ethnically diverse, with the proportion of people who identify as White British in England and Wales down from 87.4% in 2001 to 80.5% in 2011. Approximately 1 in every 13 people in England and Wales over the age of three has



a main language other than English. Polish was the most spoken language after English, with 1% of the population reporting it as their main language.

### **Policing**

Black men are approximately three and a half times more likely to be arrested than White men.

### **Criminal justice**

Black defendants, especially Black males, are more likely to be remanded in custody than other defendants. Black and Asian offenders were given the longest average custodial sentence length of 24 and 25 months respectively.

### **‘Race disparity’ or ‘intersecting inequalities?’**

#### **Intersecting Inequalities Report (October 2017)**

The Women’s Budget Group and the Runnymede Trust released the findings of their joint project at the same time as Theresa May’s Race Disparity Audit. Their report, ‘Intersecting Inequalities: The Impact of Austerity on Black and Minority Ethnic Women in the UK’ (2017), is a “cumulative impact assessment” of government austerity cuts to public services, benefits and tax credits since 2010. The report considers how the structural inequalities faced by BME women, “who earn less, own less and have more responsibility for unpaid caring roles and household work”, in areas such as employment, health, and education, have exacerbated the disproportionate impact they have experienced from austerity related cuts to public services.

The report states:

“Black families in the poorest fifth of households will see their living standards fall by over £8,400 a year on average from cuts to benefits and services.”

And also comments:

“BME women face multiple disadvantages including sexism and racism in the labour market. They face discrimination and bias at every stage of their recruitment process – during the evaluation of CVs and application forms, at the interview stage and once in post.”

### **Race in the Workplace: The McGregor-Smith Review (February 2017)**

Presents the business case for diversity and inclusion in the workplace in a manner similar to McKinsey’s ‘Diversity Matters’ and ‘The Diversity Bonus’ (Page, 2017), around harnessing a diverse pool of talent. As a result of the report a new ‘Business, Diversity and Inclusion Group’ has been launched to help government and industry to coordinate efforts to progress representation, inclusiveness and participation in the workplace. Interestingly the report dismisses the recent popular trend for ‘unconscious bias’: “We need to stop hiding behind the mantle of ‘unconscious bias’ – Much of the bias is structural and a result of a system that benefits a certain group of people.” The report also states:

“14 per cent of the working age population come from BME backgrounds, which is expected to rise 21 per cent by 2051.”

“In 2015, 1 in 8 of the working population were from a BME background, yet BME individuals make up only 10% of the workforce and hold only 6% of top management positions.”

“The potential benefit to the UK economy from full representation of BME individuals across the labour market through improved participation and progression is estimated to be £24 billion a year, which represents 1.3% of GDP.”

### **The Lammy Review: An Independent Review into the Treatment of, and Outcomes for, Black Asian, and Minority Ethnic Individuals in the Criminal Justice System (September 2017)**

Observes there is an increasing BAME middle class, and gradual increase in diversity within key institutions like the House of Commons, but in contrast notes the dire situation for BAME individuals caught up in the criminal justice system:

“Despite making up just 14% of the population, BAME men and women make up 25% of prisoners, while over 40% of young people in custody are from BAME backgrounds.”

The report acknowledges the “complexity of the term BAME” and seeks to understand and explain BAME disproportionately in the criminal justice system.

### **Race Report: Healing a Divided Britain – Equality and Human Rights Commission**

#### **Report on the need for a comprehensive race equality strategy (August 2016)**

An investigation of race equality outcomes in employment, pay, living standards, education, health, and criminal justice, based on the Equality and Human Rights

Commission’s statutory five yearly report on progress made on equality and human rights in England, Scotland and Wales.

The report’s key findings in the area of work, income and the economy, included:

“Black people who leave school with GCSEs typically get paid 11.4% less than their white peers.”

“Black workers with degrees earn 23.1 % less on average than white workers with degrees.”

“Young ethnic minorities experienced the worst long term unemployed outcomes, between 2010 and 2015 they saw a 49% rise in unemployment compared with a fall of 1% in overall long-term youth unemployment and a 2% fall among young white people.”

“There was a considerable gap in the percentage of White and ethnic minority people starting apprenticeships (89% compared with 2-5%).”

### **The Colour of Power UK: Operation Black Vote Report (September 2017)**

Operation Black Vote’s investigation into the UK’s ruling elite and the very top jobs in British society. Makes the expected harnessing of a diverse talent pool business case argument, but also presents an interesting argument in relation to intersections of race, class and gender, which is buttressed by the visual image of a gallery of all white mainly male trade union leaders which accompanies the report:

“we...thought we would see some racial and gender gaps in certain positions of power, due in no small measure to the way class and privilege play such an important part in pathways to position such as high court judges and army generals but other areas, including union leaders and football managers, clearly

demonstrates that class alone could not explain why so few BME individuals, and women were to be found in the highest positions of power.”

The Colour of Power’s overall findings are that “for more than 1,000 of the most senior posts in the UK, only 3.4% of occupants are BME, and less than 23.6% are women.”

**Racial Prejudice in Britain Today: Runnymede Trust and National Centre for Social Research Report (September 2017)**

This is a report which claims that the general trend of an increasing social liberalisation in attitudes is not mirrored in recent social attitudes surveys looking specifically at racial prejudice. The report presents findings indicating those social groups more likely to describe themselves as harbouring prejudice to people of other races:

“Gender – Men (29%) were significantly more likely than women (23%) to say they were racially prejudiced.”

“Political Party – 33% of Conservative Party supporters described themselves as racially prejudiced compared to 18% of Labour supporters.”

“EU Referendum – Those who voted to leave the EU were more likely to describe themselves as racially prejudiced. 34% of Leave voters said they were racially prejudiced, more than the 18% of Remain voters who described themselves in this way.”

**Let’s Talk About Racism Report: an interim report about the experiences of black and minority ethnic workers in the workplace, TUC (April 2017)**

Presents findings from a self-report survey of more than 5000 working people: it gives voice to the everyday experience of racism in the British workplace. The report highlights the prevalence of racial harassment in the UK workplace:

“Respondents identified that much of the harassment they were subjected to was from colleagues or managers. This suggests that employers are not effectively enforcing appropriate behaviour amongst their workforce.”

“Discrimination within performance management systems can be a factor in the lack of progression of BME workers in the workplace. This was recently highlighted by the PCS union, who found that over half the civil service members surveyed believe that performance management is used to bully and harass staff and provides scope for the operation of discriminatory practice.”

### **‘Living on the Margins: Black Workers and Casualization’, TUC (April 2015)**

Highlights that the 2008 recession has resulted in a rise in insecure and casual working patterns in the UK, including the use of zero hour contracts and agency work.

Key themes include:

Precarious employment and BME workers – BME workers have been disproportionately affected by the rise in precarious forms of work since the recession. The Quarterly Labour Force survey indicated that between 2011 and 2014 temporary working increased by 25.4 percent amongst BME employees.

BME workers and agency working – TUC research reveals that while just 11 percent of UK employees are from BME backgrounds, they hold 17 percent of temporary jobs and 21 percent of agency jobs.

Under-employment and short-hours working – TUC research indicated that in 2014, nearly half a million BME employees experienced under-employment.

BME employees working in low paid sectors – BME workers are concentrated in areas of the labour market which are traditionally low paid. In 2014, 37.4 percent of BME employees worked in low paid sectors compared with 29 percent of white employees.

Between 2011 and 2014, the number of BME workers employed in low pay industries – including the service and social care sectors – increased by 12.7 percent but by only 1.8 percent amongst white employees.

Young Black workers and precarious work – casualisation has disproportionately affected young BME workers, according to TUC study of the Labour Force Survey. 15.2 percent of young BME workers were in non-permanent jobs compared to 8.4 percent amongst young white workers.

Young workers aged 20-29 from BME backgrounds are nearly twice as likely to be working on a temporary basis as their white counterparts.

### **Racial Violence and the Brexit State, Jon Burnett Institute of Race Relations**

**(December 2016)**

Briefing based on analysis of 134 racist incidents reported in the media in the first months after the referendum from 24 June to 23 July 2016.

Police announcements on referendum related crime:

In the fortnight after the result, British Transport Police received 119 allegations of racist abuse or violence taking place on British railways.

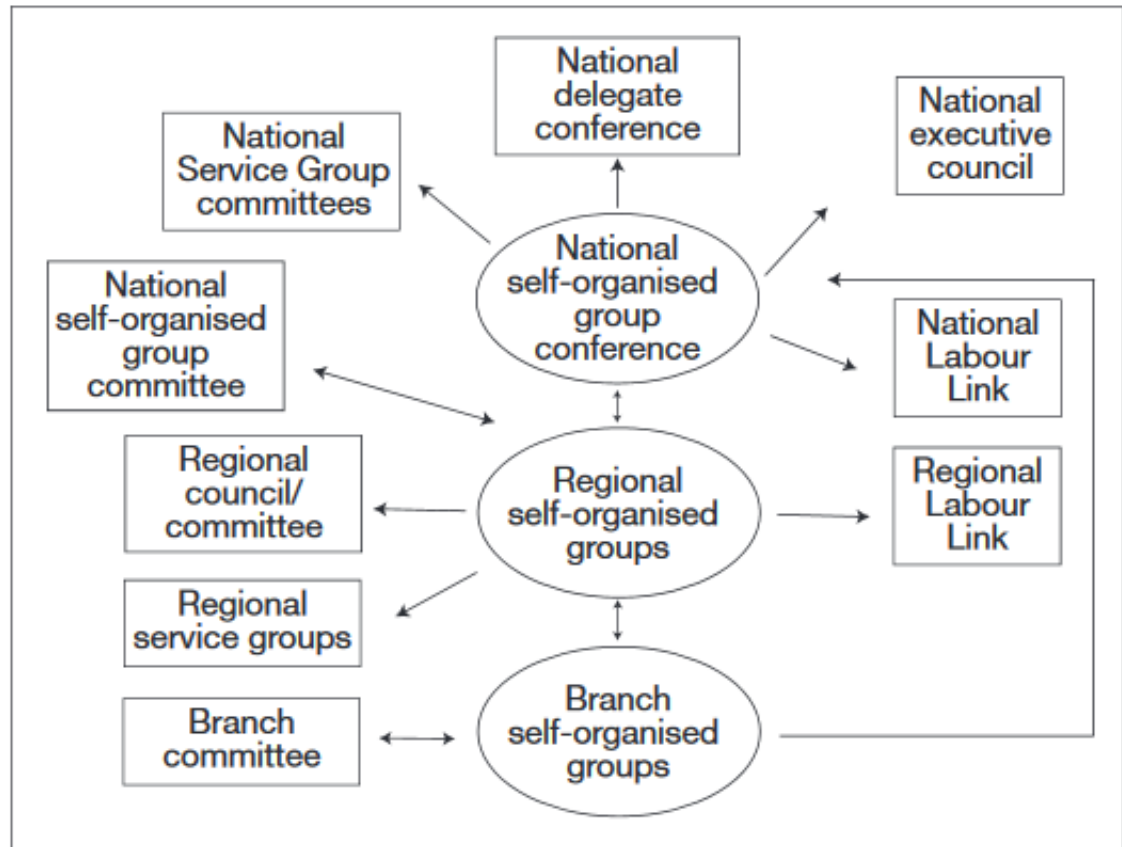
Between 24 June and 2 July, 599 racist incidents were reported to Scotland Yard: an average of 67 per day, compared to 44 per day prior to the referendum.

“Racism always needs to be understood from the vantage point of those who experience it, in the case of post-referendum violence, primarily Muslims, and eastern European migrants, but also Black and Jewish communities who have also been harassed as our data testifies.”

“The ‘newness’ of post-referendum racism is rooted in and sustained by the structural racism of old.” (Burnett, 2016:8)

## Appendix 2 UNISON Black Self-Organised Group structures

**How does self-organisation link with the rest of the union?**



Source: Organising for Equality: UNISON Guidelines on Self-Organisation, 2014, UNISON, page 6

## **Appendix 3 NHS BME Network overview**

### ***Introduction:***

The independent national NHS BME Network was launched on 4 June 2010 at the Hilton Park Lane to be an independent and effective voice for BME staff, patients, service users and carers to ensure the NHS delivers on its statutory duties regarding race equality.

Membership of the Network is open to all Black and Minority Ethnic (BME) people.

### ***BME definition:***

Any person whose ancestral origins are African, Asian, Caribbean, Chinese, Irish, Japanese, Middle Eastern, North African, Romany. The indigenous peoples of the South Pacific Islands, the America, Australia and New Zealand. People from mainland Europe and any persons visiting from overseas.

### ***Members can demonstrate their personal and professional support for:***

- The elimination of racial discrimination in the NHS
- The elimination of ethnic health inequalities
- Effective BME patient and public engagement
- Personal and professional development of BME staff
- Local BME Networks

### ***The Network offers the following benefits to members:***

- An opportunity to bring about change in the NHS
- An opportunity for BME people to be heard
- Access to better and more appropriate healthcare
- Information and Interpretation of NHS Policy
- Access to a network of people of shared vision



***The Executive Committee consists of:***

- Chair
- Vice Chair
- Treasurer
- Secretary
- Assistant Secretary
- BME Patient/Service User Liaison Officer (x2)
- Public Relation/Communication Officer
- Local BME Network Facilitator (x2)
- BME Medical Representative
- BME Mental Health Liaison Officer

***Local NHS BME Network – based in Local NHS Trust***

The Local NHS BME Network was launched in 2012 and its structure, membership and constitution are based on and closely mirror those of the national independent NHS BME Network, to which is it affiliated.

## Appendix 4 Interview schedule: members

**Table 3: Members interview schedule**

Q: Which do you prefer Black or Black and Minority Ethnic (BME) please explain why?
<p>Prompts:</p> <ul style="list-style-type: none"> <li>• How do some ethnic ‘new migrant groups’ e.g. South Asian, Filipino, Chinese, Arabic, dual heritage, relate to a ‘Black’ or ‘BME’ definition?</li> <li>• ‘Black’ – politically black</li> <li>• ‘Black’ – African diaspora</li> <li>• ‘Brown’</li> <li>• ‘Muslim’</li> <li>• ‘People of colour’ – ‘visible minorities’</li> <li>• Does use of ‘BME’ reflect ‘new ethnicities’ – new and emerging migrant communities, multiculturalism, equality and diversity in the workplace?</li> <li>• Majority vs ‘ethnic minorities’</li> </ul>
Q: How do NHS BME Staff Networks support BME Workers?
<p>Prompts:</p> <ul style="list-style-type: none"> <li>• Group support</li> <li>• Membership</li> <li>• Courses – training</li> <li>• Participation in local and national NHS BME Network activities and events</li> </ul>

<ul style="list-style-type: none"> <li>• Representations and negotiations with managers/organisational leaders</li> </ul>
Q: How do UNISON Black Self Organised Groups support BME Workers?
<p>Prompts:</p> <ul style="list-style-type: none"> <li>• Group support</li> <li>• Representation – case work</li> <li>• Courses – access to training and learning opportunities</li> <li>• Participation in local and regional Black Self Organised Group</li> <li>• Participation in UNISON National Black Members Conference</li> <li>• Community organising activities</li> </ul>
Q: How do you understand race equality?
<p>Prompts:</p> <ul style="list-style-type: none"> <li>• Stephen Lawrence Inquiry</li> <li>• Macpherson Report / institutional racism</li> <li>• Positive duty to promote race equality</li> </ul>
Q: How do you think the Equality Act can be used to challenge racism in the workplace?
<p>Prompts:</p> <ul style="list-style-type: none"> <li>• Public sector equality duty</li> <li>• Nine ‘protected characteristics’</li> <li>• Equality Impact Assessments</li> </ul>

<p>Q: How are identities of race, ethnicity, gender and class important to you in the workplace?</p>
<p>Prompts</p> <ul style="list-style-type: none"><li>• Individual and collective</li><li>• Multiple identities</li><li>• Other identities - occupation/expertise, religion, sexuality, disability</li></ul>

## Appendix 5 Interview schedule: key informants

**Table 4: Key informant interview schedule**

Q: How has Black self-organisation changed and evolved in the last ten years?
Q: What do you think are the differences and similarities between trade union Black self-organisation and BME Staff Networks?
Q: How do you think the change from the CRE to the EHRC and 2010 Equality Act has impacted on BME workers?
Q: How have neoliberalism and austerity politics impacted on Black workers and communities?

## **Appendix 6 Research information letter**

I am a student on the Professional Doctorate in Researching Work Programme based at London Metropolitan University. I am currently collecting data in the field work stage of my research thesis and would like to inform you about the purpose of this research and invite you to take part in this research study.

### **Research aims**

The title of the research study is “Black Workers and BME Networks Organising Against Racism in the NHS Workplace”. The study explores Black and Minority Ethnic (BME) self-organisation and collective organisation against racial discrimination in the workplace by investigating a local and national NHS BME Network and local and regional UNISON Black Self-Organised Groups (SOGs). A key aspect of the research is to explore the ways in which people with different and intersecting social identities participating within the NHS BME Networks and UNISON Black SOGs understand ideas of race equality, social justice and anti-racism.

The research is also interested in exploring BME workers’ views on institutional racism as defined by The Stephen Lawrence Inquiry and Macpherson Report, and the goal of pursuing race equality in the workplace in relation to the 2010 Equality Act, which replaced the Race Relations Amendment Act 2000. I hope to conduct interviews with members of the local and national NHS BME Network and members of the local and regional UNISON Black SOGs.

### **What happens if you participate?**

If you decide to take part you will be interviewed by the researcher about your experiences. The interview will be audio-recorded with your consent. Taking part in the study is voluntary and participants can withdraw from the interviews and study at any time. The

interviews will take approximately 45 minutes, at a time and place most suitable and convenient for the participant.

### **Confidentiality and use of the information you provide for this research**

Research participants' names will be anonymised in the research and any subsequent research outputs. The interviews will be transcribed and stored electronically. Data storage will adhere to the provisions of the UK Data Protection Act 1998, with all recordings and material password protected and locked away at a secure location.

The research thesis may use quotations of participants' words from their interviews: the research consent forms will ask for confirmation that participants are happy for quotations to be used.

### **Ethical approval**

This study has been ethically reviewed and approved by the London Metropolitan University's Ethics Review Committee.

### **Researcher contact details**

I hope you will be willing to participate in this study. If you require more information, please do not hesitate to contact me. Thank you.

Yours sincerely,

Nigel Carter

[Contact details follow]

## Appendix 7 Consent form

### Consent to Participate in Research:

I agree to take part in this study.

Taking part will include being interviewed and audio recorded.

I have read and understood the research information sheet.

I have been given the opportunity to ask questions about the research.

I know that taking part is voluntary and that I can stop at any time.

I understand my real name will be anonymised in the research.

I understand that my words may be quoted in the research reports.

Name (printed) \_\_\_\_\_

Signature\_\_\_\_\_

Date\_\_\_\_\_

### Interview Audio Recording Consent:

I agree to audio recording at\_\_\_\_\_

Signature\_\_\_\_\_

Date\_\_\_\_\_

### Interviewer:

Signature\_\_\_\_\_

Date\_\_\_\_\_



## Appendix 8 Map of main themes

The following figure illustrates the relationship between the key thematic categories and sub categories of the research.

