The ERINN Report

Working Towards Eradicating Racism in the Norfolk NHS Ten Years On

May 2011

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Foreword

Eradicating Racism in the Norfolk NHS is fundamental in ensuring that the dignity and rights of all service users and providers are protected. Monitoring progress towards this goal is an important priority.

Norfolk is increasingly becoming a multi cultural society hosting a rich mix of cultures and minority ethnic communities, which is pleasingly reflected in the number of minority ethnic staff who are joining the NHS. Correspondingly, in larger numbers, members of minority ethnic communities are benefiting from services and care provided by the NHS. It is our intention to maintain the highest standards of care and support by providing environments that are safe and free from harassment and discrimination.

With the introduction of the Equality Act in 2010, it is clear that there is a need to widen our concerns and ensure that harassment and discrimination is eradicated over all the range of protected characteristics.

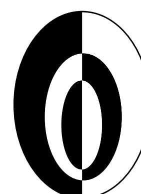
This report builds on work previously undertaken in 2001. It provides some very useful indications of what has changed over the period of 10 years and what issues should form the focus of our concerns today. It is a celebration of the progress made towards eradicating racism, harassment and discrimination and it raises awareness and provides a timely indication of what remains to be done.

Most importantly, this report gives voice to the views, ideas and experiences of our own NHS workforce.

I acknowledge and thank all of the partners at the NHS in Norfolk for their support and contribution to this review and trust that they will carefully consider the results and agree local actions in response to them.

Sheila Childerhouse
Chair – NHS Norfolk

NHS partners:
NHS Norfolk
Norfolk Community Health and Care NHS Trust
Norfolk and Waveney Mental Health NHS Foundation Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
East of England Ambulance Service NHS Trust
GP Practices in Norfolk



Norwich & Norfolk Racial Equality Council

Executive Summary

In 2001 an important piece of research was undertaken which set out to identify issues relating to race and ethnicity within the NHS in Norfolk. The result of this project was "The ERINN Report – Working Towards Eradicating Racism in the Norfolk NHS – May 2001". In 2011, this project was repeated and also expanded to include other protected characteristics from the 2010 Equality Act. This project has enabled an informed a contemporary dialogue around these issues ten years on. In 2011, 1387 people from the six NHS Trusts and GP practices in Norfolk responded to a survey. This report is based upon their feedback, views, ideas and stories.

Since 2001 much has changed. There is still much work to be done., but it is clear that there have been indications of a positive shift in responses to discrimination and harassment. Likewise acts of racism occur less often in 2011.

Examples of this include the following:

- In 2001 over 50% of the visible minority ethnic staff felt that there was racial discrimination in job selection procedures. In 2011 only 2% of minority ethnic staff had experienced this and over 87% had neither experienced nor noticed discrimination in job selection.

- In 2001 over 56% of the visible minority ethnic staff felt that there was racial discrimination in selection procedures for internal promotion. In 2011 only 12% of minority ethnic staff had experienced this and nearly 83% had neither experienced nor noticed discrimination relating to internal promotion.

- In 2001 85% of the visible ethnic minority staff felt that racism was a problem within the local NHS. Approximately 60% of the White British staff shared this view. In 2011 86% of all staff believed that racism was not a problem or that it was being dealt with effectively. The percentage of minority ethnic staff who felt that racism was not being effectively addressed had dropped to 39% in 2011.

- In 2001 about a third of all staff did not know if interpreters were available if required and many staff who said that interpreters were available qualified their answers. In 2011 10% of all staff did not know how to access translation services and a further 12% were unsure.

- In 2001 50% of the White British staff and 40% of the visible minority ethnic staff would try to make alternative arrangements for patients who refused treatment because of racial differences. In 2011 66% of all staff would try to make alternative arrangements in such circumstances.

47% of the 2011 respondents believed that the profile of racial awareness has been raised over the past 10 years and respondents felt that there was a greater likelihood of organisational support should they be the subject of harassment or discrimination, compared with 10 years ago. However, there is still much work to be done.

In the 2011 study 29% reported that they were unaware of the mechanisms available for reporting racial incidents at work. Not being able to understand accents was the largest communication issue reported. Ageism was the greatest harassment and discrimination issue reported. Addressing wider issues raised regarding the protected characteristics and entrenched racism remains a challenge. The report also reflects on service user experience drawing on the findings of an NHS Norfolk survey in 2010 and comparing this with the ERINN survey.

Dr Steven Wilkinson and Dr Kathleen Lane
University of East Anglia
May 2011

Contents

Foreword 3
Executive Summary 5
Background 8
The Project 8
Project Deliverables 8
Project Management 8
Ethics 9
Analysis 9
Feedback Overview 9
- Organisation 9
- Gender 9
- Equality Act 2010 9
- Disability 9
- Religious Belief 10
- Sexual Orientation 10
- Age 10
- Ethnicity 10
- Language 11
- Staff Category 11

Analysis of Survey Responses - Ten Years On 12
- Racism 12

Equality and Diversity 15
- Racism, Equality and Diversity Discussion 16
- Ageism 16
- Offensive Behaviour - Racism 17
- Belief 18
- Sexual Orientation 19
- Intolerance of Disability 20
- Other Examples of Discrimination 21
- Gender 22
- Remaining Categories 22

Organisational Response 23
- None 23
- Action or Response 24

Racial Awareness and Equality and Diversity Training 26
Reporting Mechanisms 27
Communication 28
Interpretation and Translation Services 31
Contact with Ethnic Minorities 31
Ten Years On 34
Service Users 39
Summary of Main Findings 41
- Racism 41
- Equality and Diversity 41
- Reporting Mechanisms 41
- Interpretation and Translation Services 42
- Contact with Ethnic Minorities 42
- 10 Years On 42
- Service Users 42

Conclusions 43
Project Partners 44
Glossary 44
Appendix A - Extracts from the Equality Act 2010 45

Background

In 2001 an important piece of research was undertaken which set out to identify issues relating to race and ethnicity within the NHS in Norfolk. This information was to be used to

- raise awareness of staff to issues raised;
- enhance local reporting and recording mechanisms; and
- develop a common approach to race equality issues throughout the NHS in Norfolk.

The result of this project was "The ERINN Report – Working Towards Eradicating Racism in the Norfolk NHS – May 2001".

In 2011, this project was repeated and also expanded to include other protected characteristics from the 2010 Equality Act ("Appendix A - Extracts from the Equality Act 2010" on page 45). This project has enabled an informed and contemporary dialogue around these issues ten years on.

The Project

This project builds on the work undertaken in 2001[1]. The 2001 survey was in two parts. One part collected responses from NHS employees. A second part collected responses from patients. A recently completed project conducted by researchers from the University of East Anglia (UEA), *A Survey of the Health Needs of Black and Minority Ethnic Groups in Norfolk*,[2] went some way towards addressing the issues within the 2001 ERINN patient survey. Therefore it was decided that the patient survey would not be repeated on this occasion, however, the UEA report would be used to provide commentary on the same issues that were within the 2001 survey.

While the 2001 survey was conducted in paper form using the post, the 2011 survey sent out to staff was constructed and delivered electronically using a Surveymonkey® account held by UEA. This provided the opportunity for the survey responses to be transferred to the Trust Surveymonkey® accounts for further and individual Trust analysis. The survey was also available in paper form on request (in line with current NHS 'electronic communication' policy).

1 *The ERINN Report – Working Towards Eradicating Racism in the Norfolk NHS – May 2001.*

2 *A copy of the report, A Survey of the Health Needs of Black and Minority Ethnic Groups in Norfolk, can be requested by emailing steven.wilkinson@uea.ac.uk*

The project team gratefully acknowledges the assistance received with locating the email addresses of potential respondents and distributing the survey link.

A Focus Group conducted at the end of the project was designed to validate and further develop the themes and findings of the survey. Given that there is great potential for the Hard to Reach to be missing from the survey responses, this activity was also designed, in part, to address this imbalance. This meeting was also designed to consider the implications of this report and begin to discuss a strategic response. The meeting took place after the submission of this report.

The project included the following steps:

1. Recreating, updating and distributing a revised survey
2. Conducting an analysis of the survey responses
3. Conducting a comparative analysis of the 2001 and 2011 Survey responses
4. Conducting a narrative response to the patient survey questions
5. Constructing a report
6. Conducting a Focus Group
7. Disseminating the Final Report

Project Deliverables

The outcomes of this project are:

- the survey
- a database of responses (available for further analysis by partner Trusts)
- an analysis of survey responses
- a Final Report

Project Management

A steering group with stakeholders from each participating organisation was formed and hosted at NHS Norfolk by Jonathan Cook (Director with Responsibility for Equality and Diversity) and Jennifer Downie (Equality and Diversity Manager). The steering group was responsible for the inception and oversight of this project. The assistance of members of this group is gratefully acknowledged.

Principal Investigator, Dr Steven Wilkinson, led the university-based project team which included Dr Kathleen Lane and Mrs Julie Goodridge. The project was delivered through the Centre for Applied Research in Education in the School of Education and Lifelong Learning at the University of East Anglia. The project was managed on behalf of the university by Sue Johnson (UEA Consulting

Ltd.). The assistance of Sue and her team in the management of this project is gratefully acknowledged.

Ethics

This project was governed by UEA's ethics policy and guidelines, however, ethics approval to deliver this project was successfully gained through Norfolk NHS. Assistance with this process is gratefully acknowledged.

Analysis

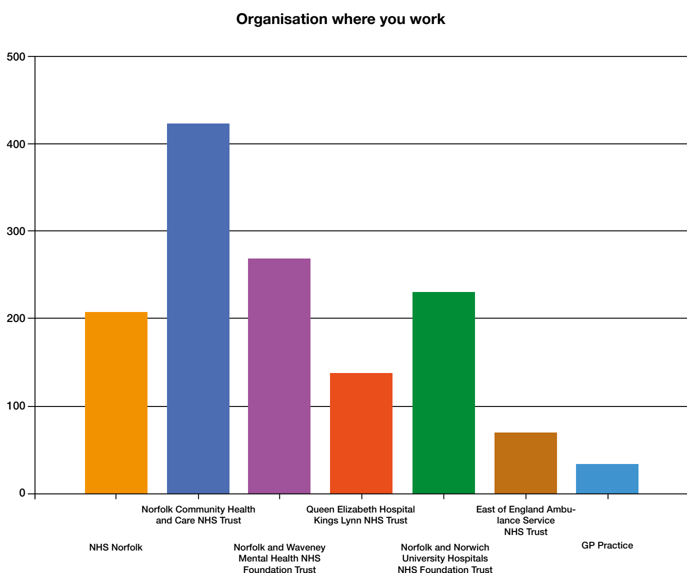
A database that facilitated analysis was used in this project. The Surveymonkey® platform enables the generation of tables and graphs. An enhanced subscription also allows the use of SPSS (Statistical Package for the Social Sciences). SPSS was used to analyse the free text by coding and categorising data into themes and by providing weightings of themes as they emerged.

Feedback Overview

In 2011, 1387 people from the NHS in Norfolk responded to the survey. This compared with 1270 responses to the 2001 survey. The following provides a breakdown and description of this response group.

Organisation

The following chart shows the proportional organisational response:



Gender

The gender of respondents to the 2011 survey is indicated in the following table[3].

Are you	Number	%
Male	358	25.9
Female	1,011	73.2
Transgender	3	0.2
Prefer not to say	9	0.7

Equality Act 2010

Respondents were asked to indicate if they had a disability, their religious belief and their sexual orientation. The following table indicates the number and percentage of responses received.

The Equality Act 2010 recognises a number of protected characteristics. Please tell us (if none of the following applies - please move to the next question)	
Answer Options	**Response Count**
about any disability you may have	207
your religion/belief	416
your sexual orientation	360
answered question	**494**
skipped question	**893**

Disability

207 people responded to the question 'Please tell us about any disability you might have'. Of these, the following conditions were identified:

- Long term condition
- Dyslexia
- Cancer
- Physical disability
- Hearing disability/deaf
- Arthritis
- Macular disease/partially sighted
- Insulin dependent diabetes

3 Trans (or Transgender) is an umbrella term used by people whose gender identity and/or gender expression differs from their birth sex. Caution is advised regarding this response as trans people may have identified as their birth gender or the gender that they currently identify with... There is a significant body of law that protects the rights of transsexual people in all areas of society. 289748/Trans: A practical guide for the NHS http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089941

Religious Belief

416 people responded to the question 'Please tell us your religion/ belief'. Their responses indicated the following:

- Christian
- Muslim
- Atheist
- Jewish
- Church of England
- Non-denominational
- Agnostic
- Protestant
- Roman Catholic

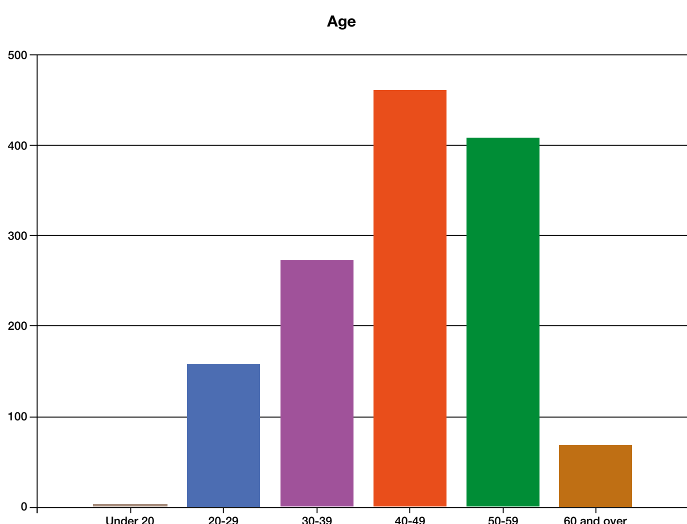
Sexual Orientation

360 people responded to the question 'Please tell us your sexual orientation'. Their responses indicated the following:

- Heterosexual
- Gay
- Bisexual
- Straight
- Married

Age

The following chart shows the age range of the respondents.



Ethnicity

In 2001, 87.56% of all responses were from people of White British ethnic origin. In 2011 this group comprised 85.1% of all responses. The following table indicates the ethnic origin of all responses.

Ethnic Origin		
Answer Options	**Response Percent**	**Response Count**
White British	85.1%	1169
Indian	2.0%	27
Pakistani	0.1%	2
Bangladeshi	0.0%	0
Any other Asian Background *	0.7%	10
Caribbean	0.4%	6
African	1.7%	24
Any other Black background *	0.2%	3
Chinese	0.7%	10
White and Black Caribbean	0.4%	6
White and Black African	0.3%	4
White and Asian	0.5%	7
Any other Mixed background *	0.4%	6
Irish	1.5%	20
Any other White background *	4.0%	55
Gypsy or person of a nomadic lifestyle	0.1%	1
Any other ethnic group *	1.7%	24
* If you have answered "Any other" then please specify		77
answered question		**1374**
skipped question		**13**

'Any other' respondents included the following:

Danish
Mediterranean / Caucasian
Danish/Algerian
US
English
South African
American
European
Finnish
Canadian
British/Dutch
French
British - other mixed background
Filipino
American/British
Spanish
Polish
New Zealander
Arabian
South European
British/Swiss
Scottish/Indian
Dutch
Black British
Japanese
North America
Black British (Caribbean)

Language

Respondents were asked to indicate their first language.

Please tell us your first language	
Answer Options	**Response Count**
	1238
answered question	**1238**
skipped question	**149**

93% of respondents said English was their first language. Other first languages indicated were:

Afrikaans
Akan- (Ghanaian language)
Arabic
Bengali
Danish
Dutch
French
Filipino
Finnish
German
Gujarati (an Indian Language)
Hausa (an African Language)
Hindi
Japanese
Konkani (an Indian Language)
Lithuanian
Maltese
Manipuri (an Indian Language)
Malayalam (an Indian Language)
Mandarin Chinese
Ndebele (a South African Language)
Portuguese
Prefer not to say
Punjabi
Russian
Sanskrit
Scottish
Shona (a Zimbabwean language)
Swedish
Tagalog (a Filipino Language)
Tamil
Telugu (an Indian Language)
Welsh
Zulu

(+ 3 others, Jeddi, Fowl and Norfolk)

Staff Category

Respondents were asked to identify their staff category. The following table shows the responses to this question

Staff Category		
Answer Options	**Response Percent**	**Response Count**
Medical/Dental	6.6%	87
Nursing/Midwifery	33.1%	436
Allied Health Professional	15.5%	204
Senior Management	7.9%	104
Admin/Clerical	31.9%	420
Pharmacy	0.8%	11
Maintenance/Works	0.3%	4
Science/Technical	3.0%	40
Ancillary	1.3%	17
Other (please specify)		64
answered question		**1316**
skipped question		**71**

'Other' staff category responses included the following:

- Project Management
- Day-care Manager
- IT Support 3
- Research 2
- Housekeeper
- IM&T
- mental health practitioner
- Clinical community
- Facilities 2
- Information Analyst
- Business Intelligence
- public health
- Healthcare Assistant
- Technical Instructor
- Psychologist 3
- Social Worker 2
- Quality Assurance
- community outreach/ support 3
- social work student 2
- mental health therapist IAPT
- OT/PT assistant
- Middle Management
- Trainer 2
- Community Nursery Nurse
- House Keeper 2
- rehab assistant
- Community Support Worker
- HR Advisor
- Lecturer
- assistant practitioner
- Manager
- Porters
- Chaplain
- Catering
- Communications
- Lab Assistant – clinical
- Logistics
- emergency medical dispatch

Analysis of Survey Responses - Ten Years On

Racism

Key Findings - 2001
1.1.4 19% of staff said that they had witnessed experienced or reported incidents of racist jokes and banter within the previous 12 months. Between 4% and 9% of staff had witnessed or experienced other forms of harassment and discrimination which included name-calling and verbal abuse, being ignored or isolated due to racial differences, unnecessary staring and unfair (racially motivated) complaints.

Key Finding 2011
The following table shows all responses from all staff.

Which of the following, if any, have you noticed or experienced over the last 12 months?

Answer Options	Noticed	Experienced	Neither Noticed nor Experienced
Racially motivated physical abuse	26(2.2%)	12 (1%)	1162 (97.2%)
Racially motivated verbal abuse	124 (10.3%)	45 (3.8%)	1042 (88.8%)
Racist jokes	258 (21.5%)	113 (9.4%)	846 (70.4%)
Racist banter	243 (20.4%)	82 (6.9%)	874 (73.3%)
Being isolated due to racial differences	60 (5%)	37 (3.1%)	1102 (92.4%)
Racist graffiti	34 (2.9%)	8 (0.7%)	1142 (96.5%)
Racially motivated damage to property	17 (1.4%)	5 (0.4%)	1165 (98.1%)
Unnecessary staring	84 (7%)	49 (4.1%)	1067 (89.4%)
Racial discrimination in job selection	27 (2.3%)	21 (1.8%)	1146 (96.1%)
Racial discrimination in promotion	22 (1.8%)	22 (1.8%)	1150 (96.4%)
Racial discrimination in selection for training	15 (1.3%)	19 (1.6%)	1158 (97.1%)
Racial discrimination in allocation of merit awards	13 (1.1%)	13 (1.1%)	1161 (98%)
Racial discrimination in employee appraisal	19 (1.6%)	11 (0.9%)	1157 (97.5%)
Racial discrimination in the application of disciplinary procedures	24 (2%)	13 (1.1%)	1154 (97%)
Racially motivated complaints made against Black or ethnic minority staff	59 (5%)	24 (2%)	1110 (93.2%)
Other (please specify)			

Summary of other forms of discrimination and supporting comments[4]:

Racist content in language continues to be used in a social context. An example of this is deliberately failing to remember how to pronounce a staff member's name even when gently reminded. It may also be subtle or stem from a lack of experience with other cultures or working with people from other cultures. Attitudes of staff towards BME patients were interpreted as racist. A lack of diversity in the region may be a contributing factor. Banter included examples of a regional nature (e.g., '*Normal for Norfolk*').

'We know who we're talking about'

'typical for Norfolk'.

Members of staff have noticed or experienced racism from and between patients in a number of ways. Patients with dementia in EMI care homes are a particular case, as are prisoner groups. Carers are a target for discrimination and staff are particularly vulnerable when home visiting.

Complaints made about staff may be racially motivated. It was reported that independent contract staff have made racist comments towards NHS staff. A manager had also

4 Note - All text in italics has been directly quoted without being edited

been accused of race bias in a selection interview. This turned out to be an unfounded and malicious accusation.

Job discrimination for BME staff was evident and lack of knowledge of procedures did not help in this matter. BME staff reported difficulty in finding a job.

Examples of racism between staff were reported. In particular, '*black on black*' racism between different African nationalities and between male and female Black staff has been noticed.

Communication is sometimes difficult between staff with strong accents or with those with little or poor English. This was a particular problem when speaking over the phone. Potentially racial '*jokes*' made about White staff by non-White staff in other languages also occurs. Ethnic minority patients and staff have refused to speak English – even when they allegedly can do so. BME staff speak in their own language in front of other staff and patients, which causes some discomfort and is regarded as poor etiquette. On the other hand, in some cases, non-English-speaking patients are still unable to have printed appointments or information in their own language.

'can't you understand English'.

Racism has also been demonstrated in the differing treatment in enforcing infection control measures. Misconceptions may occur when, for example, ethnic minority patients feel they are getting poor treatment because of their skin colour and a further misconception by an ethnic minority staff member who assumed that a White doctor was '*being difficult*' because of race. While such perceptions were unfounded, they did cause stress.

Racism by ethnic minority patients and staff upon English staff has also been reported. Patients specifically ask for a '*white doctor'*.

Harassment is also felt when colleagues comment about weight or hair colour.

Allegations of positive discrimination occur when it is felt that a minority ethnic staff member has not been subjected to the same disciplinary actions or has not had their poor performance questioned. An example of this was the reported failure to discipline a member of staff for dress-code violation allegedly due to concerns that the person would accuse the Trust of being racist or sexist.

Key Finding 2001

1.1.12 Over 50% of the visible minority ethnic staff felt that there was racial discrimination in job selection procedures.

1.1.14 56% of the visible minority ethnic staff felt that there was racial discrimination in the selection procedures for internal promotion.

Key Finding 2011

The following table shows only those responses from minority ethnic staff

Which of the following, if any, have you noticed or experienced over the last 12 months?

Answer Options	Noticed	Experienced	Neither Noticed nor Experienced	Response Count
Racially motivated physical abuse	14 (8.5%)	9 (5.5%)	144 (87.3%0	**165**
Racially motivated verbal abuse	33 (19.4%)	33 (19.4%)	114 (67.1%)	**170**
Racist jokes	46 (27.4%)	48 (28.6%)	82 (48.8%)	**168**
Racist banter	46 (28.2%)	38 923.3%)	84 (51.5%)	**163**
Being isolated due to racial differences	23 (13.8%)	28 (16.8%)	120 (71.9%)	**167**
Racist graffiti	7 (4.3%)	4 (2.5%)	151 (93.2%)	**162**
Racially motivated damage to property	7 (4.3%)	5 (3%)	152 (92.7%)	**164**
Unnecessary staring	20 (12%)	32 (19.3%)	118 (71.1%)	**166**
Racial discrimination in job selection	12 (7.1%)	18 (10.7%)	139 (82.7%)	**168**
Racial discrimination in promotion	9 (5.4%)	20 (12%)	138 (82.6%)	**167**
Racial discrimination in selection for training	11 (6.5%)	17 (10.1%)	140 (83.3%)	**168**
Racial discrimination in allocation of merit awards	8 (4.9%)	12 (7.4%)	143 (88.3%)	**162**
Racial discrimination in employee appraisal	11 (6.7%)	11 (7.4%)	142 (86.6%)	**164**
Racial discrimination in the application of disciplinary procedures	9 (5.5%)	11 (6.7%)	145 (87.9%)	**165**
Racially motivated complaints made against Black or ethnic minority staff	27 (16.2%)	17 (10.2%)	124 (74.3%)	**167**
Other (please specify)				**3**

Equality and Diversity

Additionally in 2011 respondents were asked

Which of the following have you noticed or experienced over the last 12 months?			
Answer Options	**Noticed**	**Experienced**	**Neither Noticed nor Experienced**
Age related discrimination	151 (12.7%)	38 (3.2%)	1011 (84.8%)
Age related harassment	51 (4.3%)	18 (1.5%)	1122 (94.4%)
Disability discrimination	66 (5.6%)	12 (1%)	1112 (93.6%)
Disability harassment	23 (1.9%)	6 (0.5%)	1162 (98%)
Sexual Orientation discrimination	59 (5%)	18 (1.5%)	1109 (93.7%)
Sexual Orientation harassment	40 (3.4%)	11 (0.9%)	1129 (95.7%)
Religion/Belief discrimination	55 (4.6%)	18 (1.5%)	1120 (94.4%)
Religion/Belief harassment	27 (2.3%)	20 (1.7%)	1128 (96.2%)

Summary of other forms of discrimination and supporting comments:

Age-related discrimination can be found in consultations with patients; for example, a consultation may be directed via a relative. Also age-related discrimination can be found in young people being overlooked.

Professional prejudice was reported. An example of this was where a profession was deemed as unnecessary and non-essential within a service. Another example of discrimination was where a respondent expressed difficulty with loyalty to a staff member who was consistently under-performing.

Examples of positive action included people with a disability being offered an interview (as per Trust policy). It was thought that this was irrespective of whether they fulfilled all the requirements of the person specification for the post.

Discrimination on the basis of gender was reported. This included gender-related '*banter*' and harassment and discrimination against females.

Sizeism was reported as a perceived form of discrimination and was experienced.

There were reports of inappropriate use of humour, including sexist banter and jokes, belief-based banter and jokes regarding being deaf. A lack of tolerance for deafness was also reported.

Religion/belief-based discrimination from respondents was reported. An example of this was reports of staff being harassed on the basis of non-religious belief or religious belief by respondents who hold strong beliefs.

Stereotyping on the basis of a particular label and/or reference to a person was given as an example of discrimination. For example, the use of the term "the prisoner" was used rather than the generic term "patient". While this is not discrimination under the law, it was felt to be so by respondents.

Key Finding 2011

The following table shows the responses to this question from minority staff.

Which of the following have you noticed or experienced over the last 12 months?				
Answer Options	**Noticed**	**Experienced**	**Neither Noticed nor Experienced**	**Response Count**
Age related discrimination	18 (10.8%)	8 (4.3%)	143 (85.6%)	167
Age related harassment	7 (4.2%)	4 (2.4%)	155 (93.4%)	166
Disability discrimination	13 (7.8%)	1 (0.6%)	152 (91.6%)	166
Disability harassment	9 (5.4%)	1 (0.6%)	158 (94.6%)	167
Sexual Orientation discrimination	17 (10.2%)	5 (3%)	144 (86.7%)	166
Sexual Orientation harassment	9 (5.4%)	4 (2.4%)	153 (92.2%)	166
Religion/Belief discrimination	17 (10.2%)	9 (5.4%)	144 (86.2%)	167
Religion/Belief harassment	11 (6.6%)	8 (4.8%)	148 (89.2%)	166

Racism, Equality and Diversity Discussion

Respondents were asked to expand on any of their responses.

Ageism

21% of comments referred to Ageism.

'a definite move to get rid of people over the age of 50 in favour of younger and dare I say it more attractive colleagues.'

Older staff reported being the subject of attention or being discriminated against. Examples of this included the perception that job opportunities were more often given to younger people or that age restrictions prevented older people from applying for positions. It was suggested that older staff did not seem to do so well during reviews as did their younger respondents. It was felt that some workplaces demonstrated a preference for younger staff. Age discrimination may also have been shown in job applications. Others felt it was difficult to find work after moving to Norfolk, due to age. There were reports of staff not having their contracts renewed after the age of 66 due to '*age or illness*'.

'job applicants CV's was marked 'school age makes person too old for job'

'no adjustments of physical training to suit age related conditions'.

Other examples of age discrimination included being excluded from training due to age. Training preference has been given to younger staff.

'not worth training'

Managers openly make reference to older staff and have allegedly dismissed staff who were over the age of 65 prior to the change in legislation which would have prevented this. Respondents were reporting being forced to retire or feeling pressure to retire against their wishes.

'I have had considerable discrimination with regard to promotion due to my age and considerable verbal harassment from certain work "colleagues".'

Staff felt excluded from particular jobs because their age. They felt this was discriminatory. Agency staff believed they were excluded from being employed on wards due to their age.

'older staff were being told to keep up with younger staff'.

Ageist humour was also reported. Jokes and banter regarding age were regarded as harassment.

There were also allegations and examples of discrimination which favoured older people. It was reported that on occasions older members of staff 'were chosen for more desirable tasks'.

'patients were given differing follow up care due to their age'.

Ageism was an issue relating to patient care. It was reported that GPs did not refer patients for assessment due to age. It was also suggested that older persons have limitations on service access.

'an older man was sent to work on the ward for a night shift, the staff found this quite funny.'

In one example an older member of staff was not prepared to take instruction from younger member of staff on a higher band. It was reported that less experienced people were being given responsibility over older experienced staff.

'An older member of staff talks down to me and criticises my education.'

Younger staff also felt age discrimination. In some instances older respondents do not respect younger respondents and criticise them for their perceived lack of experience. Patients have also considered younger staff to be less capable.

'If you are young, people tend to think you are not professional, responsible or capable of doing your job right.'

'not knowing what life's about'

'too old to do the job'

Offensive Behaviour - Racism

20% of comments related to Offensive Behaviour, including racism.

Actions, conversations, humour and behaviours that may not have been intended as offensive may have been perceived as such. An example of this was racist jokes and comments that respondents found offensive. Inappropriate words are used in the workplace (such as ‘Negro’). While the offence may not have been intended, respondents (particularly Black respondents) do feel uncomfortable with this term.

‘Norfolk is a region where ‘quiet’ racism takes place.’

Respondents reported covert demonstrations of discrimination and prejudice. For example, comments were made about economic migrants and immigrants (mainly Eastern Europeans). Such comments can leave respondents feeling uncomfortable.

‘it’s subtle & at times verbal harassment which you cannot find any reason except for either racial or gender bias.’

Racism is also perceived through unexplainable actions such as staring and the appearance of feeling uncomfortable around people of minority ethnicity. It was suggested that it took a long time for BME people to be accepted in this region (respondents from the Philippines were cited as a particular case).

Racism was also overt in cases such as assumptions about Black or people with ‘*other colour skin*’ being regarded as ‘*troublemakers*’. Overt racism also took the form of harassment. This was the case on particular ‘*wards*’ and often involved patients. Other examples of overt racism included White staff avoiding being on ‘*special observation*’ at the same time as the BME agency staff. In another case, comments were made by a White colleague about the way that BME staff were eating.

Staff reportedly found it difficult to listen to other staff who had a foreign accent. Name-calling was also reported.

‘one colleague had been called “rag head’ by ward staff in a ‘kindly!’ way’.

Complaints have been made against BME staff on the basis of their culture. White staff groups have deliberately sat apart from BME staff reinforcing this divide.

Racism was not restricted to migrants and immigrants. Welsh respondents also experienced racism. It was implied in a corporate email that the Travelling community were ‘*suspicious and dangerous*’. A respondent was constantly asked where she came from by a service user, when she had already told him she was born in Manchester. Racism was also felt by respondents who were in mixed race relationships.

Reported cases of racism included offensive behaviour among and between patients (including those with dementia), family and staff. This included verbal abuse, racist jokes and banter within the workplace as well as cases of physical abuse (e.g., hitting) and the text-messaging and emailing of racist jokes. Patients and families have complained about being seen by a BME staff member, expressing their preference for an English doctor. Such requests have gone so far as the patient refusing treatment.

‘patients requesting a white dentist or a GP from this country’

Offensive behaviour was not always racist. For example, sexual comments made to female students were reported as were comments about people's body shape (size).

It was the case that some staff did not perceived their or others' behaviour or language to be an act of racism, while others may have considered this to be the case.

'She is oblivious to the racial/disability remarks/ jokes she makes'.

It was suggested that the impact of racist behaviours on BME staff (in terms of their psychological well-being) should be reviewed. One respondent expressed the belief that it was better to endure racism and have a good assessment than to '*rock the boat*.'

Belief

13% of comments related to belief.

It was reported that patients/ clients and staff have made general negative comments about religious beliefs.

Low staff numbers in one particular setting meant that it was difficult for staff to celebrate their belief because others wanted those particular days '*as public holiday*'. This particular issue had been successfully addressed for some.

'staff from 'overseas' have not be allowed leave at Christmas to celebrate their faith with their family and celebrate cultural traditions.'

During a training event 'a trainee commented on one of her employees requesting certain time off for her religion'. The trainer explained that this could not happen. The trainee cited the example that staff preferred not to work at Christmas. The trainer replied '*yes but that's not a religious event*'.

'Nurses have been chanting Christian songs in order to take the Mickey!'

Banter and comments about beliefs are perceived as offensive and disparaging. These include taking the '*Lord's name in vain*' and '*Pope bashing*'. Staff have reported being 'ridiculed' and openly 'mocked' for their beliefs. Harassment and discrimination was reported from clinical staff towards Jehovah's Witnesses. A patient belonging to the Baptist Church was reported as being '*very verbal at expressing his dislike of homosexuals during a conversation*'. Religious humour was reported with particular reference to jokes relating to Islamism and Judaism. There were also '*negative reactions relating to Pagan beliefs and ideas*'.

One staff member reported not being '*allowed to wear a cross*'. Another felt discriminated against because of his/her clothing, going so far as to suggest that this also impacted on the perception of his/her work capability.

Staff who have '*fundamentalist*' beliefs felt they should not express these for fear of discrimination and a sense that it makes respondents feel '*uncomfortable*'. Some have reported being defined by their beliefs. It was reported as unacceptable to have '*open Christian views*'. It was felt that negative ideas of Islam were expressed by staff and in the media. Preference has been given to other ethnic groups accommodating '*policy and procedures expedited to placate "rites" that are not in the Koran*'.

Conversely staff can feel '*bombarded by religion*'. Others felt that exclusive access on the basis of religion is wrong. This included '*ladies only*' session in fitness centres – where it was perceived that this was only to accommodate religious beliefs.

'I am an atheist, I work here and do not need reminding of religion.'

'I have Muslim roots. I was repeatedly asked by Muslim colleague why I do not wear head scarf nor pray.'

Sexual Orientation

13% of responses related to sexual orientation.

Discrimination on the basis of sexual orientation has taken the form of gay people being excluded.

Sexual Orientation harassment has taken the form of derogatory comments, mistrust and humour, staring and being made to feel uncomfortable. Abusive words have been used to describe people's gender orientation. It was suggested that verbal abuse is largely ignored. It is often the case that jokes and banter aren't '*aimed at anyone in particular, and no harm [is] meant*.'

The use of the term '*gay*' has also been used in a context to mean other things – such as reference to a person's religious beliefs as being '*gay*'. There is banter about being gay amongst staff and patients. Some staff occasionally respond to patients when this occurs.

Comments regarding sexual orientation have been made by and between staff and patient groups and have been communicated verbally and via email.

Patient care has also been the subject of sexual orientation discrimination with a reported case of prejudice being exercised when making appointments.

'not being included in projects or meetings because of being gay'.

'this was lack of understanding rather than homophobic per se'.

'Some staff do find it amusing to comment on my sexual orientation which does not bother me however I know others that it would bother them.'

'a colleague expressed homophobic views via email which was sent to a number of other members of staff.'

'it makes you fearful of having any issues with these individuals as they will play the sexuality card even though it isn't appropriate.'

Staff said that if they were '*in a single sex relationship*' they '*would not admit it*' to respondents. '*A member of staff was told by another member of staff that his parents should disown him as he is gay.*'

Staff had reported a level of awareness of the '*Gay lesbian movement within the NHS*' which they felt had become '*very militant'*. It was felt that there was a positive action for gay people which is active discrimination against heterosexual staff. Staff have also reported verbal objections to '*Pride display in foyer of building*.'

'As a middle-aged, white, heterosexual male I am disadvantaged in every field of my work. The "pink and rainbow mafias" have replaced the Masons as the corrupt bullies within our trust.'

Intolerance of Disability

9% of responses related to intolerance of disability.

Staff reported issues relating to travel and transport. A member of staff claimed their '*flexibility*' had been questioned because of their use of taxis for transportation.

The issue of '*reasonable adjustments*' was discussed with respondents reporting difficulties in obtaining these resulting in, for example, difficulties in entering offices. The issue of '*wheelchair awareness with in community settings*' was also raised.

Difficulties have also been reported regarding access for patients. It was also thought that information is not produced in an accessible format so those with impairment are unable to access it. There are limited resources for people with learning disabilities within the health sector and there are also concerns about the care people with a learning disability receive within primary and secondary care.

Harassment has been reported by respondents who are hearing-impaired. There were reports of malicious complaints and bullying. Complaints have also been made by patients regarding staff who are hearing-impaired. This has included complaints about use of '*Text Relay*' services. Family members have also complained about service providers with hearing impairments.

It was suggested that Managers have also discriminated against staff with a disability.

'parking issues for people with LTC (long term conditions) and/or disabilities'.

'relocating our service to new third floor premises where lifts cannot be used in an emergency evacuation, thereby limiting accessibility'.

'individuals with disabilities/learning disabilities [were] not being able to access mainstream health and social services due to lack of reasonable adjustments and ignorance of the law.'

'service user asked to be seen by a normal hearing person when offered an appointment.'

Exclusion was reported. An example of this was where clients with disabilities had not been offered jobs due to speech impediments. In another example a person who came for an interview could not get up the stairs; it was mentioned by a panellist that the person would not get the job because of this.

Staff with disabilities were considered a liability as illustrated in the following example: '*High pressures environments mean people with even mild disabilities can be perceived as causing extra work for others if their disability means they are unable to function at 100%*'.

'more recently a service user queried whether I was suitable to complete my job as I was deaf'

'lack of opportunities presented to a member of staff with a disability - work tending to be all given to her able peer even though this women was capable of completing her job role.'

Other Examples of Discrimination

8% of responses related to other forms of discrimination.

It was reported that in some cases people who could not think or speak clearly for themselves were being ignored by the system. This included patients, especially those with mental health problems.

Reverse (or positive) discrimination was also reported. An example of this was given in the following case example: '*Staff have noticed an increase in the race card being used so that patient's can get their own way.*' One respondent observed that their *'Trust is so keen to be seen not to discriminate that if anything there has been discrimination against White British.'*

Verbal abuse was reported as a '*problem*' in some workplace settings. Racial discrimination was reported in a case where a patient complained about being seen by a '*non-Caucasian.*'

The isolation of ethnic minorities by other ethnic minority staff occurs and minority protest groups have formed. Isolation has also been reported on the basis of religious belief.

Work quality has been the subject of review where the staff in question just happened to be Black.

It was suggested that some managers have been disregarding complaints about discrimination.

'An ethnic member of staff in my department who persistently misbehaves is allowed to avoid disciplinary action as they threaten to claim racial harassment whenever they are confronted. We are fed up with this happening.'

'It was referred to HR who simply moved her and did not address the issue at all.'

'I have experienced assumptions of my race, religion, background and first language'.

'I feel I have been the victim of harassment when a written complaint has been completely disregarded by Management.'

Gender

4% of responses related to gender.

Gender discrimination has taken the form of stereotyping. Another example was reported in the following case: It was suggested that there seems to be no policy to ensure that both genders are represented equally in the workforce.

The sexual harassment of female students continues to be an issue.

Issues were raised regarding inequality in the number of women occupying the higher-paid positions in the NHS. This has included the perception of discrimination against females in terms of employment opportunities. Conversely it was suggested that in one case a female had been placed in a management position after coming last in interview.

Preference has also been shown for female employees.

A gender bias against men also takes the form of harassment in some cases.

'A woman being criticised for being emotional after being told some bad news. Told it keep it out of the workplace, told 'typical woman response'.'

'There was a presentation by a senior manager that used all males to represent wrong doings in the UK, with good things mainly represented by females.'

'New manager wanted to employ younger women - wasn't interested in experience.'

A male colleague was joked about in his presence, and he was embarrassed.

'The NHS is rife with anti-male harassment and sentiment. Many things are said about "men" that would be completely unacceptable in any other context.'

Remaining Categories

Other responses were categorised as Fitting In (2%), and Language (2%). The remaining 4% of comments related to staff who claimed they worked in a '*Supportive*' workplace.

One particular organisation was described as a place where you needed to '*fit in'.* Certain people were not made to feel included – and no particular reason was given. Respondents reported having the feeling of being a '*Foreigner*' in the workplace. This can be triggered by situations such as names that are difficult to pronounce. One respondent reported being referred to as a foreigner and feelings of being left out in the '*click*'.

Language-based discrimination has taken the form of exclusion from job opportunities. For example, there have been occasions where there is a lack of consideration of language needs within research projects. Preference is shown for English speakers. This is usually due to cost constraints within projects or the nature of the project in that the assessment materials are only available in English or only validated in English.

Language has also been a problem regarding staff and patient communication. Communication barriers are a real issue for the health service, where the make-up of the hospital staff does not reflect that of the local population and where such a barrier can potentially interfere with a patient's clinical care. Due to fears of appearing racist or offensive, patients and staff are reluctant to discuss communication problems.

'your face must fit to get on'

'What I have heard on a number of occasions are patients struggling to find a polite way of explaining that they couldn't understand what a nurse or doctor was saying to them, as the professionals first language was not English.'

'Foreign staff talk in their own language even when seated with lone English person. This applies to theatre and the coffee rooms making staff feel isolated and uncomfortable.'

Staff can feel comfortable speaking with each other in their own language without understanding the isolating impact this has on those around them at the time.

Other respondents said that they worked in supportive and inclusive environments that were *'cordial and understanding'.*

'I work in a very supportive small team that are welcoming and inclusive to all'.

One respondent said, '*The organisation in which I work takes any form of discrimination very seriously.'* Another reported that any homophobic or racist statements were *'challenged by staff'*. It was suggested the lack of any form of discrimination might have been due to *'a predominantly white British population in Norfolk'.*

'I have felt a completely professional attitude to all racial and sexual orientation matters in my work place.'

6% of responses were not categorised as they did not contain a response to the question.

Organisational Response

Key Finding - 2001

1.1.5 47% of the visible minority ethnic staff responded that, if they were to report a racist incident, they were not confident that the issue would be satisfactorily dealt with and 50% of these staff felt that they would be seen as trouble-makers.

Key Finding 2011

Respondents were asked, 'With respect to any of the above - what, if any, action was taken?

None

53% of responses indicated that no action was taken.

'she felt too vulnerable to take action'.

The 'none' response can be categorised in a number of ways.

Respondents said that they were 'unaware' of any response, leaving the possibility open that a response may have been made which they were unaware of.

'Reported this during exit interview. No action was taken as far as I know and I was told that Norfolk wasn't as multicultural as London and comments are to be expected to some extent.'

A reason given for no action being taken related to the vulnerability of the aggrieved person. In one reported case the staff member concerned 'resigned'.

There were incidences where respondents had made a complaint and subsequently nothing was done about it. Others indicated that no follow-up action was taken and this was what they had '*come to expect in Norfolk*'. In another example where an incident was reported to senior management and no action was taken, it was thought that the manager concerned lacked courage to deal with the incident.

'Most has been in "humour" and as "humorously" been quashed by those around.'

On occasions where offence has been taken, respondents did not acknowledge that their actions were perceived as offensive, many claiming it was intended as humour.

'It has been highlighted to the management but he is allowed to continue with his actions.'

Incidents involving patients were sometimes not reported or no subsequent action was taken due to their status as patients and where in some cases their condition was adjudged to be a contributing factor to the offence.

In some instances where managers were present during an incident, it was presumed that they would take on the responsibility of follow-up action. In some of these cases, no such action was taken. In one case the manager was responsible for causing the offence.

'it appears to be 'acceptable' to make these comments'.

Respondents suggested that it would be '*difficult*' to raise a complaint in their organisation. Some felt that their organisations would not respond to such reporting.

Those who complained felt that their complaints were '*ignored*'. In one incident when a report was made the staff member concerned was '*told to be quiet'.*

Some respondents said that they did not take action and gave no explanation for doing so. It was also reported that action wasn't taken when a situation was '*noticed*' but not '*experienced*'.

There was also a range of incidents where no action was required and where any action was deemed to be unnecessary.

In many cases any it was reported that it was *'unnecessary to take any action'.*

'it was taken light-heartedly and no offense was taken.'

Incidents were reported that had occurred a long time (e.g. *'2 years'*) ago. It was thought to be too late to take any action.

It was suggested that should action be necessary, a suitable organisational action could be taken through activities such as appraisal. However, it was felt that this opportunity was not being taken.

Action or Response

In 40% of cases reported, action was taken.

'I challenge all of the above if I witness it.'

Forms of response / action that were taken included the following:

One form of response was that which was undertaken by the aggrieved people and observers themselves.

'asking the sender not to include me in their forward lists in future as I find it offensive.'

In cases involving patients, one solution was avoidance. For example, the member of staff may be given the opportunity not to visit a particular patient. Reasonable changes have also been made at the patient's request.

'spoke with patient that behaviour was not tolerated'

In some cases involving patients direct action was taken such as in the following examples: Nursing staff have confronted patients and asked them to stop. They have told patients their language and behaviour were unfair, nasty, and not tolerated. Where patients prefer clinicians based on ethnicity, explanations have been offered.

'we politely explain about what they have just said and offer them the most clinically appropriate clinician for their needs, irrespective of race.'

One form of action that was taken by managers was to encourage the reporting of incidents. On other occasions managers have suggested staff speak to the person concerned, indicating that they had their support. It was suggested that '*continuing work was needed to raise awareness of actions that could be taken, through education.'*

'Action has been taken to encourage staff to take these issued forward.'

In other cases management has directly dealt with the situation. Managers have also intervened by moving people. If the situation demanded it, formal procedures were enacted such as *'investigation and disciplinary processes'*, *'grievance procedures', 'incident forms'* and *'complaint… being processed according to HR policies/procedures.'* This included '*on-line*' reporting. However, formal processes were not always successful.

'The person was taken aside and told to not use that language and keep personal comments to themselves.'

Managers also addressed issues across staff groups such as ward-based '*debriefs*'. It was felt that managers supported their staff.

'Senior staff members, dealt with racially motivated complaints very quickly, standing by their staff member'.

A form of action used to overcome issues relating to leave to observe religious holidays included advanced planning and requesting duty to be organised a year in advance.

'Printed material off internet & talked to college'.

Individuals' learning needs have also been supported where their actions resulted from a lack of knowledge or understanding.

'I talked to colleagues at work and the person that said it came and apologised to me personally without me having to ask. No further action needed to be taken.'

Appraisal was regarded as an appropriate venue for addressing reported complaints and examples were offered where this was the case.

Some forms of redress included the issuing of an '*apology*'. Often complaints were resolved with an apology. Other forms of redress include a change in line management.

'Change of line management provided positive resolution.'

Racial Awareness and Equality and Diversity Training

In 2001 there was no systematic Equality and Diversity training. The 2011 survey sought to gauge the impact of training that had taken place since the 2001 survey. The first question asked was, 'Have you received NHS provided Training' in 'Equality and Diversity' and in 'Racial Awareness'?. 'Yes' respondents were able to indicate if this training was 'Face to Face or On-line'. The following table indicates responses to these questions.

Have you received NHS provided training in						
Yes						
Answer Options		**Face to face**	**Online**		**Other**	**Response Count**
Equality and Diversity		279 (27.3%)	699 (68.5%)		43 (4.2%)	1021
Racial Awareness		126 (24.4%)	314 (60.7%)		77 (14%)	517
No						
Answer Options		**No**		**Response Count**		
Equality and Diversity		198 (100%)		198		
Racial Awareness		604 (100%)		604		
						Question Totals
Other related topics (please specify)						46

'Other related topics' and supporting comments included the following:

- Disability/ Disability awareness (reasonable adjustments)
- Training session for our department about Traveller families
- Training on Domestic abuse and honour based violence
- Using interpreters
- Working in a culturally sensitive way
- Conflict Resolution
- Refugee and Asylum Seekers training
- Training on new public sector duties
- Part of my psychological Wellbeing practitioner course
- Infection control, protection issues
- KSF equality and diversity employment law Diploma
- Welcoming disabled people
- Trust induction
- Interviewing skills, communication skills
- Vulnerable adults
- Coordinating a diabetes study in ethnic populations
- Religion/belief awareness
- (bi)cultural competence

Respondents indicated that they had undertaken training '*outside*' of the NHS. Some had undertaken both face-to-face and on-line training. For some, relevant training was included in '*core learning modules*' and '*mandatory training*' for their positions. One respondent felt that Equality and Diversity and Racial Awareness were undertaken at the same time in the same programme.

Others reported that training was '*not available'* or that they were '*awaiting an opportunity to update with E-learning'*, or that they had only been in post a short time.

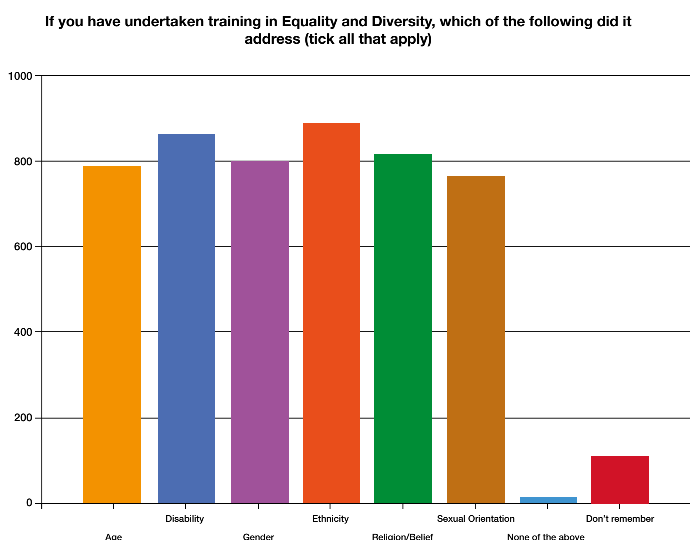
Others felt that they had acquired training through their involvement with related work such as '*Mission Projects*' and '*Research Projects'.*

It was suggested that *'Diversity material covered during Trust induction was very brief.'* One respondent reported their training comprised the following: '*Read 2 pages from a book'*.

Respondents were asked about their training. The following table shows the responses to these questions.

If you have undertaken any of the training indicated above, to what degree did it			
Answer Options	**To a large extent**	**To some extent**	**Not at all**
build on your knowledge of these issues	165	658	201
provide you with skills	105	521	390
change your behaviour	37	284	697

Regarding this training, participants were also asked what the training addressed. The following chart shows their responses to this question.



Reporting Mechanisms

Respondents were asked about their awareness of reporting mechanisms. The following table indicates their response to this question.

Are you aware of the mechanisms available for reporting racial incidents at work?		
Answer Options	**Response Percent**	**Response Count**
Yes	70.8%	865
No	29.2%	356
answered question		**1221**
skipped question		**166**

Key Finding - 2001

1.1.6 23% of the visible minority ethnic group were not confident that their manager, supervisor or professional lead was committed to eradicating racial harassment and discrimination.

1.1.8 85% of the visible ethnic minority staff felt that racism was a problem within the local NHS. Approximately 60% of the White British staff shared this view.

Key Finding 2011

The following table shows responses to the listed statements from all staff.

Do you think that racism within the local NHS		
Answer Options	**Response Percent**	**Response Count**
remains a problem that is not being effectively addressed	14.7%	179
remains a problem that is being effectively addressed	25.4%	310
is not a problem	60.2%	734
answered question		**1220**
skipped question		**167**

The following table shows responses to the listed statements from minority ethnic staff.

Do you think that racism within the local NHS		
Answer Options	**Response Percent**	**Response Count**
remains a problem that is not being effectively addressed	39.5%	68
remains a problem that is being effectively addressed	26.2%	45
is not a problem	34.3%	59
	answered question	**172**
	skipped question	**29**

Communication

In 2011 staff were asked about language and communication problems. The following table shows the responses to this question.

In my experience communication problems arise due to language difficulties with the following Black and Minority Ethnic populations		
Answer Options	**Response Percent**	**Response Count**
staff	41.8%	478
patients	46.5%	531
visitors	25.3%	289
none of the above	38.1%	436
Please explain		421
answered question		**1143**
skipped question		**244**

'Please Explain' and supporting comments can be summarised as follows:

Not being able to understand accents was the largest communication issue reported. This was particularly difficult if the communication took place over the telephone or via a recording because visual clues, such as body language, were not available to aid interpretation. This difficulty was exacerbated if the staff member felt it would be rude or disrespectful to ask the patient or respondent to repeat what they had said.

Accents were not limited to those speaking English as a second language, the local Norfolk dialect, also created communication barriers.

Words that caused particular problems included names, encryption passwords, jargon, informal expressions, and words that had more than one meaning.

This problem occurred in a range of workplace environments but was predominant on wards, particularly where a range of staff from various ethnic backgrounds worked together.

The problem of accents was particularly acute for elderly, hard of hearing and patients with dementia.

There was some suggestion that careful listening was not always exercised and that repetition was necessary. Some felt that communicating with colleagues and patients who spoke with a strong accent was stressful.

In a broader sense, '*communication barriers'* was the next largest issue raised. It was felt that poor communication caused problems with patients accessing services.

Poor communication between Trusts was cited.

Particularly vulnerable groups included the elderly, hard of hearing, those with dementia or mental health problems, patients on certain medications and those nearing the end of life.

It was also suggested that communication over health matters was especially problematic and communication problems between English speakers was a frequent occurrence. Misunderstandings often occurred and information about treatments and next steps were often misinterpreted or misunderstood. Difficulty in communication during consultations was a particular problem when conveying complex medical issues and when undertaking admissions processes. Patients who experienced communication problems did not always seek clarification from the practitioner, but would speak about this problem with other staff.

Communication problems also were made increasingly difficult in situations where staff with English as a second or other language were rotated. It was suggested that English was a particularly difficult language to become proficient in.

It was suggested that teamwork, open-mindedness and patience helped overcome communication barriers. Taking care to learn names and pronunciation was recommended.

The next largest response theme concerned translation and interpretation services.

Concerns around the cost of translation services raised the issue of competing priorities and the value of the service. Some respondents felt they were unable to use the service or were encouraged to avoid it due to cost. It was also reported that the service was not used '*often enough*'.

The use of family members to act as translators and interpreters was reported.

Other respondents said that they made use of INTRAN frequently. On occasion this was difficult due to the hour of the day that the translation was required, the range of languages which needed to be accessed (e.g. some African

'there have been informal complaints from patients and staff via the media of the need to spend so much on translation services which would be 'better spent' on direct patient care'.

'the service was always available and responsive.'

'clients value having interpreters there'.

languages, '*Swahili, Arabic and Farzi'* and a *'lack of female interpreters'),* the location of the translation needed (i.e., in the community during a crisis) or the availability of translators. It was reported that translators were not always available or sometimes did not turn up for appointments. The presence of translators was greatly appreciated. This was particularly the case for asylum-seekers.

'important to get the same interpreter to provide a service when offering psychotherapy to non-English speaking clients, this is essential when establishing a therapeutic relationship.'

Access to the same interpreter on each occasion was reported as being problematic.

It was reported that consultations through interpreters and translators could be '*very challenging'*. In some instances further consultations were requested or required.

Translation into written text was also used.

The next largest theme was Language.

'there are a lot more people around who do not speak English.'

There was a noticeable increase in other languages spoken within the region.

Problems with language were reported concerning staff, patients and visitors. It was reported that visitors claimed not to understand English in an attempt to bypass the patient visiting rules.

Accessing services was a particular problem for people without English language. Contributing to this was a reported shortage of signage and written materials in other languages.

Patients would '*seem to understand*' when this was not necessarily the case. Other patients would report that they were not able to understand advice, medical information or treatment instructions and that this could lead to serious consequences.

Verbal handovers were regarded as a problem. Written English was also considered to be poor in some cases.

Receptionists experienced particular language difficulties.

Some respondents suggested that tolerance of those who did not speak English was necessary. Staff speaking 'to each other in a language other then English in front of other members of staff, and patients and visitors' was regarded as a problem for some. Some particular cultures preferred to speak in their common language when communicating with each other.

'Some staff will talk in their own language while bathing or dealing with patients. Patients feel very vulnerable when they do not understand the staff.'

It was reported that '*Some patients have been in the country for many years and refuse to learn English. Others who have recently arrived have not had time to learn English and just turn up without an interpreter.'*

Locum doctors and agency staff were regarded as groups who do not always have sufficient skills in English to be able to communicate effectively with colleagues, service users and carers.

Some respondents offered the view that English should be a compulsory language for all immigrants and settlers to this country and a '*standard*' for English usage should be set.

There was also a large group of '*uncategorised*' comments. Within the uncategorised group respondents suggested that there were no issues with language relevant to their workplace or role.

Interpretation and Translation Services

Key Finding - 2001
1.1.11 About a third of all the staff did not know if interpreters were available if required and many staff who said that interpreters were available qualified their answers.

Key Finding 2011
In 2011 staff were asked if they were aware of how to use interpretation and translation services. The following table indicates their response to this question.

Do you know how to access interpretation and translation services?		
Answer Options	**Response Percent**	**Response Count**
Yes	77.7%	949
No	10.4%	127
Not sure	11.9%	145
answered question		**1221**
skipped question		**166**

Contact with Ethnic Minorities

Key Finding - 2001
1.1.7 Many local NHS staff have little or no contact with people from ethnic minorities. Some staff clearly associate the problems of racism more with areas of the country in which there are high concentrations of Black and minority ethnic people. Conversely, there are many staff who see the problems of racism in Norfolk as being more acute than other areas of the country because of this lack of ethnic diversity and cultural awareness.

1.1.9 Many staff reported incidents of patients discriminating against minority ethnic doctors. 19% of White British staff reported that racial harassment and discrimination by patients and visitors towards Black and minority ethnic staff was common. Over a third of the Black and minority ethnic staff said that it occurred commonly.

Key Findings - 2011
In 2011 staff were asked about ethnic or racial issues arising through patient contact. Two questions were asked, one regarding 'patients refusing treatment' and the other about 'consequent actions'. The following two tables provide the responses to these questions.

Have you noticed or experienced patients refusing treatment from a member of staff on account of racial or ethnic differences?		
Answer Options	**Response Percent**	**Response Count**
Yes	32.4%	304
No	58.4%	547
Not Applicable	9.2%	86
	answered question	**937**
	skipped question	**450**

In your experience if a patient declines treatment from you because of either your or their ethnic origin would you		
Answer Options	**Response Percent**	**Response Count**
Refuse treatment and explain why	6.5%	61
Try to make alternative arrangements	65.6%	615
Not know what to do	4.9%	46
Not Applicable	25.8%	242
Please Explain	174	
	answered question	**937**
	skipped question	**450**

Key Finding - 2001
1.1.10 50% of the White British staff and 40% of the visible minority ethnic staff would try to make alternative arrangements for patients who refused treatment because of racial differences.

44.3% of responses suggested that an explanation of the circumstances was necessary.

'we have some people with services because they are detained. It would not be possible to refuse treatment in these cases.'

Examples of particular circumstances where patients declined treatment included groups who did not have any choice in the matter. In such cases, patients are counselled about their attitude and minimum adjustments made to maintain safety and security. Support is offered to staff concerned. Other particular circumstances included complicating factors; for example, if a patient is delusional or if the situation is acute.

'For people who are acutely ill, it is important that treatment is offered and any issue of racism is dealt with when this is appropriate.'

Removing barriers to care provision was regarded as intrinsic within the role. One such barrier was identified as '*stress*'. Staff indicated that they would try and understand the problem and persevere in completing treatment but only if it did not cause further distress.

Staff felt strongly about protecting the '*rights of the patient*' indicating that it would depend on the context of why the patient was concerned about racial issues. It was also suggested that patients can always decline service access.

'following conflict resolution training I am aware of alternative options.'

In situations where there was no option, this was explained to the patient. It was suggested that it was acceptable to decline to change arrangements to facilitate a racially-motivated request. In real terms there may be little in the way of therapeutic rapport as a result of this though.

'If the treatment was not of a serious or critical nature, and no other staff were available that the patient would engage with, it would be communicated to the patient the rationale why the treatment was put on hold until they agreed.'

Staff felt they have a '*duty of care*' towards the patient, which prevents them from refusing treatment. Staff indicated that they would respond professionally.

One respondent said, *'I would not feel I would have the support from HR / management if I refused treatment.'* And *'if anything did happen management would not give much if any support.'* In one case a staff member felt let down by management as in the following example: '*This has happened and I do not feel that it has been handled correctly by management and that another worker has been put in place without addressing the issues with the client.'* Some departments dealt with the issues on a team basis. In one department it was reported there were '*Notices up around department explaining that patients cannot refuse to be treated by someone because of their race'*.

'I have experienced a few patients telling me I'm a foreigner but I have explained that if they don't let me nurse them they will have to wait and be seen later by someone else. In all cases patients have accepted that I nurse them.'

Others said that they would refuse treatment on purely racially-motivated grounds.

Staff felt that management had a role to play in such cases.

'I would be colluding with unacceptable behaviour to accommodate someone's prejudicial beliefs.'

Staff believed that ethnic origin alone would not be a suitable reason to cease treatment. However, they also recognised that 'cultural' considerations may need to be observed and respected such as in the following example: '*It is important to be aware of the cultural differences between the different ethnic groups and to work with them to make sure that everyone gets the correct treatment and not to take it personally if a patient doesn't accept you.'* Staff also felt that, if communication was a problem, they would *'try to accommodate alternative arrangements.'*

'I would not refuse them. Just because someone is racist / using discriminatory behaviour does not mean they should not be treated. I do not believe I have the right to judge my patients.'

Staff said that they would explain to the patient that racist behaviour was unacceptable. It was suggested that '*In this area many locals have little or no experience of other ethnic origins and have an inherited belief that certain people are 'different' and therefore to be avoided or not trusted.'*

It was thought that in some situations to pass a patient onto another service provider may '*put a colleague in a situation when the patient may be nasty or aggressive.'* Alternatively, 'A*n alternative arrangement can help the patient comply with medication.'*

Many staff reported that this had not occurred in their experience.

24% of respondents felt that patients' preferences should be observed.

Respondents felt strongly that any patient has the right to decline treatment. It was suggested that patient preference regarding '*gender issues'* was a similar case. Open communication and listening to patients' requirements were regarded as '*key to all working practices*'. In some workplaces care plans have been formulated allowing for certain patients to receive treatment from White staff only because it was in the best interest of the patient.

Preference may also have been exercised due to the nature of the patient's condition. If, for example, a patient has experienced extreme distress in the presence of certain ethnic groups due to past experiences of abuse, then in such cases declining treatment

'the person has been referred to the service for a reason and should still get the treatment needed.'

'If it was purely a racial issue I would refuse treatment.'

'Patients are entitled to ask for a different therapist and probably don't need to say why.'

'They may have had a life experience which makes them feel anxious or have mistrust and this is not a good foundation to be delivering care.'

is linked to symptoms of PTSD rather than racial prejudices.

A suggestion was made that there are always ways around issues to keep all parties happy, and that patients have enough difficulty being in hospital and ill without having to cope with people they find difficult to deal with.

Exercising a patient's preference is not only due to ethnicity. One respondent said, '*we do sometimes experience a pure personality clash with the patient, and it is best to hand over the treatment to another colleague to give the patient the best experience possible.'* And '*I have had patients refuse to see me because I am not their usual health care professional*.'

In some reported situations meeting the preference of patients was just not possible.

15.% of responses indicated that there would be a need to seek assistance.

Respondents suggested they would try to ask another member of staff to assist. The form of assistance required included:

- assistance with patients
- assistance with decision-making
- assistance from the patient
- undefined assistance

6.3% of responses indicated issues specific to gender.

In some circumstances gender can be an issue and respondents have met requests such as providing female interpreters for some female patients when asked by the family. It was suggested

'Some people are just inherently racist.'

'I am not the loser in this case it is the patient.'

'if they refuse treatment it is their prerogative.'

'It would be difficult to make alternative arrangements, as all colleagues are also White.… this is not currently available within the local workforce, and it would be necessary to address this with patients where it arises as an issue.'

'would ask another member of team to visit patient'.
'I would discuss this with my supervisor and seek advice.'

that preference for a particular gender of carer or service provider can be misinterpreted. It may be due to '*personal beliefs*' and not any form of racial discrimination.

'Ask the patient to explain the reasons to my manager.' *'sign post else where if appropriate.'*

The combination of gender and culture was an important issue. Cultural differences with regard to female patients (touch, exposure of the body by/to a male) provide strong justification for the exercising of patient choice.

'some patients like to be seen by male or female.'

2% of responses indicated issues relating to belief.

Similar to findings in the gender discussion, some religions will not allow men to touch women. It was suggested that health care providers '*must be sensitive to individuals' religious beliefs.*'

'It may be that their ethnic origin made it inappropriate for them to see a woman and discuss their intimate difficulties.'

Ten Years On

Respondents were asked to describe how racial awareness within the NHS in Norfolk has changed over the last 10 years or since they commenced working with the NHS. The following is a summary of the responses to this question.

'promoting awareness is clearly higher on the agenda.'

47% of respondents believe that the profile of racial awareness has been raised over the past 10 years.

'now there is a real determination by employers to raise awareness.'

It was suggested that the profile of racial awareness had been raised through '*mandatory training, staff networks, action plans and board reports*' and '*Issues raised and highlighted more frequently*' and through the '*BME SSN (Staff Support Network) and awareness days for black history month*'. It was suggested that change '*was supported with HR and Union involvement.*'

'I feel that knowing it is not acceptable and subject to disciplinary supports a better understanding of disability, cultural and those with learning difficulties.'

Respondents felt that there was a greater likelihood of organisational support compared with 10 years ago. For example, respondents felt they were continually reminded that racial abuse, covert or overt, is not acceptable. Clear signage is now visible in most locations to identify what is deemed appropriate and inappropriate behaviour within the NHS.

'I feel the organisation would support a positive stance to combat racism.'

It was suggested that an increasing BME population in the region was largely a contributing factor. This change had led to '*tolerance of different cultures and race.*' An increasingly diverse population has thrown up potential difficulties in everyday life, whereas 10 years ago there were very few ethnic minorities in Norfolk so it never came into the daily realm of thinking. Now it does and this has required staff to think more deeply about equality and diversity issues on a practical as well as a theoretical level. A contributing factor to the greater ethnic mix in the region was identified as '*higher education institutions.*'

'Well done!!!"

'Diversity has grown in my short time within Norfolk and in that respect so has racial awareness.'

Equality and Diversity is a contemporary term which encompasses racial awareness. Some respondents felt more familiar with this term.

'I am more aware of the equality and diversity as an aspect of my practice than specific racial awareness.'

Behavioural change has also been noticed as a consequence of the raised profile. For example one respondent noted a realisation amongst staff regarding how people treat one another and how to give other people respect. Respondents felt that people seem to be less xenophobic now than they were 10 years ago.

'The number of staff who hold racist views has decreased a lot.'

It was observed that language and humour had changed over the 10-year period.

'Racial jokes are no longer funny but hurtful.'

Regarding employment, there has been a visible increase in Black and minority ethnic staff employed as well as those from Eastern Europe.

'There seem to be far fewer racially based comments and stereotypical remarks made now'

Additional change has been felt through '*transparency and equality in recruitment of staff; equitable access to services for patients; staff understanding responsibility for challenging inappropriate behaviour; understanding specific needs of BME populations'* and through '*greater understanding of cultural issues, and greater use of and expectation to use interpreters.'*

In speech therapy there is an expectation of continual professional development around people who have English as an additional language. Greater attempts for signs to have symbols which also improve understanding for clients/patients with learning difficulties were mentioned. It was also suggested that health care workers were better able to cope with different sexual orientations and exercised a greater willingness to overcome barriers such as language.

It was noted that awareness did not necessarily imply that there was a problem but enabled staff to be prepared should any issues concerning race arise.

Awareness also came through wider experiences.

'I have lived outside this county and outside this country and it helps to understand a wider perspective.'

16% of respondents felt that racial awareness had not changed over the previous 10 years in the NHS in Norfolk.

One set of reasons given for the perception of *'no change'* was that there was as high a level of awareness 10 years ago as there was today. Respondents felt that things had not changed because they had always treated everyone as equals and in this respect the NHS in Norfolk has always been consistently good.

'I already had significant awareness through my role which included an element of ensuring diversity.'

Other respondents said that they had not noticed any change. In particular, the responses indicating that they had been working in the Trust for less than the 10-year period invariably reported they had not noticed any changes.

'I have realised how entrenched racism still is in Norfolk.'

Some respondents felt that there had been no change and that there were still low levels of awareness.

'Compared to other areas I have worked in Norfolk remains racially discriminate.'

16% of respondents mentioned training.

'The equality and diversity training has definitely helped.'

Respondents reported a vast improvement in awareness training and said that more training and literature are available to staff on the subject. It would seem that this training has had an impact.

Others believed that training had enhanced their knowledge. Training has also raised awareness and helped to change and challenge behaviours.

'I feel I have always been racially aware however the training etc received supports my learning.'

Training has also prepared staff in the event of discrimination. For example, *'I have not encountered any racial problems however due to training I am more aware of what might happen.'*

Training was also associated as a contributing factor in raising the profile of equality and diversity.

'I was glad to see diversity training focused on differences between individuals rather than on making assumptions about racial groups.'

One respondent commented, '*There is much more awareness in terms of on-line / face to face courses that each member of staff is expected to attend and achieve a good level of understanding.*' In some cases training has been mandatory.

'Online training in issues like this just ticks boxes.'

However, for some the training had not been effective. Critics of the on-line training indicated that it is not the best medium for this subject. Respondents said that they found these courses to be pointless and simply a political 'box ticking' exercise. It was also acknowledged that training could only go so far in addressing this issues.

'I do recognise the need to tackle racism where necessary although I don't think the training courses are particularly effective.'

15% of respondents felt that this was not an issue for them.

Respondents felt that, for them, racial awareness and/or equality and diversity had never been an issue. Respondents who had moved to England from other countries have expressed surprise at how few ethnic people work in the NHS in Norfolk. However, they have also indicated that they have not had any problems with racism and have quickly felt welcome. Others said that racism had never been an issue in their working life and that they did not believe that racism is a problem in their department.

'Have not come across racism since working in the NHS in Norfolk.',

Others claimed racism has not been a problem in the last 10 years or that they have not '*noticed*' it.

'I sometimes think that we over-react and in doing so can make life harder for us.'

It was suggested that there was an over-reaction to a perceived problem. Other felt that some comments they heard may be thoughtless but few are deliberately hurtful.

Respondents felt that this was a tick-box exercise to show it is being taken seriously, but with such a small ethnic minority amongst the patients, although much higher amongst staff, there is no social friction. It was suggested that staff were judged on their competence and enthusiasm, not their racial origin.

'Endless directives from on high about a very small problem in Norfolk.'

One reason given for this not being seen as an issue was from respondents who work in an area where racial awareness has always been a priority. Others claimed that they had only been in the Trust *'a short time'* and therefore not had time to notice anything of this nature. Others felt that they were in a location that did not encounter any issues.

'The only propaganda that brings it to the forefront for our conversation is these surveys.'

Others have indicated that this has always been the case, the situation has not changed and in their experience racism has never been a problem.

'mine is a very small view on the world from a fortunate and enviable position of inclusivity.'

One respondent felt that the only problems that occurred were those that stem from staff-to-patient language barriers.

Respondents were able to draw on wider experience and compare the situation in Norfolk with other locations. Staff who have had experience in other regions have not noticed any problems in Norfolk. Those who have worked in diverse areas like Birmingham and Leeds, as well as in Norfolk, believe that Norfolk does not have a problem with racism.

'Coming from America where this is very much part of the cultural fabric to Norfolk I recognize there is racial awareness by people, but it appears to be a nonissue here.'

Respondents do not think there is any difference in awareness/ views within the NHS.

15% of respondents felt that more work was needed in this area.

It was recognised that more work was needed to raise the awareness of racial discrimination and equality and diversity. Examples of this included certain groups, Travellers, socially disadvantaged and in particular people who were not born in Norfolk who sometimes feel uncomfortable or isolated. Such people are often the butt of jokes in the workplace and those in the workplace tolerate such behaviour even when an individual feels harassed. These are often the unseen local race differences.

'Over the last ten years I have worked in a number of local healthcare trusts and for the Strategic Health Authority, and can honestly say that my immediate colleagues and other staff in these organisations have never exhibited any signs of racial discrimination in my presence,'

Respondents said '*we have further to go*' in this area. As Norfolk changes to a more multi-cultural area more vigilance regarding previously latent racism may be needed. Some felt that there are still pockets of racism and not enough corporate engagement with equality and diversity. It was suggested that within the White majority population there are still a residual core, reflective of society at large, with whom it is still challenging to engage and provoke changes in attitude and behaviour. Staff are very aware of racial laws and try to avoid being racist. However, people have found subtle ways of expressing racism.

'Norfolk is 50 years behind other areas of the UK. The culture is very poor around racism.'

'Ingrained prejudice through ignorance is difficult to shift.'

One respondent felt that there '*Still seems to be an automatic defence regarding the Bennett Enquiry and a failure by line managers to adequately address the racism displayed by some members of staff, particularly when directed towards other staff.'*

'It goes underground'. It isn't logical and is based on fear and natural selection. The cure may be curiosity but for some that is elusive.'

Within certain client groups of adults with learning disabilities there remains a strong prejudice against foreigners and homosexual people. This has not changed over the ten-year period.

Areas where work still needs to be undertaken include the demonstration of attitudes through behaviour. Respondents report feeling shocked by the casual racist attitudes of a lot of their colleagues. Online diversity and discrimination training has not been effective in changing attitudes for some people and it is suggested that this training is not taken seriously by staff within the organisation.

'Definitely racial awareness has changed for the better but it still has a long way to go.'

Another area of work lies in the process for reporting, as it is thought there is still institutional racism which people are unaware how to raise.

'One of the things that I have noticed over the last few years is that clients / carers / parents attitudes towards foreigners has hardened and for the first time in 20 years I've started to feel a foreigner again.'

Reverse (or inverse) discrimination was also reported. It was thought that, because of the people from other countries entering the UK, staff had to be more careful in their '*approach to their way of life'* or they are accused of being racist. However they felt that they were not offered the same protection. It was felt the deficiencies in the work or behaviour of minority ethnic staff were overlooked or even praised.

'I feel very uncomfortable at times listening to conversations that take place, which tend to be a reflection of ignorance and unchallenged preconceptions, rather than malice, but are still inappropriate.'

It was thought that managers were concerned that they would be seen as racist if they addressed certain issues. Other felt that the '*swing*' towards anti-racism had gone too far at times and that political over-correctness caused some to feel as thought they were 'treading on eggshells'. It was thought that sometimes the issues were blown out of proportion, allowing other issues to be neglected such as religious discrimination which can be much more subtle but still as pervasive.

Cases where there is a perception of reverse discrimination can cause disharmony. There was a situation in one Trust where national flags where not allowed to be displayed as a gesture of support and patriotism during the World Cup. However, flags in support of '*black awareness week'* were allowed to be displayed in the reception area. This raised certain complaints from British people who felt they were prevented from celebrating their heritage and enjoying their sporting successes. This situation caused frustration and some felt that it undermined the social cohesion agenda.

'I do get irritated when people use the race card to get their own way.'

'Even though I am an atheist I get irritated when Christian colleagues are asked to not celebrate Christian beliefs for fear of upsetting other religious believers!'

Reverse discrimination can take the form of the perception of preferential treatment. Some had experienced respondents being able to '*use their colour*' to get them what they felt they *'deserved rather than what they had earned'*. It was felt that some people were ready to use the '*race*' card as a way of achieving what they want.

'in the past I have witness minor groups getting preferable treatment as a way of counter acting any possible allegations of racism from senior management, whereas I feel in some cases if they had been white British heterosexual it was harder to get on courses, promotion and if complaints were made the non minority was more severely handled.'

It was thought that managers were not prepared to deal with those who exploit their racial advantage, in case they too are classed as racist. It seems to some that White and British felt they were not 'heard.'

Cultural awareness was seen to pose specific difficulties in areas such as understanding different outlooks and behaviours with regard to health, attending appointments, and using A&E.

Others felt that the '*general public'* were the '*main problem not staff attitudes.*' While others again felt that there was the potential for the problem to be exaggerated.

The perception of racial imbalance was also raised. BME employees mentioned a sense of unease, working in a predominantly White environment.

'I am not sure we are very good at meeting the healthcare needs of hard to reach groups across the county.'

However, others believed there were token appointments made within their organisation while others have observed that there have been increasing numbers of ethnic healthcare professionals which some local people do not understand fully.

'I also think there are - those who want to move on and those who hold on to stories from the past as if they were current realities.'

While some acknowledge progress has been made, others felt there was still some work to be done. It was felt that change is often portrayed as brilliant on paper but not in deeds. It was suggested that no amount of training can address the fact that some people are '*small minded bigots*', and the disciplinary procedure should be used more robustly to address this where hostility and racism are present. Others still feel the situation has '*got worse'*.

'Slightly better but still not brilliant'.

'people now know how to discriminate discretely.'

There was further criticism of the on-line training method. It was thought that training had become e-learning, rather than face-to-face, which was not adequate to address this issue. Many stigmas, opinions and personal attitudes can be hidden over a computer. It is not only about ethnic groups; discrimination comes in many different guises and can be felt by the victim in many different ways that cannot be addressed over a computer.

'Although the on line learning is quick and effective in achieving targets, I believe it has the lost the ability to challenge and get a sense of real issues.'

6% of responses made reference to support networks/mechanisms.

'its a shame that we still have to carry out surveys like this because some people still have blinkers.'

The presence of BME staff groups was recognised. BME respondents were pleased to have a space where they were able to share without feeling intimidated. Other initiatives have included *'the BME SSN'* (staff support network) and '*awareness days'* for Black History Month and '*racial equality schemes and support mechanisms for its staff and the population they serve.'* This has included '*greater involvement of minority groups within the organisation.'*

'Staff are encouraged to join BME group, LGBT group, disability groups if they feel they need support.'

There was also improved HR and Union support including '*access to gaining help, advice and action.'* and *'regular Board reporting*'. It was thought that the *'NHS has acknowledged there is a problem and has taken measures to solve it.'*

'most people would now report an incident. I think at last things are getting better!!.'

It was also suggested that the role of the hospital chaplain has widened to a mediatory one in certain instances. The chaplains are now offering *'training to staff in this area.'*

'Greater access to interpreters'.

Translation and interpretation services (INTRAN) were also mentioned. It was also suggested that the service had improved. Patients were also using the interpreters as it was reported that non-English speakers demand interpreter services.

'I used to work in an area with a large Asian population and finding and interpreter was virtually impossible 10 years ago, today it is much easier and they do work well.'

Alongside this patient information leaflets have now been translated into different languages and more visible posters for translation service and more patient literature in different languages are readily available.

Others suggested that in practice interpreter services are more limited. There was concern that more eastern Europeans were increasing the '*spend on translation services.'* However, it was also reported that staff from minority ethnic groups such as Eastern Europe were being assigned to eastern European patients.

Auditing has improved using systems such as Linx on the forms which clinicians have to fill in when they see patients and which admin then have to input into computer systems.

The remaining 2% of comments were not coded as they did not respond to the question.

Service Users

Key Finding - 2001
1.1.15 Minority ethnic service users often said that they experienced "indirect" or "subtle" racism when accessing local NHS services. Most commonly they felt ignored or isolated and felt there was a lack of understanding of culture and diversity.

Evidence provided during the 2010 survey for NHS Norfolk of the health needs of BME groups in Norfolk [5] indicated that direct or subtle racism might still exist. For example, in a perceived case of inequitable access, a woman from a BME group reported that the doctor's receptionist had given her an appointment to see the doctor two weeks ahead, although the patient immediately ahead of her had obtained an appointment from the same receptionist two days later. Problems with getting past the gatekeeper of health services were cited by several advocates for BME groups in the survey.

Key Finding - 2001
1.1.16 All of the service users who responded to the survey agreed that there was a need to train local NHS staff in race/cultural awareness.

5 S. Wilkinson, K. Lane and A. Stöckl, *A Survey of the Health Needs of Black and Minority Ethnic Groups in Norfolk*, August 2010, University of East Anglia, unpublished report.

The 2010 report surveying the health needs of BME groups included the following testimony: a member from the Gypsy and Traveller community stated that a specialist declined to arrange to treat his child on the grounds that the family would not keep the appointment (the child was then seen by another specialist). A community support worker pointed out that getting appointments quickly and easily outside normal working hours not only helped those from BME communities, whose work schedules and commitments sometimes reflected haphazard timings, but also would support all NHS users and as such demonstrated good practice. It was also reported that some communities are reluctant to share information on health with people who are perceived to be outside their own community and culture.

Poor healthcare access has been reported in the literature, as has a lack of cultural awareness. Overcoming prejudice or exclusion is discussed in mental health studies and the Royal College of Psychiatrists has called for the NHS to lead in reducing discrimination.

Key Finding - 2001
1.1.17 The service users generally expressed a strong willingness to be involved and work with the local NHS to eradicate racial harassment and discrimination.

According to the 2010 survey referred to above, many members of BME groups are willing to promote awareness of cultural differences and to help eradicate racial harassment and discrimination. Perceptions and stereotypes can be hard to dislodge, it was reported by some, using examples such as the less-than-positive reception they experienced owing to their dietary customs and lifestyle practices, including the sedentary lifestyles which are typically linked to cultural codes or behaviour.

Key Finding - 2001
1.1.18 Language difficulties and a lack of available translation and interpretation services were often cited by service users as being barriers to accessing services effectively.

Evidence gathered in 2010 indicated that some people from the majority community might assume that BME groups can speak English and understand more than they actually do. An example was cited by one community-based refugee worker that a GP had turned to the child of a patient to act as an interpreter. In another example, a language difficulty complicated the ability of someone from a minority group in accessing mental health support.

Key Finding - 2001
1.1.19 Many service users felt that more could be done to improve 'sign-posting' in local NHS hospitals and clinics for those who did not speak English as their first language.

Findings from the 2010 survey included statements from hospital-based pastoral staff and community-based workers with immigrants on a range of issues dealing with language. Sometimes this reflected variable use of translation services: for example, it was reported that not enough use or inappropriate use was made of existing translation services and that little translation was done of leaflets and other forms of written communication.

The challenges posed by language difficulties and by communication barriers are cited widely in the literature. For example, the different attitude to what constitutes treatment and what qualifies as preventive measures in health have been reported, as have patchy or inadequate take-up of information, interpretation and translation services.

Summary of Main Findings

This section sets out the main findings from the 2011 ERINN survey.

Racism

% of respondents who have noticed or experienced the following:

	All Staff	BME
Racially-motivated physical abuse	2.8%	12.7%
Racially-motivated verbal abuse	11.2%	32.9%
Racist jokes	29.6%	51.2%
Racist banter	26.7%	48.5%
Being isolated due to racial differences	7.6%	28.1%
Racist graffiti	3.5%	6.8%
Racially-motivated damage to property	1.9%	7.3%
Unnecessary staring	10.6%	28.9%
Racial discrimination in job selection	3.9%	17.3%
Racial discrimination in promotion	3.7%	17.4%
Racial discrimination in selection for		
training	2.9%	16.7%
Racial discrimination in allocation of merit		
awards	2.0%	11.7%
Racial discrimination in employee		
appraisal	2.5%	13.4%
Racial discrimination in the application of		
disciplinary procedures	3.0%	12.1%
Racially-motivated complaints made		
against Black or ethnic minority staff	2.8%	25.7%

Equality and Diversity

% of respondents who have noticed or experienced the following:

	All Staff	BME
Age-related discrimination	15.2%	14.4%
Age-related harassment	5.6%	6.6%
Disability discrimination	6.4%	8.4%
Disability harassment	2%	5.4%
Sexual Orientation discrimination	6.3%	13.3%
Sexual Orientation harassment	4.3%	7.8%
Religion/Belief discrimination	5.4%	13.8%
Religion/Belief harassment	3.8%	10.8%

Key issues:

- Addressing covert and overt racism, harassment and discrimination
- Understanding organisational, managerial and individual responses
- Addressing communication problems (e.g., strong accents and language)
- Addressing positive (inverse) discrimination
- Understanding the impact of training

Reporting Mechanisms

29.2% of respondents were unaware of mechanisms for reporting racism at work.

% of respondents who thought that racism:

	All Staff	BME
remains a problem that is not being effectively addressed	14.7%	39.5%
remains a problem that is being effectively addressed	25.4%	26.2%
is not a problem	60.2%	34.3%

Interpretation and Translation Services

% of response to the question, ‘Do you know how to access interpretation and translation services?’

Yes	77.7%
No	10.4%
Not Sure	11.9%

Key issues:

- Understanding cost and usage concerns
- Addressing access/availability issues

Contact with Ethnic Minorities

32.4% of patients refuse treatment on account of racial differences.

Staff response:

Refuse treatment and explain why	6.5%
Try to make alternative arrangements	65.6%
Not know what to do	4.9%

Key issues:

- Understanding context (e.g., gender- or belief-related reasons)
- Observing patient preference
- Understanding why 15% would need to seek assistance

10 Years On

47% of respondents believe that the profile of racial awareness has been raised over the past 10 years.

16% of respondents felt that racial awareness had not changed over the past 10 years in the NHS in Norfolk.

16% of respondents mentioned the impact of training.

15% of respondents felt that this was not an issue.

15% of respondents felt that more work was needed to address Racism, Equality and Diversity issues in the workplace.

Key issues:

- Organisational response indicates less tolerance
- The impact of training has raised awareness
- Entrenched racism remains a problem
- BME and E&D support networks provide valuable resources and support

Service Users

Key Issues:

- Indirect or subtle forms of racism are still experienced by service users
- Cultural awareness training remains an identifiable need
- BME service users remain committed to addressing issues of racism
- Language continues to be a barrier to accessing healthcare

Conclusions

This report has attempted to provide two distinct forms of information. On the one hand it provides an indication of the contemporary situation regarding discrimination and harassment relating to the ‘protected characteristics’ under the Equality Act 2010, of staff within the NHS in Norfolk. On the other hand, it attempts to describe the changes that have occurred over the last 10 years. In this respect, this report becomes a longitudinal study.

When reading this report, it is important that the issues discussed be put into perspective. While much of the discussion in this report focuses on problems and concerns, comparatively little discussion addresses the things that are not problematic or concerning respondents. There is a great deal of evidence in this report that suggests that discrimination and harassment are either not a problem or are being well managed, however comparatively less of this is discussed.

Additionally, it is not possible through the medium of a survey to establish absolute truth. Much of what has been reported can be regarded as ‘perception’. However, if something is believed to be true, then it is often true in its consequences. If an individual feels they have been harassed or discriminated against, the impact of this is just as real for that individual, regardless of the basis of the action or the mitigation. Therefore addressing the impact of discrimination and harassment is a complex process.

The information provided in this report has broad potential in a range of applications. A strategic response may be formed using certain aspects of this work or by using the report in its entirety. The report may provide material for training or academic purposes (such as informing related studies). This report may also be used as a comparator for other organisations to appraise their own situations against. It has not been an intention to project the findings of this study beyond the ‘reporting’ output stage. However, this report does provide the starting place for a great deal of interesting and related work.

Therefore, this report does not include ‘recommendations’, which is not to suggest that recommendations are not necessary. The impact of the recommendations of the 2001 study has been evidenced in this report. However, the use of this report in the development of a strategic response is in itself a discrete task, which should be undertaken independently, drawing upon the relevant stakeholder buy-in and expertise.

Each of the partners involved in this project will now have the opportunity to investigate the response database. Partners will be able to compare the responses of their own organisations with those of the region. Partners will also be able to form their own response to this report and make direct use of it within equality and diversity action planning.

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Glossary

Black History Month	A celebration of Black culture – held in October. http://www.norfolkblackhistorymonth.org.uk/
INTRAN	INTRAN is a multi agency partnership providing language services throughout the Eastern Region http://www.intran.org/cms
Linx	The London Internet Exchange ("LINX") is an Internet exchange point (IXP) situated in London. It was founded in 1994 by a group of Internet service providers.
Positive Action	As a general rule, "positive discrimination" is prohibited in employment In contrast, "positive action" is permitted and may even be required in certain circumstances. http://www.timeshighereducation.co.uk/
Staff Support Network	Groups formed to engage minority staff groups such as those on the following site; http://www.norfolk.nhs.uk/sexual-orientation
Text Relay Services	Text Relay connects people using a textphone with people using a telephone or another textphone. It lets deaf, hard of hearing and speech impaired people stay in touch with friends and family, and call businesses over the telephone http://www.textrelay.org/

Project Partners

NHS Norfolk	http://www.norfolk.nhs.uk/
Norfolk Community Health and Care NHS Trust	http://www.nchandc.com/
Norfolk and Waveney Mental Health NHS Foundation Trust	http://www.nwmhft.nhs.uk/
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	http://www.qehkl.nhs.uk/
Norfolk and Norwich University Hospitals NHS Foundation Trust	http://www.nnuh.nhs.uk/
East of England Ambulance Service NHS Trust	http://www.eastamb.nhs.uk/
GP Practices in Norfolk	http://www.norfolk.nhs.uk/your-gp-practice
Norwich and Norfolk Racial Equality Council	http://www.nnrec.org.uk/
Unison	http://www.unison.org.uk/healthcare/index.asp

Appendix A - Extracts from the Equality Act 2010

Protected characteristics

Each characteristic is addressed in the new Act in summary as follows:

Age

The Act protects employees of all ages but remains the only protected characteristic that allows employers to justify direct discrimination, i.e. if an employer can demonstrate that to apply different treatment because of someone's age constitutes a proportionate means of meeting a legitimate aim, then no discrimination will have taken place. The Act continues to allow employers to have a default retirement age of 65, as long as the default retirement age remains.

Disability

The Act includes a new protection arising from disability and now states that it is unfair to treat a disabled person unfavourably because of something connected with a disability. An example provided is the tendency to make spelling mistakes arising from dyslexia. Also, indirect discrimination now covers disabled people, which means that a job applicant could claim that a particular rule or requirement disadvantages people with that disability.

The Act includes a new provision which makes it unlawful, with limited exceptions, for employers to ask about a candidate's health before offering them work.

Gender reassignment

It is discriminatory to treat people who propose to start to or have completed a process to change their gender less favourably, for example, because they are absent from work for this reason.

Marriage and civil partnership

The Act continues to protect employees who are married or in a civil partnership. Single people are however not protected by the legislation against discrimination.

Pregnancy and maternity

The Act continues to protect women against discrimination because they are pregnant or have given birth.

Race

The Act continues to protect people against discrimination on the grounds of their race, which includes colour, nationality, ethnic or national origin.

Religion or belief

The Act continues to protect people against discrimination on the grounds of their religion or their belief, including a lack of any belief.

Sex

The Act continues to protect both men and women against discrimination on the grounds of their sex.

Sexual orientation

The Act continues to protect bisexual, gay, heterosexual and lesbian people from discrimination on the grounds of their sexual orientation.

Types of discrimination

The new Act also extends some of these protections to characteristics that previously were not covered by equality legislation. Employers and business owners now need to be aware of the seven different types of discrimination under the new legislation. These are:

Direct discrimination - where someone is treated less favourably than another person because of a protected characteristic.

Associative discrimination - this is direct discrimination against someone because they are associated with another person who possesses a protected characteristic.

Discrimination by perception - this is direct discrimination against someone because others think that they possess a particular protected characteristic. They do not necessarily have to possess the characteristic, just be perceived to.

Indirect discrimination - this can occur when you have a rule or policy that applies to everyone but disadvantages a person with a particular protected characteristic.

Harassment - this is behaviour that is deemed offensive by the recipient. Employees can now complain of the behaviour they find offensive even if it is not directed at them.

Harassment by a third party - employers are potentially liable for the harassment of their staff or customers by people they don't themselves employ, i.e. a contractor.

Victimisation - this occurs when someone is treated badly because they have made or supported a complaint or grievance under this legislation.

http://www.equalities.gov.uk/equality_act_2010.aspx
(accessed 15th April 2011)

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