Responding to Race Inequalities in the National Health Service (England): Accountability and the Workforce Race Equality Standard

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Purpose – This paper examines the efforts of National Health Service (England) (NHSE) to respond to employee-based racial inequalities via its Workforce Race Equality Standard (WRES). The WRES constitutes a hybridised accountability initiative with characteristics of the moral and imposed regimes of accountability.

Design/methodology/approach – The study conceptualises the notion of responsive race accountability with recourse to Favotto *et al*.'s (2022) moral accountability model and critical race theory (CRT) and, through it examines the enactment of WRES at 40 NHSE trusts using qualitative content analysis.

Findings – Despite the progressive nature of WRES that seeks to nurture corrective actions, results suggest that trusts tend to adopt an instrumental approach to the exercise. Whilst there is some evidence of good practice, the instrumental approach prevails across both the metric reporting that trusts engage in to guide their actions, and the planned actions for progress. These planned actions not only often fail to coalesce with the trust-specific data but also include generic NHSE or equality, diversity and inclusion initiatives and mimetic adoptions of best practice guidance that only superficially address racial concerns.

Social implications – Whilst the WRES is a laudable voluntary achievement, its moral imperative does not appear to have translated into a moral accountability within individual trusts.

Originality/value – Responding to calls for more research at the accounting-race nexus, this study uniquely draws on CRT to conceptualise and examine race accountability.

Keywords Racial discrimination, Moral accountability, Race accountability, Critical race theory, NHSE

Paper type Research paper

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1. Introduction

Racial inequalities and discrimination have and continue to plague society in different spaces and spheres, and through different forms. Indeed, Annisette (2009, p.463) purports that race is "one of the most potent forces of our times". Despite calls for research to examine the accounting-race nexus (see, for example, Annisette, 2003, 2009; Annisette and Prasad, 2017) and critical accounting researchers' efforts to shine light on practices of power, privilege and oppression (Gallhofer and Haslam, 2019; Manetti *et al.*, 2021), the plight of racialised communities in modern society has been largely overlooked in our discipline. Recent exceptions include studies that have captured the role of accounting and "accounting logic" in immigration policy and the responsibilisation of immigrants (Agyemang, 2016; Agyemang and Lehman, 2013; Lehman *et al.*, 2016), and counter stories of asylum seekers (Twyford *et al.*, 2022). Our paper contributes to this emergent literature by exploring the efforts of National Health Service (England) (NHSE) – the English healthcare provider – to respond to workplace race inequities via a bespoke reporting standard to tackle racial discrimination.

Race is a societally constructed concept that has historically been mobilised and maintained to create a hierarchical order in society. This order has, in turn, been used to determine the access, rights, and privileges that some racial communities can enjoy over others in social, economic and political contexts. Today racism operates in complex, subtle and 'convenient' ways (Gillborn, 2015), and is so institutionalised that it has become "dangerously ordinary" – often unnoticed, overlooked, and insufficiently challenged (Delgado and Stefancic, 2012, p.6). Seemingly neutral systems, processes and policies in government, organisations and society more widely insidiously perpetuate racial inequalities amongst citizens, migrants, service-users, employees and others.

NHSE is one of the biggest employers in the UK and the largest employer of ethnic minority[1] employees (Bhayankaram and Bhayankaram, 2022). Such diversity of the workforce may frame NHSE as a success story, although racial inequalities have been a longstanding concern for NHSE. The Covid-19 pandemic accentuated the effects of such inequalities when ethnic minority healthcare workers were disproportionately represented in healthcare workforce lives lost to the virus (Amnesty, 2020). Post-pandemic, surveys by the British Medical Association (BMA) (2022) and the Royal College of Nursing (RCN) (McIlroy and Maynard, 2021) continue to highlight concerns and experiences of racism.

In our study, we examine the enactment of the Workforce Race Equality Standard (WRES) – a reporting standard developed by NHSE in 2015 as an accountability initiative to encourage and enable disparate NHSE institutions to respond to racial discrimination within their own local settings. We argue that the WRES reflects a hybridised accountability initiative with characteristics from the two principal regimes of accountability - moral and imposed accountability (Favotto *et al.*, 2022; Roberts, 2009). The WRES is grounded in a moral imperative to seek justice for its employees and, in this capacity, nurtures a responsive and progressive form of moral accountability (Favotto *et al.*, 2022) in which accountors actively seek to remedy problematics for their ethnic minority constituents. It is also an imposed accountability regime in that all NHSE and affiliated organisations are mandated to engage with the WRES process with scrutiny from an oversight body.

We mobilise Favotto *et al.*'s (2022) notion of moral accountability as a form of responsiveness to address racism through recourse to critical race theory (CRT), an adaptation we call *race accountability*. We then examine the enactment of the WRES through this race accountability framework for 40 trusts by analysing their WRES reports using qualitative content analysis. As a praxis-oriented framework that has a clear social justice mandate, CRT befits Favotto *et al.*'s notion of accountability as responsiveness. It also offers a race-conscious lens that

centralises racial inequalities and underscores sources of racism and nurtures the development of actions and interventions to engender a more egalitarian and respectful society (Bell, 1995; Crenshaw, 1988, 2011).

The paper contributes to the literature on race and accountability and, in so doing, responds to critical accounting's calls to break the silence on race (Annisette, 2003). It is structured as follows. Section 2 provides a brief overview of NHSE and its WRES. Section 3 reviews the extant accountability literature to contextualise the WRES as a hybridised accountability initiative. Section 4 outlines our use of CRT to mobilise the notion of race accountability followed by an overview of the data collection methods. In section 6, we present the findings of our analysis, which are subsequently discussed in section 7. The final section closes with our concluding thoughts.

2. NHSE and its WRES

Formed in the aftermath of World War II, the NHS was founded upon the principles of social justice and especially notions of universality and equity to ensure that all UK citizens received free and 'at the point of access' high-quality healthcare (Merali, 2006). Today, NHSE serves a population of 55 million people and employs over 1.2 million staff, making it one of the world's largest employers (Bulut, 2023). It is also the largest employer of ethnic minorities: one quarter of NHSE staff and 40%+ of the medical workforce are ethnic minorities compared to 13% of the working-age adult population in the UK (Bhayankaram and Bhayankaram, 2022; Rolewicz *et al.*, 2022).

Despite this diversity, inequity issues related to gender, disability status, religion and race that contravene its justice-based ethos have long troubled NHSE (Carter *et al.*, 2013; Sealy, 2020; Shahid, 2022). On race, concerns include under-representation of ethnic minorities in leadership positions; and lower pay levels, inequitable outcomes in recruitment and disciplinary hearings, a greater likelihood of bullying and harassment for ethnic minority colleagues relative to their white counterparts (Archibong *et al.*, 2019; Kline, 2014; Rimmer, 2016).

In 2015, following ongoing and unresolved concerns over racial inequality, the Equality and Diversity Council of NHSE (E&D Council) developed the WRES. The WRES mandates all NHSE and affiliated organisations with an income of £400,000+ to prepare annually a WRES report that records their performance against nine pre-established and 'difficult to game' (p.25) race-related indicators (NHSE, 2019b) and, present a corresponding action plan to respond to identified inequities. At the national level, NHSE subsequently aggregates the data to monitor progress centrally and shares good practice. Furthermore, since 2016, the E&D Council has charged the Care Quality Commission (CQC), the English healthcare regulator and assessor, with the responsibility to oversee individual institutions' WRES performance through specially trained Equality and Diversity Specialist Advisors, as part of their care inspections.

The nine WRES indicators (see Table 1) seek to address four key themes of racial discrimination: under-representation of ethnic minority workforce at senior levels (I9); absence of fairness and equity in recruitment (I1 & I2); inequitable career development opportunities (I4 & I7); and culturally embedded daily work experiences, including issues of bullying and harassment and disciplinary actions (I3, I5, I6 & I8). Whilst five of the indicators rely on data from employee databases, four are drawn from an annual NHSE staff survey which enables trust-level comparisons in responses from ethnic minority and white employees.

<Insert Table 1 here>

NHSE also created the Model Employer Framework (MEF) (2019a) to further guide organisations' race agenda and increase diversity and inclusivity at leadership levels. Yet,

despite these efforts, progress has been patchy (Dawson *et al.*, 2019). Further, during the pandemic, the disproportionate fatality rate for ethnic minority workers (Amnesty, 2020) was linked to their hostile working conditions (Farah, 2020). For example, these workers had inadequate access to personal protective equipment (BMA, 2020; Kinnair, 2020) and Covid risk assessments, despite calls from NHS leadership for such provision in light of emerging evidence about the disproportionate impact of the virus upon ethnic minorities. Furthermore, there was an absence of remedial actions for at-risk staff (Elahi, 2021). Post-pandemic, the BMA (2022) and the RCN (McIlroy and Maynard, 2021) suggest that change for their members has been limited, with few expressing confidence that NHSE has been delivering on its commitment to address institutional racism (NHS Confederation, 2022).

3. Enabling accountability: situating the WRES

As a socially constructed phenomenon, accountability is a relational concept that manifests in multiple forms in a myriad of different contexts. Moreover, the accounting literature has increasingly recognised accountability as an ethical construct: as their activities impact others, organisations have a moral responsibility to these others (Unerman and Bennett, 2004). Earlier conversations of accountability have regarded it as a process through which organisations explain and justify their actions, and are judged and sanctioned or rewarded, as deemed suitable by distant others (Roberts and Scapens, 1985). This form of accountability embodies a moral order by determining the rights and obligations of the different actors. Moreover, what matters is made visible through a variety of externally imposed systems such as codes of conduct and reporting initiatives that call on organisations to account for activities related to these 'matters' (Goncharenko, 2023). As organisations and individuals comply with and respond to prerequisite processes and reporting metrics herein, disclosures are premised on the principle of transparency (Messner, 2009; Roberts, 2009). Here, as actors communicate authentically with significant others about the issues that matter, they are prompted to engage in activities that are supportive of such matters and their related metrics. The reporting expectations/requirements, together with the surveillance mechanisms that oversee them, result in what scholars refer to as imposed accountability (Helle and Roberts, 2024; O'Dwyer and Boomsma, 2015).

Despite its normative appeal, enactment of this imposed form of accountability is problematic. Dillard and Vinnari (2019) explain that this reporting-led accountability prioritises the interests of dominant stakeholder groups while failing marginalised groups. Further, Cooper and Lapsley (2021) draw attention to the disproportionate emphasis on metrics – where metrics become *the* form of accountability. Within these contexts, scholars (Cooper and Lapsley, 2021; Everett and Friesen, 2010; Roberts, 2009) reflect on how an imposed accountability regime socialises actors with an instrumental mentality. Its coercive and disciplinary characteristics may place a distorted focus on the calculable, consequences of which may be counterproductive to relevant constituent groups by concealing what really matters (Cooper and Lapsley, 2021) or encouraging actors to take defensive measures when confronted with uncomfortable truths (Messner, 2009). Similarly, under the disguise of transparency, disclosure initiatives and guidelines appear to serve as springboards from which organisations can legitimate their activities to create and maintain particular self-images - all the while continuing with 'business as usual' (Parsa *et al.*, 2018). Such managerialist practices depart from the underlying ethical construct of accountability as the importance of responsibility and care for others (McKernan, 2012) and are replaced with chasing metrics and managing organisational reputations. This said, in an internal context, investigating the under-researched topic of Equality, Diversity, and Inclusion (EDI) in accountability, Castilla (2015) noted how an imposed regime of accountability of a performance-reward system that required managers to formally justify their bonus recommendations helped reduce employee pay gap by gender, race and nationality. This effect was observed when combined with transparency in pay outcomes.

In recent times, an alternative, more authentic form of accountability, focused on a socialising form of accountability (Roberts, 2009) has been discussed in the literature. Framed in Levinasian ethics, it is motivated by the ethical encounter with the other and the sense of moral responsibility that this generates towards the other. So anarchic is the feeling towards the other that the actor cannot but respond and react to (the claims of) them (Roberts, 2009; Shearer, 2002). This felt moral responsibility is so intrinsic to humans that accountability manifests as an authentic and non-instrumental relationship with others. Furthermore, Bauman also explains that "the realm of morality is enclosed in the frame of sympathy, of the willingness to serve, to do good" (1995, p.60), which entails recognising, empathising and addressing the circumstances of the others (O'Leary *et al.*, 2023).

Within this context, while earlier Levinas-informed accountability research (Roberts, 2009; Shearer, 2002) emphasised the self in relation to the other – by calling on *our* responsibility to the other, more recent envisions of Levinasian thought prioritise the other in and of themselves (Favotto *et al*., 2022). In this instance, Favotto *et al.* (2022) reimagine accountability as a form of responsiveness – a response of care and concern for the other, regardless of the self. Accountability here manifests in the form of actions with and towards the other. Moreover, the authors assert that this form of accountability is necessarily speculative as a response to what emerges in lieu of the other. Herein, Favotto *et al.* (2022) recognise the value of practices such as audit and metrics to collect data about which actors are curious and reflect upon to enable responsiveness (Figure 1, Panel A). Similarly, applying Favotto *et al.*'s model in the non-governmental organisation (NGO) context, O'Leary *et al.* (2023) highlight the importance of dialogues and openness with the other to enhance understanding of this other's situation. Moreover, in search for improved practices, Favotto *et al*. (2022) emphasise the role of experimentation, and a desire to continually improve and reflection for the betterment of the other. Fundamentally, through its emphasis on responsiveness, Favotto *et al.*'s (2022) notion of accountability is progressive in that it seeks to "inspire future action rather than crystallise the past" (p.12).

Central to this conceptualisation of accountability, however, is the expectation that a felt moral responsibility to others is intrinsic to humans and that it will supersede all other organisational objectives and priorities. Yet, research points to an absence of such expectations. Goncharenko (2023), for example, draws attention to episodes of sexual misconduct in the non-profit sector and how organisational responses to such acts seek to protect organisational reputation over beneficiary protection and care. Similarly, despite NGOs' felt responsibilities towards the communities whose lives they seek to influence, their actions can result in othering the other (Dhanani, 2019). However, O'Leary *et al.* (2023) demonstrate how a humanitarian NGO operating in a crisis situation actively overcame such othering by building networks of solidarity and support with the communities they sought to serve, creating a sense of belonging and empowerment to ease their pain. Favotto *et al.* (2022) extend this scope of felt accountability – designing and improving handling facilities to respond to the sensitivities of farm animals. Moreover, Helle and Roberts (2024) reflect on how an enhanced system of accountability at a multinational company enabled the co-existence of imposed accountability and felt responsibility while, O'Dwyer and Boomsma (2015) demonstrate an NGO's efforts to secure influence over the accountability imposed by an external donor in tune with its felt responsibility.

Situating the WRES into this broader accountability literature, we argue that it operates as a hybridised accountability initiative with characteristics from both the imposed and moral regimes of accountability. While a formal analysis of the content of the WRES is beyond the scope of this paper, its voluntary efforts towards ethnic minority workers' experiences around recruitment, progression and bullying and harassment appear to respond to experiences of racism as discussed in Section 2. Moreover, the WRES is responsive and progressive in accordance with Favotto *et al.*'s (2022) notion of accountability in that it calls on organisations to develop action plans to remedy racial discrimination. In addition, in this capacity, the WRES

operates a system of metrics to help organisations to identify and understand the specific areas of concern at their local level (Gilbert and Rasche, 2008) and reflect and develop remedial actions accordingly (Green, 2005; Suarez, 2018). Furthermore, as Favotto *et al*. (2022) recommend, since its development, the E&D Council has itself reflected on and evaluated the WRES initiative to ensure its relevance (Dawson *et al.*, 2019). In spite of the moral underlying motivations, given the size of NHSE and the large number of disparate units that make up the institution, the WRES is implemented as a form of imposed accountability: organisations are mandated to engage with the standard and produce an annual report that is not only placed in the public domain but also required to be endorsed by the board and subsequently scrutinised by CQC. As a hybridised initiative of responsive accountability, we examine the enactment of the WRES through recourse to race accountability by NHSE institutions to foster racial equality. We do so by coupling Favotto *et al.*'s (2022) model of responsive accountability with CRT to develop a framework of race accountability.

4. Mobilising race accountability: insights from critical race theory

Perceiving racism as iniquitous, CRT originated in legal studies to theorise inconspicuous patterns of racist practices in the development and implementation of laws in the US. Informed by multiple disciplines including history, legal studies, politics, philosophy, sociology, feminist and postcolonial studies, CRT places issues of race and racism within a social, political, and historical context to attend to and challenge dominant frameworks, ideologies and structural practices that privilege white people while oppressing ethnic minorities in often pervasive and insidious ways (Bell, 1995; Delgado and Stefancic, 2012). CRT has been positioned as a framework and a movement rather than a theory (Parker and Villalpando, 2007) to reflect its intentions to incite change. Within this praxis-oriented space, CRT has a clear moral and ethical stance (Lawrence and Hylton, 2022): seeking to develop solutions to engender a more egalitarian and respectful society and achieve social justice (Bell, 1995; Crenshaw, 1988, 2011).

CRT purports that the historical creation of a hierarchy of white (male) supremacy has enabled this dominant group to define, manipulate and retire racial identities in society to protect and advance the interests of white communities (Delgado and Stefancic, 2012). While efforts of its associated feminist theory have made some progress towards parity between women and men, CRT recognises that such endeavours have selectively benefitted white women while ethnic minority women continue to be marginalised and oppressed. Albeit a transdisciplinary approach employed to explain social phenomena in various fields, CRT has attracted little attention in accounting. In a rare foray, Twyford *et al.* (2022) drew on CRT, more specifically, its emphasis on the emancipatory potential of counter-stories as a form of accountability to explain the "mundane, ever-present, and constant infiltration of racialisation" in offshore detention centres in Australia (p.333).

CRT coheres around a set of tenets (Table 2). Tenet 1 commits to the social justice agenda to create a more equal and respectful society by centralising race and racial discrimination (Tenet 2) and its intersection with other forms of discrimination (Tenet 3). Tenet 4 underscores the significance of the lived experience and experiential narratives to (better) understand the plight of the marginalised. Finally, Tenets 5, 6 and 7 emphasise the underlying causes of racism – white privilege, structural racism and interest convergence, respectively, to challenge post-racial world ideologies to fulfil CRT's commitment to its constituents.

<Insert Table 2 here>

CRT enables adaptation of Favotto *et al.*'s (2022) notion of responsiveness as a form of accountability (Figure 1, Panel A) to what we conceptualise as race accountability (Panel B). This is because both are committed to notions of justice and concern for the other, and this commitment is exercised by responding to this other through planned actions and interventions. The resulting framework not only has theoretical appeal to examine

organisations' anti-discrimination practices but, as a praxis-oriented approach, may also guide institutional practices.

In its efforts to centralise race and racial issues (Tenet 2) including recognition of intersectionality (Tenet 3), the race accountability framework commences with Favotto *et al.*'s (2022) notion of data about which organisations will be curious and reflect upon to understand the position of the other. Such data may be collected through techniques such as audits and metrics in accordance with Favotto *et al.* (2022) to capture the different manifestations of discrimination and the extent to which they pose a concern. Moreover, organisations should engage in dialogues with the other (O'Leary *et al.*, 2023), promoting openness because in a CRT context, such interactions enable prioritisation and validation of ethnic minority voices as a source of experiential knowledge (Tenet 4) from which to inform racial redress (Leonardo, 2002). However, in contrast to O'Leary *et al.*'s (2023) idea that dialogues and openness support co-responsiveness to improve the position of the other, CRT advocates that the work of redress should not actively engage victims of racism. Not only would such an expectation burden the other to put right what they are not responsible for, but meaningful solutions, as subsumed in CRT, include disrupting and dismantling deep-seated, biased practices that only those in positions of power can enact (Nance-Nash, 2020).

Necessarily, the actions that emerge from responsive race accountability are speculative: responding to remedy the problematics witnessed in the data. This said, CRT informs the development of responsiveness accountability by underscoring the causes of racism. Specifically, it draws attention to the notion of white privilege (Tenet 5), and structural and institutional forms of racism (Tenet 6) engrained in organisational practices that interventions and solutions should seek to challenge and disrupt (Lawrence and Hylton, 2022). Simultaneously, actors need to be conscious of and actively overcome any presence of interest convergence (Tenet 7) as they engage with the race accountability process, recognising that such practice is antithetical to the very notion of racial equality. Finally, CRT, like responsive accountability, is aspirational – advocating experimentation and improvement to achieve change which will entail continual re-evaluation and re-assessment of data practices and planned actions.

<Insert Figure 1 here>

In academia, while CRT has traditionally been linked to qualitative, interpretive methods to capture the lived experiences of ethnic minorities, it has recently been advanced to reimagine how quantitative methodologies can purposefully contribute to critical race research (Garcia *et al.*, 2018) by consciously considering power relations at play in historical, social, political and economic settings. Similarly, Lawrence and Hylton (2022) have connected CRT to semiology to analyse media platforms as semiology also seeks to dismantle systems of oppression. Our study contributes to prior CRT research by developing a CRT-informed concept of race accountability and examining through it the enactment of WRES.

5. Research approach

This paper employed qualitative content analysis, an increasingly popular research approach in accounting/sustainability research (see Boiral, 2016; Cooper and Slack, 2015; Dhanani and Kennedy, 2023). Combining an interpretivist orientation of data with a systematic data collection process allows for its subjective interpretation (Hsieh and Shannon, 2005) based on a pre-established framework. As such, whilst the approach enables data collection for relatively large sample sizes via its coding framework, its qualitative orientation also allows for the recording of data on aspects not initially captured by the coding framework (Boiral, 2016; Krippendorff, 2018). Furthermore, qualitative content analysis considers social meanings in language (and non-verbal materials) (Krippendorff, 2018). Such meanings are integral to discussions of race, and even though not the primary objective, allowed us to reflect on

language usage to understand organisations' (conscious or subconscious) race perceptions (Lutz and Collins, 1993).

We collected the WRES reports of 40 randomly selected health trusts in England[2] for 2019, 2020 and 2021 (the most recent reports at the time of the study). We gathered the indicator data reports and action plans from the organisations' websites or, when not available, via a freedom of information (FOI) request[3]. Some trusts failed to respond to the mandatory FOI request, whilst others could not locate the requested data – raising questions about the seriousness with which they approached the WRES exercise. In both cases, such trusts were excluded and replaced with the next one in the randomised list. Those that shared at least two-thirds of the documents requested were included in the sample. Thus, our final sample comprised 108 indicator data reports and 102 action plans, either as standalone documents or combined. Although the data was mostly narrative in nature, some organisations used tables and graphs to present their indicators – all forms of data, bar images, were included in our analysis. Studying three years' worth of reports was considered important to allow us to examine Favotto *et al.*'s (2022) notion of accountability as both progressive and speculative. This approach helped us observe adaptations to plans in response to emerging metrics data and narratives from lived experiences, and reflections and assessments of interventions enacted, respectively.

In accordance with qualitative content analysis, the data was systematically analysed at three levels (see, for example, Dhanani, 2019; Vasquez Heilig *et al.*, 2012). Also, all four researchers were involved in data collection, each taking primary responsibility for 10 trusts. For *Level One* analysis, an initial coding framework that closely followed the expectations of the WRES was developed. It sought to understand trusts' (i) underlying motives for engaging in the WRES exercise; (ii) their reporting practices for the nine indicators; and (iii) the nature of the interventions in their action plans. Whilst all three features aligned closely to the enactment of Favotto *et al.*'s (2022) notion of accountability as a form of responsiveness and in turn our perception of race accountability, emphasis at this level was placed on the former two.

Specifically, the researchers recorded presentations of the motives together with coverage of the Covid-19 pandemic, considering its aforesaid significance as a reflection of trusts' moral responsibility towards their ethnic minority workforce, and also added commentaries about the extent to which these disclosures aligned to the moral imperative of the WRES and race accountability (informed by moral accountability and Tenet 1). Similarly, for the metric data, we summarised the data provision practices and accompanying commentaries' practices of the trusts. We also commented on the completeness of information provided; (accuracy of) interpretation and evaluation of this information by trusts in accordance with Favotto *et al.*'s notion of reflection and curiosity and Tenet 2's idea of centralising race, including evidence of practices of impression management such as selectively in reporting (Cooper and Slack, 2015). Further, we assessed the extent to which individual activities in the action plans were linked to trusts' indicator performance as evidence of speculative accountability; and reflected on developments and changes in trusts' reporting practices and the planned actions between 2019 and 2021 as an indicator of reflection and progression in accordance with Favotto *et al.* and CRT's broader agenda of progress. For the action plans, we recorded the interventions trusts identified in their planned actions.

To increase the validity of our coding frame and ensure consistency, all researchers initially coded data for the same trust and shared experiences. The initial coding framework was finalised following several iterations. Entire WRES reports were coded in Excel, and whilst the framework pre-empted many categories of data and data presentation, it was also adaptive and allowed for the incorporation of additional ideas and concepts.

Level Two analysis focused principally on the action plans through recourse to the race accountability conceptualisation and tenets of CRT. The analysis here was organic, developed in an abductive manner that entailed an intensified iterative process of reflection where the research team met on several occasions to discuss the planned interventions in lieu of Tenets 4 – 7, associated with understanding the differing underlying bases of discrimination and in turn responding to them. This process facilitated a deeper understanding and application of these tenets. Specifically, Tenet 4 (lived experience) was linked to examine trust efforts that gave voice to their minority ethnic workforce to share their lived experiences – to help inform the development of specific remedial actions. Tenets 5 and 6 that connect to foregrounding white privilege and institutional structures that allow or enable discrimination were applied to the suggested interventions more widely – examining whether these interventions gave consideration and/or disrupted these features. Tenet 7 considered the authenticity of organisational interventions – assessing whether they depicted practices of converging interests - meeting white interests whilst attempting to respond to minority ethnic discrimination. Consideration was also given to practices which operate in opposition to the fundamentals of CRT. For example, for Tenet 5, organisational emphases on interventions to eliminate shortcomings of ethnic minority employees to address disparities were deemed to be oppositional to recognising white privilege as they implied whiteness as a reference point. Disclosures related to Tenet 3, concerned with intersectionality, were broadly absent in the trusts' reports and this may be explained by the absence of the concept of intersectionality in the WRES.

Following the development and finalisation of the analytical framework, the authors independently prepared summaries for each trust they were responsible for, including excerpts from the WRES reports as examples and evidence (see Boiral, 2016). Subsequently, the researchers exchanged their trusts and a second researcher engaged with the WRES reports and prepared summaries, before co-producing a final, joint summary. Moreover, the researchers recognised the dual space in which Tenet 4 transcended – while organisations presented forms of data capture of the lived experience as planned actions with intentions to put in place systems and structures to capture such detail, the race accountability framework recognises the lived experience as a source of data to guide subsequent actions. In keeping with the framework, the analysis is presented as a form of data capture. Similarly, the research team recognised the interlinkages between the tenets informing the planned actions (Tenets 5 – 7) and how planned actions may fit different themes. For example, efforts geared towards training and up-skilling ethnic minority colleagues in their endeavour to foster calibration of this group to white norms links to the contested notion of white privilege (Tenet 5), and equally, as aforementioned, the individual orientation of such actions to correct systemic issues links to structural and institutional racism (Tenet 6). Here, the research team met to decide how to record such findings, including splitting up remedial interventions, as appropriate.

Finally, in the *Level Three* analysis, trusts' summaries were aggregated into a single document – organising the data by tenet and within this, by intervention for the planned actions. Under Tenet 4, lived experience, for example, the team identified recorded reverse mentoring programmes and the role of ethnic minority networks as proposed interventions.

The next section presents the findings which sequentially capture the different phases of the race accountability framework, drawing on examples from the trusts as illustrations (see, Boiral, 2016). Given the diversity of possible interventions to address racial concerns, below, we report on the most popular actions whilst also reflecting on those specifically aligned to moral race accountability.

6. Findings

6.1 Motivating WRES: a moral imperative?

The WRES exercise is rooted in a social justice agenda and while many of the sample trusts provided an underlying motive for their WRES engagement, surprisingly, approximately half stated the purpose of their reports was merely to fulfil the requirements of the standard (for example, University Hospitals Bristol and Weston, 2020). This signals an instrumental approach to addressing race issues rather one of felt responsibility grounded in proactive recognition for change.

Some trusts used language suggestive of business-based rationales by plainly ticking internal, prepopulated box options to express the underlying motives for their WRES document. For instance, at Cumbria, Northumberland, Tyne and Wear, the WRES exercise was framed by concerns of reputation management and risk, rather than a morally-oriented, race-relevant agenda with management ticking *"... to be regarded as a great place to work"* (2021, p.1) and management of *"reputational risk ... if legislation and best practice is not followed which may have detrimental effect on attraction and retention of staff"* (2021, p.2) as their relevant motives.

Some trusts coupled their business justifications with a moral contextualisation.

> "[…] Now more than ever Covid-19 and the Black Lives Matter movement highlighted the **moral case for the WRES**. We are committed to understanding and tackling inequality and recognising its impact on the lived experiences of our BME and all colleagues and communities..." (Torbay and South Devon, 2021 p.9, emphasis added).

And, Sandwell and West Birmingham (2021, p.3) sought to go a bit further, expressing intention to challenge and take responsibility for racial inequalities entrenched in their organisational culture:

> "... we will work to change the deep-rooted cultures of race inequality in the system, learn more about the importance of equity, and build capacity and capability to work with race. Continuous embedding of accountability to ensure key policies has [sic] race equality built into their core, so that eventually workforce race becomes everyday business."

Opening with a personal narrative – a lived experience - in the form of a letter entitled *"racism is a wound"* (p.1) from a lead nurse, Salisbury's 2021 WRES report commenced with a social justice imperative.

However, despite the timeframe of our analysis and the effects of the Covid-19 pandemic on both NHS workers and ethnic minorities, curiously only 13% of sample trusts referred to Covid-19 as an impetus for WRES reporting in 2020, with only marginal improvement (20%) in 2021 (as seen in Torbay and South Devon above). And rather than acting as a motivating force, a similar proportion of trusts instead referenced the pandemic in excusing the incompleteness of their WRES data and their disengagement from planned actions.

6.2 WRES metrics: a starting point for race accountability

Metrics and accounting are the starting point for accountability by foregrounding where we are at and providing a basis for curiosity and critical reflection (Favotto *et al.*, 2022). Ideally, for trusts, the WRES data helps to locate and reflect on their 'race positions' in order to inform the development of progressive actions. Across the three-year period examined, we found that trusts generally engaged with the quantitative data requirements though not all offered accompanying narratives reflecting on the data and trends over time. Moreover, despite its centrality to instigating race accountability, we identified numerous weak practices, which cast doubt over the organisations' authentic engagement with the data and intentions to both fully comprehend and address issues of racial discrimination. These included (a) incomplete data

provision and an absence of curious reflection and (b) (mis)representation of data and instrumentality through practices of impression management.

A. *Limited accounting: incomplete data*

From our sample, 10% of the data reports and action plans from trusts were missing and irretrievable, whilst for other trusts, we noticed incomplete presentation and omissions of specific aspects of indicator data. For example, the Dudley Integrated Health and Care report (2021) omitted its I4 data without explanation. York and Scarborough (2019) failed to report their staff survey data (I5 – I8) whereas Medway (2020) reported the prior year's data without making this explicit.

Other trusts failed to include comparative data for some indicators, which is required both to help understand the position of their ethnic minority workforce and to assess the impact of speculative interventions as part of the continuous improvement agenda. Several trusts, including Royal Brompton & Harefield, only partially presented their survey findings (I5- I8) - recording only responses from ethnic minority staff. In the absence of results on white staff's experiences, it was not possible to assess the relative positions of ethnic minority and white staff. Similarly, some trusts provided no comparative data over time: North Bristol (2021) omitted this data for I2 - I4, in contrast to the four years' worth of data for I5 -18.

In addition, many trusts engaged with their data disclosure only prescriptively, with some consistently failing to provide contextual commentary and a discussion of the data (East Lancashire, Oxford Health, and Sheffield) and others repeated remarks across years (Hounslow and Richmond Community Healthcare) questioning genuine reflection and curiosity of the data. In other cases, narrative comments merely described the metrics, which meant that once again any authentic and meaningful consideration of racial considerations were absent (Sherwood Forest, 2019 and North Bristol, 2019, 2020, 2021).

B. *Limited accounting: (mis)representing data*

We also observed inaccuracies in the data presented by several trusts, which may reflect a lack of care and attention to the race cause and, in turn, an instrumental approach to race accountability that stymies an authentic attempt at speculative responsiveness. Some trusts misinterpreted their data, describing any increase in indicator data as 'good news', even when such data pertained to experiences of bullying and harassment or the likelihood of better outcomes for white staff compared to their ethnic minority counterparts (Torbay and South Devon, 2021). University Hospitals Sussex (2019) presented both positive and negative metrics in green-coloured text, which is typically used to signal improved performance. Similarly, others interpreted their data differently in different parts of the same report: Medway (2019), for example, suggested *"indicators 5-7 have only stabilised"* in the executive summary but in a later commentary noted *"deteriorating"* performance of these very metrics.

Alongside the aforementioned examples of misrepresentations, several trusts managed their data by either selectively reporting on or drawing attention to specific data and explaining away other data. Constituting forms of impression management, such practices disallow a coherent and accurate understanding of the accounting data from which to develop responsive actions and/or create a defensive approach to race accountability. Yet, from the trust perspective, as has been reported in prior research, metric reporting combined with scrutiny of such reporting may have resulted in the actions witnessed (Cooper and Lapsley, 2021).

Amongst the practices observed, trusts emphasised positive developments: for instance, Worcestershire Acute (2021), for I1 only discussed data for Bands 8a[4] and above for which the trust had outperformed the nationally set target. Blackpool (2021) and Royal Brompton & Harefield (2020) only commented when their performance excelled in comparison to regional and national averages. While Mid Yorkshire (2020), in contrast to the WRES guidance, failed

to provide a meaningful comparison between their ethnic minority and white staff data, instead opting to highlight its marginally superior performance for the former in comparison to the national average. Similarly, Blackpool reported new senior-level appointments made in 2020 in both 2020 and 2021, which served to enhance the performance in the latter:

> "A welcome addition to the Board, was the appointment of a Non-Executive from a BAME background in January 2020 and a VSM also from a BAME background." (2020, p.6; 2021, p.3)

Moreover, in a high-level action plan document for 2021, Medway qualified its extensive levels of planned activity by citing resource constraints, thus minimising expectations and excusing management:

> "...the timescale set is extremely challenging in practice…capacity will potentially be an issue." (pp.1-2)

Finally, some organisations attempted to explain away their results, attributing changes in the indicators to external factors rather than their internal practices (Clatworthy and Jones, 2003). Royal Brompton & Harefield, for example, erroneously referred to the high representation of ethnic minority employees in London to explain its poor I2 & I3 data:

> "… **given that London has the highest proportion of BME staff in its workforce,** metrics 2 [1.88] and 3 [1.37] score less well than the national picture." (2020, p.4, emphasis added)

Only a small number of trusts provided a more robust analysis of their data, supplementing their indicator information and interrogating race issues within the trust. These practices reflect Favotto *et al.*'s (2022) notion of improvement and reflection - adjusting metrics to enhance outcomes for the other. Bolton, for example, called itself out as amongst the ten worst performers in 2020, whilst Salisbury (2021) voluntarily calculated a new ratio – the disparity ratio – recently introduced by the NHSE to assess progression from lower pay bands to higher ones:

> "Our disparity ratio is 9.80. This means that white staff are 9.80 times more likely to progress from lower to the upper employment bands than BAME staff. […] When we compare ourselves with other organisations...we see that our disparity ratio is the highest..." (pp.13-14)

Further, on recruitment and selection, Salisbury supplemented its likelihood ratio for I2 with an additional measure that captured the likelihood of being shortlisted post-application to better understand the sources of inequality:

> "A larger proportion of BAME applicants met the minimum requirements for the role...BAME Applicants were 6 times more likely to be subject to the shortlisting process than White applicants. […] White applicants were 3 times more likely than BAME applicants to be offered interviews. The above figures indicate that, although a large number of BAME applicants meet the minimum requirements for the role, they are less likely to progress through...interview process." (2021, p.16)

Responsive accountability is about drawing on the accounting calculative practices, and reflecting on what they tell trusts to inform change. Yet, amidst some productive and progressive practices, indicator disclosures and reflections appeared to have been predominantly motivated by an instrumental approach – providing core information to meet WRES requirements. Moreover, in some instances, there appeared to be a flawed

understanding of the metrics and as has been seen in prior imposed accountability research, trusts also felt a need to highlight progress. Such practices question trusts' authentic curiosity about their data and earnest efforts to understand and reflect on their race positions so as to inform and evaluate subsequent steps and actions, lessening the notion of accountability as progressive and speculative.

6.3 Beyond the metrics: engaging with lived experience

Our conceptualisation of race accountability should give voice to the marginalised other both to contextualise metric data and to learn further about the manifestations and effects of discrimination to inform the development of remedial interventions. Trusts, however, as aforementioned, typically identified efforts to give constituents a voice as remedial actions in their plans rather than as forms of data capture from which to act. Analysis of such action plans pointed to two key spaces through which to give voice of ethnic minority staff: (i) reverse mentoring programmes in which senior managers – often board members - were paired with ethnic minority colleagues; and (ii) in network forums set up specifically to support ethnic minorities.

Reverse mentoring initiatives gained popularity amongst the trusts over the timeframe examined. Whilst some trusts, such as West Hertfordshire, appeared to understand the premise and intent of reverse mentoring,

> "Pairing Board members with BAME reverse mentors in order to educate leaders about diversity issues by exposing them to challenging and insightful conversations and experiences that they may otherwise never encounter." (2020, p.15),

paradoxically, many framed it as enabling the career development of ethnic minority staff, operating alongside activities like coaching and leadership programmes to enhance trusts' equal opportunities (I4) performance:

> "BME staff access to mentoring (including reverse mentoring), shadowing, … NHS Leadership Academy and other courses." (East Lancashire, 2019, p.4)

Moreover, even within the above West Hertfordshire case, there was a tendency to see this intervention as an exercise in and of itself - with little evidence of consequential progression to remedial actions based on issues identified, across the three-year period of study. Consequently, there is concern that initiatives like reverse mentoring may become mimetically adopted rather than systemically integrated – bypassing the essence of the intervention in accordance with the race accountability framework. This was the case even in the small number of trusts that attempted to link the intervention to senior management performance (Kent Community Health, 2021), although Imperial College Healthcare reflected on how it supported the trust response to the pandemic.

The establishment and proliferation of race equality networks was the most notable feature of planned interventions across the trusts. Traditionally established as support networks run by and for employees largely on a volunteer basis, recently, there has been a surge in more formalised employee networks, which potentially offer spaces to capture lived experiences and experiential knowledge of marginalised groups.

We observed varying discussions on the role of networks in shaping some of the planned activities and agendas in trusts to help improve the lived experience of ethnic minority staff. In many cases, these conversations were still emergent despite WRES reporting practices being in place since 2015. In some instances, the establishment of a network was presented by some

as an action as if the mere set-up would in and of itself, like the reverse mentoring initiative, disrupt deep-seated biases.

Where trusts saw networks as spaces for ethnic minority voice, they often served as safe spaces for colleagues to share experiences in, which while invaluable, distanced and potentially excused organisations from learning from and responding to experiential knowledge to ultimately address discrimination:

> "Promote REACH Network Drop-in Service to create safe space for Network members to share feedback on activities or raise cultural issues/concerns to a respective Co-Chair…in confidence. Provide support to those who need it." (Northampton General, 2021, p.2)

Indeed, networks as sources of experiential knowledge transpired only occasionally:

> "[…] empowering our BME colleagues to use their voices through the network, sharing their lived experiences to educate and to improve outcomes for BME colleagues, all staff and patients…" (Torbay and South Devon, 2021, p.11)

As with reverse mentoring schemes, however, no concrete actions flowed from such interactions. Conversely, at Torbay and South Devon, the idea of lived experience - *"have a voice that counts"* (2021, p.24) - was narrowly advanced in terms of a voice in diverse recruitment panels to inform interview outcomes, eschewing the entire notion of learning and understanding to inform redress. Similarly, Cumbria, Northumberland, Tyne and Wear (2019) used ethnic minority voices to understand and remedy the barriers these colleagues faced with the intention to meet preconceived ideas of 'whiteness' (Leonardo, 2002):

> "… we need to establish how BAME staff can break through barriers that may exist to ensure that **staff are capable of applying for and securing** Band 8 and above jobs." (p.7, emphasis added)

Whilst here the 'lived experience' is drawn upon to inform change in accordance with our notion of race accountability, the way in which it is mobilised is in contradistinction to structural disadvantages ethnic minority people experience. Finally, networks and employee voice served to assist trusts to (co-)generate new ideas and initiatives for improvements; and/or monitored trusts' planned activities:

> "Utilise the BAME Staff Network to identify actions to improve this metric [I8]." (Portsmouth Hospitals University, 2019, p. 4)

Reliance on networks for key responsibilities may result in organisations leaning disproportionately on marginalised groups (Nance-Nash, 2020) to do the work of antiracism (Liu *et al.*, 2021) especially when network leaders juggle their roles with their existing responsibilities (BMA, 2022) and have limited scope to disrupt systems and structures that undergird discrimination.

Overall, while many trusts gave their workforce a voice, how this voice materialised and was 'utilised' appeared tangential to organisational learning to inform responsiveness. There was, as yet, limited evidence of efforts to reflect on colleagues' experiential knowledge to guide remedial action, although trusts created the infrastructure to capture such detail.

6.4 Towards a speculative accountability: formulating action plans

With the WRES constituting a regime of speculative accountability in which trusts remedy metric-driven issues of racial discrimination, the planned actions were expected to be responsive to, that is correspond with, the trust-specific data. However, in practice, we

observed that while some trusts (e.g. East Sussex Healthcare, 2019, 2020) had simply not published any action plans, in other cases, action plans were at times developed independently of, and became unaligned to, the individual trusts' indicator metrics. As a result, not only were the suggested actions generic and vague, but trusts also failed to address metrics with poor outcomes. Oxford Health, for example, despite significantly fluctuating results for I3 did not endeavour to address issues of differential disciplinary outcomes for their ethnic minority staff relative to their white counterparts, limiting the scope of speculative accountability.

Alongside the lack of alignment between actions and indicator performance, we also observed much repetition in actions put forward over our three-year analysis. For example, in the case of Torbay and South Devon, several actions were reiterated over the course of the three years but were presented as 'new' actions each year. Similarly, Blackpool replicated its 2020 action plan in 2021 with the occasional update of figures. This mere reproduction of actions with little evidence of reflection and evaluation of interventions and the metrics data over time is symptomatic of an instrumental approach to developing the action plans rather than one rooted in a responsive form of accountability, questioning in turn trusts' efforts towards speculative accountability.

Furthermore, a significant proportion of trusts co-prepared their WRES reports with their Workforce Disability Equality Standard (WDES) reports, an exercise akin to the WRES, with a focus on employees with disabilities in NHSE. Although some of these trusts prepared clear separate sections for their WRES and WDES data and corresponding action plans, for others this combined approach resulted in a single action plan that diluted trusts' responses to inequalities based on race (or disability). For example, while Medway (2021)'s joint high-level action plan resulted in generic actions that lacked bespoke applicability to its race data, at York and Scarborough (2021), some actions were oriented towards their WDES objectives:

> "Ensure fairness in interviews through the introduction of a 'fulfil or explain' system on interview outcomes (WRES & WDES), and achieving Disability Confident Level 1 (Committed) status." (Medway, 2021, p.1)

> "Reduce level of presenteeism experienced by BAME and disabled groups of staff." (York and Scarborough, 2021, p.4)

In the latter instance, not only is the action not relevant for the Trust's ethnic minority employees – contravening the notion of speculative accountability, but the failure of the organisation to reflect on this imagined action for this group is suggestive of a superficial approach and a lack of understanding of pertinent race relevant issues.

However, there were some notable exceptions where trusts not only linked the actions to specific indicators (e.g., University Hospitals Bristol and Weston, 2021, singled out their worst-performing indicators to prioritise actions), but also shared information regarding timescales, ongoing progress, and the responsible leads per action, enabling progress to be monitored (i.e., East Lancashire, 2019 & 2020; St Helens and Knowsley, 2019 & 2020).

The three sub-sections below present the findings for the final but iterative stage of race accountability – interventions that organisations planned in response to matters of concern. Following our CRT-informed approach, trusts' actions here were analysed with reference to efforts to challenge white privilege and disrupt structural racism and similarly the accountability process more widely, for evidence of practices of interest convergence.

6.5 Responsive accountability: tackling systemic privilege or "fixing" race?

Race accountability should seek to challenge taken-for-granted assumptions that belie race neutrality within organisations and institutions and respond to manifestations such as white

privilege (Panel B) (Lawrence and Hylton, 2022). Indeed, one principal concern for NHSE is the polarisation of its workforce including representation of ethnic minorities at the different pay bands including the board level; and less favourable outcomes for ethnic minority colleagues' interview processes, disciplinary proceedings and career progression than their white counterparts. Such outcomes are indicative of white privilege, yet the sample trusts failed to reflect on this notion overtly or covertly when discussing their data and developing subsequent remedial actions. Instead, most trust interventions included an array of increasingly common diversity initiatives such as training, coaching and mentoring activities specifically targeting ethnic minorities to equip them with the skills and leadership traits needed for progression. Often labelled as positive actions, such interventions sought to:

> "…offer development opportunities such as Interview skills, CV & Application completion skills and coaching as a blended offer…" (Midlands Partnership, 2020, p.2)

> "Introduce a BAME leadership Programme, with the aim to provide employees with insights, tools and techniques **to take charge of their careers and develop their confidence in navigating their career path**." (Coventry and Warwickshire Partnership, 2019, p.4, emphasis added)

Remedial actions tended to focus on efforts directed at 'fixing' ethnic minorities to help them develop winning behaviours. But these measures often overlook endemic racial biases that reside in institutional structures and so address them as shortcomings of ethnic minorities rather than reflecting on the root causes. This approach, however, presupposes a 'neutral' meritocratic ideology regarding 'success' pathways, thus eschewing the inbuilt systemic biases that can affect the careers of ethnic minority groups and also exhibits a lack of reflexivity by the trusts in planning interventions (Lawrence and Hylton, 2022).

Coventry and Warwickshire Partnership's (2019) intention to help ethnic minority colleagues *"take charge of their careers"* (p.4) and Royal Berkshire's workshop to develop *"participants' attitude, knowledge and skills, enabling them to: communicate in a range of professional settings; compete effectively for jobs"* (2020, p.6) both testify to the denigration ethnic minorities are subjected to and reinforce the privilege and power differentials between them and their white counterparts. Importantly, these practices occurred despite NHSE's recent guidelines on racial equality (2019a) cautioning against overly focusing on 'deficit' practice.

Some trusts sought to improve equity of opportunity in career progression by formalising recruitment to secondments to minimise informal, networking-based secondments that can favour white employees. By so doing, however, they overlooked the impact of bias in recruitment that has plagued NHSE and indeed as evidenced by trusts' (e.g. Royal Berkshire, 2020) performance for I2 (see also Section 6.6). Efforts towards race accountability to improve fairness may, therefore, not yield the desired benefits as underlying assumptions remain unchallenged.

Our analysis also highlighted trust endeavours to redress a lack of racial representation at the senior level and champion race equity by appointing diverse non-executive directors (NEDs) (Midlands Partnership, 2019). However, as Abebe and Dadanlar (2021) argue, whilst ethnic minority NEDs may strongly advocate for inclusive practices, they likely lack the resources and/or power to implement such policies. Hence, this potential 'quick fix' underplays the systemic change needed from a thorough review of career progression pathways and, in turn, undermines a deeper sense of responsibility and responsiveness to ethnic minorities.

Yet, again, amidst the largely unreflexive practices to 'develop' ethnic minority staff, a small number of trusts engaged in more meaningful suggestions, including endeavouring to gain a deeper understanding of the reasons for disparities (Midlands Partnership, 2021) and *co-*

designing 'solutions' with the ethnic minority network based on more interactive and insightful conversations about race (Bolton, 2020). Similarly, East Lancashire highlighted the limitations of training courses as a panacea to fostering greater inclusion:

> "ELHT should avoid a reliance on sending staff away on courses as the sole or primary means of encouraging more BME staff development. Such courses can be invaluable but there is growing evidence that the key to staff development is whether such courses are complemented by opportunities for "stretch assignments" such as acting up, secondment, involvement in project teams or developing pilots." (2020, pp.4-5)

Here, the Trust called for greater action than merely passing responsibility onto individuals, recognising that training without significant institutional response is insufficient for redressing systemic leadership imbalances.

Overall, there was limited evidence of trust actions to challenge an important feature of CRT-infused race accountability – white privilege. Paradoxically, efforts focused extensively on 'fixing' race, reinforcing privilege and power differentials between ethnic minorities and their white counterparts. Even when there was such recognition, interventions naively overlooked systemic, structural issues in practices such as recruitment, to which we now turn.

6.6 Responsive accountability: disrupting structural racism?

Race accountability calls on organisations to reflect on and challenge the underlying structures that reproduce privilege and marginalise minority communities. Since these systemic practices underpin and reproduce discriminatory behaviours, organisational efforts to dismantle these barriers are critical to redressing longstanding issues. Notable persistent challenges for NHS trusts around recruitment, disciplinary processes, career progression opportunities and issues of bullying and harassment are key structural priorities identified in WRES indicators and responded to in action plans.

A. *Recruitment and selection*

To address racial inequalities in recruitment, suggested actions typically included (a combination of) EDI and unconscious bias training for recruiting managers; diverse interview panels; and values-based recruitment:

> "Overhaul recruitment and promotion practices to ensure staffing reflects the diversity of the community as well as regional and national labour markets. [Planned actions]: Panel for posts 8b and above including at least one appropriately trained BAME staff member; Mandatory D&I training for recruiting managers within six months of employment; … [and] values-based recruitment embedded…" (West Hertfordshire, 2020, p.17)

The language of "overhaul" of recruitment processes is also deployed by Mid Yorkshire (2020, 2021) and Dudley Integrated Health and Care (2021), without specifying what this might entail. Managerial training and diversity on interview panels were also frequently cited as remedial actions across our sample trusts (West Hertfordshire, 2020; Whittington Health, 2021, and Mid Yorkshire, 2020). These mechanisms are intended to disrupt interviewer bias and potential nepotism in recruitment processes. Further, values-based recruitment that entailed inclusion of EDI-related questions at interviews was described as a *"non-traditional interview process"* that sought to *"meet diverse needs"* (Derbyshire Healthcare, 2020, p.5).

However, given the lack of specificity regarding how these practices were to be enacted, they came across more as generic EDI initiatives than those addressing race-specific (intersectional) issues. Moreover, prior research offers little support that stand-alone diversity training affects change. It is argued that it may indeed even have a converse effect (Ely and

Thomas, 2020). Similarly, evidence on the role of diverse panels used for senior roles (typically Band 8a/8b and above) is mixed (Yang and Liu, 2021). A further critical issue is that this approach was not applied when recruiting nursing and medical staff who face amongst the most discriminatory challenges (BMA, 2022; McIlroy and Maynard, 2021). Nurses are typically recruited at Band 5 and progress to Bands 6 and 7, whilst medical professionals do not follow the traditional banding system that trusts apply this practice to. Furthermore, values-based recruitment does not fundamentally change the recruitment process as implied by Derbyshire Healthcare. Not only does this approach simplify the notion of structural discrimination by suggesting an erroneous link between EDI-related interview questions for candidates and successful ethnic minority interview outcomes, but it also begs the question of white interview panellists demanding EDI views from those who experience discrimination.

A small number of organisations outlined actions to hold recruiting managers accountable for their recruitment decisions (Cumbria, Northumberland, Tyne and Wear, 2021), by having the Director of Workforce personally check shortlists, panel representation and recruitment outcomes for senior-level appointments and seeking explanations for non-appointment (Whittington Health, 2019-2021). Whilst there is supporting evidence for such practice (see Castilla, 2015), this process again did not apply to nursing and medical staff recruitment. Apart from one trust that adjusted its recruitment criteria to cater for the limited opportunities and experiences of ethnic minority candidates, organisations largely failed to incorporate CRT's interrogation of the use of white majoritarian experiences as criteria against which to assess ethnic minority success.

B. *Disciplinary processes*

Disciplinary actions and possible further repercussions for ethnic minority staff are a significant concern in NHSE, in part, because of the persistent discrepancies in the number of disciplinaries between ethnic minorities and white staff, but also because it links race to professional incompetence. Trusts engaged in limited activities to address such inequity, for example, by simply emphasising their policies around disciplinary action (Royal Brompton & Harefield, 2020; Imperial College Healthcare, 2020). Two noteworthy interventions included the cultural ambassador programme and practice of a 'just culture'. The former, developed by the RCN, entails training ambassadors participating in disciplinary hearings to ensure that conscious or unconscious cultural biases do not influence process outcomes (2020). Despite NHSE (2019a) endorsing this programme as part of its 'fair experience for all' document, only a small number of organisations adopted it, and there was variation in practice. For example, whilst some extended this approach to also include informal investigations, such as grievances to encourage more equitable outcomes, others only partially drew on it in the final stages of formal investigations.

In 2018, NHSE introduced a practice of 'just culture' to encourage an organisational environment characterised by learning from serious incidents that threatened patient safety; openness; and support. The intention was to encourage staff to speak up without fearing retribution so that lessons could be learnt. This intervention was more popular than the RCN's cultural ambassador programme, in the trusts' race action plans. Seen to significantly reduce the number of disciplinaries and grievances, Mid Yorkshire (2019) explained of the practice:

> "Whilst … a positive for all staff, the Trust expect [sic] that it will lead to equalisation of the proportion of BAME and White staff who do enter formal processes." (Mid Yorkshire, 2019, p.7)

Although a potentially positive development, the expectation here assumes that ethnic minorities are subjected to formalised processes for poor conduct in accordance with the deficit model, overlooking the discriminatory undertones that influence such outcomes. Very few organisations, such as University Hospitals Bristol and Weston and Mid Yorkshire,

suggested plans to tailor their programmes to specifically address the position of their ethnic minority colleagues.

C. *Cultural change*

To quash bullying and harassment, key interventions comprised reviews and dissemination of dignity and respect policies and frameworks either as generalised EDI practices or as specific race-related practices, along with the use of Freedom to Speak Up (FTSU) programmes to encourage staff to declare inappropriate and unfair behaviours. Bolton, for example, developed the VOICE Behaviour Framework (2020, 2021) to articulate how staff should display the trust's values in everything they do, whilst Hull University Teaching Hospitals (2020, 2021) launched a 'Zero Tolerance to Racism' campaign. Regardless, we observed what Ahmed (2007) refers to as policies 'do[ing] the doing', insofar as trusts conveyed more details about preparing their initiatives rather than how they would be executed fairly. The mere presence of policies without evidence of planned interventions that showcase genuine efforts towards zero tolerance or inclusive behaviours is unlikely to overcome deep-seated biases.

On the FTSU programme, Francis (2015) developed this intervention to nurture speaking up in the NHSE following an inquiry into a major scandal where a culture of silencing led to major safety concerns for patients, and stresses for staff. Together with training front-facing FTSU guardians who would engage with and support staff in speaking up, Francis called for robust backstage activities that guaranteed efficient inquiries and effective and fair outcomes for all complaints and grievances.

Whilst many trusts explicitly referred to FTSU guardians, including diverse guardian representation to encourage ethnic minority colleagues to speak up, there was limited, if any, reference to backstage activities that supported speaking up. Royal Brompton & Harefield, for example, sought to address the significant levels of bullying and harassment of ethnic minority staff (I6: 34% and 30% for 2019 and 2020, respectively), with an *"education solution for those accused of bullying"* (2019, p.5 and 2020, p.5). The 2019 report (p.2) noted that *"2 staff … completed the training"*.

Unsurprisingly, the few trusts that reviewed participation in FTSU programmes noted limited engagement from ethnic minority employees. Rather than reflecting on this disengagement as a result of the much-publicised fears of retaliation and experiences of 'nothing happens' (BMA, 2020), these trusts naively or conveniently assumed it to be a consequence of lack of awareness and in turn sought to publicise the programmes:

> "… there have been a limited number of reports [on the call it out – sort it out' programme] … further promotion of the scheme [therefore] is currently taking place." (Rotherham Doncaster and South Humber, 2021, p. 8)

Finally, in addition to the ideas of 'fixing' race, a few trusts offered development programmes for ethnic minority colleagues that included training that was directed at enabling attendees to better handle experiences of bullying and discrimination:

> "Our Making It Right initiative has … inspired participants towards career progression. The programme is made up of four one day workshops which are aimed at … enabling them [participants] to ... **feel empowered to conduct themselves constructively when faced with discrimination or conflict at work**." (Royal Berkshire, 2020, p.6, emphasis added)

So, rather than taking institutional responsibility for eliminating a culture of bullying and harassment, this initiative pushes the onus back to employees to 'cope' with discrimination they experience. Again, these perhaps well-intended actions manifest in ways that show

limited understanding of, and may in turn, do little to destabilise the root cause of systemic issues,

Overall, while authentic efforts to responsive race accountability call for dismantling institutional structures and processes that underlie discrimination, trusts appeared to rely on generic NHSE or EDI initiatives with a 'race twist' through references such as anti-racism policies and zero tolerance policies or use of diverse interview panels. There was little reflection into the playout of such schemes in practice – for example how the practice of diverse interview panels would seldom apply to nursing and medical staff. Even in instances when trusts sought to review their programmes, they made naïve assumptions with little reflection around silences from the ethnic minority community. As such, NHSE organisations fell short on disrupting structural and institutional forms of discrimination and, in turn, their race accountability journey.

6.7 WRES actions: responsive race accountability or enabling interest convergence?

Race accountability urges institutions to consciously reflect on efforts to address race inequities to mitigate against actions that serve dual interests rather than primarily focusing on race. Acts of converging interests are an affront to race accountability. While earlier sections analysing trust action plans evaluated efforts towards responsive race accountability to foster justice and fairness, this section considers whether planned interventions were indicative of converging interests rather than specifically race-led actions in and of themselves.

In the WRES I1 & 2 capture, many trusts noted an increase in the overall representation of ethnic minority staff during the three-year period, at the trust level and across specific pay bands. This was often attributable to positive international recruitment of nurses, and to a lesser degree, doctors. Some organisations credited this to trust efforts:

> "Analysis of the data shows that the increase in proportion [of overall BAME] has come … mainly as a result of our hard work and success with our overseas nursing recruitment." (**Deputy Director of Workforce**, Queen Victoria, 2020, p.3, emphasis added)

However, improved outcomes in I1 and 2 are not indicative of consciously motivated efforts to improve representation; rather, international recruitment serves to fill high levels of vacancies in nursing, and, to a lesser degree, medicine. Therefore, targeted recruitment successes such as those exhibited by Queen Victoria are perhaps self-serving – enabling trusts to maintain their level and quality of healthcare provision. Paradoxically, Bond *et al.* (2020) note these are amongst the very staff who experience discrimination throughout their career journey, commencing with building positive relationships to ease their transition into their new environment.

Similar practices were observed apropos career progression. Rotherham Doncaster and South Humber reported bespoke training for ethnic minority staff in 'areas of need'. This indicates a purposive approach rather than inherently moral equity of opportunity:

> "The … teams have been consulting and working closely with the REACH Network … and have conducted a training needs analysis survey to ascertain which areas require more focus, as a result BME colleagues have been approached to take part in the Talent Management program and 1:1 Career Development Coaching sessions…" (Rotherham Doncaster and South Humber, 2021, p.8)

While these individual forms of reporting practices are indicative of converging interests, fundamentally, does the nature of the engagement with the WRES exercise by many trusts

constitute an enactment of interest convergence? We reflect on this question in our discussion.

7. Discussion

NHSE's efforts to respond to longstanding concerns of workforce racial inequalities through the WRES have been motivated by moral intent and a desire to inspire change in a progressive manner. Cascading across all NHSE trusts and affiliated organisations, the standard is, however, mandated upon the organisations, resulting in what we classify as a hybridised initiative of accountability with characteristics of both moral and imposed accountability. Our study sought to critically reflect on the extent to which WRES is fostering racial redress for its ethnic minority workforce by examining its enactment across a sample of trusts. To this end, we coupled Favotto *et al.*'s framework of moral accountability with CRT to envision a model of progressive race accountability through which we analysed trusts' practices including the interplay between disclosing data and developing race-led action plans.

Drawing on CRT in this way allowed us to pivot a focus on racialisation and leverage the framework to advocate for racial equity in an accountability context. With its focus on theory, experiential knowledge, and critical awareness, CRT illuminates and unapologetically challenges undergirding systems of racial power and privilege that perpetuate racial inequities. As a result, it enabled us to elevate Favotto *et al.*'s (2022) morally-oriented progressive framework of accountability to offer a comprehensive and nuanced, race-specific model of accountability with which to examine organisations' practices of redress.

Our findings, between 2019-2021, suggest that trusts enacted WRES in a principally instrumental manner, contradicting the moral imperative that inspired the development of this standard and underlies progressive race accountability. While some trusts occasionally showcased authentic practices and engaged in ethical reflection that resonated with the spirit of WRES - for example, through a more robust analysis of their data, contextualising and creating additional metrics - a predominantly instrumental approach prevailed across all core features of responsive race accountability. We identified numerous issues with how organisations presented and interpreted their metrics data; observed little effort to capture the lived experience of the other to inform planned actions; and there was weak evidence for speculative accountability - planned actions were often disconnected from the trust-specific data. Similarly, in contrast to the ideas of imaginative actions and intentions of continuous improvement central to race accountability, trusts tended to deploy generic EDI initiatives rather than race-specific (intersectional) actions that catered for their nursing and medical staff who face amongst the most discriminatory challenges; rely on 'quick fixes' such as appointing NEDs to improve board representation; and mimetically adopt interventions identified as best practices. Fundamentally, these approaches, which constitute forms of instrumental practice, fail to recognise and address the power and privilege differentials between ethnic minority colleagues and their white colleagues, and the structures, systems and cultures that enable and sustain them. Moreover, and on the contrary, efforts that sought to 'fix' ethnic minority 'deficits' reinforce the very power differentials ethnic minorities experience by depicting them as 'not measuring up'.

The instrumental orientation resonates with prior research into imposed regimes of accountability (Cooper and Lapsley, 2021; Parsa *et al.*, 2018) even though the WRES emerged from a felt accountability, and serves as a progressive guide, a toolkit, to initiate trusts' race agenda. In fact, the instrumental approach persisted despite WRES's fundamental difference from other accountability initiatives through its emphasis on progressive accountability and, in turn, a downplay on metrics and audits. Rather, the very patterns of instrumentality that metrics in accountability initiatives socialise actors into (Everett and Friesen, 2010) including managing impressions of the metrics data, were replicated – here, in the context of what was aspired as speculative and progressive accountability. Such practices

prevailed across trusts and over time despite oversight from CQC to monitor and audit trusts' WRES reports. Tackling entrenched racial inequities is slow, and requires meaningful thought and reflection. In responding to the pressures of engaging with the WRES exercise annually and populating action plans, trusts perhaps end up engaging in superficial and instrumental responses. Equally, trusts', and potentially CQC's, instrumental responses to the obligatory exercise may reflect an engagement with the letter of the WRES rather than the spirit of the initiative. Regardless, the instrumentality signals an absence of a felt responsibility and/or the failure of morally-embedded and progressive initiatives to arouse such responsibility and, in turn, limits the enactment of responsive and speculative (race) accountability to achieve real change. We consider further the notion of felt responsibility in the WRES context.

Scholarship into morally informed accountability focuses on the moral agent - the very notion of felt responsibility is that it is engendered from within and acted upon in agents' professional spaces, including when imposed regimes oppose such felt responsibility (Helle and Roberts, 2024; O'Dwyer and Boomsma, 2015). Here, as aforementioned, the WRES may prompt and guide NHS managers' anti-discrimination endeavours. Racial discrimination is, after all, a complex societal phenomenon that is challenging to address even amongst those committed to the cause. In this capacity, research and practice, including guidance from NHSE, also suggest that engagement from senior management is central to discrimination work (Green, 2005; Suarez, 2018). Senior managers cannot only nurture and direct anti-discrimination work, but active engagement is critical because such work requires an overhaul of systems and structures not to mention organisational cultures. Yet, our research suggests that the WRES exercise appeared to be a siloed activity – often located within HR departments and undertaken by EDI officials. Senior management engagement was restricted to operational interventions such as participation in (reverse) mentoring schemes, with the exception of practices at a small number of trusts including Whittington Health (2021) which had introduced a board-level EDI director role. In fact, boards at only one-third of the trusts in 2019 endorsed their WRES reports as minimally required by the initiative. This deteriorated to only one in five by 2021, not to mention endorsement of the instrumental approaches as witnessed in this paper - sometimes authored by HR directors. While a small number of trusts planned to make inclusivity-related objectives a part of the senior managers' portfolio, details of the operationalisation of such plans were absent. As such, on felt accountability, our findings suggest an absence of ownership for change at senior levels.

Overall, we see from our findings that whilst the development of WRES and its progressive nature are a laudable feat, its enactment is still operating largely at the instrumental level rather than as an inspiring moral race accountability. It is perhaps, therefore, not unexpected that the initiative has achieved little change for its ethnic minority workforce, including by NHSE's own admission (BMA, 2022; Dawson *et al.*, 2019). Aside from the lack of change, WRES has failed to give due consideration to intersectionality in accordance with the race accountability framework. Women are highly represented in NHSE's workforce and while the institution has made notable efforts to address gender equality, WRES has neglected to recognise the distinct experiences of ethnic minority women who make up a significant portion of the medical and nursing workforce–assuming their experiences are the same as those of their male counterparts and white women. Fundamentally, and paradoxically, NHSE risks WRES serving as a tool with which trusts converge interests – an antithesis to race accountability. Instrumental engagement with WRES endorsed by CQC's indicative silence enables trusts to showcase a commitment to racial redress and anti-racism through their annual reporting, all the while maintaining the status quo and continuing to perpetuate dominant interests and privilege and power differentials.

8. Concluding thoughts

Organisational contexts tend to be political with social and structural relations that connect to inequalities, including but not limited to race as seen at NHSE. Efforts towards redress are

complex given the engrained nature and historical roots of such inequities and the positions of power and privilege they wield for some groups over others. Yet, a moral accountability perspective developed by Favotto *et al.*, (2022) offers a responsive and in turn progressive way forward for reform. NHSE's WRES, a bespoke reporting standard developed to tackle longstanding issues of racial discrimination, is indeed a practical example of morally informed progressive accountability although it operates as a hybridised initiative with characteristics of the imposed regime of accountability, too.

Against the backdrop of widespread calls for greater accountability and commitment to addressing systemic race inequities and research into race and accounting, our study examined the enactment of WRES at 40 NHSE trusts through recourse to our conceptualisation of responsive race accountability. In so doing, it makes two principal contributions to the literature. First, to our knowledge, this paper is the first to develop such a conceptualisation – coupling CRT with Favotto *et al.*'s (2022) envisioning of progressive accountability. Through this, not only do we demonstrate the wider appeal of Favotto *et al.*'s model of progressive accountability, but we also contribute to recent interdisciplinary scholarship (e.g. Lawrence and Hylton, 2022) that has sought to mobilise CRT-based research by emphasising the significance of accountability in race discussions. Second, the study makes an empirical contribution to the emergent race research and the extensive research examining diverse accountability initiatives in accounting through its focus on NHSE's WRES and, in particular, its progressive yet hybridised nature that has to date attracted limited attention in accounting. In so doing, it also contributes to the broader literature that explores the complex relationship between the imposed and felt forms of (race) accountability, which is ever more relevant in the public sector where expectations of tackling longstanding inequalities are increasingly evident.

NHSE offers fertile ground for future race research. For example, gaining insights into the role of the CQC and how trusts perceive and approach the WRES exercise and, exploring the voices of the marginalised may shed light into why the instrumental response to race accountability might prevail and, help inform future progress. Moreover, our race accountability framework, we believe, has wide-reaching implications – to examine not only the play-out of race accountability initiatives as seen in this paper but also to inform and analyse individual organisations' efforts to address racial discrimination. Despite the Sewell Report (HMG, 2021) blanketly suggesting that the UK is not an institutionally racist society, racial discrimination is problematic in numerous public sector institutions including higher education and policing where accountability initiatives with a similar ethos to, but with distinct characteristics from, the WRES, including the HE sector's Race Equality Charter and the Police Force's Race Action Plan, have been developed (Advance HE, 2024; Baroness Casey of Blackstock, 2023). Similarly, in the US, in the wake of the murder of George Floyd and the support for the Black Lives Matter movement that ensued, numerous organisations made a commitment to respond to racial discrimination. These developments warrant investigation to progress redress for discrimination.

Finally, our paper draws attention to the complexities and limitations of responses to systemic issues of race discrimination through mechanisms that endeavour to foster a proactive accountability. But without careful consideration and moral reflection on race-specific issues, outcomes may be limited in their emancipatory potential.

Table 1: Nine WRES Indicators

	Workforce indicators
1	% of staff in each banding compared with the % of staff in the overall workforce disaggregated by clinical, non-clinical and medical
2	Relative likelihood of ethnic minority staff being appointed from shortlisting across all posts compared to white staff (ratio)
3	Relative likelihood of ethnic minority staff entering the formal disciplinary process compared to white staff (ratio)
4	Relative likelihood of white staff accessing non-mandatory training and Continuous Professional Development compared to ethnic minority staff (ratio)
	Staff survey indicators
5	% of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months
6	% of staff experiencing harassment, bullying or abuse from staff in the last 12 months
7	% of staff believing that the trust provides equal opportunities for career progression or promotion
8	% of staff having personally experienced discrimination at work from a manager, team leader or other colleagues in the last 12 months
	Board representation indicator
9	% difference between the organisation's board membership and its overall workforce

Source: NHSE (2019b)

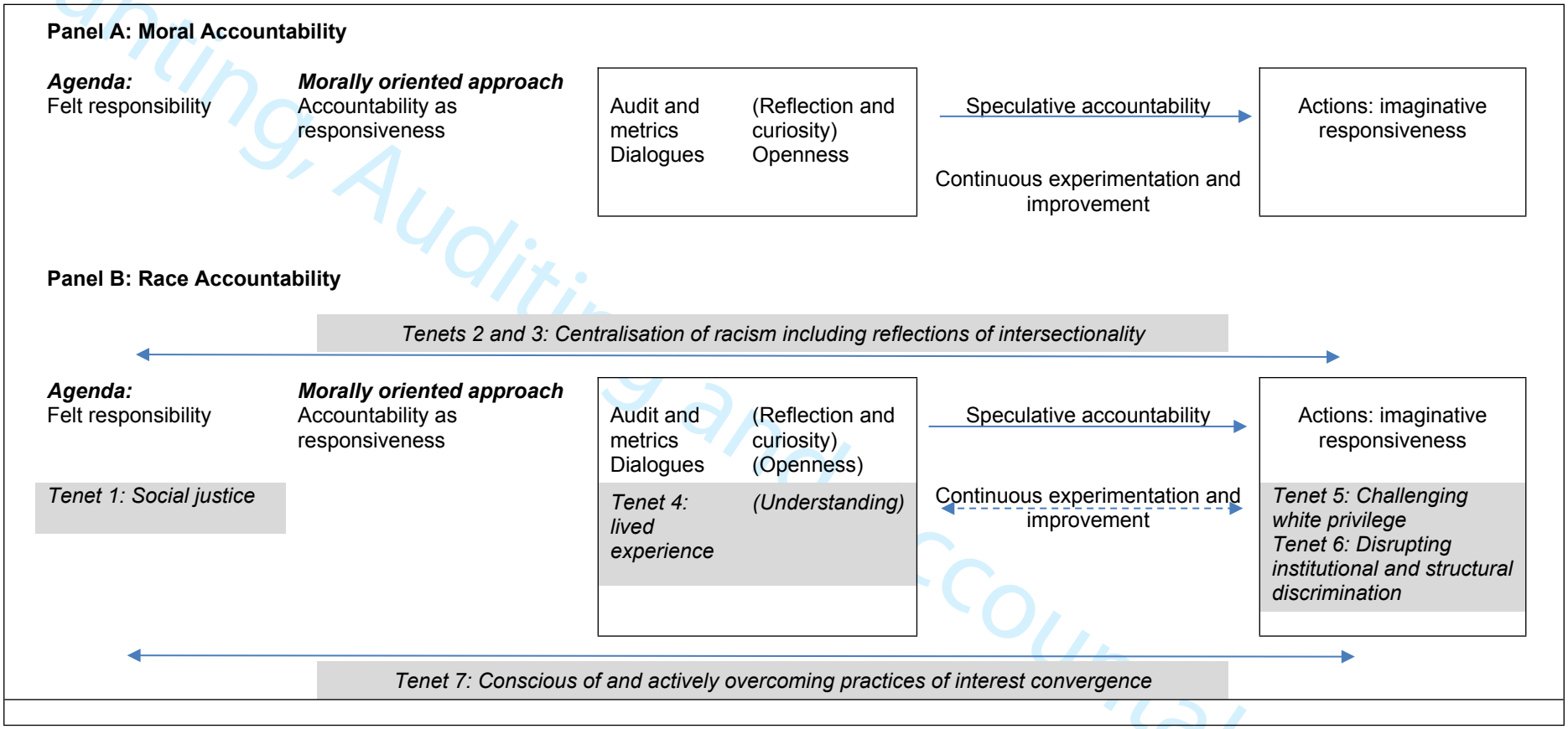
Table 2: Tenets of CRT

Tenet	Description
1: Social justice	Integral to CRT is notion that racialization as a form of domination and ideology contributes significantly to social injustice. Thus, efforts to eliminate racial oppression – calling attention to racism, how it functions, and its underlying bases - are situated in the social justice agenda. Rejects the notion that organisations and societies can have neutral orientation and objectives.
2: Centralisation of race	Acknowledges that racism is ingrained in the fabric of society and race as a social construct invokes hierarchical power through which dominating groups create, maintain and reinforce the notion of race and resulting racial inequalities to serve their own social, economic, and political interests and gain. Given the historical and continued dominance by white people, both white people and ethnic minorities regard and treat white people as superior. Societal acts and behaviours by both white people and ethnic minorities are considered in relation to the 'norm' of mainstream whites, which, in turn, gives rise to the notion of white privilege (see Tenet 5).
3: Intersectionality	Recognises significance of the intersectional nature and impact of structural oppression and subjugation arising from other identity characteristics, such as gender, class, and disability.
4: The lived experience	Advocates the importance of learning from the experiential knowledge of ethnic minorities to understand the inequalities and inequities they experience and centralises these lived experiences as the basis for racial reform. Rejects a majoritarian mindset in which the presuppositions, wisdoms, and shared cultural understandings of persons in the dominant group are drawn on to nurture racial reform.
5: White privilege	Various advantages and privileges materialise for white people - simply from being white. Concept operates much like male privilege with systems and structures operating to deliver advantages to particular groups to the exclusion of others. Rejects white people's discomfort and defensiveness towards the notion of white privilege on the basis that such experiences are not a consequence of their whiteness. Rejects notions of white liberal ideas such as merit and equal opportunity, and colour-blindness that enable a post-racialised world; on the contrary, such concepts continue to advance the interests and entitlement of white people.
6: Racism as institutional and structural	Stresses that racism is not just a personal/individual issue, but rather structural processes and systems continue to marginalise and oppress ethnic minorities. Incidents of racial discrimination should therefore not be deemed isolated events; rather organisations should reflect on structural issues within their policies and practices.

7: Interest Convergence	Reflects on the seemingly supportive actions for racial justice that are pursued only when they further the interests of white communities – actions are enacted when interests of black and white communities converge. Actions and policies may be partial or even retracted when the interest convergence has subsided, thus ensuring that white people's positions are neither challenged nor threatened.

Sources: Bell (1995); McIntosh (1989)

Figure 1: Race Accountability Framework



Note: In mobilising race accountability (Panel B), this paper integrates the tenets of CRT - depicted as shaded aspects - with Favotto *et al.*'s (2022) framework (with adaptation from O'Leary *et al.* (2023) of moral accountability (Panel A).

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Notes

[1] Per the Commission on Race and Ethnic Disparities (2021) recommendation, we avoid using BAME and BME terms in our paper (source: https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities/summary-of-recommendations#recommendation-24-%20%20%20%20%20%20%20%20%20%20disaggregate-the-term-bame). Instead, we employ 'ethnic minorities,' following the UK government's guidance (2021) (source: https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity#:~:text=BAME%20and%20BME,-We%20do%20not&text=In%20March%202021%2C%20the%20Commission,than%20as%20a%20single%20group). However, terms like BAME, BME, BEM are quoted in the findings section to reflect language used by trusts in our sample.

[2] A list of the studied trusts can be provided upon request.

[3] The Freedom of Information Act 2000 provides public access to certain information held by public authorities. Members of the public are entitled to request information from public authorities, whereas the latter are legally obliged to respond to the request https://www.nidirect.gov.uk/articles/freedom-information-and-data-protection#:~:text=Freedom%20of%20information%20(FOI)%20gives,yourself%20under%20data%20protection%20legislation).

[4] The NHS operates a national pay system in which based on their job roles, staff are graded on a banding system (Bands 1 (lowest) -9 (highest)). This system applies to all clinical and non-clinical roles, with the exception of medical professionals and very senior managers who have their own separate scales.