The Involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings

Confronting Inequality: Celebrating Diversity
The Involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings

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A summary of research carried out by the Centre for Inclusion and Diversity, University of Bradford on behalf of NHS Employers and NHS Institute for Innovation and Improvement
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Introduction

It is clearly important that NHS organisations have the ability to apply disciplinary procedures to their staff, usually as a last resort, in order to ensure that staff behave in an appropriate and professional manner. Anecdotal evidence and a growing body of empirical studies indicate that Black Minority Ethnic (BME) doctors are more likely to be referred to the GMC and to be on long-term suspension. Similar problems are known to exist within nursing. Comparatively less is known about the experiences of minority ethnic staff from other occupational groups and in non-clinical posts within the NHS.

In response to concerns raised by human resources managers about this issue, the present study was undertaken between June 2008 and November 2009 to assess the extent of involvement of BME staff in disciplinary procedures within the NHS and to identify good management practice in this area. More specifically, the objectives were to analyse trusts’ disciplinary data to assess whether black and minority ethnic staff were overrepresented in disciplinary procedures, examine reasons for the involvement of BME staff in informal and formal disciplinary proceedings and engage with professional regulatory bodies to examine monitoring systems in relation to disciplinaries. The study also compared literature on the experience of disciplinary proceedings amongst BME staff working in other public sector organisations and identified examples of good practice in relation to fair and transparent disciplinary proceedings.

Method

The study was undertaken in four distinct phases. Firstly, we conducted a web audit of 398 NHS trusts in order to compare the disciplinary rates of BME staff with their white counterparts; secondly, we examined disciplinary policies and practices of NHS trusts through workshops with 11 human resources managers and 9 representatives of health professions regulatory bodies; thirdly, we analysed the experiences and views of 91 staff at five BME staff network events and related forums. Finally, we conducted a literature review to compare the experience of BME staff involvement in disciplinaries within the NHS with those working in other public sector organisations. In addition, we undertook two workshops with 30 service managers to validate the solutions suggested by the research participants to ensure that the recommendations would be relevant and workable by the end users.

Disciplinary data, policies and practices in NHS trusts

Despite the statutory requirement laid down by the Race Relations Amendment Act (2000) to publish annual statistics relating to the number of staff involved in disciplinaries broken down by ethnicity, our web audit revealed only one-fifth (80) of all NHS trusts published recent disciplinary data of this nature that could be included in our study. Analysis of the data showed that overall, BME staff were almost twice as likely to be disciplined in comparison with their white counterparts. In acute, primary care, mental health and learning disability and care trusts, BME staff were significantly overrepresented in disciplinary proceedings. Within the one ambulance trust for which there was valid data the difference between BME staff and their white counterparts was not statistically significant.
The inconsistency with which disciplinary data continues to be collected by some trusts means that we do not possess an overall picture of the involvement of BME staff in disciplinary procedures within the NHS. However, this study has shown that BME staff tend to be disproportionately represented in NHS disciplinaries. There is clearly a great deal more that should be done to provide stronger statistical evidence on this issue. We still do not know whether there are certain ethnic groups who are more likely to be disciplined and we have only identified some of the areas of NHS employment in which BME staff are more likely to be disciplined. At the same time, it is important to consider, based on the evidence we do have, why such imbalances might be occurring. Both the GMC and the NMC are currently conducting research on this topic.

Improved ethnic monitoring of disciplinary data is crucial. Trusts need to develop robust systems for data collection and analysis relating to all aspects of employee relations. This data needs to be broken down by all diversity strands. Comparative benchmarking of NHS trusts’ disciplinary and grievance data should be undertaken to assess performance. In order to better understand the reasons behind disproportionality in relation to black and minority ethnic groups, there is a need to make use of root cause analysis, independent review of cases and post case review, and exit interviews. Where possible this process needs to encourage involvement from BME staff networks, trust board champions of diversity, Trades Unions and professional bodies.

Management practices and competencies

It was generally felt that line managers found it difficult to deal with issues relating to disciplinaries and there were often inconsistencies in the application of disciplinary policies. It was acknowledged that the informal stage of the disciplinary process was critical in sorting out minor issues and that some managers were hindered in this process by a lack of confidence in applying informal strategies with BME staff. It was perceived that managers were more likely to discipline BME staff over insignificant matters and that disciplinary concerns involving staff from minority ethnic backgrounds were not always considered to have been dealt with fairly and equitably by human resources managers. It was agreed that performance issues were not addressed in a timely fashion, often with a lack of effective feedback, performance appraisal, support and monitoring of progress with regard to BME staff. There was also a sense that line managers were incorrectly using a disciplinary policy to address performance issues. Part of the problem, it was perceived, stemmed from some managers not being equipped with the relevant skills and knowledge to be able to manage a diverse workforce and to deal effectively with conflict situations.

It is evident that the disciplinary policy is in need of streamlining and greater clarity achieved regarding the difference between disciplinary, capability and performance issues. It was suggested that NHS Employers could support trusts by providing a toolkit to help managers plan disciplinary procedures and also developing a system for disseminating information arising through lessons learnt from disciplinary cases. At the same time, trusts could develop a toolkit to guide values and behaviours which would underpin their recruitment and development needs.
Organisational culture

While human resources managers felt that their respective trusts were making some progress in addressing equality duties around ‘race’, they were aware that issues of equality were not always adequately considered by line managers in formulating and implementing policies. Human resources managers and BME staff also mentioned the existence of attitudes within their trusts that fostered a culture which could not be easily challenged and which castigated individuals whose behaviour did not conform to accepted organisational norms. In such an organisational climate, ‘race’ was highlighted as a factor that could impact upon decisions made in relation to the disciplining of BME staff, although at the same time it was recognised that discrimination in its more covert forms was not always easy to detect.

Trusts need to develop and define their core values and replicate this process through every part of the organisation. In order to create greater transparency in relation to decision making, managers need to ensure that all processes relating to discipline are impact assessed and action taken. In order to challenge any poor customs and practices within trusts, there is a need to devise innovative educational programmes and activities to raise awareness and engender better understanding of cultural differences at all levels within the organisation. Trusts should also ensure that equality and diversity competencies as outlined in the Knowledge and Skills Framework are used as essential criteria for job selection and performance management and linked to clear accountability, where those lacking the competency are given suitable development opportunities.

Support networks

Exclusion from informal networks meant that BME staff who were involved in disciplinaries were more reliant upon formal structures and sources of support within their respective organisations. Staff did not always know how or where to access appropriate support at a time when they were often traumatised and concerned about the impact that undergoing a disciplinary process would have upon their career, family and social circle. Feelings of isolation were expressed as being particularly acute amongst staff trained overseas. Union representation was characterised by some BME staff as not sufficiently sensitive to their needs. For some BME staff involved in disciplinaries, there was a tendency to downplay their perception of discrimination for fear of losing access to internal support.

The use of competency frameworks needs to be improved to ensure clarity in terms of the behaviours, values and skills expected to be exhibited at all levels within the workplace. Such frameworks could also be used for appraisals and recruitment. Just as patient experience has become a key performance indicator, it was thought that staff experience should count towards a trust’s score and that use of talent management programmes could be an indicator of employee satisfaction and progression within the organisation. There was also a strong consensus that Trades Unions need to work more closely with BME staff and if appropriate other staff representatives should constructively address issues that could lead to disciplinary action at the lowest level of intervention if and when they arise.

Behaviour and attitudes of BME staff members

A number of issues were raised in relation to the conduct of BME staff, some of which related to their position within the organisation and the nature of work they performed. For human resources managers, the higher proportion of BME staff in disciplinaries could be partly explained by the area of work in which they were
employed and its prevailing management culture. It was pointed out that in some areas there was an expectation amongst managers for staff to ‘clock in’ and a lot of disciplinaries in these areas of work had arisen as a result of timekeeping issues.

For a number of regulators, issues arising from different styles of communication amongst staff for whom English was not their first language were a significant factor. It was felt that the different ways in which individuals expressed themselves could easily be open to negative interpretation by their colleagues, line managers and patients and if left unchecked, could have serious consequences for the individual. It was felt that sufficient attention was not always given to transmitting the ethos and values of the NHS to new members of staff, as well as the organisational culture of the NHS in which staff were expected to work. This was thought to be disadvantageous for staff recruited from other countries who may previously have been trained differently and accustomed to different working styles. There was also speculation that amongst BME staff working in lower pay bandings, there might be less commitment to the organisation and lack of appreciation of the implications of not performing to an expected standard. Furthermore it was thought that BME staff working in posts without access to a computer might not be aware of the existence of a disciplinary policy. Staff working in higher bandings, particularly in nursing, were recorded in some trusts as being disciplined as a result of complaints made by patients and it was thought that such complaints might have arisen as a result of the differential training of nursing staff recruited from other countries.

A number of suggestions were forwarded to improve the transition for new staff joining the NHS. It was felt important that trusts set up personalised induction programmes in the first six months of employment to meet the needs of individuals recruited from overseas, which should include the provision of information about local cultures, customs and practices. Indeed, better communication of organisational policies and procedures for all new members of staff was recommended. Staff with limited fluency in conversational English should be made aware of opportunities to learn English locally and access should be provided for anyone who is going to be subject to a disciplinary process to individuals with an understanding of the process/counselling service, particularly at the informal stage. Advocacy may also be a useful option to consider.

**BME staff, disciplinaries and the public sector**

The extent of BME staff involvement within NHS disciplinaries resonates with their experience in other public sector organisations, most notably within the police service and local government. Reasons for the disproportional representation of BME staff in these sectors appear to be similar to those identified in the NHS and relate to a tendency amongst managers to formalise the disciplinary process too quickly, the presence of discriminatory attitudes, lack of clarity concerning disciplinary policies and a failure to train staff appropriately. Strategies that have been put in place to address this issue include the introduction of reverse mentoring, access to mediation, clearer performance appraisal systems, simplification of the disciplinary policy and improved training around equality and diversity issues.
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