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Black and Minority Ethnic: Disproportionality in disciplinary proceedings – Recommendations

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Abstract

An in-depth knowledge review and analysis of literature on the involvement of Black and Minority Ethnic (BAME) staff in NHS disciplinary proceedings from 2008 to 2017 as did 15 semi-structured interviews with key stakeholders. The research findings indicate that BME staff are disproportionately represented in NHS disciplinary proceedings, there is a continuation of inappropriate individual disciplinary action and a failure to address organisational shortcomings. Six factors emerged: closed culture and climate; subjective attitudes and behaviour; inconclusive disciplinary data; unfair decision making; poor disciplinary support and disciplinary policy mis-application were all identified as underpinning the disproportionate representation of BME staff in disciplinary procedures. Disciplinary policy needs streamlining and greater clarity needs to be achieved regarding the difference between disciplinary, capability and performance issues and to this respect we make several recommendations.

Introduction

Disciplinary processes are difficult on a personal level, organisational level and in terms of employment relationship. There is a certain level of trust and respect within the employment relationship, and once this is eroded, it may be difficult or even impossible to recover at a later stage. Within any employment and in particular the health sector, it brings to the

forefront matters relating to a practitioner's performance, capability and conduct (Kline, 2013).

In theory all legal frameworks are applied within the framework of fair practice and equitable treatment. In the context of disciplinary processes within the NHS and private health providers with the United Kingdom, this process is defined by just cause, the correct application of procedures, consistently of treatment and following the rules of natural justice. In theory this is the underlying principles which define disciplinary procedure within the NHS and other health providers (Sehmi, 2015). However, this is not always the case in the treatment of Black and Minority Ethnic (BAME) staff in NHS disciplinary proceedings.

Discussion

Archibong and Darr (2010) web audit of 398 NHS trusts compared the disciplinary rates of BME staff with their white counterparts; it examined disciplinary policies and practices of 11 NHS trusts and analysed the experiences and views of 91 staff at five BME staff network events and related forums. The study revealed only one-fifth (80) of all NHS trusts published recent disciplinary data of this nature that could be included in the study. It highlighted that BME healthcare professionals were twice as likely to be disciplined in comparison to their white counterparts in the NHS. BME staff were significantly overrepresented in disciplinary proceedings in acute, primary care, mental health and learning disability and care trusts. The inconsistency with which disciplinary data was collected by some trusts meant that it was difficult to establish an overall picture of the involvement of BME staff in disciplinary procedures within the NHS. For example it was not possible to establish which ethnic groups are more likely to be disciplined or the areas of NHS employment in which BME staff are more likely to be disciplined. This study identified five key causes of the disproportionate number of BME staff involved in NHS disciplinary proceedings: organisational culture, poor management practice, including lack of experience and confidence, poor leadership, including a lack of diversity amongst leaders, poor awareness of equality and diversity, and attitudes and behaviours of staff members.

There were often inconsistencies in the application of disciplinary policies and 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. Managers were also erroneously using disciplinary procedures to deal with performance issues, with a lack of clarity between disciplinary, capability and 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.

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.

BME staff who were involved in disciplinary procedures were more reliant upon formal structures and sources of support within their respective organisations. They 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. For some BME staff involved in disciplinary procedures, there was a tendency to downplay their perception of discrimination for fear of losing access to internal support. 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.

Recommendations

Tackling disproportionate representation of BME Workforce in disciplinary procedures

Disproportionate representation of BME Workforce in NHS disciplinary procedures can be prevented, managed and remedied through identification of contributing factors and application of innovative interventions. Indeed, a number of interventions aimed at reducing disproportionate representation of BME staff in disciplinary procedures emerged during the study. These are presented in three stages: interventions to decrease the likelihood of BME staff entering the formal disciplinary process, actions during the disciplinary hearing and remedial actions after disciplinary hearing has taken place.

Interventions to decrease the likelihood of BME staff entering formal disciplinary process

These interventions have in common the introduction of a "filter" between the raising of a possible concern and the triggering of a formal disciplinary process. These interventions are likely to be effective because they draw on the evidence that significant numbers of staff (including, disproportionately, BME staff) are likely to enter the disciplinary process when such a formal step is neither necessary nor appropriate. Key principles for organisations to consider include creating a culture which enables staff to acknowledge mistakes, enabling timely and effective use of informal strategies for dealing with employee relation issues, enabling appropriate disciplinary policy understanding, interpretation and practice through providing training for managers, and enabling BME and other staff understanding of, and adaptation to required communication and work style.

Actions taken during disciplinary

There are actions to be taken during the disciplinary process which enable coming to a fair, transparent and consistent outcome at the end of disciplinary procedures. These actions also prescribe the support of BME staff during disciplinary procedures through the provision of culturally competent support. Key principles for organisations to consider include having a diverse disciplinary hearing panel, unconscious bias training for managers, enabling staff awareness of and access to strong and reliable disciplinary support networks, enabling effective staff reflection on experience and support during the disciplinary process.

Remedial actions undertaken after disciplinary proceedings

These are actions to be taken at the conclusion of disciplinary proceedings. These actions revolve around ensuring that disciplinary data are visible and transparent, lessons are learnt and evidenced, and quantitative data are corroborated by qualitative data. Key principles for organisations to consider include identification of disciplinary issues and trends, enabling lessons to be learnt and evidencing how these lessons have been embedded into practice as outlined in figures one.

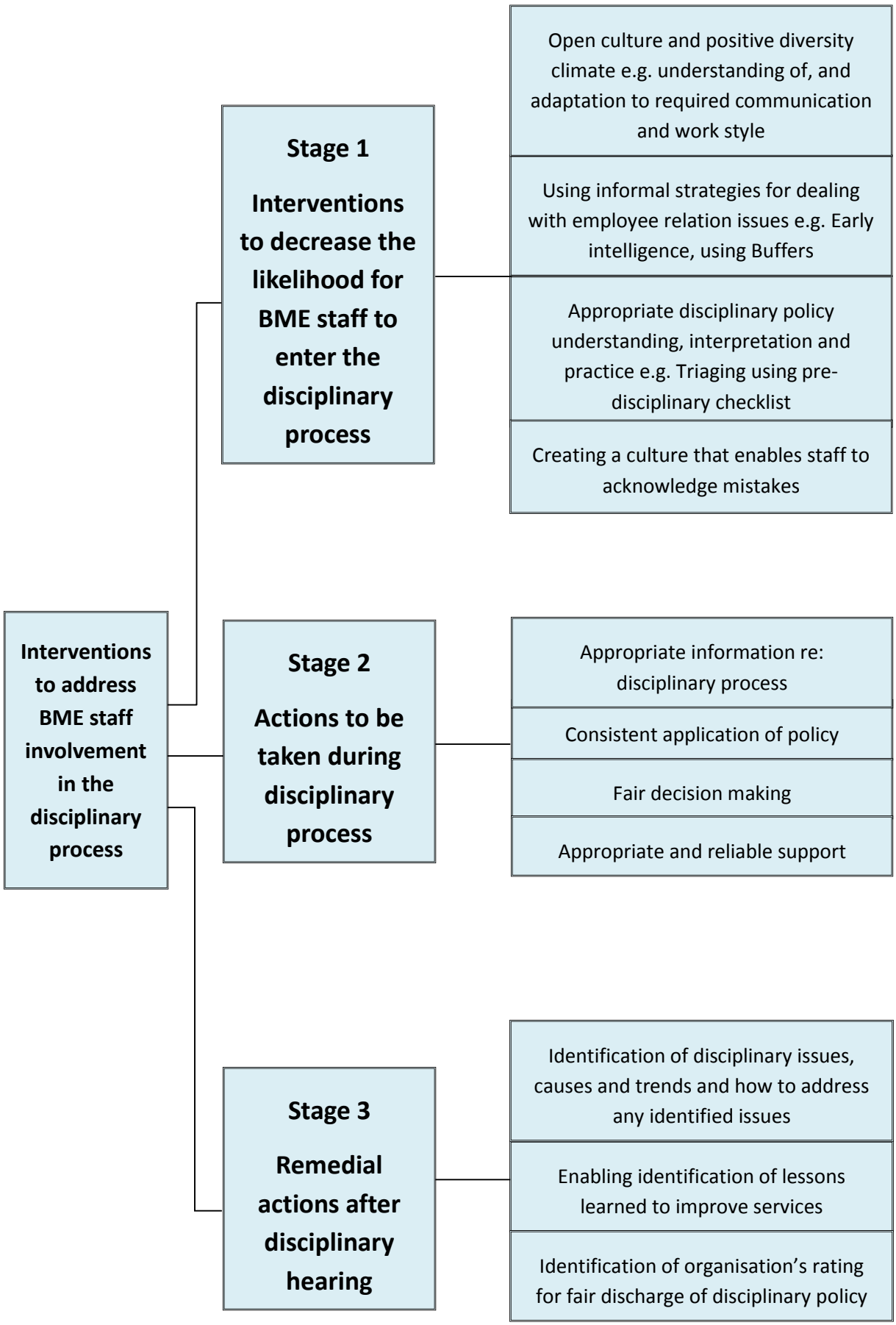

Figure 1: Tackling Disproportionate representation of BME Workforce in disciplinary procedures

Whilst some progress has been made in raising the awareness of the over-representation of BME staff in NHS disciplinary proceedings, progress is slow and the problem persists as evident in the findings from current evidence. Six key factors have been identified as contributing to the over-representation of BME staff in NHS disciplinary proceedings: closed culture and negative diversity climate; subjective attitudes and behaviours; inconclusive disciplinary data; unfair decision making; poor disciplinary support and disciplinary policy mis-application.

By addressing individual issues in a piecemeal way, without consideration of key contributing factors, actions taken are unlikely to be effective in the long term or provide significant and sustainable change. Moreover, it is evident that the disciplinary policy needs streamlining and greater clarity needs to be achieved regarding the difference between disciplinary, capability and performance issues. Whilst sufficient attention was not always given to relaying information on Trusts, the ethos, values and culture to new staff and managers were not always considering race equality issues in formulating and implementing policies. Worryingly, there were reports of inconsistent management practices in relation to disciplinary procedures which reflected a lack of confidence amongst managers in dealing with performance issues relating to staff from ethnic backgrounds different to themselves.

Disciplinary process was characterised by a lack of transparency and accountability with BME staff who were often not fully aware of the implications of the evidence they were expected to prepare which consequently disadvantaged them owing to their unfamiliarity with the process. However, we advocate that interventions to tackle disproportionate representation of NHS BME staff in disciplinary procedures be initiated in three broad stages. This should border on interventions to decrease the likelihood for BME staff to be disproportionately represented in the disciplinary process, actions taken during disciplinary procedures and remedial actions after disciplinary hearing has taken place. In achieving this, we advocate that Social Partners such as Health Regulatory Boards and Trade Unions:

- Work closely with employers and BME staff in acknowledging and promoting better understanding of cultural differences;
- Enable mandatory notification of diverse data and effectively communicate performance standards;

- Recognise that processes of referral are important in addressing risks of discrimination and request explanation from NHS organisations that frequently refer similar unfounded cases.

Employers similarly have a role to play. In particular the onus falls on NHS Trust boards and senior management to ensure that:

- Systems and structures are redesigned underpinned by the ethos of cultural competence;
- Encourage open and authentic dialogue about equality and diversity, promote engagement and dialogue between BME staff networks and Trust boards diversity champions;
- Transparency is evidenced and accountability pursued in using generated data to acknowledge the levels of inappropriate referrals of BME staff into formal disciplinary investigations;
- Streamlining the disciplinary process and developing clarity on the difference between disciplinary, capability issues and performance issues;
- Consider how best to insert a 'filter' and/or decision tree prior to the commencement of disciplinary investigations.

Importantly, we acknowledge that disproportionate representation of BME staff in disciplinary procedures is not an issue with a unidimensional cause and consequently BME staff also have a role to play. Thus, we advocate that BME staff:

- Maintain professional accountability and standards of professional practice as set by the appropriate regulatory body applicable to their profession;
- Undertake relevant learning opportunities for required communication including English and adapting to working styles of the UK work environment;
- Acknowledge mistakes when they happen as well as clearly apologising, providing appropriate explanation of what went wrong and correcting mistakes quickly and effectively;
- Recognise the enormity and impact of disciplinary process and seek support from available support networks;
- Challenge disproportionate use of policies and unfair decisions appropriately; being able to access, query and discuss any unfair decisions made against them with managers and support networks as required.

Conclusions

Within the context of disciplinary action BAME staff are disadvantaged, these recommendations are made to ensure that consistency of treatment is not just considered but applied and that the reliability and fairness of these procedures is reinforced. It is important that the NHS and employers in general consider that we are at all times dealing

with human beings with legitimate expectations, inalienable human and legal rights and with real feelings. All too often the processes are prioritised at the expense and to the detriment of the individual. This is wrong and immoral.

There are differences in treatment, with privileged staff treated differently from others for committing the same misconduct or breach of rule. Health employers legally must try to ensure that they act in a competent manner when dealing with disciplinary cases. When this does not happen, it does not only harm the trust relationship which has been built between the employer and employees but more damagingly it is a corrosive poison which exacerbates the discrimination of black people and ethnic minorities. The actions and decisions of the leadership responsible for effecting disciplinary action should ensure that the application of procedures is fair, reliable, it is this that protect vulnerable and those ill-equipped to engage with these matters. These recommendations are rooted in the common good, we cannot have a commonwealth built without freedom and justice for all.

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