Manuscript title: Disrupting Disproportionality in NHS Disciplinary Proceedings for Better and Inclusive Workplace for BME staff.

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Title: Disrupting Disproportionality in National Health Service (NHS) Disciplinary Proceedings for Better and Inclusive Workplace for Black Minority Ethnic (BME) staff

Abstract

Objectives - The purpose of the study was to investigate the involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings.

Design - The study involved an in-depth knowledge review and analysis of literature on the involvement of BME staff in NHS disciplinary proceedings from 2008 to 2017 and semi-structured interviews with 15 key stakeholders.

Setting - Participants were stakeholders from both primary and secondary care and included Equality and Diversity leads, Human Resource Professionals, NHS Service Managers, Representatives of Trade Unions and Health Professional Regulatory Council Representatives.

Results - The study indicates that to date, BME staff are disproportionately represented in NHS disciplinary proceedings. Evidence gathered points to the continuation of inappropriate individual disciplinary action and failure to address organisational shortcomings. Six factors which included: closed culture and climate; subjective attitudes and behaviour; inconclusive disciplinary data; unfair decision making; poor disciplinary support and disciplinary policy mis-application were identified as underpinning the disproportionate representation of BME staff in disciplinaries.

Introduction

The National Health Service in England (NHS) is the largest employer of Black Minority Ethnic (BME) staff with these individuals comprising 14% of the NHS (Archibong & Darr, 2010). Whilst it is important that the NHS has the powers to apply disciplinary procedures towards ensuring that staff behave in a professional and appropriate manner, the evidence to date indicates that disciplinary procedures are disproportionately applied to BME staff and biased in application (Likupe, Baxter, Jogi & Archibong, 2014), (Seston, Fegan, Hassell & Schafheutle, 2015), (Royal College of Midwives, 2016), (West, Nayar, Taskila and Al-Haboubi), 2017). Staff from BME backgrounds face discrimination during NHS recruitment processes (Kline, 2013), promotion (Esmail, Kalra & Abel, 2007), representation during disciplinary procedures (NHS England, 2017; NHS England, 2019) and bullying within the workplace (Kline & Prabhu, 2015). In addition, as evidenced by a UK report on failings on patient safety and quality of care, there

is a disparity in the treatment of BME staff who report patient safety incidents compared to their non BME colleagues (Francis, 2013).

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 (West, Taskila & Al-Haboubi, 2017). BME staff are still disproportionately represented in NHS disciplinary proceedings, despite the development of the NHS Workforce Race and Equality Standard [NHS England, 2015; 2016; 2017). Whilst this is sobering, it is nonetheless clear that racial biases underpin important personnel decisions with BME employees who are often held to different standards (Bennett, Preece, Farquharson and Bradley, 2016). These negative experiences impact on the wellbeing of BME staff and their ability to deliver care to the standards congruent with the NHS. Moreover, to close the £30 billion funding gap of the NHS by 2020/21 (NHS England, 2014), it is clear that the costs that arise from disproportionate treatment of a section of its workforce is a cost the NHS can ill afford. This underpins the need to situate fairness at the centre of all NHS disciplinary procedures.

This article presents the findings from research commissioned by NHS England Workforce Race and Equality Standard Team (WRES) to inform ongoing actions to ensure that NHS employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The purpose of the study was to examine progress made since an earlier study undertaken in 2008 investigating the involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings (Archibong and Darr, 2010). Independent researchers working closely with the Centre for Inclusion and Diversity at the University of Bradford were engaged from September 2016 to July 2017 to investigate this. In addition, these researchers were tasked with providing examples of changes made by NHS Trusts and

the setting out a guide for good practice. Towards achieving this, the objectives of the study were to:

- identify and analyse previous published and grey research on involvement of BME staff in NHS disciplinary proceedings from 2008 to 2017;
- examine Trusts' disciplinary data to assess whether there are changes in BME staff representation in disciplinary proceedings;
- identify contributing factors for the disproportional representation of BME staff in disciplinary proceedings;
- highlight interventions and examples of good practice in relation to fair and transparent disciplinary proceedings.

Following previous studies which identified disproportionate representation of BME staff in disciplinary proceedings, the WRES was developed in order to enable standardised collection of data across service providers to help deconstruct the problem (Archibong & Darr, 2010). A recent publication of the analysis of the data collected from WRES shows the problem of disproportionate representation of BME staff in disciplinaries still occurs to date (NHS England, 2018). This article responds to this by highlighting interventions and examples of good practice in relation to fair and transparent disciplinary proceedings.

Methodology

The study was guided by strict ethical and diversity competent research principles with sensitivity to the experience of research participants being of paramount importance and cultural competence informing the entire research. A multi-dimensional methodological approach was adopted in addressing the complex, sensitive and potentially contested issues associated with the study. Ethical approval to proceed with the study was not required as the

study was construed and commissioned as an organisational development project. However, appropriate processes were utilised to ensure that ethical principles were followed. Prior to commencing the study, issues congruent with informed consent, anonymity, data protection and confidentiality were addressed.

The study involved two key methods: Firstly, an in-depth knowledge review and analysis of literature on involvement of BME staff in NHS disciplinary proceedings from 2008 to 2017. We chose the knowledge review approach because it provides a thematic, explanatory, exploration of the relevant literature useful in informing a more reflexive policy and practice, when the evidence base is weak or speculative (Sellick and Howell, 2003). The knowledge review involved gathering available evidence and undertaking a broadly narrative review of available published and grey literature. A search strategy was devised to ensure access to as wide a scope of the available literature as possible. Pilot work had alerted to a possible scarcity of literature on this topic therefore no restrictions were placed on the type of literature and no research quality or design criteria were used. Several electronic databases and internet sites were searched. All abstracts of the articles retrieved from the initial extraction process were read carefully and, if deemed relevant, were included. Efforts were made to obtain all relevant studies.

Secondly, a round table discussion and semi-structured interviews with 15 key stakeholders were held. These stakeholders included Equality and Diversity leads, Human Resource Professionals, NHS Service Managers, Representatives of Trade Unions and Health Professional Regulatory Council Representatives. The aim of the roundtable discussions and interviews were to gauge the views and experiences of participants, particularly to explore in detail the reasons for over representation of BME staff in disciplinaries and how issues arising from disciplinaries in relation to BME staff were being managed on personal and

organisational levels. Participants were also encouraged to identify and share examples of good practice. The interview guide for this part of the study was drawn from the findings of the Knowledge Review.

Findings and discussion

The relative likelihood of BME staff entering the formal disciplinary process compared to white staff is 1.24 across all NHS trusts in 2018, a reduction from 1.37 in 2017 (NHS England, 2018). Whilst BME staff were 1.2 to 2 times more likely to enter the formal disciplinary process in 162 [70%] NHS trusts, the relative likelihood of BME staff entering the formal disciplinary process was higher than 2.1 to 3.0 in 39 [16.9%] trusts and higher than 3.0. in 20 [8.7%] trusts. The Knowledge review revealed disproportionate involvement of BME staff across all disciplines [Seston et. al., 2015; Sprinks, 2014; RCM, 2016; West et. al., 2017). Six key factors at both individual and organisational levels were uncovered as contributing to over-representation of BME staff in NHS disciplinary proceedings:

'Closed culture'

It was uncovered that BME staff were likely to get involved in disciplinaries as a consequence of being closed to the culture of the organisation. There were reports of attitudes within trusts that fostered a culture that could not be easily challenged and which castigated individuals whose behaviour did not conform to accepted organisational norms. Such organisational culture and climate does not foster an environment that enables quality care delivery and cost savings that the NHS clearly needs. Such culture breeds race and cultural conflicts causing silent workplace oppression with consequent invisible wounding to workers (Alleyne, 2004), (Alleyne, 2005). This culture along with its values and climate has been referred as 'closed'. This culture creates a climate where bullying and harassment is not sufficiently challenged

and where disproportionate representation of the BME workforce in disciplinaries is not easily detected:

> *"Where a BME member of staff or BME members of staff were getting disciplined and in fact a lot of similar activities were going on but were being dealt with in an informal way and from a HR point of view it was very difficult to address."*
>
> *HR Manager*

Moreover, it was uncovered that sufficient attention was not always given to transferring ethos, values and information on culture to new staff, and equality issues such as 'race' were not adequately considered by managers in formulating and implementing policies. This further constrains a positive diversity climate and mitigates against acquiring the knowledge base for both BME and managerial staff to successfully challenge closed culture in a climate of diversity:

> *"There's this culture where things are being said and it's being accepted within that environment and nobody puts a stop to it. How are we going to overcome this situation? You can understand it from staff's point of view"*
>
> *HR Manager*

This speaks for the need to explicitly identify triggers of closed culture such as cultural conflicts and misfit of organisational values and vision with personal norms. Importantly, once these triggers are identified, solutions for addressing them must be implemented, underpinned by the reality of each organisation.

Subjective attitudes and behaviour

It was uncovered that where BME staff attitudes and behaviours did not conform to accepted norms, these individuals were most likely to be involved in disciplinaries even when these attitudes or behaviours did not reflect a breach in performance standards (Sehmi, 2015). However and worryingly, BME staff were not always prior to disciplinaries, given the opportunity through training or informal mentoring to understand expected behaviour. Participants also reported a lack of understanding of cultural differences and a lack of BME staff in senior positions to challenge stereotypes and offer support to junior colleagues. Participants maintain that managers misinterpret behaviours of staff from different backgrounds and do not seek clarification from BME staff as a consequence for a lack of cultural competence and the discomfort which stems therefrom:

> *"I think one of the key things from my experience is attitudes and perspectives on assertiveness and aggressive ... I'm quite a vocal person and I will speak my mind. If I feel something is not right I will say, and it can be taken that I'm being aggressive but to me, I'm being assertive. I've actually asked or voiced my opinion on something and I think that's cropped up time and time again and that is something that is the springboard so to speak that actually widens the net to … disciplinary actions because they are deemed as aggressive."*
>
> *African Nurse*

It is clear that a factor fuelling the disproportionate representation of BME staff in disciplinaries is a lack of cultural competence in senior staff (Archibong and Darr, 2010). This makes the case for all NHS managers to be culturally competent. Acquiring such competence should be made a perquisite for progressing into management positions.

Inconclusive disciplinary data

Data available on disciplinary actions are inconclusive due to data not being consistently recorded across NHS organisations. Without sufficient data to identify the causes of disciplinary actions, it becomes impossible to monitor and support managers and other decision makers involved in the process:

> *"Information [about disciplinaries] is power otherwise you have to go with what the managers say."*
>
> *Equality and Diversity Lead*

Disciplinary data information required for monitoring of disproportionate representation of the BME workforce does not only stop with data on the disciplinary process captured from trusts, it includes information on the disciplinary process undertaken by regulators such as the GMC and NMC (Sehmi, 2015). However, participants maintain that an associated problem with disciplinary data as evidenced in the NHS is the unfocused use of such data, *"It's not that the data is not there, it's learning how to use it, apply it and the value of it"* (HR Manager).

Similarly, participants maintain that BME staff are unwittingly subjected to disciplinaries as a result of a lack of desire to ascertain relevant information and uncover the salient issues underpinning emerging disciplinary data, "*"We should take the opportunity to drill down from the data to find out the causes, and underlying issues. We need to recognise that although time to drill down is a real issue it could save us time in the long run. It could also save us money"* (HR Manager).

Since the seminal study conducted by Archibong & Darr (2010), there has been the introduction of WRES which now enables NHS organisations to collect standardised data across Trusts. The analysis of data from WRES 2015, has been a great step forward as it allows

comparative benchmarking of NHS Trusts' disciplinary data. The data for 2015, 2016 and 2017 shows that there is still disproportionate representation of the BME workforce in disciplinary actions to date. This reinforces the need to better understand the reasons behind disproportionality in disciplinaries in relation to black and minority ethnic groups.

Unfair decision making

Participants implicated unfair decision making towards the BME workforce at different levels of the disciplinary process and interestingly related this unfair process to a lack of BME senior managers being involved with the process, "*Experience demonstrates a tendency to show more leniency towards people of a similar ethnicity to the manager which has resulted in BME staff being treated unfairly!"* (Equality and Diversity Lead).

In addition, participants also implicated a lack of understanding of the benchmarks for entering formal disciplinaries and implicated this as a factor influencing unfair decision making which adversely affects BME staff, "*there is need to have corridor conversations with BME staff more often than having formal meetings and taking notes … this can be daunting!"* (HR Manager).

There were also report of instances where staff from minority ethnic groups were subjected to unnecessary close supervision from managers unfairly:

> *"…there was a black male nurse who perceived that he was treated unfairly but his white counterparts perceived that he was treated fairly… For this black male nurse, any time he was late for work the manager wanted to sit down and have a formal discussion about his lateness but if any of his colleagues [who were also the manager's friends] turned up late the discussion was always informal – something like come on now… need to try to get in early next time… When the manager in this incident was*

asked why she treated the black man in the way she did, she said she didn't want to be accused of anything! She said she was protecting herself; I think there is a culture [not just about race] where there is in-circle and out-circle"

HR Manager

From the evidence collated, it is clear that unfair decision making leads to higher representation of BME staff in disciplinaries in comparison to their white counterparts. Similar to the experiences of participants in Likupe and Archibong (Likupe and Archibong, 2013), it may seem on face value that a simple difference in culture is at work. Whilst this is not contested, it is nonetheless important that the root causes of this unfair decision making be identified and addressed.

Poor disciplinary support and discipline policy misapplication

Poor support in the workplace for BME staff who face disciplinary action is a factor which contributes to the disproportionate representation of the BME workforce in disciplinary proceedings (Archibong and Darr, 2010). For example, some BME staff are only comfortable discussing disciplinary issues with their peers, most often in a comfortable language, but this could be seen as inappropriate:

"There were some cases where we got emails from employers and from a nurse saying that she had been banned from speaking Polish in the workplace. It was all again down to the fact that one of the reasons she was speaking Polish was because it was part of her support network to sit in her break with her friends. Now if she was denied that, she was being denied her support network that her white British colleagues had while they sat round and had a cup of tea and could talk about things."

BME staff

Participant narratives also indicate that BME staff may not be aware of the gravity of disciplinary processes and how to conduct themselves in disciplinary proceedings, *"BME employees don't understand the enormity of the outcome of a disciplinary matter. So they tell themselves, 'I could go in there and handle this matter. I can talk for myself because I'm going to talk the truth.' ……. not knowing that it's not as straightforward as just going….."* (Union representative).

In relation to discipline policy misapplication, participants were unanimous in agreement that disciplinary policies were not properly applied, and worryingly, applied in the first instance to BME staff where an informal approach would be appropriate, "*Disciplinary process is there for a reason; but we have resorted to formal process where a more informal/forgiving/developmental approach would have been appropriate"* (HR Manager).

Furthermore, participants reiterated 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:

> *At individual level, you can justify why each of them needed to be cautioned but the question underneath the assessment was why is it that only BME staff got to the point of facing disciplinary? The emphasis was for us to do something different… to say we need to do something informal / challenge the process that produces over-representation of BME staff."*
>
> *HR Manager*

Several triggers such as the arbitrary application of rules and a lack of culturally competent qualified managers have been identified as root causes for the poor disciplinary support and discipline policy misapplication associated with BME staff disciplinaries. Whilst these triggers

are not new and have consistently been evidenced in the literature (e.g. Sehmi, 2015), the bone of contention appears to be the reactiveness of practice to these triggers. This underpins the need for clear disciplinary policies advocating for informal resolution as a first step in disciplinaries and the need to ensure that NHS staff, irrespective of grade, are culturally competent.

Conclusion

It is evident that disciplinary policy needs streamlining and greater clarity needs to be achieved regarding the difference between disciplinary, capability and performance issues. Consequently, we advocate that interventions to tackle disproportionate representation of NHS BME staff in disciplinaries be initiated in three broad stages bordering on interventions to decrease the likelihood of BME staff to be disproportionately represented in the disciplinary process, actions taken during disciplinaries and remedial actions after disciplinary hearing has taken place. The recommendations will be discussed in the follow up article.

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