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

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

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March 2010

ISBN 9978 185143 264 6

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ACKNOWLEDGEMENTS

This study was undertaken with the support and guidance of a large number of organisations and individuals. We are indebted to members of NHS Employers Equality and Diversity Core Reference Group whose initial concern about the involvement of BME staff in disciplinary proceedings led us to conduct this piece of research.

Once underway, the study was guided by members of the Disciplinary Research Advisory Group with useful insights and assistance given by members of the main Trades Unions – RCN, RCM, UNISON and Unite/CPHVA. The process of data collection was assisted greatly by a team of facilitators - Dr Neslyn Watson-Druee, Bijal Ruparalia and the cooperation of participants who kindly volunteered to take part in the study, including human resources managers, service managers, representatives of health professional regulatory bodies, members of BME staff networks, the Pan-London Equality and Diversity Network, the NHS Confederation BME Leadership Forum and the National BME Committee of the Ambulance Service. We are extremely grateful to the service managers who were involved in the later stages and whose involvement helped us to ensure that the recommendations arising from the study were grounded in the real world of the NHS.

We would like to thank NHS Institute for Innovation and Improvement for funding the partnership which culminated in this research, and for the specialist support and useful insights provided by Liz Maddocks-Brown. We would like to acknowledge the commitment and considerable assistance made by Maroline Lasebikan in her capacity as an independent adviser for this research. We are also grateful to members of NHS Employers, particularly Professor Carol Baxter, Paul Deemer and Mohammed Jogi for their invaluable contributions throughout the study and their helpful comments on earlier versions of this report.

Despite all the above contributions, the researchers remain responsible for any errors or misunderstandings reflected in this report.
Executive Summary

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.

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.
CHAPTER 1: INTRODUCTION

This report presents findings from research funded by the NHS Institute for Innovation and Improvement, conducted in response to concerns expressed by a group of NHS human resources managers who were members of NHS Employers’ Equality and Diversity Core Reference Group (CRG) about perceived disproportionate representation of BME staff involved in their trust disciplinary proceedings. NHS Employers supported the implementation of the research plan and facilitated access to the study participants.

The Centre for Inclusion and Diversity at the University of Bradford was engaged from June 2008 to November 2009 to examine the involvement of BME staff in disciplinary procedures and to identify good management practice in this area. The research involved a web audit of NHS trusts’ disciplinary data, an examination of disciplinary policies and practices of NHS trusts and health professions regulatory bodies, an exploration of the experiences and views of BME staff in relation to disciplinaries within their organisation and a literature review to compare the experience of the NHS with other public sector organisations in relation to disciplinaries and BME staff.

1.1. Background to the study

There is widespread recognition that in the face of real financial challenges, NHS organisations need to review the way in which they work with staff (Farrar, 2009). Lord Darzi’s report ‘High Quality Care For All’ (2008) stresses the need for the NHS to deliver greater efficiencies against a vision for trusts to provide the highest quality of care for patients and good value for the taxpayer. This same message underlies QIPP, which advocates innovation and improved productivity, doing things better and getting things right first time as crucial for the NHS workforce to deliver the required efficiencies. Targets set by individual trusts to increase productivity will not be achievable without ensuring that everyone is pulling in the same direction.

Research from the Chartered Institute for Personnel Development (CIPD) and the business psychology firm OPP, Fight, flight or face it (2008) estimates that the average UK employee spends over two hours a week dealing with conflict, with a knock-on effect on working hours lost. Within the NHS, getting it wrong can have serious consequences for the organisation as well as individual members of staff. It has been estimated that, in 2003, the average cost of the exclusion of an NHS doctor was £188,000 (NAO, 2003). Understanding how to resolve workplace conflict has the potential for reducing financial – as well as emotional costs for the NHS and could eliminate unnecessary waste for many trusts struggling to make savings in the present economic climate (NHS Employers, 2009).

The NHS Constitution (2009) emphasises that each member of staff needs to be more clear about his/her role and responsibilities as well as the standards of professional practice.
against which performance is measured. The recently published Health and Well-Being Report (2009) also highlights the need for greater support within the workplace to improve good health and reduce levels of stress amongst staff so that individuals feel valued and are able to work effectively regardless of who they are, the role they perform and the level at which they work within the organisation.

At the same time, NHS organisations should also be able to apply disciplinary procedures to staff members in order to ensure that staff behave in an appropriate and professional manner, albeit as a last resort. Paramount in considering the need for disciplinary action is the safety of the patient, and this is particularly relevant to the majority of disciplinary procedures involving clinicians. A recent National Audit Office report (NAO, 2003) stated, ‘where patient safety is at risk, the opportunity to exclude staff from work, or restrict their activities so that the situation can be defused and investigated at the earliest opportunity, is vitally important’. Disciplinary procedures can also exact a heavy personal toll on the individuals who are subjected to them as the report explains ‘...exclusion can result in reduced self esteem and depression, and in some cases, the clinician may feel suicidal. The clinician’s family can also be adversely affected. A number of clinicians never work again, even if they are exonerated by enquiries.’

It follows from this that the disciplinary procedures applied should be transparent, fair and ‘fit for purpose’. This has not always been the case in the past. The Department of Health’s report (2006) in response to the Harold Shipman inquiry noted that Shipman ‘would, of course, have passed any approval of fitness to practice with flying colours.’

1.1.1. The nature of disciplinary procedures

For clinical staff in hospital and community settings disciplinary procedures can take the form of:

- formal suspension, or exclusion, from work, pending investigation;
- informal suspension: special leave, extended sick leave, or ‘gardening leave’;
- restriction of practice – for example, avoidance of certain procedures, or type of patients;
- other measures, such as clinical audit, agreement to undertake research activities, attendance on training courses etc.

In the case of General Practitioners, PCTs can opt for formal or informal action as appropriate. Formal action comprises one or more of the following.

- Suspension and removal from the PCTs performers list of GPs application to the Family Health Services Appeals Authority to have the GP disqualified nationally.
- Referral to the General Medical Council.
Informal action might include providing support and development opportunities or measures such as agreement on pursuing remedial action.

The list of bodies involved in disciplinary process is quite extensive and includes:

- Department of Health, which provides central guidance on disciplinary procedures and oversees cases which have been in progress for more than six months.
- Professional Regulatory Bodies – such as, for doctors, the General Medical Council (GMC), for dentists the General Dental Council (GDC), for nurses, the Nursing and Midwifery Council (NMC) and for the Allied Health Professions, the Health Professions Council (HPC). These are responsible for maintaining professional registers and conducting disciplinary investigations which can result in clinicians being removed from their respective register. They are also responsible for encouraging members to undertake appropriate continuing professional development activities.
- Professional Royal Colleges – these provide external expertise and can be invited by NHS trusts to undertake independent assessments of clinicians.
- The National Patient Safety Agency (NPSA) which leads on, and contributes to, improved, safe patient care by informing, supporting and influencing healthcare organisations and individuals working in the health sector.
- The National Clinical Assessment Service (NCAS), a division of the NPSA, set up to provide a support service to NHS organisations which have concerns over the performance of an individual doctor or dentist.
- NHS trusts, which are responsible for investigating all exclusions, and the management of the process.
- Primary Care trusts – responsible for GPs and Dentists Professional Associations.
- Trades Unions, which can provide support and assistance for excluded staff.

1.1.2. Disciplinary proceedings and BME staff

Since the inception of the NHS, black and minority ethnic staff have made an immense contribution to the way health services are delivered in this country, often being cited as the ‘backbone’ of the service when labour has been in short supply (Akinsanya, 1988; Obrey and Vydelingummm, 2004). More recently there is ample evidence of individuals of BME background working at the forefront of their clinical areas with considerable experience, expertise and skills from which the NHS has benefitted (see for example http://news.bbc.co.uk/1/hi/health/3693338.stm). Anecdotal evidence and a growing body of empirical substantiation suggest however that staff from BME backgrounds are overrepresented in disciplinary procedures and that disciplinary processes are not being applied consistently within the NHS (Esmail and Everington, 1994; Lyfar-Cissé, 2008). This is an issue of concern, given that individuals of BME background currently make up 14% of the NHS workforce and the NHS is the largest employer of BME staff in England.
Formal investigations, which have been made into this issue at a national level, have focused on clinical staff, and within that group, mostly on doctors and dentists in hospital and community settings. Statistics from various national sources and case studies from the National Clinical Assessment Service suggest that BME doctors experience differential treatment at local level in that they are more likely to be referred to the GMC and to be on long-term suspension (NCAS, 2006). BME medical staff are also more likely to be involved in disciplinary proceedings than their white counterparts at consultant grade (NAO, 2003), and clinicians whose primary qualification has been gained overseas are more likely to be involved in disciplinary procedures than either BME or white clinicians trained in the UK (Allen, 2000).

Allen’s report concluded ‘it is possible that the complaints about overseas qualifiers are simply more serious and that their disproportionate referral rates and outcomes of hearings are fair and reasonable ... however, until there are some objective measures which can demonstrate this, the GMC remains open to accusations of bias.’

Since the publication of this report, the National Clinical Assessment Service (NCAS) has been established to provide support to NHS organisations around clinical disciplinary procedures and to serve as a possible alternative to referral to the GMC and GDC. Steps have also been taken by the Department of Health to improve the guidance on discipline and the exclusion of doctors and dentists (DH, 2003). The GMC’s Equality Scheme (2010) however, continues to provide evidence that ‘overseas qualifiers’ are overrepresented in disciplinary cases: ‘Our latest annual analysis of fitness to practise statistics showed that, as in previous years, a greater proportion of enquiries about international medical graduates are investigated as opposed to being closed at triage, and that a greater proportion of such cases are referred for adjudication by case examiners.’

This finding is supported by recent analysis of all the cases referred to NCAS indicating that in the hospital and community sector, UK qualified practitioners (white and BME) are less likely to be referred to NCAS or excluded or suspended than non-white practitioners qualifying outside the UK. It also points out that more concerns about clinical care are reported in relation to the latter (NCAS, 2009). No evidence, however, is provided that non-white UK qualified practitioners are being referred or excluded disproportionately and the report therefore recommends putting support measures in place for practitioners qualifying outside the UK. The report also recommends improved ethnicity monitoring of primary care contractors to allow analysis of a similar nature to be undertaken.

Less is known about the involvement of minority ethnic staff in disciplinaries in other health care professions compared to the medical profession, although similar problems are known to exist within nursing. As far back as 1990, it was revealed that BME nurses ‘are over represented amongst those reported for investigation of alleged professional misconduct’ (King’s Fund Equal Opportunities Task Force, 1990). More recent studies highlight a similar pattern of overrepresentation of BME nurses in disciplinary proceedings which does not appear to be changing (Beishon et al., 1995, Carter, 2000). Whilst managers highlight this
persistence (irrespective of outcome) as evidence of BME nurses being ‘difficult’ thereby perpetuating stereotypical assumptions, BME staff regarded their high numbers as evidence of attitudes among managers. The failure of senior managers to investigate the claims of BME staff that the disciplinary process was heavily weighted against them was also seen as having serious implications for their promotion prospects (Carter, 2000).

1.1.3. Disciplinary data and ethnic monitoring

Since the implementation of the Race Relations (Amendment) Act (2000), all NHS organisations, as public authorities, have been required to monitor their staff by ethnicity across a range of indicators. This includes the number of staff involved in disciplinary procedures each year. Comparing this data against the proportion of BME staff in their employing organisation’s workforce as a whole would indicate how “representative” BME staff are in disciplinary procedures. This information is also required to be made public - for example, in the organisation’s annual report, or on its web site. These statistics do not appear to be centrally collected, which would facilitate their analysis, and the degree to which they are readily available to the public varies across the organisations. Within individual NHS organisations, data relating to all staff involved in disciplinary procedures should be available, broken down by ethnicity. There is currently no analysis of this on an NHS-wide basis.

For clinical professions other than doctors and dentists, data is scarce. The Nursing and Midwifery Council (NMC), for example, produces statistics on members referred for ‘fitness to practice’ reasons. This is broken down by year, type of allegation, complaint, sector, setting, outcome and decision, but not by ethnicity (see NMC, 2008). It is not clear at this stage, whether disciplinary case data is collected and analysed by ethnicity by other regulatory bodies, such as the HPC and GDC. We do not have a national breakdown of the GP workforce by ethnicity to use for comparison against statistics on disciplinary procedures in primary care such as those produced by NCAS.

1.1.4. The involvement of BME staff in disciplinaries

The inconsistency with which disciplinary data has been collected by some trusts means that we do not currently possess a clear overall picture of the involvement of BME staff in disciplinary procedures. It would be potentially informative to know more about the types of issues / complaints which are being brought against staff, broken down by ethnicity. This might establish patterns of referral or trends around certain types of issue such as clinical practice, the quality of care provided to patients and relationships with other staff members. The experiences of BME staff employed in non-clinical posts, for example as porters and cleaners, has not been examined and little is known about how other factors such as disability might impact upon the performance of BME staff during disciplinaries.

There is obviously a great deal more that should be done to provide stronger statistical evidence on this issue. At the same time it is important to consider, based on the evidence we
do have, why such imbalances might be occurring and the role that could be played by suggested factors such as the lack of awareness about cultural differences, inadequate training, perceptions of the value of overseas qualifications and prejudice.

1.2. Aim and objectives of the study

The main aim of the study was to examine the involvement of BME staff in disciplinary procedures and to identify good management practice in this area. The research objectives were to:

- analyse trusts’ disciplinary data to assess whether minority ethnic staff are overrepresented in disciplinary procedures;
- examine reasons for the involvement of BME staff in informal and formal disciplinary proceedings;
- explore how ethnicity intersects with other diversity strands in different occupational groups;
- compare the involvement of BME staff in disciplinary proceedings in the NHS with other public sector organisations;
- engage with professional regulatory bodies to examine monitoring systems in relation to disciplinaries;
- highlight examples of good practice in relation to fair and transparent disciplinary proceedings.

1.3. Structure of the report

This chapter sets out the background to the study and its formal aims and objectives. The remaining chapters are structured as follows.

- Chapter 2 addresses the methodology and design of the study.
- Chapter 3 presents findings from analysis of disciplinary data and views on disciplinary policies and practices in the NHS.
- Chapter 4 addresses the views and experiences of BME staff relating to disciplinary proceedings.
- Chapter 5 presents a literature review comparing the experiences of four other public sector employers with that of the NHS.
- And finally in Chapter 6 we present conclusions and recommendations.
CHAPTER 2: METHODOLOGY

Before commencing fieldwork for the study, a series of meetings took place with key stakeholders including members of the NHS Employers Equality and Diversity Core Reference Group, the Disciplinary Research Advisory Group, the NHS Diversity Forum and representatives of the main Trades Unions for health professionals. Our discussions with these groups proved extremely useful in helping us to refine our research questions and ensured that from the outset of the study, the different stakeholders were provided with a sense of ownership and involvement of the research process. The research team was guided throughout by a project advisory group consisting of equality and diversity practitioners and relevant individuals from NHS Employers, NHS Institute for Innovation and Improvement and the Department of Health, with input from union representatives.

We acknowledge that the topic of disciplinaries needed to be examined with great sensitivity, given that the process of being disciplined is generally viewed in negative terms and as a punishment for inappropriate behaviour. In addition, there was a possibility that BME staff could feel reluctant to discuss their personal involvement and views in relation to the disciplinary process for fear of sanction. Our request for staff members to provide information on this subject could also have been considered as an invasion of their privacy (Lee, 1993). Given these possibilities, the study was designed using a diversity competent research approach with sensitivity to the experience of research participants being of paramount importance (Archibong et al., 2009).

It is emphasised that to acquire a genuine and deep understanding of the issues affecting members of minority communities, cultural knowledge must inform the entire research process. Merely including a particular underserved population in the sample or targeting an underserved population does not make a study cross-cultural (Okereke et al., 2008). Cultural competence must infuse and suffuse the entire research process of planning, theory development, instrumentation, analysis, and interpretation to ensure cross-cultural validity and reliability’ (Brandt, 1999). In this respect, we were mindful that those being researched should acquire a shared understanding of the study and have trust and confidence in the research process and its expected outcomes. The diverse nature of the research team in terms of gender, ethnicity, religion and professional background helped to facilitate this rapport by ‘reducing inter-subjective distances’ (Papadopoulos and Lees, 2002) and promoting a sense of commonality on many levels. It also ensured that information collected from individuals working at different levels within their organisations was collected both sensitively and accurately.

As it was HR managers themselves who had requested an exploration of this issue, it was not necessary to obtain ethical approval to proceed with the study, as the research was deemed to constitute a form of service development. Nevertheless we utilised the appropriate processes to ensure that ethical principles were followed, for example by compiling an
information sheet for study participants to explain the confidential nature of the research, outline the study design and provide details of a contact person throughout the duration of the study.

In order to meet the objectives of the research, a mixed methodology using both qualitative and quantitative methods was employed based upon a rationale that ‘seeks elaboration, enhancement, illustration, (and) clarification of the results from one method with the results from another’ (Greene et al., 1989, pp. 259). A multi-method approach is thought to be particularly useful in addressing complex, sensitive and potentially contested issues where stakeholders might have different perspectives (Adamson, 2005). It also provides the opportunity for a ‘transformative-emancipatory’ approach, in which research findings acquire a practical meaning of use in developing interventions (Caracelli and Greene, 1997; Mertens, 2003; Adamson et al., 2004).

In this study it was crucial to use a mixed methodology to acquire an in depth understanding of the disciplinary process from the perspective of all those individuals involved in the process, both directly and indirectly. As such, simply providing statistical evidence to show that BME staff were overrepresented in disciplinaries would not have provided any insight into how managers dealt with disciplinary issues on a practical level or how BME staff felt about their involvement in the disciplinary process. Using just a quantitative approach would not have helped us to explore possible causes and in turn, to develop practical solutions to address the issue. Qualitative methods were needed to scratch beneath the surface in order to find out more about the actual lived experiences of all relevant stakeholders in relation to the disciplinary process, thereby providing us with meaningful and robust study findings.

The study was undertaken in four distinct phases: firstly a web audit of NHS trusts’ disciplinary data; secondly an examination of disciplinary policies and practices of NHS trusts and health professions regulatory bodies; thirdly an exploration of the experiences and views of BME staff in relation to disciplinaries within their organisation and finally a literature review to compare the experience of the NHS with other public sector organisations in relation to disciplinaries and BME staff. The figure below provides a summary of the phases of the study and the research design:
2.1. Phase 1: A web audit of disciplinary data

The first phase of the research involved undertaking a desk-based search of NHS trust’s websites in order to analyse the data they published in relation to disciplinaries. We used the NHS Choices web site in order to identify existing NHS trusts. The website listed a total of 417 trusts as shown in table 1.

<table>
<thead>
<tr>
<th>Organisation type</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute trusts</td>
<td>172</td>
</tr>
<tr>
<td>Primary Care trusts</td>
<td>149</td>
</tr>
<tr>
<td>Mental Health/Learning Disability trusts</td>
<td>74</td>
</tr>
<tr>
<td>Ambulance trusts</td>
<td>12</td>
</tr>
<tr>
<td>Care trusts</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>417</strong></td>
</tr>
</tbody>
</table>

Source: http://www.nhs.uk/servicedirectories/Pages/
The web audit took place between November 2008 and January 2009. This fell within a period of reconfiguration within the NHS. Hence, a further examination of the list led to a reduction of the total numbers of existing trusts by 19 – that is from 417 to 398. This reduction was to the result of double counting as follows.

- The number of mental health trusts was reduced from 74 to 59 (because 15 trusts were amalgamated into primary care trusts but had appeared in both listings).
- The number of primary care trusts was reduced from 149 to 148 (because 1 trust was listed twice).
- The number of acute trusts was reduced from 172 to 170 (because a primary care trust and a mental health trust had appeared in both listings).
- The number of ambulance trusts was reduced from 12 to 11 (because of the merging of two trusts into one organisation).

Contrary to our original intention, it was not possible for us to examine how ethnicity intersected with other diversity strands such as gender and disability, in different occupational groups owing to the limitations of data collected by trusts. Consequently it was necessary to focus the web analysis on ethnicity data. A search was undertaken on each organisation’s web site in order to identify first, the total number of individuals in the workforce broken down by ethnicity and second, the total number of staff involved in disciplinary procedures by ethnicity. Data was considered to be valid only if it related to a period from 1 April 2006 onwards and covered a continuous 12 month period.

The approach for each search involved accessing each organisation’s home page and searching for any references to key terms on this page or subordinate web pages, including ‘About us’, ‘Workforce data’, ‘Published Reports’ and ‘Equality and Diversity’. Each search was continued, if necessary, for up to 30 minutes for relevant data and when found, was transferred to a recording template.

Whilst conducting the audit, we encountered a number of different ways in which information relating to disciplinaries was recorded on web sites. In order to ensure that the validity of the audit findings was not compromised we chose to exclude workforce and/or disciplinary data that was not sufficiently robust for the purpose of our analysis. As such, we discarded disciplinary data presented by trusts in percentage rather than numerical form; as whole time equivalents rather than headcounts; as aggregated ethnic group data rather than as separate ethnic groupings; and data that combined disciplinary activity with other employment related issues such as grievances. A total of 318 trusts audited by the research team had not published disciplinary data that met the requirements for the research’s inclusion criteria. This made it impossible for us to include these trusts in our statistical analysis. Consequently, only 80 (20%) of the 398 trusts were subsequently audited as shown in table 2.
Table 2: Total number of trust websites examined

<table>
<thead>
<tr>
<th>Trust type</th>
<th>Total identified</th>
<th>Total with valid data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>170</td>
<td>34</td>
</tr>
<tr>
<td>PCT</td>
<td>148</td>
<td>28</td>
</tr>
<tr>
<td>Mental Health/ Learning Disability</td>
<td>59</td>
<td>15</td>
</tr>
<tr>
<td>Ambulance</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Care</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>398</td>
<td>80</td>
</tr>
</tbody>
</table>

2.2. Phase 2: Disciplinary policies and practices in the NHS

(a) The views of human resources managers

From the 15 trusts that had initially volunteered to participate in the study, an email invitation was sent to human resources managers to attend a one day workshop. The aim of this workshop was to explore in more detail how issues arising from informal and formal 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 that had been put in place within their respective organisations to address this issue (see Appendix I). The workshop was attended by nine human resources managers and two equality and diversity practitioners.

(b) The role of healthcare regulatory bodies

A focus group was also held to examine the experiences of the main health care regulatory bodies in relation to disciplinaries, and to examine their systems for data collection in relation to BME staff and disciplinaries. This focus group was attended by representatives from the Nursing and Midwifery Council, General Medical Council, the General Dental Council, Health Professions Council, General Optical Council, General Orthopaedic Council, Royal Pharmaceutical Society of Great Britain and Pharmaceutical Society of Northern Ireland. In addition, two individual in-depth interviews were held with representatives from the Nursing and Midwifery Council and the General Medical Council. Discussions with focus group participants centred around five key areas as outlined in Box 1.
Box 1 – Key areas explored in focus groups with regulatory bodies

1. Within the professions that you regulate, generally how effective do you think the professions are in dealing with disciplinary or fitness to practice matters?

2. What do you perceive as the main reasons that black and minority ethnic minority staff are being disciplined?

3. Is there any evidence from within the profession you regulate that black and minority ethnic staff are disproportionately represented in fitness to practice procedures?

4. Are you aware of any good practice or case studies examples in relation to FTP and performance management within the profession or your regulatory body?

2.3. Phase 3: Views and experiences of members of BME staff networks

Having collated the views of those responsible for the implementation of disciplinary policies, our focus shifted to the views and experiences of BME employees working in NHS organisations. We organised five focus groups which were held in NHS trust venues in different parts of the country. Three of these focus groups were organised to coincide with scheduled BME staff network meetings and were attended by members of these networks as well as representatives from health care unions. The remaining two focus groups involved members of the NHS Confederation BME Leadership Forum and members of the Pan-London Equality and Diversity Network respectively (see Appendix II).

Each focus group discussion was facilitated by an external consultant and a member of the research team. For each discussion, efforts were made to ensure that the facilitators were equipped with relevant insight and knowledge to be able to understand and empathise with the issues raised by participants, and be able to probe sufficiently in relation to NHS organisational policies and practices (Gunaratnam, 2003). For focus group participants, this helped to create a comfortable environment in which they were able to talk openly about issues of concern in relation to their own and colleagues’ experiences of disciplinary proceedings which in turn lent credibility to the research findings. On average, the focus groups lasted approximately two hours and took place on trust premises. All focus group discussions were tape recorded and transcribed in full.

Membership comprised individuals from minority ethnic groups as well as other NHS employees with an interest in issues affecting BME staff.
Discussions with focus group participants centred on the five questions listed in Box 2.

Box 2 – Key areas explored in focus groups with members of BME staff networks

1. How well their respective organisation dealt with disciplinary matters generally.

2. The main reasons they felt staff from black and minority ethnic backgrounds were disciplined.

3. Aspects of the disciplinary processes they felt might place staff from black and minority ethnic backgrounds at a disadvantage.

4. Ways to improve the situation for staff from black and minority ethnic backgrounds.

5. Ways to help improve the situation for managers.

2.4. Phase 4: Review of other public sector organisations

Having identified a number of key themes relating to disciplinary practices within the NHS, the final phase of the fieldwork involved conducting a literature review to compare the experiences of four other public sector employers with that of the NHS. For this purpose, we selected Transport for London, the police service, the higher education sector, local government and central government (Department of Health, Department of Work and Pensions and the Home Office). In conducting this literature review our aim was to benchmark the performance of the NHS with other public sector organisations, identify literature about disciplinaries relating to these organisations and possibly learn from examples of good practice employed to address any ethnic imbalance in their disciplinary processes.

2.5. Management and analysis of results

2.5.1. Analysis of quantitative data

Analysis of data from the web audit involved comparing the proportion of BME staff and white staff who were disciplined within the 80 NHS trusts. Mantel-Haenszel Chi Square test methodology was used to compare these proportions, but where the observed or expected numbers in any cell were less than 5, a Fisher Exact test was used. The statistical software
package used for quantitative data analysis was Epi-Info version 6. A p value less than 0.05 was considered statistically significant.

2.5.2. Qualitative data analysis and validation

A considerable amount of rich and detailed data was generated from our discussions with HR managers, regulators and BME staff networks. Our main concern was to ensure that the data we had collected from these different sources were analysed systematically with a high level of rigour. By combining organisational and professional contexts with the views of individuals, we wanted to provide a rounded picture of the way in which disciplinary procedures are undertaken within NHS trusts. More generally, our aim was to present a coherent and credible account on which to base policy and practice which made sense of the disciplinary process, while also giving expression to the different individuals involved in and affected by the underlying policy.

In order to make sense of this data, we employed ‘framework analysis’ an analytical technique described by Ritchie and Spencer (1994) and used widely to analyse policy related research (see Twigg and Atkin, 1994). Framework analysis involves five key stages; a detailed familiarisation with the transcripts, identification of key themes to form a coding frame, indexing material according to this coding frame, mapping the data and finally, interpreting the findings in the context of other research and policy considerations.

Having read the entire transcripts independently, a series of meetings were held between the research team and the Disciplinary Research Advisory Group to identify, refine and discuss recurring themes. Our analysis developed a broad framework to make sense of these themes (both as descriptive categories and in relation to each other), while relating these themes to characteristics of the participants.

2.6. Developing tangible and relevant recommendations for trusts: a process of reflection with service managers

When undertaking research of this type, there is a series of practical and theoretical tensions which have to be resolved. The first concerns a view on how to synthesise quantitative and qualitative findings. Firstly, in practical terms, this means comparing the accounts of different stakeholders and explaining any similarities and differences in their narratives (see Smith, 2006). Secondly, our research findings are set within the context of current theoretical debates and empirical findings as a means of establishing further explanatory accounts.

However, mixed method approaches raise particular issues in relation to validity and reliability, which have particular relevance in relation to the qualitative component of the study (Creswell, 2003). At a superficial level, the project engaged with the more traditional concerns of validity and reliability. The external reliability of the study, which ensured the research, could be theoretically replicated, was guaranteed by a dynamic reflection on the
appropriateness of the methods, in a way that ensures justification of and transparency in research design (Atkin and Chattoo, 2007). Internal validity was ensured by establishing the degree of consistency with which instances were assigned to the same category by different researchers or the same researcher on different occasions, through a series of team meetings. In practical terms, for example, this meant codes allocated to transcripts were checked by other members of the team. More generally, through a process of constant discussion, the research team reached a consensus on what was captured in the interviews. This process helped to ensure the validity of the project, which was further enhanced by the principles of constant comparison (Glaser and Strauss, 1967).

Conventional approaches to reliability and validity can encourage a naïve positivistic conception of research, which fails to accept how knowledge is produced. This is why the research team was committed to a broader conception of reflexivity, in which the research was theoretically and methodologically justified as well as considered within the broader social and political context in which the research findings occurred (Alvesson and Skoldberg, 2000). The purpose here is to demonstrate a transparent account in which key research decisions are justified.

A fundamental principle of our study was acknowledging that not all recommendations have the same possibility of being realised and examining how this is negotiated among the different stakeholders in the process of achieving observable outcomes. All study participants were asked to identify solutions that could help to make disciplinary proceedings fair and transparent. In order to ensure that the recommendations would be relevant and workable by the end users, two workshops were undertaken with service managers to validate the solutions suggested by the research participants.

2.7. Project monitoring and evaluation

Monitoring and evaluation of the project have been carried out at three levels to facilitate appropriate partnership working with all stakeholders.

The Research Team: Research team meetings took place on a regular basis to ensure appropriate execution of the research plan.

The Disciplinary Research Advisory Group: The management board (see Appendix III), made up of external and research team members, was responsible for overseeing and ensuring quality and efficiency throughout the research project. The group met at least five times during the duration of the project and there was ongoing communication and involvement between the research team and the group members. The group’s level of involvement varied depending on the stages of the project, as the research required.

The Core Reference Group: Three meetings were held with the NHS Employers Equality and Diversity Core Reference Group which acted as the steering group for the project.
2.8. Summary

The table below provides a summary of the research methods employed and research participants included in the study.

Table 3: Breakdown of the phases of fieldwork

<table>
<thead>
<tr>
<th>Phase</th>
<th>Method of data collection</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Web audit</td>
<td>80 NHS trusts</td>
</tr>
<tr>
<td>Phase 2</td>
<td>(a) Workshop</td>
<td>9 HR managers; 2 Equality and Diversity practitioners</td>
</tr>
<tr>
<td></td>
<td>(b) Focus group and 2 interviews</td>
<td>9 regulatory bodies</td>
</tr>
<tr>
<td>Phase 3</td>
<td>5 focus groups</td>
<td>91 representatives of BME staff networks</td>
</tr>
<tr>
<td>Phase 4</td>
<td>Comparative literature review</td>
<td>Transport for London; Metropolitan Police Service; 3 Central Government departments (Home Office, Department of Health, Department for Work and Pensions); Local Government</td>
</tr>
<tr>
<td>Validating solutions</td>
<td>2 workshops</td>
<td>30 Service managers</td>
</tr>
</tbody>
</table>
CHAPTER 3: DISCIPLINARY DATA, POLICIES AND PRACTICES IN THE NHS

This chapter presents findings from the web audit which was undertaken to assess the extent of involvement of BME staff in NHS disciplinary procedures. Drawing upon data collected from workshops, the chapter begins by discussing HR managers’ views of the reasons for disproportionate representation of BME staff in disciplinaries along with challenges in relation to managing disciplinaries and suggestions for change. Finally the chapter presents findings emerging from the focus group and interviews conducted with regulators.

3.1. Disciplinary data and ethnic monitoring in the NHS

Of the 80 trusts from which data could be obtained for auditing, BME staff were almost twice as likely to be disciplined compared to their white counterparts. These findings were statistically significant (see table 4 below)

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Total Nos.</th>
<th>Nos. Disciplined</th>
<th>Rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>241,215</td>
<td>1,128</td>
<td>8.8</td>
</tr>
<tr>
<td>White</td>
<td>207,516</td>
<td>1,633</td>
<td>7.9</td>
</tr>
<tr>
<td>BME</td>
<td>33,699</td>
<td>495</td>
<td>14.7</td>
</tr>
</tbody>
</table>

χ² MH = 154.19, p<0.000001

In Acute, Primary Care, Mental Health and Learning Disability and Care trusts BME staff were significantly overrepresented in disciplinary proceedings (see tables 5 - 8).

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Total Nos.</th>
<th>Nos. Disciplined</th>
<th>Rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>157,267</td>
<td>1,405</td>
<td>8.9</td>
</tr>
<tr>
<td>White</td>
<td>131,952</td>
<td>1,060</td>
<td>8.0</td>
</tr>
<tr>
<td>BME</td>
<td>25,315</td>
<td>345</td>
<td>13.6</td>
</tr>
</tbody>
</table>

χ² MH = 75.10, p<0.00001
Table 6: Disciplinary rates - Primary Care trusts $n=28$

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Total Nos.</th>
<th>Nos. Disciplined</th>
<th>Rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>48,328</td>
<td>236</td>
<td>4.9</td>
</tr>
<tr>
<td>White</td>
<td>43,693</td>
<td>169</td>
<td>3.9</td>
</tr>
<tr>
<td>BME</td>
<td>4,635</td>
<td>67</td>
<td>14.5</td>
</tr>
</tbody>
</table>

$\chi^2$ MH = 96.66, $p<0.00001$

Table 7: Disciplinary rates - Mental Health and Learning Disability trusts $n=15$

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Total Nos.</th>
<th>Nos. disciplined</th>
<th>Rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>28,837</td>
<td>376</td>
<td>13</td>
</tr>
<tr>
<td>White</td>
<td>25,440</td>
<td>308</td>
<td>12.1</td>
</tr>
<tr>
<td>BME</td>
<td>3,397</td>
<td>68</td>
<td>20.0</td>
</tr>
</tbody>
</table>

$\chi^2$ MH = 14.57, $p<0.00013$

Table 8: Disciplinary rates - Care trusts $n=2$

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Total Nos.</th>
<th>Nos. disciplined</th>
<th>Rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>2,078</td>
<td>52</td>
<td>25.0</td>
</tr>
<tr>
<td>White</td>
<td>1,835</td>
<td>40</td>
<td>21.8</td>
</tr>
<tr>
<td>BME</td>
<td>243</td>
<td>12</td>
<td>49.4</td>
</tr>
</tbody>
</table>

$\chi^2$ MH = 6.69, $p=0.01$

Within the one Ambulance trust for which there was valid data the difference between BME staff and their white counterparts was not statistically significant as shown in table 9.
Table 9: Disciplinary rates - Ambulance trusts n=1

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Total Nos.</th>
<th>Nos. disciplined</th>
<th>Rate per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>4,705</td>
<td>59</td>
<td>12.5</td>
</tr>
<tr>
<td>White</td>
<td>4,596</td>
<td>56</td>
<td>12.2</td>
</tr>
<tr>
<td>BME</td>
<td>243</td>
<td>3</td>
<td>27.5</td>
</tr>
</tbody>
</table>

Fisher exact 2 tailed. P value = 0.16

3.2. Views of human resources managers

The majority of human resources managers attending the workshop felt that the findings from the web audit resonated with experiences within their own organisations. However, the results came as a surprise to one of the managers who stated that the workforce figures over the past 18 months in their trust did not show any BME member of staff had been disciplined. BME staff made up 5 to 6% of the workforce in this trust.

3.2.1. Reasons for disproportionate representation of BME staff in disciplinaries

A number of explanations were forwarded as to why BME staff might be disproportionately represented in disciplinaries. Reasons forwarded related to the organisational culture of trusts, attitudes of managers and the clarity of disciplinary policies.

Management practices and competencies

It was generally felt that line managers found difficulty dealing with issues relating to disciplinaries and were often inconsistent in their application of disciplinary policies. On the one hand, a tendency was noted for managers to deal with issues relating to the performance and conduct of BME staff ‘by the book’ and with a tendency to proceed more quickly to a formal stage. This tendency to formalise the disciplinary process was seen as disadvantageous for black and minority ethnic staff. In contrast a scenario also existed whereby managers showed an initial reluctance to take any form of action if BME staff were involved:

You get managers who are frightened to deal with things and they get to a point where it becomes very difficult. They are frightened of dealing with a particular issue because they are worried that they will be called racist. The issue then becomes a much bigger issue, it escalates.
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 communicating on an informal level with BME staff. This in turn militated against the development of any sort of rapport between BME staff and managers where feedback on performance might be expected and acted upon. It was pointed out that while a manager might happily admonish a white member of staff for making a minor error with the aim of curbing bad practices for the future, the same error made by a BME staff member might initiate formal disciplinary proceedings with more serious sanctions. A dilemma for managers who were dealing with BME staff seemed to involve getting the right balance between the two extremes:

*I think that there is a point but that sometimes managers go that extra mile and do confront but then the perception of the BME member of staff can feel they are being treated badly, it’s about perceptions. It can vary from too soft a touch to too heavy a touch.*

There was a perception that part of the problem stemmed from some managers, particularly those individuals moving from direct care to management positions, not being equipped with the relevant skills and knowledge to be able to manage a diverse workforce and to deal effectively with conflict situations. Disciplinary matters involving staff from minority ethnic backgrounds were not always considered to have been dealt with in the correct manner by HR managers. There was also a sense that line managers were incorrectly implementing a disciplinary policy to deal with performance issues and an indication that the role of Union representation could be further developed to improve the support structures.

**Organisational culture**

Whilst human resources managers felt that their respective trusts were making some progress in addressing equality duties around ‘race’ and ethnicity, there was awareness that issues of equality were not adequately considered by managers in formulating and implementing policies. Indeed in some trusts, there appeared to be an under recognition of the value of black leadership programmes and more generally the need to be fully compliant with the statutory requirements placed upon public sector organisations. Evidence seemed to suggest that attention to diversity and representation on disciplinary panels within trusts could impact on the environment for BME staff involved in disciplinary hearings:

*We have done some work in our trust and found that if you were BME or female, you were more likely to have a severe outcome from a disciplinary. That was a worrying trend. We couldn’t get a root cause for this, but when you look at the make up of panels in our trust we know they are more likely to be white males and there were very few females and senior BME members of staff sitting on panels.*
Human resources managers 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. For example, it was pointed out that BME staff who spoke amongst themselves in a language other than English in their workplace caused their English speaking colleagues to feel uncomfortable and in extreme cases led to bullying behaviour. Some managers could see a correlation between a culture in which bullying and harassment were insufficiently challenged within their trusts and an over representation of BME staff in disciplinaries. In such an organisational climate, prejudice 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.

**Behaviour of BME staff**

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 HR 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 within the area of support services, there was an expectation amongst managers for staff to ‘clock in’ and a lot of disciplinaries in this area of work had arisen concerning timekeeping.

There was also speculation that amongst BME staff working in the 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. It was also thought that BME staff 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. It was thought that such complaints might have arisen as a result of the differential training of nursing staff recruited from other countries.

**Ethnic monitoring**

Human resources managers noted that although disciplinary data was being collated by their trusts as part of the statutory requirement, clarity needed to be given to how trusts could best collect these statistics and analyse them in a meaningful way. As one manager stated:

> I think there is a systemic weakness with a lot of the evidence gathering that takes place including monitoring, statistical collection, duty compliance, so to move forward and look at trends is incredibly difficult. The evidence is just not there to drive conclusions. This filters through to create weaknesses in the policy development side.
Human resources managers were aware of the level of detailed reporting that could be undertaken in relation to disciplinaries through Electronic Staff Record (ESR) but stressed that there were varying levels of interest in this data amongst senior leaders and no guidance available on what constituted good monitoring practice. As a result, disciplinaries were not always monitored with any sort of system, particularly around those staff being disciplined and the level of sanctions applied. The following quote typifies the stage at which most of the trusts represented at the workshop appeared to have reached:

_We report on it [disciplinaries] but what we don’t do is look at proportionality as part of the analysis. Information is sometimes requested from our BME forum, but it is an add on not a regular reporting requirement. We record the data but we are only in the early stages of looking underneath it to see what it means._

### 3.2.2. Challenges in relation to managing disciplinaries

Having identified factors affecting the disproportionate representation of BME staff in disciplinaries, HR managers were asked to identify policies and practices that they felt had influenced the disciplinary process (see Appendix IV). They also highlighted some of the major challenges they faced within their organisations in dealing with the causes of disciplinaries.

**The role of line managers**

The role of managers was considered to be crucial within the disciplinary process and it was felt that greater clarity was needed in relation to managers’ skills, competency, authority and power. In terms of building relationships with their staff, being able to converse with BME staff on an informal level was felt to be a challenge for some managers, as was knowing how to assess the right time to take appropriate action to prevent the escalation of issues. On the whole it was felt that decisions made by managers became more prudent the higher up they were positioned within the organisation hierarchy. It was recognised by HR managers that ‘we don’t always give people the tools they need to do the job well’ and that more innovative training was required for different levels of management beyond the mandatory requirements that challenged people’s perceptions and helped them understand different cultural norms. It was also stressed that staff needed sufficient protected time to access training opportunities.

The human resources function was seen to provide a supportive role to managers, a role that it was admitted, did not always go far enough in challenging discriminatory attitudes. For human resources managers, difficulties arose in challenging management behaviours that were considered to be ineffective or negative because of the fear of being accused of discrimination or causing offence to someone for whom such behaviour was culturally acceptable. The prospect of having to face legal action was also seen as an unnecessary threat that formalised proceedings too quickly and needed to be avoided. Scope for improving partnership working with Trades Unions was also recognised.
Cultural change

Effecting organisational cultural change was identified as another major challenge. One manager emphasised the need to ensure that trusts had reached a stage where they were ready to embed good practice in the culture of the organisation rather than simply tick a box. The challenge in this respect was for ‘senior managers to walk and talk that culture.’ Given the pressure to focus upon targets, numbers and Key Performance Indicators (KPIs), the question arose as to how trusts could:

*transfer the learning that we do to meet accreditations into everyday business, for example every report that has to be run to meet a requirement, should then be used to increase the standard of management practice.*

In addition, it was felt necessary to engage with staff at all levels within the organisation to the extent that they understood and worked to the values and standards of behaviour expected. Achieving a strong sense of consistency and belonging was considered to be more difficult in trusts that were geographically dispersed, such as ambulance trusts where communication was a big issue. Managers also pointed out that efforts to improve the system could actually cause a backlash, which could lead in the short term to increased cases of bullying and harassment.

Effective systems

Participants recognised that there was a need to standardise or streamline systems and policies to ensure that the disciplinary policy maintained its visibility amongst Trust’s more operational business activities. A number of issues emerged during the session relating to monitoring systems and the analysis of disciplinary data. Electronic Staff Record (ESR) was widely recognised as a useful system for collecting, storing and manipulating data relating to disciplinaries but it was pointed out that not all NHS trusts were currently using the system to greatest effect. Given the capability of ESR, it was considered to be an important resource in highlighting linkages and patterns between variables that could help trusts to better understand disciplinary trends. As one participant suggested:

*We should take the opportunity to drill down from the data to find out the causes, the 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.*

Despite these benefits and the abundance of data made available through ESR, some human resources managers were still reluctant to share information about their disciplinary data ‘because we are not really sure of some of the factors and how to address them’. Another framework that it was thought could prove useful in relation to disciplinaries was provided by the National Health Service Litigation Agency (NHSLA) whose rating system could be utilised to assess the organisation’s position with regard to effective fair and equitable discharge of
disciplinary policies. The NHSLA was also considered to be an attractive option for trusts because of the reduced insurance premium it offered them if they were successfully assessed.

In terms of measuring staff competencies the Knowledge and Skills Framework (KSF) was recognised as an important tool that could be used to clarify the role of a large number, but not all staff working in trusts. Although some Directorates had developed alternative frameworks to align better with the type of work their staff were undertaking, there was agreement about the benefits of using a comprehensive system that was capable of linking with regulatory requirements and competencies. One manager could see the importance of this in reducing disciplinaries:

“If you don’t give someone the opportunity to understand the expected behaviour then you are disadvantaging them in taking the disciplinary action first.”

3.2.3. Suggestions for change

Workshop participants made a number of suggestions as to how trusts, supported by NHS Employers could reduce the number of BME staff disproportionately involved in disciplinary action, in some cases drawing upon measures that had already been put in place within their own trusts.

At an organisational level, it was recognised that trusts need to work on and define their core values and replicate this in all levels of management. Addressing the development and training needs of specific groups was also mentioned and to this end one of the participating trusts had already introduced a management / team leader development programme. Training had also been delivered to help staff to understand the difference between performance management and disciplinary issues. In one trust, materials were also made available to staff in the form of borough profiles and a diversity folder illustrating the variety and diversity of the local areas. Human resources managers also highlighted the need for an appropriate induction and training programme for staff recruited from overseas and close working with Trades Unions to constructively address issues at the lowest level of intervention, if and when they arose. In order to improve accountability during proceedings it was suggested that board members be given details about managers who were involved in disciplinaries. The introduction of a human resources code of conduct was also felt necessary.

In order to better understand the reasons behind disproportionality in relation to minority ethnic groups, a number of methods were suggested to explore the factors at play including root cause analysis, independent review of cases and post case review, undertaken in a similar way to case conferences. Some managers also thought conducting exit interviews might shed some light on reasons behind the escalation of events. NHS Employers were seen as an important source of support in providing templates that could guide the development of good practice when reporting on disciplinary data. Managers also welcomed
guidance from NHS Employers on how to standardise their policies on disciplinaries and thought an electronic approach that provided feedback and a trend analysis feature would be useful.

Competency frameworks were recognised as the most effective way of ensuring clarity in terms of the behaviours, values and skills expected to be exhibited at all levels within the workplace. Frameworks such as this, it was pointed out, could also be used for appraisals and recruitment as was the case at Guy’s and St Thomas’ Hospital Trust. In addition, within ESR it was pointed out that there were a number of modules to develop a tool kit to guide values and behaviours that could underpin recruitment and development needs. Undertaking employment surveys, KPI reporting and talent management were thought to act as an indication of employee satisfaction and progression within the organisation.

3.3. The role of regulatory bodies

Data emerging from the focus group and interviews conducted with regulators is presented under three themes; firstly, ethnic monitoring and fitness to practice (FTP) procedures, secondly involvement of BME staff in FTP proceedings; and thirdly, professional standards and diversity.

3.3.1. Ethnic monitoring and fitness to practice (FTP) procedures

There was a general consensus amongst representatives of the participating regulatory bodies that the procedures they had instituted to assess the capability (commonly referred to as ‘fitness to practice’) of their respective members were operating in an effective and fair manner. Not all of the participants felt, however, that they possessed accurate data to assess whether ethnic groups were disproportionately represented in such cases.

Regulators explained their efforts to monitor FTP data by ethnicity as part of their duties as public sector organisations but felt that they were not in a position to assess whether overrepresentation existed within their respective professions. This was largely because the data they were collecting was not linked to the detailed information provided by members on registration. One member of the forum summarised what appeared to be a common experience within the group:

*The issue is that we don’t have the data at the moment to be able to say ... what ethnicity people are on registers, and therefore being able to use that to measure whether or not they are disproportionately represented in FTP. Without having that data and it being robust enough to be at least 20 per cent of your register and [you] actually want 100 per cent to make those comparisons. The statistics just aren’t there at the moment to be able to do that. It will be realistically about 2 to 3 years before even some of us will have that information.*
Some of the regulators had made positive steps to address this problem. The GMC and NMC were both improving their data systems to monitor their workforce by ethnicity with some involvement from the Equality and Human Rights Commission. For the GMC this had been a big learning curve:

*It's not that the data is not there, it's learning how to use it, apply it and the value of it. It's been a considerable change in direction.*

At the time of writing, the GMC was using this ethnicity data to inform a research study examining suspected overrepresentation of minority ethnic doctors involved in disciplinary proceedings. Similarly the NMC was about to embark on a large scale data collection exercise to help identify trends in relation to the involvement of its members in fitness to practice procedures:

...*we have six hundred and seventy thousand people on the register and starting from next month we are going to be asking them to provide us with diversity information so that we can start monitoring what’s happening at fitness to practice... it’s going to take us a year to do it and it will take probably another year until we start to get meaningful data from fitness to practice.*

In addition the NMC was intending to conduct research around fitness to practice processes to examine whether they were fair and equitable, looking specifically into which individuals underwent referrals and what happened to them once they had been referred.

Whilst the importance of possessing monitoring data about the different diversity strands in relation to disciplinaries was recognised, a number of issues were raised. First, it was pointed out by one regulator that members of the NMC might be reluctant to provide information ‘because it’s about FTP and people are going to feel really defensive and frightened.’ It was also questioned whether the use of Census categories to record ethnicity would be helpful in highlighting issues such as communication barriers, that needed to be addressed by the profession:

*We know that at the moment, that the rising issues we get at the moment, when we go out and talk to nurses and midwives is about European issues, it’s to do with language, but we are never going to pick that up because they will just tick ‘white other’. And what does ‘white other’ mean because the South Africans, Australians of whom we have a lot on our register as well will be ticking that box, and so what I have realised is, I’m very, very glad we are doing this work and I really hope it will help us but at the same time it is a blunt instrument.*
3.3.2. Involvement of BME staff in FTP proceedings

Given the paucity of data collection in relation to FTP and ethnicity, not all the regulators represented within the forum were able to state whether the extent of involvement of BME staff in their profession’s disciplinary proceedings was disproportionate to their membership. The GMC clearly acknowledged that there was an overrepresentation of international medical graduates in its fitness to practice procedures; an area which was currently being researched by the organisation who:

*have been very committed to trying to work out what this issue is not least of all because we need to understand for our own purposes what the factors are and what we actually see in FTP and also what are we actually getting in terms of referrals.*

Other regulators did not feel they were in a position to draw any firm conclusions. The NMC speculated that males as opposed to females were overrepresented in FTP proceedings in areas such as mental health nursing and that males of minority ethnic background, by virtue of working in greater numbers in that field, were more likely to be referred. A representative from the Health Professions Council did not think that minority ethnic groups featured highly in their FTP proceedings as he explained:

*I mean we, it’s slightly different, we are in a slightly different position in that it doesn’t appear to me that there is an over representation of BME registrants in our fitness to practice proceedings. Having said that we haven’t collected data, we are in the process of doing this. [You can get an] indication from names but based upon this ... I don’t think there is overrepresentation ... [They are] overwhelmingly white. Young women complaining about middle aged men.*

Based upon their familiarity with cases involving minority ethnic staff, representatives from the different regulatory bodies identified a number of reasons to explain the involvement of individuals within disciplinary proceedings.

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 interpreted negatively by colleagues, line managers and patients and if left unchecked, could have serious consequences for the individual. As two regulators pointed out:

*...the unfamiliar often brings unexpected behaviour ... people are unfamiliar with the cultural background and perhaps are dealing with people with very different accents, there are real communication issues, or there can be real communication issues. And one would see that as a legitimate reason for complaint.*
What we are concerned about is they start to get low level complaints which build up and then you have certain employers who have a policy that says if you have had this number of complaints it gets escalated to a formal complaint. So that is something that we would like to look at, it can be a huge issue.

In relation to this communication issue, a few of the regulators also felt that the situation had been made worse by existing language testing rules. It was pointed out that whilst medical graduates from non-EU countries were expected to undergo the Professional and Linguistic Assessment Board (PLAB) test to demonstrate their competency in terms of clinical and communication skills, there was an assumption that individuals recruited from countries within the European Union possessed an acceptable level of linguistic competency and therefore did not need to be tested. This was the situation facing the NMC in relation to language testing:

...now we have this issue where we have people coming from EU countries who do not always speak English well. The majority of referrals for English language issues haven’t been from outside the EU but are from inside the EU. For example people from Australia we have to ask them to take an English test but someone from Poland doesn’t take an English test. Now the Equality and Human Rights Commission are looking into this for us because they think it may be bad advice from the EU. The English language does crop up in FTP cases quite a lot.

Closely linked to communication was the issue of cultural difference. Regulators highlighted that differences in the way people from other cultural groups behaved and interacted with patients could quite easily serve as grounds for taking disciplinary action. Not making eye contact with patients was the most commonly cited example that could be interpreted negatively. Other behaviours influenced by culturally specific norms related to particular working styles as a representative from the NMC illustrated:

Nurses from Eastern Europe were coming over here and finding it difficult to act autonomously and were constantly asking for reassurance and feedback and they were just culturally unaware that over here the role of a nurse now is far more – go ahead and do it- we’ve got nurses managing whole clinics and managing doctors and that to them was just something that they were terrified by.

Regulators saw as very important the need to acknowledge and better understand such differences. Regular equality and diversity training sessions for staff members were seen as integral to this process as a way to remind those making decisions of their responsibilities in relation to the requirement of race relations legislation. To this end, some of the regulators had undertaken an impact assessment of their fitness to practice processes. At the same time it was felt equally important for regulatory bodies to provide health professionals recruited internationally with a better understanding of the cultural norms, customs and practices of this country.
Sometimes though it was not simply a case of raising awareness of different cultures. Regulators were aware that managers’ attitudes towards the behaviour of minority ethnic staff could be shaped by ingrained stereotypical views, leading to disciplinary decisions that did not necessarily relate to prevailing professional standards, as the following example illustrates:

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 work place. But 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.

Disparities in the way different ethnic groups were treated were also evident in other areas. A strong perception existed within the nursing profession that individuals who were not native English speakers were subject to unnecessarily close supervision. Similarly, it was felt that the kind of complaints sometimes made by service users towards minority ethnic staff would not have been levelled at their white counterparts.

For internationally trained health professionals, isolation and a lack of support and guidance were also identified as factors contributing to their referral. Regulators recognised that they themselves had a limited role in providing informal support to their members. Nevertheless, the GMC in particular had been involved in a number of research projects to better understand the support needs of members, particularly those trained internationally. Findings arising from a study undertaken to compare the experiences of non UK trained clinicians coming to practice for the first year in the UK with those of UK qualified graduates suggests there is a need for employers to promote induction periods slightly differently, with the provision of information at induction that covers information about cultural differences so that they are better understood. Alongside this the GMC has been involved in the development of a training tool for clinical managers to help support individuals early on, to avoid reaching a stage where their fitness to practice might be questioned. The GMC was also considering the possibility of a web portal to serve as an information forum for internationally trained graduates.

3.3.3. Professional standards and diversity

Support issues relate to a more general point raised by regulators about the way in which professional standards are developed by regulators and the effectiveness of regulatory bodies in communicating these standards to their members as well as to the general public. In this respect all the regulators saw some scope for providing clearer information about the role they played and about their complaints procedures. It was highlighted by the NMC that their
members had expressed a need for greater clarity between fitness to practice and disciplinary issues. In addition they needed guidance:

so that members know when to make a complaint, when something is dangerous, when someone can be referred and to have that feeling of responsibility.

Subsequently the NMC had developed a new improved code of conduct which is featured on its website and appears to address many of the queries raised by consultation exercise with its members. Another regulator with a much smaller membership explained their method of disseminating information to its members:

we handle comparatively small number of cases but we try to analyse each case. We then produce learning points and have a news letter that we send to registrants so ... for example in the case previously stated it will go out as how to better demonstrate insight when handling a complaint ... the sort of things a patient might expect.

Similarly the GMC has utilised various channels to ensure that the guidance materials it produces around topics such as quality assurance, confidentiality etc. reach its intended audience. In this respect the GMC has worked closely with undergraduates in the UK to help them understand the significance of issues relating to fitness to practice and to familiarise them from an early stage with the role of regulators. Raising awareness about their purpose as regulatory bodies amongst the public was also seen as a way to raise awareness about their organisation amongst minority ethnic groups with a view to attracting more involvement from them.

Regulators recognised the need for investigating panels to reflect the diversity within their respective professions to ensure that different perspectives were brought to bear upon the decision making process, which was currently thought to be dominated by middle class white males. Considerable thought and planning had been exercised by regulators in order to work out how to achieve this aim and at the same time ensure fairness for both parties. It was evident that some regulators were actively targeting underrepresented groups to become members of their panels. To this end, one of the regulatory bodies made sure that the panel included a female member and someone from a minority ethnic background. Others felt it was sufficient that panel members, regardless of their ethnic background, should display an awareness and commitment to issues relating to diversity and difference.

Representatives from the different regulators provided a number of examples of good practice that they were aware of relating to fitness to practice issues and minority ethnic groups, although it was emphasised that employers were more likely than regulators to have developed good practice. There was also awareness that engagement with employers needed to be improved so that trusts had a better understanding about why and when to contact relevant regulatory bodies, as one of the regulators explained:
Generally people will go through the disciplinary process by their employers and it then becomes a matter which comes through. The standards that we have should mean that individual practitioners, if they have a concern also have a duty to advise us if someone’s fitness to practice is affected, they should also be contacting us at that point.

Finally, it was felt that regulators needed to develop closer links with employers to help ensure findings of research undertaken by bodies such as the GMC were acted upon. At the same time regulators recognised that they needed to work more closely with each other on issues relating to fitness to practice. The joint health care regulators’ forum on equality and diversity consisting of all the health care regulators and the Social Care Council was seen as reflective of this commitment.

3.4. Summary

Findings from the web audit showed that BME staff working in NHS trusts were more likely to be disciplined compared with their white counterparts. For all these trusts, with the exception of the one Ambulance trust, the differences were statistically significant. Explanations forwarded by human resources managers for this pattern of overrepresentation related to some inconsistencies in management practices and behaviours, and an organisational culture within the NHS that did not easily accommodate difference. Issues were also 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. To avoid unnecessary disciplinary proceedings, regulators felt it was important to improve awareness of professional standards amongst members and stressed the need for closer working relationships between themselves and trusts to help achieve this aim. Both human resources managers and regulators recognised the need to improve systems for ethnic monitoring and a number of the regulatory bodies were also undertaking research projects to investigate the underlying causes of overrepresentation of BME staff within their respective health professions in more detail.
CHAPTER 4: PERCEPTIONS AND EXPERIENCES OF BME STAFF NETWORKS IN RELATION TO DISCIPLINARY PROCEEDINGS

This chapter presents the findings from the focus groups conducted with three BME staff networks, members of the NHS Confederation BME Leadership Forum and the Pan-London Equality and Diversity network. Issues raised by BME staff in relation to disciplinary processes were grouped into key themes relating to organisational culture, application of the disciplinary policy, transparency of the disciplinary process, monitoring systems and management competencies and practices.

4.1. Reasons for disproportionate representation of BME staff in disciplinaries

4.1.1. Organisational Culture

There was unanimous agreement amongst respondents that their organisations could and needed to improve the effectiveness of dealing with disciplinary matters. It was felt that insufficient/lack of understanding of different cultures on the part of managers sometimes led to a misinterpretation of staff behaviours or attitudes and could consequently explain a greater likelihood of staff from different cultural backgrounds being disciplined. This was most commonly mentioned to be a cause for disciplinaries amongst African staff, whose behaviour was perceived to be inappropriate and intimidating as the following quote from a female African nurse indicates:

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.

In some organisations African and African Caribbean people, particularly males were thought to be the most likely grouping to be disciplined. For many BME staff members it was acknowledged that the confidential nature of disciplinaries meant that it was not always possible to ascertain whether they had been treated unfairly. The disparity in treatment, however, was apparent to some BME staff who were in a position to reflect upon the outcome of cases involving BME staff with cases of a comparable nature involving white staff:

I will give you an example, a Divisional Director from a black and minority ethnic background overspent his budget by £2,500.00 and capability issues were used to dismiss him without pay, nothing. Similarly his white colleague was £1,000,000.00 overspent and that colleague was promoted to Executive Director.
This scenario was also described in another trust:

> I used to work in IT covering the whole hospital and part of my job was to police the trust website and one day we had a situation where a guy from the BME community was viewing very bad pornography and within two hours of me reporting it he was actually dismissed straight away without even asking why he was viewing it or nothing, straightway he was formally dismissed. A month later there was another doctor, a senior (white) doctor who was doing a similar thing and it was even worse ... they were some of the worse things that you can actually imagine and I took this to my manager and he came back and said, ‘He is too important for the trust, he cannot be touched’. He still used to do it sometimes but people would say nothing about it.

Similarly it was difficult for these differences not to be apparent to a union representative:

> The main reasons I think at present that BMEs tend to get disciplined is for attitude ... you don’t necessarily see the comparisons but as a Trade Union representative within a unit I’ve actually seen the comparisons.

In terms of the induction of new staff into the organisation, it was felt that sufficient attention was not always given to transmit the ethos and values of the NHS, as well as the organisational culture of the NHS in which staff would be 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, for example more authoritarian ways of delegating tasks. Thus there was a possibility that within the NHS, such staff could be disciplined for behaviour classed as bullying or harassment. The potential for misinterpreting behaviour of staff members from a different culture was highlighted to be an issue not just for the white and black population but also for staff from different minority ethnic groupings working alongside each other in the NHS. As such, it was argued that a Zimbabwean manager might not necessarily understand the cultural nuances displayed by a Filipino nurse, and similarly an African doctor might misinterpret the comments made by a Pakistani health care assistant. This is further complicated because white nursing assistants do not always value the seniority of qualified BME nursing staff, and are sometimes reluctant to respond in ways that address patient safety issues and clinical governance.

In addition, it was recognised that for staff recruited from overseas, English might not necessarily be spoken as the first language. Consequently staff found that that they were not necessarily expressing themselves and communicating information to colleagues and patients in the same way as their white counterparts, which could cause problems. For example, a nurse trained in Dubai explained how for her, the phrase ‘I am feeling sick’ could as easily be interpreted as wanting to vomit as someone feeling generally unwell.
Repeatedly BME staff mentioned the existence of a custom and practice culture and gave numerous examples which drew both on the explicit and hidden cultures within their organisations. Staff felt that part of this ‘culture’ included acceptable ways of working which were not always spoken about explicitly with staff from black and minority ethnic backgrounds, so that a lack of clarity remained as to ‘how things are done around here’. They also needed clear guidance about values and behaviours which would not be tolerated. In some instances, it was felt that white colleagues gathered information in an ‘underhand way and used this information to settle disputes’. The following comment described how this culture operates:

*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. If I reported somebody for a racial remark or something like that, I know what’s going to be happening to me ... they make your life hell and that’s the situation we’re faced with. So we really need to look at that. You might have evidence of staff who reported things but that’s far and few between, I bet it’ll be outweighed by the numbers that haven’t actually reported.*

Exclusion from this culture was thought to have a negative effect upon BME staff in terms of being disciplined as highlighted by the following statement:

*Having worked as a HR manager in two separate … trusts … you often find different cultures … When I worked in [name of institution], for instance you had the formal disciplinary procedures but there was a traditional way of dealing with disciplinary matters, very much in an informal way and people understood etc. But if you were from a BME background and you weren’t necessarily aware of the culture, it was often very difficult and what you would often find was BME people getting involved in the formal procedure because they weren’t part of the culture and we saw that happening ... 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.*

Similarly in another organisation, the ingrained organisational custom and practice culture served to maintain the status quo through unwillingness on the part of management to challenge unacceptable behaviour of white staff as explained:

*I think that there could be a culture within the management arena to almost judge and really sanction that a person is guilty or not guilty from the outset … and I think sometimes it can be a biased system because culturally there are certain individuals that you won’t confront, that you won’t address, and they’ve been an*
issue for donkeys’ years ... So I think there is a vast amount dependent upon the individual and the history that they have within the organisation and so I think there is an issue there and it’s specific to the management team. It’s changing their culture in the way in which they view and initiate a disciplinary procedure.

Many BME participants also characterised the culture as one where they were often subjected to bullying and victimisation, with little opportunity and a lack of confidence to complain. As a result of this, some staff members were left feeling confused with nowhere to air their grievances about issues such as being passed over for promotion, not getting formative feedback on their performance, not being coached or supported, having an excessive workload and sometimes experiencing stress. A member of staff employed by an ambulance trust could identify strongly with this:

There are a lot of things which are accepted by road staff which technically shouldn’t be and because we accept ... they’re not reported, then if they are reported they are not taken seriously by management, initially you will try and resolve the issue locally without having to take it through a formal process and I think this is probably where ... there may be a flaw there because it shouldn’t be encouraged to escalate.

Complaints from patients regarding the capability of BME staff were also used as the basis for disciplinary action against BME staff as a union representative explained:

A patient may complain about the nurse being rough ... The last time somebody called me to do a case for them where she was accused of roughing the patient she was bathing. The patient complains, so the attitude is …‘Oh we have to come down, we have to discipline.’ Yet if it is a white person who might have done the same sort of bathing, with the same sort of outcome, it is treated differently.

An impression was formed that BME staff are more likely to be disciplined for insignificant things based upon professional jealousies and stereotypical views. There was also a tendency to exaggerate minor mistakes made by BME staff so that in nursing, minor drug errors and absence of record keeping were recorded as ‘gross misconduct’ and a lack of a signature on something suddenly became ‘falsification of records’. Timekeeping was also mentioned as an issue that caused BME to be disciplined.

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 of being disciplined upon their career, family and social circle. For those individuals who suspected that there was an element of discrimination involved in the reason for their disciplinary, there was a
tendency to downplay or avoid mentioning this because of the complications it introduced in accessing support internally.

**Clarity of the disciplinary policy**

Comments made by participants indicated that the disciplinary policy was not effectively communicated to staff members. Many BME staff felt that the disciplinary policy was too complicated and lengthy and exhibited insufficient understanding of how disciplinary procedures were implemented. A number of issues were thought to disadvantage BME staff who were involved in disciplinaries. One individual explained how BME staff tended to approach disciplinaries without appreciating the level of skills and expertise needed to achieve a positive outcome:

*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.’ They tell themselves, ‘I have nothing to hide’ ... not knowing that it’s not as straightforward as just going...*

Often BME staff involved in disciplinaries whose first language was not English felt hampered by their spoken English, which affected their confidence levels when expressing themselves in disciplinaries. In addition it was felt that if people struggled to say what they needed to say or articulated issues and concerns in a manner that may not have been accepted by the host culture when they were being disciplined, this might create further problems. It was noted that BME staff often failed to keep a detailed and accurate record trail of issues leading up to their disciplinary and this was thought to work against them.

Some individuals felt that the disciplinary procedure was designed to curb appeals and that sanctions were often applied when they did appeal. The system was perceived to work in favour of the manager, leaving the individual member of staff isolated and without knowledge or adequate support as illustrated by the following quote made by a BME member of staff:

*Information [about disciplinaries] is power otherwise you have to go with what the managers say.*

Despite this advantage, it was made evident that owing to the complexity of the process, some managers were using the disciplinary process incorrectly to discipline people under the wrong policies.

A persistent issue that emerged from the focus group with staff members related to the failure of managers to resolve issues involving BME staff at the informal stage. This was felt to be a reflection of the poor channels of communication that existed between managers and BME staff. As a result of this, BME staff felt that the only option available for managers to improve performance was to use disciplinary action, as a number of individuals explained:
There is an issue to be addressed, about white managers still not being comfortable with working with staff from a different background than themselves. A lot of the challenging of behaviour that would go on informally with a white manager and a white staff member just does not happen, so all that de-escalation does not happen in the system.

Similarly, we were told by a BME staff member:

Everything gets formalised so quickly, that shouldn't be, my white colleagues would do the same thing and they don't go through what I had to go through. Managers actually turn the other cheek.

BME staff also experienced that the formalisation of issues was sometimes done covertly with little feedback given to BME staff as the following incident provided by an equality and diversity practitioner illustrates:

I had a situation where an event we'd booked ... The hotel inadvertently put on the trust’s credit card £200 for hotel accommodation for people from other trusts and I had taken this up with the hotel. I had the authority to authorise the payment. I got an email from our Director of Finance saying that this was financial mismanagement ... This Director of Finance is supposedly an accountant and therefore he knows or should know so his professional culture should tell him that you do not email the accusation of financial mismanagement without due regard. When I brought this up and tried to phone him to discuss it, he then became elusive. I then went to my director. The next minute I was called into a meeting to discuss my behaviour that I had been insubordinate to question why he could accuse me of financial management and furthermore because I had said to him I haven’t been able to get hold of you please phone me. And then I’d said to him don’t worry just pop it in writing what you mean by financial mismanagement and then I said have a good weekend, I was told the phrase ‘have a good weekend’ was sarcastic and was unacceptable and inappropriate on my part ... It’s something I’ve spoken to other BME people and found ‘yes’ they found notes on their files yet they haven’t been through any disciplinary procedure.

In addition to the tendency to formalise disciplinary process, many BME staff discussed the lack of transparency in policies and procedures that were employed when dealing with BME staff. Respondents agreed strongly that their organisations were often ineffective in dealing with disciplinary cases as a result of the lack of transparency in the disciplinary process. In such cases, union members commented that managers muddled disciplinary and capability issues and that union members were often not given information. A union representative commented:
Even though we are playing a strategic role, we are not being consulted by managers where a matter relates to a black member of staff … I get BME staff coming to me to say I am getting talked to about x, y or z, I am being told I won’t have a job after my next assessment. On the other hand when I speak to HR, they are saying but we have disciplinary or capability involving this person … there is a lack of clarity and transparency, thus our ability to offer support is diminished.

**Transparency of the disciplinary process**

A number of issues were raised in relation to the way in which decisions were made about the need to undertake disciplinary action within organisations, particularly the lack of accountability for the decisions made by line managers. In many instances it was felt that decisions made by individual line managers were barely challenged by human resources managers to ensure due process. In some instances, the way disciplinaries were dealt with was described as ‘hit and miss’ and where the investigating team or management team had not necessarily followed correct procedure, there was a likelihood that the investigation would be terminated. At the same time it was widely felt that managers with good skills of persuasion could easily influence less competent union representatives to drop a case. Staff noted that in such cases no sanctions were issued against the managers who have not followed the correct procedure but the BME person under investigation could be subjected to victimisation.

While it was acknowledged that union representatives could play a useful role in assisting staff members involved in disciplinaries, many individuals were concerned about the level of understanding of their union representative during the disciplinary process.

On the whole, BME staff did not feel that union representatives were always competent in dealing with issues that involved a ‘race’ element and consequently were not able to build up a relationship of trust with them, further compounding their isolation. On the other hand, in-house representatives were perceived to introduce an element of bias. BME staff highlighted that there was currently a lack of union representatives, managers and human resources personnel who were from BME backgrounds. A white union representative related:

> Where I come from, it’s very diverse and 80 per cent of our workforce is BME staff so it wouldn’t be surprising that it is highly representative in terms of the BME group in terms of discipline. Where I have some problem is that in terms of the 1 or 2 per cent of the upper echelon or the leadership are white. So we have this problem here where we don’t have the sort of consistency in application of how things are applied...

Indeed on a number of occasions, we were informed about cases of bullying which BME staff had not had the confidence to report at the time, despite knowing that channels existed within the organisation to deal with such incidents. The fear of any negative repercussions
prevented the individuals involved from challenging such behaviour at the time. As the union representative above commented:

... there are a lot of things happening on the ground but I'm not sure if it is being properly handled.

This apparent failure on the part of trusts to deal effectively with bullying behaviour was evident from the use of staff counselling and support services in some trusts to report cases which had not been dealt with officially, either through disciplinary, grievance or bullying and harassment policies. It was also thought that NHS boards were neither sufficiently in touch with staff experience nor was there adequate evaluation of staff issues at board level.

The lack of transparency in relation to the decisions made during the disciplinary process led to poor expectations and a lack of confidence amongst BME staff that cases would reach a favourable outcome for them. In addition, a failure to adhere strictly to the requirements of their trust’s disciplinary policy contributed to a mistrust of the system and a strong perception amongst BME staff that decisions were not being made on objective grounds. Incidents related to us by BME staff provided evidence of a complex relationship between line managers and human resources departments within their trusts. On the one hand, some line managers were dealing with disciplinary issues themselves rather than consulting with HR managers and were making decisions that union representatives and HR managers lacked the confidence to challenge. On the other hand, there were cases cited of HR managers showing total support for decisions made by line managers to ensure that neither manager would be fully to blame if an incorrect judgement had been made.

A union representative reflected upon this relationship:

… You get HR managers who will tell the managers what to do and you get HR managers, no matter what you do as a union representative, the HR manager will be corporate with the organisation. The problem with cases of discrimination is the proof around the comparator, and if you don’t know case law around race cases… It is most difficult and most unions and law firms will say you have got to have some chance of success, for them to pick up a case and run with it. So my observation is that it is often down to individual managers, and if individual managers get it wrong, you don’t see HR managers being dismissed for years of errors, so it is really quite difficult.

Some BME staff were not happy with the length of time taken for disciplinaries to be brought to a conclusion. In some instances the process was protracted by unnecessary delays and could last up to two years.
4.1.2. Management practices and competencies

The overrepresentation of BME staff was also thought to be reflective of poor systems of performance management within organisations. It was agreed that performance issues were not addressed in a timely way, often with a lack of effective feedback, performance appraisal, support and monitoring of progress with regard to BME staff. A human resources manager who attended one of the BME staff networks could identify with this situation in his own trust:

One of the things that I’m certainly aware of … most of our staff are not properly managed full stop. Only 20 per cent of our staff have had an appraisal/PDR so 80 per cent are not being properly managed at all and likewise the managers who are supposed to be doing this haven’t been properly trained … so they don’t know that they are not doing anything … properly, they think they’re doing … the right thing. The whole thing’s chaotic in my view.

An equality officer described a similar scenario within her Trust:

I couldn’t vouch for the effectiveness of my organisation because our appraisal process whereby staff meet to discuss goals, needs, wants, how they can be developed is not effective and less than 5 per cent of all our staff have had an appraisal … I came from organisations, national, statutory where 100 per cent of staff had been appraised and so knew where they were going, why they were going and could each quarter say ‘I’ve got a problem with you’ or your manager could say ‘I’ve got a problem with you’ before you were there … you weren’t going down the disciplinary route, you were going down a performance management for effectiveness but we don’t have that.

There were countless comments made in relation to managers who were perceived not to have been trained to manage staff effectively. Some BME staff noted that their managers had insufficient understanding of the disciplinary process and knew very little about how to implement it. It was also noted that some managers did not possess leadership and cultural competency skills required to manage a diverse workforce. The quote below summarised this point:

I don’t believe that we train our managers to manage people and as a result there can be a breakdown in communication and I think the perception is far worse with BME staff than perhaps the wider staff community, that’s the first thing. And I have to say I think there’s an issue around cultural competency whether our organisations actually manage a diverse workforce … it’s institutional racism. I think there are systems in place that actually actively encourage it.

Similarly it was noted:
Management culture is not one where a lot of managers have gone through management training and have a theoretical background etc. So people have worked themselves up into these jobs and I think that again links to the effectiveness of the organisation because the actual process of identifying an issue with a BME member of staff is not informed by procedure, management experience and practice. It’s very much dependent upon sub-based cultures, so you can see organisational culture as well as the empires within different sites so I think that really relates to that and without that sort of standardised training, that is not just a one-off thing but a regular programme of training for managers just to say it’s not just about the procedure and the policy it’s about the conditions. Let’s argue for the sake of when it comes to BME staff, has there been undue pressure or overload in terms of workload that has put that individual in that predicament in the first place? Are we talking about their capacity or capability or has the organisation or the manager or a colleague put them into situation which is expecting too much therefore the disciplinary has arisen?

What was clear to some BME staff was that managers were choosing to judge their performance by different criteria than that of their white counterparts with regard to disciplinary and capability issues. It was acknowledged that managers had considerable scope to interpret the disciplinary policy and that the outcome of a disciplinary depended upon on how an individual manager chose to look at it. In terms of assessing the actions of BME staff, there was generally felt to be less flexibility on the part of managers. There was also a suspicion amongst some staff that managers were questioning behaviours and actions that were perceived to be irrelevant to their performance:

They pick up on things that are totally insignificant, just a waste of time and I feel the hidden agenda behind that is to get that person … to lose their temper … If you get called in for something, you are basically not aware of anything, once you lose your temper; they use it to their advantage.

This links to another point raised by some staff about the way the grounds for disciplinary action were recorded. Where staff detected that racial intolerance might be at play, it was felt that the official reason provided by a manager to the human resources department might not be the actual reason behind a line manager’s decision to discipline a BME member of staff. This lack of transparency in management behaviour was found to be common across trusts as the following example illustrates:

... there was a general memo asking for interested parties to put their names forward to act up … I followed the same process, put my name forward as did any other staff member who was interested but I was the only one who wasn’t given the opportunity … other members of staff were being begged to do the role and didn’t want to do it, yet I had volunteered and wasn’t given the opportunity. I had to go
through a formal process, convening a meeting with the station manager ... to discuss the reasons why I wasn’t given the opportunity. He then come out and said, ‘well we’ve got issues with you, I’ve heard this, I’ve heard that.’ Obviously I confronted him because I saw it as a dereliction of the manager’s responsibility that if he had information about me he should’ve addressed it personally with me to give me the opportunity to accept or not what he had heard. Then give me the opportunity to correct my behaviour if it was necessary.

The lack of informal dialogue between managers and staff to address issues of concern meant that managers did not always provide BME staff with formative feedback, thus missing opportunities given to staff for training to improve their performance. Staff recruited from overseas were most vociferous in highlighting this issue.

The pattern of under management or over management of BME staff repeatedly mentioned in the focus groups was thought to reflect a lack of confidence amongst managers in dealing on a practical level with issues of cultural diversity. It could also be seen as a strategy employed to avoid any accusations of discrimination. This was further substantiated by observations that disciplinary action taken by managers were frequently accompanied by the comments ‘I hope you realise that this isn’t racially agitated’.

Concern was also raised about managers’ lack of ‘softer skills’ as well as their commitment to organisational values such as dignity and respect. There appeared to be a lack of review as to what constitutes productivity in case mix and case assessments, in particular what it takes to give a quality service to patients with diverse needs. One staff member expressed her anxiety about this:

_I have seen someone being disciplined just for providing a long time for the patient because he had to explain things to the patient and the manager said, ‘Oh it’s wasting time, and you should have seen ten people ... he has only seen five people’ and the patients were happy ... so I’ve noticed the managers didn’t like that ... and also it has happened to me as well because I try to explain things and I try to be thorough in whatever I do ... so sometimes they say, ‘You are wasting time’._

4.1.3. Commitment to equality and diversity

In relation to ethnic monitoring, participants felt that there was a clear need to improve the process of data collection relating to disciplinaries with recognition that some trusts were not collecting disciplinary data broken down into ethnic categories.

In addition it was recognised that the disciplinary policy and process were not adequately integrated with the Equality Impact Assessment process. Staff questioned whether members of disciplinary panels had undertaken any form of equalities training and also highlighted a perceived absence of BME staff sitting on disciplinary panels.
4.2. Suggestions for change

Staff were asked to suggest ways which would help the situation both for themselves as potential subjects of disciplinary proceedings and for managers with responsibility for initiating these proceedings. On the whole, staff felt that there was considerable scope for improvement in relation to the way in which staff were managed within trusts. It was suggested that existing systems were strengthened so that staff complaints in relation to grievances, harassment and victimisation were managed fairly, efficiently and effectively. Organisational development and training was seen as crucial, particularly for issues of diversity and human rights, which many considered should be mandatory. Staff thought training needed to cover a wide range of areas relating to people skills, communication, performance management, disciplinaries and interpreting behaviours. For BME staff, issues highlighted for structured personal and professional development focused upon Agenda for Change dimensions and levels of competency in relation to service improvement, quality and health and safety. There was a recognition that staff development and training needed to facilitate their empowerment. To this end, it was evident that BME staff needed help to understand the more formal aspects of disciplinary proceedings, including how to prepare and structure reports. It was felt that managers could learn a lot about cultural competency and equality issues from the expertise of Equality Champions.

The importance of managers and staff learning together was seen as extremely beneficial, as was the need for multidisciplinary training involving people from different staff grades using innovative methods of training. E-learning was suggested as a commonly employed training technique that could be backed up by face-to-face learning situations (including case studies and other experiential training), involving patients and staff from diverse backgrounds. Some staff also thought it was important to use training sessions to explore working in an organisation with a largely white management structure. The concept of reverse diversity mentoring, such as staff helping managers to understand diversity matters, was also discussed.

On the whole, staff also felt that management needed to give more attention to equality and diversity issues. For example, it was felt that managers needed to ensure that equality and diversity competencies as outlined in the Knowledge and Skills Framework were essential criteria for job selection and performance management, linked to clear accountability where those lacking the competency were given suitable development opportunities. Some individuals also mentioned the importance of toolkits to ensure managers carried out equality impact assessments on their staff groups so that measures were put in place to address any disproportionality in relation to disciplinaries. Staff talked about the need for dialogue between BME staff networks and trust board champions on diversity in order to monitor workforce data presented to trust boards particularly to review the numbers of BME staff subject to capability, performance and disciplinary procedures. Just as patient experience has become a key
performance indicator; it was felt that staff experience should count towards a trust’s scorecard, so that any disproportionality in relation to different ethnic groups could count against a trust. Comparative benchmarking of NHS trusts’ disciplinary data was also felt to be important.

Staff thought that there was a need for simplification of the disciplinary policy and greater clarity regarding the difference between disciplinary, capability issue and performance issues. The general understanding was that a disciplinary issue should be dealt with through the disciplinary procedure, a capability issue required training and development and a performance issue needed performance monitoring. Both the ACAS Guide to Discipline and Grievance at Work along with the Code of Practice on Disciplinary and Grievance Procedures were identified as important managerial resources to support organisations to cope effectively with disciplines.

Once the disciplinary process had been initiated, it was felt that there needed to be the right level of support at the informal stage, for staff and managers. Some BME staff thought that it would be useful to have a list of other BME colleagues they could approach for help during a disciplinary process. They also thought an effective counselling service would be advantageous. To avoid proceeding to the formal stages of a disciplinary, mediation between both parties was suggested as an option but at the same time there was concern that mediation could be used to hide matters that should be brought into the formal setting. The need for objectivity through the involvement of an independent representative or human resources manager was considered crucial and one idea put forward was for monthly meetings to take place between managers and the human resources department in order to discuss potential disciplinary cases. Staff thought it would be useful to build a point into the disciplinary process where managers could consider whether their decisions were being unduly influenced by racism, and agreed that there was a need for more BME managers.

In light of the difficulties experienced by staff recruited from other countries, it was felt that specific action needed to be employed to meet their needs. There was strong demand expressed for the NHS to develop and deliver programmes which addressed issues concerning its organisational culture and sub-cultures. For staff with limited fluency in conversational English, another suggestion forwarded was to raise awareness of English language classes taking place in local colleges. It was also felt that such staff members of staff for whom English is a second or third language might benefit from advocacy where appropriate.
4.3. Summary

Discussions with BME staff about their views and experiences of disciplinary proceedings highlighted a number of concerns relating to the transparency of the disciplinary process and managers’ application of the disciplinary policy. BME staff felt that there was a tendency for managers to misinterpret behaviours or attitudes of staff from cultural backgrounds that were different to their own and were also more likely to formalise disciplinary proceedings in cases involving BME staff. There was mention of an established custom and practice culture within trusts which influenced standards and the way in which staff were expected to work. In general BME staff involved in disciplinary proceedings had been concerned about the level of understanding around these issues by unions, the homogeneity of disciplinary panels and the lack of accountability in terms of the way decisions had been reached. In some cases, racism was suspected. Staff expressed the need for more tailored induction programmes, more innovative ways to give training on equality and diversity, and access to mediation to resolve issues as early as possible.
CHAPTER 5: COMPARATIVE REVIEW OF OTHER PUBLIC SECTOR ORGANISATIONS

Having examined the experiences of managers and BME staff in relation to disciplinary proceedings within the NHS, this chapter examines literature relating to the experiences of BME staff in relation to disciplinary processes within four other public sector organisations; the police service, local government, central government and higher education. The comparative review was undertaken in order to benchmark the performance of the NHS in relation to BME staff and disciplinaries against comparable organisations, to examine the experiences of minority ethnic staff employed in other sectors and identify any examples of good practice within other sectors in relation to disciplinaries that could be transferred to the NHS.

5.1. The Police Service

Disciplinary procedures have been the subject of considerable investigation in recent years. Of most relevance are the Taylor Inquiry (2005) which involved a thorough review of police disciplinary procedures and the Morris Inquiry which was set up by the Metropolitan Police Authority as a result of concerns about unfairness and discrimination in the way some types of employment matters were dealt with by the Metropolitan Police Service (Morris et al., 2004). Through analysis of available statistics, this inquiry ‘showed clear disproportionality’ in the way that minority ethnic officers were being treated in relation to the management of their conduct. The inquiry highlighted concerns about how the Directorate of Professional Standards managed investigations and the accountability of senior managers for the way in which investigations were conducted. In addition, problems were identified with the disciplinary system in respect of delays, the use of suspension, the treatment of individuals and the actual conduct of investigations. Around the same time, members of minority groups working as civilian support staff (including traffic wardens and community support officers) were found to be overrepresented in police disciplinary procedures. 38% of those disciplined during a seven month period in 2005 were members of minority ethnic groups whilst less than 24% of civilian staff were drawn from those minorities. Evidence also exists to suggest that minority ethnic staff are more likely to be convicted following criminal and misconduct investigations (HMIC, 2006) and a disproportionate number resign or are sacked early on in their careers (Bennetto, 2009).

5.1.1. Reasons

Within the police service, there has been speculation that overrepresentation of BME staff in disciplinary proceedings could be the result of failures in training, either of staff or their managers, a misunderstanding by managers of the disciplinary policy or resulting from discriminatory beliefs (Cobain, 2006). It was found that managers and middle-ranking officers lacked confidence in dealing with complaints involving officers from ethnic minorities, so these
more often resulted in a formal hearing, rather than being dealt with informally (Foster, 2005). It has also been suggested that some managers and middle-ranking officers may be more likely to play it ‘by the book’ when dealing with BME staff because they feared being accused of discrimination. There was also an opinion within the Black Police Association that disciplinary policies were not always applied consistently, resulting in BME officers being pursued over trivial matters.

5.1.2. Solutions

Having identified a range of explanatory factors for the overrepresentation of BME staff within disciplinaries, a number of recommendations have been made by these reports in order to improve the conduct of disciplinary proceedings within the police service.

- Moving away from bureaucratic processes to more streamlined and simpler disciplinary procedures (Bennetto, 2009).
- Taking steps to eliminate discriminatory management practice which has led to a disproportionate number of investigations of BME officers.
- Ensuring that disciplinary matters relating to individuals are kept confidential and not discussed with third parties in a public forum.
- Putting in place measures to ensure that officers under investigation (other than covert investigations) are kept informed of developments and that officers are told of the detail of any charges at the time they are told of a decision to discipline them. In addition, officers under investigation need to be provided with a written record of the outcome of any investigation and a summary of the reasons for that outcome.
- Reviewing the conduct of disciplinary hearings to make them less akin to criminal courts. For example, in sensitive cases, or where there are vulnerable witnesses, more attention is paid to the layout of the room and other practical considerations, such as allowing those involved to be accompanied by a friend or partner, so that the process is less daunting for all those included in disciplinary cases.
- Establishing a new model of case management, with input from outside the Directorate of Professional Standards, to ensure that it is held to account for the progress of investigations.
- Building the confidence of managers to enable them to manage all aspects of difference (Morris Inquiry, 2005).
- Adoption of the ACAS Code of Practice on Disciplinary and Grievance Procedures.
- Introduction of a new Code of Ethics known as the Standards of Professional Behaviour with specific reference to unlawful or unfair discrimination.
• Use of mediators to resolve disputes, in particular at the informal stage to avoid moving into formal disciplinary proceedings (Coaker, 2008). In addition, the need for mediators in different parts of the country to be brought together on a regular basis to share experience and refresh their knowledge of common developments in mediation techniques.

• It is evident that five forces – the Metropolitan Police Service, Greater Manchester, Northumbria, Leicestershire and Lancashire – have commissioned research work into the reasons for the overrepresentation of black and minority ethnic staff in disciplinary procedures. It is recommended however that further research using a co-ordinated approach is undertaken to examine the disproportionate number of investigations conducted into officers from BME backgrounds (HMIC, 2006; Bennetto, 2009).

5.2. Transport for London

Transport for London (TfL) has been routinely collecting disciplinary data in recent years and the ethnic background of staff involved in disciplinaries is monitored closely. Recent statistics reveal that BME staff working within the organisation are not overrepresented in disciplinary proceedings despite there being an increase in the percentage of disciplinary cases brought against BME staff from 21% in 2005/2006 to 34% in 2007/8, which is reflective of their presence within the workforce. Career progression and harassment, however, have been highlighted as issues for BME staff and it is recognised that the organisation has an underrepresentation of BME employees at senior levels.

A recent study revealed that some BME staff feel that they have to overachieve to justify the positions they hold and that if they make a mistake, it will be regarded more seriously than a mistake made by a non-BME colleague. Transport for London was generally seen as having a positive approach to race equality among its employees, because of its policies and efforts to encourage equality and inclusion. Staff from across different groups generally felt that if they experienced any problems in the workplace, particularly with discrimination, they would feel comfortable raising the issue. Some were concerned that this would have a negative effect on their career, and others said they thought it better to ignore it. Despite this, staff generally saw TfL as an organisation that took such issues seriously and would support staff appropriately. Some BME staff valued staff network groups and BME colleagues from other areas as sources of support and assistance if they were having a problem.

5.2.1. Solutions

• A number of strategies have been implemented by TfL to promote a supportive work environment within the organisation based upon fairness and equality:
A management development framework which aims to equip managers with the skills necessary to develop themselves and their teams. TfL’s management development framework provides line managers with a clear understanding of their role in the performance management and development of their teams. All TfL middle managers are encouraged to take part in the programme and TfL will report the numbers of people who have attended, and their department. HR business partners and Learning and Development teams will also work with directors and their teams to ensure that development plans are in place for all staff.

A series of training and cultural change programmes, including ‘Valuing people through fairness and inclusion’ and London Underground’s Managing Diversity Competence Programme. Both of these focus on how behaviours can have a positive or negative effect on working environments and relationships with colleagues or staff. These courses have been judged to be very useful by those who have attended.

‘Safecall’ a 24-hour telephone support service which can be used by anyone working for TfL or any of its subsidiaries including contractors and agency staff if things go wrong.

A mentoring scheme which is open to all employees but specifically encourages applications from BME employees. Currently 55 per cent of all mentees on the scheme are from BME groups and 30 per cent of mentors are BME managers.

The Black, Asian and Minority Ethnic (BAME) Staff Network Group works closely with HR and other areas of the business to identify issues and devise appropriate solutions.

Provision of faith rooms.

Strategies to attract BME candidates for senior roles.

5.3. Local Government

Our review of local authorities was limited mainly to information available on council websites and revealed that minority ethnic groups were overrepresented in disciplinary procedures within some of the authorities publishing disciplinary data, including Bristol City Council and Nottinghamshire County Council. The overrepresentation of BME staff in disciplinaries has also been explored by Tamkin (2000) who examined eight local authorities in London, all of which had an excellent record for employing minority ethnic staff, relatively good representation of minority ethnic groups at managerial level, a strong commitment to practicing equal opportunities but disproportionate levels of minority ethnic groups facing disciplinary action.
Tamkin’s study (2000) revealed that disciplinary cases were dealt with appropriately, with no
evidence of cases being processed at an inappropriate disciplinary level, suggesting that the
disciplinary system per se was not the cause of the disproportionality. The ethnicity of the
individual was found to be one of the key influencing factors upon managers’ decisions on
use of formal procedures. This worked two ways; either managers strove ‘at all costs’ to avoid
using formal disciplinary procedures with black and ethnic minority staff and ‘bent over
backwards’ to be seen to be fair, or managers invoked formal disciplinary procedures: ‘from
the start, keep it all on record and make sure your back’s covered’, for fear that informal
approaches could be interpreted as harassment or bullying.

In terms of their role, managers found dealing with poor performance one of the most difficult
issues to address. Managing poor performance was characterised by unclear rules, unclear
standards of expectation, procedures that were difficult to manage, lack of sanctions and lack
of support from senior managers and personnel. Further, minority ethnic staff were much
more likely to be given as exemplars of poor performance by white staff working in these
organisations and their behavior was more likely to be described negatively in terms of work
commitment, team working, quality of work, attendance, self-motivation, customer focus, time
management, work knowledge, reliability, attention and interpersonal skills (Rick et al., 2000).
In summary, the study found that there was a basic lack of clarity about what constitutes good
performance in a job and low levels of confidence amongst managers in the systems
available to support them in achieving good performance.

5.3.1. Solutions

- Review understanding/communication to managers about acceptable standards of
  behavior and performance, and when disciplinary procedures need to be instigated.
- Simplification and streamlining of disciplinary process.
- Development need for human resources professionals to champion changes in
  practice.
- Consider linking aspects of performance management into appraisal. This could be
  structured in a way that then supports use of disciplinary procedures if the problem
  persists.
- Better performance appraisal systems for individual staff based on clear and agreed
  standards for performance and behavior.
- Training for managers and human resources specialists in managing equality and
  diversity.
- Provision of appropriate support for managers, including peer support for
  inexperienced managers.
- Access to mediation for both parties at an early stage. Nottinghamshire County Council provides a mediation support and advice service to all employees of the Social Services Department and has a full time, permanent manager and a team of trained volunteer mediators, who have been recruited from various service areas and grades within the Social Services Department. Mediators tend to work in pairs to deliver the mediation service to employees who can refer themselves or be referred by someone else such as a trade union representative, personnel officer or friend (Further information about this service is available at: http://www.nottinghamshire.gov.uk/employeemediation.pdf).

- Access to staff networks for minority ethnic employees. Nottinghamshire County Council recognises that minority ethnic staff might need to discuss their situation with colleagues and therefore provides opportunities for employees to attend the corporate black workers’ group which was formed in 2007. This group serves as both a support network for employees and a consultation network for reviewing county council policies and services especially through equality impact assessments.

5.4. Central Government

Information about disciplinaries was analysed from three central government departments - the Home Office, the Department for Work and Pensions and the Department of Health.

5.4.1. Home Office

It is acknowledged by the Home Office that at present its disciplinary data is not being analysed to its fullest. The Overarching Race, Disability and Gender Equality Scheme: Progress Report (2008) states that there is a need both for more accurate monitoring of disciplinary data by ethnicity and for the disciplinary policy and its equality impact assessment to be reviewed on an annual basis. The human resources department and the department’s black workers support group, ‘The Network’, are seen to play a key role in this process and in establishing best practice with regard to its disciplinary proceedings. The Network was launched in 1999 and its role includes assisting the development of new and existing policies, where necessary, with regards to minority ethnic staff and providing a support network for staff.

5.4.2. Department of Health

Data relating to disciplinaries and BME staff was not easily accessible through the Department of Health website although this information is routinely collected. The Department of Health’s Single Equality Scheme 2009–2012 states ‘that where a discrepancy arises in the data, action is taken to address the issue’. The Corporate Management Board considers quarterly statistics and reports broken down by each equality strand. These are also published on the internal DH website.
5.4.3. Department of Work and Pensions

Since 2006, the Department of Work and Pensions has been publishing its disciplinary data broken down into two groupings, white staff and minority ethnic staff. The data shows that in comparison to the white staff group, a greater proportion of minority ethnic staff have consistently been involved in disciplinary proceedings. There is no indication as to whether and in what way the Department aims to address this issue, though. A large number of initiatives has been introduced to develop staff and give them the potential to succeed, including reverse mentoring and mentoring circles. In order to demonstrate its commitment to diversity, various events have been organised such as a diversity week in November 2008 which encouraged staff to learn more about each other and a diversity conference in Birmingham providing an opportunity for delegates to share ideas about diversity and for diversity awards to be presented.

5.5. Higher Education

Very little has been published about the experience of minority ethnic staff of disciplinary procedures within higher education. This may be explained by the failure on the part of many institutions to collect information about employment relations. Furthermore, there is no centrally collated information for the sector on records of disciplinary action as institutions are likely to collect this information in different formats (Connor et al., 2008). In 2004 it was found that only a quarter of institutions monitored disciplinary proceedings whilst in 1996 it was found that only 11 per cent monitored their grievance and disciplinary procedure. It is evident that some institutions still face difficulties in analysing this type of data because of the low declaration rates and/or relatively small numbers of minority ethnic staff employed in this sector (Labinjo, 2008). Limited resources also prevent some institutions from undertaking monitoring (Connor et al., 2008).

More generally within the higher education sector, Mirza (2009) contends that the prospect of being disciplined is a possibility for many black staff even if they meet expectations in terms of their work performance. She adds that black staff’s skills and intellectual capabilities are under constant scrutiny and black academic staff have to bear a ‘burden of invisibility’ because they are few in number. This ‘burden of invisibility’ is played out with black staff being ‘viewed suspiciously and any mistakes [being] picked up and seen as a sign of misplaced authority’. She further suggests that black staff have to work harder for recognition outside of the confines of stereotypical expectations. A recent review of literature relating to the experience of black and minority ethnic staff in higher education concluded that there was a need for further research that specifically investigated the experience of professional and support staff at all levels (Leathwood et al., 2009).
A web search of disciplinary issues in relation to BME staff within higher education institutions identified only two universities that had put in place specific strategies to help minority ethnic staff. The University of Wolverhampton has produced a user friendly leaflet for its staff and students explaining how to access advice (Race Equality Action Plan 2003-4) whilst the University of East London promotes its network as a source of help and support for minority ethnic staff facing disciplinary proceedings (Labinjo, 2008).

5.6. Summary

The extent of BME staff involvement within NHS disciplinaries resonates with their experience of employment in other public sector organisations, most notably within the police service and in local government. The reasons advanced for the overrepresentation 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, discriminatory attitudes, lack of clarity around disciplinary policies and inadequate staff training. 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.
CHAPTER 6: CONCLUSION

This study set out to explore whether black and minority ethnic staff employed in NHS trusts are more likely to be involved in disciplinary proceedings and if so, to analyse the underlying factors to explain this overrepresentation. In answering this question, the research has highlighted a number of issues, some of which are mirrored in other sectors, relating to the experience of minority ethnic staff in relation to disciplinary proceedings, the confidence and effectiveness of managers in handling disciplinary cases and the transparency of disciplinary proceedings themselves. At the same time it has drawn attention to important organisational challenges which the NHS faces and will have to address if it aims to deliver a health service that in itself is fit for purpose in meeting the needs of its users. Not least the need for improved systems of data collection around disciplinaries without which further research on this topic will be seriously hampered. Finally, in conducting this research, one of our aims was to identify good practice taking place within organisations in relation to disciplinaries and to share these exemplars of innovative working with other organisations across the NHS. A number of projects came to light during the course of the study and these are described in some detail below.

6.1. Examples of Good Practice

Case study 1: Mediation

*Guy’s and St Thomas’ NHS Foundation Trust* recognised that unresolved conflict could severely disrupt workplace communication, performance and employee job satisfaction and be costly in terms of productivity and possible legal fees. Workplace mediation could be seen as a pragmatic approach to dealing with conflict, providing the opportunity for those experiencing conflict situations in the workplace to identify any underlying issues, explore options, avoid a blame culture and reach a workable outcome through a written agreement. The trust, in partnership with unions, agreed to be an NHS pilot site for workplace mediation with full support from the management executive.

The scheme was easy to set up internally, is inexpensive and uses in-house expertise. Initially, five union representatives and five management representatives including HR, clinical managers and non-clinical managers were chosen for a working group which was facilitated by ACAS. The group held six meetings and agreed the detail of the scheme, developed a procedure and policy, advertised for and selected mediators and supported the scheme after its launch. The scheme was publicised with road shows on each site, through leaflets, an in-house magazine article and team briefings. The scheme is also mentioned in the corporate induction and has been integrated into management training courses in harassment and bullying, discipline grievance and into the trust’s dignity and respect policy.
Participation is voluntary and is controlled by two coordinators who also undertake monitoring. The mediation process is confidential, notes are not kept and rights of access to other policies are not removed. Twelve accredited mediators were trained and receive time off for mediation and meetings, including quarterly peer group meetings and quarterly meetings with the working group.

The mediation process involves initial contact with one of the co-ordinators and the allocation of a mediator. The mediator meets with each party separately before holding a joint meeting with them and a written agreement is drawn up. No representatives attend the meetings. During year one the scheme saw 23 cases. Of these 11 were completed, 8 did not get underway, three were partially completed and one became a formal case. The median duration of a case from referral to resolution was three weeks, and cases take from one to one and a half days to complete. There were some challenges involved in setting up the mediation scheme. It was agreed that mediators would be accredited, not just trained, which became a lengthy process. There were also practical issues involved, such as booking rooms and the availability of mentors. Some staff were reluctant to participate in mediation and initially there was a slow rate of uptake. In terms of benefits, the trust values mediation as an informal way to resolve potentially difficult situations and the avoidance of issues escalating unnecessarily. The scheme also links with other initiatives and brings the added benefits of working in partnership.

**Case Study 2 - Fair Play Advisor Scheme**

*Royal Liverpool and Broad Green University Hospitals NHS Trust* decided to develop a confidential peer support service to help staff address difficulties in the workplace after an internal staff survey revealed that 9% of staff felt they had been discriminated against. The ‘Fair Play Scheme’ was developed as a confidential advice service for staff and involve trained volunteers recruited to provide impartial advice. The aim of this scheme was to work towards having a higher success rate in resolving concerns in the informal process and improve staff morale by dealing with issues quickly and efficiently.

The scheme was formally launched in March 2009. Positions for Fair Treatment Advisors were advertised within the Trust and interested staff were interviewed. The scheme consists of named trained volunteers. Employees with a concern contact an advisor by email or phone. The advisor then decides on the best way to deal with the issue and either responds over the phone/email or arranges to meet the employee to discuss. The advisor will listen to the employees concern and provide advice in line with trust policies. The advisors are seen as the first point of contact and their role is to confidentially discuss concerns and provide guidance on polices as well as signposting to internal and external support mechanisms.

As well as providing advice to individuals, advisers were given the remit to meet as a network to identify common concerns and contribute to the development of positive and preventative
action to improve communications and relationships between and amongst staff. In addition, it was hoped that the scheme would prevent most issues from going to the formal process, thus reducing the cost of an investigation and stress on the parties directly involved including their witnesses.

Though early days, evidence suggests that the scheme allows parties to work together in a respectful, safe and open environment. Secondly it assists the parties in arriving at a mutually agreed resolution. Thirdly it promotes communication and cooperation. Fourthly it allows the parties involved to control the decisions that affect their lives. Fifthly it benefits others involved by reducing conflict. Lastly it is confidential, avoiding public disclosure of personal problems. Consideration is being given to how the trust intends to monitor and evaluate the scheme. Monitoring is important to provide basic data on the numbers of users of the service, broken down into various categories (e.g. harassment of lesbians and gay men, sexual and/or racial harassment, etc). This will enable the trust to identify any particular patterns of issues, and thus alert the trust to areas on which they need to concentrate additional attention and/or resources. It will also enable the trust to identify what resolutions were achieved in each case and those where complainants decided not to proceed with formal complaints.

Case study 3: Use of decision trees

Imperial College Healthcare NHS Trust, like many organisations took the decision that front line managers should carry out activities which were traditionally within the remit of human resources, such as providing coaching and guidance, undertaking performance appraisals and dealing with discipline and grievance issues. Imperial NHS Trust developed the ‘incident decision tree’ to help managers determine a fair and consistent course of action towards staff involved in employment relations issues, including disciplinary matters. The reason behind using decision trees was to create an easily understood and visible structure for evaluating complex decisions and working towards consistent application of policies and practices. They also helped supported the trust’s aim of creating an open culture.

The trust developed a decision tree adopting a type of graphical model hosted on the trust’s intranet that acts as a guidance document. Different decision trees exist and they cover the areas of capabilities, grievances, disciplinaries, team development and job roles. The tool comprises an algorithm with accompanying guidelines and poses a series of structured questions to help managers decide whether a certain course of action, for example a disciplinary is needed or whether alternatives might be feasible. The approach encourages key decision makers to consider systems and organisational issues in the management of staff and because decision trees form part of a centralised intranet portal system, their use promotes consistency in decision making.
Management development was undertaken to familiarise managers with decision trees. Managers were guided through a series of structured questions for example involving a disciplinary issue about the individual's actions, motives, and behaviour at the time of the incident. Managers were encouraged to recognise that before the process of decision making was undertaken they needed to understand the problem for which a decision was needed. It was emphasised that only when the problem was analysed properly could all aspects of the problem be clearly understood. Thus the first stage involved analysis and defining the problem. Managers were also encouraged to classify the problem in order to decide who must take the decision and who needs to be consulted and informed.

The decision tree framework is built upon an expectation that managers will explore a range of solutions and choose the most appropriate option. Decision trees are seen as self-supporting insightful tools that provide a framework for decision-makers to quantify the value of different outcomes and the probabilities of achieving them but cannot ‘provide the answers’. As with all decision making methods, it is made clear to line managers that decision tree analysis should be used in conjunction with common sense, trust polices and reference to human resources – as such, decision trees are to be seen as just one important part of manager’s decision making tool kit.

Feedback has revealed the ‘decision tree’ to be an excellent and logical and systematic decision-making process that helps managers to address the critical elements that result in a good decision. By taking an organised approach, they are less likely to miss important factors, and can build on the approach to make better decisions and ensure that they have followed due process. It has allowed managers to work with staff to create a constructive environment and through exploring alternative options it has allowed managers to see the ‘bigger picture’. Lastly use of the decision tree has enabled managers to clearly communicate their decision in a rationale manner and to take appropriate action.

**Case study 4: Research to examine the experiences of UK, European and non-European medical graduates making the transition to the UK workplace**

With funding from the General Medical Council, NHS North East and Newcastle University conducted a comparative study to explore issues faced by doctors entering the workplace and that might lead to later performance problems amongst particular ethnic groups. The study included cohorts of international medical graduates (European and non-European) and arose in response to a growing body of evidence highlighting performance problems occurring as a result of the transition process, from either one country to another or from one stage of training to another. The research involved conducting questionnaires and interviews with doctors as well as their educational supervisors in order to establish factors which help or hinder the transition to the UK workplace and differences in the performance of overseas and UK graduates during the transition into the first year of practice.
On the whole, the study found that overseas doctors arrived ready to start work with more self confidence in their ability to do the job than the UK doctors and were more prepared for NG tube, acute management and anatomy. UK doctors on the other hand were more confident in applying the principles of holistic care, and considering how social and psychological factors impinge on health. They were also more prepared for history taking and communication.

Factors that overseas doctors thought could hinder their transition included a long gap before starting work, lack of exposure to clinical practice in the UK and insufficient information about living and working in the UK. Since working here, overseas doctors had noted a number of cultural differences which they felt could affect their performance. These differences related to language and communication (particularly with nurses), working as part of a team, conducting practical procedures and the importance placed upon ethical and legal issues within the workplace.

The transition for overseas doctors had been helped by factors such as the Professional and Linguistic Board (PLAB) exam, clinical attachments, the induction programme and the review process. Shadowing was also highlighted as a useful way to clarify their role, familiarise themselves with the hospital system and ‘new’ equipment, address gaps in clinical practice and improve communication with colleagues and nurses. Additional factors that overseas doctors felt might help their transition included stronger support structures (mentoring, peer support and the availability of role models), regular feedback on their performance (including areas for improvement) and a buddy scheme put in place starting from the time of their induction. The study concluded that overseas doctors begin their working lives in the UK having been trained with different models of practice and a different ethical framework to influence practice and cause problems when working in the UK.

**Case study 5: Improved partnership working**

*Wolverhampton City Primary Care Trust (PCT)* was formed in April 2002 following a merger of the Wolverhampton Health Care Trust, the local Health Authority, and three local Primary Care Groups (PCGs). It employs around 2,000 direct staff, and has recognition agreements with 11 NHS trade unions. Prior to this restructure, in the late 1990s ACAS was approached by trade unions and senior management at Wolverhampton Health Care Trust to help them set in place a ‘partnership’ approach to management-union employment relations resulting in a Partnership and Staff Involvement Agreement. The sustainability of this agreement was seriously threatened by the restructuring of the trust and its evolution from a Health Care Trust to a PCT with unions believing that they were being ‘sidestepped’ by management in terms of important decisions relating to organisational change. The unions suspended the partnership agreement but both parties remained committed to the principles of working in partnership and recognised that something needed to be done to get the partnership ‘back on track’.
ACAS was approached for help and developed a workshop programme attended by 25 Trades Union and management representatives. The workshop enabled participants to explore the immediate issues relating to the suspension of the agreement and reviewed the underlying values, principles and barriers to partnership working. This was essential given the change in personnel that had occurred following the formation of the PCT. Participants felt that the workshop was productive, was very effective in reviewing the shortcomings of the partnership agreement and was relatively free of tensions. By the end of the workshop the partnership agreement had been rewritten and an action plan for implementation was formulated.

Following the approval of the revised partnership agreement by the new Trust Board, partnership was rolled out across the PCT and, according to management and union representatives, appeared to be working effectively. In order to ensure that the message of the ACAS workshop was firmly instilled across the organisation, a further round of ‘working together’ training sessions were delivered by senior union and management representatives. These sessions were specifically aimed at educating line managers about the principles and values of partnership.

That the partnership approach was back on track was evident in the way the Trust was dealing with the implementation of Agenda for Change. A series of joint project boards were set up to tackle specific aspects of the programme and a number of staff ‘away-days’ were held to inform and engage staff about the nature of the programme and its likely impact within the organisation.

**Case study 6: Building employee involvement in decision-making**

*Basildon Primary Care Trust (PCT)* was established in April 2001. It provides community services and primary care, and funds secondary services. Employing around 400 staff, it has recognition agreements with five trade unions. In mid-2003, the Trust approached ACAS for help because its Joint Staff Forum (JSF) comprising of representatives from management and the trade unions, was widely considered to be ineffective. This was due to several factors. First, as a result of the restructure that formed the Trust, some managers had little experience of working with union representatives. Second, many trade union representatives – including the Chair of the JSF – did not represent the views of staff in the Trust, as they had been seconded from other NHS sites. Against this backdrop, ACAS was approached to advise on how to improve the effectiveness of the JSF.

ACAS organised two facilitated workshops to find solutions to improve the functioning and effectiveness of the JSF, and to look at ways of increasing numbers of employee representatives on the Forum, including representatives of non-union employees. The first workshop was attended by senior or strategic level management and union representatives and focused on ways of placing the Forum at the heart of the change programme at the Trust.
The second involved operational managers and union representatives and considered practical strategies for improving employee ‘voice’ and the functioning of the Forum. Action plans were generated at the end of workshops, and the ACAS adviser produced a report for the organisation of what had been discussed and agreed during the workshops. These were used by the head of HR and staff side chair (lead union representative) to produce a combined action plan. This was taken to the Forum for approval and a JSF sub-group was established to take the plan forward.

Overall, employee representation and involvement in decision-making has increased within the Trust. The number of trade union representatives has increased, with more involved in the JSF. The five new JSF representatives have been formally trained and accredited by unions; one non-union representative is in post and a second will be appointed from an under-represented staff group. The Trust now also has seven dedicated, accredited trade union ‘Agenda for Change representatives’, who attend JSF meetings when Agenda for Change items are discussed, a move that has been welcomed by both the union and management. It was acknowledged that without these representatives, the JSF would not be able to deal effectively with Agenda for Change.

The composition of management representatives on the JSF is also now more consistent and management presence has been strengthened. Both the union side and HR agreed that the Forum’s effectiveness has been greatly improved. Meeting agendas are more clearly delineated, with time specifically allocated for tackling strategic issues, and there is a clearer view of which issues should be dealt with by the JSF, and which should be resolved locally, at department level. For the Head of human resources, the improvements in representation and consultation have also had tangible benefits for the general climate of employment relations. The high level of trust between management and union has had a positive impact on staff. Feedback indicates that staff are happy with how Agenda for Change was implemented and communicated to the workforce.

Throughout 2004, ACAS helped the Trust implement the action plan further by delivering training workshops for managers around broader human resources issues, including attendance management, and running workshops for management and trade union representatives on partnership working. This was deemed important in taking forward Agenda for Change, but also represented an opportunity for the Head of human resources to assess whether genuine partnerships had been formed within the trust. For her, the extent of joint working between staff and management had improved immeasurably, with clear benefits for the implementation of Agenda for Change. The partnership workshop also led to the insertion of jointly agreed principles of partnership into the organisation’s trade union recognition agreement, as well as a statement on facilities time and a suggested staff charter (which would incorporate a set of principles on employee involvement within the Trust).
**Case study 7: Monitoring and analysis of disciplinary data**

Bradford Teaching Hospitals NHS Foundation Trust employs just over 4,500 members of staff, has an annual budget of approximately £300 million and consists of two teaching hospitals. These hospitals serve a local population of approximately 500,000 made up of 75% white British, 20% Asian or Asian British and 5% other ethnic groups.

Regular annual monitoring of the Trust’s disciplinary data alerted the Trust to the fact that BME staff were consistently overrepresented in their disciplinary proceedings. More detailed analysis as illustrated by the graph below showed that BME staff were twice as likely as white staff to be subjected to disciplinary action.

**Figure 2: Disciplinaries broken down by ethnic group (January 2008 – December 2008)**

![Disciplinary data graph]

Having recognised that there was a disproportionate impact on BME staff from their disciplinary procedures, the Equality and Diversity Manager arranged a meeting with members of the BME network to discuss the trust’s disciplinary procedure and hear any concerns that staff might want to air. The response from the BME network was very encouraging. Although there was concern about the figures presented, they were happy to establish dialogue on how to address the issue and suggested that the findings were also presented to Trust managers. As a consequence, the trust is currently carrying out Equality Impact Assessment (EqIA) of the employee relations function, the aim of this process being to capture issues and implications relating to all six equality strands and human rights on 19 employee relations policies (including the disciplinary policy).
An equality team has been put together made up of clinical and non-clinical service managers, matron, trade union, Assistant Director of Human Resources, two members of the BME Network and the Equality and Diversity Manager. This group has met on several occasions and is almost at the point of going to out to consult on the issues and implications. Following consultation, if the EqIA uncovers any potential discriminatory practice, an action plan will be developed for the service managers to implement as necessary.

6.2. Key messages

The web audit of NHS disciplinary data revealed that overall, BME staff were almost twice as likely to be disciplined as their white counterparts. In Acute, PCT, Mental Health and Learning Disability and Care trusts, BME staff were significantly over-represented 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.

Our discussions with human resources managers and BME staff networks identified a number of factors perceived to explain the disproportionate number of BME staff involved in disciplinary proceedings. Issues arising from a lack of familiarity with local customs, differences in styles of communication, limited fluency in English, and time-keeping were factors identified by BME staff to explain their greater likelihood of being disciplined. They also mentioned a tendency amongst managers dealing with incidents involving BME staff to over scrutinise their behaviour and to formalise the disciplinary process too quickly. Similar patterns of behaviour were witnessed amongst managers working with BME staff within local authorities and the police service.

It was thought that inconsistent management practices in relation to disciplinaries reflected a lack of confidence amongst managers in dealing with issues relating to staff from different ethnic backgrounds. In some cases it masked underlying racism that was not always challenged by human resources departments, but unless BME staff could identify comparable cases in which there was differential treatment of white staff, it was difficult to establish whether discrimination was at play.

In terms of the induction of new staff into the organisation, it was felt that sufficient attention was not always given to transmit the ethos and values of the NHS, nor the organisational culture in which staff would be expected to work. There was repeated mention of a custom and practice culture existing within the NHS which was seen as perpetuating unwritten workplace norms and was instrumental in reproducing an environment in which bullying and victimisation of individuals displaying difference was commonplace.

BME members of staff who were trained overseas and whose behaviour was called into question by their managers often felt isolated and unsupported. Union support was generally considered to be in need of improvement. The disciplinary process was characterised by a lack of transparency and accountability. BME staff involved in disciplinary proceedings were
not fully aware of the implications of the evidence they were expected to prepare and felt disadvantaged owing to their unfamiliarity with the whole process.

6.3. Implications for policy, practice and research

Conducting the web audit alerted us to the large number of NHS trusts not currently complying with the legislative requirements for public sector organisations to publish disciplinary data broken down by ethnicity. Our web search identified that only one fifth of all NHS trusts were publishing valid data that could be included as part of our analysis. We recognise that some trusts with small numbers of BME staff, despite monitoring these statistics, had chosen not to publish the data publicly to preserve the anonymity of the individuals involved. Overall, the majority of trusts were not collecting data in a manner that would aid meaningful analysis. It is imperative for the health and social care sector to refocus its policy direction around diversity monitoring, particularly to disaggregate disciplinary data by occupational groupings. This will reflect the commitment of NHS trusts to address workforce inequalities and their adherence to the principles underlying the NHS Constitution, which clearly states that all members of staff, regardless of ethnic background, feel sufficiently valued and supported in their particular area of work. Further research is required to compare the experiences of BME staff with groups from other equality strands, working in different occupations and at different levels in relation to disciplinaries. As more detailed monitoring data becomes available, it would also be useful to examine experiences across ethnic groups. In addition, a comprehensive intervention study is necessary to evaluate the impact of different strategies on disciplinary rates.

The study highlights that, despite considerable progress in developing the race equality agenda, NHS organisations would need to rethink their investment of resources to ensure that staff are culturally competent and able to work comfortably with issues of diversity and difference. It is evident that a diverse workforce brings considerable scope for cross-cultural learning and benefit to the organisation. Equally important is the need to ensure that despite differences, all members of staff work towards shared professional standards and a common understanding of their roles and responsibilities, including what constitutes acceptable behaviour and what will not be tolerated in the interests of patient safety.

6.4. Recommendations

Having been presented with a number of factors thought to help explain the greater involvement of BME staff in disciplinaries, we encouraged research participants to provide us with a series of recommendations they felt would help to create a transparent and fairer disciplinary process. These recommendations were further validated towards the end of the study by conducting two workshops with experienced managers from a range of service areas. The input of these individuals was vital at this stage to help ensure that the solutions suggested to us by BME staff, human resources managers and regulators were reasonable,
practical and achievable. The recommendations are listed under the constituency for which they have most relevance, and highlighted in bold. Where possible, reference to recent, relevant NHS policies have been made to help trusts to integrate the recommendations from this study into existing or planned organisational strategies.

6.4.1. Senior management and trust boards

The recent interim Health and Well-Being Report (2009) stresses that staff health and well-being are not just the responsibility of occupational health departments or well-being advisers, but of every single member of staff. The welfare of the workforce needs to be seen as central to the NHS and recognised as a crucial issue at board level as much as at front line level. It is envisaged that adopting innovative approaches to supporting staff health and well-being will free up resources that can be reinvested in better and more appropriate services. Any costs will be outweighed by the benefits to NHS organisations. As well as financial benefits from reduced costs of sickness absence, increased productivity, lower spending on staff turnover, agency spending and ill-health retirement, there will be benefits to patient care and patient satisfaction as they are treated by familiar and happier staff members.

*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 the diversity strands. Just as patient experience has become a key performance indicator; staff experience should count towards a trust’s scorecard.* This data will support the evidence base that trusts have available to support their work around race equality or their Single Equality Scheme in terms of both benchmarking and developing the ‘business case’ around equality and diversity.

The NHS Constitution states that the NHS is accountable to the public, communities and patients that it serves. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. *In order to improve accountability during disciplinary proceedings, boards should be given details relating to the nature of the data, a review of the numbers of BME staff who are subject to capability, performance and disciplinary procedures and manager’s competencies and skills in assessing the case. Efforts need to be made to recruit a more diverse mix of people to sit on panels to assess cases.*

*Encourage engagement and dialogue between BME staff networks and trust board diversity champions to monitor human resources and workforce data presented to trust boards.* Such activities will require top management leadership and staff participation to ensure that they are incorporated into the core business of the organisation as part of what it means to be a good employer.
The NHS Constitution states that the NHS should aspire to the highest standards of excellence and professionalism to ensure that patients are treated by appropriately qualified and experienced staff with a properly approved or registered organisation. *In order to ensure that the NHS workforce is ‘fit for purpose’ and is equipped to provide a consistently high standard of care to its patients, it is imperative for trusts to better understand the reasons behind disproportionality in relation to minority ethnic groups and disciplinary procedures through use of root cause analysis, independent review of cases and post case review, and exit interviews.*

*NHS trusts need to develop better communication of organisational policies and procedures for all new members of staff from the outset of their employment.* As part of this induction, their duty to accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to their profession or role needs to be emphasised.

*Comparative benchmarking of NHS trusts’ disciplinary and grievance data should be undertaken to assess performance. Members of minority ethnic groups should be involved in the development and evaluation of disciplinary procedures on a regular basis.*

**6.4.2. Human Resources and Service Managers**

The NHS Constitution states that all staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, treated with respect and their views given attention. They must have the tools, training and support to deliver care, and opportunities to develop and progress. At the same time, when mistakes happen, staff should be prepared to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively. In addition, the organisation needs to learn lessons from complaints and claims and use these to improve NHS services.

The Department of Health stresses in their report - *A High Quality Workforce* (DH, 2008) that the delivery of high quality education and training is an essential part of delivering high quality patient care. The NHS constitution also pledges to provide all staff with opportunity for personal development, access to appropriate training for their jobs and line management support to succeed. *It is vital that the appraisal system is used to identify and address the development and training needs of all staff. It is clearly evident that training is needed to help staff to understand the difference between performance management and disciplinary issues.*

A High Quality Workforce also sets out a commitment to ensure staff have consistent and equitable opportunities to update and develop their skills. *It is crucial 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.*
In line with NHS Core Standards which highlight the need to address discriminatory practices, trusts must ensure that equal opportunities are available for staff members to access relevant training and personal development opportunities so that they are competent in the skills and knowledge required to deliver responsive health care services. *As part of this requirement, trusts should consider devising innovative educational programmes and activities for their staff to raise awareness and better understand cultural differences at all levels within the organisation.*

*Use of talent management programmes as an indicator of employee satisfaction and progression within the organisation make full use of data management systems relating to disciplinaries including ESR and equality impact assessment.*

*There is a need to streamline the disciplinary process and develop greater clarity regarding the difference between disciplinary, capability issues and performance issues. A review of existing disciplinary policies and procedures should be conducted to ensure that they include clear definitions as to what constitutes formal and informal stages of the disciplinary process. Existing systems relating to employee relations should be simplified, clarified and strengthened, so that all parties involved are informed about the outcome.*

A High Quality Workforce stresses the need to ensure that all staff have clear roles and objectives, annual appraisals and professional development plans. *For individuals recruited from overseas in the first six months of employment, it would be useful to set up personalised induction programmes including the provision of information about local cultures, customs and practices. Staff with limited fluency in conversational English should be made aware of opportunities to learn English locally with financial support provided by their employers.*

Well-being is influenced by individual personal perception and requires an organisational culture of care, supported by good management practices and positive behaviours. In light of significant levels of stress within the workforce and a strong perception that senior managers do not take a positive interest in their health and well-being, support services should be made available to staff when and where they need them, in ways that meet their requirements and preferences, and at their request. *As part of its commitment to high quality care, trusts should provide appropriate support for anyone who is subject to a disciplinary process to improve his/her understanding of the process/counselling service, particularly at the informal stage.*

### 6.4.3. Trade Unions

The NHS Constitution states that all staff have a right to be treated fairly, equally and free from discrimination. *It is important for Trades Unions to work closely with BME staff, NHS Employers and, if appropriate, other staff representatives to constructively address issues that could lead to disciplinary action at the lowest level of intervention if and when they arise. Unions might want to consider reviewing their own support mechanisms for BME staff being disciplined.*
6.4.4. NHS Employers

There is a challenge facing NHS organisations of maintaining good employment relations and of the NHS being recognised as the employer of choice. Having a reputation as an employer that cares about its staff and values their contributions can help an NHS trust achieve this both in its own right and as part of an overall reward package for staff. Investing in its workforce can bring benefits both for patient care, by having strong and consistent teams of staff, and financially because motivated and happier staff are likely to be more productive and to remain with their employer. NHS Employers can facilitate this process by:

*Developing competency frameworks to ensure clarity in terms of the behaviours, values and skills expected to be exhibited at all levels within the workplace.*

*Providing support for trusts by developing a toolkit to help managers in monitoring disciplinaries and managing disciplinary proceedings in a culturally competent manner.*

*Considering developing a human resources and management code of conduct.*

*Disseminating information arising through lessons learnt and good practice relating to disciplinary procedures.*
REFERENCES


the NHS workforce through to recovery. London: NHS Employers


### Appendix I

Exploring the involvement of BME Staff in Disciplinaries

HR Directors Workshop March 20th 2009 11am - 3pm

<table>
<thead>
<tr>
<th>Time</th>
<th>Content</th>
</tr>
</thead>
</table>
| 11.00 - 11.15 | Part One: Setting the scene  
Welcome and introductions  
Confidentiality and ground rules  
Purpose of the session  
How the information will be used |
| 11.15 - 11.30 | Part Two: Overview of the Research  
Research objectives  
Research design phases one to four  
Presentation of research findings from phase one – Web audit results |
| 11.30 - 12.00 | Part Three: Group Discussion  
Exploring the web audit results |
| 12.00 - 12.45 | Part Four: Group Discussion  
Exploring Organisational Challenges |
| 13.15 - 13.55 | Part Five: Group Discussion  
Exploring Personal Challenges |
| 13.55 - 14.25 | Part Six: Group Discussion  
Examining What Constitutes Good Practice |
| 14.25 - 14.45 | Part Seven: Group Work  
Exploring the Role of NHS Employers |
| 14.45 - 15.00 | Summary and next steps |
## APPENDIX II

### Summary of focus groups / workshops undertaken with managers, regulatory bodies and BME staff networks

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Confederation offices, London</td>
<td>20th March 2009</td>
<td>A group of 9 HR Managers and 2 Equality and Diversity Managers from across the NHS convened specifically because of their interest in the issue of BME representation within disciplinary procedures.</td>
</tr>
<tr>
<td>Yeovil Acute Foundation Trust</td>
<td>23rd April 2009</td>
<td>A group of 15 line managers, HR managers and BME staff from across the Trust with experience of dealing specifically with disciplinary processes involving BME staff.</td>
</tr>
<tr>
<td>Guy’s and St Thomas’s Hospital London</td>
<td>24th April 2009</td>
<td>A group of 12 representatives from the pan-London equality and diversity staff network group on behalf of a variety of different types of NHS organisations across London.</td>
</tr>
<tr>
<td>Liverpool PCT</td>
<td>5th May 2009</td>
<td>A group of 18 members of the Liverpool BME NHS Staff Network from five local trusts and a representative from a healthcare union.</td>
</tr>
<tr>
<td>Ambulance Service BME Committee</td>
<td>28th May 2009</td>
<td>A group of 8 members of the Ambulance Service BME Committee representing services from across England and Wales.</td>
</tr>
<tr>
<td>Health professions regulatory bodies</td>
<td>21st September 2009</td>
<td>A group of 9 policy/equality leads representing health professional regulatory bodies including the NMC x2, GMC, Health Professions Council x2, General Optical Council, General Orthopaedic Council, Royal Pharmaceutical Society of Great Britain, Pharmaceutical Society of Northern Ireland.</td>
</tr>
<tr>
<td>Service managers</td>
<td>13th October and 30th November 2009</td>
<td>Two workshops – involving 30 service managers from a range of NHS organisations across the UK.</td>
</tr>
</tbody>
</table>
Disciplinary Research Advisory Group

Terms of Reference

The role of the Disciplinary Research Advisory Group will be to oversee, and to ensure quality and efficiency throughout the research project. The Group will meet three times for the duration of the project. There will also be ongoing communication and involvement with the Group members. Levels of involvement of the Group will vary depending on the stages of the project, as the research requires.

Objectives

- To participate in discussions and offer advice on the development and progress of the research study
- To support, promote and offer advice on dissemination and implementation of the research project and advise on other relevant activity
- To maintain commercial and intellectual confidentiality as required.

Membership

Obi Amadi Community Practitioners and Health Visitors Association (CPHVA)
Alex Ankrah South East Coast Ambulance Trust/National BME Committee of the Ambulance Network
Prof Carol Baxter NHS Employers (Chair)
Liz Maddocks-Brown NHS Institute for Innovation and Improvement
Paul Deemer NHS Employers
Wendy Irwin Royal College of Nursing
Mohammed Jogi NHS Employers
Monika Kalyan Kings College Hospital
Carol King Kings College Hospital
Sharon Murray South London and Maudsley NHS Trust
Swarnjit Singh Guys and St Thomas Hospital
Carole Smith NHS Employers
Ricky Lawrence Department of Health
Joanne Mc Connell Department of Health

Research Team

Prof. Uduak Archibong CfID Bradford University
Dr Aliya Darr CfID Bradford University
APPENDIX IV

Policies and practices identified as having a bearing upon the implementation of a disciplinary policy:

- Grievance policies
- Attendance policies
- Codes of Conduct
- Sickness absence management
- Bullying and Harassment policies
- Performance and conduct
- Counter fraud
- Reporting [SUI]
- Whistle Blowing
- Appraisal
- Equal Opportunities
- Recruitment
- Employment of Ex Offenders
- Information governance
- CRBs
- Complaints procedures
- Contracts and Terms and Conditions
- Medical / Dental
- Professional Registration
- Right to Work
- Mediation Services
- Peer Support Systems
- Listening Ears
- Counselling Services
- Staff Networks
- Joint Staff Committee
- FT Trade Union Facilitator
- HR Managers Trouble Shooting
- E&D Team contacts
- Welfare Dept
- Occupational Health Dept
- Chaplain Services
- Employee Assistance Programme - [external and impartial]
- Education and Training – [Capability instead of warning]
- Clinical Supervision
- Coaching and Mentorship