A fair experience for all:

Closing the ethnicity gap in rates of disciplinary action across the NHS workforce

NHS Workforce Race Equality Standard (WRES) strategy

A fair experience for all:

Closing the ethnicity gap in rates of disciplinary action across the NHS workforce

Version number: 1

First published: July 2019

Prepared by: The WRES Implementation team

Classification: OFFICIAL

Other formats of this document are available on request. Please send your request to: england.wres@nhs.net

Foreword

Organisations across the NHS are working diligently to improve workforce race inequality, but we all know we need to do more and at pace. Black and minority ethnic (BME) staff constitute almost a fifth of the total NHS workforce, yet the experiences they often face do not correspond with the values upon which the NHS proudly stands. It cannot be right that some of our hardworking staff are still more likely than their colleagues to face unfair treatment and discrimination in the workplace.

We cannot afford the cost to staff and patient care that comes from unfairness for a large section of the NHS workforce. The "business case" for race equality in the NHS is now a powerful one. NHS England and NHS Improvement, with their partners, are committed to tackling race discrimination and creating an NHS where all staff are fully engaged and supported – not least for the sake of our patients.

At the NHS People Conference, in May 2019, I announced that together, across the NHS, we will have a concerted focus to reduce the disproportionate ethnicity gap in entry into the formal disciplinary process – and to reduce the overall rate of unnecessary disciplinary action. We will do this by setting clear aspirational goals for ourselves and by undertaking robust support and advice – including through the sharing of replicable good practice in this area.

This helpful document presents us with the opportunity to make a real difference in this area. It presents stretching but achievable goals in this area for NHS organisations, and highlights good practice and recommendations for to bring about improvements to the culture of the health service – supporting organisations to shift from, the often, toxic environment of blame to one of support and learning.

I encourage all NHS staff to read this document and reflect on what we can all do to help deliver on its ambitious objectives. I look forward to seeing continuous improvements on this critical agenda over the coming period.

Prerana Issar
Chief People Officer
NHS England and NHS Improvement

01 The case for workforce race equality

The NHS is the practical expression of a shared commitment by all that make up our diverse British society. Every day, nurses, doctors, other clinical and non-clinical staff impact the lives of people all over the country and beyond.

Ever since its inception in 1948, the NHS has depended on the talents of its diverse workforce, including those from other countries. Yet, the experiences and opportunities that black and minority ethnic (BME) staff in the NHS face, do not always correspond with the values of the NHS Constitution.

To be a model employer, the NHS needs to be an inclusive employer with a diverse workforce at all levels. However, having a diverse workforce at all levels is not the end game for organisations; staff also need to feel fully engaged and supported within the workplace. This is critical as it impacts upon patient care, patient safety as well as organisational efficiency.

We know that one of the main factors believed to affect patient satisfaction is the experience of staff working in the NHS. Research shows that the extent to which an organisation values its minority staff is a good barometer of how well patients are likely to feel cared for[1]. Increased staff engagement also leads to lower levels of absenteeism, decreased spend on agency staff, and increased organisational efficiency and productivity[2].

This document is not a definitive blueprint to this agenda, but an evolving guide to help support local practices in promoting workforce race equality.

1. https://www.england.nhs.uk/publication/links-between-nhs-staff-experience-and-patient-satisfaction-analysis-of-surveys-from-2014-and-2015/

2. https://www.england.nhs.uk/publication/employee-engagement-sickness-absence-and-agency-spend-in-nhs-trusts/

02 The need for accelerated improvement

Since its introduction in 2015, the Workforce Race Equality Standard (WRES)[3] has required NHS trusts and clinical commissioning groups (CCGs) to self-assess annually, on nine indicators of workforce equality, including on an indicator that looks at the relative likelihood of BME staff entering the formal disciplinary process compared to their white staff counterparts in the same organisation.

In 2018, 10,818 white staff and 3,363 BME staff entered the formal disciplinary process across NHS trusts in England. These are lower overall figures than those observed in 2017, when 11,857 white staff and 3,854 BME staff entered the formal disciplinary process.

Table 1: The relative likelihood for BME staff entering the formal disciplinary process compared to white staff in NHS trusts

	2016	2017	2018
All NHS trusts	1.56	1.37	1.24

For the period 2016 to 2018, there has been continuous improvement for this indicator. The relative likelihood for BME staff entering the formal disciplinary process compared to white staff has improved from 1.56 in 2016 to 1.24 in 2018.

Within 176 (76.2%) NHS trusts in England, in 2018, the relative likelihood of BME staff entering the formal disciplinary process compared to white staff was outside the 0.8 – 1.25 non-adverse relative likelihood zone, based on the 'four-fifths rule'[4].

For 41 NHS trusts, the relative likelihood was less than 0.8; white staff in these trusts were more likely to be adversely impacted by the formal disciplinary process. For 135 NHS trusts, the relative likelihood was higher than 1.25; BME staff, especially those working in certain parts of the workforce, including frontline staff, those in clinical roles and junior administration in these trusts were more likely to be adversely impacted by the formal disciplinary process.

Whilst the data show continuous improvement over time in this area, there is still more to do to overcome the scale of the challenge.

3. https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/

4. http://uniformguidelines.com/uniformguidelines.html#18

03 Variation in rates of disciplinary action

When we look at NHS trusts grouped by geographical regions in England, we find that there have been improvements in reducing the likelihood of BME staff entering the formal disciplinary process across all regions over the past three years. However, we also find that trusts in the London region remain the most challenged. In comparison, NHS trusts in the south region appear to be doing better.

Table 2: The relative likelihood for BME staff entering the formal disciplinary process compared to white staff in NHS trusts, by region

Region	2016	2017	2018
London	1.99	1.80	1.77
Midlands & East	1.56	1.28	1.18
North	1.42	1.27	1.36
South	1.17	1.16	1.12

Variation in performance on this indicator is not just restricted to region. We also find variation by the type of NHS trust. Acute and mental health trusts have seen year-on-year improvements in reducing BME entry into the formal disciplinary process. In general, community provider and ambulance trusts have not shown the scale of improvement that we would like to see.

Table 3: The relative likelihood for BME staff entering the formal disciplinary process compared to white staff, by trust type

Trust type	2016	2017	2018
Acute	1.45	1.26	1.14
Mental Health	1.80	1.73	1.69
Community Provider	2.48	3.35	2.70
Ambulance	1.33	1.58	1.74

The data presented above relate to NHS trusts; the data for the national healthcare arm's length bodies show similar patterns, and CCG data (to be collected and published from 2019 onwards) are likely to be no different. To close the ethnicity gap in disciplinary action, and to reduce the overall levels of unnecessary disciplinary action across the NHS, we need ambitious goals underpinned by effective and evidence based replicable good practice.

04 Our ambition: closing the ethnicity gap in disciplinary action

The WRES team provides direction and tailored support to NHS trusts, CCGs and increasingly to the wider healthcare system, enabling local NHS and national healthcare organisations to:

- identify the gap in treatment and experience between white and BME staff;

- make comparisons with similar organisations on level of progress over time;

- take remedial action on causes of ethnic disparities in indicator outcomes.

There is robust evidence for the effectiveness of having an ambition that is based upon a commitment to specific goals, monitored by frequent feedback.[5] Organisations are more likely to focus on an issue at hand if an official goal or aspiration exists to act as a reminder of what needs to be achieved. Aspirational goals should embody challenge, specificity, and need to be reinforced by accountability.

Overarching aspiration for the NHS

Statistical analyses based upon WRES data and trajectory, for the likelihood of BME staff entering the formal disciplinary process within NHS trusts, help to inform the national aspirational goals in this area for 2020, 2021 and 2022 These national aspirations are set-out in table 4 below and relate to all NHS trusts, CCGs and national healthcare arm's length bodies (ALBs).

5. Jayne, M.E., & Dipboye, R.L. (2004). Leveraging diversity to improve business performance: Research findings and recommendations for organisations. Human resource management, 43(4), 409-424

Table 4: Expected rate of improvement in closing the gap in the likelihood of entry into the disciplinary process between BME and white staff across NHS trusts, CCGs and the national ALBs

2020	2021	2022
51% of NHS organisations within the non-adverse range of 0.8 and 1.25*	76% of NHS organisations within the non-adverse range of 0.8 and 1.25*	90% of NHS organisations within the non-adverse range of 0.8 and 1.25*

*0.8 and 1.25 refers to the relative likelihood of BME staff entering the formal disciplinary process compared to white staff as measured by WRES indicator 3

A stretching and yet achievable, aspiration for the NHS would be to reach equality in terms of the likelihood of staff entering the disciplinary process for both white and BME staff across at least 90% of all NHS organisations by 2022.

This will be measured by the proportion of organisations with a relative likelihood for BME staff entering the formal disciplinary process compared to white staff within the non-adverse relative likelihood range of 0.8 and 1.25. The ambition considers trusts with small numbers of BME staff whose data can be easily skewed by a single person entering the formal disciplinary process. Where there are very small numbers, statistical testing will be used to check if there are significant differences.

Aspirations at organisational level

At an organisational level, there will be two related goals:

1. to ensure that the relative likelihood for BME staff entering the formal disciplinary process compared to white staff is within the non-adverse range of 0.8 – 1.25.

2. to reduce the overall likelihood and number of staff entering the formal disciplinary process for both white and BME staff.

The above national model, and the 2022 timeframe (table 4), can be applied to local NHS organisations, considering their respective workforce composition. In table 5, all three organisations aspire to locate the relative likelihood of BME staff entering the formal disciplinary process compared to white staff between 0.8 and 1.25. However, because of their distinct baselines for this indicator, they are likely to face different challenges in achieving the aspirational target.

Table 5: Goal setting: the example of three NHS organisations

Organisation	Likelihood of white staff entering the formal disciplinary process	Likelihood of BME staff entering the formal disciplinary process	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff at 2018	Ambition: relative likelihood of BME staff entering the formal disciplinary process compared to white staff by 2022
A	1.17%	0.41%	0.35	0.8 - 1.25*
B	0.45%	1.72%	3.79	0.8 - 1.25*
C	1.50%	4.55%	3.04	0.8 - 1.25*

* 0.8 and 1.25 refers to the relative likelihood of BME staff entering the formal disciplinary process compared to white staff as measured by WRES indicator 3

Organisation A will have to reduce the likelihood of white staff entering the formal process to levels similar to those of BME staff.

Organisation B will have to achieve the same goal by doing the opposite e.g. reducing the relative likelihood for BME staff entering the formal disciplinary process compared to white staff, from 3.79 to less than 1.25, by 2022. This will be achieved by reducing the likelihood of BME staff entering the formal process to levels similar to those of white staff.

Organisation C will have to reduce the relative likelihood for BME staff entering the formal disciplinary process compared to white staff, from 3.04 to less than 1.25, by 2022. But it will also have to reduce the likelihood of both BME and white staff entering the formal process so that it is in line with the national median/averages.

Disciplinary data are available to each NHS organisation, and each organisation will be able to calculate the scale of their challenge. We also acknowledge that individual trusts and CCGs will know their workforce processes and will therefore be ideally placed to develop their own robust action plans to support this agenda.

Organisations are expected to discuss these matters at board meetings, and to develop and agree the following with the national WRES team:

• understanding of their aspirational goals in this area for the next three years: to close the gap on white and BME staff, and to reduce the overall likelihood of both BME and white staff entering the formal process;

• a robust action plan to deliver the change required;

• how to work with the national WRES team and track progress against these aims.

Arm's length bodies leading the way

As employers, the national healthcare ALBs should be leading the way on the workforce race equality agenda. In the same spirit of transparency and continuous improvement, the ALBs should also work towards the system-wide aspiration of closing the gap in disciplinary action between BME and white staff in their respective workforce – and in doing so, decreasing the overall rate of unnecessary disciplinary action.

05 Supporting delivery of the ambitions

The WRES team will support the wider system to focus on driving improvements in closing the ethnicity gap in entry into the formal disciplinary process – and in reducing the overall level of unnecessary disciplinary action across the NHS. A clear focus will be upon both sharing replicable good practice as to what works in this area at a practical level, as well as supporting the transformation of cultures within organisations to those that are underpinned by learning and compassion.

Replicable good practice

Table 6. Four models of good practice for reducing the disproportionate gap in BME and white staff entering the formal disciplinary process

Model	Pros	Cons
1. **Decision tree checklist –** The tool comprises an algorithm with accompanying guidelines and poses a series of structured questions to help managers decide whether formal action is essential or whether alternatives might be feasible. (Developed by the National Patient Safety Agency (NPSA)).	Keeps responsibility for considering all evidence with managers. Offers managers a very clear, evidence-based framework for considering the evidence.	Subjective variations in decisions are not likely to be reduced.
2. **Post action audit –** Managers are made aware that all decisions to place staff through the formal disciplinary process will be reviewed on a quarterly or bi-annual basis using robust information on each case to discern any systemic weaknesses, biases or underlying drivers of adverse treatment of any staff group.	Keeps responsibility with managers. Can help embed better practice in those areas identified as needing support.	In the short term it cannot prevent unnecessary formal disciplinary action.
3. **Pre-formal action check by a director level member of staff and/or panel –** An executive board member of the organisation – or a panel that includes an executive board member – review all cases and decide whether they should go to formal action.	Consistency of approach.	Reduces responsibility of managers to make the appropriate decision and take responsibility for it.
4. Pre-formal action check by a trained lay member – A trained lay member reviews cases and challenges any perceived bias in the process before cases go to formal action.	External scrutiny approach further reduces risks of bias and adds objectivity to the process.	Increased risk of loss of confidentiality. Requires consistency in approach.

Guidance relating to the management and oversight of local investigation and disciplinary procedures

In 2019, NHS England and NHS Improvement made recommendations that all NHS boards should consider how they oversee investigations and disciplinary procedures. The seven key recommendations are presented below:

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Advisory, Conciliation and Arbitration Service (ACAS) 'code of practice on disciplinary and grievance procedures' and other non-statutory ACAS guidance; the General Medical Council's 'principles of a good investigation'[6]; and the National Midwifery Council's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied (as cited in the previous section) that provides for full and careful consideration of context and prevailing factors when determining next steps.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with sufficient resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

6. https://www.gmc-uk.org/-/media/documents/dc11437-principles-of-a-good-investigation_pdf-75546780.pdf

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Compassionate and learning culture

We know that workforce race equality requires organisations to go beyond operational change because of compliance and regulation against processes and targets. Whilst these features are critical, the parallel challenge here is that of cultural and transformational change on this agenda.

It is essential that every leader at every level of the organisation ensures they promote and model both compassion and inclusion in all their interactions. Only then will everyone who works in, and uses, health services see that these values are the lived genetic structure of the NHS.

Research and evidence[7] show that to improve in this area organisations need to have several conditions in place:

First, we need compassionate leaders who pay attention to those they lead. They must seek to understand through talking with their staff the challenges they face in delivering care. Their focus must be how they can help those they lead to provide the high quality, compassionate care they wish to offer.

Second, it is important that every team has clear, agreed upon and challenging objectives aligned with the organisation's vision and that every individual is clear about their role and what they are required to do in their work.

Third, we must create an environment of enlightened people management, nurturing the engagement and positive emotions that ensure staff thrive and enjoy their work place interactions.

Fourth, we must continue to create the conditions for quality improvement and innovation in our organisations. Changing culture also means ensuring that all leaders understand the central role inclusion plays in the efficiency and effectiveness of our health services.

Fifth, building effective teams ensures team members feel a sense of cohesion, optimism and efficacy in their work. Effective teams have dramatically reduced stress levels which in turn means less aggression, harassment and discrimination.

[7] https://www.hsj.co.uk/workforce/bme-staff-are-still-struggling-heres-what-you-can-do-about-it/7024327.article

Conclusion and next steps

In the management of people-related issues and conduct of workplace relationships, there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances.

Whilst there will always be some occasions when disciplinary action is necessary and appropriate, the differential rate of disciplinary action between BME and white staff in the same organisations is striking.

We have set the NHS, and ourselves, an ambitious challenge of closing the ethnicity gap in entry into the formal disciplinary process by 2022 and have outlined a holistic set of interventions to help guide us.

Demonstrable leadership, accountability and support interventions will help organisations to continuously improve on workforce race equality. Progress in this area will be monitored and benchmarked for continuous improvement over time as part of the annual WRES data collection and publication.

This document will help you deliver the twin priorities of reducing the ethnicity gap in entry into the formal disciplinary process, as well as reducing the overall levels of disciplinary action amongst all staff. It is however guidance, it is recognised that many organisations are already working to reduce the gap in experience of their BME and white staff across all nine WRES indicators. The issues existing in the race inequality agenda are ingrained, multifactorial and complex, needing many different, innovative and creative solutions for us to employ in order to ultimately reach the goal of a fully inclusive and fair NHS for all our staff.