Factors related to the disproportionate representation of BME nurses in NHS disciplinary proceedings

by Uduak Archibong (FRCN 2012)

Uduak Archibong
MBE, FWACN, FRCN, professor of diversity, University of Bradford, Bradford, England

Email
u.e.archibong@bradford.ac.uk

It is important that NHS organisations can apply disciplinary procedures 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 General Medical Council (GMC). Comparatively less is known about the experiences of minority ethnic staff from other occupational groups in the NHS.

This article discusses the findings abstracted from a larger study to assess the extent of involvement of BME staff in disciplinary procedures in the NHS over ten years. The original study in 2008 comprised several distinct phases, including a web audit of NHS trusts, and an examination of disciplinary policies and practices through workshops with human resources managers and representatives of health profession regulatory bodies, alongside workshops with service managers to validate study recommendations to ensure relevance to the end users.

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 in the NHS that was considered to perpetuate unwritten workplace norms and was instrumental in reproducing inequalities.

Disproportionality in NHS disciplinary proceedings.

Abstract

Background/aims This article investigates the representation of black and minority ethnic (BME) staff in NHS disciplinary proceedings.

Methods The study involved an in-depth knowledge review and analysis of literature on the representation of BME staff in NHS disciplinary proceedings from 2008 to 2017, as well as semi-structured interviews with 15 key stakeholders. Participants were stakeholders from both primary and secondary care and included equality and diversity leads, human resource professionals, NHS service managers, representatives of trade unions and health professional regulatory council representatives.

Findings The knowledge review indicates that to date, BME staff are disproportionately represented in NHS disciplinary proceedings. Evidence gathered demonstrates the continuation of inappropriate individual disciplinary action and failure to address organisational shortcomings against BME members of staff.

Conclusions Overall, six factors were identified as underpinning the disproportionate representation of black minority ethnic staff in disciplinaries: closed culture and climate; subjective attitudes and behaviour; inconclusive disciplinary data; unfair decision making; poor disciplinary support; and disciplinary policy misapplication.

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Introduction and background

I was first contacted by members of NHS Employers Equality and Diversity (E&D) Core Reference Group (CRG) in 2007 led by Professor Carol Baxter, who was the head of NHS Employers E&D team. The CRG was concerned about the involvement of black and minority ethnic (BME) staff in disciplinary proceedings brought to their attention by human resources managers. In response, I led the Centre for Inclusion and Diversity (CfID) of the University of Bradford in 2008 in a study to assess the extent of involvement of BME staff in disciplinary procedures in the NHS, and to identify good management practice in this area (Archibong and Darr 2010).

Our study took place during a period of widespread recognition of financial challenges in NHS organisations (Farrar 2009) and 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 (Department of Health 2008). In addition, the NHS Constitution (Department of Health 2009) mandated NHS staff to be more aware of their roles and responsibilities in elevating standards of professional practice. Employers were reminded to provide greater support in the workplace to improve the health of, and reduce levels of stress, among staff, irrespective of who they were, the role they performed or the level at which they worked in the organisation (Boorman 2009). At the same time, NHS organisations should be able to apply disciplinary procedures to ensure staff behave in an appropriate and professional manner to safeguard patient safety. It follows from this that the disciplinary procedures applied should be transparent, fair and 'fit for purpose' (Archibong et al 2013).

However, there was a growing body of evidence which suggested that staff from BME backgrounds were overrepresented in disciplinary procedures and that disciplinary processes were not being applied consistently in the NHS (Esmail and Everington 1994, Lyfar-Cissé 2008). This was of serious concern, given that individuals of BME background made up 14% of the NHS workforce with the NHS being the largest employer of BME staff in England. We were always being reminded by the work of Akinsanya (1988) and Obrey and Vydelingum (2004) of the immense contribution made to the delivery of health services in the UK by BME staff who were deemed the 'backbone' of the service at a time when labour was in short supply.

I was curious to establish why the people who had given so much to the NHS would experience such structural racial inequalities and I wanted to give voices to BME staff to present their lived experience. More specifically, the objectives of the study were to analyse trusts' disciplinary data to assess whether BME 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 disciplinary proceedings. The study also compared literature on the experience of disciplinary proceedings among BME staff working in other public sector organisations and identified examples of good practice in relation to fair and transparent disciplinary proceedings.

The key findings of the study were:

- BME NHS staff were almost twice as likely to be disciplined. BME staff were significantly overrepresented in disciplinary proceedings in acute, primary care, mental health and learning disability and care trusts.
- Five key causes of the disproportionate number of BME staff involved in NHS disciplinary proceedings were: organisational culture; poor management practice, including lack of experience and confidence; poor leadership, including a lack of diversity among leaders; poor awareness of equality and diversity; and attitudes and behaviours of staff members.

Influence and impact

Following publication of our work (Archibong and Darr 2010), many health care unions, including the Royal College of Nursing (RCN) (Sprinks 2014) and the Royal College of Midwives (RCM) (2012, 2016), sent freedom of information (FOI) requests to trusts to gather information about staff subject to disciplinary proceedings, broken down by ethnic group.

Findings from the RCN request suggest that BME nursing staff were highly over-represented during formal investigation and disciplinary processes in the NHS. The RCM report showed that over a five-year period, a higher proportion of BME midwives than white midwives had been dismissed during disciplinary proceedings. During the five-year period, 38 midwives were dismissed and 37 of these were from a BME background.

Out of the 37 BME midwives dismissed, 32 were black or black British. Overall, from July 2010 to June 2015, 13.2% of the BME midwives who faced disciplinary proceedings were dismissed, compared with 0.7% of the white midwives who faced disciplinary proceedings. I believe that such a level of disproportionality could never be a mere coincidence, but a subject of structural inequality faced by BME staff in the NHS. The high levels of discrimination against BME staff in the NHS have been widely evidenced (Berwick 2013, Likupe and Archibong 2013, Kline 2013, 2014, Likupe et al 2014).

Staff from BME backgrounds have been reported to face discrimination during NHS recruitment processes (Kline 2013), promotion (Esmail et al 2007), access to training, representation during disciplinary procedures and bullying in the workplace (Kline and Prabhu 2015, Sehmi 2015).

The Francis (2013) report highlighted that BME staff who have reported wrongdoings in their organisation frequently feel like they have been treated less favourably than non-BME staff who reported similar issues in the same organisations. These negative experiences have been shown to have a direct impact on the productivity of NHS BME staff (Kline and Prabhu 2015).

Following a number of research activities that identified disproportionate representation of BME staff in disciplinary proceedings, the NHS England Workforce Race and Equality Standard (WRES) was developed to enable standardised collection of data across service providers to help identify the scale of the problem. In 2016/2017, I was commissioned with CfID colleagues by the WRES team, to inform ongoing actions and to examine the extent to which NHS employees from BME backgrounds received fair treatment in the workplace.

We examined progress made in the ten years following a study conducted in 2008 (Archibong and Darr 2010) on the involvement of BME staff in NHS disciplinary proceedings (Archibong et al 2019a). The study specifically sought to analyse published academic and government literature on the representation of BME staff in NHS disciplinary proceedings from 2008 to 2017; examine trusts' disciplinary data; identify contributing factors for any disproportionality; and highlight interventions and examples of good practice in relation to fair and transparent disciplinary proceedings.

I was concerned to see that while BME staff were 1.2-2 times more likely to enter the formal disciplinary process in 162 (70%) NHS trusts, the relative likelihood of BME staff entering the formal disciplinary process was higher than 2.1-3.0 in 39 trusts (16.9%); and higher than 3.0 in 20 trusts (8.7%). Six key factors at both individual and organisational levels, not dissimilar to the factors in the 2018 study, were uncovered as contributing to over-representation of BME staff in NHS disciplinary proceedings. These factors were: close culture, subjective attitudes and behaviour, inconclusive disciplinary data, unfair decision making, and poor disciplinary support and discipline policy misapplication.

In addition to providing some examples of changes made by NHS trusts, we have suggested ways of preventing, managing and remedying the disproportionate representation of the BME workforce in NHS disciplinary proceedings (Archibong et al 2019b), which emerged from the study. These are presented in three stages: interventions to decrease the likelihood of BME staff entering the formal disciplinary process, actions during the disciplinary hearing, and remedial actions after disciplinary hearing has taken place.

Our study has concluded that while progress is being made in raising the awareness of the over-representation of BME staff in NHS disciplinary proceedings, progress is slow and the problem persists. Evidence gathered points to the continuation of inappropriate individual disciplinary action and failure to address organisational shortcomings. Collectively, the studies undertaken since our earlier study (Archibong and Darr 2010) show that BME staff are still disproportionately represented in NHS disciplinary proceedings.

Recent publications of the analysis of the data collected from WRES (NHS England 2017, 2018, 2019) show there is still disproportionate representation of BME staff in disciplinary proceedings. It is reasonable to suggest that the slow progress in dealing with this problem may be due to a combined force of structural inequalities, discrimination and bias.

Our contributions have influenced work at regional (Bradford District NHS Care Trust 2020), institutional (West Hertfordshire NHS trust 2016), professional (GMC 2019, West and Nayar 2016, West et al 2017), national and international (Priest et al 2015) levels.

I have been involved in leading debates at different professional platforms such as the General Pharmaceutical Council (2016).

Our work has served to address the gap in empirical data that did not provide the reasons for the disproportionate discipline of BME NHS staff or the misrepresentation of disciplinary policy as an individual deficit (Traynor et al 2013), often resulting in BME employees being held to a different standard (Luksyte et al 2013).

Current and future relevance

More recently, there has been ample evidence that individuals of BME background work at the forefront of their clinical areas with considerable experience, expertise and skills from which the NHS has benefitted (see, for example, the work of BME healthcare professionals during the COVID-19 pandemic). However, the COVID-19 pandemic has magnified the racial inequality that exists in the NHS. For example, we have witnessed BME healthcare staff being 'whitewashed' out of media coverage of the coronavirus crisis, with the focus being mainly on white colleagues.

I cringed at the sight of the UK Prime Minister interviewing three retired white nurses in commemoration of the 72nd anniversary of the NHS. Where were the BME nurses who had sacrificed so much since the inception of the NHS and were, sadly, over-represented in COVID-19 deaths? And why was there such an omission at a time that coincided with the 72nd anniversary of the merchant vessel Empire Windrush arriving at Tilbury docks carrying 492 workers from the Caribbean? These workers came to the UK to assist with post-war reconstruction and many of the Windrush generation went on to work in, and thus support the establishment of, the newly created NHS (Naqvi 2020). The arrival of the Windrush helped to mark a new chapter in the birth of our NHS and the growth of multicultural Britain (Naqvi 2020).

Discrimination against BME staff in the NHS reflects wider discrimination, racism, and health inequalities in the UK and globally. BME NHS staff are less likely to be treated favourably, they have poorer experience of recruitment and promotion processes (Kline 2013, Esmail et al 2007), and progression opportunities, with evidence of substantial under-representation of BME staff in senior leadership positions (West 2014), a situation that has changed little in over 30 years. There is a clear link between discrimination and aggression against staff to patient satisfaction (Dawson 2009).

Recently, the world's population reached a watershed moment in relation to issues of race and inequality. The combination of the feeling of being unheard over the years, a growing number of cases of injustice, and the death of George Floyd in the United States, have collided to culminate in people demanding accountability and real actions in tackling racism in all its forms.

The elevated profile of the Black Lives Matter campaign has posed a real challenge for senior leaders of increasingly diverse organisations to dismantle structural inequalities. Even the acronym 'BME' is being contested and provoking offence for some (Fakim and Maccaulay 2020).

The NHS cannot be silent to the widespread and systemic racial inequity and prejudice plaguing the health sector (Kline 2014) and nursing and midwifery (Brathwaite 2018, Likupe et al 2014, Wren Serbin and Donnelly 2016). Staying silent is being complicit and is not compatible with the founding principles of the NHS, the NHS Constitution (2009) and our nursing values (Moorley et al 2020, NMC 2020).

Our fight to dismantle institutional racism must go beyond rhetoric to the acceptance and application of an anti-racist approach. It is time to do much more to tackle systemic racism by adopting a holistic approach. This will mean taking decisive actions against racial injustice at organisational level, including the NHS. This may involve providing psychologically safe spaces for critical reflection, equipping leaders and managers to lead the change, and leaders co-creating actions with BME colleagues, both within and beyond the health sector.

It is time to improve the culture and leadership of the NHS to ensure all staff members are valued, treated fairly and with respect, and equipped to provide exceptional levels of patient care (NHS Resolution 2020).

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