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Article

Strategic Workplace Forum October 2020

Members of the Mills & Reeve employment health and care team share their experience of four key topics relating to the future of work in the NHS

Establishing the framework to facilitate flexibility (Jog Hundle)

What is the current position in the NHS?

The Covid pandemic has certainly had a transformative effect on working practices in the NHS. However this has been from a relatively low base in terms of best practice. The 2019 staff survey found that only 54% of staff were satisfied with opportunities to work flexibly, and the 2020/21 NHS People Plan identifies 11 key actions around flexible working. This includes an overarching direction to “be open to all clinical and non-clinical permanent roles being flexible”.

What is the legal framework?

The employment law framework in this context focuses primarily on transparency, rather than seeking to dictate particular working arrangements. For those starting work after 6 April 2020, the requirements for the content of written particulars of employment have been extended to require employers to include more information about the pattern of working hours and days, and how these are determined. However, there is no explicit requirement to document flexible working arrangements as such.

Flexible working requests were for many years seen almost exclusively in the context of women returning from maternity leave. A free-standing right to request flexible working arrangements was first introduced in 2002. The requirements have since been modified a number of times, but it remains a right that is restricted to employees who have completed six months' continuous service. In addition, the provisions setting out when an employer is entitled to refuse a request have not been changed. The reasons to support a refusal are very broad. So it was easy for an employer to say no, provided that the proper process has been followed, and always assuming that the employee was not disproportionately disadvantaged as a member of a protected group.

While the underlying law has not been changed, the experience of the pandemic is likely to have a transformative effect on the way these requirements are interpreted. In particular, it will be difficult to refuse a formal request for a permanent change in working arrangements where the employee is able to demonstrate that they have worked effectively when adopted on a temporary basis during the pandemic.

What should NHS employers be considering to underpin new working practices?

As we have seen, current employment law has not fully caught up with the growth of flexible working. However there are three underlying principles which should guide employers seeking to document changes in workplace practice:

- **Transparency:** any new working arrangements must be documented clearly so that workers and their managers can understand them. In many cases this will involve issuing revised written particulars of their employment.
- **Due process:** one of the key aims of the flexible working legislation is to ensure that an employer considers any requests in a reasonable manner. Employers are now facing the challenge of scaling up existing processes to cope with significant increases in volume while at the same time shortening the time frame for making decisions. NHS employers will need to review existing flexible working policies to ensure that they remain fit for purpose. In the light of the People Plan and the continuing pressure on capacity, NHS employers will need to consider extending the availability of the formal procedure to all employees, rather than restricting it to those who have accrued six months' service.
- **Fairness:** responding to a crisis will not be regarded as sufficient reason for departing from basic principles of fairness in the workplace, or failing to audit arrangements for the risk of indirect discrimination. A fair approach to determining requests will need to be developed and documented, particularly where there are competing or hard to manage requests.

Most organisations will be looking to engage with their workforce and their representatives in a way that obviates the need for formal flexible working requests. However, that remains an option for employees who qualify for the right and who are not satisfied that their needs to work flexibly have been addressed.

Reviewing COVID-related changes to job content

It has not only been working arrangements that have changed in response to the pandemic. It has also necessitated some significant changes to job content. Many clinical staff have been redeployed to help deliver acute care or have been asked to act up in more senior roles. At the height of the first wave there may not have been enough time to document these changes fully, or to agree how long these arrangements should continue.

Just as with flexibility-related changes to working practices, employers need to check that the scope and duration of these arrangements are properly documented.

Remote hearings: opportunities and pitfalls (Rebecca Harker-Smith)

Are there any legal barriers?

Fortunately there is nothing in current employment law which requires meetings to be held face to face (unless this is required by a worker's contract or set out in a relevant procedure) provided that this does not compromise the effectiveness of the meeting. That said there are some passages in the ACAS Code of Practice on Disciplinary and

Grievance Procedures which reveal an assumption (though not an express stipulation) that these meetings will be normally conducted in person.

So when deciding how to hold a particular hearing – whether this is a disciplinary or grievance hearing, or a formal consultation meeting – employers have a largely blank canvas to paint on. However local procedures will need to be checked and if necessary revised to ensure that they permit remote hearings in appropriate circumstances.

The primary consideration will be the reason for the hearing and the need to respect the spirit of any relevant legal requirements directed at its purpose. Employers will also need to consider the personal circumstances of those participating. In some circumstances – for example collective consultation with a large section of the workforce - managing meetings remotely can be a positive advantage.

If opting for arrangements that include any element of personal contact, an appropriate health and safety risk assessment will of course need to be undertaken while the coronavirus remains a threat.

Key ingredients of a successful remote hearing

In our experience, the following arrangements will need to be in place to make remote hearings effective:

- **A secure video conferencing platform**: most larger employers will by now have access to a suitable arrangements and will have worked out what settings to apply to ensure confidentiality
- All participants must have an **adequate broadband connection**: there is no point attempting to hold a fully remote hearing unless this condition is satisfied, though it might be possible to adapt the meeting so that some participants are present in person while others join remotely, or to allow some participants to join by phone
- **Clear housekeeping rules**: all participants must be directed about appropriate use of their web-cam and microphone, and adequate provision needs to be made in advance for breaks, since participating in remote hearings is more taxing then when attending in person
- **Papers in advance:** when not meeting in person it is all the more important to set out a clear agenda and timetable and ensure that all relevant documents are circulated (ideally in electronic form) well in advance

When should other arrangements be considered?

A hearing in person, or partly in person, is likely to be required where:

- The worker or another key participant does not have a good command of English
- The worker does not have suitable facilities at home to conduct a remote hearing
- The subject matter is particularly sensitive, and confidentiality cannot be adequately preserved in a home setting
- A key participant has a disability which would make participating in a remote hearing particularly difficult
- The complexity of the matters under consideration makes a remote hearing particularly challenging

Returning to the workplace: the limits to consensus (Danni Belbin)

Overview

The end of shielding (at least on a national basis) has combined to bring issues about bringing staff back to work who cannot work effectively from home into sharp focus. In that context the new flexibilities being adopted across the NHS have been very helpful in re-designing many jobs so that they can be done from home, but there will be always some roles where this is impossible.

In most cases agreement about suitable arrangements can be reached, but there are an increasing number of cases where the legitimate interests of the employer and the health-related concerns of the employee clash. At a time when the whole workforce is under acute stress, finding a suitable solution is not always easy, particularly for front line staff.

Key considerations

Before taking any steps to bring matters to a head, the following information needs to be gathered. Some of this is sensitive personal information, and thought should be given about how best to obtain this, with suitable safeguards in place to reflect data protection and confidentiality requirements.

- Are the necessary Covid-secure arrangements in place in the relevant workplace?
- What is the current guidance about returning to the workplace on a national and local level?
- How would the member of staff travel to work?
- Does the member of staff have any medical conditions or disability which would make them vulnerable or extremely vulnerable to a COVID infection?
- Are any members of their household in a similar position?
- Is it completely clear that the job cannot be done effectively from home, and if so what are the reasons?

Possible solutions

Guidance from NHS Employers on supporting a return to work suggests a number of possible solutions could be considered including phased returns, or re-deploying staff to work in a lower risk area. It may also be possible to adapt ways of working, to minimise contact with patients or other staff members. Alternatively if some but not all of the job can be done from home, it may be possible to agree a revised job plan for a temporary period, with an appropriate pay reduction.

If travelling to work is a concern, can the hours of work be flexed to allow travel during a quieter time of the day, or can parking arrangements be made to allow the employee to drive to work?

There will in any event be a legal requirement to consider all of these steps by way of reasonable adjustments if the employee has a relevant disability. There is no requirement to make adjustments to working arrangements to accommodate the needs of another member of the employee's household who is disabled. However, employees in this situation are still protected in relation to direct associative discrimination – ie less favourable treatment because they are associated with a disabled person, even if they are not disabled themselves.

Another area to explore for employees with medical conditions is whether they are in fact fit for work. In such circumstances, transferring them to occupational sick pay may be an option, though not if they have already been placed on special leave and sick pay entitlement has been exhausted. Using accrued holiday entitlement may also be worth considering, at least as a stop-gap while other options are explored.

Finally it may also be possible to reach agreement on a defined period of unpaid leave, perhaps framed as a sabbatical or similar.

Steps to take in the absence of an agreement

If a solution cannot be agreed informally, the first step would be to document the proposed solution formally and to invoke the relevant local procedure. In most cases a capability-related procedure is likely to be the most appropriate, since it would be difficult to frame genuinely-held fears about health (however mistaken) as misconduct.

Most NHS employers will be rightly reluctant to consider dismissal as a possible sanction, at least at the outset. The severest sanction to begin with is likely to involve withholding pay for the period during which the employee is unwilling to attend the workplace. However, a practical way forward is to agree with the employee an unpaid sabbatical or a period of unpaid leave of defined length, subject to review. In many cases NHS employers will have little option but to do this to ensure appropriate use of public funds.

Progressing race equality (Becky Pallot)

The unique position of the NHS

As the NHS People Plan 2020/21 points out, the NHS is the largest employer of people from minority ethnic backgrounds in the country, who lost their lives in greater numbers than any other group during the peak of the COVID pandemic. In making a number of recommendations to improve diversity it states:

> "Systemic inequalities are not unique to the NHS. Each of us must listen and learn – from our colleagues, and from society – and take considered, personal and sustained action to improve the working lives of our NHS people and the diverse communities we serve."

We comment below on selected initiatives to progress this agenda, both inside and outside the NHS. In the current climate, pressure to progress race equality both within the NHS and in the wider public sector is only likely to grow.

WRES indicators

Since 2015 all NHS organisations have been required to demonstrate how they are addressing race equality issues through the Workforce Race Equality Stands. Published annually, the WRES indicators have provided "compelling evidence" of ethnic variation in staff experience and have been a catalyst for organisational change.

In September, NHS England published WRES indicators for the medical workforce to ensure employees from minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace. With 41 percent of the doctors in the NHS being from minority ethnic backgrounds, one of the key priorities for the WRES according to the document has been to develop a specific set of indicators that would enable ethnic variations in the experience of the medical workforce to be assessed

But why are different data required for doctors? Race inequality is complex and difficult, addressing it is critical on multiple levels. There are also wider implications for the health service: evidence shows that a motivated, inclusive and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety. So having a set of indicators capable of illuminating racial inequalities in the medical workforce, will strengthen the broader strategy of making all parts of the NHS a better place to work for people of all ethnic backgrounds.

A full set of data against these new indicators will be reviewed and published as part of the annual WRES data report for NHS trusts later in the year – enabling the monitoring of progress in the NHS race equality agenda.

Diversity targets

One key action required in the People Plan is the described as follows:

> "By October 2020, employers, in partnership with staff representatives, should overhaul recruitment and promotion practices to make sure that their staffing reflects the diversity of their community, and regional and national labour markets. This should include creating accountability for outcomes, agreeing diversity targets, and addressing bias in systems and processes. It must be supported by training and leadership about why this is a priority for our people and, by extension, patients.
>
> Divergence from these new processes should be the exception and agreed between the recruiting manager and board-level lead on equality, diversity and inclusion (in NHS trusts, usually the chief executive)."

This represents a challenging programme of action, in a legal framework that has only limited measures to support positive action. One particular challenge about setting diversity targets is that, however justified, they do not override the core equality principle behind the Equality Act, which only allows positive discrimination in recruitment in very limited circumstances. However the following steps, if implemented correctly, will be lawful:

- Mentoring schemes to develop talent
- Contextual recruitment, so that academic attainments can be adjusted to reflect socio-economic factors
- Widening the net for recruitment to attract applications from a wider range of candidates

- CV-blind recruiting
- Ensuring diversity on interviewing panels
- Using similar tools when considering candidates for internal promotion

Ethnicity pay reporting

Ethnicity pay statistics have been collected in the NHS for some years, and in 2018 a goal was set by the then health minister Stephen Barclay to eliminate the NHS ethnicity pay gap by 2028. Since much of the gap is associated with the underrepresentation of a number of minority ethnic groups at senior levels in the NHS, this target was linked with a goal to ensure their representation at very senior management levels will match that across the rest of the NHS workforce within the same time frame.

The picture outside the NHS is less advanced in most of the UK (though significant steps have been taken by the devolved administrations in Wales and Scotland). Consultation on making ethnicity pay reporting a national requirement for larger employers closed in January last year, but no response to the consultation has yet been published.

A petition to implement this reporting reached 100,000 signatures earlier this year, triggering a response from the Government on 26 June. It cited the “genuine difficulties in designing a methodology that produces accurate figures that allows for interpretation and action from employers, employees and the wider public”. It also said that it was “important that any reporting protects employee anonymity and avoids undue burdens on business.”

At its simplest, the proposal is to mirror the requirements of gender pay reporting, which requires employers with at least 250 workers to publish median and mean pay gap figures, as well as giving details of the distribution of men and women across pay quartiles. The main complicating factor is how exactly to report on race. What classification should be adopted and how granular should the ethnicity breakdown be?

It seems clear that to be effective some breakdown between different ethnicities will be required, since average hourly pay varies significantly not only across the five main ethnic categories identified in the 2011 census, but also within the 18 constituent sub-groups. However these difficulties do not appear insuperable, particular for the largest employers.

It seems reasonable to assume that progressing this issue is likely to be a priority for the newly established Commission for Race and Ethnic Disparities. Although the NHS is already reporting on pay disparities on a national level, there is a concern that any new national legislation will not necessarily reflect the reporting methodology currently used in the NHS. In addition, more granular reporting (eg at a Trust rather than national level) could expose individual NHS organisations to a greater degree of public scrutiny.

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