Improving disability support through local action: briefing on FOI findings

Background

The BMA sent a Freedom of Information Request to 224 NHS Trusts/Health Boards across the UK in September 2024, asking for details of how they managed disability-related issues including provision of reasonable adjustments and disability-related absence.

166 organisations (74%) responded to this request.

This request is intended to support local negotiation to improve disability support. It is grounded in two specific ARM policies:

1) *That this meeting is appalled that despite recommendations by NHS Employers and the Equality and Human Rights Commission, employers continue to record disability related absence as sick leave. This combined with the use of the Bradford Factor is discriminatory in its approach and we demand that the BMA lobbies all NHS and HSCNI employing organisations to implement recording of disability related absence separately.*

2) *That this meeting notes with grave concern the findings of the BMA's survey of disabled doctors and urges the BMA to lobby all departments of health and employers to:– i) mandate for a Disability Champion in all employing organisations to widen support and increase career longevity and to demonstrate valuing all doctors living with disability and long-term conditions; and ii) ensure that those employers who have already appointed a Disability Champion promote this role and its function within their respective organisations.*

The findings are also intended to support local negotiation on improvements relating to the provision of reasonable adjustments, as highlighted by the BMA disability survey 2020.

Where effective local processes and procedures can be negotiated, this can reduce the amount of time spent handling issues one by one, and more importantly can also prevent poor treatment of disabled colleagues happening in the first place. Some issues, such as negotiating workplace adjustments, will require a highly bespoke approach, tailored to the needs of individual doctors, and reflecting the specifics of the role and the job setting. Clear policies and processes setting out employer responsibilities and duties provide a solid framework for managing these situations and ensuring all disabled doctors are treated consistently, fairly and receive support in a timely fashion.

This briefing sets out the key findings from the FOI request and recommendations for areas where local BMA reps/member relations could seek to work with employers to address unwanted variations in available support for disabled doctors.

Key Findings (UK wide)

Recording of disability-related absence

What is the issue? Disability and sickness are not the same thing. Disabled staff may, however, require time off work to help them manage their disability, for example to attend appointments, for rehabilitation, or to adjust to new adaptive equipment. For attendance recording and on ESR, it is good practice that such absence should be identified separately so that it can be differentiated from sickness absence. This time off is sometimes known as disability-related absence. The purpose of this provision is to ensure that disabled staff are not disadvantaged by absence management processes that have trigger points for the commencement of formal procedures.

What we found:

- Less than a quarter (22%, 37 organisations) of respondents said that they recorded disability-related absence separately from sick leave. A number of organisations stated that the reason for this was that this could not be done on the ESR, although others indicated that the system did allow for this. NHS Employers guidance indicates that recording disability-related absence is in fact possible via ESR, suggesting a training requirement for some trust/health board staff. More broadly, NHS Employers may need to review what can be done to raise awareness of how to use the ESR to record this effectively.

- Only one of the 17 organisations that used Bradford Factor scoring for performance management recorded disability-related absence separately from sickness absence. This potentially means that these organisations will find it harder to adjust performance management trigger points, potentially discriminating against disabled staff. See next section for further information on use of Bradford factor scoring.

Suggested actions/lobbying points:

As set out in the BMA's ARM policy, all trusts/health boards should be required to record disability-related absence separately from sickness absence, so that disabled doctors are not disadvantaged by inflexible performance management processes. There is facility for disability-related absence to be recorded via the ESR and reps should establish whether training is needed for trust/health board staff to ensure this is done correctly. The recording of disability-related absence should be clearly set out in a trust/health board disability leave policy.

Use of the Bradford Factor

What is the issue? The Bradford Factor or Bradford score is an HR absence monitoring methodology employed by a range of employers, including within the NHS. It is grounded in the theory that a repeated number of short absences has a greater impact on business operations than fewer but longer periods of absence.

The Bradford factor is calculated using the formula S2 x D = B, where S is the total number of separate absences by an individual, D is the total number of days of absence of that individual and B is the Bradford Factor score.

Example: one 14-day period of absence = 1 x 1 x 14 = B of 14

14 periods of one day absence = 14 x 14 x 14 = B of 2744

The Bradford Factor is viewed as potentially discriminatory towards some disabled people since the methodology cannot take into account reasons for absence such as underlying health conditions or disability. This is particularly the case for people with hidden, progressive and/or fluctuating conditions. Use of the Bradford score to set automatic trigger points after which disciplinary action or absence management policies may be implemented is variable, but widely viewed as being punitive rather than supportive.

Reliance on the Bradford factor is likely to drive presenteeism across the profession, making it difficult for people with long term and fluctuating conditions to manage their health well, and negatively impacts on organisational culture and perceptions of the organisation as open to flexible working and supportive of the health and wellbeing of employees.

What we found:

– 17 Trusts or Health Boards who responded (10%) still used the Bradford Factor as part of the absence and performance monitoring approach.

– The range of trigger points used varied considerably, with the lowest set at a score of just 80, and the highest at a score of 300.

– Only one of the 17 organisations who used this methodology said that they recorded disability leave separately from sickness absence. This potentially compounds issues in terms adjusting trigger points to take disability into account, which is a recognised reasonable adjustment.

Suggested actions/lobbying points:

Use of the Bradford Factor is considered outdated and potentially discriminatory, and the vast majority of organisations have already moved to more nuanced absence monitoring tools. Remaining Trusts/Health Boards should move away from this methodology and introduce a system of absence management that can be adjusted to account for disability-related absence.

Paid Disability leave/Disability leave policies

What is the issue? Disability leave is planned or unplanned time off from work for a reason related to someone's disability. It is a type of 'reasonable' adjustment which disabled staff may be entitled to under the Equality Act 2010, and is listed as an example of a reasonable adjustment in the Code that accompanies the Act.

Disability leave will not be necessary for all disabled employees, but it is one of a range of possible adjustments that might be appropriate for some people in some contexts. For many staff it may be an occasional few hours planned in advance for treatment or assessment, or a longer period of time for recuperation. At other times or for other staff it may be unplanned time off work related to a person's disability. Disability leave may also be used while other reasonable adjustments are being put in place by the employer, if it is not appropriate or possible for the employee to remain at work or be redeployed during this period.

It is important that disability leave is paid. Disability leave is an absence that is directly related to the employee's disability or health condition and is being requested to eliminate discrimination against disabled people as well as to ensure the workplace offers a safe and healthy environment. Experiences from other leave, such as paternity/ maternity support leave, shows that take-up is very low if it is unpaid or low paid.

Time spent on disability leave should be counted as continuous service for all contractual benefits, including accruing annual leave, sick leave and pension rights.

What we found:

– Fewer than a quarter (24%, 39 organisations) responding organisations had a standalone disability leave policy. A further seven said they referenced this elsewhere such as sickness absence or reasonable adjustment policies. 72% of responding organisations said they had no disability leave policy.

– Less than half (47%, 78 organisations) said they offered paid disability leave. Of these, only one in five (21%, 34 organisations) who offered paid leave had a policy that underpinned this (respondents indicated that this was often at local management discretion). A lack of clear policy that underpins the provision of paid disability leave may potentially resulted in inconsistent approaches to granting paid leave when required.

Suggested actions/lobbying points:

All organisations should be encouraged to develop a standalone disability leave policy, which includes (as a minimum) the provision of both paid and unpaid disability leave, the circumstances in which paid disability leave can be requested, and the process for doing so. It should specifically include a provision that paid disability leave can be accessed while an employer is putting reasonable adjustments in place to support the disabled employee.

Disability champions/advocates

What is the issue? As detailed in our Disability in Medicine survey, we know that the lack of support for disabled doctors in work, education and training is having a detrimental impact on their wellbeing and career progression. Successive reports of the Workforce Disability Equality Standard (WDES) and NHS Staff Survey show that more must be done to achieve parity of experience and outcomes for disabled staff, in areas such as bullying and harassment and formal capability processes. Even when there is support available, many doctors and medical students are not aware that it exists, such as a disability champion or disability network in their organisation. Encouragingly where they did exist and were known about, they were rated as effective.

A disability champion is a strategic role to promote and improve support for disabled staff within their workplace. Visibility is key in pushing for a disability inclusive workplace culture. A holder would educate, collaborate, advocate and influence decisions made at hospital board level. This could result in improved staff retention, reduced absenteeism, higher levels of staff satisfaction and disability disclosure and lower levels of bullying, harassment and complaints.

What we found:

– 90% of respondents (151 organisations) had staff networks open to disabled doctors.

– 72% (119 organisations) had a senior Board level sponsor.

– 57% (91 organisations) were able to confirm that they had people with lived experience of disability.

– 12% (20 organisations) had specific paid roles to support disabled doctors as distinct roles from general Equality Diversity Inclusion (EDI) or Professional Support Unit (PSU) support. These include workplace adjustment coordinators and paid disability advocate/champion roles.

Suggested actions/lobbying points:

All organisations should be encouraged to support disabled people's networks and to ensure that there are mechanisms for the lived experience of disabled doctors to be fed into decision-making at a senior level. As per the ARM motion and our own research, disabled doctors do not always know how to access available support. Trust/health boards need to be particular aware of the challenges faced by particular groups including new starters, resident doctors on rotational training, and those who work less than full time for disability reasons. In the longer term, we support the development of a specific paid role to enable this, and trusts/health boards should be encouraged to look at existing best practice in developing such a role.

Centralised reasonable adjustment support

What is the issue? Employers have a statutory duty to make reasonable adjustments to their workplace environment, policies and processes to reduce disadvantage faced by disabled staff. Our disability in the medical profession survey found that disabled medics reported significant barriers to accessing reasonable adjustments. Just over half (55%) of disabled doctors and medical students who require reasonable adjustments say they have obtained them. 69% of disabled doctors surveyed said that Improving access to adjustments was a top priority for action.

Difficulties securing adjustments included: lengthy and complex processes, slow or only partial implementation, lack of engagement in the process by employers and schools, perceived costs and impacts on others, and fears about asking in case of negative career consequences. There are likely to be particular issues for locum and locally employed doctors, and those on rotational training.

The BMA advocates for employing organisations to have one **centralised process, a single point of access and a centrally held budget** for the provision of adjustments. Evidence shows that centralisation can have the following benefits:

- Making it easier for disabled employees and managers to know how to navigate the process, removing the onus from individual employees and managers.
- Greater consistency in considering and implementing individual requests when managed by a dedicated and experienced individual/team.
- Ensures effective management accountability for the speed and effectiveness of the entire end to end process.
- Builds organisational understanding of where systemic changes may be needed (through enabling greater oversight of common issues).
- Enables organisational knowledge – what has worked in the past and how to overcome any barriers.
- Supports compliance with monitoring against national standards e.g. Workforce Disability Equality Standard.
- Cuts administrative costs and saves time through reducing duplication of activity and through greater familiarity with the relevant processes.

What we found:

- Less than half of respondents (44%, 73 organisations) had a standalone reasonable adjustments policy. The remaining organisations either had no policy, or had information scattered through different policies or guidance documents, making it difficult for users to locate.

- Only one in five (19%, 31 organisations) had a centralised budget for providing reasonable adjustments. The remainder fund these from local departmental budgets, which can lead to difficulties between disabled doctors and budget holders if adjustments require costs. It can also lead to variation in approach between different organisations or departments.

– Only 14% of respondents (23 organisations) had a centralised process for disabled doctors to request and receive adjustments. This is also likely to contribute to unwanted variation in support. Adjustments are instead requested through local managers who may have relatively little training or experience in implementing adjustments for different conditions and disabilities.

Suggested actions/lobbying points:

All Trusts/Health Boards should be encouraged to produce a standalone reasonable adjustments policy. The policy should be developed with input from disabled staff and reviewed on a regular basis, and should include (as a minimum):

- **An employer commitment to the social model of disability and to supporting disabled employees by removing access barriers, tackling discrimination that they face, and implementing best employment practice.**
- **An employer commitment to consider and implement all reasonable adjustment needs within a specified timeframe.**
- **Clear details of how and to whom an employee will be expected to submit a request for adjustments.**
- **An employer commitment to allow the employee to be accompanied by a union representative to any meetings to discuss adjustments, if requested by the employee.**
- **A commitment from the decision-maker to respond to the request in writing within 14 days setting out what has been agreed (including timescales for implementation).**
- **Where an adjustment is not agreed by the decision-maker, a commitment for the employer to explain the rationale for this decision in writing, and details for the process for the employee to challenge this decision, for example under the employer's grievance procedure.**

All new members of staff joining the organisation, for whatever length of time, should be given information on how to access this policy, regardless of whether they have previously disclosed any disability. It is particularly important that this information is available to those on rotational training, locally employed doctors, locums and those on clinical placements.

All Trusts/Health Boards should be encouraged to identify a centralised budget for the provision of reasonable adjustments for disabled staff. This should be accompanied by a centralised process for requesting adjustments, to reduce the requirement for disabled doctors to negotiate individually with line managers to get adjustments agreed. Trusts/Health Boards should ensure that this process is managed by staff with specific understanding of equality legislation in relation to reasonable adjustments and knowledge of support routes such as Access to Work.

Findings by nation

Scotland

Scotland has a 'Once for Scotland' workforce policies programme. The workforce policies have been developed to be used consistently throughout the NHS in Scotland. There should therefore be no local variation from the policies, as these apply to all Boards.

We received responses from 12/14 Boards. NHS Ayrshire and Arran and NHS Forth Valley did not reply, although can be assumed that their responses would be broadly in line with other Boards under the Once for Scotland policy.

Key findings:

- No organisations in Scotland use Bradford Factor Scoring.
- No organisations in Scotland record disability absence separately from sickness absence.
- No organisations in Scotland have a separate disability leave policy.
- No organisations in Scotland offer paid disability leave.
- 50% of respondents (6 organisations) had a disability network, although only 2 organisations had a senior level sponsor for the network and only 4 could confirm whether they had lived experience representation in their network.
- No organisations in Scotland had a paid disability champion/advocate role.
- 25% of respondents (3 organisations) had a separate reasonable adjustments policy. These appear to have been locally developed and do not form part of the core Once for Scotland policy suite.
- No organisations in Scotland had centralised budgets or processes for requesting/implementing adjustments.

Wales

Wales has seven Health Boards/Trusts, all of which responded to the request.

Key findings:

- No organisations in Wales use Bradford Factor Scoring.
- Two out of seven (29%) record disability absence separately from sickness absence.
- No organisations in Wales have a separate disability leave policy.
- Four out of seven (57%) offer paid disability leave.
- 86% of respondents (6 out of 7 organisations) had a disability network and 5 had a senior level sponsor for the network, although only 2 could confirm whether they had lived experience representation in their network.
- No organisations in Wales had a paid disability champion/advocate role.
- Two out of seven (29%) had a separate reasonable adjustments policy.
- No organisations in Wales had centralised budgets or processes for requesting/implementing adjustments.

Northern Ireland

Northern Ireland has five Trusts. Four out of five responded to the request.

Key findings:

- No organisations in Northern Ireland use Bradford Factor Scoring.
- No organisations in Northern Ireland record disability absence separately from sickness absence.
- No organisations in Northern Ireland have a separate disability leave policy.
- Only one organisation (Belfast) offers paid disability leave.
- No organisation had a disability network or a senior level sponsor for disabled doctors, and only one could confirm whether they had lived experience representation in their organisation.
- Only one (Belfast) had a paid disability champion/advocate role.
- Two out of four respondents had a separate reasonable adjustments policy.
- No organisations in Northern Ireland had centralised budgets or processes for requesting/implementing adjustments.

England only

149/198 Trusts in England replied (75%)

Key findings:

- All 17 organisations that still use Bradford Factor scoring are in England.
- Less than a quarter of respondents (23%, 35 organisations) record disability absence separately from sickness absence.
- 34 organisations (23%) have a separate disability leave policy.
- 64 organisations (43%) offer paid disability leave.
- 95% (142 organisations) had a disability network, and 80% (119 organisations) had a senior level sponsor for disabled doctors. 60% (89 organisations) were able to confirm whether they had lived experience representation in their organisation.
- 15 organisations (10%) had a paid disability champion/advocate role.
- 71 organisations (48%) had a separate reasonable adjustments policy.
- 31 organisations (21%) had centralised budgets for requesting/implementing adjustments and 23 organisations (14%) had a centralised process.

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