

A new way forward for disciplinarys



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The ways in which the NHS deals with disciplinary staff problems is a mess: antiquated, costly, legalistic, full of double standards, prone to conscious and unconscious bias, and – on occasions – deadly unfair. Here senior NHS HR director Dean Royles and sacked whistleblower Narinder Kapur join forces to make the case for major reform.

The Problem

Justice, fairness, truth, and compassion are emotional words. The very mention of them demands a response and they are all concepts we have seen working for good, and we have experienced what happens when they are disregarded or abused.

We both have many years' experience in the NHS, are passionate about preserving an institution free at the point of need and often talk up the wonderful things the NHS has achieved for our society. We both know it's not perfect and we have enjoyed debating ways to make the NHS fairer.

One of the areas that has taxed us is disciplinary and capability procedures for staff and for doctors in the NHS. For doctors and dentists, this is known as Maintaining High Professional Standards (MHPS), and is a nationally negotiated policy. For other NHS staff, be they nurses or neuropsychologists, employers are free to draw up their own procedures. There is much we agree on:

- There are clear double standards in the NHS, with one set of policies and procedures that apply to doctors and dentists, and another set of procedures that apply to other NHS staff. This 'apartheid' clearly sows the seeds for justifiable complaints of unfairness.
- Current procedures are antiquated and are now not fit for purpose (MHPS is over 10 years old).
- Neither employers nor employees have confidence in their ability to help resolve concerns quickly and fairly.
- There is a disproportionate impact on BME staff.
- They take too long to get issues resolved.
- Delays impact negatively on doctors, their family, patients and on employers and the public purse.
- The procedures have become damaging to morale and motivation, and have negative effects on trust and confidence between employers and employees.

- They represent an unsatisfactory process for resolving issues in the case of staff raising concerns and whistleblowing.
- They need a significant overhaul.

Although we have different (but often overlapping) solutions to the problems that exist, we both see the urgent need for change. The status quo is untenable with regard to positive employee relations, and without change, concerns and injustice will continue to exacerbate.

It is not fair that there are two separate systems to manage important issues like conduct and capability. It is in the interests of all concerned – NHS employers, NHS staff, patients, the government, the public purse and the reputation of this country in the eyes of the world – for the current system to be subject to a major review and for improvements to be put in place.

A new way forward for disciplinaries: the whistleblower's view



Narinder Kapur

Narinder's Solution

I would like to start with a brief mention of the case of Amin Abdullah. Amin was of Indian origin and grew up in an orphanage in Malaysia. He fulfilled his dream of becoming a nurse in the NHS, and during his training he won an award from the hospital that later employed him.

In Malaysian tradition, he regarded the NHS as part of his 'family'. On February 9, 2016, not long after he qualified and a few weeks after going through a harrowing and drawn-out dismissal procedure, he set himself on fire outside Kensington Palace just days before an appeal hearing against his sacking. He died a slow, agonising death.

Amin was an outstanding nurse but was being disciplined because of the way in which he stood up for a colleague — he was one of 17 NHS staff who signed a petition in support of the colleague when a patient complained, but he was the one singled out for punishment.

Sadly, Amin Abdullah's case is far from an isolated incident. There are numerous other cases, going back as far as the landmark case of Graham Pink in 1990, the nurse sacked after raising concerns, and who wrote of his experiences in his book, *A Time to Speak*.

Health secretary Jeremy Hunt's statement in the House of Commons on March 9 2016 — that a “culture change must also extend to trust disciplinary procedures” — is at long last a clear recognition that there are sometimes major flaws in how staff are treated in the NHS.

Jeremy Hunt's public support for Professor Nadey Hakim, the surgeon unfairly sacked by the same trust as Amin Abdullah, is to be welcomed and admired, but as a newly qualified nurse Amin did not have the financial resources of a senior surgeon with a private practice who could probably afford an expensive legal team – yet another example of disparities in the current system.

In his 2015 report on whistleblowing in the NHS, Sir Robert Francis heard that some disciplinary hearings are little more than one-sided kangaroo courts: “Repeatedly we hear of unaccountable managers protecting themselves and undertaking biased investigations, character assassination, lengthy suspensions, disciplinary hearings which resemble kangaroo courts, and ultimately dismissal of staff who previously had exemplary work records” (p. 162).

Sir Robert Francis also documented staff being driven to consider suicide. There must be something wrong with a system that results in unfair dismissal judgments for a world leading transplant surgeon (Nadey Hakim), a young talented pancreatic consultant surgeon (Aditya Agrawal), and a past-president of a national society (Narinder Kapur), to name but a few recent cases.

There is no requirement for any staff involved in dealing with a dispute to undergo training in conscious or unconscious bias, even though there is ample evidence from a variety of sources, including employment tribunal judgments, that bias is likely to occur in such settings.

Unconscious bias is now widely recognized as a major issue in healthcare, and even in the highest levels of the British justice system (Lord David Neuberger, Head of Supreme Court, 2015).

The NHS spends millions of pounds each year on legal fees relating to ‘problem staff’, and thousands of man-hours of staff time are spent on protracted legal and non-legal proceedings arising from the handling of such staff.

This is money and time that the NHS can scarcely afford in these times of austerity and which could instead be allocated to patient care. Currently, the only beneficiaries are lawyers' bank accounts.

When things go badly wrong for patient safety, there are often extensive efforts to ‘learn lessons’, whether it be a local Root Cause Analysis or external independent inquiries, depending on the seriousness of the incident. There is now even a separate body, the Healthcare Safety Investigation Branch, to investigate major patient safety incidents.

Is it not equally vital to learn lessons when things go badly wrong with regards to how staff are treated? If someone dies as a result of an unfair dismissal decision, should that not be classed as a form of ‘Never Event’? Can we justify one set of standards for patients and another set of standards for staff?

What is needed is a fundamental review of current procedures, something that BME leaders and leading whistleblowers have been repeatedly requesting.

For remedies to this situation, I look to great leaders such as Mahatma Gandhi. Gandhi often pronounced that the problems human beings face, and their solutions, are as old as the hills. For Gandhi, there were two basic truisms to enlightened existence – ‘Truth’ and ‘Love’.

Keeping these ‘basics’ in mind, when dealing with staff who are classed as ‘problems’ the NHS should respect three principles for investigation - Independence, Expertise and Plurality.

Thus, Independence means that an investigatory or disciplinary panel should have members that are independent of the employer, to help prevent conscious and unconscious bias and to prevent kangaroo courts and witch-hunts.

Expertise means that there should be relevant expertise brought to bear, whether it be in the speciality of a staff member under investigation, or more generally expertise in wider issues.

Plurality simply means more than one person on an investigatory or dismissal panel, since at present NHS Trusts are, for example, free to have just a single dismissing officer to decide the fate and livelihood of a member of staff.

When deciding on ‘treatment’ or ‘punishment’, there should be respect for two key principles – Proportionality and Compassion.

Proportionality would take into account the past record of staff, whether patients were harmed, whether wrongdoing was deliberately enacted, whether the person shows insight and remorse if he / she has done wrong, how likely it is that a future similar offence will be committed, how likely it is that remediation would help, etc.

At present, NHS employers are in a difficult position, as they often only have a choice between retaining someone and sacking them. A system that respects proportionality could involve staff losing one, two or three months’ salary for offences categorized in a reformed framework as serious at graduated levels, but not classed as dismissible.

Such a system could also involve having a ‘Two Written Warnings’ rule for some cases that are currently classed as ‘gross misconduct’.

Compassion would involve not only psychological support, but also an ‘Impact Assessment’ of the planned punishment on the individual – family, finances, well-being, etc and would also include support for redeployment.

What is needed is a fundamental review of current procedures, something that BME leaders and leading whistleblowers have been repeatedly requesting. Such a review would gather hard evidence and would sample views from a wide range of sources, including employers, employees, trade unions, employment tribunal judges, the legal profession, MPs, whistleblowers etc.

It would take into account published research related to key issues such as unconscious bias. It would explore why BME staff are over-represented in disciplinary hearings.

It would gather information on financial expenditure and financial controls in relation to staff disputes, and related issues of transparency and accountability. It would look at healthcare models outside the UK for dealing with disciplinary matters.

Such a review would ideally be wide-ranging in its scope, would encompass undergraduate and post-graduate training of NHS staff, and would also seek the views of regulatory bodies such as the General Medical Council, Nursing and Midwifery Council and Health and Care Professions Council, as well as supportive bodies such as the National Clinical Assessment Service, Advisory, Conciliation and Arbitration Service and the Social Partnership Forum. The review could consider proposals such as that for a Staff Support Commission.

One of the key aims of a review would be to put in place mechanisms and procedures to help prevent disputes in the NHS getting out of control to the point that they end up in threatening correspondence, in legal exchanges, in dismissal and appeal hearings, in employment tribunals, or in spurious referrals to regulatory bodies, all of which can prove extremely costly, badly damaging to reputations, and terribly distressing to individuals and their families.

A new way forward for disciplinaries: the HR Director's view



Dean Royles

Dean's solution

Trust between employers and an employee is the basis of a healthy and productive working relationship. This trust has been damaged, sometimes because managers and clinical leaders don't get it right but it is also constantly undermined at national and system level by the vilification and the demonisation of NHS managers.

It appears anything positive in the NHS happens despite managers and anything negative is directly attributed to them. It seems funding decisions, national policy and regulations can only be seen as a force for good by politicians despite evidence to the contrary. Commentators only blame leadership for failure; rarely do they identify a lack of funding as the prime issue.

In this context trust is difficult to build, to maintain and to improve. Poor headlines have resulted in national and political solutions that introduce new 'rules', 'guardians' and 'regulations', all aimed at 'protecting' staff from apparently poor managers.

Maintaining High Professional Standards (MHPS), the disciplinary procedure for doctors, is a case in point. Unlike the disciplinary processes for all other NHS staff, MHPS is mandated nationally.

Hundreds of local employers are required to use a national policy. It's a policy that is negotiated, negotiation has led to compromises and a wordy solution and that has in turn allowed managers and trade unions to interpret its meaning; cue more lawyers, more case law, more complexity, more undermining of trust.

As a result, many NHS HR professionals will privately admit to the abdication of informally trying to resolve issues of capability, conduct and poor behaviour of doctors. The problem gets passed to lawyers. The BMA do the same. This cannot continue. To overcome this we must allow employers to rebuild trust.

All other local disciplinary policies and procedures are developed locally in line with ACAS guidelines and the principles of national justice (they apply to more than a million non-medical staff). We have the local experience to gain trust, to use experts appropriately to train panels in fair processes and unconscious bias and to make compassionate decisions for staff and patients.

When we get it wrong, as we occasionally do, we should be held to account. It's what we get paid for. Undermining local trust through imposed 'independent experts' and inappropriate national rules, more knee jerk regulations and more 'guardians' will only make matters worse.

Managers and leaders are trusted with huge budgets and the recruitment of thousands of staff each month. The healthcare of millions of patients is their responsibility. They should be trusted to manage staff when things go wrong too.

Without trust between employers and employees we inexorably erode the trust between the NHS and patients, and in so doing, undermine the NHS itself.

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