British Journal of Healthcare Management

The organisational harm, economic cost and workforce waste of unnecessary disciplinary investigations

Andrew Cooper and colleagues highlight the harm, cost and waste that can be caused by unnecessary and poorly managed employee investigations and highlights areas that need to be addressed to improve this area of human resources practice.

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How to cite this article:
Cooper A, Rogers J, Phillips C, Neal A, Wu N, McIntosh B. The organisational harm, economic cost and workforce waste of unnecessary disciplinary investigations. British Journal of Healthcare Management. 2024. https://doi.org/10.12968/bjhc.2024.0024

In 2018, over 14 000 staff entered the formal disciplinary process across NHS trusts in England (NHS England, 2019). While this process plays an essential part in managing challenging and complex workplace issues, there are concerns that it is excessively and inappropriately used. At a time when the NHS is facing increased workforce pressures, significant challenges in staff morale and a recruitment and retention crisis, it cannot afford to allow the poor application of human resources policies and processes to cause the waste of both its greatest and most expensive resource: its people.

Over the last 20 years, there has been a major focus on avoiding patient harm (Leape, 2021), eliminating waste (Berwick and Hackbarth, 2012) and addressing variation in care (Noon, 2003). While these efforts have been mainly in relation to the delivery of clinical services, there is an increasing need for a similar focus to be applied to corporate services in healthcare, including the delivery of human resources practice.

The following case study (shared with permission) provides an example of how these processes can go wrong and the severity of the consequences. The individual involved has been given the pseudonym Anne.

Case study

Anne had worked for the NHS since she was 18 years old as a nurse and midwife. Over 37 years, she had held various roles, including managing busy maternity wards and supporting staff as they looked after expectant mothers. She loved her job and was highly committed to caring for others.

Anne had planned to provide many more years of service, but a query over her revalidation, which should have been easily addressed, quickly spiralled into a severely harmful experience. It led to an internal employee investigation and referral to her professional body, in which she was alleged to have committed serious misconduct by failing to follow the correct process for revalidation. This investigation and involvement of her professional body took 15 months to complete.

Eventually, it was concluded that there was no case to answer, and the human resources team at Anne's organisation acknowledged that its formal disciplinary policy should never have been used to address the issue. However, the damage had been done: Anne described how the process and the way she had been treated had made her feel like 'a criminal'. She felt isolated and unsupported by both her organisation and professional body, causing her to experience chronic anxiety at the thought of returning to work, even after the conclusion of the investigation.

While Anne had not intended to take early retirement, she felt that it was her only option. This brought her NHS career to an end in a painful and wasteful manner.

Anne stated:

> **'To this day, I am still not sure what it was all about. I am not sure what I had done wrong or what they were trying to achieve by putting me through the process.'**

Avoiding harm

Anne's case shows the level of harm that individuals can experience through poorly commissioned and managed disciplinary processes. This story is not unique; a significant number of NHS employees are being taken through unnecessary disciplinary processes (Hussain, 2022). Staff under investigation are often left isolated and unsupported (Hussain, 2022) and may face long-term consequences (A Better NHS, 2023). The psychosocial impact cannot be underestimated.

In addition, there is a growing appreciation of the impact that employee investigations have on the staff involved in delivering these procedures (Neal et al, 2023). These individuals can be adversely affected by managing the complex relationships and emotional distress of those involved, and the subsequent impact of the process. There is also potential for wider cultural harm to other staff members who witness how colleagues are being treated. This can undermine their confidence in both the investigation process and the teams that implement them (Hom et al, 2012).

Relationships are fundamental to working life and healthcare teams often have close bonds. Poorly led investigations can lead to a breakdown of trust in leadership and create a culture of fear. Colleagues of the authors who are involved in post-investigation repair have described how these processes can have a ripple effect on the wider team, leading to questions such as 'Am I next?'. A highly punitive culture (whether perceived or evidenced) can threaten psychological safety in an organisation, leading to a wider impact on patient safety and the delivery of care, both in terms of staff capacity and their sense of confidence to challenge unsafe practice and behaviour (O'Donovan et al, 2021).

Drawing on learning from the patient safety movement, the concept of 'avoidable employee harm' (Jones et al, 2023) was developed to highlight the impact of processes that could cause unnecessary harm on those being taken through them. It used the employee investigation process to illustrate its' working definition:

> **'Where harm occurs to employees because of an identifiable and modifiable workplace cause, the future recurrence of which is avoidable by reasonable adaptation, subsequent adherence to and thoughtful implementation of a workplace process or policy.' (Jones et al, 2023).**

Eliminating waste

The negative experiences of staff under investigation are driving a major change in NHS Wales, with a new approach to how employee investigations are commissioned and delivered. Thus far, a pilot programme developed in one NHS Wales organisation has led to a 71% reduction in the number of avoidable investigations commissioned (Rowsell, 2024). While the moral case for change is clear, the level of waste involved in the poor application of human resources processes is equally compelling. The case study describing Anne's story covers waste on a number of levels, including:

- Financial and economic
- The unfulfilled value of an individual's training and experience
- Missed opportunity to learn and develop the organisation to prevent similar situations
- Wider human potential.

Financial waste is often the most straightforward type of waste to calculate in these situations. This includes lost work days, related backfill arrangements and potential legal and settlement costs (Kline, 2017). The aforementioned NHS Wales' pilot study estimated potential savings of over £700 000 per year by avoiding unnecessary investigations (Rowsell, 2024). However, the economic impact and missed opportunities to deliver on core business goals as a result of management and corporate services running unnecessary processes is more challenging to estimate, but is likely significant (Phillips, 2023).

The loss of an employee with substantial skills and experience at an organisation cannot be underestimated. Accumulated knowledge, insight and appreciation of how a system operates can take years to recover. In the case study, it was noted that Anne had intended to provide many more years of service, had it not been for the poor decision to start an unnecessary

formal process. The NHS depends on the discretionary effort of its workforce going the extra mile, driven by a commitment to and passion for patients. Poorly managed human resources processes can lead to these efforts being lost, both directly from those who leave, and indirectly from those who remain and feel disillusioned by the actions of their organisation.

Organisations often fail to reflect, learn and change practice after a situation like the one experienced by Anne (Kaur et al, 2019). A desire to move on quickly and a focus on other priorities prevent organisations from fully understanding the cost to the system and wider staff, and identifying and making changes to avoid similar situations in the future (Creel et al, 2021).

The waste of human potential from situations such as Anne's is seldom considered. Instead of a positive departure from the NHS into retirement, Anne left early, feeling rejected and valueless. Individuals may need many years to recover from experiences such as these, depriving them, their family, friends and wider communities of the value and contribution they make beyond the workplace.

Addressing variation

One of the major issues with the application of the disciplinary process is the variation that exists both between and within organisations (Mannion and Davies, 2018). These variations can occur between different functions, professions and individual managers; some may be influenced by new approaches to managing and supporting employees through these processes, while others may not.

Through work to drive forward a change in approach to the investigation processes in NHS Wales, the authors have observed three main areas of variation that have a substantial impact on the outcome:

Inconsistency in the application of the disciplinary policy

The actual disciplinary policy is seldom the problem – it is the way in which it is applied that causes the harm and waste. These processes are rarely delivered in a cultural vacuum, so it crucial to understand the way in which an organisation manages error, and whether it focuses on taking a learning approach as opposed to a punitive one. The authors believe that organisations need to ensure they have a clear set of guidelines for their managers, highlighting the importance of thorough information gathering and the process for decision making. They must also champion a 'last resort' approach to disciplinary processes, wherever possible.

Inconsistency in the support provided to those being taken through an investigation process

The failure to provide an adequate duty of care to employees who find themselves in this process must be addressed with urgency. The authors' believe that support should be underpinned with an understanding and appreciation of the psychosocial impact and the needs of the individual at the different stages of the investigation, considering pre-existing vulnerabilities. The person's individual risk should be assessed and acted on appropriately.

Failure to provide support to those leading investigations

In the authors' experience, colleagues often comment on the challenge of running complex and emotionally charged investigation processes alongside their existing responsibilities. This can lead to processes taking far longer than they need to, extending the distress for those involved and increasing waste to the system. The failure to understand and mitigate the psychological demands of this work can also have a negative impact on the investigators, contributing to occupational burnout, moral distress and maladaptive coping behaviours, such as bias, withdrawal of empathy and externalisation.

Too high a cost

The cost of getting these human resources processes wrong is too high, impacting the workforce, organisational culture and potentially the patients and communities that the

NHS seeks to serve. In an era of resource constraints – particularly in relation to the workforce – the attractiveness of an organisation's culture and commitment to employee wellbeing (demonstrated through the application of its policies and processes) can have a substantial impact on its recruitment potential and ability to retain staff (Teoh et al, 2023), making it much more than just an issue for human resources.

However, human resources staff can play a major role in providing greater clarity on the best option to take when addressing workplace issues and ensure that less formal approaches are considered wherever possible, only proceeding with the execution of formal policies and processes as a last resort. There also needs to be greater recognition that simply following a policy is not enough to avert harm to those involved in these processes; wrap-around support can play a large part in reducing the negative effects, as well as enabling successful restoration and reintegration into an organisation following a process that has not led to dismissal.

For further information about the programme to improve employee investigations in NHS Wales, readers are directed to: http://bit.ly/NHS-Wales-employee-investigations.

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