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Review Article

Kafka Lives: Consideration of Psychological Wellbeing on Staff under Investigation Procedures in the NHS

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Abstract: Culture change in the UK National Health Service (NHS) became a national concern following the Francis enquiry (2013) with increasing initiatives to develop models of compassionate management. This call was intended to create an environment to address investigations in the best possible manner creating a nurturing environment for staff and in turn their patients; a truly no-blame culture. Whilst principles of justice and compassionate are intended to underpin staff investigations, our clinical experience at the coal-face in working with Staff under Investigation (SUI) has proved that this is (too often) not the case. SUI often find they have little information about the complaint against them, little communication to clarify and await the outcome in general isolation from organisational or team access, until they are invited to the attend and explain their position. The resultant anxiety and distress mean that they are left traumatised by the investigation procedure itself. This brief paper aims to highlight the avoidable stressors caused by investigation procedures in the UK NHS themselves and aims to highlights aspects of these polices which require greater attention. This in turn would support a beneficial outcome for the investigation procedures overall. Whilst focusing on the UK, the generic processes of investigation have a number of commonalities which allow this information to be applicable to a range of health care services and investigation procedures.

Keywords: Culture, National Health Service (NHS), environment.

INTRODUCTION

He that would keep a secret must keep it secret that he hath a secret to keep (Sir Humphrey Appleby – Yes Prime Minister written by Jonathan Lynn)

Culture change in the NHS became a national concern following the public enquiry of professional misconduct in mid -Staffordshire (The Francis Report, 2013). Subsequent policies aimed to validate challenging staff experiences and contextualise them within deeper NHS culture acknowledging the fluctuating relationship between patient experience of care and staff experience of clinical delivery. Whilst those investigations came from concerns around professional misconduct – they recognised that the treatment of staff was part of the problem with the report drawing attention to the widespread (often misplaced) expectations upon staff and the impact that this had on clinical delivery and service outcome (Health Foundation, 2014; Health Education England, 2019)

The growing call for a model of compassionate management and the introduction of principles such as 6 C's; care, compassion, competence, communication, courage and commitment - intended for staff and patients alike have been intended to underpin all subsequent processes with implementation intended to become an integral part of generic healthcare policy (Cummings and Bennet, 2021, West, 2019)

West (2019) makes the point that compassionate management does not equate to an absence of personal responsibility, nor does it mean replacing professional standards for endless understanding to the point where implementing organisational policy becomes prohibitive. It is about creating an environment to address challenges in the best possible manner and ensure that the resultant experiences enable staff to grow; this in turn creating a nurturing environment for their patients. It is about making a painful process as painless as possible with the focus on *productivity not punishment*. Compassionate management does not excuse or exclude poor behaviours be it as a result of individual differences and behaviour or concerns regarding professional competence but aims to work with those very factors which we know influence attempts at changing attitudes and behaviour. A truly no-blame culture.

In spite of the recognition of the complexity of this situation, the shift to compassionate culture has often been perceived by staff to stem from and focus largely on healthcare service outcomes with little sense of a genuine concern for staff as individuals.

Clinical experiences of working within a therapeutic context with Staff Under Investigation (SUI) suggest that the experience of staff is incongruous with these good intentions and SUI often find themselves under extreme pressure and distress as well as, confusion, shame, social and emotional isolation and trauma simply *as a result* of the investigative procedures extending well beyond the end of the investigation.

As Sir Humphrey observes in the opening quote, the process of investigations is shrouded in secrecy. Intended to protect the individuals involved, details of complaints are restricted and those under investigation are often unaware there has been a complaint filed until they are subject, quite without warning, to formal procedures.

With little warning, SUI find themselves in a Kafkaesque situation where they are sent home, restricted from contact with workmates with little information as to why and advised to wait 'in the dark' until they are contacted and advised of the allegations against them. The impact of this in the mental health of those SUI is obvious.

This brief paper is the result of working as a therapist with NHS staff, across levels of seniority, undergoing formal investigation. The clinical work referred to is offered under generic staff support services and is not part of the formal SUI protocol. The paper aims to highlight the common stressors identified by SUI and raises questions around implementation of staff investigation policies and the related apparent absence of attention given to the wellbeing of SUI.

Current investigation procedure

The purpose of an internal investigation is clear: to obtain an impartial view of the facts and answer fundamental questions; what happened? When did it happen? What was said or done and by whom? Who witnessed the events? Was the SUI advised they or their behaviour was problematic and if not why? Has the event been discussed with anyone? What is the personal impact? Who is responsible? Did the event contravene local / national policy? What actions need to be taken to prevents a re-occurrence?

The fundamental aim is to ensure that the investigation is carried out within the boundaries and principles of local ‘just and compassionate’ frameworks, working towards a balance of ensuring that the investigation *primarily* establishes facts upon which to form a conclusion as opposed to finding facts that confirm a pre-existing judgement/ complaint.

The benefits of any staff investigation process centres on both actively identifying and managing staff concerns proactively as well as demonstrating adherence to ethics and a preservation of professional standards. The absence of such processes increases risk at a number of personal and professional levels, such as victimisation, impact on mental health, avoidable litigation as well as increased disillusionment with the professional role and subsequent resignations (Chaffer et al, 2019 Also Practitioner Health links – see refs).

Investigations generally involve two stages which vary slightly at a local level; Actions prior to investigation and investigation procedures themselves.

Stage 1-Action prior to investigation involves:

- Confirming whether the process will be informal or formal
- Suspension of SUI or not as related to a process of risk etc.
- SUI is then advised on a meeting of the potential investigation and within 48hours *should ideally* be provided with a reason for the complaint (less details).

Stage 2-Investigation procedures:

- Collection of verbal and written information (including emails) from the complainant, the SUI, witnesses as well managers (team and organisational) and trade union members as required.
- SUI advised of details
- Any counter grievance to the original investigation is also - as above.

As issues are categorised into broad categories of Grievance, Disciplinary or Prevention of bullying/ harassment time frames may vary between 10 to a maximum time frame of 30 days for Grievances investigations to be completed.

It is important to note that at a local policy level, employee wellbeing during the process comes with its own frame of reference and assurance. The focus of the well-being assessment ascertains the extent to which the SUI is able to continue their role and has access to support i.e., a primary focus on returning to work as opposed to emotional wellbeing. These protocols may differ for those SUI who are suspended.

What is of note is that there is no mention of specific considerations given to managing and supporting staff well-being. This in itself is of concern and implies that any emotional consequences of this procedure for the SUI are de minimis with no quarter given to their distress, rather focusing on the complainant and the investigation protocols. Furthermore, we see an absence of any follow up action and support for the SUI post investigation and their reintegration into their workplace- which often comes with its own challenges.

On reflection then, whilst there are a range of investigation guidelines which set up a structure for the investigations there is an apparent lack of consideration given to the wellbeing of SUI– pre- during and post investigation, leaving the burden of responsibility of that care of be raised by the SUI themselves whilst they are being investigated.

Impact of staff investigations on the Staff member under investigation

In spite of compassionate culture initiatives in trusts across the country, it is unclear what and how many SUI actually experience this during their investigations with no specific figures available.

The literature in this area reveals a surprising absence of relevant research. Overall focus appears to centre on initiatives around general well-being of NHS staff, identification of emotional impact of working in healthcare professions, management of both staff and patient safety complaints and improvements on investigation procedures for patient safety only. Topic specific information suggests no research studies and offers only a handful of (contextual) commentaries and personal opinion articles; this itself indicating the lack of attention given to this is and so awareness of the problem.

In considering the relevance of available research there are a number of commonalities which may shed light on the experiences of SUI in general terms.

In an early comment in the BMJ, Pinnock (2004) observed that poor communication by healthcare staff was at the heart of patient problems within the NHS. He cited issues such as poor handling of complaints as well as a lack or absence of liaising between services as contributing to the problem.

Ryan (2019) on reflecting on her experiences of raising a complaint *against* the NHS points out that *"the assumption of catharsis is misplaced and works to erase the considerable emotional 'accountability' labour that families undertake during these processes {questioning} whether such investigations are an effective way of holding stakeholders to account"* p224. This raises the importance of the question of accountability of investigators regarding implementation of procedures albeit, in this case, around patient safety.

Similarly, a more recent commentary in the BMJ (Iacobucci, 2019) highlighted how investigations around patient safety would now prioritise cases that allowed the best learning opportunity, which in turn would mean investigating teams are *"no longer asked to judge 'avoidability,' predictability, liability, fitness to practise or cause of death."* This was important in that it did appear to acknowledge the more negative outcomes of investigation procedures. However, the initiative focuses on practical not emotional management – though of course, the two would not be mutually exclusive.

A poignant opinion piece by Kapur (2020) describes both his own experience and that of staff nurse Amin who supported a colleague under (whistleblowing) investigations. He highlights the extreme end of the investigation procedure, where staff were not only absented from any support system but actively targeted because of being under investigation. He alluded to the NHS LT plans admission of not valuing staff contributions and being unable

to ensure fair treatment and respect. He added that for doctors specifically, mental distress to the point of suicidal ideation and action is present for this SUI. The unfortunate irony here was in both cases - both Kapur and nurse Amin were awarded for excellence in their professional service (http://www.abetternhs.com/).

We see then that the issues of poor communication and unclear lines of accountability for the emotional impact of procedures as well as problematic wider system issues all apply to the context of staff investigations and the personal experiences of SUI.

Emotional impact of SUI

In working therapeutically with SUI, our clinical practice-based evidence suggests that the main form of support available is personal action by the SUI and not through any formal request by the investigating team. There is a reliance on friends and family and generic staff support services to share their concerns – most of whom remain as unclear about the implementation style of investigations as the SUI themselves.

The authors direct therapeutic work with SUI under generic support services suggests that SUI face feelings of heightened anxiety, distress, confusion, mistrust and betrayal as well as trauma and depression. The space / time delay between intention and action i.e., being 'sent home' and being advised of allegations is one of extreme distress with no option to access clarity with many SUI reporting that emails from investigating teams/ managers either offered cryptic or no clear information at all with some staff reporting it a common experience for their enquiries (via phone-call or email) to remain unanswered. During the waiting period then it is understandable that SUI report experiencing additional problems such as a lack of concentration, an inability to sleep or complete their daily routine with consequences for the individual as well as their families. Additionally, post investigation SUI can be left with an increased sense of disillusionment and despair around justice and fairness which can lead to long term impact on their sense of emotional safety and containment in general as well as having practical implications regarding their return to work.

What is of greatest concern is that the *emotions are a direct reaction to the process and style of implementation* rather than the complaint itself.

Increasing our understanding of the issues facing SUI

Given the authors experiences of working to support SUI, there are a number of common themes which arise from therapy which raise issues at both a systemic and individual level:

Consideration of systemic issues facing SUI

- There appears a *lack of distinction between concepts of discretion, privacy and isolation*. This may go some way to explaining the lack of action taken to support SUI, with an assumption that the secrecy protects both parties though by virtue of their position in the investigation this clearly cannot be the case.
- An apparent *lack of attention to the more nuanced aspects of procedure itself* means that there is an arguably disproportionate response to incident reporting with one procedure covering all variety of complaints. As such SUI can feel the same level of threat and distress for a misunderstood remark to professional incompetence.
- There appears to *be an absence of consideration given to the role of behavioural/ attitude change.* If the aim of investigations is to encourage staff to take responsibility in recognising and changing their behaviour then necessarily, the process cannot be isolated from outcome. SUI are often left disillusioned not only about their profession but also a sense of being unjustly treated. Neither of these fulfils the intended aim of an investigation and at the very least is likely to result in a) No change in attitude b) increased negativity towards good intentions of systems
- There appears to be *a gap between values and their actualisation*. The experiences of SUI suggest that there is no accountability as to *implementation* of values of just and compassionate management. This raises questions as to the function of those values, especially if their implementation is not monitored in cases where they are most needed.

All of the above suggest that *if support systems are not overseen or uncoordinated along the issues raised* then that itself is of concern. In such cases, where little/ no consideration is given to the negative impact of staff investigations upon the mental health (both short and long term) of SUI, current local procedures demonstrate a focus on the complainant without ensuring the equity of due process. Understandably this can leave SUI feeling they have been found 'guilty before trial' with the emphasis on having to prove one's innocence.

Questions to consider about policy implementation

Following are a number of questions posed in order to reflect on how current implementation of investigation policies may more readily incorporate values of justice and compassion whilst continuing to uphold professional standards.

- Is the response to all complaints proportional to the complaint? If so, what are the assumption behind that decision and how does the uniformity impact on the psychological well-being of SUI?
- Are there differences in instruction following the formalisation of a complaint for the complainant and the SUI? If so, then what is the reasoning behind this and what does this suggest in terms of values of just and compassionate culture?
- Do investigation teams consider the optics of protocols from the perspective of the SUI? If so what messages does the system give to the SUI about their position in the investigation?
- What is the frequency of the communication between the investigation team and the SUI regarding progress update? Who initiates this and how often?
- What support is available to staff upon reintegration to their teams or indeed those staff, who as a result of being under investigation, decide to terminate their contract?
- Accepting the complexity of the situation, is the process audited overall as with other aspects of healthcare?

The questions may in some cases confirm existing procedure is successful. Where the answers do raise concerns, this creates an opportunity to address gaps in protocol implementation and actualise values of compassionate management thus creating a more robust model of investigation, facilitating clarity and awareness for all involved.

CONCLUSION

Staff investigation procedures are a necessary part of good health care. Whilst the investigations are advised to be carried out with compassion, the experience of staff at the coal face remains concerning - many of whom experience distress caused not by the action or accusation but primarily the implementation of the procedure itself. Greater consideration needs to be given to avoidable harm manifest in these investigations in order to reduce the negative impact of investigations but ultimately to create a healthier work environment for staff and patients alike.

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