We have facilitated a number of sessions on ‘Improving People Practice’ with people working in HR in the NHS. This paper sets out a summary of the discussions and ideas around the practical implementation of the recommendations set out in the letter from Baroness Dido Harding dated 24 May 2019.

The detail below sets out the key points of discussion against each of the seven recommendations in that letter. There is no “one size fits all” approach and different ideas will work for different organisations. Similarly, some of the ideas could face practical problems in implementation. However, we hope that the paper provides a useful guide for those who are focusing on how to implement the recommendations.

1. Adhering to best practice

Local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally the ACAS ‘code of practice on disciplinary and grievance procedures’ and other non-statutory ACAS guidance; the GMC’s ‘principles of a good investigation’; and the NMC’s ‘best practice guidance on local investigations’.

Fact finding and checklists

- Understand the current culture within an organisation using employee relations data in order to establish where to target efforts.
- “Fact-find” gateways could be established before moving to a formal process: an initial look at the evidence to establish whether or not there is a concern to take forward formally.
- Scrutiny of fact finding could be by a senior manager, executive or Non-Executive Director review. Alternatively, there could be a decision-making group (DMG) comprising senior managers to verify decisions to move to formal processes.
- Language is important – is any initial investigation a ‘fact find’, an ‘initial enquiry’ or a ‘review process’? If there is a grievance, does an ‘informal’ process suggest to the employee that concerns are not being taken seriously?
- There is a need to ensure that independence and objectivity are maintained. Consider if there is any actual or potential conflict of interest at the start of the process for anyone involved. Do you incorporate it into a checklist? Plan in advance who will be involved in the process – but not too far down the line or it may be suggested that you are pre-judging outcomes.
- Consider whether ‘just culture’ be implemented as a separate policy or embedded in other policies? What fits best with your organisation?

Formal process

- Think about whether it is appropriate for formal processes to be kept in the same line management/division or should it move outside department (either invariably or in specific cases)?
- HR have a role in any review/DMG process, not as decision makers but in ensuring that there is consistency by decision makers.

Investigators

- Ensure there is a diverse bank of investigators and panels to reflect the diversity of the organisation. Think about how you can achieve this.
- Use external investigators where appropriate, particularly with high-profile or complex cases. Can you set up links with local Trusts to have a network of investigators available or develop an in-house investigation function in order to reduce the time which is spent investigating matters?
- Implement formal training for investigators.
Reviews
• Consider at what stage processes are reviewed: at the very start and if a decision is made to go to a hearing? At each stage make sure that reviewers are looking at nuance and bias.
• Anyone who is reviewing a process should be senior enough or independent so that they are able to stop a process because of their concerns.
• Establish checks and diary reminders are in place to ensure that regular communications with staff involved are taking place.
• Consider whether regular internal HR reviews or a ‘time out’ approach would ensure independent peer review – especially in long running cases where there is a risk of positions becoming entrenched.
• Introduce debriefings following complex investigation processes for team learning.
• Where someone is returning to work, consider the steps which are put in place to support the individual.

Culture
• Speak to ED&I groups and look at WRES data to understand the culture within an organisation in respect of disciplinary matters.
• Where the current approach to disciplinary matters needs to change, ensure you have case studies and evidence from other organisations regarding the benefits of this new approach.

2. Applying a rigorous decision-making methodology

Recognise that formal management is not always necessary or appropriate and that a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

The principle of plurality should be adopted - important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

Decision Management Group and panels
• Do you have a DMG as a sense-check? Many Trusts already use that approach for doctors so should it be extended?
• How do you ensure diversity in the DMG and keep the caseload manageable?
• Do you ensure your policy provides for any decision relating to sanction is made by a panel rather than by one person alone? This has significant advantages but may, potentially, delay the hearing (an extra diary to coordinate) and take up further management resource.
• How do you ensure the panel is well informed?
  − HR support for panel to advise on policy and best practice
  − External advice where appropriate e.g. clinical / financial matters which are outside the hearing officer’s expertise?

Template decision making document
• Consider whether it is beneficial to develop a template decision making document and/or a risk assessment matrix?
  − Ensure you have a written record to justify decision
  − Use questions from NHS Improvement / NHS Resolution guidance:
  − Repeat at the end of the investigation to assist decision-making on whether to move to hearing stage
  − Repeat at the end of the hearing to ensure continuous learning
  − Prompt questions such as – is there even a case to answer?

Review
• Consider how to ensure a “helicopter view” rather than a view from those deeply involved in the case already.
• HR have an important part to play in ensuring consistency.
• After the event, have a lessons learned session.

3. Ensuring people are fully trained and competent

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

• Instigate training for all case managers, investigators and panels on the essential aspects of an investigation to ensure the report is robust, impartial and stands up to scrutiny.
• Training for case managers, investigators and panels should also deal with preconceived ideas and unconscious bias, on just culture and empowering managers to make decisions and feel comfortable with this.
• Emphasise the need for objectivity throughout the process.
• Involve staff groups in designing the training and the new approach to decision making.
• Develop training options such as podcasts, webinars and peer review.
• HR must have the courage to challenge if they consider that individuals are not suitable for roles or if poor decisions are being made.
• Introduce informal ‘courageous conversations’ training so that managers feel able to have informal conversations much earlier on.
• It is an easy issue for CQC to check this as part of well led assessment, so need to collate this information to satisfy CQC.
4. Assigning sufficient resources

Before commencing investigation and disciplinary processes, ensure that those with specific responsibilities are provided with the resources they will need. Consider the independence of those charged with such responsibilities (especially members of disciplinary panels).

**Investigations**

- Do you ask HR to carry out investigations, have a dedicated standalone team or ask managers to carry out investigations with HR providing support? Where you are relying on managers, whilst HR must give robust advice on policy and practice, managers must take responsibility for their decisions at each stage of the process.
- Allow time for investigations by reviewing the workload of the investigator. Delay is a key concern in any Tribunal process so this investment up front can pay dividends.
- Do you ensure that time spent on investigations is protected so individuals feel they can carry out the job properly. Do you ensure that there is backfill to provide cover?
- Do you have specific note takers in meetings in order to produce the most comprehensive notes possible? Alternatively, has consideration been given to recording meetings?

**Support**

- Consider ensuring that the individual involved has a buddy/mentor – link to an individual/organisation not involved in the process to whom the individual can speak to and be supported by. However, is that role properly defined? Will the employee under investigation (or the mentor/buddy) see the role differently and start to treat it as an advocate/counsellor role?

**Panels**

- Ensure sufficient technical experts on panels.

**Momentum**

- Is an executive/NED lead needed to ensure that momentum is maintained?
- Consider booking in the hearing date at the start of the process and ensure everybody works towards it. Ensure that dates are checked on a regular basis and decide who is responsible for this? Perhaps more than one person to ensure that nothing is missed.

5. Decisions relating to implementation of suspensions or exclusion

A decision to suspend/exclude an individual should not be taken by one person alone and except where immediate safety or security issues prevail, should be a measure of last resort that is proportionate, time bound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

- Do you have a risk assessment template or decision tree?
- Is a senior manager involved in each case? Is there oversight by a director? Should you have a DMG for suspensions?
- What can you do to keep the person in work? Consider restrictions instead of suspension: suspension must be last resort.
- Should you have executive approval for each suspension – consider when executives get involved and how regularly? Consider what level of information is provided to the Board, as you may need to reserve managers for subsequent hearings/appeals – you do not want to expose them to risk of allegation of bias because of the level of detail to which they have been exposed at Board.
- Consider how you communicate suspension to the individual and the rest of the team.
- Regular review – suspension must be time bound and should be actively lifted if no longer applicable. Is this done as part of a case conference? If so, who should be involved in that – investigator or case manager?
- Do you have a buddy/mentor outside of the process to support the employee involved and act as their contact during suspension?
- Keep in regular contact with the individual.

6. Safeguarding people’s health and wellbeing

Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed with professional occupational health assessments for those requiring support.

Establish a communication plan with people who are the subject of an investigation or disciplinary procedure, forming part of the associated terms of reference. Communication should be timely; comprehensive; unambiguous; sensitive; and compassionate.

Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a ‘never event’ which, therefore, is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

- Assess the systems which are currently in place.
- Do you offer Occupational Health and staff counselling to those undergoing formal processes? Is this followed up appropriately or do you fulfil your duty by simply putting it in a letter?
- Do you have a buddy/mentor outside of the process to support the employee involved?
- Appreciate the impact on individuals, but not only the individual who is the subject of disciplinary action. Support may also be required by investigators, witnesses or those on a panel.
• Are managers trained to read the signs that an individual needs further support?
• Do you need a communication plan for the rest of the team in terms of specific cases? How do you do this in the context of having to keep the process confidential? Can you agree wording with the employee under investigation?
• Do you need a communication plan with the individual to ensure that they are kept regularly up to date with progress? Ensure that those under investigation do not simply sit at home with no idea of what is happening.
• The letter requires a review of process where the employee has suffered serious mental or physical harm as a result. When do you assess this – during or at the end of the process? Do you undertake a “never event” type of investigation? Whatever is put in place needs to be robust and you need systems for checking that this recommendation is being addressed.
• At the end of the process, a debrief session may be useful for all those involved.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at Board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process, justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

• It is essential to raise awareness at Board level.
• Comprehensive data should be provided to the Board, for example:
  – Number of procedures
  – Reasons for those procedures (can be high level, for example conduct/capability)
  – Adherence to process (confirmation that process has been followed)
  – Justification for any suspensions/exclusions (set out the process that has been followed, e.g. is the DMG/risk assessment complete?)
  – Decision making relating to outcomes (have issues been upheld)
  – Impact on patient care and employees (highlight any concerns regarding wider impact)
  – Employment Tribunal case work
  – Lessons learned (to ensure that any recommendations or wider learning points are taken forward – often an area that is overlooked)
• Use of spreadsheet format – live document to be updated regularly.
• Consider whether this needs to be full Board/Board sub-committee to ensure appropriate oversight.

• Need to be cautious of level of detail provided in order to be GDPR compliant and to ensure Board is kept ‘clean’ in case they are involved in any subsequent process? However, balance with need to satisfy Board that appropriate processes have been followed.
• The information could be anonymised – not provide name/location of member of staff involved.
• This is a key area that be examined as part of a CQC well-led assessment.

Contact

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